



Greenstar Social Marketing Private-Sector Activities in PAIMAN Project:

Process Evaluation of Greenstar Social Marketing Initiatives to Improve and Expand Maternal and Newborn Health Services and Coverage



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Dr. Munir Afridi

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Acknowledgments

One of the responsibilities of the Population Council in the PAIMAN project was to conduct process evaluation of the private-sector initiatives being implemented by Greenstar in the project districts. Therefore, a process evaluation study was designed and data was collected from the field and then analyzed. This final report is an outcome of collaborative efforts of Population Council staff and Greenstar zonal and regional staff. Dr. Arshad Mahmood, Director Monitoring and Evaluation, Population Council, provided invaluable inputs and was instrumental in producing a quality report. The survey was implemented under the guidance of Dr. Munir Afridi, Program Manager, Population Council.

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List of Abbreviations

AMHS	Assistant Manager Health Services
ANC	Antenatal Care
BHU	Basic Health Unit
CAM	Communication, Advocacy and Mobilization
CDK	Clean Delivery Kit
CS	Clinic Sahoolat
DHQ	District Headquarter
EMOC	Emergency Obstetric Services
FHO	Female Health Officer
FOW	Female Outreach Worker
FP	Family Planning
FWW	Family Welfare Worker
GL	GoodLife
GSM	Greenstar Social Marketing
HH	Household
HSO	Health Service Officer
IEC	Information, Education and Communication
IPC	Interpersonal Communication
IPCO	Interpersonal Communication Officer
LHV	Lady Health Visitor
LHW	Lady Health Worker
MHS	Manager Health Services
MIS	Management Information System
MNH	Maternal and Newborn Health
MOW	Male Outreach Worker
PAIMAN	Pakistan Initiative for Mothers and Newborns
RHC	Rural Health Center
TBA	Traditional Birth Attendant
THQ	Tehsil Headquarters
TT	Tetanus Toxoid

Executive Summary

The Pakistan Initiative for Mothers and Newborns (PAIMAN) is a five-year program funded by the United States Agency for International Development (USAID). PAIMAN works with the Government of Pakistan on the implementation of the full spectrum of interventions necessary to address mother and newborn health, focusing on ten districts throughout Pakistan.

Greenstar Social Marketing has established a health care private provider network (GoodLife clinics) that is primarily in the urban areas in 10 districts of the PAIMAN project. This network provides maternal and newborn health and reproductive health and family planning services and products. Several other initiatives have been undertaken by Greenstar at the community level to improve and expand MNH and RH/FP services - through: GoodLife clinics; GoodLife clinic sahoolat (free consultations) for the communities; interpersonal communication (IPC) activities in the communities; involvement of TBAs in MCH services; marketing of clean delivery kits (CDKs); birth preparedness and complication readiness; public-private partnerships; vouchers for health schemes; and training of health care providers.

The process evaluation was conducted from November 2008 to January 2009 in five randomly selected districts (from among those in the PAIMAN project). The main activities/areas that the process evaluation focused on were GoodLife clinics, clinic sahoolat events, IPC activities for demand generation for clinic sahoolat, involvement of TBAs and clients served by TBAs, clean delivery kits (CDKs), and training for health care providers.

Interviews were conducted with 51 TBAs and 94 clients of these 51TBAs. In addition, interviews were conducted with 573 community respondents, 26 individuals who had attended clinic sahoolat events (exit interviews), 16 GSM outreach workers and 20 GoodLife clinic service providers.

The information collected in this survey points to areas where Greenstar strategies are close to being fully met as well as to areas where the strategies are not being met. It is our hope that some of the detailed findings will allow Greenstar to focus on those areas most in need of attention. In the present case, the findings point to very specific problem areas that can be addressed by bringing to bear more rigor in adhering to Greenstar's own standards and strategies, and this is well within their purview.

While this particular study focused on the specific strategies and activities of Greenstar Social Marketing, it also provides a useful guideline to issues that must be fully addressed in conducting health outreach in a country like Pakistan, and, most importantly, it underscores the importance of follow-up to make sure that programmatic efforts are, in fact, unfolding in the field as planned.

In the end, any and all improvements in the implementation of Greenstar initiatives will help reduce maternal and infant mortality and morbidity, and that is a valuable outcome to this process evaluation.

1. Introduction

Private-Sector Activities Under PAIMAN

Greenstar Social Marketing has established a health care private provider network (GoodLife clinics) that is primarily in the urban areas in the ten districts of the PAIMAN program. This network provides maternal and newborn health (MNH) and reproductive health and family planning (RH/FP) services and products. A number of initiatives have been undertaken by Greenstar at the community level to improve MNH and RH/FP services and expand coverage through:

- GoodLife clinics
- GoodLife clinic sahoolat (free consultation for the communities)
- Interpersonal communication (IPC) activities in the communities
- Involvement of traditional birth attendants (TBAs) in MCH services
- Marketing of clean delivery kits (CDKs)
- Birth preparedness and complication readiness
- Public private partnership
- Vouchers for health scheme
- Training of health care providers

Process Evaluation

Objectives

The objectives of the process evaluation of the PAIMAN project's private sector initiatives were to:

- Assess the process under which the activities of several subcomponents of the private sector (under GSM) were implemented;
- Identify shortcomings (gaps) in the process, if any; and
- Recommend corrective measures to improve the implementation of these components during the remaining period of the project.

Components Evaluated

In consultation with Greenstar, it was decided that only activities that were completed or were being fully implemented would be included in the process evaluation. This decision led to focusing the process evaluation on the following Greenstar private-sector components:

- GoodLife clinics and service providers
- Clinic sahooolats
- Outreach workers and IPC activities
- TBAs
- Clean delivery kits
- Community response (regarding IPC, clinic sahooolats, and CDKs)

Methodology

The process evaluation gathered data on quantitative aspects of the component. Since the private sector in the PAIMAN project has sub-components and a variety of interventions where franchisee, community and providers are inter-related, all three stakeholders were assessed.

Important activities were identified and then sites within the districts were selected. This was followed by development of evaluation tools for each category/area.

Identification of interviewers from respective areas was done and their training on the evaluation tools was conducted in Islamabad from November 3-13, 2008. Data collection was done from 15 November 2008 to 16 January 2009. All filled-in questionnaires were then edited, data were entered and analyzed, and findings were shared with the PAIMAN project team.

Coverage

The plan for the process evaluation was to involve the following targeted areas and individuals.

- 5 districts were randomly selected from the ten districts covered by PAIMAN, with at least one district from each of the 4 provinces of Pakistan. The selected districts, shown by province, were:
 - Balochistan: Lasbella
 - NWFP: Buner
 - Punjab: Jehlum and Dera Ghazi Khan
 - Sindh: Sukkur
- 4 private health facilities (all GoodLife clinics) that offered clinic sahooolat services to communities in each of the five selected districts were randomly selected from a list provided by Greenstar zonal offices.

- 2 communities out of the targeted population surrounding a GoodLife clinic (list provided and communities identified by Greenstar), where IPC activities were either completed or currently underway, were randomly selected. These communities were mapped by professionals, households were listed and guiding maps were prepared.
- 25 households in each of the selected communities were randomly selected from the household listing prepared by local experts (Federal Bureau of Statistics [FBS]). From these communities and households, eligible women, participants of neighborhood meetings, orientation meetings with influential were selected to be interviewed.
- 10 TBAs were randomly selected in each of the five selected districts from a list provided by Greenstar. These TBAs were engaged with GSM in and around the public-sector Rural Health Centers (RHCs). These were supported and upgraded by the PAIMAN project. However, TBAs in Jehlum were selected around the DHQ hospital because there was no TBA trained around the upgraded RHC.
- 20 TBA clients (two from each of the 10 selected TBAs -- one who was referred by the TBA and one who was served by her) were randomly selected from each TBA's list of clients from the three months preceding the survey.

Evaluation tools

A variety of topics were covered by each assessment tool, To gain the most insight into activities and topics (e.g., CDKs, knowledge of MNH in the communities, etc.), the same activities and topics were explored within each group interviewed. The following assessment tools were developed for evaluating each component and are shown according to the components they covered:

1. GoodLife clinics, services and providers; clinic sahoolat, activities, client and community response; outreach workers and IPC; CDKs

Four assessment tools (questionnaires) were developed to evaluate IPC and clinic sahoolat activities. Questionnaires were developed to assess detailed information about the role and knowledge of outreach workers in IPC and key IPC issues, to gain insight into community response to IPC and experience with clinic sahoolat, to obtain feedback from women who attended clinic sahoolat events about these events, and to obtain information about providers and their knowledge and opinions on several key issues. These tools were shared with GSM to obtain their input in order to make them more productive and useful; their feedback was incorporated into the final questionnaires. The four assessment tools were:

- Structured questionnaire for outreach workers (males and females)
- Structured questionnaire for community (eligible females; influential and eligible males)

- Structured questionnaire for service providers (doctors/LHVs)
- Structured questionnaire for clients attending clinic sahoolats (females)

2. TBAs, services and knowledge; CDKs; clients' responses to TBA services and knowledge of MNH in communities

Two additional tools were developed to assess the role of TBAs and obtain feedback from their clients about services during pregnancy and delivery.

- Structured questionnaire for TBAs
- Structured questionnaire for TBAs clients (both served and referred) (included topics such as: TBA services received; knowledge of MNH in community)

The first questionnaire was designed to gain information from TBAs about their selection; training; services, including referrals; knowledge and use of CDKs; and knowledge of MNH in their communities. The second questionnaire was used with TBA clients and covered topics such as: TBA services received and knowledge of MNH in their communities.

Data collection

Three data collection teams were deployed; each team consisted of two female interviewers and one male supervisor/interviewer. One team in one district completed the entire process in twenty working days. The team deployed in Punjab covered two districts (Jehlum and DG Khan), while the team in Sindh covered two districts, one in Sindh (Sukkur) and another in Balochistan (Lasbella). The team assigned to NWFP covered only Buner district. Composition of the teams is shown in an appendix.

A ten-day training, including field visits, was arranged in Islamabad for the survey teams. A session by a Greenstar representative was reserved for the first day of training for an orientation session on the project. Two Greenstar staff members from the Rawalpindi zonal office actively participated in the training and provided guidance and explanations on various issues related to IPC and service providers.

Interview Summary

After 40 working days in the field in the five districts, data from service providers, outreach workers, communities, TBAs and their clients was gathered. The following is a summary of the number of interviews conducted with each category of respondent.

Table 1. Number of interviews, by type of respondent, according to district

Description	Buner	Jehlum	Sukkur	DG Khan	Lasbella	Total
Interviews with I/C GL clinics						
Lady doctors	0	2	2	1	2	7
Lady health visitors (LHV)	1	0	2	2	1	6
FWW/midwife/nurse	3	2	1	1	0	7
Total	4	4	5	4	3	20
Interviews with outreach workers						
Female outreach workers	1	3	2	3	1	10
Male outreach workers	1	1	1	2	1	6
Total	2	4	3	5	2	16
Interviews at HHs level						
Eligible contact at HHs	24	160	183	158	24	549
Influentials	0	6	1	8	2	17
Representatives from neighborhood meeting	3	4	0	0	0	7
Total	27	170	184	166	26	573
Interviews with TBAs						
Traditional birth attendants	10	11	10	9	11	51
Interviews with TBAs clients						
Clients delivered by TBAs	15	14	12	16	10	67
Clients referred by TBAs	5	5	5	2	10	27
Total	20	19	17	18	20	94
Exit interviews of CS clients						
Clinic sahoolat clients	6	5	5	5	5	26

2. Traditional Birth Attendants

Introduction

The Greenstar private-sector activities under the PAIMAN project focused mainly on the training of TBAs because of the important role they play in improving MCH services in rural areas. Providing a system to improve the quality of care given by TBAs was one way to contribute to the overall goal and objectives of the GSM private-sector initiative to reduce maternal and infant mortality and morbidity.

Strategy/Intervention

One strategy that Greenstar undertook was to offer quality training and periodic refresher training to TBAs. The training was designed to help TBAs as they carried out their duties in providing services to their clients, which include:

- Care for mothers during pregnancy, delivery and postpartum
- Refer pregnant mothers in case of emergency
- Care for newborns
- Care for health of children
- Provide family planning services/advice

In order to achieve the objectives, Greenstar developed a strategy to identify TBAs, train them and develop referral linkages with health service providers in their respective areas. The following summarizes some of Greenstar's strategies regarding involving TBAs in the effort to reduce maternal and infant mortality and morbidity rates:

The criteria for selecting TBAs for training were straightforward. Two TBAs per village were to be selected for each health facility in the catchment area. Each selected TBA was to meet the following criteria:

- Be at least 25 years of age
- Have a minimum of five years of experience as a TBA in her area
- Be accepted by the community and have a recommendation letter from CHC of her community

During training, the following topics were to be covered:

- Pregnancy
- Labor and delivery
- Postnatal care
- Newborn care
- Family planning
- Child care
- Registration and referral
- Community health education
- Simple recordkeeping

Other training details were:

- Two training courses, in phases, were to be carried out, as follows: each course/phase was to last for six weeks and training was to be conducted for five days each week and for five hours each day.
- Two midwives from EDO (H) office were to act as trainers and one midwife from the nearest health facility was to be engaged.
- Training materials, an illustrated brochure, etc., were to be given to each TBA during training. These materials were to help the TBAs remember the main points of training, including implementing an operative referral system, establishing close collaboration with midwives, and linking with village health committees.

Under the Greenstar strategy, TBAs should be selected in those locations where they can easily refer clients to a Rural Health Center, THQ Hospital or DHQ Hospital. As such, PAIMAN-upgraded Rural Health Centers were identified and TBAs working around these RHCs were interviewed. In two districts, Jehlum and Buner, the survey teams were unable to find GSM-trained TBAs around RHCs; therefore, TBAs working in and around DHQ hospitals were randomly selected.

As shown in Table 1.1, earlier, there were 51 TBAs randomly identified in five selected districts to take part in this evaluation. The number of TBAs by district was: Buner – 10, DG Khan – 9, Jehlum – 11, Lasbella – 11, and Sukkur – 10. These TBAs were interviewed to obtain information on their personal characteristics, their training process, their awareness about the status of MNH in their communities, services offered, the monitoring they received from Greenstar, etc.

Findings

Background Information

Age, education, length of service. Table 2.1 shows the background characteristics of the 51 TBAs trained by Greenstar. According to GSM’s strategy, younger TBAs were to be identified and trained. However, the ideal age suggested for TBAs was more than 25 years. As shown in Table 2.1, 2 of the 51 TBAs were 25 years of age or less; many were in much higher age groups. As for education, 42 of the 51 TBAs trained by Greenstar had no education.

2.1. Background characteristics of 51 TBAs

Characteristic	Number
Age	
≤ 24	1
25-39	12
40-54	28
≥ 55	10
Education	
None	42
Class 1-4	5
Class 5-8	4
Length of service (in years)	
≤ 4	16
5-9	9
10-14	7
≥ 15	19

GSM indicated in their strategy paper that TBAs should have at least five years of experience in their area/village/community before being engaged in training and assigned areas for provision of MNH services. The feedback from TBAs in this regard can also be seen in Table 2.1. Around one-third of the TBAs (16 out of the 51) reported their length of service to be less than 5 years.

Coverage and Coverage-Related Issues

Households. The population of the areas/villages where GSM-trained TBAs were working was assessed to understand the coverage and workload of the TBAs. Around one-third (19 TBAs) of the 51 TBAs were working in communities where the total HHs did not exceed 100. Another one-fifth (20 TBAs) were working in villages where the population of each village was between 101-250 households; 12 were working in areas with between 251 and 400 households, and 10 were working in areas with 401 or more households.

As for the number of households that TBAs reported being responsible for, it is evident that the TBAs were focused on a limited number of households. Around half of the TBAs were focused on 50 or fewer households (26 of 51 TBAs). Other breakdowns: 9 TBAs were responsible for 51-150 households, 11 were responsible for 151-300, 2 were responsible for 300-400, and 3 were responsible for 401 and more.

Other TBAs. The standard indicated by GSM is that there should be two TBAs in each catchment area. Therefore, TBAs were asked about the presence of other TBAs. One-quarter of the TBAs (13

TBAs) reported that they were the only TBA in their community/village/ locality; however, in a follow-up question asking the TBAs to name the number of other TBAs in the area, 2 TBAs then said that they were the only one, indicating that the actual number of TBAs who were the only TBAs was 15 instead of 13.

There were 36 TBAs who reported the number of other TBAs in their area. The majority reported that there was one *more* GSM-trained TBA (17 out of 36), 5 said that there were 2 more, 3 said that there 3 more, and 1 said that there were 4 or more.

GSM TBA Training

It was universally acknowledged that all 51 TBAs interviewed had received training from GSM. These trainings were conducted in different periods of time, in different composition of batches, and within a variety of locations.

Letter of recommendation. It was GSM policy that only TBAs who submitted a recommendation letter from their community would be trained. Essentially, the recommendation letter was to indicate that the TBA provided useful services to the women in the village. Three-fourths of the TBAs (38 out of 51) had recommendation letters from community elders, while one-fourth (13 TBAs) reported that they did not.

TBAs trained by GSM over time. Many of the TBAs reported that they were trained less than one year before the survey (18 of 51 TBAs). The rest were trained from 1-2 years prior to the interviews (16 TBAs) or more than 2 years prior to the interviews (17 TBAs).

Topics covered during TBAs trainings. The TBAs were asked to recall the topics covered in their TBA training. The topic remembered by most of the TBAs was labor and delivery (42 TBAs), followed by birth preparedness/complication readiness (39 TBAs). Neonatal care and/or childcare were mentioned by 32 TBAs and pregnancy and use of CDKs were recalled by 30 TBAs each. The least remembered topics were postnatal care (19 TBAs), community health promotion (9 TBAs) and family planning (8 TBAs).

Locations and timing of trainings. GSM's strategy paper indicated that the best location for the training of TBAs would be Rural Health Centers in order to promote better understanding among TBAs and RHC staff. It was assumed that this would help in addressing the issues of referral and supervision between TBAs and RHC staff.

However, TBA trainings were actually held in variety of locations, including RHCs. There were 20 TBAs who reported being trained at an RHC and 10 reported the DHQ. Another 10 reported being trained at private premises and 11 reported being trained at the zonal office of Greenstar.

Training phases, duration and training batch composition. It was reported by 50 TBAs that their training was conducted in one phase (one was not sure). The duration of training was reported to range from 5 to 8 days, with different hours per day also reported. Six hours was the most commonly reported hours per day for training (16 of 51 TBAs), with 5 hours a close second (15 TBAs). Others reported: 4 hours (3 TBAs), 7 hours (8 TBAs), 8 hours (6 TBAs), and 9 hours (3 TBAs). The mean number of reported hours was 6.2 hours per day.

Small training batches are considered to be most effective because they allow for more interaction between the trainers and participants, creating a better learning environment. Smaller groups also make it more convenient when demonstrating skills and gives better opportunities for everyone get a chance to express themselves.

Most of the participants reported that there were either 11-20 or 21-30 participants in their training batch (21 reporting each). Six participants reported that their batch size was 8-10, and 3 reported that their batch size was 31.

IEC and training material, Invitation procedures and certification of TBAs. It was mentioned in GSM TBA strategy papers that IEC and training materials, including Dai Nama, free CDK kits, GS booklet, PAIMAN brochure, clinic sahoalat brochure and simple illustrated brochure, were to be distributed during the training of TBAs. CDK free samples, Dai Nama, referral cards and the Greenstar booklet were the most commonly received materials during TBA training (39, 31, 26 and 18 TBAs, respectively). Less common materials distributed were handouts (1 TBA), PAIMAN brochure (3 TBAs), IEC materials (4 TBAs), and a simple illustrated brochure (5 TBAs).

Various options were adopted by GSM for inviting participants for TBA training courses. From the reports of the TBAs, the most common form of an invitation was a verbal request (29 TBAs), followed by a message through another TBA (12 TBAs). Other less commonly reported forms of an invitation came through being formally invited by GSM to attend training (7 TBAs), being invited by a representative from the RHC (1 TBA), and other forms (2 TBAs).

As per policy, after successful completion of training, each TBA was to get certification from GSM. Around three-fourths of the TBAs reported receiving a certificate after completion of their training. It was interesting to note that of those TBAs (39) who reported that they have received a certificate, only 26 TBAs were able to show the certificate to interviewers.

Training incentives and holding of one day orientation trainings. TBAs were to get incentives for trainings; these were to include travel costs, refreshments and per diem for attending trainings. Nearly all TBAs were paid a per diem and given refreshments; however, provision of transport or

cost reimbursement for travelling was reported by only 4 and 5 TBAs respectively. Only 2 TBAs reported the provision of IEC materials and 7 reported other incentives.

It was essential for a TBA to attend and participate in orientation meetings organized by the HSO of GSM each month. The feedback from the TBAs indicated that one-fifth of the TBAs interviewed had never attended orientation trainings. Those who attended orientation trainings (41 TBAs) were further asked the number of trainings sessions they attended in the year before the survey. Though 4 TBAs had not attended any training sessions, 10 had attended 1-2 sessions, 20 had attended 3-4, 10 had attended 5-6 and 7 had attended 7 or more.

Awareness/Knowledge of TBAs about MNH Problems in Their Communities

During the training, all TBAs were to be taught and given information on the various dimensions of MNH problems and their implications so that they can be aware of and alert to the maternal and child health problems in their communities. In order to gauge their knowledge and awareness about maternal and child health, TBAs were asked about the status of MNH in their communities.

Knowledge about maternal health problems. Two out of fifty-one TBAs reported that their community had no maternal health problems. The other forty-nine gave multiple responses. More than two-thirds (35 TBAs) cited poor health of mothers as a major problem, followed by low iron in blood (33 TBAs) and low nutritional status (26 TBAs). Least cited maternal health problems were high mortality rate (1 TBA), lack of FP services and no immunizations during pregnancy (10 TBAs each). A low rate of antenatal checkups was reported as a problem by 17 TBAs and a low rate of postnatal checkups was reported by 12 TBAs. (Note: TBAs could name more than one problem.)

Knowledge about infant and child health problems. It was universally acknowledged by all TBAs across the five districts that there were Infant and child health problems in their communities. In terms of specific problems they reported, diarrhea was cited as a problem most often (38 TBAs), followed by ARI/pneumonia (25 TBAs), low birth weight (18 TBAs), and poor immunization status (16 TBAs). Jaundice and malnutrition were each mentioned as problems by 12 TBAs and worms and itching and tetanus were each mentioned by 10 TBAs. Nine TBAs cited the poor knowledge of mothers for managing newborn/infant/child health problems as a problem in their community and 3 cited TB as a problem. High infant/child mortality was cited by only 1 TBA and the same was true for mothers not breastfeeding their infants. (Note: TBAs could name more than one problem.)

Services and Referrals by TBAs

After completion of training, TBAs are required to perform some MNH service delivery package in their respective areas. To understand how the TBAs think about their role and responsibilities, and the services they are actually providing in their communities, they were asked specific questions about their work.

Provision of services. All of the TBAs reported that they were well aware of their duties and that they were providing MNH services in their communities. When asked to name specific services they were providing (they could name as many services as they provided), most reported that they were conducting normal deliveries (42 out of 51), followed by 36 who reported that they were providing care during pregnancy. Thirty-five said that they referred complicated cases, 34 provided newborn care, 29 provided postnatal care, and 21 provided health education to mothers. Advice on breastfeeding was provided by 15 TBAs, on child nutrition by 11 and family planning by 11.

TBAs were questioned regarding their performance in conducting deliveries during the three months before the survey. Five TBAs reported that they had conducted no deliveries during this time, 3 had conducted 1, and 6 had conducted 2. However, 12 TBAs reported having conducted 3 deliveries, 7 had conducted 4-5, 9 had conducted 6-10, and 9 had carried out 11 or more deliveries.

Referral services for clients. More than three-fourths of the TBAs (40 of 51) reported that they did refer clients to other health facilities. However, 11 TBAs said that they did not refer clients. Those who reported that they did refer clients were asked about the reasons they referred clients (they could name any number of reasons). The most common reason for referring clients was because of danger signs in pregnancy (37 TBAs), followed by obstructed labor or premature rupture of membrane (29 TBAs). Postpartum hemorrhage accounted for 17 referrals. Seven TBAs reported they referred abortion cases and the same number referred because there were twins or the birth was breach. Five referred for laboratory tests, 3 for family planning and 1 for other reasons.

As per policy, TBAs were to refer their clients to PAIMAN-upgraded RHCs. When asked where they usually referred clients, 14, of the 40 who said they made referrals, reported the RHC was where they usually referred clients, followed by 12 who said they referred to a private clinic or maternity home and 10 who referred to the THQ or DHQ. Only 1 TBA referred to a BHU and 3 referred to other places. The non-availability of female staff at the BHUs might be the reason that so few referred clients there.

Those who reported that they referred client were asked about the number of their referral cases during the three months preceding the survey. Twenty-two TBAs said that they had referred clients in the preceding three months, while 18 said that they had not. As for the number of referrals, 8 TBAs had referred 1 client, 6 had referred 2, 3 had referred 3, 2 had referred 4, 2 had referred 5 and 1 had referred 6. The TBAs were asked about the main reason they had made these referrals. Most were for complications during pregnancy or problems during delivery (15 TBAs each mentioned these problems) Postpartum hemorrhage was said to be the main reason by 2 TBAs, neonatal care was named by 1 TBA, and 2 reported other reasons.

The TBAs who reported that they had referred clients were also asked if they had given any referral slip to the clients to facilitate their entry when they arrived at the health facility. Twenty-nine TBAs had given their clients a proper referral slip, 11 had not.

Feedback from clients. Obtaining feedback from a referred client regarding their health status is important in providing an overall high quality of care. Getting feedback improves the client-patient relationship and helps to develop trust between provider and client. All TBAs who referred clients were asked about the mechanism of getting feedback from their clients about their health status after they had been referred. Two channels of contacts were mentioned by a majority of the TBAs, namely, that they remained in touch with the clients all the time (22 TBAs) and that they visited the client's home periodically during the illness period (17 TBAs). Three TBAs said that the client contacted them and another 3 reported other means of getting feedback.

Clean Delivery Kit (CDK)

Clean delivery kits were introduced in PAIMAN districts to be used by service providers, including TBAs, when they conducted normal deliveries. The use of CDKs minimizes the chances of infection to both mother and infant and helps to avoid post-delivery complications.

Awareness and use of CDK. All 51 TBAs interviewed were aware of CDKs and all had used CDKs while conducting deliveries in their respective areas at some point. The TBAs were asked about the frequency of use of CDKs during the three months preceding the survey. Five TBAs had not used a CDK in the last three months, 11 reported using 1 to 2 CDKs, 18 reported using 3-5 and 17 reported using 6 or more CDKs.

CDK supply mechanism and cost. GSM workers or representatives were the major source of supply of CDKs for the TBAs (for 40 out of the 51). Nine TBAs reported their source to have been the chemist, 1 reported the source to have been a doctor or LHV, and 1 reported another source.

Responding to a query regarding purchase of CDKs, 13 TBAs indicated that they had not purchased a CDK but had free samples from GSM. The 38 TBAs who reported that they had

purchased a CDK were asked about the cost they paid for purchasing one CDK. As per GSM policy, the unit cost of CDK was Rs. 18 to all service providers, including TBAs. Half of the TBAs who had purchased one or more CDKs had paid Rs. 18 (19 of 38 TBAs). However, 12 TBAs paid between Rs. 19 and 28, while 7 had paid Rs. 10 to 17.

CDK promotion in the communities. TBAs were encouraged during training to promote the use of CDKs during deliveries in their communities. Therefore, various promotional materials were developed, including posters, brochures and charts, for TBAs to use in demonstrating the usefulness of CDKs to their communities. Most of the TBAs (43 out of 51) reported that they did promote the use of CDKs; 8 reported that they did not. The 43 were then asked to name all of the ways in which they promoted the use of CDKs: 26 said that they promoted the use of CDKs through health education, 12 said that they gave a demonstration of the usefulness of CDKs, 3 said they used a chart, poster or brochure, and 4 said that they used other means of promoting the use of CDKs.

TBAs were also asked if they had any CDK promotion material. A large majority (46 of 51) did not have any promotional material. Those who had promotional material had very limited materials.

TBA knowledge about CDKs. TBAs knowledge about the contents of the CDKs was also assessed. Most of the TBAs were aware of the contents of the CDKs, however, only a few TBAs knew that the pack is sterilized and contains pictorial instructions and an information leaflet. Forty-three TBAs named the following items as being in a CDK (unprompted): cotton balls, thread, razor blades and a plastic sheet. Disposable gloves were named by 41 TBAs, and 40 (each) mentioned plastic cord clamps and gauze. Thirty-nine mentioned soap and 26 mentioned sanitary pads,

Effect of CDK use on TBAs and plans for future use. All TBAs were asked to give feedback on their income and client load before and after the use of CDKs during delivery. Most reported that the use of CDKs had increased their client load (32 of 51), while 18 said that there had been no change. Only 3 said that their client load had decreased. As far as the effect of CDKs on their income, most reported that their income had increased (30 out of 51), while 18 said that it remained the same. Only 3 reported that their income had decreased.

TBAs were asked about their future plans regarding booking of pregnant women for care and delivery during the three months following the survey. Seventeen TBAs had no pregnant women on their list for the coming three month, while 15 had 1-2 pregnant women booked, 12 had 3-5, and 7 had 6 or more booked.

Stock of CDKs. TBAs were asked about the stock position of CDKs and about their supply mechanism. Stock out was also ascertained for the three months preceding the survey. Nine out

of 51 TBAs had experienced some degree of stock out in the preceding three months; while 42 had never been out of stock.

All TBAs were questioned regarding the CDK stock they had available on the day the survey team visited. Unfortunately, 8 TBAs had no CDKs in stock on that day; however, 11 had 1 CDK, 22 had 2-5, and 10 had 6 or more.

Supervision, Monitoring and Reporting

As per GSM strategy, TBAs were to be supervised by health services officers (HSOs) and their performance was to be monitored and reported regularly. Therefore, the survey teams asked the TBAs questions about supervision and monitoring.

The majority of the TBAs reported that they were regularly supervised by the HSO (41 of 51), while 10 reported that they had had no supervision.

Those who had regular supervision were further asked about the most recent visit by their supervisor. As far as timing of the most recent visit, 7 reported that they had been visited in the current week, 5 said they had been visited in the week before, 9 in the two weeks before, 8 in the 3-4 weeks before, and 6 in the 5-8 weeks before the survey. All together, 29 TBAs reported having had supervision within one month prior to the survey.

Recordkeeping and Reporting

Recordkeeping and report submission are important for many reasons. They are key elements for assessing the effectiveness of interventions and preparing for future logistics and supervision. Thirty-five TBAs indicated that they kept records of the clients they served in their communities, whereas 16 TBAs did not keep any records on their clients. However, when those TBAs who kept records were further asked where they kept their records, 9 reported that they kept their client records in their private registers, while 26 reported that they did not keep any written record of their clients. This confusion certainly indicates that the number not keeping any records on their clients is much greater than the 16 who initially said they did not keep records.

All TBAs were asked about their submission of progress reports to GSM. About half (26 TBAs) said that they did submit reports. Unfortunately, the other half (25 TBAs) reported that they did not submit reports to GSM

Feedback by Supervisors

Two-thirds of the TBAs (34) reported that they received feedback on their performance from their supervisors. However, one-third (17 TBAs) said that they had no feedback from their supervisors about their performance.

Those who received feedback were asked about the type of feedback they received and the issues discussed during feedback sessions. The TBAs could give as many responses as were accurate. Most of the TBAs (20) reported being given feedback about improving the quality of their services, while 12 were given feedback on the use of CDKs. Eleven reported being given feedback on proper referral and follow-up and 8 on improving their counseling skills. The least feedback was given in areas like use of IEC materials and following procedures and standards across all districts (2 TBAs). Three TBAs gave other responses.

3. TBA Clients

TBAs are contributing in improving the health of mothers and children through provision of domiciliary services in their catchment areas. Their clients, as the primary beneficiaries of the services offered by TBAs during pregnancy, labor and the postpartum period, were interviewed to obtain their views about TBA services. Ninety-four clients were selected and interviewed from among the clients of the 51 TBAs who also participated in the survey.

Characteristics

Background information on the TBA clients was collected during the interviews to help gain an understanding of the clients TBAs usually serve; information was collected on age, education, fertility, and current pregnancy status.

Table 3.1 shows the personal characteristics of the TBA clients. At the time of the interview, 70 percent were below the age of 30, 70 percent were illiterate, 98 percent were currently married and 96 percent were not pregnant.

Table 3.1. Percentage of 94 TBA clients interviewed, according to specific characteristics

Characteristic	Percent
Age (in years)	
15-19	14.9
20-24	22.3
25-29	33.0
30-34	16.0
Literacy	
Literate	29.8
Illiterate	70.2
Marital status	
Currently married	97.9
Not currently married	2.1
Pregnancy status	
Pregnant	4.3
Not pregnant	95.7

Findings

Awareness of MNH

TBAs clients were asked a variety of questions about MNH and how MNH issues affect their communities. When asked, 82 percent of the 94 TBA clients thought there were problems with maternal health in their communities, 73 percent thought there were problems in newborn health and 90 percent thought there were problems in child (under age 5 years) health.

Those who said that maternal health is a problem in their communities (77 clients) were asked about the kinds of problems there were. More than two-thirds (71 percent) indicated poor health of mother, followed by low iron in blood (58 percent) and low nutritional status (33 percent). The least reported problems were high mortality rate (3 percent) and lack of FP services (13 percent).

Of the 69 clients who thought there were newborn health problems in their community, nearly half of the respondents (48 percent) indicated low birth weight was a major problem. The rest of the newborn health issues were not indicated as problems to nearly the same extent. One-fifth of the respondents said each of the following were problems of newborns in their communities: poor immunization, poor knowledge of mother to manage newborns, and vomiting. The least cited problem was high infant mortality (3 percent).

Regarding various health problems of children less than five years of age, the 85 respondents who reported there were health problems of children under five years of age in their community indicated that chest infection/pneumonia (89 percent) and diarrhea (77 percent) were the major problems. Lack of immunization was mentioned by only 7 percent of respondents.

Pregnancy

MNH messages. All TBA clients interviewed were aware of the existence of trained TBAs in their communities and knew that these TBAs provided services during pregnancy and deliveries. However, when asked if the TBA gave MNH messages, 88 percent of clients said that she did, while 12 percent said that she did not. Those who said the TBA did give MNH messages (83 clients) were asked what MNH messages the TBA gave during their last or current pregnancy. The specific message mentioned the most had to do with better nutrition (74 percent), followed by advice on TT injection (52 percent), ANC (48 percent) and personal hygiene (47 percent). The least indicated MNH messages had to do with family planning (2 percent) and breastfeeding (5 percent). Messages on use of CDK were recorded as 13 percent. Knowledge and awareness of these MNH topics needs to be strengthened by TBAs through effective communication in their respective communities.

Clients were also asked about the mode of delivery of MNH messages by the TBAs. The most frequent mode of delivery of messages was through home visit by TBAs (86 percent) followed by calling TBAs at home (22 percent). Group meetings remained the least mentioned channel of delivery for MNH messages (2 percent); another 5 percent indicated other responses.

Home visits. All clients were asked about the frequency of visits made by TBAs in a month. More than a quarter (28 percent) of the clients indicated that TBAs conducted at least one to three visits per week. More than two-fifths (44) said TBAs visited one to three times per month. Only a few clients reported that TBAs had not visited their homes at all (3 percent). Around 12 percent of clients indicated that TBAs were called either whenever needed or only for delivery services.

Examination. All clients were asked about the services offered by TBAs with regard to examination during their last pregnancy and discussion about the danger signs of pregnancy.

Most (87 percent) of the TBA clients reported that the TBA examined them in their last pregnancy; only 53 percent said that TBAs talked about the danger signs of pregnancy.

Referral. Danger signs of pregnancy were present in 28 percent of the TBA clients in their last pregnancy. Of these, 73 percent (19 out of 26) were referred to health facilities by TBAs. Of those referred, 10 clients were referred to private facilities; the rest were referred to RHCs (4 clients), DHQ/THQs (3 clients), and maternity homes (2 clients).

Those clients who were referred by TBAs and attended the health facilities were further asked about any type of referral slips given to them by TBAs. Only 6 of the 19 referred clients were given a referral slip, 13 were not given a referral slip.

Labor and Delivery

All TBA clients were asked about the timing of the delivery of their last birth. In total, around two-thirds (66 percent) of the TBA clients gave birth within the three months preceding the survey).

Place of delivery. Not surprisingly, the most common location for deliveries was the client's home (77 percent overall); this was the most common delivery location in all five districts. Private health facilities were utilized by 16 percent of the TBA clients and government health facilities were least utilized (7 percent) for deliveries.

Timing of TBA assistance. Those who delivered at home (71 clients) were asked about when the TBA was called for assistance during the delivery: more than two-thirds reported that the TBA was immediately called for assistance, while 28 percent reported that the TBA was already present with them.

Type of services provided. Home delivery clients (71 clients) were asked to indicate the type of services provided by the TBA during delivery. Ninety-four percent confirmed that the TBAs provided assistance during the entire delivery period. Seventy percent reported that they were provided post-delivery services, and more than half (56 percent) indicated that TBAs provided care for the newborn. Advice on breastfeeding and neonatal health, combined, were the least-served areas: just over one-quarter of the clients (27 percent) said that TBAs provided advice on these topics.

Awareness and use of CDK. Three-fourths of the home-delivery clients (53 out of 71 clients) reported being aware of clean delivery kits. Those who said they were aware of CDKs were further asked if a CDK was used during their last delivery: 93 percent (49 out of 53 clients) responded that a CDK was used in their last delivery. These 49 clients indicated that the TBA had had a CDK with her and that the use of a CDK during delivery was beneficial for health.

Complications and referral during delivery. All clients who give birth during the 24 months preceding the survey were asked if they experienced any complications during the delivery and if they were referred by the TBA to a health facility. Twenty-three percent of these clients (21 out of 92) experienced complications during their last birth. Of those who experienced complications, 81 percent (17 out of 21) reported being referred by the TBA to a health facility.

The 21 clients who experienced complications in their last delivery before the survey were asked to indicate the type of complication they experienced. The most common complication reported was prolonged labor (9 of 21 clients), followed by breach presentation (7 clients). Twins, uterine rupture, perineal and vaginal tear, and hemorrhage were reported by 2 clients each.

Newborn Health

The role of TBAs in the health of newborns is very critical in educating mothers regarding early initiation of breastfeeding, immunization, hygiene, etc. Therefore, clients were asked about the health problems experienced by newborns and the assistance provided by TBAs.

Complications in newborns and referrals. More than one-fifth (21 percent) of the clients delivering within 24 months of the survey reported that their newborn developed complications after birth (19 out of 92 clients). Those who developed complications were asked if the TBA referred them to a health facility for their baby's complications: half (53 percent; 10 out of 19) responded that their babies were referred by TBAs to health facilities.

The 19 clients who reported that their newborn had complications were asked what type of complications they had. Close to half reported that their newborn was weak and cold (47 percent; 9 of 19), while around one-third (37 percent; 9 of 19) reported that the newborn had yellow discoloration of the skin. Fewer clients reported complications such as fever/drowsy (21 percent; 4 of 19) and not sucking well (11 percent; 2 of 19).

Postnatal Care

Postnatal care is essential for the health of mothers and their newborns. The role of TBAs is very important in conveying health education messages and adoption of best health practices, including breastfeeding, immunization and family planning.

Postnatal advice, complications and referral. More than three-fourths (78 percent) of the TBA clients who had delivered in the 24 months preceding the survey reported that the TBAs advised them about postnatal checkups; 22 percent did not receive advice about postnatal checkups.

Thirteen of the 92 TBA clients (14 percent) experienced complications during the postnatal period. All thirteen clients who experienced complications during the postnatal period were asked to indicate the type of complications they had (clients could report more than one symptom). The most commonly mentioned complication was fever and aches (7 clients), followed by weakness (5 clients). The least-reported complications were postpartum hemorrhage (2 clients) and postpartum infection (1 client); another 4 clients reported other symptoms.

The 13 clients who reported postpartum complications were asked if the TBA referred them to a health facility. About half of these clients (7 of 13) said that they were referred to a health facility by the TBA. Of the 7 clients who were referred for postnatal complications, only 2 reported being issued a referral slip by the TBA.

MNH advice during postnatal period. Of the 92 clients who had asked about the advice given by TBAs on maternal and newborn health, more than 80 percent (74 clients) reported that they had received MNH advice during the postnatal period. Personal hygiene and exclusive breastfeeding were the most frequently reported messages (57 and 55 percent, respectively), followed by immunization (38 percent). Less than one-fifth of these clients mentioned family planning or advice on nutrition/balanced diet, and very few mentioned advice on mother/child health or growth monitoring.

Client Satisfaction

Ninety-two clients were asked to indicate whether they are satisfied with the services provided by TBAs during their last delivery and if they would utilize the services of the TBA during future deliveries. All clients but one (99 percent) reported being satisfied with the services provided by the TBAs. All but 3 clients (97 percent) indicated that they would use the services of the TBA for future deliveries.

4. GoodLife Clinic Service Providers

Background

Greenstar Social Marketing has established a health care private provider network that is primarily in the urban areas in 10 districts of the PAIMAN program. This network provides MNH and RH/FP services and products. The network is under the umbrella of GoodLife, a sister organization of Greenstar Social Marketing; this helps to segregate the FP and MNCH services provided by Greenstar. To become a GoodLife provider, doctors and lady health visitors (LHVs) participate in training provided by Greenstar Social Marketing. Incentives for providers to become members of the franchise include clinical training opportunities – which do not exist systematically in the Pakistani private sector – and having their services promoted by outreach workers and non-media marketing.

It is this component of promotion by outreach workers that allows the provider to reach out to the target population. Through one-on-one and small group outreach, Greenstar workers are able to increase awareness of life-saving information, including the availability of quality, low-cost – or free/reduced rate -- clinic sahoolat consultations from private health providers.

GoodLife private health providers remain part of the network only if they adhere to quality standards prescribed for service delivery. Based on their level of medical training and the type of clinic facilities (i.e., whether they have a labor room or an operation theatre), providers are classified into three categories: GoodLife Basic Silver, GoodLife Advanced Gold, and GoodLife Surgical. Each cadre of providers will have associated competency expectations and the opportunity to move to a higher level of recognition within the network for the provision of quality services. For example, by providing sustained quality of care for a six-month period, a provider can move from the Silver to Gold level. All providers are to be certified and an individual contract should be signed between each provider and the franchisee.

As part of the GoodLife contract, all Silver and Gold GoodLife providers received two weeks of IPC coverage around their clinics within three months of being trained in the complete package of MNH curricula. Trained staff delivers IPC activities, following standardized guidelines and procedures in all districts. All interventions, messages, and materials have been developed specifically for this intervention and according to PAIMAN community-advocacy-communication (CAM) Roadmap guidelines. IPC activities began during the third quarter of the second year of program implementation (July - September 2006).

Sample

A total sample of 20 service providers -- a mix of lady doctors, LHVs and others (FWWs, midwives and nurses) -- was drawn from the list provided by Greenstar zonal offices in five selected districts. In order to have geographical representation within the districts, effort was made to draw a sample based on tehsil/taluka level. Following this strategy, this survey was able to develop a sample of four service providers who operate as GoodLife clinic service providers in each district as per the GSM list. In the end, it was possible to complete interviews with 19 service providers.

Findings

Characteristics

Work. Of the 19 service providers interviewed, 8 were MBBS doctors, 6 were FWW/FWCs and 5 were LHV/nurses.

These service providers were asked to indicate the time of establishment of their private practice in their respective localities. The following is a breakdown of the length of time since they had established their practices in their communities: 11 had established their practice 25 or more months before the survey, for 5 the time period was 13-24 months, and for 3 it was 11-12 months before the survey.

All 19 of the service providers interviewed were asked to indicate their status as full-time practitioners or working somewhere in the government as well. Thirteen providers were full-time private practitioners, while 6 service providers were also government employees in addition to being private practitioners and GoodLife service providers. Those who were government employees were further asked to indicate the departments where they work: 4 were employees of the Population Welfare Department, 1 was employed by the Health Department, and 1 by the Social Security Department.

As for the timing of their clinics: 9 service providers reported that their clinics were open 24 hours a day; 6 reported that their clinic operated for three to six hours in the morning, 3 reported operating three to six hours in the evening, and 1 reported operating three to six hours both morning and evening.

Training. Under GSM strategy, GoodLife clinic service providers are given training in four major aspects of maternal and neonatal health: family planning, newborn immediate care, childcare and emergency obstetric care (EmOC). These are followed by technical sessions and site visits by

trainers. Once they successfully complete all modules then they become GoodLife clinic service providers through formal agreement with GSM.

All service providers interviewed had received training in some areas of MNH from Greenstar. Training in neonatal and child health was received by 16 of the 19 providers), followed by antenatal and postnatal care (15 providers) and family planning (12 providers). Only 7 service providers received training in EmOC. None of the service providers in any of the five districts had completed all four modules of the GSM training course in MNH.

In terms of timing of the training, 8 of the service providers received training during the year before the survey, 6 from 13 to 24 months before the survey, while 5 trained two years or more prior to the survey.

The location of the training conducted by GSM for GoodLife service providers was mostly within the same district where they had their clinic (14 providers); another 5 were trained in a district other than the one where they had their clinic.

In the GSM strategy, it is recommended that half-day trainings be arranged followed by technical sessions given by the trainers at the provider's clinic. In terms of the duration of the trainings, 9 service providers reported that the total duration of their training was 1-3 days, 6 reported the duration to be from 4-6 days, and 3 providers reported their training as 7-9 days. One service provider could not recall the duration of training she had received.

Having smaller groups trained at a time are effective and provide an opportunity for frequent interaction and focused attention between trainees and trainers. Therefore, all service providers were asked to indicate the number of individuals in their GSM training group. Eight service providers indicated that they were trained in a group of 7-10 participants, 6 service providers mentioned that their group consisted of 11-15 participants, while 3 said that their group consisted of 16-20 participants. Only 2 service providers reported that their group had 21-30 participants.

The service providers were asked to indicate the provision of training material by the organizer during training sessions. It was confirmed by all service providers that they received some type of training material; however, none received all types of training material developed by GSM. The two materials most reported as having been received were clean delivery kits (received by 14 service providers) and Greenstar booklet (by 10 providers).

To another question regarding the procedure adopted by GSM for inviting trainees for trainings, 9 participants were invited through formal request and another 9 percent through a verbal request by GSM. One participant reported that she was invited by another provider to attend the training.

Incentives were provided to participants: 18 of the 19 participants reported that they were paid incentives for attending the trainings. Some trainees receive more than one incentive. Most (15) reported being provided with lunch and refreshments, followed by those (10) who reported being paid a cash allowance.

GSM contract. Under GSM strategy, it is mandatory to have an agreement with service providers in order to brand their clinics as GoodLife clinics; therefore, the service providers were asked if they had a formal contract agreement with GSM for establishment of a GoodLife clinic. A majority of the service providers (15) responded that they did not have a formal contract with GSM. Only 4 providers reported that they had a formal contract with GSM for GoodLife clinics. The 4 who said they had a contract were asked to show the contract: only 1 provider was able to show the contract agreement, while one other was able to show a copy of the agreement.

Awareness

MNH issues. The 19 service providers were asked about their awareness of MNH issues in the communities where they operate their clinics. Most (16) thought that maternal health was a problem of their community; however, 3 said that maternal health was not a problem. Similarly, 17 of the providers said that newborn and child health were problems confronted within their communities, but 2 said that these were not problems.

The 16 service providers who indicated that maternal health was a problem were further asked about specific maternal health problems. Low iron in blood (anemia) was the most frequently cited problem (9 providers), followed by poor health (7 providers). Numbers acknowledging other specific problems were small. The maternal health problem mentioned the least was lack of family planning services (1 provider).

Similarly, the 17 providers who reported that there were problems of newborn and child health in their communities were further asked about specific problems. A majority of providers cited diarrhea (13 providers), followed by pneumonia and poor knowledge of mother to handle newborn (9 providers each). High mortality was mentioned by only 1 service provider.

PAIMAN. GoodLife clinic service providers were asked about the PAIMAN project. Of the 19 GSM providers, whose responses could overlap, 14 knew that PAIMAN was a program about mothers and newborn health, 5 knew that it was for pregnant women and their children, and another 5 mentioned that PAIMAN is a private family planning program. Few knew anything else about the program, and 2 did not know anything about PAIMAN.

Services

Facilities. All 19 service providers were asked about the availability of in-patient facilities at their clinic/hospital and if they provided basic EmOC services. Of the 19 providers, 12 reported that they provided basic EmOC services at their facility. There were 5 providers who reported that they had in-patient facilities. The number who reported they had an operating theater available - 3 providers - was the same as the number who said that they could provide emergency obstetric services

Referrals. GSM providers were asked about the referral of patients to other health facilities. Sixteen providers reported that they referred clients to other health facilities in emergency cases. Of these, the cause of most of the referrals was obstructed labor (12 providers), followed by eclampsia (8 providers), post-abortion complications and postpartum hemorrhage (4 providers each).

Clinic sahoolat events. All GSM service providers were asked about the holding of clinic sahoolat events for their respective communities. All but one of the GSM service providers were providing clinic sahoolat events (18 providers).

Mode of contact. The 18 providers who conducted clinic sahoolats were asked about how the Greenstar staff contacted them to organize a clinic sahoolat. The providers could name more than one method of being contacted. The most frequent way in which providers were contacted was by the interpersonal communication officer (IPCO) and workers (9 providers) and telephone contact from someone at GSM (9 providers). The next most frequently cited form of contact was through the assistant manger health services (AHMS).

Timing. Under the GSM strategy, the first clinic sahoolat would be organized in the first three months after training. These service providers were asked to indicate the timing of the first clinic sahoolat they organized for their community. The most reported timings were just after receiving training and within three months of training (5 providers each).

Organization. The providers who organized clinic sahoolat events were asked how many they had organized after completing their training. There were 11 providers who had organized 4 clinic sahoolat events or more since their training. Another 3 had organized three clinic sahoolat events after completion of their training.

Those service providers who organized more than three events in a year were asked how this happened. Most (6 providers) said that these events were organized as special events by GSM. Three service providers said that they did not know the reason(s) for the high number of clinic sahoolat events organized at their clinics.

The service providers were asked to indicate the timing of the most recent CS event held at their clinics. The most responses (6 providers) were that a clinic sahoolat event had been held more than 12 weeks before the survey; this was followed closely by 5 providers reporting that they had held a clinic sahoolat event 8-12 weeks before the survey and 4 reporting that they had held an event 1-2 weeks before.

As per GSM strategy, one CS event is to be attended by about 30 clients. Service providers were asked to mention the number of clients attending their last CS events. The number of clients mentioned most often fell into the range of 11-20 clients (mentioned by 6 providers), followed closely by more than 30 clients (5 providers) and 21-30 clients (4 providers).

The service providers who provided clinic sahoolat events were asked about the type of patients attending CS events. The responses were fairly evenly split between “mostly women” and “women with children” (10 and 8 providers respectively)

Service providers who conducted CS events were asked to indicate the reason patients attended the events; they were able to provide more than one response. The largest number (17 providers) reported that the clients come for antenatal care; this was followed by those coming for family planning (13 providers). There were fewer reports of clients coming for other reasons.

Service providers were asked to record their responses about the duration of CS events. Five out of the 18 providers reported that these events last 4 hours, followed by events lasting either 2 or 5 hours (4 providers each). Two service providers said that events lasted six hours.

The service providers were also asked to indicate any benefit/s they got from holding CS events at their clinics. Of the 18 GSM providers, 14 reported that organizing CS events had benefitted their private practice; the others said that CS events had not benefitted their private practice.

Those who benefitted from CS events were asked to mention some of the benefits they felt they received; providers could name more than one benefit. The most reported type of benefit from the 14 providers who reported that they had received some type of benefit from organizing a CS event(s) was that the number of their patients increased, while 7 said that the benefit was free publicity for their clinics. Five providers thought that the quality of their services improved. Other benefits were mentioned by only a few providers.

To a separate question on problems faced by the service providers during CS events, 6 providers responded that they faced problems while conducting CS events. When asked about the type of problems they faced, 2 indicated the problem had to do with a lack of administrative and logistical support by GSM workers, 1 mentioned no one was there to control the gathering and another said that the community was not supportive.

When the service providers were asked about the expenditure on the CS events by the organizer, only 5 reported that the organizer had spent money on the event, the other 13 reported that they did not. Those who indicated that the organizer spent money on the CS events, were asked what the expenditures made by the organizers were for: all 5 indicated that money had been spent on refreshment for the clients.

Clean Delivery Kits

All of the service providers interviewed were aware of clean delivery kits. However, responses on the stock of CDKs at their clinics varied somewhat. Fifteen service providers confirmed the availability of CDKs, while 3 did not have any CDKs in stock.

Of those who reported that they did have a stock of CDKs available, 7 of the providers had a stock of 1-5 CDKs, while 5 had 11 or more CDKs and 3 had 6-10.

When asked about the source of their supply, half (9) of the providers reported having received their supplies through GSM outreach workers, followed by 4 providers who reported that they had gotten their CDKs in the open market. Other sources from Greenstar were the health services officer (2 providers) and the medical officer (1 provider).

Providers were asked about their use of CDKs in deliveries during the three months preceding the survey: 15 providers used CDKs in that period, while 3 reported that they did not. The service providers were also asked if they advise pregnant women to use CDKs during home deliveries: 15 reported that they did and 4 reported that they did not.

When it came to explaining the benefits of the use of CDKs, 16 service providers responded that they explained the benefits of using a CDK to pregnant women, while 2 said that they did not explain the benefits. Of the 16 who did explain the benefits of using a CDK, all 16 told pregnant women that the use of a CDC minimized the chances of infection. Fifteen service providers also indicated that CDK use provides a clean and safer birth option. Fewer explained other important benefits.

The availability of CDK promotional material was asked from service providers. Only 3 service providers reported that they had promotional material for CDKs, while 15 did not have such materials. The type of promotional material these 3 service providers had included a product brochure in Urdu (2 providers), while detailing aid in Urdu was reported by 1 service providers.

Supervision, Monitoring and Reporting

The service providers were asked about supervision during clinic sahoolat events. Of the 18 providers who organized CS events, 12 reported that there was someone available from PAIMAN/GSM to supervise the work during CS events.

These 12 providers who reported having ever been supervised, were asked to indicate the specific supervisors who had supervised CS events at their clinics. Seven reported supervision by a female outreach worker, 5 by an interpersonal communication officer, 5 by an assistant manager health services or female health officer. The presence of a PAIMAN district coordinator, assistant area manager health and manager health services were each reported by one provider. Asking about supervision by GSM staff at the last CS event before the survey, 6 of the 12 providers reported that there was supervision by GSM staff and 6 reported that there was no such supervision.

The 6 providers who reported that the last clinic sahoolat event before the survey had been supervised/attended by GSM staff were asked about the role of GSM staff during the last CS events. The providers could name more than one role/activity. Four reported that the GS staff had assisted in the treatment of clients. Other services provided by the GSM staff were each only mentioned by 1 provider.

Regarding any feedback received from GSM staff during the last CS events, 3 of the 6 service providers said that they had no feedback from GSM staff. Those who received feedback mentioned feedback about quality improvement and improvement in counselling skills.

The 18 providers were asked about GSM monitoring of their GoodLife clinics. The providers could name any GSM staff who monitored their GoodLife clinic. Fifteen of the 18 providers reported that their GoodLife clinic had been monitored by GSM staff; 3 reported that their clinic had not been monitored. Of the 15 whose GoodLife clinic was monitored, 9 reported that the GSM staff monitoring the clinic was a female health officer, 5 reported the monitor was the manager of operations, and 4 reported the interpersonal communications officer did the monitoring. Fewer reports were made about the assistant manager health services and female outreach workers.

The 15 service providers who were monitored by GSM were asked to indicate what was checked by the GSM monitoring staff during their last visit to the clinic. Providers reported the following GSM staff activities during the last visit by GSM staff to their GoodLife clinic: collected the progress report – 5; checked the clinic record - 4, did nothing – 4. Other activities (e.g., provided CDK, delivered IEC material, etc.) were reported by very few providers.

To a question regarding the visit of any senior staff member from GSM -- other than the regular supervisor -- in the year preceding the survey, 9 providers confirmed that some senior staff

members from GSM visited their clinics in the preceding year. These 9 were asked who visited their clinic. The manager operations was reported to have visited 5 clinics, while a regional manager visited 2 clinics. Two service providers did not know the designations of the GSM people who visited their clinics.

Providers were asked about recordkeeping for their MNH patients and submission of reports. Only 4 FSM service providers out of the 18 indicated that they kept records on their patients. Regarding submission of report on a monthly and weekly basis to Greenstar, only 7 service providers said that they submitted the reports and 11 said that they did not submit reports on a monthly or weekly basis.

5. Greenstar Outreach Workers

Strategy

The detailed strategy for Greenstar outreach workers and the effective use of their services in demand generation is presented in the appendix. Through the monthly activities of Greenstar workers, Greenstar expected to yield about 460 interpersonal contacts with women by each FOW/FHO, and about 420 contacts with men by each MOW. The total number of IPC contacts would depend on the type of unit operating in each city/town/ village.

Sample

A total of 16 outreach workers were interviewed about their roles and responsibilities in IPC and clinic sahoollats and their knowledge about MNH issues in their communities. Because the role of male workers in IPC activities is somewhat different from the role assigned to female outreach workers, in our sample 6 male outreach workers (MOW) were also included.

Characteristics

The background characteristics of the outreach workers interviewed are shown in Table 5.1. Six of the 10 outreach workers were males; 10 were females. The largest single age group was 20-24 years (6 workers). There were 9 below the age of thirty and 7 above. Half of the workers (8 workers) had matriculate qualifications; the other 7 workers had achieved intermediate to Master's levels of education. Nine outreach workers were currently married and the other 7 were not married or were divorced.

Table 5.1. Sixteen outreach workers interviewed, according to specific characteristics

Characteristic	Number
Gender	
Male	6
Female	10
Age (in years)	
20-24	6
25-29	3
30-34	3
≥35	4
Education	
Matric	8
Intermediate	4
Graduate	3
Master	1
Marital status	
Married	9
Not married	6
Divorced	1

Findings

Employment

The outreach workers were asked about the duration of their employment as outreach workers for IPC activities under GSM. Eight of the 16 outreach workers had been employed for 7-12 months, 3 had been employed for 3-6 months and 3 for 13-18 months, while 2 had been employed for 19 or more months.

Training

Duration. One outreach worker did not receive any training in IPC and clinic sahoolat activities. However, the 15 who did receive training were asked about the duration of training. Most (6 workers) reported that their training lasted for 2 days, followed by 5 who reported it lasted 3 days.

Number of participants. The 15 outreach workers who were trained were asked to indicate the number of participants in their training batch and the location of their training. Just over half of the workers (8 workers) said that their training batch had 2-10 participants; the other 7 reported 11 or more participants, and most of these reported 21 or more participants in their training. One-third of the workers responded that they were trained in a batches consisting of 21 or more participants.

Venue. Regarding the venue for their training, 9 workers said they were trained at GSM regional/zonal offices; 5 said they were trained in the same districts at private venues, and 1 was trained in another district.

Awareness

Responsibilities. All of the outreach workers were aware of their job description/duties. When asked about specific responsibilities, to which they could give more than one response, 13 said that they were responsible for facilitating clinic sahoolat events. Fewer indicated other responsibilities.

Maternal health. All 16 of the outreach workers confirmed that mothers, newborns and children in their communities are facing health problems. On specific maternal health issues, 14 mentioned low nutritional status, followed by poor health of women (12 workers) and low iron in blood (anemia) (8 workers) and lack of family planning services (8 workers). Fewer workers mentioned other specific maternal health issues/problems).

Newborn and child health. Given the opportunity to indicate a variety of specific problems of newborns in their communities, the poor knowledge of mothers to manage their newborns was mentioned by the highest number of workers (11 workers), followed by poor immunization status (8 workers) and no breastfeeding (bottle feeding) (7 workers). Other specific newborn problems were mentioned by fewer workers. As for indicating the problems of children under the age of five years, 13 workers reported that diarrhea is a major health problem, followed by chest infection (11 workers) and under-nourishment (8 workers).

IPC Activities Overall

Type of activities and timing before clinic sahoolats. It was reported by all workers that they conducted IPC activities in their communities. When indicating the activities that they carried out, neighborhood meetings were conducted by all 16 workers, orientation meetings were arranged by 15 workers, and HH visits were conducted by 9 of the 10 female outreach workers (men do not conduct HH visits).

GSM strategy says that IPC activities should begin in the community two weeks prior to a clinic sahoolat event. Outreach workers were asked about the timing of the start of their IPC activities in the communities before organizing a clinic sahoolat event. All 16 workers responded that the IPC activities were launched in the communities just 3 days before the date of the clinic sahoolats.

Venue. As for the different venues at which the workers conducted neighborhood meetings, the most often reported venue was the house of an influential, followed by an LHW health house (7 workers). Other venues were named less often. The outreach workers were also asked about the options they considered appropriate for selecting a place for neighborhood and orientation meetings. Given the opportunity to indicate a number of options they considered important when making such a selection, 11 workers indicated a comfortable place was important, while 9, each, indicated a place that was accessible and that was familiar to men and women. Only 1 worker thought that any place was appropriate.

Timing. Questions were also asked of the workers about the timing of the last IPC meeting held in their respective communities. Nine of the 10 female outreach workers had conducted household visits within the two weeks before the survey; 1 never conducted any HH meeting. Male workers do not conduct HH visits. In the two weeks before the survey, 15 workers had conducted neighborhood meetings and 16 workers had conducted an orientation meeting.

Incentives. All 16 outreach workers were asked about the payment of incentives to participate in IPC meetings (neighborhood and orientation meetings). Most (13 workers) indicated that they paid incentives to IPC meeting participants; 3 workers said that they paid no incentives. Those

who paid incentives were further asked about the type of incentives they paid to participants. Multiple responses were possible. Nine workers indicated that gave tokens for availing services at clinic sahoolats and 5 workers provided various types of gift items to participants, while 4 workers said they also provided refreshment to meeting participants.

Messages. The workers were asked to mention the types of message they gave to pregnant women and mothers of newborns and children during household and neighborhood meetings. Most outreach workers gave advice on antenatal checkups to pregnant women (15 workers), followed by advice on TT injections (14 workers) and advice on nutrition (13 workers). Other important topics of advice for pregnant women were mentioned by fewer workers. The least-mentioned message was about giving colostrums to babies.

Messages given to mothers of newborns and children under 5 years of age included care of newborns (13 workers), followed by immunization, nutrition and breastfeeding (10 workers each). Least mentioned topics were family planning and growth monitoring.

IPC materials/payment for refreshments. The outreach workers were asked about the distribution of IPC material during neighborhood meetings and orientation sessions. Brochures on MNH were distributed by all outreach workers and tokens for clinic sahoolats were distributed by 15 workers. Fewer workers reported other options.

All outreach workers confirmed that they arranged refreshments for IPC meeting participants, though earlier, when talking about incentives, few mentioned refreshments as an incentive. However, when asked about the provision of funds for such activities and the amount they received for refreshments for one neighborhood meeting, 3 outreach workers reported that they did not get any funds for refreshments, while 13 confirmed the receipt of funds. Of the 13 who received funds, 12 received up to Rs. 100 per neighborhood meeting, while 1 worker mentioned Rs. 200 per meeting.

Problems. These workers were asked if they faced any problems while conducting meetings at the household and neighborhood levels and at orientation sessions. There were 6 female workers who said that they faced problems while conducting HH-level meetings, while 4 female workers said that they had no problems. Since the 6 male workers do not conduct HH meetings, they did not respond to this question. Half of the 16 outreach the workers (8 workers) reported that they faced problems in conducting neighborhood meetings, and 7 workers reported that they encountered problems in conducting orientation meetings in the communities. The problems these workers mentioned were primarily about non-cooperation of the community and the fact that women and men were not able to spare time for these meetings.

Workload/targets. GSM strategy indicates that each worker should conduct eight orientation meetings in a month with twenty participants in each meeting. The workers were asked about the work plan for the number of contacts they make in a month under various types of IPC activities.

- **Orientation meetings.** While responding about their plans/targets for orientation meetings, a majority of workers (11 workers) indicated that they planned to conduct only two orientation meetings in a month. No worker was planning to conduct the target of eight orientation meetings in a month.
- **Neighborhood meetings.** The targets set by GSM for neighborhood meetings are 12 and 40 meetings each month by female and male workers respectively. Three out of 6 male workers confirmed that they conducted more than 40 meetings and 3 reported only 12 neighborhood meetings in the communities. Eight out of 10 female workers met their targets of conducting neighborhood meetings in the communities.
- **Clinic sahoolat events.** Each female worker should participate in 4 CS events in a month as per GSM strategy. Responses about participation in clinic sahoolats per month were good: 11 workers (69 percent) responded that they facilitate six clinic sahoolats in a month, while 4 workers (25 percent) informed that they conduct twelve clinic sahoolats in a month. One worker (6 percent) participated in 2 clinic sahoolats in a month.
- **Household visits.** Female outreach workers are required to make 200 HHs visits every month. Female workers were asked to indicate their number of contacts during household visits. Nine of the 10 female outreach workers interviewed made contact with 270 or more contact points. One worker made 135 contacts at the household level in a month; this low level of contact could be due to scattered population. Under the GSM strategy, each worker is responsible for making a total of 420 (FOW) or 460 (MOW) contact points every month through HHs visitation, neighborhood meetings and orientation meetings with influentials. Seven workers made 300 or less contacts in a month, while 8 workers indicated contacts in the range of 301-400 in a month. Only 1 worker mentioned that her contact points in a month were more than 400.

Supervision and recordkeeping. All outreach workers indicated that they have their supervisors to facilitate their IPC tasks in their respective areas. However, when they were asked about the supervision of their activities during their last IPC meeting, only 6 workers responded that their supervisors were present at the last meeting.

Feedback. Information about feedback ever given by supervisors about IPC meetings was collected in the survey. Overall, 3 workers said that their supervisors had given no feedback on their IPC activities. Those workers who confirmed feedback from their supervisors were further asked to identify areas in which they received feedback. A majority of the 13 workers who had

received feedback named “process of conducting meetings” as a topic they received feedback on, followed by communication skills (7 workers). The least mentioned area on which feedback was received was distribution of tokens.

Recordkeeping. Workers were asked about recordkeeping for different activities performed under IPC meetings. A majority of the workers (14 workers) were maintaining their records on a community activity weekly summary form. The household form was maintained by 8 female workers and the household weekly summary by 7 female workers (these forms are maintained only by female workers). Other workers named additional forms of recordkeeping.

Clinic Sahoolat Events

Support to clinic sahoolats. Female workers were asked to indicate the total number of clinic sahoolat under their jurisdiction in a year: 8 said that they are responsible for 72 clinic sahoolats under their jurisdiction in one year. However, only 6 of the 8 female workers confirmed their participation in 72 CS events in one year. One worker reported that she was responsible for only 15 CS events in a year, but 3 workers reported having participated in 15 CS events. One worker reported responsibility for 24 CS events in one year and she reported participating in this exact number of events. The implication of these numbers is that 3 female workers who said they were each responsible for 72 clinic sahoolats actually only participated in 15 each.

The role of female workers in CS event was assessed by asking the workers to indicate the services they provided in the last CS event they attended. Seven workers were collecting tokens from patients, while 6 were also facilitating patient flow at the event. Filling in MIS forms and assisting service providers in counseling and treatment were indicated by 2 workers each. Other services were only mentioned by 1 worker each.

Participants. These workers also gave feedback about the number of patients who attended their last CS event. GSM strategy proposes that a CS event be attended by 30 clients. However, 9 female outreach workers reported that their last CS event was not attended by the target number of clients. Only 1 worker said that there were more than 26 patients at the last CS event she attended.

Funds for CS events. According to the GSM strategy, Rs. 1000 would be provided for one CS event to facilitate the clinic activities. However, only 2 female outreach workers confirmed that they were provided funds for CS events, while 8 workers reported that they were not given any funds for holding CS events. Those who received funds were further asked to indicate the amount of money they received for one CS event. Both of the workers who said they received funds reported that they had received Rs. 500 for one CS event.

Recordkeeping. Recordkeeping for patients who attend clinic sahoolat events was also a question for the female outreach workers. Six workers reported that they kept records for all clients attending CS events, while the others did not keep records. Those who did not keep records by themselves were further asked to indicate who else was responsible for keeping records of CS events and all replied that client records are maintained by the IPCO and assistant manager health services (AMHS).

Benefits. All female outreach workers confirmed that they believe that CS events are beneficial activities for their community. The two most frequently mentioned benefits that workers named were: free consultation and services to clients (7 workers) and improving maternal and child health in the community (6 workers). Four workers each mentioned providing medicines at a subsidized rate and offering family planning services.

6. Clinic Sahoolat Event Participants

GSM is committed to the provision of quality MNH services at GoodLife clinics. GoodLife service providers are trained by GSM in this regard. Quality is ensured through on-site supervision by trained doctors and provision of feedback and technical advice on the spot. The service providers have to adhere to quality standards prescribed for the delivery of services. The provision of IEC materials and facilitating and supporting the organization and running of CS events at GL clinics is also ensured.

Sample

Exit interviews were held with 26 clients at clinic sahoalat events. A few of these events were arranged especially for the survey teams. Table 6.1 shows the distribution of clients in each district. The purpose of the exit interviews was to understand the level of satisfaction of clients about the services provided during CS events.

Characteristics

Background characteristics were gathered from the clients with regard to age, education, marital status, current pregnancy, and number of children. Specific characteristics are shown in Table 6.1. The biggest single age group was 26-30 years (12 clients), followed by 21-25 (6 clients). The clients were almost evenly split between literate and illiterate. All clients except 1 were currently married. Four clients had no children and 4 had 5 or more children. Most had 1-4 children, with more having 3-4 (11 clients). Eight clients were currently pregnant. All 25 currently married clients were asked to indicate the age of their youngest child: 13 had children two years or younger and 12 had children more than two years (6 of these had children who had just turned 5 or were older than 5).

Table 6.1. Number of CS event participants interviewed, according to specific characteristics

Characteristic	Number
District (N = 26)	
Buner	6
DG Khan	5
Jehlum	5
Lasbella	5
Sukkur	5
Age (in years) (N = 26)	
≤20	5
21-25	6
26-30	12
≥30	3
Literacy (N = 26)	
Literate	13
Illiterate	13
Marital status (N = 26)	
Currently married	25
Not currently married	1
Number of children (N = 25)	
0	4
1-2	6
3-4	11
≥5	4
Age of youngest child (N = 25)	
≤12 months	3
13-24 months	10
25-36 months	3
37-48 months	1
49-60 months	2
≥61 months	6
Pregnancy status (N = 25)	
Pregnant	8
Not pregnant	17

Findings

Attendance

Prior clinic visits. Most (18) of the clients who were interviewed after the CS events had come to this clinic for the first time; 8 had visited the clinic before (2 had been there 1-2 times prior to the CS event; 6 had been there 3 or more times).

Reasons for choosing this CS event. Clients could give any number of reasons for choosing the particular CS event they had attended before being interviewed. The main reasons given were: free services and medicines (15 clients), competent service provider with good behavior (12 clients), and the clinic was close to their home (10 clients).

Purpose of visit. The clients came to the clinic sahoorat for advice and treatment for a variety of problems. Clients could name more than one reason for attending the CS event. Equal numbers reported that they had come for general health issues and family planning (9 clients each), while 8 clients named antenatal care as the reason for their attendance, and 2 were there for infant/child health.

Decision to attend. Clients were asked to indicate who in the family had made the decision to attend the CS event. Eleven of the CS clients reported that they made the decision to attend the CS event themselves; another 9 said it was a joint decision. The husbands and mothers/mothers-in-law as the ones granting permission to attend the CS event was reported by 6 clients (4 = mother/mother-in-law; 2 = husband).

Token. GSM strategy explains that clients coming to attend a CS event should have a token for availing free services. During the exit interviews, clients were asked about if they had had a token with them for obtaining free services. Eighteen of the 26 clients did have a token; 8 did not. Those who had a token were further asked to indicate the source of the token: 17 reported that an outreach worker had given them the token, while 1 client was given a token by a neighbor.

Companion. Attending a clinic sahoorat event without being accompanied by relatives or elders is sometimes difficult for women; therefore, clients were asked to indicate the companion who came with them to the CS event. Fourteen clients attended the events accompanied by other women from their localities; 2 women with their child; 1 woman with her husband and 5 women attended the event alone.

Transportation and travel time. The proximity of the health facility to the client's home is important for women trying to access health care. As stated above, 10 of the women said that they attended the particular CS event at which they were interviewed because it was close to

their home. To judge proximity, clients were asked to indicate the time it took them to reach the CS event from their home. Many (10 clients) were able to reach the event within 5 minutes; another 11 said that they were able to reach the event from 6 to within 15 minutes.

The means of transport used to reach the clinic was ascertained from the clients. The majority (23) walked to the event, 2 used public transportation, and 1 used personal transport.

Problems. The clients were asked to indicate any problems they encountered to reach the CS events. All replied that they did not face any problems. They were further asked about any payment they made for services: 2 clients said that they paid Rs. 20 and Rs. 50 to the service providers. However, they both said that the amount they paid was affordable.

Services

The 26 clients responded about the type(s) of treatment they had received at the clinic sahoolat events: 8 clients each said that they were only given advice, that they were only prescribed/provided medicine, or that they were provided medicines and advice. However, 2 clients said that the provider did not give them advice or medicine.

Eight of the CS-event clients were examined by the service provider; these 8 clients were asked about the type of examination performed. The clients could give more than one response. Half (4) of the clients indicated that their abdomen/lower abdomen was palpated. Eye examination and blood pressure check-up were each reported by 3 clients. Other types of exams were named by 1 or 2 clients each.

Client Satisfaction

As for client satisfaction, most of the clients reported that the problem(s) they had come to the CS event to deal with was solved at the event. However, 4 clients indicated that their problems were not solved after attending the clinic sahoolat event. One client reported that the service provider mentioned other places to could go for their particular problem, while the rest said they were not told about other places/clinics.

Patient-client interaction/satisfaction. Adequate interaction between service providers and clients, including sufficient time for counseling, examination and advice, would lead to greater acceptability of advice and treatment and would improve trust between providers and clients. Twelve clients reported they had between 0 and 5 minutes with the provider (1 reported she did not even have one minute for consultation), while 9 reported that they received between 21 and 60 minutes.

When asked how they felt about the consultation time with the provider (asked if it was too short, too long or just right), most (21 clients) said that the time given by the service provider for consultation was about right, while 2 said that it was too short (and another 2 said they did not know). When asked to say if they were satisfied with the time given to them by the provider, 25 said that they were satisfied.

As for satisfaction with the services provided by the provider at the CS event, 21 said that they were satisfied, 4 said that they were somewhat satisfied, and 1 said she was not satisfied.

Quality of Services

Specific questions were asked regarding the quality of the services offered by the service providers at CS events. All 26 of the clients said that the providers listened to them, and almost all (25 clients) said that the provider understood the problem and explained the illness to them. However, reports on how the provider assessed the illness varied. Half (13) of the clients said that the provider only asked questions without an examination, 3 said that the provider only did a physical examination without asking questions, 9 were both asked questions and examined, and 1 said that the provider did nothing.

Future Intentions

Clients were asked about their future intentions regarding the use of the specific clinic for other than CS events. Most (24 clients) responded that they would come to the same clinic for treatment on non-CS event days. They also confirmed that they would recommend the same clinic to their friends and relatives and that they fully understood the explanation given by the service providers regarding their problems. However, 2 clients stated that they would neither come again to this clinic nor would they recommend this clinic for treatment and services. Additionally they both reported that they did not understand the explanation the service provider gave them about their illnesses.

7. Community Members

Conducting IPC activities, organizing clinic sahoorat events and ensuring availability of CDKs are activities designed to improve maternal, neonatal and child health in communities around Greenstar’s GoodLife clinics. During the process evaluation, an effort was made to access two communities located in and around each GoodLife clinic in order to better understand the views of members of these communities on project activities. The two communities were randomly selected in consultation with outreach workers who confirmed that these communities were covered in their previous IPC schedule. Once the communities were identified, they were mapped by experts from the Federal Bureau of Statistics, and household listings were completed, along with a sampling of 25 households in each community where information was to be collected. The survey teams set a target of 200 respondents in eight communities in a district. In cases where HHs in the sample had had no meeting with outreach workers, the next house was taken as a substitute, and so on. This process was continued until at least 25 eligible contacts in the mapped list in a community had been identified.

Sample

Details regarding the sample and finding eligible contacts at the household level are presented in the appendix.

Characteristics

Table 7.1 shows respondents by age groups. More than a quarter of the clients (27 percent) were in the age group 26-30 years. Slightly

Table 7.1. Percent of community members interviewed, according to specific characteristics (N = 573)

Characteristic	Percent
District	
Buner	4.7
DG Khan	30.0
Jehlum	29.7
Lasbella	4.5
Sukkur	32.1
Gender	
Female	97.6
Male	2.4
Age (in years)	
≤20	3.3
21-25	18.0
26-30	27.1
31-35	18.0
36-40	17.5
41-45	10.6
46+	5.6
Literacy	
Illiterate/no schooling	40.5
Class 1-5	23.9
Class 6-8	8.4
Class 9-10	13.8
Class 11-12	7.0
Class 13+	6.5
Marital status	
Currently married	97.0
Widowed/divorced	3.0
Number of children	
0	3.1
1-2	29.3
3-4	34.4
≥5	33.1
Pregnancy status	
Pregnant	9.6
Not pregnant	90.4

more than one-fifth of the respondents (21 percent) identified during household visits were below the age of 25 years. More than 50 percent were more than 30 years of age. The mean age of the respondents was 32.4 years.

Forty-one percent of the respondents were illiterate and 24 percent had attended Class 1-5. Roughly two-thirds had Class 5 or less education, with most being illiterate, and one-third had above Class 5 education.

Nearly all of the respondents were female (98 percent); 2 percent were male, and nearly all were currently married (97 percent). Eighteen respondents (3 percent) had no children, while there was a split of roughly one-third each for 1-2 children (29 percent), 3-4 children (34 percent) and 5 or more children (33 percent). Finally, nearly one-tenth of respondents were pregnant at the time of survey.

Findings

Awareness about MNH

Respondents were asked to indicate MNH issues they considered to be problems for their communities. Three separate questions were asked, one each on maternal health, newborn health and health of children under five years of age.

Maternal health. Table 7.2 shows that 23 percent said that maternal health was not a problem of their communities and 30 percent said that newborn health was not a problem. Fewer (12 percent) thought that health problems of children under five years of age were not a problem. These responses reflect that a strong IPC campaign on MNH issues is required to educate the communities on maternal and child health.

Table 7.2. Percent of community members reporting specific maternal, infant and child health problems in their communities

Variable	Percent
Maternal health problems in the community (N=443)	
Poor health	66.6
Low iron in blood (anemia)	42.7
Low nutrition status	40.6
Low antenatal check-up	25.7
Lack of family planning services	25.2
No postnatal check-up	18.5
High complications in delivery	18.3
No immunization during pregnancy	14.4
Lack of access to female service providers	8.8
Abortions	5.0
Don't know	2.3
High mortality	1.8
Newborn health problems in the community (N = 404)	
Low birth weight	52.7
Cough/fever/pneumonia/chest infection	34.4
Jaundice	26.7
Poor knowledge to manage newborn	21.0
Diarrhea	17.1
Poor immunization status	12.1
No breastfeeding (bottle feeding)	9.7
Vomiting	5.4
TT immunization	3.2
High mortality rate	2.0
Don't remember	1.5
Other	3.0
Health problems of children under 5 years of age in the community (N=506)	
Chest infection	86.4
Diarrhea	60.3
Undernourished	11.1
Itching/skin diseases	9.1
Lack of immunization	5.1
Don't know	1.0

Note. Respondents could name more than one problem in each category.

Those who reported that maternal health is a problem of their communities were further asked to indicate the type of maternal health problems their communities were facing. Table 7.2 shows that two-thirds (67 percent) mentioned poor health of mothers, followed by anemia (43 percent) and low nutrition status (41 percent). Other maternal health problems were mentioned by from 26 to 2 percent of respondents.

Newborn health. Multiple responses were obtained regarding the types of problems the respondents felt that newborns faced in their communities (from those respondents who had said that newborn health was a problem in their communities). Just over one-half of the respondents mentioned low birth weight (53 percent), one-third mentioned cough/pneumonia/fever (34 percent), and just over one-quarter mentioned jaundice. Other problems are shown in Table 7.2.

Children's health. The responses of those who reported that there were health problems for children less than five years of age in their communities are also shown in Table 7.2. A majority of those responding (86 percent) mentioned chest infection and cough, followed by diarrhea (60 percent). All other problems were mentioned by about one-tenth of the respondents or less.

Interpersonal Communication

Contact with outreach workers. All respondents (573) identified during household visits were asked whether Greenstar workers had ever visited them at the household level or in the community. Twenty-one respondents (4 percent) indicated that they were never visited by Greenstar workers in the community or at HH level.

Those who confirmed the visit of the workers (552) were asked to mention the time since they were last visited in their home/community by a worker. The majority of the respondents (63 percent) mentioned that workers last visited them more than 8 weeks before the survey, 19 percent had been visited in the 2 weeks before the survey, 11 percent within the last 4 weeks and 7 percent within the last 8 weeks. Two respondents (<1 percent) did not know how long it had been.

The 573 community respondents were asked if they have ever attended a meeting organized by a Greenstar worker in their communities. Only 135 respondents (24 percent) said that they had attended meetings, most of which were neighborhood meetings (88 percent), while 10 percent had attended orientation meetings. Two percent could not recall the type of meeting they attended.

The 438 respondents who had never attended a meeting with a Greenstar worker were asked to mention whether they had ever attended a clinic sahoalat event organized by GoodLife clinics for

their communities. There were 125 respondents (29 percent) who reported that they had ever attended clinic sahoalat events arranged by Greenstar workers.

Outreach messages. Overall 446 women were visited by workers at the household level and/or had attended neighborhood meetings. These women were asked to indicate the type of messages the workers conveyed to pregnant women and women with newborns and with children less than five years of age during these meetings. One-fifth (20 percent) of the respondents said that nothing was conveyed by workers to pregnant mothers during these meetings. More than half (54 percent) said that the messages were about family planning, and 38 percent said they were for advice on antenatal visits. Fifteen percent said that birth preparedness plans were mentioned, 12 percent said TT injections were mentioned, 10 percent said danger signs of pregnancy, 7 percent (each) said that postnatal check-ups and health education were discussed. Finally, 5 percent said that nutrition was given as a message and 2 percent said that use of CDKs was a message given.

As for messages to mothers with newborns, two-fifths (39 percent) of the respondents said there were no messages given related to newborn or child health during these meetings. Most of the messages given to mothers of newborns and children under 5 were reported to be about family planning (35 percent) and nutrition (20 percent). These were followed by immunization (16 percent), neonatal care and breastfeeding (14 percent each). Messages on weight monitoring and health education were recorded the least (both around 5 percent). Another 7 percent reported that they did not know about the types of messages given to mothers with newborns and children under 5 years during household visits and neighborhood meetings.

In addition to MNH messages, these respondents were also asked about advice regarding clinic sahoalats and the availability of tokens to attend free clinic sahoalat events at GoodLife clinics. While most respondents were advised to attend CS events, 9 percent (41 respondents) were not. The 405 respondents who said they were advised about clinic sahoalat events were further asked about the receipt of tokens for free consultations. While most (73 percent) were given tokens, more than a quarter (27 percent) were not.

The respondents were asked to indicate motivation factors mentioned by the workers in their last meeting for attending clinic sahoalats. Sixty-two percent mentioned free consultation as the motivation factor indicated by workers for attending clinic sahoalat, while 40 percent said free medicine, and 35 percent reported the availability of family planning services at the clinic sahoalat as the motivating factor. Medicine at a subsidized rate was mentioned by 15 percent of respondents. However, all other motivating factors were mentioned by less than 10 percent of respondents (i.e., quality of MNH services offered, clinic is patient friendly, immunization facility available, provider is good and friendly and expert doctor will check you). Three percent of

respondents reported that the workers had never mentioned any motivating factor to encourage them to attend a clinic sahoolat.

Counseling cards. Respondents (445) were asked about the use of counseling cards by the workers during discussions on various MNH issues at the HH level and at other meetings. Almost two-thirds of the respondents (65 percent) said that no counseling card was used by workers during discussion; 35 percent said that a counseling card was used.

Neighborhood meetings. Community respondents were asked to record the attendance at any neighborhood meeting ever attended in the past, the time when that meeting was held and the number of participants in each meeting they attended.

More than a quarter (29 percent) said that they had ever attended a neighborhood meeting, while 71 percent did not attend. Those who attended a meeting were further asked the time of their last meeting held with an outreach worker: more than half (56 percent) reported that the last meeting was held more than eight weeks ago.

Regarding the number of participants per meeting, half of the respondents (49 percent) reported that there were 6-10 participants in a meeting and 27 percent reported there were 11-15 participants.

Community respondents who had attended neighborhood meetings were also asked about the venues for holding neighborhood meetings. The most cited venue for meetings was the respondent's own house (23 percent), followed by an immediate neighbor's house (22 percent), health house of LHWs (21 percent), and the house of influentials (13 percent). Other responses were minimal: community center/common public space (2 percent); other responses and those who did not know accounted for 19 percent.

Giving some incentives to participants for attending neighborhood meetings has been proposed in the GSM strategy. The community members who had attended neighborhood meetings were asked about incentives. Nearly half of the respondents (48 percent) had not received any incentives for attending meetings. Those who received incentives (52 percent) were asked about the type of incentives they had received during neighborhood meetings. Multiple responses were recorded. Sixty-nine percent said that they had been given refreshments, 57 percent reported receiving tokens for free services at clinic sahoolat events, and 30 percent reported receiving gifts.

Those who had ever attended a meeting and been visited by workers at the household level (448) were asked about problem(s) they faced during the meetings they attended. Overall, 13 percent of the respondents said that they faced problems. Given an opportunity to name what they thought were problems, most (92 percent) of these 59 respondents reported that that it was a

problem that the meeting was too short. The next most frequently mentioned problem was that the time of the meeting was not convenient (27 percent). One-fifth (20 percent) indicated that the concept of the meeting was not clear to them. Finally, 8 percent indicated that the language and terminology used during these meetings were difficult to understand.

The community respondents were also asked about the types of IPC material they received during meetings and household visits. Nearly half of the 448 respondents (49 percent) mentioned that they received no IPC material from Greenstar workers. Forty-seven percent said they were given brochures, while only small percents mentioned anything else (this includes poster, give aways and don't know responses).

Clinic Sahoolat Event

Clinic sahoalat facilities are arranged at GoodLife clinics to provide free services, consultation and medicines at subsidized rates for MNH problems. The communities are informed about CS events before they happen by outreach workers through home visits and neighborhood meetings.

Awareness. Respondents were asked about their awareness regarding clinic sahoalat facilities for their communities. Of the 573 respondents, most (92 percent) were aware about the clinic sahoalat facilities in their respective areas; only 8 percent were not aware about clinic sahoalats. The 525 who were aware of CS events were further asked to indicate if they have ever attended a clinic sahoalat. Only one-third of these respondents (33 percent) confirmed that they have ever attended a clinic sahoalat organized at GoodLife clinics.

The 525 respondents who were aware about the clinic sahoalat facilities were also asked to mention the type of program under which these free clinics were operating. Multiple responses were reported. A majority reported that it is a program for family planning (86 percent), followed by a program for expecting mothers and newborns (85 percent) and a program for maternal and newborn health (84 percent). Two-thirds of the respondents also indicated that it is a government program to improve our health, while more than one-fifth (22 percent) also mentioned that clinic sahoalat is a private-sector program for MNH.

Source of information about CS events. The 173 respondents who had ever attended a clinic sahoalat event were asked about the source of the information they received about the events. The majority of the community members were informed by outreach workers (91 percent). Only a few percent received their information from any other source, with friends and neighbors being the highest of these at 6 percent. Banners and posters were hardly mentioned by respondents as the source of information (less than 1 percent).

Time since last CS event. As for the timing of the last CS event attended, of the 173 respondents who had ever attended a CS event, the most frequent response was four weeks before the survey (34 percent), while the next largest percent (29 percent) said that the last event they had attended was at the other end of the range at 37 or more weeks before the survey. The next mentioned time (all in four-week intervals) was 25-28 weeks (8 percent); all other four-week intervals were reported by even fewer respondents.

Transport to CS event. The community members were also asked about the mode of transport they used to reach clinic sahoalat events. The majority of the 173 respondents (72 percent) walked in a group to reach the events they attended, while one-quarter (25 percent) also reported walking, but they walked alone to the event. Use of other modes of transport (bus/van, taxi/tonga/rickshaw and personal transport) were only 1 percent each.

Only 4 clients out of 173 faced problems in reaching clinic sahoalat events. The problems were mostly related to the distance of clinics from their homes and finding the location of the clinic sahoalat.

Tokens. When asked about the availability of tokens, most of the 173 respondents said that they had a token available for utilizing the services at the CS events they attended. Most of these tokens were distributed by outreach workers (96 percent). Only 4 percent named another source of the tokens (i.e., neighbors, LHWs or friends).

Of the 28 respondents who said they did not have tokens for free services at the CS event they attended, 10 respondents said that the service providers checked them without tokens and 9 said that the worker helped them and accompanied them during the consultation even though they had no token. Another 7 respondents said that no token was required and 2 said that they had gotten a token at the clinic.

Topics during consultation. The 173 respondents who attended CS events said the most common topics discussed during consultations with service providers were family planning (36 percent), followed by antenatal care (23 percent) and childcare (19 percent). Other topics were discussed much less frequently: menses problems (13 percent), general health (6 percent), postnatal care and newborn care (5 percent each), and, finally, delivery care, pregnancy confirmation and want more children (all 2 percent each).

Costs. Around three-fourths of CS clients (74 percent) used the free services during CS events and paid nothing to service providers. However, 14 percent reported that they paid for medicines and 4 percent paid for the services they received. Around 2 percent of the clients reported to have

paid for services as well as for medicines, and 6 percent paid for laboratory tests and other non-medicine items.

There were 78 (45 percent) of the respondents who were given medicine at the CS events they attended. When they were asked if the medicines they got during the CS events were cheaper than the market rate, more than two-thirds (69 percent) responded that the medicines were cheaper than in the market, 5 percent said that the medicines were not cheaper, and one-quarter (26 percent) did not know about the price of the medicine they received.

Usefulness of CS activities. The 173 respondents were asked if they thought the clinic sahoalat activities were useful for their communities. Seventy-nine percent) said that organizing CS events at GoodLife clinics was a useful activity for the communities, whereas one-fifth (20 percent) said CS events were not beneficial for the communities. Only one percent respondents said that they did not know whether CS events were useful or not.

Those who said that the CS events were useful (136 respondents) were asked about the ways in which they thought these events were beneficial for the communities. More than half of the respondents thought that a benefit was that CS events provide free services (58 percent) and that poor people can take the benefit of these services (57 percent). More than a quarter (27 percent) said that it improves the MNH status in the communities; another quarter (24 percent) mentioned that the availability of family planning services at these events was a benefit.

The 34 clients who had attended CS events and thought they were not useful were asked to indicate their reasons. Their reasons were: no benefit to poor people (25 respondents) and no free services and no medicines provided at subsidized rate (11 respondents each). Six respondents said that the CS events did not provide medicines, and 4 said that family planning services were not offered. Two respondents (each) said that mothers and children do not attend and that MNH services are not provided; two respondents gave other reasons.

Clean Delivery Kits

Awareness and use of clean delivery kit are both promoted during IPC sessions through outreach workers. TBAs and GoodLife service providers are also tasked with promoting the use of CDK and ensuring their availability during labor, particularly for home-based deliveries. Respondents were asked about clean delivery kits. The main respondents were those who had delivered a baby in the last 24 months. Currently pregnant women were also asked to indicate their intention for use of CDKs when they delivered.

Awareness. The 261 women who had delivered in the last 24 months were asked about their awareness of CDKs. Awareness about CDKs was very low. Only 15 percent reported that they were aware of clean delivery kits.

Source of knowledge. Those who reported being aware of CDKs (40 respondents) were asked to indicate the source of the information they received about CDKs. Most (11 respondents each) mentioned either that a GoodLife clinic service provider or others (i.e., family/friends/neighbors) were the source of their information. Eight respondents mentioned outreach workers, 6 mentioned TBAs, and 4 respondents said hospital staff at an RHC/THQ/DHQ was their source.

Usefulness. Respondents were also asked about the usefulness of CDKs. Only 2 out of the 40 respondents who were asked this question said that there were no benefits to using CDKs during deliveries. The 38 respondents who indicated that CDK use during deliveries was beneficial mentioned several benefits. A majority (33 respondents), who could name more than one benefit, thought that CDKs were a benefit because they protect the mother and baby from infection. The next most frequent response (9 respondents) was that CDK use avoided complications during and after delivery. Finally, 3 mentioned other benefits and 4 said they did not know what the specific benefits were.

Source of CDK promotional material. Only 11 of the 40 respondents had seen CDK promotional material. When these 11 were asked about the source of the material, and could provide more than one response, most (4 respondents) mentioned that nurse/midwife/LHV were their source, while outreach workers and TBAs were each mentioned by 3 respondents. Two named LHWs as the source and 1 said the source was chemist shop.

Place of last delivery. Respondents who delivered their last baby in the 24 months preceding the survey were asked to indicate where their delivery took place. More than half of 254 respondents (52 percent) reported delivering in private hospitals, while 31 percent delivered at home and 15 percent delivered at a government health facility. Other locations and no information accounted for 2 percent of the responses.

Assistant during last delivery and use of CDK. The 78 respondents who delivered at home were further asked about the assistance provided during delivery and use of CDKs during that delivery. Most of the home-based deliveries (83 percent) were assisted by dai/TBAs. LHV/nurse/midwife conducted twelve percent of deliveries, while 3 percent were assisted by mothers-in-law. Very few mentioned the assistance of their friends and other relatives (1 percent). No information accounted for 1 percent.

The use of CDK during deliveries in the communities remained very low. Out of 78 respondents who delivered at home, only 13 respondents (15 percent) said that a CDK was used in their deliveries. Of the 13 respondents who said that a CDK was used in their delivery, most said that it was made available by TBAs (8 respondents), followed by LHV/nurse/midwife (3 respondents). One said the CDK was available through LHWs, and one mentioned other sources.

Currently pregnant women (55 respondents) were asked about the place for their forthcoming delivery. There were 26 respondents who planned to deliver at a private health facility, 18 who planned to deliver at home, 4 who planned to deliver in a government health facility. Seven of the currently pregnant women had not decided where they would deliver. Those who expected to deliver at home were further asked whether or not they planned to use a CDK during their delivery; only 7 respondents said that they planned to use a CDK, while 11 respondents did not intend to use a CDK.

8. Conclusion

It should be noted that there is a great deal of effort going into Greenstar's initiatives and activities to reduce maternal and newborn morbidity and mortality through its outreach and clinics, provider training and services. However, a process evaluation such as this is first about finding the weaknesses in a system rather than its strengths. For whatever number of services or training that are not fully reaching pregnant women and mothers of newborns, there are services and information that are reaching more women than in the past. Greenstar is encouraged to improve and strengthen its initiatives so that more accurate information and more comprehensive services reach more women, with greater acceptability.

Because numbers of certain groups in this study are small, Greenstar should do further investigation with individuals within their system to verify the findings and make corrections accordingly. The data contained here will be a guide to Greenstar as it looks for areas that need to be strengthened and expanded. There are also areas that should be re-examined to better understand the causes of problems reflected in the process evaluation findings. An example of this is the fact that 13 of the 51 TBAs interviewed had no recommendation letter from their community as a Greenstar strategy says they should. This might speak to a problem or not. This is just one example in which follow-up will be useful.

It seems clear that all groups – provider, client, worker -- need more and better information, whether in trainings or at outreach sessions or clinic counseling events. While most providers of all stripes, did know that, in general, there were maternal and newborn health problems in their communities, the range of awareness of all issues varied considerably. When giving messages, providers and outreach workers alike, appear to not cover a very broad range of MNH topics. Too many community members thought that there were no maternal and newborn health problems in their community. Again, in terms of the flow of needed information, all 19 GoodLife service providers reported that they did not receive a full package of all IEC and other training materials during their training

There are a number of areas that require further scrutiny to determine exactly where communication is failing to reach all groups. Greenstar can probably do more of this during its trainings and outreach to better understand where breakdowns are occurring. For example, while the use of clean delivery kits is important, and was something Greenstar was promoting, and 43 of the 51 TBAs did have a CDK in stock on the day of the interview, 8 TBAs were out of stock. Among the TBA clients, 75 percent did know about CDKs, but 25 percent did not; however, 87 percent said that they had not received any messages about CDKs during their pregnancy. Most of

the GoodLife clinic providers did have a CDK on the day of the interview, 3 did not, but 15 did not have any promotional material, and 4 said they did not recommend their clients use a clean delivery kits. Among community members, 85 percent of the women who had delivered in the 24 months preceding the survey were not aware of CDKs and of those who delivered at home, only 17 percent used a CDK during their last delivery. Of the community members who were pregnant at the time of the interview and wanted to deliver at home, 18 (61 percent) had no intention of using a CDK for their upcoming delivery.

Areas that require more diligent oversight include monitoring/supervision and recordkeeping by all providers. Improvements in these areas might have repercussions in other areas, as more contact within a well-functioning system could improve relationships, function and content.

While the scope of Greenstar's initiatives is broad, and is to be applauded, many specific activities need to be more thoroughly supervised and assessed.

Appendix 1. Strategy for Greenstar Outreach Workers and Their Activities

Strategy

The following section describes the strategy for the activities of Greenstar outreach workers. Female outreach workers (FOWs), female health officers (FHOs) and male outreach workers (MOWs) will conduct IPC activities at in-station cities with permanent supervision. For AMHS out-station and all AAM units (sites without permanent supervision), female health officers (FHOs) will be available. FHOs are by profession LHV, nurses, or midwives. MOWs will be of the same qualification, for both in- and out-station supervisory areas. Teams can contract with community based organizations (CBO/CBW model) to conduct IPC activities. Regardless of the model adopted, recommended staff numbers and type of outreach workers will relate to the “units” in each city/town/village.

All AMHSs and AAMs will make a monthly plan by the 25th of each month. This plan will include AMHS and AAM activities, including trainings and IPC. Required additional staff will be hired and trained to complete IPC staffing needs in every district. All Greenstar IPC supervisory staff is trained to oversee IPC efforts for GoodLife. IPC teams will hold periodic review meetings with their supervisors and operational managers for feedback and support.

Table A1.1. IPC activities that will be conducted for two weeks around GoodLife clinics, according to GoodLife clinic audience

Activity	Audience for GoodLife clinics
Orientation meetings	<ul style="list-style-type: none"> Male and female influencers and gatekeepers important to promoting, supporting and adopting healthy behaviors for improved maternal, neonatal, and reproductive health
Household visits	<ul style="list-style-type: none"> Women with neonates and children under age five Pregnant women Women with identified unmet need for adopting family planning or changing current family planning method
Neighborhood meetings with men and women	<ul style="list-style-type: none"> Married men of reproductive age (15-49) who fulfill one or more of these characteristics: <ul style="list-style-type: none"> - Have wives who are currently pregnant - Have one or more children up to age five - Married women and men of reproductive age who fulfill criteria for household visits and those identified as household and community level influencers
Clinic sahoolat	<ul style="list-style-type: none"> Women and children qualifying for counseling and treatment on MNH and RH

IPC activities will be conducted by outreach workers around selected GoodLife clinics for a period of 14 days. After this, the worker (or team) will shift to another clinic. This pattern will be repeated until all clinics have been covered. Each clinic will be covered at least once a year; however, IPC activities may be repeated more than once a year, around selected clinics, at the discretion of field teams and based upon guidelines.

The number of outreach workers is calculated according to the number of clinics available in every territory where the GoodLife network operates:

Table A1.2. Recommended outreach staffing, by type of staff, according to number of clinics

Unit	Number of clinics in territory	FOW	MOW	FHO	MOW
A	1 – 24	1	1	1	1
B	25 – 49	2	1	2	1
C	50 – 74	3	1	3	1
D	75 – 99	4	2	4	2
E	100 – 124	5	2	5	2

The number of activities per worker provides a target for reaching at least the minimum number of persons to achieve the expected results. Activity break-up for persons contacted by outreach workers and officers per month (Table A1.3).

Table A1.3. Number of monthly activities and contacts targeted, according to specific workers and budget

Proposed activity	FOW / FHO		MOW		Budget
	Activities per month	People attending	Activities per month	People attending	
Orientation meetings	8	20	8	20	0
Household visits	200	200	0	0	0
Neighborhood meetings	12	120	40	400	Rs 10 / contact
Clinic sahoolat	4	120	0	0	Rs 1000 / event
Contacts/worker/ month	Female -- 460		Male -- 420		

Recommended number of activities by type of worker in CBO & budget for each activity. Number of activities may be adjusted within staff team as long as activity and output targets are met.

Appendix 2. Household Sampling Information (for Community Response)

Sample

In Buner district, a total of 828 household were listed in eight communities around four GoodLife clinics and all were visited by a survey team. Only twenty-five eligible contacts were identified who were either accessed by outreach workers at HH level, neighborhood meetings and in orientation meetings. In two communities attached to Khursheda clinic, 200 HHs were visited but not one of these had been contacted by outreach workers. After visiting 285 HHs in communities around Naseem Akhtar clinic, only 6 were identified with confirmed contact with an outreach worker.

In district Lasbella, no clients in five communities had been visited by an outreach worker. In two communities around Liyari clinic, the survey team found 22 HHs from which it was confirmed that an outreach worker had visited. In all, 475 HHs were mapped and all were visited by the team; however, only 25 clients confirmed that they had been approached by outreach workers.

In Sukkur, the number of household visits by outreach workers was somewhat satisfactory. A total of 1,247 HHs were mapped in eight communities around four GoodLife clinics: 526 HHs were visited and 185 eligible contacts were identified for interview. Communities around Ashfa and Saad clinics were well accessed by outreach workers; however, one community around Arbab clinic and two communities around Awais were not adequately approached by workers.

Eight communities in Jehlum were mapped with 1,247 HHs around four GoodLife clinics. The survey team after visiting 894 HHs was able to trace 169 eligible contacts approached by workers through HH visitations, neighborhood meetings and orientation meetings. Contacts by outreach workers were very scattered around three GoodLife clinics. The community around Rajput clinic received the least visits by outreach workers; the survey teams, after visiting all mapped HHs (200), were able to identify only 20 contacts eligible for interview. A total of 1,210 HHs were mapped around four GoodLife clinics in eight communities in DG Khan. After visiting 1,018 HHs, the survey team was able to locate 164 eligible contacts that had meetings with outreach workers in the past. All of the HHs mapped (583) in the four communities around two clinics (Shaheen and Aiman clinics) were visited; however, only 64 contacts were identified that had been accessed by workers

Table A2.1. Number of households listed, households visited and eligible contacts, by district and clinic

District	HH listings	HHs visited	Eligible contacts	Remarks
BUNER DISTRICT	828	828	27	It was planned to identify 25 HHs in one community for interviews, thus total of 200 HHs in eight communities in a district was planned for filling of questionnaire. However, the target was not achieved due to poor HHs visitation by outreach workers. Additionally, the team found only three male clients in the entire district who were accessed by workers in neighborhood meetings. No client of orientation meeting was found in district Buner.
LASBELLA DISTRICT	475	475	26	25 respondents were planned at HH level to be interviewed in each community, thus the district target was 200 respondents. After visiting 475 HH, only 26 respondents were identified. This included two male respondents from orientation meetings and none from neighborhood meetings.
SUKKUR DISTRICT	1027	526	184	The identification of respondents from the communities was better in Sukkur, as compared to Buner and Lasbella. Our survey team was able to located 184 eligible contacts in the entire district against the target of 200.
JEHLUM DISTRICT	1247	894	170	Identification of clients (eligible contacts) was satisfactory I communities in and around three GoodLife clinics. However, desired level of clients could not be identified in two communities located in the vicinity of Rajput clinic.
DG KHAN DISTRICT	1220	1018	166	The survey team was able to locate the required number of clients residing in communities around two GoodLife clinics. However, desired number of clients in communities around two clinics could not be traced for interview after visiting all listed HHs. There were 31 contacts available in all 324 HHs around one clinic and 35 total contacts after visiting 259 HHs around another clinic.

Appendix 3. Fieldwork Teams

Name	Designation
NWFP: Buner	
Niaz Mohammad	Logistic Supervisor
Gul-e-Rana	Interviewer
Deeba Chanda	Interviewer
Seema Gul	Interviewer
Punjab: Jhelum and D.G. Khan	
Mohammad Imran pasha	Logistic Supervisor
Anjum Seemab	QCS/Interviewer
Fakhra Rasheed	Interviewer
Sindh and Balochistan: Sukkur and Lasbella	
Tahir Jabbar	Logistic Supervisor
Saira Memon	QCS/Interviewer
Saira Nazir	Interviewer