



SUKH INITIATIVE ANNUAL REPORT

YEAR I & II
NOVEMBER, 2013
TO JUNE, 2015



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

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

Provincial Government Partners



Project Implementing Partners



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ABBREVIATIONS & ACRONYMS

ACHP	Aman Community Health Program
AHCS	Aman Healthcare Services
AKU	Aga Khan University
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ATH	Aman Telehealth
AUHI	Aman Urban Health Institute
CAC	Community Advisory Committee
CBO	Community Based Organization
CHS	Community Health Supervisor
CHW	Community Health Worker
CRG	Community Representative Group
CTS	Clinical Training Skills
DoH	Department of Health
FLE	Family Life Education
FP	Family Planning
HTSP	Healthy Time and Spacing of Pregnancy
IUCD	Intrauterine Contraceptive Device
KAP	Knowledge, Attitude and Practice
LSBE	Life Skills Based Education
LHW	Lady Health Worker
MCPR	Modern Contraceptive Prevalence Rate
MHFA	Mental Health First Aid
MNCH	Maternal, Newborn and Child Health
MoU	Memorandum of Understanding
MVA	Manual Vacuum Aspiration

MWRA	Married Women of Reproductive Age
NCMNH	National Committee for Maternal and Neonatal Health
NGO	Non Governmental Organization
PAC	Post-Abortion Care
PAFP	Post-Abortion Family Planning
PDM	Permanent Door Marking
PMU	Program Management Unit
PNC	Pakistan Nursing Council
PPFP	Post-Partum Family Planning
PWD	Population Welfare Department
QIQ	Quick Investigation of Quality
RTI	Regional Training Institute
SMB-R	Standard-based Management and Recognition
SRHR	Sexual and Reproductive Health and Rights
STC	Sukh Town Coordinator
TAG	Technical Advisory Group
TDM	Temporary Door Marking
TFMC	Total Family Member Count
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VCAT	Value Clarification and Attitude Transformation
WPF	World Population Foundation

MESSAGE

Sukh Initiative has completed nearly two years of implementation and is now entering the most challenging phase of the project. Our goal to increase the use of modern family planning methods and contraceptive prevalence rate in peri-urban Karachi, faces unique challenges and we are proud to share the new ways we explored to cross them.

Pakistan is country that faces various political and economic changes and challenges, which can impact or affect the way humanitarian projects work. The development sector plays a key role in improving Pakistan's social indicators, and we have worked with change makers and beneficiaries to raise awareness and make sustainable differences. Globally, and especially in Pakistan, poverty and social inequality is directly linked with ever-increasing populations. Pakistan is the sixth most populous country in the world, contributing 2.5% to the global population. The current annual growth rate for Pakistan is 1.49% and urbanization is occurring at a rapid rate of 3%. Nearly 35% of the population lives in urban areas, and this rate is expected to increase to 50% by the year 2025.

Out of all the major cities in the country, Karachi is the fastest growing with an 80% increase in its population between the years 2000 and 2010. The estimated population of Karachi is 18.5 million as of July 1, 2014. Home to a wide range of migrant ethnic communities, Sukh Initiative reaches 1 million people, particularly married women, in four peri-urban centers which are home to Sindhis, Pakhtuns and Balochis, collectively speaking approximately six different dialects and languages.

This report captures the work of our communities, field teams, implementing partners, government departments and donors that have worked tirelessly to make a positive change, which will hopefully benefit Pakistan in the decades to come.

The team and I thank you all for your support and look forward to the success of this project for a healthy, prosperous Pakistan.

Dr. Haris Ahmed
Head of Sukh Initiative



SUKH INITIATIVE AT WORK

Context in which we work

Sukh Initiative emerged from commitments made at the London Summit on Family Planning held in July 2012 and is a joint partnership between three foundations, namely Aman Foundation, Bill & Melinda Gates Foundation and David & Lucille Packard Foundation. Together, their mission is to increase the use of modern contraceptives in Karachi, Pakistan by 15% among 1 million married women in selected communities. The project began in 2013 and will continue till 2015.

Over a period of 5 years and with an investment of \$15 million dollars, the project aims to achieve this goal with the support of 7 implementing partners. The prescribed framework of activities for achieving the mission is based on its three broad objectives:

- Increase demand for family planning services
- Improve access to family planning services and improved quality of services
- Ensure the long term sustainability of the program

The mission was set out with a vision to empower families to access family planning by increasing knowledge, improving quality of services and giving more options in order to realize the goals of Family Planning 2020, a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have.

The collaborating foundations are represented at the Steering Committee and take decisions on the program's strategies and priorities in the context of country and provincial family planning policies and plans. A Program Management Unit based at Aman Health Care Services, provides operational leadership and oversight. Under the program head, the Program Management Unit coordinates the activities and interventions of the program that are carried out by implementing partners.

Where we work

Karachi is the most populous city in Pakistan, and for administrative purposes it is divided into three tiers: districts, towns, and union councils. The union council is the smallest administrative unit within the system with an average population of 75,000. An initial baseline survey based on the socio-economic status of its population identified two districts in Karachi, namely Malir and Korangi. The program is being implemented in 18 union councils of four towns, which are Korangi, Landhi, Bin Qasim, and Malir, covering approximately one million population and representing about 4% of the total population and 10% of total urban slum population. The selected target regions of the Sukh Initiative had no coverage of the Lady Health Workers Program for Family Planning and Primary Healthcare from the provincial government.

The program catchment area is divided into 10 operational boundaries, each with



an approximate population of 100,000. In each of the operational boundaries, field stations have been established at the most central and relatively secure locations. A field coordinator is in-charge of the overall operations at these field stations. Twenty-five community health workers (5 male and 20 female), two community health supervisors and one social mobiliser are affiliated with each field station.

The operational philosophy of Sukh Initiative encourages the engagement with and support to existing family planning and reproductive health-related initiatives and programs, be it by public sector or private sector. In this regard, Jhpiego and DKT Pakistan, develop synergies with different health facilities and programs in the area with an aim to expand access to family planning and reproductive health-related health services and improve quality.

Implementing partners

Aman Community Health Program

Lead partner for door-to-door service

Aman Community Health Program provides free of cost preventive health services to the underserved urban population. It aims to bring health to their doorsteps through Aman Community Health Workers. These health workers have accessibility and acceptability to community members, and have proven to provide uplift to the overall coverage and use of services by underprivileged individuals and households.

Jhpiego

Partner for provision of quality services by public health facilities

Jhpiego is an international, non-profit health organization affiliated with Johns Hopkins University. For 40 years and in over 155 countries, Jhpiego has been working to prevent



the needless deaths of women and their families. It does so by collaborating with health experts, governments and community leaders to provide high-quality health care for their people. Jhpiego develops strategies to help communities care for themselves by training competent health care workers, strengthening health systems and improving delivery of care. Jhpiego engages with the public health sector in order to realize the objective of Sukh Initiative.

Aman Telehealth

Partner for telehealth helpline services

Aman Telehealth is a 24/7 health helpline service facility, providing timely health advice and referral information in over five languages via medical software containing over 85 medical algorithms and 600 disease summaries. This service can be accessed by dialing 9123 from mobile networks and 111-11-9123 on landlines. Trained Telehealth nurses backed by trained doctors, nutritionist and mental health counselors provide services to an average call volume of 600 to 700 inbound and outbound calls a day. Aman Telehealth maps health facilities, including hospitals, maternity homes, diagnostic centers and blood banks, mainly in Karachi and some other parts of Pakistan, and has a database of over 10,000 private healthcare providers and 3,500 healthcare facilities about their contact information, working hours, fee structure and more. For more information, please visit: <https://www.theamanfoundation.org/program/aman-telehealth/>. Aman Telehealth aims to empower and encourage women and youth in particular to avail the widely available mobile phone services to seek timely medical counseling. Public health related SMS alerts highlighting preventive measures to avoid risky health behaviors are also sent through this service.

Aga Khan University

Partner for measurement

Aga Khan University is an institution of academic excellence that plays an important role as an agent for social development. A leading source of medical, nursing and teacher education, research and public service in the developing world, the University prepares men and women to lead change in their societies and to thrive in the global economy. Based on the principles of impact, quality, relevance and access, the University has campuses and programs in Afghanistan, East Africa, Pakistan, and the United Kingdom. Its facilities include teaching hospitals, nursing schools, medical colleges, institutes for educational development, an examination board, and an institute for the study of Muslim civilizations.

Aahung

Partner for family life education

Aahung is a non-profit organization founded in 1995 with a mission is to use a rights-based approach to improve access to quality sexual and reproductive health information and services to contribute towards a healthy society. Aahung has been successful in developing culturally informed strategies to respond to the sexual health needs of the Pakistani population and in bringing attention to sexual health issues and concerns in medical and educational institutions, non-government and government organizations across Pakistan. It runs a Life Skills Based Education program, which aims to introduce critical reproductive health information and management skills in line with the emerging capacity of young people.

Aahung engages with the youth through different means and methods in project areas with a specific goal to impart Family Life Education based on its Life Skills Based Education curriculum.

DKT Pakistan

Partner for provision of quality services by private health facilities

DKT Pakistan works in the private sector to provide modern contraception at affordable prices as well as in the area of social franchising. DKT's Dhanak clinics, more than 750 in number, serve the community in the rural areas of Pakistan.

Center for Communication Programs Pakistan

Partner for strategic communication

Center for Communication Programs Pakistan is a non-governmental organization providing technical leadership in strategic social and behavior change communication design, programming, research, and capacity strengthening. Center is a sister organization of Johns Hopkins Center for Communication Programs based in Baltimore, United States. Center has been working with public and private sector organizations. Center has expertise in design, implementation, and evaluation of strategic communication, including development of campaigns, materials, and special events. It also has unparalleled experience in advocacy and community mobilization campaigns in Pakistan, and an extensive outreach across the country, with nationwide reach through well-entrenched and community-based networks of religious leaders, journalists, communication activists and community-based workers.

Program model

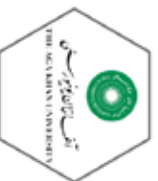


15% increase in use of modern contraceptives among
1 million target population

Increase demand for
family planning services

Improve access and quality
of family planning services

Sustainability





IMPACT IN 2013-15

Direct engagement with communities

Door-to-door services provide individual and personalized attention to women and allow the program to cater to specific individual needs. These include information, counseling, distribution of contraceptives, supplements, and referrals to other partners and local resources through both male and female community health workers. Community health workers have a passion to serve communities and are selected from a population of 5,000, with at least 10 years of formal education and are 18–35 years old. Using the same criteria, male community health workers were also selected from the community from a population size of 20,000.

Community health workers refer women with specific family planning needs to nearby quality service providers. Pregnant women in particular are referred to maternity homes that offer post-partum and post-abortion family planning care. Youths are encouraged to participate in family life education sessions, which are planned and held within the community. Married couples are recommended to use the helpline call center service

Community Health Workers – A Ray of Hope

'Perseverance for improvement of maternal health', this is the slogan Shahida adopted when she first joined the ranks of CHWs to increase use of family planning services in her community. Working in the poor community of Union Council Rehri Goth, Shahida met Hawa, a mother of three, during her routine household visit. Hawa, like other women in her society, was totally against family planning. Hawa was suffering from anemia and had never used any family planning method. Her three children, youngest being six-month old, were born at short intervals. Shahida, kept on interacting with Hawa and her family to convince them that having another child, without an appropriate spacing, would have very serious effects on her health. She informed the family that in Pakistan more than quarter of maternal deaths are due to post-partum hemorrhage, which actually is due to severe anemia, one of the side effects of repeated pregnancies within short intervals. Giving them examples from women who were anemic and died during childbirth due to severe bleeding, Shahida made Hawa and her family change their opinion about family planning. Accompanied by Shahida, Hawa had an implant inserted by a local provider. Hawa was counseled on the effects of implant and where to reach in case of any side effects. Hawa now is totally transformed, she is more empowered and instead of fearing of an unwanted pregnancy, she is more involved in the betterment of her family. Hawa's physical condition has improved tremendously and she has started advocating for spacing to her friends and family members, and makes herself available to participate at Support Group Meetings. Two women from Hawa's house, her close relatives, have also got implant insertions, convinced from the counseling done by Hawa, who continues to advocate for birth spacing.

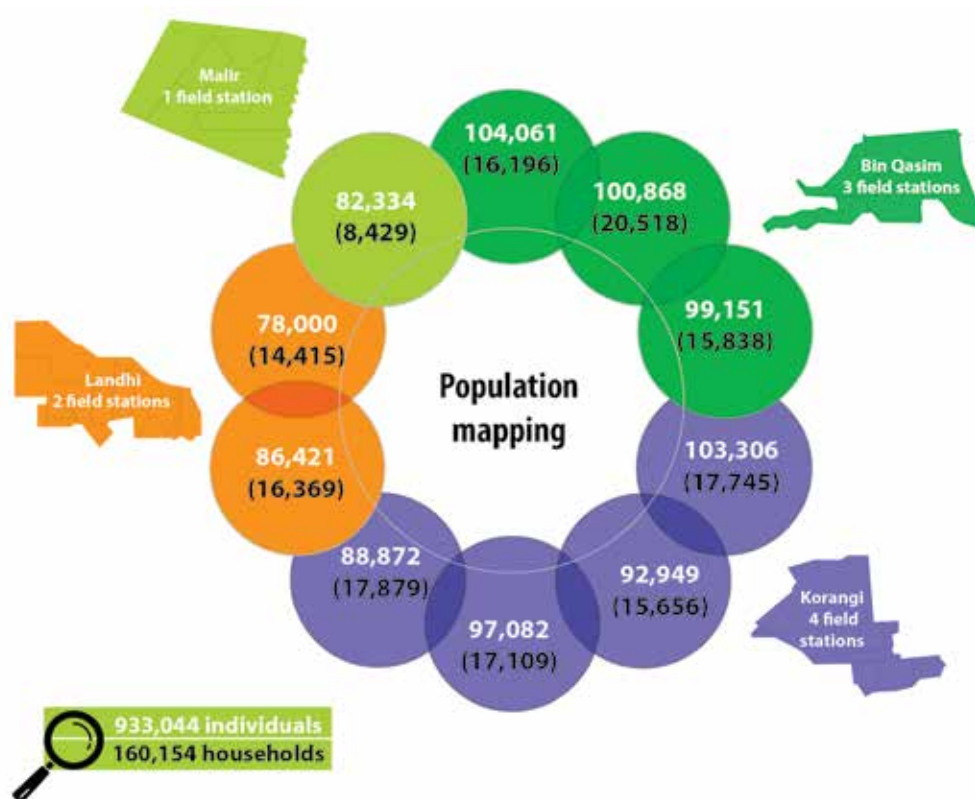
by Aman Telehealth for further information and counseling needs. They also support Aman Telehealth by providing the mobile numbers of married men, women and youth for outbound calls, SMS and reminders. Male mobilization is also an integral part of these services, informing men on the importance of birth spacing and encouraging them to have inter-spousal communication on topics of family spacing and reproductive health.

Mapping of project sites

The mapping of project sites was completed in May 2015 by Aman Community Health Program. The sites are identified in consultation with Aman Healthcare Services and decided upon by the Steering Committee.

A two-phased approach has been adopted to map the population in the project area. In the first phase, total family member count was conducted during the first two quarters of Year II to estimate the population within the selected geographical areas. With the consent of family members, field teams obtained information about the number of family members living in the house, after which unique identification codes were allotted to each household. Temporary and permanent door markings were used for future referencing. Community health workers also did Household Profile Registrations by collecting specific data, including the number of married women of reproductive age, children under the age of five, newlywed couples, and women with low parity (having up to two children).

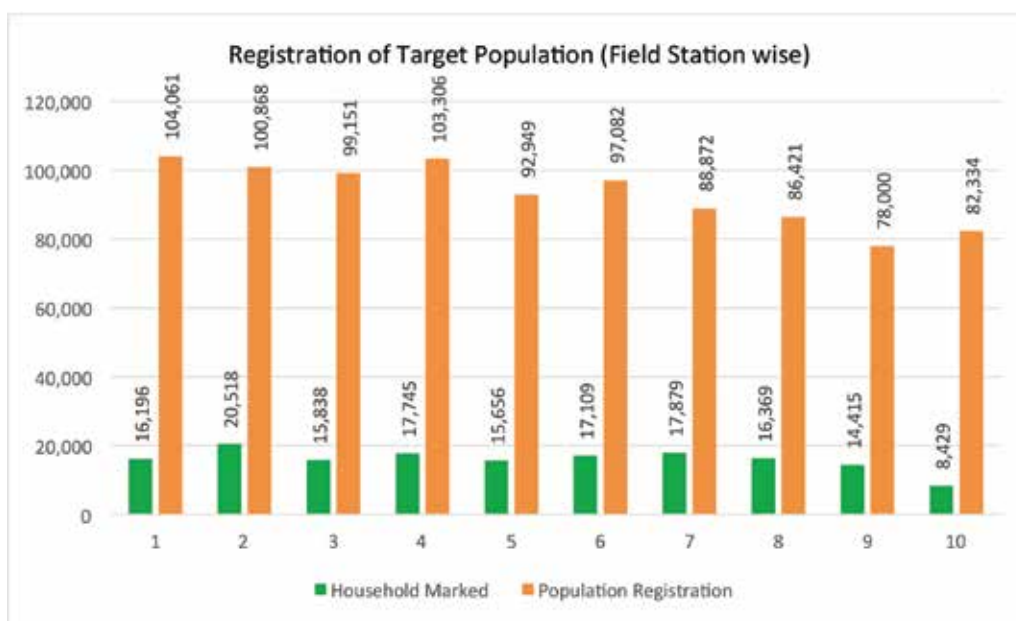
During Year I and II, data of 93% (933,044 individuals) of the target population was collected from January 1, to June 30, 2015.



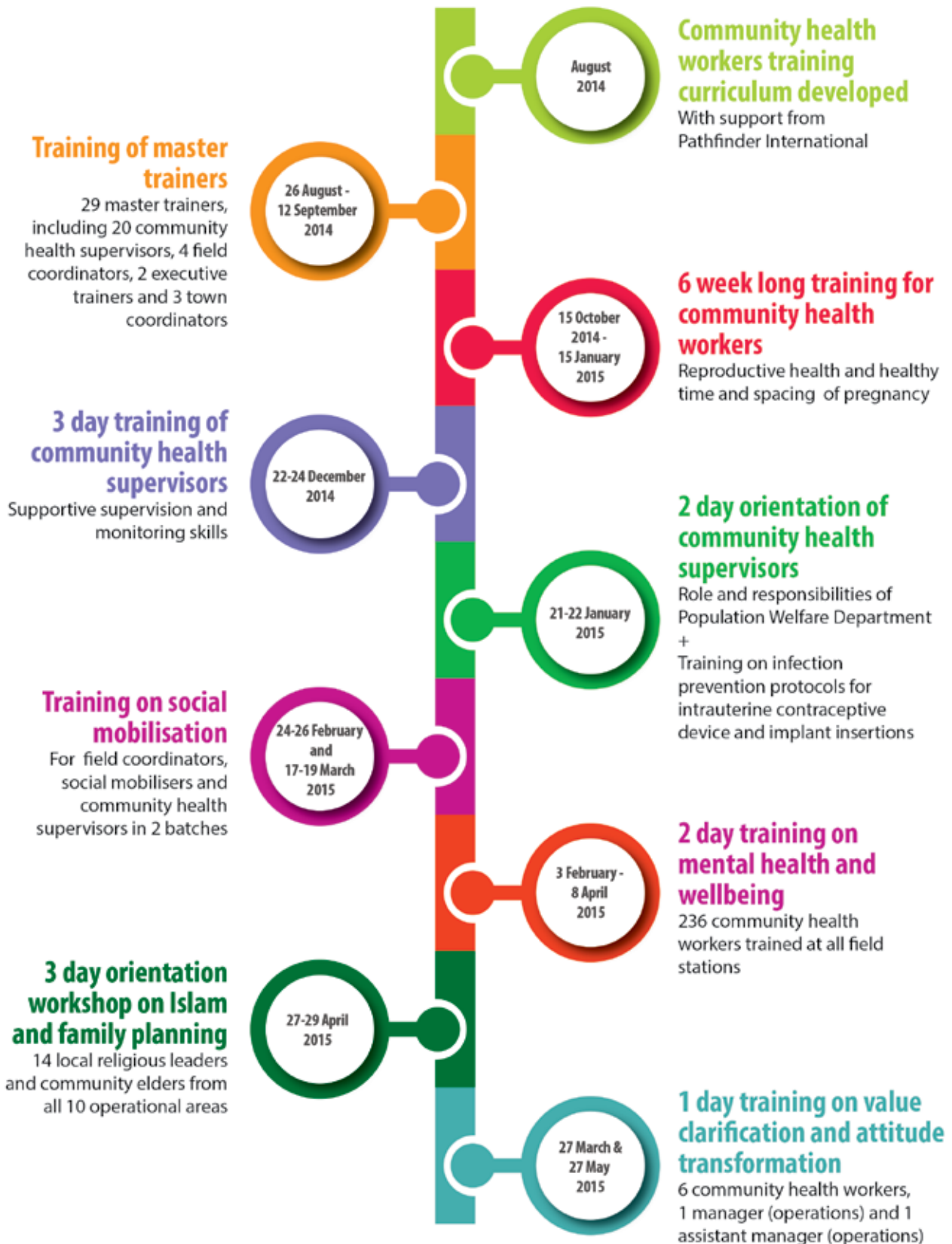


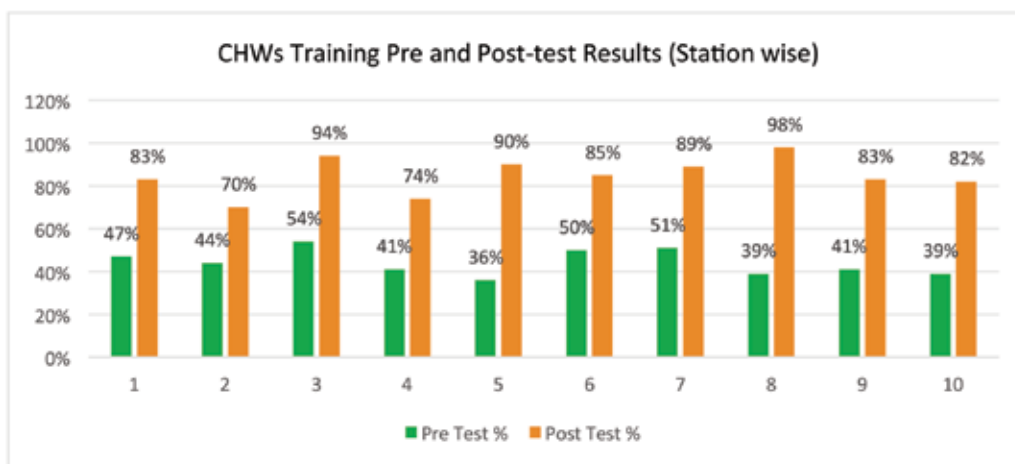
Monitoring and quality assurance of training

Monitoring and supportive supervision of step-down training was jointly conducted by Aman Urban Health Institute and Pathfinder International. Pre and post-test evaluations were done to assess overall performance of community health workers at each field station, identify areas of strengths and weaknesses, and provide regular feedback to the trainers to improve their training.

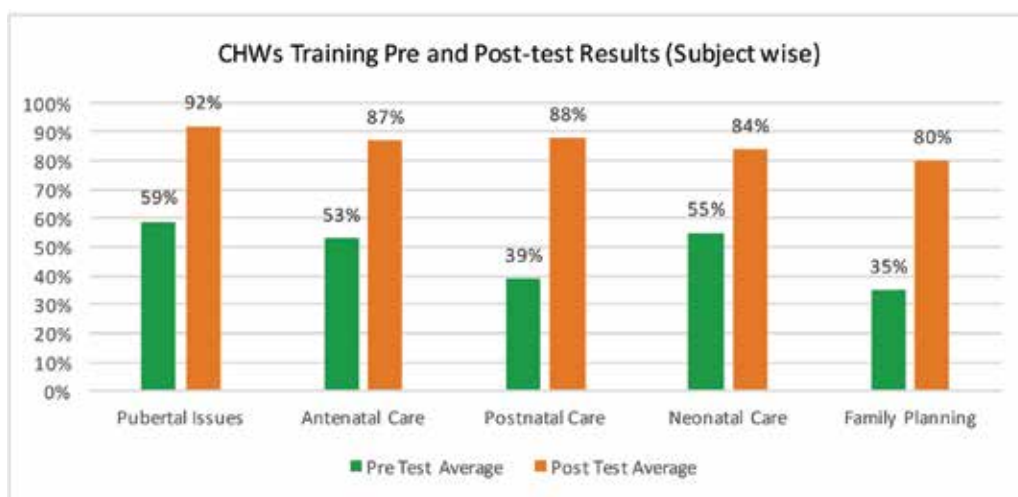


Training of field staff and other stakeholders





Average scores achieved by community health workers in pre-test and post-test. There was a maximum of 59 per cent increase in knowledge.



The performance of each station was directly related to the interest of trainers and trainees as selection was locally done from the areas being served. Most of the stations performed well, while refreshers were suggested for those achieving less than 80 per cent marks. Average gain in knowledge was also analyzed subject-wise, which included puberty-related issues, antenatal care, post-natal care, neonatal care and family planning.

Community engagement

Aman Community Health Program engaged with the community at two levels: one at the grassroots level with members from the households by forming community based organization/community based organization; and the second with community notables through community advisory committees, one each for a population size of 100,000.

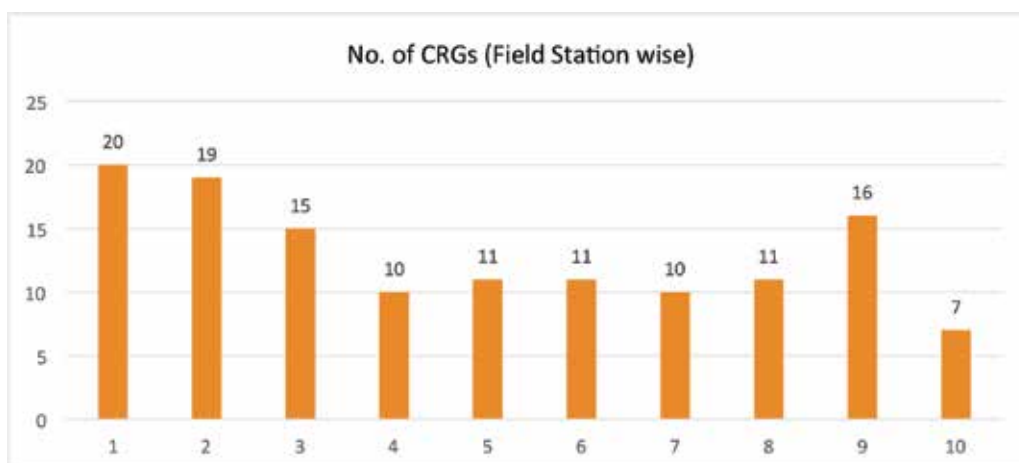
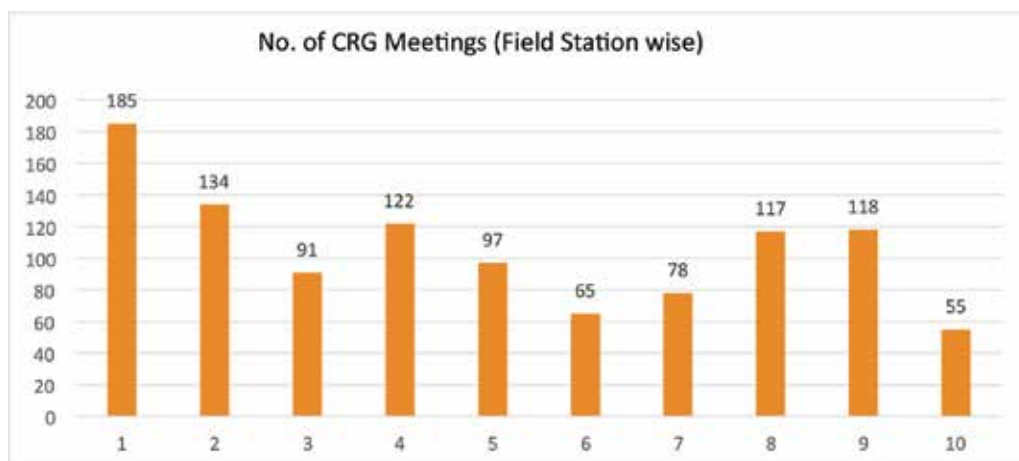
Community representative groups/community based organization

Two community representative groups/community based organizations were formed in communities for every 20,000 people, with separate groups exclusively for females and males. Each community representative group/community based organization has five

designated members and meets at least once a month. These community representative groups/community based organization facilitate project implementation and provide solutions for day-to-day challenges. As many as 130 of these were formed since inception of the program. Social mobilizers facilitated in organizing these meetings. Over 1,060 meetings were conducted during Year II. These were helpful in promoting community ownership of the program and directly support the work of community health workers.

Community advisory committees

These were formed by Aman Community Health Program with representation of key community stakeholders which included local leaders, activists, religious leaders, prominent political personalities and community elders. One community advisory committee exists per 100,000 persons, each having seven to 10 members that meets once a quarter to review progress of the program and extends its support to community-based interventions. These committees have a bigger mandate than community representative groups/community based organization as they help identify schools for interventions by Aahung, nominate private clinics for starting DKT's Dhanak centers, identify sites for establishing Telehealth booths, and support baseline survey activity by



Identifying Champions

"I can, and I will!" Zulekhan, 39, says with conviction to her fellow colleagues at Sukh Community Advisory Committee (CAC), of which she is a member. Married at 16 to a fisherman Yousaf, Zulekhan is now a mother of four children, and lives in Rehri Goth, a peri-urban strip of Karachi, next to the shoreline. She shares the emotional turmoil she went through when married at an early age; "I was so scared to leave my home, friends and family, at a time when I needed them the most, and move to a new environment where every day I had to prove that I was a responsible adult." She is committed to stop early age marriages in her community, and appreciates Sukh to provide her a forum from where she can do that. Sukh Initiative, a five-year project working in underserved and low income communities of Karachi, aims to improve family planning counseling and services through a demand and supply model of interventions. The project is also working with youth to empower them in decision-making, especially on early age marriages. CACs within the project, provide an opportunity to community elders and notables to act as change leaders and facilitate CHWs in their door-to-door counseling services, and to promote healthy behavior. Zulekhan is a champion-in-making to the cause of Sukh, as the project progresses from its inception to a full-scale implementation in these communities.

Aga Khan University. In Year II, 10 community advisory committees were formed for each field station. They held 36 meetings in the year.

Services

In Year II, each of the community health worker provided door-to-door services to 1,500 persons. Service to an additional 2,000 persons was to be given in Year III of the program. After successfully completing training sessions, community health workers reached out to committees upon completing their first cycle of interventions from May to June 2015, while concurrently completing family profile registration of all the 5,000 persons under them. Community health workers continued to provide needs-based services to the community during the registration process.

Number of household visits	
Regular	202,162
Follow - up	15,066
Support Group Meetings	
Female support group meetings (MNCH, FP, FLE)	1,494
Participants in female support group	13,259
Male support group meetings (MNCH, FP, FLE)	697
Male support group participants	5,333

Referrals

Method-wise referral of family planning services

From January–June 2015, all referrals were made to existing public and private facilities for family planning services. For this purpose, a list of all public sector health facilities under the Department of Health and Population Welfare Department were provided by the Program Management Unit to Aman Community Health Program and Aman Telehealth. Community health workers and Telehealth call agents referred clients to the listed facilities. In addition, a list of existing private sector facilities franchised by Marie Stopes Society and Green Star Social Marketing was also shared with community health workers and Aman Telehealth.

Method-wise referrals out of a total of 4,306	
Condoms	38 %
Injectable	21 %
Pills	17 %
IUCD	10 %
Tubal ligation	9 %
Implants	5 %

111 clients were referred for post partum family planning, 20 for post abortion family planning and 95 for post abortion care. Community response to counseling has received encouraging response in a short span of time.

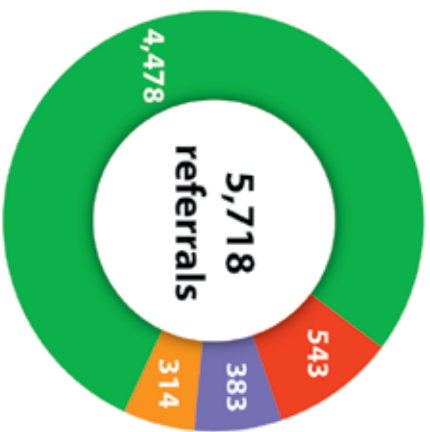
Maternal care referrals

Community health workers referred women for ante and post-natal care, and for facility-based delivery. Out of 5,718 referrals, 4,478 were for antenatal care, 543 for TT, 383 for post natal care and 314 for deliveries.

Early Marriage

'Education and awareness are the two powerful tools to prevent child marriages' a quote that moved Rahila, a CHW during her basic training from Lath Basti, a community with low female literacy, where early marriages are a common practice. Even though Rahila had joined Sukh to contribute in improving the health of mothers and children, but now knowing the hazards of child marriage, she pledged to herself to stop this practice to the best of her ability. Rahila met Khadija, a playful innocent 14-year-old girl, during her routine household visit and came to know, from her parents, that she would be married within a month. Rahila felt disturbed, and talked to both Khadija and her mother of the detrimental consequences that Khadija will have to live with, if they have this wedding. Moreover, being underage and not having her Identity Card at the time of marriage, this was an illegal action and punishable by law. But Rahila was not getting support from the family as they continue to prepare for the wedding. Rahila asked her supervisor Sughra to accompany her to counsel the parents and convince them to postpone the marriage of their daughter. Both Rahila and Sughra continued to visit Rahila and her family to counsel them on the hazards of early age marriage and it was only after regular visits over two weeks that they both were able to convince Khadija, her mother and grandmother, to postpone the marriage till Khadija is 18 years of age. The women discussed with the male members of the family, who were also counseled by male CHWs individually and during male support group meetings, and as a result the family agreed to postpone the wedding only one week before the event. Sukh works with young girls and boys, to make them responsible adults, and it is only because of CHWs like Rahila, who work with personal conviction to bring a change in bad practices in the community which have direct psychosocial and physical effects on health of young girls.

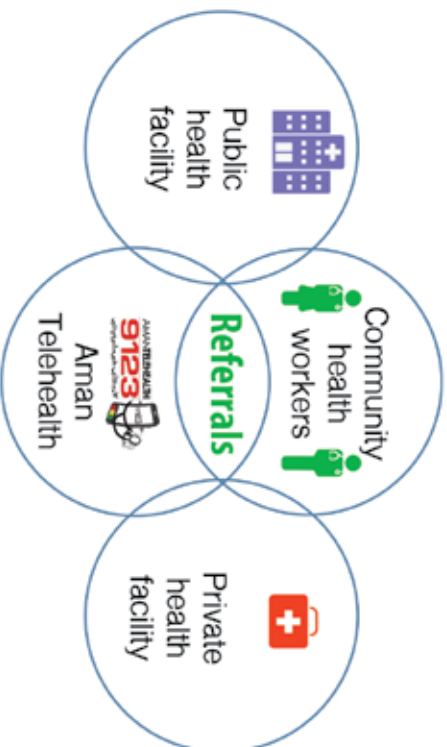
Maternal care referrals



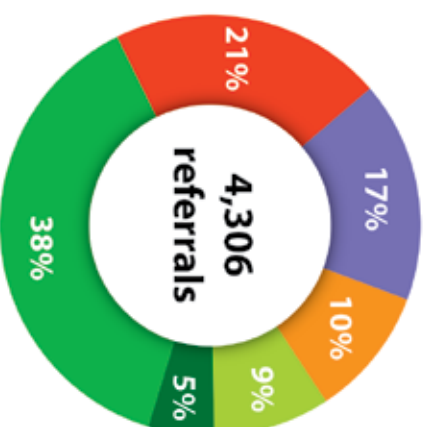
- Antenatal care
- Tetanus toxoid
- Post natal care
- Deliveries



Community health workers also make referrals for antenatal care, post-natal care and facility based delivery.



Method wise referrals

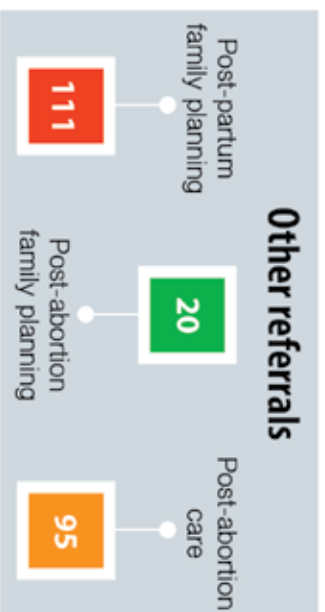


- Condoms
- Injectible
- Pills
- Intrauterine contraceptive device
- Tubal ligation
- Implants



Referrals are made by community health workers through door-to-door counseling and support, and by Telehealth call agents. Community members are referred to listed public and private facilities for family planning services.

Other referrals



Family life education

Aahung joined the program in May 2014 to lead the family life education component. The main focus of family life education is on providing information to the youth on topics such as maternal health, maternal rights, pubertal changes and development, communication skills, appropriate and legal age of marriage, and responsible decision-making skills.

Between the period of May and August 2014, Aahung finalized the Youth Engagement Strategy and conducted a one-day introductory workshop on family life education for the field coordinators and community mobilisers.

Advocacy and networking

As a first step to implement the Youth Engagement Strategy, Aahung undertook the following activities:

Mapping of private and public schools, and alternate learning institutes

Mapping was carried out on 10 project sites with approximately 100 secondary schools and alternate learning institutes. To form partnerships, 30 secondary schools, 7 private schools, 23 government schools and 10 alternate learning institutes were shortlisted. An additional 30 secondary schools were shortlisted for future intervention.

Signing of MoU with public and private schools and alternate learning institutes

In Year II, the program and Sindh Education Department signed an MoU for providing family life education in selected government secondary schools. The agreement also allowed Aahung to increase its coverage from an initial 15 public schools to 23 schools. Moreover, efforts were made to reach an understanding with 7 other private schools and 10 alternate learning institutes and sign MOUs with them in the first quarter of Year III.

Networking and linkages

Linkages have been established between the program and Provincial Institute for Teacher Education. Similar linkages and synergies were developed between government administrators and working relations were established with district officers from the Department of Education and related government departments.

Module and Material Development

Aahung initiated the process of family life education module and material development by requesting organizations working on family life education and life skills-based learning in Pakistan and India to share developed material. These included Rutgers-WPF, Rozan, Tarshi and CREA. Family life education modules and materials were then updated. These included the following:

Community Module for out-of-school young people aged 16-22 years

In Year II, the Aahung team worked on developing a pictorial module for out-of-school young people in all project sites. This module focuses on key topics, such as the importance of having a National Identity Card, early marriage prevention, maternal health





and importance of birth spacing. This is being used by community health supervisors, community health supervisors and social mobilisers.

Family life education module for school going adolescents aged 12-15 years

Aahung's existing modules on life skills-based education have been successfully tested and implemented in various schools across Karachi and Sindh province for over 15 years. The content of these modules were shared with the Sindh Education Department, which endorsed them during the MoU signing phase. This module will be ready for implementation in the first quarter of Year III.



Capacity Building

Training of community health supervisors

In September 2014, Aahung conducted a two-day training for 20 community health supervisors. The objective of the training was to clarify the concept of family life education, highlight its importance, and develop the capacity of community health

supervisors as master trainers to further train community health supervisors. The trained community health supervisors would then be expected to directly hold family life education sessions for young community members in the age bracket of 16 to 22 years.

Roll-out of family life education training with 250 community health workers

Once the supervisors are trained, Aahung provides them with on-site support in rolling out the same training to community health workers. Under the program, 250 community health workers from all field stations received a two-day training on a format similar to the one given to community health supervisors. These trainings provided community health workers with a platform to share their experiences. Many case studies were discussed highlighting prevalent adolescent and youth related issues such as puberty, early marriages and violence.

Training Aman Telehealth call agents and operational team members on sexual and reproductive health and rights and family life education

In December 2014, Aahung conducted a detailed focus group discussion with 10 Aman Telehealth staff in order to carry out needs assessment on current understanding of sexual and reproductive health and rights and family life education. The other objective of the needs assessment was to analyze the calls that were being received related to these topics on a regular basis. Based on the findings of the needs assessment, it was determined that there was a need to train the Telehealth team on key family life education topics such as pubertal changes, menstruation, nocturnal emissions, masturbation and early marriage. Sexual and reproductive health and rights topics such as vaginal discharge, premature ejaculations, sexual violence and sexual dysfunction were also highlighted as core areas lacking basic knowledge. A comprehensive training module was developed based on these findings. Aahung also revised Telehealth's existing protocols related to various sexual and reproductive health and rights topics and developed new protocols on family life education related topics. Furthermore, Aahung supported Telehealth in developing SMS on family life education for mass dissemination within the target communities.

During January and February, 2015, two training sessions were conducted for 28 Aman Telehealth call agents and operational team members on key concepts related to sexual and reproductive health and rights, and family life education.

Capacity building training sessions conducted on family life education with government secondary school teachers

In May 2015, Aahung conducted two training sessions with 39 teachers from 15 government secondary schools to increase participants' knowledge on family life education, including clarifying myths and misconceptions associated with puberty, gender discrimination and their effects. The training also aimed to increase participants' comfort in communicating with adolescents on family life education and related issues. The trainers made use of case studies, conducted debates, group work and audio visual aids to ensure that participants were fully engaged and motivated. Quantitative results from the pre- and post-test have shown that there was 75 per cent increase in knowledge related to pubertal processes, such as menstruation and nocturnal emissions, as well as personal hygiene. Participants were also a lot more aware of legislation around early marriage in Sindh, and gained additional knowledge related to marriage certificates or 'nikkahnamas'.



The last two days of the training focused on conducting mock implementation sessions of the family life education modules in order to provide confidence in conducting these same sessions in classrooms. An open feedback mechanism fostered an open environment of learning and sharing. At the end of the training, teachers were informed to implement modules with students once schools reopened in the first half of Year III.

Conducting parent sensitization sessions through schools and alternate learning institutes

In Year II, Aahung conducted parent sensitization sessions in all schools and learning institutes that were mapped. These sessions introduced parents to family life education, and gained their confidence and permission to run family life education in schools. Five parent sensitization sessions were held in Year II against the planned target of 40 sessions, as the management of all the schools and learning institutes requested that parent sensitization sessions take place only after the teachers had been trained. This was done to ensure that teachers were clear on topics and could provide support to Aahung in mobilizing parents and responding to their queries and concern.

Training healthcare providers

Aahung trainers are in the process of developing modules and training tools to enhance the capacity of doctors and local healthcare providers on adolescent sexual and reproductive health and the provision of youth-friendly services. These training sessions will commence in Year III.



Mass Communication

Development and airing of docudrama on family life education

The first of three short docudramas was developed in Year II of the program. Majority of case studies were on issues of early marriage, a topic with which community members were relatively comfortable and open for discussion, and was taken as the theme for the first docudrama. The docudrama is in the process of being filmed and will be aired on local cable channels in the project sites in the first half of Year III.

Monitoring and Evaluation

Finalization of family life education Indicators

Indicators were reviewed at the Steering Committee meeting held in February 2015. Aahung incorporated revisions and the indicators were finalized in March 2015.

Development of MIS system and tools

Once the indicators and project activities were finalized, Aahung developed a comprehensive MIS system to track all the related activities and interventions. Multiple tools were developed to track the qualitative and quantitative progress to monitor the quality interventions. After the finalization of MIS and related tools, these were shared with the Program Management Unit, and Aahung's internal M&E department conducted a comprehensive training.

Impact evaluation research study

Other than process monitoring, Aahung had planned for conducting extensive baseline evaluations with teachers and students from a sample number of schools from 30 partnerships that were formalized with public and private secondary schools. The tool development for the baseline evaluation was initiated at the end of Year II, and Aahung is in the process of designing effective evaluation tools that will be used for the baseline evaluation.

Telehealth helpline service

During Year I, groundwork was carried out for making Telehealth helpline service operational with a backed up 24/7 call center. In order to systematically implement the service:

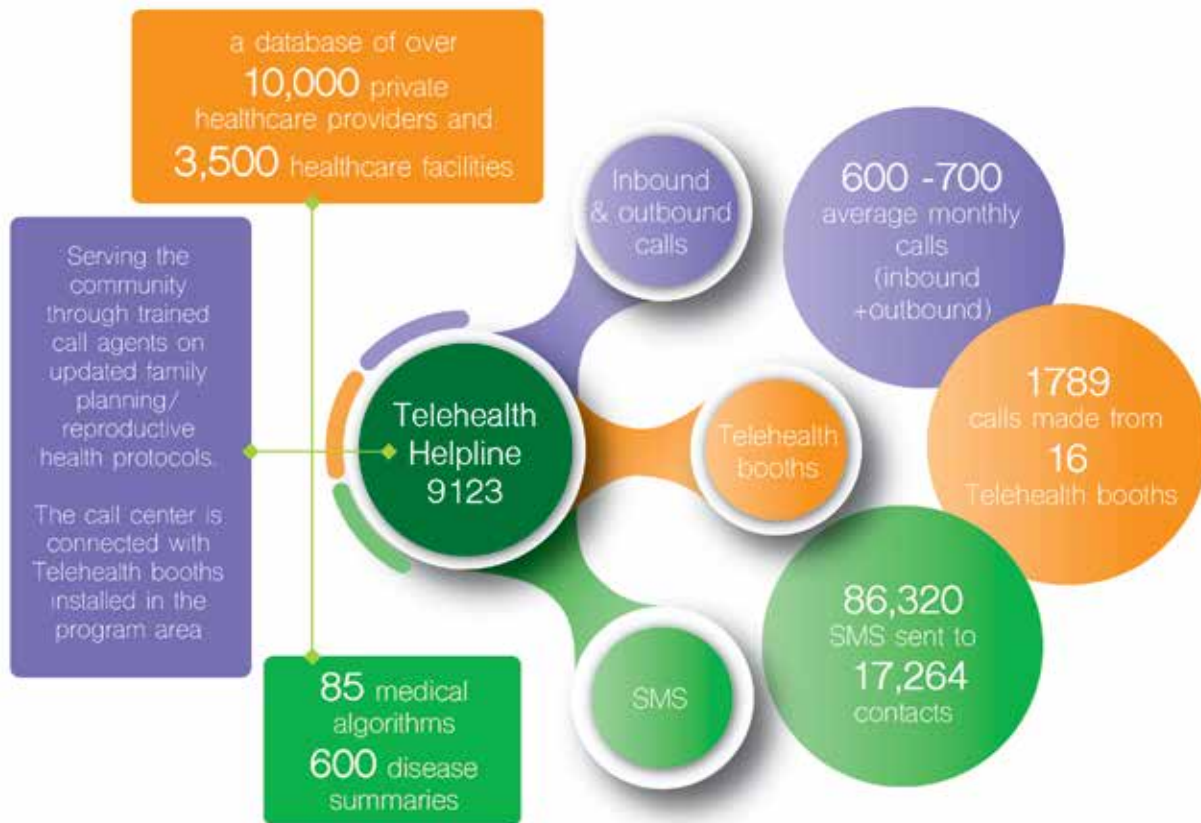
- Call center agents were trained on family planning and reproductive health and related protocols were updated and developed. Moreover, train the trainer sessions were conducted.
- A helpline number was established.
- Information, education and communication materials were prepared; training of trainers on Telehealth service was also conducted.
- Awareness campaigns to project the benefits of using the helpline were held.

Aman Telehealth provided lead in setting up the service and initiated the process of updating the existing family planning and reproductive health protocols for call agents with technical inputs from Jhpiego and National Committee for Maternal and Neonatal Health, a technical arm of the Ministry of Health, Government of Pakistan.

The service was launched on February 2014. Also known as '9123 helpline' to create recall for the number to dial, the service was integrated with the five existing telecom service providers in the country who agreed to charge subsidized rate of 0.5 cent per minute on all inbound calls, making the service commonly accessible and user-friendly. To spread the word about the helpline, educational material was developed and widely disseminated. Moreover, it trained 25 community health supervisors on how to introduce the helpline to communities during household and, male and female group counseling sessions. The trainers were also trained on the importance of getting consent from females to receive calls, and how to seek advice on their family planning and reproductive health and other health-related issues. The helpline and its benefits were introduced at two Community Advisory Committee meetings organized by Aman Community Health Programs.



Telehealth booths installed in different towns

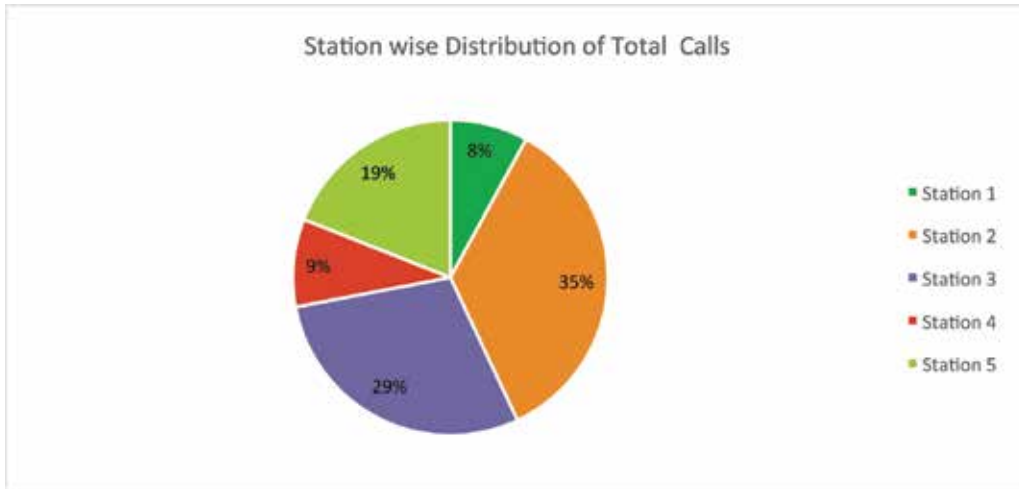


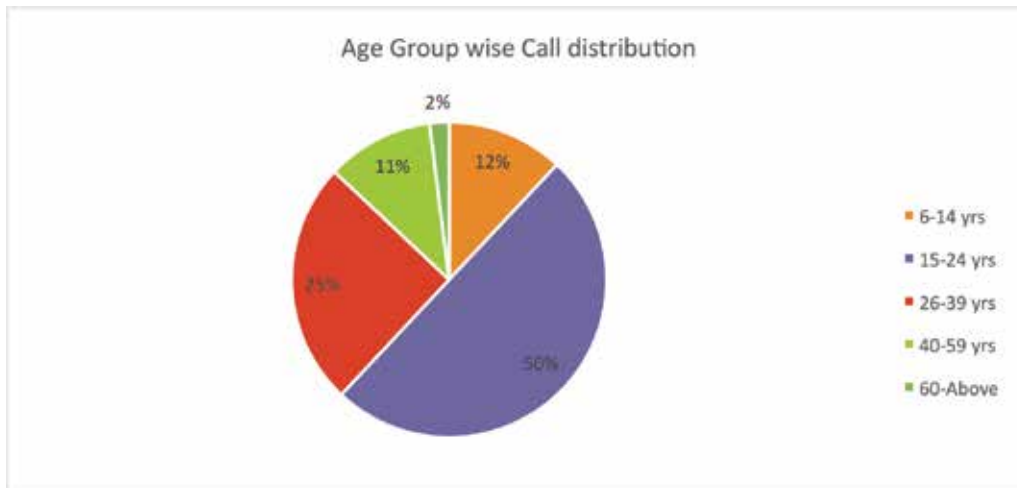
During Year II, Aman Telehealth conducted the first training in collaboration with Jhpiego and Aahung on family planning/reproductive health and family life education for call agents, key management staff, and the monitoring team of Aman Urban Health Institute. The training focused on family planning and reproductive health issues particularly with reference to abortion and post-abortion care, the importance of family life education, adolescents' psychological and physical development, pregnancy and maternal health, and interpersonal communication skills.

Telehealth phone booths were installed in Year II as part of the strategy to expand the coverage of the helpline service and encourage its use. The site selection criteria for the booths was developed by Aman Telehealth and took into account concerns for accessibility and confidentiality, safety and security of device, availability of electricity and mobile signals, and commitment from stakeholders. In the first phase, 16 Telehealth booths were installed by June 2016.

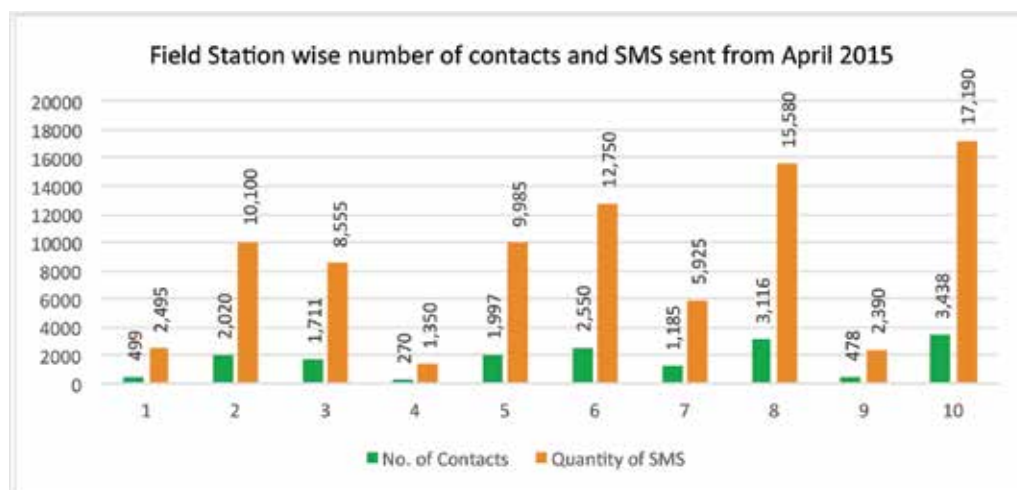
The service began receiving inbound calls from January 2015, as community health workers spread the word during their visits and interactions with community members. As a standard operating procedure, the call agents register clients upon receiving their inbound calls by noting their basic information and allocating a unique ID number to them. Upon receiving consent of the clients during their interaction with community health workers or call agents, follow-up/outbound calls are made, and health-related SMS are sent on the mobile numbers of clients.

Month-wise outbound and inbound call details





SMS dissemination was initiated from April 2015 on fortnightly basis. SMS were sent to 17,264 phone numbers collected from community health workers.



For quality assurance purpose, Aman Telehealth developed a quality tool to evaluate call agents' knowledge, attitude and practices about family planning counseling and best choices of contraceptive methods. The key quality indicators are customer satisfaction and compliance with protocol. To maintain the compliance of family planning and reproductive health related protocols, Aman Telehealth regularly conducted assessment tests on quarterly basis for understanding gaps in knowledge, attitude and practice of call agents, and plan refresher training sessions accordingly.

Improving access & quality of family planning services at public health facilities

Jhpiego played a lead role in improving access to family planning services (by method) at public health facilities, and for the improvement of quality of services for communities in the program's coverage areas. A strategy was developed to synergize and coordinate mechanisms with health facilities operating under different tiers of local government, and build their along with the program staff. Teams were hired and conducted in-house training on Clinical Training Skills and comprehensive family planning package and standard-based management and recognition. It was also considered essential to focus on manual vacuum aspiration training, medical management of incomplete abortion, follow-up mechanism of clients and partnership with the implementing associates.

As a number of health facilities exist under the administration of Karachi Metropolitan Corporation, Sindh Employees' Social Security Institution, and Department of Health within the program area, an additional mapping exercise of all public health facilities in the project area was carried out. GIS coordinates were noted for 42 Family Welfare Centers, and facility assessments were performed. The District Population Welfare Officer (East) from Population Welfare Department was assigned to facilitate the mapping and selection of Family Welfare Centers, Mobile Surgical Units and Reproductive Health Services Centers in the catchment areas. This led to the mapping for 42 of such facilities, where 35 Family Welfare Centers, 3 Mobile Surgical Units, and 2 Reproductive Health Services Centers for project intervention were selected. Facilities were also mapped with Karachi Metropolitan Corporation, Sindh Employees Social Security Institution and other health departments. Of the 40 maternity homes in the area, 14 have been identified so far.

Separate memorandums of understanding for each department of health were planned in view of their independent administrative and governance systems. Jhpiego and Jinnah Sindh Medical University signed an agreement to develop academic program focusing on family planning and post-partum family planning. Moreover, an understanding was reached between the two parties regarding Sindh Government Hospitals at Korangi and Saudabad to serve as clinical training sites. Jinnah Sindh Medical University developed



Location of affiliated public health facilities

Population Welfare Department offers community-based services through its Family Welfare Centers (FWC), one for a population of 20,000. The Centers provide FP counseling and services, excluding tubal ligation and vasectomy, by a mid-level provider known as the Family Welfare Worker (FWW). These centers are located in rented buildings. Over the years FWCs have not been able to serve the community at large. This is true even in Sukh project area, where our baseline results show that out of 57 per cent of the current FP users are receiving services from public sector facilities, only four per cent are getting it from FWC (currently an average of only two to three IUCD clients are entertained in a month at FWC). One major barrier to this poor performance is the stigma of these facilities being exclusively for FP and being within the community women in the catchment area do not want to be seen going to such a center as they fear that the community would think that they were using some type of FP method.

master trainers from within their staff, and improved the technical and family planning skills of the healthcare providers working at these hospitals. Jhpiego also developed understanding with Karachi Metropolitan Corporation and Sindh Employees Social Security Institution in order to access to their health facilities.

Program Management Unit signed an MoU with Population Welfare Department to develop Family Welfare Centers, and to improve the quality of their services and build their image within communities. Jhpiego organized weekly Family Health Days at these centers. Community mobilizers, community health workers and lady health workers gave counseling to women on family planning and encouraged them to go to the centers on Family Health Days, giving them a referral slip for the same. Pregnant women were also provided antenatal care and counseling on post-partum family planning.

The number of clinical trainers and counselors was increased after learning of acute shortages of technical staff at intervention sites to implement the standard family planning service protocols, systemize record keeping, and to set a trend of counseling and on-the-job training. Counseling was considered a critical and essential element in the high uptake of family planning services.

Capacity development of implementing partners was carried out on family planning, including post-partum family planning, post-abortion care and post abortion family planning. Significantly, two training workshops were held on Value Clarification and Attitude Transformation for nominated team members from Aga Khan University, Aahung, Aman Telehealth, Aman Community Health Program and Program Management Unit. The first was held on March 31, 2015 with 14 participants, and the second on June 1, 2015 with 17 participants. A workshop on infection prevention was also conducted for 10 support staff.

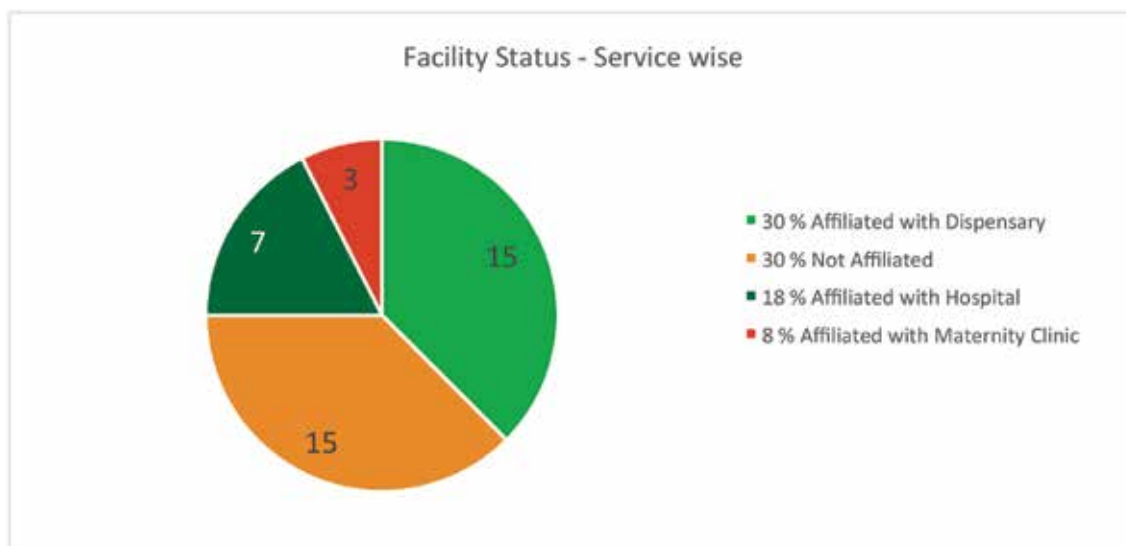
To ensure the effectiveness of Telehealth service, Jhpiego reviewed the existing training curriculum related to job aids and counseling for operators and incorporated content on family planning, post partum family planning, post abortion care and post abortion family planning. Algorithms for Telehealth service and training curriculum were field-tested, followed by training of 30 Telehealth operators. Training sessions were held with 10 participants from February 2 - 4, 2015, and with 20 participants on February 17-20, 2015. To meet initial referral needs, two crash training courses for 33 healthcare

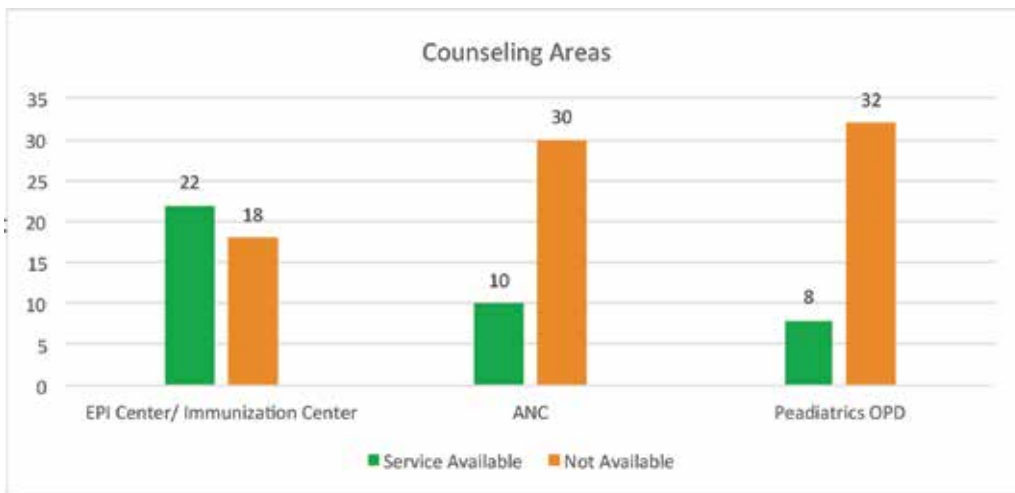
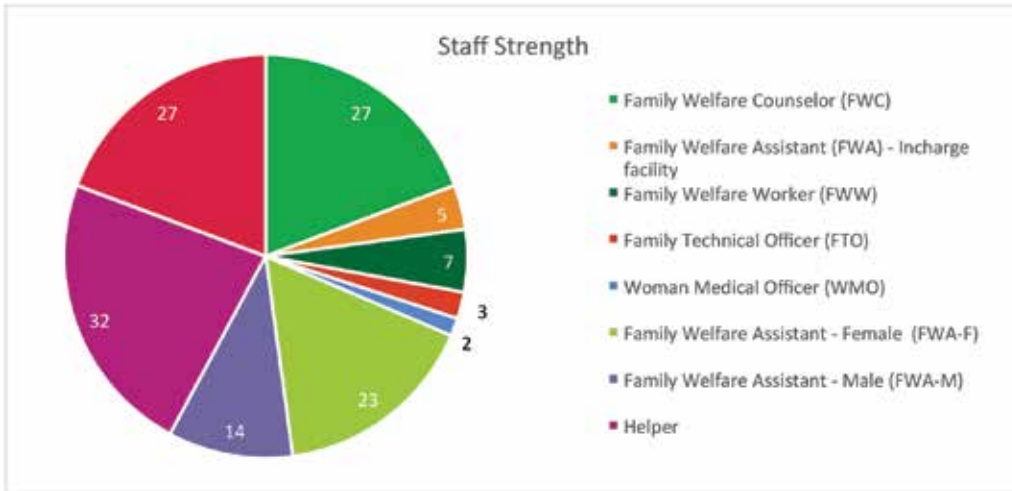
providers from Population Welfare Department were conducted at its Regional Training Institute on family planning counseling and interval intrauterine contraceptive devices. Master trainers from Population Welfare Department facilitated these training sessions.

As part of the intervention, the capacity of 2 clinical training sites and the Regional Training Institute at Clifton were strengthened. The selected clinical training sites were Sindh Government Hospitals (Korangi, Saudabad) and JPMC (Jamshed Town). A Skill Lab was developed and Jhpiego provided Zoe Simulators, implant, intrauterine contraceptive devices, post partum intrauterine contraceptive devices, and manual vacuum aspiration kits. They also provided items for demonstration of infection prevention procedures, job aids, posters and other communication materials. A similar skill lab was developed at the Regional Training Institute for demonstration and practice of trained staff with the support of Population Welfare Department, Government of Sindh.

The information material developed for the program were adapted from Jhpiego Punjab's post partum family planning project. Posters, job aids and other materials were reviewed and modified according to the target audience. Printing of these materials is in process and will be disseminated in Year III.

Baseline assessment of clinical site was conducted for 40 family welfare centers and aimed at identifying prevailing gaps. Thereafter, an action plan was developed to address them. Site strengthening and up gradation of 40 Population Welfare Department facilities was initiated. An MIS application was developed and data collection of geographical coordinates was initiated with the help of M&E department.

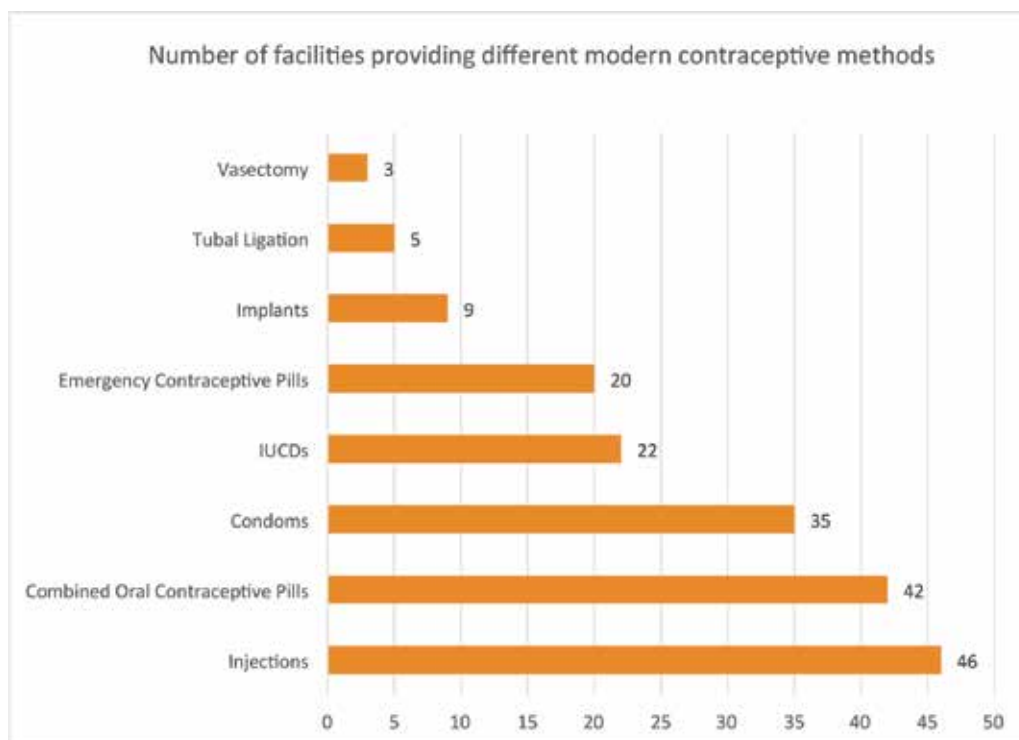




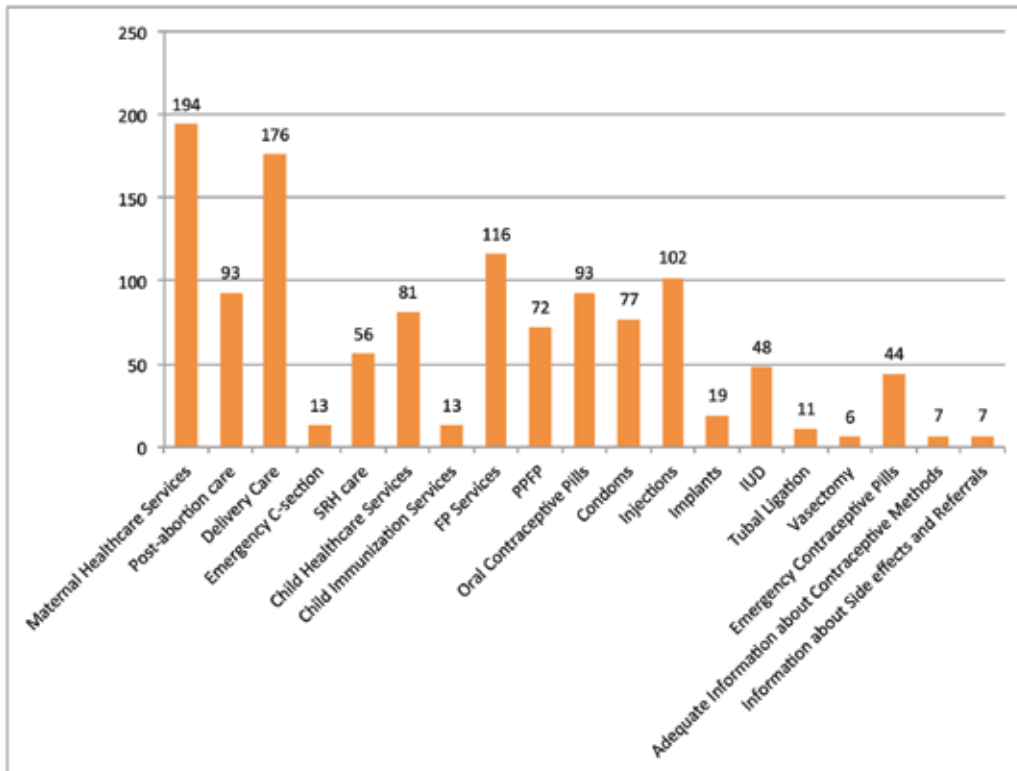
Improving access & quality of family planning services at private health facilities

The program area was mapped for all private facilities related to maternal and child health, pharmacies and educational institutions, and general infrastructure from October–November 2014. A total of 2,503 facilities and institutions were mapped, of these 40% were health or health-related facilities with 34% being general clinics, 28% medical stores and 21% maternity centers. The mapping helped identify that:

- General clinics and medical stores are the major types of health facilities available in these areas.
- More than half of delivery/maternity care providers are unskilled traditional birth attendants.
- Considerable number of informal birthing places, such as maternity centers are headed by lady health visitors and midwives.
- General hospitals, maternity centers, clinics and pharmacies are providing family planning counseling and services.
- Family planning centers with good quality counseling and full extent of family planning services are scarce.



FP/RH services provided at private sector health facilities



To ensure universal coverage, a strategy was developed to engage private sector clinics and nursing homes. In this connection, DKT provided safe and affordable options for family planning through social marketing and ran its family planning program titled 'Dhanak'. Soon after joining as an implementing partner in May 2015, DKT revisited the strategy, and planned to franchise its services to private sector clinics, introducing six family planning/reproductive health products from September 2015 onwards. These franchise packages include refurbishment and standardization of facilities with basic toolkits, equipment and one-time supply of commodities over the program life.

With an objective to reach out to approximately 0.8 million people, ages 18–40, with reproductive health information through mass media advertising in the program catchment area, DKT:

- trained 80 service providers and their support staff on maternal, newborn and child health, family planning, post partum family planning and post abortion care.
- conducted 960 education sessions about modern contraceptive methods.
- covered 1,500 outlets in the area with family planning products.

Training in Quality Monitoring Tool were given to four Quality Supervisors, four Area Sales Managers and two Regional Managers, with capacity building in PPIUD counseling and insertion skills conducted by Jhpiego. DKT worked with community health workers and lady health workers to increase the client flow to Dhanak Centers.

MONITORING AND EVALUATION

As the measurement partner, Aga Khan University is responsible for providing external and independent measurement of program impact through sample quantitative and qualitative methods within the 1 million population of the program catchment area. Data collection was planned at three different stages of the project by AKU, i.e., before the initiation of the project (baseline); at the midpoint of the project (midline); and at the conclusion of the project (endline).

At baseline measurement, data was collected through focus group discussions, household surveys, in-depth interviews of key informants, elicitation interviews of target population and mapping of facilities and institutions in the catchment areas of the program. At midline and endline, the same data collection will be repeated to evaluate and assess progress and performance of the program to assess the achievement of its final goal of increasing contraceptive prevalence rate at 15% and increase in use of modern methods of contraception. The program's impact will be measured as per the objectives and goals outlined and agreed upon in the program's framework. For this purpose, key performance indicators were prepared according to the activities of implementing partners within the program's framework. An additional responsibility for the measurement partner is to help Program Management Unit through performance management.

During the period from May to August 2014, the following activities were completed:

Development of key performance indicators for each implementing partner

Key performance indicators emerging from the activities of each implementing partner, and as per the objectives and program goals were outlined and agreed upon in the program's framework. Implementing partner indicator was accomplished through a development of framework which describes process indicators for them. The process was completed in May 2014.

Development of mapping tool

A mapping tool for private sector was developed, which is a semi-structured questionnaire to assess various factors of private health facilities identified during mapping exercise of the catchment area.

Mapping of the site

All private facilities providing maternal and child health services, pharmacies, educational institutions and general infrastructure within the program area's population were mapped. Once the private health centers were identified, administrator, managers and any concerned authority of the facility were approached to help complete a quick checklist on the address, approximate number of clients attending these clinics per month, type of family planning methods usually being provided, maternal child health centers providing post partum family planning and post abortion care services, as well as pharmacies



providing family planning methods.

Focus group discussions

These were carried out during the reporting period to inform the baseline and were held with different groups of people from program catchment area:

- (i) married men/women of reproductive age on family planning
- (ii) male/female youth (12–18 years), and
- (iii) parents of youth on family life education and Telehealth.

Review of MIS and reporting tools

Review of MIS and reporting tools of all the implementing partners and Program Management Unit was initiated. A program for online and/or manual data entry system was brainstormed between Aga Khan University and Program Management Unit. Aga Khan University also contributed in numerous meetings with donors, Program Management Unit and implementing partners since joining the program. These meetings were held primarily to develop technical proposals, identify and prioritize indicators, brainstorm implementation strategies, and finalize SOPs, amongst other activities.

Impact Evaluation: Sukh Baseline Survey

The baseline household survey was conducted and qualitative assessment made at 10 Sukh field stations, located in the four towns of Karachi, i.e., Korangi, Landhi, Bin Qasim and Malir. Overall, the baseline data collection had two main goals:

1. Establish a baseline for the evaluation of the impact of the Sukh Initiative strategies for midline and endline assessments.

2. Provide benchmarks for target setting, decision making and course correction against which progress can be measured and success assessed.

The survey was carried out from November 21, 2014 to January 2, 2015, which included focus group discussions and interviews of key informants. The following activities highlight the process adopted for these surveys:

Baseline data collection tools

Various data collection tools were prepared for the baseline assessment. All data collection tools were shared with the Program Management Unit, implementing partners and donors for their feedback.

Field preparation

Formal activities for field preparation were initiated by Aman Community Health Program as early as June 2014. This was a multi-tier activity in which basic assessment of the field site population was made. It entailed:

- Collecting maps of the field sites.
- Developing a Field Observation Tool based on participatory rapid appraisal approach.
- Pretesting data collection tools.
- Staff hiring and training for data collection.
- Carrying out mock interviews during training and formulation of teams.

For the quantitative survey, 52 female interviewers were hired and trained, while for qualitative component, a team of four field staff was hired and trained in October 2014. Training focused on sampling techniques in detail. The mapping team was trained through a formal three-day knowledge and skilled-based training for taking Geographical Information System coordinates.

Data collection

Focus group discussions

Pre-testing of guidelines for this activity was undertaken in August 2014, which helped modify and finalize guidelines prior to final data collection. Sixty activities were conducted at the community level with married women of reproductive age, married men, girls and boys of 16–18 years and parents of youth. These were conducted using a guideline. One focus group discussion of each of the target groups was conducted at each of the 10 stations. In each of these, 8 to 10 individuals participated. Transcriptions were done simultaneously.

Key informant interviews

Seventeen interviews were conducted with stakeholders at both the program and community levels. The key informants included Town Technical Officers of the Departments of Health and Population Welfare, administrator and healthcare providers of the most frequently utilized hospital/ facility, head of the local NGOs, pharmacist, religious leader and Imam of Mosque.

Household survey of married women of reproductive age

For household survey, people in the age brackets of 15–49 years, who either were residing in the intervention sites for the last six months or those who recently moved in and showed intentions to stay there for at least one year, were the respondents. It covered details on demographics, their household possessions, information of individual woman on background characteristics, basic knowledge and understanding of family planning and family life education. Specific questions regarding Telehealth, post abortion care and healthy time and spacing of pregnancy were added to the adapted questionnaire.

A two-staged cluster sampling was adapted. Initially random clusters were selected using block randomization technique from each field station. The first household was selected randomly using pen technique. However, subsequent houses were selected using fifth number through systematic sampling technique, till the achievement of required sample size from that cluster. The total number of random clusters for each town was selected proportionate to their population size. Teams were provided with list of randomly selected clusters from each area by Aman Community Health Program. A total of 5,340 married women of reproductive age from ages 15–49 were interviewed.

Data handling

The sequence of activities in data entry was as follows:

- Data mapping
- Data entering
- Editing of quantitative and qualitative data

The entire process of data management including data entry was carried out by Data Management System, using Epi Data. Consistency checks were run to identify any problems. Discrepancies identified were then reconciled through recourse to the original questionnaires prior to data analysis.

Data Analysis and Report writing

Data from mapping and quantitative household survey was analyzed and the final draft of quantitative survey was completed in April 2015, while the report of qualitative survey was finalized by June 2015.

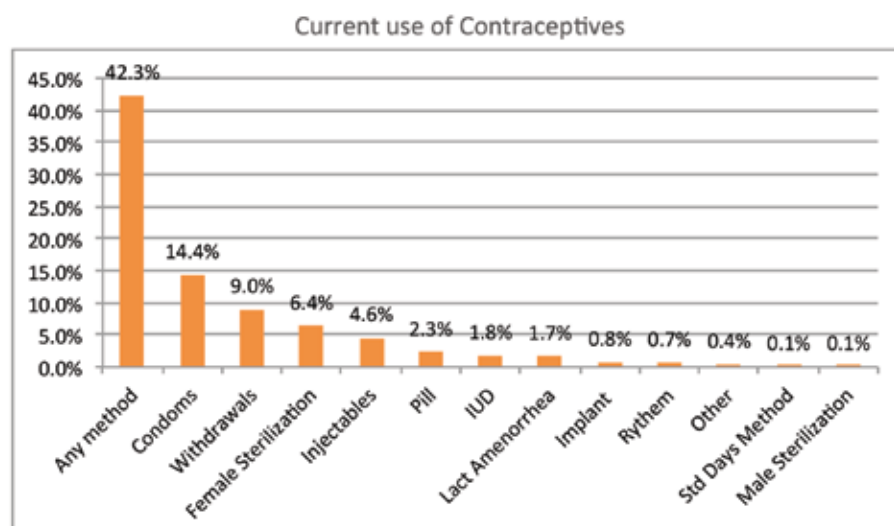
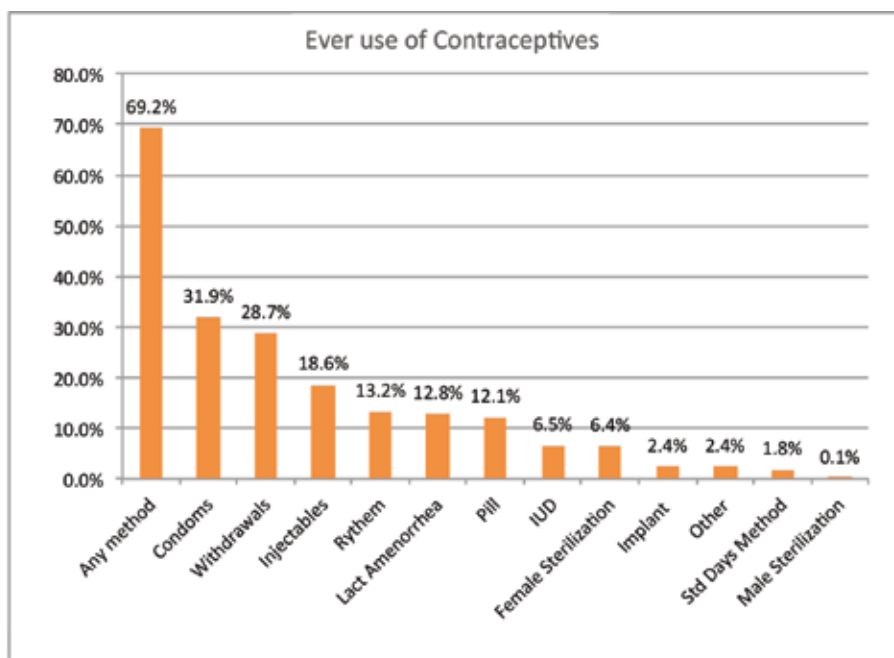
Monitoring of the data collection

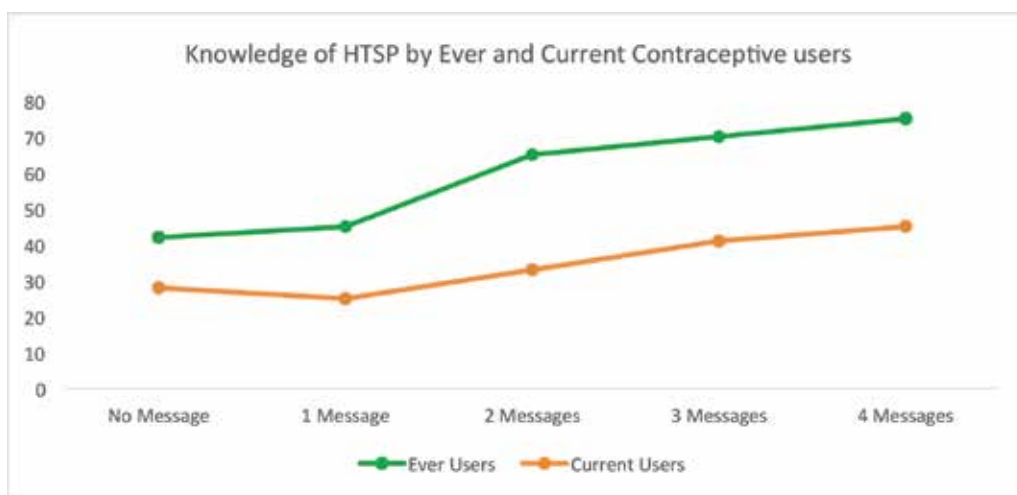
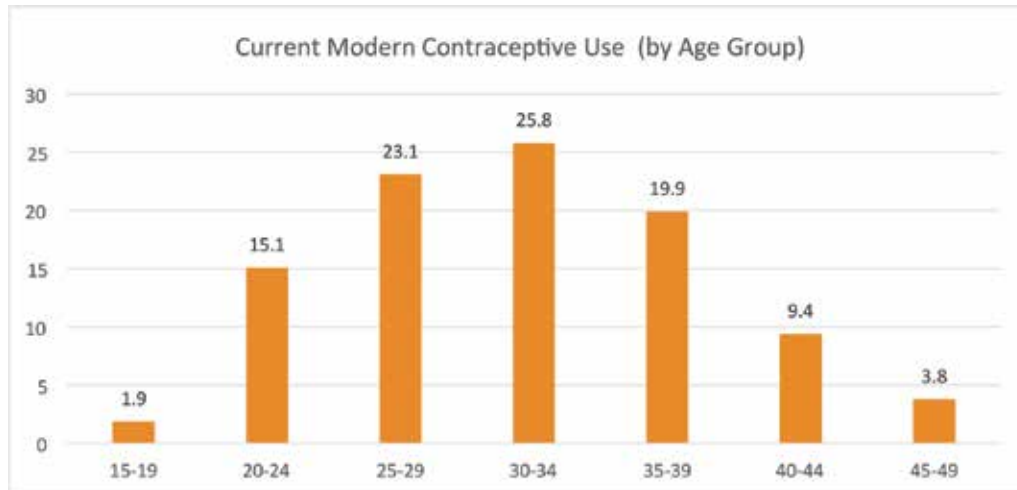
Monitoring was done on stringent basis, both in the field and on a daily basis by supervisors at the field site to identify incomplete/missing information, and subsequently at the department data editors comprehensively reviewed the questionnaires for completeness, and corrected coding, and other areas. Any errors identified in the edited data forms were then reviewed and corrected. Additionally, a two-person team designated and trained for this purpose on regular basis did spot checking of the mapping team, visited landmarks for accurate markings, observed interviews of married women of reproductive age at each station, re-interviewed a few randomly selected forms at each station, spot checked data quality, and also observed activities of field supervisors.

Key findings

Quantitative survey

- The median age of the women interviewed was 30 years (IQR 25–35 year). Majority of the women (67.4%) were in the age group of 20–34 years. About 64% had formal education whereas 36% had never attended a school. Among those who had formal education, 22% acquired primary education, 15% attended middle school, and more than a quarter of respondents (27.5%) received secondary or higher education.
- Approximately 4% of married women of reproductive age in the sample were in the age group of 15–19 years. Of these, 20% were pregnant at the time of interview, and 53.3% had already given birth.





- Wealth quintiles for Sukh Initiative's population indicate that 37.9% of population was poor, out of which 20.1% were the poorest. In addition, 42% were in the lowest quintiles of wealth (poorest: 25.6%; and poor: 16.3%).
- Respondents in the age group of 25–29 years (36.6%) had at least two living children. They belonged to Urdu (35.2%), Sindhi (19.0%), and Bengali (7.0%) speaking segments of population.
- Six out of every ten women had four or more antenatal visits during their last pregnancy, while rest of them either had less than the optimal number of visits or no visits at all (5.4%). About 33% of women could name the facility from where they sought antenatal care. Of these, 68% and 25.5% utilized services from private and public sector facilities, respectively.
- The ever and current use of contraceptive methods was linearly associated with the number of messages known to women. Among women with no knowledge or with knowledge of any one of the messages related to healthy time and spacing of

pregnancy, the use of contraceptives was more or less same; however, the ever and current use of contraceptive methods increased linearly with knowledge of two or more messages. Most commonly known messages were related to age at marriage and having a gap of 24 months after a live birth before planning next conception.

- Ninety seven (97) per cent of women were aware of any modern method of contraception. Sixty nine (69) per cent women reported ever using any contraceptive method with 59 per cent ever using a modern method of contraception. Approximately 42 per cent and 32 per cent women were current users of any method and any modern method of contraception, respectively.
- Among current users, women with one to two children were mostly using condoms (60%), injectable (14%), pill (6.5%) and IUD (5.0%). By third child, the preference for method reduced for condom (49%), remained nearly the same for injectable (14.9%), but increased for female sterilization (14.9%). No significant change was observed for use of pill (6.3%) and IUD (6.9%). After third child, the preference for female sterilization more than doubled (34.4%), condom use further reduced (36.4%), injectable and pill use remained almost the same at 15.1% and 8.5%, respectively.
- Approximately 57% of women were not using any method of contraception at the time of interview. These women were mostly uneducated or had primary level of education, with low parity of one to two children. Nearly 31% of responses to non-use were related to health reasons, i.e., ongoing breastfeeding (10.4%), desire for more children (14.4%), or being pregnant (5.9%). Approximately 6% of women expressed opposition to contraceptive use; these included, opposition by husband (4.2%), self-opposition (1.8%) and opposition by others (0.2%). Nearly, 7% of women expressed health related concerns. Approximately, 22% of responses were related to women's beliefs, attitudes towards contraceptive use, and sexual practices. Of these, most commonly mentioned reasons were infrequent sex (8.0%), natural spacing (5.1%), and lack of need for family planning (4.0%).
- The highest use of modern contraceptive method was observed in Urdu speaking (36.7%) women and lowest observed in Balochi (5.1%) and Hindko (6.8%) speaking women. Punjabi, Sindhi and Pushto speaking women had more or less same per cent of use, i.e., 15.5%, 11.1%, and 11.9%, respectively.
- Approximately 46% of all women who started family planning but discontinued later were in the age group of 20–29 years.
- Only 21% of current users were informed about the side effects of the method and 19% were asked to contact a person in case of a side effect. Fourteen (14) per cent of current users mentioned experiencing a side effect. Most common side effects were headache (19.8%), excessive bleeding (18.6%), irregular menses or no menses (17.6%), and nausea and dizziness (9.7%).

Qualitative survey

Focus group discussion participants and key informants unanimously informed that universal awareness about the family planning program exists but this adequate knowledge of family planning methods is not translated into practice.

“We have to treat women with respect and have to take care of their needs: If they are healthy , we all are healthy”.

Abdul Ghafoor, Community Representative and CAC member.

- Men in nearly all focus groups, healthcare administrators and community leaders mentioned that the main focus of family planning programs is on women, and therefore, men are less informed. Women on the other hand, explained this as men's disinterest in family planning.
- The majority of men and key informants expressed that most of the family planning centers are providing services for women only, and there is need to involve men in family planning programs. Healthcare providers also informed that comprehensive family planning, post partum family planning, post abortion care and post abortion family planning services are not actively offered to men and women of these areas.
- Facilitative factors for family planning, as seen by several women were: females being educated; support from married woman's mother; and changing social values.
- Youth can only make decisions about education, employment or minor day-to-day issues, but all major decisions especially those related to marriage are taken by their parents.

Dissemination of Baseline findings

Two seminars were held in June 2015 to disseminate the baseline findings at community and stakeholder levels and to mark the close of the Year II.

Dissemination seminar for community

This seminar was organized on June 10, 2015, in Korangi town, Karachi, and had participation of more than 400 members of Sukh community, officials of the Population Welfare and Health Departments, as well as representatives of implementing partners.

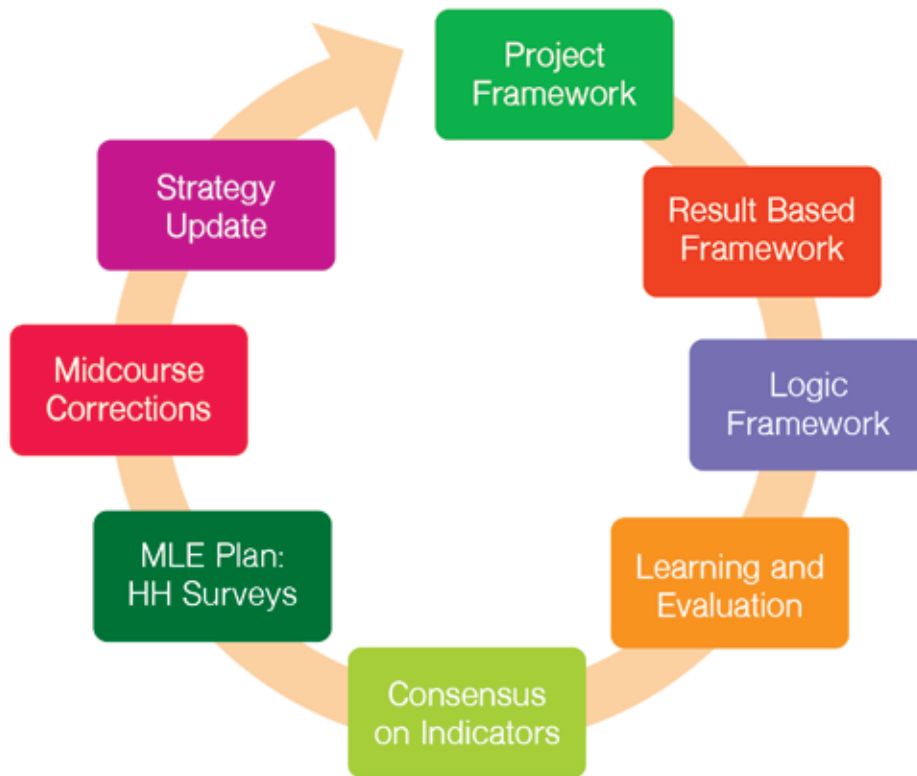
Dissemination seminar for stakeholders

The event was organized on June 16, 2015. It had participation of stakeholders, government and political representatives, development sector partners and civil society representatives. The seminar had three panel discussion sessions; one with implementing partners, second with renowned professionals in family planning/reproductive health, and the third was with government representatives.

Result-based framework and key performance indicators

In order to have effective program monitoring and process evaluation, result based framework for the program was developed and shared with the Steering Committee at its meeting held in Dubai, UAE, on February 22-23, 2015. Key Performance Indicators were developed in accordance with the program's framework keeping in view the activities of

Program monitoring and process evaluation



each implementing partner.

MIS and Reporting Tools

A technical advisor, Ms. Samia Amin from Mathematica, visited the program in October 2014, to review and streamline the program monitoring and evaluation process built on key performance indicators, which are based on the objectives and goals of the program and multiple activities of implementing partners. This also helped create learning questions for each implementing partner. As a follow-up Aga Khan University had meetings with all implementing partners to discuss and plan evaluation and monitoring through spot checks and mid-line evaluation for process and progress according to laid down indicators. This was done based on the result based framework to prepare a final synchronized MIS for all implementing partners' data. The monitoring visits will be initiated by mid-August 2015 in all the field stations of the program, and the field plans will be shared accordingly. Program Management Unit along with Aga Khan University brainstormed a program for online and/or manual data entry system, however it has yet to be finalized.

MIS Portal

The Monitoring & Evaluation plan included the development of an integrated IT solution which provides an android/mobile application to capture the data in the field, through mobile devices (android tablet). The system will also assist in scheduling visits and community follow-ups with real time GIS tracking of field workers. Additionally, it includes a web interface that displays the information for management reporting with the functionality of a planning tool for partners to integrate their activities. The mobile application will work as a client tracking tool for the community health workers, whereas

COMMUNICATION AND ADVOCACY

Government involvement and patronage of the project is vital for the sustainability of the program interventions in the long-run. The program at its initial stages developed partnerships with different government departments through the following initiatives:

Engagement with government departments

Letter of Collaboration with Lady Health Workers Program and Aman Healthcare Services

The Program Management Unit signed a letter of collaboration with National Program for Family Planning and Primary Healthcare, Sindh, in June 2015. The agreement aims to include 250 lady health workers in the program intervention areas and improving counseling skills and referrals by them for family planning / reproductive health services. Program Management Unit will train master trainers on a revised curriculum. Later, these master trainers will roll-down training for lady health workers in their respective healthcare facilities. Program Management Unit will also train lady health supervisors on supportive supervision. The trained lady health workers will conduct support group meetings.

MoU with Population Welfare Department and Department of Education

The MoU with Population Welfare Department signed on April 24, 2015 and is effective till August 31, 2018. The purpose of this agreement is to increase clientele for Population Welfare Department services centers by complimenting services from Aman Community Health Services, Jhpiego and other implementing partners. This will include referrals from the community to their facilities. The MoU will allow the program to select 80 facilities. This collaboration will also include: facility need assessment, facility upgrade/standardization, capacity building of Population Welfare Department healthcare providers (training, IEC material and quality assurance), as well as scaling up of MIS system developed by Jhpiego for the project level facilities and later for the Population Welfare Department facilities.

The MoU with Department of education was signed on February 16, 2015 with the objective to develop a broad consensus and ownership of the program interventions and formation of project Steering Committee (Youth) in Karachi. In this connection, the Department of Education, Program Management Unit and Aahung will collaborate for reviewing family life education curriculum, mapping of education institutes, capacity building and conducting parent sensitization session, and coordination and monitoring.

Meetings with Health and Population Welfare Departments

Sukh Initiative became a member of the Provincial Technical Committee as a result of the meetings with the high officials of Department of Health and Population Welfare Department. Director General Health and Secretary Population Welfare Department made available all resources within Population Welfare Department for the program. The

Involving Government from Inception to Implementation

Focusing on partnership with the government enhances political will and leads to greater and sustainable impact. “We own this project, it is for the benefits of our people and we will work with Sukh to learn from it, of what can be adapted by the Government”, remarked Mr. Iqbal Hussain Durrani, Secretary Health at the end of an exclusive meeting held in March 2014 at Karachi. The meeting was jointly chaired by Mr. Iqbal Hussain Durrani, Secretary Health, and Mr. Muhammad Saleem Raza, Secretary Population Welfare Department, Government of Sindh, and was participated by representatives from the three Foundations, PMU and AHCS. With this reassurance, the PMU started to work with ExpandNet to develop a sustainability model for Sukh, and identified four intervention areas for scaling-up. These areas are: (i) Including Lady Health Workers (LHWs), community-based mobilizers from the health department, covering 1,000 population in FP demand generation activities; (ii) Establishing FP/ RH clinical training sites within health department facilities; (iii) improving quality of services at Family Welfare Centers (FWCs), community-based FP/ RH service centers of Population Welfare Department; and iv) including Family Life Education (FLE) curriculum in Board of Curriculum, Sindh. Departments of Health, Population Welfare and Education were engaged through series of individual meetings, to discuss project strategies. The foundations were flexible to accommodate the suggestions from the departments and to revisit strategies for scalable best practices. With this, the PMU was able to achieve an understanding from the Health department to allow Sukh to develop three facilities as training sites, and 250 LHWs to be part of the mobilization team. Both health and population departments endorsed the curriculum developed by Sukh for community mobilization. Moreover, Population Welfare department agreed in principal for Sukh to improve clinical competencies at 40 FWCs by training the staff at these facilities and also provide supportive supervision with a joint supervisory team. Sukh is now a member of existing Provincial and District Technical Committees, working under the Population Welfare Department with participation of Health Department. These committees review monthly and quarterly progress of project activities. Education Department has permitted Sukh to conduct FLE training at public schools in project area. Sindh Curriculum Board has formed a joint task force to review FLE for institutionalization. As next step for the PMU is to formalize these commitments through a memorandum of understanding, signed with these departments. The support from government departments exceeded expectations.

program has attended three meetings in Year II of its implementation, highlighting its progress and seeking support, which was readily been extended.

Meeting of Technical Advisory Group

This serves as a coordination mechanism and provides technical advice, recommendations and support to Sukh Initiative for attainment of program goals. This committee consists of an august group of experts that foster coordination and synergy between the program and the government departments in Sindh. Technical Advisory Group is well-represented by senior management from the three foundations, implementing partners, members of provincial assembly, Government Departments (Health, Population Welfare, and Education and Youth Affairs). It also includes members from private sector such as Pakistan Nursing Council, USAID, UNFPA, Rutgers-WPF, NCMNH, and social marketing companies.

The program held two meetings in July 2014 and February 2015. The first was introductory and brainstorming meeting where members were introduced to the program and their key technical inputs were sought. In the second meeting, the baseline survey was shared with the members for their feedback and suggestion.

MANAGEMENT AND COORDINATION

For effective management of different program activities, extensive coordination was made between Program Management Unit, implementing partners, government departments, Sindh development partners and the donor foundations. The Program Management Unit further formalized the level of interaction to make the coordination activities more regular, interactive and result-orientated. Some of these activities include meetings of the Steering Committee, teleconferences with donor Foundations, monthly meetings of implementing partners, as well as participation in the meetings of District Technical Committee.

Strategic Management

Steering Committee Meetings

In two years, three meetings of the Steering Committee were held. Two in-person meetings were held in Karachi during initial phases in November 2013 and March 2014. The third meeting was held in Dubai, UAE, on February 22–23, 2015. In this two-day meeting, baseline survey report was presented that suggested making certain changes in the implementing strategy. Some of the key decisions made included redoing data analysis of the quantitative part of the baseline survey, revising the strategy document with more emphasis on advocacy, using impact indicators in the result-based framework as well as approval of the revised budget.

Teleconferences with donor foundation

Monthly teleconferences provided an opportunity for the Program Management Unit to share project updates and get feedback and strategic direction on issues and challenges. The frequency of these meetings has now been reduced from once a month to every alternate month. In the Year II, 10 teleconference meetings were held.

Operational Management

Monthly meetings with implementing partners

The Program Management Unit conducts monthly meetings with implementing partners to capture their respective monthly progress with an aim to ensure that all stakeholders were up-to-date with project implementation status. In Year II, 12 meetings of Field Operations and 12 Senior Management Team meetings were held. These meetings were held at two levels. On every fourth working day of the month, a field operation meeting was held where monthly planner of partners was discussed and field level issues and challenges were addressed, especially related to inter-partner collaboration. The second level of interaction was with senior management from each partner, who met every second Wednesday of the month. This Senior Management Team shared project updates and discussed operational issues.

Development Partners Forum

The country office of the Packard Foundation organized a Health Development Partner Forum. This forum provided a venue for the donor group working on maternal, newborn and child health, and family planning/reproductive health in Sindh to develop synergies and avoid duplication of efforts.

District Technical Committee

This meeting was held on a monthly basis at EDO – Health Office, where representatives of different government hospitals and various NGOs working on family planning/reproductive health met and shared their performance and reviewed previously agreed action plans.



CRITICAL LEARNING

During the initial phases of the program, there were challenges in beginning field activities.

Addressing community resistance, focus on partnership, concern of religious leaders and other stakeholders were a part of this and have been addressed to a great extent. Being the foundation year, the focus remained on streamlining procedures. The program was faced with the following challenges during site mapping in its catchment area:

Community response

The criteria for site selection was the community's general acceptance for family planning/reproductive health, however during site mapping, the teams faced resistance from small clusters of hardliners within these communities who were accustomed to certain values where women's education was not a priority, and the cultural values continued to over shadow logical values. A two-prong approach was thus developed.

Firstly, the intervention approach was redesigned to integrate family planning/reproductive health with maternal, neonatal and child health, nutrition, and health education to develop a family life model that was more acceptable to the community. Secondly, the community representative groups/community based organization and community advisory committee members were sensitized to these issues and were asked to use their influence and to address hardliner elements and discuss the program implementation strategy with them. These quick remedies bore fruit and provided acceptance of the program in inaccessible communities, who were encouraged enough to allow their girls to join the community health workers cadre. It was simpler for teams to reach and meet with the communities using Aman Foundation's well-known and highly respected Aman ambulance service.

Concern of religious leaders

Religious leaders from various sects were skeptical about the motives of the program and possible political associations it may have. This was abated soon as all the teams of field stations were hired from the same community, and community advisory committees and community representative groups/community based organization included community notables and elders that helped address these concerns individually and collectively.

An innovative approach by Field Station #8 helped cement religious support, whereby a video recording was made of a well-respected religious leader who agreed with the strategic objectives of Sukh and extended his support during the implementation. This video was used during discussions with other community religious leaders who found his comments supportive and reaffirmed their support to the program.

Anticipation and realities in program implementation

The initial strategy of Sukh program was to reach the community with a phased approach. However, mapping of the program site highlighted that this approach might not be feasible as the community honored its myths and perceptions of family planning and reproductive health. It was, therefore, decided to develop a one-go approach and reach the community as a whole and continue the interaction throughout the project life. The flexibility from the donor foundations facilitated in developing more realistic and strategic approaches despite delay in implementation of the program.

Change of leadership at Program Management Unit

The incumbent Head of Sukh Initiative joined the program in the third quarter of Year I. The recruitment of key project staff at Program Management Unit was initiated in the same period.

Delay in developing results-based framework

The result-based framework tracking sheet was to be developed by December 2013 and was delayed till all implementing partners were on board earlier. The framework was ready in August 2014.

High turnover of community health workers and office staff

Major turnovers in office staff and community health workers resulted from the initial pay scale. They were hired at less than government minimum wage rate, and in many cases it was the first out of home and work exposure. This led to the departure of trainees after attending training sessions. Pay scales was adjusted thereafter and various training sessions were planned to keep them motivated.

Poor health seeking behavior

Like most under-privileged areas of developing countries, the communities in the program catchment areas had no/low health mandate. People had bare access to basic necessities like food and shelter, and there was lack of security, basic infrastructure and health facilities. The community expected financial aid alongside medicine for general ailments that were not mandated as part of the intervention.

Working with educational institutes

A large number of private schools in the intervention area with low student strength owing to high level of poverty existed. Children often preferred to work rather than study. The socio-economic and political context of certain areas made it challenging to advocate with school management to work on family life education. The program teams continuously engaged with these schools to expand the teachings of family life education.

It was challenging to sign MoUs with private school and alternate learning institutions. A significant amount of time was spent conducting meetings and advocacy work on family life education with the management of private schools and alternate learning institutes. After months of continuous engagement, these institutions are now ready to partner with the program and MoUs will be signed in the first quarter of Year III. Sindh Education Department allowed teachers' training just before summer vacation in May 2015. A gap of two months between the time teachers receive training and when they start rolling out training with the students may become a challenge.

Bureaucratic hurdles working with the government departments

Working with government departments was a challenge due to red tapism and unnecessary protocols. Financial sustainability and scalability of health programs transferring from private to public domains also lack of ownership.

Placement and acceptance of phone booths

In most of the cases, installation of a phone booth at a specific location was guided by an influential person of the community. Initially the acceptance of, and comfort level towards, phone booth service was low. It also resulted in fake or irrelevant calls. The Aman Telehealth team faced challenges in controlling non-serious callers from the booths and interaction with multi-lingual people in the community.

Another challenge was that most of the numbers provided to Aman Telehealth for outbound calls were not from the catchment sites and the community members had a general tendency of changing numbers. Due to this, 20% contact numbers were not responsive. There was a visible challenge to gain direct access to married women of reproductive health through telephone, who either did not have their own mobile phones or were reluctant to share their contact details. 20% of those contacted were still not interested in getting themselves registered. Short message delivery has been a challenge as the contact numbers were not complete, validated or categorized. Moreover, comprehensive understanding of family planning related SMS is a challenge due to poor education level in the catchment areas.

Security of telephone booths

Social and political pressures proved a major challenge in gaining consent and agreement of stakeholders/influencing bodies of the community for the installation of telephone booths. Places exist where stakeholders have to turn the telephone set off and place it in the community's custody in late evening and night time.

Political will and sustainable impact

Support from the government has been strong. After the initial interactions with senior government officials at Department of Health and Population Welfare Department, the program team was encouraged by the strong political will to improve health and wellbeing of citizens with assistance from NGOs. Both departments extended assistance and resources that were required for the program's implementation. In their capacities, Department of Health has proposed to make 250 lady health workers part of the program, whereas Population Welfare Department has agreed to allow the program to work with 40 of its family welfare centers.

During Year I, the program focused on providing a platform that enabled strategy development of stakeholders, devising policies and scale best practices for the benefit of a larger community. Year II focused more on how these strategies were performing and identifying areas for re-strategizing to achieve the project target. Pivotal in Year II were collaborations with government partners and the addressing of specific challenges. The program now works as a consortium with multiple public and private partners that are interlinked, and the program is making efforts to ensure that all partners are well-coordinated and understand the importance of each other's roles.

Post-abortion Importance of Spacing

18-year-old Ameer Bano from Ameen Jatt Para, had a miscarriage just eight months after her marriage. She was visited by Saeeda, a Community Health Worker from Sukh Initiative, and counseled her on post-abortion family planning practices. Ameer Bano was, however, reluctant to adopt any FP method because of her believe that as a newlywed she has to have her first child as soon as possible so that she was not subjected to humiliations of being infertile from her family and neighbors. Saeeda continued to counsel her on the importance of spacing for six months after abortion, however she was not making any headways. Saeeda, changed her approach and met with Ameer Bano's mother-in-law and discussed the health complications if Ameer Bano gets pregnant soon after abortion, but even her mother-in-law was reluctant to agree. As a next step, Saeeda thought of inviting them to Support Group Meeting which was organized every week to hold discussion with women about the importance of spacing families and for experience-sharing. Saeeda asked the women in the group to support Ameer Bano and her mother-in-law in making the right decision. During the meeting, Saeeda discussed the importance of spacing after an abortion. Other women in the group gave many examples to Ameer Bano and her mother-in-law of the ill-effects of repeated pregnancies especially after abortion and that too at a young age. Both Ameer Bano and her mother-in-law asked many questions, and after getting satisfactory response, they agreed to opt for a short acting reversible method. Saeeda accompanied both to a nearby facility, where Ameer Bano chose to use an injectable method. Worrying for the betterment of each and every client in the community is the hallmark of success for CHW Saeeda, who could have left the family as non-responsive, but her quest to transform lives and bring healthy behaviors in all, made her approach the family again and again and elicit support from women in the community for Ameer Bano's quality of life.

Learnings from Year I

Importance of a well-structured approach for successful implementation

The program's implementation strategy was developed after taking several factors into consideration. Key among them was brainstorming different approaches from similar national, regional and global projects, and put them into the project's context.

Synergizing efforts to form an integrated approach with implementing partners

Sukh is a complex project with multiple solution levers provided by different partners. Over the course of interaction with implementing partners, the role of Program Management Unit has addressed concerns and facilitated the needs of all partners. Moreover, synergizing their efforts to form an integrated approach has been a project hallmark.

- Aahung's expertise in working with youth in schools and colleges on family life education was limited when it came to communities. Discussions with their team and Aman Community Health Program led to the development of a plan that enabled Aahung to reach out to young girls and boys (16 years and above) in the community through male and female community health workers, and engage in community sensitization on family life education through community representative groups/ community based organization and community advisory committees, street theater and docudramas.

- Aga Khan University's baseline survey has undergone several changes since its first proposal in October 2013 to the one latest in June 2014. Suggestions of Lot Quality Assurance Sampling study and panel survey were changed to midline survey and cluster sampling. During this course, the need for capacity building of its team was also identified, and with the support from Packard, Mathematica provided initial feedback on the baseline questionnaire. Donor Foundations and Program Management Unit agreed to receive technical support in monitoring and evaluation on permanent basis that can continue to work with Aga Khan University over the life of the project. This will facilitate in impact evaluations and MIS interpretations.
- PMU's discussion with Aman Telehealth for promoting the helpline service resulted in the development of a marketing strategy, which included the use of FM radio, local cable operator networks and the involvement of community workers and groups for wider dissemination.

Involving stakeholders from inception

Involving key stakeholders from project inception allowed for developing ownership amongst them. Working closely with Health and Population Welfare departments has allowed for more support and understanding to develop between them and the program.

Interacting with the community before initiating activities

Interacting with community gatekeepers and influencers before initiating field activities has facilitated good will and acceptance among the community. It has also provided an insight to the aspirations and apprehensions of the community elders with regards to family planning and reproductive health. This gave the team opportunities to make contextual changes in the approach and also sensitize community gatekeepers to the importance of such initiatives as a health intervention. As a result, the teams were able to work in these communities, and community elders and influencers became involved in forming community representative groups/community based organization and community advisory committees structures, nominating females from their communities to work as community health workers with the program.

Beginning with the end in mind

With support from Gates Foundation, the program team began working with ExpandNet to develop a sustainability model, focusing on the concept of 'beginning with the end in mind'. The team has been trained by ExpandNet on steps to scale-up and initiate discussions on process documentation of the program.

Learnings from Year II

Implementation partnership strategy with Aman Community Health Program

The prescribed implementing strategy to form community advisory committees and Community representative groups/community based organization and involving the community at grassroots level in project activities, proved to be successful and resulted in building good trust amongst the community.

Training duration

It was observed that conducting a family life education master trainers training in two

days was an unrealistic target and that gaps in the training. This has been increased to a minimum of four days to ensure quality learning and effectiveness.

Training content

The first family planning and reproductive health training conducted with Aman Telehealth staff focused heavily on content and received low response from the participants. The Aahung team revised this to ensure that the second training focused more on participatory methodologies, like case studies, group work and mock calls. It was also understood that future training should staff be hands-on, using activities such as mock calls to give more confidence and practice. Moreover, it was observed that Aahung would have to conduct more follow-ups with the trained staff after the training sessions to ensure that they were effectively implementing family life education protocols and guidelines.

Working with alternate educational institutions

During the mapping process, teams identified several alternate learning institutions in the community such as vocational centers and coaching centers. Mapping revealed that students were enrolled for a short time and it was realized that family life education modules needed to be shorter and concise so as to impart information in a limited timeframe.

Telephone booth service

The success of this service depended on the involvement of partner field teams and community stakeholders throughout the process, i.e., from site selection to the installation to the operation of booths. It also became apparent that community health workers and CHNs must work in close coordination with the Telehealth team for feedback and suggestions on ongoing orientation sessions held in the community.

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