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SUKH سُکھ
Sehat Apnana, Sukhi Gharana
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Sukh Initiative (2013-2018)

Implementation Strategy

Sukh Initiative empowers women to access contraception by increasing knowledge, improving quality of services and expanding their basket of choices, contributing to the goals of FP2020.

Table of Contents

List of Acronyms

AKU	Aga Khan University
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ATH	AMANTELEHEALTH
BeMonC	Basic Emergency Obstetric and Newborn Care
CAC	Community Advisory Committee
CBO	Community Based Organization
CeMonC	Comprehensive Emergency Obstetric and Newborn Care
CHS	Community Health Supervisor
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
EPI	Expanded Program of Immunization
FGD	Focus Group Discussion
FLE	Family Life Education
FP	Family Planning
HTSP	Healthy Timing and Spacing of Pregnancy
IUD	Intra-Uterine Device
KMC	Karachi Metropolitan Corporation
KPI	Key Performance Indicator
LHW	Lady Health Worker
LSBE	Life Skills Based Education
MCPR	Modern Contraceptive Prevalence Rate
MIS	Management Information System
MNCH	Maternal Newborn Child Health
MnE	Monitoring and Evaluation
MWRA	Married Women of Reproductive Age
PAC	Post-abortion Care
PAFP	Post-Abortion Family Planning
PNC	Postnatal Care
PPFA	Post-partum Family Planning
PWD	Population Welfare Department
QA	Quality Assurance
RH	Reproductive Health
SESSA	Sindh Employee Social Security Administration
SRHR	Sexual and Reproductive Health and Rights
STAG	Sukh Technical Advisory Group
TF	Total Fertility

Introduction

This document outlines the project details for a $15 million investment to increase the modern contraceptive prevalence rate among married women in a 1 million population from Karachi, Pakistan; to test the proof of concept that the Sukh Initiative can effectively deliver quality information, counseling, supplies, referrals and services to women of reproductive age and men within their families for Family Planning (FP) and Mother and Newborn Child Health (MNCH); and demonstrates impact on reducing unintended pregnancies to government in order to adopt and scale up throughout Karachi and Pakistan.
This document is comprised of the implementation strategies of all the implementing partners of the Sukh Initiative and defines the process and procedure of all activities planned towards achieving the project objectives. It begins with an introduction to the Aman Foundation and Aman Health Care Services, the Foundation's leading partner in the implementation of Sukh Initiative. The document, then describes the context for which the project was conceptualized and is now being implemented with the support of other implementing partners. Finally, it describes three strategic objectives for partners of the Sukh Initiative, and provides a framework of activities to achieve the project's target objectives.

The Aman Foundation

The Sukh Initiative emerged out of commitments made at the London Summit held in July 2012 and is a joint partnership between three Foundations: the Aman Foundation, the Bill & Melinda Gates Foundation, and the David and Lucile Packard Foundation. The Aman Foundation is a local, not-for-profit trust, based and operating in Pakistan, born out of the belief that Pakistanis must take the lead in solving Pakistan's problems. The Aman Foundation aims to champion dignity and choice for the underserved, focusing on Health, Nutrition and Education through direct intervention, and aspiring to derive scalable, sustainable and systemic change in Pakistan, as outlined below.

> *Healthcare*. Development and implementation of healthcare systems ranging from Emergency Medical Response, Community Health Workers, and TeleHealth initiatives to Mother-and-Child Clinics.
>
> *Nutrition*. Provision of nutritious and hygienic meals to schoolchildren to reduce hunger and malnutrition; increasing enrolment and attendance simultaneously.
>
> *Education and Skills*. Vocational Training Institute designed to transform unemployed and untrained youth into productive members of society and the Teach for Pakistan Program, a nationwide movement of graduates and young professionals that commit two years to teach in under-resourced schools.

In addition to its social development initiatives, the Aman Foundation engages in venture philanthropy by providing strategic grants to high-social-impact organizations that work in the Foundation's core areas of focus. The Aman Foundation awarded this project to Aman Health Care service to lead in implementation.

About Aman Health Care Services (AHCS)

In line with its vision of a vibrant and healthy Karachi, the Aman Foundation has created a three-pronged healthcare eco-system in the form of Aman Health Care Services (AHCS). AHCS conducts outreach initiatives targeted toward essential healthcare issues, with a focus on mother & child health (MNCH). The core components of this strategy are to bring care to the home of the most vulnerable, to provide care during transfer, and to establish accessible healthcare facilities for mothers and children. The at-home component is delivered by AMANTELEHEALTH and the Aman Community Health Program (ACHP), the latter contributing to health promotion and disease prevention at home through its cadre of community health workers (CHWs). The AMANAMBULANCE delivers the en-route component through the provision of high quality and timely ambulance services. A network of low-cost and high quality Mother & Child hospitals is also planned for the near future.

AHCS leads the Sukh Initiative and also facilitates partners in implementation of the program. It plays the role of the 'prime', housing the Program Management Unit (PMU) of the Sukh Initiative. The AHCS is responsible for strong performance management and data solutions such that different strategies are synergized and aligned, and high impact drives the success of the project.

About the Sukh Initiative

Context

Promotion of family planning – and ensuring access to preferred contraceptive methods for women and couples – is essential to securing well-being and autonomy of women, while supporting health and development of communities. Findings of the Pakistan Demographic and Health Survey (PDHS) 2012-13 show only a 5% increase in CPR rate to 35% in the last six years. Majority of contraceptive users use a modern method (26% of currently married women) and 9% use traditional methods. Among the modern methods, condoms and female sterilization are the most common methods being used (both 9%). The practice of all other modern methods is far lower, in the range of 2-3% (Injectable: 3%; IUD, pills, and LAM: 2% each). The use of withdrawal has increased more than twofold since 2006-07 (from 4% in 2006-07 to 9% in 2012-13). Correspondingly the total fertility rate (TFR) has shown a downward trend with the recent PDHS showing a TFR of 3.8 compared to the 2006-07 PDHS which showed a TFR of 4.1.

In Karachi, which is ranked amongst the top ten most populous cities of the world, with a population estimated to be more than 21 million, the reported contraceptive prevalence rate (CPR) is 45%. However compared to other similar cities internationally, CPR in Karachi is lowest among its peers - Dehli and Jakarta. Figures from a baseline study of 3 districts of Karachi conducted by the Falah project show that a total of 51%, 50% and 34% of all married women in the sample of Lyari, Orangi and Gadap respectively were currently using some method of contraception and 41.4%, 34.2% and 29.2% were using a modern method. There is some evidence that population pockets within Karachi also have CPR rates which are much below the national average and in many cases these are similar to rural populations. One example of this is Ibrahim Haidri a peri-urban community of Karachi where a baseline conducted for Aman's Community Health Program found an MCPR of 28%.

Furthermore, an analysis of the Falah baseline data conducted by McKinsey and Company shows that of the 45% CPR in Karachi, 22% of MWRA use traditional methods and the remaining use modern methods, though majority are using condoms. Prevalence rate of traditional methods is 15% higher than the average rate of other comparable cities, resulting in a higher rate of unplanned pregnancies and abortions, perhaps as high as up to 1 in 3 pregnancies being unplanned, and 1 in 7 aborted. Nearly 3/4 of women who use traditional contraceptive methods do so due to fear or experience of side effects from modern methods. Condoms are used by 35% of MWRA in this group, despite the cost and reliance on husbands to obtain them. Although condom use has been increasing in recent years, failure rates and discontinuation rates after 1 year of use remain high. Traditional contraceptive method users and condom users require substantial effort to encourage a switch to more reliable modern methods, and to increase the efficacy of current methods.

The analysis further showed that of the MWRA that express an unmet need but do not currently demand a contraceptive method; 47% report lack of understanding/awareness (largely caused by the fact that most users are not provided with much information at the time of accepting contraception) as a key barrier preventing the use of family planning, while 33% report social pressure and 20% report family pressure (due to lack of couple communication, discouragement from husbands, etc.) as key barriers preventing the use of family planning methods.

In the analysis 30% of women in a population are either pregnant or who wish to conceive and 75% of these women prefer families of 4 or fewer children. Of this group, the majority are yet to meet or have just met their target family size, indicating that limiting is not a priority, but that there may be opportunity for spacing.

For all of these three groups of the analysis, but especially for the women with an unmet need require male involvement to reduce barriers towards family planning and they must also be part and parcel of any solution. Men are often viewed as gatekeepers. According to the PDHS 2007, 9% of currently married women age 15-49 who are not using contraception and who do not intend to use in the future, cited husbands disapproval as the main reason for not using a modern contraceptive method. Falah baseline data, showed that only 6% of men stated that they have had regular discussions with their wife on family planning while half have never broached the subject. Male involvement is important and if they are involved it can result in long term benefits for women through reducing barriers and increasing the demand for contraception.

Young people form the largest cohort of Pakistan's population. At this stage in life it is crucial to inculcate positive values, provide them with correct knowledge, and support them in developing essential skills that will enable them

to make better decisions about their lives. This is likely to influence long term demand and longer term behavior change.

On the supply side the McKinsey assessment found that the quantity of supply (in terms of location or product availability) does not appear to be a major issue, although not enough is known about availability of method mix and reasons for low access. However, according to Azmat et. al, "There is considerable demand for FP in Pakistan that remains unmet, as supply-side efforts have lagged behind demand creation." In fact, twice as many women have an unmet need than those availing FP services. Supply-side programs, from as early as the 1970s, showed spectacular results even in extremely remote or culturally conservative locations. Thus, it appears that supply-side approaches are needed to complement demand creation. Under current conditions, they may provide much higher short-term returns on investment in FP than simply creating demand."

Much evidence shows that quality of care on the supply side is more likely to be an issue that impacts demand. Falah baseline data from Gadap shows that 75% of MWRA view doctors and lady health workers as trusted sources of advice for the adoption of family planning methods. Yet issues of low quality of care, including inadequate knowledge of care-givers, inadequate method mix, and lack of counseling, result in inadequate motivation.

Sukh Initiative is positioned to improve the health of mothers and children by appropriate spacing of pregnancies and by expanding access and quality of both information and services for one million population in four towns of Karachi namely Bin Qasim, Korangi, Landhi & Malir.

Sukh Initiative proposes that demand is stimulated through a diverse set of touch points and similarly the intervention population must have access to improved quality of service provision and a basket of choices. These will be implemented through multiple holistic channels or solution levers. These solution levers include:

1. Door-to-door services
2. Family life education
3. Call center services
4. Provision of quality family planning services
5. Advocacy

The Goal of the Sukh Initiative

The Sukh Initiative goal is to increase modern contraceptive use by 15% amongst married women in a population of one million in selected communities in Karachi, Pakistan. In context to Pakistan, this will translate in improving maternal health by reducing unintended pregnancies. One of the guiding principles of Sukh is an integrated and strategic approach with the involvement of all stakeholders.

Project Framework

	Results	Results Measurement	Assumptions
Strategic Area: Family Planning	Increase in birth spacing	Increase in closed interval between pregnancies/births Baseline/endline	Use baseline to gauge probable increase
		Increase in open interval (most recent birth to the date of interview) Baseline/endline Semi-annually from CHW service data	
	Decrease in unintended pregnancies/births	Proportion of women who state that their last pregnancy/birth was ill timed or unwanted Baseline/endline Semi-annually from CHW service data	Use baseline to gauge probable decrease
Project Goal: Increase in current use of modern contraception	Modern contraceptive prevalence rate	15%%age points increase in MCPR Baseline/Endline Semi-annually from CHW service data	The population remains stable without major demographic shifts/migration Other govt. and civil society programs catering to the SUKH INITIATIVE population continue to keep their family planning contributions the same Baseline indicates high level of unmet need
	No. of women who discontinued but switched	Semi-annually from CHW service data	
	Increase in MCPR attributable to lowest two income quintiles of intervention population	Baseline/Endline	
	Increase in MCPR by age group	Baseline/endline	
	Increase in MCPR by parity	Baseline/endline	
	Increase in MCPR attributable to long term methods	Baseline/endline Semi-annually from CHW service data	
	Increase in first time acceptors of modern contraceptives	Baseline/Endline Semi-annually from CHW service data	
	Increase in number of women transitioning from traditional to modern methods	Baseline/Endline Semi-annually from CHW service data	
Objective 1: Increase in demand for FP services (Demand = CPR + Unmet Need)	Unmet need for family planning by reason	Baseline/endline	Knowledge is incomplete and there are high attitudinal barriers for FP Socio-political environment stays stable Community leaders support program initiatives Substantial penetration of telephone usage and people are comfortable to speak about sensitive areas on the phone There is comfort with boys and girls 16+ years. accessing family life education
	Increase in MWRA and their husbands citing knowledge items reflecting demand (proportion accurately reporting health benefits of pregnancy spacing and timing; proportion knowing one source of modern contraceptive service by each method	(Refer to MEASURE indicator database) Baseline/Endline Midline (18 months)?	
	Increase in number of MWRA and their husbands citing at least three attitudinal items reflecting demand (e.g. mean ideal family size; no son preference, proportion MWRA reporting intention to adopt modern contraception; reported spousal communication about FP) by number of years of marriage	(Refer to MEASURE indicator database) Baseline/Endline	
	Increase in number of family planning clients at trained local service providers and trained maternity homes	Baseline/Endline of facilities Six monthly from service provider service data	
	Increase in number of calls on FP to the call center from intervention sites (by location & by age)	Six monthly from call center service data	
	Increase in knowledge of girls and boys (+16) from intervention communities regarding maternal health, marriage rights and communication (indicator to be finalized with implementing partner for Family Life Education)	Baseline/Endline (FDGs) Six monthly increase in post test scores from service data of FL partner	
Objective 2: Improved access to FP services (by method) and	Increase in number of maternity homes providing PP/PA FP services, by method	Baseline/endline of facilities Annually from maternity home service data	Adequate number of service providers is already present and willing to work with Sukh Initiative for increase in scope and quality of services.
	Increase in number of local providers providing FP services, by method	Baseline/endline of facilities Annually from service provider service data	

with improved quality of service	80% of local FP service providers and maternity homes which are in the program have least 5 modern methods available	Baseline/Endline of facilities Annually? from service provider and maternity home service data	Commodity availability at low cost for service providers
	Maintain a mean value of client satisfaction score of at least 80% for door to door services	Measured by QA team Six monthly	
	Maintain a mean value of client satisfaction score of at least 90% for TeleHealth services	Measured by QA team Six monthly	
	Maintain a mean value of client satisfaction score of at least 80% for PP/PAC FP services in maternity homes	Measured by QA team Six monthly	
	Maintain a mean value of client satisfaction score of at least 80% for local FP services in community	Measured by QA team Six monthly	
	Quality of care indicators will be identified and measured for service delivery points	Refer/choose from MEASURE database of FP indicators for a range of tested indicators on quality	
Objective 3: Ensured long-term sustainability of program focus	Community has continued access to quality call center and FP services beyond program period	Call center, service provider and maternity homes service data collected 2 years after site closure (subject to funding availability)	The Sukh Initiative model demonstrates cost effectiveness and impact Government sustains its commitment to family planning and continues its commitment to integration of health and population departments.
	MCPR from end line is maintained 2 years beyond site closure	Survey 2 years after site closure (subject to funding availability) Existing national/Karachi surveys which show MCPR – 2 years after site closure LMIS/Bureau of statistics data on commodity consumption	
	Evidence of resource mobilization for continuation and/or scale-up of at least 2 Sukh Initiative best practices.		
	Evidence of enhanced enabling policy environment for delivery of quality FP services.		

Activities

- Door-to-Door service provision for FP to 1 million population
- Outbound and inbound services call center services for FP
- 56,000 unmarried girls and boys (16+) participate in Family Life Education
- Develop quality of care of 80 private local FP service providers serving intervention community, and of PP/PA FP in 120 maternity homes
- Develop quality of care of 20 public FP service providers serving intervention community and of PP/PA FP in 30 maternity homes
- Advocate Sukh Initiative program learnings to development partners & govt.

Project Management Unit (PMU)

The AHCS has structured the Project Management Unit (PMU) to ensure the success of the Sukh Initiative. The PMU fulfils its role by providing coordination mechanisms among all project stakeholders and by developing and managing program monitoring systems. It also works in liaison with advocacy partners to enable program sustainability.

The functions of the PMU are:

1. Operationalizing the program design through setting up administrative mechanisms for funding and selection of implementing partners through transparent selection processes and based on defined criteria. AHCS will be the primary recipient of the program funds and will ensure a transparent mechanism for release of funds to selected implementing partners.

2. Coordination between all stakeholders of the program including:
   Implementing partners
   GAP steering committee (For structure and functions of steering committee, see Annex I)
   Concerned government line departments
   Technical Advisory committee

   Coordination involves regular meetings to inform stakeholders of program successes and challenges, and establish and maintain mechanisms of program reporting. Coordination is also required to ensure the strategic participation of all program stakeholders in the advocacy strategy of the program. Fulfill all reporting requirements for donors.

3. Developing and managing program monitoring and PMIS systems that track and measure the progress of the program components towards outcomes. The PMU will facilitate monthly performance dialogues with implementing units in order to use emerging monitoring and PMIS data strategies to meet challenges, and where necessary, adjust program plans to ensure success towards program goals.

4. Establishing an independent and external evaluation of program impact through a rigorous program measurement plan including a baseline and an endline and a midterm assessment.

5. Ensuring financial transparency for the program. The prime will be responsible for ensuring regular financial reporting as per the requirements of the steering committee and also ensure financial transparency with implementing partners.

6. Working closely with advocacy partners, towards Sukh advocacy agenda that contributes towards program sustainability. The purpose of Sukh advocacy includes resource mobilization for continuation and/or scale-up of at least 2 Sukh best practices and for an enabling environment for delivery of quality FP services.

7. Establishing and implementing a communication strategy for Sukh with clear guidelines that articulate the program goals, key messages, brand structure, and mechanisms of sharing learnings effectively with all stakeholders.

Sukh Partners

AHCS plays the role of the 'prime' with regards to the contracting agreement with donor Foundations, and managing for the success of the program. However, specific strategies will be sub-contacted internally within AHCS and to external organizations with relevant capacity. Project Management Unit will sign sub-grants with internal partners (ATH and ACHP), whereas AHCS with external partners (Jhpiego, Aahung, DKT and AKU). Partners will implement different aspects of the program, and partnerships are as follows:

Measurement Partner – Department of Community Health Sciences, Aga Khan University The role of the measurement partner will be to provide an external and independent measurement of program impact through a cross sectional survey of a sample population within the 1 million intervention population in the form of a baseline and an endline. Program impact will be measured as per the objectives and program goals outlined and agreed upon in the Sukh program framework. The measurement partner will conduct a mid-term assessment of program progress towards identified goals and also an independent analysis of progress monitoring and PMIS data on an annual basis and participate in an annual review of program progress.

Door-to-Door Services – Aman Community Health Program will be implementing this strategy of Sukh in 1 million catchment area. The PMU will have an internal service agreement with Aman Community Health Program (ACHP) for the successful delivery of this strategy. The head of ACHP will provide leadership to this component directly.

Call Center Services – AMANTELEHEALTH will be implementing this strategy of Sukh. The PMU will have an internal service agreement with AMANTELEHEALTH for the successful delivery of this strategy. The head of AMANTELEHEALTH will provide leadership to this component directly.

Strengthening Public Sector Family Planning Services – Jhpiego: Jhpiego will be the implementing partner for this strategy. Jhpiego has previous experience in working with capacity building of public sector institutions for family planning services.

Strengthening Private Sector Family Planning Services: DKT Pakistan will be the implementing partner for this component. DKT Pakistan works in the private sector to provide modern contraceptive products at affordable price as well as in the area of social franchising. DKT's Dhanak clinics which currently number over 750 today serve the communities in the rural areas of Pakistan.

Family Life Education – Aahung: The implementing partner for this strategy is Aahung, who has previous experience in working with young girls and boys in communities on the sensitive issues related to maternal health, marriage rights and communication.

Advocacy – PMU: Sukh will partner with other stakeholders to contribute towards advocacy for family planning policy. A joint work plan will be developed with partners for the agreement of implementation of the advocacy strategy as outlined in the Sukh program framework. However the partnerships will not be based on any exchange of funds, and partners will implement activities through their own budgets.

Objective 1. *Increase in Demand for FP Services*

About 17% of married women of reproductive age wish to space or limit the number of children but they do not demand modern contraception. In addition, of women who are using family planning, 60% of users employ contraceptive methods that are considered 'least effective or reliable'. 22% of this group use traditional methods and 35% use condoms.

Sukh Initiative aims to increase demand for family planning services especially amongst women who have already expressed a desire to limit or space their children and aims to promote the demand for more effective and long term methods leading to the goal of a 15% increase in modern contraceptive prevalence rate (MCPR) from current rates of MCPR in the intervention communities. Sukh Initiative demand generation activities will prioritize women from lower income houses, women below 30 years of age, and women of 2 para or less to promote messages around healthy timing and spacing of pregnancy.

In Pakistan, nearly 63% of the population is under 25 years of age. Most girls and boys in this age group are yet to enter into marital relationships. The average age of marriage according to the Pakistan Social and Living Standards Measurement Survey 2008 for girls is 19.5 years and this is higher in urban populations. This age group lacks critical information about family health and rights, and life skills; and is particularly vulnerable in this regard as they are ill equipped to enter into healthy relationships where they are able to take decisions about their own reproductive health.
Sukh Initiative therefore aims to address the lack of knowledge and skills of young girls and boys regarding maternal and reproductive health, before they enter into marital relationships thus enabling them to make more informed decisions about their own health. While this is unlikely to translate into an immediate increase in demand for modern family planning methods, influencing the attitudes of this age group towards open communication and an understanding of the dangers of too many children, is likely to result in a longer term demand for family planning and birth spacing once they enter marital relationships.

Sukh initiative will generate demand for FP services through field-based activities at community level (door-to-door services and community mobilization) and institutional level (public and private secondary schools as well as *madaris* and vocational centers as AMANTECH) and through technology (AMANTELEHEALTH).

Distribution of Project Population

The targeted population will be rolled down in three phases. Project implementation will start from July 2014-YII, and a total of 400,000 population will be given coverage for services. Each station will be delivering services to a 40,000 population. Hence, each Female (Aman Community Health Worker) CHW will cover a population of 2,000 and male CHW will work for 8,000 population in their respective impact areas. (One male CHW will work as team member with four CHWs to cover male population. 2,000 population x 4CHWs population = 8,000 male CHW population). Each CHW will deliver services to its target population through a two-month cycle.

In Year III (July 2015), 700,000 population will be served through Sukh project. Each Field Station will deliver services to a population of 70,000. Hence, 1,500 population will be added to deliver services in addition to 2,000 population. Each CHW will have a mandate of giving services to a population of 3,500 and similarly male CHW will be responsible for 14,000 (One male CHW will work as team member with 04 CHWs to cover male population. 3,500 population x 4 CHWs = 14,000 population). Each CHW will deliver services to its target population through a two-month cycle.

In Year IV (July 2016), all the population of 1,000,000 (One million) will be covered. Each Field Station will deliver services to a population of 100,000. Hence, 1,500 population will be added to deliver services in addition to 3,500 population. Each CHW will have a mandate of giving services to 5,000 population and similarly male CHW will be responsible for 20,000 population (One male CHW will work as team member with 04 CHWs to cover male population. 5,000 population x 4 CHWs = 20,000 population). Each CHW will deliver services to its target population through a two-month cycle.

Demand Generation Through Community-based Activities

Field-based activities will target households and community at large through door-to-door services and community mobilization activities. The idea is to create awareness among MWRA, youth, elders, religious leaders, and community gatekeepers and engage them in promoting and adopting MNCH and SH&FP services.

Door-to-Door Services

Door to door services will allow for Family Planning services through individual and personalized attention to women and allow the program to cater to specific individual needs for information, motivation, distribution of condoms, pills and supplements, and referral to other solution levers. Women with specific family planning needs will be referred to quality service providers locally, pregnant women to maternity homes that offer postpartum and post abortion family planning.

Door-to-door services will be provided by Aman Community Health Workers (CHWs) and Lady Health Workers (LHWs) of the National Program. CHW will be a local member of the community where ACHP will implement the Sukh project. CHWs will be identified by Community Based Organizations (CBOs)/Community Advisory Committee (CAC), would be of 18 to 35 years of age, and with qualification at least up to 10th grade. In order to make project sustainable, Sukh will sign MoU with National Program and engage LHWs to create demand in LHWs areas for MNCH and RH&FP services.

CHWs will be supervised by Community Health Supervisors deployed at each Field Station. CHSs will be qualified a Community Health Nurse, Lady Health Supervisor or a Community Midwife. Each CHS will have a team of 10 females CHWs and 2/3 male CHWs. CHS will supervise and monitor CHWS at household visits and support group formation/meetings, and validate and verify the services record. CHS will also form females CBOs in the communities (five female CBOs in the catchment areas of each ACHP Station). CHS will develop monthly reports from the services record (till the application is developed and ready to feed data directly by CHWs/CHSs/Social mobilizers, Field Coordinators and managers). For job description of CHWs, CHSs, Social Mobilizers, and FCs, see annex II.

Training of Health Workers

Comprehensive trainer and trainee manuals will be developed in accordance with the objective of Sukh Initiative. The guide book for trainers will include lessons, training methodology, suggested training aids, discussion points, case studies, examination methodologies, Family life education, knowledge and skill assessment guidelines, and checklists. Information, Education and Communication (IEC) material will be developed reflecting the standard messages for FP/MNCH/PAC/RH for the CHWs. The curriculum will be shared with Population Welfare Department (PWD) and Health Department for formal endorsement.

Initially a cadre of trainers (Community Health Supervisors and Field Coordinators) will be trained on developed curriculum and they will, then, conduct step-down trainings to community health workers. The Trainings will be designed as of training sessions (classroom) and hands-on training. Training sessions will equip CHWs with knowledge and skills and hands-on part of training will improve their communication, counseling and service skills in the field. The trainings will enable CHWs to:

- Raise awareness about FP, PPFP & PAFP, PAC, MNCH, FLE & Mental Health
- Counsel on Family Planning/Postpartum Family Planning/PAC/ANC/PNC/facility-based delivery/FLE
- Door to Door Services though regular and follow up visits (ANC, PNC, dispel myths on FP, side effects management, contraceptive supplies).
- Refer to health facilities for FP, PAC and ANC, PNC, delivery)

Apart from this, Refresher Training of CHWs will be conducted annually on the basis of need assessment. Community Health Supervisors will monitor skills performance and knowledge delivery, and will keep identifying the gaps and area of improvement. On the basis of their monitoring observations CHSs will conduct refresher annually and weekly if needed. ACHP team will arrange exposure visits for CHWs on nearby government and health facilities to explore and enhance their knowledge regarding FP client treatment process and environment at different health facilities.

Household visits and follow-up visits

Each female CHW will visit 12 households per day and 3 households for follow-up on the assigned working days, whereas male CHWs will visit the households for in-person meetings with husbands on need basis.

An estimated number of 105,000 thousand MWRA (15% of 0.7 million) will be the focus of family planning services through household visits during the year. All MWRA will receive 05 visits generally and at least 05 Cycles (Visits) of services will be given to each MWRA (Household) in third year, counting to 432,000 Household Visits.

Services to be rendered by CHWs

Female CHWs will create awareness among and provide counseling to eligible women of reproductive age (MWRA) and decision makers in the household regarding Family Planning. Male CHWs will create awareness on Family Planning, PAC and MNCH among married men, decision makers (of Households), local influencers, and gate keepers through Support group meetings and corner/in person meetings (If needed) and through CAC and CBOs with Male population. Once the awareness is being created among the community and they are sensitized to adopt FP, they will be informed of choices for birth spacing available and refer nearest identified health facilities for services.

The role of CHWs will be to ensure that all MWRA have knowledge of Healthy Timing and Spacing of Pregnancy (HTSP) and are practicing modern methods of FP willingly. To ensure access to FP services, female CHWs will provide condoms and pills to the MWRA. When MWRA are convinced to adopt Long term Family Planning method, they will be referred to the identified Health Facilities through Referral Slips. Female CHW will visit Households and conduct Support Group Meeting regularly. She will schedule follow up visits per client per method requirement like she will be giving visits to Clients of RCs, CoCs and Injectable in every Cycle to ensure counseling and motivation to adopt Long Acting methods. Regular 2 or 3 follow up visits in initial cycle after insertion of Implant & IUCD, and one time visit after sterilization will be conducted. Male and female CHWs will guide the MWRA on adverse effects, in case of any complication occurring as a result of using a FP method or refer to the Community Health Supervisor or identified Referral Facility.

Family Planning Services

Male and female CHWs will create awareness among MWRA, married men, decision makers (of Households) local influencers and gate keepers on post abortion care and motivate them to avail post abortion care service. MWRA who gets motivated will be referred to facilities to avail services regarding FP, PAC, or MNCH.

CHWs will provide knowledge to MWRA and married men on HTSP messages especially on the message related to Spacing after abortion. CHW will counsel to MWRA and married men to use any FP method after Abortion and make referral to the facility for FP (If required).

Family Life Education

Male and female CHWs will deliver Family Life Education (FLE) messages to unmarried youth (girls of ages 15-18 years and boys of ages 16-22) and to newlywed couples. Each female CHW will form 08 Support Groups of unmarried female youth and newlywed women of reproductive ages, whereas each male CHW will form 08 Support Groups of unmarried male youth and newlywed men. Hence 2,000 (200 female CHWs + 50 male CHWs x 08 SG) Support Groups will be formed.

To provide awareness on FLE, CHWs will conduct support group meetings with the targeted group. CHWs will also encourage young people within the homes/institutes to participate in family life activities being held within the community by Aahung. In order to reach the target number of young people, each CHW will conduct two support group sessions per month in which they will ensure that a minimum of 3 young people aged 16 to 22 years also participate. Through this strategy, it is expected that at least 1,500 young people will be educated on FLE per month (250 CHWs x 2 session/month x 3 young people/session = 1500 young people per month). Assuming the CHWs will implement these sessions for a total of 36 months during the course of the project, we hope to reach 54,000 out-of-school youth on FLE through this strategy.

TeleHealth

CHWs will support and facilitate communities and will link them with Tele health services. CHWs will collect contact numbers to further share with Tele Health. Tele health will send text messages and phone calls for information and further needs of counseling. To orient the community, CHWs will assist MWRA and male household members to first call Tele health center which will be considered as “Consent” to receive calls and text messages from Tele health services. They will also promote Tele health helpline 9123.

Tele health will also install Tele health phonebooths in different areas to make the utilization of Tele health services for information and counseling easier. Community health workers will encourage and promote the use of Tele booth service.

MNCH (Maternal, Neonatal and Child Health) and Immunization

CHWs will provide antenatal care services to pregnant women and support for registration at a facility for delivery and facilitation for tetanus toxoid. CHWs will provide antenatal care for early recognition of any complication and timely referral. They will motivate and refer women for delivery to facility where quality post-partum/post-abortion family planning services are available. CHWs will also provide information on benefits to mother and child health through birth spacing post-partum family planning.

CHWs will provide postnatal care through postnatal checkup for early recognition of any complication and timely referral. She will provide her information specifically on exclusive breastfeeding, immunization of new born and post-partum family planning.

CHWs will conduct household visits to provide other health services to the community, like; measurement/assessment/treatment/referral for temperature, diarrhea, ARI, anemia, Scabies, STI, worms, Blood Pressure, height & weight, and injuries.

CHWs will maintain the status of immunization of all children under two years of age, and with help of male CHWs, will ensure complete immunization. They will also be monitoring the growth of children less than five years of age. CHWs will prove knowledge and counseling to parents of children, and severely malnourished children will be referred.

Referral Strategy

For specific Family Planning needs, female CHWs will refer clients to identified referral health facilities or as per client's choice. Each referral will be made by CHW through referral slip record. There will be a set of three referral slips for each referral. One slip will be given to client to further hand over to Health Care Provider for Facility record, second slip will be maintained by CHW for her record, and the third will be remaining at CHS for record maintenance. Data collected on referrals will be entered into the MIS on a regular basis in collaboration with ACHP and ATH. Referral slips will be used as a means of verification for service provision and referrals.

Referrals will be made for improved family planning services, reproductive health and MNCH.

CHWs will refer Potential FP clients for specific family planning needs, like, temporary modern method (Injectable), long acting method and permanent method. In case of any complication occurring as a result of using a FP method, referrals will be made identified referral health facility.

CHWs will refer women to avail post-abortion care, antenatal & postnatal care and for facility based delivery. Pregnant women will be advised to seek antenatal care at least four times during pregnancy, and two times after delivery.

CHWs will also refer clients of other services like temperature, diarrhea, ARI, anemia, scabies, STI, worms, blood pressure, height & weight, and injuries etc. to the health facilities.

CHW will refer all children of aged under two years for immunization and severe malnourished children to health clinics.

Community Health Workers will record the data on MIS registers (Hard form) and report it on structured reporting format to CHS on weekly basis.

Community Mobilization Activities

Male CHWs will mobilize the community on FP, PAC, MNCH and FLE through formation of support groups and then regular monthly meetings. CHWs will mobilize the community through group meetings, or corner meetings, or in-person meetings with married men, community influencers and gate keepers regarding FP by addressing myths, misconception, and Islamic concepts about FP. CHWs participates in meetings with Community Representative Groups (Previously titled as CBOs) and CACs regularly to raise the awareness of and mobilize the Community Representative Groups on project agenda, FP, PAC, FLE and MNCH and to get their support in mobilizing families as well. CBOs and CACs will consist of elders, religious leaders, and community gatekeepers; and they will be sensitized about FP, SRH through FLE model. CHWs will hold meetings with these stakeholders to address socio-cultural and religious barriers to accessing such services by MWRA and husbands. For details about social mobilization, CBOs and CACs, see Annex III.

Demand Generation at Institutional Level

Sukh will also work with public and private secondary schools as well as *madaris* and vocational centers to generate demand for FP and RH services among youth. Sukh Initiative aims to address lack of knowledge and skills among boys and girls regarding maternal and reproductive health, enabling them to make informed decisions about their health through Family Life Education (FLE). The goal of FLE is to empower young people to make positive and informed decisions about their reproductive lives and its objective is to increase access of young people to quality and age appropriate family life/life skills based education.

The FLE/LSBE curriculum will be developed as a two-stage one; the first stage targeting 12-15 year old boys and girls, while the second stage will target 16-24 year old boys and girls. The first stage will cover topics about puberty, body parts and their functions, concept of a healthy family, gender, decision making and, communication skills. The second stage will build upon the concepts introduced in the first stage and introduce information about early marriages, maternal health risks, marital rights, and domestic violence.

FLE/LSBE will be provided through **three strategies** as follows:

Institutionalization

FLE/LSBE to be integrated in institutions reaching out to adolescents and young people. The capacity of local learning institutions, such as secondary schools, *madaris*, colleges and vocational training institutions will be developed to integrate FLE/LSBE topics into their course work. The process will include sensitization and capacity development of administration, parent bodies and staff of the various partner institutions. The faculty and teachers will go through a comprehensive training of trainers and be provided with FLE/LSBE teachers guides and accompanying workbooks for girls and boys. Aahung team will ensure that the various FLE/LSBE lessons are implemented during the course of the year and on-site teaching support will be provided when required. Annual refresher trainings will also be provided to the staff of these institutions. Edutainment activities reaching a wider audience such as theater, art competitions, and debates on FLE/LSBE topics will be organized at least once a year in each institution. Through this process, Aahung expects to target both age brackets of young people, i.e. 12-15yr olds and 16-24yr old boys and girls.

Community Outreach

FLE/LSBE will be integrated into community outreach programs in order to reach out-of-school adolescents and young people. Aman community health workers and Lady Health Workers (LHWs) from the area will be trained through a master trainer model and provided with short visual FLE materials to be used in their community outreach programs. Aahung will provide technical input in the development of these materials and in the training of Master Trainers. Through the community outreach program, Aahung expects to target youth who are 16+yrs of age.

Mass Communication

FLE/LSBE messaging will be integrated into mass media initiatives in order to dispel socio-cultural norms that perpetuate unhealthy reproductive practices. Low-cost media strategies such as cable television, radio, and social media will be used to further disseminate key FLE/LSBE messages. Aahung will also develop short films/docu-dramas that can be shared with various television channels for airing with a wide audience.

Demand Generation through Technology (AMANTELEHEALTH)

AMANTELEHEALTH is a 24-hour round the clock, 26-desk Health Helpline service, with over 3 shifts with medical advisors, counselors, and doctors providing health advice and referral information over the phone. This empowers and encourages women, and youth, in particular to avail the widely used mobile phone services to seek timely medical counseling that otherwise would not be accessible to them. Through successful early stage interventions, AMANTELEHEALTH aims to curb complications arising from unattended medical conditions and overcome barriers to accessing health services, such as lack of transportation, and high cost etc.

The call center services are providing family planning and family life education information to callers, counseling through outbound calls, and sending SMS adherence reminders and other information through a dedicated helpline 9123 accessible from all mobile networks throughout the country. Sukh call center services will also potentially help sustain the community's access to information, counseling and referral services, even after the end of the program period. The call center is also integrally linked with the other solution levers of Sukh; including the door to door component for following up with the community women and men for ongoing information, counseling needs, providing young girls and boys with information needs and queries which will be accessed confidentially and anonymously, and SMS reminders and follow up calls with clients of maternity homes. Call Center Agents will be trained on standard protocols of MNCH, FP, PPFP, PAFP, PAC, FLE, VCAT and Gender Sensitization.

Sukh Telephone Booths will be installed, in consultation with implementing partners, at selected sites to increase access to MWRA, husbands, young girls & boys for TeleHealth services. ATH will coordinate with ACHP for reassurance on security of telephone booths. Promotion of booth services will be made through marketing activities

likes distribution of brochures and awareness sessions. Booths will also be installed in selected schools; teachers, students, and parents will be encouraged to use these services to get required information. For Strategic Objectives of AMANTELEHEALTH, see Annex IV.

Objective 2. *Improved access & quality of FP services*

Much evidence shows that quality of care on the supply side is more likely to be an issue that impacts demand. Falah baseline data from Gadap shows that 75% of MWRA view doctors and lady health workers as trusted sources of advice for the adoption of family planning methods. Yet issues of low quality of care, including inadequate knowledge of care-givers, inadequate method mix, and lack of counseling result in inadequate motivation.
Sukh initiative will work with public and private health facilities to improve access to family planning services with improved quality of service. Jhpiego will work with Public Health facilities, and DKT with private ones. Within the purview of the Sukh initiative, Jhpiego and DKT will complement the work of other Sukh consortium partners and provide not only improved access to Family Planning services, improved quality of service (than currently available), as well as an increase supply and access to a broader range of modern contraceptives (PAFP and PPFP materials). Apart from that, youth friendly services will also be provided to young people to access quality and youth-friendly reproductive health services, such facilities will be upgraded and trainings will be provided to health care providers.

Public Health Facilities

Jhpiego's work will complement the work of other Sukh Initiative consortium partners focused on monitoring and evaluation (M&E), advocacy and community-level activities, among other components. Through participation in Sukh over the course of approximately four years (November 2014 – August 31, 2018), Jhpiego will seek to increase access to a wider method mix of FP and PAC services for women and families in Karachi by supporting the attainment of the following project outcomes in the selected project areas of Karachi:

> **Outcome 1**: There will be enhanced enabling environment (policy, sectorial, and community levels) for delivery of quality Family Planning/Reproductive Health (FP/RH) services
>
> **Outcome 2**: There will be increased supply and access to a broad range of FP, Postpartum Family planning (PPFP), and Post Abortion Family Planning (PAFP) services at public sector health facilities
>
> **Outcome 3**: There will be improved quality of FP services, including PPFP and PAFP, in public sector health facilities

Jhpiego's objective in the Sukh Initiative will be to intervene in 80 health facilities (40 from Population Welfare Department [PWD] and 40 from Department of Health [DoH] Karachi Metropolitan Corporation [KMC], and Sindh Employee Social Security Administration [SESSI]), 3 Clinical training sites (tertiary care hospitals), and one Regional Training Institute (two from Zone 1 and one from Zone 2). In future, other facilities might be selected from Zone 2 in case targeted MCH centers are not found functional in Zone 1.

> **Zone 1**: Sukh Catchment Areas, selected Union councils in Landhi, Korangi, Bin Qasim and Malir Towns.
>
> **Zone 2**: Areas outside Sukh Catchment Areas within a 12–18 kilometers radius, facilities receiving high referrals from SCA, the nearest tertiary care facility JPMC will be selected as one of the training site.

The overall principles guiding the implementation of Sukh are as follows:

- Jhpiego will work in close collaboration with the Department of Health [DoH], Population Welfare Department [PWD], and the District Government. Instead of developing a parallel system, Jhpiego will invest on strengthening the existing DoH and the PWD system. See Annex V
- Interaction and engagement of the stakeholders will be maintained through the Sukh Technical Advisory Group (TAG). Regular consultative meetings will be done with TAG and guided by jointly developed PPFP strategy and implementation plans for Karachi.

- All activities when possible will be completed in collaboration with the implementing partners; ACHP for community mobilization, ATH for client follow up, Aahung for youth services, and AKU for research and monitoring.

As a consortium partner, Jhpeigo will select and upgrade Sukh facilities in three phases: 40 in each phase (phase 1: July-Sep 2015, Phase II: Oct-Dec 2015, Phase III: Jan- Mar 2016). Jhpiego will collaborate with Aahung for trainings of Youth Friendly Services and conduct technical workshops for 80 Health Care Providers (HCPs) from public sector (40 maternity homes and 40 FP clinics). Jhpiego will conduct Trainings of Trainers (ToT) for DKT Master Trainers and will also actively participate in promotion of ATH helpline 9123.

Curriculum for Trainings

- Jhpiego will use the global Postpartum Family Planning (PPFP) Learning Resource Package (LRP) that has already been endorsed by the Department of Health (DoH) Sindh under Jhpiego's maternal health project (MCHIP). The LRP covers the technical areas of FP, PPFP, ANC, PAFP and PNC.
- Jhpiego will develop PPFP content to be integrated into the TeleHealth curriculum and an algorithm on FP for Tele-health agents.
- Jhpiego will hold a desk review to select IEC materials or any other training materials needed from materials that are already developed by other programs and projects.
- Jhpiego will also endorse the training materials by other stakeholders such as Department of Health (DoH), Population Welfare Department (PWD), KMC, SESSI, Lady Health Worker Program (LHW), and Maternal Newborn and Child Health Program (MNCH).
- Jhpiego will develop a curriculum review committee, and with help from PMU will arrange curriculum review meetings with individual stake holder and get signed letters for all of its training materials. A notification or a personal letter and permission to use their logo on the curriculum by the stakeholders will be considered as endorsement of the training materials.
- All training materials including manuals, job aids, and IEC materials, will be branded as per Sukh branding guidelines prior to printing.
- Trainings will only be initiated after the material is endorsed.

Trainings

Jhpiego's competency based training methodology will combine knowledge/classroom-based learning, followed by practice on humanistic simulators before becoming eligible for practicing on a real client under close supervision.

Jhpiego will conduct two types of training, outlined as follows.

Crash training course: Jhpiego will select approximately 10 providers from 80 facilities (40 maternity homes and 40 FP clinics) and impart a two-day refresher course on pills, injections, interval IUCDs, and counseling to cater the initial need of ATH and ACHP.

Routine training: Jhpiego will hold the routine trainings shown in the table below. These trainings aim at improving behavior and attitude of staff at lower level cadres to deliver adequate services, enhancing capacity of health care providers, and improving skills of mid-level and senior management for supervision. (For details on trainings see annex VI).

No.	Trainings	No. of Trainings	No. of Participants
1	Trainings for SUKH Staff on VCAT	9	135
2	TOT for Tele Health Operators on algorithm (FP)	3	20
3	Conduct clinical training skills course for the providers	1	5
4	Conduct effective teaching skills course for the Regional Training Institute	1	10
5	Infection Prevention Workshop for support staff of the training sites	7	70
6	Training of Trainers on Comprehensive FP Package	3	30
7	Conduct crash training course on pills, injections, interval IUCDs, and counseling, only for PWD – Health facilities	1	40
8	Training of Service providers from FP clinics and maternity homes on Comprehensive FP Package	15	180
9	Training of support staff on VCAT and counseling	20	240
10	Training of small facility providers on medical management of abortion and FP counseling	4	40
11	Conduct Refresher trainings after TNA at 6 months follow-up of certified Health care providers	6	60
12	Conduct Refresher trainings of support staff after Training needs assessments at 6 month's follow-up	6	60
13	Conduct supportive supervision training for Mid-Level Management of DOH and PWD	2	20
14	Conduct supportive supervision training for Senior Management Team of DOH and PWD	1	10

Facility Strengthening

Jhpiego has divided the supply into four categories: Human Resources, Equipment, FP commodities, and IP Supplies. Jhpiego will depend on stakeholders to ensure that these four categories are available to the selected facilities. Jhpiego and Sukh Program Management Unit (PMU) will develop and sign Memorandum of understandings (MoUs) with DoH, PWD, KMC, and SESSI. The key stakeholders in their MoUs will clearly outline the role of the parties in ensuring implementation of minimum acceptable service delivery standards.

1) Human Resources: Existing human resources at the intervention sites will be utilized for capacity building and quality service provision. Jhpiego will also assign counselors and trainers in selected facilities in order to implement Jhpiego's performance standards, supportive supervision and monitoring of acquired skills, and services.

2) Equipment: Jhpiego will be assessing the availability and quality of the instruments for routine FP service provision and in health facilities and camps. The information will be gathered through baseline assessment of the facilities. Gaps identified will be discussed with the concerned departments for provision of instruments within their own resources. In-case the instrument are not provided from the concern departments, Jhpiego may also provide the starter kits depending upon the budget for facility upgradation at the selected high caseload facilities.

3 and 4) FP commodities and IP Supplies: Jhpiego will advocate for streamlining contraceptive supplies to facilities and will develop mechanism to ensure supply of commodities to different health departments through consultative meetings between DoH, PWD, SESSI, and KMC. Monthly review will be done for FP & IP commodities during supportive supervisory and monitoring visits. (See Annex VII for Intervention details)

Follow-up systems

There will be a strong follow-up system of training and service provision by internal and external monitoring partners to ensure timely detection of complications, their management and referrals, client satisfaction and quality of service, validation of availed services by SBMR, telephonic follow up by ATH, ACHP visits to follow up clients, midline and end line evaluation by AKU (for details on SBRM see Annex VII A&B: A = Supportive Supervision, B = SBMR field Guide). A joint monitoring plan with the respective health departments will be prepared in order to ensure sustainability of implemented follow up system.

Succession Plan

Jhpiego intends to have all Sukh activities adopted by the government by the end of 2017. Jhpiego will implement a succession plan where the focus will be on the capacity building of the government counterparts on conducting supportive supervision visits, developing action plans, data collection, analysis, and interpretation. Transition Committee comprising trainers, senior faculty members, consultants, Head of Nursing from Health and Population Department will be formed to ensure compliance with the quality standards implemented. This Committee will ensure continuation of the intervention through regular meetings, sustaining services in terms of supplies, setting targets, collecting data and conducting trainings for new recruits. It will also ensure sustenance of newly added services of PPFP/PPIUCD in practices. Jhpiego will continue to provide technical support as and when requested. This will help ensure sustainability of the intervention and enable the Government Departments to guide for training and setting targets.

Client follow-ups

The clinical follow up of clients will be done after service provision as a routine at their respective Sukh facility. The ACH agent will observe the client for any signs of danger and refer her immediately to a designated hospital in case of emergency. The clients from Sukh Catchment Areas availing services from JPMC during intervention will be followed up by ACHP household visits.

Telephonic follow-ups

Those clients who are unable to visit the clinics will be followed up through calls by AMANTELEHEALTH Agents. The calls will be of two types:

- Routine Follow-up as provided schedule for individual FP services
- Adverse event/complications, complaints/concerns

The Aman Tele Health Agents: Tele Health booths will be installed at high case load facilities, where clients can easily make calls. All the clients will be registered with ATH and follow up calls will be done according to provided schedule by Jhpiego.

Management Information System

Jhpiego will incorporate project indicators related to service delivery, referrals, and counseling in their MIS tools. Data will be collected on a regular basis from concerned departments and will be included into Sukh MIS. Then it will be analyzed and presented in monthly staff meetings and annual reports.

Monitoring and Evaluation System

Jhpiego will use the Standards Based Management and Recognition (SBM-R) tool and for quality improvement and monitoring at all facilities. Each facility will conduct assessments on evidence-based standards, and action plans will be developed based on gaps identified. A Quality Improvement Team (QIT) will be setup at each facility, comprising of the head of administrative staff, selected health providers, and Jhpiego representative to implement the action plans. The task of QIT will be shifted to the concerned staff as a part of succession plan.

Clinical Audit. The clinical competency of each HCP will be assessed on Jhpiego quality standard checklist as a baseline for quality of care followed by: i) Orientation of selected facilities on Jhpiego's SBMR Protocols Orientation Workshop and; ii) Quality Improvement Process for stakeholders and sharing of FP Standards.

Facility Audit. This audit of 40 FP Clinics and 40 Maternity Homes will be similar to the training site assessment and will look at equipment, infrastructure and supplies of family planning services. The observations of facility audit will be analyzed and the gaps identified at these 80 facilities will be shared with the respective departments. A joint action plan will be developed for facility up-gradation in terms of necessary equipment, supplies and, modifying infrastructure.

Jhpiego's quality assurance component comprises of i) training; ii) site strengthening; iii) supportive supervision; and iv) Adverse event management. Training and Supportive supervision are described in the sections above. Monitoring of the trainings and site strengthening will be based on SBM-R standards. For site strengthening QIT will be established at each facilities and QIT will be responsible for implementation and monitoring of facility action plan. As a part of quality assurance component, Jhpiego will also implement an adverse event management monitoring and reporting system.

Clients receiving services from Sukh facilities will be closely followed at FP/maternity care centers for post service counseling, management of side effects and support in case of any complications. This will be done in collaboration with PWD, ACHP and LHW program and by ATH.

Private Health Facilities

DKT will work to improve availability and access to better modern contraception methods, increase number of family planning providers in four towns identified as well as ensure the consistent and continuous supply of quality product. Although women of reproductive age will be primary beneficiaries, DKT will work to bring about behavioral change as well as expand its reach to young adults.

DKT Pakistan will use following strategic approach while implementing project interventions to achieve proposed project outcomes thereby contributing in overall project impacts.

- Review mapping and select 80 facilities to be strengthened (For selection of clinics, see Annex X)
- Capacity building of selected service providers in family planning
- Innovative franchising (Dhanak Health Care Centers) and segmentation of facilities
- Improving referral system
- Continuous quality assurance and supportive supervision
- Deployment of effective monitoring, evaluation and reporting system
- Increasing availability of family planning commodities and PAC products
- Planning and executing targeted behavior change communication campaigns
- Incorporating lessons/experience in project implementation
- Coordination with other partners and local stakeholders

Pre-assessment.

DKT will work closely both with the Aga Khan University and Aman Community Health teams to assess the existing service providers and begin a process of dialogue of inclusion into the Sukh Initiative. MNCH will be approached for lists of Community Midwives (CMWs) deployed to recruit community mid wives in locations selected. General practitioners and private hospitals are being approached and identified as potential partners willing to expand their services into the area of family planning. Pre-assessment exercises by Social Program teams will assess both the facility, potential of the area, ease of access, and availability or lack of facilities for the community.
For purposes of service data collection for RBF, pre-assessment will include interviews, perceptions, sales/stock data or any evidence (documentary or verbal) to form a pre-intervention baseline.

Capacity building.

DKT has signed an MOU with various partners for ensuring the success of the Sukh initiative and to expand its outreach. Currently DKT has an MOU with MNCH and will call upon MNCH to supply lists of trained CMW's in the four towns identified in the baseline survey. DKT's MOU with Jhpiego ensures that two master trainers will be trained for further step down training to its providers. Jhpiego will also provide support and assistance in accessing its training centers to enable clinical training. Service providers will then receive training in Family health and clinical training on IUD's. Good service delivery is a vital component in ensuring greater up take as well as lower discontinuation.

Training

1. Two-day training by DKT to providers covering infection control, family planning, and overview of products.
2. Clinical training: 2 day training on clinical insertion, on-site or off-site by Jhpiego
3. MIS training: 1 day training by DKT
4. Advocacy training: 1 day by Aahung on Family health and counseling young people
5. MVA and PAC training: 1 day provided by DKT
6. Refresher training: Family planning – 12 months after service provider deployment

Training will begin in September 2015 for the first cycle of providers. Jhpeigo will provide training as per the approved material.

Marketing

DKT marketing teams will assess the needs and culture of each area of operations as well as the needs of a project. Activities are planned around local celebrations, events and in close coordination with community influencers. Activities such as the Mobile Video Unit (MVU) showing docudramas, Heer tea parties, and health camps will be organized to mobilize the community and also to increase foot fall and awareness of the Service providers. Activities will focus on a diverse audience, which includes males, MWRA's as well as the youth.

Heer Tea Parties are smaller group gatherings, which hold sessions separately with both male and female and target communities within the immediate surrounds of the clinic. Attendance varies between 50-55 participants, both men and women. The MVU targets larger groups and a population within 3-5 kilometer radius of the clinic or service provider. Three shows by invitation and two shows for the general public are conducted at the site. Estimated attendance will be around 150 people.

Additionally, DKT will be initiating other activities such as parent and teacher meetings which serve yet another platform to talk to young parents and to advocate family spacing, reproductive health and to make them aware of the options available in modern contraception and service delivery providers.

It is also anticipated that Aahung will join in some of the DKT activities to promote youth advocacy wherever possible. AMANTELEHEALTH, another implementing partner will also promote Sukh and Dhanak centers as well as mobilization activities by means of SMS messaging.

Social Mobilization

ACHP workers as well as the field workers of all IP's, medical practitioners, pharmacies, retail outlets will be approached to provide referral to the nearest DHCC facilities available. List of existing Dhanak clinics in the target areas or in the peripheries will be shared with ACHP so that they can refer to nearest Dhanak facilities allowing the targeted population great access and choice. By directing traffic to an implementing partner (where convenient for the MWRA's), ACHP will be able to collect data and study results of referral system.

ACHP and DKT field teams will visit jointly field offices and existing Dhanak clinics as well as SUKH program clinics together to build confidence and strengthen the referral system.

DKT will also provide to the SUKH project a directory of all the Dhanak Health centers which will be updated periodically so that a ready reference is available. 1,000 directories will be printed and published twice per annum over the life of the program. These will be distributed to the households in the intervention area.

Segmentation.

The Sukh initiative will add to the capacity of existing providers in the area as well as add to the overall capacity. It will do so by accrediting existing hospitals or doctors clinics as Silver Line Clinics which will provide premier FP and MVA facilities where they either did not exist before or were sporadic. Second tier will be of GP's or group clinics with certified medical practitioners or private practices where there may be a medical provider but there are no facilities to add FP services. In such cases, additional facilities will be created so that the remit of family planning can be added to the services provided. The GP may either provide services himself or attach a CMW/LHV to assist in dealing with female patients. A system of cross referral will be implemented generating greater outreach. The third segment will be clinics built for community midwives or LHV's in the area who may not be able to practice due to the lack of a birthing center. The DHCC clinics will help bridge the gap between services needed and available and become a center for FP services in the area.

Supply

DKT sales team will assign two MIO's over the four towns who are over seen by an Area Sales Manager. Each MIO will ensure constant stock level checks and supply to each provider. These will be monitored by the PM and the M&E coordinator both through reporting and a closed circuit monitoring systems (through smartphones). Each MIO will be tasked to visit the provider once a week. Each provider will also be visited by a Health services personnel like a CMW/Health supervisor or Doctor who will collect feedback and run periodic stock checks.

Monitoring

Monitoring will be carried out by the project team using the Dhanak Health Care Service management information system, project reporting tools and methods in conformity with internal policies as well as commitments made in MoU with Aman Health Care Services. The area will be strengthened by periodic and scheduled field visits by the

team (Head of Monitoring and evaluation, Head of Health Program, Head of Quality Assurance, Head of Social Program, and National Sales Manager) from DKT Pakistan country office.

Quality Assurance

With the concept of continuous quality improvement, DKT Pakistan will introduce Quality Improvement and Client Safety tool (Customized from QIPS tool used by Jhpiego) through health supervisor on monthly basis after formal training. Facility inventory, family planning services, infection control measures, and referrals will be key intervention areas to be assessed. Based on observations, possible corrective measures will be advised to service provider. However, supervisor and regional health manager/project manager will also take possible corrective measures in coordination with respective DKT department or coordinator. Summary report by health supervisor will highlights the quality scoring of facility and brief action plans. Progress and compliance will be monitored by Head of Health Programs and Head of Quality Assurance. Head of Monitoring and Evaluation and/or M&E/QA coordinator will do spot check periodically.

The quality of data reported from the field will be ensured through random verification of records at field level through M&E/QA coordinator and office level through Quality Assurance Executive.

Quality evaluation of training will be one of the measurable criteria submitted to AKU for evaluation. Although Jhpiego will provide training as per the approved format and manual, midterm assessment will evaluate the efficacy of the training provided and its contribution towards improving the CPR rates of the project.

MIS Tools and Data Management

Health Management Information System (HMIS) includes client records (Family Planning Cards and Switcher Credential Cards), recording register, Client Card keeping box (for easy follow-ups and record retrieval – Learning of SWAT project), manual and/or automated/real time monthly service utilization reports – refers to monthly reporting of services delivered by type of services and quantity delivered, follow ups and referrals.

For initial assessment, the Social Program will do pre-assessments for location and facility, whereas the health supervisor will assess competencies. Standardized post assessment and facility/quality audit tool will be used to ensure/assess standardized branding after construction immediately and after six months respectively.

DKT Operations will be responsible for complying DKT standards for procurement and civil work required for Dhanak branding. All related forms and tools will be used to record the process. For outreach/below the line activities, standardized outreach data collecting tool will be used for data collection in the field. All collected data will be entered in the respective software or MS program (Designed for respective department/program) from manual records (except client data – which will be maintained at facility level). Health, Social program and outreach MIS related data will be cross verified by Data base officer and QA executive during data entry and data summarizing. To address the issues of demotivation and data recording at facility level, understanding with providers and investment on clinics in terms of civil work and equipment will facilitate DKT in bringing motivation. In addition to that incentive mechanism will be established to ensure better recording of data at field level. In the event of a discontinuation or noncompliance, corrective action will include counseling, involvement of community influencers. (With the help of ACHP) And in case there is no resolution, DKT will whitewash the clinic and remove all branding as well as seek return of all equipment.

Youth Friendly Services

The objective of this initiative will be to improve access of **young people to quality and youth-friendly reproductive health services.** It aims to cater to the demand for services that will result from raising awareness about RH amongst young people. Through this objective we aim to provide young people with safe and non-judgmental services by **creating youth friendly spaces** and **sensitizing health care providers** and strengthening their capacity to address issues related to young people's sexual and reproductive health and providing referrals where required.

Youth Friendly Spaces

Aahung will also work on creating three youth friendly spaces over the course of the project cycle in existing vocational centers, community centers, and schools who are willing to provide some space. If an institution is agreeable and has the required space, Aahung will support them in refurbishing the space to make it more youth friendly. The space will be equipped with a private AMANTELEHEALTH booth so that young people can make calls to the TeleHealth number without any hesitation. The space will have IEC materials related to youth issues, a

computer and internet facilities. The staff manning these spaces will be thoroughly trained on youth related issues and already trained educators from other institutions or schools will be encouraged to voluntarily organize and run FLE sessions in these spaces. Budding counselors and therapists from reputable mental health institutions may also be contacted to provide subsidized counseling services to young people in these spaces.

Training of Health Care Providers

Aahung will support JHPIEGO and DKT by developing a comprehensive module on provision of Youth Friendly Services (YFS) with regards to SRHR and planning a healthy family. Through this module, medical personnel will be introduced to the concept of FLE and related issues that are facing young people. They will also be trained on how to effectively counsel young people on issues related to SRHR and provide them with accurate information. For this purpose, health care providers, nurses and CMWs from the target districts will be trained on the provision of YFS and will be given refresher trainings in subsequent years.

Aahung will also collaborate with DKT in order to attend their outreach sessions in the project sites, and promote FLE messaging. Similarly, Aahung will invite DKT to participate in forums working with teachers and parents so that they are able to raise awareness on their work.

Objective 3. *Long-term sustainability of program*

By planning for sustainability, the Sukh Initiative aims to foster the independence of the program in the long run, and aims to sustain the impact of the program beyond the 5-year period. The third objective of the program directly plans for sustaining the first two objectives, thus ensuring that resources, and activities work directly towards this aim.

The Sustainability of Sukh can be seen on several levels.

> Firstly the program would be sustained through changed social norms within the intervention community with regards to family planning, including reduced attitudinal barriers, greater acceptance of side effects and increased community demand for services.
>
> Secondly institutionalization of key solution levers, especially provision of quality family planning services within the community as well as with maternity homes would provide ongoing services to the intervention community beyond the program period. An increase in demand for services would also add a commercial incentive to private providers to continue to provide quality services.

Thirdly an increasingly supportive environment from the government and other stakeholders for family planning and ownership of program learnings could result in the up scaling of Sukh Initiative successes, and sustaining them beyond the program period.

The program aims to respond to several aspects of sustainability, as follows.

Demand

Sustained demand for family planning beyond the program period within the 1 million intervention population in Karachi: The program aims at increasing MCPR by 15% in the intervention community. Most of this increased demand will continue beyond the program period as a portion of women in the intervention population once they have been facilitated to overcome both demand and supply barriers and they develop a comfort with accessing methods which they are familiar with, are more likely to continue to control their own fertility and plan their families. There is no doubt that some of this depends on the continued availability of quality services, which the program also aims to address.

Education

Girls and boys receiving family life education will also be better equipped through change in knowledge and attitude to make better decisions around marriage and family, which includes their birth spacing behavior. It is strategic to build the knowledge and skills of young people on the assumption that their reproductive life lays ahead of them. Thus this intervention is looking to develop a future demand for family planning.

Capacity

Continued institutional capacity to deliver family planning services beyond program period: "*Make services high quality and low cost, and clients will come forward.*" (Ashford L. S., Haws J. M., Family Planning Program Sustainability: Threat or Opportunity, Studies in Family Planning, Vol. 23, No.1, Jan 1992). Through Sukh Initiative several service delivery mechanisms' capacity will be improved to deliver higher quality services to the intervention population. This includes the services of at least 100 community based FP service providers, as well as PP/PA FP services at maternity homes that will be upgraded for improved quality. With increased demand and increased capacity, service providers will be more inclined to sustain a higher standard of service beyond the program period.

Resource mobilization

Resource mobilization for continuation and/or scale-up of at least 2 Sukh best practices: The Sukh Initiative will engage closely with government and other development partners to share emerging learnings and success at every stage of the program. In particular strong engagement with the health and population departments as well as with the LHW program will be critical for possible potential of scale up through the public sector. Sukh will also work with ExpandNet to explore possibilities for scale up. Engagement with donors with a portfolio for reproductive health will also be relevant for future program adoption of Sukh best practices. Engagement with key stakeholders will be through the formation of an advisory committee that meets every 6 months. It is hoped that involvement at an advisory level will increase ownership of the program and increase the likelihood of continuation or scale up of Sukh activities.

Enhanced enabling environment

Enhanced enabling environment (policy, sectoral, and community levels) for delivery of quality FP services: Sukh program advocacy to share learnings and promote best practices will be conducted with key stakeholders at policy, sectoral, and community levels. At the policy and sectoral level Sukh will work in partnership with other stakeholders to ensure a continued dialogue on effective family planning policies and the allocation of resources towards family planning programs and services. Strong social mobilization at the community level will ensure that the community develops an understanding of family planning as a life-saving intervention and also one that promotes an optimal family size based on the individual desires of couples. In this way an enhanced enabling environment for family planning services will pave the way for future programs delivering family planning in Pakistan in general and Karachi in particular. Interaction and engagement of the stakeholders will be maintained through the Sukh Technical Advisory Group (TAG). Regular consultative meetings will be done with TAG and guided by the jointly developed Postpartum Family Planning (PPFP) strategy and implementation plans for Karachi. FLE Module will be adopted by the Department of Education, Sindh, and this will ensure imparting of education based on FLE to students in public schools.

Evaluation

The task of monitoring and evaluation will be performed by the measurement partner i.e. AKU. The measurement partner will help Program Management Unit (PMU) to manage project through performance management. The measurement partner therefore will 1) inform the program, 2) monitor and evaluate 3) assess progress and performance, 4) develop the capacity of PMU and 5) support research.

Inform program

As measurement partner, AKU is responsible for providing an external and independent measurement of program impact through data collection at baseline, midline, and endline of a sample population within the 1 million intervention population.

The **baseline** information by the measurement partner will inform the program on indicators through qualitative information (by conducting focus FGDs and in-depth interviews) and through the household survey. Mapping of facilities and institutions of private sector will be done and shared with Sukh partners.

Monitor and Evaluate

At Midline and Endline, household surveys will be repeated to assess impact, progress, and performance at midline, and finally impact at endline to assess the achievement of its final goal of increasing CPR at 15% points and increase

in use of modern methods of contraception. Impact of Program will be measured as per the objectives and program goals outlined and agreed upon in the project's program framework.

Assess progress and performance

For this purpose, Key Performance Indicators (KPIs) will be prepared according to activities of implementing partners within the program's framework. An indicator tracking table will be developed and shared with all the partners and consensus gained. All the partners will share their progress through these indicators every four months in a joint meeting. These indicators will be captured through MIS of the implementation partners. The measurement partner will conduct meetings, will visit the sites for spot checks (observations of field visits, group meetings, workers registers, data tracking and back checks and to observe data management and quality. Checklists will be developed in consultation with all the partners on which monitoring visits will be based.

Development of PMU and partners' capacity for data management, monitoring progress etc.

The additional responsibility for the measurement partner will be to help Program Management Unit (PMU) to manage the project through performance management. They will also assist in the preparation of the project's MIS database, carry out independent analysis of progress monitoring and PMIS data on an annual basis and participate in an annual review of program progress.

Support research for Sukh

- Presentation of Sukh data at national and international forums. Publications in peer reviewed journals.
- Conducting in-depth research related to FP and MNCH at Sukh sites

Annex I. The Steering Committee

Structure

The Sukh Initiative is unique in its mechanism of 3 private foundations coming together to implement commitments emerging out of FP2020. The Steering Committee of the program will consist of representation from all three Foundations to provide advice to the Program Management Unit in the implementation of the grants totaling $15 million. At least one representative from each donor must participate in each virtual or in-person meeting of the Steering Committee. A representative of the AHCS and Head of Sukh will attend with voice but no vote.

Frequency and organization of meetings

There shall be at least one meeting of the Steering Committee annually. The Head of Sukh Initiative will request in writing for meetings with at least 30 days' notice and will attach the agenda of the meeting and documents to be considered. Donors may also call for meetings through the Head of Sukh. The calls to the meetings will be sent by the Head of Sukh in writing (email is acceptable) to each of the donors. If Head of Sukh does not call for a Steering Committee meeting within a term of ten business days following the request of any of the Donors, the Donors can make the call directly by sending it in writing to the rest of the Donors and to the AHCS with at least 30 days' notice and will attach the agenda of the meeting and documents to be considered. No later than five days prior to the meeting, the donors will send any comments and questions on matters to be discussed.

Head of Sukh will be responsible for drafting the minutes of the meetings and will distribute them to the donors for comments no later than ten working days after the meeting. The donors will send back their comments and suggestions no later than 15 working days after receiving the minutes. If no comments are received from a given donor, the minutes will be considered approved. The Head of Sukh will incorporate the comments and suggestions and send the minutes back to the donors for final approval. Minutes will describe actions required for follow up with associated deadlines.

The Steering Committee may determine additional aspects of its internal organization and decision-making, consistent with these Operating Guidelines.

Functions and responsibilities

Functions and responsibilities of the Steering Committee include:

1) Establish Sukh's strategies and priorities in the context of country and provincial family planning policies and plans.
2) Establish a unified annual reporting mechanism (See operational cycle below) for the PMU.
3) Provide input on technical members of the Advisory Group.
4) Consider input from the Advisory Group in its decisions.
5) Provide advice and guidance on the selection of implementing partners as recommended by the PMU for various strategies of Sukh, based on short listing on selection criteria.
6) Approve results framework and tracker and any subsequent changes to the framework and measurement of program goals and objectives.
7) Support advocacy for program sustainability and success.
8) Participate in planned, joint site visits to be financed by the donors.
9) Review and approve annual reports, work plans and associated budgets as proposed by the PMU. Each donor will have to individually approve changes to their budget in accordance with the individual grant agreements.
10) Review audited financial statements relating to the Sukh.
11) Approve amendments to the Operating Guidelines with the agreement of AHCS.
12) Approve the addition of new donors and members to the Steering Committee with the no-objection of AHCS.
13) Review and, where appropriate, make and approve recommendations to terminate non-performing operations.
14) Request from AHCS and/or the Head of Sukh and review any additional information that the Steering Committee deems necessary to comply with its obligations.

15) Approve and amend communications strategy for the Sukh, with the no-objection of the AHCS.
16) Review specific media materials related to the Sukh prior to its release, with the no-objection of the AHCS.

Voting mechanism

Decisions of the Steering Committee shall be taken by unanimous consent. Each Donor will be entitled to one vote.

New members

The admission of new members must be approved by unanimous vote from the Steering Committee with the no objection of AHCS. The Steering Committee may determine the minimum amounts to be contributed by future donors or additional conditions for the admission of such future donors. Any future donor will contribute a fair share of the Sukh's administrative/fixed costs. Any new member of the Steering Committee must sign a grant agreement with a Sukh partner to confirm funding and agree with these operating guidelines.

Annex II. Job Descriptions

Position: Community Health Worker **Grade:** Assistant	**Functional Reporting:** Community Health Supervisor **Administrative Reporting**: Community Health Supervisor
Department: Aman Community Health Program **Location**: Field	

Job Specification	
Qualification: Matric (HSC)	Experience: 1 Year Community Experience
Training/Courses: Community Health related course/Communication skills	Age: 18-35 years (Flexible) Gender: No preference

Job Description

Organization Chart (Immediate line & functional relationship)

General Purpose
The role of the community health worker initiates with building trust with individuals in household within a specified community, and the community as a whole. The community health worker is the most integral part of the program. Their core role is to provide treatment and referral services, along with health education targeted at the specified disease prevalent within the community. The community health worker also works with the community to form support groups of pregnant women, FP clients and young mothers, which focus on mother and child health education.

Job Responsibilities and Authorities
Mapping of households through unique ID numbers
Registration of each household on PPRF (Population Profile Registration Form) on tablets
Registration of all family members including MWRA's and children (1-5 years)
Referral of any serious diseased person to Health Care facilities
Household visit as per plan
To provide health education on MCH & Birth Spacing/FP to women/couples for demand creation and improved health seeking behavior
Formation and weekly sessions of women support groups (FP Clients & Pregnant Women)
Follow up of existing Family Planning clients
Provision of FP methods (pills and condoms)
Referral of FP clients for long term methods to health facilities
Collection of field data on regular basis
Development of Referral Networks
Awareness raising on importance of ANC/PNC/Safe Delivery/PAC/Breast feeding and vaccination
Awareness raising of unmarried youth on family life education
Provision of Iron, Folic Acid as per requirement to pregnant women/PLWs
Motivation and Facilitation for EPI and TT vaccination
Support and guidance to Social Mobilizers, ACHNs and Field Coordinators for community monitoring
To play an enabling and healing role in the specified communities.
To educate health committees about socio environmental conditions related to the prevalent and specified disease.
To follow and act in accordance with all Aman confidentiality agreements.
To carry out their role, in accordance with all other Aman's policies and procedures.
To assist in any other task assigned by the community health supervisor, in relation to the program.
To document and suggest any changes/modification required for effectiveness and efficiency of the program to the community health supervisor.
To ensure accurate information to be provided to all community members, regarding the program.
To organize community members and form health committees.
To hold sessions of the health committees for knowledge, reflection and action by the community members.

Competency Matrix
Technical Skills: Data collection skills and ability to read & write
Management Skills: Communication skills and influencing skills

Key Attributes
Bilingual (As per community)
Is able to work with the community in a fair and unbiased manner
Should be a member of the community, they are working in.

Position: Community Health Supervisor **Grade:** Executive	**Functional Reporting:** Field Coordinator **Administrative Reporting**: Field Coordinator
Department: Aman Community Health Program **Location**: Field	

Job Specification	
Qualifications: Diploma in Nursing (RN) or Bachelor's in Nursing (BScN) Lady Health Visitor Community Midwife	Experience: 2-3 years' experience in a hospital or Community clinic. Aware of medical terminology and facts.
Training/Courses: Community Health related course/Communication skills	Age: 20-30 years Gender: Female preferred

Job Description

Organization Chart (Immediate line & functional relationship)

Field Coordinator → Community Health Supervisor

General Purpose

The primary responsibility of the Community Health Supervisor is to supervise the community health workers. The job focus would be ensuring quality service provision/referral and health education by the CHW. The supervisor would also review quality of the data collected by the CHW, ensure biweekly/monthly reporting and would provide assistance where required to the CHW in terms of the clinical intervention. The supervisors would also supervise the community health worker though house visits and each community health supervisor/community health nurse would be responsible for 5-6 visits every day.

Job Responsibilities and Authorities

Guide the CHW with setting goals and objectives. Communicate the programs goals and objectives to the CHW clearly throughout the program.
To conduct trainings and refreshers for CHW.
Provide assistance and support to the CHW for timely completion of the specified tasks. Guide the CHW with planning and smooth implementation of the specified tasks.
To monitor house to house service delivery, through visits, participatory monitoring, interviews with community members etc.
To provide close supervision with a special focus on clinical interventions.
To monitor CHWs performance at each household, by making routine visits with the CHW.
Each Supervisor is to visit 5-6 households each day.
Provide support and guidance in planning or on job to the CHW in provision of health education, awareness sessions.
Conduct Health Education Awareness Session in community or CBOs.
Provide support and guidance to the CHW in forming Support Groups/committees etc.
Assist and guide the CHW in data collection and management. Review data collected by the CHW on daily/weekly and monthly basis.
Share field data on regular basis and generate reports.
Liaise with other members of the field office to ensure timely delivery of medicine, supporting items.
Play a motivating and enabling role for the CHW. Communicate any opportunities with Aman for future grown and advancement.
Work closely with other supervisors and other field office staff to ensure timely completion of goals.
To conduct weekly meetings with the CHWs. Highlight issues where applicable to senior management.
Maintain all relevant records of the center in a systematic order.
To act in accordance with the Aman confidentiality agreement.
To act in accordance with other Aman Policies and procedures.
Provide leadership and supervision to the community health worker.
Any other task assigned by the Coordinator.

Competency Matrix

Technical Skills: MS-Office, basic knowledge of data review and management, familiarity with the tools, concepts & methodology of quality management, record management
Management Skills: Interpersonal skills, leadership, organization, team management, prioritization and delegation

Key Attributes

Ability to work closely with the Community Health Worker.
Positive attitude, good judgment
Ability to work under pressure

Position: Field Coordinator **Grade:** Assistant Manager	**Functional Reporting:** Manager Operations **Administrative Reporting**: Manager Operations
Department: Aman Community Health Program **Location**: Field	

Job Specification	
Qualifications: MBBS/Bachelor's Degree (BSCN) from HEC recognized institution preferably Masters in Social Sciences (MSc)/Masters in Public Health (MPH) from a HEC recognized university.	Experience: 3-5 years of work experience in program implementation and management of community based projects. Experience of working with underserved/vulnerable communities is preferred
Training/Courses: Community health related course	Age: 30 to 50 years Gender: Male/Female

Job Description

Organization Chart (Immediate line & functional relationship)

General Purpose
The purpose of this position is to maintain and oversees the implementation of ACHP programs. Monitors administration to established standards and procedures. Identifies opportunities for improvement and resolves any discrepancies & Problems.

Job Responsibilities and Authorities
Have a clear and comprehensive understanding of the program. Provide a leading role in implementation of the program on a daily basis.
Responsible for all operational management of the field office.
Responsible for daily supervision and management of all field staff.
Responsible for overseeing and coordinating the referral system in the area.
Play a lead role in implementing policies, procedures, organizational structure for the program in accordance with Aman and program policies at the field office level.
Assist in implementation of all monitoring tools; including systems developed for tracking and monitoring of data for the specified area.
Responsible for overseeing the IT system of the office.
Play a lead role in ensuring training and capacity building of all administrative staff of the program.
Oversee the field office in accordance with Aman's operational and HR policies.
Coordinate and work with all staff to resolve operating problems, difficulties, and authorize field operational procedures within the Aman framework.
Cultivate and manage relationships with local bodies, partners, communities etc.
May ask to review records, examine offices.
Watch people as they work on the floor.
They can meet with the high-ranking staff to discuss any problems and work on a resolution.
Any other task assigned by the Manager

Competency Matrix
Technical Skills: Data analysis, MS-Office, proficiency in working with databases.
Management Skills: Leadership and management, communication, ability to work with diversity, ability to work independently, efficiently, and assess priorities with a high level of accuracy, commitment to values of equity, integrity and access for all, good analytical abilities to grasp the key points from complicated details, a team player, willing to learn.

Key Attributes
Sound judgment and professionalism.
Positive attitude.

Annex III. Social Mobilization

Social Mobilization has a vital role in this project. The structure of Social Mobilization consists of Community Based Organizations (CBOs) and Community Advisory Committee (CACs). The CBO is a representative group of male and female (separately) from 20,000 (maximum) population. Hence for a 100,000 population, 5 Male and 5 Female groups are formed.

Community Advisory Committees (CACs)

Community Advisory Committees (CACs) will be formed with participation of key persons of communities and local leaders to address their community's needs and to support the local leadership for the solution of Health problems in cooperation with project. The formation of CAC converge attention of the local leadership on Health agenda in context of SUKH. There is no segregation of this forum on gender basis.
01 CAC is formed at each Field Station and quarterly meetings will be organized.

Community Based Organizations (CBOs)

CBOs (Community Based Organizations) will be formed in community. CBOs are formed on smaller group of population than CAC. Keeping in view the political challenges in some pockets, the term of CBO may be replaced as Community Representative Groups (CRGs)/*Mohalla* Management Committees (MMCs). Social Mobilizers facilitate to communities in formation of CBOs/CRGs/MMCs. Formation of these forums (CRGs/CBOs or MMCs) on smaller group of population will help us to promote community member's participation and community ownership towards their Health issues especially in scope of SUKH project. One CBO will be formed over 20,000 population to ensure the participation. CBOs will be formed separately for men and women.

Community Based Organizations of Men

CBOs (Community Based Organizations) will be formed in community. Social Mobilizers will facilitate to communities in formation of Community Based Organizations (CBOs)/Community Representative Groups (CRGs)/*Mohalla* Management Committees (MMCs). Men CBOs will be formed and facilitated by a male Social Mobilizer. Details of responsibilities of Social Mobilizer are attached as Annex XVI

Community Based Organizations of Women

CBOs (Community Based Organizations) for women will be formed in community. Community Health Supervisors facilitate to communities in formation of Community Based Organizations (CBOs)/Community Representative Groups (CRGs)/*Mohalla* Management Committees (MMCs). The responsible person for Social Mobilization activities is Social Mobilizer but keeping in view the social cultural values of community, Community Health Supervisors (females) will play their role to organize Women CBO formation and meetings.

Community Health Assembly (CHA)

Community Health Assembly will be a forum of mass mobilization of community and for community by encouraging CBOs & CACs to share their role, participation and progress for community Development. This forum will provide opportunity to community to be informed of Health activities in their area especially under Sukh Project.

The objectives of CHA activity are:

- To mobilize and synergize Local leaders, CBOs and community members
- Provision of Forum to share local efforts, activities and progress on Health and Community Development by stake holders
- Creating awareness, raise voice and develop ownership of community on Health agenda

CHA will be a gathering of local, public and private stakeholders including:

- General Community
- CBO members
- CAC members
- Health Department
- Population Welfare Department
- Private Health Practitioners
- Sukh partners
- Government & Private Educational representatives

All the activities of the project will be carried out under the supervision of the Field Coordinator, who will be responsible for administration of Standard of Procedures.

Annex IV. *Strategic Objectives of AMANTELEHEALTH*

TeleHealth outlines 8 strategic objectives in order to increase demand and referral follow-ups

1. Enabling trained call agents at TeleHealth for responding and dealing calls for MNCH, FP, PPFP, PAFP, PAC, FLE and referrals information
2. Increase awareness and promotion of AMANTELEHEALTH Services (9123) in the one million targeted population of Sukh catchment areas through different marketing initiatives.
3. Increase health seeking behavior related to modern contraceptive methods in the targeted population of Sukh Community through standard SMS on FP, PPFP, PAFP and PAC and FLE.
4. Increase inbound calls by initiating marketing and promotion activities in the Sukh Catchment population.
5. Increase access to MWRA, husbands, young girls & boys for TeleHealth services using Sukh Telephone Booths
6. Contact opt MWRA+ Husband, young girls & boys via outbound calls for MNCH, FP, PPFP, PAFP, PAC, and FLE information by registering them on the Sukh TeleHealth system for advise, counseling and information on MNCH, FP, PPFP, PAFP, PAC, and FLE.
7. Enhance AMANTELEHEALTH Health Directory System by incorporation of public and private service providers' information and Health Care Facilities available in the Sukh targeted population.
8. Integrate AMANTELEHEALTH System with Sukh MIS Application for regular updates and data integration.

Annex V. Enhancing an enabling environment

Approach

1. Working in close collaboration with key stakeholders such as the DoH, PWD, district government, and others will be critical in creating an enabling environment for sustaining these interventions.
2. Working with existing resources to strengthen them by building capacity of these resources and investing in systems and processes to sustain resources will be a key approach throughout the proposed activities.

Consultative Meetings with the policymakers & Sukh

Jhpiego will be doing **Consultative Meetings** with the policy makers & Sukh TAAG for learning urban and peri-urban health challenges, understanding level of FP awareness in Karachi and will be sharing PPFP strategy & implementation plan.

Orientation seminar:
This is a startup Activity; the Seminar will be arranged for the stakeholders on service delivery role of Sukh.

Development of a joint PPFP strategy for Karachi:
To guide the PPFP and PAFP work in Karachi, Jhpiego will facilitate the development of a joint PPFP strategy for Karachi with leadership from the DoH and the PWD and advocate for the incorporation of FP, PPFP and PAFP into the Planning Comission-1 plan for Karachi.

In addition to the DoH and PWD, Jhpiego will also collaborate with the MNCH and the LHW program through consultative meetings on a regular basis as well as through the TAG platform.

Jhpiego will finalize a working mechanism with the PWD, District Government, and SESSI and support the PMU in the development of a working mechanism with DoH and would start execution of field operations as soon as the documentation formalities are completed.

MoUs:

- Sharing of draft MoUs (Involving IPs)
- Finalize MOUs with PWD, KMC and SESSI
- Facilitate signing of MoU between PWD, KMC and SESSI for Contraceptive supplies
- Sign MoU with concern stakeholders if required (JSMU, NCMNH, MNCH, LHW Program, CSM, etc.)

Ensure supply of commodities in public sector:
Jhpiego will advocate for streamlining contraceptive supplies to Hospitals and to develop mechanism to ensure supply of commodities during consultative meetings with DoH, PWD. Monthly review will be done for FP & IP commodities during supportive supervisory visits.

Regular updates and frequent interaction with Government:

- Participation and sharing of Sukh updates on District Technical Committee Meeting on Monthly basis
- Participation on regular consultation meetings with PWD, DoH, District government and other stake holders

Impact at policy level:
Pathfinder international is also working on a policy document for FP with the government of Punjab and Sindh, Jhpiego will work with Pathfinder to integrate some of the best practices into the policy document to ensure sustainability (please see sustainability section for details). Jhpiego will be contributing to the policy document currently being led by Pathfinder international.

Access to intervention sites and Service providers:
Sukh will be doing consultative meeting with Health and Population Departments to allow access to respective facilities/Institute and HCP in project area.

Mapping of intervention sites:
Jhpiego will conduct a mapping exercise of the public sector facilities in project-defined geographic areas of Karachi in consultation with the DoH and PWD.

The target for selection is 80 health facilities (40 family welfare clinics and 40 maternity homes); 3 clinical training sites for PPFP and PAFP; one Regional Training Institute.

Selection Zones:
Zone 1: Sukh catchment Areas, selected Union councils in Landhi, Korangi, Bin Qasim and Malir towns.
Zone 2: Areas outside Sukh Catchment Areas within a 12–18 kilometer radius, facilities receiving high referrals from SCA, and the nearest tertiary care facility. JPMC is selected as one of the training sites.

Site Selection:
The facilities will be selected in collaboration with the DoH, PWD, and the district government based on selection criteria.

- Select facilities from the list of mapped facilities including three clinical training sites and one Regional Training Institute
- Select site for PAC clinical practicum

Selection Criteria for selection of intervention sites:

- Availability of human resources
- Client case load
- Availability of BEmONC and CEmONC services
- Willingness and commitment from the facilities staff

JPMC has been selected as an intervention and training sites due to following reasons along with the selection criteria:

- JPMC receives highest referral from the SCA (source of information, SGH Korangi, SGH Ibrahim Hyderi, Willow's field workers, ACHP Station In-charges and MCH staff of DOH)
- JPMC is a high case load tertiary care hospital

Clinical Training Site Assessment:
Clinical training site needs assessment will be performed for three clinical training sites and one regional training institute

Strengthen three Clinical Training site and one Regional Training Institute (PWD)

- Develop skills lab at the Regional Training Institute
- Upgrade labor room and develop skills lab at the clinical training sites

Clinical Facility Audit:
The selected facilities will undergo a clinical assessment that will look at equipment, infrastructure and supplies of family planning.

- PWD
    - RHS – A
    - FWCs
    - MSU

- DoH, KMC and SESSI
    - Tertiary Hospitals
    - Maternity Homes
    - Dispensaries
    - BHUs and RHCs providing ANC, PNC and FP Services

Facility Up- gradation (FP Clinics and Others):
The observations of clinical training sites and facility audit will be analyzed and the gaps identified will be shared with the respective department. A joint action plan will be developed to rectify the gaps. Jhpiego will provide the PPFP equipment starter kits, simulation models (e.g., implant arm and pelvic models and the Laerdal/Jhpiego innovative PPIUCD simulation model called Mama-U), and PAC/PAFP materials including MVA kits, to support HCPs to practice new skills on models prior to clinical practice under close supervision.

Site strengthening of Sukh facilities:
Within Sukh budget, the clinical training sites and the selected facilities will be upgraded in terms of necessary equipment, basic support in modifying infrastructure and supplies of family planning for initial period of intervention.

Clinical Training Sites:
Upgradation of Labor rooms of three clinical training sites, i.e. SGH Saudabad, JPMC and SGH Korangi will include

- Paint (LR & skill lab)
- Minor repairs (electric wiring, switch boards, plumbing and windows)
- Placing FP Counters
- Development of skill lab at 4 training sites would include the following items

Sr. #	Items for Skills Lab	Quantity
1	Interval IUCD Kit	1
2	Postpartum IUCD Kit	1
3	Implant Insertion/Removal Kit	1
4	MVA Kit double Lock System With Complete Cannulas & Gel Reusable	1
5	Zoe Models	1
6	Mama-U Model	1
7	Hands on Implant Model	1
8	Handheld Uterus Model	1
9	Dust Bins with Lid, foot operated	3
10	Cotton Rolls	1
11	Measuring Cup	1
12	Towel (Hand held size)	5
13	Goggles (transparent)	1
14	P/V Light Halogen Smaf type China adjustable	2
15	Electric Boiler Normal local	1
16	Surgical Trolley	1
17	Bucket Stand with 2 bucket with lids	1
18	Water Tub	1

19	Brush with Handle	1
20	Disposable Gloves for Examination	1
21	Surgical Gloves	1
22	Utility Gloves	1
23	Bleach (Unicon 32%) or Safe (26%)	1
24	Pyodine Bottle	1
25	Mackintoshes	1
26	Disposable Caps	1
27	Disposable Masks	1
28	Aprons	1
29	Demonstration Trolleys	2
30	Demonstration Tables	2
31	Stethoscope	1
32	BP Apparatus	1
33	Green Drapes for Instruments	4
34	Plastic Spray bottle china Pure PVC Transparent	1
35	Large Buckets with Lid for Waste Disposal 50 Ltr Pure imported (pvc) Unbreakable transparent	3
36	Table for Counseling	1
37	Revolving Chair for Counseling Table	1
38	Polk's Chairs	2
39	Patient Examination Stool	1
40	White board with Stand	1
41	Cloth Hampers trolley Parachute with lid	1
42	Emergency Light Double tube	1
43	Dettol Soap with Soap stand	1
44	Counseling Poster	1
45	TIHART Poster	1
46	Loading IUCD Poster	1
47	PPIUCD Insertion Poster	1
48	Post Abortion Care Poster	1
49	Family Planning Timing Poster	1
50	Infection Prevention Poster	1
51	Hand washing Poster	1
52	Chlorine Making Poster	1
PPIUCD Kit		
	Forceps Jar (1)	1
	Instrument Tray with Lid	1
	Iodine Cup Small	1
	Sponge Forceps Straight	1
	Cheatle's Forceps	1
	Sims Speculum – Medium	1
	Kelly Forceps	1
Implant Insertion/Removal Kit		
	a) Chitter forceps with Forceps Jar	1
	b) Instrument Tray with Lid	1
	c) Galipot	1
	d) Sponge Forceps Straight	1
	e) Scalpel	1
	f) Scissors Operating	1
	g) Artery Forceps Straight	1
	h) Small curved artery	1
	i) Kidney Basin	1
	j) Needle Holder	1
	k) Scissor Irus curved	1
Interval IUCD Kit		
	a) Forceps Jar	1
	b) Instrument Tray with Lid	1
	c) Pyodine Cup Small	1
	d) Kidney Basin	1
	e) Uterine Sound Sims	1
	f) Artery Forceps Straight	1
	g) Crocodile Forceps	1
	h) Scissors	1

	i) Sponge Forceps	1
	j) Cusco Speculum	1
	k) Valsellum	1

Service delivery outlets:

- Renovation (Minor repair and renovation of 80 facilities as per facility upgradation plan phase wise)
- IP supplies (listed below)

Sr. #	Items for Skills Lab	Quantity
1	Dust bins with lid, foot operated	3
2	Cotton Rolls	1
3	Measuring Cup	1
4	Towel (Hand held size)	5
5	Goggles (transparent)	1
6	Electric Boiler Normal local	1
7	Bucket Stand with 2 bucket with lids	1
8	Water Tub	1
9	Brush with Handle	1
10	Disposable Gloves for Examination	1
11	Surgical Gloves	1
12	Utility Gloves	1
13	Bleach (Unicon 32%) or Safe (26%)	1
14	Pyodine Bottle	1
15	Mackintoshes	1
16	Disposable Caps	1
17	Disposable Masks	1
18	Aprons	1
19	Green Drapes for Instruments	4
20	Plastic Spray bottle	1
21	Large Buckets with Lid for Waste Disposal	3
22	Cloth Hampers trolley Parachute with lid	1
23	Dettol Soap with Soap stand	1
24	Counseling Poster	1
25	TIHART Poster	1
26	Loading IUCD Poster	1
27	PPIUCD Insertion Poster	1
28	Post Abortion Care Poster	1
29	Family Planning Timing Poster	1
30	Infection Prevention Poster	1
31	Hand washing Poster	1
32	Chlorine Making Poster	1

Annex VI: *Trainings*

Crash training course on pills, injections, interval IUCDs & counseling: To meet the initial need for referral sites, Jhpiego will selected approximately 10 providers from 5-10 facilities and take them through a two day refresher course on pills, injections, interval IUCDs and counseling. ATH and ACHP would be sending them referral until the programmed trainings are initiated.

Selection of trainers and HCPs:

- Finalize selection criteria for trainers and service providers
- Identify Master/Trainers from PWD and Health
- Identify 80 service HCPs from public sector (40 maternity homes & 40 FP clinics)

Selection criteria for trainers:
In consultation with PWD and DoH, Jhpiego will finalize selection criteria for trainers and services providers.

- Should be based in Karachi and are willing to participate in Sukh intervention as a Master Trainer
- Is not planning to retire or move out of Karachi in next two years

- Working in a health care facility (clinic or hospital) that provides women's health services including antenatal care (ANC), labor and childbirth, and postpartum care, including FP
- Familiar with providing general FP services (if learners are not proficient in these services, the course may be lengthened to allow for sufficient clinical practice)
- Willing to update their knowledge and acquire the skills and attitudes essential to provide PPFP services
- Enthusiastic to learn adult learning principles
- Experienced in facilitating workshops
- Willing to develop a Personal Learning Plan and take the plan back to their workplace and show it to their coworkers and supervisor as part of their effort to implement what they have learned
- Committed to conducting step-down (cascade) training using the training package
- For training on Implant insertion skills, trainers must be also be medical doctors

Training of Trainers for Clinical Training Sites:
Selected Trainers from four clinical training sites will be developed through training on clinical training skills and effective teaching skills modules in addition to Comprehensive FP training including PPFP and PAFP.

Infection prevention orientation will also be provided at all four training sites prior to initiation of clinical practice.

Comprehensive FP Training: Jhpiego's training packages will combine knowledge/classroom-based learning, followed by practice on humanistic simulators and observation of the trainers applying the methods before trainees apply their skills and knowledge on real clients under close supervision of trainers at the clinical training site.

Methodology: Training modules for health providers consist of about 6-12 days total in training (depending on type of provider) over approximately three or four months and will be led by the trained clinical trainers with support from Jhpiego's staff who are established master trainers.

Training of Sukh Staff and HCPs on VCAT:
Jhpiego will conduct a VCAT orientation for all Sukh staff and HCPs. The objective of VCAT is to let people discover their values through a process of honest self-examination; to correct different myths prevailing among providers for providing PAC services; and changing their attitudes and finally actions (practices). The lower level cadres at the facilities such as the cleaners, ayahs, chowkidars, ambulance drivers, etc. are targeted participants for this training. This is a one-to-two day course that will prepare the participants to counsel on PPFP and PAFP/PAC and facilitate referrals for services as needed.

Training of small health facility providers on medical management of abortion and PPFP and PAFP counseling: While surgical management of PAC is being provided by maternity homes and beyond, there are numerous small health facilities that are also receiving cases of incomplete abortion. Jhpiego will train these one-manned health facility providers on medical management of incomplete abortion using misoprostol and PPFP and PAFP counseling, so that there are no missed opportunities for FP.

PAC trainings: The scope of work under PAC would include the following for maternity care providers which will complement ongoing efforts in the private sector and avoid duplication of training activities for PAC:

- Trainings on MVA and PAFP
- Training on use of Misoprostol for incomplete abortion. Jhpiego expects that this training will reduce the number of referrals and work load of tertiary care hospitals as well as reduce the risk of time spent by women who seek critical care during an emergency.
- For health facilities that do not offer PAC services, these providers will be trained mainly on identifying complications, conducting timely referrals and counseling for FP.

Training Government staff on Supportive Supervision:

- A supportive supervision orientation for the top management of DoH and PWD will be done. Later on, a detailed 'how to' conduct supportive supervision will be done for mid-level managers at the DoH and PWD prior to the initiation of the monitoring visits.

Refresher Trainings:

- Conduct Refresher trainings after Training needs assessment at 6 months follow-up of certified Health care providers
- Conduct Refresher trainings of support staff after Training needs assessments at 6 month's follow-up

Training materials and modules: Jhpiego will update available materials (Training & IEC) on FP/RH endorsed by Provincial Health and Population Welfare Departments for trainings and as per need of target service providers.

Standard Quality Care:

- Standard based management and recognition tool (SBMR)

CTS Training Module:

- Clinical Training Skill Course Materials (Learner's guide, Reference manual and Facilitator's guide for training skills for Health Care Providers).

Comprehensive FP Module:

- Learner's guide, Reference manual and Facilitator's guide for PPIUCD clinical services.

Postpartum Family Planning Module:

- Learner's Notebook and Trainer's Guide for providing Post-partum Family Planning (PPFP) Services.

Training Targets:

Trainings	No of Trainings	No of Participants
Trainings for SUKH Staff on VCAT	9	135
TOT for Tele Health Operators on algorithm (FP)	3	20
Conduct clinical training skills course for the providers	1	5
Conduct effective teaching skills course for the Regional Training Institute	1	10
Infection Prevention Workshop for support staff of the training sites	7	70
Training of Trainers on Comprehensive FP Package	3	30
Conduct crash training on basic pills, injections, interval IUCDs, and counseling	1	40
Training of Service providers from FP clinics and maternity homes on Comprehensive FP Package	15	180
Training of support staff on VCAT and counseling	20	240
Training of small facility providers on medical management of abortion and FP counseling	4	40
Conduct Refresher trainings after TNA at 6 months follow-up of certified Health care providers	6	60
Conduct Refresher trainings of support staff after Training needs assessments at 6 month's follow-up	6	60
Conduct supportive supervision training for Mid-Level Management of DOH and PWD	2	20
Conduct supportive supervision training for Senior Management Team of DOH and PWD	1	10

Aahung will collaborate with Jhpiego for the trainings on youth friendly services. One day will be added in Comprehensive FP training on Aahung's module on FLE.

Annex VII: Intervention Details

Facility	Services Available at present	Intervention by Jhpiego	Process Indicators (What we will do)	Beneficiaries	Outcome Indicators (What change would occur)
Regional Training Institute (PWD)	Skill labs for IP and IUCD	Establish Skill lab for PPFP and PAFP services	Provide set up for PPIUCD skill practice Equip master trainers and trainers with training skills as per Jhpiego standards	Regional Training Institute (PWD) Master trainers, trainers and trainees	RTI will be upgraded by addition of PPIUCD skill lab and skilled master trainers for comprehensive FP training skills
Clinical Training Sites: Teaching/Non-Teaching Hospitals	ANC, PNC, Normal delivery and caesarian No Family planning method is offered (except Korangi 5,where PPIUCD and implants are offered)	Develop Skill Labs Train HCPs on comprehensive FP services and Trainings of PPFP, PAFP, MVA and use of Misoprostol Set FP counters at ANC outpatient department Develop QIT Perform Supportive Supervision and ensure quality of services	Provide set up for PPIUCD skill practice FP counters available at ANC Equip master trainers and trainers with training skills to learn and implement supportive supervision with existing resources	MWRA Post-grad specialists (Obstetricians/gynecologists) Female Medical Officers Nurses Midwives Lady Health Visitors (LHVs) Quality of training Systems, service delivery procedures processes Population welfare department, as CYP generated as a result of our intervention will be counted as PWDs performance indicator	Skill labs available within hospital premises for acquiring FP service delivery skill. Inclusion of FP service counseling at ANC, PNC and first stage of labor for PPIUCD and implants Facilities up-graded as Clinical training sites for PPFP and PAFP Trained HCPs available 24/7 for FP Improved quality of services as per SBMR protocols D&C replaced by MVA Infection prevention techniques in place as per Jhpiego standards
	Poor standards of infection prevention protocols	Train Support staff on IP Ensure implementation of IP standards by training, facility up gradation and supportive supervision Sharing pre and post intervention data with management and technical team for by in	Training workshops on IP followed by supportive supervision and action planning accordingly	Support Staff Clients HCPs Facility reputation	Improved Infection prevention practices Lower infection rates Increase number of services and satisfied clients
Hospitals and Maternity Homes: Teaching/Non-Teaching Hospitals and Maternity Homes governed by: Department of Health (EDO Health) Karachi Municipal Corporation (KMC) Sindh's Employee	ANC PNC Normal Caesarian section delivery in selected facilities	Train HCPs on PPFP and PAFP Train HCPs on MVA+ use of Misoprostol and PAFP Train Support staff on IP Develop QIT Perform Supportive Supervision	Facility up-gradation Training workshops planned and followed by supportive supervision and action planning accordingly with existing resources	MWRA Post-grad specialists (Obstetricians/gynecologists) Female Medical Officers Nurse Midwives Lady Health Visitors (LHVs) Support staff Dispensers Cleaners	Trained HCPs and FP services available 24/7 Improved quality of services as per SMBR protocols Improved Infection prevention practices Improved knowledge of clients and HCP on FP + HTSP Satisfied FP clients with low drop outs

Social Security Institute (SESSI)					
Family Health Clinics (FHCs) also known as RHS - A Centers (PWD)	Offer all FP methods, including female sterilization and non-scalpel vasectomy	Training needs assessment, gap identification Training HCPs on PPFP and PAFP Train Support staff on IP Develop QIT Perform Supportive Supervision Monthly family health day for promotion of FP and awareness raising of community on location of underutilized facilities and services	Training workshops focus on PPFP/PPIUCD followed by supportive supervision and action planning accordingly within existing resources	Master trainers Facility In-Charge (senior medical person) Woman Medical Officer Female Welfare Counselor (FWC) Female Welfare Assistant (FWA) (male and Female) Helper PWD	Trained HCPs available Improved quality of services as per SMBR protocols Improved Infection prevention practices Increase number of Increase FP services and high continuation rate Awareness on PPFP/PPIUCD counseling, follow up of entire team Addition of PPIUCD column as a performance indicator in PWD reports Increase in CYP
FP Clinics/PWD Outlets: Family Welfare Centers and Mobile Service Units	Offer limited FP methods: IUCDs, pills, injectable	Training needs assessment, gap identification Training HCPs on PPFP and PAFP Train Support staff on IP Develop QIT Perform Supportive Supervision Monthly family health day for promotion of FP Awareness raising of community on location of underutilized facilities and services	Facility up-gradation Training workshops planned and followed by supportive supervision and action planning accordingly with existing resources	Female Welfare Counselor (FWC) Female Welfare Assistant (FWA) (male and Female) Other support staff	Increase in CYP Trained HCPs available Improved quality of services as per SMBR protocols Improved Infection prevention practices Overall awareness on PPFP/PPIUCD improved Follow up and referral s and record of referred PPIUCD available

Annex VII: Supportive Supervision

Introduction:
Post-training supportive supervision (SS) visits to the facilities are essential to help providers and facilities to initiate and scale up family planning services at their health centers/hospitals, translate updated competencies into action in providing services to clients and ensure the quality of FP services as per standards checklists.

The purpose of the guidelines for supportive supervision is an effort to maximize the outcome of the SS visits by:

- Listing major steps of implementing supportive supervision visits for FP services
- Reminding the key tools that can be used for effective supportive supervision.

Number of Supportive-Supervisory visits:
The first support visit should be conducted after the selected providers are trained on competency based training related to FP, to help them initiate the services by:

- Orienting all concerned staff and management on FP
- Establish the system of counseling for ANC, early labor and postpartum cases (where necessary)
- Ensure availability of instruments for IUCD/IMPLANT/PPIUCD and registers at places of insertion (Procedure room, Labor room, OT and postpartum insertion site in wards)
- After orientation, the trained providers should be encouraged (and supported, if needed) to provide on-job coaching to other providers to increase the number of service-providers at the facility

Preferably this mandatory first support visit should be conducted within first month of the training. The subsequent SS visits should be decided based on the specific needs of different facilities, but one should make a minimum of one visit to each facility in 3 months' time to ensure that the services are scaled up at the individual facilities and services are provided as per counseling and insertion checklists, which also include infection prevention steps, by addressing the gaps through proper interventions. The plan of the visit can be made right after the service provider's training.

Person responsible for making Supportive Supervision visit:
Concerned Clinical Staff/Trainer will do the SS visit to the assigned facilities. Depending on the need identified in subsequent support visits by state person, the plan for future support visit(s) will be made.

Based on the kind of need identified in the support visit or provider's feedback, the responsible team member will be addressing the needs of identified facilities.

(Example, if support is required to provide guidance on any technical step for PPIUCD insertion or removal, the clinical staff needs to provide on-job demonstration of that particular step on client (if not possible, then on model) and make sure through return demonstration from the provider/s that they have mastered the step/s. If any technical question is asked, the correct response should be provided by clinical staff making the SS visit. If the correct answer to the question is not known, clinical staff should admit that she would get back with the right answer after consulting concerned senior technical member).

Basic skills and approaches required to conduct Supportive Supervision:
The Clinical/Program staff should be:

- Updated on relevant technical knowledge on HCTU, IUCD and PPIUCD
- Familiar with the protocols, performance standards, and checklist.
- Ready to demonstrate the skill (counseling/insertion) to build their confidence on the trainer (OJT)
- Communicating effectively

Counseling and IUCD insertion skills are essential for establishing credibility. Involve health care providers or concerned facility-staff in identification of strengths and areas for improvement using performance standards/counseling and insertion checklist.

Planning for Supportive Supervision visits:
Preferably the first mandatory support visit should be conducted within first month of the training of providers. Based on the need of facilities and the criteria to visit each facility once in a month, further calendars will be made.

Preparation for supportive supervision visits:
The SS visits should be arranged in such a way when clinical staff can observe service delivery and provide feedback to the concerned service delivery staff.

Organize the SS visits by:

- Reviewing the protocols checklists
- Reviewing the last month's report of the facility or recollecting the findings of last visit to the facility, to understand which aspect needs strengthening
- Developing clear action plan for the visit based on the need of the facility or whether it is the first visit or the visit for orientation
- Collecting and carrying helpful materials, checklists, reference manual, CD of PPIUCD/IMPLANT/IUCD insertion video, job aids
- Informing the concerned point person of the facility about the date and time of the visit.

Plan to spend sufficient time to conduct the SS visit. The amount of time of a SS visit varies depending on the needs of the facility/providers and circumstances at the facility.

Clarify your expectations for performance with the providers:

- Share or re-emphasize the desired level/status of services or performance or the need for scaling up PPFP/PPIUCD services at the facility, as compared with the current levels/status.
- While interacting with the providers, refer to the checklist/job-aid/performance standards to make providers familiar with them so that the providers can do self/peer- assessment and take corrective measures.
- If required/possible, run the CD of PPIUCD/Implant? insertion steps on your laptop and let the providers observe the steps. This can be followed by a discussion.

Keep record of Supportive Supervision:
Maintain records of supportive supervision as per given formats

Maintain proper documents:
The staff involved in SS, e.g. HCP for Insertion, Aya for IP, Motivator for counseling etc.)

Identify needs to strengthen capacity of providers to provide quality services:

Keep providers motivated:

- Clinical staff should always seek feedback from providers and communicate in such a way that the provider should feel valued. Acknowledge the provider's or facility's achievements. Share the performance level.

Carry at least following items for SS visits:

- Checklist
- Reference manual
- Job aids like counseling kit, flip book, PPIUCD/IMPLANT insertion steps video.
- Family Planning handbook, MEC wheel, etc.
- Model for insertion demonstration

Annex VIII: *Health Camp*

Goal**:** "Improved uptake of quality family planning in SUKH catchment areas through initiating health camps"

Objectives:
Increasing access to quality family planning services focusing LARC's to poor and marginalized groups/people in SUKH catchment areas.
Promoting healthy behavior particularly focusing reproductive health in the community through effective inters personal communication (ACHP) strategy.

Health Camp Strategy and Methodology:
The proposed of Health camp is designed to meet the unmet need of family planning services in the non-affording communities in SUKH catchment areas. It is to be noted that under the national program, the LHWs/CHWs are already distributing pills and condoms to couples in underserved communities, so these methods would be excluded from Health camp strategy. The Health Camp strategy is particularly designed to promote long term family planning methods especially focusing to IUCDs and Implants for this neglected segment of the society.

Frequency Health Camp:
This activity will be pilot for two months. The frequency would be one camp per station per week, total 40 camps per month roughly/

Target Group:
Newly-wed women, pregnant women, women with one or more children, and women in need of birth spacing

Selection of Team:
Jhpiego will be responsible for overall implementation and management of this initiative. SUKH ACHP has already established 10 station

offices with strong field team of CHW (interpersonal communication). Jhpiego has prepared 40 (Family health center) as SUKH network of service providers in collaboration with PWD. These already established systems will be used to initiate Health Camps to reach MAWRAs in SUKH catchment areas.

Provider's Selection:
Population Welfare Department (PWD) will identify service providers from (MSU) mobile service unit team that can provide quality FP services in the selected SUKH ACHP stations. The providers will be a mix of lady doctors and LHVs that provide FP and RH services to their clientele. Refresher course will be given to providers on FP methods, counseling techniques and referral slip filling and referral process. The camp will be organized mainly in selected ACHP stations

Selection Criteria: The providers would be selected from within the PWD MSU teams. Providers working near or within SUKH ACHP stations and inserting IUDs and Implants would be preferred.
Letter of Understanding: An agreement will be signed between Jhpiego and PWD. Improvements in Quality of Care parameters would be part of the LoU, with requirement to reach min 90% benchmark in ten critical indicators.

Develop referral slip booklets for CHW:
The referral token/slip has three types of slips, and the Community Health worker (CHW)/Lady Health Worker (LHW) will fill the client's information, like name, number, and CNIC on all three slips, as follows:

- Slip 1: CHW/LHW will fill the slip completely (e.g. particular information about services)
- Slip 2: Service provider will fill the rest of sections on slip 2 and 3 after providing services. Service provider will put slip 2 in drop box for record (for ACHP)
- Slip 3: Service provider will hand over slip 3 to client and CHW/LHW will collect this slip from client

Before Organizing Health Camp:
Jhpiego clinical trainer in consultation with DPWO (District population welfare Officer), and ACHP field coordinator will prepare the schedule of Health camp for each station
Prior to the Health Camp day, CHW community Health Worker (ACHP) from the respective Station team will visit individual households. Referral slips will be distributed, having details of the health camps which includes time, date, venue and name and number of the service provider at that health camp.

CHW (ACHP) will prepare list of all the referrals through referral slips given for that particular Health Camp and submit it to her Supervisor, which will later be used for data analysis.

CHW is advised to refer at least 12-15 clients including 4 IUCD, and 3 implant cases on Health camps

Distribute IEC materials on Health Camps

Dissemination/communication of Health Camp Day

Jhpiego team Submit monthly schedule for Health Camp to TPWO (Town Population Welfare Officer) and ACHP field team

Field coordinator of respective station will plan meeting with CHS (Lady Health supervisor) monthly and circulate a polite reminder for referral of clients (two days before each camp)

Jhpiego team will conduct meeting with MSU staff for necessary arrangements and distribution of roles/responsibilities before one day of each camp

Resources and equipment: (TPWO and MSU Team)

- Checked and ensured enough quantity/stock of contraceptives
- Checked and ensured necessary equipment and instrument for IUCD insertion in enough quantity and in working order
- Checked and ensured infection prevention material in enough quantity and equipment in working order
- Checked and ensured working condition of sterilizer and availability of alternative sterilization facilities

Marketing and promotion of Health camp:

- A permanent banner will be fixed at visible place with information for health camp
- CHW (ACHP) will inform the community about health camp during her routine house hold visits
- ATH agents will send SMS to all registered MAWRAs/Support groups/ACHP team and CHW

On Health camp Day

- The Service provider (MSU team) will keep the one copy referral slip in drop box after providing service
- ACHP team will collected these referral slips on monthly basis and maintain record on excel sheet which will be used for data analysis.
- Service provider will register each client and will counsel her for FP/RH. (Depending on the number of clients and work load on that particular health camp day, service provider may ask the women to revisit family welfare center for any services like IUCD).
- Monitoring visits will be done jointly with PWD Head/District Office Staff.

Services provided:

- During a Health Camp day, the service provider will counsel clients for antenatal care, prenatal care, FP, PAC, and minor ailments as per client's RH need.
- The service provider/In charge of facility will provide FP and PAC services as per clients need
- Immediate feedback on performance and quality will be provided by the QI Team.

Reporting:

Data collection for all of the activities on Health camp day will be collected in a pre-designed tool and procedures. Data collected at all levels will be entered, compiled, analyzed and presented into simple indicators and results will be shared with stakeholders to keep them apprised, motivated and involved in this activity. The findings and action planning will be shared with PWD.

Follow up:
CHWs will meet with referred women to get feedback regarding services provided at FWCs to suggest any improvement in service provision.

HEALTH CAMP Planner (Pilot)
Sept.2015

s#	Stations	Total # of camps in pilot period	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	13	21	22	23	24	25	26	13	28	29	30
1	Station 1	9	x		x					x		x					x		x					x		x					x	
2	Station 2	9		x		x					x		x					x		x					x		x					x
3	Station 3	8			x		x					x		x					x		x					x		x				
4	Station 4	5	x							x							x							x							x	
5	Station 5	5		x							x							x							x							x
6	Station 6	4							x							x						x							x			
7	Station 7	8					x		x					x		x					x	x					x		x			
8	Station 8	5	x							x							x							x							x	
9	Station 9	4				x							x							x							x					
10	Station 10	5		x							x							x							x							x
	Total Camps	**62**	**3**	**3**	**2**	**2**	**2**		**2**	**3**	**3**	**2**	**2**	**2**		**2**	**3**	**3**	**2**	**2**	**2**		**2**	**3**	**3**	**2**	**2**	**2**		**2**	**3**	**3**

HEALTH CAMP Planner (Pilot)
Oct.2015

s#	Stations	Total # of camps in pilot period	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1	Station 1	9	x		x					x		x					x		x					x		x					x	
2	Station 2	9		x				x			x				x			x				x			x				x				x
3	Station 3	8			x		x					x		x					x		x					x		x				
4	Station 4	5	x							x							x							x							x	
5	Station 5	5		x							x							x							x							x
6	Station 6	4							x							x							x							x		
7	Station 7	8					x		x					x		x					x		x					x		x		
8	Station 8	5	x							x							x							x							x	
9	Station 9	4						x							x							x							x			
10	Station 10	5		x							x							x							x							x
	Total Camps	**62**	**3**	**3**	**2**		**2**	**2**	**2**	**3**	**3**	**2**		**2**	**2**	**2**	**3**	**3**	**2**		**2**		**2**	**3**	**3**	**2**	**2**	**2**		**2**	**3**	**3**

Annex IX: *Family Health Day*

The activity has been adopted from the Pathfinder's "model for change" implemented in District Kasur - Punjab for Jhpiego's Sukh Initiative

Family Health Day (FHD) is a dedicated day held once every week at the Family Welfare Center by Family Welfare Workers for provision of quality FP/RH services especially long acting contraceptives (IUCD).

The main objective of Family Health Day:

- Increase soft image of Family Welfare Centers
- Provide access to quality FP services
- Promote and focus on long acting FP
- Enhance coordination in between Population Welfare and Health Department
- Bridge the community and FWC staff through LHW program
- Support Family Welfare Workers and assess their skills, knowledge, and adherence to required procedures and standards

Family Health Day protocol:

- Dedicated day of the week which is convenient for the FWC will be reserved for IUCD (Implant and BTL referrals on RHS-A only) in coordination with the DPWO and TPWO.
- Family Health Days will be linked with national and routine immunization days.

Frequency of FHD:
This activity is scheduled after July 2015 and onwards

40 FP Clinics	4 FHDs in a Month	40 * 4 = 160 FHDs in a Month

Develop referral slip booklets for LHWs/FWAs. The referral token/slip has three types of slips:

- Community Health worker (CHW)/Lady health Worker(LHW) will fill the Clients information, like name, cell #, address, CNIC # on all three slips
- Slip 1: CHW/LHW will fill the slip completely (e.g. particular information about services)
- Slip 2: Service provider will fill the rest of sections on slip 2 and 3 after providing services
- Service provider will put slip 2 in drop box for record (for Jhpiego and ACHP)
- Slip 3: Service provider will hand over slip 3 to client and CHW/LHW will collect this slip from client

Before Organizing Family Health Day:

- TPWO in consultation with DPWO (District population welfare Officer), and EDO-Health (Executive district officer-Health) prepared the schedule of FHDs for each FWC/MSU/RHS in the district.
- Prior to the FHD, FWA (female) from the respective FWC teamed up with LHWs of her catchment area and visit individual households. Referral slips will be distributed, having details of the FHD which includes time, date, venue and name and number of the FWW(Family Welfare worker) at that FWC
- ACHP will do the similar activity in areas not covered by LHWs/FWA
- FWA (female), LHWs and ACHP will prepares list of all the Referral through referral slips given for that particular FHD and submit it to DPWO, which will later be used for data analysis.
- LHWs along with FWAs to increase clientele at FWCs: Each LHW/FWA was advised to refer at least 4 IUCD, 3 postpartum (only for MCH) and 3 implant (Only for RHS-A centers) cases on FHD.
- ATH (Aman Tele Health) will install tele booth in zone A Family Welfare Clinic

Distribute IEC materials on Family Health Day, HTSP, PAC and other FP.

Target group for FHD:
Newly-wed women, pregnant women, women with one or more children, and women in need of birth spacing

Dissemination/communication of Family Health Day

FWW/FWA/ACHP support group formed at DPWO level:

- Submit monthly schedule for FHD to TPWO(Town Population Welfare Officer)
- Plan meeting with LHS (Lady Health supervisor) monthly and circulate a polite reminder for referral of clients (two days before each FHD)
- Conducted meeting with FWC staff for necessary arrangements and distribution of roles/responsibilities before one day of each FHD
- Discussed with FWC friends (Committee formed by FWW) about schedule, support and presence on FHD

Resources and equipment:

- Checked and ensured enough quantity/stock of contraceptives
- Checked and ensured necessary equipment and instrument for IUCD insertion in enough quantity and in working order
- Checked and ensured infection prevention material in enough quantity and equipment in working order
- Checked and ensured working condition of sterilizer and availability of alternative sterilization facilities

Marketing and promotion of FHD:

- A permanent banner was fixed at visible place of FWC with information for FHD
- FWA (female) informed the community about FHD during her routine visits
- Male mobilizer informed the community about FHD during his routine visits
- ATH agents will send SMS to all registered MAWRAs/Support groups/ACHP team and CHW

On Family Health Day

- The Service provider/In-charge facility will keep the one copy referral slip in drop box after providing service
- Jhpiego's team will collected these referral tokens on monthly basis and compared from the list of invitees to identify those women who missed being there.
- FWW registered each client and will counsel her for FP/RH. (Depending on the number of clients and work load on that particular FHD, FWWs may ask the women to revisit FWC for any services like IUCD).
- District Project Coordinating Team also coordinated to provide the services of Family Health Mobile Unit (MSU) at these FHD.
- Monitoring visits will be done jointly with PWD Head/District Office Staff

Services provided:

- During a Family Health Day, the Family Welfare Worker counseled clients for antenatal care, prenatal care, FP, PAC, and minor ailments as per client's RH need.
- The service provider/In charge of facility will provide FP and PAC services as per clients need
- Immediate feedback on performance and quality will be provided by the QI Team.

Reporting:
Data collection for all of the activities on the Health day will be collected in a pre-designed tool and procedures. Data collected at all levels will be entered, compiled, analyzed and presented into simple indicators and results will be shared with stakeholders to keep them apprised, motivated and involved in this activity. The findings and action planning will be shared with PWD and DOH.

Follow up: LHWs and FWAs will meet with referred women to get feedback regarding services provided at FWCs to suggest any improvement in service provision.

Annex X: *Clinic Pre-selection Criteria*

CMW HOUSE/DHANAK HEALTH CARE CENTER – URBAN

- Population of 10000 people in 5 km radius
- Low density of Family planning providers
- Free product/services not commonly available
- Trained/certified practitioners available
- Agreement by sales team about sales potential of the area
- Provider willing to commit for long term (2-3 years) and buy reasonable stock
- Has good standing in community and is assisting in a minimum 2 births a month
- Willing to undertake trainings periodically
- Willing to provide service utility and product uptake data
- Area should be feasible for various community mobilization and marketing activities.

DHANAK PLUS HEALTH CARE CENTERS – URBAN CENTERS

- Certified Doctor male or female providing GP care or specialist care but not family planning OR
- Certified LHV or Nurse providing delivery services and other family health care but not actively promoting family planning and modern contraceptives.
- Private sector provider
- Population of 10000 people in 5 km radius
- Low density of Family planning providers in the immediate vicinity
- Reasonable clientele of 10-15 patients daily
- Owns premises or has long term lease arrangement
- Has space in existing set up or area to build an attached room
- Is willing to allow CMW/LHV to be added to structure and promote family planning and modern contraceptive use.
- Is happy to receive and make cross referrals
- Will assist CMW/LHV by providing assistive consultancy
- Will agree to undertake training periodically
- Will commit to continuing with the FP initiative for 2-3 years minimum
- Willing to provide service utility and product uptake data
- Willing to buy a reasonable amount of product on monthly basis
- Must be agreed by DKT sales team after reviewing area sales potential
- Area should be feasible for various community mobilization and marketing activities.

SILVER LINE CLINICS – URBAN CENTERS

- Small medical centers run by GP or LHV's providing medical services
- Premises must be owned by practitioner(s)
- Population of 10000 people in 5 km radius
- Private sector provider
- Low density of Family planning providers in the area
- Providing delivery services if possible and willing to add family planning and MVA services
- Owns premises or has long term lease arrangement
- Has space in existing set up or area to build an attached room
- Is willing to allow CMW/LHV to be added to structure and promote family planning and modern contraceptive use.
- Is happy to receive and make cross referrals
- Will assist CMW/LHV by providing assistive consultancy
- Will agree to sign a 2-3year services agreement
- Willing to buy a reasonable amount of product on monthly basis
- Must be agreed by DKT sales team after reviewing area sales potential
- Area should be feasible for various community mobilization and marketing activities.

"Sukh Initiative is a multi-donor funded, family planning and reproductive health project, primed by Aman Healthcare Services; implemented through a consortium of local and international organizations, in a selected one million underserved peri-urban population of Karachi, Sindh; with an aim to increase modern contraceptive prevalence rate by 15% points"

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