

Prepared for

Office of Population
Bureau for Science and Technology
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024
and USAID/Islamabad
under PIO/T No. 391-0469-3-60341

PD-ABC-908

72076

**FINAL EVALUATION
OF THE PAKISTAN
POPULATION WELFARE
PLANNING PROJECT
No. 391-0469**

by

**John McWilliam
Evelyn Bazalgette
Mario Jaramillo
Benjamin Lozare**

**Fieldwork
May 4 - May 30, 1990**

Edited and Produced by

**Population Technical Assistance Project
DUAL & Associates, Inc. and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271**

**Report No. 89-072-113
Published April 15, 1991**

TABLE OF CONTENTS

GLOSSARY	v
ACKNOWLEDGMENTS	vii
EXECUTIVE SUMMARY	ix
1. INTRODUCTION	1
1.1 Purpose of the Evaluation	1
1.2 The Overall Population Welfare Plan	1
1.3 The PWP Project	2
1.4 The Evaluation Report	2
2. CONTRACEPTIVE USE AND ASSESSMENT OF PROGRAM EFFORTS	5
2.1 Trends in Contraceptive Prevalence	5
2.2 Contraceptive Method Mix according to Surveys	6
2.3 Assessment of Program Performance	7
3. CONTRACEPTIVE SUPPLIES AND LOGISTICS	13
3.1 USAID's Input in Contraceptive Commodities	13
3.2 Procurement of Contraceptives	17
3.3 Commodity Storage	18
3.4 Commodity Distribution System	19
3.5 Monitoring and Service Statistics	19
3.6 Dependence on Donated Supplies	20
4. VOLUNTARY SURGICAL CONTRACEPTION (VSC)	23
4.1 Government VSC Activities	23
4.2 NGO VSC Program	25
4.3 Outputs of Overall VSC Program	25
4.4 Issues of Concern with VSC	30
5. NON-GOVERNMENTAL ORGANIZATION ACTIVITIES	35
5.1 Background	35
5.2 Objectives of the NGO Project	36
5.3 USAID Inputs	36
5.4 Project Outputs	36
5.5 Issues of Concern	41

6.	EFFORTS TO IMPROVE DISTRICT OPERATIONS: THE FAMILY PLANNING INPUTS INTO THE HEALTH PROGRAM	45
6.1	Background	45
6.2	USAID Inputs	46
6.3	Project Outputs	46
6.4	An Issue of Concern	46
7.	IEC ACTIVITIES	49
7.1	Component Design and Objectives	49
7.2	USAID Inputs	49
7.3	Project Outputs	50
7.4	Impact	50
7.5	Issues of Concern	51
8.	INSTITUTIONAL DEVELOPMENT IN DEMOGRAPHIC, SOCIOMEDICAL, AND MEDICAL RESEARCH	55
8.1	National Institute of Population Studies (NIPS)	55
8.2	National Research Institute of Fertility Control (NRIFC)	60
8.3	National Research Institute for Reproductive Physiology (NRIRP)	62
8.4	Reasons for Differences in Development of NIPS, NRIFC, and NRIRP	63
9.	TRAINING	65
9.1	Objectives	65
9.2	USAID Inputs	65
9.3	Project Outputs	65
9.4	Issues of Concern	66
10.	LESSONS LEARNED	69
11.	MAJOR CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE DIRECTIONS	71
11.1	Major Conclusions	71
11.2	Long-term Recommendations for Government Consideration	73
11.3	Long-term Recommendations for USAID Consideration	75

List of Tables

Table 1	Original and Amended Project Components and Summary Costs	3
Table 2.1	Selected Targets of Five Year Plans	5
Table 2.2	Assessment of Program Performance from 1985 to 1989 in Crude CYPs	8
Table 2.3	Average Targets and Performance in Crude CYPs per Day in December 1989	9
Table 2.4	RHS-As: Productivity in Terms of Crude CYPs per Day Based on Targets and Performance during December, 1989	10
Table 3.1	Estimates of Contraceptive Use, 1982-1987	13
Table 3.2	Contraceptive Needs Projections, Project Amendment, 1985	13
Table 3.3	Consumption of Contraceptives within the PWP from 1986 to 1989	14
Table 3.4	Contraceptives Supplied by the Population Welfare Planning Project from March 1982 to date	14
Table 3.5	Expenditures and Unexpended Balance for Logistics Component, March 31, 1990	17
Table 4.1	VSC Procedures of the Population Welfare Program 1985-1989	26
Table 4.2	Number of Acceptors of Family Planning Methods at Reproductive Health Service A and B Centers 1985-1989	27
Table 4.3	Number of Acceptors of Family Planning Methods from the NGO Sector, Supported by AVSC and the Family Planning Association of Pakistan, through VSC Service Centers Part 1: Sterilization	28
	Part 2: Reversible Methods	29
Table 5.1	NGOCC Outlets Compared to June 1990 Targets by Province and Type of Outlet	37
Table 5.2	Increase in Family Welfare/Family Health Centers, According to Source of Funding and Year	38
Table 5.3	Comparative Statement of Birth Aversions through NGOCC Outlets: Targets and Achievements 1984 to December 1989	39

List of Figures

Figure 1	Shipment of Condoms to Pakistan by Quarter, from 1983 to 1990	15
Figure 2	Shipments of Orals to Pakistan by Quarter, from 1982 to 1989	16
Figure 3	Shipments of Copper T IUDs to Pakistan by Quarter, from 1985 to 1989	16

List of Appendices

Appendix A	Scope of Work
Appendix B	Sites Visited
Appendix C	List of Documents Consulted
Appendix D	Recommendations
Appendix E	Analysis of Productivity of Service Points
Appendix F	Projections of Contraceptive Needs
Appendix G	Additional Comments on the PWD's IEC Program

GLOSSARY

ADP	Annual Development Plan
A.I.D.	U.S. Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
CBD	Community-based distribution
CBR	Crude birth rate
CEDPA	Centre for Development and Population Activities
CPR	Contraceptive prevalence rate
CPT	Contraceptive Procurement Table
CYP	Couple year of protection
FHC	Family Health Center
FPAP	Family Planning Association of Pakistan
FPIA	Family Planning International Assistance
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWW	Family Welfare Worker
HPN	Health, population and nutrition
IEC	Information, education, and communication
IUD	Intrauterine device
JHU/PCS	Johns Hopkins University/Population Communication Services
MCH	Maternal and child health
MOH	Ministry of Health
MSU	Mobile service unit
MWRA	Married women of reproductive age
NGO	Non-governmental organization
NGOCC	Non-governmental Organization Coordinating Council
NIH	National Institutes of Health
NIPS	National Institute of Population Studies
NORPLANT®	A method of contraception which releases the synthetic hormone levonorgestrel through capsules inserted beneath the skin of the upper arm
NRIFC	National Research Institute of Fertility Contraception
NRIRP	National Research Institute for Reproductive Physiology
NWFP	Northwestern Frontier Province
PWD	Population Welfare Division
PWP	Population Welfare Planning Project
RHS	Reproductive Health Service Center
Rs.	Rupees (Pakistan unit of currency)
RTI	Regional Training Institute
SMC	Social Marketing of Contraceptives (project)
TAF	The Asia Foundation
TGI	Target Group Institutions
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development (mission)
VSC	Voluntary surgical contraception

ACKNOWLEDGMENTS

The evaluation team would like to express its appreciation to USAID/Pakistan and the Population Welfare Division of the Government of Pakistan for being invited to undertake the final evaluation of the Population Welfare Planning project. The team hopes that the findings, conclusions, and recommendations of this report will be useful in guiding the project through its final months and in helping to determine strategies for the future.

The team could not have accomplished its task without the help and cooperation of many individuals working in the Population Welfare Division in Islamabad and in Punjab, Northwest Frontier, and Sindh provinces, the population research institutes of Pakistan, and the many NGOs and private sector groups working in family planning. The assistance provided by the Health, Population, and Nutrition Office of USAID in setting up and coordinating the visits to many organizations in Pakistan deserves special thanks. The list of organizations is found in Appendix B.

Team members would particularly like to recognize the encouragement they received from the Secretary of the PWD, Dr. M. J. Jillani, to critically examine the Population Welfare Planning project. His candor in discussing the project's strengths and weaknesses set the team's tone in examining the project.

EXECUTIVE SUMMARY

Introduction

The final evaluation of the Pakistan Population Welfare Planning (PWP) project was undertaken 15 months prior to the project's completion date of September 30, 1991, in order to 1) identify immediate actions that are required to fulfill the project's objectives before the project ends, and 2) take stock of the current family planning situation in Pakistan as the first step in identifying needs that should be addressed in a possible follow-on project.

The project began in 1982 and a mid-term evaluation took place in 1985. Subsequent to this evaluation, an amendment was made to the project agreement, adding new project components and funds in order to better accomplish the project goals. The amended \$74 million project included various components: the provision of contraceptives, which constitutes the largest proportion of total USAID funding; assistance to voluntary surgical contraception (VSC) activities; assistance to the non-governmental organization (NGO) sector in providing family planning services; the integration of family planning in the Government of Pakistan's (GOP) Health Program; the implementation of an information, education, and communication strategy; institutional development in evaluation, demographic, and biomedical research; and human resources development.

The evaluation came at a time of significant happenings on the population scene in Pakistan. A new secretary with a doctorate in demography had recently been appointed to head the Population Welfare Division (PWD). The government had increased the budget of the PWD and had taken steps to raise it to ministry status. A new mechanism to provide funds directly to the private sector for family planning was being developed by the PWD. In addition, a new health policy that included family planning as a service to be provided through Ministry of Health (MOH) facilities had been issued.

Overall Program Accomplishments

1. **Contraceptive prevalence appears to have increased over the project period.** It is estimated that, at present, prevalence may be in the range of 16-18 percent compared to the 1985 Contraceptive Prevalence Survey (CPS) figure of 9.1 percent. This estimate, if confirmed by the Demographic and Health Survey (DHS) scheduled to take place in late 1990-early 1991, will signify a break in the low level of contraceptive use evident in Pakistan over the past thirty years.

2. **More effective and longer-term methods, namely the IUD and voluntary surgical contraception, are becoming important contributors to contraceptive prevalence, and their contribution to future increases in prevalence is anticipated by the government.**

3. **The PWD strategy to increase the number of outlets that provide family planning services has met with some success: facilities are in place and paramedical and medical staff have been trained to provide services.** However, efforts to increase the productivity at existing outlets will likely be more cost-effective than further increasing the number of service outlets.

4. **The PWD's encouragement of private sector initiatives in family planning has strengthened the overall family planning program.** The Non-governmental Organization Coordinating Council (NGOCC), which is supported by both the government and donor organizations, has shown that it has the potential to foster collaboration between private sector organizations and government. In addition, the companion Social Marketing of Contraceptives project funded by USAID has been successful in providing condoms through commercial channels and is planning to widen its product line to include other contraceptives.

5. **The development of an evaluation and research institute for the PWD program, the National Institute of Population Studies (NIPS), has provided a needed input into the program and some of its evaluation and research projects have already produced data that can be used by program decision makers.** Further strengthening of the institutional capacity of NIPS is required to ensure that the PWD program has a well-equipped institution with evaluation and program policy decision-making capability as the program expands.

PWP Project's Contributions to the Program

USAID is the largest donor in the provision of family planning assistance in Pakistan. Over the past nine years, it has obligated about \$64 million worth of assistance. USAID's contribution through the PWP project includes the following:

- **The provision of most of the contraceptives used in the government and NGO programs.** Commodities have been provided on a timely basis and there seldom have been any difficulties in contraceptive logistics. USAID's construction of the central warehouse for contraceptive commodities in Karachi made a significant improvement in the storage of the commodities, and its assistance in developing a manual of contraceptive logistics has been important in making the entire system of contraceptive handling and distribution in the country highly professional.

- **Support to the NGO sector in the development of the NGOCC and the provision of general technical assistance in family planning services and specialized assistance in VSC.** The NGOCC offers a rational framework in which NGOs can collaborate in the provision of family planning. Even though there have been start-up difficulties in establishing the NGOCC as a quasi-private/government organization, the government's and USAID's commitment to its success is important to ensure that the NGO community becomes an active partner in the family planning program.

- **Support to the institutional development of NIPS.** The provision of a long-term adviser and a series of short-term consultants provided the needed institutional support for NIPS to become firmly established and to produce research of a high standard. In addition, five research fellows are receiving advanced demographic training in the United States.

- **Support to the integration of family planning in the MOH.** The long sought-after collaboration between the PWD and the MOH was facilitated by a PWD-sponsored family planning training program for selected MOH staff. Although much more needs to be done in addition to training to integrate family planning into the health system, this was an important first step and shows just how involved and complex the introduction of family planning services through the health system will be.

Shortfalls in the PWP Project

Besides those areas in which USAID assistance made a real difference in the implementation of the PWD's family planning program, there were some shortfalls in the project that have had significant negative effects on the family planning program.

- **The information, education, and communication (IEC) strategy was not implemented.** For numerous reasons, the PWD did not use the funds allocated for implementing the IEC plan developed in the Project Paper, with the result that the PWD's current IEC strategy is not based on market or audience research, IEC materials have not been pre-tested and are not in adequate supply, and the same weaknesses identified five years ago in the PWD's IEC strategy are still present today. Recently, an agreement with the Johns Hopkins University/Population Communication Services project (JHU/PCS) was signed to provide IEC technical assistance for the remainder of the project period.

- **The NGO sector program has not developed as originally anticipated.** There has been an over-emphasis on opening service outlets rather than developing innovative NGO projects that could reach more potential acceptors as well as provide services.

- **Training opportunities in overseas programs and the provision of long- and short-term technical assistance have not been accessed by the PWD.** The Project Paper and Project Amendment rightly pointed out the need for extensive training of PWD staff, particularly the mid-level managers who will take over the program in the next few years. Very few mid-level professionals have been trained, and with the retirement of almost all senior staff within the next five to ten years, the program's viability is in question. Also, very little technical assistance has been used by the PWD. As a result, institutional strengthening and on-the-job training have not taken place as planned.

General Concerns with the Program

Contraceptive Commodities

One of the greatest difficulties that must be addressed by the PWD and USAID is that of long-term provision of contraceptives. At present, most of the contraceptive commodities are supplied by USAID, and the government and USAID have not decided on how contraceptives will be supplied to Pakistan after the present project is completed.

Target Setting

Birth aversion, the target setting methodology currently being used by the program, is inadequate. The conversion factors used for averted births undercounts the effectiveness of sterilization and overcounts the effectiveness of condoms.

Strategic Planning

Stratifying the population into target groups and developing specific approaches for these groups has not been a predominant feature of the program until recently when an urban strategy was initiated. Focusing attention on specific groups, particularly those who may be ready to choose a

method, should be encouraged. At the same time, this attention should not reduce efforts being made by the program with other groups also in need of services. Quality of care aspects of service provision should be a major focus in determining what services will be provided and how.

Reimbursement for VSC

The program presently uses a case-by-case system to reimburse institutions performing VSC services as well as to reimburse the client and motivator. Disbursements have not always been timely. In addition, there are questions as to the adequacy of the actual amount of reimbursement and whether other systems to support VSC services would be preferable.

Private and Public Sector Cooperation

Initiatives in the private sector in the last five years have proved to be quite positive. The social marketing and NGO projects have shown that the private sector has the capability and willingness to provide family planning services. Less attention has been paid to involving the private for-profit sector in family planning. Even if this sector were to become more involved in family planning, however, it would take considerable time before it would be equipped to supply a significant portion of the contraceptive needs of the country. Therefore, family planning services will still need to be provided by the public sector for large segments of the poor population.

Institutional Constraints

Many of the implementation delays that the project has experienced are due to institutional problems of the various agencies involved in the project; these problems are not necessarily project-specific. The Government of Pakistan has been severely hampered in spending development assistance funds due to the restrictions placed on ministry budgets by the International Monetary Fund. The PWD's Annual Development Plan has not permitted the full allocation of USAID resources or other donor resources to be included in it. Institutional problems of USAID assistance are evident in the mismatch in the timing of the project planning periods of USAID and the government. Therefore, the government's planning documents (PC-Is), which give the objectives, activities, and planned budgets for the various government projects do not correspond with USAID's project papers. These examples of the lack of "institutional communication" need to be examined and solutions found that will facilitate the implementation of the family planning program.

Recommendations

The full report contains a total of 57 recommendations. Some of these concern activities that should be undertaken in the short term; the remainder are for activities that should be undertaken over the long term, and are addressed directly to either the GOP or USAID. This summary provides those considered by the evaluation team to be the most critical to the future success of the Pakistan family planning program.

General

1. The institutional problems that have led to delays in program implementation should be addressed by the various agencies involved in the family planning program.

2. The government should avail itself of all opportunities for technical assistance by candidly recognizing the areas in which the program is weak and addressing the problems in these areas unequivocally.

3. USAID should continue its support to the Population Welfare Program at the completion of the current project. A public sector project is necessary in Pakistan for the immediate future since the majority of contraceptive users depend on the public sector to provide their contraceptive needs. Efforts to promote private sector family planning initiatives should be encouraged; however, this does not negate the need for a public sector program.

4. USAID should consider adding another population post in the Health, Population, and Nutrition office to manage a follow-on PWD population project.

Contraceptive Commodities

5. The PWD should organize a national workshop on long-term contraceptive needs assessment, with participation of national and international experts, and representatives of the donor community.

6. USAID should undertake, in cooperation with the government, a feasibility study of local production of contraceptives.

Service Delivery

7. The PWD should undertake a cost-effectiveness study of the different service delivery outlets in its program.

8. The methodology currently in use to establish and update short-term targets for districts, provinces, and the whole country should be revised.

9. The Family Planning Inputs into the Health Program project should be watched very closely for lessons that need to be learned in any expansion of family planning services in health units.

10. The government should concentrate additional resources and effort in the urban and peri-urban areas for the next few years, while maintaining present levels of services in the rural areas, and should take care not to overextend its service delivery and contraceptive distribution network.

11. USAID should provide assistance to the PWD and the Ministry of Health in developing and implementing a quality assurance system for VSC, and a training and institutional development program for the PWD VSC program, parallel to the one going on in the NGO sector, should be developed.

12. USAID should expand its assistance in the private sector to include not only assistance to NGO projects (see below), but to for-profit enterprises, e.g. private practitioners.

Training

13. The urgent need for adequately trained mid-level staff in the PWD program should be addressed immediately at the highest levels in the PWD.

14. **USAID should provide assistance in establishing model family planning centers as the training area for clinical services, sterilization in particular.**
15. **USAID should provide assistance**
 - **in sending significant numbers of PWD staff from all program areas on specially planned and carefully prepared study tours to high-quality family planning service countries in the Asia region and selected countries in other regions; and**
 - **in sending key mid-level managers, those who will become senior managers in a few years, on long-term training and internships in their respective fields.**

Research

16. **The program should assign top priority to research in the epidemiology of reproduction and in program-oriented operations research, and should de-emphasize basic physiological and biochemical research on reproduction.**
17. **USAID should undertake, with the cooperation of the PWD,**
 - **a periodic study of characteristics of contraceptive users to determine the current profile of the contracepting population;**
 - **a national follow-up study to determine continuation rates and use-effectiveness rates of each contraceptive method and for extended use of all methods; and**
 - **a study of the cost-effectiveness of different approaches to contraceptive service delivery.**
18. **USAID should provide assistance to the PWD in operations research that would be integrated into the various aspects of the PWD's service program.**

IEC

19. **Funds should be made available immediately for the development of an IEC campaign with policymakers and PWD staff as targets.**
20. **Short-term technical assistance should be secured to**
 - **demonstrate what an effective IEC campaign can do. A model IEC campaign should be launched which has all the required elements for effectiveness, i.e., audience research, pre-testing of materials, regular evaluations, and use of high-caliber creative talent.**
 - **address the bureaucratic constraints inhibiting organizational communication.**
 - **boost research and evaluation capabilities.**
21. **USAID should provide long-term technical assistance in the areas of communication research and evaluation; communication strategy and planning; communication management; and organizational communication.**

NGO Project

22. USAID should take immediate steps to work with the NGOCC in reviewing the activities it supports to ensure that the innovative nature of NGO efforts is encouraged and that resources are not being used exclusively to open up new outlets.
23. The NGOCC should explore mechanisms for allowing it to meet basic accountability requirements of the government without having to conform to all the procedures required of government departments.
24. USAID should continue the use of performance-based disbursements for the NGOCC, but should make sure that criteria also include elements to ensure quality control and encouragement of innovative approaches as well as elements covering program and financial system mechanisms necessary for basic efficient functioning (such as were used previously).

1. INTRODUCTION

The Pakistan Population Welfare Planning (PWP) project was authorized in April 1982 as a five-year activity with a life of project funding of \$25.6 million and Rs. 21 million (equivalent to approximately \$2 million in 1982). Project funding increased to \$40 million in May 1985 in order to purchase more contraceptives for the project; in August 1986, an additional Project Amendment increased the budget to \$74 million. The Project Assistance Completion Date has accordingly been extended three times and is now set at September 30, 1991.

1.1 Purpose of the Evaluation

The purpose of this final evaluation was to analyze both project accomplishments and the larger programmatic concerns of population activities in Pakistan. The evaluation was to assess specifically the role played by USAID in the population sector through the PWP project. Based on the findings of the evaluation, the evaluation team was to make recommendations for actions to be taken in the remaining 15 months of the project and to provide an assessment of the desirability of USAID assistance and the direction of this assistance beyond September 1991. See Appendix A for the evaluation scope of work, evaluation methodology, and the names of the evaluation team members and the Population Welfare Division (PWD) officers who facilitated the evaluation exercise.

1.2 The Overall Population Welfare Plan

With the Government of Pakistan's (GOP) Sixth and Seventh Five Year Development Plans, family planning in Pakistan has regained some of the ground lost during the 1970s. Beginning in the 1980s, the GOP has given more open support to family planning; recently, it has taken on a higher-profile advocacy role with the appointment of a new secretary who holds a doctorate in demography to head the PWD. The government has also increased the PWD budget¹ and has taken steps to raise the division to ministry status. A new mechanism to provide funds directly to the private sector for family planning is being developed by the PWD. In addition, a new health policy that includes family planning as a service to be provided through Ministry of Health (MOH) facilities has been issued.

The GOP's Population Welfare Plan, which is central to the PWP Project, has two principal objectives:

1. Creation of an awareness of the importance of small family size and behavioral change, and
2. Provision of family planning services on a reliable and sustained basis.

The plan, implemented by the PWD, represents an intensive, broad-based approach to fertility reduction. Its main features and areas of emphasis include the following:

¹Family planning remains a part of the development budget, however, thus not giving it the same degree of stability it would have if it fell within the regular government budget.

- Decentralization of planning functions by making Pakistan's provinces responsible for implementing the nationwide family planning effort;
- Increased outreach activities by creating Family Welfare Centers which will provide an array of family planning services to the population at large;
- The involvement of non-governmental organizations (NGO) and the provision of a variety of contraceptive services through increasing outreach activities;
- Training of a broad base of personnel in the health and population sub-sectors in a variety of disciplines; and
- A communication strategy that includes radio, television, the press, and person-to-person communication.

1.3 The PWP Project

The purpose of the PWP project is "to strengthen the GOP's population planning, evaluation, research, motivational, and logistics capabilities and performance." The Project Paper supported four activities: 1) management information, 2) provision of contraceptive supplies and improvement of the logistics supply network, 3) biomedical and sociomedical research, and 4) personal motivation and awareness activities. USAID assistance complements other assistance provided to the Population Welfare Plan by the World Bank and UNFPA.²

While retaining the original project purpose, a major Project Amendment was added to the project expanding the scope of USAID funding to other areas: 1) voluntary surgical contraception, 2) NGO programs, 3) improvement of district operations, 4) mass media, and 5) mid-level management training. See Table 1 on page 3 for the original and amended project components and summary costs.

1.4 The Evaluation Report

This report will discuss the major components of the Population Welfare Plan that received USAID assistance. Recommendations for actions to be taken in the remaining project period are provided within each section of the report and are compiled in Appendix D. The final section of the report discusses the major conclusions and provides recommendations for future directions; some of these recommendations are addressed to the PWD and others are addressed to USAID.

Throughout the evaluation, the evaluation team attempted to analyze USAID-assisted project activities in the context of the main features of the Population Welfare Plan as enunciated above, as well as through the provisions of the Project Paper and the Project Amendment.

²USAID has also funded the Social Marketing of Contraceptives project which provides condoms through commercial channels; the project plans to widen its product line to include other contraceptives.

Table 1

**Original and Amended Project Components and Summary Costs
(\$000)**

Components	Original Project (\$000)	Proposed Amendment (\$000)	Total (\$000)
1. Management Information and Research	2,900 600		
= Program Monitoring, Research and Evaluation	3,500	5,000	8,500
2. Contraceptive Supplies and Logistics	35,200	9,700	44,900
3. Voluntary Surgical Contraception	--	5,100	5,100
4. NGO	--	3,800	3,800
5. District Operation	--	1,100	1,100
6. Mass Media	--	5,700	5,700
7. Personal Motivation	600		600
8. Mid-level Management Training	<u>--</u>	<u>600</u>	<u>600</u>
TOTAL:	<u>39,300</u>	<u>31,000</u>	<u>70,300</u>
Evaluation	100	300	400
Contingency	<u>600</u>	<u>2,700</u>	<u>3,300</u>
GRAND TOTAL:	<u>40,000</u>	<u>34,000</u>	<u>74,000</u>

2. CONTRACEPTIVE USE AND ASSESSMENT OF PROGRAM EFFORTS

2.1 Trends in Contraceptive Prevalence

Despite more than 30 years of formal family planning programs, Pakistan's contraceptive prevalence rate (CPR) has increased very slowly -- 5.5 percent in 1968, 3.3 percent in 1979, and 9.1 percent in 1985 -- and fertility rates remain stable at a very high level. Table 2.1 shows the targets set in the GOP's Five Year Plans since 1965 for crude birth rate (CBR), total fertility rate (TFR), and CPR.

Table 2.1

Selected Targets of Five Year Plans

PLAN	CBR	TFR	CPR
1965-70	41	6.3	6.5
1972-77	44	6.8	9.2
1978-83	40	5.9	25.0
1983-88	36	5.4	18.6
1988-93	38	-	23.5

These modest targets have not been achieved -- the CBR is estimated to have been 45.51 in 1972, 44.49 in 1977, 43.46 in 1983 and 42.26 in 1988. The 1984-85 Contraceptive Prevalence Survey (CPS) indicated a CPR of 9.1 for "non-pregnant" married women of reproductive age. If pregnant women are included in the denominator (as is customary), the CPR in 1984-85 would have been around 7.5. In addition, the expected benefits of family planning for the health of mothers and children has not occurred.

The slowness of growth in contraceptive prevalence, only 3.6 percent in 17 years, suggests that continuation rates and use-effectiveness rates are very low in Pakistan. If one of the explanations for this extremely low growth is that continuation is actually very low, then one of the main objectives of the family planning program should be the improvement of continuation rates.

On the other hand, if continuation rates are low for the initial method adopted by the users who, after abandoning this method, continue using another one, the end of the first segment of use does not mean interruption of contraception but merely a change of method. "Extended use" continuation rates (of all successive segments of different methods or the same method) may not be so low; in this case, an impact in prevalence rates can be realized.

Without a more current CPS, it is difficult to estimate contraceptive prevalence changes since 1985; fortunately, a Demographic and Health Survey (DHS) will take place later this year. Service

Previous Page Blank

statistics, contraceptive procurement data (presented in Section 3 of this report), and projections based on survey data do indicate, however, that contraceptive prevalence has increased at a higher level than in the past, and may be between 16 and 18 percent; this would mean that there are approximately 2.7 to 3 million current users of contraception in Pakistan. Thus, if this increase is proved correct by the DHS, Pakistan's progress in terms of contraceptive prevalence during the project period will actually have been substantial.

2.2 Contraceptive Method Mix according to Surveys

Oral Contraceptives. The proportions of all methods used have been somewhat erratic in Pakistan. The proportion of oral contraceptives in the method mix, for example, decreased from 18.8 percent in 1975 to 9 percent in 1980 and then went back up to 15.2 percent in 1985. Based on the program's perception that oral contraceptives are not well accepted by the population, official policy is now calling for a drastic reduction of the already low proportion of orals in the method mix to approximately one-third of the current figure. This policy is reflected in the fact that the total amount of orals requested and received from USAID increased only slightly between 1985 and 1989 compared with the increase in supplies of IUDs, condoms, injectables, foams, and number of sterilizations performed.

IUDs. The proportion of IUD users grew from 12.3 percent in 1975 to 17 percent in 1980 and then declined to 9.1 percent in 1985. Since then, the IUD has been promoted intensely and the reported consumption through the program has risen from 221,897 IUDs in 1985 to 512,080 in 1989. Based on recent experience in other Muslim countries, it is anticipated that this trend of fast growth will continue for a few years and will stabilize before reaching a level of consumption of 1,000,000 units per year.

Sterilization. Female sterilization has followed a similar pattern: the percentage of users of this method decreased from 18.8 percent in 1975 to 9 percent in 1980 and increased to 29 percent in 1985. There are clear indications of great demand for female sterilization where the service is offered; a few of these service sites are achieving significant levels of performance (10 to 15 operations per day, five days per week). There is also a growing number of private physicians promoting surgical methods of contraception in the largest cities. All of this suggests that larger numbers of operations are performed every year, both within and outside the formal program. Even so, given the low overall contraceptive prevalence rate, the reported increase in female sterilizations performed by the program is not actually very impressive: 60,786 cases in 1985 and 86,159 in 1989. If the number of operations performed outside the program has grown at the same speed, it is probable that the prevalence rate of sterilization is either stable or growing very slowly. The small number of operations compared with the size of the female population hardly compensates for the growth of the population.

Male sterilization has been slow in taking off. A few NGO clinics are performing vasectomy procedures.

Injectables. The proportion of injectables in the method mix has been rather stable at around 6 percent. There appears to be a great demand for and acceptance of this method; it is anticipated that there will be a rapid expansion of its use if the supplies provided by UNFPA become more regular. Statistical information confirms this view: the 156,141 injections given in 1985 increased at

an annual average of 120,000 per year to reach 640,755 in 1989. Unknown amounts were consumed through private commercial sources. Although this increase is remarkable in relative terms, it is less significant in absolute terms and its impact on the method mix is small. Due to this fact, only a moderate increment in its proportion in the method mix is anticipated in the near future.

Vaginal Foams. The proportion of vaginal foams in the method mix was 1.2 percent in 1985. It is anticipated that there will be a moderate growth in the near future.

Traditional Methods. Traditional methods represented 18.9 percent of all contraceptive users in 1985. Trends from 1985 to 1989 are unknown but it is probable that the availability of modern methods is reducing the relative importance of traditional methods in the method mix. On the other hand, it is possible that the proportion of users of traditional methods may be growing because the demand for modern contraception is expanding faster than contraceptive supplies. This phenomenon was observed in the past in countries such as Turkey, Peru, Haiti, Bolivia, and Sri Lanka, and is currently seen in Colombia and Brazil. The considerable demand for the condom in Pakistan (see below) could be an indication of this possibility.

Condoms. The condom proportion in the method mix was stable at around 20 percent between 1975 and 1985. For several reasons, it has been assumed that there is an unusually high preference for condoms in Pakistan. The first and most immediate reason is that condoms represented 90 percent of the total cost of USAID-donated contraceptives from 1982 to 1989. A second reason is that 20 percent of the method mix is indeed a rather high proportion. However, 20 percent of a prevalence of about 10 percent means that only about 2 percent of all couples are using the condom as their basic contraceptive method, a really very modest figure. Many developing countries have condom prevalence rates higher than 2 percent.

A third reason lies in the methodology used to standardize the couple years of protection (CYP) produced by each method. If, as is done in Pakistan's program, 100 condoms are counted as one crude CYP or 0.45 standardized CYP, and a sterilization is also counted as one crude CYP or one standardized CYP, then the value of sterilization within the total output of the program is greatly underestimated, and correlatively the value of the condom is overestimated. If instead of computing standardized CYPs using this simplified methodology, the ordinary calculation of crude CYPs is employed using 100 condoms, 13 cycles of orals, 4 injections, 4 Delfen tubes (vaginal foam), 1/2.2 IUDs and 1/10 sterilizations as CYP conversion factors, the relative importance of condoms is diminished.

2.3 Assessment of Program Performance

2.3.1 Contraceptive Use according to Service Statistics

According to Table 2.2 on page 8, which provides data on contraceptive use through the program, the relative importance of condoms and sterilization is decreasing. Orals are also decreasing very slowly. On the other hand, Delfen vaginal foam shows a small increase, injectables slightly more, and the IUD has the fastest growth.

Table 2.2

Assessment of Program Performance from 1985 to 1989 in Crude CYPs

	Orals (1000)	Condom (Mill)	IUD (1000)	Steriliz (1000)	Delfen (000)	Inject (1000)
1985	1,128	80.8	222	60.8	69.3	156
1986	1,273	87.6	267	72.5	83.3	295
1987	1,755	115.2	422	73.6	104.0	425
1988	1,698	122.6	421	75.5	130.0	494
1989	1,565	115.4	512	86.2	159.0	641
Crude CYPs (Thousands)						
1985	86	808	488	608	17	39
1986	98	876	587	725	21	74
1987	135	1,152	928	736	26	106
1988	131	1,226	926	755	33	124
1989	120	1,154	1,126	862	40	160
Proportion by Method						
1985	4.2	39.5	23.9	29.7	0.8	1.9
1986	4.1	36.8	24.7	30.4	0.9	3.1
1987	4.4	37.3	30.1	23.8	0.8	3.4
1988	4.1	38.4	29.0	23.6	1.0	3.9
1989	3.5	33.3	32.5	24.9	1.2	4.6

Note: This table has been prepared with data supplied by USAID/Islamabad, taken from the service statistics system of the national family planning program. The first part of the table shows amounts of contraceptive materials delivered to users and numbers of sterilizations performed from 1985 to 1989. The second part contains numbers of crude CYPs produced by the amount of contraception for each method. The third part gives the percentage of CYPs for each method produced by the program each year.

2.3.2 Productivity of Service Delivery Outlets

In an effort to assess overall program performance, the average production of crude CYPs per day in each category of service delivery points has been calculated. These calculations are based on the quantities of contraceptives reported delivered by each service delivery point as reported by

the PWD. The month of December 1989 was chosen as a basis for the analysis after it was determined to be an average month.³

Two tables have been prepared for each type of service, one with the average target for CYPs per day, the other with the average performance in CYPs per day. Table 2.3 provides the average targets and performances of each type of service outlet, and Table 2.4 on the next page presents the results in the most productive type of services, the Reproductive Health Services centers, Type A (RHS-As) (see Section 4 for a discussion of these centers). The tables prepared for the other types of service outlets are provided in Appendix E.

Table 2.3

Average Targets and Performance in Crude CYPs per Day in December 1989

	Target	Performance
Family Welfare Centers	4.63	6.37
Reproductive Health Service Centers A	48.16	22.61
Reproductive Health Service Centers B	10.58	5.73
District Distribution Points	0.94	2.36
Provincial Line Departments	1.75	0.25
Family Planning Association	5.67	3.77
NGOs under NGO Coordinating Council	1.85	2.27
Target Group Institutions	1.11	0.43
Social Marketing Distribution Points	0.04	0.03

As seen in these two tables, the program targets for RHS-A centers of 48 CYPs per day (equivalent to four or five sterilizations or 20 IUDs per day) were not met; only 22.6 CYPs were produced, slightly less than half the target.

The strategic importance of high productivity outlets, such as the RHS-As can be seen in the following equivalences of performance: 1 RHS-A provided as much contraception as 3.5 FWCs or 6 Family Planning Association outlets or 53 Target Group Institution outlets or 90 Line Department outlets.

³This was done by comparing the number of family planning and non-family planning cases in December at Family Welfare Centers (FWC) with the average number for the seven months prior to December. The number of total cases, the number of family planning cases, and the percentage of family planning cases within the total were very similar:

	Average	December
All cases	342	341
Family planning cases	136	138
Percent Family planning	39.6	40.5

Both targets and actual performance figures were studied in order to ascertain averages and to judge the reasonableness of the targets. It was concluded that these targets are not only reasonable and realistic, but also achievable with moderate effort.

Table 2.4

**RHS-As: Productivity in Terms of Crude CYPs per Day
Based on Targets and Performance during December 1989**

Contraceptive Targets				
53 RHS-As	Per Month All Thousands¹	Per Month per Center Units²	Per Day per Center Units³	CYPs per Day⁴
VSC	5.6	106.4	4.4	44.32
<u>Other Methods</u>				
Condoms	98.4	1,856.0	77.3	0.77
Orals	3.1	58.8	2.4	0.19
IUDs	1.3	25.3	1.1	2.32
Injectables	2.2	40.9	1.7	0.43
Foam	0.7	12.4	0.5	0.13
Productivity Target in Crude CYPs per day				48.16
Contraceptive Performance				
VSC	2.6	48.4	2.0	20.18
<u>Other Methods</u>				
Condoms	64.7	1,220.8	50.9	0.51
Orals	2.1	40.3	1.7	0.13
IUDs	0.9	17.0	0.7	1.56
Injectables	0.8	14.5	0.6	0.15
Foam	0.4	7.8	0.3	0.08
Actual Productivity (Performance) in CYPs per day				22.61

¹Figures in the first column were taken from Table 2 of the Performance Report of the PWD for December 1989 and are presented in thousands.

²The second column results from dividing the first column by the number of centers.

³The third column results from dividing the second column by 24 working days per month.

⁴The fourth column is the product of the third column multiplied by the respective CYP conversion factor.

Productivity indices for all categories of service outlets are very low in Pakistan and, as a consequence, the productivity of the whole system is low. Even the average of 22.6 CYPs per day for clinics based on surgical methods, such as an RHS-A, is very low, and these are the most productive units of the family planning program. Since the figure of 22.6 is an average, this means that half of all RHS-As are below that figure. Only a few produce more than 100 CYPs per day.

These various indicators and levels of productivity reveal a great deal about the potential of the program to meet its ultimate targets of increasing contraceptive prevalence, reducing fertility, and improving health and welfare. One of the most frequent questions asked about family planning in Pakistan is why contraceptive prevalence has grown so slowly even with the substantial effort that is being made by national and international organizations. To assist in answering this question it would be helpful to study the Pakistan program's results in comparison with international standards or with similar programs. The family planning program of Colombia, for example, has only 42 clinics. The two most productive, which are located in Bogota and Medellin (cities the size of Karachi and Lahore), produce 1,400 and 900 CYPs respectively per day, and 21 of the 42 clinics produce more than 100 CYPs per day.⁴

Productivity also needs to be viewed in terms of costs per CYP. Although assessments and evaluations have been undertaken of the various service delivery strategies, little attention has been given to the cost-effectiveness of the outlets. Besides looking at productivity indicators, an examination of the costs of service provision would help planners to determine more effective and efficient service provision strategies.

2.3.3 Strategic Planning

The PWD program has recently initiated a strategy to provide more family planning services in the major urban areas. This initiative is in the right direction of targeting resources to groups of women who may be more ready to accept contraceptives. However, without contraceptive prevalence data that would provide hard evidence of the degree of contraceptive acceptance in various strata of women (urban, peri-urban, rural; educated, uneducated; employed outside the home; etc.) it is very difficult for the program to plan strategically. Once these data are known, it will be possible to target more accurately different categories of women and men for family planning. For the present, emphasis can be placed on the urban sectors, but it is important that efforts in rural areas not be diminished.

2.3.4 Target Setting

The evaluation and monitoring system of the PWD has established targets for all levels of the program, for each type of delivery outlet, and for each contraceptive method. These targets are in terms of births averted, a unit of measurement that many observers find inadequate. Although a complete critical analysis of the methodology utilized in the calculation of births averted is beyond the scope of the evaluation, some comments are pertinent due to the importance of the subject and the systematic use of this concept to assess program performance.

⁴Profamilia: Informe de Actividades de Servicio, 1989. Table 50, page 65. Bogota. Marzo, 1990.

The intention behind the adoption of births averted as the achievement indicator was to standardize the unit of output as a common value for all contraceptive methods.⁵ The use of births averted has the merit of clearly identifying the programmatic objective and the net output of contraception, i.e., the avoidance of undesired births.

Targets have the greatest value for planning, management, and evaluation purposes when they are expressed in terms easily understood by program personnel. Although the concept of births averted is understandable at all levels, its actual translation into specific activities to be performed may not be clear at lower levels. For this reason it is wise to establish local targets in more concrete terms, such as amounts of contraceptives to be distributed by month, as is the norm nowadays.

In addition, some of the conversion factors used for averted births in Pakistan are clearly inadequate:

1 averted birth is equivalent to	3.74 sterilizations 5.76 IUDs 41.61 injections 97.38 oral cycles 832.29 condoms
-------------------------------------	---

Using these values, with sterilization as the basis for comparison, equivalences can be made for these various methods:

1 sterilization is equivalent to	1.54 IUDs 11.13 injections 26.04 oral cycles 223.00 condoms
-------------------------------------	--

It is evident that one sterilization has more impact on fertility than 1.5 IUDs, 26 cycles of oral contraceptives, or 223 condoms. Thus, with this system of measurement, the net effect is that the effectiveness of sterilization is undercounted, while the effectiveness of condoms, in particular, is overcounted.

Recommendations

- 1. The PWD should undertake a cost-effectiveness study of the different service delivery outlets in its program. USAID assistance in this assessment should be provided, if requested.**
- 2. The methodology currently in use to establish and update short-term targets for districts, provinces and the whole country should be revised. The conclusions of this study should be converted into a *Manual of Target Setting and Updating* that can play in this area the same important role of the *Manual of Contraceptive Logistics*. USAID assistance in the revision of the target methodology should be provided, if requested by the PWD.**

⁵An alternative unit, the CYP as it is currently used, was discarded under the rationale that the CYP methodology calls "protection" what actually is "use." True "protection" is related not only to time of use but also to use-effectiveness.

3. CONTRACEPTIVE SUPPLIES AND LOGISTICS

3.1 USAID's Input in Contraceptive Commodities

Table 3.1 provides the estimates of contraceptive use as set forth in the Project Paper.

Table 3.1

Estimates of Contraceptive Use, 1982-1987

	1982	1983	1984	1985	1986	1987
MWRA	14,700	15,100	15,600	16,000	16,500	17,000
CPR	5.0	6.0	7.5	8.75	10.0	11.0
Users	735	906	1,070	1,400	1,650	1,870
% Condom	60	54	48	41	36	33
% Orals	15	19	23	27	31	35
% IUD	16	15	14	13	12	11
% Injectables	2	4	6	8	9	9
% Sterilizations	5	6	7	9	10	10
% Other	2	2	2	2	2	2
Condoms (Mill)	44	49	56	57	59	62
Orals (Mill)	1.4	2.2	3.5	4.9	6.7	8.5
IUD (Thou)	118	136	164			
Vaginals	1.5	1.8	2.3	2.8	3.3	3.7

When the project was amended in 1985, actual use of condoms had risen from 8.9 million units in 1982 to 43.2 million in 1983 and to 58.6 million in 1984. Consumption of oral contraceptives was far below the projected quantities: 0.2 million in 1982, 0.6 in 1983, and 0.7 in 1984. IUDs were also below the targets: 78,000; 96,000; and 152,000 respectively. Due to these trends, new targets of consumption were adopted for the remaining life of the project.

Table 3.2

Contraceptive Needs Projections, Project Amendment, 1985

	1986	1987	1988	1989
Condoms (Mill)	102	146	161	175
Orals (Mill)	1.5	1.7	1.8	2.0
IUDs (Copper-T) (Thou)	33	137	227	262

The expected needs of condoms were greatly increased, while a slowly growing trend for orals and an aggressive one for IUDs were adopted. These targets were very ambitious for condoms and orals but the performance of the IUDs greatly surpassed expectations.

Table 3.3

Consumption of Contraceptives within the PWP from 1986 to 1989

		1986	1987	1988	1989
Condoms	(Mill)	88	115	123	115
Orals	(Mill)	1.3	1.8	1.7	1.6
IUD (Copper-T) +Lippes Loop	(Thou)	267	422	421	512

Consumption of other contraceptives not supplied through the project has grown even faster: Delfen vaginal foam from 69,000 units in 1985 to 159,000 in 1989, and injectables from 156,000 to 641,000 between the same years. Sterilization also has grown but at a slower rate: from 60,800 in 1985 to 86,200 in 1989.

From the beginning of the project (March 1982) to the beginning of this evaluation (May 1990), a constant supply of contraceptive commodities has flowed from the U.S. to Pakistan. The following table summarizes the total provision under the project.

Table 3.4

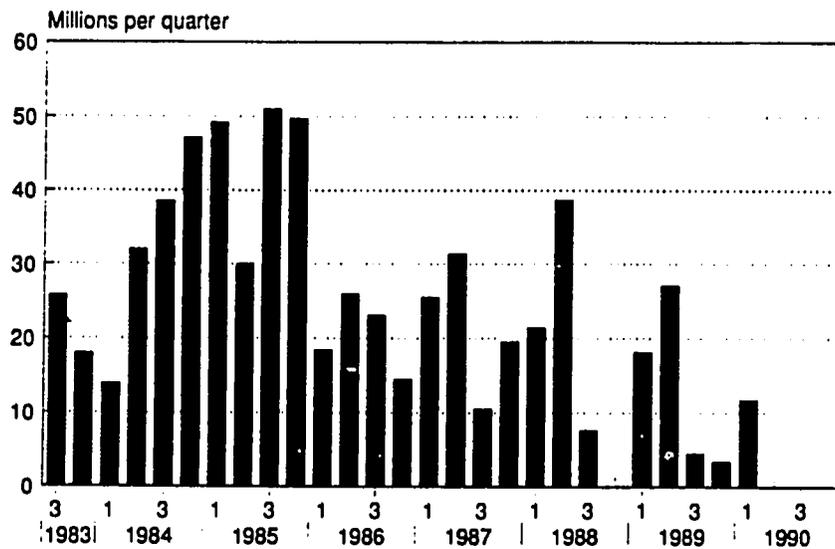
**Contraceptives Supplied by the Population Welfare
Planning Project from March 1982 to Date**

	Quantity Shipped	Cost US\$
Condoms	657,942,000	30,133,261
Orals	11,298,000	1,630,732
Copper-T IUDs	1,188,000	1,202,138
IUD Loops from US	300,000	118,957
IUD Loops locally procured	450,000	96,291
Total Cost		33,181,379

The supply of condoms has been continuous; with only one exception, one or more shipments have been sent in each quarter from 1983 to the first quarter of 1990. The flow has been irregular, however, with an excessive supply between 1984-1986, and an insufficient, more discontinuous supply during the last two years.

Figure 1

**Shipment of Condoms to Pakistan
by Quarter, from 1983 to 1990**

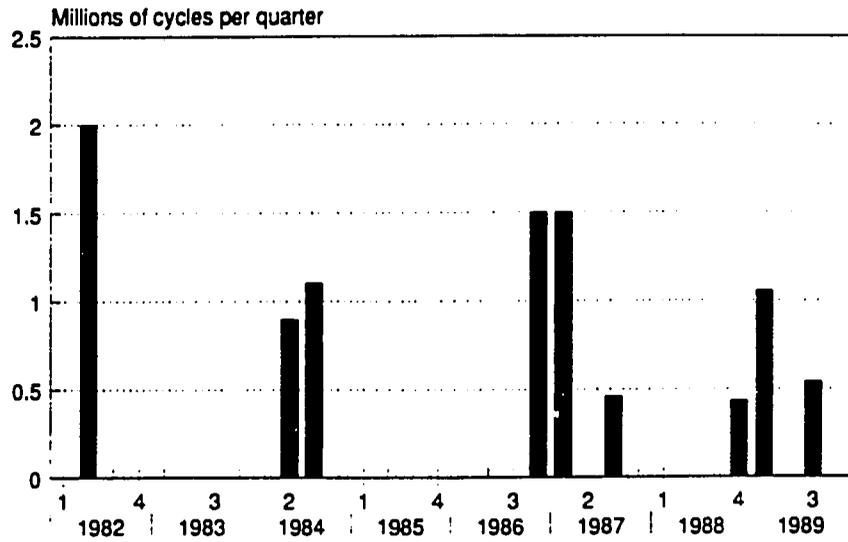


Irregular supply during the last one and a half years has been associated with an excessive push of condoms aimed at performance improvement. This has happened, in part, because it is believed that condoms are an inexpensive method and in part because the enthusiasm of program staff to meet or even surpass targets can contribute to larger quantities of commodities being issued than are actually needed. This is especially true with respect to the condom: the quantity most frequently issued to each customer in Pakistan has been found to be 50 condoms, and issuances of 100 are not rare. The probability of consuming all 100 condoms received in a single purchase is highly questionable. With such practices, it is not surprising that a shortage of condoms is now observed on a national scale, despite the distribution of 115 million units in 1989 and 121 million in 1988.

Shipments of oral contraceptives have been irregular -- periods during which massive amounts of supplies were sent have alternated with periods of no supply. This situation may have been caused by overly optimistic projections of consumption and exaggerated "desired end of year stocks" in the Contraceptive Procurement Tables (CPT) (which have been the rule in Pakistan) along with poorly designed shipment schedules.

Figure 2

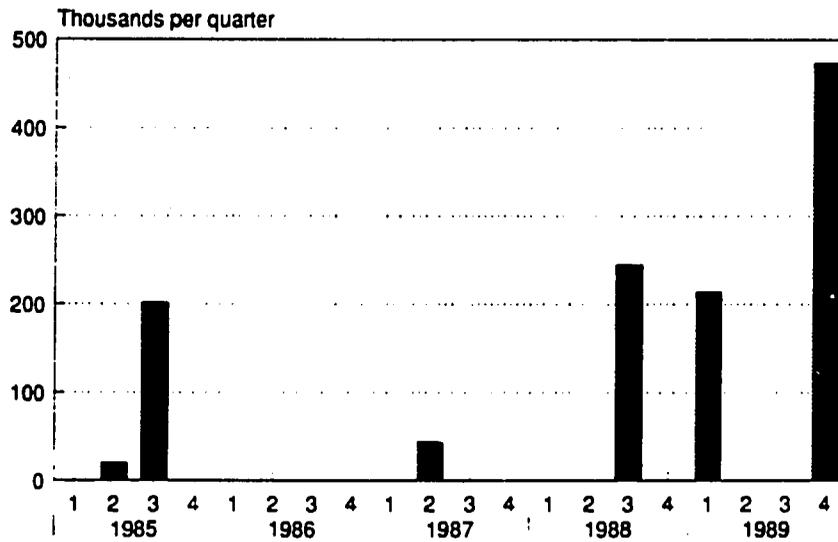
**Shipments of Orals to Pakistan
by Quarter, from 1982 to 1989**



The supply of the Copper-T IUD has also been discontinuous but the trend is one of rapid growth.

Figure 3

**Shipments of Copper T to Pakistan
by Quarter, from 1985 to 1989**



A Pipeline Report of the logistics component as of March 31, 1990, indicates that 80 percent of the funds earmarked for logistics were expended during 84 percent of the time for which the project was negotiated.

Table 3.5
Expenditures and Unexpended Balance for Logistics Component
March 31, 1990

	Amount Earmarked	Distribution	Accruals	Unexpended Balance
Commodities	40,846,114	29,967,063	2,837,168	8,041,883
Technical Assistance	11,330	7,760	0	3,570
Miscellaneous	86,578	31,172	0	55,406
Other	4,253	4,200	0	3
Total	40,948,222	30,010,155	2,837,168	8,100,862

3.2 Procurement of Contraceptives

Every year the PWD's Monitoring and Statistics Wing and USAID prepare a set of CPTs. These CPTs serve to estimate the contraceptive needs for the following three years, desired end of year stocks, quantities to be shipped, shipment schedules, and funds to be allocated by USAID. Specifications are sent to A.I.D.'s Office of Population in Washington, D.C., where the procurement process is centralized. Sometimes technical assistance has been provided by the U.S. Centers for Disease Control and/or A.I.D.'s Family Planning Logistics Management project for this purpose.

Although the entire process of procurement between the placement of a commodity order and the receipt of the first shipment can take a full year (since more than one purchase order is in process at any given time), there is a continuous flow of commodities from factories in the U.S. to the central warehouse in Karachi. Twenty-six different commodity orders were processed between 1982 and the first two months of 1990. These orders generated 64 shipments of condoms, 17 shipments of oral contraceptives, and 15 of IUDs.

Officers of the PWD and USAID interviewed by the evaluation team all agree on the efficiency of the process of procurement, shipment, and customs clearance. The average lead time (between date of shipment and date of reception) of condom shipments has been 62 days; this time has been constant during the period 1983 to 1990. The transport of pills takes slightly longer at times because these shipments are smaller and more prone to be kept waiting until containers are completely full.

All indications are that commodities are handled carefully. According to information provided by USAID, the proportion of missing quantities is very small: an average of only 0.03 percent for condoms, 0.09 percent for orals, and 0.15 percent for Copper-T IUDs. The proportion of cartons damaged has been a little higher: 0.9 percent for condoms, 1 percent for orals, and 1.1 percent for IUDs. Damaged cartons do not necessarily mean a loss of commodities, however; most of the time the contents are in good, usable condition.

3.3 Commodity Storage

3.3.1 Central Warehouse

At the central level, all contraceptive materials are stored in a single, recently constructed warehouse that is situated very close to Karachi's port facilities. The warehouse fulfills all requirements of safety, temperature, and protection from physical agents. The storeroom and its annexes are clean and everything indicates careful handling of products.

Each product is stored in its special area and each lot is stored separately with adequate circulation space. Production and expiration dates of the contraceptives are clearly marked. The storekeepers and dispatchers state that "first-in, first-out" rules are meticulously observed. Only contraceptive materials and equipment for the family planning program are stored in this facility.

Although the warehouse has enough office space for the entire logistics staff, an inadequate power supply has delayed their relocation from the limited office space they are now occupying at USAID's Karachi office.

The personnel in charge of the warehouse, along with the good functioning of all operations related to distribution, indicates that staff have been adequately trained and have had long experience in logistics management.

The construction of this warehouse was a wise decision on the part of the GOP and USAID and constitutes one of the most valuable outputs of the project.

3.3.2 District Storage Capacity

In the few districts visited by the evaluation team, there was very limited storage capacity, usually only a few square meters, and many district offices are located in rented buildings, which prevents their being remodeled. Because of this situation, it is not always possible to maintain a safety stock of at least a one-month supply, even in districts with a population of several million and hundreds of distribution outlets. In several places, the commodities are not even put in a storeroom, instead they are distributed immediately to the outlets, or remain in the district for only a few days. This situation is not completely undesirable, however, since what is important is to move the supplies to the delivery points, not to maintain inactive stocks at the central and middle levels. If the storage situation in other districts is similar to that observed by the evaluation team and the condom remains a major part of the public program (since condom storage requires the most space), it will be necessary for the PWD to address this problem.

3.4 Commodity Distribution System

The central warehouse supplies 78 districts under a "pull" system with variable quantities and flexible fixed/variable intervals. A norm of two-months maximum and one-month minimum stock has been established at the district level. The lead time between central and district levels normally is no longer than one week.

Transportation is handled through a contract with a private distribution organization which utilizes railroad and trucking lines; it is exceptional for commodities to be sent by air.

Distribution from the districts to service outlets is handled by program staff responsible for logistics functions. These officers are well trained, motivated, and committed to their duties. This is partially the result of an intensive training process in which 2,800 persons participated. Transportation of commodities usually is made by vehicles permanently assigned to the district office. So far, these vehicles seem to be sufficient for the task. Current plans for expansion of the distribution network, however, could seriously strain the system.

3.5 Monitoring and Service Statistics

The logistics function and the information system of the PWP project have achieved a high degree of professionalism, maturity, and efficiency, which is probably best exemplified by the PWD's Service Statistics and Monitoring System. Almost all evaluation and planning done is based on this system.

3.5.1 Requisition Forms/Monthly Activity Reports

All private and public sector service outlets complete a contraceptive requisition form, usually every month, indicating the average monthly use or sales, the desired stock level, the stock available at the time of re-order, the replenishment request, and the amount of money collected and deposited from sales of contraceptives. These data are provided for condoms, oral contraceptives, vaginal foams, IUDs, and injectables. A monthly activity report is also completed which indicates the number of new and subsequent visits attended for family planning and non-family planning purposes. These two forms constitute the basic elements of the information system; in addition, a complete set of standard forms is replicated at the district and provincial levels.

The evaluation team observed how the forms are completed at the local level, how they are received and aggregated at the district level and then at the provincial level, and finally at the central level in the Monitoring and Statistics Wing of the General Secretariat of the PWD. The evaluation team also applied different tests to check for consistency between client's reports, contraceptive stock registers, sales ledgers and monthly management sheets at service delivery outlets, and consolidation sheets at the district level. A high degree of consistency was found.

3.5.2 Performance Monitoring Report

Information from 1,254 FWCs; 163 RHS centers; 3,493 distribution points; and 585 NGO outlets is collected regularly every month. Information is also received from about 5,000 other service delivery points, albeit with less regularity. All this information flows upwards and reaches the central

level in less than one month. With this information, the Monitoring and Statistics Wing prepares a consolidated Performance Monitoring Report for the whole country in a very brief period of time. This is an outstanding demonstration of efficiency and maturity, seldom observed in more developed programs.

A sample of one of these reports (March 1990) contains 70 full-page tables, most of which compare the achievements and targets in each province, district, contraceptive method, and type of service delivery outlet. Comparisons between performance of the current month and the previous one and with the same month of the previous year are made and ratios are calculated. The report also contains a detailed national, provincial, and district status inventory of contraceptives. A three-page executive summary of these reports is prepared and circulated to high-level government officials.

3.5.3 Postings of Performance and Supply Status

In all places visited -- centers, hospitals, district and provincial headquarters, and central offices -- tables and graphs were found on the walls indicating the performance and the supply status month by month, for the last two years. Personnel interviewed were clearly aware of their performance and knowledgeable about the meaning of the tables and graphs.

3.5.4 Manual of Contraceptive Logistics

Another major project achievement was the preparation of the *Manual of Contraceptive Logistics*. This well-edited, 90-page manual has a structure geared to the reality of the Pakistani logistics system, and describes in a rational sequence the system's objectives and policies, its structure, operational procedures, the role of the system at each level and within each category of service outlets; it also describes each of the formats used for requisitions, inventory control, and reporting.

The manual has been the principal training guide and reference source for the numerous personnel involved in logistics and reporting functions. It has served well as the unifying element for this vital function of the program, providing for standardization and precision of all elements of the logistics process.

3.5.5 Data Collection

All data collection and reporting is done manually at the local and district levels, and by microcomputer at the provincial level and the central Monitoring and Statistics Wing.

Officers interviewed are satisfied with the information system as it is now: they are confident that the data are of high quality, they do not feel the need to reduce the workload by switching from monthly to quarterly reports, and they are not interested in computerization below the provincial level. The evaluation team is in agreement on all of these points.

3.6 Dependence on Donated Supplies

The family planning program of Pakistan, in general, and the PWP project, in particular, relies on supply methods predominantly; thus large quantities of contraceptive commodities are required. Because of budgetary constraints and the availability of donated contraceptives, practically all the public and private programs in Pakistan are using donated commodities.

This dependency on donations makes the family planning program very vulnerable. The situation is made even more serious when the high proportion of condom use is considered. The condom is not only a less effective method with low continuation rates, it is very expensive, requires more storage space and transportation capacity, and needs to be frequently tested for quality control when stored at high temperatures, as is the case in Karachi and in many of the district warehouses around the country.

The government, however, has neither the industrial capacity to produce all the contraceptives it requires nor the financial resources to pay for their importation. Only long-term measures can begin to address this situation.

One such measure would be an improvement in the method mix with a larger proportion of permanent and long-acting methods and a concomitant reduction in the expensive and less effective condom method. Even if the long-acting methods are also imported or donated, an increase in their use will bring about a reduction in total cost and an increase in continuation and effectiveness rates.

A second long-term measure would be to diversify sources of supply to avoid the danger of being cut off from only one source. A consortium of donors to coordinate the provision of commodities through a concerted plan would be of great benefit to Pakistan. Such a consortium would also benefit the donors themselves because the economic and logistics burden would be divided among them. A diversification of sources of supply is necessary now and will become crucial very soon -- an addition of only 10 points in the contraceptive prevalence rate will double the cost of supplying Pakistan.

The third long-term measure is local production of contraceptives. If the expansion of the market continues, its size will soon be large enough to justify investments. A feasibility study may be useful in this respect.

Recommendations

- 1. A study should be undertaken of the current situation of district warehouses with regard to needs of space and improvements to guarantee adequate storage of the quantities of contraceptive commodities that are required by the district both as operation stock and as a three-month buffer.**
- 2. As part of the DHS to take place this year, a logistics module should be designed in order to make sure that all aspects related to logistics, such as availability of contraceptives, accessibility, preferences, use, consistency of use, amounts used in a year, and other relevant issues are included and investigated in an appropriate manner. Also, a male component should be included in the DHS. If there is a country where such a study is necessary it is Pakistan, and the extra cost is fully justified by the importance of the country and the magnitude of its program. In this component, due to the importance of the condom as a male contraceptive and the amount of funds provided by USAID for condoms, brand identification should be specified.**
- 3. The PWD should organize a national workshop on long-term contraceptive needs assessment, with participation of national and international experts, and representatives of the donor community. The conclusions of such a workshop would be the basis for the preparation of a**

set of projections of contraceptive needs from now to the year 2000.⁶ The main objective of this workshop should be to answer two questions: How many contraceptives will be needed, and how will they be paid for? USAID assistance in this workshop should be provided, if requested.

⁶See Appendix F for two sets of contraceptive needs for Pakistan from 1985 to 2000, which have been prepared by the evaluation team utilizing the Target Setting Model.

4. VOLUNTARY SURGICAL CONTRACEPTION (VSC)

The USAID project has supported VSC activities through both the PWD and NGO systems; therefore, the discussion of VSC that follows is divided into the strategy and inputs used in each of these systems. Following this, the cross-cutting issues with regard to VSC will be discussed, namely the number and quality of VSC procedures performed, the quality of training and technical assistance provided by USAID, and other issues affecting VSC acceptance in Pakistan.

4.1 Government VSC Activities

VSC services have become an important part of the PWD program. Assistance over the past 10 years to provide training in VSC, to renovate and build Reproductive Health Service (RHS) centers to provide VSC services, and to provide funds for operating the program has been supplied by the government, Pakistani NGOs (particularly the Family Planning Association of Pakistan), and donors (particularly UNFPA). USAID's involvement in VSC started in 1986 with the inclusion in the Project Amendment of funds for institutional reimbursement for procedures undertaken in government-approved VSC outlets.

4.1.1 Service Outlets Providing VSC

The PWD's approach to provision of VSC services is to use existing government medical facilities and to provide extension services where no permanent service outlet is present. Three types of service outlets are used: 1) teaching hospitals or large hospitals in urban areas; 2) district, sub-district, and private hospitals; and 3) mobile units, usually attached to teaching or urban hospitals, which make periodic visits (sometimes called "camps") to rural areas where procedures are performed in district or sub-district hospitals.

Each of these outlets for VSC is managed in different ways. The teaching urban hospitals that are part of the PWD program are referred to as RHS-A centers. In these centers, operating room space is provided exclusively for VSC, and the PWD provides financing for renovations of the space, staff salaries, equipment, and all costs associated with the procedure. Ten staff positions are sanctioned for RHS-A centers, including one physician, one theater nurse, one theater technician, and two family welfare workers. In district and other hospitals referred to as RHS-B centers, VSC activities are provided by the hospital through its own staff and facilities and PWD reimburses the hospitals for providing their services. The mobile units are attached to RHS-A centers and they make one to three visits per month to smaller urban centers and rural areas. The PWD staff employed in the RHS-A centers usually participate in these camps.

4.1.2 USAID Reimbursement of Services

The overall objective of the PWD program is to increase the number of the three types of outlets and to train more staff to perform the procedures, thereby increasing the number of procedures performed. USAID's role has been primarily to reimburse the different service outlets for the cost of the procedures performed. The rate schedule for reimbursement varies depending on the type of center performing the service.

<u>Cost Item</u>	<u>RHS-A Center</u>	<u>RHS-B Center</u>	<u>Extension Team</u>
Institutional reimbursement	Rs.50	Rs.50	Rs.70
Service Charges			
- Hospital Gynecologist	15	50	20
- Medical Superintendent	5	20	10
- Daily allowance			20
- Operation Theater/ Hospital Staff		50	10
- Nutritional Resuscitation			5
- Client	50	50	50
- Referrer/Motivator	15	15	15
Total	<u>Rs.135</u>	<u>Rs.235</u>	<u>Rs.200</u>

Institutional reimbursement is primarily for the medicine, supplies, and equipment necessary to perform the procedure. Service charges for hospital gynecologists are for their services, either to perform the procedure as in the case of the RHS-B and extension outlets, or in case of complications in the RHS-A centers. In RHS-A centers, regular PWD staff perform the procedure. The medical superintendent and hospital gynecologist assure coverage in the hospital and provide back-up as needed. The client charge is primarily for reimbursement of transportation costs and for a small amount of food during recovery. Women who bring in a client also get a small sum of money.

Over the three-year project period covered by the Project Amendment, USAID was to reimburse the PWD for over 200,000 VSC cases, provide long-term technical assistance to help in the implementation of the program, and provide short-term technical assistance for VSC training and evaluation. It was anticipated that the technical assistance services to the PWD in VSC would come in the form of a Cooperating Agency agreement, presumably with the Association for Voluntary Surgical Contraception (AVSC).

The Project Amendment budgeted \$5.090 million for institutional reimbursement to the PWD. Other inputs included six months of short-term technical assistance and U.S.-based and regional training. The total funds planned for VSC activities through the PWD were \$5.3 million.

As of March 31, 1990, USAID had earmarked \$947,995 for this component in the public sector. Most of the funds have been spent on institutional reimbursement (\$877,318). The remainder has been spent on printing of materials, primarily VSC consent forms. Only \$41,039 remains in the present budget.

4.2 NGO VSC Program

4.2.1 Strategy

Aware of the limits to the growth of publicly administered contraceptive service outlets, the PWD adopted a strategy to use NGOs for provision of services. A number of NGOs, with some government assistance, had provided family planning services in the past (see Section 5). By formally including the NGO sector in the bilateral assistance program with USAID, however, a breakthrough was made in allowing the private sector to become much more active in family planning. The general objectives were 1) to train physicians through the establishment of two training centers, 2) to assist in the establishment of a supervision and monitoring system for VSC, and 3) to expand VSC services within NGOs.

A buy-in to AVSC was initiated to assist NGOs to upgrade their services. The main objectives of the AVSC buy-in included the establishment of three to five new VSC service delivery points; assistance in designing renovations of VSC delivery points; provision of specialized equipment; identification of training needs; provision of regional training; strengthening of four to six NGOs providing VSC services as a part of general family planning service delivery; establishment of an effective medical quality monitoring and assurance system for private sector VSC; development and field testing of IEC materials; adaptation/development of standard curricula for counseling VSC clients; and the establishment of a model counseling training program including the conduct of workshops on counseling.

4.2.2 USAID Inputs

Specific inputs in the Project Amendment for VSC in the NGO component included the following: 10 person months of short-term technical assistance; 15 short-term training courses in the U.S. and 5 regional courses for VSC; a series of in-country workshops for NGOs concerning VSC; the support of 20 NGO VSC projects; and the establishment of two model training centers for VSC.

The total funds budgeted for VSC activities under the NGO component were \$1,666,114. Included in this amount was the buy-in to AVSC, amounting to \$1,150,000.

4.3 Outputs of Overall VSC Program

Over the three-year period of the Project Amendment, USAID inputs for reimbursement were to be provided for 200,000 VSC procedures. Reimbursements were to be made for PWD and NGO VSC outlets. According to available budgetary information, about \$900,000 has been provided for institutional reimbursements. This would translate into about 100,000 procedures being reimbursed from USAID funds, assuming an average cost of reimbursement of Rs.190 or \$9.00 (average of three reimbursement rates).

VSC procedures undertaken through the PWD program over the period 1985-1989 total 368,571 (see Table 4.1). Each year there has been an increase in the number of procedures performed, averaging 9.2 percent.

Table 4.1
VSC Procedures of the Population Welfare Program
1985-1989

Year	Number of Sterilizations	Percent Change
1985	60,786	.0%
1986	72,498	+19.0%
1987	73,615	+ 1.5%
1988	75,513	+ 2.6%
1989	86,159	+14.0%
Total	368,571	

From the data on procedures undertaken in RHS-A centers and RHS-B centers in three provinces over the past four years, it can be seen that the RHS-A centers, which are limited in number, are doing double the number of procedures being done in the RHS-B centers (see Table 4.2 on page 27).

Significant numbers of VSC procedures are being performed by NGOs. See Table 4.3, Part 1 on page 28, for the number of VSC procedures done and Table 4.3, Part 2 on page 29, for the number of reversible methods provided in NGO VSC service outlets from 1986 to 1990.

This table shows the ranking of the NGOs supported by AVSC and by the Family Planning Association of Pakistan (FPAP) in terms of sterilizations performed during the various reporting periods as well as other methods. As can be seen, some NGOs are performing many more procedures than others; the top ranking NGO project is the Reproductive Health Extension Service which is performing an average of 22 procedures a day. The performance rate of the static clinics has not been as high. The most productive static clinic (Private Hospital Project) averages about 8 procedures per day. The two lowest ranking NGOs are performing only 16 and 23 per month, for an average of less than one per day.

Most of the NGO VSC service centers also provide temporary methods of family planning. FPAP's model center in Lahore recorded 3,547 IUD insertions over a one-year period. Table 4.3, Part 2, shows the CYP per month for reversible methods. The VSC service center with the highest CYP was the model center in Lahore, due to the high CYP conversion factor of the IUD.

Table 4.2

**Number of Acceptors of Family Planning Methods at Reproductive Health Service A and B Centers
1985-1989**

Reproductive Health Service A Centers						
Period	VSC	IUD	Inject	Pills	Condom	Foam
NWF Province						
85-86	2,876	1,286	1,499	3,175	4,088	325
86-87	2,695	1,623	2,320	4,247	60,714	413
87-88	2,673	2,996	2,430	9,006	77,768	795
88-89	2,321	2,447	3,039	8,146	75,516	716
Punjab Province						
85-86	19,525	3,821	1,208	3,121	8,291	681
86-87	18,590	4,213	1,151	2,667	8,788	966
87-88	18,431	4,954	1,010	3,054	7,491	1,202
88-89	18,799	6,296	2,029	4,922	21,314	1,160
Sindh Province						
85-86	7,256	2,600	454	4,161	116,567	207
86-87	8,212	2,645	780	2,966	144,711	449
87-88	8,449	3,174	893	5,730	240,668	1,127
88-89	8,244	3,400	969	5,144	209,144	1,196

Reproductive Health Service B Centers						
Period	VSC	IUD	Inject	Pills	Condom	Foam
NWF Province						
85-86	1,192	579	443	1,621	523	32
86-87	1,151	675	708	1,655	5,964	22
87-88	1,313	1,123	720	1,586	8,434	44
88-89	1,482	859	722	1,873	6,993	82
Punjab Province						
85-86	10,922	1,815	1,512	3,644	12,558	498
86-87	10,009	3,104	2,095	3,634	15,606	629
87-88	11,933	3,247	2,210	4,643	19,979	1,340
88-89	11,899	2,111	1,944	2,280	55,987	518
Sindh Province						
85-86	1,825	355	114	629	7,244	32
86-87	2,287	632	654	1,277	25,200	92
87-88	2,960	561	809	1,625	27,797	117
88-89	2,573	576	1,862	987	15,482	121

Table 4.3

**Number of Acceptors of Family Planning Methods
From the NGO Sector, Supported by AVSC and the Family Planning
Association of Pakistan, through VSC Service Centers**

Part 1: Sterilization

	From	To	Months	Vasectomy	Tubal Ligation	Total	Acceptors Per Month
<u>AVSC-funded projects</u>							
MCH	Apr 86	Nov 89	(43 mo)	94	5,012	5,106	118.7
FPAP-AVS	Oct 86	Dec 89	(38 mo)	230	3,777	4,007	105.4
Pak Medico	Dec 85	Jan 90	(49 mo)	22	4,372	4,394	89.7
Behbud	Jul 86	Aug 89	(37 mo)	69	2,729	2,798	75.6
PSPP/Mayo	Oct 86	Sep 89	(35 mo)	1,364	0	1,364	39.0
PVHNA	Aug 88	Dec 89	(16 mo)	11	521	532	33.3
APWA	Jul 87	Sep 89	(26 mo)	2	793	795	30.6
PSPP	Jan 86	Jan 90	(48 mo)	453	636	1,089	22.7
Subtotal				2,245	17,840	20,085	514.7
<u>FPAP-funded projects (Jan. - Dec. 1989)</u>							
Reproductive Health Extension Services			(12 mo)	0	7,515	7,515	626.2
Private Hospital Project			(12 mo)	0	2,747	2,747	228.9
Model Center Karachi			(12 mo)	0	1,265	1,265	105.4
Model Center Lahore			(12 mo)	0	981	981	81.8
FPAP Private Doctors			(12 mo)	0	196	196	16.3
Subtotal				0	12,704	12,704	1,058.6
TOTAL				2,245	30,544	32,789	1,573.3

Averages per month in the last column are for the whole NGO, independent of the number of outlets. The table was sorted in descending order of monthly averages.

Source of data: project files.

Table 4.3

**Number of Acceptors of Family Planning Methods
From the NGO Sector, Supported by AVSC and the Family Planning
Association of Pakistan, Through VSC Service Centers**

Part 2: Reversible Methods

	From	To	Months	Injection	IUDs	Condoms	Foam	Orals	CYPs Per Month
<u>AVSC-funded projects</u>									
MCH's	Apr 86	Nov 89	(43 mo)	5,412	269	37,356	0	3,924	60.9
FPAP-AVS	Oct 86	Dec 89	(38 mo)	467	706	6,264	0	185	46.0
Pak Medico	Dec 85	Jan 90	(49 mo)	428	336	3,900	0	473	18.8
Behbud	Jul 86	Aug 89	(37 mo)	167	694	7,812	248	208	46.6
PSPP/Mayo	Oct 86	Sep 89	(35 mo)	0	0	0	0	0	0.0
PVHNA	Aug 88	Dec 89	(16 mo)	52	75	3,756	892	43	27.6
APWA	Jul 87	Sep 89	(26 mo)	313	173	35,604	72	434	33.3
PSPP	Jan 86	Jan 90	(48 mo)	684	431	100,474	323	1,430	48.2
Subtotal				7,523	2,684	195,166	1,535	6,697	281.5
<u>FPAP-funded projects (Jan. - Dec. '89)</u>									
RHE (mobile) Services			(12 mo)	130	0	50	0	118	.8
Private Hospital Project			(12 mo)	0	0	0	0	0	0.0
Model Center Karachi			(12 mo)	574	840	35,700	642	864	216.3
Model Center Lahore			(12 mo)	178	3,547	101,800	1,510	2,116	790.5
FPAP Private Doctors			(12 mo)	0	0	0	0	0	0.0
Subtotal				882	4,517	137,550	2,152	3,098	1,007.6
TOTAL				8,405	7,201	332,716	3,687	9,795	1,289.1

FPAP has been successful in providing VSC and reversible methods of family planning. The organization is well established and has many years of experience in providing family planning services. AVSC-assisted NGOs have been somewhat less successful in overall performance in terms of numbers of procedures performed. These NGOs are mostly new to family planning and there is great variation in the reported performance of their service outlets, with most of the outlets taking about 15 to 18 months to build up a relatively stable client load.

To increase the number of clients, 13 AVSC outlets receiving AVSC assistance have either direct or indirect links with outreach services that are designed to increase the client load. One NGO has a mobile reproductive health unit attached to three of its VSC centers. One project, with four static outlets, is designed to use private physicians as outlets for free VSC services.⁷

AVSC is also providing assistance in vasectomy. As can be seen from Table 4.3, Part 1, about 2,250 vasectomies have been performed under the project, with half being done at AVSC's training center. (See Section 4.4.4 for a discussion of vasectomy training). With the slow growth of vasectomy in Pakistan, there is not an immediate problem in its wider provision in clinical facilities. If vasectomy were to be widely promoted, however, a number of essentially cultural issues will need to be addressed. In Pakistan, sterilization procedures are usually offered by a physician of the same sex as the client; thus physicians cannot be utilized as effectively as they would be if it were acceptable for them to perform VSC procedures for either sex. In addition, clinic arrangements and hours have to take into account the cultural separation of men and women and the resulting need for additional space for recovery after the procedure.

Overall, both the age and parity of the women choosing VSC are high -- the average age is around 35 years and parity is around 7. There does not seem to be a downward trend for either of these figures as yet.

4.4 Issues of Concern with VSC

4.4.1 Reimbursement of Costs

Funds for reimbursing hospitals for performing VSC and providing money to physicians, clients, and referrers have been a part of the VSC program in Pakistan for some time. There is the expectation among medical personnel that they will be reimbursed for the performance of a service that is not considered part of their job descriptions. Drugs and supplies in most hospitals and RHS-A centers are in short supply; therefore, if VSCs were to be performed without funds being allocated for this service, it is doubtful that surgeons would use their limited supplies on non-emergency procedures.

Fees to clients are not viewed by VSC staff as incentive payments. The evaluation team was assured that women would not be motivated by Rs. 50 to undergo a sterilization procedure. The evaluation team is satisfied that the money provided to the women in Pakistan does not appear to act as an incentive to undergo sterilization in either PWD or NGO facilities. The PWD and the physicians performing procedures are well aware of India's experience in sterilization almost 15 years ago, when sterilizations were not always voluntary. The fee to the referrer is a finder's fee, which serves to motivate satisfied users to bring into the centers women who wish to have a procedure. In Pakistani society it is very difficult for a woman to travel alone; if a woman chooses to avail herself of a VSC procedure, another woman must accompany her. The referrer is usually this companion.

⁷This project is currently not functioning because the physicians have not received the institutional reimbursement from the government. This situation points to a general problem with regard to including private physicians in subsidized VSC services: the present reimbursement schedule does not cover the costs for private practitioners to do the procedure. This project is under revision and plans are being made to open a special center to combine efforts previously spread among several private clinics.

Certain funds in the reimbursement scheme go to the hospital gynecologist and/or medical superintendent. These funds allow the VSC unit access to the hospital and coverage if there are any complications. The lack of full support from MOH staff in hospitals to include sterilizations as part of their regular duties makes this payment necessary. Naturally, it would be preferable if the MOH would direct its hospital staff to support VSC fully without a payment being required.

Although adjustments to the present system should be carefully studied before implementation to avoid any negative impact on the numbers of procedures being performed, there are areas in which changes might be appropriate. For example, there does seem to be some justification for a review of the cost of supplies needed for the procedure -- prices have gone up and Rs. 50 may no longer be sufficient. Also, the payment to the client may not be necessary since she is usually well motivated by the referrer to come to the center. A further indication that the client may not require payment has been shown by the fact that when reimbursements have not been paid to clients after surgery because of fund disbursement problems (see below), and the client is asked to return to collect her money, she often does not return. It is not known, however, whether this has affected the number of clients coming for the procedure.

The payment to the referrer, on the other hand, is necessary; indeed, a number of persons interviewed suggested that the amount should be increased. Because transportation and food expenses must come out of this money, there is little left for the referrer's time and effort. An examination of different levels of reimbursement for the referrer and client would make a good subject for operations research. It would be useful to do such research in the remaining project period in the expectation that changes may be made in the reimbursement schedule.

4.4.2 Efficiency of Reimbursement Procedures

On the whole, the USAID-PWD system for institutional reimbursement for VSC procedures has been timely and efficient. At the same time, there have been some delays in the system caused by consolidation of the number of procedures at the district and provincial level before submission to headquarters for reimbursement. More recently, these delays have been fewer. Once the claims have been received by USAID, a check has been issued promptly.

Difficulty seems to arise, however, in the actual disbursement of funds from the central government to the provincial level. It has been reported that it can take three to four months for this process to be completed. Some information also indicates that there are insufficient funds to reimburse clients immediately after they have undergone procedures and that they are asked to return to collect their money. This lack of funds to pay the clients for the procedures has been blamed by many persons interviewed on the delay in reimbursement from the government for previous sterilizations undertaken. The evaluation team did not have time to investigate this claim.

One NGO project has tried to deal with the long delays in receiving funds for reimbursement from the government by establishing a revolving fund from which institutional reimbursements can be made rapidly. The government payment is then made straight into the fund when it arrives. This is a possible solution for other NGOs since they should have the flexibility to set up such a system. Dealing with this situation at RHS-A and MOH RHS-B centers, however, is not as simple due to government procedures that must be followed.

4.4.3 Voluntary Nature of Surgical Contraception

Clients for a sterilization procedure must complete consent forms, which include the agreement of their spouses. In addition, the clients receive counseling from center staff. Depending on the type of facility, this counseling may be done by a family welfare worker (FWW) or counselor or family welfare assistant (FWA) and the physician performing the procedure. Various examinations are made by the physicians and a client history is taken. As illustrated in Tables 4.2, 4.3, and 4.4, RHS centers and NGO VSC centers provide a wide range of other contraceptive choices. The choice of method is made in consultation with the center staff and the client, even though the predominant purpose of the center may be sterilization.

4.4.4 Training

For the NGO component, the AVSC buy-in was to finance two major centers for training, primarily to serve the NGO and private sector. AVSC is currently providing ongoing training through in-country workshops and overseas. (See Section 9 concerning overseas training funded by USAID.) It is also assisting in the development of training curricula for VSC and a counseling training curriculum. So far, AVSC has funded three counseling workshops through the NGO Coordinating Council (see Section 5.4.3). The workshops were carried out at the Regional Training Institutes in Karachi and Lahore and in Karachi at Council headquarters; altogether 61 persons were trained.

Some training in minilaparotomy techniques is offered in the AVSC-assisted projects, but thus far minilaparotomy training has not been a major focus of AVSC assistance.

Training in vasectomy is undertaken in one AVSC-assisted project. The course lasts for two weeks, and two to three physicians are trained per course. There are three trainers in the program and they have trained 64 physicians since the program began in 1987. The main constraint faced by the program is the lack of clients: trainees need to observe six or seven procedures under supervision and then perform satisfactorily a minimum of five under supervision before being certified. As the average demand for vasectomy has dropped slightly at this training center (possibly because the service is now being offered in more centers), fewer clients are available for training purposes. Program staff try to persuade clients to delay the operation until the next course is to be offered. They also send messages to physicians and NGOs requesting referrals for vasectomy. In this way the training center can usually muster about 20-24 cases per course.

In contrast to the progress being made in the NGO system, few training activities are taking place in the government sector. In RHS-A centers that are teaching hospitals, the chief gynecologist may use the RHS-A center for teaching medical students sterilization procedures, or she may refer the students to the PWD staff doing the procedures. These centers with their large caseloads are ideal settings for teaching minilaparotomy procedures to medical students, thus producing a large cadre of trained staff. If the training is not systematic and of the highest standard, however, problems may occur in the future in the provision of sterilization by the physicians trained. This problem was recognized in a review and needs assessment mission of the PWD's RHS program undertaken by AVSC in collaboration with PWD staff in December 1986. The mission identified the need for the development of standard curricula for surgical team training and orientation workshops and retraining through refresher courses for service personnel. Although some of the work that AVSC is doing in curricula development in the NGO component may be applied to the government program, there is still a need for direct technical assistance to PWD and MOH personnel in VSC. Funds are available

for a buy-in under the Project Amendment for this assistance and a formal request by PWD could access these funds.

4.4.5 Quality Assurance System

In the NGO sector, AVSC is assisting in the development of a quality assurance system in those centers with which it is working. This system seems to function well and appears to be understood thoroughly by the personnel working in the service delivery sites. AVSC has also carried out a number of supervisory and monitoring visits to VSC projects; the directors of these projects have seen this as a valuable contribution.

No formal system for quality assurance exists in the government system. At government hospitals the chief gynecologist assumes responsibility for quality assurance; complications are referred to her and there is no system for the reporting/ investigation of complications by either the PWD or the MOH. The RHS supervisory staff of the PWD is very small and it cannot be expected that this unit could take on the responsibility for quality assurance, reporting, and monitoring of VSC in government facilities nationwide. Some system does need to be developed, however, to ensure that high standard services are provided, that complications are reported, and that a thorough investigation (including a clinical review) is made of each complication. This should be done not only to ensure the health of individual patients, but to remove the possibility of the ill-effect that reports of complications or poor performance standards would have on the motivation of women to undergo a sterilization procedure.

Recommendations

1. The PWD should undertake an operations research study of the reimbursement schedule in the next 15 months to ascertain whether and at what levels institutional and personal reimbursement should be provided for the VSC program. This study should include an examination of the bottlenecks in the procedures used by the government to reimburse VSC centers and alternative mechanisms that could be recommended to the government and USAID to overcome any problems that may be encountered. USAID assistance should be provided.

2. A training and institutional development program for the PWD VSC program, parallel to the one going on in the NGO sector, should be developed. The PWD program should take full advantage of the AVSC technical assistance in the NGO sector, where possible, for its own VSC work. Although it may be too late in the project period to activate the buy-in mechanism for AVSC assistance to the RHS program, in a follow-on project, a training and institutional development program for VSC in the public sector should be a condition for assistance in VSC. USAID assistance should be provided in the remaining project period to plan for this program.

5. NON-GOVERNMENTAL ORGANIZATION ACTIVITIES

5.1 Background

The GOP has a long history of supporting family planning activities carried out by NGOs, going back to the days before the Population Welfare Program existed. The first organized family planning service program in Pakistan was started in 1952 by the Family Planning Association of Pakistan; shortly thereafter, the government began to provide the program with funds.

In the Sixth Five Year Plan, the PWD saw the need to involve NGOs more systematically in the delivery of family planning services. It planned to allocate Rs. 50 million to an NGO project that would include an NGO Coordinating Council (NGOCC) which would review and advise on project proposals from NGOs, liaise with the government and NGOs, and assist in the implementation of relevant policies.

Discussions on the form and functions of the NGO project began in 1983 when the PWD convened a group of leading NGOs. The basic NGO project concepts were mutually agreed upon, but the allocation of primary responsibility became a key issue whose resolution was necessary before implementation was possible. Over the next 18 months, the primary role was attributed first to the NGO sector (with FPAP assuming a major role among the NGOs), then to the PWD, which saw the NGOCC as an extension of the PWD since it would be its project (a position unacceptable to the NGOs). A compromise eventually defined the NGOCC as an autonomous body with ties to both the government and active NGOs.

The institutional structure of the NGOCC consists of four distinct components:

- The Policy Board, which is composed of 10 government members and 4 persons nominated from the NGO sector; it is chaired by the Minister for Population Welfare. Its function is to provide long-term policy direction, to set operational and financial guidelines, to review the progress of the NGO project, and to examine and approve the financial requirements of the NGO sector as submitted by the Council (see below).
- The Council, which is a management body, is made up of 16 voting members nominated individually by the Minister for Population Welfare from the NGO sector and 11 ex officio members representing government divisions. The Council is charged with identification of NGOs for involvement in population activities; encouragement and assistance in development of NGOs and their projects; review and approval of projects (including budget levels) submitted, whether funded by the government or external sources, and evaluation of their implementation; disbursement of funds for approved projects (except those funded directly by external agencies) and the collection of annual audited accounts from NGO projects; and preparation of annual budgets for submission to the government and negotiation of external assistance for NGOs as appropriate.
- The Secretariat, which is the body of paid staff appointed by the Council to assist it in fulfilling its assigned functions.
- The network of NGO institutional members who pay an annual membership fee to be eligible to receive funding through the NGOCC.

Previous Page Blank

5.2 Objectives of the NGO Project

The objectives of the NGO project are to involve NGOs as fully as possible in the efforts of the Population Welfare Program in order to achieve its specific goal: "to promote a small family norm and provide the means for achieving this objective." In order to achieve this goal, two quantitative objectives were given to the NGOCC:

- A total of 925 service outlets are to be established by the NGO sector, through the NGOCC, by the end of the Seventh Five Year Plan (June 1993); this target breaks down as follows:

778	Family Health Centers
50	Mobile service units
30	VSC centers
60	Community-based distribution points
7	Audio-visual vans (already existing, no expansion planned)
- A target of 346,000 births averted has been set, 48,000 of which is to be achieved by June 1990.

5.3 USAID Inputs

USAID's support to the NGO project is intended to strengthen both NGOs and the NGOCC. This is to be accomplished by broadening the role of NGOs in the delivery of family planning services through the provision of technical assistance, training and financing for the institutional development of the NGOCC, funding for 15 projects of various Pakistani NGOs, and contraceptive commodities.

5.4 Project Outputs

5.4.1 NGO Outlets

Table 5.1 on the opposite page shows the reported number of outlets according to the latest NGOCC lists as compared to the target levels set for the end of budget year 1989-1990. Of the 609 NGOCC outlets that were targeted for the 1989-1990 budget year, 531 outlets have been established or 87 percent. In no province has the overall target been achieved, although in the Punjab the shortfall is only 2.5 percent. In Balochistan, 54 percent of the target has been reached. The greatest achievement of targets is in community based distribution (CBD) points and VSC centers: CBD points are double the target and VSC centers are exactly on target. Only 74 percent of the targeted numbers of Family Health Centers (FHC) have been opened, and the number of FHCs funded directly by outside NGOs falls far short of the number anticipated, except in Northwest Frontier province.

A discussion of project outputs to date in terms of targets achieved is handicapped by several factors. There is a lack of precision as to what is meant by "CBD points" and "mobile service units" (MSU). Both CBD outlets and individuals who deliver small supplies to clients can be considered to be the supply point in a community. They can also be considered to be the point of contact

Table 5.1

**NGOCC Outlets^a Compared to June 1990 Targets
by Province and Type of Outlet**

	<u>Target</u>	<u>Actual</u>	<u>% Achieved</u>
All of Pakistan			
FHC Program funded	459	355	77.3
NGO funded	72	38	52.8
Total FHCs	531	393	74.0
VSC Centers	19	19	100.0
CBD Points	54	109	201.8
MSU	5	10	200.0
Total Service Outlets	609	531	87.2
Punjab^b			
FHC Program funded	215	204	94.9
NGO Funded	25	14	56.0
Total FHCs	240	218	90.8
VSC Centers	11	14	127.3
CBD Points	22	31	140.9
MSH	3	6	200.0
Total Service Outlets	276	269	97.5
Sindh			
FHC Program funded	116	73	62.9
NGO funded	22	4	18.2
Total FHCs	138	77	55.8
VSC Centers	7	3	42.8
CBD Points	16	52	325.0
MSU	2	3	150.0
Total Service Outlets	163	135	82.8
NWFP^c			
FHC Program funded	98	63	64.2
NGO funded	23	66	87.0
Total FHCs	121	83	68.6
VSC Centers	1	2	200.0
CBD Points	11	22	200.0
MSU	0	0	--
Total Service Outlets	133	107	80.4
Balochistan			
FHC Program funded	30	15	50.0
NGO funded	2	0	0.0
Total FHCs	32	15	46.9
VSC Centers	0	0	--
CBD Points	5	4	80.0
MSU	0	1	--
Total Service Outlets	37	20	54.0

Note: Targets for audiovisual vans are excluded as no increase in their number was planned.

^aBased on list provided by the NGOCC, May 1990.

^bIncludes Islamabad.

^cIncludes the Northern Areas.

between an outside supplier of contraceptives and the outreach CBD worker. It would appear that some of each kind of outlet exists in the varied NGOCC CBD projects, but the most common count of points is areas served. Similarly, although the PC-1⁸ identifies MSUs by numbers of vehicles, there is some confusion in lists of outlets as to whether it is points visited or vehicles that are being counted. As far as possible, CBD points refer to contact points between outreach and the supply source, and MSUs refer to projects only, since information on vehicles is not readily available.

The shortfall in the number of FHCs funded directly by NGOs may reflect a real lack of interest in funding the Family Welfare Clinic (FWC) model on the part of international NGOs. It is important to note that the NGO component placed an excessive stress on the creation of FHCs that resemble the government's FWC concept, rather than encouraging creative new approaches to service delivery. Indeed, the PWD's target for increasing the number of its FWCs over the Population Welfare Plan period is minimal. There seems to be instead an effective transfer of responsibility for expanding the numbers of FWC/FHC type outlets from the PWD to the NGO sector. Furthermore, as is shown in Table 5.2, this responsibility is then passed on from the NGOCC-funded sector to NGO-to-NGO (i.e., international NGO to national NGO) funding sources.

Table 5.2

**Increase in Family Welfare/Family Health Centers,
According to Source of Funding and Year**

Budget Year	Increase in Target Number of FWCs/FHCs		
	PWD	NGOCC Funds	NGO-NGO Funds
87-88/88-89	0	+45	0
88-89/89-90	+ 25	+45	+ 53
89-90/89-90	+ 20	0	+ 53
90-91/91-92	+ 37	0	+ 97
91-92/92-93	+ 20	0	+ 97
Total	+102	+90	+300

Source: PC-1.

⁸The PC-1 is the GOP Planning Commission's project document.

It would be worth analyzing the comparative impacts of CBD, MSU, and FHC units in areas where they are working and considering a revision of targets in light of the results. This might require a detailed study if the data are not readily available in NGOCC records.

5.4.2 Births Averted

As shown in Table 5.3, the NGOCC has fallen short of the targets of birth aversion set for its projects, the highest yearly total being 72 percent.

Table 5.3

**Comparative Statement of Birth Aversions through NGOCC Outlets:
Targets and Achievements 1984 to December 1989**

Years	Targets for Birth Aversion	Achievements	% of Target Achieved
1984-85	5,784	37	5.8%
1985-86	10,633	3,750	35.3%
1986-87	14,500	10,431	71.9%
1987-88	19,500	12,567	64.4%
1988-89	40,000	23,931	59.8%
July-Dec. 1989	24,000	19,155	79.8%

These figures, however, may not adequately reflect the magnitude of the births averted. First, there is reason to believe that under-reporting is occurring in many centers, although this may be somewhat compensated for by over-estimates from others. Under-reporting may be due to difficulties with record keeping, poor follow-up, and lack of information concerning referrals, especially for voluntary sterilization. Second, it should be noted that not all service outlets of NGOCC member NGOs are covered in NGOCC statistics. Results in projects not funded by or through the NGOCC are not automatically reported. For example, FPAP alone services 110 clinics and 1,286 non-clinical outlets through its total program, yet only 113 are counted in the NGOCC network. It is to be hoped that, in time, lists of projects and outlets not funded by the NGOCC will be made available to the NGOCC database. In addition to providing an overall picture of NGO contributions to national targets, this information would be useful in coordinating projects and minimizing project activity overlap.

5.4.3 Contribution of A.I.D. Cooperating Agencies

USAID has been contributing technical assistance to both the NGOCC and to NGOs through A.I.D. Cooperating Agencies (CA), thus providing a steady stream of technical assistance to the NGOCC and its member NGOs. USAID has played an important facilitating role in support of these organizations. Faced with the reality of complex bureaucratic procedures for the approval and release of funds, which can severely restrict the capacity of NGOs to carry out activities because of cash-flow

problems, USAID has helped identify and promote the introduction of mechanisms that allow some of the more lengthy stages of normal government funding release systems to be by-passed. An agreement has been reached whereby international NGOs can transmit funds directly to national NGOs. The GOP now clears the donor agency and approves the project; once this has been done the donor NGO only has to ensure that the NGOCC is informed of the disbursements of funds to the local NGO.

A number of CAs have provided technical assistance in different ways.

Family Planning International Assistance (FPIA). FPIA worked closely with the NGOCC on developing basic systems for identifying needs, processing proposals, and monitoring projects when the NGOCC Secretariat started to function. FPIA helped the NGOCC identify its staffing needs and provided funding for core staff, planning to phase out of this funding as the GOP took over responsibility for funding the necessary posts. As yet, the transfer of responsibility to the GOP for half of the posts thus created has not taken place. This poses an urgent problem, particularly when FPIA future funding is in question.

AVSC. AVSC has provided frequent technical assistance, mainly in the development of systems for managing and monitoring VSC services. This more specialized technical assistance has been given primarily to the seven NGOs that are providing such services, although AVSC has also helped the NGOCC to carry out workshops and develop the training components concerning counseling for sterilization.

Centre for Development and Population Activities (CEDPA). CEDPA has provided technical assistance in project development and management areas, both through specific projects in five NGOs and through the NGOCC in planning training and workshop activities to meet identified needs in the NGO sector.

The Pathfinder Fund. Pathfinder has provided technical assistance to both the NGOCC and to local NGOs through the presence of a country coordinator who plays an active, ongoing support role in designing and developing projects. Pathfinder has contributed to the production of a variety of technical reference materials, particularly those concerning project development and family planning service delivery, and has funded a number of innovative projects with local NGOs. One of these projects distributes contraceptives to physicians for use in their private practices. While this has only been done in a few urban areas, it points to the potential offered by targeting private practitioners in the for-profit sector for providing family planning services.

5.4.4 Overseas Training

Thus far, 17 NGOCC candidates have traveled to the U.S. for training. Although the number of trainees is greater than the 12 aimed for under this input, the length of the courses is considerably shorter than that planned -- the longest was seven weeks. Most attended CEDPA courses, which has a distinct advantage since CEDPA follows up trainees and assists in-country training activities organized by those it has trained. Study tours of Asian CBD activities have also been organized; a number of NGO candidates have benefitted from these.

The bureaucratic procedures involved in processing NGOCC candidates for training abroad are ponderous and lengthy. Applications have to be processed through the PWD and USAID, a procedure which can take considerable time. USAID's Health, Population, and Nutrition (HPN) Office, however, has taken the lead in attempting to reduce the amount of time required for the approval of training candidates.

5.5 Issues of Concern

5.5.1 Impediments to the NGOCC's Autonomy

The NGOCC was designed as an autonomous body to facilitate increased contributions to the national population welfare program. From its inception, however, it has been neither a governmental body nor a non-governmental body but rather it has found itself in the center of a tug-of-war between government and NGO sector requirements. On the one hand, the NGOCC needs to retain a maximum degree of autonomy to allow for flexibility and rapid response in order to attract members of the NGO community it is designed to serve. On the other hand, the government, which was instrumental in the creation of the NGOCC and which has committed government funds for its support, feels it needs to impose the same kinds of bureaucratic requirements that it imposes on government bodies to establish financial accountability.

If all government procedural orders were to be followed exactly, however, the NGOCC would be unable to carry out the functions which it has been assigned. The NGOCC must be able to ensure that funds are provided on a regular basis to its NGOs for salaries and supplies. It needs to be able to provide funds for innovative activities. The regular government procedures for transfer of funds are very lengthy and, at times, the NGOCC and the NGOs have been without funds. Thus, the importance of NGO-to-NGO funding (whereby CAs can directly fund NGO activities without the funds being channelled through the government) is that it keeps funds out of the bottleneck. The program-based disbursement arrangement that USAID used for part of its support to the NGO sector also seems to have avoided the bottleneck of the government disbursement system. If the NGOCC is to retain the credibility it needs to work through the NGO sector, a mechanism must be found to allow the NGOs to undertake activities without undue restriction by the government.

5.5.2 Composition of the NGOCC Council

There are two concerns with regard to the composition of the NGOCC Council: 1) Ministerial nomination of Council members is of individuals not NGOs, and some nominees are not from NGOs that are institutional members of the NGOCC. Some Council members are seen, therefore, as having been appointed in an individual capacity rather than as representatives of their NGOs. This does not encourage a sense of involvement and commitment on the part of NGOs which is needed for the NGOCC to develop its potential more fully. At present, most NGOs feel no responsibility for the NGOCC, viewing it as a source of funding towards which their only responsibility is accountability for funding received. 2) Few of the present Council members are currently active members of experienced and dynamic NGOCC institutional members. More Council members from such NGOs could greatly strengthen the Council and help the NGOCC fulfill its role.

5.5.3 Inadequate Use of NGO Potential for Innovation

The NGO sector has an enormous potential for expanding the delivery of contraceptive services in Pakistan -- the number of NGOs that have expressed the will to participate is a clear demonstration of this desire. Unfortunately, as set out in government plans, the NGO project has stated its targets in terms of numbers of outlets created, in particular, the number of Family Health Centers. Thus, the NGOCC is under pressure to produce large numbers of FHCs through the NGO sector. In fact, it has started to use the term "outlet" almost as a synonym for "project." This tendency has increased over the last two years to the point where the project concept has been almost lost. An outline of staffing and budgets for a "model" FHC kind of center has become not a guide but rather a standard for project submissions. NGOs' strengths lie in their flexibility and ability to respond to local situations in innovative ways. These strengths should be encouraged and built upon rather than inhibited (as they now are) by the imposition of rigid models based on scaled-down versions of government services.

Indeed, the slower rate of growth in the number of NGOs joining the NGOCC may be, in part, a reaction against the rigidity of the "model" framework. NGOs with more experience in project development have found ways to develop multi-component projects in which FHCs may be only a minor part of the total activities, but inexperienced small or new NGOs find themselves channeled into outlet creation using the standard model. The NGOCC needs to review its real objective: if the number of births averted is the primary objective then a deviation from the number of outlets given as targets may be acceptable as long as birth aversion targets are achieved. Only by experimenting with innovative approaches, and monitoring their impact, can the NGOCC hope to achieve the birth aversion targets. Family Welfare Centers have not proved consistently effective (see Section 2), so there is reason to question the value of replicating them on a smaller scale through the NGO sector.

5.5.4 Need for Quality Control of NGO Projects

Although USAID's use of performance-based disbursements was a successful mechanism for encouraging development of management systems, in the future such a mechanism should include quality control of funded projects. Also, USAID has not participated as planned in the full project planning and monitoring process of more than one selected project, which was designed to assess the quality of the NGOCC's work. Fortunately, Pathfinder has undertaken this role in all its projects. More needs to be done by USAID, however, in assuring the quality of all its NGO-supported projects.

5.5.5 Need to Consolidate NGO Network

If the NGO sector is to achieve its potential contribution to the primary objectives of the Population Welfare Program, the existing NGOCC structure and network needs to be consolidated. A recent agreement with The Asia Foundation (TAF) reflects an awareness of the need (identified by a number of evaluations of the NGOCC) to strengthen NGOCC monitoring systems and its capacity to provide technical and management guidance to participating NGOs; to improve coordination of NGO programs in urban areas; and to modify the planning process and staff structure of local outlets. A problem not specified in the TAF agreement is the need to shift the focus from outlets alone to projects that serve outlets and include other activities; TAF should help the NGOCC address this problem.

In addition, as noted in Section 5.4.3, the question of who will provide the salaries of the NGOCC Secretariat once FPIA funds have been phased out has yet to be decided. Also, there is a problem with regard to turnover of personnel in the Secretariat. This turnover is due, at least in part, to the fact that although Secretariat staff are paid according to government salary scales, they are employed on a contract basis and thus do not receive all the benefits that government staff in equivalent posts receive. A future problem may be the lack of continuity of good staff if funds are not available.

5.5.6 Distribution of Contraceptives

The NGOCC projects have received their contraceptive supplies directly from the central warehouse in Karachi. This has generally worked out well. If an outlet has been short of a particular contraceptive commodity, an emergency supply has been mailed from Karachi. In some cases, district population officers of the PWD have made contraceptives available. It will be important as the public sector program begins to deal with its own contraceptive requirements (see Section 3.6) for the NGO sector to be a part of this exercise. The Family Planning Association of Pakistan, for example, has many outlets and serves a large population; a steady and reliable supply of contraceptives is vital to its mission. Close cooperation between the NGO community and the government and international donors is necessary to ensure the continued supply of contraceptives to NGOs.

Recommendations

- 1. In the immediate future, the NGOCC should recognize the incompatibility of achieving both birth aversion targets and targets for number of outlets, and should shift emphasis to achieving the birth aversion target. In order to achieve this, the NGOCC should take steps to encourage efforts that are designed to upgrade existing centers and extend outreach and follow-up visits in order to generate greater awareness and demand in areas where access to family planning services already exists, rather than open new outlets.**
- 2. USAID should take immediate steps to work with the NGOCC in reviewing the activities it supports to ensure that the innovative nature of NGO efforts is encouraged and that resources are not being used exclusively to open up new outlets. Particular attention should be given to the 10 new outlets being assigned to USAID. USAID assistance should be based on clear project proposals, preferably those of an innovative character or those designed to upgrade services offered.**
- 3. Over the remaining 15 months of the present project, USAID, either through the NGO Coordinator in its HPN office or through a consultancy, should participate with the NGOCC in the identification, design, monitoring, and evaluation of at least two new activities. These activities could be developed using an operations research framework so that the lessons learned from them may be applied in the development of future NGO activities.**
- 4. In the short term, the NGOCC should work with the government and USAID, if necessary, to find alternative sources of funding for NGOCC staff who are presently paid by FPIA. In the longer term, more Secretariat staff should be hired to carry out the NGOCC program.**

6. EFFORTS TO IMPROVE DISTRICT OPERATIONS: THE FAMILY PLANNING INPUTS INTO THE HEALTH PROGRAM

6.1 Background

The Project Amendment approved funds to test a strategy for field level supervision. However, when the PC-1 (the government planning document) was submitted to the government for approval it was rejected due to its recurrent cost implications and the fact that resources were focused on one province.⁹

Following the rejection of this project, the PWD developed another one for which it could use the unallocated USAID funds. This new project, Family Planning Inputs into the Health Program, was a nationwide effort involving provincial health and population welfare departments, and, as such, was viewed as a breakthrough because the government as well as USAID have long wished for an active participation of the MOH in the delivery of family planning services. The relevant section of the Project Agreement (Sixth Amendatory Agreement) was amended to include that "the objective of this component will further be achieved by expanding the base of family planning service delivery to all public sector health facilities. For this purpose the District Population Welfare Officers will actively participate in (a) arranging necessary training of the government doctors and paramedics, (b) delivery of contraceptive supplies to health outlets, and (c) maintaining close and continuous coordination with Health Department Officials."

The activities that were planned to carry out this project included 1) training of various levels of health personnel (male and female physicians, lady health visitors, female and male paramedics, etc.) in the provision of family planning, 2) orientation of project directors and managers (district health officers and district population welfare officers, 3) provision of supplies and equipment (IUD kits, cash boxes, registers and reports, sign boards), and 4) provision of contraceptives.

In order to get this project moving as quickly as possible, the PWD and USAID decided to provide some funds in advance for expenses incurred in setting up the project. Usually all USAID payments are for reimbursement of what the government has already spent. The system of providing funds in advance greatly assisted in the speed of implementation and may serve as a possible option for other USAID-assisted projects.

⁹To address the need for supervision of FWCs and the further extension of service delivery, another project plan was submitted in the GOP's Seventh Five Year Plan. This supported mobile service units and had components supporting both technical and non-technical supervisory staff who would work with the FWC staff. This project was accepted and is presently being implemented. In line with the previous rejection of non-technical supervisory staff at the

Previous Page Blank

6.2 USAID Inputs

The total amount of USAID funds budgeted for this project was \$1.393 million. This was to include funds for travel and per diem expenses for trainers and trainees, supplies and equipment, management and evaluation activities, and a miscellaneous component. The expenditures as of March 31, 1990, were \$153,503.

6.3 Project Outputs

Since a major part of the project is training of health personnel, targets were set for training various cadres of health workers who work in a variety of health establishments. Training was also to be provided to groups of trainers who could go back to the health establishments and train health staff in family planning. This training was carried out by selected Regional Training Institutes and training facilities of the MOH. The training materials, curriculum, and instruction varied in content, duration, and quality in the different training centers. After training, some of the participants received training materials, e.g., a kit of different types of contraceptives that could be used for teaching, an IUD kit, a cash box for holding the proceeds from sales of contraceptives, registers for recording contraceptive users, etc.

As of March 1990, 3,896 various cadres of health care staff have been trained through the project. It is estimated that about 1,280 health outlets now have at least one trained staff in family planning. The target number of health care staff to be trained over the whole project period is 12,763, and the target of health outlets providing family planning at the end of the project is 4,412. Most of these outlets have been provided with some supplies and equipment to set up a family planning system. However, a regular system of contraceptive supply, coordination, and monitoring has not yet been established.

6.4 An Issue of Concern

This project represented a great challenge and the PWD should be congratulated for beginning the process of including family planning in the health system of the country. As of May 1990, the official policy of the government is to include family planning as part of general health services; this project's pioneering effort may have contributed to this policy change.

The implementation of the project has been a sobering experience for the PWD staff involved. They now realize what an enormous job it would be if family planning were to be fully incorporated into the health system. The problems faced by this project in coordinating training and ensuring its quality, providing contraceptives to the service outlets, supervising staff, developing a record keeping system, designing systems of monitoring by district officers, etc., would be magnified many times over in any expansion of project efforts. One lesson learned from this experience is that the PWD should not dilute its resources in order to bring about the incorporation of family planning in the MOH; rather, the MOH, with PWD's assistance, should take the lead in this task. This is especially appropriate in a country where high infant and maternal mortality underscore the importance of family planning as a health measure.

Recommendation

1. **The Family Planning Inputs into the Health Program project should be watched very closely for lessons that need to be learned in any expansion of family planning services in health units. This project should be viewed as an experimental one, and different approaches should be encouraged and documented. If operations research studies are undertaken during the Seventh Five Year Plan period on various aspects of this project, many of the findings on service delivery strategies could be applied in family planning and health programs. An evaluation of the project should be undertaken in the next 15 months to document the successes and constraints the project has experienced so far. USAID should provide assistance to this evaluation.**

7. IEC ACTIVITIES

7.1 Component Design and Objectives

The IEC component of the project was intended to stimulate contraceptive acceptance through mass media. The component was added to the project in 1986 with the Project Amendment, which recognized the need to go beyond the population of current acceptors and reach new users.

The component design viewed IEC as a process rather than a product and in this respect differed from the usual approach taken by the PWD. The essential elements of this process involved market research, field testing of materials, and periodic evaluation, elements which had usually been missing in PWD IEC efforts. In short, the incorporation of these elements in the IEC component design implied a "demand" rather than a "supply" orientation to IEC, or put in another way, an audience rather than a message orientation to the communication process.

Specifically, the IEC component aimed to

- conduct periodic market or audience research activities within the project;
- implement a systematic communication strategy through a mass media program based on regular audience research;
- produce a weekly 10-minute radio program;
- produce one film;
- provide for 28 hours of 25-minute slots of TV broadcasts;
- provide for 32 hours of radio broadcasts;
- place 10,680 newspaper advertisements; and
- generate lessons from the project experience through an impact evaluation.

7.2 USAID Inputs

Over the period 1986 to 1989, \$5,642,590 was planned for the IEC component. The component was expected to tap private sector resources in an implementation mode similar to the mass media campaign of the USAID-funded Social Marketing of Contraceptives Project. This meant that optimal private sector performance was to be secured by giving the private sector agencies involved operational autonomy in media plan development and in day-to-day implementation, upon approval of plans by the PWD. Market research and advertising services were to be obtained through a host-country contract, while payment of vouchers for services were to be submitted through the National Development Finance Corporation to USAID for direct payments to the firms involved.

Given the cultural and socioeconomic diversity of Pakistan, it was expected that a multi-faceted communications strategy would be necessary to address the family planning-related concerns of potential clients. Therefore, the IEC component plan called for USAID to support quantitative and qualitative research studies (e.g., market research and focus group research) to identify important beliefs regarding childbearing, to assess the effectiveness of current family planning messages and media activities, and to identify potentially effective alternatives for different segments of the population. A series of market research studies and testing of IEC materials was to be conducted July-December 1986, July-December 1987, and July-December 1988. An amount of \$230,000 was to be set aside for this purpose.

A three-year media campaign with a budget of \$5,225,000 was envisioned with appropriations for various media defined in the project document.

A mid-project evaluation of the IEC component was planned for July-September 1988 and an impact evaluation for July-September 1989.

7.3 Project Outputs

Only a small amount of USAID funds has been utilized for IEC activities -- as of March 31, 1990, only \$12,952 of USAID funds have been disbursed to support this component. This has been due to 1) the pre-condition that audience research be undertaken before the utilization of USAID funds (none was done), and 2) the World Bank's provision of funds to PWD for IEC activities until June 1989. Thus far, two activities have taken place:

- A series of preliminary reports on the evaluation of the PWD IEC program submitted by the National Institute for Population Studies (NIPS) in December 1988, February 1989, and June 1989. (Although this evaluation is being regarded as a substitute for the required small-scale market or audience studies stipulated in the IEC plan, it should be noted that no USAID IEC funds were used to support this activity.)
- Contribution to a Safe Motherhood Conference conducted in March 1990.

An additional expenditure of funds for IEC-related activities is pending. On May 5, 1990, the PWD made a request for release of IEC funds from USAID for a total amount of \$1,647,826 (Rs. 36,005,000) for two periods, July 1989-June 1990 and July 1990-September 1991. This request was made in lieu of an earlier request for funds dated November 6, 1989, in the amount of \$314,370 (Rs. 6,869,000) covering PWD IEC activities for a six-month period (November 1989 to April 1990). The request reportedly was not granted because it covered activities not specified in the component design. The most recent request for funds also includes activities not specified in the Project Agreement, thus making the activities difficult to evaluate since they were not based on the Project Agreement.

7.4 Impact

In view of the PWD's inability to utilize USAID funds allotted for IEC and to carry out the required activities according to the project design, the only conclusions that can be reached concerning impact are in terms of the consequences of not having an IEC program that is based on audience research, rigorous pretesting procedures, a systematic communication strategy, and appropriate evaluation procedures.

Some of the consequences of the lack of such a program include the following: 1) The PWD communications strategy and plan in the current Seventh Five Year Plan (1988-1993) were unable to benefit from the results of the market and audience research planned in the IEC component. 2) Current PWD IEC materials have not been pretested. 3) There is a serious lack of IEC materials at provincial and district offices, Family Welfare Centers, as well as at other family planning service delivery outlets, e.g. RHS centers, NGO facilities, etc. 4) Weaknesses in the present PWD IEC

campaign that were identified by earlier empirical studies still need to be acted upon (the IEC component was designed to address these weaknesses).

One finding which may succinctly describe present IEC efforts can be gleaned from their impact on PWD staff themselves. In a survey of Family Welfare Workers, only 62 percent reported themselves as ever-users and only 13 percent said that they are current-users of contraception.

Within the last two years, however, activities related to the IEC component have increased. A short-term communication consultant was assigned to NIPS to undertake research and evaluation activities, and a buy-in for technical assistance with Johns Hopkins University/Population Communication Services (JHU/PCS) to undertake a mass media campaign was negotiated. This increase in activities appears to be due to a more aggressive leadership at USAID's Office of Health, Population, and Nutrition.

7.5 Issues of Concern

7.5.1 Deviations from the IEC Plan

As conceptualized in the component design, the IEC plan was to include a sequence of tasks wherein some tasks were dependent on the completion of other tasks. The most critical task was the conduct of market or audience studies that were meant to serve as the basis for formulation of a systematic communication strategy, the development and pretesting of sample materials, and the implementation of a mass media campaign. The delay of the first task has meant that the other subsequent tasks have also been delayed. Several factors have caused these deviations from the IEC plan:

1. The required technical assistance for designing the market or audience research in the first two months of the project, as planned, was not availed of at all.
2. The Ministry of Finance did not allow sub-contracting of marketing research services to the private sector; the basis for this decision was apparently the availability of NIPS to do the studies.
3. Alternative arrangements to allow NIPS to undertake the studies took a lot of time. NIPS embarked on a major evaluation of the PWD IEC program instead of the required small-scale audience research, focus group discussions, and pretesting of materials. (A useful preliminary report was submitted on December 11, 1988; see Appendix G for a brief discussion of this report's findings.)
4. USAID management did not intervene effectively and quickly enough to have the market research aspects of the project begin or to make alternative decisions on how the component could be executed. No memorandum of understanding between USAID and PWD concerning the IEC plan was drawn up, which may have provided a basis for action by the PWD.
5. The PWD saw little reason to push ahead with the IEC plan because a) it already had funds from the World Bank for IEC activities, and b) PWD's PC-1 for communications did not include the IEC plan, and since PC-1s are the operative documents for undertaking activities, the PWD did not feel compelled to carry out the plan.

6. PWD staff may not have participated fully in the development of the IEC plan and, therefore, did not have a sense of ownership with regard to it.

7.5.2 General Constraints

The current thinking worldwide in communication recognizes three interrelated dimensions of IEC: 1) organizational communication, 2) mass communication, and 3) interpersonal communication. Of the three, organizational communication is the most recent concern and involves the challenge of using communication to establish synergy among different organizations with parallel though sometimes divergent missions, roles, and activities concerning population welfare. Although both research and experience have shown that organizational communication is of critical importance, this dimension of IEC appears to have been neglected in many national population programs.

In addition, current literature on IEC has identified five elements necessary for implementing an effective IEC campaign:

- a strong commitment or will to communicate;
- a research-based and systematic communication strategy and plan;
- a high level of individual skills among IEC staff;
- the ability of IEC staff to work as a team; and
- adequate resources.

The PWD's IEC program has some deficiencies both with regard to the three interrelated dimensions of an IEC program and to the five elements required to make an IEC program effective.

1. There is a variable commitment to population communication at the policy level. This is manifested by a) inadequate budgetary allocations for IEC -- the IEC budget for all provinces in 1989-1990 was only \$116,704 (Rs. 2,550,000), a grossly inadequate budget; b) an unclear policy -- among some senior staff of donor agencies, NGOs, and the PWD there is a perceived lack of political commitment on the part of some sectors of the GOP to support the population welfare program in general and the IEC effort in particular; and c) an inconsistent implementation program -- policy vacillations have created long periods of hiatus in IEC activities. Even within periods of enthusiastic IEC work, a wide variance in outputs can be seen; e.g., the printing of IEC materials has varied widely over the last eight years.

2. There is a lack of coherent and systematic communication strategic thinking and plans due to a lack of trained staff at the federal and provincial levels. This situation is evidenced by the NIPS 1989 evaluation of the PWD communication activities which concluded that PWD IEC activities lacked a well-defined program, adequate training of program personnel, pre-testing of media messages, and clear-cut directions for IEC, its modification, monitoring and evaluation. The evaluation report also noted that the media approach was directed to all audiences without any well-defined segmentation of target groups.

3. The PWD has a limited capability to conceptualize, plan, implement, and evaluate an IEC program. An analysis of the NIPS's evaluation data, a review of documents and plans, and interviews with IEC personnel show that the present PWD IEC program has a limited appreciation of and capability for audience research and pretesting of IEC materials, and that existing communication plans are deficient in a number of areas. (See Appendix G for a discussion of these communication plans).

4. Deficiencies in organizational communication prevent optimal development of teamwork within the PWD and among agencies that relate to the PWD, such as the Ministry of Finance and Economic Affairs, Ministry of Health, Ministry of Information and Broadcasting, NGOs, and USAID. For example, the IEC program's resource problem does not lie in a lack of resources; the issue is how to utilize existing donor resources within a very limited Annual Development Plan (ADP) ceiling.¹⁰ This ceiling for population activities is woefully low. A case in point is the \$5.7 million which remain unspent while the program is seriously strapped for funds.

Other bureaucratic constraints which contribute to the lack of good institutional communication include the following: a) frequent changes in government, which have created a constant need to orient new policymakers to the consequences of population growth and the need for family planning; b) the usual mismatch between program plans and the ADP process; c) procedural problems in releasing federal funds to provincial agencies, e.g., the first release of funds in a fiscal year is usually made in September, a three-month delay which often causes a cessation of IEC activities (this "stop-and-go" type of IEC campaign is hard to imagine happening in a commercial advertising campaign); d) uneven application of or compliance with policy, e.g., provinces are required to have their IEC materials printed by the Printing and Production Directorate in Lahore¹¹ but this does not seem to be required of the province of Sindh; and e) delays in payment of salaries which often lower morale of staff.

Recommendations

1. **Funds should be made available immediately for the development of an IEC campaign with policymakers and PWD staff as targets.** This may involve popularized versions of the RAPID¹² presentations, policy conferences, workshops, briefings, and one-on-one sessions with key decision-makers.

2. **Short-term technical assistance should be secured to**

-- demonstrate what an effective IEC campaign can do. The short-term technical assistance to be rendered by JHU/PCS in August 1990 will help achieve this aim.

¹⁰International Monetary Fund (IMF) guidelines place restrictions on ministry budgets. One result of this has been that programmed donor funds are rarely fully expended.

¹¹A good case study could be based on the Printing and Production Directorate of PWD in Lahore which has excellent facilities and well-trained staff but is not being optimally used due to lack of financial resources. It usually is not advisable to maintain in-house printing capabilities to support development programs because tackling development problems alone is already a big challenge. Even publishing firms and other commercial enterprises stay away from in-house printing and simply buy printing services. The PWD printing directorate in Lahore, however, seems to be exceptionally well managed and endowed with good facilities. Optimal use of this facility is a worthwhile short-term objective.

¹²The RAPID presentation developed by the Resources for Awareness of Population Impacts on Development (RAPID III) project is an interactive computer simulation model which uses colorful graphics generated on a large screen to show population and development relationships.

-- address the bureaucratic constraints inhibiting organizational communication. Funds should be provided for research and appropriate organizational communication interventions, e.g., meetings and conferences, project management information systems, etc., designed and supervised by organizational communication specialists. This should not be perceived as a cost but as a significant investment towards achieving greater teamwork and harmony among the agencies concerned with population welfare.

3. A model IEC campaign should be launched which has all the required elements for effectiveness, i.e., audience research, pretesting of materials, regular evaluations, and use of high-caliber creative talent. Innovative approaches such as the use of the "enter-educate" concept, a strategy which combines entertainment with education and which has been found to be effective in many countries, should be seriously considered. Similarly, the use of "neo-literate" language (maximum use of visuals with sparse use of appropriate printed words) in IEC materials shows some promise based on experiments in this area made by some NGOs.

4. Findings of the NIPS evaluation study of PWD's IEC program should be deliberated at the policy and implementation levels of the PWD and acted upon. Funds to support a conference or series of meetings for this purpose should be made available. The participation of the Interprovincial Coordinating Committee, which is mandated to coordinate program implementation, is crucial.

8. INSTITUTIONAL DEVELOPMENT IN DEMOGRAPHIC, SOCIOMEDICAL, AND MEDICAL RESEARCH

Four institutes constitute the PWD's research capability: the National Institute of Population Studies (NIPS), the National Research Institute of Fertility Control (NRIFC), the National Research Institute for Reproductive Physiology (NRIRP), and the Monitoring and Statistics Wing of the PWD. Assistance to develop these institutes was considered important to the PWD, and USAID agreed to provide funds for institutional development. USAID assistance to three of these institutes is evaluated in this section; the other, the Monitoring and Statistics Wing of the PWD, was discussed in Section 3 in reference to its program monitoring role.

8.1 National Institute of Population Studies (NIPS)

8.1.1 Background

As stated in the Project Paper, one of the reasons for the lack of success in Pakistan's family planning program was poor program administration and management. One of the strategies proposed to overcome this problem was to strengthen the data collection, analysis, and dissemination aspects of the PWD program so that program managers would have the data necessary to make informed program decisions.

The Project Paper called for USAID assistance to be provided to strengthen a newly created unit of the PWD -- the Population Development Center (PDC). The PDC, as originally planned, was to be formed by merging two directorates of the PWD: the Demographic Policy Implementation Research Center (DPIRC) and the Directorate of Registration and Statistics. However, in 1984 when the government formally approved the establishment of a population research institute, the name for the Center was changed to the National Institute of Population Studies (NIPS) and the merger of the two directorates did not take place. Instead, NIPS was to be constituted from the existing staff of the DPIRC and the service statistics/monitoring functions of the Directorate of Registration and Statistics remained within the PWD.

It was not until March 1986 that NIPS began to function as an institution. The delay was due to internal discussions within the government concerning the placement of NIPS -- whether it should be a part of the Pakistan Institute for Development Economics or an autonomous organization under PWD, what the rank of the executive director should be, and what NIPS' scope of work should include.

8.1.2 USAID Inputs

To carry out the institutional development of NIPS and to undertake its specified tasks, the government was to provide funds for personnel, research, equipment, books, and a miscellaneous component. Donor agencies, in this case USAID, were to provide funds for technical assistance, training, equipment, maintenance of equipment, CPS and other surveys, and books and publications.

The USAID budget for NIPS as of March 31, 1990, was \$1.9 million. Expenditures total about \$1.15 million, leaving a balance of funds of about \$760,000. Implementation in terms of USAID funds expended is about 51 percent.

8.1.3 Component Outputs

The planned project outputs in the Project Paper were developed prior to the formal establishment of NIPS by the government. Therefore, some of the planned outputs of NIPS per the Project Paper were not produced due to the change in NIPS' function by the time the institute was established.

Surveys and Special Studies. A very important output expected from this component of the project was a series of contraceptive prevalence surveys to be used in the monitoring and evaluation of the family planning program. One was undertaken in 1984 by the PWD (before NIPS was established) and another one was planned for 1988. The latter survey was postponed to 1989 and was changed to be a demographic and health survey which would be executed with the assistance of the Demographic and Health Survey project (DHS) of the Institute for Resource Development, Inc. Due to government budgetary constraints, however, this survey has been further delayed to 1990. Final government approval for undertaking the survey was given on May 26, 1990, and the survey will commence within the year.

NIPS has undertaken three general types of studies: evaluations of PWD activities, population surveys, and secondary analysis of demographic data. The quality of much of the research undertaken by NIPS and analysis of data are of a high standard. This is due to the hard work of senior-level demographers on staff and the technical assistance provided through USAID. Taking into account that NIPS only began functioning in 1986, the accomplishments of the Institute in terms of research undertaken have been good.

Factors that have inhibited the production of more research include lack of a full complement of senior staff to supervise research, lack of trained research associates to carry out demographic research, lack of a field structure to collect data, and lack of funds for research. This last point is due to the fact that there are ADP restrictions on the amount of funds that can be spent on research, even if funds are available from USAID.

Seminars and Workshops. Six different categories of seminars and workshops were proposed in the Project Paper. Most of the seminars and workshops held at NIPS could be categorized under the Population and Development rubric or training, and were targeted for researchers and analysts. Visiting demographers, senior NIPS staff, and USAID-funded technical advisors would present papers to NIPS staff on various population and development topics or on demographic techniques. Over a two-year period, 1988-1989, about 21 such seminars were held.

The other five categories of seminars were not as well developed. Two important population policy seminars were held --one was to discuss the results of the 1984 Pakistan Contraceptive Prevalence Survey data with NIPS and PWD staff, and the other was the RAPID presentation to the prime minister and her cabinet, secretaries and advisors, which was executed in collaboration with PWD and with technical assistance from The Futures Group.

To date, there have been no seminars or workshops organized by NIPS for program administrators and managers at the national and provincial levels to interpret data, assess implications of findings for policy and program formulation, and to develop strategies for action. Similarly, there have been no workshops on techniques of self-evaluation, training methodology, or target setting. The non-implementation of these workshops is a serious failing of the total program, since, as

recognized in 1982 when the Project Paper was written, program evaluation, target setting, and data utilization were weak areas. They still are, and the lack of attention to them has had a significant impact on the program. (See Section 2 for a discussion on target setting and better data utilization for planning purposes.)

It should be noted that NIPS professional staff were aware of the need for national seminars on various topics. A yearly seminar series was envisaged at one time, and there was interest in hosting a seminar for countries within the region. However, the lack of human resources within NIPS to organize these seminars and the lack of political will of the NIPS and PWD administration to host them did not allow such seminars to take place.

Training. The planned in-country training of 5 to 15 NIPS junior staff members per year at local universities or through in-service training programs did not take place. Instead, some NIPS staff have been sent for short courses/seminars to Karachi University, which has an exchange program with the University of London, whereby experts give workshops on various topics, such as indirect measurement techniques.

Some in-house training at NIPS for senior and junior staff has taken place. Two-month courses on demographic techniques were taught by the resident advisor (see technical assistance below) and other senior staff during 1988 and 1989.

The planned internship program with departments of social sciences and economics was not established. This program was to allow advanced students to work at NIPS or similar organizations in order to learn the fundamentals of data collection, processing, analysis, and related skills. A fellowship program with the University of Michigan's Population Studies Department was approved by NIPS and three or four fellows were expected to come to NIPS to undertake research. However, the association between the two centers did not take place; the reasons for the breakdown are not clear. It is unfortunate that this linkage between the University of Michigan and NIPS did not come about, since it would have benefitted both institutions.

Overseas training of NIPS staff for 3 to 12 months did take place. One NIPS staff member and a number of PWD staff attended a course at the University of London on demographic target setting and macro-level program evaluation; one staff member attended a five-month population and development course in the U.S.; and recently, three staff members returned from training in Washington, D.C., on application of the RAPID model to Pakistan. In addition, the NIPS Director attended a meeting of the International Union for the Scientific Study of Population (IUSSP), and the former executive director of NIPS visited Bangladesh in connection with operations research being sponsored by the University Research Corporation.

Six staff members -- five in the U.S. and one in Australia -- are presently attending a year-long training course that will lead to masters degrees in demography/sociology. NIPS would like to send three more research associates to the United States for masters training this year. However, the paper work with the PWD, USAID, and the intended universities has not been completed, thus causing concern that the research associates may not be able to go in September 1990.

Publications and Information Dissemination. The most important NIPS publication to date is the *State of the Population in Pakistan, 1987*. This highly professional, well-done publication can be used as a sourcebook for population in Pakistan and can stand up to the scrutiny of demographers internationally.

NIPS staff includes a technical editor who greatly adds to the capability of the institute. USAID has provided NIPS with a photocopy machine.

From the beginning of NIPS it was intended that it would publish a population journal, both to disseminate population research findings and to motivate research staff to publish more of their data. The first issue of the journal should be published in the near future.

NIPS has developed a capacity for micro-computer storage of all its own survey data as well as data from other sources that it uses in its research. This is the first step in the development of a data bank.

Technical Assistance. USAID has provided both short- and long-term national and international technical assistance to the development of NIPS and the implementation of its research program.

The Project Paper called for the support of three senior Pakistani researchers to serve for three years each at NIPS. It was planned that these researchers would be Pakistanis working abroad who would return to Pakistan; there was the possibility that they would stay on at NIPS upon completion of their three-year assignments. Although this long-term secondment was not possible, three well-known Pakistani demographers did return to Pakistan as senior visiting fellows of NIPS for a period of two months each, and were able to assist NIPS staff in the analysis of the Pakistan Contraceptive Prevalence Survey.

Long-term technical assistance for institutional development of NIPS and short-term technical assistance for specific research areas was provided by the International Science and Technology Institute, Inc. (ISTI). The Westinghouse Corporation also provided short-term technical assistance in the implementation of the 1984-85 Pakistan Contraceptive Prevalence Survey.

The quality of technical assistance provided by both national and international advisers was of a high standard. More assistance could be used to further the research program and to strengthen the institution. The systematic collection, analysis, and dissemination of research data are required for the policy and program decision making. As of March 31, 1990, funds were still available for technical assistance under the present project.

Service Statistics. The Project Paper provided for technical assistance and funds for computer programming to assist in the design, testing and installation of a service statistics system. Due to the retention of the Monitoring and Statistics Wing within the PWD, the monitoring of the program was not transferred to NIPS as originally anticipated.

Data Processing. USAID funds have provided eight computers to NIPS. A decision taken by USAID to consolidate the computer orders for all USAID-funded projects, however, held up their purchase and affected the ability of NIPS to process data. During the long period without computers, NIPS staff had to borrow computer time from a commercial bank's computer system.

The number of computers provided is not sufficient considering 1) the number of staff who will be returning from their studies as well as the newly recruited senior staff, and 2) the expectation that the research load will increase in the next few years with the DHS and other scheduled surveys and research projects. More computers will also be needed in order to permit researchers to take on their own projects and work independently.

8.1.4 Institutional Development

Staffing. At the present time there are 23 professional and 17 administrative staff at NIPS. Of the professional staff, three are senior fellows; this number was only recently increased from one. With so few senior staff, it has been very difficult to undertake research without technical assistance. The original plan for NIPS provided for 10 senior-level positions; however, only two positions at the director general level and the three senior fellow positions have been sanctioned. Without an increase in sanctioned posts at the senior level, NIPS will be unable to develop fully its research program.

In addition, most of the research associates do not have demographic training, thus increasing the difficulty in undertaking research. This problem may diminish somewhat upon the return of six research associates studying demography abroad. Even so, a long-term staff development plan for NIPS is needed to ensure the training of more research associates at the masters and doctorate levels.

Administration. The administration of NIPS has been very fluid. There have been five changes in chief executives in three years, thus making it difficult for the Institute to chart a clear course in research and to develop as an institution.

A new chief executive was recently appointed. In his short tenure, he has taken a number of decisive moves that will strengthen NIPS. These include establishing rules and regulations for NIPS, regularizing staff posts, and convening meetings of the Board of Governors of NIPS to establish policy. His administrative ability is required to develop the institution into a first class research body and it will be important that he remains in this post for some time to avoid the previous problems in leadership. For technical matters he must rely on his senior staff, since he is not a demographer. It is important that the posts at the director general level be filled as soon as possible.

Recommendations

1. **The sanctioned posts for NIPS in the senior categories should be filled as soon as possible.** Until there is adequate coverage by senior research officers, technical assistance should be provided. At a later stage in the development of NIPS, technical assistance may not be as necessary, but at this fragile stage in institutional development, short- and long-term advisors are necessary to undertake research tasks. All funds available for technical assistance to NIPS under the project should be used.

2. **The training of NIPS junior professional staff should continue at both the masters and doctorate levels.** Immediate action should be taken by all parties concerned to ensure that the planned admission of three NIPS staff to U.S. training programs in the fall of 1990 takes place.

3. **Once the personnel situation at NIPS has been improved USAID should provide more funds for research activities.** Different ways should be explored for donor agencies to provide such funds to NIPS since the government budget does not include adequate research funds. For example, the DHS will provide substantial funds for research activities that are needed for the institute to grow. Although it has taken some time for the DHS project to be approved by the government, the project will allow NIPS to expand its research capability as well as providing the government vital data.

8.2 National Research Institute of Fertility Control (NRIFC)

8.2.1 Background

The National Research Institute of Fertility Control (NRIFC) has the responsibility under the PWD to conduct clinical trials on currently available and new contraceptives prior to their introduction in Pakistan; to perform sociomedical and socio-demographic studies and surveys; to test condoms; and to act in association with WHO as a collaborative center for clinical research. The Project Paper noted the lack of funds available to the NRIFC to undertake collaborative research with Pakistani universities, the reduction in its staff and the lack of staff in specific areas, the inadequate equipment used for condom testing, and the very inadequate facility occupied by the Institute.

At the request of the GOP and because USAID recognized that the Pakistan population program would be better served by an efficient and effective institute, USAID agreed to provide significant technical assistance, training, and commodity inputs as well as to construct a building to house the NRIFC. The Project Paper did not include a work plan or a description of how these resources were to be used; there is, therefore, no indication of what outputs were to be produced. The 1984-1988 government plan, however, did discuss the research to be included in NRIFC's program. Research was to be focussed particularly on the improvement of existing methods of fertility regulation, i.e., to make the oral pill, the injectable contraceptive, the IUD, barrier methods, and sterilization safer, more effective, more acceptable, and easier to use and to provide.

8.2.2 Inputs

The total USAID funds committed in the Project Paper for the FY 1982-1986 period was \$1.205 million. In the Project Amendment for the FY 1986-1989 period, the U.S. funds committed were \$1.778 million. The USAID budget for this component as of March 31, 1990, showed the total budget to be \$775,160. Expenditures have amounted to \$517,943. About 67 percent of the funds budgeted have been spent. The largest amount of expended funds, \$317,120, was used for the construction of the new NRIFC building in Karachi.

8.2.3 Component Outputs

The outputs for this component have been limited for two reasons. First, the Project Paper and Amendment never specified outputs. Second, until the building was completed, the NRIFC was not in a position to accommodate substantial equipment in its old facility or to use technical assistance effectively.

New Building for the NRIFC. The main output has been the building constructed in Karachi to house the NRIFC. Even though the building is now completed, electricity and telephone services have not been installed. Therefore, the move of staff has only been accomplished on a partial basis; most staff remain in the old premises.

Training. There have been few institutional courses provided to NRIFC staff through USAID. The reason so few staff have received training is that many nominees for training could not fulfill certain government requirements (see institutional development below). One staff member is scheduled to attend a three-month course in medical technology, but the funding documents have not been approved as yet.

Research. Some USAID-funded research has been undertaken by NRIFC in collaboration with Family Health International (FHI) through a buy-in. Three studies have been initiated: NORPLANT trials, a barrier method study and, just recently, a breastfeeding study. The NORPLANT study has been under way for about two years, and over 500 women have received NORPLANT implants in selected pilot clinics throughout Pakistan. Although it is too early to publish results, after one year of experience with the total study population, there have been few complications/removals. NRIFC and FHI are encouraged by the preliminary findings of the trials and plans are being made to extend the pilot project to a larger population. (NORPLANT cannot become a contraceptive in the program until the results of the NRIFC research have been studied by the Federal Drug Agency of Pakistan and it rules favorably for NORPLANT's inclusion.)

Other ongoing studies of the NRIFC include the following:

- Field study of Cu-T380A
- Chinese study of Copper-T device
- Effect of contraceptives on HB and glucose levels
- Effects of hormonal contraceptives on intermediary metabolism
- Clinical evaluation of therapeutic effectiveness of ethinyl estradiol and estrone on prolonged bleeding in women using DMPA for contraception
- Study of Marvelon oral contraceptive
- Impact of integration of family planning with MCH and other development programs

8.2.4 Institutional Development

The building constructed for NRIFC is of the highest standard. Unfortunately, the cost in maintenance may become a problem; indeed, one of the reasons the full complement of staff has not occupied the building is the very high charge to install electricity.

The sanctioned staff for the NRIFC is 83; there are at present only 14 researchers in position. The difficulty in acquiring PWD financing for staff posts is well known. In addition, there are problems involved with sending junior staff on overseas training. Both these situations constitute major impediments to institutional development. The director of the NRIFC noted that the names of her junior staff have been submitted many times to the PWD without having any success in actual placement in training programs. There is a requirement that staff to be trained must receive higher than average ratings on their performance reviews for three years. New staff tend not to get such ratings and therefore are not eligible for training programs until they are in the service for a longer time. Also, because most senior staff are all over 50 years of age, they are not allowed to go on training per government rules. With a limited number of years left before retirement of NRIFC senior staff, there are no replacements ready to take over the responsibility of running the organization.

The NRIFC has a wide network of service provision centers, both public and private, with which it collaborates in the testing of contraceptives and other field trials. The physicians and health providers in these centers are, in a sense, an extension of NRIFC's staff. These centers are important for the Institute and the PWD program; however, they have not been fully utilized.

The mid-term evaluation of the NRIFC identified many of the same problems -- lack of trained staff, equipment shortages, and the need for technical assistance. Most of the recommendations of that evaluation, however, were not acted upon.

Recommendation

1. **The unexpended funds for this component should be reviewed by the NRIFC director in collaboration with USAID to see where they would be best placed, taking into account the institutional development needs of the research body and the potential role of the Institute in a future USAID-assisted program.**

8.3 National Research Institute for Reproductive Physiology (NRIRP)

8.3.1 Background

The NRIRP has the responsibility under the PWD program to undertake basic biomedical research for developing contraceptives; to develop and standardize methods for the determination of sex hormone levels in blood and urine; to conduct basic research in reproductive endocrinology as it relates to fertility and infertility; and to identify indigenous medical plants/prescriptions with potential antifertility properties and to determine their efficacy. As part of the Project Amendment, USAID proposed to fund NRIRP for the provision of technical assistance, training of staff, and commodities and equipment for its laboratories. Similar to the assistance provided to NRIFC, there was no work plan or description of how these resources were to be used and, therefore, there was no indication of how the outputs were to be produced.

Ongoing NRIRP studies include the following: 1) laboratory studies of indigenous resources including the collection and extraction of the properties to be tested, the application of the properties to the male and female reproductive physiology (via experiments on rats), and the identification of the chemical constituents of the properties; 2) screening of indigenous drugs or formulations marketed by traditional drug salesmen that are purported to have antifertility properties; 3) infertility investigation and management; 4) the development and standardization of radioimmunoassay and in vitro bioassay techniques relevant to fertility regulation; and 5) the biological production of RIA reagent (using rabbits and guinea pigs).

8.3.2 USAID Inputs

The estimated total funds to be committed by USAID for the NRIRP was \$2.0 million for the years 1986-1989. The USAID budget for this component as of March 31, 1990, showed the total budget to be \$266,000. Expenditures have amounted to \$112,942. About 43 percent of the funds budgeted have been spent. All of this amount has been used for the purchase of laboratory and scientific equipment.

8.3.3 Component Outputs

As stated above, there were no specific output measures for USAID assistance. The overall output of the USAID assistance was expected to be the full functioning of the NRIRP.

A detailed plan for equipping the NRIRP and for the provision of technical assistance and training was drawn up by a consultant in consultation with the director of NRIRP in late 1985. The Project Amendment was based upon this plan. At that time, it was stated that in order for the NRIRP to function effectively, long-term technical assistance (at least three to five years) would be

necessary and that post-graduate education of key staff at the masters and doctorate levels must be undertaken. Technical assistance needs, a tentative training schedule, and a list of priority instruments and equipment were drawn up.

Most of these inputs have not been provided. The PWD and USAID have given little attention to NRIRP's institutional development. The NRIRP was given approval for a professional staff of 25; at present, there are only 6. Without adequate staff, training cannot take place and the usefulness of technical assistance is limited.

The NRIRP has been given property within the grounds of the National Institute of Health for construction of its own facility. It was expected that the NRIRP would have its own building, in line with the decision taken to build a separate building for the NRIFC. Although a new building would certainly improve the conditions for research for the NRIRP, a higher priority may need to be given to staff recruitment and development.

Recommendation

1. **The unexpended funds for this component should be reviewed by the NRIRP director in collaboration with USAID to see where they would be best placed. USAID's priority for basic contraceptive research should be discussed, taking into account the fact that the results of any research undertaken now will have little effect on the PWD's service delivery strategy in the near future.**

8.4 Reasons for Differences in Development of NIPS, NRIFC, and NRIRP

There are a number of reasons for the success of USAID's assistance to NIPS and, by contrast, the lack of success of USAID's proposed assistance to NRIRP and NRIFC.

- **The Project Paper and Project Amendment descriptions of USAID's assistance for NIPS was output-oriented; for NRIRP and NRIFC it was input-oriented. Thus, with NIPS there was a way for USAID and the PWD program to monitor its research and institutional development; with the other institutions there was not.**
- **The immediate needs of the PWD program required a mechanism to undertake evaluation research. Because NIPS could provide this mechanism, the government and USAID paid more attention to NIPS. There was no immediate imperative need for the research of NRIRP and NRIFC in the implementation of the service delivery program.**
- **A senior demographer with many years experience in institutional development of similar institutes in other countries in Asia and in the United States served as the resident advisor at NIPS. Leading demographers and social scientists, both Pakistani and international, worked at NIPS on short-term assignments. The lack of technical assistance at the two other institutions from project funds contributed to their limited results.**

- **A significant number of NIPS' research staff have taken up fellowships for degree training; this will lead to more and higher quality research, which will be self-generating. Although more training will be required at NIPS to make it a premiere research institution, the almost total lack of human resource development at the other institutions relegates these institutions to a lower level of research capability.**

9. TRAINING

9.1 Objectives

As a major strategy to get the family planning program moving again in the early 1980s after a period of inactivity, it was decided to stress training and observation and study tours in order to expose Pakistani policymakers and health, population, and education officials to population programs in the U.S. and other countries. Fifty short-term training and/or observation visits were to be undertaken by Pakistani participants. These visits could also be used to attend international conferences and workshops on population issues. In addition, experts from the U.S. were to visit Pakistan to consult or teach; 15 of these short-term visits were planned.

Additional training was added to the project in the Project Amendment. In this case, its aim was not so much to motivate policymakers and opinion leaders, but rather to train a cadre of Pakistani professionals to take over management positions of senior population/family planning professionals who would soon be retiring. A deficiency of trained staff in the areas of demography, statistics, medicine, social science, IEC, and training methodology was noted in the Project Amendment. Ninety-six person months of long-term training in the fields of population, program planning, management and evaluation, program operations management, sociology and demography for mid-level managers not identified in other components of USAID assistance was to be provided through this component. Short-term training for a total of 54 person months was planned in the areas of program planning, program evaluation, community participation, community-based distribution, financial management, social planning, analytical skills development, curriculum development, and population education. These training opportunities could include study tours in the U.S. and other countries to expose program personnel to new developments in their respective fields.

9.2 USAID Inputs

In the Project Paper, \$660,000 was planned for motivation/observation study tours and short-term technical assistance. The actual budget for this component as of March 31, 1990, was \$121,859; the total expenditure for this line item was \$112,061.

In the Project Amendment, \$531,755 was planned for long-and short-term training for mid-level management training. The actual budget for this component as of March 31, 1990, was \$910,643; the total expenditure for this line item was \$306,255.

9.3 Project Outputs

The number of persons who participated in motivation/ observation tours up to March 1990 through this component of the project was about 33 participants compared to the planned 50. Other short-term observation tours might have been financed under other components but most were recorded under this component. Some technical assistance was also provided under this component by The Futures Group in the adaption of the RAPID presentation for Pakistan.

The mid-level professional training that has taken place in the project so far has provided opportunities for 37 professionals to be sent overseas.

Training has also taken place for other groups; however, it is difficult to know whether the funds came out of the specific component concerned or out of this mid-level training component. Over the project period, 18 persons have been sent on short-term training from the NGO sector, and 5 staff from NIPS have been sent on long-term training and 1 on short-term.

In addition to the motivation/observation tours, training has taken place in the following areas: management (24 participants), demography (16 participants), medical training (10 participants), evaluation (8 participants), women in management (6 participants), training (5 participants), and communication (4 participants).

Eleven out of the 12 long-term courses (12 months or more) were for masters or doctorate degrees in demography; the twelfth was in management.

Most of the training events were for one month (41); there were 19 events of two-months duration, and 12 of over a year.

Most courses took place in the U.S.; however, a number of PWD officials visited Thailand, Indonesia, and countries in Europe to attend workshops and seminars.

Not including those persons going on motivation/ observation tours (see above), the number of persons being supported by USAID for long- and short-term professional training on a yearly basis is very low. In the last three years, the numbers have been 9 for 1987, 13 for 1988, and 5 for 1989. About 20 persons have been identified for training overseas this year. Whether they will actually go, however, is not known.

9.4 Issues of Concern

Training Plans. Participant training plans for the project have been drawn up for the years 1989 and 1990. The number of participants given in the plan to go for long- and short-term training in 1989 was 71, for 1990 it was 138. These training plans are not action plans; they seem more like paper exercises performed to satisfy a bureaucratic rule requiring that participant training plans be drawn up. Training plans for years previous to 1989 do not seem to exist.

Training Needs. The heads of at least five major projects/components of the PWD that are receiving assistance from USAID (some of which have training funds earmarked in the USAID budgets for the component) complained that they have tried for three and four years to get some of their staff trained, but to no avail. They have followed the official procedures. Although it is understood that at times bureaucratic red tape can delay one or two participants from going on training, the number of cases and complaints concerning the lack of responsiveness on the part of the government and USAID points to a systemic problem. The only example of training taking place as planned is at NIPS, which has five staff in the U.S. receiving demographic training. This success is due to the fact that the resident advisor expedited most aspects of the approval process himself. Three more staff members are due for training this fall and there is justifiable concern that some bureaucratic difficulty will stop them from starting their courses.

Training Emergency. In order to justify the new budget line item for training of mid-level staff, the Project Amendment stated that, over the next few years, most of the professionals in the PWD program will be at senior levels and will retire after 25 years of service. Many of these professionals have been with the program since its beginning and received training early in their careers to enable them to run the program. Now they are ready to leave and there are no professionals ready to take over the reins of the population program. Both the current project and any future project need to focus more on identifying capable junior and mid-career professionals for overseas training rather than sending senior professionals on training courses since they will be leaving the service in a few years.

Recommendations

1. **The urgent need for adequately trained mid-level staff in the PWD program should be taken up immediately at the highest levels in the PWD.**

2. **The training requirements and specifications as stated in the Project Paper and the Project Amendment should be reviewed with each head of the components/organizations within the PWD receiving assistance from USAID. If these specifications are no longer required or if other ones are now needed, these requirements should become a part of the training plan for the project. With only one year to go under this project agreement, immediate action should take place to enable as many appropriate candidates as possible to receive overseas training beginning this fall. Highest priority should be given to this by USAID's Health, Population, and Nutrition Office.**

10. LESSONS LEARNED

1. **Cultural and religious restrictions placed on women's mobility -- impairing their access to family planning services -- require that program planners develop strategies that take such restrictions into account.** The payment of the female motivator for VSC services has been essential since she accompanies the client to the hospital for the procedure: two women are able to take public transportation, but a woman travelling alone is problematic in the Pakistan context.

2. **The gender of the service provider affects the type of services performed and the perception of the intervention by the client.** In Pakistan the service provider is generally the same sex as the client. This fosters a good relationship leading to a more positive view of the contraceptive being supplied. As the family planning program expands, more male services providers will be brought into the program and tubectomy and vasectomy will be increasingly promoted. As a result, problems may arise concerning gender differences between the provider and client and the way services are offered. These problems will need to be addressed in training and service provision.

3. **Service statistics, while useful for certain types of decision making within the family planning program (e.g., contraceptive commodity projections), are not particularly useful for strategic planning.** Periodic national survey data are required for this purpose. Pakistan's lack of up-to-date national contraceptive prevalence survey data is a major impediment to strategic planning for the family planning program.

4. **A well-executed IEC program is a necessary ingredient in creating demand for family planning in countries where the demand for family planning is limited.** The absence of a comprehensive IEC program has greatly inhibited Pakistan's progress in increasing contraceptive prevalence.

5. **The use of targets, such as births averted or CYPs, has its greatest value for planning, management, and evaluation.** Care needs to be taken to ensure that the targets accurately reflect the use-effectiveness of the contraceptives being used in the program and that the targets are not used at the service delivery level to promote one method over another.

6. **Public sector programs are essential in countries, such as Pakistan, in which the private, for-profit sector is not well developed and where the per capita income of the population is very low.** Current attempts by USAID and the government to involve the private, for-profit sector in family planning activities do not negate the need for a public sector family planning program.

7. **Operations research and the testing of approaches to service delivery before their wide-scale implementation are important functions in a family planning program.** The absence of these research and testing functions can lead to cost inefficiencies and low productivity of service.

**11. MAJOR CONCLUSIONS
AND
RECOMMENDATIONS FOR FUTURE DIRECTIONS**

11.1 Major Conclusions

1. **Contraceptive prevalence appears to have increased over the project period. It is estimated that, at present, prevalence may be in the range of 16-18 percent compared to the 1985 CPS figure of 9.1 percent. This estimate, if confirmed by the DHS to take place this year, will signify a break in the low level of contraceptive use evident in Pakistan over the past thirty years.**

2. **More effective and longer-term methods, namely the IUD and voluntary surgical contraception, are becoming important contributors to contraceptive prevalence, and their contribution to future rises in prevalence is anticipated by the government.**

3. **The PWD strategy to increase the number of outlets that provide family planning services has met with some success: facilities are in place and paramedical and medical staff have been trained to provide services. However, efforts to increase the productivity at existing outlets will likely be more cost-effective than further increasing the number of service outlets.**

4. **The PWD's encouragement of private sector initiatives in family planning has strengthened the overall family planning program. The NGOCC, which the government supports as do donor organizations, has shown that it has the potential to foster collaboration between the private sector organizations and government. At the same time, there has been an over-emphasis on opening service outlets rather than developing innovative NGO projects that could reach more potential acceptors as well as provide services. (The companion Social Marketing of Contraceptives project funded by USAID has been successful in providing condoms through commercial channels and is planning to widen its product line to include other contraceptives.)**

5. **The development of an evaluation and research institute for the PWD program, the National Institute of Population Studies, has provided a needed input into the program and some of its evaluation and research projects have already produced data that can be used by program decision makers. Further strengthening of the institutional capacity of NIPS is required to ensure that the PWD program has a well-equipped institutional evaluation and program policy decision-making capability as the program expands.**

6. **The PWD did not use the USAID funds allocated for implementing the IEC plan developed in the Project Paper, with the result that PWD's current IEC plan is not based on market or audience research, IEC materials have not been pre-tested and are not in adequate supply, and the same weaknesses identified five years ago in the PWD IEC strategy study are still present today. It is quite remarkable that contraceptive prevalence has risen as it has without an effective IEC strategy; if one were in place, the expectation is that there would be much higher levels of contraceptive use.**

Previous Page Blank

7. Two major deficiencies in family planning management are the lack of survey data and the lack of adequately trained mid-level management personnel. The last contraceptive survey was undertaken in 1985, making it almost impossible for managers to develop service delivery strategies based on the characteristics of the target population. Few mid-level PWD managers have received advanced training. Many of the senior staff who are soon to retire have also not updated their skills with the result that new approaches being used in other countries are not being tried in Pakistan.

8. Because technical assistance has not been used extensively by the PWD, institutional strengthening and on-the-job training have not taken place as planned.

9. One of the greatest difficulties that must be addressed by the PWD and USAID is that of long-term provision of contraceptives. At present, most of the contraceptive commodities are supplied by USAID, and the government and USAID have not decided on how contraceptives will be supplied to Pakistan after the present project is completed.

10. The long sought-after collaboration between the PWD and the MOH was facilitated by a PWD-sponsored family planning training program for selected MOH staff. Although much more needs to be done in addition to training to integrate family planning in the health system, this was an important first step and shows just how involved and complex the introduction of family planning services through the health system will be.

11. Many of the implementation delays that the project has experienced are due to institutional problems of the various agencies involved in the project; these problems are not necessarily project-specific. The Government of Pakistan has been severely hampered in spending development assistance funds due to the restrictions placed on ministry budgets by the International Monetary Fund. The Annual Development Plan of the Ministry of Public Welfare has not permitted the full allocation of USAID resources or other donor resources to be included in it. Institutional problems of USAID assistance are evident in the mismatch in the timing of the project planning periods of USAID and the government. Therefore, the government's planning documents (PC-Is), which give the objectives, activities, and planned budgets for the various government projects do not correspond with USAID's project papers. These examples of the lack of "institutional communication" need to be examined and solutions found that will facilitate the implementation of the family planning program.

12. Birth aversion, the target setting methodology as it is currently being used by the program, is inadequate. The conversion factors used for averted births undercounts the effectiveness of sterilization and overcounts the effectiveness of condoms.

13. Stratifying the population into target groups and developing specific approaches for these groups has not been a predominant feature of the program until recently when an urban strategy was initiated. Focusing attention on specific groups, particularly those who may be ready

to choose a method, should be encouraged. At the same time, this attention should not reduce efforts being made by the program with other groups also in need of services. Quality of care aspects of service provision should be a major focus in determining what services will be provided and how.

14. **The program presently uses a case-by-case system to reimburse institutions performing VSC services as well as to reimburse the client and motivator. Disbursements have not always been timely. In addition, there are questions as to the adequacy of the actual amount of reimbursement and whether other systems to support VSC services would be preferable.**

11.2 Long-term Recommendations for Government Consideration

General

1. **The government should preserve the program's unity, integrity, autonomy, and single-mission orientation. The program has succeeded in developing a structure that is dedicated to population welfare, something which many countries have tried to do but have not succeeded in accomplishing. The program can mature and be effective only if it is not saddled with secondary objectives and if it can keep its operational units and resources intact. The government should not lose sight of the core mission of the program -- to reduce Pakistan's population growth.**

2. **The institutional problems that have led to delays in program implementation should be addressed by the various agencies involved in the family planning program. More effective "institutional communication" may lead to fewer financial and resource difficulties, and less bureaucratic red tape that can delay program progress.**

3. **The government should avail itself of all opportunities for technical assistance by candidly recognizing the areas in which the program is weak and addressing the problems in these areas unequivocally.**

Contraceptive Commodities

1. **The government should gradually reduce dependence on donated contraceptive commodities. Several modes offer promising possibilities:**

- a) **the reduction of the proportion of more expensive and less effective barrier methods while increasing the proportion of more permanent methods;**
- b) **the upgrading of clinical training and service quality to promote higher continuation and better use-effectiveness rates;**
- c) **the study of the feasibility of local production of orals, injectables, condoms, vaginals and even Copper-T IUDs; and**
- d) **the adoption and enforcement of more rational norms for Copper-T IUD's removal.**

Service Delivery

1. **The government should concentrate additional resources and effort in the urban and peri-urban areas for the next few years, while maintaining present levels of services in the rural areas.** The conditions for success are most favorable in the urban areas where the most modern, affluent, and powerful segments of society reside. Only when these segments are won will the program have a solid political, technical, and financial base to expand its action to the more difficult population segment to reach, i.e., those in the rural areas. Although the program can continue its involvement in communities in rural areas, it must not lose sight of the fact that a more effective strategy is to involve industry and other areas of production, and the commercial and service sectors in urban areas.

2. **The program should not overextend its service delivery and contraceptive distribution network.** Inefficient outlets must be closed without hesitation, and rather than open more, the program must improve the quality and productivity of those already in operation. The multi-sectoral approach can be continued but it must be made clear that this is a cooperative arrangement of all sectors with the program. The program cannot duplicate or reinforce other social services with scarce family planning resources. These programs must begin to reinforce the efforts of the PWD with their own resources. The MOH, for example, should be encouraged to draw on its own resources to address maternal health and family planning needs: it should not depend on the PWD to strengthen the MOH program.

3. **The program should allocate a larger share of resources to involve the services of private medical practitioners and other private for-profit groups in contraceptive service delivery.** Assigning performance targets in terms of CYPs of a large magnitude should accompany any resource allocation to NGOs or the private for-profit sector.

4. **The program should address the right audience: males and women 30 years of age and above.** Pakistan is a male dominated society and the program must reflect this reality. Men's work places and the public arena are equally suitable places for motivation activities, along with maternal and child health services. Almost half of total fertility is generated after the age of 30 and a larger proportion of pregnancies are undesired and fall into the high risk category. Once the needs of the over-30 are satisfied, more program resources can be concentrated on younger women. Postponement of first birth may apply to more developed countries but the realities of Pakistan's culture runs contrary to this rule.

Training

1. **The government should send out every year a significant number of carefully selected program officers for two weeks each to countries with highly successful family planning programs.** Longer-term internships of key staff to work in these programs should also be undertaken. Since many of the senior staff will be in retirement soon, there is a need for grooming the next generation of program managers. These observation tours and internships will greatly help in their preparation. In some cases, longer-term academic courses may be needed. The government should encourage such training.

Research

1. **The program should assign top priority to research in the epidemiology of reproduction and in program-oriented operations research, and should de-emphasize basic physiological and bio-chemical research of reproduction.** There is a need to create the missing components of the evaluation system such as periodical studies of characteristics of users, national follow-up studies, periodical update of targets with revised methodology, annual cost assessment, cost-benefit study, and male fertility and male prevalence surveys parallel to female surveys.

IEC

1. **An active and energetic IEC program for family planning should be instituted.** The concept of family planning need no longer be camouflaged. A low-visibility campaign yields low results.

2. **Communication should be made the responsibility of all elements of the program since communication cuts across all activities.** The program's most senior managers, clinic physicians, and family welfare motivators in the field must see themselves as communicators and observe the basic principles of effective communication.

3. **Communication should be selective and with the right audience.** As stated earlier, the focus at this time should be on urban areas, males, and women 30 years of age and above. When success is evidenced in these audiences, the communication focus can be changed.

4. **Resources must be provided to encourage wider collaboration with private sector communication talents.** Communication specialists from Pakistan's communication industry and the NGO sector constitute a rich pool of talent which can provide significant inputs to the IEC effort.

NGO Project

1. **The NGOCC should explore mechanisms for allowing it to meet basic accountability requirements of the government without having to conform to all the procedures required of government departments.**

2. **Nominations for NGOCC Council members should be from among NGOs, from among the institutional membership of NGOCC, and care should be taken to ensure a fair representation of the active NGOs participating in the NGO project.** In addition, the NGOs nominated to the NGOCC should select their own representatives to the Council in the same way as government departments select theirs.

3. **The staffing pattern and conditions of service of the NGOCC staff should be reviewed in order to hire and retain quality staff.** Training may be necessary for inexperienced NGOCC staff.

11.3 Long-term Recommendations for USAID Consideration

General

1. **USAID should continue its support to the Population Welfare Program at the completion of the current project.** A public sector project is necessary in Pakistan for the immediate

future since the majority of contraceptive users depend on the public sector to provide their contraceptive needs. Efforts to promote private sector family planning initiatives should be encouraged; however, this does not negate the need for a public sector program.

2. USAID should consider adding another population post in the HPN office to manage a follow-on PWD population project.

Contraceptive Commodities

1. USAID should undertake, in cooperation with the government, a feasibility study of local production of contraceptives. This would be a first step toward national self-sufficiency in this vital area. Concurrent with this study, USAID should provide assistance to the GOP in exploring other sources of contraceptives in the commercial sector and developing strategies on how to "broker" arrangements with pharmaceutical companies and manufacturers that may lead to below market price contraceptives being supplied to Pakistan. This effort should be coordinated with the Social Marketing of Contraceptives (SMC) project.

Service Delivery

1. USAID should provide assistance to the PWD and Ministry of Health in developing and implementing a quality assurance system for VSC.

2. USAID should expand its assistance in the private sector to include not only assistance to NGO projects (see below), but to for-profit enterprises, e.g. private practitioners.

Training

1. USAID should provide assistance in establishing model family planning centers as the training area for clinical services, sterilization in particular. These centers of excellence should adopt international standards of quality and productivity to realize the objective of upgrading national standards. A productivity of no less than 200 CYPs per day or 1000 per week is an adequate standard for a center of excellence. RHS-A centers, Regional Training Institutes, and the NRIFC could be considered as possible sites for these centers.

2. USAID should provide assistance in sending significant numbers of PWD staff from all program areas on specially planned and carefully prepared study tours to high-quality family planning service countries in the Asia region and selected countries in other regions. Four or five groups should be sent yearly to these countries to look at the various aspects of their programs. The selection of participants would be carefully done between PWD and USAID and the funds would be provided directly through the USAID mission.

3. USAID should provide assistance in sending key mid-level managers, those who will become the senior managers in a few years, on long-term training and internships in their respective fields. Internships with successful family planning programs in the Asia region should be considered.

Research

1. USAID should undertake, with the cooperation of the PWD,

-- a periodic study of characteristics of contraceptive users to determine the current profile of the contracepting population. A study of condom users was conducted recently by the SMC project. This type of study should be made at least every two years for a national sample of users of all types of contraceptive techniques, using the files of client's reports as the statistical universe. NIPS has shown interest in doing this type of study and it should be provided with the funds to undertake such work.

-- a national follow-up study to determine continuation rates and use-effectiveness rates of each contraceptive method and for extended use of all methods. This study should be carried out every five years and more often for special groups of users.

-- a study of the cost-effectiveness of different approaches to contraceptive service delivery. The SMC project has already done such a study in its area. A step forward should be to extend it to the whole list of service outlets currently in operation. It is not wise to think in expansion of subsystems if their respective costs are unknown. Cost-effectiveness is the key parameter of all planning operations.

2. USAID should provide assistance to the PWD in operations research that would be integrated into the various aspects of the PWD's service program. Program managers need help in answering strategic questions.

3. USAID should provide assistance to the PWD in revising its current plan of analysis of information that is collected every month through the reporting system. This should be done in order to produce more analytic District Performance Reports instead of, or as a complement to, the current aggregate performance report. A complete set of performance indicators should be adopted to judge the quantity and quality of contraceptive and non-contraceptive services provided by the program, beyond the three aspects considered in the current report: comparison with the previous month, with the same month of the last year, and supply status.

IEC

1. USAID should provide short-term technical assistance to boost research and evaluation capabilities. In the long-term, a training program should be provided at the graduate degree level to create a cadre of well-trained communication research and evaluation specialists at the federal and provincial levels. NIPS should be assisted to enhance its capability for communication research and evaluation.

2. USAID should provide funds for publication and dissemination of communication research outputs and USAID should support communication research in the following areas:

- Research into how a strong IEC referral program can be developed using satisfied clients as motivators.**
- Applied socio-anthropological studies on husband-wife communication and relationships.**

Data on husband-wife communication patterns and decision-making processes are crucial in formulating communication strategies aimed at influencing behavior of husband-wife dyad and in determining specific contents of IEC productions and materials such as soap operas, dramas, etc.

- Development of IEC standards and procedures for monitoring and maintaining IEC media productions. (See Appendix G for a look at some current IEC standards.)
- Determination of message sequence strategies appropriate to Pakistan's social and economic milieu.

3. **USAID should provide long-term technical assistance in the areas of communication research and evaluation; communication strategy and planning; communication management; and organizational communication.** As these areas cover different specializations, several short-term consultants and a long-term resident advisor may be needed to provide assistance at the federal and provincial levels.

4. **USAID should provide funds for an IEC training program aimed at producing graduate-level cadres proficient in IEC, at both the federal and provincial levels.**

NGO Project

1. **In any extension of USAID's support to the NGO project, USAID should specify priority project areas for funding to include innovative approaches to outreach activities and should continue the allocation of part of its budget for funding of innovative and demonstration projects.** These projects should reflect innovative thinking and flexibility rather than promoting a single model of service delivery. In addition, they should be expected to achieve significantly higher contraceptive targets and should be monitored closely.

2. **USAID should continue the use of performance-based disbursements for the NGOCC, but should make sure that criteria also include elements to ensure quality control and encouragement of innovative approaches as well as elements covering program and financial system mechanisms necessary for basic efficient functioning (such as were used previously).**

Appendices

Appendix A
Scope of Work

Appendix A

Scope of Work

USAID/Islamabad, Pakistan Final Evaluation of the Population Welfare Planning Project No. 391-0469

EVALUATION SCOPE OF WORK

1. ACTIVITY TO BE EVALUATED

USAID/PAKISTAN is undertaking a final evaluation of the Population Welfare Planning (PWP) Project No. 391-0469. The project was authorized in April 1982 initially as a 5-year activity with life of project (LOP) funding of \$25.6 million and Rs.21 million (approximately \$2 Million) P.L. 480, Title I Mondale funds. While the rupee assistance, which was for construction of warehouse and research facilities, remained the same, the LOP dollar costs were first increased to \$40 million in May 1985 and again to \$74 million in August 1986. The latter increase was accompanied by a major Project Paper (PP) amendment which expanded the scope of the project substantially by adding several new activities and also extended the Project Assistance Completion Date (PACD) from September 30, 1987 to September 30, 1989. The PACD was subsequently extended again to September 30, 1991.

2. PURPOSE OF THE EVALUATION

We intend to use this evaluation as a vehicle to analyze both project accomplishments as well as larger programmatic concerns of population activities within Pakistan. The purpose, therefore, of the evaluation will be to provide an objective assessment of USAID's role in the population sector of Pakistan specifically through the PWP Project. Based on the achievements of the PWP Project against targeted objectives and an assessment of future potential, the evaluation should comment upon the desirability of continuing U.S. assistance beyond the current PACD and recommend an appropriate strategy and direction for future U.S. assistance.

3. BACKGROUND

This project has been underway since FY 1982, providing assistance to the Government of Pakistan (GOP) for strengthening the capability of the Population Welfare Division in implementing the GOP's population program. The project is composed of nine components aimed at improving family planning education, motivation and delivery of goods and services directly as well as through non-government intermediaries. The nine components include:

- 1) Program monitoring, research and evaluation
- 2) Contraceptive supplies and logistics
- 3) Voluntary surgical contraception (VSC)
- 4) Support to non-governmental organizations (NGO)
- 5) Strengthening of district operations
- 6) Communications
- 7) Mid-level management training
- 8) Personal motivation
- 9) Construction of warehouse and research facilities

With the exception of contraceptive supplies, implementation of all other components has remained slow for a variety of reasons. While the construction of warehouse and research facilities have been completed, assistance under the Communication component has not yet commenced. A brief summary of each component's current implementation status follows.

A) Program Monitoring, Research and Evaluation

The project assisted in developing the institutional capabilities of (1) the National Institute of Population Studies (NIPS), Islamabad; (2) the National Research Institute of Fertility Control (NRIFC), Karachi; (3) the National Research Institute of Reproductive Physiology (NRIRP), Islamabad; and (4) the Monitoring and Statistics (M&S) Wing of PWD/Islamabad. Of these four research institutions, major project efforts were directed towards NIPS which started functioning in 1986 as a semi-autonomous organization to undertake population related research and evaluation primarily in sociological and demographic areas. Although NIPS is still not a viable institution, project assistance has developed its staffing, computer and other facilities enabling it to carry out a number of research studies, analysis and evaluations. NIPS will soon be undertaking a national Demographic and Health survey (DHS) in collaboration with Westinghouse/IRD.

The NRIFC is responsible primarily for clinical research including contraceptive trials and testing. The project assisted NRIFC in modernization of its research equipment including condom testing apparatus; staff development through foreign training; and is carrying out clinical trials of Norplant Implants, Copper-T IUDs and foaming tablets in collaboration with FHI.

Assistance to NRIRP, PWD's biomedical research unit, consists of provision of research equipment and supplies only. Likewise, the M&S Wing received little project assistance due principally to the availability of assistance from UNFPA and other donors.

B) Contraceptive Supplies and Logistics

This component has received the major share of project assistance. As of December 1989, over 30 million dollars worth of contraceptives have been procured and another 4 million dollars worth of supplies are on order. The project has met the Pakistan population program's entire need for condoms, oral pills and IUDs. In addition, a contraceptive logistics system was designed, a manual printed, and field staff trained in its use so as to improve the contraceptive management and accountability process.

C) Voluntary Surgical Contraception (VSC)

Assistance under this component consists of (a) funding for institutional reimbursement for VSC procedures performed by government and NGO service outlets and, (b) a \$1.15 million buy-in for the services of the Association for Voluntary Surgical Contraception (AVSC) to provide technical assistance and supervision, and to offer quality VSC services in the NGO sector. The project is also in the process of contracting with a local audit firm to verify institutional reimbursement and compliance with AID's requirements for voluntarism.

D) Support to NGO's

The project assisted in developing the institutional capability of the NGO Coordinating Council to increase and improve the role of NGO's in the national population

program. For this purpose, a total of \$ 0.81 million was provided to NGOCC in three tranches which enabled NGOCC to improve its management capabilities and fund additional NGO service outlets. A PIO/T has been processed for a buy-in to the Pathfinder Fund for additional activities and discussions are underway with the GOP for a cooperative agreement with the Asia Foundation to strengthen NGOCC management and training capabilities.

E) District Operations

Under this component, the project has procured IUD kits and other locally available equipment and supplies. It is also financing the training of public sector health service providers with a view to making family planning services available to all government health facilities. The activity is intended not only to expand FP service availability substantially but also to develop the long desired collaboration between Health and Population programs.

F) Communication

Activities under this component have not yet commenced and the entire budgeted amount remains unutilized. Although PWD has been carrying out a mass media publicity program, USAID declined to provide project assistance for continuing this program until a communication strategy was designed after conducting audience research and seeking advice from communication experts. Recently, such research has been carried out and short term technical assistance also provided by Johns Hopkins University (JHU) consultants. A PIO/T is also in process for more active and longer involvement of JHU in the redesign and implementation of an effective communication program.

G) Mid-Level Management Training

This component provides funds for non-clinical training for the professional development of managerial staff in a broad range of Pakistani institutions engaged in family planning activities. A training plan was developed by the Population Welfare Division for the first time in 1989 and the activity showed some progress. The training plan for 1990 has also been finalized.

H) Personal Motivation

Under this component, the project provides for (a) visits of community and opinion leaders to observe successful family planning programs in other countries, and (b) visits of foreign scholars and experts from these countries to Pakistan. Implementation of this component remains very slow. Only one observational visit of Pakistani Parliamentarians has taken place and only a few Pakistani professionals have participated in population-related seminars and workshops abroad.

I) Construction of Warehouse and Research Facilities

Construction of both the Warehouse and NRIFC buildings has been completed after substantial delay. The two buildings are currently being furnished.

4. STATEMENT OF WORK

The evaluation team will carry out a careful analysis of accomplishments under the PWP Project. Specifically it should focus on initial project objectives under each of the nine project components as well as the following issues and questions:

- 1) The extent to which institutional development has occurred within the National Institute of Population Studies (NIPS), National Research Institute of Fertility Control (NRIFC) and National Research Institute of Reproductive Physiology (NRIRP); effectiveness of the NIPS long-term advisor; the quality and quantity of research undertaken by NIPS, NRIFC and NRIRP; the potential to expand and improve research capabilities over the next 5 years; desirability of continuing assistance to these three research institutions and the relevance of their to project objectives.
- 2) Effectiveness of the NGOCC in coordinating and monitoring NGO activities. What is the potential for substantially strengthening and expanding NGO activities through current operating procedures and the present management system?
- 3) Adequacy of institutional reimbursement procedures for voluntary surgical contraception (VSC). Does current/potential demand for VSC warrant a significant expansion in VSC service delivery? Adequacy of oversight and coordination between NGO and government VSC service delivery points; potential client and GOP interest in nationwide availability of Norplant once approved by FDA.
- 4) Adequacy and comprehensiveness of contraceptive supply logistics and management, including storage and in-country distribution; adequacy of current system for supplying contraceptives to NGOs; adequacy of contraceptive reserves; and the extent to which the new contraceptive logistics system introduced in January 1988 is being effectively implemented.
- 5) Overall assessment of the GOP's efforts in information, education, and communication including capability, appropriateness of messages and overall strategy, effective program implementation, etc.
- 6) Steps required to streamline and accelerate implementation of project activities during the remaining life of the PWP Project.

A worldwide audit of AID contraceptive supply/management was conducted during late 1989 and CDC consultants reviewed the contraceptive supply and logistics during late January 1990. Likewise, the Communication component will be receiving technical assistance from the Johns Hopkins University Center for Communication Programs in early 1990, hopefully during the period of this evaluation. These efforts should provide valuable insight and appraisal for use by the evaluation team. The evaluation team need not go into detail regarding the demographic impact of the GOP's Population Welfare Plan or AID project assistance. Sufficient reliable data will not be available until after completion of the population census scheduled for 1991 and the Demographic and Health Survey which is to commence in March/April 1990.

Following an evaluation of project activities, and taking into account existing data and assessments, specifically the World Bank's report on Rapid Population Growth in Pakistan: Concerns and Consequences, the evaluation team should:

- 1) Assess the progress made by the GOP in implementing its Population Plan in general and the AID-financed activities in particular. This assessment should be from both

84-

programmatic as well as management perspectives taking into consideration that program implementation has remained slow.

- 2) Discuss the major constraints that have adversely affected implementation of GOP's Population Program and are likely to do so in the future. What are the causes and effects of these constraints on AID-funded activities? Which of these constraints can be resolved and how, taking into consideration the prevailing conditions and the available resources?
- 3) Assess, based on an objective assessment of the project, the GOP's commitment and capability to implement its Population Plan and AID projects. Taking into consideration the assistance provided or committed to the program by other foreign donors, what changes does the team recommend in the strategy, implementation mechanisms, and levels of AID assistance through a follow-on project?
- 4) Provide recommendations for future efforts to promote project sustainability.
- 5) Consider, given progress and problems to date on the Social Marketing of Contraceptives Project and the NGO component of the PWP project, whether or not USAID should endeavor to integrate both public and private sector population programs.

5. EVALUATION METHODOLOGY

The evaluation team reviewed documents provided by USAID, PWD, and other organizations in Pakistan (see Appendix C). It also interviewed staff from USAID, other donors, PWD, NGOs, commercial sector organization, etc. (see Appendix B).

For the first week the team reviewed documents, interviewed officials based in Islamabad, and visited PWD facilities as well as the facilities of government and non-government organizations participating in the PWP project. During the second and third weeks, the team split up and visited PWD, NGO and other related organizations involved in the Project in three provinces: Punjab, Northwest Frontier, and Sindh. The last week of the assignment, the team verified its findings and wrote the report.

The report was presented to the Secretary of PWD and to USAID on May 31, 1990.

6. THE EVALUATION TEAM

The composition of the evaluation team was:

John McWilliam	Family planning services and research (Team Leader)
Evelyn Bazalgette	NGO involvement in program
Mario Jaramillo	Commodities and logistics
Benjamin Lozare	Information, education and communication.

In addition, the PWD nominated two senior staff members to participate on the team as facilitators, Dr. Sajida Samad and Mr. Shafiq.

Appendix B

List of Organizations Contacted

Appendix B

List of Organizations Contacted

Islamabad

**USAID
Population Welfare Division
Canadian Embassy
World Bank
National Institute of Population Studies
National Research Institute of Reproductive Physiology**

Rawalpindi

**Rawalpindi Reproductive Health Service (A) Center
Behbud Association
Lalyal FHC
Family Welfare Centers**

Peshawar

**Provincial Population Welfare Department
District Population Welfare Office
Regional Training Institute
Reproductive Health Service (A) Center
APWA Clinic
NGOCC Field Office**

Mardan

Pathfinder's Male Community Worker Program

Faisalabad

**District Population Welfare Office
NGOCC Field Office
All Pakistan Women's Association
Anjuman Rifah-e-Amma Jhopal Family Health Center
Chinchawala Family Health Center
Maternal and Child Welfare Association of Faisalabad
Tanzeem-e-Sehato Semaji Behbud
Family Planning Association of Pakistan Zone Office
Sukhi Ghar Markaz**

Lahore

**Provincial Population Welfare Department
District Population Welfare Office
Provincial Health Department
Regional Training Institute
Population Welfare Training Institute
Reproductive Health Service (A) Center
Management Training Institute for Doctors
Family Planning Association of Pakistan
Family Welfare Centers**

Arrat Foundation
Lahore Model Center & Static Contraceptive Surgery Unit
Manga Mandi II Family Health Center
Maternal and Child Welfare Association of Pakistan
MCWA Punjab Urban MCH Complex
Mayo Hospital
Women's Development and Welfare Center, Model Town Ext.
Ad Ocean
Pakistan Society for Planned Parenthood
NGOCC Field Office
Punjab Social Services Board

Karachi

Provincial Population Welfare Department
District Population Welfare Office
Directorate of Clinical Training
Population Welfare Training Institute
National Research Institute of Fertility Control
Reproductive Health Service (A) Center
Family Welfare Centers
Central Warehouse, PWD
NGOCC Secretariat
The Pathfinder Fund
Imtiaz Memorial Charitable Association
New Karachi Urban Community Development Council
Pakistan Voluntary Health and Nutrition Association
People's Welfare Society, Channessar Goth
Press Institute of Pakistan
PSI Marketing Associates
Interflow
Pak Medico International
Pakistan Voluntary Health and Nutrition Association
Model Center, Malir Colony

Appendix C

Bibliography

Appendix C

Bibliography

General Documents

- The Population Policy Imperatives, M.S. Jilani, NIPS Occasional Series Papers No. 7, January 1987.
- Manual of Contraceptive Logistics, Chapter 10 PWD, Monitoring and Statistics Wing, September 1987.
- Strategic Planning and Management of Population Welfare Programme in Pakistan, Masood Nabi Nur, PWD, Islamabad, May 1988.
- A Proposal of Short-Term Planning for Re-Activation of Family Planning Activities in the Urban Areas of Lahore, K. M. Nasrullah, District Population Officer, October 1989.
- Report on the Evaluation of UNFPA Assistance to the Family Health Manpower Development Programme of Pakistan, UNFPA, New York, December 1985.
- Situation Analysis of Children and Women in Pakistan, UNICEF and NIPS, January 1988.
- Evaluation of the Outreach Component in the Family Welfare Centers in Pakistan, Report of a Pilot Project in Rawalpindi District, NIPS, Michael Semple and Yameema Mitha et al, NIPS, October 1988.
- The State of Population in Pakistan, Abdul Razzaque Rukanuddin and M. Naseem Iqbal Farooqui, NIPS, November 1988.
- Rapid Population Growth in Pakistan, Concerns and Consequences. February 2, 1989.
- Project Paper: Pakistan - Population Welfare Planning. March 1982.
- Project Paper: Pakistan - Population Welfare Planning, June 1986.
- Mid-Project Evaluation Report, PWP Project. November 14, 1984.
- Population Welfare Program, Seventh Five Year Plan, 1988-93.
- Pakistan Contraceptive Prevalence Survey, 1984-85.
- Strategic Planning and Management of Population Welfare Program in Pakistan.
- A Brief Report on PWP Activities During the First Two Years of the Seventh Five Year Plan 1988-90.
- Pakistan Trip Report for Audit of Condom Test Field Laboratories (June 27-30, 1988).
- An Overview of the Centrally Funded Contraceptive Project No. 936-3018. September 29, 1989.
- Information System of Contraceptive Movement.
- Manual of Contraceptive Logistics.
- A Review of Pakistan Voluntary Health and Nutrition Association, 1982-86.

Trainers Manual for District Training Workshop, June 1987.

Teaching of Family Planning.

Function, Resources, and Management of Family Welfare Centers, June 1987.

Evaluation Report for UNFPA on Performance of Family Welfare Centers in Pakistan.

Family Welfare Centers Evaluation Survey Report, 1985.

Performance Monitoring Report of Population Welfare Program, February 1990.

Technical Assistance to National Institute of Population Studies (NIPS).

ICOMP Occasional Paper No. 2: Population Welfare Programme of Pakistan. M. A. Kareem Iqbal, International Council on Management of Population Programmes, December 1987.

Population Sector, Sixth Fifth Year Plan 1983-88. Planning Commission Working Group, Report.

Population Welfare Programme - Seventh Five Year Plan, 1988-93.

Statement Showing Position of Technical Staff of National Institute of Population Studies (NIPS).

PC-1 Documents

Population Welfare Planning Programme, Communication Plan 1984-88. July 1985 Government of Pakistan Ministry of Planning and Development Population Welfare Division Islamabad.

Population Welfare Planning Programme, 1981-84. Pakistan Reproductive Health Service Project (five components). April 1981. Government of Pakistan Ministry of Planning and Development, Population Division Islamabad.

Population Welfare Division, Reproductive Health Services Project (Modified), June, 1985. Government of Pakistan Ministry of Planning and Development, Population Welfare Division Islamabad.

Population Welfare Planning Programme, 1981-84. NRIFC, Socio-Medical Research and Support Activities. April, 1981. Government of Pakistan Ministry of Planning and Development Population Division Islamabad.

Population Welfare Planning Programme, 1981-84. Population Development Center (Now NIPS), April 1981.

Population Welfare Planning Programme, Population Development Center, 1982-87. July 1982 (now NIPS).

Population Welfare Programme, National Institute of Population Studies, 1984-88.

Population Welfare Programme, 1984-85. Family Welfare Centers Project, June 1985.

Population Welfare Programm, 1985-88. Family Welfare Centers Project, December 1985.

Population Welfare Programme, 1988-93. Federal Activity and Punjab, Sindh NWFP, and Baluchistan Provinces (5 PC-1s).

IEC Documents

Social Marketing Contraceptives Briefing Paper, PSI Marketing Associates, April 1990.

Community Survey Regarding Child Survival Themes at Village Tehkal Payan, Peshawar, Regional Training Institute, PWD, Peshawar, by Dr. Mrs. Siddiqua Shakeeb and Dr. Tudfail Mohhammad, 1987.

Contents of Population Education Included in Textbooks of Secondary Schools, PWD.

Trip Report: Visit to Islamabad, Phyllis Piotrow, PCS, May 1986.

Manoff International Recommendation, Draft Request for Proposal for Communication Plan for 1986-88, PWD.

Retrieval of IEC Material and Preparation of an Inventory, Alauddin, NIPS, May 1989.

Evaluation of the Pakistan Social Marketing Contraceptives Project, Carl Allen et al, Population Technical Assistance Project, Arlington, Virginia, February 23, 1989.

Request for Proposal, Social Marketing of Contraceptives Project.

Request for Proposal, April 1989 Communications.

Trip Report: JHU/PCS Visit to Pakistan Needs Assessment, Moncef Bouhafa, May 5, 1989.

Draft Request for Proposal Communication Plan, 1986-88, PWD.

Recommendation: An Alternative Approach to Selecting an Advertising Agency for the Communication Plan 1986-1988 of the Population Welfare Department of the Government of Pakistan. May 1986, Manoff International.

Summary of the Working Paper on Communication Strategy, PWD. The Family Planning Program in Pakistan: What Went Wrong. Warren C. Robinson, Makhdoom A. Shah and Nasra M. Shah.

Evaluation of Population Welfare Communication Programme of Pakistan, 1988. (A Preliminary Report) National Institute of Population Studies Islamabad, Pakistan June 1989.

Population Welfare Division Communication Program. An Assessment Based on Results of the Survey of the Population Welfare Communication Program by Moncef M. Bouhafa, Consultant to NIPS, 1 February 1989.

A Report on Some Preliminary Findings for the National Survey to Evaluate the Population Welfare Communication Programme by Brian L. Pitcher, NIPS Consultant, December 11, 1988.

NGO Documents

The Foundation for International Training. Report on Institutional Review of NGO Coordinating Council for Population Welfare and Its Constituents, April 1986.

- 92 -

NIPS, Performance of the Non-Governmental Organizations in Family Planning Programme in Pakistan, 1987. November 1989.

Behbud report.

MCWA Annual Report, 1989.

Paasban - FPAP Annual Report, 1989.

Simi Kamal. A Handbook on Project Development and Implementation. NGO-CC/Pathfinder, Karachi. September 1988.

Enid Spielman. Briefing Paper on NGOs, USAID, 1988.

Project documents, correspondence, records at USAID and at NGOs.

Appendix D
Recommendations

Appendix D
Recommendations

General

Long-term for Government Consideration

1. **The government should preserve the program's unity, integrity, autonomy, and single-mission orientation. The program has succeeded in developing a structure that is dedicated to population welfare, something which many countries have tried to do but have not succeeded in accomplishing. The program can mature and be effective only if it is not saddled with secondary objectives and if it can keep its operational units and resources intact. The government should not lose sight of the core mission of the program -- to reduce Pakistan's population growth.**

2. **The institutional problems that have led to delays in program implementation should be addressed by the various agencies involved in the family planning program. More effective "institutional communication" may lead to fewer financial and resource difficulties, and less bureaucratic red tape that can delay program progress.**

3. **The government should avail itself of all opportunities for technical assistance by candidly recognizing the areas in which the program is weak and addressing the problems in these areas unequivocally.**

Long-term for USAID Consideration

4. **USAID should continue its support to the Population Welfare Program at the completion of the current project. A public sector project is necessary in Pakistan for the immediate future since the majority of contraceptive users depend on the public sector to provide their contraceptive needs. Efforts to promote private sector family planning initiatives should be encouraged; however, this does not negate the need for a public sector program.**

5. **USAID should consider adding another population post in the HPN office to manage a follow-on PWD population project.**

Contraceptive Commodities

Short-term

6. **A study should be undertaken of the current situation of district warehouses with regard to needs of space and improvements to guarantee adequate storage of the quantities of contraceptive commodities that are required by the district both as operation stock and as a three-month buffer.**

7. **As part of the DHS to take place this year, a logistics module should be designed in order to make sure that all aspects related to logistics, such as availability of contraceptives, accessibility, preferences, use, consistency of use, amounts used in a year, and other relevant issues are included and investigated in an appropriate manner. Also, a male component should be included in the DHS. If there is a country where such a study is necessary it is Pakistan, and the extra cost is fully justified by the importance of the country and the magnitude of its program. In this component, due to the importance of the condom as a male contraceptive and the amount of funds provided by USAID for condoms, brand identification should be specified.**

95

8. The PWD should organize a national workshop on long-term contraceptive needs assessment, with participation of national and international experts, and representatives of the donor community. The conclusions of such a workshop would be the basis for the preparation of a set of projections of contraceptive needs from now to the year 2000.¹ The main objective of this workshop should be to answer two questions: How many contraceptives will be needed, and how will they be paid for? USAID assistance in this workshop should be provided, if requested.

Long-term for Government Consideration

9. The government should gradually reduce dependence on donated contraceptive commodities. Several modes offer promising possibilities:

- a) the reduction of the proportion of more expensive and less effective barrier methods while increasing the proportion of more permanent methods;
- b) the upgrading of clinical training and service quality to promote higher continuation and better use effectiveness rates;
- c) the study of the feasibility of local production of orals, injectables, condoms, vaginals and even Copper-T IUDs; and
- d) the adoption and enforcement of more rational norms for Copper-T IUD's removal.

Long-term for USAID Consideration

10. USAID should undertake, in cooperation with the government, a feasibility study of local production of contraceptives. This would be a first step toward national self-sufficiency in this vital area. Concurrent with this study, USAID should provide assistance to the GOP in exploring other sources of contraceptives in the commercial sector and developing strategies on how to "broker" arrangements with pharmaceutical companies and manufacturers that may lead to below market price contraceptives being supplied to Pakistan. This effort should be coordinated with the Social Marketing of Contraceptives (SMC) project.

Service Delivery

Short-term

11. The PWD should undertake a cost-effectiveness study of the different service delivery outlets in its program. USAID assistance in this assessment should be provided, if requested.

12. The methodology currently in use to establish and update short-term targets for districts, provinces and the whole country should be revised. The conclusions of this study should be converted into a *Manual of Target Setting and Updating* that can play in this area the same important role of the *Manual of Contraceptive Logistics*. USAID assistance in the revision of the target methodology should be provided, if requested by the PWD.

¹See Appendix F for two sets of contraceptive needs for Pakistan from 1985 to 2000, which have been prepared by the evaluation team utilizing the Target Setting Model.

13. **The Family Planning Inputs into the Health Program project should be watched very closely for lessons that need to be learned in any expansion of family planning services in health units. This project should be viewed as an experimental one, and different approaches should be encouraged and documented. If operations research studies are undertaken during the Seventh Five Year Plan period on various aspects of this project, many of the findings on service delivery strategies could be applied in family planning and health programs. An evaluation of the project should be undertaken in the next 15 months to document the successes and constraints the project has experienced so far. USAID should provide assistance to this evaluation.**

Long-term for Government Consideration

14. **The government should concentrate additional resources and effort in the urban and peri-urban areas for the next few years, while maintaining present levels of services in the rural areas. The conditions for success are most favorable in the urban areas where the most modern, affluent, and powerful segments of society reside. Only when these segments are won will the program have a solid political, technical, and financial base to expand its action to the more difficult population segment to reach, i.e., those in the rural areas. Although the program can continue its involvement in communities in rural areas, it must not lose sight of the fact that a more effective strategy is to involve industry and other areas of production, and the commercial and service sectors in urban areas.**

15. **The program should not overextend its service delivery and contraceptive distribution network. Inefficient outlets must be closed without hesitation, and rather than open more, the program must improve the quality and productivity of those already in operation. The multi-sectoral approach can be continued but it must be made clear that this is a cooperative arrangement of all sectors with the program. The program cannot duplicate or reinforce other social services with scarce family planning resources. These programs must begin to reinforce the efforts of the PWD with their own resources. The MOH, for example, should be encouraged to draw on its own resources to address maternal health and family planning needs: it should not depend on the PWD to strengthen the MOH program.**

16. **The program should allocate a larger share of resources to involve the services of private medical practitioners and other private for-profit groups in contraceptive service delivery. Assigning performance targets in terms of CYPs of a large magnitude should accompany any resource allocation to NGOs or the private for-profit sector.**

17. **The program should address the right audience: males and women 30 years of age and above. Pakistan is a male dominated society and the program must reflect this reality. Men's work places and the public arena are equally suitable places for motivation activities, along with maternal and child health services. Almost half of total fertility is generated after the age of 30 and a larger proportion of pregnancies are undesired and fall into the high risk category. Once the needs of the over-30 are satisfied, more program resources can be concentrated on younger women. Postponement of first birth may apply to more developed countries but the realities of Pakistan's culture runs contrary to this rule.**

Long-term for USAID Consideration

18. **USAID should provide assistance to the PWD and Ministry of Health in developing and implementing a quality assurance system for VSC.**

19. **USAID should expand its assistance in private sector to include not only assistance to NGO projects (see below), but to for-profit enterprises, e.g. private practitioners.**

Training

Short-term

20. A training and institutional development program for the PWD VSC program, parallel to the one going on in the NGO sector, should be developed. The PWD program should take full advantage of the AVSC technical assistance in the NGO sector, where possible, for its own VSC work. Although it may be too late in the project period to activate the buy-in mechanism for AVSC assistance to the RHS program, in a follow-on project, a training and institutional development program for VSC in the public sector should be a condition for assistance in VSC. USAID assistance should be provided in the remaining project period to plan for this program.

21. The urgent need for adequately trained mid-level staff in the PWD program should be taken up immediately at the highest levels in the PWD.

22. The training requirements and specifications as stated in the Project Paper and the Project Amendment should be reviewed with each head of the components/organizations within the PWD receiving assistance from USAID. If these specifications are no longer required or if other ones are now needed, these requirements should become a part of the training plan for the project. With only one year to go under this project agreement, immediate action should take place to enable as many appropriate candidates as possible to receive overseas training beginning this fall. Highest priority should be given to this by USAID's Health, Population, and Nutrition Office.

Long-term for Government Consideration

23. The government should send out every year a significant number of carefully selected program officers for two weeks each to countries with highly successful family planning programs. Longer-term internships of key staff to work in these programs should also be undertaken. Since many of the senior staff will be in retirement soon, there is a need for grooming the next generation of program managers. These observation tours and internships will greatly help in their preparation. In some cases, longer-term academic courses may be needed. The government should encourage such training.

Long-term for USAID Consideration

24. USAID should provide assistance in establishing model family planning centers as the training area for clinical services, sterilization in particular. These centers of excellence should adopt international standards of quality and productivity to realize the objective of upgrading national standards. A productivity of no less than 200 CYPs per day or 1000 per week is an adequate standard for a center of excellence. RHS-A centers, Regional Training Institutes, and the NRIFC could be considered as possible sites for these centers.

25. USAID should provide assistance in sending significant numbers of PWD staff from all program areas on specially planned and carefully prepared study tours to high-quality family planning service countries in the Asia region and selected countries in other regions. Four or five batches should be sent yearly to these countries to look at the various aspects of their programs. The selection of participants would be carefully done between PWD and USAID and the funds would be provided directly through the USAID mission.

26. USAID should provide assistance in sending key mid-level managers, those who will become the senior managers in a few years, on long-term training and internships in their respective fields. Internships with successful family planning programs in the Asia region should be considered.

98

Research

Short-term

27. **The PWD should undertake an operations research study of the reimbursement schedule in the next 15 months to ascertain whether and at what levels institutional and personal reimbursement should be provided for the VSC program. This study should include an examination of the bottlenecks in the procedures used by the government to reimburse VSC centers and alternative mechanisms that could be recommended to the government and USAID to overcome any problems that may be encountered. USAID assistance should be provided.**

28. **The sanctioned posts for NIPS in the senior categories should be filled as soon as possible. Until there is adequate coverage by senior research officers, technical assistance should be provided. At a later stage in the development of NIPS, technical assistance may not be as necessary, but at this fragile stage in institutional development, short- and long-term advisors are necessary to undertake research tasks. All funds available for technical assistance to NIPS under the project should be used.**

29. **The training of NIPS junior professional staff should continue at both the masters and doctorate levels. Immediate action should be taken by all parties concerned to ensure that the planned admission of three NIPS staff to U.S. training programs in the fall of 1990 takes place.**

30. **Once the personnel situation at NIPS has been improved USAID should provide more funds for research activities. Different ways should be explored for donor agencies to provide such funds to NIPS since the government budget does not include adequate research funds. For example, the DHS will provide substantial funds for research activities that are needed for the institute to grow. Although it has taken some time for the DHS project to be approved by the government, the project will allow NIPS to expand its research capability as well as providing the government vital data.**

31. **The unexpended funds for this component should be reviewed by the NRIFC director in collaboration with USAID to see where they would be best placed, taking into account the institutional development needs of the research body and the potential role of the Institute in a future USAID-assisted program.**

32. **The unexpended funds for this component should be reviewed by the NRIRP director in collaboration with USAID to see where they would be best placed. USAID's priority for basic contraceptive research should be discussed, taking into account the fact that the results of any research undertaken now will have little effect on the PWD's service delivery strategy in the near future.**

Long-term for Government Consideration

33. **The program should assign top priority to research in the epidemiology of reproduction and in program-oriented operations research, and should de-emphasize basic physiological and bio-chemical research of reproduction. There is a need to create the missing components of the evaluation system such as periodical studies of characteristics of users, national follow-up studies, periodical update of targets with revised methodology, annual cost assessment, cost-benefit study, and male fertility and male prevalence surveys parallel to female surveys.**

Long-term for USAID Consideration

34. USAID should undertake, with the cooperation of the PWD

-- a periodic study of characteristics of contraceptive users to determine the current profile of the contracepting population. A study of condom users was conducted recently by the SMC project. This type of study should be made at least every two years for a national sample of users of all types of contraceptive techniques, using the files of client's reports as the statistical universe. NIPS has shown interest in doing this type of study and it should be provided with the funds to undertake such work.

-- a national follow-up study to determine continuation rates and use effectiveness rates of each contraceptive method and for extended use of all methods. This study should be carried out every five years and more often for special groups of users.

-- a study of the cost-effectiveness of different approaches to contraceptive service delivery. The SMC project has already done such a study in its area. A step forward should be to extend it to the whole list of service outlets currently in operation. It is not wise to think in expansion of subsystems if their respective costs are unknown. Cost-effectiveness is the key parameter of all planning operations.

35. USAID should provide assistance to the PWD in operations research that would be integrated into the various aspects of the PWD's service program. Program managers need help in answering strategic questions.

36. USAID should provide assistance to the PWD in revising its current plan of analysis of information that is collected every month through the reporting system. This should be done in order to produce more analytic District Performance Reports instead of, or as a complement to, the current aggregate performance report. A complete set of performance indicators should be adopted to judge the quantity and quality of contraceptive and non-contraceptive services provided by the program, beyond the three aspects considered in the current report: comparison with the previous month, with the same month of the last year, and supply status.

Information, Education, and Communication (IEC)

Short-term

37. Funds should be made available immediately for the development of an IEC campaign with policymakers and PWD staff as targets. This may involve popularized versions of the RAPID² presentations, policy conferences, workshops, briefings, and one-on-one sessions with key decision-makers.

38. Short-term technical assistance should be secured to

-- demonstrate what an effective IEC campaign can do should be encouraged. The short-term technical assistance to be rendered by JHU/PCS in August 1990 will help achieve this aim.

-- address the bureaucratic constraints inhibiting organizational communication. Funds should be provided for research and appropriate organizational communication interventions, e.g., meetings and

²The RAPID presentation developed by the Resources for Awareness of Population Impacts on Development (RAPID III) project is an interactive computer simulation model which uses colorful graphics generated on a large screen to show population and development relationships.

conferences, project management information systems, etc., designed and supervised by organizational communication specialists. This should not be perceived as a cost but as a significant investment towards achieving greater teamwork and harmony among the agencies concerned with population welfare.

39. A model IEC campaign should be launched which has all the required elements for effectiveness, i.e., audience research, pretesting of materials, regular evaluations, and use of high-caliber creative talent. Innovative approaches such as the use of the "enter-educate" concept, a strategy which combines entertainment with education and which has been found to be effective in many countries, should be seriously considered. Similarly, the use of "neo-literate" language (maximum use of visuals with sparse use of appropriate printed words) in IEC materials shows some promise based on experiments in this area made by some NGOs.

40. Findings of the NIPS evaluation study of PWD's IEC program should be deliberated at the policy and implementation levels of the PWD and acted upon. Funds to support a conference or series of meetings for this purpose should be made available. The participation of the Interprovincial Coordinating Committee, which is mandated to coordinate program implementation, is crucial.

Long-term for Government Consideration

41. An active and energetic IEC program for family planning should be instituted. The concept of family planning need no longer be camouflaged. A low-visibility campaign yields low results.

42. Communication should be made the responsibility of all elements of the program since communication cuts across all activities. The program's most senior managers, clinic physicians, and family welfare motivators in the field must see themselves as communicators and observe the basic principles of effective communication.

43. Communication should be selective and with the right audience. As stated earlier, the focus at this time should be on urban areas, males, and women 30 years of age and above. When success is evidenced in these audiences, the communication focus can be changed.

44. Resources must be provided to encourage wider collaboration with private sector communication talents. Communication specialists from Pakistan's communication industry and the NGO sector constitute a rich pool of talent which can provide significant inputs to the IEC effort.

Long-term for USAID Consideration

45. USAID should provide short-term technical assistance to boost research and evaluation capabilities. In the long-term, a training program should be provided at the graduate degree level to create a cadre of well-trained communication research and evaluation specialists at the federal and provincial levels. NIPS should be assisted to enhance its capability for communication research and evaluation.

46. USAID should provide funds for publication and dissemination of communication research outputs and USAID should support communication research in the following areas:

- Research into how a strong IEC referral program can be developed using satisfied clients as motivators.
- Applied socio-anthropological studies on husband-wife communication and relationships. Data on husband-wife communication patterns and decision-making processes are crucial in formulating communication strategies aimed at influencing behavior of husband-wife dyad and in determining

specific contents of IEC productions and materials such as soap operas, dramas, etc.

- Development of IEC standards and procedures for monitoring and maintaining IEC media productions. (See Appendix G for a look at some current IEC standards.)
- Determination of message sequence strategies appropriate to Pakistan's social and economic milieu.

47. **USAID should provide long-term technical assistance in the areas of communication research and evaluation; communication strategy and planning; communication management; and organizational communication. As these areas cover different specializations, several short-term consultants and a long-term resident advisor may be needed to provide assistance at the federal and provincial levels.**

48. **USAID should provide funds for an IEC training program aimed at producing graduate-level cadres proficient in IEC, at both the federal and provincial levels.**

NGO Project

Short-term

49. **In the immediate future, the NGOCC should recognize the incompatibility of achieving both birth aversion targets and targets for number of outlets, and should shift emphasis to achieving the birth aversion target. In order to achieve this, the NGOCC should take steps to encourage efforts that are designed to upgrade existing centers and extend outreach and follow-up visits in order to generate greater awareness and demand in areas where access to family planning services already exists, rather than open new outlets.**

50. **USAID should take immediate steps to work with the NGOCC in reviewing the activities it supports to ensure that the innovative nature of NGO efforts is encouraged and that resources are not being used exclusively to open up new outlets. Particular attention should be given to the 10 new outlets being assigned to USAID. USAID assistance should be based on clear project proposals, preferably those of an innovative character or those designed to upgrade services offered.**

51. **Over the remaining 15 months of the present project, USAID, either through the NGO Coordinator in its HPN office or through a consultancy, should participate with the NGOCC in the identification, design, monitoring, and evaluation of at least two new activities. These activities could be developed using an operations research framework so that the lessons learned from them may be applied in the development of future NGO activities.**

52. **In the short term, the NGOCC should work with the government and USAID, if necessary, to find alternative sources of funding for NGOCC staff who are presently paid by FPIA. In the longer term, more Secretariat staff should be hired to carry out the NGOCC program.**

Long-term for Government Consideration

53. **The NGOCC should explore mechanisms for allowing it to meet basic accountability requirements of the government without having to conform to all the procedures required of government departments.**

54. **Nominations for NGOCC Council members should be from among NGOs, from among the institutional membership of NGOCC, and care should be taken to ensure a fair representation of the active NGOs participating in the NGO project. In addition, the NGOs nominated to the NGOCC should select their**

own representatives to the Council in the same way as government departments select theirs.

55. The staffing pattern and conditions of service of the NGOCC staff should be reviewed in order to hire and retain quality staff. Training may be necessary for inexperienced NGOCC staff.

Long-term for USAID Consideration

56. In any extension of USAID's support to the NGO project, USAID should specify priority project areas for funding to include innovative approaches to outreach activities and should continue the allocation of part of its budget for funding of innovative and demonstration projects. These projects should reflect innovative thinking and flexibility rather than promoting a single model of service delivery. In addition, they should be expected to achieve significantly higher contraceptive targets and should be monitored closely.

57. USAID should continue the use of performance-based disbursements for the NGOCC, but should make sure that criteria also include elements to ensure quality control and encouragement of innovative approaches as well as elements covering program and financial system mechanisms necessary for basic efficient functioning (such as were used previously).

Appendix E

Analysis of Productivity of Service Delivery Points

Appendix E

Analysis of Productivity of Service Delivery Points

The purpose of this analysis is to assess the daily production of contraceptive services, both in terms of targets and performance, for each type of service outlet, in order to judge if targets are realistic and if performances are reasonable.

This analysis has been made with data taken from Table 2 of the PWD's Monthly Performance Report corresponding to December 1989.

FWC's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

1,257 FWC's	TARGETS			CYP's Per day
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	
Condoms	4082	3247.4	135.3	1.35
Orals	72.8	57.9	2.4	0.19
IUD's	37.5	29.8	1.2	2.73
Injectables	36.8	29.3	1.2	0.30
Con Surgery	0	0.0	0.0	0.00
Foam	6.7	5.3	0.2	0.06
Productivity in Crude CYP's per day				4.63

FWC's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

1,257 FWC's	PERFORMANCE			CYP's Per day
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	
Condoms	7350	5847.3	243.6	2.44
Orals	124	98.6	4.1	0.32
IUD's	43.6	34.7	1.4	3.18
Injectables	43.4	34.5	1.4	0.36
Con Surgery	0	0.0	0.0	0.00
Foam	9.6	7.6	0.3	0.08
Productivity in Crude CYP's per day				6.37

RHC-A's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

53 RHC-A's	TARGETS			
	Per month	Per month	Per day	CYP's
	All Thousands	Per Center Units	Per Center Units	Per day
Condoms	98.4	1856.0	77.3	0.77
Orals	3.1	58.8	2.4	0.19
IUD's	1.3	25.3	1.1	2.32
Injectables	2.2	40.9	1.7	0.43
Con Surgery	5.6	106.4	4.4	44.32
Foam	0.7	12.4	0.5	0.13
Productivity in Crude CYP's per day				48.16

RHC-A's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

53 RHC-A's	PERFORMANCE			
	Per month	Per month	Per day	CYP's
	All Thousands	Per Center Units	Per Center Units	Per day
Condoms	64.7	1220.8	50.9	0.51
Orals	2.1	40.3	1.7	0.13
IUD's	0.9	17.0	0.7	1.56
Injectables	0.8	14.5	0.6	0.15
Con Surgery	2.6	48.4	2.0	20.18
Foam	0.4	7.8	0.3	0.08
Productivity in Crude CYP's per day				22.61

107

RHC-Bs: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

110 RHC-B's	TARGETS			CYP's Per Day
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	
Condoms	100.0	909.2	37.9	0.38
Orals	2.5	23.1	1.0	0.07
IUD's	1.5	13.5	0.6	1.24
Injectables	3.1	28.0	1.2	0.29
Con Surgery	2.3	20.5	0.9	8.55
Foam	0.6	5.5	0.2	0.06
Productivity in Crude CYP's per day				10.58

RHC-B's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

110 RHC-B's	PERFORMANCE			CYP's Per day
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	
Condoms	13.9	126.7	5.3	0.05
Orals	0.5	4.4	0.2	0.01
IUD's	0.3	2.6	0.1	0.24
Injectables	0.3	2.5	0.1	0.03
Con Surgery	1.4	12.9	0.5	5.39
Foam	0.1	0.5	0.0	0.01
Productivity in Crude CYP's per day				5.73

108

D.D. POINTS: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DA
Based on targets and performance during December 1989

3493 POINTS	TARGETS			
	Per month All Thousands	Per month Per Point Units	Per day Per Point Units	CYP's Per day
Condoms	282.7	80.9	3.4	0.03
Orals	5.8	1.7	0.1	0.01
IUD's	0.0	0.0	0.0	0.00
Injectables	0.0	0.0	0.0	0.00
Con Surgery	0.0	0.0	0.0	0.00
Foam	0.1	0.0	0.0	0.00
Productivity in Crude CYP's per day				0.04
Productivity in Crude CYP's per month				0.94

D.D. POINTS: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DA
Based on targets and performance during December 1989

3493 POINTS	PERFORMANCE			
	Per month All Thousands	Per month Per Point Units	Per day Per Point Units	CYP's Per day
Condoms	373.3	106.9	4.5	0.04
Orals	58.7	16.8	0.7	0.05
IUD's	0.0	0.0	0.0	0.00
Injectables	0.0	0.0	0.0	0.00
Con Surgery	0.0	0.0	0.0	0.00
Foam	0.0	0.0	0.0	0.00
Productivity in Crude CYP's per day				0.10
Productivity in Crude CYP's per month				2.36

LINE DEPT.: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

752 CENTERS	TARGETS			
	Per month	Per month	Per day	CYP's
	All Thousands	Per Center Units	Per Center Units	Per day
Condoms	529.9	704.7	29.4	0.29
Orals	21.5	28.6	1.2	0.09
IUD's	9.6	12.7	0.5	1.16
Injectables	11.0	14.7	0.6	0.15
Con Surgery	0.0	0.0	0.0	0.00
Foam	3.3	4.4	0.2	0.05
Productivity in Crude CYP's per day				1.75

LINE DEPT.: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

752 CENTERS	PERFORMANCE			
	Per month	Per month	Per day	CYP's
	All Thousands	Per Center Units	Per Center Units	Per day
Condoms	82.1	109.1	4.5	0.35
Orals	2.2	3.0	0.1	0.01
IUD's	1.5	1.9	0.1	0.18
Injectables	1.4	1.9	0.1	0.02
Con Surgery	0.0	0.0	0.0	0.00
Foam	0.1	0.2	0.0	0.00
Productivity in Crude CYP's per day				0.25

110.

FPAP: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

168 CENTERS	TARGET'S			
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	CYP's Per day
Condoms	68.2	405.9	16.9	0.17
Orals	2.7	16.1	0.7	0.05
IUD's	2.2	13.3	0.6	1.22
Injectables	10.4	62.0	2.6	0.65
Con Surgery	1.4	8.4	0.4	3.51
Foam	1.2	6.9	0.3	0.07
Productivity in Crude CYP's per day				5.67
Productivity without sterilizations				2.15

FPAP: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

168 CENTERS	PERFORMANCE			
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	CYP's Per day
Condoms	55.4	329.7	13.7	0.14
Orals	2.5	14.7	0.6	0.05
IUD's	1.5	9.1	0.4	0.63
Injectables	3.4	20.3	0.8	0.21
Con Surgery	1.0	5.9	0.2	2.47
Foam	1.2	7.1	0.3	0.07
Productivity in Crude CYP's per day				3.77
Productivity without sterilizations				1.30

111

NGO-CC: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

417 CENTERS	TARGETS			
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	CYP's Per day
Condoms	120.2	288.2	12.0	0.12
Orals	5.4	13.0	0.5	0.04
IUD's	3.1	7.5	0.3	0.68
Injectables	1.3	3.1	0.1	0.03
Con Surgery	1.0	2.3	0.1	0.95
Foam	0.8	1.9	0.1	0.02
Productivity in Crude CYP's per day				1.85
Productivity without sterilizations				0.90

NGO-CC: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

417 CENTERS	PERFORMANCE			
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	CYP's Per day
Condoms	169.7	406.9	17.0	0.17
Orals	1.1	2.7	0.1	0.01
IUD's	2.3	5.6	0.2	0.51
Injectables	7.6	18.2	0.8	0.19
Con Surgery	1.4	3.2	0.1	1.35
Foam	1.7	4.0	0.2	0.04
Productivity in Crude CYP's per day				2.27
Productivity without sterilizations				0.92

112

TGI's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

184 CENTERS	TARGETS			
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	CYP's Per day
Condoms	143.2	778.4	32.4	0.32
Orals	1.0	5.5	0.2	0.02
IUD's	0.2	1.3	0.1	0.12
Injectables	0.3	1.6	0.1	0.02
Con Surgery	0.3	1.5	0.1	0.62
Foam	0.2	1.3	0.1	0.01
Productivity in Crude CYP's per day				1.11

TGI's: PRODUCTIVITY IN TERMS OF CRUDE CYP'S PER DAY
Based on targets and performance during December 1989

184 CENTERS	PERFORMANCE			
	Per month All Thousands	Per month Per Center Units	Per day Per Center Units	CYP's Per day
Condoms	47.6	258.4	10.8	0.11
Orals	1.3	6.9	0.3	0.02
IUD's	0.2	1.1	0.0	0.10
Injectables	0.1	0.6	0.0	0.01
Con Surgery	0.1	0.5	0.0	0.19
Foam	0.1	0.5	0.0	0.00
Productivity in Crude CYP's per day				0.43

Appendix F
Projections of Contraceptive Needs

Appendix F

Projections of Contraceptive Needs

Two sets of projections of contraceptive needs for Pakistan from 1985 to 2000 have been prepared, utilizing the Target Setting Model prepared by The Futures Group and The Population Council.

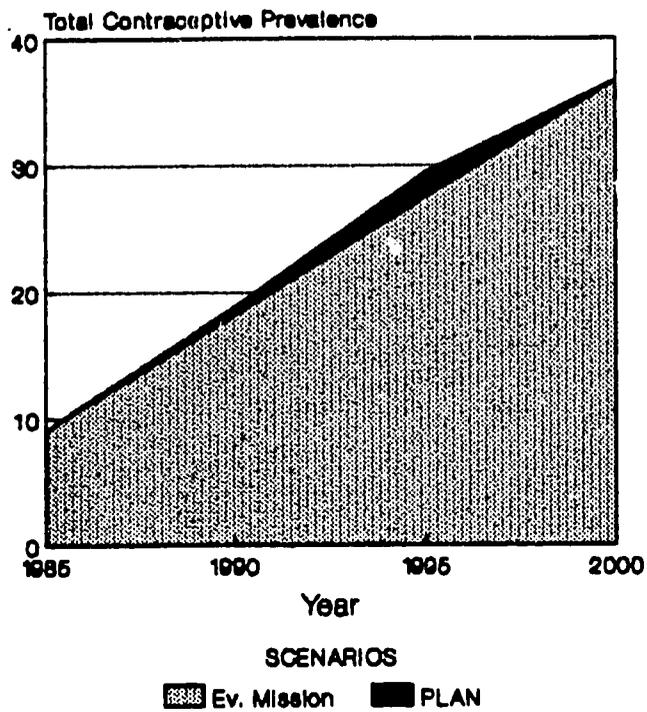
The first projection is based on the assumptions that were apparently used in setting the targets for the Seventh Five Year Plan: a substantial increase in the proportion of IUDs in the method mix, a moderate increase in the proportions of injectables and vaginals, and a drastic reduction in the proportions of condoms and oral contraceptives. This projection's IUD targets are so ambitious that all other methods (sterilization and traditional) are constrained to reduce their proportions because the total (i.e., 100 percent) cannot be expanded.

The second projection is based on more probable assumptions: a drastic decrease in the proportions of traditional methods and oral contraceptives; a moderate reduction in the proportion of condoms; a transitory decline in sterilization with a recovery of momentum within a few years; a fast increase in the proportions of injectables and vaginal foams; a continuation of the current rapid ascending trend of the IUD for only a few years, followed by a period of stabilization and, finally, at the end of the century, a massive replacement of the IUD with sterilization.

PAKISTAN

CONTRACEPTIVE NEEDS PROJECTION

**Total Contraceptive Prevalence Forecast
PAKISTAN: 1985 - 2000**



F-3 -
P A K I S T A N

This projection of Pakistan contraceptive needs is a tentative forecasting exercise prepared with the Population Council/Futures Group **TARGET SETTING MODEL**, aggregate version, developed by Bongaarts and Stover, with the purpose of assessing the probable impact of the amounts of contraceptives consumed between 1985 and 1989, and the eventual impact of the Seventh Five Year Plan targets of consumption, on contraceptive prevalence rates

The Target Setting Model estimates the amount of contraceptive users and quantities of contraceptive materials needed to reduce the **Total Fertility Rate (TFR)** from a figure in the beginning year to the level set for the last year of the projection.

This document contains the assumptions and results of two different scenarios. The first one tries to follow the targets of the **Seventh Five Year Plan 1988-1993** the second one follows what we believe are more realistic expectations of method mix for the rest of the Five Year Plan. Both have the same long term targets of fertility and improvement of the method mix until the end of the century.

The figures of **Women in Reproductive Age** were taken from **THE STATE OF POPULATION IN PAKISTAN** published by the National Institute of Population Studies, Islamabad 1988.

The **Total Fertility Rate** for 1985 was taken from the **WORLD POPULATION PROFILE 1987** prepared for the US Bureau of the census by Jamison, Johnson and Engels. Rates for the years between 1985 and 2000 were adopted according to the desired growth of contraceptive prevalence and other parameters of the projections to match the most probable evolution of prevalence and method mix after the last survey of 1984-85, as well as the targets of the Seven Five Year Plan, on one hand, and what we believe that is more realistic and achievable, on the other.

To simplify the presentation of these two scenarios we will call **PLAN SCENARIO** the first one which tries to follow the targets of the Seventh Five Year Plan, and **MISSION SCENARIO** the second one.

Total Fertility Rates and Women in Reproductive Age 1985-2000

		1985	1990	1995	2000
TFR	PLAN SCENARIO	6.73	5.94	5.09	4.50
	MISSION SCENARIO	6.73	5.99	5.24	4.50
WRA	BOTH SCENARIOS	21,602	24,735	26,203	31,671

117

We use in these projections lower **Annual Use Effectiveness Rates** and higher **Average Annual Discontinuation Rates** than in most of the projections of this series because we have received information that Pakistani rates are remarkable low. We use as a standard the most commonly accepted **CYP Conversion Factors** to calculate contraceptive consumption.

Effectiveness, Discontinuation and Consumption rates by method, both scenarios.

METHOD	EFFECTIVENESS	DISCONTINUATION	CONSUMPTION
Pill	0.95	0.40	13
IUD	0.95	0.30	
Fem Sterilization	0.99	0.10	
Male Sterilization	0.99	0.05	
Injectables	0.98	0.40	4
Other	0.70	0.50	
Condom	0.85	0.50	100
Vaginal tablets	0.85	0.50	100

The **Method Mix for 1985** was obtained from the Pakistan Contraceptive Prevalence Survey 1984-85 published by the Population Welfare Division (PWD), Ministry of Planning and Development, Pakistan.

Proportions of all methods in the Method Mix have been somewhat erratic in Pakistan, partially due to discontinuity in supply and radical changes in population policy and the family planning program.

The proportion of orals decreased from 18.8% in 1975 to 9% in 1980 and then went up to 15% in 1985. No mathematical technique is adequate to forecast future trend of orals based on these figures. The best criteria are the trends of consumption after 1985, which are very well documented by the PWD, and the policy of the program regarding the selective promotion of each method. A real reduction has been observed and another even more drastic one is the official policy of the program. The Plan scenario reduces the proportion of orals from 15.2% in 1985 to 6.25% in 1990, to 4.57% in 1995 and to 6% in the year 2000.

IUD proportion grew from 12.3% in 1975 to 17% in 1980 and then it declined to 9.1% in 1985. After this year IUD has been promoted intensely and the reported consumption through the program rised from 221,897 units in 1985 to 512,000 in 1989. The targets of the Seventh Five Year Plan anticipate the consumption of more than one million in 1993. Based on recent growth patterns of IUD use in other developing countries, and on the fact that the fastest increases are taking place in moslem countries, we anticipate that this trend of fast growth will continue for a few years and will stabilize before reaching a level of consumption of one million per year.

Female Sterilization followed a similar pattern: decreased from 19.8% in 1975 to 9% in 1980 and increased to 29% in 1985. How real has been this jump of twenty percentage points in only five years is something difficult to verify without another survey. There is a clear indication of great demand of female sterilization in most of the places where it is offered; a few services are achieving significant levels of performance (10 to 15 operations per day, five days per week); a growing number of private doctors perform both female and male sterilizations, and several groups of professionals are devoted to promoting surgical method in the largest cities. All of this suggests that larger numbers of operations are performed every year within and outside the formal program.

Nevertheless, the reported increase of female sterilizations performed by the program is not very impressive: 60,786 cases in 1985 and 86,159 in 1989. If the amount of sterilizations performed outside the program grew at the same speed it is probable that the prevalence rate of sterilization is either stable or growing very slowly because these small amounts of cases (compared with the size of the women population) hardly compensate for the growth of the population and the reduction of active users due to menopause. If this is the case then the proportion of sterilization into the method mix probably is decreasing rather than increasing.

Since the targets of the plan anticipate an increase of only a few thousands of sterilizations, we anticipate that this method will make a dip from 29% in 1985 to 23% in 1990, with a slow recuperation toward 1995, and a 35% by the year 2000.

Male Sterilization has been stable close to zero percent level. We expect a very slow progress, to only 0.57% in 1995 and 2% in 2000.

Proportion of **Injectables** has been rather stable around 6%. Authorities and program workers agree on the existence of a great demand and acceptance of this method and anticipate a rapid expansion of the market if supplies from the donor agency become more regular and predictable. Statistical information confirms these beliefs: the 156,141 injections of 1985 increased at an annual average of 120,000 to reach 640,755 in 1989. Unknown amounts were consumed through private sources. Although this increase is remarkable in relative terms, it is less significant in absolute terms, and its impact in the method mix is small. It is why we anticipate a moderate increment of its proportion in the near future.

Condom proportion in the method mix was stable around 20% between 1975 and 1985. After this last year the proportion has been decreasing slowly according to statistics of consumption, and the targets of the plan anticipate even faster reductions in proportion, stabilization in prevalence and small increase in the absolute amount of condoms consumed. We expect a gradual reduction from the current proportion of 26-27% to 17% by the year 2000.

Vaginal Methods proportion in the method mix was 1.2 in 1985. We anticipate a moderate growth until 1992 and a faster one until the year 2000.

Traditional methods represented 18.9% of all users in 1985. Trends from 1985 to 1989 are unknown, but it is probable that the growing availability of modern methods is reducing their relative importance in the method mix.

	Method Mix			
	1985	1990	1995	2000
PLAN SCENARIO				
Pill	15.20	6.25	4.57	6.00
IUD	9.10	33.00	36.86	24.00
Female Sterilizat	29.00	23.00	24.29	35.00
Male Sterilization	0	0	0.57	2.00
Injectables	6.60	6.10	7.57	9.00
Other	18.90	4.00	3.71	3.00
Condom	20.00	26.00	19.14	17.00
Vaginals	1.2	1.65	3.29	4.00
MISSION SCENARIO				
Pill	15.20	6.75	6.00	6.00
IUD	9.10	30.00	28.29	24.00
Female Sterilizat	29.00	24.00	27.14	35.00
Male Sterilization	0	0	0.57	2.00
Injectables	6.60	6.35	8.29	9.00
Other	18.90	4.00	3.71	3.00
Condom	20.00	27.25	22.71	17.00
Vaginals	1.20	1.65	3.29	4.00

The **Percentage of women who are married** is 74% according to the US Bureau of the Census. Projections of the Seventh Five Year Plan are based on a proportion of 75% married. The report **RAPID POPULATION GROWTH IN PAKISTAN, CONCERNS AND CONSEQUENCES**, a recent study of the World Bank, indicates that the average age at first marriage is 20 years, rather high for South Asia standards. The same study also reports that it is probably increasing because proportions of single women below 20 grew from 46% in 1961 to 71% in 1981. For this reason we reduce the proportion of married women to 70% in 2000.

Postpartum infecundability and breastfeeding are still very high but a trend of slow decrease is observed.

Induced abortion rates are unknown. We have omitted this parameter in these projections because we lack a basis for its estimation.

Target Setting Model
05/23/90 21:25:40

TFR TARGETS

Title = P A K I S T A N - IUDMAXIMUM

First year = 1985

Last year = 2000

	1985	1990	1995	2000
TFR	6.73	5.94	5.09	4.50
Women aged 15-49 (Thousands)	21602.0	24735.0	28203.0	31671.0

"P L A N" S C E N A R I O
This Projection tries to follow the
targets of the Seventh Five Year Plan

- F-8 -

METHODS

Method	Effectiveness	Discontinuation	Consumption
Pill	0.95	0.40	13.0
IUD	0.95	0.30	
Female sterilization	0.99	0.10	
Male sterilization	0.99	0.05	
Injectables	0.98	0.40	4.0
Other	0.70	0.50	0.0
Condom	0.85	0.50	100.0
Vaginal Tablets	0.85	0.50	100.0

METHOD MIX

	1985	1990	1995	2000
Pill	15.20	6.25	4.57	6.00
IUD	9.10	33.00	36.86	24.00
Female sterilization	29.00	23.00	24.29	35.00
Male sterilization	0.00	0.00	0.57	2.00
Injectables	6.60	6.10	7.57	9.00
Other	18.90	4.00	3.71	3.00
Condom	20.00	26.00	19.14	17.00
Vaginal Tablets	1.20	1.65	3.29	4.00

PROXIMATE DETERMINANTS

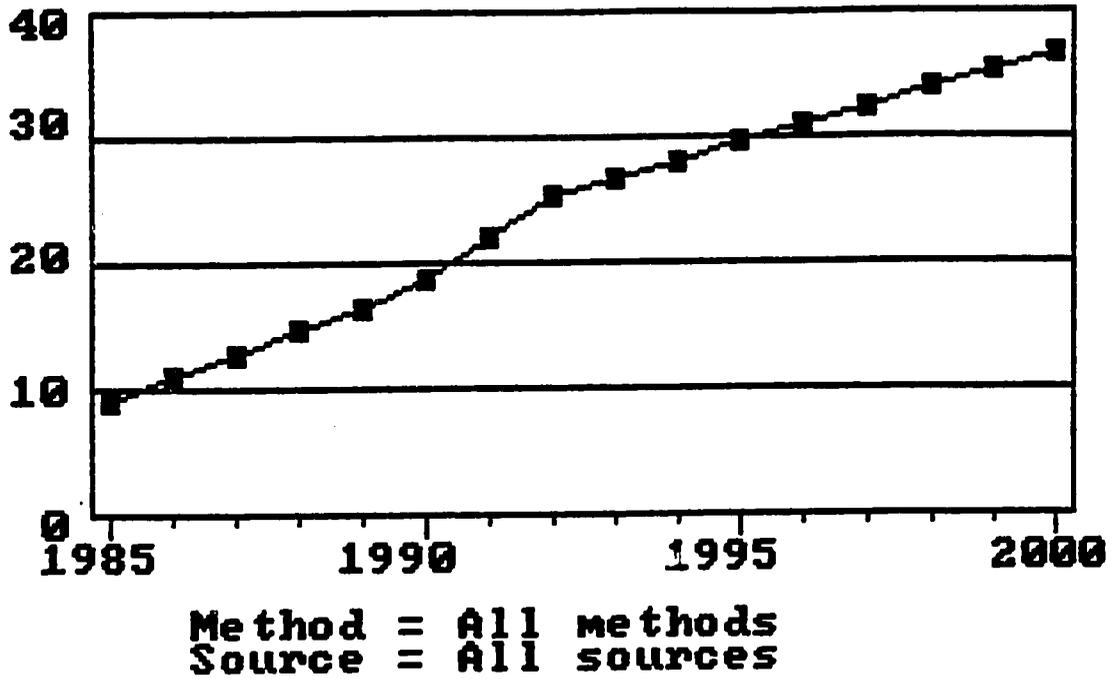
	1985	1990	1995	2000
Prevalence (%)	9.1			
Percent WRA married	75.0	73.3	71.7	70.0
Duration of postpartum infecundability (months)	11.2	10.8	10.4	10.0
Induced abortion rates per 1000 women 15-19	0.00	0.00	0.00	0.00

P A K I S T A N - IUDMAXIMUM

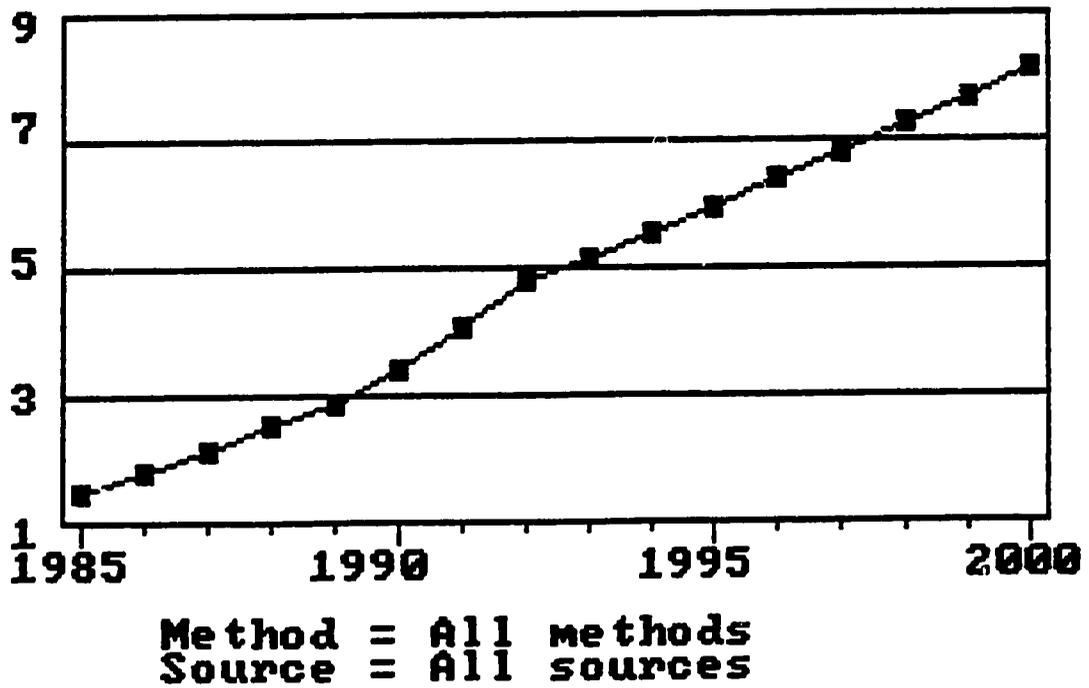
Output Table for All methods from All sources

Year	Percent MWEA Using	Number Using (Thousands)
1985	9.1	1474.3
1986	10.9	1810.6
1987	12.7	2159.1
1988	14.5	2519.7
1989	16.3	2892.2
1990	18.8	3411.2
1991	21.9	4065.5
1992	25.2	4774.2
1993	26.6	5161.9
1994	28.1	5558.6
1995	29.5	5964.8
1996	31.0	6381.2
1997	32.4	6809.1
1998	33.8	7246.3
1999	35.3	7690.7
2000	36.7	8139.7

Percent MWRAs Using



Number Using (Millions)



P A K I S T A N - IUDMAXIMUM

Output Table for Pill from All sources

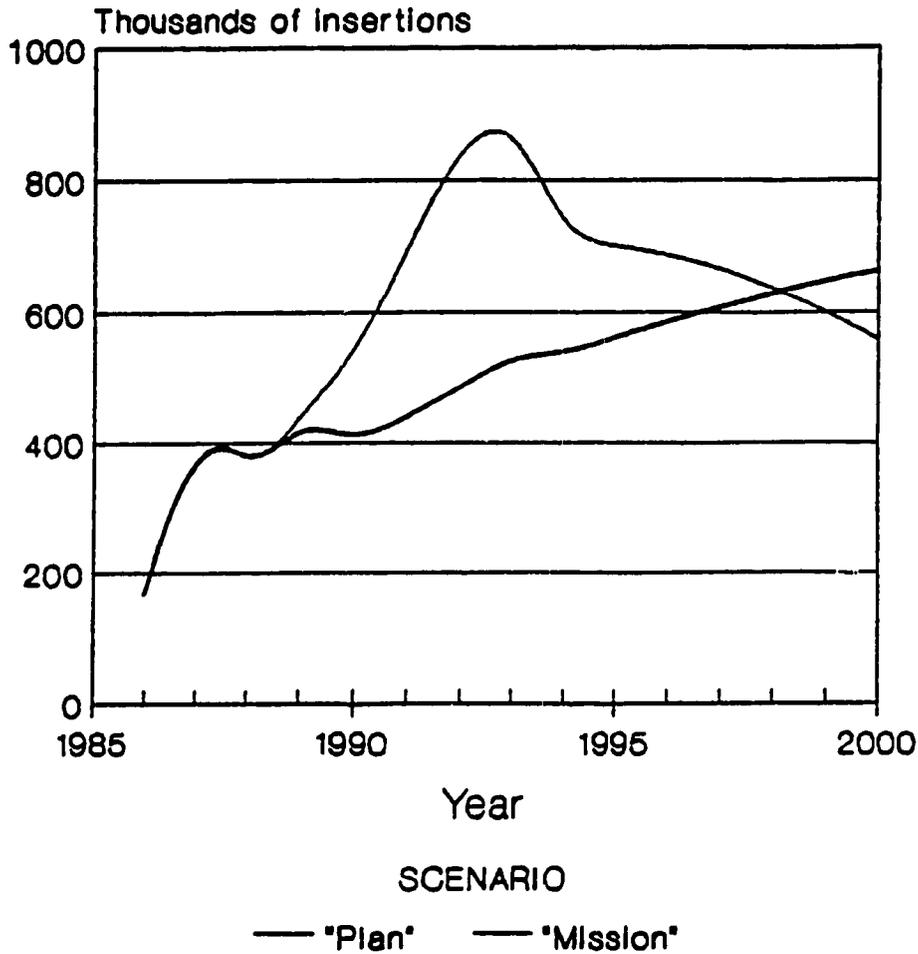
Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Cycles (Thousands)
1985	1.4	224.1		
1986	1.4	238.1	105.9	3095.3
1987	1.4	239.7	99.2	3115.6
1988	1.3	228.0	86.6	2964.5
1989	1.1	202.5	67.9	2631.9
1990	1.2	213.2	93.7	2771.6
1991	1.2	223.6	97.8	2906.9
1992	1.2	226.8	94.8	2948.1
1993	1.1	206.5	72.7	2684.2
1994	1.2	238.2	116.4	3096.9
1995	1.3	272.7	132.1	3544.8
1996	1.5	309.9	149.0	4029.3
1997	1.7	350.2	167.3	4552.4
1998	1.8	393.4	186.7	5113.8
1999	2.0	439.5	207.3	5713.1
2000	2.2	488.4	229.1	6349.0

P A K I S T A N - IUDMAXIMUM

Output Table for IUD from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Insertions (Thousands)
1985	0.8	134.2		
1986	1.6	259.4	167.8	167.8
1987	2.5	422.1	245.0	245.0
1988	3.6	624.3	336.1	336.1
1989	4.9	867.6	441.4	441.4
1990	6.2	1125.7	533.3	533.3
1991	7.9	1463.6	695.0	695.0
1992	9.8	1861.9	862.6	862.6
1993	11.2	2168.0	896.7	896.7
1994	11.1	2191.7	711.4	711.4
1995	10.9	2198.4	702.0	702.0
1996	10.6	2197.9	686.8	686.8
1997	10.3	2159.5	665.6	665.6
1998	9.9	2111.8	637.3	637.3
1999	9.4	2043.5	601.6	601.6
2000	8.8	1953.5	558.2	558.2

**PAKISTAN: Number of IUD insertions
according to two projections
1985-2000**



This is the main difference between the two projections: the emphasis in promoting the IUD.

The Seventh Five Year Plan has very ambitious targets of IUD insertion

The mission believes that lower targets of IUD are more realistic and compatible with the promotion of other methods.

125

P A K I S T A N - IUDMAXIMUM

Output Table for Female sterilization from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Procedures (Thousands)
1985	2.6	427.6		
1986	3.0	502.4	124.6	124.6
1987	3.4	572.2	128.1	128.1
1988	3.7	636.2	130.6	130.6
1989	3.9	694.1	131.9	131.9
1990	4.3	784.6	171.2	171.2
1991	4.8	894.4	201.1	201.1
1992	5.3	1002.6	212.2	212.2
1993	5.3	1032.4	146.4	146.4
1994	6.2	1230.3	318.5	318.5
1995	7.2	1448.6	360.9	360.9
1996	8.2	1686.5	406.4	406.4
1997	9.3	1945.5	455.1	455.1
1998	10.4	2225.7	506.5	506.5
1999	11.6	2527.0	560.1	560.1
2000	12.9	2848.9	615.8	615.8

P A K I S T A N - IUDMAXIMUM

Output Table for Male sterilization from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Procedures (Thousands)
1985	0.0	0.0		
1986	0.0	0.0	0.0	0.0
1987	0.0	0.0	0.0	0.0
1988	0.0	0.0	0.0	0.0
1989	0.0	0.0	0.0	0.0
1990	0.0	0.0	0.0	0.0
1991	0.0	0.0	0.0	0.0
1992	0.0	0.0	0.0	0.0
1993	0.0	0.0	0.0	0.0
1994	0.1	15.9	15.9	15.9
1995	0.2	34.1	19.4	19.4
1996	0.3	54.7	23.1	23.1
1997	0.4	77.8	27.1	27.1
1998	0.5	103.5	31.4	31.4
1999	0.6	131.8	35.9	35.9
2000	0.7	162.3	40.7	40.7

P A K I S T A N - IUDMAXIMUM

Output Table for Injectables from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Injections (Thousands)
1985	0.6	97.3		
1986	0.7	115.9	59.5	463.5
1987	0.8	133.9	66.7	535.5
1988	0.9	151.2	73.6	604.7
1989	0.9	167.7	80.2	671.0
1990	1.1	208.1	110.9	832.3
1991	1.4	260.2	139.7	1040.8
1992	1.7	319.9	169.1	1279.5
1993	1.9	361.3	176.0	1445.3
1994	2.0	405.0	195.7	1619.9
1995	2.2	451.6	217.0	1806.5
1996	2.4	501.4	239.8	2005.5
1997	2.6	554.5	264.0	2217.8
1998	2.9	610.8	289.6	2443.0
1999	3.1	670.2	316.4	2680.8
2000	3.3	732.6	344.3	2930.3

P A K I S T A N - IUDMAXIMUM

Output Table for Other from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	1.7	278.6		
1986	1.7	274.8	141.2	0.0
1987	1.5	247.2	115.5	0.0
1988	1.1	194.6	76.2	0.0
1989	0.7	115.7	22.4	0.0
1990	0.8	136.4	81.0	0.0
1991	0.9	162.6	97.2	0.0
1992	1.0	191.0	113.0	0.0
1993	1.1	206.5	114.9	0.0
1994	1.1	214.4	115.4	0.0
1995	1.1	221.5	118.8	0.0
1996	1.1	227.9	121.7	0.0
1997	1.1	233.5	124.2	0.0
1998	1.1	238.1	126.2	0.0
1999	1.1	241.7	127.6	0.0
2000	1.1	244.2	128.3	0.0

PAKISTAN - IUDMAXIMUM

Output Table for Condom from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	1.8	294.9		
1986	2.4	398.3	257.0	39833.9
1987	3.1	518.2	327.3	51818.0
1988	3.8	655.1	406.8	65513.0
1989	4.6	809.8	495.8	80980.3
1990	4.9	886.9	498.8	88690.6
1991	5.3	975.7	550.6	97572.9
1992	5.5	1050.3	582.7	105032.1
1993	5.3	1032.4	529.0	103238.8
1994	5.5	1087.9	593.1	108790.1
1995	5.6	1141.8	620.4	114182.7
1996	5.8	1194.2	646.9	119420.4
1997	5.9	1245.1	672.7	124509.0
1998	6.0	1294.0	697.2	129398.7
1999	6.1	1340.4	720.2	134038.3
2000	6.2	1383.8	741.3	138375.3

PAKISTAN - IUDMAXIMUM

Output Table for Vaginal Tablets from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	0.1	17.7		
1986	0.1	21.7	13.2	2172.8
1987	0.2	25.9	15.5	2590.9
1988	0.2	30.2	17.8	3023.7
1989	0.2	34.7	20.2	3470.6
1990	0.3	56.3	39.6	5628.4
1991	0.5	85.4	58.4	8537.6
1992	0.6	121.7	80.8	12174.2
1993	0.8	154.9	96.5	15485.8
1994	0.9	174.7	100.5	17469.9
1995	1.0	196.0	112.3	19598.5
1996	1.1	218.8	124.8	21878.6
1997	1.2	243.2	138.3	24318.2
1998	1.3	269.1	152.6	26914.9
1999	1.4	296.6	167.6	29664.2
2000	1.5	325.6	183.4	32558.9

128

TFR TARGETS

Title = P A K I S T A N

First year = 1985

Last year = 2000

	1985	1990	1995	2000
TFR	6.73	5.99	5.24	4.50
Women aged 15-49 (Thousands)	21602.0	24735.0	28203.0	31671.0

"MISSION" SCENARIO
Projection with less ambitious targets of
IUD, suggested by the Evaluation Mission

- F-17 -

METHODS

Method	Effectiveness	Discontinuation	Consumption
Pill	0.95	0.40	13.0
IUD	0.95	0.30	
Female sterilization	0.99	0.10	
Male sterilization	0.99	0.05	
Injectables	0.98	0.40	4.0
Other	0.70	0.50	0.0
Condom	0.85	0.50	100.0
Vaginal Tablets	0.85	0.50	100.0

METHOD MIX

	1985	1990	1995	2000
Pill	15.20	6.75	6.00	6.00
IUD	9.10	30.00	26.29	24.00
Female sterilization	29.00	24.00	27.14	35.00
Male sterilization	0.00	0.00	0.57	2.00
Injectables	6.60	6.35	8.29	9.00
Other	13.90	4.00	3.71	3.00
Condom	20.00	27.25	22.71	17.00
Vaginal Tablets	1.20	1.65	3.29	4.00

PROXIMATE DETERMINANTS

	1985	1990	1995	2000
Prevalence (%)	9.1			
Percent WRA married	75.0	73.3	71.7	70.0
Duration of postpartum infecundability (months)	11.2	10.3	10.4	10.0
Induced abortion rates per 1000 women 15-19	0.00	0.00	0.00	0.00

130

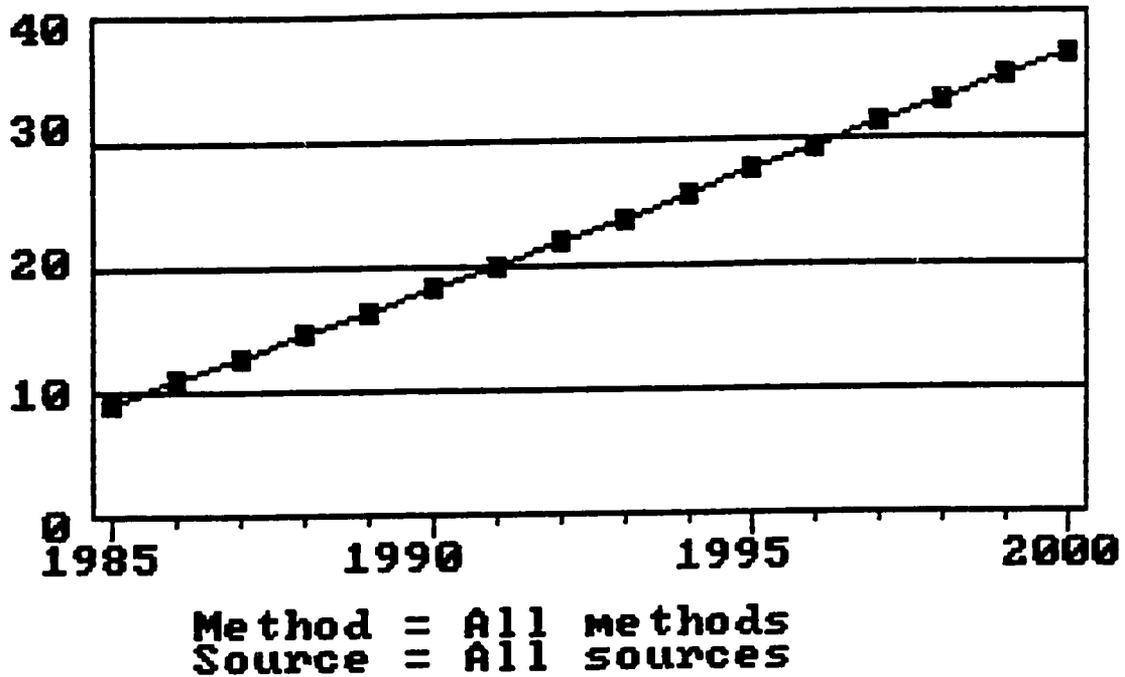
PAKISTAN

Output Table for All methods from All sources

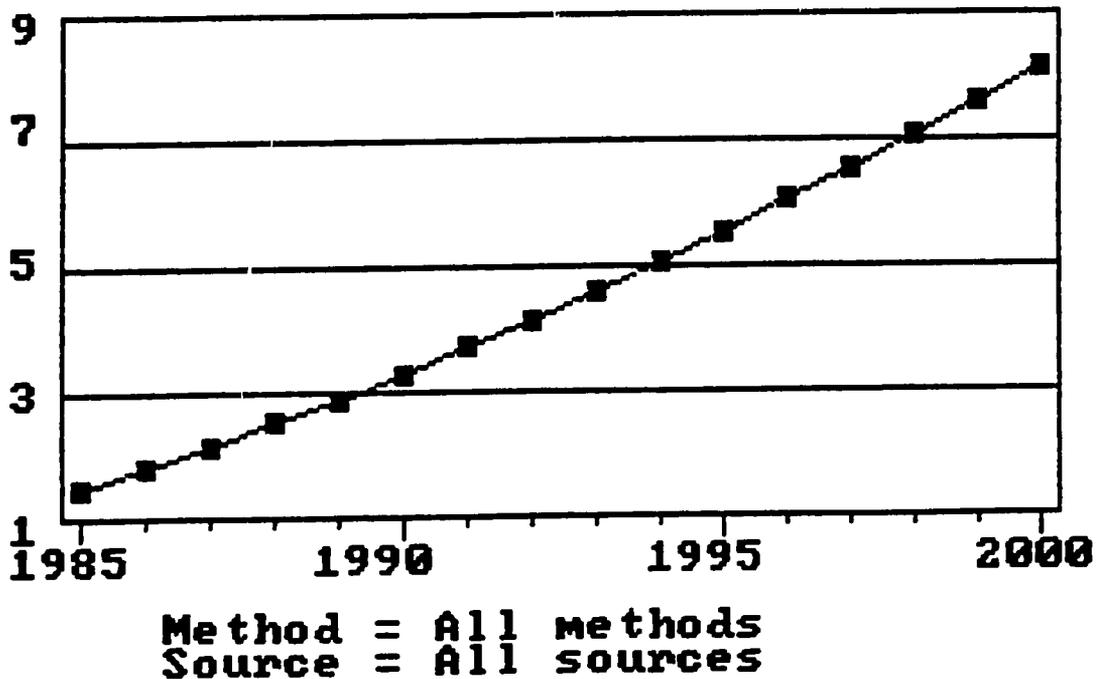
Year	Percent MWEA Using	Number Using (Thousands)
1985	9.1	1474.3
1986	10.9	1810.6
1987	12.7	2159.1
1988	14.5	2519.7
1989	16.3	2892.2
1990	18.2	3297.8
1991	20.1	3720.5
1992	21.9	4161.4
1993	23.8	4619.7
1994	25.7	5084.7
1995	27.5	5562.5
1996	29.4	6053.7
1997	31.2	6559.1
1998	33.0	7076.8
1999	34.9	7604.6
2000	36.7	8139.7

731

Percent MWRA Using



Number Using (Millions)



P A K I S T A N

Output Table for Pill from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Cycles (Thousands)
1985	1.4	224.1		
1986	1.4	238.1	105.9	3095.3
1987	1.4	239.7	99.2	3115.6
1988	1.3	228.0	86.6	2964.5
1989	1.1	202.5	67.9	2631.9
1990	1.2	222.6	103.1	2893.9
1991	1.3	241.8	110.5	3143.8
1992	1.4	260.1	117.4	3381.1
1993	1.4	277.2	123.7	3603.3
1994	1.5	305.1	141.5	3966.1
1995	1.7	333.8	153.7	4338.6
1996	1.8	363.2	166.3	4721.9
1997	1.9	393.5	179.2	5116.1
1998	2.0	424.6	192.4	5519.9
1999	2.1	456.3	205.7	5931.6
2000	2.2	468.4	219.1	6349.0

P A K I S T A N

Output Table for IUD from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Insertions (Thousands)
1985	0.8	134.2		
1986	1.6	259.4	167.8	167.8
1987	2.5	422.1	245.0	245.0
1988	3.6	624.3	336.1	336.1
1989	4.9	867.6	441.4	441.4
1990	5.5	989.4	396.9	396.9
1991	6.0	1116.2	440.6	440.6
1992	6.6	1248.4	486.3	486.3
1993	7.1	1385.9	533.5	533.5
1994	7.5	1481.8	535.6	535.6
1995	7.8	1573.4	561.6	561.6
1996	8.1	1660.4	586.1	586.1
1997	8.3	1742.8	609.1	609.1
1998	8.5	1819.8	629.7	629.7
1999	8.7	1890.3	647.8	647.8
2000	8.8	1953.5	662.8	662.8

PAKISTAN

Output Table for Female sterilization from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Procedures (Thousands)
1985	2.6	427.6		
1986	3.0	502.4	124.6	124.6
1987	3.4	572.2	128.1	126.1
1988	3.7	636.2	130.6	130.6
1989	3.9	694.1	131.9	131.9
1990	4.4	791.5	178.1	178.1
1991	4.8	892.9	193.5	193.5
1992	5.3	998.7	209.7	209.7
1993	5.7	1108.7	226.1	226.1
1994	6.6	1300.2	320.5	320.5
1995	7.5	1509.8	360.8	360.8
1996	8.4	1738.3	404.0	404.0
1997	9.5	1986.5	450.4	450.4
1998	10.5	2254.5	499.0	499.0
1999	11.7	2542.1	549.8	549.8
2000	12.9	2848.9	602.4	602.4

PAKISTAN

Output Table for Male sterilization from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Procedures (Thousands)
1985	0.0	0.0		
1986	0.0	0.0	0.0	0.0
1987	0.0	0.0	0.0	0.0
1988	0.0	0.0	0.0	0.0
1989	0.0	0.0	0.0	0.0
1990	0.0	0.0	0.0	0.0
1991	0.0	0.0	0.0	0.0
1992	0.0	0.0	0.0	0.0
1993	0.0	0.0	0.0	0.0
1994	0.1	14.5	14.5	14.5
1995	0.2	31.8	18.3	18.3
1996	0.3	51.9	22.4	22.4
1997	0.4	75.0	26.9	26.9
1998	0.5	101.1	31.7	31.7
1999	0.6	130.4	36.7	36.7
2000	0.7	162.8	42.0	42.0

P A K I S T A N

Output Table for Injectables from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Injections (Thousands)
1985	0.6	97.3		
1986	0.7	115.9	59.5	463.5
1987	0.8	133.9	66.7	535.5
1988	0.9	151.2	73.6	604.7
1989	0.9	167.7	80.2	671.0
1990	1.2	209.4	112.2	837.7
1991	1.4	256.7	135.4	1026.9
1992	1.6	310.0	161.3	1240.1
1993	1.9	369.6	190.0	1478.3
1994	2.1	414.0	200.0	1656.2
1995	2.3	460.9	221.0	1843.6
1996	2.5	510.2	243.2	2041.0
1997	2.7	562.2	266.6	2248.8
1998	2.9	616.7	291.0	2466.8
1999	3.1	673.6	316.3	2694.2
2000	3.3	732.6	342.4	2930.3

P A K I S T A N

Output Table for Other from All sources

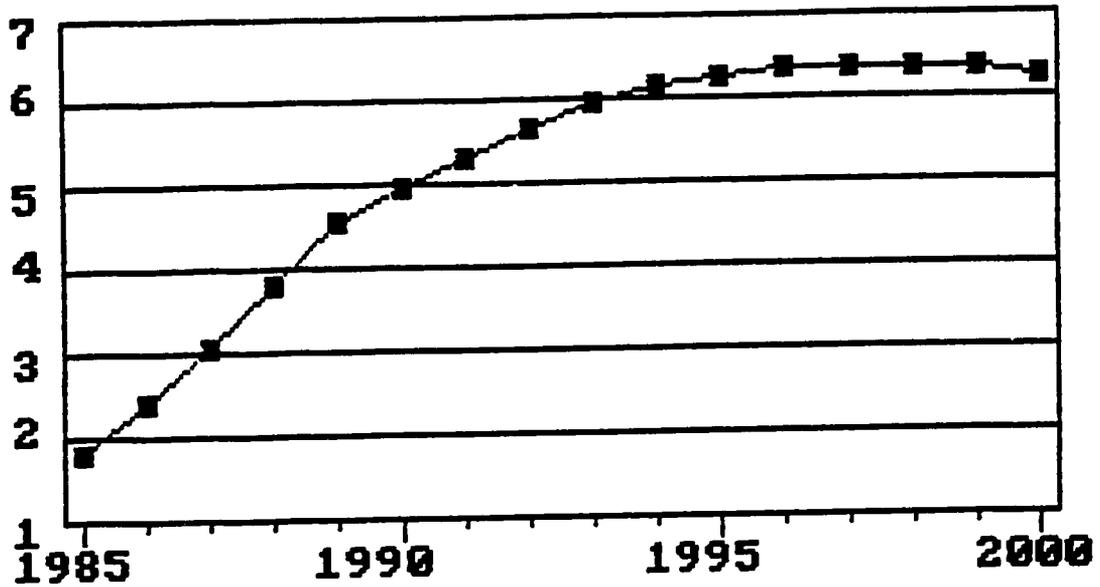
Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	1.7	278.6		
1986	1.7	274.8	141.2	0.0
1987	1.5	247.2	115.5	0.0
1988	1.1	194.6	76.2	0.0
1989	0.7	115.7	22.4	0.0
1990	0.7	131.9	76.5	0.0
1991	0.8	148.8	85.6	0.0
1992	0.9	166.5	95.1	0.0
1993	1.0	184.8	105.0	0.0
1994	1.0	196.1	107.6	0.0
1995	1.0	206.6	112.6	0.0
1996	1.0	216.2	117.2	0.0
1997	1.1	224.9	121.3	0.0
1998	1.1	232.5	124.7	0.0
1999	1.1	239.0	127.6	0.0
2000	1.1	244.2	129.6	0.0

P A K I S T A N

Output Table for Condom from All sources

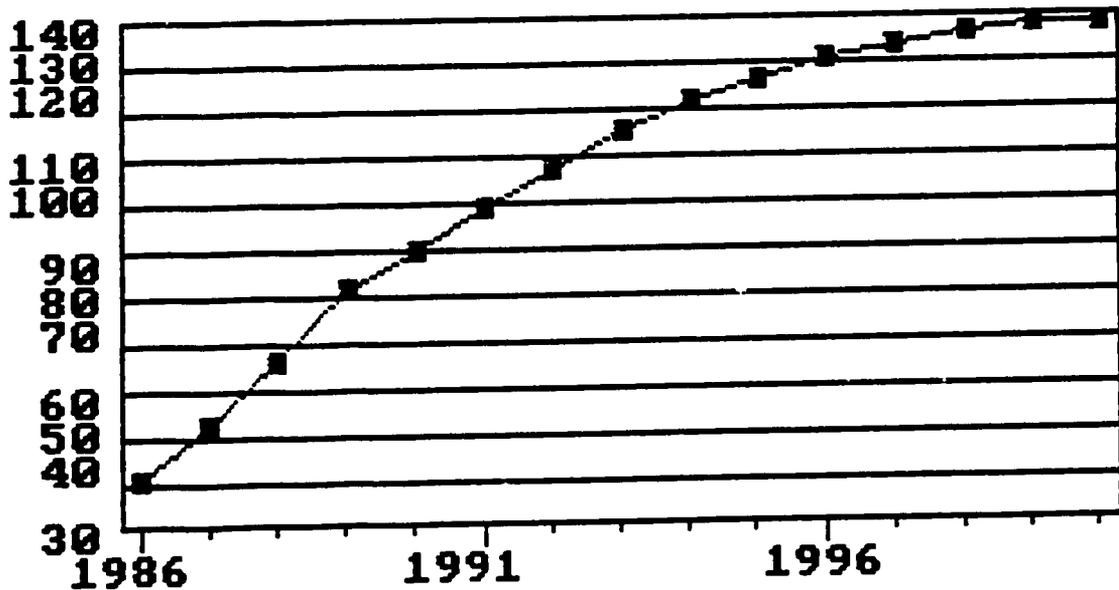
Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	1.8	294.9		
1986	2.4	398.3	257.0	39833.9
1987	3.1	518.2	327.3	51818.0
1988	3.8	655.1	406.8	65513.0
1989	4.6	809.8	495.8	80980.3
1990	5.0	898.7	510.5	89866.2
1991	5.3	985.9	555.2	98594.0
1992	5.7	1071.6	599.0	107156.4
1993	6.0	1154.9	641.3	115491.3
1994	6.1	1213.1	659.5	121307.6
1995	6.3	1263.5	682.1	126349.0
1996	6.3	1305.9	700.3	130586.3
1997	6.4	1339.9	714.0	133992.8
1998	6.4	1364.8	722.6	136482.0
1999	6.3	1379.7	725.5	137969.6
2000	6.2	1383.8	722.5	138375.3

Percent MWRAs Using



Method = Condom
Source = All sources

Annual Number of Units (Millions)



Method = Condom
Source = All sources

P A K I S T A N

Output Table for Vaginal Tablets from All sources

Year	Percent MWRA Using	Number Using (Thousands)	Annual Number of Acceptors (Thousands)	Annual Number of Units (Thousands)
1985	0.1	17.7		
1986	0.1	21.7	13.2	2172.8
1987	0.2	25.9	15.5	2590.9
1988	0.2	30.2	17.8	3023.7
1989	0.2	34.7	20.2	3470.6
1990	0.3	54.4	37.8	5441.4
1991	0.4	76.1	52.1	7813.1
1992	0.6	106.1	68.7	10611.6
1993	0.7	138.6	87.7	13859.0
1994	0.8	159.8	93.4	15960.6
1995	0.9	182.8	106.2	18276.9
1996	1.0	207.6	120.0	20755.4
1997	1.1	234.3	134.8	23425.3
1998	1.2	262.9	150.6	26285.4
1999	1.3	293.3	167.3	29332.1
2000	1.5	325.6	185.0	32558.9

Appendix G

Additional Comments on the PWD's IEC Program

Appendix G

Additional Comments on the PWD's IEC Program

1. Some Findings of NIP's Preliminary Report

NIPS' preliminary report used multivariate techniques to estimate program impact. Multiple regression models and path analytical techniques showed low correlations between respondents who first received family planning information from interpersonal sources and respondents who received information from the mass media, thus suggesting two distinct audience segments. The data showed high correlations in household ownership of media suggesting that television owners are likely to have access to radio and newspapers as well.

The report provides excellent insights into the PWD IEC program, but some points need to be considered in interpreting the data:

- Because the description of the sampling scheme did not mention whether or not adjustments were made with regards to respondents whose spouses were also interviewed, it is possible that a portion of media ownership data reflected double counting, i.e. the same radio set in a household was reported by the husband and his wife who are both respondents.
- The studies treat "spouse" as a source of family planning information. If husband and wife are treated as a dyad, as they should be, spouse should be regarded as a target of an IEC program and not as a source. In this case, tracing the sources of information of spouses would be useful and might reveal an underestimation of media effects.
- Readers should be aware of "media echo" effects in survey research, wherein a survey echoes back how a particular medium was used. Findings, therefore, do not necessarily reflect inherent weaknesses or strengths of a particular medium but, perhaps, merely echo how that medium was used, e.g., effectively or not effectively. The literature in this area suggests that determining how well a medium can be used is more productive than determining inherent strengths and weaknesses of various media. Much research has been done to establish media strengths and weaknesses with use of experimental designs and innovative methods only to be confounded by the wide variance in media skills and techniques applied in a situation, e.g., a well-produced radio program can be more effective than a poorly produced television show despite the added visual dimension of television. It is difficult to identify, therefore, a "magic" or "ideal" medium.

(See " A Report on Some Preliminary Findings for the National Survey to Evaluate the Population Welfare Program," by Brian Pitcher, NIPS Consultant, 1988; " An Assessment Based on the Results of the Survey of the Population Welfare Communication Program by Moncef Bouhafa, NIPS Consultant, 1989; "Evaluation of the Population Welfare Communication Program of Pakistan, NIPS, 1989).

2. Discussion of Current IEC Plans

An analysis of the NIPS's evaluation data, a review of documents and plans, and interviews with IEC personnel show that the present PWD IEC program has a limited appreciation and capability for audience research and pretesting of IEC materials, and that existing communication plans are deficient in a number of areas.

- Lack of clear measurable objectives.
- No clear prioritization of activities or targets.

Pakistan is a male dominated society, but the IEC effort lays greater stress on women. Although much of IEC implementation is at the provincial level, there is a lack of clear provincial IEC objectives and strategy that reflect provincial conditions. Because messages and media mix are determined at the federal level through PC-1s and budget allocations, what remains to be measured are means-oriented physical targets such as number of radio spots broadcasted, audio-visual van showings made and training activities held, etc. Provincial IEC materials are essentially translations of national themes and their design and production do not seem to reflect local culture and situations. There is little evidence of communication research at the provincial level to guide provincial communications planning.¹

- Lack of clear and concrete project mileposts or indicators.
- Little appreciation for the time dimension in planning and implementation. Specifically, there is little evidence of a multi-stage approach or thinking about long-term communication strategy.
- Little evidence of coordination between the media campaign and interpersonal communication.
- An urgent need for a sharper understanding of communication strategy.

There seems to be an awareness of media mix but there is no clear articulation of overall approach, target selection, message, presentation and prioritization strategies. There is little attempt to coordinate media with audience segments and messages. The "comprehensive" approach that is usually taken leaves little room for concentration of effort or focus.

- An urgent need for a system to monitor communication needs and activities that would allow quick interventions should they become necessary.

Availability of IEC materials in Family Welfare Clinics (FWCs) is uneven. They are available in "model clinics" but others have not received IEC materials in four years. IEC materials are lacking in RHS and other units providing family planning services. Also, some AV vans are in need of repair.

- Little evidence of any serious IEC evaluation work (with the exception of the NIPS's recent evaluation study), especially at the provincial or implementation level.

3. Current IEC Standards

Current IEC standards can be gleaned from a series of print ads placed recently by the Punjab Population Welfare Office which show the following deficiencies.

¹Despite lack of formal training in IEC and communications research, the Punjab Provincial Communications and Training Officer showed remarkable initiative when he implemented a small scale study (no funds used) which determined audience preferences among the 25 family planning films (mostly more than 15 years old) which AV vans of the province are showing.

741

- a) **There is major spelling error in the ad's headline, an error that has not been corrected despite repeated placements.**
- b) **The ad places addresses of selected Punjab welfare clinics in national papers whose circulation go beyond Punjab, a practice which is not cost-effective.**
- c) **The ad highlighted Contraceptive Surgical Clinics, which unwittingly may have triggered unwarranted fear or anxiety among readers.**
- d) **One of the logos used is not the standard PWD logo. In commercial advertising, a manual is usually issued regarding logo standards, i.e., basic proportions, typeface, color schemes, methods of display, etc. No deviations are permitted to encourage maximum audience recall.**

Other basic errors which reflect level of IEC standards include the practice of placing posters behind doors of FWCs which then become hidden when doors are kept open (which is usually 90 percent of the time), and displaying IEC materials far above the level of the human eye, sometimes about seven feet high.