

STRENGTHENING ACCESS TO HIGH-QUALITY FAMILY PLANNING SERVICES IN URBAN PAKISTAN

SUKH ENDLINE EVALUATION FINDINGS

Mathematica:
Swetha Sridharan
Anitha Sivasankaran
Kimberly Smith
Evan Borkum

RADS:
Adnan A. Khan
Hania Hussain
Inaam ul Haq
Asmita Bano

February 2021

Mathematica

Research And Development Solutions

TABLE OF CONTENTS

ACRONYMS

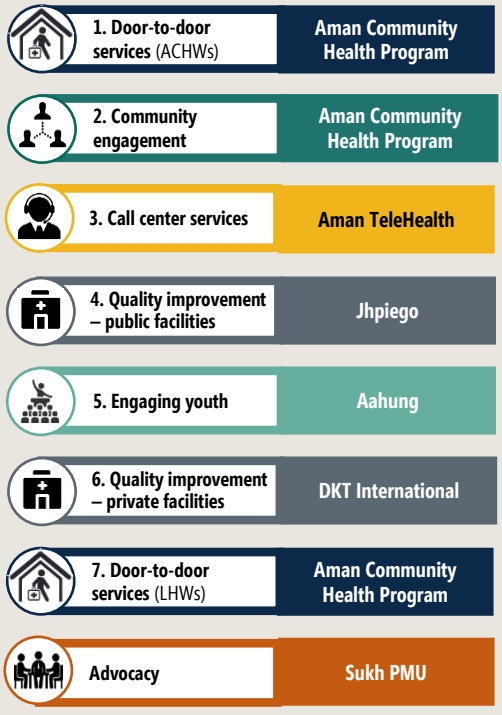
ACHP	Aman Community Health Program
ACHW	Aman Community Health Worker
AHCS	Aman Health Care Services
AKU	Aga Khan University
CAC	Community Advisory Committee
CCP	Johns Hopkins Center for Communication Programs
CHS	Community Health Supervisor
CRG	Community Representative Group
DoH	Department of Health
FGD	Focus group discussion
FHD	Family Health Day
FLE	Family Life Education
FOM	Field operations management
FP	Family planning
FP2020	Family Planning 2020 Summit
FWC	Family Welfare Center
HNWI	High net worth individual
HTSP	Healthy timing and spacing of pregnancies
ICFP	International Conference on Family Planning
IDIs	In-depth interviews
IEC	Information, education, and communication
IUCD	Intra-uterine contraceptive device
KMC	Karachi Municipal Corporation
LARC	Long-acting reversible contraception
LHW	Lady Health Worker

LSBE	Life skills-based education
mCPR	Modern contraceptive prevalence rate
MLE	Measurement, learning, and evaluation
MNCH	Maternal, newborn, and child health
MVA	Manual vacuum aspiration
MWRA	Married women of reproductive age
PAC	Post-abortion care
PAFP	Post-abortion family planning
PDHS	Pakistan Demographic and Health Survey
PMIS	Project monitoring information system
PMU	Program Management Unit
PPFP	Post-partum family planning
PPIUCD	Post-partum IUCD
PWD	Population Welfare Department
QI	Quality improvement
RADS	Research and Development Solutions
RH	Reproductive health
SBMR	Standards-Based Management and Recognition
SDA	Service Delivery Assessment
SESSI	Sindh Employees' Social Security Institution
SMT	Senior Management Team
SRHR	Sexual and reproductive health and rights
TAG	Technical Advisory Group
ToC	Theory of change
VCAT	Values clarification and attitude transformation
VTC	Vocational training center
YFS	Youth-friendly space

EXECUTIVE SUMMARY

Following the Family Planning Summit in London in July 2012, the Aman, Bill & Melinda Gates, and David and Lucile Packard Foundations came together to form the Sukh Initiative, a multi-partner, multi-component urban health program that sought to increase access to and uptake of family planning (FP) and reproductive health (RH) services in Pakistan. The five-year (2013-2018) initiative was a response to slow progress on key reproductive health indicators over the past three decades in Pakistan and the need to address urban gaps in existing family planning programs in the face of rapid urbanization occurring in the country. As the fastest growing major city in Pakistan, with an estimated population of 21 million in 2014, and the location of the Aman Foundation, Karachi was selected as the focal geography for the initiative. Sukh covered four townships in Karachi, representing a population of one million married women of reproductive age (MWRA): Bin Qasim, Korangi, Landhi, and Malir. The overarching goals of the Sukh Initiative were to increase the modern contraceptive prevalence rate (mCPR) by 15 percentage points among MWRA in the intervention area, and to influence the next generation, by sensitizing youth on RH issues and empowering them to lead responsible, healthy lives.

FIGURE I. SUKH INITIATIVE – KEY COMPONENTS AND IMPLEMENTING PARTNERS



Note: Initiative components are listed in the order they were included in the initiative. Advocacy took place throughout the initiative.

To achieve these goals, the Sukh Initiative included a complementary and holistic set of interlinked demand- and supply-side interventions that incorporated best practices emerging over the past decade from RH programming in Pakistan and other countries (Figure I). The initiative's 360-degree approach involved introducing new and improving existing services, and reaching MWRA and youth through as many channels as possible to amplify its impact. A cornerstone of this approach involved deploying a new cadre of community health workers—Aman Community Health Workers (ACHWs)—to provide door-to-door FP services in areas of the city not covered by the government's LHWs, and to connect MWRA with other FP services supported by the initiative, including telehealth and facility-based services. Eventually, the initiative also included efforts to strengthen government LHWs in the intervention area. In addition to these FP services targeting MWRA, the initiative also included male and youth outreach components, supported by ACHWs and LHWs, as well as life skills-based education (LSBE) for youth in schools. To create a strong enabling environment for these services, Sukh included a broader community engagement effort to reach key influencers such as married men, community gatekeepers, and political and

religious leaders and increase their openness to FP. At the policy level, the initiative engaged in targeted advocacy to government stakeholders—to obtain their buy-in for its urban FP programming and make the case for their long-term adoption of promising elements of Sukh. Initiative components were implemented by a range of partners (Figure I). A Program Management Unit (PMU) was formed integrate and coordinate efforts across these partners, lead and execute on the strategic vision for the initiative, engage in progress tracking and data-driven decision-making, and spearhead advocacy to the government.

EVALUTION OVERVIEW

From its inception, the Sukh Initiative included a measurement, learning, and evaluation (MLE) component to track implementation progress, generate evidence, and capture actionable learning to inform program improvement and scale-up decisions. In addition to the PMU-led program monitoring effort mentioned above, the MLE effort included an external evaluation effort centered on baseline, midline, and endline assessments. The baseline and midline assessments, led by Aga Khan University (AKU), focused on measuring preliminary two-year (2014-2016) results and identifying areas for program improvement. The endline effort, led by Research and Development Solutions (RADS) and Mathematica, focused on capturing overall four-year (2014-2018) results and learnings.

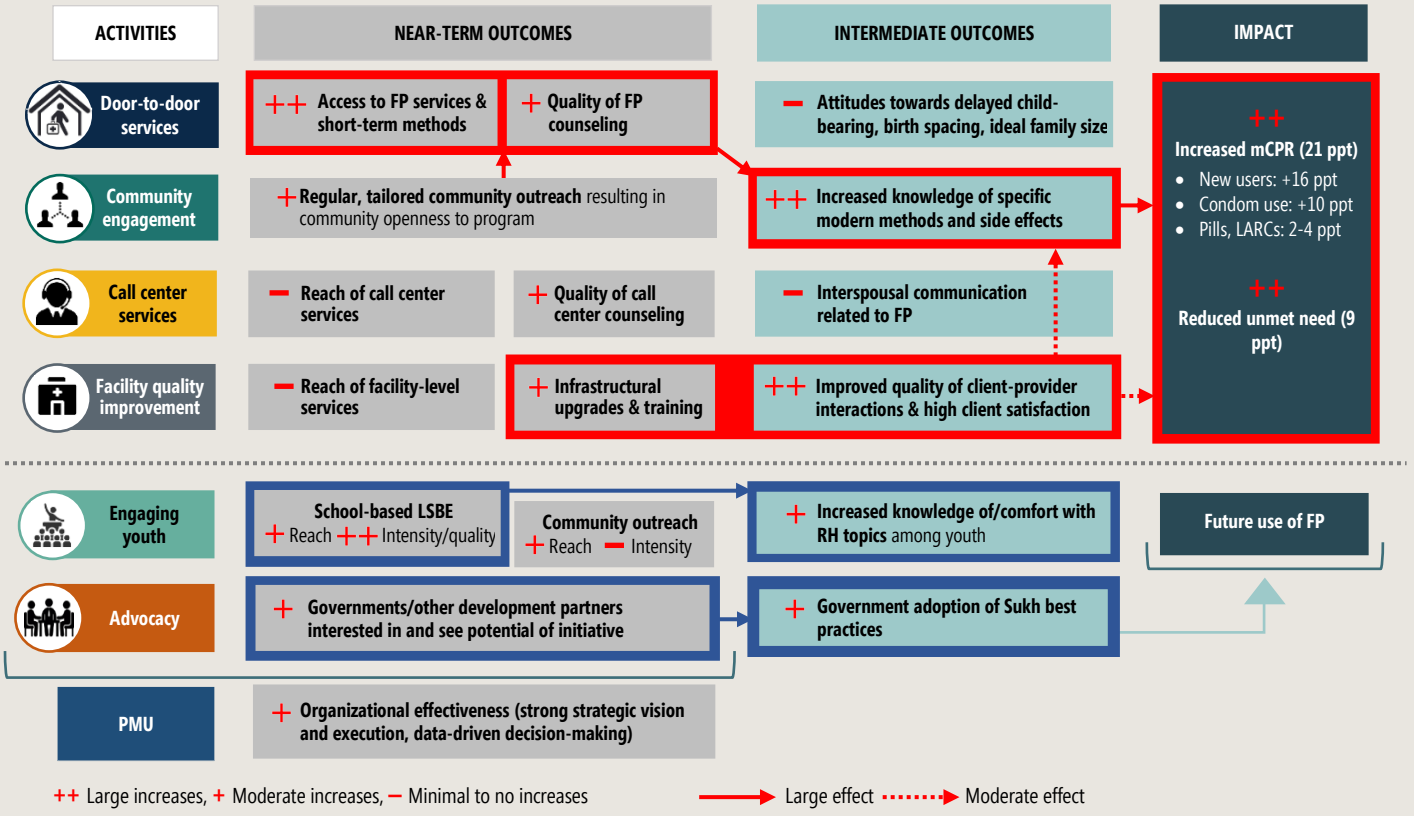
The objectives of the endline evaluation were to: (1) measure the initiative's contribution to observed changes in targeted FP/RH outcomes in Sukh intervention areas, (2) document and assess how the initiative was implemented and evolved over time and what did and did not work well, (3) assess the sustainability and scalability of key program components, (4) gauge the organizational effectiveness of the partnership structure, and (5) generate learning to help inform decision-making related to replicating and/or scaling program components. To meet these objectives, we adopted a mixed-methods approach aimed at improving the rigor and depth of our findings. In particular, the evaluation drew on two large, cross-sectional surveys of MWRA in Sukh's ACHW catchment area, conducted at baseline (2013) by AKU with a sample of 5,140 women and at endline (2018) by RADS with 3,038 women. These data were complemented by and triangulated with data collected through 122 in-depth interviews (IDIs) and focus group discussions (FGDs) with 260 stakeholders who were involved in and targeted by the program, as well as service delivery assessments at 22 facilities. The endline evaluation also drew on a range of secondary data sources, including program documents, program monitoring data collected by the Sukh PMU and its implementing partners, and the Pakistan Demographic and Health Survey (PDHS).

KEY TAKEAWAYS

Figure II provides a visual summary of key evaluation findings—described in detail below—on the strength of the implementation of Sukh interventions and their contribution to observed changes in targeted outcomes.

Among MWRA in the Sukh intervention area, mCPR increased by 21 percentage points. This increase was driven by supply side factors, primarily the availability of home-based FP services

FIGURE II. SUMMARY OF ENDLINE EVALUATION FINDINGS



and commodity distribution, as well as improvements in facility-based service provision and related, substantial increases in knowledge of specific methods and side effects. Across all Sukh interventions, the ACHW component had the most reach and intensity, with three-quarters of MWRA reporting exposure to door-to-door services by ACHWs at endline. CACs established by Sukh helped door-to-door services gain a foothold in the highly conservative communities in the intervention area. Recruiting local women to act as ACHWs engendered trust and led to greater openness among MWRA to receiving FP/RH information and services. Moreover, ACHWs filled a key gap in FP/RH services—operating in areas without LHWs and where women's mobility is restricted, and thereby providing many women with easy access to FP counseling and methods for the first time. Consistent with this, our findings indicate that the increase in mCPR was driven by (1) new FP adopters (accounting for 16 percentage points of the 21 percentage point increase) and (2) increased use of condoms, which were distributed by ACHWs, with overall unmet need decreasing by 9 percentage points. Sukh's operational infrastructure and processes ensured that ACHW services were delivered with quality and intensity. Close supportive supervision from Sukh's field station staff and data-based tracking increased accountability, leading to relatively regular door-to-door visits and helping to ensure the quality of the counseling provided.

Sukh also strengthened facility-based service provision, making critical improvements in infrastructure and FP counseling during FP, delivery-related PPFP, and PAC visits. This likely contributed to the increase in mCPR, as reflected in observed increases in LARC use (which remains relatively rare). However, the overall reach of facility services was low (only 15 percent of MWRA had visited a facility for FP or delivery services in the six months prior to the endline survey), indicating that improvements in facility-based services likely had a lower level of impact on mCPR than the widely accessed door-to-door services. Finally, while we found little change in attitudes toward the timing and spacing of births or ideal family size, there were large increases in knowledge of almost all modern methods, driven by substantial increases in the proportion of clients receiving counseling about different FP methods and their side effects over the course of the initiative.

The other components of Sukh's 360-degree approach that involved reaching women through call center services and influencing married men and youth were not as successful and/or had limited reach. Despite strong trainings of TeleHealth agents and male mobilizers under Sukh, call center services and outreach to married men were hampered by design constraints, as well as weaker-than-envisioned linkages to other initiative components. Only 15 percent of endline survey respondents had heard of Aman TeleHealth services, suggesting that ACHWs, LHWs, and facility staff were not consistently informing women of this resource or linking them to it. In addition, less than half of MWRA owned mobile phones (41 percent), and only 4 percent had heard of the Aman telephone booths. As a result, only 4 percent of MWRA had received a call from a Telehealth agent by the end of the initiative, and less than 2 percent had placed a call to the call center. There were few male mobilizers and the activities they were asked to conduct to target husbands—support group meetings and corner meetings—were not responsive to most men being away at work and hard to reach during the day. Moreover, they did not systematically target outreach to husbands of MWRA served by ACHWs/LHWs. Finally, the youth component of Sukh was successful in reaching young men and women through school-based LSBE and increasing their confidence as well as understanding of issues related to puberty, marital rights, and gender-based violence. However, the community-level outreach to youth was lighter touch and largely siloed from the rest of the initiative, in part because it addressed a distinct population that, in the short term, may not directly contribute to targeted changes in mCPR.

Through consistent, strategic engagement with government, Sukh enabled the scale-up of several of its key components, informed policy, and fostered greater integration between the PWD and DoH. The initiative successfully leveraged the networks and connections of donor representatives, PMU staff, and implementing partner staff to engage with the government from the start, drawing increased attention to urban FP and generating interest in key solutions to lagging FP/RH indicators. Regular engagement continued throughout the initiative, either through planned or ad hoc group or individual meetings, and ultimately enabled several advocacy wins, including (1) large-scale task shifting of key FP services (implant insertion and administration of the first contraceptive injection) to mid-level providers, (2) adoption and rollout of LSBE to schools across Sindh, and potentially, (3) adoption of Sukh's LHW model. Sukh's participation in several government platforms for FP/RH coordination, and key steps it took on the ground as part of its facility component, also supported the integration of PWD and DoH, thereby reducing systems-level inefficiencies in FP/RH service provision. Jhpiego placed FP counselors from PWD at the antenatal counters it established at DoH facilities, a step the Sindh government adopted more widely. Jhpiego also helped to re-energize and increase the productivity of joint district technical committee meetings, such that DoH and PWD officials at the

district level were coordinating around human resources, commodities, service provision, and quality assurance. Sukh's advocacy made skilled use of data and evidence. The Sindh Minister of Population Health made the decision to ingrate PWD counselors into DoH facilities under her jurisdiction upon seeing Jhpiego's reports of a 50 percent increase in PPFP adoption following this change. Program data and preliminary evaluation results were also used successfully to generate interest among Sindh government stakeholders in adopting Sukh's door-to-door services model for its LHWs.

The PMU was an adept manager of processes, but may have been too focused on meeting targets rather than learning and strategy; as a result design constraints and implementation challenges were not always addressed and synergies and linkages between interventions were sometimes missed. The PMU adeptly managed and oversaw its field stations and used data for tracking progress toward pre-set targets. However, this focus on meeting targets precluded a broader learning orientation. Implementing partner meetings did not promote exchange of ideas and creative problem-solving. And data and on-the-ground learning were not proactively used to address challenges faced by individual components or strengthen linkages across components. For instance, the design of the call center services and male mobilization components remained largely the same over the course of the initiative, despite early indications of the accessibility challenges posed by low mobile phone access and limited access to men during the work day. Key synergies were also not always leveraged. For example, less than half of the ACHWs mentioned referral facilities, few received the call center number from ACHWs, and (as mentioned) outreach to married men was not systematically integrated with door-to-door services to MWRA.

KEY LESSONS AND IMPLICATIONS

- **Mobilizing highly localized community-based FP/RH service provision in underserved areas can substantially improve FP outcomes, especially when buttressed by intensive programmatic supports.** Our findings confirm Sukh's hypothesis—that hiring and rapidly training local women to provide community-based FP/RH services in underserved areas can bring about significant improvements in knowledge of modern contraceptive methods and their side effects and access to these methods, both key drivers of FP uptake. This is a critical finding in today's status quo in urban Pakistan, where coverage of (and focus on FP) by government LHWs continues to be uneven. Key ingredients for successful mobilization of these services are to (1) obtain early buy-in from key community gatekeepers, such as political and religious leaders, to gain entry into conservative communities; (2) hire local women to ensure trust and minimize challenges in engaging women around sensitive FP/RH issues; (3) focus service provision on FP, and (4) provide strong supportive supervision and clear schedules and targets to ensure accountability and increase regularity of visits.

  These learnings can inform enhancements to existing LHW service provision as well. For instance, LHWs have a wide range of responsibilities beyond FP (22 job functions are listed in their terms of reference) and thus focus on current government priorities or the most pressing needs of their clients. Providing incentives for FP may foster greater focus on these services. Clear targets for FP service provision, found to be helpful by LHWs participating in Sukh, may also be a way to motivate LHWs to prioritize FP service provision during their home visits. Finally, given LHWs are not always from

the communities they serve, and thus lack the networks, familiarity with customs, and language skills needed to easily engage with their clients around FP/RH issues, tailored training is particularly important. Our findings show that the training provided by Sukh linked FP/RH sensitization to LHWs' own life experience and helped them learn how to overcome the shame and hesitation that usually held them back in discussing FP with their clients.

- **Misconceptions about FP methods are very difficult to change in communities with low literacy; innovative strategies are needed to dismantle existing myths and prevent the spread of new misinformation.** A range of myths about the dangers of using modern contraceptive methods continue to persist in Sukh's intervention areas (e.g., that IUCDs led to abdominal swelling, that injections caused body pain, and that implants "freeze" arms). These are regularly cited as reasons for non-use or discontinuation, and thus merit targeted attention. Sukh's sensitization around side effects of modern contraceptive methods was quite successful—the endline survey showed a 21 percentage point increase in current users reporting that they were informed about side effects. Potentially, provision of information about side effects could integrate *preemptive* messaging around common myths, explaining what women may hear about modern contraceptive methods and their harmful effects and why that is inaccurate.

- **Shifting attitudes around delayed childbearing is challenging; it may be easier to make the case for delaying marriage, which in turn may require closer integration of programming for unmarried youth and MWRA.** While shifting attitudes around delaying, spacing, and limiting births may not be critical in efforts focused narrowly on increasing mCPR in underserved areas, improvement in these outcomes may be important for additional and longer-term increases in mCPR in Karachi. For instance, our endline survey findings show that only about half of the MWRA perceived a benefit to delaying the first child after marriage. It is possible, however, that this was linked to the perceived impossibility of delaying childbearing—given the deeply entrenched social norms around having children immediately after marriage. Indeed, several MWRA we interviewed spoke about the benefits of delaying marriage instead of delaying childbearing, indicating this may be more feasible. Aahung's LSBE curriculum covered marriage and marital rights; if this included some discussion of the advantages of getting married at a slightly later age, including having children at a later age, this may set the stage for delayed childbearing. Work with MWRA could then focus on outcomes that are easier to influence following marriage, such as limiting births, another outcome where there is room for change.

- **New strategies are needed to surmount the substantial challenges involved in reaching and sensitizing married men, who are away at work for most of the day.** Influencing married men's thinking about FP/RH issues is critical. Qualitative data indicate that they play a key role in deciding the number of children that couples have and also weigh in on the choice of contraceptive. In-person engagement is challenging, given men's work responsibilities during the day. Group-based sensitization is also difficult, particularly when it is possible some men may be particularly religious and have strong, long-standing objections to FP. Mobile phone outreach may provide a solution, given men have far greater access to mobile phones than women. It also provides the opportunity for private conversations about FP.

- **Strengthening referrals and ensuring PPFP counseling is provided uniformly may increase the use and influence of facility-level services.** Less than one in five endline survey respondents reported visiting a facility for FP or delivery services in the past six months. This might have been driven by inconsistent provision of referrals to facilities (only about 40 percent of endline survey respondents who had received a visit from an ACHW reported that she had talked to them about Sukh referral facilities). However, MWRA from these conservative communities had very limited mobility. A key opportunity to reach these women is immediately after delivery, for which many do visit facilities. It is important to ensure that all women receive PPFP counseling after birth, which survey findings indicate may be very effective in promoting FP uptake (nearly 70 percent of women who reported that a provider discussed FP with them or their husbands after delivery were using a modern method at endline). Finally, client-centered counseling remains key. Providers, like LHWs, indicated the training they received on how to tailor the information they provided to the needs of the client was new and important. Both client experiences and SDAs suggest this may be happening, but that more information and use of visual aids may further strengthen communication and understanding about FP methods.

- **Ensuring that multi-component initiatives operate in an integrated manner requires a strategic coordinating body to regularly identify and leverage synergies and engage in data-driven learning and decision-making.** The Sukh model's program logic was mostly sound, with its multiple components designed to feed into one another. However, given each component was led by a different partner, ensuring these theoretical linkages played out as envisioned in the field required strategic, flexible management, which the PMU provided sometimes but not always. Ensuring different components are operating in sync with each other, and that the initiative is greater than the sum of its parts, requires regular identification and leveraging of synergies, as well as a willingness to walk away from or heavily modify interventions that are not gaining traction. Adaptive management of this kind is highly reliant on strong real-time performance monitoring systems. The key lesson from Sukh is to not only develop monitoring data collection platforms and dashboards and establish forums for discussion of results, but also build a learning orientation into the DNA of the initiative. A learning orientation is necessary to ensure that program data are used for more than reporting and small changes to implementation plans, and instead foster deep reflection on what is and is not working on the ground and motivate action to increase efficiency, effectiveness, and sustainability.

1. INTRODUCTION

Pakistan's family planning (FP) program, one of the oldest in the world, has been working to provide women and their families with options to manage their desired family size and plan the timing of pregnancies since the 1960s. Yet, increases in contraceptive use have been slow and uneven. The modern contraceptive prevalence rate (mCPR) rose from 9 to 26 percent between 1990-1991 and 2012-2013, but has since plateaued, with only one in four married women currently using a modern FP method (MacQuarrie and Aziz 2020). Pakistan faces a number of challenges to increasing modern contraceptive use. These include cultural preferences for larger families, religious objections to contraception, and women's limited decision-making autonomy and mobility (Tabassum et al. 2014). In addition, the vast size of the country and its population, as well as political strife and varying levels of political and donor support for FP, have made achieving universal coverage of FP services difficult. Large service delivery gaps persist in both rural and urban areas, with rapid urbanization putting intense pressure on urban health systems (Jabeen et al. 2017; Hamid and Stephenson 2006). In recent years, the government has shown a strong commitment to addressing these challenges and unmet need for FP. During the 2012 London Family Planning 2020 (FP2020) Summit, it committed to increasing mCPR to 55 percent, and providing universal access to reproductive health (RH) services, by 2020. It also committed to including contraceptive services in the essential services package and strengthening the quality and reach of the Lady Health Worker (LHW) Program, a community health worker program focused largely on rural areas and urban slums. Provinces have developed or updated population policies to align with the FP2020 goals, with Sindh and Punjab also developing Costed Implementation Plans to guide policy implementation and help meet provincial mCPR goals.

Leveraging this momentum, the Aman, Bill & Melinda Gates, and David and Lucile Packard Foundations launched a $15 million FP initiative in Pakistan to help the country meet its FP2020 targets. Known as the "Sukh" Initiative, the five-year (2014-2018) effort focused on Karachi, the largest city in Pakistan and location of the Aman Foundation, and sought to address critical gaps in service delivery and unmet need exacerbated by rapid urbanization. Drawing on learnings from the Gates Foundation's global urban FP investments and the Packard Foundation's 15 years of FP grantmaking in Pakistan, the initiative adopted a holistic set of interlinked supply- and demand-side interventions to reach, influence, and serve married women of reproductive age (MWRA) and youth. Through its 360-degree approach, the Sukh Initiative sought to increase mCPR by 15 percentage points among MWRA in the intervention area (four peri-urban townships of Karachi covering a population of one million), and influence the next generation by sensitizing youth on RH issues and empowering them to lead healthy, responsible lives.

The Sukh Initiative's 360-degree approach involved introducing new and improving existing services, and reaching MWRA and youth through as many channels as possible to amplify its impact. A cornerstone of this approach involved deploying a new cadre of community health workers—Aman Community Health Workers (ACHWs)—to provide door-to-door FP services in areas of the city not covered by the government's LHWs, and to connect MWRA with other FP services supported by the initiative, including telehealth and facility-based services. Eventually, the initiative also included efforts to strengthen government LHWs in the intervention area. In addition to these FP services targeting

MWRA, the initiative also included male and youth outreach components, supported by ACHWs and LHWs, as well as life skills-based education for youth in schools. To create a strong enabling environment for these services, Sukh included a broader community engagement effort to reach key influencers such as married men, community gatekeepers, and political and religious leaders and increase their openness to FP. At the policy level, the initiative engaged in targeted advocacy to government stakeholders—to obtain their buy-in for its urban FP programming and make the case for their long-term adoption of promising elements of Sukh.

Since its inception, Sukh has included a strong measurement, learning, and evaluation (MLE) component to track implementation progress, generate robust evidence on results, and capture actionable learning. As part of this effort, the initiative commissioned a multi-phase, multi-partner external evaluation to measure its contribution to targeted outcomes and draw out learnings that could inform program improvement and potential replication. This report summarizes the results of the endline, led by Research and Development Solutions (RADS), in partnership with Mathematica. The goals of the endline are to: (1) assess the aggregate results of the Sukh Initiative and measure its contribution to observed changes in key FP/RH outcomes in intervention areas; (2) develop a strong understanding of how the program was implemented and evolved over time, and gain insight into perceptions of the program among beneficiaries and other stakeholders; (3) assess the sustainability, replicability, and scalability of key program components; (4) gauge the organizational effectiveness of the partnership structure; and (5) generate learning that could help inform decision-making related to sustaining, replicating, and/or scaling-up program components, as well as contribute to the evidence base around urban FP/RH programming.

This report begins by providing a detailed overview of the Sukh Initiative (Section 2). Section 3 presents the evaluation approach and limitations. Sections 4, 5, and 6 present findings on the implementation, impact, and cost-effectiveness of the Sukh Initiative, respectively. Section 7 summarizes the key findings and discusses implications for future FP programming.

2. OVERVIEW OF THE SUKH INITIATIVE

FIGURE 2.1. KEY MILESTONES IN THE FORMATION AND EVOLUTION OF THE SUKH INITIATIVE

2012	**JUL.**	Early conversations about partnership between Aman, Gates, and Packard Foundations at and after **London Summit**
2013	**FEB.**	**McKinsey** contracted to conduct situation analysis of FP in Karachi to inform initiative design
	NOV.	**Global launch** at ICFP; formation of **PMU** (led by consultant)
2014	**MAR.**	Pakistan launch; new head of Sukh Initiative joins; **implementation begins** with mapping of project sites
	JUN.	**ACHP, Aahung, Aman TeleHealth**, and Aga Khan University join initiative
	AUG.	**TAG** created
	OCT.	**Jhpiego** joins initiative
2015	**FEB.**	**Aman Clinic** joins initiative
	JUN.	**DKT** joins initiative
2016	**FEB.**	Partnership with **LHW program** finalized
2017	**JAN.**	**CCP** joins initiative to support communications and advocacy
2018	**SEP.**	**Close of field-level implementation** for most Sukh components
2019	**JUN.**	**Close of LHW and TeleHealth** components

2.1. FORMATION OF THE SUKH INITIATIVE

Conceptualization of the Initiative

The Sukh Initiative was conceived at the 2012 London Summit on FP. The Summit, hosted by the United Kingdom and the Gates Foundation, aimed to elevate FP on the global health agenda, and bring renewed momentum to the RH sector. Specifically, the Summit sought to secure political commitments to its 2020 targets and financial commitments for FP/RH services, with a particular focus on donors and high net worth individuals (HNWIs) from the Global South. As part of this effort, the Gates Foundation engaged in discussions with the head of the soon-to-be-formed Aman Foundation, based in Karachi, Pakistan. At the time, the Gates Foundation was in the process of entering Pakistan and the Aman Foundation was new to the FP/RH space, with both looking for high impact opportunities in the country. The Packard Foundation joined these discussions at the London Summit, bringing insights from its many years of engagement in the RH sector in Pakistan. These early discussions of opportunities to advance progress toward 2020 FP targets in Pakistan were the genesis of a donor collaboration that evolved into the Sukh Initiative.

Following the London Summit, the Aman, Gates, and Packard Foundations continued conversations around FP needs and opportunities in Pakistan, identifying synergies in their strategic priorities, and recognizing the potential for impact and learning that a large-scale co-funded effort would present. The Gates Foundation was looking to expand learning around urban RH, a key focus for its FP team. The Aman Foundation had a strong interest in supporting impactful work in Karachi. And the Packard Foundation was preparing to exit Pakistan and wanted to both position its key FP/RH investments for sustainability and share its accumulated knowledge with those carrying forward the FP/RH agenda in the country. By collaborating, and bringing together their unique strengths, the donors believed they could help Pakistan make meaningful progress toward its FP2020 goals. In particular, by integrating the Aman

Foundation, a domestic institution with its own financing and potential for partnership with the government, the hope was to establish a strong, long-term champion for FP/RH issues in Pakistan.

Strategic Visioning, Design, and Launch

To inform the design of the initiative, the donors brought in global consulting firm McKinsey and Company to conduct a situation analysis of FP in Karachi. The analysis illuminated several key barriers to modern contraceptive use. On the demand side, they found there was low awareness and understanding of FP, and deeply entrenched fears regarding side effects of contraceptives. Another demand-side factor driving women's non-use was disapproval from or limited communication with husbands. The situation analysis also assessed the potential for longer-term demand by examining knowledge and attitudes related to FP/RH among youth—who are at a life stage where they are developing attitudes and priorities that are key determinants of future FP use. It found that young people were highly susceptible to peer and other external pressures and lacked supportive relationships. Awareness of FP/RH issues was also limited among youth, who did not always have access to reliable, unbiased sources of information. On the supply side, the situation analysis identified poor quality of care as a key factor limiting FP use. Key quality gaps included lack of tailored FP counseling, inadequate knowledge of FP methods among providers, and limited method mix.

To address these trends, McKinsey proposed a holistic set of demand- and supply-side interventions under an umbrella initiative with a strong focus on performance management. They found that many FP interventions to date had not adopted a continuous program improvement focus and thus limited their opportunity for impact. They proposed that demand be cultivated through multiple diverse touch points and that the supply side interventions adopt a strong quality improvement focus.

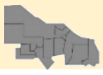
To help operationalize these recommendations, and maximize the initiative's overall effectiveness, the donors put in place several organizational supports. These included establishing a Program Management Unit (PMU) in November 2013 to (1) lead and execute the strategic vision for the initiative; (2) identify, integrate, and coordinate among the partners; (3) develop and operationalize a project monitoring information system (PMIS) for progress tracking and data-driven decision-making; (4) oversee administration and finances; and (5) spearhead advocacy to the government to promote scale-up. The PMU was originally led by a consultant, with a formal head of initiative hired in March 2014. The PMU was guided by a steering committee composed of donor representatives, with whom it met on a quarterly basis. The initiative also formed a Technical Advisory Group (TAG) to ensure the rigor of the technical aspects of the program and support its long-term sustainability. The TAG comprised representatives of development partners working on FP/RH in Pakistan, government officials, and other local FP/RH experts.

As they built this scaffolding, the donors also officially launched the initiative. The global launch was at the International Conference on Family Planning in Addis Ababa in November 2013, with a local launch, led by the governor of Sindh province held in Pakistan in March 2014. The three foundations committed $15 million to the effort, $5 million from each donor.

Site Selection

During the design period, from late 2013 to early 2014, the PMU selected implementation sites, all underserved lower socio-economic areas that were not served by the government's LHWs or other development partner FP efforts. Among those, it selected areas that were determined to be safer and less volatile, and sought to ensure variation in population density (with the inclusion of both urban and peri-urban towns), socioeconomic background, and ethnic makeup. To facilitate efficient implementation, the PMU also prioritized western and northwestern towns in the city, which were close to Aman's other activities, and sought to select a set of towns adjacent to one another. Based on these criteria, the PMU ultimately selected 18 union councils in four towns—Bin Qasim, Korangi, Landhi, and Malir—to cover its target of 1 million MWRA. Figure 2.2 summarizes key characteristics of the four towns. Three towns—Korangi, Landhi, and Malir—have some common characteristics: they are established lower middle class and urban towns with large Pashtun migrant populations that have been in Karachi for a long time and have assimilated into the local community (with some exceptions). Bin Qasim is a peri-urban, largely fishing community on the coast that has a smaller and newer migrant population.

FIGURE 2.2. SNAPSHOT OF FOUR TOWNS WHERE THE SUKH INITIATIVE WAS IMPLEMENTED

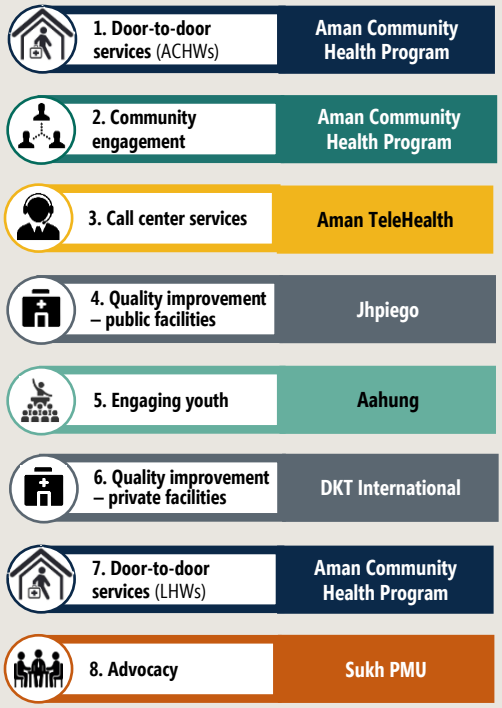
	Town	Location	Key industry	Other characteristics
	Malir	Urban/peri-urban	Army	• More disadvantaged than Landhi and Korangi, though it is gentrifying rapidly • Army cantonment covers a lot of the town • Some go to work in factories in Landhi and Korangi
	Landhi	Urban	Industrial	• Urban slum • Many work in factories
	Korangi	Urban	Industrial	• Highly urban, better off than other towns (good infrastructure) • Industrial zone employs many
	Bin Qasim	Peri-urban	Fishing	• More disadvantaged than Landhi and Korangi • Smaller, but newer migrant population • Coastal community with large fishing industry; men are away at sea for 1-2 months at a time

Malir, Landhi, and Korangi have large Pashtun communities that arrived a long time back and have largely homogenized, but there are pockets that are very traditional and isolated (even not allowing outsiders to enter without permission).

Selection of Solution Levers and Partners

In response to McKinsey's recommendation to assemble a holistic set of supply- and demand-side interventions to address barriers to modern contraceptive use, the donors and PMU identified a range of solution levers for the initiative, and identified implementing partners to lead these solution levers (Figure 2.3). In their selection of interventions and partners, they drew on the successes, learnings, and partnerships of the Packard Foundation, which had been invested in the FP/RH space in Pakistan since 1998, and leveraged the Aman Foundation's NGO arms and existing investments.

FIGURE 2.3. SUKH IMPLEMENTING PARTNERS



To ensure that women received tailored sensitization and services to help increase demand for FP and address unmet need, the initiative envisioned including a large "door-to-door services" or community-based outreach and service delivery component, to be led by one of Aman Foundation's NGO arms, Aman Community Health Program (ACHP). This component focused on underserved areas, that is, neighborhoods within the selected towns that were not covered by government LHWs, and entailed the development of a new cadre of community health workers to conduct outreach and service provision. In response to McKinsey's recommendation to cultivate demand through diverse touch points, ACHP was also tasked with leading a broad-based community engagement effort. Another Aman Foundation NGO entity, Aman TeleHealth, was brought in to run a phone-based outreach effort.

To ensure women sensitized through community and phone-based outreach were able to access long-acting reversible contraception (LARC) and other high-quality FP/RH services at facilities, the initiative brought in Jhpiego, which had developed with Packard Foundation support a strong post-partum family planning (PPFP) model. To reach youth, the initiative also integrated Aahung, another longstanding Packard Foundation partner with deep expertise in life skills/RH education for youth. These first five partners and solution levers (1 to 5 in Figure 2.3) were all brought in to the initiative at roughly the same time—in mid to late 2014. Two other components were integrated later on. In mid-2015, the initiative integrated a private sector effort led by DKT International—intended to expand access to high-quality facility-based services. In mid-2016, ACHP also extended the initiative to LHWs in three of the four intervention towns, who received capacity-building and support to enhance the quality and coverage of their FP-related outreach and service provision.

In addition to the implementation partners shown in Figure 2.3, the initiative also brought in evaluation, communications, and other technical partners to enhance its effectiveness in achieving targeted mCPR and sustainability outcomes. Aga Khan University conducted a baseline and midline assessment of the initiative, focused on measuring preliminary two-year results (2014-2016) and identifying areas for program improvement. RADS, in partnership with Mathematica, conducted the endline evaluation, which focused on capturing overall four-year results (2014-2018) and generating learning on program implementation, sustainability, and scale-up that could be useful to both Pakistani and global stakeholders.

To support dissemination of learning and advance scale-up, the initiative brought in the Johns Hopkins Center for Communication Programs (CCP). As communications partner, their role was to conduct audience mapping and strategic dissemination to promote replication and institutionalization of Sukh solution levers. Also in support of scale-up, ExpandNet was brought in early on to train Sukh staff and members of the provincial government on critical steps to take to position the initiative for scale-up and

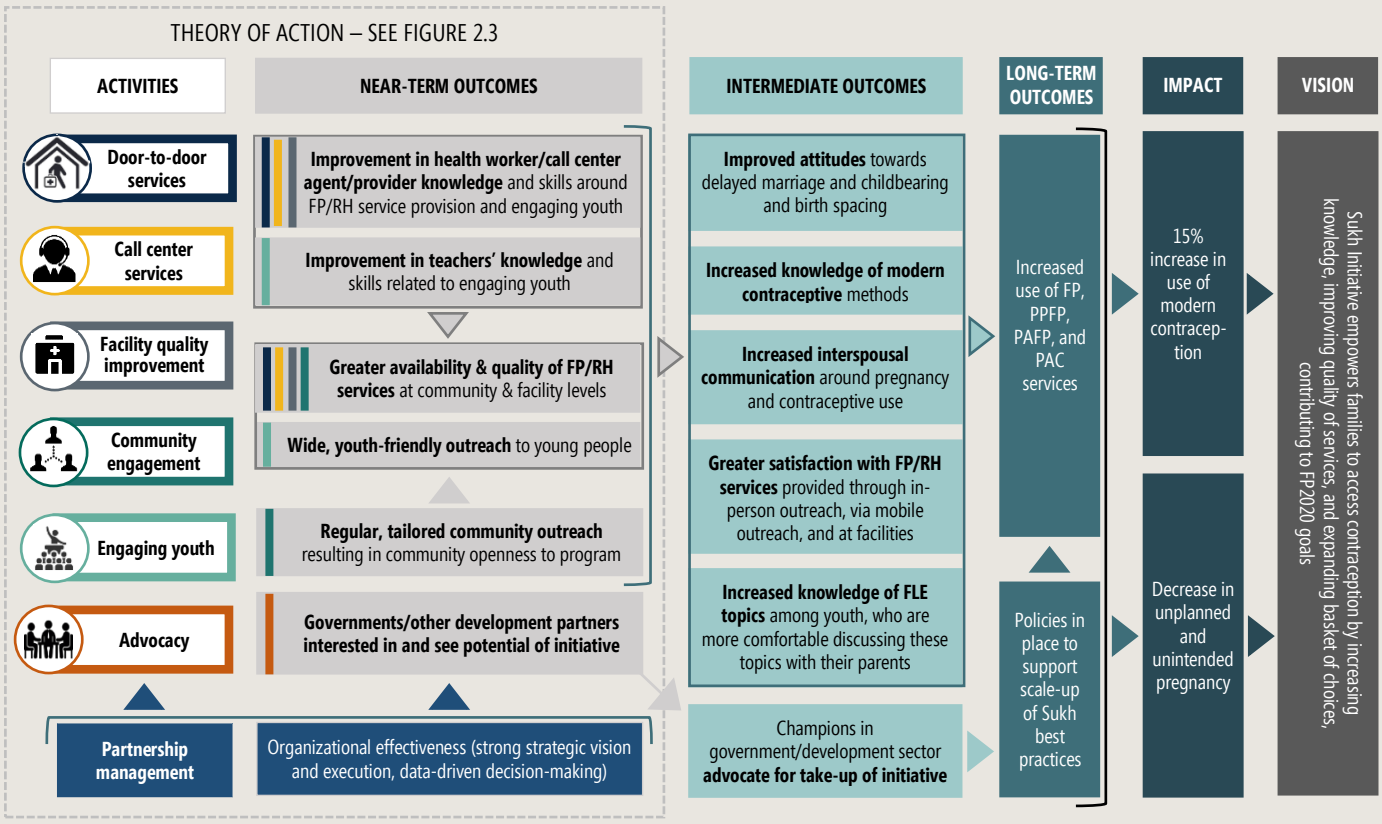
sustainability. The work of each partner, how their activities intersect, and how they are coordinated by the PMU, are described in the Theory of Change (ToC) and Theory of Action (ToA) below.

2.2. THEORY OF CHANGE

Figure 2.4 depicts the Sukh ToC, which builds on the ToC developed by the PMU, adding more detail to guide and structure the endline evaluation. Below, we describe the key components of the ToC, beginning with the initiative's overarching vision and intended impact, and mapping backwards to long-term, intermediate, and near-term outcomes and key initiative activities.

To contribute to Pakistan's FP2020 goals (**vision)**, Sukh aimed to (1) increase mCPR by 15 percentage points among one million MWRA in selected areas in four peri-urban townships of Karachi (Korangi, Landhi, Bin Qasim, and Malir), and (2) enable a decrease in unplanned and unintended pregnancy (**impact**). To achieve this impact, the initiative sought to increase use of FP services in the intervention area (including PPFP and post-abortion family planning [PAFP]). A small component of the initiative also sought to increase use of post-abortion care services in the intervention area. To ensure these **long-term outcomes** were sustained in the intervention geographies, and make their achievement possible on a larger scale, the initiative also had institutionalization goals. Critically, it aimed to ensure that policies

FIGURE 2.4. SUKH INITIATIVE THEORY OF CHANGE



Note: This theory of change diagram draws on the ToC developed by the initiative, adding more detail to flag key areas for measurement.

were in place to support the scale-up of Sukh best practices (through persistent advocacy and building champions within government).

To advance these long-term outcomes, the Sukh Initiative aimed to improve key **intermediate outcomes**, including positive shifts in FP/RH-related knowledge and attitudes, increased interspousal communication and joint decision-making around pregnancy and contraceptive use, and greater satisfaction with services provided as part of the initiative. As mentioned, the initiative also sought to position future generations to make informed, responsible RH decisions. To that end, it sought to empower young men and women with vital information on Family Life Education (FLE) topics, including puberty and related changes, protecting and caring for their own bodies, violence and preventative strategies, maternal health, and healthy nutrition and hygiene. To make progress on these intermediate outcomes, the initiative had several targeted **near-term outcomes**, which are advanced by an integrated set of supply- and demand-side intervention **activities**. The details of these activities and near-term outcomes are captured below in the ToA.

2.3. THEORY OF ACTION

Figure 2.5 represents the Sukh Initiative's ToA. It describes (1) near-term outcomes targeted by the initiative; (2) the key intervention components of the initiative, the activities they entail, and how they intersect with and complement each other; and (3) the organizational architecture that supports the initiative.

Near-Term Outcomes

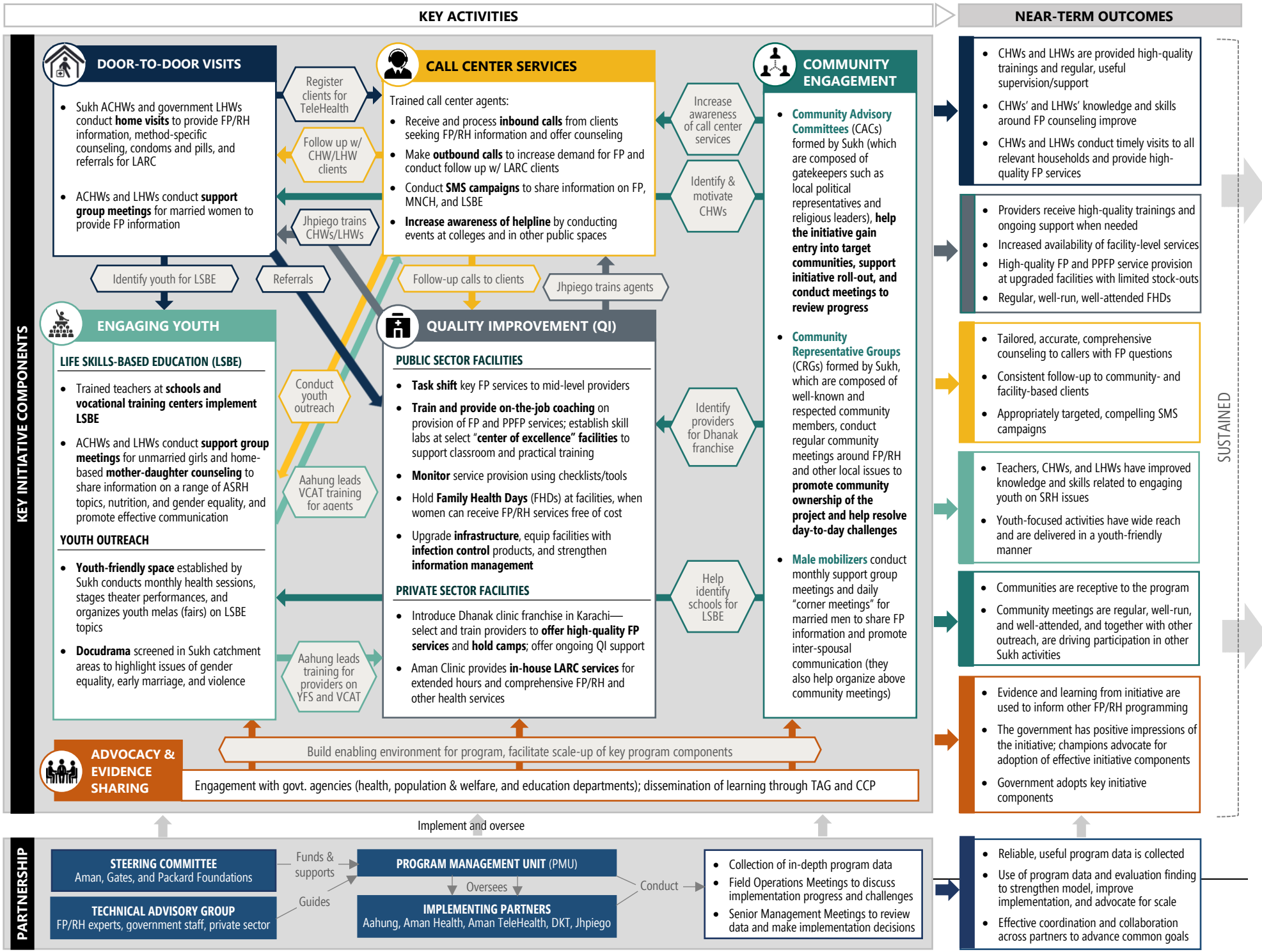
To advance the intermediate outcomes described above, the Sukh Initiative aimed to empower and build the capacity of existing and new FP actors at the community and facility levels (including ACHWs, LHWs, and facility-level providers), generate broad-based community-level support for the initiative and build momentum toward changing FP norms (among critical household and community gatekeepers), and ensure that services and commodities are readily available and delivered with quality.

Key Intiative Components and Activities

Door-to-Door Services

As mentioned, in areas not served by government LHWs, implementing partner ACHP recruited a new cadre of community health workers, ACHWs, who were required to have at least 10 years of formal education and ideally some experience with health mobilization. ACHWs were recruited from the communities being served, and tasked with conducting home visits to MWRA. These visits included provision of FP/RH information, method-specific counseling, FP products (condoms and pills), and referrals to facilities for LARC, emergency contraception, and other FP needs. ACHWs were trained with technical support from Pathfinder International, with the curriculum focusing on FP, post-abortion care (PAC), maternal, newborn, and child health (MNCH), nutrition, health education, interpersonal communication, and community organization.

FIGURE 2.5. SUKH INITIATIVE – THEORY OF ACTION



Eventually, in 2016, the ACHP also integrated LHWs into this community-based service delivery effort in three out of the four towns targeted by the initiative (Bin Qasim, Landhi, and Malir). Home visits were already part of LHWs' mandate, but through in-depth training and ongoing support, Sukh aimed to improve the quality of these visits and the counseling and services provided. ACHWs and LHWs also conducted support group meetings for MWRA twice a month, covering topics related to FP, MNCH, and PAC. ACHWs received Rs. 14,000 a month to engage in Sukh activities (raised at a later date to Rs. 18,000). In addition to their government salary, LHWs received a small stipend from ACHP for conducting the support group meetings.

For the implementation of door-to-door services, the four towns in the implementation area were further divided into 10 field stations with an approximate population of 100,000 each**.** Each field station was staffed by a Field Coordinator in charge of the overall operations, two Community Health Supervisors (CHS), one Social Mobilizer, 20 ACHWs, and five male mobilizers (see community engagement section below for more details on male mobilizers). These field teams launched rollout by conducting a household census and mapping in the catchment area—developing a comprehensive listing of all households and their members to help identify and prioritize MWRA for door-to-door services.

Community Engagement

ACHP established two types of community-level groups to build a supportive environment for the expanded delivery and take-up of FP/RH services. It formed Community Advisory Committees (CACs) (one per 100,000 people—10 altogether), which were composed of community gatekeepers such as local politicians, community elders, and religious leaders. CACs conducted quarterly meetings, which also included other community members. These meetings were intended to build and solidify community acceptance of the program, support the rollout of key initiative components, and review progress. CACs also provided the on-the-ground input needed on several implementation decisions for other Sukh Initiative elements; for instance, they helped to identify providers for the Dhanak franchise and schools for life skills-based education (LSBE) rollout.

ACHP also formed Community Representative Groups (CRGs) (one male and one female CRG per 20,000 people), which were composed of well-known and respected community members with interest in and motivation to make change happen around FP/RH issues. CRGs convened monthly community meetings around FP and other local issues. CRG leaders also reached out to potential FP users, provided basic counseling, and connected them to providers. They visited family members of potential FP users to help obtain their buy-in and support ACHWs in their work.

ACHP also recruited male mobilizers as part of its efforts to build an enabling environment. Like ACHWs, these individuals were expected to have at least 10 years of formal education, fall within the age bracket of 18 to 35 years, be motivated to serve the community, and ideally have some background in mobilization. ACHP tasked male mobilizers with leading the organization and facilitation of the above community meetings, and also conducting additional meetings for married men. These included monthly support group meetings (like those ACHWs and LHWs conducted for MWRA), more informal daily "corner" meetings conducted with smaller groups of married men as they were available, and ad hoc one-on-one meetings. With these interactions, male mobilizers sought to create awareness around healthy timing and spacing of pregnancies (HTSP), FP, PAC, and MNCH. With married men, they also promoted inter-spousal communication.

Call Center Services

Implementing partner Aman TeleHealth launched a dedicated FP/RH helpline, which placed outbound calls to MWRA to share FP/RH information, follow up on conversations with ACHWs and LHWs and visits to facilities, promote adherence, and field questions on side effects. The helpline also processed inbound calls. Call center agents were trained on how to respond to questions on FP, PPFP, PAC, and maternal and child health. They also received training on LSBE topics in order to be able to respond to calls from youth regarding RH issues. To ensure inbound calls could be made privately, and to enable women without a mobile phone to use this offering, Aman TeleHealth also installed phone booths in easily accessible sites in the towns. In addition, the call center had a broader awareness-building focus. It conducted SMS campaigns to share information on key FP/RH topics and also conducted outreach at universities and other public places to spread the word about the helpline to youth.

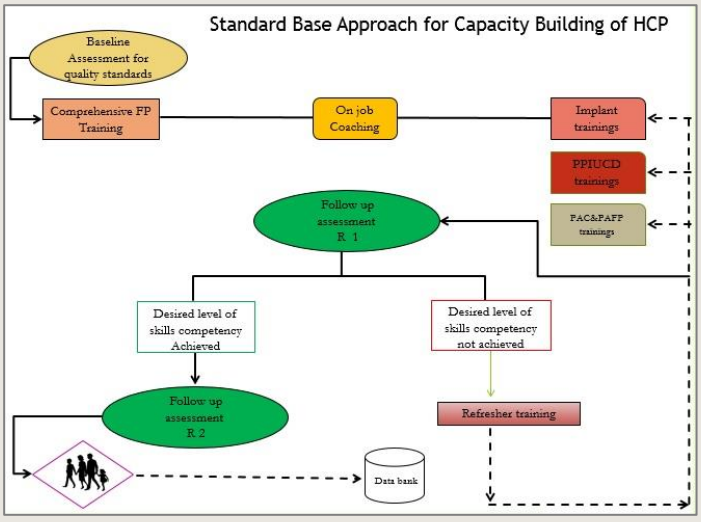
Quality Improvement at Facilities

To ensure that women in its catchment area, including those referred for LARC and other FP/RH services by ACHWs and LHWs, had access to high-quality services at health facilities, Sukh undertook a range of quality improvement efforts at both public and private facilities. Implementing partner Jhpiego worked with public facilities (Figure 2.6), and had a strong focus on infrastructure. It provided support with upgrading overall infrastructure, "rebranding" facilities to attract additional clients, and setting up FP counseling counters and separate areas for PPFP service provision. Jhpiego also sought to ensure availability of commodities by strengthening recordkeeping and information management systems. To motivate improvements in care, Jhpiego rolled out its Standard Based Management and Recognition (SBMR) tool at Sukh facilities, and used it to conduct baseline and follow-up assessments, monitor quality of service provision, and drive action to address identified issues. Finally, Jhpiego provided training to a variety of public providers on comprehensive FP and PPFP packages, PAC and PAFP service provision, infection prevention, youth-friendly services, and values clarification and attitude transformation

FIGURE 2.6. TYPES OF PUBLIC FACILITIES PARTICIPATING IN THE SUKH INITIATIVE

Family Welfare Centers (FWCs)	PWD facilities staffed by Family Welfare Workers who provide all FP services except permanent methods and implants
Reproductive Health Centers	PWD facilities staffed by medical doctors who provide all FP services
Maternal Child Health Centers	Centers run by the Department of Health (DoH), Karachi Municipal Corporation (KMC), and Sindh Employees' Social Security Institution (SESSI) that provide all FP and PPFP methods except permanent methods
Dispensaries	DoH, KMS, and SESSI sites that provide all FP services except permanent methods and implants

FIGURE 2.7. SUKH INITIATIVE'S APPROACH TO PROVIDER CAPACITY-BUILDING IN PUBLIC FACILITIES



Source: Sukh Initiative Year 3 Narrative Report
Note: HCP = health care provider.

(VCAT). This was supplemented with on-the-job coaching on implant insertion and removal, insertion of post-partum intra-uterine contraceptive devices (PPIUCDs), and manual vacuum aspiration (MVA) (see Figure 2.7 for Sukh's approach to training providers).

In addition to taking these steps to improve quality of services, Jhpiego also sought to increase service access. To this end, it established at the health facilities a weekly Family Health Day, when women could receive a range of FP/RH services free of cost. Jhpiego acted as technical advisor to some of the other Sukh implementing partners. For instance, it supported the trainings of ACHWs, LHWs, and call center agents.

DKT Pakistan took the lead on quality improvement at private facilities, selecting and integrating private providers in Karachi into its Dhanak clinic franchise. It provided basic equipment to the providers, established an inventory system to ensure they had a continuous supply of FP commodities, and trained providers (with support from Jhpiego and Aahung) on FP, PPFP, PAFP, and PAC service provision, youth-friendly services, and values clarification and attitude transformation. It also supported them to hold (1) *Heer Apas* (informal teas), which entailed a facilitated discussion around FP, antenatal and postnatal care, nutrition and other related topics, and provision of the basket of choices available at the clinic; and (2) health camps to increase access to and adoption of FP methods. ACHWs and LHWs were asked to refer clients to private facilities when suitable.

To further expand access to services, Aman Clinic was integrated in February 2015. Aman Health Care Services established this facility to offer high-quality primary health care services at an affordable price. Under Sukh, Aman Clinic offered LARC service provision for extended hours and also provided "doorstep" services through a mobile outreach unit.

Engaging Youth

Sukh also sought to influence the next generation and shape future demand for and use of FP/RH services. To do so, it brought in Aahung, which had developed and had been implementing across Karachi and other parts of Sindh a school-based LSBE/FLE program. The LSBE curriculum provides information on puberty and bodily changes, legal age of marriage, gender equality, peer pressure, maternal health, sexual violence, and the importance of planning a family. It also seeks to build critical communication, negotiation, and conflict resolution skills among young men and women. Under Sukh, Aahung implemented LSBE in 28 more schools, rolling out two modules—for classes six and seven and classes eight and nine—covering youth aged 11-16 years. It developed an online version of the curriculum for vocational training centers. As part of Sukh, Aahung also sought to engage with youth through community-based outreach. It trained ACHWs and LHWs to conduct group meetings with unmarried girls and their mothers, which focused mainly on enhancing knowledge related to early marriage. It also trained them to conduct home-based "mother-daughter" counseling; ACHWs and LHWs visited each mother-daughter pair five times and provided information and counseling related to adolescent health, early marriage, gender equality, and nutrition.

Finally, Aahung reached out directly to young people in Sukh areas. It established a Youth-Friendly Space in Korangi, which conducted monthly health sessions on FLE topics, staged plays on these issues, and held youth melas (or fairs), which organized interactive activities such as puppet and music shows, stalls, and quizzes to share SRHR information. Aahung also developed and screened a docudrama in Sukh catchment areas to share messages around gender equality, early marriage, and violence.

Aahung also provided technical assistance on engaging with youth to other Sukh partners. For instance, for the TeleHealth component of the initiative, it trained call center agents on how to respond to questions on RH from adolescents. It also trained providers from Jhpiego and DKT on youth-friendly service provision and VCAT.

Advocacy

Sukh promoted the scale-up of program components and acted as a technical resource to policymakers through outreach to key government agencies. The PMU and implementation partners engaged with the Sindh health, population welfare, and school education and literacy departments and provincial and district committees. This outreach entailed one-on-one meetings with key champions in government at key junctures, as well as participation in regular meetings of technical committees set up by government.

Partnership Structure

As mentioned, a PMU was formed to oversee the Sukh Initiative's work. It supported the development, execution, and refinement of initiative strategy; selected and oversaw the work of partners; conducted advocacy to the government around the take-up of key initiative components; and collected, visualized, and used program monitoring data for decision-making. The PMU was overseen and provided strategic guidance by a donor-led Steering Committee, with which it met on a quarterly basis. It also formed and met on a semi-annual basis with a Pakistan-based TAG, which offered technical support. Finally, as part of its coordination function, it convened implementing partners for monthly meetings to discuss implementation progress and challenges. This structure was intended to ensure that the initiative was identifying and leveraging synergies across its different components and making active use of data, evidence, and learning to test its assumptions and hypotheses, refine the initiative model and implementation approach, and make the case for scale-up.

3. ENDLINE EVALUATION APPROACH

The Sukh endline evaluation effort was part of a larger, multi-partner evaluation effort that sought to inform program improvement, measure the initiative's contribution to targeted outcomes, and capture learnings that could inform potential replication and scale-up. The baseline and midline evaluation assessments, led by AKU, focused on measuring the baseline program context and preliminary, two-year (2014-2016) results to inform the program design and subsequent refinement. The endline effort, led by RADS in partnership with Mathematica, focused on measuring overall four-year (2014-2018) results and identifying key learnings. Below we describe the objectives of and approach to the endline evaluation and data sources used, as well as limitations of the evaluation.

3.1. OVERVIEW OF THE ENDLINE EVALUATION

The objectives of the endline evaluation were to: (1) measure the initiative's contribution to observed changes in targeted FP/RH outcomes in Sukh intervention areas, (2) document and assess how the initiative was implemented and evolved over time and what did and did not work well, (3) assess the sustainability and scalability of key program components, (4) gauge the organizational effectiveness of the partnership structure, and (5) generate learning to help inform decision-making related to replicating and/or scaling program components.

Appendix A presents the specific evaluation and learning questions addressed under the endline evaluation, which were organized around four domains: (1) impact and effectiveness, (2) implementation learning, (3) advocacy and influence, and (4) partnership structure and processes. Our investigation of questions in each domain often featured a mix of quantitative and qualitative data, yielding a mixed-methods approach aimed at improving the rigor and depth of our findings. In particular, the evaluation drew on two large, cross-sectional surveys of MWRA in Sukh's ACHW catchment area, conducted at baseline (2013) by AKU and at endline (2018) by RADS. These data were complemented by and triangulated with data collected through in-depth interviews (IDIs) and focus group discussions (FGDs) with a variety of stakeholders involved in and targeted by the program, as well as a range of secondary data sources, including program documents, program monitoring data collected by the Sukh PMU and its implementing partners, and the Pakistan Demographic and Health Survey (PDHS).

Below, we provide an overview of the four evaluation domains, before discussing in more detail the main data sources used for the evaluation.

1. **Impact and effectiveness.** This domain focused on measuring the Sukh Initiative's contribution to changes in mCPR, as well as a range of other FP/RH outcomes, including knowledge and attitudes, demand for and use of services, and availability and quality of services. It also sought to understand the extent to which and how each component (or "solution lever") contributed to observed shifts in targeted outcomes. To measure changes in outcomes, the evaluation relied on the baseline and endline surveys of MWRAs conducted in 2013 and 2018. However, because the baseline evaluation

design did not allow for inclusion of a credible comparison group—and, in turn, attribution of changes in survey outcomes to Sukh alone—this domain required a contribution analysis approach. Along with survey data, it drew on program monitoring data, qualitative data, and other secondary data sources to build a credible, evidence-based narrative around the initiative's contribution to observed changes in outcomes, using the results chain underlying the initiative's ToC (Figure 2.4) as a framework for the assessment (Mayne 2011). As part of this domain, drawing on implementation findings, the endline evaluation also sought to assess the relative contribution of individual solution levers to observed changes in outcomes.

2. **Implementation learning.** This component examined how the initiative and its multiple solution levers were rolled out, how the initiative was received by on-the-ground implementers (such as ACHWs, facility staff, etc.), the reach and intensity of key activities, and the perceived quality of information and services received by MWRA, married men, and youth. The evaluation also tried to draw out key learnings around implementation successes and challenges and identify promising approaches and practices. Guided by the initiative's theory of action (Figure 2.5), this domain drew on and involved triangulation across survey, program, and qualitative data.

3. **Advocacy and influence.** In addition to assessing the effectiveness of the Sukh Initiative's on-the-ground activities, the evaluation also examined the influence of its advocacy efforts, particularly in promoting and supporting scale-up of program components. In particular, it explored the extent to which government engagement efforts were successful in building an enabling environment for the program, promoting and supporting scale-up of program components, and contributing to ongoing strategy and policy efforts. This component drew largely on interviews with program stakeholders and their interactions with key government officials, as well as publicly available information on policy developments.

4. **Partnership structure and process.** Drawing on a variety of program data and interviews with key program stakeholders, this component assessed the organizational effectiveness of the partnership and the initiative's overall architecture. It explored how the partnership was structured and how the PMU, implementing partners, and Steering Committee interacted and collaborated. It also examined the PMU's approach to managing the partnership, and the extent to which and how it engaged in data-driven decision-making and supported and harmonized partners' efforts to advance the initiative toward its targeted goals and objectives.

3.2. DATA SOURCES AND ANALYTIC APPROACH

Survey of MWRA

As noted above, the endline evaluation drew on survey data collected from MWRA in the Sukh Initiative's ACHW catchment areas across the four intervention towns in 2014-2015, before program activities began, and in 2018, as the initiative was winding down. The baseline survey effort provided pre-program outcome measures, as well as key characteristics of the target population and program context. To measure changes in outcomes over the program period, as well as the reach and intensity of, and experiences with, the program, endline data were collected from MWRA in the same ACHW

catchment areas in 2018, as program activities were ending. Changes in outcomes were estimated by calculating the average change in a given outcome across MWRA in the baseline and endline samples. Endline data were also used to provide descriptive information on program implementation. While the baseline and endline samples were both representative of the ACHW catchment area, the sampling design was slightly different for each round. Below, we provide more detail on the baseline and endline sample and data collection.

Sample Design and Data Collection

Baseline survey data were collected between November 2014 and January 2015 from a sample of 5,140 MWRA across the 10 Sukh field stations. These data were collected by AKU before implementation of program activities to (1) establish a baseline for the impact evaluation and (2) provide benchmarks for target setting, progress measurement, and program decision-making. The second objective required that the data be representative at the station level to enable tracking and decision-making within (as well as across) program management teams. The survey sample was distributed across the stations proportional to their population size, with MWRA in the sample randomly selected using a cluster sampling approach (Aga Khan University 2015). Using a listing of all households in each of the 10 stations (provided by ACHP), each station was divided into blocks of 200 to 250 households. Within each station, blocks were randomly selected for inclusion in the survey, with the number of blocks selected proportional to the population size. From each selected block, 50 households were randomly selected by first selecting one house randomly and approaching every fifth house thereafter until reaching the targeted number of households.[1] As mentioned, the baseline survey only included households in the ACHW catchment areas; it did not include households in areas served by LHWs.

To measure changes in outcomes, as well as program reach, intensity, and perceptions, RADS conducted an endline survey in October 2018, after most Sukh activities had ended. Data were collected from a sample of 3,038 MWRA distributed roughly equally across the four Sukh towns. Within each town, the sample was divided across the stations in the town proportional to the size (population) of the station. Similar to the baseline, the endline survey used a cluster sampling approach, whereby (1) within each station, blocks of 250 households were created from lists provided by ACHP; (2) blocks in each station then were randomly sampled, with the number of blocks selected proportional to the station's population size; and (3) 50 households were randomly in each selected block, with the MWRA within the household selected for the survey. Because RADS did not have information on the clusters (the exact geographical boundaries of the blocks within each station) selected for the baseline survey, the clusters selected at endline were likely different from those included in the baseline sample. However, both the baseline and endline samples were designed to be representative of the ACHW catchment area. In contrast to the baseline sample, the endline sample was not designed to be representative at the station level.

Survey Measures

The endline survey captured information on respondent and household characteristics and a range of outcomes related to knowledge of and attitudes toward FP/RH topics; various components of the

[1] If a household had more than one eligible woman, one woman was randomly selected for the interview. In case of refusals, instructors were instructed to approach the next house walking in the same direction.

program; and availability, quality, and use of FP/RH services (Figure 3.1). It covered topics similar to those in the baseline survey to enable measurement of changes in outcomes over time. However, it also collected additional information to measure the full range of targeted FP/RH outcomes (for example, postpartum and post-abortion FP) and gain insight into the reach, uptake, content, and perceived quality of each solution lever under the initiative (for example, services provided by ACHWs).

FIGURE 3.1. KEY TOPICS COVERED IN MWRA ENDLINE SURVEY

Domain	Topics covered
Respondent and household characteristics	Age; mother tongue/language; literacy and education; occupation; length of time in current location; whether spouse lives with respondent; spouse's age and occupation; duration of current marriage; age at first marriage; whether respondent had a say in choosing husband and timing of marriage; household wealth index
Sources of information	Frequency of consumption of newspaper, radio, television; ever watched docudrama on early marriage; access to mobile phone
Attitudes towards marriage	Age at which boys should get married; age at which girls should get married; benefits of delaying marriage
Attitudes towards timing of and spacing between births	Appropriate age for first pregnancy; appropriate amount of time between pregnancies; benefits of delaying birth; benefits of spacing births
Pregnancy/birth history	Pregnancy and birth history and current status; number of live children, ages, and sex; whether (last) pregnancy was planned
Experiences with most recent delivery	Type of facility; type of provider; satisfaction with provider; antenatal care visits
PAC	Abortion history; perceived benefits of post-abortion care; experience with post-abortion treatment, if applicable
Post-abortion FP	Receipt of information about FP methods; method used, if any
Use of contraceptive methods	Awareness about and use of contraceptive methods; reasons for choosing method; sources of method; reasons for discontinuing method (if applicable); reasons for not using contraceptive methods (if applicable)
FP counseling	Receipt of information about side effects and treatment; experience with any side effects and treatment, if applicable; receipt of information about other methods; experience with FP service provider
Postpartum FP	Receipt of information about postpartum FP; method used, if any
Accessibility of FP services	Awareness about facilities providing FP services in the area and accessibility of services; payment for FP services
Fertility and spacing preferences	Desired fertility and parity; desired spacing; spouse's preferences; intent to use FP; decision-making on contraceptive use
Information about FP	Heard about FP in previous 12 months; source of information and perceived effectiveness of FP messaging
Spousal communication	Communication with husband about timing, spacing, and number of children; communication with husband related to FP use; discussion on other MNCH topics
Home visits and services provided by ACHW	Awareness of ACHW; visits from ACHW; frequency of visits; information provided; discussion on FP methods, benefits, side effects; discussion on FP during pregnancy and after delivery; information about or referrals to Sukh facilities; receipt of any supplies/commodities from ACHW; receipt of informational materials about FP and perceived usefulness
Quality of services provided by ACHW	Most recent visit by ACHW; time spent; whether ACHW talked to mother-in-law or husband during visit; perceptions about quality of ACHW; satisfaction with ACHW services
Mother-daughter counseling	Whether ACHW has visited to speak to respondent and adolescent daughter, if applicable; topics discussed; perceptions about visit and usefulness
Visits by male mobilizers	Whether male mobilizer has spoken to husband about FP

Domain	Topics covered
Community engagement	Community support group meetings on RH/FP, frequency, topics discussed; perceived usefulness; visits by community influencer; youth-focused meetings to discuss RH, topics discussed; acceptability of talking to youth about RH/FP issues
Facility services for FP or delivery care	Visits to facility for FP or delivery care; type of facility visited; access to facility; availability and experience with FP services at facility; quality of services
Family Health Days (FHDs)	Awareness of FHDs; participation in and perceived usefulness of FHDs
Aman TeleHealth services	Awareness of Aman TeleHealth services; use of telehealth services; perceived quality of services

Analytic Approach

Drawing on the baseline and endline surveys, we conducted a pre-post analysis to examine changes over time in key targeted outcomes. However, because the baseline and endline samples included a different cross-section of MWRA from the ACHW catchment areas, we first examined differences in respondent and household characteristics at baseline and endline. We found statistically significant differences in the education and mother tongue of survey respondents across the two rounds, possibly because of sampling differences across the two rounds and high migration. To account for these differences, we reweighted the baseline sample to match the proportion of the MWRA in the endline sample in each education subgroup (no education, primary, middle school, and more than middle school) and for whom the mother tongue was Urdu. Appendix Table A1 summarizes the characteristics of the reweighted baseline and endline MWRA samples. We then estimated changes in a regression framework and included sampling weights to account for differing sampling probabilities, as well as the reweighting. The pre-post analysis was limited to the outcomes for which there were comparable measures at baseline and endline. For outcomes available only in the endline survey, we provide descriptive statistics.

As mentioned, the survey was also used to provide descriptive information on program reach, intensity, and experiences among MWRA.

Qualitative Data

The endline evaluation also drew on extensive qualitative data collection with a variety of stakeholders—including those receiving, implementing, overseeing, and supporting program interventions. These included (1) MWRA, married men, and their key influencers (mothers/mothers-in-law); (2) youth; (3) on-the-ground implementers of program activities, including ACHWs, LHWs, call center agents, public and private providers, and teachers; (4) program staff at the PMU and implementing partner organizations; and (5) government officials. FGDs and IDIs with these stakeholders provided insight into how the initiative was rolled out and perceived on the ground, key contextual and program-specific factors influencing program implementation and outcomes, prospects for scale-up, and the organizational effectiveness of the initiative. In total, we conducted 122 FGDs or IDIs, collecting data from 260 respondents. Data were collected in March 2019, and supplementary interviews were conducted in March 2020 with an additional set of LHWs to learn more about their participation in the initiative. Figure 3.2 provides more detail on the qualitative sample and data collection approach.

FIGURE 3.2. RESPONDENTS FOR QUALITATIVE DATA COLLECTION

Stakeholder	Method	# of FGDs/IDIs	# of participants	Selection approach
Beneficiaries and influencers				
MWRA	IDI	20	20	5 IDIs per township
	FGD	2	20	1 FGD per township, where possible
Married men	FGD	4	32	1 FGD per township
Mothers/mothers-in-law	FGD	4	29	1 FGD per township
Unmarried girls (school-going)	FGD	3	24	Random selection of 1 girls' school and 1 boys' school per township; FGD with girls and boys who received LSBE in grades 7-9
Unmarried boys (school-going)	FGD	3	28	
Unmarried girls (out of school)	FGD	4	25	1 FGD per township with out-of-school girls who participated in support groups or family counseling
On-the-ground implementers				
ACHWs	IDI	11	11	3 IDIs per township
Male mobilizers	IDI	4	4	1 IDI per township
LHWs	IDI	20	20	2 IDIs per township in first round, and 4 IDIs per township in second round
Public providers	IDI	9	9	Random selection of 5 family welfare centers, 1 reproductive health center, 2 maternal child health centers, and 2 dispensaries that Jhpiego worked with; IDIs with doctors, LHVs, or other staff members trained by Jhpiego at these facilities
Private providers	IDI	8	8	Random selection of 2 DKT clinics per town
Call center staff	IDI	4	4	IDIs with trained call center agents as available during half-day period
Teachers	IDI	6	6	2 IDIs per town, per school, with one male and one female teacher (teacher at vocational training center to be included if possible)
Stakeholders managing and guiding initiative				
Sukh initiative and partner staff	IDI	12	12	Key staff at Sukh Initiative PMU and implementing partner organizations
Donor representatives	IDI	7	7	Steering group members
Key FP/RH actors in Pakistan				
Government officials	IDI	1	1	Population and Welfare Department
Total		122	260	

IDIs and FGDs were recorded and transcribed verbatim and then translated from Urdu into English. They were then coded using a qualitative analysis software package (NVivo) based on a detailed coding scheme. We systematically reviewed coded data to compile evidence around the key learning questions. We triangulated this information with our analysis of the survey and program data.

Service Delivery Assessments

RADS conducted service delivery assessments (SDAs) at a sample of facilities at endline. Facilities were selected from a list of Sukh-supported public and private sector health facilities obtained from the PMU. From this list, a total of 10 public sector facilities supported by Jhpiego were selected: 5 Family Welfare Centers, 2 Maternal and Child Health centers, 2 dispensaries, and 1 Reproductive Health Center. In addition, 12 private sector facilities were selected: 2 DKT clinics per town and 4 Aman clinics. Facility assessment tools were adapted from those that had been used in prior evaluations and validated for use in Pakistan. Clinical vignettes, also adapted from previous evaluations in Pakistan, were used to assess the capabilities and quality of services delivered by providers at selected clinics. Quality of services provided by health care providers was assessed using clinical vignettes.

The SDA instruments captured information on facility infrastructure, equipment, and supplies; availability of FP/RH services; training received by and knowledge of providers; and service delivery processes. Because the assessments were done at one point in time, at endline, they only provide a snapshot of service delivery quality at the end of the initiative. In addition, SDAs were not conducted at comparison facilities, so the evaluation team was not able to compare quality in Sukh-supported facilities to that in similar non-Sukh facilities, or to draw definitive conclusions about the impact of Sukh on service delivery quality at participating facilities. Instead, the SDAs were used to validate other data and reports on support provided to facilities under Sukh, and to gain additional insight into the availability and quality of services available to women in Sukh intervention areas at the time of the endline assessment.

Sukh Program Data

To measure program rollout, reach, and intensity, we drew on the monitoring data collected by the Sukh PMU. The bulk of these data came from ACHWs and LHWs, who recorded information on the door-to-door visits they conducted as well as key target outcomes of the initiative including the number of contraceptive methods distributed and use of contraception. These data were collected and synthesized manually for the first few years of the initiative, but in Year 4, ACHP operationalized electronic data collection, which entailed ACHWs and LHWs collecting these data through mobile applications on Android tablets. The data were aggregated and displayed on a web interface to facilitate program management and decision-making at the station level as well as across the implementation sites. This web platform also integrated some data from other implementing partners, though the focus was on the door-to-door services component of the initiative.

In addition to using monitoring data maintained by the PMU and implementing partners, we leveraged the many program documents generated by the initiative to describe the program's implementation and detail key successes and challenges. These included annual narrative reports (both the aggregate reports from the PMU as well as reports from individual implementing partners); the McKinsey landscape and partner assessments; Sukh's implementation, training, community mobilization, and communications strategies; Sukh's implementation mapping; and reports from other evaluations, such as Aahung's family counseling cohort study.

3.3. EVALUATION LIMITATIONS

- **The lack of a comparison group does not allow for attribution of changes in outcomes to Sukh alone, or to specific components.** As noted above, the baseline survey conducted by AKU did not include data collection in a comparison area where program activities were not implemented. A comparison group design would have helped distinguish program effects from secular trends by comparing changes in outcomes in comparison areas to those in intervention areas, with changes in the comparison areas representing a counterfactual (what would have happened in the absence of the program). At endline, in consultation between the Sukh PMU, the Steering Committee, a decision was made to not construct a comparison group using retrospective data on outcome measures. Given that Sukh towns were purposively selected (as described in Chapter 2) and other health-related programs were being implemented concurrently in other towns in Karachi, identifying a credible comparison group would have been challenging. Moreover, the 2012-2013 PDHS was not representative at the town or Karachi level, limiting its usefulness for identifying a comparison area or broader secular trends in Karachi over the program period. To address this shortcoming, the endline evaluation adopted a contribution analysis approach to assessing the impact of the initiative, using the initiative's ToC and ToA and multiple quantitative and qualitative data sources to develop a plausible, evidence-based narrative around the initiative's effects on targeted outcomes.

- **Differences in sample and survey design across rounds**. As mentioned above, the baseline and endline surveys were conducted by different organizations and used slightly different sampling designs. Moreover, there was insufficient information to identify clusters sampled at baseline and sample from the same clusters at endline, which could have resulted in differences between MWRA sampled at baseline and endline. In addition, while the endline survey was designed to ensure that baseline questions used to measure key outcomes were captured and asked in a comparable way, some changes were made to the endline survey to improve the flow and organization of the survey, which could have elicited slightly different responses. Moreover, there were data quality issues at baseline and endline which led to dropping some key outcomes, such as the source of contraceptive methods.

- **Survey did not cover LHW areas.** The baseline MWRA survey only included ACHW catchment areas in the four intervention towns because, at the outset, the initiative did not intend to include areas already served by LHWs. As noted in the previous chapter, the LHW component began substantially later than other program components—in 2016. To assess implementation and results in LHW areas, the endline assessment relied on in-depth qualitative data collection with LHWs, MWRA served by LHWs, implementing partner staff supporting LHWs, and government staff overseeing the LHW program.

- **Lack of a population-based youth survey.** Although the initiative targeted youth, no baseline or follow-up surveys were conducted with youth, precluding an assessment of changes over time in targeted youth outcomes in Sukh catchment areas. However, a small share of youth in the Sukh catchment area were reached through the youth component, making qualitative interviews more suitable to assess the impact of the youth component. RADS faced some challenges with the qualitative data collection from youth. At one school, respondents seemed to have advance

knowledge of the questions they were asked and provided prepared answers. Interviews conducted at this school were excluded from the analysis.

- **Lack of baseline facility assessments to measure changes in quality.** The baseline data collection effort did not include health facility assessments that could be used to assess changes in quality in participating facilities over the course of the initiative. However, to gain insight into changes in the quality and availability of FP/RH services, the baseline and endline surveys included questions about the availability, content, and perceived quality of services received by MWRA.

- **Challenges in accessing comprehensive, consistent program data.** The program data enabled us to develop a picture of the rollout and implementation of the initiative, and triangulate information from the survey, but it had some limitations. The data underlying the web platform were difficult to access, requiring us to hire consultants to visit ACHS' offices and obtain the data. Further, disaggregated data were not always available. For example, some indicators were not available at the town level, to help trace variation in implementation across the towns. And change over time was tracked using different time periods/intervals for different indicators, which made it challenging to tell a consistent story of how implementation varied over the course of the initiative. Overall, data maintained by the PMU on components of the initiative other than door-to-door services were more limited and harder to access and tabulate. Our review of annual reports and other program documents helped to fill some of these gaps.

- **Inability to isolate impacts of individual intervention components.** By design, the Sukh initiative's intervention components were closely integrated to advance joint goals, making it difficult to measure their effectiveness in isolation. However, we drew on and triangulated across survey, program, and qualitative data sources to gain insight into how individual intervention components may have contributed to observed changes in outcomes.

4. FINDINGS: IMPLEMENTATION OF THE INITIATIVE

This chapter provides an overview of implementation across partners and summary findings, followed by more detailed findings on implementation successes and challenges by program component and the operational effectiveness of the Sukh Initiative. Our goal is to offer insight into the strength of each component's implementation, and the extent to which components worked in sync with each other as designed and planned, thereby enabling us (in the next chapter) to pinpoint the aspects of the initiative that drove impacts and how. The implementation analysis also yielded lessons about how to successfully roll out and harness the potential of a multi-partner, multi-component initiative like the Sukh Initiative, which are summarized in Chapter 6.

SUMMARY FINDINGS: SCOPE, REACH, AND QUALITY OF IMPLEMENTATION

- **Door-to-door services were well-executed, reaching a large number of MWRA and providing largely high-quality home visits.** This component was central to the initiative's goals, helping to address critical gaps in access to FP/RH services in the intervention area and serve as the "glue" between other initiative components. It thus received a sizeable proportion of initiative funds, with which ACHP built a new cadre of around 230 ACHWs, trained and strengthened the capacity of around 200 LHWs (Figure 4.1), and set up an extensive supervision and monitoring system to support ACHWs and LHWs and keep them accountable. To set up this extensive field-level infrastructure, ACHP relied heavily on one of its community engagement platforms, Community Advisory Committees, composed of local political and religious leaders. These bodies helped ACHP gain entry into highly conservative communities in the intervention area and make it acceptable for ACHWs to visit households and discuss sensitive FP/RH issues with MWRA.

  Leveraging this community buy-in and ACHP's field-level support, ACHWs and LHWs conducted regular home visits and achieved wide coverage in their areas. Program data indicate that over 160,000 MWRA were reached by ACHWs and LHWs (Figure 4.1), and around three-quarters of endline survey respondents reported receiving door-to-door services by ACHWs. The visits were well-received by MWRA, who appreciated the doorstep access to FP methods and counseling. The majority of endline survey respondents (over 90 percent) expressed that ACHWs were knowledgeable, respectful, and trustworthy.

- **Facility-level quality improvement had more mixed success—establishing strong capabilities around FP/RH outreach and service provision, but facing implementation challenges linked to contextual hurdles (particularly in the private sector).** Jhpiego and DKT helped to build new skills related to implant insertion and PPFP among public providers and the range of FP services offered by private providers (respectively), and made critical upgrades to over 80 facilities (Figure 4.1). However, these services appeared to have low reach. Only 15 percent of endline survey respondents had visited a facility for FP or delivery services in the six months prior to the survey.* This low reach was likely driven by limited mobility among MWRA, a hard-to-surmount demand-side challenge. The private sector quality improvement efforts were additionally constrained by supply-side issues. Ownership and commitment to quality among DKT's providers were low, due to the availability of more lucrative opportunities in Karachi, which resulted in several providers leaving or being dropped from the franchise. The private sector component also had more limited impact because it was in operation for a shorter time than other components—about two years.**

---

* Program data on FP service delivery are unavailable for the private sector component and only available for years 3 to 5 for the public sector component (Figure 4.1).

** The PMU commissioned a mapping to better understand the profile and capacity of private sector FP/RH service providers in Karachi prior to selecting a partner and designing this component.

- **Given it did not directly advance the initiative's goal of increasing mCPR, the scope of the youth engagement component was narrowed early on; however, school-based LSBE did make strides in improving students' sexual and reproductive health and rights (SRHR) knowledge.** Aahung expanded its tried and tested school-based LSBE model to 28 schools in Karachi, training 120 teachers on the course and building the support of school leaders and parents to ensure the long-term sustainability of the course (Figure 4.1). With LSBE classes held once or twice a week, students' knowledge of topics related to puberty, marital rights, and gender-based violence improved. Community-level efforts focused on out-of-school youth were well-received by on-the-ground implementers, particularly LHWs, but were too narrow in in scope and intensity to have a significant influence on youth. Only 30 ACHWs and 30 LHWs were trained on family counseling, reaching 1,600 youth over one year of implementation. The Youth-Friendly Space was delayed in opening due to infrastructural hurdles, wound down early, and was active a little more than a year. The ACHW and LHW support groups for youth operated for longer and reached over 50,000 out-of-school girls, but were "one-touch" sessions, focused on improving factual knowledge around a very narrow set of topics (Figure 4.1). These community-based activities also faced substantial parental pushback, which made implementation challenging.

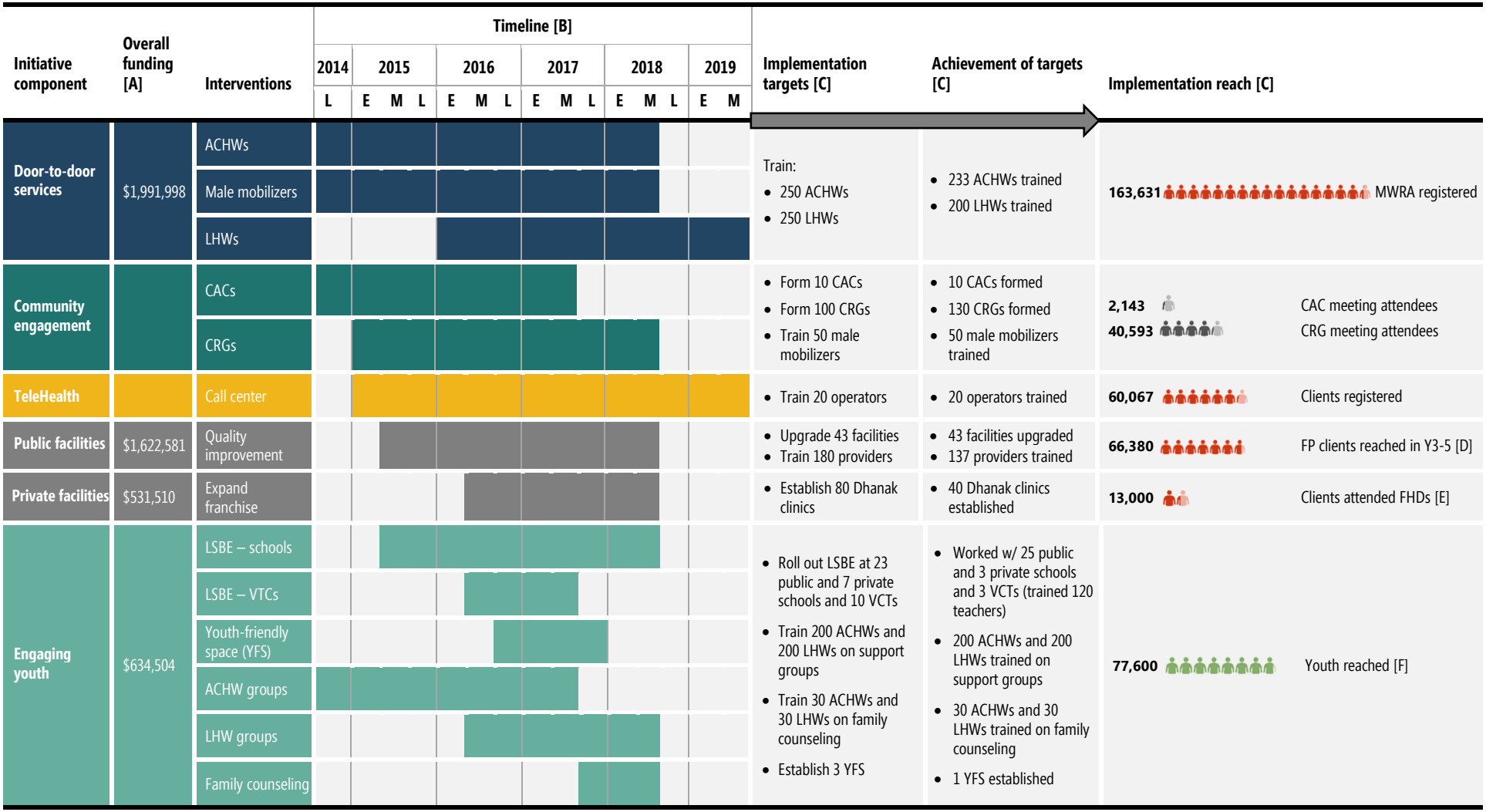
- **Call center services and male engagement were not designed to grapple with key contextual challenges.** Call center services registered over 60,000 MWRA (Figure 4.1), but their reach thereafter was limited. Program data indicate that only 1 to 4 percent of yearly incoming calls focused on FP. In addition, only 4 percent of endline survey respondents had received an outbound call from TeleHealth in the prior 12 months. This minimal reach was due mainly to mobile phone ownership being very low among MWRA. With limited access to their own phones, women were disinclined to place or receive calls to discuss private FP/RH issues, a status quo that is unlikely to change soon. Outreach by male mobilizers to married men was similarly encumbered; support group meetings were halted and corner meetings were held sporadically because men were away for work during the day and hard to reach. Alternative mechanisms for reaching married men—that grapple with these very real access barriers—may need to be explored. For instance, mobile outreach could be diverted to target men, given they have greater access to mobile phones and are so difficult to reach through in-person activities.

- **Connections between different components of the initiative were often weak, which led to missed opportunities for increasing program effectiveness.** The Sukh Initiative was designed to have key interventions feed into and leverage each other's efforts, but this occurred inconsistently. The most successful linkage in the initiative was between the door-to-door services component and the CACs, which helped the initiative gain a foothold in the community and ease the way for ACHWs to begin conducting home visits. Additionally, Jhpiego acted as a strong technical trainer, building capacity on FP/RH counseling and service provision among public providers, private providers, call center agents, ACHWs, and LHWs. However, other key linkages were weaker. The youth component was most distantly linked with the rest, given its focus on a relatively distinct target population. In addition, there were low rates of referral to facilities by ACHWs, LHWs, and call center agents. It was unclear how Community Representative Groups (CRGs) were supporting door-to-door services and other initiative components. And outreach to married men was not systematically aligned with door-to-door services to MWRA. These low levels of integration may have been driven by the limited coordination and collaboration among partners and the somewhat circumscribed strategy role played by the PMU (see below).

- **Through consistent, strategic engagement with government, Sukh enabled the scale-up of several of its key components.** The initiative engaged closely with the government from the start of the program to increase awareness of its work, share updates, and make the case for scale-up of best practices. These efforts yielded several advocacy wins, including large-scale task shifting of key FP services (implant insertion and administering the first injection) to mid-level providers, adoption and rollout of LSBE to schools across Sindh, a new PPFP policy, and potentially, adoption of Sukh's LHW model.

- **The PMU was a skillful manager of process, keeping multiple partners on track to meet initiative goals, but could have played a stronger learning role.** The PMU played an important role in identifying and bringing implementation partners on board, developing the scopes of work for these organizations, getting resources out to them, and holding them accountable to the identified goals and timelines. However, it did not always look strategically across these partners to leverage synergies and strengthen the initiative's internal cohesion. It also missed opportunities for learning. Implementing partner staff felt that while they met frequently to coordinate, these meetings could have been used more effectively to facilitate idea-sharing. Key informants felt that Sukh's expansive program data collection and visualization efforts were used mainly for reporting and tracking targets, rather than more in-depth analysis to inform decision-making on the ground.

FIGURE 4.1. ROLLOUT AND IMPLEMENTATION OF KEY INITIATIVE COMPONENTS



[A] Amounts provided by the PMU. DKT's and Aahung's amounts, provided in yearly increments in Pakistani rupees, were converted to USD using the exchange rates at the end of each reporting period.

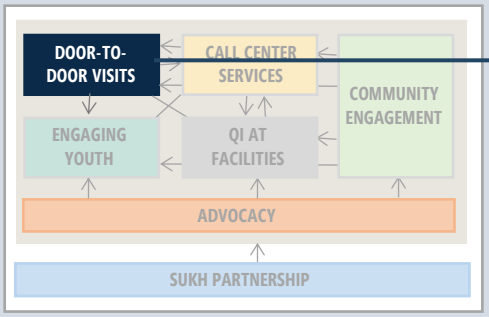
[B] E = Early, M = Mid, and L = Late.

[C] Sources = Sukh program data, Sukh narrative reports, and implementing partner narrative reports. Note that these are illustrative indicators. More details on breadth of operationalization and reach of implementation are provided below, in the sections covering individual components of the initiative.

[D] Prior to Y3, clients were being referred to all PWD and DoH facilities in the Sukh area, not just those selected for capacity-building under Sukh.

[E] Data on FP clients served outside of FHDs were inconsistently available. **[F]** 16,000 youth reached through school-level LSBE, 50,400 through support groups, 1,600 through family counseling, 600 registered at the youth-friendly space, 3,000 reached through theater performances, and 6,000 through youth *melas*. Not included are Aahung's estimates for people reached through its airing of two docudramas.

4.1. DOOR-TO-DOOR SERVICES



- ACHWs and LHWs conduct **home visits** to provide FP counseling, condoms and pills, referrals for LARC
- ACHWs and LHWs conduct **support group meetings** for married women to provide FP information

SUMMARY FINDINGS

Door-to-door services were rolled out efficiently, had expansive reach, and entailed high-quality home visits. ACHWs reached over 160,000 MWRA, including 75 percent of women residing in ACHW areas at endline. MWRA in both ACHW and LHW areas reported getting visits at least once every few months, were grateful for the easy availability of FP commodities at their doorstep, and felt that ACHWs and LHWs were respectful and knowledgeable about FP methods. The success of this component is due in part to the intensive trainings, supportive supervision, and monitoring provided by ACHP. ACHWs and LHWs noted that they gained vital new FP information and gained critical counseling skills through the trainings. Once implementation began, ACHP field staff guided ACHWs at every turn—developing workplans for visits, tackling difficult cases, and resolving stock-outs—and also provided substantial accountability and oversight to LHWs.

Our analysis also indicated some challenges under this component. While ACHWs and LHWs provided detailed counseling on FP methods, they did not always provide information on side effects and how to address them. Additionally, linkages to facilities and call center services could have been stronger. Of endline respondents who had been visited by an ACHW, fewer than half had received a referral to a Sukh facility. Only 13 percent of endline respondents had received information about the call center from an ACHW or LHW.

Rollout of Door-to-Door Services

Both ACHWs and LHWs showed a high level of appreciation for the trainings—especially guidance on how to "counsel" clients rather than merely provide information—and LHWs were grateful for training on how to administer injectables. Both ACHWs and LHWs felt the trainings built their confidence in speaking about FP within the community, a daunting prospect for many given the taboo nature of the topic. Specifically, they said the training taught them to not be ashamed of sharing information on FP and to broach the topic openly and without reserve, which ultimately allowed for more productive conversations. Additionally, they noted that the coaching they received on *how* to offer FP information was new, teaching them how to (1) "build up" to conversations about FP and (2) actively listen to and align counseling with clients' preferences. LHWs also appreciated the in-depth nature of the technical aspects of the training, including what steps to take before providing the first dose of the injectable contraceptive (a new task that shifted to LHWs under Sukh).

The government's rollout of other priority health programming created inefficiencies in door-to-door service provision—affecting ACHW retention and LHWs' focus on FP. Retention of trained ACHWs and male mobilizers was challenging due to higher-paying polio campaigns. At one point, the number of ACHWs dropped to less than 150, though 233 had been trained in total. To address this issue, the Sukh PMU asked the DoH to avoid recruiting ACHWs for their polio campaigns, and also offered medical benefits to ACHWs to promote retention. LHWs' work was also affected by the government's prioritization of other health programming. As mentioned, ACHP hoped to expand LHWs' focus on FP; in the past, LHWs had spent around 6 percent of their time an FP, but with ACHP's advocacy, the DoH had committed to increasing this to 50 percent (Oxford Policy Management Group, LHW assessment 2008). However, this transition did not take place until nearly the end of the initiative when DoH started hiring private workers for immunization campaigns to relieve LHWs for other tasks.

> *"Before Sukh our mind set was to register houses and to tell the people about family planning and at the start of the visit we used to hesitate…But now after the training, we know the art of bringing the client closer, like by asking her about her child and then gradually asking about the milk she is giving the baby and then about family planning. We build up the conversation instead of being blunt."*
>
> *- LHW*

Reach and Intensity of Door-to-Door Services

ACHW door-to-door services reached around three- quarters of MWRA, and visits by ACHWs and LHWs were relatively frequent. Though Sukh did not fully "saturate" its intervention area, it did provide wide coverage, with around 75 percent of endline survey respondents reporting that they had received a visit from an ACHW. Visits were relatively frequent, and roughly aligned with ACHP's recommended frequency of once every three months. Two-thirds of women reported receiving a visit every two to six months, and one-fifth reported being visited at least once a month (Figure 4.3).

Although LHW areas were not included in the MWRA survey, qualitative interviews with MWRA indicated the LHW visits were also conducted fairly regularly, about once a month or once every few months. LHWs explained that they visited these households frequently because of the highly conservative nature of the communities, noting that shifting attitudes and changing behaviors required repeat visits.

FIGURE 4.3. MWRAS' EXPOSURE TO DOOR-TO-DOOR VISITS BY ACHWS

.	Sample size	Mean (%)
Ever received home visit from any health worker	3,038	81.8
Aware of ACHW in area	3,035	76.7
Ever received home visit from ACHW	3,024	74.6
Frequency of visits by ACHW (respondents who have received a visit from an ACHW)		
Every week	2,211	0.8
Less than every week but at least once in a month	2,211	16.5
Less than once a month but at least once in six months	2,211	65.1
Rarely/no schedule	2,208	17.5

Source: Endline survey data.

ACHWs and LHWs did not follow household prioritization criteria closely, but did target pregnant women and new mothers in their

FIGURE 4.4. PRIORITIZATION AMONG CLIENTS FOR DOOR-TO-DOOR SERVICES

Characteristics of respondents receiving door-to-door services

	Ever received a home visit from ACHW	Never received a home visit from ACHW
Mean age (years)	31.2	30.9
Pregnancy and birth history		
Currently pregnant	7.3	9.1
Ever given birth	92.7	88.5
Mean age at time of first birth (years)	20.9	20.9
Mean number of children alive	3.0	2.7
SAMPLE SIZE[1]	2,259	765

Source: Endline survey data.
[1] Sample size for mean age at time of first birth is 2,080 for women who have received a visit and 673 for women who have never received a visit.

FP counseling provided by ACHWs to women who had been pregnant in the past 2 years

	Sample size	Mean (%)
Discussed FP during pregnancy	732	71.9
Discussed FP after delivery	722	71.5

Source: Endline survey data.

visits. ACHP had ACHWs conduct a mapping to identify and prioritize certain subsets of women for door-to-door services, including those from lower-income quintiles, women below 30 years of age, and women with two living children or less. Young MWRA and non-users of FP were to be targeted for immediate services and those considering FP were to be revisited within two weeks of the initial visit. For LHWs, ACHP also aimed to improve the method mix by having LHWs focus on LARC among low-parity women, providing injections or referrals for IUCDs and implants. Our survey data, however, suggest that this type of detailed prioritization of household visits was rare among ACHWs and LHWs. In ACHW areas, there were no notable differences in characteristics such as age, age at time of first birth, and number of children between women who had received a visit from an ACHW and those who had never received a visit (Figure 4.4). ACHWs did seem to be targeting pregnant women and new mothers. Seventy-two percent of women who had been pregnant in two years prior to the survey reported that the ACHW discussed FP with them during their pregnancy, and the same proportion reported that FP was discussed with them after delivery (Figure 4.4).

Qualitative data on LHW service provision suggests that LHWs also did not follow very detailed criteria for prioritizing household visits. MWRA interview respondents reported that LHWs began to visit either after they got pregnant or after one of their children was born. (It was unclear after which child, and whether parity was a factor in determining whether a household would be targeted for door-to-door services). This is in line with LHWs' overarching focus on maternal and child health rather than FP, which ACHP started to shift through its training and capacity-building, but is a deeply entrenched status quo that may need longer to transform.

Quality of Door-to-Door Services

ACHWs and LHWs built strong, trusting relationships with MWRA, increased access to modern methods, and provided detailed, but not always comprehensive counseling on FP. However, referrals were relatively infrequent and LHWs faced challenges engaging with migrant households.

FIGURE 4.5. MWRAs' PERCEPTIONS OF ACHW VISITS

	Sample size	Mean
Satisfaction with ACHW		
ACHW knowledgeable about FP	2,000	96.5
Felt comfortable asking questions about FP	2,258	90.9
ACHW good at answering respondent's questions	2,250	94.5
ACHW treats respondent with respect	2,258	99.6
ACHW would be helpful if respondent wanted a discussion with husband about initiating FP	1,576	78.3
ACHW likely to be available when respondent needs help	1,594	77.7
Would use services provided by ACHW in the future	1,827	72.1
Recommend services provided by ACHW to a friend or family member	1,851	78.4

Source: Endline survey data.

- **Women generally reported very high levels of satisfaction with door-to-door services, noting that ACHWs and LHWs were knowledgeable, respectful, and trustworthy.** Over 90 percent of endline respondents who had been visited by an ACHW felt that the ACHW was knowledgeable about FP, they could comfortably ask her questions about FP, she was good at answering questions, and she treated them with respect (Figure 4.5). (Only about 70 percent said they would use the services provided by the ACHW in the future and 78 percent would recommend the ACHW to a friend, but this may be because the services had ended at the time of endline data collection.) MWRA were similarly appreciative of LHWs' services. They frequently used the words "nice" and "trustworthy" to describe these health workers, and indicated a general openness to having them visit and discuss FP.

> *"It will be very difficult for me to buy contraceptives from the market. [The LHW] is making things very easy for us… It will be impossible to use contraceptive if health worker stops coming to our houses."*
>
> *- MWRA*

- **MWRAs appreciated the greater accessibility to contraception that door-to-door services provided.** MWRAs almost uniformly noted that they would have more limited access to FP methods if ACHWs and LHWs were to stop their visits. Visiting shops to procure contraceptives was considered inappropriate and interview respondents were very grateful that these health workers made FP methods available in the privacy of their homes. Around 35 percent of endline respondents visited by an ACHW reported receiving contraception from her (Figure 4.6).

- **ACHWs and LHWs provided detailed counseling on the range of methods available, but did not always share information on potential side effects.** Among MWRA who had received a visit from an ACHW, just above 80 percent had received some counseling on modern methods from the ACHW, but only around 40 percent reported that the ACHW had discussed side effects of the methods (Figure 4.6). This may be due to visits being rather short—only about 40 percent of endline survey respondents who had been visited by an ACHW reported that the health worker had spent more than 10 minutes in their house during the most recent visit.

FIGURE 4.6. QUALITY OF VISITS BY ACHWS

	Sample size	Mean
Supplies provided by ACHW (respondents who have received a visit from an ACHW):		
Received any supplies from ACHW	2,181	41.5
Received FP commodities from ACHW (condoms, pills, ECP, injections)	2,181	35.2
ACHW shared phone number (respondents who have received a visit from an ACHW)	2,127	23.5
FP counseling by ACHW (respondents who have received a visit from an ACHW):		
Talked to respondent about any modern method	2,102	81.5
Explained benefits of using FP	2,028	71
Discussed possible side effects of using FP	1,956	46
Informed what to do if experienced side effects	1,895	40.8
Most recent visit by ACHW		
Spent more than 10 minutes in respondent's house	2,258	41.5
Talked to husband	2,175	3
Talked to mother-in-law	2,151	15.3
Referrals to health care facilities by ACHW (respondents who have received a visit from an ACHW):		
Talked to respondent about Sukh referral health care facilities in the area	1,988	40.2
Received a referral slip from ACHW	2,067	11.2

Source: Endline survey data.

Similarly, LHWs also provided information on FP methods, grounding this counseling in broader guidance on ideal birth spacing and how long to wait to conceive after a miscarriage or abortion. Only some MWRA reported receiving information on side effects from LHWs.

"[The ACHW] provides in-depth information about all the services and their side effects. Then it is up to us to choose any method, but she informs us well during her visit."

- MWRA

"Yes, [the LHW's] visits were very helpful. Earlier, before marriage we normally are not aware of such methods, we have just heard the names of these methods. But we didn't know what these methods actually are. So, her visits helped us understand these things."

- MWRA

- **LHWs faced some language and cultural issues in engaging with migrant households in Sukh intervention areas.** Some LHWs noted that it was difficult to access women in some of the very conservative migrant households in the four towns of Karachi, and that they sometimes did not speak the same language as their clients in these communities (e.g., Balochi or Pathan). ACHWs did not report these issues—likely because they were selected from the very same communities they served by respected community leaders that ACHP had engaged as part of the CACs and CRGs. In fact, they seemed to have strategies in place for engaging with conservative households, noting for example, that citing certain Quranic or Hadith verses was helpful in shifting attitudes regarding childbearing and FP.

- **There was limited engagement of key influencers of MWRAs' FP/RH decision-making, such as mothers-in-law and husbands.** ACHWs interviewed often spoke about how they engaged with mothers-in-law and husbands of their clients to ease the pathway to FP adoption, calling out in particular their strategies of emphasizing the confidentiality they would preserve, being frank and direct about the value of FP, and of bringing Quranic verses into the conversation. However, in reality, there was limited engagement with family members during door-to-door visits. Only 15 percent of endline survey respondents who had been visited by an ACHW reported that the ACHW spoke to their mother-in-law during the most recent visit and only 3 percent reported that she spoke with their husband (Figure 4.6). Many of these households in peri-urban Karachi comprise only nuclear families, so it is possible mothers-in-law are not present for ACHWs to engage with (and are not actually influencing MWRAs' decision-making around FP/RH). Husbands of MWRA, however, continue to play a critical role, and may have been hard to reach because they are away at work during the day. Three-quarters of survey respondents who had been visited by an ACHW said it would be helpful if the ACHW were to begin a discussion with their husband about initiating FP (Figure 4.5).

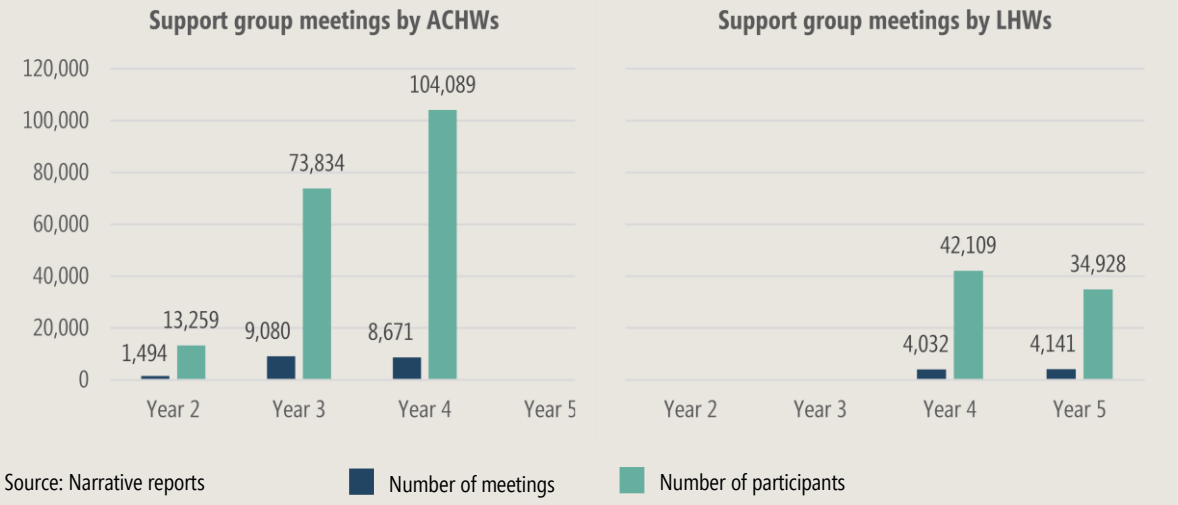
- **Referrals to Sukh health facilities and call center services were low.** Forty percent of endline survey respondents who had received a visit from an ACHW reported that the ACHW had talked to them about Sukh referral facilities. One reason this percentage is not higher could be that MWRA prefer short-term methods; as mentioned, about a third of endline respondents reported receiving contraception from the ACHW. For their own part, ACHWs may be limiting referrals to facilities because they are cognizant of the limitations on women's mobility. Referrals to call center services were also limited. Only 13 percent of endline respondents had received information about the call center from an ACHW or LHW.

> *"So in that area it's different in the sense that those Pushtoon women cannot at all leave the house. It's impossible for them. So there are mothers-in-law or brothers-in-law to contend with. And so many politics and issues that we have to add in those additional visits."*
>
> *- LHW*

Other Community-Based Outreach to MWRA

Support group meetings were an important supplement to door-to-door services, but were more well-executed by LHWs. Under Sukh, ACHW and LHWs were also required to hold group meetings with MWRA in their catchment area twice a month to discuss FP, MNCH, and PAC topics. Program data indicate that the number of ACHW-led meetings, and correspondingly the overall reach of these meetings, increased from Year 2 (mid-2014 to mid-2015) to Year 4 (mid-2016 to mid-2017) (Figure 4.7). However, ACHP stopped these meetings in 2017 because it felt they were not effective in driving behavior change, and wanted ACHWs to focus on their door-to-door visits. After they were integrated

FIGURE 4.7. BREADTH AND COVERAGE OF SUPPORT GROUP MEETINGS



into the program, LHWs also began to conduct support group meetings for MWRA. They had received prior training from another organization on the support group methodology, which ACHP leveraged in rolling out these meetings rapidly. In Years 4 and 5, LHWs conducted about 4,000 meetings each year, reaching between 35,000 and 42,000 women (Figure 4.7).

LHWs interviewed indicated they had a systematic approach to conducting support meetings, holding them twice a month and targeting specific groups of women, including those on short-term methods, those with high parity, post-partum women, etc. (They had quotas for types of women to include.) They used the information, education, and communication (IEC) materials shared by Sukh to explain information, and had "role models" share their experience, for example, they might have a woman using an IUCD attend and report that she had not had any problems.

Almost none of our MWRA interview respondents in ACHW areas had attended support group meetings, likely because these had ended a couple of years before the survey was conducted. In LHW areas, however, several MWRA respondents had attended support group meetings, and reported that they provided information on the range of available FP methods and their pros and cons, which facilities to visit, the importance of birth spacing, and a few MNCH topics. Interviewees had a generally positive reaction to the meetings, noting that a fair amount of the information shared was new to them.

Supervision

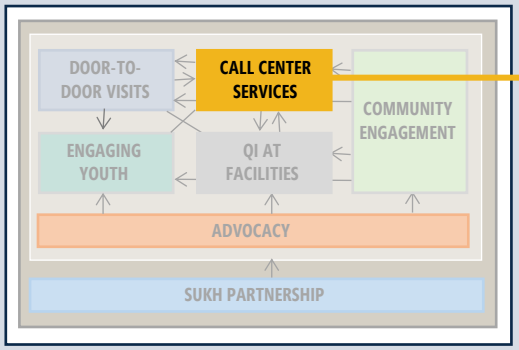
ACHP program staff provided intensive oversight and support to both ACHWs and LHWs. Our interviews indicate that ACHP field staff were regularly in contact with ACHWs and LHWs, and helped guide their work and facilitate smooth implementation. They helped ACHWs develop work plans for households to visit, were frequently brought in to help with difficult cases, and addressed stock-outs. They also checked ACHWs' registers frequently, and while this didn't translate into data-driven feedback

to ACHWs, it did provide a high measure of accountability—ACHWs reported that ACHP program staff examined registers closely, catching and asking them to fix errors.

LHWs received supervision from both ACHP and the government, and reported that the latter increased in frequency during the initiative. ACHP program staff attended LHWs' support groups and accompanied them on a few home visits following the support group, which put pressure on LHWs to perform well. Program staff seemed to take these visits seriously, and used them to conduct quality checks on LHWs—to the point where it became uncomfortable for LHWs, who reported that ACHP asked clients questions about their quality of care in front of them.

> *"For example, there was a woman who wanted to use the methods for birth control, but she was afraid of using them. She said that she was afraid that if she used the injection her menses would be irregular. So we called our supervisor who came right away."*
>
> *- ACHW*

4.2. CALL CENTER SERVICES



Trained call center agents:

- Receive and process **inbound calls** from clients seeking FP/RH information and offer counseling
- Make **outbound calls** to follow up w/ LARC clients
- Conduct **SMS campaigns** to share information on FP, MNCH, and LSBE
- **Increase awareness of helpline** by conducting events at colleges and in other public spaces

SUMMARY FINDINGS

There was limited awareness of the call center component—only 15 percent of MWRA had heard of call center services at endline. This was driven by limited marketing and promotion of the service (by ACHWs or LHWs or through other platforms). The call center also suffered low accessibility. Very few MWRA had access to mobile phones and phone booths established as part of the initiative had limited effectiveness (given they offered little privacy for conversation around sensitive FP topics). As a result of these limitations, inbound calls focused on FP were rare—which meant, in turn, that call center agents made few referrals to facilities. They also found it difficult to reach women with adherence reminders.

Sukh developed a strong internal capability around FP/RH counseling at Aman TeleHealth. Partnering with Jhpiego and Aahung, Aman TeleHealth provided training on FP/RH methods, counseling approaches, VCAT, and strategies for engaging youth. What made a particular impression on call center agents was the detailed guidance about how to engage with clients—such as simplifying technical terms and sharing them in Urdu rather than English, ensuring callers felt respected and heard, and avoiding directive guidance and instead facilitating informed decision-making. This base of knowledge was enhanced through ongoing supports. Call center agents were offered refresher trainings every few months and also met with each other on a weekly basis to share their experiences and address

gaps in knowledge. When they received questions they did not know how to respond to, they had the option of calling on the Aman TeleHealth staff doctor.

Call center services had very limited reach—given poor mobile phone access, privacy concerns, and limited marketing. This component was intended to maximize the coverage of the initiative—by helping with the "saturation" of the coverage area together with door-to-door services—and strengthen FP adherence. However, it faced challenges in executing on this vision; only 15 percent of MWRA in the endline sample had heard of call center services and only 11 percent could correctly recall the helpline number (Figure 4.8). More detail is provided below on the reach of the individual services offered by Aman TeleHealth.

FIGURE 4.8. REACH OF AMAN TELEHEALTH SERVICES

	Mean (%)
Aware of Aman TeleHealth services	14.6
Knows Aman TeleHealth service phone number (verified)	10.6
Inbound/outbound calls/SMS from Aman TeleHealth	
Ever called TeleHealth services (last 12 months)	1.7
Ever received a call from TeleHealth services (last 12 months)	3.7
Ever received SMS from TeleHealth services (last 12 months)	1.8
Ever received both call and SMS (last 12 months)	1.2
Aman telephone booth	
Heard of Aman telephone booth	4.3
Ever used Aman telephone booth	0.2
SAMPLE SIZE	3,038

- **There were few FP-focused inbound calls.** Program data indicate that only between 1 and 4 percent of calls received each year were related to FP (not shown). Endline survey results corroborate these findings, with only 1.7 percent of MWRA reporting that they had called the helpline in the 12 months prior to the survey (Figure 4.8). This is due in part to the helpline being more well-known for providing information on other health issues, rather than FP/RH. Indeed, program staff noted that they did not promote the Sukh helpline widely through mass media, unlike their other helplines, given the geographically narrow scope of the target population. Our interviews indicate, further, that ACHWs and LHWs did not often mention the call center in their conversations with MWRA (they mainly called TeleHealth, or had their clients call TeleHealth, if they were uncertain of the course of action on a problem). One critical outcome of this low incidence of incoming FP calls was that a key linkage in the Sukh Initiative was not realized. The call center services component was intended to be a key source of referrals to facilities. However, with few incoming calls focused

on FP, call center agents rarely sent callers to facilities for FP/RH services. Very few providers reported receiving clients referred by TeleHealth.

Youth were also a target audience for TeleHealth, which conducted in-person outreach at several youth events and festivals to register young people for call center services. Youth in the FGDs we conducted had heard of Aman TeleHealth, but did not know what number to call or what services were available.

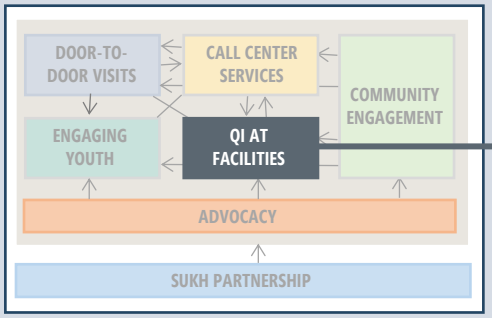
- **Outbound calls duplicated rather than supplemented door-to-door services, could not always ensure adherence, and frequently did not reach households, particularly female clients within them.** The call center services component was intended to supplement the reach of ACHWs and LHWs, thereby helping to advance Sukh's goal of saturation. However, TeleHealth agents were asked to call, register, and provide detailed FP counseling (over four calls) to clients mapped through door-to-door services, who had already received the same detailed FP counseling from ACHWs/LHWs. This put significant burden on program beneficiaries—call center agents noted that clients often had a negative reaction to being asked the same extensive series of questions again. It also meant call center services did not expand Sukh's coverage beyond that achieved by door-to-door services. Another goal of call center services was to help promote adherence, which some agents found challenging to operationalize. Specifically, they noted they did not have a mechanism in place to time their calls to align with the three-month intervals when clients were due for injections. They merely called after clients had received an injection and reminded them to get their next injection three months later.

  Most critically, outbound calls very infrequently reached MWRA. Only 4 percent of endline survey respondents had received a call from TeleHealth in the last 12 months (Figure 4.8). Program data indicate that they had a lot of difficulty reaching their contact; they were able to connect with only between 18 and 25 percent of those who were called each year (not shown). Often, this contact was the head of the household, not the MWRA client, given few women owned mobile phones and many were relying on their spouse's phone.

- **The telephone booths were rarely used, given the limited privacy they offered.** Aman TeleHealth tried to give MWRA a different avenue to access the call center by installing telephone booths in the intervention area and providing telephone sets to ACHWs, but this did not improve reach. Less than 5 percent of endline respondents had even heard of Aman telephone booths and almost no one had used them (Figure 4.8). The Aman TeleHealth team themselves felt that the booths were not easy to use, were inconveniently located, and did not offer enough privacy. The ACHP team felt that the helpline only received calls from booths managed by women or those that allowed users to take telephone sets home to talk and return them after use.

- **SMS messages promoting positive FP/RH behaviors were sent regularly, but very few reported receiving them.** TeleHealth agents reported that they developed options for SMS messages on a monthly basis, with their supervisor selecting the final choice each month. Messages covered delayed marriage, birth spacing, breastfeeding, and other topics, and varied based on audience. Their reach seems to have been very limited, however. Only 1.6 percent of endline survey respondents said they received an SMS from Aman TeleHealth in the 12 months prior to the survey (Figure 4.8).

4.3. QUALITY IMPROVEMENT AT HEALTH FACILITIES



- Upgrade infrastructure, provide equipment/supplies
- Establish/reactivate platforms for FP service provision (FP counseling counter, Family Health Days/camps)
- Capacity-building around FP and PPFP service provision
- Quality assessments/monitoring

SUMMARY FINDINGS

Jhpiego and DKT helped to strengthen long-term capacity in Karachi's health system around FP/RH service provision—by making critical facility upgrades and building new skills related to implant insertion and PPFP among public providers and a range of FP services among private providers. However, it is unclear the extent to which women were taking advantage of the new and improved services. Less than one-fifth of women surveyed at endline had visited a facility for FP or delivery care in the previous six months (though among those who did visit a facility, satisfaction with FP/RH services was high). This could be linked to the referral system from ACHWs and LHWs suffering some challenges (as described above), limitations on women's mobility, and the challenges faced in operationalizing a large network of private clinics (through the Dhanak franchise).

Sukh made strides in improving the quality of FP service provision in its partner public facilities, and eventually in its partner private facilities, which encountered early implementation challenges.

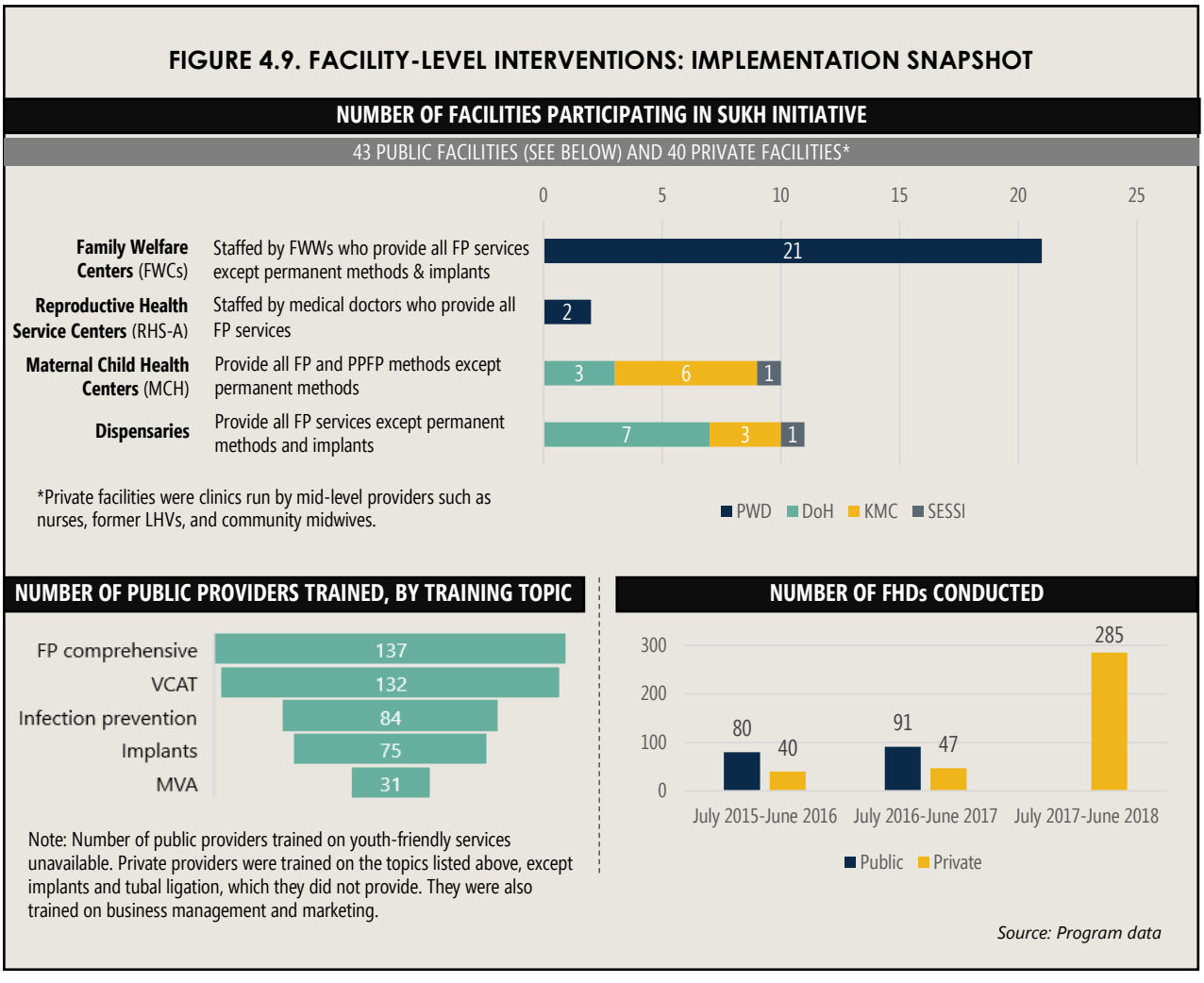
- **Public providers felt that Jhpiego's training helped strengthen the quality of FP counseling, but found the quality assessments less useful.** As part of their support to partner public facilities, Jhpiego undertook a variety of infrastructural improvements—including structural work, provision of equipment and supplies, and establishment of skill labs and dedicated spaces for FP counseling. The creation of these dedicated spaces facilitated greater integration between DoH

> *"Yes, there has been a lot of change. We now counsel a lot better than before. We do everything according to the client. There are individual needs. Everyone has their own perception. We keep in view number of children of a patient and also their body to know whether they have any such illness that makes a certain method not suitable for them."*
>
> *– Public provider*

and PWD. For example, Jhpiego placed FP counselors from PWD at the antenatal counters it established at DoH facilities (see the advocacy section and Figure 4.13 below for more detail). Overall, the extent of the infrastructural updates varied by facility, and were noted by respondents when they were particularly extensive, but not highlighted when they entailed more superficial improvements. More consistently mentioned were the benefits of the training that providers received (Figure 4.9). While facility providers did not express the same level of enthusiasm for Sukh trainings as other field-level implementers such as ACHWs, LHWs, and call center agents, they did report that it strengthened their knowledge around implants, which they knew very little about prior to the training, as well as manual vacuum aspiration (MVA) and PPFP. They also felt the training led them to counsel differently—based on the individual needs and circumstances of the client. The third activity Jhpiego undertook to improve quality of FP/RH services at facilities was to conduct monthly or bi-monthly quality assessments. Some providers felt this took up too much of their time and did not always yield useful feedback.

- **Quality concerns limited private providers' engagement in Sukh, but some participating clinics experienced improvements to their infrastructure and FP counseling.** DKT expanded its Dhanak

FIGURE 4.9. FACILITY-LEVEL INTERVENTIONS: IMPLEMENTATION SNAPSHOT



franchise to Karachi as part of the Sukh Initiative, initially planning to support 80 private facilities altogether. However, only 64 met the inclusion criteria to be a franchisee—that is, the facility had qualified doctors, nurses, LHVs, or certified community midwifes, was willing to provide FP services, and passed the quality assessment conducted by DKT. Qualified providers received support to make infrastructure improvements, FP commodities, essential equipment kits, and training on FP methods and business management (Figure 4.9). They were also required to participate in monthly or more frequent quality monitoring assessments. This monitoring process revealed service provision and quality gaps at several clinics early on, leading DKT to drop those sites. Ultimately, DKT retained 41 of the original 64 facilities in the Dhanak franchise. Key informants felt this outcome was driven in part by DKT's focus on maximizing the number of IUCDs provided (to increase CYPs), rather than improving quality of care. DKT program staff, on the other hand, reported that quality suffered because many providers were not strongly committed to running a clinic and were attracted instead to more lucrative job opportunities in Karachi. They felt that providers "need to be entrepreneurs that really want to make the clinic succeed" and noted that a key lesson learned for them has been to add an assessment of entrepreneurial skills to their initial screening and assessment criteria.

Among the 41 clinics retained in the Dhanak franchise, quality concerns receded with time. Though some providers felt not much had changed since DKT began working with them, and that the infrastructural improvements could be more substantial, most private providers interviewed reported having a positive experience with Dhanak. Many felt the equipment they were given, particularly the sterilization equipment, contributed to improved hygiene and cleanliness. They reported learning more about how to engage clients around FP and to modify counseling based on the varying needs of their clients. Some also reported that they improved their recordkeeping and that the quality assessments and monitoring were an important accountability check.

FIGURE 4.10. KNOWLEDGE AND USE OF FACILITY-LEVEL SERVICES

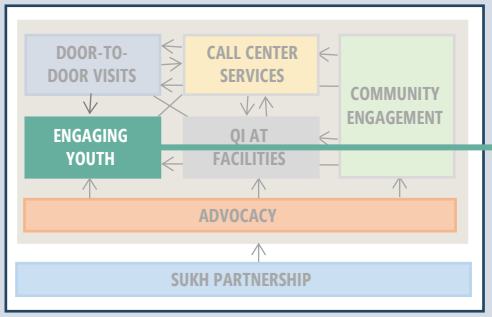
	Sample size	Mean (%)
Aware of a maternal/child health clinic in area where women mostly go for pregnancy and delivery care	2,818	14.3
Visited a health facility for FP or delivery care in previous 6 months	3,038	14.6
Type of facility visited (women who had visited facility for FP or delivery care in previous 6 months)		
Public	465	36.7
Dhanak (DKT)	465	1.1
Aman Clinic	465	5.0
Other private	465	57.2
Awareness and use of FHDs		
Aware of any FHD/camps in area	2,820	7.1
Ever visited FHD/camp	2,820	3.3

Source: Endline survey data.

Utilization of facility-level services was low among MWRA, due in part to weak linkages between this component and door-to-door and call center services as well as women's limited mobility. Across the four intervention towns, Sukh worked with a range of facilities run by different government departments, each providing a slightly different set of FP/RH services (Figure 4.9). They also conducted an increasing number of FHDs, particularly at participating private facilities over the course of the initiative (Figure 4.9). However, less than one-fifth of women surveyed at endline had visited a facility for FP or delivery care in the previous six months, with most reporting that they visited a private facility other than the Dhanak clinics and Aman clinic (57 percent of those who had visited a facility for FP or delivery care in the past six months) or a public facility (37 percent) (Figure 4.10). Only 1 percent reported visiting a Dhanak clinic, although the qualitative data suggest that women may not have always been able to distinguish between different types of private facilities. FHDs were similarly underutilized. Only 7 percent of endline survey respondents had heard about FHDs/camps held in their area, and only 4 percent had ever visited an FHD/camp.

Several program-related factors likely contributed to these low levels of service use. First, as mentioned above, ACHWs, LHWs, and call center agents did not refer women to facilities on a regular basis. Also, while the number of FHDs increased over time, they were inconsistently held. Due to logistical challenges, including inconsistent supply of commodities from PWD for FHDs/camps held at FWCs and provider unavailability for FHDs/camps organized at PWD clinics, they were intermittently stopped for weeks or months at a time. Program staff and ACHWs felt that the highly conservative nature of these communities, and the mobility barriers women faced, may have also limited facility visits.

4.5. ENGAGING YOUTH



- LSBE for girls and boys at schools (two modules—for classes 6-7 and 8-9 respectively)
- LSBE at VTCs (e-course)
- CHW- and LHW- led engagement of out-of-school girls through one-off support group meetings and family counseling (which entailed five home visits to mother-daughter pairs)
- Youth-friendly space conducting awareness-building sessions, fairs, and theater performances

Aahung's youth engagement efforts had wide coverage—reaching 16,000 in-school and 61,600 out-of-school youth. However, their success varied by the intensity of the activities conducted and the extent of the pushback received from family members. School-based LSBE, consisting of two 14-module units rolled out through weekly classes and incorporating clear strategies for resolving parental concerns, was well-received. Youth reported greater awareness of changes related to puberty, detailed knowledge of marital rights, and increased insight into gender-based violence. Community-level engagement of out-of-school youth has great potential; LHWs, who have enormous and wide-ranging responsibilities, were excited about the opportunity that the support groups and family counseling offered to serve a new population that they had had limited success with in the past. However, these activities, as well as the outreach conducted by the Youth-Friendly Space, were constrained by their limited intensity and/or parental concerns. Most community-level youth interventions (such as the support group meetings and activities conducted by the YFS) were designed to be "one-touch" and thus could not meaningfully shift attitudes around FP/RH issues. These efforts were handicapped, as was the family counseling intervention, by parents' substantial discomfort with their daughters learning about FP. For instance, in some households identified for family counseling, mothers asked that they receive the FP information and pass it on to their daughters.

Aahung's community-level outreach efforts were reduced in scope early in the design phase, given cost considerations and that they did not directly contribute to the initiative's goal of increasing mCPR. In the initiative's design phase, McKinsey proposed that Aahung engage in a six-touch model to conduct SRHR outreach to unmarried youth at the community level and change their behaviors. When the large costs of this approach became clear, however, Aahung was asked to narrow the scope of its approach to a one-touch model. The team at Aahung acted on this directive, designing an approach for one-off support group meetings conducted by LHWs and ACHWs. But they needed to modify the anticipated outcomes of this community outreach effort from long-term behavior change to knowledge acquisition, which was more feasible to accomplish through a one-touch model. Key informants hypothesized that this narrowing of scope may have been driven by the initiative's strong focus on boosting mCPR, which sensitizing unmarried youth can only contribute to in the longer term. They also noted some level of discomfort among initiative leaders with engaging youth around SRHR issues.

Despite these constraining factors, Aahung rolled out several interventions as part of the Sukh Initiative, including a school-based LSBE effort and a youth-friendly space. In the last year of the initiative, Aahung had a small pocket of funds remaining and was able to pilot a small multi-touch community outreach model, which involved training 30 ACHWs and 30 LHWs to meet mother-daughter pairs five times in their homes to facilitate discussion around FLE topics (Figure 4.11). We discuss the reach and influence of these efforts below.

FIGURE 4.11. SCOPE AND REACH OF YOUTH ENGAGEMENT INTERVENTIONS

	Scope	Reach
SCHOOL-BASED YOUTH ENGAGEMENT		
LSBE	• 28 schools engaged • 3 VTCs engaged (120 teachers trained)	• 16,000 youth
COMMUNITY-BASED YOUTH ENGAGEMENT		
1-touch support groups	• 200 ACHWs trained • 200 LHWs trained	• 50,400 youth
Home-based 5-touch family counseling	• 30 ACHWs trained • 30 LHWs trained	• 1,600 youth
Youth-friendly space	• 1 established	• 600 registered • 3,000 reached through theater performances • 6,000 reached through youth mela

Source: Program data and narrative reports.

Notes: Not included are Aahung's estimates for people reached through its airing of two docudramas.

School-based LSBE—delivered at high intensity and successfully resolving parental pushback—made a strong impression on middle and secondary school students, who mentioned their increased confidence and improved understanding of puberty, marital rights, and violence; however, LSBE implementation at VTCs was more challenging due infrastructural hurdles. Aahung's training helped teachers see the value of sensitizing youth on SRHR issues. Indeed, the teachers we spoke to felt the course was highly relevant to day-to-day challenges youth faced and called out the importance, in particular, of talking to young people about domestic violence, a widely prevalent issue in their communities. However, LSBE rollout at schools otherwise got off to a rocky start, with several teachers noting that parents came forward when the LSBE course was initiated, and indicated they felt these topics were inappropriate for discussion with their children. Teachers and school leadership

followed Aahung's guidance on how to handle these situations, projecting positivity and explaining the on-the-ground realities of the SRHR issues children are grappling with today and why talking to them about these matters is important. This approach was largely successful; together with the parental engagement activities, it appears to have tamped down parental pushback over time and allowed for teachers to conduct LSBE classes regularly and cover a range of topics through Aahung's two curricula, each with 13 to 14 modules, for grades 6-7 and 8-9 respectively. In Year 5, Aahung reported that nearly all its partner schools were holding LSBE classes once or twice a week. In total, it estimates LSBE reached 16,000 youth (Figure 4.11).

This regular sensitization by motivated teachers helped to advance knowledge and shift attitudes among youth. Overall, students recalled the information they received on puberty, marital rights, violence

FIGURE 4.12. INFLUENCE OF LSBE

- **Greater awareness of changes with puberty and discarding of myths.** When asked what information they recalled from the course or what they knew about the changes that puberty brought about, many talked about the themes Aahung had highlighted in the LSBE course: menstruation, hygiene, noctural emissions, etc. Girls reported that the course helped to dismantle certain myths they had heard about puberty, e.g., that bathing during menstruation could lead to weakness or to water entering the body and enlarging the organs.

"We gained information regarding all the bodily changes that happen [in adolescence] and we now know about the rights of men and women."

- **Detailed knowledge of Nikah Nama, or Islamic marriage contract.** When asked about the Nikah Nama (the Islamic marriage contract), students, particularly male students, offered a lot of detail—that it is a mutual agreement between men and women to marry, that it included witnesses who attested the two parties were marrying of their own free will, that it offers a girl a final chance to carefully consider her answer, that it specifies the money due to the woman if her husband initiates a divorce, and more.

"We got new information about many aspects of life that we didn't know before these sessions."

- **Insight into and action around gender-based violence.** The information on gender-based violence seems to have made an impression on LSBE participants. Both boys and girls mentioned that this information, at least the framing around what is and is not appropriate in terms of physical contact, was new to them. In addition, teachers reported that some girls came to them outside of class to share experiences of sexual abuse, leading them to speak with parents and seek to address these situations.

"We are also able to take decisions regarding our education and the courses that we want to take."

- **Some increases in confidence, but rigid gender norms, strict parental control, and limitations on mobility limit independence.** Many girls said they felt more confident as a result of the course, and would feel comfortable making decisions about about their day-to-day lives and about their education without their parents' input. However, they indicated they faced several contextual constraints in living their lives, going where they wanted to, and making key life decisions. Mainly, gender norms seemed largely intact, with both male and female respondents noting mostly that girls should stay home and do household chores, while boys go out to work. Relatedly, many girls faced significant limitations on their mobility; as they became adolescents, they reported that their parents placed a lot of restrictions on leaving the house alone or without a head covering and interacting with outsiders, which in turn limited the educational and work opportunities they could pursue. Also, while girls felt they had more independence in making smaller day-to-day decisions, they felt more significant life decisions—such as when or whom to marry—should still be made by their parents (as did most boys).

"Even if I like someone, I would marry according to my parents' wishes. Your parents' choice is better than what you choose for yourself."

"Those boys who marry on their own actually go against the parents' decision lose their parents prayers. They do not have respect in our society."

against women, and indicated improved knowledge in each of these areas. On the other hand, while they noted the course sought to improve their decision-making and communication skills, self-awareness, and self-respect and several felt they gained increased confidence to voice their preferences to their families, our interviews indicate several contextual barriers restricted students' independence. Specifically, gender norms had remained largely intact, with adolescent girls largely expected to stay home and contribute to their households, and parents still made decisions that mattered, such as around marriage. See Figure 4.12 for more detail.

LSBE was more difficult to roll out in VTCs, where Aahung aimed to deliver the content through an e-course. Key challenges included technological and connectivity issues at the centers, limited ownership of LSBE among center leadership, and high student drop-out rates. Given these constraints, Aahung wound down this component of its work (only three VTCs were engaged overall). It leveraged the e-course, however, sharing it with partner schools as a reference.

Aahung helped to build capacity around and enthusiasm for community-level youth engagement among LHWs, but its training had more limited influence on ACHWs. ACHWs, for whom all the information they were trained on was largely new, felt that all the training they received through Sukh was useful and enlightening, but did not call out the youth engagement component in particular. However, LHWs, whose day job is to conduct home visits focused on MNCH and FP, spoke at length about how interesting and useful they found this part of the Aahung training. They indicated that they had felt handicapped in the past in terms of communicating with young people about these issues, and appreciated that the training gave them the tools to engage this new population. LHWs thought the visual aids—mainly pictures presenting scenarios for discussion—were particularly useful. They noted that these scenarios resonated with them because they were representative of LHWs' own experience of marriage and childbearing and all of the challenges they faced.

> ***"We didn't know how to talk to girls, so we used to hide from them and not share certain information with them. But now we can easily convey that information in a way they understand."***
>
> *– LHW*

Community-level youth engagement, while it had relatively broad reach, was not very intensive and was encumbered by parental concerns; it did not make a strong impression on youth. The support group meetings, youth melas, and theater performances reached many thousands of people (50,400, 6,000, and 3,000, respectively [Figure 4.11]). However, as mentioned, they were largely "one-touch" events and so were by design limited in the extent to which they could shift attitudes toward

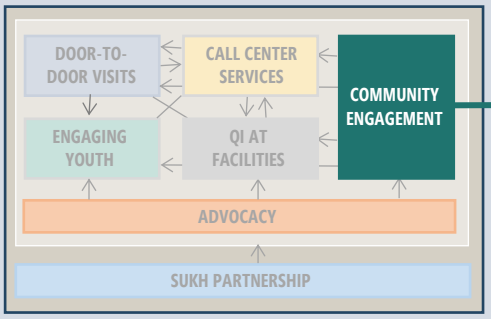
FP/RH issues. (Some out-of-school girls participated in multiple support group meetings, but since these were designed to be one-off meetings, they only provided information on a narrow set of topics rather than trying to shift attitudes). Thus, when asked about their impressions of the support group meetings, out-of-school girls did not have much to say. They noted they received information about puberty, menstruation, hygiene, early marriage, and FP, but they did not say much about their perspectives about the information shared. They did note that they appreciated the job aids and the scenarios discussed during the meetings.

Family counseling offered more opportunity to expand knowledge and shift attitudes among unmarried girls, through five home visits. However, during these visits, ACHWs/LHWs often only met with mothers, who were not comfortable with young girls being reached with FP messages. ACHWs/LHWs were allowed to engage with girls on non-sensitive topics such as anthropometric measurements and providing basic information on nutrition (from the "level one" LSBE course), but mothers wanted to be present for discussions about topics such as puberty and changes to the body, pregnancy, and fertility. More often, mothers insisted that the ACHW/ LHW share information with them to pass on to their daughters.

The YFS was constrained by similar contextual issues. It grappled with low rates of participation at its awareness-building sessions from girls, who had restricted mobility. That said, it was expanding its coverage over time, reaching 100 in its first year, and 500 in the next, and learning how best to leverage its space and activities to reach and engage youth. Despite this progress, the YFS was closed down once its targets were met although there were funds remaining and the program period for Sukh was not at its end. This may have been a missed opportunity to extend the initiative's influence on young people and foster sustainability (Aahung had designed the center to be eventually transitioned to city government authorities).

4.6. COMMUNITY ENGAGEMENT

SUMMARY FINDINGS

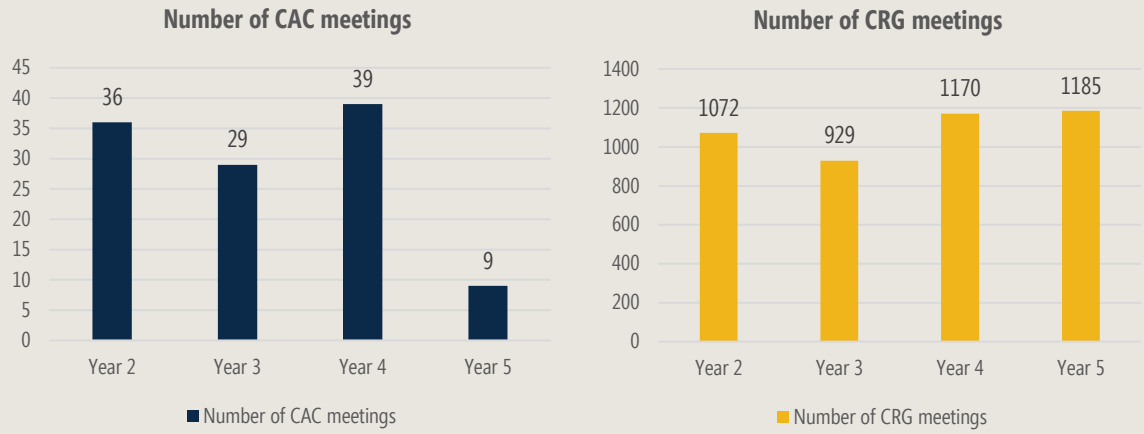


- Form CACs (including political, religious, and community leaders) to introduce and legitimize Sukh to the community
- Form CRGs (including key community gatekeepers) to support door-to-door services and conduct community meetings to increase awareness of FP issues
- Recruit male mobilizers to conduct support group meetings for married men and community leaders and corner meetings for men to increase awareness of FP issues and promote interspousal communication

By establishing CACs, Sukh helped win the support of local political and religious leaders. This was critical in helping Sukh gain a strong foothold in these highly conservative communities that were wary of outside influence, and allowed for the establishment of the expansive field infrastructure needed to ensure the success of door-to-door services. CRGs also helped increase the effectiveness of door-to-door services by conducting one-on-one outreach to households that ACHWs reported were pushing back on FP use. This is in addition to conducting regular community meetings to discuss FP and other development issues with community members over the course of the initiative. Outreach by male mobilizers, though largely well-received by men in the community, had low reach—given men are away for work during the day and difficult to access.

Community engagement via community leaders and influencers was an important component of the program early on, but some elements were scaled back as the initiative gained traction on the ground. Sukh formed 10 CACs (one per field station) and 130 CRGs to build a strong enabling environment for the initiative. We were unable to interview members of these groups given they were wound down some time before the endline data collection was conducted, but program staff, MWRA, and male mobilizer interviews and narrative reports gave us insight into the strength and usefulness of this initiative component.

FIGURE 4.13. NUMBER OF CAC AND CRG MEETINGS CONDUCTED, OVER TIME



Source: Program data.

- **CACs acted as a critical platform for engaging with political and religious leaders, and helped Sukh gain entry into the target communities, but they were less needed over time.** Program staff interviews indicate that CACs were very useful at the start of the program. Sukh was operating in a complex implementation environment, with diverse ethnic groups, strong religious leanings, intermittent security issues, and varying political affiliations. The latter was of particular concern—one party was in the seat of power in Malir, another in Bin Qasim, and yet another in Landhi and Korangi. The CACs, based as they were in each town, helped Sukh obtain the critical buy-in they needed from these political representatives. CACs also proved useful in engaging religious leaders, another set of gatekeepers whose trust Sukh needed to gain in order to implement its programming. The groups were a useful platform for dispelling the belief among religious leaders that Sukh was seeking to dismantle traditional norms. For example, in one case, ACHP field staff recorded their discussion with a highly respected religious leader in one of Sukh's intervention areas, in which he indicated he was on board with Sukh's objectives and offered his "all-out" support for implementation. They then shared this video with other religious leaders, using it to make the case for Sukh and obtain their buy-in as well. This type of support was found to be critical for building an enabling environment for the program and enabled Sukh to (1) establish the large field infrastructure needed to ensure the success of door-to-door services and (2) ensure ACHWs received minimal pushback from the community as they conducted door-to-door visits. Over the course of

implementation, once this buy-in was solidified, CAC meetings were less needed. As seen in Figure 4.13, CAC meetings dropped significantly in the last year of the initiative.

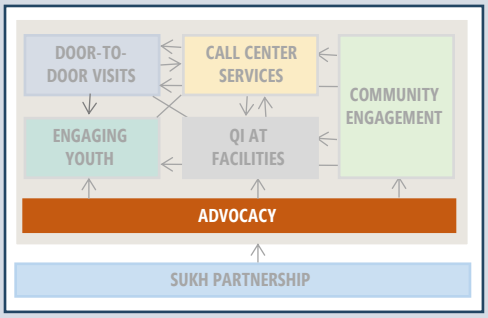
- **CRGs supported ACHWs' work and conducted awareness-building meetings throughout the initiative, but ultimately had limited reach.** CRGs were another means to saturate the intervention area and support a 360-degree initiative approach. Program data and grantee reports indicate they have been relatively successful in doing so. They have stayed active throughout the initiative, with about a thousand meetings conducted each year for community members (male mobilizers—see more below—helped to organize these meetings). However, at endline, only 3 percent of MWRA reported attending a community support group meeting (not shown). Though CRGs had limited reach, they enabled other initiative components to expand or enhance their efforts at the community level. Jhpiego and Aahung leveraged CRG meetings to raise awareness around FP and adolescent sexual and reproductive health issues, with Aahung conducting docudramas, for example. In addition, CRG members supported ACHWs by visiting elders and other family members and overcoming their objections to FP use. CRGs also appear to have been useful for planning and problem-solving around other community-level issues (such as sanitation, water, schooling, and so on).

Outreach to married men by male mobilizers had low reach and was initially met with some hesitation, but ultimately appreciated; it was difficult to coordinate this outreach very closely with door-to-door services for MWRA. Sukh's 50 male mobilizers, who participated in the same 13-week training as the ACHWs, conducted monthly support group meetings with married men, elders, religious leaders, and community leaders and influencers, as well as daily corner meetings and ad hoc one-on-one visits with married men. The support group meetings were discontinued in Year 5 because the group-based interactions were found to not be optimal for discussion of these relatively sensitive issues. Corner meetings, which were more informal and included smaller groups of participants, were continued through Year 5. However, given challenges in accessing men, who are away at work during the day, the meetings were held fairly infrequently and were sparsely attended. Those who participated, however, viewed these meetings positively. Though initially the male mobilizers were viewed with some suspicion, married men appear to have grown to trust them and to reach out to them with questions or to obtain contraceptives (mainly condoms). Male mobilizers did note that men from certain ethnic groups and those who were particularly religious were difficult to persuade to adopt FP, or at the least to open their minds toward FP. They called in their Sukh field coordinators to help with these cases.

Outreach by male mobilizers was intended to work in sync with door-to-door services—to bring about shifts in FP/RH attitudes and behaviors among both married men and MWRA at once. There were some examples of this alignment; a few male mobilizers noted that they targeted the husbands of women visited by ACHWs for their outreach, and a few ACHWs noted they called on male mobilizers to speak with husbands of MWRA who were pushing back on use of FP. However, neither happened universally or systematically, and the main mode of outreach to married men that continued through Year 5 was corner meetings, which were by nature somewhat ad hoc and inclusive of whoever was available at a certain time in a certain place.

4.7. ADVOCACY

SUMMARY FINDINGS

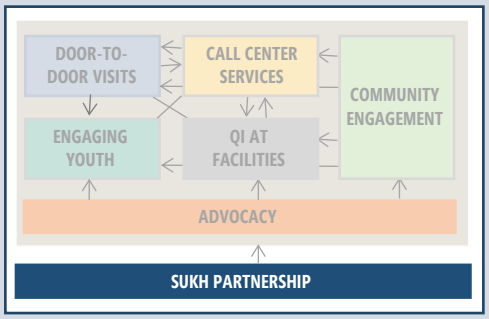


The Sukh Initiative engaged closely with the government from the start of the program to increase awareness of its work, share updates, and make the case for scale-up of best practices. These efforts yielded several advocacy wins, including large-scale task shifting of key FP services (implant insertion and administering the first injection) to mid-level providers, adoption and rollout of LSBE to schools across Sindh, a new PPFP policy, and potentially, adoption of Sukh's LHW model.

Sukh's extensive advocacy to the government has enabled scale-up of several key elements of the initiative. The PMU, implementing partners, and donors' in-country staff leveraged their expansive networks to conduct skillful outreach to government. Through planned and ad hoc meetings with the relevant government stakeholders, they built a strong understanding of and commitment to Sukh's goals from the very start of the initiative, and then conducted regular outreach to these champions to keep them up to date on progress, enlist their support in resolving challenges, and ultimately encourage them to adopt key initiative elements. Three critical wins are Sukh's successful advocacy to (1) train mid-level providers at the facility level to insert implants, (2) train LHWs to administer the first injection, and (3) scale LSBE across Sindh. There is also government interest in adopting Sukh's LHW model. Sukh also contributed to greater collaboration between DoH and PWD, which were historically isolated from one another. These and other achievements are described in greater detail in Figure 4.14.

4.8. ORGANIZATIONAL EFFECTIVENESS OF THE SUKH PARTNERSHIP

SUMMARY FINDINGS



The Sukh Initiative, in addition to testing whether the integration of a series of complementary FP interventions could meaningfully and sustainably advance FP outcomes, was also testing a complex organizational structure—one funded by a partnership between international and local donors and implemented by many country partners, all brought together by a central strategy and coordination entity (a PMU) and aligned around a shared focus on measurement and learning.

Our interviews indicate that the PMU was skilled in management across the multiple components and partners in the initiative, and very effective at building strong partnerships with government. However, it could have played a stronger strategy and learning role. It often focused too intently on meeting pre-set targets rather than testing hypotheses and contributing to knowledge around FP/RH in urban Pakistan and leveraging this learning to systematically advance the policy agenda.

FIGURE 4.14. KEY ADVOCACY WINS

Facilitation of task shifting	The Sukh Initiative successfully advocated for task shifting to both mid-level providers at the facility level and LHWs at the community level. At the facility level, its government outreach led to national standards being revised such that mid-level providers were permitted to conduct implant insertions. This has trickled down to the provincial level, with the Sindh PWD requiring all facilities in its jurisdiction to implement this change. At the community level, Sukh won support from the government for training LHWs to take on the provision of the first injection.
Scale-up of LSBE to schools across Sindh	Through Sukh, Aahung connected with a critical champion in government early on, which was helpful in increasing government buy-in for LSBE and making progress on integrating it into public school curricula. Momentum flagged for some years, but revived in 2018, at which point the government integrated 10 LSBE themes into the relevant textbooks, and Aahung trained 516 master trainers on LSBE, who had, as of late 2019, trained 7,000 teachers.
Strengthened PPFP policy	Jhpiego drew on its extensive experience integrating PPFP into facility-level service provision, and conducted a series of consultative workshops, to draft a PPFP strategy for Sindh, which was endorsed by DoH and PWD.
Enhanced integration between DoH and PWD	Sukh facilitated a partnership between officials and health workers belonging to the two departments to advance FP/RH in Sindh. This integration was embedded in the design of the facility component of the initiative; Jhpiego placed FP counselors from PWD at the antenatal counters it established at DoH facilities, which it reports led to a 50 percent increase in the adoption of PPFP services. Seeing this success, the Minister of Population Health had all facilities under her jurisdiction set up antenatal counseling counters and take on FP counselors. This integration between DoH and PWD also manifested itself at the policy and planning level. Jhpiego helped to re-energize and increase the productivity of joint district technical committee meetings, such that DoH and PWD officials at the district level were coordinating around human resources, commodities, service provision, and quality assurance.
Adoption of monitoring tools	PWD is interested in adopting Jhpiego's Standards-Based Management and Recognition (SBMR) quality assessment tool and has requested that Jhpiego train PWD master trainers and senior doctors on the use of the tool and more broadly on supportive supervision.
Potential adoption of LHW model	The Sindh government is planning to begin the Sukh Karachi Initiative (SKI), a two-year program funded by the government that seeks to cover a population of 2 million living in urban slums with outreach by LHWs. The program will draw on training and IEC material developed under the Sukh Initiative and adopt some of the best practices for monitoring and implementation that emerged under Sukh. These practices include a dedicated officer for all LHW townships, a model adopted in areas where Sukh partnered with the LHW program, rather than one per district, and additional training and materials for LHWs in Sukh areas. The government requested that the Aman Foundation coordinate and monitor SKI activities. ACHP has submitted a proposal for this work, which has received preliminary approval, pending a feasibility assessment.

The PMU was an effective manager of implementation across multiple Sukh interventions and implementing partners, but had some challenges with financial management. Key informants noted the PMU played an important role in identifying and bringing implementation partners on board, developing the scopes of work for these organizations, getting resources out to them, and holding them accountable to the identified goals and timelines. These organizational skills were particularly critical given that there was frequent turnover among implementing partner leads. The PMU skillfully integrated these new staff, built their understanding of other Sukh activities and the Sukh context, and ensured they implemented established processes and adhered to pre-set timelines. Where the PMU faced some

challenges was financial management—Aman systems and processes were not set up to allow for clear, by-donor reporting of how funds were used. These capabilities improved after the Steering Committee brought KPMG in to help review and improve the initiative's financial management.

The PMU did not always play a strong overarching strategy role. Respondents indicated that this was a challenge from the start—that the PMU may have lost momentum on the strategy front when there was a change in leadership just as the design was being refined and plans for rollout were falling into place. Ultimately, key informants felt the PMU was overly focused on meeting targets—informed perhaps by the business background of several Aman stakeholders. While these targets were critical in ensuring efficient implementation and a focus on progress and performance, interviewees felt they kept the PMU focused on execution against a pre-set vision for Sukh, instead of identifying and solving for problems faced in the urban FP/RH space in Pakistan and using that learning to systematically drive policy agendas. Certainly, the PMU was skilled at government engagement and driving scale-up of certain Sukh best practices, but these were opportunistic and ad hoc advocacy efforts, and were not grounded in any overarching effort to understand what does and does not work in urban FP in Pakistan.

The PMU's partner meetings were helpful in coordinating implementation and ensuring that partners adopted a collective mindset focused on the initiative, but could have done more to foster joint reflection and problem solving. The PMU organized monthly Field Operations Management (FOM) meetings for implementing partners to share progress, review data, identify issues, and make corrections. Usually the week after the FOM meeting there was a Senior Management Team (SMT) meeting, when partners reviewed performance and made implementation decisions based on input from the FOM meeting. Some implementation partners felt these meetings were useful in giving them a forum to rectify any miscommunications, ensure complementary not overlapping scopes, and reconcile data errors or mismatch in records (such as between ACHW referral data and provider records). Frequent meetings also helped the partners weather the early "growing pains" of a multi-partner initiative; while initially partners were inclined to try to take credit for progress made by the initiative, over time they began to view these as shared achievements. Some key informants did flag a few ways in which these meetings fell short on facilitating collaboration among implementing partners. They felt that the meetings often focused too heavily on logistical coordination and reporting, and entailed a sequence of share-outs by partners, rather than facilitating discussion and shared reflection around challenges and learnings.

> *"The other challenge was getting every partner aligned and synchronized because you could not get ownership of the project. It was ownership of the organization, ownership of the individual. They wanted to showcase their work; their organization's input rather than the project input. ... that also took a lot of time... we talked with everyone, we continuously highlighted that it's not me and you, it's us. So, I think we were able in the last two years..."*
>
> – Sukh PMU

> *"There was a lot of management of accountability but not management or learning for programmatic effectiveness to improve."*
>
> – Steering Committee member

The initiative set up extensive monitoring and evaluation efforts, but these did not always yield in-depth learning—given both design issues and a focus on meeting targets. The PMU

commissioned a multi-year external evaluation of the initiative and also developed and operationalized an expansive program data collection, synthesis, analysis, and visualization effort, with an online dashboard showing real-time data collected by ACHWs and LHWs in the field. However, the extent to which the dashboard and underlying program data were used to inform program improvement and strategic shifts was unclear. While Sukh program staff indicate that these data were shared and discussed during the monthly meetings, these conversations appear to have focused on progress towards meeting targets and what implementation challenges to address to advance that progress. The PMU did not undertake in-depth analysis of these data with a view to shedding light on program design. For instance, interviewees felt that program data could have been used to study the variation in implementation contexts and "micro-cultures" across the towns, how those could be driving shifts in FP outcomes, and implications for the design of Sukh interventions working with these communities.

Evaluation efforts, for their part, were handicapped by certain design issues. A comparison group was not identified at baseline, which placed limitations on the rigor of the evaluation. The midline did not use the same sampling as the baseline and also did not integrate detailed questions about the program to adequately study program implementation and assess its effect on impact. Finally, the evaluation did not include any survey measurement around the youth component of the initiative.

The initiative was not entirely successful in achieving its goal of establishing a strong, long-term funding partner championing FP/RH in Pakistan. A key objective of establishing a multi-donor partnership was to bring international donors with FP expertise together with a new, energized country-based donor looking to make a positive local impact, and thereby establish a strong FP/RH champion in Pakistan with its own financing and potential for partnering with the government. There was potential for this goal to be realized early on, with Aman Foundation leadership engaging extensively with the other donors and the Sukh stakeholders around FP/RH. However, with several leadership changes over time, the Aman Foundation's priorities also evolved and the institution became more focused on its other, also vital health-focused projects, such as its ambulatory care initiative. Some of Sukh's efforts will continue, as mentioned above, with Aman Foundation's support, but a broader, more enduring focus on FP/RH may not be in the cards.

Housing the PMU within the Aman Foundation led to some conflation between funding and implementing responsibilities and uneven influence among donors on programmatic direction. The PMU was hosted by—and co-located with—the Aman Foundation, sharing administrative, finance, and other functions with the funder. Not unexpectedly, this muddied the lines between donor and implementer to some extent, with the implementer maybe not receiving the objective input and guidance it might in other situations. It also led to the priorities of non-local donors not always receiving initiative-level prioritization. Relatedly, co-located with the PMU and Aman Foundation were also the other Aman NGO arms acting as implementing partners—ACHP and Aman TeleHealth. This again may have led to some unconscious prioritization of these initiative components over others.

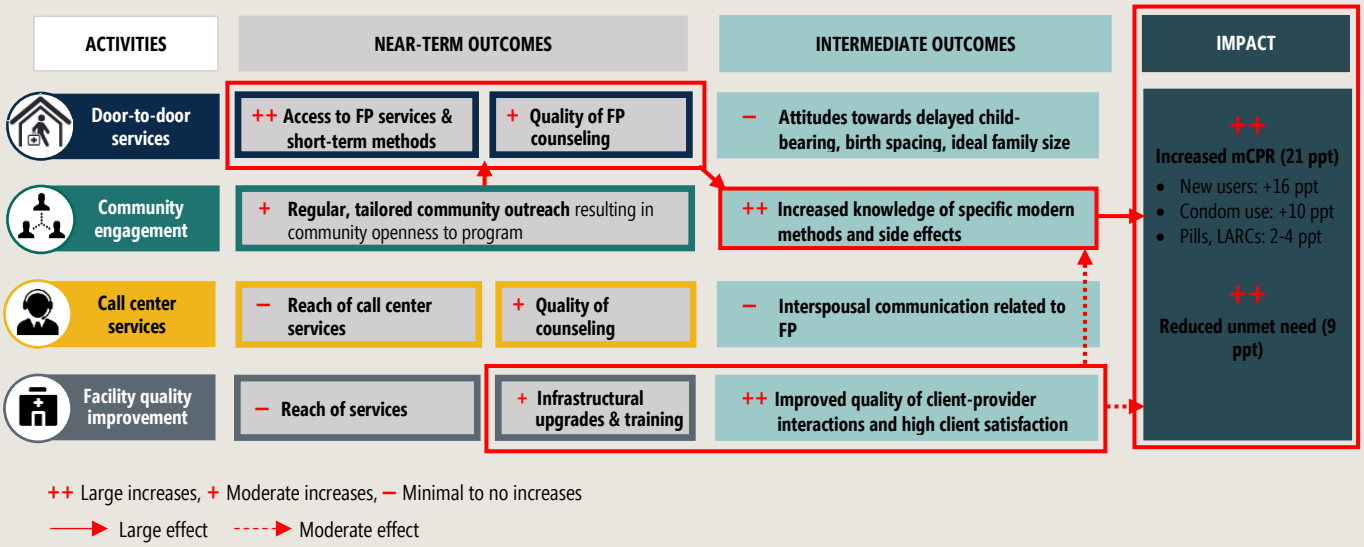
5. FINDINGS: IMPACTS OF THE INITIATIVE

This chapter assesses the extent to which the intermediate, long-term, and impact outcomes envisaged in the Sukh ToC were achieved, focusing on outcomes directly related to MWRA. (Outcomes related to youth engagement and advocacy are covered in Chapter 4.) The analysis draws primarily on the quantitative baseline (2014) and endline (2018) surveys of MWRA in ACHW catchment areas in the four towns in which the initiative was implemented. Specifically, we use the survey data to examine changes between baseline and endline in key outcomes. (Where we do not have comparable baseline and endline data we cannot estimate changes over time but still present the endline means for context.) Although observed changes cannot be fully attributed to the initiative given the lack of a comparison group, they indicate the extent to which envisaged outcomes in the ToC were achieved. We triangulate these findings from the survey data with those from the qualitative, program, and SDA data—including implementation findings discussed in Chapter 4—to better understand which solution levers drove these changes, or why the envisaged changes were not achieved.

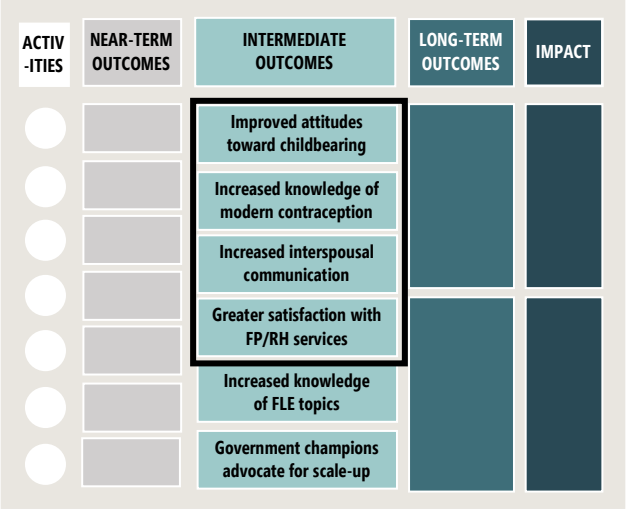
SUMMARY OF IMPACT FINDINGS

Figure 5.0 provides a visual summary of findings on the contribution of Sukh interventions to observed changes in targeted outcomes. As shown, the initiative achieved its impact goals, as evidenced by a 21 percentage point increase in mCPR and a 9 percentage point decrease in unmet need for FP. While these changes may not fully attributable to the initiative, they are unlikely to be driven by trends in urban Sindh province, which were slightly negative over the same period. Linking implementation and outcome results, we conclude that the door-to-door ACHW services and, to a lesser extent, facility quality improvements drove these large changes in impact outcomes. ACHWs filled a critical gap in FP service provision, providing easy access to high-quality FP counseling and methods in areas not serviced by LHWs, and facility investments and provider trainings resulted in improved client-provider interactions around FP. Both likely contributed to large observed increases in knowledge of most modern methods. However, low and largely unchanged levels of use of facilities, combined with large increases in new FP adopters and use of condoms (distributed by ACHWs), suggest that ACHW service provision was the predominant factor driving large increases in contraceptive uptake. The call center component, as well as efforts to reach men, had very limited reach, and the most intensive youth intervention (LSBE in schools) was unlikely to have affected mCPR during the intervention period.

Figure 5.0. SUKH INITIATIVE: PATHWAYS TO IMPACT



5.1. INTERMEDIATE OUTCOMES

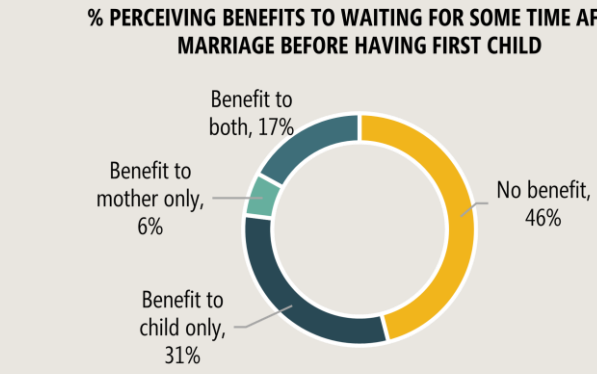


The Sukh ToC envisaged that the initiative's activities would result in several intermediate outcomes that would contribute to increased uptake of FP services and methods by MWRA. These included improved attitudes toward delayed childbearing and birth spacing, improved knowledge about modern contraceptive methods, increased interspousal communication around pregnancy and contraceptive use, and greater satisfaction with FP services provided through in-person outreach, via call center services, and at facilities. Below, we present the key findings for each of these outcomes in turn.

Attitudes Toward Delayed Childbearing and Birth Spacing

The initiative sought to shift attitudes in support of delayed childbearing and birth spacing among MWRA. These changed attitudes were ultimately expected to contribute to increased demand for FP services and methods to delay childbearing and achieve desired and healthy spacing of pregnancies.

FIGURE 5.1. ATTITUDES TOWARD TIMING OF PREGNANCY



Notes: N=3,021.
Source: Endline survey data.

"I have seen girls giving birth to their first child at the age of 18. But I think they shouldn't at this age, because internally she is not healthy enough to give birth to her child before the age of 22."

– MWRA, Korangi

"First child should be born early…If a girl is physically healthy and can look after her child, then it is the right age"

– Mother-in-law of MWRA, Malir

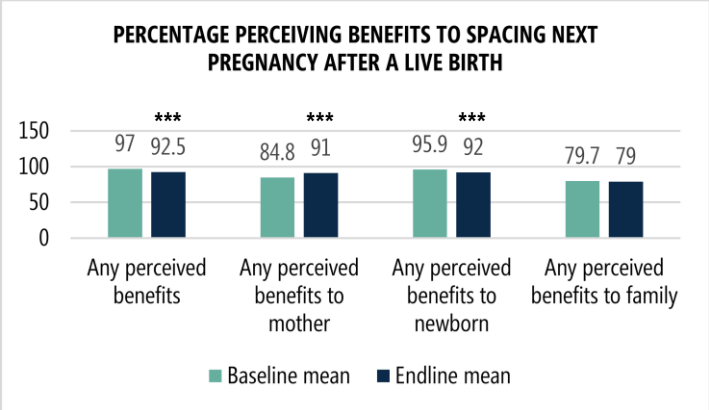
At endline, about half of MWRA perceived a benefit to delaying the first child after marriage. Fifty-four percent of MWRA surveyed at endline reported that they perceived a benefit to waiting for some time after marriage before having a first child. Almost all of these women believed there were benefits for the child, but less than half believed there were any benefits to the mother (Figure 5.1). This suggests that there was still scope for improvement in attitudes around timing of first childbearing.

However, because these outcomes were not measured at baseline, we were unable to assess whether these endline levels represented an improvement over baseline levels. Qualitative data reveal an important nuance. Many MWRA interviewed indicated they were aware of the health benefits to the mother in delaying marriage, because that in turn meant a delay in childbearing. Few indicated it would be possible to get married and subsequently delay childbearing, given norms around immediate childbearing are so strong. This was corroborated by mothers-in-law of MWRA, who felt that women should wait until they were physically and emotionally mature to get married, but that as long as they were mature at the time of marriage, there was no reason to further delay childbirth.

There were no major changes in attitudes toward birth spacing over the course of the initiative, but positive attitudes were already very common at baseline. At endline, about 93 percent of MWRA reported that they perceived a benefit to spacing births, only a small decrease from baseline (Figure 5.2). The percentage of MWRA perceiving benefits to the mother, newborn, and family were also high and similar in magnitude to baseline levels. The perceived ideal number of children was identical at baseline and endline, at 3.6 (not shown), suggesting that changes in preferences about family size were unlikely to drive any changes in contraceptive use. Future FP programming for these populations may consider homing in on financial reasons for limiting births in any sensitization activities; in our qualitative interviews, many MWRA said they were worried about inflation and its effect on their financial security and ability to provide for many children.

Overall, there is little evidence of major changes in attitudes toward delayed childbearing or birth spacing over the course of the initiative. There is still substantial room for improvement in attitudes toward timing of first childbearing, but desirable attitudes toward birth spacing were already very common at baseline.

FIGURE 5.2. ATTITUDES TOWARD SPACING BETWEEN BIRTHS



Notes: *** p<0.001; Baseline sample size = 5,140; endline sample size = 3,038.
Source: Baseline and endline survey data.

"The gap among children provides a space to concentrate on child and also save some money. Moreover, it is also beneficial for the mother's health."

- MWRA, Bin Qasim

"See, we should have only that number of kids that we can afford, kids need everything these days, so to fulfill these needs, 2 kids are enough. If I feel that now we have enough resources to have another child, I'll have one.

– MWRA, Landhi

Knowledge About Modern Methods of Contraception

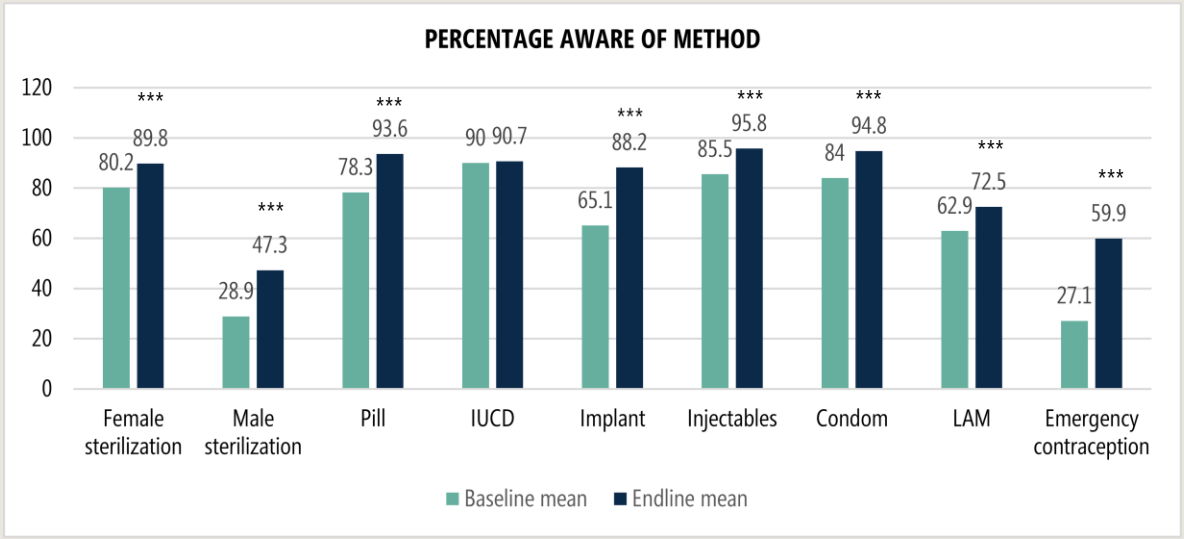
One important potential barrier to uptake of contraception that the project sought to address was lack of knowledge about modern methods. This includes both knowledge about the existence of the method (awareness), as well as knowledge about side effects and common misconceptions around specific methods.

Knowledge about almost all modern methods of FP improved between baseline and endline, likely driven by information shared during ACHW visits. Although almost all MWRA were aware of at least one modern contraceptive method at both baseline and endline, there were significant increases in knowledge of a range of specific modern methods. These include emergency contraception (33 percentage points), implants (23 percentage points), pills (15 percentage points), and male sterilization (18 percentage points) (Figure 5.3). This is despite high baseline levels of knowledge about many methods, which might have suggested limited scope for improvement.

It is plausible that these improvements in knowledge were driven by MWRA's interactions with ACHWs. Specifically, knowledge about individual modern methods was between 6 and 13 percentage points higher for MWRA ever visited by an ACHW compared to those who were not (not shown). These correlations could partly reflect underlying differences in the types of women visited, but are also consistent with impacts of ACHW visits. Further, as described in Chapter 4, MWRA exposure to ACHW visits was high (at 75 percent of MWRA), suggesting that ACHW visits introduced by the initiative had sufficient reach to result in large overall changes in knowledge.

Increased discussion of modern methods with women or their husbands after delivery at a facility is another potential driver of the increase in knowledge. At endline, about 45 percent of MWRA reported such discussions after their most recent delivery. We do not have baseline data on this outcome, but the

FIGURE 5.3. KNOWLEDGE ABOUT MODERN CONTRACEPTIVE METHODS

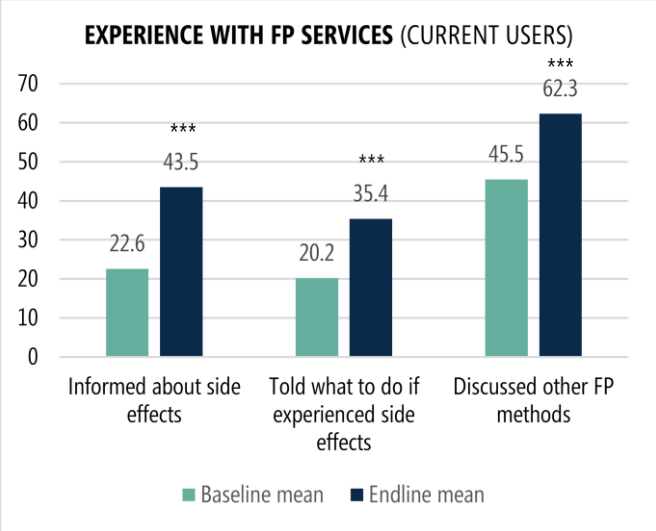


Notes: *** p<0.001; Baseline sample size = 5,055-5,125; endline sample size = 3,038.
Source: Baseline and endline survey data.

qualitative data suggest that this might have been a substantial improvement over baseline because very little formal PPFP counselling was occurring at facilities before the initiative was introduced. These PPFP discussions are correlated with knowledge about individual modern methods, which is between 3 and 11 percentage points higher for MWRA who reported such discussions compared to those who did not. However, given the lack of baseline data and lower potential reach of PPFP counselling at facilities (48 percent of MWRA delivered at a facility in the three years before the endline), the evidence that this solution lever drove changes in knowledge is weaker than that for ACHW visits.

There was an improvement in knowledge about side effects of modern methods. Fears or misconceptions about side effects may be barriers to the use of modern methods and may influence method choice—and are therefore another important aspect of knowledge. At endline, 44 percent of current users reported that they were informed about side effects compared to 23 percent at baseline (Figure 5.4). Moreover, about one-third of current users at endline report that they were told what to do if they experienced a side effect compared to only one-fifth at baseline. Similarly, 62 percent of women at endline reported that the provider had discussed other FP methods when they obtained FP services compared to 46 percent at baseline.

FIGURE 5.4. KNOWLEDGE ABOUT SIDE EFFECTS AND ALTERNATIVE METHODS



Notes: *** p<0.001; Baseline sample size = 1,894-1,943; endline sample size = 1,701-1,746.
Source: Baseline and endline survey data.

Increases in knowledge about modern methods occurred as envisaged in the ToC. Specifically, there were large improvements in knowledge about most types of modern methods, even though initial levels of knowledge were high. There was also improved knowledge about side effects among users of modern methods. The most likely avenue for these large improvements was home-based counseling by ACHWs, although PPFP discussions at facilities might also have played a role.

Interspousal Communication

Given the important role of husbands and mothers-in-law in FP decision-making in Pakistan, attitudes of and communications with these key influencers around childbearing and contraceptive use can be key determinants of contraceptive uptake. Recognizing this, Sukh trained ACHWs to engage with husbands and mothers-in-law, and trained male mobilizers to engage with husbands.

The rates of interspousal communication about topics related to FP remained low at endline, with a small decline in reported discussions around pregnancy timing. At endline, about 42 percent of

women had discussed when to get pregnant with their husbands, a decrease of 5 percentage points compared to baseline (Figure 5.5). Less than two-thirds of MWRA had ever discussed the number of children they would like to have with their husband, and a similar fraction had discussed spacing between pregnancies or FP with them. (We were unable to assess changes in these outcomes since baseline because they were not measured at baseline.) Among MWRA who had discussed FP with their husbands, over 90 percent reported having made a joint decision about using FP in the most recent discussion.

In contrast to survey results, qualitative data suggest that interspousal conversations around the number of children to have were frequent, with men often playing the deciding role. In several cases, women reported wanting fewer (3 to 4) children, whereas men wanted to have more and pushed back on women's preferences. Men's involvement in the choice of FP was not universal, but was common. MWRA reported that their husbands weighed in on the safety of the contraceptives they were using, indicated they preferred not to use condoms, or expressed irritation when certain contraceptives led to bleeding or spotting outside of menstruation and limited intercourse. What emerged as a potential

"Yes, someone spoke to me about the ideal number of children to have, after the birth of my youngest daughter. I was having an operation to not have more kids. But my husband didn't agree to it."

- MWRA, Malir

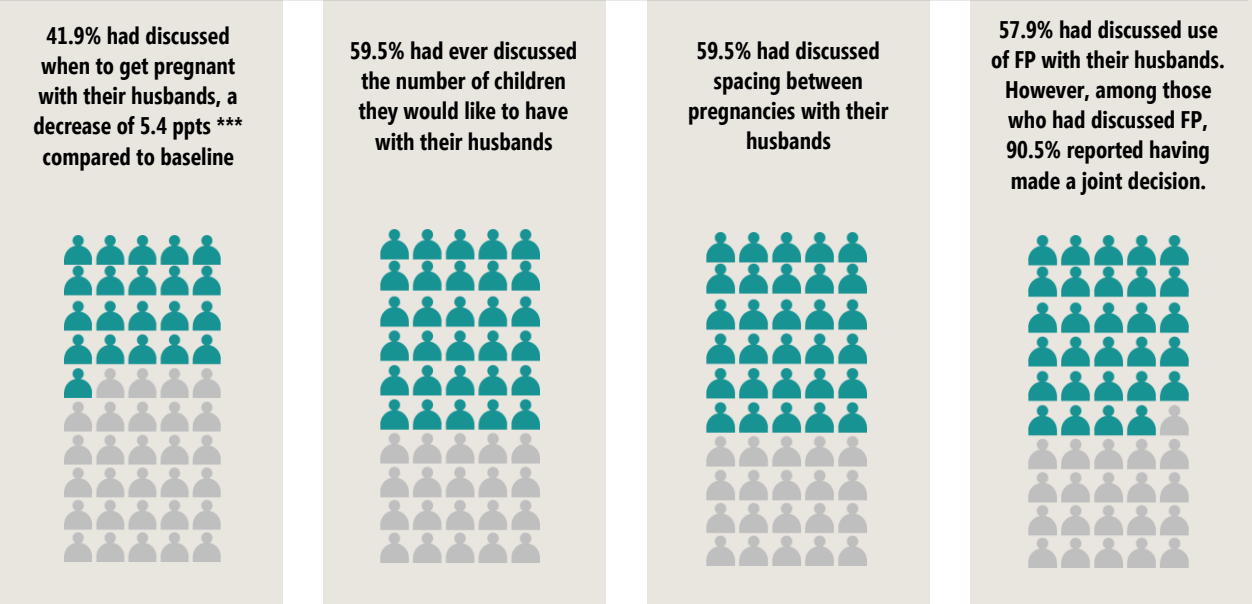
"Women should decide because she is the one who has to give birth to the child, take care of her child and her family."

- MWRA, Korangi

"We don't like tying of the tubes because it also stops menses and there can be problems with that. Implants and IUC is also not very good. There is also this method of putting capsules in the women. That is also not a good way since it initiated menses. It makes women really worried and they think they are about to die. So I also told my wife not to use this method and that using a condom is ok."

– Married man, Bin Qasim

FIGURE 5.5. SPOUSAL COMMUNICATION ABOUT FP



Notes: *** p<0.001; baseline sample size = 5,058; endline sample size = 2,793-2,894; N for made a joint decision whether to use FP = 1,631.
Source: Baseline and endline survey data.

vehicle for change was several women's belief that they *should* have a say in FP. Leveraging this sense of empowerment, while at the same time tackling men's attitudes, may enable real interspousal communication around FP and shared, informed decision-making.

This aspect of the TOC did not materialize as envisaged, consistent with implementation findings in Chapter 4 suggesting that activities focused on engaging married men had limited reach. The group meetings that they supported were not well-suited to discuss FP and they found it difficult to reach many men for corner meetings because they were away at work all day. Further, ACHWs generally had very limited engagement with family members of MWRA served.

Quality of and Satisfaction with FP Services

Both high-quality FP services delivered by ACHWs and at facilities—and high client satisfaction with services received—were expected to contribute to increased uptake and continuation of FP. Because ACHWs had not been deployed at the time of the baseline survey, and SDAs at facilities were not conducted as part of the baseline data collection for the evaluation, our analysis of quality outcomes relies on MWRA reports of their FP client experiences and endline SDAs at selected facilities. (Because the reach of telehealth services was very low, as described in Chapter 4, we do not focus on quality of and satisfaction with those services here.)

Quality of client-provider interactions around FP appears to have improved. Among current users of a modern contraceptive method, the quality of interactions with their FP provider(s) appears to have improved over the course of the initiative. As shown in Figure 5.4, the proportion of current users who were informed about side effects, told what to do if they experienced side effects, and had discussed FP methods other than their current method during a recent FP visit (to the source of their most recent method) increased by 15 to 21 percentage points. Increases were generally larger for public versus private facilities, with discussion of side effects and multiple FP methods being more common during visits to public facilities at baseline and endline (not shown). However, there is still room for improvement across all provider types. As mentioned above, at endline, less than half of current users had discussed side effects with their FP provider at endline, and only 62 percent had discussed FP methods other than their current method with a provider. The percentage of MWRA who reported discussing side effects with a provider was around or below 50 percent across all provider types visits (ACHW and public and private facilities), and lowest among women who had visited a private facility (31 percent).

Satisfaction with ACHW and facility-based FP services was high at endline, consistent with qualitative and SDA data suggesting that providers were generally well-equipped to deliver FP services. As shown in Chapter 4, the endline survey data suggest that the vast majority of MWRA were satisfied with door-to-door services provided by ACHWs, reporting that ACHWs were knowledgeable, respectful, trustworthy, and available when needed (Figure 4.5). (There are no equivalent baseline measures because the initiative introduced ACHWs in areas not served by community health workers.) Similarly, the vast majority of endline survey respondents who had visited a health facility for FP or delivery care in the previous six months reported that they felt the provider was knowledgeable about FP, good at answering questions, respectful, and committed to maintaining confidentiality (Figure 5.6). Just under 90 percent indicated that they would return to the facility for services in the future, and 86

percent were willing to recommend the services to a friend. Among those who had a specific method in mind before going to the facility, around 92 percent said they received that method (Figure 5.6).

Consistent with MWRA reports (Figure 5.6), the SDAs indicated that most facilities were generally well-equipped for FP service provision at endline—providing a comfortable waiting room and an area where FP counseling could be done in private, and having essential FP supplies. In addition, observations of client-provider interactions suggested that providers were generally trained in how to provide client-centered and respectful FP services, with all providers asking about the client's history and current situation and providing counseling and responses to questions about specific FP methods (not shown). However, in only half of the interactions observed were visual aids or samples of contraceptive methods used to support counseling and responses to questions. In addition, while in all cases facility staff provided information and counseling on IUCDs, counseling on other methods was less common; in roughly 70 percent of interactions observed, providers gave information on pills, condoms, injections, and/or implants, and in only 30 percent of interactions observed were permanent methods discussed. This may reflect client needs and preferences at the time of the service observed, but is also consistent with survey and qualitative findings suggesting that providers tended to focus on select methods in their

FIGURE 5.6. PERCEPTIONS OF FACILITY-LEVEL SERVICES

	Sample size	Mean (%)
Visited a health facility for FP or delivery care in previous 6 months	3,038	14.6
Client satisfaction		
Provider knowledgeable about FP	428	99.7
Provider good at answering respondent's questions	465	97.2
Felt comfortable asking provider questions about FP	465	94.0
Provider treated respondent with respect	460	93.0
Obtained method of choice at facility (women who had a specific method in mind before going to facility)	177	92.1
Believed information will be kept confidential	333	90.7
Information provided during visit was just right	423	38.5
Would return to the facility for services in the future	392	88.5
Recommend services provided by facility to a friend	399	86.7
Facility infrastructure and processes		
Facility had a waiting room	428	89.2
Facility had a separate/designated FP counseling counter	399	77.7
Facility had a private space for FP counseling/service	378	72.9
Wait time to see provider (minutes)	465	20.4
Other clients could hear when meeting with provider	364	16.1
Charged for services	465	55.8
Amount paid adequate for services received	248	82.0

Source: Endline survey data.

interactions with clients. These findings are also consistent with a relatively low percentage (one-third) of MWRA feeling that the information provided during FP visits was "just right" (Figure 5.6).

Qualitative interviews told a similar story, with women noting that they had a generally positive experience and were treated respectfully, and providers noting substantive improvements to facilities and FP counseling due to the initiative's investments and provider trainings. With a few exceptions, most MWRA felt the wait times were not too long (20 minutes, on average, according to MWRA surveyed). Opinions were mixed among MWRA on whether private or public facilities were more optimal. Some preferred public facilities because services were provided free of cost, but others felt private providers were more respectful. Proximity to the facility was ultimately one of the most important factors for most women deciding to visit a facility for services.

FIGURE 5.7. QUALITY OF PAC SERVICES

	Endline sample size	Endline mean (%)
Among women who had a check-up after abortion		
Believe information will be kept confidential	476	90.4
Provider treated respondent with respect[a]	624	99.1
Felt comfortable asking provider questions about services received	624	95.9
Provider good at answering respondent's questions[b]	624	98.2
Provider knowledgeable about PAC[c]	600	99.2
Information provided during visit was just right[d]	603	40.9
Would return to the facility for services in the future	493	67.3
Recommend services provided by facility to a friend	515	77.3
Facility infrastructure and processes		
Facility had a waiting room	598	89.7
Facility had a private space for PAC	575	91.8
Wait time to see provider (minutes)	603	19.6
Other clients could hear when meeting with provider	538	16.8
Believe information will be kept confidential	476	90.4
Charged for services	624	74.2
Amount paid adequate for services received	457	77.7

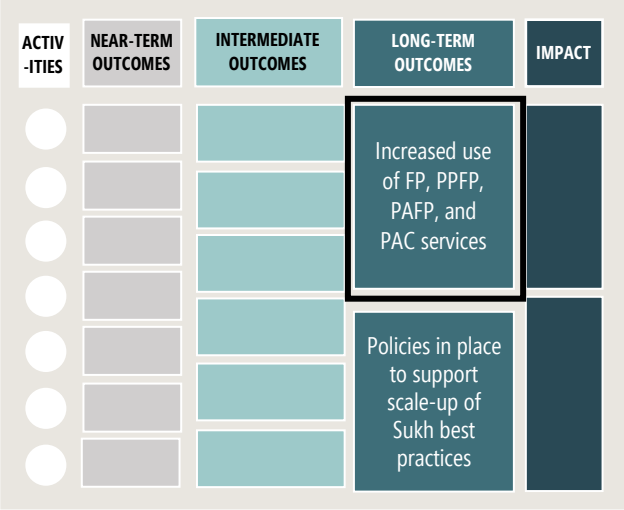
Source: Endline survey data.
a Share responding "yes, always" or "sometimes" to the question, "Did the health care provider treat you with respect during your visit?" Other response options were "no, never."
b Share responding "very good" and "somewhat" to the question, "How good do you think the provider was at responding to your questions?" Other response options were "can respond to some questions" and "not good."
c Share responding "very knowledgeable" and "somewhat knowledgeable" to the question "How knowledgeable was the provider about post abortion care services?" Other response options were "not knowledgeable" and "don't know."
d Share responding "just about right" to the question, "Do you feel the information given to you during your visit was too little, too much, or just about right?" Other response options were "too little," "too much," and "not applicable."

Experiences with PAC services were also generally positive, with a few exceptions. Most women who had a check-up after an induced or spontaneous abortion believed their information would be kept confidential by the provider (90 percent); felt comfortable asking the provider questions about services received (96 percent); and felt the provider was good at answering their questions (98 percent), was knowledgeable about PAC (99 percent), and treated them with respect (99 percent) However, similar to MWRA perceptions of FP services, only 41 percent felt the information provided during the visit was the right amount. Further, only 67 percent of women said they would go back to the same provider for services in the future, and 77 percent would recommend the services to a friend (Figure 5.7). This finding may reflect women's aversion to talking about or revisiting services associated with spontaneous or induced abortions.

Qualitative data on PAC services were very limited, but did indicate there were some negative experiences. One woman said the facility she went to when experiencing a miscarriage felt ill-equipped to treat her and provide her the immediate attention she needed. Another woman noted the unsanitary conditions in which she was provided PAC services. Again, we were able to speak with very few women who received these services, so these examples may not be indicative of a larger trend.

Quality of and satisfaction with FP services introduced or improved under Sukh were generally high, as envisaged in the ToC, with some notable exceptions and room for further improvement. It is therefore plausible that these quality improvements would have contributed to the expected increase in the use of FP services. However, as described in Chapter 4, relatively few women regularly used public facilities for FP services, whereas ACHWs reached about three-quarters of MWRA. This suggests that the scope for quality improvements at facilities to increase population-level use of FP services was more limited than the scope for introducing high-quality ACHWs.

5.2. LONG-TERM OUTCOMES

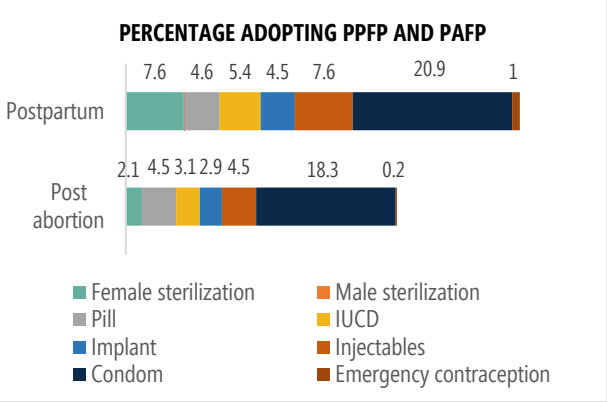


In the long term, the ToC expected that the intermediate outcomes described above would lead to increased use of FP, PPFP, PAC, and PAFP services, which are channels for increasing modern contraceptive use.

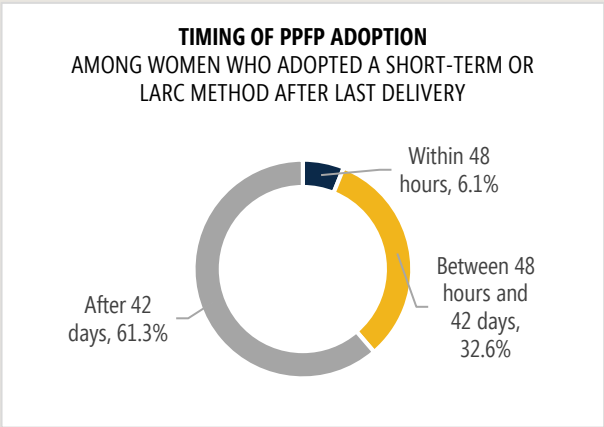
ACHWs distributed a high volume of short-term contraceptive methods to MWRA during door-to-door visits. As described in Chapter 4, the ACHWs hired and trained by the initiative had a wide reach, with about three-quarters of endline MWRA survey respondents reporting that an ACHW had visited them. In addition to providing FP-related counseling during these visits, ACHWs distributed FP commodities (mostly condoms and contraceptive pills), which were reported by about one-third of MWRA visited. Using program data on the number of MWRA in the ACHWs' catchment area, this suggests that about 36,000 MWRA received FP commodities from an ACHW over the course of the initiative. Program monitoring data suggest that ACHWs distributed more than 1.6 million condoms and about 95,000 one-month packs of pills to these MWRA—an average of 46 condoms and 2.6 packs of pills per MWRA who received commodities from an ACHW. The qualitative findings in Chapter 4 suggest that ACHWs were providing commodities to women who would not otherwise have received them, rather than substituting for other sources. Below, we show that ACHW visits were positively correlated with use of modern methods at endline, especially condoms.

At endline, about half of MWRA who gave birth had adopted a modern method of contraception. About 8 percent of MWRA who gave birth were sterilized after their most recent delivery (almost none of their husbands were), 18 percent adopted LARC (IUCDs, implants, or injectables), and 27 percent adopted short-term methods (pills, condoms, or emergency contraception) (Figure 5.8). Among those adopting LARC or short-term methods, almost 40 percent adopted the method

FIGURE 5.8. ADOPTION OF PPFP AND PAFP

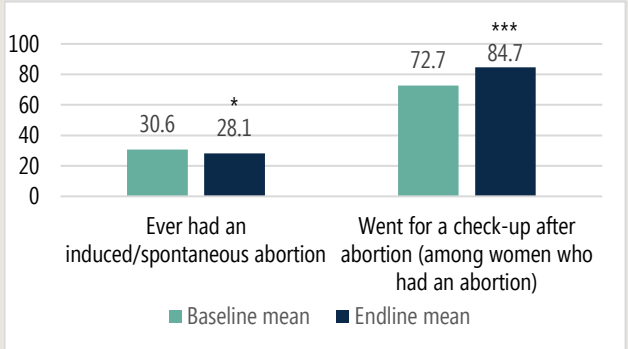


Notes: N = 2,756; LAM is excluded from the definition of modern methods.
Source: Endline survey data.



Notes: N = 1,693.
Source: Endline survey data.

FIGURE 5.9. PERCENTAGE OF WOMEN USING PAC SERVICES



Notes: *** p<0.001; Baseline sample size = 5,139 1,529; endline sample size = 3,038, 756

within six weeks of delivery (Figure 5.8). Combined with those who were sterilized, this suggests that about one-quarter of all MWRA who had given birth at endline adopted a modern method soon after their most recent delivery. Adoption of modern methods by women who gave birth is strongly associated with the provider discussing FP with the woman or her husband after delivery. Specifically, 69 percent of women who experienced these discussions after the last delivery were using a modern method at endline, compared to only 36 percent who did not experience them (not shown).

As discussed in Chapter 4, qualitative data from providers discussed suggest that FP infrastructure and service provision at facilities (where most women give birth) improved substantially due to the initiative, which might have improved uptake of PPFP. However, we do not have equivalent baseline data to assess these changes over time. Further, there was still substantial room for improvement in PPFP at endline. For example, only about 46 percent of MWRA reported that the provider had discussed FP with them or their husbands after their most recent delivery (not shown).

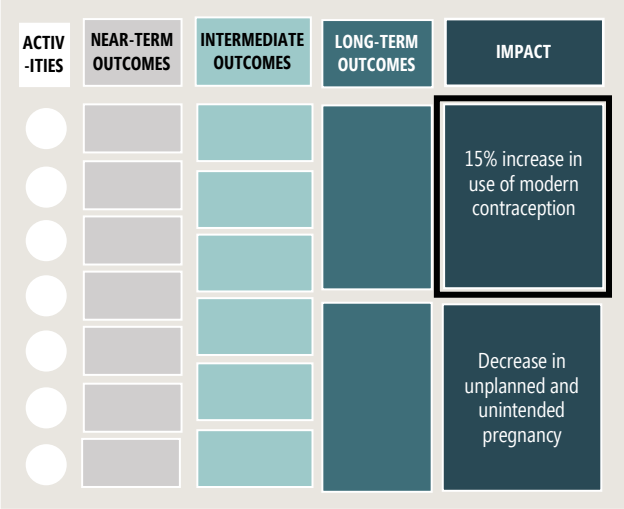
There was an increase in the use of PAC services since baseline, with most women receiving abortion and PAC services at private facilities. About 30 percent of MWRA at baseline and endline reported having had an induced or spontaneous abortion (Figure 5.9). Of these women, 82 percent reported having a facility abortion at endline (no comparable measure at baseline), with about three-quarters of these going to a private rather than a public facility (not shown). Among women who had an induced or spontaneous abortion, 73 percent went for a check-up after the abortion at baseline compared with 85 percent at endline (12 percentage point increase) (Figure 5.9). Again,

about three-quarters of these checkups were conducted at a private rather than a public facility (not shown).

At endline, about one-third of MWRA who had an induced or spontaneous abortion adopted a modern method of contraception. About 2 percent of MWRA who had an abortion were sterilized after their most recent abortion, 11 percent adopted LARC methods, and 23 percent adopted short-term methods (mostly condoms) (Figure 5.8). In Chapter 4 we describe improvements to PAC and PAFP services at private facilities, where the majority of abortion services are provided, which might have improved these outcomes. However, the extent to which they improved is unclear given the lack of equivalent baseline measures.

Widespread receipt of FP commodities—especially condoms—from ACHWs during door-to-door visits was an important dimension of increased service use attributable to the initiative. Given the substantive improvements in PPFP, PAC, and PAFP services at facilities according to qualitative data, it is plausible that use of these facility-based services also improved due to the initiative. However, a lack of baseline data limits our ability to assess changes in outcomes, such as adoption of modern methods soon after delivery or having a post-abortion check-up, over the course of the initiative. Further, regardless of whether these outcomes had improved since baseline, there was still substantial room for improvement in many of them at endline.

5.3. IMPACT OUTCOMES

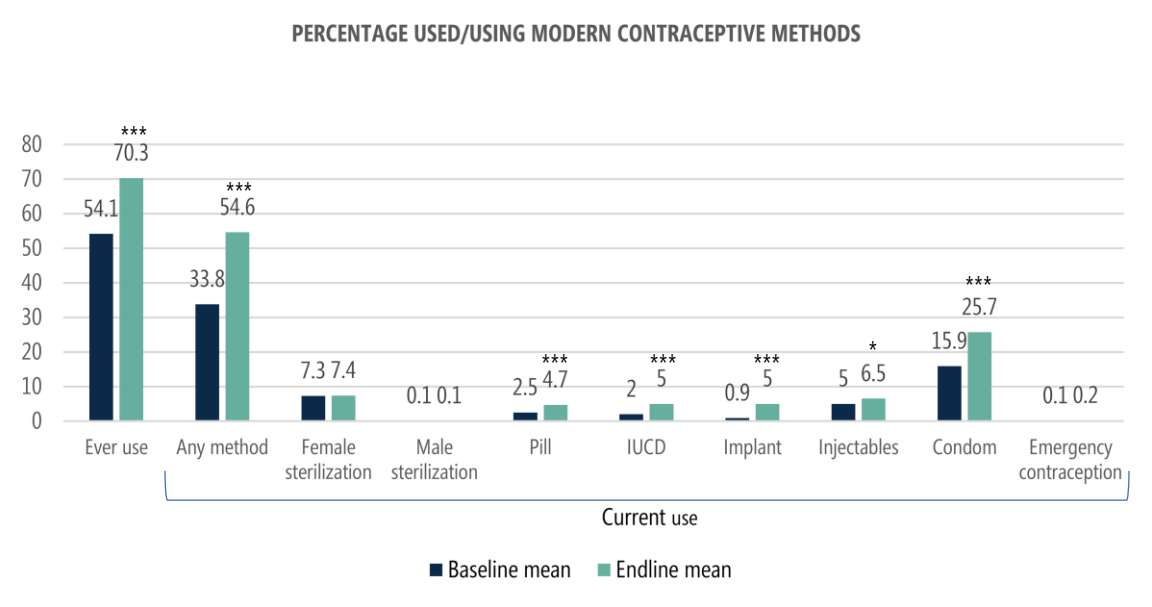


Ultimately, the initiative was intended to achieve changes in two key long-term family planning outcomes: (1) an increase of 15 percentage points in the use of modern contraceptive methods; and (2) a decrease in unplanned or unintended pregnancies (no numerical target specified). In this section, we examine whether and how these changes were achieved.

Among MWRA, current use of modern methods of contraception increased by 21 percentage points, from 34 percent in 2014 to 55 percent in 2018. This large increase in the use of modern methods (Figure 5.10), which exceeded the initiative's target of 15 percentage points, contrasts with a slight decrease from 33 percent to 28 percent across all urban areas of Sindh province over roughly the same period (PDHS 2012–13; PDHS 2017–18). Although the large increase in the initiative geographies cannot be fully attributed to the initiative given the absence of a counterfactual, this broader downward trend suggests that it is unlikely to have been driven by external factors at the country or province level.

The overall increase in current use of modern methods in large part reflects adoption by new users, as the percentage of MWRA who had ever used a modern method increased by 16 percentage points between baseline and endline (Figure 5.10), accounting for three-quarters of the increase in current use. The increase in current use was driven by a range of methods, but particularly by condoms, which were

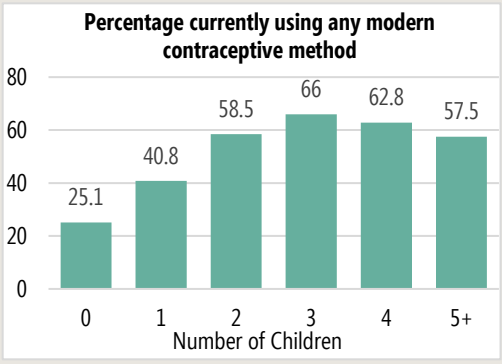
FIGURE 5.10. USE OF MODERN CONTRACEPTIVE METHODS



Notes: * p<0.05, *** p<0.001; baseline sample size = 4,518; endline sample size = 2,803; baseline N = 5,140 and endline N = 3,038 for ever used any modern contraceptive method. Currently pregnant women are excluded from the sample. LAM is excluded from the definition of modern methods. If LAM is included, overall use of modern methods increases from 35.8 percent at baseline to 57.4 percent at endline, an increase of about 22 percentage points (***). (Current use of LAM increased from 2.0 percent at baseline to 2.9 percent at endline.)

Source: Baseline and endline survey data.

FIGURE 5.11. CONTRACEPTIVE USE BY PARITY (ENDLINE)

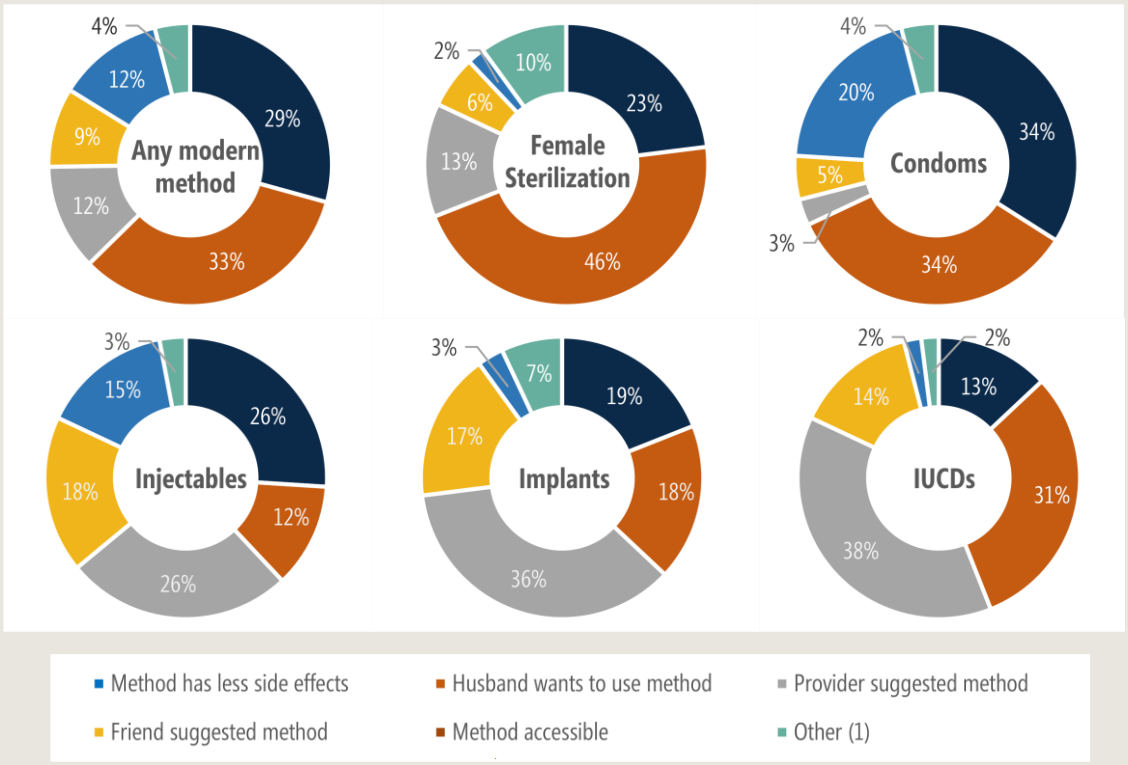


Notes: N = 254; Currently pregnant women are excluded from the sample. LAM is excluded from the definition of modern methods.
Source: Endline survey data.

distributed through door-to-door ACHW services under the initiative. Specifically, current use of condoms increased by 10 percentage points between baseline and endline (Figure 5.9), and this was by far the most common modern method used at endline. There were also substantive increases—relative to low baseline levels—in the use of implants (4 percentage points), IUCDs (3 percentage points), and oral contraceptive pills (2 percentage points) which, combined, represent 9 percentage points of the increase in contraceptive use. The use of specific methods at endline was broadly consistent with the program data, which again suggest that condom use predominated. Contraceptive use was lowest among women with no children, suggesting that most women were not seeking to delay the first birth after marriage (Figure 5.11).

Despite these positive trends in modern contraceptive use, qualitative data indicate several continuing concerns among MWRA about the safety and convenience of various methods (e.g., that IUCDs led to abdominal swelling, that injections caused body pain, that it was difficult to remember to take contraceptive pills, and that implants "freeze" arms and lead to either excessive bleeding or inconsistent

FIGURE 5.12. REASONS FOR SELECTING CURRENT METHOD



(1) Other includes: Don't know any other method; Couldn't get any other method; Method is cheap.
Notes: Any modern method N = 1,863; Female sterilization N = 228; Condoms N = 689; Injectables N = 208; Implants N = 140; IUCDs N = 139.

menstruation). However, these views were not universal, by any means. Many also called out the convenience of implants, for instance, and there were few worries about condoms, other than that some men preferred not to use them. Nevertheless, the above myths could be targeted and dismantled more directly through sensitization in future FP programming for this population.

Overall method choice was driven by husband's preference for a method (33 percent), concerns about side effects (29 percent), recommendation by a provider (12 percent), accessibility (12 percent), and recommendation by a friend (9 percent) (Figure 5.12). However, the most common reasons for selecting a specific method vary by method. Accessibility was an important factor for current users of condoms and pills, provider recommendation was an especially important reason for selecting LARC methods (IUCD, implants, and injectables), and having fewer side effects was an important consideration across methods, but to a varying extent. Taken together, this suggests that the initiative's focus on FP counseling through ACHWs and at facilities, and distribution of pills and condoms by ACHWs, was appropriate.

We also examined differences in the increased use of modern contraceptive methods across the four towns included in the study. Three towns (Korangi, Malir, and Landhi) had a comparable increase between baseline and endline of between 12 and 18 percentage points in use of modern methods, whereas one town (Bin Qasim) had a much larger increase of 41 percentage points (Appendix Table A.2). The large change in Bin Qasim is driven largely by much higher rates of adoption of modern methods by MWRA who had given birth. At endline, 71 percent of these MWRA in Bin Qasim reported adopting a

modern method after their most recent delivery, compared with between 42 and 52 percent in the other towns (not shown). (The equivalent measure is not available at baseline.) Consistent with this, several measures related to the initiative's intermediate outcomes are higher in Bin Qasim than in other towns. For example, discussions about FP immediately after delivery, receipt of information about Sukh facilities from ACHWs, and willingness to revisit or recommend FP service providers were all higher in Bin Qasim than other towns (Appendix Tables A.3 and A.4); many of these measures are positively correlated with use of modern methods.

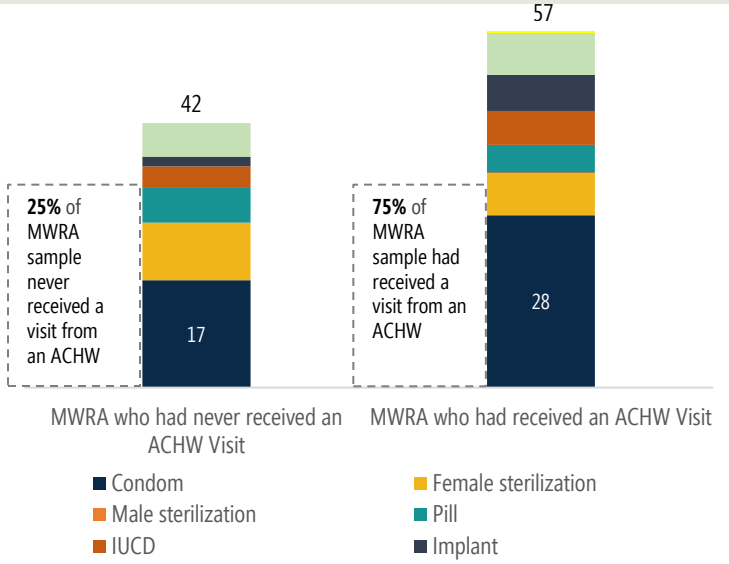
> ***"I do not talk much to my husband about it. At first, when I informed him about contraceptives, he told me that if I was okay with it then he did not have any problem. After the first husband-wife talk, we did not have conversation about it again."***
>
> *– MWRA, Bin Qasim*

There are several possible explanations for the larger increase in use of modern methods in Bin Qasim compared to the other towns. First, it is possible that ACHWs were more active in providing information about FP and/or FP commodities in Bin Qasim. However, the fraction of MWRA visited by ACHWs (according to survey or program data), the services provided by ACHWs during visits (according to survey data), and the average number of FP commodities per MWRA distributed by ACHWs (according to program data) were not systematically higher in Bin Qasim. Second, baseline levels of contraceptive use in Bin Qasim were lower than in other towns, suggesting more scope for rapid improvement. However, this does not explain why endline levels of modern contraceptive use exceed those in other towns. Third, it is possible that the different sampling approaches at baseline and endline might have led by chance to a lack of comparability in the two samples in Bin Qasim, despite our efforts to align the observable socio-demographic characteristics of the two samples by reweighting (as described in Chapter 3.) In this scenario, the endline sample might have been more likely to take up modern methods than the baseline sample in part due to sampling variation. The qualitative data do not indicate any substantial differences in implementation across the four towns. It is possible, however, that men in Bin Qasim may have been less involved in decision-making around FP, thus allowing women to identify and use their preferred contraception without much pushback.

Ultimately, we were unable to identify a clear explanation for the larger increases in Bin Qasim. Regardless of the explanation, however, Bin Qasim appears to be an outlier that might not be representative of the impacts of the initiative in other locations. Therefore, as a robustness check, we re-estimated the change in modern contraceptive use omitting Bin Qasim; the overall increase for the other three towns is 13 percentage points, which is still close to meeting the initiative's target.

The increase in use of modern methods was driven in part by door-to-door services that provided condoms and pills to women in their homes. Use of modern methods at endline was higher among women who had received a home visit from an ACHW than among those who had not. Among women who have received a visit from an ACHW, 57 percent were currently using a modern method compared to 42 percent of women who had never received a visit from an ACHW (Figure 5.13). Most of this difference is explained by women who used condoms, with 28 percent of women who had received a visit from an ACHW currently using condoms compared to 17 percent of women who had not (Figure 5.13).

FIGURE 5.13. PERCENTAGE CURRENTLY USING MODERN CONTRACEPTIVES, BY FREQUENCY OF ACHW VISITS



Notes: Endline sample size = 516 for never received ACHW visit and 2,287 for received ACHW visit. All numbers exclude pregnant women. LAM is excluded from the definition of modern methods.

Source: Endline survey data.

"My husband and I feel awkward getting such things. We have to buy it from shop, so it doesn't look appropriate. It is difficult for us. If we get it at home then this would be best. Sometimes my husband forgets to bring it from medical store. Then it seems tough writing the name of the medicine on a paper and giving it to my daughter to bring medicine. So we rely on CHW to suggest and provide us FP methods."

– MWRA, Landhi

"Usually, the workers of the Aman Foundation provide me the services of the family planning. They guide us well by discussing the details of the product. Whenever we needed anything they provided. As we cannot go to the medical store so we obtain the service through the CHW."

– MWRA, Landhi

The qualitative data suggest that many women reported relying on ACHWs to obtain FP information and methods. Provision of methods at women's homes by ACHWs particularly helped women with limited mobility and women who are hesitant to buy contraceptives in public to access methods easily and discreetly, and reduced dependence on husbands to obtain these methods. This is especially important for condoms, a method for which accessibility was cited as an important constraint (Figure 5.12). Almost one-third of current users at endline reported obtaining their current method from an ACHW.

There were notable increases in the use of LARCs, but concerns about side effects may have limited broader adoption. The use of LARCs increased by 8 percentage points in the ACHW catchment area between baseline and endline, although the overall levels of use of these methods remained relatively low at endline (16 percent) (Figure 5.10). Among women using LARCs, provider recommendation was cited as a key factor influencing adoption of LARCs (Figure 5.12), suggesting that improvements in the quality of FP counseling by ACHWs and at facilities may have been important drivers of this increase. However, as noted above, qualitative data suggest that concerns about side effects were widely prevalent, and thus may have limited the extent of adoption of LARCs, despite improvements in knowledge about side effects described earlier. Moreover, men (who play an important role in method choice) also prefer condoms over LARCs, citing side effects as a concern.

Among non-users at endline, lack of knowledge and access to methods were not key barriers to use of contraceptives. Among non-users, 50 percent reported that they were trying to become pregnant (Figure 5.14). Opposition to use, particularly by husbands, and fear of side effects were the most common

"[Condoms are] a safe method and you can stop using anytime. Once the kids have grown you natural[ly] want to have more kids and then you can have one if you stop using condoms."

– Married man, Bin Qasim

"I have used RC, pills and injection. I don't want to go on long term, I'm afraid."

– MWRA, Landhi

"Many husbands don't allow their wives for long-term, that's why [people mostly use condoms]."

– LHW, Malir

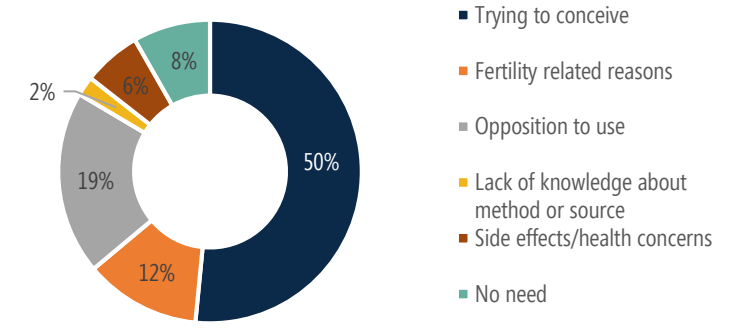
"We don't like tying of the tubes because it also stops menses and there can be problems with that. Implants and IUC is also not very good. There is also this method of putting capsules in the women. That is also not a good way since it initiated menses. It makes women really worried and they think they are about to die. So I also told my wife not to use this method and that using a condom is ok."

– Married man, Bin Qasim

"[Women] faced a lot of difficulties (bleeding, itching, etc.). Because of this, there was a drop in IUCD usage. When we were introduced to the implant, many women took it and they liked this method."

– LHW, Bin Qasim

FIGURE 5.14. REASONS FOR NOT USING CONTRACEPTIVES (ENDLINE)



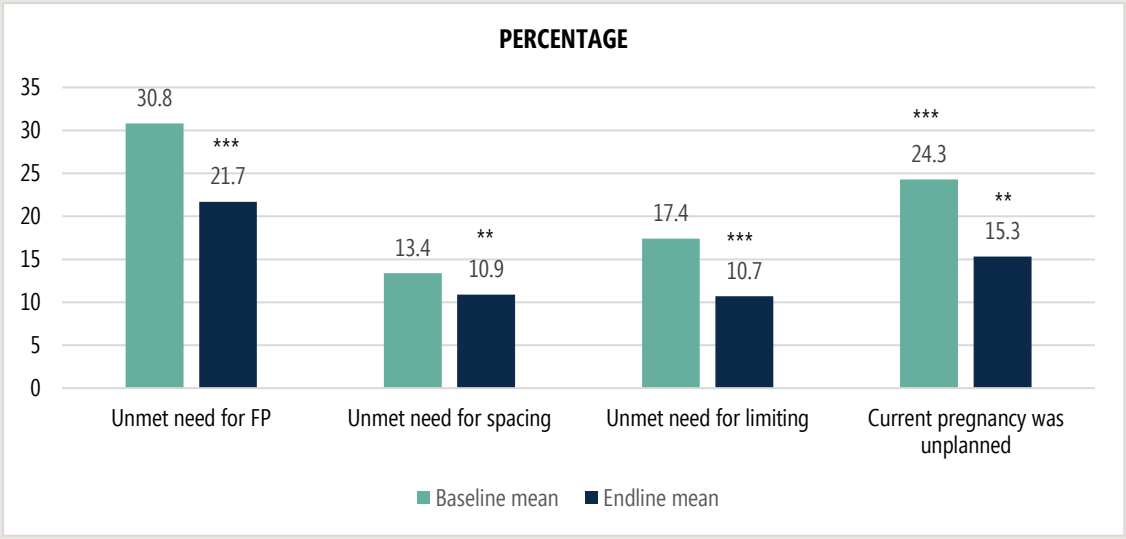
Notes: N = 590.
Source: Endline survey data.

reasons for not using contraceptives among women who were not trying to become pregnant, perhaps reflecting the program's limited reach among married men, as discussed earlier. On the other hand, only 2 percent of non-users reported lack of knowledge about methods and/or sources for methods or lack of availability of methods as a reason for not using contraceptives, suggesting that supply constraints were not a barrier to use at endline. However, we cannot rule out that these barriers were more important at baseline and were overcome by the initiative.

Between baseline and endline, unmet need for FP and the share of unplanned pregnancies each decreased by 9 percentage points. Unmet need decreased from 31 percentage points at baseline to 22 percentage points at endline (Figure 5.15). This included a decrease of 3 percentage points in unmet need for birth spacing and a decrease of 7 percentage points in unmet need for limiting. Moreover, among women who were pregnant at the time of the surveys, only 15 percent reported that their current pregnancy was unplanned at endline compared with 24 percent at baseline. These findings suggest that women's ability to delay, avoid, and plan their pregnancies improved during the intervention period.

The initiative successfully met its impact goals as measured by changes over time in modern contraceptive use and unmet need. Although these changes cannot be fully attributed to the initiative, they are unlikely to have been driven by broader trends in urban Sindh province, which were slightly negative over the same period. Linking back to the findings on implementation, intermediate outcomes. and long-term outcomes discussed earlier, the key conclusions about how these changes were achieved are as follows:

FIGURE 5.15. UNMET NEED FOR FAMILY PLANNING



Notes: ** p<0.01, *** p<0.001; Baseline sample size = 5,140; endline sample size = 3,038. Sample for planning status of current pregnancy only includes pregnant women; baseline sample size = 596; endline sample size = 235.
Source: Baseline and endline survey data.

- *The large changes in contraceptive use were achieved despite the very limited reach of the telehealth intervention, suggesting that they were driven by the initiative activities related to ACHWs and facilities.*
- *The initiative made limited inroads into changing attitudes toward delayed childbearing and birth spacing, desired family size, or increased interspousal communication about FP, which can largely be ruled out as important channels for the large changes in contraceptive use observed.*
- *The large increase in knowledge about the existence of various methods may have contributed to these changes, although there is evidence that a lack of knowledge was not the binding constraint (at least by endline). Improvements in more detailed knowledge about modern methods may also have played a role, especially because perceptions of side effects affect contraceptive use and method choice.*
- *Improved quality of services from ACHWs and facilities, as proxied by client experiences and satisfaction, likely also contributed to these changes. Although we are limited by a lack of equivalent baseline data, findings from qualitative data emphasized that facilities benefited from improved infrastructure and were better positioned to provide FP and PPFP services, findings also supported by endline SDAs. Facility improvements might be especially important in providing LARCs, which increased substantially relative to low baseline levels and for which provider recommendations are key to uptake.*
- *Improved access to contraception via ACHWs helped to increase uptake of modern contraceptive methods. In particular, condoms distributed during door-to-door visits greatly improved access to this short-term method, which is by far the most popular in the cultural context of urban Pakistan.*

6. SUMMARY AND IMPLICATIONS

Below we summarize topline implementation and impact findings and draw out lessons around urban FP and operationalizing a multi-component, multi-partner initiative.

6.1. KEY TAKEAWAYS

Among MWRA in the Sukh intervention area, mCPR increased by 21 percentage points. This increase was driven by supply side factors, primarily the availability of home-based FP services and commodity distribution, as well as improvements in facility-based service provision and related, substantial increases in knowledge of specific methods and side effects. Across all Sukh interventions, the ACHW component had the most reach and intensity, with three-quarters of MWRA reporting exposure to door-to-door services by ACHWs at endline. CACs established by Sukh helped door-to-door services gain a foothold in the highly conservative communities in the intervention area. Recruiting local women to act as ACHWs engendered trust and led to greater openness among MWRA to receiving FP/RH information and services. Moreover, ACHWs filled a key gap in FP/RH services—operating in areas without LHWs and where women's mobility is restricted, and thereby providing many women with easy access to FP counseling and methods for the first time. Consistent with this, our findings indicate that the increase in mCPR was driven by (1) new FP adopters (accounting for 16 percentage points of the 21 percentage point increase) and (2) increased use of condoms, which were distributed by ACHWs, with overall unmet need decreasing by 9 percentage points. Sukh's operational infrastructure and processes ensured that ACHW services were delivered with quality and intensity. Close supportive supervision from Sukh's field station staff and data-based tracking increased accountability, leading to relatively regular door-to-door visits and helping to ensure the quality of the counseling provided.

Sukh also strengthened facility-based service provision, making critical improvements in infrastructure and FP counseling during FP, delivery-related PPFP, and PAC visits. This likely contributed to the increase in mCPR, as reflected in observed increases in LARC use (which remains relatively rare). However, the overall reach of facility services was low (only 15 percent of MWRA had visited a facility for FP or delivery services in the six months prior to the endline survey), indicating that improvements in facility-based services likely had a lower level of impact on mCPR than the widely accessed door-to-door services. Finally, while we found little change in attitudes toward the timing and spacing of births or ideal family size, there were large increases in knowledge of almost all modern methods, driven by substantial increases in the proportion of clients receiving counseling about different FP methods and their side effects over the course of the initiative.

The other components of Sukh's 360-degree approach that involved reaching women through call center services and influencing married men and youth were not as successful and/or had limited reach. Despite strong trainings of TeleHealth agents and male mobilizers under Sukh, call center services and outreach to married men were hampered by design constraints, as well as weaker-than-

envisioned linkages to other initiative components. Only 15 percent of endline survey respondents had heard of Aman TeleHealth services, suggesting that ACHWs, LHWs, and facility staff were not consistently informing women of this resource or linking them to it. In addition, less than half of MWRA owned mobile phones (41 percent), and only 4 percent had heard of the Aman telephone booths. As a result, only 4 percent of MWRA had received a call from a Telehealth agent by the end of the initiative, and less than 2 percent had placed a call to the call center. There were few male mobilizers and the activities they were asked to conduct to target husbands—support group meetings and corner meetings—were not responsive to most men being away at work and hard to reach during the day. Moreover, they did not systematically target outreach to husbands of MWRA served by ACHWs/LHWs. Finally, the youth component of Sukh was successful in reaching young men and women through school-based LSBE and increasing their confidence as well as understanding of issues related to puberty, marital rights, and gender-based violence. However, the community-level outreach to youth was lighter touch and largely siloed from the rest of the initiative, in part because it addressed a distinct population that, in the short term, may not directly contribute to targeted changes in mCPR.

Through consistent, strategic engagement with government, Sukh enabled the scale-up of several of its key components, informed policy, and fostered greater integration between the PWD and DoH. The initiative successfully leveraged the networks and connections of donor representatives, PMU staff, and implementing partner staff to engage with the government from the start, drawing increased attention to urban FP and generating interest in key solutions to lagging FP/RH indicators. Regular engagement continued throughout the initiative, either through planned or ad hoc group or individual meetings, and ultimately enabled several advocacy wins, including (1) large-scale task shifting of key FP services (implant insertion and administration of the first contraceptive injection) to mid-level providers, (2) adoption and rollout of LSBE to schools across Sindh, and potentially, (3) adoption of Sukh's LHW model. Sukh's participation in several government platforms for FP/RH coordination, and key steps it took on the ground as part of its facility component, also supported the integration of PWD and DoH, thereby reducing systems-level inefficiencies in FP/RH service provision. Jhpiego placed FP counselors from PWD at the antenatal counters it established at DoH facilities, a step the Sindh government adopted more widely. Jhpiego also helped to re-energize and increase the productivity of joint district technical committee meetings, such that DoH and PWD officials at the district level were coordinating around human resources, commodities, service provision, and quality assurance. Sukh's advocacy made skilled use of data and evidence. The Sindh Minister of Population Health made the decision to ingrate PWD counselors into DoH facilities under her jurisdiction upon seeing Jhpiego's reports of a 50 percent increase in PPFP adoption following this change. Program data and preliminary evaluation results were also used successfully to generate interest among Sindh government stakeholders in adopting Sukh's door-to-door services model for its LHWs.

The PMU was an adept manager of processes, but may have been too focused on meeting targets rather than learning and strategy; as a result design constraints and implementation challenges were not always addressed and synergies and linkages between interventions were sometimes missed. The PMU adeptly managed and oversaw its field stations and used data for tracking progress toward pre-set targets. However, this focus on meeting targets precluded a broader learning orientation. Implementing partner meetings did not promote exchange of ideas and creative problem-solving. And data and on-the-ground learning were not proactively used to address challenges faced by

individual components or strengthen linkages across components. For instance, the design of the call center services and male mobilization components remained largely the same over the course of the initiative, despite early indications of the accessibility challenges posed by low mobile phone access and limited access to men during the work day. Key synergies were also not always leveraged. For example, less than half of the ACHWs mentioned referral facilities, few received the call center number from ACHWs, and (as mentioned) outreach to married men was not systematically integrated with door-to-door services to MWRA.

6.2. LESSONS AND IMPLICATIONS

- **Mobilizing highly localized community-based FP/RH service provision in underserved areas can substantially improve FP outcomes, especially when buttressed by intensive programmatic supports.** Our findings confirm Sukh's hypothesis—that hiring and rapidly training local women to provide community-based FP/RH services in underserved areas can bring about significant improvements in knowledge of modern contraceptive methods and their side effects and access to these methods, both key drivers of FP uptake. This is a critical finding in today's status quo in urban Pakistan, where coverage of (and focus on FP) by government LHWs continues to be uneven. Key ingredients for successful mobilization of these services are to (1) obtain early buy-in from key community gatekeepers, such as political and religious leaders, to gain entry into conservative communities; (2) hire local women to ensure trust and minimize challenges in engaging women around sensitive FP/RH issues; (3) focus service provision on FP, and (4) provide strong supportive supervision and clear schedules and targets to ensure accountability and increase regularity of visits.

  These learnings can inform enhancements to existing LHW service provision as well. For instance, LHWs have a wide range of responsibilities beyond FP (22 job functions are listed in their terms of reference) and thus focus on current government priorities or the most pressing needs of their clients. Providing incentives for FP may foster greater focus on these services. Clear targets for FP service provision, found to be helpful by LHWs participating in Sukh, may also be a way to motivate LHWs to prioritize FP service provision during their home visits. Finally, given LHWs are not always from the communities they serve, and thus lack the networks, familiarity with customs, and language skills needed to easily engage with their clients around FP/RH issues, tailored training is particularly important. Our findings show that the training provided by Sukh linked FP/RH sensitization to LHWs' own life experience and helped them learn how to overcome the shame and hesitation that usually held them back in discussing FP with their clients.

- **Misconceptions about FP methods are very difficult to change in communities with low literacy; innovative strategies are needed to dismantle existing myths and prevent the spread of new misinformation.** A range of myths about the dangers of using modern contraceptive methods continue to persist in Sukh's intervention areas (e.g., that IUCDs led to abdominal swelling, that injections caused body pain, and that implants "freeze" arms). These are regularly cited as reasons for non-use or discontinuation, and thus merit targeted attention. Sukh's sensitization around side effects of modern contraceptive methods was quite successful—the endline survey showed a 21

percentage point increase in current users reporting that they were informed about side effects. Potentially, provision of information about side effects could integrate *preemptive* messaging around common myths, explaining what women may hear about modern contraceptive methods and their harmful effects and why that is inaccurate.

- **Shifting attitudes around delayed childbearing is challenging; it may be easier to make the case for delaying marriage, which in turn may require closer integration of programming for unmarried youth and MWRA.** While shifting attitudes around delaying, spacing, and limiting births may not be critical in efforts focused narrowly on increasing mCPR in underserved areas, improvement in these outcomes may be important for additional and longer-term increases in mCPR in Karachi. For instance, our endline survey findings show that only about half of the MWRA perceived a benefit to delaying the first child after marriage. It is possible, however, that this was linked to the perceived impossibility of delaying childbearing—given the deeply entrenched social norms around having children immediately after marriage. Indeed, several MWRA we interviewed spoke about the benefits of delaying marriage instead of delaying childbearing, indicating this may be more feasible. Aahung's LSBE curriculum covered marriage and marital rights; if this included some discussion of the advantages of getting married at a slightly later age, including having children at a later age, this may set the stage for delayed childbearing. Work with MWRA could then focus on outcomes that are easier to influence following marriage, such as limiting births, another outcome where there is room for change.

- **New strategies are needed to surmount the substantial challenges involved in reaching and sensitizing married men, who are away at work for most of the day.** Influencing married men's thinking about FP/RH issues is critical. Qualitative data indicate that they play a key role in deciding the number of children that couples have and also weigh in on the choice of contraceptive. In-person engagement is challenging, given men's work responsibilities during the day. Group-based sensitization is also difficult, particularly when it is possible some men may be particularly religious and have strong, long-standing objections to FP. Mobile phone outreach may provide a solution, given men have far greater access to mobile phones than women. It also provides the opportunity for private conversations about FP.

- **Strengthening referrals and ensuring PPFP counseling is provided uniformly may increase the use and influence of facility-level services.** Less than one in five endline survey respondents reported visiting a facility for FP or delivery services in the past six months. This might have been driven by inconsistent provision of referrals to facilities (only about 40 percent of endline survey respondents who had received a visit from an ACHW reported that she had talked to them about Sukh referral facilities). However, MWRA from these conservative communities had very limited mobility. A key opportunity to reach these women is immediately after delivery, for which many do visit facilities. It is important to ensure that all women receive PPFP counseling after birth, which survey findings indicate may be very effective in promoting FP uptake (nearly 70 percent of women who reported that a provider discussed FP with them or their husbands after delivery were using a modern method at endline). Finally, client-centered counseling remains key. Providers, like LHWs, indicated the training they received on how to tailor the information they provided to the needs of the client was new and important. Both client experiences and SDAs suggest this may be happening,

but that more information and use of visual aids may further strengthen communication and understanding about FP methods.

- **Ensuring that multi-component initiatives operate in an integrated manner requires a strategic coordinating body to regularly identify and leverage synergies and engage in data-driven learning and decision-making.** The Sukh model's program logic was mostly sound, with its multiple components designed to feed into one another. However, given each component was led by a different partner, ensuring these theoretical linkages played out as envisioned in the field required strategic, flexible management, which the PMU provided sometimes but not always. Ensuring different components are operating in sync with each other, and that the initiative is greater than the sum of its parts, requires regular identification and leveraging of synergies, as well as a willingness to walk away from or heavily modify interventions that are not gaining traction. Adaptive management of this kind is highly reliant on strong real-time performance monitoring systems. The key lesson from Sukh is to not only develop monitoring data collection platforms and dashboards and establish forums for discussion of results, but also build a learning orientation into the DNA of the initiative. A learning orientation is necessary to ensure that program data are used for more than reporting and small changes to implementation plans, and instead foster deep reflection on what is and is not working on the ground and motivate action to increase efficiency, effectiveness, and sustainability.

REFERENCES

Hamid, S., and R. Stephenson. "Provider and Health Facility Influences on Contraceptive Adoption in Urban Pakistan." I*nternational Family Planning Perspectives,* vol. 32, no. 2, June 2006, pp. 71–78.

Jabeen, N., U. Farwa, and M. Jadoon. "Urbanization in Pakistan: A Governance Perspective." *Journal of the Research Society of Pakistan,* vol. 54, 2017, pp. 127–136. http://pu.edu.pk/images/journal/history/PDF-FILES/9_54_1_17.pdf.

MacQuarrie, K. L. D., and A. Aziz. "Trends, Differentials, and Determinants of Modern Contraceptive Use in Pakistan, 1990-2018." DHS Further Analysis Reports No. 129. Rockville, MD: ICF, 2020.

Mayne, J. "Contribution Analysis: Addressing Cause and Effect." In *Evaluating the Complex: Attribution, Contribution, and Beyond,* edited by K. Forss, M. Marra, and R. Schwartz. New Brunswick, NJ: Transaction Publishers, 2011, pp. 53–96.

Oxford Policy Management. "Lady Health Worker Programme: External Evaluation of the National Programme for Family Planning and Primary Health Care." 2002.

Tabassum, A., A. E. Khan, M. Arif, and M. W. Ali. "Exploring the Socio-Cultural Barriers to Modern Contraceptive Use Among Pakistani Women." *IOSR Journal of Humanities and Social Science*, vol. 19, no. 5, May 2014, pp. 98–102.

APPENDIX

Table A1. Respondent Characteristics

	Baseline sample size	Baseline mean	Endline sample size	Endline mean	Difference
Mean age (years)	5,139	30.4	3,038	31.1	0.7 ***
Education and literacy					
Never attended school	5,138	43.9	3,038	43.9	0
Years of schooling (reweighted)	3,226	8.6	1,537	8.7	8.3
Literate: can read and write			3,038	48	
Exposure to media					
Reads a newspaper at least once a week	5,115	3.8	3,038	1.8	-2 ***
Watches television at least once a week	5,130	52.6	3,038	44.5	-8.1 ***
Listens to the radio at least once a week	5,130	1.6	3,038	0.8	-0.8**
Access social media platforms at least once a week			3,038	9.3	
Ever watched docudrama on early marriage			3,038	15.2	
Access to mobile phone					
Own mobile phone	3,407	9.8	3,038	40.8	31 ***
Shared mobile phone	3,407	0.7	3,038	41.3	40.6 ***
Use mobile phone at least once a week	3,011	80.2	3,038	43	-37.2 ***
Marital status and spouse characteristics					
Currently living with spouse	5,132	98.1	3,038	97.9	-0.2
Mean age at the time of first marriage (years)	5,124	19.2	2,933	19.6	0.4 ***
Mean duration of current marriage (years)	5,138	11.3	3,037	11.5	0.3
Pregnancy and birth history					
Currently pregnant	5,125	11.7	3,038	7.8	-3.9 ***
Ever given birth	5,140	92.6	3,038	91.6	-1
Mean age at time of first birth (years)	4,693	20.5	2,766	20.9	0.4 ***
Mean number of children alive	5,140	3.1	3,038	2.9	-0.2 **
Mother tongue					
Urdu (reweighted)	5,134	37.8	3,038	37.8	0
Punjabi	5,134	12.7	3,038	13.6	0.9
Sindhi	5,134	12.5	3,038	14	1.5
Pushto	5,134	11.6	3,038	15.5	3.8 ***

Table A.2. Impact Outcomes by Town

	Korangi: Baseline mean	Korangi: Endline mean	Malir: Baseline mean	Malir: Endline mean	Bin Qasim: Baseline mean	Bin Qasim: Endline mean	Landhi: Baseline mean	Landhi: Endline mean	All: Baseline mean	All: Endline Mean
Current use of any modern contraceptive method	36.4	47.9	37.0	51.4	30.1	70.6	32.6	50.5	33.8	54.6
Current use of modern contraceptive methods:										
Female sterilization	7.4	5.7	9.6	10.5	6.9	9.9	7.0	6.5	7.3	7.4
Male sterilization	0.1	0.1	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.1
Pill	1.4	1.8	3.1	2.7	3.3	11.8	3.7	3.3	2.5	4.7
IUCD	2.4	4.8	1.3	4.8	1.7	5.7	2.0	4.7	2.0	5.0
Implant	1.1	5.4	1.2	4.5	0.7	4.3	0.7	5.6	0.9	5.0
Injectables	5.0	2.4	4.2	6.2	5.5	14.2	4.4	6.6	5.0	6.5
Condom	19.0	27.5	17.4	22.5	11.7	24.5	14.7	23.8	15.9	25.7
Emergency contraception	0.0	0.3	0.2	0.1	0.1	0.1	0.1	0.0	0.1	0.2
SAMPLE SIZE	1,854	730	250	666	1,670	726	744	681	4,518	2,803

Table A.3. Intermediate Outcomes/Pathways by Town: FP Services

	Korangi: Baseline mean	Korangi: Endline mean	Malir: Baseline mean	Malir: Endline mean	Bin Qasim: Baseline mean	Bin Qasim: Endline mean	Landhi: Baseline mean	Landhi: Endline mean	All: Baseline mean	All: Endline mean
Informed about side effects (FP services)	20.4	27.3	27.8	53.2	27.0	68.8	20.6	40.4	22.6	43.5
Told what to do if experience side effects (FP services)	17.7	19.5	25.2	49.5	24.0	58.5	19.7	33.1	20.2	35.4
Discussed other methods (FP services)	45.1	52.4	51.3	76.4	43.3	73.2	47.2	62.7	45.5	62.3
Would visit or obtain FP services from provider again		50.0		78.4		84.6		72.1		65.0
Would recommend FP services from provider to a friend		60.8		84.8		91.4		81.2		74.4
Used any modern method after last delivery		41.5		51.0		70.5		52.4		51.8
Respondent or husband sterilized after last delivery		6.5		10.2		9.5		6.7		7.7
Facility delivery (most recent delivery among women who had a live birth in the previous 3 years)		85.8		85.2		82.4		80.6		83.9
Provider discussed FP methods with respondent and her husband after last delivery (women who have ever given birth)		43.7		45.2		52.7		38.5		45.5
SAMPLE SIZE	873--900	397--683	114--120	245--618	577--604	427--698	324--326	259--677	1,894--1,936	1,316--2,746

Table A.4. Intermediate Outcomes/Pathways by Town: ACHW

	Korangi: Endline mean	Malir: Endline mean	Bin Qasim: Endline mean	Landhi: Endline mean	All: Endline mean
Aware of ACHW in area	79.9	84.4	71.5	70.3	76.7
Ever received a visit from an ACHW	76.9	83.9	70.8	67.6	74.6
Received a home visit by ACHW in previous 6 months	42.7	66.0	43.3	44.5	45.4
ACHW knowledgeable about FP	94.8	97.5	98.9	96.7	96.5
Felt comfortable asking questions about FP	88.8	90.5	96.4	88.6	90.9
ACHW good at answering respondent's questions	93.3	93.6	98.6	92.0	94.5
ACHW treats respondent with respect	99.5	99.3	100.0	99.2	99.6
ACHW would be helpful if respondent wanted a discussion with husband about initiating FP	62.0	89.1	95.8	91.7	78.3
ACHW likely to be available when respondent needs help	63.7	85.9	94.0	86.5	77.7
Would use services provided by ACHW in the future	61.7	79.2	90.4	70.5	72.1
Recommend services provided by ACHW to a friend or family member	71.1	84.8	91.0	77.2	78.4
Ever received any brochures or written information material about FP	8.8	12.6	32.2	5.2	14.7
ACHW talked to respondent about Sukh referral health care facilities in the area	29.1	53.7	65.3	27.1	40.2
Received a referral slip from ACHW	6.1	13.4	24.1	3.8	11.2
Received any supplies from ACHW	38.4	48.2	46.8	37.9	41.5
Ever contacted ACHW for supplies	7.2	9.7	12.4	5.6	8.6
Frequency of visits by ACHW					
Every week	1.1	0.7	0.5	0.2	0.8
Less than every week but at least once in a month	19.0	17.9	16.1	7.1	16.5
Less than once a month but at least once in six months	58.1	70.6	72.6	71.7	65.1
Rarely/no schedule	21.8	10.8	10.5	21.0	17.5
Received a home visit by ACHW in previous 6 months	42.7	66.0	43.3	44.5	45.4
SAMPLE SIZE	408--792	405--706	466--793	280--745	1,576--3,035