

Pakistan

The doorstep project

The environment for sexual and reproductive health (SRH) is challenging in Pakistan, which has many factors generally associated with high fertility rates: very low literacy level among women, low educational attainment, poverty, high infant and child mortality, a preference for sons, poor access to health facilities, low status of women, conservatism and religious opposition. The **Family planning and reproductive health services at the doorstep project** aims to bring accessible and affordable services to the people of Chakwal, thereby improving quality of life.

Located in the densely populated region of Punjab, the project is implemented by the Family Planning Association of Pakistan (FPAP).

The project offers a broad range of interlinked reproductive and family health services to Chakwal – one of the least developed, most traditional and poorest districts in Punjab – through a variety of community-based service delivery channels. Through socially and culturally acceptable interventions, the project promotes informed choice and provides a wide range of modern contraceptives. By fostering full community involvement,

FPAP has developed an innovative and effective model which specifically targets the status of women, male motivation, younger couples and young people, with emphasis on lower income groups.

This project demonstrates the effectiveness of creating a positive attitude towards SRH issues in a traditional society by focusing on community mobilization, skills development and vocational training. These activities laid the foundations of the project, and allowed FPAP to gradually shift the focus towards the more sensitive topics of women's empowerment and SRH.

The project corresponds to the five priorities in IPPF's strategic plan: to meet the needs of young people, to increase access to services, to address issues related to abortion and HIV/AIDS, and to strengthen advocacy for SRH.

PROJECT TITLE

Family planning and reproductive health services at the doorstep project

IMPLEMENTED BY

Family Planning Association of Pakistan (FPAP). FPAP was set up in 1953. It is one of the pioneers and leading providers of SRH services in Pakistan, working in collaboration with the government and other NGOs.

PROJECT AIM

To bring accessible and affordable sexual and reproductive health services to the people of Chakwal.

FUNDING

IPPF Vision 2000 Fund

BUDGET

US\$1,920,702

DURATION

October 1995 to December 2003





Skills training and income-generating activities are an important entry point to embark on the culturally more sensitive issues of sexual and reproductive health.

WIDE GULF BETWEEN KNOWLEDGE AND USE

The socio-demographic indicators for Chakwal were less favourable than for other areas of Pakistan, according to a baseline survey in 1995. It also showed that health service provision in Chakwal was below the national average, with only one doctor per 5,157 people.

Access to sexual and reproductive health services was even worse, with only a very limited choice of contraceptive methods available at most government facilities. Only 41% of health providers in the district provided SRH services, and only 25% of these were specifically trained for this purpose.

The baseline survey identified a wide gap between knowledge of family planning (78%) and the actual use of contraception (13%) among married women.

These factors were compounded by the conservative attitudes of religious leaders, resistance from husbands and mothers-in-law, the low status of women, a belief in the predestination of fate, and the lack of understanding that family planning can save the lives of mothers and children.

AFFORDABLE, ACCESSIBLE AND ACCEPTABLE SERVICES: AT THE DOORSTEP

The contraceptive prevalence rate increased from 13% in 1995 to 40% in 2003 and 81,427 new family planning users were recruited, of whom 28% were under 25 years. 74% of these new clients chose IUDs, followed by 12% for injectables and 9% for tubal ligation. 80% of SRH clients live in rural areas. The service delivery infrastructure covers 63% of the population, and 56% of married women of reproductive age have gained access to high quality services.

The project brings together a broad network of services, with a family health hospital as the nucleus for rural family health centres, mobile service units, private practitioners, traditional birth attendants and community-based distribution agents. The approach is known as 'doorstep delivery', emphasizing the presence of the project in people's own communities.

The provision of general health services through the network is an important trigger point which offers the potential to attract new SRH clients.

Quality of care is a hallmark of service delivery. Focus group participants judged the services as accessible and affordable, felt their concerns were fully heard with their right to confidentiality fully respected, found the staff welcoming, and appreciated the exemption policy for clients who cannot afford to pay.

The family health hospital offers family planning (condoms, spermicides, oral contraceptives, injectables, IUDs and tubal ligation), SRH services (pregnancy testing, ultrasound, fertility/infertility,

gynaecological care, antenatal, post-natal, immunization, post-abortion care, cervical smears, breast examinations, menopause, menstrual problems, diagnosis and treatment for sexually transmitted infections, HIV counselling and testing) and general health services.

Using premises provided free by the district government, and open from 8am–2pm six days a week, the family health hospital is strategically located in the town centre, bordering on one of the poorer urban areas of Chakwal Town.

The main reason for setting up the hospital was to deal with referrals from other outlets in the service delivery chain. Vasectomy clients are referred to the district headquarter hospital.

Five family health centres offer family planning (counselling, oral contraceptives, injectables, IUDs, condoms, spermicides), SRH services (counselling, pregnancy tests, antenatal, post-natal, immunization, breast examinations) and general health services.

Community ownership is the pillar of the family health centres, and village committees play a major role in running the centres. Premises are provided free by the community. The centres are open from 8am–2pm, four or five days a week. Staff spend at least one day a week on outreach activities in the surrounding communities.

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Two mobile service units offer family planning (counselling, oral contraceptives, injectables, IUDs, condoms, spermicides), SRH services (counselling, pregnancy testing, antenatal, post-natal, immunization, breast examinations) and general health services.

The mobile service units serve rural populations who have limited access to other facilities. Each unit is run by two female health visitors; one unit also has a male motivator.

The locations for mobile service visits are identified and provided by the community. Teams visit selected locations once or twice a month, and cover 71 communities every month.

Private practitioners offer contraceptives, and information, education and communication materials supplied by FPAP.

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To increase the availability and accessibility of services, the project engages 59 private practitioners who buy contraceptives from FPAP to use in their private practices.

Traditional birth attendants offer contraceptives, and information, education and communication materials supplied by FPAP.

Traditional birth attendants have a special status in Pakistan's social structure as advisers on reproductive health, healers, birth attendants, matchmakers and communicators. Rather than abandoning this traditional approach, the project set up an initiative to train 227 traditional birth attendants in safe delivery and contraceptive methods.

Community-based distribution agents offer information, oral contraceptives and condoms.

The project has 214 community-based distribution agents, mainly based in rural locations, offering services from outlets such as shops and private homes.

Community-based distribution is an important strategy that furthers the project's goal of taking services as close to the people as possible.

MOBILIZE, ORGANIZE, MOTIVATE, ACTIVATE

The project provides a variety of development activities: literacy classes, skill development and income-generating initiatives. These foster strong support for the project.

The project focuses on building the institutional capacity of community groups to manage their own development in the future. The groups are involved in many areas of community life. The project gives them the skills and confidence to improve their quality of life through their own efforts in activities such as improving health, hygiene, sanitation, nutrition and education.

Skills training and income-generating activities are an important entry point to embark on the culturally more sensitive issues of sexual and reproductive health.

RESHAPING SOCIAL ATTITUDES TOWARDS WOMEN

The highly successful Girl Child initiative – aimed at young women aged 13 to 19 and based on a UNICEF model – provides young women with information, education and skills training, and helps them gain confidence and respect within the family. Many have developed income-generating skills such as stove-building and sewing. Young women can now openly discuss sensitive and previously taboo topics, such as SRH, gender-based violence and abortion. 16,928 girls and young women took part in Girl Child activities.

Women's status is low in Pakistan. Throughout their lives, women face the hostility of gender discrimination – personal and legal restrictions, lack of education, gender-based violence and exclusion from decision-making.

The empowerment of women has a direct relationship with SRH. Lack of information about their reproductive health and rights exposes women to the risk of unwanted pregnancies, which often lead to unsafe abortion with potentially fatal consequences.

At the outset, the project was determined to gain community support to reshape social attitudes towards girls so that the obstacles to their development could be removed. It started by seeking backing from community leaders and the fathers, brothers and mothers of potential Girl Child participants.

Project activities empower girls and young women to take decisions related not only to their sexual and reproductive health needs but also within the household. This is done by forming women's groups and through information and education classes (health, nutrition, hygiene, SRH), skill development activities (computer skills, typing, tailoring) and general community development and capacity-building activities (leadership skills, community organization, tree planting).

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Girls who take part in the initiative demonstrate confidence, self-awareness, knowledge and a spirit of enterprise. They report that they are now given more status in the house and that parents consult their views. They have learnt about women's rights and many parents now talk to their daughters before arranging a marriage. Girls feel less shy about discussing their health problems. They have started to learn modern skills, such as computing, to enable them to go and work in the town. Some have received loans to buy tools and materials to enable them to set up their own garment-making business.

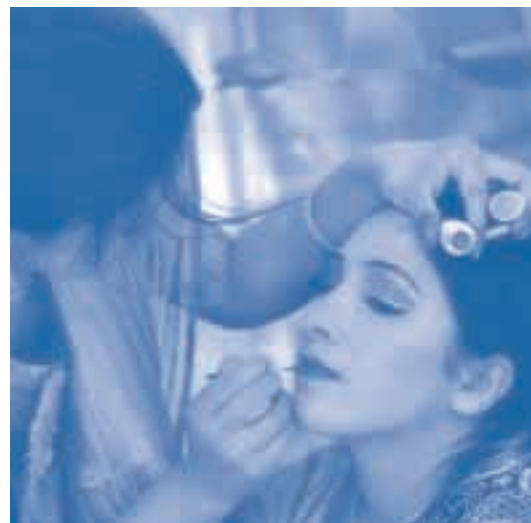
The positive effects of the project's investment in girls are incalculable.

A participant in a women's group in Chakwal recounts how attitudes about the status of women gradually changed as the result of the project, and the impact this has had on the lives of women.

"I'm living in a rural area. The area used to be very conservative. No, as a matter of fact the area was not conservative, the mind of people was conservative. Through the doorstep project people's thinking and attitudes have developed. In my village there are now monthly meetings and I participate. My husband now allows me to visit others. Before I did not have any right to talk to others."

(Source: Final Evaluation, March 2004)

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profile

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REACHING OUT TO MEN ... SHIFTING PATERNALISTIC ATTITUDES

Although a shift in family planning use with a stronger focus on male methods has not yet occurred, the meaning of male involvement has evolved beyond the mere selection of contraceptive method.

Recognizing that in a conservative society decisions relating to reproductive health, including contraception, are rarely the sole responsibility of women, the project worked hard to gain acceptance among men.

Male involvement was initially interpreted as an increase in use of male contraceptive methods. During project implementation, however, the emphasis shifted and began to focus on gender inequality, encouraging men as family decision-makers to support women's SRH needs, tackling issues such as domestic violence, and promoting men as responsible partners.

While male methods of family planning are still less popular, the dialogue between women and men on SRH issues has become much more open, and men now show a much more positive attitude towards contraception.

Youth resource centres raise awareness of young men's SRH needs and encourage their participation in the work of the project. The centres provide information and education, and young men are also trained as peer counsellors. Activities include skill development, leadership skills, recreational shows and sports.

CREATING ACCEPTANCE AND BUILDING MOMENTUM AT COMMUNITY LEVEL

Community acceptance and ownership of project activities are significant milestones in a particularly conservative area. Mobilizing the community to take up SRH services, as well as activities focused on women's empowerment and male involvement, clearly show that the investment in community organization and mobilization has been successful. The support of religious leaders and the Association of Journalists has provided a significant contribution to this achievement.

PARTNERSHIPS ... PATHWAY TO SUSTAINABILITY

Strong partnerships with the communities, government and NGOs provide important contributions towards future sustainability. However, although cost recovery and cost-effectiveness have increased during the course of the project, they will need to be strengthened further to increase the sustainability of service delivery.

Positive attitudes towards empowerment, gender equality and community mobilization are now firmly embedded in the project communities. Whatever the longer term viability of the project, these achievements are here to stay – these attributes and benefits cannot now be reversed.

INNOVATION AND EXPERIMENTATION

In testing new approaches, FPAP has learnt several lessons.

- Through its integrated approach, FPAP has shown that it is possible to make a huge investment of time and effort in skills and vocational training, without losing sight of the ultimate project goal – improving the SRH situation for the population.
- Integrating SRH into UNICEF's Girl Child model (a model to improve the status of girls and young women in society) is a powerful way of informing young women about sexual and reproductive health and rights.
- FPAP's next challenge is to improve the image and uptake of condoms and emphasize their importance for dual protection.
- While mobile services are very effective in reaching remote and marginalized communities, overhead costs are relatively high and cost recovery potential is limited.

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The project is located in Tehsil Chakwal (one of three sub-divisions of the Chakwal district) in the south-western Punjab region, with a catchment population of 600,000.

- **Population is 149.1 million, with 31% aged 10–24.**
- **Human Development Index ranking: 142 out of 175 countries.** (Source: UNDP 2004)
- **Average life expectancy at birth is 60 years.**
- **The infant mortality rate is 91 per thousand live births.**
- **The maternal mortality rate is 200 per hundred thousand live births.**
- **The total fertility rate is estimated at 4.8 with only 28% of married women aged 15–49 practising family planning (20% for modern methods).**
- **Only 18% of all births are assisted by trained personnel.**
- **Population living with HIV/AIDS (15–49) is 0.1%.**
- **The literacy rate among adults is very low at 21% for women and 60% for men.**

(Source: PRB 2002/2003)

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