END-LINE of EVALUATION REPORT

PILOT PROJECT

Contribution to the Achievement of FP2020 Contraceptive Prevalence Rate objectives of Pakistan in Punjab province

March, 2020

Medecins-du-Monde, France, Pakistan Office

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ACKNOWLEDGEMENTS

An evaluation assignment has many perks, which strengthen an organization's professional profile, provide the opportunity to visit new areas, meet different people, witness local sectoral issues, make lifelong friends and experience the unique cultures of Pakistan.

First, we would like to thank MDM management for trusting Action Consulting and awarding this assignment. We are grateful to have this creative opportunity to review the application of the concept in the context of the project review, which has increased our professional exposure.

There are many who have supported our work during the assignment. We want to thank each and every one of them, starting with the sincere, dedicated and experienced MDM team which includes Ms. Alexandra van Marcke, Dr. Rubina Moin and Mr. Waqas Ahmed. During the entire course of this assignment we were impressed by their willingness to positively critique their own work; to see them listening and learning, and because of their ability to think 'outside the box'.

Finally, I would also like to acknowledge my most valuable resource, i.e., the social mobilizers' team in Lahore led by Ms. Roohi Maqbool, the PWD staff, volunteers and beneficiaries of this project. Without their time and input, it would not have been possible to complete this assignment on time and at the desired level of quality.

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Team Leader

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ACRONYMS

ACPL	Action Consulting Private Limited
ADP	Annual Development Plan
BHU	Basic Health Units
CIP	Costed Implementation Plan
CIPP	Context, Input, Process and Product
CPR	Contraceptive Prevalence Rate
CPROP	CPR Objectives in Punjab
CSO	Civil Society Organizations
CYP	Couple-Years of Protection
DAC	Development Assistance Committee
DOP	District Officer Population
ECP	Emergency Contraceptive Pill
EHSP	Essential Health Service Package
FGD	Focus Group Discussion
FP	Family Planning
FPAP	Family Planning Association of Pakistan
FPC	Family Planning Counselling
FWA	Family Welfare Assistants
GATHER	Greet, Ask, Tell, Help, Explain, and Return
HTSP	Healthy Timing and Spacing of Pregnancy
IDI	In-depth Interview
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device

KPK	Khyber Pakhtunkhwa
LHW	Lady Health Worker
M&E	Monitoring and Evaluation
MDM-F	Médecins du Monde France
NOC	No Objection Certificate
OJT	On-Job Training
PAPAC	Pakistan Alliance for Post abortion Care
PMCB	Pre-Marital Counselling Booklet
POP	Progesterone-Only Pill
PPIF	Punjab Population Innovation Fund
PWD	Punjab Welfare Department
QOS	Quality of Service
SCP	Supreme Court of Pakistan
SO	Specific Objectives
SOP	Standard Operating Procedures
SRHR	Sexual and Reproductive Health Rights
TFR	Total Fertility Rate
TNA	Training Need Assessment
TOC	Theory of Change
TOT	Training of Trainers
UNDP	United Nations Development Program
WOM	Word-of-Mouth

EXECUTIVE SUMMARY

In 2017 *Medicines du Monde* France (MDM)[1] began implementing a pilot project in Lahore in partnership with the Population Welfare Department (PWD) of Punjab. The Project is partially funded by the *Agence Française de Développement* (AFD). The purpose is to improve the quality of the family planning (FP) services for vulnerable communities and to empower those community members to raise their voices and access their Sexual and Reproductive Health Rights (SRHR).

This report presents the findings of the end-line evaluation of the pilot project titled "To contribute to the Achievement of FP2020 Contraceptive Prevalence Rate Objectives of Pakistan, in Punjab Province" (referred to as FP2020-CPROP (CPR Objective in Punjab). FP2020-CPROP took place from November 2017 to March 2020 in Lahore district, in partnership with the PWD, in six of their centers and catchment areas that included one Family Health Clinic (FHC) and five Family Welfare Centers (FWCs): these serve over 55,000 low-income households in the following areas of Shalamar Town in North Lahore: 1) China Scheme, 2) Shad Bagh, 3) Mughalpura, 4) Kotli Peer Abdul Rahman, 5) Shadipura/Lakhodeer and 6) Kot Khawaja Saeed. **(**Please see Table 2 for disaggregated demographic data.)

FP2020-CPR-OP had three components:

- Demand-generation through community mobilization
- Capacity building and technical assistance to PWD field staff and counsellors at FWCs, and
- Advocacy for SRHR in Punjab province.

Through this three-pronged approach, the project sought to achieve three results: a) increased availability and quality of family planning services, b) mobilize the communities on their rights to access family planning services, and c) strengthen the influence of provincial SRHR actors through a common SRHR advocacy.

In December 2019 MDM commissioned this project evaluation to assess its approach to family planning and SRH in Punjab in the pilot phase. Specifically, the evaluation looked at a) how well targeted communities have been mobilized, b) how much new demand for FP services has been generated, c) how well received are MDM's efforts by the PWD and thus, d) draw recommendations for scale-up and replication in the next project phases across Punjab. The evaluation methodology is rooted in (i) OECD Development Assistance Committee (DAC) criteria of relevance, effectiveness, efficiency, sustainability and impact and (ii) the CIPP (Context, Input, Process and Product) model. Project evaluation data was collected from all key stakeholders by means of in-depth interviews (IDIs), focus group discussions (FGDs), a community survey and exit interviews. In all 471 responses inform this evaluation, which took place from December, 2019 to March, 2020.

Pakistan is the fifth most populous country in the world with its population currently estimated at 212 million (207.8 million according to 2017 census). The battle for population control in Pakistan has to be fought in the plains of Punjab which occupies 26 percent of the land area of the country yet accommodates more than 50 percent of the total population. PWD spearheads

[1] https://www.who.int/workforcealliance/members_partners/member_list/mdm/en/

implementation of the Punjab Population Policy 2017, which has set goals to a) stabilize population growth, b) reduce fertility and c) facilitate achievement of sustainable development goal (SDG) objectives related to universal access to reproductive health care services. In line with the policy objectives, Punjab has also committed to achieving national FP2020 targets that the federal government had set in 2012 at the London Summit. Along with the Department of Health, PWD is responsible for progress towards the Punjab FP2020 objective: Achieve Universal access to Reproductive Health and raise contraceptive prevalence rate (CPR) by 55% (revised to 50%). MDM's implementation of the pilot program is aligned with PWD's efforts made towards achieving FP2020 targets.

MDM's presence in Pakistan dates back to 1996. In Punjab it successfully handed over to the Provincial government a 10-year project on gender-based violence in 2014. From July 2015 to June 2017, MDM implemented a pilot project for PWD and built the capacities of 15 centers for the adolescent in all nine divisions of Punjab. Building on the success of this project, MDM, after a thorough needs-scoping with stakeholders, decided to work on family planning. In close collaboration with PWD, MDM designed this 2-year pilot project, which was launched under formal partnership with PWD in November 2017.

MdM's initial assessment lasted for one year. This is quite a lengthy assessment period for a pilot program. But it laid the foundation for a solid partnership with a government entity, which gave MdM the challenge of improving low-performing FP service outlets.

The FWCs supported by MdM during the pilot project were under-performing because of a) lack of nonexistent awareness about the presence of government-run FWCs in the area, b) poor and even negative perceptions of FWCs and c) lack of staff capacity and proper reporting.

Using global best practices, MdM started with an assessment phase. MDM, while taking along FWC field staff, carried out detailed social mappings of the pilot project areas, to understand the catchment areas' global features. MDM identified the key local stakeholders in the community and potential volunteers, who were recruited into support groups called Friends of FWC (FFWC). As the core element of its social mobilization component, MDM reactivated the female community support groups called Friends of Family Welfare Centers (FFWC) and innovated by creating male FFWCs. This action was also supported by the findings of an MDM-commissioned study that explored socio-cultural barriers to FP. The male and female FFWCs functioned under a well-defined TOR and were mobilized by MDM and FWC field staff to serve as a bridge between the FWC and the community. They were thus instrumental in addressing the two issues of low awareness and lack of capacity building and reporting.

Post assessment, MDM set out to address the identified challenges. It rolled out its capacity building component that provided training to FWC counsellors on best practices of FP counselling and members of FFWCs inaccurate FP/SRH information and social mobilization technique. Simultaneously, social mobilization was started by involving FWC field staff and FFWCs. MDM's pilot project achieved positive results with the community it served. It generated word of mouth promotion about FP/SRH and FWC services that reached over 200,000 people. All users surveyed indicate that they are likely to refer their FWC to others because of the quality of services they received. About 97 percent of visitors rated their experience at an FWC as either excellent or good. All 290 survey respondents find FWCs beneficial for their contribution to health and welfare of the community; they also unanimously endorsed the need for young men and women to seek FP counselling before marriage and 99 percent of them agree to providing SRH education to youth. All survey respondents acknowledge that the FFWCs have

performed a useful social service and recommend their replication, especially of male-led FFWCs.

MDM's advocacy component developed necessary relations with three stakeholders and agreement on common SRH advocacy objectives. Being responsive to PWD's requirements and thanks to strong partnership relations developed, MDM ended up achieving much more than it planned. MDM took the lead in revising the SRH Bill for Punjab by successfully carrying out consultations with civil society organizations working on SRH. MDM also led the development of Pre-Marital Counselling Booklet on behalf of PWD. MDM is now an emerging SRH advocacy organization that needs to further build its credentials in the SRH advocacy landscape in Pakistan.

By virtue of its performance in the project, its unique field-based approach that built capacity of PWD staff, and the overall usefulness of its social mobilization, especially its innovation of male-FFWCs. MDM gained the trust and confidence of the community it served and PWD staff at all levels. The FFWCs-male achieved notable results in terms of increased community acceptance of FP and FWCs. This innovation stands out as MDM's lasting contribution to PWD from this pilot.

Additionally, MDM established that the capacity building should encompass not only FWC counsellors but also FWC's social mobilizers and FFWC members. Capacity building comes out as a best practice from this pilot. Hence FFWC-male and all-encompassing capacity building are practices that PWD can adapt into its system.

The Project's social mobilization component was found to be quite resource-efficient at a cost of Rs. 86 (Euro 0.52) per person reached. Its program and administrative costs allocation was in line with going accepted standards (10-18 percent of the budget)

FP2020-CPROP's activities resulted in greater acceptance of FP, and reduced the stigma attached to FWCs.

The Project generated demand, increased the flow of users, both male and female, to FWCs and enhanced the quality of services delivered at FWCs.

The Project's theory of change stands proven, especially the component related to male-led mobilization; it is a true social innovation well executed under the project. Success in capacity building and social mobilization were achieved as intended.

Overall the project is a success and MDM's drivers of success can be summarized as:

1) Responsiveness to PWD needs and working very cooperatively with government
2) Adaptive and active management
3) A well-targeted implementation strategy based on social and community mobilization, especially the innovation of male-led FFWCs
4) Capacity building that encompassed counsellors, field staff and support groups
5) Focusing on improving the service delivery at the grassroots
6) Delivering as per commitment
7) Being open in giving credit to all those with whom MDM worked in advocacy, and
8) Strengthened community trust and confidence.

RECOMMENDATIONS

Although the project has undoubtedly been successful, MDM needs to be cognizant of challenges in scalability, recognition and risk mitigation. Section 4 of the report contains the complete list of recommendations for scaling up, project design and management, partnership and network building, the use and widespread integration of technology into functions and service delivery, and brand-building, visibility and evidence-based advocacy.

The recommendations are summarized below.

- Bolster efforts to de-stigmatize family planning, addressing cultural and religious concerns, and highlighting the plethora of benefits of family planning methods
- Build risk mitigation into the program design, based on the assumption that SRHR will invite backlash.
- Improve project design and management (e.g. by conducting a baseline survey against which to measure performance, running an FP tracker that monitors changes in community attitudes, and using well-recognized indicators like CYP, FPC and CPR).
- Create a formal referral mechanism between FFWC and FWC to learn exactly how many clients are coming from which member of FFWC.
- Make provision for supplying general medicines at the FWCs, as this will attract more people to the FWCs.
- Behavioral improvement is required of FWC staff and FFWCs. It is also necessary to make the FFWCs aware of gender issues, especially in relation to gender equality in access to health.
- Garner a stronger commitment from PWD at all levels, including: crafting a common vision for the next phase, mutually setting performance expectations and strengthening a joint monitoring and oversight mechanism.
- Strengthen advocacy by collaborating with reputed partners like UNFPA, FPAP and allow them to take the lead.
- Develop stronger capacity for use of social media, including for data collection and monitoring. This should include (a) developing an Android-based reporting app backed with cloud computing and (2) making 3-5 minute video clips for training and information.
- Build on the evidence of MDM's programming success, including both social innovation and program result data, for evidence-based research and reporting and for advocacy. Given the scale and duration of the proposed long-term project, it will be useful to develop a results-based program framework.

By implementing these recommendations for scale-up phases, it is truly hoped that MdM will be able to make bigger contribution to "the Achievement of FP2020 Contraceptive Prevalence Rate Objectives of Pakistan, in Punjab Province."

1. INTRODUCTION

Médecins-du-Monde (MDM) France has been active in Punjab since 1996 and has implemented several programs on mother and child health, sexual and reproductive health (SRH) and gender based violence (GBV). In 2017 MDM started implementing a pilot project in Lahore in partnership with the Population Welfare Department (PWD) of Punjab, to improve the quality of the family planning (FP) services for vulnerable communities and empower them to raise their voices and access their SRH rights (SRHR).

This report presents the end-line evaluation of the pilot project titled "To contribute to the Achievement of FP2020 Contraceptive Prevalence Rate Objectives of Pakistan, in Punjab Province." For the sake of brevity, we will refer to this project as FP2020-CPROP (CPR Objective in Punjab).

1.1 BRIEF DESCRIPTION OF THE PROJECT

FP2020-CPROP started in November 2017 and ran until February 2020 in Lahore district, in partnership with the PWD in at its six Centers: one Family Health Clinic (FHC) and five Family Welfare Centers (FWC) that serve over 55,000 low-income households in the following areas of Shalamar Town in North Lahore: 1) China Scheme, 2) Shad Bagh, 3) Mughalpura, 4) Kotli Peer Abdul Rahman, 5) Shadipura/Lakhodeer and 6) Kot Khawaja Saeed. (See Table 2 for demographic data disaggregated by location, gender and age.)

FP2020-CPR-OP had three components:

- Demand generation for Family Planning through community mobilization
- Capacity building and technical assistance to PWD field staff and counsellors at FWCs, and
- Advocacy for SRHR in Punjab Province.

Through this three-pronged approach, the project sought to establish the following results:

Result 1:	The availability and quality of family planning services are strengthened at selected Family Welfare Centers
Result 2:	Targeted communities are sensitized and mobilized on their rights to access family planning services, and
Results 3:	Provincial SRHR actors' influence is strengthened through identification and promotion of common SRHR objectives

The project sought to benefit 57,238 people: 175 would benefit directly and include training participants such as a pool of trainers, FWC staff, support groups, Medical Officers, Tehsil Officer and MDM social mobilizers (SMs). Indirect beneficiaries were targeted in two groups: community awareness sessions (CAS), participants (target: 19,440) and additional users of FP services (target: 37,623).

By implementing this pilot, MDM wanted to establish that its social mobilization approach can generate community acceptance of FP, additional client traffic to FWCs, and enhanced service quality and thus an increase in uptake of various FP services and methods available at these centers.

1.2 CONTEXT AND PURPOSE OF EVALUATION

As the project came to end, MDM commissioned its evaluation.

1.2.1 SCOPE AND OBJECTIVES OF THE EVALUATION

This is an end-line evaluation and it covers the pilot project implemented by MDM. The evaluation covers:

- The 6 PWD centers and their catchment area targeted in the pilot phase (one Family Health Clinic and five Family Welfare Centers located in Shalamar town of Lahore District) and
- The 3 main components of the project: social mobilization, capacity building of the partner and advocacy that were implemented from June 2018 to March 2020.

The main objective of this evaluation was to assess the approach to family planning and more globally SRH in Punjab implemented by MDM with PWD in the pilot phase. The specific objectives of the evaluation were:

- To assess the field and rights-based approach developed by MDM in partnership with PWD to:
  i.
  ii. generate demand for modern family planning methods in the targeted communities
  iii. respond to the needs for SRH and FP of the communities in the targeted areas;
  iv.
- To evaluate the PWD perception, capacity and willingness at the different levels (field, district and provincial office) and assess the opportunities and challenges in terms of ownership by PWD and sustainability of the approach.
- To draw recommendations for scale-up and replication phases across Punjab.

1.2.2 NATURE OF THE EVALUATION

Pilot projects build on premises or hypotheses, which are tested against reality when the pilot is actually implemented in the field. MDM's hypotheses for this pilot were:

- That there is enough unmet need for FP services but because of lack of awareness people are not coming to PWD-run FWCs and availing FP services;
- That PWD-run centers suffer from lack of visibility, poor perception of quality of services and stigmatization;
- That proper trainer and capacity building leads to improved field and in-center results in term of client inflow, FP services uptake and client satisfaction at every center;
- That the force volunteerism can be ignited for the improvement of SRH in the community
- That unified voices strengthen SRHR and thus need to be brought together for advocacy.

This evaluation is therefore focused on providing evidence-based information to support these hypotheses. The aim is "learning" and the evaluation aims to furnish analysis,

conclusions and recommendations in light of lessons learned, so as to improve, scale-up and replicate this approach throughout Punjab.

1.3 METHODOLOGY OF THE EVALUATION

The evaluation methodology is rooted in two widely used and well-respected models which were used to design the evaluation matrix that answers evaluation questions raised in the Terms of Reference (TOR) given in Annex 5.1.

1.3.1 EVALUATION MODEL AND FRAMEWORK

The TOR had used OECD Development Assistance Committee (DAC) criteria[2] to categorize the MDM evaluation questions.

DAC CRITERIA WITH CIPP MODEL

DAC criteria of relevance, effectiveness, efficiency, sustainability and impact were used along with the **CIPP** (Context, Input, Process and Product) evaluation model. **CIPP** requires the evaluation of context, input, process and product in judging a program's value.[3] Both frameworks offer distinct advantages and complement each other to provide much deeper insights from the evaluation. Combining the two frameworks resulted in a compact but comprehensive evaluation matrix (Annex 5.2) that became the basis for the research plan and the design of data collection tools.

1.3.2 RESEARCH PLAN, DATA COLLECTION AND ANALYSIS

The evaluation research plan consisted of secondary and primary sources of information.

DESK REVIEW

First a thorough desk review was conducted to gain an understanding of a) the need and context prevailing when the pilot project was designed, b) changes in the project made over time in response to emerging needs of PWD, and c) project performance as captured by internal monitoring and evaluation (M&E) functions.

The desk review also proved helpful in designing the questionnaire and survey tools. The list of documents reviewed is provided in Annex 5.3.

DATA COLLECTION

Project evaluation data was collected under a research plan that covered all key stakeholders, internal and external. Data collection took place by means of in-depth interviews (IDIs), focus group discussions (FGDs), a community survey and exit interviews. The following tools were used and are provided in Annex 5.4.

[2] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm
[3] https://en.wikipedia.org/wiki/CIPP_evaluation_model

Quantitative data collection tools	Qualitative data collection tools
1. Community survey tool 2. Exit interview questionnaire	1. FGD guide for community members 2. FGD guide for community volunteers 3. FGD guide for field staff 4. FGD guide for CSOs and private stakeholders 5. IDI master guide for MDM and PWD managerial staff, FWC counsellor in-charge and SRH activists

Table 1: Data collection tools

All tools were finalized for field-use after feedback from MDM. Both the community survey and exit interview tools were translated into Urdu and field-tested before being finalized and administered.

SAMPLING AND DISTRIBUTION

The inception report envisaged an overall sample of 380 responses from all data collection methods. Against this target Action Consulting Pvt. Limited (ACPL) achieved the 471 total responses that now inform this evaluation report.

QUANTITATIVE DATA ANALYSIS

The community survey and client exit interviews yielded the quantitative data for this evaluation.

Community survey

Sampling planned and actual – Community Survey					
Centre area/ location	**Total number of households (HH)**	**Area HH percentage**	**Planned sample**	**Prorated sample**	**Actual achieved**
China Scheme	10,426	19%	40	45	59
Shad Bagh	12,565	22%	40	54	67
Mughalpura	4,768	9%	40	20	23
Kotli Peer Abdul Rahman	8,400	15%	40	36	41
Shadipura/ Lakhodeer	15,970	29%	40	69	82
Kot Khawaja Saeed	3,744	7%	40	16	18
Total Households	55,873	100%	240	240	290

Table 2: Sampling planned and achieved – community survey

The community survey equally covered male and female respondents across four age groups and two predominant religions: Muslims and Christians.

Gender			
	Total	*Male*	*Female*
Base: all respondents	290	141 (49%)	147 (51%)

Age (years)					
Base: all respondents	**Total**	14-24	25-35	36-46	50+
	290	24 (8%)	151 (52%)	85 (29%)	30 (11%)

Complete survey demographics and results are available in Annex 5.6.

Exit interview of FWC clients

Sampling planned and actual – Exit Interviews					
Centre area/ location	**Households**	**HH percentage**	**Planned sample**	**Prorated sample**	**Actual achieved**
China Scheme	10,426	19%	10	11	13
Shad Bagh	12,565	22%	10	13	14
Mughalpura	4,768	9%	10	5	6
Kotli Peer Abdul Rahman	8,400	15%	10	9	9
Shadipura/ Lakhodeer	15,970	29%	10	17	17
Kot Khawaja Saeed	3,744	7%	10	4	3
Total Households	55,873	100%	60	60	62

Table 3: Sampling planned and achieved – exit interview

Complete results of the FWC client exit interviews are provided in annex 5.7.
Total planned target for quantitative data was 300 (240 plus 60); ACPL achieved 352 (290 plus 62). Initially, uniform samples were planned for each area. Actual sample distribution was prorated on the basis of household density percentage. A team of six enumerators (3 women and 3 men) were trained on how to run the tools in the catchment areas of the respective FWCs. Households were randomly selected from within a 1-2 kilometer radius of an FWC in each of the locations.

Both female and male respondents were targeted with a planned ratio of 50:50. We achieved 51 (female): 49 (male), covering four age groups: 14-24 years (8 percent), 25-35 years (52 percent), 36-46 years (29 percent) and 50+ years (8 percent).

The community survey and exit interview data was analyzed via world's foremost software, SPSS (Statistical Package for Social Sciences). Simple descriptive statistics have been used to present the data from relevant questions in terms of percentages and means for each area, gender, religion and total.

QUALITATIVE DATA ANALYSIS

The qualitative research plan targeted 118 respondents and achieved 119 by means of FGDs and IDIs as per the table given below:

1. FGDs				**Conducted**
Respondent Type	Method	Male	Female	Total
Community members	FGD	1	2	3
Community Volunteers	FGD	2	2	4
Field staff – PWD	FGD	1	1	2
Total FGDs		4	5	9
Total respondents – FGD (Persons/ FGD)			10	90
2. IDIs				**Conducted**

Respondent Type	Method	Remarks	Total
counsellors/ Centre incharge	IDI	Per center	6
MDM staff	IDI	Field & P. Mngt	8
Community leaders	IDI	Per Center (M+F)	4
PWD staff	IDI	Field/District/ Province	9
SRH activists	IDI	Estimated	1
CSOs	IDI	Estimated	1
Total touch points – IDIs			29
Total coverage – Qualitative			**119**

Table 4: Qualitative research plan

The majority of IDIs and FGDs were directly transcribed as they were conducted. Some of them were tape-recorded with respondents' permission and later relevant sections were transcribed and translated for inclusion in this report.

Every effort was made to ensure that enumerators and respondents understood the practices of 'informed consent" and confidentiality.

A list of persons consulted in both FGDs and IDIs is provided in annex 5.5.

METHODOLOGICAL ADEQUACY AND LIMITATIONS

Insights from analysis of over 470 total responses feed the evaluation findings and 'lessons learned'. This sample combination of quantitative and qualitative is quite robust for a 'pilot' project whose beneficiaries have similar demographic characteristics: a population of about 55,873 is well represented by 470 responses. The overall sampling is therefore statistically significant.

We have used simple descriptive statistics to present quantitative data, which is further strongly supported by qualitative insights, in order to present evidence on the successes/failures of the project and to capture 'learning' from this pilot in line with the TOR for this evaluation.

Although the evaluation findings have been based on a very robust sample combination for a pilot project, there are certain limitations that readers/users of this report need to be aware of: there was no baseline data on FP and SRH-related knowledge, attitudes and practices (KAP) of beneficiaries in the project areas. In the absence of a baseline, the findings of the end-line community survey cannot be compared and thus validated in a statistically significant manner.

1.3.3 DURATION AND TIMELINES OF EVALUATION

The evaluation was completed in phases as shown in Table 5.

Phases	**Dates**
ACPL's performance period under the Contract	December 16, 2019 to March 31, 2020
Inception phase completed (inception report)	19 December, 2020
Survey Instruments finalized	08 January, 2020
MDM applied for No Objection Certificate (NOC) for fieldwork	10 January, 2020
NOC received	07 February 2020

ACPL begins field work	11 February, 2020
ACPL finishes field work	25 February, 2020
Data analysis and draft report	20 March, 2020
Final report and presentation	30 April, 2020

Table 5: Evaluation timeline

1.3.4 PRESENTATION OF EVALUATION FINDINGS

In line with the scope of evaluation, the findings are presented in the following pages.

Chapter 2 gives **project description and the development context** in which this pilot has been implemented

Chapter 3 is the main section of this report and details the **evaluation of project interventions and results**

Chapter 4 addresses the question of **impact and sustainability**, and finally

Chapter 5 draws **conclusions, and identifies lessons learned and makes recommendations.**

2. DEVELOPMENT CONTEXT AND PROJECT DESCRIPTION

Pakistan is the fifth most populous country in the world with its current population estimated at more than 212 million[4] based on the official Census of 2017 which puts the number at 207.8 million.[5] Its population growth rate of 2.40 percent is the highest in South Asia and stands in sharp contrast to the 1.0–1.5 percent growth rate of other South Asian countries.[6] Pakistan's population has increased more than six-fold since the first post-independence census held in 1951. This massive growth in population possesses serious challenges for the country's socio-economic development.

According to the United Nations Development Program (UNDP) report published in September 2019, [7]the high growth in population can be attributed to a number of factors. Pakistan has the lowest contraceptive prevalence rate (CPR) in South Asia: this has stagnated at 35 percent over the last couple of years. One in five married women in Pakistan is unable to access effective methods of family planning if they want to avoid pregnancy and plan the number and spacing of their children. Low contraceptive prevalence may be further attributed to weak service delivery systems and markets and to cultural norms.

From 1993 to 1998, Pakistan ran a successful family planning program which was instrumental in reducing fertility rates and increasing contraceptive prevalence. The key element of the program was the recruitment of trained Lady Health Workers (LHWs) to provide primary health care and family planning services to women at the community level. The LHWs were pivotal in expanding family planning services to the poor and educating them on the available methods. However, from 2000 onwards, successive governments' attention to family planning programs has started to reduce. The UNDP report further notes 'that population and family planning is now again getting space on the government's policy agenda'.

The governmental efforts are also acknowledged by FP2020, which is an outcome of the 2012 London Summit on Family Planning at which more than 20 governments made commitments to address the policy, financing, delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies, and donors pledged an additional US$2.6 Billion in funding. [8] FP 2020 also acknowledges that *'since first making a commitment to FP2020 in 2012, Pakistan has demonstrated ongoing efforts toward the promotion of family planning.'* This renewed commitment by Pakistan is supported by concrete actions such as:

- Preparation by all four provinces of Costed Implementation Plans for family planning and developed family planning task forces comprised of public and private sector stakeholders.
- Ensuring easy access to a range of available FP methods coupled with training of mid-level service providers in the public and private sectors to provide IUDs and implants.

[4] https://en.wikipedia.org/wiki/Pakistan
[5] http://www.pbs.gov.pk/content/population-census
[6] Population Growth: Implications for Human Development, UNDP, https://www.pk.undp.org/content/pakistan/en/home/library/development_policy/dap-vol6-iss1-population-growth.html
[7] ibid.
[8] http://www.familyplanning2020.org/pakistan

- Promoting acceptability of family planning by onboarding men and religious leaders as part of its social mobilization efforts.
- Establishment of adolescent centers by governments of Punjab, Sindh, and Khyber Pakhtunkhwa (KPK).

FP2020 notes that *'to continue promoting strong government commitment, Pakistan is working to strengthen collaboration among regions under a devolved system in order to reach 6.7 million additional users and increase CPR to 50 percent by 2020.'* The obstacles on this path are many and they are well documented. According to Population Council studies the main contributing factors in the low uptake of FP among men and women are: [9]

- difficulties in reaching public health facilities
- poor quality of care at these facilities, particularly, the discouraging attitudes of providers,
- frequent stockouts of contraceptives, and
- inadequate counseling, especially regarding possible side effects of contraceptives.

Such studies also highlight that the private sector is often perceived by users to offer better quality of care.

2.1 POPULATION GROWTH CHALLENGE OF PAKISTAN AND PUNJAB

The battle for population control in Pakistan has to be fought in the plains of Punjab which occupies 26 percent of the land area yet accommodates more than 50 percent of the total population. Punjab's population profile is presented in the table below:[10]

Population Profile Punjab		
Indicators	**Pakistan**	**Punjab**
Total Population	207.8 million	110 million
Population Growth Rate	2.40%	2.13%
Population Density (per sq. km)	236 persons	536 persons
Urban Population	75.6 million	40 million
Rural Population	132 million	70 million
Crude Birth Rate	25.6 per 1000	N.A.
Crude Death Rate	6.7 per 1000	N.A.
Adult Literacy (10 years and above)	70% male, 49% female	71% male, 55% female
Primary Net Enrollment	97% boys, 81% girls	101% boys, 92% girls
Income per Capita	$1,560.70	N.A.
Infant Mortality Rate	66 per 1000 live births	65 per 1000 live births
Maternal Mortality Rate	178 per 100,000	N.A.
Contraceptive Prevalence Rate (CPR)	35.40%	40.70%
Total Fertility Rate (TFR)	3.1	3.5
Unmet Need for Contraception	20%	17.50%

Table 6: Population profile of Punjab

[9] Improving Access to Family Planning Services through the Private Sector in Pakistan A Stakeholder Analysis, p 1, http://www.familyplanning2020.org/sites/default/files/Private-Sector-Stakeholder-Analysis-July-15_aa3.pdf
[10] Source: https://pwd.punjab.gov.pk/population_profile (Date Accessed: March 12, 2020)

Although Punjab's CPR is 5.3 percent higher than that of Pakistan, the benefits of improved CPR are offset by higher than average TFR in Punjab. Fully cognizant of the implications of high TFR, the government of Punjab has been focusing on reducing future fertility under the Punjab Growth Strategy 2018, which notes that *"contingent upon family planning efforts, future TFR will determine whether the population of Punjab will rise to 140 million or 188 million by 2050. Investing in a rapid fertility decline through a strong family planning program could make a difference of 48 million more people in Punjab by 2050."*[11]
To achieve this objective, the Punjab Government has been striving to:

- increase resource allocation for an accelerated fertility decline by strengthening the Population Welfare Program;
- ensure contraceptive procurement and availability;
- undertake capacity building of the PWD while expanding the coverage and quality of its services to uncovered areas.

The main focus of the Punjab government is on tackling inequality within the province by engaging community volunteers and subcontractors and provision of mobile units.[12]

2.1.1 PUNJAB WELFARE DEPARTMENT (PWD)

PWD spearheads implementation of the Punjab Population Policy 2017 which envisions *"promoting prosperous, healthy and knowledge based society where every family is planned, every member nurtured and all citizens are provided with the opportunity and choice to attain improvement in the quality of their lives."*[13] Under this policy PWD has set goals to a) stabilize population growth, b) reduce fertility and c) facilitate achievement of sustainable development goals (SDG) objectives related to universal access to reproductive health care services. The Policy adheres to four basic principles to achieve its goals: equity, efficiency, volunteerism, and sustainability. Five of the 12 major areas requiring priority attention that have been identified in the Population Policy 2017 are:

1) Converging service availability at community level
    - attend couples with unmet need for contraception
    - supportive role of government departments and development partners, and
    - adhering to quality of services
2) Contraceptive commodity security
3) Advocacy, demand generation and social mobilization
4) Human resource development
5) Enlisting support of NGOs/ development partners and private entities.

Since the promulgation of the Population Policy, PWD has been focusing on short term policy objectives that were to be achieved till 2020:

- Lower wanted family size to 2.5 by 2020
- Actively promote three messages related to Healthy Timing and Spacing of Pregnancy (HTSP) to reach out all women by 2020.
- Ensure necessary contraceptive security at all service delivery outlets

[11] Punjab Growth Strategy 2018, Accelerating Economic Growth and Improving Social Outcomes, p 16, https://pwd.punjab.gov.pk/system/files/Punjab-Growth-Strategy-2018-Full-report.pdf
[12] ibid
[13] https://pwd.punjab.gov.pk/overview

- Achieve a fertility level of 3.3 births per woman by 2020.

At the same time PWD has the following long term policy objectives to be achieved till 2030.

- Ensure universal coverage and improve access to safe and quality family planning and reproductive health services to the most remote and far flung areas of the Province by 2025.
- Raise contraceptive prevalence rate to 60 per cent by 2030.
- Strive to attain replacement level fertility of 2.1 births by 2030.

In line with the policy objectives, Punjab also committed to FP2020 targets, which, in a way, bridges Punjab's short and long term objectives and helps achieve them.

PUNJAB FP2020

In the London Summit on Family Planning 2012, Pakistan committed to achieving universal access to reproductive health and raising the CPR to 55% by the year 2020. In view of the ground realities in Pakistan, the CPR was reduced by Punjab from 55% to 50% by 2020.[14],[15] The commitments made by the government of Pakistan cover the realms of policy, finance and service delivery. PWD has made some notable progress towards achieving this objective such as:[16]

- Provincial public-sector spending on FP increased from Rs.107.200 million in 2012-13 to Rs.1,472.281 million in 2016-17 (1273% increase)
- Rs.1,500 million for the development schemes in the annual development plan (ADP) 2017-18 and Rs.4,197.293 million in the current budget have been allocated
- Punjab Population Innovation Fund (PPIF) with Rs.200 million in 2016-17 and Rs.250 million in 2017-18 has been established to support innovate FP/RH projects of public and private sector
- PWD has procured contraceptives worth Rs.830 million from 2014-17 whereas Health Department has purchased commodities worth Rs.1,192 million
- Draft Costed Implementation Plan (CIP) for Rs.20.141 billion (Rs.12.102 billion for Health Departments and Rs.8.039 billion for PWD) has been prepared
- Established 600 new Family Welfare Centers, 11 new Family Health Clinics, refurbished 92 Family Health Clinics, and reactivated 86 Mobile Service Units
- Uninterrupted supply of contraceptives ensured
- Contraceptives services have been included in Essential Health Service Package (EHSP) and contraceptives are provided free of cost.

PWD claims that Punjab's CPR has risen from 41 percent in 2012 to 47 percent in 2017 and will reach 52 percent by 2020.[17] PWD's progress sheet emphasizes that "Integrated efforts by joining hands of the public and private sectors will help achieve the CPR target of 55 percent by 2020."[18]

[14] Figures for other provinces are: Sindh 45%; KP 42%; Balochistan 32%.

[15] https://pwd.punjab.gov.pk/fp2020
[16] ibid
[17] ibid
[18] ibid

2.2 MDM AND THE PUNJAB WELFARE DEPARTMENT

MDM has been working in Punjab and especially in Lahore since 1996. After handing over a 10 year project on gender-based violence to the provincial government in 2014, MDM experts explored further opportunities in the field of sexual and reproductive health and rights in Punjab. MDM held needs scoping meetings with relevant actors and stakeholders. It then decided to work on family planning in partnership with PWD and thus help PWD in achieving its assigned mandate.

From July 2015 – June 2017, MDM implemented a pilot project to build the capacity of 15 newly established adolescent centers in 9 divisions of Punjab. This project was successfully handed over to PWD. While implementing this adolescent project MDM explored further opportunities to work directly with the communities and generate demand for modern family planning. Hence this pilot project, CPROP-2020, was designed in close collaboration with PWD.

The project was launched under formal partnership with PWD in November 2017.

2.2.1 MDM'S PARTNERSHIP AND PROGRAMMING APPROACH

In order to start a new intervention in any area of the world, MDM conducts an exploratory mission that includes visiting the potential area with a team of experts, assessing the requirements in that area, meeting the partners and stakeholders to identify where MDM can add value.

Similarly, the MDM mission arrived in Pakistan for this pilot project and met PWD as it has the core mandate for family planning and population welfare in Punjab. MDM team also approached the Punjab Department of Health but they requested MDM to cover a full district or a region for the FP intervention, which was not possible at that moment. MDM's initial assessment lasted for one year, which is quite a long period for an assessment phase of a pilot program. But it laid the foundation for a solid partnership with a government entity. MDM patiently worked with PWD, which wanted *"to see the potential of our services, our commitment to work with government and how to start an outreach program in the communities. PWD wanted us to work in low CPR districts and within such district assigned us low-performing centers in challenging localities to test our resolve and see if the proposed intervention model works or not. The centers supported by MDM were low performing and underutilized as per PDW's own, internal assessment."*

MDM accepted the challenge because it was confident of the value-addition its programmatic approach brings from its global operations that are "built on five priority areas one of them is "promoting Sexual and Reproductive Health (SRH), Harm Reduction (HR) and fighting HIV."[19]

The MDM team in Pakistan took on the challenge of creating demand for FP services for the selected low-performing centers, enhancing the quality of services delivered at those centers

[19] https://www.medecinsdumonde.org/en/about-us

and mobilizing the community towards greater acceptance of FP in general and FWCs in particular. In addition it entered into broader advocacy initiatives in partnership with CSOs and key stakeholders working on enabling environment for SRH in the province of the Punjab. The MDM pilot project therefore has three components:

1) Social mobilization aimed at demand generation and community empowerment
2) Capacity building and technical assistance aimed at enhancing quality of services at the FWCs, and
3) Common advocacy for SRH and FP in Punjab province.

The FWCs assigned to MDM by PWD were considered low-performing because of:

> ***No awareness about the presence of government-run FWC in the area:*** The FWCs have been operational in the areas for over 10 to 15 years and yet the people were not aware of them, where the centers are located, what services are available there and what the timings for service delivery are.
>
> ***Poor or negative perception of FWCs:*** Due to lack of engagement with the host communities, the FWCs were perceived to be delivering poor quality of FP services and the center staff was not welcome by the communities who attached negative associations like "child killers" "sinners" and "family stoppers" with the male and female staff. This unwelcoming attitude discouraged the staff from reaching out to the communities and thus generate client flow to their centers.
>
> ***Lack of staff capacity and proper reporting:*** Smug in a secure government job that has little or no accountability for low performance, the center staff has inadequate capacity to engage with the host community, tell them about FP services available at their centers and handle objections and questions from prospective clients. Suffering from low motivation, the center staff resorted to presenting padded-up data of their center performance to PWD. The problem is further compounded by a) non-availability of staff caused by recruitment delays and b) assignment of dual duties to FWC staff members. FWC in-charge, who is also the chief FP counselor, are trained professionals with at least 15-20 years of experience and have undergone either 18 month departmental training or 2 year diploma program. FP professionals however require continued professional development and refresher training to stay connected with best practices. Without the refresher training and on-job mentoring, skills of the FWC counsellors had considerably weakened resulting in low satisfaction of clients who came to the center.

Initially MDM explored the option of implementing the community mobilization component through a local CSO, and directly handle the capacity building and advocacy components. However during the planning phase MDM decided to get first-hand experience of social mobilization and thus to manage all three components within MDM for better results and accountability.

2.3 PROGRAM DESIGN AND PLANNED TARGETS

MDM, in line with its programming approach and keeping in view of the main challenges the PWD was faced with, designed the pilot project with a well-defined objective, "To contribute to the Achievement of FP2020 Contraceptive Prevalence Rate Objectives of Pakistan, in

Punjab Province." This project, FP2020-CPROP (CPR Objective in Punjab), through its three main components, social mobilization, capacity building and advocacy, sought to establish the following results:

Result 1:	The availability and quality of family planning services are strengthened at selected Family Welfare Centers
Result 2:	Targeted communities are sensitized and mobilized on their rights to access family planning services, and
Results 3:	Provincial SRHR actors' influence is strengthened through identification and promotion of common SRHR objectives

By achieving these results, the project planned to benefit 57,238 people, divided into direct and indirect beneficiaries as per the following table:

Beneficiary	Planned target	Beneficiaries' description
Direct	175	Training participants such as a pool of trainers, FWC staff, support groups, Medical Officers, Tehsil Officer, MDM social mobilizers (SMs)
Indirect	37,623	Additional users
Indirect	19,440	Awareness session participants
Total	57,238	

Table 7: Beneficiaries target under the pilot

On the promise of increasing client flow to FWCs, client satisfaction in the centers and increased FP service uptake from each center, PWD assigned its low-performing FWCs located at the following locations in Shalamar Town Lahore. Social mapping done by MDM in collaboration with PWD field staff established the following data for the project areas:

Centre area/location	Households
China Scheme	10,426
Shad Bagh	12,565
Mughalpura	4,768
Kotli Peer Abdul Rahman	8,400
Shadipura/Lakhodeer	15,970
Kot Khawaja Saeed	3,744
Total households covered	55,873

Table 8: Location and households of FWCs

2.4 MDM'S THEORY OF CHANGE

MDM's theory of change (TOC) is simple: providing accurate and timely SRH/FP information to motivated community volunteers empowers the community, reduces myths and misconceptions about FP and helps raise awareness, which in turn generates demand for FP services delivered at FWCs.

By implementing this pilot, MDM wanted to establish that its theory of change and resulting social mobilization approach can generate client traffic to FWCs and thus increase uptake of various FP services and methods available at these centers. Demand generation can increase client flow, but quality of service at FWCs would determine whether clients remained

satisfied and consistently return for sustained use of FP methods thus increasing CPR in the areas serviced by the FWC. Training, coaching and guidance of FWC staff would ensure quality of services (QOS) and resulting client satisfaction. The service delivery was supported by active advocacy towards an enabling environment for SRH in the pilot project area.

It was reasoned that if MDM's pilot succeeds in improving couple-years of protection (CYP), then the programming model and its underlying TOC would stand proven. Then the model could be scaled up across the vast network of PWD-run FWCs. The model would thus strengthen PWD, the government department responsible for population control in Punjab. The model's success would also provide the basis for evidence-based advocacy for FP and SRH in a broader context in collaboration with other civil society organizations (CSOs) and stakeholders. The three components would thus work in sync with each other and lead to proving MDM's belief that it is only by complementing the provincial government that the national targets of FP2020 CPR Objectives of Pakistan, in Punjab may be achieved.

2.5 PROJECT IMPLEMENTATION TIMELINE

MDM implemented the project, FP2020-CPROP, in phases and rolled out the activities as follows:[20]

Timeline	Key project activities and accomplishments
November 2018	MDM initially intended to implement the program in Chiniot district but it could not get the NOC.
March 2018	MDM decided to shift the project from Dist. Chiniot to Lahore internally and started discussion with PWD authorities at provincial level.
May 2018	PWD authorities allowed MDM to shift the project from Chiniot to Lahore and assigned 1 FHC and 5 FWC.
May 2018	MDM conducted the assessment of the assigned facilities.
May 2018	In the last week of May 2018 revised MOU with PWD was signed.
June, 2018	Officially started the operation on 01 June, 2018.
June – September 2018	Carried out one-month orientation and introduction at each center including an in-depth assessment of available services at each center.
	MDM and respective center staff jointly undertook social mapping activity. MDM submitted a social mapping report to PWD. Completed identification of stakeholders to know the community, identify volunteers for Friends of Family Welfare Center male and female -support groups and gather current data and last six month data on FP trends in the intervention areas.
	Conducted onboarding meetings with identified male and female volunteers and had the Friends of Family Welfare Center groups reactivated and formulated.
	Concurrent assessment of PWD's information, education and communication (IEC) was completed and visibility-related gaps in IEC identified.
	Redesigned IEC material in consultation with PWD and got it approved from District Officer Population (DOP). Redesigned IEC material mentioned a) center's address, b) free-of-cost availability of FP services and c) center's timings (8 am to 3 pm).
	Five large panaflexes prepared and handed over to each center for display at public places in order to raise awareness about the existence of FWC and services available.
	Printed and provided to all centers a one-pager and a three-fold page leaflets with updated information on FP methods and center location-addresses
	Family planning counseling table calendar was printed and made available to all centers.

[20] Developed from project progress reports and interview with MDM project team

	Carried out baseline of all the assigned centers and determined current client flow and service uptakes based on last six-month data at each center.
	Identified problems of deliberate over-reporting and in discussion with PWD agreed upon a baseline project performance benchmark that was 5 percent lower than the reported monthly center results.
October – December 2018	MDM developed a Trainers' Module for training of mid-level service providers on Implanon[21] method and provided soft-copy of the training manual to PWD for their review and approval.
	Because there was more demand for the FP counselling table calendar, MDM, upon PWD's request, reprinted more copies of the calendar instead of spending money on Implanon 5-day training of trainers (TOT).
	Commissioned research study on social-cultural barriers to FP
	By the end of 2018, MDM mobilized 10 FFWCs, 2 each of male and female volunteers in 5 targeted centers
	Developed a training needs assessment on FP counselling, conducted the assessment with FWC ICs from the targeted facilities and developed the training contents for2 day training on FP counseling
January – March 2019	Upon request of PWD, MDM undertook development of Pre-Marital Counselling Booklet (PMCB) by taking on board CSOs working on SRH. PMCB was done in replacement of couple counselling that was in the project design.
	The joint development initiative, under the advocacy component of the project, resulted in three booklet series under PMCB: one for community, one for community counsellors working at Basic Health Units (BHU) and one trainers' module.
	Designed and delivered 2-day training on FP counselling for FWC in-charge/counsellors and trained the first group of 42 from 20 centers (2 persons/FWC).
	Conducted the first session for capacity building of FFWC members and trained about 100-plus male and female volunteers on accurate SRH/FP knowledge, their role in FWC, myths and misconception and social mobilization skills.
	Research study on social-cultural barriers to FP in the project areas was completed and its recommendations used into project activities. Findings of this report were shared with PWD authorities as well for their information, review and feedback.
	PWD requested MDM's assistance on SRH bill that was being made on the directives of the Supreme Court of Pakistan. Along with that MDM was also asked to support PWD to develop the premarital counselling booklets for Community, for counsellors and trainers in March 2019.
	MDM carried out the consultative meetings with all stakeholders – FPAP, Shirkat Gah, Simorgh, Baidari, Aurat Foundation, SPO, regional training institute Lahore PWD, director technical and deputy secretary technical PWD.
April – May 2019	Carried out one-day intensive refreshers and OJT sessions with the training center in-charges/counsellors on FP counselling.
	MDM held consultative meetings with all relevant stakeholders and prepared the first draft SRH Bill with due acknowledgement to all those involved in it.
	The first draft of the Bill was circulated for feedback and two meetings were held first at the provincial level and then at the national level from the platform of the Pakistan Alliance for Post abortion Care (PAPAC).
	Based on the feedback received, MDM finalized the SRH Bill and submitted it to PWD, which took up the further process towards making it a legislation.PWD submitted the draft bill to the Health Department for furtherance.
	Result: Increased visibility of FWC: painted their main gates in the same green color of the PWD logo.
	Provided equipment including fridge, air conditioners, lighting, fire extinguishers etc. as required by each of the FWCs. All five FWCs and FHC were rehabilitated and equipped to deliver FP services.
	Conducted a second session for capacity building of FFWC members and further

[21] Implanon is an etonogestrel implant is used in women to prevent pregnancy. It is a form of birth control that contains a hormone in a flexible plastic rod about the size of a matchstick. It is effective for 3 years when inserted just beneath the skin of a women's upper arm. (https://www.goodrx.com/implanon/what-is)

June – August 2019	trained another 100-plus male and female volunteers on accurate SRH/FP knowledge, myths and misconception and social mobilization skills.
	FFWC membership number rose to 96 (50 female and 46 male) of the target number of 10 FFWCs (5 male and female each).
	Equipped the FWC with fans, room air cooler, fridges, and UPS stabilizers in targeted facilities. Painted the walls of the FHC room, waiting area and insertion room.
Sept. – December 2019	Transition plan with PWD made for handing over the FWCs
	Supplied sufficient IEC material, panaflexes and standees to all FWCs to help them continue demand generation.
	Second reprinting of FP counseling table calendar completed to meet PWD's request.
January – March 2020	Provided the 2nd printed FP calendars to PWD 3,000 copies.
	Designed and printed the FP counselling booklets and handed over to PWD.
	Commissioned end-project evaluation to document lessons learned.

Table 9: Quarter-wise activities of project implementation

2.6 PROJECT MANAGEMENT, COORDINATION AND OVERSIGHT

Project activities were completed and delivered on time thanks to two fully resourced management structures MDM created for coordination at the national and provincial project management levels. (See Annex 5.8).

A close-knit 3-tier mechanism for coordination with PWD was created for timely information sharing and problem solving.

Daily operational coordination took place with FWC staff as activities were implemented in respective communities and at the Centers. Monthly progress review meetings at every center took place in which FFWC members, FWC staff and MDM's social mobilization team participated. They reviewed progress of last month and planned improvements for the center itself in coming months. Their plans were then taken up for decisions, if required, at the next level.

Joint monitoring teams were formed at tehsil and district levels and regular monthly meetings took place for project updates and resolution of issues. PWD's district office staff, Tehsil Population Officer and FWC staff were brought together at meetings held at MDM office. At these meetings all those involved reviewed progress, removed coordination gaps, confronted hard problems and found their solutions. Finally, policy-level coordination took place with the Secretary, PWD, in which regular briefing was provided to senior PWD staff by MDM staff members from Lahore and Islamabad.

Initially MDM field staff led these meetings. Since January 2020, PWD staff has taken the lead and in this last quarter, MDM's role was to observe, mentor and provide feedback, where necessary. All meetings use one template for recording minutes of the meeting, work plan and data collection tools provided by MDM and improved with feedback from PWD.
In previous interventions, MDM has successfully used this method of handing over various projects to respective government departments it has worked with, thus ensuring the long term sustainability of its interventions. As a result, PWD relied on MDM's track record and agreed to partner with it for this pilot project under the joint monitoring and oversight mechanism to achieve mutually agreed objectives and results.

2.7 PROJECT RESULTS FRAMEWORK

FP2020-CPROP's activities were monitored for results under a framework that had one Overall Objective supported by two specific objectives (SOs), and three results each with well-defined indicators against the set targets.[22]

Overall objective: To contribute to the achievement of FP2020 CPR objectives of Pakistan, in Punjab province	
Specific Objective **To improve the response of family planning needs within the targeted communities of Lahore district**	**SO1:** Number of additional users of modern methods of contraception in the structures supported
	SO2: (Method Information Index) Percentage of users who estimate have been properly informed and are able to make enlightened choice
Result 1 **The availability and quality of family planning services are strengthened at selected Family Welfare Centers**	**1.1** % of targeted structures providing at least three modern FP methods and emergency contraception Baseline: Target: 100%
	1.2 % users reporting being satisfied about the FP services offered in the targeted structure Baseline: Target: 80%
	1.3 % of FP consultation in line with quality criteria (information on different available method, information on potential side effects and related actions and respect of confidentiality) Baseline: Target: 90%
Result 2 **Targeted communities are sensitized and mobilized on their right to access family planning**	**2.1** % of supported structure having active groups of "friends of FWC" (active: having regular meetings with the FWC staff and having an agreed plan for mobilization/action) Baseline: Target: 80%
	2.2 % of awareness sessions (conducted by FWC staffs in communities) presenting access to contraception with the right/choice lens (information on different method of FP, on services available free of charge, FP as a birth spacing method and a right for individual) Baseline: Target: 70%
Result 3 **Provincial SRHR actors' influence is strengthened through identification and promotion of common SRHR objectives**	**3.1** Number of identified provincial SRHR actors with whom common advocacy SRHR objectives are agreed upon. Baseline: Target: 3

Table 10: Project results framework

Under SO1, the program attempted to generate users of the following five modern methods at every FWC: Injection, Condom, Intrauterine Contraceptive Device (IUCD), Emergency Contraceptive Pill, Progesterone only Pill.

[22] MDM file: 2 MDM Pakistan_Punjab LogFrame-II

Uptake of the modern methods normally results from the Family Planning Counselling (FPC) provided at FWCs. FPC would also determine changes in Method Information Index (MII), measured as percentage of users who have been properly informed and are able to make enlightened FP choices under SO2.

For SO1 and SO2, the project results were to be achieved at two levels: the Center and the community. The Center's performance was to be measured with three indicators of two different types: exit and input.

Indicator	Type of measure	Source
All FWCs provide at least three modern FP methods	Exit	FWC monthly reports
80 percent of the FWC client are satisfied with FP counselling they received	Exit	Exit interviews
Percentage of FP consultations in line with quality criteria	Input	Expert observation checklist

Table 11: Exit and input indicators for SOs

Community empowerment was to be measured by the number of FFWCs created and capacitated to have accurate information to further spread awareness in the community.

Indicator	Type of measure	Source
Number of FFWCs with active membership	Output	MDM project progress reports
CAS conducted by MDM	Output	MDM's M&E data
Right knowledge of FP among participants of CAS	Outcome	MDM's M&E data

Table 11: Output and outcome indicators

MDM collected baseline of FP users in targeted centers calculated as average over the period Jan-18 to July-18, prior to MDM intervention to serve as a benchmark against MDM's performance in FP2020-CPROP.

FP Users' Baseline at FWCs Assigned to MDM			
FWC	**Target Correction**	Total/Jan-July - 2018	Average
China Scheme		305	44
Shad Bagh		412	59
Mughal Pura		554	79
Daroghe Wala		569	81
Lakhoo Deer		241	34
Kot Khawaja Saeed		1489	213
Total		3570	510
Baseline	**5%**	**3392**	**485**

Table 12: FP users' baseline -- Jan. to June 2018

For the advocacy component, the target was simple: bring three CSOs on board for common advocacy on SRH and FP.

The evaluation determined that MDM successfully completed all activities whether planned or on-demand of PWD. The pilot FP2020-CPROP has successfully achieved all its results at both output and outcome levels.

3. EVALUATION OF PROGRAM INTERVENTIONS AND RESULTS

This section presents an in-depth evaluation of:

- Programmatic interventions, including social mapping
- Improvements brought about at FWCs because of capacity building undertaken by MDM
- Changes in community attitudes due to volunteerism of FFWCs created and capacitated in this pilot
- Achievement of MDM's advocacy efforts and
  Impression and feedback of PWD.

In FP2020-CPROP three interventions (discussed below) were simple but very effective in producing the desired results, which MDM measured using the relevant indicators. Before any of the three interventions could start at the FWCs, MDM undertook a thorough assessment of each FWC and conducted a social mapping of the catchment area. MDM then presented their findings to the PWD and fine-tuned its project interventions to the needs to PWD.

3.1 PRE-ROLLOUT ASSESSMENTS BY MDM

Having sought approval from relevant officers of PWD, the MDM team involved the FWC staff from the very beginning. The 2nd Assessment Report on FWC-FHC (dated October 2018) Lahore records the MDM approach, *"After the agreement of the relevant officers from PWD the MDM MEAL assistant visited the targeted Family Welfare Centers and the Family Health Clinics and completed the assessment template* ***in collaboration with the In-charges*** *(emphasis added) of each FWC/FHC."*[23] Similarly the FWC's field staff was brought on-board for conducting the social mapping exercise. While MDM controlled the research design, data analysis and report writing, PWD's field staff appointed at each FWC carried out data collection in the field (i.e. in the communities where the project was being conducted) along with the MDM team as per the Guidelines for Social Mapping. [24]

Both social mapping and FWC assessments were very thorough. Social mapping profiled[25] each catchment area in terms of

- Population, Education and health facilities, existing CSOs, geographical map of the area and FP coverage and eligible couples.

Social mapping resulted in MDM and PWD thoroughly knowing the area and demographics of the population. The exercise also established a reliable list of eligible couples that constitute the total FP coverage potential in each area. MDM validated the data it generated with voters' list and the general population profiling done by the Election Commission of Pakistan. This "bi-angulation" of findings increased the authenticity of the social mapping exercise. PWD's district officials were on-boarded first and the FWC's field staff was actively involved by MDM throughout the SM exercise. The results of the social mapping

[23] FHC/FWC Assessment Report – II in MDM Catchment Area – Lahore, p.3.
[24] Social Mapping Report, p. 13
[25] Ibid, p.6-10

were displayed in visual form at every center and at offices of PWD and MDM. The display served as a constant reminder of achievement that was made possible by joint efforts that also built capacities of FWC field staff in a very subtle but effective manner. Convinced of the overall benefits of social mapping, the District Officer, Population (DOP) of PWD "wanted to carry out social mapping across Lahore's over 100 FWCs."

Once the social and demographic dynamics of the catchment areas were known, MDM zeroed in on the five FWCs and one FHC it had to improve under the pilot. Using the same collaborative style, MDM carried out assessment of the Centre as per a very detailed and through template that it uses globally, thus applying global best practices of assessing FP/SRH service delivery outlets. FWCs' assessment took place in two rounds. MDM's first round of assessment[26] of five FWCs and one FHC examined

1) Access (convenient location, distance travelled, facility hours, and public transport.)
2) Structure (physical state of the building, doors with locks, medical screens, curtains, privacy areas.)
3) Utilities (power, gas, back-up generator, water)
4) Staffing (fully staffed or not, staff trained or not, fulltime, contractual, part-time)
5) Provision of services (post abortion care, sexual abuse or violence, contraception, antenatal care, postnatal care, other services)
6) Supplies of medicines and contraceptives (sources, types and frequency of supplies)
7) Facility environment (comfortable setting, audio-visual privacy, waiting area, IEC materials)
8) Supportive policies (written guidelines, standard operating procedures (SOPs), record-keeping and reporting)
9) Publicity and visibility (direction signs, outer branding, promotion material)
10) Volunteer support groups (active or not, how many from male and female)
11) Youth involvement (methods of engaging with youth), and
12) Fee charged, if any.

The first assessment was general in nature: it was meant for stock taking and to learn what exists on an As-Is basis. It did not result in any actionable recommendations, although that it identified severe lack of training where this was the case. It concluded that *"it has been understood from the assessment that staff is not trained at all in security and safety. Apart from the security and safety staff no refresher session was organized on SRHR /RH, GBV, Counselling on FP in the last two years."*[27]

The second assessment was more specific towards needs identification of the 5 FWCs and one FHC in terms of visibility, safety and security, physical structure improvements, provision of utilities, equipment and contraceptive stocks, general hygiene, and IEC material.[28]

This assessment resulted in recommendations…	**Which were …**
● Provision of BP apparatus, thermometer, examination lights, instrument trays, handling of examination instruments to avoid risks of infections.	meant to enhance QOS at FWCs and FHC

[26] Health Facility Assessment Report
[27] Ibid, p.9
[28] Op. cit.

• Pregnancy test should be available at facility	
• In-charges of FWCs are not using IEC material for counselling of clients • In-charges of FWCs reserve the IEC material for their future needs and do not share with social mobilizers or family welfare assistants (FWAs) for use in community during the orientation and mobilization sessions. • More printed material, with accurate information and mentioning FREE services should be provided at FWCs/ FHC.	aimed at increasing the effectiveness of social mobilization and FP counselling
• Main gates should be painted with color of PWD to make rented building identical to a FWC • More focus required on visibility so that maximum population of the catchment area could know about the existence of FWC in their area.	needed for center's visibility, branding and increasing client flow
• Training / sensitizations of FWC staff is required toward counselling ethics, keeping the clients' information confidential and maintaining health and hygiene.	capacity building gaps to be covered via training or developing SOPs
• Building owners should be engaged to repair in buildings • Negotiations with Department through in-charges to appoint the allocated staff at each center.	other gaps for action by PWD.

Table 13: Recommendations from FWC assessments

Social mapping assessment outcomes

The initial MDM assessments were so thorough and detailed that they shook FWC staff out of their comfort zones. The staff felt threatened and intimidated and felt that MDM was *'spying on us'*. It took them a while to realize that MDM was there to support them. MDM remained completely open, candid and transparent with FWC In-charges and PWD staff who completed the templates and were made to realize that the gaps identified would *"actually help them do their jobs better because some of their complaints that were unaddressed would be resolved."* FWC in-charges viewed this promise with lot of suspicion and skepticism:

> *"we did not believe that anything would happen…as we have been conveying to our higher-ups the problems we were facing…after months and even years of efforts we sort of gave up….how could MDM solve age-old issues? Only when the first batch of updated IEC material and panaflexes arrived and the Center's gates were painted did we start trusting MDM."*
>
> *"One of the very important activities of MDM was the printed flyers which we distributed in the community. This need was identified by MDM and action taken to support us."*
>
> *FGD of FWC counsellors and staff*

Senior PWD officials acknowledged that important benefits came from the pre-rollout assessments:

> *"Social mapping awakened us to realize how getting in touch with the community brings several benefits like knowing your potential clientele, accuracy of couples' registration, increased motivation and capacity of our own staff who would never speak out in front of groups and speak to them so confidently….Centre-level assessment brought to our notice that small things matter a lot and such things actually do not cost a lot of money. Some of the things we already knew but could not do anything because of lengthy government procedures…MDM promptly took care of such little MDM things like putting center's address and free service notice of IEC material."*

"I think the Center assessment made respective incharges realize where their center stands on international standards…it made us realize as well…some of the services are not suited for our centers like domestic violence counselling…but providing confidentiality, keeping (the Center) clean and tidy, reporting accurately…all add up to serving the FP clients and meeting their needs".

The pre-rollout assessments established MDM's professionalism and helped it gain trust and credibility at all levels of PWD: from the Centers' field staff to FWC counsellors incharge to DOP to Secretary PWD. Quality of information provided by social mapping and two center assessments proved highly valuable in designing, molding and deriving results from the two key interventions of capacity building and social mobilization, aimed at generating demand in the communities and improving QOS at the respective FWCs.

3.2 CAPACITY BUILDING

The capacity building package of the pilot FP2020-CPROP consisted of a) 2-day training for FWC counsellors complemented with one-day on-job mentoring-cum-observation checklist by a qualified FP practitioner, b) one-day training for FFWCs on conducting community awareness sessions and c) on-field training of FWC field staff who learned social mobilization techniques while working with MDM staff in the field.

3.2.1 FWC COUNSELLORS

MDM conducted an in-depth training needs assessment (TNA) of FWC incharges after an initial training gap was identified in the FWC assessment. The MDM team developed a TNA template using a set of qualitative questions to assess the level of knowledge of the FWC incharges based on their day to day requirement to counsel the clients and eliminate barriers in adapting different methods of family planning. The TNA was administered after feedback from the DDO, PWD and the Doctor in charge of FHC Kot Khawaja Saeed, which is at a teaching hospital. The knowledge level of the respondents was assessed on the following parameters:

1) Knowledge on Sexual and Reproductive Health
2) Counselling Skills
3) Interpersonal Communication Skills and use of Material
4) Technical Knowledge and Expertise
5) Understanding Behaviors and Attitudes
6) Documentation and Record Keeping.

A rating scale was defined to mark their knowledge and skills according to their responses i.e. "beginner" "Intermediate" and "advanced".[29]

The evaluation found that the TNA exercise was of a rudimentary nature because it only checked knowledge based on the open-ended answers respondents provided to questions posed to them. For a small-scale covering only five respondents the TNA served the purpose quite well but the same TNA is ill-suited for application on a wider scale. TNA proved

[29] Report on Training Need Assessment of FWC In-charges & FWW, November, 2018, p. 5

indeed helpful in tailoring the capacity building intervention to remedy the knowledge gaps of FWC counsellors.

The findings of the TNA fed into the development of 2-day training for FWC counsellors and MDM trained a total of over 40 female counsellors. Although the number of counsellors in the catchment area was only five, PWD reckoned that "all FWC incharges have the same knowledge gap". Instead of training only the five targeted counsellors, MDM, upon request of PWD accommodated 40-plus counsellors, 2 each from 20 FWCs in Lahore.

FWC counsellors of the five target Centers were further trained by means of a refresher OJT by a qualified Doctor at each center. The refresher was an intensive 1-on-1 mentoring based on an observation checklist used to assess how well a live consultation session delivered by FWC incharge conforms to best practices in FPC. (The OJT refreshers were not offered to the other 15 FWC incharges).

Capacity-building outcomes for FWC counsellors

Feedback by FWC counsellors on the initial 2-day training was found to be mixed: some praised it, some did not:

"There was nothing new in this training as such"

"I have attended more intensive trainings before; this training refreshed what I already know"

"I really liked the GATHER technique[30]…and have even displayed it in my center…it constantly reminds me of the steps I should follow in every consultation with the client."

"The PWD provided "Initial Service Training", when we joined the department, but the training provided by MDM was far better than the "IST". The MDM orientation covered all aspects including, counselling session, all methods, mobilization tools, etc."

Four out of five attendees recalled the GATHER technique and liked it as an addition to their know-how.

All unanimously acknowledged the value of one-day on-job training (OJT) session with Dr Asma, the qualified FP practitioner MDM hired for the 1-on-1 mentoring session. This is because...

"OJT enhanced my technical skills of consultation…particularly the aspect of client confidentiality was weak…mentoring made me overcome it."

"It provided me instant feedback on what I was doing wrong and what I need to change for better consultation."

[30] The **GATHER** approach to counseling--Greet, Ask, Tell, Help, Explain, and Return--has documented effectiveness in FP programs. https://www.ncbi.nlm.nih.gov/pubmed/10096107

"When we actually do things, we do not think about any checklist or sequence of steps. You need someone more experienced, more knowledgeable who observes you and then guides you."

"It was a different and quite unique experience…for me training always meant class-room teaching."

"Now I think I can observe others like me and guide them as I was guided by Dr Asma."

By virtue of the capacity building, especially the OJT component, the quality of consultation improved. FWCs became aware of GATHER technique and tried to implement it as a consultation process. They also became sensitized towards clients' need for absolute confidentiality and safe-keeping of their personal information and FPC records. Quality of consultation directly translates into client satisfaction.

FAMILY WELFARE ASSISTANTS

Bringing clients to an FWC is the job of two Family Welfare Assistants (FWAs), with one male and one female FWC employed at each center. FWAs are typically expected to go door-to-door and fill out a lengthy form for registration of eligible couples in the area. On average there are roughly 10 to 11 thousand households per FWC. The two FWAs work as one team and both visit together. If they cover three households per day, 360 days of the year, carpet registration would take 9-10 years! The sheer enormity of the task is demotivating, and rightly so. Knocking every door in the area and introducing their center and its services to the dwellers, who already had a negative perception of FP, was the only method they knew of or at least were following for generating client flow to their respective centers. The problem gets further complicated by the fact that not all five centers have the sanctioned staff strength of two FWAs even as of today! Three of the 5 FWCs had only one FWA working there for the two year duration of the pilot program. On top of that no training in social mobilization was ever given to the FWAs working at the FWCs. The need for FWAs was to be able to organize and handle groups, motivate them, deliver them the right information and face their objections regarding FP with confidence. No easy task indeed for individuals who had never in their lives handled hostile groups on a tough subject like FP!

MDM worked around the challenge by taking FWAs directly into the field with active and equal involvement during social mapping. MDM's experienced social mobilizer tagged FWAs along with them on community mobilization sessions. FWAs first observed, then co-delivered and finally starting taking the lead in delivering community awareness sessions and other mobilization activities like the information desk on their own while MDM team members watched, encouraged and guided them.

Capacity-building outcomes for FWAs

All FWAs are beholden to MDM for giving them skills and confidence in public speaking.

"I now have the confidence to face people in groups."

"I learned objection handling from my MDM colleagues."

"Instead of knocking every door and facing rejection, I now feel empowered to deal groups…even mixed one with male and female…I was too shy to speak with females."

FWC incharges, who are their direct supervisors acknowledge the impact MDM's hand-holding has created in the personalities and performance of their FWAs.

"My FWAs have now gained the respect and recognition in the community…previously they were looked down up…but now they are seen as respectable and doing a much-needed service."

"He was unable to motivate clients to come to the center…now people come here because of him."

MDM's value is summarized by a senior FWA, who says,

The community gathering and session was another impressive input by MDM. Initially MDM staff conducted the session, they trained us too, to conduct sessions in the community. We initially hesitated but later we even distributed condoms in the community sessions. It was an excellent on-job training.

The best endorsement of MDM capacity building comes from the District Demographer, a senior officer at PWD, who shared his experience of an FWA before and after MDM's hand-holding.

"I met a person about whom I thought that he could never do anything worthwhile in his life…when I heard him speak (on the topic of FP) in front of a small crowd, I was simply surprised. Credit of his personality transformation goes to the experience he had with MDM team on social mobilization."

The indirect but very effective means of capacity building of FWAs did strengthen every FWC as now its own staff started generating client inflow.

3.2.2 FRIENDS OF FWC

While FWAs are the internal source of demand generation for the FWC, friends of FWC (FFWCs) are volunteer support groups, external to the center but integral to creating acceptance of the FWC in the community and demand for FP services offered there. MDM also created, reactivated and built the capacity of the FFWC members to strengthen their knowledge on SRHR and family planning services, to orient them about the functioning hierarchy and working mechanism of the PWD/FWC, and to inform them about their roles and the objectives of the FFWC.

About 200 FFWC members, equally divided into male and female, went through four one-day training sessions organized between December 2019 and January 2020. During the day-long training, the MDM facilitators delivered the following sessions:

- Definition of family planning, objective and benefits of FP
- FP methods available in Pakistan
- Refresher on the barriers to the success of FP in Pakistan
- Refresher on the roles and responsibilities of FFWC
- Volunteerism and community development, and

- Referral within the community.

Capacity-building outcomes for FFWC members

Prior to attending the training, the volunteers had been briefed about their role as FFWC members by the MDM team. Although FFWCs were already active and were conducting CAS and other community activities like corner meetings and information desks, there were gaps in their functioning. This one-day capacity building removed these gaps as the participants also learned from each other in a bigger group of fellow volunteers from localities different from their own. Peer learning and sharing of stories in these training events greatly motivated the members of FFWCs. The training made them feel 'important and valued' as volunteers.

"It felt good to come to the training in a nice environment…although for one day only. We learned a lot from other FFWC members…especially how they handle questions related to stigma, myths and wrong information about FP"

"We were working in our area and thought we were doing a most difficult work. Other FFWC is dealing with more difficult conditions…they go out and convince migrant workers from KPK. That is really cool."

"I learned and realized social benefits of SRH/FP services…I was lobbying for roads, removal of garbage…now I spread the message of proper FP and send people to FWC in my area."

Capacity building of FFWC members boosted volunteer-led social mobilization and led to much better results than MDM had anticipated.

3.3 SOCIAL MOBILIZATION

The cornerstone of MDM's community mobilization component was 'creating community-led volunteer support groups for men and women, called Friends of Family Welfare Centers (FFWC), developing their structural links with the centers and empowering them to exercise their SRH rights in their community',[31] thereby generating much needed demand for FP services made available at FWCs in their areas.

The reactivation and formation of female and male FFWCs was an integral part of the project "which was intended to sustain the community mobilization along with the staff of FWC (that is, FWAs responsible for mobilization at FWCs)". Social mobilization was the first roll-out activity. As a first step in the project implementation MDM team and FWAs worked together and reactivated five FFWC (female) at five targeted centers and formed five Male FFWC groups at five FWCs where MDM was intervening. Each FFWC group in comprised of 10-15 active members chosen after evaluating them on seven criteria:[32]

- Each member must be residing in the catchment area and actively participating in community engagement activities. Members should have in-depth/good knowledge

[31] MDM Project Document
[32] TORS for FFWC prepared by MDM and PWD

regarding, interests and economic conditions of the people living in their targeted communities.

- Must be willing to spread the message of PWD; have excellent communication skills, and ability to engage the indigenous community.
- Active members of the local council or part of any social/community work, teachers, local religious leader, welfare workers -local people trust him/her
- The person who willing to conduct awareness-raising sessions in his/her community and act as a bridge between the local community and FWC.
- Able to organize and participate in monthly coordination meetings with the staff of FWC to plan his/her monthly activities linked with the promotion of FWC and services of FWC- in coordination with MDM social mobilization team and FWC staff.
- Give feedback to FWC in-charge and MDM on issues or problems of the community to ensure the outreach and clear the myths and misconceptions of people linked with Family Planning services.
- Not only facilitate the FWC staff to register the eligible couples, but also refer them to FWC for the FP services.

FFWCs operated under a well-defined TOR that spelled out roles and responsibilities of each member and how they are required to work in collaboration with FWAs to support FWC in their area. The TOR required FFWC members to:

- Conduct community awareness-raising session along with FWC staff once in a week;
- Participate in the monthly meeting to develop a plan for the month for performance of FWC and evaluate the progress of FWC along with the staff of FWC.
- Conduct community meetings with different stakeholders and influential people and act as a representative/messenger of FWC in the image building of FWC.
- Bridge the gap between the community and FWC by providing the right information to community members and share the needs of the community with the staff of FWC.
- Promote the concept of healthy birth spacing.
- Assist FWC in-charge to maintain contact with influential people (clerics, teachers, and counsellors, etc.) of the area
- Refer community members to FWC/ FHC.
- Assist and participate in different events organized by FWC/PWD in the community to raise awareness about family planning.

In addition to the TOR which was used for orientation and on-boarding, MDM developed criteria for active membership:

- Minimum 2 month working experience with FWC as a volunteer,
- Regularly attending the monthly meeting called by the In-charge at end of each month and sharing the progress of the assigned tasks
- Facilitating the FWC staff in identifying the registering the new FP clients
- Conducting the regular meetings with the community influential persons to promote the FWC services

- Referral to other available services in their communities based on needs (general health issue, FP services).
- Act as focal person in the community to clarify the myths and misconceptions regarding FP services.

The goal was to have active FFWC members throughout the life of the project.

Under the project, MDM established 10 FFWCs: 5 each for female and male. The active membership now attends at 97 (47 male / 50 female). FFWCs were established in the 3rd quarter of 2018, when the implementation started and gradually more were made and maintained throughout the duration of the pilot FP2020-CPROP.

Number of FFWC before Project	=	0
Targeted number of FFWC groups	=	10 (5 male / 5 female)
Project achievement to date (FFWCs)	=	10 (5 male / 5 female)
Project achievement to date (members)	=	97 (47 male / 50 female)

All 10 FFWC were created in Quarter 3, 2018 and have been functional since then.

3.3.1 REACTIVATION OF FFWC-FEMALE

The idea of FFWC was not new or novel; PWD had created FFWCs comprising all women for every FWC. But these FFWCs were inactive and non-functional for a number of reasons: the principal one being that women were not allowed by the men in their families; , FFWC-F were not provided any capacity building, and they were also not supported for logistics and refreshments in case they held awareness sessions. Using its screening process, MDM and FWC teams only reactivated women-led FFWCs around the five FWCs of the project.

3.3.2 SOCIAL INNOVATION OF FFWC-MALE

Formation and activation of men-led FFWC is a true social innovation by MDM. This innovation came from observation and need assessment phase of MDM, at the beginning of the project. The usefulness of the idea was further confirmed after the research on social barriers to FP was completed under the project in March 2019. Research findings revealed, *"that more than physical accessibility to the centers related to FP, FP usage is mainly affected by social beliefs and perceptions along with societal makeup especially related to decision making."*[33] The study further explained that *"insights from qualitative data show that there is an underlying patriarchal thread in these decisions (regarding FP methods)."*[34] The study recommended to *"Engage with male community members in family planning information and services."*[35]

MDM acted upon the recommendation and decided to form and run FFWCs-male. This decision had a most profound impact on the results.

[33] SRHR Assessment in Surroundings of Selected Population Welfare Centers, p.4
[34] ibid
[35] Ibid, p.43

3.3.3 PERFORMANCE OF FFWCS

MDM and FWAs supported FFWCs to hold community awareness sessions, which increased every quarter.

Community awareness sessions held								
Name	**2018-Q3**	**2018-Q4**	**2019-Q1**	**2019-Q2**	**2019-Q3**	**2019-Q4**	**2020-Q1**	**Total**
# of community awareness sessions conducted by MDM SM team	2	69	57	42	24	23	12	229
# of community awareness sessions conducted by members of FFWC	0	2	28	46	97	119	80	372

Table 14: Number of CAS held every quarter

Within this data lies another important trend: the number of CAS conducted by MDM gradually decreased and members of FFWCs were increasingly enabled to take over the responsibility of conducting community awareness sessions. In the last three quarters FFWCs accounted for more than 80 percent of the CAS held. FFWCs conducted over 60 percent of the number of CAS held (Figure 3).

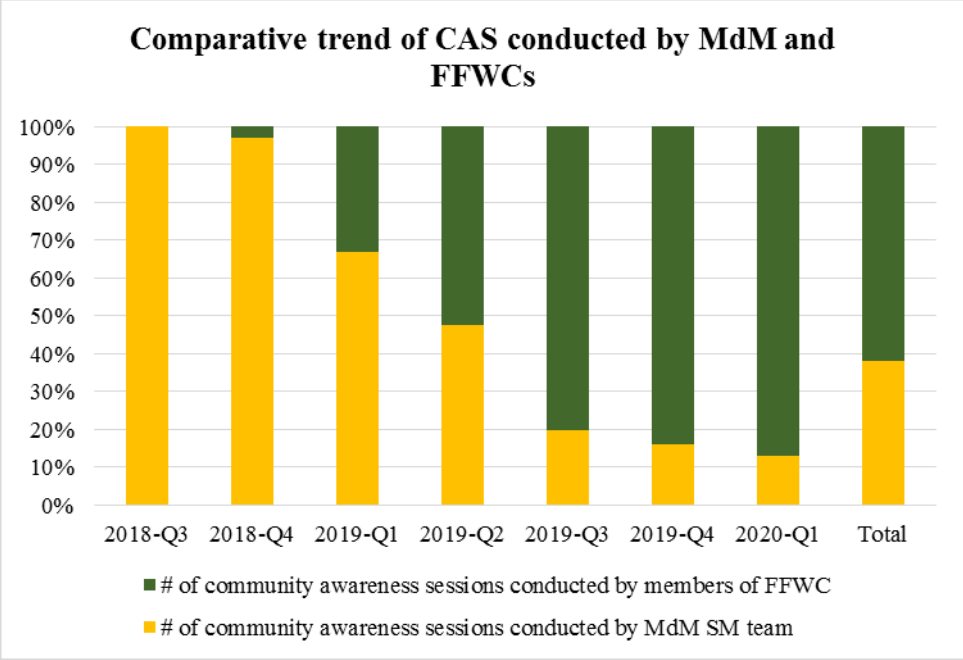


Figure 1: Trend of community awareness sessions held every quarter

Similarly, other community activities, like corner meetings and information desks show an increasing trend in the number of events held and participation therein. Here too the community volunteers (FFWCs), progressively took the lead in organizing these activities.

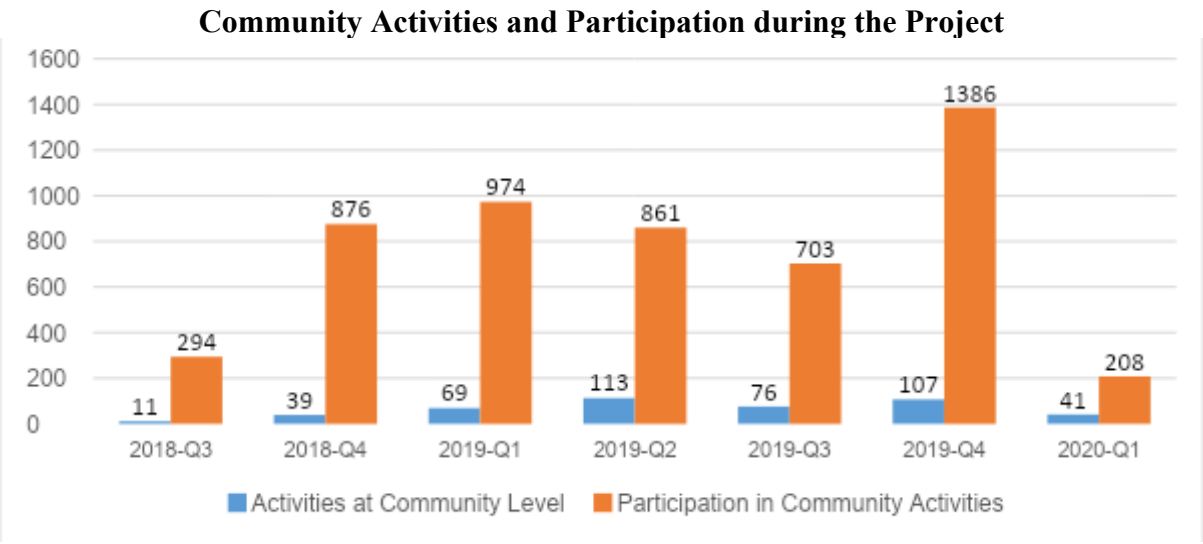


Figure 2: Community activities and participation during the project

Community mobilization reached over 21,987 participants from over 1,000 events.

Types of mobilization activity	Events	Participants
Community awareness sessions	601	16,676
Activities at community level	456	5,302
Total outreach of community mobilization	**1057**	**21,978**

Table 15: Summary of community mobilization

COMMUNITY FEEDBACK ON FFWC'S ROLE

FFWCs performance as captured by MDM's internal data is also corroborated by the findings of the community survey conducted for this evaluation. Community is well-aware of FFWCs in their area, have attended CASs organized by them multiple times and found these sessions very useful.

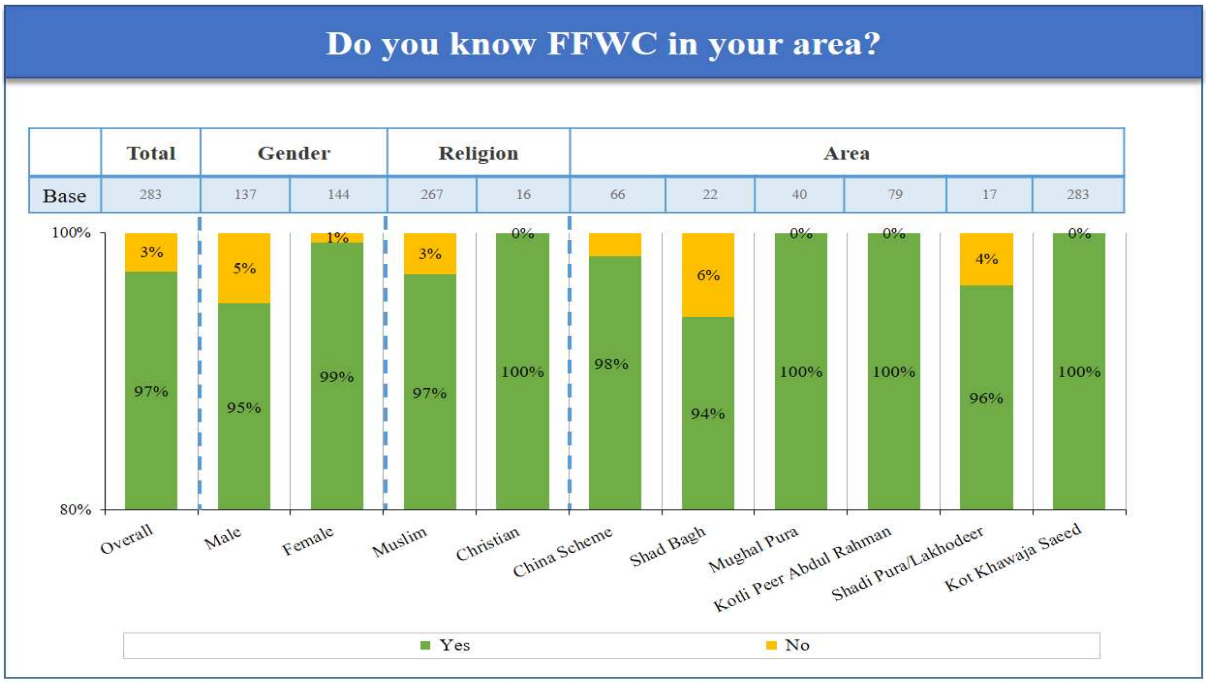


Figure 3: Do you know FFWC of the area?

The majority of respondents, 97 percent overall, do in fact know FFWCs in their area. This was the case regardless of gender, religion, and area.

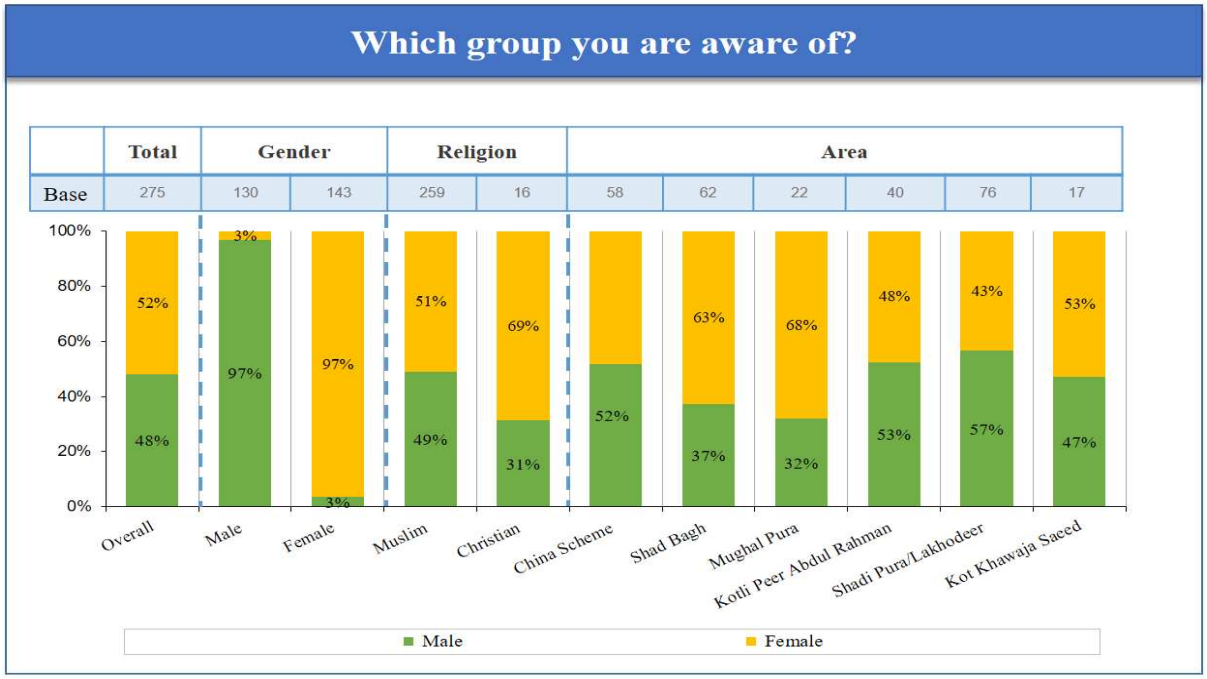


Figure 4: Which FFWC are you aware of?

There is an almost even divide overall, as 48 percent respondents know of a male group while 52 percent a female group. 97 percent of men are aware of the male group while 97 percent of women are aware of a female group. The approximately even divide persists between the two religions and in all the areas.

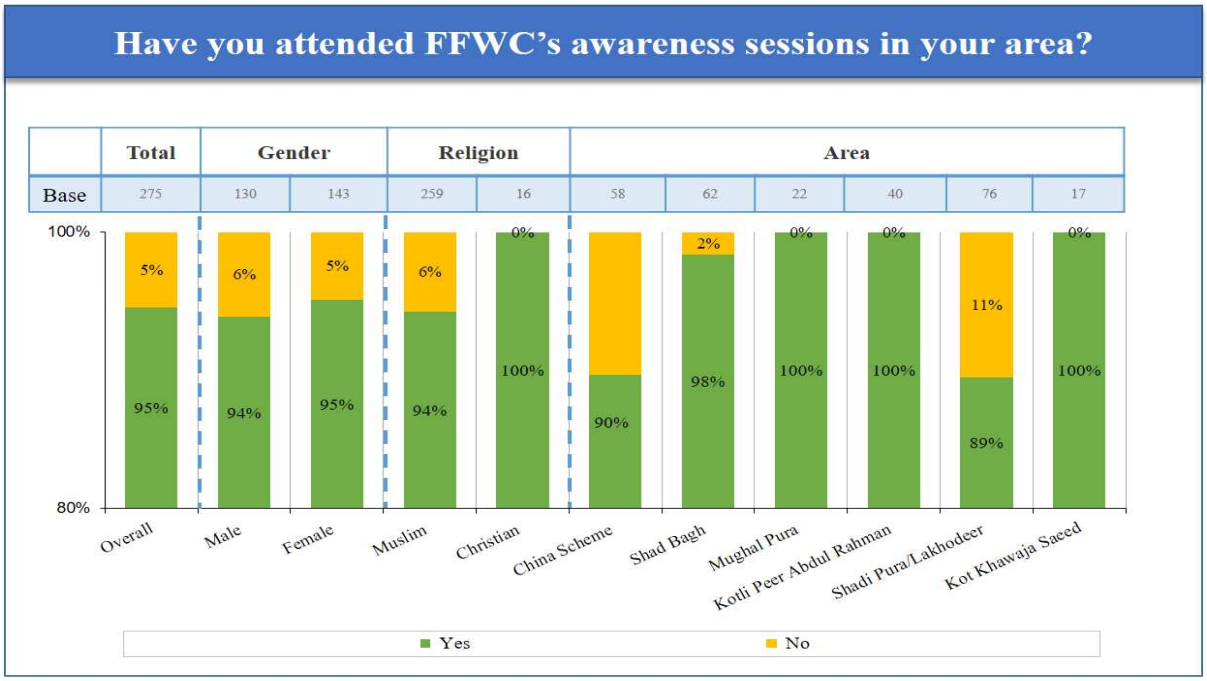


Figure 5: Have you attended FFWC awareness sessions

The majority of respondents, 95 percent overall, have attended an awareness session conducted by the FFWC. Notably, 10 percent of China Scheme respondents and 11 percent of Shadi Pura respondents answered in the negative.

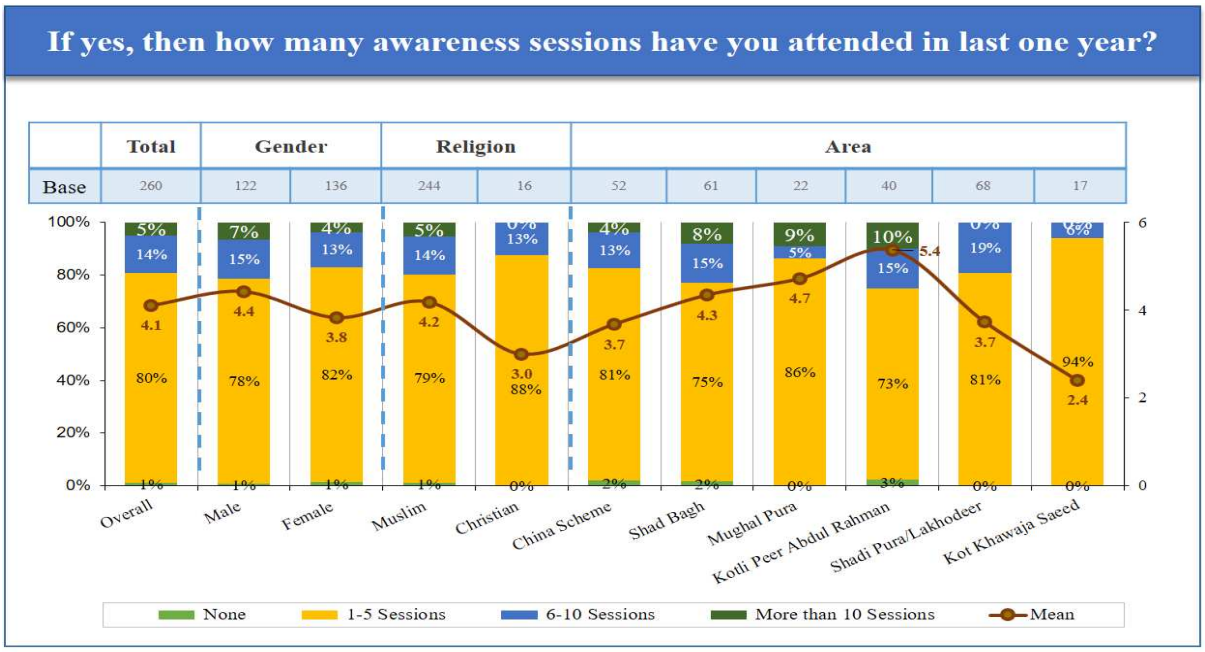


Figure 6: How many FFWC sessions attended in one year

Overall, 80 percent respondents have attended 1 to 5 sessions, averaging at 4.1. Notably, Kotli Peer Abdul Rahman respondents attended an average of 5.4 sessions, the highest among the areas. Whereas, Kot Khawaja Saeed respondents attended an average of 2.4 sessions, the lowest among the areas.

Of the 15 respondents who did not attend the FFWC sessions, most cited two reasons: the unsuitability of timing and that meetings were held away from their residence.

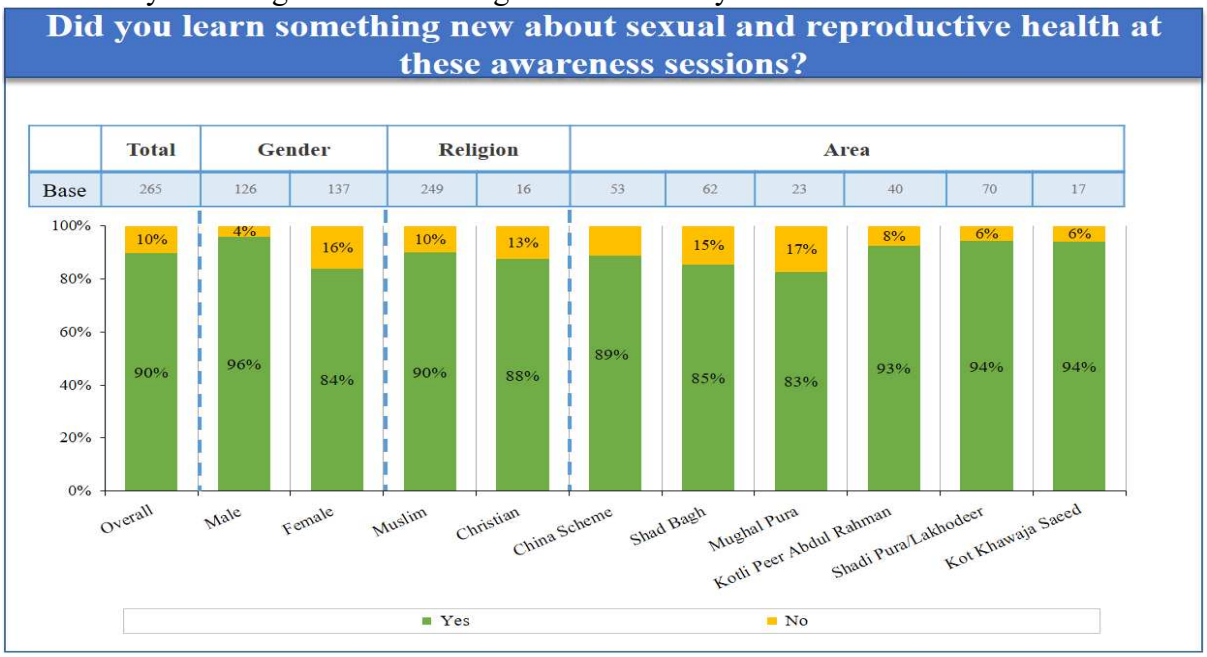


Figure 7: Did you learn something new about FP at awareness sessions by FFWC

The majority of respondents, 90 percent overall, regardless of gender, religion, and area did learn something new vis-à-vis SRH.

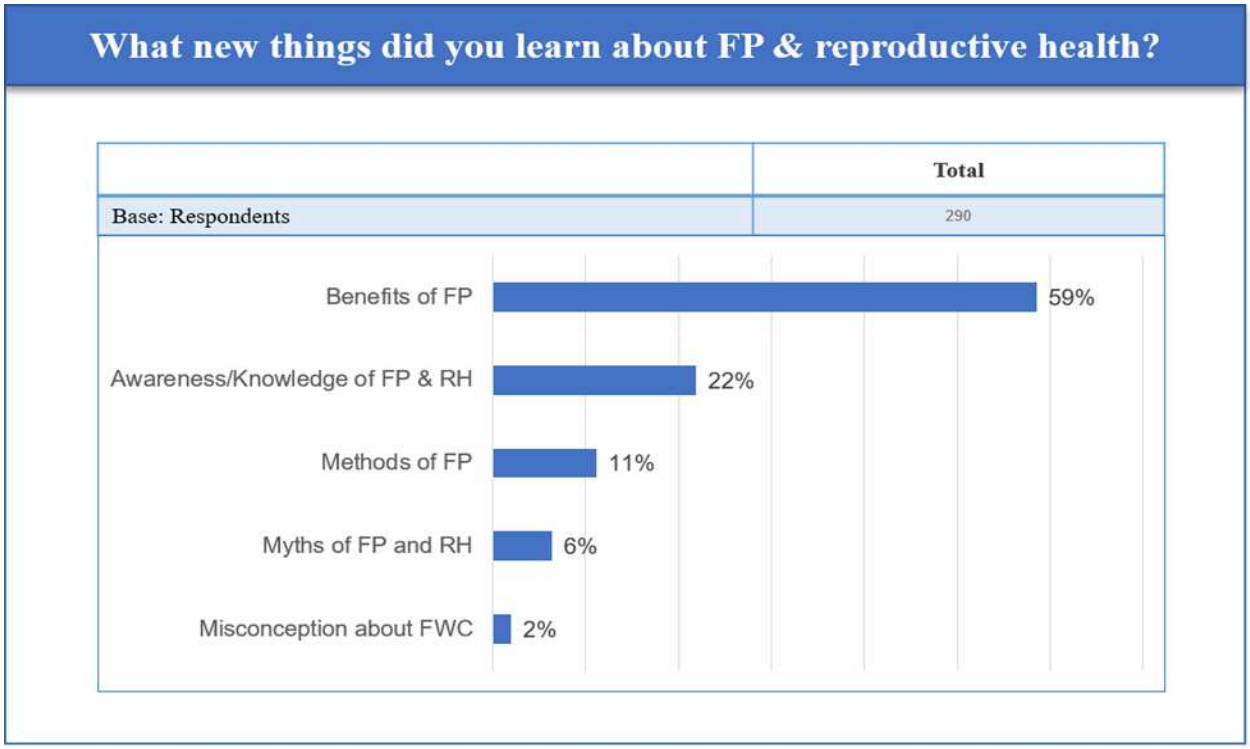
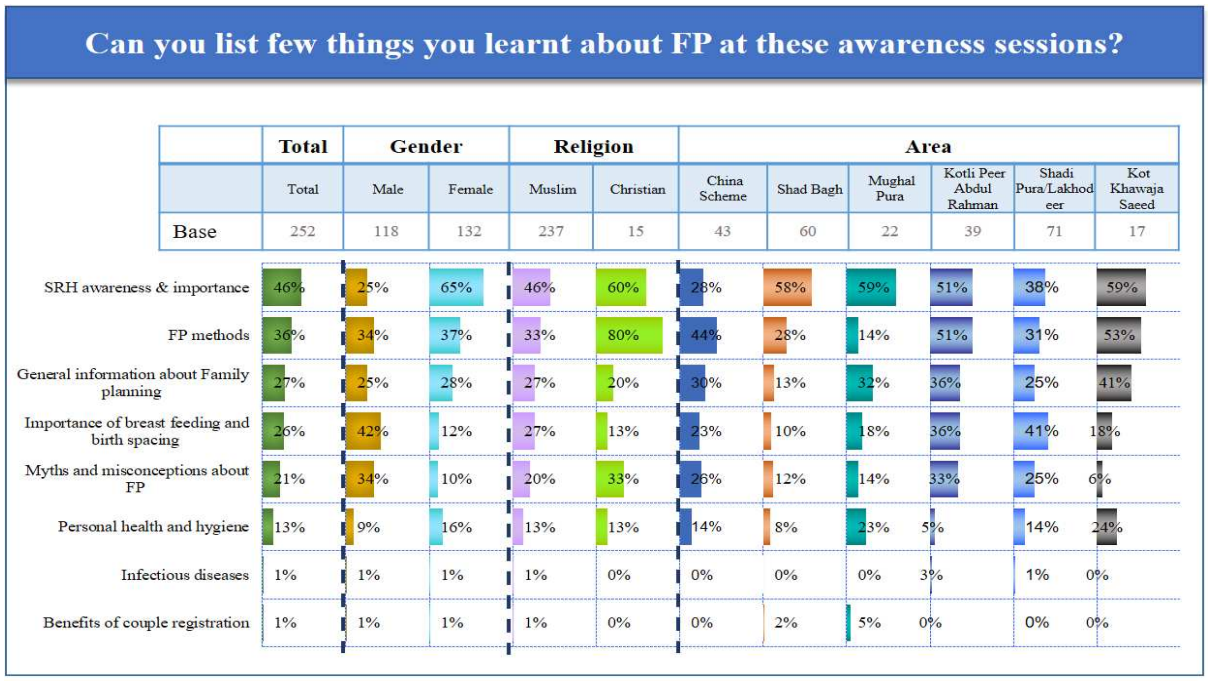


Figure 8: What new things you learned about FP/SRH?

The majority of respondents, 59 percent, learned something new regarding the benefits of family planning, 22 percent about knowledge of family planning and reproductive health, 11 percent method of family planning, 6 percent regarding myths about family planning and reproductive health, and 2 percent misconceptions about the family welfare clinic.



	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	252	118	132	237	15	43	60	22	39	71	17
SRH awareness & importance	46%	25%	65%	46%	60%	28%	58%	59%	51%	38%	59%
FP methods	36%	34%	37%	33%	80%	44%	28%	14%	51%	31%	53%
General information about Family planning	27%	25%	28%	27%	20%	30%	13%	32%	36%	25%	41%
Importance of breast feeding and birth spacing	26%	42%	12%	27%	13%	23%	10%	18%	36%	41%	18%
Myths and misconceptions about FP	21%	34%	10%	20%	33%	26%	12%	14%	33%	25%	6%
Personal health and hygiene	13%	9%	16%	13%	13%	14%	8%	23%	5%	14%	24%
Infectious diseases	1%	1%	1%	1%	0%	0%	0%	0%	3%	1%	0%
Benefits of couple registration	1%	1%	1%	1%	0%	0%	2%	5%	0%	0%	0%

Figure 9: List things learned about FP at awareness sessions

Overall, 46 percent of respondents learned SRH awareness and its importance, 36 percent about family planning methods, 27 percent general information about family planning, 26 percent about the importance of breastfeeding and birth spacing, 21 percent about myths and misconceptions, and 13 percent learned personal health and hygiene. This trend was evident across the gender, religion, and area categories.

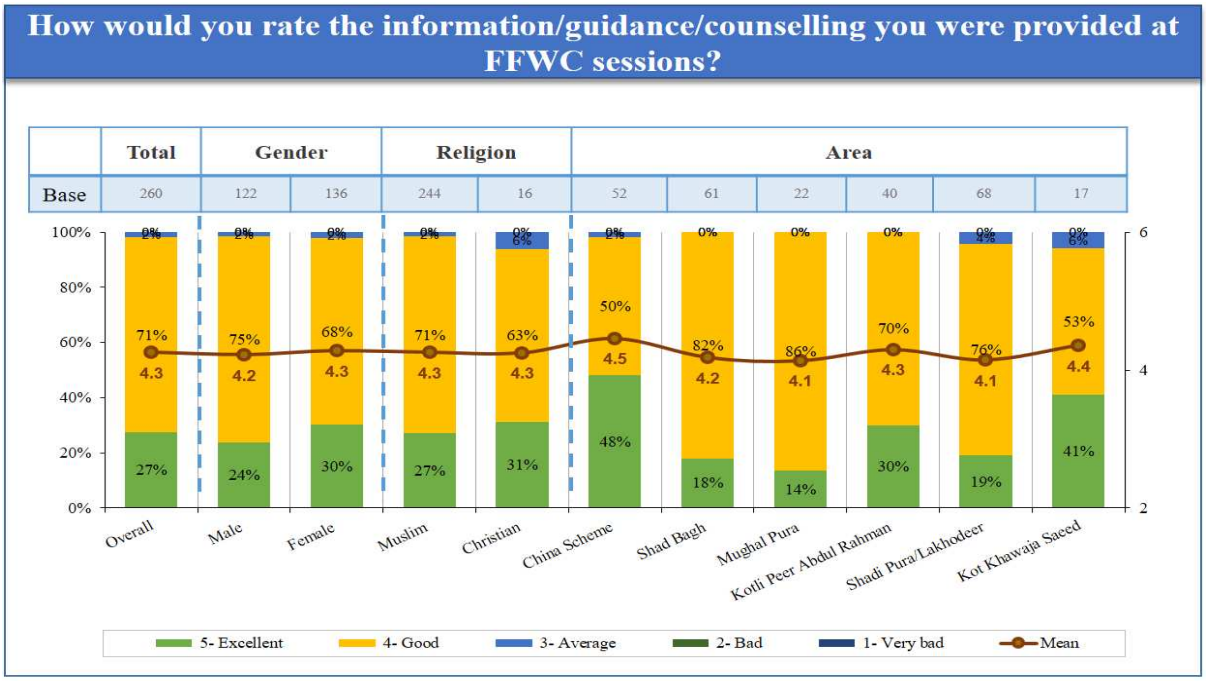


Figure 10: How do you rate guidance provided at FFWC sessions?

With an average of 4.3 out of 5, the respondents overall rated the FFWC services as "good'. The mean ratings for the gender, religion, and area categories were similar.

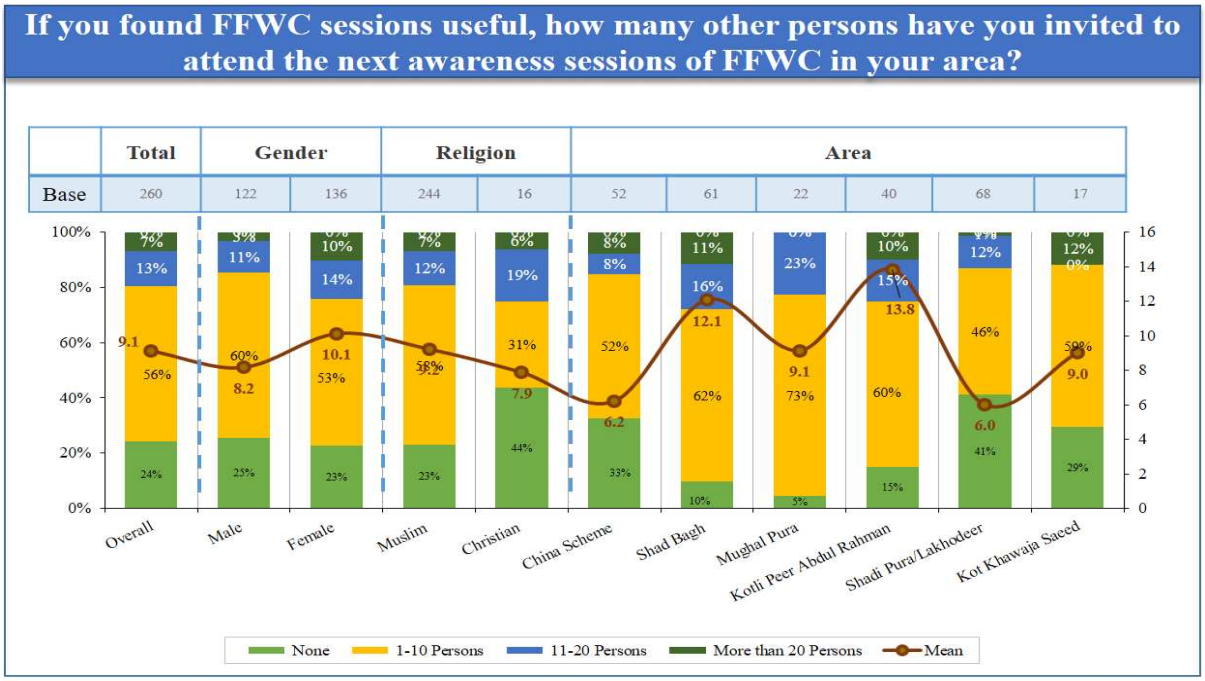


Figure 11: How many others have you invited to FFWC sessions?

Of the respondents who found the FFWC sessions useful, the overall majority (56 percent) invited 9.1 persons to the next session. While men on average invited 8.2 persons, women invited 10.1. China Scheme and Shadi Pura respondents on average invited 6.2 and 6.0 persons respectively, the lowest among all areas; whereas Shad Bagh and Kotli Peer Abdul Rahman respondents invited an average of 12.1 and 13.8 respondents, the highest among the areas.

Outcomes of social mobilization by FFWCs

Two types of outcomes resulted from social mobilization by FFWCs: a) increase in FP knowledge and satisfaction from attending CAS and b) FP message amplification by way of positive word-of-mouth.

At the end of every CAS, MDM measured the level of satisfaction from and changes in knowledge gained by the participants to see how effective CAS has been.

Against a target overall satisfaction level of 70 percent, MDM M&E data shows 77 percent satisfaction recorded from 613 (3.7 percent) of the participants. Knowledge gained through pre- and post-tests of 795 (4.7 percent) assessed participants reveal a consistent pattern every quarter except Q4, 2019.

Knowledge Gained by Quarter (%age)

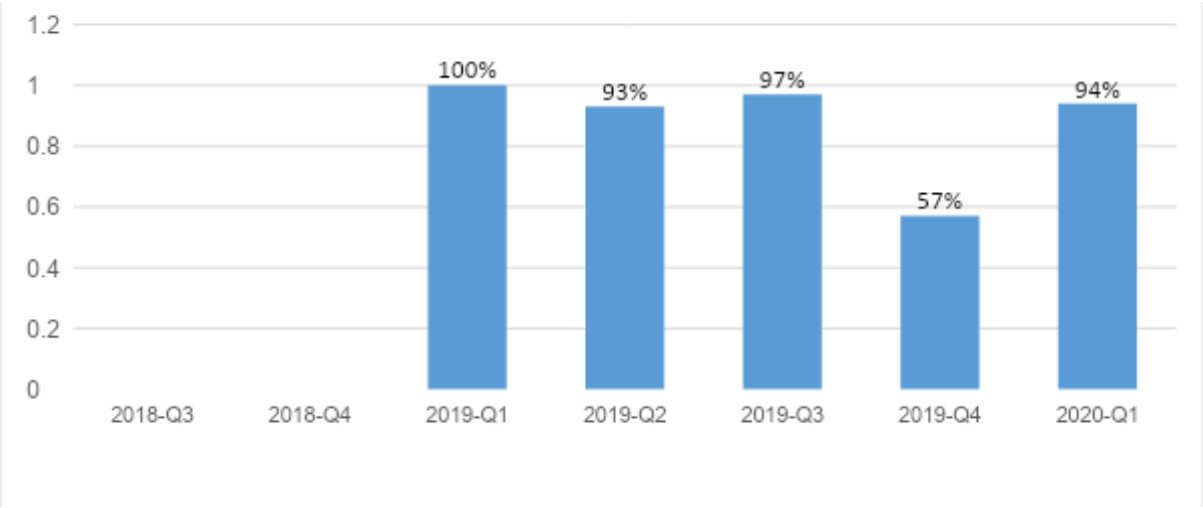


Figure 12: Knowledge gained in CAS

FP/SRH AWARENESS AMPLIFICATION

Amplification refers to the extent to which a message is spread by people through word-of-mouth (WOM). Figure 14 shows that, overall, every person who attended CAS by FFWC amplified the message by 9.3X; with women reporting to have told 10 more persons, on average, while men's reported word-of-mouth was eight.

On the basis of overall magnification factor of 9.3X, awareness outreach from community mobilization by FFWCs can be estimated:

Types of mobilization activity	Participants	WOM amplification factor	Estimated awareness outreach

Community awareness sessions	16,676		155,086
Activities at community level	5,302	9.3X	49,308
Total outreach of community mobilization	**21,978**		**204,394**

Table 16: Awareness amplification through word-of-mouth

FFWCs have not only amplified FP/SRH messages but also been effective in delivering these messages because they take pride in the work they do!

"We are FFCW by our choice, to help the community, to save youth and spread whatever knowledge we have." FFWC-Female

"One of the key impacts of FFWC is the acceptability, because we are from the same community, they trust us more than the FWC staff. They believe that we are talking about their benefit and betterment." Member of FFWC-Male

3.4 ADVOCACY

MDM set out to achieve a modest result: "identified provincial SRHR actors with whom common advocacy SRHR objectives are agreed upon (target: 3 CSOs)."[36] The nature of this result shows that MDM wanted to enter into advocacy and "get its feet wet" by bringing on board partners for common advocacy on child marriage, generalization of pre-marital counselling on FP and post-abortion care practice. MDM had not set an agenda of its own advocacy objectives. A senior member of an advocacy CSO comments:

"Advocacy especially in SRH is neither MDM's mandate nor its forte (in Pakistan). It has also not previously worked in the field of FP and SRH. The SRH Bill resulted from pressure of a ruling by SCP. The federal government prepared a sample draft and asked each province to adopt it….Punjab Department of Health prepared the first provincial draft in consultation with CSOs, other than MDM. Health department later handed over the process to PWD, which was working with MDM, which had the budget and the willingness to support PWD under this project. MDM thus grabbed the opportunity and, in consultation with key stakeholders, facilitated the second draft which Punjab government sent to the federal government in compliance to SCP ruling."

MDM's contribution in preparation of the SRH Bill was that it responded well in time to the request made by PWD and brought more than the targeted three CSOs from the SRH sector. It brought together the Family Planning Association of Pakistan (FPAP), Shirkat Gah, Bedari, and Simorgh Resource Centre. Other CSOs also later joined the consultation process as MDM gained the trust and confidence of these organizations.

"…their main concern was who would get the credit…we assured them that all those providing inputs and time will be duly acknowledged and we did just that…not only for the SRH Bill but also for pre-marital counselling booklet, which is another achievement by us in this project."

Building on the relationship, MDM again leveraged knowledge and expertise of the partner CSOs and PMCB, which was again requested by PWD because MDM had built a reputation that it delivers what it commits.

[36] Project logframe

"To us all NGOs who approach are the same…only with passage of time some prove their worth by virtue of performance others don't. Naturally, over time, performance separates them and we value them accordingly."

Deputy Secretary, Technical, PWD

MDM started with a vague agenda for advocacy but ended up with concrete achievements like the SRH Bill and PMCB under the advocacy components. It has built a relationship with more than just three CSOs. Its contribution is recognized, but stakeholders also caution that it is not 'an advocacy brand' despite these results.

3.5 EVALUATION OF PROJECT RESULTS

FP2020-CPROP aimed for results at the Centre and the community levels. The project sought to increase users' traffic and their satisfaction from the services they received. This was possible when social mobilization mechanisms and practices were able to enhance the acceptability of FP in general and FWCs in particular.

3.5.1 RESULTS AT FWC LEVEL

All five FWCs and one FHC assigned to MDM have increased traffic, service uptake and QOS of users. (Figure 14).

MDM's internal data provide the following information:

Project records 12,135 total users to date. They have utilized various FP services as follows:

FP Service Uptake at FWCs

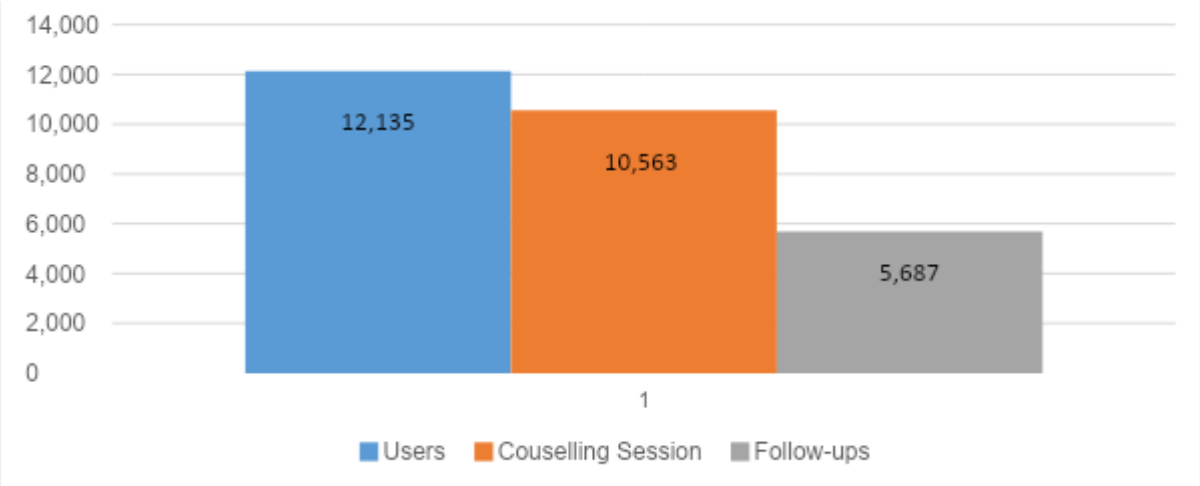


Figure 13: FP service uptake at FWCs

From the total users are derived the additional FP users that MDM generated during this project. The target for additional FP users was set at 3,060.[37] MDM has generated 3,201[38] additional FP users from Aug. 2018 to Feb.2020, which is 105% of the target.

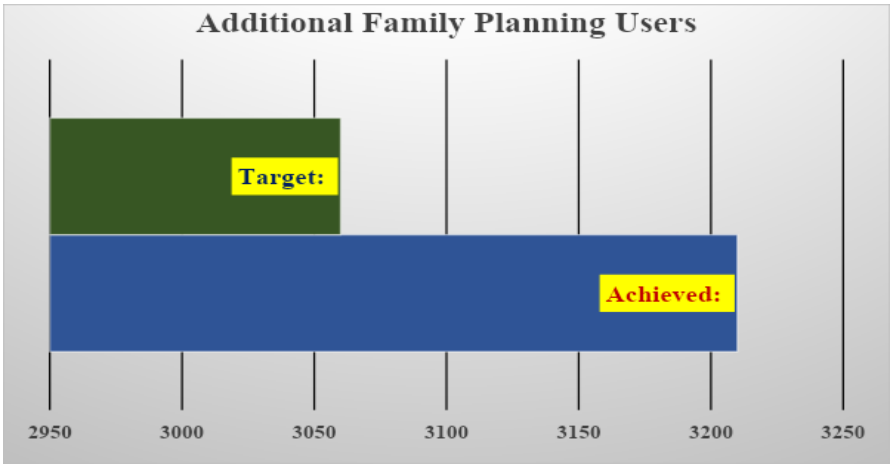


Figure 15: Additional FP users: target and achievement to date

From the total users are derived the additional FP users that MDM generated during this project. The target for additional FP users was set at 3,060 in the project log-frame. MDM has generated 3,201 additional FP users from Aug.2018 to Feb.2020 (Additional users for March 2020 not included), which is 105% of the target.

The additional FP user target resulted from gradual and persistent monthly increases at the PWD's family health clinic and welfare centers for which demand mobilization was undertaken by respective FFWCs, male and female.

Overall Increase in Monthly Average of New FP Users		
Service Center	*FHC (1)*	*FWCs (all 5)*
Monthly average - Baseline	213	59
Monthly average – Aug 18-Feb 20	226	90
Increase in the monthly average new FP users	**6%**	**34%**

Table 17: Overall increase in monthly average new FP users

An overall 34 percent increase in monthly average of new FP users is the combined effect of more new FP users coming at all six centers every month.

[37] Project logframe
[38] Additional users for March 2020 not included.

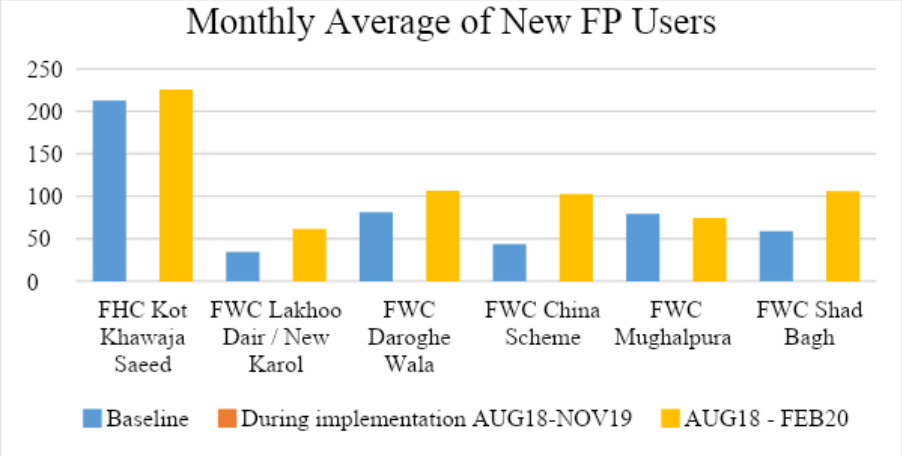


Figure 15: Center-wise trend of monthly average increase in new FP users

MDM regularly conducted random exit interviews at FWCs to monitor users' post-visit level of satisfaction.

Figure 16: FP users' satisfaction level through project duration

Against the targeted level of 80 percent client satisfaction, FWCs attained 81 percent level of satisfaction from FP services delivered to clients at 5 FWCs and FHC after MDM's intervention at these FWCs under the pilot project.

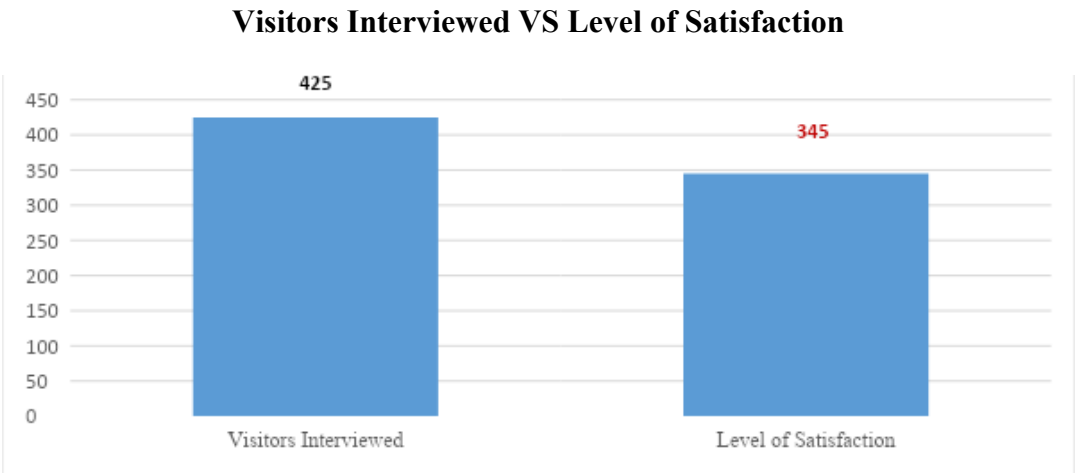


Figure 17: Overall satisfaction level against project target

EVALUATION EXIT INTERVIEWS

MDM internal data is corroborated from findings of the exit interviews conducted for this evaluation. Exit interviews focused on finding underlying causes of client satisfaction such as availability of required services, waiting time, provision of IEC material, quality of consultations, level of confidentiality/privacy. Exit interviews also found about their overall experience and how likely they are to recommend the FWC to others based on their own experience.

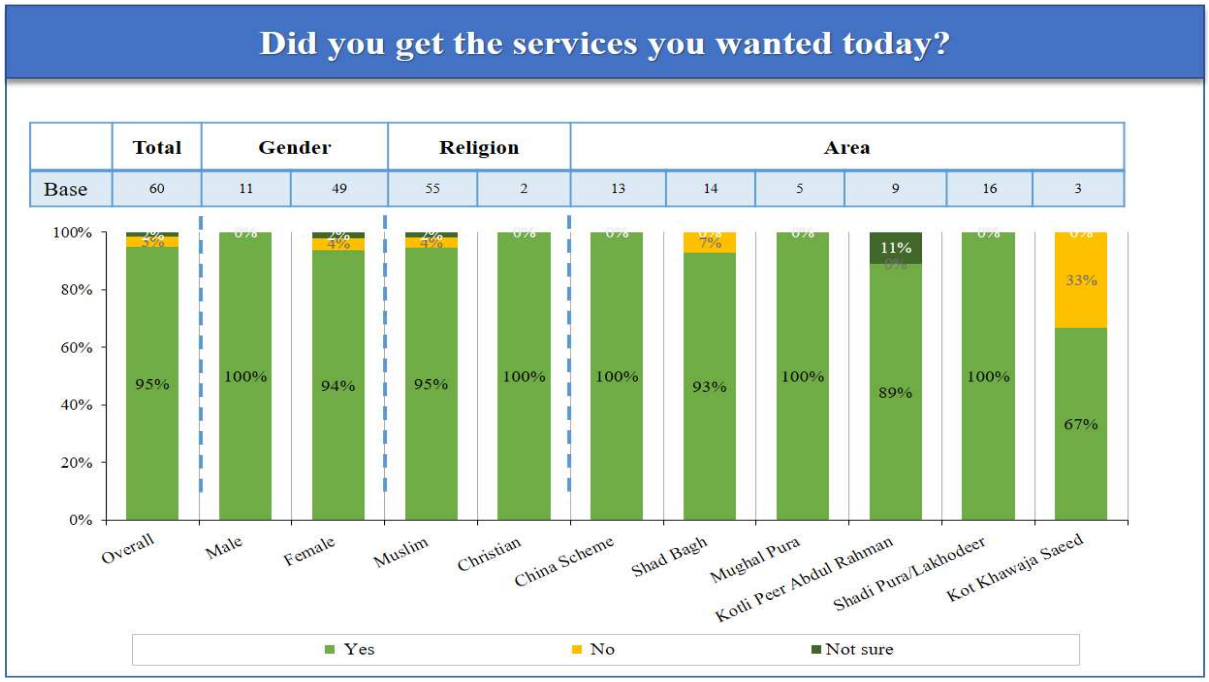


Figure 18: Did you get the services you wanted today?

The majority of respondents, regardless of gender, religion, and area of residence, believe they received their desired services. It is, however, notable that 33 percent of Kot Khawaja Saeed respondents at the FHC answered in the negative.

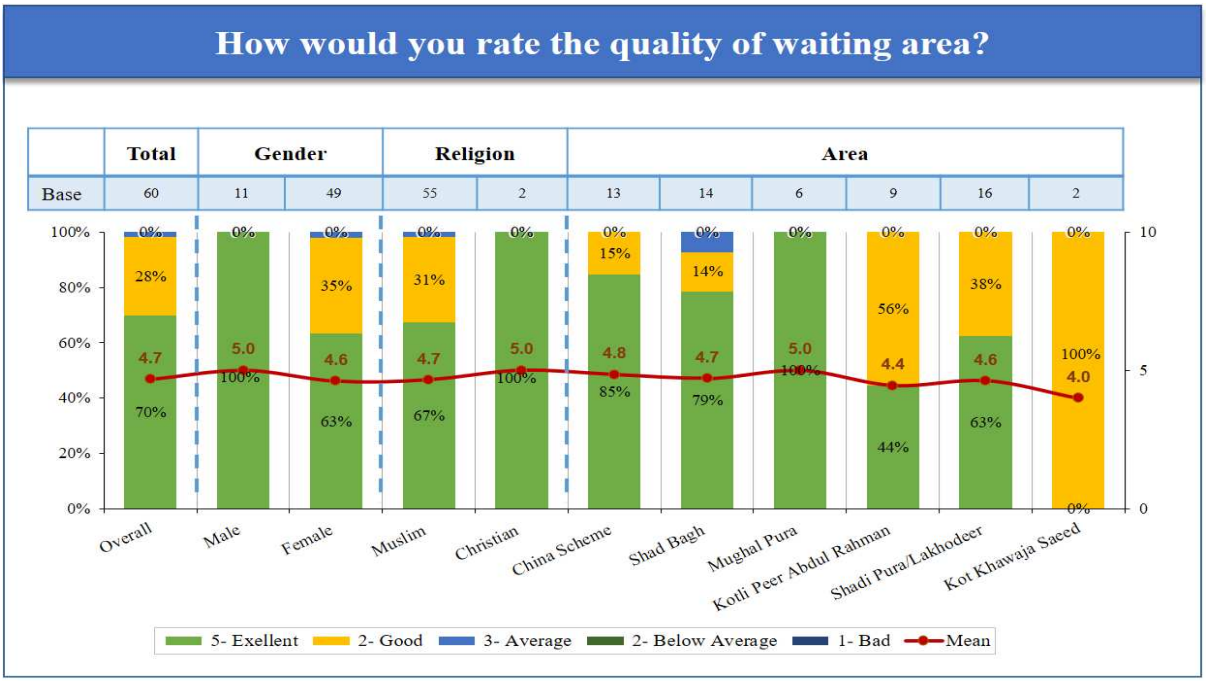


Figure 19: How would you rate quality of waiting area?

Overall, regardless of gender, religion, and area of residence, the clients rated the waiting time area 'excellent' and 'good'. However, in Kot Khawaja Saeed, all the respondents rated the only 'good'.

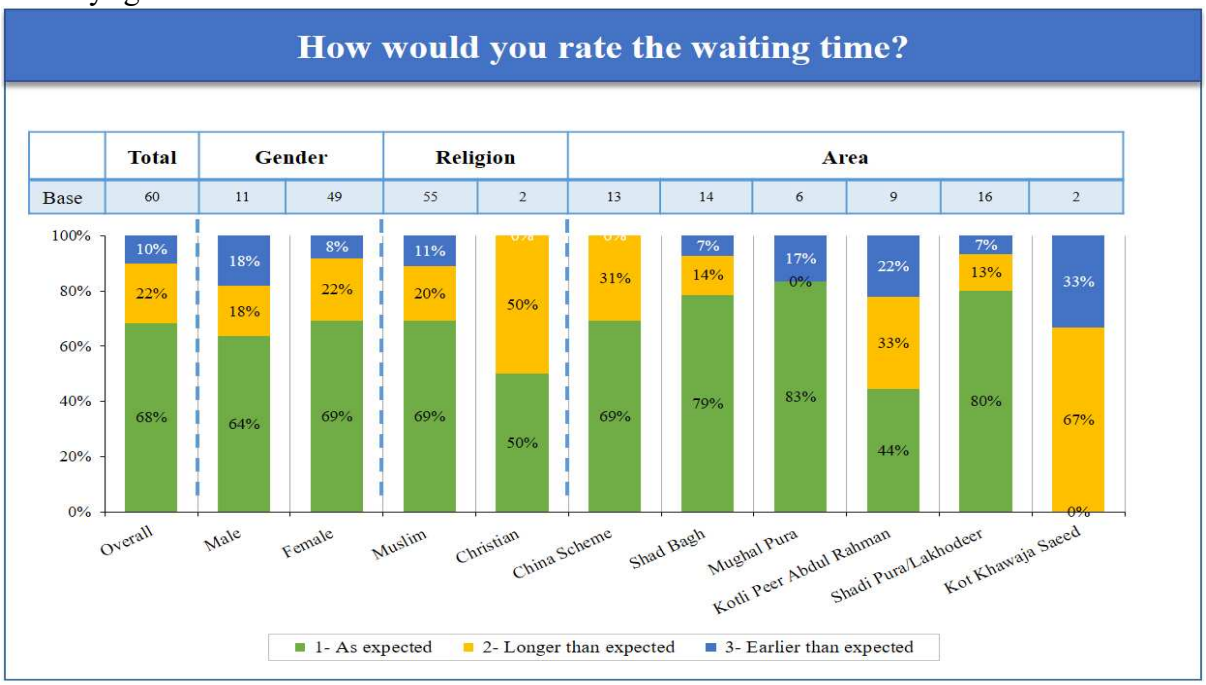


Figure 20: How do you rate waiting time?

Overall, the waiting time met the expectation of the clients. However, 50 percent of Christian clients, compared to only 20 percent Muslims clients, felt it was longer than expected. Notably, 33 percent of respondents from Kotli Peer Abdul Rehman and 67 percent from Kot Khawaja Saeed felt that the waiting time was longer than expected.

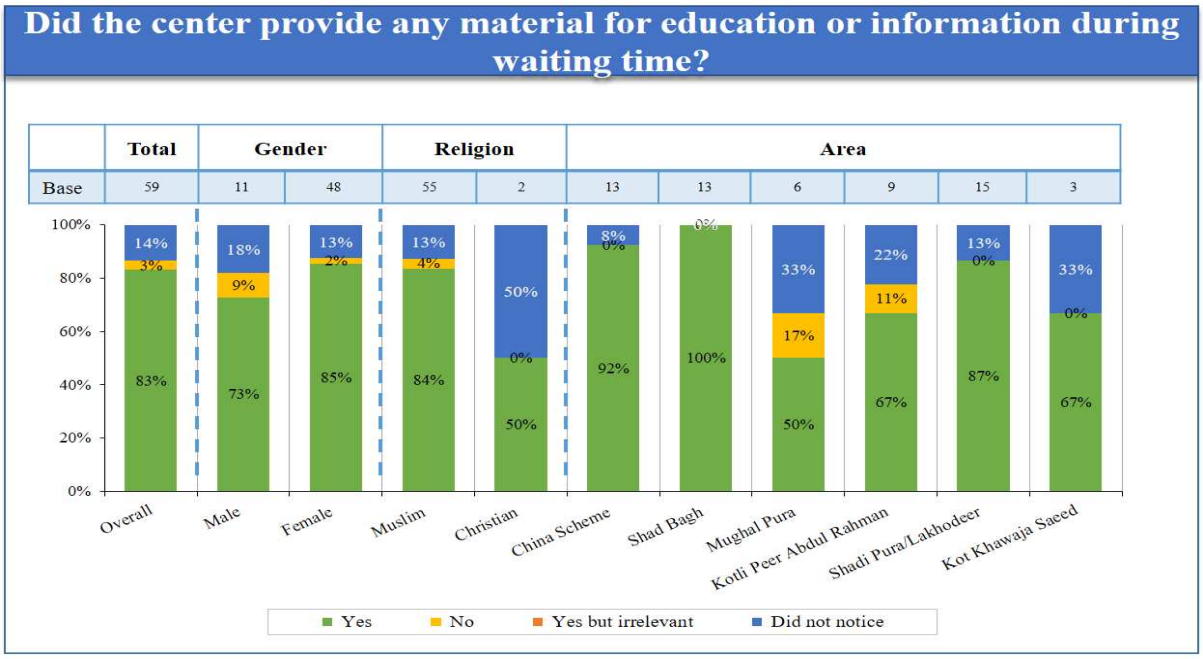


Figure 21: Did the center provide IEC at the waiting area?

The majority of respondents found that their respective center did provide informative material during the waiting period; however, a disparity in affirmative responses between Christian and Muslims was observed, as 84 percent of Muslims compared to 50 percent of Christians answered 'yes'. It is also notable that 17 percent of Mughal Pura respondents answered 'no'.

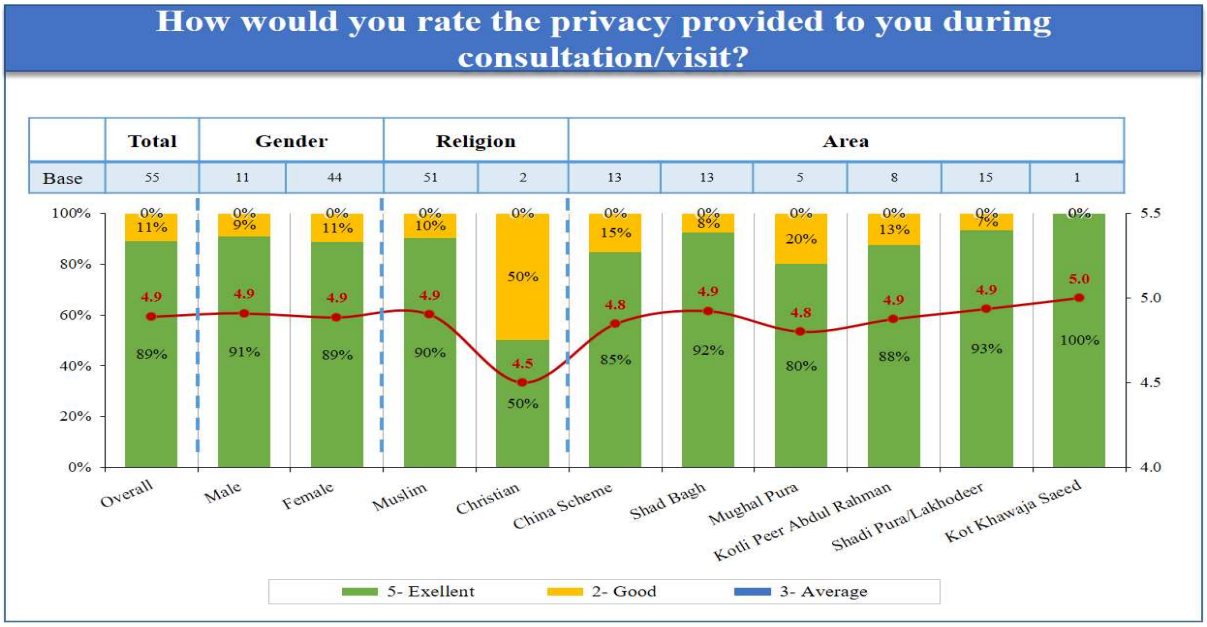


Figure 22: How do you rate the privacy provided?

Overall the level of privacy was rated excellent, with a mean rating of 4.9. Among all categories, Christian respondents gave the lowest mean rating of 4.5.

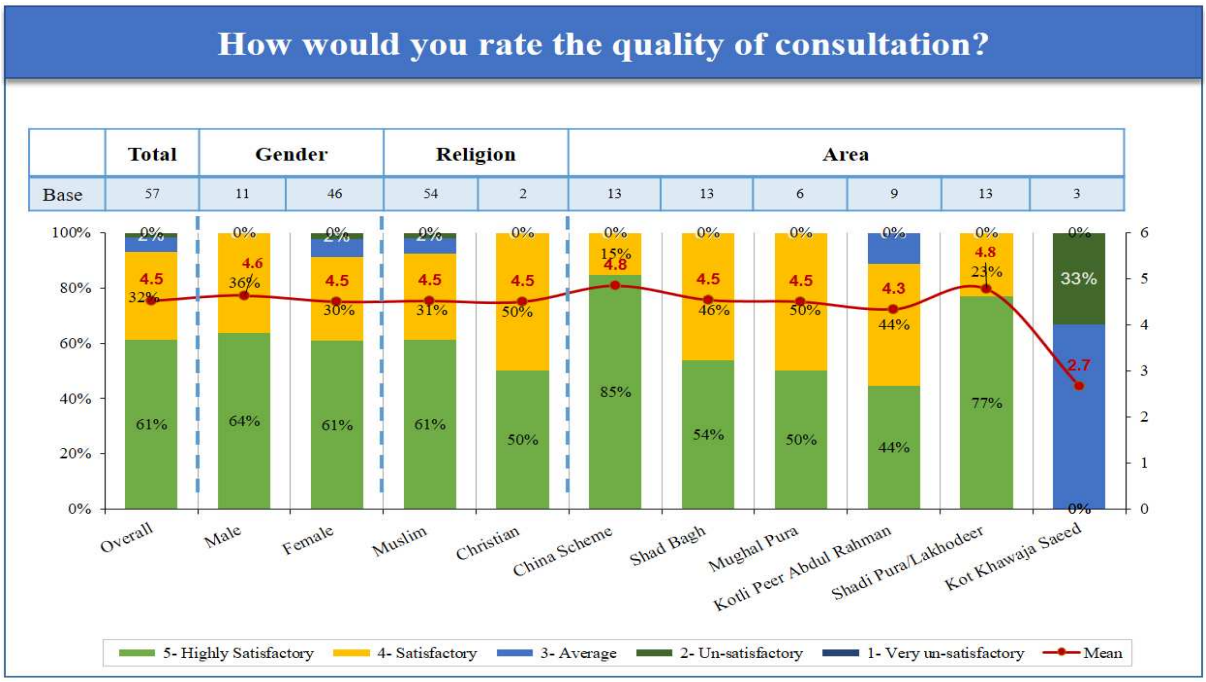


Figure 23: How do you rate the quality of consultation?

Overall the quality of consultation was rated satisfactory, with a mean rating of 4.5. The greatest deviation from the mean was observed among Kot Khawaja Saeed respondents, with a mean rating of 12.7. This was also the only group where a significant proportion of respondents, 33 percent, found the quality of consultation unsatisfactory.

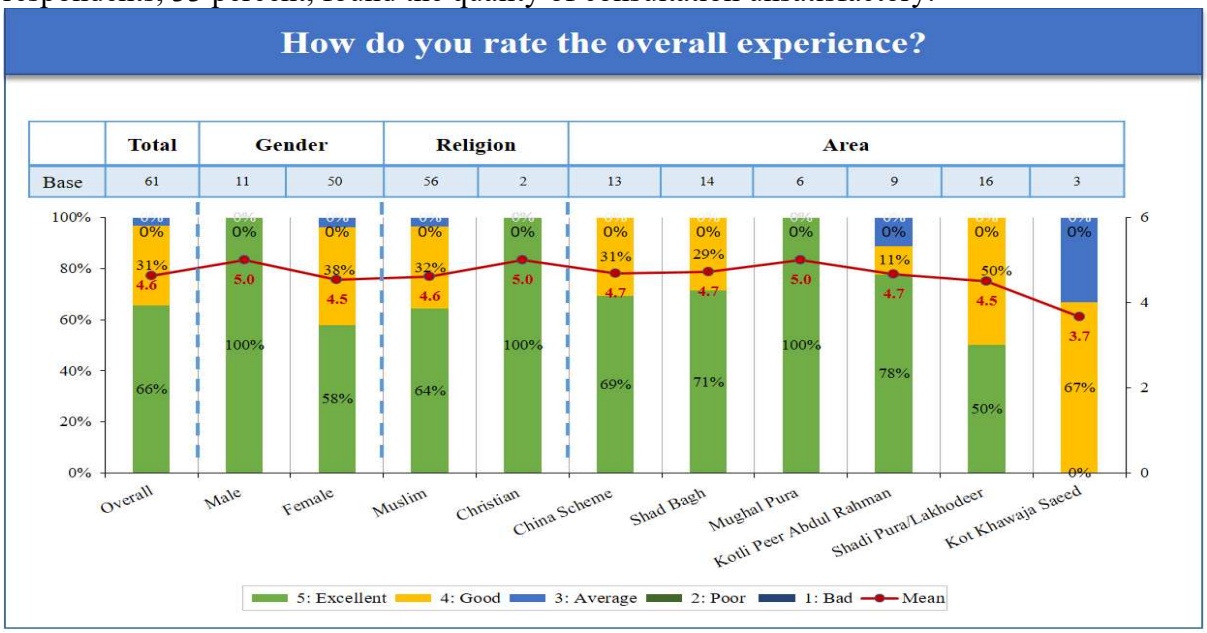


Figure 24: How do you rate overall experience?

The experience at the FWC was rated good overall, with an average rating of 4.6. Kot Khawaja Saeed respondents gave a rating well below that of all other areas.

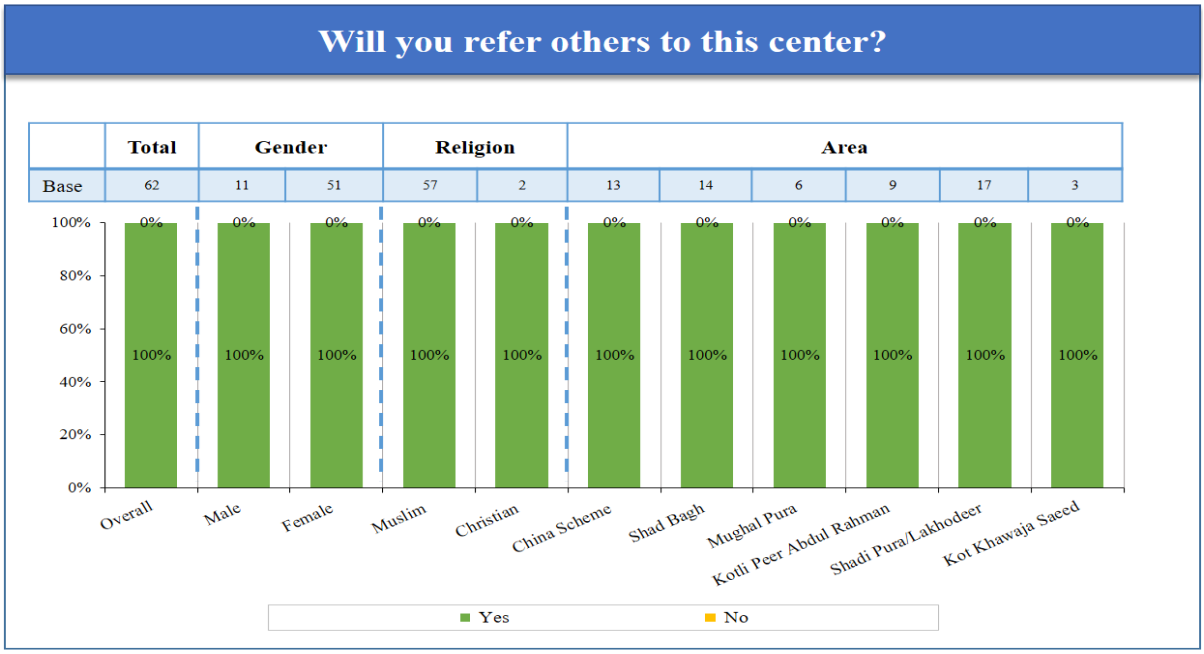


Figure 25: Will you refer others to this center?

All respondents, regardless of gender, religion, and area of residence, said they would recommend the FWC to others. And this is the highest endorsement of improvements brought at the centers under the FP2020-CPROP project.

3.5.2 RESULT AT THE COMMUNITY LEVEL

Acceptability of and satisfaction with FP services offered at FWCs increased because of extensive social mobilization undertaken jointly by FFWCs and FWAs with support from the MDM field team. The community survey asked questions about FP/SRH needs of the married as well as unmarried persons. First, findings from the married respondents are presented and then answers on FP/SRH needs of both married and unmarried are presented. Next, all respondents provide their feedback on the role and contribution of FWCs and FFWCs, and, finally their expectations and recommendations are summarized in this section on results at the community level.

FINDINGS OF THE COMMUNITY SURVEY: FP NEEDS, KNOWLEDGE AND PRACTICES OF MARRIED RESPONDENTS.

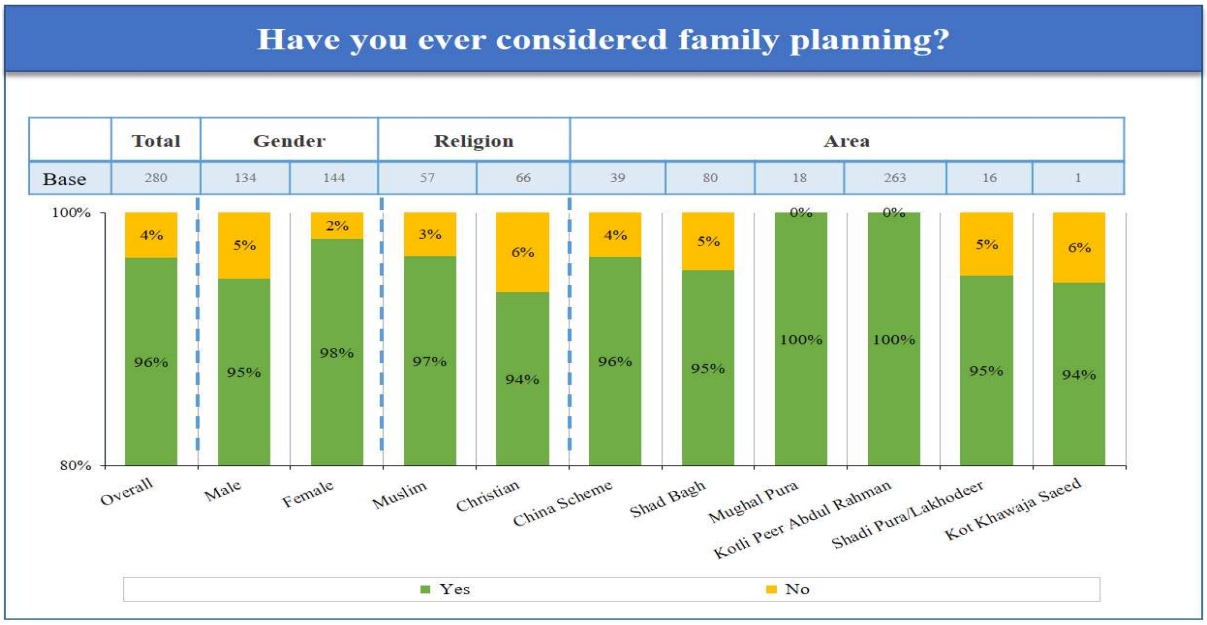


Figure 26: Have you considered FP?

The majority (96 percent), of participants have considered family planning. The responses among the genders, religions, and areas of residence did not demonstrate significant deviation from the overall response.

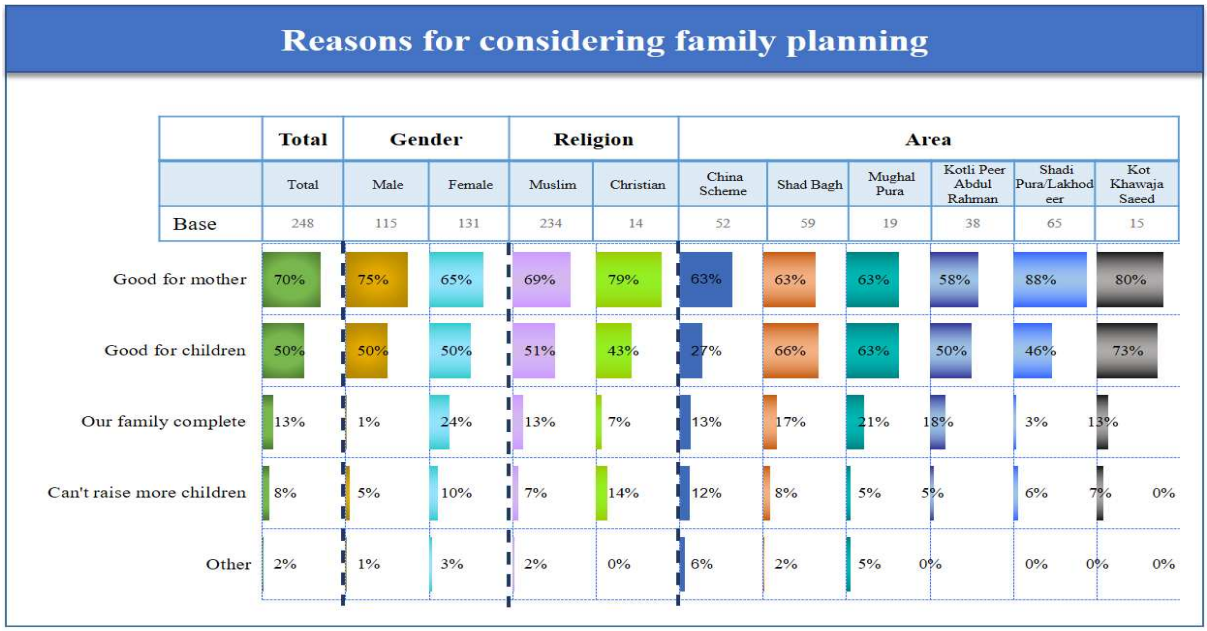


Figure 27: Reasons for considering FP?

70 percent of the respondents overall considered family planning because they believe it is beneficial for mothers, while fifty percent also believe it is beneficial for the children. These two remained the primary reasons though the gender, religion, and area categories.

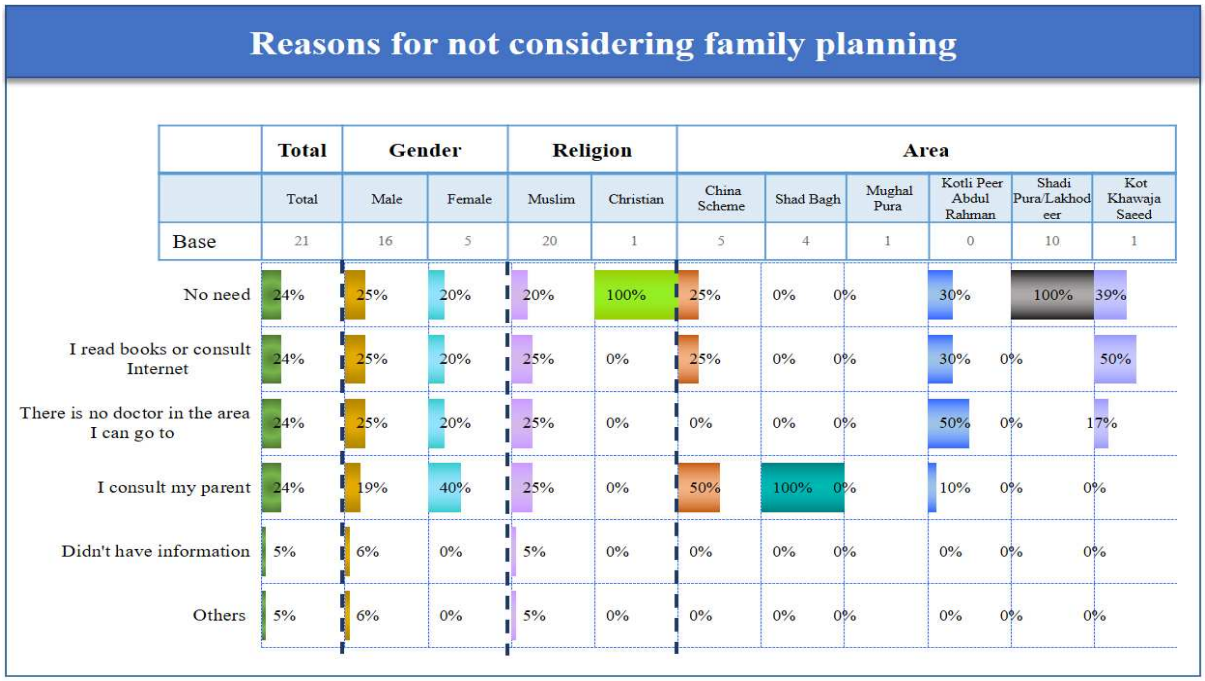


Figure 28: Reasons for not considering FP?

Against 92 percent respondents who considered FP, there were 8 percent (21 respondents) who have not given any thought to using FP because they do not feel the need to, they do not have access to a doctor in their area, and/or they consult with their parents.

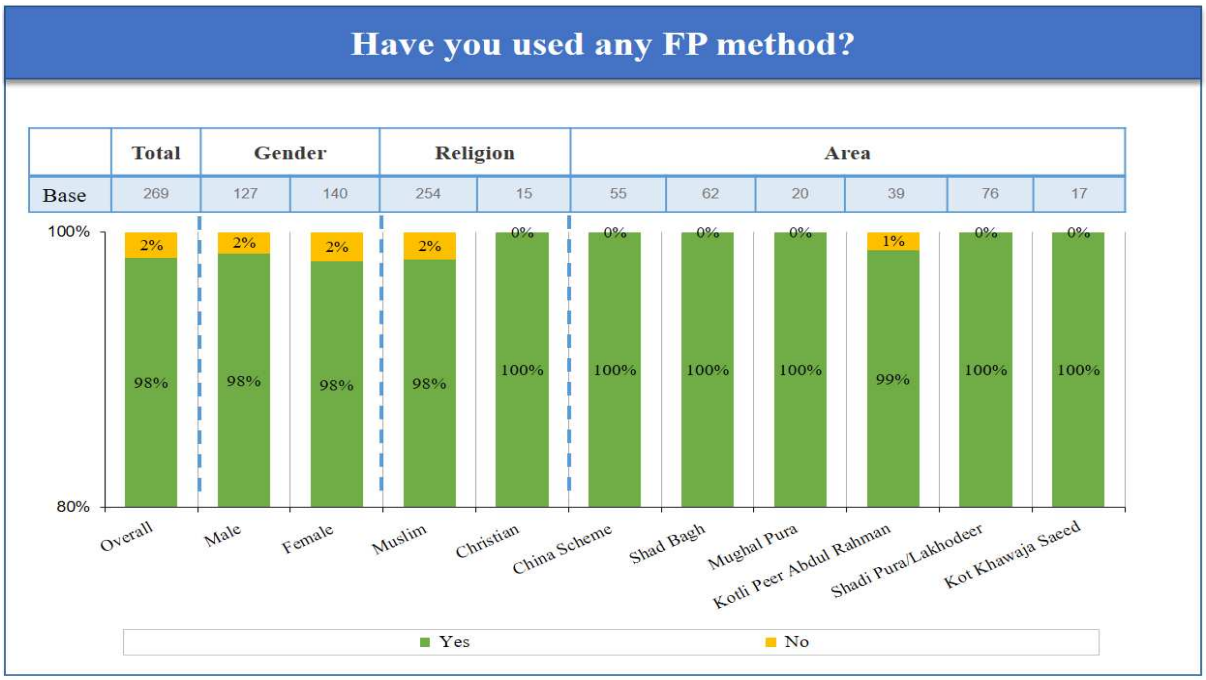


Figure 29: Have you used any FP method?

The majority of respondents, regardless of gender, religion, and area, have used some form of family planning.

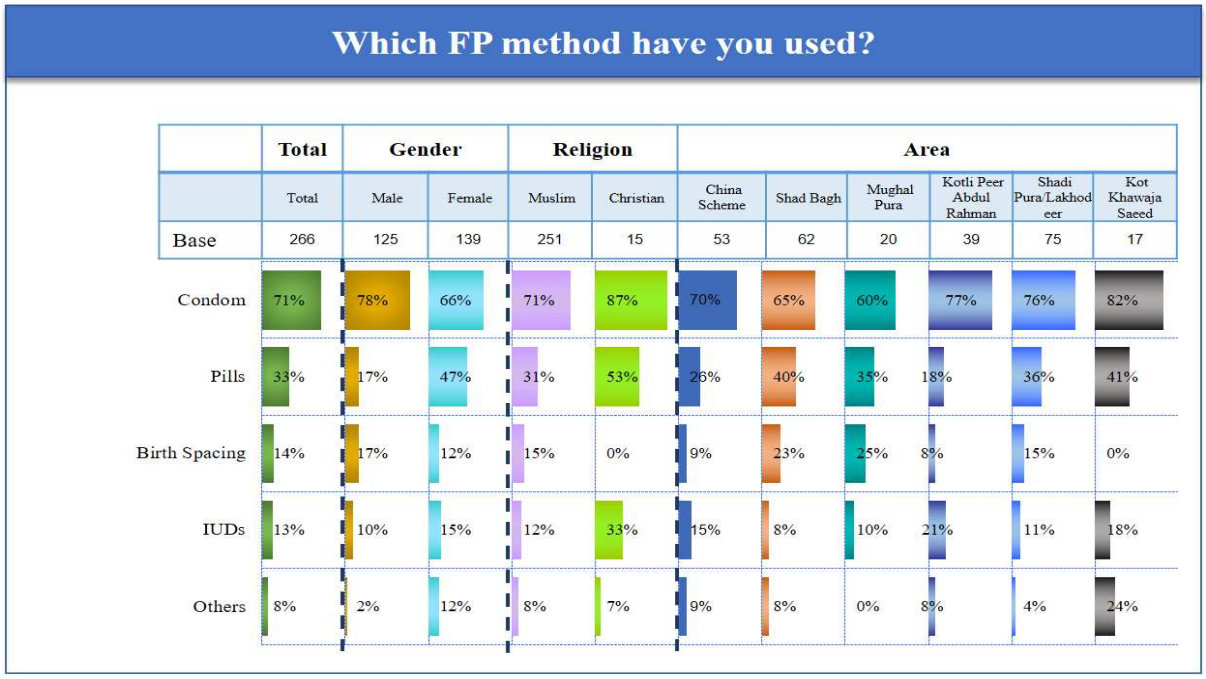


Figure 30: Which FP method used?

Condoms and the contraceptive pill are the most popular methods of family planning used, as 77 percent respondents overall have used condoms and 33 percent the pill. Notably, in Kot Khawaja Saeed, 24 percent respondents use other methods.

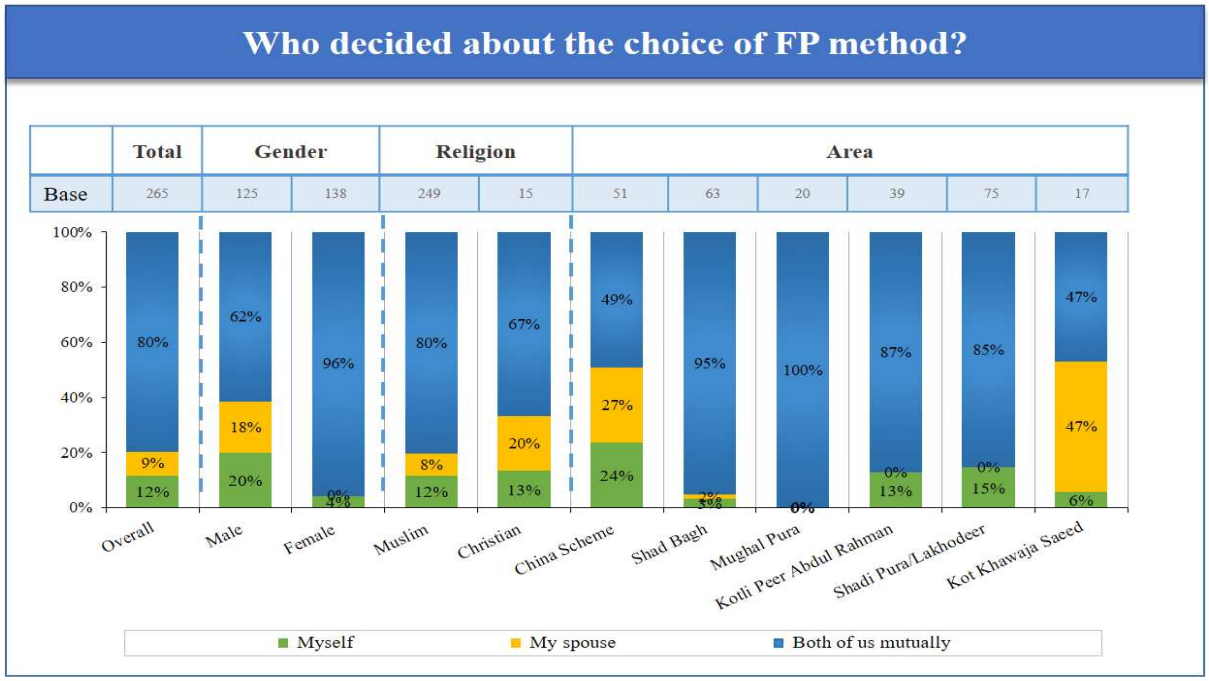


Figure 31: Who decided about the choice of FP method?

Overall, 80 percent of the respondents said they mutually decided their choice of family planning with their spouses. Notably, 96 percent of women, compared to 62 percent of men, gave this answer. In Kot Khawaja Saeed 47 percent of the respondents had their spouses decide the method of family planning, followed by 27 percent in China Scheme.

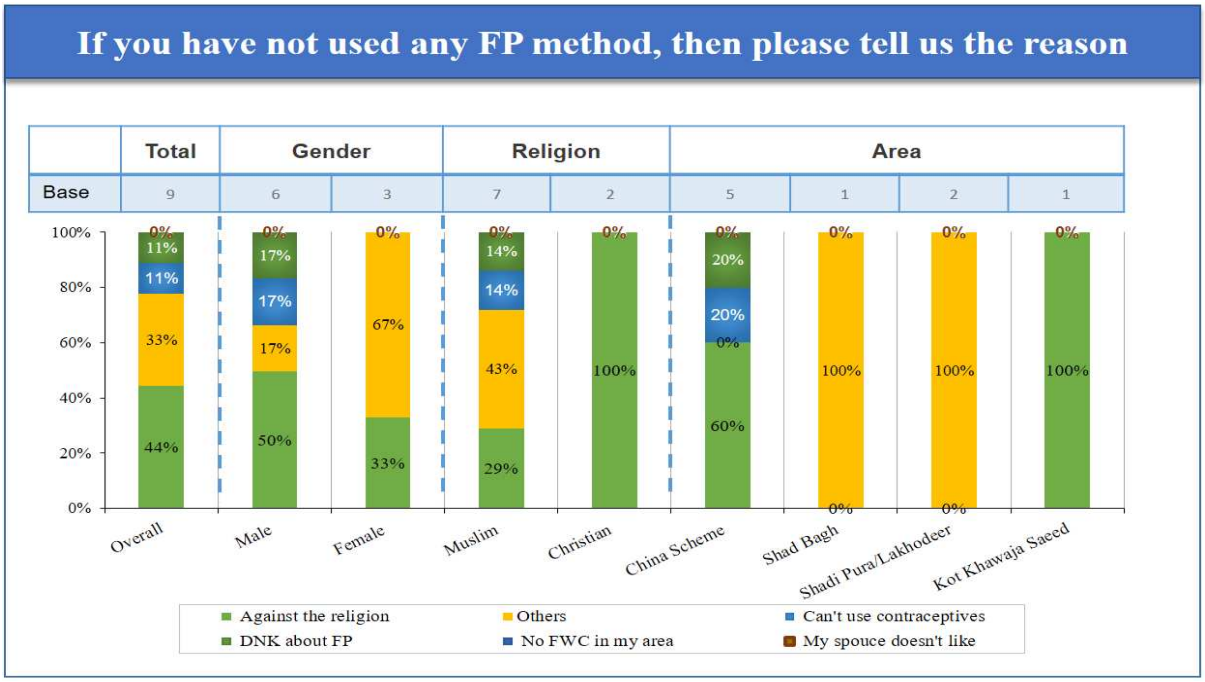


Figure 32: Reason for not using any FP method?

Overall, 44 percent of respondents have not used any method of family planning because they believe it is against their religion, while 33 percent had other reasons. 17 percent of men, compared to zero women, said they cannot use contraceptives.

ANSWERS BY BOTH THE MARRIED AND UNMARRIED REGARDING FP/SRH

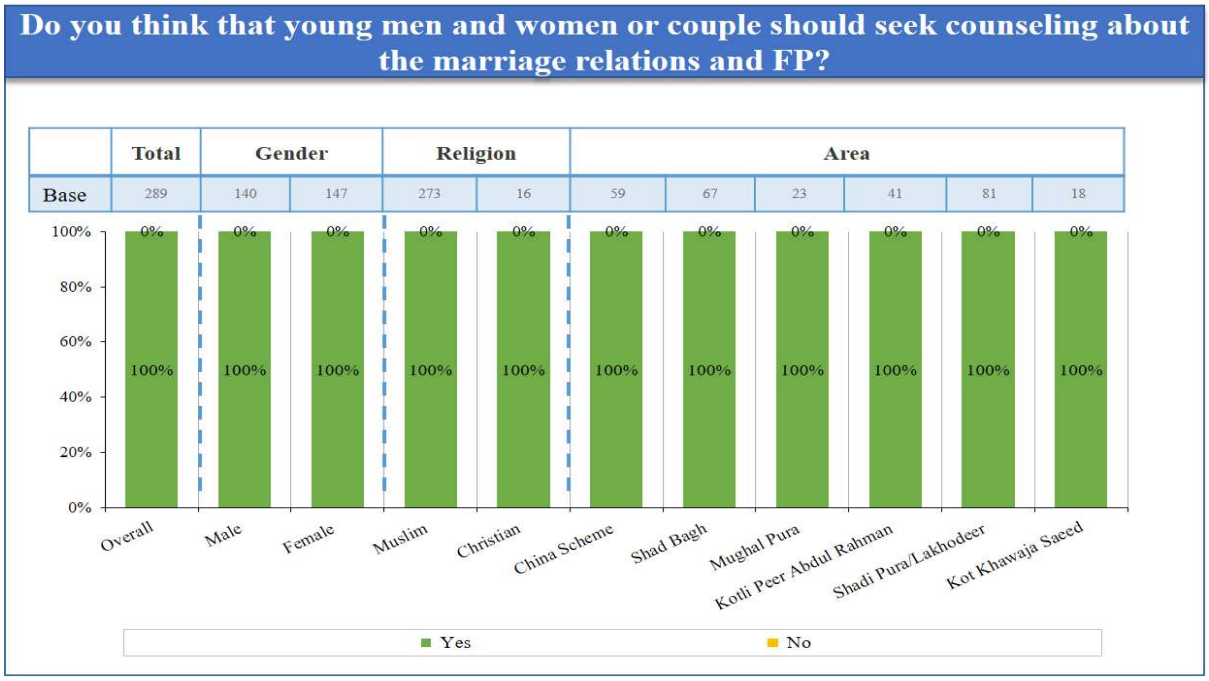


Figure 33: Do you think youth should seek FP counselling about marriage and FP?

All respondents believe that youth and young couples should seek counselling regarding family planning and sex education. This is a consensus endorsement of the need for youth's education and counseling regarding SRH/FP.

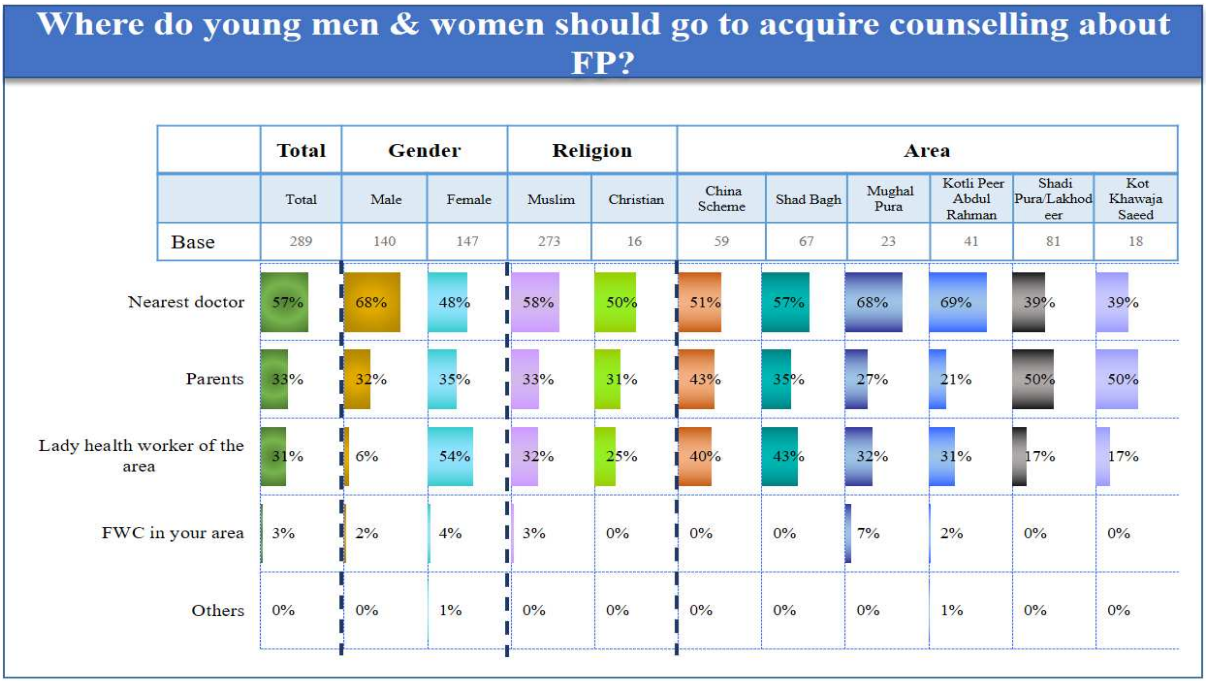


Figure 34: From where should young men and women acquire FP counselling?

57 percent of respondents overall believe that young men and women should seek family planning counselling from a doctor, 33 percent answered 'parents', and 31 percent said 'lady health worker'. These responses were the most popular in all areas, and among both gender and religion.

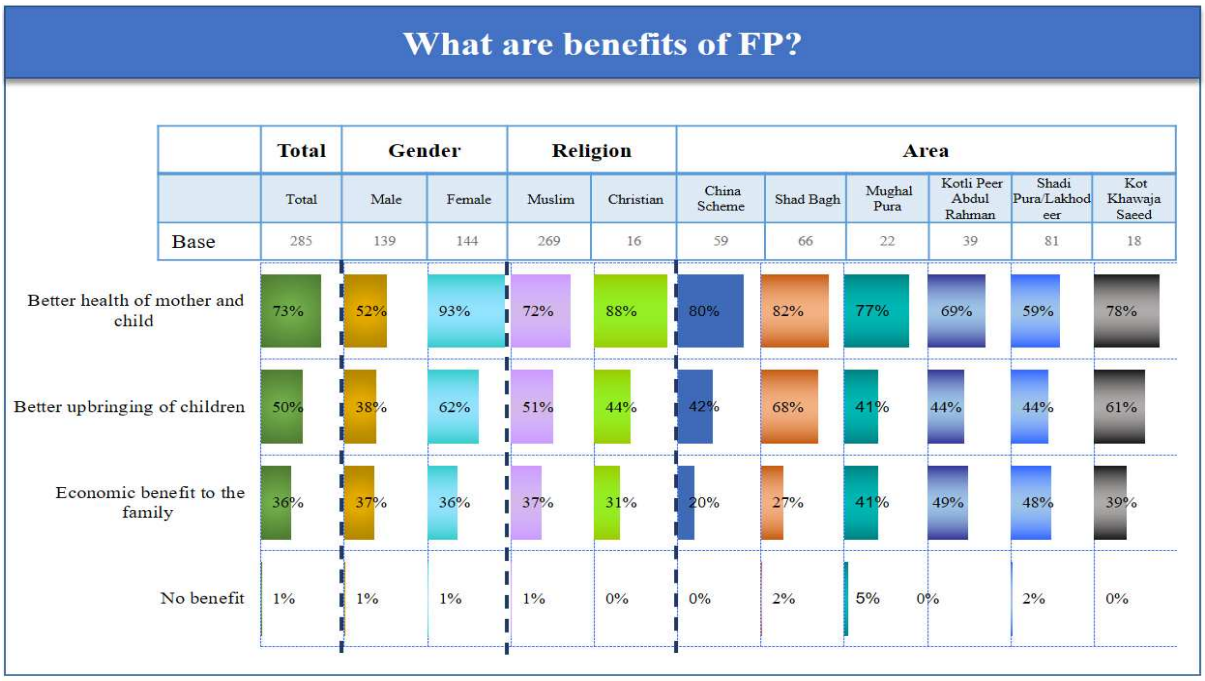


Figure 35: What are the benefits of FP?

73 percent of respondents overall believe that family planning can improve maternal and infant health, 50 percent believe it can lead to better upbringing of children, and 36 percent believe in the economic benefits of family planning. These responses remained popular in all areas and regardless of gender and religion.

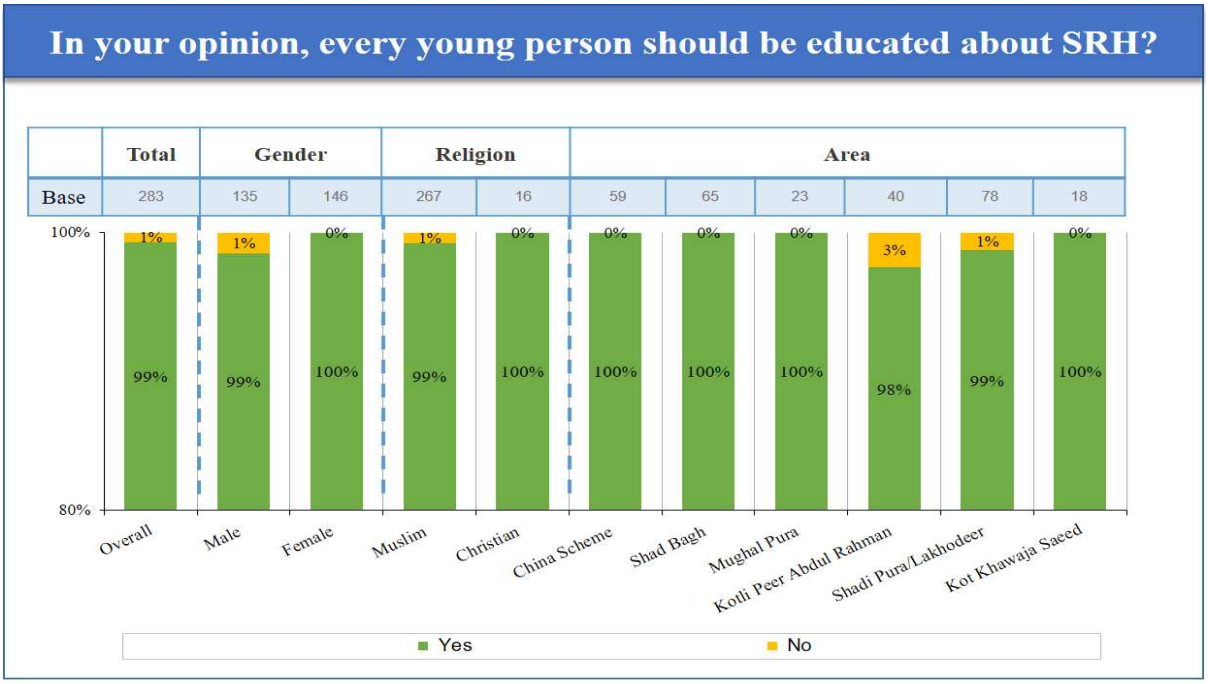


Figure 36: In your opinion should every young person be educated about SRH?

The majority of respondents, regardless of gender, religion, and area of residence believe that the youth should be educated about sexual and reproductive health.

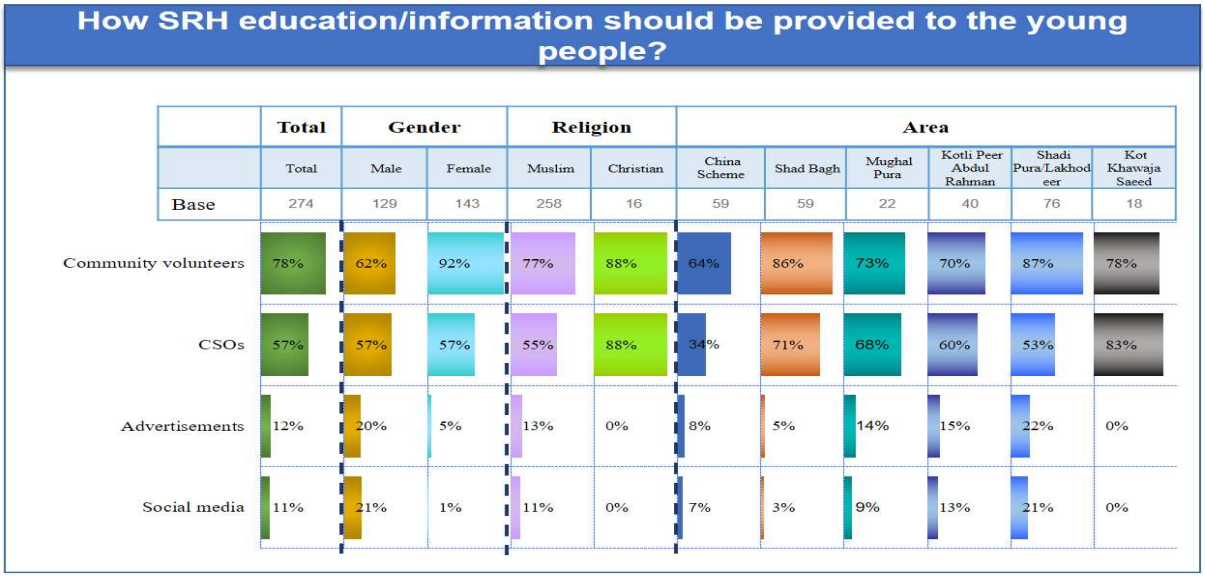


Figure 37: How should SRH education be provided to young people?

Community volunteers and CSOs were the most frequently cited media for the dissemination of SRG education to youth, as 78 percent overall selected the former and 57 percent the latter. 20 percent of men, compared to only 5 percent of women selected advertisements; similarly, 21 percent of men compared to a mere one percent of women

selected social media. Advertisements and social media were also selected by respondents of Mughal Pura, Kotli Peer Abdul Rahman, and Kot Khawaja Saeed.

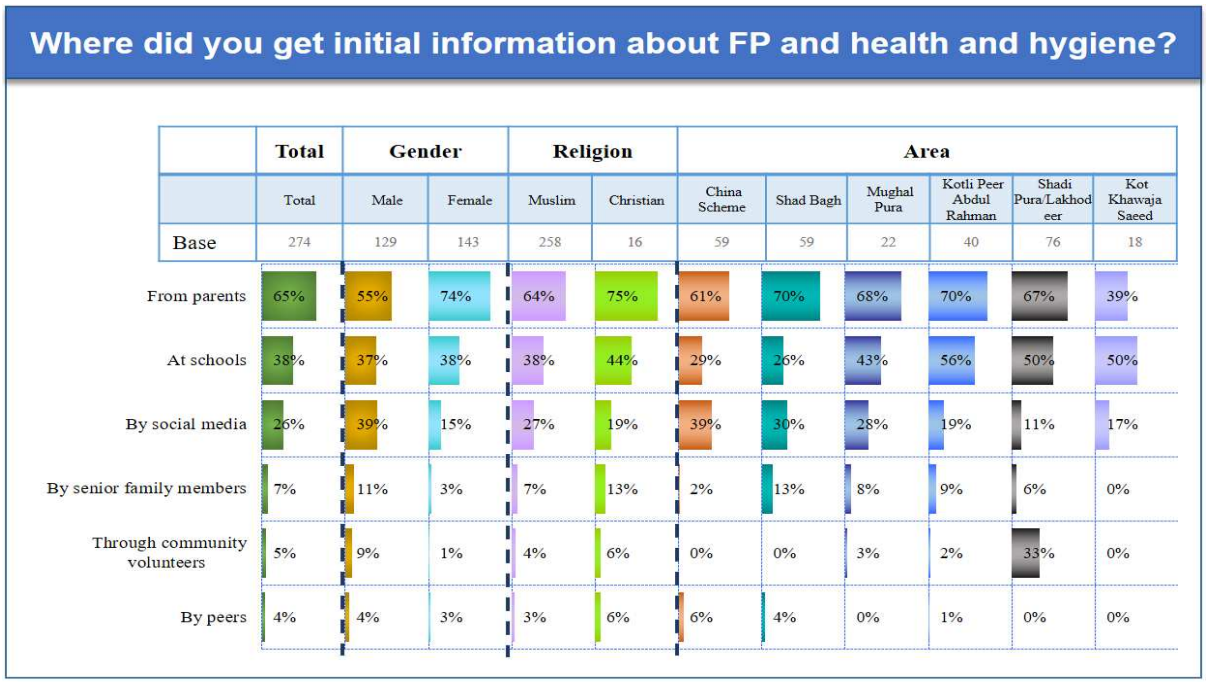


Figure 38: Where did you get initial FP information?

65 percent of respondents overall received initial information about family planning, health, and hygiene from their parents, 38 percent from school, and 26 percent through social media. These three sources of information were most frequently cited, regardless of gender, religion, and area. It is notable that 33 percent of Shadi Pura respondents received information from community volunteers, indicating that perhaps the state of community programs pertaining to health and family planning are more active there.

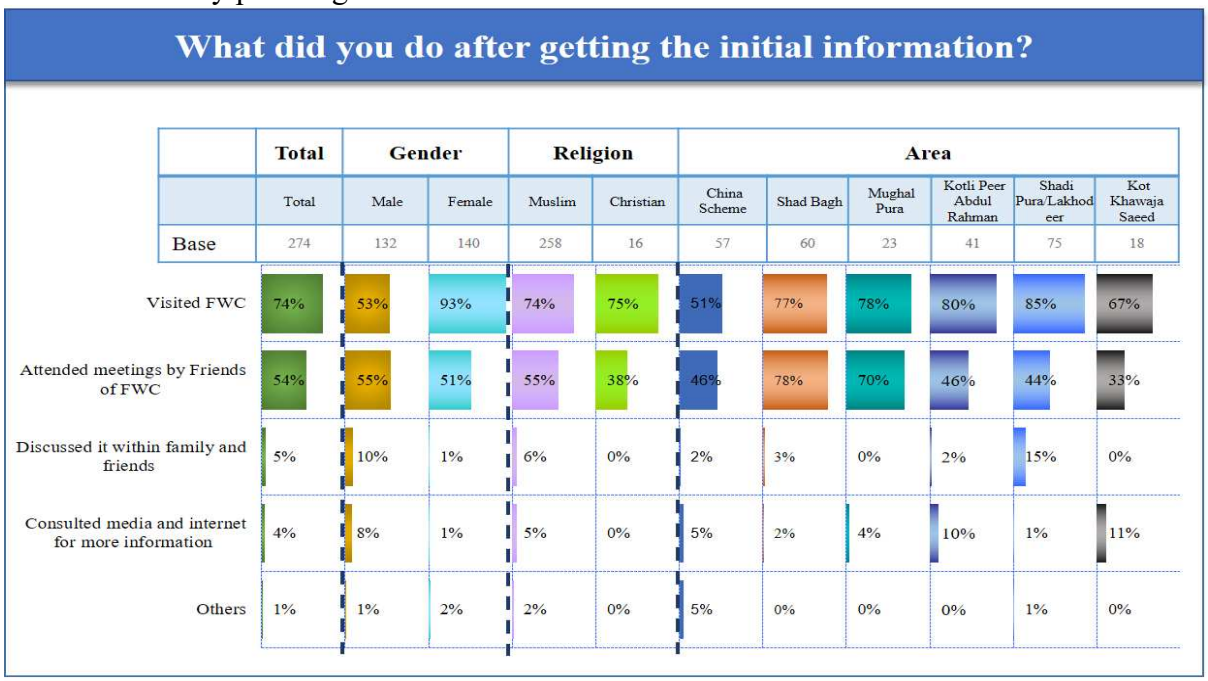


Figure 39: What did you do after getting initial FP information?

After getting the initial information, 74 percent of respondents overall visited a family welfare clinic, and 54 percent attended meetings by Friends of FWC. These were the most frequent responses across gender, religion, and area categories.

SUMMARY OF COMMUNITY SURVEY FINDINGS ON FP NEEDS

Generally, the majority has considered family planning. The primary reason for considering family planning was belief in its benefits for mothers and children. However, the majority of respondents, regardless of gender, religion, and area, have used some form of family planning. Condoms and the contraceptive pill are most frequently used methods. The decision of considering family planning for most respondents was reached at through mutual agreement with spouses.

Of the respondents who have not used family planning methods, most believe it is against their religion, while some had other reasons. The importance of family planning is realized by the majority of respondents, as all of them believe that youth and young couples should seek counselling regarding family planning and sex education. This education, most believe, should be provided by doctors, parents, and female healthcare professionals. With regard to the benefits of family planning, most respondents believe that family planning can also, lead to better upbringing of children, and prove economically beneficial for families. The majority of respondents, regardless of gender, religion, and area of residence, believe that the youth should be educated about sexual and reproductive health. This education, most believe should be provided via community volunteers and CSOs. It was noted that parents, schools, and social media were the most popular means through which respondents received initial information regarding SRH, health, and hygiene. After receiving the initial information, most respondents visited a family welfare clinic and attended meetings by FFWC.

3.5.3 COMMUNITIES' ACCEPTANCE OF FWCS

There is increased awareness about FWCs and people are getting FP services offered there.

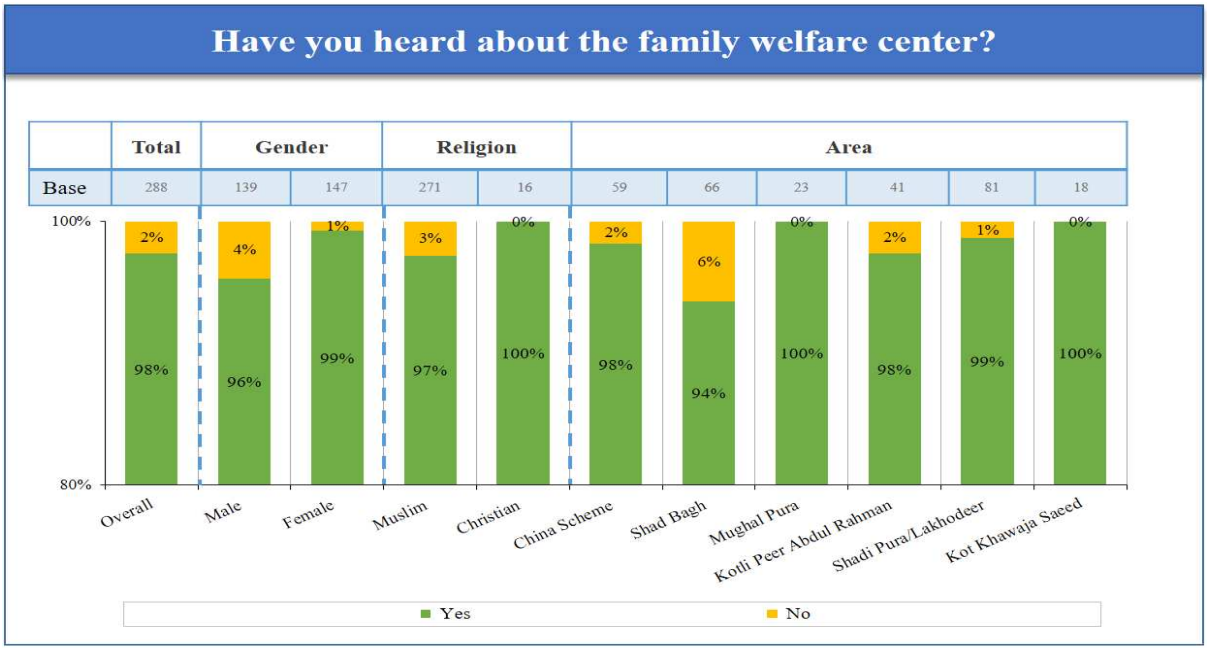


Figure 40: Have you heard about FWC?

The majority of respondents, regardless of gender, religion, and area, have heard about the FWC.

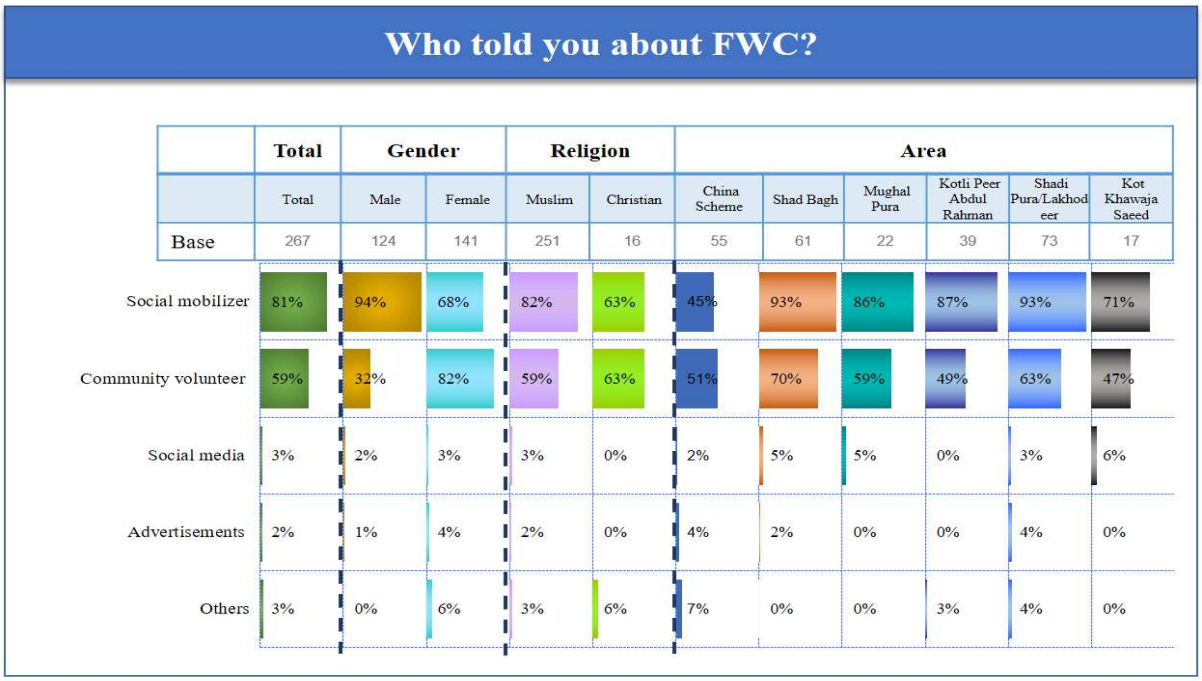


Figure 41: Who told you about FWC?

Most respondents, regardless of gender, religion, and area learned about the FWC through social mobilizers and community volunteers as 81 percent overall chose the former and 59 percent the former.

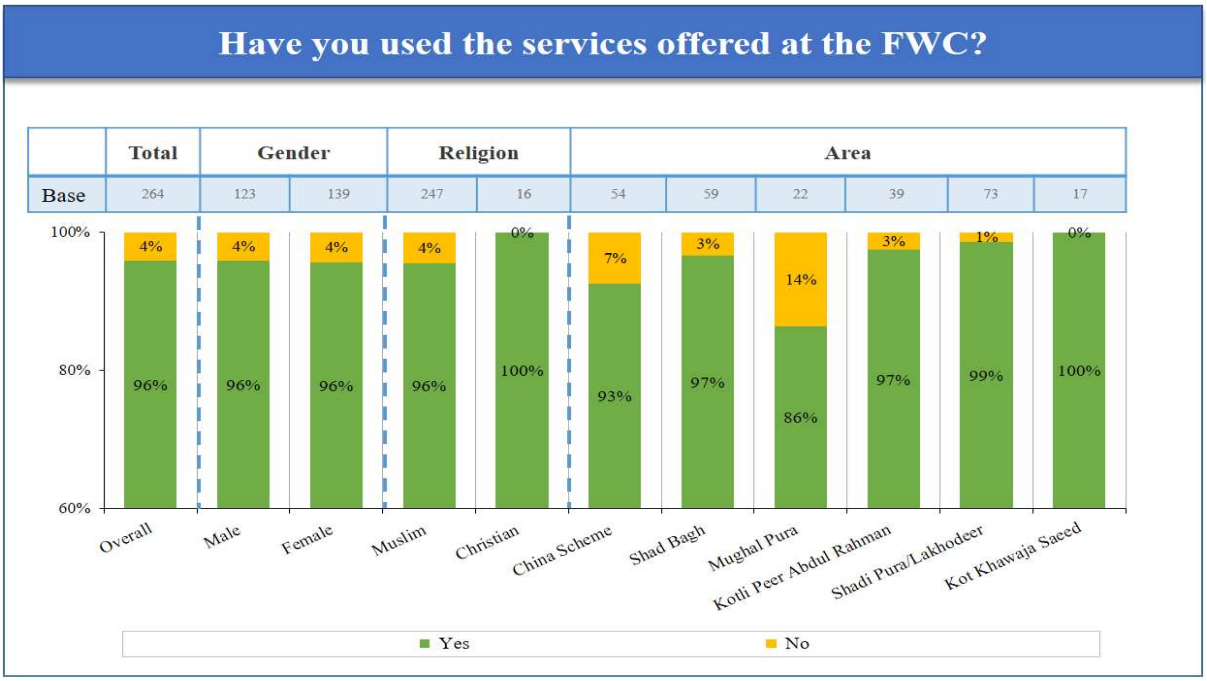


Figure 42: Have you used FR services at FWC?

The majority of respondents (96 percent), regardless of gender, religion, and area have used FWC services.

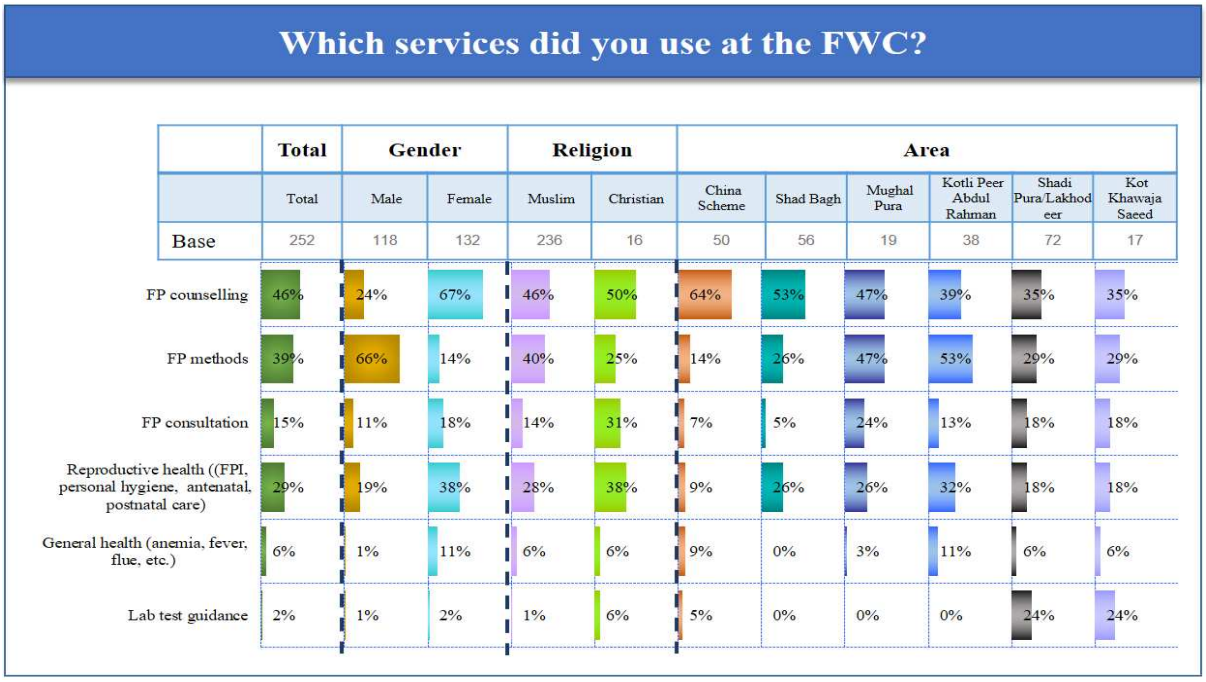


Figure 43: Which services used at FWC?

46 percent respondents overall used the family planning counselling, 39 percent learned family planning methods, 29 percent learned about reproductive and sexual health, and 15 percent used family planning consultation. The majority of men, (66 percent) used FP methods, while the majority of women used FP counselling. Notably, 24 percent respondents of each Shadi Pura and Kot Khawaja Saeed received guidance on pregnancy tests from labs.

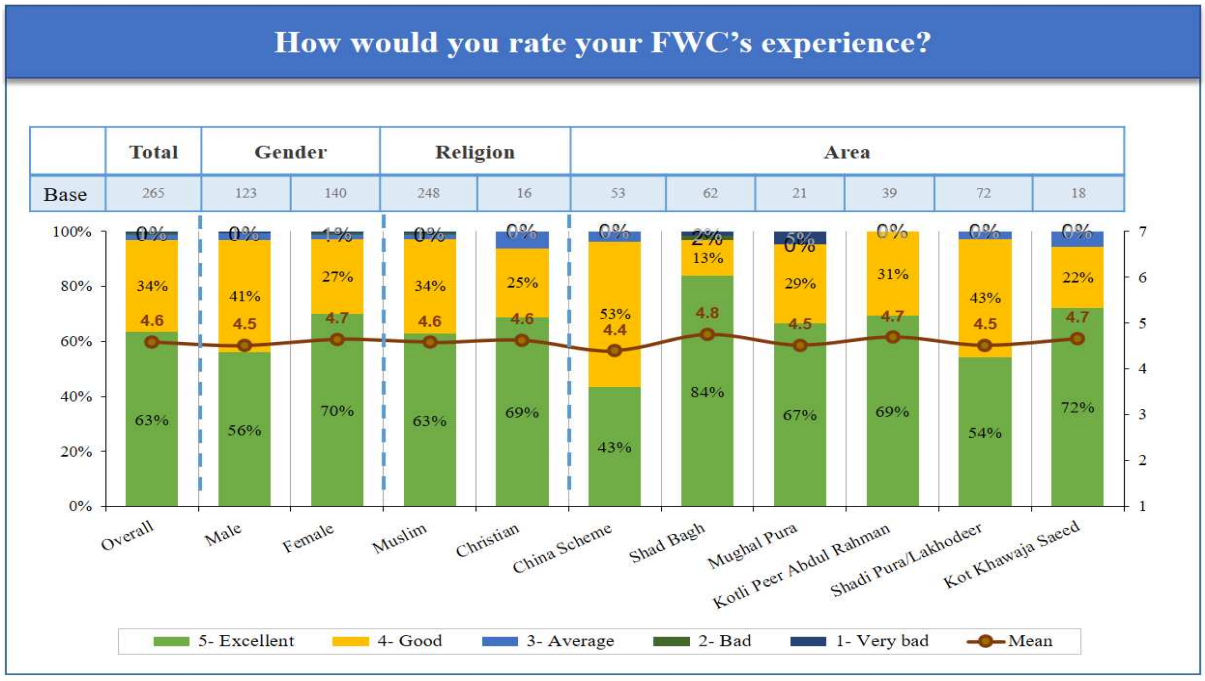


Figure 44: How do you rate your FWC's experience?

Overall, 63 percent respondents rated the FWC experience 4.6 on average. The mean for either genders or religions as well as all the areas hovered around this mean rating.

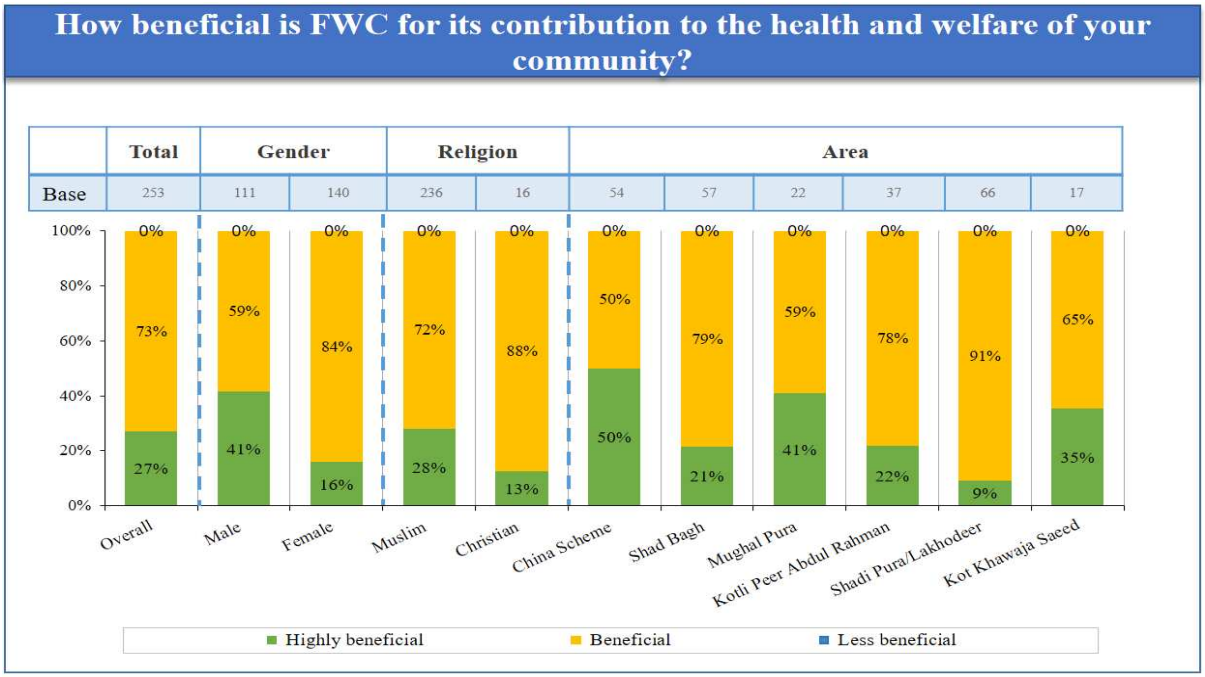


Figure 45: How beneficial is FWC's contribution to health and welfare of the community?

The majority response, 73 percent of the respondents overall, indicates that the FWC was beneficial for the health and welfare of the community.

SUMMARY OF FINDINGS ON FWCS

The majority of respondents, regardless of gender, religion, and area, have heard about the FWC. The same majority of respondents have also visited the center, with the lowest visitation rate observed in Shadi Pura. Most respondents learned about the FWC through social mobilizers and community volunteers. The majority of respondents have in fact used FWC services. The most commonly used services include family planning counselling, family planning methods, reproductive and sexual health, and family planning consultation. Lab testing guidance was also commonly accessed in Shadi Pura and Kot Khawaja Saeed.

Overall, the majority of respondents gave an excellent rating to the FWC. On average, respondents have recommended the FWC to 9.4 persons. Christians recommended fewer people than Muslims. The highest mean was observed in Shad Bagh and the lowest in Kotli Peer Abdul Rahman. The majority response overall indicates that the FWC was beneficial to the health and welfare of the community and that clients are satisfied with the quality and range of services.

3.5.4 ACKNOWLEDGEMENT OF MDM SOCIAL MOBILIZATION

The MDM social mobilization built on reactivation of FFWC-female and formation of FFWC-male is widely acknowledged and appreciated by people living around all centers that were focused upon in this project. Knowledge about and acceptance of FWCs increased as a result of efforts by FFWCs.

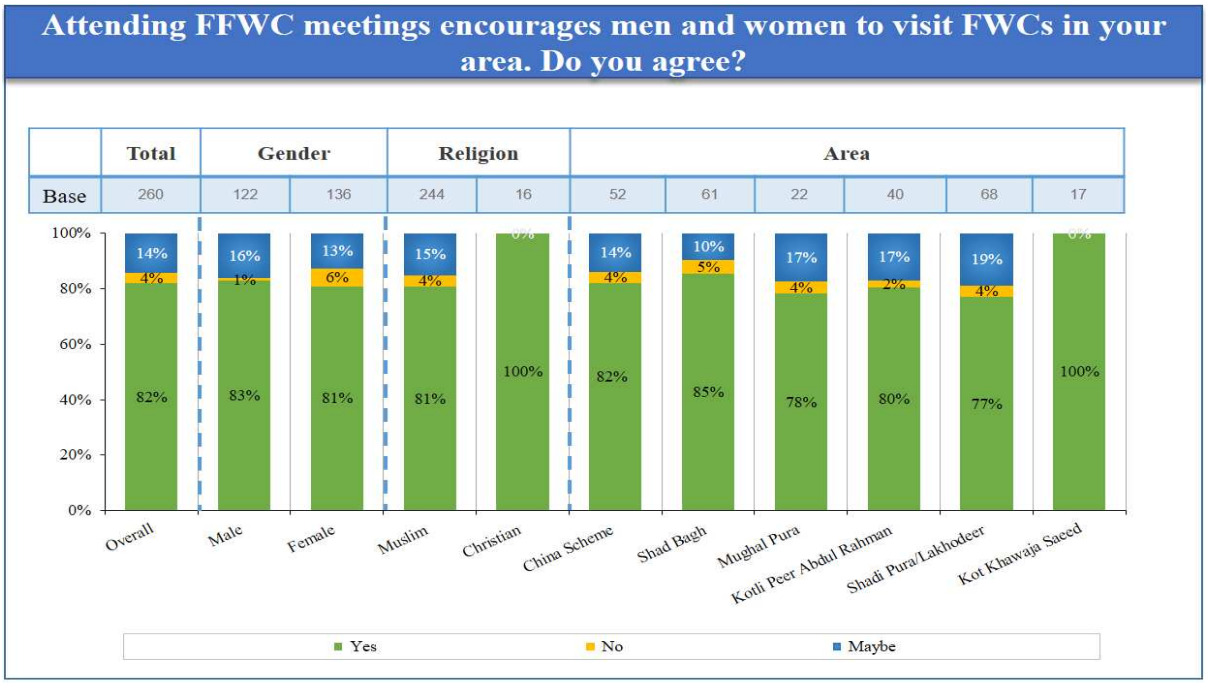


Figure 46: Attending CAS session by FFWC generates encourages men and women to visit FWC. Do you agree?

All respondents, regardless of gender, religion, and area, believe that attending the FFWC meetings does in fact encourage people to visit the family welfare clinic in their area.

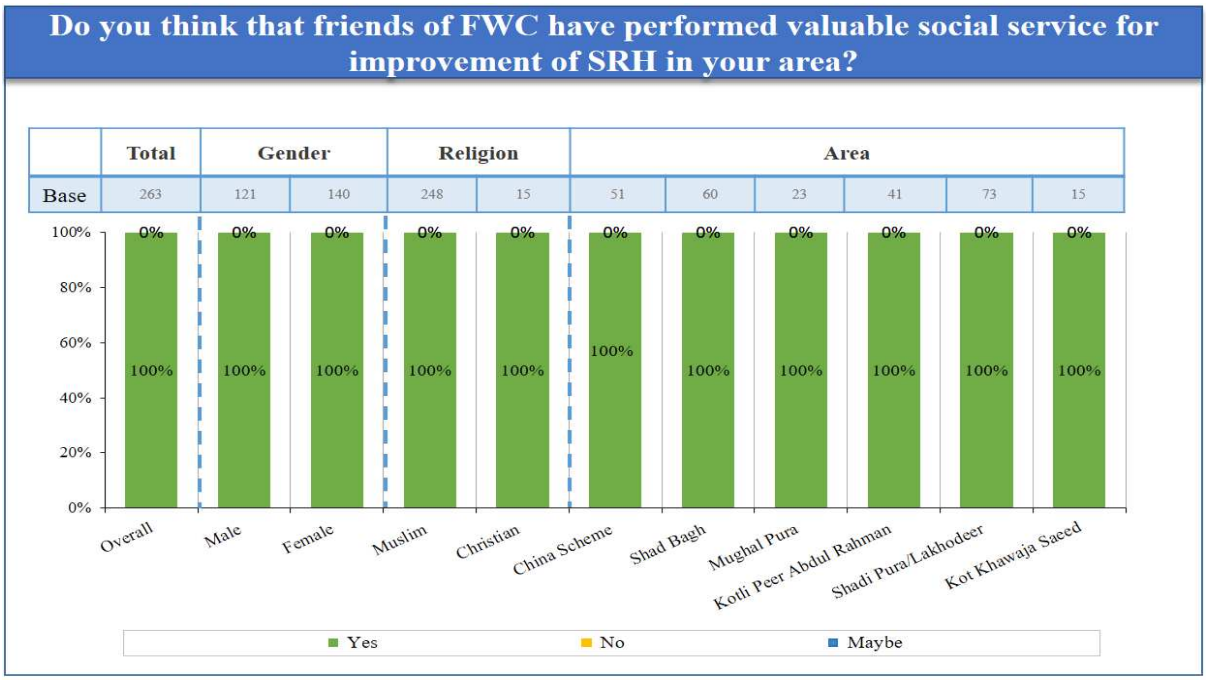


Figure 47: Do you think FFWC have performed valuable service for improvement of SRHR in the community?

All respondents unanimously believe that the FFWCs have performed valuable social services for improving the sexual and reproductive health in their given area. **This indeed is a very significant result that not a single respondent disagreed with the question of the social value of FFWCs.**

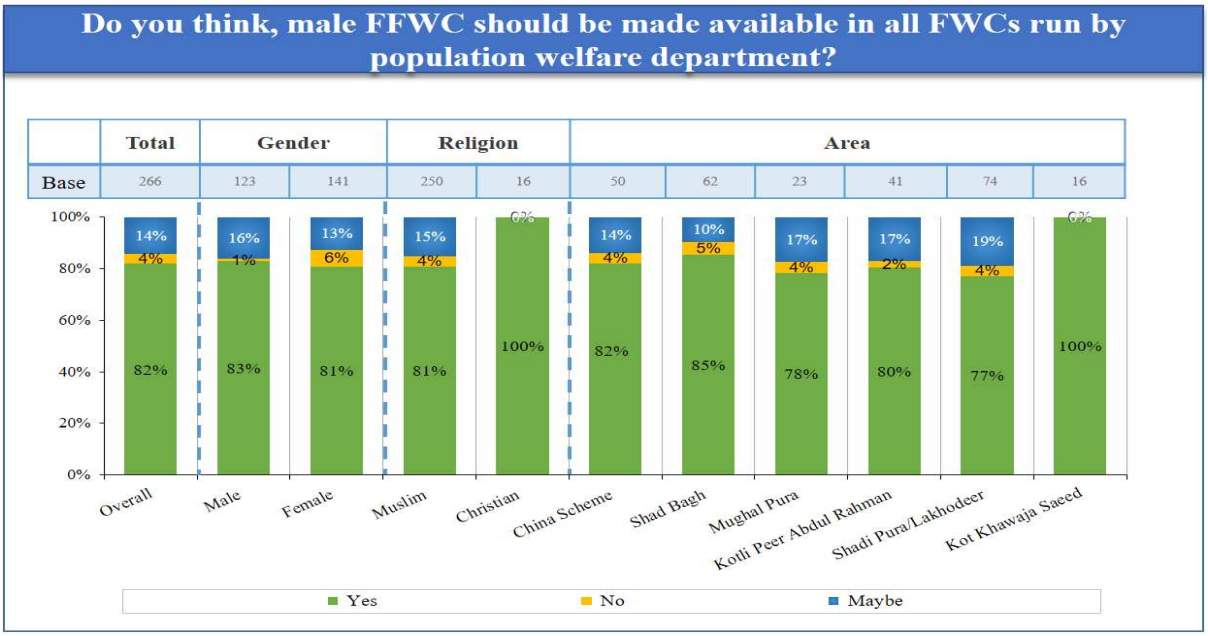


Figure 48: Do you think male FFWC be established at all FWCs run by PWD?

The majority of respondents (82 percent), think that male FFWCs should be present in all family welfare clinics run by the PWD.

SUMMARY OF FINDINGS ON FFWCS

The response for the friends of the family welfare clinic has been positive overall. The majority of respondents know of the FFWC in their area. This was the case regardless of gender, religion, and area. The male respondents are aware predominantly of male FFWCs while female respondents of the female FFWCs. The majority of respondents have attended an awareness session conducted by the FFWC. Notably, 10 percent of China Scheme respondents and 11 percent of Shadi Pura respondents answered in the negative. Overall, most respondents have attended 1 to 5 sessions, with a mean of 4.1. Notably, Kotli Peer Abdul Rahman respondents attended an average of 5.4 sessions, the highest among the areas. Kot Khawaja Saeed respondents attended an average of 2.4 sessions, the lowest mean among the areas.

Of the respondents who did not attend the FFWC sessions, most cited the unsuitability of timing and said that meeting places are quite distant from their residence. The majority of respondents, regardless of gender, religion, and area, did learn something new about sexual and reproductive health. Specific areas of learning include the benefits of family planning; knowledge of family planning and reproductive health; various methods of family planning; myths about family planning and reproductive health; and, misconceptions about the family welfare clinic. Within the aforementioned areas, most respondents learned SRH awareness and its importance, about family planning methods, general information about family planning, about the importance of breastfeeding and birth spacing, about myths and misconceptions, and regarding personal health and hygiene.

With an average of 4.3, the respondents overall rated the FFWC services as ‘good’. Of the respondents who found the FFWC sessions useful, the overall majority invited 9.1 persons to the next session. Men on average invited fewer people than women. China Scheme and Shadi Pura respondents on average invited the least number of people; whereas, Shad Bagh

and Kotli Peer Abdul Rahman respondents invited the greatest number of people. The majority of respondents, regardless of gender, religion, and area, believe that attending the FFWC meetings does in fact encourage people to visit the family welfare clinic in their area. All respondents also unanimously believe that the FFWCs have performed valuable social services for improving the sexual and reproductive health in their given area. The majority of respondents overall, however, think that male FFWC members should be present in all family welfare clinics run by the PWD.

3.5.5 COMMUNITY EXPECTATIONS FOR FUTURE

Learning from their experience at FWCs and from interactions among each other on the topic of FP and SRH, the communities have certain expectations for the future. Respondents also provide some valuable suggestions that MDM and PWD can consider for future programming.

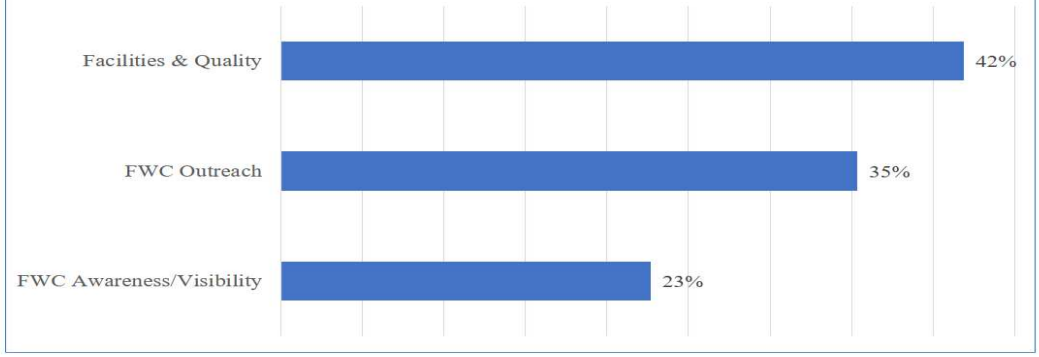
Which of the following method for raising SRH awareness do you recommend for use in future?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	282	138	142	266	16	55	66	23	41	80	17
Community awareness session	90%	94%	86%	89%	100%	87%	83%	91%	85%	98%	100%
Social Media (Facebook, WhatsApp, Instagram & Youtube)	41%	41%	41%	42%	25%	29%	41%	48%	59%	43%	24%
Print media (newspaper magazines, journals)	14%	22%	7%	14%	13%	27%	8%	13%	7%	13%	24%
Electronic media (TV, Radio)	12%	12%	13%	12%	19%	22%	18%	9%	10%	5%	6%
Short message services (SMS)	8%	7%	10%	8%	13%	5%	14%	0%	2%	9%	18%
Others	20%	21%	18%	20%	19%	22%	17%	26%	12%	24%	12%

Overall, 90 percent of respondents believe community awareness sessions should be used for raising SRH awareness, 41 percent suggest social media, 14 percent print media, 12 percent electronic media, 8 percent SMS, and 20 percent suggested other methods.

What are your suggestions for the FWC for improving SRH services

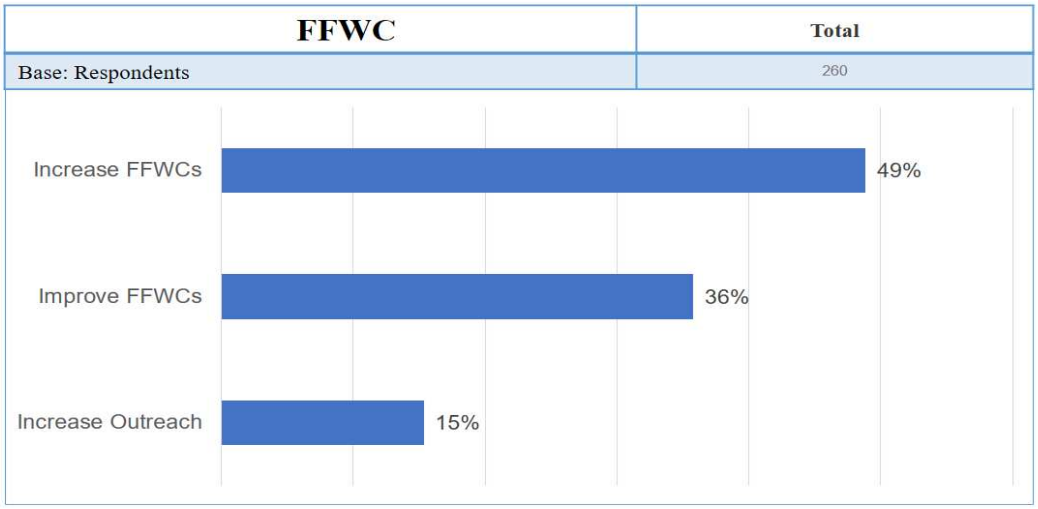
FWC	Total
Base: Respondents	260



Most respondents, 42 percent, suggest improvements in facilities and quality of service, 35 percent suggest FWC outreach expansion, and 23 percent FWC awareness and visibility. Specifically they have given suggestions like:

- Improve the behavior of FWC staff members
- Staff should be cordial
- Use social media
- There should be a contact number provided to help arrive at location, maybe a toll-free helpline for on-phone counselling
- In every locality within a Union Council, there should be FWCs
- Alongside women's health, they should also focus on children's health
- Make health cards for women
- Medicines for children should be at FWC.

What are your suggestions for the FFWC for improving SRH services



49 percent respondents believe the number of FFWC should be increased, 36 percent want to improve the quality of the FFWC, while 15 percent suggest increasing outreach in order to improve SRH services. Respondents have provided some useful suggestions for the FFWCs:

- Enlist more volunteers, and ensure their registration with the government
- The group should get government identification
- Group should receive government identification card
- As per the population, increase the number of FFWC (as per PWD/Health Department criteria)
- Friends should be cordial and should have more experience and knowledge about SRH. They should hold sessions in every street more regularly
- Friends should be cordial and their number should be increased
- New ideas and information should be available to them and to us from them
- Women should be educated about new FP methods
- Conduct more sessions and educate men in the areas

- There must be some "Activity Room" for FFWCs somewhere in the community or at FWC, where we can sit, talk, plan and discuss our meetings.
- If we (FFWCs) have some sort of identification (ID, uniform, etc.) will have better results in our counselling and motivation.

3.5.6 RESULTS AT THE PWD LEVEL

"No other NGO took ownership of the tasks and targets like MDM did. And I have worked with countless NGOs in my 25 years of service with PWD."

"Listen! When MDM commits something to us; it delivers on its promise. There are many who talk; very few who deliver."

From numerous quotes of appreciation, these two sum up the results MDM has been able to achieve at the PWD level. PWD officials acknowledge that "by working with MDM as a partner, our staff capacity has indeed increased…not only in the field but also at the supervisory level." MDM showed to PWD how effective supervision and project execution is done. By working very sincerely MDM has earned respect and recognition at all tiers of its interaction with PWD.

MDM was completely responsive to PWD's emerging needs. The project activities were not like a "straitjacket" for PWD. Whenever, PWD requested, MDM responded to the request and delivered what was asked if the request was aligned with MDM strategy and project objectives, for example, FP table calendar, training manual for Implanon and SRH Bill consultations. That is how MDM built its credibility as a trusted partner of the government. In addition, MDM "never moved out an inch from the areas assigned to it under the MOU with the government." This attribute of MDM is acknowledged by PWD: "we feel like we are working with an extension of PWD…only that MDM is more flexible, is better resourced, has closer knowledge of grassroots and most importantly (it) always operates within the parameters agreed with the government."

One very important achievement by MDM is its contribution to achieving truthful, timely and accurate reports at all FWCs. Prior to the project there used to be a time lag of one-month at least before FWCs reported client data to PWD. There was a practice of over-reporting data to create monthly buffers through which FWC staff used to show their "performance". FWC's performance monitoring mechanism created by MDM recorded data on a weekly basis. Two sources of records were thus created, one at every FWC and one with MDM. Thus in this pilot, MDM established a) how important it is to report accurate data and b) FWC staff can be motivated towards rightful actions.

All these achievements were made possible by a small team working very closely at three levels with PWD on this pilot project. PWD's senior officials acknowledge that performance of FWCs has indeed improved due to partnership with MDM and, more importantly:

a) important lessons have been learned, (e.g., awareness raising is key to demand generation, effective field-level supervision ensures results, training of field must not be neglected, there is huge unmet need for SRH/FP services especially for the youth);
b) new innovation has been made to work, (like men-led support groups, FFWCs, created community ownership of FP and FWC like never before) and

c) some crucial bridgeable gaps have been identified (e.g. need for timely and truthful performance reporting mechanism that provides real-time updates, need for proper branding, and provision of general medicines at FWCs).

At the same time, they also caution MDM, and very rightly so, against the scaling up challenge MDM faces: "It is quite easy and manageable to show results on a small scale…MDM must be given credit for it, no doubt. But how MDM will maintain the same intensity and devotion (as in this pilot) when phase II begins remains to be seen. That will be their biggest challenge."

3.5.7 RESOURCE EFFICIENCY OF THE PROJECT

The key reason MDM was able to keep the level of intensity was that the project team was very properly resourced. In contrast with PWD, which could not recruit full strength of staff at the five FWC and one FHC assigned under the project, MDM operated a fully functional team throughout the duration of the project. In this manner some of the burden because of lack of FWC staff was shouldered by MDM in community mobilization. Overall results of social mobilization when analyzed proved that this activity was very resource-efficient.

Total budget for SM	Total SM activities	Cost per unit
Euros 104,139 **Pak Rupees 17,182,935** **(165 rupees/euro)**	21,978 (CAS plus other activities)	Euros 4.7/activity Or Rs. 782/activity
	Outreach of 200,000+	Euro 0.52 per person reached Or Rs. 86 per person reached.

Table 18: Cost efficiency of social mobilization

As per the project design, MDM should have trained 10-12 FWC counsellors (two from each center). It trained 40+, which contributed to enhancing other FWCs under PWD as well. From this angle, the capacity building was also quite efficient. However, OJT from a qualified doctor is an intensive activity. It can be done well for a small number of FWC counsellors with less budget for an extended period. If and when scaled up, OJT may require heavy budgets.

Overall the line allocation of total budget was found to be within reasonable range on which international NGOs operate: admin and communication cost was 10 percent, international staff 2.7 percent, logistics & transport 3.5 percent of the total cost. National staff constitutes 71 percent and direct program cost was 12 percent of the total budget. From the program budget perspective, the project is cost efficient: MDM spent 444 euros or 73,262[39] rupees per month per center. However when the total budget is taken into consideration, the project cost efficiency rapidly declines mainly because of the national staff cost allocation of 71 percent.

3.6 RESULTS FOR MDM, IMPACT AND SUSTAINABILITY

The very nature of MDM intervention was that it was a pilot project which sought to establish that its design works: male-led community mobilization promotes acceptance of FP and SRH services delivered at FWCs. Capacity building enhances QOS and in turn user

[39] 1 euro = 165 rupees

satisfaction. Sustainability of any pilot lies in the fact that it is accepted for scaling up, in which it is further proved that the intention model that worked well at smaller scale can also produce results across larger space.

MDM's intervention has left behind social institutions, FFWCs, run by volunteers, who are willing to continue promoting FP and supporting FWCs in their communities, which have an unmet need and are increasingly accepting the importance of SRH counselling and guidance for the younger generation. PWD values MDM as a trusted partner that can be relied upon because of its delivery, commitment and compliance with regulations. PWD has confidence in MDM's grassroots approach, which no one else is undertaking. These are the ingredients of sustainability on which scaling-up can take place.

4. CONCLUSION AND RECOMMENDATIONS

MDM has created high impact at a limited scale and its intervention model stands proven. It now has increased its knowledge of context and the SRH sector in Pakistan, while meeting or exceeding all the targets of FP2020-CPROP

MDM's target, in the pilot project was to	MDM ...
Train 174 counsellors, trainers, volunteers	**Trained 240+**
Reactivate 5 FFWCs-female	**Achieved 100 percent**
Form 5 FFWCs-male	**Achieved 100 percent**
Enable all FWCs towards providing at least three modern FP methods and emergency contraception	**Achieved 100 percent**
% of FP consultation in line with quality criteria (information on different available method, information on potential side effects and related actions and respect of confidentiality) Target: 90 percent	**92 percent**
Show user satisfaction of 80%	**Showed 81 percent**
Raise awareness of 19,440 people	**Reached 21, 978 participants in all activities**
Have 70 percent gain in knowledge gain through awareness sessions (conducted by FWC staffs in communities) presenting access to contraception with the right/choice lens (information on different method of FP, on services available free of charge, FP as a birth spacing method and a right for individual)	**Achieved 77 percent**
Generate 3060 additional FP users for FWCs	**Generated 3210 users from August-18 to Feb. 2020[40], which is 105% the target. In addition there is 34% increase in monthly average of additional users**
Identify 3 CSOs and provincial SRHR actors with whom common advocacy SRHR objectives are agreed upon.	**Not only identified but extensively worked with more than 4.**

Table 19: Summary of project achievements versus targets

In addition to success in targets achievement, the project also yielded other valuable accomplishments like gaining PWD's trust, communities' confidence, and respect from CSOs and stakeholders. Apart from winning PWD's trust, the project has provided PWD low-cost solutions that can be adopted to improve demand generation for wider FWC network across Punjab. Such solutions are a direct outcome of this pilot project, like proven effectiveness of male-led support groups, payoff from training of FWAs and FFWC members in terms of greater community awareness and mobilization and usefulness of branding, sign-posts and accurate IEC material for generating traffic to FWC.

Project design was tuned to meeting communities' unmet FP needs and its activities were well aligned to the strategic objectives. All stakeholders acknowledge that SRH education is a must and, more importantly, the overall environment is becoming conducive for work in the field of SRH and FP.

[40] Additional users for March 2020 not included.

Project activities resulted in greater acceptance of FP, reduced stigmas attached to FWCs, generated demand, increased flow of users, both male and female to FWCs and enhanced quality of service delivered at FWCs. MDM's theory of change stands proven, especially the component related to male-led mobilization; it is a true social innovation well executed under the project. Success in capacity building and social mobilization were achieved as intended.

Success in the advocacy part of the project was not intended and planned as such but was achieved nevertheless. It has now given MDM much-needed recognition but it still has to go a long way before MDM is truly acknowledged as an effective advocacy organization in the field of SRH like UNFPA, FPAP etc.

Overall the project is a success and MDM's drivers of success can be summarized as:

1) Responsiveness to PWD needs and working very cooperatively with government
2) Adaptive and active management
3) Social mobilization approach, especially the innovation of male-led FFWCs
4) Focusing on improved service delivery at the grassroots
5) Capacity building that encompassed counsellors, field staff and support groups
6) Delivering as per commitment
7) Being open in giving credit to all those who MDM worked with in advocacy, and
8) Community trust and confidence.

MDM can ride on the success of FP2020-CPROP. But it needs to be cognizant of…
Scalability challenge: MDM will face the challenge of organizational capacity as it scales up from 6 FWCs in one small area to over 40 all across Lahore. MDM's capacity building and social mobilization capacities have indeed been strengthened under the pilot. But its staff competencies and systems capacities need to be increased massively to deal with multi-layered complexities that will arise while handling over 40 FWCs in diverse communities having different expectations. PWD's field staff, coordination team and management expectations will further add to complexities. MDM needs to be reminded that 'organizations focus on making their pilots more workable rather than scalable.'[41] This is because many pilots are usually designed with scaling as the last thing in mind, because perhaps the extent of scaling-up is not entirely known. The team's primary concern remains focused on making the pilot work and it is assumed that what works as a pilot would automatically work when the pilot of scaled up.

Recognition challenge: Under the project MDM dabbled into advocacy and proved its mettle, although it is still not recognized as reputed an advocacy organization known for its distinguishable contribution in this field.

Risk mitigation challenge: SRHR and FP is a sensitive topic in Pakistan. Scaling up will make MDM more visible, which means more risks and higher potential of inviting negative media attention.

Adaption challenge: Closely linked to the scalability challenge are the adaptation issues that might need to be resolved with PWD. The project has yielded several best practices that can be adapted by PWD and implemented across its entire network of FWCs for a system-wide

[41] Pilot Pathology, Schrage, Michael p.48, https://books.google.com.pk/

improvement. Large-scale adaptation requires bigger commitment for change from people affected by it. PWD, like all government bureaucracies, would likely resist adapting lessons learned on a wider scale. What works in a pilot often fails when its practices are adopted on a wider scale.

4.1 LESSONS LEARNED AND SUGGESTIONS FOR IMPROVEMENT FUTURE INTERVENTIONS

Lessons learned and actionable recommendations arising from this evaluation for PWD and MDM are as follows:

4.1.1 POSITIVE SPILL-OVERS FOR PWD

Successful completion of FP2020-CPROP offers an opportunity for PWD to improve its functioning and service delivery across its wider network of FWCs. The following recommendations can be put forth for PWD:

1. Put as much emphasis on training of FWAs as is given to capacity building of counsellors. FWAs are on the frontline of demand generation; the better trained they are, the more demand they can be expected to generate for their FWCs. Their skill-building in effective social mobilization and on-going refreshers will not only equips them professionally but will also motivate them personally.
2. Replicate male-led support groups and create a non-monetary reward and recognition system for all FFWCs based on their contribution to promotion of FP in their communities. There is a well-established practice of FFWC-Female for the FWC network. Adding FFWC-Male is just an extension of the existing practice. However, the support groups need to be continuously kept engaged and motivated as was done in this pilot. Capacity building of FFWC members is also required and can be handled at PWD's training institute.
3. Update centers' location information and, directional signs for simple but uniformly branded centers.
4. Provide sanctioned staff strength at each center before expecting performance for a well-resourced center does deliver results. This staffing challenge, already known to PWD, stands highlighted once again.
5. Install timely, truthful and technology-enabled FWC performance reporting system.

These are easily implemented recommendations as they fall within available resources and means at the disposal of PWD.

4.1.2 RECOMMENDATIONS FOR MDM

PROJECT DESIGN & MANAGEMENT

- MDM must conduct a thorough baseline survey and monitor its performance regularly against the baseline. The qualitative TNA it used is ill-suited for large-scale adoption. MDM has very useful assessment templates which should be further tailored based on the experience gained in this pilot.

- MDM may also consider implementing an FP tracker, which is a tool-based way of continuously measuring the changes in service consumption over time, both in terms of users' usage of it and what they think about it.
- MDM's current indicators were good for the purpose; they may not work very well for a large project that is expected to prove results to experts in the field. MDM is thus advised to have a very robust and well-knit results framework which measures performance along well-recognized indicators like CYP, FPC and CPR.
- Risk mitigation must be built into the program design. It can be taken "as given" that working of SRHR will invite unexpected backlash. A communication expert or public relation agency may be hired.
- Efforts to de-stigmatize family planning should be bolstered, addressing cultural and religious concerns, and highlighting the plethora of benefits of family planning methods.
- General awareness outreach should be expanded to schools and community centers, as a significant portion of the population get their initial information regarding SRH and family planning from these sources.
- Formal referral mechanism may be created between FFWC and FWC to exactly know how many clients are coming from which member of FFWC.
- Provision for supply of general medicines should be made as they attract users to the centers. MDM in the pilot phase supplied equipment and job-aids, which improved QOS at FWCs. It may devise a mechanism for general medicines as well.
- Behavioral improvement is demanded of FWC staff and FFWCs. Similarly, FFWCs need to be made aware of gender issues so that they understand the issues of equality in access to health. The scope of training and capacity building may be increased to cover all such topics.
- Build on the evidence of MDM's programming success, including both social innovation and program result data, for evidence-based research and reporting and for advocacy. Given the scale and duration of the proposed long-term project, it will be useful to develop a results-based program framework.

PARTNERSHIP AND NETWORK BUILDING

- Social mobilization, on-field execution and relationship management with PWD are widely accepted core strengths of MDM. To a lesser degree the capacity building competence of MDM is also acknowledged while advocacy is definitely not. As it scales up the pilot, MDM must decide which aspects of the program it should handle itself because they fall within its core expertise and in which aspects it wants to leverage expertise of others. All such functions like capacity building, advocacy and research, M&E may be outsourced to partner organizations with core expertise in such functions.
- In the next phase, the project is to be scaled up by 6-7 times (40+ FWCs in Lahore). This expansion will result in wider interaction with PWD staff at the field, district and provincial levels. MDM is advised to garner a stronger commitment from PWD at all levels. Crafting a common vision for the next phase, mutually setting performance expectations and strengthening joint monitoring and oversight mechanisms could be the means of achieving PWD's ownership and commitment at all levels of interaction. MDM could also consider crafting a role for the Health Department in the next phase.
- Advocacy, especially in the field of SRH and FP, is not MDM's core strength; it may consider collaborating with reputed partners like UNFPA, FPAP and let them take

lead. In so doing MDM can increase the efficacy of advocacy with empirical evidence from on-ground practice.

USE AND INTEGRATION OF TECHNOLOGY

- Community enjoys a decent level of access to social media and has even recommended it to MDM as a means of reaching out. Similarly, current practice of manual data collection will likely break down when used for 40 centers across Lahore. This requires MDM to think of integrating information technology across all its functions and for service delivery as well. ***Well-integrated technology can help small teams deliver big results***.
- An Android-based reporting app should be developed backed with cloud computing (Android-based because it is the most common and most widely-used open-source platform and cloud-computing because it is the cutting edge low-cost as it does not require investment in IT hardware and servers that run hassle-free 24/7).
- Video clips of 3-5 minutes duration can be made and used for training and informing.

BRAND BUILDING, VISIBILITY AND EVIDENCE-BASED ADVOCACY

- This pilot has generated evidence for MDM's programming success, especially regarding social innovation of FFWC-male. This success story can be used further for MDM's visibility and brand promotion. Program result data can be used for evidence-based research and reporting.

If MDM truly prepares itself for meeting the challenges ahead, chooses the right partners, creates technology-based systems, trains staff accordingly, builds on its result-producing male-led social mobilization, and keeps on working closely with PWD as transparently as it has so far and strengthens relations with advocacy partners, the phase II of the project will be an even better success. MDM will thus make a bigger contribution to "the Achievement of FP2020 Contraceptive Prevalence Rate Objectives of Pakistan, in Punjab Province."

ANNEXES

Annex-1

Terms of Reference

DOCTORS OF THE WORLD – FRANCE

EVALUATION TERMS OF REFERENCE TEMPLATE

PROJECT TITLE: To contribute to the achievement of FP2020 Contraceptive Prevalence Rate objectives of Pakistan, in Punjab province
COUNTRY: Pakistan
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CONTEXT

ORIGINS OF REQUEST

Medecins-du-Monde (MdM) is present in Punjab since 1996 and has implemented several programs on mother and child health, sexual and reproductive health (SRH) and gender based violence (GBV). In 2017 MdM started implementing a pilot project in Lahore in partnership with the Population Welfare Department (PWD) of Punjab, to improve the quality of the family planning (FP) services for vulnerable communities and empower them to raise their voice and access their SRH rights (SRHR). The intervention proposed to build the capacity of the public institution for FP, which is PWD, MdM partner, while raising awareness in the communities and creating community-led support groups. The third component of the project is advocacy, which the objectives for this pilot phase was to identify the SRHR actors and relevant subjects for further strategy.

This evaluation is meant to draw the lessons of the pilot phase experience in order to improve the approach developed for the next phases of the project. Indeed, this 2-years pilot is followed by a 5-years project (Phase II and III) in which the approach developed will be scaled-up in Lahore (Phase II) and PWD will be capacitated to replicate it in the other districts of the Province (Phase III).

BRIEF INTRODUCTION TO THE PROJECT

The general objective of MdM project is to contribute to the achievement of FP2020 related to the Contractive Prevalence Rate (CPR) objectives of the Government of Pakistan[1], in Punjab province, and specifically to improve the response of family planning needs within the targeted communities of the District of Lahore.

MdM designed and implemented this 2 years project in partnership with the Punjab Population Welfare Department (PWD) in 6 centers: 1 Family Health Clinic (FHC) and 5 Family Welfare Centers (FWC). The project started in November 2017, although due to administrative challenges, MdM started the activities implementation in Lahore in June 2018. The total project cost is of 600,000 euros over 2 years, and is partially funded by the French Development Agency (AFD) and by MdM. The project and ends in March 2020.

Through its three main components, this FP project is a pilot aiming:

1. To address the demand side of FP with an innovative community mobilization strategy;

Social mobilization component: MdM raises awareness in the communities on SRH and FP by conducting sessions and organizing social mobilization activities in order to provide accurate information on FP and modern methods and eliminate misconceptions on FP, creating community-led volunteer support groups for men and women, called Friends of Family Welfare Centers (FFWC), developing their structural link with the centers and empowering them to exercise their SRH rights in their community;

[1] FP2020 CPR objectives of Pakistan are : 1- Achieve universal access to reproductive health by 2020/ 2- Raise CPR to 55 percent by 2020

2. To improve the supply side by providing technical support to PWD and building their capacity in order to ensure access to quality family planning services;

Capacity building of PWD: within the framework of this project, MdM technical support to PWD concerns in particular the counselling on FP capacities of PWD staff (assessment and update the SOPs and tools for counselling on FP, including supporting PWD in developing and implementing their strategy on couple counselling, organization of trainings for their staff, provide on-job coaching on counselling and training manual on counselling and implanon;

3. To analyse the advocacy environment related to SRHR in Punjab and to identify opportunities for MdM to be carried out in the next phases.

Advocacy: during this pilot phase MdM liaised with the active SRHR stakeholders in Punjab. During this pilot phase MdM cease the opportunity given by PWD to draft the Punjab SRH Bill on behalf of PWD. This opportunity has given a good exposure to MdM in the SRHR landscape in Punjab and drove the design of MdM advocacy strategy for the coming years.

This pilot phase has received a positive response from the targeted communities as well as from PWD with which MdM has developed a strong partnership. MdM intends to scale-up this tested approach at a larger scale in Lahore (Phase II, 3 years, tentatively 2020-2022) and provide the technical support to PWD and capacitate them to replicate this approach in the other districts of Punjab.

EVALUATION OBJECTIVES AND TARGET READERSHIP

EVALUATION OBJECTIVES

The main objective of this evaluation is to assess the approach to family planning and more globally SRH in Punjab implemented by MdM with PWD in the pilot phase. The aim is “learning”, it is expected from the evaluation some analysis, conclusions and recommendations allowing to draw lessons learned to improve, scale-up and replicate of this approach in Punjab. The specific objectives of the evaluation are:

- To assess the field and right-based approach developed by MdM in partnership with PWD to 1) generate demand for modern family planning methods in the targeted communities and 2) to respond to the needs of SRH and FP of the communities in the targeted areas;
- To evaluate PWD perception, capacity and willingness at the different level (field, district and provincial office) toward MdM and project aim and approach, and assess the opportunities and challenges in terms of ownership by PWD and sustainability of the approach after the project completion;
- To draw recommendations for the following scale-up and replication phases in terms of sustainability of the approach

EVALUATION SCOPE

The evaluation covers:

- The 6 PWD centers and their catchment area targeted in the pilot phase (1 Family Health Clinic and 5 Family Welfare Centers; Lahore District);
- The 3 component of the project: social mobilization, capacity building of the partner and advocacy;
- The project implementation period from June 2018 to March 2020;

EVALUATION USERS

The results of this evaluation will be communicated to and used by:

- MdM mission in Pakistan and HQ: to feed the SRH programing in Punjab and improve MdM approach for the scale-up and replication phases, as well as to document this experience and disseminate the lessons learnt in other MdM missions;
- The partners in the field: the Punjab PWD, Depatment of Health and other SRHR actors, in order to promote ownership of MdM approach and its replication;
- The project donor, AFD – Agence Francaise de Developpement, as the evaluation is a contractual requirement;

Possibly, some results from the evaluation could be shared with NGOs and Civil Society Organizations (CSOs) in Punjab or other provinces in Pakistan, if it is deemed relevant. They will also be used to give feedback to the supported communities, throuhg the Friends of the Family Welfare Center.

EVALUATION CRITERIA

Relevance

1- Is MdM approach, designed through and with PWD, relevant to address the targeted populations' identified needs in terms of SRHR and FP?
2- Did the project's the target group (married women and men of the reproductive age group) was the most relevant regarding the issues identified and considering the cultural context?
3- How has the program strengthened the capacity of PWD? Does the capacity building activities designed and conducted in the pilot phase for PWD staff answer the needs and gaps identified in terms of quality of services?
4- ,
5- What is the level of coherence of the program regarding Governement of Pakistan and more specifically Punjab PWD priorities, and where does MdM stand regarding the other partnerships of PWD in Punjab?
6- To what extend the program helped to build the capacity of woman and men to be active and influential as decision making regarding FP and sexual and reproductive health??
7- Was the work done by MdM on the SRH bill and pre-marital counselling manual (that came during the project implementation) relevant as per the project objectives? How has it impacted MdM partnership with PWD?

Effectiveness

1- Assess the effectivness of MdM social mobilizaion activities for the overall goal of the project. Answer should give a perspective per gender and age group.
   a. Have the targeted communities increased knowledge about their SRH rights, about FP benefits and methods and the services available?
   b. Are the communities empowered to organize themselves, raise their voice and pursue social mobilisation around FP after MdM project completion?
2- Was the HR set-up of the program team effective to achieve the project objectives? Analyze the share between social mobilization, capacity building and advocacy.

Sustainability/Connectedness

The pilot phase will be followed by Phase II and III where MdM will focus on capacity building and development of a sustainable system of supervision and monitoring, in order to ensure that PWD will be able to pursue the activities. Although assessing sustainability at this stage will not be relevant, we want to assess the following:

1- To what extent PWD took owership of the project at the different level of the organization, at the field, district and provincial level? Is PWD willing to replicate MdM approach at a broader level in Punjab Province?
2- Does PWD has the capacity to sustain the appraoch in the future, considering their resources (human and financial) as well as their existing set-up? Is the improved quality of services provided sustainable?
3- What are the main challenges that may prove difficult in implementing MdM pilot phase approach to PWD's existing setup?
4- To what extent the social mobilization model developed and implemented in the community is sustainable?

Efficiency

1- Is the partnership with PWD a cost-effective approach to address FP needs in the targeted communities?
2- Is the project HR structure efficient to achieve the community mobilization and empowerment objective? The capacity building and quality of care objective?
3- Are the social mobilization activities cost-effective?;
4- Considering the organizational expertize of MdM, its experience in the local context and its reputation in Punjab, is the partnership approach implemented efficient to ensure a sustainable improvement in the FP services?
5- What is the cost of the project per beneficiary? Is it considered cost-effective as per international standards in FP?
6- Were the project's resources (financial and HR) used in the best way to attain the results?

Impact

1- Has the quality of the FP services provided improved in the targeted centers whitin the project lifetime? To what extent the coordination work of MdM with PWD and the partnership developed during the pilot phase has contributed to the improvement of the quality of the services provided?
2- What is the impact of the the project on the unmet FP needs in the community?
3- Has the project empower the communities regarding their SRHR rights? Provide analysis per gender and age groups.
4- What is the impact of the support group/Friends of Family Welfare Center (FFWC) in terms of empowerment in the communities? Provide analysis per gender and age groups.
5- What is the opinion of targeted communities, beneficiaries of the project (both FP users and PWD staff members), and PWD managerial staff of the project, its design, activities and implementation?
6- Was the advocacy objective able to achieve its desired result (linking up with SRHR actors, creation/joining of SRHR alliance or forum, contribution in promotion of SRH rights etc.)?
7- What is the impact of the project on gender in the communities, in terms of transforming gender relations on SRH matter? On empowerment and co-empowerment of partners?

Impact refers to the effects an intervention has on its environment in the broadest sense - technical, economic, social, financial, etc. These are the long-term, positive and negative, expected and unexpected effects brought about directly or indirectly, intentionally or unintentionally, by the project. For example: Has the project improved health? Has it reduced child mortality? Has the project had an impact on the role of women in society?

ADDITIONAL USEFUL CRITERIA

Partnership with PWD:

1- Does PWD and MdM have a shared vision of the project's objectives?

2- How efficient was the collaboration between MdM and PWD regarding the design and implementation of the project?
3- What is the level and type of involvement in the project and partnership of both organisations?
4- How are the roles, activities and resources distributed between the partners?
5- How do the skills and resources of each partner complement each other?
6- Is the relation between PWD and MdM transparent? What are the communication channel in place? Will they insure a sustainable relation?

Coverage and equity:

- Does the project address the specific needs and strategic interests of girls and boys, men and woman in terms of SRH?
- Has the project addressed sexuality as a bio-psychosocial concept, crossed by gender?

PREFERRED METHODOLOGIES

QUANTITATIVE/QUALITATIVE METHODS

Both quantitative and qualitative methods are expected. The consultant will propose a methodology along with the tools that will be reviewed and approved by the Steering committee of the evaluation during the inception phase that will be held before the start of the data collection and field work.

KEY DOCUMENTS

During the briefing a detailed list of key documents will be provided to the selected consultant (maximum 10 documents, up to 80 pages each).

KEY PERSONS/INSTITUTIONS

To conduct this evaluation, MdM expects the candidate to interview the beneficiaries, the members of the support groups, MdM staff, PWD staff at the field, district and provincial level, and CSOs involved in the draft of the SRH Bill.
During the briefing a detailed list of these people and institutions will be provided to the selected consultant, who will be able to propose additional interviewees.

STEERING COMMITTEE

The steering committee is composed of the Medical Referent (HQ), the General Coordinator (Mission), the Deputy General Coordinator (Mission), the Medical Coordinator (mission), the project Manager (mission), as well as a PWD representative as observant.

The role of the steering committee is to: Validate the evaluation timetable, Validate the Terms of Reference, Select the evaluation team, take part in the briefing/inception meeting with the evaluator, read and comment on the provisional final report and then the definitive version of the final report; Complete the 'Evaluation Feedback' form; Play an active part in disseminating the evaluation deliverables and conclusions (phase 9); Follow-up on implementing the recommendations (phase 10).

The steering committee will provide the necessary guidance and support to the consultants to insure that the objectives of the evaluation are understood and fulfil.

TIMETABLE

Specify the period during which the evaluation can and must be carried out: possible start date; latest date for submitting the final report; period during which the fieldwork phase can take place, depending on the availability of interlocutors (elections, annual leave and public holidays), and the accessibility of sites (rainy season and harvests); dates envisaged for presenting the findings, etc.

The evaluation should be conducted between December 2019 and March 2020.

Preparation or inception phase *Document review and briefings*	Draft of inception report by: 20th of December Validation of inception report by: 27th of December 2019
Preparation of the tools	December 27th ,2019: 1st draft of the tools for NOC application January 17th, 2020: final tools *MdM will apply for NOC on the 30th of December upon validation of the first draft of the tools*
Fieldwork phase Data collection	15 days, between January and February 2020 *After testing the tools and receiving NOC approval*
Analysis, initial findings presentation and first draft of Evaluation Report	February; first draft by 29th of February 2020
Evaluation report Finalized and composed (printable format)	10th of March 2020
Findings restitution	By 31st of March 2020 (workshop in Lahore or Islamabad)

The activity schedule is for guidance and is liable to be modified at any time, depending on the context and on the security situation in particular.

EXPECTED DELIVERABLES AND PRESENTATION OF FINDINGS

DELIVERABLES

1. **Inception report:** at the end of the preparatory phase, this report will be produced by the consultant and submitted to the steering committee for feedback and approval, before the beginning of the evaluation. The inception report should state the objectives of the evaluation and propose a methodology, including the work plan and tools that will be used.

2. **Preliminary results:** following the fieldwork phase, the preliminary results of the evaluation will be presented in the form of a word document and a power point (or other type of presentation) and shared to the project team as well as with the steering committee for presentation, discussion and recommendation in preparation of the final report.

3. **Final report:**
   a. A **provisional final report** will be produced and share with the steering committee for review and feedback.
   b. The **definitive final report** should include these comments, feedback and discussion.

   Several versions of the final report may be exchanged between the consultant and MdM steering committee, as well as various exchanges and discussions may take place before validation of the definitive final report by MdM.

The main body of the evaluation report (the final report) must run to between 40 and 50 pages, excluding annexes, be submitted in Word, 12-point font and single spacing, and must include the following:

- Executive summary (maximum of 5 pages)

- Introduction
- List of acronyms
- Context (description of the project)
- Evaluation objectives and chosen criteria
- Methodology and limitations
- Principal results and analysis
- Conclusions and recommendations (presented according to evaluation criteria)
- Completed recommendations follow-up sheet
- Annexes: ToR, list of persons met and timetable, questionnaires, interview guides, observation grids, etc.

4. **Abridged version** of the report for distribution to stakeholder: this will present a summary of the evaluation context, findings and recommendations, and will be submitted by the consultant based on the definitive final report, to MdM committee for feedback and approval. This version should be no longer than 5 pages, submitted in word, 12-point font and single spacing

PRESENTATION OF FINDINGS

The restitution of the results will be organised as following:

- Facilitated workshop (1/2 day) at the field and/or coordination office with the team members and the partners of the project (PWD and other CSOs)

Specify the number of sessions envisaged to present the findings (e.g. in the field, at head office, at Executive Committee and donor meetings) and the desired format (e.g. formal presentations, facilitated workshop, etc.). Specify the timetable for reporting-back sessions, with some potentially taking place several weeks or months after submission of the evaluation report.

ORGANISING THE EVALUATION

LOGISTICS AND ADMINISTRATION

Equipment

An office space and a printer can be made available to the consultant in MdM Lahore office in Punjab, for the duration of the field-based assessment only. *Specify the types of equipment available to the evaluation (computers, printers, emergency cases, PEP kit, vehicles, etc.)*

Means of communication

The consultant should have its own means of communication. An internet connection can be provided in MdM Lahore office in Punjab for the duration of the field-based assessment only *Specify the different means of communication available to the evaluation (Internet, mobiles, Thurayas, HF, video-projector, tape recorder, camera, etc.).*

Travel/Accommodation

The consultant will be responsible for arranging its own travel to and from Pakistan / Lahore.
MdM can support the consultant's field work with one car / driver (who knows the various project locations and partners location). The cost will be charged to the consultant. *Specify the different means of transport used for travelling around and the rules which apply (e.g. vehicles travelling in a group, etc.)*

Administrative formalities

The consultant must be able to obtain him/herself the necessary visa for Pakistan, if need be. MdM can assist in the case of a French national or Resident in France only.

NoC will be obtained by MdM prior to the field assessment. *Specify the procedures for obtaining visas, travel permits, obligatory registrations, protocol visits, etc. The consultant is responsible for obtaining his/her visa and must undertake to do so.*

Other

If need be, MdM can provide contacts for translators and/or interpreters in the field for data collection. The consultant will bear the fees of the translator/interpreter. *For example, state whether MdM can provide a translator/interpreter in the field for collecting data (interviews and questionnaires).*

SECURITY

The consultant will be briefed about MdM's security rules and will need to abide by them, by signing them off upon arrival. Non-respect of MdM's security rules will be considered a breach of contract. *Specify any security procedures which will apply throughout the evaluation.*

STEERING AND REPORTING-BACK/PROGRESS REPORTS

Progress reports should be shared with the steering committee every 2 weeks during the consultancy, either by mail or phone. *Specify the frequency of any telephone updates and whether written progress reports should be forwarded prior to these telephone sessions.*

EVALUATION BUDGET

Simplified budget for evaluation/capitalisation exercise:

	Number of days	Unit cost EUR	Total EUR	Comments
Fees				
Perdiem *(if living costs not covered by MdM)*				
Travel				
International				
National				
Accommodation				
Interpreter				
Translation costs *(e.g. report)*				
Communication				
Other *(specify)*				
TOTAL INC. TAX			12,000	All above fees should be included in the total amount

skills required to lead the evaluation process A pairing of two consultants is preferable for the evaluation: one technical person with the SRH knowledge and experience, and one evaluation expert;
The consultant/s can be international or national;
A women is strongly recommended due to the cultural context and thematic of the project;
Proven track record in project evaluation (experience evaluating at least 2 comparable projects)

Annex-2

Evaluation Design Matrix

Evaluation Focus	Key Need/Issue	Evaluation Questions	Main Methodologies	Reference to TOR
Context	Obtaining socio-cultural environment	To what extent has the socio-cultural environment become restrictive or conducive to SRH rights and FP services? What it is likely to be in future? How the question of equity has been addressed?	Desk review Stakeholders' interviews	Relevance Coverage Equity Connectedness
Input	Appropriateness of project design and strategies	How have the project design and related strategies worked throughout the project life?	Program staff interviews OCA	Effectiveness Efficiency
Process	Coordination between partners towards quality of implementation	What is the quality of implementation in terms of resources used versus results achieved?	Budget review M&E reports review Interview with staff and partners, OCA	Resource Efficiency Partnership with PWD:
Product	Results achieved (Quantity, Quality, Replicability and Durability)	How can the results continue in future? Is there continued demand for SRH/FP services and how good if PWD's capacity to deliver? To what extent there is alignment of vision between PWD and MdM?	Exit interviews Beneficiaries' survey Care-givers' interview Key informants' interviews	Impact, Sustainability and Connectedness

Annex-3

List of Project Documents Consulted

1- Project Proposal
   1.1 Initial Proposal : Proposal AFD-PUNJAB - DEC- MdM -PWD 2017
   1.2 Revised Proposal: MdM_Pakistan_SSR Pendjab_NIONG_V3 révisée

Note on Proposal *- AFD proposal for Punjab project*

Two project documents:
- *Initial proposal:* ***Proposal AFD-PUNJAB - DEC- MdM -PWD 2017***
- *Revised proposal (April 2018):* ***MdM_Pakistan_SSR Pendjab_NIONG_V3 révisée****.*

The revised proposal being in French, the changed are explained below:
- *Concerns the change of location from Chiniot to Lahore as project NOC hasn't been granted*
- *Administrative risk regarding NOC issuance for the initial project sites (Chiniot) had been underestimated (p.38)*
- *No-cost extension of 4 months – new project end is March 2020.*
- *The change of location implies a change of targeted population from rural to urban and peri-urban.*
- *Logframe, objectives and activities are unchanged.*

2- Project LFA, Objectives and indicators
   2.1 See Proposal
   2.2 Excel version: 2 MdM Pakistan_Punjab LogFrame
3- Roles and responsibilities arrangements of MdM and PWD
   3.1 MoU with PWD: 3.1 MoU-MdM-PWD-May2018

   3.2 Letter to PWD for project reallocation to Lahore

   3.3 PWD approval letter for project reallocation to Lahore

4- Annual reviews or assessment reports
   4.1 Project progress - presentation to the partner - Aug2018 to Nov2019

5- Activities or work plan : see gantt chart in the proposal

6- Visits and meeting report by the M&E
   6.1 Social Mobilization Reports (folder)
   6.2 2019_10 Monthly Monitoring Report - Punjab Project - Final
7- Progress Reports (if any): Donor Interim Report AFD
   7.1 Rapport-execution-intermediaire-mono-pays-EN-MdM-Punjab-IR1-Nov2017-Dec2018
   7.2 Programme-activites-previsionnel-EN

8- List of Activities: see gantt. chart and proposal

9- Financial Documents (allocated budget Vs. activities)
   9.1 MdM_Pakistan_SSR Pendjab_Canevas financier_VF_pour avenant
   9.2 Budget_2017 Pak Mission_24months new proposal 040517

10- Organogram of MDM Project
   10 PAK Mission Organigram_NOV 2019

11- List, address and contacts of centers
   11 Contact details of centers and mobilization team

12- Beneficiaries data: gender wise, center wise, service-wise and total
    12.1 FWC services data Global
    12.2 FWC services database - Baseline calculations

13- Population of catchment area, if available
    13 Social Mapping Report Lahore

14- PRE survey or need assessment survey if conducted
    14.1 Lahore Health Facility Assessment Report
    14.2 2nd Assessment Report FWC-FHC Lahore

15- Extra documents: Research Study on the socio-cultural barriers to FP in the catchment Area
    15.1 ToR Published Research Study FP Barrier Analysis
    15.2 MdM Punjab_Study of socio-cultural barriers to FP - Final Report-MAY19

Annex-4

Data Collection Tools
4.1 - Community Survey Tool

Date: _____ Form No. _____ Enumerator _____ (ID)

Assalam-o-Alaikum: My name is _____. As you know MDM has implemented a heath project in your area for the provision of safe and easy access to family planning and SRH related issues in your area to promote safe health practices at the household levels. This phase of the project is almost completed and before the start of the next phase, MDM wanted to evaluate the impact of this project and its intervention. This information and field experiences will allow to improve, scale-up and replicate this approach in Punjab. For this purpose, we will ask you few questions which I hope you would not mind answering. It will take approx. 20-30 minutes of your time. Your name will not be mentioned in the report, or any place which may hurt your reputation."

If respondent agrees; start the survey:

Demographics

1. Name of the Respondent _____
2. Religion [ ] (1-Muslim, 2-Christian, 3-Sikh, 4-Other _____)
3. Age [ ] use code from list 01
4. Sex [ ] 1-Male, 2- Female, 3-Others
5. Area of residence (Use code from list 02)
6. Level of education [ ] *(use code from List no. 03)*
7. What is your employment status? [ ] *(1-Employed, 2-Unemployed)*
8. What is your household monthly income? [ ] *(use list no. 04)*
9. Marital status [ ] (1-Single, 2-Married, 3-Diverced, 4-Widdow, 5-Other _____)
10. What was your age at marriage? *(use code from list no. 01)*

List 01	
1	14-24
2	25-35
3	36-46
4	50+

List No. 02	
1	China Scheme
2	Shad Bagh
3	Mughal Pura
4	Kotli Peer Abdul Rahman
5	Shadi Pura/Lakho Der
6	Kot Khawaja Saeed

List No. 04	
1	1000 to 10000 rupees
2	11000 to 20000 rupees
3	21000 to 30000
4	31000 to 40000
5	41000 to 50000
6	More than 50000
7	No income

List No. 03	
1	No formal education
2	2-3 years of schooling
3	Primary incomplete (4 years)
4	Primary complete (grade 5 pass)
5	Middle school incomplete (grade 6-7 pass)
6	Middle school complete (grade 8 pass)
7	High school incomplete (grade 9 pass)
8	High school complete (grade 10 pass)
9	College incomplete (grade 11 pass)
10	College complete graduate (12 year)
11	University / Post graduate (13-16 years)

Current Knowledge, Attitudes, and Beliefs Regarding FP

1. (Ask Question 1-12 with Married Respondents)
2.
3. How many children do you currently have? Total [ ] Boys [ ] Girls [ ] (insert numbers please)
4. Do you have desires for more children? [ ] 1-Yes, 2-No
5. If Yes above, how many more children do you desire to have? [ ] (insert numbers)
6. How many times have you/your wife been pregnant in the past? [ ] (insert numbers)
7. During a pregnancy how often do you/your wife visit the doctor? [ ] (insert code from list 05)
8. Have you ever considered family planning? [ ] 1-Yes, 2-No.
9. If Yes, why [ ] (Select a response from list 06)
10. If No, why not [ ] (Select a response from list 07)
11. Have you used any FP method? [ ] 1-Yes, 2-No
12. Which FP method have you used? (1. Condom, 2. Pills, 3. IUDs 4. Birth Spacing, 5. Others_____)
13. Who decided about the choice of FP method? [ ] 1-Myself, 2-My spouse, 3-Both of us mutually
14. If you have not used any FP method, then please tell us the reason (Select a response from list 08)
15. (Ask question 13-19 from un-married respondents)
16. Do you think that young men and women should (or couple) seek counseling about the marriage relations and family planning? [ ] 1-Yes, 2-No.
17. If answer is yes then based on your own experience where do think young men and women should go for such counseling? (1. Nearest doctor, 2. Parents, 3. FWC in your area, 4. Lady Health Worker of the area, 5. Others _____)
18. What are the benefits of FP? (1. Better health of mother and child, 2. Better upbringing of children, 3. Economic benefit to the family, 4. No benefit, 5. Others _____)
19. In your opinion, every young person should be educated about SRH? [ ] 1-Yes, 2-No.
20. If your answer is YES above, then how SRH education/information should be provided to the young people? 1. From parents, 2. At schools, 3. By senior family members, 4. Through community volunteers, 5. By peers, 6. By social media, 7. Others _____)

List 05	
1	No Visit
2	1-3 Visits
3	4-8 Visits
4	More than 8 Visits
5	Only when there is a problem

List 06	
1	Good for Mother
2	Good for Baby
3	Cannot Afford more kids
4	Family is complete
5	Other _____

List 07	
1	I consult my parent instead Mother/Father
2	I consult my friends
3	I don't think doctor's advice is needed
4	There is no doctor in the area I can go to
5	I read books/ consult Internet (Please specify)
6	Others _____

List 08	
1	Against the religion
2	Don't know how to use Contraceptives
3	Don't know about FP
4	Don't know about the Family Welfare Centre in my area
5	My husband / wife does not like it
6.	Others _____

21. Where did you get initial information about FP and health and hygiene? (1. CSOs, 2. Community volunteers, 3.advertisements, 4. Media (please specify_____), 5.Others _____)

22. What did you do after getting the initial information? (1. Attended meetings organized by Friends of FWC, 2. Visited FWC, 3.discussed it within family and friends, 4. Consulted media and internet for more information (please specify_____), 5.Others

Evaluation of Family Welfare Center

1. Have you heard about the Family Welfare Center? ☐ 1-Yes, 2-No.
2. Have you visited the Family Welfare Center? ☐ 1-Yes, 2-No.
3. Which Family Welfare Center did you visit? _____ (Select from list)
4. How often do you visit the Family Welfare Center? ☐ 1-Daily, 2-Once a Week, 3-Once a Month, 4-Quarterly, 5-When Needed
5. Have you used the services offered at the Family Welfare Center? ☐ 1-Yes, 2-No.
6. Which services did you use at the Family Welfare Centre? ☐ (you may check multiple options from the list 09)
7. Who told you about FWC? (1. Social Mobilizer, 2. Community volunteer, 3. Media, 4.advertisements, 5. Others _____)
8. How would you rate your Family Welfare Center's experience? ☐ (1-very bad, 2-bad, 3-average, 4-Good, 5-Excellent)
9. If you found the services at FWC useful, how many persons have you recommended to visit FWC in your area? ☐ (insert number: 0 to 10 as told by the respondent)
10. How beneficial is FWC for its contribution to the health and welfare of your community? ☐ (1-Highly beneficial, 2-Beneficial, 3-Less beneficial)

List of FWCs	
1	China Scheme
2	Shad Bagh
3	Mughal Pura
4	Kotli Peer Abdul Rahman
5	Kot Khawaja Saeed

List 09	
1	Information only
2	**Family Planning Counselling**
3	**Family Planning Consultation**
4	**Reproductive Health** (FPI, Personal Hygiene, General Health, Antenatal, Postnatal care)
5	**General Health** (Anemia, Fever, Flue, etc.)
6	**Lab test guidance**
7	**FP methods**
8	Other _____

Friends of Family Welfare Centers (FFWCs)

1. Do you know Friends of Family Welfare Centers in your area? ☐ 1-Yes, 2-No.
2. Which group you are aware of? ☐ 1-Male, 2-Female.
3. Have you attended FFWC's awareness sessions in your area? ☐ 1-Yes, 2-No.
4. If YES, then how many awareness sessions have you attended in last one year? ☐ (insert number)
5. If NO, then please tell us the reason for not attending? (Select from list 10)
6. Did you learn something new about sexual and reproductive health at these awareness sessions? ☐ 1-Yes, 2-No.
7. What was that? _____(Record Verbatim)
8. Other than what you have mentioned above, can you list few things you learnt about family planning at these awareness sessions? ☐ (you may check multiple options from the list 11)
9. Did you ask questions regarding SRH and FP during community sessions? ☐ 1-Yes, 2-No.
10. How would you rate the information/guidance/counselling you were provided at FFWC meetings? ☐ (1-very bad, 2-bad, 3-average, 4-Good, 5-Excellent)
11. If you found FFWC sessions useful, how many other persons have you invited to attend the next awareness sessions of FFWC in your area? ☐ (insert number 0 to 10: as told by the respondent)
12. Attending FFWC meetings encourages men and women to visit FWCs in your area. Do you agree? ☐ 1-Yes, 2-No.
13. Do you think that Friends of FWC have performed valuable social service for improvement of SRH in your area? ☐ 1-Yes, 2-No.
14. Do you think, male FFWC should be made available in ALL family welfare centers run by Population Welfare Department? ☐ 1-Yes, 2-No, 3-Maybe
15. If yes, what benefit will male volunteer provide?_____

List 10	
1	Timings don't suit me
2	Meetings are held far from my home
3	Not allowed to attend
4	Meetings are not useful.
5	Others _____

List 11	
1	Family Planning Methods
2	SRH awareness & importance
3	Personal Health and Hygiene
4	Infectious Diseases
5	General information about Family planning
6	Benefits of couple registration
7	Myths and misconceptions about FP
8	Importance of breast feeding and birth spacing
9	Others _____

Usefulness of Services & Suggestions for Future

1. Which of the following method for raising SRH awareness do you recommend for use in future? Please recommend top 2 methods only.
   [ ] [ ] (Use multiple codes from List 12)

List 12	
1	Community awareness session
2	Short message services (SMS)
3	YouTube videos
4	Social Media (Facebook, WhatsApp, Instagram)
6	Print media (Newspaper, magazines, journals)
7	Electronic media (TV, Radio)
8	Others _____

2. What are your suggestions for the following for improving SRH services:

a) Family Welfare Center / PWD_____

b) Friends of FWCs _____

c) Community Leaders/Members _____

d) Others. _____

- The End-

Annex-4.2

Exit Interview

Date: _____ Form No. _____ Enumerator _____ (ID)

"***Assalam-o-Alaikum:*** My name is _____. As you know MDM has implemented a heath project in your area for the provision of safe and easy access to family planning and SRH related issues to promote safe health practices at the household levels. This phase of the project is almost completed and before the start of the next phase, MDM wanted to evaluate the impact of this project and its intervention. This information and field experiences will allow to improve, scale-up and replicate this approach in Punjab. For this purpose, we will ask you few questions which I hope you would not mind answering. It will take approx. 20-30 minutes of your time. Your name will not be mentioned in the report, or any place which may hurt your reputation. "

If respondent agrees; start the survey:

1. Age [ ]
2. Sex [ ] (1-Male, 2- Female, 3-Others)
3. Marital status [ ] (1-Single, 2-Married, 3-Diverced, 4-Widdow, 5-Oher__)
4. Name of the Center / Area [ ] (Select form List 01)
5. How did you know about this place? a. MDM Mobilizer, b. Friends of FWC, c. advertisement, d. searched myself, other _____
6. How many times you've come before? a. First time, b. visit monthly, c. six monthly, d. when needed, e. other _____
7. What Service(s) you came for today? [ ] (List 02)
8. Did you get the services you wanted today? [ ] 1-Yes, 2-No, 3-Not Sure, 4-Others _____
9. Do you know, what other services are available at this center? [ ] (get the answer from the list 03)
10. What other services should be available at this facility?_____ (which is not listed above)
11. How long it takes you to come here from where you live? a. 15m, b. 30m, c. 60m, d. 90m, other _____min.
12. Which of the following services your counselor mentioned today? [ ] (Select the most appropriate from list 03)

List No. 01	
1	Shalimar Town
2	China Scheme
3	Shad Bagh
4	Mughal Pura
5	Kotli Peer Abdul Rahman
6	Shadi Pura/Lakhodeer
7	FHC _____

List No. 02	
1	Family planning
2	Maternal and newborn care
3	Prevention and management of gender-based violence (GBV)
4	Services for prevention & management of STI
5	Other, (specify)
6	Don't know

List No. 03		Check
1	Pregnancy Related Tests/examinations	
2	Anemia	
3	Abortion	
4	Personal Health & Hygiene	
5	Water Borne Diseases	
6	Environmental Hygiene	
7	Family Planning (awareness and methods)	
8	Mother & Child Care (Birth Spacing, breast feeding, etc.)	
9	Others _____	

13. How would you rate the quality of waiting area ☐ 1-Exellent, 2-Good, 3-Average, 4-Below Average, 5-Bad.
14. How would you rate the waiting time ☐ 1-as expected, 2-longer than expected, 3-earlier than expected)
15. Did the center provide any material for education or information during waiting time? ☐ 1-Yes, 2-No, 3-Yes but irrelevant, 4-Did not notice, 5-Other_____
16. How would you rate the privacy provided to you during consultation/visit ☐ 1-Exellent, 2-Good, 3-Average, 4-Below Average, 5-Bad.
17. How would you rate the quality of consultation? ☐ 1-Highly Satisfactory, 2-Satisfactory, 3-Average, 4-Below Satisfactory, 5-Un-satisfactory
18. If you answer is 4-5, then tell us the reason
    _____
19. How do you rate the overall experience? ☐ (Rate from scale 1-10)
20. Will you refer others to this center? ☐ 1-Yes, 2-No
21. If you could make only one suggestion for improving services at this facility?
    _____
    _____

Thank you very much for your Time.

Annex-4.3

FGD Guide - Community Members

"Assalam-o-Alaikum: My name is _____. As you know MDM has implemented a heath project in your area for the provision of safe and easy access to family planning and SRH related issues in your area to promote safe health practices at the household levels. This phase of the project is almost completed and before the start of the next phase, MDM wanted to evaluate the impact of this project and its intervention. This information and field experiences will allow to improve, scale-up and replicate this approach in Punjab. For this purpose, we will ask you few questions which I hope you would not mind answering. It will take approx. 30-45 minutes of your time. Your name will not be mentioned in the report, or any place which may hurt your reputation."

May I continue with the questions?_____ No _____

Process information about the FGD	
Date of FGD	
Venue of FGD	
Duration of FGD (in minutes)	
Number of facilitators	
Number of note takers	
Recordings (Yes/No)	
Language	
Number of participants	
Type of participants (age, gender, married / unmarried youth)	
Reasons for non-participation (e.g. too old to come to FGD location)	
Description of any external circumstances that interrupted the FGD (e.g. presence of children, noise, dominant participants)	
Other comments about the FGD you'd like to mention	

I. Program Planning and Need Assessment

1. When was the first time you heard about family planning in your life?
2. What did you understood when you first heard about FP?
3. Roughly what percentage of population in this area do you think are in need of FP and /SRH services?
4. Who currently provides them such services? (Prompt till they mention FWC)
5. Do you think SRH is an important health issue in this community? Why and why not?
6. Who do you think need SRH services most?
   - Children age 8-12

- Adolescent (13-18)
- Young unmarried men
- Unmarried women
- Married couples
- Couples planning to have children
- Couple having 2/3 children

7. Please explain why do you think this group that you identified is in most need?
8. What will happen if proper SRH services are not provided to them? What harm will it cause?
9. Should young people be allowed to receive SRH services?

- Is it acceptable?
- Which services are they allowed to access and under which conditions?
- What are the challenges for young people to access SRH services? Have your ideas about young people accessing SRH services changed?

10. If yes, how?

- Explore role of information and sources of information
- Role of media
- Community mobilization activities
- Roles played by government and private service providers

II. Context, Cultural Norms and Current Practices Access to Services

1. Has people's thinking about FP and SHR changed? Prompt: are people now more open and easy in discussing SRH and FP?

- How has this thinking changed?
- What has contributed to those changes?

2. What in your opinion is the biggest barrier in acceptance of FP?

- Prompt further if 'Religion is cited as the reason:
- Bangladesh also a Muslim-majority country has successfully brought down its population growth rate, though it had higher rate than that of Pakistan in 1971. If BD can do it, why not Pakistan?

3. Where do young people in your community get information about SRH and FP?

- Where did young people used to get their information? Why has that changed? For who?

4. Parents should be the source of SRH guidance and information for both young men and women when they need it. Do you agree? Why and why not?
5. Program Interventions: Role, benefits and Effectiveness
6. Has parents in this community been prepared to guide on SRH and FP?
7. What has contributed to capacity of parents and community members in guiding youth about SRH and FP?
8. Are you familiar with Friends of Family Welfare Centre in your areas?
9. What do FFWC do in your area? How have their activities benefited you?

Explore:

- Effects on opinion or behaviour on young people, family members, male partner, family influencer
- Awareness and demand generation for family planning
- Awareness about need of SRHR services
- Usefulness of referrals to FWC services
- The opinion and behaviour of your community in general

10. The FWC in your area is considered valuable by the community. Do you agree? Why and why not?
11. Do you know of any other FP center? If yes, how your FWC is different from the other one?
12. Women should have the right to choose FP methods for themselves. Comment.
13. Male members of this community support FP. Yes. No. Why?
14. Male members realize the benefits of FP but they do not support use of contraceptives by women without their consent. How much do you agree to this statement?
15. There is need for improvement in every health program. What suggestions do you have for….

- FWC and its staff
- Population welfare department

Thank you very much

Annex-4.4

FGD Guide - Community Volunteers

"Assalam-o-Alaikum: My name is _____. As you know MDM has implemented a heath project in your area for the provision of safe and easy access to family planning and SRH related issues in your area to promote safe health practices at the household levels. This phase of the project is almost completed and before the start of the next phase, MDM wanted to evaluate the impact of this project and its intervention. This information and field experiences will allow to improve, scale-up and replicate this approach in Punjab. For this purpose, we will ask you few questions which I hope you would not mind answering. It will take approx. 30-45 minutes of your time. Your name will not be mentioned in the report, or any place which may hurt your reputation."

May I continue with the questions? _____ ***No*** _____

Process information about the FGD	
Date of FGD	
Venue of FGD	
Duration of FGD (in minutes)	
Number of facilitators	
Number of note takers	
Recordings (Yes/No)	
Language	
Number of participants	
Type of participants (age, gender, married / unmarried youth)	
Reasons for non-participation (e.g. too old to come to FGD location)	
Description of any external circumstances that interrupted the FGD (e.g. presence of children, noise, dominant participants)	
Other comments about the FGD you'd like to mention	

I. Program Planning and Need Assessment

1. When was the first time you heard about family planning in your life?

II. Context, Cultural Norms and Current Practices Access to Services

1. What in your opinion is the biggest barrier in acceptance of FP?
   - Prompt further if 'Religion is cited as the reason:
   - Bangladesh also a Muslim-majority country has successfully brought down its population growth rate, though it had higher rate than that of Pakistan in 1971. If BD can do it, why not Pakistan?
2. Where do young people in your community get information about SRH and FP?
   - Where did young people used to get their information? Why has that changed? For who?
3. Has people's thinking about SRH and FP changed? How and why?
4. Parents should be the source of SRH guidance and information for both young men and women when they need it. Do you agree? Why and why not?

5. Do you think SRH is an important health issue? Why and why not?
6. Should young people be allowed to receive SRH services?

- Is it acceptable?
- Which services are they allowed to access and under which conditions?
- What are the challenges for young people to access SRH services? Have your ideas about young people accessing SRH services changed?

7. If yes, how?

- Explore role of information and sources of information
- Role of media
- Community mobilization activities
- Roles played by government and private service providers

8. Program Interventions: Role, benefits and Effectiveness
9. Why did you choose to become a volunteer in this program? What motivated you to do this volunteer work?
10. Do you think the SRH is an important BUT NEGLECTED issue for the youth?
11. If the answer is YES probe further for reasons.
12. How has this program affected the opinion or behavior of your parents/caretakers? Community in general?

    i. Do you feel supported by them?
    ii. How do you feel supported?
    iii. Do they allow you to go to a health facility to access SRH services?
    iv. Has the support / opinion / behaviour by your parents/caretakers changed? If yes, how? What has contributed to those changes?

13. Do you think that your volunteering is creating an impact? How?
14. How have you promoted male support for FP in this community? How did you champion this idea? What difficulties you faced?
15. Has male support for FP increased, decreased or remained the same? Any story of change in your knowledge?
16. What is the role of social media in informing youth about SRH? Is this media helpful?
17. Community sensitization about FP/SRH improved health and wellbeing in your community. Do you agree? Do you recommend such sensitization programs for other communities as well?
18. Do you think this program be expanded across Punjab? Why and Why not?
19. What are your recommendations to expand this community engagement activities on FP and SRH? How would you replicate / expand it. Please give at least three recommendations

1. _____
3. _____

Thank you very much

Annex-4.5

FGD Guide - Field Staff

"***Assalam-o-Alaikum:*** My name is _____. As you know MDM has implemented a heath project in your area for the provision of safe and easy access to family planning and SRH related issues in your area to promote safe health practices at the household levels. This phase of the project is almost completed and before the start of the next phase, MDM wanted to evaluate the impact of this project and its intervention. This information and field experiences will allow to improve, scale-up and replicate this approach in Punjab. For this purpose, we will ask you few questions which I hope you would not mind answering. It will take approx. 40-45 minutes of your time. Your name will not be mentioned in the report, or any place which may hurt your reputation "

May I continue with the questions?_____ ***No*** _____

Process information about the FGD	
Date of FGD	
Venue of FGD	
Duration of FGD (in minutes)	
Number of facilitators	
Number of note takers	
Recordings (Yes/No)	
Language	
Number of participants	
Type of participants (age, gender, married / unmarried youth)	
Reasons for non-participation (e.g. too old to come to FGD location)	
Description of any external circumstances that interrupted the FGD (e.g. presence of children, noise, dominant participants)	
Other comments about the FGD you'd like to mention	

II. **Context, Cultural Norms and Current Practices Access to Services**

1. What in your opinion is the biggest barrier in acceptance of FP?
   - Prompt further is 'Islam' is cited as the reason:
   - Bangladesh also a Muslim-majority country has successfully brought down its population growth rate, though it had higher rate than that of Pakistan in 1971. If BD can do it, why not Pakistan?

2. Where do young people in your community get information about SRH?
   - Where did young people used to get their information? Why has that changed? For who?

3. Do you think SRH is an important health issue? Why and why not?
4. What will happen if proper SRH services are not provided to them? What harm will it cause?
5. Should young people be allowed to receive SRH services?
   - Is it acceptable?
   - Which services are they allowed to access and under which conditions?
   - What are the challenges for young people to access SRH services? Have your ideas about young people accessing SRH services changed?

   If yes, how?

   - Explore role of information and sources of information
   - Role of media
   - Community mobilization activities

III. Program Interventions: Role, benefits and Effectiveness

1. What has contributed to those changes?
2. What role have you played as member of the field staff of PWD?
3. How does the community see your interaction with them on this sensitive topic of SRH?
4. What challenges did you face working in this community?
5. Explore:
6. community attitude towards FP, lack of awareness
7. lack of proper training on modern FP
8. support from the government
9. others:_____
10. Were you trained for social mobilization and field work? If yes. By whom?
    Explore: which training they found useful and why? Probe for feedback on MDM's capacity building.
11. How is PWD's collaboration with MDM useful?
    List three specific benefits MDM has brought:
    1. _____
    2. _____
    3. _____

    Explore:
12. Service delivery at FWC
13. Personal capacity enhanced
14. Uptake of services
15. Effects on opinion or behaviour on young people, family members, male partner, family influencer
16. Awareness about need of SRHR services
17. Usefulness of referrals
18. The opinion and behaviour of your community in general
19. The FWC in your area is considered valuable by the community. Do you agree? Why and why not?

20. Do you know of any other FP center? If yes, how your FWC is different from the other one?
21. Collaboration with MDM has strengthened organizational capacity of PWD. Right or wrong? Why?
22. In what ways do you think organizational capacity has been strengthened?
23. There is need for improvement in every health program. What suggestions do you have for….
24. FWC and its staff
25. Population welfare department
26. Do you think this program be expanded across Punjab? Why and Why not?
27. If you were to expand this program across Punjab, what are THREE steps that you will under take
    1. _____
    2. _____
    3. _____

Thank you very much

Annex-4.6

FGD Guide - CSO & Private Stakeholders

"***Assalam-o-Alaikum:*** My name is _____. As you know MDM has implemented a heath project in your area for the provision of safe and easy access to family planning and SRH related issues in your area to promote safe health practices at the household levels. This phase of the project is almost completed and before the start of the next phase, MDM wanted to evaluate the impact of this project and its intervention. This information and field experiences will allow to improve, scale-up and replicate this approach in Punjab. For this purpose, we will ask you few questions which I hope you would not mind answering. It will take approx. 20-30 minutes of your time. Your name will not be mentioned in the report, or any place which may hurt your reputation. "

May I continue with the questions? _____ ***No*** _____

Process information about the FGD	
Date of FGD	
Venue of FGD	
Duration of FGD (in minutes)	
Number of facilitators	
Number of note takers	
Recordings (Yes/No)	
Language	
Number of participants	
Type of participants (age, gender, married / unmarried youth)	
Reasons for non-participation (e.g. too old to come to FGD location)	
Description of any external circumstances that interrupted the FGD (e.g. presence of children, noise, dominant participants)	
Other comments about the FGD you'd like to mention	

I. Context, Cultural Norms and Current Practices Access to Services

1. Which cultural values and norms influence young people's sexual behavior in the communities?
   - What are the consequences of these norms and values for young people's sexual behaviour?
   - Have the cultural norms and values in your community changed?
   - How have they changed?
   - What has contributed to those changes?
2. What are the main challenges for CSOs working in the field of SRH?
3. What in your opinion is the biggest barrier in acceptance of FP?
4. Who do you think need SRH services most?
   - Children age 8-12
   - Adolescent (13-18)

- Young unmarried men
- Unmarried women
- Married couples
- Couples planning to have children
- Couple having 2/3 children

5. Please explain why do you think this group that you identified is in most need?
6. What will happen if proper SRH services are not provided to them? What harm will it cause?
7. What role have you played in the SRH space? CB? Advocacy? Awareness? Social Mobilization? Service Delivery?
8. In the last 3 year, what significant changes has taken place in the SRH space in Punjab? Are these changes positive or negative?
9. What has contributed to those changes?

MDM's Program

10. Are you familiar with MDM's program called of Contribute to the achievement of FP2020 related to the Contractive Prevalence Rate (CPR) in Punjab?
11. Have you collaborated with MDM on this program?
12. How do you think this program is different from other SRH programs you know of?
13. What benefits has this program brought?
    - Explore:
    - Effects on opinion or behaviour on young people, family members, male partner, family influencer
    - Awareness about need of SRHR services
    - Usefulness of referrals
    - The opinion and behaviour of your community in general
    - Policy changes (which please name?)
    - Punjab SRH Bill
    - **Focus on PRE-MARITAL COUNSELLING**
14. What did you collaborate with MDM?
15. Punjab SRH Bill?
16. Pre-Marital Counselling Booklet? How?
17. Why do you consider these two as important? Pre-Marital counselling has been going one form some time? Why is this special?
18. What factors contributed most to the preparation/presentation of Punjab SRH Bill?
    - Prompts:
    - Government's willingness
    - Volunteer youth support
    - Timing
    - Endorsement of influences
    - Media
    - Collaboration of CSOs
19. What suggestions do you have for future expansion of MDM's program?

In-Depth Interviews

Annex-4.7

FGD Guide - Key Informant Interview

Interviewer: Read the consent statement below to the interviewee prior to conducting the interview.

Hello! My name is_____ and I represent Action Consulting that has been assigned to conduct a project evaluation. This program delivered with the help of Population Welfare Department, Government of Punjab was focused on improving access to family planning services through Family Welfare Centre in you areas. The Program also worked on policies, systems, and services related to family planning. The information you provide may help to improve policies, programs and services. We would appreciate it if you could answer some questions. If you participate, you will not benefit directly from your participation. But your participation may result in improved future sexual and reproductive health policies and services. Your opinions and the information you give during the interview will remain confidential.

May I continue with the questions?_____ No _____

Process information about the IDI	
Date of IDI	
Venue of IDI	
Duration of IDI (in minutes)	
Number of facilitators	
Number of note takers	
Recordings (Yes/No)	
Language	
Name of the Interviewee	
Type of participants (age, gender, married / unmarried youth/Designation/Organization)	
Description of any external circumstances that interrupted the IDI (e.g. presence of children, noise, dominant participants)	
Other comments about the IDI you'd like to mention	

Respondent Type	Focus
Community Leader	Contextual/External
CSOs	Contextual/External
SRH Activists	Contextual/External
MdM Staff	Internal/Inter-organizational
PWD Staff	Internal/Inter-organizational
Centre Incharge	Internal
FWC Counselors	Internal

Context, Cultural Norms, Policy Environment, Access to Services

1. What are the main challenges for CSOs working in the field of SRH?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

2. What in your opinion is the biggest barrier in acceptance of FP?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

3. Which cultural values and norms influence young people's sexual behaviour in the communities?
    a. What are the consequences of these norms and values for young people's sexual behaviour?
    b. Have the cultural norms and values in your community changed?
    c. How have they changed?
    d. What has contributed to those changes?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

4. How has the external environment changed in the last three years? Has it become conducive or restrictive for SRH?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

5. Is MDM's program aligned with PWD's priorities? What are PWD's priorities and how does MDM address them?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

6. How valuable is the role played by MDM in helping PWD meet its priorities?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

7. How do you compare MDM's contribution vis-a-vis other CSOs working in the field of SRH?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

8. How do you view MDM's approach of creating Friends of FWC comprising males in the community? Has it increased
    a. Awareness of FP
    b. Demand for services
    c. Acceptance of SRH
    d. Referrals and service uptake?

How?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

9. How does the project address the specific needs and strategic interests of girls and boys, men and woman in terms of SRH? Get specific examples.

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

10. How has the program strengthened the capacity of PWD?

    a. Onsite coaching

    b. Pre-marital counselling

    c. ?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge	7 FWC Counselors

11. How were the capacity building activities designed?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge	7 FWC Counselors

12. Were you aware of the GATHER technique before? If not how useful did you find it?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge	7 FWC Counselors

13. If MDM withdraws its support, how will you sustain social/community mobilization?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge	7 FWC Counselors

14. After CB from MDM how has your approach to counseling changed? Specific examples?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge	7 FWC Counselors

15. What changes have occurred at the FWC as a results of MDM program? Specific examples.

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge	7 FWC Counselors

16. What systems were previously missing that are now available after MDM's collaboration?

    a. M&E

    b. Referral Management

    c. In house database of beneficiaries

    d. Reporting

    e. Etc.

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

17. Have you collaborated with MDM on this program? How do you think this program is different from other SRH programs you know of?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

18. What is MDM's biggest achievement in your opinion?

19. 1. Community Leader	20. 2. CSOs	21. 3. SRH Activists	22. 4. MdM Staff	23. 5. PWD Staff	24. 6. Centre Incharge/Counsellors

25. What is MDM's biggest organizational challenge?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

26. What is PWD's biggest organizational challenge?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

27. Do you think MDM's approach adopted for this pilot can be scaled up in Punjab?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

28. What do you think would be main hurdles in scaling up?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

29. What is your top recommendation for MDM/PWD when it goes for scaling up in the future?

1. Community Leader	2. CSOs	3. SRH Activists	4. MdM Staff	5. PWD Staff	6. Centre Incharge/Counsellors

Thank you!

Annex-5

List of Persons Interviewed

Activity: **Planning and Field Survey Orientation**
Respondents: **Action Enumerators and MDM Staff**
Location: **China Town Scheme**
Date: **12 February 2020**

Sr.	MDM Social Mobilizers	Gender	Action Enumerator	Gender
1	Ms Roohi	Female	Mr. Shadab Fariduddin	Male
2	Mr. Mahmood Ahmed	Female	Mr. Shahzad Bukhari	Male
3	Mr. Shaikh Faisal	Male	Dr. Aniqa Muhammad	Female
4	Ms. Bakht Bari	Male	Mr. Shahbaz Latif	Male
5	Ms. Humaira Faizan	Female	Ms. Sehrish Aftab	Female
6	Ms. Nazia Naseem	Female	Ms. Amna Shahzadi	Female
7	Ms. Kalsoom Zehra	Female	Mr. Abdul Rahman	Male
8	Mr Zareen Taj (Malik Khalid Steel Mills)	Male	Mr. Shadab Fariduddin	Male
9	Mr Nadeem(Malik Khalid Steel Mills)	Male	Mr. Shadab Fariduddin	Male
10	Mr Aamir(Malik Khalid Steel Mills)	Male	Mr. Shadab Fariduddin	Male
11	Mr Faisal(Malik Khalid Steel Mills)	Male	Mr. Shadab Fariduddin	Male
12	Ms Humaira Faizan (SM, Team Lead, MdM)	Female	Mr. Shadab Fariduddin	Male
13	Ms Alexa (Deputy CR)	Female	Mr. Shadab Fariduddin	Male
14	Mr Waqas (GM,MdM)	Male	Mr. Shadab Fariduddin	Male
15	Mr Sarfraz Kazmi (FPAP)		Mr. Shadab Fariduddin	Male
16	Dr Aysha Qureshi (DS, PWD)	Female	Mr. Shadab Fariduddin	Male
17	Mr Tahir Ahmed Siddiqui (PWD)	Male	Mr. Shadab Fariduddin	Male
18	Mr Imran Yaqoob (PWO, PWD)	Male	Mr. Shadab Fariduddin	Male

Activity: **Focus Group Discussion**
Respondents: **Community Members, Elders and Activists – (Male)**
Location: **China Town Scheme**
Date: **21 February 2020**
MDM Rep: **Mr. Mahoood**

Sr.	Name	Age	Address
1	Mr. Mohammad Abdullah	49	New Karol
2	Mr. Abdul Shakoor	35	Mughalpura
3	Mr. Hakim Mohammad Naeem	50	China Scheme

4	Mr. Mohammad Irfan	25	Shad Bagh
5	Mr. Waqas Khalid	31	New Karol
6	Mr. Mahboob Ilahi	30	New Karol
7	Mr. Ayaz Baig	45	China Scheme
8	Mr. Mohammad Shabbir Khan	50	China Scheme
9	Mr. M. Irfan Siddiqui	35	Kotli Peer Abdul Rahman
10	Mr. Imran Iqbal	38	Shah Bagh
11	Mr. Saber Hussain	27	Baghat Pura

Activity: **Focus Group Discussion**

Respondents: **Community Members, Elders and Activists – (Female)**
Location: **Mughalpura**
Date: **21 February 2020**
MDM Rep: **Ms. Nazia Naseem**

Sr.	Name	Age	Address	Contact
1	Ms. Shumaila	30	New Koral	-
2	Ms. Najma Gull	42	China Scheme	-
3	Ms. Parween	48	China Scheme	-
4	Ms. Rehana Bibi	50	New Karol	-
5	Ms. Shazia Iqbal	41	Shad Bagh	-
6	Ms. Fehmida Bano	50	Mughalpura	-
7	Ms. Amina Tanweer	43	Shadbagh	-
8	Ms. Kiran	32	Kotli	-
9	Ms. Shabana	28	Kotli	-
10	Ms. Aysha Shahzad	30	Mughal Pura	-

Activity: **Focus Group Discussion**
Respondents: **PWD Fiedl Staff – (Male)**
Location: **Mughalpura**
Date: **22 February 2020**
MDM Rep: **Ms. Nazia Naseem**

1	Mr. Amjad Ali	55	Shad Bagh
2	Mr. Mohammad Shafique	51	Mughalpura
3	Mr. M.Shaid Khan	27	Daroghawala

Activity: **Focus Group Discussion**
Respondents: **PWD Field Staff – (Female)**
Location: **Mughalpura**
Date: **22 February 2020**
MDM Rep: **Ms. Nazia Naseem**

Sr.	Name	Age	Address
1	Ms. Amina Khanum	29	Mughalpura Center
2	Ms. Farkhanda Jabeen	30	Mughalpura Center
3	Ms. Bushra Khanum	52	China Scheme

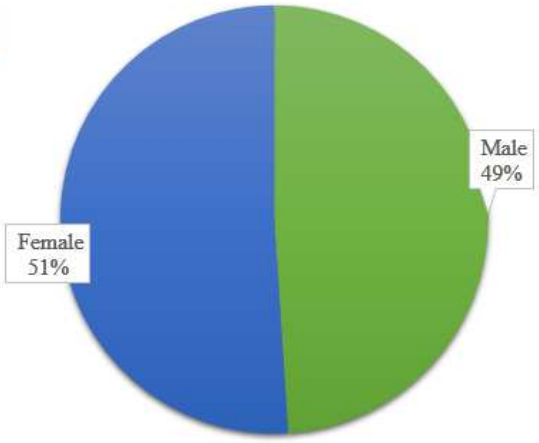
Annex - 6

Community Survey Demographics and Results

DEMOGRAPHICS - (SECTION – A)

Gender of respondent

	Gender		
	Total	Male	Female
Base: all respondents	290	141	147

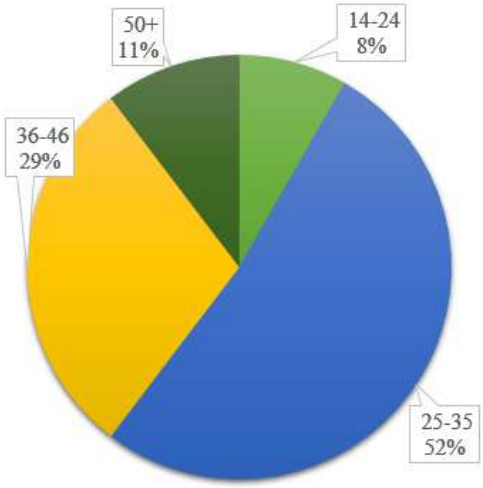


Religion of respondent

	Religion		
	Total	Muslim	Christian
Base: all respondents	290	274	16

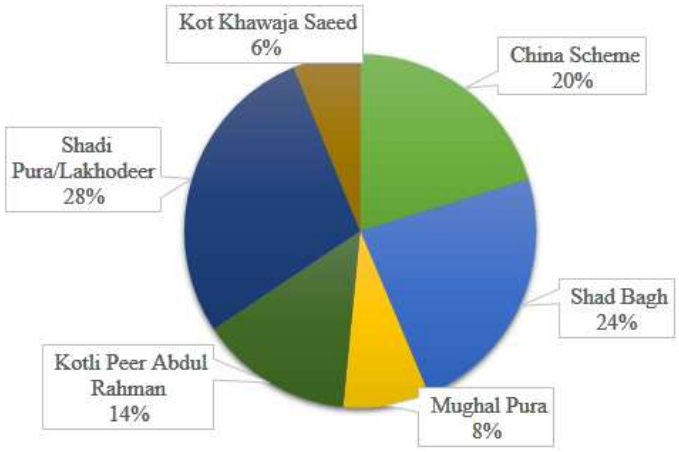
Age of respondent

		Age (years)			
	Total	14-24	25-35	36-46	50+
Base: all respondents	290	24	151	85	30



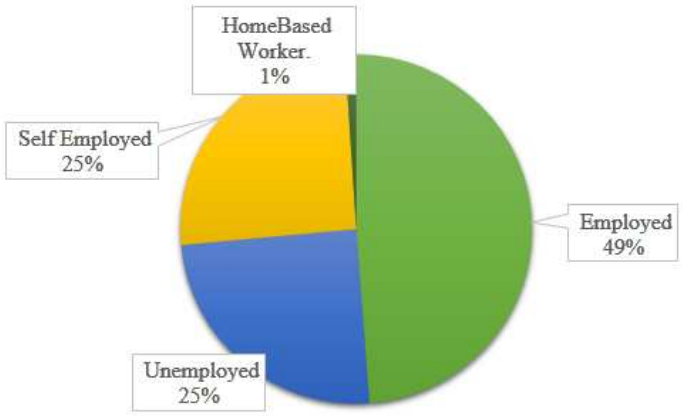
Area of residence

		Area					
	Total	China scheme	Shad bagh	Mughal pura	Kotli peer abdul rahman	Shadi pura/ lakhodeer	Kot khawaja saeed
Base: all respondents	290	59	67	23	41	82	18



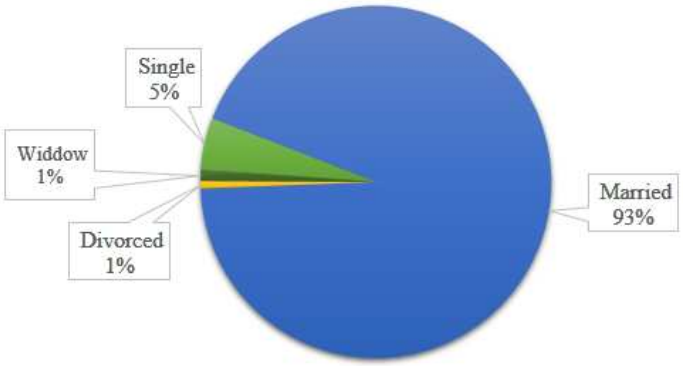
Employment status

		Employment status			
	Total	Employed	Unemployed	Self employed	Home based worker.
Base: all respondents	290	142	72	74	2



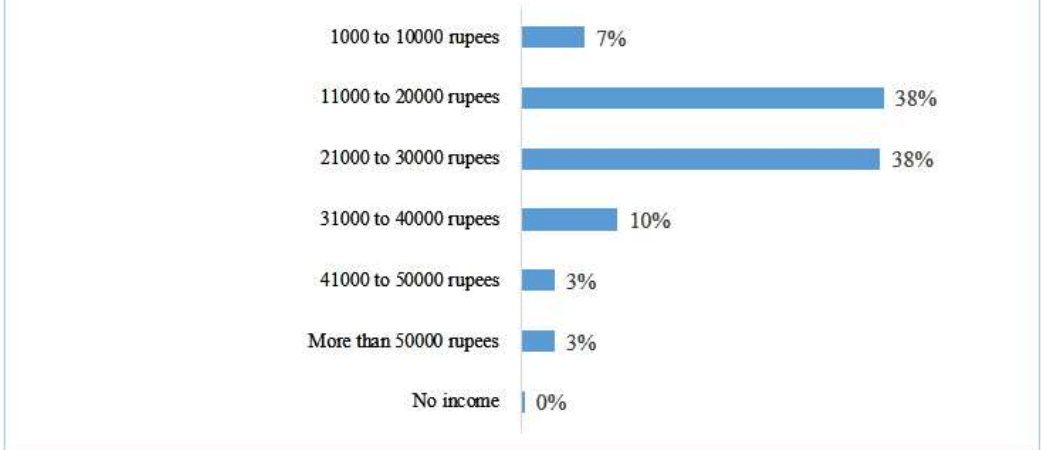
Marital status

		Marital status			
	Total	Single	Married	Divorced	Widow
Base: all respondents	290	14	274	1	1



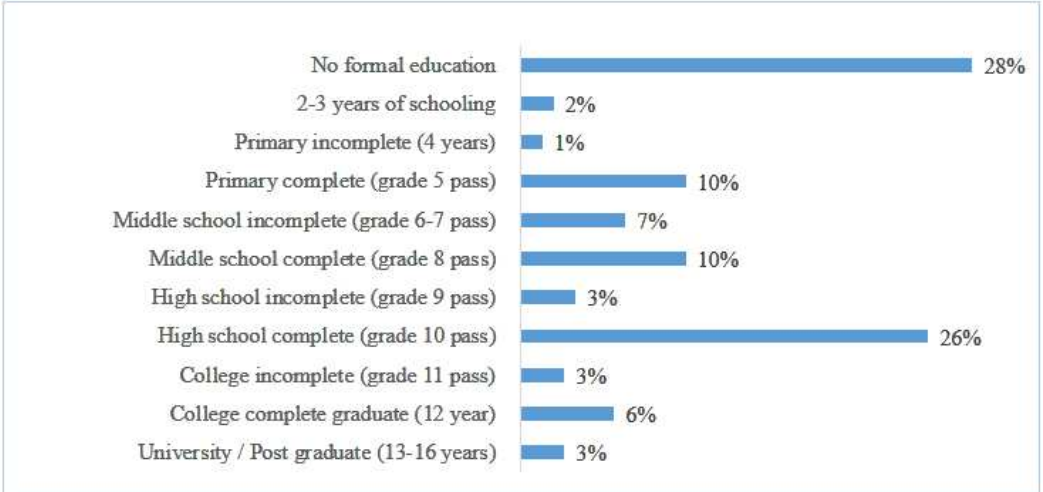
Household monthly income

	Total
Base: all respondents	290



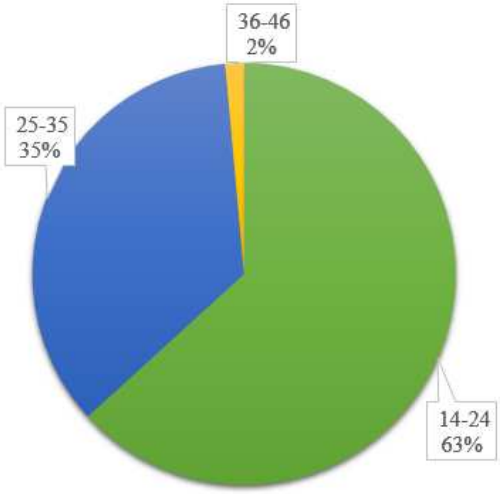
Level of education

	Total
Base: all respondents	290



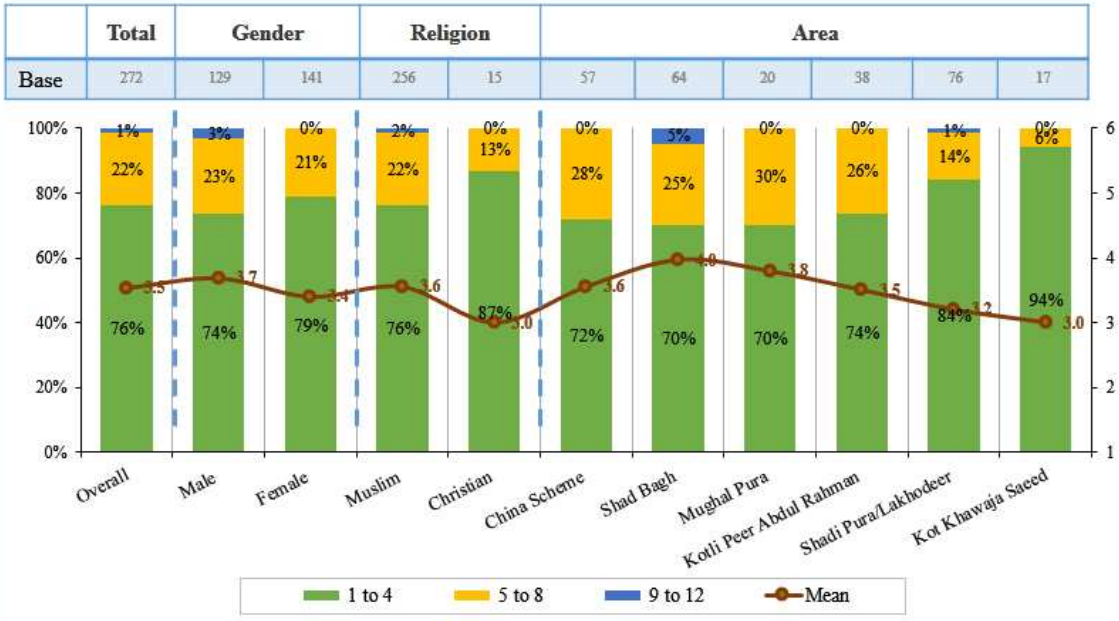
Age of respondent at marriage

		Age (years)		
	Total	14-24	25-35	36-46
Base: all respondents	290	177	98	4

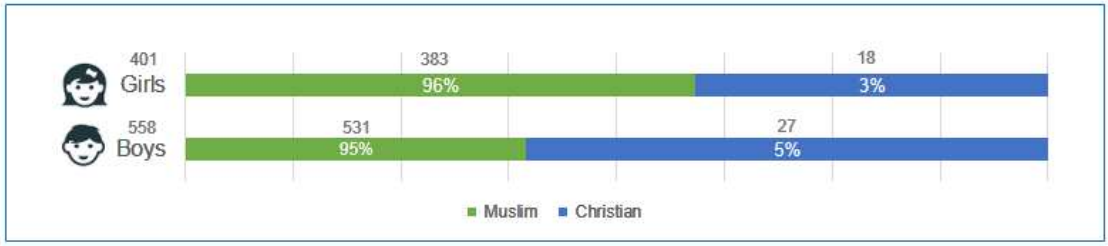


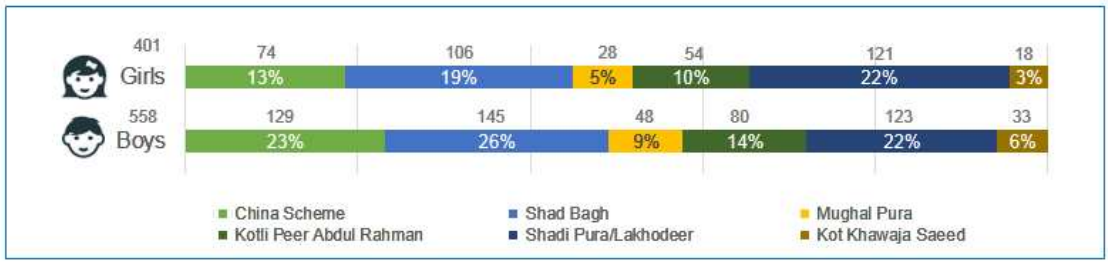
B. Current knowledge, attitudes, and beliefs regarding FP

B1 Number of children currently have

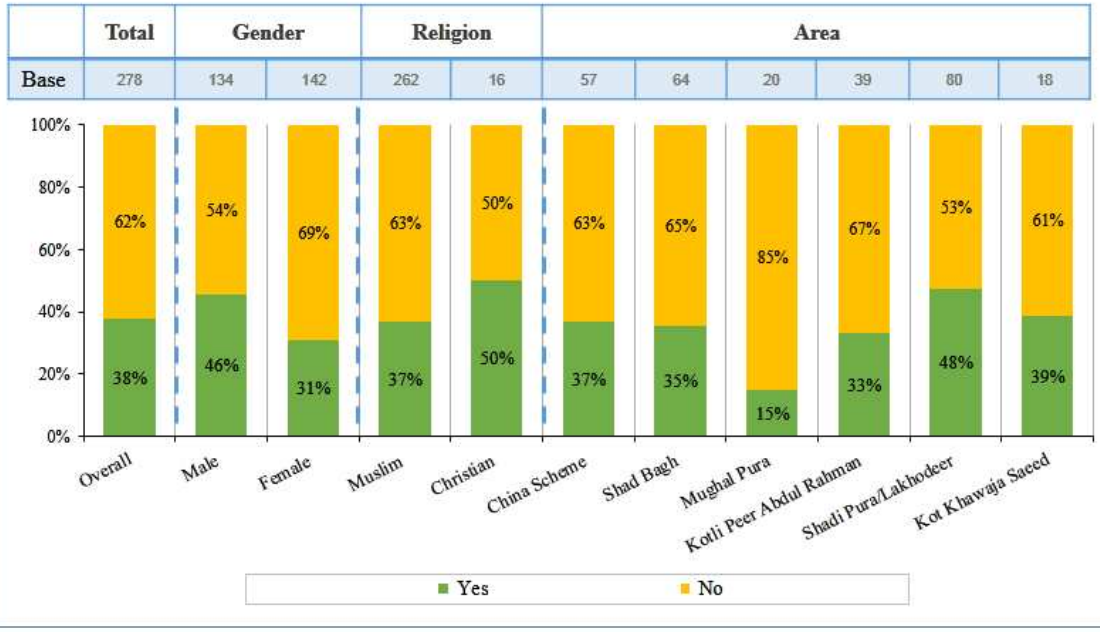


B1 Number of boys and girls

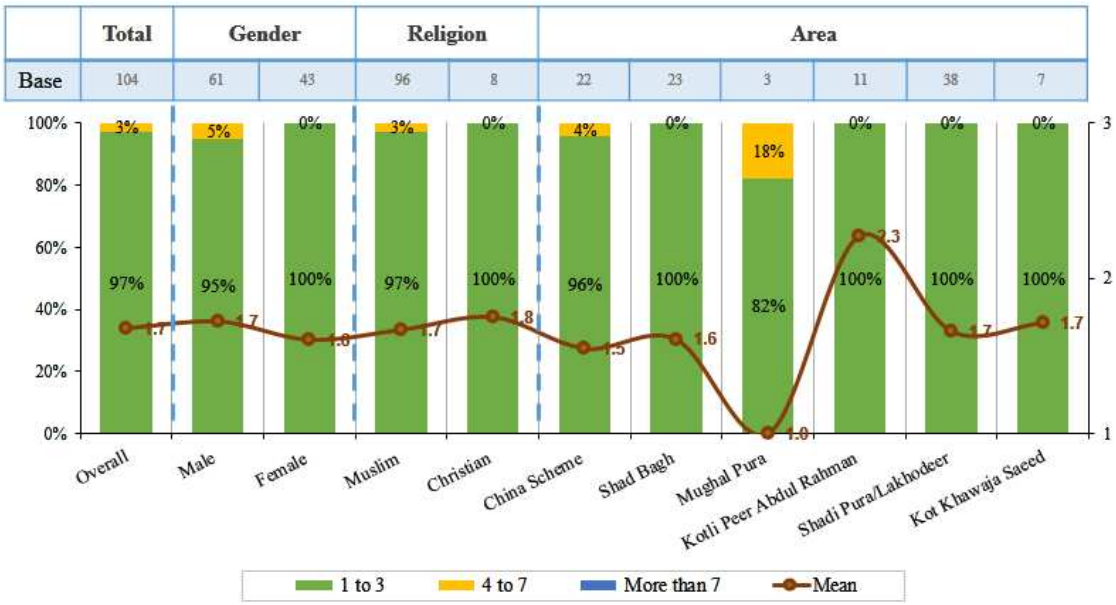




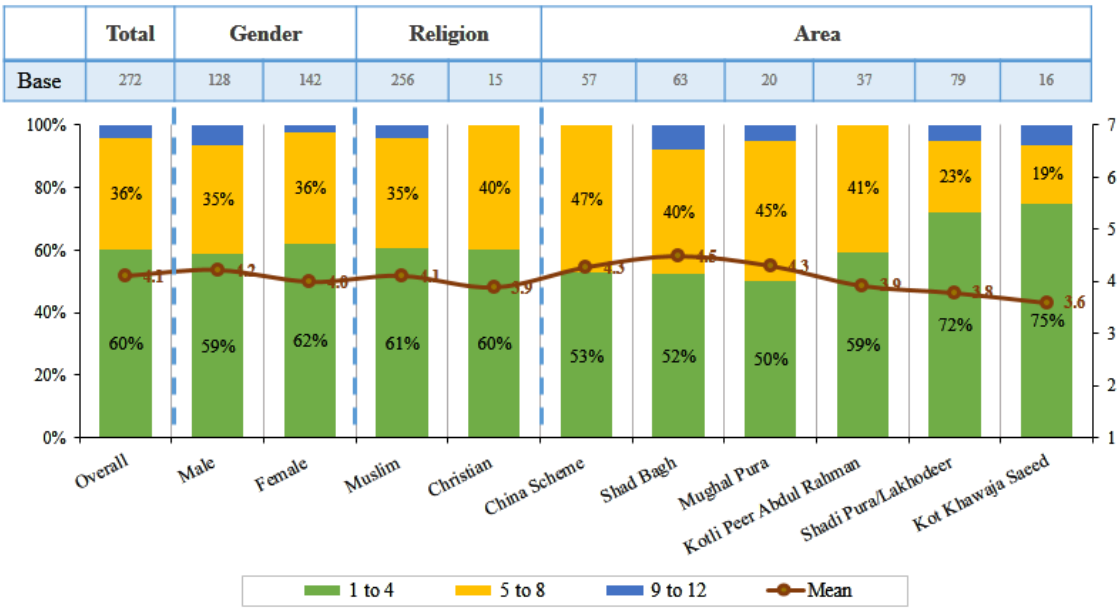
B2 Do you have desires for more children?



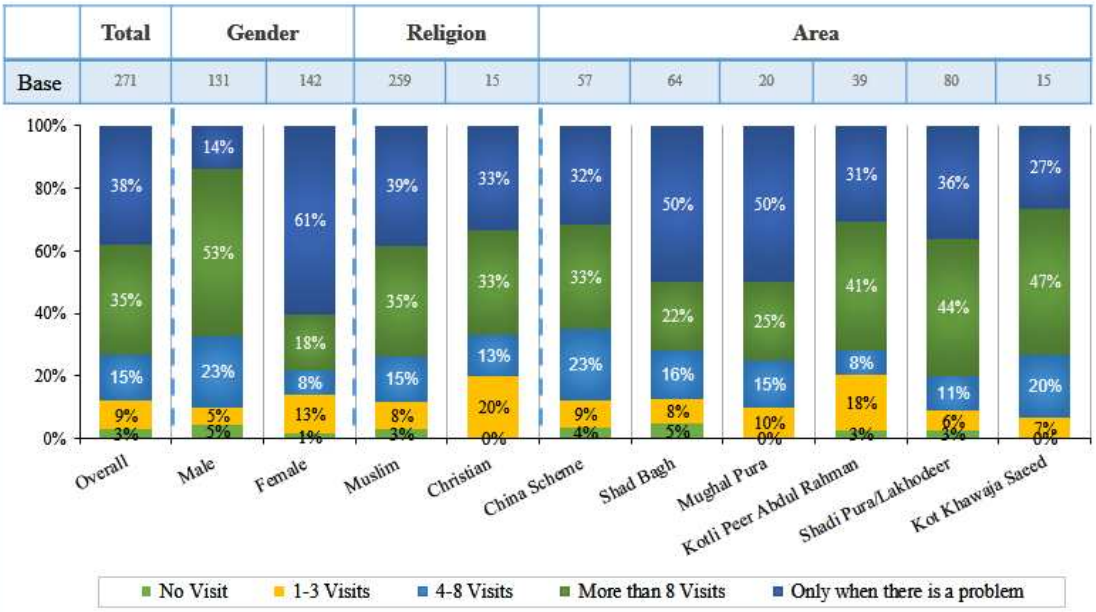
B3 How many more children do you desire to have?



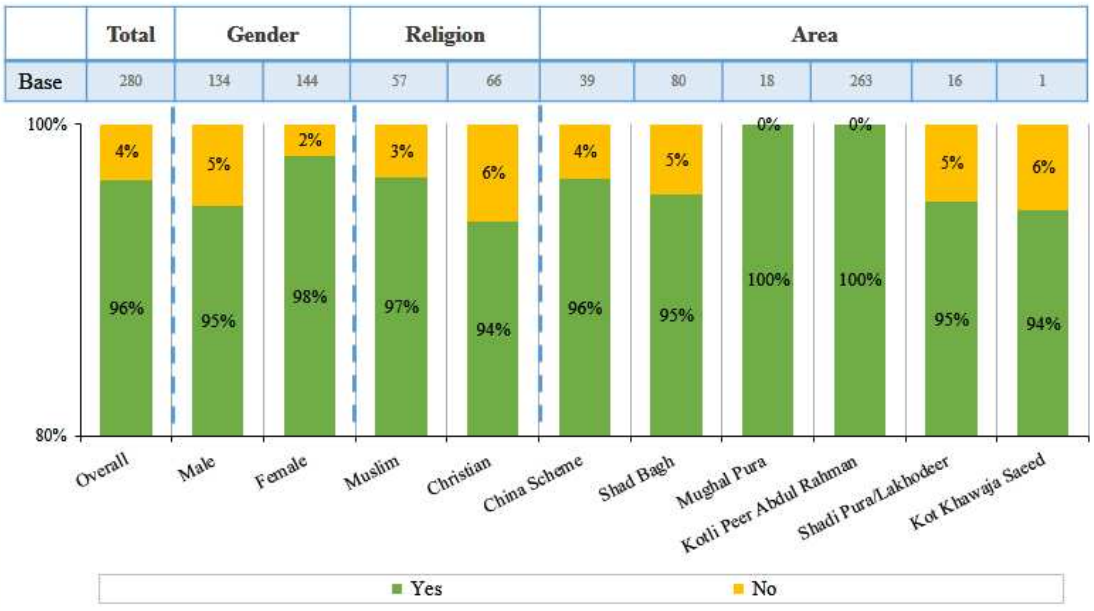
B4 How many times have you/your wife been pregnant in the past?



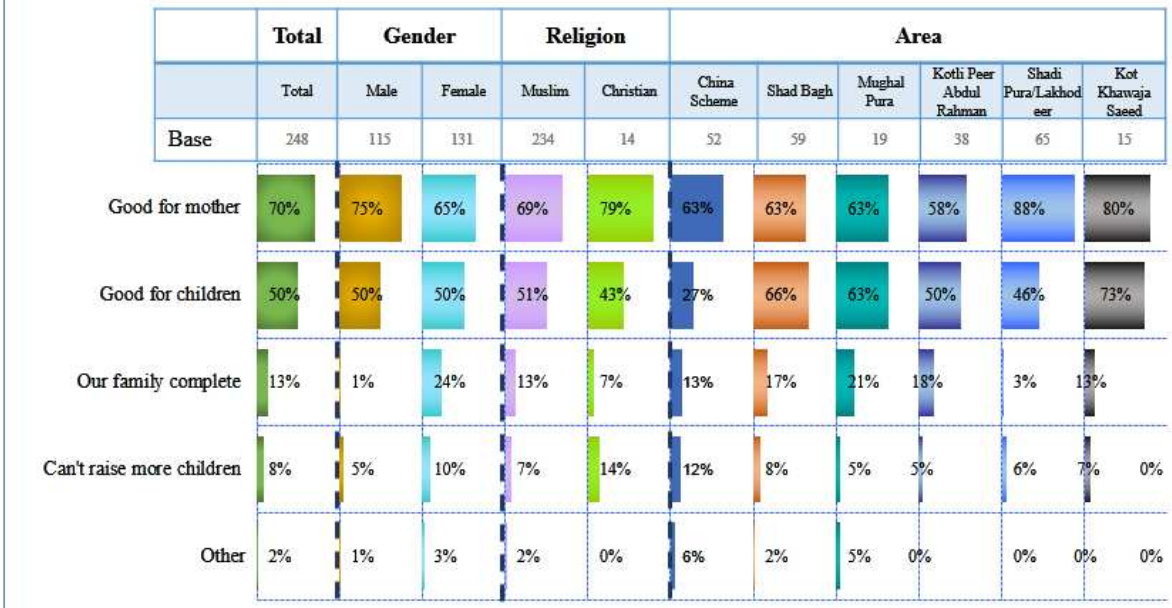
B5 During a pregnancy how often do you/your wife visit the doctor?



B6 Have you ever considered family planning?

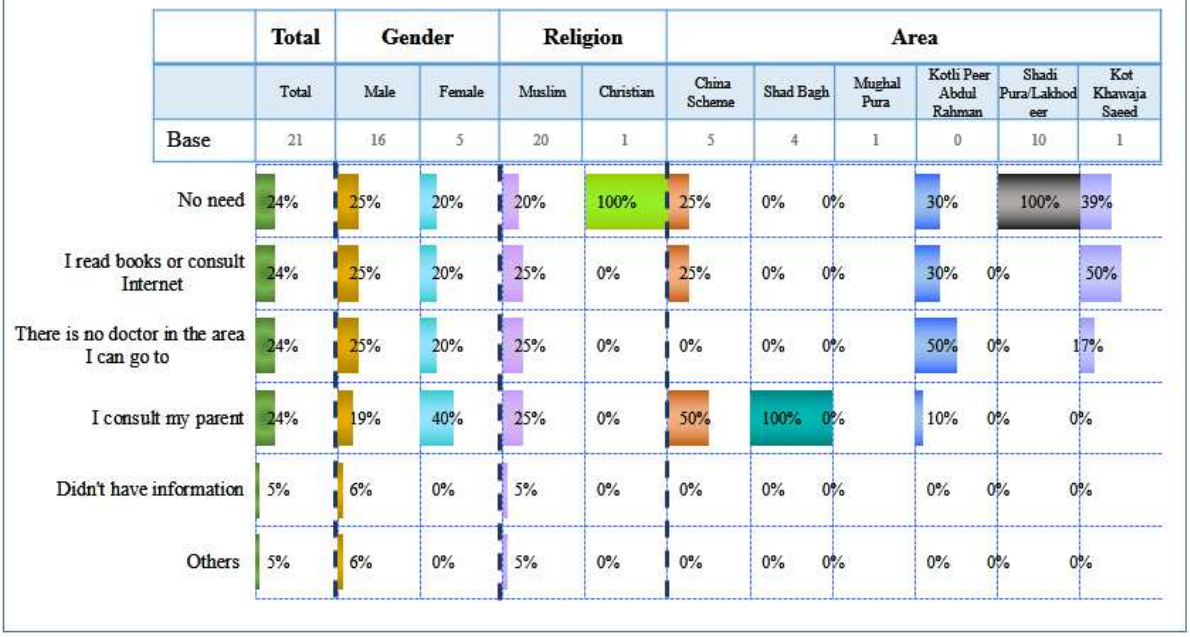


B7 Reasons for considering family planning



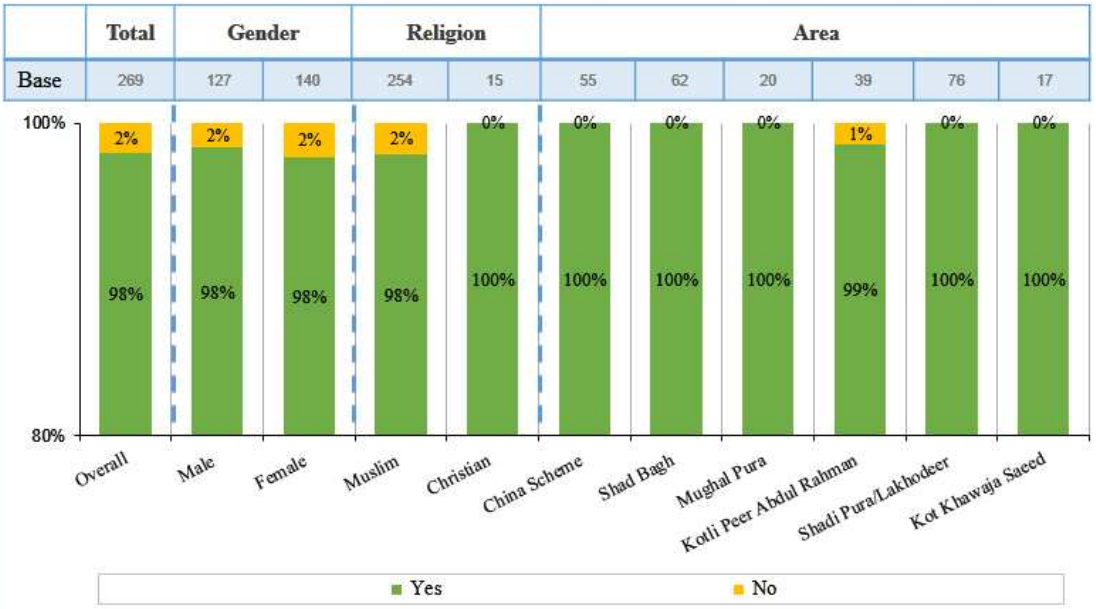
	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	248	115	131	234	14	52	59	19	38	65	15
Good for mother	70%	75%	65%	69%	79%	63%	63%	63%	58%	88%	80%
Good for children	50%	50%	50%	51%	43%	27%	66%	63%	50%	46%	73%
Our family complete	13%	1%	24%	13%	7%	13%	17%	21%	18%	3%	13%
Can't raise more children	8%	5%	10%	7%	14%	12%	8%	5%	5%	6%	7%
Other	2%	1%	3%	2%	0%	6%	2%	5%	0%	0%	0%

B8 Reasons for not considering family planning



	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	21	16	5	20	1	5	4	1	0	10	1
No need	24%	25%	20%	20%	100%	25%	0%	0%	30%	100%	39%
I read books or consult Internet	24%	25%	20%	25%	0%	25%	0%	0%	30%	0%	50%
There is no doctor in the area I can go to	24%	25%	20%	25%	0%	0%	0%	0%	50%	0%	17%
I consult my parent	24%	19%	40%	25%	0%	50%	100%	0%	10%	0%	0%
Didn't have information	5%	6%	0%	5%	0%	0%	0%	0%	0%	0%	0%
Others	5%	6%	0%	5%	0%	0%	0%	0%	0%	0%	0%

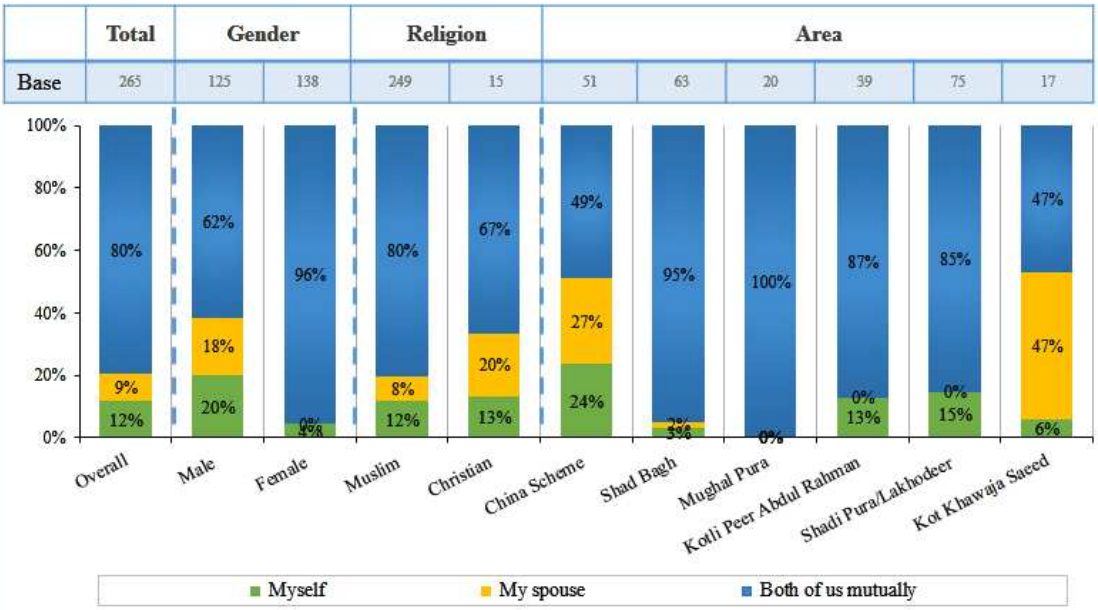
B9 Have you used any FP method?



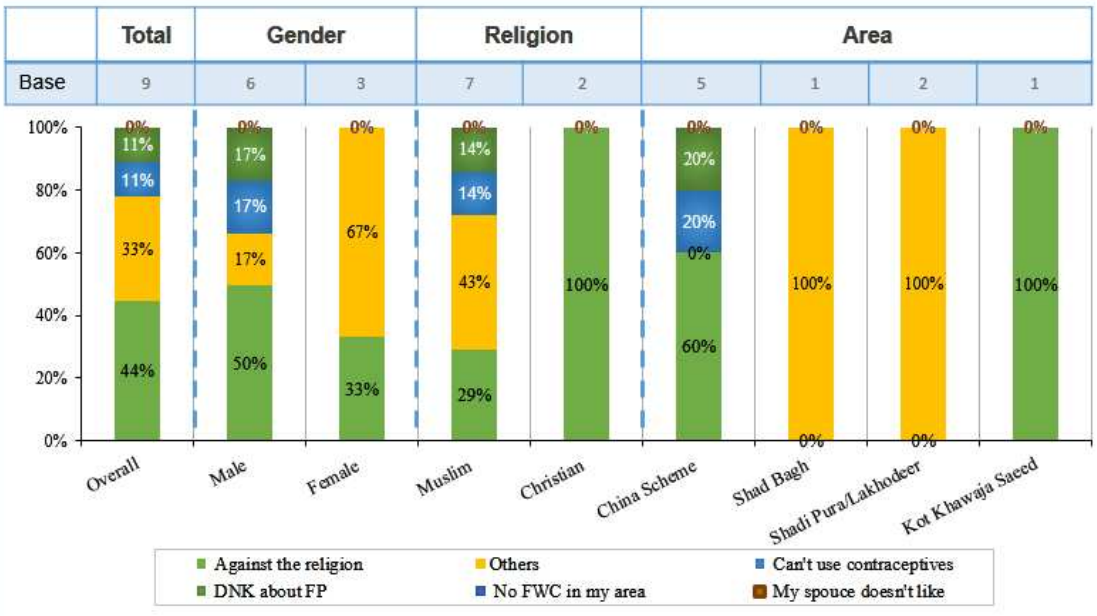
B10 Which FP method have you used?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	266	125	139	251	15	53	62	20	39	75	17
Condom	71%	78%	66%	71%	87%	70%	65%	60%	77%	76%	82% 0%
Pills	33%	17%	47%	31%	53%	26%	40%	35%	18%	36%	41% 0%
Birth Spacing	14%	17%	12%	15%	0%	9%	23%	25%	8%	15%	0% 0%
IUDs	13%	10%	15%	12%	33%	15%	8%	10%	21%	11%	18% 0%
Others	8%	2%	12%	8%	7%	9%	8%	0%	8%	4%	24% 0%

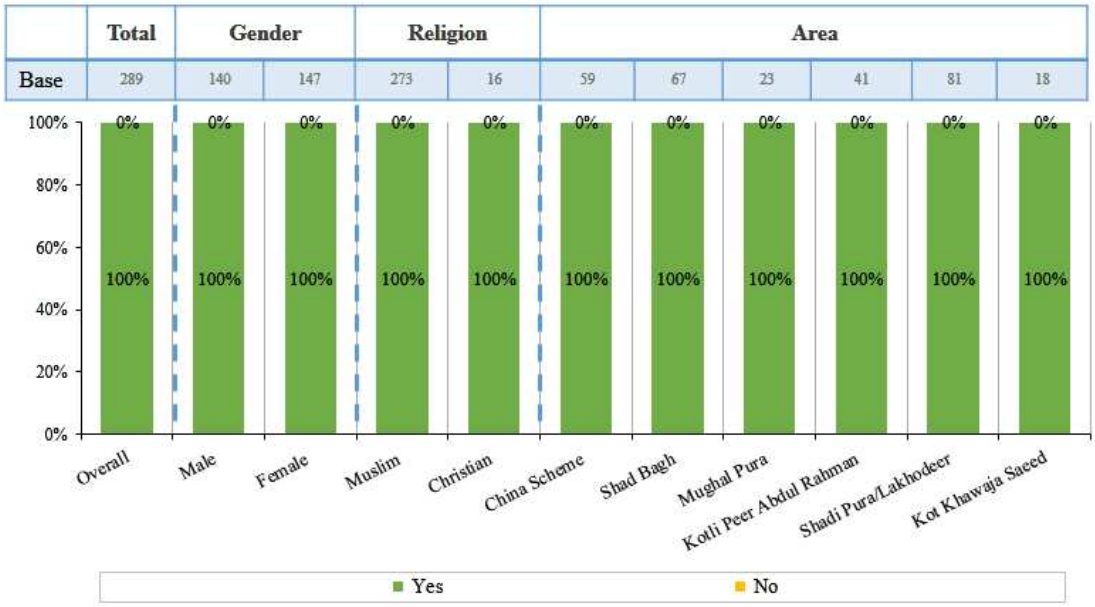
B11 Who decided about the choice of FP method?



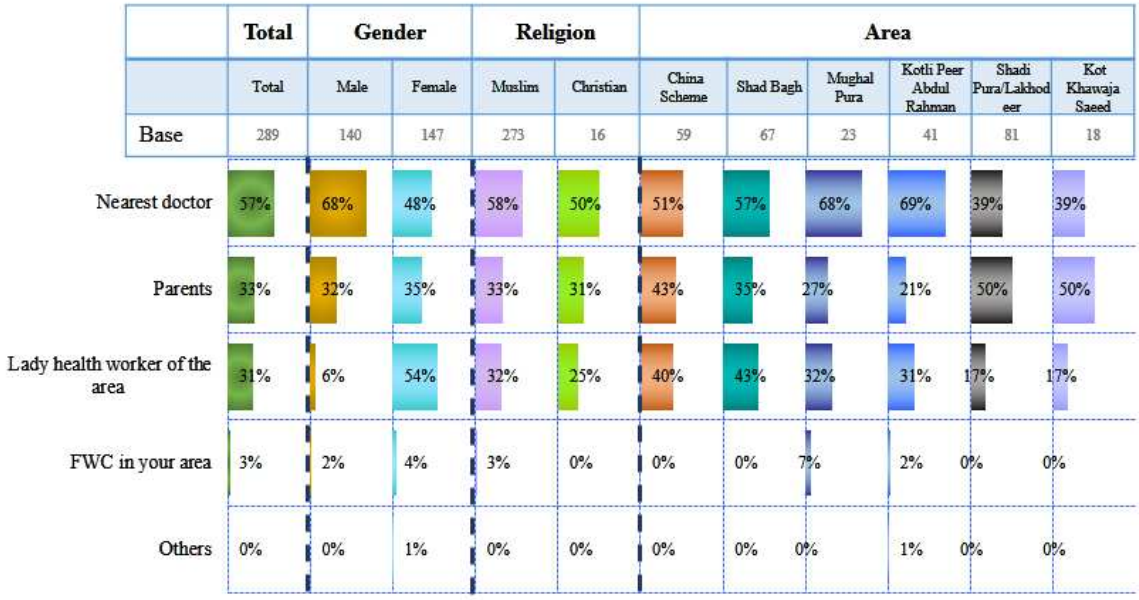
B12 If you have not used any FP method, then please tell us the reason



B13 Do you think that young men and women or couple should seek counseling about the marriage relations and FP?



B14 Where do young men & women should go to acquire counselling about FP?

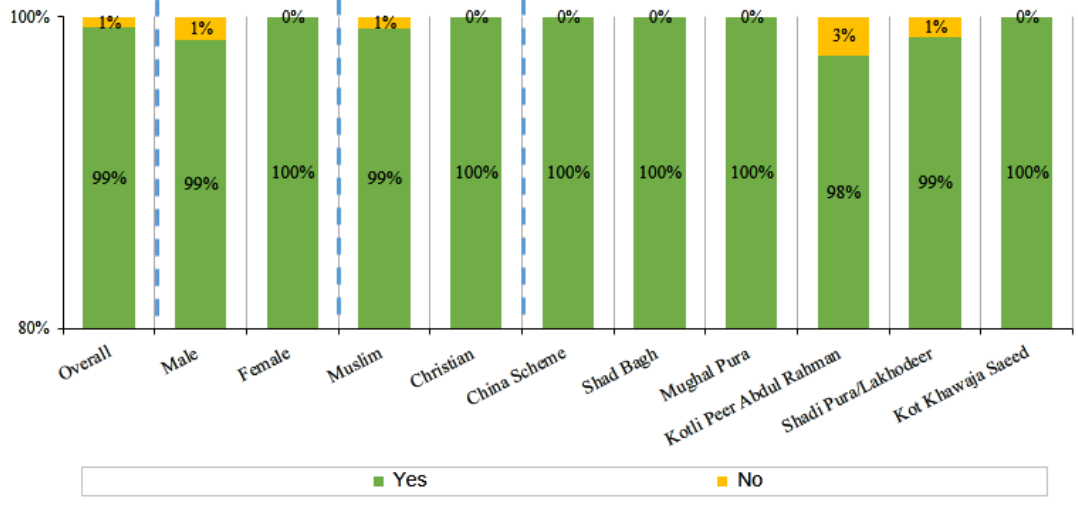


B15 What are benefits of FP?

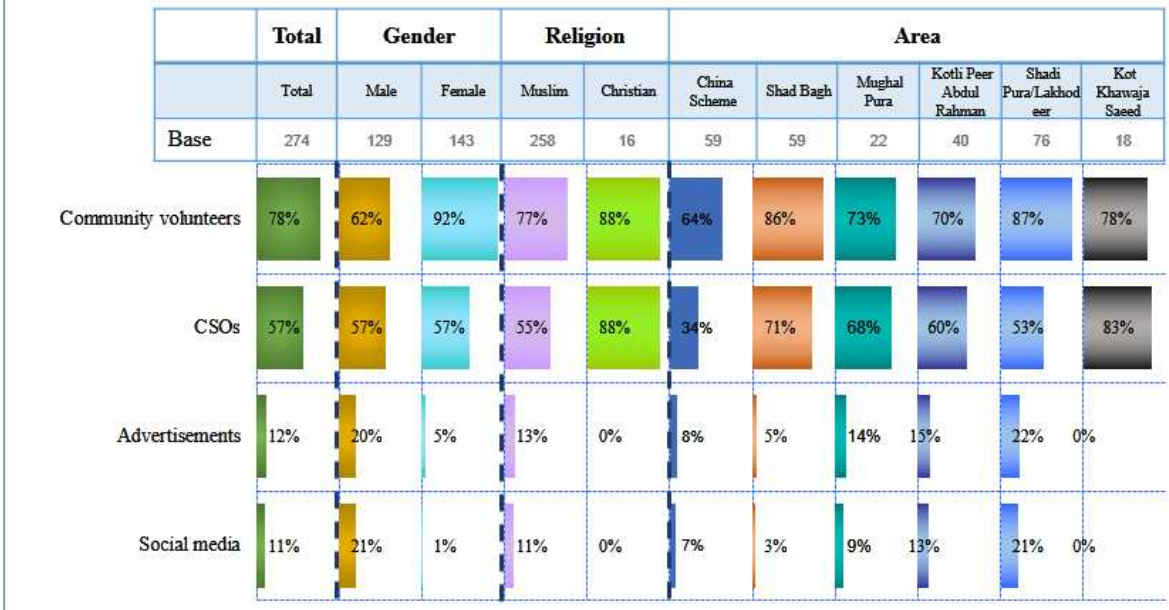
	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	285	139	144	269	16	59	66	22	39	81	18
Better health of mother and child	73%	52%	93%	72%	88%	80%	82%	77%	69%	59%	78%
Better upbringing of children	50%	38%	62%	51%	44%	42%	68%	41%	44%	44%	61%
Economic benefit to the family	36%	37%	36%	37%	31%	20%	27%	41%	49%	48%	39%
No benefit	1%	1%	1%	1%	0%	0%	2%	5%	0%	2%	0%	0%

B16 In your opinion, every young person should be educated about SRH?

	Total	Gender		Religion		Area					
Base	283	135	146	267	16	59	65	23	40	78	18

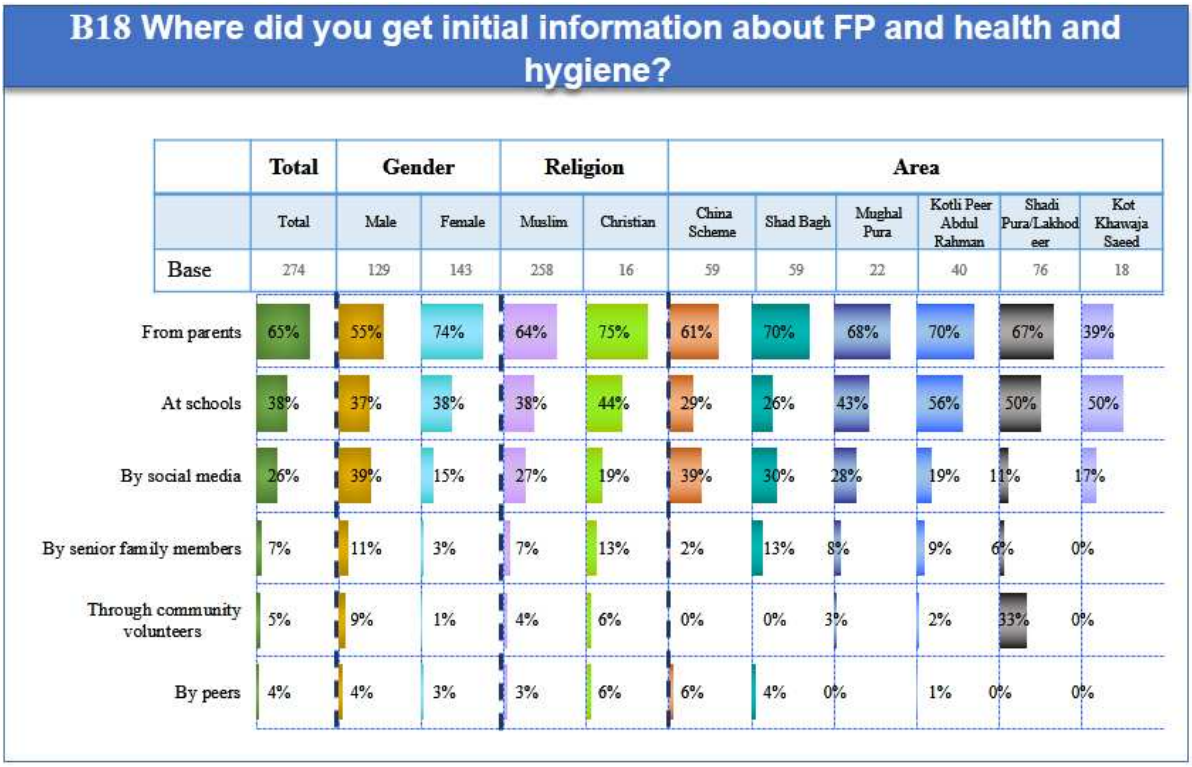


B17 How SRH education/information should be provided to the young people?



	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	274	129	143	258	16	59	59	22	40	76	18
Community volunteers	78%	62%	92%	77%	88%	64%	86%	73%	70%	87%	78%
CSOs	57%	57%	57%	55%	88%	34%	71%	68%	60%	53%	83%
Advertisements	12%	20%	5%	13%	0%	8%	5%	14%	15%	22%	0%
Social media	11%	21%	1%	11%	0%	7%	3%	9%	13%	21%	0%

B18 Where did you get initial information about FP and health and hygiene?



	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	274	129	143	258	16	59	59	22	40	76	18
From parents	65%	55%	74%	64%	75%	61%	70%	68%	70%	67%	39%
At schools	38%	37%	38%	38%	44%	29%	26%	43%	56%	50%	50%
By social media	26%	39%	15%	27%	19%	39%	30%	28%	19%	11%	17%
By senior family members	7%	11%	3%	7%	13%	2%	13%	8%	9%	6%	0%
Through community volunteers	5%	9%	1%	4%	6%	0%	0%	3%	2%	33%	0%
By peers	4%	4%	3%	3%	6%	6%	4%	0%	1%	0%	0%

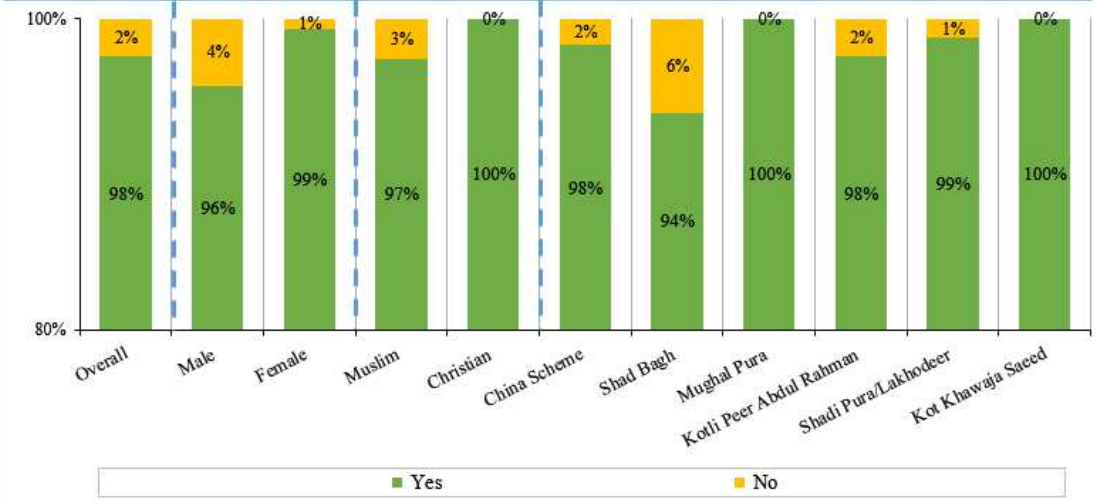
B19 What did you do after getting the initial information?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	274	132	140	258	16	57	60	23	41	75	18
Visited FWC	74%	53%	93%	74%	75%	51%	77%	78%	80%	85%	67%
Attended meetings by Friends of FWC	54%	55%	51%	55%	38%	46%	78%	70%	46%	44%	33%
Discussed it within family and friends	5%	10%	1%	6%	0%	2%	3%	0%	2%	15%	0%
Consulted media and internet for more information	4%	8%	1%	5%	0%	5%	2%	4%	10%	1%	11% 0%
Others	1%	1%	2%	2%	0%	5%	0%	0%	0%	1%	0% 0%

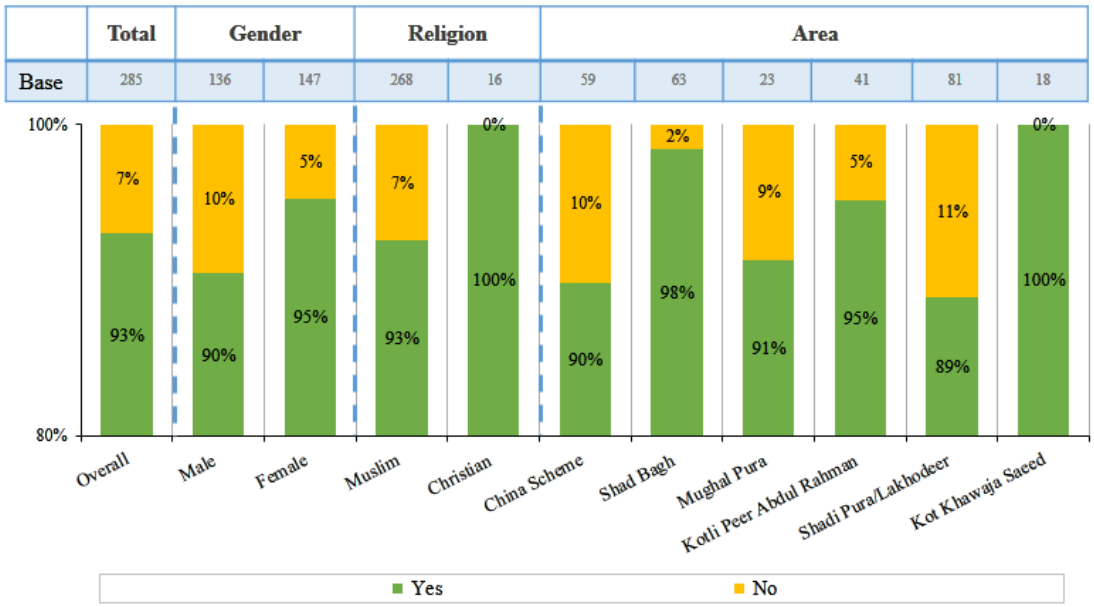
C. Evaluation of Family Welfare Center

C1 Have you heard about the family welfare center?

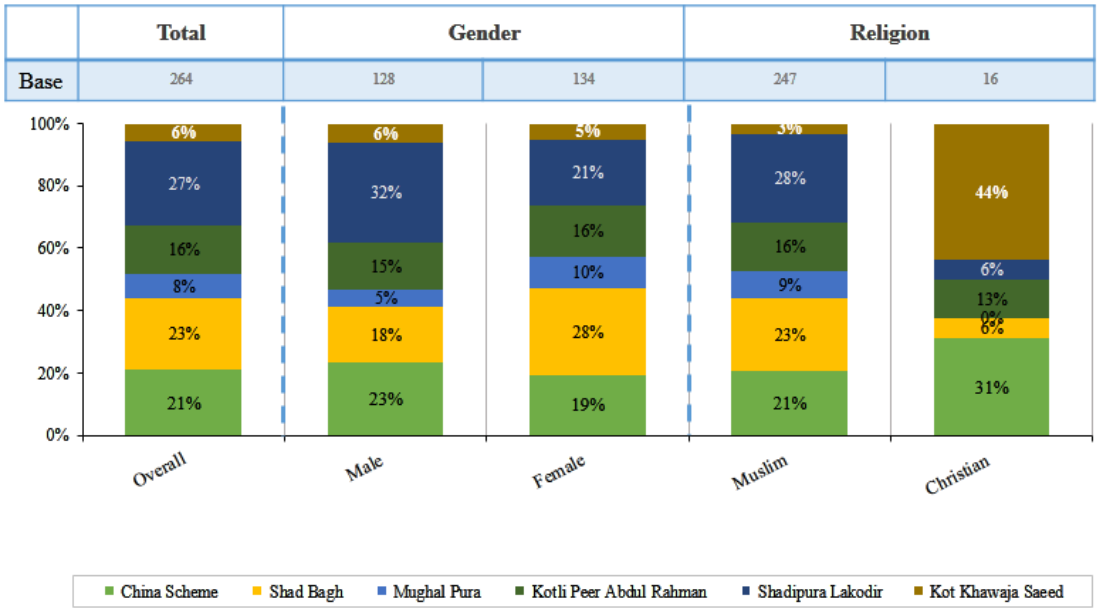
	Total	Gender		Religion		Area					
Base	288	139	147	271	16	59	66	23	41	81	18



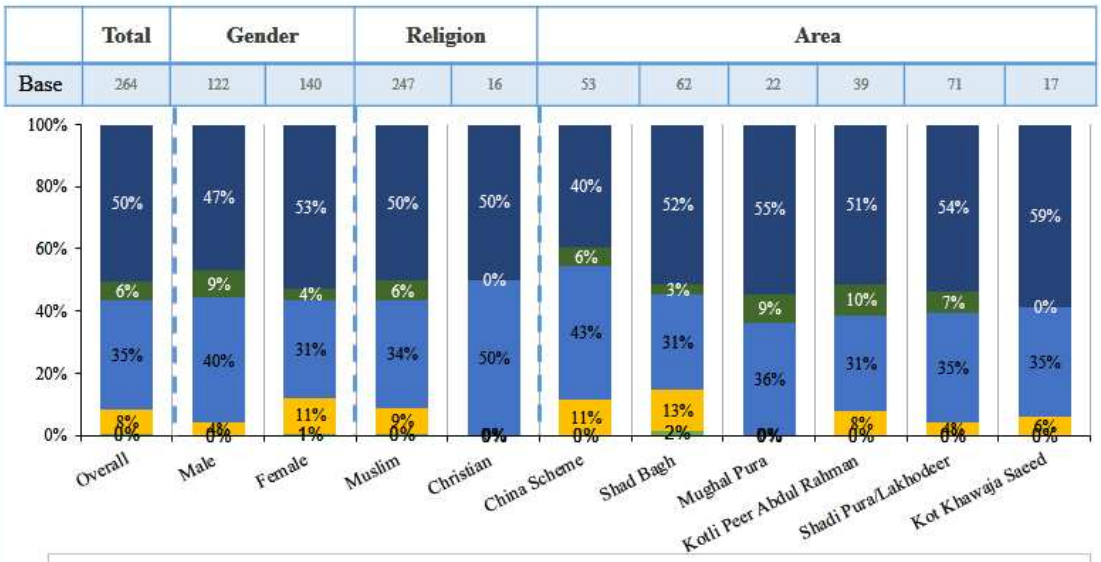
C2 Have you visited the family welfare center?



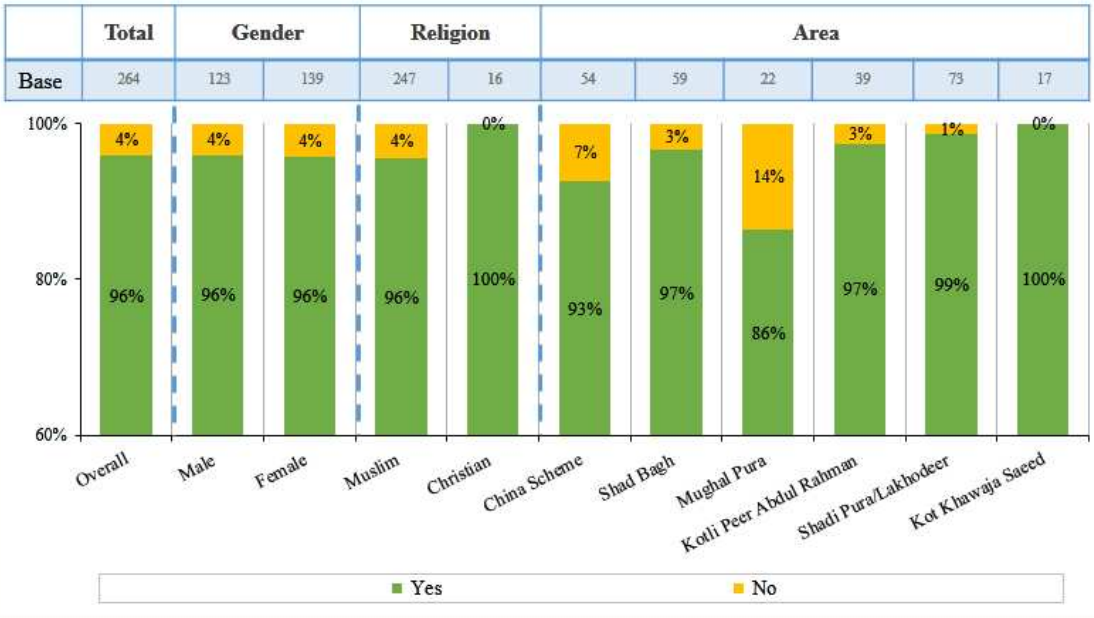
C3 Which FWC did you visit?



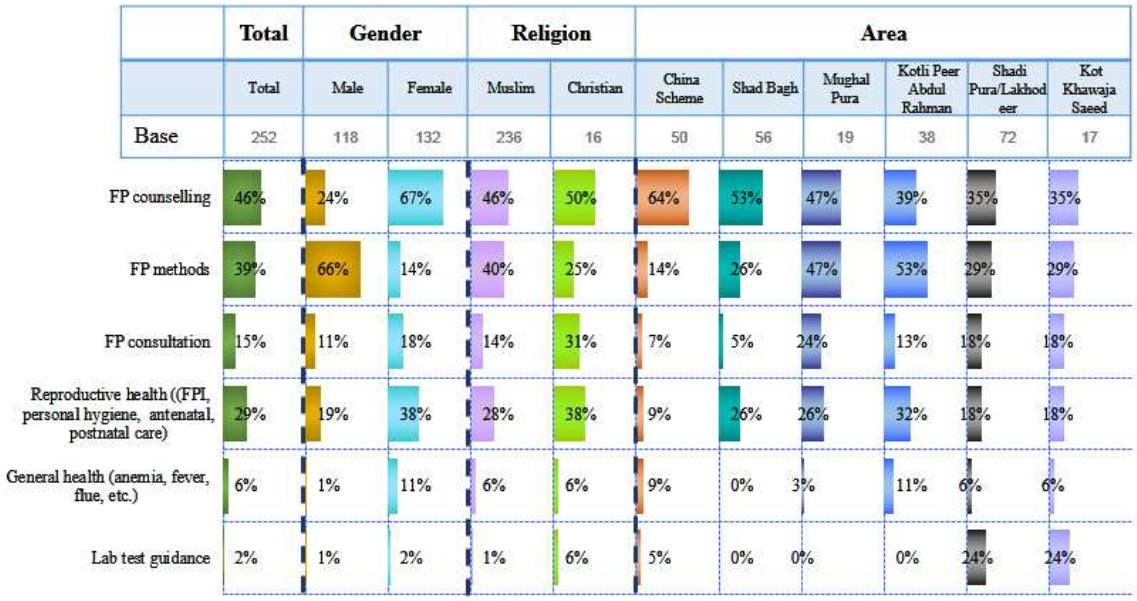
C4 How often do you visit the FWC?



C5 Have you used the services offered at the FWC?

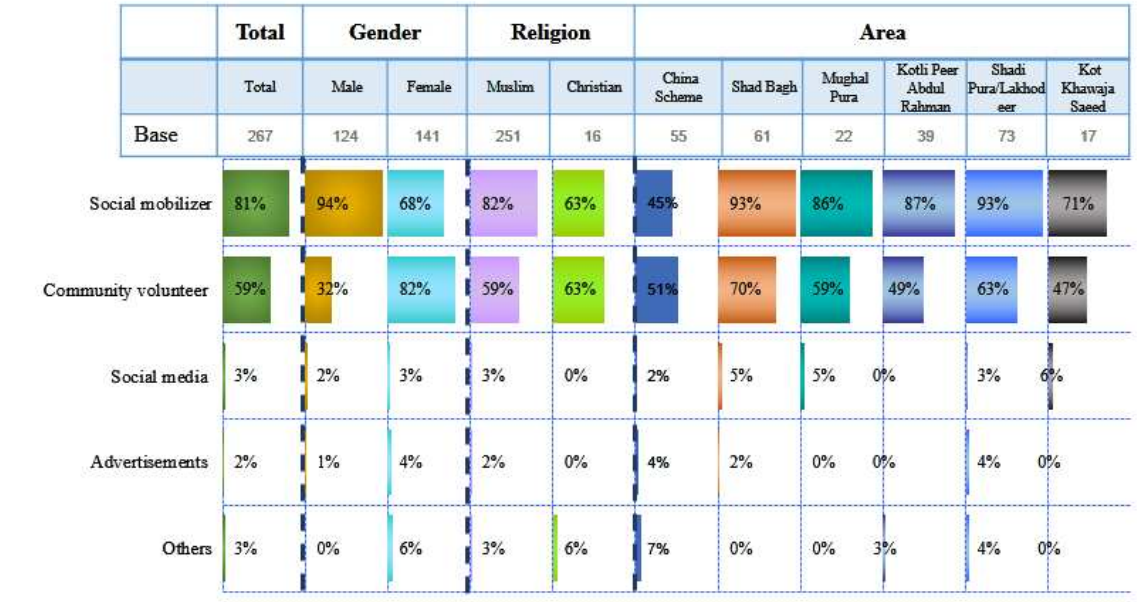


C6 Which services did you use at the FWC?



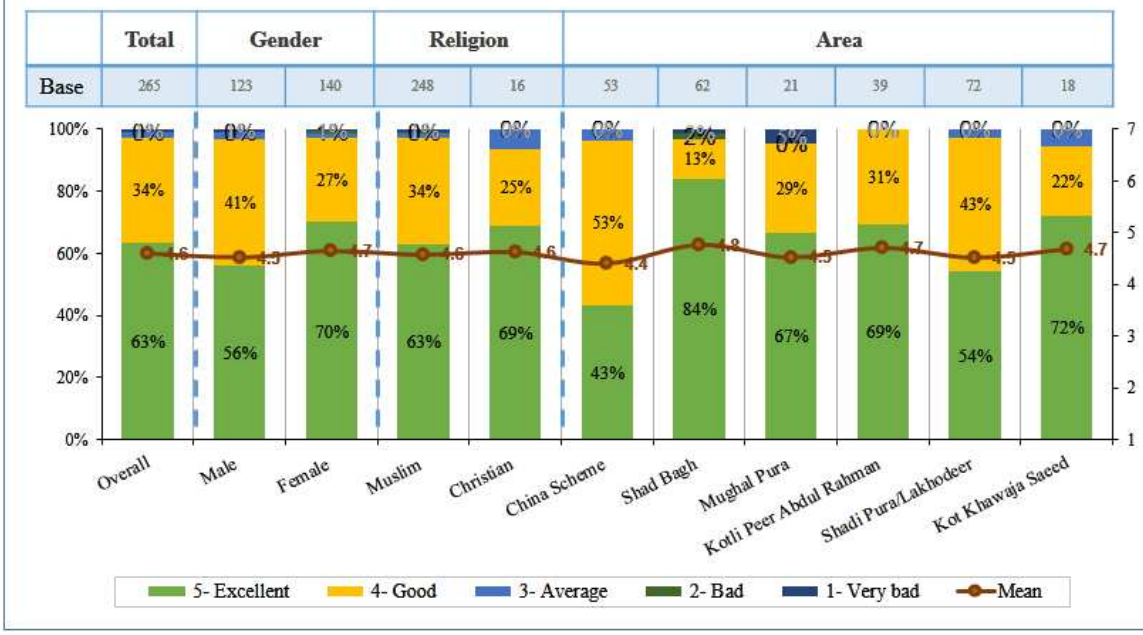
	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	252	118	132	236	16	50	56	19	38	72	17
FP counselling	46%	24%	67%	46%	50%	64%	53%	47%	39%	35%	35%
FP methods	39%	66%	14%	40%	25%	14%	26%	47%	53%	29%	29%
FP consultation	15%	11%	18%	14%	31%	7%	5%	24%	13%	18%	18%
Reproductive health ((FPI, personal hygiene, antenatal, postnatal care)	29%	19%	38%	28%	38%	9%	26%	26%	32%	18%	18%
General health (anemia, fever, flue, etc.)	6%	1%	11%	6%	6%	9%	0%	3%	11%	6%	6%
Lab test guidance	2%	1%	2%	1%	6%	5%	0%	0%	0%	24%	24%

C7 Who told you about FWC?

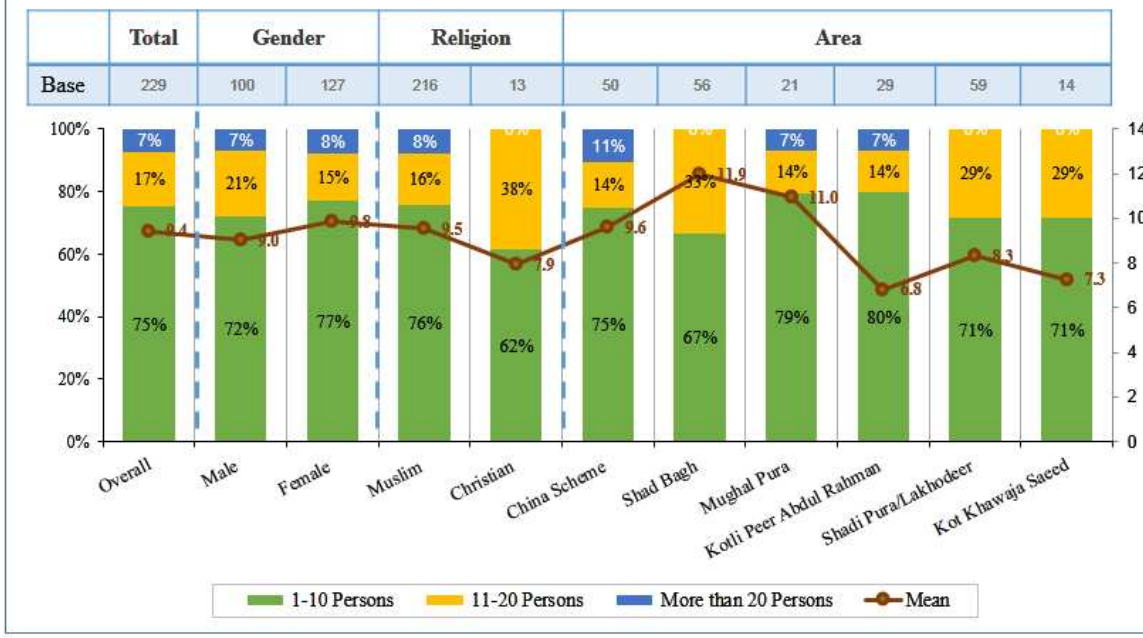


	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	267	124	141	251	16	55	61	22	39	73	17
Social mobilizer	81%	94%	68%	82%	63%	45%	93%	86%	87%	93%	71%
Community volunteer	59%	32%	82%	59%	63%	51%	70%	59%	49%	63%	47%
Social media	3%	2%	3%	3%	0%	2%	5%	5%	0%	3%	6%
Advertisements	2%	1%	4%	2%	0%	4%	2%	0%	0%	4%	0%
Others	3%	0%	6%	3%	6%	7%	0%	0%	3%	4%	0%

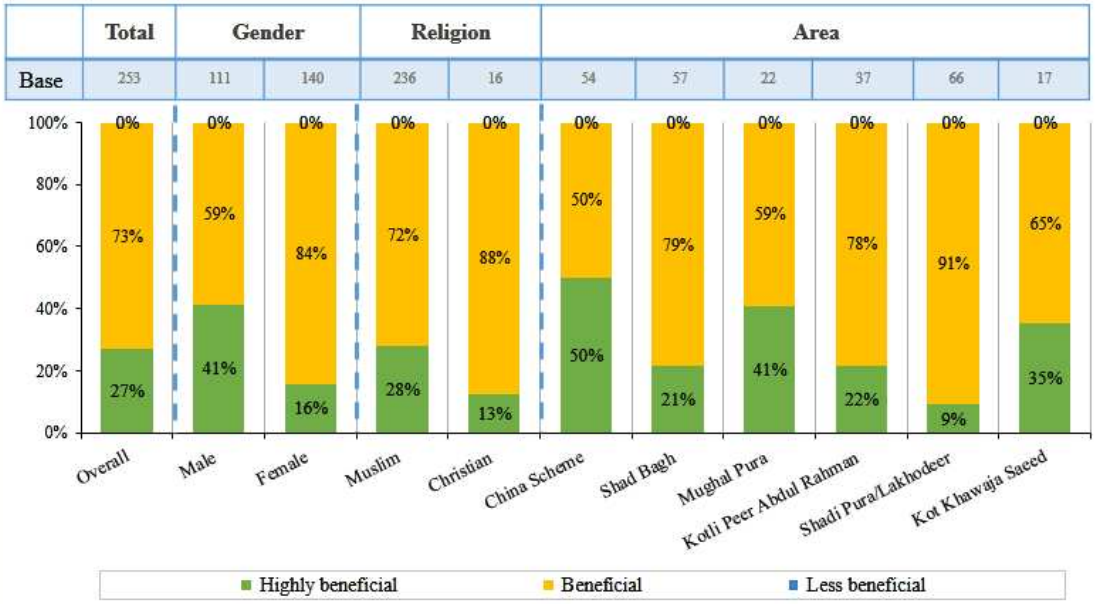
C8 How would you rate your FWC's experience?



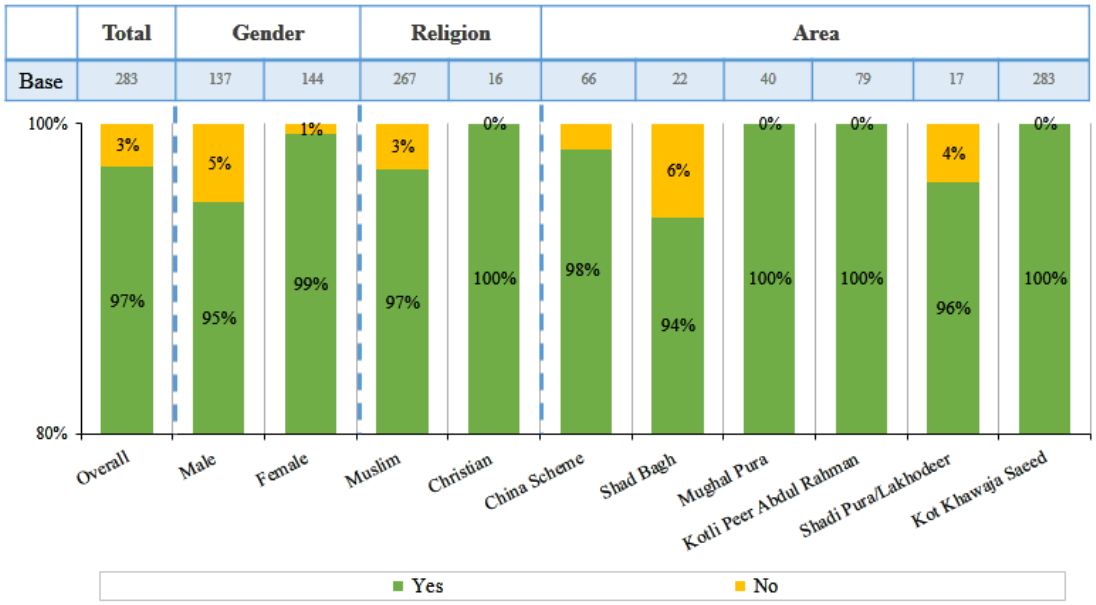
C9 If you found the services at FWC useful, how many persons have you recommended to visit FWC in your area?



C10 How beneficial is FWC for its contribution to the health and welfare of your community?

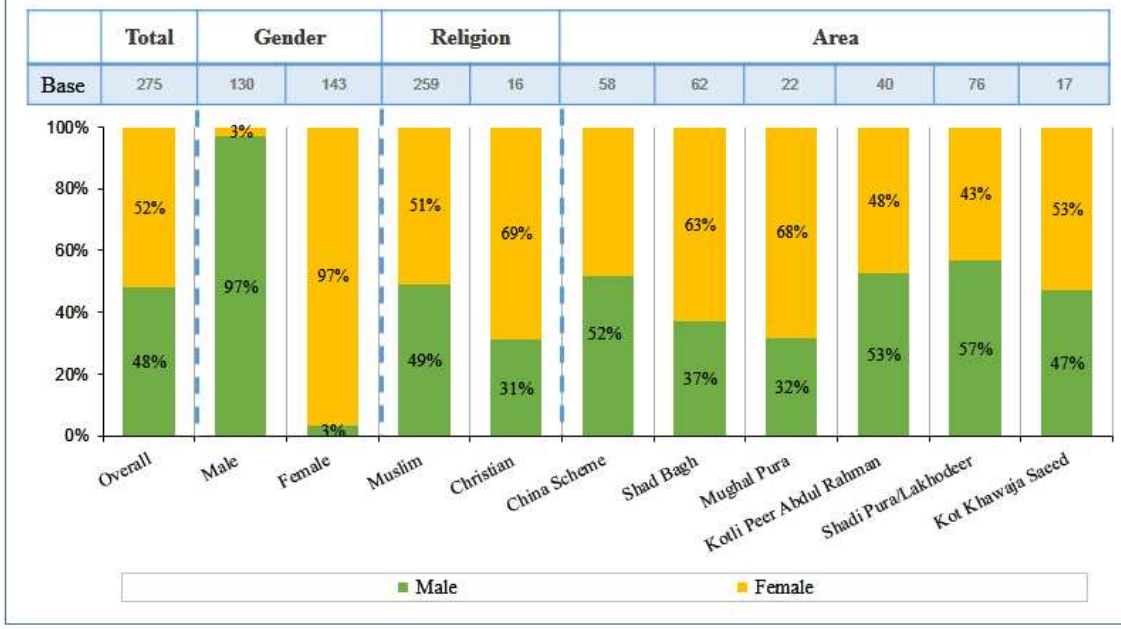


D1 Do you know FFWC in your area?

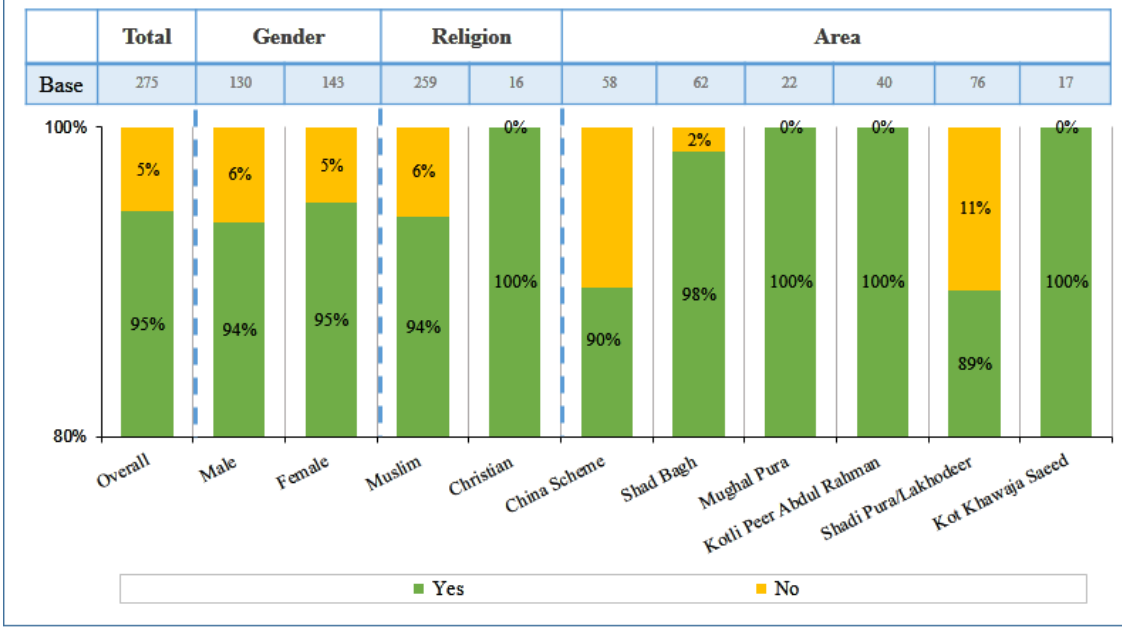


D. Friends of FWC (FFWCs)

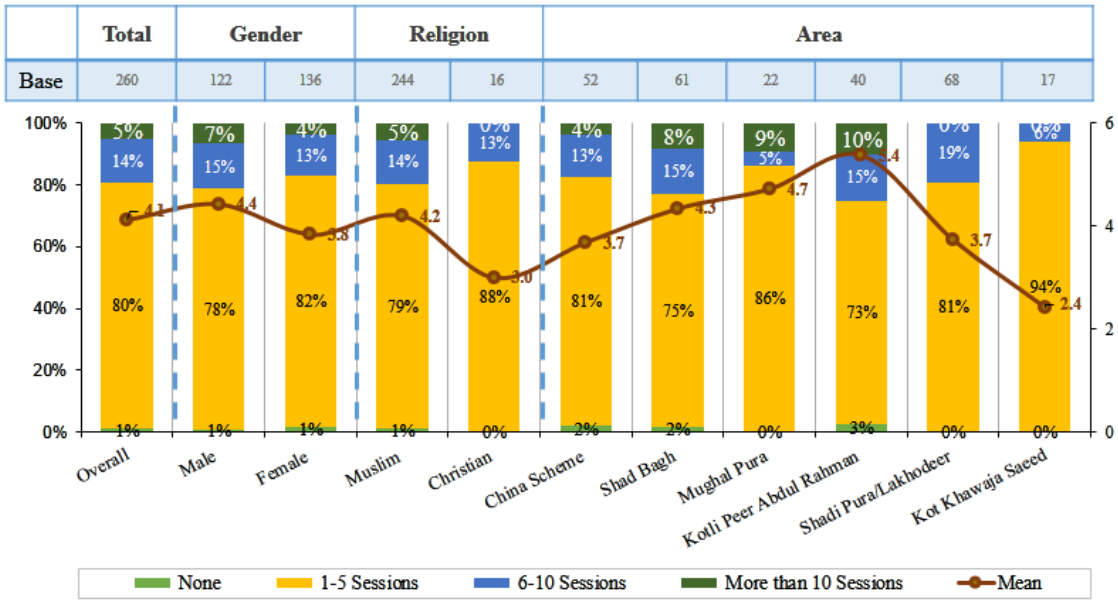
D2 Which group you are aware of?



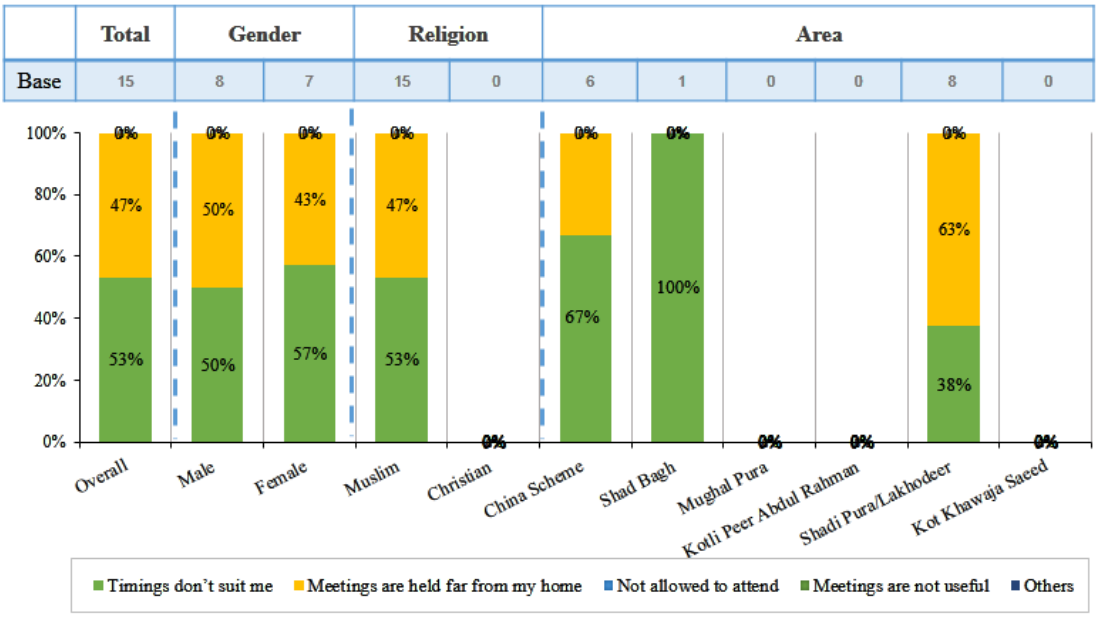
D3 Have you attended FFWC's awareness sessions in your area?



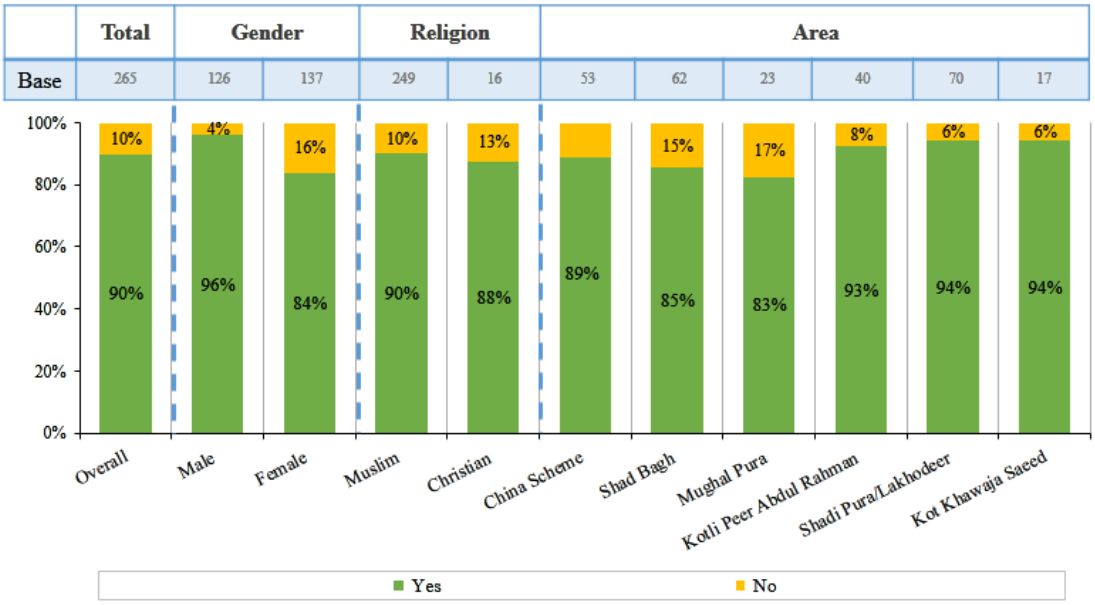
D4 If yes, then how many awareness sessions have you attended in last one year?



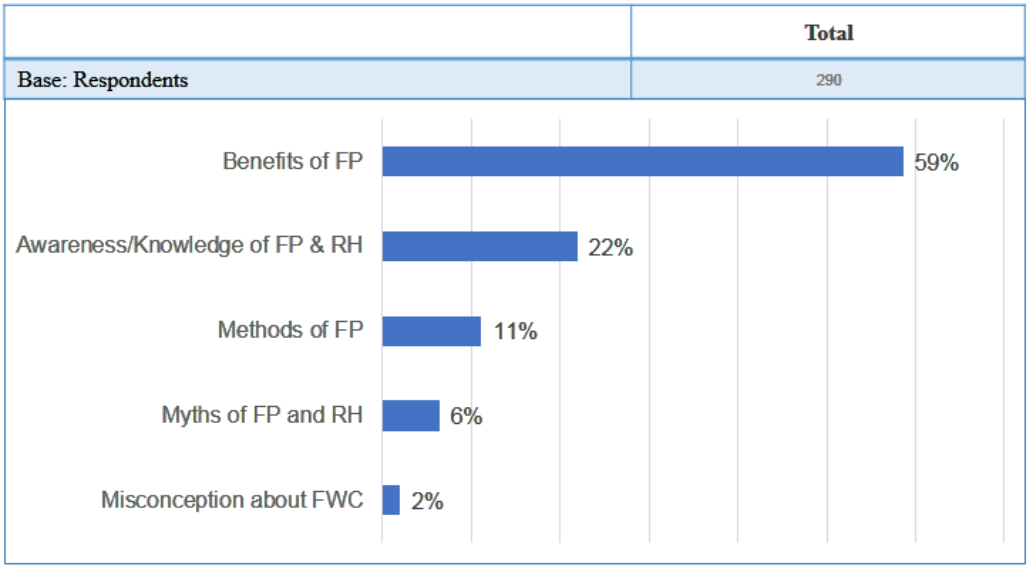
D5 If no, then please tell us the reason for not attending?



D6 Did you learn something new about sexual and reproductive health at these awareness sessions?



D7 What new things did you learn about FP & reporductive health?

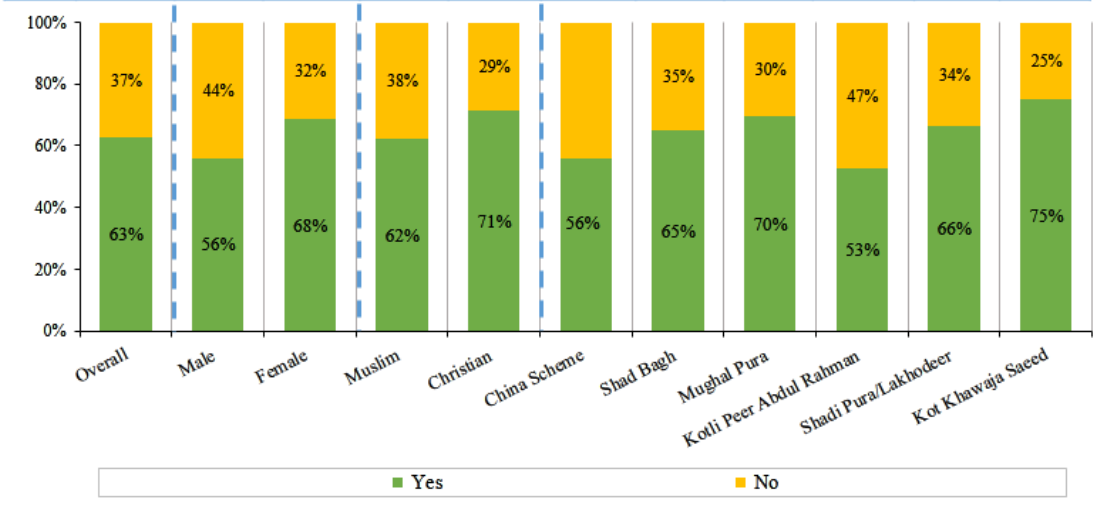


D8 Can you list few things you learnt about FP at these awareness sessions?

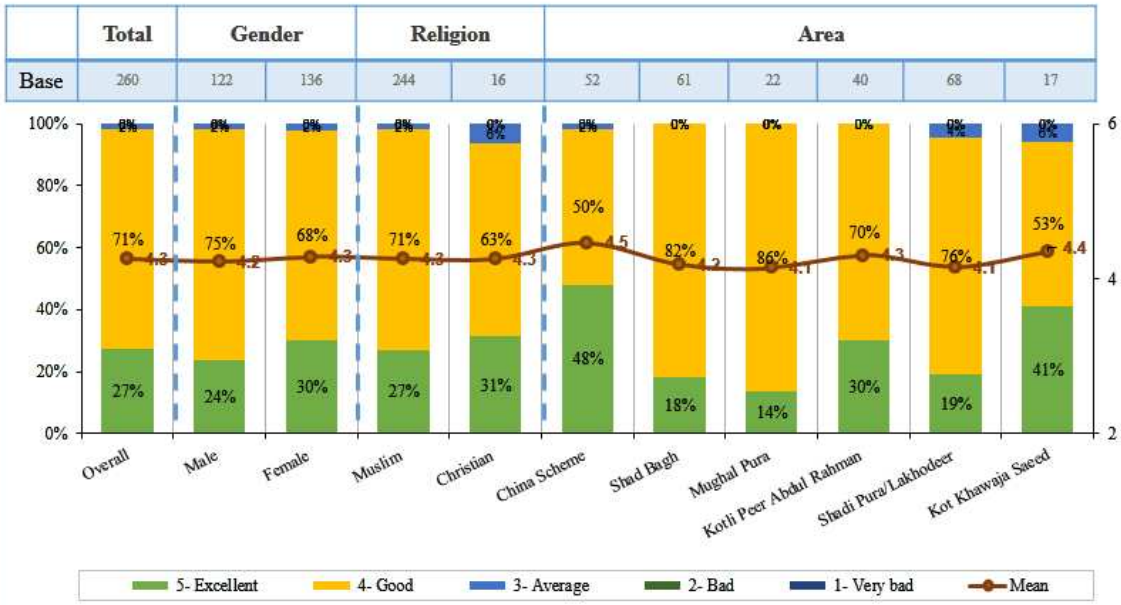
	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	252	118	132	237	15	43	60	22	39	71	17
SRH awareness & importance	46%	25%	65%	46%	60%	28%	58%	59%	51%	38%	59%
FP methods	36%	34%	37%	33%	80%	44%	28%	14%	51%	31%	53%
General information about Family planning	27%	25%	28%	27%	20%	30%	13%	32%	36%	25%	41%
Importance of breast feeding and birth spacing	26%	42%	12%	27%	13%	23%	10%	18%	36%	41%	18%
Myths and misconceptions about FP	21%	34%	10%	20%	33%	26%	12%	14%	33%	25%	6%
Personal health and hygiene	13%	9%	16%	13%	13%	14%	8%	23%	5%	14%	24%
Infectious diseases	1%	1%	1%	1%	0%	0%	0%	0%	3%	1%	0%
Benefits of couple registration	1%	1%	1%	1%	0%	0%	2%	5%	0%	0%	0%

D9 Did you ask questions regarding SRH and FP during community sessions?

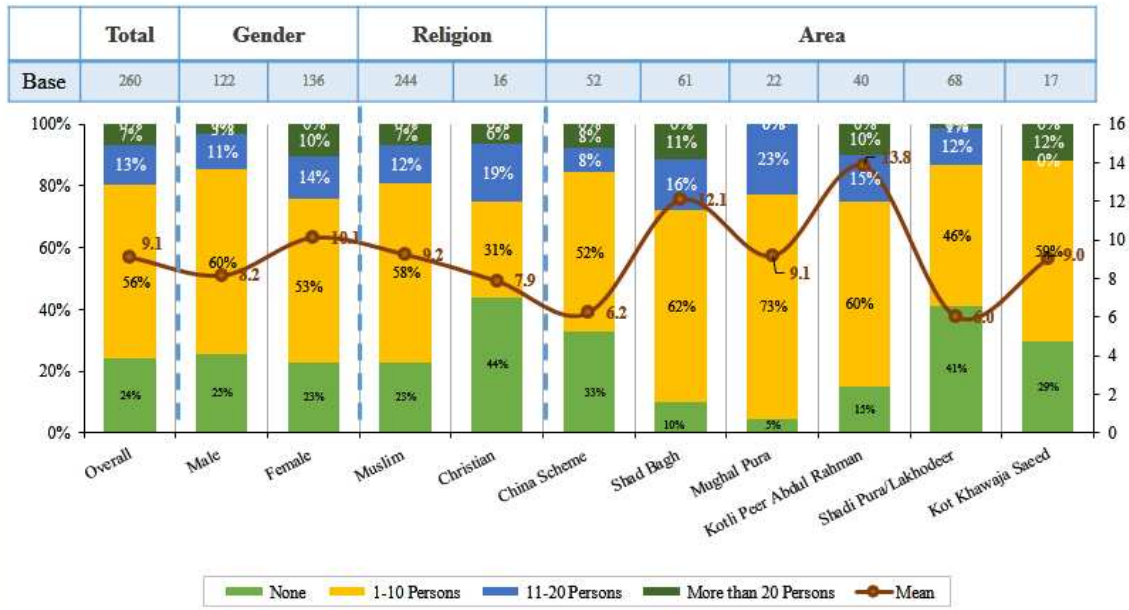
	Total	Gender		Religion		Area					
Base	255	123	130	241	14	50	60	23	38	68	16



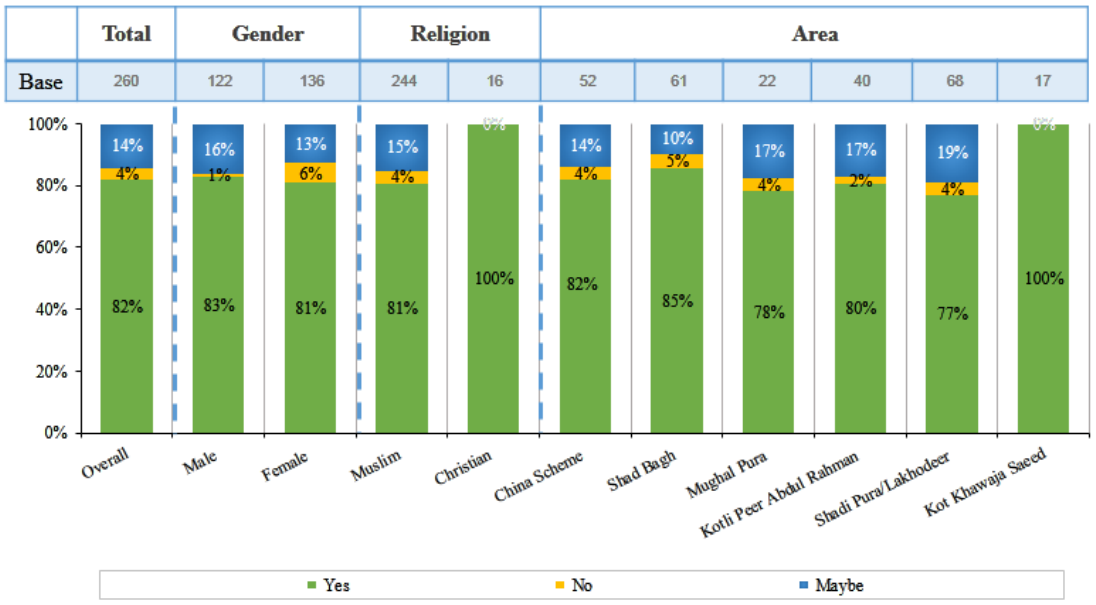
D10 How would you rate the information/guidance/counselling you were provided at FFWC sessions?



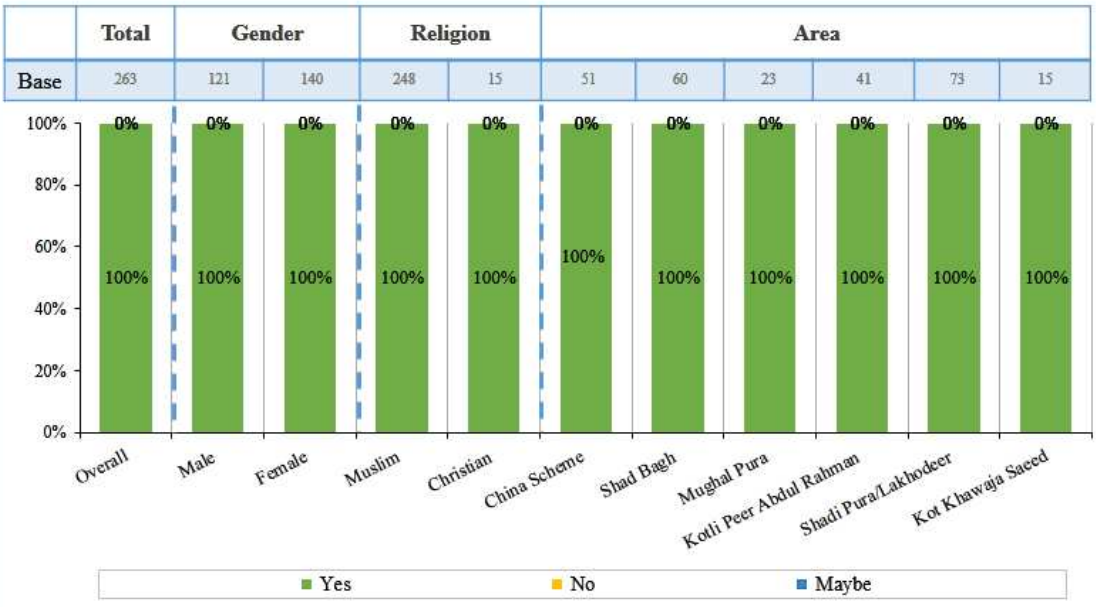
D11 If you found FFWC sessions useful, how many other persons have you invited to attend the next awareness sessions of FFWC in your area?



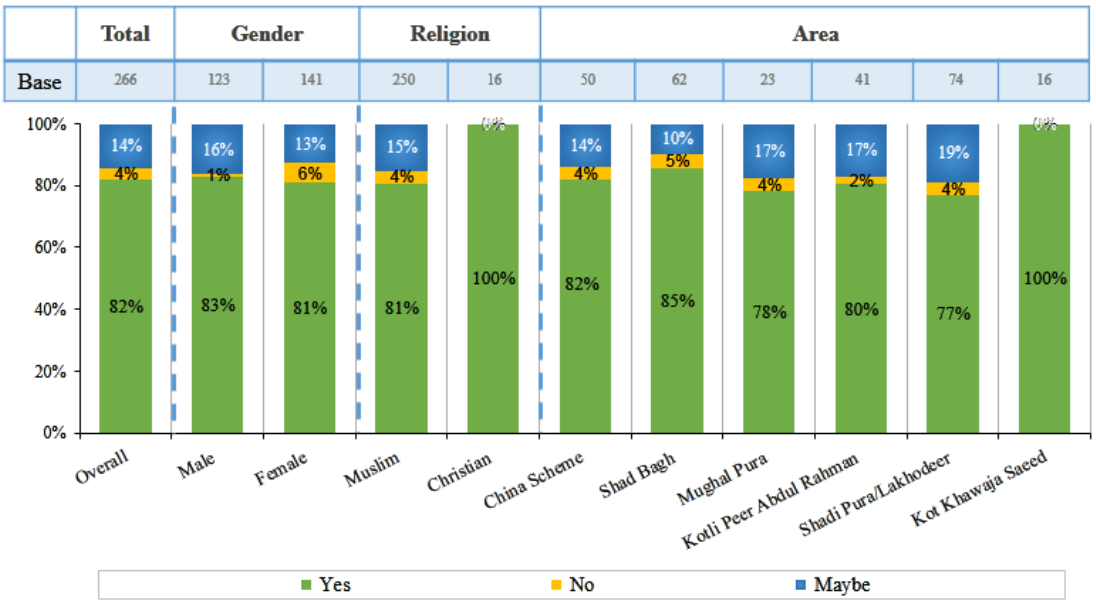
D12 Attending FFWC meetings encourages men and women to visit FWCs in your area. Do you agree?



D13 Do you think that friends of FWC have performed valuable social service for improvement of SRH in your area?



D14 Do you think, male FFWC should be made available in all FWCs run by population welfare department?



D15. What is the benefit male volunteers?

Verbatim
• Behtar rehnumai milti hai
• Agar mard smjh jayen tw poora gharana theek ho skta hai
• Logo ko behtar agaahi de sakte hain
• Mard, mard razakaaron ko behtr tareeqy se apna masla bta skaty hain
• Mard ko mard se maloomat lena asaan hota hai
• Mardon ka mardo k sath family planning pe baat krna behatr tareeqa hai
• Mard ghar ka sarbarah hai unko samjhana zyada acha hai
• Aurten mardon k tabe hain wo samjh gye tw khandan samajh gya
• Log un par aitmaad karty hain un se asaani se mila ja sakta hai
• Mard bat nahi mantay unko information honi chaye
• Mard dusray mardon jo mansuba bandi per amada karain
• Mardon ko munsuba bandi per agree karain males
• Takay mard razakar dusray mardon ko family planing pe razamand kr sakain

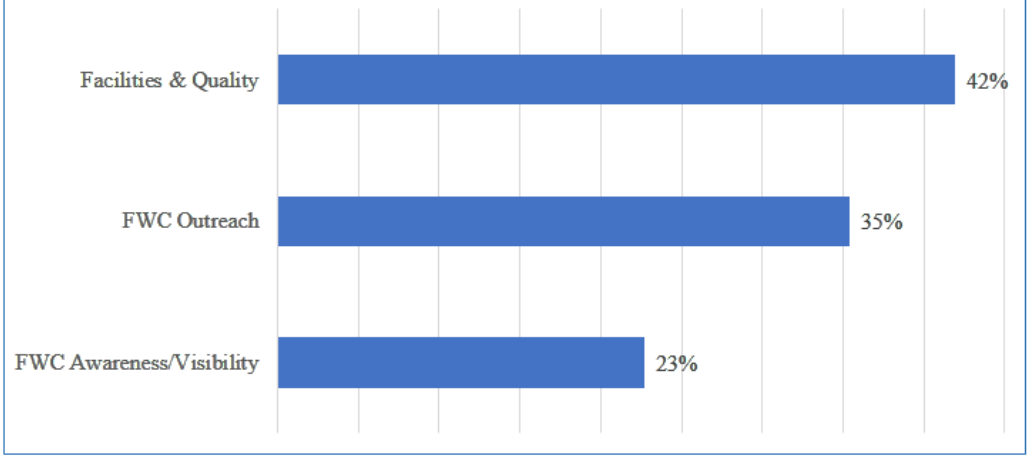
E. Usefulness of Services & Suggestions for Future

E1 Which of the following method for raising SRH awareness do you recommend for use in future?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	282	138	142	266	16	55	66	23	41	80	17
Community awareness session	90%	94%	86%	89%	100%	87%	83%	91%	85%	98%	100%
Social Media (Facebook, WhatsApp, Instagram & Youtube)	41%	41%	41%	42%	25%	2	41%	48%	59%	43%	24%
Print media (newspaper magazines, journals)	14%	22%	7%	14%	13%	2	8%	13%	7%	13%	24%
Electronic media (TV, Radio)	12%	12%	13%	12%	19%	2	18%	9%	10%	5%	6%
Short message services (SMS)	8%	7%	10%	8%	13%		14%	0%	2%	9%	18%
Others	20%	21%	18%	20%	19%	2	17%	26%	12%	24%	12%

E2.1 What are your suggestions for the FWC for improving SRH services

FWC	Total
Base: Respondents	260

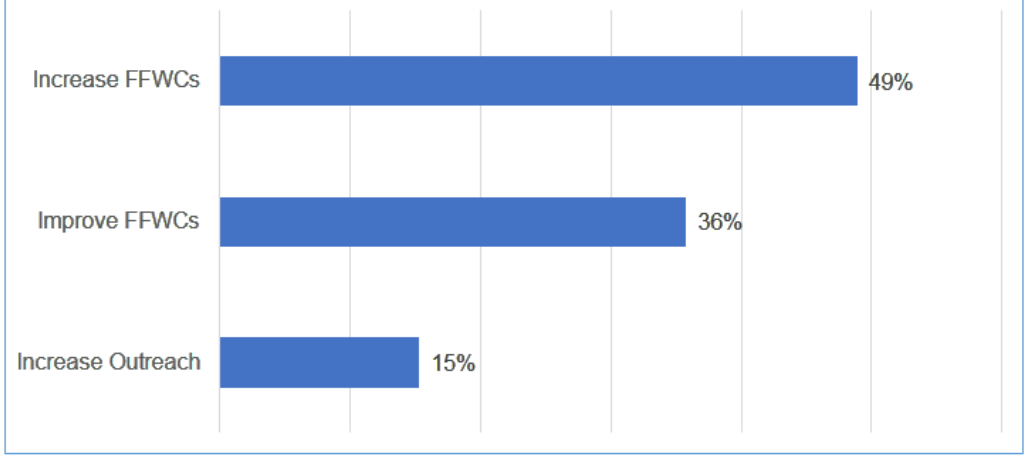


E2.1 What are your suggestions for the FWC for improving SRH services

Verbatim of FWC
• Staff ka behavior behtar krain
• Use of social media
• Koi call number honi chahiya for location
• Centre asi jga hu jaha sbko asani hu
• Khush ikhlaq hon
• Auraton k sath bcchon ki sehat per focus
• Bchon ky lia dwayan
• Bchon ky lia doctor hon

E2.2 What are your suggestions for the FFWC for improving SRH services

FFWC	Total
Base: Respondents	260



E2.2 What are your suggestions for the FFWC for improving SRH services

Verbatim of FFWC
• **Females k health cards bnayain**
• Mazed log bharti kren unki baqaida govt se registration ho
• Group ko sarkari tor par shanakht den
• Abadi k lehaz se dosto me izafa karen
• Har ilay me union ki satah par fwc hony chahiye
• Khush ikhlaq ho
• Khush ikhlaq ho aur har gali me session kre
• Tajarba kaar
• Group ko government card ki shanakht di jaye
• Khush ikhlaq ho or inki tadad me bhi izafa karen
• Zyada kaam karne waly hon
• Khush ikhlaq ho
• Dosto se acha taluq hai, khush ikhlaq hona chahiye
• Group ko parhaya jay
• Nay nay mashwaray or malumat hon
• Auraton ko updated methods se agha karain
• Ziada session krwayain, mardon ko b agahi dyn

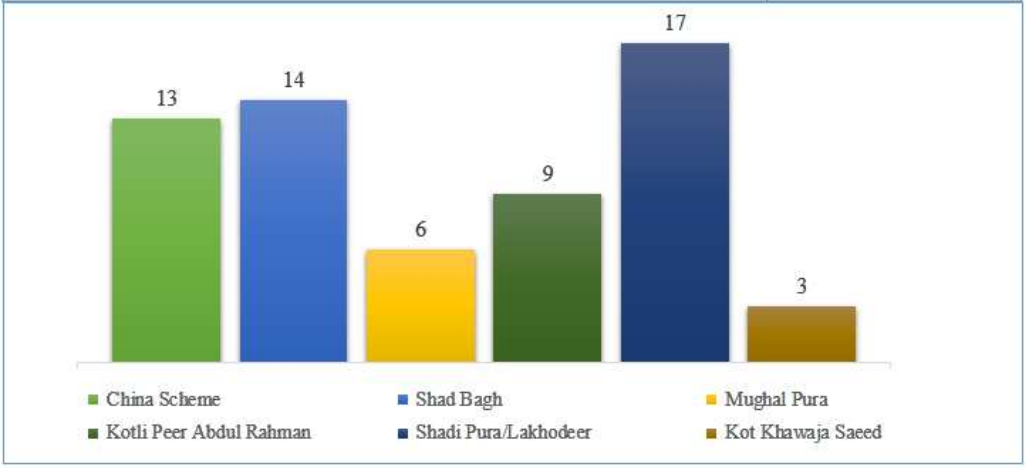
Annex – 7

FWC Client Exit Interview Results

A. DEMOGRAPHICS

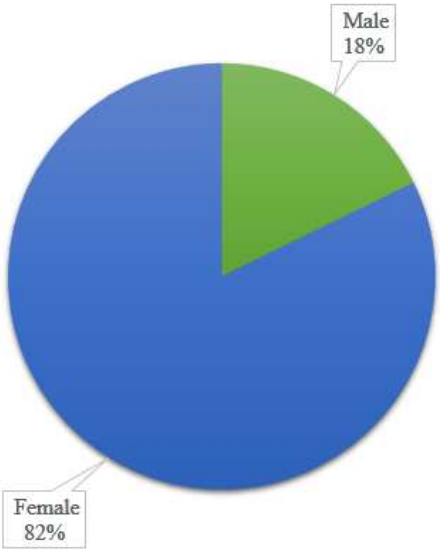
Area wise sample breakup

	Total
Base: all respondents	62



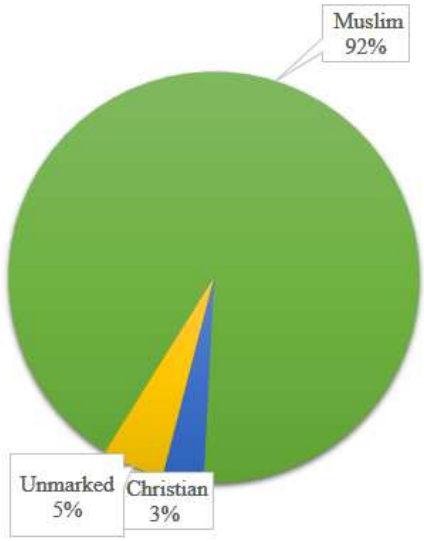
Gender of respondent

	Gender		
	Total	Male	Female
Base: all respondents	62	11	51



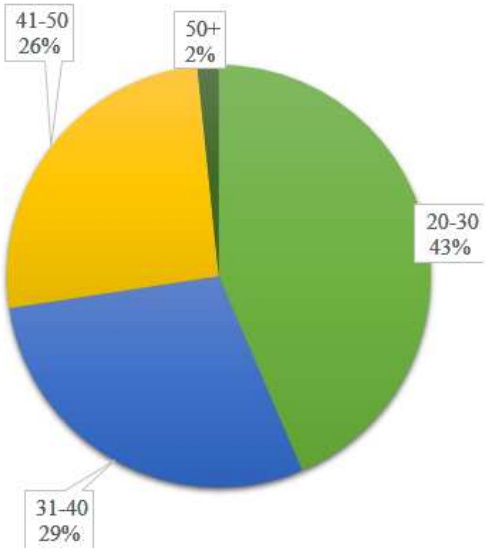
Religion of respondent

	Religion			
	Total	Muslim	Christian	Unmarked
Base: all respondents	59	57	2	3



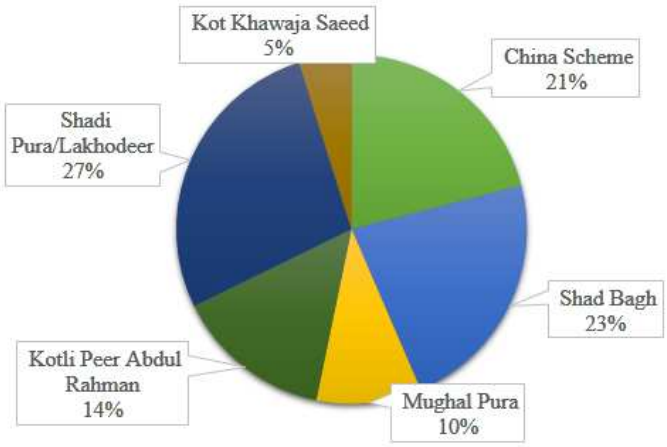
Age of respondent

	Age (years)				
	Total	20-30	31-40	41-50	50+
Base: all respondents	62	27	18	16	1



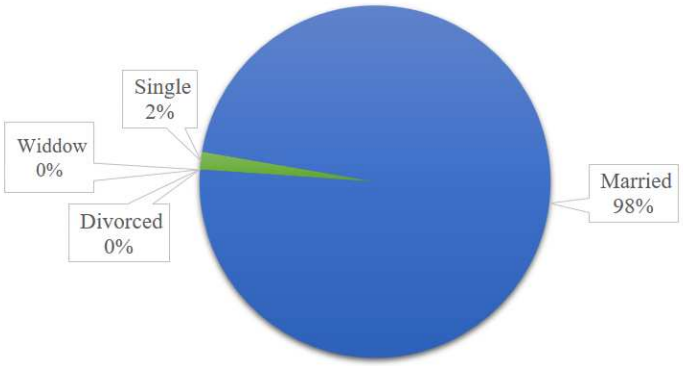
Area of residence

		Area					
	Total	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base: all respondents	62	13	14	6	9	17	3



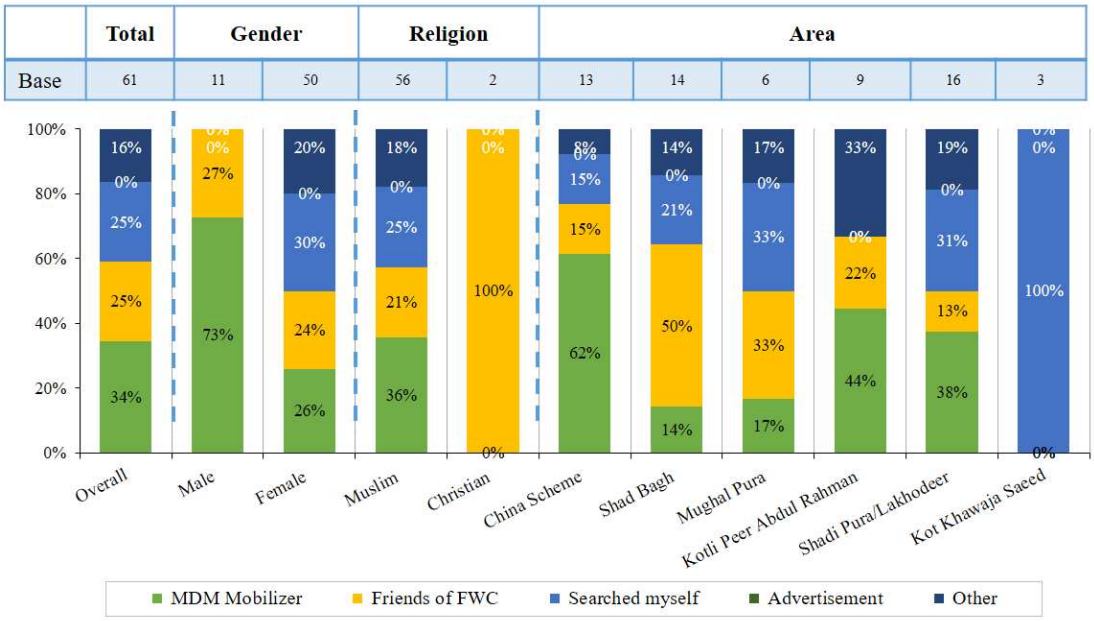
Marital status

		Marital status			
	Total	Single	Married	Divorced	Widow
Base: all respondents	62	1	61	0	0

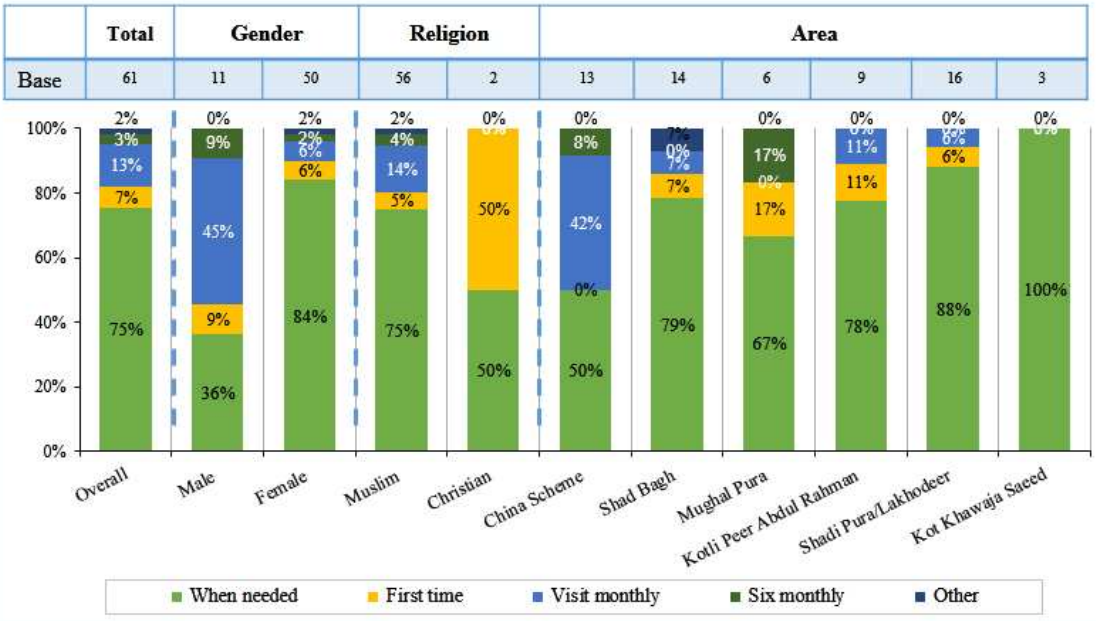


B. EXIT INTERVIEWS OF FWC CLIENTS

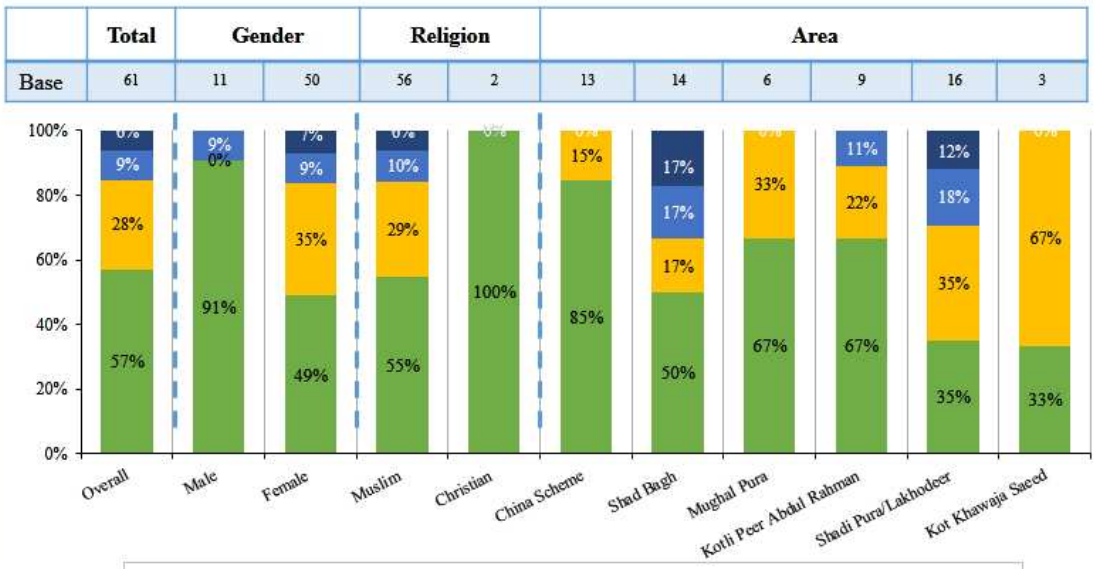
EI-6. How did you know about this place?



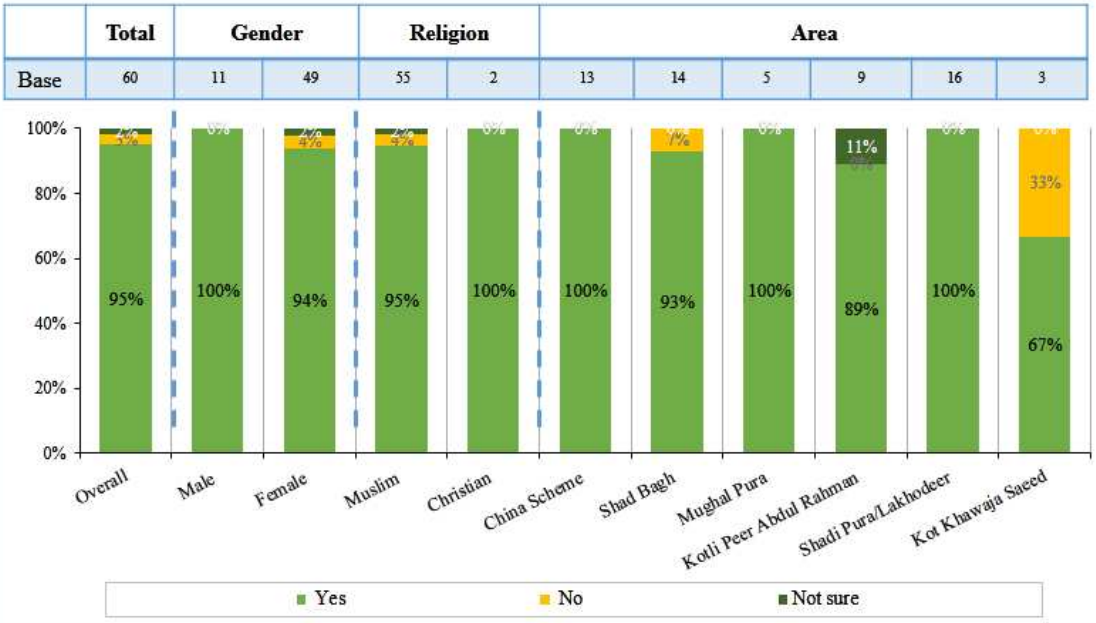
EI-7. How many times you've come before?



EI-8. What service(s) you came for today?



EI-9. Did you get the services you wanted today?

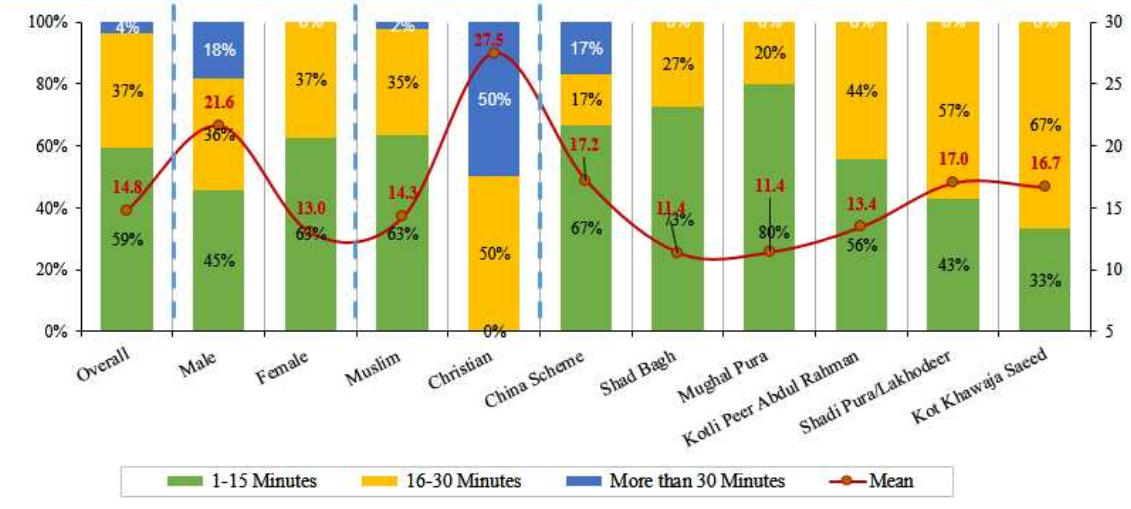


EI-10. Do you know what other services are available at this center?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	50	9	41	46	1	8	12	5	9	14	2
Family planning (awareness and methods)	54%	67%	51%	57%	0%	75%	58%	20%	56%	50%	50%
Mother & child care (birth spacing, breast feeding, etc)	52%	33%	56%	52%	0%	50%	67%	60%	33%	57%	0%
Anemia	48%	11%	56%	50%	0%	13%	50%	60%	67%	50%	50%
Pregnancy related tests/examinations	46%	0%	56%	48%	0%	38%	50%	40%	33%	57%	50%
Personal Health & Hygiene	38%	0%	46%	39%	0%	13%	58%	0%	22%	64%	0%
Abortion	34%	11%	39%	35%	0%	13%	50%	20%	11%	57%	0%
Water borne diseases	30%	11%	34%	28%	100%	13%	42%	20%	11%	50%	0%
Environmental hygiene	28%	0%	34%	28%	0%	13%	42%	0%	11%	50%	0%

EI-11. How long it takes you to come here from where you live?

	Total	Gender		Religion		Area					
Base	54	11	43	49	2	12	11	5	9	14	3



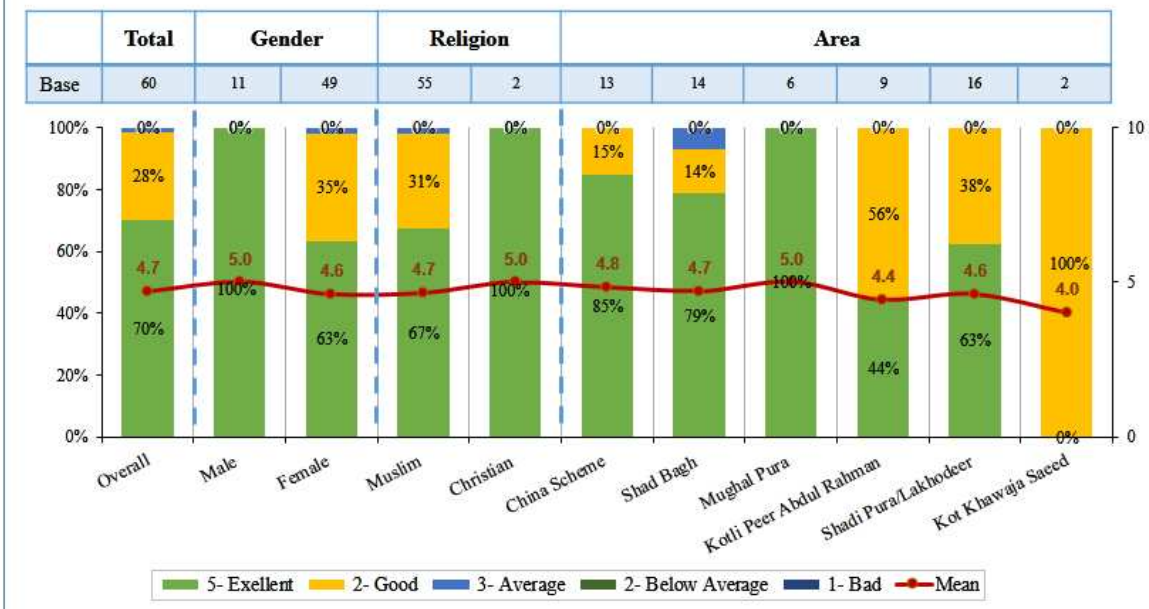
EI-12. What other services should be available at this facility?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	43	11	32	39	2	9	8	5	7	11	3
Pregnancy related tests/examinations	56%	64%	53%	56%	50%	78%	38%	40%	43%	64%	67%
Anemia	42%	27%	47%	44%	0%	44%	38%	20%	14%	64%	67%
Family planning (awareness and methods)	40%	18%	47%	38%	50%	2	50%	20%	14%	64%	67%
Mother & child care (birth spacing, breast feeding, etc)	37%	9%	47%	36%	50%		50%	40%	14%	55%	67%
Water borne diseases	37%	18%	44%	38%	0%	2	50%	0%	14%	64%	67%
Personal Health & Hygiene	37%	27%	41%	36%	50%		38%	40%	29%	55%	67%
Abortion	37%	18%	44%	36%	50%		50%	20%	14%	55%	100%
Environmental hygiene	30%	0%	41%	31%	0%		38%	0%	0%	64%	67%

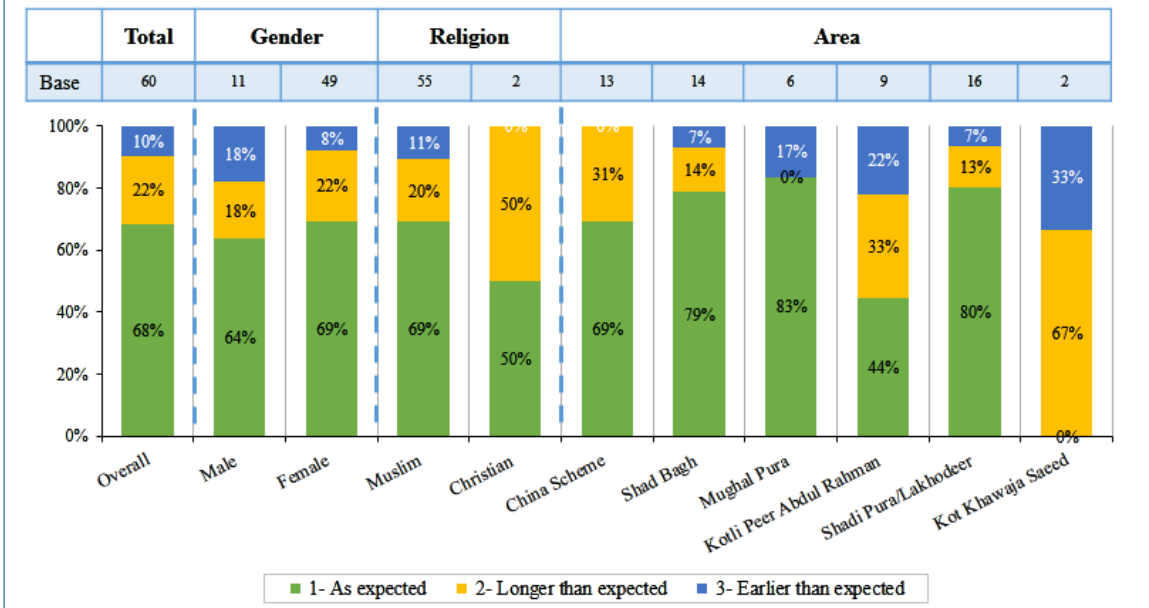
EI-13. Which of the following services your counselor mentioned today?

	Total	Gender		Religion		Area					
	Total	Male	Female	Muslim	Christian	China Scheme	Shad Bagh	Mughal Pura	Kotli Peer Abdul Rahman	Shadi Pura/Lakhodeer	Kot Khawaja Saeed
Base	17	7	10	16	1	7	2	1	6	1	0
Mother & child care (birth spacing, breast feeding, etc)	59%	86%	40%	56%	100%	86%	50%	0%	50%	0%	0%
Others	18%	0%	30%	19%	0%		50%	0%	0%	100%	0%
Family planning (awareness and methods)	18%	29%	10%	19%	0%		0%	100%	17%	0%	0%
Personal Health & Hygiene	12%	14%	10%	13%	0%		0%	100%	17%	0%	0%
Abortion	12%	14%	10%	13%	0%		0%	100%	17%	0%	0%
Pregnancy related tests/examinations	12%	0%	20%	13%	0%		0%	0%	17%	0%	0%
Environmental hygiene	6%	0%	10%	6%	0%		0%	0%	17%	0%	0%

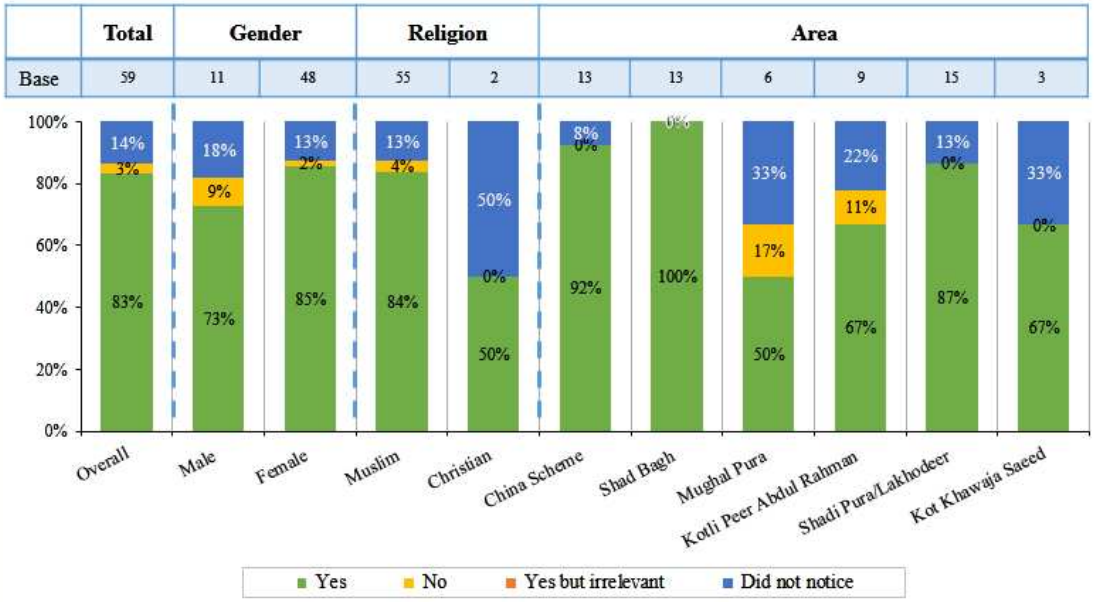
EI-14. How would you rate the quality of waiting area?



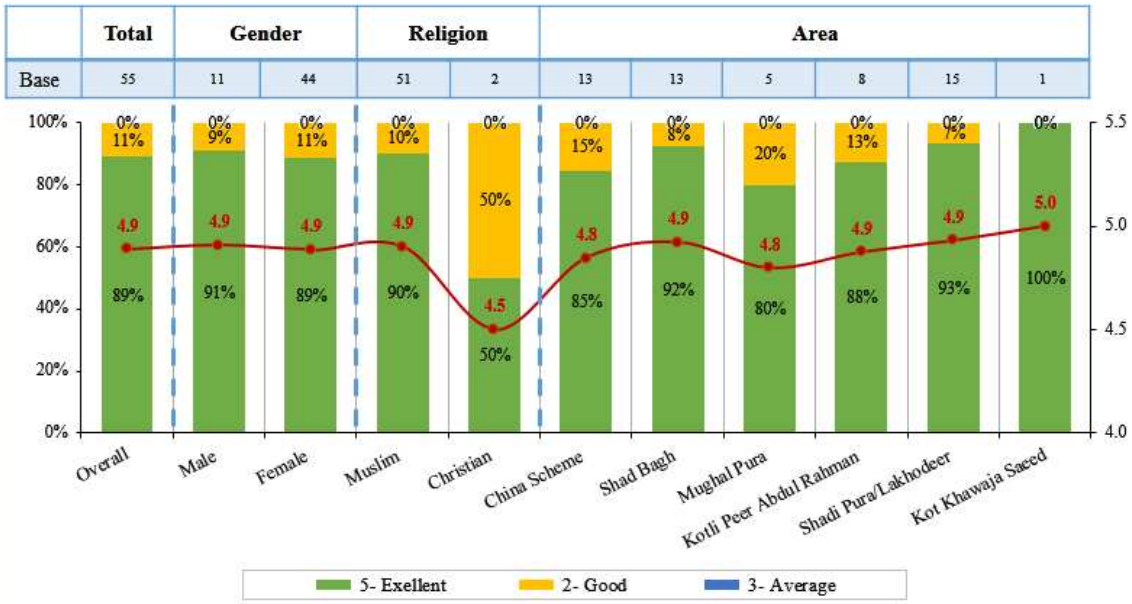
EI-15. How would you rate the waiting time?



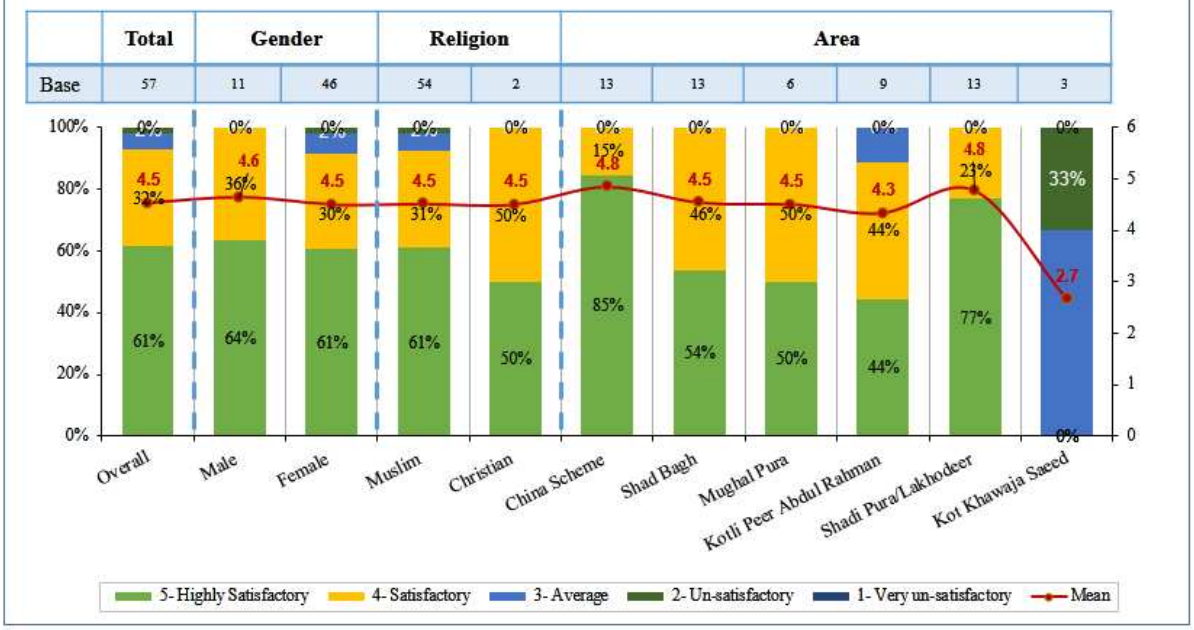
EI-16. Did the center provide any material for education or information during waiting time?



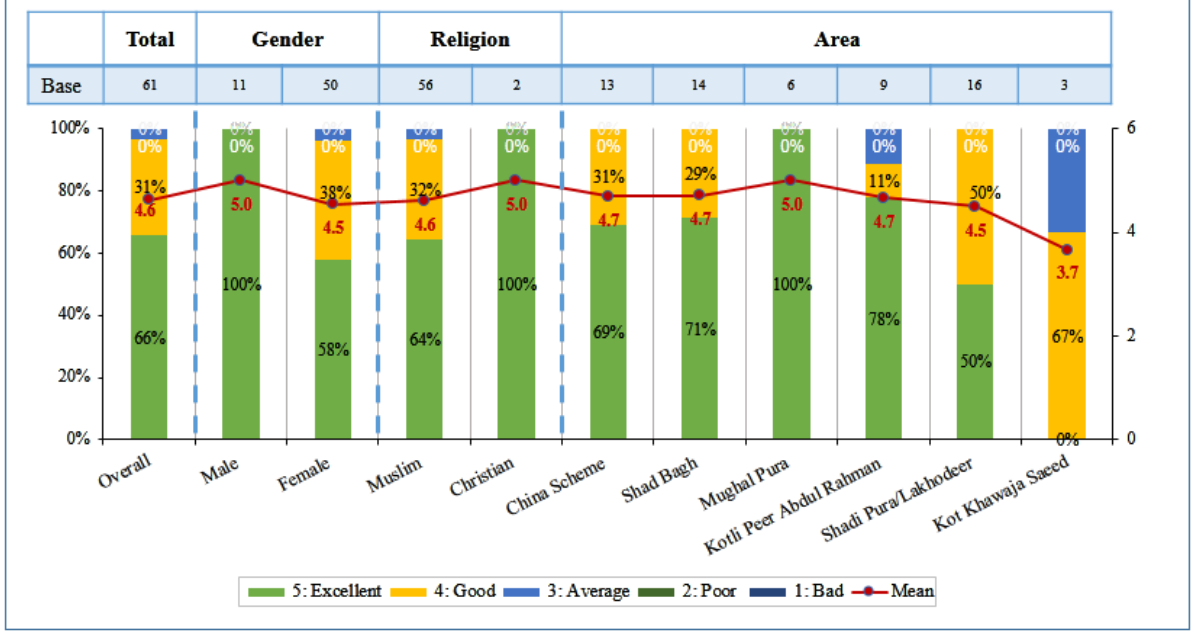
EI-17. How would you rate the privacy provided to you during consultation/visit?



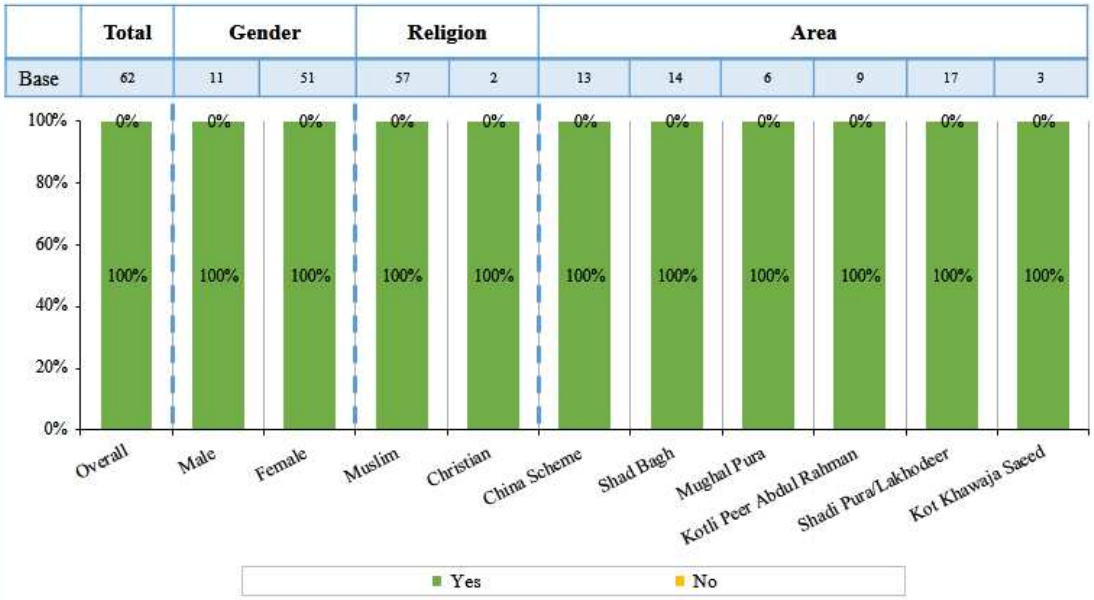
EI-18. How would you rate the quality of consultation?



EI-20. How do you rate the overall experience?



EI-21. Will you refer others to this center?

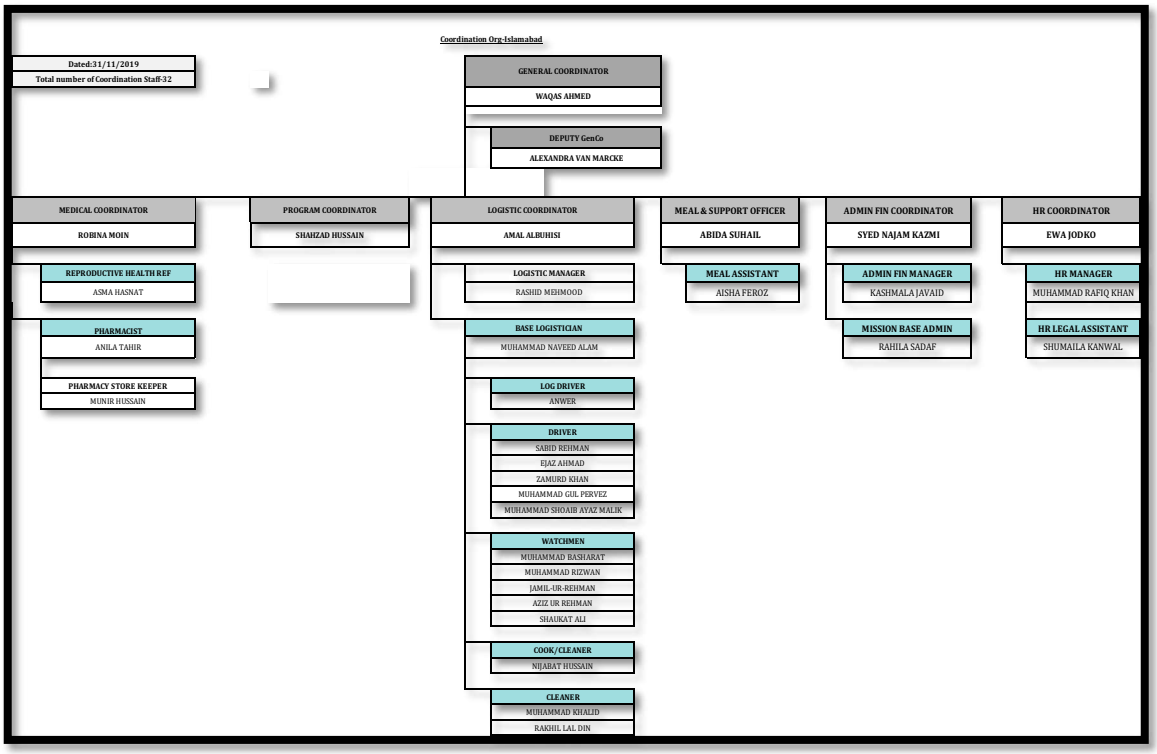


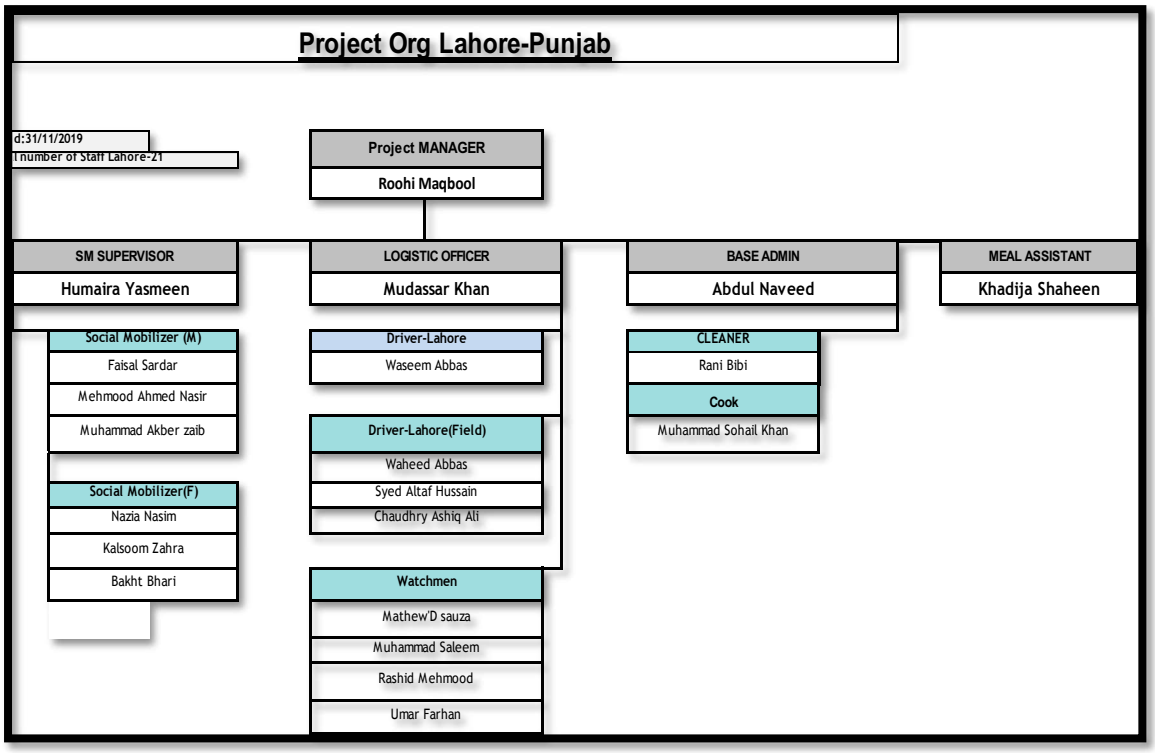
If you could make only one suggestion for improving services at this facility?

Verbatim
• Nursery should be there
• All antenatal and postnatal care
• Education of staff on behaviour required
• Availibility of medicine /supplement general medicine
• Yaha general adwiyat k sath test ki sahulat bhi faraham karen jis se log asaani se matwajja hon gy
• USG, Medicine availabity ensure
• Children vaccine required, delivery set required
• Availability of medicine, staff issues
• All medicines are very good but make sure the availibilty of medicines and child care also
• USG and pregnancy checkup.
• Hamal check krwanay wali kit, ultrasiund machines
• Ultrasound machines, bchon ki dawai
• Staff Should be increased and work hard
• Sign board hony chahiya or cable py b advertisement chalaye jayen
• Digar adwiyat b honi chahiya
• General medicine availibilty
• More awareness session more staff required

Annex - 8

Project Management Structures





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