ASSESSMENT OF COMPLIANCE WITH THE TIAHRT AMENDMENT AND POLICY DETERMINATION 3 IN PAKISTAN

JUNE 18 – JULY 2, 2006

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ACRONYMS

AMHS	Assistant Manager Health Services
BCC	Behavior change communication
BHU	Basic health unit
CA	Cooperative agreement
CMW	Community midwife
CPR	Contraceptive prevalence rate
DFID	Department for International Development
DHS	Demographic and Health Survey
FP	Family planning
FWC	Family welfare center
FWW	Family Welfare Worker
GH/PRH	Global Health/Population and Reproductive Health
GOP	Government of Pakistan
IEC	Information, education and communication
IUD	Intra-uterine device
JSI	John Snow International
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
NGO	Non-governmental organization
NIPS	National Institute of Population Studies
NP-FP/PHC	National Program for Family Planning and Primary Health Care
MOH	Ministry of Health
MOPW	Ministry of Population Welfare
MSI	Management Systems International
PAIMAN	Pakistan Initiative for Mothers and Newborns Project
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PD-3	Policy Determination 3
RHSC-A/B	Reproductive Health Services Center (A=public facility; B=private facility)
RHC	Rural health center
RLA	Regional Legal Advisor
SOAG	Strategic Objective Agreement
TFR	Total fertility rate
VS	Voluntary sterilization
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This report describes and analyzes findings from an assessment conducted in Pakistan from June 18 to July 2, 2006. The assessment, which was requested by USAID/Pakistan in August 2005, reviewed the Mission's family planning activities with respect to compliance with the Tiahrt Amendment on voluntarism in family planning and USAID's Policy Determination 3 (PD-3) on voluntary sterilization (VS). The assessment team included a representative of USAID/Washington/Global Health Bureau/Office of Population and Reproductive Health and two staff from Management Systems International.

USAID/Pakistan supports family planning (FP) through both health and social marketing activities. In particular, the Mission supports two contraceptive social marketing networks, Greenstar and Key Social Marketing, as well as a maternal and newborn health project, the Pakistan Initiative for Mothers and Newborns (PAIMAN). The Mission initially requested the assessment to review two issues for compliance with the Tiahrt Amendment. First, Mission personnel had observed in one location that Lady Health Workers (LHWs) appeared to have targets for the recruitment of voluntary sterilization clients. The Tiahrt Amendment prohibits the use of targets for numbers of family planning acceptors or acceptors of a particular method. Second, compensation payments are made to voluntary sterilization clients and referral agents under both the Ministry of Population Welfare (MOPW) and the Greenstar programs. The Tiahrt Amendment also prohibits the payment of incentives, but Policy Determination 3 provides guidance on what constitutes acceptable recompense (and is not, therefore, considered an incentive) for costs associated with voluntary sterilization. Accordingly, the team focused its review on these areas. With assistance of staff from the Islamabad office of Population Council, the team interviewed public and private sector FP managers, providers, referral agents and clients in forty-one facilities in six districts over a period of two and a half days.

The first issue addressed by the team was the scope of application of Tiahrt and PD-3, given the nature of USAID's assistance to FP in Pakistan. The team concluded that Tiahrt applies throughout the areas where USAID-supported private sector social marketing programs, Greenstar and Key, operate. It also concluded that Tiahrt applies to public sector FP activities in geographic areas where Greenstar, Key or PAIMAN support or will support public sector FP service delivery. This support generally takes the form of broad-based FP training in counseling and service delivery for LHWs or, in the case of PAIMAN, for LHWs and community midwives. The team concluded that USAID's support for government voluntary sterilization activities is "indirect" within the terms of PD-3, and that therefore PD-3 does not apply to the government's VS program. Nevertheless, the team recommends that the Mission address the issue of VS acceptor payments in the public sector program, in accordance with PD-3, as a means of assuring compliance with Tiahrt and that it encourage continued use of PD-3 type informed consent forms for VS in the public sector, as a best practice which supports Tiahrt objectives on comprehensible information.

Targets: The team found no use of targets for service providers in the private sector social marketing programs USAID supports, only tracking of quantitative data. In the decentralized public FP program, the team found no evidence of any widespread or systematic use of targets of the type prohibited by Tiahrt. It did, however, find in one district that LHWs had targets for numbers of VS acceptors of the type prohibited by Tiahrt. (The targets are apparently vestiges of an earlier initiative in which district health managers were encouraged to find ways to increase FP acceptance.) Although USAID is not currently supporting public sector FP activities in the particular district where targets were found, it is expected to do so in the future under PAIMAN. The team is not aware of targets in the four or five districts where USAID partners (Greenstar and its subrecipients) are currently conducting LHW training, however the team did not visit those specific areas. The team did not, during its visit, learn of any instance or location

where Tiahrt violations should be considered likely at the present time. However, if targets for LHWs are in place in districts where USAID is currently funding FP activities, then USAID's program is vulnerable to Tiahrt violations. Similarly, if targets persist in areas where USAID will be expanding its support for public FP services, the program will be vulnerable to Tiahrt violations in the future.

Incentives/Payments for VS: The team found no evidence of payments or other rewards to program personnel for achieving targets or quotas, in violation of Tiahrt. The team found that sterilization clients in the public system and Greenstar network generally receive Rs. 250-275 (US$ 4.38-4.82), medicines and often transport. Referral agents, such as LHWs or others who accompany clients to the procedure, receive Rs. 150-175 (US$ 2.63-3.07). Public sector doctors receive no per case payments, but may occasionally receive the referral agent fee. Greenstar network facilities receive Rs. 1,500 (US$26.31) per case to cover all facility costs, including overhead costs, lab support, payments to the surgical team, as well as client and referral agent fees. The team believes these amounts to be well within PD-3 guidelines on permissible payments intended to remove financial barriers to VS.

Comprehensible Information: The team found no evidence of a pattern or practice of failing to provide comprehensible information to clients regarding the contraceptive method chosen. The team also concluded that the standards of informed consent are generally being met, despite occasional lapses. Service providers were aware of their obligation to provide comprehensible information to clients on an array of methods and particularly on the method chosen. The vast majority reported that they generally provide this information verbally—spending between 5-10 minutes or more with individual clients. While the team saw some excellent information, education and communication (IEC) materials, useful for counseling both literate and illiterate clients, the distribution of these materials in both public and private sector facilities was very limited. The team saw almost no Tiahrt-style posters accessible for client viewing in any facilities.

Recommendations: The team makes the following recommendations for Mission action:

- Ensure that LHW targets are not being implemented in the four or five districts where Greenstar is currently conducting LHW training.
- Follow-up at appropriate levels within the Government of Pakistan to ensure that LHW targets are not and will not be implemented in the 10 PAIMAN districts or in other areas where Greenstar and Key are or will be assisting public FP service provision. For practical and policy reasons, it is generally advisable to stress compliance with Tiahrt requirements throughout the areas where USAID's private and public sector partners are collaborating.
- With assistance from the Regional Legal Advisor, make determinations in accordance with PD-3 regarding the reasonableness of compensation payments to 1) VS acceptors in both the public and private sector networks that USAID supports, and 2) referral agents and providers in the Greenstar private sector network.
- Monitor and follow-up any proposed changes in the current levels of payment related to VS.
- Work with implementing partners to ensure they continue to emphasize the importance of quality counseling, particularly the provision of comprehensible information on the method chosen, to service providers during training and supervision visits.
- Work with the MOH/MOPW and implementing partners to develop a locally appropriate version of a Tiahrt-style contraceptive methods wall chart, and ensure its distribution to health facilities and service providers receiving support under its programs.
- Work with the MOH/MOPW and implementing partners to improve and maintain the supply of counseling/IEC materials to service providers, and particularly to LHWs. Preferably materials would be produced in sufficient quantity to allow clients to take them home for further consideration or reference.

- Work with Greenstar and, to the extent feasible, the MOPW, to reinforce with service providers the need for proper procedures when obtaining informed consent for VS.
- Work with implementing partners to develop systematic mechanisms for monitoring and reporting on Tiahrt and PD-3 issues.
- Work with implementing partners to assure that training materials for LHWs and community midwives address issues of voluntarism and targets, so that they are aware of activities that would be considered impermissible.
- Work with implementing partners to establish regular mechanisms to orient all existing and new staff on the family planning requirements.

INTRODUCTION AND CONTEXT

This report describes and analyzes findings from an assessment conducted in Pakistan from June 18 to July 2, 2006. The team included Sarah Harbison from USAID/Washington/Global Health Bureau/Office of Population and Reproductive Health (GH/PRH) and two staff from Management Systems International (MSI) – Patricia Ramsey and Debbie Gueye. Ms. Ramsey served as team leader. In August 2005, USAID/Pakistan contacted GH/PRH requesting an assessment of the Mission's family planning portfolio in relation to the provisions of the Tiahrt Amendment[1] and USAID Policy Determination 3 (PD-3).

The USAID/Pakistan health program includes family planning through both health and social marketing activities. In particular, the Mission supports two contraceptive social marketing networks, Greenstar and Key Social Marketing, as well as a maternal and newborn health project. The Mission initially requested the assessment to review two issues for compliance with the Tiahrt Amendment. First, Mission personnel had observed in one location that Lady Health Workers (LHW) - Ministry of Health personnel at the community level - appeared to have targets for numbers of voluntary sterilization (VS) clients that they were expected to recruit. The Tiahrt Amendment prohibits the use of targets for numbers of family planning acceptors or acceptors of a particular method. Second, compensation payments are made to VS clients (male and female), clinicians and referral agents under both the Ministry of Population Welfare (MOPW) and the Greenstar programs. The Tiahrt Amendment also prohibits the payment of incentives, but Policy Determination 3 provides guidance on what constitutes acceptable recompense (which is not, therefore, considered an incentive) for costs associated with voluntary sterilization. Given this situation, USAID/Pakistan requested assistance in reviewing its family planning activities.

The scope of work for the assessment included the following objectives:

- Review the use of "targets" within the MOPW and Ministry of Health (MOH) systems to determine whether they function as those prohibited by the Tiahrt Amendment.
- Assess the levels of compensation being paid to sterilization clients and clinical staff, under both the MOPW and Greenstar programs, and make recommendations as to whether they are reasonable within the guidance set forth in PD-3.
- Assess whether complete information is provided to clients at contraceptive "camps".[2]
- Review on-going monitoring efforts to ensure compliance of family planning service delivery projects with the Tiahrt and PD-3 requirements.

The complete scope of work is included as Annex 1.

METHODOLOGY

During its trip to Pakistan, the assessment team held meetings with staff from the USAID/Pakistan Office of Health, Population Council, Greenstar Social Marketing, the Futures Group, which implements the Key Social Marketing program, partner organizations which implement the Pakistan Initiative for Mothers and Newborns Project (PAIMAN), the Ministry of Health, and the Ministry of Population Welfare. A complete schedule of activities can be found in Annex 2 and a list of key contacts is in Annex 3.

[1] Currently a proviso under Title II, Child Survival and Health Programs Fund, of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2006.
[2] A "camp" is a free clinic day organized by a Greenstar private provider.

From June 22-24, four teams of assessment team members and Population Council staff conducted field visits to six districts around the country: Islamabad, Rawalpindi, Jhelum, Haripur, Lahore and Karachi. These districts were selected based on the presence of USAID-supported activities, geographic diversity, and accessibility. Interviews were conducted with more than 100 respondents, including public and private family planning service providers, outreach workers (LHWs and agents of the social marketing projects), family planning clients, VS clients and, in some districts, local officials of the MOPW and the MOH. The facilities were selected by the teams based on convenience, generally using clinic lists provided by Greenstar and Key, and an attempt to include a variety of facilities/providers (public/private, large/small, etc.). All clients interviewed were selected from those present at the facilities at the time of the team visits. Prior to the trip, questionnaires and discussion guides had been finalized with the assistance of Population Council staff and translated into Urdu. These can be found in Annex 4. Table 1 below summarizes the number of respondents interviewed by category. The majority of the facilities visited (37 of 41) were private, primarily providers in the Greenstar network.

TABLE 1: SUMMARY OF RESPONDENTS INTERVIEWED BY LOCATION AND CATEGORY

	Facilities	Clinic Staff Interviews	Outreach Worker Interviews	Family Planning Clients	Family Planning Observations	VS Client Interviews	Total Interviews
Haripur	3	2	3	1	0	5	11
Islamabad	3	3	2	4	1	0	10
Jhelum	2	3	7	5	0	2	17
Karachi	17	17	4	1	0	1	23
Lahore	9	10	3	10	2	4	29
Rawalpindi	7	8	4	3	0	0	15
Total	41	43	23	24	3	12	105

On June 29, team members led a training session on the family planning statutory and policy requirements for approximately 20 representatives of USAID/Pakistan and implementing partners. The cooperative agreements for the Mission's three main health/family planning projects, as well as a sample of sub-agreements, were also reviewed for inclusion of the appropriate clauses.

PAKISTAN AND THE STATE OF FAMILY PLANNING

Pakistan, the seventh most populous country in the world, has a population of approximately 145 million people (as of 2003). It has relatively poor health and economic indicators compared to other countries in Asia, with high maternal mortality (350-435 deaths per 100,000 live births), high infant mortality (an estimated 83 infant deaths per 1000 births), and high neonatal mortality (60% of infant mortality rate).

Family planning in Pakistan has a long history; efforts go back to 1952 when the Family Planning Association of Pakistan, an affiliate of the International Planned Parenthood Federation, was established. Since that time, there have been a number of starts and stops, shifts in policy and changes in programmatic approach. From the mid-fifties to 1970, there was relatively strong political support for the program; basic infrastructure was put in place in the public sector and a range of contraceptives was

introduced. In the early seventies, there was political opposition to the program, and many activities came to a halt. Then, in the late ‘70s and early ‘80s, when family planning activities became more acceptable, a “population and development” approach was promoted. By the 1990s, a strong base of support for reproductive health services had been established at all political levels and family planning outlets were becoming widespread. Since 2000, the Musharraf government has become increasingly supportive of family planning programs, giving political prominence to the Ulaama (religious leaders) Conference on Family Planning in May, 2005, as well as the Population Summit and establishment of the National Population Commission in September, 2005. Population and family planning is currently receiving the highest level of political support in Pakistan. Government financial support is increasing and donor financial support and technical assistance is well received.

It is clear that a significant fertility decline is underway in Pakistan, which started in the mid to late 1980s. (Miller and Haque, 2004). From the period between 1987 and 2001, the total fertility rate (TFR) dropped from 6.9 to 4.1, and it is likely that further declines have occurred in the last five years (data collection for the 2006 DHS will begin this summer). A major contributing factor to this decline is contraceptive use, measured by the contraceptive prevalence rate (CPR). Pakistan’s National Institute of Population Studies (NIPS) national survey (2003) is the most recent source of data on this issue, although the final report of this survey has yet to be published. Contraceptive prevalence for married women of reproductive age (all methods) was 32.1 percent in 2003 (NIPS), up from 11.8 in 1990 and 23.9 in 1996. Age at marriage, which has been rising, also contributes to declining fertility.

Despite the fact that CPR has risen steadily over the last fifteen years, unmet need for contraception is still substantial. Unmet need is a measure of the number of married women of reproductive age who wish to space or limit their children and are not using contraception. The NIPS 2001 survey indicates that overall unmet need is approximately 33 percent, with unmet need for spacing at 12.1 percent and unmet need for limiting at 20.9 percent. These numbers highlight the importance of further expanding the availability of temporary, long term, and permanent contraceptive methods in order to meet the needs of all women and couples at various stages in their reproductive life cycles.

The National Population Policy of Pakistan (2002) identifies rapid population growth as a threat to economic and social development, as well as to improvements in the health of the population. The policy suggests that high population growth rates undermine efforts to reduce poverty and to increase the living standards of the population. The overall vision of the policy is to achieve population stabilization by 2020 through accelerated declines in fertility and mortality rates by promoting increased access to and quality of services, and broader knowledge, greater demand and informed choice on the part of individuals in order to achieve optimal birth spacing. In operational terms, the policy proposes to reduce the high unmet need for family planning services by “bringing FP services into the fold of health outlets, and developing greater partnerships between various arms of the public and private sector.” Service provision expansion will place special emphasis on underserved poorer areas of cities and the rural areas, and will utilize community-based workers to make information and services more available. Advocacy at the national and provincial levels, as well as training and capacity building to improve provider skills, are key components of the policy.

The responsibility for implementing the Population Policy is shared by the MOPW, the MOH, and the National Program for Family Planning and Primary Health Care (NP-FP/PHC), which is a special program of the MOH. The responsibilities of the MOPW include advocacy, policy setting and planning, development of IEC materials, social marketing, training for voluntary sterilization (VS) and provision of family planning and VS services. Structurally, the MOPW maintains policy and administrative offices at the national and the provincial levels, as well as twelve regional training centers. Service delivery outlets include family welfare centers (FWCs) and Reproductive Health Service Centers (RHSC) where VS and other contraceptive methods are provided. The MOPW also operates a limited number of mobile health

units. There are two types of reproductive health service centers. An RHSC-A operates within an MOH facility, most often a district hospital, but the MOPW provides the staff and supplies for VS and other methods (the hospital may provide support staff, such as an anesthetist). In order to expand the availability of VS services beyond public hospitals, the MOPW also certifies private clinics to provide VS and reimburses them according to an established cost structure. These facilities are known as RHSC-B.

The responsibilities of the MOH include provision of a broad range of health and family planning services through a range of outlets across the country. Service facilities, starting from the lowest level, include Basic Health Units (BHUs), Rural Health Centers (RHCs), dispensaries, and hospitals at the Tehsil and District levels, and teaching hospitals. Providers employed by the MOH include doctors, lady health visitors (LHVs), who provide all contraceptive methods except VS, and lady health workers (LHWs), who are community-based outreach agents who provide information and motivation on family planning methods (as well as other basic health information), refer for clinical methods, and distribute pills and condoms. The LHWs are supervised by Lady Health Supervisors (LHSs). The LHW program is under the NP-FP/PHC of the Ministry of Health. The LHWs are responsible for an integrated package of health and family planning services in the community, and reflect a movement toward integration of the health and family planning activities in order to increase efficiency and expand availability of services. They are typically linked with a Rural Health Center

SUMMARY OF USAID FAMILY PLANNING PROGRAMS

The current program of USAID support started in 2003 and is formalized in a Strategic Objective Agreement (SOAG) with the Government, and in Cooperative Agreements (CAs) with Greenstar Social Marketing, the Futures Group, which implements the Key Social Marketing project, and JSI, which is the lead partner implementing the Pakistan Maternal and Newborn Health (PAIMAN) project. USAID's support to family planning is part of a larger health support program, all of which is covered by the SOAG. The five-year, $115 million program is designed to increase access to, and the quality of, health and reproductive health services.[3] The program supports ten out of twelve objectives outlined in the GOP's Reform Strategies for the health and population sectors in the Ten Year Perspective Development Plan (2001-2011). The program promotes the health of women and children through interventions that can be sustained over the long term, with an emphasis on utilization and quality of services. Concerning family planning, by working with the private sector, USAID is assisting in a nationwide expansion of reproductive health services to peri-urban and rural areas by offering women a wider range of contraceptive choice, better information and closer service delivery centers. USAID is also collaborating with other donors, including UNFPA and DFID, to maximize efficiency of the program and assure commodity availability.

USAID's primary support to family planning activities in Pakistan is implemented through two social marketing programs, Key Social Marketing and Greenstar Social Marketing. While Key uses a "manufacturer's model" to enhance local capacity to produce and market unsubsidized contraceptives, Greenstar works with private sector doctors and LHVs to improve the availability of subsidized contraceptives and the quality of family planning counseling and services. Both Key and Greenstar have strong community outreach mechanisms designed to improve knowledge, enhance demand, and increase access to family planning services.

In 2003, when the current agreements were put in place, the Mission emphasized the importance of reaching the poorest of the poor, targeting subsidies to those most in need, and assuring collaboration and

[3] The SOAG was amended in August 2006, with funding increased to $168,538,000.

coordination between the two social marketing partners and the activities of the Government's program. This emphasis and coordination required substantial planning, but areas of responsibility have been outlined, coordination with Government programs is well-established, and work plan activities of both Key and Greenstar are now under way.

Greenstar, a locally incorporated social marketing organization, has developed a branded line of subsidized contraceptive products which are distributed nationally through pharmacies and a network of Greenstar-associated private providers, who operate their own clinics. These providers, including doctors and LHVs, are offered training in basic and advanced family planning and are supported by Greenstar with IEC materials, refresher training, and commodity resupply. They are regularly visited by a supervisor who brings supplies, assesses the quality of the facility and the services being provided, and reviews performance. Greenstar also employs community outreach workers who work in their communities to increase knowledge of and demand for family planning, and refer women to Greenstar clinics for initiation of contraceptive use, resupply, and voluntary sterilization. The Greenstar provider, working with the community outreach worker, frequently organizes "camps." A camp is a free clinic day, generally held by an LHV or doctor who is providing temporary methods. On camp day, the consultation and (sometimes) the method is provided free. A camp may also be held by a Greenstar-associated doctor to provide VS. Greenstar also manages a program for VS providers within its network who are seeking reimbursement for VS from the MOPW and "plusses up" the level of MOPW reimbursements with program income generated under the USAID cooperative agreement (CA). In addition, Greenstar is implementing media campaigns designed to promote the concept of birth spacing and expand knowledge of all family planning methods. Interpersonal communication counseling materials and training are being provided. Greenstar is also training LHWs, through its subgrantees, to improve coverage and mobilize demand for family planning in rural areas of five districts.

Key Social Marketing, a project of the Futures Group, works with the private pharmaceutical sector, using a "manufacturer's model," to expand availability of unsubsidized contraceptives, and to market these full-priced contraceptives nationally under the Key logo. A network of private sector providers, including doctors and LHVs, has been trained. Key has developed media messages to create demand for short- and long-term methods of contraception and has trained doctors and LHVs to conduct community outreach through the Mahalla Sangat program; "mahalla sangat" refers to a community meeting. At these community meetings, the LHV provides information, promotes birth spacing, provides non-clinical family planning methods and refers for clinical methods. Audio cassettes are also distributed to promote additional couple and community-level discussion and promote use of family planning. Key's CA reflects plans to expand its assistance to the government's program by providing training in motivation and modern method provision to LHWs. However, these plans are currently on hold due to concerns about overlap with the Greenstar program.

The purpose of the PAIMAN project, an activity supported with health funds, is to improve maternal and newborn health in 10 districts through capacity building of existing programs, structures, and people working within health systems and communities. In addition to increasing awareness and promoting positive maternal and neonatal health behaviors, PAIMAN is working to increase access to maternal and newborn health services, including essential obstetric care. The project works extensively with the government, aiming to improve management and services at all levels within the 10 districts. A special focus of the project's technical assistance is the LHWs. PAIMAN has received permission from the MOH to work with the NP-FP/PHC and Save the Children (a PAIMAN partner) will be involved in training LHWs. The project is currently revising the curriculum for LHWs based on a life-cycle approach, and will provide training to LHWs in this integrated approach. LHWs will prepare maps showing families in their catchment areas and identify various maternal and child health needs of each family. Family planning counseling, method provision, and referral for surgical methods are key activities for LHWs. Although the LHWs' FP-related activities are not specifically a focus of the PAIMAN project, these

activities will benefit from PAIMAN training to develop LHW skills in working with small groups and improving interpersonal communications. This integrated approach, implemented at the ground level by the LHWs - employees of the MOH - effectively links USAID's support for public sector health activities to public sector FP service delivery.

In sum, the Pakistan family planning program is being implemented by a number of partners and stakeholders, each of whom is making a major contribution to its current success. The Government, NGOs, donors, and the private sector are all contributing to the progress that has been achieved in making high quality family planning and reproductive health services available to all economic sectors of the population. For its part, the Government's population policy and programs through the MOPW and the MOH emphasize informed decision-making by individuals and couples and increased access to affordable services. At the same time, the Government's population policy acknowledges the challenges both to economic development and to the health of mothers and children of sustained high fertility and rapid population growth. A comprehensive system of service delivery outlets and service providers, with the community-based LHW program as the ground-level building block, has been developed and is becoming fully operational. The coverage of the system is extensive and the potential for impact is great. Increased coordination between private and public sector FP services and increasing integration of public sector health and FP activities appear to be two positive and potentially fruitful program directions. At the same time, it means that, although USAID focuses its assistance on private sector FP and public sector health, it must nevertheless remain alert to Tiahrt compliance issues in public sector FP service delivery in Pakistan.

TIAHRT REQUIREMENTS AND RELATED POLICY

THE TIAHRT AMENDMENT

The Tiahrt Amendment, first passed in 1998 as part of the U.S. annual foreign operations appropriations law, provides that funds appropriated under the act shall be made available only to voluntary family planning projects that meet the following requirements:

1) service providers or referral agents in the project shall not implement or be subject to quotas or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes);
2) the project shall not include payment of incentives, bribes, gratuities, or financial reward to: (A) an individual in exchange for becoming a family planning acceptor; or (B) program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning;
3) the project shall not deny any right or benefit, including the rights of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual's decision not to accept family planning services;
4) the project shall provide family planning acceptors comprehensible information on the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method; and
5) the project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits.

The Tiahrt Amendment requires that the USAID Administrator report to the U.S. Congress within 60 days of determining that a single violation of provisions involving targets and quotas, financial rewards, withholding of benefits or experimental contraceptives has occurred. It requires reporting on violations of the comprehensible information requirement only where a pattern or practice of violations is found to exist.

THE 1999 TIAHRT GUIDANCE AND USAID POLICY DETERMINATION 3

Elements of the Tiahrt Amendment are interpreted, to the extent possible, in accordance with USAID's *Guidance for Implementing the "Tiahrt" Requirement for Voluntary Family Planning Projects* (hereinafter, the 1999 Guidance)--guidance which was issued in April 1999 after extensive consultations between USAID and Congressional staff. In addition to providing interpretations of specific Tiahrt elements (e.g., pertaining to targets and quotas), the Tiahrt Guidance incorporates by reference USAID Policy Determination 3[4] and states that "USAID will continue to implement other statutory and policy requirements and objectives in accordance with existing guidance."

PD-3 contains specific requirements for USAID-supported family planning programs that involve direct support for voluntary sterilization, including requirements for informed consent and ready access to other methods. An addendum to PD-3 establishes limitations on payments to acceptors, service providers, and referral agents as well as guidance for determining, in instances where USAID provides direct support for sterilization, whether such payments are reasonable.

At present, the addendum to PD-3 is USAID's chief source of guidance on the types of payments to acceptors, service providers, and referral agents that are permissible *as a matter of policy*--payments that are not considered to operate as incentives for sterilization. The underlying principle is that payments are permitted when they make sterilization equally financially accessible to clients as other FP methods. Thus, PD-3 states that "recompense to acceptors for legitimate, extra expenses related to VS program services such as transportation, food during confinement, medicines, surgically related garments and dressings and the value of lost work are not considered incentive payments and are eligible for USAID support." It adds: "For example, payment for lost work must correspond to a reasonable estimate of the value of lost labor over a reasonable duration of convalescence." In a similar vein, per-case payments to service providers are acceptable under PD-3 when they are determined to be "reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for the providers to carry out VS procedures compared to provision of other methods of family planning." Finally, PD-3 permits limited payments to referral agents, stating "When extra expenses are incurred in informing and referring VS acceptors, a per-case payment of these costs is acceptable."

PD-3 is particularly useful for interpreting the Tiahrt provision relating to acceptor payments.[5] In incorporating PD-3 by reference in its official guidance, USAID has essentially confirmed that it reads the policy and statute together. Interpreting Tiahrt in the context of PD-3, USAID has continued its support for family planning programs that involve limited reimbursement or compensation payments to VS acceptors, provided that they are geared toward making VS equally accessible as other methods and that the payments are reasonably related to the expenses clients incur in undergoing the procedure.

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[4] USAID originally issued PD-3 as PD-70, on June 14, 1977. An addendum was issued to PD-70, on February 9, 1981. Both the PD and its addendum were re-issued as part of USAID's Policy Paper on Population Assistance in September 1982.

[5] PD-3 is less relevant for interpreting Tiahrt in the case of payments to service providers and referral agents, because, under the statute, payments to "program personnel" are only prohibited in the context of targets and quotas, which are prohibited elsewhere under the statute. Thus, Tiahrt violations involving payments to providers and referral agents are more likely to hinge on whether targets and quotas are present.

Under PD-3, the Agency is responsible for determining the reasonableness of payments in the local context, in instances where USAID provides direct support for VS.

KEY LEGAL ISSUES

The team focused its assessment around the following key legal issues:

- **Applicability of Tiahrt and PD-3**: Does the nature of USAID assistance to private and public sector FP service delivery in Pakistan trigger application of the Tiahrt Amendment and, if yes, to what geographic area does Tiahrt apply? Does the nature of USAID assistance to private and public sector VS service delivery in Pakistan trigger application of PD-3?
- **Targets for LHWs:** Are targets applied to LHWs in Pakistan and, if so, are they of the type prohibited by Tiahrt? Are targets applied in geographic areas where USAID currently provides or plans to provide assistance that directly benefits FP service delivery, for purposes of Tiahrt?
- **Compensation Payments for VS Acceptors/Providers:** Are compensation payments made to acceptors of sterilization and to referral agents in private and public sector facilities consistent with guidance on permissible payments under PD-3? Are payments to VS service providers consistent with PD-3?

The team also addressed provisions on comprehensible information under Tiahrt, requirements for informed consent under PD-3, and other issues, as set forth in its scope of work.

FINDINGS AND ANALYSIS

APPLICATION OF TIAHRT

LAW AND POLICY

Application of the Tiahrt Amendment is established by the following introductory language in the statute: "Funds [made available under this heading] shall be available only to voluntary family planning projects…and that any such voluntary family planning projects shall meet the following requirements…" Elaborating on the kinds of "projects" covered by Tiahrt, the 1999 Guidance states, on p. 2, that:

> Tiahrt requirements apply to service delivery projects (discrete, self-contained family planning activities that deal directly with "acceptors"—people) to which USAID provides assistance (funds, goods or services). The projects would include, for example, publicly operated clinics, mobile outreach/seasonal clinics, commercial or private clinics and community based door-to-door services when USAID provides support for any of these projects.

The 1999 Guidance adds that: "The Tiahrt requirements do not apply to USAID assistance for other kinds of population activities—such as a broad information campaign, surveys and data collection, strategic planning, evaluation, biomedical and social science research and publications—that are not *conducted by or for the direct benefit of a specific FP service delivery project*." (Emphasis added.)

The Guidance states that "the Tiahrt clause focuses on the service delivery component, or "project", conducted by an organization that may receive assistance. If no USAID assistance is provided to the service delivery project(s) implemented by an organization, USAID may provide support to other components of an organization's program or other activities conducted by an organization without reviewing how its service delivery projects are implemented." It adds: "The Tiahrt requirements apply only to an organization's family planning service delivery projects for which USAID provides assistance. USAID is not responsible for an organization's family planning service delivery projects that are financed by other sources of funds." Finally, the Guidance makes clear that assistance may be in the form of cash, technical assistance, commodities or training.

Based on the Guidance, Tiahrt will apply when and where USAID assistance in any form provides direct benefit to specific FP service delivery activities.

FINDINGS AND ANALYSIS

As noted above, USAID's assistance for FP service delivery is focused primarily on supporting growth and development of private sector networks under the Greenstar and Key programs. Assistance to the private networks focuses, in turn, largely on service delivery, including training of service providers in counseling and basic and advanced service delivery, and on supply of IEC materials and FP commodities.[6] Greenstar uses its USAID funding almost exclusively to support training and supervision of service delivery, including support for "camp" days offered by providers in its network. Futures Group, under the Key program, concentrates on training for service delivery and demand generation through Mohalla Sangats. Given this direct support for service delivery, it is clear that Tiahrt applies throughout the private networks supported by USAID/Pakistan under the Greenstar and Key Social Marketing Programs.

However, as indicated above, Greenstar and Key, to a lesser extent, are increasingly collaborating with the public sector on FP service delivery in Pakistan, as follows.

- Based on interviews and review of documents, it appears that Greenstar has, in the past, provided training to approximately 50 public sector providers in surgical sterilization techniques[7] and that Greenstar sends its physicians to the MOPW for clinical training in VS.
- Through an agreement with Save the Children, Greenstar is currently training LHWs (who are employees of the MOH) in FP counseling and service provision in four districts, including Haripur, Swath, Swabi, and Abbotobad. Greenstar also has an agreement with the Pakistan Voluntary Health & Nutrition Association (PAVHNA) to train service providers, possibly including public sector providers, in Larkana district.
- Until recently, LHWs referred FP clients into the Greenstar private network on an ad hoc basis. However, Greenstar and the MOH have recently signed a Memorandum of Understanding, which among other things expands this to a more routine practice.
- Greenstar, using "non-federal" program income, manages aspects of the process by which MOPW reimburses Greenstar private clinicians for providing VS services, and itself reimburses additional amounts for those services.[8] Both Greenstar and Key provide clinical and other service

[6] Under the Greenstar CA, commodities are funded, not by USAID, but by DFID and UNFPA. For the Key program, Futures Group's CA states that it leverages commodity supplies from private local manufacturers at no cost to the project.

[7] Greenstar advised that training for public sector doctors was initially covered using USAID funding under the CA, but that it was adjusting its budget to cover these costs with its non-federal program income.

[8] Greenstar gathers documentation from its network providers, submits and follows up requests for reimbursement to the MOPW. It also augments the amount reimbursed to the providers, based on a formula which is closer to full cost

delivery training to private sector providers who, in significant numbers, also spend part of their day working in the public sector.

- The Futures Group CA for the Key program reflects plans for significant investment in training LHWs in counseling and demand generation and also proposes future involvement in a vouchering system for government reimbursement of VS performed by Key network providers. Plans for Key's expanded coordination with the public sector appear to be on hold at the moment and may not be implemented. Should these plans be re-instituted, however, this would represent a significant expansion of USAID's support for public sector FP in Pakistan.

The increasing coordination between government and private sector in FP service delivery evidenced by these program activities appears to be a very positive programmatic step. At the same time, when coordination translates into USAID assistance for the direct benefit of public sector service delivery, it triggers application of Tiahrt in the geographic areas where the benefited service delivery takes place.

Of the activities cited above, some appear to imply direct benefit to public sector service delivery—such as training for public sector physicians in surgical techniques and training for LHWs in FP counseling and service provision in four or possibly five districts. In contrast, there is a reasonably strong argument to be made that accepting referrals from LHWs, participating in the MOPW reimbursement system, sending Greenstar providers for training in the public sector, and training private providers who also work in the public sector involve only indirect benefits to public sector service delivery. Depending on the circumstances, we might for general policy reasons hesitate to parse the facts too closely in order to argue that Tiahrt applies only to the former activities and not the latter as a matter of law. Nevertheless, the argument can legitimately be made, and this is the approach that the team has taken.

The situation with respect to the PAIMAN program is similar. As indicated above, PAIMAN, although it receives only health monies and is focused on maternal and newborn health activities of the MOH, also includes activities which, when implemented, will involve direct benefits for public sector FP service delivery in 10 districts. These activities include: working with the MOH to emphasize skills building in the LHW curriculum; refresher training for LHWs in FP counseling, referral and service delivery; and identifying and training a new cadre, Community Midwives (CMWs), in counseling, referral and service delivery. While it is not yet clear where or whether the CMWs will have an institutional home, it is possible that they will serve as MOH employees. In any case, they will likely serve as an important link for prospective FP clients into public sector service delivery.

The above described PAIMAN activities are all still in the start up phase. Once they begin to be implemented, they will trigger application of Tiahrt to service facilities in the 10 PAIMAN districts.

CONCLUSIONS

Tiahrt currently applies to private sector service delivery throughout the USAID-supported Greenstar and Key service delivery networks. It also applies to public sector service delivery activities in the geographic areas where Greenstar is currently providing assistance which directly benefits those activities, that is, at minimum, in the 4 or 5 districts where Greenstar is currently providing training for LHWs in family planning counseling, referral and service delivery. Should Greenstar expand its training for LHWs, Tiahrt will apply in those new areas. In the event Key initiates training for LHWs under existing language in its CA, Tiahrt would apply at least in those areas as well. Tiahrt will also apply to public sector FP service delivery in the 10 PAIMAN districts when the program begins providing direct benefits to public service FP delivery through support for training of LHWs and CMWs.

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recovery for the provider than the MOPW payment alone. This additional payment is financed with Greenstar's program income under the CA, which is treated as additional, non-federal support for the program.

APPLICATION OF PD-3

POLICY

Application of PD-3 is determined under different standards than Tiahrt. First, PD-3 applies only to voluntary sterilization programs and, by its own terms as set forth in Section 2 of its 1981 Addendum, applies only "if USAID funds are used for whole or partial direct support of the performance of VS activities." The Addendum goes on to state that the provisions of PD-3 do not apply in the case where "VS activities may be part of the host country's program, but USAID funds are not used to support such services." It elaborates:

> For example, if USAID support for VS program activities is geographically confined to particular parts of a country, PD-3 applies only to those areas with VS program activities supported by USAID. PD-3 does not apply if activities and projects are only *peripherally related to provision of VS services*, for example, USAID support for construction of multipurpose buildings or *broad-based training in reproductive health which includes VS techniques.* Finally, in USAID supported population and family planning programs in host countries which use USAID funds for activities other than VS and VS support activities, with their own or other non-USAID funds, PD-3 does not apply. (emphasis added)

That broad-based reproductive health training is distinguished as only indirect or peripheral support for VS is an important aspect of the guidance on application of PD-3. In contrast, Tiahrt applies whenever USAID finances FP-related training for service providers, with an exception only for "short-term, widely attended training conferences or programs."

FINDINGS AND ANALYSIS

Consistent with the discussion above, it appears that USAID is providing direct support for VS in the private sector through Greenstar, since USAID's funding goes to support not only training for doctors in surgical sterilization techniques, but also for supervision and operation of periodic "camp" or free clinic days where VS is performed. Accordingly, USAID must be attentive to compliance with PD-3 requirement within the private sector Greenstar network. Although the Key program is not currently working in the area of VS, if Futures Group were to initiate the VS voucher program described in its CA, this would give rise to application of PD-3 to such activities.

With respect to Pakistan's public sector program, it appears that USAID's support for VS, through Greenstar and eventually through PAIMAN, is or will be limited to broad-based reproductive health and family planning training for LHWs, which includes training on referral for VS. Under PD-3, these types of activities are considered "only peripherally related to provision of VS services" and therefore do not trigger application of PD-3.

Because PD-3 is not applicable to USAID's support for Pakistan's public sector VS program, it is not necessary for the public VS program to comply with PD-3 requirements. Nevertheless, in this particular instance, the team believes it is useful to address acceptor payments and informed consent in the public VS program, in a manner consistent with PD-3, as a means of addressing Tiahrt concerns.

With respect to acceptor payments, PD-3 provides a mechanism by which USAID can review and determine, for the record, that public sector acceptor payments serve only as reasonable compensation for costs associated with the VS procedure and do not constitute prohibited incentives or financial rewards in exchange for sterilization under Tiahrt. Without such an analysis in place, USAID support for the public VS programs remains vulnerable to criticism and potential Tiahrt violations. The private sector currently

follows, and will probably continue to follow, the government's lead in setting the level of compensation. Thus, the team considers it advisable for the Mission to address the issue of VS acceptor payments in the public and private sector programs together, in accordance with PD-3.[9]

With respect to informed consent, the public sector's current use of informed consent documentation of the type specified in PD-3 is a best practice and a useful way to promote Tiahrt objectives on comprehensible information. The team believes it is advisable for the Mission to encourage continued use of PD-3 type informed consent for VS in the public sector, to the extent it is feasible to do so given USAID's indirect involvement in public sector VS. These practices are expected to reduce vulnerability to Tiahrt violations and challenges to voluntarism over the long run.

CONCLUSIONS

PD-3 applies to Greenstar's VS program. If, in the future, Key begins to implement VS activities as described in its CA, PD-3 will apply to those activities. Although PD-3 does not apply to the public sector, the team believes it is advisable to address acceptor payments in the public and private sectors together, in accordance with PD-3 procedures. This will help address potential Tiahrt concerns in the government's program and takes into account the government's role in setting acceptor compensation policies for both public and private sector VS. The team also considers it advisable to encourage continued use of PD-3 type informed consent documentation, as a best practice, in the public sector as well.

TARGETS FOR LHWS

LAW AND POLICY

Section 1 of the Tiahrt Amendment provides that, in service delivery projects supported by USAID, "service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes)." The 1999 Guidance defines "quota or target" as "a predetermined number…that a service provider or referral agent is assigned or required to affect (SIC) or achieve."

FINDINGS AND ANALYSIS

In its field work, the team found no evidence of quotas or targets being assigned to individual providers in the private sector networks supported through Greenstar or Key Social Marketing. In one instance, a Key LHV made reference to an expectation that each gathering of a Mohalla Sangat would yield two FP acceptors, but upon further inquiry it appears that this number was merely a planning indicator to enable Mohalla Sangat leaders to judge whether their messages were affecting behavior; it was not a number that providers were required to achieve.

Similarly, in public sector facilities, the team saw no evidence of *systematic* application of targets, as targets are defined by Tiahrt, to any FP providers or referral agents. (NB: Many FP service providers in the public system also function as referral agents for the methods that they do not provide. For example,

[9] Unlike the case of payments to acceptors, where a PD-3 analysis is relevant to determining whether an incentive or financial reward violative of Tiahrt exits, the team is not recommending the Mission conduct a PD-3 analysis of payments to public sector providers or referral agents as such an analysis would have no bearing on the Tiahrt analysis. This is the case because Tiahrt is triggered by payments to program personnel only when targets are also present, which is not the case here.

LHWs refer clients to LHVs for IUD insertion and both LHWs and LHVs refer clients to doctors at public hospitals or private clinics for VS.) Public facilities appeared to use statistical information, which they might refer to as "targets", to measure their success or failure to satisfy prior estimates of unmet need. These numbers were used to track the facility's relative performance from year to year, but they did not represent numbers that individuals or even the facilities were required to achieve.

Although the team found no systematic use of targets, in one district visited by an assessment subteam, there were consistent reports that LHWs were subject to a target of one sterilization client per month among a team of either two or three LHWs. This was initially reported by an LHS and LHV at one facility and subsequently confirmed by a group of LHWs working from the same facility. That day, another LHV confirmed this practice in that particular district. Finally, a former district health official from the same district confirmed the practice and related the following history of targets in the province. He indicated that some years earlier provincial officials had made a strong push to increase family planning acceptance. Committees were established at the district level and met regularly to review progress. Targets for LHWs were instituted at this time and were enforced through threats of salary suspensions. Although, to the assessment team members, the targets appeared quite low, the former official indicated that even at this level LHWs found the target difficult to achieve. This appears to be the type of target prohibited by Tiahrt.

The former official explained that, within a year of the creation of the district committees, there was new emphasis placed on a target-free, optimal birth spacing approach. At this point, many facilities that had imposed LHW targets dropped them, while some did not. The district health system was highly decentralized and individual facilities were allowed to pursue their own practices. The interviewee indicated that district-level committee meetings eventually fell off; he was not aware of any systematic use of targets in the relevant district at the time of the assessment.
The district where targets were found is not one where Greenstar subrecipients or PAIMAN partners are currently training LHWs. The team is not aware of targets in the four or five districts where USAID partners are currently conducting LHW training, however the team did not visit those specific areas. The team did not, during its visit, learn of any instance or location where Tiahrt violations should be considered likely at the present time. However, if targets for LHWs are in place or persisting in districts where USAID is currently funding FP activities, then USAID's program is vulnerable to Tiahrt violations. Similarly, if targets persist in areas where USAID will be expanding its support for public FP services, the program will be vulnerable to Tiahrt violations in the future.

At the national level, MOH and MOPW officials were for the most part unanimous in their opposition to the use of targets to promote family planning acceptance. One or two officials contradicted themselves on this subject, but when asked for clarification agreed that the target-free approach was preferred. It was not always clear whether they were referring to targets as Tiahrt defines them, or other kinds of indicators.

CONCLUSIONS

The team found no use of targets for service providers in the private sector social marketing programs USAID supports, only tracking of quantitative data. In the decentralized public FP program, the team found no evidence of any widespread or systematic use of targets of the type prohibited by Tiahrt. However, based on the limited review conducted by the team, it appears that there remains some "vestigial" use of targets, of the type prohibited by Tiahrt, by some public sector facilities in some districts where USAID may be working in the future under the PAIMAN program.

RECOMMENDATIONS

The team recommends the Mission follow up to ensure that LHW targets are not being implemented in the four or five districts where Greenstar is currently conducting LHW training. It also recommends the Mission follow up at appropriate levels within the GOP to ensure that LHW targets are not and will not be implemented in the 10 PAIMAN districts or in other areas where Greenstar and Key are or will be assisting public FP service provision. For practical and policy reasons, it may be generally advisable to stress compliance with Tiahrt requirements throughout the areas where USAID's private and public sector partners are cooperating.

PAYMENTS FOR ACCEPTORS, REFERRAL AGENTS AND PROVIDERS

LAW AND POLICY

Under Section (2) of the Tiahrt Amendment, USAID-supported FP projects shall not include payment of incentives, bribes, gratuities, or financial reward either to "an individual in exchange for becoming a family planning acceptor" or to "program personnel for achieving a numerical target or quota of a total number of births, number of family planning acceptors, or acceptors of a particular method."

PD-3, which is incorporated by reference into the 1999 Tiahrt Guidance, however, permits compensatory payments to VS acceptors which are limited to amounts necessary to cover "legitimate, extra expenses related to VS program services, such as transportation, food during confinement, medicines, surgically related garments and dressings and the value of lost work." PD-3 also allows per case payment to referral agents "when extra expenses are incurred in informing and referring VS acceptors" and per case payments to VS providers when the payments are "reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for the providers to carry out VS procedures compared to provision in other methods of family planning."

In programs where acceptor, referral agent and provider payments are made, PD-3, if applicable, requires that a country or program-specific determination of the reasonableness of such payments be made locally, based on a thorough knowledge of social and economic circumstances.

FINDINGS AND ANALYSIS

Payments to Acceptors: VS acceptors in the Greenstar network receive Rs. 275 (US $ 4.82), of which Rs. 250 is paid by the MOPW; the remaining Rs. 25 is covered by Greenstar from non-federal program income generated through its activities. (The MOPW routinely pays acceptors Rs. 250 (US$ 4.38) in connection with voluntary sterilization in the public system.) The amount of the payment is set by MOPW policy. Greenstar follows the government's lead, but includes a small additional amount in an effort to more fully cover the individual's cost. Acceptors sometimes receive transportation to and/or from the service site, while others are expected to use the payment to cover transportation costs. They often receive medicines, such as vitamins, analgesics and antibiotics, to take home and a refreshment at the service site. Team members heard of some instances where acceptors receive less than the established amount.

The compensatory sum of Rs. 250-275 was universally described as covering lost wages and nourishment for the acceptor for a brief convalescence period. With minimum wages approximating the equivalent of US$ 50 per month, the amount paid equals three or, at the most, four days of wages to cover convalescence. Some acceptors stated that the amount was not enough and one said she could not even buy a bag of fruit with the money. Under the circumstances, it appears that what the MOPW and Greenstar offer to VS clients is well within what would be considered reasonable under PD-3.

The team found no evidence of other payments to FP acceptors. Because Greenstar's payments to VS acceptors appear consistent with PD-3, the team believes they do not violate Tiahrt.

Payments to Referral Agents: Persons who refer individuals for VS in the Greenstar network receive Rs. 175 ($3.07). (Persons who refer individuals for VS under the MOPW system receive Rs. 150 ($2.63)). The amount is intended to cover the person's transportation and time spent with the client and at the facility. As with acceptor payments, the amount paid to referral agents is set by MOPW policy; Greenstar follows the government's lead in this, but with a small "plus up" to more fully cover the referral agents' costs. The team was advised that anyone who accompanies the client to the Greenstar service facility can receive the referral agent payment, including a neighbor or family member. However, it seemed that in many cases the person referring was an LHW, who also receives a monthly salary from the MOH, or other community health motivator.[10] The vast majority of interviewees reported that the person making the referral must accompany the VS client in order to receive the payment. In the rare case where a VS client may come to the clinic alone, the referral agent payment may be paid to the clinic or to the doctor.

In reviewing the Greenstar payments to referral agents, again the team considered this payment to be quite small, reflective of the referral agents' costs in accompanying the patients to VS clinics and consistent with what is permitted under PD-3 for referral agent payments.

Payments to Providers: For the most part, individual VS providers in the public and private sectors do not appear to receive per-case payments for performing sterilization. Public sector doctors are paid monthly salaries and universally reported that they receive no additional payment in connection with performing sterilizations. The same appears to be true of private doctors who are employed on salary in large Greenstar clinics or hospitals.

The one type of VS provider who may be viewed as receiving per case payments for VS is a doctor who owns and operates her own clinic in the Greenstar system. As noted above, because MOPW lacks sufficient facilities to meet the demand for VS, it implements a policy under which it reimburses private clinics that are certified to perform VS Rs 850 (US$ 14.91) per sterilization.[11] This amount is calculated to include the estimated cost of the facility, the surgeon, operating theater and supervisory staff, the lab facility, client and referral agent payments that must be made, and refreshment for the client. Greenstar clinics receive this amount plus an additional sum, paid from Greenstar resources, for a total of Rs. 1500 (US$ 26.31) per case. The amount paid by Greenstar is said to be closer to achieving full coverage for a clinic's cost in providing VS, although it apparently still falls short. Within this sum, the amount calculated to cover the cost of the surgeon is Rs. 150 (US$ 2.63) for a non-Greenstar clinic and Rs. 175 ($3.07) in the case of a Greenstar clinic. A chart showing the breakdown of these costs, which was provided to the team, is included as Annex 5.

Although there is no indication that individual salaried doctors at Greenstar clinics receive additional per-case payments based on these reimbursements, it is clear that the amount of money that a Greenstar clinic owner/operator receives would increase directly with the number of VS procedures she performs. That said, the amounts reimbursed to private clinics for performance of VS are consistent with the types of compensation permitted under PD-3, which include "anesthesia, personnel costs, pre and post-operative care, transportation, surgical and administrative supplies." The amounts do not appear to be excessive and, in fact, there are real questions about whether they are adequate to cover costs. Finally, the amounts

[10] As background regarding the public sector facilities in the field, while visiting public sector facilities, team members encountered family welfare workers and family welfare assistants, both categories of personnel under the MOPW system, serving as referral agents for VS and receiving referral agent payments.
[11] In the Pakistan system, private clinics authorized to perform VS in return for reimbursement from MOPW are referred to as Reproductive Health Service Centers "B", or RHSC-Bs.

available for payment to a clinic owner-provider do not appear to make provision of VS more attractive than provision of other FP methods.

Payments to Program Personnel: The team found no evidence of any payments or other financial rewards made to program personnel in return for achieving specific quotas or targets, in violation of Tiahrt.[12]

CONCLUSIONS

With respect to Tiahrt, which applies to both the public sector and the private sector networks that USAID supports, the team concludes that:

(1) payments to VS acceptors appear consistent with PD-3 and thus do not violate Tiahrt. The team found no evidence of other payments to FP acceptors.

(2) there is no evidence of any payments or other financial rewards made to program personnel in return for achieving specific quotas or targets, in violation of Tiahrt.

With respect to PD-3, which applies to the Greenstar private sector network only, the team concludes that payments to referral agents and provider-owners appear to be low and consistent with the limitations set forth in PD-3.

RECOMMENDATIONS

The team recommends that the Mission, with assistance from the Regional Legal Advisor, make determinations in accordance with PD-3 regarding the reasonableness of compensation payments to 1) VS acceptors in both the public and private sector networks that USAID supports, and 2) referral agents and providers in the Greenstar private sector network, and that it monitor and follow up any proposed changes in the current levels of payment.

DENIAL OF BENEFITS

Under Section (3) of the Tiahrt Amendment, USAID-supported FP projects "shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual's decision not to accept family planning services." The team did not find any evidence of policies or situations where benefits would be or were denied to an individual for refusing to accept family planning.

COMPREHENSIBLE INFORMATION/INFORMED CONSENT

LAW AND POLICY

The Tiahrt Amendment requires that FP projects provide clients with comprehensible information on the benefits and risks of the method chosen. In addition, PD-3 includes a requirement for documenting a client's informed consent prior to undergoing voluntary surgical sterilization.

FINDINGS AND ANALYSIS

Counseling: In general, family planning service providers described their counseling of family planning clients in appropriate terms, saying that they discuss the different methods available, as well as provide

[12] One LHV reported that she had received an award as the top performing LHV in her district in the prior year, not for achieving any particular target, but for across the board performance and that she was given a make-up case. Such an award would not violate the Tiahrt Amendment, as the 1999 Tiahrt Guidance indicates that non-financial, small-value items that are provided to individuals to acknowledge general good performance are permitted.

information on the advantages, disadvantages and side effects of the method chosen. Providers reported that they spend an average of 5-10 minutes on counseling a client. Some noted that they may provide less detailed information to less educated or illiterate women because they felt that they would not be able to understand it. The team was also told that it is common for women to ask for and accept a provider's recommendation about the best method to use, as they are often unwilling to make a choice independently.

IEC materials: Greenstar, the MOH and the MOPW have all produced good quality IEC materials on family planning in general as well as on specific methods. These include flip charts, booklets, and leaflets. The availability of these materials at health facilities, however, was variable. A number of providers visited had only the flipchart and perhaps some marketing posters (which do not generally include information on disadvantages or side effects). Very few had enough booklets/leaflets to distribute them to clients. In addition, there were almost no contraceptive methods wall charts (i.e., Tiahrt posters) seen in any of the facilities, and the team understands that these have not been produced in Pakistan. LHWs at a public facility had a good quality flip chart, but said they did not have IEC material (like brochures) to hand out. The pills that they sell do come with informational inserts.

Package inserts for some of the Greenstar and Key contraceptive products were also reviewed. While some of these (for example, the Greenstar insert for injectables) are very well done in both English and Urdu with excellent diagrams, some other inserts appear to be available only in English. Greenstar also uses a helpful record form for IUD insertion, which includes detailed information on risks, benefits and contraindications in both English and Urdu, and is to be given to any woman accepting an IUD. This item contains only a few illustrations, which may be difficult to interpret. Thus, while effective for counseling literate women, it may be of limited use in counseling the illiterate.

Informed consent: Counseling on VS is generally provided at both the point of initial contact/counseling and again at the time of the procedure. The MOPW has a standard consent form that is used in both public and private facilities that perform VS. The form is printed in Urdu and has separate sections for literate and illiterate women. Pakistan law requires the husband's consent for his wife to undergo the procedure, and this is usually provided in the form of a written note that is attached to the consent form (as men do not generally accompany women to the facility). The team saw the forms at the relevant facilities visited. In addition, for clinics in the Greenstar network, the Assistant Manager Health Services (AMHS) reviews and collects the forms on a monthly basis as part of the process of validating the procedures before reimbursement is made to the facility.

At one private hospital, it was observed that one of the three forms reviewed did not have the signature of the client. The manager noted that the husband's consent was present, but the team pointed out that it was also necessary to have the woman's signature. At another public facility the team observed that clients were signing the consent forms following the procedure, at the same time they were receiving and signing for their allowance payments.

CONCLUSIONS

The team found no evidence of a pattern or practice of failing to provide comprehensible information to clients regarding the contraceptive method chosen. In addition, the team feels that the standards of informed consent are being met on the whole, despite the two lapses cited above. Service providers were aware of their obligation to provide comprehensible information to clients on an array of methods and particularly on the method chosen. While the team saw some excellent IEC materials, useful for counseling both literate and illiterate clients, the distribution of these materials in both public and private sector facilities was very limited. The team saw no Tiahrt-style posters accessible for client viewing in any facilities.

RECOMMENDATIONS

The team makes the following recommendations regarding comprehensible information and informed consent for Mission action:

- Work with implementing partners to ensure they continue to emphasize the importance of quality counseling, and particularly the provision of comprehensible information on the method chosen, to service providers during training and supervision visits.
- Work with the MOH/MOPW and implementing partners to develop a locally appropriate version of a contraceptive methods wall chart, and ensure its distribution to health facilities and service providers receiving support under its programs.
- Work with the MOH/MOPW and implementing partners to improve and maintain the supply of counseling/IEC materials to service providers, and particularly to LHWs. Preferably materials would be produced in sufficient quantity to allow clients to take them home for further consideration or reference.
- Work with the MOPW and Greenstar to reinforce with service providers the need for proper procedures when obtaining informed consent for VS.

EXPERIMENTAL CONTRACEPTIVE METHODS

The Tiahrt Amendment requires that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits. The team is not aware of any experimental methods of FP being used in Pakistan. Accordingly, the provision of Tiahrt relating to use of experimental methods is not applicable.

MONITORING

The importance of monitoring program activities for potential Tiahrt and PD-3 vulnerabilities was discussed during the training session with USAID/Pakistan health and contracts personnel and implementing partners. This included a review of illustrative activities and tools. The team observed that no systematic monitoring has been done to date.

MISSION

The USAID/Pakistan health staff is significantly constrained in its ability to monitor field activities by the security and travel restrictions within which the team operates. Thus they are dependent upon the implementing partners to be their eyes and ears in the field. The Mission has made a point of briefing the partners regarding the statutory and policy requirements and obtaining their support. In addition, they have held discussions with the MOH and MOPW to bring them up to date.

PARTNERS

PAIMAN: JSI, the lead partner under the PAIMAN project, has been particularly conscientious about providing information on the Tiahrt Amendment to subawardees and recipients of community mobilization and innovative project grants. For the community mobilization grants, the provisions are reviewed during the agreement signing session, and a copy of the provisions and Tiahrt Guidance are provided. Given that family planning is not currently part of the scope of work for any of the community mobilization/innovative project grants under PAIMAN, the team noted that this level of attention for these recipients is not necessary.

Greenstar: Greenstar has a supervisory mechanism in place that is well suited to monitoring compliance issues. The AMHS is supposed to visit each provider in her catchment area every 8-12 weeks. During these supervisory visits, she conducts a check of quality standards, replenishes the supply of contraceptive products and counseling materials, and talks with clients regarding the provider's performance. This mechanism would be a good opportunity to specifically address the provision of comprehensible information with providers (as well as to observe performance during counseling sessions) and to get feedback from clients on their satisfaction with the services. In addition, when visiting providers who perform voluntary surgical sterilization, the AMHS should thoroughly review the use of informed consent forms.

Key: Key's relationship with service providers is looser than Greenstar's and the project does not have the resources to follow-up all providers who are trained. The focus for supervision is on the standards-based management and recognition program, whereby 150 trained LHVs will receive regular visits from Key staff and have their performance evaluated against quality standards. Counseling is currently one of the skills evaluated, and this mechanism could provide an opportunity to include other topics related to voluntarism and informed choice.

COMPLAINTS MECHANISM

Clients and community members are also an important part of a compliance monitoring system, particularly for detecting coercive practices. Family planning and voluntary sterilization clients at facilities visited were asked whether they would feel able to complain if they were ever dissatisfied with the services they received. Responses reflected the cultural norms, whereby women would generally only complain to their husbands about poor service; for those receiving services in the private sector, their response would be to seek services elsewhere. For clients in the public sector, some felt that the district health officials would take the side of the providers and nothing would be done. The public health system does not appear to have any formal system for receiving client complaints.

In the private sector, there is no overriding regulatory body, but clients generally have more choices about where to seek services. Although Key and Greenstar do not exercise any real authority over the providers in their networks, they can use their visits to clinics to talk with clients and discover any quality or voluntarism issues that might be present. Greenstar also has a national hotline, the number for which is provided on their television advertisements, which people could call to report problems.

As noted above, the team did not find any evidence of coercion in either the public or private systems of family planning services. Therefore, there does not seem to be a need to put any particular emphasis on establishing a formal complaints mechanism.

RECOMMENDATIONS

The team makes the following recommendations regarding monitoring of compliance issues:

- Work with implementing partners to develop systematic mechanisms for monitoring and reporting on Tiahrt and PD-3 issues.
- Work with implementing partners to assure that training materials for LHWs and community midwives address issues of voluntarism and targets, so that they are aware of activities that would be considered impermissible.
- Work with implementing partners to establish regular mechanisms to orient all existing and new staff on the family planning requirements.

SUMMARY OF CONCLUSIONS

Application of Tiahrt and PD-3: Tiahrt currently applies to private sector service delivery throughout the USAID-supported Greenstar and Key service delivery networks. It also applies to public sector service delivery activities in the geographic areas where Greenstar is currently providing assistance which directly benefits those activities, that is, at minimum, in the 4 or 5 districts where Greenstar is currently providing training for LHWs in family planning counseling, referral and service delivery. Should Greenstar expand its training for LHWs, Tiahrt will apply in those new areas. In the event Key initiates training for LHWs under existing language in its CA, Tiahrt would apply at least in those areas as well. Tiahrt will also apply to public sector FP service delivery in the 10 PAIMAN districts when the program begins providing direct benefits to public service FP delivery through support for training of LHWs and CMWs.

PD-3 applies to Greenstar's VS program. If, in the future, Key begins to implement VS activities as described in its CA, PD-3 will apply to those activities. Although PD-3 does not apply to the public sector, the team believes it is advisable to address acceptor payments in the public and private sectors together, in accordance with PD-3 procedures. This will help address potential Tiahrt concerns in the government's program and takes into account the government's role in setting acceptor compensation policies for both public and private sector VS. The team also considers it advisable to encourage continued use of PD-3 type informed consent documentation, as a best practice, in the public sector as well.

Targets for LHWs: The team found no use of targets for service providers in the private sector social marketing programs USAID supports. In the decentralized public FP program, the team found no evidence of any widespread or systematic use of targets of the type prohibited by Tiahrt. However, based on the limited review conducted by the team, it appears that there remains some "vestigial" use of targets, of the type prohibited by Tiahrt, by some public sector facilities in some districts where USAID may be working in the future under the PAIMAN program. The district where targets were found is not one where Greenstar subrecipients are currently training LHWs. The team is not aware of targets in the four or five districts where USAID partners are currently conducting LHW training, however the team did not visit those specific areas.

Payments to VS acceptors, providers and referral agents: With respect to Tiahrt, which applies to both the public sector and the private sector networks that USAID supports, the team concludes that:

(1) payments to VS acceptors appear consistent with PD-3 and thus do not violate Tiahrt. The team found no evidence of other payments to FP acceptors.
(2) there is no evidence of any payments or other financial rewards made to program personnel in return for achieving specific quotas or targets, in violation of Tiahrt.

With respect to PD-3, which applies to the Greenstar private sector network only, the team concludes that payments to referral agents and provider-owners appear to be low and consistent with the limitations set forth in PD-3.

Denial of benefits: The team did not find any evidence of policies or situations where benefits would be or were denied to an individual for refusing to accept family planning.

Comprehensible information and informed consent: The team found no evidence of a pattern or practice of failing to provide comprehensible information to clients regarding the contraceptive method

chosen. In addition, the team feels that the standards of informed consent are being met on the whole, despite the two lapses cited above.

SUMMARY OF RECOMMENDATIONS

The team makes the following recommendations for Mission action:

Targets for LHWs:

- Ensure that LHW targets are not being implemented in the four or five districts where Greenstar is currently conducting LHW training.
- Follow-up at appropriate levels within the GOP to ensure that LHW targets are not and will not be implemented in the 10 PAIMAN districts or in other areas where Greenstar and Key are or will be assisting public FP service provision. For practical and policy reasons, it may be generally advisable to stress compliance with Tiahrt requirements throughout the areas where USAID's private and public sector partners are operating.

Payments to VS acceptors, providers and referral agents:

- With assistance from the Regional Legal Advisor, make determinations in accordance with PD-3 regarding the reasonableness of compensation payments to 1) VS acceptors in both the public and private sector networks that USAID supports, and 2) referral agents and providers in the Greenstar private sector network..
- Monitor and follow-up any proposed changes in the current levels of payment.

Comprehensible information and informed consent:

- Work with implementing partners to ensure they continue to emphasize the importance of quality counseling, and particularly the provision of comprehensible information on the method chosen, to service providers during training and supervision visits.
- Work with the MOH/MOPW and implementing partners to develop a locally appropriate version of a contraceptive methods wall chart, and ensure its distribution to health facilities and service providers receiving support under its programs.
- Work with the MOH and implementing partners to improve and maintain the supply of counseling/IEC materials to service providers, and particularly to LHWs. Preferably materials would be produced in sufficient quantity to allow clients to take them home for further consideration or reference.
- Work with Greenstar and, to the extent feasible, with the MOPW to reinforce with service providers the need for proper procedures when obtaining informed consent for VS.

Monitoring of compliance issues:

- Work with implementing partners to develop systematic mechanisms for monitoring and reporting on Tiahrt and PD-3 issues.
- Work with implementing partners to assure that training materials for LHWs and community midwives address issues of voluntarism and targets, so that they are aware of activities that would be considered impermissible.
- Work with implementing partners to establish regular mechanisms to orient all existing and new staff on the family planning requirements.

ANNEX 1:

SCOPE OF WORK

Assessment of Vulnerabilities under the Tiahrt Amendment and Policy Determination-3 in Pakistan

I. Objectives

To assess vulnerabilities in the USAID-supported Pakistan family planning program under the Tiahrt Voluntary Family Planning Amendment and PD-3 requirements and to make recommendations regarding specific findings from the assessment. Specifically:

- Review the use of "targets" within the Ministry of Population Welfare system to determine whether they function as those prohibited by the Tiahrt Amendment
- Assess the levels of compensation being paid to sterilization clients and clinical staff, under both the Ministry of Population Welfare and Greenstar programs, and make recommendations as to whether they are reasonable as per Policy Determination 3.
- Assess whether complete information is provided to clients at contraceptive camps
- Review on-going monitoring efforts to ensure compliance of family planning service delivery projects with the Tiahrt and PD-3 requirements.

II. Background

The principles of voluntarism and informed choice have been at the center of USAID's family planning assistance program since its inception in 1967 and have guided it ever since. In 1982, USAID issued a policy paper on population assistance, which clearly states its commitment to voluntarism in the provision of family planning services. More recently, in 1994 the International Conference on Population and Development gave special attention to these principles and their implementation, incorporating them into the Conference's Program of Action, which was endorsed by 179 governments, including the United States and many of the countries where USAID supports population programs. In 1998, Congress enacted an amendment (the Tiahrt Amendment) to the FY99 Appropriations Act, which legislated specific requirements for voluntary family planning service delivery projects to protect family planning clients. The amendment has been re-enacted with the Appropriations Acts every year since and is expected to remain a part of appropriations law for the foreseeable future.

The USAID/Pakistan health program includes family planning activities through its reproductive health and social marketing components. In particular, the Mission supports two contraceptive social marketing networks: Greenstar and Key. The Mission feels that there are two areas of the family planning program that it supports that may give rise to vulnerabilities under the Tiahrt Amendment. First, the Ministry of Population Welfare (MOPW) uses the term "targets" in relation to family planning users. In particular, Mission personnel have observed that Lady Health Workers have targets for numbers of voluntary sterilization clients. Second, compensation payments are made to sterilization clients (male and female), clinicians and referral agents under both the MOPW and the Greenstar Programs. Given this situation, USAID/Pakistan requested assistance in reviewing its family planning activities.

III. Legal and Policy Requirements

The Tiahrt Amendment While the principles of voluntarism and informed choice guide USAID's entire population program, the specific requirements of the Tiahrt Amendment apply to *projects* that receive USAID family planning assistance (in the form of funds, goods, services) *and* involve service delivery activities. The Tiahrt Amendment requires that:

- Service providers and referral agents not implement or be subject to quotas or other numerical targets;
- Individual family planning acceptors not be subject to incentives tied to the acceptance of a family planning method and program personnel not be subject to incentives tied to the achievement of predetermined targets or quotas;
- Individuals not be denied rights or benefits based on their decision not to accept family planning services;
- Family planning acceptors be provided comprehensible information on the health benefits and risks of the method chosen; and
- Studies of experimental family planning methods advise participants of potential benefits and risks.

A project that is subject to the Tiahrt requirements is defined as a discrete activity through which a governmental or non-governmental organization provides family planning services to people and for which family planning assistance including funds, or goods or services financed with such funds, are provided.

A single violation of the Tiahrt requirements (or in the case of the comprehensible information requirement, a pattern or practice of violations) must be reported to Congress.

Policy Determination 3 (PD-3) PD-3 applies to all funds for family planning activities appropriated under the Foreign Assistance Act of 1961, as amended, and to all entities receiving funds. Key points include:

- USAID assistance to voluntary sterilization (VS) service programs requires that surgical sterilization procedures be performed only after the individual has voluntarily presented himself or herself at the treatment facility and given his or her written informed consent to the sterilization procedure.
- Where VS services are made available, other means of family planning should also be readily available at a common location, thus enabling a choice on the part of the acceptor.
- No USAID funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS. Further, the fee or patient cost structure applied to VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another method.
- PD-3 further address the importance of quality in the provision of VS services, the desire to integrate VS into the total package of health care services in the country, and the need to consider local policies and practices when implementing VS programs.

IV. Assessment Team Composition

The assessment team should include several disciplines and include individuals with knowledge of the national program situation, USAID's principles of voluntarism and informed choice, and the specific requirements of the Tiahrt Amendment and PD-3 to conduct the assessment. While a principal objective of the assessment is to look at issues of Tiahrt vulnerability, USAID's population program sets more comprehensive standards for itself as reflected in its Maximizing Access and Quality (MAQ) guidance. It

may be desirable to include on the team someone who is familiar with USAID's broader quality of care initiatives.

The team should include:

- The Regional Legal Advisor (if available) and/or Legal Consultant
- A policy or program advisor, with experience with USAID FP programming in the field and with knowledge about the Tiahrt Amendment and USAID's MAQ initiative
- Two Mission PHN staff (one USDH and one FSN), if possible.

Given the security situation in Pakistan, the expatriate assessment team members may have constraints in conducting site visits. If this is the case, then the assessment team may need to work with and train staff from local agencies who can conduct the site visits and interviews in the field. This is reflected in the proposed schedule of activities below.

The Population Council Pakistan Office through the FRONTIERS Program will provide logistical support to the assessment team and cover the costs of this support. Support services and assistance will include the following activities:

- Identify and train potential consultants and/or temporary help from local Pakistani agencies as appropriate to conduct the site visits and interviews.
- Help the Mission identify the most appropriate contacts including Ministry officials, state officials, and service delivery providers.
- Provide the assessment team an initial 2-hour briefing on the health sector and how services are organized and provided in Pakistan.
- Assist in compiling key documents for review; photocopying and creating sets of documents for the assessment team.
- Assist the assessment team in the creation of questionnaires and data collection forms.
- Facilitate data collection and documentation; data synthesis and analysis.
- Arrange for translators and interpreters to assist the assessment team on site visits.
- Schedule site/field visits, interviews and arrange for transportation of the assessment team.
- Provide office space for daily work and meetings of the assessment team.

The Population Council will work with the Mission to prepare for the arrival of the assessment team and will provide support to the assessment team during the in-country assessment.

V. Scope of the Assessment

The assessment team will work closely with the USAID Mission to assess potential vulnerabilities under the Tiahrt and PD-3 requirements with particular emphasis on targets and incentives. The assessment will cover the FP activities/projects supported with the Government of Pakistan and in the private sector.

<u>Use of Targets or Quotas</u>
Scope. To review whether numerical "production" quotas or targets are used to influence the performance of front-line service providers and referral agents. Note that "production" targets should not be confused with planning targets, which may be used to estimate training, staffing or re-supply needs for the service delivery point and which are allowed.

Suggested methodology: Review of policy/planning documents; interviews with national and local health officials; site visits to health facilities to interview front-line providers; review of clinic and individual planning and performance records.

Suggested preparatory activities: Collection of government policy/planning documents that refer to targets. Selection of sites to visit and logistical preparations; Preparation of discussion guides.

Existence of "incentives, bribes, gratuities or rewards" for achieving targets
Scope. To review the compensation payments being made to service providers and clients under voluntary sterilization programs (MOPW and Greenstar) and determine whether these payments constitute incentives, bribes, gratuities or financial rewards to individuals in exchange for becoming family planning acceptors, or program personnel for meeting *predetermined* "production" quotas for acceptors of family planning methods. (Note that this requirement applies to all program personnel, not just front-line service providers and referral agents.)

Suggested methodology: Review of policy/planning documents; Interviews with national and local health officials; Site visits to health facilities to interview front-line providers; site visits to communities to interview referral agents and a sample of individuals referred to services; Review of clinic and individual planning and performance records.

Note that because the use of "incentives, bribes, gratuities or rewards" for achieving targets may not be formally acknowledged or documented, special efforts should be made to interview program managers, front-line providers, referral agents, and clients during site visits. Where applicable, the site visits should include non-clinic based service delivery points, for example, community-based distribution or social marketing activities. In addition to looking for objectively verifiable situations, the assessment team should be aware of perceptions among clients or front line providers that may suggest potential Tiahrt and/or PD-3 vulnerabilities.

Suggested preparatory activities: Collection of state policy/planning documents on the voluntary sterilization programs. Selection of sites to visit and logistical preparations; Preparation of discussion guides

Denial of rights or benefits to those who choose not to use family planning services
Scope. To determine whether evidence exists of the denial of rights or benefits to individuals or couples based on their decision not to accept a family planning method.

Suggested methodology: Review of policy/planning documents; Interviews with national and local health officials; Site visits to health facilities to interview front-line providers and family planning clients.

Suggested preparatory activities: Collection of state policy/planning documents on the ASHA and JSY schemes. Collection of service delivery protocols, standards of care and other organization level policies. Identification of sites where schemes are being implemented.

Comprehensible Information and Informed Consent
Scope: To assist the Mission in determining whether there are vulnerabilities in the family planning program concerning 1) the provision to family planning acceptors of comprehensible information describing the benefits and risks of the contraceptive method chosen, and 2) obtaining informed consent for voluntary sterilization.

Suggested methodology. Review of records noting the translation, distribution and posting of wall charts that have been developed specifically to avoid vulnerability with respect to the comprehensible information requirement of the Tiahrt Amendment; Site visits to 1) observe family planning counseling sessions at service delivery points; 2) review informational materials provided to family planning clients; 3) interview family planning clients; 4) review procedures for and records of informed consent for voluntary sterilization clients.

Suggested preparatory activities. Records of wall chart distribution and posting can be prepared in advance of the assessment team visit. In addition, the Mission may wish to review pre- and in-service training protocols and supervisory tools to ensure comprehensible information is provided describing the benefits and risks of the contraceptive method a family planning acceptor has chosen, and that procedures are established for obtaining informed consent.

Monitoring

Scope. To review on-going monitoring activities to ensure that they anticipate and may be used to prevent situations where Tiahrt and PD-3 vulnerabilities might occur and, to ensure the completeness of efforts to document activities undertaken to ensure compliance with Tiahrt requirements.

Suggested methodology: Review existing guidelines for field visits by USAID Mission staff; Review use of other mechanisms for monitoring compliance, for example use of CA staff; Review files and documentation, including records of interviews with clients and front line providers.

Suggested preparatory activities. In advance of the assessment visit, the Mission should prepare a description of on-going monitoring activities for family planning service delivery projects.
The Population Council will support the Mission by gathering and synthesizing information on how USAID-funded CAs monitor activities for compliance.

Complaints, allegations and violations

Scope: To review mechanisms for: (1) receiving complaints about family planning service delivery projects or for obtaining reliable information that may warrant further investigation; (2) investigating such complaints or reliable information; (3) determining whether such complaints or reliable information indicate Tiahrt or PD-3 violations; (4) correcting violations, if any are identified; and (5) satisfying statutory reporting requirements.

Suggested methodology. Discussions with relevant Mission and cooperating agency staff; review of formal procedures. The Population Council will support the Mission to gather information from host country organizations and review formal procedures.

Suggested preparatory activities. The assessment team with the support of the Population Council will gather information from organizations providing family planning services on the mechanisms by which they handle complaints, allegations and violations (e.g. ombudsman's office, complaint boxes, or other mechanisms) and conduct interviews with relevant organizations such as women's advocacy groups.

Overall Understanding

Scope. To assess general understanding of basic requirements of the Tiahrt Amendment and PD-3 by:

- USAID Mission staff, particularly members of the relevant Strategic Objective (SO) Team, Contracts Officer, and relevant monitoring and evaluation staff.
- In-country representatives of cooperating agencies and partners.
- Foreign NGOs and government counterparts responsible for directly implementing family planning service delivery activities that receive USAID family planning assistance (in the form of funds, goods or services) *and* implement family planning service delivery activities.

Suggested methodology. The assessment team will review the Tiahrt legislation and PD-3 and its implications for family planning service delivery projects with relevant Mission staff and key staff from organizations responsible for implementing family planning service delivery projects allowing ample time for discussion. The assessment team will also meet with counterpart agencies, review work plans and project documents, including Memoranda of Understanding, contracts and bilateral agreements (including

SOAGs) to ensure that the relevant clauses are in the agreements and documents and are understood by all partners.

Suggested preparatory activities: Mission staff and Population Council should prepare a briefing for the assessment team on the family planning service delivery environment in Pakistan that will include (but is not limited to) information on existing policies, service delivery standards, key implementing partners, how the family planning program has evolved over time, what is done in terms of client information, education and communication, how service delivery providers of various cadres are trained and who trains them (in both the public and private sectors), and procedures used to obtain informed consent for contraceptive sterilization.

The Population Council will assist the Mission and the assessment team to:

(1) Compile and review all relevant project documents, including MOUs, SOAGs, bilateral agreements, and subcontracts, to ensure that they include the required Tiahrt language and other clauses applicable to family planning activities.
(2) Organize supporting documents in a binder prior to the arrival of the assessment team.
(3) Prepare briefing for the assessment team on the family planning service delivery environment in Pakistan

VI. Assessment Preparation and Schedule

General preparatory activities. Prior to the arrival of the assessment team, the Population Council and/or their local hire consultants should gather, make copies and compile for the assessment team sets of service delivery protocols, standards of care, service delivery guidelines and other organization and country-level policies, as well as planning documents for selected district level family planning offices or service delivery points and management and performance records. The assessment team, with support of the Population Council, will develop data collection forms and questionnaires for each category of person to be interviewed in the field. Before conducting site visits, the assessment team will work with the Mission and Population Council to develop a methodology for conducting the field work, as well as for analyzing the findings. After the field visits, the assessment team, with the support of the Population Council, will conduct the analysis of the data and findings from the site visits.

The assessment should take approximately two weeks to complete. If the preparatory activities are implemented as outlined above, then the following schedule is proposed:

Week 1. Team arrives in country and has initial briefings in the Mission, GOP and implementing agencies. Team reviews requirements with Mission and other staff. Team works with colleagues to finalize assessment methodologies and instruments. Begin field work. (If selected team members cannot go to field, continue review of documents and reports.)

Week 2. Finish field work. Team reviews data from field and analyzes for vulnerabilities. Prepares findings and recommendations in consultation with Mission, partners, and GOP, as needed and appropriate. Prepares outline and initial draft of report. Conducts de-briefings for Mission and counterparts as appropriate.

VII. Assessment Products

The assessment will result in the following products:

- Short plan with the methodology and questionnaires
- Outline for the report
- Draft report and de-briefing powerpoint and/or briefing handout
- Final report that identifies all key findings and recommendations

VIII. Other Considerations

Given its legal status in Pakistan, the Population Council and its staff reserve the right not to accept tasks or actions proposed by the assessment team which have not been outlined or agreed within this scope of work, which may be inconsistent with its status, and may suggest alternative sources of support as appropriate.

Given its major support role, the Population Council will have the opportunity to review and comment on the draft assessment to ensure findings and definitions are consistent with those identified by its staff prior to its final submission to the Mission.

ANNEX 2

SCHEDULE OF MEETINGS AND ACTIVITIES

DATE	ACTIVITY
Sunday, 6/18	Team arrives Pakistan
Monday, 6/19	Briefing with USAID/Pakistan Health Office Briefing with Population Council on family planning in Pakistan
Tuesday, 6/20	Meeting with representative of PAIMAN project Meeting with representatives of Greenstar and Key Social Marketing projects Meeting with D.G. Program, Ministry of Population Welfare
Wednesday, 6/21	Finalization of questionnaires and discussion guides
Thursday, 6/22	Pre-testing of instruments in Islamabad and Rawalpindi
Friday, 6/23	Field visits in Lahore, Karachi, Islamabad, Rawalpindi
Saturday, 6/24	Field visits in Lahore, Karachi, Jhelum, Haripur
Sunday, 6/25	Teams return to Islamabad
Monday, 6/26	Meeting with National Program for Family Planning and Primary Health Care, MOH Visit to RHS "A" Center, Federal Government Services Hospital Debriefing of field visits with teams
Tuesday, 6/27	Discussion of results Preliminary debriefing with USAID/Pakistan Health Office
Wednesday, 6/28	Report drafting Follow-up meetings with PAIMAN and Greenstar Preparation for partner training Conference call with USAID/Washington
Thursday, 6/29	Training for USAID/Pakistan Health Office and implementing partners on legislative & policy requirements, compliance monitoring activities Report drafting
Friday, 6/30	Debriefing with USAID/Pakistan senior management Report drafting
Saturday, 7/1	Report drafting
Sunday, 7/2	Team departs Pakistan

ANNEX 3

KEY CONTACTS

ORGANIZATION	NAME /TITLE
Futures Group, Key Social Marketing Project	Ashfaq Rahman, Country Representative (Islamabad)
	Dr. Nabeel Akram, Training and Quality Manager, (Islamabad)
	Rabia Bashir, Manager Marketing (Islamabad)
	Farooq Ahmed, Regional Director (Lahore)
Greenstar Social Marketing	Dr. Farhana Zareef Khan, Senior Program Manager RH (Islamabad)
	Supriya Madhavan, General Manager Program Support (Islamabad)
	Dr. Afshan Ameen, Manager, Special Projects (Lahore)
Ministry of Health, National Program for Family Planning and Primary Health Care	Dr. Muhammad Haroon Jehangir Khan, Deputy Director General Health, National Coordinator
	Dr. Malik M. Safi, Deputy National Coordinator
Ministry of Population Welfare	Mian Muazzam Shah, Director General Program (Islamabad)
	Dr. Naveed, Additional Secretary Technical, Punjab Province
	Abdul Haleem, District Population Welfare Officer, Lahore District
Pakistan Initiative for Mothers and Newborns (PAIMAN)	Dr. Nabeela Ali, Chief of Party
	Mohammad Babar Hussain Khan, Director Finance
	Ambreen Niazi, Grants Coordinator
	Shereen Rahmat Minhas, Team Associate, BCC
	Dr. Shuaib Khan, Program and Grants Manager
	Dr. Rakhshaan Khan, National Training Manager
Population Council Pakistan	Peter Miller, Deputy Country Representative
	Dr. Abdul Wajid, Deputy Program Manager
	Muhammad Shafique Arif, Field Operations Manager
USAID/Pakistan	Cathy Jane Bowes, Director Health Office
	Mary E. Skarie, Population, Health and Nutrition Officer
	Dr. Samia Altaf, Health Advisor
	Jonathan Addleton, Mission Director

ANNEX 4

QUESTIONNAIRES AND DISCUSSION GUIDES

PAKISTAN
Clinic Staff Interview

When you begin the discussion, please first introduce yourselves and the purpose of your visit as follows:

My name is _____. Our team is affiliated with the donor agencies that are providing funding to support health and family services in Pakistan. We are here to collect some information about family planning services in this district. I will be asking you some questions about family planning services at this facility.

The results of our interview and data collection will be used to better understand the current situation in this district and to identify areas that might be strengthened. The responses you give me are confidential and will be summarized with the responses of other people we interview at different sites around the country. In addition to our interviews with health facility staff, we will also be gathering information from health facility managers and clients, and district health staff.

The information we collect will be analysed by the Population Council in Islamabad and by Management Systems International (MSI) in the United States, and the data will be stored in both places.

Do you have any questions? If you have questions later, you can contact Dr. Zeba Sathar at the Population Council office in Islamabad.

Do you agree to participate in this interview? If you wish, you may stop the interview at any time.

Clinic Staff Interview

Q#	Question	Response Options (Circle appropriate response)
1.	District	
2.	Date of interview	___ ___ / ___ ___ / ___ ___ ___ ___ d d m m y y y y
3.	Name of interviewer(s)	
4.	Name of facility	
5.	Type of facility (public/private)	
6.	Title of interviewee	

COMPREHENSIBLE INFORMATION

1. What family planning methods do you offer to clients here at this site? For which methods do you have to refer to other facilities?

2. How are decisions made about which method a client should use?

3. What kind of information do you give a client about the method he/she has chosen?

(Y or N for each of the following)

- Health benefits and risks
- Conditions that might render the use of the method inadvisable
- Adverse side effects known to be consequent to use of the method

4. Do you have materials to help you in counseling family planning clients?

If yes, please show them to me.
Describe:

5. *Observe: Is there a contraceptive methods wall chart ("Tiahrt Poster") displayed in the consultation room?*

If yes, please describe.

6. What is the average amount of time that you spend with each client? Do you feel that you have enough time to spend with family planning clients to give them the information that they need?

7. Are they generally able to understand the information that you give them, and use it to make a decision about a method?

TARGETS / QUOTAS

8. Does this facility have numerical goals for numbers of family planning users?

9. Do individual service providers have numerical goals for numbers of family planning users? *(NO → Q 19)*

10. Are there numerical goals for other types of health interventions? Which ones and what are they?

11. Are there numerical goals for new users?

12. Are there numerical goals for continuing users?

13. Are there numerical goals for different contraceptive methods?

14. What is the goal for number of users?

15. How is this number set?

16. Is some responsible for checking whether you have met this number? How does that work?

17. What happens if you do not meet the goal?

18. What happens if you get more users than expected?

SERVICE/COMMODITY FEES

19. Do you charge clients for either family planning services or contraceptive products?

20. What are the charges (by method)?

    - For services:
    - For products:

21. How are the charges set?

INCENTIVES / REIMBURSEMENTS

22. Do you receive anything in exchange for getting clients to use family planning methods?

If yes, please describe. (Do you receive something for getting a certain number of clients to use FP methods? For getting a certain number to use any specific method?)

23. Do you receive a monthly salary?

24. Are you paid or reimbursed on a per-case basis for family planning consultations?

If yes, please describe. (How much are you paid for different methods?)

25. Do you or anyone else give anything to clients in exchange for agreeing to use any family planning method, or a specific method?

If yes, please describe.

26. Do you or anyone else reimburse clients for costs associated with coming for a family planning consultation or procedure (such as transportation or lost wages)?

If yes, please describe.

27. Do you or anyone else provide other types of payments or benefits in connection with FP?

If yes, please describe.
What is the purpose of such benefits?
Are clients aware of these payments before coming in for FP services?
Do you think the benefit influence their decisions concerning FP?

INFORMED CONSENT

28. Do you provide counseling on voluntary sterilization? (NO → END)

29. What do you tell clients about voluntary sterilization?

30. Is voluntary sterilization provided at this clinic? (NO → END)
If not, do you provide referrals to other facilities for this service?

Do you generally refer to a private facility or a public facility?

31. Does the clinic use a specific form to obtain consent for voluntary sterilization procedures? *(NO → END)*

32. Review the form. Does the form contain the following elements?

i. Explanation of surgical procedures to be followed
ii. Attendant discomforts and possible risks
iii. Benefits to be expected
iv. Availability of alternative methods of family planning
v. Purpose of the operation and its irreversibility
vi. Option to withdraw consent anytime prior to the operation
vii. Written in a language the patient understands and speaks

33. What do you do if a sterilization client is unable to read the consent form?

34. Do you keep the signed forms here?

35. For how long do you keep the forms?

36. Does anyone monitor the use of the consent forms (for example, someone from the district)?

37. Can I please review the forms? *Check for :*

- Language in which the form is written:_____
- Name of client: Yes / No
- Date of the procedure: Yes / No
- Signature of client: Yes / No
- Signature of spouse: Yes / No

Thank you very much for your time. The information that you have provided will contribute to improving the health services.

Is there anything that you would like to add to the information that you have given me, or are there any questions you would like to ask me?

PAKISTAN
Family Planning Client Exit Interview

When you begin the interview with the client, please first introduce yourselves and the purpose of your visit as follows:

My name is _____. Our team is affiliated with the donor agencies that are providing funding to support health and family services in Pakistan. I am here to collect some information about family planning services in this district. I will be asking you some questions about the family planning services you have received and your impressions about the services in general.

The results of our interview and data collection will be used to better understand the current situation in this district and to identify areas that might be strengthened. I am not recording your name or any other information that could be linked to you. The responses you give me are confidential and will be summarized with the responses of other clients from different sites around the country. Your participation will not affect your ability to receive health services in the future. In addition to our discussions with clients, we will also be gathering information from health facility staff and district health staff.

The information we collect will be analysed by the Population Council in Islamabad and by Management Systems International (MSI) in the United States, and the data will be stored in both places.

Do you have any questions? If you have questions later, you can contact Dr. Zeba Sathar at the Population Council office in Islamabad.

Do you agree to participate in this interview? If you wish, you may stop the interview at any time.

Family Planning Client Exit Interview

Q#	Question	Response Options (Circle appropriate response)	Skip to
1.	District		
2.	Date of interview	___ ___ / ___ ___ / ___ ___ ___ ___ d d m m y y y y	
3.	Name of interviewer(s)		
4.	Type of facility	Public ..... 1 → Private 2	Q 6
5.	Affiliation	Greenstar ..... 1 Key 2	
6.	What is your age?	___ ___ years	
7.	How many living children do you have?	___ ___	
8.	What was your primary reason for coming to the clinic today?	For family planning services ..... 1 For other services ..... 2 Other: _____ 3	
9.	Is this the first time that you are coming for family planning services?	Yes ..... 1 → No..... 2	Q 11
10.	How long have you been using family planning?	___ ___ months / years *(circle one)*	
11.	Why have you decided to use family planning?	Don't want any more children..... 1 Birth spacing ..... 2 Mother's health ..... 3 Other: _____..... 8 Don't know / no answer 9	
12.	Had you already decided on a specific family planning method before your consultation?	Yes ..... 1 No..... 2	

Q#	Question	Response Options (Circle appropriate response)	Skip to
13.	Do you feel that the provider gave you the information you needed to make a decision about the best method for you?	Yes ..... 1 No..... 2	
14.	Do you feel that <u>you</u> made the decision about which method to use?	Yes ..... 1 No..... 2	
15.	Did anyone else influence the decision about which method to use?	Yes ..... 1 No..... 2 →	Q 17
16.	Who influenced the decision?	Husband ..... 1 Other family ..... 2 Health care provider..... 3 Other: _____..... 8 Don't know / no answer 9	
17.	What method was chosen?	Oral contraceptive (pill) ..... 1 IUD..... 2 Injection ..... 3 Sterilization ..... 4 Condom..... 5 Natural family planning ..... 6 Other: _____..... 8 Don't know / no answer 9	
18.	Why was this method chosen? *(multiple responses allowed)*	Yes No Clinician recommended it .....1 .....2 Effectiveness .....1 .....2 Fewest side effects .....1 .....2 Easy to use .....1 .....2 Easily reversible.....1 .....2 Permanent.....1 .....2 Privacy (others don't know).....1 .....2 Low cost.....1 .....2 Other: _____.....1 .....2 Don't know / no answer 1 2	
19.	Did you pay for the services that you received	Yes ..... 1 No..... 2 →	Q 21

Q#	Question	Response Options (Circle appropriate response)	Skip to
20.	How much did you pay?	Rs _____	
21.	Did anybody give you anything in exchange for agreeing to use this method?	Yes ..... 1 No..... 2 →	Q 27
22.	What did you receive in exchange for agreeing to use this method?	Money: _____ ..... 1 Food: _____..... 2 Clothing: _____..... 3 Other health/social services..... 4 Other: _____..... 8 Don't know / no answer 9	
23.	Who gave it to you?	Health care provider..... 1 Government official ..... 2 Community health worker..... 3 Other: _____..... 8 Don't know / no answer 9	
24.	Did you know that you would receive this benefit before you came to the site for family planning services?	Yes…….1 No……..2	
25.	Why is this benefit being given?	Encourages people to accept FP…….1 Helps with expenses like travel, etc……2 Other:……..3 Don't know…….4	
26.	Did this benefit influence your decision to accept family planning?	Yes……..1 No……...2	
27.	In your understanding, what are the advantages of using this method? *(multiple responses allowed)*	Yes No Help prevent anemia (low iron) ..... 1 ..... 2 Help prevent menstrual cramps..... 1 ..... 2 Help prevent irregular bleeding ..... 1 ..... 2 Help prevent STIs ..... 1 ..... 2 Privacy (others don't know)..... 1 ..... 2 Low/no risk of pregnancy 1 2	

Q#	Question	Response Options (Circle appropriate response)	Skip to
		Easily reversible ..... 1 ..... 2 Other: _____..... 1 ..... 2 Don't know / no answer 1 2	
28.	In your understanding, what are the risks/ possible side-effects of using this method? *(multiple responses allowed)*	Yes No Abdominal pain ..... 1 .....2 Upset stomach ..... 1 .....2 Bleeding between periods ..... 1 .....2 Headaches ..... 1 .....2 Pelvic infection..... 1 .....2 Other: _____..... 1 .....2 Don't know / no answer 1 2	
29.	In your understanding, under what conditions should you stop using this method? *(multiple responses allowed)*	Yes No Severe abdominal pain ..... 1 .....2 Heavy bleeding..... 1 .....2 Suspected pregnancy ..... 1 .....2 Other: _____..... 1 .....2 Don't know / no answer 1 2	
30.	How do you feel about the quality of services you received today? *(such as cost, courtesy, availability of supplies)*	Generally satisfied..... 1 Generally dissatisfied ..... 2 →	Q 32
31.	What about the service makes you satisfied? *(multiple responses allowed)*	Yes No Friendly staff ..... 1 .....2 Wide choice of methods..... 1 .....2 Enough information to make decision ..... 1 .....2 Reasonable / no cost..... 1 .....2 Clinic close to home..... 1 .....2 Very eager for services..... 1 .....2 Other: _____..... 1 .....2 Don't know / no answer 1 2	All → Q 33
32.	What about the service makes you dissatisfied? *(multiple responses allowed)*	Yes No Too expensive ..... 1 ..... 2 Provider/staff was rude ..... 1 ..... 2 Provider/staff did not provide enough information about method choices ..... 1 ..... 2 Desired method not available..... 1 2	

Q#	Question	Response Options (Circle appropriate response)	Skip to
		Clinic too far from home ..... 1 ..... 2 Other: _____ ..... 1 ..... 2 Don't know / no answer 1 2	
33.	In the future, if you were ever dissatisfied with the services, do you feel you would be able to make a complaint?	Yes ..... 1→ No 2	Q 35
34.	Why would you not be able to make a complaint?	Nothing would be done about the problem .....1 Health staff would no longer serve me.....2 Don't have time to deal with it.....3 Other: _____.....8 Don't know / no answer 9	All → Q 37
35.	To whom would you go to make a complaint?	Health facility manager ..... 1 Community leader ..... 2 Political representative ..... 3 Other: _____ ..... 8 Don't know / no answer 9	
36.	Do you think that there would be a response to your complaint?	Yes ..... 1 No 2	
37.	Is there anything else you would like to tell me about the family planning services in your community?	Yes ..... 1 No ..... 2 →	END
38.	What would you like to tell me?	Compliment:_____ _____ ..... 1 Complaint:_____ _____ 2	

Thank you very much for your time. The information that you have provided will contribute to improving the health services.

Is there anything that you would like to add to the information that you have given me, or are there any questions you would like to ask me?

PAKISTAN
Sterilization Client Interview

When you begin the interview with the client, please first introduce yourselves and the purpose of your visit as follows:

My name is _____. Our team is affiliated with the donor agencies that are providing funding to support health and family services in Pakistan. I am here to collect some information about family planning services in this district. I will be asking you some questions about the family planning services you have received and your impressions about the services in general.

The results of our interview and data collection will be used to better understand the current situation in this district and to identify areas that might be strengthened. I am not recording your name or any other information that could be linked to you. The responses you give me are confidential and will be summarized with the responses of other clients. Your participation will not affect your ability to receive health services in the future. In addition to our discussions with clients, we will also be gathering information from health facility staff and district staff.

The information we collect will be analysed by the Population Council in Islamabad and by Management Systems International (MSI) in the United States, and the data will be stored in both places.

Do you have any questions? If you have questions later, you can contact Dr. Zeba Sathar at the Population Council office in Islamabad.

Do you agree to participate in this interview? If you wish, you may end this interview at any time.

Sterilization Client Interview

Q#	Question	Response Options (Circle appropriate response)	Skip to
1.	District		
2.	Date of interview	___ ___ / ___ ___ / ___ ___ ___ ___ d d m m y y y y	
3.	Name of interviewer(s)		
4.	What is your age?	___ ___ years	
5.	How many living children do you have?	___ ___	
6.	What is your occupation?	Housewife..... 1→ Vendor..... 2 Farmer ..... 3 Other: _____.... 8 Don't know / no answer 9	Q 8
7.	On average, how much do you earn each month?	Rs _____	
8.	What is your husband's occupation?	Daily subsistence worker.....1 Vendor.....2 Farmer .....3 Other: _____.....8 Don't know / no answer 9	
9.	On average, how much does your husband earn each month?	Rs _____	
10.	When did you have the ligation procedure?	___ ___ / ___ ___ ___ ___ m m y y y y	
11.	Where did you have the procedure? *(name of facility)*		
12.	After the ligation, how long did it take before you could resume your normal activities (*i.e. how long was the recovery period*)?	_____ days	

Q#	Question	Response Options (Circle appropriate response)	Skip to
13.	Why did you have the ligation?	Don't want any more children ..... 1 Previous pregnancy complications ..... 2 Can't support more children ..... 3 To receive money ..... 4 Other: _____ ..... 8 Don't know / no answer 9	
14.	How did you know about the ligation services offered by the district?	Advertising/information campaign ..... 1 Lady health worker ..... 2 Midwife/doctor at health facility ..... 3 Friend/family ..... 4 Local official ..... 5 Other: _____ ..... 8 Don't know / no answer 9	
15.	Did anybody motivate you to have ligation?	Yes ..... 1 No ..... 2 →	Q 17
16.	Who encouraged you to have the procedure?	Husband ..... 1 Other family ..... 2 Friends ..... 3 Nurse/midwife ..... 4 Government official ..... 5 Lady health worker ..... 6 Other: _____ ..... 8 Don't know / no answer 9	
17.	Did the health care provider give you information about other available family planning methods, in addition to ligation? If yes, which ones?	Yes ..... 1 No 2	
18.	Did the health care provider explain that tubal ligation is a permanent procedure, and that you would not be able to have any more children?	Yes ..... 1 No 2	
19.	Do you feel that **you** made the decision to have ligation?	Yes ..... 1→ No 2	Q 21
20.	Who made the decision?	Husband ..... 1 Other family ..... 2 Nurse/midwife 3	

Q#	Question	Response Options (Circle appropriate response)	Skip to
		Community health worker.....4 Other: _____.....8 Don't know / no answer 9	
21.	Did anybody give you anything at the time of the ligation, or after the procedure?	Yes.....1→ No 2	Q 24
22.	Are you aware that you are entitled to payment for transportation or other costs following sterilization?	Yes..... 1 No ..... 2→	Q 32
23.	Did you receive this payment following your ligation?	Yes.....1 No .....2→	Q 31
24.	What did you receive? *(describe)*	Money: _____.....1 Food: _____.....2 Clothing:_____.....3 Other health/social services.....4 Other: _____.....8 Don't know / no answer 9	
25.	Who gave it to you?	Health care provider .....1 Government official.....2 Lady health worker.....3 Other: _____.....8 Don't know / no answer 9	
26.	When did you receive it?	Before the procedure *(# days)*_____ .....1 After the procedure *(# days)*_____.....2 Other: _____.....8 Don't know / no answer 9	
27.	Why do you think you were given this benefit?	To help pay for cost of procedure.....1 To pay for related travel .....2 To pay for food during recovery .....3 To pay for medicines.....4 To compensate for lost wages .....5 To encourage me to accept VS.....6 Other: _____.....8 Don't know / no answer 9	If not money → Q29
28.	What did you use the money for? *(multiple responses allowed)*	Yes No To pay for transportation..... 1..... 2	

Q#	Question	Response Options (Circle appropriate response)	Skip to
		To buy food ..... 1..... 2 To buy clothing ..... 1..... 2 To buy medicine ..... 1..... 2 To pay bills ..... 1..... 2 Other: _____... 1..... 2 Don't know / no answer ..... 1..... 2	
29.	Before the procedure, did you know that you would receive this benefit?	Yes.....1 No .....2 →	Q 31
30.	Was the benefit a motivating factor in your decision to have ligation?	Yes.....1 No 2	
31.	How do you feel about the quality of services related to your ligation procedure?	Generally satisfied.....1 Generally dissatisfied 2	
32.	In the future, if you were <u>ever</u> dissatisfied with the quality of family planning services, do you feel that you would be able to make a complaint?	Yes.....1→ No 2	Q 34
33.	Why would you not be able to make a complaint?	Nothing would be done about the problem .1 Health staff would no longer serve me.....2 Don't have time to deal with it.....3 Shy/don't want to cause problems.....4 Other: _____.....8 Don't know / no answer 9	All → Q 36
34.	To whom would you go to make a complaint?	Health facility staff.....1 Community leader .....2 Local official .....3 Spouse/family.....4 Other: _____.....8 Don't know / no answer 9	
35.	Do you think that there would be a response to your complaint (i.e. would the problem be addressed)?	Yes.....1 No 2	
36.	Is there anything else you would like to tell me about the family planning services in your community?	Yes.....1 No .....2 →	END

Q#	Question	Response Options (Circle appropriate response)	Skip to
37.	What would you like to tell me?	Compliment:_____ _____ ..... 1 Complaint:_____ _____ 2	

Please note any other relevant details about the client's story:

Thank you very much for your time. The information that you have provided will contribute to improving the health services.

Is there anything that you would like to add to the information that you have given me, or are there any questions you would like to ask me?

OBSERVATION OF FAMILY PLANNING COUNSELING SESSIONS

(Note: this should be done before a provider is interviewed, or with different providers)

1. Does the provider ask about the client's needs/wishes regarding family planning methods?
Describe:

2. What family planning methods are discussed?
Describe:

3. Does the provider offer different family planning methods?
Describe:

4. Does the client freely choose his/her preferred method?
Describe:

5. Is the following information provided about the chosen method? (Y or N for each)

    i. Health benefits and risks
    ii. Conditions that might render the use of the method inadvisable
    iii. Adverse side effects known to be consequent to use of the method

Describe:

6. Does the provider use the contraceptive methods wall chart ("Tiahrt Poster") or other counseling materials during the session?

    Describe:

PAKISTAN
Lady Health Worker Interview

When you begin the discussion, please first introduce yourselves and the purpose of your visit as follows:

My name is _____. Our team is affiliated with the donor agencies that are providing funding to support health and family services in Pakistan. We are here to collect some information about family planning services in this district. I will be asking you some questions about family planning services in this community and your role as a Lady Health Worker.

The results of our interview and data collection will be used to better understand the current situation in this district and to identify areas that might be strengthened. I am not recording your name. The responses you give me are confidential and will be summarized with the responses of other people we interview at different sites around the country. In addition to our interviews with Lady Health Workers, we will also be gathering information from health facility staff and clients, and district health staff.

The information we collect will be analysed by the Population Council in Islamabad and by Management Systems International (MSI) in the United States, and the data will be stored in both places.

Do you have any questions? If you have questions later, you can contact Dr. Zeba Sathar at the Population Council office in Islamabad.

Do you agree to participate in this interview? If you wish, you may end the interview at any time.

Lady Health Worker Interview

Q#	Question	Response Options (Circle appropriate response)	Skip to
1.	District		
2.	Date of interview	___ ___ / ___ ___ / ___ ___ ___ ___ d d m m y y y y	
3.	Name of interviewer(s)		
4.	How long have you been working as a lady health worker?	_____ months / years	
5.	What are your responsibilities in terms of family planning services?	Provide information to people..... 1 Provide referrals to health facility..... 2 Accompany clients to the facility..... 3 Distribute family planning products..... 4 Other: _____..... 8	
6.	For what FP methods do you provide counseling?	Yes No Condoms .....1 ..... 2 Oral contraceptives.....1 ..... 2 IUDs .....1 ..... 2 Injectables .....1 ..... 2 Sterilization .....1 ..... 2 Other: _____.....1 ..... 2 Don't know / no answer 1 2	
7.	What FP methods do you offer? (Multiple responses permitted.)	Yes No Condoms .....1 ..... 2 Oral contraceptives.....1 ..... 2 IUDs .....1 ..... 2 Injectables .....1 ..... 2 Sterilization .....1 ..... 2 Other: _____.....1 ..... 2 Don't know / no answer 1 2	

8.	For which methods do you refer clients to another provider? (Multiple responses permitted.)	Yes No Condoms .....1 ..... 2 Oral contraceptives.....1 ..... 2 IUDs .....1 ..... 2 Injectables .....1 ..... 2 Sterilization .....1 ..... 2 Other: _____.....1 ..... 2 Don't know / no answer 1 2	
9.	To what type of provider do you generally refer?	Public.....1 Private 2	
10.	What information do you provide prospective FP clients regarding these methods?	Yes No Benefits .....1 ..... 2 Risks.....1 ..... 2 Contraindications .....1 ..... 2 Side effects .....1 ..... 2 Other: _____.....1 ..... 2 Don't know/no answer 1 2	
11.	Is your pay based on a regular fixed amount, or on the number of clients that you serve?	Regular fixed payment ..... 1→ Per client served ..... 2 Other: _____..... 8→ Don't know / no answer ..... 9→	Q 15
12.	Do you receive any additional payment for making referrals for family planning?	Yes..... 1 No..... 2 →	
13.	Are payments different depending on the method that the client is referred for?	Yes..... 1 No..... 2 →	Q 15
14.	How much do you receive for each method?	IUD - Rs _____ Injection – Rs_____ Sterilization – Rs _____	
15.	Do you charge for the services that you provide to clients?	Yes..... 1 No..... 2 →	Q 17
16.	How much do you charge?	Rs _____	
17.	Do you charge for the products that you provide to clients?	Yes..... 1 No..... 2 →	Q 19
18.	How much do you charge?	Rs _____	

19.	Is that money yours to keep?	Yes..... 1 No..... 2	
20.	Do you have a numerical goal for family planning users that you are supposed to achieve?	Yes..... 1 No..... 2 →	Q 27
21.	What is the number of users you are supposed to get?	_____ per week / month / quarter *(circle one)*	
22.	Who sets this number?	Health facility in-charge..... 1 Lady health supervisor ..... 2 District coordinator ..... 3 Other: _____..... 8 Don't know / no answer 9	
23.	How is this number set?	Using a formula..... 1 Based on community need ..... 2 Other: _____..... 8 Don't know / no answer 9	
24.	Are you involved in setting the goal?	Yes..... 1 No..... 2	
25.	What happens if you don't achieve the goal?	Payment is withheld ..... 1 Other benefits withheld ..... 2 Nothing..... 3 Other: _____..... 8 Don't know / no answer 9	
26.	What happens if you meet the goal or get more family planning users than expected?	Extra payment received..... 1 Extra benefits given..... 2 Nothing..... 3 Other: _____..... 8 Don't know / no answer 9	
27.	Do you or anyone else in this community ever give people anything in exchange for using family planning?	Yes..... 1 No..... 2 →	END
28.	What do you or others give? (describe)	Money: _____ ..... 1 Food: _____..... 2 Clothing: _____..... 3 Other: _____..... 8 Don't know / no answer 9	

29.	What is the purpose of giving this benefit?	Help cover client's expenses related to using FP..... 1 Encourage clients to accept FP..... 2 Other: _____..... 8 Don't know / no answer 9	
30.	To approximately how many people has this benefit been given in the last month?	_____	

Thank you very much for your time. The information that you have provided will contribute to improving the health services. Is there anything that you would like to add to the information that you have given me, or are there any questions you would like to ask me?

ANNEX 5:

GOVERNMENT AND GREENSTAR REIMBURSEMENT RATES FOR VS

Government's Reimbursement For VSC Cases (for RHS"B")	Greenstar's Reimbursement For VSC Cases
Surgical Facility Rs 250 (Expense of medicine and other items bearded by organization)	Surgical Facility Rs 600 (Private clinic has to bear this expense which is equal to Rs. 325)
Gynecologist Rs. 150 (Paid staff of organization)	Gynecologist Rs. 250 (Private Doctor)
Support Staff -------- (Paid Staff)	Support Staff Rs. 50 (Private Staff)
Hospital MS Medical Superintendant Rs. 5 (Organization)	Hospital MS Rs 50 (Owner of Private setup)
O.T Staff Operating theater Rs. 20 (Paid Staff)	O.T. Staff Rs 50
Lab Facility Rs. 5 (Organization)	Lab Facility Rs. 20 (Private)
Client Rs. 250 (Transport provided to client after surgery by organization)	Client Rs.275 (No transport provided to client, taxi fare included in Rs 275)
Referral Rs. 150 (Govt. paid motivator Rs. 150 is additional incentive)	Referral Rs. 175 (Local people)
Refreshment Rs 20	Arranged by provider for client Rs. 30
Total Rs: 850	**Total Rs: 1500**

ANNEX 6:

KEY GUIDANCE DOCUMENTS

Addendum to Policy Determination 3: Additional A.I.D. Program Guidance for Voluntary Sterilization Activities. USAID: September 1982.

Guidance for Implementing the "Tiahrt" Requirements for Voluntary Family Planning Projects. USAID: April 1999.

Policy Determination 3: USAID Policy Guidelines on Voluntary Sterilization. USAID: September 1982.

Technical Guidance on the "Comprehensible Information" Paragraph of the Tiahrt Clause. USAID: April 1999.