RESEARCH AND DEVELOPMENT SOLUTIONS
AKHTER HAMEED KHAN RESOURCE CENTER
Policy Brief No. 51, February 2019
DOI: 10.13140/RG.2.2.13989.96489

Towards Model Cities:
Rising Family Planning in a Holistic Empowerment Model

The Challenge

A number of programs have attempted to change Pakistan's stagnant CPR (34%, DHS 2017-18). However, only a few standout. There are key features of these successful programs. Nearly all of them – i.e. the Lady Health Workers (1993-98), Marie Stopes Society (2008-09), the Sukh Initiative (2015-18) and now the AHKRC urban laboratory (2018 onwards) - included some form of community outreach and that programs were designed to cover a designated geographic area. The former relates to the ability to reach households and MWRA that may have limited access to information or services; and the later to the ability to actually measure results in a geographically distinct location.

Following Pakistan's pledge at the 2012 London summit to increase its CPR to 50% by 2020,[1] considerable donor funding was introduced into the country – mostly as programs implemented by NGOs. Meanwhile there was little or no change in government funding for

has changed very little in the past 2 decades, despite considerable investments to deliver expensive[2] supply side programs through clinics or shops.[3] Yet, DHS 2017-18 shows that many users remain unconvinced of the need for FP despite high unmet need. Government and donor programs continue to ignore young couples, often recycling the same users without reaching out to additional users and do little to address the very high discontinuation rates. In all of this, the one bright light is the fact that virtually successful FP programming in Pakistan has included some form of outreach.

The Urban Slum Low Cost Outreach Model

We demonstrate a locally integrated, low cost ecosystem of FP programming that builds on the needs of community women, involves their husbands in FP promotion, and energizes local women as outreach workers (*Aapis*). Aapis generate income through outreach and by selling common commodities to their neighbors and referring potential users to local public and private providers for FP services.

Dhok Hassu-Dhok Mangtal are urban slums in Rawalpindi, with a population of 278,000 (45,000 households). It has one government dispensary but 109 private healthcare providers; 3 government and 116 private schools. There are no lady health workers. Our annual survey in November 2017 had shown a contraceptive prevalence of 32%, nearly all with modern methods and around 17% of these with condoms and unmet need of 41%.

SALIENT POINTS

- CPR increased by 12% in the first 11 months
- Drop out was 7% of additional users
- Outreach workers earn USD 25-125 a month
- Household visits cost USD 1.6 and USD 11 per woman served with FP services
- The program uses indigenous resources that already exist in the community without needed large external interventions or investments
- Being community based, the program is flexible and adapts quickly to local needs

Intervention Methodology

In year one, supported by the Ambassador Fund Program (SGAFP-USAID), AHKRC had experimented to develop a cadre of entrepreneurial local women that would generate an income by selling household and health products to their neighbors. These women had previously felt it difficult to even leave their homes unchaperoned. They were trained in outreach, entrepreneurship and other interpersonal skills and were given a starter grant. Thereafter, around 25 women – called Aapis - were able to generate Rs. 3,000-15,000 (USD 25-125) a month, sometimes doubling their household income.

In the year 2, with support from the Punjab Population Innovation Fund (PPIF), Aapis were additionally trained in special counseling skills using an **modification of cognitive behavior therapy (mCBT)** through a training regime developed by the Department of Behavioral

1 FAMILY PLANNING 2020 COMMITMENT
GOVT. OF PAKISTAN. http://www.familyplanning2020.org/pakistan
2 Abbas K, Khan AA and Khan A. Costs and Utilization of Public Sector Family Planning Services in Pakistan. JPMA 2013. 63 (4, suppl 3) S33-S39
3 Khan AA, Khan A, et al. Family Planning in Pakistan: Applying What We Have Learned. JPMA 2013. 63 (4, suppl 3) S3-S10

Studies (DBS) at the National University of Science and Technology (NUST). Aapis then visited households to create demand for FP in the communities while also generating profits through sales of common women-child need/demand products or from referrals (for a fee) to private health providers for FP services. If they faced refusal to use FP, they applied mCBT to open a dialogue with local women and their husbands about the benefits of FP and preventive health. This dialogue was led by current FP users from these communities - **positive deviance inquiry** - in community meetings to ***recast FP as a social norm***. These community sessions were held by male and female social mobilizers with support from the Aapis.

Women who wanted to start or continue condoms or pills were given these for free (granted by the Punjab Population Welfare Department - PWD). Those that wanted to receive an injection, IUD, implant or tubal ligation were referred to either a nearby government or private healthcare provider. Nine local providers were trained in quality FP services in support from the PWD and the NGO FPAP. Aapis also followed up within 1-2 weeks after someone initiated FP to ask about side effects and discontinuation.

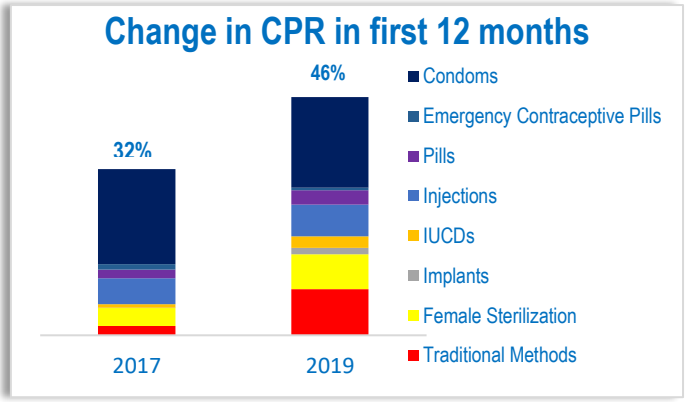
Intervention Results	
Households reached	33,289 (75%)
Follow up visits	8,173 (25%)
Baseline CPR (from survey)	32% (14,400 users)
Baseline unmet need	41%
Additional users	6,339
Additional CYP served	28,387
CPR at 12 months (from survey)	46%
mCPR at 12 months (from survey)	39%
Estimated Discontinuation	25%
Costs per HH reached	PKR 190 (USD 1.6)
Cost per women served with FP	PKR 1,469 (USD 10.5)
Cost per CYP	PKR 578 (USD 4.13

Real Time Dashboard and Household Map

Progress is documented and followed using an online dashboard; data are also being converted into geographic maps. Aapis were given Rs. 3,000 (USD 25) monthly for data collection; while expanding their sales during household visits.

Current Results

As of November 2018 (11 months into the intervention) 36 Aapis had visited 30,162 HHs (67% MWRA in the community) and recruited 6510 additional FP users (21% FP uptake in HH visits, 14% additional FP users). Condoms or pills or tubal ligation (referrals) contributed 38% and LARCs or injections 67% of new users. A total of 8100 mCBT sessions had been conducted with



approximately 27% success in conversion to new users per session. An ongoing review is tracking the 6 month discontinuation rate and our preliminary estimates suggest 7% switching or discontinuation.

Program and Policy Implications

1) We present a low cost and effective model of both urban family planning and women's economic engagement.

The model costs around one-sixth of current public sector (lady health worker) programs of rural outreach and can be the potential solution to empowering women in urban slums while improving health outcomes.

2) While promising in the first appearance, more in depth research is needed to understand the specific role of mCBT by low literacy women.

3) It may be possible that the initial high unmet need was met with availability/ connection with services and that this will start slowing down as unmet need is saturated. In which case additional demand creation with mCBT or other means may become crucial.

4) The initial women's Economic-RH model provides a credible option of Evidence-Based Advocacy and Methodology. The next logical step in program design is to scale up to other Rawalpindi urban slums – estimated population 1-1.5 million) to see uptake and results at citywide coverage level. Involvement of the government and donor decision makers in this process would be valuable in local as well as national scale up.

For more information please contact

AHK Resource Center
www.ahkrc.org
Ayesha Khan
ayesha@khans.org

Research And Development Solutions
www.resdev.org
Adnan Khan
adnan@resdev.org