

## **REPORT**

# **Assessment of Expansion of Family Welfare Centers and Community Based Family Planning Workers**

**Submitted to**

**Directorate General Mentoring and Evaluation Planning and  
Development Department, Government of Punjab**

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## **LIST OF ACRONYMS**

TFR	Total fertility rate
GOP	Government of Pakistan
FWCs	Family Welfare Centers
PWDP	Population Welfare Department Punjab
ADP	Annual Development Program
CBFPWs	Community Based Family Planning Workers
P&D	Planning and development
CPR	Contraceptive Prevalence Rate
MICS	Multiple Indicator Cluster Survey
MCH	Maternal and child health
NGOs	Non-Governmental Organizations
IEC	Information Education and communication
LHWs	Lady Health worker
FWA	Family welfare assistant
FWW	Family Welfare Worker
LHV	Lady Health Visitor
FP	Family planning
FHC	Family Health Clinics
FH	Female helper
IUCD	Intra uterine contraceptive device
THQ	Tehsil Head Quarter
DHQ	District Head Quarter
TPWO	Tehsil Population Welfare Officer
DPWO	District Population Welfare Officer
FTO	Field Technical Officer
WMO	Women medical officer
MSU	Mobile service unit
PERI	Punjab Economic Research Institute
UC	Union Counsel
BHUs	Basic Health Units
PGR	Population growth rate
FR	fertility rate
PDHS	Pakistan Demographic and Health Survey
KIIs	key informant interviews
PD	Project Directors
SPSS	Statistical Package for Social Sciences
OECD	Organization for Economic Co-operation and Development
DAC	Development Assistance Committee



## **EXECUTIVE SUMMARY**

Population Welfare Department Punjab (PWDP) launched an Annual Development Program (ADP) scheme titled “Expansion of Family Welfare Centers and Introduction of Community Based Family Planning Workers (CBFPWs) 2014-18.” Through this scheme, 1000 new Family Welfare Centers (FWCs) were proposed to be established in 22 districts of Punjab and 1200 Community Based Family Planning Workers (CBFPWs) be introduced in 13 districts by 2018. The original PC-I was approved by PDWP on 02-01-2015 with an allocation of Rs. 3779.219 Million for the period 2014-18. During the Review Meeting ADP 2016-17 for population planning held on 16-03-2017 in P&D Department, it was proposed by the Health Section of P&D Department to limit the scope of the ADP Scheme. Accordingly, it was decided to reduce the scope of the Project and 600 FWCs were established and 900 CBFPWs were recruited. The project was designed to ensure universal coverage and improved access to quality services by 2018, raise Contraceptive Prevalence Rate (CPR) to 45%. With the help of both FWCs and CBFPWs, it was planned to deliver family planning services, ANC, PNC, child care and provide treatment for general diseases of women and children.

At the end of the program, third part evaluation of the project was assigned to Institute of Social and Cultural Studies, University of the Punjab, Lahore. The institution conducted third party evaluation of the program using Development Assistance Committee (DAC) criteria of evaluation i.e. relevance, effectiveness, efficiency impact and sustainability of the program using mix method research approach. For this, the principle of evaluation were strictly followed i.e. objectivity, independence of evaluators, participation of stakeholders, transparency, focus and reliability.

Quantitative survey was conducted among the beneficiaries, non-beneficiaries and service providers i.e. FWWs and CBFPWs and in-depth interviews were conducted from the management team of the program. Cross-sectional survey design was used in quantitative approach and exploratory qualitative component was also included. For collecting data from beneficiaries, exit survey, a technique which is used for collecting quantitative data from individuals who separate himself/herself from an organization, was conducted and data from service providers and management was collected at their workplace. Structured survey questionnaire was designed separately for each respondents i.e. beneficiaries of FWC, beneficiaries of CBFPWs, non-beneficiaries, FWWs and CBFPWs. In addition, semi-structured key informant guide was used for collecting data from management and a separate Observation and Record Form was designed for recording the observation of interviewers and maintenance of record at FWCs. Quantitative data was analyzed using SPSS and thematic analysis technique was used for qualitative data analysis.

Results indicated that the performance of the program was satisfactory in term of relevance, effectiveness, efficiency, sustainability and impact. The program increased the access of clients to family planning services, ANC, PNC and child care. A majority of the beneficiaries 74.4% were satisfied from the provision of services. The program also increased 21% clientage of family planning. Although the program increased CPR yet the program was not able to achieve the set target of CPR. Beneficiaries also claimed that visiting FWCs and CBFPWs had improved their own health and the health of their newborns. According to observational results, a majority of the FWCs have easy access, convenient working hours and the staff of the centers was respectful and friendly. On the other hand, the number of service providers and service providing

centers were less and staff and commodities were found insufficient. Based on the results of the study, following recommendations are proposed.

1. There is a need of better and effective coordination among public-private and non-governmental organizations at community level. Electronic and print media could be helpful in dissemination of information among the relatively younger population.
2. For social mobilization, the influence and clout of various actors in the community such as elected members of local bodies, community notables, religious leaders, and other influential members of the community may get onboard and their services can be utilized.
3. Field staff should be increased in each FWC especially in the thickly populated areas. well-staffed and operationally active FWCs may be established in the areas/localities where there is high concentration of poor and marginalized sections. In addition, CBFPWs should be provided in those UCs where FWCs are not working.
4. Systematic and information technology driven mechanism of supervision, monitoring and reporting may be introduced at all levels. It could make the system more efficient and cost-effective.
5. The program is relevant to socio-economic development of the province and country; therefore, the services should be strengthened and made more effective by providing more resources and political support. Overall, the program is effective and efficient therefore, the scope of the program should be expended to the whole province. However, program inputs and activities need to be improved to enhance the performance.

# INTRODUCTION

## 1.1 Background

Pakistan is the sixth populous country in the world with estimated 207.77 million population. Pakistan has the higher population growth rate (1.43%) as compared to India (1.13%) in 2017 (Sughra et al., 2018). Population growth rate in Pakistan is even higher as compared to the world (1.07%) per year in 2017 (Cleland et al., 2006). Similar to higher population growth rate, under-five mortality is 74.9 deaths per 1,000 live births and maternal mortality is 178 deaths/100,000 live births. Therefore, it is the need of the time to systematically control higher population growth rate for uplifting the socio-economic status and improve child and maternal health.

Family planning is a proven strategy to control higher birth rate, child and maternal mortality. Cleland et al. (2006) reported that promotion of family planning in those countries which have higher birth rate is helpful to reduce poverty, child and maternal mortality. It is also positively associated with women empowerment, universal primary schooling and environmental sustainability (Yaqoob et al., 2018). Estimating the severity of the higher birth rate and potential benefits of family planning, many developed and developing countries started family planning programs (Jacobson, 2018). In the past four decade, the programs raised contraceptive practices and reduced total fertility rate (Cleland et al., 2006). However, the contraceptive prevalence rate (CPR) remained lower and TFR and unmet needs of family planning remained higher in many developing countries including Pakistan (Noreen et al., 2018). Hence, it is dire and urgent need to invest more resources on family planning program and make it more acceptable and effective by increasing community participation and political support.

## 1.2 Project description

Population growth in Pakistan increased in since 1940s because of reduction in mortality and persistent high birth rate. Population grew from 33 million to 207.77 million till 2017. Therefore, Government of Punjab started first population planning program independently through a non-governmental organization “Family Planning Association of Pakistan in 1953 (Population Welfare Department, 2019). Although, the program of family planning was started in 1947 in collaboration with national and international donors for overcoming the rapidly increasing population yet the program was unable to gain success and fertility rate decreased very slowly. Therefore, during 9<sup>th</sup> period plan (1998-2003) of Population Welfare Program, it was planned to establish 990 Family Welfare Centers (FWCs) to increase access to family planning services and reduce unmet family planning needs. From 2003-2008 total numbers of FWCs increased to 1500. The proposed number of FWCs could not be achieved till Jun-2014 because of the 18<sup>th</sup> constitutional amendment.

Given this backdrop, Population Welfare Department Punjab (PWDP) proposed a scheme Annual Development Program (ADP) scheme titled “Expansion of Family Welfare Centers and Introduction of Community Based Family Planning Workers (CBFPWs) 2014-18.” Through this scheme 1000 new FWCs were proposed to be established in 22 districts of Punjab and 1200 Community Based Family Planning Workers be introduced in 13 districts by 2018. The original PC-I was approved by PDWP on 02-01-2015 with an allocation of Rs. 3779.219 Million for the period 2014-18. During the Review Meeting of ADP 2016-17 for population planning held on 16-03-2017 in P & D Department, it was proposed by the Health Section of P & D Department to limit the scope of the ADP Scheme titled “Expansion of Family Welfare Centres and Introduction of Community Based Family Planning Workers 2014-18.” Accordingly it was

decided to reduce the scope of the Project from establishment of 1000 FWCs to 600 FWCs and from induction of 1200 CBFPWs to 900.

Because of capping the scope of the project, 600 FWCs and 744 CBFPWs were inducted instead of 1000 FWCs and 1200 CBFPWs. The gestation period of the scheme in original PC-I was July 2014-June 2018 (FY 2017-18). However, the gestation period was extended for six months i.e. July to December 2018 (FY 2018-19) so that the remaining tasks (Final Evaluation and shifting the above mentioned Centers/CBFPWs on current budget) may be completed. The original cost of the scheme was Rs. 3779.219 (Million). However, due to reduction in scope the revised cost was Rs. 2280.851 (Million) which was less than the original cost.

### **1.2.1 Project Objectives**

The objectives of the project are divided into major and minor objectives. The detail of the project objectives is as under;

#### **A. Major objectives of the project**

The project is aimed to achieve the following major objectives;

1. To ensure universal coverage and improve access to safe and quality services by 2018;  
and
2. To raise Contraceptive Prevalence Rate (CPR) to 45% by 2018 through expansion of FWCs and Community involvement by revival of Community Based Family Planning Workers.

#### **B. Minor objectives of the project**

However, there are three minor objectives of the project which are mentioned below;

1. To increase demand for small family and social approval of family planning;
2. To reduce unmet need by increasing access to good quality information, advice and services; and
3. To increase community participation and accountability.

### **1.2.2 Family Welfare Centers**

A Family Welfare Center is one of the main service delivery networks of the Program established in both urban and rural areas. Each center caters to population of 5,000 to 7,000 through the static facility and a population of 15,000-25,000 by arranging satellite camps. During the 9th plan period (1998-2003) 990 FWCs were established. During the 10th plan period (2003-2008) the number increased to 1500. However, during 11th plan period the number of FWCs was proposed to be increased from 1500-1800 which was not achieved because of structural limitations. Each center is currently catering more than 60,000 beneficiaries. The number of FWCs is increased to 2100 by 2018 to improve coverage and access to family planning services at each union council of the selected twenty-two districts on the basis of low CPR (Contraceptive Prevalence Rate) (MICS Punjab, 2011).

### **1.2.3 Functions of FWCs**

Each FWC was designed to perform the following functions:

- 1) Provide family planning counseling, supplies and follow up for all family planning methods.
- 2) Provide Maternal and Child Health (MCH) services and treatment for minor medical ailments through static facility as well as satellite camps in rural areas.
- 3) Provide well-baby care, including nutrition advice and growth monitoring.

- 4) To establish referral linkages with appropriate facilities.
- 5) Monitoring and periodic evaluation of the performance to assess quality of services being provided, through interviews, client records, follow-up visits and focus group discussions.
- 6) Ensure availability of contraceptives, medicines and other supplies and maintaining equipment in good working condition.
- 7) Organizing group meetings of stakeholders such as elected representatives, satisfied clients, teachers, hakims, private practitioners, religious scholars, shopkeepers, and representatives of local Non-Governmental Organizations (NGOs) and other active members of community.
- 8) Holding regular meetings with elected women councilors to elicit their support.
- 9) Organize IEC campaign and distributing IEC material on better health practices and family planning within the community.
- 10) To extend outreach services through Mobile Service Units attached with the FWCs located at the Tehsil Headquarter level.

#### **1.2.4 Services provided by FWCs**

The FWCs provide the following services to their beneficiaries:

##### **1. Contraceptive delivery services**

Family planning advice is provided to all eligible couples within the population covered by FWCs. A wide range of safe and effective contraceptives delivery services are provided to the beneficiaries. The program officials would also provide maximum support and assistance to Lady Health Workers/NGOs involved in contraceptive delivery services. The contraceptives are



provided to the Family Welfare Centers established under this scheme from Population Welfare Program Punjab.

## **2. Maternal and child health care**

Maternal and child health care is provided through pre and post natal examination, routine testing of urine for protein and sugar of pregnant women, prophylaxis against nutritional anemia's, promotion of child spacing, guidance and encouragement of breast feeding and proper hygienic practices, prevention and treatment of diarrhea in children and referral of children for immunization against childhood killer diseases as well as of pregnant women for tetanus immunization.

## **3. Medical care**

Medical care (prevention and treatment) will be provided for common ailments of women and children. For this purpose a number of medicines, considered safe for dispensation by paramedics will be available at each center.

### **1.2.5 Staffing Pattern of FWCs**

For the provision of above mentioned services to beneficiaries, following staff was proposed to be hired:

Table 1.1: Staffing pattern of FWC

Sr. No.	Position	BPS	Number
1.	Family Welfare Worker	08	1
2.	Family welfare assistant FWA (Male)	05	1
3.	FWA (Female)	05	1
4.	Female Helper (Aya)	01	1
5.	Chowkidar	01	1
Total			5

### **1.2.5.1 Eligibility criteria of family welfare worker**

The following eligibility criterion was proposed for the recruitment of Family Welfare Worker (BS-8).

- 1) Candidates having FWW course from Regional Training Institute of Population Welfare Department.
- 2) Candidates with Metric qualification also having Lady Health Visitor (LHV) diploma from Health Department.
- 3) Preference will be given to the candidates having FWW course from Regional Training Institute of Population Welfare Department and the LHVs will be considered for recruitment of remaining vacant posts.

### **1.2.5.2 Job responsibility of FWW**

Job responsibilities of FWWs were divided into two parts i.e. services delivery and counseling. Detail of job responsibility is as under:

#### **1. Service delivery**

- 1) Act as In-charge Family Welfare Worker of FWC, will supervise the work of the staff.
- 2) Perform Family Planning (FP) counseling, contraceptive services, including Intra Uterine Devices (IUDs) insertion and refer Norplant, sterilization cases after initial screening to Family Health Clinics (FHC) and to the extension camps arranged by the Family Health Clinics (FHC).
- 3) Attend cases of general ailments and refer clients to higher level facility, when necessary.
- 4) Provide mother & child care services, child nutrition and arrange immunization services in collaboration with government health services, where possible.

- 5) Supervise and support FWA (female) to ensure regular home visits for motivation and follow up.
- 6) To supervise the work of FWA (F) and ensure to update eligible couple register and to prepare a list of couples having one child, pregnant women, antenatal and postnatal clients for counseling and spacing.
- 7) To supervise the work of FWA (M) to ensure the maintenance of record regarding the registration of eligible couples as well as motivation among the male community.
- 8) Maintain and update client record cards/registers and prepare monthly reports of various activities.

## **2. Counseling**

Besides providing services at FWC, FWW provide counseling to different clients who visit them about family planning and routine health issues. They provide counseling to clients for increasing their awareness and guide them to not suffer from general health issues. Specifically, the topics of counseling are as under:

- a. Adolescent problems
  - b. Infertility
  - c. Nutritional disorders
  - d. Cervical and breast cancer
  - e. STD/AIDS/Hepatitis
  - f. Breast feeding
- 2) Give orientation to clients on breast examination.
  - 3) Maintain record for counseling of each client.

- 4) Responsible for keeping update IEC material/literature for enhancing her own knowledge and/or of the clients.
- 5) Assign villages/areas to FWA (M & F) for motivation and counseling of eligible couples, if sufficient clients are not coming to FWCs.
- 6) Follow up of FP cases especially IUCD & Injectable through FWA (female).
- 7) Client satisfaction, arranging periodic satisfied clients' meetings.

Each family welfare center is also providing a male family welfare assistant FWA, female family welfare assistant (FWA), Female helper (FH) and chowkidar. Eligibility criteria and job responsibility of FWAs, FH and Chowkider are given in Annexure 1. On the other hand, each FWC was provided plant and machinery, furniture and fixture, signboard and medicine for providing services related to contraceptive delivery, maternal and child health and medical care to beneficiaries.

### **1.2.6 Community Based Family Planning Workers**

Despite increasing the number of FWC, the program did not achieve the desired outcome. The program faced many hurdles such as inadequate coverage of population and poor service facility in the field, particularly in rural areas. To create rural infrastructure for provision of family planning services at the door step of the rural population, Community Based Family Planning Workers (CBFPWs) were introduced. For this purpose, it was planned to induct 900 Community Based Family Planning Workers during the project period for providing diverse type of services i.e. contraceptive delivery, child and maternal health care and medical care.

#### **1.2.6.1 Eligibility criteria of CBFPW**

The selection of CBFPW is required to meet the following criteria:

1. The Worker should be a local female resident of the village.
2. She should be a married woman with age between 22 to 35 years, preferably having not
3. more than two children. Divorced/separated/widows will also be eligible. However, the candidate should not be pregnant at the time of selection. Previous experience showed that training suffered a lot in such cases.
4. She should be mentally and physically fit.
5. She should be a matriculate, relax-able to middle where suitable candidates are not available.
6. The Worker should be willing to undertake training at places identified by District Population Welfare Officer.
7. She should be willing to make regular home visits in her area for the responsibilities assigned.
8. She should also be willing to install sign board outside her residence displaying availability of Family Planning and Health Services.

#### **1.2.6.2 Responsibility of CBFPW**

Following are the responsibilities of CBFPW:

1. Register all eligible couples (married women age 15-49 years) in her village and update the record regularly and maintain separate information about acceptors of Family Planning;
2. Visit 8-10 eligible couples every working day and ensure a revisit every two months;
3. Motivate and counsel clients for adoption and continuation of practice of Family Planning methods;

4. Provide Family Planning Services (except IUCD) to the eligible couples in her village through regular home visit as well as at her residence;
5. Refer motivated clients to nearest Family Welfare Centre (FWC), Family Health Clinic at THQ/DHQ Hospitals for IUCD insertions, contraceptive surgery and initial dose of injectable;
6. Provide treatment for some of the common ailments, teach personal hygiene and advise on nutrition;
7. Assist Mobile Service Unit and Family Welfare Centre staff in arranging camps in her village;
8. Keep close liaison with influential women of her village including lady teachers, Traditional Birth Attendants; and Community Midwives.
9. Submit monthly progress report to the Tehsil Population Welfare Officer (TPWO)/ District Population Welfare Officer (DPWO) containing information about the home visits, number of Family Planning acceptors by methods and stock position of contraceptives.

CBFPWs were provided training of four month in four phases. The training was subject of modification as per background knowledge of community based family planning workers. They were trained in Training centers i.e. FHC and FWCs. However, the supervision of CBFPWs is assigned to DPWO/WMO, FHC, MSU/ TPWO/ Field Technical Officer (FTO) or Family Welfare Counselor (FWC).

### **1.3 Rationale of the evaluation**

For only development project, its evaluation by a third party is essential. This is third party evaluation which is intended to evaluate all the project activities of “Expansion of Family

Welfare Centers and Introduction of Community Based Family Planning Workers 2014-18” initiated to achieve the planned objectives. This evaluation facility assessment includes the activities of this project such as the establishment of Family Welfare Centers, hiring of Staff for FWCs, Procurement of machinery & equipment, purchase of furniture & fixture, purchase of vehicle, publicity & advertisement, fair & exhibitions, induction of Community Based Family Planning workers. On the other hand, improvement in CPR, direct effect of pre-natal & post-natal services, registration of married couples, contraceptive delivery services will also be assessed.

#### **1.4 Objectives of the evaluation**

The present evaluation aims to evaluate all the project activities initiated to achieve the planned objectives. Specifically, the objectives of this evaluation are as under;

- 1) To analyze universal coverage and improve access to safe and quality services by considering efficiency, effectiveness, relevance, sustainability and impact.
- 2) Assess the delay of activities, if any, due to administrative, financial, technical and other reasons.
- 3) Identify gapes and short comings in the process of implementation of the scheme.
- 4) To analyze design of the project viz-a-viz internationally best implemented design in similar environment and inform how the performance can be improved in order to achieve planned results.
- 5) Efficiency and effectiveness of contraceptive services provided during this project.
- 6) To analyze direct effect of Pre-natal and Post-natal services provided under this project on maternal and children health.
- 7) To evaluate competencies/effectiveness of FWCs staff and CBFPWs.

- 8) Evaluate beneficiary's satisfaction and community participation.
- 9) To analyze the raise in the use of contraceptive methods viz-a-viz improvement of Contraceptive Prevalence Rate (CPR) with respect to base line CPR 2011.
- 10) Counterfactual analysis of the Family Planning and Reproductive Health Services
- 11) Identify the limitations, challenges faced and risks faced during execution of project and suggest their time bound mitigation measures for current projects and improved planning for efficient execution of projects in future.

## **1.5 Organization of the report**

The present evaluation includes total five chapters. Chapter wise detail of the report is as under:

### **Chapter No. 1**

First chapter is the introduction of the report. This chapter includes background of the program and project description. Project description is further divided into project objectives, family welfare centers, functions of family welfare centers, services provided by family welfare centers, staffing pattern of family welfare centers. On the other hand, this section also includes information about community based family planning workers. In addition, this chapter also includes rationales of the evaluation and objectives of the evaluation.

### **Chapter No. 2**

Chapter deals with the criteria of evaluation. Detail of OCED/DAC criteria is explained in the chapter and its relevance is also provided in the chapter.

### **Chapter No. 3**

The chapter is explains methodology of the report. Research approach, design, sample and sampling, tool of data collection, ethical considerations, fieldwork experiences and data analysis is discussed in this chapter.



#### **Chapter No. 4**

The chapter is about the results of evaluation. Results are provided in both table form and in the form of graphs. In addition, both univariate and bivariate results are provided.

#### **Chapter No. 5**

The chapter demonstrates the application of theory of change on the project activities. In revised theory of change, inputs, activities, output, immediate outcome, intermediate outcomes and impact of the program are discussed.

#### **Chapter No. 6**

The chapter, conclusion, lesson learnt and recommendations are provided.

## **2. CRITERIA FOR ASSESSMENT**

### **2.1 Introduction**

The present chapter is about the criteria of assessment used in this third-party evaluation. In the first section of the report, conceptual definition of the evaluation is provided. In the second section, five OECD/DAC criteria of relevance, effectiveness, efficiency, impact and sustainability is covered. In the last section, international evaluation principles and standards are discussed.

### **2.2 Conceptual definition of evaluation**

According to Development Assistance Committee (DAC) of Organization for Economic Cooperation and Development (OECD) evaluation is the systematic and objective assessment of an on-going or completed project or program, its design, implementation and results. The purpose of the evaluation is to determine the relevance, fulfillment of objectives, development efficiency, effectiveness, impact and sustainability of the on-going or completed project/program. Most of the time, evaluations are carried out by some external or independent party. Both intended and non-intended outcomes of the project/program are assessed through evaluation. Evaluations are also categorized based upon the time of evaluation i.e. mid-term evaluation and/or final evaluation.

### **2.3 DAC criteria of evaluation**

DAC proposed criteria of evaluation for issues like poverty, gender, health and environment. By default, there are five components of DAC criteria of evaluation i.e. relevance and fulfillment of the objectives, development efficiency, effectiveness, impact and sustainability.

### 2.3.1 Relevance

Relevance, is the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country need, global priorities and partners' and donor's policies. The program under assessment is about the provision of family planning services, child and maternal care and medical care to target group. Relevance is operationalized into the provision of family planning services, maternal and child health care and medical care to target group. In addition, type of target group, method to approach beneficiaries, place to motivate beneficiaries and total number of visit by service providers for motivation are also included.

**Table 2.1: Indicators of the relevance of program and relevant data collection tools**

	Indicators	Data collection tool
Relevance	<ul style="list-style-type: none"><li>• Mobilization of beneficiaries about services</li><li>• Utilization of family planning services</li><li>• Antenatal check-ups</li><li>• Post-natal services for mother and child</li></ul>	Questionnaire for beneficiaries
	<ul style="list-style-type: none"><li>• Target group</li><li>• Method to approach beneficiaries</li><li>• Place to motivate beneficiaries</li></ul>	Questionnaire for FWWs and CBFPWs

### 2.3.2 Effectiveness

According to DAC, effectiveness refers to the extent to which an intervention has attained, or is expected to attain its major relevant objectives efficiently in a sustainable fashion and with a positive institutional developmental impact. Effectiveness is operationalized into the average number of beneficiaries who are availing family planning, antenatal care and post-natal care, average number of men and children who are visiting service delivery centers. It also includes the target and achievement per month of service providers i.e. FWWs and CBFPWs.

**Table 2.2: Indicators of the effectiveness of the program and relevant data collection tools**

	Indicators	Data collection tool
Effectiveness	<ul style="list-style-type: none"> <li>• Average number of meeting with beneficiaries for their counseling</li> <li>• Average number of women who are taking services</li> <li>• Average number of children who are taking services</li> <li>• Average number of men who are taking services</li> <li>• Per month target and achievement</li> <li>• Satisfaction from program achievement</li> </ul>	Questionnaire for FWWs and CBFPWs
	<ul style="list-style-type: none"> <li>• Appropriateness of the services</li> <li>• Satisfaction with the staff of the service providers</li> <li>• Satisfaction with the method of family planning</li> <li>• Satisfaction with the overall experience of service utilization</li> <li>• Satisfaction with the guidance of the service providers</li> <li>• Satisfaction with care provision during antenatal and post-natal care</li> </ul>	Questionnaire for beneficiaries

### 2.3.3 Efficiency

Efficiency refers to a measure of how economically inputs are converted into results. Efficiency is measured by assessing the cost-benefit analysis of the program. This includes appropriateness and justification of the results achieved according to input resources. Moreover, efficiency also refers to the in time impact of the services provided by the program.

**Table 2.3: Indicators of the efficiency of the program and relevant data collection tools**

	Indicators	Data collection tool
Efficiency	<ul style="list-style-type: none"> <li>• Availability of waiting room</li> <li>• Appropriateness of location</li> <li>• Appropriateness of building</li> <li>• Cleanliness in the center</li> <li>• Ease of access</li> <li>• Record maintenance</li> <li>• Security measure</li> <li>• Service delivery</li> </ul>	Observation and record form
	<ul style="list-style-type: none"> <li>• Community mobilization</li> <li>• Average time spent at the service center</li> <li>• Working hours of service delivery center</li> <li>• Information about alternative methods of FP</li> <li>• Time for consultation</li> <li>• Opportunity to ask questions and clarify doubts</li> <li>• Explanation of method</li> <li>• Privacy</li> <li>• Friendly and respectable consultation</li> <li>• Cost of services</li> <li>• Appropriateness of the services</li> <li>• Revisiting service center</li> <li>• Referring to other women</li> </ul>	Questionnaire for beneficiaries

#### 2.3.4 Impact

According to the DAC definition of impact, it refers to positive and negative, direct and indirect and primary and secondary effects produced by the program. The results and real differences for the beneficiaries are included in the impact of the program. The impact is operationalized into the improvement in mothers' own health, child health and the response of community members about the service providers.

**Table 2.4: Indicators of the impact of the program and relevant data collection tools**

	Indicators	Data collection tool
Impact	<ul style="list-style-type: none"> <li>Improvement in mothers' health</li> <li>Improvement in child health</li> <li>Satisfaction from the services</li> </ul>	Questionnaire for beneficiaries
	<ul style="list-style-type: none"> <li>A response of community members               <ol style="list-style-type: none"> <li>Imam Masjid</li> <li>Local community on average</li> <li>Men on average</li> <li>Women on average</li> <li>Local leadership</li> <li>Local government organizations</li> <li>Local non-governmental organization</li> </ol> </li> <li>Satisfaction from community participation</li> </ul>	Questionnaire for FWWs and CBFPWs

### 2.3.5 Sustainability

DAC defines sustainability into the continuation of benefits from a development intervention after major development assistance has been completed. In other words, it is the probability of continued long-term benefits for the relevant stakeholders. The resilience to a risk of the net benefit flows over time. Sustainability is operationalized into the continuity of service delivery by the beneficiaries, ability of the beneficiaries to continue services without external assistance, community participation, referral to other beneficiaries (potential beneficiaries) by the user of services (beneficiaries).

**Table 2.5: Indicators of the sustainability of the program and relevant data collection tools**

	Indicators	Data collection tool
Sustainability	<ul style="list-style-type: none"> <li>Referral to other beneficiaries (potential beneficiaries) by the user of services (actual beneficiaries)</li> </ul>	Questionnaire for beneficiaries
	<ul style="list-style-type: none"> <li>Ability to continue service utilization</li> <li>Ability to continue service utilization without external assistance</li> <li>Local community participation</li> </ul>	Questionnaire for FWWs and CBFPWs
	<ul style="list-style-type: none"> <li>Ability of the target group to receive positive</li> </ul>	Interview guide for

	effects of the intervention	management
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## 2.4 International evaluation principle and standards

The principles and standards of evaluation increase the credibility of the assessment. Major international evaluation principles and standards are as under:

### 2.4.1 Objectivity

In its conception and implementation, every evaluation needs to achieve a maximum level of objectivity and impartiality. For the purpose of achieving objectivity, the methodology is explicitly designed according to the objectives of the evaluation. The methodology is discussed in detail with relevant stakeholders for maximizing the objectivity of the findings. Different perspectives are included for generating objective evidence i.e. beneficiaries, employees and management of the program. Results, conclusions, and recommendations are drawn from empirical pieces of evidence.

### 2.4.2 Independence of evaluators

The evaluators have expert knowledge of the field of public health and family planning. In addition, this is third-party evaluation and evaluators have no link with the staff involved in operational activities. Evaluators are from reputed public sector university and they don't have any link with both funding agency and execution agency.

### 2.4.3 Participation of stakeholders

It is very important to collect empirical evidences from the field. Therefore, evaluators involved all the major stakeholders in the process of assessment. For achieving this objective, data is collected from both the beneficiaries of FWCs and from the beneficiaries of CBFPWs. Both

FWWs and CBFPWs are also the respondents of the evaluation. In addition, management of the program is also interviewed.

#### **2.4.4 Transparency and focus**

For achieving transparency and focus, the evaluation assignment is clearly defined. The assessment focused upon the objectives of the evaluation. These objectives are then operationalized into variables for collecting data and generating inferences.

#### **2.4.5 Reliability**

Collecting and utilization of both primary and secondary data are necessary for a comprehensive assessment of any project. However, it is more important to be cautious when collecting primary data from the field. Primary data is a backbone for proving the assessment and the conclusions in a credible fashion. Therefore, the tool of data collection was presented to the technical team of Directorate General Monitoring & Evaluation, Planning and Development and approved tools of data collecting were used in the field.



### **3. METHODOLOGY**

#### **3.1 Introduction**

The present chapter deals with the detail methodology of evaluation. The chapter starts with research approach and the rationales to use mix method research approach. Research approach is followed by research design. Population of the study and sample is also explained in the chapter. Moreover, the method to determine sample size and sampling techniques is elaborated. The researchers also provided the detail of the tool of data collection, data collection process, ethical consideration and analysis technique.

#### **3.2 Research approach**

In the present study, researchers conducted both desk research and field work. Both primary (field data) and secondary (desk review) data was analyzed to compile evidence based observations and recommendations. At first step, researcher reviewed previously available project reports, PC-I, PC-IV, midterm evaluation report, performance reports of both FWCs and CBFPWs and district wise performance reports. Reports and reviews related to family planning, national surveys i.e. Multiple Indicator Cluster Survey (MICS) and Pakistan Demographic and Health Survey (PDHS) were also included in desk research.

Field data was collected using mix method research approach for the evaluation of the program of “Expansion of family welfare centers and introduction of community based family planning worker (2014-18). The objectives of the evaluation were divided into two parts as per the nature of objectives (exploration, description and explanation) and the researchers selected separate research approach for both sections of the objectives. Qualitative research approach was used for collecting data from the management of program. On the other hand, quantitative research approach was used for the evaluation of the service delivery. For evaluating service delivery,

data were collected both from service providers and beneficiaries of the services. This implies that the present study used mix method research approach for the evaluation of the program.

Mix method research approach is best suited for generating comprehensive and in-depth understanding of the phenomenon. This approach is preferred when the objectives required both exploration and explanation of the phenomenon. Key insights and findings generated by the study will provide baseline information and that will be used for evidence-based planning. Mix method approach is also expected to identify gaps in existing service delivery and shall enable Population Welfare Department and other development partners to bridge the gaps.

### **3.3 Research design**

For the evaluation of the service delivery, the researcher used cross sectional survey design. Cross sectional survey design is the best quantitative research design for collecting single time data from the respondents. Separate Surveys were conducted with service providers and beneficiaries of both the service providers i.e. FWWs and CBFPWs. However, client exist survey technique was used for collecting data from the beneficiaries of the program. Moreover, survey was also conducted with non-beneficiaries. For collected data from non-beneficiaries, household survey was conducted in the catchment area of centers. Information related to FWCs is recorded by using structured observation and record form. The form included close ended questions about availability of furniture and fixture, medicines and medical equipment, staff at each FWC and different board i.e. elephant board, face board and direction board provided to FWCs.

On the other hand, for the qualitative part of the evaluation, an exploratory qualitative component was included. For the purpose of data collection, semi-structured key informant

interviews (KIIs) were conducted for collecting in-depth and contextual information from the key stakeholders related to the program of “Expansion of family welfare centers and introduction of community based family planning workers (2014-18)”. The respondents include key project management officers and officials.

Eight teams were hired comprising of two trained survey enumerators in each team. Face to face interviews were conducted by using structured survey questionnaire from the in-charge of FWCs. In-charge of FWCs (who also works as Family Welfare Worker) were also interviewed to fill the record section of the “Observation and Record Survey” as well. Similarly, beneficiaries of both FWWs and CBFPWs were also interviewed by using structured survey questionnaire and a client exit survey technique was used because of the sensitivity of the topic. Similarly, enumerators conducted household survey in the catchment areas for collecting information from non-beneficiaries. Key informant interview guide was used for collecting data from both the officials and officers working in the management of the project.

### **3.4 Population**

There are number of different respondents in the present evaluation i.e. beneficiaries (family planning, child and mother care and general patients) and service providers (FWWs and CBFPWs). Population of beneficiaries includes both the beneficiaries of Family Welfare Centers and CBFPWs. On the other hand, all the FWWs from 22 districts where FWCs were established and CBFPWs from 13 districts where CBFPWs were recruited were included into the population of the study. At the time of evaluation, a total of 756 CBFPWs were providing their services in 13 districts. However, there were 600 FWCs in 22 districts where 591 FWWs were providing their services. Project management team i.e. District Population Officers and Project Director were also the part of population.

### 3.5 Sample size

Currently, a total of 3,495,412 beneficiaries are getting different services both from FWCs and CBFPWs. Using the equation of Cochran proportion sampling at 5% margin of error, 95% confidence interval and 50% sample proportion, sample size was calculated. The formula is as under:

$$n_0 = \frac{Z^2 pq}{e^2}$$

Where:

Z= is 1.96 at 95% confidence level for normal tables

e= is the desired level of precision (95%)

p= is the (estimated) proportion of the population (50%)

q=1-p

Sample size was calculated by putting the values of  $n_0$  into below formula

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

This formula generated a sample of 385 beneficiaries. We assumed non-response rate of 4%, hence by including this non-response rate, the total sample size increased to 401. Randomly selected sample of 401 was considered enough to generate statistically significant inferences. A proportionate sample size was calculated for 8 districts as per their real share in total number of FWCs. Sample was proportionated because the number of FWCs were not same in all the districts. On the other hand, there were four different types of beneficiaries who were getting services from FWCs and from CBFPWs. Therefore, the sample was also proportionated

according to the types of the beneficiaries of different services i.e. family planning, mother and child care and general treatment.

**Table 3.1: Services wise distribution of sample of beneficiaries**

Services	Clients/Patients	Ratio	Sample size
Family planning	1,555,913	0.45	178
Mother care	226,188	0.06	26
Children	472,926	0.14	54
General patients	1,240,385	0.35	142
Total	3,495,412	1	401

Using the same equation of Cochran proportion sampling at 10% margin of error, 90% confidence interval and 50% sample proportion, total number of calculated sample for FWWs was 83. Total sample was proportionated on selected eight districts of Punjab where FWCs were providing services. On the other hand, 756 CBFPWs are working in 13 districts out of these 22 districts. Using Cochran proportion sampling formula at 10% margin of error, 90% confidence interval and 50% sample proportion, total calculated sample size was 85. From selected eight districts, CBFPWs were working only in five districts; therefore, the total sample size of CBFPWs was proportionated on five districts (Table 3.2).

**Table 3.2: Sample distribution of FWWs, CBFPWs and beneficiaries**

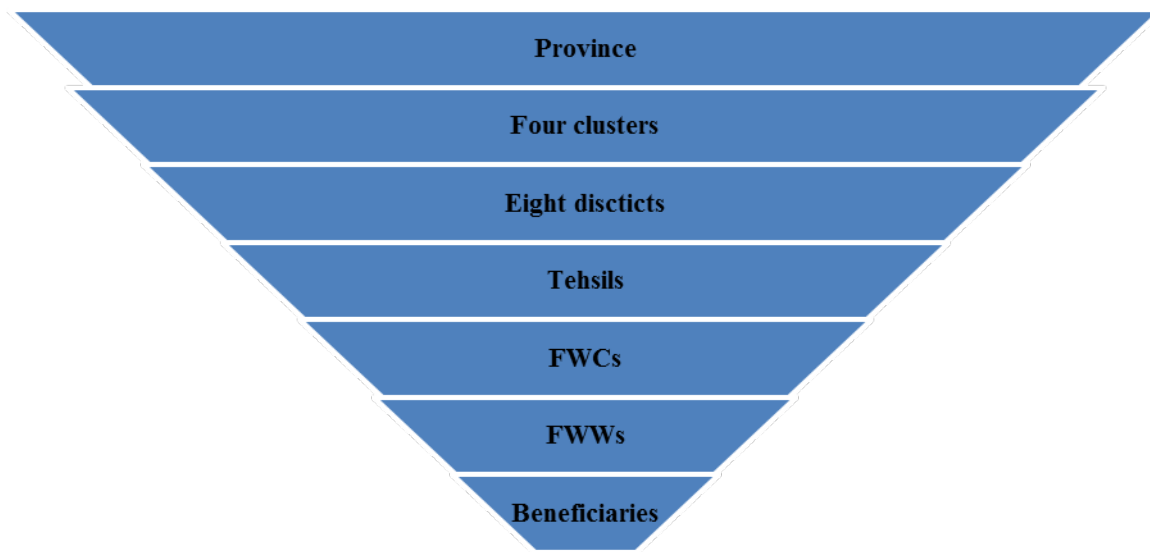
Districts	Sample			Total
	FWW	CBFPW	Beneficiaries	
D.G.Khan	5	24	19	48
Jhelum	8	0	34	42
Kasur	14	11	68	93
Khushab	6	12	39	57
Layyah	4	20	19	43
Okara	15	0	72	87
Muzaffar Gharh	8	18	39	65
Sargodha	23	0	111	134
Total	83	85	401	569

A total of 35 interviews were conducted among non-beneficiaries for conducting counterfactual analysis. A total of 16 KIIs were conducted among project management team and was stopped when saturation point was achieved. . From each district, two KIIs were conducted at the workplace of the project management team.

### **3.6 Sampling technique**

For selecting representative sample, Punjab province was divided into four clusters i.e. Northern, Central, Western and Southern. From each cluster, randomly two districts were selected. This implies that at first stage of sampling, cluster sampling was used. At second stage of sampling, randomly Tehsils were selected. Similarly, FWCs were selected from the selected Tehsils. Therefore, the present evaluation involved multi-stage probability sampling technique. For selecting non-beneficiaries, random walk was conducted in catchment area of selected service providing centers. For selecting household, interviewers used right hand walk and skipping of one household in their random walk was performed. From selected household, reproductive age women 15-49 who were not availing the services of FWCs or CBFPWs were interviewed. On the other hand, purposive sampling technique was used for selecting respondents for exploratory qualitative component of the evaluation. Only those project management officers and officials were interviewed who had direct link with the project either in execution or monitoring of the services.

**Figure 3.1: Sampling techniques**



The following tables shows the selection of 8 districts out of 22 districts where the program was expanded.

**Table 3.3: Region wise selected districts for data collection**

Sr. No	Selected Districts	Region
1	DG Khan	South
2	Jehlum	North
3	Kasur	Central
4	Layyah	West
5	MuzafarGharh	South
6	Okara	Central
7	Khushab	North
8	Sargodha	West
Total	8	4

### 3.7 Data collection tools

Six types of tools were used for data collection. For collecting data from beneficiaries of FWCs and CBFPWs two different structured questionnaires were used. Moreover, structured survey questionnaires were used for collecting information from FWWs and CBFPWs respectively. This implies that data was collected using two different survey questionnaires from both FWWs and

CBFPWs. Fourth type of tool of data collection was “Observation and Record Form” which was filled by interviewers based on their observations and record of FWC. In addition, a separate structured survey questionnaire was designed for non-beneficiaries who did not benefited from any of these services. Sixth tool of data collection was key informants guide which was used for collecting data from project management. Detail of each tool of data collection is mentioned in Annexure 1.

For constructing structured survey questionnaire, the objectives of the evaluation were operationalized into measurable variables. In addition, standardized tools to evaluate services delivery by family planning programs were also reviewed and the standard questions were included in the tools for collecting empirical data. The survey questionnaires included close ended questions measured at nominal, ordinal and ratio level of measurement. In addition, few open ended questions were also asked for measuring the observations and recommendations to improve service delivery by the FWCs both for beneficiaries and service providers. On the contrary, semi structured key informant guide was used for data collection from the management of population department and the project under study. Only semi-structured questions were included in the guide for helping interviewers to collect data and readjust questions as per the context and situation.

### **3.8 Ethical considerations**

It is key point in evaluation activities to collect empirical data from the field for generating inferences and key findings. However, it is not always easy to collect data from the field when the studies focus on culturally sensitive topics i.e. violence against women and family planning. Because respondents’ participation in research activity might give birth to problem of their



security and family disputes might also emerge. Therefore, it is very important to carefully collecting data because information sharing might pose threats to the personal or social life of the respondents.

Keeping in mind the potential threats of information sharing, the study took special care of ethical considerations when collecting data from the beneficiaries. Enumerators were asked to assure voluntary participation, confidentiality, anonymity and no harm to respondents. For achieving these objectives, special training and protocols were provided by the research team to enumerators. Enumerators provided detail description of the project and the purpose of data collection and took both verbal and written consent from the respondents to participate in interview. Field team was trained to ask sensitive questions after building rapport with the respondents. Moreover, identifiable information was removed instantly from the questionnaire and unique IDs were allotted for assuring anonymity.

### **3.9 Field work**

Fieldwork was conducted from Thursday 22<sup>nd</sup> November to 1<sup>st</sup> December 2018 except on Sunday 25<sup>th</sup> November 2018. For collecting data, districts were divided into eight teams. Each team was comprised of two trained enumerators. Every team includes both male and female enumerators/interviewers. For collecting data from beneficiaries client exit survey was conducted. However, household survey was conducted in close vicinity of both FWCs and CBFPWs for collecting data from non-beneficiaries. Interviews from FWWs, District Population Welfare Officer (DPWO), Project Directors (PD) and CBFPWs were conducted at their respective workplace.

### **3.10 Analysis**

Quantitative data was analyzed using Statistical Package for Social Sciences (SPSS) IBM Version 21.0. Analysis was carried out at two levels. At first level, univariate descriptive analysis was carried out. In univariate descriptive analysis, evaluators provided results in both tabular (tables) and graphical format (bar graphs and pie charts etc.). At second stage, bivariate descriptive analysis was carried between socio-demographic characteristics and the variables of service delivery by both FWCs and CBFPWs. On the other hand, qualitative data was analyzed using thematic analysis techniques. First of all, all the interviewers were transcribed in English language. After familiarization with the data, initial codes were identified. From the codes, different categories were identified and themes were generated by putting similar categories into themes. The results and findings of the evaluation were discussed side by side for generating observation and providing recommendations.

## **4. RESULTS OF THE ASSESSMENT**

In the present chapter, results of the evaluation are presented. SPSS IBM version 20.0 is used for quantitative data analysis. Results are presented graphically and in tabular form. The findings are given according to DAC criteria i.e. relevance, effectiveness, efficiency, impact and sustainability.

### **4.1 Relevance of the project**

In this section, relevance of the project services with beneficiaries' needs and the policy of the interventions were assessed. This program was also related to the overall development policy and planning of the province. Because, the provision of family planning services, maternal and child health care and lowering population growth rate are important components of Development Policy and Planning including universal access to health and poverty reduction (Pakistan Vision, 2025; Punjab, Growth Strategy, 2018).

#### **4.1.1. Relevance of the program with Pakistan's Development Policy and Planning**

The program is relevant to the overall socio-economic development of the country. Pakistan population is expected to increase to over 227 million 2025. In addition, as per the current population estimates, the proportion of younger population will also increase till 2025. These projections are believed to give birth to large number of issues. First of all, it is not possible for any country to move into the high income countries without reducing population growth rate. Higher population growth rate is expected put pressure on economic growth of the country. Because government had to invest both development and non-development funds for meeting the diverse needs of the population. These needs of the population are related to health, education, housing, police and other infrastructure etc. On the contrary, these funds might be invested in

productivity growth. These findings suggest that it is more important to lower population growth rate in the country (Pakistan Vision 2025).

Secondly, decreasing fertility rate has positive effects as well. It creates a demographic division in among the population. For example, it decrease the dependency ratio i.e. ratio of working to non-working or the ratio of child and old people verses adults. In addition, it can also increase the capacity of the human resources which is positively related to the productive capacity of the population. It is estimated from the amount of investment by any country in human development i.e. health, education and training by realizing demographic division in population. On the other hand, it is also the need of the time to invest more and more fulfilling nutritional needs of the population. However, climate is changing and water resources are being depleting day by day. This will in turn pose major challenge faced by the country in coming years.

It is noted in National Nutrition Survey that approximately 60% the population in Pakistan is facing food insecurity. Moreover, about 50% children and women are malnourished. These nutritional deficiencies are expected to lower intellectual faculties among school going children. Adults might experience intergenerational inequities of opportunities and income. Therefore, it is concluded that growing population in Pakistan give birth to a number of threat to climate change, depletion of water resources, food and nutrition security socio-economic indicators of development.

Higher population growth rate is expected to increase population which poses a challenge for the government to provide job opportunities for such huge number of people. As the number of individual is increasing in workforce but meaningful job opportunities are lesser. At current scenario, about 1.5 million new job are need in the country to keep unemployment rate at existing level. However, for increasing productivity in the country full employment is required.

For protecting social fabric in the country it is also required to increase full employment which will in turn raise family income and consumption, maintain self-esteem and reduce income disparities.

For overcoming the challenges posed by higher population growth rate, it is important to start interventions that will operationalize the objectives relevant to lower population growth rate. The program “Expansion of Family Welfare Centers and Introduction of Community Based Family Planning Workers” is aimed to increase CPR in the countries and increase access to ANC and PNC services in the districts where CPR is lower and population growth rate is higher. For this purpose, FWCs are functional in 22 districts and CBFPWs are operational in 13 districts. This implies that the current program has high degree of relevance to development policy and planning of the country.

#### **4.1.2 Importance of program for target group**

A majority of the respondents claimed that the program was pertinent with unmet need of beneficiaries for family planning, maternal and child health care. The service providers reported to motivate and counsel both married and unmarried beneficiaries about family planning services. It is the achievement of this program that information about family planning methods and the services of family planning were accessible at Union Council (UC) levels in the district where intervention was started. The beneficiaries belonging to lower socio-economic class particularly living in rural areas were unable to pay for family planning services. Therefore, this program provided them very reasonable platform for gaining information about family planning methods and the services of family planning. Besides providing the services of family planning, this program increased access to maternal and child healthcare. Both ANC and PNC and general

medicines were provided at FWCs and by CBFPWs. The availability of these services increased free of cost and timely access to ANC and PNC.

The findings showed that about 70.8% of the beneficiaries were using family planning services i.e. condoms (30.4%), oral pills (17.4%), IUD (26.1%) and injectable (26.1%) from CBFPWs. Besides the services of family planning, beneficiaries were also availing ANC and PNC. About 69.2% of the respondents reported that they visited CBFPWs for their routine checkup during their last pregnancy. About 50% of these respondents visited CBFPWs three times, 27% visited four times and 23% visited more than 4 time during their last pregnancy.

About 90% of the respondents who visited CBFPWs were satisfied from the provision of ANC. Data also indicated that 87.5% of the respondents visited CBFPWs after

**Table 4.1:Socio-demographic Characteristics of the respondents**

Characteristics	FWC %	CBFPW %	Non Beneficiary %
Age			
≤ 24	12	13.8	14.3
25-29	40	26.2	34.3
30-34	29	32.3	34.3
35-39	70	15.4	14.3
≥40	90	12.3	2.9
Qualification			
Primary	23	45.2	0
Matric	40	19.4	48.6
Intermediate	6.8	9.7	25.7
Graduation	5.1	1.6	5.7
Illiterate	25	24.2	0
Master and above	0%	0%	5.7
Working status			
Yes	6.9	21.1	5.7
No	93	78.9	94.3
Family members			
≤3	8.6	0	8.6
>8	23	20	28.6
4-5	33	27.7	34.3
6-7	36	52.3	28.6
Family income			
≤10000	15	0	0
10000-20000	51	30.8	31.4
20000-30000	28	23.1	60
>30000	7.4	46.2	8.6

delivery. About 42.2% claimed that they visited CBFPWs after their delivery for newborn checkup, 19.1% for their own checkup and about 18.6% visited for family planning services.

Similarly, the beneficiaries of FWCs were also availing the services of family planning, ANC, PNC and newborns checkup. Data collected from the beneficiaries of FWCs indicated that 72% of the respondents were availing family planning services from FWCs. About 23.4% of these beneficiaries were using condoms, 11.9% oral pills, IUD (32.8%), injectable (29.4%) and only one respondent was using IMPLANON from district Sargodha. It was observed that 68.7% of the beneficiaries visited FWCs for ANC. About 43.2% of them visited FWCs for two times, 31.3% visited 3-4 times and 22.4% visited 5 times or more than five time for ANC. About 90.8% of the respondents claimed that they visited FWCs after their delivery either for their own checkups or the checkup of their newborn (74.7%). In addition, about 34.9% of the beneficiaries visited FWCs for the vaccination for their newborn. However, 87.7% of the respondents claimed that they visited FWCs after their delivery for availing family planning services.

#### **4.1.3 Relevance of the program with strategic goals**

The program is positively related to the strategic goals of the country. For example, it is very hard to gain socio-economic development without significant investment in population welfare and family planning. Investment in family planning and other such interventions is believed to decrease population growth rate in the country. Moreover, it is found that higher population growth rate burdened economy which is a major challenge for many developing countries not a day. The program is also important for giving birth to demographic division which in turn decrease dependency ratio in the country and enhance living standard of the people. Investment in family planning is pertinent because it is very difficult to fulfill nutritional needs of rapidly increasing population. In addition, it is not possible for the government to create employment opportunities for the population along with meeting their health and educational needs. Higher

population growth rate is also expected to put pressure on climate change as the resources are being depleted day by day because of greater needs of the population (Pakistan Vision 2015).

## 4.2 Effectiveness of the project

The majority of the respondents from program management reported that the objectives of the program are realistic because it is possible to improve child and maternal health and provision of family planning services. The effectiveness of the program is found mild as the program increased CPR significantly but the cost of the program remained relatively higher. It was planned to increase CPR to 45% in three years but the program was capped which reduced scope of the program. Despite being capped, the program increased access of the clients to safe and healthy contraceptive methods and clients perceived improvement in their own health and the health of their children. According to one of the respondents from program management;

*“The scope of the program was decreased and as per plan in PC-I, physical target was not achieved. In addition, the program faced many challenges in implementation. Because of unnecessary delay and lack of strong political will, it became very difficult for the program to achieve major objectives.”*

However, service providers approached influential stakeholders from local community and provided the information of family planning and child and maternal health care. In about three years of functional activities of FWCs and CBFPWs, about 623,005 beneficiaries' availed condoms, 429,483 used oral pills, 228,952 used IUD, 255,834 used injectable, 1,596 availed IMPLNON and cases of Contraceptive surgery are about 17,043. About 226,188 mothers availed ANC and PNC. In addition, beneficiaries of the program also included children 472,926 and 1,240,385 general patients. According to one of the respondents the program was providing free general medicine, contraceptives and maternal and child care.



*“One of the most effective achievements of the program is the provision of services to poor segment of the population which were being neglected since 1947. However, the segment of the population is major contributor to increase population growth rate. Therefore, it is correct that the program targeting real objectives through real time provision of services.”*

According to the objectives of the program, FWWs and CBFPWs were planned to target married couples for providing family planning services and maternal and child health care. The assessment results indicated that FWWs were targeting married women (25.5%), unmarried boys (22.6%) and third main target group of the FWWs are children (22.1%). However, they were also targeting couples and unmarried female. Only 5.1% husbands were being targeted by FWWs for their counseling to avail services from FWC. However, in patriarchal societies like Pakistan, decisions are not taken by wives alone. Therefore, it is good technique to target husbands as well because one of the most frequent/prevalent contraceptive methods in Pakistan is male condoms. On the other hand, target group of CBPFWs also included wives (87%), husbands (22%) and children (1%). The comparison of both the target group of FWWs and CBFPWs indicated that married women were major target of both FWWs (25.5%) and CBFPWs (85%).

According to one of the respondents from management of the program;

*Field worker of FWCs and CBFPWs target all eligible couple to motivate them to use family planning services. For achieving these objectives, they meet with husband and wife, husbands and wives separately as well. In addition, target group of the field staff also include child and general patients.*

The FWWs and CBFPWs were asked to provide data about average number of beneficiaries per month who were taking their services i.e. FP, ANC and PNC and general treatment etc. On average, 121 women per month were availing the services of FP, 11 women were availing ANC,

59 women per month were availing PNC from FWCs. It was found that on average 521 men were utilizing different services by FWCs. However, a total of 76 children were getting general treatment from FWCs. Above mentioned results indicated that majority of the centers were being attended by male beneficiaries for getting general treatment and family planning services. On the other hand, CBFPWs reported that on average 53 women were availing family planning services, 9 women were availing ANC and 8 women were availing PNC. The beneficiaries of CBFPWs also included 29 men and 14 children per month.

FWWs and CBFPWs were asked about their target and achievement per month i.e. referral and counseling of the beneficiaries to Basic Health Units (BHUs), Rural Health Center (RHC) and Tehsil Head Quarter (THQs)/ District Head Quarter (DHQs). FWWs reported that on average, they were referring 13 cases and 63 clients were provided counseling of FP and they were successfully achieving their target of referral and counseling. In addition, FWWs were successfully achieving the target of follow up of 79 clients per month. On the other hand, CBFPWs reported that their average target for referral was 12; average target for counseling was 36 and average target for the follow up of family planning services was 20 clients per month. Data collected from CBFPWs indicated that they mostly achieved set targets.

The majority of FWWs claimed that the local stakeholders knew about the importance of services provided by both FWCs and CBFPWs. About 66.3% of the FWWs claimed that Imam Masjids considered that the services provided by FWCs are necessary, while 11.6% of the FWWs claimed that Imam Masjids considered these services unnecessary. About 84% of the FWWs claimed that men, women, overall local community, governmental institutions, and NGOs were fully aware of the necessity of family planning service for the community.

Table 4.2: Response of local community about the services provided by FWCs						
Local community	Negative		Average		Positive	
	f	%	f	%	f	%
Imam Masjid	10	11.6	19	22.1	57	66.3
Local community on average	0	0	8	9.3	78	90.7
Men on average	2	2.3	11	12.8	73	84.9
Women on average	0	0	0	0	86	100.0
Local leadership	1	1.2	8	9.5	75	89.3
Government Institution	2	2.4	1	1.2	81	96.4
NGOs	1	1.2	9	10.6	75	88.2
Others i.e. religious leader, teachers	0	0	7	20.0	26	80.0

On the other hand, the majority of CBFPWs consider that local stakeholders see their services necessary for the society. For example, 27.3% Imam Masjids, 66.2% men, 87.7% women, 49.2% of overall local community, 84.6% of government institutions, 81% NGOs have positive response towards the services. Only 15.2% of the CBFPWs reported that the response of Imam Masjids was negatives about their services. However, when talking about the hurdles faced by the program, one of the respondents responded:

*There are some cultural and religious factors which become hurdle when we ask respondents to avail the services of family planning. In addition, the desire of son demotivates couple to avail services and popular notion is that every child brings his/her livelihood with him/her.*

The majority of FWWs (72.1%) were highly satisfied from community participation in the program. similarly, 70.1% of the CBFPWs were highly satisfied from community participation in the program. However, only 29.9% of the CBFPWs were satisfied from community

participation. This implies that community was motivated and fully cooperated with service providers (i.e. FWWs and CBFPWs).

The development policy and technical planning of the program was found effective. The program offered both dynamic and static facilities for the provision of the services. In addition, CBFPWs were also inducted to increase the clientage of the program. CBFPWs were recruited in villages where static facility of the family planning was not available. Moreover, the program was also found effective in term of community participation. For increasing community participation, key influential persons from the local community were included into welfare committee. However, no other arrangements of community participation were found. Although, the program include systematic involvement of Population Welfare Department and Health Department for increasing contraception yet coordination is less with other public institutions and private organizations. According to the one of the respondents:

*At policy and planning level, the program was well planned. For increasing contraception in the districts having lower CPR, it was planned to provide both static and dynamic facilities which was achieved as well. However, coordination with other national and international departments remained non-effective.*

#### **4.4 Efficiency**

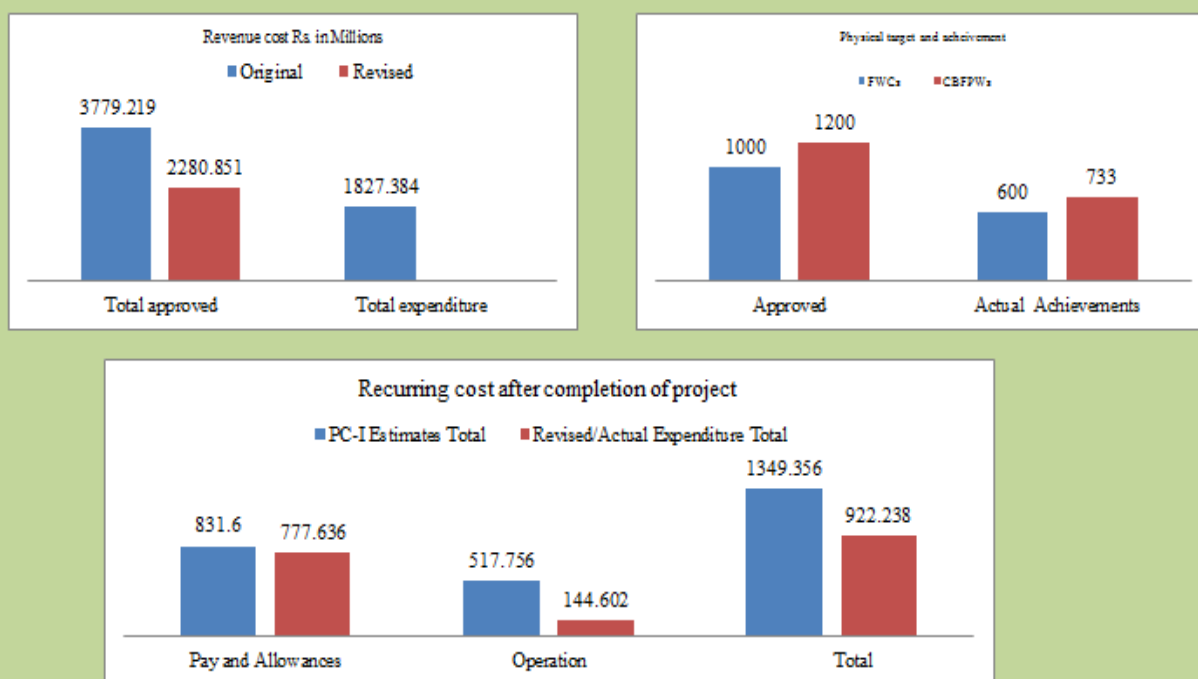
The findings of both quantitative and qualitative data showed that the efficiency of the program was satisfactory. A majority of the beneficiaries were highly satisfied from the services and availed FP services and maternal and child health care. Service providers were mobilizing community, guiding and motivating them to avail family planning service. For measuring efficiency of the program, location and appropriateness of the FWCs and record maintenance was assessed. Additionally, it was also assessed that how the service providers mobilized the community and provided the counseling and guidance sessions to the beneficiaries.

Furthermore, the referral mechanism and availability of staff, medicines and medical equipment were also assessed in FWCs.

#### 4.4.1 Budget and financial phasing of the project

Total original cost of the project in PC-1 was Rs. 3779.219 million and revised cost was 2280.851 million. However, total expenditure of the project was Rs. 1827.384 million. In PC-1, it was planned to establish 1000 FWCs and to recruit 1200 CBFPWs during 2014-2018. However, 600 FWCs were established and 733 CBFPWs were recruited (Figure 4.1). According to financial phasing of the project, 2280.851 million was provided in PC-1 phasing, 2635.062 were provided in Annual Development Program (ADP) allocation, 2126.412 million were released. In recurring cost, a total of 1349.356 million were provided for pay and allowances and operations. However, total expenditure was 1827.384 million till 30<sup>th</sup> June 2018.

Figure 4.1: Budget and financial phasing of the project



These results indicate that total funding was provided from local provincial budget and there is no other source of funding for implementing the program. In addition, proper quantification of budget is also not provided which can be used to estimate the cost according to service providers i.e. FWCs and CBFPWs. However, cost per user is estimated by dividing total expenditure (1827.384 million) by number of clients of FP, ANC, PNC, Child care and general patients (4,118,199). The calculated cost per user was 444 rupees per beneficiary till Dec 2018.

#### 4.4.2 Appropriateness of FWCs

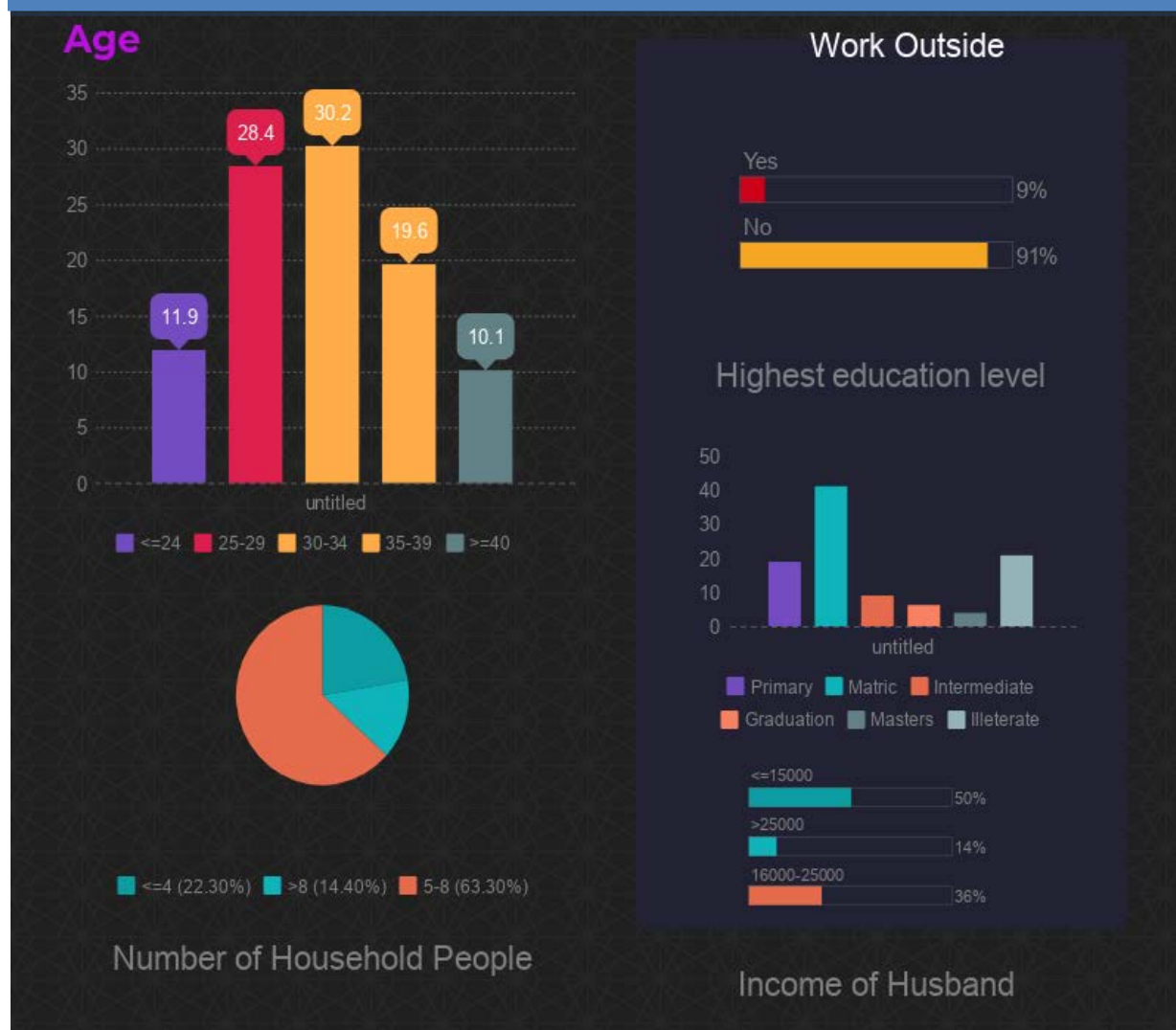
For checking the appropriateness of the FWCs, interviewers recorded the appropriateness of location, access to FWC,

Table 4.3: Appropriateness of services		
Characteristics	FWC %	CBFPW %
Visiting alone		
Yes	95	62
No	5	39
Easy access		
Yes	97	92
No	3	8
Convenient hours		
Yes	94	86
No	6	14
Information about FP		
Yes	92	95
No	8	5
Sufficient time for consultation		
Yes	89	95
No	11	5
Opportunity to ask questions		
Yes	95	96
No	5	4
Explanation of FP services		
Yes	92	95
No	8	5
Sufficient privacy		
Yes	99.7	98
No	0.3	2
Friendly and respectable dealing		
Yes	98	95
No	2	3
Services according to needs		
Yes	91	99
No	9	2
Revisiting service providers		
Yes	40	23
No	60	77

cleanliness of the center, ownership of the building and signboard outside of the center. Based upon the observation of interviewers, centers were appropriate in term of location, access, cleanliness, ownership of the building and display of signboards. According to the observation of the interviewers, a majority of the centers (97.6%) have appropriate location but the location of 2.4% of the centers was not appropriate. About 96.4% of the centers were easy to access.

However, there were two FWCs which were not easy to access by the beneficiaries. In addition, building of the three FWCs were provided by respective community voluntarily and only one center did not have any signboard.

Figure 4.2: Socio-demographic characteristics of the beneficiaries



The conditions of the hired buildings were satisfactory. Location and condition of the building was satisfactory for security measures. On the other hand, beneficiaries of the FWCs were also asked from approximate distance between their home and FWC for measuring the accessibility.

Results indicated that 70% of beneficiaries have walking distance, 22.2% have 1-2 kilometer, 4% have 3-4 kilometers and 3.1% of the respondents reported distance of above 4 kilometers between FWC and their home. Beneficiaries usually covered this distance using motor bike (25.6%), public transport (15.5%) and bicycle (6%).

#### 4.4.3 Availability of staff

According to PC-1, it was planned that the five membered staff would manage each FWC. FWW would work as the in-charge of the center and supposed to be responsible for overall service delivery by the center.

Two assistants i.e. male FWAs and female FWA, one Aya and one Chowkidar would be provided for starting operational activities. However, out of 85 centers, four centers did not have FWW, 19 centers did not have male FWA,

Table 4.4: Availability of staff in FWCs				
Staff	Sanctioned	Hired	Present	Vacant
FWWs	85	82	81	4
FWA (male)	85	67	66	19
FWA (female)	85	74	72	13
Aya	85	83	81	4
Cowkider	85	80	79	6
Total	425	386	379	46

13 centers did not have female FWAs and 6 centers did not have Chowkidar. This implies that majority of the centers have sufficient staff. However, service delivery might be enhanced by increasing staff in the centers where staff was not available or sufficient.

Management of the project was also asked to provide their opinion about the availability of the staff in FWCs. A majority of the respondents from the management of the project reported that staff was inadequate for running FWCs efficiently. They recommend increasing field staff in each FWC for social mobilization of the beneficiaries. Currently, there were only two FWAs at each center who have to cater the population of 5000-7000 through static facility and population



of 15,000-25,000 by arranging satellite camps. Two FWAs and one FWW who was also the in-charge of the FWC and have to take care of every aspect of the FWC were not able to reach every expected beneficiary. According to the one of the respondents:

*At initial level, the program faced delay. Actually the program started on 2<sup>nd</sup> January 2015 instead of 1<sup>st</sup> July 2014. Besides this delay, trained staff was not available. Non-availability of trained family welfare workers and the slow recruitment process of the staff at district level also caused further delay in starting functional activities in FWCs. Currently; staff is not adequate for running operational activities.*

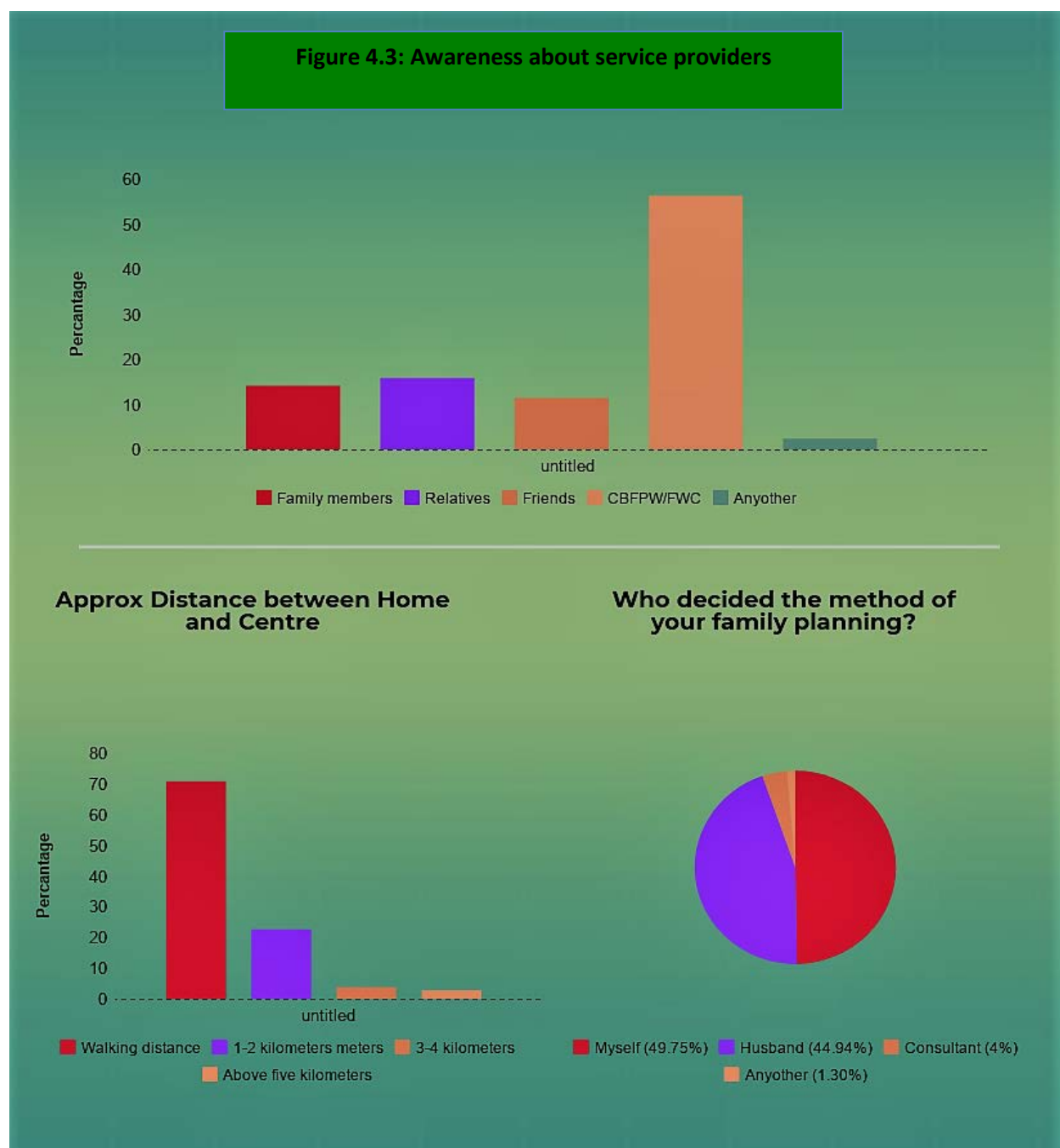
#### **4.4.4 Record maintenance**

For checking the efficiency of the FWCs, interviewers were specially trained to check the record i.e. ODP register, stock register and register of visitors' record of the centers. For this purpose, interviewers physically checked the entries on different registers in the center. It was found that almost every center had maintained OPD registers, register of medical equipment and register of visitors. However, six centers had no record of stock registers and registers of visitors. The condition of record maintenance was average in the majority of the centers and one center was found non-satisfactory in term of record maintenance.

#### **4.4.5 Beneficiaries of social mobilization part of Family Planning Program**

Data collected from the beneficiaries of the CBFPWs indicated that almost every beneficiary (98.5%) was approached by the CBPFW for using the services of family planning. Only nine women reported that CBFPW did not contact her for availing family planning services. When respondents were asked about the sources of information about CBFPWs, 14.9% reported that their family members such as husband, parents etc. provided information about CBPFWs. However, 22.4% of the beneficiaries reported that their relatives and 10.4% were provided

information by their friends. Approximately 52.2% of the respondents claimed that they were approached directly by CBFPWs.



Similarly, the majority of beneficiaries (96.1%) reported that CBFPWs guided them about family planning methods and family planning services. Only three women were not guided by CBFPWs because of lack of privacy problem. In addition, the majority of the beneficiaries (96.6%) were satisfied from the counseling about family planning by CBFPWs.

The majority of the beneficiaries of FWCs were also approached by the field staff. However, 2.8% of the beneficiaries were not approached by the field staff. Those who were approached by the field staff were satisfied from their guidance and counseling about family planning.

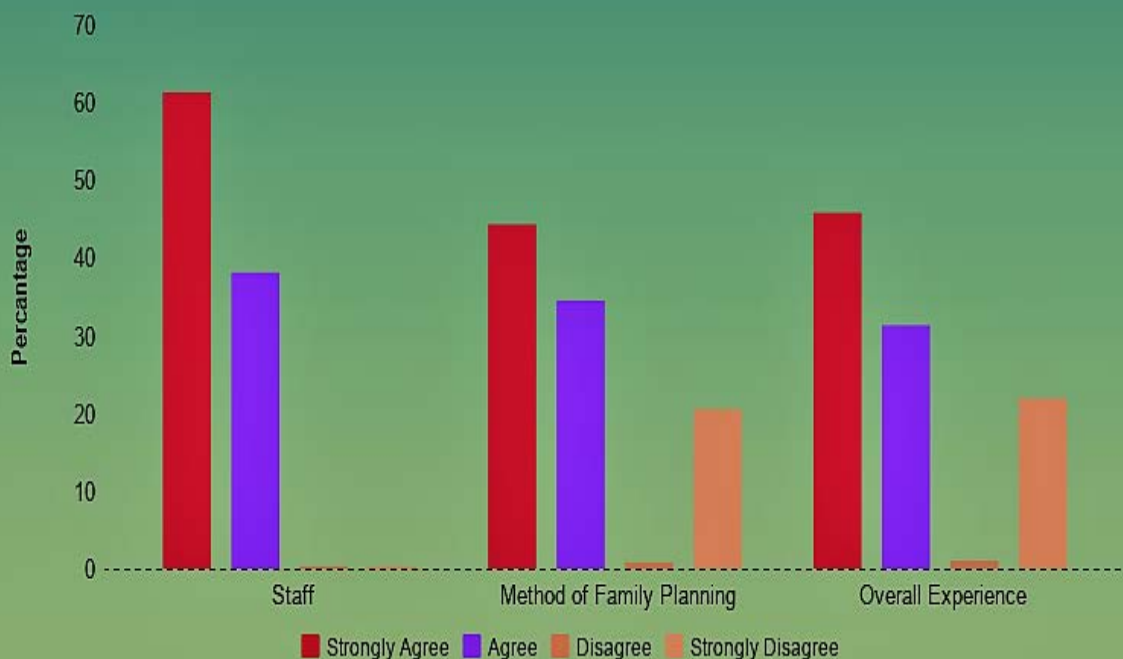
When asked about the sources of information about FWCs, 13.6% reported family members, 19.4% reported relatives, 12% reported friends and 55.1% claimed that they heard about the services from the field staff of FWC. However, counterfactual analysis indicated that the majority of the non-beneficiaries were being contacted by field staff but they were not availing family planning services from FWCs and by CBFPWs. These results indicated that

Table 4.5: Social mobilization of beneficiaries		
Variables	f	%
<b>Approached by CBFPWs</b>		
Yes	315	97.2
No	9	2.8
<b>Provision of guidance about family planning</b>		
Yes	319	99.1
No	3	0.3
<b>Satisfaction from CBFPWs</b>		
Yes	320	99.1
No	3	0.9

social mobilization of the clients need more focused strategies to increase clientage of the FWCs and CBFPW. The qualitative interviews with program management indicated lack of partnership and coordination with specialized departments for social mobilization of the clients about family planning and other services provided at FWCs and by CBFPWs. According to one of the respondents:

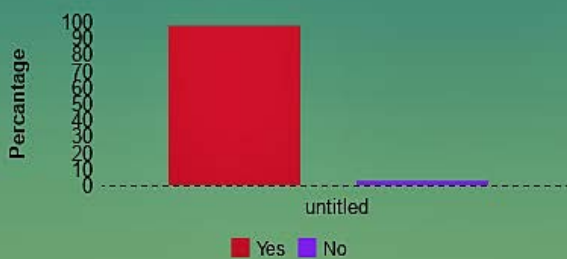
*Technical support for social mobilization of the clients is not effectively provided by other departments. Therefore, field workers are forced to use traditional method of social mobilization. However, successful implementation of the program required inevitable technical assistance from both national and international agencies.*

**Figure 4.4: Clients' satisfaction from service providers**

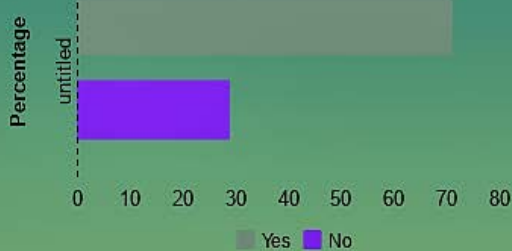


Level of satisfaction with FWC AND CBFPW

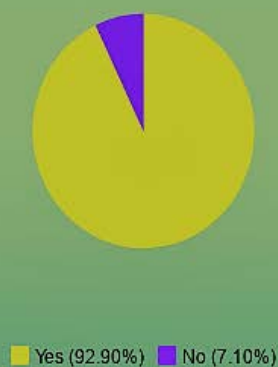
Figure 4.5: Clients' social mobilization utilization and satisfaction from service providers



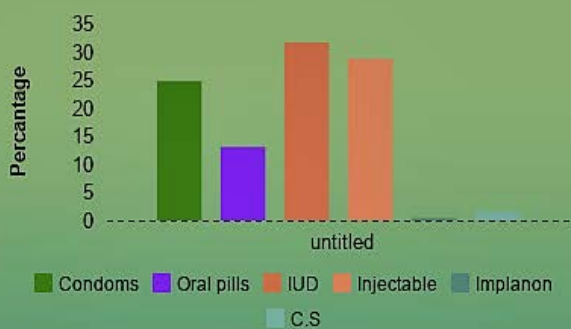
Have you ever approached by the field staff of CBFPW & FWC?



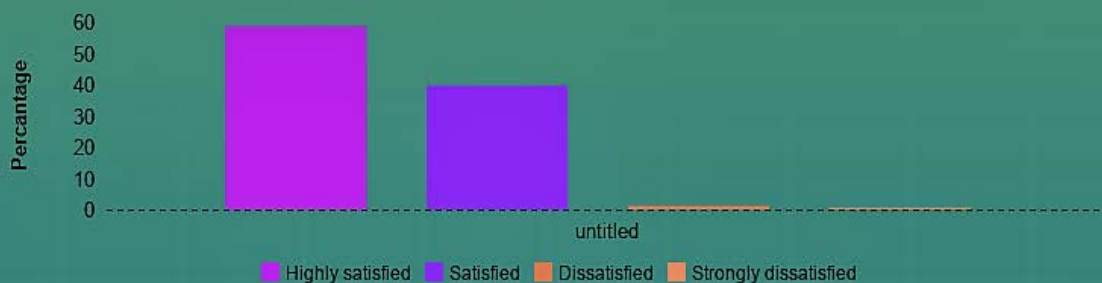
Are you using any family planning methods by CBFPW & FWC?



Have you visited FWC & CBFPW after delivery?



Which family planning method you are using?



Are satisfied with the services provided by FWC & CBFPW for improving child and mothers' health?

#### 4.4.5.1 Method and place to motivate beneficiaries

Results of the data provided by FWWs indicated that majority of the beneficiaries (67%) were directly approached by field staff and 39.1% were approached using referral.

But only 6% of the beneficiaries of FWCs were being approached and motivated to use family planning at their doorstep (at home) and 93.4% were visiting FWCs for getting information about family planning. On the contrary, majority of the CBFPWs (98.5%) reported that they approached their beneficiaries directly and about 16.4% beneficiaries were approached through referral from the users of services. In addition, the majority of the CBFPWs (94%) were approaching their beneficiaries at their home. However, 23.9% of the beneficiaries were

Table 4.6: Method, place and number of meeting for motivating beneficiaries		
Variables	f	%
Method		
Direct visit	67	60.9
Referral	43	39.1
Place		
In their homes	6	6.6
In FWC	85	93.4
Meetings		
<=2	30	36.1
3	22	26.5
<=5	17	20.5
Every month	14	16.9

visiting CBFPWs (in CBFPW's home) for availing the services. These results indicated that most of time clients were being briefed about family planning methods at FWCs. However, the clients who were not able to attend FWCs cannot get information about family planning.

Beneficiaries of CBFPWs reported that they were provided services free of cost. During consultation, every beneficiary was briefed about alternative methods of FP. Only one respondent claimed that her family planning method was solely decided by her consultant. However, 65.6% of the respondents claimed that they themselves decided the method of their family planning.

About 32.8% of the beneficiaries reported that their family planning method was decided by her husband. Respondents were also asked about their number of visit to CBFPWs. It was observed from the data that 46.8% of the respondent visited CBFPW once in a month, 27.4% visited once a week, 21% visited once in three months and about 4.8% of the beneficiaries visited irregularly. From the beneficiaries of CBFPWs, about 23.1% reported that they had to revisit CBFPWs either because of her non-availability or absence of services etc.

For checking the proficiency of the services provided by FWCs, beneficiaries were asked about the services, service providers and service centers as well. Results indicated that the majority of the respondents (42.9%) spent 5-10 mints in the centers, 41.7% spent 11-20 mints, 11.6% spent 21-30 mints and 3.7% spent more than half hour in the center for availing services. In addition, 41.2% of the beneficiaries of FWCs visited once a week, 44.9% visited once a month and about 14.3% visited once in three month. However, about 40% of the beneficiaries reported that they had to revisit FWCs either because of the non-availability of technical staff or services. In addition, the majority of the respondents claimed that working hours were convenient for them and they were informed about FP methods during their visit of FWC.

Beneficiaries claimed that they were given sufficient time for consultation according to their needs in the center. Beneficiaries reported that they were given full opportunities to ask questions, clarify their doubts and method of FP was explained clearly. Only one beneficiary reported that she had not provided sufficient privacy during her consultation with the FWW. Similarly, only one respondents claimed that services were not provided free of cost. However, there was a consensus among the beneficiaries that they were treated respectfully and the response of the staff of FWC was friendly. Only 4.5% of the beneficiaries reported that they

were practicing family planning method decided by their consultant. However, 47.7% of the respondents claimed that they themselves decided their FP method and same number of respondents reported that their husbands decided the method of FP.

#### **4.4.6 Counseling of beneficiaries**

It is the major responsibility of service providers i.e. FWWs and CBFPWs to motivate eligible couples for availing family planning services. For the sake of motivation, service providers meet expected beneficiaries for their counseling. At initial level, on average they meet beneficiaries twice a month (36%). About 26.5% of FWWs reported that they met thrice a month and about 20.5% met five times in a month for the counseling of the beneficiaries. However, about 16.9% of FWWs were meeting with new clients only once in a month. This implies that FWWs were meeting twice or less to their expected clients. On the other hand, 69.4% of the CBFPWs reported that they met their expected beneficiaries once a month, 11.3% twice a month, 9.7% thrice a month, 4.8% four times and same number of CBFPWs met five time in a month for the counseling of clients.

#### **4.4.7 Proficiency of services**

Beneficiaries of both FWCs and CBFPWs were asked about their contact/consultation time duration with CBFPW. About 60.7% of the beneficiaries reported 11-20 mints, 24.6% reported 5-10 mints and 13.1% stated 21-30 mints were spent for consultation with service providers. Only one beneficiary claimed that it took more than half hour in consultation with CBFPW. About 86.2% of the beneficiaries reported that the working hours of CBFPWs were convenient. From beneficiaries of CBFPWs, about 95.4% reported that they were informed about contraceptive methods and the time spent for consultation was sufficient.



With respect to professional expertise of CBFPW, a majority of the beneficiaries reported that the use of contraceptive method was explained clearly. About 98.4% of the respondents claimed that they were provided sufficient privacy during their meeting with CBFPW. In addition, 95.4% of the beneficiaries claimed that they were treated in a friendly and respectable way.

#### 4.4.8 Appropriateness of the services

Beneficiaries of both FWCs and CBFPWs were asked to provide their feedback about the appropriateness of the services and service providers. It was found that 61.5% of the beneficiaries visited the home of CBFPW alone. However, 7.7% of the beneficiaries reported that it was not easy to visit CBFPWs. Only one respondent claimed that the services provided by CBFPWs were not according to their needs. Results indicated that 60.3% of the respondents were highly satisfied from CBFPWs. Similarly, 54.7% were highly satisfied from the methods of their family planning. When

Table 4.7: Average time spent at service center		
Service center	f	%
<b>FWC</b>		
5-10 min	137	42.9
11-20 min	133	41.7
21-30 min	37	11.6
31-59 min	9	2.8
More than one hour	3	0.9
<b>CBFPW</b>		
5-10 min	15	24.6
11-20 min	37	60.7
21-30 min	8	13.1
31-59 min	1	1.6

asked about overall experience with CBFPWs, 63.9% were highly satisfied from overall experience with CBFPWs. Moreover, the majority of the beneficiaries of CBFPWs were satisfied with their guidance and counseling about FP, ANC and PNC.

The majority of the beneficiaries of FWCs 94.7% claimed that they visited FWCs alone and it was easy for them to visit FWCs. None of the respondents claimed that they face any difficulty to visit FWC. The majority of the respondents claimed that the services provided by the FWCs

were according to their needs of family planning. Therefore, the majority of the respondents remained satisfied from the provision of services at FWCs. The data also indicated that 61.5% of the respondents were highly satisfied from the staff of FWCs. About 42.2% of the respondents were highly satisfied and 24.3% were highly dissatisfied from their family planning methods. Similarly, 24.3% of the beneficiaries were highly dissatisfied from their overall experience at FWCs. Only 6.4% of the respondents who availed ANC claimed that they were not satisfied from their routine checkups.

#### 4.4.8 Satisfaction from program achievement

Majority of the FWWs and CBFPWs were satisfied from the program achievement regarding family planning services and maternal and child care. About 74.7% of the FWWs were highly satisfied regarding the achievement of the program about FP services. Similarly, about 81% were highly satisfied from the provision of maternal and child care. In addition, about 72.1% of the FWWs were highly satisfied with the proposed methods of FP.

<b>Table 4.8: ANC visit by beneficiaries</b>		
<b>Characteristics</b>	<b>FWC %</b>	<b>CBFPW %</b>
<b>ANC</b>		
Yes	69	69.2
No	31	30.8
<b>Number of visit</b>		
<=2	43	10
3-4	31	70
>5	22	20
<b>Satisfaction</b>		
Yes	94	90
No	6.4	10

On the other hand, 79.1% of the CBFPWs were highly satisfied from the achievement of program about FP, provision of maternal and child healthcare. However, interview with one of the respondents from District Population Welfare Officers indicated a need to improve the standard of proposed family planning methods. He opinioned:

*The methods of family planning are not up to date. We are using low quality family planning methods which are not consistent with needs of the beneficiaries. We lack technical staff and technical support for running sophisticated family planning methods.*

#### **4.4.9 Delay and shortcoming in project implementation**

The program “Expansion of Family Welfare Centers and Introduction of Community Based Family Planning Workers 2014-18” was planned to start from 1<sup>st</sup> July 2014 to 30<sup>th</sup> June 2018 as per PC-I. But actually the project started from 2<sup>nd</sup> January 2015 and ended on 30<sup>th</sup> June 2018. However, PC-I was revised and the scope of the project was limited which reduced physical target and 600 FWCs were established and 733 CBFPWs were recruited. Based on the planned physical target of the program in PC-I, major objectives of the program were to ensure universal coverage and improve access to safe and quality FP and reproductive health services by 2018, to raise CPR to 45% by 2018 through expansion of FWCs and community involvement by revival of Community Based Family Planning Workers, to increase demand for small family and social approval of FP, to reduce unmet need by increased access to good quality information, advice and services and to increase community participation and accountability.

As the actual scope of the project was not achieved i.e. instead of 1000 FWCs 600 were established and instead of 1200 CBFPWs only 733 were recruited. Therefore, the program was less likely to achieve the set target i.e. to raise CPR to 45% and other major objectives. In addition, the program also faced some other challenges which caused a delay in the implementation of the program. For example, at the time of recruitment, trained FWWs were not available. FWWs have to work as the in-charge of the FWCs; therefore, the availability was necessary for starting functional activities. Moreover, complexity in the recruitment process delayed program and low incentives for field staff caused dropout. For example, out of 85

centers, four centers do not have FWW, 19 centers do not have male FWA, 13 centers do not have female FWAs and 6 centers do not have Chowkidar. Desk review and interviews with management indicated that the availability of logistic and financial arrangement at district and tehsil level was not up to date. For example, TD and DA for field staff of the center is not fixed which in turn inhibit the ability of the field staff to mobilize beneficiaries.

## 4.5 Impact

Both qualitative and quantitative results indicated that the program has positive impact on the overall wellbeing of the beneficiaries. In addition, the effects of the program were also positive for improving CPR (family planning), access to health care for mother and child. The program was providing general medicine to all the members of target groups i.e. women, men and children. It was also the positive impact of the program that majority of the local community members have positive attitude towards the services provided by the program.

### 4.5.1 Contraceptive prevalence rate (CPR)

The program was intended to increase CPR to 45% in the districts where CPR was lower according to the data provided by MICS. For measuring long term impact of the program, CPR was calculated. CPR is the percentage of the women who are practicing themselves or their partners are practicing any form of contraception. CPR is measured for reproductive age women 15-49 years of age. It is calculated by dividing total users of contraception with total reproductive age women in that particular area. For calculating CPR, following formula was used:

$$CPR (\%) = \text{No of users} \times 100 \div \text{Married women of reproductive age (15 – 49)}$$

For calculating contraceptive prevalence rate, year wise performance report i.e. 2015-2016, 2016-2017 and 2017-2018 was used which contain total number of users of FP who availed

family planning services from FWCs and total reproductive age women living in catchment area. Average CPR for the year 2015-2016 were 10% which increased to 24% in 2016-2017 that further increased to 47% in 2017-2018. However, average CPR in 2015-2018 was 27%.

Average CPR in 2017-18 is higher to the estimated modern CPR for the year 2016-2017 (Pakistan Bureau of Statistics, 2018). In addition, according to key findings of Pakistan Demographic and Health Survey (2017-2018) 34% of the reproductive age women were using family planning services and the most common type of family planning is male condoms and female sterilization. However, some limitations were faced while calculating CPR i.e. lack of properly maintained data, provision of contraceptive services out of catchment area, date of establishment of centers were different in different districts and number of users also include those users who revisited centers.

#### **4.5.2 Impact of the program on other sectors**

According to qualitative data provided by the management of the program the impacts of the program were diverse i.e. financial and social impacts. Massive population of the province affects each and every sector. Respondents claimed that population explosion placed great deal of burden upon economy. Reduction of population growth rate (PGR) is beneficial for socio-economic development of the country. In addition, reduction in PGR would disperse benefits for other sectors of the country i.e. health, education etc.

The reduction in PGR will affect employment opportunities and will increase the per capita income. Moreover, it is also believed that reduction in PGR affect living standard of overall population. By generating employment opportunities it affect both directly and indirectly the living standard of the people. According to Afzal (2009), there is negative association between high PGR and economic development of the country. He analyzed the data from 1981-2015

collected in Pakistan Economic Survey and International Financial Statistics yearbooks and used multivariate analysis to find out the relationship between high PGR and measures of economic development. The negative association between high PGR and economic development is an indicator that high population growth rate is a real problem faced by Pakistan. Therefore, reduction in PGR is inevitable.

Respondents also claimed that decrease in PGR and increase in CPR is beneficial for social sector as well. Population explosion increases the burden of poverty. According to one of the respondent:

*High population growth rate is negative for the overall development of the country and province as well. Our program is aimed to increase contraceptive prevalence rate to reduce population growth rate. Decrease in population growth rate will surely improve living standard of the people by increasing their access to health and education facilities.*

A majority of the respondents were of the view that positive impacts of the program were diverse. They further claimed that the most important impact of the program was on social sector. Increase in CPR would affect the social development and increase the opportunities towards employment and quality of life. According to one of the District Population Welfare Officer, decrease in family size and population growth rate would decrease deprivation and absolute poverty. In addition, one of the respondents claimed that reduction in population and increase in CPR would decrease marginalization among poor families. Five respondents out of 16 claimed that the program also have positive implications on environment. According to one of the respondents:

*Individual affect environment both negatively and positively. But negative affect is greater than positive. Everyone use some resources which create his/her impact*

*on environment. Higher the number of people who use resources greater is their impact on the environment. In simple words, high population growth is negative for sustainability of the resources available in the environment.*

#### 4.5.3 Increasing access to health care services

For measuring the short term impacts of the program, respondents were asked about the increase in their access to health care service. Data collected from the management of the program indicated that the program provided free of cost FP services, ANC and PNC. These services were being provided at door step to the beneficiaries of CBFPWs and beneficiaries were also visiting FWCs for availing the services.

About 97.4% of the beneficiaries of CBFPWs reported that they felt improvement in their child's health and 1.5% of the respondents claimed that visiting CBFPW did not improve their health. However, 6.25% of the

Table 4.10: Improvement in mother and child health

CBFPWs	f	%
Own health		
Yes	45	93.75
No	3	6.25
Baby's health		
Yes	38	97.4
No	1	1.5
FWCs		
Own health		
Yes	249	98.8
No	3	1.2
Baby's health		
Yes	216	96.0
No	9	4.0

respondents reported that the services provided by CBFPWs did not improve their own health. On the other hand, the majority of the beneficiaries of FWCs reported that visiting FWCs improved their own health (98.8%) and the health of their newborns (96%) (Table 4.10). When beneficiaries were asked about the level of satisfaction from the services provided at FWC for

improving their own health and their newborns' health, 61% were highly satisfied and 38.3% reported that they are satisfied from the provision of ANC and PNC services by the program.

## 4.6 Sustainability

Sustainability of the program indicates the ability of the beneficiaries to continue the services of family planning, child and maternal health care provision from CBFPWs and FWCs. In addition, data was also collected against the question from management whether the services can be continued if the external assistance is withdrawn. A majority of the respondents from program management reported that external assistance is necessary for the sustainability of the intervention. The program had a significant number of field workers who are mobilizing clients on the bases of the funds allocated to the program. In addition, majority of the respondents perceived that it is difficult to manage program activities without external assistance. It was necessary for them to interact with beneficiaries. Therefore, both CBFPWs and FWCs were inevitable for the provision of services.

### 4.6.1 Ability to continue services

There were both affirmative and negative responses by FWWs and CBFPWs about the ability of the beneficiaries to continue utilizing the services of family and the ability of the beneficiaries to continue the

Table 4.11: Ability to continue services				
Service provider	Highly satisfied	Satisfied	Dissatisfied	Highly dissatisfied
<b>FWWs</b>				
Ability of beneficiaries to continue services	36 (41.9%)	16 (18.6%)	29 (33.7%)	0 (0%)
<b>CBFPWs</b>				
Ability of beneficiaries to continue services	40 (59.7%)	20 (29.9%)	6 (9%)	1 (1.5%)

services of family planning without external assistance. Majority of the FWWs (41.9%) were highly satisfied from the ability of beneficiaries to continue the services of family planning. Similarly, about 18.6% of FWWs were satisfied from the ability of the beneficiaries to continue



using the services of family planning. However, about 33.7% of the FWWs were dissatisfied from the ability of the beneficiaries to continue family planning services.

On the other hand, (59.7%) of the CBFPWs were highly satisfied from the ability of their beneficiaries to continue the services of family planning and (29.9%) were satisfied from the ability of beneficiaries to continue the services of family planning. However, (10.5%) of the CBFPWs were dissatisfied from the ability of the beneficiaries to continue the services of family planning (Table 4.11).

When talking about the management of the program, the majority of the respondents claimed that beneficiaries were not able to continue family planning services without external assistance.

According to one of the respondent:

*It is not possible for the beneficiaries to continue the utilization of family planning services. Motivation is continuously required from service providers. In addition, majority of the beneficiaries are using services because of their continuous interaction with service providers and because the services are free of cost.*

Beneficiaries of both CBFPWs and FWCs were asked if they will refer other women to avail the services of family planning and other services provided by CBFPWs and FWCs. About 98.5% of the respondents reported that they would refer other to CBFPWs. On the other hand, the majority of the beneficiaries of FWCs also claimed that they would refer other women to utilize the services. By comparing the beneficiaries of CBFPWs and FWCs, the beneficiaries of FWCs were more likely to refer expected beneficiaries to avail the services as compared to the beneficiaries of CBFPWs.

#### 4.6.2 Counterfactual analysis

For assessing the comparison between what actually happened and what would happen in the absence of the FWCs, a counterfactual analysis was done. For the purpose, a household survey was conducted among reproductive age women 15-49 years of age who were not using services from FWCs and CBFPWs and were living in the catchment area of service center. In household survey, respondents were asked about their use of family planning services and satisfaction with the service, ANC and PNC, general treatment for themselves and their newborns. About 41% of the non-beneficiaries of FWCs and CBFPWs reported that they were using contraception (Figure 4.6). The respondents who were using family planning methods, 57.1% reported that they were using condoms and 42.9% were using oral pills (Figure 4.6). However, more than half (57.1%) of the respondents were satisfied from their family planning methods. About 21.4% of the respondents reported that they were availing family planning service from government hospitals, 28.6% from private clinic and about 50% were availing family planning services from any other sources like medical stores etc.

In majority of cases, husbands were deciding the method of family planning. However, about 42.9% of the women reported that they themselves decided their family planning method. When respondents who were using family planning methods were asked why they were not using family planning services from FWCs or CBFPWs, 4.8% reported that services were non-satisfactory and 23.8% were not satisfied from the staff.

Results indicated that about 51.7% of the non-beneficiaries received ANC during their last pregnancy. About 72.7% of these respondents visited private clinic, 21.2% visited government hospitals and 6.1% visited other service providers i.e. private hospital and quacks. On the other hand, 48.6% of the non-beneficiaries of FWCs and CBFPWs reported that they received PNC

after their last delivery. About 42.4% of the respondents claimed that visited government hospitals, 51.5% visited private clinic and 6.1% visited any other sources like quacks and medical stores.

Results found that the majority of the non-beneficiaries (60.6%) visited government hospitals for the checkup of their newborn. However, about 27.3% visited private clinic and 12.1% visited quacks and medical stores etc. for the checkup of their newborns. On the other hand, about 34.3% of the respondents visited government hospital, 60% visited private clinic and 5.7% private hospitals, quacks and medical store for their routine checkup (Figure 4.6).

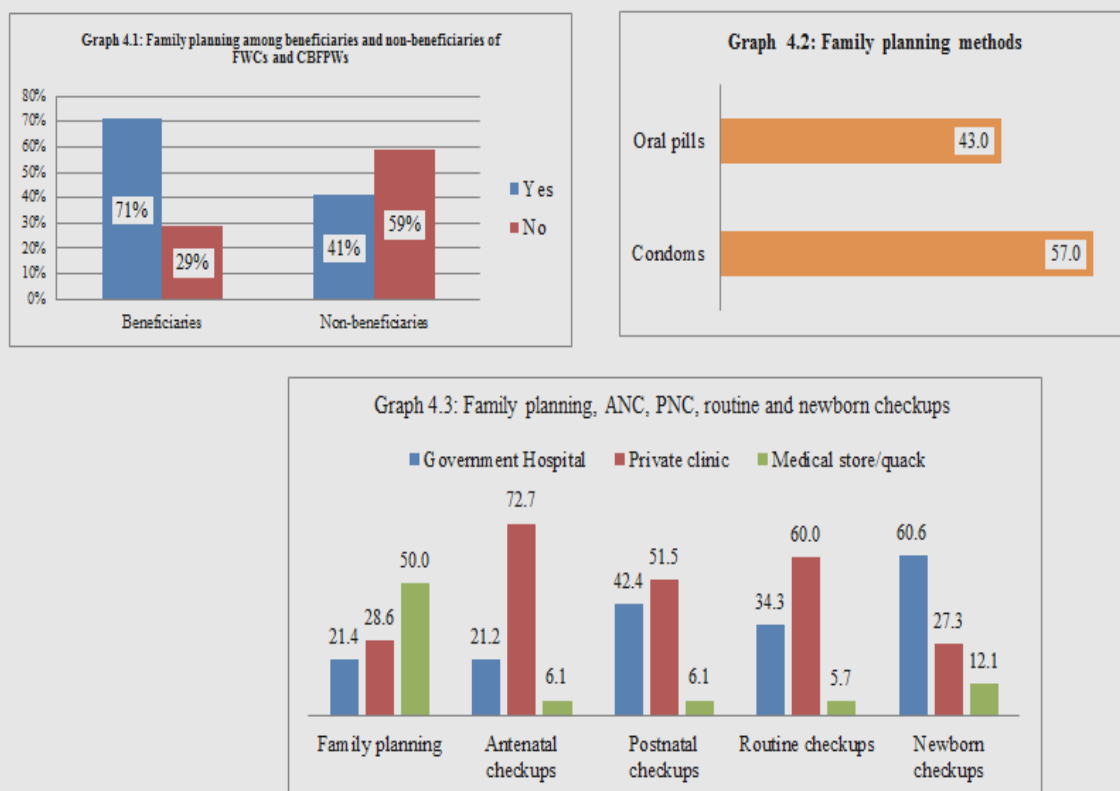
The majority of the non-beneficiaries 82.9% claimed that they were not visiting FWCs or CBFPWs for their routine checkups because they are not satisfied from the staff and about 17.1% reported they the services provided at FWCs and by CBPFWs are not satisfactory. Respondents were asked either they were contacted by the field staff of FWCs or by CBFPWs. The majority of the respondents (80%) reported they were contacted by the field staff of FWCs or by CBFPWs. However, 45.8% of the non-beneficiaries reported that they were not satisfied from the counseling of field staff of the program.

#### **4.6.3 Sustainability of project design**

Both developed and developing countries faced the problem of high fertility rate (FR) and high PGR. However, FR and PGR are higher among developing countries. High FR and PGR have negative consequences for the socio-economic development. Therefore, different program and interventions were started to reduce FR and PGR. Nevertheless, each country started programs and interventions according to their local context and population distribution. For example, CPR in Bangladesh is 61% that is double as compared to Pakistan. Streatfield and Kamal (2013) when talking about the success of family planning services in Bangladesh reported that it is the

outcome of huge number of female FWAs. FWAs were working under National Family Planning Programme and they were providing nationwide services in the whole country.

Figure 4.6: Counterfactual analysis of family planning



FWAs in Bangladesh register eligible couple and provide them family planning services. They also visit those eligible couple who cannot go outside of their home for availing family planning services. FWAs are moderately educated and they visit every house in their catchment area after every two months. They provide information and awareness about family planning. In addition, they also provide temporary and short term family planning services i.e. condoms and oral pills. However, they refer cases to Health Department for permanent contraceptive methods i.e. contraceptive surgery. The successful working of family planning program in Bangladesh is also

attributed to its widespread cooperation and coordination among Family Planning Programme and other national and international NGOs.

Similarly, India adopted family planning program in 1949 and emphasizes on legislation regarding family planning program. The focus of legislation was to improve program design, strategies and implementation. Design of family planning program in India is similar to the design of family planning of Bangladesh. In the new population policy in 1977, family planning program was integrated with other health services and for providing access to remote rural areas, family welfare centers and satellite camps were arranged. The field workers of family planning centers started door to door campaign and focused on two child norm and permanent family planning methods. For providing awareness about family planning services and methods, both electronic and print media was mobilized. It was planned to provide incentives to poor people for encouraging them to educate their children. In addition, family planning program also focused on proper marriageable age adoption.

For achieving similar objectives as Bangladesh and India, Pakistan also started family planning program in 1960 and Population Welfare Department (PWD) was established. But political turmoil in the country and lack of proper legislation hampered the ability of program to increase CPR and decrease PGR. In in last years of 19s, FWCs were established and CBFPWs were recruited to provide family planning services at UC level and the program under evaluation was an extension of that intervention.

The program was started in the districts having low CPR as per the findings of MICS. For achieving the set target of the program, FWCs were established and CBFPWs were hired to start services of family planning, maternal and child health care and general health care to women and children. Each center was provided facilities in static facility center and satellite camps. In

addition, CBFPWs provided service in rural areas where centers were not established. This implies that the program provided services through three strategies i.e. static FWCs, satellite camps and CBFPWs.

Family planning program of Pakistan is similar to family planning program of Bangladesh and India. However, PWD of Pakistan had less cooperation and coordination with national department and international organizations. In addition, door to door campaign is less prevalent in Pakistan. In addition, the program in Pakistan is not nationwide as in Bangladesh and India. In nutshell, program design is similar to the designs of two neighbor countries with similar context.

## **5. THEORY OF CHANGE**

In the present chapter, theory of change is offered based upon the assessment of program. For the purpose, program inputs are linked to program activities, program activities are linked to program output, program output are linked to immediate and intermediate outcomes which are then linked to the impact of the program. In addition, the causal link among the components of theory of change is discussed.

### **5.1 Input of the program**

For the implementation of the program “Expansion of Family Welfare Centers and Introduction of Community Based Family Planning Workers 2014-18” following inputs were provided:

1. Funding
2. Partnership
3. Technical assistance
4. Leadership

Following are the key findings related to funding, infrastructure, furniture and fixture, technical staff, partnership and leadership:

#### **5.1.1 Funding**

- The program is implemented in 22 districts of the Punjab and total funding is provided from development budget of the province. Other sources of funding i.e. federal and national and international donors are not available. This implies a lack of coordination with both national and international institutions for availing funding for the project.

- There is a lack of proper quantification of budgeting separate for FWCs and CBPFWs for the estimation of the resources needed to expand the program in 36 districts of the province. In addition, district wise budgeting is also not available.

These findings indicated that funding was only provided from the provincial budget without any assistance from national and international stakeholders for expanding the program and decreasing financial burden on provincial government. In addition, based on the available information, it is difficult to estimate required cost for expanding the program.

### **5.1.2 Partnership**

Following are the key findings related to the partnership of the program:

- The program is related to population planning. The sponsoring agency and executive agency is “Population Welfare Department, Punjab. In addition, same department is responsible for operation and maintenance of the program. However, other stakeholders are also involved for providing family planning services i.e. health department which is not mentioned in either PC-I or PC- IV.
- Historically, it is proven that the program of family planning services need supportive partnership from both provincial and national level partners i.e. Health Department, Social Welfare Department and international partners i.e. WHO, UNICEF, World Bank. However, there are very few stakeholders who were providing help for the proper implementation of the program i.e. Health Department.



- The role and responsibilities of stakeholders who are involved in the implementation of the program are not clearly mentioned. Proper communication and mutual sharing of roles and responsibilities are not decided.
- There is a lack of systematic large scale partnership other than Population Welfare Department and Health Department for efficient implementation of the program.

This implies a need to enhance partnership between different stakeholders not only for funding but also for campaigning, social mobilization, service delivery and execution of the program.

### 5.1.3 Technical assistance

Following are the key findings related to technical assistance in the project.

- Findings based upon the review of the project documents and interviews with management of the program indicated that technical assistance was only provided by Population Welfare Department and Health Department but no other stakeholders were providing technical assistance.
- Technical assistance was being provided in monitoring, record maintenance and for designing guidelines, protocols by Population welfare Department for smooth functioning of the program. None of the technical department was providing technical assistance funding and executing agency.

This implies that technical assistance was not provided for implementation of the program. There is a lack of coordination among specialized departments for technical assistance.

#### 5.1.4 Leadership

Following are the key findings related to leadership of the program:

- There is a lack of commitment of political leadership to transform commitments into empirical actions for increasing CPR and decreasing PGR.
- There is a dearth of political will which caused delay in the implementation of the program. This delay indicated poor leadership and lack of commitment among different stakeholder of the program.
- Program was capped and the actual scope was limited. This also indicated poor planning, will and commitment of the leadership which caused late and inadequate release of funds for establishing FWCs and hiring CBFPWs.

This implies that leadership showed poor will and commitment to implement and execute program timely. Actual physical target of the program was not achieved because of the poor planning and commitment from the leadership of relevant stakeholders.

### 5.2 Activities of the program

Following activities are performed for achieving the objective of the program:

1. Establishing FWCs
2. Recruiting staff for FWCs
3. Recruiting of CBFPWs
4. Trainings of the staff
5. Provision of medicines and medical equipment
6. Supervision, monitoring and reporting
7. Social mobilization

### 5.2.1 Establishing FWCs

Following are the key finding about establishing FWCs:

- Physical target to establish FWCs was not implemented as per the plan in PC-I.
- Staff members of each FWC included one FWW, one female FWA, one male FWA, one Aya and one Chowkidar.
- It was planned that each center will cater the population of 5000-7000 but two FWAs were provided at each center to mobilize expected beneficiaries.
- FWCs were designed to provide three types of services i.e. contraceptive delivery services, maternal and child health and medical care to women and children which put FWCs under pressure.
- Results indicated that four FWCs were without FWWs, no FWA (male) in 19, and no FWA (female) in 13, and no Aya in 4 centers. In addition, 6 centers were without Chowkidar.
- Each center has a local committee comprised of major stakeholders from the local community to plan programs, identify resources, organize activities and monitor the implementation.
- The rent allowed for the building of the centers was planned to Rs. 6000-8000. None of the center was rented above the planned cost in PC-I.

These findings indicated that the numbers of FWCs were less even the target set to establish FWCs was not achieved and there is a dropout of staff working at FWCs.

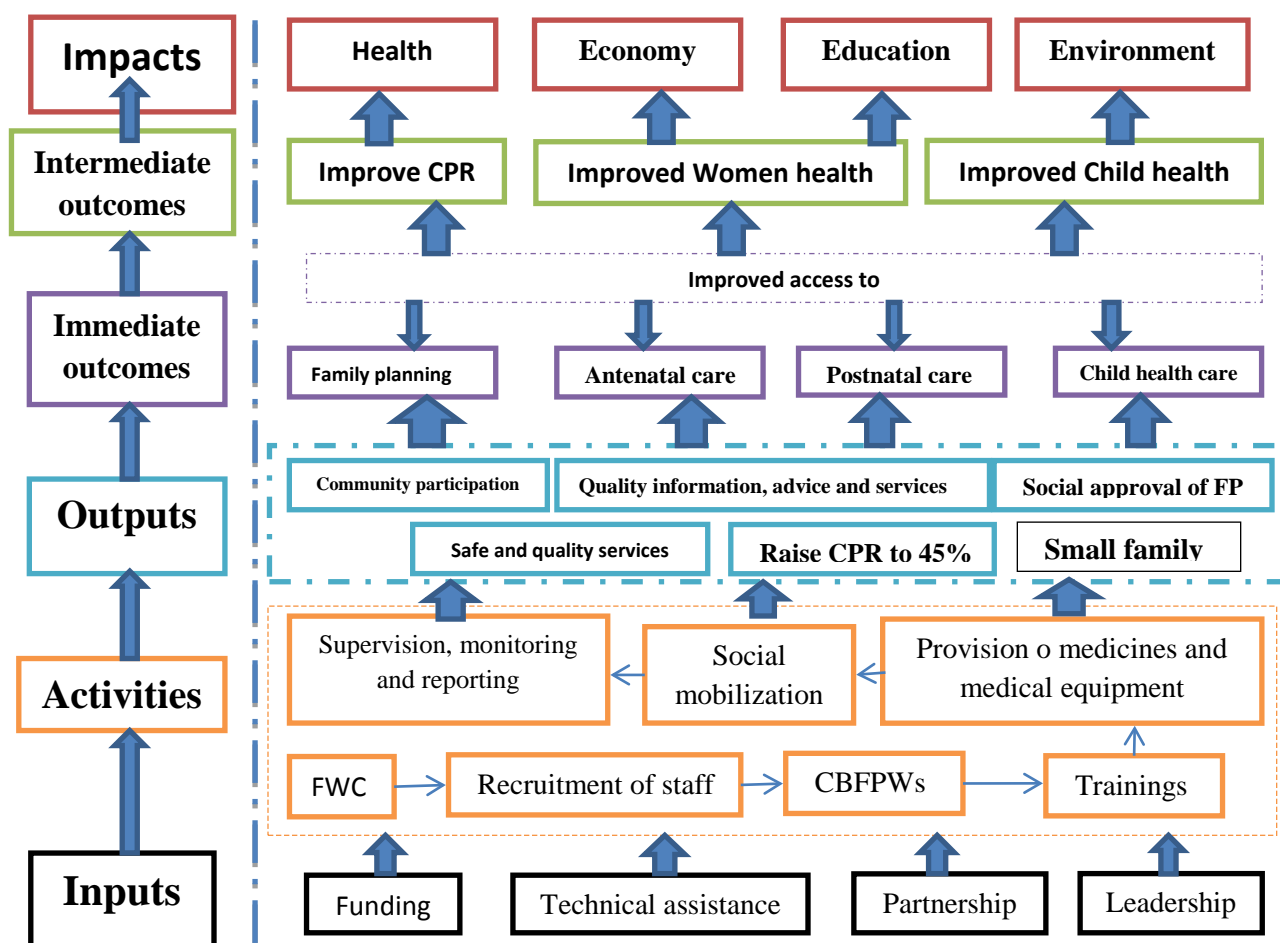
### 5.2.2 Recruiting staff for FWCs

Following are the key findings related to the recruitment of staff at FWCs:

- Each center was planned to have staff of five members including one FWW, two FWAs, one Aya and one Chowkidar.
- Eligibility criteria for the candidates of FWWs were strict and only those candidates were eligible for the post those had FWW course or had matriculation with Lady Health Visitor diploma.
- Selection process was found very complex which involve three members i.e. Director General PWD, Additional Secretary (A&F) PWD and Director (Technical) PWD.
- FWWs were required to perform three main task i.e. in-charge of FWCs, service delivery at FWCs and counseling to clients about family planning and routine health issues.
- Each centers was also planned to recruit two FWA i.e. one female and one male.
- Eligibility criteria for FWAs were matric with science at least 2<sup>nd</sup> division, permanent residence of the respective UC and for quota the condition of permanent residence are relaxed.
- For each center one Aya and one Chowkidar was also recruited.
- The recruitment committee of FWAs, Aya and Chowkidar was departmental selection committee at district level.

These findings indicated that the eligibility criteria of FWWs and FWAs were strict and the selection process was also complex particularly for the selection of FWWs. In addition, the number of staff in center is not enough for performing the routine activities of the centers.

**Figure 5.1: Revised theory of change**



### 5.2.3 Recruiting CBFPWs

Following are the key findings related to the recruitment of CBFPWs:

- It was planned to recruit CBFPWs in rural areas and areas where FWCs were not established.
- According to PC- I, 1200 CBFPWs were planned to be hired but actually 733 were hired.
- Selection criteria included matriculation and middle in case no suitable candidate was found, local resident of the village, married, divorced/separated/widows, mentally and

physically fit. They were selected by the departmental selection committee at district level.

- It was planned to recruit CBFPWs on contract bases with a salary of Rs. 9,000 and yearly increment of Rs. 200.
- It was also planned to provide at least one CBFPW for 4000 population and she will be deployed in a village having at least 1000 population. This implies that the clients living in villages having population less than 1000 were unable to avail services at their door step.

These findings indicated that one CBFPW had to provide services to large number clients and the honorarium is not as per her tasks. In addition, the clients living in remote and small villages were unable to get benefit from CBFPWs.

#### **5.2.4 Training of staff**

Following are key findings related to the training of the staff:

- Desk review indicated that the training to FWWs and FWAs was not provided and it was FWW who is responsible for the role performance of FWAs and Aya.
- Each CBFPWs was provided training of four month in four phases about the topics i.e. orientation of the family planning program, working with community which includes enlisting of the households, family planning motivation and counseling, conception and contraception, contraceptives and contraception, treatment of minor ailments, first aid use of medicines and stitch removal, health education, record keeping, revision and assessment.

- CBFPWs were provided training by Women Medical Officer of Family Health Center or FWW.
- Every CBFPW was bond to attend one day meeting in the training center as specified by DPWO.

However, the majority of the CBFPWs were found satisfied from the contents of the training.

To the best of our knowledge, there was no internal or external assessment or evaluation of training conducted and the content of the training.

These findings indicated that training to FWWs and FWAs was not provided and they were not offered refresher courses as well. In addition, it was also observed that training process of CBFPWs is complex which comprised of four phases and extended to four month.

### **5.2.5 Provision of medicines and medical equipment**

Following are the key findings about the provision of medicines and medical equipment:

- It is found that the procurement process of the medicine and medical equipment was complex and all the procurement was performed at provincial level.
- This provincial level procurement caused delay in the transportation of medicine and medical equipment to FWCs.
- Inventory registers were not maintained at FWCs and stock registers at FWCs were found poorly managed.
- There is insufficient supply of medicines and medical equipment at FWCs.
- Beneficiaries also claimed that they had to revisit centers because of the lack of medicines or other services.

- Logistics facilities and distribution of medicine caused delay in the arrival of medicines and medical equipment at centers.

These findings suggested that supply of medicine and medical equipment was found insufficient and there was a lack of logistics and distribution of commodities to service providers.

### **5.2.6 Monitoring, supervision and reporting**

Following are the key findings related to the monitoring, supervision and reporting of the staff working in the program and reporting:

- Desk review and qualitative interviews with the management indicated that FWCs were regularly monitored by District/Tehsil Population Welfare Officers.
- However, there were no set targets and the numbers of visits vary as per geographical location and number of centers in district/tehsil.
- It was planned that DPWO will visit centers after every two months and TPWO will visit every month.
- Technical staff was asked to visit regularly for the training of on job staff in FWC. But no target was set for the purpose.
- Each DPWO was asked to work as Drawing and Disbursing Officers (DDO) for the utilization of funds allocated for ADP scheme to the respective district.
- Every FWW report their monthly performance at prescribed form to DPWO.
- Every FWC was also supervised and monitored by Women Medical Officer (WMO) of concerned FHC.
- For sharing experiences, review meetings were also arranged at district and tehsil level.



- There was lack of evaluation both internal and external for checking the suitability, reliability of monitoring, supervision and reporting.

These findings indicated that monitoring, supervision and reporting is regular. However, there is lack of digitalization in the monitoring, supervision and reporting of the services. In addition, external or internal evaluation was missing.

### **5.2.7 Social mobilization**

Following are the key findings related to social mobilization of clients for availing services:

- Data collected from the beneficiaries indicated that field staffs of FWCs and CBFPWs contacted clients for availing services and the majority of the clients were satisfied.
- Field staff of FWCs and CBFPWs was using both direct visit and referral to mobilize clients.
- In majority of the cases, social mobilization is being provided by direct visit by field staff.
- However, counterfactual analysis indicated that 20% of the beneficiaries were not contacted by field staff.
- About 14.3% of non-beneficiaries reported that they were not provided any information about family planning.
- About 42.9% of the non-beneficiaries reported that they were not satisfied from the guidance/information provided by the field staff.
- Besides welfare committee, there was no other mechanism used to mobilize clients for using the services provided at FWCs and by CBFPWs.

These findings indicated that the mechanism to mobilize clients was based on field visit of field staff and welfare committee and no other stakeholders were involved for the social mobilization of the clients. In addition, the uses of informal methods to mobilize clients were not reported.

### **5.3 Output of the program**

Following are the primary and secondary outputs of the program:

- To ensure universal coverage and improved access to safe and quality services by 2018
- To raise contraceptive prevalence rate to 45% by 2018
- To increase demand for small family and social approval of family planning
- To reduce unmet needs by increasing access to good quality information, advice and services
- To increase community participation and accountability

#### **5.3.1 Universal coverage and improved access to safe and quality services**

Following are the key findings related to universal coverage and improved access to safe and quality services:

- The program increased clients' access to family planning, mother and child health and general health care to women and children.
- For providing universal access, service providers targeted married couple, children, married women and men for providing family planning services, ANC, PNC and child care as well.

- On average, 121 women were taking family planning services, 59 women were taking PNC and 11 women were taking ANC per month.
- On average, 76 and 14 children and 52 and 29 men were availing the services from FWCs and CBFPWs respectively.
- Majority of the clients (70.8%) were found visiting service centers for availing family planning services and (24.7%) were using condoms, (13%) were using oral pills and (31.6%) were using IUD and about (28.7%) reported the use of injectable.
- Data also indicated that 68.8% of the women visited service centers for ANC.
- About 88.7% of the beneficiaries visited service centers for PNC.
- About 86.6% of the beneficiaries visited service centers for family planning.
- About 71.9% of the beneficiaries visited service centers for their newborn's checkup.
- Non-beneficiaries were found visiting, private clinic, government hospital and medical stores for availing the services of family planning.

These findings indicated that service centers improved the access of clients i.e. married couple, pregnant women and children towards family planning, maternal and child care. However, the program had not provided universal coverage of family planning and good quality services to the clients. For example, the majority of the non-beneficiaries were visiting private clinic, government hospital and about 6% were visiting medical stores and quacks etc. for ANC and PNC.

### **5.3.2 Contraceptive prevalence rate (CPR)**

Following are the key findings about CPR:

The program was intended to increase CPR to 45% in the districts having low CPR.

The program increased 21% clients of family planning from 2015-2018.

Although the program increased CPR, but program failed to achieve 45% CPR.

Counterfactual analysis indicated that 41% were using contraception i.e. condoms and oral pills.

Primary data collected from beneficiaries indicated that 71% of the beneficiaries of FWCs or CBFPWs were using contraception i.e. condoms, oral pills, IUD and C.S etc.

These findings indicated that program increased the clientage of family planning but the increase was not substantial. There are 59% of the non-beneficiaries and about 29% of the beneficiaries who were not availing contraception from service providers.

### **5.3.3 Increasing demand for small family and social approval of family planning**

Following are key findings related to the demand of small family and social approval of family planning:

- Interviews with management of the program indicated that the majority of the clients were using family planning methods for their demand of small family.
- Data collected from beneficiaries indicated that family planning is necessary for child and mother's health.
- They reported that family planning is the cheapest and safest way to fulfill their desire for small family.
- In the open ended section of the survey, one of beneficiaries reported that she and her husband planned to have only two children. After two children, they visited FWCs and now they were living happily with their children.
- Service providers i.e. FWWs, FWAs and CBFPWs guide clients about the needs and benefits of small family and they motivate clients to practice family planning methods.

- There is increase in the CPR which indicated social approval of family planning services in the districts which were identified having low CPR.
- It was included in the job description of the female FWAs to motivate eligible couple to adopt FP for improving both child and mother health and about 14.04% went for IUD and about 1.02% of the users selected C.S.
- When beneficiaries were asked why they were using family planning method, the majority claimed that family planning is the need of the day and small family is healthy family. They can educate their children easily when family is small.
- The data collected from service providers indicated that the majority of the local stakeholders have positive response towards FP. However, 11.6% of Imam Masjids have negative response towards FP.

These findings indicated that the program increased the demand for small family by increasing permanent contraceptive method IUD and C.S. In addition, increase in CPR indicated social approval of family planning.

#### **5.3.4 Reducing unmet needs**

Following are the key findings related to the reduction of unmet needs through access to good quality information, advice and services:

- Data collected from the beneficiaries indicated the program provided them easy access to service centers (98.7%).
- Majority of the beneficiaries reported that working hours of service centers (FWCs) and CBFPWs were convenient (97.7%).

- Data also indicated that the majority of the beneficiaries were provided information about family planning by service providers.
- About 99.7% of the beneficiaries reported that they were provided enough time for consultation according to their needs.
- About 99.5% of the beneficiaries reported that service providers explained the method of family planning clearly.
- It is also found that the majority of beneficiaries were provided sufficient privacy during their consultation with service providers.
- About 99% of the beneficiaries reported that they were treated in a friendly and respectful way.
- However, about 34.8% of the beneficiaries reported to revisit service center or service providers for availing services.
- Data collected from beneficiaries also indicated that services were provided free of cost.
- Majority of non-beneficiaries reported that service providers were providing non-satisfactory information and services or they were not satisfied from the staff.

These findings suggested that the program provided access to good quality information, advice and services.

### **5.3.5 Community participation**

Following are key findings about community participation in the program:

- Data collected from both FWWs and CBFPWs indicated that they were satisfied from community participation in the program activities.

- Desk review and interviews with management indicated that key stakeholders from local community were involved in welfare committee who were engaged with FWCs to implement program activities.
- Interviews with management of the program indicated that majority of the local stakeholders consider that services are necessary and according to the needs of local community.
- Data collected from FWWs and CBFPWs indicated that local community i.e. average men, women, religious leaders, local leadership, local government and non-government organization had positive response towards the services provided by FWCs and CBFPWs.

These finding indicated that community participation in the program activities was satisfactory and the majority of the stakeholders had positive response toward the services. However, rigorous community participation from other stakeholders of relevant department was missing for coordination, planning and execution of program activities.

## 5.4 Outcome of the program

Outcome of the program are divided into two sections i.e. immediate outcomes and intermediate outcomes. Following are the immediate outcomes of the project:

- Improved access to family planning services
- Improved access to ANC
- Improved access to PNC
- Improved access to child health care
- On the other hand following are intermediate outcomes of the program:

- Improvement in family planning practices
- Improvement in women health
- Improvement in child health

#### **5.4.1 Immediate outcomes**

Key findings related to immediate outcomes are as under:

- The program increased access to family planning services at almost door step to rural population where CPR was very low. About 71.1% of the beneficiaries reported that they were availing family planning services from FWCs or from CBFPWs.
- Beneficiaries reported that they were getting services free of cost from service providers i.e. FWCs and CBFPWs.
- Data collected from the beneficiaries reported that about 68.8% of the beneficiaries visited FWCs and CBFPWs for ANC.
- It was also found that about 92.9% of the beneficiaries reported that they were visiting FWCs or CBFPWs for PNC.
- About 71.9% beneficiaries claimed that they visited FWCs or CBFPWs for their newborn's checkup.
- However, counterfactual analysis indicated that the majority of non-beneficiaries (72.7%) were visiting private clinic for ANC and 21.2% were visiting government hospitals.
- Similarly, about 51.5% of non-beneficiaries were visiting private clinic and about 42.4% were visiting government hospital for PNC.



- It was observed from counterfactual analysis that 60.6% of non-beneficiaries were visiting government hospital and about 27% were visiting private clinic for their newborn's checkups.

These findings indicated that immediate outcomes of the program were satisfactory. However, the access of the services was limited among non-beneficiaries because of the lack of proper information and guidance provided by field staff.

#### **5.4.2 Intermediate outcomes of the program**

Following are the key findings related to intermediate outcomes of the program:

- The program increased CRP to 21%. This implies that the program improved family planning practices. However, the majority of the beneficiaries were using condoms (38.57%) and oral pills (30.42%) which were not permanent and long acting contraceptive methods. But the usages of long acting and permanent contraceptive methods were required to increase.
- About 58.6% were highly agreed with the statement that visiting FWCs or CBFPWs had improved their own health and the health of their babies.
- Interview with management revealed that the program outcomes were positive for increasing decision making ability and leadership qualities among the beneficiaries.
- Qualitative data also indicated that the program enhanced the ability of the beneficiaries to continue the services of FP.
- However, it was also found from quantitative survey that beneficiaries were not able to continue FP services without external assistance from key stakeholders. Qualitative

interviews strengthen these findings that sustainability of the program was not possible without external assistance and motivation.

These findings suggested that intermediate outcome of the project were significant for increasing the utilization of family planning services, ANC and PNC. However, the beneficiaries were not able to continue the services of without external intervention.

## **5.5 Impact of the projects**

Key findings related to the impact of the project are as under:

- The program increased 21% user of FP which is expected to decrease PGR in the country.
- The reduction in PGR affects other sectors i.e. economy, health, education, employment and environment.
- Reduction in PGR increases employment opportunities and per capita income.
- Lower PGR increases living standards of general population.
- There is positive association between lower population growth rate and socio-economic development.
- Lower population growth rate have positive association with poverty reduction.

These findings based upon desk review indicated that the impact of the program are enormous and the program have long lasting impact on all the other sector which are directly or indirectly related to population explosion.

## **6. Conclusions, Lesson learned and Recommendations**

This chapter presents conclusions, lessons learnt from desk review, qualitative interviews with management and survey from FWWs, CBFPWs, beneficiaries and non-beneficiaries of the program. In the end of the chapter, recommendations are enlisted.

### **6.1. Conclusions**

The current study is a third party evaluation of ADP Scheme titled “Expansion of Family Welfare Centers and Introduction of Community Based Family Planning Workers 2014-18.” The program was aimed to provide universal coverage and improved access to safe and quality services by 2018 and to raise CPR to 45%. These centers started operational activities from 2nd January 2015 with the help of 600 new FWCs and 733 CBFPWs. It was the part of the program to check its performance and impact on clients in term of both major and minor objectives. At the end of the program, third party evaluation was conducted by the Institute of Social and Cultural Studies, University of the Punjab, Lahore. For conducting evaluation effectively, mix method research approach was used. In addition, DAC criteria of evaluation were followed and revised theory of change was proposed based upon the findings.

The evaluation concludes that the program is relevant to the overall socio-economic development of the country as well as the province of Punjab. The design of the program is output oriented and was successful in providing relevant services to clients as per their needs. The program is also successful to reduce unmet need of family planning and increased CPR. Clients were of the views that after visiting FWCs and CBFPWs they experienced improvement in their own health and newborn’s health. Clients further reported that the program is efficient in term of service delivery and it is easy to access FWCs and CBFPWs. The clients also reported that they were

treated at the centers with respect and the behavior of the staff was courteous and friendly. Despite its success stories, the program needs improvement in some dimensions.

First, strong political commitment is needed to make the program more efficient and sustainable at grass root level. Second, effective coordination among private and non-government organizations is required for the smooth functioning of the program. Third, technical assistance from relevant stakeholders might increase the performance of the program. Moreover, it is also required to increase field staff in FWCs and number of CBFPW so that quality family planning services, ANC and PNC services could be provided to greater number of clients. Besides, increasing the number of field workers, proper training is required for performing routine activities. In nutshell, the program is required to continue services because the program has high degree of utility and acceptability at public level. The program is also viable and sustainable as FWCs are operational in 22 districts and CBFPWs are functional in 13 districts. It is the most effective and cost-efficient investment to accelerate the socio-economic development of the province.

## **6.2 Lessons learnt**

Empirical evidence suggested that the program increased CPR and improved child and mother health. However, there are few limitations and shortcomings which are mentioned below:

- It is not possible to implement any social development program without strong political will, commitment and support. Unnecessary delays in implementation of the program reflected the fact that very strong political support is missing. For the success of a project sufficient resources and constant administrative support is required. For effective implementation and execution of the program, proper coordination among all the relevant

stakeholders is inevitable. The lack of coordination among the stakeholders slowdown the objectives to achieve in true spirit.

- National and international partnership needs to be strengthened. Such partnership and collaborations are necessary for effective campaigning, social mobilization, service delivery and execution of the program. Furthermore, international partnerships are instrumental in introducing innovative ideas and new technologies which provide support and strength to the project activities.
- Family welfare is a multi-sectoral social development activity. Partnership and coordination between different sectors was not visible in campaigning, social mobilization and service delivery. The number of FWCs was not as per the needs of the clients. Similarly, the number of CBFPWs was also insufficient according to the population and unmet needs of family planning.
- There were frequent dropout of staff from FWCs and CBFPWs. The recruitment and training of new staff need time and resources. Such hurdles delay the provision of planned services.
- Eligibility criteria of FWWs, FWAs was strict and the selection process was complex which resulted delay in the implementation of the program.
- The honorarium of the CBFPWs was not as per their work-load and tasks of the field. Low monetary incentives undermine their job commitment and performance.
- Proper training to FWWs and FWAs was not provided and internal training of the workers was not accessed and evaluated.

- The training duration of the CBFPWs was four months and there was no comprehensive mechanism for internal or external evaluation of the trainings. In the absence of proper evaluation system, the effectiveness of the training could not be assessed.
- FWWs or the staff of FWCs has to visit district office for getting medicine and medical equipment. The mechanism of the distribution of supplies was not proper. Additionally, medicines and medical equipment were not sufficient in quantity to fulfill the needs of the clients.
- Family planning services were provided by many stakeholders i.e. public institution, private enterprises, various professionals and different non-governmental organizations. Because of lack of coordination and absence of information sharing mechanism, these services are overlapping, hence wastage of resources.
- There was a dearth of real time supervision, monitoring and reporting from FWCs or CBFPWs to district office and to program management team. Such a disconnect undermines the efficiency of the program.
- Social mobilization at community level seems weak and uncoordinated. Only the field staff and one welfare committee cannot create social mobilization.
- The program has successfully connected the clients to family planning, antenatal and postnatal health care services. However, due to lack of proper human resource and organizational strength, the service providers are unable to provide universal family planning services to the clients. The program increases contraceptive prevalence rate as per the objectives. Nevertheless of the program, a substantial number of beneficiaries were using temporary methods for family planning i.e. condoms and oral pills.

- The program was successful in increasing clients access to good quality of information, advice and services. Overall the beneficiaries were found satisfied with the dealing of the staff in providing family planning services.
- Religious leaders are very influential in Pakistani society. Their opinion towards family welfare related services matters a lot for the clients. The data showed that a significant numbers of Imam Masjids have negative response towards family planning services. It is important to change the perception and opinion of religious leaders and keep them on board.
- Field staff needs to be more sensitive about the questions and concerns of the clients. The field staff must understand the fact that if the client is not satisfied or convinced, the services will remain unutilized or underutilized. So the satisfaction and motivation of the client is the single most important factor for the success of the program.
- The data showed that the clients subsidize many conspiracy theories about family planning as well as the objectives and operations of the program. Such conspiracy theories could undermine the efficiency of the program, but also weaken the bond of trust and good will between the field workers and community at large.
- It was noted that the clients have to visit service providers for availing family planning services. Since not all women have freedom or resources to visit service providers so it is advisable to develop a mechanism to provide services at the doorstep especially for the socially excluded population.
- Despite many limitations and short-comings the program increased CPR. A majority of beneficiaries after getting information and services of the program, they believe that it is

beneficial for their own health and the health of their children. Their experience of visiting and interacting with FWCs and CBFPW was pleasant and positive one.

### **6.3 Major Success of the Program**

- Empirical data showed that, overall, the program is relevant to the socio-economic development of the province and country at large. It was also noted that there is a consistency between program design and output.
- The provision of services was according to the needs of the clients and the design of the program was consistent with the objectives of the program.
- There is consistency between the needs of the target group and the design of the program for reducing unmet needs of family planning and health care provision to women and children.
- Data showed that the local community was well-aware of the provision of services at FWCs or by CBFPWs.
- The program is found effective and the objectives of the program were realistic. Increase in the access and improvement in family planning services, mother and child health and community participation are visible and empirically verifiable.
- The program's success was not only restricted to increase the CPR, antenatal and postnatal care but also had positive impact on the women's health, health of their newborn and health of their families. The reason for general improvement of health was that the program connected clients with the healthcare system and, as a result, they were better aware of their general health problem and their timely treatment.
- The program is viable and sustainable as FWCs were established in 22 districts of the province and almost all of them are in functional position, though success of the program



varies from district to district. Similarly, CBFPWs are working in 13 districts and almost all of them are working efficiently. Overall, the program has a success story; it has lasting positive impact on family welfare and overall socio-economic development of the province.

- The program has both short-term and long-term impacts. For example, higher the prevalence of contraceptive rate is expected to decrease Population Growth Rate (PGR).

## **6.4 Recommendations**

Based on empirical data the following recommendations are presented for improving the implementation and execution of the program:

- Strong political will and commitment is required for allocation of sufficient funds, timely release of funds and meticulous implementation of the program.
- There is a need of better and effective coordination among public-private and non-governmental organizations at community level. Electronic and print media could be helpful in dissemination of information among the relatively younger population.
- For social mobilization, the influence and clout of various actors in the community such as elected members of local bodies, community notables, religious leaders, and other influential members of the community may get onboard and their services can be utilized.
- National and international stakeholders should be involved for funding, campaigning and social mobilization. Such involvement and coordination could also bring innovative ideas and methodologies to the activities of the program.
- Technical assistance should be provided by specialized national and international institution and organizations.

- The number of FWCs and CBFPWs may be increased for providing the services of family planning, ANC and PNC.
- Field staff should be increased in each FWC especially in the thickly populated areas. More well-staffed operationally active FWCs may be established in the areas/localities where there is high concentration of poor and marginalized sections. In addition, CBFPWs should be provided in those UCs where FWCs are not working.
- Efforts should be made to retain staff, especially the committed and competent local staff by increasing incentives and by relaxing eligibility criteria; dropout of staff could be decreased.
- Recruitment of FWWs should be at district level for decreasing the delay in the implementation of the program.
- FWWs and FWAs should be provided training for carrying out their routine activities i.e. social mobilization of the clients, counseling and guidance etc. It is also necessary to develop some mechanism of eternal evaluation of the effectiveness of the trainings.
- The duration of training for CBFPWs should be decreased and training of maximum two month should be provided at initial level and refresher trainings should be arranged periodically.
- The honorarium of CBFPWs should be increased for their motivation to provide quality services. Performance indicators may also be developed and some monetary incentives may be awarded to the best performance.
- FWCs and CBFPWs should be provided medicines and medical equipment at their workplace by developing effective logistics service delivery system at district level offices.

- The services of family planning ought to be provided at one platform and only serious cases should be referred to THQs/DHQs.
- Systematic and information technology driven mechanism of supervision, monitoring and reporting may be introduced at all levels. It could make the system more efficient and cost-effective.
- For providing universal coverage and access to quality services, local community members should be involved for social mobilization. Volunteers from local community representatives of NGOs and other members of civil society may be encouraged to arrange different activities to boost up public participation in the program.
- There is a need to motivate couples to use permanent and long lasting family planning services. This task could be achieved if the program gets social approval and people understand the multi-dimensional benefits of small family.
- Field staff should visit expected clients more than once for encouraging them to avail family planning services. Additionally, attractive slogans, locally understandable and acceptable banners and promotion material may be useful to enhance the public participation in the program.
- Ownership and leadership qualities among the beneficiaries should be improved for sustainable use of family planning services.
- The program is relevant to socio-economic development of the province and country; therefore, the services should be strengthened and made more effective by providing more resources and political support. Overall, the program is effective and efficient therefore, the scope of the program should be expended to the whole province.

## References

- Cleland, J., Bernstein, S., Ezeh, A., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*, 368(9549), 1810–1827. doi:10.1016/s0140-6736(06)69480-4
- Jacobson, J. L. (2018). *Women's health: The price of poverty*. In *The Health Of Women* (pp. 3-32). Routledge.
- Multiple Indicator Cluster Survey. (2011). *Bureau of Statistics, Planning and Development Department - Government of the Punjab, Pakistan*
- Noreen, K., Khan, K. A., Khan, N., Khan, S. A., & Khalid, N. (2018). Contraceptive prevalence rate, unmet need for family planning and its associated factors among women of reproductive age group. *Pakistan Journal of Public Health*, 8(2), 63-69.
- Pakistan Bureau of Statistics. (2018). *Contraceptive Prevalence Report 2016-2017*. Government of Pakistan. Statistics division, Pakistan Bureau of Statistics
- Government of Pakistan. *Pakistan Vision 2025. Planning Commission*. Ministry of Planning and Development & Reforms,
- Sommer, U. (2018). Women, Demography, and Politics: How Lower Fertility Rates Lead to Democracy. *Demography*, 55(2), 559-586.
- Statista. (2016). <https://www.statista.com/statistics/615512/crude-birth-rate-in-south-asia-2016-by-country/>. Retrieved on 14/10/2018.
- Sughra, M., Fatima, F., Marrium, M., & Abbas, K. (2018). Maternal health expenditures and health seeking behavior among lowest wealth quintile of the rural population in an under developed district

of the Punjab, Pakistan. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology*.

Yaqoob, T., Bibi, R., & Siddiqui, J. S. (2018). Effects of Economic and Population Factors on Health Expenditures: Special Case of Pakistan. *Pakistan Journal of Engineering, Technology & Science*, 6(2).

## Annexes

### Annex 1: Observation and Record Form

<b>Name of the Center</b>	_____	<b>Name of the in-charge</b>	_____
<b>Established since</b>	_____	<b>Total rooms in FWC</b>	_____
<b>Waiting room</b>	1. Yes      2. No	<b>Total chairs in waiting room</b>	_____
<b>Location is appropriate</b>	1. Yes      2. No	<b>Access is easy?</b>	1. Yes      2. No
<b>Center is clean</b>	1. Yes      2. No	<b>Building is hired?</b>	1. Yes      2. No
<b>Sign board outside of FWC?</b>	1. Yes      2. No	<b>Record of patients is maintained?</b>	1. Yes      2. No

Q1. The condition of building is?

Satisfactory

2. Non-satisfactory

Q2. What is the rent of the building?

Rent	Sanctioned	Actual
Building	6000-8000	

Q3. Record of following registers is maintained?

Registers	Yes	No	Last entry date
OPD	1	0	
Medicine stock	1	0	
Equipment	1	0	
Inventory	1	0	
Visitors	1	0	
Another register _____	1	0	

Q4. Security measures are appropriate?

1. Yes      2. No

Q5. For observer: Are you satisfied with the overall record, maintenance and location of FWC?

1. Yes      2. No

Q6. Total number of working staff at each FWCs?

Staff	Sanctioned	Hired	Present	Vacant
FWWs	1			
FWA (male)	1			
FWA (female)	1			
Aya	1			
Cowkider	1			
Total	5			

Q7. What is the total number of furniture fixture?

Sr. No	Name of Items	Planned	Actual
1	Bed / cot with mattress & pillow 2	1	
2	Office Table	2	
3	Chairs	3	
4	Benchs	2	
5	Screen	2	
6	Revolving Stool (Metallic)	1	
7	Cupboards	3	
8	Racks for paper etc.	2	
9	Wooden Stool (L=2' x W=1-1/2 x H=2')	1	

Q8. What is the total number of sign boards in each FWC?

Sr. #	Type of Sign Boards	Planned	Actual
1	Elephant Board	1	
2	Face Board	1	
3	Direction Board	2	

Q9. What is the total number of medicines sanctioned and consumed in last three months?

Items	In last three months	
	Received	Consumed
Tab. Paracetamol		
Syp. Paracetamol		
Tab. Mafenamic Acid		
Tab. Hyoscine – N butyl bromide + Paracetamol		
ORS Packets		
Tab. Multivitamin with minerals		
Tab. Calcium lactate /Carbonate Vitamin D		
Syp. Mebendazole		
Tab. Magnesium Hydroxide +Aluminium Hydroxide		
Syp. Amonium Chloride (120 ml) Bottle		
PovidoneIodine Solution		
Glucourine sticks		
Tab. Matronidazole		
Tab. Loratadine		
Cap. Ampicilline + Cloxacilline		
Cap. Doxycycline		
Syp. Multivitamin with minerals		
Tab. Ferrous Fumerate + Folic Acid		
Syp. Dextromethorphan		
Tab. Mebendazole		
Gama-Benzene Hydrochloride		
Tab. Chlotrimazole with Applicator		
Bandages		
Disposable gloves		



Q10. What is the quantity of medical equipment?

Sr.#	Name of Items	Sanctioned	Actual
1	Dressing Trolley	1	
2	Kidney tray (set of 3) S.S.	2	
3	Bowl (6" diameter) S.S.	3	
4	Tray with lid (2 x 10 x 6) S.S.	2	
5	Deep Tray with lid (large size) S.S.	1	
6	Glass Jar (medium size)	1	
7	Vaginal speculum, bi-valve (medium)	3	
8	Vaginal speculum, bi-valve (large)	2	
9	Sponge forscsp	5	
10	Vulsellum double tooth	5	
11	Dressing forceps (medium)	5	
12	Scissors, blunt ended (medium)	5	
13	Cheatle's forceps	2	
14	Artery forceps (medium)	5	
15	B.P. Apparatus (Desk type)	1	
16	B.P. Apparatus (Moveable with stand)	1	
17	Foetoscope	1	
18	Stethoscope	2	
19	Thermometer	2	
20	Midwifery Kit	1	
21	Sterilizer (Boiling type) (430x200x150mm)	1	
22	Overall (White)	2	
23	Gynea Lamp	1	
24	Uterine sound (preferably plastic)	3	
25	IUCD Insertion Table	1	
26	Examination couch	1	
27	Steps for Table	1	
28	Weighing Machine (Adult)	1	
29	Weighing Machine (Baby)	1	
30	Syringe Cutter	2	
31	Ceiling Fan	2	
32	Blanket	1	
33	Table cover (green)	1	

34	Bed sheet (Febron)	6	
35	Pillow covers (Febron)	6	
36	Draw sheet 1-1/2 x 1-1/2 meter	6	
37	Draw sheet 1 x 1 meter	6	
38	Duster (cloth)	6	
39	Plastic Bucket with cover (10 litre capacity)	1	
40	Mug Plastic	2	
41	Water set	1	
42	Stove	1	
43	Deghcha with lid (medium size)	1	
44	Tea set	1	
45	Strainers	2	
46	Utility Gloves	6 pairs	
47	Sauspan	1	
48	Water Cooler	1	
49	Towels	3	

## Annex 2: Questionnaire for Beneficiaries of FWCs

Socio-demographic characteristics			
D1	What is your current age?	Mention in years_____	
D2	At what age you were married?	Mention in years_____	
D3	What is the highest level of education you have completed?	Mention completed years____	
D4	Do you work for pay outside the home?	Yes	No
D5	How many people (including you) are living in your household?	Mention number_____	
D6	What is your total combined family income per month?	Thousands/month_____	
D7	What is the total number of your children both boys and girls?	Mention number_____	
D8	What is the age of your last child?	Mention in years_____	
D9	Who is the head of household?	Mention relation_____	
D10	What is the income of your husband?	Thousands/month_____	
D11	What is the education of your husband?	Mention completed years____	
D12	What is the profession of your husband?	Mention_____	

### Section 1

Q1. From whom you heard about FWC?

Family members 2. Relatives 3. Friends 4. FWW 5. Any other\_\_\_\_\_

Q2. Who decided to avail these services?

Myself 2. Husband 3. Both 4. Any other\_\_\_\_\_

Q3. When you start visiting FWC?

1-3 month ago 2. 4-6 month ago 3. 7-9 month ago 4. 10-12 month ago 5. Before one year

Q4. What is the approximate distance between your home and FWCs?

Walking distance 2. 1-2 kilometers 3. 3-4 kilometers 4. Above five kilometers

Q5. What mode you usually take to cover this distance?

Bicycle 2. Motor bike 3. Public transport 4. Any other\_\_\_\_\_

Q6. Who accompany you to FWC?

Husband 2. Other family members 3. Any friend 4. Any other\_\_\_\_\_

Q7. Who decided the method of your family planning?

Myself 2. Husband 3. Consultant 4. Any other\_\_\_\_\_

Q8. How many time you visited FWC?

Once a week 2. One a month 3. One time in three months 4. Any other\_\_\_\_\_

Q9. What is average time spent at FWC?

5-10 min

11-20 min

21-30 min

31-59 min

More than one hour

## Section 2

Q2.1. Please answer the bipolar question mentioned in below grid? (Other centers for family planning)

Number	Statements	Yes	No
1	Do you visit FWC alone?	1	0
2	Was it easy to get to the FWC?	1	0
3	Are the FWC hours convenient?	1	0
4	Were you informed about other contraceptive methods?	1	0
5	Was the time spent in consultation sufficient to discuss your needs?	1	0
6	Did you feel that you had the opportunity to ask questions and clarify doubts?	1	0
7	Was the use of the method(s) explained clearly to you?	1	0
8	Did you have sufficient privacy (during your consultation)?	1	0
9	Did you find the clinic area clean?	1	0
10	Were you treated in a friendly and respectful way?	1	0
11	Were the services free of cost?	1	0
12	Do you think that services are appropriate for meeting your needs?	1	0
13	Have you ever revisited FWC because of any issue like absence of staff or services?	1	0
14	Will you refer other women to avail these services?	1	0

## Section 3

3.1. How much you are strongly agree (4) and disagree (1) with the following statements?

Sr. No	Statements	SA	A	D	SD
1	You are satisfied with the staff in FWC?	4	3	2	1
2	You are satisfied with your method of family planning?	4	3	2	1
3	You are satisfied with your overall experience at FWC?	4	3	2	1

Q28. Have you ever approached by the field staff of FWC?

No 2. Yes (if yes)

Q29. Did they guide you about family planning?

Yes 2. No

Q30. Are you satisfied with their guidance?

Yes 2. No

#### Section 4

Q4.1. Are you using any family planning methods by FWC?

Yes 2. No

Q4.2. Which family planning method you are using?

Sr. No.	Family planning services
1	CONDOM
2	ORAL.PILLS
3	IUD
4	INJECTABLE
5	IMPLANON
6	C.S

Q4.3. From where you avail family planning services?

FWC 2. FWW 3. Any other \_\_\_\_\_

Q4.4. Are you satisfied with your family planning method?

Yes 2. No

#### Section 5

Q5.1. Did you visit FWC for your routine check-ups during your last pregnancy?

Yes 2. No

Q5.2. If yes, how many visits?

Mentioned number \_\_\_\_\_

Q5.3. Are you satisfied with routine check-up during your last pregnancy?

Yes 2. No

Q5.4. Have you visited FWC after delivery?

Yes 2. No

Q5.5. If yes, which services you are availing in FWC?

Variable	Yes	No
----------	-----	----

New born check-up	1	0
Vaccination/EM	1	0
Own check-up	1	0
Family planning	1	0

Q5.6. Do you think that visiting FWC improved?

Variable	Yes	No
Own health	1	0
Baby's health	1	0

Q5.7. Are you satisfied with the services provided in FWC for improving child and mothers' health?

Highly satisfied    2. Satisfied    3. Neutral    4. Dissatisfied    5. Strongly dissatisfied

### **Section 6**

Q6.1. How the services of FWC might be improved?

Q.6.2. How community can facilitate family planning services?

Q.6.3. How the overall services of family planning can be improved?

### Annex 3: Questionnaire for Beneficiaries of CBFPWs

Socio-demographic characteristics			
D1	What is your current age?	Mention in years_____	
D2	At what age you were married?	Mention in years_____	
D3	What is the highest level of education you have completed?	Mention completed years____	
D4	Do you work for pay outside the home?	Yes	No
D5	How many people (including you) are living in your household?	Mention number_____	
D6	What is your total combined family income per month?	Thousands/month_____	
D7	What is the total number of your children both boys and girls?	Mention number_____	
D8	What is the age of your last child?	Mention in years_____	
D9	Who is the head of household?	Mention relation_____	
D10	What is the income of your husband?	Thousands/month_____	
D11	What is the education of your husband?	Mention completed years____	
D12	What is the profession of your husband?	Mention_____	

#### Section 1

Q1. From whom you heard about CBFPW?

Family members 2. Relatives 3. Friends 4. CBFWP 5. Any other\_\_\_\_\_

Q2. Who decided to avail these services?

Myself 2. Husband 3. Both 4. Any other\_\_\_\_\_

Q3. When you start visiting CBFPW?

1-3 month ago 2. 4-6 month ago 3. 7-9 month ago 4. 10-12 month ago 5. Before one year

Q4. What is the approximate distance between your home and center of CBFPW?

Walking distance 2. 1-2 kilometers 3. 3-4 kilometers 4. Above five kilometers

Q5. What mode you usually take to cover this distance?

Bicycle 2. Motor bike 3. Public transport 4. Any other\_\_\_\_\_

Q6. Who accompany you to CBFPW?

Husband 2. Other family members 3. Any friend 4. Any other\_\_\_\_\_

Q7. Who decided the method of your family planning?

Myself 2. Husband 3. Consultant 4. Any other\_\_\_\_\_

Q8. How many time you visited FWC/CBPFW?

Once a week 2. One a month 3. One time in three months 4. Any other \_\_\_\_\_

Q9. What is average time spent at CBFPW?

5-10 min

11-20 min

21-30 min

31-59 min

More than one hour

## Section 2

Q2.1. Please answer the bipolar question mentioned in below grid? (Other centers for family planning)

Number	Statements	Yes	No
1	Do you visit CBFPW alone?	1	0
2	Was it easy to get to CBFPW?	1	0
3	Are the CBFPW center hours convenient?	1	0
4	Were you informed about other contraceptive methods?	1	0
5	Was the time spent in consultation sufficient to discuss your needs?	1	0
6	Did you feel that you had the opportunity to ask questions and clarify doubts?	1	0
7	Was the use of the method(s) explained clearly to you?	1	0
8	Did you have sufficient privacy (during your consultation)?	1	0
9	Did you find the clinic area clean?	1	0
10	Were you treated in a friendly and respectful way?	1	0
11	Were the services free of cost?	1	0
12	Do you think that services are appropriate for meeting your needs?	1	0
13	Have you ever revisited CBFPW center because of any issue like absence of staff or services?	1	0
14	Will you refer other women to avail these services?	1	0

## Section 3

3.1. How much you are strongly agree (4) and disagree (1) with the following statements?

Sr. No	Statements	SA	A	D	SD
1	You are satisfied with CBFPW?	4	3	2	1
2	You are satisfied with your method of family planning?	4	3	2	1



3	You are satisfied with your overall experience at CBFPW?	4	3	2	1
---	--	---	---	---	---

Q28. Have you ever approached by CBFPW?

No 2. Yes (if yes)

Q29. Did they guide you about family planning?

Yes 2. No

Q30. Are you satisfied with their guidance?

Yes 2. No

#### Section 4

Q4.1. Are you using any family planning methods by CBFPW?

Yes 2. No

Q4.2. Which family planning method you are using?

Sr. No.	Family planning services
1	CONDOM
2	ORAL.PILLS
3	IUD
4	INJECTABLE
5	IMPLANON
6	C.S

Q4.3. From where you avail family planning services?

FWC 2. CBFPW 3. Any other \_\_\_\_\_

Q4.4. Are you satisfied with your family planning method?

Yes 2. No

#### Section 5

Q5.1. Did you visit CBFPW for your routine check-ups during your last pregnancy?

Yes 2. No

Q5.2. If yes, how many visits?

Mentioned number \_\_\_\_\_

Q5.3. Are you satisfied with routine check-up during your last pregnancy?

Yes 2. No

Q5.4. Have you visited CBFPW after delivery?

Yes 2. No

Q5.5. If yes, which services you are availing from CBFPW?

Variable	Yes	No
New born check-up	1	0
Own check-up	1	0
Family planning	1	0

Q5.6. Do you think that visiting CBFPW improved?

Variable	Yes	No
Own health	1	0
Baby's health	1	0

Q5.7. Are you satisfied with the services provided by CBFPW for improving child and mothers' health?

Highly satisfied    2. Satisfied    3. Neutral    4. Dissatisfied    5. Strongly dissatisfied

### **Section 6**

Q6.1. How the services of CBFPW might be improved?

Q.6.2. How community can facilitate family planning services?

Q.6.3. How the overall services of family planning can be improved?

#### Annex 4: Questionnaire for FWW

Basic information			
D1	What is your age?	Mention in years_____	
D2	What is your total experience?	Years____Months _____	
D3	What is the highest level of education you have completed?	Matric Intermediate Graduation Master and above	
D4	When you were hired?	Mention year_____	
D5	Did you receive induction training?	1. Yes	2. No
D6	What is the name of institution which provided induction training?	Mention name_____	
D7	When induction training was provided?	Mention year_____	
D8	Did you receive any refresher training?	1. Yes	2. No
D9	Total number of refresher training so far?	Mention number_____	
D10	What is the name of institution which provided refresher training?	Mention name_____	
D11	When last refresher training was provided?	Years____Months _____	
D12	Are you satisfied with the content of refresher training?	1. Yes	2. No
D13	Are you satisfied with the duration of refresher training?	1. Yes	2. No

#### Section 1

Q1. What is your job description? (More than one answer is possible)

Job description	
In-charge of FWCs	1
Family planning services	2
Child and mothers' health	3
Referral	4
Supervise and support the FWA	5

Maintain client record	6
General record	7
Counseling of beneficiaries	8
Follow up of FP cases	9
Maintain quality of care	10

Q2. Who is your target group? (More than one answer is possible)

Target group	FWW
Wives	1
Husbands	2
Both	3
Children	4
Unmarried girls	5
Unmarried boys	6

Q3. How you approach beneficiaries? (More than one answer is possible)

Direct visit      2. Referral      3. Any other \_\_\_\_\_

Q4. Where you approach beneficiaries? (More than one answer is possible)

In their homes      2. In FWC      3. Any other \_\_\_\_\_

Q5. On average, how many times you meet with beneficiaries for their counseling at initial level?

Specify average number per month\_\_\_\_\_

Q6. On average in a month, how many times you visit beneficiaries?

Sr. No	Beneficiaries	Average/month
1	Wives	
2	Husbands	
3	Both	
4	Children	
5	Unmarried girls	
6	Unmarried boys	

Q9. How is the response of following community members about your services?

Sr. No	Name	Negative	Average	Positive	Don't know
1	Imam Masjid	0	1	2	99
2	Local community on average	0	1	2	99
3	Men on average	0	1	2	99
4	Women on average	0	1	2	99
5	Local leadership	0	1	2	99
6	Local governmental institution	0	1	2	99
7	Local non-government organizations	0	1	2	99
8	Any other _____	0	1	2	99

Q10. On average, how many women are taking your services for?

Sr. No	Name	Specify average number per month
1	family planning services	
2	Antenatal care	
3	Post-natal care	

Q11. On average, how many men are taking your services?

Specify average number per month \_\_\_\_\_

Q12. On average, how many children are taking your services for basic health facilities?

Specify average number per month \_\_\_\_\_

Q13. What is your target and achievement per month for?

Goals	Target/month	Achieved
Referral		
Counseling		
Follow up of FPs		

## Section 2

Q14. How much you are highly satisfied (4) and highly dissatisfied (1) with the following statements?

Sr. No	Statements	HS	S	DS	HDS
1	How much you are satisfied with your job?	4	3	2	1
2	How much you are satisfied with the proposed methods of family planning?	4	3	2	1
3	How much you are satisfied with your overall experience of working in this program?	4	3	2	1
4	How much you are satisfied with community participation in your area?	4	3	2	1
5	How much you are satisfied with the program achievement regarding family planning services?	4	3	2	1
6	How much you are satisfied with the program achievement regarding mother and child health	4	3	2	1
7	How much you are satisfied with the ability of target group to continue family planning services without any assistance?	4	3	2	1

Q15. Which steps do you think are necessary for improving the services of family planning and improving child and mother health?

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### Annexure 5: Questionnaire for CBFPW

Basic information			
D1	What is your age?	Mention in years_____	
D2	What is your total experience?	Years____Months_____	
D3	What is the highest level of education you have completed?	Matric Intermediate Graduation Master and above	
D4	When you were hired?	Mention year_____	
D5	Did you receive induction training?	1. Yes	2. No
D6	What is the name of institution which provided induction training?	Mention name_____	
D7	When induction training was provided?	Mention year_____	
D8	Did you receive any refresher training?	1. Yes	2. No
D9	Total number of refresher trainings so far?	Mention number_____	
D10	What is the name of institution which provided refresher training?	Mention name_____	
D11	When last refresher training was provided?	Years____Months_____	
D12	Are you satisfied with the content of refresher training?	1. Yes	2. No
D13	Are you satisfied with the duration of refresher training?	1. Yes	2. No

#### Section 1

Q1. What is your job description? (More than one answer is possible)

Job description	
Registration of couples	1
Visiting eligible couples	2
Motivation for using FP	3
FPSs to beneficiaries	4

Visiting home for FPSs	5
Referral to FWC and THQs	6
Provide general treatment	7
Assist MSUs	8
Community involvement	9
Monthly report	10

Q2. Who is your target group? (More than one answer is possible)

Target group	
Wives	1
Husbands	2
Both	3
Children	4
Unmarried girls	5
Unmarried boys	6

Q3. How you approach beneficiaries? (More than one answer is possible)

Direct visit      2. Referral      3. Any other \_\_\_\_\_

Q4. Where you approach beneficiaries? (More than one answer is possible)

In their homes      2. In your home 3. Any other \_\_\_\_\_

Q5. On average, how many times you meet with beneficiaries for their counseling at initial level?

Specify average number per month \_\_\_\_\_

Q6. On average in a month, how many times you visit beneficiaries?

Sr. No	Beneficiaries	Average/month
1	Wives	
2	Husbands	
3	Both	
4	Children	
5	Unmarried girls	
6	Unmarried boys	

Q9. How is the response of following community members about your services?



Sr. No	Name	Negative	Average	Positive	Don't know
1	Imam Masjid	0	1	2	99
2	Local community on average	0	1	2	99
3	Men on average	0	1	2	99
4	Women on average	0	1	2	99
5	Local leadership	0	1	2	99
6	Local governmental institution	0	1	2	99
7	Local non-government organizations	0	1	2	99
8	Any other _____	0	1	2	99

Q10. On average, how many women are taking your services for?

Sr. No	Name	Specify average number per month
1	Family planning services	
2	Antenatal care	
3	Post-natal care	

Q11. On average, how many men are taking your services?

Specify average number per month \_\_\_\_\_

Q12. On average, how many children are taking your services for basic health facilities?

Specify average number per month \_\_\_\_\_

Q13. What is your target and achievement per month for?

Goals	Target/month	Achieved
Referral		
Registration of couples		
Visiting eligible couples		

## Section 2

Q14. How much you are highly satisfied (4) and highly dissatisfied (1) with the following statements?

Sr. No	Statements	HS	S	DS	HDS
1	How much you are satisfied with your job?	4	3	2	1
2	How much you are satisfied with the proposed methods of family planning?	4	3	2	1
3	How much you are satisfied with your overall experience of working in this program?	4	3	2	1
4	How much you are satisfied with community participation in your area?	4	3	2	1
5	How much you are satisfied with the program achievement regarding family planning services	4	3	2	1
6	How much you are satisfied with the program achievement regarding mother and child health	4	3	2	1
7	How much you are satisfied with the ability of target group to continue family planning services without any assistance?	4	3	2	1

Q15. Which steps do you think are necessary for improving the services of family planning and improving child and mother health?

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## **Annexure 6: Interview Guide for Management**

Q1. Do you think that the program complies with development policy and planning of the Punjab and how?

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Q2. How important is the program for improving?

Family planning

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Child and mothers' health

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Contraceptive prevalence rate (CPR)?

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Q3. How the program is relevant and aligned with overall development goals of the province?

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Q4. Were the originally defined objectives of the development intervention realistic? (Explain)

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Q5. Do you think that the objectives of the development intervention have been achieved?

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Q6. What are the major contributions of this program for target group?

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Q7. Which factors were crucial for the achievement of the project objectives so far?

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Q8. Which factors were crucial for the failure of the project objectives so far?

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Q9. What is the quality of development-policy and technical planning and coordination about this program?

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Q10. How we can judge the quality of development-policy and technical planning and coordination?

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Q11. How the financial resources and other inputs be efficiently used to achieve goals in this program?

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Q12. How many people have been benefited by the project your districts?

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Q13. What would the development have been like without this program?

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Q14. How the program affected ownership and leadership of the target group? (Strengthen the ownership and leadership)

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Q15. Do you think that the target group is capable and prepared to receive the positive effects of the development intervention without support in the long term? (how much input is necessary)

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Q16. If target group is not capable to continue services without support, how much input is necessary per beneficiary?

Q17. Do you think that the target group is able to adapt sufficiently to external changes and shocks related to their participation in the program?

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Q18. Do you think that the activities, results and effects will continue after the program has ended?

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Q19. What are the major achievements of this program so far?

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Q20. What is the mechanism of monitoring of the services provided by this program?

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Q21. What is the mechanism of review meeting and for frequently review meetings are held?

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Q22. How the program built the capacity of the staff?

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Q23. What are your suggestions to improve the overall working of this program?

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## **Annexure 7: Bivariate cross tabulation of services with demographic information**

**From whom you heard about CBFPW?**

	<b>Family members</b>	<b>Relatives</b>	<b>Friends</b>	<b>CBFPW/FWC</b>	<b>Anyother</b>	<b>Total</b>
<b>Sargodha</b>	15	3	18	55	2	93
	28.8%	5.2%	42.9%	26.6%	22.2%	25.3%
<b>Laiya</b>	3	3	0	12	0	18
	5.8%	5.2%	0.0%	5.8%	0.0%	4.9%
<b>Kasur</b>	12	24	7	11	1	55
	23.1%	41.4%	16.7%	5.3%	11.1%	14.9%
<b>D.G Khan</b>	1	2	0	18	0	21
	1.9%	3.4%	0.0%	8.7%	0.0%	5.7%
<b>Muzzafargarh</b>	0	0	0	39	0	39
	0.0%	0.0%	0.0%	18.8%	0.0%	10.6%
<b>Khushab</b>	9	10	5	10	0	34
	17.3%	17.2%	11.9%	4.8%	0.0%	9.2%
<b>Okara</b>	8	14	7	41	4	74
	15.4%	24.1%	16.7%	19.8%	44.4%	20.1%
<b>Jehlum</b>	4	2	5	21	2	34
<b>Sargodha</b>	7.7%	3.4%	11.9%	10.1%	22.2%	9.2%
	52	58	42	207	9	368
<b>Total</b>	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**What is the approximate distance between your home and centre of CBFPW**

	<b>Walking distance</b>	<b>1-2 kilometers meters</b>	<b>3-4 kilometers</b>	<b>Above five kilometers</b>	<b>Total</b>
<b>Sargodha</b>	67	23	4	1	95
	24.3%	26.1%	26.7%	9.1%	24.4%
<b>Laiya</b>	16	2	0	0	18
	5.8%	2.3%	0.0%	0.0%	4.6%
<b>Kasur</b>	46	13	5	5	69
	16.7%	14.8%	33.3%	45.5%	17.7%
<b>D.G Khan</b>	19	1	1	0	21
	6.9%	1.1%	6.7%	0.0%	5.4%
<b>Muzzafargarh</b>	29	9	1	0	39
	10.5%	10.2%	6.7%	0.0%	10.0%
<b>Khushab</b>	7	26	1	3	37
	2.5%	29.5%	6.7%	27.3%	9.5%
<b>Okara</b>	64	9	2	1	76
	23.2%	10.2%	13.3%	9.1%	19.5%
<b>Jehlum</b>	28	5	1	1	35
<b>Sargodha</b>	10.1%	5.7%	6.7%	9.1%	9.0%
<b>Total</b>	276	88	15	11	390
	100.0%	100.0%	100.0%	100.0%	100.0%



**Who decided the method of your family planning?**

	<b>Myself</b>	<b>Husband</b>	<b>Consultant</b>	<b>Anyother</b>	<b>Total</b>
<b>Sargodha</b>	16	74	2	0	92
	8.6%	44.3%	13.3%	0.0%	24.7%
<b>Laiya</b>	14	3	0	0	17
	7.6%	1.8%	0.0%	0.0%	4.6%
<b>Kasur</b>	33	21	6	5	65
	17.8%	12.6%	40.0%	100.0%	17.5%
<b>D.G Khan</b>	19	0	0	0	19
	10.3%	0.0%	0.0%	0.0%	5.1%
<b>Muzzafargarh</b>	37	1	0	0	38
	20.0%	0.6%	0.0%	0.0%	10.2%
<b>Khushab</b>	10	21	6	0	37
	5.4%	12.6%	40.0%	0.0%	9.9%
<b>Okara</b>	35	40	1	0	76
	18.9%	24.0%	6.7%	0.0%	20.4%
<b>Jehlum</b>	21	7	0	0	28
<b>Sargodha</b>	11.4%	4.2%	0.0%	0.0%	7.5%
<b>Total</b>	185	167	15	5	372
	100.0%	100.0%	100.0%	100.0%	100.0%

**What is average time spent at CBFPW?**

	<b>5-10 min</b>	<b>11-20 min</b>	<b>21-30 min</b>	<b>31-59 min</b>	<b>More than one hour</b>	<b>Total</b>
<b>Sargodha</b>	55	28	10	0	0	93
	36.2%	16.5%	22.2%	0.0%	0.0%	24.5%
<b>Laiya</b>	3	8	5	0	0	16
	2.0%	4.7%	11.1%	0.0%	0.0%	4.2%
<b>Kasur</b>	33	24	9	2	0	68
	21.7%	14.1%	20.0%	20.0%	0.0%	17.9%
<b>D.G Khan</b>	5	11	1	1	0	18
	3.3%	6.5%	2.2%	10.0%	0.0%	4.7%
<b>Muzzafargarh</b>	6	30	1	0	0	37
	3.9%	17.6%	2.2%	0.0%	0.0%	9.7%
<b>Khushab</b>	1	21	8	7	0	37
	0.7%	12.4%	17.8%	70.0%	0.0%	9.7%
<b>Okara</b>	32	35	8	0	1	76
	21.1%	20.6%	17.8%	0.0%	33.3%	20.0%
<b>Jehlum</b>	17	13	3	0	2	35
<b>Sargodha</b>	11.2%	7.6%	6.7%	0.0%	66.7%	9.2%
<b>Total</b>	152	170	45	10	3	380
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Did you have sufficient privacy (during your consultation)?**

	<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Sargodha</b>	95	0	95
	24.9%	0.0%	24.8%
<b>Laiya</b>	17	0	17
	4.5%	0.0%	4.4%
<b>Kasur</b>	63	1	64
	16.5%	50.0%	16.7%
<b>D.G Khan</b>	20	0	20
	5.2%	0.0%	5.2%
<b>Muzzafargarh</b>	39	0	39
	10.2%	0.0%	10.2%
<b>Khushab</b>	37	0	37
	9.7%	0.0%	9.7%
<b>Okara</b>	75	1	76
	19.7%	50.0%	19.8%
<b>Jehlum</b>	35	0	35
<b>Sargodha</b>	9.2%	0.0%	9.1%
<b>Total</b>	381	2	383
	100.0%	100.0%	100.0%

**Were you treated in a friendly and respectful way?**

	<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Sargodha</b>	95 24.6%	0 0.0%	95 24.5%
<b>Laiya</b>	17 4.4%	0 0.0%	17 4.4%
<b>Kasur</b>	66 17.1%	2 100.0%	68 17.5%
<b>D.G Khan</b>	21 5.4%	0 0.0%	21 5.4%
<b>Muzzafargarh</b>	39 10.1%	0 0.0%	39 10.1%
<b>Khushab</b>	37 9.6%	0 0.0%	37 9.5%
<b>Okara</b>	76 19.7%	0 0.0%	76 19.6%
<b>Jehlum</b>	35 9.1%	0 0.0%	35 9.0%
<b>Sargodha</b>			
<b>Total</b>	386 100.0%	2 100.0%	388 100.0%

**Have you ever revisited CBFPW because of any issue like absence of staff or services?**

	<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Sargodha</b>	6	13	19
	10.7%	12.4%	11.8%
<b>Laiya</b>	1	6	7
	1.8%	5.7%	4.3%
<b>Kasur</b>	25	13	38
	44.6%	12.4%	23.6%
<b>D.G Khan</b>	1	7	8
	1.8%	6.7%	5.0%
<b>Muzzafargarh</b>	0	14	14
	0.0%	13.3%	8.7%
<b>Khushab</b>	9	28	37
	16.1%	26.7%	23.0%
<b>Okara</b>	12	24	36
	21.4%	22.9%	22.4%
<b>Jehlum</b>	2	0	2
<b>Sargodha</b>	3.6%	0.0%	1.2%
<b>Total</b>	56	105	161
	100.0%	100.0%	100.0%

**Have you ever approached by the field staff of CBFPW?**

	<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Sargodha</b>	90	5	95
	23.7%	50.0%	24.4%
<b>Laiya</b>	18	0	18
	4.7%	0.0%	4.6%
<b>Kasur</b>	67	2	69
	17.7%	20.0%	17.7%
<b>D.G Khan</b>	20	1	21
	5.3%	10.0%	5.4%
<b>Muzzafargarh</b>	39	0	39
	10.3%	0.0%	10.0%
<b>Khushab</b>	37	0	37
	9.8%	0.0%	9.5%
<b>Okara</b>	74	2	76
	19.5%	20.0%	19.5%
<b>Jehlum</b>	34	0	34
<b>Sargodha</b>	9.0%	0.0%	8.7%
<b>Total</b>	379	10	389
	100.0%	100.0%	100.0%

**Which family planning method you are using?**

	<b>Condoms</b>	<b>Oral pills</b>	<b>IUD</b>	<b>Injectable</b>	<b>Implanon</b>	<b>C.S</b>	<b>Total</b>
<b>Sargodha</b>	6	4	15	10	1	0	36
	9.8%	12.5%	19.2%	14.1%	100.0%	0.0%	14.6%
<b>Laiya</b>	9	4	5	0	0	0	18
	14.8%	12.5%	6.4%	0.0%	0.0%	0.0%	7.3%
<b>Kasur</b>	12	7	13	7	0	0	39
	19.7%	21.9%	16.7%	9.9%	0.0%	0.0%	15.8%
<b>D.G Khan</b>	5	2	4	4	0	1	16
	8.2%	6.3%	5.1%	5.6%	0.0%	25.0%	6.5%
<b>Muzzafargarh</b>	2	2	10	13	0	0	27
	3.3%	6.3%	12.8%	18.3%	0.0%	0.0%	10.9%
<b>Khushab</b>	4	4	13	16	0	0	37
	6.6%	12.5%	16.7%	22.5%	0.0%	0.0%	15.0%
<b>Okara</b>	21	8	12	15	0	3	59
	34.4%	25.0%	15.4%	21.1%	0.0%	75.0%	23.9%
<b>Jehlum</b>	2	1	6	6	0	0	15
<b>Sargodha</b>	3.3%	3.1%	7.7%	8.5%	0.0%	0.0%	6.1%
<b>Total</b>	61	32	78	71	1	4	247
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Did you visit CBFPW for your routine check-ups during your last pregnancy?**

	<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Sargodha</b>	30	31	61
	12.5%	28.4%	17.5%
<b>Laiya</b>	18	0	18
	7.5%	0.0%	5.2%
<b>Kasur</b>	61	6	67
	25.4%	5.5%	19.2%
<b>D.G Khan</b>	7	12	19
	2.9%	11.0%	5.4%
<b>Muzzafargarh</b>	15	22	37
	6.3%	20.2%	10.6%
<b>Khushab</b>	26	11	37
	10.8%	10.1%	10.6%
<b>Okara</b>	65	11	76
	27.1%	10.1%	21.8%
<b>Jehlum</b>	18	16	34
<b>Sargodha</b>	7.5%	14.7%	9.7%
<b>Total</b>	240	109	349
	100.0%	100.0%	100.0%



**Have you visited FWC after delivery?**

	<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Sargodha</b>	13	2	15
	4.8%	9.5%	5.1%
<b>Laiya</b>	15	1	16
	5.5%	4.8%	5.4%
<b>Kasur</b>	62	5	67
	22.7%	23.8%	22.8%
<b>D.G Khan</b>	20	1	21
	7.3%	4.8%	7.1%
<b>Muzzafargarh</b>	38	0	38
	13.9%	0.0%	12.9%
<b>Khushab</b>	35	2	37
	12.8%	9.5%	12.6%
<b>Okara</b>	62	6	68
	22.7%	28.6%	23.1%
<b>Jehlum</b>	28	4	32
<b>Sargodha</b>	10.3%	19.0%	10.9%
<b>Total</b>	273	21	294
	100.0%	100.0%	100.0%

**Are satisfied with the services provided by CBFPW for improving child and mothers' health?**

	<b>Highly satisfied</b>	<b>Satisfied</b>	<b>Dissatisfied</b>	<b>Strongly dissatisfied</b>	<b>Total</b>
<b>Sargodha</b>	23	49	0	0	72
	11.7%	36.8%	0.0%	0.0%	21.4%
<b>Laiya</b>	13	3	1	0	17
	6.6%	2.3%	25.0%	0.0%	5.1%
<b>Kasur</b>	35	32	1	0	68
	17.8%	24.1%	25.0%	0.0%	20.2%
<b>D.G Khan</b>	10	6	0	0	16
	5.1%	4.5%	0.0%	0.0%	4.8%
<b>Muzzafargarh</b>	11	5	1	0	17
	5.6%	3.8%	25.0%	0.0%	5.1%
<b>Khushab</b>	18	17	0	2	37
	9.1%	12.8%	0.0%	100.0%	11.0%
<b>Okara</b>	60	15	1	0	76
	30.5%	11.3%	25.0%	0.0%	22.6%
<b>Jehlum</b>	27	6	0	0	33
<b>Sargodha</b>	13.7%	4.5%	0.0%	0.0%	9.8%
<b>Total</b>	197	133	4	2	336
	100.0%	100.0%	100.0%	100.0%	100.0%



## **Annex: Pictures of field visits**

### **DG Khan**

Pictures: Building of FWC	Picture: Facility Room and facilities

### Jhelum

Pictures: Building of FWC	Picture: Facility Room and facilities

### **Kasur**

Pictures: Building of FWC	Picture: Facility Room and facilities

**Khushab**

Pictures: Building of FWC	Picture: Facility Room and facilities

**Layyah**

Pictures: Building of FWC	Picture: Facility Room and facilities



### **Muzaffar Garh**

Pictures: Building of FWC	Picture: Facility Room and facilities

## Okara

Pictures: Building of FWC	Picture: Facility Room and facilities

### Sargodha

Pictures: Building of FWC	Picture: Facility Room and facilities