



Situation Analysis of Health Facilities with Special Reference to Family Planning Services in Pakistan

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Acronyms

BHU	Basic Health Unit
BP	Blood Pressure
CCA	Client Centered Approach
CCFPS	Client Centered Family Planning Services
CPR	Contraceptive Prevalence Rate
DG	Director General
DHIS	District Health Information System
DHQ	District Headquarter
CLR	Contraceptive Logistics Report
DOH	Department of Health
DSM	District Support Manager
DTC	District Technical Committee
EDO	Executive District Officer
FALAH	Family Advancement for Life and Health
FP	Family Planning
FWC	Family Welfare Centre
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUD	Intra Uterine Device
IUCD	Intra Uterine Contraceptive Device
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Mother and Child Health
MDGs	Millennium Development Goals
PC	Population Council
PHC	Primary Health Care
PPHI	People's Primary Healthcare Initiative
RH	Reproductive Health
RHC	Rural Health Centre
SAHR	Salutation, Assessment, Help and Reassurance
STD	Sexually Transmitted Disease
THQ	<i>Tehsil</i> Headquarter
USAID	United States Agency for International Development

Acknowledgments

FALAH, a USAID funded five year project, was launched in 2007 which was implemented by a consortium including Population Council as a lead partner along with other organizations: Greenstar, HANDS, Jhpiego, Mercy Corps, RSPN and Save the Children, US. FALAH aimed to improve the health of women and children leading to overall health and prosperity of family through repositioning of family planning with the promotion of the idea of birth spacing. One of the objectives of the project was to enhance demand for and quality of birth spacing services in public sector specifically at health facilities being the large network for delivery of services. With this objective FALAH also aimed to ensure contraceptives availability with concerted efforts in collaboration with Government functionaries. For strengthening of contraceptives flow, training on contraceptives logistics management was imparted to health staff and thereafter sensitization of the health authorities and others concerned was realized highlighting non-availability of contraceptives as one of the reasons for lower contraceptive use.

To measure the impact of above mentioned activities, this study was conducted in project districts. Population Council's professional staff was engaged for this study. Training of the staff for the field work was accomplished by the team of public health specialists. We would like to thank Dr. Zakir Hussain and Dr. Muhammad Saleem for their contribution in training the field teams on the SAHR components. We would like to particularly acknowledge the hard work of Ms. Shagufta Naheed, Ms. Tahira Perveen, Ms. Lubna Mahmood, Ms. Ashfa Hashmi, Ms. Bushra Bano, Ms. Farzana Arif and Ms. Zubaida Khanum for quality data collection. They worked not only themselves diligently but supervised the field team in the field. We should also pay thanks to Mr. Ali Ammad who gave layout to this report.

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Executive Summary

Despite Pakistan’s long history of family planning (FP) efforts, dating to the 1950s, desired success has yet to be achieved, due to information, education and communication (IEC) strategy weaknesses, leading to misconceptions by the public that FP means limiting children; as well as focus on women with no, or less, attention on men; and FP programs’ isolation from the ‘mainstream’ health system. The FALAH project, launched in 2007, funded by USAID, and implemented by a consortium of partners led by The Population Council, sought to shift FP perception to birth spacing from child limiting, as well as actively attempting to engage men, and building provider capacity.

This report details the findings of an assessment of FALAH’s FP and birth spacing impact. The study assessed public health facility readiness for offering FP and birth spacing services by interviewing in-charges and providers, as well as assessing the types of services provided and service providers’ characteristics. The study also examined the facilities’ quality of care through observing client and provider interactions, while client satisfaction was assessed in exit interviews. The main findings are summarized below:

a) Health Facility Readiness

Virtually all health facilities had electricity, but few (39%) had provisions for ensuring continued power during periodic outages. Female medical staff delivering FP/birth spacing services, among others, were posted at 87 percent of facilities, and on the day of the visit, 79 percent of these were available; overall staff presence on the day of visit was at 84 percent. Sixty-nine percent of facilities’ male staff were trained according to Client Centered Family Planning Services (CCFPS)-Basic, while 70 percent of facilities’ female staff were trained in CCFPS-Advance, and 51 percent of facilities’ female staff were trained in IUCD skills.

The vast majority (91%) of facilities are delivering birth spacing services, but 30 percent did not have a separate client examination room. Similarly, 94 percent of facilities offered birth spacing counseling, but just under half (47%) had no separate room. An IUCD kit was available in 62 percent of facilities, and 60 percent of facilities provided male clients with birth spacing counseling. While 90 percent of facilities with trained staff displayed IEC materials, only 57 percent of facilities with untrained staff did.

Trained providers more clearly understood the concepts of birth spacing and FP compared to untrained providers. For example, 78 percent of trained, compared with 50 percent of untrained, providers thought FP means “plan your family according to your resources”; conversely, 26

percent of untrained providers and eight percent of trained providers defined FP as limiting children.

During counseling sessions , the majority of trained providers (77%) addressed FP, while 64 percent of trained providers addressed birth spacing. Two-thirds of facilities reported contraceptive availability at the time of visit, with little difference according to whether a trained provider was present. More facilities (76%) with trained providers were proactively requisitioning contraceptive supplies compared to facilities (64%) in which no provider was trained.

The average number of FP clients seen monthly in each facility was 29; two-thirds of these were new, and one-third was for follow-up or return visits. While 84 percent of providers had worked with a client within the past 10 days, 16 percent worked with their last client more than 10 days previously.

b) Quality of Care

The largest proportion of clients (44%) sought treatment from Basic Health Units (BHUs), while 34 percent went to Rural Health Centers (RHCs). Observations of provider-client interactions revealed that trained providers performed much better than untrained providers. Just over half of interviewed clients/patients traveled to health facilities on foot, incurring no transportation cost. Moreover, 92 percent of clients reported that services were affordable.

Among FP clients, the majority either started or re-supplied a method, followed by attending facilities for side effect issues. Women attended by trained (46%) providers were more likely to report questions asked of them, as well as examination, than women attended by an untrained (39%) provider; examinees of trained providers were more likely to be informed of the reasons for their exam (73% versus 60%), to report that their needed methods or medicines were available in the same place (81% versus 73%), and provided with follow-up instructions (89% versus 77%). Overall levels of satisfaction were high, at 93 percent; 98 percent said they would recommend that others attend the same facility.

In conclusion, the study's overall findings confirm FALAH had a positive impact on FP and birth spacing services in its target districts. FALAH can be considered a successful model, and one that should be replicated elsewhere.

Chapter 1: Introduction

1.1 Background

Family planning (FP) services in Pakistan started in the 1950s in the private sector, and thereafter in the public sector. The country's FP program has not been able, however, to achieve its desired success. Pakistan's population has more than quadrupled since 1950, reaching 177 million in 2011 (Finance Division 2011). Recent fertility estimates are available from two main sources: PDHS 2006-07, which estimates a TFR of 4.1 (NIPS and Macro International Inc. 2008), and the Pakistan Demographic Survey (PDS), which estimates TFR at 3.7 in 2007 (Federal Bureau of Statistics 2007). Overall, Pakistan's reproductive health (RH) indicators are poor. According to the Pakistan Demographic and Health Survey 2006-07, the maternal mortality rate in Pakistan was 276 per 100,000 live births. Infant mortality declined from 96 deaths per 1,000 live births in 1990 to 78 deaths per 1,000 live births in 2005, while neonatal mortality remained at 54 per 1,000 live births from 1990 to 2006 (NIPS and Macro International Inc. 2008). These indicators are worse for women in poor households (Sathar et al. 2004).

Only 30 percent of currently married women use any contraceptive. Among contraceptive users, the most common method is female sterilization (8.2%) followed by condom use (6.8%). Traditional methods of withdrawal and rhythm were also quite popular: 7.9 percent of women reported using them (NIPS and Macro International Inc. 2008). Less than half (48%) of modern method users rely on the public health sector for services, while 30 percent use the private sector, and 12 percent use the commercial sector. In the public sector, the most important FP service sources are government hospitals and RH service centers (RHSC; 32% of users), with only 1.6 percent through RHCs and MCH centers (NIPS and Macro International Inc. 2008).

The public health sector includes District Headquarter Hospitals (DHQs), Tehsil Headquarter Hospitals (THQs), Rural Health Centers (RHCs), and Basic Health Units (BHUs). Currently, in rural areas, at BHUs and RHCs medical officers/medical technicians, dispensers and lady health visitors (LHVs) provide a range of Primary Health Care (PHC) services. Although FP services are a part of the general preventive health care package, they are limited in the public health sector. FP services in the general preventive health package include information on birth spacing benefits, provision of condoms, pills, injectables, and IUCD insertion. It is imperative FP becomes a priority for PHC and RH programs to reduce Pakistan's maternal and child mortality. The health sector should deliver FP information and services as part of its PHC package, not just as an implicit additional service. To make a real difference and make FP an intrinsic part of the health system, prioritizing it at all service delivery levels is necessary. To make it happen, FALAH trained health care providers in public sector facilities in project districts on client-centered FP services.

Quality of care is now a central concern in the international FP and RH care community (RamaRao and Mohanam 2003), and Situation Analysis is a popular measurement approach that helps policymakers and managers set plans. Situation Analysis is comprehensive and standardized, systematically assessing both FP and RH program service delivery readiness, as well as client quality of care (Miller et al. 1998).

A health facility assessment evaluated the health system's strengths and weaknesses. Health facility assessments generate information on indicators of service readiness and quality. Health facility assessment data are useful as independent analyses of system strengths and weaknesses, and aid health managers in their decision-making processes. Health facility readiness is measured either by a one-item indicator (a counseling room or consultation table, for example) or with a multi-item measure (Fapohunda 2012). This assessment has utilized a multi-item measure, for most accurately assessing functioning facilities and help making them as fully operational as possible.

1.2 Introduction to FALAH

Family Advancement for Life and Health (FALAH) was a USAID-funded project, implemented 2007 to 2012 by a consortium of partners led by Population Council. The project promoted birth spacing and increased contraceptive use, as well as addressing barriers contributing to Pakistan's slow pace of fertility decline, including:

1. FP misconceptions among the general public;
2. FP activity focusing on women with less, or no, focus on men;
3. FP program isolation from the Health Department.

FALAH repositioned FP in Pakistan by promoting the concept of birth spacing, with special emphasis on mother and child health leading to families' overall health and prosperity. This strategy increased FP service demand (Mahmood 2012). In addition, the project also focused on men by organizing special activities, such as group meetings with men and involving religious *Ulama* in promoting birth spacing for health benefits (Population Council 2009).

FALAH made efforts to improve FP and birth spacing service quality by training health personnel, specifically utilizing Client-Centered Family Planning Services (CCFPS)-Basic, CCFPS-Advance, and IUCD insertion skills. CCFPS-Basic was provided to male Health Department providers, notably doctors, health technicians, and dispensers. CCFPS-Advance targeted female providers, with in-depth knowledge of contraceptive technology and side effect management. IUCD training, in proper insertion and removal skills, was provided to those trained on CCFPS-Advance. Both the Basic and Advance trainings also include a counseling component.

“The logistic system is a vital part of any program, including family planning, which provides services. A logistic system provides excellent client service by fulfilling the six rights: ensuring that the right goods, in the right quantities, in the right condition, are delivered to the right place, at the right time, for the right cost” (Ministry of Population Welfare 2007). FALAH addressed contraceptive supply through its contraceptive logistics management training for district and facility personnel. As a follow-up, for strengthening facility contraceptive supply, during the project a series of visits in FALAH districts quantified contraceptive availability and identified its related problems. Efforts were made to resolve supply issues on the spot or, if necessary, higher management of the Health and Population Welfare departments as well as the People’s Primary Health Care Initiative (PPHI) was involved. Visits were made to EDOs (Health), District Support Managers (PPHI), LHW Program Coordinators, District Population Welfare Officers and other related officers and staff, especially at facilities.

During field visits contraceptives were found, overall, generally available from District Population Welfare Offices and LHWs, however Department of Health (DoH)/PPHI clinics were not as well supplied, and contraceptive availability was a big issue at DoH clinics. Therefore, the study focused on improving supply at the DoH/PPHI and its facilities, identifying issues and problems and attempting to solve them immediately, at all levels.

The project originally focused on 20 districts, with some swapped due to security concerns, and a 2009 expansion led to coverage planned in 26 districts. Ultimately, after curtailment by USAID, full implementation occurred in 15 of the 26 districts. This report evaluates health facilities in 14 districts in which both baseline and endline household surveys were also conducted:

Khyber Pakhtunkhwa: Charsadda, Mardan, Swabi, and Mansehra;

Punjab: Bahawalpur, Dera Ghazi Khan, Jhelum, and Rajanpur;

Sindh: Dadu, Ghotki, Larkana, Sanghar, Sukkur, and Thatta.

1.3 Study Aims and Objectives

FALAH has made extensive efforts to generate demand for birth spacing services, improve quality of service provision, and strengthen contraceptive supply systems for facilities. The overall aim of this study is to assess both health facility readiness for providing clients birth spacing services, as well as quality of services. Specifically, the study assesses:

1. Facility promotion of FP/birth spacing;
2. Availability of quality birth spacing services;
3. Availability of a range of contraceptive methods;
4. Service provider FP knowledge;

5. Attitudes and behavior of trained (on SAHR) and untrained service providers towards FP clients;
6. FP client satisfaction.

1.4 Methodology

Situation Analysis methodology was developed by Population Council for assessing FP program functions at the 'grass root' level. In this methodology, data are collected on availability, function, and services, as well as quality. Information is collected on key indicators of FP services, quality of care, and performance of service outlets. The standard instruments for all situation analyses include an inventory for facilities and services, an observation guide for client-provider interactions, an exit questionnaire for FP clients at service outlets, and a guide for provider interviews (Mensch et al. 1994).

Situation Analysis assesses facility readiness for FP services as well as quality of service. Readiness encompasses infrastructure, contraceptive supply and logistics, building repair, management information systems, and staff availability. Quality addresses interactions between client and provider (RamaRao and Mohanam 2003). This Situation Analysis is comprised of these elements.

The study was conducted in a sample of 11 health facilities (5 BHUs, 4 RHCs, 1 THQ hospital and 1 DHQ hospital) in 14 FALAH districts in three provinces, with facilities in each district chosen randomly. Four research tools collected information on multiple items, assessing facility infrastructure and readiness, provider-client interaction, and data on quality of care indicators (Miller et al. 1997):

1. Questionnaire for health facility in-charges;
2. Service provider questionnaire (Female Medical Officer, Female Medical Technician, LHV);
3. Guide for observing provider-client interactions; and
4. Facility-based client exit interviews.

Staff training was conducted December 1-3, 2011, with 10 participants at Population Council's Islamabad office. After the training, field staff was divided into five teams, each with a Population Council staff member and one experienced, CCA-trained LHV hired for the task. One team member interviewed facility in-charges and service providers, while the other observed client-provider interaction and interviewed those clients at their exit. Client and provider interactions were observed without making providers aware their observation. A maximum of three clients for each provider were observed and interviewed, depending client availability, but provider interviews were not limited. Data collection took place from December 2011 to January 2012.

Table 1.1 shows the number and type of facilities covered, and Table 1.2 reflects the number of observations and in-charges, providers interviewed as well as exit interviews for this study.

Table 1.1: Number of facilities covered in the survey by the type of interview/observations

Module	DHQ Hospital	THQ Hospital	RHC	BHU	Total
In-charge interviewed	10	12	44	75	141
Providers interviewed	9	12	42	73	136
Observations	8	11	40	66	125
Exit Interview of clients/patients	8	11	42	65	126

Table 1.2: Number of interviews/observations

Module	Total
Interviews of In-charge of health facility	141
Provider interviews	175
Observations	432
Facility-based exit interviews	432

Chapter 2: Health Facility Readiness

Chapters 2 and 3 discuss health facility readiness for FP and birth spacing services; readiness refers to infrastructure, contraceptive supply and logistics, building conditions, management information systems, and trained staff availability (RamaRao and Mohanam 2003), all of which help determine health facility utilization by clients and patients. This chapter details findings from interviews with in-charges, discussing infrastructure, assigned staff present during visits, services and related available necessities, trained staff, IEC activities, storage, and facility performance with FP/birth spacing clientele.

2.1 Infrastructure

Infrastructure, along with amenities, affects facility readiness and performance. Key indicators have been picked for seeing infrastructure/buildings of the facilities. Uninterrupted electric supply is imperative to make the facility fully functional especially in emergency case. Sometimes patients/clients have to wait for a long for consultations/examinations. So waiting area protected from sun and rain and toilets for female patients are necessity. Cleanliness is much more important as well to avoid infections. The existence of all such amenities and cleanliness was observed /judged by the visited survey team. As seen in Table 2.1, almost all the facilities visited were electrified. It is encouraging if compared with Kenya where only 47 percent of the health facilities surveyed had electricity (Fapohunda 2012). However, given the current situation with frequent power load shedding – particularly in rural areas – it is noteworthy that 61 percent of facilities had no substitute arrangement of a generator or UPS. This may have implications for the care of patients. Other indicators, however, were satisfactory: 83 percent had separate toilets for females; 95 percent had a waiting area, and so on.

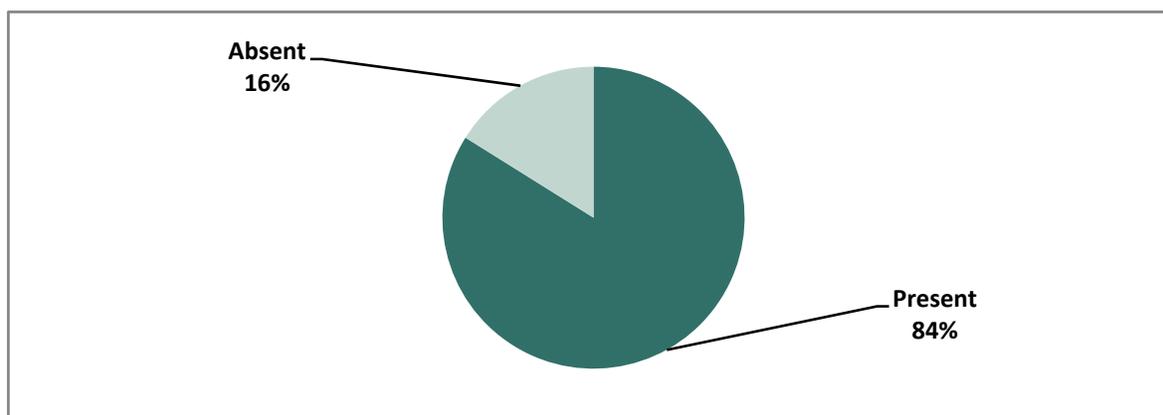
Table 2.1: Percentage of health facilities possessing basic infrastructure

Facilities having:	Facilities	Percent
Electrification	141	98.6
Generator or UPS	140	38.6
A separate toilet for female clients/patients	140	82.9
Waiting area arrangements for clients/patients	141	95.0
Sitting area protected from sun and rain	139	96.4
Cleanliness	140	85.0

2.2 Staff

Staff absence at a facility can undermine public confidence and, thus, utilization of its services. This is particularly important with FP, because failure to receive service can result in unwanted pregnancy. This survey found that 84 percent of assigned staff was on duty during its visits, an encouraging percentage, if compared with a previous study in 170 health facilities in 19 randomly selected districts in Punjab and Khyber Pakhtunkhwa (then NWFP): In Punjab, only 42.5 percent, and in NWFP 72 percent, of required staff was present (Ali et al. 2008).

Figure 2.1: Percentage of staff present on day of visit



2.3 Services

Consistent with a holistic, integrated FP approach, services should be offered in ‘mainstream’ health facilities. Indeed, FP/birth spacing services are mandatory in Pakistan’s public sector health facilities. This survey examined the extent to which this commitment is fulfilled.

a) Birth Spacing Services

Table 2.2 shows that 91 percent of facilities in 14 FALAH districts in this survey provided birth spacing services; an earlier assessment of public health facilities in Kohat district indicated 86 percent of assessed facilities were offering FP services (WHO 2010). In this survey, only 70 percent of facilities had a separate examination room, IUCD kits were available in 62 percent of facilities, and female medical staff delivering FP/birth spacing services, among others, was posted at 87 percent of visited facilities in these 14 districts. Female staff presence on the day of visit was 79 percent. In the absence of female staff at a facility, female clients are reluctant to seek FP services from male personnel, especially in rural communities, as observed in an earlier study (Bruce 1990). It was also observed that 60 percent of facilities visited had male FP clients, reflecting male FP involvement. Male involvement could partially be attributed to FALAH, which has made efforts

to motivate male participation by holding husband group meetings providing information on birth spacing benefits for mother and child health. Moreover, it is encouraging that 94 percent of facilities offer counseling, but only 53 percent had a separate room for this purpose.

Table 2.2: Number and percent of health facilities by the type of services available for birth spacing

Services	Facilities	Percent
1. Birth spacing services	141	90.8
i. Separate room for examination of clients	140	70.0
ii. Necessary equipments/apparatus for examination*	140	98.6
a. Examination table		97.8
b. IUCD kit		61.6
c. Equipment for sterilization of instruments		74.6
d. Blood pressure cuffs		98.6
e. Syringes		99.3
f. Antiseptic lotion		85.5
g. Any other		15.2
iii. Female medic and paramedic posted	139	87.0
iv. Female staff present on the day of visit	138	79.0
v. Facilities receiving male clients for birth spacing	141	59.6
2. Staff dealing with male clients for birth spacing services:*	82	
a. Male Medical Doctor		67.1
b. Male Health Technician		37.8
c. Dispenser		18.3
d. Any other		7.3
3. Counseling services for birth spacing	141	94.3
i. Separate room for counseling services	132	53.0

*Multiple response variable

b) Staff Training

One of FALAH's objectives was strengthening public health facility capacity by training providers on CCFPS-Basic and Advance, as well as on IUCD skills. These trainings utilized the SAHR approach (Sathar et al. 2005), along with other technical aspects. The details of SAHR components are given at Annex-I. This survey's findings show that 87 percent of visited facilities had at least one staff member with at least one FALAH training. At 69 percent of facilities, male staff was trained on CCFPS-Basic (Table 2.3). At 35 percent of facilities, a male doctor was trained in CCFPS-Basic,

followed by 25 percent of facilities with a trained dispenser, 23 percent with a male health technician, and 10 percent with other male staff trained in CCFPS-Basic.

Table 2.3: Percentage of facilities with at least one staff member trained, by type of training and staff

Indicator	Facilities	Percent
1. Training received on CCFPS-Basic	139	69.1
i. Male Medical Doctor		35.3
ii. Male Health Technician		23.0
iii. Dispenser		24.5
iv. Any other		10.1
2. Training received on CCFPS-Advance	139	69.8
i. Female Medical Doctor		18.7
ii. Female Health Technician		7.2
iii. LHV		49.6
iv. Any other		13.7
3. Training received on IUCD	141	51.1
i. Female Medical Doctor		15.6
ii. Female Health Technician		7.8
iii. LHV		35.5
iv. Any other		7.1
4. Number of facilities with at least one trained personnel	141	86.5

Multiple response variable

For CCFPS-Advance, survey findings show, at 70 percent of facilities, female staff was trained on CCFPS-Advance. At 50 percent of facilities, LHVs were trained on Advance, while at less than one-fifth (18.7%) of facilities female doctors were trained on Advance. At half of visited facilities (51%), at least one female staff member was trained on IUCD insertion/removal. At 36 percent of facilities, LHVs were trained on IUCD skills (insertion and removal).

Trained staff is likely to better deliver health services (RamaRao and Mohanam 2003). FALAH has endeavored to help the public health sector overcome its quality of service and training deficit by training a number of health personnel for providing quality services (Table 2.3). Chapter 4 elaborates the impact of trained staff.

c) IEC Material Display

As mentioned in Chapter 1, FALAH repositioned FP by promoting the concept of birth spacing for mother and child health benefits, and thereby developed a Behavior Change Communication (BCC) strategy. The BCC strategy focused on birth spacing and related concepts, supported by providing contraceptive posters (Tiaht poster) to providers, which they are supposed to display at their facilities, as well as providing clinic-based counseling materials what are supposed to be utilized during client counseling sessions at facilities. These materials, especially those displaying information pictorially, can be very useful in rural settings with high levels of illiteracy.

Table 2.4 illustrates BCC material availability at facilities with trained and untrained providers. If a provider has ever been trained through FALAH, these BCC materials should be displayed and utilized; they are provided at training. As expected, 90 percent of facilities with trained staff, compared to 57 percent of facilities without trained staff, had BCC materials prominently displayed. This encouraging, compared with earlier study in which only 41 percent of FP clinics had pamphlets with information on contraceptive methods in Pakistan (Cernada et al. 1993).

Materials displayed at facilities mostly explained contraceptive methods (72% of facilities with trained providers compared with 59% with untrained providers). Thirty-seven percent of facilities with trained staff and only 15 percent of facilities with untrained staff displayed materials on FP/birth spacing benefits, and 26 percent of facilities with trained staff, and only seven percent with untrained staff, displayed materials on benefits of pregnancy after age 18 and under 35. Although HTSP material was available for trained providers, only one quarter displayed it.

Table 2.4: Percentage of facilities with availability of IEC material by training status*

Indicator	Trained	Untrained
1. Facilities with IEC material displayed	90.2	57.1
2. Topics on IEC material displayed*		
i. Methods	71.6	59.3
ii. Benefits of birth spacing/FP	36.5	14.8
iii. Benefits of pregnancy after 18 and before 35 years	25.7	7.4
iv. Abuses of pregnancy before 18 and after 35 years	2.7	0.0
v. Tiaht poster	37.8	18.5
vi. Other	28.4	44.4

*Multiple response variable

Table 2.5: Number and percent of facilities, by type and protocol of storage of contraceptives

Indicator	Facilities	Percent
1. Contraceptives placed*:	119	
i. In cupboard of staff's room		54.6
ii. In drawer		12.6
iii. In a separate store		14.3
iv. In a separate store along with medicines		20.2
v. Any other place		7.6
2. Protocol for storage in a store being adopted*:	34	
i. Clean		47.1
ii. Cross- ventilated		41.2
iii. No direct sunlight on stored commodities		67.6
iv. Supplies properly placed		38.2
v. Bin Cards affixed		38.2

*Multiple response variable

d) Contraceptive Storage

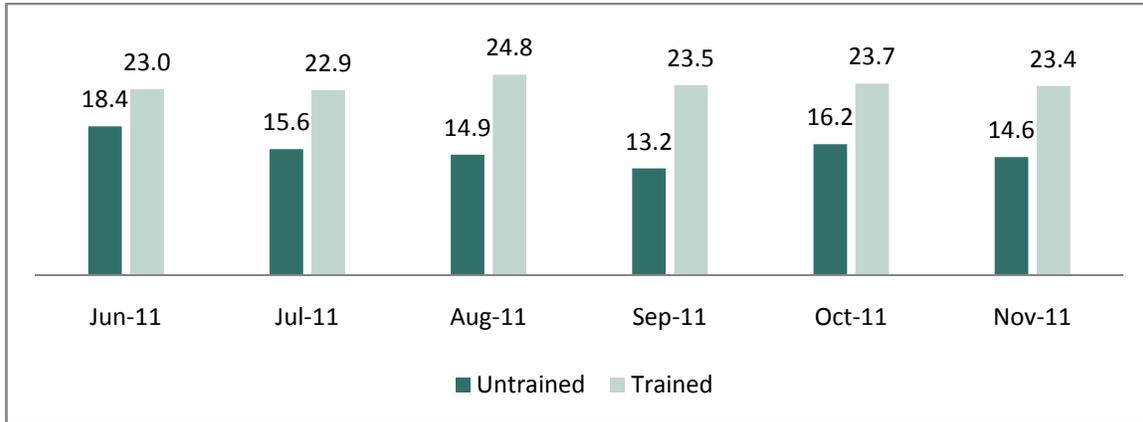
Contraceptive storage plays an important role in ensuring its provision, in good condition. If contraceptives are not stored according to protocol, they can expire, be damaged or spoiled, and their efficacy can be undermined. During the visit, facility in-charges were asked where contraceptives were stored (Table 2.5). In most cases (55%) contraceptives were stored in a staff's room cupboard, followed storage with medicines (20%), and only 14 percent were placed in a separate store. Facilities tended to have either no supplies or very few supplies: hence the tendency to keep contraceptives in the cupboard in their room. Bin cards with expiration dates were found in only 38 percent of facilities; the absence of these can increase the risk of contraceptive expiration. The overall storage picture is not very encouraging.

e) Facility FP Service Performance

Information was collected on the number of FP/birth spacing clients and patients who had attended a facility in the last six months for assessing facilities' monthly performance for client attendance differentials. Information was collected from facility client attendance registers. As expected, the performance of facilities in which CCA-trained providers were available had significantly more FP clients than facilities in which CCA-trained providers were not available.

Figure 2.2 clearly shows performance trend for the last six months in facilities with trained and untrained staff: In November 2011 facilities with trained providers were attracting almost 60 percent more clients than untrained provider facilities.

Figure 2.2: Average number of FP clients per facility, for last six months, by training status of facilities



Chapter 3: Health Facility Functioning

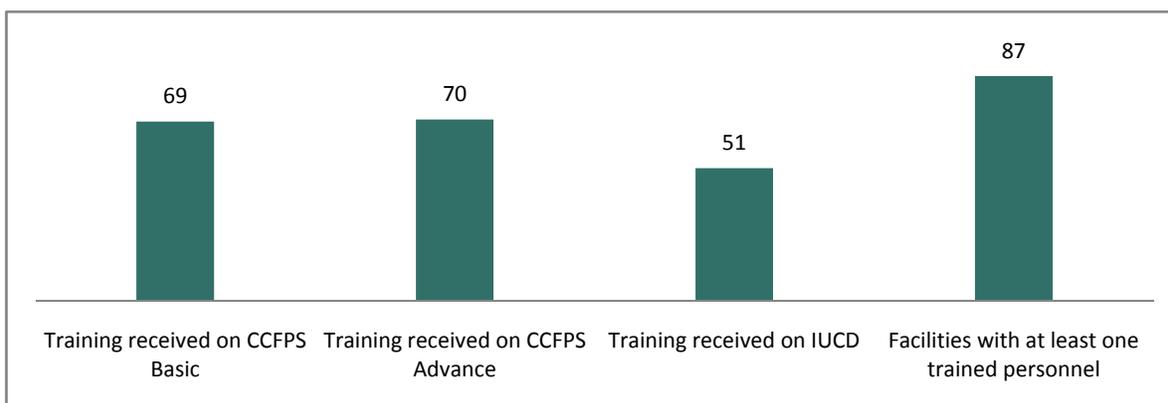
This chapter discusses the survey’s findings from health provider interviews and helps determine facility readiness by assessing provider knowledge, counseling services, contraceptives supply, and client record-keeping and reporting, including side effects.

3.1 Facilities with Trained Staff

Figure 3.1 shows the percentage of facilities whose staff have any training including FALAH CCA training. Eighty-seven percent of facilities had at least one staff member trained by FALAH, while 69 percent of facilities’ male staff was trained on CCFPS-Basic, 70 percent of facilities’ female staff was trained in CCFPS-Advance, and 51 percent of facilities’ female staff was trained in IUCDs.

Contraceptive logistics training was provided to staff dealing with medicine and contraceptive storage, as well as to a few providers; more than five percent of providers took contraceptive logistics training.

Figure 3.1: Percentage of facilities whose staff received training, by type of training received *



*Multiple response variable

3.2 Service Provider Characteristics

a) FP Knowledge

If providers have proper knowledge and understanding of FP/birth spacing concepts, they will better explain and counsel clients, and better provide FP/birth spacing services as well, based on clients’ requirements. Female provider knowledge is particularly relevant, since most clients are women and only feel comfortable talking to female providers (Bruce 1990). In the survey, almost all providers interviewed were females. Moreover, in the analysis, knowledge differentials are presented by trained and untrained providers, for training impact. More than half (53%) of those interviewed were trained, and rest, 47 percent, had no training by FALAH (Table 3.1).

Table 3.1: Percentage of providers by knowledge of FP/birth spacing, according to training status

Characteristic	N	Percent	
		Trained	Untrained
Providers	175	53.1	46.9
Knowledge			
1. Birth Spacing/FP is part of Health	175	100.0	97.6
2. Family Planning means:	172		
i. Plan your family according to your resources		78.3	50.0
ii. Small Family Norm		5.4	11.3
iii. Limiting the Children		7.6	26.3
iv. Limit up to two children		3.3	5.0
v. Any other		5.4	7.5
3. Birth spacing means:	171		
i. Interval between children		22.8	48.1
ii. At least two years interval between two children		12.0	17.7
iii. At least three years interval between two children		22.8	21.5
iv. At least 24 months space between the one child and next		38.0	5.1
v. Any other		4.4	7.6

FP miscomprehension has been considerable, with the general public interpreting IEC slogans such as *Bachay do hee* Acchay and *Kam Bachay Khushhal Gharana* as meaning they should limit their number of children. All those interviewed, however, expressed the belief that FP is part of health care. Twenty-six percent of untrained, and eight percent of trained, providers regard FP as limiting children. Among trained providers, 78 percent, and among untrained, 50 percent, of providers reported belief that FP means “Plan your family according to your resources.”

FALAH promoted healthy timing and spacing of pregnancy (HTSP) and trained providers in HTSP, in which messages included pregnancy intention two years after preceding child birth, while earlier training had revolved around Optimal Birth Spacing Initiative (OBSI), which recommended three to five years birth intervals. Findings show HTSP birth spacing, “At least 24 months’ space between the child birth and next pregnancy,” was understood by 38 percent of trained, and five percent of untrained, providers, while a further 23 percent of trained, and 22 percent of untrained, providers understood the OBSI concept, “At least three years interval between two children.” It appears providers are still influenced by OBSI’s concept of FP, so the HTSP concept must be further emphasized, so providers can relate it to the two years of breastfeeding mentioned in the Holy Quran.

b) Counseling and Comprehensible Information

Counseling should provide clients with information on FP/birth spacing and related topics, specifically mother and child health benefits. A range of options, including contraceptive methods, needs explanation, in accordance with client health compatibility. FP/birth spacing misconceptions and myths can be altered with sound argumentation. After a client has accepted FP/birth spacing, comprehensible information, meaning easily understandable, should be provided, and clients should then have detailed information on method use, side effects and management, effectiveness, and other necessary information. FALAH trained providers on all of these elements. Not even all trained providers provide such information to clients during counseling (Table 3.2). Although trained providers' emphasis now is on method use, effectiveness, and possible side effects, the most important aspect, handling side effects, is neglected, contributing to method discontinuation, which is higher among women not adequately counseled about side effects. In Gambia, 51 percent of clients not properly counseled discontinued use, compared with 14 percent who were well-counseled (RamaRao and Raji 2003). Counseling, so important for method continuation, is still weak in Pakistan. To increase FP clientele and improve its continuation, more training on counseling is needed, with sound knowledge and techniques.

Table 3.2: Counseling topic and comprehensible information, by training of provider

Services	N	Percent	
		Trained	Untrained
1. Counseling	175	98.9	93.9
2. Counseling topics*:	169		
1. Birth spacing		64.1	53.2
2. Pregnancy before 18 and after 35 may be dangerous		8.7	3.9
3. FP		77.2	74.0
4. Inter-spousal communication		14.1	1.3
5. Age at marriage		3.3	0.0
6. Other		56.5	49.4
3. Comprehensive information on*:	169		
1. Availability of other methods		40.2	39.0
2. How to use method		89.1	74.0
3. Contraindications		21.7	24.7
4. Effectiveness/duration of effectiveness		67.4	53.2
5. Advantages compared to other methods		30.4	23.4
6. Possible side effects		67.4	61.0
7. What to do if experienced side effects		5.4	10.4
8. Possibility of switching the method		6.5	10.4
9. Any other		8.7	14.3

*Multiple response variable

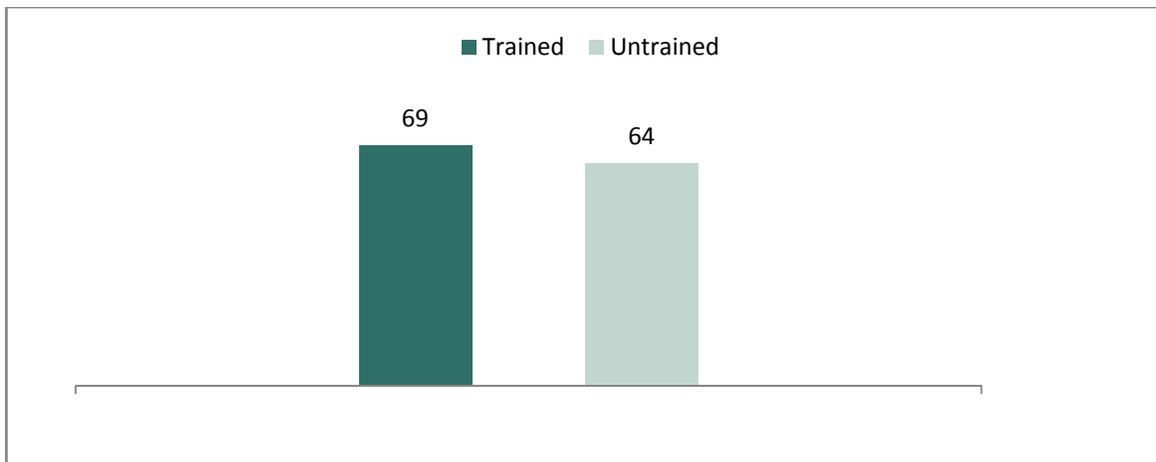
3.3 Contraceptive Stock

The ultimate goal of the contraceptives logistics system is ensuring contraceptive availability at service delivery outlets so clients can procure their chosen methods during their planned visits to facilities. At facilities, those responsible for managing contraceptives should be trained in timely record-keeping of contraceptives logistics data, as well as submitting reports along with routine monitoring reports, and they need to ensure standard formats for record keeping and reporting are always available in their facilities. Logistics record formats are of no value unless they are complete, with accurate information, for making logistics decisions. In this situation analysis, contraceptive stocks and logs were observed in visited facilities.

Contraceptive Availability, Recording, and Reporting

Contraceptive availability in facilities is essential for FP service provision, especially in rural areas. Facility contraceptive availability was made possible by FALAH's efforts addressing contraceptive supply, by training district and facility health personnel on contraceptive logistics management. Sixty-nine percent of facilities in which at least one trained provider was available reported contraceptive availability during the facility visit, along with 64 percent at facilities where no FALAH-trained provider was available (Figure 3.2). To strengthen contraceptive supply, a series of field visits quantified contraceptive availability and identified potential problems if contraceptives were unavailable. Efforts were made to resolve supply issues on the spot or, if necessary, by involving higher management of the Health and Population departments, as well as PPHI ,EDOs (Health), District Support Managers of the PPHI program, LHW Program Coordinators, District Population Welfare Officers, and other related officers and staff, in particular LHVs (as focal persons for contraceptives in facilities). As a result, these survey findings show little difference between facilities with CCA-trained providers and those without them.

Figure 3.2: Percentage of facilities with contraceptive availability on the day of visit, by training status



Almost one-third of visited health facilities did not have any contraceptives on the day of their visit (Table 3.3). District headquarter (DHQ) hospitals primarily comprised stocked out facilities. DHQ providers thought FP services were already available at RHS-A centers and, therefore, believed they did not need to stock contraceptive commodities. RHS-A centers, run by the Population Welfare Department, are on DHQ hospital premises and provide a full range of contraceptive methods, but only one quarter of health facilities reported contraceptive stocks of more than a month, while most had only a one month stock for every method. According to the contraceptive logistics manual, at least two months' buffer stock is required for the district store and facilities (Ministry of Population Welfare 2009).

During FALAH, central warehouse contraceptive stock was limited, so district contraceptive distribution was rationed (Ministry of Population Welfare 2010), but which resulted in a stock out.

Table 3.3: Usual contraceptive stock, by type of contraceptive and availability, and provider training status

Method	Percent	
	Trained	Untrained
i. Condom		
a. No Stock	32.0	38.5
b. One month	39.2	35.9
c. Two months	10.3	12.8
d. Three months	14.4	10.3
e. More than three months	4.1	2.6
ii. Oral pills		
a. No Stock	32.0	35.9
b. One month	38.1	41.0
b. Two months	11.3	10.3
c. Three months	14.4	10.3
d. More than three months	4.1	2.6
iii. Injectables		
a. No Stock	33.0	35.9
b. One month	34.0	43.6
c. Two months	10.3	7.7
d. Three months	17.5	10.3
e. More than three months	5.2	2.6
iv. IUD		
a. No Stock	36.1	46.2
b. One month	32.0	33.3
c. Two months	9.3	7.7
d. Three months	18.6	12.8
e. More than three months	4.1	0.0

Number of facilities 136

The study also attempted to identify how providers try to minimize stock outs, and their outcomes. It is a point of satisfaction that 75 percent of trained, and 63 percent of untrained, providers immediately reported stock outs to in-charges; but even after their reporting, around 40 percent did not receive supplies, with almost one third arranging supplies from other sources.

In a well-designed contraceptive logistics system, facilities request contraceptives based on established inventory control (Government of Pakistan, 2007), with established maximums/minimums. When central warehouse stock is insufficient and supplies are rationed, facility stock outs are common. District DoH/PPHI also face stock outs due to central warehouse issues.

Table 3.3A: Type of action on stock outs and reporting result, by provider training status

Indicator	N	Percent	
		Trained	Untrained
Action taken by providers:	67		
1. Immediately reported to the In-charge		75.0	63.0
2. Not reported		0.0	14.8
3. Other		25.0	22.2
Result of reporting	63		
1. Supplies received from EDO(Health)/PPHI		12.5	21.7
2. Not received		42.5	39.1
3. Arranged from other source		32.5	30.4
4. Not resolved		12.5	8.7

The requisitioning system plays a critical role in contraceptive availability. System demand is initiated by health facilities (on a DOH-2 Form), through the EDO office, DoH and the district project office, PPHI. The EDO office and PPHI district manager requisition contraceptives from the central warehouse (CLR-6 Form) quarterly (Ministry of Population Welfare 2007).

Table 3.4: Method of submission of monthly contraceptive demand, by provider training status

Indicator for facilities submitting monthly contraceptive demand	Percent	
	Trained	Untrained
1. DOH2 Form	76.3	64.1
2. Simple Paper	6.2	18.0
3. Verbally	4.1	2.6
4. No	13.4	15.4

To make the system work efficiently, staff guidance on the requisitioning system was provided by FALAH and, as a result, instructions from EDOs (Health)/District Support Managers, PPHI to facility

staff for requisitioning, and from higher levels to EDOs (Health). (Please see Annex-II) Table 3.4 shows that 76 percent facilities had started sending demands from facilities on DOH-2 Form where the providers were trained, compared to 64 percent of facilities where no provider was trained.

Most facilities report receiving fewer supplies than needed for all methods (Table 3.5). Slightly higher proportions of facilities with trained providers received fewer contraceptive supplies than facilities without trained providers, which is due to higher FP clientele in facilities where trained providers were available. Lower proportions of facilities reported supplies of injectables and IUDs commensurate with their demand, compared to condoms and oral pills. IUDs and injectables are only dispensed by health providers, however, whereas condoms and oral pills are available over-the-counter.

Table 3.5: Percentage of facilities, by contraceptive supply, compared to demand, according to training

Indicator		Percent facilities	
		Trained	Untrained
1. Condom	According to demand	64.9	66.7
	Less than the demand	35.1	33.3
2. Oral pills	According to demand	64.9	66.7
	Less than the demand	35.1	33.3
3. Injectables	According to demand	56.7	59.0
	Less than the demand	43.3	41.0
4. IUD	According to demand	54.6	53.8
	Less than the demand	45.4	46.2

Number of Facilities=136

Table 3.6: Contraceptive stocks and maintenance status of FP registers, by provider training status

Indicator	N	Percent	
		Trained	Untrained
Facilities maintaining contraceptive stock register	136	72.2	64.1
Facilities maintaining contraceptive stock register regularly	93		
1. Maintained and updated		87.0	83.3
2. Maintained but not updated		5.8	16.7
3. Not maintained		7.3	0.0
Facilities maintaining FP Client Register	136	78.4	61.5
Facilities maintaining FP Register regularly	98		
1. Maintained and updated		86.5	70.8
2. Maintained but not updated		10.8	29.2
3. Not maintained		2.7	0.0

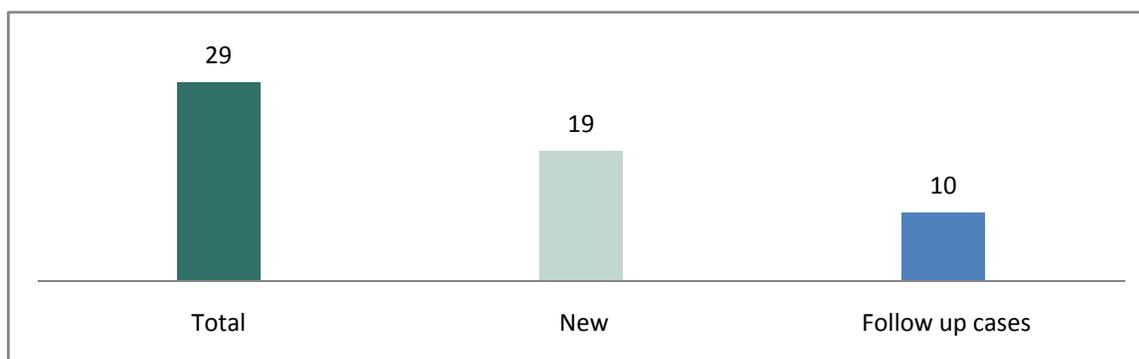
When contraceptives stock registers were examined, 72 percent of facilities with trained providers maintained their stock registers, compared to 64 percent of facilities without trained providers. Maintenance was slightly better at facilities with CCA-trained providers compared to facilities without CCA-trained providers. Similar results are seen in maintenance of FP client registers (78% trained versus 62% untrained) (Table 3.6).

3.4 Client Load and Side Effect Reporting

a) Average Client Load

The average number of FP clients for facilities for the month prior the survey is not encouraging; investigation is needed. It should be noted, however, that new clients outnumbered follow-ups.

Figure 3.3: Average FP client load per facility during last month (N =115)



Trained providers had more clients, using all contraceptive methods except condoms (Table 3.7). Most clients, overall, choose injections, followed by the pill. Forty-six percent of trained, and 41 percent of untrained, providers received their last client on the day of visit. Among the 33 percent of trained, and 41 percent of untrained, providers who received an FP client during the last five days, flow was less, and so too for those who received their last client within the last 10 days. Worryingly, around 16 percent had not received any client during the past 10 or more days. There were small differences between trained and untrained providers in this regard. If no new client accepts family planning methods at a particular facility, this means counseling services at the facility are weak, and if no follow up visits, this could be due to non-availability of contraceptives at the facility among others.

Table 3.7: Client load and duration since last FP client, by provider training status (Multiple Response Variable)

Indicator	N	Percent	
		Trained	Untrained
Clients received last month by method:	120		
1. Pills		84.2	81.8
2. Injections		98.7	86.4
3. IUD		60.5	52.3
4. Condoms		53.9	63.6
Provider received last client :	132		
1. On the same day		46.2	40.7
2. Within last 5 days		33.3	40.7
3. Within last 10 days		5.1	1.9
4. More than last 10 days		15.4	16.7

b) Side Effect Reporting

Minor side effects are common for most contraceptive users in the first few months of use, which concerns clients and is the biggest factor in contraceptive discontinuation. If proper side effect counseling is provided before contraceptive use, discontinuation rates can be reduced. Table 3.8 shows that trained providers received fewer clients with side effects compared to untrained providers for injectables and IUCDs, which shows that trained providers' clients were likely better prepared for side effects through their counseling.

Table 3.8: Average number of clients per provider who reported receiving clients for side effects, by method during last month and training status of providers

Clients who reported side effects by method /per provider during the last month	N (Providers)	Average number of clients per provider	
		Trained	Untrained
1. Pills	17	2.3	2.3
2. Injection	88	2.8	3.1
3. IUD	33	1.6	3.1
4. Condom	5	1	1

Table 3.9 shows that trained providers had fewer clients reporting serious side effects such as heavy bleeding (32% of trained provider clients versus 63% of untrained provider clients), infection (2% for trained versus 16% for untrained), and IUCD expulsion (2% for trained versus 11% for untrained), signifying trained providers' proper client selection, appropriate counseling, observing proper infection prevention practices, and following proper insertion techniques.

Table 3.9: Percentage of providers who received complications for side effects, by type of side effects according to provider training

Indicator	N	Percent	
		Trained	Untrained
Providers received complaints of side effects during last month	166	87.8	85.5
Side effects commonly reported*:	122		
Heavy bleeding		32.3	63.2
Irregular bleedings		69.2	57.9
Weight gain		10.8	15.8
Weakness		12.3	12.3
Spotting		53.8	40.4
Infection		1.5	15.8
Nausea/giddiness		12.3	8.8
Headache		3.1	10.5
Backache		16.9	7.0
Allergy		4.6	3.5
Irritation		1.5	1.8
White discharge		9.2	10.5
IUD expelled		1.5	10.5
Pain in low abdomen		18.5	17.5
Body swelled		1.5	3.5
Others		9.2	12.3

*Multiple response variable

Chapter 4: Quality of Care

Quality of care refers not just to the technical competency, effectiveness, and care a provider offers clients but also the human aspect of care, “the way individuals and clients are treated by the system providing services” (Bruce 1990, Jain 1989). Quality of care for clients/patients at health facilities greatly influences whether they return and encourage or discourage others from doing so. In FP and RH services, quality of care has shown to increase contraceptive use (Creel et al. 2002).

Observations of client–provider interaction and client exit interviews help determine whether trained providers differed from untrained providers in client treatment, the findings of which are detailed in this chapter.

4.1 Methodology

In this study, 126 health facilities were surveyed, with 432 observations of client-provider interaction and an equal number of exit interviews. The objective of the observations was to note any differences in the treatment of clients by untrained and trained providers, while exit interviews aimed to grasp the client’s level of satisfaction with the quality of care received.

Exit interviews were conducted with clients/patients immediately after their consultation with the provider, while their experience was fresh and they could express their views better than if the interviews were conducted at a later time. Exit interviews were conducted with the same patients/clients whose interactions with their providers were observed by the survey team at the selected public sector health facilities.

Providers included female doctors and health technicians, LHVs, midwives and nurses (in case they are service providers), both trained and untrained in CCFPS-Advance and IUCD insertion and removal. During the observations providers were assessed on their technical expertise, with special attention to their compliance with the SAHR framework, a component of FALAH’s CCFPS training developed by Population Council helping providers holistically assess client RH needs and provide a range of suitable options (Sathar et al. 2005).

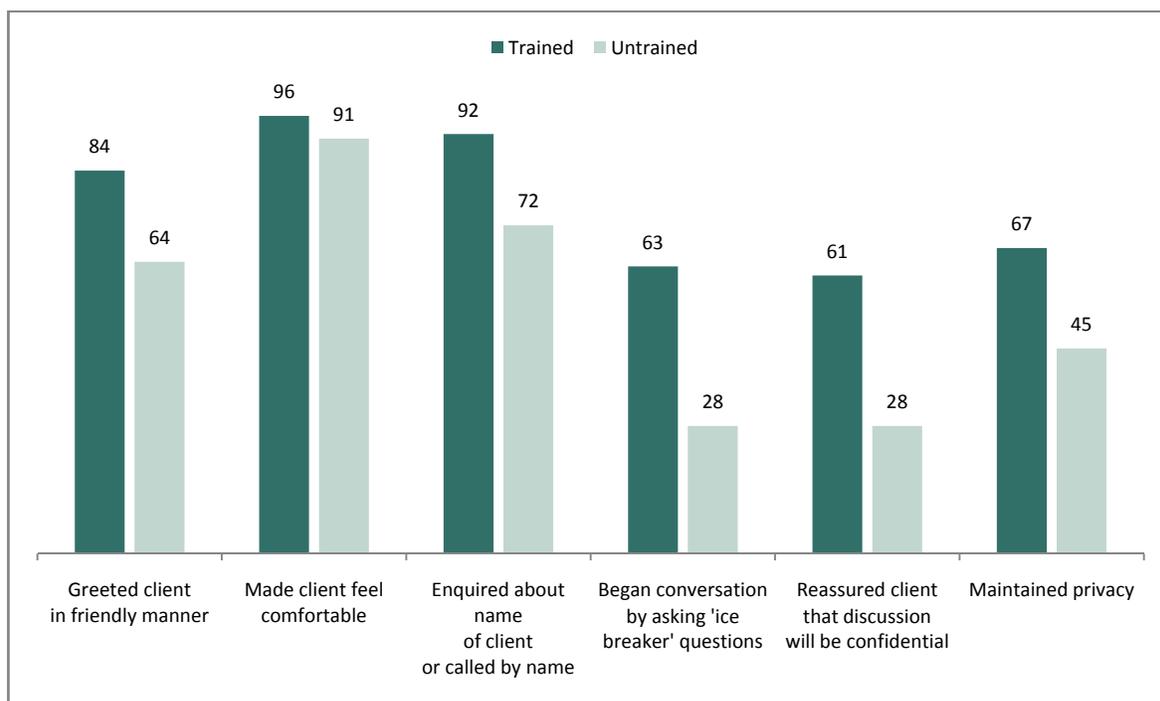
4.2 Findings

a) Client salutation

Salutation stresses the need for greeting clients with respect, building rapport, and ensuring confidentiality so clients can comfortably discuss their problems with their providers. Figure 4.1

shows the differentials for the various aspects of salutation, including how the client is welcomed, shown respect, and displays confidence in free and open discussion about her problems, considering the provider as a friend. There were marked differences in each ‘salutation’ component between trained and untrained providers, with the former performing much better. Particularly marked was the difference between asking ‘ice-breaker’ questions and reassured about confidentiality; these two aspects can significantly affect consultation quality, as they determine how comfortable clients feel about discussing their problems with providers.

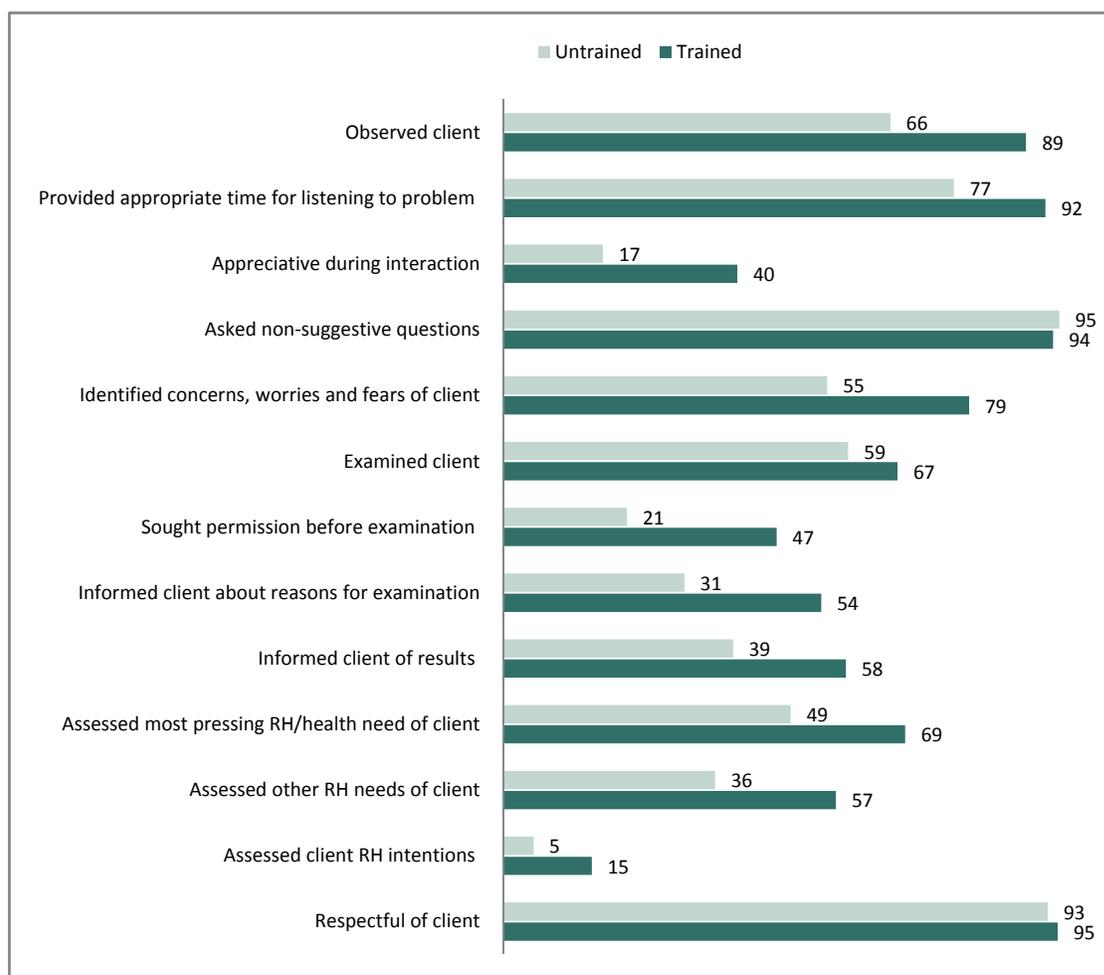
Figure 4.1: Impact of SAHR training component ‘Salutation’ on provider behavior and interaction with clients by their training status



b) Assessment

Assessment aims to not only understand the immediate medical issues clients present but also place these issues within a proper context. Providers must listen attentively and give enough time to clients, taking care not to dismiss or disregard anything clients might want to report. A holistic approach must be adopted by providers for identifying the social contexts of client issues and needs. Permission must be sought before any examination, and results must be explained.

Figure 4.2: Impact of SAHR training component ‘Assessment’ on provider behavior and interaction with clients, by provider training status

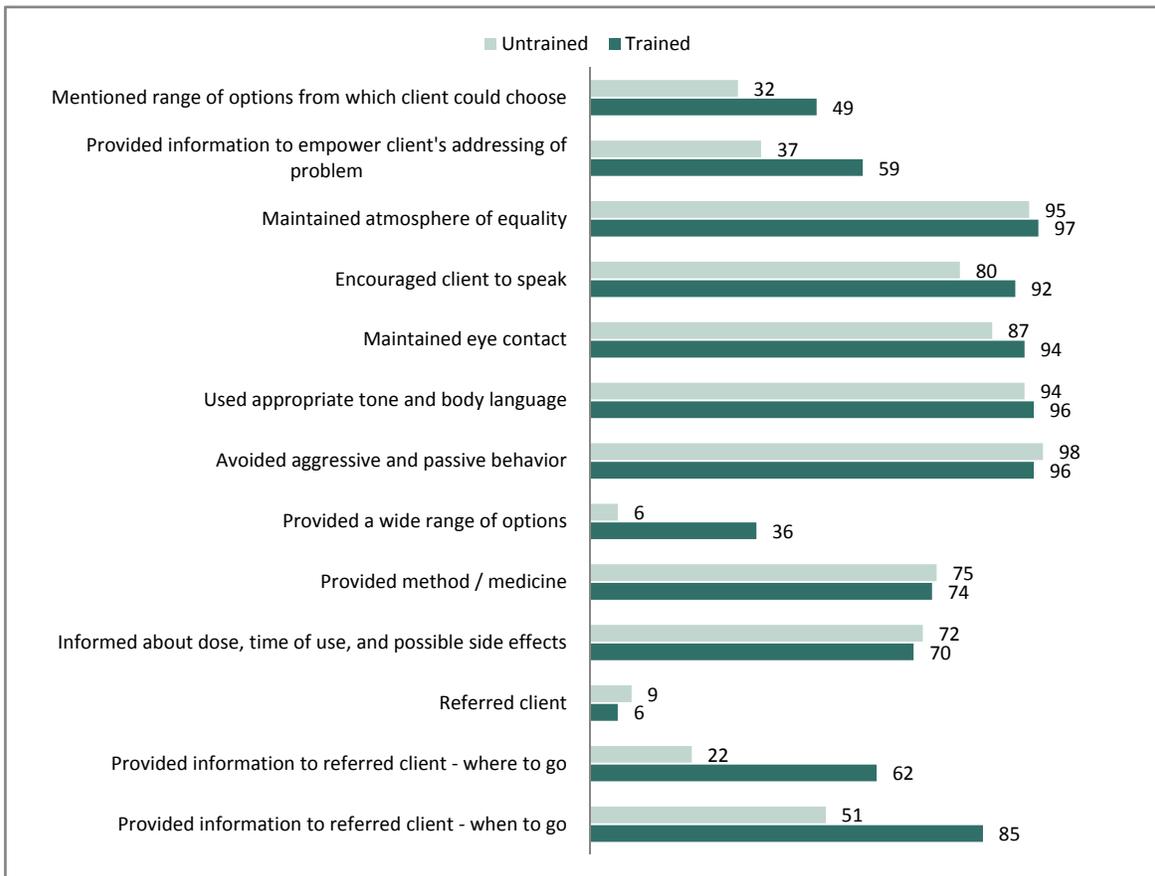


This is the second step, after salutation, and aims to maintaining client/patient confidence by creating a friendly atmosphere so they can openly discuss their issues, which helps providers making real judgments and assessments. Client/patient assessment satisfaction is a pre-requisite for treatment. Figure 4.2 provides client satisfaction with trained and untrained provider treatment during their assessments. Observations of client-provider interactions show that both trained and untrained providers generally were not dismissive towards clients, but trained providers, however, were better at devoting sufficient time to listening to client problems and assessing clients’ other RH needs. Trained providers were also better in identifying client concerns and fears than untrained providers. Both trained and untrained providers scored the least in assessing clients’ RH intentions, with the indicator “assessment of most pressing RH/health need of client” also requiring “more attention” from both provider cadres.

c) Help

The provider must offer and explain the range of options and choices available for clients' needs, for example, suggesting medicines (or FP methods) or providing advice and answers to any questions clients may have. If necessary, providers must also refer clients to appropriate higher level facilities and provide comprehensive information. This is the third step, and after assessment/examination and client/patient diagnosis, providers prescribe treatment by suggesting medicine or providing advice. Figure 4.3 shows how trained and untrained providers perform in helping clients understanding their treatment. It is encouraging that the vast majority of providers maintain an atmosphere encouraging clients to speak; however, again, trained providers performed better than untrained providers in almost all elements. Trained providers are far ahead of their untrained colleagues in providing clients with a range of FP options. Both trained and untrained providers make very few referrals, though the former are significantly better in guiding clients/patients on where to go when referrals are made. However, in providing information about medicine dosage, time of use, and possible side effects, trained providers lag slightly behind untrained providers.

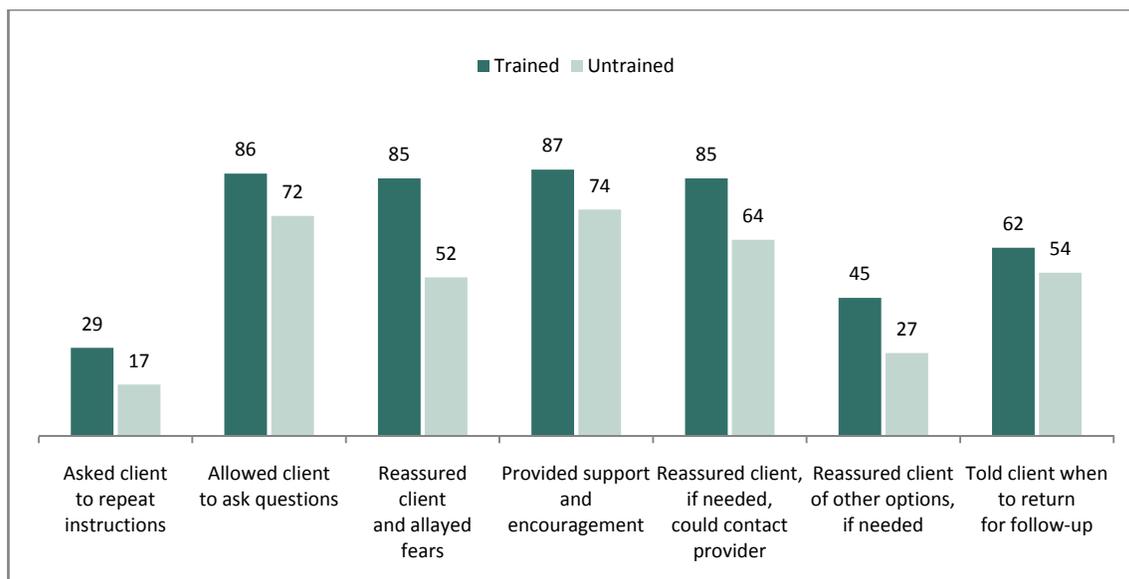
Figure 4.3: Impact of SAHR training component 'Help' on provider behavior and interaction with clients, by training status



d) Reassurance

The provider must make sure that the client has understood what has been explained to him regarding treatment and prescription (including the next appointment if necessary). The provider should reassure the client that in case of any problem the solution provided to him can be renegotiated and that he can approach the provider any time if the original problem persists. As the last step for provision of quality services providers are expected to reassure clients about the treatment suggested. They must also themselves be assured that the client/patients have understood the treatment and prescription; making this effort will further increase the confidence of the client in the provider, thereby encouraging them to make use of the services again and recommend these to others. As seen in Figure 4.4 below trained providers do better than untrained providers in allaying clients' fears and reassuring them and advising on follow-up visits. However, both trained and untrained providers were weak in reassuring clients that if their condition does not improve they can return for a consultation to discuss other options. They were also paying less attention by asking clients to repeat instructions given by them.

Figure 4.4: Impact of SAHR training component 'Reassurance' on provider behavior and interaction with clients by their training status



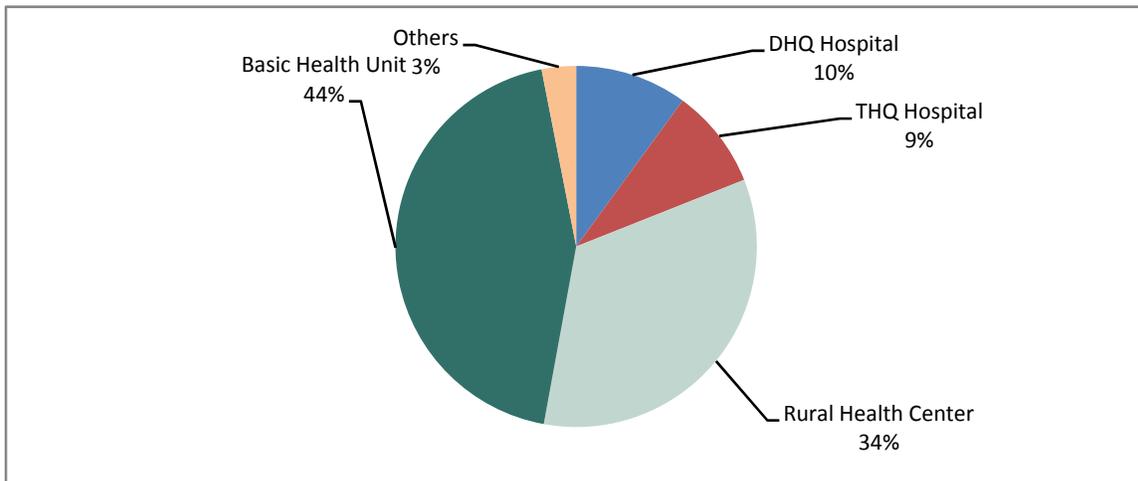
4.3 Client Satisfaction: General Patients

Clients have a right to information for appropriate, informed RH decisions, and providers should respect their dignity and confidentiality (Rudy et al. 2003). Client-provider interaction includes all face-to-face communication between clients and service providers. Counseling is the most important form of client-provider interaction, with a specific purpose requiring special knowledge and skills. Client satisfaction may not necessarily mean quality is good; it can indicate low client expectations instead (Liz et al. 2002).

a) Treatment Seeking

The distribution of clients interviewed shows the majority of interviewees were from BHUs (44%), followed by RHCs (34%) (Figure 4.5).

Figure 4.5: Percentage of clients/patients, by type of facility consulted for usual treatment



b) Female empowerment for Visiting Health Facilities

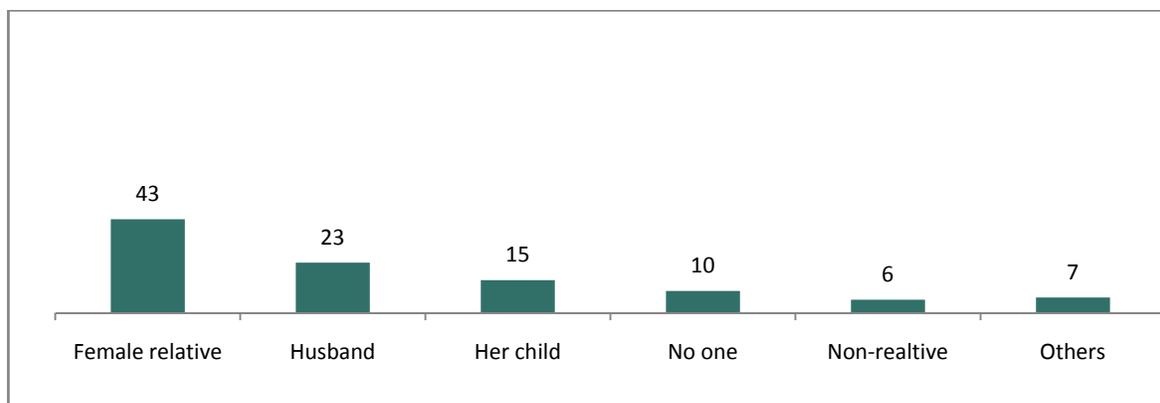
Women’s visits to health facilities can help reduce morbidity and maternal mortality and also presents opportunity for FP use/ adoption, through counseling. Table 4.1 details the percentage of clients/patients, distributed by individuals advising clients/patients and determining their health facility visits. It is encouraging to note, while almost half of women (46%) decided jointly (in consultation with other family members) to visit a facility, one quarter (25%) made the decision on their own. Further, 30 percent of women said they chose that particular facility on their own, followed by 25 percent who chose the facility jointly with the family, and 18 percent came on their husband’s advice.

Table 4.1: Percentage of client/patient health decision-making and advice

Decision/Advice by	By decision *	By advice
Self	24.5	29.9
Husband	19.2	17.6
Jointly	46.4	25.2
Mother	5.3	6.5
Mother in law	7.1	8.3
Sister in law	1.1	4.5
Other	5.7	8.0

*Multiple response variable

Women's mobility is restricted in Pakistan. Earlier studies on their access to health services have emphasized restricted mobility's role as a major impediment (Sathar and Kazi, 1997; World Bank 2005). In Figure 4.6, the distribution of women clients, by person accompanying them to the health facility, shows only 10 percent visiting facilities on their own. Women patients require someone to accompany them even to visit a health facility. Findings show that 43 percent of patients visited the facility with a female relative, while 23 percent were accompanied by their husbands. Visiting a health facility with their husband can also encourage spousal communication.

Figure 4.6: Percentage of clients/patients accompanied to health facility

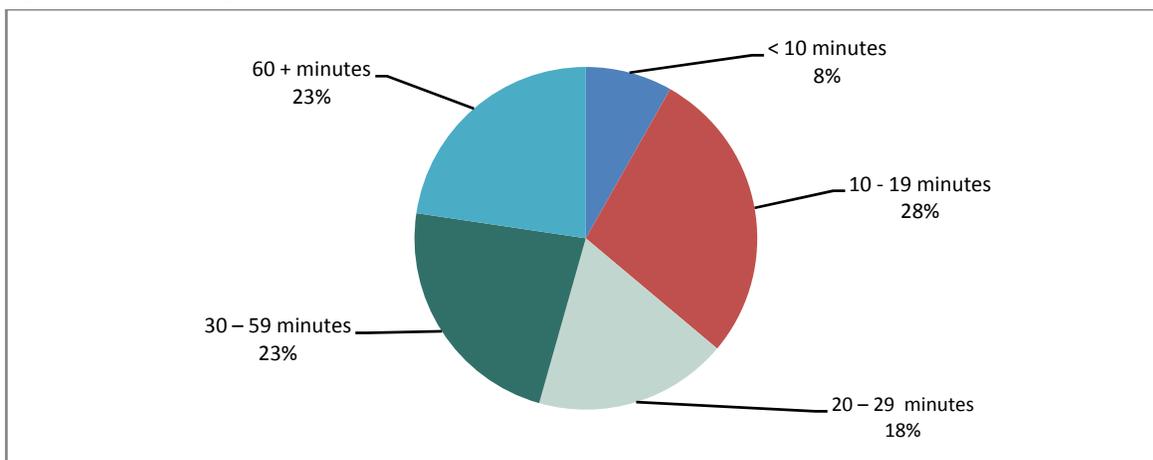
Multiple response variable

c) Travel to Health Facilities

Travel to health facilities affects treatment seeking and health facility access. Many women cannot easily get to health facilities, which often are far apart. Even if public transportation is available, traveling alone may not be socially acceptable for women. Furthermore, traveling long distances may make it difficult for some women to obtain services secretly.

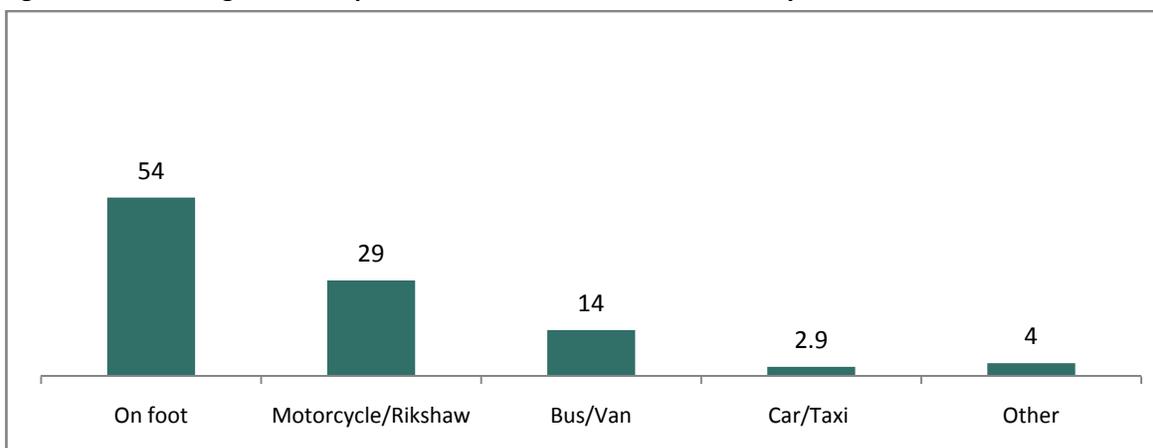
Over one quarter (28%) of interviewees could reach a facility within 10 to 19 minutes, and 54 percent within half an hour, but for a further near quarter (23%), travel took an hour or more (Figure 4.7). As discussed earlier, a number of women bypassed BHUs and traveled to RHCs, with most probably seeking quality services or female staff. Quality services within easy access of women would increase their utilization and help ensure patient needs are satisfactorily met.

Figure 4.7: Percentage of clients/patients, by time taken to reach health facilities



Fifty-four percent of patients reached health facilities on foot, followed by 29 percent by rickshaw or motorcycle (Figure 4.8). Other means of travel are not common. For over half of women there is no financial transportation cost in accessing health facilities and, for the most part, facilities are within walking distance. A small percentage does incur some travel costs.

Figure 4.8: Percentage of client/patient means of travel to health facility



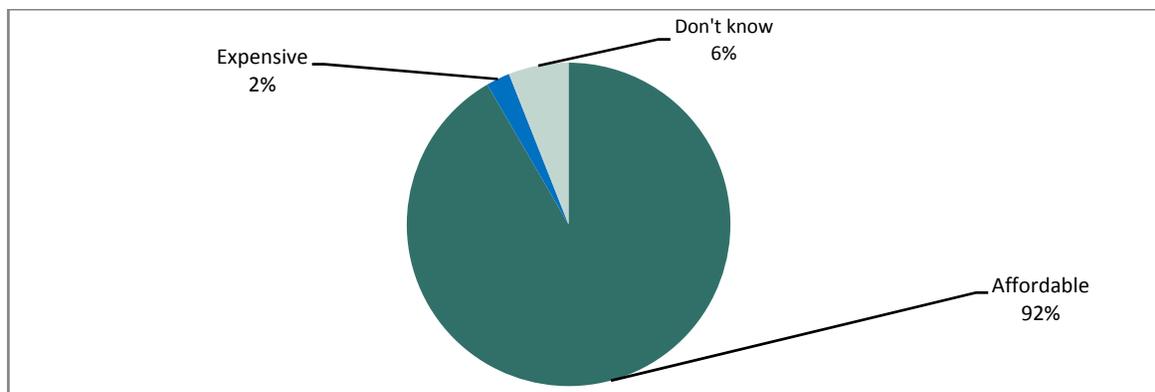
d) Service cost

Service cost also determines whether people seek services, specifically FP services. Findings show, overall, only 37 percent of clients/patients reported paying service fees. In Pakistan's health facilities contraceptives are free, but in some cases (Table 4.2) nominal charges are paid by clients. Of those paying the most (89%) paid up to Rs. 5, the regular *purchee* (registration) fee at public health facilities. Health services and consultations at government facilities are free, but laboratory services are not. The vast majority (92%) of clients/patients found services affordable, which means cost is not an issue in public sector health service utilization (Figure 4.9).

Table 4.2: Percent of patient payments, by cost

Rupees paid	Percent Clients/Patients
1-2 Rs.	33.5
3-5 Rs.	55.3
6-50 Rs.	8.1
>Rs. 50	3.1
Total	100

Figure 4.9: Percentage of clients/patients by opinion about service affordability

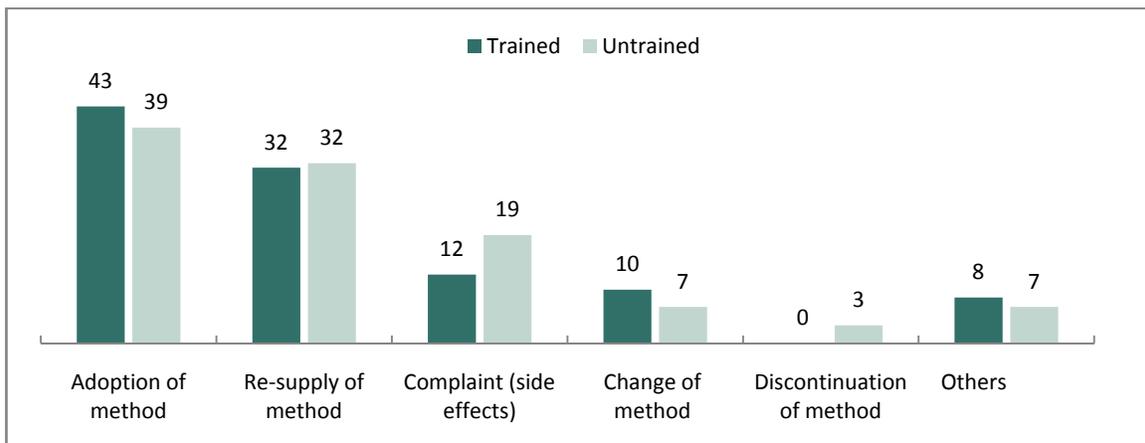


A waiting area (Table 2.1) was available at 95 percent of facilities. Seating arrangements are essential for client/patient ease and comfort, especially for old and pregnant women. Almost 97 percent of interviewees reported that seating was available at their facility.

4.4 Client Satisfaction: FP Clients

The most common reason for FP client visits to facilities was method adoption, followed by re-supply, side effect complaints, and method change; discontinuation visits were negligible. Disaggregation of visit objectives by trained and untrained providers showed considerable similarity: Trained providers received more visits for method adoption and change, while untrained providers received more visits relating to side effects (Figure 4.10). Contraception discontinuation is mainly due to side effects (Naz and Mahmood 2012). Clients with problems or concerns should be given careful attention and counseling, and not just for clients with side effects, but also for new clients for method adoption, with whom providers should discuss potential side effects proactively and take concerns about side effects seriously. Clients should also express concerns, needs, and preferences. About one third of clients at facilities returned for follow-up or contraceptive re-supply. Most are satisfied clients with no particular problems or concerns, with about 10 percent attending facilities to change contraceptive method due to dissatisfaction.

Figure 4.10: Percentage of clients by the objective of visit to facilities for family planning according to the training status of providers



Multiple response variables

Overall, FP clients were satisfied with provider interaction and opportunity to discuss their issues, yet their responses were somewhat less positive for untrained providers' understanding of their problems. There were also marked differences for provider attitude towards clients: While trained providers have an inviting attitude, 12.5 percent of untrained providers were reported to as dismissive towards clients. In general, for new clients, most already have a method in mind. For those who need help selecting a method, the provider should explore the client's personal situation, RH intentions, and method preference, if any, and then fill any knowledge gaps and correct any misperceptions (Rudy et al. 2003). Table 4.3 shows that 46 percent of clients of

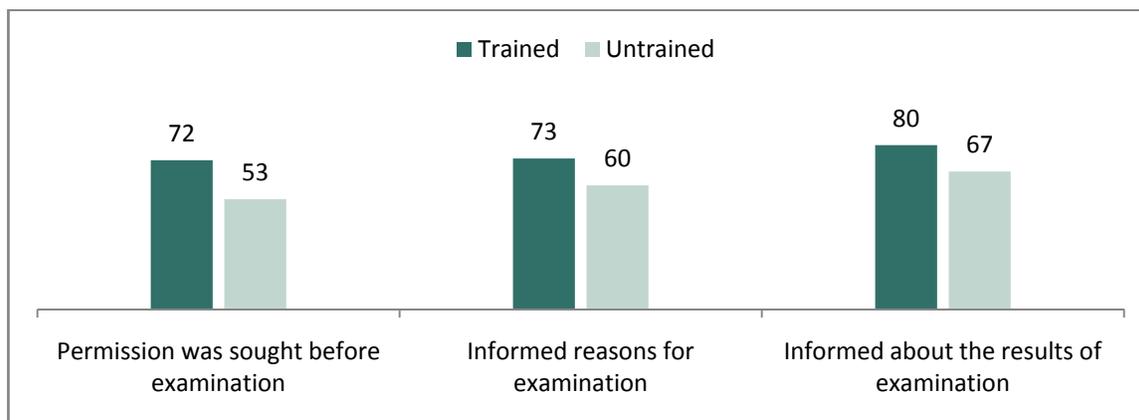
trained, and 39 percent of clients of untrained, providers reported questions exploring their personal situations and examination as well, and further, 43 percent of clients of trained, and 42 percent of clients of untrained, providers were also asked questions but were not examined. It is possible, however, that these unexamined clients did not need an examination. One tenth of clients of untrained providers, compared to three percent of clients of trained providers, reported providers not asking any questions about their situation nor examining them.

Table 4.3: Percentage of client assessments, by type and provider training

Provider assessed the problem as:	Trained	Untrained
Did nothing	2.8	9.7
Examined only	2.8	6.5
Asked only	43.1	41.9
Both asked and examined	45.8	38.7
Client description	5.6	3.2

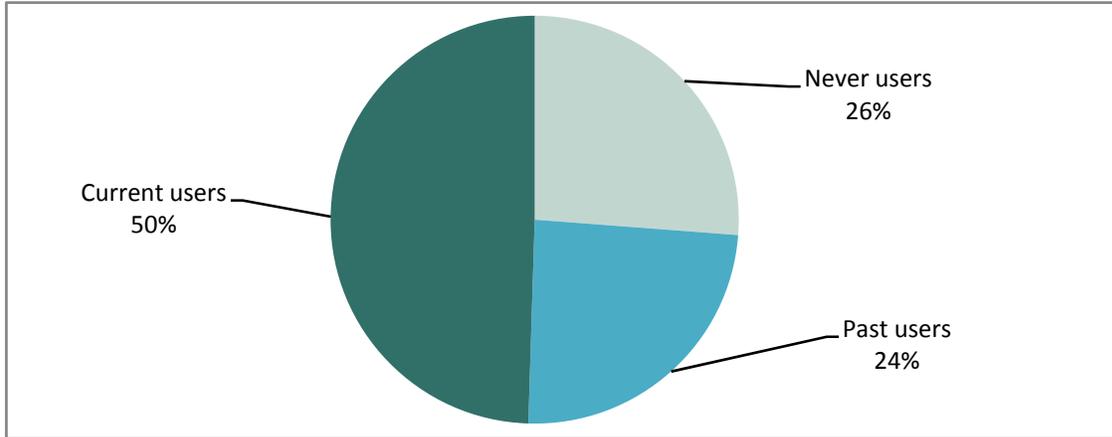
For clients who were examined, permission by trained providers was sought for 72 percent of their clients, and 53 percent of untrained provider clients, while 73 percent of clients visiting trained providers and 60 percent of clients of untrained providers were informed of the reasons for their examination. Providers must get permission prior to examination and provide essential information clearly, in terms clients can understand. Some clients from whom permission was not sought, nor reasons given, possibly needed only minor examinations such as checking blood pressure. Eighty percent of clients were provided their examination results by trained providers, but untrained providers only offered results to 67 percent of their clients (Figure 4.11).

Figure 4.11: Percentage of clients informed about examination, by training of providers



While just over a quarter of respondents never used any contraceptive method at the time of the exit interview, almost 50 percent used contraception, and just under a quarter were prior users.

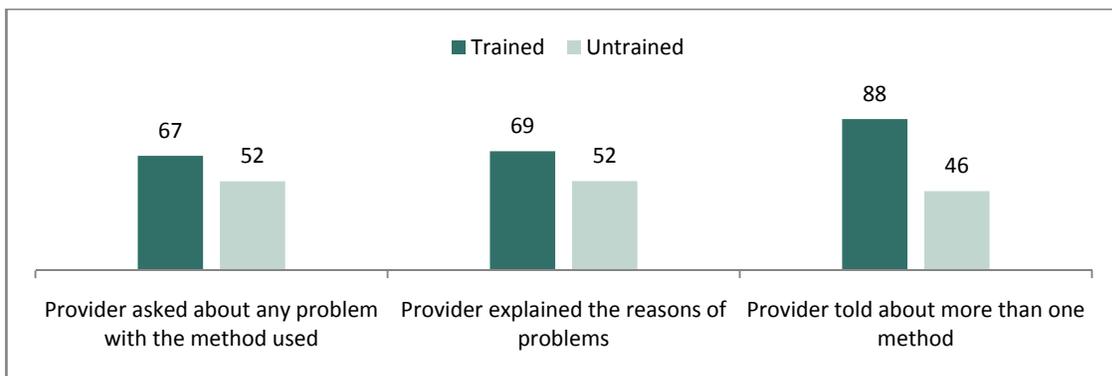
Figure 4.12: Percent contraception use at exit interview



A provider can help an FP client in several ways: For new FP users, the provider must give all necessary and relevant information on available FP methods, and if the client has come for re-supply, the provider should ask about and address any problems the client/patient may be facing with the current method, and recommend another method if appropriate.

Sixty-seven percent of clients attended by trained, and 52 percent clients attended by untrained, providers confirmed being asked about problems with their current FP method, and 69 percent of clients of trained, and 52 percent of clients of untrained, providers had possible reasons for their problems explicated. While 88 percent attended by trained providers, and 46 percent of clients attended by untrained provides, were advised about more than one FP method, exit interviews confirmed that trained providers provide more information to FP clients compared to untrained providers (Figure 4.13).

Figure 4.13: Help for clients, by percent of clients of trained and untrained providers



Discussions about counseling usually focus on helping the "new" client choose an FP method. According to clients interviewed, almost half (48%) stated they did not receive any information from untrained providers about FP methods, and only more than a quarter (28%) received information on side effects. A vast majority (95%) of clients sought information on FP methods from trained providers, but only 56 percent received information on possible side effects from them. Fifty-four percent of clients were informed about new method duration and effectiveness by trained providers, but only about one quarter received this information from untrained providers. During method adoption, counseling that helps clients choose and learn to use a method that suits them has a positive impact on method adoption, continuation, regimen compliance, and resulting health outcomes (Rudy 2003).

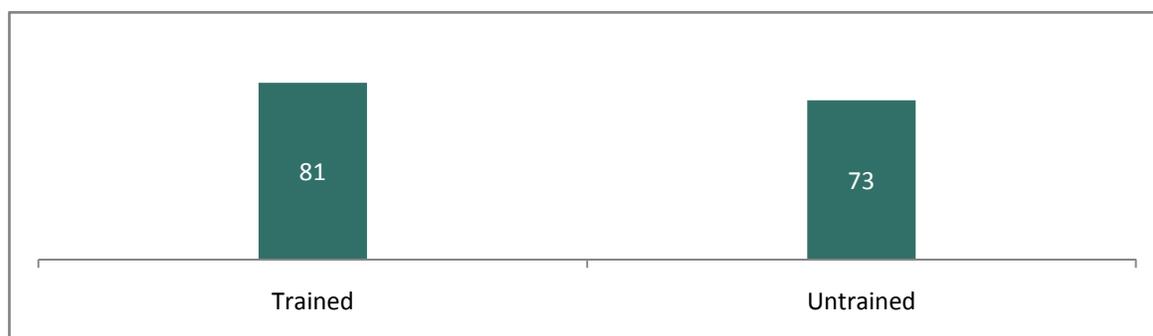
Table 4.4: Percentage of clients provided FP information, by type of information and provider training

Information provided about FP method/s	Trained	Untrained
Nothing	5.1	48.0
Pros and cons of method(s)	8.5	4.0
How to use method	32.2	16.0
Effectiveness-duration	54.2	28.0
Effectiveness-level	6.8	4.0
Possible side effects	55.9	28.0
Ability to protect from STDs	3.4	0.0
Others	6.8	0.0

Multiple response variables

If clients can obtain needed treatment at the same facility at which they are assessed, this increases chances they will utilize health services and recommend them to others. Moreover, local (BHU) method or treatment availability can stop patients from going to higher-level facilities, thereby easing their patient load. The study found, for trained providers, 81 percent of clients/patients obtained their necessary treatment or method at the same place, while this was true for only 73 percent of clients/patients of untrained providers (Figure 4.14).

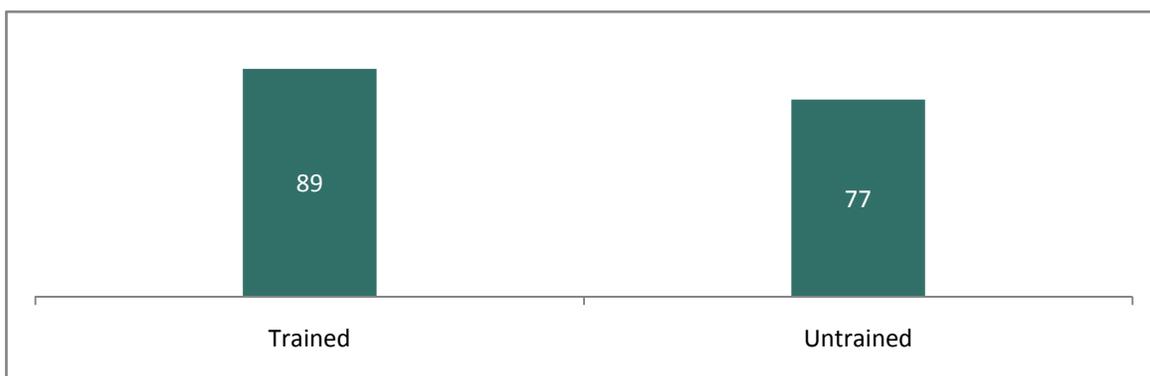
Figure 4.14: Percentage of clients reporting availability of method by the status of training of the provider



In cases which client/patient need cannot be addressed in the same facility, an important element for ensuring their satisfaction is proper referral, which includes accurate guidance about where to go, what to ask for, some indication of the procedure and cost involved. The study found few FP clients referred for services elsewhere—however, each documented referral was by a trained provider. The small number of referrals, however, could indicate that facilities were able to address most client need.

Clear instruction about follow-up visits is important for ensuring clients get the full benefit (effectiveness) of their treatment or method. More clients were told when to come for follow-up by trained providers than from untrained providers (89% versus 77%). Those not instructed on follow-ups could potentially have been sterilization clients at higher-level facilities such as THQ and DHQ hospitals, therefore not requiring follow-up (Figure 4.15).

Figure 4.15: Percentage of clients instructed on follow up visits, by provider training status



Identifying and assessing client service satisfaction is important in policy- and decision-making and can provide useful information for improving services.

Ninety-three percent of clients were satisfied with services provided and a further four percent were somewhat satisfied; only three percent showed dissatisfaction (Table 4.5). Moreover, 98 percent of clients said they would advise others to visit the same facility.

Table 4.5: Percentage of satisfied clients

Satisfaction of clients	Percentage
Yes	93.1
No	3.0
Somewhat	4.0
Advise someone to attend facility	98.0

Based on client-provider interactions and exit interviews, quality of care by providers trained in CCFPS is much better than untrained providers' care. The difference is apparent from the consultation start, when trained providers attempt to put a client at ease, ensuring confidentiality much more often than untrained providers. While both trained and untrained providers generally allow clients sufficient discussion and do not adopt dismissive attitudes, trained providers also identify clients' worries and fears, almost always providing information on different FP methods and possible side effects. Comparatively, almost half of untrained providers' clients did not receive FP method information, and only a quarter were provided information on side effects. Trained providers also generally employ a more holistic approach, assessing client social contexts and other health needs, and advise on follow-up visits more frequently than untrained providers.

The findings on quality of care are crucial and emphasize the need for offering CCFPS or SAHR trainings on a wider scale. With their more engaging attitude, trained providers will not only contribute to method continuation by existing clientele, but their holistic approach and advice on different FP choices will also attract new FP users.

Chapter 5: Conclusion

This assessment, following FALAH's implementation, examined both public health facility readiness for providing FP/birth spacing services and quality of services. Facility readiness was evaluated by interviewing in-charges and providers, collecting data on infrastructure, services, staff availability, and contraceptive supplies. Service quality was measured through observing interactions between clients and providers, as well as exit interviews with clients at facilities. As the study primarily constitutes situation analysis as well as an evaluation of FALAH interventions, specifically training, the central part of the analysis is assessing the differences between trained and untrained facilities and staff. A facility is considered 'trained' when at least one staff member is FALAH-trained and, likewise, "trained staff" are those trained by FALAH. Visible and notable differences between trained and untrained staff have been discovered relating to service delivery.

Facility condition and readiness for service, including electrification, separate toilets for female clients or patients, waiting areas protected from sun or rain and cleanliness, have been found satisfactory, but uninterrupted electric supply is an issue at most facilities. Staffing is adequate. Counseling is important in FP/birth spacing service adoption, yet almost half of facilities have no separate room for counseling, which focuses primarily on FP/birth spacing with little attention to other aspects. IEC materials are prominently displayed by most facilities. Contraceptive availability is reasonably good and improved as a result of FALAH efforts, but stock outs are an issue. Specifically, lack of buffer stock is critical, for which FALAH made successful corrective efforts, and GoP agreed to provide three months' buffer stock to not only FALAH districts but all districts of Pakistan. Eighty-seven percent of facilities had at least one staff member trained in any one of the FALAH trainings. Regular contraceptive requisitioning was lacking, and as a result of FALAH's efforts, the situation improved, with 76 percent of facilities with trained providers now regularly requisitioning contraceptive supplies. For contraceptive supply sustainability, additional measures were suggested during field visits. For quality of services, the SAHR approach enhanced trained staff's skills. Overall, results are better in all aspects for trained staff compared to untrained staff.

FALAH's objective was to prepare public health facilities for better quality birth spacing/FP services, and thereby increase contraceptive prevalence. From evidence gathered in this assessment, it can be confidently stated that facilities and staff trained under FALAH are delivering better services. As a result, CPR increased in FALAH districts overall from 29.4 percent to 37.9 percent (Mahmood 2012). An independent analysis on contraceptive continuation rates in Pakistan also shows better continuation for users who were provided comprehensible information at method adoption (Saman and Mahmood 2012). SAHR training changed some important elements of provider attitude and behavior, but certainly more efforts are needed to sustain these changes and train other providers for dispensing quality services.

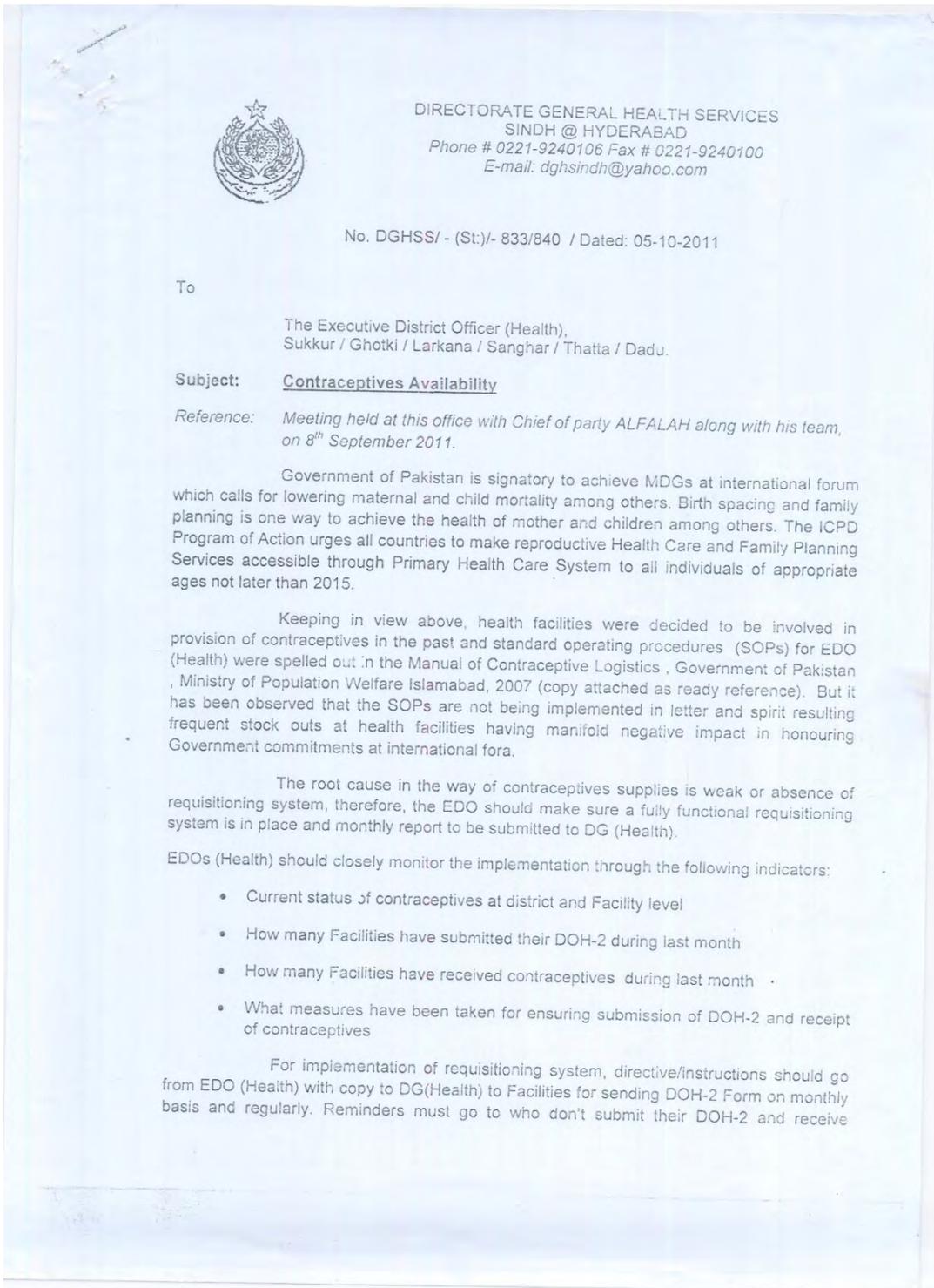
Annex-I

Figure A1 SAHR, a systematic approach to meeting client's reproductive health needs

TREAT THE CLIENT WITH RESPECT AND DIGNITY		
Salutation →	Welcome in a courteous and friendly manner	Ensure privacy and confidentiality
	Show interest, empathy, and concern	Maintain atmosphere of equality
	Show respect to the client and other family members	Call the client by his/her name
	Create a tension-free and relaxed atmosphere	
ASSESS THE CLIENT'S REPRODUCTIVE HEALTH NEEDS		
Assessment →	Observe the client	Assess client's reproductive health intentions
	Listen carefully	If not pregnant, intent to have another child and when
	Use communication tools like reflective listening	If pregnant, ask about intended place of delivery and delivery attendant
	Provide ample time for consultation	Breastfeeding intentions
	Identify the client's concerns, worries, and fears	Child immunization intentions
	Assess the client's most pressing health need	Assess decisionmaking power in the household
	Assess other reproductive health needs (maternal health, child health, family planning)	Explore preexisting knowledge of health issues/problems
	Examine the client, if necessary	Determine underlying attitudes and health beliefs without becoming judgmental
	Ask permission to examine	
	Explain reasons for examination	
Inform client of findings, including causes and prognosis		
HELP NEGOTIATE A SOLUTION TO THE CLIENT'S REPRODUCTIVE HEALTH NEEDS		
Help →	Address client's concerns and issues	Empower the client to address her/his needs
	Provide information about options appropriate to her/his reproductive health needs	Provide ample information about the negotiated solution
	Negotiate a mutually agreeable solution	If the client has to be referred, provide him/her information about
	Maintain an atmosphere of equality	Where to go
	Provide ample time for listening to client's concerns	When to go
	Encourage the client to speak	Distance involved
	Avoid blaming the client	Convenient mode of transportation
	Maintain eye contact with client	Costs to be incurred
	Use appropriate tone and body language	Total time travel would take
	Avoid aggressive and passive behavior	Directions as how to reach the referred facility
	Be assertive	Involve family members, if present, in negotiated solution and referral
REASSURE THE CLIENT AND RENEGOTIATE IF NECESSARY		
Reassurance →	Ask the client to repeat instructions to ascertain understanding about	Provide support and encouragement
	How to take medicine	Reassure client that in case of need, he/she can contact the provider
	How to use contraceptives	Work with the client to overcome obstacles
	How to follow other instructions	Renegotiate solution, if necessary
	Allow client to ask questions	Community worker should also inform the client that provider will visit the client for follow-up
	Determine client's level of understanding	client can call provider, if necessary
	Explore client's ability to follow the negotiated solution	client can visit provider directly
	Reassure and allay client's fears	

Source: Sathar Z, Jain A, RamaRao S, Haque MU and Kim J. Introducing Client-centered Reproductive Health Services in a Pakistani Setting. *Studies in Family Planning* 2005, 36:3; 221-234

Annex-II



(2)

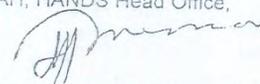
contraceptives with copy to DG (Health). For ensuring correctness of DOH-2 Forms, continuous orientation of LHV's or dealing providers is very much essential.

Monthly meetings of the staff may be the useful Forum for the purpose where District store staff should do this job.

1. Strong distribution system for the delivery of contraceptives to Facilities be developed and reported to D.G office so that in the presence of contraceptives at district store no one facility is left out with out receipt of contraceptives. Supplies be made to Facilities each month at their door step instead of calling the staff for supplies.
2. Strict monitoring of Facilities be made by EDO (Health) and other concerned authorities and notices be served to such facilities who don't have contraceptives and have not made immediate report to the concerned authorities. At least two visits be made by EDO (Health) each month.
3. In case of submission of CLR-6 to District Population Welfare Office/ Central Warehouse follow up be made and queries be satisfied if any. However, in case of non supply for more than one month, the report may be made to DG (Health) for taking up the matter with Central ware house at appropriate level.
4. As consumption of contraceptives for the previous quarter is the main hindrance in the way of supplies, the case of relaxation will be taken up with concerned authorities till fully functional requisitioning system. By the time the supplies be demanded on average base formula for district and Facilities with the demand of buffer stock. Copy of the CLR-6 be also sent to D. G office as well.
5. Don't wait for the stipulated time for submission of CLR-6 if stock out occurs at district store. Likewise instruction be issued to Facilities for immediate reporting to district if stock out occurs at facilities and all necessary measures be taken for immediate supplies to the such facilities apart from routine distribution.
6. Currently pending supplies from Central warehouse be reported immediately to take up the matter with Central Warehouse/other appropriate authorities.
7. Contraceptive supplies must be an essential agenda item in staff/DTC meetings to ensure contraceptive supplies at district and facilities.
- 8.

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HEALTH SERVICES SINDH @ HYDERABAD

- Copy submitted to Secretary Health, Health Department, Govt. of Sindh, Karachi.
- Copy to Zulfiqar Ali Sario, Provincial Coordinator FALAH, HANDS Head Office, Karachi.


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