



COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

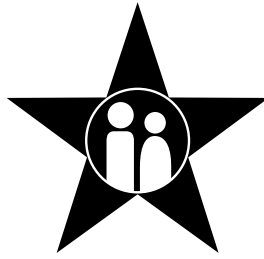
TECHNICAL PAPER SERIES

SOCIAL FRANCHISING AS A STRATEGY FOR EXPANDING ACCESS TO REPRODUCTIVE HEALTH SERVICES

A case study of the Green Star service delivery network in Pakistan

By Julie McBride, MPH, and Rehana Ahmed, MD
SEPTEMBER 2001





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This publication was prepared by the Commercial Market Strategies Project (CMS). It is intended to serve as a reference for donors, governments, and potential implementing agencies that wish to address some of the same needs as the Green Star program. Material from this publication may be reproduced provided CMS and the authors are acknowledged as the source. Opinions expressed in this report are those of the authors and do not necessarily reflect the views of the sponsoring agencies.

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Contributors

The Commercial Market Strategies Project

The Commercial Market Strategies (CMS) project is a recognized leader in private sector development for reproductive health and family planning. Funded through a five-year contract (1998–2003) with USAID, CMS works to increase access to and demand for reproductive health and family planning in developing countries through the private sector. The CMS project has worked in over 25 countries and has fully staffed program offices in over seven countries.

The CMS project is implemented by a consortium of organizations: Deloitte Touche Tohmatsu (prime contractor), Abt Associates, Meridian Group International and Population Services International.

CMS produced the Green Star case study to serve as a reference for donors, governments, researchers and potential implementing agencies.

Population Services International

Population Services International (PSI) develops and implements programs worldwide to empower low-income individuals and communities to lead healthier lives. A nonprofit group headquartered in Washington with projects in more than 50 countries on five continents, PSI is one of the world's leaders in social marketing.

Social Marketing Pakistan

Social Marketing Pakistan (SMP) is a Pakistan-based NGO established by PSI in 1991 at the request of USAID and the Government of Pakistan. SMP was designed to expand PSI's functional role in the project and to operate the franchise. SMP and PSI operate as a joint venture. PSI has a minority share on the SMP board and an important, though not decisive, voice in SMP strategic matters.

About the Authors

Julie McBride has been with PSI since 1995. She spent two-and-one-half years in Pakistan contributing to the development of the Green Star project, specifically by adding hormonal contraceptives to the product line. Since 1998, she has been based out of PSI's Washington, DC, headquarters, where she specializes in developing and marketing pharmaceutical products and health services for PSI programs worldwide. Ms McBride's professional background includes pharmaceutical marketing, sales, and advertising in the commercial sector. She received her Master's degree in Public Health from New York University in 1995.

Rehana Ahmed, MD, served as National Medical Coordinator of Social Marketing Pakistan (SMP) from 1995 to 2000, and as Director of Health and Training and a member of the SMP Board of Directors from 2000 to the present. Dr Ahmed has also held leadership positions with the Family Planning Association of Pakistan, lectured at the Aga Khan University in Pakistan, and practiced as an ObGyn in both England and Pakistan. She received her Bachelor's of Medicine and Surgery from Karachi University in 1967.

About the Green Star Case Study

This case study chronicles Social Marketing Pakistan's experience designing and implementing the Green Star Network as documented and interpreted by Population Services International (PSI). Social Marketing Pakistan (SMP) and PSI operate as a joint venture, with SMP functioning as a local affiliate.

As the Green Star Network is often cited as an example of a successful social franchise, the Commercial Market Strategies (CMS) project produced the case study to illustrate how this model can expand access to quality reproductive health products and services. CMS works to expand access through the private sector and often uses franchising and networking strategies to achieve this goal.

Preface

In 1996, Population Services International (PSI) and Social Marketing Pakistan (SMP), in conjunction with the Government of Pakistan, began implementing an innovative program to offer family planning services and a range of contraceptive products — including oral contraceptives, injectables, and IUDs — to low-income urban women. Pakistani women have, on average, more than five children. This high fertility rate, combined with a young population, has made Pakistan the world's sixth most populous nation and the third most significant contributor to worldwide population growth. At the same time, the majority of married Pakistani women of child-bearing age say that they do not wish to become pregnant, yet only 24 percent are using a family planning method of any kind — and nearly one third of these women rely on traditional methods of family planning.

To address this clear, unmet need, PSI and SMP created Green Star. Green Star is a network of family-planning franchises: privately owned and managed clinics and pharmacies in low-income urban areas that offer reliable family-planning services and quality contraceptive products under the Green Star logo. The Green Star Network is a great success. In its first five years (1995–2000) Green Star grew to include nearly 12,000 doctors, paramedics and pharmacists in more than 40 cities, and provided more than 900,000 couple-years of protection to Pakistani women and men.

Green Star's success — and the success of similar programs in other countries — illustrates the power of *social franchising* to do for social services what it has done for fast food: take a successful small-business model and copy it quickly, faithfully, and on a strikingly wide scale.

Social franchising is just one of many ways in which public–private partnerships and the innovative use of private-sector insights and techniques are helping to make social services more accessible to individuals, families and communities around the world.

In this case study, Julie McBride and Rehana Ahmed — two of the people who helped build the Green Star Network — discuss their experiences in detail, including:

- The social and economic conditions that helped make franchised family planning possible in Pakistan: an unmet demand for family planning services, a population willing to pay for health care and an untapped capacity among private health-care professionals to provide family-planning services.
- The specific assets and tools necessary to successful franchising: the business model, training, quality assurance, etcetera.
- Lessons learned from Green Star's mistakes.

By documenting their experiences with Green Star, the authors hope to help others working in this important and rewarding field.

Acknowledgments

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Credit is due to all those who have contributed to the development and ongoing operations of the Green Star project, including Zafar Iqbal, Social Marketing Pakistan's Chairman of the Board, and Riaz Mahmood, SMP's Chief Executive Officer, and all the hard-working SMP staff. Several PSI staff have contributed to Green Star's design, development, and operations over the years, including Dana Hovig, Carol Squire, Will Warshauer, Jackie Gaskell, John Hetherington, Sohail Agha, Dominique Meekers, Dick Johnson, Steve Chapman and Judith Timyan.

CMS, PSI and SMP are extremely grateful to the agencies that have contributed funds to support the Green Star project, most notably the United States Agency for International Development for funding this study and to Germany's Kreditanstalt fur Wiederaufbau and the Packard Foundation, without whom the project would not have been possible.

Acronyms

AID/W	United States Agency for International Development/Washington
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CBD	community-based distribution
CBO	community-based organization
CBT	competency-based training
CMS	Commercial Market Strategies project
CPR	contraceptive prevalence rate
CSM	contraceptive social marketing
CSR	corporate social responsibility
CYP	couple-year of protection
DFID	Department for International Development (UK)
DHS	demographic and health surveys (produced by Macro International, see References)
EC	emergency contraception
FP	family planning
FPAP	Family Planning Association of Pakistan
FPSD	Family Planning Services Division
GDP	gross domestic product
GoP	Government of Pakistan
GSN	Green Star Network
GS1	Green Star 1 Providers
GS2	Green Star 2 Providers
GS3	Green Star 3 Providers
GS4	Green Star 4 Providers
HIV	human immunodeficiency virus
IEC	information, education and communication
IUD	intrauterine device
JHPIEGO	JHPIEGO Corporation: A non-profit affiliate of Johns Hopkins University
KfW	Kreditanstalt für Wiederaufbau
KSM	Key Social Marketing Program (The Futures Group International)
LHVs	lady health visitors
MCH	maternal and child health

MD	medical doctor
M&E	monitoring and evaluation
MoH	Ministry of Health [Pakistan]
<i>mohalla</i>	English translation: neighborhood
MoPW	Ministry of Population Welfare [Pakistan]
MOU	memorandum of understanding
MSI	Marie Stopes International
MWRA	married women of reproductive age (15–49)
NDFC	National Development Finance Corporation
NGO	nongovernmental organization
NIPS	National Institute for Population Studies [Pakistan]
OC	oral contraceptive
ORS/ORT	oral rehydration salts/therapy
PAC	post-abortion care
PHN	population, health and nutrition
PNC	postnatal care
POP	point of purchase
PRB	Population Reference Bureau
PSI	Population Services International
PVO	private voluntary organization
RH	reproductive health
RHC	reproductive health care
Rs	rupees (Pakistan's currency)
RTI	reproductive tract infections
SMP	Social Marketing Pakistan
STD/STI	sexually transmitted diseases/infections
TAG	technical advisory group
TFGI	The Futures Group International
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
VSC	voluntary surgical contraception



قابل اعتماد فیما ی پلاننگ





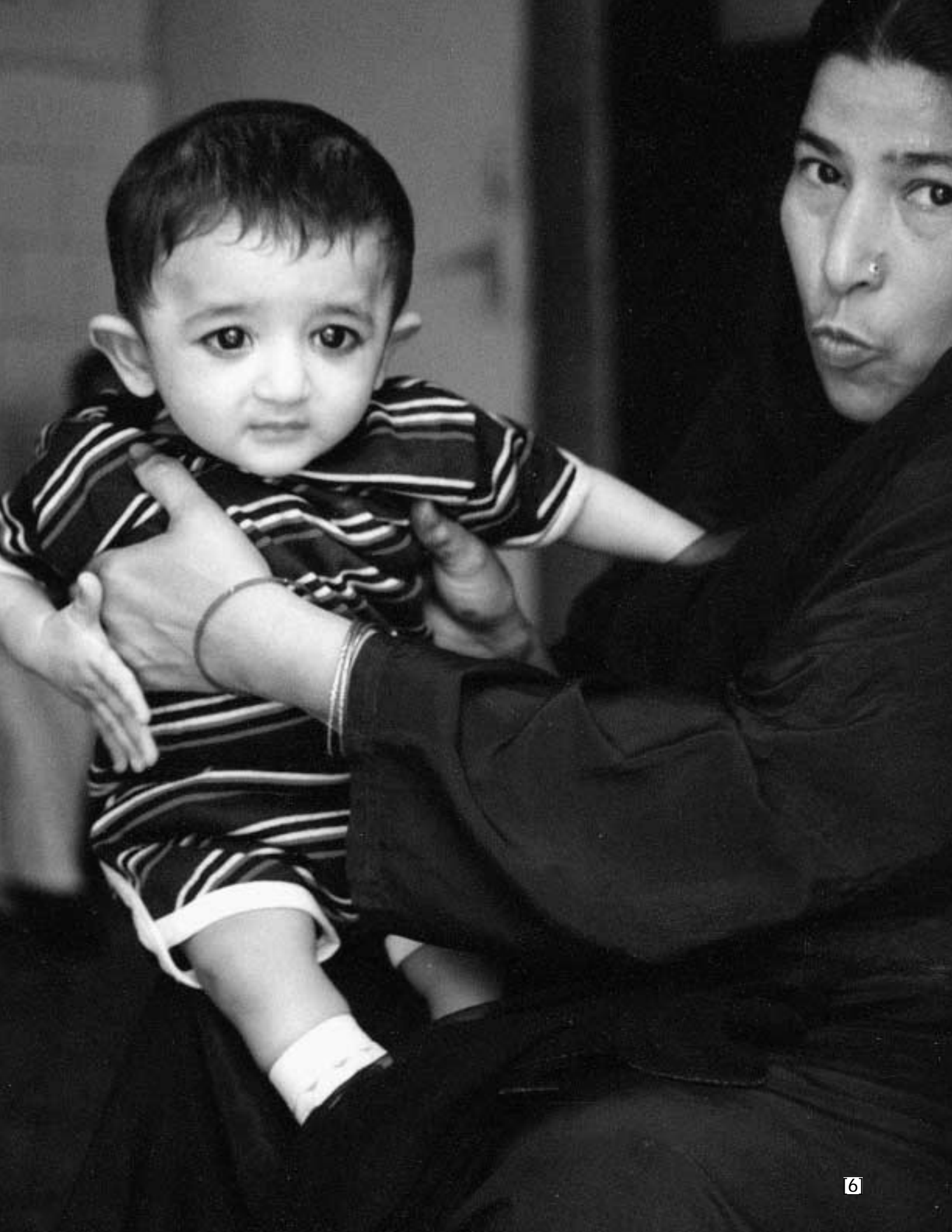
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- [1] Friendly client/provider relations are an important part of the quality of care at Green Star clinics. A client who is happy with the service is much more likely to return to the clinic, and to tell her friends.
- [2] Atiqa Odho, a famous and well-respected Pakistani film actress, was the Green Star spokesperson for several years.
- [3] The Green Star model franchises already existing clinics. These clinics delivered health services to low income women before SMP arrived, and most will continue to deliver an improved and expanded range of services to Pakistani women long after donor funding ends. In this way, the social franchising model is sustainable.
- [4] SMP places Green Star sign boards over clinics which have completed training and been certified by SMP staff. These signboards are featured in all marketing efforts, and potential clients are encouraged to look for the Green Star for trustworthy family planning products and services.
- [5] The Green Star model includes training of family planning providers. Dr Alia Mohallah speaks to a group of women at the clinic of a Green Star lady doctor.
- [6] Low-income women and their children are the principal focus of Green Star marketing, outreach and service delivery efforts. Most Green Star clinics are situated in urban slums and low-income neighborhoods and towns.





The Green Star Network

Introduction

Rapid population growth and the poor health status of women in Pakistan are to a large extent consequences of an inadequate health care system, particularly the inability of the system to meet women's reproductive health needs. While Pakistan can be credited with having one of the world's oldest national family planning programs, inconsistent strategies and weak implementation have resulted in ongoing program failures. Resource constraints have also placed serious limitations on the public sector's ability to provide access to quality reproductive health services. The private sector, while playing a significant role in health care delivery in Pakistan, has had only limited involvement in the provision of family planning services. As a result, geographic coverage of family planning services is inadequate, with services accessible to only 25 percent of the population (Rosen, 1996).

In recognition of the need to expand access to family planning, the Government of Pakistan (GoP) developed a national plan to extend services to rural areas by providing training to female health workers posted in rural health centers (GoP, 1999). At the same time, to enable the channeling of government resources toward meeting rural needs, Pakistan sought ways to involve the private sector in expanding access in less developed urban areas. Population Services International (PSI) and its local affiliate, Social Marketing Pakistan (SMP), designed the Green Star Network of family planning service providers to contribute to the Government of Pakistan's family planning goals by complementing its rural-based public service expansion strategy with an urban-based private sector strategy.

The Green Star Network was designed to harness the potential of private sector health providers who were willing to upgrade their knowledge and skills in order to add family planning to the services they offered. In 1995, SMP began implementing the Green Star Network with funding from the government of Germany's Kreditanstalt für Wiederaufbau (KfW). The aim of the Green Star Network is to contribute to increased use of contraception by making high quality family planning services and products more widely available and affordable to low-income people throughout urban Pakistan.¹

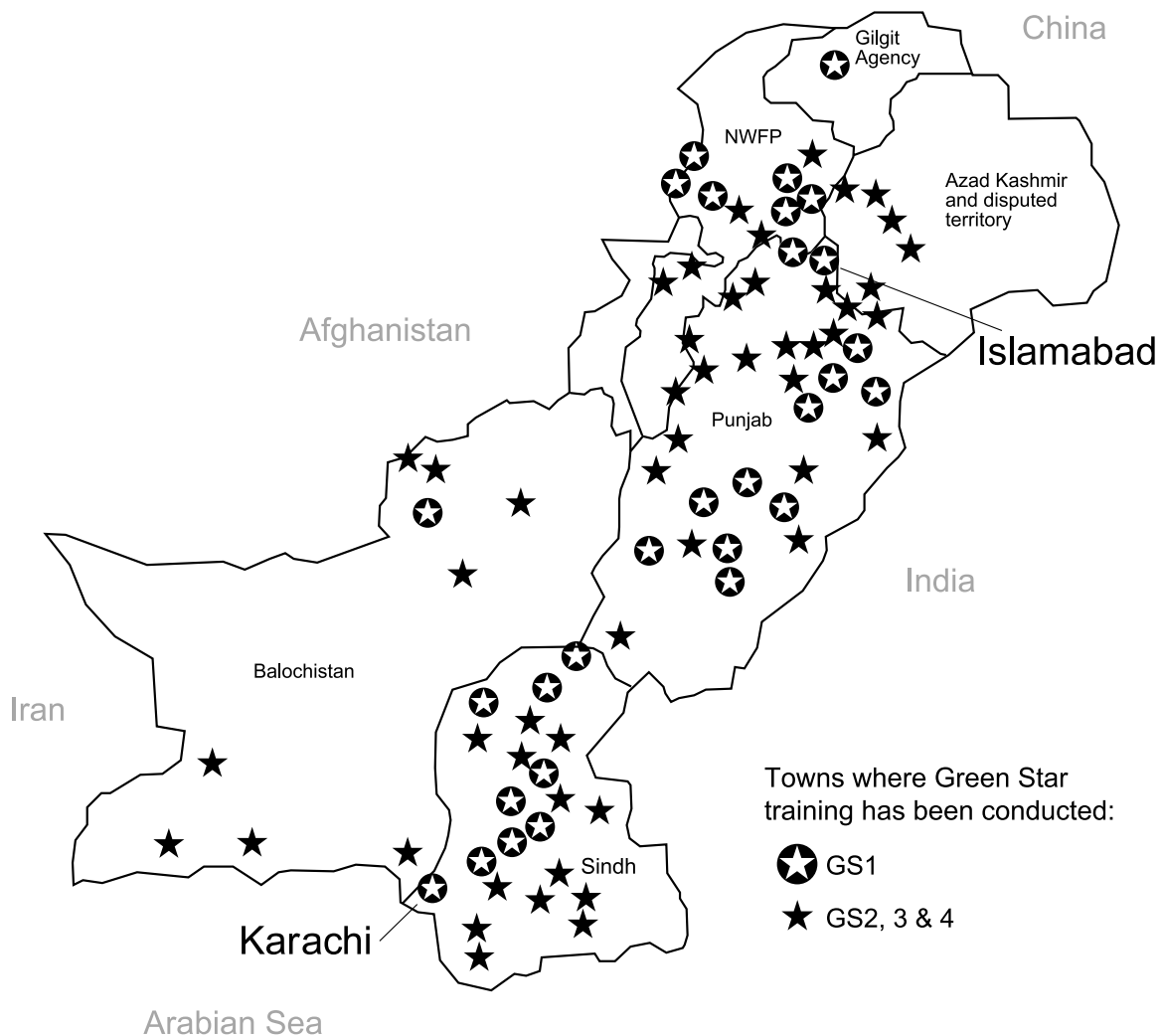
In its first five years (1995–2000), the Green Star Network grew to include more than 11,000 private health providers in more than 40 cities, receiving more than 10 million client visits per year. Figure 1 on the next page uses the location of Green Star Provider training sessions to illustrate the geographic distribution of the network. Over the same period of time, contraceptive prevalence rates among married women of reproductive age in Pakistan increased from 17.8 percent in 1995 to 23.9 percent in 1997. Further, while the use of oral contraceptive pills (OCs) and injectable contraceptives (injectables) in Pakistan remained virtually unchanged between 1991 and 1995 (prior to Green Star) both methods experienced a dramatic rise in use between 1995 and 1997. OC use increased by 29 percent and injectable use increased by 40 percent. IUD use also increased substantially — 62 percent — over the same period of time (Pakistan DHS, 1992; Population Council, 1998; NIPS/LSHTM, 1998).

¹ Low-income people are those earning between 4,000 and 6,000 rupees [Rs] per month.

The success of the Green Star Network demonstrates that good family planning services can be delivered effectively and efficiently to low-income populations through the private sector if health providers are equipped and motivated to do so. By designing the Green Star Network to operate as a social franchise, SMP provided both the means (through training, ongoing technical support, supplies of contraceptives and information, education, and communication materials) and the incentive (increased clientele through affiliation with the Green Star brand) to health providers to deliver quality services. The results have been extremely positive.

This case study outlines the principles behind the design of the network and its various operational components, achievements and challenges. It also documents the development and growth of the Green Star Network and shares hard-gained experience that may be valuable to others who are designing and/or implementing similar programs.

Figure 1: The Green Star Network in Pakistan (location of provider training sessions)



Background: The Pakistan Context

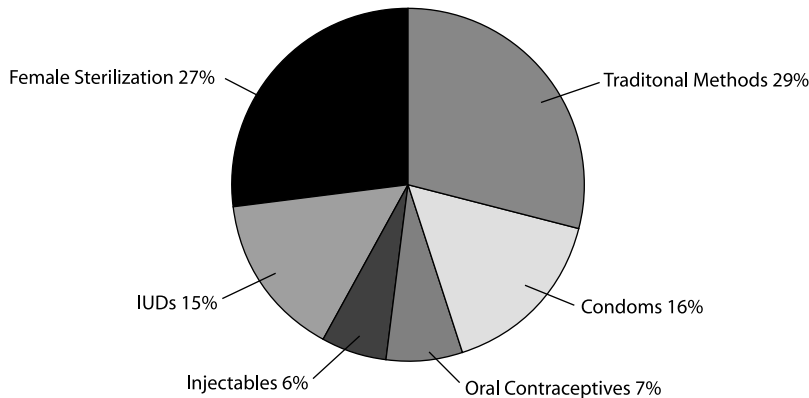
Pakistan has a population of 150 million (PRB, 2000). It is the world's sixth most populous nation and the third most significant contributor to worldwide population growth. High fertility rates (5.6) combined with a young population (43% below the age of 15) put Pakistan's population growth rate at approximately 2.8 percent per year in 2000 (PRB, 2000) — higher than that of any other large Asian nation. At this rate, Pakistan's population will double in just 25 years (PRB, 2000), resulting in a dramatically increased burden on already scarce resources. Per capita income (based on GDP) in Pakistan is currently just US\$ 470 per year. An estimated 34 percent of the population lives below the national poverty line (World Bank, 2000). During the 1990s unemployment doubled in Pakistan and poverty grew by 41 percent. In just four years, the proportion of people consuming fewer than the recommended 2,200 calories a day increased by 32 percent (NIPS/LSHTM, 1998). Population pressures are degrading natural resources such as arable land and water at an alarming rate (Rosen, 1996). Already, 60 percent of Pakistan's population has no running water or other basic amenities.

Family Planning in Pakistan

Although population growth in Pakistan is high, national trends in family planning are positive, with fertility rates declining and contraceptive use increasing. At the same time, there is much progress to be made. Successive fertility surveys have documented a large and consistent unmet demand for family planning. The latest such study (NIPS/LSHTM, 1998) reveals that while 61 percent of married women of reproductive age (15–49 years old) say that they are currently sexually active but do not wish to become pregnant at this time, only 24 percent are using a family planning method of any kind. The remaining 37 percent are at risk of having an unintended pregnancy.

Among women using contraception, a large proportion (30%) relies on traditional methods of family planning, which are not as effective as modern methods. The remaining women use surgical contraception (25%), condoms (17.7%), IUDs (14.4%), oral contraceptives (6.9%) and injectables (5.9%) — see figure 2, below. Use of female-controlled spacing methods — IUDs, oral contraceptives, and injectables — is particularly low and represents a much smaller proportion of the method mix than in most other Asian countries. Moreover, contraceptive discontinuation is over 80 percent for women who have ever used pills or injectables and over 60 percent for those who have ever used an IUD. Women cite side effects as a primary reason for discontinuing their method (NIPS/LSHTM, 1998; SMAR, 1996).

Figure 2: Contraceptive Methods Used in Pakistan



Source: NIPS/LSHTM, 1998. Numbers do not add to 100 percent because of rounding.

Pakistan's low contraceptive prevalence rate (CPR) has been attributed to several factors, including:

- insufficient public sector supply of family planning services;
- inconsistent availability of contraceptives; and
- a lack of accurate, reliable information about family planning methods — for health providers as well as consumers.

Other Health and Social Indicators in Pakistan

Other health and social indicators reflect the poor circumstances of women in Pakistan. In 1997, 45 percent of women of reproductive age were found to be anemic (NIPS/LSHTM, 1998), a factor associated with maternal deaths as well as malnutrition. More than three-quarters (76%) of all adult women in Pakistan are illiterate (World Bank, 1997). The country is one of the few in the world with a higher number of men than women — there are 92 women for every 100 men (World Bank, 1997) — owing in large part to the low social status of women and the impact of their consequent treatment on health. Maternal and child mortality rates are correspondingly very high: one child dies for every 10 live births (91 per 1,000 according to PRB, 2000) and the country has one of the highest maternal mortality rates in the world — estimated at 340 per 100,000 nationwide (World Bank, 1997). Most of these deaths are preventable. Moreover, these figures do not convey the serious health problems among the mothers and infants who survive.

The Public Health Sector in Pakistan

The Government of Pakistan now spends less than one percent of its budget on health care (GoP, 2000) and even less on family planning services. The Ministry of Population Welfare (MoPW) administers family planning through a system parallel to (as opposed to integrated with) the Ministry of Health's primary care system. Per capita spending on family planning in Pakistan (approximately US\$ 0.30) is significantly lower than that of neighboring countries such as Bangladesh (approximately US\$ 1.40) (Rosen, 1996).

In all, there are about four times as many public sector primary care facilities (approximately 6,000 according to Rosen, 1996) as there are family planning clinics run by the Ministry of Population Welfare (approximately 1,500, according to the GoP's *Pakistan Economic Survey*, 1999). As a consequence, an estimated 85 percent of the population has access to primary health care (World Bank, 1997), while only 25 percent has access to family planning services (Rosen, 1996). Public sector family planning clinics reach only 10 percent of the population and half that or less in rural areas (Rosen, 1996). Nongovernmental organizations and private clinics reach the other 10 to 15 percent of the population that has access to family planning services (Rosen, 1996).

The MoPW administers family planning services through a thinly spread network of facilities that provide all contraceptive methods except sterilization. These facilities include approximately 1,500 family welfare centers and 130 mobile service units. Sterilization is available through another 80 specialized sterilization clinics run by the MoPW. In addition, approximately 5,000 traditional midwives are employed to provide educational messages about family planning to their communities (Rosen, 1996).

Problems with staff motivation, training and supervision as well as with contraceptive supply have limited the effectiveness of public sector family planning clinics. For example, a 1992 field survey found that only 75 percent of family welfare centers had a full range of family planning methods available (Rosen, 1996). Weak supervision has resulted in high absenteeism of family welfare staff. Other research shows that the care offered at public sector facilities is highly variable and often of dubious quality (Population Council, 1998). As a result, consumers lack confidence in the public health system and either turn elsewhere for services or, as is often the case with family planning, go without services. A 1992 survey found that family welfare centers saw an average of only three family planning clients a day (Rosen, 1996).

The Private Health Sector in Pakistan

The private sector plays a significant role in health care delivery in Pakistan. According to the 1999 *Pakistan Economic Survey*, the private sector accounts for nearly two-thirds of all health expenditures in the country. The Pakistan Medical Association reports that roughly one-half of all registered medical doctors in Pakistan — 40,000 of about 80,000 (GoP, 1999) — practice in the private sector. While the private sector in Pakistan is well developed, however, its facilities are largely urban, and they offer primarily curative treatment, as opposed to preventive services like family planning. Further, the private sector is highly unregulated, resulting in varying qualities of care (GoP, 1999).

Reluctance among private sector providers to deliver family planning services is based on their lack of training in and practical exposure to this particular specialization. Because family planning is considered to be a low-prestige field, with no recognition for specialization, there is little professional incentive to specialize in family planning. In addition, many providers share consumers' negative attitudes and misconceptions about contraceptive methods and would rather not get involved in this controversial area of service delivery (Rosen, 1996; Semiotics, 1996). In short, there is tremendous untapped potential among private sector providers to deliver family planning services.

From the Social Marketing of Condoms to Franchising Family Planning Services: Evolution of the Green Star Network

To increase contraceptive use in Pakistan, the Government of Pakistan (GoP) and USAID introduced a jointly operated condom social marketing project (the Social Marketing of Contraceptives Project) in April 1985. In December of that year PSI, Woodward Pakistan Ltd (a local commercial pharmaceutical manufacturing and marketing firm) and the National Development Finance Corporation (a semi-autonomous state organization) were contracted to implement the project. The project launched the *Sathi* brand of condoms in January 1987.

In 1991, USAID and the GoP reorganized the project implementation structure to expand the functional role of PSI, and PSI established a local NGO, Social Marketing Pakistan (SMP), to operate the project. In an attempt to increase the financial sustainability of the project the price of the *Sathi* condom was raised from Rs 1.00 to Rs 1.50 in April 1991 and raised again — to Rs 2.00 — in November (Agha and Davies, 1998). The following year, 1992, sales of *Sathi* condoms plummeted from six million per month to less than three million per month.

At the same time, USAID began implementing a phased closeout in accordance with the Pressler Amendment.² Although all aid to Pakistan was discontinued due to its nuclear program, the social marketing project was to continue operating until its funds were depleted.

PSI's program goals and approach to pricing stipulate that a social marketing program's or provider network's sustainability is predicated on delivering quality products and services at prices that are affordable to a large number of customers. Further, customers must be satisfied with the products and services they receive. Upon reviewing the project, PSI concluded that SMP would not be able sustain the program's positive health impact without external funds to subsidize the cost of the condoms (i.e., external funds were necessary to keep the condom affordable for the low-income target market). Therefore, in 1993, PSI decided to use its own funds to support the program until a new donor could be found. In 1994, the Pakistan Ministry of Population Welfare contracted with SMP to maintain social marketing of *Sathi*. Sales revenues covered most of the operating costs. PSI continued to donate the additional funds required to maintain operations and to support the resident technical advisor while it looked for a donor to help fund the project.

In January 1995, the German government's development bank, Kreditanstalt für Wiederaufbau (KfW), contracted with SMP to continue marketing *Sathi* condoms, expand the social marketing activities to include IUDs and a second brand of condoms, and establish a service delivery network through which women could obtain IUD insertions. In 1996, KfW provided additional funds for the introduction of hormonals (OCs and injectables) and expansion of the Green Star Network. Project expansion was based on the premise that greater contraceptive choice leads to higher contraceptive acceptance. Providing a service delivery component was viewed as necessary to the success of marketing clinical methods like IUDs and injectables, as their acceptance is highly dependent upon quality care, the availability of which was extremely limited in Pakistan.

² Imposed in October 1990, the Pressler Amendment to Section E(e) of the Foreign Assistance Act cut off all United States bilateral economic and military assistance to Pakistan because of non-certification of a lack of nuclear capability. USAID began implementing a phased closeout in July 1991. The US government resumed non-military assistance to Pakistan in 1995.

SMP launched the Green Star Network and IUD on a pilot basis in 1995 and expanded the program in 1996. OCs, injectables, and a second brand of condom were launched in 1996 (Davies and Agha, 1997). Section 2, entitled *Design*, describes the process of creating the network and the structural changes undertaken by SMP to accommodate this rapidly growing project.

Figure 3: Milestones in Green Star's Development

Year	Milestone
1985-86	USAID and the GoP introduce the Social Marketing of Contraceptives Project. PSI, Woodward Pakistan Ltd and the National Development Finance Corporation are contracted to implement the project.
1987	January: PSI introduces condom social marketing to Pakistan with the launch of <i>Sathi</i> condoms.
1991	PSI establishes Social Marketing Pakistan (SMP), a local NGO, to implement the project. In accordance with the Pressler Amendment, USAID begins a phased closeout.
1993	USAID funding is completely withdrawn from Pakistan in September — PSI decides to continue condom social marketing with its own funds.
1994	Pakistan Ministry of Population Welfare contracts with SMP to maintain social marketing of <i>Sathi</i> . PSI continues to donate funds to maintain operations and support the resident technical advisor while looking for a donor to fund the project.
1995	January — Government of Germany (via KfW) provides SMP with funds for continued condom social marketing, the launch of a new condom, an IUD and the Green Star Network. 300 providers (female GPs and a select female paramedics with the ability to insert IUDs) are successfully recruited and trained as Green Star providers in the cities of Karachi and Rawalpindi/Islamabad. These providers are labeled GS1 . SMP begins implementing Green Star Network pilot in December 1995.
1996	KfW provides SMP with funds for the introduction of hormonals (OCs and injectables) and for expansion of the Green Star Network. SMP introduces the MultiLoad IUD, the oral contraceptive Nova, the injectable contraceptive NovaJect and Touch condoms under the Green Star umbrella. Training for GS1 providers is expanded to other districts of Karachi and to the city of Lahore. Pilot phase ends in December 1996.
1997	Green Star pilot evaluation is conducted. Revisions are made to project design based on evaluation findings. Green Star Network is expanded to include three new types of service providers: (1) GS2 providers — primarily male MDs and some female MDs who do not deliver IUDs; (2) GS3 — pharmacists; and (3) GS4 — female junior paramedics (total network to date includes 1,124 GS1; 2,724 GS2; 295 GS3; and 1,038 GS4).
1998	Network is expanded to include 1,803 GS1; 3,608 GS2; 2,529 GS3; and 2,142 GS4.
1999	Network is expanded to include 2,352 GS1; 4,258 GS2; 2,586 GS3; and 2,142 GS4.
2000	Network comprises more than 11,000 Green Star providers: 2,571 GS1; 4,258 GS2; 2,586 GS3; and 2,142 GS4 in over 40 cities throughout Pakistan. Additional funding received from Packard, Hewlett, and DFID. Network expands services to include maternal and child health, post-abortion care, and STI treatment and counseling.
2001	In April, network expands to include voluntary surgical contraception through selected Green Star providers.

Figure 4: History of PSI and SMP funding in Pakistan — Project Implementation Structure

Donor	Amount	Period of funding	Funding specifications
USAID	US\$ 3.6 million of approx US\$ 30 million was allocated to PSI*	1986–Sept 93	Condom social marketing
PSI	Approx. US\$ 750,000	Sept 93–ongoing	Bridge funding, technical assistance, fundraising support
KfW	US\$ 15 million (DM 30 million)	Jan 95–Dec 99	Green Star Network, condoms, IUD
	US\$ 9 million (DM 18.5 million)	Jun 96–Dec 99	Hormonals, Green Star Network
	No cost extension	Up to Dec 01	Green Star Network
Packard	US\$ 2.3 million	Jan 00–Dec 01	Green Star Network strengthening
DFID	US\$ 3.8 million	May 00–Nov 01	Condom commodity support; behavior change communications
Hewlett	US\$ 600,000	Jan 00–Jan 01	Hormonals
Total	US\$ 35,050,000	1986–2002 (16 years)	

Note: US\$ calculations are based on 1999 yearly average exchange rate of US\$ 1 = DM 2

* Supplemental amounts totaling approximately US\$ 30 million were awarded over the same period of time to the co-implementing agencies for contraceptive social marketing including the Government of Pakistan's MoPW and Woodward Pakistan Ltd (condom manufacturers).

Design

The objective of the social marketing program from the outset was to increase use of contraceptives in Pakistan. To this end, the program was designed to increase the availability and quality of family planning services, especially making choice of method an option for more low-income Pakistanis. The network began by offering a comprehensive package of family planning services that included provision of counseling, hormonal methods prescription and administration, and IUD insertions. Over time, variations of the family planning service delivery package were added to accommodate a broader range of service providers and thereby facilitate the expansion of the network. Today, as described in Section 6, *Next Steps*, the project is further expanding its service scope to include reproductive health services such as VSC, STI treatment and post-abortion care.

Green Star's Stakeholders

The Green Star Network is targeted to low-income women and men with unmet demands for family planning. These consumers participated in research to assess their particular needs, concerns, expectations and preferences related to family planning services.

Health care providers are also regarded as project beneficiaries and were included in the development of the service delivery protocols and training curricula. Formal contacts with health professionals were made through the Pakistan Medical Association, whose endorsement has proved to be important to the program's credibility.

NGOs

Key family planning-related NGOs were involved in the Green Star project design and continue to be involved in its implementation. These groups, including the Family Planning Association of Pakistan and Marie Stopes International, are part of the Green Star Network referral system. SMP also collaborates with the Futures Group's Pakistan Private Sector Population Project (a DFID-funded project more commonly known as the *Key Social Marketing* project) by sharing information and coordinating training programs to maximize coverage and impact of family planning services. In addition, SMP consulted JHPIEGO (a non-profit affiliate of Johns Hopkins University) to develop and evaluate the training curricula.

Private Sector Organizations

The involvement of Schering/Medipharma and Organon as product suppliers has been extremely important to the success of the project. Their understanding of the program's needs and their responsiveness to SMP requests for technical information and support ensures that product is always available and appropriately marketed in Pakistan. Other private organizations involved in program design and implementation include subcontractors such as advertising agencies, distributors and research firms.

The Government of Pakistan

SMP works with the Government of Pakistan to ensure that their program activities complement one another. For example, the government's Population Welfare Program seeks to narrow the gap between met and unmet need for family planning by expanding access to quality health care. The

GoP's program focuses primarily on extending services to the rural population, while SMP works to maximize coverage in urban areas (GoP, 1999).

Green Star Donors

There are several donors to the Green Star project, including KfW, DFID, and the Packard and Hewlett Foundations. Each donor has its own reporting requirements, and SMP generates monthly and quarterly reports to keep donors abreast of project activities and progress in meeting objectives.

Service Delivery: The Franchise Model

As noted by Smith, 1997, and Laukamm-Josten, 1998, franchising is "a highly successful, commercial mechanism to replicate a proven business strategy." Within the commercial sector, it is used to expand the distribution of products and services of a specified quality by harnessing the skills and interest of private sector entrepreneurs (Smith, 1997). Social franchising applies the principles of franchising to initiatives that are designed to bring about social change. With social franchising, revenue-generation serves to motivate the private sector to participate. Financial benefits do not extend to the franchiser, as they do in commercial franchising. The theory behind social franchising is akin to that of social marketing; in both cases, proven commercial strategies are applied to the social sector to achieve social goods, such as improving the health status of a population.

According to Laukamm-Josten (1998), an organization is engaged in social franchising if:

- a group has been allowed to distribute services under the organization's name and using the organization's project plan or system of operations; and
- in exchange for this privilege, certain criteria have been fulfilled, such as adherence to specified quality standards.

Three key components must be in place for social franchising to function:

- the **business format**;
- the **brand**; and
- **quality assurance**.

The business format defines the services that are being franchised and how they must be delivered by franchisees. The brand links a particular service delivery point with the franchise in the minds of the consumers. The brand is advertised to consumers as an indication of high quality, affordable services. If marketed properly, over time the brand will build up a great deal of equity.³ For the franchisees, the primary benefit of association with a high-equity brand is increased business. However, in order for a franchise to succeed, the brand must live up to its claims. Thus, mechanisms must be in place to ensure that the franchisees consistently deliver high quality products and services:

³ For more information on branding and services marketing please refer to the proceedings of CMS's May 2001 technical advisory group meeting: *Marketing Reproductive Health Services: Moving Beyond Traditional Social Marketing*. The document is available electronically at www.cmsproject.com.

- **Quality Assurance** mechanisms include training and support provided by the franchiser to enable franchisees to deliver goods and services in accordance with specified quality standards.
- **Monitoring and Evaluation** mechanisms ensure that franchisees are in fact operating in accordance with the protocols of the franchise.

Social franchising is well suited to expanding and improving reproductive health services in developing countries, especially in countries with overburdened public health systems and an underutilized private sector. Specialized reproductive health services and longer term family planning methods — for example, voluntary counseling and testing, management of sexually transmitted infections, and post-abortion care — require trained providers and the establishment of minimum quality standards. Social franchising provides a mechanism for expanding access to high quality reproductive health services. Increasing the number of providers delivering quality reproductive health services expands physical access; including pricing policies in the business format improves economic access; and brand advertising improves cognitive access to family planning.

In addition to benefiting consumers, franchising benefits franchisees and the franchiser as well. Franchisees benefit from training and technical support, which improve their ability to meet growing client demands, and from national and local franchise promotions, which create demand for their services. The franchiser benefits by using an efficient mechanism to replicate a proven service delivery model, thereby substantially increasing social impact.

The Progression from Social Marketing to Social Franchising

Social marketing is suited to delivering reproductive health products when product information can be given through educational materials and advertising campaigns, and when the client does not need a service provider for guidance or to administer a method. However, adoption and continued use of long-term contraceptives, such as injectables and IUDs, is highly dependent upon skilled providers. As SMP planned to expand its program from condom social marketing to providing these long-term methods as well as other more technical reproductive health products, it faced both a program necessity and an ethical obligation to ensure that clients had access to quality services. After a thorough assessment of the reproductive health service delivery system in Pakistan, social franchising was determined to be the most viable way of ensuring access to quality services.

Developing a Model for Social Franchising

There are two principal types of social franchise, with several variants of each model: stand-alone franchises and fractional franchises (Smith, 1997; Laukamm-Josten, 1998). In a stand-alone social franchise, the franchiser provides the infrastructure and equipment, and then franchises the space to providers. The franchiser and franchisee share operating costs. PROSALUD in Bolivia is an example of a stand-alone social franchise. In a fractional social franchise, a package of services is added to an existing business — to a service delivery point in the case of a reproductive health franchise — to create an additional service and income stream for the franchisee.

These two different models are appropriate in different circumstances. A fractional social franchise may be more effective where there is a supply of health providers with established businesses and underutilized capacity that can form a pool of franchisees. A stand-alone model of

service delivery may be called for in countries that have a supply of health providers without sufficient infrastructure and equipment to provide quality services.

Each model of social franchising has advantages and disadvantages. The main benefit of stand-alone franchising is that it allows better control of the quality and pricing of franchisees' services. Its main disadvantage is that it requires a great deal of seed capital to implement and is expensive to replicate. The main advantage of fractional franchising is that it can be replicated efficiently, by building on existing resources and infrastructure. The franchiser in the fractional model does not need to have large amounts of seed capital, as the franchiser is not providing infrastructure. Because this model builds on the capacity of existing businesses, it is likely to be more sustainable in the long term. The main disadvantage of the fractional model is the difficulty and complexity it presents in controlling the quality and price of services.

The Green Star Model

SMP designed the Green Star model of franchising to meet Pakistan's specific needs and circumstances:

- high unmet demand for family planning;
- consumer willingness to pay for health services as demonstrated by the high use of the private sector for curative treatment, even among the poor;
- limited capacity of the public sector to meet its citizen's reproductive health needs;
- a highly developed private health sector, with an ample supply of health practitioners with established practices;
- underutilized capacity in the private sector to provide reproductive health services; and
- low levels of reproductive health knowledge among private sector service providers, with limited opportunities for professional training and continuing education.

These circumstances all supported the development of a fractional model of social franchising in Pakistan.

The Green Star Network is designed to provide functioning service delivery points with a franchisable package of high quality reproductive health services. Partnerships are formed between SMP (the franchiser) and selected providers (the franchisees) with the agreement that these providers will integrate a defined package of reproductive health services and deliver those services according to quality standards established by SMP. In return, the provider/franchisee receives specialized support, training and rights to the franchise brand for as long as the franchisee maintains minimum quality standards (monitored by SMP). The franchisee also benefits from the brand equity created by the franchiser.

The relationship between franchiser and franchisees is governed by an enforceable contract. This feature is particularly important because the success of the franchise depends on the reputation of the brand. If SMP finds a franchisee to be in breach of contract — that is, if monitoring reveals that quality standards are not consistently met — then SMP reserves the right to remove the provider from the franchise. However, SMP's ongoing technical support is intended to identify and solve problems. Therefore, SMP provides training or upgrades franchisees' skills before they get to the point of needing to be removed from the network.

Operational Components of the Network

This section describes how each of the components of a social franchise — business format, brand and quality assurance — functions in the Green Star Network.

The Business Format: Service Delivery Packages and Protocols

As noted above, the business format defines the services that are being franchised and how they must be delivered by franchisees. The Green Star Network addresses the major elements of its business format as follows.

Service Delivery Packages

To date, Green Star Network service delivery packages have been restricted to family planning services. The network began with a comprehensive package of family planning services that included: (1) the provision of counseling; (2) prescription and administration of hormonal methods; and (3) IUD insertions. However, because of cultural restrictions on who can give pelvic exams in Pakistan, only female medical doctors could offer this package of services. Over time, variations of the service delivery package were added to accommodate a broader range of service providers and thereby facilitate the expansion of the network. The Green Star Network now includes three different service delivery packages, offered by four types of service providers. These are:

- **Family planning counseling, prescription and administration of hormonal methods and IUDs** provided by licensed female medical doctors and selected female paramedics operating privately owned clinics in low-income urban areas. (Because of restrictions placed on who can give pelvic exams in Pakistan, only female providers are selected for this service delivery package.) These providers are referred to as Green Star 1 (GS1) providers.
- **Family planning counseling and prescription and administration of hormonal methods** provided by licensed male medical doctors (or female doctors who do not have the professional setting or interest to provide IUDs) operating privately owned clinics in low-income urban areas. These are providers are referred to as GS 2 providers. As of 1997 some junior paramedics (Lady Health Visitors and midwives) operating privately owned clinics in low-income urban areas began to offer this package. Junior paramedics are referred to as GS4 providers.
- **Family planning counseling and referral** provided by licensed pharmacists operating privately owned pharmacies in low-income urban areas. This cadre of providers is called GS3.

In 2000, SMP expanded the range of reproductive health products offered through selected Green Star providers to include such options as testing and treatment for sexually transmitted infections and HIV, post-abortion care, and maternal and child health services. Voluntary surgical contraception was added in April 2001.

Service Delivery Protocols

In order to ensure that quality standards would be high and uniform across all Green Star outlets, SMP developed protocols describing how the franchised service should be delivered. The protocols were modeled after the quality of care framework developed by Bruce and Jain (Bruce 1990; Jain 1989, 1992; Jain and Bruce 1993, 1994; Jain *et al*, 1992), widely recognized as a gold standard in quality health care. The Bruce–Jain framework revolves around six defining elements, which have been adapted slightly for Green Star:

- choice of methods;
- correctness and completeness of information given to users;
- technical competence of providers;
- client–provider interaction;
- continuity of care; and
- appropriateness and acceptability of services.

The Green Star training curriculum was developed to provide the knowledge and skills required to deliver services according to these protocols. While the training workshops made clear what was expected of providers, the protocols were not distributed as such. At the writing of this case study in 2000, SMP was developing detailed service delivery protocols for distribution to all Green Star outlets (see Section 7, *Lessons Learned* and Appendix B).

The Green Star Brand

In order to create a franchisable brand of reproductive health services, consumer research was conducted to identify a symbol that people in Pakistan would recognize easily and associate with quality and trustworthiness — attributes identified as important to consumers.⁴ After testing several logos, colors and tag lines, the Green Star symbol was selected as the most compelling way to identify the franchise, along with the tag line “Trustworthy Family Planning.” To represent family planning, two people were included in the center of the star, representing either a couple or two children. The Green Star has the advantage of being easily recognized in both visual and verbal media, by color and form. (The drawbacks of adding human figures to the star are discussed in Section 7, under *Lessons Learned*.) The Green Star logo was registered as a trademark in Pakistan in order to protect it from being copied and misused by providers who are not a part of the network and who may not meet its standards of care.

Rollout of the Brand

Signboards with the Green Star logo are presented to all franchisees and installed outside their outlets to identify them as members of the Green Star Network. Different sizes and styles of signboards were developed to represent the three service packages. For example, GS1 providers — trained to provide the full range of services, including IUDs — are given large, individually customized signboards for their clinics. GS2 providers, who are not trained in IUD insertions,

⁴ See Shore, Dr David: “Creating Brands People Know and Trust” in the proceedings of CMS’s May 2001 technical advisory group meeting: *Marketing Reproductive Health Services: Moving Beyond Traditional Social Marketing*. The document is available electronically at www.cmsproject.com.

receive smaller standardized square signboards. Pharmacists and junior paramedics (GS3 and GS4, respectively) use smaller standardized metal signs.

The Green Star logo is also placed on the packaging and inserts of all Green Star contraceptive products to create brand equity and a sense of ownership among Green Star providers.

Advertising and Promoting Green Star

SMP designed an advertising campaign to create awareness of the Green Star brand and what it symbolizes as well as to create demand for services at outlets displaying the Green Star symbol. The campaign highlights Green Star service features such as quality, trustworthiness and affordability, informs consumers how to find a Green Star outlet, and urges them to do so for their families' well being and future prosperity.

Once a critical mass of about 150 franchisees was established and operating in Karachi, the advertising campaign was launched. This figure for critical mass was an estimate of the minimum number of providers that would be necessary to meet initial demand created by the campaign. The figure of 150 sites was also determined to be large enough to make the network visible to consumers, without which the advertising campaign would be ineffective. The Green Star ad campaign was initially launched only in Karachi. Later, it was rolled out nationally to coincide with the expansion of the network nationwide. Media used to communicate the Green Star message included television, radio, print and outdoor (billboard and wall-painting). Promotional materials for the Green Star brand, including pamphlets, stickers, and posters, were also developed and placed at points of purchase. In Karachi, a local group was hired to distribute 200 pamphlets in the neighborhoods around each of the 150 clinics in the city, promoting individual service providers by stamping them with clinic names and addresses. Several local launch events held to coincide with the national rollout drew large audiences that included representatives from the government, press and donor organizations. At each launch event, a certificate ceremony formally recognized new members of the Green Star Network. These events received a great deal of supportive press coverage and contributed to improving awareness and creating positive perceptions of the network.

Green Star continues to run ads based on consumer research. Campaign messages address key barriers to accessing family planning identified in local research, including:

- mistrust of existing family planning service providers;
- lack of knowledge about where to seek quality services;
- lack of confidence in the safety or efficacy of the methods available; and
- lack of social support for family planning from husbands and the larger family and community (SMAR, 1996).

In response to the lack of social support advertising messages reinforce the need to consider family planning and a television campaign modeling how to discuss the subject with a spouse was developed. Messages have also highlighted the availability of trustworthy and quality services at service delivery points displaying the Green Star. The campaign's call to action consistently encourages consumers to seek advice about family planning from a Green Star provider.

SMP also promotes the Green Star through community events and public relations activities. Successful events include:

Free medical camps. Free medical camps provide consumers with counseling, examinations and treatment. Free samples of pharmaceutical products, including condoms, oral contraceptives and antibiotics, are distributed. Medical camps are held in the vicinity of Green Star clinics and average 200 attendees per day. Some camps have registered as many as 650 visits, with 100 clients counseled for family planning. Evaluation indicates that of those who come for family planning, over 30 percent become new acceptors. Additionally, neighborhood providers reported notable increases in clients after these events.

Community events. SMP regularly sponsors community sports and musical events, such as *kabadi* wrestling matches, which are very popular among Pakistani men. Other local events include theatrical shows, photography exhibits, walks and bicycle races. During these events, a commentator promotes Green Star products and services.

Visits from community motivators. With the assistance of Green Star field trainers, female community motivators visit resident women in catchment areas around Green Star clinics to provide family planning information and inform women about their local clinics.

“Town-storming.” Town-storming activities are undertaken in small towns. The area sales manager and local distributor arrange multiple promotional activities, such as displaying banners and posters, improving product display, and increasing products’ shelf levels (quantity) at retail outlets.

Mohalla meetings. Mohalla (neighborhood) meetings, begun in spring 1998, have been an especially successful form of community-based promotion. These meetings, which are advertised by individual Green Star providers, are held in enclosed areas, often a Green Star doctor’s clinic. Small groups of women and both Green Star trainer-doctors and Green Star clinic providers are present. These private venues provide opportunities for questions and concerns to be addressed and for one-on-one counseling to be given — an arrangement that increases the comfort level of potential clients, as well as the value of information they receive. Many women in Pakistan have limited access to information, given restrictions placed on them by husbands, the culture and illiteracy. Mohalla meetings bring information to women in their own communities in safe places where their husbands will allow them to go. Nothing is more powerful at motivating behavior change than the interpersonal communications between women and providers at these meetings. On average, SMP conducts 28 *mohalla* meetings per month, with 70 to 75 attendees per meeting, directly reaching 24,000 women per year. As many as 20 percent of attendees at these meetings schedule family planning appointments with Green Star providers on the spot. The first *mohalla* meeting for couples was held in July 1999, drawing a sizable crowd of 150 people. At the couple meetings the provider-sponsors go beyond promoting family planning services and discuss oral rehydration salts, nutrition and other health-related subjects.

Trade promotions. To help motivate Green Star vendors to market their products and services, SMP holds trade promotions such as bonus competitions and offers. Seminars and workshops are held for Green Star trained service providers, including pharmacists, who also receive newsletters and technical updates such as the bimonthly *PSI/SMP Matters*.

Involving opinion-leaders. Green Star public relations and advocacy shape the views of influential groups, including policy makers, journalists and thought leaders.

Green Star’s campaign of advertising and promotions has resulted not only in increased consumer demand for services at Green Star outlets, but also in increased interest among service providers

to become members of the franchise. Today, there is near universal awareness in Pakistan of the Green Star and what it symbolizes. Research carried out in low-income urban areas in 1997 (Aftab Associates, 1997), found that 93 percent of respondents recognized the Green Star logo and were able to identify it correctly as a symbol of high quality family planning at affordable prices.

Green Star advertising and promotions continue to target women and men who have an unmet demand for contraceptive health services using messages designed to:

- reinforce the perceived benefits of family planning;
- encourage couples to discuss family planning;
- increase acceptability of modern contraceptives;
- position Green Star as a trusted source of family planning advice; and
- motivate couples to seek out more information from Green Star outlets.

Assuring Quality Franchisees

Selecting, training and supporting providers who have the greatest likelihood of succeeding as franchisees are all important parts of quality assurance. From the outset, SMP established a transparent process for franchisee selection using clearly defined criteria. With experience, these selection criteria were revised to incorporate qualities predictive of successful Green Star outlets. Green Star training and follow-up have also been adapted to take advantage of experience and lessons learned.

Selection Criteria

Today, different types of service providers — physicians (both female and male), paramedics and pharmacists — play diverse but critical roles in Green Star’s delivery of family planning services. However, when the project began in 1995 the emphasis was on creating a network of providers whose services would include insertion of IUDs. For this reason, franchisee selection was limited to female providers only. Selection criteria further limited providers by professional qualifications, including only registered general practitioners (GPs) holding an MBBS (Pakistan’s medical degree).⁵ GPs seemed the best initial Green Star provider class because they offer general medical and pediatric services and therefore provide a good constellation of health care to their clients. In addition, by offering family planning services they could serve more of their clients’ health needs and at the same time improve their own financial viability. Using GPs as providers also assures confidentiality with regards to using family planning services — clients at Green Star clinics operated by general practitioners might be seeking any number of services other than family planning. For all these reasons, female GPs were the first family planning providers to form the Green Star Network.

⁵ A smaller number of qualified paramedics — midwives and lady health visitors who operate clinics suitable for IUD insertion — were also recruited into the network as GS1 providers. However, most GS1 providers are female doctors.

Other criteria used in selecting GS1 providers include:

- having been operational for a minimum of one year with a self-sustaining practice and existing client base;
- being located in an area where low-income people live or work, with a focus on providing services to these clients; and
- being willing to provide family planning services at reduced fees to low-income clients.

Additionally, all GS1 practitioners are required to have access to a medical facility adequate for IUD insertions — a private room or screened area for the consultation, electricity, running water and a clean, well-maintained environment (see Key of Quality indicators on the GS1 Supervisory Activity Sheet, Appendix A).

Since its inception, the Green Star Network has expanded to include additional cadres of health professionals and male practitioners. In 1997 male doctors (GS2) were added to the network in a bid to increase the participation of men as family planning clients. Research as well as every-day observation indicates that husbands are critical decision makers in family planning in Pakistan (SMAR, 1996; Market Research Link, 1995). Moreover, many Pakistani men will not seek advice from a female doctor. GS2 providers were therefore added to Green Star to motivate men to use contraceptives themselves, talk with their wives about contraception, take responsibility for family planning and support their wives when their wives choose a method. Further, including GPs who are interested in delivering family planning services but not qualified to perform clinical procedures such as pelvic exams and IUD insertions dramatically expands the availability of basic family planning services and contributes to an extensive referral network.

Later in 1997 pharmacists (GS3) were recruited into the network (well after GS2 training was underway). Research indicated that pharmacists were important first sources of family planning information for consumers and could heavily influence their decision to adopt family planning or not. Including pharmacists greatly expands the availability of both accurate family planning information and Green Star products, and facilitates referrals to appropriate Green Star providers.

Junior paramedics were eventually included in the network as GS4 providers because many low-income people who cannot afford doctors go to these health professionals for medical treatment. Many junior paramedics, particularly lady home visitors, work in the poorest neighborhoods and often have a larger clientele than doctors. As with GS2 doctors, GS4 providers deliver family planning counseling services and administer non-clinical methods such as hormonal contraceptives. GS4 clinics must have electricity and running water, and must be clean and well maintained.

Through experience, SMP found that ideal Green Star providers typically own their own businesses. These providers tend to be stable in their employment and are also easier to track. They are often younger and more receptive to training, have positive attitudes toward family planning, and are strong entrepreneurial types. Clinics run by husband and wife teams usually do very well, perhaps in part because of the cross-referrals they can provide. GPs just beginning their practices are frequently champions, probably in part because of the benefit they gain from SMP's marketing services, including local promotional events.

Recruiting Providers

At the outset of the pilot project, recruiting physicians to join the Green Star Network was a challenging endeavor. Newly hired field staff had to map out existing providers and identify those with the potential to become network members. Mapping strategies included obtaining lists of providers and their addresses from medical associations and pharmaceutical companies, interviewing pharmacists in low-income areas, and simply searching neighborhoods street by street for clinics. Once clinics were mapped out, Green Star staff visited them to identify potential candidates. To be considered, clinics had to meet basic minimum standards, including maintenance of a clean facility, presence of a female GP and a willingness to provide family planning services. Green Star staff would then interview those providers who met the minimum standards to assess their level of interest in participating in the network. At this stage of the project selling the concept of the network was as important as screening potential network members.

Enlisting members at the beginning was particularly difficult because the Green Star was unheard of. Participating in such a project required a leap of faith on the part of the provider. Thus, the first providers to join the network were female GPs who were truly committed to improving their practice and who felt that the training they would receive provided enough benefit to offset the risks of being associated with this new initiative. However, training had to be scheduled in such a way that the providers would not have to close their clinics. Therefore, to accommodate this need, the training program was revised from five full days to 10 half-days.

The process of recruiting and selecting Green Star Network members has become much easier as the brand has grown in recognition and respect. Membership announcements and applications are made available to providers through SMP sales promotion officers, journal ads, association meetings and mass mailings. Interested providers send their applications to Green Star staff. As of the writing of this study there is a waiting list to become a member, and so Green Star recruiters can apply much more stringent criteria to the provider selection process.

SMP is currently considering the possibility of charging franchise membership dues. These dues might help to focus the self-selection of franchisees on those providers most motivated to join the network and deliver services in accordance with Green Star protocols. Dues could be used to supplement training and advertising. The feasibility of initiating a franchise dues system depends largely on the benefits providers perceive from being members of the Green Star Network.

Training Staff and Upgrading Facilities

Training is central to assuring quality of care at Green Star outlets. In order for providers to deliver services according to Green Star protocols, they must be trained in what is meant by quality and how to deliver quality services. To this end, SMP designed the Green Star training curriculum. Providers must successfully complete this training course before they can be certified as Green Star Network members.

JHPIEGO provided SMP with its non-country-specific training packages for IUD insertion and removal, infection prevention, and clinical skills. These materials provided the framework for the provider training packages that SMP developed. In addition, the SMP training division worked closely with a training consultant to develop the program and a special course in trainer preparation. The curriculum on hormonal methods was based on the results of a training needs

assessment among GPs, with existing curricula adapted for presentation through the competency-based training (CBT) approach.⁶

Special attention was given to staff teamwork in preparing training materials and in the training itself. Materials included case studies for analysis, role-playing and discussion exercises, and basic family planning information appropriate to each Green Star provider cadre. These materials are presented in the form of a trainer's manual for each of the four categories of Green Star providers and for the Green Star trainers. Participants take these materials home for ready reference.

SMP also developed a family planning reference manual for all trainees based on the JHPIEGO *Pocket Guide for Family Planning Service Providers* and reference materials from the Program for International Training in Health (INTRAH). This manual is an easy-to-use guide to delivering family planning services for every Green Star provider. The manual covers client assessment, counseling techniques, appropriate uses for different contraceptives and side effects management for each type. The manual was designed to integrate with the Green Star training courses.

SMP hires medical doctors to conduct in-house training courses, rather than contracting this function out. This arrangement has several advantages. Each of these in-house trainers later monitors the clinics of the Green Star providers that she/he has trained, which affords continuity, consistency, and ongoing social and technical support for Green Star health professionals.⁷ Additionally, it has been observed that trainees hold their colleagues who serve as trainer-monitors in high regard, a circumstance that may contribute to the motivation of Green Star franchisees. As of the writing of this case study, SMP maintains 20 Green Star trainer-monitors across the country.

Potential Green Star providers interested in the network who have met the selection criteria are invited to participate in a training course designed specifically for their type of practice. There are four different training courses:

- **GS1 — Licensed female MDs and paramedics.** The GS1 course is designed to train and certify female doctors and paramedics.⁸ These registered medical practitioners operate clinics in low-income urban areas. Topics covered include family planning counseling, IUD insertion, prescription and administration of hormonal methods, side effects management, infection prevention, and clinic management. GS1 training is a 40-hour course, given over ten half-days (four in the classroom and six in the clinic). To date, more than 2,000 women have been successfully trained as GS1 practitioners.
- **GS2 — Male and female MDs who do not have IUD delivery capabilities.** Male doctors (and female doctors who do not have the professional setting or do not wish to provide IUDs) receive a one-day course on counseling techniques, hormonal prescription and administration,

⁶ In traditional training, the unit of progression is time and the training is teacher-centered. In a CBT system, the unit of progression is mastery of specific knowledge and skills, and so training is learner- or participant-centered. Competency-based training for reproductive health professionals is training based upon the participant's ability to demonstrate attainment or mastery of clinical skills performed under certain conditions to specific standards (the skills then become competencies) (Sullivan, 1995).

⁷ Female trainer-monitors work with GS1 and GS4 providers. Male trainer-monitors work with GS2 and GS3 providers.

⁸ Criteria for paramedics becoming GS1 providers include: a successful history of GS4 practice, suitable facilities for the insertion of IUDs and IUD insertion training.

and management of possible side effects. Of the 4,500 doctors who have successfully trained as GS2s, 70 percent are men.

- **GS3 — Pharmacists.** Interested and qualified pharmacists receive a half-day of GS3 training in the importance of family planning, hormonal contraceptives, management of side effects and recommended referrals. More than 2,500 pharmacists have completed the GS3 training course.
- **GS4 — Junior paramedics.** Junior paramedics, including many who work as lady health visitors, receive a one-day training course in counseling techniques, hormonal prescription and administration, and handling of possible side effects. More than 2,200 paramedics have successfully completed the GS4 training course.

All four Green Star training curricula address the six essential elements of quality as defined in the service delivery protocols. Particular emphasis is placed on developing counseling skills and proactively discussing family planning with clients. In keeping with the competency-based training approach, every trainee is given the same test, appropriate to his or her provider cadre, both pre- and post-training, to establish a baseline and test the trainee's competency at the end of Green Star training.

To maximize participation and minimize dropouts, courses are held at times that are convenient for providers and transportation is offered to each trainee from his or her home to the training location and back. While most training programs in Pakistan offer monetary incentives for participants, Green Star training does not. The lack of financial incentives has not impeded participation.

All health providers who complete the training course and pass the exam are awarded a certificate and invited to become members of the Green Star Network. This certificate has become highly regarded among medical professionals in Pakistan and the majority of those who receive it opt to join the Green Star. Health professionals who decide to join Green Star enter into a formal franchising agreement with SMP (see discussion of the agreement below).

Once the agreement is signed, SMP provides the franchisee with the physical upgrades necessary to conform to the requirements of the network (for example, painting or the provision of essential equipment — nothing too costly) and installs a Green Star sign outside the outlet, identifying it as a Green Star provider. Outlets are also provided with information, education and communication materials, including a counseling flip chart and family planning product samples. Doctors and paramedics who have been trained to provide IUD services are also given IUD instrument kits and sterilizers.

Green Star certified providers are welcome to participate in refresher training courses at any time and are encouraged to send new staff to training workshops. In some cases, if services are found to be substandard, providers are required to undergo remedial training to maintain their Green Star Network membership.

The Green Star training program is evaluated and refined on a regular basis. JHPIEGO provided a comprehensive evaluation of all four Green Star training programs in 1998 (Vogel *et al*, 1998). While this study suggested a variety of small improvements — many of which Green Star has since implemented — the evaluators concluded that SMP has “a strong and effective . . . training program.” The JHPIEGO study found that notable accomplishments in Green Star training include:

- an excellent use of adult learning techniques;
- trainers who are strong content experts;
- learning objectives clearly based on identified needs;
- good use of team training and competency-based training; and
- strong and effective participation by the learners.

Field Support

The extensive follow-up component of the Green Star project sets it apart from most training programs. SMP has 30 Green Star trainers nationwide. Beyond training, one of their main functions is to perform regular support and monitoring visits to Green Star outlets to answer technical questions, assist with procedures, and identify and solve problems providers might face in delivering family planning services. Green Star trainers support and monitor the same providers they have trained, providing a sense of continuity and mutual commitment to network members.

In 1999 alone, SMP training staff conducted more than 14,000 support and monitoring visits to Green Star providers. Green Star sales promotion officers made an additional 7,631 visits in 1999.

Follow-up visits are made most frequently to providers who are new to the network in order to provide them with the support they need to integrate the Green Star family planning component into their practices. As providers become more confident and proficient, monitoring and support visits decrease in frequency, but they are never discontinued.

The ongoing support function that Green Star trainers perform is vital to ensuring that providers continue to deliver quality services. Green Star trainers visit Green Star providers on a regular basis to assist them with any problems they may be facing in their practice and to reinforce the concepts they learned in training. Trainers can identify if further training is required at a particular Green Star outlet and make arrangements accordingly. Green Star trainers also coordinate the upkeep of Green Star signboards and supply outlets with information, education and communication materials and Green Star products. Mutually respectful relationships are formed between Green Star trainers and network members. This facilitates the open communication required to identify potential problems and devise solutions — such as remedial training or working groups — before problems become serious.

Additional support is available to Green Star members by way of a 24-hour telephone hotline where messages can be left for Green Star trainers who respond promptly to requests.

Monitoring Quality of Care

SMP's quality of care monitoring system seeks to ensure that services delivered at Green Star outlets are consistent with the Green Star protocols. When entering into the franchise agreement, providers are informed that the quality of their services will be periodically monitored. The value and success of the franchise depends on the overall quality perception of the Green Star brand, which in turn is dependent on consumer experience and word of mouth. Even a few poor quality sites can damage the brand image and thus harm the reputation of all outlets affiliated with the brand. It is therefore of paramount importance that SMP monitor the quality of services delivered at Green Star outlets.

SMP monitors quality of service delivery through two methods: internal supervisory visits and external mystery client surveys.

- **Internal supervisory visits.** Members of the SMP field staff make quarterly supervisory visits to Green Star providers. During these visits, the staff evaluate selected indicators that reflect the quality of care described in the service delivery protocols, including the outlet's physical condition; record keeping; information, education and communication materials; and contraceptive supplies available. For GS1 outlets, the visiting staff monitors IUD insertions and infection prevention procedures. The information is recorded in a supervisory activity sheet and submitted to senior management for review (see Appendix A).
- **Mystery client surveys.** SMP contracts with a research agency to conduct periodic mystery client surveys among Green Star outlets. Researchers pretending to be clients going to Green Star outlets for counseling conduct the surveys. Afterward visiting the outlet, the researchers record their experience on a monitoring form. The purpose of these visits is to monitor elements of quality of care not easily observed by Green Star supervisors. For example: the provider's interpersonal skills, technical competence, choice of methods offered, and so forth. Results of these surveys are submitted to senior management for review.

Management Information System

The Management Information System (MIS) was developed as a tool for program managers to monitor Green Star performance over time. Data on Green Star outlets and from forms completed during support and monitoring visits are entered into the system. Client data and sales figures are also entered into the system. Clinic performance reports are generated to assess quality of care indicators and quantity of product purchased. The latter serves as a proxy for the number of clients who adopt a contraceptive method at a given clinic.

Referral System

A referral system linking the different levels of service providers ensures that clients in need of more specialized interventions, such as IUDs or surgical contraception, are directed to the appropriate service delivery point. Two types of referral mechanisms are in place: internal and external.

- **External referral** sites include specialized NGOs and hospitals that are equipped to handle procedures such as surgical contraception or complications needing special attention.
- The **internal referral** mechanism facilitates appropriate referrals within the Green Star Network. All Green Star providers receive an internal referral list outlining the services offered by each provider. Using this list, a GS2 provider who has a client for whom the IUD is appropriate can easily refer her to a GS1 provider qualified to insert IUDs.

Contraceptive Supplies

To ensure that Green Star outlets are able to offer the full range of quality contraceptives at affordable prices, SMP markets contraceptives under the Green Star brand and distributes them to Green Star outlets. The Green Star contraceptive portfolio includes the following products:

- **Touch condoms.** Touch is a slightly higher priced condom than SMP's *Sathi* brand and public sector products, with a superior quality image.
- **MultiLoad IUD.** MultiLoad is a Cu375 intrauterine device manufactured by Organon.
- **Nova oral contraceptives.** Nova is a low-dose combined hormonal contraceptive pill, manufactured by Schering AG under the trade name Microgynon.
- **NovaJect injectable contraceptives.** NovaJect is a two-month progesterone-only injectable contraceptive, manufactured by Medipharm (Pvt) Ltd, a licensee of Schering AG, under the trade name Noristerat.

Green Star brand contraceptives, with the exception of the MultiLoad IUD, are distributed through a commercial distributor to the appropriate outlets.⁹ SMP also has its own specialty sales force that supplies Green Star products directly to Green Star providers and outlets on a monthly basis. IUDs are distributed only to GS1 providers; other products are distributed to all Green Star providers. Products are priced so that they are affordable to low-income clients, yet profitable to sell.

Letter of Agreement

As mentioned above, once a provider has successfully completed a training course and decided to become a Green Star member, she or he enters into a formal franchising agreement with SMP. This agreement functions as an enforceable contract governing the relationship between the two parties. It outlines the roles and responsibilities of each party and stipulates the terms under which the agreement may be terminated. The agreement also limits SMP's liability.

How the Components Work Together

Together these major components and their operating subcomponents form the foundation of the Green Star Network. The business format defines what the service is and how consumers can expect it to be delivered. The service delivery protocols guide providers. The Green Star brand assures consumers of the quality they will receive from Green Star outlets and creates demand for providers' services. Brand equity serves as an incentive for providers to maintain the quality standards needed for Green Star membership. And, most important, the quality assurance mechanisms — provider selection, training, support, monitoring and contractual obligations — enable providers to deliver quality services and ensure that they do so in accordance with the franchise requirements. The result is increased accessibility and use of quality family planning services in Pakistan.

Green Star Management

SMP is headquartered in southern Karachi. PSI and SMP operate as a joint venture partnership to implement social marketing projects in Pakistan, including the Green Star Network. As the executing agency for the Green Star Network, SMP has managerial autonomy — subject to policy guidance from the Pakistan Ministry of Population Welfare and KfW.

In total, 175 local staff and two expatriate advisors are employed by SMP in Pakistan.

⁹ Commercial oral contraceptives are sold mostly through chemists (pharmacists — GS3). GS1, 2 and 4 providers can also prescribe and sell hormonals (OCs and injectables).

SMP's Organizational Structure

PSI designates the SMP executive director and SMP board members designate the chief executive. The SMP board of directors consists of six SMP members and three members appointed by PSI.

The board of directors has three main roles: providing guidance in strategy and policy; developing contacts with donors and other stakeholders in both the public and private sectors; and providing oversight of SMP management. The board meets once every three months and is not involved in the day-to-day management of the organization. At its meetings, the board reviews past activities, discusses the future of the program and approves each year's financial accounts.

SMP's organizational structure evolved to accommodate its responsibilities as a franchiser. A training division was added and staff hired to oversee and implement the operational components of the Green Star Network. There are four functional divisions within SMP: training, marketing and sales, commercial (finance), and administration/logistics. A divisional coordinator, who reports to the SMP chief executive and is based out of SMP's office in Karachi, heads each department. The structure of each of these divisions is further described below.

Training Division

The training division comprises three regional field managers who report to the national medical coordinator. Each regional field manager supervises two teams of trainers; each team consists of three to six women and two to three men. Trainers are based in both regional and sub-regional offices; in cities that do not have SMP offices, trainers work from home offices. Each of the three regions also has an administration and logistics officer, a recruitment officer and an MIS officer. Female trainers work with GS1 and GS4 providers and are associated with specific training sites. Male trainers are mobile and work with GS2 and GS3 providers at various sites. Green Star trainers are responsible for:

- recruiting Green Star members;
- organizing and leading training workshops;
- conducting monitoring and support visits; and
- coordinating the provision of product and information, education and communication supplies with sales promotion officers.

All trainers have professional backgrounds in health care and have successfully completed the SMP training of trainers course conducted by SMP master trainers.

Marketing and Sales

Under the marketing coordinator, the marketing and sales department is divided into two distinct functions. One handles the marketing and sales of ethical products and services, including hormonal contraceptives, the IUD and the Green Star Network itself. The other implements the marketing and sales of over-the-counter products, namely *Sathi* and Touch brand condoms.

The marketing coordinator ensures that all marketing activities work together to support the overall Green Star campaign. (All products, except *Sathi*, are linked to the Green Star logo.) The ethical products and services manager is responsible for developing and implementing marketing strategies for the Green Star Network, hormonal contraceptives and the IUD. This person also supervises three regional sales managers who, in turn, each supervise a team of eight to 12 sales

promotion officers. A total of 30 sales promotion officers nationwide are responsible for detailing and selling Green Star products directly to physicians and generating orders from pharmacists in their territories. They also form an important link between Green Star providers and SMP. A national commercial distributor distributes all Green Star products except MultiLoad to pharmacies through its 10 branches and 150 sub-distributors nationwide. (MultiLoad is distributed to GS1 providers only via SMP staff.) Area sales managers are responsible for condoms only, and focus primarily on promoting and distributing condoms to non-traditional outlets and monitoring distributor activities.

Commercial and Administrative Division

The commercial and administration division is in charge of the day-to-day logistics of the organization. This division is responsible for product tenders and procurement, product testing and warehousing. In addition, the division is responsible for all SMP-related administrative matters. Hence, the coordinator is in charge of managing all SMP offices and providing administrative support across the country.

Implementing the Green Star Network

The Green Star Network was implemented on a pilot basis from December 1995 to December 1996. The pilot phase involved testing the franchise business model for GS1 in 300 clinics located in two urban areas of Pakistan: Islamabad and Karachi.

Evaluation

Evaluation of the Green Star pilot was completed in January 1997. The purpose of the evaluation was to assess the effectiveness of the project to date and determine which factors most influence success in order to provide a practical blueprint for expansion. To evaluate the pilot, data were collected from the following sources:

- The results of a series of surveys administered by an external research agency. The agency conducted two rounds of surveys at pilot clinics to measure changes over time.¹⁰
- Information gathered and used in SMP's internal MIS.
- Qualitative information provided by SMP's Green Star field staff.

The data from these three sources were combined and compared to formulate and confirm interpretations of perceived trends.

Principal findings of the evaluation are as follows (Agha *et al*, 1997).

Clinic Performance

The evaluation measured the degree to which the project was able to expand the private sector's capacity to provide high quality family planning services and to increase use of family planning and the total number of clients. The evaluation found that:

- There was a doubling of the average number of family planning clients at Green Star clinics within a six-month period (from 1.8 to 4 clients per clinic per day).
- There was a substantial increase in total clients at Green Star clinics during the pilot project period: the average number of clients coming to Green Star Network clinics increased from 14 to 19 per clinic per day.
- There was a steady increase in quarterly purchases of IUDs, injectables, condoms and OCs by Green Star clinics.
- Prices for IUD and injectable contraceptive administration at Green Star clinics appeared to be higher than recommended.

¹⁰ The external surveys of the Green Star pilot clinics were closely modeled on the Population Council's situation analysis approach to evaluating family planning clinic facilities. For more information about this approach please visit www.popcouncil.org or refer to Robert A. Miller *et al*, *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health: A Handbook* (New York: Population Council, 1998).

Quality of Care

The evaluation was designed so that the performance of Green Star clinics could be measured in relation to the elements of quality of care as defined in the Bruce–Jain framework both soon after training and again within six months of training. Overall, availability of contraceptive supplies and counseling skills improved significantly. One remaining weakness among project clinics was the lack of a mechanism to follow up with individual family planning clients. Technical competence in terms of clinical skills, specifically IUD insertion and infection prevention, was ensured and evaluated through competency-based clinical training before induction into the Green Star Network.

Additional findings include:

Choice of Contraceptive Method

- Availability of IUDs, OCs and injectables at Green Star clinics increased from 50 percent to over 90 percent during the pilot phase.
- Availability of the agreed upon method during the mystery client survey increased from 76 percent to 96 percent.

Information Given to Clients

- Providers gave information on three or more contraceptive methods to 86 percent of mystery clients.
- Detailed explanation of how the IUD works — its effectiveness, how it is used, its contraindications and its side effects — increased from over 40 percent to over 70 percent between the first and second round of mystery client surveys.
- Detailed explanation of injectables given by over 60 percent of providers.

Client/Provider Relations

- In almost all cases, Green Star providers greeted clients respectfully and socialized with them. Other staff members were friendly and helpful to clients.

Follow-Up

- By the second round survey, 85 percent of providers informed clients when to return for follow-up.
- Daily record keeping by providers was not complete enough to allow systematic follow-up of new family planning acceptors.

Appropriate Constellation of Services

- In the design of the Green Star Network, general practitioners were chosen as the most suitable service providers for family planning because they already have a clientele for general medical and pediatric services. Introducing family planning to their range of services allows doctors to better serve the needs of existing clientele, as well as to attract new clients.

Refinement

Based on the findings of the evaluation, some revisions were made to the franchise business model prior to expansion. These included:

- Selection criteria for GS1 were weighted toward those providers who own and operate their own clinics rather than toward larger clinics or hospitals employing doctors.
- The training was modified to increase emphasis on counseling for side effects.
- Ongoing support was included as a central element in the expansion phase.
- The amount of information required for client record keeping and MIS was reduced.

Expansion

After the pilot project, the Green Star Network was expanded in two ways:

- by increasing the number of female doctors nationwide in the GS1 cadre; and
- by developing alternative service delivery packages to accommodate a wider range of providers in the network.

Since the end of the pilot phase in December 1996, SMP has expanded the network of GS1 providers from 500 in Karachi and Islamabad to 2,571 nationwide. In 1997, provider cadres GS2, GS3 and GS4 were added — they have contributed to the growth of the network by more than 9,000 providers. In 2000, the network comprised 11,557 providers nationwide (table 1).

Table 1: Growth of the Green Star Network

Year	GS1: Female MDs & paramedics	GS2: MDs without IUD capacity	GS3: Licensed pharmacists	GS4: Junior paramedics	Total Green Star providers
1995	300	-	-	-	300
1996	499	-	-	-	499
1997	1,240	2,724	295	1,038	5,297
1998	1,803	3,608	2,529	2,142	10,082
1999	2,352	4,258	2,586	2,142	11,338
2000	2,571	4,258	2,586	2,142	11,557

Numbers of practitioners for each year are cumulative.

Achievements

In its first five years of operation, the Green Star Network greatly increased the accessibility of family planning services to low-income people throughout Pakistan. At the same time, SMP has grown into one of the largest social marketing programs in the world, as measured both by number of beneficiaries and by level of funding base. This section highlights some of SMP's major achievements through the Green Star project.

Expanded Access to Family Planning

Through Green Star, SMP rapidly expanded physical access to family planning by integrating family planning services into more than 11,000 private sector outlets that did not systematically provide these services.

Not only has the number of outlets providing family planning increased, the cadres of providers who offer family planning services have also been expanded to include private sector pharmacists and paramedics, as well as female and male physicians. Preliminary results of a provider survey conducted by the University of North Carolina (2001) show that members of the Green Star Network are nearly twice as likely to deliver family planning services as their non-Green Star counterparts in the private sector.

Green Star has made family planning services much more geographically accessible to the target population of low-income urban Pakistanis. Green Star health providers provide family planning services to people in 40 urban areas of the country. Fifty million people are within the network's area of coverage.

An estimated 74 percent of Green Star clients are from low-income groups — those earning less than Rs 6,000 per month (SMP, 1998).

Green Star has also expanded cognitive access to family planning services by increasing awareness of modern contraceptive methods and where they can be obtained.

Knowledge of contraceptive methods is an important determinant of contraceptive use. The Green Star project, through its communications and media campaigns and highly visible network of service delivery points, has contributed to the rise in knowledge of different family planning methods among women in Pakistan. In 1995, knowledge of any method of family planning was 90.7 percent among married women of reproductive age (Population Council, 1998). By 1997, two years after Green Star began, knowledge among these women had increased to 94.3 percent (NIPS/LSHTM, 1998). Particularly compelling is increased knowledge about the modern female-controlled methods that Green Star promotes: OCs, injectables and IUDs. Among these women, awareness of OCs increased from 72.7 percent to 86.6 percent; of injectables, from 80.5 percent to 86.0 percent; and of IUDs, from 80.5 percent to 86.0 percent over the same two-year period (1995–97).

But before women can use contraceptives, they must know where to obtain them. Green Star's advertising and promotions campaigns were designed to create awareness not only of the methods available, but also of where they can be found. This knowledge, too, has risen sharply since the early 1990s. In the early 1990s, only 25 to 30 percent of married women of reproductive age in Pakistan who knew about the pill, IUD or injectable also knew where to get them (Pakistan DHS,

1992). By 1997, around 70 percent of these women knew where they could get contraceptives (NIPS/LSHTM, 1998).

While some doctor's offices and clinics may have provided family planning services before joining the Green Star Network, these venues were not clearly identified as doing so. Consumers may not have been aware of the availability of contraceptive services at a particular clinic. By visibly branding sites with the Green Star logo and advertising the logo as a symbol of high quality family planning at affordable prices, SMP created widespread consumer awareness of contraceptive products and services and where they can be obtained. A 1997 media effectiveness study found unprompted awareness of Green Star to be almost universal: 94 percent of those surveyed recognized Green Star (AAL, 1997). The Green Star program is so successful that its name and logo are now synonymous with family planning.

Green Star has expanded psychosocial access to family planning by integrating it with a broad range of primary health care services and by improving providers' attitudes toward family planning service delivery.

In Pakistan, as in many other countries, there is a heavy social stigma associated with family planning. While SMP's goal was to increase visibility of family planning services — making them easier to find — it was also important to do so in ways that did not stigmatize contraceptive users. To this end, SMP designed the Green Star program so that family planning services would be integrated with already existing health facilities known to offer a range of curative and preventive treatments other than family planning. A client walking into an outlet displaying the Green Star logo is not identified as a seeker of family planning services, and his or her privacy is maintained.

Further, clients may be more inclined to ask Green Star providers for family planning advice because they do not fear being judged by the provider. Training and communications aimed at Green Star providers dramatically improved their attitudes toward family planning and addressed misconceptions that might otherwise have negatively affected their advice to clients. Providers are also trained to initiate a discussion about family planning with clients seeking other services.

Improved Quality of Family Planning Services

Monitoring and evaluation of the Green Star Network has demonstrated that Green Star providers' performance across the six Bruce-Jain quality of care elements is good, and that improvements in quality have continued over time.

A wide variety of studies have shown that Green Star has improved quality of care through the increased skill and competency levels of its providers. An evaluation of the network following its first year used several measures — including external surveys, information gathered for the Green Star MIS and qualitative information provided by Green Star staff — to assess its impact (Agha *et al*, 1997). Together these data indicate a number of positive findings:

- The availability of IUDs and hormonal contraceptives increased by 80 percent in Green Star clinics.
- The availability of the client's choice of method increased from 76 percent to 96 percent.
- By the end of Green Star's first year of operation, providers gave information about three or more contraceptive methods to 86 percent of mystery family planning clients.
- Detailed explanations were given about the IUD to 70 percent of family planning clients and about injectables to 60 percent.
- In almost all cases, Green Star providers and their staffs treated clients respectfully and cordially.
- By the final survey, 85 percent of providers informed clients about when they should follow up on their visit.

Later research has yielded similar positive results for other groups of Green Star providers. A 1998 study of GS2 providers (based on hundreds of mystery client interviews, direct interviews and full-day client counts) indicated that these doctors showed improved interpersonal skills, improved knowledge of contraception and greater willingness to promote family planning (Management Information Ltd, 1998). A 1999 study of Green Star pharmacists (based on approximately 1,000 interviews, largely by mystery clients) found that GS3 providers were more knowledgeable about contraceptives, more alert to family planning customers and their needs, and more confident in providing information than untrained providers (Raasta, 1999). Similar research by the same authors on GS4 providers indicated that trained providers rated more highly than comparable untrained providers in terms of contraceptive knowledge, ability to manage side effects, propensity to recommend family planning methods, and willingness and confidence in counseling couples as well as women alone (Raasta, 1999).

SMP has expanded the choice of contraceptives available to low income people through the introduction of four low-cost family planning products under the Green Star brand — an OC, an injectable, a condom and an IUD. These products were developed to fill a market gap between public and commercial sector commodities and are priced at a level that consumers are willing and able to pay. Attractive margins were built into the pricing structure to motivate businesses to stock the products. Green Star social marketed products are also distributed through non-network commercial channels, as well as through Green Star outlets. Altogether, Green Star contraceptives are available in more than 30,000 retail outlets nationwide.

Increased Use of Family Planning Services and Methods

Increase in Family Planning Clients in Green Star Clinics

PSI research found that Green Star outlets experienced an increase in the number of their family planning clients (Agha *et al*, 1997). During the network's first year, the number of family planning clients seen by female MDs and paramedics more than doubled, from 1.8 to 4 per day. The total number of clients coming to these clinics (for any reason) increased from 14 to 19 per day.

In order to estimate changes in the number of family planning visits throughout the network, PSI undertook an analysis that projected family planning use based on extrapolations from a limited number of outlets (Hovig, 1999).¹¹ This extrapolation suggested that more than 10 million visits are made to clinics with female providers annually and that at least two million of these visits are for family planning. From this, it is estimated that clinics with female providers receive approximately 15 family planning client visits per week.¹² Preliminary findings from a 2001 University of North Carolina provider survey support this estimate: The survey found that Green Star providers of all types received an average of 16 family planning clients per week (UNC, 2001) (see table 2, below).

Continuing to extrapolate these findings to the entire network of 11,557 Green Star providers, PSI estimates that, overall, the Green Star Network receives some 30 million client visits related to family planning each year. Assuming that each family planning client visits a Green Star outlet at least four times per year (for consultation or re-supply), PSI estimates the total number of clients to be approximately 7.5 million.¹³ Some of these clients may be responding directly to Green Star marketing and promotions, whereas others may have sought out family planning regardless of Green Star. In either case, clients requesting family planning services most likely received better quality care than they would have without Green Star because of the program's training and quality assurance components. It is estimated from the retail audit that approximately two-thirds of clients receiving contraceptives from a Green Star outlet receive a Green Star brand. (It is also expected that some do not choose to use any modern method despite receiving counseling.)

Table 2: Estimated family planning client visits received by Green Star

Year	Family planning client visits*
1995	7,800
1996	389,220
1997	4,131,660
1998	7,863,960
1999	8,843,640
2000	8,843,640
Cumulative total, 1995–2000	30,250,740

* Estimating that each provider receives 15 family planning clients per week.

¹¹ The analysis was based on four 1999 retail audits of GS1 providers; sample sizes were 200, 173, 164 and 153, respectively

¹² Two million family planning client visits per year/52 weeks per year/2,500 GS1 clinics = 15 family planning visits per week.

¹³ Thirty million client visits total/4 visits per client = 7.5 million clients.

Expanding the Contraceptive Market in Pakistan

Since Green Star began, the overall contraceptive market has expanded. In 1998 and 1999, approximately 20 percent of all Pakistani couples who used a modern contraceptive method obtained it through SMP. In 2000 alone, SMP products protected nearly one million couples from unintended pregnancies. Since 1995, SMP family planning products have produced over 4.5 million couple-years of protection. Moreover, these figures fail to reflect notable sales increases in public sector contraceptives during the same time — sales that may have been enhanced by Green Star’s widespread marketing campaigns.

Sales are a good proxy for measuring contraceptive use. The fact that sales of Green Star and other contraceptive products have consistently increased indicates that overall use of contraceptives is rising. SMP social marketed products contributed to market expansion both directly and indirectly. The use of hormonal contraceptives (pills and injectables) in particular had been stubbornly low in Pakistan: between 1991 and 1995, contraceptive prevalence estimates indicate that the use of these contraceptives remained virtually flat.¹⁴ Subsequent to SMP’s introduction of Green Star services in 1995 and Green Star’s offering hormonal contraceptives in 1996, both sales data and contraceptive prevalence data show a significant rise in the use of all modern methods, and particularly of hormonal methods. Between 1996, when Green Star hormonals were introduced, and 2000, the total national market for injectables grew by 53 percent, and for pills by 80 percent. Hormonal sales are detailed in tables 3 and 4, below. Figure 5 maps out national CYP growth and figure 6 the CYPs generated by Green Star.¹⁵

Table 3: Total Pakistan oral contraceptive market, 1994–2000

OC sales, in unit cycles						
Year	SMP’s Nova	Nordette 21 (commercial)	Nordette 28 (KSM)	Ovral (commercial)	GoP	Total OC sales
1994	-	405,000	-	560,000	930,735	1,895,735
1995	-	540,000	-	640,000	1,126,655	2,306,655
1996	6,000	516,776	-	644,873	1,327,826	2,495,475
1997	148,000	412,704	103,504	545,433	1,910,917	3,120,558
1998	268,616	235,000	515,446	549,000	1,879,038	3,447,100
1999	346,025	190,000	649,894	542,000	1,945,358	3,673,277
2000	520,000	180,000	684,336	452,000	2,675,238	4,511,574
Cumulative total	1,288,641	2,479,480	1,953,180	3,933,306	11,795,767	21,450,374

Sources: SMP sales from SMP sales report/MIS; public sector sales from GoP; commercial sector sales from Wyeth; KSM sales from The Futures Group International’s Key Social Marketing project (DFID-funded).

¹⁴ Between 1991–95 the estimated CPR for OCs in Pakistan remained flat at 0.7 percent and injectables rose slightly: from 0.8 to 1 percent. (Sources: 1991 rates from Pakistan DHS, 1992; 1995 rates from Population Council, 1998)

¹⁵ **A note on CYPs:** A couple-year of protection (CYP) is the estimated protection provided by family planning services during a one year period, based on the volume of all contraceptives sold or distributed free of charge during that period. The CYP is calculated by multiplying the quantity of each method by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed to obtain a total CYP figure. The conversion factors used by the PSI/SMP to calculate the impact of the Green Star Network are: 1 CYP = 13 cycles of OCs; 6 injectables; 100 condoms; 0.286 IUDs. Sales figures from SMP sales reports were used to calculate CYPs.

Table 4: Total Pakistan injectable market, 1994–2000

Injectable sales, in unit ampoules or vials					
Year	Commercial sector	Public sector	KSM Depo-Provera	SMP NovaJect	Total injectable sales
1994	67,904	963,234	-	-	1,031,138
1995	74,324	1,268,162	-	-	1,342,486
1996	83,145	1,101,194	-	4,000	1,190,339
1997	65,437	1,522,655	15,943	63,408	1,667,083
1998	29,043	1,497,672	68,073	89,688	1,684,476
1999	33,400	1,407,398	103,614	125,688	1,670,100
2000	25,461	1,454,158	149,302	189,831	1,818,752
Cumulative total	378,714	9,214,473	336,932	472,615	10,404,374

Sources: SMP sales from SMP sales report/MIS; public sector sales from GoP; commercial sector sales from Wyeth; KSM sales from The Futures Group International's Key Social Marketing project (DFID-funded).

Green Star had better success with IUDs than with OCs or injectables. Though the tables might seem to suggest otherwise, Green Star did not have much impact on the condom market, nor was it intended to. In 2000, for example, Green Star IUDs accounted for almost 195,000 couple-years of protection — more than Touch condoms, Green Star OCs and injectables combined.¹⁶ In 2001, Green Star should deliver around 300,000 couple-years of protection with the IUD. This is not surprising considering the historically high discontinuation rates for OCs and injectables in Pakistan.

In the case of OCs, the rising and falling levels of various OC products and programs are due to several factors other than Green Star's influence.

- Wyeth decided to exit the Pakistan commercial OC market by the end of 2000: Nordette 21 and Ovral are no longer distributed in Pakistan.
- In 1996, Wyeth (the manufacturer of Nordette 21 and Ovral) contracted to allow the Key Social Marketing (KSM) program to distribute Nordette 28. Nordette 28 was to be socially marketed under a manufacturer's model.
- In 1997, Key Social Marketing consumers began switching from Nordette 21 to Nordette 28 as Wyeth phased out Nordette 21.

The authors do not believe that the Nova OC “cannibalized” the sales of commercial oral contraceptives. Nova was a new product provided via a largely new service delivery channel and targeted to low-income women. SMP was careful to segment the market and only target women that could not afford the commercial brands. The dramatic drop in sales of Nordette 21 and Ovral is likely to have been caused by Wyeth's decision to exit the commercial OC market in Pakistan by the end of 2000.

Conversely, it is easier to document the Green Star Network's positive impact on the distribution and sales of government contraceptives. A series of audits at Green Star outlets and found that many were selling government OCs and injectables because government contraceptives were even cheaper than social marketing brands, and thus they offered providers a higher profit

¹⁶ Since we are assessing the impact of the Green Star Network on the overall contraceptive market in Pakistan the *Sathi* brand of condoms are left out of this calculation. *Sathi* condoms were social marketed long before the launch of the network.

margin. These audits indicated that Green Star product sales did not represent all the CYPs that were being delivered via Green Star outlets. In fact, the total number of CYPs delivered via Green Star was about 50 percent higher than social marketing sales statistics show. From all analyses, it was concluded that Green Star played a significant role in expanding the overall contraceptive market, as well as contraceptive use, particularly for OCs.

To date, SMP has sold 148,270 IUDs (see table 5), generating approximately 518,945 couple-years of protection. MultiLoad IUD sales have consistently increased since the brand was launched in 1996, indicating that clients are increasingly satisfied with the method.

Table 5: Total Pakistan IUD market, 1994–2000

IUD sales, in unit IUDs			
Year	Public sector	SMP's MultiLoad	Total IUD sales
1994	420,000	-	420,000
1995	483,000	80	483,080
1996	550,000	5,537	555,537
1997	660,000	18,621	678,621
1998	987,315	27,360	1,014,675
1999	971,056	41,119	1,012,175
2000	756,080	55,553	811,633
Cumulative total	4,827,451	148,270	4,975,721

Sources: Public sector sales figures for 1994–97 are based on CPR data for IUDs; public sector figures for 1998–2000 are based on GoP data; SMP sales are based on SMP sales reports/MIS.

By 2000, sales of Green Star's Touch condom rose to six million condoms per year, more than the combined distribution of all other NGOs in the country, and more than any other commercial brand in Pakistan with the exception of PSI/SMP's first condom, *Sathi*.

Table 6: Pakistan condom market

Condom sales, in unit condoms					
Year	Total commercial	Public sector	SMP's Sathi	SMP's Touch	Total condom sales
1987	-	-	34,000,000	-	34,000,000
1988	-	-	34,000,000	-	34,000,000
1989	-	-	44,000,000	-	44,000,000
1990	-	-	73,800,000	-	73,800,000
1991	-	-	73,400,000	-	73,400,000
1992	-	-	34,200,000	-	34,200,000
1993	-	-	51,000,000	-	51,000,000
1994	13,700,000	15,700,000	48,400,000	-	77,800,000
1995	17,500,000	15,900,000	58,000,000	-	91,400,000
1996	16,600,000	21,400,000	84,900,000	2,010,002	124,910,000
1997	12,300,000	19,000,000	99,200,000	4,376,496	134,876,490
1998	11,900,000	19,000,000	106,700,000	6,114,033	143,714,030
1999	7,200,000	26,000,000	46,584,000	5,311,605	85,095,650
2000	9,100,000	42,000,000	59,593,488	6,030,394	116,723,882
Cumulative total	88,300,000	159,000,000	847,777,488	23,842,530	1,118,920,018

Sources: Commercial sales are from Aftab Associates Retail Audit; public sector sales are from GoP; SMP sales are from SMP sales reports/MIS.

Overall, contraceptives supplied by SMP represent 20 percent of all modern family planning methods used in Pakistan today. PSI and SMP have generated 9,413,041 couple-years of protection since *Sathi* condoms were first marketed in 1987 (table 7).

Table 7: SMP CYPs generated since *Sathi* was launched in 1987

Year	Sathi condoms		MultiLoad IUD		Touch condoms		NovaJect		Nova OC		Total CYPs
	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs	
1987	34,000,000	340,000	0	0	0	0	0	0	0	0	340,000
1988	34,000,000	340,000	0	0	0	0	0	0	0	0	340,000
1989	44,000,000	440,000	0	0	0	0	0	0	0	0	440,000
1990	73,800,000	738,000	0	0	0	0	0	0	0	0	738,000
1991	73,400,000	734,000	0	0	0	0	0	0	0	0	734,000
1992	34,200,000	342,000	0	0	0	0	0	0	0	0	342,000
1993	51,000,000	510,000	0	0	0	0	0	0	0	0	510,000
1994	48,400,000	484,000	0	0	0	0	0	0	0	0	484,000
1995	58,000,000	580,000	80	280	0	0	0	0	0	0	580,280
1996	84,900,000	849,000	5,537	19,360	2,010,002	20,100	4,000	667	6,000	462	889,589
1997	99,200,000	992,000	18,621	65,108	4,376,496	43,765	63,408	10,568	148,000	11,385	1,122,826
1998	106,700,000	1,067,000	27,360	95,664	6,114,033	61,140	89,688	14,948	268,616	20,663	1,259,415
1999	46,584,000	465,840	41,119	143,723	5,311,605	53,116	125,688	20,948	346,025	26,617	710,244
2000	59,593,488	595,935	55,553	194,241	6,030,394	60,304	189,831	31,639	520,000	40,000	922,119
Cumulative total	847,777,488	8,477,775	148,270	518,376	23,842,530	238,425	472,615	78,769	1,288,641	99,126	9,412,473

1 CYP = 13 cycles of OCs; 6 injectables; 100 condoms; 0.286 IUDs. Sales figures from SMP sales reports were used to calculate CYPs.

In 2000, a total of approximately 4,670,373 couple-years of protection were generated by all sectors from modern methods, excluding VSC (table 8). From this figure, it can be estimated that the modern method contraceptive prevalence rate was somewhere around 23 percent in 2000¹⁷ — a substantial increase from the 17 percent reported in 1997.

Table 8: Total CYPs from modern methods in Pakistan, 2000

Source	Method				Total
	IUD	Condom	OC	Injectable	
SMP	194,241	656,239	40,000	31,639	922,119
GoP	2,646,280	420,000	205,788	242,360	3,514,428
Commercial	0	91,000	48,615	4,244	143,859
KSM	0	0	52,641	37,326	89,967
Total	2,840,521	1,167,239	347,044	315,569	4,670,373

According to the Pakistan Contraceptive Prevalence Survey 1994–95 (Population Council, 1998) and the Pakistan Fertility and Family Planning Survey (NIPS, 1998), contraceptive use increased by 34 percent between 1994 and 1996. The sales data translated into couple-years of protection are consistent with this estimate, showing a 40 percent increase in CYPs generated by modern methods (excluding sterilization) over the same period of time (table 9). Data on contraceptive

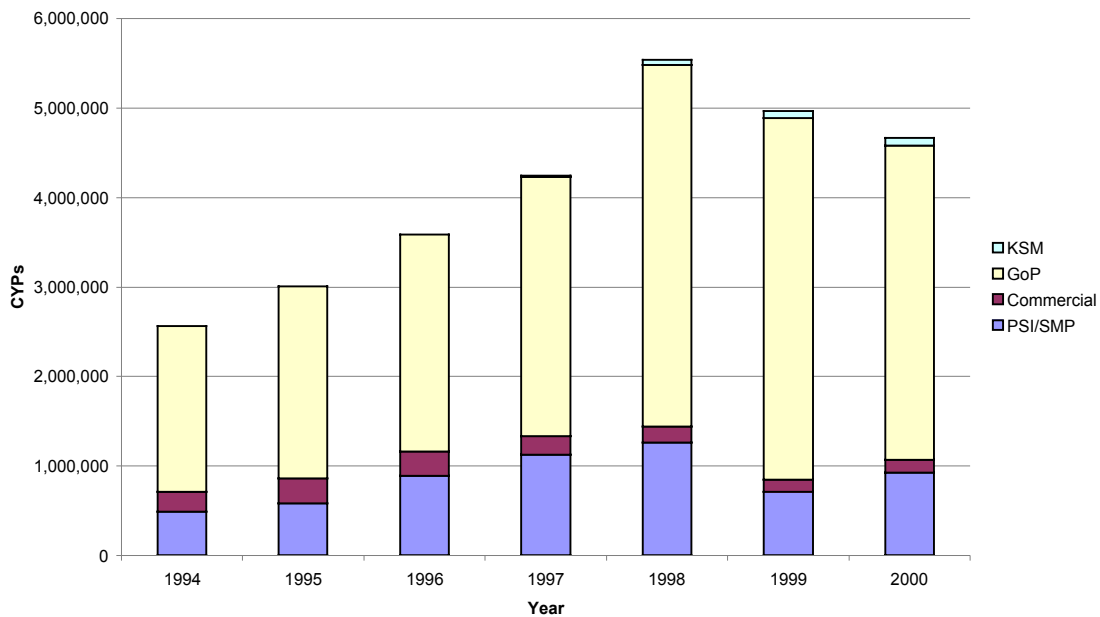
¹⁷ 4,670,373 CYPs / 20 million MWRA

prevalence beyond 1996 have not yet been gathered. However, sales figures translated into CYPs can be a reasonable proxy for use and suggest that contraceptive prevalence has continued to rise.

Table 9: National CYP growth, 1994–2000

Year	CYPs				Total
	SMP	Commercial	GoP	KSM	
1994	484,000	222,548	1,859,134	-	2,565,682
1995	580,280	278,157	2,147,526	-	3,005,963
1996	889,589	269,215	2,424,673	-	3,583,477
1997	1,122,826	207,609	2,900,769	11,948	4,243,152
1998	1,259,415	184,148	4,039,756	56,668	5,539,987
1999	710,244	133,874	4,042,905	75,895	4,962,918
2000	922,119	143,859	3,514,428	89,967	4,670,373
Cumulative total	5,968,473	1,439,410	20,929,191	234,478	28,571,552

Figure 5: National CYP growth, 1994–2000¹⁸



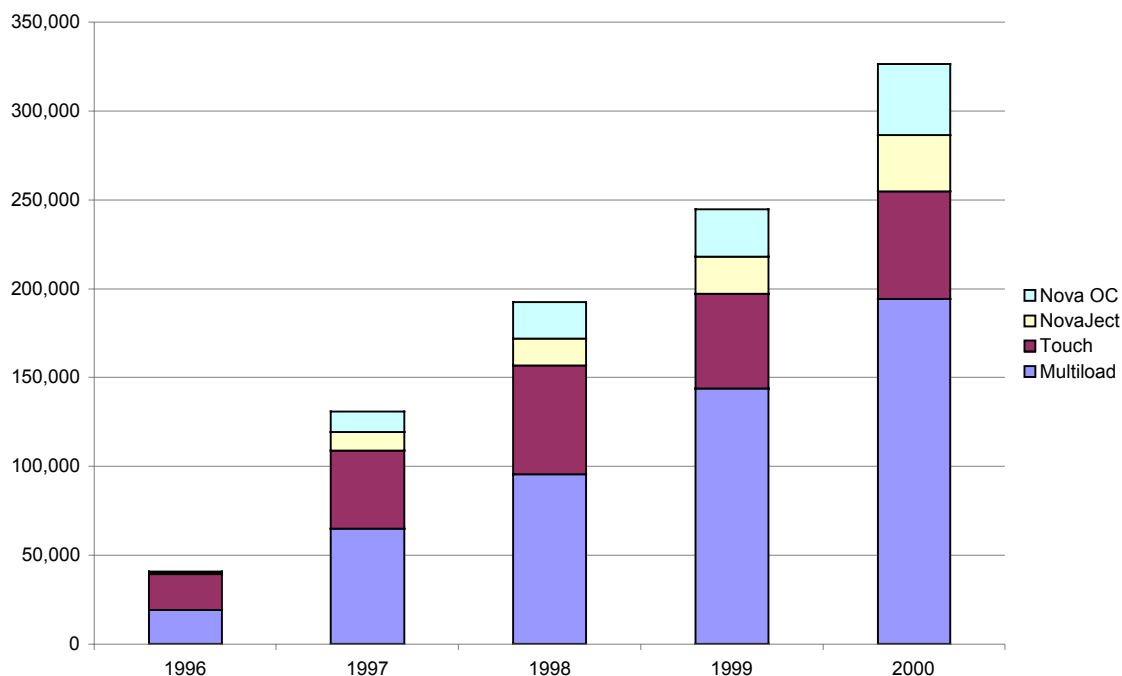
¹⁸ Please note that KSM CYPs for 1997 do not show up on figure 5 because the quantity is too small. Please refer to table 9.

Because *Sathi* condoms were already available previous to the launch of the Green Star Network, excluding them from the analysis of the couple-years of protection generated by Green Star products gives a more direct indication of the impact of the network. Such analysis reveals that SMP, through its Green Star activities, generated 934,698 CYPs in five years — from 1995–2000 (table 10). Over the same period of time *Sathi* alone generated 4.5 million CYPs. Green Star products have thus contributed to 17 percent of SMP’s total CYPs generated since 1995. CYPs generated by Green Star products have grown by an average of 36 percent per year over the past few years (figure 6).

Table 10: Couple-years of protection generated by Green Star products

Year	MultiLoad IUD		Touch condoms		NovaJect		Nova OC		Total CYPs
	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs	
1995	80	280	0	0	0	0	0	0	280
1996	5,537	19,360	2,010,002	20,100	4,000	667	6,000	462	40,589
1997	18,621	65,108	4,376,496	43,765	63,408	10,568	148,000	11,385	130,826
1998	27,360	95,664	6,114,033	61,140	89,688	14,948	268,616	20,663	192,415
1999	41,119	143,723	5,311,605	53,116	125,688	20,948	346,025	26,617	244,404
2000	55,553	194,241	6,030,394	60,304	189,831	31,639	520,000	40,000	326,184
Cumulative total	148,270	518,376	23,842,530	238,425	472,615	78,770	1,288,641	99,127	934,698

Figure 6: Couple-years of protection generated by Green Star products¹⁹



¹⁹ Please note that NovaJect and Nova OC CYPs for 1996 do not show up on figure 6 because the quantity is too small. Please refer to table 10.

National contraceptive trends have improved since the establishment of the Green Star Network. While these trends cannot be solely attributed to the Green Star program, they indicate that Green Star has very likely made a notable contribution to the national effort to improve contraceptive use. Green Star's objective is to increase both the demand for family planning and the percentage of demand satisfied. Since Green Star began in 1995, overall demand for family planning in Pakistan among married women of reproductive age increased from 55 percent in 1994–95 to 61 percent in 1996–97 (table 11). This change represents a growth in demand of 11 percent over two years. Further, the gap between demand and use narrowed, with 33 percent of demand satisfied in 1994–95 increasing to 39 percent in 1996–97 — a growth in demand satisfied of 18 percent (Population Council, 1998; NIPS/LSHTM, 1998).

Table 11: Growth in total demand for family planning and demand satisfied

Percentage MWRA	1990–91	1994–1995	1996–1997
Total demand	39.9	55	61
Percent of demand satisfied	29.7	33	39

Sources: 1990-91 rates from Pakistan DHS, 1992; 1994–95 rates from Population Council, 1998; 1996–97 rates from NIPS/LSHTM, 1998.

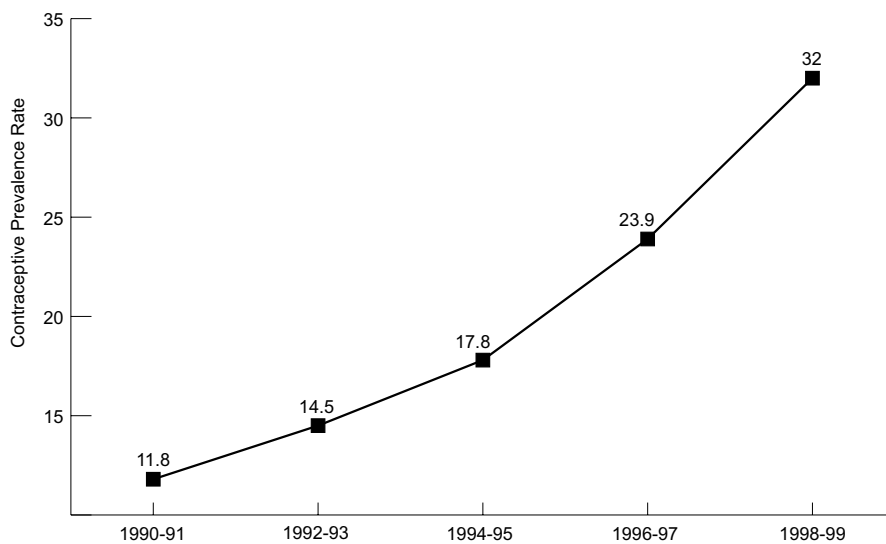
While contraceptive prevalence rates had been increasing prior to the establishment of Green Star, the rate of increase was lower (see table 12 and figure 7). Moreover, while OC and injectable use rates remained virtually unchanged between 1990 and 1994, use of both methods rose dramatically between 1994–95, when Green Star was launched, and 1996–97 (a 129% increase for OCs and a 40% increase for injectables). IUD use also increased substantially over the same period, by 62 percent (Pakistan DHS, 1992; Population Council, 1998; NIPS/LSHTM, 1998).

Table 12: Pakistan contraceptive prevalence

Method	Year		
	1990–91	1994–95	1996–97
OCs	0.7	0.7	1.6
Injectables	0.8	1.0	1.4
IUDs	1.3	2.1	3.4
Condoms	2.7	3.7	4.2
Female sterilization	3.5	5.0	6.1
Total modern	9.0	12.6	16.9
Total traditional	2.8	5.2	7.0
Total CPR	11.8	17.8	23.9

Sources: 1990-91 rates from Pakistan DHS, 1992; 1994–95 rates from Population Council, 1998; 1996–97 rates from NIPS/LSHTM, 1998.

Figure 7: Growth in the contraceptive prevalence rate, 1990–99²⁰



High method discontinuation rates in Pakistan in the past have indicated poor user satisfaction and have stifled growth in overall contraceptive use. Green Star's aim is to improve client satisfaction by providing better quality care. This improved care should lead not only to greater client satisfaction, but also to higher continuation rates, and in turn to a higher contraceptive prevalence.

Current use of contraceptives as a proportion of ever-use is one measure of continuation rates, but it is a crude measure: it does not, for example, consider reasons for discontinuation. Ideally, discontinuation rates should reflect only discontinuation due to unnecessary reasons, such as erroneous fears or poor management of side effects among women who still wish to use contraception. A more exact measure can be obtained only by keeping careful records of client contraceptive use over time. While measuring continuation rates by the current- to ever-use ratio is not ideal, it does indicate trends. The data available show that while continuation rates in Pakistan remain low by international standards, they have improved since 1995. For example, over the two years since Green Star began, OC continuation rates have increased from approximately 12 percent to 21 percent (a 75% increase), and IUD continuation rates have increased from 39 percent to 47 percent (a 20% increase).

Green Star's Sustainability

PSI's mission is to improve the health of low-income and other vulnerable people through social marketing. Given this objective, sustainability is defined in terms of *enduring health impact* (as opposed to financial sustainability, which focuses on fiscal issues such as cost recovery). For PSI, sustainability is the ability to improve the health of low-income and vulnerable people through the social marketing of health products and services, for as long as necessary.

In the case of the Green Star Network, SMP believes that the program's sustainability is predicated on: (1) delivering affordable quality products and services to a large number of low-

²⁰ Figure 7: Please note that 92/93 and 98/99 figures are estimates based on growth trends.

income consumers; and (2) ensuring that those customers are satisfied with the products and services they purchase. In this context, the training, quality assurance and monitoring tools developed by SMP contribute to Green Star’s sustainability.

One of PSI’s strategies for achieving positive public health impact and continuing that impact over time is to minimize financial vulnerability²¹ by:

- maximizing efficiency and controlling costs through sound financial management;
- developing a diversified funding mix; and
- maximizing sales revenues from social marketed products in a manner consistent with serving the poor.

SMP uses this strategy to improve Green Star’s sustainability, continuously tracking the program’s financial position (see below).

Improved Efficiency in Operational Costs

Figure 8 shows annual cost efficiency trends for PSI/SMP’s overall program since its inception in 1987 until 2000 (years 1–14). Table 13 gives the same information in different form. Overall, the trend in total cost per couple-year of protection is downward, from US\$ 8.88/CYP in 1987 to just US\$ 4.51/CYP in 2000. Increased costs in 1996 reflect higher expenditures for research, marketing and training related to the introduction of IUDs, injectables and OCs.

Figure 8: Total PSI/SMP cost per couple-year of protection, 1987–2000 (years 1–14)

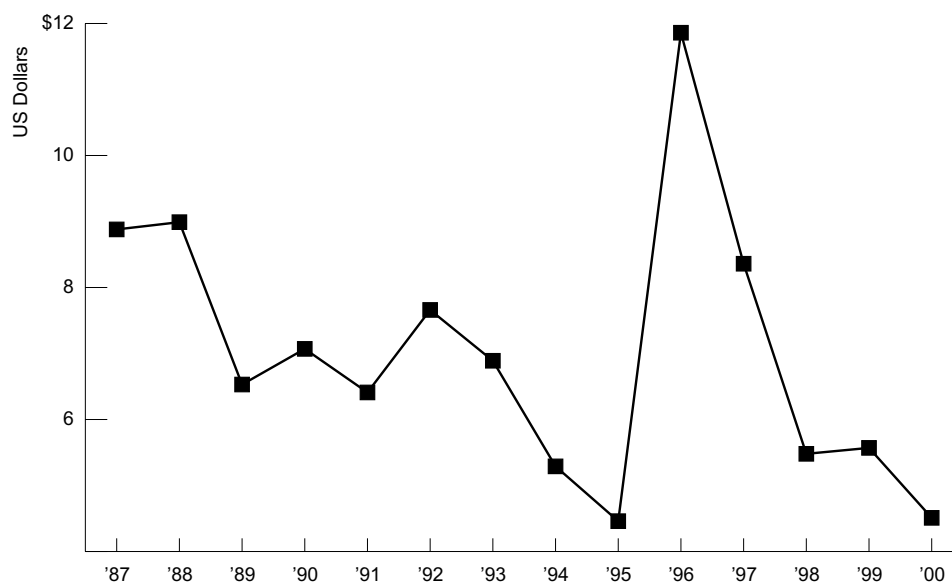


Table 13: Cost per couple-year of protection, 1987–2000 (in US\$)

²¹ Other sustainability strategies include maximizing health impact and strengthening institutional capacity. For more information about PSI’s approach to sustainability please visit http://www.psi.org/why/program_continuity.htm.

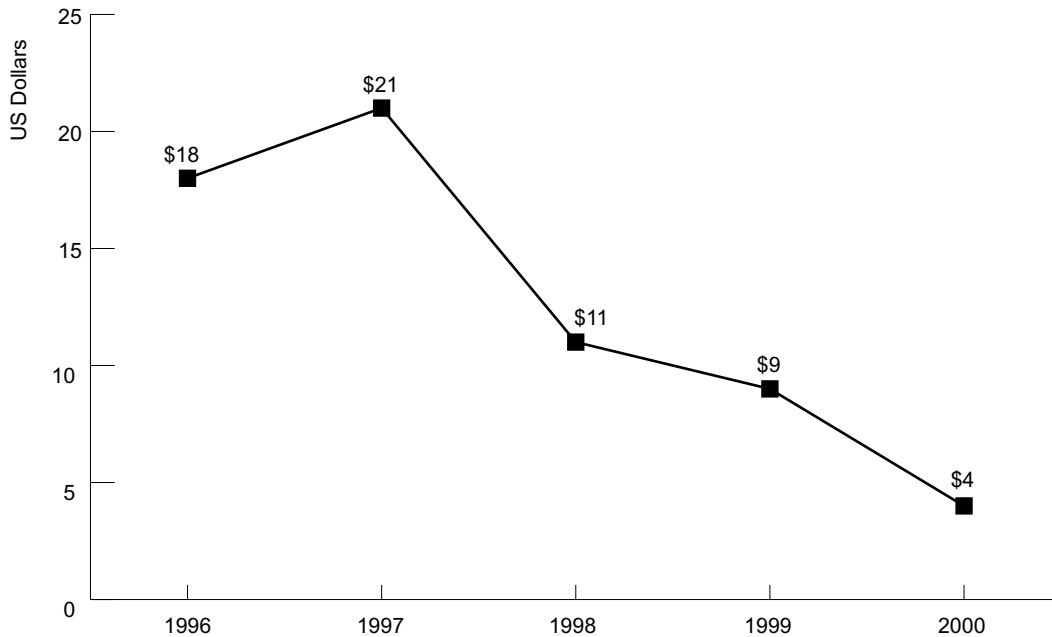
Year	Total CYPs	Total program costs	Cost per CYP
1987	340,000	\$ 3,019,200	\$ 8.88
1988	340,000	\$ 3,056,600	\$ 8.99
1989	440,000	\$ 2,873,200	\$ 6.53
1990	738,000	\$ 5,217,660	\$ 7.07
1991	734,000	\$ 4,704,940	\$ 6.41
1992	342,000	\$ 2,619,720	\$ 7.66
1993	510,000	\$ 3,513,900	\$ 6.89
1994	484,000	\$ 2,560,360	\$ 5.29
1995	580,280	\$ 2,588,048	\$ 4.46
1996	889,589	\$ 10,547,964	\$ 11.86
1997	1,122,826	\$ 9,391,421	\$ 8.36
1998	1,259,415	\$ 6,906,069	\$ 5.48
1999	710,244	\$ 3,954,614	\$ 5.57
2000	922,119	\$ 4,155,341	\$ 4.51

Table 14 and figure 9 show costs and couple-years of protection related to the Green Star project only (that is, excluding data for *Sathi* condoms). In 1996 and 1997, costs are high — US\$ 18 and US\$ 21, respectively, per couple-year of protection — due to the significant investments required to launch IUDs, OCs, and injectables in late 1996, and to expand the Green Star Network nationally in 1997. Those investments paid off, however, and since 1997 costs have dropped consistently to US\$ 4 per CYP in 2000.

Table 14: Cost per CYP since Green Star began, 1995–2000 (in US\$)

Year	MultiLoad IUD		Touch Condoms		NovaJect		Nova OC		Total CYPs	Total program costs	Cost/CYP
	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs			
1995	80	280	0	0	0	0	0	0	280	\$ 98,427	\$ 352
1996	5,537	19,360	2,010,002	20,100	4,000	667	6,000	462	40,589	\$ 714,986	\$ 18
1997	18,621	65,108	4,376,496	43,765	63,408	10,568	148,000	11,385	130,826	\$ 2,767,843	\$ 21
1998	27,360	95,664	6,114,033	61,140	89,688	14,948	268,616	20,663	192,415	\$ 2,035,786	\$ 11
1999	41,119	143,723	5,311,605	53,116	125,688	20,948	346,025	26,617	244,404	\$ 2,096,108	\$ 9
2000	55,553	194,241	6,030,394	60,304	189,831	31,639	520,000	40,000	326,184	\$ 1,220,564	\$ 4

Figure 9: Cost per CYP since Green Star began, 1995–2000 (years 1– 5)



Diversifying the Funding Base

Beyond taking measures to control program costs, SMP has also diversified its funding base to minimize the risk of funding shortfalls. SMP has thus far succeeded in expanding Green Star’s funding base from one donor — Kreditanstalt für Wiederaufbau (KfW) — to KfW, the Department for International Development (UK), and the Hewlett and Packard Foundations.

Cost Recovery: Sales Revenues from Social Marketed Products

Because the program’s primary objective is to improve the health of underserved, low-income people, sales revenues from Green Star social marketed products are not expected to cover all costs. SMP only maximizes sales revenues to the extent compatible with realizing its mission. PSI believes that programs financed solely by sales revenues do not continue to achieve meaningful health impact among low-income clients. Therefore, the primary role of sales revenues is to increase program effectiveness:

- Revenues motivate private providers and distributors to deliver necessary products and services.
- Consumers value and are more likely to use products that they purchase. (The same is true for franchisees valuing the benefits of belonging to the network. See Section 7, *Lessons Learned*.)

As cost recovery increases and operating costs decrease, Green Star will become less dependent on donors for program funds. However, it is important to remember that cost recovery is a tactic *supporting* the project’s primary goal: to improve the health of the poor. So, while SMP strives to improve efficiency and cost recovery, it does not attempt to achieve full cost recovery.

Problems and Challenges

Existing Green Star operations, combined with SMP's social marketing of contraceptive products, serve a huge unmet need by delivering easily accessible, inexpensive, high quality reproductive health services to low-income Pakistanis. No other nongovernmental reproductive health project in Pakistan has Green Star's geographic breadth, capacity to reach into low-income populations on a large scale, or national impact.

These achievements, however, have not come without problems and challenges. Difficulties centered on establishing and maintaining quality of care, pricing services to give target populations financial access to the network and maintaining provider engagement with the project. A few of these problems and challenges are outlined below.

Compliance with Green Star Quality Standards

SMP's limited ability to enforce compliance with Green Star quality standards has resulted in higher than desired variability in quality among Green Star providers.

Supervisory and mystery client visits to Green Star offices and clinics found that, while the quality of care at Green Star outlets has clearly improved overall, care remains quite variable among outlets. Over all four Green Star cadres, provider skills — both technical and administrative — range from excellent to poor, with too many providers falling below Green Star's minimum standards. Some providers focus their practice on particular methods of contraception, rather than counseling women about their full range of options. A SMP study prompted by the low use of Green Star's MultiLoad IUD by some GS1 clinics found that many GS1 doctors still lack confidence in their skill at inserting IUDs and therefore tend to promote other methods (Rizvi, 1998). Also, patient follow-up is often weak. While most providers tell patients roughly when to return, they often do not take measures to ensure that patients do in fact return. Because client record keeping is minimal, follow-up is logistically difficult.

While quality expectations are clearly articulated to providers when they join Green Star and are trained, and franchisees are told that their performance evaluations will be based on these expectations, SMP currently does little to enforce compliance other than removing the Green Star signboard from problem outlets. SMP hesitates to penalize providers and remove network members, focusing instead on improving services at poorly performing sites by offering remedial training and encouragement. This system should be re-evaluated and strengthened to improve compliance with quality standards.

Mechanisms to Control Pricing

SMP's lack of mechanisms to control pricing has resulted in higher than recommended prices being charged for products and services at some Green Star outlets.

Prices charged for Green Star products and services, particularly for MultiLoad IUDs, are frequently higher than SMP recommends. Private providers are motivated by profit and will charge accordingly. Green Star does not have adequate measures in place to enforce compliance with pricing recommendations. However, it may be that pricing takes care of itself by responding to market conditions. While prices are sometimes higher than SMP would recommend, there is no evidence that pricing at Green Star outlets has posed a barrier to use among the poor.

The Need For Immediate Results

Lack of immediate results — that is, increased client flow, the most important franchise benefit — has sometimes resulted in decreases in providers' willingness and/or ability to deliver quality family planning services.

Over time, some providers lose their motivation to deliver quality family planning services, and thus their commitment to the Green Star Network. This happens primarily among providers who have not, for whatever reason, experienced a significant growth in business after joining the network. It is difficult to maintain providers' motivation without a perceived reward. In several cases, the benefits of delivering quality family planning services are delayed and require patience on the part of the provider.

Maintaining Provider Skills

A provider's ability to deliver good care may decline over time if he or she does not have the opportunity to practice newly acquired skills with family planning clients.

Green Star providers can obtain remedial training and practice with clients at NGO partner sites, but taking advantage of such opportunities is not always feasible. SMP needs to develop a more formal mechanism to ensure that Green Star Network members are able to practice the skills they acquire in training. This point also highlights the importance of conducting an ongoing marketing campaign to generate client flow to franchise members and thereby keep providers motivated.

Managing a Rapidly Growing Network

Logistical difficulties in administering such a vast and rapidly growing number of outlets stretched the capacity of SMP staff to effectively manage the network and have resulted in a loss of control over aspects of service provision.

To a certain extent, SMP compromised quality to promote the rapid growth of the network. Quality can only be maintained through rigorous site supervision and monitoring. A staff of 20 trainers cannot provide adequate coverage for a network of 11,000 providers. To monitor franchisee performance effectively would require that each site receive a supervisory visit at least once a month. A staff of 20, each visiting up to 10 outlets per day (a high estimate), working five days per week in the field, would be able to cover 4,000 outlets total per month.²² Clearly, SMP does not have the resources to provide monthly visits to a network of 11,000. This has resulted in the loss of control mentioned above.

SMP attempted to address these problems through targeted interventions, such as:

- increasing the frequency of monitoring and support visits to problematic outlets;
- organizing meetings among high and low performing outlets to learn more about the qualities of high performing providers and barriers faced by lower ranking providers; and
- facilitating the organization of community events designed to generate demand for particular Green Star outlets and enhance provider commitment to the network.

²² 20 staff members x 10 outlet visits/day x 20 days per cycle = 4,000

In some cases, these interventions helped to motivate providers. In other cases, SMP decided to end the outlet's membership in Green Star. Further interventions have been designed to address the problems and are described below in Section 6, *Next Steps*.

Sustaining Provider Involvement

Health care providers' involvement and support are crucial to Green Star's success.

The Green Star Network is targeted to low-income women and men with unmet demand for family planning. At the risk of stating the obvious, customer satisfaction is essential to the network's success. At the same time, health providers are important Green Star stakeholders. Without their involvement in designing and implementing the project, it is unlikely that Green Star could have earned clients' respect and support. Health providers — doctors, pharmacists and paramedics — were formally involved in the development of the service delivery protocols and training curricula through formative research to determine their specific training needs and preferences. Further, SMP's training team (composed of health professionals) created an ongoing dialogue with the medical community and thereby also informally involved them in the process of developing the network.

The Future of Green Star: Next Steps

With recently awarded funds from the Packard Foundation, SMP will address several of the challenges described in the previous sections and will build on an already solid foundation to strengthen the Green Star Network and increase its overall impact. Over the next two years, SMP will work to achieve the following:

- raise the standard of care that is consistently provided by franchisees;
- strengthen franchisee business practices;
- increase client flow to franchisees;
- expand the reach of the Green Star Network;
- broaden the range of reproductive health services provided by Green Star;
- establish integrated Green Star hubs to enhance service delivery and referral at the district level; and
- monitor, evaluate and disseminate results and lessons learned.

Raising the Standard of Care

The *quality* of care is paramount to the success of the Green Star Network and will be the subject of intensified effort. As noted above, quality varied among Green Star outlets. SMP will respond with initiatives including:

- creating refresher training courses for providers;
- undertaking more rigorous monitoring of franchisees;
- developing more stringent provider selection criteria based on the characteristics and experiences of high performing outlets;
- preparing detailed operations manuals and a more detailed letter of agreement articulating franchise expectations; and
- instituting quality of care incentive schemes.

Strengthening Franchisee Business Practices

To improve the financial viability of Green Star outlets, SMP will add a business management module to the training curricula. Also, SMP will quantify the increased financial returns that result from joining the Green Star Network and disseminate that information to providers to encourage them to improve their business skills.

Increasing Client Flow

SMP plans to introduce new outreach strategies to attract family planning clients. These strategies will include helping Green Star providers focus on catchment areas as marketing units to target for potential clients.

In return for increasing client flow, business volume and clinician prosperity, SMP will ask for an increased commitment from Green Star providers to remain members of the franchise. Providers

will be expected to contribute to the growth of their clinics, follow certain business practices, deliver quality reproductive health services, and provide timely and accurate data on their work.

Expanding the Network's Reach

With Packard funds, SMP will pilot the following two interventions to expand the reach of the Green Star Network to new, underserved, low-income couples in urban slums and peri-urban areas.

- Partnering with community-based organizations (CBOs).
- Introducing mobile reproductive health clinics.

At the end of the two-year Packard Foundation grant, SMP will evaluate the impact of these pilot interventions, assess lessons learned from them, and seek to replicate their successes.

Community-Based Organizations

Initially, SMP will work with 13 CBOs in three urban squatter settlements in Karachi, with a total population of around 120,000. In tandem with the CBOs, SMP will conduct research to establish a baseline of barriers to contraceptive use and identify productive communications channels and methods. This information will enable SMP and the CBOs to design appropriate community-based interventions.

Mobile Clinics

SMP will test the feasibility of franchising mobile reproductive health clinics, much as the static clinics in the network have been franchised. These mobile clinics will travel to villages not served by Green Star or other service delivery networks.

Broadening the Range of Reproductive Health Services Provided

Again with Packard Foundation funding, SMP will increase the range of reproductive health services available at selected Green Star outlets. Specifically, SMP will add three services to the Green Star Network:

- voluntary surgical contraception;
- treatment of complications after unsafe abortion; and
- treatment of sexually transmitted diseases (STDs) and reproductive tract infections (RTIs).

These services are currently either unavailable or unaffordable among poor women in Pakistan, and those services that are available are of poor quality.

Voluntary Surgical Contraception

Voluntary surgical contraception (VSC) is currently the most-used modern contraceptive method in Pakistan. Unfortunately, VSC is only recently becoming available through Green Star, enabling the network to begin fulfilling one of its fundamental reproductive health principles: choice of contraceptive method. VSC has important advantages: it is under the woman's control and does not require partner compliance; failure rates are low; it is permanent; and it requires neither maintenance nor continuous monetary outlay. From a public health perspective the ease

and efficacy of VSC translates into substantial demographic impact and reduced maternal mortality.

SMP will make high quality, affordable VSC services available via Green Star. Within the context of the hub system (described below) the project will add VSC capabilities to carefully selected Green Star clinics. SMP will develop a competency-based training curriculum, drawing on materials such as those developed by EngenderHealth and JHPIEGO. In the context of VSC's permanency, it is especially important that the client's choice is fully informed, and so effective counseling will be given the attention it requires. The creation of a competency-based surgical contraception curriculum for Pakistan will itself be an important contribution by the project, as existing curricula are inadequate. SMP will share the curriculum with other organizations that conduct VSC training, including the Pakistan Ministry of Health.

Post-Abortion Care

Care for the complications of unsafe abortion is urgently needed in Pakistan. SMP proposes to integrate post-abortion care (PAC) into the range of reproductive health services offered by Green Star clinics. Once the referral mechanism is strengthened and Green Star Plus facilities (described below) are in place, Green Star will be well prepared to address this difficult problem. The Green Star Network provides SMP with the platform to reach both practitioners and women with information about where to turn during these serious emergencies.

SMP will select, train and equip its best female doctors (GS1) in the medical management and counseling of post-abortion trauma. SMP will also assess whether changes need to be made in the Green Star referral system (to include emergency referrals, for example) by gathering information on emergency transport available, distance to referral doctors' offices, etcetera.

RTIs / STDs

The obstacles to diagnosing and treating RTIs and STDs are multiple: time-consuming laboratory tests, expensive prescriptions, unsuccessful outcomes if patients are under-medicated and lack of protection from re-infection by partners. In addition, people in Pakistan often to seek pharmacist-mediated treatment before turning to a physician.

SMP will take an important step forward through Green Star by introducing an appropriate technology known as *syndromic management*. Recommended by the World Health Organization, syndromic management effectively diagnoses illnesses through the evaluation of symptoms, without laboratory work. This process has been condensed into simple assessment and decision flowcharts. SMP plans to complement primary care management of RTIs/STDs by training Green Star providers in syndromic management and integrating Green Star Plus clinics as referral points for severe, complicated and drug-resistant infections.

PSI has experience social marketing an STD treatment kit in Cameroon and Uganda, and will assist SMP to introduce a similar product to Pakistan. The kit's purpose is to enhance the likelihood of a successful outcome. It will probably comprise:

- STD medication and instructions for use;
- *Sathi* condoms and instructions; and

- educational materials on the need for protection while still infectious, the possibility of re-infection from a partner, the delicate subject of partner notification and how to avoid STIs in the future.

The kit will be packaged to maximize correct product use, thereby avoiding partial treatment and the consequent problems of recurring infection and resistant bacteria.

Green Star Plus: Establishing Integrated Hubs

SMP will establish referral and training hubs at the district level, thereby ensuring that clients receive the best available service from the most appropriate provider and strengthening the Green Star franchise as a whole.

At the center of the hubs will be Green Star Plus clinics. Green Star Plus clinics will be developed primarily from the most motivated and financially viable GS1 providers (female doctors providing IUDs). Clients will be able to expect the best quality and most comprehensive reproductive health services from Green Star Plus clinics. Green Star Plus clinic staff will be trained to provide VSC as well as other reproductive health services and will represent the highest point in the Green Star referral network. At the time of this report, six providers have been trained in VSC — they form the beginnings of a Green Star Plus provider cadre.

Green Star providers will receive referred clients from community-based organizations (see above) and will in turn be responsible for treating clients or referring them to other Green Star providers in their hub. In this way, clients can enter the Green Star Network in their district at any level and will be referred within the integrated hub to the appropriate counselor and provider (or, if necessary, to emergency or specialist services).

The Green Star hub binds all providers in a district into a referral network that:

- provides greater reproductive health impact in the community and a broader choice of reproductive health services to the client;
- establishes strong links with the community, as follow-up will be facilitated and inaccurate rumors about family planning limited;
- ensures that clients are referred to the appropriate level of Green Star provider;
- promotes the Green Star franchise, increasing the client flow and financial return to each provider; and
- allows monitoring of impact at a district level.

Monitoring, Evaluating, and Disseminating Results

The activities described in this section will strengthen the capacity of the Green Star Network to deliver quality reproductive health services to low-income Pakistanis. Several research activities will enable SMP to monitor various interventions and evaluate their impact. Information and lessons learned will be disseminated within Pakistan and internationally in cooperation with the Packard Foundation. Planned research includes the following:

KAP Study

A KAP study will be conducted at the beginning and end of the community-based organization intervention to identify barriers to acceptance of and satisfaction with contraceptive methods and reproductive health care in the organization's catchment area. SMP will evaluate improvements in these areas at the end of the project.

Consumer Profile Surveys

Regular surveys will analyze Green Star clients' responses to marketing activities and their satisfaction with Green Star services. This information will help SMP improve interventions over time. The surveys will also establish whether the Green Star Network is reaching its intended beneficiaries.

Monthly Sales Reports

The SMP MIS system traces sales performance in all Green Star outlets. These reports will be modified to include the new activities funded by the Packard Foundation.

Sharing Information with Stakeholders

SMP will disseminate research results and lessons learned to all project stakeholders, as well as to other donors and NGOs that may be interested. Monthly activity reports and copies of research reports are currently sent to the GoP and other SMP partners. Toward the end of the two years, SMP will organize a formal seminar where all stakeholders may present and discuss the results of the Packard-funded improvements to Green Star and share lessons participants have learned in the process.

Lessons Learned from the Green Star Experience

Evidence to date indicates that the Green Star Network has made notable contributions to family planning in Pakistan. The network's experience has also yielded valuable lessons about social franchising as a model for expanding access to reproductive health services. These lessons should only be applied in other circumstances with appropriate caution. That point notwithstanding, many of the things Green Star learned the hard way may be of value to others. A good number of these lessons have become the impetus for new Green Star initiatives, which were covered briefly in the last section, *Next Steps*.

Perhaps the most important lesson of the Green Star experience is the capacity for social franchising to support a very rapid scale-up in the delivery of health care services. On the opposite side of this coin are the great difficulties encountered in monitoring outlets and managing information from a large number of franchisees brought on board quickly. These two facts are reflected in many of the more specific observations offered below.

Project Design

All aspects of franchise operations should be field tested and optimized before expanding the network. Developing a franchise requires a great investment of time and money. Program managers need to remember that franchising is, by definition, a mechanism for rapidly expanding a proven business model. The entire franchise is at risk of failing if its business model is flawed. The only way to prove the viability of the model is to test it. Before franchising a service, the service delivery model and all its functional components must be developed and tested to ensure that they can be operated feasibly and that, taken together, they bring about the desired result. Only then should expansion of the franchise occur.

Initial buy-in and endorsement of key stakeholders lends credibility to the franchise and facilitates its growth. Involving stakeholders in the initial design phase of a project is key to obtaining their buy-in. Project managers should ensure that they identify and consult with stakeholders from the outset and that they involve stakeholders in key design issues. It is also important to obtain the endorsement of a locally recognized and well respected medical institution. Potential clients and providers will see the franchise as a much more credible and attractive proposition if it is affiliated with a credible institution such as the local medical association. The likelihood of obtaining such endorsement is greatly increased if the institution is involved in the project design. For example, project managers might submit service delivery protocols to the local medical association for review and approval.

Before designing the functional components of the franchise, the service being franchised must be clearly defined. What is the product? How will it be delivered? To whom and by whom? And under what circumstances will it be delivered? There was a tendency to design functional aspects of the Green Star franchise before defining precisely what they were meant to accomplish. For example, the Green Star training program was designed to impart the knowledge and skills required to deliver services according to the Bruce-Jain quality of care framework. In practice, this meant that while the training curricula generally defined quality of care, they did not define all of the specific aspects of service delivery that Green Star providers would be expected to follow, such as hours of operation, clinic appearance, etcetera. SMP has since recognized the need for clear guidelines covering all aspects of service delivery. These guidelines help both the franchisee and the franchiser understand precisely what it is that they are marketing to consumers

— that is, what consumers should be able to expect from franchisees. Only after defining the product should components of the franchise, such as training and evaluation, be developed.

A fully functional and reliable Management Information System must be in place before implementing the franchise so that data can be recorded accurately from the beginning of the project and proper monitoring and evaluation can occur. The MIS should be designed to adapt to changing data requirements over time. Reasonably reliable data are essential to evaluate a program and its effects. While the need for a sound data system seems obvious, experience has shown that it can be very difficult to achieve. The system must be based on a thorough needs assessment and must respond to the development and use of well-designed paper records and data models at appropriate decision points in the program's life.

Additionally, program staff must understand and have confidence in the MIS. If they do not, they will create their own independent systems for record keeping. Reliability problems with SMP's MIS resulted in Green Star training, sales and finance staff maintaining different, overlapping data systems (in addition to the MIS). Not only is this inefficient, but it also results in conflicting information that is difficult for program managers to interpret and manage.

The importance of reliable and coherent MIS data cannot be overstated: information is the basis of the feedback loop that allows the franchiser to monitor franchisee performance and thus maintain appropriate control of the franchise. Data also provide the basis for evaluation, which is critical to assessing and improving the services franchisees provide.

Finally, the MIS must perform a variety of different functions efficiently, such as tracking sales and quality of care, and still yield systematically consistent results.

Over the course of Green Star's development, project staff and management found it necessary to add new parameters to the MIS, particularly to improve measures of quality, keep track of changes in providers' status (progressing from a GS4 to GS1 rating, for example, or leaving one clinic for another) and note the retraining of providers. These new kinds of information and analysis were added to the MIS on a piecemeal, ad hoc basis.

Finally, the MIS was originally designed to monitor the SMP program as a whole. Problems arose when staff attempted to use the MIS simultaneously as a tool to monitor individual providers. Because the underlying MIS data model was not designed to do this, the MIS began to produce data mismatches when different types of data analysis were performed. Other problems arose as well, including inaccuracies in sales tracking, poor or erroneous information supplied by providers, and inadequate efforts to match needed MIS functions with appropriate skills and training in MIS department staff.

A franchise dues system — asking franchisees to contribute even a minimal amount — should be established from the outset of the project. Asking franchisees to contribute to the network through fees or dues adds value to the franchise, helps screen out providers who are not serious, makes franchisees feel vested in the network and therefore more committed to its goals, and helps with cost recovery. At the beginning of the project, SMP was concerned with finding providers willing to participate in the network and was reluctant to create unnecessary barriers to participation, such as charging franchisers a fee. Even so, after establishing a certain degree of brand equity and demonstrating the success of the business model on a small scale, SMP might have been able to charge membership fees to new franchisees. However, expansion proceeded without introducing a fee system. Recently, when SMP explored the possibility of introducing fees to assist with cost recovery, it discovered that the 11,000 Green Star members, some of

whom have taken part in the program for five years now, are reluctant to pay for something they already receive for free.

Brand development should accommodate possible expansion of the franchise into new health product categories, such as nutritional supplements for maternal and child health.

The Green Star has been promoted as a symbol of “Trustworthy Family Planning.” As a result of this exclusive association with family planning, the brand will not accommodate the program’s expansion into offering nutritional supplements or working in HIV/AIDS prevention. The equity of the Green Star brand would have greatly facilitated the introduction of these new products and services had it been associated with the broader category of trustworthy health care. Instead, SMP is developing another brand for which equity will have to be built — a much more difficult undertaking than adding products to a pre-existing umbrella brand like Green Star.

The international partnership between PSI and SMP seems to be a successful structure for both designing and implementing the Green Star program.

The PSI/SMP partnership was based in part on PSI’s experiences in other countries. SMP and PSI operate as a joint venture. PSI has a minority share on the SMP board and an important, though not decisive, voice in SMP strategic matters. SMP is an independent nonprofit organization, as well as PSI’s local affiliate in Pakistan. Within the partnership, PSI is specifically responsible for providing technical assistance, fundraising support, new ideas and technologies, and lessons learned from its social marketing programs around the world. PSI also has a fiduciary responsibility vis-à-vis certain donor funds that flow directly to SMP (that is, PSI conducts internal audits and signs off on financial reports to KfW). Over time, PSI has provided technical assistance on MIS, financial management, training curricula design, etcetera. SMP has identified excellent local human resources, implemented the program, and built its own capacity to the point that it now provides technical consultants and assistance to other PSI programs that wish to replicate Green Star.

Implementation

Female service providers have been more effective than males. Research shows that two categories of providers — female doctors and junior paramedics or Lady Home Visitors (LHVs), GS1s and GS4s, respectively — generate the greatest increase in family planning clients. Research also indicates that these providers have been most able to change their behavior and service provision practices to conform to Green Star protocols. SMP contraceptive sales (quantity sold/outlet) were highest to these providers. LHVs particularly work in lower-income neighborhoods, reaching SMP’s primary target audience.

The poorest performers are male doctors — GS2 providers. Male doctors are least interested in providing family planning services (as they are not lucrative) and have not improved their service delivery practices in a substantial way. With the benefit of hindsight, SMP should have begun training and franchising junior paramedics and LHVs much sooner, and not spent as many resources training male doctors.

A contractual agreement that clearly stipulates the roles and responsibilities of franchiser and franchisee and that outlines the mechanisms used to enforce contractual compliance (tools to measure performance, a grading system and standardized action plans for performance levels) is necessary — but not sufficient — for maintaining control over the quality of services offered by franchisees. A strong contractual agreement can and must be balanced with the need to make membership appealing. Initially, Green Star contracts were loose and inclusive: They offered providers very attractive arrangements because the program’s

immediate goal was to recruit franchisees and develop a large network. With the benefit of hindsight, SMP believes that establishing a more restrictive agreement with Green Star providers from the outset might have encouraged them to better follow recommended practices, procedures and pricing. The new contracts to be signed with clinics taking part in the Green Star hub system will test the value of stronger contract obligations and enforcement mechanisms.

In implementing the franchise, the focus should first be on quality of providers recruited, second, on quantity. A strong sense of the attributes associated with high performing providers (those who achieve impact) helps to inform selection criteria and improve the overall performance of all franchisees. The types of providers SMP recruited for Green Star evolved over the course of the network's development, based on greater understanding of predictors of provider performance. The pilot phase of the project enabled SMP to identify traits predictive of successful GS1 providers. For example, the better performing physicians are those who own their own clinics, as they are generally more stable and easier to track over time. Also, younger, less experienced providers were found to be more amenable to new service delivery approaches and more motivated to perform well. These and other factors were incorporated into the selection criteria for GS1 providers during the expansion phase. The expansion phase for GS1 providers proceeded cautiously: Each provider was carefully considered before selection. However, the expansion phase for the other Green Star cadres was aggressively focused on increasing the number of outlets. Quality might have been better controlled through more careful provider selection and monitoring in all cadres.

As noted earlier, after a national expansion that introduced paramedic providers (GS4) into the network, SMP found that it might have been better to recruit them at an earlier stage rather than seeking GPs — particularly male GPs. Paramedics have most effectively reached Green Star's target client group. Moreover, they benefit more than other providers from their association with Green Star. Paramedics appear to value the benefits they receive through association with the network and are therefore more highly motivated as a group to maintain Green Star membership by adhering to the network protocols and providing quality care.

A strong support and monitoring team large enough to cover franchisees adequately and with appropriate frequency is necessary to control the quality of the franchise. This point has been made at some length in earlier sections, but it is important to re-emphasize the logistical and managerial challenges of supporting over 11,000 different outlets with supervision and training visits, technical support and commodity supply. Even so, Green Star's follow-up system — limited though it is — has proven to be one of the most beneficial features of the network. Having trainers follow-up with providers is clearly an important contributor to the program's success. But the training course is only the beginning of a very long process — providers need to feel comfortable with their work and stay motivated over the long run. This is exactly what the follow-up system accomplishes. During site visits, trainer-monitors give providers the opportunity to ask questions and discuss concerns. Because trainers personally recruit and teach the providers they later monitor, providers are comfortable with them. Trainers help providers maintain their motivation, even when their family planning clientele is not large. Finally, a strong monitoring and support team is required to ensure that practitioners follow acceptable clinical practices and maintain appropriate client records.

Data collection requirements from providers should be kept to a minimum, and forms designed so that they are easy to complete. Providers are reluctant to keep client records, and any hope of their doing so will be lost if record keeping requirements are too complex or time consuming. SMP has found that most providers are not accustomed to keeping client records at

all and were reluctant to do so for Green Star. The initial data collection requirements were designed to enable SMP to monitor a wide range of project indicators, including method continuation rates and client profiles. As it turned out, most providers felt that the required forms were too complicated and time consuming, and so many did not complete them. Revisions to client record keeping requirements were subsequently made to reduce the amount of information collected. The result was that more providers were willing to keep records, and the project was able to collect more reliable and consistent, albeit superficial, information about Green Star clients.

A quality training program is extremely important. To the extent possible, the training program should be developed in-house so that the franchiser has direct control over the quality and scheduling of training. A study tour of Indonesia's private sector family planning project impressed upon Green Star's design team the importance of having trainers skilled in both content as well as training methodology and techniques. After assessing the availability of trainers in Pakistan, it was decided that SMP would develop an in-house training team and training facilities. The added expense was determined to be minimal in the long run and well worth the benefits of having greater control over the quality and scheduling of training.

SMP relied on the expertise of JHPIEGO in establishing Green Star training programs for all four cadres of providers. The process involved identifying training needs; developing training curricula to address identified needs; writing a trainer preparation course; recruiting and training master trainers who would be responsible for developing new trainers; preparing training materials and procuring training equipment (for example, lifelike pelvic "Zoe" models); and identifying partner NGOs to be used as clinical training sites. JHPIEGO performed a formal and comprehensive evaluation of these training programs and found them to be of very high quality (Vogel, 1998).

SMP recruited qualified medical professionals (mostly doctors) to perform the functions of training, recruiting and follow-up for the Green Star Network. This decision was based on the premise that service providers would be more amenable to learning about service delivery procedures from medical professionals than from non-medical professionals, more inclined to value the program offerings and more willing to participate in the training program. A great deal of the network's success and the resulting status that Green Star has achieved among the professional community of health providers can be attributed to its highly credible and professional training and monitoring staff.

Other aspects of the Green Star training program that have contributed to its success include the following:

- scheduling the course so that it is broken into shorter sections over a longer period of time (10 half days for GS1) to accommodate physicians' need to maintain their practices while receiving training;
- devoting a significant portion of the curriculum to counseling skills — from the client's perspective good counseling differentiates Green Star providers;
- using audio-visual materials such as videos, slides, flip charts, etcetera, to enliven presentations;
- using JHPIEGO's competency-based training methodology;
- using lifelike pelvic Zoe models and hand-held uteri for skill development; and
- devoting time to developing the trainers.

To the extent possible, community-based activities should be incorporated into strategies to create demand. These activities should involve network members. In the network's first year, marketing was conducted through an intensive initial advertising campaign and through the GS1 female doctors the network had trained. As the network grew, Green Star began to try to reach more potential clients by direct public contact through activities like community meetings, medical camps and special events. These events attract significant numbers of people from the target audience and convey more in-depth information than is possible via mass media.

Mohalla meetings (described earlier), organized by provider clinics with the help of the Green Star field staff, have been especially effective in helping to increase the clientele of the clinics and motivate clinic personnel.

Signboards should be designed so that they are attractive and efficient to produce; systems for installing and maintaining them should be in place before expanding the franchise. A provider's affiliation with the franchise is communicated to the public through the logo displayed on a signboard at the site of his or her practice. The display should therefore be attractive and visible to passersby. As outlined earlier, four different signboards were developed to differentiate each cadre of provider. GS1 signboards were custom designed for each GS1 clinic — an approach that proved costly and time consuming. The standardized signboards developed for the other types of providers were much easier to produce and install in a timely and cost efficient manner.

Maintaining signboards proved to be more difficult than expected. Green Star trainer-monitors must assess the condition of the signboards during their visits to network outlets. Any maintenance requirements should be communicated to the appropriate personnel for action. Unfortunately, gaps have appeared in identification, communication and follow-up. Franchisers should see to it that a system is in place to ensure that all three aspects of maintenance are fully functional at all times.

Care should be taken to provide ongoing motivation to franchisees. While involvement in the franchise should benefit providers economically (through increased clientele) other incentives must be built in to the program to keep providers motivated when they do not see immediate or clear economic rewards. SMP found that giving providers public recognition for their contributions to society through membership award ceremonies with distinguished guests and the press served to motivate providers. Special events and seminars for Green Star Network members were also successful in making providers feel that they are part of something special.

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Appendix A: Green Star Monitoring & Evaluation Tools

Clinic Grading Checklist

The proposed grading of outlets according to points is as follows:

- A = 90 and above
- B = 70–89
- C = 50–69
- D = Less than 50

Please note the following recent changes to the Key of Quality indicators on the Supervisory Activity Sheet (next page).

1. Physical Stamp

- 1.3.1 **Posters:** Two new posters were developed, so “posters” now refers to any GS poster and not specific posters. ABC posters will no longer be used.
- 1.3.2 **Brochures:** Family planning and newer topic brochures under development.
- 1.7 **Record Keeping:** Record keeping is allotted 10 points. If the provider is maintaining a good ML record, she gets the full 10 points. If she is maintaining some ML and hormonal records, she gets 5 points. If no ML record is being maintained then she gets 0 points.
- 1.8 **Certificate:** Certificates will not be graded (i.e., no points allotted). However, the trainer-supervisor must note the presence of the certificate and write in any pertinent comments. Other certificates, in addition to the GS1 certificate, will be added later on (e.g., RTI/STDs).

2. Procedure Room

- 2.2.3 **Examination Table:** “Clean sheet” has been added to encourage providers to properly cover the client to ensure client’s dignity.
- 2.5.1 **Disposable/Surgical Gloves:** “Disposable/Surgical Gloves” have been added, as they are mandatory in the procedure room.
- 2.6.1 **IUCD Poster:** Pre-mounted posters will be provided by SMP.

3. Infection Prevention

- 3.2.1 **Chlorine Solution:** Chlorine solution is allotted 6 points if five percent chlorine is being used. Any other grade of chlorine is allotted three points.

Note:

If “Y” is ticked then the attained score and the allotted score are the same, if “N” is ticked then the score becomes zero. There are intermediary scores except in the cases of Record Keeping (1.7) and Chlorine Solution (3.2.1), mentioned above.

Supervisory Activity Sheet GS1 Trained Outlets

Client Name: _____ Client Code: _____
 Provider Name: _____ Provider Code: _____
 Month & Year Trained: _____ Staff Code: _____ SPO Code: _____
 First Visit: ___/___/___ Available: Yes No Second Visit: ___/___/___ Available: Yes No

1. Physical Setup

S #	Key of Quality Indicators	Y	N	Attained Score	Allotted Score	Comments
1.1	Board	1.1.1			1	
		1.1.2			1	
		1.1.3			1	
1.2	Logo	1.2.1			1	
		1.2.2			1	
		1.2.3			1	
1.3	IEC Material	1.3.1			2	
		1.3.2			2	
1.4	Counselor Kit	1.4.1			1.5	
		1.4.2			1.5	
1.5	Privacy for Client	1.5.1			3	
1.6	Reference Manual	1.6.1			4	
1.7	Record Keeping	1.7.1			10	
1.8	Certificate	1.8.1			0	
		1.8.2				
Total					30	

2. Procedure Room

S #	Key of Quality Indicators	Y	N	Attained Score	Allotted Score	Comments
2.1	Board	2.1.1			7	
2.2	Examination Table	2.2.1			3	
		2.2.2			2	
		2.2.3			2	
2.3	Source of Light	2.3.1			3	
		2.3.2			3	
2.4	Cleanliness	2.4.1			2	
					2	
2.5	Disposable/Surgical Gloves	2.5.1			3	
2.6	IUCD Insertion Poster	2.6.1			3	
Total					30	

3. Infection Prevention

S #	Key of Quality Indicators	Y	N	Attained Score	Allotted Score	Comments
3.1	Facility for Hand Washing	3.1.1			3	
		3.1.2			3	
3.2	Chlorine Solution	3.2.1			6	
		3.2.2			4	
3.3	Components of Instrument Cleaning	3.3.1			2	
		3.3.2			2	
		3.3.3			2	
		3.3.4			2	
3.4	Components of Instrument Boiling	3.4.1			4	
3.5	Components of Instrument Storage	3.5.1			4	
3.6	Antiseptic Solution (except Dettol)	3.6.1			2	
3.7	Destructclip	3.7.1			3	
3.8	Method of Clinic Waste Disposal	3.8.1			3	
Total					40	

A=90 and above
 B=70-89
 C=50-69
 D=Less than 50

Final Attained Score: _____
 Attained Grade: _____
 Action Plan: _____

Appendix B: Green Star Network's Provider Service-Delivery Protocols

Choice of Methods

Green Star providers must:

- Have an adequate supply and range of family planning methods available.
- Ensure that client is counseled on the range of methods available.
- Ensure that the client receives their chosen method.
- Refer client to another provider for methods that are unavailable at their outlet.
- Not place unnecessary restrictions on client eligibility for a particular method.

Information Exchange

Green Star providers must:

- Give an overview of all available methods to first time and undecided clients.
- Give the client in-depth information about the method they request, including side effects.
- Ask the client questions to clarify her/his particular family planning needs.
- Make information, education and communication materials on methods available to clients.
- Give information in a complete, concise and non-biased manner.
- Refer clients to other sources for further information if needed.

Technical Competence

Green Star providers must:

- Be knowledgeable about contraception and be able to explain contraceptive benefits, risks, eligibility criteria, contraindications, side effects and management of side effects.
- Be able to demonstrate skills in hormonal method administration (GS1, 2 and 4 only).
- Be able to demonstrate skills in IUD insertions (GS1 only).
- Prescribe methods appropriately.
- Ensure that all new staff who will be delivering family planning services to clients receive Green Star training.
- Follow proper infection prevention procedures.

Interpersonal Relations

Green Star providers must:

- Establish a friendly, polite, respectful and nonjudgmental rapport with clients.
- Respect the privacy of their clients.
- Ensure that all staff at their outlet are polite and friendly to clients.

Continuity of Care

Green Star providers must:

- Be able to recognize and manage possible side effects associated with methods.
- Be able to easily re-supply a client's contraceptive method of choice.
- Encourage the client to return as needed.
- Schedule an appointment for a return visit.
- Maintain records of client visits.
- Refer client to higher-level service provider if necessary.

Acceptability and Appropriateness of Services

GS3 providers must ensure that:

- The pharmacy is neat.
- Information, education and communication materials are displayed.
- The Green Star signboard is maintained.
- Green Star products are stocked and stored in a neat, clean and appropriate manner.

GS1, 2 and 4 providers must ensure that:

- Waiting room is clean and has a Green Star family planning poster as well as information, education and communication materials displayed.
- Exam room is clean and private.
- Clinic has running water, electricity and toilet.
- Costs of services are acceptable to all clients.
- Days and hours of operation are convenient to clients.
- Client waiting time is reasonable.
- Confidentiality of client is maintained.
- Other health services are available at the clinic.