

Mid-Term Assessment of Social Marketing Program (2003 – 2008)

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LIST OF ABBREVIATIONS:

AIDS	Auto Immune Deficiency Syndrome
AMHS	Assistant Manger Health Service
ANC	Ante Natal care
CBD	Community Based Distribution
CBOs	Community Based Organizations
CPR	Contraceptive Prevalence Rate
CSM	Contraceptive Social Marketing
CTO	Cognizant Technical Officer
CYP	Couple Year of Protection
CWS	Central Warehouse Store
DFID	Department for International Development
DG	Director General
DHS	Demographic Health Survey
DoH	Department of Health
DoPW	Department of Population Welfare
DPWO	District Population Welfare Officer
DHQ	District Head Quarter
EBM	Evidence Based Medicine
EC(s)	Emergency Contraceptive(s)
ECP	Emergency Contraceptive Pills
EmONC	Emergency Obstetric and Neonatal Care
EDO	Executive District Officer
EOP	End of Project
FGI	Futures Group International
FLCF	First Level Care Facility
FMCG	Fast Moving Consumer Good
FP	Family Planning
FPAP	Family Planning Association of Pakistan
FSW	Female Sex Worker
FWC	Family Welfare Center
FWW	Family Welfare Worker
GoP	Government of Pakistan
GP(s)	General Practitioner(s)
GSK	GlaxoSmithKline
GSM	Green Star Social Marketing
GS-I	Green Star I
HIV	Human Immunodeficiency Virus
HMIS	Health management Information System
HCP	Health care provider
IA(s)	Implementing Agency (Agencies)
ICPD	International Conference on Population and Development
INTRAH	Program for International Training in Health / IntraHealth International, Inc.
IPC	Inter Personal Communication
IUCD	Intra Uterine Contraceptive Device
IUD(s)	Intra Uterine Device(s)
IEC	Information Education and Communication
JHPIEGO	John Hopkins Population Information Program

KAP	Knowledge, Attitudes, and Practices
KSM	Key Social Marketing
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)
LCDP	Lyari Community Development Program
LHV	Lady Health Visitor
LHW	Lady Health Worker
LSHTM	London School for Hygiene and Tropical Medicine
MDG	Millennium Development Goals
MIS	Management Information System
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MoU	Memorandum of Understanding
MSS	Marie Stopes Society
MSUS	Mobile Service Units
MTDF	Medium Term Development Framework
MVA	Manual Vacuum Aspiration
MS	Mohalla Sangat
MCH	Memorial Christian Hospital
MIS	Management Information System
MWRP	Married Women of Reproductive Age
NACP	National AIDS Control Program
NGO	Non Government Organization
NIPS	National Institute of Population Studies
NWFP	North West Frontier Province
OPD	Out Patient Department
OC(s)	Oral Contraceptive(s)
PAIMAN	Pakistan Initiative for Mothers and Newborn
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PNC	Post Natal Care
PPP	Public Private Partnership
PRHFPS	Pakistan Reproductive Health and Family Planning Survey
PSI	Population Services International
PTL	Permanent Tubal Ligation
RFP	Request for Proposal
RH-AID	Reproductive Health-AID
RHSC "A"	Reproductive Health Services Centres "A"
RHSC "B"	Reproductive Health Services Centres "B"
RHS	Reproductive Health Specialist
RHC	Rural Health Center
RTIs	Reproductive Tract Infections
SBMR	Standard Based Management Review
SC	Steering Committee
SCF US	Save the Children Fund United States
SM	Social Marketing
SOMs	Social Marketing Organizations
SMP	Social Marketing Program
STI	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases
SOPs	Standard Operating Procedures
TAMA	Technical Assistance Management Agency

TFR	Total Fertility Rate
TFG	The Futures Group
TOT	Training of Trainers
TQC	Training and Quality Coordinators
TPO	Training Program Officers
UDL	UDL Distributions (Pvt) Ltd.
UNFPA	United National Population Fund
USAID	United Nations Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization
ZAFA	ZAFA Pharmaceutical Laboratories (Pvt) Ltd.

1. Executive Summary

USAID is collaborating with DFID and UNFPA to support the Social Marketing program in Pakistan. This is through two programs, Greenstar Social Marketing (GS) and Key Social Marketing (KSM). USAID is providing \$50 million over five years, 2003-2008, for marketing support, while DFID and UNFPA are providing \$18 million to provide commodities to Greenstar Social Marketing (GS). USAID marketing support is divided between two social marketing organisations, \$27m to KSM and \$23m to GS.

The goal of SM program is to increase contraceptive usage as measured by CYPs. The Government of Pakistan (GoP) aims to increase the modern method contraceptive prevalence rate (CPR) to 35% by the end of the project, and the share provided by social marketing is expected to rise from 33% in 2003 to 45% by 2008.

The two social marketing programs are now supporting 17 brands of OCs, condoms, injectables, EC and IUDs. GS markets condoms, oral contraceptives, emergency contraceptive, IUDs and 3 types of injectables. These products are supplied by donors or are purchased through revenues. KSM markets a similar range of products; some are supplied by a local manufacturer, ZAFSA, while others are imported brands. Donors do not provide funding for provision of KSM commodities.

GS focuses its attention on a franchise of clinics where the providers have been trained to various levels in family planning (FP) and in fitting IUDs, and also in distributing its products through commercial distributors for sale in the retail trade.

KSM works through ZAFSA's distributors for that manufacturer's products and through commercial distributors for the other brands. Both social marketing (SM) organizations have their own sales forces to complement the distribution through the commercial trade.

Both organisations support their brands on mass media. KSM uses successful inter-personal communication programs with Mohalla Sangat (women groups run by trained public sector Lady Health Visitors) and GS has commenced a Clinic Sahoolat program (free service days at trained provider clinics). GS also promotes the GS clinic network.

Both organisations are dedicated to targeting markets for the underserved populations. KSM works with sub-populations of less than 25,000 in an area, while GS targets those people whose family income is less than Rs.7,000 (\$120) per month. However, the bulk of their sales is still in urban and peri-urban areas.

1.1 THE MARKET

Condom sales/issues are about 180 million per annum in a population of 160 million people. These are supplied by the SM programs, where GS is

dominant, the public sector through Ministry of Population & Welfare (MOPW), and Lady Health Workers (LHW), a long standing program where nearly 100,000 women call door to door to provide FP counselling and distribute products (mainly condoms and OCs).

Oral Contraceptives run at about 12 million cycles per annum, and Injectables at 2.5 million. The public sector dominates these products although the SM products are growing steadily.

There are about 1 million IUDs fitted each year and 160,000 sterilisations carried out. In total, condoms are increasing slowly, OCs are growing, Injectables are becoming more popular, IUDs are static and there is continuing growth in sterilisations. Total CYPs are flat and it is unlikely that the GOP goals will be met.

There is a continuing interest in women limiting, rather than spacing their family sizes, but only after they have had several children. There is a preference for long-term methods of contraception, but the short-term methods being promoted by the SM organisations are growing slowly. There is an estimated 28% unmet need, most of which is for limiting.

1.2 THE SM PROGRAMS

Both programs have indicators related to CYP targets and cost/CYP. GS has achieved its cost/CYP, overall CYP targets and is on-target with its overall budget spend. KSM, due to having to rebuild its organisation at the beginning of the support, is well short of its initial CYP and cost/CYP targets, and looks as if it will remain so.

GREENSTAR: has restructured its organisation, appointed new distributors and expanded and decentralised its sales force. It is expected that this will better serve its focus on its strategic target of clinic based development and expansion of IUD and other FP service delivery. An extensive new community outreach program began in December 2005.

They have been much more active with GoP at federal level and commenced a pilot program working with LHWs. In addition they have collaborated with Save the Children program and PAVHNA, a local NGO, to develop programs in 5 rural areas of the country.

Although just bedding in with their reorganised sales and health service field staff, the supervision of their clinics and quality of care needs some attention. Infection control is one area that needs major attention both in training and in supervision. The AMHS probably have too different many roles to perform to be able to concentrate sufficient attention to this problem area. GS style is to aim to deliver their targets, but they appear to have a little less focus on quality of care.

Although GS has developed some very innovative television spots, GS has a limited marketing budget in their grant which is now fully spent.

KSM: has expanded its sales force, but is falling short on its CYP targets, which were probably too ambitious in the first place. They do provide quality training and have good medical capacity and community mobilisation. In working with a local manufacturer they are improving local capacity, which is appreciated by GoP.

However, in part due to a delay in being fully operational, they are well behind on the program targets and have only spent 47% of their three-year budget, as at March 31st 2006.¹ Nonetheless, KSM's cost per CYP remains high at \$10.55.

KSM's plan to work with JSI to expand sales through the Lady Health Worker program was not feasible and had to be cancelled. KSM continues its Mohalla Sangat program, and is initiating Mohalla Sangat with men. Up to 40% of the program reaches communities with populations of less than 25,000. KSM has developed a series of branded and generic mass media communications, but is underspent on its marketing budget.

1.3 COLLABORATION

It appeared that the two programs were running similar programs and possibly having duplication in some areas. USAID encouraged these two basically competitive organisations to agree areas where there could be collaboration. Some progress has been made and now there is collaboration on research, some mass media advertisements, training of health providers and some selling of GS brands by KSM. This has improved efficiencies to some degree. However, it is probable that this is the limit to which collaboration can be taken.

Having two social marketing organizations has provided donors with a choice of approaches to SM. Competition is likely to have improved the sales of the products. Maintaining two donor-funded SM organizations is costly, however, and an important criterion for donors to bear in mind is that continuing investment should not only support existing products and programs but be focused on reaching new people for FP.

1.4 RECOMMENDATIONS

1.4.1 Increasing the demand for FP and CPR:

Apart from detailed operational recommendations to the SM organizations(See section 8), there is a need from a health perspective to more heavily promote the use of short term contraceptive methods to encourage birth spacing among married women at an earlier age. Although the SM organizations have been promoting their brands with messages which address this issue, it needs a concerted effort by GS, KSM and GoP to promote the concept of birth spacing, as opposed to long-term methods which

¹ KSM has realigned the budget by year, this being different from that submitted in the RFA i.e the RFA 3-year budget was \$16.05m as opposed to KSM working budget of \$18.24m.

limit family size. This should form the thrust of a generic campaign, as well as both organisations promoting their branded products.

1.4.2 Budget Re-alignment

Within the two programs there is a case for re-aligning the budgeted monies. KSM presently has sufficient funds to continue its own program and work on generic projects, (as agreed between GS and KSM although not formally adopted by USAID), including research and mass media, which would benefit the whole market. However it needs clear direction and a confirmed mandate to do so. GS initially budgeted only for marketing funds for communications in years 1-3, with the remaining years to be covered through sales revenue. Additional USAID funds for marketing would enable GS to provide expanded support for birth spacing using an integrated social marketing approach of working with providers, products, interpersonal and mass media communications. Such SM activities would benefit the whole market also. The evaluators recommend that funding be transferred from KSM to GS. A figure of about \$3-4 million is suggested as an appropriate amount.

USAID should examine whether or not it is feasible and sensible to transfer some marketing funds from KSM to GS for the remaining life of the project. This would need a revision of the objectives of both organizations, and possible amendment to agreements.

1.4.4 Sustainability

Both organisations, particularly KSM, need to develop long term strategies should there be a withdrawal of donor support. KSM may be slightly better placed in that it does not require donor funding for its commodities, but there are doubts as to whether or not ZAFSA will be in a position in 2008 to continue marketing and selling the brands currently supported by KSM. A change in the structure of the relationship with ZAFSA has the potential of keeping the ZAFSA brands on the market after the USAID funding ends. The evaluators recommend that up to \$500,000 of the KSM funds should be allocated to develop a business plan for the SM brands with ZAFSA. This could involve an organisation such as PSP-One or the Concept Foundation. It is recommended that any manufacturer/commercial model program be structured to foster the manufacturer's interest in growing the market and present evidence of progress toward full commercialisation on an annual basis.

GS has revenues generated by the sales of its products, but there is no way they could continue at present volumes without continuing donor support for commodities. They are using higher priced brands to cross subsidise the other brands targeted at poorer populations, but it will be several years before sustainability for all products can be achieved. In any future support for SM programs, donors should recognise the need for funding commodities, and forecast funding requirements should be prepared well in advance of the end of the present support period.

However, before the recommendations for sustainability are made, it is necessary that a comprehensive long-term strategy for IAs and donors, is developed and implemented. USAID, DFID, UNFPA and SMOs need to develop this. Furthermore MoPW should be involved in the whole strategic thinking process, firstly for FP as a whole and then the role of social marketing,

1.4.5 Improving efficiency and effectiveness of the National Program

The MTFD document strongly emphasises the need to have an integrated approach to reproductive health and family planning. A fragmented approach by many stakeholders leads to waste, and duplication of efforts and resources

It is recommended that a national level review of all the programs (including the role played by private sector) contributing to population and development be conducted. This should lead to the development of a national strategy (having individual provincial/district focus), which would have favourable implications in strengthening SM in Pakistan and its important contribution in achieving the MDG targets. USAID, DFID, UNFPA should commence this process with MOPW, MOH and other GoP parties.

1.4.6 Improving responsiveness, efficiency and effectiveness

There is an absence of a sufficiently high-powered committee within the national FP program which takes strategic and long-term decisions or takes responsibility for coordinating both GoP and SM efforts in achieving increased contraceptive prevalence goals. Although a steering committee, with representation of donors, provincial Population Welfare departments and other stakeholders, has been put in place and is doing some useful work, it is only very recently that it has been chaired by the Secretary or Additional Secretary. It is recommended that the donors put pressure on MOPW and MOH to develop a documented operational framework whereby all parties, including the SM organisations, can work together to achieve the Pakistani MDG and other family planning goals.

At present, although sales and issues of contraceptive products are increasing, uptake at national level from whatever source is only just keeping pace with population growth and is not increasing CPR. Data on sales/issues is fragmented and of differing types. Donors should work with SMOs, MOPW, MOH and LHW program to agree the real volumes of products reaching consumers and monitor the movements of all contraceptive products on a regular basis such that there is one unified estimate of market size and change.

The contribution of both organizations is appreciated by the GoP, especially at federal level. The SM programs make the major contribution to developing the consumer market, where the public sector does not have the skills or capacity. There is useful collaboration with other NGOs on the ground. Partnership agreements have been made between MSS and DoPW, Sindh and Punjab, for contracting out some of the FWCs. In addition, the RH

related NGOs such as FPAP, PAVHNA have close interaction with MoPW and DoPW in terms of organising surgical camps and processing of payments for tubal ligation by the MoPW. However, the provincial public sector do not understand social marketing or what the SM organizations are trying to achieve. It is recommended that both SM organisations continue to develop positive programs and federal level, and to establish linkages and mutual understanding at provincial levels.

1.4.7 Donor Support

One of the benefits of social marketing is that all of the components – training, procurement, interpersonal and mass media communications, sales, etc. - are brought together and integrated with a single consistent message. Donors are also important for keeping FP high on the Government's agenda (and the private sector agenda too) and supporting SM as largest single contributor to CYPs. It is recommended that USAID continue to support SM as it develops its plans for an enhanced RH program.

2. INTRODUCTION & BACKGROUND

There has been a Social Marketing Program in Pakistan for over 20 years. Social Marketing Pakistan (SMP) commenced by marketing Sathi condoms for family planning (FP) and, during the 90's added oral contraceptives (OC), Injectables and IUDs. Commodity support was provided by DFID and other donors. This organisation was re-branded Greenstar Social Marketing (GS) in 2003 as it built a "franchise" of clinics through which to sell its products and provide a pool of trained clinicians in the private sector.

In 1996, DFID commenced supporting a Futures Group initiative under the name Key Social Marketing (KSM). This organisation used a "manufacturer's model" taking commercial oral contraceptive and injectable products and marketing these under the manufacturer's brand names. They also trained private sector clinicians and developed the Key franchise similar to Greenstar, although support for the franchise has now been dropped. In 2000, supply of OCs was switched to a local manufacturer, ZAFSA, and KSM continued marketing the new brand Famila. Assistance was provided to ZAFSA who later developed its own brand of injectable, which is also marketed by KSM.

In 2003, a quadripartite Memorandum of Understanding (MOU) was signed between DFID, UNFPA, USAID and the Government of Pakistan (GoP). DFID and UNFPA fund the supply of commodities to GS to the value of \$18 million and USAID awarded two agreements for the Social Marketing Program (SMP) totalling \$50m. This funding is divided between GS (\$23m) and KSM (\$27m) respectively, and the program runs from September 2003 to August 2008. The total SMP investment in Pakistan is therefore \$68 million over this five year period.

In 2005, USAID encouraged both GS and KSM to develop a collaborative plan, with the overall objective to increase efficiencies and cost effectiveness of services, minimise duplication of effort in training and service delivery; and report unduplicated results on the indicator Couple Years Protection (CYP). An MOU was agreed between the two organisations but, although USAID amended the SMO agreements to incorporate this, there was never a realignment of budgets or programs, thus invalidating the MOU.

The overall focus of SMP is to help married couples make informed decisions about the timing and number of desired children by offering a wide range of modern contraceptive choices, better information and improved quality public and private service delivery centres.

Today these two programs provide more than one quarter of all modern contraceptives used in Pakistan and the program has demonstrated considerable impact including increasing overall contraceptive awareness, availability and utilization as well as increasing the use of SM products, and fostering private sector participation in the production and distribution of contraceptive products.

The current SMP agreements are in the third year of implementation and, as part of USAID Pakistan's due diligence, a mid-term evaluation was carried out in Pakistan by an evaluation team² between April and June 2006. The

² The team comprised independent international consultants Alan Handyside and Elizabeth Gardiner, local consultants Dr. Inayat Thaver and Dr. Samina Mohsin, with assistance from Ashif Irshad and Khurram Abbass from AASR.

objectives were to assess the effectiveness of the program components (excluding DFID and UNFPA inputs), document "lessons learned", present results achieved to date, and provide recommendations for overall program improvement and strengthening.

3. SOCIAL MARKETING PROGRAMS

3.1 Program Background

Social marketing aims to increase family planning (FP) use by making quality family planning products available and communicating a variety of behavior change messages that encourage correct and consistent family planning use. In Pakistan, social marketing also works extensively with private sector family primary care service planning providers to improve the quality of the family planning services that they are also delivering.

The goal of the USAID-funded SM program is to increase contraceptive usage as measured by CYPs. The Government of Pakistan aims to increase the modern method contraceptive prevalence rate (CPR) to 35% by the end of the project, and the share provided by social marketing is expected to rise from 33% in 2003 to 45% by 2008.

The social marketing organizations are funded to take on separate but complementary activities. Both are addressing the issue of meeting unmet demand for products and services especially for limiting methods, while also creating demand for a range of FP products and services. The primary differences between GS and KSM relate to management structure, relationship to the products/brands, the target audiences and relationship with providers.

3.2 Social Marketing Models

The different models of the SMOs have been identified as possible approaches to the social marketing of contraceptives in most of the policy/strategy documents of Government of Pakistan (GoP).

The RFA for this project, invited by the USAID, was based on the “two-model” design. A DIFD review recommended two competitive models along with “managed competition” and to move towards “total market” approach. This was also been reflected in the Project Memorandum developed by DFID for its support to this project. In addition, the original RFA emphasised the need for the participating SMOs to extend their services to rural areas to reach the poor and marginalised population³. These policy directions have also been echoed in GoP’s strategy for social marketing (SM).

However, there have been major deviances in the program design, starting from the bidding process. GS put up an original proposal to cover rural areas in 50 districts, thus using up most of the budget available with USAID. KSM could not generate enough CYPs by extending its services to rural areas and its initial proposal had targets to increase the CYP share by marketing locally manufactured contraceptives. Thus SMOs were asked to revise their proposals: KSM to increase its overall targets and GSM to decrease its

³ There is some disagreement on definitions with KSM noting that “marginalised populations” are rural and GS advocating that “marginalised” are poor and may also be in urban and peri-urban areas.

budget. The final agreement between USAID and GS was to target only five districts, for addressing the access to services in rural areas, while focusing on marginalised populations in urban and peri-urban areas. The final agreement between KSM and USAID sets very high CYP targets for populations of less than 25,000.

A Steering Committee of key stakeholders exists but initially this was chaired by USAID. The then focal person from USAID encouraged some “partnership arrangements” between the two SMOs, which has further distorted the original “two-model” approach. Though a quadripartite arrangement among development partners and GoP has been signed, the GoP, through Ministry of Population Welfare (MoPW) has never intervened to clarify the strategic focus of these SMOs, especially in the context of existing policy and strategy document such as National Population Policy and MTDF.

3.2.1 Key Social Marketing

KSM is a five-year project that builds on The Futures Group’s work in Pakistan developing a manufacturer’s model for delivery of family planning products. Rather than develop its own brands, KSM works with manufacturers and importers to make available high-quality commercial contraceptives. No donor funds are used to purchase the products. Under this USAID funded project, KSM was to continue its previous support of Famila 28 oral contraceptives, single dose Emkit emergency contraception and Depo Provera injectable contraceptives⁴, and introduce other pill brands, a condom brand and Famila injectable. A voucher system for sterilization services was also planned. The aim was to convert users from subsidized and free product to the KSM-supported brands, and provide an ambitious 6.4 million CYPs over the life of the project. The exit strategy intended to graduate the products into the commercial market once donor support ended.

During the USAID funded program period, KSM has worked with Pakistani manufacturer Zafa to introduce Famila injectables and to continue the Emkit emergency contraceptive and Famila 28 OCs. KSM has also worked with Biogenics to keep Hamdam condoms on the market, and with UDL to continue Depo Provera sales⁵ and to introduce Intense and Spark condoms. No voucher system has been introduced, and no other OC brands have been introduced.

Before the start of the project KSM had trained 17,000 providers including 1000 doctors and 2000 LHVs. With USAID funding, in addition to selling the products in clinics and pharmacies, KSM aimed to encourage the update of FP training by working with private health providers particularly in rural areas. John Snow International (JSI) was to work with the Lady Health Worker program to improve LHWs’ skills, supervision, logistics and MIS. KSM’s plan was to subcontract JHPIEGPO to train and certify private doctors and LHVs

⁴ Subsidised until the Zafa injectable product was launched.

⁵ Depo Provera’s manufacturer, Pfizer, has decided to discontinue commercial sales of Depo Provera in Pakistan and will instead only manufacture to contract. However, significant stocks of Depo remain in the country that KSM and UDL will continue to distribute.

as qualified FP providers, either for FP Basic (hormonals and condoms) or for FP Advanced (also including IUD insertion and sterilization).

During the USAID supported period, KSM has trained over 12000 providers in FP basic hormonal update and 448 in FP Advanced. However, certification efforts have proven to be too great a challenge. Futures Group explored the possibility of setting up a certification board that would certify private sector providers based on delivery of quality services for clinical methods. After a series of discussion with various stakeholders, a consensus was reached that a quality certification program through establishing an independent certification board may not be a feasible proposition under the current project. Instead it was acknowledged that quality of family planning services particularly in clinical methods could be ensured through Performance and Quality Improvement (PQI) system at the trained health facility. Consequently, JHPIEGO is instead adding SBMR training. The LHW program has not been receptive to KSM's offer of training and product sales, so KSM has suspended those efforts. Four organizations have worked with JHPIEGO to deliver the training including Memorial Christian Hospital, FPAP, RH Aid and Aga Khan Foundation. In 2005 the latter organization withdrew from the program and, as part of the collaboration initiative with GS, it was agreed that GS would take over the training role vacated by Aga Khan Foundation, In addition to GS, all the training organizations are using a standardised uniform training manual developed by JHPIEGO and KSM. GS is using two separate manuals; one for GS training using GS manuals developed seven years ago, and other for conducting KSM training using manuals developed by JHPIEGO and KSM.

KSM has a centralized structure, meaning that planning and decisions are made at the head office in Islamabad and carried out by staff who may be in regional offices. There are 174 long-term staff and 279 staff on short-term contracts, all of whom work on the USAID-supported FP program. JHPIEGO is a subcontractor providing technical assistance and training has been outsourced to four other organizations.

3.2.2 Greenstar Marketing

GS is a Pakistani organization affiliated with PSI that manages a network of clinics.⁶ With USAID funding, GS aims to increase the viability of its cost-recovery model whereby donors (DFID and UNFPA) contribute some of the contraceptives and these products are sold at a subsidized cost. Other products are procured by GS and sold at a cost-recovery price with the aim of minimizing the long-term cost of products to donors. Franchise membership and/or training fees are also expected to contribute to cost recovery. While no timeline is in place for the project to be entirely self-supporting, GS aimed to have at least two products recovering 100% of the cost by the end of the period of current USAID support.

⁶ Confusingly, both the organisation and the network of FP providers are called Greenstar. As an organisation, Greenstar's activities are not limited to FP but also include work on HIV, TB and MCH.

At the present time GS markets Sathi and Touch condoms, Novadol OCs, Nova OCs, ECP emergency contraception, Femiject one month injectable, Novaject two month injectable, and Megestron three month injectable, as well as Multiload and Safeload IUDs. Two products - Safeload and Touch - are already full cost-recovery products. Franchise membership/training fees have been reduced to compete with the KSM paid training.

GS also aimed to sell products via pharmacies, shops and clinics. The network of 12,000 FP/RH-trained providers (including pharmacies) was to be expanded to increase the number of clinics providing quality services. 1500 new providers including at least 5% in rural areas would be added and trained. At least 70% of the GS product users were to be low income (below Rs.7,000 per month). Also, GS was to work with PAVHNA and Save the Children Fund (SCF) to train 70 private providers in rural areas and bring them into the GS network. Five percent of the CYPs were to be in the targeted rural districts. Additionally, the number of clients for other RH services at GS clinics was to double.

Since 1995, GS has trained 16719 providers but presently only 10159 of these exist on the GS MIS database. This is due to providers moving premises and/or discontinuing the provision of FP services. During the USAID funded period, GS has exceeded its goals and trained 2777 providers, 1998 on FP advanced, 462 for general practitioners, and 317 for paramedics. Providers in 5 rural areas have become part of the GS network and 94 have been trained. GS has also signed a general agreement with the Lady Health Workers (LHW) which allows for training and product distribution. However, no training activities with the LHWs have yet taken place under the USAID-funded FP project.

GS has decentralized its selling and distribution arrangements over the life of the USAID project. Now, there are three regional offices divided into zones. The North comprises 8 zones, Central has 12 and South has 9 zones. Each zone is adequately staffed, and a few zones are divided between two teams. In total, GS has a staff of 546, about 40% of whom are in operations and sales. One quarter work on an unrelated TB project. The rest allocate some of their time to the USAID-funded FP program and charge other programs when they are working on non-FP work. Training is done in-house.

3.3 Products and Strategies

3.3.1 IUDs

Both KSM and GS have placed particular emphasis on growing the market for IUDs for limiting births. This is a logical strategy given that 85% of women with unmet need express a desire for limiting. The SMOs have an important role to play in meeting the demand for services. USAID's continued financial support of IUD provision amongst a range of other methods is especially important given that the IUD is the primary longer-term method the mission supports in light of US Government concerns regarding sterilisation policies."

For a method like an IUD, a branded strategy is not as important as for other methods, since the woman being fitted with an IUD has little preference for which brand is being fitted, other than issues regarding length of time the IUD will be in place and clinical recommendation concerning side effects. Rather than have its own brand, KSM sells GS's Multiload and Safeload IUDs, with each organization getting "credit" toward its own CYP contributions. This is an excellent example of need-driven, as compared to donor-driven collaboration between the two programs.

3.3.2 Hormonals

The two programs currently market three OCs, two ECs and five injectables. GS intends to introduce a cost-plus recovery OC and KSM may work with ZAFSA to introduce one- and two-month injectables. Strategies with the brands have aimed at increasing segmentation to decrease donor subsidy on the brands.

3.3.2.1 Oral Contraceptives

There is little differentiation between brands of OC in Pakistan in terms of formulation. Price, packaging and positioning of Nova, Novodol and Famila 28 are all different, but the formulations are the same, with the exception of the 7-day iron tablet placebos in Famila 28. Both social marketing organizations have been advocating for some time a policy change which would allow over the counter sales of OCs. This has the potential to benefit lower income and more rural potential users if it were to be effected.

3.3.2.2 Injectables

The injectable market is both growing and shifting. KSM's support to Depo Provera will be phased out by end of project as Depo's manufacturer, Pfizer, plans to withdraw retail selling of Depo and retain only the tender business. ZAFSA has introduced Famila 3 month injectable and is considering the introduction of one- and two-month injectables. GS now has the full range of injectables on the market. Price segmentation for injectables, as far as consumers are concerned, is somewhat difficult to measure given that the provider charges a fee for the injection service.

3.3.2.3 Emergency Contraceptives

In early 2003 Key Social Marketing introduced ZAFSA's brand of emergency contraceptive, Key Emkit. This is a two pill formulation each consisting of 0.75Mg dose. At the same time, ZAFSA has registered a single dose formulation which is yet to be launched. Key will introduce a special audiocassette to reinforce the new single dose regimen." The ECP from GS is a two-pill formulation and the recommended price is the same as that from KSM.

3.3.3 Condoms

The aim of the social marketing programs is to ensure condom availability and expand choice. This could well decrease the 70% market share of the subsidized brand Sathi. GS is marketing Sathi and Touch condoms, and KSM has Hamdam, Spark and Intense products.

3.4 Distribution

Both social marketing organizations use distributors and their own sales and promotion teams to make the products available in shops, pharmacies and clinics. Over the life of the project, both SMOs have increased the size of their sales/promotion forces.

3.4.1 Greenstar

At the start of the USAID support, GS had one pharmaceutical distributor that managed distribution nationally. In 2005, GS split the distribution between several regional distributors for fast moving consumer goods (FMCG) outlets and a national pharmaceutical distributor for pharmaceutical outlets.

Concerned about the distribution effectiveness of their products, in March 2006, GS conducted an analysis of its distribution system. This concluded that, although the distribution of non-condom products was acceptable, the sales calls made by the distributor were largely order taking rather than spot sales and promoting the GS products. In addition, there was relatively low interest on the part of the distributor in selling condoms because of the need for wide coverage but comparatively low margins on this product category.

Consequently, in May 2006, GS signed a new agreement with IBL for distribution in the South. IBL are the distributors for Gillette, GSK, Proctor and Gamble as well as Pakistan Mobile and are the largest distributor in Pakistan on a turnover and coverage basis. They will warehouse and distribute the entire range on a regional basis, carry out order taking, as well as making spot-sales to grocery, paan shops, superstores etc. The GS-IBL agreement is on a cost plus basis, meaning that IBL will earn the distributor margin plus GS will pay the distributor for expenses of the sales teams. Hopefully this will address the previous low-margin problem experienced by previous distributors.

The changes in distribution make it extremely difficult to evaluate GS distributive effectiveness, especially as there is some overlap between the GS sales force and the distributor. It also demonstrates that there is no easy single perfect solution to distribution in Pakistan. However, it is clear that GS made an evidence-based decision regarding the distributor change. However, the new system will cost more, and an increase in sales over time will demonstrate whether the change has been a worthwhile investment.

Sales & Detailer Team:

With GS's decentralization, the sales team has also been expanded. There are now Area Manager Health Services (AMHS) and medical detailers providing coverage of the GS clinics. These personnel have different roles although there is potential for overlap between them and the distributor teams.

Each AMHS, usually a trained graduate doctor, is responsible for about 60 clinics which provide IUD services, and 95 which provide FP but not IUDs. They also have other functions. However, it is the medical detailer that actually sells products to the GS clinics.

The medical detailers are trained in FP and sales, and in an urban area cover 200 doctors and 200, out of 400, chemists. They see on average 5-6 chemists and 8 doctors per day. In addition to his/her own selling, part of the role of the GS medical representatives is to monitor the work of the distributors to the chemists. Their compensation is a bi-annual bonus for performance, and they do not receive a sales commission. They also recommend to the AMHS which clinics could be considered for training.

In terms of outlet coverage, in the South, GS covers approximately 28,000 outlets directly and 10,000 more are supplied by the wholesalers/distributors. In volume terms, GS sales teams distribute about as much product as do the distributors. Of course the proportion of sales made by the GS sales force varies by product. Table 1 shows these proportions.

TABLE 1
PROPORTION OF SALES MADE BY GS SALES FORCE

CONDOMS	OCs	FEMIJECT	MEGESTRON	NOVOJECT
3-5%	20%	50%	50%	<20%

This is mainly to do with the nature and natural distribution of the product to the different outlet types. Condoms and OCs are sold predominantly in the retail trade which are covered by the distributors, while the Injectables are sold to clinics covered by the medical detailing team. It may also indicate that the length of time the product has been on the market positively influences the ability of a commercial distributor to more easily sell the product category: the longer a product is on the market, the less direct selling effort by GS's own sales team may be required to make it generally available.

3.4.2 Key Social Marketing

As described above, KSM has various distributors for its different products and, during the life of the USAID funded project have enlarged its own sales force.

The distribution of ZAFSA hormonal products is via 40 ZAFSA distributors and 8-10 wholesalers. The ZAFSA distributors tend to cover discrete regions of the country and distribute both pharmaceutical and non-pharmaceutical products.

They only sell to wholesalers, have a limited field and marketing staff, if any, and primarily fill orders. KSM has no agreements directly with the ZAFAs distributors and works only with the manufacturer on marketing aspects.

UDL distributes Depo, Spark and Intense. UDL distributes over 600 products including those of Pfizer and Beecham. They distribute to both pharmacies and FMCG outlets. Depo is also carried by Pfizer's own distributor. UDL has a team of sales people that visit chemists, but not clinics, who take orders and sell. Unfortunately, Depo is not of particular interest to UDL because of the relatively low distributor margin on its sales.

KSM's Hamdam condoms are distributed by Biogenics. They work with one pharmaceutical distributor and about 30 FMCG distributors, including City International in Karachi.

KSM field force:

The team includes sales personnel and detailers. KSM has 39 sales promotion officers (SPOs), 28 sales officers (SOs), 11 sales area managers and 5 regional sales managers. Sales officers (SOs) focus on the availability of KSM-supported products at chemists and shops, while the SPOs aim to create demand among providers. Under this USAID project, KSM has added the sales officers and the regional offices.

The sales team mainly focuses on the retail outlets while the SPO supplies the KSM-trained providers. They do spot selling for cash, and take orders on credit, and are targeted such that 25% of the outlets they cover are to be in underserved areas. The Mohalla Sangat supervisor also sells product to the LHV's for the session. Again, there is some overlap between the outlets covered by the SOs, SPOs and the distributors.

Since KSM does not "own" any of the products under its manufacturers model, for products to be sold by its own sales team, KSM purchases from the distributor and sells on to wholesalers and retailers. For instance, UDL sells Intense and Spark to KSM's sales team on 15-day credit, up to a limit of about Rs.12,000. UDL gives the KSM sales team a 5% discount.

Approximately 80% of KSM sales are made by the KSM sales team while the remaining 20% are by the distributors. This is a significant shift from the start of the project when approximately 20% of the sales were by KSM's own team. KSM made this strategic decision in recognition of the need to increase availability quickly and demonstrate the sales potential of the products to their manufacturers and distributors.

While the strategy appears to have been effective in the short-term for increasing availability, such high cost expenditures cannot be maintained in the manufacturer's model that KSM is implementing. KSM will need to determine a strategy to transfer direct sales to the distributors so that the products will become commercial by the end of project. The plan is to retain the sales force until KSM annual OC sales reach 5-6 million (which is

estimated to happen in about 2010) and annual condom sales reach 3-5 million. This does not appear likely to happen by the end of the current USAID-funding, given that cumulative condom sales over the life of the project (until March 2006) were just under 4 million. .

In order to bolster its CYP contributions, KSM sales officers also sell GS's cost recovery products including Touch, Safeload and Multiload and will sell Nova when it reaches full price. While distribution of the IUDs by KSM is necessary to ensure the availability of IUDs, it is unusual that KSM should distribute GS products which are competitive to their own condoms and OCs.

Results: The only evaluations of sales and availability are the SMOs' MIS and the condom retail audit. KSM is in the process of conducting a "Market Penetration Study" to verify its MIS to determine the actual number of providers supplied with KSM products. GS is also verifying the data in its MIS.

The condom retail audit data provides an on-going assessment of the availability of condoms at urban shops (not pharmacies). GS condoms are available in about 41% of outlets; 50% availability would be considered excellent, so condom availability is considered very good. In March, of those outlets stocking condoms, Sathi is available in 98% of shops, Touch in 51%, and Hamdam in 20%, representing the top three most available brands.

Unfortunately, these data do not reveal the availability of condoms to targeted populations such as low income or rural people.

In terms of the impact of distribution, GS has about 30% of its CYPs coming from IUDs at GS clinics, 20% of CYPs from pills and injectables via the GS clinics and 50% of CYPs through over the counter sales of OCs and condoms. 95% of Sathi sells through the trade and just 5% via clinics. GS OCs are about 60% to the trade and 40% via providers and the injectables range from 50-65% via providers, depending on the brand/type of injectable.

Since some of KSM's sales are made by distributors who do not work for KSM, comparative data for KSM is not available. However, about 20% of Spark and Intense sales are to shops and the remaining 80% to chemists.

Although not tasked with conducting a distribution survey, the review team found that the products were available in clinics, pharmacies and shops. While few outlets stocked all products from both SM organizations, the ±100 clinics and pharmacies visited by the review team each had at least one brand of each method available.

3.5 Pricing

Both social marketing organizations have recognized that the primary growth in the market will come from low- and middle-income people. In this context, the SMOs must therefore aim to make the products not just available but also affordable to C and D socio-economic groups.

3.5.1 Pricing Models

Overall, the two social marketing programs recognize that the programs cannot rely exclusively on subsidy to make the products affordable. While neither program aims to be completely “sustainable”, which would be a challenge in a low income country such as Pakistan where maintaining and increasing CPR is such a high priority, we have seen that reliance on a single donor for family planning is a risky strategy. Both KSM and GS have therefore factored into their models the possibility of a cessation of donor funding. Cross subsidy and a reliance on commercial manufacturers and distributors are used to decrease donor cost while maintaining affordable prices on most products.

Key Social Marketing: KSM’s pricing model is that of the manufacturer’s model, whereby commercial manufacturer’s and distributors come to agreement with KSM to sell the products, usually at lower prices. KSM’s agreement to market Depo Provera initially provided a donor-funded subsidy for Depo along with marketing and distribution support. The KSM condoms are sold at commercial prices with marketing and distribution support from KSM.

KSM’s strategy with ZAFSA is based on achieving economies of scale. KSM’s negotiations with ZAFSA have encouraged ZAFSA to sell Famila 28, Famila and Emkit at low prices in order to achieve high volume. Over time, should ZAFSA’s hormonal products reach a certain volume (estimated at 8-10 million in total), ZAFSA’s costs of production will go down as raw materials can be purchased at volume discounted prices. Put simply, KSM expects that high volume sales will increase ZAFSA’s interest in continuing the hormonal line.

What makes the manufacturer’s model a compelling strategy in this instance is that ZAFSA is a *generic* company that aims to drive the price down and the volume up in order to undercut the contraceptives produced by international companies. Such a business model fits with social marketing’s affordability and volume objectives in a way that Western branded hormonal manufacturers, such as Pfizer or Wyeth, whose model is based on higher pricing and lower volume sales, will never match.

KSM’s partnership with ZAFSA has contributed to creating an international reputation for ZAFSA. In the process, ZAFSA has recognized the potential for contract manufacturing of hormonals for both the domestic and export markets and already this year is projected to sell approximately 5.2 million OC cycles of which Famila comprises just over half. Now in a competitive environment, KSM has had to struggle at times to remind ZAFSA about the potential for building the market for its own hormonal brands and the value of brand equity.

Despite the challenges with ZAFSA, the KSM-ZAFSA relationship is putting the manufacturer’s model to the test. The promise of the manufacturer’s model is that the investment made by donors in building the ZAFSA brand will permit the

“graduation” of the brand to the commercial market. Despite having pioneered the manufacturer’s model in Pakistan, first with Wyeth and now with ZAFSA, KSM is not hopeful that they will be able to commercialize the ZAFSA products. This may in part be due to the fact that KSM’s strategy has not capitalized on this opportunity from the commercial viewpoint. The KSM agreement with ZAFSA fails to outline specific targets and objectives that would lead to a commercially viable hormonal business. Instead KSM is simply providing marketing support with an unspecified assumption that this will contribute to the viability of ZAFSA’s hormonal business.

Looking forward on other aspects of the product range, Depo will be phased out. The post-2008 strategy for Spark, Intense and Hamdam is not clear, but the model suggests that these products would be “graduated” to fully commercial brands with no subsidy.

Greenstar: GS pricing is based on cross-subsidy. At least one brand of each method is subsidized to ensure a low consumer price, and at least one brand of each method is sold at a cost-plus price to recover revenues to cross-subsidize the lower price brand. Already two of GS’s products, Touch and Safeload, are recovering more than cost. The GS model does not recover 100% of the subsidies on all products any time before 2020, and projections on cost recovery levels are dependent on volume and price projections which are highly subject to change. While certainly such a model is more sustainable than a model that only uses subsidized products, progress toward recovery should be monitored – and audited – annually to ensure that cost recovery is increasing.

In the case of condoms, donor investments have supported Sathi’s availability at subsidized prices and increased consumer choice through brand introduction. The presence of other brands may begin to take some of Sathi’s 70% market share, but even at 50% market share, cost recovery on such a large a volume of condom sales (approximately 100 million) could never be close to cost. Sathi is projected to require at least \$1 million in product support in 2008. However, with the potential to offset a growing HIV/AIDS problem, donors may wish to continue investing in condom subsidy in Pakistan. Touch, Hamdam, Spark, Intense and a new brand that GS is planning to introduce in 2007 can reduce the donor cost somewhat by decreasing Sathi’s market share and, in the case of Touch and the new brand to be introduced, contribute revenues to the subsidy.

From the UNFPA and DFID commodities valued at \$18 million, which includes packaging and testing costs, GS expects to generate revenues of \$1.7 million, reflecting a cost recovery of about 9%. About 50% of the expenditures and 75% of the program income is from condoms. Over time, these percentages are expected to increase.

3.5.2 Pricing Structures

The price structures of the two organizations are shown in Annex-3.

For the most part, the trade appears to adhere to the recommended consumer prices. The team observed that consumer prices were slightly higher in clinics, e.g. Sathi were Rs.5 for 4 in shops and Rs.10 for 4 in clinics. Novodol was Rs.8 in pharmacies and Rs.20 in clinics. This discrepancy may be attributable to the inclusion of the clinic's service fee in the price of the products. The consumer price for IUDs is set by the provider who includes her insertion fee. Providers reported charging anywhere from Rs.50- Rs.500, depending on the client's ability to pay.

The condom retail audit confirms that Hamdam, Touch and Sathi are for the most part sold at their recommended prices. In the past year of the audit, Hamdam experienced a slight price rise in January and February 2006, but this appears to have now settled back down.

Another strategy used by both SMOs is to charge more for smaller product packs. This type of discounting follows commercial principles in that smaller packaged products actually cost more to produce and distribute. For example, a single cycle of Famila or Nova costs more per cycle than a three pack. Similarly, GS is introducing a 10 condom "value pack" of Sathi, which will stay at the current condom price of 1.25 per condom, while the smaller 4-pack will increase in price. Touch will adopt the same packing and pricing strategy.

3.5.3 Discounting

Although consumer prices tend to be adhered to, there are varying margins within the trade brought about by discounting. This is because of the need to deliver on CYPs in a competitive contraceptive market, and this increases the SMOs' temptation to offer price promotions to the trade. KSM's price promotions have resulted in a large volume of product on the market at a lower price. For instance, one ZAFSA distributor complained about the trade promotions that KSM sales staff were offering. By selling injectables on promotion at "buy 5 get 2 free", this has resulted in a consumer price lower than the recommended retail price. There have been reports that Emkit, with a consumer price of Rs.10, was available in the market at Rs.4-Rs.5, and Famila could be purchased by the wholesalers at Rs.20 and sold at Rs.12.50. The wholesalers are reportedly able to offer such discounts because a trade promotion on a single product is applied across the product range.

KSM believes this came about because the sales team were not well managed by the regional managers and began selling to wholesalers. KSM has now put the necessary controls in place to limit this discounting across the product range. Communications about the promotions would also foster better relations with the distributors.

KSM's distributors also offer volume discounts. If a customer purchases Rs.5,000 worth of product he receives an additional 5% discount. UDL offers a wholesale price such that if 11 cartons are purchased, the 12th is free. ZAFSA also has run its own promotions such as selling a dozen for the price of eleven.

GS has also run trade deals in the past on Sathi, which resulted in overstocking of the trade in 2002/3. This practice has now been ceased, with a resulting impact on primary sales which declined in 2004. Now the balance between consumer demand and trade stocks has become more stable, primary sales are increasing again. (See Section 5) However, GS is also offering Multiload at a discounted price the results of which are so far unclear, aside from the decline in revenues.

3.5.4 Pricing levels

One of the challenges for the SMOs is to determine what prices are considered “affordable” and when price is seen to be a barrier to purchase. No studies to date have indicated that price is a barrier to usage, other than among a very small percentage of people. KSM and GS believe that the hormonal contraceptive market is relatively price insensitive, and therefore that prices could be increased. Condoms are generally believed to be a little more sensitive, but this is more so at trade levels. Both SMOs support the idea of using real market conditions to pilot test prices, rather than willingness-to-pay studies, which run the risk of not reflecting reality.

The SMOs have, however, hesitated to raise prices, possibly on account of concerns about a potential loss of CYPs brought on by price hikes. Under this project, GS planned to subcontract the London School for Hygiene and Tropical Medicine (LSHTM) to help with appropriate pricing structures. This study has not taken place, as GS and LSHTM have not been able to come to agreement on the study. Instead, GS has gone ahead on its own with pricing changes to meet cost recovery goals.

Both models in part rely on the ability to raise prices. Both SMOs agree that if donor support were to end tomorrow, it would be better for consumers to have access to the products at slightly higher prices than to have the products withdrawn from the market entirely because insufficient revenues were generated. With no donor support for marketing and distribution, sales volumes would drop. A slight increase in price could make up for a shortage of donor funds.

However, there are difficulties in raising prices since, in Pakistan, prices are controlled by the Ministry of Health. These price controls present a threat to both models. If prices cannot be raised, ZAFSA may lose interest if it is required to maintain the prices for the Famila products and Emkit, and GS may not be able to recover enough revenue on its cost-recovery brands to cross-subsidize the others. In pursuing the ability to raise prices, for good marketing and sustainability reasons, it would be useful to have an outside organization monitoring the impact of GS's price changes and it is recommended that the LSHTM study go ahead. Ideally this should involve both GS and KSM pricing.

3.6 Promotional Tools

This section focuses on the marketing at the trade level.

Logos: The Key and GS logos are on the product packs, at the clinics and in the training. GS logos are widely recognized and perceived to be a symbol of family planning. The strong linkage of GS' logo with FP was confirmed with a study to determine if the logo could be expanded to include maternal child health products. Anecdotally, several clinic providers reported customers commenting on FP as soon as the KSM sign went up. What is not known is whether consumers also understand the KSM and GS logos to be a mark of quality. Research around perceptions of the logos could clarify this issue and guide the use of the logos.

Signboards for Clinics: Both GS and KSM use signboards to signal to the consumer the location of the trained providers. For GS-trained providers the signboard symbolizes a trained provider who is a member of the GS network. The network and logo are advertised in an effort to attract more clients to the trained providers for FP. However, when a provider becomes inactive in the network, GS does not take down the signboards unless the clinic actually closes. GS's rationale is that the provider is at least trained, has a signboard, and therefore merits being set apart from the clinics of untrained providers. However, with more than 6,000 providers trained in FP by GS since 1995 but no longer active in the network, the presence of signboards at inactive clinics dilutes the meaning of the board, and indeed of membership in the network.

GS is delaying any decisions about the signboards until the pilot of the Good Life clinics is underway, on the assumption that most GS clinics over time would become Good Life clinics with the GS sub-brand. However, given that the role of the Good Life clinics will take several years to establish, there is a need to address the position of GS signboards now. In addition, the team is concerned that the transition to Good Life clinics will diminish the prominence of GS, and indeed of FP, in the clinical offering.

For KSM, the signboard indicates that KSM has given the provider IUD training but does not necessarily convey membership of a network. The logo is included in the advertising, but KSM does not directly advertise the 400+ KSM-trained providers and has no plans or budget to do so. Some of the Key-trained providers perceive the signboard to be marketing for Key, but fail to recognize that the board is actually intended to help promote the provider. These issues point to the gaps in KSM's marketing strategy with its trained providers, which are detailed in the Training section.

Provider Loyalty Scheme: One of the biggest challenges of management of the GS network is in retaining provider interest and commitment to the network. This is because the providers are independent, and the clinics are not owned by GS. In addition, FP is not generally the largest revenue-earner for the providers. GS is in the process of developing an incentive scheme for the providers who are active members of the GS network to earn points redeemable for gifts. Like Clinic Sahoolat, which is designed to build a larger

client base, this loyalty scheme should help to increase GS provider loyalty to the network, but it is too early to measure.

Point of Sale (POS) Materials: The team observed point of sale materials at many clinics, but found them less evident at pharmacies and shops. At the outlets visited, products were visible in most clinics and pharmacies, and condoms on display in most shops. KSM clinics also had displays of posters outlining treatment and FP algorithms. Some GS clinics observed needed updating of the promotional materials such as the very popular GS curtain. Merchandising (product display) at GS clinics was excellent.

Product Promotions: The team was impressed by a trade promotion of Sathi at a stall outside a shop. However, the team feels that both KSM and GS sales teams need training in how best to promote the products in the competitive contraceptive market, without de-campaigning the other brands.

3.7 Mass Media

KSM's budget includes \$11.6 million (refer detailed budget breakdown of KSM for the heads of Advertising, Promotion and Communication) for mass media and trade promotion, while GS's budget is \$2.5 million for the same. This discrepancy is a source of tension between GS and KSM. As part of the compromise discussions, KSM was encouraged to allocate some of its resources to communications that would benefit both programs. In practice such collaborative communications are extremely difficult to achieve on account of the subjectivity of communications and the competition between the brands.

The two projects have identified two different barriers to contraceptive use and continuation. Through qualitative research, KSM identified counseling on side effects as an important reason why women discontinued methods. GS's analysis of the recently conducted KAP study led them to the conclusion that social support, particularly from the husband and the mother-in-law, is the important factor for increasing contraceptive trial and usage. Each SMO has designed mass media communications that address these barriers.

Both KSM and GS are to be credited with conducting the analysis of the barriers and for developing evidence-based mass media communications to address the barriers to contraceptive use. The two projects have identified two different barriers to contraceptive use and continuation. Through qualitative research, KSM identified inter alia counseling on side effects as an important reason why women discontinued methods. GS's analysis of the recently conducted KAP study led them to the conclusion that social support, particularly from the husband and the mother-in-law, is the important factor for increasing contraceptive trial and usage. Each SMO has designed mass media communications that address these barriers and have pre-tested their materials before production. Both also recognize that interpersonal communications are equally important and effective as mass media (see Behaviour Change Communications)

3.7.1 Key Social Marketing: KSM has produced two OC spots, three injectable adverts and one condom ad for radio and television.

Branded mass media: The first OC TV and radio ads were produced and began airing in September 2004. A new OC advertisement was finalized during this review and began airing. The target for KSM OC advertising is women under 35 with at least one child. The focus of these messages is to attract new users and also provide information on what to do if a pill is missed.

For injectables, KSM has aired three advertisements since August 2004 and is currently developing a new concept for injectables. The ads will target women with two or more children.

KSM developed its condom advertisement in August 2005. The target audience is people with up to one child. A new concept will be developed from July 2006. KSM is now developing a concept for an IUD ad to target women with three or more children.

KSM has done well to use the research to identify the key issues to be addressed, particularly for the hormonal methods. The focus on side effects was drawn from their qualitative studies on usage, behavior, attitude and perceptions of FP. However, reviewers felt the advertisements lack creativity and are not too different from public sector FP ads. Post-testing of these advertisements among target audiences should explore consumer impression of the creativity and fresh presentation of the messages.

Category advertising: In 2005, following the collaborative agreement between the SMOs, KSM changed the ending of its OC and condom ads to include not just KSM's products but also GS's cost-recovery brands in what can be called "category advertising." The condom ad now pictures Touch along with the three KSM brands and may also add MSS's Excite condom which is to become cost-recoverable. In October 2005 KSM added Nova to the OC ad, although Nova is not yet cost-recoverable. Confusingly, the IUD advertisement will include both Multiload and Safeload, even though Multiload is a subsidized brand. The injectable ads will only include Famila and Depo.

The idea of advertising an assortment of the brands of the same method pictured at the end is experimental. Unlike traditional branded social marketing, this type of advertising of rival brands in the same advert has no place in commercial marketing. For this reason, prior examples are few but include Netmark's advertising for bed nets in Zambia and Nigeria. From a purely marketing standpoint, the decision to do category advertising makes little sense: consumers would have little perception of why some, but not all brands, would be promoted. KSM's policy on what brands to include is also unclear; KSM initially said it would support only cost recoverable brands, but Multiload, which is highly subsidized, is included in the advertisement. Its inclusion draws into question KSM's rationale for excluding subsidized brands.

Marketing Plans: KSM does not have marketing plans for any of its products. A marketing plan, usually written annually, details the marketing strategy and positioning for the product, outlines the branded and generic marketing activities over the course of the year and allocates marketing expenditures per activity. The absence of the marketing plans makes it extremely difficult to understand the strategic thinking that has gone into planning to spend such a large marketing budget and to verify that the money is being well spent. Such plans would also help enable staff (other than the Director and Marketing Manager), the distributors and, importantly, ZAFAs to appreciate and understand the brand positioning and the unique selling proposition of each product.

Collaboration with GS: KSM has collaborated with GS on the marketing under pressure from USAID and GS. Such forced collaboration has done little to help increase FP usage. KSM provided GS with the concept for the advertisements that were developed in 2005/2006, but did not solicit GS input on the creative development process.

Generic mass media: In 2005/06 KSM developed the “Motivational Campaign” featuring four adverts depicting people from four areas of Pakistan. The ads encourage FP use, birth spacing of three years as well as communication with spouse and provider. The messages include rumours and misconceptions about side effects, the economic benefits of family planning, the benefits of FP to health of the children and spouse and the right to family planning. They carry the tag line, “Only if you talk to your spouse about FP will things move forward.” The ads carry a large Key logo and smaller logos of the MoPW and GS with the voiceover “Talk to your nearest health worker or doctor.” The ads conclude with a page with the words “Message brought to you by Key Social Marketing in partnership with Greenstar Social Marketing and the Ministry of Population and Welfare.”

The adverts are high quality production and KSM has made a good effort to represent all people of Pakistan using regional voices and dress. However, the messages lack creativity and come across as traditional public health messages, especially with the “brought to you by...” message at the end. KSM and their agency included this because that is how all adverts on FP end in Pakistan. Ending the message with “talk to a provider” would appear to be more effective.

In terms of media buying, approximately 85% of the media spend is on PTV and the majority of the radio spend is on PVC. The next step will be for the ads to be dubbed into regional languages to be aired on regional channels.

KSM reports that the following spots have aired

KSM Spots, as of November 2003-March 2006

TV

Pills	1,052
Injectables	1,126
Condoms	497

Radio

Pills	934
Injectables	1,020
Condoms	464
Cinema	
Pills	478
Condoms	72

Thus, a total of 2,675 television spots and 2,418 radio spots have aired over the 2.5 year life of the project.

Spend: KSM is well under spent on its marketing budget, having spent approximately \$3.8 million of an \$11.6 million budget for mass media and promotions or approximately 32% of the budget at mid-project.

3.7.2 Greenstar: GS currently has three ads promoting its brands and its clinic network through television and radio.

Branded advertising: GS has one advert for Sathi, one for hormonals and the other for the GS network for FP. The messages focus on male involvement and support of the mother-in-law, which were identified in the KAP as key factors for FP use.

The current hormonals and GS clinic ads are very creative in that they play on a popular television series to add an element of humour to FP advertising, which is a first for Pakistan. The messages in these two ads are apparent without being sermonizing and there is a clear linkage made between the products and the GS network. The Sathi ad is visually very appealing and clever in the way that it conveys the brand in a market where showing the condom pack is prohibited.

ECP is promoted via print and radio with non-USAID funds.

There is some concern that the ads are targeting a higher income person, rather than the Cs and Ds. Follow up research with Cs and Ds should be done to measure the impact of these ads on lower income people.

What seems unusual is that the GS network ads do little to emphasise the quality of the services. Additionally, after 10 years of the GS network, it could be time to consider adverts that reflect quality care to the consumer.

GS reported that the following spots have aired from 2004-2006: 8,103 TV spots and 20,257 radio spots. Some, like the ECP ads, were aired with non-USAID funds. About 60% of the TV ads and 80% of the radio spots were for Sathi. Hormonals received about 25% of the TV spots and 10% of the radio ads. The GS clinic made up the remaining approximately 10% of both TV and radio. 70% of the TV ads are for Sathi. In addition to the spots developed with USAID funding, GS briefly aired previously developed Touch, Multiload and Nova/Novaject adverts in 2004.

Generic Mass Media: GS has not developed a generic mass media campaign. Should additional resources become available to GS, they have

indicated that they are prepared to develop a birth spacing campaign that would complement and be integrated with other elements of social marketing – including work with providers, product distribution and branded communications.

Marketing Plans: GS has written brand strategies for each of products. These help to clarify for the staff and distributors what the product strategies are. They also provide a means through which the marketing activities can be measured year on year.

Spend: USAID funding has supported the production and airing of the television and radio spots. GS has spent 100% of its \$2.5 million budget. GS is to air the adverts using non-USAID money, likely to be program income, for the remainder of the project.

3.8 Behavior Change Communication

This section explains and analyses the interpersonal communications (IPC) conducted by KSM and GS.

For interpersonal communications, the two organizations have taken two different approaches that aim to link the community and clinical services. One of the challenges with interpersonal communications is the high cost, due to the need to reach individuals in a one-on-one or small group setting. But such an investment may prove worthwhile, as IPC tends to be more effective than mass media communications in finally converting interested people into contraceptive users.

The perception of the team is that the two primary IPC activities – Mohalla Sangat and Clinic Sahoolat – are broadening the contacts between FP providers and potential FP users and providing an opportunity for one-on-one and small group communications on FP. It is probable that these activities are moving consumers along the behaviour change continuum toward FP adoption.

3.8.1 Greenstar:

Clinic Sahoolat: GS has developed its Clinic Sahoolat strategy around the goal of getting many women to the GS clinics for FP services. As part of the process of joining the GS network, clinics are asked to provide one day of free FP services (but not products). Clinic Sahoolat was, in part, a response to a finding that service, not product, prices were a barrier to FP adoption. In return for free services, GS spends two weeks in the community to promote the Clinic Sahoolat to increase the client volume for the clinics. GS staff goes door to door and have community meetings to drum up interest in and awareness of the special clinic days. On the free day at the clinic, GS staff attend the clinic and have an opportunity to re-train and monitor the providers in their actual clinic setting. Clinic Sahoolat provides an opportunity to link interpersonal communications (door to door visits, community meetings, etc) with the clinical services and the products.

GS began Clinic Sahoolat in December 2005. Since that time, GS has held a Clinic Sahoolat just about every day. Clinic Sahoolat is done in communities with at least 5 providers in order to be cost efficient. Thus the program is targeting more urban areas, and the free services are likely to attract a lower income clientele.

One advantage of Clinic Sahoolat is that GS can measure the results of the door to door visiting and community meetings based on how many people turn up at the Clinic day, how many adopt a method, how many first time users (which the providers like especially), etc. Another positive feature is that the promotion of Clinic Sahoolat provides an opportunity to link product promotion, the community and clinic services and also with training and supervision of the GS-trained provider, though the latter requires some attention.

The team visited several Clinic Sahoolats and found them to be very popular with patients. The evaluators cited issues to be considered as GS develops its Clinic Sahoolat program: Some of the GS providers, particularly doctors (who likely have a steady practice) do not like the fact that the services are free. Other providers such as LHVs find the Clinic Sahoolat a good way to build their client base. Another challenge is to manage the client flow and ensure that confidentiality, quality of care and infection control measures are maintained. Further, there is some indication that not enough time is being taken in some communities to build community support among key influencers. GS might consider the need to slow the rapid pace of roll out of Clinic Sahoolat and spend more time in each community.

Importantly, GS will need to measure the impact of Clinic Sahoolat. Currently, not all data being collected is being included in the data base and analyzed. GS should objectively review the data and use it to improve and modify Clinic Sahoolat as needed. Additionally, a study should be conducted by the end of 2006 to determine the impact of Clinic Sahoolat on FP use – i.e. were people who attended Clinic Sahoolat more likely to use FP than those who did not attend? The research should also study the impact on new and lapsed users and examine the FP drop out rates. Finally, the study should measure the impact of the program on people of lower middle income.

Other IPC: GS is also supposed to develop a soap opera with FP themes. The production and airing of this show is late and needs to commence soon.

Spend: GS has spent about \$481,000 out of a total LOP budget of \$558,000 (86%). Cost overruns are anticipated in this category (which is permitted) given that GS has yet to produce and air the soap opera; air time will likely be donated. Clinic Sahoolat has an annual budget of about \$1 million per year, much of which is attributable to staffing and transportation costs rather than the communication and education line item.

3.8.2 Key Social Marketing: KSM's interpersonal communications strategy focuses on providing information to clients especially in rural communities

through the Mohalla Sangat program that KSM developed and has been running for years. LHVs are recruited to organize FP information sessions in the community. The target is to reach 7 non-users, 3 lapsed users and 2 satisfied customers at each session. The session is structured around a cassette, which is discussed and then provided to each of the participants so that she may listen to it with her husband or pass it on to a neighbour. During the session the LHV displays products which included the KSM range as well as Multiload, Novaject, Novadol and Sathi from GS and the GoP's Copper T and unbranded condoms. The LHV provides FP to clients who request it at the end of the session.

At the follow up session, a cassette on emergency contraception is played and participants are asked if they listened to the cassette with their husbands and discussed family planning. KSM reports that one of the challenges is to encourage community members to return for the second session. KSM aims to have 10 sessions every 2 months (5 introductory and 5 follow up) with 12 participants each in each session.

The LHV has a two-day training on FP and communications. Supervision is an important component of Mohalla Sangat. The program is very closely monitored: a KSM Mohalla Sangat manager attends 70-80% of the meetings and provides feedback on the sessions and monitors the reports. She also back-checks reports by following up with 2 clients and 2 participants. The supervisor also sells product to the LHV. A number of the LHVs conducting Mohalla Sangat for KSM are also members of the GS network.

Management of Mohalla Sangat is a separate function from KSM's sales and training, but Mohalla Sangat staff participate in the monthly sales meeting at the regional office. Nonetheless, there was some sense that more could be done to integrate Mohalla Sangat into the sales, marketing and training elements of KSM's programs. For instance, it seems important for Mohalla Sangat supervisors to be aware of KSM-trained clinics in her region, which was not always the case.

The team visited several Mohalla Sangat sessions. The sessions offer an excellent opportunity to convey FP information in a small group format, which provides an important opportunity for discussion of myths and concerns as well as the positive aspects of FP. The sessions also link the community to the provider, although in some remote areas the provider did not have a clinic in the community. KSM should make every effort to identify FP providers in the communities where Mohalla Sangat is held in order to create an opportunity for follow up within the community. Male doctors may be able to provide these follow up services.

Since 2003 the program has reached 1000,000 women, and an additional 150,000 had attended before 2003. Of particular note, 40 % of total Mohalla Sangat sessions are carried out in towns of less than 25,000 population. We conclude with some certainty that the program is reaching its rural audiences.

KSM has done a qualitative evaluation of the Mohalla Sangat program, which found a number of positive achievements of the program and that the program was well liked. But the study was not able to conclude that Mohalla Sangat had an impact on FP use. A study should now be conducted to determine the long-term impact of this activity in FP usage. Only then will we be sure whether the relatively high cost of the program, primarily on monitoring, is having the intended impact.

Male Mohalla Sangat sessions began in March 2006 so it is too early to evaluate them. Given the important role of the husband in decision-making on FP, these could prove to be an important component of the program and their impact should also be determined.

Spend: KSM has a budget of approximately \$375,000⁷ for MSP under IPC. As of March only 50% of the budget (\$186,527) had been spent.

3.8.3 Public Sector BCC: In terms of BCC carried out by the public sector, the team met with the MOPW's communications division. MoPW has conducted a mass media campaign using famous people who discuss the importance of FP. Unfortunately, the campaign was done in more of a preaching style, rather than personal. The celebrities did not say "I use family planning because..." but rather said the usual messages about why using FP is beneficial. It is hard to imagine that such a campaign has an impact, and unfortunately the impact of the campaign was not measured.

The next campaign is in development, and the MoPW is following the brief of GS as a model for the development of the campaign.

The MoPW focuses on reproductive health, not just family planning, with a special interest in awareness and motivation especially in rural areas. Much of their work is centred on "Ambassadors" including singers, social workers and other well-known people. They have encouraged journalists to write articles explaining that Islam is not against FP and have a TV serial that addresses FP and Islam. The MoPW also produces a newsletter and has a website (www.mopw.gov.pk). The MoPW also has a series of radio programs: an interactive live show with a professor on maternal health on Saturday afternoons, Population Forum, with interviews with the government at national and district level every Tuesday, a youth program and a family planning "clinic" targeting urban youth. Listenership was not reported.

Importantly, the MoPW sees that the social marketing programs have opportunities to do things that the Government is not able to do. Also, the MoPW recognizes the quality of the SM advertisements and asked their advertising agency to make ads like the social marketing program advertisements. GS and KSM are considered "the biggest partners in the Government program" on account of their large contribution to CYPs (25%): 60% of condoms, 50% of pills and 10% of IUDs.

⁷ This budget includes Purchase Services, Mohalla Sangat Meetings, LHW MS Meetings under V - ODCs and MS Research under VI - Subcontracts.

3.9 Reaching the Underserved

The two SMOs define “underserved” differently, but the definitions are not contradictory. For GS, underserved is defined in socio-economic terms: individuals with income of less than 7,000 rupees per month and GS is also aiming to conduct 5% of its work in rural areas. KSM defines underserved in geographic terms: communities of less than 25,000 people.

Both groups need FP social marketing. The KAP found that 49% of urban people have never used contraception, so there is work to be done in urban communities also to increase demand for and uptake of FP. However, GS is proposing to raise the income level to 10,000 rupees per month which the evaluation team considers too high. Maintaining the Rs. 7,000 limit is recommended.

The challenge is to measure if GS and KSM have reached the underserved. The upcoming DHS may also provide some information on the socio-economic levels of users of specific brands which would be instructive for both programs. The DHS data on brand of OC,Injectable and condom used could be examined by socio-economic level.

KSM has established strict criteria to ensure that the providers it trains and the communities where it holds Mohalla Sangat are for the most part rural. An independent evaluation of the training and Mohalla Sangat should be used to confirm that KSM is indeed serving rural communities.

For KSM there is somewhat of a mis-match in that their focus is on rural communities, yet the products they sell are more expensive than GS’ products. This, together with the pressure to deliver CYPs, has caused KSM to begin selling GS products, a practice that the team recommends discontinuing (other than IUDs as KSM does not market an IUD of its own).

Under this project, at least 70% of GS clinic clients are to have income levels of 7,000 rupees or less. GS has not conducted research since the USAID funding began to determine the income levels of GS network clients, although the 2004 Cluster Study did record this information about the clinics. This research needs to be conducted and/or analysed in order to draw conclusions about the lower income reach of GS clinics.

GS was supposed to form a Technical Consultative Group, comprising the Population Council, INTRAH and the London School of Hygiene and Tropical Medicine to “improve targeted segmentation, collect and analyse information on the gap between knowledge and behavior, and evaluate program results.” The Group has not been formed, but in 2004 the two SMOs developed common definitions for indicators together with the Population Council.

GS's subcontracts with SCF and PAVHNA are designed to pilot test the feasibility of GS reaching an underserved rural population. GS was able to train 94 rural providers and has opened new clinics and outlets in the five pilot districts. It is difficult to measure whether those figures are sufficient to be considered "reaching the rural underserved." GS should consider working with PAVHNA and SCF to conduct low-cost simple research such as MAP to determine if these rural communities have access to products and services. This seems feasible given that the PAVHNA and SCF budgets are only 43% and 39% spent, respectively.

3.10 Research

Here the past and future research activities of each SMO are briefly described and analysed.

Overall, although both GS and KSM have conducted some research, the SMOs are behind on their research plans. In part, the delay is due to the challenges of conducting collaborative research. The most pressing concern is the establishment of a baseline since the results of the KAP are not commonly accepted. (Population Council has concerns regarding the validity of some aspects of the data)

As discussed in the Reaching the Underserved section, the lack of information about equity of access to products and services marketed by the SMOs is a gap in the programs that should be addressed by additional research. Neither of the SMO was entirely specific in proposing the research that would be undertaken, so there appears to be some flexibility on how the programs will measure results. The important issue is that at least some of the research needs to begin soon in order to be able to demonstrate results by EOP.

Another important challenge for measuring the impact of the programs is to know whether an increase in sales represents an increase in method use or reflects brand switching. KSM believes that growth in sales represents actual increase in use regarding OCs, because users are unlikely to switch due to brand loyalty. National CPR surveys, including the DHS, are well positioned to measure prevalence, brand switching and dropout. The DHS will also be a useful tool for measuring socio-economic and geographic reach of the programs.

3.10.1 Key Social Marketing: KSM has conducted several studies. (Annexure-6)

Analysis: KSM is to be credited with conducting good analysis of the qualitative research on FP and the reasons for not practicing FP. The analysis was used to develop the communications messages that focus on side effects counseling as the research highlighted that counseling on side effects was the key difference between users and non-users.

"The study on private FP providers unfortunately did not provide comparative data about the relative quality of GS, KSM-trained or other private clinics. A

follow up study in partnership with GS, who is planning such a study, would be instructive.

“The verification of the MIS data (confusingly called the “Market Penetration Survey”) is a useful exercise to ensure that the sales team reports are accurately reflecting the actual sales, i.e. are they selling products in as many outlets as they say. However, it is also important to verify access to the product from the consumer level to ensure that consumers can find the products when and where they need them. GS is planning a pharmacy audit, which should provide this information. For KSM the important component of this is to ensure that rural consumers have access; KSM should ensure that rural availability is analysed. Another aspect that would be of interest is to record the outlets selling KSM products by GPS, so that a physical mapping of availability can be conducted and compared with socio-economic and population data.

Spend: The KSM re-aligned budget for research is \$437,616 of which \$78,000 (18%) was spent at mid-project. The payment for the KAP was yet to be paid, but even so the project is very underspent on research.

Planned: KSM is planning a recall study on the condom advertisement similar to that done with the hormonal ad in June 2005.

As noted in the BCC section, the Mohalla Sangat study unfortunately did not determine whether Mohalla Sangat participants are any more likely to use FP than those who do not attend. Now that more than 220,000 people have attended a Mohalla Sangat session, a study should be conducted to measure the impact of the program on FP usage. Ideally, this would be included in a national study such as the DHS, but KSM is planning its own follow up study for July 2006. An independent review of the study design should be conducted to ensure that the study will deliver objective findings.

KSM is also planning to evaluate its training program. The research team is considering a mystery client survey and/or a training needs assessment to determine whether the providers are addressing client concerns.

KSM’s verification of its MIS data is expected to be repeated at regular intervals (its “Market Penetration Study” that checks to see if outlets recorded as visited by the KSM salesforce were in fact visited and are stocking KSM products). While this provides useful management information to KSM, it does not reveal whether clients have access to KSM products. Such availability data would be useful to obtain, particularly to determine if rural consumers have sufficient access to KSM’s products.

3.10.2 Greenstar has conducted the following studies:

Quantitative:

KAP Survey (2004/2005): Conducted with KSM and Population Council, the study was completed in 2005 but the release of the data is delayed because some of the findings are controversial. There are some concerns about the

methodology used by the interviewers. The data collection was delayed for more than a year because Federal Bureau of Statistics did not want to provide sampling data. Now, USAID, MoPW, GS, KSM and Population Council need to come to agreement on how the data will be used and agree that it can serve as the baseline data. If it is to be used, a segmentation table should be developed using the data to demonstrate the differences between FP users and non-users.

Condom retail audit: GS has hired AC Neilson to conduct a review of urban shops (not pharmacies) to measure the availability of condoms. The audit is ongoing. As noted in the Distribution section, in March 2006 41% of shops carried condoms, and of those 98% have Sathi, 51% have Touch and 20% have Hamdam. These data are useful for ensuring that the projects are succeeding in making product available. However, it would be helpful to know the GPS location of the shops and combine this data with socio-economic data to measure how accessible the different condom brands are to the target audiences.

TRaC (2005) surveyed households in communities near GS providers and included client exit interviews and a provider survey. GS has decided not to repeat this survey because they thought the data were not of good quality and the cost of monitoring of the research was too high.

INTRAH (2005) conducted an evaluation of GS training. Overall the study found the training to be adequate, but recommended several changes which have yet to be implemented.

Alternative Business Model for Family Planning Service Delivery Cluster Evaluation: This survey, which was not funded by USAID, was conducted in 2001 and 2004 to evaluate the services that private providers are offering. It included an assessment of the availability of products, the level of training of the providers, the clinics' participation in the GS network and the providers' perceptions of the GS network and training.

Evaluation of Family Welfare Centers (2004). This was not funded by USAID.

Qualitative:

Advertisement Recall and Test of Effectiveness of Sathi and Hormonal Advertisements (2004) to review the acceptability of the Sathi and hormonal ads developed with USAID funds.

Barriers to non-use and Motivation to use FP (2004): The reviewers were not provided with information on this study.

Barriers to condom stocking at paan shops/Kiryana stores (2004) was used to assess the distributor network. These findings were part of the assessment that led to the change in distributor to IBL.

Advertisement recall and test of effective for GS Clinics (2004) to review the acceptability of the GS clinic advertisement that promotes support from mother in law and husband.

Usage, Attitude and Package Testing for Touch Condoms (2005) to review and revise the Touch packaging and positioning.

Providers' perception of the GS network (2005): The reviewers were not provided with information on this study.

Pre-testing of adverts packaging and storyboards for Touch (2006) was used to revise the Touch packaging and develop a new advert.

Analysis: The GS research is delayed and the pace will need to pick up in order to deliver findings that can be used to improve the outcomes of the project. Interestingly, GS has not yet conducted studies on consumers' perceptions of the GS clinics. Given that the network includes at least 10,000 providers and is being promoted by GS, it would seem necessary for GS to understand what perceptions consumers have about the clinics. This is planned for 2007.

The KAP data was used to determine that social support especially from husbands and mother in laws was a determining factor in FP use. GS used this information to develop the mass media ads.

It was difficult to determine if GS is using all of the research data to the fullest extent possible. Staff members made little reference to the availability of the research or its role in decision-making. This may reflect that they have absorbed the information already into their programs, or that they are not familiar with the research. GS should make sure that the findings are being used effectively.

Planned: GS is planning the following studies:

- Provider audit (2006) to verify the MIS and determine which providers are still part of the network.
- Provider study on counseling skills (in 2007 with KSM and Population Council) to compare the counseling skills of NGO clinics, GS network clinics and other private clinics.
- Pharmacy audit (2006) to determine the availability of FP products at the pharmacy level, much as the condom audit does for condoms. This was initially estimated to cost 15 million rupees per quarter when 1.5 million was budgeted, so there have been some delays in starting this survey.
- Omnibus consumer tracking survey (2006) to understand the exposure of the target audience to GS advertisements.
- Pricing survey (postponed indefinitely) to analyze the market response to price changes together with the London School of Hygiene and Tropical Medicine. This is discussed in detail in the Pricing section.
- Continuation of retail audits (quarterly) to look at customer off-take of condoms in non-pharmaceutical outlets.

- INTRAH evaluation of training was to be repeated at the end of the project, but the budget is already 200% spent. GS should propose how training will be evaluated.
- FP Methods and Brands Knowledge, Attitudes and Practice Tracking Survey
- Client satisfaction survey about the GS care, providers and products

Spend: GS has spent \$427,000 of its \$1.3 million budget (including subcontracts), or approximately 34%. With all of the studies planned for 2006-2007, there is some concern that the budget will be insufficient, but no new allocations for research are recommended at this time. The delays need to be overcome quickly.

Indicators: Both GS and KSM appear to be capable of conducting and outsourcing high-quality research but have not prioritized the research to the extent necessary. Some independent review by Population Council to ensure that the studies are asking the questions that need to be answered would be helpful to ensure that the programs achieve their goals. Independent review could help to mitigate against the conflict between the two SM organizations over the approaches to research.

Both organizations maintain MIS systems, although both perceived a need to review the data contained within them. The MIS data could be used more to modify the communications and sales to ensure that they are increasing demand for FP. GS has decentralized its MIS data collection but has not yet finalized its querying and reporting capabilities in the regional offices.

It is important for the program to finalize its Project Implementation Plan as soon as possible so that clear indicators can be agreed and measured.

3.11 Competition

Competition could be most effectively used at the service delivery level where KSM-trained and GS network providers could feel a certain degree of rivalry – and indeed pride – in their affiliation with KSM or GS. Similarly, competition between the products has the potential to increase demand for the methods and for FP as a whole. Instead competition was strongest at the head office level, where the two SMOs were competing for funds and approval from USAID on the validity of their approach. Unfortunately, this was allowed to sink below a level of professionalism and was at times unproductive.

GS is charged by some to lack transparency. However, after reviewing the situation, none of the evaluators believed this was a deliberate effort on the part of GS to cover up financial or other wrong-doings. The charge is a result of MOPW particularly suggesting that they had requested but not received financial and other information, such as lists of GS providers. However, correspondence between GS and MOPW and Planning & Development shows that these items were indeed delivered to MOPW. However, because GS is such a large organization with a high profile it is inevitably prone to greater scrutiny and rumour. In such an environment, any apparent lack of

responsiveness runs the risk of being perceived as a cover-up. Added diversity to the board, including perhaps a member of the GS clinical network, may help to allay those criticisms. But GS will have to be extra-responsive in order to overcome this perception.

3.12 Staffing

KSM is limited by the skills of its staff which, with some exceptions at the managerial level, are not as strong as they might be. The director is a hands-on manager with highly relevant skills, especially regarding KSM's marketing.

GS has however suffered from large turnover in part due to the shift to a decentralized structure which took place in mid-2005. GS management attributes the turnover to a changing job that requires staff to spend more time in the field and the introduction of performance indicators. However, the change appeared to be well thought out and well timed, with a decision taken to introduce radical changes by an incoming managing director.

3.13 Training by SMOs

3.13.1 Greenstar

The GS proposal laid out the following training objectives:

- train 2,500 new franchisees — 2 percent in rural areas (which is 50 out of 2500) — to provide four core FP methods
- provide refresher training, emphasizing longer-term method procedures and counseling, for every Greenstar 1 (female doctor) franchisee at least once every two years
- train at least 25 percent of all Greenstar 2 (male doctor) franchisees and 25 percent of all Greenstar 1 franchisees in STI management

Since inception of the training program, a total of 21,526 person trainings have been conducted. For details please refer Annexure 4 Section Training Sub-Section – d Training Targets.

The training of Green-star Social Marketing (GS) is competency based. The training component of Greenstar focuses on building technical competency in longer-term methods, improving provider counselling skills, and integrating reproductive, maternal and child health services with family planning.

The training unit is headed by General Manager Health Services. GS training network is managed through its central training institute in Karachi and operationalized in the three GS regions. The training has a wider spectrum beyond family planning and includes RH components like STI management, counselling of newly wed couples, Emergency Obstetric and Neonatal Care (EmONC), antenatal and postnatal training, and post abortion care, and child health. The FP training package is operated through Greenstar social

marketing and RH package is planned to be operated through the Good Life network.

There are four sets of training for FP entitled GS I-IV. These are tailored to meet the different needs of service providers. GS-I offers training of service providers for IUCD insertion based on four days of classroom presentation followed by six days of clinical training. GS-II, III and IV training focuses on hormonal contraception.

Training Material: Greenstar has developed the following manuals on FP methods and Quality Franchise.

#	Name of Manual	Year
1.	Family Planning Methods for General Practitioners – Training Manual	February 1998
2.	Clinic Training Program Trainer Manual for Female Private Practitioners	February 1998
3.	Family Planning Methods for Paramedics – Trainers Manual	Not Given
4.	Greenstar Franchise Quality Manual	September 2003
5.	Interpersonal Communication – Trainers Manual and Reference Guide	March 2006

In response to previous evaluations of the GS network, GS has restructured to allow for its AMHS staff to visit each of the clinics providing IUD insertion at least six times a year. Clinic Sahoolat provides an important opportunity for further one-on-one training and feedback to the provider in her natural clinic surroundings. However, some aspects of the CS program will need to be enhanced as the program evolves.

Under the new reorganised structure implemented in late 2004, three operational general managers oversee three regional subdivisions. Regions are further subdivided into zones and zones into territories. In each territory there are teams/units composed of a Medical Representative who services male providers, an Assistant Manager of Health Services (AMHS) or trainer who services all female providers, an Interpersonal Communications Officer who focuses on community mobilization, and a Sales Promotion Officer who oversees all sales outlets.

This reorganisation resulted in a change to the scope of work for the trainers. Now the trainers, in addition to classroom training and follow-up, have the additional responsibility of contraceptive sales. In each territory AMHS/trainers provide follow up services to a minimum of 80 GS-I trained private providers every four to six weeks. This is to reinforce both clinical knowledge and skill content of the training, to facilitate implementation of infection prevention practices with support staff in the private clinics, and to provide the physician with necessary supplies and contraceptives. In addition, trainers are expected to meet and recruit new physicians into the network as well as facilitate a given number of courses. Currently, 36 AMHS

are facilitating the GS-I course. A further six vacant positions are in the process of being filled.

3.13.1.2 GS Training Teams

Following the re-organization, the work-load of the training team has increased. They now have to perform multiple tasks in a stipulated time period. These responsibilities include recruitment of health care providers for KSM under those subcontracted to GS, organize and conduct classroom and clinical training of GS and KSM networks, follow-up technical visits, sales of IUCD, attend Clinic Sahoolat and facilitate VSC activities. Furthermore the trainers are being currently trained on RH issues like STI, HIV, Post Abortion Care, EmOC, Maternal and Neonatal Health and are conducting training of health care providers in the GS network. It was found that each AMHS was on an average covering 80 to 100 service providers within the city of operation (except in Balochistan). In addition she was also covering an additional 20 to 25 health care providers outside the city of operation. One of the AMHS was also managing 160 health care providers. The AMHS interviewed have also revealed that they have been given the targets of selling 350 to 500 Multiloads and conduct 15 to 20 Clinic Sahoolat per month. AMHS has to attend all the Clinic Sahoolat activities within city and at least fifty percent out of the city in her area of operations. These are intensive and extensive activities and require a lot of time, and in achieving these targets, the efforts in the field by the AMHS and IPC team are commendable.

3.13.1.3 Training Team Competency

The training teams are trained on a wide variety of topics. This training of trainers (TOT) primarily takes place either on the job or in TOT events. There appear to be different levels of competencies, skills and knowledge among the training teams. This has a direct impact on the training, quality of care assessment and follow-up support offered by the training teams. Since GS is also training KSM service providers, this scenario will most likely affect both GS and also the KSM training.

There appears to be a lack of standardization and competency in the practical training for Multiload insertion. Further there is lack of uniform and consistent infection prevention techniques practiced by the trainers in the field. Many variations exist in the actual insertion techniques mainly regarding sequencing of steps and handling of instruments. It appears that due to reorganization, high turnover of staff, recent recruitments and scaling up of activities, GS is not able to keep pace with the quality of clinical skills of trainers. Interviews with trainers revealed that they are either trained by their fellow trainers or receive on job training through merely observation of conducted trainings by the fellow trainers.

Recently drafted Standard Operating Procedures (SOPs) focus on the process of classroom training only. However, SOPs for clinical training are missing, which may have implications on the quality of care

3.13.1.4 Clinic Sahoolat

Clinic Sahoolat is a community mobilization intervention designed to address the issues of FP through interpersonal communication. MWRA who live within five kilometres of the clinic are approached during a two-week period prior to the CS, and motivated clients are invited to attend the service provider's clinic and receive free FP services. The GS-I trainees facilitate the CS to enhance the counselling/quality of care skills of the health care provider. The CS also helps in increasing the clinic's clientele.

Clinic Sahoolat started in December 2005. Data was only available for two months and no baseline data was available. The data provided by GS on Clinic Sahoolat is indicative of enhanced coverage and offering services to a wider number of people over two months i.e. February – March 2006. The number of FP adopters per CS remained constant over the two months, but GS will have to monitor the proportion of FP adopters to ensure there is no fall off in this.

TABLE 2
Clinic Sahoolat Records for GS – February/March 2006

	Area	February (number)	March (number)	Percentage increase (decrease)
1.	Clinic Sahoolat	226	448	198 %
2.	Number of Clients attending clinics	6,933	15,255	220 %
3.	Number of Family Planning Adopters	2,876	5,654	196 %
4.	Percentage of FP adapters out of total clients attending	41%	37%	(4%)

Further the data provided is also not complete. This has hampered further analysis of RHS and cannot be commented on at this stage. Interestingly there are 25 cases of VSC for men referred from an activity which is conducted only for women.

3.13.2 KSM

The KSM proposal laid out the following training objectives:

1. Strengthen knowledge and counseling skills of private sector health providers on hormonal contraceptives;
2. Provide knowledge and hands on training in IUD insertion among selective private sector providers who qualify for offering this service;
3. Education providers on quality assurance techniques and tools and ensure compliance;
4. Education providers on KSM and its objectives/ activities and reinforce the role of these providers in increasing CPR and improving maternal / child health

Details of target completion (95% FP Basic & 41% FP Advance) can be found in Annexure-4 section KSM sub-section Findings-Training Targets

Prior to the current USAID financial support, KSM was only giving half day hormonal training to the service providers. This training package has now been increased to include training of female health care providers for IUD insertion under the Standard Base Management and Recognition (SBMR) Program. Training is subcontracted to four organizations named Family Planning Association of Pakistan (FPAP), Memorial Christian Hospital (MCH), Reproductive Health-AID (RH-AID) and GS while technical support is provided through JHPIEGO. GS is also using the JHPIEGO manual for FP Advanced and SBMR training of KSM. The TOT of the subcontracted organisations was done by KSM to ensure quality standards across the four organizations.

JHPIEGO has been instrumental in developing the several manuals on FP methods for KSM. Details are shown in Annex 4

These training materials for both hormonal and IUD insertions are consistent with most recent worldwide updates in FP. The KSM training team is also in the process of preparing and adapting a reference checklist for screening the client for different contraceptive methods according to WHO criteria.

SBMR is a joint quality training initiative of JHPIEGO and Futures Group for private sector providers, successfully tested in other countries. It is an alternative program to that proposed by KSM for its Quality Certification Program. The overall purpose of SBMR is to attract a greater number of FP clients seeking services and to generate increased number of satisfied clients through improved client-focused quality of services from private sector providers. According to this performance and quality improvement model there will be improved and sustained provision of quality FP services by private sector LHV's.

Performance standards applicable to FP services for IUDs, pills and injections have been adapted and developed to achieve compliance with at least 80% of performance standards. SBMR Facilitators have been trained for conducting baseline and follow up assessments and monitoring visits, resulting in the development of action plans with provider clinics. For enhanced follow-up, trained service providers are being linked to KSM MIS for regular capacity building refresher courses and follow up visits. Monitoring and evaluation is

envisaged to measure progress by performance standards tools through self-assessment by both SBM providers and facilitators. As an incentive for the service providers' adherence to the quality of care, they will be awarded the certificate of recognition.

KSM's training team is headed by the Training and Quality Manager supported by two Training Program Officers (TPO) and three Training and Quality Coordinators (TQC) for each region.

TQCs are responsible for finalising the training plan, liaising with the partner training organizations, monitoring training quality (non-technical), conducting quality checks and collecting feedback on the training from providers. In addition, they support the information system to ensure consistent and reliable reporting, provide logistical and recruitment support for the IUD refreshers/Skill Enhancement and SBM-R, and assist the TPO in verification and baseline assessments of the recruited candidates.

TPOs are responsible for monitoring trainings and providing technical support to the trained providers in the field, supervising the training and quality coordinators, coordinating with the sales and Mohallah Sangat, maintaining data on sales and training for the respective regions and providing field and technical support in ongoing research.

In 2005, follow up for FP basic trained providers was carried out every quarter by the training department. In 2006, KSM is doing follow up of 25% of providers trained on hormonal methods. Training workshops are attended by either the TPO or a consultant for the full 6 days and/or during the 2/3 days practical training. This is to help build the capacity of training organisations and also to give feedback and inputs to KSM training team regarding further training needs.

3.13.2.1 Mohalla Sangat

This is the community-based activity for interpersonal communication conducted by KSM in areas comprising less than 25,000 population. Approximately 40 % of these sessions are conducted in these under served areas. There are ten sessions comprising 5 basic and 5 as follow up conducted by a contracted LHV over a two-month period. Following selection of the area by the Sales representative or the MS manager, LHVs working in that areas are identified who either have few FP clientele or have just established a new clinic. They are trained for two days in counselling and motivating MWRA. In addition, the LHV has to maintain a record by registering all the clients who attend the sessions and adopt any of FP methods in order to provide follow-up for discontinuation, rejection or change of method and new adopting clients over a period of one year.

Each session comprises of 12-15 participants among whom two participants are users, three are ever users and rest are non users. Cassettes comprising complete information on FP methods for barrier and hormonal methods, IUD and EC are listened to and clarified by the LHV to the participants in the basic

sessions. Cassettes are provided to the participants and they are asked to listen to them with their husbands. They are also encouraged to pass on this cassette to any interested married female family members or friends where they think there is potential for FP. They are followed up in follow-up sessions where their queries are clarified and they are encouraged to adopt any of methods, as all of products are displayed in both the sessions. It is recorded in survey that 25% of the clients adopt FP after session.

Female field supervisors randomly check 25 percent of the clients coming to sessions. If there are more interested clients in the area than can join in then the process is repeated. Feedback meetings with LHVs are held to discuss their successes, challenges, and problems faced in field. Mohallah Sangat for males are held in the same area by Male field mobilisers and a video cassette has been developed, pre-tested and is being used.

LHVs who have conducted Mohallah Sangat activities successfully for more than one year are requested to bring their regular satisfied clients to a client review meeting. The experiences of these clients are discussed, in addition to their initial concerns and reasons for not adopting FP before, and they are further encouraged to talk to the peers and family members.

3.13.2.2 KSM Training Teams

There are no training teams within KSM as KSM contracts out the training. The current outsourcing of training to the 4 different organisations has posed challenges which include:

- Maintaining a uniform standard of training among the four sub-contracted organisations
- Ensuring continuity of rapport with the service providers in follow up visits
- Coverage remains limited for Female Service Providers for IUD as only 406 service providers are trained in 10 districts of Pakistan. However the number of service providers trained in hormonal contraceptives is about 10,000 during the USAID supported period.

Technical support to the FP basic providers is limited.

KSM has subcontracted the training to four organizations i.e. GS, FPAP, RHAID and MCHC. The main service providers to be trained are LHVs, who are selected through a set criteria, followed by training and then regular supply of commodities according the need and demand of the provider.

One of the critical issues noted is the continuity of rapport among the service providers and KSM in follow up visits. Health care provider is trained by a sub contracted organization and they are followed up the staff of KSM. This creates a missing link between the health care providers and the KSM's follow up technical teams, leading to a sense of disruption and confusion among the service providers about the follow up plan and activities.

The SBMR initiated for increasing the quality of care is targeted for LHVs. In 2006, it will be applied for only 150 LHVs. KSM need to implement SBMR

carefully taking in account the educational level of LHVs. Curriculum and the terminologies need to be simplified and translated in easy language so that they can comprehend it fully. Discussions with both GS and FPAP revealed that the selection criteria proposed by KSM was considered very challenging. This is due to the reason of serving underserved areas where it is hard to find a clinic run by doctor.

The time lines for training have not been followed by organizations as discussions on both the development of curriculum and practical training sites took a long time to resolve. In addition, training sites for FP Advance and SBMR training were not available in the location where the clinics are situated. Time was consumed when KSM took up the issue of sites for practical training (GS were getting their trainees trained in facilities of either government like RHS "A" centre or other organizations facilities). After six months of negotiation now GS has identified the facilities where practical training can be conducted.

Another reason given for the delay was inappropriate selection criteria of participants applied by the sub contracted organizations. Initial problems have been resolved. Now KSM need to accelerate the training activity to achieve given targets.

KSM envisages increasing the number its service providers trained on IUD insertion. Maintaining quality of care will be a challenge for a larger number of service providers for KSM in future due to its limited staff. It is of concern whether or not KSM will be able to maintain its quality of SBMR training and provide follow up technical support. Maintaining standards of quality of care will be a challenge for KSM with the increase in number of trained clients and specifically SBMR providers.

3.14 Quality of care

Almost all the clinics visited revealed that providers were responsive towards their clients, and products were available in good amounts at all clinics. Usually there was stock of product sufficient for two or more months. All the clinics had billboards displaying logos of one of the SMOs on their respective clinics. Almost all clinics were displaying IEC material but this was mainly in the examination room rather than the waiting room. A clinical algorithm/protocol was only displayed for Multiload in either the waiting or examination room, but only in those clinics of formerly trained providers.

Elaborate quality assurance guidelines and quality assurance mechanisms are not in place for infection prevention with GS. Quality of care is inbuilt in the Greenstar Franchise Quality Manual. However its standards for practical counselling and infection prevention were not met. Though counselling is influenced by factors like OPD patients, timing of clinic and attitude of the service provider, yet counselling was not properly done. Providers did not explain the side effects in an effective manner. Most of the providers were method specific as it was observed that providers leaned towards IUCD. Limited time for counselling renders the client vulnerable to discontinuation

and apprehension about the effectiveness of any modern method of contraceptives. Most of the clinics visited had unprepared instruments and autoclaves were frequently in cupboards covered with other materials and implicitly unused.

Contrary to the Clinic Sahoolat concept of providing a practical opportunity for on-the-job training & monitoring the quality of service, it was observed that there was a conflict between quantity and quality. On average there were 15 - 20 clients for Clinic Sahoolat and equal amount of OPD clients sitting together, all eager to go home early and making it impossible for the provider to provide quality services. Thus training a health care provider in her own clinical setup was not the proper planned activity and hence training does not impart the required level of confidence and skill.

As mentioned previously, trainers infection prevention skills were not up to the mark, examples of this were that in many clinics instruments were not sterilized properly after first use and never put back into the chlorine solution. Boiling time was inadequate. Almost everywhere it was observed that providers wear gloves not to keep the procedure aseptic but to save their hands from soiling, and none of the clinics wiped the examination table with 0.5% chlorine after examining the client.

Clinical training of IUD insertions takes place in designated clinical training centres such as a public facility like RHS "A" centres and other organizations like FPAP. The trainees are sent there without mentoring or monitoring. Training for IUD insertion is mostly carried out by a LHV. Otherwise it is understood by the provider that the AMHS will facilitate the provision of IUD clients. Interviews with service providers and trainers revealed that most of the clinical training now takes place at Clinic Sahoolat rather than at designated clinical training centres. It was also revealed that Clinic Sahoolat is done on priority for service providers recently trained. Since GS focus inter alias fall on IUD insertions, observations in the clinics revealed the field staff counsellor plays a key role in the client's method selection.

3.14.1 Infection Prevention

Infection prevention is one area which needs immediate attention especially in Greenstar Franchised GS-I clinics. Poor standards of infection prevention were observed in clinics and especially practical application was observed where Clinic Sahoolat was held. Infection prevention practices were lacking in both GS trainers and providers assessed.

According to the MIS of GS, an average of four Multiload IUDs are inserted during each Clinic Sahoolat. In almost all attended GS clinics, there was only one complete and one incomplete set IUD of insertion kits available, even during the Clinic Sahoolat activity. Except in three clinics, none of the clinics had pyodine. Chlorine was available but mostly it had never been used. Hand washing was observed to be not regularly practised by the providers, nor was protective clothing regularly worn. None of the service providers cleaned the genitals of the clients correctly.

In many sites visited, a problem with sterilisation and inadequate boiling of instruments was observed. In one instance, the boiling of the instruments was only initiated when enquired upon. In most cases, it appears that providers wear gloves not to keep the procedure aseptic but to save their hands from soiling. None of the clinics wiped the examination with 0.5% chlorine after examining client. There were no polythene bags in the dustbins except in two to three of the observed clinics.

This is primarily due to the following reasons:

1. None of the clinics visited has any clinical or infection prevention standard operating procedures displayed;
2. The assessed knowledge, observed attitude and practices of infection prevention of the trainers and health care providers was scanty and considered reflective of lack of due importance in the curricula;
3. At the clinics visited there is a preference for IUD sales and much emphasis is given to the IUD;
4. Field staff - AMHS (trainers) is given targets, and performance is based on sales rather than focus on supervision;
5. It was also found that the some of field staff - AMHS (trainers) was the old GS providers so who were not given proper training.

For KSM, the infection prevention activities were well managed. The reason could be that HCP were trained almost a year ago and recently attended refresher courses and were effectively managing their Operating Theatres services. Standardized training guidelines could also be attributing factor. Furthermore, there are at present a manageable number of IUD trained providers for monitoring, which could be a factor in assuring quality. However, with the expansion of the number of IUD providers trained and with few staff deputed for technical support and follow up, it is envisaged that the standards may not be maintained over the passage of time.

One of the SBMR training in Multan attended by RHS revealed that the training team, Training and Quality Coordinator, Training Program Officer and JHPIEGO consultants were present throughout the training and helping each participant on every step of the training curriculum. Each step / module was discussed comprehensively with minor details fulfilling the criteria of competency based training. Each participant was going through practical practice individually, supported by the trainers and the monitors. SBMR carries with itself a comprehensive package of quality training from method mix to infection prevention and client focus approach. All of this was facilitating the concept of enhancing the competency base of the trainee.

Eleven SBMIR tools including method mix and infection prevention attempt to address quality assurance. Each tool is prescribed / written in a comprehensive, detailed and sequential manner covering each area/topic step by step. This methodology ensures that required information is fully recorded by the trainee during and after the training. Trainees can always consult information on steps, sequences on any area of training during their

practical application in their own clinical setup. These are essential innovations which will demonstrate that quality assurance mechanisms can be placed effectively. Trained providers are followed by KSM staff and this gives regular and useful assistance to the provider in dealing with the issues in their clinical setup, thereby increasing their technical capacity. (For further details, please refer to Annex 4)

It was noted that quality of care was compromised in FP basic trained clinics of KSM. The counselling and quality of care both were compromised in these clinics. It could be due to the focus of both SMOs towards IUCD method, or could be relating quality of care with IUCD. Counselling skills and quality of care of FP basic trained providers needs to be enhanced.

Unless these issues of quality of care are addressed there is a risk that this may affect the unmet need of family planning. It may also contribute substantially to increasing the reproductive morbidity of women in a country going through epidemiological transition where Hepatitis B and Hepatitis C are great concern to the health experts.

The above are qualitative observations only but indicate a need for a third party evaluation of the infection prevention component. This third party evaluation should be subcontracted by USAID directly.

3.14.2 Effectiveness of Quality of Care and Client Satisfaction

Adoption of family planning by most clients is after they have had 4-5 children. The stated reason for finally seeking FP services is mainly the economic burden due to the cost of educating their children. Very few mentioned the health and upbringing of child and mother respectively. This explicitly suggests that the approach is mostly for limiting rather than optimal birth spacing. Additionally, it was reported that the reasons for late starting were the fears of side effects. Almost all respondents had seen advertisements on television, yet none had tried to approach a health care provider to clarify their queries about family planning method. This shows that awareness regarding the services is present but there is still a reluctance to seek FP services. This clearly indicates that demand needs to be addressed through interpersonal communications and/or mass media campaigns which confronts unmet need rather than just creates awareness.

No study for client satisfaction has so far been conducted under the USAID funding. A joint study has been planned in the year 2006; however has not yet been operationalized due to differences in approach of both the organizations. There is a strong case for conducting this study with clients to determine their satisfaction.

Money issue

An important area of distinction between the two programs is the issue of who should pay for the training. GS charge Rs. 500 per trainee for registration and annual franchise fee whereas KSM provides reimbursement transportation to

its workshop participants at the rate of Rs. 500 per day. Since hormonal workshops are for one day, therefore, participants get Rs.500 for transportation. In IUD training, since the workshop is for 6 days therefore participants receive reimbursement for transportation at the rate of Rs. 500/day for 6 days making a total of Rs. 3000 at the end of the workshop. Thus there is no uniform policy to address this issue. KSM point of view is that since the health care providers are invited from elsewhere, hence they are paid Rs. 500 per day. GS' argument is that providing incentives contradicts the overall SM principle of encouraging payment for products and services. These are operational issues and should have been dealt at the time of contractual arrangements between the two SMOs. They now need to be finalised between KSM and GS.

A full draft of the training and quality of care report can be found in Annex 4.

4 PUBLIC SECTOR AND SMOs

4.1 Strategic approach for achieving MDG 5, related to CPR and TFR

The Millennium Development Goal--MDG5, aims to reduce maternal mortality by three-quarters between 1990-2015. The success of this goal is measured through indicators which include: (i) maternal mortality ratio, (ii) proportion of births attended by skilled attendants, (iii) contraceptive prevalence rate, (iv) total fertility rate, and (v) antenatal care consultations (the last three indicators have been included by GoP). Thus out of these five indicators, two directly relate to the strategies and programs developed by Ministry of Population Welfare (MoPW). Following table (4.1) illustrates current status and targets to be achieved⁸.

Table 4.1
MDG5: STATUS AND TARGETS RELATED TO FAMILY PLANNING

MDG5 indicators	Contraceptive prevalence rate (CPR)	Total Fertility Rate (TFR)
Definition	Proportion of eligible couples for family planning programs using one of the contraceptive methods.	Average number of children a woman delivered during her reproductive age.
1990-1991	12	5.4
2000-2001	30	4.1
2004-2005	36	3.5
PRSP Targets 2005-2006	41.7	3.7
MTDF Targets 2005-2010	51	2.7
MDG Targets 2015	55	2.1

Though CPR and TFR have improved over time, but the rate of progress remains slow. Some of the reasons identified by Planning Commission include limited rural coverage, lack of motivation and involvement of men, contraceptive insecurity and sub-optimal use of health facilities for family planning.

The Medium Term Development Framework for 2005-2010 developed by Planning Commission shares concerns regarding serious implications for attainment of sustainable development if a relatively high growth momentum of Pakistan's population continue to exist. The overall vision is to pursue stabilization of population as a development priority. Only if all stakeholders, such as the public health sector and NGOs, make coherent and conscientious efforts to achieve the MDG targets will the period of achievement be reduced.

⁸ Pakistan Millennium Development Goal Report 2005, produced by Planning Commission, Centre for Research on Poverty Reduction and Income Distribution, Islamabad, www.crpidd.org

The chapter on Population Welfare in MTFD concludes that success of the population program during this period depend on functional integration between health and population outlets of the country; it says “this will also enable to achieve the replacement level of fertility in 2015 rather than 2020”.

4.2 Government of Pakistan’s strategic approach for social marketing

The Population Policy of Pakistan identifies public private partnership (PPP) as one of the key areas of policy focus. It states that social marketing will be encouraged and facilitated to intensify efforts in urban/semi urban areas and move to rural areas in collaboration with registered medical practitioners, hakims, homeopaths, paramedics, chemists and networking with community based organizations (CBOs). Initiatives for local production of contraceptives would be supported and facilitated to reduce dependency on imported products.

The Population Sector Perspective Plan translates the policy into plans and implementation strategies, envisages that the role of MoPW is “providing an enabling environment” and “complete operational autonomy” to the Social Marketing Organizations (SMOs). This autonomy is identified in the areas of management including recruitment, training, price fixation, responding to market requirements and resource generation for project continuity.

4.3 Contributions of SMOs to national goals and target

As mentioned earlier, the MTFD recognizes the contributions made by SMOs. However, there is no unanimous agreement, especially among various public sector ministries/departments, on the extent of contributions made by the SMOs. Nevertheless, there is a general agreement that they are contributing to the MoPW/GoP policy and strategies, especially in terms of addressing the MDG 4 and 5 which relate to maternal and child health.

SMOs are contributing substantially in raising awareness and bringing behavioral changes among the general population. Though it is premature to determine the exact contributions made in bringing behavioral changes, the Ministry and Departments of Population Welfare appreciate the fact that electronic media and IPC campaigns supported by SMOs have definitely increased awareness regarding family planning among the general masses.

4.4 Institutional arrangements

4.4.1 Stakeholders

Most of the policy and strategic documents, especially related to the role of MoPW, appear to see the ministry’s role as facilitative and supportive to SMOs who are contributing to the national goals. The project since its inception has been mainly steered by the USAID. Thus the initial Steering Committee was de facto chaired by USAID, having a representative from MoPW (the Director of Social Marketing Program). However, just before the annual review conducted by DFID, in September 2005, the Steering

Committee was chaired by the Secretary of MoPW. Since then no meeting has been held. The MoPW has been consistently of the view that it would like to maintain the autonomous status of SMOs.

4.4.2 Between SMOs and GoP

Even before the commencement of the present program, the SMOs have been interacting mainly with MoPW, but not with Ministry or Departments of Health (MoH/DoH). GS has been relatively more active, as they had been submitting claims for reimbursement of surgical contraceptives, through their RHS-B (Reproductive Health Services) centres, managed by their network providers. Recently, GS also had some interaction with MoH for registering some of their products, such as “Clear-Seven”⁹. The National Manager of LHW Program had signed a broad MoU with GS for joint collaborative efforts in FP and maternal and child health. However, this MoU has come to an end. GSM has conducted an evaluation, which highlights that though the activities of the FWCs have increased, it could not be sustained because there were two parallel staff working in these FWCs, one from GSM and one from DoPW. This has created tensions among the staff. In addition, the staff of DoPW was also expected to report to their management in addition to GS. However, there are potential issues in terms of implementation of various proposed interventions.

Another PPP arrangement fostered by GS was with MoPW, in which the Ministry had agreed to contract out two Family Welfare Centres (FWCs) based in Lahore to be managed by GS, by utilizing the existing staff and including additional staff if the need be. It appears that this agreement was not made with a thorough consultation of the provincial staff and had faced many problems in smooth implementation.

KSM has not been very proactive in fostering any partnership arrangements; they attribute it to their priority engagement with re-structuring within the organization and modifying their approaches. Thus no concrete example of any partnership arrangements could be cited at the federal level.

4.4.3 Between MoH and MoPW

A formal partnership framework does not exist between either of the public sectors, MoH and MoPW. However, at ministerial level an inter-provincial meeting is held annually in which, in addition to MoH and MoPW, the provincial minister and/or Secretaries of both the departments of Health and Population Welfare participate and discuss areas of mutual interest. One of the recent decisions made in these meetings was to physically relocate the FWCs to the health outlet of Department of Health (DoH) in all the provinces.

⁹ The seven days combination of drug treatment for sexually transmitted infections.

4.5 Issues and challenges at Federal level

4.5.1 Lack of trust and formal partnership arrangements

Both SM implementing partners strongly feel that they do not have as much stake with the public sector as with the donors. There are so many internal issues in getting through some formal partnership arrangements with the government counterparts; some of them include: personal attitude and preferences, lack of good governance, unrealistic expectations, inadequate understanding of the role of social marketing, gaps in capacity and above all internal tensions between the federal and provincial staff. Therefore, most of the institutional linkages thus far developed are on an individual basis and are in pilot phase. The latest MoU signed between GS and LHW Program appears to be a major break through, but there are a number of issues which need to be resolved first, especially with the coordinators of Program at provincial and district levels. There is no formal partnership agreement between SMOs and the Provincial Departments of Population Welfare. Some of the secretaries had no clear understanding of the concepts related to social marketing, thus some shared their complete ignorance about the program and some of them said that they should be working in rural and difficult areas, just as any other NGO. The SMO till the time of review were not sharing their progress reports with the Provincial Departments; this results in mistrust and lack of any collaborative arrangements at a level where real implementation is taking place.

The Public Sector, though appreciative of the role of SMOs, appear to have a sense of suspicion and mistrust of the claims made by the GS and KSM. According to them there are issues related to transparency and accountability, lack of sharing of reports, especially financial accounts, mis-use of public funds and inadequate professionalism within the organisations. In addition, both the ministries see them as just another NGO and expect them to work for the poor and in rural areas, providing services free of charge. GS refute these allegations and insist they have responded to MOPW demands.

4.5.2 Gaps in comprehensive and a unanimous procurement approach:

Currently, a comprehensive and unanimous approach for procuring the contraceptives does not exist and practically, procurement is not based on the national projections and needs. Thus it appears that more commodities have been procured than the requirement needs by some of the public sector departments, with the result that it may either be mis-used or wasted; the case in example is IUDs—it was informally shared that almost 3.0 Million IUDs have been procured by MoPW, with the result that there is pressure on the staff to move towards longer term contraception; the staff in turn have to show their performance, sometimes by showing fictitious figures.

4.5.3 Disintegrated approach to health and population

GoP Health Policy Objectives include encouragement of private sector in supporting the population targets set by public sector and also to provide

reproductive health services. The focus of most of the public sector objectives as regards CSM has been restricted to FP services. In addition, though GoP is a signatory to ICPD and has produced a package of services for Reproductive Health (RH), it is managed as separate or individual vertical programs. As mentioned earlier, both FP and RH are claimed to be provided by both the ministries (MoH and MoPW), but only FP services are largely provided by MoPW, and the other health services (such as maternal and child health, sexually transmitted infections including HIV/AIDS) by MOH/DOH

4.5.4 Need for validity and comprehensiveness of the data

As mentioned earlier, there are various claims by both public and private sectors regarding the CYPs and the ultimate CPR and Growth Rate. The latest survey conducted by NIPS in 2003 has not yet been publicly shared and the current figures for various indicators being quoted are based on projections. Above all, in spite of an elaborate monitoring and supervision system, there has not been a third party evaluation of the performance of GoP and the private sector vis-a-vis the performance and impact on certain key indicators; one would hope that the currently planned DHS will be able to respond to some of these issues. There are parallel MIS systems of both the ministries; the reports by SMOs are submitted directly to the MoPW, rather than to individual provincial governments. The team was unable to get hold of a comprehensive data on CYPs (and its trend over the years) either at provincial or district or even capital city levels. Last but not the least there is no formal mechanism to bring all the stakeholders together to discuss some of these issues and carry out a comprehensive planning exercise; be it federal, provincial or district level.

4.5.5 Measurement issues for CYP

Corollary to the above is the results of a new study conducted by Population Council which illustrates that there are 900,000 back door abortions conducted in a year to avert pregnancy. As these are by and large “un-official” and illegal, they are not counted in any of the official figures. Whether these high numbers for abortions are influencing the current CYPs, needs further discussion.

4.6 Provincial strategies

4.6.1 Public Sector Strategies

The Public Sectors (DoH and DoPW) are providing FP services by the following different mechanisms at the provincial levels. DoPW has: (i) primary level care centres, labelled as Family Welfare Centres (FWCs), (ii) Mobile Service Units (MSUs) for out reach activities, (iii) Male Mobilisers and (iv) the Reproductive Health Services (RHS) known as RHS-A Centres which are located in the tertiary (in cities) or secondary (at district levels) level care hospitals managed by DoH. All these outlets provide a variety of services, except for Voluntary Surgical Contraception (VSC) which is mainly performed at RHS-A.

MoPW procures contraceptives and distributes to both DoPW and DoH of all provinces. Recently, a federal level decision has been made to move all the FWCs to the first level care facilities (FLCFs) of DoH, which has generated mixed reactions.

It appears that the provincial level population programs are more disposed to longer and terminal methods of contraception. Thus the DoPW-Punjab appears to be now focusing more on longer term and terminal methods (they call RHS-A as a “flagship program”). However, in Sindh, though there is no particular emphasis, but VSC is more commonly practiced as in Punjab. The NWFP and Baluchistan are also having increased demand for IUDs from clients.

All the Provincial DoPWs also emphasise awareness raising campaigns, applying culturally acceptable methods and sources such as involving religious leaders, and media campaigns on spacing and family norms and its association with prosperity. They are also offering FP services through the service delivery outlets of corporate sectors.

The secretarial and senior level staff of the DoPW claimed to have moved away from the “target-achievement” approach; however, most of the FWCs visited by the team were assessed/monitored on their “performance” which relates to meeting the targets.

The DoH does not have any well-defined strategies for addressing FP. Thus, it is more of a passive and facilitative role; the lady health visitors (LHVs) and Female Medical Officers (FMOs) are responding to the needs of clients. The commodities are provided at nominal fees, and commodities from SMOs are dispensed at market rates. With the recent move from MoPW, FP has been decentralized at DoPW level; which means the departments can and should develop their own strategies according to the needs and requirements of their local context. It should be realised that the real implementation is at the district and Tehsil levels. Thus after devolution, it would be expected that each individual provincial Population Departments will have developed their strategic approaches.

The fact that one of the provincial Secretaries is openly promoting longer term methods (IUDs and surgical contraception) is contrary to the real spirit of family planning choice. Per se there is nothing wrong in responding to the demands of the clients; however in this particular province, because of the above guidelines from the secretary, enough efforts are not made by these LHVs and FMOs to counsel for the choices and giving options for spacing.

LHW Program, though strictly speaking is not part of the DoH initiative in terms of its execution and financing, but the implementation is through the DoH. FP services provided by LHWs include: (i) counselling the eligible couples in her catchment areas, (ii) providing condoms and pills, (iii) follow-up of injections at some places and (iv) referring the clients for longer and

terminal methods to the outlets of both government and private sectors. However, the level of service delivery by LHWs is influenced by access and attitude of DOH staff towards the clients, and the LHWs personal motivation and efforts. In practice, each LHW delivers about 8 CYP per annum yet more than 100 eligible couples have been allocated to each LHW. It is estimated that, if sufficient product were made available then the LHWs could achieve 15 CYP per annum.

A MoU has been signed between the National Manager/Coordinator of LHW Program for exploring possibilities of working together for counselling, provision of services and an indirect marketing of their products. It was noted that most of the Provincial Program Coordinators were either not aware or were apprehensive of this arrangement. This apprehension is based on the fact that they (Provincial Program Managers) have not been taken into confidence and some of them have not been shared the MoU. This in the public sector is a “non-starter”; thus even if they would accept it (as it is coming from the top), there will lot of hurdles for GSM in taking this process forwards. LHW Program staff at NWFP was concerned about being affiliated with the SM FP services, and LHW Program Punjab felt that it might lead to duplication of efforts. Interestingly, Baluchistan LHW Program and some of the district coordinators from Sindh saw it as an opportunity for training the LHWs in social mobilisation, with the possibility of conducting joint monitoring and utilising some of the commodities of GS, if the LHW program runs short of commodities, as has been happening previously. On balance, most of the Program officials welcomed SMOs, if they are planning to provide the services to the poor, especially in rural areas.

4.6.2 Roles and contributions of Public sector and SMO

Public Sectors Family Planning is the mandate of Ministry of Population Welfare (MoPW), which is then implemented DoPW, at the provincial levels. MoPW also distributes commodities to the DoH at provincial levels. Thus the main data generated for FP such as CYP and the CPR (though difficult to attribute it solely to MoPW/DoPW), reflects their performance. CYP trends (as contributed by Departments of Population Welfare) for all the four provinces of Pakistan from 1999-2000 to 2004-2005, are not very encouraging; it has not seen either a significant change or actually have gone down, in that period of five years. However, it should be noted that the CPR (from various sources of data) for the provinces has actually increased over this period. Table 4.2 illustrates these trends for CYPs and Table 4.3 shows comparisons of the key indicators according to provinces.

Table 4.2
CYP TRENDS 1999-2000 TO 2004-2005

Provinces/CYP in Million	Contributions by MoPW/DoPW only						Contribution by GS for the period July 2005 to March 2006
	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	
Punjab	3.297	2.985	3.574	3.602	3.320	3.009	0.673
Sindh	1.087	0.955	0.817	0.946	0.967	1.005	0.360
NWFP	0.442	0.436	0.413	0.606	0.456	0.468	0.185
Baluchistan	0.113	0.094	0.098	0.089	0.087	0.087	0.033
Contributions by SMOs							
KSM	0.098	0.125	0.151	0.192	0.232	0.278	
GS	0.670	0.897	1.143	1.474	1.748	1.459	

Table 4.3
STATUS OF KEY INDICATORS ACCORDING TO PROVINCES
(Data extracted from Chapter 9 of Population Welfare, MTFD Report)

Provinces	1997-2000 (PRHFPS)*		2003 NIPS Survey	
	TFR	CPR	TFR	CPR
Punjab	4.7	30.0	**	33.9
Sindh	4.7	26.8	**	31.8
NWFP	5.1	23.5	**	30.3
Baluchistan	5.4	15.9	**	19.0
TOTAL	4.8	27.6	4.06	32.0

* Source: Pakistan Reproductive Health and Family Planning Survey (PRHFPS): 2000-2001

** TFR for 2003 is yet to be released by NIPS

As mentioned earlier, another interesting trend as noted during this period is the move towards increases in CYP s contributed mainly by the longer term and terminal methods, such as IUD (sometimes Injectables) and VSCs. It appears that the focus on spacing of family is either not promoted or not preferred by the client.

The DOPW appear to be mainly involved in implementation and management of programs rather than planning. The role of the Provincial Departments after their decentralization has been to do some sound planning. Most of the service delivery activities, such as FWCs (some of them already moved to the RHC of DoH) RHS-A and some community mobilisers are working directly under the District Population Welfare Officer.

The role of DoPW would be to have some sound planning (it was surprisingly noted that some of the secretaries were not even aware and/or sensitive to the CYP trends and stagnation of CPR), advocacy and monitoring, rather than directly implementing the program. Thus, in spite of de-federalization, the DoPW is not involved in active planning role for their respective provinces and even the reports are submitted to the MoPW which are then compiled and sent back. None of the key officials was able to share detailed data and its analysis on the trends.

The main contribution to FP as claimed by DoH is through the LHW Program.

4.6.3 Roles and Contributions by SMOs

Both the SMOs at the provincial levels have undergone structural changes into more autonomous regions. Unfortunately, the regional demarcation by both GS and KSM does not coincide either with each other or with the provincial geographical distribution. The individual regions of GS are now conducting a bottom up planning for their geographical regions. However, this planning appears to be influenced by the agreed targets that need to be achieved at the end of project. In addition each region is making efforts to increase their service outlets and providers. But there is no proactive effort to conduct some strategic planning for the individual provinces, keeping in mind the current CPR, TFR and the trends in CYP.

The NWFP will soon be having support from KFW for SM, through GS. It appears that KFW is strongly pursuing two major interventions to promote IUDs and public private partnership by asking GS to work with DoPW in NWFP. One of the options being advocated by KFW is to use the FWCs in evenings, with support from GS, and to distribute their products. In addition, for the poor, they intend to promote a “voucher scheme”. It seems that there are some differences of opinion within DoPW regarding how and what this new project would be contributing. The project has been in the planning stage for last four years; it is hoped that it would be signed very soon.

With a newly expanded field force, KSM will increase distribution of their commodities to smaller towns. In addition, they claim to use various opportunities to market their products when either the Public sector LHV or LHWs are gathering for some monthly meetings and/or trainings. Thus, quite a number of these LHVs who have a private practice are using KSM products in evenings, in their clinics.

4.7 Institutional arrangements with Public Sector and other private sectors

4.7.1 Within Public Sector

A provincial level Coordination exists between DoH and DoPW, wherein the secretaries of DoH and DoPW, including the Provincial Coordinator of LHW Program regularly meet to discuss areas of mutual interest related to program management. Recently, the point of discussion has been the shifting of FWCs to health facilities. There were conflicting statements from DoH and DoPW regarding collaborations between the DGs (Director Generals) of two departments. However, this coordination has not addressed policy and strategic issues related to FP and/or RH, especially when health is a provincial subject, and at least in two provinces, Punjab and NWFP, sectoral reform initiatives are planned and implemented. Similarly, there are institutional problems in public sector, especially within DoPW. The DoPW sends all the reports to MoPW, which then aggregates and feeds it back to

the provinces. Similarly, most of the decisions are made at the federal level and then shared afterwards, without any consultations.

A District Technical Committee has been established, which is chaired by the EDO Health. Regular meetings are held at the district level among the District Coordinator of LHW Program, EDO Health and DPWO for facilitating various activities, especially organization of camps for IUDs and surgical contraception.

LHWs usually also do not refer the clients for surgical camps to RHS-A centers but to the camps managed by other NGOs such as FPAP, MSS and GS. The RHS-A centre gets its clients from the tertiary level care hospitals and service delivery outlets (both private and public).

4.7.2 Between Public sector and SMOs

There is no forum for regular interaction of SMOs with DoH and DoPW. No proactive efforts by any of the SMOs could be noted, which would indicate the need for the development of some formal linkages with either DoH or DoPW. The only formal linkage by GS is for coordinating the camp activities and for reimbursement of payments for contraceptive surgery. GS has been training some of the Lady Health Workers Supervisors (LHS) and referrals are being made to GS Network provider by the LHWs. GS intends to work with DoPW by acquiring some of the FWCs; this is part of forthcoming project that will be supported by KFW in NWFP, and some proposals in Punjab are also under consideration. In several meetings held with senior officials of public sector, a total ignorance about the role of KSM and its activities was shared.

At district level, both SMOs have trained various staff of DoH; both KSM and GS trained a number of LHVs working in the public sector. In addition, both SMOs have been utilising experts from the Public sector as Master Trainers for FP in their training sessions. All the above interactions with public sector are informal and have not resulted in a formal contractual arrangement or even for an understanding to work within some framework of PPP. The only recent development is signing of MoU at federal level by GS with LHW Program.

4.7.3 Between SMOs and other NGOs/private sector

The SMOs have developed institutional linkages with other private organizations, especially the NGOs have been either for delivering specific services, conducting training and procuring commodities. Some selective examples are cited below.

GS has contracted PAVHNA for working in rural area (District Larkana) as part of their USAID-funded program; other four rural districts are managed by SCF. PAVHNA has conducted mapping of service providers, basic and refresher trainings of 30 services providers each formal and informal sectors, and pre-tested the messages developed by GS. PAVHNA has been working in Larkana through their three partner CBOs, involving 60 CBD workers.

Interestingly, the CBD workers do not promote any particular brand but have all the brands of GS, KSM and/or MOPW. This facilitates informed choices by the clients. PAVHNA feels that there is a need to have a constant follow-up and feedback; one cannot expect there to be measurable behavioural change after only a couple of weeks only.

Lyari Community Development Project (LCDP) working for MCH for last two decades signed a MoU one year ago to carry out IPC and community mobilisation activities. The IPC workers, paid by GS, are liaising with LCDP; 5 IPC workers are conducting various activities in community. However, the LCDP feels that the clients should be motivated continuously and services be provided at the doorstep. It is also felt that FP is not a priority in the community.

KSM has sub-contracted FPAP for conducting training for hormonal contraceptives and IUDs. Specific targets and curriculum has been provided by KSM, which is applied by FPAP. There is no formal interaction of FPAP with GS, except that the FPAP is procuring condoms directly from GS headquarters at Karachi. There is the likelihood of double counting CYPs in this program since GS count any sales as a contribution to their CYP, while at the same time FPAP is also calculating their CYP according to distribution of these condoms to the end-users.

4.8 Issues and challenges at provincial/district levels

4.8.1 Lack of integrated approach for FP/RH.

The Population Program though “de-federalized” is still being executed from the federal level through Ministry of Population Welfare (MoPW). Similarly, most of the preventive programs are also executed and supported through MoH. However, most of the implementation and management of health system is the responsibility of provinces. The provincial governments are now expected to take over and support the provincial programs, including the Population Welfare; though this would materialize only when the timeframe for the current PC1 is over in 2007-2008.

The Provincial DoPW is not involved in comprehensive planning and designing of integrated population programs involving all the stakeholders. A better opportunity and potential could be to involve district governments in planning for population welfare programs.

It appears that in spite of claims for moving on to RH from FP after ICPD initiative, there has been no real progress in terms of an integrated approach to RH. Many policy planners and program managers are still pressing for a concerted approach to address the goals related to reducing just the fertility and growth rate. This has led to selective approaches for RH by various implementing partners, leading to wastage of resources and missing a number of opportunities for improving the reproductive health.

An interesting example related to RH approach is lack of male involvement in not only counselling and advocacy but also for providing services to address male reproductive health problems including FP. Traditionally, males have been blamed for their lack of participation, but they have not been offered any services exclusively for them.

Another issue which has been a cause of concern is inadequate understanding, by most of the senior as well mid-level officials of public sector, of the roles and responsibilities and operational modalities followed by SMOs. Neither the public sector nor the SMOs have made serious efforts to dispel some of the myths, especially the general thinking that they are just like other NGOs providing FP and RH services.

4.8.2 Institutional relations and role of development partners

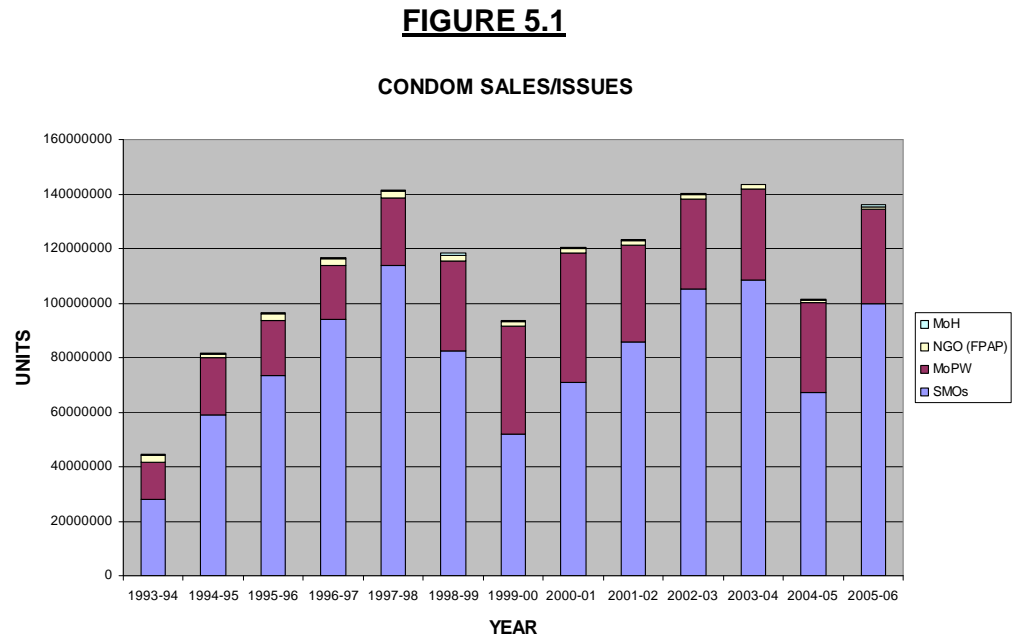
The SMOs at the provincial levels have either not developed any formal linkages or the linkage and/or partnership arrangements are adhoc, relating to a specific activity or project. Two examples which have resulted in confrontations include moving of FWCs to FLCFs, and signing of MoU with National Program Manager of LHW Program with GS. Similarly, the SMOs are not accountable to their provincial public sector partners, as they have signed a contract with the donors and their direct partners are the MoPW and the Steering Committee. One of the challenges would be to foster institutional relations at the provincial levels so as to improve the performance both at provincial and district levels.

5 PRODUCT MARKETS

As we have seen, product is supplied to consumers by MOPW, MOH, the SMOs and the LHW program. In addition there are other commercial suppliers.

5.1 Condoms

Figure 5.1 shows condom trends in sales by the SMOs and issues from MOPW and MOH.



The market is dominated by sales from the SM organisations, particularly Sathi from GS. Sales of Sathi declined in the late 90's due to overstocking the trade and, as a result of two consecutive price increases in the space of a year and a change in distributor, the trade released considerable volumes of stock into the retail trade. Therefore, SMP, as it was then before re-branding to GS, could not sell at the same rate as in previous years. In fact, consumer sales did not decline and Sathi primary sales recovered steadily up to 2002/3. A similar situation arose then, in that that GS engaged in heavy trade dealing in these years and, as a consequence, the trade became overstocked in comparison to consumer off take. This resulted in a sharp fall in primary GS sales in 2004, from which it has recovered in 2005/6.

In addition to the above data from MOPW and the SMOs, there is a supply of condoms (and OCs) distributed by the LHWs. Data for these products are not well recorded. UNFPA can supply figures on what they have procured for MOH to give to the LHW program. Central Warehouse Stores(CWS) can supply issues to the LHW program, yet the LHW program cannot provide any data on the actual volume of product issued to the individual LHWs or their issues to clients.

LHW program reports that condom issues from CWS to the LHW program are as follows:

TABLE 5.1
CONDOM ISSUES TO LHW PROGRAM BY CWS
(Million)

	2001/2	2002/3	2003/4	2004/5	2005/6
CONDOMS(m)	98.1	37.2	74.3	-	(158.1)*

*These are procured but not yet issued.

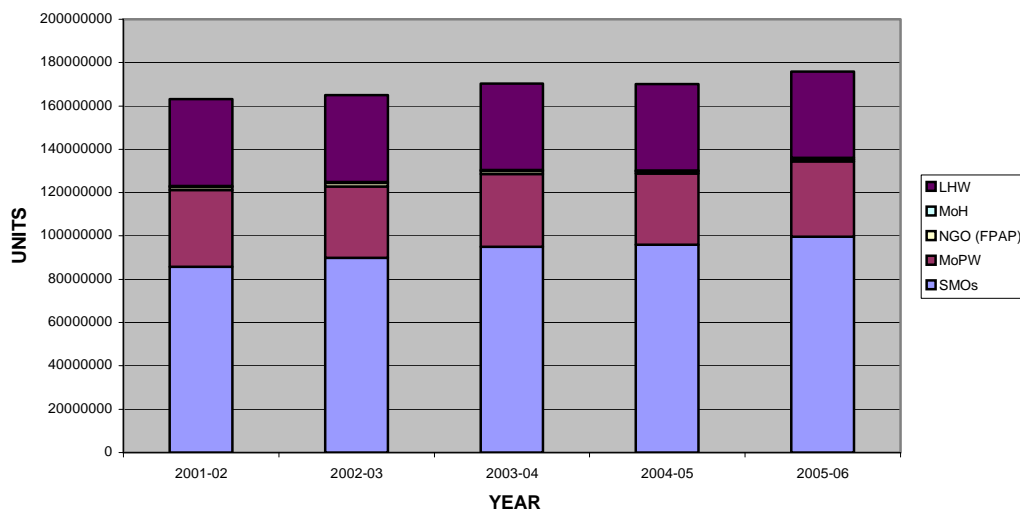
**Source: LHW Program via CWS

It appears from these data that between 2001/4 CWS has issued 209.6 million condoms to the LHW program. These have lasted, or had to last, for 5 years. Therefore, the LHW program is issuing condoms at a rate of about 40 million per annum or 420 condoms per LHW per annum.

If these figures are added to the MOPW and SMO data, and smoothed out for known year to year variations, then the history over the last 5 years appears as in Figure 5.2.

FIGURE 5.2

TOTAL PAKISTAN CONDOM ISSUES/SALES

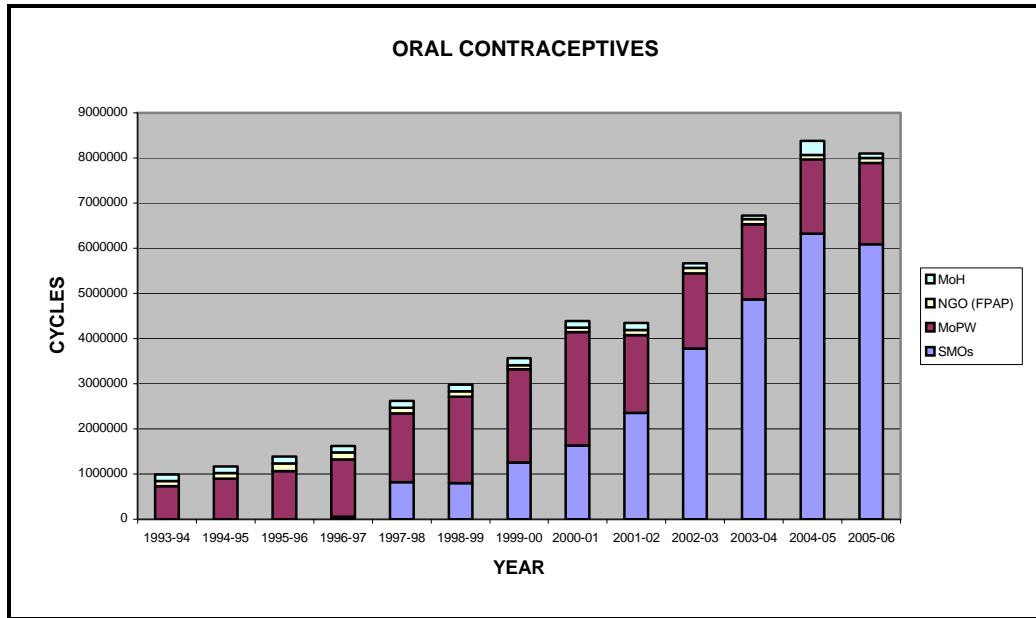


Overall the condom market is growing very slowly, with the SMOs making the real growth. Until such time as the LHW issues data becomes available, it is not possible to determine any movements between the sources of condoms. However, what is clear is that there is no real growth in this product sector.

5.2 Oral Contraceptives

Figure 5.3 shows the growth in the OC market, using long term data from MOPW and the SMOs.

FIGURE 5.3



The major growth has come from the SMOs, such that they now provide 75% of all OCs issued/sold by the MOPW and the SMOs. Within the SMO share, it appears as if there has been a fallback in 2005/6 from the previous year. This is due primarily to the fact that during the period 2004/5 there was some export of Nova OCs to Syria and Iran which inflated the sales during that period. This practice was due to differential pricing margins operated by the manufacturer in the various countries, which enabled product purchased at normal trade prices in Pakistan to be transported out of the country and sold elsewhere for a high profit. This has now been controlled and sales in 2005/6 are believed to be domestic Pakistan.

The LHW program also issues OCs. Again, as in the case of condoms, data is limited and Table 5.2 shows issues by CWS to the LHW program.

TABLE 5.2
OC ISSUES TO LHW PROGRAM BY CWS
(Million)

	2001/2	2002/3	2003/4	2004/5	2005/6
OC(m)	8.97	1.22	9.60	-	(16.15*

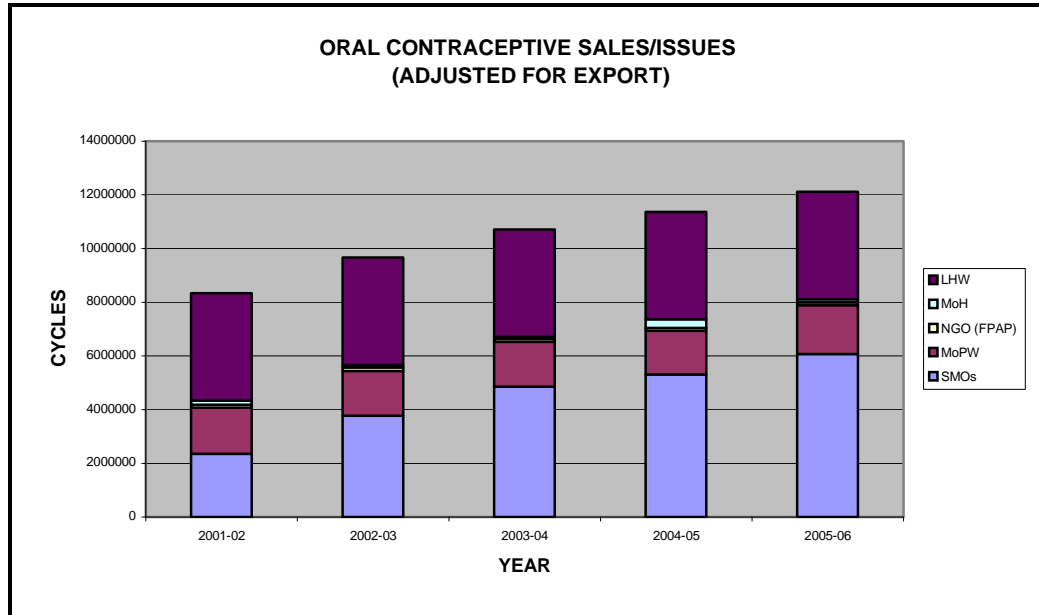
*These are procured but not yet issued.

**Source: LHW Program via CWS

As with condoms, there were issues made during the period 2001/4 but nothing since, although there are products procured and waiting to be issued, according to LHW Program. Thus, on average, LHW program utilise about 4 million cycles of OCs per annum, or about 40 cycles per LHW per annum.

When these data are added to the sales made by SMOs, adjusted for export, and those of MOPW, they show a total market for OCs worth about 12 million cycles per annum and growing.

FIGURE 5.4

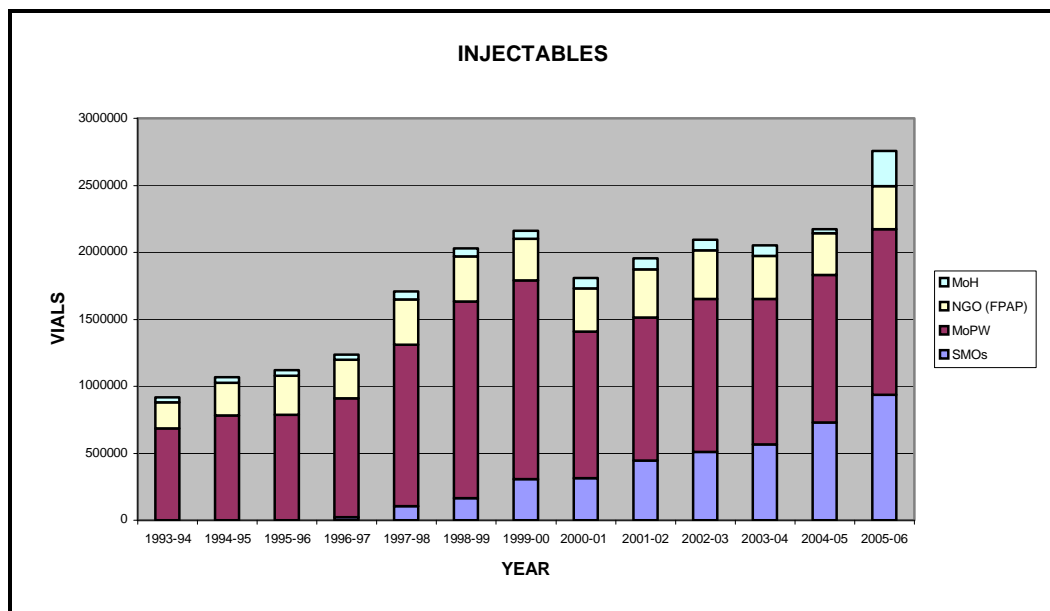


In terms of share, when one includes the LHW data, the SMOs, although providing the growth to the sector, are achieving about 50% of the market.

5.3 Injectables

Figure 5.5 shows the market for Injectables. These products are not supplied by the LHW program.

FIGURE 5.5



These products have been mainly flat in consumption over recent years, except for a large and unusual issue made to MOH in 2005/6, and some steady growth being made by the SMOs. The market is changing in that there are increasing sales of 2 month and 1 month products, and the MOPW data will need some adjustment to correctly reflect this. At present, in term of share, the SMOs hold about one third share.

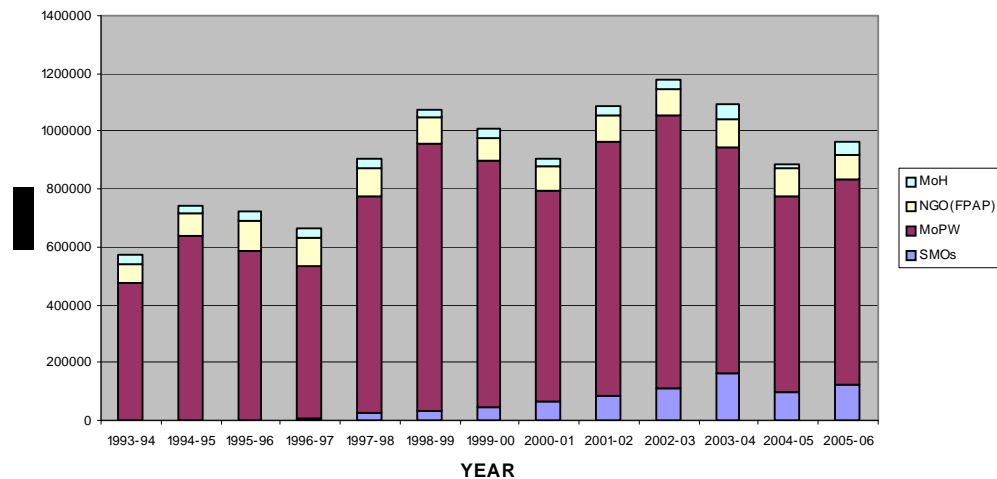
5.4 IUDs

The number of IUDs issued by MOPW appears to be overstated when compared with likely actual uptake. Their data report issues of around 700,000 IUDs being fitted each year over the last three years. Given the CPR rates for this method from numerous surveys in recent years, this is not actually credible. Either there is considerable wastage of public sector IUDs, or they are being fitted and then replaced in a very short time. There are observations of women being fitted with IUDs but, when they returned home, their husbands demanded that they return to the clinic and have it removed. If this practice is widespread, then it may, in part, account for the high issue rates. There is also the possibility of unofficial export of IUDs to other countries.

Notwithstanding this, Figure 5.6 show sales and issues for IUDs from MOPW and SMOs.

FIGURE 5.6

IUD's

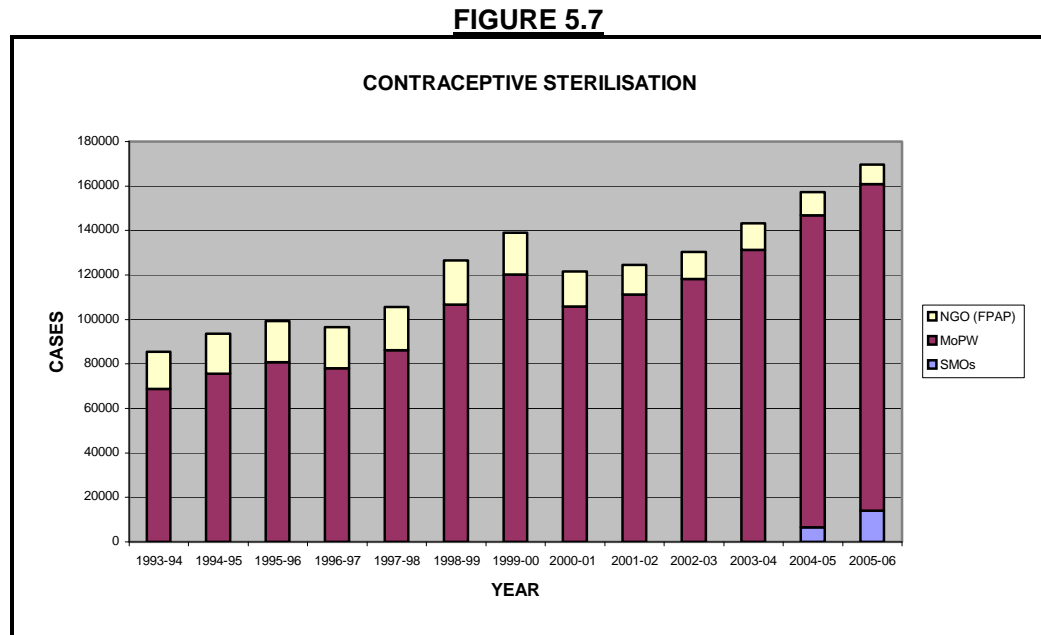


The market is dominated by the public sector with the SMOs only taking about 10% of products fitted. As indicated above, the public sector issues are abnormally high. There have been changes in the MOPW issues in that there used to be targets for monthly issues given to each clinic. These targets were removed in 2002/3 and may well have affected the recorded issues of IUDs rather more than other products, thus producing an apparent decline over

recent years. It is more likely the case that issues during the years prior to 2003 were even more inflated than they are now.

5.5 Contraceptive Sterilisation

Although this method has only recently been introduced into the GS program, it is an important method as far as FP is concerned in Pakistan. Figure 5.7 shows the recorded CS from MOPW.

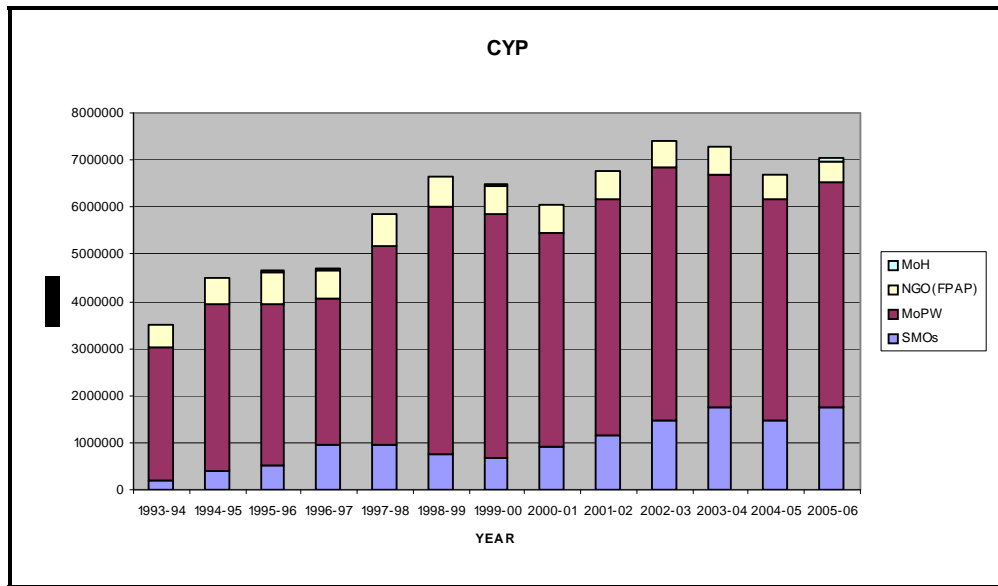


This method has been growing steadily for many years and, despite all the efforts to promote birth spacing, as compared to limiting, MOPW records ever increasing numbers of women choosing to adopt this method of FP. However, this is usually after the women has had several children and later in her life. While making an important contribution to FP in an increasing population, sterilisation is still seen as a method of choice for a woman. If however, the CPR rate is to increase, then there needs to be substantial uptake of spacing methods by younger women.

5.6 Couple Years Protection(CYP)

Figure 5.8 shows the CYPs produced annually by the public sector and the SMOs, but not including the contributions made by the LHW program. This is in order that the long term trend can be seen, since data from LHW program is only available for the last 5 years.

FIGURE 5.8



It will be seen that there was apparent growth in CYPs during the 1990's and again from 2000/1-2002/3. Since then however, there has been no growth in CYPs. These results can be due to many reasons since all the methods, and their own individual changes are aggregated together. For example, the falls in 2004/5 can be attributed in part to the decline in Sathi sales and also the changes in reporting of IUDs in MOPW. Yet, it is known from audit data that Sathi sales to consumers have not been declining and it is simply that the sales made in the trade are those reported for inclusion in the CYP data. It is also probable that issues of IUDs were being recorded at too high a level in previous years and the apparent decline is not an accurate reflection of the true situation.

When one adds in the LHW data of average issues of 40 million condoms and 4 million OCs per annum, the total country CYP levels rise to about 7.78 million. Because of the timing of the actual issues from CWS to the LHW program(see Tables 5.1 & 5.2), it is more likely that CYPs accruing from the LHW program have been flat to declining, rather than the other way around. Thus, even taking into account concerns over the public sector IUD data, sales of Sathi and the contribution made by the LHW program, it has to be concluded that national CYPs have not increased during the period of the present quadripartite agreement. This has grave implications for CPR.

5.7 Contraceptive Prevalence Rate

The data from previous surveys, figures from the NIPS survey (not yet officially published), and the KAP survey conducted by the SMOs, but not yet published, are shown in Table 5.3.

TABLE 5.3

	PDHS 1990/91	PCPS 1994/95	PFFPS 1996/97	PRHFPS 2000/01	NIP 2003	SMOKAP 2005/06
ANY METHOD	11.8	17.8	23.9	27.6	32.0	29.2
MODERN METHOD	9.0	12.6	16.9	20.2		20.3
TRAD. METHOD	2.8	5.2	7.0	7.4		8.9

CPR has been increasing from 1990 to 2000/1 and, in the last published survey, PRHFPS, the Any Method rate was 27.6% and that for Modern Methods was 20.2%. The unpublished NIP survey appeared to show an increase in Any Method CPR of two percentage points per annum between 2000/1 and 2003, to reach 32%. However, the more recent study by the SMOs shows that the Any Method rate is 29.2% and that for Modern Methods is 20.3%. As seen earlier, there has been no increase in CYPs in recent years and, with an ever increasing population, it is not possible that the Modern Method CPR has grown in the last 3 years. Unfortunately, in some GoP circles, the trend shown by the unpublished NIP data is being accepted as true and, even worse, is being extrapolated at the same rate such that claims are now being made that the overall CPR is now 36% in 2005. Unless there has been a considerable growth in Traditional Methods, this does not seem possible or likely. Furthermore, with a static CPR it is unlikely that the PRSP and MTFD goals will be hit unless there is a concerted effort by all parties, GoP and SMOs to increase the use of Modern Method contraception.

6. BUDGET

6.1 KSM

As at June 2006, KSM had spent only \$4.376 million through its Pakistan office and \$4.171 through its Washington office. Thus its total burn rate against its three-year budget of \$18,243,793 is 47%.

It has been discussed elsewhere that there was considerable delay in getting the project going, since the KSM operation had been considerably run down prior to the signing of the present agreement. It took nearly 9 months to recruit personnel and obtain an office and equipment. Consequently there was very little spent on programmatic expenses. In addition, the discussions with GS during 2004/5 to try and reach some increased collaboration resulted in very little being spent on training, marketing or research in that period. To date the burn rates on marketing, training and research are only 60%, 49% and 18% of the three year budgeted line items making a total expenditure for just these three items of \$6.239 million out of a budget of just over \$11.5 million. It is of note that over the 3 years no spend has been claimed by FGI under its indirect rates. Even if claims had been made pro-rated against actual spend this would add a further \$770,000 (7%) to the overall spend.

6.2 GS

By contrast, GS has spent 91% of its three-year budget as at March 2006. Thus, the spend is \$11.7 million against a budget of \$12.89 million, and it is estimated that by the end of the fiscal year spend will be exactly on target. In total, GS has spent 51% of its total 5-year program budget

Unlike KSM, GS has relatively small budgets for marketing, training and research. Of the \$3.087m marketing budget, all of this has been spent, 87% of the \$3.39m training budget has been spent, but only 50% of the research budget is recorded as being spent, although not all of the costs for the shared KAP study have been included yet.

All of the detailed budget spend for both SMOs is shown in Annex 5.

6.3 Cost/CYP

Cost/CYP, although an important control measure as a deliverable, varies enormously within and between the programs. Table 6.1 shows the annual cost/CYP as derived from financial data supplied by the SMOs.

TABLE 6.1
COST/CYP (\$)

	2003/4	2004/5	2005/6	AVERAGE
KSM TARGET	13.25	10.48	6.10	
KSM ACTUAL	5.62	17.06	10.55	11.45
GS TARGET	4.77	4.48	4.05	
GS ACTUAL	7.85	8.55	2.88	3.64

Of course, these data are subject to all kinds of influences. The fact that KSM continued to sell products which had been on the market for some time during the first year of operation of the present project, and not spend much USAID funding, means that the cost/CYP is quite low in that year. Cost/CYP then increases as KSM commenced to spend budgeted monies, but sales could not be expected to increase commensurately in the same short time period. Overall their average cost/CYP at \$11.45 is a mix of relatively low product sales against target, and equally low spend against budget. What is clear is that, compared to the targeted cost/CYP, KSM is not meeting its targets, and is still high compared to many other SM programs around the world. This is mainly due to the high number of CYPs that the program was to deliver not being achieved. . Since it is recognised that KSM is unlikely to hit its CYP targets, what is also now needed is a reduction in spend if cost/CYP is deemed to be an important measure of program success.

GS has one of the lowest overall cost/CYP in worldwide SM programs. Its CYPs depend heavily on Sathi sales, and inclusion of program revenue, mainly from Sathi, has historically produced low costs/CYP. Despite this, during the period of the USAID funding, GS has had mixed results. The initial higher cost/CYP is attributable to the fact that Sathi condom sales, and to a lesser extent OC sales, fell back during the early years of the project, yet GS were still spending USAID funds. In the latest year, sales and therefore CYP improved, and GS spending has been relatively light, thus giving a remarkably low cost/CYP. The average for GS at \$3.64 indicates good sales against a modest spend, and has surpassed the mid-program target. However, since they now have no marketing funds available, it is uncertain what will happen to sales in the future years, although, in the absence of further funding, costs will also likely be lower.

Comparison of cost/CYP between the two programs is not a simplistic exercise and cost/CYP in itself is a crude measure of efficiency. The GS program reflects a lower cost/CYP but, if the costs of donated product are added into the calculation, then the results will be different in absolute terms. One may have expected that KSM model, with no product purchase costs other than those which are purchased from distributors such as Hamdam, would have had lower costs/CYP.

This leads to the question as to whether or not cross subsidy programs are more cost efficient than the commercial/manufacture's model. This is difficult to determine from simple cost/CYP since much depends on what the funding is provided for in programs, which may be mandated with carrying out activities for things other than merely developing sales of products. For example, if a program is funded to carry out research, or develop generic marketing which may benefit the whole national market, and another program is not funded to do this, even with identical CYPs one program may appear more cost efficient than the other. Only by stripping out non-product sales related costs can a reasonable comparison be made. In the present situation and given the differing histories of the two SMOs, it may be more meaningful to derive, measure and compare cost/new additional CYP. However, what is clear in the present situation is that the volume of CYPs delivered by the KSM

model has not been realised, and KSM'S cost/CYP have not decreased as targeted.

6.4 Program Income

GS product is supplied under grants from DFID and UNFPA. As they make sales, these products generate income. Table 6.2 shows the income derived from products supplied by UNFPA during the course of the present project.

TABLE 6.2
GS PROGRAM INCOME FROM UNFPA SUPPLIED PRODUCTS

Description	Qty			Selling Price	UNFPA PROGRAM INCOME (Rs.)	UNFPA PROGRAM INCOME (US\$.)
	Received Up to March 06	Consumed	Balance			
Sathi	167,201,136	60,753,966	106,447,170	0.90	54,678,569	918,968
Touch - Ribbed	4,600,512	2,296,560	2,303,952	2.45	5,626,572	94,564
Touch - Dotted	10,609,920	6,239,280	4,370,640	2.45	15,286,236	256,912
Touch - Classic	1,152,000	-	1,152,000	1.93	-	-
Multiload	570,000	170,536	399,464	15.00	2,558,040	42,992
Megestron	117,800	4,940	112,860	29.38	145,137	2,439
Nova Ject	558,761	391,741	167,020	13.06	5,116,137	85,986
Femiject	164,439	42,025	122,414	9.79	411,425	6,915
Nova Pills	696,360	502,862	193,498	8.28	4,163,697	69,978
Nova "3" (1 cycle)	1,798,575	1,451,604	346,971	7.34	10,654,773	179,072
Vitalet	155,272	113,337	41,935	8.00	906,696	15,239
					99,547,284	1,673,064

As can be seen, the sales of products generated from UNFPA supplied commodities has amounted to \$1.67m over the three year period to date.

KSM also generates revenues on its sales which go to the manufacturer and distributors, and are therefore not included in this report.

7. USAID INVOLVEMENT

7.1 Management Involvement

During the period of the present support, it is felt that USAID appears to have become the dominant donor partner in the quadripartite agreement. Although DFID and UNFPA provide funding for commodities, itself an essential part of the project, this only applies to GS. KSM, although previously funded by DFID, has no real involvement with their previous donors. As a corollary, DFID and UNFPA recognise the roles they have to play in supporting the SM project but, because they have no programmatic involvement, appear to receive less information about the progress of the projects, and have other health projects to support, perhaps feel isolated from the present project. This is unfortunate as there is much to be gained by bringing several donor experiences to major health initiatives.

USAID involvement with the SM program has suffered from several changes in health personnel within the donor organisation. During the period of the project there have been four Health Officers in less than three years. These constant changes, individual preferences, experiences and opinions of SM programs has made life difficult for the implementing agencies. There has been one CTO during the period which has been a constant factor.

With differing individuals involved there are inevitably differing approaches to the SM program. This leads to differing support for such things as collaboration between the SMOs, the development and value of PPP, and the general role that SM should play in the spectrum of health initiatives. One of the reasons why this has arisen is that there is no real agreed strategic approach agreed between the partners, donors and GoP. If this had been in place then many of the difficulties experienced by the SMOs (and USAID) would not have occurred.

On a day-to-day basis, there is a reasonably good rapport between the donors and the IAs. The problem is direction. Initially, it was envisaged that there would be some form of management control but in fact, with two established historically competing IAs, this was always going to be difficult. Both SMOs recognise the others professional skills but, because USAID signed two individual agreements with individual performance targets, there was always going to be some degree of self interest by the IAs. As has been identified, there is a need to grow the market and, while both SMOs concur that this is desirable, much of the time is spent thinking about individual challenges and competition. USAID, as lead donor, has not been sufficiently involved in the strategic direction of the project as a whole or the SMOs to make this work. Similarly, USAID involvement with the GoP, particularly MOPW, has not really addressed the fundamental issue of individual contributions to achieving national goals. While donors cannot always take the lead on this because of political protocol, it cannot be left to the SMOs or MOPW to drive the whole initiative along.

Information flow between the SMOs and USAID in terms of reporting appears to be satisfactory. However, these regular reports are not always shared with

other donors and there appears to be little reaction or comment on the formal reporting carried out by the SMOs. The balance between micro-managing and distance responsibility is difficult to achieve, especially when the Health Officers change frequently. Unfortunately the SMOs can feel isolated and work on the basis that the only interest the donor has in achieving CYP or cost/CYP results. In a developing SM initiative, there are variables such as indicate behaviour change that can indicate progress, and these do not form any part of the SM indicators at present.

7.2 Collaboration

During 2004/5, USAID determined that a greater degree of collaboration would benefit both SMOs and improve efficient use of USAID funds. USAID encouraged the two competitive SMOs to examine ways in which they could work better together. The SMOs met several times over an extended period and worked towards meeting the direction given by USAID.

The result was directional changes aimed at helping behavioural change, the format of media development and transmission, changes in training arrangements and brands sold by the two SMOs, and accounting for credit of product sales. The proposed collaboration points are outlined below, incorporated into the SMOs' agreements but there has been no re-alignment of budgets or programs.

7.2.1 Increased demand and use through coordinated BCC Campaigns:

- Generic Mass Media would be developed in coordination with MOPW, GS and KSM to address unmet need and addressing key enabling factors. KSM would lead the campaign development with input from GS. Production costs would be shared and media paid for by KSM, since they had a greater budget.
- Method Specific Commercial Branded mass media would be led by KSM and based on method specific knowledge. Equal space and mention would be given to all brands that are tagged to a particular advertisement. Brands in transition from subsidized to full-price would be included in method-specific advertising under separate agreements between GS and TFG, such as that for Nova. In essence this led to corporate product range advertising which the evaluation team feels is not the best way to promote products to maximum effect.
- Below The Line (BTL) Activities and trade promotions. Each SMO could develop its own promotions but if method specific promotions were to take place then all brands from both SMOs would be included.
- Interpersonal Communications (IPC) – Both organisations would undertake their own IPC activities at the community level, particularly in more underserved areas. In addition, KSM operated Mohalla Sangat activities would offer all Greenstar FP brands, including subsidized ones, for sales to participants who may desire to purchase them.

7.2.2. Increased quality FP services offered in the private sector:

Training. KSM would sub-contract GS to undertake the training of private sector health providers in districts of southern Pakistan which were previously assigned by KSM to the Aga Khan Foundation. It was agreed that KSM may consider contracting GS to conduct training in other areas. In terms of Follow-up and Quality Monitoring, each organization would be responsible for the follow-up and quality monitoring of providers whose training they had paid for. There would be efforts made to harmonize the processes and tools through which monitoring and evaluations could be done.

7.2.3 Changes in Product Distribution

KSM agreed to cease negotiations to import its own IUD brand and to sell Safeload supplied by GS.

KSM would support and distribute any GS brands that achieved full price status in line with their Manufacturer's Model mandate. This has not always happened in practice. KSM would support GS' Nova OC if GS was permitted to increase the price of Nova OC.

7.2.4 Other areas of collaboration

- KSM and GS would share equally the CYPs generated from all sales of Safeload by GS through their trained providers and also sales of all GS brands through the KSM managed Mohalla Sangat sessions.
- Both SMOs would agree to a common set of indicators to be provided to the donors through which their efforts will be evaluated and to jointly fund research projects that will contribute towards advancement of common objectives under this program. These are agreed but not yet formalised.
- Both SMOs would agreed to jointly pursue policy goals that have been identified and placed by them before the Secretary, MOPW and to use common definitions in all areas of reporting and to ensure comparability. This is underway.
- Both SMOs would agree to work together in the spirit of collaboration and open channels of communications at all levels to ensure better planning and coordination. This has happened, to some extent.

In essence, both SMOs made a serious effort to find areas where they could collaborate which is sensible. However, they have probably reached the limit of collaboration as long as USAID has separate agreements and targets with each SMO individually.

7.3 Competing Models

Having two social marketing organizations has provided donors with a choice of approaches to SM. Competition is likely to have improved the sales of the products. Maintaining two donor-funded SM organizations is costly, however, and an important criterion for donors to bear in mind is that every new dollar spent needs to reach new people for FP.

The tension between affordability and availability is a healthy one. Having acknowledged that the growth of contraceptive market is going to be at the low- mid-market range, the two models need to ensure that their products are affordable to C and D socio-economic groups, especially for hormonals.

At the same time in an environment where funding is unstable, investments in brands today need to have a long-term impact. KSM's program has been promising to graduate the program to a commercial endeavor since it began 10 years ago. Likewise, GS needs to demonstrate that its model is growing revenues to support subsidized brands.

For condoms, the strategy of introducing multiple brands only makes sense if it can be demonstrated that having multiple brands increases usage of condoms overall and/or takes significant market share from Sathi. Donors may find it more cost effective to invest in the subsidy on the well-known brand than to invest in introducing new brands, even though the cost of the Sathi subsidy is rising.

The combination of the shortfalls on deliverables by KSM and the need to demonstrate the possibilities for the manufacturer's model indicate that it is time to graduate KSM to a commercial market. If Zafa is not willing to take up the brands and continue to sell them after more than five years of support on quality, branding, marketing and distribution, then we can conclude that a manufacturer's model is not a viable cost effective strategy, other than in building local capacity.

The newly proposed model appears to be viable and sustainable, but only until the end of this project cycle, at which point a decision needs to be made regarding KSM support and ZAFAs' viability.

7.4 Rural Expansion

Social marketing has gradually expanded into Pakistan's rural areas. Certainly, the focus of SM to date has been on urban and peri-urban areas where a majority of clinics and shops are located. From a public health standpoint, the fact that 49% of urban people have never used contraception is a compelling reason for SM organizations to retain an urban and peri-urban focus.

GS's subcontracts with Save the Children and PAVHNA have demonstrated that SM can reach an underserved rural population. GS was able to train 94 rural providers and has opened new clinics and outlets in the five pilot

districts. Likewise, at least 40% of KSM's communications take place in rural areas. Thus, SM programs are able to expand into rural areas.

However, the fact remains that reaching rural communities is more expensive than reaching urban and peri-urban areas – whether through social marketing or other RH approaches. GS' initial proposal to focus on rural areas was determined to be too expensive, and KSM's Mohalla Sanghat outreach in rural areas requires extensive oversight and backchecking. The cost analysis when compared with reaching poor and underserved urban and peri-urban populations highlights that reaching rural areas costs more. If donors are willing to pay for rural outreach, SM can reach to rural areas. Funding remains the major obstacle to expanding to rural areas.

8. DETAILED RECOMMENDATIONS

FINANCIAL

1. USAID should agree and officially acknowledge a reduction in the KSM CYP target, and consider a reduction in KSM's budget proportional with its revised CYP target to improve cost efficiency measures.
2. USAID should re-allocate funding from KSM's marketing budget to GS to develop and air new ads and IPC, focusing on the use of hormonal for birth spacing. A figure of about \$3-4 million is suggested as an appropriate amount.
3. KSM should continue to build the market share of cost-recovery brands and develop strategies for the commercialisation of those brands with reduced or no donor investment from 2008.
4. Make \$500,000 of KSM's funds available to contract a commercially-oriented consultant such as PSP-One or the Concept Foundation to work with Zafa to develop a long-term commercial interest in maintaining the Famila and Emkit brands.
5. Donors should identify sources of funding to support Sathi and other brands requiring support beyond 2008.
6. GS should have an annual external review/audit on cost recovery.

INDICATORS

7. USAID, in conjunction with the SMOs, should complete the PMP – either for each program or for SM as a whole, including baseline indicators from the KAP. If the KAP is too controversial, use the 2001 NIPS or 2006 DHS data as baseline. Indicators other than CYP should be added such as those that measure elements of behavior change – speaking with husband, visiting provider, etc. and specific indicators for birth spacing such as the number of younger women adopting a method, should be included.
8. Once the baseline variables are determined a comparative study of the indicators should be conducted in 2008.

PRODUCTS

9. Donors should continue support for IUD provision.
10. The SMOs should consider introducing different OC formulations as part of the strategy to increase CPR by increasing variety of contraceptives choice.
11. KSM should consider discontinuing selling of GS products except for IUDs.

12. All providers to be granted full permission to stock and sell all products regardless of which organization has trained them.
13. Donors and the SMOs should make a concerted representation to the GoP to review the status of OCs and authorize over the counter sales.

PRICING

14. GS should test out price elasticity by raising consumer prices and monitoring its impact on the market together with LSHTM and, ideally, KSM.
15. The SMOs, the MoPW and USAID should advocate for the relaxation of price controls on social marketing products.

COMMUNICATION

16. KSM should establish better linkages with distributors to inform them of marketing strategies.
17. SMO trade promotion offers should be communicated to the distributors and monitored closely both internally and externally.
18. KSM should develop formal marketing plans.

RESEARCH

19. GS and KSM should conduct research to measure equity of access for rural, urban and low income individuals. Ideally, such research would use a GPS so that a geographic depiction of the data could be presented.
20. Integrate clinic and sales locations with population and income data, ideally using GPS.
21. GS and KSM should conduct an evaluation of the Clinic Sahoolat and Mohalla Sangat to determine if they have had an influence on contraceptive use, e.g. have more contraceptive users attended a Mohalla Sangat/Clinic Sahoolat than non-users. The study should include cost comparison. This would clearly define the impact of the two programs.
22. GS should ensure that monitoring data collected on the day of CS is relevant and consistent, and forms part of regular monitoring of the program.

NETWORK STRATEGY

23. Although not part of the CA between USAID and GS, GS should outline its strategy for ensuring the continued prominence of GS/FP in the Good Life clinics.
24. GS should monitor the Good Life clinics to measure changes in FP provision in order to be able to address any observed decreases quickly.

25. GS should reconsider the criteria for withdrawal of the membership in the network and take down signboards of inactive members. Active members could be consulted to determine what they think should be done with the signboards of inactive members.
26. KSM should reconsider the viability and functionality of the signboards by the KSM-trained providers

ADVERTISING

27. GS to post-test their ads to make sure that the target audiences of Social Class Cs and Ds understood them and related to them.
28. KSM to revise the generic ads to eliminate the “this message brought to you by” message.
29. KSM to revise their branded ads to focus on the KSM-supported brands.

TRAINING

30. The GS training unit should prepare a separate annual training work-plan with clear training objectives which should become part of the overall annual work-plan submitted to USAID. This should be based on lessons learnt from previous experiences and should be prepared in consultation with the implementers.
31. GS annual reports for training should include the detailed lists and cadres of service providers trained in any given area, rather than only depicting numbers of health care providers trained.
32. GS should update its training curriculum. The manual should include a detailed learning guide for Multiload IUCD insertion depicting actual steps used including infection prevention and post insertion counselling.
33. Competency of the service provider should be measured using standardized tools as post test. This would facilitate in recording the quality standards in the GS network.
34. The practical competency of trainers as part of TOT, especially in the areas of infection prevention needs to be improved. GS needs to standardize the knowledge and skills of the trainers by reviewing the TOT curriculum, including periodically assessing trainers and master trainers for continued competency.
35. In order to strengthen the clinical/practical training, GS should develop clinical standard operating procedures (SOPs) for the trainers. These should be peer reviewed and approved by an independent committee comprising of obstetricians, public health specialists and general practitioners.

36. Manager health services should be re-trained for infection prevention, counselling and especially for standardization IUCD competency skill.
37. GS should not expand new GS-I trainings as the targets have been achieved. Efforts should be placed on improving quality of care by strengthening the capacity of its own training team.
38. GS should consider introducing male trainers for training male providers. Large groups for training should be avoided.
39. KSM needs to follow up on the implementation of the SBMR. This needs to be evaluated over the next two years on the basis of its technical reliability.
40. KSM should consider scaling up technical follow-up / monitoring visits to enhance and strengthen the knowledge base/skills of the paramedic service providers. This may require increasing the number of KSM training personnel.
41. Key conceptual areas of concern, including side effects, need to be revisited by KSM team and focused. Specifically for health care providers such as LHVs, her knowledge to diagnose the correct treatment of side effects and differentiate for common gynaecological problems need to be enhanced.
42. KSM should develop exit strategies on how to provide continuing support to its providers in the event of cessation of funding.

CLINIC SAHOOLAT

43. GS should continue to expand its CS program and monitor it to ensure that the quality of the activities are not compromised by desire to achieve numbers. Greater emphasis should be placed on ensuring ownership by the health care providers, community participation and confidentiality of clients.
44. Extra sterilized sets for Multiload insertion should be prepared in order to facilitate the health care provide.

MOHALLA SANGAT

45. Mohallah Sangat should continue to be expanded further to offer services in remote un-served and underserved populations. KSM should ensure that the provision of services and products in these remoter areas is consistently available to meet the generated demand.
46. There is a need to make session more interactive and of higher quality by enhancing the counselling and communication capacity of LHV.
47. The cassettes are not only translated in Urdu but also in regional languages such as Sindhi, Pashto, Saraki and Punjabi. With the expansion of KSM services in the underserved population, various clients are coming from different regional and ethnic background, and do not necessarily fully comprehend these languages. KSM should consider translating the cassette

into the additional local languages such that it becomes more effective in producing impact.

NATIONAL QUALITY STANDARDS

48. There is a need for an independent quality certification board in the country to ensure consistent quality in FP programs (may be extended to RH later on) for sustainable results. Donors should engage with MOPW to develop a coherent strategy for a Quality Certification Initiative that is supported by a sound infrastructure and a realistic and time-bound action plan. Standards-Based Management & Recognition (SBMR) program could serve as first step towards this initiative. A Public-Private partnership sector initiative should be explored to improve quality of public service delivery outlets.
49. In order to develop and sustain quality at the private sector level GoP should be encouraged to establish national standards to which the private sector can strive to attain recognition (by MOPW/ MOH).

9. Future Directions

The SM program is funded for another 2 years. It is making good progress in several product areas and increasing CYP, is leading the behaviour change in the community, and needs continued support.

Market analysis reveals that the total market for most contraceptives is flat or growing only very slowly, and is not keeping pace with population growth to grow the national CPR. While the SM component is making useful gains, this is insufficient on its own. The public sector also needs to increase uptake of its products and services. Overall, the team believes that the social marketing organizations should increase their focus on birth spacing. Social marketing's integrated approach with mass media and IPC, together with access to products and services provided by trained providers, creates an opportunity to have real impact on birth spacing. A focused social marketing effort particularly use of hormonals for women with one or two children could generate enough new FP users to create the tipping point phenomenon so needed in FP in Pakistan. Specifically, the SM organizations should follow up with FP basic providers to ensure that they are providing a balanced and positive message about hormonals and recognizing opportunities to encourage their use.

Given that most SM messages to date have been branded, there now needs to be a focus on generic behavior change messages using both mass media and interpersonal communications, as well as continuing with brand promotion. This initiative on birth spacing should be carried out alongside and in addition to the SMOs continuing work to meet the unmet demand for IUDs and sterilization. Agreement needs to be reached between the donors, particularly USAID, and the SMOs on what their respective roles are to be in relation to influencing generic promotions leading to behaviour change.

Overall, the BCC strategies were found to be good, with the exception of the "category" marketing undertaken by KSM. It is not possible for the evaluators to assess the "effectiveness" of the BCC strategies as this would require evidence of change in behaviour (i.e. uptake of FP), knowledge of products and FP, recall of messages etc. The DHS will answer this in part.

In the remaining time of the present agreement(s), major efforts should be put behind ensuring that the SMOs work as efficiently as possible in maximising their contribution to the national goals. They need help in doing this, not least of which is the development of an effective Steering Committee which has national aims at its core. The objectives for the SMOs need to be quantified in what they can reasonably be expected to do and achieve for themselves, and where they can assist in creating behaviour change which benefits the national good.

The mandates for both SMOs need a careful re-evaluation with their donors, and clarification of their goals to be achieved in the remaining two years. Simple CYP and cost/CYP targets will not suffice if the SMO contribution is to be optimised. The absence of any baseline indicators is unsatisfactory. This

is a large and important program which needs to demonstrate change. A speedy resolution of differences on the KAP information needs to be made, baseline indicators agreed, objectives to be reached by EOP, and individual SMO contributions quantified, where possible. This is not an easy process and a conscious effort must be made by SMOs and stakeholders to reach an early agreement on this.

Much has been said regarding training and quality of care, and individual recommendations have been made as to how these aspects can be improved. Particularly for GS, as it continues to expand its network and improve the availability of contraceptive methods in the private sector, effort must be put behind ensuring quality of care. Failure to do so will damage the credibility of the GS network and inhibit uptake of the services being made available.

Both Mohalla Sangat and Clinic Sahoolat are making positive contributions. These too need some refinement if their full value is to be realised.

Monitoring and evaluation is weak. The SMOs have developed, or are developing their own MIS systems which will enable better management. However, the focus of these appears to be substantially directed at internal and separate program MIS. USAID itself should not become involved in micro management, but should pay greater attention to the monitoring of how the program is progressing in terms of impact in areas other than simply CYP or cost/CYP. Whilst reporting from the SMOs is satisfactory in terms of timeliness and reporting on numeric achievements, USAID should hold regular contact meetings with both SMOs to ensure that programmatically the initiative is progressing in the right way.

In a changing environment, both SMOs need encouragement to work towards transition, if not exit strategies. The notion that the SM program is a test of models is probably theoretical. Both organisations have their own philosophies and KSM works on the basis of a PPP model with the objective of handing over to local and international suppliers, while GS works on the principle of cross-subsidisation. Both of these should be respected, and both should be working towards increased sustainability.

KSM needs a clear mandate that it should be working towards a different role in supporting and transitioning a local manufacturer within a certain timeframe. Support for this with an outside agency has been recommended. Having tested the manufacturer's model with both Wyeth and Upjohn in an earlier program, and now generic (Zafa), the team questions whether or not the time has come to graduate the model to the commercial market. If Zafa is not willing to take up the brands and continue to sell them after more than five years of support on quality, branding, marketing and distribution, then perhaps the manufacturer's model is not a viable cost effective strategy, other than in building local capacity. KSM will need to determine what it should do with Key-trained providers, the brands and the Key logo. USAID and KSM should work towards a manufacturer/commercial model program that is structured to fostering the manufacturer's interest in growing the market. This will need

monitoring and evidence of progress toward full commercialisation presented on an annual basis.

GS needs to be encouraged towards generating revenue to support its subsidised brands, and this may mean increasing funding in the short term as long as this is tied to specific sustainability objectives.

It is the view of the evaluators that allowing both SMOs to continue in a competitive environment until the end of the current funding period is probably the best way forward. They will collaborate where necessary, provided that there are common goals, but any further enforced collaboration should be avoided if at all possible.

At a national level, Pakistan needs to have an integrated approach to reproductive health and family planning. The present disintegrated approach by so many stakeholders is leading to waste and duplication of efforts and resources.

Although the policy and MTFD documents strongly support social marketing, there is no formal document and framework translating the policy directions and describing operational strategies and rules of engagement and partnership arrangements at various operational levels. This strategic framework has to consider the current situation, existing potentials and opportunities and a broader future vision for SMOs in Pakistan. In that context, the role of development partners is very crucial. They have to not only play as “honest broker” between the public sector and SMOs, but also ensure that assistance is offered for strengthening the capacity and some mechanism is developed to monitor the implementation of a new SM strategy. Expecting all these to happen without sound financial and technical assistance from development partners is literally impossible. USAID, DFID and UNFPA, among others have a crucial role in guiding this initiative, and this should be commenced in as short a time as possible.

An area that would also warrant further attention would be the strengthening of the capacity within the MoPW and DoPW, especially for pragmatic planning, management and supportive supervision. In addition, the role of both the MoH and the DoH should also be included so as to ensure a wider perspective and operational opportunities for the SMOs. Thus it is recommended that a national strategy (having individual provincial/district focuses) be soon developed. This would have favourable implications in strengthening SM in Pakistan and its important contribution in achieving the MDG targets.

Both the SMOs claim to offer services for the underserved, which does not necessarily mean the poor and people living in rural areas. Unfortunately, most of the data used by the public sector or the SMOs is not only inconsistent (in terms of defining the indicators and measurement modalities such as CYPs, undeserved and poor), it is not collated as a single source data and there is no dissemination mechanism which includes regular feedback.

The national strategy (to be developed) needs to address this issue of serving the underserved by taking into account the roles and responsibilities of each of the partners, operational feasibility and above all the willingness and affordability to pay for the services. The Public sector has to come up with a firm commitment for serving the types of population, operational strategies and innovative approaches (e.g. by offering contractual arrangements, as has been applied by the public health sector) for serving the underserved, be it poor, vulnerable or living in rural areas.

While defining a national strategy for the underserved, the operational feasibility and cost-effectiveness of the services offered by SMOs have to be considered. Thus it is recommended that the SMOs be encouraged to initially offer services to the urban slum dwellers; they are not only underserved, but not even counted in the official figures. The Public Sector Programs, including the LHW Program does not focus on urban slums, which is a growing phenomenon and would influence the national figures if detailed aggregated analysis is conducted for the health and population status of the urban slums. As discussed earlier, depending on the strategic definition for the SM, the roles and responsibilities of SMOs for rural areas need to be revisited.

Annexure 1

PEOPLE MET DURING THE ASSIGNMENT:

PUNJAB:

Dr. Anjum	Senior staff of FPAP
Mr. Amjad Abbas	Senior Manager Operations
Ms. Bushra Ahsan	Family Welfare Worker, Department of Population Welfare, Punjab, Lahore
Dr. Emmanuel Isaac Bhatti	Memorial Christian Hospital (Sialkot)
Dr. Fareeha Naeem	FP Advance, Pir Wadhai, Badar Colony
Dr. Farhana Zareef	Islamabad Office GSM
Dr. Farzana Naqvi	FP Advance KSM service provider, Lahore
Ms. Farhat	Family welfare worker, Family welfare center, SherShah DPWO Multan, Tehsil Multan Saddar
Mr. Farhat Abbass	Regional Director (Chakwal)
Dr. Firdous Suhail	Family Planning Association of Pakistan
Mr. Farooq	AMHS, Greenstar Social Marketing
Mr. Faheem Razi	Sales Promotion Officer, KSM, Lahore
Mr. Haris	Sales Manager, KSM, Multan
Dr. Iffat Umer and other staff	Tehsil Population Welfare Officer, Multan
Dr. Itrat	NGO clinic –APNA in Multan
Imtiaz Ilahi Paracha	GS I, Batool Hospital
Mr. Javed Sadiq	District Officer Health, Department of Health, Multan
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Annexure 2

DOCUMENTS CONSULTED:

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- An Evaluation of the Effectiveness of the Greenstar Clinical Training Program; Patrice M. White, Cnm, Drph, Consultant Intra-health International Chapel Hill, North Carolina, Usa December 2005
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- Review of DFID's social marketing projects, social marketing policy and strategy in Pakistan, undertaken on behalf of the department for international development, February – March 2002.
- Reports and material provided by both SMOs, KSM and GS.
- Roberto Rivera, FHI; Roy Jacobstein, EngenderHealth; Erin McGinn, FHI
- Standards Based Management and Recognition Tools / Protocols – A set of 11 tools
- Support to the inception of the USAID – DFID – UNFPA – GoP Contraceptive Social Marketing Program in Pakistan – John Meadley – DFID Health Systems Resource Center March 2004
- The Essentials of Contraceptive Technology, Robert A.Hatcher, M.D., M.P.H., Ward Rinehart, Richard Blackburn, Judith S Geller, James D.Shelton, M.D., M.P.H. March 2003
- Unwanted Pregnancy and Post-Abortion Complications in Pakistan: Findings from a National Study. October 2004, Population Council
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Annexure 3

Price Structures:

The price structures of the two organizations are as follows:

Approximate Prices & margins for KSM-supported products:

	Famila 28 (pack of 3)	Famila	Emkit	Depo	Intense/ Spark (3)	Hamdam (3)
Distributor	21	44	7.73			
Retail	23-25	46-48	8.5	76.5	19.10/3	
Consumer	30	70	10	90-100	25	10-12

GS Price structure & margins

Distributor Network :	Direct Distributors													
		Sathi	Touch-Blue	Touch-LE	Nova 1s	Nova 3s	Novodol 1s	Novodol 3s	ECP	Novaject	Magestron	Femiject	Multiload	Safeload
Trade Price	Rs.	4.00	6.40	8.10	9.70	25.80	6.15	15.60	7.65	15.30	34.42	11.47		
Distributor's Margin %	%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%		
Distributor's Margin	Rs.	0.40	0.64	0.81	0.97	2.58	0.61	1.56	0.77	1.53	3.44	1.15		
Company Price to Distributor	Rs.	3.60	5.76	7.29	8.73	23.22	5.53	14.04	6.89	13.77	30.98	10.32		
Trade Price	Rs.	4.00	6.40	8.10	9.70	25.80	6.15	15.60	7.65	15.30	34.42	11.47		
Sub-Distributor Discount %	%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%		
Sub-Distributor Discount	Rs.	0.32	0.51	0.65	0.78	2.06	0.49	1.25	0.61	1.22	2.75	0.92		
Price to Sub-Distributor	Rs.	3.68	5.89	7.45	8.92	23.74	5.66	14.35	7.04	14.08	31.67	10.55		
Trade Price	Rs.	4.00	6.40	8.10	9.70	25.80	6.15	15.60	7.65	15.30	34.42	11.47		
Wholesale Discount %	%	2.70%	2.70%	2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
Wholesale Discount	Rs.	0.11	0.17	0.22	-	-	-	-	-	-	-	-		
Price to Wholesale	Rs.	3.89	6.23	7.88	9.70	25.80	6.15	15.60	7.65	15.30	34.42	11.47		
Trade Price	Rs.	4.00	6.40	8.10	9.70	25.80	6.15	15.60	7.65	15.30	34.42	11.47		
Retail Margin %	%	20.00%	20.00%	19.00%	15.21%	14.00%	23.13%	22.00%	23.50%	23.50%	23.51%	23.53%		
Retail Margin	Rs.	1.00	1.60	1.90	1.74	4.20	1.85	4.40	2.35	4.70	10.58	3.53		
Price to Consumer	Rs.	5.00	8.00	10.00	11.44	30.00	8.00	20.00	10.00	20.00	45.00	15.00	25.00	75.00
Cost/CYP		125.00	266.67	333.33	148.72	130.00	104.00	86.67	130.00	120.00	180.00	195.00	10.00	15.00

Annexure 4

(The views expressed in this section are those of the author and not necessarily those of the entire team)

TRAINING

The following sections describe the achievements, challenges and gaps that need to be addressed to ensure continuity of the services offered to the people of Pakistan. The recommendations are presented with the desire to see SMOs to strengthen their ability to prepare private providers to deliver high quality modern contraceptive/RH services.

1. Green-star Social Marketing (GS)

The training of Greenstar Social Marketing (GS) is competency based. The training component of Greenstar focuses on building technical competency in longer-term methods, improving provider counselling skills, and integrating reproductive, maternal and child health services with family planning (FP).

The training unit is headed by General Manager Health Services. GS training network is guided through its central training institute at Karachi and operational through the three regions. The training has a wider spectrum beyond family planning and includes RH components like STI management, counselling of newly wed couples, Emergency Obstetric and Neonatal Care (EmONC), antenatal and postnatal training, and post abortion care, and Child health. The family planning training package is operational through the Greenstar social marketing and RH package is being planned to be operationalized through the Good Life network.

The training package for FP is operational through four sets of training which are entitled as Greenstar (GS) I-IV. These are tailored to different cadres of service providers. GS-I offers training of service providers for Intrauterine Contraceptive Device (IUCD) insertion based on four days of classroom presentation followed by clinical training. GS-II, III and IV training is focused on hormonal contraception.

Training Material: Greenstar has developed the following manuals on FP methods and Quality Franchise.

Serial number	Name of Manual	Year
1.	Family Planning Methods for General Practitioners – Training Manual	February 1998
2.	Clinic Training Program Trainer Manual for Female Private Practitioners	February 1998
3.	Family Planning Methods for Paramedics – Trainers Manual	Not Given
4.	Greenstar Franchise Quality Manual	September 2003
5.	Interpersonal Communication – Trainers Manual and Reference Guide	March 2006

In late 2004 a major reorganization took place in the GS management and organizational structure. Under the new structure, three operational general managers oversee three regional subdivisions. Regions are further subdivided into zones and zones into territories. In each territory there are teams/units composed of a Medical Representative who services male providers, an Assistant Manager of Health Services (AMHS) or trainer who services all female providers, an Interpersonal Communications Officer who focuses on community mobilization, and a Sales Promotion Officer who oversees all sales outlets.

Reorganization resulted changing the scope of work for the trainers. Now the trainers, in addition to classroom training and follow-up, have the additional responsibility of contraceptive sales. In each territory AMHS/trainers provides follow up services to a minimum of 80 GS-I trained private providers every four to six weeks to reinforce both clinical knowledge and skill content of the training, facilitates implementation of infection prevention practices with support staff in the private clinics, and provides the physician with needed supplies and contraceptives. In addition, trainers are expected to meet and recruit new physicians into the network as well as facilitate a given number of courses. Currently, 36 AMHS are facilitating the GS-I course. Further six vacant positions are in the process of being filled.

Clinic Sahoolat

The GS-I trainees are facilitated in increasing their clientele and enhancing the counselling / quality of care skills of the health care provider through the Clinic Sahoolat initiative, which has started in December 2005. Clinic Sahoolat is a community mobilization intervention designed to address the issues of FP through interpersonal communication. Clinic Sahoolat provides an important opportunity for further one-on-one training and feedback to the provider in her natural clinic surroundings. Married Women in Reproductive Age living in the community within a vicinity of five kilometres of the clinic are approached during a two-week period prior to the CS, and motivated clients are invited to attend the service provider's clinic and receive free FP services. The GS-I trainees facilitate the CS to enhance the counselling/quality of care skills of the health care provider. The CS also helps in increasing the clinic's clientele.

FINDINGS

1. Training Plan:

There is no separate training plan document with clearly laid down objectives, strategies and activities. Trainings are based on the work-plan submitted to USAID. This has clearly hampered the understanding of the regional and zonal offices to understand the context and long term objectives / strategies of the training in the organization.

Recommendations

- a) *The training unit should prepare a separate annual training work-plan with clear training objectives and road map lay down and should become part of the overall annual work-plan submitted to USAID.*

- b) *The training plan should be based on lesson learnt from previous experiences and should be prepared in consultation with the implementers taking a bottom up approach. This would clarify the vision and the logic to implementers behind the training scheduling and achievements.*
- c) *The annual reports for the training should also be made and should include the detailed lists and cadres of service providers trained in any given area, rather than only depicting numbers of health care providers trained.*

2. Training Curriculum:

- i. The training curriculum is about seven years old. Training manuals do not reflect most recent recommendations of WHO medical eligibility criteria. Currently, while the training includes some components of competency based training, it does not meet the standard definition of the term. The checklist for counselling skills lacks most recent recommendations. This is also noted in the “Evaluation of the effectiveness of the Greenstar Clinical Training Program by Patrice M. White - December 2005.
- ii. Missing elements include updated methodologies the guidance on how to conduct and debrief group exercises and role plays, and objectives and schedule for the clinical training, guidelines for conducting step by step insertion of Multiload, post insertion counselling. Specific details which are crucial to assure quality were missing. Both pre and post test questionnaires do not assess the practical and the clinical application and knowledge part of training.
- iii. The draft Standard Operating Procedures (SOPs) have been developed only for trainers very recently. These SOPs focus on process of classroom training only. However, standard operating procedures for clinical training are missing, which have a direct impact on the quality of care

Recommendations

- a) *GS may initiate updating of the curriculum.*
- b) *The manual should include a detailed learning guide for Multiload IUCD insertion depicting actual steps used including steps of infection prevention and post insertion counselling;*
- c) *Competency of the service provider should be measured using standardized tools as post test. This would facilitate in recording the quality standards in the GS network.*

3. Trainee selection:

The trainees in the GS network are selected from an underserved population. **Underserved population** is defined by GS as “population or household with the monthly income of Rs.7,000 which has now been raised to Rs.10, 000 due to economic growth”. New providers are recruited into the network if they meet

selection criteria of being either a qualified medical doctor or Lady Health visitor LHV having her own clinic.

4. Training Teams

a. Dimension of scope of work:

The work load over the training team after the re-organization has placed additional responsibilities on them. Interviews with the training teams in all field visits indicate that they are over stretched by having multiple tasks to achieve in a stipulated time. These responsibilities include recruitment of health care providers for KSM under those subcontracted to GS,, organizing and conducting classroom and clinical training of GS and KSM networks, follow-up technical visits, sales of IUCD, attending Clinic Sahoolat and facilitating Voluntary Surgical Contraceptive VSC activities. Furthermore the trainers are being currently trained on RH issues like STI, HIV, Post Abortion Care, EmOC, Maternal and Neonatal Health and now conducting training of health care providers in the GS network. Bi-annual performance appraisals of the training teams are based on numbers of activities conducted.

As compared to documented 80 service provider per AMHS, it was found that each AMHS was on an average covering between 80 to 100 service providers within the city of operation (fewer in Balochistan). In addition she was also covering an additional 20 to 30 health care providers outside the city of operation. This comes between 100 to 130 providers with each AMHS and there was also one of the AMHS managing 160 health care providers. AMHS has to attend 100% of all the Clinic Sahoolat activities within and at least 50% out of the city of operations (adjacent cities).The AMHS interviewed have also revealed that they have also been given the targets of selling 350 to 500 Multiloads per quarter and in some areas they are also selling Injectable. This may indicate undue emphasis on IUCD sales by AMHS. This implies that the AMHS has to achieve sales targets for which she has to visit more number of clinics over a short period of time. Thereby it is apparent she spends more time in travelling to visit more clinics, focusing on the sales and hence spending less time on providing technical quality follow up support. For providing technical support, which all by itself is a time consuming activity, one has to spend more time with the service provider in discussing problems and providing verbal and practical solutions to these. These are intensive and extensive activities and require a lot of time. This issue of scope of work distribution was also highlighted by a senior health manager personal of GS as achieving the sales targets are scrutinized on quarterly basis and AMHS are questioned if the sales targets are not met. In simple words management is assessing the performance of field staff on numbers which is tangible and not the quality which needs proper monitoring and supervision. The efforts put in the field by the AMHS and IPC team are commendable but supervision needs attention.

Recommendations

GS needs to devise the strategy based on quality to make an effective and appropriate utilization of the services of their staff. Readdress the balance between marketing, and technical responsibilities of training staff. The

responsibility of sales from the training team should be taken and given back to the sales team. This would give time and space to the training team to concentrate on the training and providing quality follow up visits. The training section of GS needs to regroup itself to sustain the quality standards set over a decade of efforts. The skills of AMHS to supervise and provide technical support needs to be enhanced.

b. Training Team and its competencies

The training teams are trained on the related subjects. This training of trainers primarily takes place either on on-job or in training of trainers' event. There appeared differential levels of competencies and infection prevention skills along with knowledge of the training teams. This was evident through interviews and observations made in the field. This also has a direct impact on the training, quality of care assessment and follow up support offered by the training teams. Since GS is also training KSM's service providers, this scenario will most likely affect both GS's network and also the KSM providers and also other partners.

It appears with the field visits and after witnessing the trainers in the field that there is lack of standardization and competency for the practical training for Multiload insertion techniques. Further there is lack of uniform and consistent infection prevention techniques practiced by the trainers in the field. Many variations exist in the actual insertion techniques mainly regarding sequencing of steps and handling of instruments. Contaminating disposable 'clean' gloves, touching insertion instruments, failing to swab vagina and cervix with antiseptic solution before sounding of the uterus and insertion of Multiload were also observed.

It appears that due to reorganization, recent recruitments and scaling up of activities, GS is not able to keep pace with the quality of clinical skills of trainers. The TOT for family planning was held in June 2005 and AMHS met were working from three months to one year. Interviews with trainers revealed that they are either trained by their fellow trainers or receive on job training through merely observation of trainings conducted by the manager health services and fellow trainers leading to lack of standardization. Trainers were also hired from the GS-I network and were assumed capable of training.

It was ironic to note that in the field even when there was chance for the manager health services to identify gaps in the practices and train the trainers as well as the health care providers, the attitude of the managers of field staff appeared very casual.

Recommendations

- *Improve the practical competency of trainers as part of TOT, especially in the areas of infection prevention. GS needs to standardize the knowledge and skills of the trainers by reviewing the training of trainer's curriculum. Periodically assess trainers and master trainers to ensure their continued competency.*

- *In order to strengthen the clinical/practical training, GS should develop clinical standard operating procedures (SOPs) for the trainers. These should be peer reviewed and approved by an independent committee comprising of obstetricians, public health specialists and general practitioners;*
- *Need to prepare, integrate and implement a monitoring plan to ensure quality within the training unit.*
- *It is imperative to standardize and update the knowledge and skills of Manager Health Services in clinical practice and operational management. Manager Health Services should also be monitored by a technical person for standardizing his/her management practices and technical skills. Manager health services should be re-trained for infection prevention, counselling and especially for standardization IUCD competency skill. This implies and calls for Manager Health services at the regional level to be more vigilant in the field for the quality of training for her trainer (AMHS) in the field. In order to make the field visits more learning and competency based there is need that the master trainers should first enhance their competency and they should make good use of field visit to build the competency of her AMHS and the health care provider. This practice will help the manager health services as master trainer to assess trainers as well as providers post-training competency which is output of the training imparted to the trainers.*

c. Training is based on targets

Targets are set out by the Head Office in Karachi. The trainings planned centrally and target based. It appears that the targets are linked to reflect in the increase in sales of the FP products, eventually reflecting in the CYPs. Neither the Regional nor the Zonal Offices in their responses were clear about the methodology of target settings.

In order to conduct training for ten health care providers for GS-I, AMHS has to recruit at least twenty to twenty five health care providers. This enables the AMHS to ensure that at least 10 participants attend the training per quarter. If the number of participants comes down to nine, then the training is not held. Thus even the willing health care providers have to wait till the time ten participants are confirmed. This is a very cumbersome process and consumes a lot of time of AMHS. Furthermore, this requires extensive travelling and search for new service delivery outlets;

Further, interviews with field staff clearly showed that there was anxiety regarding the recruitment of new health care provider (HCP) for achieving targets for GS-I training because there is saturation and clinics are not opening with the same pace as targets given and in addition to that another factor is either refusal of health care provider or criteria is not fulfilled. During the field visits and discussion with the health care providers in GS network, it appeared that some of the service providers had received FP training from GS, KSM and the public sector. This whole phenomenon appears to be the result of target driven trainings and recruitment. It is evident that there is duplication of efforts, wastage of resources and thus, there appears an element of expansion of network rather than consolidation, which is affecting the quality of training, services and care. Further this is also augmented by the responses of the field staff trainers of GS who are

now finding it difficult to find new health care providers in their respective areas. Furthermore, GS-I service providers are also not oblivious of this fact.

A doctor in Nowshera mentioned:

"I have never bought a single product from Green star because I do not get a single client. However, right besides my home is the RHS "A" centre".

(The Green star board was placed outside her home situated in the vicinity of the DHQ Hospital.)

A GS-I service provider in Peshawar when asked about the number of FP cases coming to her responded:

"I am not receiving much of the family planning clients as the location of my clinic is not central in the community".

It was also ironic to note that one homeopathic doctor in Sindh was trained as a GS-I service provider. This is against the medical rules and ethics to train an unqualified person in invasive medical procedures.

Recommendations

Training should be conducted not for head count or for the sake of it but the true spirit of training should be kept alive as it is not commercial marketing but social marketing for social good and social cause. Training should not only be done for the sake of expansion but also for the sake of building capacity.

d. Training Targets

Ever since the inception of the training program, a total of 21526 person trainings have been conducted. Among these, 16719 person trainings have been done on family planning. However, only 10,159 are recorded and followed up in the GS MIS. The remaining 6560 have either been termed as loss to follow up or closing down / shifting of clinics. Among the current 10159 service providers on the MIS, 48 percent (4838) have been trained under the USAID training. There are 6,415 projected active currently including USAID trained. Details are given in table 1.

Table 1: Number of Health Care Providers Trained since inception of program and active GS providers as on March 2006

Total person training since 1995	Trained on FP	Recorded in current MIS	Lost to follow up	No. Trained under USAID funding	Active GS Providers currently
21,526	16,719	10,159	6,560	4,838	6,415

The target for family planning training under USAID over five years was 2500¹⁰. This training target has been over achieved and so far 2777 person trainings have been conducted. The major over training that has been done is on FP Advanced GS1 where the target has been overachieved by 133 percent. For details, please refer to Table 2.

Table 2: Categories of Health Care Providers Trained under USAID funding as of March 2006

Serial no	Category of service provider	Total Training Target under USAID funding for five years	Number trained as on March 2006	Percentage target achieved as on March 2006
1.	FP-Advanced (GS1)	1,500	1,998	133
2.	FP-Basic for General Practitioners (GS2)	550	462	84
3.	FP-Basic for Paramedics (GS4)	450	317	70
	Total	2,500	2,777	111

In addition, according to the MIS of GS, in addition to the planned trainings, 560 other trainings have also been conducted with 26 service providers having been trained in family planning voluntary surgical contraception under USAID. Details are given in table 3 below.

Table 3: Other Categories of Health Care Providers under USAID funding as of March 2006

Serial no	Category of service provider	Number trained as on March 2006
I.	FP Advanced Certified (Associates)	399
II.	Chemists (GS 3)	145
III.	Family Planning Voluntary Surgical Contraception	26
	Total	560

For reproductive health trainings, the actual implementation is according to planning; however none of the trainings are reflected in the MIS of GS. Please refer to Annex – A on Greenstar Training Components¹¹.

Training Status in Rural Areas

According to the USAID RFA 391-03-03 *Greenstar Program Monitoring and Evaluation Framework*, and the outcome indicator **“Number of new Greenstar providers/franchisees trained”**, (Annex – B) Greenstar had planned to train a

¹⁰ Greenstar Monitoring and Evaluation Framework

¹¹ Traini4ng_Data_year_usaid_MIS(1).xls received via email on May 1, 2006

total of 50 health care providers in five rural districts in Pakistan in year two and three of the project. So far GS has trained at total of 54 health care providers in rural districts. Details are given in table 4.

Table 4: Health Care Providers trained in rural districts as of March 2006

District	Total No. of Providers				Total
	Urban	Rural	Katchi Abadis	No Info	
Swabi	0	13	0	17	30
Swat	4	25	0	17	46
Haripur	16	0	0	31	47
Abbotabad	7	1	0	16	24
Larkana	13	15	0	8	36
Total	40	54	0	89 (49%)	183

The issues that need to be addressed are the following:

1. What were the assumptions on the basis of which training a total of fifty health care providers planned by GS for five districts?
2. How will the results of the planned training of fifty health care providers be used for future planning and expansion to other rural districts?

Training only fifty providers in five years in five districts is not substantial input for producing substantial results which can be replicated as evidence. It is not clear whether this rural pilot was an operational research or conducted to test the ground realities. In either of the cases, the figure of fifty health care providers in five years in five districts is too small to provide any tangible difference of either health care seeking attitude or making any substantial difference to advocate for future expansion. With rural migration to urban areas, and increasing settlements in peri-urban settings, it is ironic to note that no interventions were designed for peri-urban settings. This issue is further discussed below.

Recommendations

GS should not expand for new GS-I trainings as the targets have been achieved. Efforts should be placed on improving quality of care by strengthening the capacity of its own training team. Extensive supportive supervision and monitoring of the service providers should be planned to ensure and sustain quality of care.

For any other recruitment like for RH training etc, there should be functional integration and facilitation by the sales team, IPCO team and AMHS for the process of recruitment.

5. Training Activity Process

During a FP basic KSM training conducted by GS, it was observed that there were very large group of participant for hormonal training comprising of both male and female participants. There was lack of concentration among the participant due to non serious attitude of the male health care providers, which hampered the understanding of concepts and specifically handling the issue of side effects. Male participants were also teasing the female trainer which was quite appalling.

Recommendations

Option for male trainer will be better for training male providers. Large groups for training should be avoided for better results.

In summary, it seems that element of expansion of network without consolidation, has affected the quality of training, services and care. Further, it appears that during reorganization, the training department was not given due attention which has led to compromised technical capacity of the training department and also affected the supervision and monitoring mechanisms. Technical staff seemed over powered by the management staff. The quality of training and follow up is further affected by the additional responsibility of meeting the sales targets. Sales and training are diverse objectives which need different processes to achieve their respective outputs leading to deviation of training teams from their actual objectives.

Recommendations

There should be reinforcement of training department by strengthening not only the technical wing but also supporting and involving them in the decision making. Technical personal in the health services should be involved in annual reviews of the field staff. There need to be an appropriate mix of technical and marketing staff at the senior management level in managing health services thereby achieving both objectives of quality in training and marketing equally.

6. Clinic Sahoolat

Clinic Sahoolat is creating awareness among the masses and providing an opportunity in bringing clients and service providers together for availing family planning services. There are certain necessary issues which need to tackle with in order to make good use of this prospect.

Clinic Sahoolat started in December 2005, data was only provided for two months. The data provided by GS on Clinic Sahoolat is indicative of enhanced coverage and offering services to a wider number of people over two months i.e. February – March 2006¹². However, it is important to note that despite the increase in the absolute numbers of clinic attendance and FP users, yet there is a four percent decrease in the number of FP adopters as shown in table 5.

¹² Clinic_Sahoolat_Report_Feb_March_06_(1).xls

Table 5: Clinic Sahoolat Records of GS - February & March 2006

Serial number	Area	February (number)	March (number)	Percentage effect
1.	Clinic Sahoolat	226	448	198 %
2.	Number of Clients attending clinics	6,933	15,255	220 %
3.	Number of Family Planning Adopters	2,876	5,654	196 %
4.	Percentage of FP adapters out of total clients attending	41%	37%	<u>- 4%</u>

Further the data provided is also not complete. This has hampered further analysis of RHS and cannot be commented on at this stage. Interestingly there are 25 cases of VSC for men referred from an activity which is conducted only for women. Please refer to Annex – B for details.

However, another data set provided for the months of March 2006 to May 2006 (Annex – D), reveals that the average number of clients per Clinic Sahoolat has dropped to 23. Further over the same period 256,637 tokens for attending FP Clinic Sahoolat were distributed. However, only 14 % (36129) tokens were received. Thus there appears to be a gap in the concept and implementation of Clinic Sahoolat, which needs to be revisited and corrected to make it cost effective and efficient.

The AMHS is responsible for collecting baseline information on the clients. In this basic data collection, she records the family planning utilization practices but there is no provision to collect demographic information of the clients on that given instrument. However it was told by the head office staff that basic demographic data is recorded by the Female outreach worker/Female health worker during the field visit and the visiting card given to the client. Demographic, family planning and reproductive health information are recorded on three different tools. GS has not been able to manage this data set. This renders the valuable information as useless as most of it is not used. Collecting information places an enormous burden on the resources and non use of information hampers further planning and concept of responsive management. However this data has so far not been analyzed and shared with RHS. This limits utilizing such vital information.

In a Clinic Sahoolat event, it was noted that the AMHS was wrongly noting the client's FP information by even declaring a current modern method family planning user to be a new user to start modern family planning method. This is an indication of meeting targets of getting new clients and hence the reliability and validity of the data generated from Clinic Sahoolat activity is questionable.

Clinic Sahoolat is an innovative idea to bring community and provider together for availing family planning services however there are certain issues and challenges which need to be address to continue the initiative.

Clinic Sahoolat is conducted for a community living in a radius of five kilometres of the trained GS-I health care provider. This is questioned due to following reasons:

- i. In the urban settings, there are multiple health care providers almost practising besides each other. In such situation an important issue that need to be explored further is the misuse of the free facility by the current users.
- ii. Health Systems Research in Pakistan has revealed that community does not utilize primary health facilities if the static health facility is more than one kilometre or 20 minutes walk from their residence. There are no follow up mechanisms to keep a track of current and new users of modern family planning availing services from this initiative. It was interesting to note that in one of the Clinic Sahoolat, clients were asking for the location and time of the next event as they could get the services for free. One of the doctors where clinic Sahoolat was held three months ago in Karachi said,

“FP clients came to the GS Clinic Sahoolat as they wanted to avail the free facility. At that time it was just like a sale in a general store, but with passage of time the number of family planning clients seeking services is very negligible”.

Discussions with the clients revealed that most of them were already using some type of family planning method. They had come to the clinic Sahoolat since it was a free clinic and for changing their current method of family planning. Most of the clients already had five to six children and adaptation to the modern method of family planning clearly indicated limiting family size. This explicitly suggested that the current approach is facilitating the scope of limiting family size rather than optimal birth spacing. Initially women in reproductive age were mobilized to come to the Clinic Sahoolat, whereas now since May clients are specifically called for family planning.

Mixed responses and experiences were recorded by the health care providers during field visits. Service providers specifically the doctors gave preference to their normal OPD clients, which delayed and affected the spirit of Clinic Sahoolat activity. The doctors gave more preference and priority to their normal clients. Clients were clamped together sitting in the OPD waiting area and doctor’s room but the doctor were busy with her OPD clients. The lady doctors expressed the concern that this activity was affecting their private practice as they could neither give quality time to regular clients and nor to FP clients and also could not charge to FP clients which would affect their private practice. A dichotomy was observed where by products were being charged for but health care provider was asked by GS not to charge the FP clients during the Clinic Sahoolat activity. This can lead to lack of trust or confusion among client and doctor in future. However doctor allowed the AMHS to continue the activity in either separate room or waiting room where AMHS and the field staff conducted it all by themselves. Another clinic Sahoolat was conducted by the AMHS herself without the lady doctor in the clinic

where the event was organized. One of the objectives of Clinic Sahoolat is to enhance the counselling and quality of care of the doctor by the AMHS which was not being served. This attitude and responses when discussed with the AMHS revealed that it was a challenge for them to convince the doctors for the Clinic Sahoolat activity. One of the service provider suggested that each of the motivated clients should be given special cards and she would treat them free but all of them should not be called in at one time together it cannot be managed.

Lady Health Visitors however seemed interested in Clinic Sahoolat due to two reasons. First was that Clinic Sahoolat increased their cliental and the second reason was the free availability of expert opinion in the form of a lady doctor. The mere presence of AMHS was an image booster. In another clinic Sahoolat in a major urban setting, most of the clients did not agree to any modern FP method and responded that they would consult their husbands and this was due to compromised counselling capacity of health care provider.

Observation in Clinic Sahoolat showed that confidentiality and privacy is at stake and compromised due to factors like inadequacy of space in the clinics to accommodate all clients at one time and also the urgency among the clients to go home earlier after utilizing services made them enter the doctor's examination room. This further leaves negative impact on the waiting clients as they could sense the discomfort of the client undergoing the procedure of insertion of IUCD behind the curtain which in most of the clinic is used for screening. It was evident by conversation among the clients for not opting to adopt the IUCD method. It was further confirmed by probing one of the motivated clients who was leaving and refused to sit back and wait for her turn. She said that she just wanted to leave as she could not undergo through the same experience which the client inside was suffering from.

Many missed opportunities were noted. The lady doctor providing the services was working along with her husband who was also offering the medical services to the male clients. On enquiry, it was noted that neither the staff nor the male clients had any idea of what was happening in the same clinic providing "Clinic Sahoolat". In addition, it appeared that though it was claimed to be a free service, the lady doctor was still charging fees for the services besides the price for the product and in addition the doctor also refused to sell condoms and pills demanded by one of clients in spite of those products lying on her table.

Clinic Sahoolat activity attribute to a good number of CYPs in a given time. However it is followed by sale personnel for increased uptake of commodities. There is no MIS with the service providers for the follow up of clients who were motivated and new adopters in Clinic Sahoolat activity. This lack of follow up does not reflect that the client converted for FP had compliance, rejection or change of method after Clinic Sahoolat event. It implies that client coming to Clinic Sahoolat and using any of the hormonal or temporary method attributes to the CYPs for that given time when she visited Clinic Sahoolat. She may or may be not protected for rest of year. In order to clarify it further actual objective of CYP is fulfilled when 130 cycles of pills are given to 12 people rather than 130 cycle of pills given to 130 people. This operational initiative is a missed

opportunity to record community based method specific utilization rates, and drop out rates;

While organizing the Clinic Sahoolat, limited interaction with the community had its own implications. AMHS told that in one of the clinic Sahoolat activities held ten Multiloads were inserted, and it was termed as a record number. During the time of activity, the local religious leader made announcements against the activity and family planning. Six out of ten women came back within the hour and got the Multiload removed. This is attributed to an ambitious work-plan of field IPC staff deputed for this purpose as one clinic Sahoolat is expected out of this team per week. It is critical to note that work plans of the field IPC does not give them time to reflect upon their weekly / monthly progress and re - adapt to any new challenges that they face during the field activity.

Clinic Sahoolat will be held biannually for each GS I outlet i.e., once in six months. While talking to the head of Lyari Community Development Project (LCDP) who has a long term experience with the project of community mobilization and behaviour change communication specially with CBO model. He commented that behaviour change could not happen or occur by working with community for one week twice a year. He further commented that women in the community were not allowed to go out alone and maximum not beyond their street. This was an urban squatter area, with low literacy rate. He said that fact of the matter was that FP was not a priority for the community. The LCDP also feels that the GS Network was charging higher fees and the clients may not come for follow up. Similar comments were also made by PAVHNA, who are facilitating the rural expansion of GS. This concern was shared with GS and the reply was that there was no flexibility in the model.

Similarly, the male neighbourhood meetings gave mixed reactions. While some had generated good interaction and dialogue with the participants and others appeared to be just passive participation and listening to a lecture. The impact/outcome of these meetings is dubious.

In summary confidentiality, privacy, counseling, infection prevention, MIS generated from the clinic Sahoolat activity needs attention.

Recommendations

- a. *Maintain a uniform policy of charging at the Clinic Sahoolat where either none of the two parties i.e. GS and Service Provider should charge or both should charge. The preparation for Clinic Sahoolat should be more organized to ensure ownership by health care provider and community;*
- b. *Number of Clinic Sahoolat activities planned needs to be revisited to ensure provision of quality during the activity in order to achieve its objectives. Devise a system where confidentiality and privacy of the clients is maintained and need to be improvised in a way that it does not have negative and de motivating impact on the rest of clients waiting in the facility. Prepare extra sterilized sets for Multiload insertion in order to facilitate the health care provider;*

- c. *GS should strengthen its MIS as incomplete data has no value for feedback and future decision making. There should be enhanced monitoring of data collected on the day of the activity to ensure reliability and validity. GS should immediately jot down the data management strategy otherwise purpose of putting that much of resources goes waste and un-served;*
- d. *The focus of Public Sector's Health Care Delivery System, NGOs and Partner Organizations is on urban and rural areas. However, due to internal migration to urban areas, the peri urban areas are expanding rapidly without a planned infrastructure and services. This places a challenge to the health sector to ensure availability and delivery of services in urban squatter areas.*
- e. *It appears that there are a lot of assumptions for increasing the clientele for the providers and the impact/outcome of new model of IPC may need to be evaluated. It should be a third party evaluation of clinic Sahooat at the end of first year of its inception. This evaluation should be sub contracted by USAID directly.*

REPRODUCTIVE HEALTH PACKAGE

1. GREENSTAR SOCIAL MARKETING (GS)

Greenstar Social Marketing has introduced a reproductive health package in its training program under Good Life. The elements of the RH training program include the following:

- Post Abortion Care;
- Syndromic Management of STIs;
- Emergency Contraception;
- Antenatal/postnatal Care;
- Emergency Obstetric care;
- Neonatal Care; and
- Child Care.

During interaction with the GS network service providers, it was noted that providers interviewed were missing the opportunity to discuss reproductive health issues like STIs etc. during counselling. In addition IEC materials on the topics like RH, STIs, and HIV/AIDS were lacking.

KSM is only focusing on family planning and do not address any other component of family planning.

Voluntary Surgical contraception both for males and females were advocated for and practiced in the RHS "B" centres through which GS operates. It was revealed while talking to a doctor in health department during field visit that the clients referred are well taken by the RHS-B centres of GS as they respond to the client of VSC promptly. An in charge doctor of RHS "A" in Dadu was also hired by the GS in the private hospital (RHS "B" centre) where she was conducting tubal-ligation in the evening. A few of the providers also register their concern that some women developed psychotic problems after getting the procedure done and this shows the lack of proper counselling.

2. KEY SOCIAL MARKETING (KSM)

Prior to the current USAID financial support, KSM was only imparting half day hormonal training to the service providers. This training package has now been increased to include training of female health care providers for IUCD insertion under FP Advance course and Standard Base Management and Recognition Program. Training is subcontracted to four organizations named Family Planning Association of Pakistan (FPAP), Memorial Christian Hospital (MCH), Reproductive Health-AID (RH-AID), Greenstar Social Marketing and technical support is provided through the JHPIEGO. The training of trainers of the sublet organizations was done by KSM to ensure quality standards across the four organizations.

JHPIEGO has been instrumental in developing the following manuals on FP methods for Key Social Marketing:

S. NO	Name of Manual	Year
1.	Hormonal Contraceptive Technology Update for Service Provider – Participant’s Notebook	2004
2.	Hormonal Contraceptive Technology Update for Service Provider – Participant’s Notebook in Urdu	2004 – 2005
3.	IUCD Guidelines for Family Planning Service Program – Participant’s Handbook	October 2005
4.	IUCD Guidelines for Family Planning Service Program – A Problem Solving Reference Manual	October 2005
5.	Essential Elements for Contraceptive Technology – A guide for clinic staff – Urdu	March 2003
6.	Standards Based Management and Recognition Tools / Protocols – A set of 11 tools	March 2006
7.	Mohallah Sangat Program for Paramedics	January 2006
8.	Mohallah Sangat Program – Male Mobilizers Guide	January 2006

These training material for both hormonal and IUCD insertion are consistent with most recent updates in FP globally including “Essentials of Contraceptive Technology”, “IUCD Guidelines for Family Planning Services Programs”, Clinical Training Skills”, and “WHO Medical Eligibility Criteria”. KSM training team is also in the process of preparing and adapting reference checklist for screening the client for different contraceptive methods according to WHO criteria.

SBMR is a joint quality training initiative of JHPIEGO and Futures Group for private sector providers. It is an alternate program proposed in KSM for Quality Certification Program. It has been tested by JHPIEGO in other countries successfully. The overall purpose of SBMR is to attract great number of FP clients seeking services and to generate an increased number of satisfied clients through improved client-focused quality of services from private sector providers. According to this performance and quality improvement model there will be improved and sustained provision of quality FP services by private sector LHV’s. **KSM health care providers** identified and recruited from an identified **underserved population** of a town comprising population of less than 25000.

Performance standards applicable to FP services for IUCD, pills and injections have been adapted and developed to achieve compliance with at least 80% of performance standards. SBMR Facilitators have been trained for conducting baseline and follow up assessments and monitoring visits. This facilitates in application of performance standards to conduct base line assessment for identifying gaps and root-cause analysis of provider's clinics, resulting in development of action plans with provider clinics. The implementation of these action plans takes place in which the service providers are trained under the training package prepared by KSM/JHPIEGO. Simultaneously it is be integrated with other KSM components like enhanced Sales Support for facilitating resource-needs like job aids, IUD kits, chlorine, product supply and IEC. For enhanced follow-up, trained service providers are linked to KSM MIS and for regular capacity building refresher courses and follow up visits are scheduled. Trained service providers are then advocated in the community by the Mohallah Sangat program activity on priority. Monitoring and evaluation is envisaged to measure progress by performance standards tools through self assessment by both SBM providers and Facilitators. As incentive for the service providers' adherent to the quality of care, they will be awarded the certificate of recognition.

Initially for two years while KSM was in the process of building team for implementation of training, local team of consultant as a substitute was developed to facilitate the process and technical support.

Training team of KSM is headed by the Training and Quality Manager supported by two Training Program Officers (TPO) and three Training and Quality Coordinators (TQC) for each region.

TQCs are responsible for finalizing the training plan, liaise with the partner training organizations monitor training quality (non-technical), conduct quality check and collect feedback on the training from providers, support the information system to ensure consistent and reliable reporting, provide logistic, recruitment support for the IUD refreshers/Skill Enhancement and SBM-R and assists TPOs in verification and baseline assessments of the recruited candidates.

TPOs are also responsible for monitoring trainings and providing technical support to the trained providers in the field, supervise training and quality coordinators, coordinate with components like sales and Mohallah Sangat, maintain data on sales and training for the respective regions and provide field and technical support in ongoing research.

In 2005 follow up once in a quarter for FP basic trained providers was carried out by the training an organization as it was part of their scope of work. Although KSM had inbuilt monitoring system lay down but they had to rely on subcontracted partner organizations as there were no means to verify provided information. However KSM is doing follow up of 25% of providers trained on hormonal methods this year. The follow up is done by Training and Quality Coordinators on an average back-check of 2-3 training workshops each month and 25% back checks of the trained providers. For ensuring the quality of the trainings conducted by various organizations it is responsibility of local JHPIEGO consultants to support more than to monitor. KSM ensure in almost 60-70% of training workshops either for all 6 days or for 2-3 days

during practicum are attended by either Training program officer (TPO) or consultant attends either for full 6 days or for 2-3 days during practicum. It is need based and there is an element to support in building capacity of training organizations in as many training workshops as possible and also to give feedback and inputs to KSM training team regarding further training needs.

For FP Advance trainers, two strategies are being followed as follows:

1. KSM conducts a group follow up in the form of a refresher for IUCD trained providers. It is a half day activity called Skills Enhancement workshop. There is provision of interactive discussion on the practical issues dealt by them with IUD services in field and also to refresh their skills on insertion and removal on Zoe models;
2. Those providers who were not able to attend above workshop were then scheduled to be followed up by the Training Program Officers. In addition technical follow up of IUD trained providers are being done by Training program officer. The follow up of IUCD trained provider for quality assurance is carried out by Training and Quality Coordinators and also by one of their JHPIEGO consultants in the field. Training and Quality Coordinators pays five visits per year to the IUCD trained providers for the quality assurance. There are follow up pre tested performance based SOPs being implemented for the sake of monitoring.

Mohalla Sangat is the community based activity for interpersonal communication conducted by KSM. There are ten sessions comprising 5 basic and 5 follow up sessions conducted by LHV during two months. This activity is conducted in area comprising less than 25000 populations identified by the sale promotion personal and verified by Mohallah Sangat field supervisor. Lady health visitors serving in that area are selected who either have less clientele for FP or have established new clinic. After their consensus they are hired on contract for 2 months. They are trained for this process for two days for conducting these sessions for counselling and motivating married women of reproductive age. In addition to that she has to maintain a record by registering all the clients who attended the sessions and adopted any of family planning for following them up for discontinuation, rejection or change of method and new adopting clients for one year. Place for session is decided during training and basic starter products are handed over to them.

Each session comprises of 12-15 participants among these participants two are users, three are ever users and rest are non users. There Cassettes comprising complete information on FP methods for barrier and hormonal methods, IUD and emergency contraceptives are listened and clarified during sessions by the LHV to the participant in the basic sessions. Cassettes are provided and asked to listen with their husbands and are also encourage to pass on this cassette after listening to any of married female family member or friends interested to listen or they think is potential for family planning. They are followed up in follow up sessions where their queries are clarified and they are facilitated to adopt any of methods as all products are displayed in both the sessions. Female field supervisors randomly checks 25 percent of the clients coming to sessions after the completion of two months activity. If there are more interested clients in her area than she can join in again and starts the process again. Feedback meeting with LHVs is held to discuss their successes,

challenges, problems faced in field. **Mohallah Sangat for Males** is held in same area by Male field mobilizers and a video cassette has been developed, pre-tested and is being used.

Client Meeting: An activity in which LHVs who have conducted Mohallah Sangat activity successfully for more than one year are requested to bring their regular satisfied clients for whole one year. Experience of these clients are discussed in addition to their initial queries and behaviours for not adopting family planning and they are further encouraged to talk to the peers and family members. They are also probed for the new adopters in the family after their successful experience.

Sale/Technical Feedback Meeting: LHVs of an area who were previously involved in Mohallah Sangat and trained for FP basic were invited. Renowned Gynaecologist of that area who has good reputation among the LHVs and clients was invited. The purpose of this meeting was to build liaison among the gynaecologist and LHVs for enhancing their knowledge for FP methods specifically clear understanding and management of side effects and also build a referral linkage among them. Common presented side effects by their clients are identified by showing them various transparencies and then gynaecologists were asked to clarify the queries with evidence proven by literature and brief for the management.

FINDINGS

1. Training Plan

There is a laid down training plan for the years 2005 and 2006 with written targets, quarterly schedules and geographical areas defined. There is a responsive management environment with futuristic planning and a well established documentation system.

2. Training Curriculum

The training curricula for both IUCD / hormonal training have been updated and standardized focusing both classroom and practical training using WHO criteria. Under the Standard Based Management and Recognition (SBM-R) eleven Performance Standards Assessment Tool tools have been developed by KSM with technical assistance from JHPIEGO. These are extensive quality assurance tools which facilitate in determining the level of quality of both the service providers and service outlet. These tools are extensive and intensive to manage. Since the health care providers trained for SBM-R will be lady health visitor there are challenges need to be addressed. Course along with terminologies could be difficult to comprehend by lady health visitor because of their limited knowledge, capacity and level of education.

Although, there is updated training curricula for all purposes but in order to achieve the sound impact KSM seem to have limited capacity in terms of number of staff for supervision and monitoring. Currently there are only five staff members to monitor, and provide support to ensure quality for the three regions. Therefore ongoing supervision and monitoring will be a challenge for KSM.

KSM is in the process of developing WHO medical eligibility criteria for desk reference both in English and Urdu language, Family planning choices wall chart being translated in Urdu.

KSM is also in the process of preparing following job aids for providers, particularly for SBMR:

- a) How to be reasonably sure that a woman is not pregnant.
- b) Hand washing and infection prevention.
- c) Steps to prepare chlorine for infection prevention in a clinic.
- d) Rights of clients.
- e) Management of side effects with pills, injections and IUDs.

Recommendations

- a) *Though the contents of SBMR are both extensive and intensive, as an operational research initiative it needs to continue to demonstrate that quality assurance is the critical most issue in service provision. However, KSM need to improvise an organized system in place to take this initiative very carefully to meet its objective in true sense. Course need to be simplified and translated to bring to the level of lady health visitor because of their limited knowledge, capacity and level of comprehension.*
- b) *There is a need for an independent quality certification board in the country to ensure quality in family planning programs (may be extended to RH later on) for sustainable results. There is need to develop a coherent strategy for Quality Certification Initiative that is supported by a sound infrastructure and a realistic and time-bound action plan. However, it seems quite challenging in the given unregulated private sector scenario in the country but it can always be advocated to the GOP. For sustaining the quality at the private sector level advocacy can be taken up to attain recognition by GOP.*
- c) *Standards-Based Management & Recognition (SBM-R) program if proven could serve as first step towards this initiative. As Public-Private partnership sector initiative can be taken up to improve quality of public service delivery outlets.*

3. Training Teams:

There are no training teams of KSM. Current outsourcing of training to four different organizations has posed challenges which include:

Maintaining a uniform standard of training among the four sub-contracted organizations is by all itself a challenge. Although it has been taken care of by training the trainers in these organizations by KSM but with reference to SBM-R it becomes more challenging.

One of the critical issues noted is the continuity of rapport among the service providers and KSM in follow up visits. Health care provider is trained by a sub contracted organization and they are followed up the staff of KSM. This creates a missing link between the health care providers and the KSM's follow up technical

teams, leading to a sense of disruption and confusion among the service providers about the follow up plan and activities

Coverage remains limited for Female Service Providers for IUCD as only 507 service providers are trained in 10 districts of Pakistan. KSM envisages expanding its network of service providers trained on IUCD insertion. Quality of Care is questioned as the KSM own team is limited in number and there was inadequate technical follow up due to limited staff. Number of service providers trained in hormonal contraceptives is about ten thousand. Technical support to the FP basic providers is found limited. However, it is questioned on how KSM will be able to maintain its quality of SBMR training and will provide follow up technical support. Maintaining standards of quality of care would be a challenge for the KSM with the increase in number of trained clients and specifically SBM-R providers.

In addition, in field it was found that the link between training organization, sales promotion officer, Mohalla Sangat component needs to be enhanced.

Recommendations

KSM needs to follow up on the implementation of the SBMR. This needs to be evaluated over the next two years on the basis of its technical reliability. KSM should consider establishing and expanding its own training team which should also be responsible for providing technical follow up and monitoring. Establishing the training teams is critical as in addition to ensuring implementing quality standards, it would be a complete model of SBMR which if proven successful, could be scaled up in future.

Training people does not imply that quality can be assured alone with training but there is need to establish and maintaining the process of monitoring and supervision in proper way for maintaining the standards of quality of care which KSM has to prove.

4. Training Participants

The selection criteria for training participants are as following.

Health Care Provider should:

- from an area less than 25,000 population;
- not have received FP basic training within one year from GS;
- have received any training on FP advance training from GS;
- have her own clinical setup; and
- Health Care Provider for SBMR should be an LHV serving a population of less than 50,000.

Technical knowledge of paramedic service provider trained FP basic trainings is adequate but counselling skill and management of medical problems remains limited. This was obvious in cases of management and referral of clients to higher level physicians for management of gynaecological problems. It is found that paramedics are not able to differentiate between gynaecological problems and side effects. This could be attributed to two factors:

- i. The standards of training by four sub let organization are only checked in 25 percent of the trainings and thus the standardizations among training is questionable;
- ii. There are limited technical follow-up visits and hence the level of knowledge base is likely to go down over the period of time.

It becomes challenging when SBM-R is taken in account as lady health visitor is the candidate for training. However, it is observed that they are more responsive and there is more trustworthy relation with the community.

Recommendations

KSM should consider scaling up technical follow-up / monitoring visits to enhance and strengthen the knowledge base / skills of the paramedic service providers.

Key conceptual areas and side effects need to revised and focused. Specifically for health care providers like LHV, her knowledge to diagnose the correct treatment of side effects and differentiate for common gynaecological problems need to be enhanced.

5. Training Targets

The training targets are calculated annually based on CYP targets agreed upon in the project document. For the year 2005, the FP advance training targets were not met. For FP basic training the 95 percent training target was met. For FP advance training, sixty percent of the target was not met. The reasons behind this delay were finalization of the training organization which was AKU which pulled out and other organizational issues. Another reason was the non availability of Future Groups’ branded IUCD in the first two quarters. Details are given in table 6.

Table 6: Details of Training Target for the Year 2005

Serial No.	Category of service provider	Estimated training target under USAID for year 2005	Number trained
1.	FP Basic Hormonal Update	9,000	8,587 (95%)
2.	FP Advanced	1,000	406 (41%)

In the year 2006, FP basic training is progressing according to plan, however only nineteen percent of the FP advance training and twenty seven percent of the SBMR training has been conducted so far. One of the reasons given for this delay was inappropriate selection criteria of participants applied by the sub contracted organizations. In addition, training sites for FP Advance and SBMR training were not available in the location where the clinics are situated. Details are given in table 7.

Table 7: Details of Training Target for the Year 2006

Serial No.	Category of service provider	Estimated training target under USAID for year 2006	Number Trained as on May 2006
1.	FP Basic Hormonal Update Training	6,000	3422 (57%)
2.	FP Advanced Training	225	42 (19%) 56 (37%)
3.	SBM-R Training	150	83 (55%) SBM-R Baseline assessment completed

In Balochistan the KSM has been actively operational with the presence of their staff since four months and has trained providers for FP Basic. KSM need to accelerate their performance as they are lagging behind in the training targets.

Recommendations

KSM needs to ensure that the targets are met, continuity is established, quality standards are maintained and quality of care is assured.

Mohallah Sangat

Mohallah Sangat was found to reach not only the underserved but also the un-served population. All the seven Mohallah Sangat were held in hard to reach, underserved population. In two out of seven Mohallah Sangat activities were held among communities which were never touched / approached by any female health care provider before. Mohallah Sangat raise awareness of clients for all methods of family planning collectively and client goes back to community with the information about all methods in mind even if does not adopt any method there and than but could be potential for spreading this word to rest of the members of community.

There were certain missed opportunities which need attention. Mohallah Sangat events were critical in bringing the female FP clients together. There were more focus on the audio cassette and less on probing about what the clients had learnt. The methodology was a little less interactive and clients were asked to raise the hands for clarity of concepts however it appeared that due to embracement few clients picked up their hands even when they were not fully clear. This was evident after one to one discussions were held by RHS with some of the clients.

LHV is followed up by the sales team later but opportunity to follow up the client for continuation, rejection or change of method is limited.

There appears a missing link or coordination between training, and Mohallah Sangat components. As new areas will be explored there is need to provide backup for the availability and continuation of services of family planning by

training the male providers of those areas where female service providers are not available.

In addition although the cassette has been translated to various local languages, still it is needed to enhance the communication skill of the moderator in order to achieve better impact.

The targets for the FY 2005 have been achieved as 4550 sessions were planned and 5723 were conducted. Likewise numbers of new users were estimated to be 13000 and KSM was able to convert 14741 women in the new client category. On an average, twelve women in reproductive age attend the Mohallah Sangat Activity. In the fiscal year 2004-05, among the clients attending the Mohallah Sangat, 23 percent converted to become new users of modern methods of family planning. Among the never users, 27 percent converted to the category of new users. In addition among the lapsed users, approximately one third (31%) became users again. The data from the first two quarters of 2005-06 is depicting a lower level of coverage in terms of conversion rates. Further, lapsed user conversion rate was below 33 percent in 2004-05 and has dropped to 18 percent in the first two quarters. There appears an issue pertaining to communication and this has a direct effect to cater for unmet need of family planning. Further, details of sales reports were also provided, however the information could not analysed as the total sales were in cumulative number. CYPs can be measured out the total sale, yet the estimation of FP methods by users is not possible Details are given in Table 8.

Table 8: Analysis of Mohalla Sangat Activity Output by Clients

Year	no. of session conducted	No. of participant	No of new Clients	Number & Percent distribution of New Clients among Never User Group	Number & Percent distribution of New Clients among Lapsed User Group	Av. Clients per session	Overall Average Adopters in percents	% new users of lapsed group from all lapsed providers attending MS meeting	% of new users among never users attending MS meeting
Total Q1-4 2004-05	5,723	63,015	14,741	9,932 (67%)	4,809 (33%)	11	23	31	27
Quarter 1 - October - December 2005	1,379	15,985	3,407	2,661 (78%)	746 (22%)	12	21	19	29

Quarter 2 - January - March 2006	2,770	31,739	6,173	4,828 (78%)	1,345 (22%)	11	19	17	26
Sub total Q1-Q2 2005/06	4,149	47,724	9,580	7,489 (78%)	2,091 (22%)	12	20	18	27
	9,872	110,739	24,321	17,421 (72%)	6,900 (28%)	11	22	25	27

Recommendations

Whereas Mohallah Sangat is reaching underserved areas, yet they need to strengthen the service provision as well to cater the created demand for continuation. Mohallah Sangat needs to be expanded further to offer services in remote un-served and underserved population like it is doing right now. At the same time services in that area need to be strengthened for catering the created demand by linking it with training department;

There is a need to make session more interactive by enhancing the counselling and communication and counselling capacity of LHV .There is need to translate the cassette in the local language where it is held to make it more effective in producing impact.

There is need of establishing some kind of mechanism or system to use the information by giving feedback to LHV so that there is incentive for her in form of supportive supervision and feedback so she collects complete information for the follow-up of program and this in turn will help the future program planning.

Quality of care inbuilt into the Training programs

Clinics which are based in posh urban areas offer a hygienically attractive outlook and a great look. This implies that it is due to client awareness and demand. An absolutely opposite picture is seen other parts of the urban locality and in smaller cities. This issue needs attention and it is critical because now the organizations will be expanding to smaller cities.

Almost all clinics visited revealed that provider have responsiveness towards the client. Products were available in good amounts at all clinics. All the clinics had good number of stock of products for two or more months. All the clinics had billboards displaying logos of both SMOs on their respective clinics. Almost all clinics were displaying IEC material; however few clinics had IEC material displayed in waiting area in a clinic. Most of the clinics had the IEC material placed on walls of the examination room. This gave reduced chance for any client or patient to read or observe the messages meant for them. GS IUCD insertion poster were displayed in waiting or examination room of very few GS-I clinics. In KSM clinics in addition to IEC material there were Family planning choices wall chart in English language. In addition relevant health education material on evidence based medicine on the use of oral contraceptives was also available in KSM clinics. There were no algorithms or flow charts available for injection procedures or infection prevention techniques in both types of clinics.

Quality of care is inbuilt in the Greenstar Franchise Quality Manual. However its standards for practical counselling and infection prevention were not met. Though counselling is influenced by factors like OPD patients, timing of clinic and attitude of the service provider, yet counselling was not properly done. Providers were not explaining the side effects in affective manner. Most of the providers were method specific as it was observed that providers had leaned towards IUCD. Limited time for counselling renders the client vulnerable for discontinuation and apprehensive on the effectiveness of any modern method of contraceptives. Most of the clinics visited had unprepared instruments, autoclaves were either in cupboards with a pile of other things on it pulled out by the health care providers.

Clinical training of IUCD insertions take place in designated clinical training centers as either public facility called RHS-"A" and facility of other organizations like FPAP. The trainees are sent there without mentor and monitoring. If there was unavailability of client in these facilities than there is an understanding between the GS I trainee and AMHS that clients could be arranged in the clinic where AMHS could teach. Interviews with service providers and trainers have revealed that most of the clinical training now takes place at the Clinic Sahoolat rather than designated clinical training centres and clinic Sahoolat is done on priority for service providers recently trained.

Contrary to Clinic Sahoolat concept of providing practical opportunity for on the job training & monitoring the quality of service, it was observed that there was competition between quantity and quality. On an average there were 15 -20 clients for Clinic Sahoolat and equal amount of OPD clients sitting together, all eager to go home early and making it impossible for provider to provide quality services. Thus training a health care provider in her own clinical setup was not the proper planned activity and hence training does not impart the required level of confidence and skill.

Infection Prevention

Infection prevention is one area which needs immediate attention. Poor standards of infection prevention were observed in clinics and especially practical application was observed where Clinic Sahoolat was held. Infection prevention practices were lacking in both GS trainers and providers assessed.

Chlorine was available but most had placed them deep down in their cupboards with lot of dust on it showing never ever used with closed lids never opened. Hand washing before wearing gloves or even after taking them off is not practiced by the providers. No mackintosh was worn before examination. None of the service provider cleaned the genitals of the client. Appropriate solution for cervical wash e.g., Pyodine was lacking except one HCP who used pyodine to clean cervix, rest used cotton plugs made there and than with unwashed hands soaked in dettol solution diluted in tap water to clean the cervix. According to the MIS of GS and observation in field, three to four Multiloads were inserted on an average during each Clinic Sahoolat. Sterilized IUCD insertion kits were not available for all the clients during the Clinic Sahoolat activity.

As earlier mentioned that trainers infection prevention skills were not up to the mark, e.g., in one of clinic Sahoolat where doctor was busy with her routine OPD patients, anxiety among the clients was rising due to rush. AMHS intervened and took the client for IUCD insertion. After examining the client it was found that there were no instruments on the trolley. AMHS started searching for instruments in the cupboard with the gloves on her hands meanwhile client was laying exposed on the couch when client pulled her own shawl on her bared half body due to embarrassment. Used gloves were taken off and put back in the gloves box from where they were pulled out by the AMHS. Meanwhile, doctor of that clinic helped the AMHS in finding instrument and small bottle of pyodine from cupboard. AMHS asked helper to soak the instruments in tap water in a kidney dish and AMHS poured a little amount of pyodine. AMHS reused the same pair of used gloves from the box. While handling the instrument during the procedure she also adjusted the light. While adjusting the size of Multiload thread came out of adjusting tube and the Multiload with the thread was on the hand of the AMHS. Thereafter she put back the Multiload into the inserter very confidently. When suggested to use a new

Multiload, the suggestion was ignored and same was inserted into the uterus of that poor women.

In most of the places instruments were not sterilized properly after first use and never put back into the chlorine solution. Boiling time was inadequate. In another instance boiling of the instrument was initiated when enquired upon by RHS. During boiling it was noted that the helper put another set of used instruments to the already boiling instruments. Than she took out the instruments without giving adequate time in a tray with lid kept on the floor facing down. After taking out the instruments from boiler the tray was covered with the same lid contaminating the sterilized instruments. Due to time limitation provider was holding the instrument in front of the fan to bring the temperature of tool to room temperature as to bring them in use as client was waiting on the couch half bared. Almost everywhere observed and appears that providers wear gloves not to keep the procedure aseptic but to save there hands from soiling. None of the clinics wiped the examination with 0.5% chlorine after examining client. There were no polythene bags in the dustbins except two to three clinics. I cannot comment on washing at the end of the day. These were one of those worst case scenarios observed during field visits. If this was the condition when it was being observed I wonder about the state in normal circumstances.

This primarily could be due to the following reasons:

1. The assessed knowledge, observed attitude was scanty and varied among and practices trained providers and trainers reflective of lack of due importance of infection prevention in the curriculum and supervision.
2. None of the clinics visited had any clinical or infection prevention standard operating procedures displayed.
3. It was also found that the some of field staff was the old GS I providers so they were not given proper training after taking on board and assumed trained. Others are not trained formally because of reorganization, recent appointment and due to limitation of time they were trained by there own colleagues. It was revealed after discussion with the AMHS that they start training after observing only one classroom training session.
4. Field staff is given targets, and performance is based on sales rather than focusing on supervisory roles;

Quality of Care is compromised and will adversely affect in the medium to long term not only the unmet need of family planning but will also contribute substantially to increase the reproductive morbidity of women in a country going through epidemiologic transition where Hepatitis B Hepatitis C are great concern to the health experts. Responses by the GS management about the taking off the billboards or removal of health care provider not adherent to quality standards were that billboards becomes possession property by the providers making it difficult physically and any ways these health care providers are better than quacks.

It was interesting to note that after every Multiload insertion, the client is prescribed antibiotics.

For KSM, the infection prevention activities in FP Advanced clinics were meeting the quality standards. The doctors trained for FP Advanced had a good knowledge base and also observing infection prevention techniques. This could be attributed to following

as standardized training guidelines of clinical training for IUCD insertion with infection prevention, HCP were all doctors and were trained almost a year back and recently attended refresher course, availability of operation theatre facility leading to proper sterilization of instruments, strict selection process. Further at present manageable number of IUCD trained providers for monitoring and supervision could be a factor for quality assurance. However, with the expansion of the network and with scanty staff deputed for technical support and follow up, it is envisaged that the standards may not be maintained over the passage of time.

It was noted that quality of care was compromised in FP basic trained clinics of KSM also. The counselling and quality of care were compromised in these clinics. It could be due to the focus of both SMOs towards IUCD method, or could be relating quality of care with IUCD. Counselling skills of FP basic trained providers needs to be enhanced.

Most of the doctors of both SMOs and doctors in RHSC "A" said that a great majority of their female clients were coming with reproductive tract infections in almost all over Pakistan with more prevalence in Balochistan. Some of the service providers also raised the issue of clients coming with inflamed cervix and discharge. There were also clients with severe infection who had IUCD inserted from some place. With the current infection prevention practices, women are vulnerable to get more reproductive morbidities. Thus infection prevention is an issue which needs to be addressed in greater depths and commitment. Otherwise women of Pakistan will be more vulnerable to other emerging diseases like Hepatitis C and HIV infection, which has started to pose a challenge for the Health System of Pakistan.

Recommendations

Providers were not adhering to recommended infection prevention practices. Although infection prevention is the part of the curriculum yet clinical training on IUCD insertion is not imparted. IUCD insertion is part of the service delivery package of RHS centers. Departments of Obstetrics and Gynecology focus on issues related to obstetrics and gynecology due to their workload. PMDC has laid down principles for the medical professionals however in practical daily routine, issue like infection prevention are neither adhered to, nor monitored in both public / private sector by institution in Pakistan. The clinical training of IUD insertion is imparted by LHV of the RHS center in most of the cases practically as the doctor in charge of the RHS is busy with the tubal ligation cases.. For the protection of providers as well as clients, infection prevention must take a central role in future trainings. Unless trainers are trained and supported in addition to detailed learning guides developed that specify exact steps and clinical competency measured before providers finish training, it is doubtful that the currently practices hazardous practices would change. GS needs to review its training plan of operations and follow-up intensively on the utilization of the trainings, which could eventually benefit in reduction of the burden of disease. Efforts need to be placed by both SMOs to ensure that teaching and practice standards are adhered to and quality is not compromised .Both SMOs need to develop Clinical Algorithms / flow charts for FP methods and infection prevention practices. In a situation like this if quality of care including technical competencies, infection prevention, technical follow up are not strengthened with immediate effect, women of Pakistan are prone to contribute heavily in the reproductive tract infections burden of disease.

The above are qualitative observations but indicate a need for a third party evaluation of the infection prevention component. This third party evaluation should be subcontracted by USAID directly.

Effectiveness of the quality of care and Client's satisfaction

No study for client satisfaction has so far been conducted under the USAID funding. A joint study has been planned in the year 2006; however has not operationalized due to difference in approaches of both the organizations. Another study was sub let to a marketing firm OASIS by GS. Ironically both the organizations do not agree to the results.

Users seemed satisfied in terms of accessibility and availability of these services at their doorsteps. SMO products were perceived high quality products due to the packaging as compared to the products available in government facilities which were thought fake and perceived having more side effects.

Client trust the lady health visitor more as she was a member of their own community. They have good rapport with lady health visitor and she also provides them complete confidentiality.

- i. Client looks at quality as with good medicine and good skill of doctor.
- ii. Billboards of both SMOs are perceived as facility for family planning. Clients know Greenstar as the place to get family planning services but know very well the products of KSM
- iii. Continuation of method was the fear of getting pregnant but client did not seem satisfied as they highlighted the side effects repeatedly. Major concern in the side effects was physical like weight gain, amenorrhea and infertility with hormonal methods which were in common use among most of clients. Menorrhagia with IUD is perceived to have adverse health implications and it is also disliked as it hinders or affects the couple relationship. Permanent Tubal Ligation (PTL) has taboo attach to it that children will die due to curse by God.
- iv. The application of an enhanced communication strategy by the SMOs has opened up options for clients to seek FP services. Yet during discussions with the clients, optimal birth spacing was not being focused. Although the community is aware of the family planning methods but reason for lack of utilization and adaptation is ranging from religious issues, fear of side effects, fear of cost for the treatment of side effects.
- v. Male participants have expressed reservations about the modern method of contraceptives. They showed great concern for the adverse health implication of their partner as a result of use of contraceptives. They clearly said that on an average it costs them about Rupees Thirty Five to fifty to avail the services including the product. However, it costs them about Rupees Two Thousand and more to manage the side effects including secondary infertility from Gynaecologists.
- vi. Charges for Multiload by the health care providers ranged from Rs. 300 to Rs.700 if doctor and maximum limit was even Rs. 2,000-Rs.3,000. In case of LHVs this range is Rs.100 to maximum of Rs.250. Both cadre of health care provider said that they all discounted or waived their consultation fees and also discounted the retail price of their SMO products for their poorer patients, suggesting that a increase in product price would lead to a significant reduction in their utilization. Some of the concerns were also shared by the freshly trained LHVs who had finished Mohalla Sangat activity relate to inability of clients to pay money for products.
- vii. The popular choice widely spread among the client is Injectable Contraceptives.

This is primarily because of the following reasons:

- a. It is easy to use because chances to miss the dose are less and they are convenient in regard to time span;
- b. It provides privacy to the client as she can hide it even from her husband;
- c. Injectable are socially acceptable and popular as it is not an invasive procedure.

It was evident by discussion with the service providers that for choice of method they were leaned towards Multiload. This is primarily because of the following reasons:

- i. IUD has more added monetary value;
- ii. Relatively manageable side effects which otherwise are more pronounced and for longer period of time with the hormonal methods. Though service providers offer a spectrum of modern methods of contraceptives, yet influence the final choice of FP methods for the client; and
- iii. In addition focus of organization is limiting as adaptation for family planning by the client is late after 4-5 children so it provides with a longer time for contraception and so for the organization, it provides more CYP than any other temporary method contraception of so it is available at highly subsidized rate.

Adaptation of family planning by most of the client was after at least a number of 4-5 or may be more children. Reason stated was mainly the economical burden. This economic burden was further probed and was found that it was the cost of education which has forced women to seek FP services. Very few also mentioned about the health and upbringing of child and mother respectively. However trends seem to change as very few were also coming after two children and the main reason is awareness due to education. This explicitly suggests that the approach is mostly for limiting rather than optimal birth spacing. Further exploration revealed that the reasons for late starting were the fears of side effects. Almost all respondents had seen the advertisements on television, yet none tried to approach health care provider to clarify their queries about family planning method. This shows that awareness regarding the services is there yet attitude to avail services seems limited. This clearly shows that demand needs to be increased through media campaign where by addressing unmet need rather than just creating awareness.

Interviews with service providers linked with networks of both SMOs clearly indicated that abortion is becoming very wide spread. The clients are not convinced for family planning but get abortion done very easily and it is being adapted as a family planning method. Accessibility to not only choices but also behaviour of the client is also contributing towards this practice. Service providers have cited numerous incidences in whereby women died, got hysterectomies done after getting perforated uterus and even sometimes after two to three episodes of induced abortion resort to family planning like Tubal-ligation. Each service provider claimed that there is demand for two to three cases of abortion per week however they refuse to conduct the procedure. The cliental includes both married women and unmarried girls. Service providers claimed to be prescribing emergency contraception tablets and also increased demand for that by client. Client also sometimes returned with pregnancy even with the use of any of Family planning method and that was great concern for health care provider. There were also clients who were using some method which was not successfully used and led to unwanted pregnancy leading to abortion. A married woman with five children had undergone three induced abortions by her own choice before she was counselled by a KSM trained service provider to opt for Injectable method of contraception during

Mohalla Sangat. One of the doctor also stated that she uses Multi load to induce abortion within three to five days. Inducing Multiload will contribute to CYP but will not be sustainable. Thus the issue of unmet need still needs to be address in composite fashion in the catchments populations of the networks of the SMOs.

Different trends of behaviours were found for family planning practices among various types of ethnic groups. In Balochistan polygamy is prevalent due to which second and successive wife wants to have equal number of children bear by first wife. Castes like Baloch and Pakhtoon are not in favour of Family planning but Hazara tribe from Afghanistan is very much convinced and popular method among them is pills. In Sindh tubal-ligation is highly prevalent among Hindu community. Early age marriage is prevalent among Pakhtoon and Afghans.

Few of the responses of doctors during field visit

A doctor in Lahore mentioned,

“I hardly get clients for family planning as there is no demand in the community”.

A doctor in Quetta mentioned,

“Client influx for family planning is negligible as it seems that there is saturation in the community and I think that what ever we do the child which has to be born will be born.

Recommendations

There is need to design and conduct a client satisfaction study. Client should be educated for client's right and concepts of quality of care. They should be made aware and encouraged for demanding quality of care for the services offered to them. Communication strategy needs to address unmet need by tackling diverse target audience and, issues like early marriage.

Transfer of training responsibilities to GS

KSM has subcontracted the training to four organizations i.e. GS, FPAP, RHAID and MCHS.

1. Selection Criteria

Discussions with both GS and FPAP revealed that the selection criteria proposed by KSM was considered very challenging. Further, members of the training team of GS responsible for KSM' SBMR training cited it to be a difficult process. The reason for that could be that as KSM is targeting population less than twenty five to fifty thousand so it is harder to find a private clinic run by MBBS doctors.

2. Follow-up

One of the major issues noted is that the training is conducted by one organization and follow up done by the other, leading to lack of rapport among providers and KSM. This may create a sense of disruption and confusion among the service providers about the follow up plan and activities. In addition, there was an inbuilt supervision mechanisms in the subcontracted training program over which KSM had reservations.

3. Timelines are not followed:

The time lines for training have not been followed by organizations as discussions on both the development of curriculum and practical training sites took a long time to resolve. Time was also consumed when KSM took up the issue of sites for practical training (GS were getting their trainees trained in facilities of either government like RHS "A" centre or other organizations facilities) where it could be properly monitored. After six months of negotiation now GS has identified the facilities where practical training can be conducted. It is great success on the part of GS.

5. Money issue

GS has raised the issue that they charge Rs. 500 per trainee for registration and annual franchise fee whereas KSM gives an incentive of Rs. 3000 per trainee to attend the training FP Advance. Further KSM also give Rs. 500 to each FP basic trainee. Thus there is no uniform policy to address this issue. KSM point of view is that since the health care providers are invited from elsewhere, hence they are paid Rs. 500 per day.

5. Wrong selection criteria applied

Selection criteria were not being observed by the subcontracted organizations which led to repetition of the selection and training process.

Recommendations

These are operational issues and need to be discussed within the KSM and GS. These issues should have been dealt at the time of contractual arrangements.

Coordination Mechanisms:

Both the SMOs have diverse coordination mechanisms with respect to training with different organizations.

KSM's coordination is focused on four organizations with which they have sub contracted their training component. In addition to other issues mentioned above another issue raised by one of the subcontracted organization needs attention is that there is need to increase the coordination between sales promotion officer of KSM and subcontracted organizations to reduce delay of sales and commodities to the trained providers. KSM had initial teething problems which have now been resolved and activities have started to roll.

GS has contracts with different organizations in different issues. GS in its rural district initiative in the Social Marketing Project has developed relationships with both PAVHNA and SCF US. Whereas PAVHNA has cited working relationships with GS but SCF US had a mixed response. There were initial problems of coordination and delaying in trainings which now seem to have been taken care of.

Meeting with PAIMAN revealed that despite repeated requests, the training strategy, mapping and monitoring system for the private sector health care providers in the PAIMAN districts, has not been shared, despite the fact that the project is

completing the second year of implementation. This has delayed the intervention of PAIMAN in the private sector of these ten districts. Commodities linked with training like safe delivery kit is not of quality. High turnover rate of the staff has also affected the progress of the project. Correct selection of the health care provider is the basis for future quality service delivery. Under the PAIMAN project, health care providers will be trained in EMoC. Instead of reaching out for numbers of health care providers to be trained, it is inevitable to choose and train to reach the objective of providing quality services.

Rural Implementation

GS had sub-contracted Save the Children US in NWFP and PAVHNA in Sindh to map out formal and informal health care providers in the private sector in 2004. SCF US mapped out 383 and 307 health care providers in the formal and informal private sector respectively of districts Haripur, Abbottabad, Swabi and Swat. In Sindh, PAVHNA mapped out 180 and 90 health care providers in formal and informal private sector respectively in district Larkana.

SCF US after identifying the health care providers was responsible for training the health care providers in the informal sector. Further SCF US is also responsible for creating demand for FP services through involvement and motivation through LHW, community networks, male activist, local female representatives, teachers and local leaders. SCF has trained 216 health care providers in the four intervention districts. These service providers were trained on basic FP knowledge and provide condoms only. SCF has also been able to maintain an MIS with these trained service providers, through which SCF has been able to analyze the trends of referral to various health care providers.

At the clinics of trained 216 health care providers in the informal sector of four districts, 13908 clients visited for FP services. Fourteen percent (1945) were referred to seek other long term modern methods of family planning. Interestingly, among the 1945 referred, 80 percent (1551) sought services from the public sector and only 8 percent (155) went to GS network clinics. Interestingly this is opposite to the current belief that 80 percent of the clients utilize private sector facilities. Rest of the 12 percent went to other health care providers who were neither in the public or GS network. For GS, the proportion of self referral ranged from three to fifteen percent. Details are given in Table 9 below:

Table 9: Follow up visits to Trained Hakims\Homeopaths in District Haripur, Abbottabad, Swabi, Swat-2004-2006 (Implementing Agency SCF US)

A	B	C	D	E	F	G	H	I
S. NO	Time Duration	Districts	No. Of Hakim/Homeopaths Trained	No. of Clients	Referred Clients	Greenstar	Government	Others
1	October 2004-March 2006	Swabi	56	5,416	343 (6%)	9 (3%)	261 (76%)	73 (21%)
2	October 2004-March 2006	Swat	85	5,406	677 (13%)	20 (3%)	543 (80%)	114 (17%)
3	October 2004-March 2006	Haripur	24	1,929	480 (25%)	74 (15%)	378 (79%)	28 (6%)
2	October 2004-March 2006	Abbottabad	51	1,157	445 (38%)	52 (12%)	369 (83%)	24 (5%)
Sub Total			216	13,908	1,945 (14%)	155 (8%)	1,551 (80%)	239 (14%)

Reasons given by the FP clients for using public sector include the following:

Accessibility and Affordability According to SCF, clients have stated that in the case of private sector whether Greenstar or others, they have to pay for not only the products but also the services. It was mentioned that for example clients were demanded between Rs. 1500 to Rs. 3000 for IUCD insertion, which is not affordable. In the public sector the same service is available for Rs. 3 only. In addition based on recent feedback the health care providers who were recently been trained in January 2006 in Haripur and in May 2006 in Swabi have not been supplied with contraceptives till date.

Ministry of Population Welfare (MoPW)

There is coordination of GS with MoPW on clinical training at the RHSC “A” and RHSC “B” centres¹³. RHSC “A” centres are used for clinical training for IUCD insertion and voluntary contraceptive surgery (VSC) training whereas RHSC “B” centres are used for family planning voluntary contraceptive surgery. MoPW is also does reimbursement for the VSC cases to GS. There is no coordination between the MoPW and the SMOs on standardizing the training curriculum.

MoPW has there own training wing conducting trainings regarding family planning and Reproductive health services. Training involves various cadres within program and non programme personnel like private practitioners, midwives, paramedics, lady health visitors, medical students etc. and NGOs. In addition to family planning MoPW is also focusing on Maternal Health Care, Infant Health Care, Reproductive Health of Adolescent, RTIs/STDs/HIV Aids, Early detection of breast and cervical cancer.

MoPW is in the process of reviewing the quality manual for national standard of family planning services with TAMA, and it would be valuable to involve the SMOs and MoH into this process right from the beginning.

National Program of Family Planning and Lady Health Workers (LHW Program)

The institutional framework for collaboration between MoH’s National Program for Family Planning and Primary Health Care and Greenstar has not been clearly laid down. As per the precedence of the National Program, every initiative is taken to provinces for consultation. After due consultations and revisions (if necessary) for every new initiative, the subject is brought up to the program’s Technical Committee for Innovation. In this particular case, none of the two processes were followed. In addition, the approach to the implementation is different for both the National Program and Greenstar. Whereas the National Program focuses its operations on family planning & primary health care, Greenstar on the other takes on a health delivery based on a marketing approach. Whereas the former has a pro poor approach, the latter has a marketing approach. Provincial Program Implementation Units of the National Program have also cited their apprehension that the MoU is based on focusing on the long term family planning methods and not on optimal birth

¹³ RHSC “A” – Reproductive Health Services Center “A” are public sector operationalized facilities offering a spectrum of RH services whereas RHSC “B” – Reproductive Health Services Center “B” is run by NGOs offering RH Services.

spacing. In addition to operational issues, such an initiative was considered a clash of interest in the scope of work. Services offered by LHWs are not free of cost but she is supposed to sell the contraceptives at subsidized rates as per MOPW policy and to retain the money as an incentive. Whereas rates proposed by CSM are much more higher than what have been prescribed in the LHW P.

Provincial Program Implementation Units also considered this change of scope of work to be against the local cultural and social value systems.

Regarding training, meetings with LHW program revealed two critical issues:

1. LHW program has its own training program network with trainers, training manuals and training aids all over the country; and
2. From the federal to provincial to district level, no one was aware of the MoU signed between GS and LHW Program. All of the respondents from LHW Program expressed their ignorance and reservation about the concept of linking the program with GS. Further respondents also showed apprehension about the MoU as they were not consulted on the issue.

Greenstar Training Components

	Calendar Yearly Break Down												TOTAL	Under USAID	MIS as
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006		Nov03- Mar06	on 31 Mar. 06
TRAINING															
FP Advanced (GS1)	10	433	680	435	268	148	375	423	393	479	1,227	262	5,133	1,998	3,364
FP Advanced Certified (Associates)						42	31	41	37	2	248	149	550	399	511
FP Basic															
General Practitioners (GS2)			2,724	884	650		33	153	131	188	248	15	5,026	462	2,095
Chemists (GS3)			295	2,234	96						101	44	2,770	145	3,170
Paramedics (GS4)			1,038	1,104	84		37	81	120	116	181	20	2,781	317	956
Female Paramedics (GS-4 to 1)				52	235	66	27	21					401		
FP Surgical (VSC)						0	4	9	19	12	14		58	26	63
Sexually Transmitted Infections						60	52	185	218	229	62		806	307	
Post Abortion Care						15	90	151	162	216	30		664	246	
Emergency Contraception						0	0	383	388	484	158		1413	418	
Business Management Practices						0	55	0	47				102		
Antenatal Post Natal									101	89	235	240	665	520	
Newly Wed Couple Counselling									511				511		
TB (DOTS)											178	328	506		
EmOC											43	86	129		
Neonatal Advanced												11	11		
	10	433	4,737	4,709	1,333	331	704	1,447	2,127	1,815	2,725	1,155	21,526	4,838	10,159

USAID RFA 391-03-03

greenstar PROGRAM MONITORING AND EVALUATION FRAMEWORK

INDICATORS	TARGETS				
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
A. Output Level					
CYP:	1,397,309	1,659,159	1,990,047	2,391,802	2,863,412
Urban	1,383,336	1,625,976	1,930,347	2,296,132	2,720,242
Rural	13,973	33,183	59,700	95,670	143,170
CYP broken down by method:					
Condoms	571,008	618,081	666,654	681,168	695,495
Oral contraceptives	119,231	123,077	155,077	192,295	238,446
IUDs	614,250	786,240	990,662	1,242,500	1,557,500
Injectables	71,083	88,287	109,191	130,914	154,583
VSC	21,738	43,475	72,463	144,925	217,388
Net cost per CYP (US\$)	\$4.77	\$4.48	\$4.05	\$3.70	\$3.48
Program income (social marketing revenues) as % of total project costs*	18%	x	x	x	X
Number of new greenstar providers/franchisees trained:	500	600	600	600	200
Urban	500	575	575	600	200
Rural	0	25	25	0	0

Clinic Sahoolat Report (February'06)												
Region	No of *CS conducted	No.Of clients attended the *CS	No. of FP adopters	FP methods							No. of average clients / *CS	No. of FP adopters / *CS
				IUD	Injectables	Pills	Condom	TL	Vas	Referred		
Central	129	4369	1631	524	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	34	13
South	77	2180	1016	317	541	287	52	19	Data not available	1	28	13
North	20	384	229	69	36	40	Data not available	90	5	Data not available	19	11
Total	226	6933	2876	910	577	327	52	109	5	1	31	13

* Clinic Sahoolat

Annex - D

MIS IAW Report March 05 - May 06					
Activity Code	Activity Description	No. of Meetings	No. of Participants	Tokens Given	Brochure Given
1	Household Visits	294,709	259,981	138,556	247,498
2	Orientation Meeting (Women)	5,121	19,891	6,555	13,693
3	Orientation Meeting (Men)	1,897	8,095	1,021	6,358
4	Neighbourhood Meeting (Women)	17,889	170,577	52,727	124,663
5	Neighbourhood Meeting (Men)	12,506	115,992	17,391	94,695
6	Outdoor Activities	13,156	142,956	9,815	96,156
7	Mohalla Meeting (Women)	194	5,354	1,175	2,971
8	Mohalla Meeting (Men)	95	973	70	559
9	Health Camp Activity	71	2,657	646	1,556
10	Clinic Saholat Activity	1,397	31,856	12,259	22,859
11	In-Clinics	8,615	58,444	16,422	43,819
	Total	355,650	816,776	256,637	654,827
12	Total No. of Tokens Collected	36,129			
13	Total No. of Supervisory Visit by *FHS	5,947			
14	Total No. of Supervisory Visit by *MHS	4,632			

*Female Health Supervisor

*Male Health Supervisor

Annexure 5

COST / CYP – FUTURES GROUP (KSM) - Pakistan

Period of Performance: November 01, 2003 - March 31, 2006

KSM	Category	Total Budget FY 03-04	Total Expenses through Pakistan Office FY 03-04	Burn Rates FY 03-04	Cost / CYP	Total Budget FY 04-05	Total Expenses through Pakistan Office FY 04-05	Burn Rates FY 04-05	Cost / CYP	Total Budget FY 04-06	Total Expenses through Pakistan Office FY 05-06	Burn Rates FY 05-06	Cost / CYP
	CYP				266,034				305,358				174,891
I.	Labor Total Labor	570,533	166,583	29%	0.63	512,840	291,034	57%	0.95	672,808	224,804	33%	1.29
II.	Consultants Total Consultants	127,758	30,006	23%	0.11	82,583	26,224	32%	0.09	71,872	13,458	19%	0.08
III.	Travel Total Travel	265,799	167,572	63%	0.63	463,533	311,874	67%	1.02	616,126	195,725	32%	1.12
IV.	Equipment - Field Office Total Equipment	153,918	17,548	11%	0.07	30,000	32,783	109%	0.11	40,000	8,364	21%	0.05
V.	Other Direct Costs Total ODCs	1,039,650	236,349	23%	0.89	638,462	413,998	65%	1.36	756,174	368,128	49%	2.10
VI.	Subcontracts Total Subcontracts	2,585,241	112,106	4%	0.42	3,995,113	1,685,823	42%	5.52	3,806,714	74,239	2%	0.42
VII.	TFGI Indirect Rates Total Indirect Rates	626,053	-	0%		568,018	-	0%		620,597	-	0%	
Total Expenses Trough Pakistan Office		5,368,953	730,164	14%	2.74	6,290,549	2,761,736	44%	9.04	6,584,291	884,718	13%	5.06

COST / CYP – FUTURES GROUP - USA

Period of Performance: November 01, 2003 - March 31, 2006

TFG	Category	Total Budget FY 03-04	Total Expenses through Pakistan Office FY 03-04	Burn Rates FY 03- 04	Cost / CYP	Total Budget FY 04-05	Total Expenses through Pakistan Office FY 04-05	Burn Rates FY 04- 05	Cost / CYP	Total Budget FY 04-06	Total Expenses through Pakistan Office FY 05-06	Burn Rates FY 05-06	Cost / CYP
		US \$	US \$		US \$	US \$	US \$		US \$	US \$	US \$		US \$
TFG US Expenses													
I	Labor								-				-
II	Consultants								-				-
III	Travel						27,648		0.09		3,501		0.02
IV	Equipment		9,802		0.04				-		12,228		0.07
V	Other Direct Costs		71,820		0.27		37,557		0.12		26,650		0.15
VI	Subcontracts		682,684		2.57		2,382,219		7.80		917,333		5.25
Sub-Total TFG US expenses			764,306		2.87		2,447,423		8.01		959,711		5.49

TFG & KSM Total Expenditure

I	Labor	570,533	166,583	29%	0.63	512,840	291,034	57%	0.95	672,808	224,804	33%	1.29
II	Consultants	127,758	30,006	23%	0.11	82,583	26,224	32%	0.09	71,872	13,458	19%	0.08
III	Travel	265,799	167,572	63%	0.63	463,533	339,522	73%	1.11	616,126	199,225	32%	1.14
IV	Equipment	153,918	27,350	18%	0.10	30,000	32,783	109%	0.11	40,000	20,592	51%	0.12
V	Other Direct Costs	1,039,650	308,169	30%	1.16	638,462	451,555	71%	1.48	756,174	394,778	52%	2.26
VI	Subcontracts	2,585,241	794,790	31%	2.99	3,995,113	4,068,042	102%	13.32	3,806,714	991,572	26%	5.67
VII	TFGI Indirect Rates	626,053	-	0%	-	568,018	-	0%	-	620,597	-	0%	-
Total		5,368,953	1,494,470	28%	5.62	6,290,549	5,209,160	83%	17.06	6,584,291	1,844,429	28%	10.55

Project Burn Rate

Project Budget US \$
Burn Rate Cumulative

27,000,000	6%	25%	32%
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Overall Burn Rates KSM (PAK) only

Marketing	1,948,255	201,548	10%		2,171,020	924,049	43%		2,412,140	94,722	4%	
Training	1,052,197	38,079	4%		1,917,297	881,593	46%		1,596,018	107,072	7%	
Research	178,420	5,077	3%		144,100	48,773	34%		115,096	24,781	22%	

Overall Burn Rates

Marketing	1,948,255	884,231	45%		2,171,020	2,271,732	105%		2,412,140	768,226	32%	4.39
Training	1,052,197	38,079	4%		1,917,297	1,916,129	100%		1,596,018	283,199	18%	1.62
Research	178,420	5,077	3%		144,100	48,773	34%		115,096	24,781	22%	0.14

BURN RATES – FUTURES GROUP (KSM) - Pakistan

Period of Performance: November 01, 2003 - March 31, 2006

KSM	Category	Total Budget FY 03-06	Total Expenses through Pakistan Office FY 03-06	Burn Rates FY 03-06	Cost / CYP	Total Budget FY 03-08	Total Expenses through Pakistan Office FY 03-08	Burn Rates FY 03-08	Cost / CYP
		US \$	US \$		US \$	US \$	US \$		US \$
I.	CYPs Labor Total Labor	1,756,181	682,421	39%	0.91	3,044,636	682,421	22%	0.91
II.	Consultants Total Consultants	282,213	69,688	25%	0.09	693,160	69,688	10%	0.09
III.	Travel Total Travel	1,345,458	675,171	50%	0.90	1,472,209	675,171	46%	0.90
IV.	Equipment - Field Office Total Equipment	223,918	58,695	26%	0.08	182,354	58,695	32%	0.08
V.	Other Direct Costs Total ODCs	2,434,286	1,018,475	42%	1.36	6,155,387	1,018,475	17%	1.36
VI.	Subcontracts Total Subcontracts	10,387,068	1,872,169	18%	2.51	12,398,211	1,872,169	15%	2.51
VII.	TFGI Indirect Rates Total Indirect Rates	1,814,668	-	0%	0.00	2,973,843	-	0%	0.00
Total Expenses Trough Pakistan Office		18,243,793	4,376,618	24%	5.86	26,919,800	4,376,618	14%	4.89

BURN RATES – FUTURES GROUP (KSM) – Pakistan & USA

Period of Performance: November 01, 2003 - March 31, 2006

KSM	Category	Total Budget FY 03-06	Total Expenses through Pakistan Office FY 03-06	Burn Rates FY 03-06	Cost / CYP
		US \$	US \$		US \$

TFG US Expenses

I	Labor		-		0.00
II	Consultants		-		0.00
III	Travel		31,148		0.04
IV	Equipment		22,030		0.03
V	Other Direct Costs		136,027		0.18
VI	Subcontracts		3,982,235		5.34
Sub-Total TFG US expenses			4,171,440		5.59

Total Budget FY 03-08	Total Expenses through Pakistan Office FY 03-08	Burn Rates FY 03-08	Cost / CYP
US \$	US \$		US \$

	-		0.00
	-		0.00
	31,148		0.04
	22,030		0.03
	136,027		0.18
	3,982,235		5.34
	4,171,440		5.59

TFG & KSM Total Expenditure

I	Labor	1,756,181	682,421	39%	0.91
II	Consultants	282,213	69,688	25%	0.09
III	Travel	1,345,458	706,319	52%	0.95
IV	Equipment	223,918	80,725	36%	0.11
V	Other Direct Costs	2,434,286	1,154,501	47%	1.55
VI	Subcontracts	10,387,068	5,854,404	56%	7.84
VII	TFGI Indirect Rates	1,814,668	-	0%	0.00
Total		18,243,793	8,548,059	47%	11.45

3,044,636	682,421	22%	0.91
693,160	69,688	10%	0.09
1,472,209	706,319	48%	0.95
182,354	80,725	44%	0.11
6,155,387	1,154,501	19%	1.55
12,398,211	5,854,404	47%	7.84
2,973,843	-	0%	0.00
26,919,800	8,548,059	32%	11.45

Overall Burn Rates For

I	Marketing	6,531,415	3,924,190	60%	5.26
II	Training	4,565,512	2,237,407	49%	3.00
III	Research	437,616	78,632	18%	0.11

ANNUAL BURN RATES & COST / CYP – GREENSTAR SOCIAL MARKETING PAKISTAN

Period of Performance: October 01, 2003 - March 31, 2006

Description	Oct 03-Sep 04			Cost /CYP	Oct 04-Sep 05			Cost /CYP	Oct 05-Mar 06			Cost /CYP
	Actual	Budget	Burn Rate		Actual	Budget	%		Actual	Budget	%	
CYPs				1,703,513				544,139				964,233
Expense												
Labour	870,940	1,096,472	79%	0.51	1,276,241	1,208,921	106%	2.35	785,822	661,235	119%	0.81
Consultants	113,250	149,946	76%	0.07	179,922	170,855	105%	0.33	136,090	89,700	152%	0.14
Travel	362,213	514,522	70%	0.21	438,112	333,719	131%	0.81	279,342	189,733	147%	0.29
Sub-Contracts	2,594,192	4,310,649	60%	1.52	2,221,741	1,731,424	128%	4.08	1,223,812	662,604	185%	1.27
Other Direct Costs (ODCs)	329,224	928,411	35%	0.19	534,513	549,975	97%	0.98	354,642	294,238	121%	0.37
Total Expense US \$	4,269,819	7,000,000	61%	7.85	4,650,529	3,994,894	116%	8.55	2,779,708	1,897,508	146%	2.88

Project Burn Rate

Project Budget US \$	23,000,000		
Burn Rate Cumulative	18.56%	38.78%	50.87%

Burn Rates US \$

Marketing	1,590,798	2,874,741	55%	2.92	1,143,365	212,574	538%	2.10	286,119	-	N/A	0.30
Training	935,843	1,432,853	65%	1.72	1,047,874	1,365,224	77%	1.93	958,471	593,312	162%	0.99
Research	103,432	152,653	68%	0.19	79,049	176,887	45%	0.15	23,286	83,417	28%	0.02

CUMULATIVE BURN RATES & COST / CYP – GREENSTAR SOCIAL MARKETING PAKISTAN

Period of Performance: October 01, 2003 - March 31, 2006

Description	GRAND TOTAL Period Oct 03-Mar 06			Cost / CYP	GRAND TOTAL Project Period 5 years			Cost / CYP
	Actual	Budget	%		Actual	Budget	%	
	US \$	US \$		US \$	US \$	US \$		US \$

CYP

Expense

Sub-total Labour	2,933,003	2,966,628	99%	0.91	2,933,003	6,618,950	44%	0.91
Sub-Total Consultants	429,261	410,501	105%	0.13	429,261	886,354	48%	0.13
Sub-total Travel	1,079,666	1,037,974	104%	0.34	1,079,666	2,133,635	51%	0.34
Sub-Total Sub-Contracts	6,039,745	6,704,677	90%	1.88	6,039,745	10,000,912	60%	1.88
Sub-total ODCs	951,770	1,772,623	54%	0.30	951,770	3,360,149	28%	0.30
Total Expense US \$	11,700,055	12,892,402	91%	3.64	11,700,055	23,000,000	51%	3.64

Burn Rates US\$

Marketing	3,020,282	3,087,315	98%	5.32	3,020,282	3,087,315	98%	5.32
Training	2,942,187	3,391,389	87%	4.64	2,942,187	6,991,039	42%	4.64
Research	205,768	412,957	50%	0.36	205,768	825,577	25%	0.36

Annexure - 6

List of Researches conducted by KSM (Future Group)

Year	Month	Name of research studies	Methodology	Tool	Sample	Agency	Target Audience
FY-2004		Pre-test of TV Spots on oral contraceptive (Pills) advertising campaign				MARS	
		Pre-test of TV Spots on injectable contraceptives advertising campaign				AC Nielsen	
		KAP research, (Managed by G.S)	Quantitative	Face to face interviews		Oasis International	
FY-2005	Jun-05	Advertising campaign (Pills & injectables ads) post impact evaluation study	Quantitative	Face to face interviews	2280	MARS	Married female and male, age 18-35, want no kid for next two years but not using any method, SEC B,C and D
	Jun-05	Rising Sun-A qualitative research on F.P. & reasons for not practicing family planning	Qualitative	FGDs & IDIs	19 GDs and 14 IDIs	Oasis International	Male and female, 22-35, at least one kid, SEC C,D and E, no religious barrier for FP, user and non user of FP and IDIs with influencer (Mother and mother-in-law)
	Nov-05	Research study on private health F.P Providers	Qual/Quant and desk	FGDs and IDIs & face to face interviews	15 FGDs, 19 IDIs & 271 providers face to face interviews and 76 exit interviews	AC Nielsen	Male and female GPs (Currently practicing atleast 2-3 hours a day), LHVs (must completed 2 year LHV Course and for midwives having a course of midwifery and currently practicing) and midwives for qualitative, male and female RMPs, LHVs and midwives for face to face quantitative interview and exit interviews with user of FP at least during the past 6 months
	Dec-05	Qualitative study on usage, behavior and effectiveness of contraceptives	Quantitative	Face to face interviews	660	MARS	age 18-45, SEC C, D and E, semi urban, pre urban and rural areas. Sindh, punjab and NWFP
	Jul-Aug 05	Mohallah sangat Program impact evaluation study	Quantitative	Face to face interviews	520	Oasis International	Participants of MSP and LHVs conducted the sessions
FY-2006	Jan-06	Pre-test of TV spots for motivational campaign	Qualitative	FGDs	18	Aftab Associates	Male & female, age 18-40, SEC C & D, non-user of contraceptive

Mar-06	Pre-test of TV spots for oral contraceptives	Qualitative	FGDs	9	MARS	Female and male, should have one kid, age 18-40, SEC C & D, no religious barrier to FP, speak and understand urdu
Apr-06	Pre-test of TV Spots for IUDs media campaign	Qualitative	FGDs	12	Aftab Associates	female and male, age 22-40, non user of IUD, 2-4 kids, SEC B & C
	Pre-test of mohallah sangat Program cassette	Qualitative	FGDs		MARS	
Mar-Apr 06	Market penetration and MIS evaluation study	Quantitative	Face to face interviews	4000	SMAR International	List of pharmacies, doctors and LHVs made by the field team and their orders to be verified