Community-based integrated approach to changing women's family planning behaviour in Pakistan, 2014–2016

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Setting: Karachi, Pakistan.

Objective: To assess the effectiveness of a community-based integrated approach in changing women's behaviour regarding contraceptive use.

Design: The Sukh Initiative is a multipronged approach with door-to-door services using community health workers to provide quality family planning/reproductive health services at both public and private facilities and a 24/7 family planning helpline service that provides youth skill-based education.

Methods: Retrospective pre- and post-intervention data using samples of 5140 and 3810 women, respectively.

Results: The contraceptive prevalence rate increased by 10.7%, from 42.3% at baseline to 53.0% mid-intervention, with an increase in use of modern contraceptive methods of 9.2%. A significant association was found between door-to-door counselling and the use of contraceptive methods (OR 3.4, 95%CL 2.9–4.1) and access to public and private facilities for modern contraceptives (OR 2.4, 95%CL 2.0–3.0). However, support group meetings and 24/7 helpline use did not show any association with use of contraceptive method.

Conclusion: The study helped to increase access to and choice of family planning services through a community-based approach that successfully reduced unmet needs and improved continuity in contraceptive use.

Pakistan is currently experiencing a clear imbalance in population needs and available resources.¹ Although contraceptive use increased from 11.9% in 1990 to 35% in 2013 and the fertility rate declined from 5.4 births per woman in 1990 to 3.8 in 2013, women in Pakistan still report a high unmet need for family planning services, of ~20%.² This indicates that contraceptive use in Pakistan is at suboptimal levels and inadequate to meet the growing demand for fertility services.

Although increasing access to modern contraceptive methods is one of the objectives of the post-2015 Sustainable Development Goals,³ 225 million women in low- and middle-income countries who do not wish to become pregnant are not using modern contraceptives. The overall use of contraception worldwide is 64%,⁴ but is much lower (40%) in the least developed countries. As a signatory to the FP2020 pledge, Pakistan is committed to increasing its contraceptive prevalence rate (CPR) from 35% to 55% and reducing its total fertility rate from 3.8 births per woman to 2.6 by 2020.⁵

Evidence suggests that doorstep services increase the demand for both family planning and the use of modern contraceptive methods.⁶ The use of the outreach community health model (Marginalised Areas Reproductive Health and Family Planning Viable Initiative Project, MARVI) in rural Pakistan led to an 18% increase in CPR in 2014.⁷ A meta-analysis of 13 studies showed that door-to-door counselling involving family members enhanced the success of demand interventions.⁸ In Bangladesh, doorstep services largely contributed to women's ability to regulate their fertility.⁹ A systemic review revealed that counselling of young married women and their husbands by community-based health workers increased contraception use by 1–18%.¹⁰

In Pakistan, low CPR and high unmet need are more challenging for women living in social and economic deprivation, and the use of contraceptives is very low (14–45%). Contraceptive use in underserved and peri-urban areas remains poorer than in urban areas (23% vs. 32%).¹¹ Karachi is the seventh most populous city in the world, with an estimated population of 21.2 million.¹² Recorded use of modern contraceptives in urban areas in Karachi compared to other populous cities such as Delhi, India, and Jakarta, Indonesia, has been very low. For the purpose of bridging the demand and supply gap in Karachi's peri-urban underserved population, the 'Sukh Initiative' was launched in 2013. This project aimed to provide women of reproductive age residing in selected communities with information, counselling, supplies, referrals and quality services related to family planning.^{13,14}

The present study aimed to assess changes in CPR using an integrated community-based approach in the underserved population of Karachi before and after the intervention (2014–2016).

METHODS

Study design

A comparative cross-sectional study was conducted to assess the effectiveness of community-based interventions using retrospective data from surveys conducted in 2014 (before the intervention) and in 2016 (after the intervention). The Sukh Initiative is a 60-month initiative that commenced in October 2013. The baseline survey was conducted between January and June 2014 and mid-project evaluation was conducted between December 2016 and June 2017. The present study is an interim analysis of 24 months of the intervention, from 2014 to 2016.

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Setting

Neighbourhoods of low socio-economic status not covered by the Government's Lady Health Worker (LHW) Programme or demand generation activities by other family planning-related organisations were selected for the Sukh Initiative Project. A total of 194 community health care workers (CHWs) were deployed in areas not covered by other programmes, with each CHW covering a population of 4000 compared to populations of 1000 covered by the LHW Programme. Western and north-western districts of Karachi that met the above criteria were selected, and the project was implemented in 18 Union Councils of four neighbourhoods—Korangi, Landhi, Bin Qasim and Malir—in the Malir, East and Korangi Districts. The Initiative covered a population of 1 million, representing about 4% of the total urban slums of Karachi (which account for 10% of the total Karachi population).¹⁵ A population of 0.8 million was covered by CHWs and the remaining 0.2 million by LHWs.

Intervention: demand generation through door-to-door counselling

To respond to the demand for family planning services, especially among women who have already expressed a desire to limit or space their children, and for more effective and long-term contraceptive methods, local CHWs provide individual and personalised attention to create awareness among women about healthy timing and spacing of pregnancy, promote intra-spousal communication, and cater to specific individual needs for information, motivation, and distribution of condoms, pills and injections. They also generate referrals and link married women of reproductive age (MWRA) to government and private facilities for further guidance on what method to adopt, management of side effects and how to make an informed choice about family planning methods. The CHWs initially visited each house/woman once every 3 months; to date they have already covered 130 000 women in target areas. The visiting strategy has been revised, and short-term users are visited once every quarter, long-term users once every 6 months and monthly visits are planned for traditional/ever users. No visits were planned for infertile permanent users in the revised strategy.

Counselling techniques were innovative, involving 1) male volunteers for intra-spousal communication, 2) intelligent mapping for follow-up visits, and 3) community representative groups to provide counselling on method-related myths and misconceptions. To maintain sustainability, government LHWs were later inducted. Around 200 LHWs were trained/re-oriented in the family planning curriculum to: 1) provide the first dose of injected contraceptives during doorstep visits, 2) conduct community support group meetings, 3) provide life skills-based education to young adults and 4) perform general referrals and connect MWRA to social franchises established by the Project and public facilities. Further information on the model is available in the Figure.¹⁶

Survey participants

Survey participants were MWRA (aged 15–49 years) residing in peri-urban areas of Karachi, Pakistan.

Sampling

For the baseline survey conducted in 2014, the prevalence of any use of a family planning method in urban Sindh was reported to be 42.7% (Pakistan Demographic and Health Survey 2012–2013). Assuming 2.5% as bound on the standard error, a 95% confidence level of significance and a design effect of 2.247, the minimum sample size for baseline survey was estimated at approximately 3755. In the light of the sensitivity of the issue and the high refusal rate, the sample was further increased by 30%, and the calculated sample was 5440.

After the intervention period in June 2016, a sample size of 3873 was estimated on the basis of a 2.5–7.5% increase from the 2014 baseline figures in the use of modern contraceptive methods, and by adding 10% to cover refusals.

Data collection procedure

A sample of 5410 MWRA from the 2014 baseline survey, and 3810 MWRA from the 2016 midline survey were recruited from the targeted site. A structured questionnaire was used to explore community health-seeking behaviour, family planning and reproductive health status, and knowledge and availability of resources related to maternal and child health. For the interim analysis (current study), a sample of 3810 MWRA was again assessed on family planning status, service utilisation, counselling, changes in unmet need and unplanned pregnancies. Collected data from both the 2014 and 2016 surveys were available in hard copy and electronic form (SPSS v 19; Statistical Package for the Social Sciences, IBM Corp, Armonk, NY, USA). Study variables were extracted from the electronic consolidated database, which is password-protected and accessible only to authorised persons (Sukh Initiative research team).

Ethical considerations

Ethical approval of the study protocol was obtained from the Ethical Review Committees of the Agha Khan University, Karachi, and the Sukh Project, Karachi, Pakistan. To access project data for the present study, permission was obtained from Sukh's Ethical Research Committee.

Confidentiality of study participants during the survey

Verbal and written consent (participants' signature or thumb impression) were obtained by trained research staff. Interviews were conducted in complete privacy and no personal identifiers were recorded on the main questionnaire. Participants' contact information and names were stored separately on contact information sheets. It was also clearly stated in the consent form that no study participant would be identified by name in any report or other publications.

Data analysis

A descriptive statistical analysis of demographic characteristics and inferential analysis of outcome indica-

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FIGURE Community-based integrated model. Source: Sukh Initiative, Communication, advocacy and mobilisation strategy, 2016.¹⁴

tors (factors contributing to the increase in family planning, improvement in spousal communication and type of contraceptive used) was performed using SPSS v 21. In order to adjust for variations, weighted analysis was performed.

RESULTS

A total of 5140 MWRA participated in the 2014 pre-intervention studies and 3810 in the 2016 post-intervention surveys. About 50% of the population was aged between 25 and 34 years (median 30 years, interquartile range 25–35); the fertility rate was three births per woman. The mean age at marriage was 19 years and age at first birth was 20 years pre- and post-intervention. In 2014–2016, an estimated 35% of the sampled population had no formal education and 65% were educated, with a 7% increase in women with secondary and higher education (25.6% in 2014 vs. 32.6% in 2016; Table 1).

There was a 10% increase in the overall use of contraceptives and a 9% increase in the use of modern contraceptive methods at the time of the interim analysis. The main change was observed

in the increased use of long-term reversible contraceptives (LARC), such as intra-uterine devices (1.8% pre-intervention vs. 3.4% post-intervention) and implants (0.8% pre-intervention vs. 3.7% post-intervention; Table 2).

Exposure to family planning information and services among women through CHWs increased by 22%, from 56.6% to 78.6% between 2014 and 2016 ($P < 0.001$) (Table 3). Door-to-door household-level meetings with MWRA during the interim period (2014–2016) resulted in a 13.6% increase in spousal communication ($P < 0.05$).

Service utilisation increased by 22% (from 53.4% in 2014 to 75.6% in 2016) due to the provision of additional door-to-door supplies of pills, condoms and the first dose of an injectable contraceptive. This reduced unmet needs in family planning from 36.3% to 22.6% ($P < 0.01$), and the proportion of unintended pregnancies from 23% to 7.9%. This approach was continued, and increased after the intervention.

Multivariate logistic regression showed a significant association between door-to-door counselling and the use of contraceptive methods (odds ratio [OR] 3.4, 95% confidence level [CL] 2.9–4.1),

TABLE 1 Characteristics of the underserved population of Karachi before (2014) and after (2016) the intervention

Characteristics	2014 <i>n</i> (%)	2016 <i>n</i> (%)
Total, <i>n</i>	5140	3810
Age group, years		
15–24	1253 (24.4)	859 (22.6)
25–34	2439 (47.5)	1930 (50.8)
35–44	1241 (24.1)	917 (24.1)
≥45	206 (4)	93 (2.1)
Missing information	1 (0)	11 (0)
Parity		
0–2	1930 (35)	924 (27)
3–5	2157 (42)	1520 (47.7)
>5	665 (12.9)	549 (17.2)
Missing information	388 (8)	817 (21.4)
Education		
No schooling	1839 (35.8)	1330 (35.0)
Primary	1121 (21.8)	755 (19.8)
Middle	762 (13.8)	477 (14.5)
Secondary and above	1415 (25.6)	1239 (32.6)
Missing information	3 (0)	9 (0)

accessing public and private facilities for the use of modern contraception (OR 2.4, 95%CL 2.0–3.0), referrals to clinics and the use of referral slips (OR 1.7, 95%CL 1.2–2.7), and information on sexual and reproductive health and rights among young people for uptake of contraceptive methods (OR 1.4, 95%CL 1.2–1.7). The strength of these associations was higher among users of modern contraceptive methods than among users of any method. However, support group meetings and 24/7 availability of a helpline did not show any significant association with use of contraceptive method (Table 4).

DISCUSSION

Provision of door-to-door counselling and family planning services and the promotion of spousal communication at household

TABLE 2 Use of contraception before (2014) and after (2016) the intervention among married women of reproductive age (15–49 years) in the underserved population of Karachi

Variables	2014 <i>n</i> (%)	2016 <i>n</i> (%)	Increase from baseline %
Total, <i>n</i>	5140	3810	
Any contraceptive method, %	42.3	53	10.7
Modern method			
Female sterilisation	330 (6.4)	245 (7.3)	0.9
Male sterilisation	3 (0.05)	2 (0.01)	0
Pills	119 (2.3)	92 (2.7)	0.4
Intra-uterine devices	91 (1.8)	115 (3.4)	1.6
Injectables	235 (4.5)	208 (6.2)	1.7
Implants	43 (0.8)	140 (4.2)	3.4
Condoms	739 (14.3)	716 (18.8)	4.4
Lactation, amenorrhoea	90 (1.7)	45 (1.3)	0.4
Traditional method			
Standard days method	5 (0.0)	3 (0.1)	0
Rhythm	37 (0.7)	12 (0.3)	–0.4
Withdrawal	461 (9.0)	437 (11.5)	2.4

TABLE 3 Factors contributing to changes in family planning behaviour among married women of reproductive age in the underserved population of Karachi before (2014) and after (2016) the intervention

Contributing factors	2014 <i>n</i> (%)	2016 <i>n</i> (%)	Increase from baseline %
Total, <i>n</i>	5140	3810	
Community exposure to health workers	1152 (22)	2986 (78.6)	56.6*
Received guidance on management of side effects	454 (8.8)	640 (16.8)	8.8
Abortion rate	1547 (30.1)	443 (11.7)	18.4*
Unmet need†	948 (36.6)	273 (22.6)	14*
Never user‡	1716 (30.6)	967 (25.4)	–5.2
Intra-spousal communication on family planning	2216 (43)	2159 (56.6)	13.6§
Service utilisation	2944 (53.4)	2880 (75.6)	22.2
Government facilities	335 (11.4)	722 (25.1)	13.7
Private facilities	588 (20)	817 (28.4)	8.4
Community-based door-to-door visits	294 (10)	601 (20.9)	10.9
Other shops/pharmacies	353 (12)	288 (18)	6

* $P < 0.001$.

† Cross tabulation between not currently using any form of modern contraception/ wish to use contraception and no wish to have another child in future.

‡ Has never used any form of modern contraception.

§ $P < 0.05$.

level resulted in an increase in the use of contraceptives from 42.3% to 53% during the project's interim period (2014–2016) in the urban slums of Karachi.

Changes to CPR in target areas have indicated that demand generation is significantly associated with increased use of contraception. Similar evidence was available from Bihar, an Indian province of low socio-economic status, which reported an increase from 25% at baseline to 40% due to high demands for contraception and close community follow-up.¹⁷ Another study from Nigeria showed a significant increase from 2.3% to 15.5% over the 3

TABLE 4 Adjusted impact of Sukh study interventions on use of any contraceptive method (Model I) and use of any modern method (Model II)

Project intervention	Model I (use of any method) OR (95%CI)	Model II (use of modern method) OR (95%CI)
Door-to-door counselling		
Yes	2.8 (2.4–3.3)*	3.4 (2.9–4.1)*
No	1.0 (Reference)	1.0 (Reference)
Health facility visits		
Yes	2.1 (1.7–2.5)*	2.4 (2.0–3.0)*
No	1.0 (Reference)	1.0 (Reference)
Referral slips for health facility		
Yes	1.6 (1.2–2.0)*	1.7 (1.2–2.7)*
No	1.0 (Reference)	1.0 (Reference)
Docudrama on local channel		
Yes	1.3 (1.1–1.6)*	1.4 (1.2–1.7)*
No	1.0 (Reference)	1.0 (Reference)

* $P < 0.001$.

years of intervention through behaviour change communication and community-based counselling.¹⁸ A systematic review showed improvements in key family planning indicators, such as women's awareness of family planning methods, ever use of contraception and use of appropriate contraceptive methods related to increased access to and choice of family planning methods.¹⁹ In accordance with these findings, our study results show a 9% increase in the use of modern contraceptive methods from baseline figures; as local CHWs played a significant role in providing condom, pills and injections to households, the good relationships created by these CHWs with the MWRA is the main contributing factor to the increase in CPR. This was further reinforced by public and private sector enhancement for the provision of improved quality and availability of LARC. These findings are important not only for the ongoing community-based programme, but also at national level, where the use of LARC contraceptive methods is negligible.

The door-to-door counselling provided by CHWs significantly increased contraceptive uptake and improved overall service utilisation, resulting in a stronger association with modern contraceptive methods (OR 2.4, 95%CL 2.0–3.0). A study in Malawi also reported that counselling had an added impact on modern family planning uptake and continuation 6 months after the initiation of door-to-door counselling through CHWs.²⁰ We observed increased contraceptive use and a reduction in the number of unplanned pregnancies and abortions over the 24 months of the intervention: the abortion rate fell by 18.4% and unmet need by 14%. Another study reported that access to and the correct use of modern contraceptive methods was the most reliable way to reduce unintended pregnancies and induced abortion; 40% of unplanned pregnancies worldwide occur due to ineffective or failure of contraceptive methods or non-use of contraception.²¹

The study also brought to light the issue of adolescent pregnancies (it should be noted that the mean age at marriage was 19 years and age at first birth was 20 years). Adolescent pregnancies account for 11% of additional births worldwide and contribute to 23% of the overall disease burden. The situation is even worse in low- and middle-income countries, where early childbirth is the leading cause of maternal death among those aged 15–19 years.²²

Spousal communication contributed to improved family planning practices; evidence suggests that the possible increase in modern contraceptive methods is due to couple counselling. In Zambia, whereas only 21.5% of couples were using modern contraceptive methods at baseline, >90% had adopted modern contraceptive methods post-intervention. Our study showed an increase in spousal communication; however, our current research did not find a statistically significant association between spousal communication and contraceptive use.²³ A systematic review of low- and middle-income countries showed that modern contraceptive methods with focused counselling of couples through the involvement of male mobilisation increased couple-years of protection.²⁴

Limitations and strengths

As the surveys were conducted on a large scale, the results are generalisable and the preliminary data findings can be used to improve the uptake of contraceptive use elsewhere in Pakistan or in similar settings. We used local CHWs for door-to-door counselling, and the intervention led to an increased demand for family planning services, which was sustained by engaging LHWs to cover previously uncovered areas. However, with the use of limited variables it was difficult to examine the full scope of transitions, case by case, in modern contraceptive use (discontinuation, switching and non-use). Moreover, the quality of CHW exposure could not be assessed, as this would require more in-depth quali-

tative data. The study findings are limited to the intervention area, as there were no comparative areas/groups to further extrapolate the results.

In conclusion, community-based door-to-door counselling targeted at MWRA on their doorstep positively contributed to improved access and utilisation of modern contraceptive methods in a resource-constrained setting. Successful replication of the CHW model and effective design of public-private partnership may together work to increase contraceptive use and health care utilisation.

References

- 1 Azmat S K. Models to accelerate modern family planning/contraceptive services access and uptake among married women in rural Pakistan. Doctoral thesis. Ghent, Belgium: Ghent University, 2017.
- 2 National Institute of Population Studies & MEASURE DHS, ICF International. Pakistan Demographic and Health Survey 2012–13. Islamabad, Pakistan & Calverton, MD, USA: NIPS, 2013: p 392.
- 3 Osotimehin B. Family planning as a critical component of sustainable global development. *Glob Health Action* 2015; 8: 10.3402/gha.v8.29978.
- 4 United Nations. Trends in contraceptive use worldwide, 2015. New York, NY, USA: UN, 2017.
- 5 UK Government. Family Planning Summit—July 2012: FP Summit Overview. London, UK: UK Government, 2012.
- 6 UK Aid from the British People. The state of family planning in Pakistan. London, UK: UK Aid from the British People, 2013.
- 7 The David and Lucile Packard Foundation. Understanding MARVI. Los Altos, CA, USA: David and Lucile Packard Foundation, 2014.
- 8 Belaid L, Dumont A, Chaillet N, et al. Effectiveness of demand generation interventions on use of modern contraceptives in low- and middle-income countries. *Trop Med Int Health* 2016; 21: 1240–1254.
- 9 Phillips J F, Hossain M B. The impact of household delivery of family planning services on women's status in Bangladesh. *Int Fam Plan Perspect* 2003; 29: 138–145.
- 10 Sarkar A, Chandra-Mouli V, Jain K, Behera J, Mishra S K, Mehra S. Community based reproductive health interventions for young married couples in resource-constrained settings: a systematic review. *BMC Public Health* 2015; 15: 1037.
- 11 Sathar Z, Zaidi B. UNFPA-ICOMP Regional Consultation. Family Planning in Asia and the Pacific: Addressing the Challenges. 8–10 December 2010, Bangkok, Thailand. Status of Family Planning in Pakistan. New York, NY, USA: United Nations Family Planning Association, 2010.
- 12 Government of Pakistan. Pakistan population census, 2017: preliminary results. Islamabad, Pakistan: Government of Pakistan, 2017.
- 13 Sukh Initiative. Sukh annual report. Karachi, Pakistan: Sukh Initiative, 2016.
- 14 Sukh Initiative. Communication, advocacy and mobilisation strategy. Karachi, Pakistan: Sukh Initiative, 2016.
- 15 Sukh Initiative. Progress report of Sukh Initiative, 2017. Karachi, Pakistan: Sukh Initiative, 2017.
- 16 Sukh Initiative. Progress report summary year I and II. Karachi, Pakistan: Sukh Initiative, 2016.
- 17 Daniel E E, Masilamani R, Rahman M. The effect of community-based reproductive health communication interventions on contraceptive use among young married couples in Bihar, India. *Int Fam Plan Perspect* 2008; 34: 189–197.
- 18 Krenn S, Cobb L, Babalola S, Odeku M, Kusemiju B. Using behavior change communication to lead a comprehensive family planning program: the Nigerian Urban Reproductive Health Initiative. *Glob Health Sci Pract* 2014; 2: 427–443.
- 19 Phiri M, King R, Newell J N. Behaviour change techniques and contraceptive use in low and middle income countries: a review. *Reprod Health* 2015; 12: 100.
- 20 Lemani C, Tang J H, Kop D, et al. Contraceptive uptake after training community health workers in couples counseling: a cluster randomized trial. *PLoS ONE* 2017; 12: 1–10.
- 21 Najafi-sharjabad F, Zainiyah S, Yahya S, Rahman H A, Hanafiah M. Barriers of modern contraceptive practices among Asian women: a mini literature review. *Glob J Health Sci* 2013; 5: 181–192.
- 22 World Health Organization. Early marriages, adolescent and young pregnancies: report by the Secretariat. A65/13. Geneva, Switzerland: WHO, 2012: pp 16–19.
- 23 Stephenson R, Vwalika B, Greenberg L, Vwalika C, Chomba E. A randomized controlled trial to promote long-term contraceptive use among HIV-serodiscordant and concordant positive couples in Zambia. *J Womens Health (Larchmt)* 2011; 20: 567–574.
- 24 Belaid L, Dumont A, Chaillet N, et al. Effectiveness of demand generation interventions on use of modern contraceptives in low- and middle-income countries. *Trop Med Int Health* 2016; 21: 1240–1254.

Contexte : Des enquêtes avant et après intervention ont été réalisées à Karachi, Pakistan.

Objectif : Evaluer l'efficacité d'une approche intégrée à base communautaire afin de modifier le comportement des femmes en matière d'utilisation de la contraception.

Schéma : La Sukh Initiative est une approche multiple avec des services de porte-à-porte par des travailleurs de santé communautaire, la fourniture de services de qualité en matière de planification familiale/santé reproductive, à la fois dans des structures publiques et privées, offrant une disponibilité 24/7 d'une assistance téléphonique en planification familiale et engager les jeunes pour les guider grâce à une éducation basée sur les compétences de vie.

Méthodes : On a utilisé les données rétrospectives des enquêtes avant et après l'intervention, avec un échantillon de respectivement 5141 et 3861 femmes.

Résultats : Le taux de prévalence contraceptive a augmenté de 10,7% par rapport au taux initial (42,3% contre 53,0% à mi-parcours), avec une augmentation du taux d'utilisation des méthodes contraceptifs modernes de 9,2%. Des associations significatives ont été constatées entre le conseil en porte-à-porte et l'utilisation de méthodes contraceptives (OR 3,4 ; niveau de confiance à 95% 2,9–4,1), et l'accès aux structures publiques et privées pour des contraceptifs modernes (OR 2,4 ; niveau de confiance à 95% 2,0–3,0). Les réunions de groupes de soutien et l'assistance téléphonique 24/7 n'ont cependant pas mis en évidence d'association avec l'utilisation d'une méthode contraceptive.

Conclusion : L'étude actuelle a contribué à augmenter l'accès aux services de planification familiale et le choix des méthodes grâce à une approche à base communautaire qui a réduit avec succès les besoins non satisfaits et amélioré la continuité de l'utilisation de contraceptifs.

Marco de Referencia: En Karachi, Paquistán, se llevaron a cabo encuestas antes y después de una intervención.

Objetivo: Evaluar la eficacia de una estrategia comunitaria integrada, encaminada a modificar el comportamiento de las mujeres con respecto a la utilización de los anticonceptivos.

Diseño: La iniciativa Sukh consiste en un enfoque en varios frentes, que comporta servicios puerta a puerta a cargo de agentes de salud comunitarios, provisión de servicios de planificación familiar y salud reproductiva de gran calidad en establecimientos del sector público y el sector privado, con asistencia telefónica permanente en materia de planificación familiar y búsqueda de la participación de los jóvenes en tutorías de preparación para la vida activa.

Método: Se realizó un análisis retrospectivo de los datos de una encuesta anterior a la intervención realizada a 5141 mujeres y de 3861 mujeres en una encuesta posterior a la misma.

Resultados: La tasa de prevalencia de utilización de anticonceptivos aumentó hasta un 10,7% con respecto al valor inicial (42,3% contra 53,0% en mitad del período), con un aumento de 9,2% del recurso a los métodos modernos de anticoncepción. Se observó una asociación significativa del asesoramiento puerta a puerta con el uso de métodos anticonceptivos (OR 3,4; nivel de confianza a 95% 2,9–4,1) y el recurso a los servicios de establecimientos públicos y privados para la utilización de métodos anticonceptivos modernos (OR 2,4; nivel de confianza a 95% 2,0–3,0). Sin embargo, las reuniones en grupos de apoyo y la asistencia telefónica permanente no exhibieron ninguna correlación.

Conclusión: Según el estudio realizado, se aumentó el acceso a los servicios de planificación familiar y la decisión de acudir a ellos, gracias a una estrategia comunitaria que logró reducir las necesidades insatisfechas y reforzar la continuidad de la utilización de los anticonceptivos.