Pakistan (2010): Understanding Dr Imrana (SabzSitara Provider)

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PSI's Four Pillars
Bottom Line Health Impact * Private Sector Speed and Efficiency * Decentralization, Innovation, and Entrepreneurship * Long-term Commitment to the People We Serve
**Background of the Study**

1. **Background of Health Problem**

Pakistan's population in 2007 was around 170 million and population growth rate was approximately 1.9% per annum (Government of Pakistan-2007). Forty-one percent of its population is below 15 years of age. About two-third of the population is rural. Women of reproductive age constitute about 15% of the total population. Marriage is universal and the fertility rate is high. About 3 million persons are added each year. The rapid increase in the population has jeopardized economic gains; in spite of a 327-fold increase in the national GDP between 1960 and 2006, the per capita income has increased only 9-fold (PDHS-2006-07). The rapid increase in population is adversely affecting the country's health indicators. Maternal mortality rate (MMR) is 279 per 100,000 and neonatal mortality rate is 54 per 1000 live births (PDHS-2006-07).

The population policy of Pakistan seeks to promote family planning. Different stakeholders in public, private and non-government sectors are working to promote family planning (FP) and cater to the reproductive health needs of the population. Knowledge of family planning is almost universal and approximately 96% of married women of reproductive age (MWRA) know at least one FP method. The decrease in the population growth rate from 3.7% in 1960 to 1.9% in 2007 provides evidence of the translation of FP knowledge into action.

Total demand for family planning in Pakistan comprises of 55% of MWRA and current use of contraceptives among MWRA in Pakistan is around 30% (modern method: 22%, traditional method: 8%), resulting in an unmet need of about 25% (PDHS-2006-07). Inconsistency in contraceptive use is significant as 39% (current use of modern method is 22%) of MWRA have ever used a modern method at some time in the past. Among modern methods, the condom is the most common ever used method and has been used by 17% of MWRA (PDHS-2006-07).

2. **Program Description and Objectives**

In 1995, Social Marketing Pakistan (SMP) and Population Services International (PSI) began the Green Star Clinic Project with funding from the Government of Germany via Kfw. In 2003, the organization's registered name was changed to Greenstar Social Marketing Pakistan Ltd. Greenstar Social Marketing (GSM) provides family planning (FP) products and services through its network of 7,000 private sector health service providers, located in approximately 107 districts of Pakistan. These providers have received training in IUD insertion, family planning (FP), counseling, antenatal, postnatal and delivery care. For the purposes of management, districts in which GSM operates are divided into 30 zones in four regions (South, Central, West, North).

Analysis of Couple Years of Protection (CYPs) provided through the sales of contraceptives at the zonal level shows considerable variation in performance. The performance of individual health service providers has been further measured by the Research Department of Greenstar Social Marketing and a criterion for High Performing Health Service Providers was developed by the Department. All those Health Service Performers who reported the daily volume of family planning clients, daily volume of total clients and the number of IUDs inserted in the last month above the median, are classified as High Performers.

The purpose of this study would be to assess factors contributing to high versus low zonal performance and to investigate the reasons for the varying levels of performance among health service providers. This would be achieved through an in-depth study of Health Service
Providers, the various challenges they face, their beliefs and their relationship with/understanding of their clients.

3. Research Findings

This research is part of a triad qualitative research series being conducted by the Research Department to investigate the utilization of family planning products. Research is being conducted on the three main players involved in the process of decision making regarding family planning (in the local context): The husband, the wife and the health service provider. A study on the factors motivating and influencing the husband has already been conducted. This study was titled “Ali the Intender” and will be used to support and compliment this second study on the behavior and motivation of the health service provider.

Further to this, earlier on-going quantitative studies conducted on performance level of health service providers, will also be used as reference for this study and to compliment the qualitative findings.

4. Study Rationale

Dr. Imrana, a typical health service provider, has a key role to play in influencing the behavior of FP clients yet very little is known about her. She can play a pivotal role in not only persuading the clients for FP adoption but can also convince them for a specific method as well. For the same rationale it is important to know more about her in terms of her motivators, barriers, values and beliefs towards her clients, her role as a provider, FP in general, the SabzSitara franchise and Greenstar.

Even the recent study of “Ali the Intender” points to the fact that Ali’s decision for condom use (or any other FP method), to an extent, depends upon useful counseling from a male health professional and/or LHWs. Therefore if we are able to influence the behavior of the provider and motivate her for increased FP counseling then this can have a trickledown effect. In turn this can increase the overall pie of method mix. For all this to materialize it’s important to know more about Dr. Imrana.

Currently Dr. Imrana is a medical practitioner, either a Doctor or a LHV (Lady Health Visitor, trained by a government program). As per research department findings, approximately 40% of Health Service Providers are MBBS or Postgraduates, while the remaining are LHWs or have other qualifications. Dr. Imrana operates a clinic, which also serves as a small business enterprise and source of revenue. She is simultaneously coping with many pressures, as a professional/entrepreneur and in her personal life, as a wife, mother and daughter. Dr. Imrana is also Greenstar’s primary point of contact with low-income MWRAs.

The purpose if this study is to assess what Dr. Imrana’s views are about family planning, her understanding of her clients, how (and if) she advocates family planning to her clients given the social and religious pressures involved and how she negotiates the various pressures she is faced with. The findings from the study, and the in-depth understanding gained of Dr. Imrana, would be used to reach clients and influence client behavior. We would use the study to understand how to best provide Dr. Imrana support in reaching her and our goals – i.e. increasing utilization of family planning products.

5. Research Objectives

The objective of the study is to provide an insight into Dr. Imrana to help us to influence her behavior towards increasing adoption of FP among her clients. The study will also provide an insight into the factors, personality traits, environmental challenges etc. that influence the
performance of individual health service providers. Specifically, the study objectives are to explore the following:

a. Identify ‘beliefs to reinforce’ and ‘beliefs to change’ in the following areas, that might influence Dr Imrana’s delivery of quality FP counseling and promotion of all methods particularly long-term methods [IUD] including:
   i. Her role as a provider/member of network
   ii. Her clients
   iii. FP in general
   iv. SabzSitara franchise
   v. Greenstar

b. Identify one or more character archetypes

c. Describe the level of knowledge and sophistication with which target audience members approach FP counseling, if possible, through gauging the providers reaction to a series of scenarios.

d. Understand Dr Imrana’s clinic and day-to-day experience as a provider

e. Understand how Dr Imrana can be motivated to persuade clients to adopt FP

f. Understand current brand associations [where the study objective is a behavior, this will usually be the associations target audience members make regarding the type of person who practices/doesn’t practice the desired behavior]

The research will explore the following areas:

**Archetype:**

a. What are Dr Imrana’s likes/dislikes, motivations/values in life, aspirations and goals?

b. How old is she?

c. What are her family size and structure, SEC background, education/qualification?

d. What led her to this work? What motivated her to become a provider? When did she qualify? What is her level of expertise (related to the field)? Did her expectations of the role meet with the reality?

e. How long has she had the clinic?

f. What is her daily income, profit, costs associated with running the clinic?

g. What is her typical daily routine, clinic activities, timings?

h. What are her religious views?

i. What does she do outside of work? Who are her friends?

j. Does she have a professional support network? Who does she seek professional support from? Who influences the decisions she has made in her career? Does she have a professional mentor?

k. What are her aspirations for the future of her clinic/career?
Understanding Dr Imrana's clinic and her experiences as a provider running a clinic:

a. Who are her clients/patients? What is their profile (including SEC)?
b. What is the nature of client queries? Frequency of each query in a day?
c. How many clients visit in a day? What proportion of clients are FP related in a day?
d. Do the clients typically come alone or with spouse? How do her clients make decision about FP?
e. What are Dr Imrana’s ‘good’ and ‘bad’ experiences with her clients?
f. What methods do her clients prefer?
g. What facilities and staff does her clinic have?
h. How much money does she charge for different FP methods?
i. Does she buy FP products and dispense from the clinic? If not, where do her clients source their FP methods from?
j. What methods does she most commonly recommend?
k. What role does she play in convincing the clients for FP adoption (clients seek FP advice or she plays active role in persuading her)?
l. What are her experiences of selling FP products to clients? Does she find it hard to sell FP methods to clients?
m. How does she persuade clients (strategies that she use)?

Understanding Dr Imrana's values as a provider:

a. How does she define ‘success’ for her clinic and how does she evaluate it?
b. What does she believe are the key steps to running a successful clinic? What advice would she give to other providers?
c. What role does profit play in Dr Imrana's decision and approach to FP counseling?
d. What are some of the challenges she faces running a clinic? Are there any conflicts of interest she faces?
e. What does she enjoy about her role? Are there aspects of her role that she doesn’t enjoy? Is she satisfied in this role?
f. If she was given funds to improve her clinic what would she do?
g. What does she feel are the biggest health issues facing her clients?
h. When did she join the network? Why did she join? What were her motivations for joining? What factors influenced her decision to join? What did she hope to achieve from joining the network? Has the network lived up to her expectations?
i. How will she be motivated to persuade more clients to adopt FP? What support does she believe she needs?

Beliefs about FP:

a. What does Dr Imrana believe about FP (limiting and birth spacing)?
b. What are her religious and social beliefs as related to FP?
c. What are her beliefs about different FP methods?
d. Which method/s does she believe is/are better? Which method does she believe is most convenient and effective?
Beliefs about her Clients:

a. Who does Dr Imarana believe is a ‘good client’?
b. What does she believe are some of the common problems of FP clients?
c. What does Dr Imrana believe are her clients’ main barriers to FP/choice of method?
d. What are some of the factors Dr Imrana believes influence her clients decisions on FP/choice of method?
e. What does she believe can motivate a client to practice FP?
f. Which methods does she believe her clients prefer the most and why?
g. What does she believe her clients think about each of the methods?
h. What does she believe her clients think about service charges and prices of different FP methods?

Beliefs about SabzSitara franchise and Greenstar:

a. How does Dr Imrana describe the SabzSitara franchise? What does it mean to her?
b. What does she believe is different about her clinic as a result of belonging to the GS network?
c. What does she believe are the main benefits of being a member?
d. What does she believe should change? What does she believe would improve the network/being a member of the network?
e. Does she believe that the franchise has helped in increasing ‘success’ of her clinic?
f. Does she believe that there is any social stigma in associating with the SabzSitara franchise?
g. What role does she believe GS can play in increasing the adoption of FP methods amongst the target groups?
h. What does she think about the quality of Greenstar FP products? How does she define quality?
i. What does she believe her clients think about the quality of FP products by GS? How does she think her clients define quality? What does she believe are the dimensions of quality that are important to her clients?
j. What does she believe her clients think about SabzSitara franchise and Greenstar products? What does she believe it means to her clients?

Study Methodology

1. Study Approach

Between October 2010 and January 2011 Greenstar and PSI Pakistan will conduct a FoQus study to gather information in the above mentioned areas. In-depth interviews will be used to collect data. Only one interview will be conducted with each provider due to resources and a belief that there will be minimal benefits to conducting more than one interview with this target group. It is felt that the providers will be able to articulate their views in one sitting.

It is proposed that the interview will combine structured sections with narrative/ conversational sections. Photo captured by the interviewers, which will be representative of clinic culture and community of a provider.
Trained Interviewers will be used in this study. These interviewers have experience in quickly establishing rapport with and obtaining the confidence of respondents and are well-suited, in terms of socio-demographics, to interview this target group. These trained interviewers are well aware of tools and techniques of in-depth interviewing and are more likely to manage the interview and obtain rich data. The interviewers will be both male and female. Two teams of interviewers will be selected from Karachi and Lahore. Each of the teams will consist of two females and one male. Given the significance of timely interviews and the current security/logistic situation, the inclusion of a male interviewer is important to ensure balance as well as to manage the logistics of the study. One interviewer, who is female and older/senior, will be appointed as the supervisor.

These interviewers will be based in Karachi (in Sindh) and Lahore (in Punjab), from where they will be able to easily access the Health Service Providers in rural/urban areas of Sindh and Punjab. Our sample health service providers are located in Lahore, Faisalabad, Sargodha, Hyderabad, Shikarpur and Thatta.

2. Study Sample

This study will be conducted among SabzSitara providers aged 35 to 70 in rural and urban areas of Sindh and Punjab. The qualitative study focus on the following target group of female health service providers:

- Female SabzSitara providers in rural areas
- Female SabzSitara providers in urban areas (clinics situated in lower-middle income vicinities only).

3. Sampling Strategy

In total 48 female respondents will be included in the study. The sample will have the following characteristics:

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<thead>
<tr>
<th></th>
<th>High performers</th>
<th>Low performers</th>
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<tbody>
<tr>
<td></td>
<td>Punjab</td>
<td>Sindh</td>
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<tr>
<td>Urban</td>
<td>Doctor 3</td>
<td>3</td>
</tr>
<tr>
<td>Rural</td>
<td>LHW 3</td>
<td>3</td>
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<td></td>
<td>Total 24</td>
<td>24</td>
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</table>

Study participants must be members of the SabzSitara network in the above areas. They will be randomly selected from a clinic information survey conducted by Greenstar’s Research Department in coordination with Zonal/Regional offices. All potential respondents will be contacted; they will give their consent and assign a place for interview. Due to religious and cultural factors, doctors providing Gynecological, obstetrician and maternal health services in low-income, low-literacy areas, tend to be largely women. Doctors in the Sabzsitara network are also mostly female and our sample consists of female doctors or LHVs.

Recruitment will be based on the criteria of high performance and low performance of providers in the sample area. A criterion for High Performing Health Service Providers was developed by Department. All those Health Service Performers who reported the daily volume of family planning clients, daily volume of total clients and the number of IUDs inserted in the last month above the median, are classified as High Performers.
<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
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<tr>
<td>Member of network</td>
<td>Does not meet inclusion criteria</td>
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<tr>
<td>Doctor of LHW</td>
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<tr>
<td>Male or female</td>
<td>Unwilling to be audiotaped</td>
</tr>
<tr>
<td>Living in Sindh or Punjab</td>
<td>Less than 18 years of age</td>
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<tr>
<td>Consent to participate</td>
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<tr>
<td>18+ years of age</td>
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**Data Collection**

1. **Training of Interviewers**  
The Regional Researcher and Qualitative Research Manager will deliver interviewer training for 4 days. The training will include ethics training.

2. **Interview Procedure**  
Location of interview: The interviews will take place in the providers’ place of work.

   Language(s): The interviews will take place in the provincial language or in Urdu, depending on which language the participant chooses. Data will be translated into English for analysis.

   Recording: Interviews will be recorded on digital recorders and these recordings uploaded to pc while in the field to minimize the chance of data loss. Recordings will be erased as soon as analysis is complete.

   Supervision: The qualitative research officer will provide overall supervision of the study. All 6 moderators will report to the qualitative research officer, who will be assisted by the supervisor. The qualitative research officer will make field visits with each moderator to ensure the quality of interview.

   Timeline: Data collection will be conducted over 4 weeks simultaneously in Sindh and Punjab provinces. This schedule allows time to recruit and meet with each participant and ensures that no more than two interviews in any one-day per interviewer will occur.

   These interviewers will be recruited in Karachi and Lahore and given training by the Greenstar qualitative research consultant, in addition to attending the interviewer training.

3. **Interview Guide**  
Development: The programme team, research team and members of the target population will be involved in the development of the guide as well as the FoQus Consultant and Regional Researcher.

   Topics: Archetype, Clinic information, Understanding Dr Imrana’s clinic and her experiences as a provider, Dr Imrana’s beliefs as a provider and about FP, Beliefs about her clients, SabzSitara franchise and Greenstar.

   Translation: The guide will be translated into Urdu and local languages.

   Pretesting: The guide will be pre-tested with the providers who consent to participate in the pre-test during the training process.
4. Narrative Component
The narrative component of the interview will be used to establish rapport with the provider and to generate a rich understanding of their professional experiences, beliefs, values and motivations as a provider. Narrative interviewing will focus on their typical day, types of clients, typical FP session with client, the advice they give to clients etc.

The interview will start with a questions on the health service providers background and then factual information about the clinic. This will be followed by the narrative component with a focus on their general role and experiences as a provider. Questions about their values as a provider, beliefs about FP, knowledge of clients and their thoughts about the network/Greenstar will follow.

5. Use of Photographs
Photographs will be taken with consent from providers. The standard photo-narrative approach will not be used for this study. Interviewers (with consent from the respondent) will take pictures with the respondent to document key areas of interest such as the milieu of the clinic; the local community covered by the health worker; their favourite and least favourite aspects/parts of the clinic and what they think are the best/worst aspects of the clinic for their clients.

Data Analysis

1. Transcription
Transcribers will be recruited to transcribe sections of the interviews into the original language and then translate into English. There will be 5-8 trained transcribers working on this study. Transcription will be started as the first interview is conducted and will run parallel to data collection. All interviews will be transcribed into English electronic copy.

Some sections of the interviews will not require transcribing as responses from the questionnaire or structured sections of the discussion can be entered directly into an excel spreadsheet. The qualitative research officer will be responsible for transferring these sections of the discussion. The summary text can be translated straight into English.

2. Coding
In this study codes will be used to sort the data with additional codes being added as needed to capture nuance. Some of the codes will be based upon components of the core FoQus code frame. The final codeframe will be developed over the next four weeks. For some of the codes emergent themes will be identified within the codes. Once coded by hand, electronic chunks of code will be stored in an Excel spreadsheet. The research team will verify their coding scheme with the regional researcher and modify coding as necessary.

The coding burden will be reduced by the fact that certain sections of the interview will have been summarized and entered in an excel summary sheet.

3. Data Interpretation Session
Duration: 3 - 5 days will be spent preparing for the session. The session will last for 2 - 3 days.

Participants: The Regional Researcher will lead the session with support from the Qualitative Research Manager. Programmers/marketers and researchers will attend the session.

Format: .
Portions of transcript text will be presented in a manner that allows session participants to code and analyze them in small groups. The coded data will be posted on the walls so that session participants can “shop” and compare different sub-groups of the target audience.

On day two, the team will identify themes and complete the dashboard instrument. One or more archetypes based on the photonarratives and study transcripts will be created.

4. Outputs
The outputs from the study will be a dashboard document, a category map, photo-narratives that describe the key character archetypes and a short summary report of key findings.

Human Subjects Ethical Consideration

This study has been determined to be “research” and will be initiated only after receiving written approval or written exemption from the PSI Research Ethics Board. Those implementing this study will comply with all policies and procedures of the PSI Research Ethics Board. There is no local IRB in study areas.

This study methodology has been designed to address the following ethical principles: respect for persons, beneficence and justice. Efforts are made to protect individual autonomy, minimize harm and maximize benefits and equitably distribute risks and benefits by using procedures which are consistent with sound research designs that take these issues into consideration. This study will not pose the physical risks associated with a physical procedure or intervention, such as obtaining tissue or blood samples.

Respect for persons and individual autonomy:

What are the major risks and concerns associated with participation in this study?

• Inconvenience when a survey is administered at an inconvenient time or place or simply takes too long to administer.
• Financial risk due to working time lost while completing the interview.

The most significant risk is a breach of confidentiality. The following risks are associated with a potential breach of confidentiality:

• Social risk due to stigma or other negative social outcomes of breach of confidentiality.
• Financial risk if revelations result in loss of employment or insurance coverage.

Ethical Risks for Data Collected

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<tr>
<th>Potential Risks</th>
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| Photographs of Places | Social Risks: There is risk that owners/employers of a place could experience social stigma or other negative social outcomes if the photographed place is associated with poor performance.  
Economic Risks: There is minimal risk that businesses could suffer loss of income if the photographed place is associated with poor performance.  
Legal risk: No risk |
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<tbody>
<tr>
<td>Photographs of Objects</td>
<td>There are no identified risks with taking pictures of objects.</td>
</tr>
</tbody>
</table>
| Photographs of People | Social Risks: Respondents and/or non-research participants in a photograph (photographic subjects) could experience social stigma or other negative social outcomes if he/she were identified as a poor quality provider.  
Physical Risks: No risk  
Economic Risks: There is risk that a photographic subject could lose customers because she has been identified as a poor performer.  
Legal Risk: No risk |

**Strategies to Address Risks**

Steps will be taken to protect participants against potential risks posed by their participation in this research. Participants will be encouraged to contact Sohail Agha any time to discuss any concerns they might have. All data and other information will be maintained confidentially and anonymous to the greatest extent possible. The following steps will be taken to protect against risks.

*What methods will be used to protect the privacy of subjects and to maintain the confidentiality of data?*

**Breaches of Confidentiality**

Staff ethical training. All research staff including the interviewers and supervisors will be carefully trained in human subjects protection, especially the importance of protecting privacy and confidentiality.

No personal identifying information will be collected during this study, i.e. name or initials, address, birth date (although age is acceptable), etc.

The list of identification numbers and respondents’ names and contact information (used for recruitment provided by Greenstar colleagues) will be stored separately from the data. This list of identifiers will be destroyed immediately after all data have been collected from the research participants.

Photographs will be taken by the subjects and researchers with permission from subjects; these photographs will be kept in secure are separate from the interview data.

Where photographs are taken (only with permission of the subject) faces and information that identifies the clinic will be disguised for the interpretation workshop and names/labels of locations will not be displayed/attached to the photos. Photographs will be destroyed on completion of the research. In the event of a an interpretation workshop participant recognizing a clinic participants in that session will be reminded of the need to maintain confidentiality and if someone recognizes something or thinks he/she can identify someone, those thoughts must stay in the room and remain confidential.
Signed written consent forms will be stored separately from the data. Participants will not be identifiable via the transcripts. Quotations used in reports will not be attributed to the participants using the participants’ names. Instead, speakers will be identified with broad demographic characteristics.

Participants’ rights. Research participants will be informed of all risks and protections in the written consent form. Participants will also be informed of their right to withdraw from the study and to not answer any questions they do not feel comfortable answering. Respondents will be provided contact information for a PSI employee who will be available to answer any questions about the study.

Data reporting. All data based on this research will be reported in aggregate form. No individual respondents will be identified.

Place of data collection. Interviews will take place in a private location within the providers place of work or other location specified by the provider.

Data collection and management supervision. The research manager/advisor will periodically review the data collection to ensure that no information is included that could identify the participant or others (i.e. linkage between photo and response, etc.). Field supervisors will be on site to monitor data collection to ensure that appropriate interview methodologies are being applied. Supervisors will silently observe interviews and will stop any interview in which questions are not being asked appropriately, and/or there is evident discomfort on the part of the respondent or privacy is insufficient.

The recruitment list with names and contact information for respondents will be stored separately from the data during data collection and will be destroyed on completion of data collection. Interview data will then only be identified using identifier codes. Consent forms will also be stored in a separate location to the audio recording. As soon as an interview is completed the audio recording will be sent to the transcribing company. The consent forms will be returned to the Greenstar research team. This process means that data and identifying information will not be in the same location at the same time. When the data is in the same location as the consent forms there will be no identifying information on the transcripts or audiotapes.

Inconvenience
Include logistical data collection strategies to decrease any inconvenience to the respondent, e.g., times and location of data collection; provision of transportation to the data collection site.

How will you obtain informed consent/assent? No subjects will be interviewed without their informed consent.

Prospective subjects will be read the attached statement which:
• Explains that they are being asked to participate in research
• Explains the purpose of this research and the number of subjects involved
• Clarifies the expected duration of the subject’s participation and the procedure to be followed
• Explains how the research will benefit the target groups and/or the participant, or society as a whole
• Describes potential risks if any are anticipated or explains that there are no known risks
• Explains that there will be no costs for participating
• Describes compensation for participating
• Clarifies that the subject’s participation is anonymous and that individual responses will be not be linked to identifying information
• States that the subject’s participation is voluntary and that refusal to participate will have no consequences
• States that some questions may cause discomfort and that subjects may refuse to answer individual questions or desist from the interview at any time
• Provides the name and telephone number of a PSI staff member who the subject may contact with any pertinent questions about the research, about the health topics discussed, or to whom the subject may issue a complaint.
• Explains how subjects provide verbal or written consent/assent

The only record linking the subject and the research will be the consent document and the principal risk will be potential harm resulting from a breach of confidentiality.

**Informed Consent/Assent Procedures**
A written consent/assent process will be used. To decrease risk of breach of confidentiality, all signed consent/assent forms will be kept separate from the data. The consent forms will be stored in a locked cabinet and only PSI researchers on the current study will have access to these signed forms. The participant will be given a copy of the consent/assent form to read. If unable to read, the entire consent/assent form will be read to him/her by the interviewer. After the consent/assent form has been read, the participant will be given time to ask questions. Both the participant and the interviewer will sign the consent/assent form. Participants unable to sign for themselves will make a mark on the form. The name of the respondent will be printed below the mark, and a witness to the consent/assent procedures will also sign the form. A copy of the consent/assent form will be given to the participant to keep.

**Compensation:**
Compensation will be provided to participants as interviews will take part during the providers working day or in their free time after clinic hours. This may cause a minimal level of inconvenience to these busy professionals so a token of thanks will be provided in the form of a small compensation gift. It is likely that the gift will be nutritional packets for babies and young children informed by feedback from franchise officers who are often asked for these products.

2. **Beneficence (Maximizing Benefits and Minimizing Harm)**

**Benefits of the Study**
There is unlikely to be any benefit to participants themselves; however, knowledge gained about providers will be directly used to inform future interventions with providers to improve FP service provision. Because this will improve future interventions, the potential benefits to society as a whole outweigh the risks.

**Risk and Benefit Ratio**
The proposed study will result in knowledge which will be applied to the design and implementation of interventions with providers to improve FP counseling and thus improve FP decision-making amongst clients. The potential benefits of this intervention for the larger target audience outweigh the risks to the individual participants in this research study.

3. **Justice (Equitable Distribution of Research Benefits and Risks)**
**Sampling Strategy and Recruitment**

**Justice (equitable distribution of research benefits and risks):**

As described in the sampling section above, an equal number of Doctors and Lady Health Workers will be selected randomly from within the two categories of providers (high and low performers) and across the relevant sub-groups to ensure that participation is equitable. All relevant subgroups (location, urban/rural etc.) for whom results are expected to vary will have the opportunity to participate.

In total 48 respondents will be recruited across Sindh and Punjab.

Study participants will be members of the SabzSitara network in the above areas. They will be randomly selected from a clinic information survey conducted by Greenstar's Research Department in coordination with Zonal/Regional offices. Providers be selected by the Research Department and then approached by telephone by the interviewer in advance of the interview. Informed consent will be obtained from all participants prior to the interview commencing.

**Provision of study results**

When it is feasible the results of this study will be made available to participants upon request from Greenstar.
### Appendix A– Timeline for Study

<table>
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<tr>
<th>Activity</th>
<th>Dates</th>
<th>Person responsible</th>
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<tbody>
<tr>
<td>Prepare study design</td>
<td>To be completed by 17th November</td>
<td>Esther &amp; Greenstar/PSI Research Team</td>
</tr>
<tr>
<td>Submit to REB</td>
<td>17th November</td>
<td>Esther Saville</td>
</tr>
<tr>
<td>Identify interviewers</td>
<td>To be completed by 11th November</td>
<td>Sitwat Hasan</td>
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<tr>
<td>Train interviewers</td>
<td>22nd – 26th November</td>
<td>Esther Saville/Sitwat Hasan/Ambreen Saleh</td>
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<td>Data collection</td>
<td>1st December – End of December</td>
<td>Sitwat Hasan/Ambreen Saleh</td>
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<td>Transcription and translation</td>
<td>To be completed by 20th January</td>
<td>Sitwat Hasan/Ambreen Saleh</td>
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<td>Finalizing FoQus codeframe meeting</td>
<td>14th December</td>
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<td>Complete FoQus coding</td>
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<tr>
<td>Thematic coding to be completed</td>
<td>11th February</td>
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| Coding data, preliminary data analysis, and creation of typical narratives | January - February | Esther Saville
| Preparation for interpretation session       | w/c 28th February – 4th March | Esther Saville
| Interpretation Session                       | 7th & 8th March               | Esther Saville
| Finalize dashboard and session documents     | By 18th March                 | Esther Saville                           |
Appendix B–Discussion Guide for One-on-one Interviews

Dr Imrana-The Health Provider

SECTION 1: Introduction to the Health Service Provider

First, we’d like to understand a little bit about your life outside of the clinic so I’m going to ask a few questions about your family, home, career and attitudes.

1. Can you describe your family? What is your family size and structure? What is your role in your family? Who works in your family? Who makes decisions about how money is spent? What proportion of the family income do you contribute?
2. If there was one thing you could change to improve the quality of your life what would it be?
3. Can you describe how you came to be a doctor/LHV? What factors led to you becoming a FP provider…can you tell me how it happened? [Make sure you capture their education/qualifications/training] When did you qualify? How many years have you been in this profession? Can you describe your progression? Has anyone influenced the decisions you have made in your career? Can you tell me about them?
4. How did/do your expectations of the role meet with the reality? In what way did/do they differ? Can you give me an example?

SECTION 2: Clinic information

1. How long have you had the clinic?
2. When did your clinic break-even operationally (i.e. costs of operation are completely covered by revenues)?
3. If clinic prescribes FP methods, how much money do you charge for different FP methods?
4. Who do you seek professional support from? Can you tell me about this relationship? What type of support do you seek? Do you have a professional mentor?
5. Do you have a professional support network? If so, can you tell me about this network? Can you describe the types of support you receive from this network?
6. Can you tell me about any future plans you have for your clinic? Where would you like your clinic to be in 5 years time?
SECTION 3: Understanding Dr Imrana’s clinic and her experiences as a provider

Story Narrative Prompt:
Each profession has certain responsibilities and an importance and value in society. What you feel about being a Health Service Provider working in FP? What are the responsibilities of a FP health service provider? What does she/he contribute to society? What are some of the problems FP health service providers have to face? Please take a moment to think about these questions, and then talk for as long as you want.

1. How do you define ‘success’ for your clinic? Do you think your clinic is successful?
2. Thinking about a difficult day at the clinic – what are some of the problems you might encounter? Can you describe the challenges you face in running a clinic?
3. Can you tell me what would help you to improve your clinic?
4. Is there anything that would help you to run your business more efficiently?

SECTION 4: Understanding Dr Imrana’s beliefs as a provider

1. Can you describe a typical family planning client(s) attending your clinic? What is their profile/SEC? What is their life like? What kind of challenges do they face? What are their views on family planning? Their awareness levels and attitude towards the various contraception methods (probe specifically IUDs vis-à-vis other methods)? What kinds of experiences have they had with FP and methods? Who accompanies them, their decision-making process etc?
2. Can you describe a typical interaction you might have with an FP client? What would you ask them? What questions might they ask you? Can you describe the factors that would influence what methods you recommend to them?
3. What do you think are the most popular methods for your clients and why?
4. What methods do you most commonly recommend to clients and why?
5. Can you describe the responses you get from clients when you recommend FP? Can you describe some of the barriers clients face in terms of FP? How do you deal with their concerns? Is cost for the client a factor in your/their decision-making process? Can you explain...?
6. Can you describe some of the concerns they share with you relating to specific methods? How would you deal with concerns relating to these methods? What would you tell the client?
7. What FP method do you get the most dissatisfaction reported by clients? What are the reasons they provide?
**SECTION 5: Exploring Dr Imrana’s beliefs about IUDs**

1. Can you describe overall how you feel about IUD as a method of contraception? What do you think are the advantages of this method for your client group? How about the disadvantages?

2. Are there any other factors that we haven’t discussed that would discourage you from recommending an IUD as opposed to other methods?

3. Some of the other health professionals I have spoken to mentioned the difficulty of explaining about IUDs to their clients and that this can sometimes act as a major barrier towards recommending this method. What are your views on this issue? Have you had this experience? Can you tell me about the particular aspects you find more difficult to explain than others? Can you tell me about the kinds of issues or challenges faced/queries received while explaining this method to women/their family members or spouse? How do you handle these...what additional support do you think would be helpful in this regard? (Moderator to try and get some cues for stimuli development)

4. Some of the respondents who I’ve interviewed also mentioned the fear of a dissatisfied client adversely affecting their reputation as a major barrier towards recommending this method. What is your view on this? Do you also share this view? Have you had any bad experiences of dissatisfied IUD clients? Can you tell me about this? Probe for examples.

5. Are you always able to meet the potential demand for IUDs i.e. do you have time for insertions? Are there other providers that you refer IUD clients to?

6. If there was a recommended Sabzsitara clinic nearby that specialized in IUD insertions for you to refer to, would this make your job easier? Would this increase the number of IUD referrals you would make? Do you think a referral voucher system could work? Can you foresee any problems with this approach?

7. What do you think the Sabzsitara network can do to help providers in the network to increase the number of clients receiving IUDs?

8. How many IUDs do you think you’ve inserted in your career?

**SECTION 6: Beliefs about SabzSitara Franchise**

1. When did you join the Sabzsitara network? Can you tell me about when and why you decided to join? What factors influenced your decision to join? What did you hope to achieve from joining the network? What were the incentives to join? Has the network lived up to your expectations? If so/not, why? How is your practice different now to how it was before you joined?

2. Can you describe the level of interaction you have with the Sabzsitara network? When was the last time the network (i.e. employees of Greenstar) discussed or communicated sales/performance targets to you?

3. What do you believe are the main benefits of being a member of the network? Are there any negative aspects to being a member?

4. Do you believe that the franchise has helped in increasing the ‘success’ of your clinic?
5. How do you think clients regard the Sabzsitara clinics? (Probe for negative and positive perceptions)

**SECTION 5: Openings:**

1. Can you tell me about your main sources of information on FP and FP products/methods? This can be people or written materials etc.....probe for more information on where the materials come from, in what form etc
2. You receive a lot of information from a range of sources including pharmaceutical companies, Subzsitara network, other health professionals...what sources do you most value? What sources are you most likely to take notice of?
3. In your opinion, can you tell me about the best ways to influence health care providers to adopt a new approach? Probe each of the following if not already mentioned: Medical detailing, reminders i.e. merchandise/mugs, leveraging local opinion leaders, incentives, training, interactive learning, peers, point of sales information etc
4. In your opinion what sources of information/communication are least popular/effective with health service professionals?

Thank you so much for your time.