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USAID/PAKISTAN'S MATERNAL AND CHILD HEALTH PROGRAM,
FAMILY PLANNING/REPRODUCTIVE HEALTH COMPONENT

Final Performance Monitoring Report

Cooperative Agreement No:AID-391-A-13-00007
October 1, 2013 – July 12, 2016

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List of Abbreviations & Acronyms

BCC	Behavior Change Communication
B&M	Branding and Marking
CD	Condoms
CIO	Chief Information Officer
CIP	Costed Implementation Plan
CMW	Community Midwives
CM	Community Mobilization
CPR	Contraceptive Prevalence Rate
CSM	Creating Social Marketing
CYP	Couple Years of Protection
DCO	District Coordination Officer
DO	Development Objective
EPI	Enterprise District Officer
ERP	Enterprise Resource Planning
FHE	Field Health Educator
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
FLAME	Franchise Data Utilizing Local Application
FWW	Family Welfare Workers
GM	General Manager
GoS	Government of Sindh
HANDS	Health and Nutrition Development Society
HR	Human Resource
HSSC	Health System Strengthening Component
HTSP	Health Timing and Spacing of Pregnancy
IPC	Interpersonal Communication
IR	Intermediate Results
IRMNCH	Integrated Reproductive Maternal Newborn Child Health
IT	Information Technology
IUCD	Intrauterine Contraceptive Device
JHU.CCP	Johns Hopkins University Center for Communication Program
JSI	John Snow Inc
KPI	Key Performance Indicators
LAPM	Long-Acting Permanent Method
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MNCH	Maternal, Newborn and Child Health
MSI	Marie Stopes International
MSS	Marie Stopes Society
MWRA	Married Women of Reproductive Age
NP-FP	National Program for Family Planning & Primary Healthcare
OMU	Outreach Mobile Units
OR	Outreach
PDHS	Pakistan Demographic and Health Survey
PMP	Project Management Plan
PWD	Population Welfare Department
QA	Quality Assurance
QS	Quality Scan
RH	Reproductive Health
RME	Research, Monitoring and Evaluation
SDP	Service Delivery Points
SF	Social Franchise
SFS	Senior Field Supervisor
SMH	Safe Motherhood
SOPs	Standard Operating Procedures
SSF	Suraj Social Franchise
ST	Short-term
TL	Tubal Ligation
TMS	Time Management System
TSD	Technical Services Department
USAID	United States Agency for International Development
USG	United States Government
UNICEF	United Nations Children's Emergency Fund
VfM	Value for Money

Executive Summary

The Family Planning and Reproductive Health (FP/RH) project was Component 1 of the United States Agency for International Development (USAID) Maternal and Child Health (MCH) Program in Pakistan (Cooperative Agreement: AID 391-A-13-00007), implemented by Marie Stopes Society (MSS) with support from Health And Nutrition Development Society (HANDS), Creative Social Marketing (CSM) and Marie Stopes International (MSI). The purpose of the FP/RH Project was to strengthen the delivery of integrated family planning and safe motherhood services (focused on reproductive health) in Sindh and Punjab Provinces; continuing the family planning/reproductive health work initiated under a USAID Bureau for Global Health Award to Marie Stopes International, entitled 'Support for International Family Planning Organizations' (SIFPO)[1].

The fifth development objective (DO) of the USAID MCH program is to improve MCH outcomes in the focus area. The first component contributed towards making comprehensive FP/RH services accessible, available and affordable for improved maternal and child health outcomes, and supported the following two intermediate results (IRs) under DO 5:

IR 5.1 Improved utilization of quality FP/RH and maternal, newborn and child health (MNCH) services

- Couple years of protection (CYP) in United States government (USG) supported programs
- Number of women and children receiving voluntary FP/RH and MNCH services in USG-assisted sites

IR 5.1.1: Improved availability of quality FP/RH and MNCH services

- Number of people trained in FP/RH and MNCH through USG support

The three objectives of the FP/RH project remained tied to its overall goal and included the following:

- Objective 1: Increase size and capacity of the health workforce
- Objective 2: Scaling up facility-based service delivery
- Objective 3: Scaling up outreach and community-based service delivery

FP/RH was due to receive funding from the United States Agency for International Development (USAID) for five years: from Oct 1, 2013, and ending on October 1, 2018. The project underwent detailed review in FY15 and project scope and commitments were realigned keeping in view the progress made and the challenges encountered. Subsequent to that, the project received a modification in February 2016. In June 2016, under the directive of the Agreement Officer, project activities were closed out by September 30, 2016. This followed a reduction in funding for USAID initiatives in Pakistan which affected several USAID projects.

During the life of the project (Oct 1, 2013, to July 12, 2016), FP/RH increased the use of FP methods by scaling up quality voluntary service delivery to reach women in 29 districts of Sindh province and three districts of Punjab province in Pakistan. The project contributed substantially to USAID's DO 5 with the following project results:

Table 1: Projected Results and actuals to date

Projected Project Results Oct 2, 2013, to Oct 1, 2018	Actuals to July 12, 2016 (55% of original project duration)
Serve 1,572,362 clients with FP method of choice	Served 621,082 clients with a quality voluntary FP method of choice
Generate 3.7 million CYPs (the average programmatic cost per CYP should not exceed $10)	Generated 1.5 million couple years of projection (CYPs)
300 private sector providers delivering quality FP	Trained and operationalized 301 private sector providers delivering quality voluntary FP services; enhancing both access to FP in rural and remote areas and promoting small business development for women-led businesses

[1] The USAID funded SIFPO Project, cooperative agreement number AID-A-OAA-10-00059 was implemented by Marie Stopes International from 2010 – 2015. Marie Stopes Society received field support funding under SIFPO from July 2012 – September 2013

Increased access to FP services to women/families earning less than $2.00[2] a day	Increased access to FP services for women/families earning less than $2.50 a day; an estimated 79% of the total clients served belonged to this category
Estimated 1,375 fewer maternal deaths through increased contraceptive use	500 fewer estimated maternal deaths[3] through increased contraceptive use

The FP/RH project was able to serve more clients' year on year with quality voluntary FP services through Social Franchise private providers, dedicated Outreach (OR) teams and Outreach Mobile Units. Using MSI's Impact 2 model, a summary of the impact of total voluntary services delivered under the FP/RH project can be seen. Table 2 below summarizes the service lifespan impacts on demographic, health and economic indicators which grew steadily as the project scaled up. The estimation also the impact that may fall in future years of the voluntary services delivered during the project.

Table 2: Estimated Service Lifespan Impact

	FY14	FY 15	FY16	Total
Demographic impacts				
Unintended pregnancies averted	90,776	213,205	243,116	**547,097**
Abortions averted	42,665	100,206	114,264	**257,136**
Health impacts				**0**
Maternal deaths averted	87	196	216	**500**
Child deaths averted	917	2,153	2,456	**5,526**
DALYs and economic impacts				
Maternal DALYs averted (mortality and morbidity)	5,391	12,152	13,373	**30,916**
Child DALYs averted (mortality)	77,521	182,074	207,617	**467,212**
Total DALYs averted	82,912	194,226	220,990	**498,128**
Direct healthcare costs saved (2011 GBP converted to USD)[4]	5,248,674	$11,431,003	$11,927,144	**$28,606,822**

As the project scaled up and investments made earlier in the project to train and equip providers were realized, the number of clients reached with quality voluntary FP services increased. It is estimated that 3.2% of all married women in Sindh (the largest project intervention area) are using a method of contraception they accessed through the FP/RH project[5].

[2] During the first two years of the FP/RH project, poor families included those families having a daily income of $2.50 or less. In February 2016, a modification was made in line with the revision issued by Prime Minister's National Health Insurance Program released in August 2015. Poor families were labeled as those having daily income of $2 or less. However, early closure did not allow for this assessment to take place along revised ceiling.

[3] For this report, Impacts related to unintended pregnancies and maternal deaths averted were estimated using MSI's Impact2 model: https://mariestopes.org/impact-2. Hence, the estimates reflected in this report may not match with the previously reported figures.

[4] Conversion rate GBP to USD is 1.65, 1.53, 1.4 for FY14, FY15 and FY16 respectively

[5] Market share was derived from the estimated users of FP provided by the FP/RH project (at the end of the project), divided by the number of married women of reproductive age in Sindh

Figure 1: Clients served and CYPs generated by project year

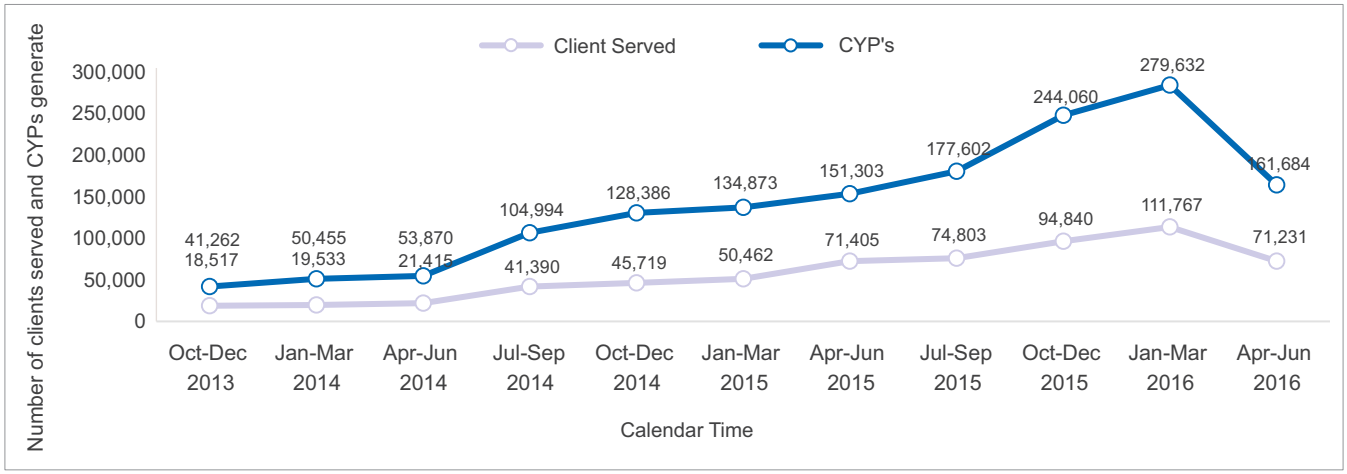
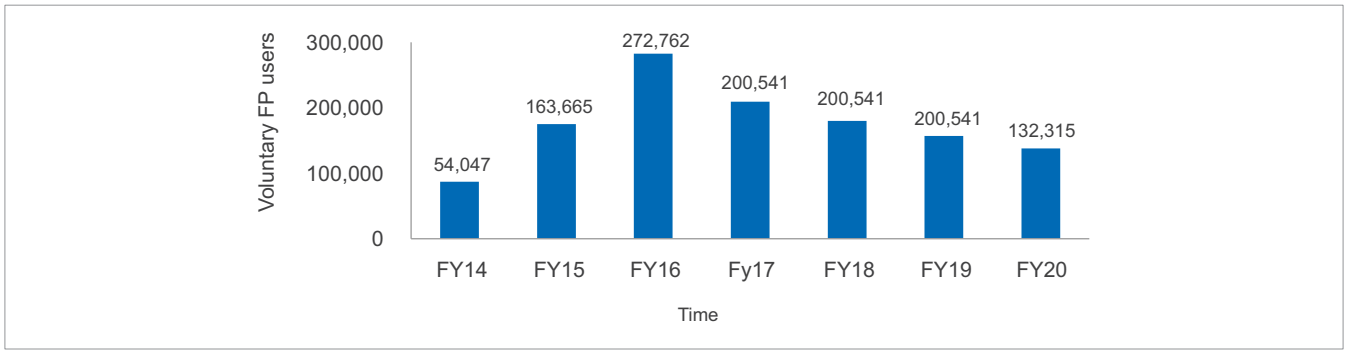


Figure 1 shows in increase in the clients served and CYPs generated as the project progressed. The drop off in the final quarter reflects the scaling back of activities requested by USAID during that period. In line with this, voluntary FP users grew as the project scaled up. Figure 2 below depicts the number of voluntary FP users over time as a result of the FP/RH project. This includes those FP users who will continue using a long acting and permanent methods (LAPM) provided by FP/RH in the future and demonstrates the longer term impact of the project, beyond its lifespan.

Figure 2: FP/RH voluntary FP users as a result of the FP/RH project[7]



The FP/RH project helped serve the poor and underserved. Service provider and site selection maximized coverage to rural and remote areas and complemented public sector service delivery. This was achieved through offering a comprehensive range of voluntary FP services, which in particular complemented provision of short term method (STM) by Lady Health Workers (LHWs) and helped to serve clients who were not able to access services, particularly LAPMs at alternative sites. 26% of clients served through FP/RH service delivery points were in the two poorest segments of society annual MSI client exit interviews (CEI) in 2013, 2014 and 2015 indicate that 20% of clients served at SF clinics lived on less than $1.25 a day and another 59.7% lived on $1.25-$2.50 a day: almost 80% of the clients served were living below the poverty benchmark of $2.50 a day. 77% of all clients served through the project accessed services through a voucher. This demonstrates how the project reduced barriers to access to voluntary services for clients who could not afford to pay for services.

The key performance indicators achieved by the end of project are reflected in the table below:

[6] For the purpose of this projection, this assumes users will not switch methods until their current one needs replacing

[7] For the purpose of this projection, this assumes users will not switch methods until their current one needs replacing

Table 3: Performance Indicators (KPIs)[8] actuals to date (through July 2016)

KPIs	Year 1 FY14 (Oct 13– Sep 2014)	Year 2 FY15 (Oct 2014– Sep 2015)	Year 3 FY16 (Oct 2015– July 2016)	Year 3 FY16 (July 2016)	Results to date (Oct 2015– July 2016)
Number of OR teams added	12	4	-2		14
Number of OMU teams added	0	4	0		4
Number of SF providers added	135	165	+45(-44)		301
OR camps held	520	1,405	1244		3,169
Total CYPs generated	250,581	592,164	685,375	-26*	1,528,120
CYP generated through SF	168,059	419,001	521,536	-26*	1,108,596
CYP generated through OR and OMU	82,522	170,069	160,895		413,486
CYP generated through MCH	0	3,094	2,944		6,038
Total clients provided voluntary FP services	100,855	242,389	277,838		621,082
Clients served through SF	78,478	198,105	217,973	827	495,383
Clients served through OR and OMU	22,377	42,594	58,154		123,125
Clients served through MCH	0	1,690	884		2,574
Voucher Clients[9]	64,757	146,859	168,094		379,710
Non Voucher Clients	13,721	51,246	50,706		115,673
Unintended pregnancies averted	90,776	213,205	243,116		547,097
Maternal deaths averted	87	196	216		500

* The negative CYPs are due to the reversal of non-verifiable cases that were adjusted in July 2016

Summary of Project Impact FY16

In FY16 of the project i.e. from Oct 1st 2015 to July 12th 2016, FP/RH provided comprehensive, high-quality FP services by:

- Working with the 301 SF A and A + providers that were operationalized in FY15
- Operating 14 OR to provide voluntary LAPM FP services; and 4 outreach mobile units (OMU) to reach women in hard-to-reach areas in Sindh and Punjab
- Recruiting and training 160 Field Health Educators (FHEs) and Senior Field Supervisors (SFSs) to mobilize communities and generate demand for FP (with this, FP/RH achieved its project commitment of operationalizing 610 FHEs and SFSs)
- Training an additional 160 public service providers and strengthening referral linkages between the Lady Health Workers (LHWs), Community Midwives (CMWs) and FP/RH service delivery points (SDP)

Achievements from Oct 2013-July 2016 for Objective 1

- Manuals on Sexually Transmitted Infections (STI), medical emergency management (MEM) and infection prevention (IP) were updated with technical support from MSS core Health Services Department (HSD) in close coordination with Marie Stopes International (MSI) technical experts. A safe motherhood (SMH) voucher management operational manual was also developed. In addition, quality assurance (QA) standard operating procedures (SOPs) for SSF, OR and SMH units were developed and implemented; a district coordination officer (DCO) handbook was developed to build the capacity of the district focal persons for the FP/RH project; an FP interpersonal communication (IPC) toolkit was developed for the LHWs and work was initiated for updating the FP section of pre-service curricula for LHWs in close coordination with the Population Welfare Department (PWD) and the LHW program
- 301 Suraj franchisees, 18 outreach (OR) teams (14 outreach teams and 4 outreach mobile units), 927 community workers including 771 FHEs and 156 senior field supervisors were trained in voluntary FP, including voluntary long acting reversible contraception (LARC) and permanent methods (PM) for qualified providers

[8] KPIs related to unintended pregnancies and maternal deaths averted were estimated using MSI's Impact2 model: https://mariestopes.org/impact-2
[9] Voucher Clients are served only in the SF; non-voucher clients reflect the clients who pay for their services at SF

- Over 350 FP service providers and over 500 field health workers received annual trainings on different FP Counselling, Communication and FP Clinical modules which were attended by a total of 5,165 participants
- 487 public service providers and managers were trained in FP counseling, communication and interpersonal skills in annual trainings
- Standard operating procedures were developed by adapting MSI quality assurance tools for SF-A, SF-A+ and OR that were aligned to local frameworks

Achievements from Oct 2013-July 2016 for Objective 2

- 301 SF providers were trained, certified and were part of the SF network at the end of project activities in July 2016
- 1,108,596 CYPs were generated by July 2016 through the SF intervention
- An estimated 361 maternal deaths were averted over the life of the project through the SF intervention
- 294 FHEs and 65 SFSs were recruited and trained to support 301 SF-A and SF-A+ providers
- Approximately 383,770 referrals were made by FHEs for voluntary FP services

Achievements from Oct 2013-July 2016 for Objective 3

- 18 FP/RH outreach teams trained and operationalized
- 14 FP/RH clinical outreach teams trained and operationalized
- 4 OMUs trained and operationalized
- 14 public sector facilities upgraded to support MSS OR team service delivery. Due to early close out, as per advice from USAID, the Maternal and Child Health Integrated Program (MCHIP) will distribute the already procured equipment to the remaining facilities
- 169 FHEs and SFSs recruited and trained to support 18 (14 OR and 4 OMU) teams by building awareness of the benefits of voluntary FP and of the outreach services
- Approximately 2,444,613 married women of reproductive age (MWRA) were reached through door-to-door visits, Mohalla and Mashwara meetings

Achievements from Oct 2013-July 2016 for Strengthening Public Private Partnership

- Organized policy dialogues aimed at the optimal utilization of the existing health workforce and infrastructure for enhanced voluntary FP uptake;
- Actively participated and supported advocacy initiatives aimed at commodity security and FP and MNCH service integration at public health facilities;
- Provided technical inputs and supported the development of CIP for meeting the FP 2020 commitments
- Trained 487 PSPs, which included 287 lady health supervisors and lady health workers and 146 community midwives in FP Methods and counseling skills
- Facilitated consensus development around the FP messages which were endorsed by the PWD, LHW and MNCH program; approval and formal notification for the same were received both by the office of DG health in Sindh and PWD in September 2016
- Provided technical assistance to the LHW program for revision of pre-service FP curricula for LHWs; gap analysis was completed and endorsed by the director of the LHW program and is expected to serve as the guiding framework for subsequent revision of pre-service FP curricula for LHWs
- Provided technical assistance to the LHW program for development of the FP IPC toolkit; the toolkit was endorsed by the director LHW program and received formal notification and approval by the office of DG health in Sindh in September 2016
- Made presentations at several forums to introduce the MSS quality assurance (QA) mechanisms and shared lessons learned; technically supported MCHIP and JSI/HSS toward development of simple, but robust, indicators and systems for monitoring the quality of FP services in public health facilities
- Procurement was completed for refurbishment of 88 public health facilities to make their operation theaters functional for conduction of OR camps there, enabling MSS and other government and NGOs to provide comprehensive voluntary family planning services; 14 facilities were refurbished, and the rest should be completed by MCHIP under the direction of USAID

[10] Mohalla meetings are conducted by FHEs with a group of MWRA who are educated on women's health issues, especially healthy timing and spacing of pregnancies and are provided information on FP methods and the voluntary FP services available in the community

[11] Mashwara (consultation) meetings include SSF provider's participation together with FHE in a group meeting, where the community women get an opportunity to ask questions directly from the provider and seek consultation on FP Services

Objective 1: Increase Size and Capacity of the Health Workforce

One of the key obstacles toward improving access to quality FP/RH services is the critical shortage of skilled health workers, particularly in rural and far-flung areas. This results in high unmet need for FP, particularly among socio-economically vulnerable populations residing in these communities. Drawing on local resources, FP/RH identified FHEs and private providers in these communities and provided high quality training in FP counselling and IPC skills. The providers also received practical FP clinical training as per their qualification and eligibility defined by the regulatory authority.

FP/RH played a vital role in building the capacity of these private providers for addressing the unmet need of underserved communities for quality, voluntary, FP information, counseling and services. This involved mentoring, supervising and providing annual refresher training as required. A small segment of private providers also received safe motherhood (SMH) counseling and clinical training and were part of a pilot intervention program implemented during the last quarter of Fy15.

FHEs supporting the private providers were trained on effective FP counseling and IPC skills. This enhanced client satisfaction through an improved quality of interaction between provider and client; facilitated increased awareness of voluntary FP options and generated demand for quality, voluntary FP services. FHEs, through door-to-door visits, and Mohalla and Mashwara meetings, were instrumental in generating demand for FP in the communities they served

Contribution of FP/RH objective 1 – assessing the impact

Objective 1 of the FP/RH project contributes to the following IRs of the USAID MCH Program framework:

- IR 5.1 Improved utilization of quality FP/RH and MNCH services
- IR 5.1.1 Improved availability of quality FP/RH and MNCH services

The outputs of the activities executed under FP/RH project objective 1 are summarized in the table below:

Table 4: Snapshot of FP/RH achievements under objective 1 from Oct 2013 to July 2016

Output 1: Number of people trained	5,652 trained during the life of the project, out of which 1,335 were trained in FY 16
Output 2: Number of male and females trained	In FY15 & FY-16, out of the total who attended the trainings, 297 were male and 5,355 were female
Output 3: Number of P ublic Service Provider s (PSPs) trained	487 public service providers were trained
Output 4: FP counseling trainings conducted	FP counseling trainings were attended by 4,109 participants
Output 5: FP clinical trainings conducted	FP clinical skills were attended by 835 participants
Output 6: SMH counseling trainings conducted	SMH counseling trainings were attended by 43 participants
Output 7: SMH clinical trainings conducted	SMH clinical skills trainings were attended by 19 participants

Module-wise Distribution of Participants Trained

During the life of project, 5,652 service providers[12] were trained; 50% were trained in FY15 due to an intensive scale-up which involved extensive recruitment. FP/RH developed training modules that were offered to private and public service providers (PSPs), as well as community field teams. These modules covered counseling and clinical skills. After receiving induction training at the time of recruitment, annual needs-based refresher trainings were offered to ensure quality voluntary FP and SMH services.

Table 5: Participants trained with USG funds segregated by modules – Inception to date

Module	Number Trained
FP clinical	835
FP counseling[13]	4,109
CM	162
SMH clinical	19
SMH counseling	43
Others	484
Total	5,652

From inception till March 2016, 835 participants received FP clinical trainings. These were hands-on trainings for developing the competence of service providers in the safe provision of different quality, voluntary FP methods as per their eligibility. Eligibility was defined for the level of FP service to be provided by each cadre, by the local regulatory authorities, i.e. the Pakistan Nursing Council and the Department of Health, as reflected in table 3. 774 received training on insertion of Intrauterine Contraceptive Device (IUCD) by the FP/RH HSD; 26 were certified for implant insertion, and another 35 for conducting tubal ligation by the PWD. Induction and refresher FP counseling trainings were received by 4,109 participants, out of which 1,009 were trained in FY 16. Both SMH clinical and counseling trainings were offered in FY 15 to a group of providers who were part of a SMH pilot intervention.

Table 6: Categories of health workers and their eligibility for FP service provision

CONTRACEPTIVE DELIVERY	Lady Health Worker (LHW)	Community Midwife (CMW)	Family Welfare Worker (FWW)	Lady Health Visitor (LHV)	Nurse Midwives	General Practitioners (GPs)
Supplies of condoms and pills						
Maintenance of Injectable contraceptives						
Initiation of Injectable contraceptives						
Insertion and removal of IUCD						
Insertion of PP IUCDs						
Insertion and removal of Implants						
Tubal Ligation						

Accepted as within existing pre-service curricula

Accepted as NOT withinexisting pre-service curricula

A Community Mobilization (CM) module was added for the FHEs in FY 16 to strengthen awareness and demand generation in intervention districts and to facilitate the behavior change intervention. This intervention was aimed at getting the target audience to recognize RH as a basic right and make informed, voluntary FP/RH decisions. The Kirkpatrick model for training evaluation was applied to the CM trainings on a pilot basis, and a total of 162 participants were trained in quarter 3 of FY 16. The model enables evaluation of trainings at four levels: the reaction, learning, behavior and results levels. At the reaction level, the CM trainings helped assess the reaction of the participants to the workshop and if it was able to meet their expectations. At the learning level, it helped assess the extent to which the learning objectives were met and knowledge enhanced. Frameworks were designed to evaluate the trainings at the behavior and result levels, presented at the (M&E) working group meetings and then finalized.

[12] These do not refer to unique numbers due to the limitation of the MIS system. It is estimated that 1,400 unique providers were trained during the project

[13] Categories included: Doctor, Nurse, Lady Health Visitor (LHV), Community midwife (CMW), Lady Health Supervisor (LHS), Midwife, and Lady Health Worker (LHW)

Sector-wise Distribution of Participants Trained

FP/RH successfully trained 487 PSPs, which included 287 lady health supervisors (LHS) and LHWs; and 146 CMWs, who were nominated by their respective departments, i.e. the National Program for Family Planning & Primary Healthcare (NPFP&PHC) and the Sindh Provincial MNCH Program. Managers of the respective programs also attended these trainings, which were widely appreciated by both programs. LHWs play an important role in the rural communities where there are often no other public service providers. They are eligible for the provision of short-term (ST) contraceptives and maintenance doses of injectables during home visits. During the trainings, LHWs were also taught about voluntary LAPMs to enable them to make referrals to trained providers, and their counseling and IPC skills were strengthened. An objective of the training was also that improved knowledge would further help them to address concerns of the clients using voluntary FP methods and reduce discontinuation rates.

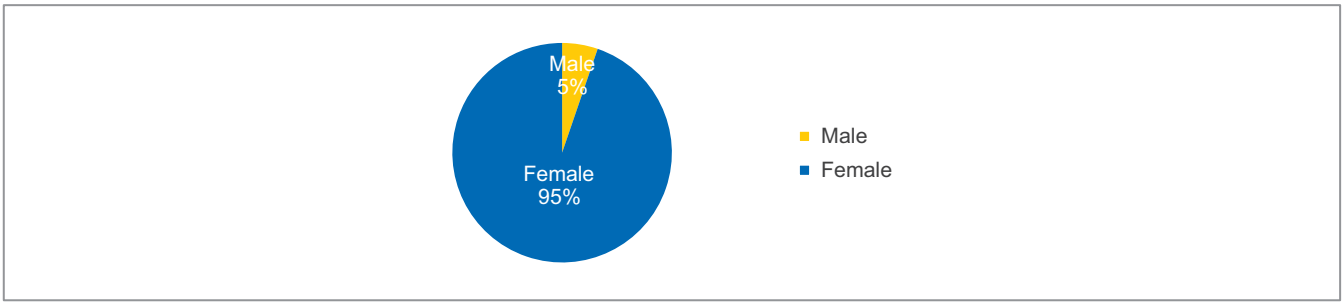
Table 6: Service providers trained with USG funds, segregated by sector – Inception to date

Sector	Number trained
Public sector providers trained	487
Private sector providers trained	5,165
Total	5,652

Gender-wise Distribution of Participants Trained

During the life of the project, 95% of all participants trained were female. This was due to the fact that the vast majority of service providers and community workers, both public (LHS, LHW and CMW) and private (FHEs) are female. Male mobilizers were taken on board to work with male household members and other community opinion leaders to create an enabling environment for increased acceptance of voluntary FP.

Figure 3: Service providers trained with USG funds segregated by gender– Inception to date



Quality Assurance

FP/RH invested heavily in assuring clinical quality of FP service provision. It is one of MSI's strengths globally, and FP/RH benefited from the expertise available at MSI, which actively supported development of standards, systems and protocols for effective implementation. QA and Quality technical assurance (QTA) were the two processes that FP/RH instituted to ensure clinical quality. Their salient features are listed in table 7 below. The QA teams at FP/RH focused on a broad range of quality indicators, whereas the annual externally-conducted QTA assessed providers and facilities on a narrower scale aimed at identifying key risk areas and the need for technical assistance. The QTA also formulated an action plan for enhancing the overall quality of the FP/RH program.

Table 7: Overview of quality assurance and quality technical assistance objectives and processes

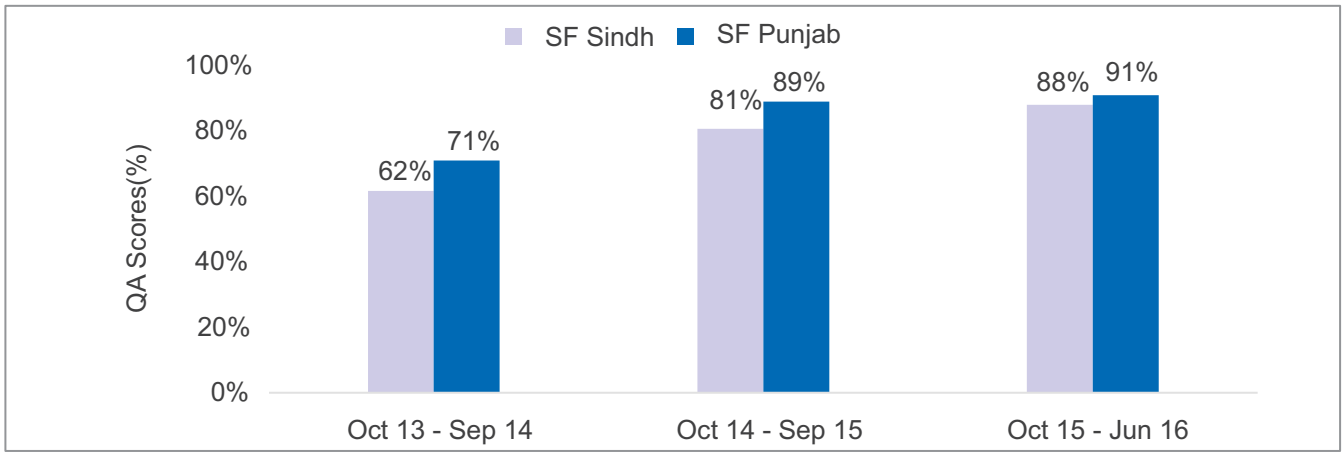
Quality Assurance	Quality Technical Assistance
Local Internal and regular processes and procedures within MSS to manage the quality of FP services and supplies provided to assure quality standards	International External and annual processes within MSI country programs to improve quality and to identify new or innovative quality initiatives that can be disseminated throughout the MSI partnership
Objective is to improve the quality of delivered services at all OR and SF of the project, as per MSS/MSI standards	Objective is to provide obstetrics & FP quality technical assistance to the specified MSI program
Conducted initially at 3 months, then biannually	Conducted annually
Cluster sampling	Random sampling
Conducted by QA monitors of HSD at FP/RH	Conducted by MSI QTA consultants
QA Target: regional offices, district offices, outreach and social franchise (SF)	QTA Target: regional offices, district offices, outreach and social franchise
MSI tools SF Quality Scan, OR QS adapted to country context.	MSI Quality Scan tools

FP/RH invested in each SF provider's training and certification prior to induction into the Suraj Social Franchise (SSF) network. A firm adherence to certification criteria was ensured by an external gynecologist, and only competent providers were franchised for voluntary FP service provision. Once certified, the providers were inducted into the Suraj network and their service quality was assured by the HSD QA teams' periodic visits using comprehensive monitoring systems. The FP/RH QA teams were instrumental in maintaining a high standard of services at all USG-supported SDPs. During their QA visits, the three quality components were monitored: client experience; client safety; and clinical effectiveness. Compliance with clinical governance, technical competence, facilities and supplies standards was ensured and incidents were recorded and categorized depending on the nature of severity. QA dashboards monitored indicators including quality and service delivery across providers to promote evidence-based decision making. Needs-based refresher trainings were offered to strengthen providers' competence. The newly inducted service delivery teams were assessed more frequently initially, every three months, and mature providers were assessed every six months.

The quality scores of the SF clinics steadily increased through the life of the project, as depicted in figure 2. The SF providers were able to create a brand image of quality services, winning the trust and confidence of their communities. This is expected to compel other service providers in the community to offer the same quality in order to retain their client base.

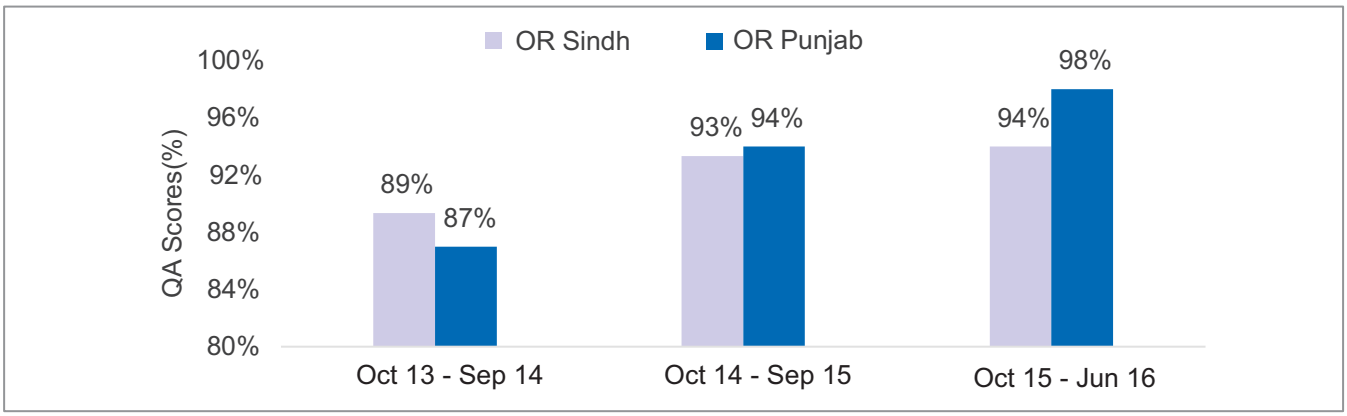
The FP/RH project has played a vital role in creating access to quality accurate information for communities, giving them a voice and empowering them to hold service providers accountable. This is expected to bring a sustainable change in health seeking behavior including ongoing demand for quality service provision.

Figure 4: Annual QA scores of SF providers, disaggregated by province



In FY14, a continuous supportive supervision (CSS) mechanism was introduced to support FP/RH SDPs to meet MSI global quality standards. CSS created a collaborative environment whereby QA monitors assessed the quality standards at USG-supported SDPs and further assisted them in taking corrective action to continuously facilitate service delivery improvements. Knowledge sharing and skills enhancement promoted empowerment and enabled providers to offer quality, voluntary FP/RH services, evidenced by the increase in QA scores over the life of the project and an increase in services provided per provider once they reached a level of maturity (i.e. being part of the network for more than 6 months). The adherence to standards and protocols developed for the outreach service delivery intervention was also regulated by the QA teams using a similar mechanism. The OR QA scores reflected improvement over time, as depicted in the figure below:

Figure 5: Annual QA scores of outreach teams, disaggregated by province



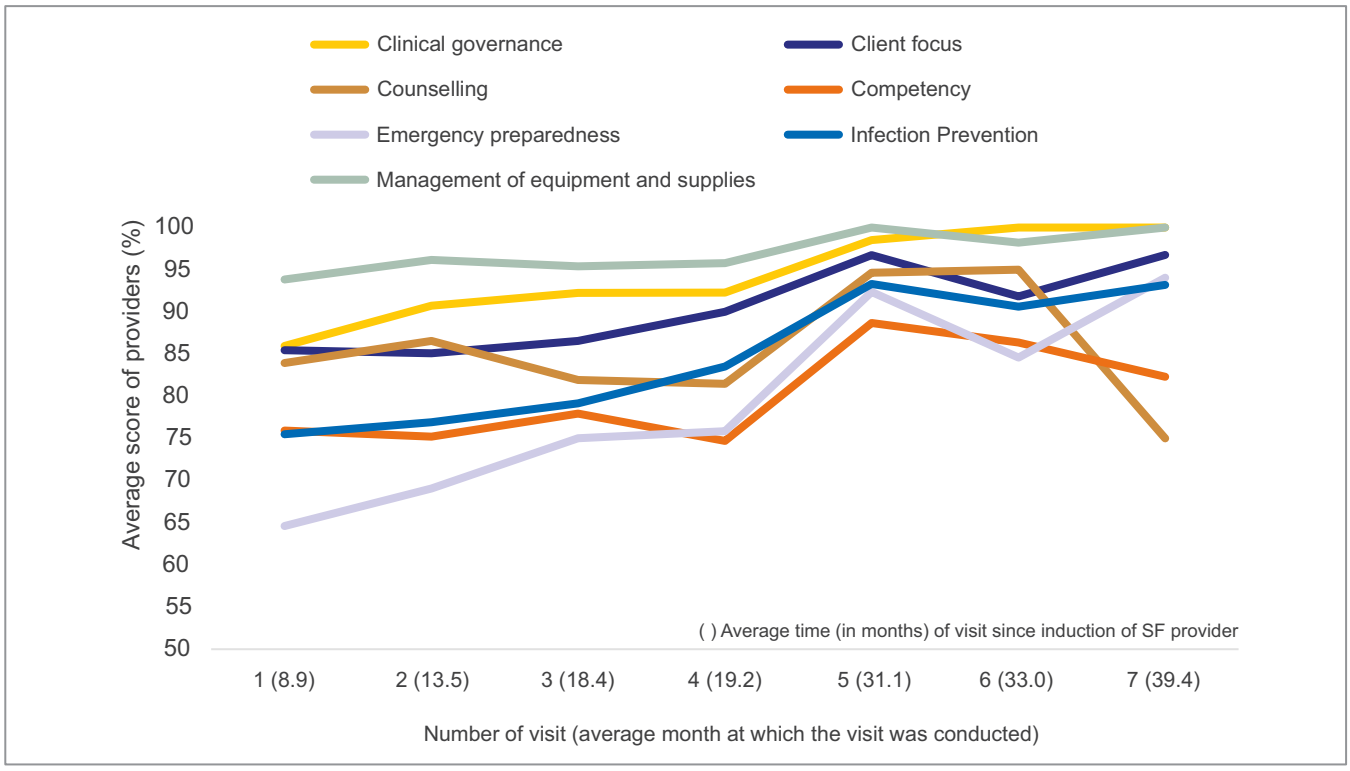
The quality assurance scores of the OR component were above the benchmark of 80% across the three years due to frequent monitoring visits and QA maintenance. Scores for FY14 were comparatively lower than rest of the years, as the OR teams took time to fully understand and meet all quality requirements to a high standard. Punjab performed slightly better than Sindh in FY15 and FY16 as a result of constant monitoring and supervision due to their lower scores in (Fy14).

Clinical performance quality of social franchise providers was assured by periodic monitoring visits, carried out by QA monitors. A standard checklist was used to assess key thematic areas: clinical governance, client focus, counseling, competency, emergency preparedness, infection prevention, and management of equipment and supplies. The research, monitoring & evaluation (RME) teams at FP/RH undertook a detailed analysis of 232 SF providers who were assessed over a period of approximately 40 months. They assessed the clinical performance of franchised providers against key dimensions of quality for the provision of FP services over time. The data was extracted from a total of 445 observations documented during QA visits that were conducted for the 232 SF providers.

The frequency of visit for each provider varied depending on when they were inducted and QA scores at each visit. The providers with lower scores were visited more frequently than the SF who had higher QA scores.

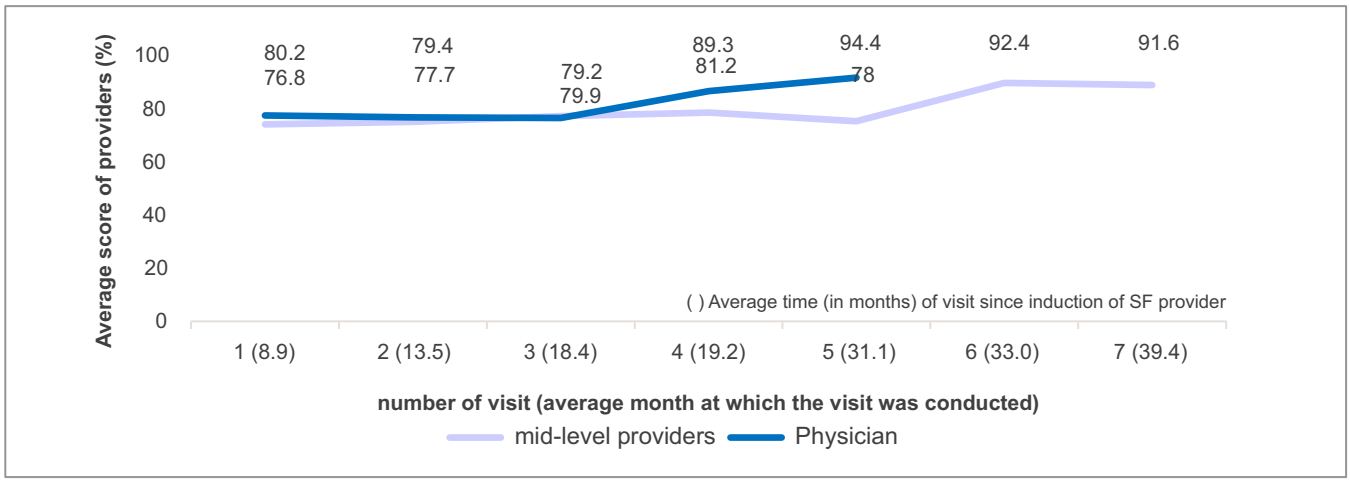
Analysis of the QA data for assessing compliance with various standards indicated that SF providers tend to perform well on management of equipment and supplies, followed by clinical governance, client focused SDPs and on the FP counseling aspects, as indicated in figure 4. The lowest score attained on the initial visit was on emergency preparedness, followed by infection prevention, which did improve considerably over time. However, SF providers required more assistance in developing 'competency of procedure' performance quality. This was found to attain a satisfactory level by the fourth visit of QA monitoring. Similar data was used for conducting needs-based refresher trainings and the improvement in scores over time in 'emergency preparedness' and 'infection prevention' are indicative of that.

Figure 6: Clinical performance of social franchise providers over time, average score by theme



There is a common perception among communities that doctors provide better quality services than mid-level providers; however, the clinical performance analysis of QA data for both SF-A and A+ providers revealed that there was little to no difference between the QA scores obtained by mid-level providers i.e. nurses, CMW, LHV, Family Welfare Workers (FWW) and medical doctors (MBBS), as assessed during QA visits. This is encouraging to note, as there is a critical shortage of doctors, particularly in rural areas. Investment in building the competence of mid-level providers in quality FP service provision is a promising strategy to meet demand.

Figure 7: SF Providers clinical quality over time: average score by cadre



The QA mechanisms were well recognized across the USAID MCH program partnerships. Institutionalization of QA mechanisms at public health facilities was picked up as one of the project's legacy areas by USAID. Based on their learnings of QA institutionalization in the private sector and the systems in place, FP/RH provided technical support towards development of FP standards for select public health facilities offering these services. They shared their QA checklist being used as part of the 'Continuous Supportive Supervision' model and assisted the technical working group, comprising members from MCHIP and John Snow Incorporated (JSI), in developing a list of indicators to monitor quality at public health facilities, which were recommended to be included in quality dashboards and DHIS. A supervisory checklist and framework for QA was agreed upon, keeping in view the public health sector context. FP/RH supported JSI/ Health Systems Strengthening (JSI/HSS) component as they took the lead for advocacy around institutionalization of quality assurance mechanisms at public health facilities

Skills enhancement, effective mentoring, and supervision by the project's QA team was vital in building the reputation of SSF in the community they served for quality FP services. They were able to build their reputation and improve their businesses. This is evidenced by the number of voucher clients served by each provider increasing over the life of the project as well as the proportion of non-voucher clients who paid out of pocket for their FP method of choice. Investment in quality standards was therefore an important investment toward promoting sustainability of the SF intervention beyond the life of the project. FP/RH teams experienced that once a women's fertility needs were adequately addressed, and she had a positive experience while taking up a reliable method of contraception, she usually did not stop seeking FP/ RH services[14]. The impact of provision of quality FP/RH services[13] and client satisfaction on long-term health seeking behaviour of clients around FP is believed to be one of the long-term outcomes of the project.

[14] Client Exit Survey FY2015 indicates that FP/RH clients will seek repeat services

Objective 2: Scaling Up Facility-Based Service Delivery

The facility-based service provision comprises a social franchise network known as 'Suraj.' It is a model in which the franchisees (the private health care providers) are given in-depth training on FP services by the FP/RH project team. Suraj play an essential role in addressing the unmet need for FP/RH in rural, remote areas. Suraj providers are located in low income localities where other providers are not usually available. They are provided with affordable, high-quality commodities for their clients and are assigned one female FHE. The FHE helps facilitate community access to FP services by conducting door-to-door household visits in and near communities where the provider is located and also conducts Mohalla and Mashwara meetings. She informs women about the Suraj providers and builds awareness to generate demand for voluntary FP methods and services. As clients are mostly women of low socioeconomic status who have minimal, if any, access to FP services, FHEs also distribute vouchers to clients seeking to avail a service but who fall below the poverty line and are unable to pay for FP services. This reduces barriers to voluntary uptake. The primary role of SF is to bridge the gap by providing access to the underserved MWRA with a wider choice of FP methods while complimenting services provided by the LHWs within the same communities.

Contribution of FP/RH Objective 2 – Assessing the impact

Objective 2 of the FP/RH project contributes to the following IRs of the USAID MCH Program framework:

- IR 5.1 Improved utilization of quality FP/RH and maternal, newborn and child health (MNCH) services
- IR 5.1.1: Improved availability of quality FP/RH and MNCH services

The output level contributions are depicted in the following table:

Table 8: Snapshot of FP/RH achievements under objective 2 from Oct 2013 to July 2016

Output 1: Adding SF providers to the SSF network	301 SF providers were added to the SSF network from inception to date
Output 2: Clients served through the Suraj network	495,383 clients served through the Suraj network
Output 3: Vouchers distributed through the Suraj network	A total of 493,600 vouchers were distributed through the Suraj network to increase access to quality, voluntary FP services and build future demand. (Out of which, 379,710 were redeemed, i.e. 77%)
Output 4: CYPs delivered through the Suraj network	521,536 CYPs were generated through services provided by the Suraj network in FY16, making a total of 1,108,596 CYPs delivered through the Suraj network since the inception of the project
Output 5: Unintended pregnancies averted through the Suraj network	An estimated 181,293 unintended pregnancies were averted in FY16, making a total of 421,522 estimated unintended pregnancies averted since the inception of the project
Output 6: Maternal deaths averted through the Suraj network	An estimated 165 maternal deaths were averted in FY16 making a total of an estimated 361 maternal deaths averted since the inception of the project
Output 7: Provision of facility based safe motherhood and FP services through MCH Rohri	1,707 clients received SMH services and 339 received FP services in FY16, making a total of 6,024 SMH clients and 1,123 FP clients served at MCH Rohri for the life of the project

SF Providers operationalized

SF providers were categorized as SF-A and SF-A+, depending on the qualification and the range of FP services they provide, as highlighted in table below:

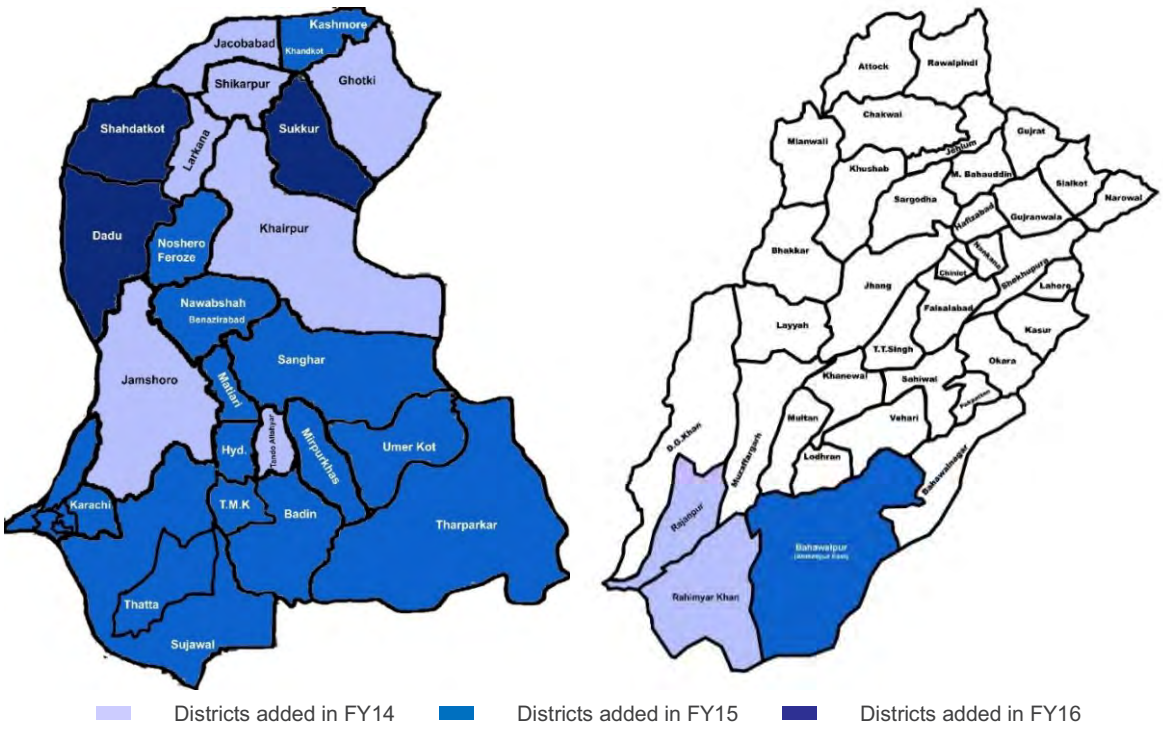
Table 9: SF Clinics established through USG

TITLE	CADRE	SCOPE OF WORK	# FOR LIFE OF PROJECT	# ACHIEVED BY Mar 2016	INTERVENTION DISTRICTS
Suraj Franchise A (SF-A)	LHVs, paramedics, nurses, etc.	SF-A provides short-term methods of FP, and IUCD as the only LTM	250	255	29 districts of Sindh and 3 districts of Punjab
Suraj Franchise A+(SF-A+)	Medical doctors (MBBS only)	SF-A+ provides a full range of ST, and LAPM	50	46	12 districts of Sindh and 2 districts of Punjab

When program modifications were made in February 2016, the number of SF SDPs was revised to 300 for the life of project. The FP/RH team was able to operationalize 301 providers by March 2016 i.e. before the phase out began. The number was reduced to 146 by the end of July 2016. This was a remarkable achievement as there is a critical shortage of health workforce in rural areas. This was made possible only due to the streamlined processes put into place by the project team. Having achieved this important benchmark, the focus was then on enhancing efficiency and effectiveness for greater impact.

Geographic Reach of FP/RH Project

The geographic reach of the project extended to 29 districts of Sindh[15] and 3 districts of Punjab provinces in Pakistan.



[15] The map shows the 5 districts of Karachi as one. With Karachi comprising of 5 districts, the total number of districts for Sindh is 29 and has been used as such throughout the report.

Social Franchise Clients

The majority of SF FP clients were under 30 years of age with an increase of 41% in younger clients between FY14 and FY15. Nearly one third had 5 or more children, and more than 70% of clients had either received no formal education or completed less than primary school education. Similarly, the majority of clients were housewives. More importantly, nearly 4 out of 5 clients lived on less than $2.50 USD a day.

Table 10: Social Franchise Client Profile

Indicators	2013	2014	2015
% of FP clients under 30 years of age	66.5	54.7	77.3
% of clients who had 5 or more children	38.3	35.2	35.0
% of clients with Education (no formal education or only some primary education)	74.0	71.9	69.6
% of clients who were Housewives	75.8	77.8	90.9
% of clients living under USD 2.50	78.0	79.1	79.7

Social Franchise under the FP/RH project proved to be an effective means of reaching the poorest sectors of society. While data from the entire project showed that the public sector was more effective at reaching the poorest quintile, 26% of FP/RH SF providers' clients were in the poorest two quintiles. Comparing FP/RH SF data with global SF providers, the FP/RH SF providers were amongst the best at providing access to voluntary FP to the poor[15].

Table 11: Wealth Quintiles of SF Providers

	Suraj Social Franchising	FP users in Punjab & Sindh	Public sector FP users in Punjab & Sindh	National FP users in Pakistan	National public sector FP users in Pakistan
Poorest	8%	8.6%	13.9%	9.9%	13.3%
Poor	18%	12.5%	16.9%	15.5%	19.2%
Medium wealth	26%	18.4%	22.0%	18.7%	22.9%
Wealthy	38%	25.6%	24.5%	23.2%	22.9%
Wealthiest	10%	34.8%	22.7%	32.8%	21.8%

Approximately 50% of all clients were FP adopters (i.e. clients who had not used an FP method in the last three months)[16]. The percentage of adopters gradually decreased over time from 47.2% in 2013 to 42.7% in 2015. The percentage of clients who switched from short-term methods to long-term methods doubled, from 9% in 2013 to 18% in 2015.

[16] FP/RH followed MSI's definition of FP adopter which is 'no prior use of any method in the last 3 months'; however, as per USAID advice the definition was changed to the 'last 6 months'. The data was captured (as per USAID proposed definition) for the first time during the 2015 Client Exit Interview. Results showed the percentage of clients adopting a modern FP method who had not used one within the past 6 months was 50.2% which did not show a big variation from the 3-month definition.

Table 12: FP Behaviors of Social Franchise Clients

Indicators	2013	2014	2015
% of clients who were FP adopters (did not use FP in the last 3 months)	47.2	46.7	42.7
% of clients who were voluntary Method Switcher (short-term to LAPM)	9.0	5.2	18

For social franchises, client exit interview data demonstrated that FHEs were the most consistent and popular source of information. The percentage of clients who obtained information through FHEs dropped in 2014, but increased to 67% in 2015. This is likely due to the induction of new providers in 2015 as, at the start, the majority of referrals are made by FHEs while conducting awareness raising activities however, once an SF provider gains a strong reputation in a community, the share of walk-in clients or referrals from satisfied users increases.

Table 13: Source of Information used by Social Franchise Clients

Indicators	2013	2014	2015
% of clients who were received FP information from FHEs	51.5	38.8	67.0
% of clients who were received FP information from public providers	28.6	31.1	11.7
% of clients who were received a personal recommendation	18.8	27.5	18.7

In the SF channel, the proximity of an SF provider, low cost/availability of voucher services and the good reputation of the provider were cited as key reasons for choosing the SF facility. The findings substantiate that access, cost and quality of services served as the main barriers for clients. The FP/RH project has addressed these barriers through its SF intervention. The increase the share of voucher/low cost may be attributed to the induction of new SF providers as FHEs tend to distribute more vouchers in the initial phase for demand generation by reaching to the poorest group.

On an average it took approximately 20 minutes for Suraj SF clients to get to the health facility for FP services – which supports the idea that women tend to go to adjacent facilities for FP services. Here, OR mobile units played a complementary role in serving potential clients that live farther away from Suraj Clinics. According to 2015 CES, only 23% of the FP clients served through SF center knew of another provider offering the method that they received from the SF clinic.

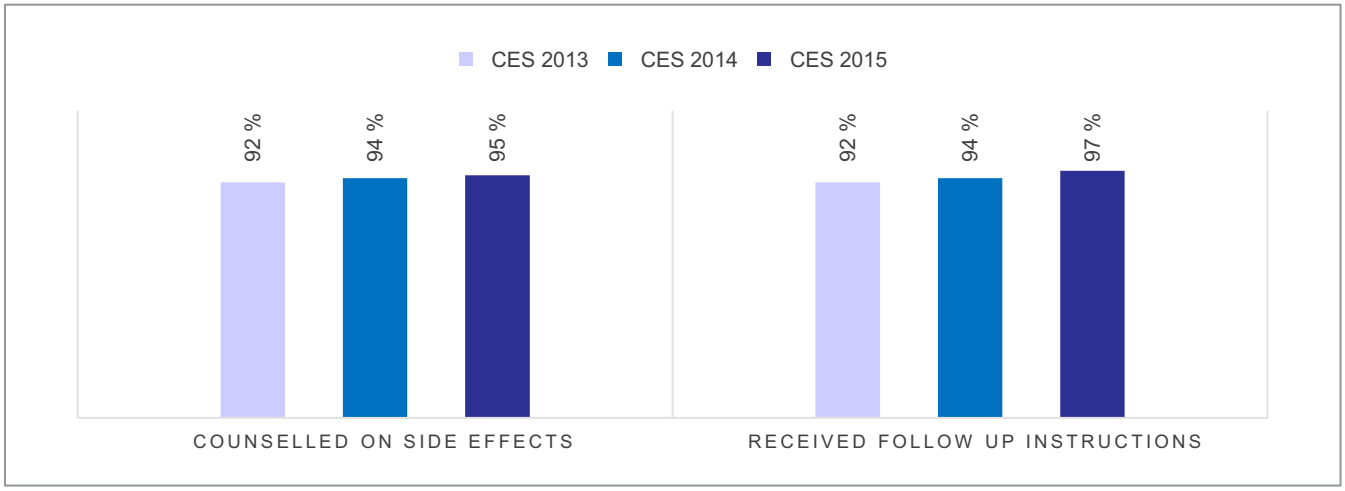
Table 14: Reason for selecting Social Franchise

Indicators	2013	2014	2015
% of clients who selected the SF because it was near by	45.6	40.6	20.9
% of clients who selected the SF because of its reputation	12.5	2.6	6.3
% of clients who selected the SF because low cost/voucher	36.9	43.2	64.1

SF Clients perception of quality of care

The majority of the clients served through the social franchise were counseled on potential side effects, and received follow-up instructions if necessary. A positive trend was observed in these indicators over the period of three years.

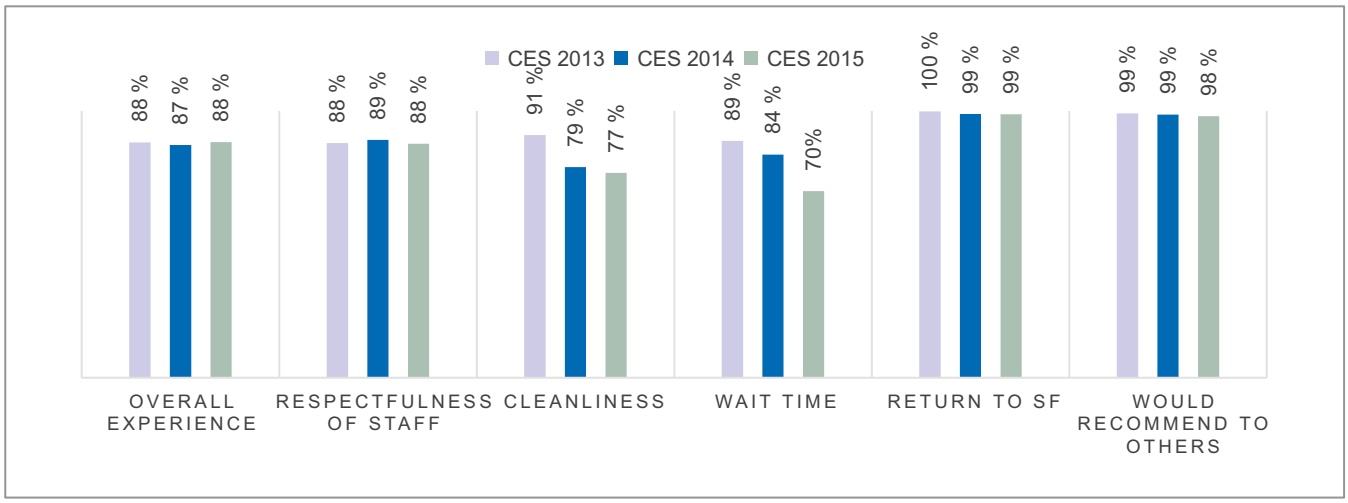
Figure 8: Perception of Quality amongst Social Franchise Clients



Satisfaction levels amongst SF Clients

Clients showed high levels of satisfaction with services provided at SF clinics. However, in 2014 and 2015 the satisfaction levels related to cleanliness and waiting times dipped. In response to this protocols were developed to improve cleanliness and QA teams were especially attentive with assessing and providing feedback on this during their visits to the QA centers. Almost all clients reported a willingness to return to the facility in future if needed and would recommend the facility to others in their community.

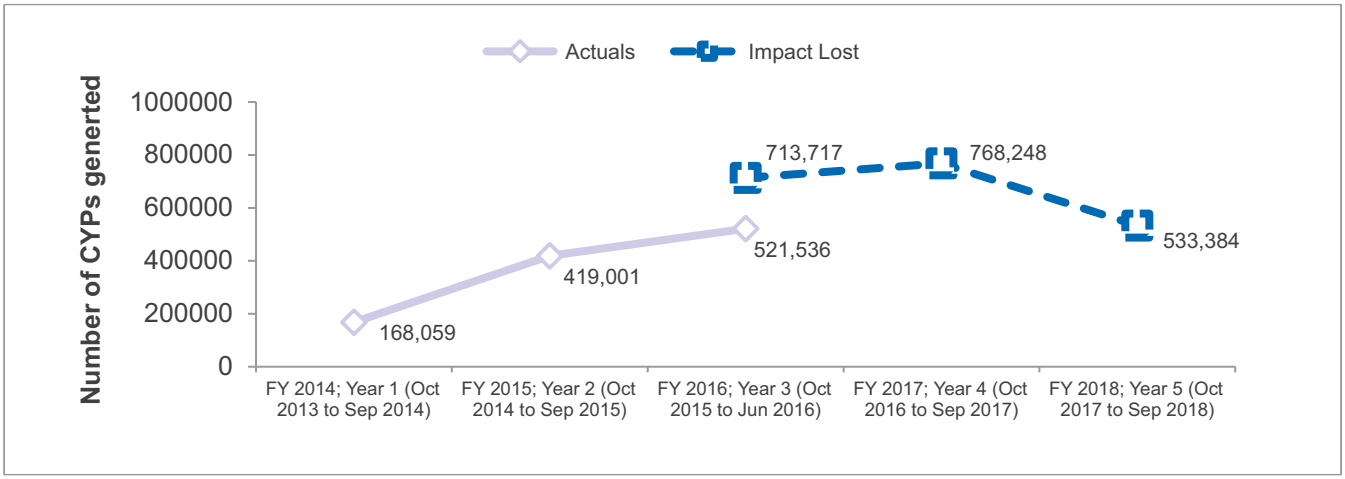
Figure 9: Satisfaction Level amongst Social Franchise Clients



CYPs generated through SF intervention

The FP/RH project generated a total of 1,108,596 CYPs over the life of the project through Suraj SF. Of the total CYPs, 60% of which were generated during FY16, despite SF being only being fully operational for eight months. This reflects the momentum the project had gathered as a result of investment made in building capacity of service providers and optimizing management efficiencies being realized.

Figure 10: FP/RH SF Channel - CYP actuals and calculated trajectory[17]



Note: The actual numbers for FY 2016 is up to 12th July 2016.

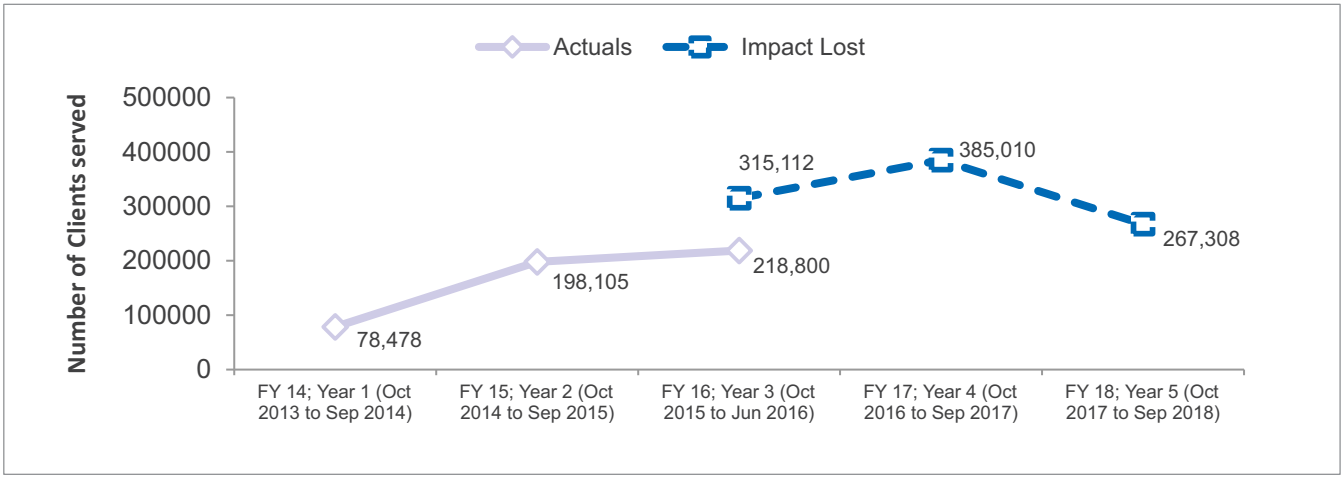
[17] In this graph the numbers used in Year 4 and 5 are based on performance growth trend seen in SF CYPs generated in previous years i.e. year 2 and year 3.

Support provided by the MSS Technical Services Department (TSD) helped create an environment for evidence-based decision making that promoted effectiveness and efficiency for greater access to services for women across Pakistan. Service methodology was monitored and used to better inform the program activities such as utilizing FHEs to promote awareness and provide information within their communities, increasing client's access to quality providers by effective mapping to establish SSF provider SDPs and offering a range of high quality, voluntary FP services to women. The success of this model provides a documented proof of concept for the government to adapt to meet the FP2020 commitments. More specifically, the SF intervention model demonstrates the significant impact of engaging with private sector providers – especially the huge potential of mid-level providers to expand coverage of quality voluntary FP services. Moreover, the importance of 'voucher' for increasing access and to address cost barriers for poor clients can certainly be considered as a viable option for FP programs in future.

FP Service Provision in SF Intervention

A total of 495,383 clients were served at the USG supported SF clinics.

Figure 11: FP/RH SF Channel – Actuals clients served and calculated trajectory[18]



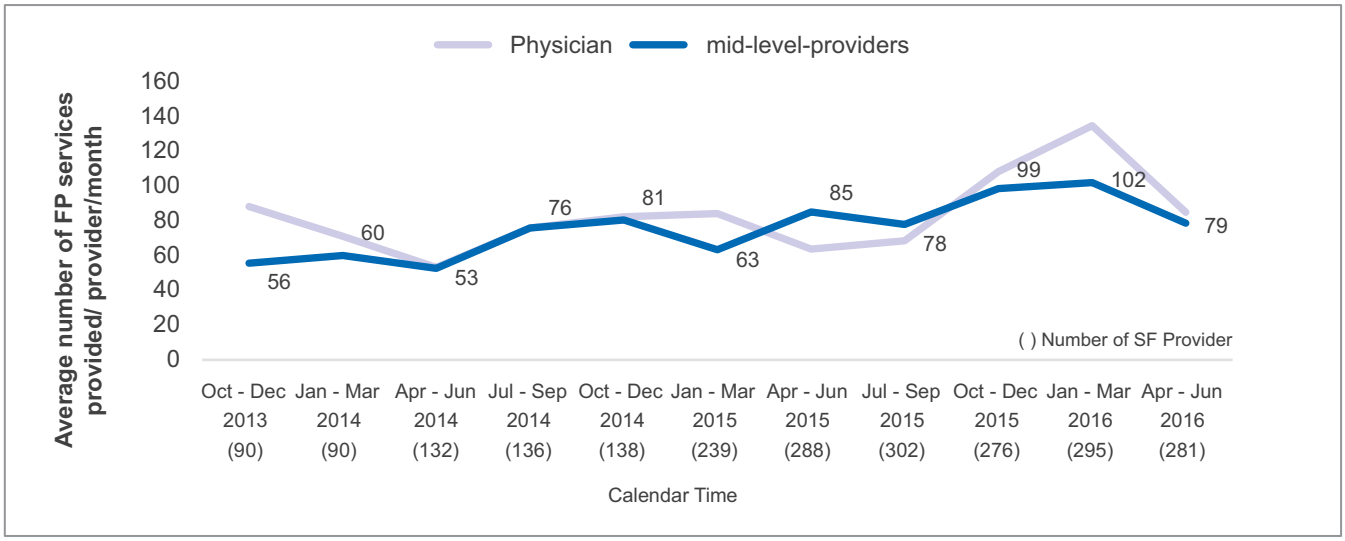
Note: The actual numbers for FY 2016 is up to 12th July 2016.

During the reporting period, the actual number of clients served was 136% higher than what was envisaged. Out of the total of 495,383 clients served, 218,800 (44%) were served during the nine months of the current year (Oct 2015 to July 2016). The highest number of services were witnessed in April 2016.

An in-depth analysis of social franchise service delivery data by the RME team revealed that, on average, the service providers increased FP service provision significantly over time as they gained more confidence in service provision. At the start of the project, the average number of FP services provided per provider per month was 20. This increased to 114 a month between January – March 2016. A similar trend was observed in CYPs. The average number of services provided by doctors (SA +) and mid-level providers (SF A) were more or less the same over the life of the project, as depicted in figure 11.

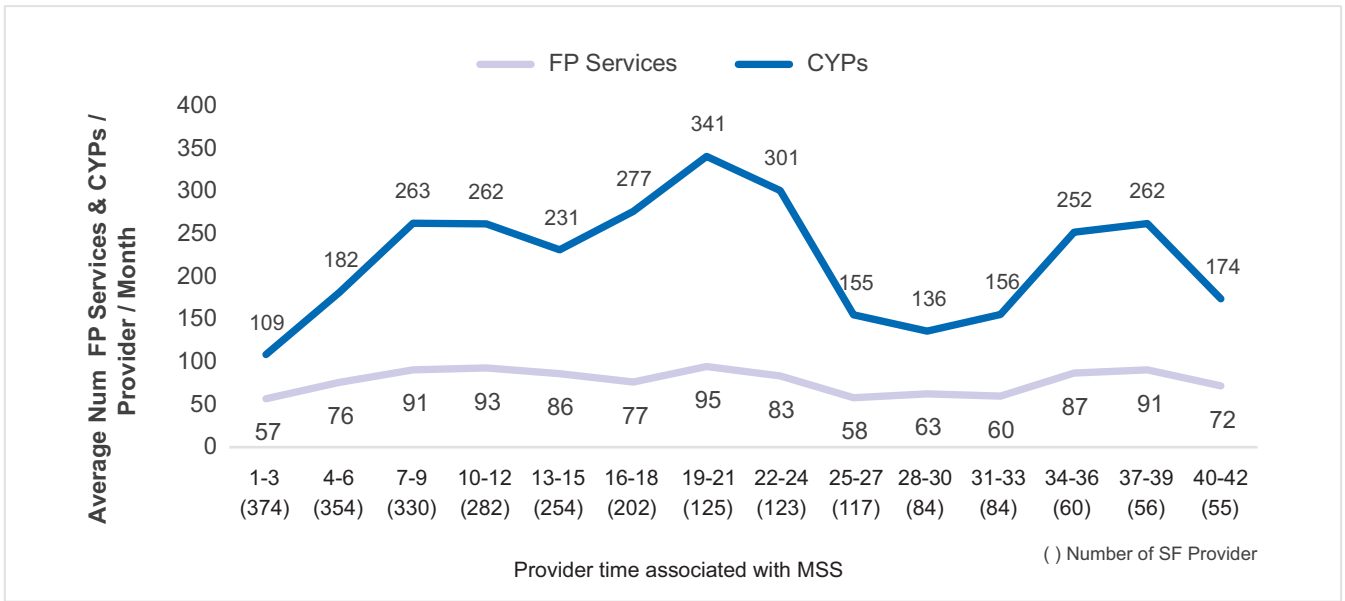
[18] In this graph the numbers used in Year 4 and 5 are based on performance growth trend seen in SF CYPs generated in previous years i.e. year 2 and year 3.

Figure 12: Average FP services per month per provider disaggregated by cadre



Similarly, there was an increase in the provision of voluntary IUCD services per provider over time. This demonstrates how providers become more confident in provision of IUCD services over time. Furthermore, a dip was noticed in average IUCD provision every time a new pool of service providers was inducted in the SF network.

Figure 13: Average FP services per provider and duration of provider's association with FP/RH



Method Mix in SF intervention

Out of the 1,108,596 CYPs generated from inception to the closure of the project, 55,430 were from the STM, 975,564 from LTM and 77,602 from permanent methods (PM). Through the life of the project, 88% of the total CYPs generated in the SF were from LTM while only 5% were from STM, despite STM clients making up 55% of clients over the life of the project. This was due to the higher CYP factor of LTPM and availability of LHWs within the catchment populations providing only STM, thereby satisfying some of the STM demand of the population.

Figure 14: Total project CYPs generated by SF Channel from inception to close of the project

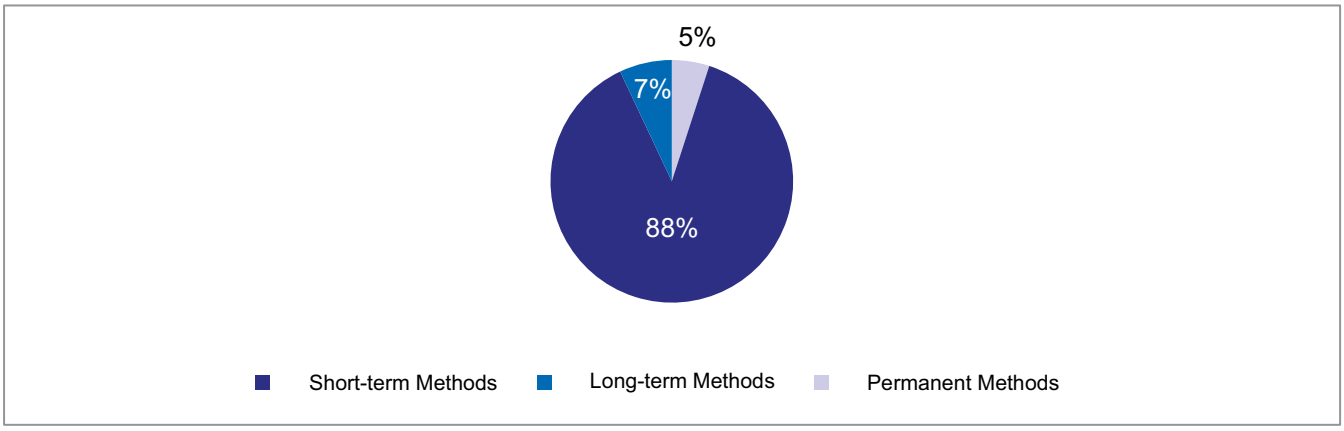
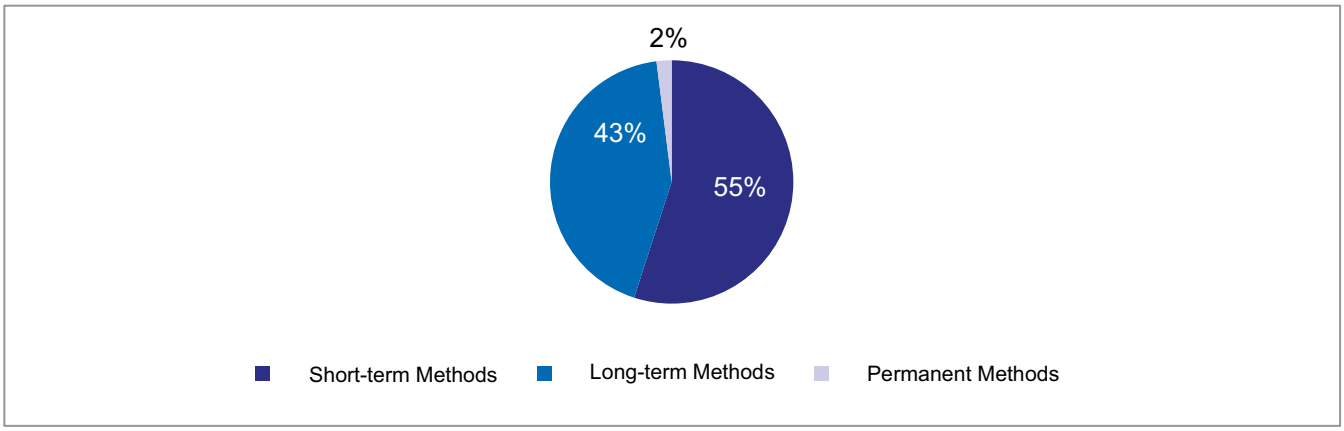
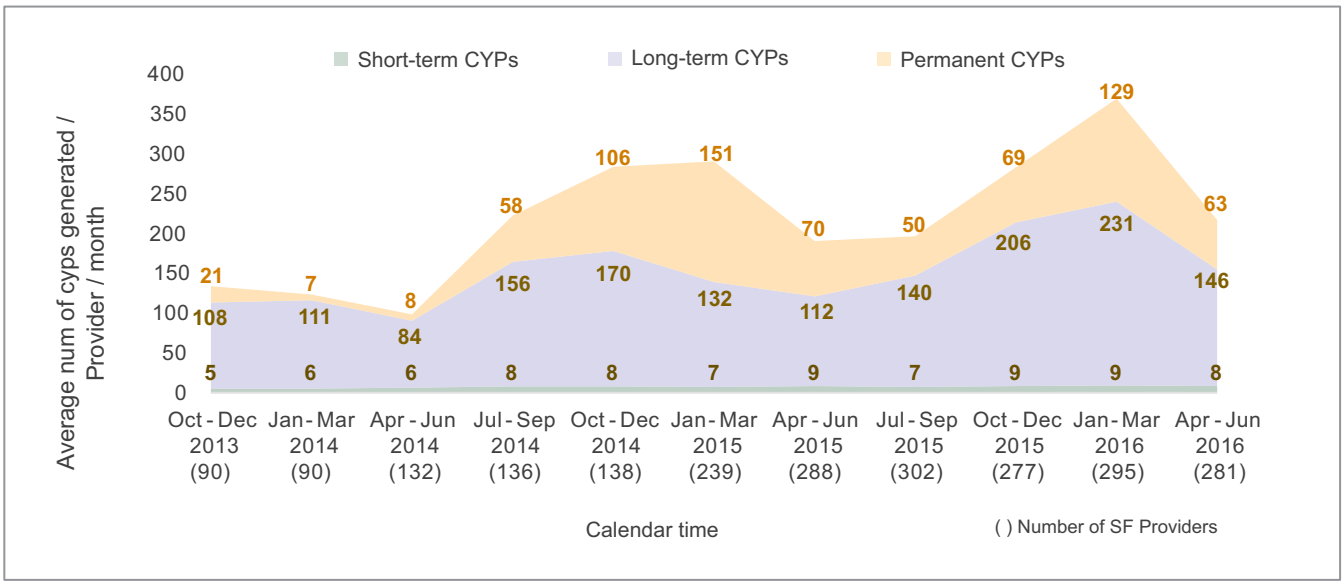


Figure 15: Clients served by SF channel from inception to close of project



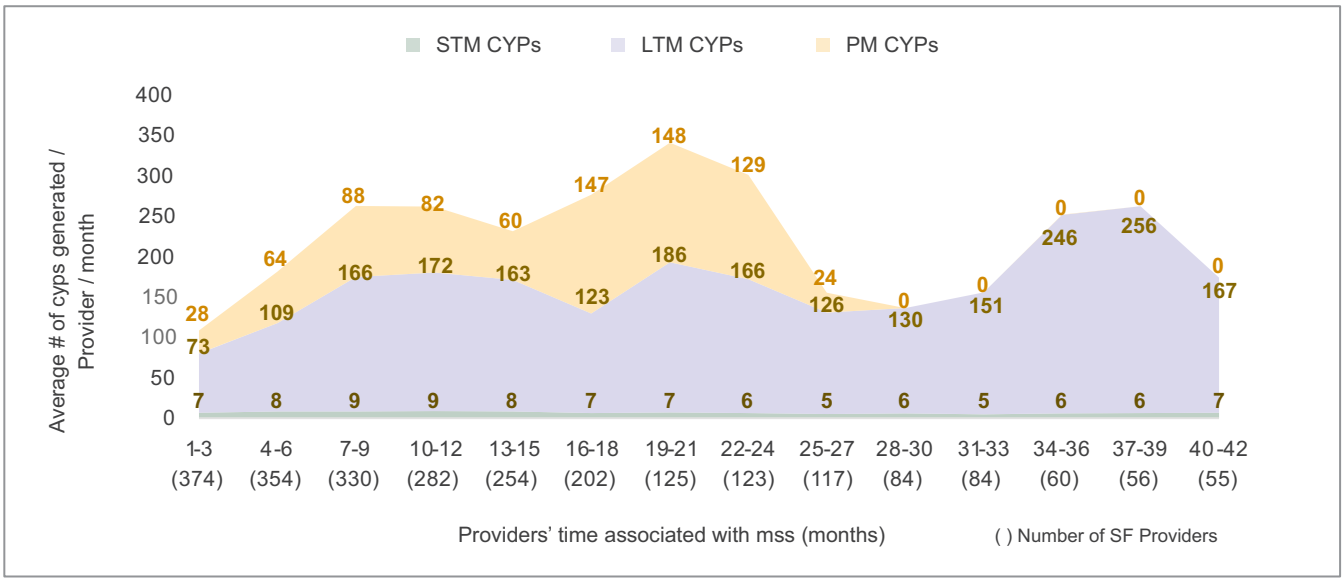
Fy16 saw an increase in the voluntary uptake of services and generation of CYPs, contributing to 47% of the total CYPs generated during life of the project through the SF Channel. The increase in delivery in FY15 reflects the network reaching the full 301 providers as well as the impact of investment in training and supportive supervision, awareness raising, demand generation and more effective coordination and management.

Figure 16: Average CYPs generated per provider distributed by method mix



As the term of provider's association with FP/RH increased, there was a diminishing provision of permanent methods to the overall average services provided per provider per month. Long term methods increased over time whereas the short term contribution remained almost constant as depicted Figure 15. This signifies the role SF plays in providing access to the underserved MWRA with a wider choice of FP methods and complimenting the services being provided by the LHWs in the same communities.

Figure 17: Average CYP generated by method mix and duration of Provider's association with FP/RH



The parity distribution of FP/RH clients served through the SF channel revealed the largest single proportion of Tubal Ligation (TL) clients had between 3-5 children, followed by clients with 6-9 children.

Figure 18: **Number of children among TL clients in SF from inception to date**

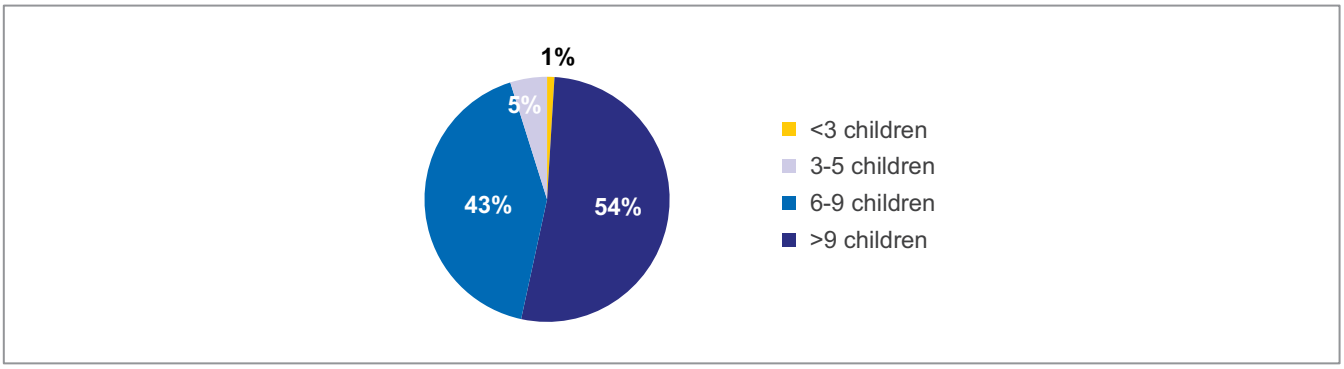


Figure 19: **Age distribution among TL clients in SF from inception to date**

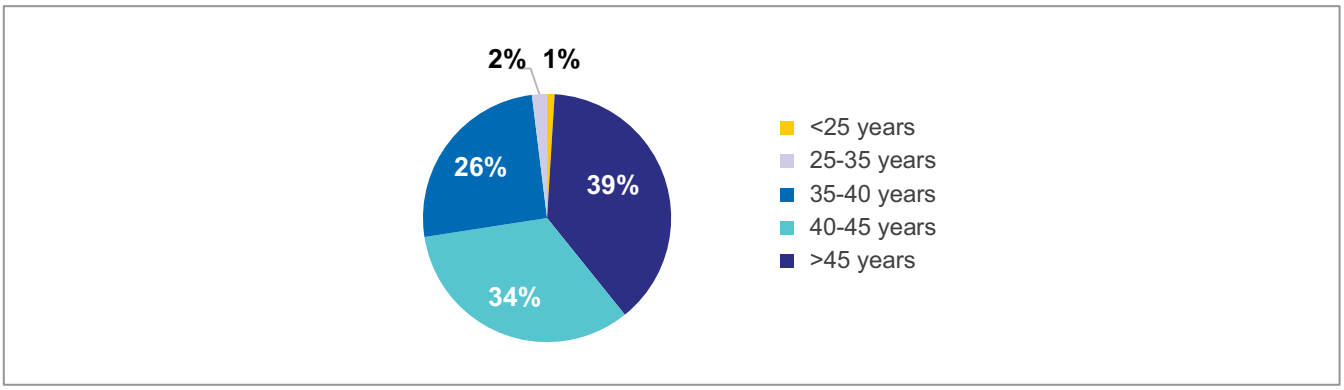


Figure above demonstrates the proportion of clients seeking a voluntary TL through SF over the life of the project. In FY15, 39% of TL clients were between 40-45 years of age and in FY16 50% of clients were between 25 to 35 years of age. The proportion of women aged between 25-35 years of age seeking a TL is indicative of the early age of marriage and first birth - the Pakistan DHS reported that 54% of women aged 25-49were married by the age of 20 and the median age of first birth was 22.2[19].

FP Vouchers in SF Intervention

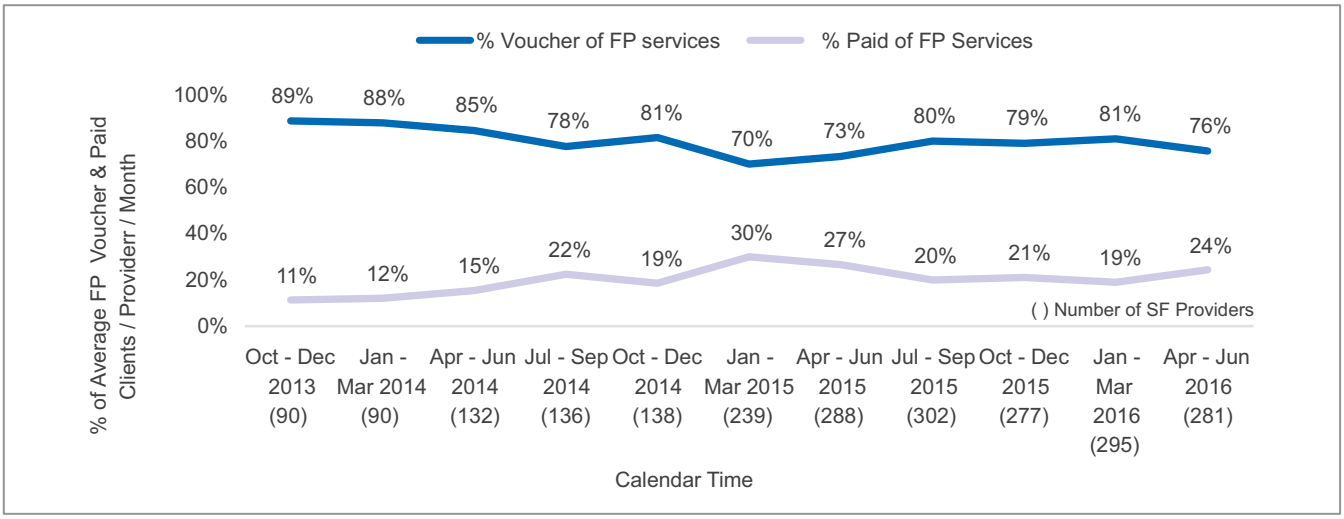
A secondary data analysis of the Pakistan Demographic and Health Survey (2013-14) reveals 6.4 million women have an unmet need for FP; among them, 2.8 million have an unmet need for spacing and 3.6 million have an unmet need for limiting[20]. Unmet need is higher in rural rather than urban settings (21.6 vs 17.1) and women in the lowest two wealth quintiles have higher unmet need compared with those in the higher wealth quintiles. This indicates a need for improved access and utilization of voluntary FP in underserved communities where poverty is a major barrier. FP/RH used FP vouchers as a demand-side financing tool to increase access to FP by marginalized women with high unmet need. Annual client exit interviews (CEI) conducted in 2013, 2014 and 2015 indicate that 20% of clients served at SF clinics live on less than $1.25 a day and another 59.7% lived on $1.25-$2.50 a day: almost 80% of the clients served were living below the poverty benchmark of $2.50 a day.

[19] Pakistan Demographic Health Survey 2012-2013
http://www.nips.org.pk/abstract_files/PDHS%20Key%20Findings%20FINAL%201.24.14.pdf

[20] Overall, 20 percent of currently married women have an unmet need for family planning, 9 percent have an unmet need for spacing, and 11 percent have an unmet need for limiting births. PDHS 2012-13

Despite being an important tool to increase access to voluntary FP services in the short term, vouchers are not a sustainable intervention. To address this, FP/RH focused on providing quality FP services and building the Suraj brand so that it became associated with reliable, safe and quality voluntary FP service provision at an affordable cost - ultimately helping clients to transition from vouchers to fee paying clients. The percentage of paying or non-voucher clients at the inception of FP/RH project was 11%, compared to 89% of clients utilizing a voucher to access services. The project aimed to increase the proportion of paying clients to 40% by the end of the five-year project in order to make the interventions more sustainable. Owing to the successful integration of FHEs in their communities and word-of-mouth advertising, particularly regarding quality of FP services at the SF clinics, over the life of the project, the percentage of non-voucher clients gradually increased to 24% in Q3 of FY16. The induction of new providers was found to be associated with increased use of vouchers in the initial months.

Figure 20: Percentage of FP voucher and paid clients per provider per month



No differences were observed in the percentage use of vouchers for short-term, long-term and permanent contraceptive methods however, voluntary PMs were only accessed through vouchers. This suggests that without voucher subsidy, clients tend to select cheaper FP services.

Figure 21: Voucher clients, segregated by method mix during the life of the project

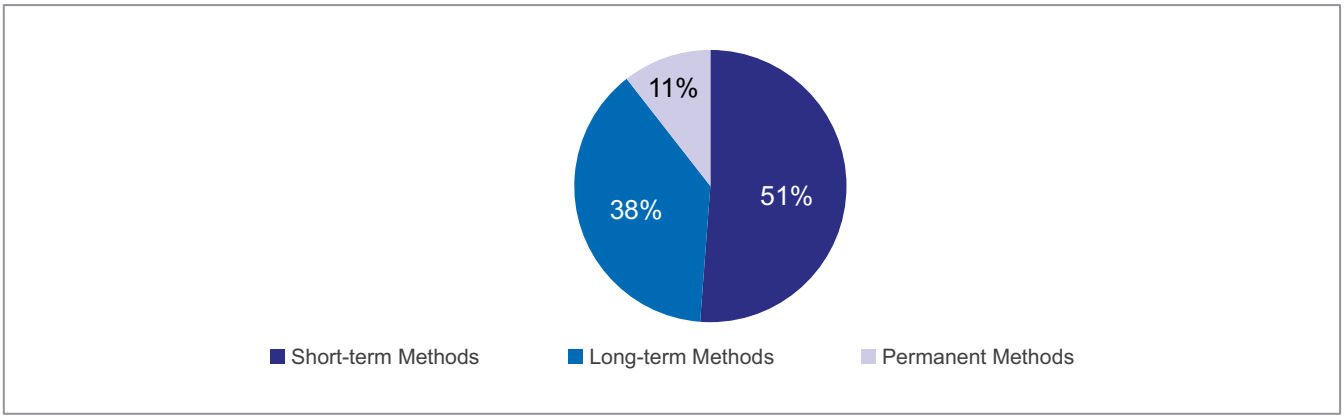
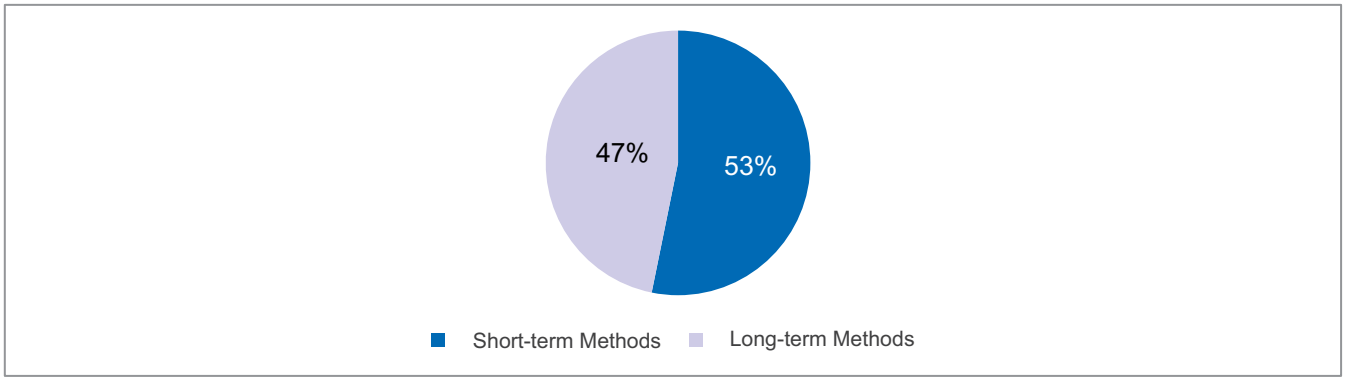


Figure 22: Non-voucher clients, segregated by method mix during the life of the project



Safe Motherhood Intervention through Facility-Based Service Delivery

MCH Rohri

The FP/RH MCH center was set up in the less-developed area of Rohri in the Sukkur district (Sindh province) to serve a population of nearly one million, covering Rohri, Sukkur, Pano Aqil and Salehpat. The services started from October 1, 2014, and during the life of project, the maternity unit at Rohri provided 3,366 antenatal services, 1,772 postnatal services, and conducted 364 normal vaginal deliveries. The center also served as a referral site for nearby health facilities for the provision of emergency obstetric care and a total of 522 caesarean sections were conducted during the life of the project. ANC visits were dependent on the time of first client referral, i.e. if a client was identified in her last trimester, then only one or two ANC were required. While PNC visits were mostly conducted for all clients that delivered at the MCH center Rohri, the service categories in the table below may include multiple visits by the same client. On June 1, 2016 USAID\Pakistan informed MSS about a change in program direction of the Mission's Health Strategy based on reduced funding for health activities in Pakistan. As such, MSS was informed that all current FP/RH project activities would close by September 30, 2016.

Table 15: SMH services provided at MCH Rohri center in FY15 (Oct 14–Sep 15)

SMH Service	FY15 (Oct 14 to Sep 15)	FY16 (Oct 15 to Jun 16)	Inception to date
Antenatal check-up	2,425	941	3,366
Postnatal check-up	1,259	513	1,772
Normal delivery	272	92	364
C-section	361	161	522

HANDS Private Health Facilities

The Health and Nutrition Development Society (HANDS) operated a model of integrated FP and safe motherhood services as a sub-awardee of the FP/RH project. It operated through four donor-approved certified private health facilities in the districts of Badin, Dadu, Kashmore and Umerkot. The selected facilities operated in areas where either the community has no access to a nearby public health facility or where health facilities were not functional for provision of EmOC services. Following USAID's approval, HANDS started its operations during the third quarter of FY15 and conducted 1,161 antenatal and 270 postnatal check-ups during the life of the project. 232 normal deliveries were conducted, and 181 clients delivered through caesarian section at these facilities.

Table 16: SMH services provided at HANDS facilities

SMH Service	FY15 (Oct 14 to Sep 15)	FY16(Oct-Dec 15)	Inception to date
Antenatal check-up	1,096	65	1,161
Postnatal check-up	260	10	270
Normal delivery	207	25	232
C-Section	145	36	181
Total	1,708		

Analysis completed at the end of the pilot phase was considered cost ineffective by the funding agency and hence discontinued.

Pilot Intervention for SMH Vouchers

With support from senior SMH voucher specialists at MSI, the FP/RH team worked to develop a model for provision of BEmONC services to marginalized communities. The aim was to increase institutional delivery of complicated cases and their early detection during antenatal visits as it is reported that only 11.8% of institutional deliveries in Sindh are conducted at the public health facilities[21]. Comprehensive emergency obstetric and neonatal care (CEmONC) was provided at four identified centers.

26 SF B were trained in BEmONC services during FY15, and three of them piloted the SMH voucher scheme services in the last quarter. During the pilot intervention, 737 SMH vouchers booklets were distributed, and a total of 827 women were served at the three SF facilities.

Table 17: SMH voucher services provided at SF-B during the pilot intervention (Oct 14–Sep 15)

SMH Voucher Service	FY15 Qtr 4 (Aug –Sep)
Antenatal check-up	686
Postnatal check-up	97
Normal delivery	59
C-section (at CEmONC referral site)	10
Total number of services provided during the pilot	852

[21] National Institute of Population Studies Pakistan, Macro International Inc. Pakistan Demographic and Health Survey 2012-13. Islamabad: Government of Pakistan; 2014

SMH Non-voucher Services

The 26 SF B providers trained in BEmONC services were provided with awareness raising and demand generation support by FHEs in their surrounding communities. FHEs made referrals for clients who could pay for services. Details of the non-voucher clients served at the 17 SF B facilities, including three who participated in the pilot intervention, are shown in the table below:

Table 18: Non-voucher clients served at Suraj B in FY15

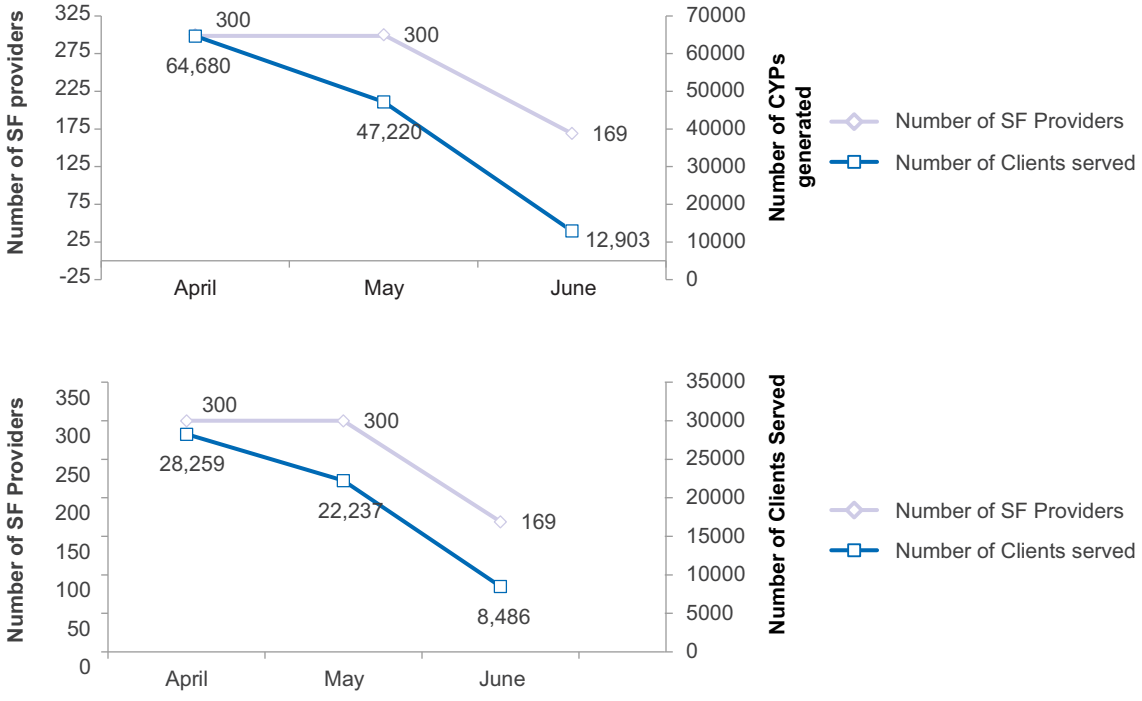
Referral Card Distribution	FY15 (Apr–June 2015)	FY15 (July–Sep 2015)	Fy15 (Apr-Sep 2015)
Total referral cards distributed	1,300	748	2,048
Total redeemed for ANC	348	325	673
Total redeemed for PNC	0	14	14
Total redeemed for NVD	0	0	0
Total clients served	348	339	687

The 6-week duration for pilot intervention was a short period for drawing inference. Thus, FP/RH designed an operational research study to measure the cost-effectiveness of delivering safe motherhood services through different voucher packages and further compare those to the sites without vouchers. However, as this activity was terminated upon USAID instructions, no insights have been gained from this study.

SF Close Out

Voluntary FP services were provided through a network of 301 SF providers across Sindh and Punjab. Due to the closure of the project, the number of SF providers was reduced to 169 toward the end of June and to zero by July 12, 2016. The following figure depicts the impact of close out on CYPs and client served through SF.

Figure 23: Impact (clients served) of close-out of FP/RH project operations in SF in Q3 (April – June 2016)



Objective 3: Scaling Up Outreach and Community-Based Service Delivery

Lack of access to contraceptives is recognized as a major contributor to the high incidence of unsafe abortions due to unintended pregnancies, the high fertility rate, and low contraceptive prevalence rate (CPR) in Pakistan. This is directly related to high maternal, newborn, and child mortality rates. Pakistan Demographic and Health Survey (PDHS) 12-13 documents that on average, one child in every household is the consequence of an unplanned pregnancy. Access to FPRH services is a challenge, particularly in remote, rural areas due to the lack of skilled providers and the limited number of health facilities, which are often not equipped for the provision of quality voluntary FPRH services. The lack of proximity to FP services, costs associated with accessing these services, gender inequities, illiteracy, cultural norms, myths and stigma further restrict MWRA from availing FP services.

The FP/RH outreach intervention was designed to mitigate these challenges. In partnership with the Department of Health, FP/RH aimed to make a comprehensive range of FP services available to underserved communities, utilizing public health infrastructure whenever possible. OR teams were trained and certified by the PWD in implant insertions and TL prior to conducting voluntary FP camps at the public health facilities with functional operating theaters to complement existing capacity to provide other methods.

The FP/RH outreach intervention made a comprehensive range of FP methods available to underserved communities who did not otherwise have access to them, particularly LAPMs. Leveraging the existing public sector infrastructure, the outreach program utilizes public health facilities with functional operating theaters in close coordination with district health officials. Camp plans were shared, and support from LHWs was solicited for making referrals for clients seeking to avail a voluntary LAPM. Working together with district health authorities, FP/RH was able to complement the existing availability of short-term FP methods being provided by the LHWs with availability of LAPM at the OR Camps.

OMUs were added as another intervention to reach clients living in communities where they neither had access to public health facilities nor private clinics for availing an FP method of choice. The intervention was designed to reach underserved clients with the highest unmet need. MWRAs were provided with a voluntary short- or long-term method of choice by trained staff in a refurbished and equipped vehicle. The OMU team in Punjab utilized PWD certified doctors who were also able to provide voluntary implant services to clients, in addition to voluntary IUCD and injectable services, thereby expanding choice.

FY14 and FY15 were the foundation years for this project, setting the base for creating sustainable impact. During the first two years of the project, OR teams were recruited, trained, and placed in the field. Due to the addition of new teams, service provision per team remained stagnant through most of FY15 compared to mature OR teams. However, after the optimal number of teams (18) were operational and teams became more mature and confident, the number of voluntary services provided per team increased. This was supported by strong operational management, well aligned systems, careful selection of camp locations and effective awareness creation and demand generation activities undertaken by the OR FHEs. Sindh reached its highest number of clients served per day with a voluntary method of their choice just as the project faced early close-out, thereby triggering the downward trend in May 2016.

Contribution of FP/RH Objective 3 – Assessing the impact

The following table indicates the output level contribution made by the activities executed under objective 3 of the FP/RH project

Table 19: Snapshot of FP/RH achievements under objective 3 from Oct 2013 to July 2016

Output 1: Outreach teams trained and made operational for provision of LAPM services	14 Outreach teams and 4 OMUs were trained and made operational for provision of LAPM services from inception to date
Output 2: Outreach camps conducted	3,169 camps were conducted, out of which 1,244 were conducted during FY 16
Output 3: Clients served through the outreach model	123,125 clients were provided FP services by the OR channel, of which 58,154 were served during FY16
Output 4: CYPs delivered through the outreach model	413,486 CYPs were delivered through the OR channel, of which 160,895 were delivered during FY 16
Output 5: Unintended pregnancies averted through the outreach model	60,766 unintended pregnancies were averted in FY 16, making a total of 159,561 unintended pregnancies averted since inception of the project
Output 6: Maternal deaths averted through the outreach model	An estimated 50 maternal deaths were averted in FY 16, making a total of an estimated 137 maternal deaths averted since the inception of the project
Output 7: Public health facilities identified and refurbished for the outreach camps	88 Public health facilities were identified, and 14 were refurbished for the outreach camps prior to the early close-out

It is important to mention the contribution made through the USG-supported FHEs of FP/RH who served as the backbone of the project and were instrumental in mobilizing communities, creating awareness and raising demand for voluntary FP services amongst the MWRA. They contributed to the following Sub IR of the USAID MCH Program Framework:

- Sub IR 5.1.2: Increased demand for FP/RH and MNCH services

A total of 359 FHEs and SFS were trained under the FP/RH project. They played a vital role in changing 00mindsets, clarifying myths and removing stigmas around FP use. Through door to door visits, Mohalla and Mashawara Meetings, they were able to reach out to 2,444,613 MWRA. Out of the total MWRA reached, 383,770were given an FP voucher for a method of their choice. A total of 621,082 clients were served through FP/RH SDPs that were supported by USAID generating over 1.5 million CYPs.

Outreach Clients

Nearly 3 of every 5 OR clients were over age 30, a trend that remained the same over the three years. In 2013 and 2014, nearly 45% of the OR clients had 5 or more children, while this percentage increased to 64% in 2015. The percentage of clients who had either received no formal education or completed only primary were around 80% and most of the women served were housewives. In 2013, nearly 81% of the clients served through outreach program were living under $2.50 USD a day. The percentage dropped to 73% in FY14, but increased to 90% in FY15. The reach to the farthest possible areas was increased especially through the OMU services to those very remote areas where no public or private HF was available. Also, with the scale up in the OR component in FY2015 the reach to these remote / poorest areas were ensured, thus reaching more poor clients in FY15.

Table 20: Outreach Client Profile

Indicators	2013	2014	2015
% of FP clients under 30 years of age	59.1	61.3	58.9
% of clients who had 5 or more children	46.9	41.8	63.9
% of clients with Education (none or less than primary)	81.0	78.2	85.9
% of clients who were Housewife	86.0	74.0	90.4
% of clients living under USD 2.50 per day	81.0	73.0	89.5

The reach of the OR program to the new voluntary FP adopters increased substantially over time, from 46.4% in 2013 to 68% in 2015. Similar trends were observed among method switchers from short-term to long-term methods: the highest percentage of method switchers was recorded in 2015 at 27.4%.

Table 21: Outreach clients -FP behaviors

Indicators	2013	2014	2015
% of clients who were FP adopters (did not use an FP method in the last 3 months)	46.4	54.3	68.0
% of clients who were method switchers (short term to LAPM)	11.6	18.4	27.4

In the outreach program, FHEs were the most popular source of information in 2013; however, this dropped considerably in subsequent years, which is due to an increased focus on networking and coordination with public health workers (LHWs) who became the main source of referrals in subsequent years.

Table 22: Source of information used by outreach clients

Indicators	2013	2014	2015
% of clients who received FP information from FHEs	75.0	15.0	27.0
% of clients who received FP information from public providers	16.6	52.8	58.3
% of clients who received a personal recommendation	6.5	27.2	11.1

In OR, the provision of free services was the predominant reason for a client visiting an OR camp – this was followed by the services being available close to their homes. According to the 2015 CES, only 13% of FP clients served through outreach knew of another provider offering the method that they availed from the outreach camp and on an average, it took 35 minutes for clients to get to an Outreach camp. This demonstrates OR's effectiveness of serving the underserved. While it is difficult to know the exact reason for trend variations between years, the change in the proportion of clients who chose OR because of its low cost between 2014 and 2015 is likely because of the greater proportion of clients reached in 2015 who lived under 2.5 USD/day.

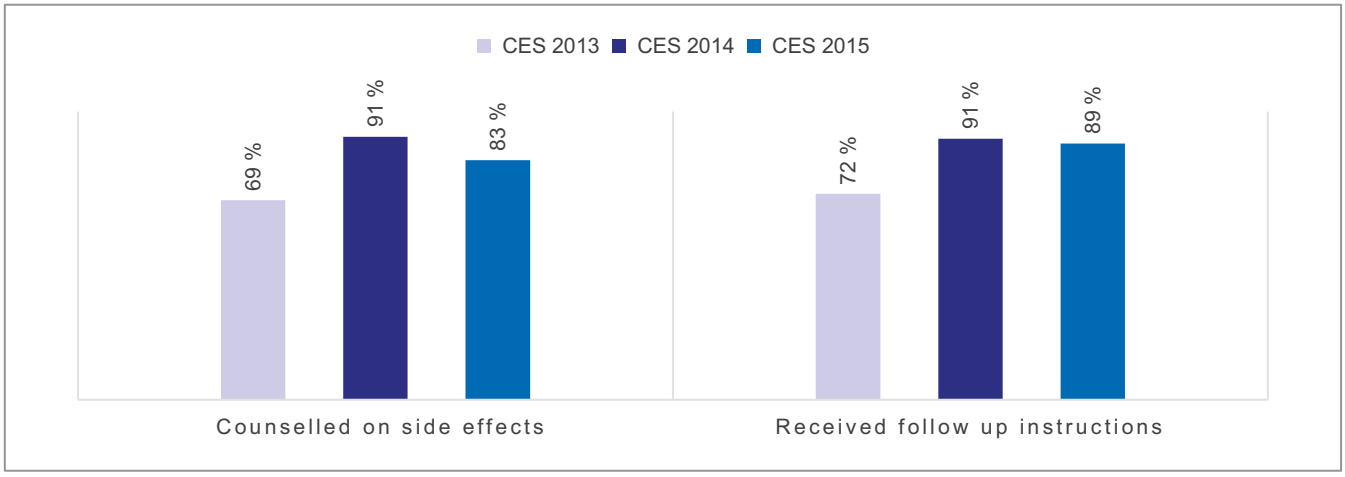
Table 23: Clients' reason for selecting outreach

Indicators	2013	2014	2015
% of clients who selected the OR because it was nearby	17.1	33.1	5.40
% of clients who selected the OR because of its reputation	8.9	6.6	0.90
% of clients who selected the OR because low cost	55.7	31.0	55.9

OR Client's perception of quality of care

The majority of clients served through the outreach program were counseled on potential side effects, and received follow-up instructions if necessary. The percentage of side effect counseling and provision for follow-up instruction were considerably low in 2013; however, a notable increase was observed in 2014 and 2015 as greater emphasis was placed on strengthening the capacity of FHEs in community mobilization and IPC skills.

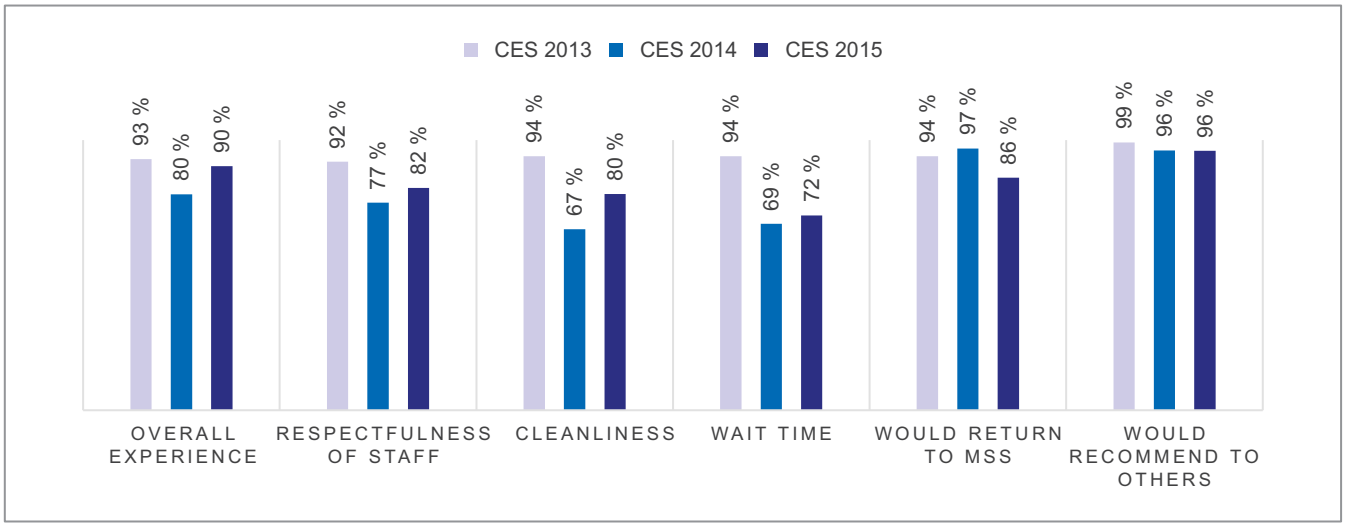
Figure 24: Outreach Clients Perception of Quality



OR Client's Satisfaction Levels

Clients were overwhelmingly satisfied with services provided in OR. However, in 2014 lower satisfaction levels were observed, especially for respectfulness, facility cleanliness and wait times. Improvements were observed in these indicators in 2015; however, more concentrated efforts are required in these areas. The improvements were in part due to the introduction of approved SOPs for QA for FP/RH that were closely monitored during implementation and reinforced through needs-based refresher trainings. Almost all clients reported a willingness to return to the facility in the future if necessary and would recommend its services to others.

Figure 25: Client Satisfaction Level - Outreach



Outreach Intervention – Teams and Camps Conducted

A total of 14 OR teams and 4 OMUs were committed in the modified program agreement. FP/RH had this many teams operational midway through the project. The focus for the FP/RH operation and field teams was then on strengthening strategies for enhancing the impact of the intervention while working closely with the Department of Health.

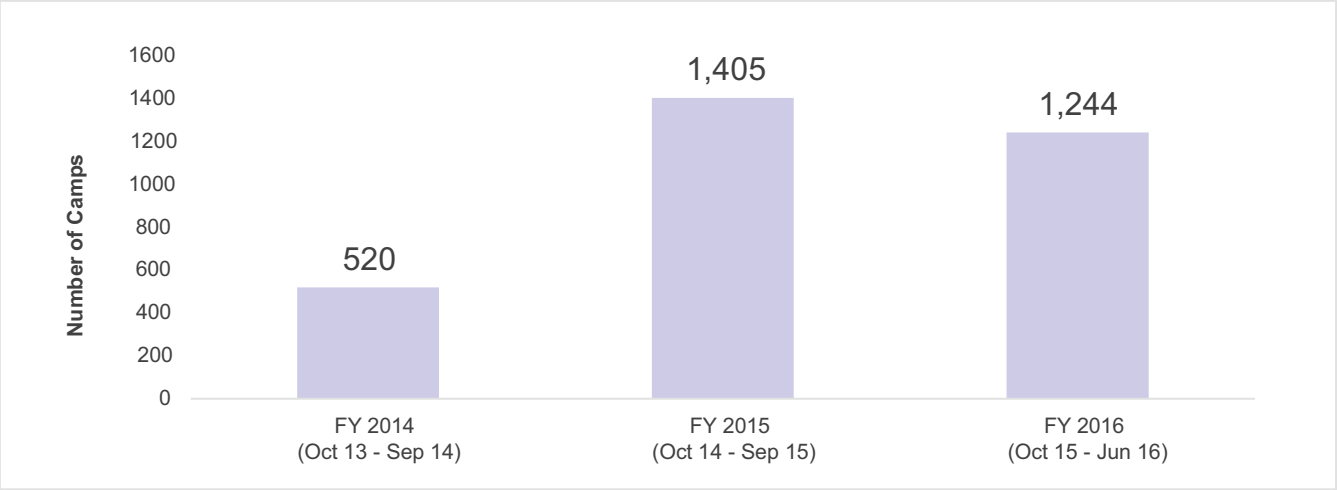
Table 24: OR teams

OUTREACH UNDER THE FP/RH COMPONENT	Committed	Achieved
Outreach teams	14	14
Outreach mobile unit teams	04	04
Total	18	18

Figure 27 depicts the number of OR camps conducted annually. The project witnessed a 63% increase in the number of camps held in FY15 compared to the previous year and a 18% increase in FY16 when compared with the same 7 month period in FY15, which was a good achievement considering that OR teams operated fully only through to April 2016 (7 out of a possible twelve months) which was followed by a slowdown and ultimate closure of services in June 2016. If FY16 had comprised 12 complete months, the growth in FY16 from FY15 would have also been 18%, reflecting the investment made in learning and management.

Challenges experienced in OR management included the number of camps and camp scheduling being affected by seasonal variances, public holidays, Ramadan, and most importantly, rescheduling of camps due to overlapping with district health officials' scheduling of health promotion activities during camp dates, such as polio vaccination campaigns conducted in the area during scheduled camps.

Figure 26: Number outreach camps conducted during life of project



CYPs Generated through OR Intervention

The impact of the OR intervention was somewhat effected by the restrictions on TL imposed by the PWD. This inhibited OR teams ability in Punjab to offer a full range of voluntary FP services to meet demand. Service provision was further affected by shortage of medicines and a delay in mandatory trainings by the PWD in Sindh. This was addressed through better coordination and liaison.

The OR intervention was designed to complement the LHWs who distributed oral pills and condoms during household visits as well as the SF intervention. An average of 14-15 FP clients were served with a voluntary FP method of their choice in each camp. The last camp for the project was conducted on June 6, 2016.

Figure 27: Average number of CYPs generated per month per camp

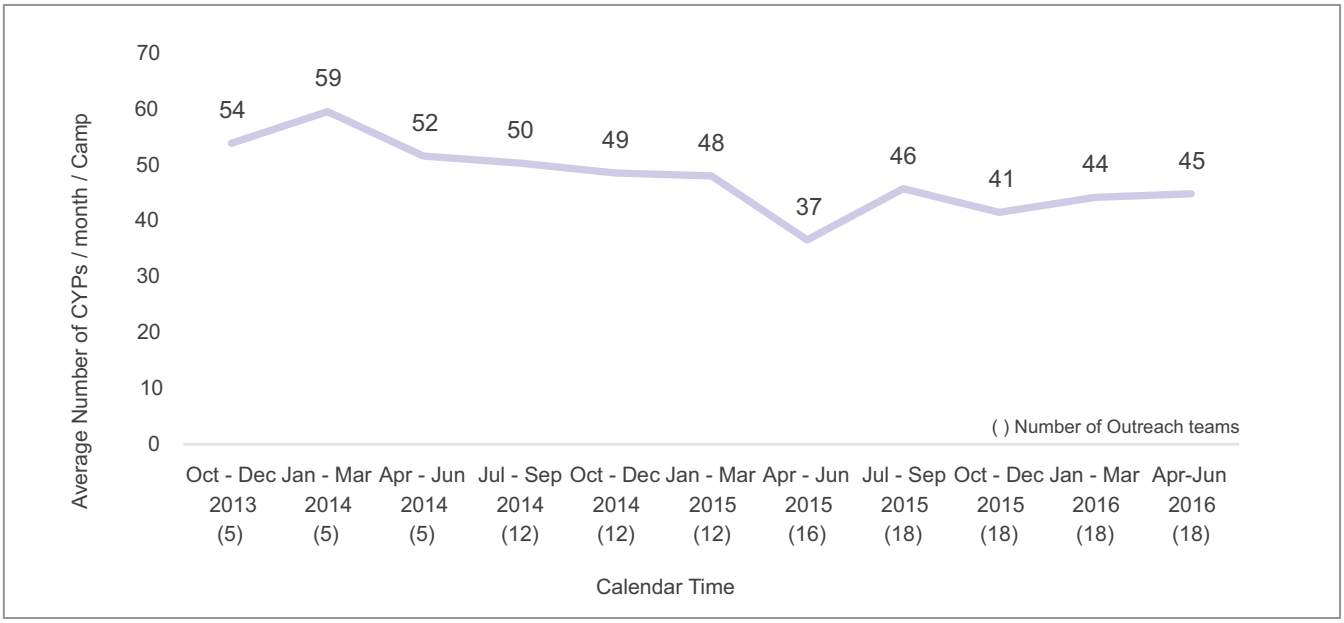
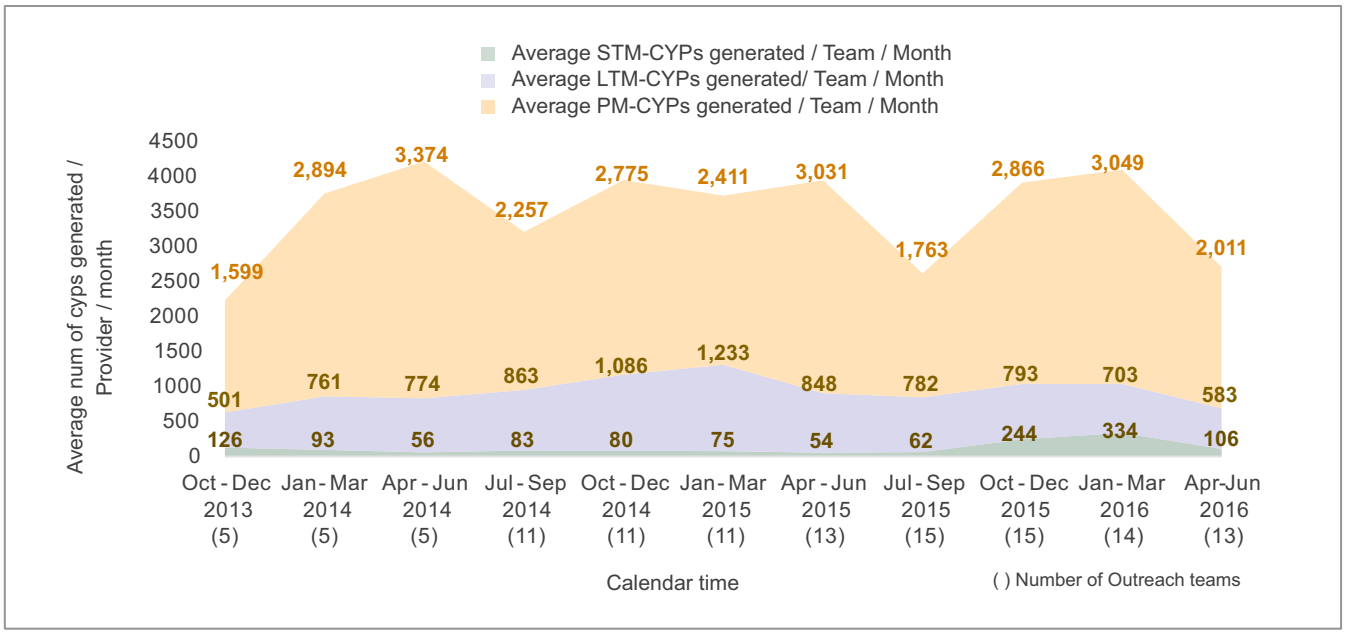


Figure 29 shows that the CYP contribution from the OR intervention was primarily from LAPMs as the OR teams were staffed by doctors certified in provision of voluntary implants and TL by the PWD.

Figure 28: Average CYPs generated per OR team per month by type of contraceptive



The OMUs in Sindh were run by mid-level providers, whereas in Punjab, these teams had PWD-trained doctors who could also provide voluntary implant services to clients seeking this method. The CYP contribution steadily increased for the LTMs in the OMUs, indicating increased awareness and demand for this service among underserved communities where it is particularly challenging to avail LTMs.

Figure 29: Average CYPs per OMU team per month by type of contraceptive

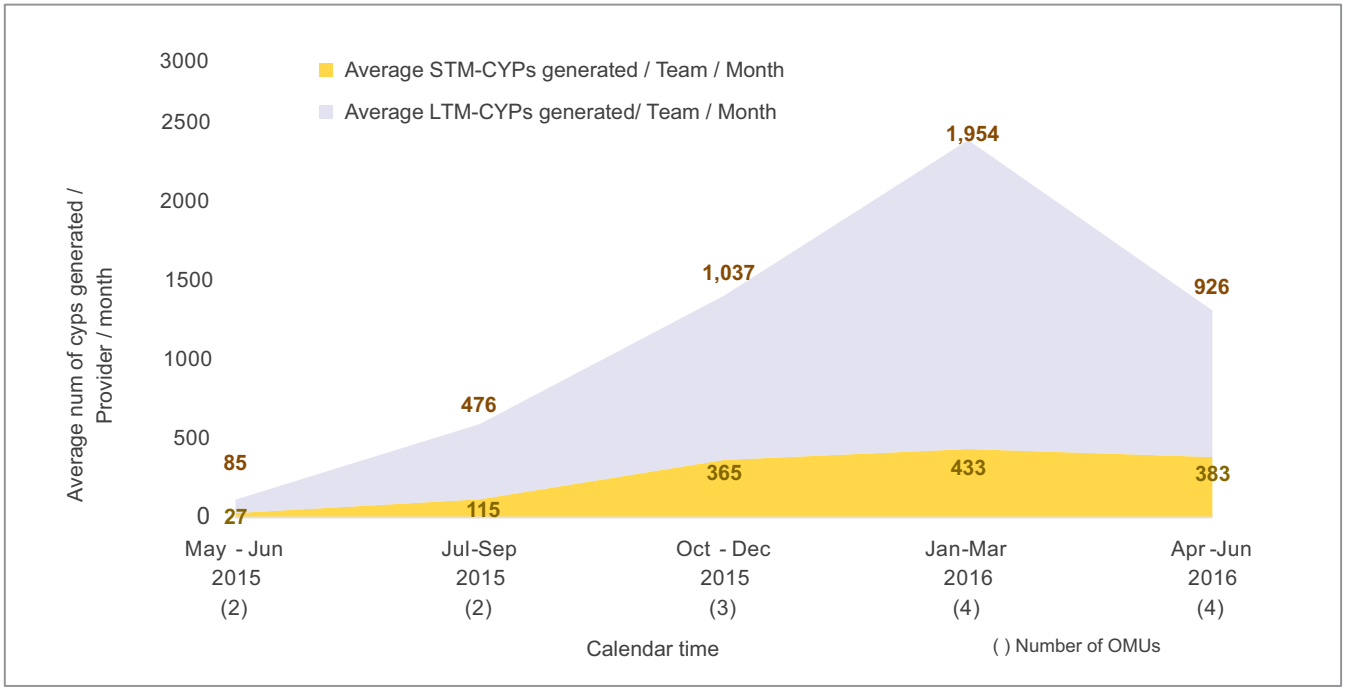
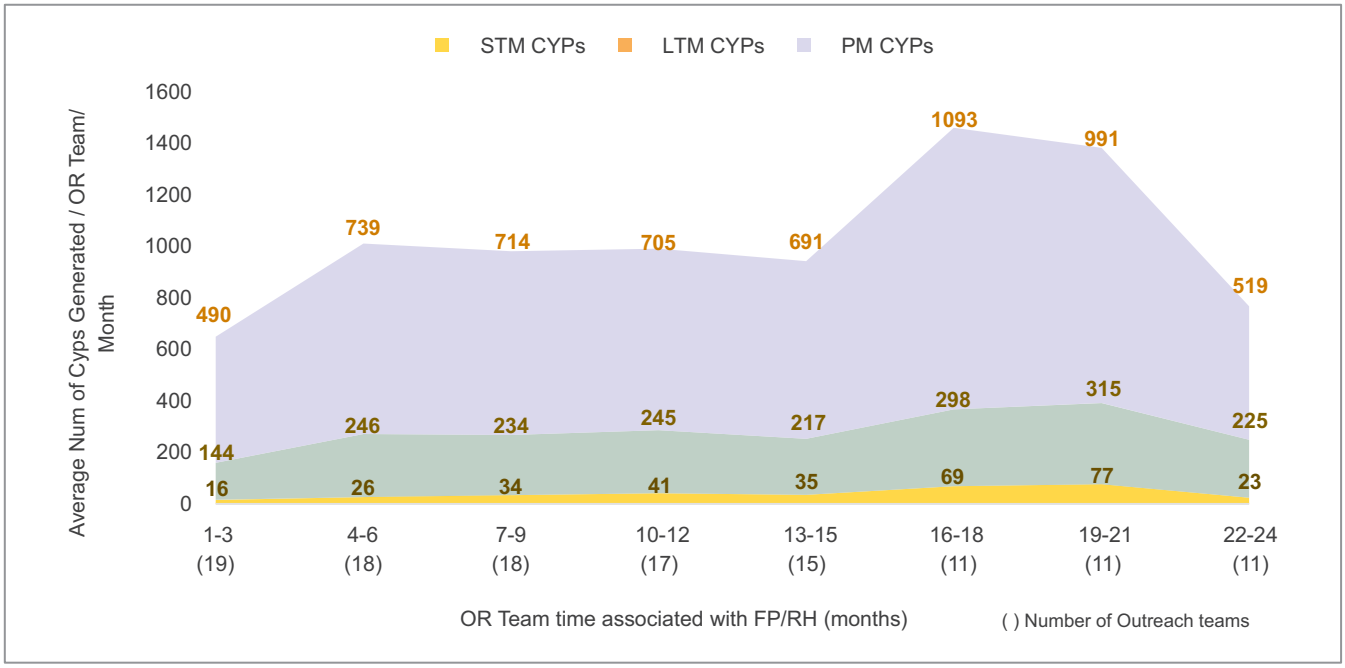


Figure 30 captures the impact of the length of association for OR teams with FP/RH and the number of clients they served with a voluntary FP method. As their association matured, the number of clients OR teams' were able to serve increased. This was due to streamlined operational processes including awareness raising, effective demand generation and increasing confidence of providers. This was due to provision of need-based refresher trainings and the effectiveness of the quality assurance mechanisms that ensured that each OR team delivered according to MSS and MSI standards. The analysis of OR data indicated that after 15 months, teams matured; thus, the need for rigorous training reduced. Teams served the clients with a mix of services that complemented other service delivery interventions; as elaborated earlier, having PWD certified doctors in the OR teams, the underserved communities were provided with access to a comprehensive range of voluntary FP methods which included PMs.

Figure 30: Length of Association in OR teams and CYPs generated

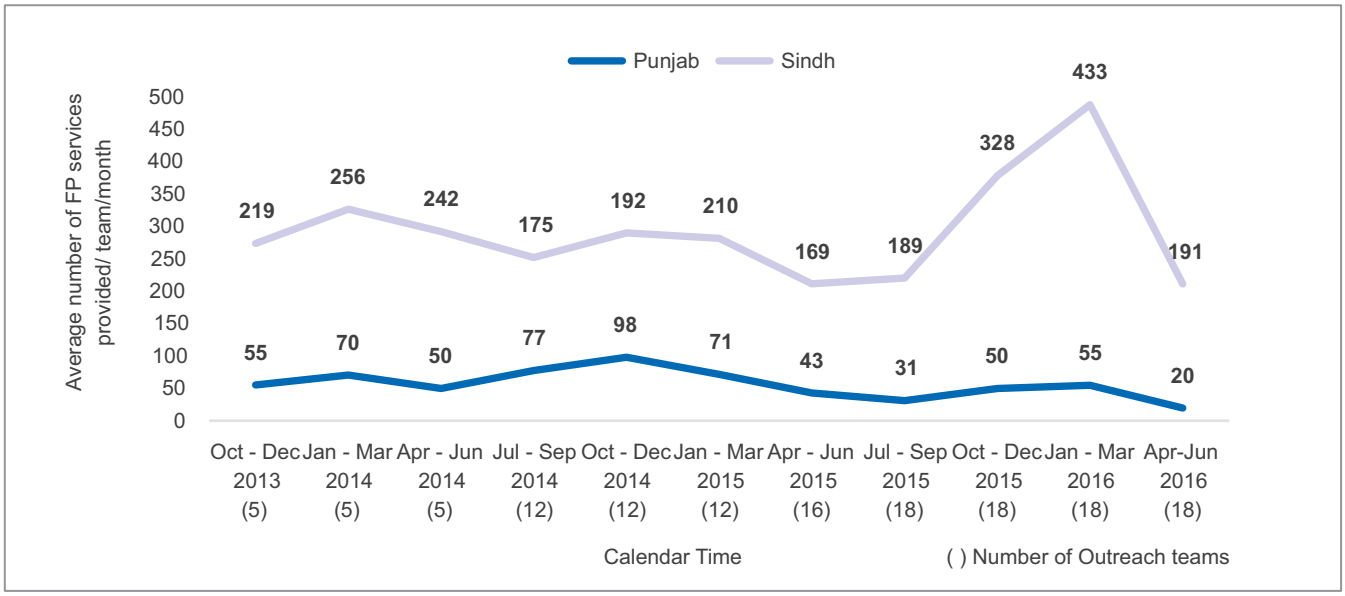


Clients served through OR Intervention

To maximize the impact of the OR intervention, customized trainings of OR teams were provided and a revised site selection criteria was introduced. All of these factors helped OR teams to serve more clients with voluntary FP methods of their choice, particularly LAPM which would otherwise be hard, if not impossible to access, in areas served by OR teams. These operational interventions to maximize impact saw teams serve 36% more clients when compared to the previous year.

Figure 32 depicts the quarter-wise provision of voluntary FP methods by OR teams segregated by province. Services per team in Punjab have remained lower compared to that in Sindh. A strategic decision to focus on meeting unmet need in Sindh and halt the scale-up in Punjab resulted in increased focus and coordination to support OR teams in Sindh. Teams in Punjab were also negatively affected by PWD restrictions that specify only PWD-trained providers are able to provide permanent methods and implants and corresponding challenges in accessing training for PWD training courses for providers. This ultimately led to the decision to convert the OR in Punjab into OMU at the beginning of FY16 after receiving USAID approval.

Figure 31: Average FP services per OR team per month by province



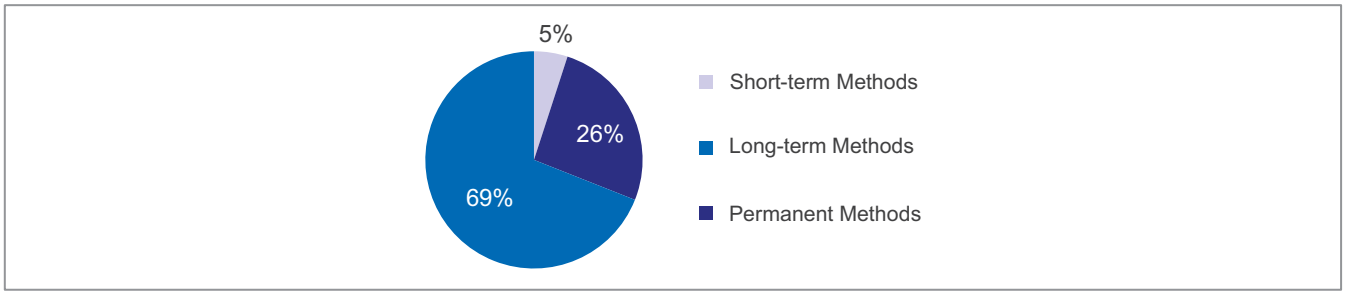
Method mix in OR Intervention

It is worthwhile to note that while over time the average services per team per month have remained the same, there was an upward trend in FY16. As teams matured and became more confident, investments made in prior years were realized with teams serving more clients with a voluntary FP method of their choice than ever before. This trends also correspond with improved QA scores - a result of the successful streamlining of QA systems, whereby SOPs and protocols were alligned to the specifics of this vital intervention.

Meaningful engagement by OR FHEs increased knowledge of FP and subsequently increased demand for voluntary FP methods. While most clients sought PM methods, there was also a significant proportion of clients who sought STMs. The provision of short-term methods in rural and far-flung communities is primarily the mandate of the LHWs however, these exceptionally important workers are often the only health workers operating in these communities and they have several objectives in addition to improving access to voluntary FP for which the LHW program was initially originated. In addition, the coverage of LHWs in Sindh is not more than 60%, and at times they face shortages of supplies. In this context, the OR intervention attracts clients who want to space births and feel short-term methods are best suited to their needs. The downward trend in service delivery began in April 2016 after the close-out decision was made.

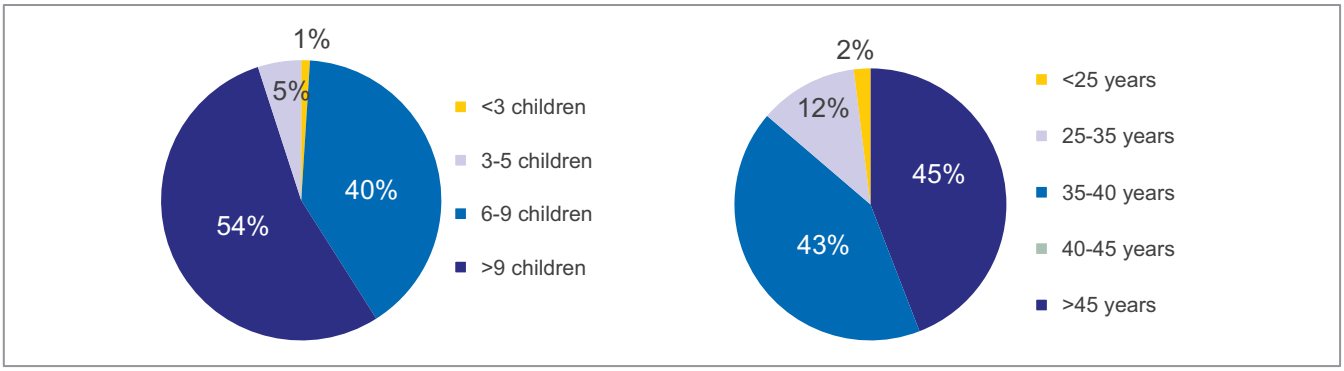
The overall CYPs disaggregation of method mix in OR signifies that 69% of the CYPs are generated by provision of PMs, 26% from provision of LTMs and only 5% of the CYPs were contributed by provision of STMs. This method mix is aligned to the FP/RH strategy, whereby OR was to complement SF and LHWs in provision of a comprehensive range of voluntary FP services.

Figure 32: CYPS disaggregated by method mix in USG-funded OR interventions



The parity distribution of FP/RH clients served through the OR channel shows that almost 40% of the TL clients had between 3-5 children and another 54% between 6-9 children. This correlates with the age groups of 25-35 years and 35-40 years respectively. This is similar to what was found in SF TL clients. This pattern also indicates the underlying prevalence of early marriage and the need for education and counseling on birth spacing and limiting the family size to improve maternal and child health.

Figure 33: Age and parity distribution among TL clients served in OR during life of project



CM and BCC through USG-supported FHEs

FHEs were the cornerstone of the FP/RH communication engagement strategy. FHEs undergo a thorough training program on effective community mobilization strategies to increase knowledge and awareness of MWRAs on FP, supporting them should they wish to avail a voluntary FP method of choice. For clients seeking to avail a service, the FHE made a referral to the nearest SDP and provided vouchers for eligible clients to take up an FP method best suited to their needs.

The FP/RH behavior change communication (BCC) model was built after a careful review of the successful models available in the local context and includes:

- Awareness building by a dedicated cadre of community workers from the same communities, i.e. FHEs who conduct door-to-door visits and group (Mohalla/Mashwara) meetings (using the MARVI[22] model); and inclusion of community social volunteers from the same community are used to complement FHEs in promotion of FP awareness
- Free vouchers to increase both access and choice of FP methods among the poor and underserved with the highest unmet need (MSS model)
- Building capacity of LHWs and CMWs in all FP methods and counseling skills through training on FP counseling, communication and IPC skills; revision of voluntary FP section of LHW curriculum; and development of an IPC toolkit on FP for LHWs (FALAH model)
- Strengthening referral mechanisms between LHWs, CMWs and FHEs to complement FP services, and provide access for MWRA to a full range of quality, voluntary FP methods available at the SF clinics and OR camps (Sanghar model)
- Provider event days and active participation in health camps, celebration of international days and district-level events to strengthen coordination among various health workers and awareness in community of FP services (Kasur & Khairpur model)
- Engaging youth as a part of community resource groups in FP/RH districts to enhance community-level support for maternal health, including FP (AAHUNG/United Nations Population Fund (UNFPA) model)
- Use of e-monitoring and mHealth initiatives using smart phones for field monitoring; performance tracking at the field level and reinforcing behaviors (People's Primary Healthcare Initiative-PPHI/AMAN model)
- Use of MCH helpline to provide access to information to MWRA and their husbands on FP, MCH topics and issues, but also acts as a resource for youth and adolescents to seek confidential information on matters related to reproductive health in an environment where sexual and reproductive health information is not readily available to youth (MSS model)

[22] A cadre of community health workers used by local NGOs

Social mobilization played a vital role in increasing awareness and creating demand for voluntary FP under the FP/RH project from the project's inception. FHEs were central to community and social mobilization activities as they worked to promote understanding about FP in the communities they served. They used a mix of mobilization activities, as depicted in table 16, to generate demand; provided vouchers to eligible clients seeking an FP method of choice; and made referrals for voucher and non-voucher clients to the FP/RH service delivery points to access voluntary, high quality FP services.

Table 25: CM activities undertaken by FHEs and number of MWRA reached

	Numbers (Oct 2013 to June 2016)
Number of household visits conducted by FHEs	2,061,343
Number of MWRA reached through household visits	2,215,827
Number of Mohalla / Mashwara meetings conducted	14,614
Number of MWRA reached through Mohalla / Mashwara meeting	228,786
Total number of MWRA reached	2,444,613

Figure 37 is a snapshot of voucher redemption rates in each district. While the number of vouchers distributed shows the intent shown by MWRAs to take up a voluntary FP services, the number of vouchers redeemed shows the number of MWRAS who actually visited the SF clinics and utilized their vouchers for FP services. It is indeed a great success that on average 99.3% of vouchers were redeemed. This demonstrates the effectiveness of FHEs in providing vouchers to women who wish to access a voluntary FP service and their effectiveness in facilitating access through reducing cost barriers to uptake.

Figure 34: Average voucher redemption rate per month from Jan to July 2016

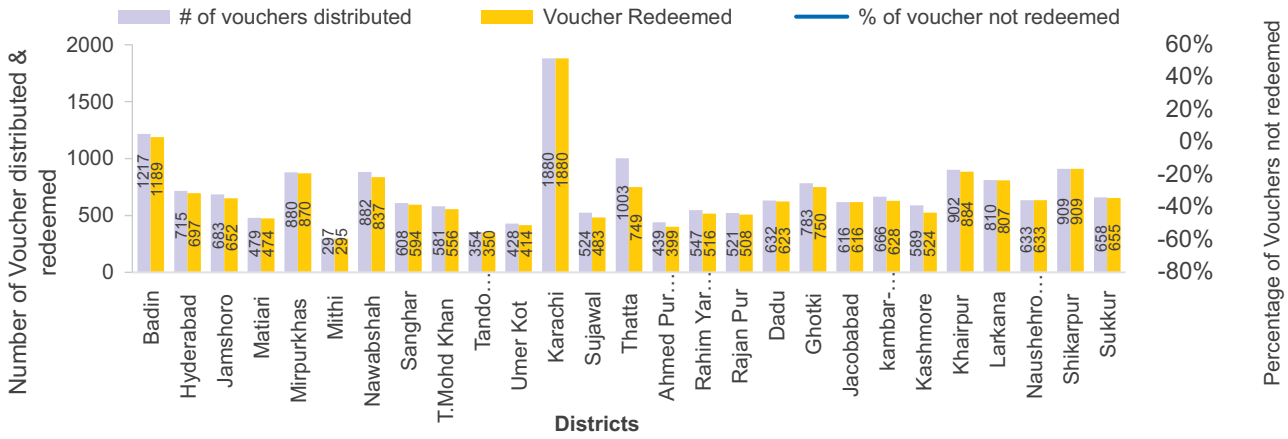
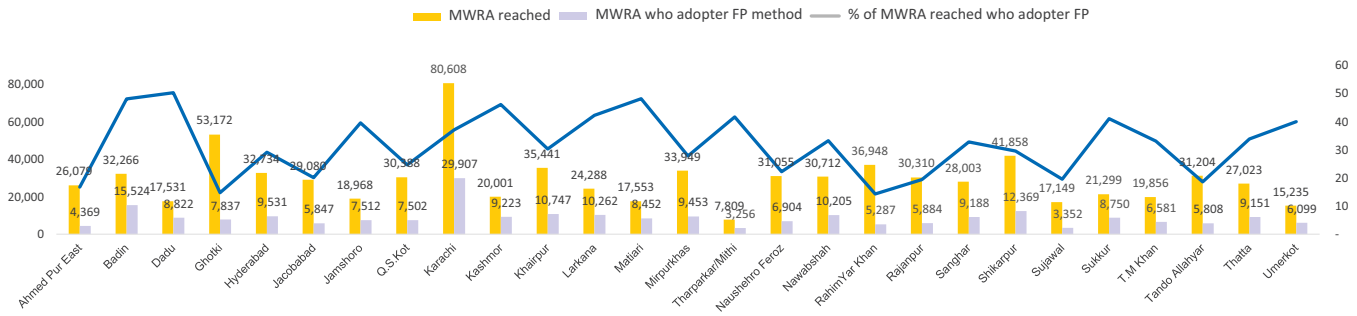


Figure 38 highlights the number of MWRAs reached by the FHEs and compares it with the number of MWRAs who actually took up the FP method following the visit. While the project was successful in reaching women, the graph still demonstrates how some women may still feel unable to access an FP method despite unmet need. Now that the FP/RH project has increased awareness and generated demand for quality, voluntary FP services, the government should continue this important work so as not to create frustration in communities with unmet demand and make use of the investments made in training and awareness raising.

Figure 35: Average number of MWRA reached and MWRA served in Oct 2015 to July 2016



OR Service Delivery Model and the Public Sector

Department of Health

The Department of Health offered its public health facilities with functional operating theaters to FP/RH for its outreach camps. Camp plans were shared in advance with the district health managers for effective coordination, administrative, and logistical support. FP/RH initiated refurbishing of the 88 public health facilities' operation theaters, out of which 14 were completed. Equipment procured for the remaining theaters was transferred to another MCH program (MCHIP). It is hoped that these refurbished public health facilities will continue to offer LAPM after the life of the project by developing the skills of their public service providers in FP service provision. In communities where LHWs provide short-term FP methods to clients during door-to-door visits, substantial support was provided by them in referring clients to the Suraj providers for long-term methods and to the outreach camps for permanent methods, particularly in areas where these FP services were not being provided at nearby public health facilities. According to the client exit survey conducted in 2014–2015, 7.2% of clients in SF and 54.6% of the clients in OR cited that LHWs were the most important source of FP information for them and their referrals were made by LHWs.

FP/RH enhanced the capacity of LHWs and CMWs in areas of FP counseling and IPC skills. This is expected to not only strengthen their role in provision of, and referral for LAPM, but also help reduce discontinuation of FP methods by effectively addressing clients' concerns. The LHWs and CMWs had an improved knowledge of the complete range of FP methods and better communication skills.

TSD worked closely with the LHW program to develop an FP IPC toolkit for LHWs, which was recently approved and notified by the office of the DG Health. The gaps in the FP section of existing curricula for LHWs were also identified after extensive consultations with the LHW program. It is expected that these will serve as a valuable guiding framework for updating the FP sections of LHW curricula.

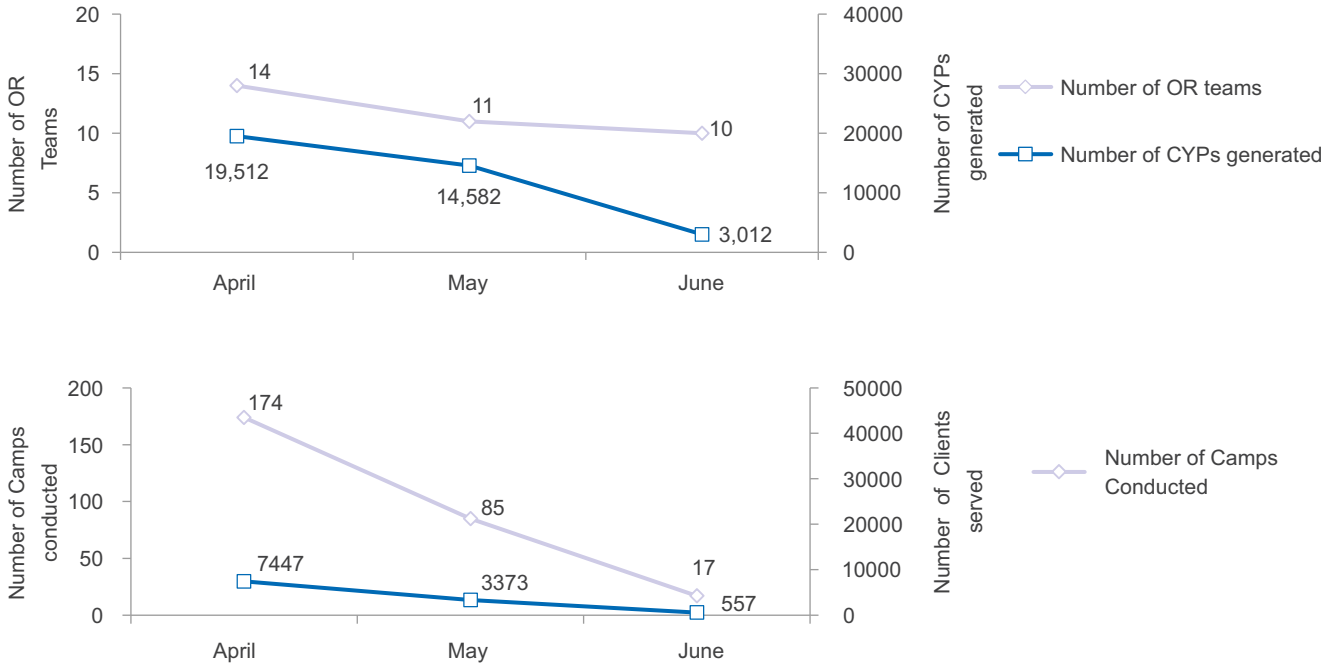
Population Welfare Department

FP/RH routinely shared service data with the PWD. PWD trained and certified the outreach doctors and SF-A+ providers in provision of implant and TL services. The TSD teams worked closely with the PWD in developing consensus around FP messages, in close consultation with the LHW and MNCH programs. These were endorsed by all stakeholders and recently notified by the Secretary of Health, PWD.

OR Close out

The number of OR teams were reduced to 11 in May and 10 in June 2016 following the announcement of project closure. Similarly, the number of OMUs was reduced to two in May and one in June 2016. As the closeout was initiated in May, the number of camps per month was brought down from 174 per month to nearly 17 per month. As a result of this, the number of clients served in the camps also came down by the same ratio, i.e. from 7447 to 577.

Figure 36: Impact of close-out of FP/RH project operations in OR in Q3 (April – June 2016)



CROSS CUTTING INTERVENTIONS

Strengthening Public-Private Partnerships

The post-18th amendment devolution awarded autonomy to provinces to develop health and population welfare policies that encourage greater ownership and accountability. It was envisaged that this would facilitate effective integration of the DoH and the PWD to offer comprehensive FPRH services utilizing the existing public health infrastructure. FP/RH supported the FP policy dialogue both at federal and Punjab and Sindh provincial levels. Although approval of PC 1 for procurement of commodities was a huge achievement, there was no funding allocated for providing commodities to NGOs. It was highlighted at multiple forums, including by FP/RH project members, that meeting the FP2020 commitments is dependent on contributions made by NGOs towards improving the mCPR. If contraceptive commodities are not made available, it will negatively impact maternal and child health outcomes and the progress toward the national FP commitments. Recently, Sindh announced a provision of commodities to NGOs, which was welcomed by all stakeholders.

Active Engagement in Technical Discussions and Policy Dialogues
FP/RH actively supported and participated in policy dialogue at the provincial and federal levels to improve the acceptance for, and availability of, FP/RH services that are effectively integrated into other MNCH services for a seamless continuum of care. FP/RH worked closely with the DoH, PWD, provincial health programs and district health offices in technical discussions, policy and health system-level dialogues that aligned with the goals and objectives of the overall FP/RH program and provided extensive technical inputs to inform policy frameworks. This included participation in the LHW program PC 1 finalization by JSI/HSS; development of the MCH program community support package by MCHIP; development of health messages and the communication strategy for the DoH by JHU.CCP; development of the PPFP framework and implementation plan for Sindh under the Sukh initiative; and the costed implementation plan for FP2020 by Pathfinder.

Increasing Access to FP through Task Sharing
In view of the inadequate number and uneven distribution of health workers, many countries have enabled mid and even lower-level cadres to deliver a select and pre-approved range of contraceptive methods after extensive competency-based training. FP/RH recognized the policy and regulatory constraints around FP/RH service delivery which restricts the role of mid-level providers in provision of a comprehensive range of voluntary FP services. Faced with a critical shortage of health workers, particularly in remote rural areas, innovative and cost effective strategies were required to extend reach to underserved communities. With a large percentage of the population having access only to mid-level providers, particularly the LHWs, enhancing their role in provision of FP services was a viable option to explore for addressing unmet need for contraception.

In August 2014, FP/RH hosted a policy roundtable titled “Increasing Access to Family Planning through Task Sharing,” which was attended by the regulatory authorities, MCH partners, Sindh DOH and PWD officials. The forum helped drive new commitments and formulated policy recommendations for optimizing health workers' roles for reaching out to an additional 5.8 million MWRA with unmet need to achieve the FP 2020 commitments. It was agreed that current actions within the FP/RH sector in Pakistan were simply not enough and, at the present rate, the country is unlikely to see the dramatic growth in the mCPR as was envisaged in the Costed Implementation Plan (CIP). The group jointly reviewed the health cadres for their suitability for training and support to enhance access to FP services. In Nov 2014, FP/RH hosted another high profile meeting in Lahore, Punjab, on “Task Sharing,” which aimed to 1) consolidate expertise and experience on how best to address barriers to accessing FP, and 2) to develop actions to optimize health workers' abilities to increase access to lifesaving FP services through training, regulation and support.

In Sindh and Punjab provinces, a consensus was reached between representatives from the regulatory authorities and the Minister of Population Welfare on how to train CMWs, FWWs, LHVs, and nurses on implant insertion. A pilot has been agreed for training LHWs on implant insertion in Chakwal district in Punjab. It was decided that, although part of the existing Pakistan Nursing Council pre-service curricula for CMWs, LHVs, FWWs, and nurses, covers implant insertion, the standards for practice need to be defined, and pre-service and in-service implant curricula must be revised and updated. PWD was initially reluctant to facilitate the implant insertion training, but recently the Sindh PWD, under CIP for FP2020, agreed to pilot train a batch of FWW in implant insertion, a positive step toward changing the landscape of FP in the country.

Coordination with District Health and PWD Officials
At the district level, the FP/RH district teams participated in district coordination meetings (DCM) of MCH partners, district technical committee (DTC) meetings and district health and population management team (DHPMT) meetings. These provided forums for sharing progress and highlighting challenges that require the support of, and partnership with, the public sector. FP/RH teams continued to work closely with the district health officials to organize OR camps at the public health facilities with functional OTs. Camp schedules were shared and adjustments were made to accommodate other activities of the DoH.

Coordination with Provincial Health and PWD Officials
At the provincial level, the FP/RH teams engaged health and PWD officials through regular meetings and held discussions on a shared agenda to improve networking, complement service provision and resolve issues related to human resource deficiencies at the grassroots level. Service delivery data was shared with the PWD, office of DGHS and the MNCH program. The teams actively participated in the provincial technical coordination committee meetings and shared their performance and future plans. FP/RH engaged in constructive dialogue with the DoH to establish an effective referral mechanism and formalize training of LHWs and CMWs in FP counseling and IPC skills. 487 PSPs were trained and are expected to provide follow-up with clients receiving a full range of FP services with effective side-effect management. This is expected to reduce the discontinuation rates of FP methods. FP/RH shared monthly service data with the PWD. PWD trained and certified the outreach doctors and SF-A+ providers in the provision of implant and TL services. FP/RH actively participated in health awareness events organized by the PWD and DOH, and often set up stalls that provided FP counseling, ANC check-ups, and provided ST FP methods on-the-spot and made referrals for those seeking LAPM to FP/RH OR camps.

Coordination with the LHW Program
Close liaison was maintained with the LHW program throughout the project lifespan. The FP/RH DCOs, SFSs and the FHEs interacted with the lady health supervisors (LHS) and the LHWs routinely shared camp plans. Their support was vital in providing referrals for LT and permanent methods. Through building effective partnerships with the public sector, FP/RH wished to deliver its commitment of improved availability, quality, and voluntary utilization of FP services, with an emphasis on LAPM to complement availability of STMs and provide access to the full range of methods.

A total of 287 lady health supervisors (LHS) and lady health workers (LHW) were trained in IPC and communication skills. The trainings were received well, and the director of the LHW program expressed his appreciation at several forums. He also issued a formal letter of appreciation (attached in Annex 6). An FP IPC toolkit was developed in close consultation with the LHW program. The LHW program also facilitated the pilot testing of illustrations and content before providing the final endorsement. The FP IPC toolkit was approved and notified by the office of DG health Sindh in September 2016 and is now available for printing and use. The need for revision and updating of the FP section of the LHW manual and FP IPC toolkit was recognized, and TA was provided to initiate this work. A gap analysis was completed and endorsed by the LHW program. This will serve as the guiding framework for the subsequent updating of the FP section of the pre-service curricula.

Coordination with the Provincial MNCH Program
FP/RH enjoyed support from the provincial MNCH program. 146 community midwives (CMWs) were trained in FP methods and counseling skills. Representatives from the MNCH program worked closely with the TSD team to revise the FP messages and actively participated in technical working group meetings.

Family Planning Technical Advisory Group (FP TAG)
FP TAG was notified by the office of the DGHS in May 2015. FP/RH served as the secretariat, and the first meeting was held in July 2015. The meeting was chaired by the DGHS. The meeting reviewed the FP TAG membership, TORs and meeting protocols. FP/RH presented its quarterly progress and provided an update on FP trainings conducted by FP/RH for PSPs. The participants discussed the Sindh health care commission and its role in ensuring provision of quality FP services as well as identifying areas of technical support from MCH partners for FY 15. The participants further discussed revitalization of the LHW program; its focus on FP; and strengthening referral support to and from the LHW program. Concerns were also raised on commodity security for NGOs and the private sector. The provincial MNCH program identified the need for capacity building of CMWs in FP skills, strategies for promoting PPFP and post-abortion family planning (PAFP), and areas of technical support from MCH partners. Later it was recommended that USAID would convene a committee where all MCH IPs will meet together with the DOH and PWD and discuss areas of mutual interest. This was expected to replace the FP TAG and MNCH TAG that was being led by MCHIP.

Refurbishment of Public Health Facilities in Sindh
FP/RH supported ongoing health systems strengthening interventions for scaling up of FP service provision. This was expected to build on the optimal utilization of the existing infrastructure and health workforce. FP/RH initiated identification, procurement and refurbishment of 88 public health facilities with functional OTs in FY14. FP/RH secured formal permission for the refurbishment of 88 selected public health facilities in Sindh in November 2014 from the office of the DGHS. TORs were agreed and signed between FP/RH and DoH for the refurbishment of health facilities in May 2015 at the DGHS office Hyderabad. To expedite the process of refurbishment, DGHS nominated the focal persons for each district. The essential missing equipment was procured to make the OTs operational for OR camps, hence enabling FP/RH and other government and nongovernmental organizations to provide comprehensive FP services at these theaters. By June 2016, fourteen health facilities were refurbished. Provision of equipment to the remaining facilities will be completed by another implementing partner due to the early closure of the project.

Table 26: FP/RH Commitments and achievements from Oct 2013-Sep 2016 for strengthening PPP

FP/RH Commitments	FP/RH Achievements
Enhanced support for initiatives aimed at accelerated scale-up of FP services	Organized policy dialogues aimed at the optimal utilization of the existing health workforce and infrastructure for enhanced voluntary FP service availability; actively participated and supported advocacy initiatives aimed at commodity security and FP and MNCH service integration at public health facilities; provided technical inputs and supported the development of CIP for meeting the FP 20202 commitments
Training of PSPs	Trained 487 PSPs, which included 287 lady health supervisors and lady health workers and 146 community midwives in FP Methods and counseling skills
FP messages	Facilitated consensus development around the FP messages which were endorsed by the PWD, LHW and MNCH program; approval and formal notification for the same were received both by the office of DG health in Sindh and PWD in September, 2016
Updated FP curricula	Provided technical assistance to the LHW program for revision of pre-service FP curricula for LHWs; gap analysis was completed and endorsed by the director of the LHW program and is expected to serve as the guiding framework for subsequent revision of pre-service FP curricula for LHWs
FP IPC toolkit	Provided technical assistance to the LHW program for development of the FP IPC toolkit; the toolkit was endorsed by the director LHW program and received formal notification and approval by the office of DG health in Sindh in September 2016
Institutionalization of QA mechanisms in public health facilities	Made presentations at several forums to introduce the MSS quality assurance (QA) mechanisms and shared lessons learned; technically supported MCHIP and JSI/HSS toward development of simple, but robust, indicators and systems for monitoring the quality of FP services in public health facilities
Enhanced outreach	Operationalized OMU in close coordination with district DOH officials for accessing uncovered areas through OMUs
Public health facilities refurbishment	Procurement was completed for refurbishment of 88 public health facilities to make their operation theaters functional for conduction of OR camps there, enabling MSS and other government and NGOs to provide comprehensive voluntary FP services; 14 facilities were refurbished, and the rest should be completed by MCHIP under the direction of USAID

Working together with other Components of USAID MCH Program

USAID/Pakistan's MCH Program comprised five interconnected and mutually reinforcing components led by national and internationally renowned public health organizations to implement evidence-based interventions. A sixth component was recently added to support advocacy and policy reforms in the area of FP.

Table 27: Components of USAID/Pakistan's MCH Program

Component	Lead Implementing Organization
FP/Reproductive Health (FP/RH)	Maries Stopes Society
Maternal Newborn and Child Health (MNCH)	MCHIP/Jhpiego
Health Communication	JHU·CCP
Health Commodities and Supply Chain	JSI/Deliver
Health Systems Strengthening (HSS)	JSI
FP Advocacy and Policy Reform	Palladium

The FP/RH Project served as one of the five interrelated components within USAID's comprehensive MCH program and had the technical lead in FP. It developed strong linkages and worked closely with the other implementing partners to exploit synergies and enhance the impact of program interventions. FP/RH teams worked closely with the MCH partners on initiatives to create an environment that fosters broader availability and accessibility of integrated FP and safe motherhood services in Sindh.

MCHIP/JHPIEGO Collaboration on MNCH

MCHIP/JHPIEGO facilitates the second component: maternal newborn child health (MNCH) services. They have the lead role in MNCH to support the introduction, scale up, and further development of high-quality, high-impact maternal, neonatal, and child health interventions, while incorporating critical FP/RH care into public and private sector services. FP/RH worked closely with MCHIP and supported the mapping of service delivery outlets (public and private sector) in their intervention districts. The FP/RH technical team supported the formation of the district coordination mechanism, and the FP/RH DCOs actively participated in district coordination meetings (DCM) in their respective districts. MCHIP supported training of FP/RH service providers in implant insertion and the helpline agents in handling of MCH queries. MCH algorithms were developed and used by the helpline agents. The performance indicator reporting sheet (PIRS) was standardized for trainings, and development of the community package for the MCH program by MCHIP was technically supported by the FP/RH team.

JHU.CCP Collaboration on Health Communication

In the first year of the FP/RH project, PSI/Greenstar led component 3 of the USAID MCH program: health communications. This was later awarded to JHU.CCP who used their behavior change communications expertise to position USD MCH program products and services with DOH- and PWD-approved messages to enhance knowledge, generate demand and promote healthy behaviors. The project will make use of a broad range of communications channels to provide cross-cutting support to all components of the MCH program.

FP/RH and JHU.CCP worked closely together and periodically reviewed areas of mutual collaboration, i.e. the helpline promotion plan, trainings on IPC toolkits, mHealth applications, and awareness raising and demand generation to support the FP/RH service delivery. FP/RH worked on the messages developed by JHU on FP. A technical working group was formed with members from MCH partners, the LHW program, MNCH program and PWD. Revisions were made as suggested by the technical working group and final endorsements and notifications were received by the Secretary of PWD and office of the DG Health. FP/RH TSD team members actively participated in BCC working group (WG) meetings and supported the development of the gender and community dialogue tool that were developed by the JHU.CCP. Their “Bright Star” promotional campaign was supported and integrated into FP/RH program activities.

USAID Deliver Collaboration on FP Commodities
JSI/Deliver led component 4: health commodities. They ensured procurement and distribution of critical contraceptive and health commodities and technically supported the public sector in strengthening their logistics management systems. JSI/Deliver successfully supported the FP/RH commodity supply without interruption throughout the life of the project.

JSI/HSS Collaboration on Health System Strengthening
JSI was the implementing partner for component 5: health systems strengthening (HSS). JSI/HSS provides valuable technical assistance to health services at the federal, provincial, and district levels to reform and improve service delivery in the post-devolution operating environment. FP/RH participated in the strategic planning workshops for strengthening the PHDC and the advocacy and policy organized by JSI. The QA teams at FP/RH worked closely with JSI to support institutionalization of QA mechanisms in public health facilities.

M&E Working Group Meeting
To streamline all performance monitoring, the M&E working group (WG) was constituted as per USAID advice. The working group comprised monitoring and evaluation experts from the five consortium partners under USAID's MCH program, select program staff and USAID representatives. The group was initially led by MCHIP. The group helped progress several FP/RH RME agenda items, such as: development of the MCH helpline log frame, MCH log frame, and the MCH mHealth strategy draft. The mandate of the working group is to share monitoring plans and indicators, approaches to data collection, results, and to maximize coordination between M&E personnel. The M&E working group meetings provide a quarterly forum for sharing program lessons and optimizing M&E resources across the USAID network. In 2015, FP/RH assumed the responsibility of leading the group in 2015 and organized four meetings between April 2015 and April 2016. During these meetings, the TORs of the working group were redefined, and it was agreed that the group would assist partners in the development and application of appropriate methodologies/indicators for performance tracking and impact evaluation of key interventions (or small scale initiatives) under the MCH program; devise data quality assessment (DQA) mechanisms to ensure data quality and effective and timely reporting; establish a mechanism for sharing information generated by the MCH program with the Health Sector Reform Unit (HSRU); and enhance the capacity of technical/program stakeholders to use evidence in strengthening advocacy.

Research, Monitoring & Evaluation

An Overview
MSS believes in evidence-based decision making and considers research, monitoring and evaluation (RME) an integral part of its program to rigorously monitor and evaluate the effectiveness and impact of FP/RH interventions. MSS established its RME department under the FP/RH project with the aim of promoting data-driven decision making by contributing to existing FP knowledge and by generating contextual evidence to support improved organizational and national policies. The RME department has a multidisciplinary team, with expertise in public health, epidemiology, statistics, anthropology and health systems research, who were supported by Marie Stopes International and Independent senior consultants.

Scope of work
MSS employed a range of approaches and tested tools to measure program progress toward strategic goals and to ensure continuous data-driven management to improve performance. These tools have proved to be effective both in Pakistan and by the MSI global partnerships. They are documented to be accurate, transparent, precise, and empower program staff and healthcare workers at different administrative levels to make evidence-based decisions for improving health outcomes in underserved areas of Pakistan.

The activities are broadly categorized into 'monitoring' and 'research' activities. Monitoring activities focus on strengthening routine data, which help to improve project performance by ensuring timely availability of quality and reliable data for decision making and report on program impact throughout the life of the project. To achieve this task, the component coordinates with various sub departments of the FP/RH project to ensure the timely generation and dissemination of information for facilitating evidence-based decision making. On the contrary, the research activities aimed at contributing to the existing FP knowledge by generating contextual evidence to support improved organizational and national policies.

FP/RH Project Monitoring Plan

At the onset of the FP/RH project, MSS put together a project M&E plan by describing the minimum set of indicators against which the program demonstrated achievements and successes over the implementation period. This monitoring and evaluation (M&E) plan offered a framework for the development of a robust M&E system, which provided information to assess and effectively guide project strategy and operations, meet internal and external reporting requirements, and inform future programming. The first plan was approved by USAID in July 2013 (see annex 1 for M&E plan version 1). Later, in year 2, the plan was amended in accordance with the changes that took place in the scope of FP/RH project. The revised plan, submitted in March 2016, comprised six outcome indicators and 11 output and process indicators that fit into four broad objectives. Developed in collaboration with USAID's health office, these indicators were identified as performance markers to assist in monitoring progress (see annex 2 for M&E plan version 2). Simultaneously, the team developed the performance indicator reference Sheet (PIRSs) for two key indicators: “Number of women and children receiving FP and maternal, neonatal and child health (MNCH) services in USG assisted sites” and “Number of people trained in FP and MNCH through USG support”. The PIRS is intended to provide USAID staff and other stakeholders with a comprehensive description of a single indicator.

Management Information System

MIS is the main source of routine data to inform management decision-making regarding tracking performance and how to maximize impact, quality improvement, and targeting of services to specific population groups. The main sources of MIS data include daily registers, stock registers, and service statistics maintained at the facilities that include outreach sites and franchisees. For the Suraj social franchise, FP/RH launched a customized central digital database called FLAME (Franchise Live Application for Monitoring & Evaluation). The aim was to provide FP/RH with a 'one window solution' for client/service data capturing and reporting. It allowed simplification and standardization of data and reports and was a scalable and replicable solution for franchise and voucher management programs. The FLAME was adapted in accordance with the FP/RH project needs/requirements and implemented in 2014.

M&E Working Group Meetings

To contribute to the existing FP knowledge by generating contextual evidence to support improved organizational and national policies, FP/RH RME presented and received approval of several research initiatives.

FP/RH Research Studies

The research studies planned were expected not only to contribute to FP/RH project strategic decision making, but also nationally and in neighboring countries. The research studies approved by the M&E WG were: a) annual client exit interview survey; b) understanding the perspectives of franchised private service providers and health workers regarding barriers to, and facilitators of, FP (Provider Insight Study); c) determining discontinuation rates among SLARC users of mobile outreach program (Outreach Study); d) understanding dynamics of postpartum FP in Pakistan (PPFP study); and e) evaluation impact of FP/RH intervention: a cluster randomized controlled trial (FPRH Evaluation). Of these approved research projects, the Provider Insight Study and Client Exit Survey were implemented during the life of the project.

Impact Estimation

MSI's Impact 2 tool is an effective means of estimating the impact of reproductive health programs. The RME team, together with the technical support of MSI, carried out different analyses to estimate the number of additional users required to meet FP2020 commitments.

The FP/RH RME team estimated the additional impact of meeting its FP2020 commitment using the MSS method-mix instead of the current method-mix in the population, as per the PDHS 12-13. The estimation was done for Sindh and Pakistan separately for the period 2015–2020; a six-year estimation. Using the MSS contraceptive method-mix, the country could avert an additional 11 million unintended pregnancies and nearly 10,000 maternal deaths. Similarly, in Sindh an additional 1.3 million unintended pregnancies and nearly 1,600 maternal deaths could be averted.

Geographic Information Systems (GIS) Mapping
RME conducted a training and data collection exercise to update the MCHIP GIS portal with all MSS facilities in the ten districts where MCHIP operates. The mapping assisted in visualizing the presence of MSS in MCHIP districts, utilizing this information for possible expansion and linkages. In addition, a request for GIS mapping and an assessment of public and private health facilities in Sindh has been developed and is under review. The overall goal of this proposed mapping exercise is to have a detailed profile of existing health services (FP/RH, MNCH) to understand the current service provision as well as serve as an effective tool for future planning aimed at improving health coverage. However, later this activity was halted and moved to the new partner, Management Systems International, by USAID.

Knowledge Sharing
Dissemination of evidence was an integral part of the RME unit to enable better and faster decision making. The RME unit strived to build a culture of knowledge sharing within the project to make informed decisions. The team developed dashboards and held monthly progress review meetings with the program team. Similarly, results from the in-depth analysis of surveys and routine services data were shared with the regional and district teams at quarterly progress review meetings.

The team also ensured wider circulation of evidence. An abstract was accepted for the 8th Asia Pacific Conference on Reproductive and Sexual Health and Rights Conference in Malaysia; five abstracts were accepted at the Fourth Global Symposium on Health Systems Research, November 14-18, 2016, in Vancouver, Canada. Unfortunately, due to funding constraints, these applications were later withdrawn. Working with MCH partners, the team published a paper which revealed that improving the quality of antenatal care at healthcare facilities and encouraging discussion of birth spacing in the communities through Mohalla meetings and/or community support groups could promote the voluntary use of contraception.

Annual Client Exit Interview
The client exit interview survey was conducted annually with the following objectives:

- Assess client characteristics by collecting sociodemographic information
- Assess if services are reaching groups with high unmet needs, i.e. the poor and underserved
- Assess clients' satisfaction level regarding their experiences at MSS facilities, including their perception of quality of services provided
- Assess counseling and communication skills of service providers
- Assess the effectiveness of marketing activities and how to communicate with clients more effectively
- Assess if clients are being offered an appropriate choice of FP methods

The survey was conducted in 2013, 2014, and 2015. The findings helped evaluate whether FP/RH servic
es were meeting the client needs and was used for evidence-based strategic planning for the subsequent area.

Key Findings

- The majority of FP clients were above 30 years of age in both SF and OR; with OR clients comparatively older and having a higher number of children. This aligns with the PDHS (2012-2013) which demonstrates women tend to opt for a permanent method services after 5 or more children and between 30-34 years of age.
- More than 70% of the clients in SF and OR had either received no formal education or completed less than primary education. These proportions were significantly higher in OR.
- One of the main commitments of the project was to reach the poorest segment of population. The results showed that nearly 4 out of 5 every clients lived on under $2.50 USD a day; the poverty levels were higher among OR clients compared to SF.
- Roughly 50% of all clients were FP adopters (had not used an FP method in the last 3 months). The percentage of adopters increased over time in OR, moving to 68% in 2015. The percentage of clients switching from short-term to long-term or permanent methods increased over time in both service delivery channels.

- For social franchises, FHEs were the most consistent and common source of information; for OR, public providers (LHWs specifically) were the common source of information.
- In the SF channel, the proximity of an SF provider, low cost/voucher and the good reputation of the provider were cited as key reasons for choosing the SF facility. However, for OR, provision of free services was the predominant reason for client visits to an OR camp – this was followed by the services being available near their homes. The CES revealed that 55% of clients said that they would still be willing to purchase an FP method in the absence of a voucher. However, this percentage was quite low (12%) in the lowest wealth quintile (CES, 2015)
- The majority (more than 80%) of clients served through the social franchise and outreach programs received a desired method of their choice. They were counseled on potential side effects and received follow-up instructions if necessary. A positive trend was observed over three years, demonstrating improvements in counselling for enabling clients to choose from the full range of contraceptive methods.
- Clients were overwhelmingly satisfied with services provided at SF and OR clinics. However, in 2014 lower satisfaction levels were observed, especially regarding facility cleanliness and wait times. Yet, almost all clients reported a willingness to return to a facility in the future and would recommend services to others.

Provider Insight Study
The RME team conducted a qualitative enquiry among social franchise providers, FHEs, SFSs, and the DCO from April–July 2015. The aim was to understand the sociocultural and organizational factors that influence delivery of quality FP services and program performance, and then explore prospects for the sustainability of FP/RH program.

Key findings:

- Respondents perceived a positive change in their knowledge and attitude toward FP over time, primarily attributed to increased access, quality counselling and community mobilization work by FHEs.
- Interpersonal care was the most important aspect of quality of care (good counseling with friendly and respectful behavior toward clients).
- Proactive and motivated FHEs and free FP vouchers are the most important determinant of higher FP client volume at SF clinics, followed by other local referral arrangements; whereas, crop harvesting and sowing seasons, absence/drop-out of FHEs, and low acceptability of FP among certain communities were reasons for lower client volumes.
- Training and continuous monitoring were well highly regarded by all service providers, FHEs and SFSs.
- FHEs and vouchers raise awareness and address the cost barrier for poor families
- Sustaining the SF program without the FHE and voucher component was challenging for almost all study participants, as it leads to a significant drop in FP client volume and not being able to serve the poorest segment of communities.
- Some providers who had a well-established business (earning higher income) showed willingness to continue FP service provision through retention of FHEs by supporting a partial salary based on their earnings
- Very few providers expressed willingness to continue FP services without vouchers, but will introduce a sliding fee scale whereby poorer women will be charged less and more affluent clients pay higher service charges.

Program Implications:

- A two-pronged (supply and demand) approach seems to have a promising effect in promoting awareness and voluntary FP service provision .
- Training should have a special focus on communication and interpersonal skills to ensure provision of quality services in respectful manner.
- Selection process of FHEs may include a psychosocial assessment of candidates and their interest toward the job. Strengthening the existing referral network of service providers with other local (public or private) community health workers may also be considered.

- Turnover of FHEs needs to be further investigated and minimized, and their replacement time should be reduced. Special training for FHEs should be conducted to deal with communities where acceptance of FP is very low.
- For financial sustainability, MSS could consider training FP providers on non-FP income-generating services (e.g. delivery, ultrasound), and commence engaging providers who expressed willingness to support FHE salary components.
- MSS to try and gradually reduce the number of vouchers, and eliminate that component, especially among providers whose earnings are comparatively higher.

MSI Insight Study

MSI conducted the Insight Study in its country programs, including Pakistan in 2014, as part of their larger market segmentation exercise. The study provided deep insights into Pakistani consumers' needs, behaviors and attitudes, to help optimize all areas of marketing to remove barriers to voluntary FP. The study revealed that 57%–60% of women in all age groups had little knowledge about FP; 57%–60% of women in all age groups would like to know more about FP; 50% of women discuss FP with their husbands and then make a decision to adopt it; and 65% stated that an 'easy to approach/talk to staff (person)' would be a deciding factor in their decisions regarding voluntary FP services. Younger women (age 20–35 years) were more willing to gain knowledge on contraceptive use and community disapproval was the most influential factor that restricted women to adopt FP.

The FP/RH BCC team is utilizing these insights to design IEC materials for the FHEs and in training staff to be approachable when interacting with clients.

MSI Technical Support

The MSI regional research advisor provided high-level technical support for planning, data collection, analysis and reporting of research initiatives. The technical assistance further supported ongoing activities, such as research conceptualization, in-depth analysis of the exit interview survey, program services, and QA data and dissemination of findings with the program senior management team. Details are provided in a later section.

Capacity Building Initiatives

Six members of the FP/RH team attended and actively participated in a manuscript writing workshop in Sri Lanka organized by MCHIP. The workshop was led by experts from MCHIP based in Baltimore. Peer discussions and challenges faced by the group members were shared to enhance learning. Moreover, the RME team conducted a session on 'data quality assurance' and 'use of data for decision making' for the regional and district teams to build their capacity in ensuring data quality and optimizing its use for decision making. MSI team members conducted training and orientation sessions on the use of the MSI Impact2.

MCH Helpline

In Pakistan, FP is still stigmatized and not discussed at home, in schools, or amongst peers. Youth have limited access to quality FP information. With 64% of Pakistan's population under 3, a TFR of 4.2 and CPR of only 26%[23], Pakistan faces the huge challenge of its population reaching 300 million by 2050. The MCH helpline helps to bridge the information gap by making information more accessible by providing clients with information about the different FP methods and the benefits of birth spacing in a confidential manner.

Under the USAID MCH Program, the FP/RH project led the operation of the helpline for all implementing partners, based on MSSs' 5 years' prior experience operating the 24/7 helpline service. As FP/RH took the FP lead, MCHIP contributed towards capacity building of helpline staff on maternal health. Initially, PSI/Greenstar facilitated helpline promotion through electronic and print media. Their role was taken up later by JHU.CCP. JSI/HSS was requested to include the helpline number on all print material used in their project and to facilitate adoption of the same by the DOH.

Helpline objective
The FP/RH helpline teams worked to promote informed, voluntary and sustainable awareness and demand for quality FP services through availability and access to a 24/7 FP/RH and MCH resource.

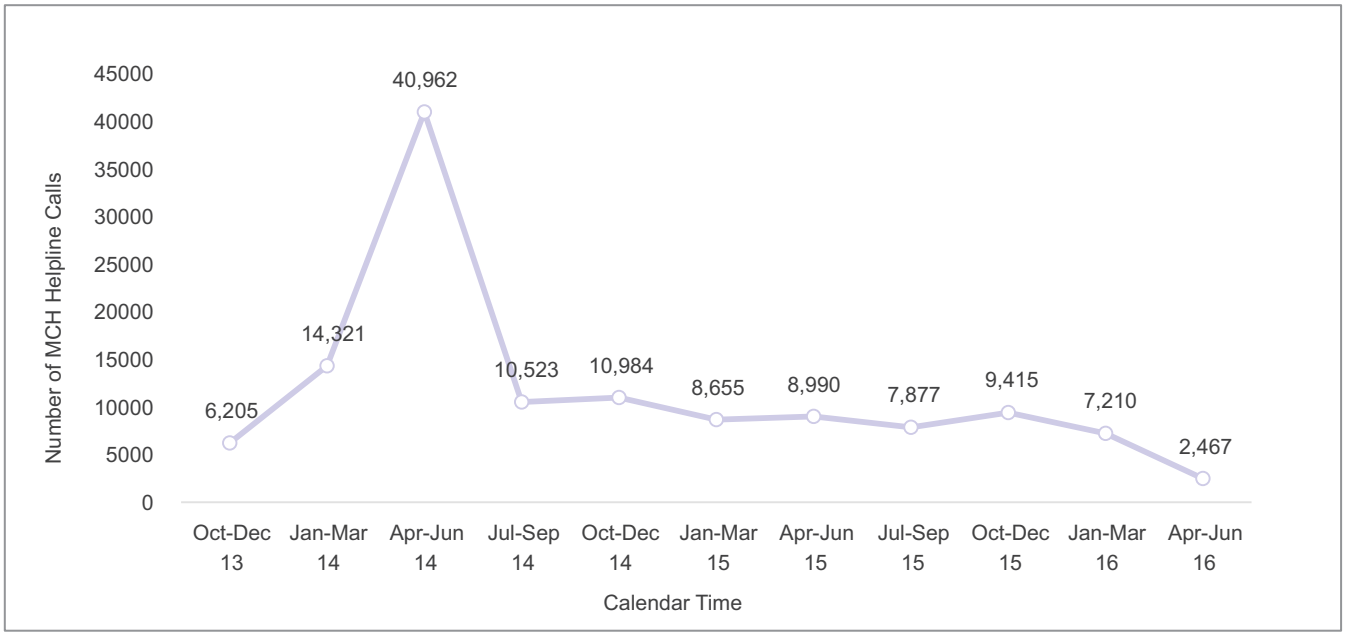
Scope of work and major activities undertaken
During FY14, a lot of effort was put into developing systems and protocols, including the helpline SOPs, with a special focus on ensuring USAID FP compliance; updating FP algorithms and development of MCH algorithms along the same lines; drafting guidelines and FAQs for handling specific queries; and strategic drafts and annual and quarterly workplans. The TSD supported by MSI experts, guided development of protocols and training materials for the helpline agents to ensure FP compliance. Certification of online USAID FP compliance was mandatory for all staff who also received training on FP and MCH supported by MCHIP. An interactive dashboard was created to effectively monitor helpline data.

A SWOT analysis was used to identify opportunities and define strategies at the time of annual work planning. A value for money (VfM) assessment was conducted to improve efficiency and effectiveness of the helpline. The communication partner did minimal promotion, and call surges were directly associated with airing advertisements on electronic media. FP/RH TSD designed a comprehensive internal helpline promotion campaign in 2016, but its implementation was affected by early closeout of the project.

Helpline dashboard
From inception to date, MCH helpline received 128,005 callers who were provided information (68%), referrals (18.3%) and side-effect management advice (13.7 5%) related to FP, RH and MCH. FP remained the most common enquiry (47%), followed by reproductive health (43%) and MCH (10%). 15.5% of the total callers were males.

[23] National Institute of Population Studies Pakistan, Macro International Inc. Pakistan Demographic and Health Survey 2012-13. Islamabad: Government of Pakistan; 2014

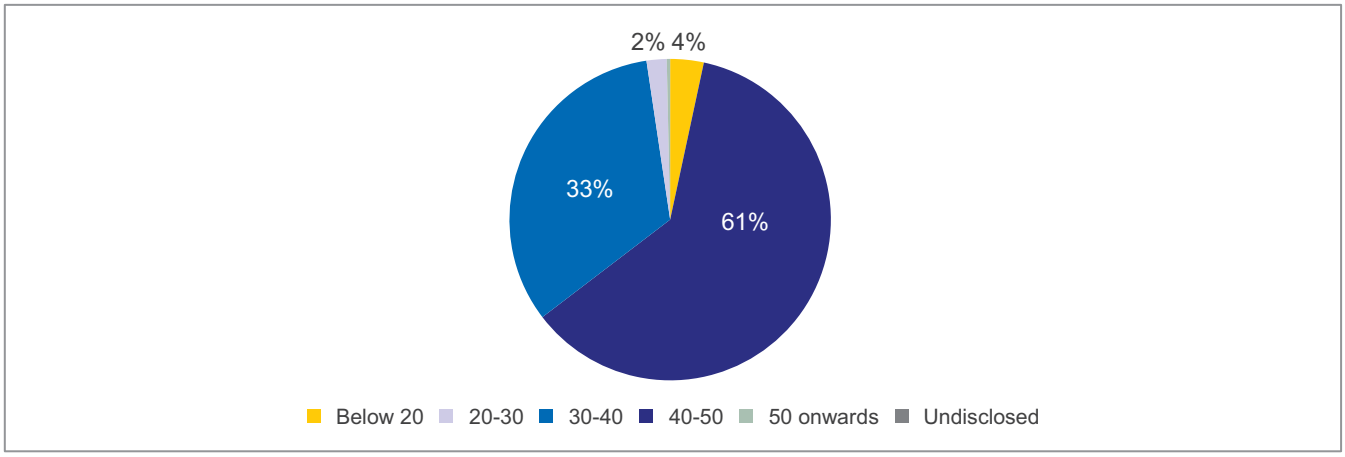
Figure 37: Trend analysis of helpline calls Oct 2013-June 2016



The mass media campaign on exclusive breastfeeding (EBF) in March 2014 saw an increase of 660% over pre-campaign call rates. However, the increase in calls was comparatively lower (24.5%) when JHU-CCP aired the FP commercials from November 25 to December 9, 2015. The difference could be attributed to the utilization of various information channels during the Greenstar campaign in April 2014 which simultaneously used several media: radio, TV, and newspaper. April 2014 was also a period of high viewership due to the airing of the Pakistan/India cricket matches.

The helpline dashboard showed that 55% of the callers were under 30 years of age. This indicates the curiosity and interest amongst this segment, likely due the non-availability of educational resources on SRH and FP and the confidentiality a helpline affords.

Figure 38: Helpline calls disaggregated by age group – Oct 2015 – Apr 2016



MCH Helpline - Value for Money (VfM) review

In April 2015, TSD undertook a comprehensive value for money analysis for the MCH helpline, assisted by MSI. The aim was to reduce the costs of operating the MCH helpline while simultaneously improving the efficiency and effectiveness of spending. VfM drivers were listed to document the value received for the money spent on the intervention along three parameters: 1) economy – an assessment of the cost related to each unit of input, e.g. salaries, training costs; 2) efficiency – an assessment of productivity per unit of input consumed, e.g. if the staff is optimally utilized; and 3) effectiveness – an assessment of whether the output achieved contributes to the outcome and goal of the FP/RH project. The analysis used the relevant metrics which allowed mathematical calculations for accurately assessing the data. As the helpline team had high quality data available for this analysis, tracking the efficiency through these metrics provided valuable insights and revealed opportunities for reducing the cost per call. Staff were reduced to improve occupancy by 59%, and the cost per call was reduced from $2.30 to $1.50, as reflected in the figures below:

Figure 39: Cost per call – a trend analysis

Challenges encountered

The MCH helpline was confronted with several challenges for which mitigation strategies were devised, as listed in the table below:

Table 28: Mitigation Strategies for Helpline Challenges

Issues/Challenges	Mitigation Strategies
Free access limited to landline users	• Assistance was requested from USAID PPP node to facilitate toll free access from all mobile networks through Pakistan Telecommunication Authority (PTA)
Delay in query resolution	• Algorithms developed and implemented in CRM
Queries for generic and psychological health concerns	• Conference call facility added in CRM • MoUs developed with organizations (Aahung, Rozan, etc.)
Callers unable to register the information about referral provided (nearest health facility, etc.)	• SMS facility introduced
Dip in QA scores of helpline calls in FY15 (< 90%)	• Frequency of on-the-job and need based refresher trainings (trainer-agent interaction) increased
Cost effectiveness of intervention	• Value for money analysis undertaken (Cost per call = $2.30)
Reduced occupancy of helpline agents (under 10%)	• Helpline staff reduced by 50% • Night shift discontinued
Missed calls during night shift and peak hours	• Outbound call facility introduced
Low number of calls	• SWOT analysis undertaken • Internal and external promotion strategies devised • MCH partners requested to support helpline promotion
Irregular performance monitoring	• Integrated dashboard developed

Lessons learned

Initiatives like the MCH helpline have significant potential to create mass impact in a country like Pakistan with restricted availability to quality FP/RH information. With 55% of callers below age 30, and 15.5% of callers being male, the intervention offers huge potential for scaling up.

Keeping in view the national statistics, 87% of households possess mobile phones (95% in urban areas and 83% in rural areas) and only 9% households have a landline (19.5% in urban areas and 4% in rural areas). To extend reach to marginalized communities and for the sustainability of similar interventions, it is vital to provide toll-free access to mobile users.

The Pakistan Telecommunication Authority (PTA) and mobile networks should support such initiatives, as was highlighted by FP/RH at several forums. This would help reach a much wider community and amplify the impact of such interventions.

Branding & Marking

Branding & Marking Objective
FP/RH had a very dynamic team supporting the B&M function. Their aim was to build the visibility and profile of the FP/RH project for a diverse audience. This was expected to promote recognition and gain acknowledgement for the assistance received from the American people to improve maternal and child health outcomes.

Scope of work
The B&M activities revolved around ensuring 100% compliance to USAID B&M guidelines for the FP/RH project. After approval of the B&M plan by USAID in July 2014, the team developed associated tools and checklists to ensure compliance at all levels of the project. Technical support was provided for regional and district offices in meeting compliance. B&M orientation sessions were conducted for project offices, regional and district teams on a quarterly basis. FP/RH TSD served as the project brand custodian and provided design and creative support for all project activities.

The district teams were asked to conduct monthly B&M compliance checks using the checklists developed by the technical services department. They shared these quarterly with the B&M manager, who entered the data into the B&M dashboard. This was reviewed by the senior team on a quarterly basis and helped identify, monitor and make action plans to meet the identified branding and marking compliance gaps.

Digital cameras were provided to the regional offices to document project activities in the field. A workshop was conducted for the regional and district teams on capturing high quality photographs, which noticeably improved the quality of reporting by the district teams.

A comprehensive brand book was developed, which served as a useful resource for the project team, particularly in the districts for meeting the B&M compliance in their respective areas of responsibility. It included information on use of logos and guidelines for co-branding. It also provided templates for making presentations and reports, etc.

The team facilitated pre-testing of new creative concepts to be used for IPC and for demand-generation activities. These were supported by the global marketing advisor. The concepts were adapted to the local context and field tested to assess their effectiveness.

Communications

Communications objective
The communications team at FP/RH worked to create an enabling environment where FP was recognized as a priority need at policy, system, community and individual levels.

Scope of work
The communications team had expertise in community mobilization, behavior change communication, graphics, report writing and in making highly quality presentations. Content was developed and used for internal and external stakeholders documenting progress, best practices and lessons learned. The team effectively showcased FP/RH project achievements at various fora.

The team facilitated the collation of information, for which reporting toolkits were developed. This allowed information to be collected from across the project for reporting against agreed frameworks. The team led development of annual work plans, annual and quarterly progress reports, working papers and concept notes, etc.

The BCC and CM team actively participated in the BCC working group meetings; led development of the FP IPC toolkit for the LHWs; created the DCO handbook; and facilitated development of FP counseling and community mobilization manuals.

Technical Assistance from Marie Stopes international

Research, Monitoring and Evaluation
The RME team worked to build the capacity of the FP/RH program by conducting quality research to support effective project delivery and build a body of knowledge for a broader impact. Various research studies were supported throughout the life of the project including, but not limited to, the: Provider Insight Study; Outreach Study; PPFP Study; Willingness to Pay Study; and annual client exit interviews. This included support for development of concept notes, questionnaires, interview guidelines, study SOPs, implementation plans, data collection strategies, data analysis and reporting.

The RME advisor provided support for the client satisfaction tool development and helped develop the performance monitoring and M&E plan for the project. This included review of monitoring dashboards and feedback on the digital dashboard TOR. Support was provided to optimize the FLAME MIS system for SF providers.

Monitoring of project impact was provided through training in the use of MSI's Impact 2 model to better understand program impact and enhance reporting against FP/RH project deliverables. Training and guidance were provided on the use of MSI's Impact 2 model and FP task sharing impact model for external advocacy

IT & ERP
The project enabled investment into MSS' systems, which will help sustain impact for the longer term. MSI supported the roll out of the enterprise resource planning (ERP) system, which is an integrated platform to better manage support office functions to streamline procedures, improve productivity and ensure tighter controls. To support the roll out, MSI provided ongoing and dedicated management and technical support for the ERP implementation. This included supporting the tendering and procurement to identify a provider, support in the assessment of need for the platform, assessment of the quality of work conducted by contractors, and provision and advice on system design. Management support for the roll-out of the system was provided including clarification of roles and responsibilities as well as risk identification and mitigation. The roll-out of this system involved a change management approach, which included how other IT and finance structures would fit with the system. Training of IT staff and support for enhancing existing IT structures, including the FLAME MIS system, were completed.

Social Franchise
To help FP/RH contribute to a sustainable, quality and effective health workforce and system, support was provided to develop sustainability strategies for social franchisees, which included an assessment of different business models. The SF advisor and SF channel lead provided support in developing indicators for management dashboards for social franchisees.

Health Financing
The health financing team offered input into the MSS/FPRH safe motherhood voucher management system, including the operational manual for safe motherhood vouchers, reporting formats for the MIS and the monitoring plan. They supported the development of sustainability strategies and explored domestic financing opportunities and strategies for social franchise providers. They gave input into the domestic diversified health financing strategy. The health financing team led a voucher scoping study which will provide a comparative analysis between practice and MSI's voucher management standards to enhance quality of the process.

Procurement & Logistics
The procurement and logistics team offered extensive support to identify sources of quality pharmaceuticals for the FP/RH project. This included a quality audit of manufacturers based on the WHO Good Manufacturing Practices guide by an external consultant. The team offered support in effective P&L processes, including assistance with development of a standard product list, supply chain mapping, and establishing standard forecast and quantification processes.

They gave support in obtaining a USAID waiver and subsequent procurement. The procurement and logistics team provided input on logistics management requirements for the ERP system and support in ordering some commodity and supplies required for the project through MSI's centralized procurement team.

Security
The security team supported effective security management for the protection of staff and assets. They gave remote and in-country assistance to develop a safety and security plan in line with MSI's essential security package as well as MSS' security manual. They provided training in basic security awareness, incident response, and special situations protocol training for FP/RH project staff. Analysis of current and emerging safety and security risks was regularly conducted in collaboration with security focal points. This included an assessment of risks, safety and security measures. Weekly meetings were held with the GM security on context updates, travelers' schedules and feedback. Security briefings were provided to all TA providers prior to travel to Pakistan and technical support was given for security incident reviews throughout the life of the project. Key systems and protocols rolled out included visitor SOPs, the Proof of Life system and the Employee Travel Monitoring System.

Finance
Effective and compliant financial management was supported through roll out of SUN6, which allows real-time data to be accessed and improves internal controls. The system also enhances teams' abilities to gather and analyze data. Training was provided on the use of SUN 6 and Vision software. MSI finance teams supported improved accounting controls and processes through a focus on fraud, bribery, and conflict of interest. The finance team assisted in providing and reviewing management responses to auditors and conducted internal audits of the project. Effective financial management support was provided through regular monitoring of project expenditure, review of monthly and quarterly reports, and supporting in donor financial management compliance

Donor Compliance
Technical teams and external consultants supported effective program management in line with USAID rules and regulations by providing

- USAID compliance and operational review
- USIAD government regulation – audit
- USG Legislative and Policy guidance
- Sub-award management guidance
- Review of narrative and financial reports to ensure compliance with USAID rules and regulations
- Support for sub-awardee management and subcontractors
- Extensive support on project close-out to ensure it is in line with donor requirements.
- Clinical quality.

TA focused on enhancing provider skills to deliver quality voluntary services and further build the capacity of technical project staff to effectively monitor and train providers to ensure quality was maintained in line with MSI's quality guidelines. Clinical governance procedures were revised to ensure consistency of messaging across service delivery channels and to orient teams responsible for inducting and quality-assuring new service providers. To further support enhanced provider capability, clinical governance and supportive supervision training was provided to a select group of quality, training, operational and research staff.

Human Resources
Support for effective human resource systems was provided through input into the staff engagement survey. HR at the MSI HQ supported recruitment and contracting of consultants and technical advisors for the project. During project close-out, support was provided for interpretation of Pakistan employment law, as well as redundancy and termination payments for staff.

Communications
The communications team supported report writing and reviews and the capturing of success stories. They supported the development of the branding and marking plan.

Success Stories

MSS Helpline: Reaching youth to promote the benefit of birth spacing

MSS Pakistan has operated a helpline since 2008. The helpline supports clients, particularly youth on their reproductive journey by providing 24/7 access to confidential and quality FP information. More than 65% of the callers are under 30 years of age.

In Pakistan, FP is stigmatized and not discussed at home, in schools, or amongst peers. Youth have limited access to quality FP information. With 64% of Pakistan's population under 30, a TFR of 4.2 and CPR of only 26%, Pakistan faces the huge challenge of its population size reaching 300 million by 2050. The MCH helpline bridges the information gap by providing clients with information about the different FP methods and the benefits of birth spacing in a confidential manner.

Shehla Noorani (assistant manager, MSS Helpline) shares that “reaching youth is most important for us, as they are the most vulnerable to unplanned pregnancies and subsequent abortions, for which the rate is quite high in the country. This often ends up in complications as they are more likely to go to untrained providers and become a victim of unsafe practices”.

The FP/RH team was considering designing mobile apps aimed at increasing access to quality information on voluntary FP services by engaging youth in universities. User-friendly mobile usage should further eliminate barriers to accessing FP information, particularly by younger age groups. It is hoped that the JHU.CCP will carry the initative forward.

Nurturing Lives

Zaibunnisa joined Marie Stopes Society in Karachi as an FHE. This is her first employment experience.

As an FHE, her duties mainly comprise of daily visits to houses in planned areas. As a first-time employee coming from a conservative family, Zaibunnissa had little confidence in her abilities. However, the training and on-the-job coaching she received from the FP/RH project's training team helped immensely. They not only coached her as to how to counsel others, but also raised her self-esteem.

She recalls:

“Initially it appeared to be very difficult. This was my first job and, being a girl in this society, I had no confidence. Such topics are so sensitive that we couldn't even discuss them with our own families. But my team was very supportive, every step of the way. I consider myself lucky to be a part of such a team that not only believes in me, but also believes in mentoring me for my professional and personal growth. Because of MSS, I will continue to work for my community with confidence and pride.”

Timely Awareness Preserving Health

Zakia Shehzad and her husband live in a low income area of Karachi with their 6-month old baby. She learned about family planning from the household visits conducted by Rabia (the project's FHE).

When Rabia first met them, both Zakia and her baby were in poor health due to an insufficient diet. Because of her MSS training, Rabia was able to get to the root cause of Zakia's ill health. Zakia's husband is a laborer and has inadequate income to provide for his family. After being counseled on the benefits of family planning and spacing from Rabia, Zakia and her husband talked to each other and opted for an IUCD.

Zakia accounted her experience by saying, “I had no knowledge of FP services, and when I was told about it, I thought that I didn't need it because I only have one baby. But the FHE told me that the main purpose of FP is to live a healthy life.”

She further added, **"We are glad that we took the FHE's advice on time. Our conditions are far from ideal, and this is why we first need to work together and provide a good life for our son before we can plan to have other children. We think that in our limited means it is better to have fewer healthier children than lots of sick children."**

Team Work at its Best

Outreach (OR) teams focus on reaching out to marginalized communities in remote and under-served areas. These areas have a high levels of unmet need due to lack of resources to travel and limited access to FP services by public service providers.

OR teams partner with the local public health authorities to provide long-term and permanent FP services (as well as short term methods) at camps organized at public health facilities equipped with operating theaters. OR teams are subject to strict quality assurance (QA) compliance. In the current year Karachi, Hyderabad and Sukkur have had impressive QA scores of 93%, 96% and 92% respectively. These results are demonstrative of exceptional team work resulting in the high quality of services provided to the community.

"We are proud of our high QA scores. Reaching out to the communities in such areas is a challenge in itself, but to maintain good quality services further adds difficulties, yet we manage to carry out our services without compromising our quality." OR Team Lead Hyderabad

Grooming future healthcare managers

Ms Farheen Firdaus Lalwani has been with FP/RH since 2015 as an assistant training manager. She had completed a diploma in general nursing and started her career as a paramedic, but always felt like she wanted to give a greater contribution to the health sector.

Farheen had the technical knowledge and the passion to work but initially lacked confidence, especially when speaking in front of a large audience. Her apprehension was exacerbated by the fact that family planning is a sensitive subject in conservative societies.

"I always thought that I could contribute more by being part of an organization or project which primarily focuses on overlooked communities which have no health facilities."

"Initially it looked so difficult, but the sessions I took with the training gave me motivation and provided a platform to carve my career path. With their guidance and encouragement, my enthusiasm, skillset and self-confidence improved. The positive attitude and assistance I got helped me acquire the skills needed to carry out my professional responsibilities in a better manner."

Global Exposure Sharing Local Successes

A research abstract titled "Impact of Training on QA Scores" was presented by Dr. Saamia Shams (DGM, QA-FP/RH) at the International Forum on Quality and Safety in Healthcare. The forum was organized by the Institute for Healthcare Improvement (IHI) and BMJ in Gothenburg, Sweden. Over 3,000 delegates from around 80 countries participated in the forum.

This presentation highlighted the impact of training on providers' knowledge and competence on FP methods and counseling skills using the MSI QA checklist. Dr Saamia briefed the participants regarding the FP/RH project and the role of quality assurance department in continuous supportive supervision of health care providers to improve their quality of services. FP/RH QA and training achievements were showcased at the forum, which helped build the project's capacity as well as visibility on an international stage.

Commenting on her experience at the forum, Dr Saamia stated, **"Such venues provide ideal opportunities to present the best practices of our project, while providing us with global networking experience. Sharing our experiences and learning from the experiences of others is the best outcome at such forums. By continuous sharing of such information, future projects can have practical information that can serve communities in a better way."**

FP/RH Best Practices - Lessons for Future Projects

As expected from a large-scale project, there were multiple execution challenges and successes facing the FP/RH management, from the grassroots level to the strategic level. It is hoped that future teams may apply these learnings in their strategic planning processes and execution.

Effective team management

A noteworthy achievement of the FP/RH project was the ability to maintain a balance between stringent donor and internal compliance requirements while supporting maximum access for clients to avail voluntary methods of choice. This was attained through effective people management and maintaining high levels of staff motivation. The organizational structure centralized and decentralized decision making whereby strategic decisions were made at the head office level, with regional and district teams empowered to make day-to-day decisions in line with the strategy. Each team member had clearly defined KPIs and collective performance was reviewed once a quarter with the Communications department playing a central role. These elements of effective team management should be replicated in other large projects.

Streamlining protocols

Successful project management should be is supported by streamlined protocols and procedures which are clearly communicated. This allows for rapid facilitation and mitigation of issues that field teams may face, particularly regarding QA and training processes. MSS tailored their standard operating procedures in accordance with donor and technical compliance requirements. These SOPs were disseminated and personnel were trained on them as per requirement. Some of these SOPs were for the Social Franchise, monitoring and reporting formats, BCC and IPC toolkits, audit and financial guidelines, etc.

Strong field force

Field Health Educators have been pivotal in educating communities on the merits of family planning and healthy birth spacing. The human element given to the project by these FHEs has been a success story in itself. FHE support to private partners in the Suraj network has played a significant role in increasing access to family planning services for poorer, underserved members of the Suraj network's communities by generating awareness, demand and sensitizing as well as mobilizing clients towards FP uptake. At FP/RH, FP services continued as SF proved to be a significant contributor towards fulfilling the unmet need of communities. Having a well-trained, passionate field force supported by a strong technical services team at the management level seems to have been a successful combination. FP/RH employed a 3-tiered system to strengthen its field force: a clearly defined job description; transparent recruitment process; and capacity building of employees on a wide range of topics.

Strong field force and a focus on interpersonal counselling

Field Health Educators have been pivotal in educating communities on the merits of FP to achieve healthy timing and spacing of pregnancy. The human element given to the project by these FHEs has been a success story in itself. FHE support to private partners in the Suraj network has played a significant role in increasing access to FP services for poorer, underserved members of the Suraj network's communities by generating awareness, sensitizing communities to the benefits of FP as well as mobilizing clients to enable access to quality voluntary FP services. FP/RH developed a theory-informed behavior change community strategy which was implemented through community mobilization, a strategy which was also shared with MCH partners for wider use and inter sectoral learning. MSS found having a well-trained, passionate field force supported by a strong technical services team at the management level proved to be a successful combination. FP/RH employed a 3-tiered system to strengthen its field force: a clearly defined job description; transparent recruitment process; and capacity building of employees on a wide range of topics.

Strengthening community networks

Strong inter community linkages with important and relevant stakeholders such as the Providers, FHEs, LHWs and clients proved to be an important factor leading to success in FP/RH related message-dissemination. With better inroads into remote areas and underserved communities, project messages will have a deeper and more lasting impact. FP/RH strengthened linkages at the grass roots level through community mobilization and by forming social action groups. These were aimed at better supporting FHEs to build social capital through enhanced community engagement and ultimately build awareness more effectively.

Risk Assessments and Contingency planning

The importance of regular risk assessments and contingency planning is a key lesson learnt. For the project to be successful, detailed and robust risk and contingency plans need to be designed and implemented. FP/RH maintained a risk register that comprised possible risks with their impact and likelihood of occurrence rated to support advanced mitigation planning. It is best to have contingency plan as detailed as possible, to be the most helpful and to review it regularly.

Improved government and provincial coordination

For any project, an increased focus on provincial-level coordination and networking with government departments is likely to pay long-term dividends. Dedicated resources for government liaison and district coordination are critical to achieve the project's goals. MSS faced some challenges in promoting ownership of FP/RH work and effective coordination with all stakeholders. For example, some information (field operations and service numbers etc.) being communicated did not reach the PWD management levels in a timely manner and MSS was at times seen as a competitor rather than an ally to the PWD. To support more effective coordination, MSS worked closely with the government through its central government liaison committee that demonstrated openness and willingness for collaborative efforts in serving the communities. As the project matured and as a result of efforts to support effective coordination, the relationship improved and MSS now enjoys a strong cordial relationship with the government and forms an integral part of various provincial and federal level task forces and working groups.

Sustainability of vouchers:

Initiatives under FP/RH to support voluntary adoptive FP behaviors and strengthen quality service provision through vouchers faced similar challenges to those faced globally and remained heavily dependent on donor funding throughout the life of the project. Despite this, during the course of project's life, out-of-pocket clients increased (11% in year 1 vs 24% in year 3) – building a case that vouchers in particular could be gradually reduced. Further to this, as mentioned earlier, the CES in 2015 revealed that 55% of clients would be willing to purchase an FP method in the absence of a voucher. In the short-term however, voucher programs will be dependent on donor funding which demands they deliver value for money[24]. In sensitive environments such as Pakistan, voucher programs will be dependent on donor funding for longer. However, as the context becomes more conducive, voucher programs need to position themselves as a demonstration of the feasibility and impact of strategic purchasing of contraception services for high impact / underserved groups. This means establishing strong relationships with Government and a robust evidence base along with beginning to lobby the Government for developing policies to support the sustainability of initiatives by linking it with the public sector health system. To promote the sustainability of this intervention, it would be beneficial to embed it within the state's insurance program.

[24] Gorter A, Grainger C, Okal J, Bellows B. Systematic Review of Structural and Implementation Issues of Voucher Programs. Options; 2012 July

Cost-effectiveness of intervention:

Throughout the implementation of the program, MSS sought to identify ways to deliver better value for money. This included the following initiatives:

a) The project team held quarterly financial meetings to identify areas of cost-containment where spending could be economized. Teams were encouraged to identify innovations capable of reducing spending while ensuring that quality and choice were not compromised. Examples include combining monitoring and staff training visits, developing master trainers capable of conducting in-house step down trainings, cost-sharing with other MSS projects for activities which are in the interest of the organization as a whole.

b) MSS implemented USAID compliance training across all management tiers which resulted in very minimal questionable cost during RCS audits in 2014-2015.

c) In April 2015, TSD undertook a comprehensive value for money analysis for the MCH helpline to reduce the costs of operating the MCH helpline while simultaneously improving the efficiency and effectiveness of spending. Using quality data available for this analysis and tracking the efficiency through these metrics provided valuable insights and revealed opportunities for reducing the cost per call. Staff were reduced to improve occupancy by 59%, and the cost per call was reduced from $2.30 to $1.50 (year 3 onward).

d) Tax exemption letter from Federal Board of Revenue for vehicle purchase saved up to USD 110,000

e) Optimizing allocation of resources among programs and interventions is another way to improve efficiency. Launch of FLAME was another example of innovation that promoted efficiency in the project. This client based management information system was developed to be invaluable for evidence based decision making. Even though it was rolled-out in only a few districts; the system has been able to serve the needs of Operations, Communications, and Technical Services Departments. Similarly, applications developed in house such as e-leave, e-travel and the QA score board enabled FP/RH to reduce errors in record keeping and reporting across multiple functional domains as well as decrease time spent by staff in administration and reporting tasks

f) FP/RH demonstrated a growing interest in management practices and principles that helped them build high-performing teams, rather than just a strong program. Staff training and capacity development were given a high priority considering the potential returns on investment made in this regard. In addition to the usual domains of management, operations, planning and compliance, FP/RH has made a focused effort in developing in-house technical expertise to reduce dependence on external consultants.