Costed Implementation Plan (CIP) on Family Planning for Sindh

GOVERNMENT OF SINDH

Population Welfare Department (PWD)
Department of Health (DoH)
Peoples' Primary Health Care Initiative (PPHI)

December 2015

SHAHEED MOHTARMA BENAZIR BHUTTO

Former Prime Minister of Pakistan

"I dream of a Pakistan, of an Asia, of a World,
where every pregnancy is planned and every child conceived
is nurtured, loved, educated, and supported."

Speech during 'International Conference on Population Development', Cairo, 1994

Launch of Costed Implementation Plan by the Honourable Chief Minister Sindh, Syed Qaim Ali Shah, December 03, 2015 at the Chief Minister's House, Karachi

(*from left to right*): Jam Mehtab Dahar, Minister for Health; Ms. Shahnaz Wazir Ali, Provincial Coordinator, Oversight and Coordination Cell for Public Health Programmes, Sindh; Dr. Azra Fazal Pechuho, Member National Assembly, Chair, Oversight and Coordination Cell for Public Health Programmes, Sindh (presenting copy of this costed implementation plan to the Chief Minister); Mr. Muhammad Saleem Raza, Secretary, Population Welfare Department; Mr. Babar Jalbani, Deputy Secretary Staff to the Chief Minister; Dr. Talib Lashari, Costed Implementation Plan Team Leader; Muhammad Siddique Memon, Chief Secretary, Sindh; Mr. Alamdin Bullo, Principle Secretary to the Chief Minister Sindh; Dr. Saeed Mangnejo, Secretary, Health, Sindh

MESSAGE OF THE CHAIR

OVERSIGHT & COORDINATION CELL FOR PUBLIC HEALTH PROGRAMS, SINDH

The 2011 London Summit on Family Planning resulted in pledges for FP2020. The London Summit was a major landmark event to rejuvenate global efforts on family planning after ICPD at Cairo in 1994 and subsequently the inclusion of FP in the Millenium Development Goals (MDGs). The 2015-2030 Sustainable Development Goals (SDGs) also contain family planning and reproductive health related targets.

One of the requirements in line with FP2020 has been to formulate a Costed Implementation Plan (CIP) by each participating country so that all relevant government departments, public and private sectors; international development partners and civil society should be on the same page in terms of strategy, targets and provision of resources.

In the above context, Sindh is the first province in Pakistan that took the bold initiative to formulate its CIP document. The Government of Sindh has already dedicated funds for the procurement of contraceptives over the next five years.

It is a matter of immense pleasure that the Oversight & Coordination Cell Sindh, worked closely with the Departments of Population and Health and the team that developed the document. The Cell provided support and guidance required. A detailed consultative process has been an important milestone. This process also included in-depth discussions with selected Lady Health Workers, Lady Health Supervisors and the Lady Health Visitors in three divisions of Sindh. This shows the credibility of the process that became the basis for the document.

The six Strategic Areas provide a road map for the province for the next five years (2015-2020). These include collaboration between health and population departments regarding functional integration at sub district level; ensuring quality of services through standards; skills development and client satisfaction; ensuring and improving supply chain of commodities; expanding services; enhancing knowledge and communication initiatives; and systems strengthening through performance management, monitoring, supportive supervision and evaluation.

I congratulate Mr. Saleem Raza, Secretary Population Welfare and Dr. Saeed Mangnejo, Secretary Health for providing their leadership and support during the entire process of the development of the document. The CIP process was largely possible due to continued dedication of the Secretary Population. The CIP Cell, PWD provided operational support in the consultative process and the data gathering. I also appreciate Dr. Talib Lashari, who developed the document. Due to his dedicated and sincere efforts the CIP process was completed successfully. It is now imperative to take this initiative forward regarding galvanizing support from development partners and at the government level for the implementation of the Plan.

I would also like to appreciate the valuable support provided by Ms Yasmeen Sabih Qazi, Country Representative, Packard Foundation through Pathfinder International.

Azra Fazal

Dr. Azra Fazal Pechuho

Chair

MESSAGE OF CHIEF SECRETARY, SINDH

The family planning program has been implemented since 1960s, however, still there is lot to be done to materialize the objective of reaching to a replacement level of fertility. The indicators related to family planning have been improving, but at slow pace. The latest estimates as per Pakistan Demographic and Health Survey (PDHS) show that Pakistan's contraceptive prevalence rate is 35% as compared to 55% commitment against MDGs. Many other developing countries are also facing similar situation. That situation prompted world leaders to gather at the London Summit and discuss the family planning related situation around the globe, more specifically in developing countries; hence, a FP2020 pledge was made. Pakistan is part of this pledge.

It is heartening to note that Sindh has been at the forefront of the FP2020 commitments of Pakistan by developing a five year Plan - the Costed Implementation Plan. This provides the basis for other provinces to build on it since after the devolution, provinces are responsible for designing and implementing policies and plans. The provinces will be contributing towards country's commitments made at the international forum. In this regard, Sindh will contribute by increasing its CPR from 30% to 45% by 2020.

The CIP Sindh takes into account the existing service delivery regarding the family planning in the province; builds it further through innovative and proven practices through accelerated activities; and later on proposes expansion of the service delivery for future sustainability. These thematic areas will be materialized through six prioritized strategic areas i.e. collaboration between Department of Population and Health regarding functional integration at taluka and UC level; quality of services; supplies of contraceptives; expanding services to rural, remote and urban slums; awareness and behavior change; performance management and accountability.

It is very positive indication that the CIP has been prepared based on a consultative process that included Population Welfare Department; Department of Health (LHWs, MNCH, PPHI); development partners and UN Agencies; INGOs and NGOs working in the areas of family planning and reproductive health.

I congratulate Dr. Azra Fazal Pechuho, MNA, Chair, Oversight Cell for Public Health Programs; Ms. Shahnaz Wazir Ali, Provincial Coordinator, Oversight Cell for Public Health Programs; Mr. Muhammad Salim Raza, Secretary Population Welfare; Dr. Saeed Mangnejo, Secretary Health; and Dr. Talib Lashari, CIP Team Leader from Pathfinder International supported through Bill & Melinda Gates Foundation for their efforts to achieve this significant milestone.

Muhammad Siddique Memon
Chief Secretary

MESSAGE OF THE MINISTER FOR POPULATION, SINDH

I felicitate the Population Welfare Department who in collaboration with the Department of Health, PPHI and other partners has taken a historic initiative to develop a five year plan on family planning called Costed Implementation Plan. This has become a basis for the future allocations in order to achieve the targets under international commitments made at FP2020 summit.

In this regard, the Government of Sindh has shown its full commitment. It has taken ownership of the population program. In this regard, during the fiscal year 2015-16 Sindh government will spend Rs. 3.4 billion on population program. An amount of Rs. 5.4 billion will be spent on contraceptives procurement over the next five years. Besides, a separate allocation of PKR 998 million has been made for achieving FP2020 commitments through a Costed Implementation Plan (CIP).

Under the CIP, the PWD and Department of Health in Sindh will be closely working. This joint working will be materialized through 'Functional Integration' at taluka and union council level. Where by LHWs and PWD staff will be collaborating regarding provision of family planning services. It's worth mentioning here that the PWD is procuring contraceptives for the entire public sector which includes all relevant health sector programs delivering FP services.

We envisage that the interventions under CIP will be supported not only through government support but development partners will also join hands in supporting the planned activities so that by 2020 the province would be able to contribute towards international commitment on FP.

I congratulate the team that developed that document after in depth consultative process.

Sayed Ali Mardan Shah
Minister for Population

MESSAGE OF THE SECRETARY POPULATION WELFARE, SINDH

It a matter of pride for the Population Welfare Department and the province of Sindh that the process of CIP has completed and now we have a clear road map for the next five years to move ahead in achieving the FP2020 targets that country set for itself at London Summit.

The province of Sindh will be contributing towards national goal of enhancing CPR to 55% by the year 2020. In this regard, Sindh will increase its CPR from currently 30% to 45% by the year 2020. The CIP document has set parameters for reaching to these targets.

In the wake of 18th Amendment, the Sindh government has taken full responsibility of the population welfare program. The province took initiative to allocate resources for the procurement of the contraceptives. A sizeable amount of PKR 998 million has been allocated for the CIP implementation which would encourage the development partners to fill in the financing gap.

The Oversight Cell led by Dr Azra Fazal Pechuho, MNA and Ms. Shahnaz Wazir Ali provided their full support and guidance at each step of the process. Dr. Pechuho also helped in removing bottlenecks that hindered the smooth way to complete the task. Thus, without the support of Dr Azra Fazal Pechuho the process of CIP could not have been completed.

One of the inspiring aspects of the CIP process has been that the entire stakeholders in the public sector sat on one table and strategized the priorities regarding family planning in the province. I can envisage that the cooperation of the Department of Health is going to provide impetus to the efforts since LHWs and the health facilities will fully participate in materializing the strategies of the Plan. In this regard, the efforts of Dr. Saeed Mangnejo, Secretary Health are laudable since under his leadership not only the Department Health and its programs have owned the CIP process but more than that country's commitment related to refocusing the LHWs on FP would be achieved.

The process of the development of the CIP was an exciting experience for all the stakeholders. A detailed consultative process took place that included 40 individual meetings. CIP Cell at PWD continuously worked with the partners. The Pathfinder International's headquarter and the country office led by Dr. Tauseef Ahmed provided technical support as well as the Bill & Melinda Gates Foundation office led by Dr. Yasmeen Sabeeh Qazi facilitated the process.

The efforts of Dr. Talib Lashari, Team Leader, CIP have been remarkable. He being author of the Report worked days and nights with full commitment and personal involvement. Due to his level of promising efforts it became possible to prepare this landmark document.

In the light of the above, i am sure, the CIP being a quality document built on evidence and consultative process, provides a great opportunity and the road map for all stakeholders to join hands and move ahead to achieve the FP2020 targets and policy objectives of the province.

Muhammad Saleem Raza
Secretary

MESSAGE OF PROVINCIAL COORDINATOR,

OVERSIGHT CELL FOR PUBLIC HEALTH PROGRAMS, SINDH

Over several decades, different initiatives have been taken in Pakistan regarding family planning and reproductive health. Two major events in 1994 are considered landmarks for FP: The International Conference on Population and Development (ICPD) at Cairo, and Pakistan's flagship Family Planning & Primary Healthcare Program (LHWs program). An improvement was noted in FP indicators over some years, but we still have a long way to go.

In the wake of the final years of MDGs, a high level and sharply focused initiative in July 2011, the London Summit was held which brought in a new national resolve and international support to the cause of family planning. I am glad to note that the country is moving ahead to fulfill its commitments under FP2020. One of the milestones in that direction is the development of Costed Implementation Plan (CIP) for Sindh.

I felicitate the Secretary Population who has shown his will, leadership and strong committment to complete this gigantic task. Besides, Secretary Health has also provided full cooperation from the Department through it's major programs including Lady Health Workers (LHWs), Maternal Neonatal Child Health (MNCH) and Public Private Health Initiaitve (PPHI) because CIP is a shared responsibility of health and population sectors. The senior officials at PWD deputed to the within CIP Cell were fully involved in the process of formulating the CIP. The development partners and INGOs/NGOs also took keen interest and provided their input in the process of consultations. Therefore, the document is based on consensus of all key stakeholders. The technical support of the Pathfinder International led by Dr Tauseef Ahmed has contributed significantly. The efforts of Dr. Talib Lashari, CIP Team Leader cannot be underestimated; he undertook the task with high professionalism and unstinting dedication. Besides, preparing the document, he was instrumental in developing the consensus around the strategic areas.

The CIP spells out six key strategies : collaboration between health and population regarding functional integration at taluka and UC level; quality of services; supplies; expanding the crucial services to remote, rural and urban slums; advocacy and awareness to avail services; and performance management and supportive supervision. I am sure, each strategy is a value addition to CIP, with the provision of financial and human resources, resolve and monitoring of progress on CIP, the province will move ahead successfully in achieving its target of 45% of Contraceptive Prevalence Rate (CPR) by the year 2020.

I wish all the best for the implementation of the Plan.

Shahnaz W. Ali

Shahnaz Wazir Ali
Provincial Coordinator

MESSAGE OF THE SECRETARY HEALTH

One of the objectives of the Department of Health is to promote preventive and public health aspects of the healthcare. The reproductive health and family planning is crucial in this regard. The primary, secondary and tertiary care facilities as well as care providers like Lady Health Workers; Lady Health Visitors; CMWs etc. have to provide family planning services as part of their overall mandate. It has been noted that over the period these providers, more specifically LHWs have been carrying out multiple tasks.

The commitments made by Pakistan under FP-2020, provided an opportunity to the Department of Health to re-strategize its family planning related tasks. In this regard, the initiative of the Population Welfare Department to formulate a joint strategy called Costed Implementation Plan (CIP) proved to be a way out whereby the Department of Health could become part of broader FP agenda in the province.

In this regard, as committed in the FP-2020 and strategized in the CIP, the Department of Health fully commits itself to re-focus the role of LHWs towards family planning and to provide through its facilities a range of modern methods on FP. The proposed strategy of functional integration at sub district level between all public sector stakeholders will prove to be a practical model in terms of family planning through pooling in resources.

The Health Sector Strategy of Sindh also emphasizes the need for integrating FP services with its MCH services and re-defining the links with PWD with a shift of FP Services through district and urban PHC system.

It is noteworthy that the Sindh government has already allocated finances for the implementation of CIP as well as procurement of contraceptives. However, there is a greater need for a public private partnership and engagement of development partners to achieve FP-2020 goals. The Department of Health has outsourced a number of primary and secondary health facilities to a number of NGO partners. The Department will ensure that these partners cater to the needs of clients seeking family planning services.

I congratulate Dr. Azra Fazal Pechuho, MNA; Ms. Shahnaz Wazir Ali, Coordinator, Oversight Cell; Mr. Muhammad Saleem Raza, Secretary Population Welfare Department; and Dr. Talib Lashari, CIP Team Leader for completion of this challenging task. Dr. Pechuho, has been relentlessly supporting the initiatives of health and population sectors in Sindh. Likewise, Secretary PWD has been instrumental in bringing closer the health and population departments on family planning initiatives.

Dr. Saeed Ahmed Mangnejo

Secretary

Costed Implementation Plan on Family Planning for Sindh (2015–2020)

Karachi, December 2015

Disclaimer

The costed implementation plan for Sindh is the document of the Government of Sindh Population Welfare Department, Department of Health, People's Primary Healthcare Initiative, with a lead role by the Population Welfare Department. The costed implementation plan has been developed in collaboration with and for the public sector, private sector, relevant development partners and international and local nongovernmental organizations. No part of the document can be reproduced unless prior permission is received from the Population Welfare Department, Government of Sindh. The Population Welfare Department, in coordination with other public sector partners, will also seek support from development partners for implementation of the plan. The private sector can collaborate on implementation of the plan with the prior consent, collaboration and agreement with the Population Welfare Department, Government of Sindh.

Citation: The costed implementation plan can be referred to in research, conference papers, presentations with the following suggested citation:

Population Welfare Department, Government of Sindh, *Costed Implementation Plan on Family Planning for Sindh (2015–2020).* Sindh, Pakistan: Population Welfare Department; December 2015

Prepared with the Technical Assistance of Pathfinder International

Table of Contents

Acronyms

BHU	basic health unit
CBO	community-based organizations
CCSC	Contraceptive Commodity Security Committee
CIP	costed implementation plan
cLMIS	contraceptive logistic management information system
CLR	Contraceptive Logistic Report
CMW	community midwives
CPR	contraceptive prevalence rate
CS	contraceptive surgery
DHDC	District Health Development Centre
DHIS	district health information system
DHO	district health officer
DHPMT	district health and population management team
DHQ	district headquarters hospital
DOH	Department of Health
DPWO	district population welfare officer
DTC	district technical committee
EmONC	emergency obstetrics and neonatal care
FLCF	first-level care facility
FP	family planning
FWC	Family Welfare Centre
GDP	gross domestic product
HANDS	Health and Nutrition Development Society
HMIS	health management information system
HSRU	Health Sector Reform Unit
HTSP	healthy timing and spacing of pregnancy
INGO	international nongovernmental organization
IPC	interpersonal communication
IUD	intrauterine device
LARC	long-acting reversible contraceptives
LHV	lady health visitors
LHW	lady health workers
M&E	monitoring and evaluation
MCH	maternal and child health
MDG	Millennium Development Goal
MNCH	maternal, neonatal, and child health
MOU	memorandum of understanding
MSU	mobile service units
MWRA	married women of reproductive age
NGO	nongovernmental organization
NIPS	National Institute of Population Studies
PC-1	Planning Commission proforma 1
PDHS	Pakistan Demographic and Health Survey
PHDC	Provincial Health Development Centre
PKR	Pakistani Rupee
PMA	performance monitoring and accountability
PPHI	People's Primary Healthcare Initiative
PSDP	Public Sector Development Programme
PWD	Population Welfare Department
RHC	rural health centre
RHS	Reproductive Health Service
RTI	Regional Training Institutes
SOP	Standard operating procedure
THQ	Taluka headquarters hospital
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VBHW	Village-based health worker

Executive Summary

World leaders and partners gathered in London in 2012 for a Summit on Family Planning in order to accelerate the achievements of the Millennium Development Goals (MDGs) related to maternal and child health (MDGs 4 and 5) and universal access to reproductive health (MDG 5b). The Summit deliberated on enhancing commitments through determined actions and mobilizing resources for the availability of high-quality, voluntary family planning (FP) services to support the rights of women and girls. More than 20 countries, including Pakistan, made their commitment to address policy and financing issues, and socio-behavioural norms that prevent women from accessing contraceptive information, services and commodities.

Pakistan's commitments included raising the contraceptive prevalence rate (CPR) to 55 percent by 2020, ensuring that all public and private health facilities to offer FP services, doubling FP funding during the following year, including FP services in the essential service package, strengthening supply chain management, providing training, increasing communication, making FP a priority with a focus on lady health workers (LHW), and scaling up public-private partnerships through contracting mechanisms.

In 2010, Pakistan introduced the 18thConstitutional Amendment, whereby the health and population welfare functions underwent devolution and were transferred to the provinces. With this paradigm shift, it became the prerogative of the provinces to develop their own policies, plans and programmes and to execute the same. Sindh is committing to attain a CPR of 45 percent by 2020 (compared to the current CPR of 30 percent) as part of its contribution towards the overall national target.

In Sindh, there are currently 13 million women of reproductive age, and this number is estimated to reach 15 million by 2020. The total fertility rate in Sindh has declined from 5.1 births in 1990–1991 to 3.9 births in 2012–2013, while the CPR has been stagnant at 29.5 percent, with 24 percent of women using modern methods of contraception for over a decade. The disparities in the province are visible with 42.7 percent CPR in urban areas and 17.4 percent in rural areas, while unmet need remains at 21 percent.

Sindh's population is projected to increase to 50 million by 2020. There are 1.747 million married women of reproductive age (MWRA) who are the current users of contraception. The users of modern methods of contraception are projected to rise to approximately 3 million by 2020. Therefore, the province of Sindh should expect 1.298 million additional users of modern methods.

Both the public and private sectors are contributing towards provision of contraceptive services. An estimated 45 percent of contraceptives are provided by the public sector. The two major sources within public sector are the Population Welfare Department (PWD) and the Department of Health (DOH). The private sector nongovernmental organizations (NGOs) provide 20.5 percent of contraceptives; private pharmacies and chemists provide 25.3 percent; private doctors contribute 2.1 percent; while shops provide 6.5 percent of the contraceptives. Thus, the combined share of private sector is estimated to be 54.4 percent. The PWD provides the services through its static and outreach facilities. Likewise, the DOH and People's Primary Healthcare Initiative (PPHI) provide FP services through the static setup and through the massive network of community health workers—the lady health workers (LHW).

Socioeconomic reasons, and cultural norms and practices have significant implications for FP in Sindh. For example poverty, lack of education, and myths and misconceptions associated with contraceptive use often hinder the adoption of FP due to issues related to access, affordability, acceptability and post-acceptance side effects.

As part of the devolution process, each province is supposed to finance their respective population and health programmes. The Government of Sindh has accordingly committed to fund its FP-related programmes including contraceptive procurement in the wake of the United States Agency for International Development's (USAID's) close out of support for such commodities. The public sector funding is complemented by donor funding, mostly channelled through NGOs.

To increase access and uptake of FP in Sindh, there are quite a number of areas of concern that need to be addressed. Through a consultative process with key stakeholders, PWDand DOH identified broad priorities to develop six strategic areas for investment in FP. This costed implementation plan (CIP) presents the strategic areas and the rationale for their selection, along with associated costs.

The strategic areas are:

Strategic Area 1 – Functional Integration: Enhancing strategic coordination and oversight between the population and health sectors at the provincial, district and subdistrict levels regarding functional integration of services at the subdistrict level.

Strategic Area 2 – Quality of Care: Ensuring quality of services by enforcing standards, improving providers' skills and ensuring client satisfaction.

Strategic Area 3 – Supply Chain Management: Improving contraceptive security to the last mile, including distribution and availability of contraceptives at service delivery points.

Strategic Area 4 – Expansion of services: Expanding services with supply- and demand-side interventions for enhancing access, especially to urban slums, peri-urban and rural areas, and creating space and linkages for public-private partnerships to reach vulnerable segments of the population including the poor and youth.

Strategic Area 5 – Knowledge and Meeting Demand: Increasing knowledge and meeting the demand for FP services by focusing on MWRA, emphasizing male engagement and young people.

Strategic Area 6: - Governance, Monitoring and Evaluation: Strengthening the health and population systems by streamlining policy planning, governance and stewardship mechanisms, and performance monitoring and accountability.

These strategic areas are guided by three principles: (1) strengthening existing systems and services; (2) accelerating interventions; and (3) innovating proving ideas, bearing high-impact practices and modern technologies, in order to achieve the following three objectives:

1. Enhance CPR from 30 percent in 2015 to 45 percent by 2020.
2. Reduce unmet need for FP from 21 percent in 2015 to 14 percent by 2020.
3. Ensure contraceptive commodity security up to 80 percent for all public sector outlets by 2018[1].

[1]An indicator can be referred from MEASURE Evaluation a commodity security database funded by USAID. The indicator is "percent of facilities whose stock levels ensure near-term product availability." Current level of stocks to be used as baseline reference. Source: MEASURE Evaluation, "Percent of facilities whose stock levels ensure near-term product availability," http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/commodity-security-and-logistics-1/percent-of-facilities-whose-stock-levels-ensure-near-term-product-availability.

In order to facilitate implementation of the CIP, a detailed implementation plan with outputs, activities and subactivities, with an annual break up, and roles and responsibilities of stakeholders, has been developed. The Provincial Oversight and Coordination Cell for Public Health Programmes of the Government of Sindh and the PWD will oversee its implementation. The CIP Cell of PWD shall be responsible for the implementation. In addition, a Technical Support Unit will be established to provide technical support in the implementation (i.e., monitoring and evaluation [M&E]; research and report writing). The district health and population management team (DHPMT) and district technical committee (DTC) at the district level shall manage the implementation, and a mechanism of functional integration (i.e., setting up roles and responsibilities of various stakeholders, necessary notifications and memoranda of understanding) shall be developed at the subdistrict level. A CIP coordinator shall be made responsible to coordinate implementation in the district, while working closely with the district officers of DOH, PWD and PPHI.

It is estimated that implementing the CIP over the next five years will have a significant impact on health, demographic and economic activities. As a result of determined action on the proposed interventions, an estimated 1,848 maternal deaths and 29,470 child deaths will be averted by the year 2020. Regarding demographic impact, an estimated 1,774,367 unintended pregnancies and 193,332 unsafe abortions will be averted, while PKR 12.187 billion will be saved by implementing the CIP, as an estimated 3,963,060 couple years of protection will be generated.

The total cost of the CIP during 2015–2020 is PKR 79.12 billion (US$ 781 million), which includes an infrastructure upgrade and mass media campaign[2]. The Government of Sindh has already allocated PKR 998 million (US$ 98 million) towards implementing the CIP[3]. It will spend approximately PKR 52.238 billion (US$ 513 million) during 2015–2020 on FP-related activities through PWD; LHW Programme; Maternal, Neonatal and Child Health Programme; PPHI; and hospital services. Development partners will spend PKR 10.287 billion (US$ 101 million) over the next three to five years. Thus, the total cost of FP interventions in Sindh during 2015–2020 will be PKR 140.647 billion.

A preliminary analysis shows a financing gap of PKR 78.1 billion (US$ 767 million). This figure is calculated by deducting Government of Sindh and other partners' allocations (PKR 62.526 billion) from the overall CIP cost of PKR 140.647 billion.

[2] An estimated amount of PKR 72 million will be spent on infrastructure and a mass media campaign.
[3] Planning and Development Department, Government of Sindh, "Annual Development Programme, 2015–2016," http://www.sindhpnd.gov.pk/projects/annual-development-program.html.

Acknowledgments

The process of CIP development has been carried out under overall supervision of the Oversight and Coordination Cell for Public Health Programmes, Sindh. The chair of the Cell Dr. Azra Fazal Pechuho, Member National Assembly and provincial coordinator Ms. Shahnaz Wazir Ali provided continued leadership support, vision and continued guidance.

Mr. Muhammad Saleem Raza, Secretary Population Welfare Department (PWD) played his lead role by being directly involved in every stage of the CIP development process by extending the required support to advance and accomplish the assignment.

Dr. Saeed Mangnejo, Secretary, DOH showed full understanding and commitment in the commonality of the cause for the health sector and provided valuable guidance during the process.

The members of the CIP Cell at PWD including Director General Mr. Bashir Mangi; Additional Secretaries Syed Ashfaq Shah, Dr. Azmat Waseem; Allahdino Ansari; and Deputy Secretary Syed Lakhadino Shah provided the required support during all stages of the process, plus the information required from the Regional Training Institutes .

Dr. Riaz Memon, Chief Executive Officer, People's Primary Healthcare Initiative (PPHI) and Dr. Sattar Chandio, Public Health Specialist, showed their commitment and extended necessary support during the consultative process. Dr. Jairam Das, Provincial Manager, LHW Programme; Dr. Sahib Jan Badruddin, Project Director, Maternal, Neonatal, and Child Health(MNCH) Programme; and Dr. Nawab Mangrio, Chief, Health Sector Reforms Unit at the DOH provided all necessary technical inputs. The PPHI also provided full support during the process of development of the document. Three focus group discussions were held with LHWs lady health visitors at Larkana, Hyderabad and Mirpur Khas to obtain their perspective based on field experience. The Pakistan Medical and Dental Council was also consulted.

The development partners including USAID; Bill & Melinda Gates Foundation; United Nations Population Fund (UNFPA); and the David and Lucile Packard Foundation provided valuable inputs during the data-gathering process. In addition, individual consultative meetings were held with international NGOs including Pathfinder International, Population Council, Population Services International, John Snow Inc. (USAID | DELIVER PROJECT and Health Systems Strengthening); Jhpiego (Maternal and Child Health Integrated Program), and Johns Hopkins University Center for Communication Programs. A number of selected NGOs were consulted including the Health and Nutrition Development Society (HANDS), Greenstar, Family Planning Association of Pakistan, Aman Foundation, Marie Stopes Society, and Aahung.

The CIP process has been supported by Bill & Melinda Gates Foundation through Pathfinder International. Pathfinder International initiated the process at the end of 2014 and Dr. Yasmeen Sabih Qazi, Senior Technical Advisor, Gates Foundation, provided her technical input and the required support during the process.

Pathfinder International headquarters and the Pakistan field office supported the CIP development process and that Dr. Tauseef Ahmed, Minal Rahimtoola, Sarah Lance, Julio Pacca, Jodi DiProfio and Thomas Park, Consultant to the Gates Foundation (in Seattle) provided technical input in the formative and conclusive phases and in the overall document formulation. Their support is acknowledged and highly appreciated.

The CIP document has been prepared by Dr. Talib Lashari, CIP team leader and Consultant of Pathfinder International. He was assisted by Muhammad Ishaq Narejo, Cost Analyst, Mr. Shabir Babar, Research Associate, who together have made insightful contributions as part of a robust team.

1 | Background and Introduction

1.1 Family Planning 2020 Context and the Commitments

World leaders and partners gathered in London during 2012 for a Summit on Family Planning in order to bring back focus on family planning (FP) and accelerate the achievements of the Millennium Development Goals (MDGs) related to maternal and child health (MDG 4 and 5) and universal access to reproductive health (MDG 5b). The Summit deliberated upon making commitments, taking determined actions and mobilizing resources for availability of high-quality, voluntary FP services, and to augment the rights of women in this regard. Furthermore, the Summit pledged to expand access of contraceptive information, services and supplies. Supported by the Bill & Melinda Gates Foundation; United Kingdom Department for International Development; United Nations Population Fund (UNFPA), and the United States Agency for International Development (USAID), the Summit made a pledge for FP2020 for a global partnership to support and strengthen the rights of women to make decisions about whether, when and how many children they may want to have during their reproductive life cycle period. More than 20 countries, including Pakistan, made their commitment to address policy and financing issues and sociobehavioural norms that prevent women from accessing contraceptive information, services and commodities.

Pakistan's commitments included increasing the contraceptive prevalence rate (CPR) to 55 percent by 2020. In line with this commitment, the Government of Sindh is determined to scale up and accelerate the FP programme in the province, with firm and open leadership support both at political and bureaucratic levels. This will make a significant contribution to achievements of FP2020 targets. Table 1.1 provides an update on Sindh's progress towards the commitments made by Pakistan at the FP2020 Summit.

1.2 The Pakistan Context

Pakistan is in transition, in terms of repositioning population, health and other social sectors. In 2010, the country introduced the 18th Constitutional Amendment through an Act of Parliament with a unanimous vote, whereby the departments of Health and Population were transferred to the provinces. With this significant devolution of power and responsibility, it is now the prerogative of the provinces to develop their policies, plans and programmes, and execute the same with a closer understanding and determination.

Pakistan's commitment of achieving a CPR of 55 percent was therefore contextualized to the four provinces, with each determining a contribution, and as a result, Sindh is committing to attain a CPR of 45 percent by 2020 as part of its contribution towards the overall national target. Table 1.2 provides a snapshot of the current status, with national and provincial commitments for 2020. The province of Sindh has developed this family planning costed implementation plan (CIP) to provide guidance for necessary activities to be included with defined targets and a road map to advance Pakistan's commitment towards its FP2020 goals.

Table 1.1 | Pakistan's FP2020 Commitments and Contribution of Sindh

Pakistan's FP2020 commitments	Current status regarding contribution of Sindh
Pakistan commits to working towards achieving universal access to reproductive health and raising the CPR to 55 percent by 2020.	Sindh has made a commitment to achieve a CPR of 45 percent in the province as part of the country's commitment against FP2020. This costed implementation plan and the regular programmes of Population Welfare Department (PWD), DOH (LHW Programme and Maternal, Neonatal and Child Health [MNCH] Programme), People's Primary Healthcare Initiative (PPHI) will be contributing towards this stated goal of CPR.
Pakistan will take forward its 2012 commitment with the active and sustained support of the Provinces by way of associating and involving all public and private health facilities into offering birth spacing services.	PWD, Sindh has trained all the Medical Officers working in basic health units (BHUs) in insertion of IUD and Implant along with conventional contraceptives and now, they are offering FP services through their facilities.
The amount spent on family planning (FP), estimated at US $151 million in 2012/13 will be increased to nearly US $200 million in 20132/14, and further raised in the future years. The contraceptive requirement assessed to be US $186 million over the period 2013 to 2020, will need to be provided for.	The Government of Sindh has spent PKR 2514.284 million on the Family Planning Programme from 2012–2013 to 2014–2015. The Government of Sindh is also committed to supplement PKR 1000.000 million in Family Planning Programme during next 4 years for new intervention in addition to regular funding of the department on current side.
Contraceptive services will be included in the essential service package of two provinces including Sindh in 2012, with the others following in 2013.	The Government of Sindh has already included contraceptives in the essential medicine list and health service package to realize its commitment.
Supply chain management, training and communication campaigns will be strengthened.	The PWD has strengthened supply chain management and arranged trainings for managers and supporting staff at provincial and district levels for professional management of this vital activity.
FP will be a priority for more than 100,000 LHW, who cover 70 percent of rural areas.	LHWs are in the network of FP and they would refer family planning cases of IUD, implant and tubal ligation to the points where such services are available.
Public-private partnerships and contractual mechanisms will help scale up access, and that the association of religious leaders and men to promote understanding of the benefit of birth spacing will make a significant contribution to accelerate acceptance and continued use rate.	All the leading private sectors organization, who provide FP services are on board. The Government of Sindh fully support and encourage in expanding family planning services in the remote areas. Religious leaders are also in the network of influential persons to promote maternal, neonatal and child health (MNCH) and that birth spacing as its integral component.

The important mechanism by which the FP2020 commitments is to be operationalized is the CIP. This plan is a multiyear strategic endeavour that maps and coordinates the investments and activities among partners to advance towards achieving the country's FP goals. The key elements of CIP include interventions needed to meet the country's goals; the costs associated with the interventions; information-sharing with donors to mobilize the needed resources; and effective measures to monitor progress against time and resources.

1.3 The Sindh Context

Sindh is the second-most populous province of Pakistan, with a population of 46 million, of which more than half reside in urban areas. Sindh is divided into 6 divisions and 29 districts (this includes 6 districts of Karachi division). Sindh province is situated within the southeastern part of Pakistan, with a total geographical area of 140,914 square kilometres[4].

This CIP articulates Sindh province's consensus-driven priorities for FP, which is envisioned to become a social contract for the government to ensure that all FP activities are aligned with the province's policy objectives. The plan prevents fragmentation of efforts, and guides existing and new partners to give a boost to FP investments and programmes. The development partners, technical agencies and civil society organizations will work in support of the cause to achieve the objectives outlined in this plan. The plan will be a dynamic document with the flexibility to revise the strategies, as needed, in order to ensure their relevance to changing policy, legislative and financial contexts.

Figure 1.1 | Map of Pakistan showing province of Sindh

Table 1.2 | FP2020 Commitments: Contraceptive Prevalence Rate Status and Targets for the Country and Provinces

Country and Provinces	2012–2013* (%)	FP2020 Commitment (%)
Pakistan	35	55
Sindh	29.5	45
Punjab	40.7	52
Khyber Pakhtunkhwa	28.1	42
Balochistan	19.5	35
Islamabad Capital Territory	59.4	-
Gilgit-Baltistan	33.6	-

Source: National Institute of Population Studies (NIPS), *Pakistan Demographic and Health Survey 2012–2013* (Islamabad: Institute of Population Studies, December 2013).

[4]Wikipedia, "Sindh," https://en.wikipedia.org/wiki/Sindh.

2 |Costed Implementation Plan Development Process (Methodology)

The process of developing the CIP for family planning in Sindh was a unique exercise carried out in Pakistan for the first time. The plan development process was initiated towards the end of 2014 when initial workshops with public and private sector stakeholders were held in Karachi to discuss the strategies and approach to be adopted for fulfilling international commitments made at the 2012 London Summit.

The development of the CIP in Sindh began in April 2015. The process was owned and led by the Population Welfare Department of Sindh, with facilitation of the process and technical support provided by Pathfinder International, and with support from the Bill & Melinda Gates Foundation. To ensure provincial ownership from the beginning, the process was steered and guided by an Oversight and Coordination Cell for Public Health Programmes, Sindh, which brought respective secretaries of the DOH and the Population Welfare Department (PWD) and key programmes together to discuss issues, prioritize and develop a family planning strategy for Sindh. The Oversight and Coordination Cell provided direction and guidance in technical terms throughout the assignment and was chaired by Dr. Azra Fazal Pechuho, supported by Secretary of the PWD Muhammad Saleem Raza Khuhro, and Secretary of the DOH Dr. Saeed Mangnejo. A CIP Cell was also set up within the PWD to support operational matters during the design, planning and execution phases of the entire exercise.

A total of 28 stakeholders were consulted through a series of consultative sessions. These included the PWD; Regional Training Institutes; Departments of Health—[its allied programmes, i.e. National Programme on FP and Primary Healthcare and the Maternal, Neonatal and Child Health (MNCH) Programme]; Provincial Health Development Centre; People's Primary Healthcare Initiative (PPHI); USAID and its implementing partners; The David and Lucile Packard Foundation; Bill & Melinda Gates Foundation; Pathfinder International; Population Council; and other stakeholders. A total of 40 consultative meetings were held to provide an enriched basis for the formulation of the CIP.

In order to facilitate and build uniformity in the consultation process, questionnaires were developed and utilized, which were in line with the specific set of stakeholders, enabling them to elaborate upon their role and how they would like to give impetus to their contributions. The areas covered through such meetings included areas of work, objectives and coverage, human resources, logistics, best practices, quality assurance, challenges, monitoring and evaluation (M&E), accountability and their outlook into the future. The stakeholders were requested to prepare a five-year plan of their activities along with estimated cost.

The information provided by various stakeholders covered two specific aspects. The first aspect relates to stakeholders' areas of work including rural and urban access, services, training and financing. The other aspect is related to best practices and innovations, quality of care, public-private linkages, donor coordination and future plans. Three focus group discussions were held with selected LHWs from Divisions of Hyderabad, Mirpur Khas and Larkana, which provided information about functioning, performance and challenges related to LHWs and lady health supervisors and their perspectives on improvement and acceleration. Three separate meetings were held with lady health visitors (LHVs) in the same cities for insights about their role, contribution and perspective on improvement.

A desk review was conducted, which included documents, research reports, papers, official files and service statistics. The review provided a better overview and insights about the efforts and progress made,

impediments encountered, and it provided a broader picture of global experiences, lessons learnt and proven practices of successes.

Specific tools were utilized for technical and costing aspects of the CIP, including the *Guidance for Developing Technical Strategy for FP Costed Implementation Plan,* a resource kit prepared by FHI360 as part of the Knowledge for Health (K4Health) Project, funded by USAID[5]. The information gathered through the consultative process was analytically applied to the Results Framework, a tool provided within the guidance. Three main steps for developing the CIP included a situation analysis, results consolidation and formulation in the relevant context, which led to planning and incorporation of activities in the CIP (Annex III).

Through the Results Framework, stakeholders' ideas were transformed into strategies, outputs and activities. Those strategies and activities were then analysed in terms of their feasibility and impact. Based on scoring for impact and feasibility, a level of priority was set covering prioritized activities. Thus, six strategic areas were identified along with key activities, presented in an implementation plan.

As a next step, costing was conducted for the strategies and corresponding activities mapped in the implementation plan. A tool prepared by USAID for the purpose of CIP costing was utilized. It is a comprehensive tool that provided the total cost of each activity and helped inform estimates of the cost for each strategic area and for FP2020 commitments.

Each aspect of the CIP developed was discussed at length with the Oversight and Coordination Cell for Public Health Programmes, PWD and DOH, and the final strategies, implementation plan, costs and prioritization were the result of discussions, negotiations and consensus built during the process.

[5]Knowledge for Health (K4Health), "Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans" (Baltimore: FHI360, K4Health Project; USAID Office of Population & Reproductive Health), (www.familyplanning2020.org/cip).

3 | Situation Analysis

3.1 Stakeholders in Family Planning

Family planning and reproductive health programmes in Sindh are implemented by both the public and private sectors. The public sector spends around 24 percent of total health expenditure on health care (total health expenditure = *combined* sum of public and private health expenditures); while out of pocket expenditures (OOP) is 61.2%, which includes private sector spending[6] (details in subsection on financing, section 5.6). In the public sector, the Population Welfare Programme; LHW Programme; Maternal, Neonatal, Child Health Programme; and Peoples Primary Health Care Initiative (PPHI) have mandates to deliver FP services. In the private sector, FP services are provided by private clinics of general practitioners, maternity homes, private pharmacies and shops. Nongovernmental organizations (NGOs) make up 7 percent of the private sector, which excludes donor funding[7]. Development partners implement FP projects through various international and local NGOs, and in some cases through the public sector. The following table shows the development partners who are working in the province (Table 3.1).

Table 3.1 | Development Partners' FP Work in Sindh

No.	Donor	Implementing Partner	Project	Geographical Area	Duration	Budget US $
1	USAID	Marie Stopes Society	Family planning and reproductive health services	All districts of Sindh/ 3 of Punjab	2013–18	70 m
2	USAID	Jhpiego	Maternal, neonatal and child health (MNCH) with family planning (FP) component	Thatta, Tharparkar, Tando Allahyar, Khairpur	2013–17	46 m (5–7 m on FP)
3	USAID	Johns Hopkins Center for Communication Programs	Health communication	Sukkur, Jacobabad, Nosheroferoz, Sanghar, Umarkot, Mitiari, Ghotki, Mirpurkhas, Shikarpur and Larkana	2014–19	24 m (FP is about 3 m)
4	USAID	John Snow, Inc.	Health systems strengthening	Sindh province		10 m
5	Bill & Melinda Gates Foundation	Pathfinder International	Population policy development in Sindh and CIP development in Sindh and Punjab	Provinces of Sindh and Punjab	2013–15	975,000

[6]Pakistan Bureau of Statistics, *Pakistan National Health Accounts 2011–2012* (Islamabad: Government of Pakistan, Pakistan Bureau of Statistics, July 2013).
[7]Ibid.

No.	Donor	Implementing Partner	Project	Geographical Area	Duration	Budget US $
6	Bill & Melinda Gates Foundation	Aman Health Care	Sukh Initiative	Karachi (Sindh province)	2014–18	5 million
7	Bill & Melinda Gates Foundation	Population Council	Landscaping of FP in Pakistan	Karachi, Sukkur, Hyderabad (few districts in Punjab and KP)	2015–16	1 million
8	The David and Lucile Packard Foundation	DKT International	Access and use of contraceptives	Provinces of Sindh, Punjab	2012–15	400,000
9	Packard Foundation	HANDS	Improve FP and reproductive health	Umarkot	2007–15	2 million
10	Packard Foundation	Shirkat Gah Women Resource Centre	Achieving MDG 5	All provinces	2012–15	250,000
11	Packard Foundation	Strengthening Participatory Organization	Access to quality FP and RH	Lodhran, Matiari, Tando, Mohammad Khan, Karachi	2013–15	250,000
12	Packard Foundation	Indus Resource Center	Life Skills based education	Khairpur, Jamshoro		
13	Packard Foundation	Rutgers WPF	Empowering girls	Sanghar, Karachi	2013–16	500,000
14	Packard Foundation	Aahung	Promoting sexual and reproductive health	Karachi (Sindh) and few districts of Punjab	2013–15	700,000
15	Packard Foundation	Aman Health Care	Sukh Initiative	Karachi (Sindh)	2014–18	5 million
16	UNFPA	PWD, Marie Stopes Society	public-private partnerships in FP Services	Ghotki (Sindh) and districts of Punjab	2014–17	5 million

Source: Email correspondence with development partners, compiled for CIP Sindh, 2015.

3.2 Intersectoral Collaboration

FP has cross-cutting linkages and effects on different social sectors, particularly in terms of early marriage, educational attainment and FP uptake, women's empowerment for decision making in the use of contraceptives, local government support of FP at the grass roots level, provision of health and FP facilities in communities with internally displaced people affected by natural disasters and conflicts, and awareness on sexual and reproductive health rights among college and university students as it relates to their future role

and responsibilities in their family life. The social-sector departments and universities are key stakeholders related to the above-mentioned areas. Therefore, Departments of education, youth affairs, women's development, local government, Provincial Disaster Management Authority, and public and private sector universities have a crucial role in the consultative process to formulate broad strategies and support the implementation of the CIP.

3.3 Demographic and FP Indicators of Sindh

Sindh has a population of 46 million, and at the current fertility level the population is expected to reach approximately 50 million by 2020.[8] Approximately three-quarters of the total urban population of Sindh is concentrated in just three urban centres: Karachi, Hyderabad and Sukkur, with 60 percent concentrated in Karachi[9]. Sindh has a large youth population, between the ages of 15 and 24, as per the United Nations (UN) definition of youth[10]. In 2010, 57 percent of the population was less than the age of 30, of which around 20.4 percent were between ages 15 and 24. Medium-term projections reveal that by 2020, 52 percent of the population will be less than 30 years and 19.1 percent between ages 15 and 24[11].

In 2015, there were approximately 13 million women of reproductive age (ages 15 to 49 years), estimated to reach 15 million by 2020 (Table 3.2). Furthermore, using the most recent proportion of married women among the total population of women, assuming it declines from 63 percent in 2014 to 61 percent by 2020, (according to projected estimates), the number of married women of reproductive age (MWRA) is projected to rise from 8.4 million in 2015 to 9.3 million by 2020.

[8]NIPS [Pakistan] and ICF International. *Pakistan Demographic and Health Survey 2012-13.* (Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International, 2013).
[9]Pakistan Defence, "Sindh Most Urbanized Province of Country: UNFPA," June 28, 2007, http://defence.pk/threads/sindh-most-urbanised-province-of-country-unfpa.6035/.
[10]United Nations Department of Economic and Social Affairs (UNDESA), "Definition of Youth," http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf.
[11]This information is based on Draft Population Policy, Sindh work conducted by Dr. Tauseef Ahmed, Pathfinder International, and another document on population projections for Sindh and Pakistan 2010-2050 prepared for M&E Working Group, USAID MCH program Sindh, July 2014.

Table 3.2 | Projected Population of Sindh: Total Population and MWRAs[12] (Midyear Figures)

Indicators	2014	2015	2016	2017	2018	2019	2020
Total population (estimated)	44,914,996	45,859,476	46,811,370	47,768,635	48,729,022	49,689,976	50,648,678
No. of women (15–49)	13,129,816	13,473,296	13,816,934	14,160,761	14,504,685	14,848,736	15,193,305
No. of married women of reproductive age (MWRA)	8,271,784	8,420,810	8,635,854	8,779,672	8,992,905	9,057,729	9,267,916
Prop married of all women in ages 15–49 (PDHS 2012–2013)	63%	62.5%	62.5%	62%	62%	61%	61%

Source: Pathfinder International
Note: These are projected estimates; actual population may be higher.

FP in Sindh made great strides between 1990 and 2001 when, due to the investment in the LHW Programme, CPR increased from 12 percent to 28 percent[13] (Table3.3). The CPR, however, was stagnant at 29.5 percent for a considerable stretch of time between 2000 and 2015, with 24 percent of women of reproductive age using a modern method to space or limit their pregnancies. Currently, though 96 percent of the women are aware of at least one method of FP, there remains a gap between practice and knowledge, with contraception use remaining quite low; an area of specific attention for planners.

[12]The population projection is based on achieving replacement level fertility by 2035 (total fertility rate = 2.1). *PDHS* data related to Sindh (prop married amongst all women) was used to reach MWRA for Sindh. MWRA is 18 percent of the total population.
[13]Mohammed Salim Wazir, Babar Tasneem Shaikh, and Ashfaz Ahmed, "National Program for Family Planning and Primary Healthcare Pakistan: A SWOT Analysis," *Reproductive Health* 10, no. 60 (2013).

Table 3.3 | Trend in FP Indicators for Sindh, 1990–2014

Indicators	PDHS 1990–1991 (%)[14]	PRHFPS 2001 (%)[15]	PDHS 2006–2007 (%)[16]	PDHS 2012–2013 (%)[17]	MICS 2013-2014 (%)[18]
Total fertility rate	5.1	4.8	4.3	3.9	4
Contraceptive prevalence rate	12.4	27.6	26.7	29.5	29
Modern contraceptive prevalence rate	9.1	20.2	22.0	24.3	24.8
Percentage with teenage births (≤18)	12.0	8.3	8.3	7.9	10
Proportion women who want no more births	35.8	43.9	48.4	51.2	-
Unmet need for contraception	23.9	- -	25.4	20.8	21.7
Infant mortality rate	91	92	78	74	82

Source: NIPS, *Pakistan Reproductive Health and Family Planning Survey 2000–2001* (Islamabad: Institute of Population Studies, 2001); NIPS, *Pakistan Demographic and Health Survey 2006–2007* (Islamabad: Institute of Population Studies, June 2008); NIPS, *Pakistan Demographic and Health Survey 2012–2013* (Islamabad: Institute of Population Studies, December 2013); Government of Sindh, *Multiple Indicator Cluster Survey for Sindh Report 2014*. Bureau of Statistics Planning and Development Department Sindh, Pakistan: 2015).

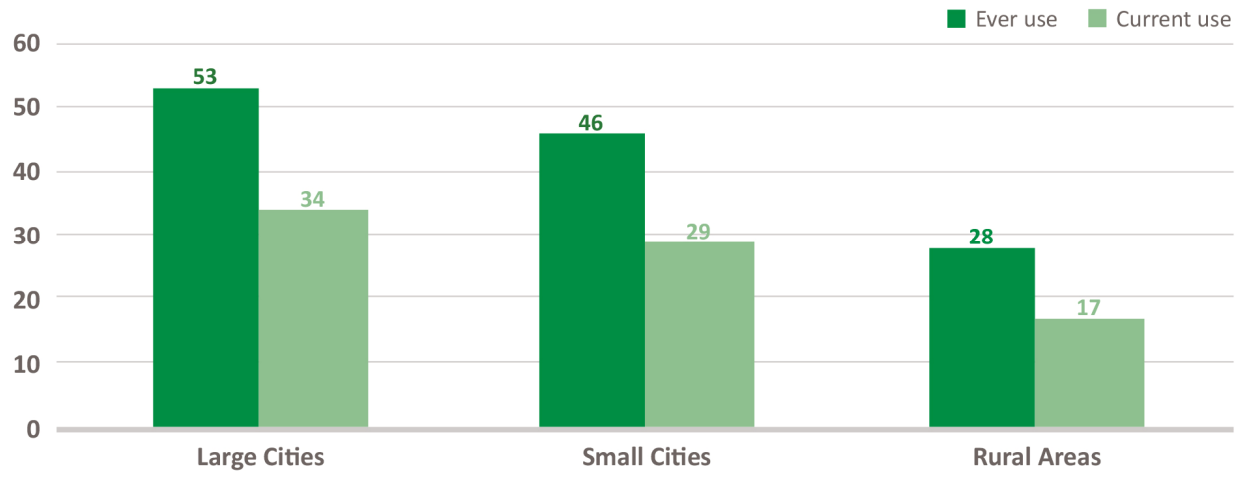
The disparities in the province are varied, with a CPR of 42.7 percent and 17.4 percent in urban and rural areas respectively, and an unmet need of 20.8 percent. By investing in reducing unmet need and increasing the CPR to 45 percent by 2020, a total of 1,848 maternal deaths and 29,470 child deaths will be averted, along with prevention of unintended pregnancies and the likelihood of resultant abortions[19].

[14]National Institute of Population Studies (NIPS), *Pakistan Demographic and Health Survey 1990–1991* (Islamabad: Institute of Population Studies, July 1992).
[15]NIPS, Pakistan Reproductive Health and Family Planning Survey 2000–2001 (Islamabad: Institute of Population Studies, 2001).
[16]NIPS, *Pakistan Demographic and Health Survey 2006–2007* (Islamabad: Institute of Population Studies, June 2008).
[17]NIPS, *Pakistan Demographic and Health Survey 2012–2013* (Islamabad: Institute of Population Studies, December 2013).
[18]Government of Sindh, *Multiple Indicator Cluster Survey for Sindh Report 2014*. (Sindh, Pakistan: Bureau of Statistics Planning and Development Department, 2015).
[19]Impact 2 estimation by Pathfinder Internatio
nal.

3.4 Contraceptive Use

Two aspects of contraceptive use are important to observe—method mix (percent distribution of contraceptive users by method) and regional differentials. The two most frequently used FP methods in Sindh are female sterilization and condoms. While knowledge of short-term methods (e.g., condoms, pills and injections) is high, the use of specific methods such as pills and injectables is low,(Table 3.4).

Figure 3.1 | Use of Modern Contraception – Sindh



Source: NIPS, *Pakistan Demographic and Health Survey 2012-13.*

Condom use is unexpectedly highly popular in urban areas while injections in rural areas are the second-most preferred method. Knowledge regarding intrauterine devices (IUDs) is reasonably high (87 percent) with ever use of contraception at 5.4 percent, which is a very small proportion of users in rural and urban areas. In contrast, awareness regarding implants is low and its use is negligible as recorded by the Pakistan Demographic and Health Survey (PDHS) 2012–2013.

Implants have been available in Pakistan (in various forms) for over a decade, but awareness and use of this method remains dismal. Trained doctors based at reproductive health service (RHS) centres as well as private providers administer implants on a limited scale. However, in the recent past, there has been a marked increase in the number of implant insertions as a result of joint efforts of PWD, PPHI and the Lady Health Worker (LHW) Programme to train more providers to administer these methods, as well as organize outreach camps at remote facilities. On average the rate of user dissatisfaction is low, and therefore the removal rate is low, at most 5 percent[20].

Regional differentials in the use of modern methods highlights the need for improved strategies for counselling, care and follow-up assurance to generate new demand and to meet existing demand with care to enhance continuation rate. An analysis of PDHS 2012–2013 data reveals that the FP sector in Sindh gave greater attention to urban areas than rural areas. Ever use of contraception was 53 percent in major urban areas, reflecting that a large proportion of urban women use modern methods. The PDHS 2012–2013

[20]Population Welfare Department, Government of Sindh.

revealed that 34 percent of women in major urban areas, 29 percent of women in other urban areas and 17 percent of women in rural areas were using modern contraceptive methods. Low, ever and current use of modern methods reflects low attention to rural areas by all stakeholders. The urban slums are generally underserved as people living in those settlements resort to use of private sector services.

The historical trend regarding use of contraceptives in Pakistan is provided in the PDHS 2012–2013. Such data on trends is not available for Sindh; however, the trend for Pakistan shows an increase of ever use of any contraceptive among currently married women up 34 percentage points in the past 22 years, from 21 percent in 1990–91 to 49 percent in 2006–2007 and 55 percent in 2012–2113 (Table 3.4).

Table 3.4 | Distribution of Ever Use of Contraceptives in Pakistan, 2012–13

Methods	Ever - Married Women	Currently Married Women
Any method	53.7	54.8
Any modern method	43	48
Female sterilization	8.5	8.7
Male sterilization	0.3	0.3
Oral pill	10.5	10.8
Intrauterine device	9.3	9.4
Injectable	13.6	13.9
Implant	0.2	0.2
Condom	21.8	22.3
Lactational amenorrhea method	9.3	9.4
Emergency contraceptive pill	0.9	1.0
Standard Days Method	0.1	0.1
Any traditional method	22.8	23.5
Rhythm	5.4	5.5
Withdrawal	19.7	20.3
Other	0.8	0.9

Source: NIPS,*Pakistan Demographic and Health Survey* 2012–2013.

Continuity of use of various methods through voluntary and informed choices from a range of methods is highly desirable to achieve an effect on fertility, which remains high over the period. Overall, 37 percent of contraceptive use episodes were discontinued within 12 months for one reason or another. The discontinuation rate of injectables is 61 percent, pills 56 percent, and condoms 38 percent[22]. Discontinuation of contraceptive use (during five years preceding the 2012–2013 survey) varied according to the method

[21]NIPS, *Pakistan Health and Demographic Survey 2012–2013.*
[22] Ibid.

used (Table 3.5)[23]. Women wanting to become pregnant used condoms or traditional methods, and as such their discontinuity of use appeared justified. However, a little less than one-third of all women discontinued use of modern methods due to side effects or health concerns. This points to the need to improve quality of services to ensure continuity of use, especially for long-acting methods. Disapproval by husbands for a specific method is not is not as serious as an issue as reported by women using contraception.

Table 3.5 | Reasons Given by Women in Sindh for Discontinuation of Contraception

Reason for last discontinuation	Pills (%)	IUD (%)	Injections (%)	Condom (%)	Periodic Abstinence	Withdrawal (%)	Total
Became pregnant	19.7	.0	3.4	15.8	37.5	24.7	**13.8**
Wanted to become pregnant	22.4	25.8	22.8	57.0	37.5	48.3	**38.4**
Husband disapproved	1.3	.0	2.8	6.7	12.5	4.5	**4.0**
Side effects	48.7	74.2	46.2	4.8	.0	5.6	**27.4**
Total cases	**83** **100%**	**31** **100%**	**145** **100%**	**165** **100%**	**8** **100%**	**89** **100%**	**521** **100%**

Source: NIPS; *Pakistan Demographic and Health Survey 2012–2013.*

A Population Council study of contraceptive use in four provinces suggests that the use of a range of methods has varied[24]. Between 2007 and 2013, the proportion of women opting for female sterilization declined from 28 percent to 25 percent and the use of all other modern methods declined during the same period[25].

There is a range of different sources to obtain contraceptives. The public sector has a large network of facilities and outlets in Sindh that provide FP services (described at length in Section 4). These facilities provided contraceptives to 40 percent of users (Table 3.6), whereas 54 percent users accessed contraceptives through private sector outlets. Within the public sector, the RHS-A centres catered to 35 percent of users, Family Welfare Centres (FWCs) to less than 2 percent and LHWs served more than 3.4 percent of women. The wide network of LHWs and extensive FWCs across all districts of Sindh served 5 percent of women for contraceptive services. This reflects underutilization of the LHW network.This cadre needs support for strengthening their roles and responsibilities. Furthermore, for more effective role of LHWs, their supervisors may be further trained in supportive supervision and monitoring so as to enhance effectiveness of LHWs contribution.

[23] Ibid.
[24] The Population Council, *Prioritizing Family Planning for Achieving Provincial Maternal, Child Health and Development Goals* (Islamabad: The Population Council, March 2014).
[25] The Population Council, *Prioritizing Family Planning for Achieving Provincial Maternal, Child Health and Development Goals* (Islamabad: The Population Council, March 2014).

Table 3.6 | Most Recent Source for Contraception in Sindh, 2012–2013

Latest Source of Current users	Current Contraceptive Users							
	Pills	IUD	INJ	Condoms	Female sterilization	Female sterilization	Implants/ Norplant	Total
Public Got: Hospitals (RHS-A)	25.5	31.4	19.4	2.1	68.7	100.0	50.0	34.9
Family Welfare Worker	3.6	17.1	3.1	0	0	0	16.7	1.7
Lady Health Worker (LHW)	14.5	0	13.3	1.7	0	0	0	3.4
Private Facilities								
Private/NG0/ Hospitals/Clinics	5.5	37.1	36.7	2.1	30.9	0	33.3	20.5
Private/Pharmacy/ Chemists	29.1	0	5.1	67.9	0	0	0	25.3
Private Doctors	0	8.6	10.2	8	0	0	0	2.1
Shops	18.2	0	4.1	13.8	0	0	0	6.5

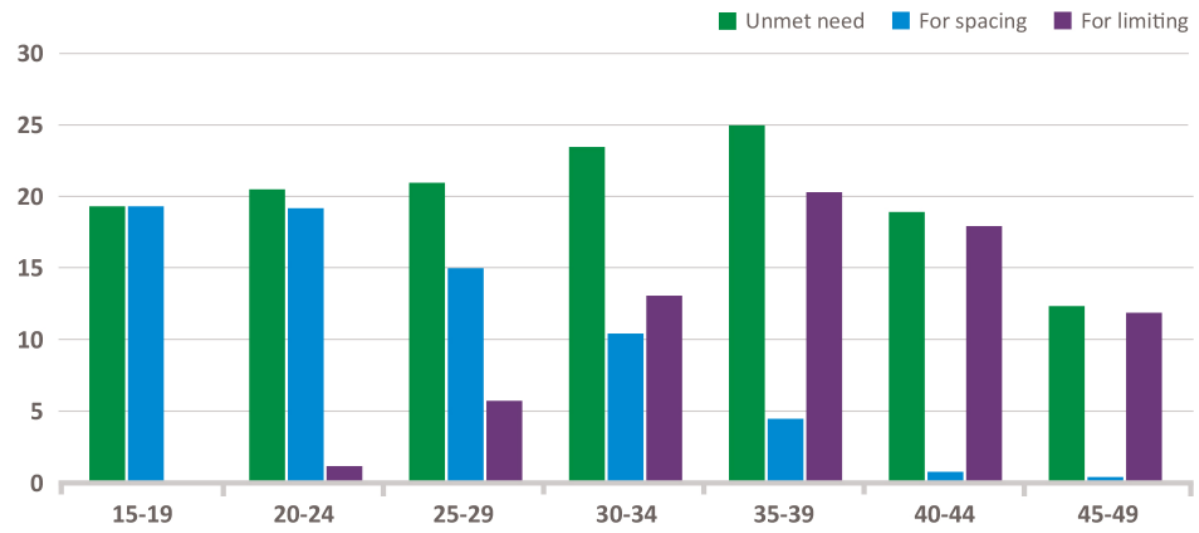
Source: NIPS, *Pakistan Demographic and Health Survey 2012–2013*.

The private sector plays a major role in the delivery of FP, with 54 percent of modern methods obtained from private sector facilities—primarily from private and NGO hospitals and clinics (21 percent), private pharmacies or chemists (25 percent), and other sources including shops and stores (9 percent). The role of the private sector (social marketing companies and development partners) cannot be ignored in this important area.

3.5 Unmet Need for Contraception

Unmet need for FP refers to women of reproductive age who are not using contraception but wish to postpone their next pregnancy (spacing) or stop childbearing altogether (limiting). Unmet need for contraception in Sindh still remains around 21 percent. Women with an unmet need may include dropouts and never users. Women who wish for spacing and limiting are two distinct groups in terms of age (Figure 3.2). Unmet need for pregnancy spacing is high among younger women (ages 15–19 and 20–24), while the desire to limit pregnancy rises with age especially from ages 30 to 44. Young age cohorts therefore provide tremendous opportunity for pursuing FP services and improving access.

Figure 3.2 | Unmet Need for Contraception in Sindh



Source: NIPS, *Pakistan Demographic and Health Survey 2012-13.*

High latent demand[26] for limiting pregnancies among women ages 30 and above is reflective of poor availability and poor quality of FP services. Furthermore, unmet need for contraception is high (25 percent) among rural women versus urban residents.

Women with an unmet need for birth limiting are less educated and concentrated in the poorest, poor and middle wealth segments of the population. Lack of women's empowerment and lack of employment further complicate the situation, resulting in low use of contraception. According to the PDHS 2012–2013, decision-making power in three main areas at the household level contributes to women's empowerment: a woman's own health care, major household purchases and visits to her family or relatives. This empowerment is influenced by a number of variables including employment, age, number of living children, residence, province, education, supportive outlook of the husband and wealth quintile. Over 50 percent of women who take all three decisions are employed, as compared to 35 percent women who are unemployed. Thus, 44.2 percent of empowered women use a method of contraceptives as compared to 25.3 percent who are not empowered[27].

Two immediate solutions to address the issue of unmet need for contraception from both an impact and feasibility perspective are (1) community-level service provision and (2) adoption of quality standards by all service providers. Demand generation and awareness campaigns coupled with improved counselling techniques and interpersonal communication (IPC) at local levels need to be streamlined, improved and made the mainstay of FP efforts to address the missing links between supply and demand, to better reach women with an unmet need for birth spacing.

---

[26] Unmet need is desiring space or limiting childbearing and not using contraceptives; latent demand is the difference between achieved fertility and desired fertility or level of unintended childbearing. Source: W. Henry Mosley, "Demand-Supply Framework for Family Planning Program Analysis and Unmet Need for Contraception," PFHS-380.665 Family Planning Policies and Programs, Johns Hopkins Bloomberg School of Public Health (JHSPH), 2006 (Baltimore: JHSPH, 2006).
[27] NIPS, *Pakistan Demographic and Health Survey 2012–2013.*

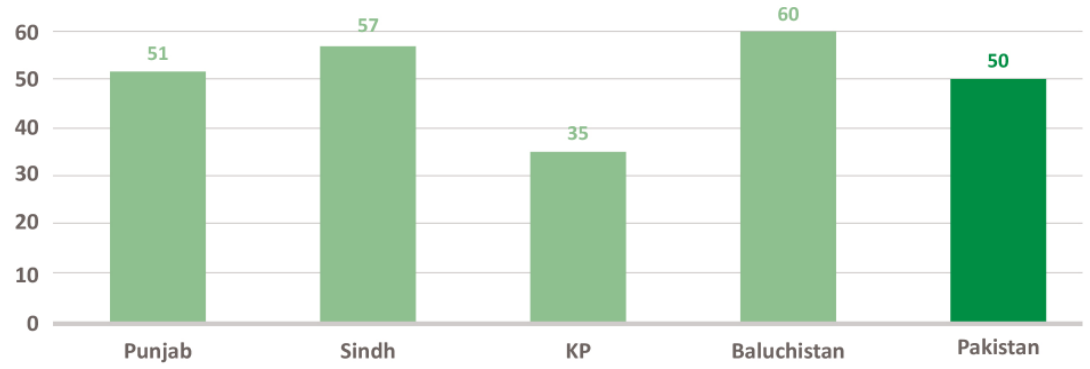
3.6 Unintended Pregnancies

Women in Sindh have 26 percent more births than desired (PDHS 2012–2013). Three characteristics emerge from recent surveys, clearly identifying the concentration of unintended pregnancies: rural (35 percent), uneducated (33 percent) and the poorest quintile (33 percent). Fertility in rural Sindh is 35 percent higher than the desired level. Social pressures and poor accessibility of services lead women in rural Sindh to face the brunt of demand for large families and to experience single or multiple factors of high-risk pregnancies, threatening their health and life. Evidence reveals that the proportion of women desiring no more births has risen from 36 percent to 51 percent (1990–2013), indicating a growing desire among women to curtail their pregnancies (Table 3.3). The inconsistency between women's fertility goals and not availing contraceptive services at the same time, results in unwanted pregnancies or women who seek recourse to induced abortion.

In addition to investing in the availability of services, it is equally important that services are confidential, located at an easily accessible location, offer respectful care to women and are delivered as per their choice at an affordable cost. It would be pertinent to ensure availability of services along with IPC and counselling support. In Pakistan, abortion is legally allowed only to save the life of a woman, but due to difficulty in interpreting the law, it has been complicated to obtain legal abortion services. The PDHS 2006–2007 revealed that around 10 percent of women reported experiencing a miscarriage or an abortion during the five years prior to the survey. As per more recent estimates[28], the proportion of unintended pregnancies rose from 38 percent in 2002 to 46 percent in 2012. The rate of unintended pregnancies increased from 71 to 93 per 1,000 women ages 15 to 49 years. In 2012, there were around 9 million pregnancies in Pakistan, of which 4.2 million were unintended. Of those unintended pregnancies, 54 percent resulted in induced abortions and 34 percent in unplanned abortions. As per provincial estimates, Sindh and Balochistan have the highest rates of induced abortions (62 percent and 63 percent, respectively). There were approximately 2.25 million abortions in Pakistan in 2012. Thus, the national abortion rate was 50 per 1,000 women ages 15 to 49. This is much higher than the rate estimated for 2002 which was 26.5 per 1,000. The abortion rate for Sindh is 57 per 1,000 women ages 15 to 49 which is higher than the national estimate. In 2012, an estimated 623,000 women in Pakistan were treated for complications of induced abortion. About 63 percent of treated women obtained post-abortion care in private facilities. In Sindh, 58 percent sought care from private facilities, a slightly lower than national average. When observed in relation to high unmet need, this phenomenon of seeking care from private facilities, demonstrates a need for immediate policy and implementation initiatives, particularly in the provision for easily accessible services to avert recourse to abortion and post-abortion care.

[28] Z. Sathar et al., "Induced Abortions and Unintended Pregnancies in Pakistan," *Studies in Family Planning* 45, no. 4 (2014): 471–491.

Figure 3.3 | Abortion Rates by Province, 2012



Source: Z. Sathar et al., "Induced Abortions and Unintended Pregnancies in Pakistan, 2012," 471–491.

Women's inability to attain their reproductive intentions can lead to high-risk pregnancies (Table 3.7).

Table 3.7 | Identifying High-Risk Pregnancies in Sindh, 2012–2013

High-Risk Aspects	Gravity of Situation in Sindh
Too early (pregnancy before age 18)	19.9%
Too many pregnancies (four or more pregnancies)	52.0%
Too close pregnancies (less than 36 months)	67.0% births
Too late pregnancy (beyond age 34)	11.2% women

Source: NIPS,*Pakistan Demographic and Health Survey 2012–2013*, Islamabad.

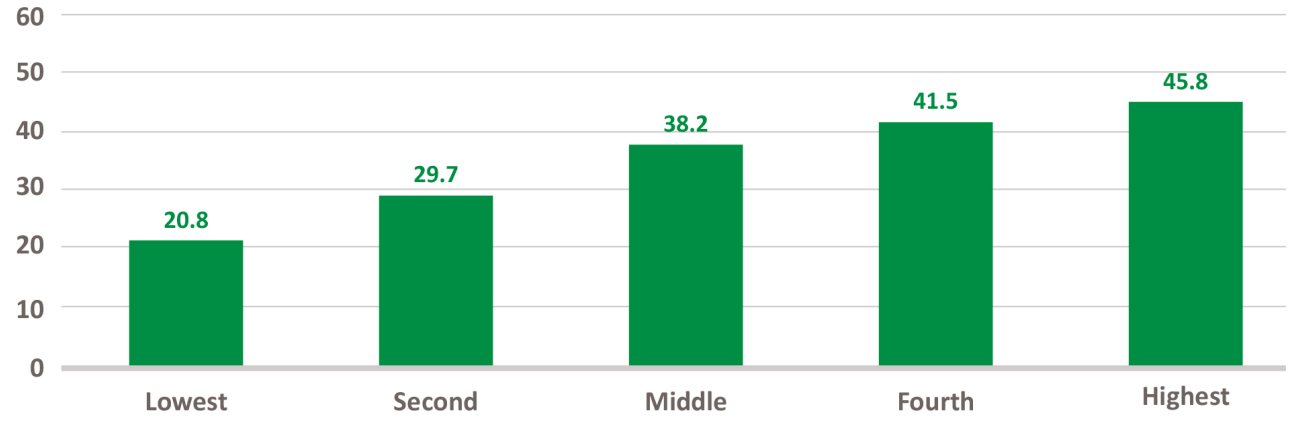
3.7 Socioeconomic and cultural Norms, Practices and Barriers to FP Uptake

Socioeconomic and cultural norms, practices and barriers have significant implications for FP. For example, poverty, education, social norms like myths and misconceptions, and preference for a son often hinder the use of FP services due to issues related to access, affordability and acceptability. In addition, weak infrastructure is another barrier for utilization of services. These barriers to FP uptake are further analysed in this sub-section:

Inequities due to poverty are evident in FP-related indicators. The data shows that use of any method among women in the lowest wealth quintile is 20.8 percent as compared to 45.8 percent in the highest wealth quintile[29]. This reflects inequality in the provision and access to FP services, especially for the poor.

Figure 3.4 | Current Use of Contraception by Wealth Quintile (% Any Method)

[29]NIPS, *Pakistan Demographic and Health Survey 2012–2013.*

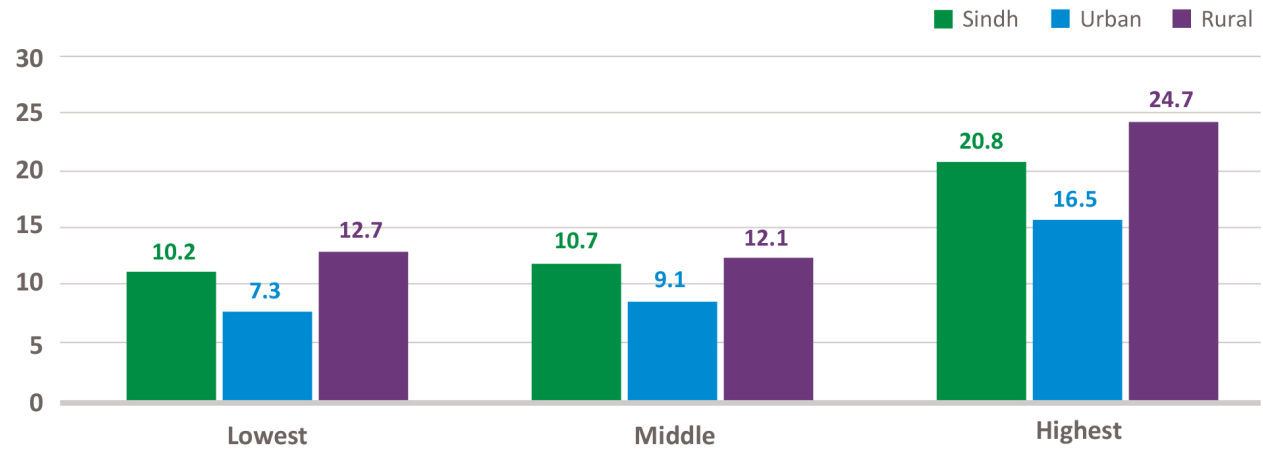


Source: NIPS,*Pakistan Demographic and Health Survey 2012–2013.*

The PDHS 2012–2013 also reveals that more poor women report experiencing side effects of FP methods than wealthier women. The survey shows that twice as many poor women experience side effects of modern methods (28.3 percent) relative to wealthier women (14 percent). The findings reflect poor quality of services (weak counselling about side effects and choice of method) at facilities serving poor women. Moreover, unmet need is highest among the poorest of the poor (24.5 percent); and lowest among the wealthy (15.3 percent). It shows that poor women get low-quality commodities or obtain services from poorly skilled providers due to lack of affordability and proper care. It shows that service delivery mechanisms are less inclusive and less supportive in rural or underserved areas.

The total demand for FP in Sindh is quite high (met need = 29.5 percent; unmet need = 20.8 percent). The FP services by public and private sectors have not kept pace with rising demand. A large proportion of health sector facilities provide FP services but at a slower pace. A recent survey revealed that women in Sindh, on average, have one birth in excess of their desired fertility, with a total fertility rate of 3.9 compared to a desired total fertility rate of 3.0. The alarming proportion of women not desiring additional pregnancies (51 percent) and experiencing unwanted pregnancies are a reflection of this critical situation. These outcomes are largely a result of lesser accessibility to and affordable quality of FP information, comprehensive counselling and care in services. Concentrated efforts are needed to reach out to women in need of FP and aligning FP services from community to facilities at district and provincial level.

Figure 3.5 | Unmet Need in Sindh (Rural vs. Urban)



Source: NIPS,*Pakistan Demographic and Health Survey 2012–2013.*

In Sindh, early marriages among girls remain a persistent practice, even though the average age at marriage has reached 20, and the legal age for marriage increased to 18. Many districts that have low female literacy also have a high proportion of women giving birth between the ages of 13 and 18. This high-risk pregnancy behaviour (around 8 percent across three PDHS between 2001 and 2013) puts the health status of women at serious risk.

A number of factors contribute to women to having an unmet need, including poor knowledge of where to access contraception, female mobility, lack of transport, poor provider-client interaction, inadequate treatment and prior counselling including explanation of side effects, limited time available for FP services, high cost of travel and high charges made by providers in the community, social pressure to have large families, perception that contraception is against Islamic teachings, lack of spousal communication on the subject matter, and her own feeling of shame and modesty to discuss such matters with a provider being perceived as a stranger.

3.8 Human Development Index

The districts of Sindh have been ranked in accordance with their human development level based on the Pakistan Social and Living Standards Measurement Survey in 2013-2014. In this regard, three indicators available in the survey were used—literacy rate (education), fully immunized children (proxy indicator for health conditions), and household with flush washroom (proxy indicator for poverty). According to the ranking, eight districts (Tharparkar, Badin, Thatta, Kashmore, Tando Muhammad Khan, Jacobabad, Umarkot and Mirpur Khas) are at a low level of human development. Whereas Karachi, Hyderabad, Larkana, Sukkur, Naushahro Feroz, Dadu and Shikarpur are higher ranking districts[30].

[30]Pakistan Bureau of Statistics, *Pakistan Social and Living Standards Measurement Survey, 2013-14* (Islamabad: Government of Pakistan, 2014).

Globally, Pakistan is ranked second to last (141 out of 142 countries) on the Gender Gap Index, with higher gender inequality[31]. While score 1 is for gender equality and 0 is for inequality, Pakistan's score is 0.5522. Contraceptive use is positively related to women's participation in household decision making. Women who cannot participate in household decision making have higher unmet need (21 percent) compared to those women who participate in household decision making[32]. Level of education plays a significant role in fertility decision making. In Sindh, women's literacy (45 percent) is quite low compared to men's literacy (72 percent), while the literacy level for the province is 59 percent.[33]

[31]World Economic Forum, "Global Gender Gap Report, 2014," accessed June 25, 2015, http://reports.weforum.org/global-gender-gap-report-2014/rankings/.
[32]NIPS,*Pakistan Demographic and Health Survey 2012–2013.*
[33]Pakistan Bureau of Statistics: 2014. *Pakistan Social and Living Standards Measurement Survey2012–2013* (Islamabad: Government of Pakistan, 2014).

4 | Landscape of the Population and Health Sectors

4.1 Organizational Structure and Collaboration Between Health and Population Welfare

Administrative structure

ThePWDhas the mandate of dispensing FP and reproductive health services in Sindh (Table 4.1). The functions of the department have been set under Rules of Business, 1986. With the passing of the 18th Constitutional Amendment in 2010, the concurrent legislative list of several functions of the federal government were abolished and devolved to the provinces.Under the 18th Constitutional Amendment the PWD's responsibilities include policy formulation and implementation, legislation, financing, procurement, human resource development, information management, donor coordination and M&E. The department will also contribute towards achieving international commitments (i.e., FP2020) as part of the country's overall commitment and developing mechanisms for donor coordination that align with provincial needs. Since devolution, financing for the department comes through the recurrent budget and the Annual Development Plan. (See organization chart of PWD Sindh in Annex XIII.)

Table 4.1 | Population Welfare Department

Administrative level	Role	Responsibility
Provincial level	Minister for Population Welfare	Provides strategic guideline and policy direction
	Secretary (civil service officer)	Administrative head of the department. He/she is also the Principal Accounting Officer bestowed with necessary financial powers
	Director General (civil service officer)	Responsible for implementation and monitoring of programme activities at all levels
	Additional secretaries (civil service officer)	4 total, with different assignments 1) administration and finance; 2) medical; 3) communication, trainings, logistics and supplies; 4) monitoring, evaluation and performance
	Deputy secretaries (civil service officer)	With each additional secretary, there are two or more than two deputy secretaries, as well as supporting section officers and other related staff
Regional	Regional directors (civil service officer)	6 total, one per regional directorate
District	District Population welfare Officer (DPWO) (civil service officer)	Head of district office for management of programme implementation in the district
Subdistrict	Taluka Population Welfare Officer heads the office (civil service officer)	Head of office to manage tehsil level activities and as a support arm for the district

The facilities under the PWD provide all modern FP services and commodities which are delivered through its different static facilities and mobile outreach services. The services provided through static facilities and outreach efforts range from comprehensive FP services including conventional and clinical methods, male and female contraceptive surgeries, and FP information and counselling.

As shown in Tables 4.2 and 4.3, the health infrastructure in the province is managed at the provincial and district levels by the DOH. The mandate of the department has transformed under the 18th Constitutional Amendment, with the transfer of the management and financing of all vertical health programmes to the provinces. The new roles and responsibilities of the department include policy formulation and implementation, legislation, financing, procurement, drug regulation and control[34], human resource development, district health information system (DHIS), public health and vertical programmes, attached departments, oversight of autonomous bodies, and M&E[35]. The department is also responsible for meeting international commitments as part of the country's overall commitments and to develop mechanisms for donor coordination that align with provincial needs.

At the district level, the management of basic health units (BHUs) in all districts, except Karachi and Nawabshah, has been contracted out to the PPHI[36]. The PPHI was initiated across the country in 2007. In addition, in some districts, 163 district headquarters hospitals (DHQs), taluka headquarters hospitals (THQs) and rural health centres (RHCs) have been outsourced to selected NGOs. Table 4.2 shows the details of the outsourced facilities.

[34] Drug regulation is also a provincial subject in the wake of the 18th Constitutional Amendment; however, through a resolution of the four provincial assemblies, this function has been kept within the federal Drug Regulatory Authority

[35] Health Sector Reforms Unit, Department of Health, *Situation Analysis for Post Devolution Health Sector Strategy of Sindh Province* (Sindh: Government of Sindh, 2011).

[36] Khalife Bille et al.,"Implementing the District Health System in the Framework of Primary Health Care in Pakistan: Can the Evolving Reforms Enhance the Pace Towards the Millennium Development Goals?" *Eastern Mediterranean Health Journal*16, no. Suppl (2010): S132-S144.

Table 4.2 | Health Facilities Outsourced to NGOs in Sindh in 2015

District / Division	Category of Facility	Number Outsourced	NGO
Badin	District headquarters hospital (DHQ)	1	Indus Hospital, Karachi
All districts (except those where urban health centres are established and those where rural health centres [RHCs] are with PPHI)	RHC	105	Integrated Health Systems (IHS)
Division Larkana	Taluka headquarters hospital (THQ)	3	HIS
Thatta and Sijawal (2 districts)	All facilities	13	Merlin International
Thatta and Sijawal	Ambulance Service	All facilities	Aman Foundation
Gadap and Bin Qasim Townships of Karachi Division	Government hospitals, RHCs, BHUs, dispensaries	23	HANDS
Khairpur	DHQ	1	HANDS

Source: Department of Health, *Public-Private Partnership Node*¸ October 30, 2015.

As per agreements, the budgets related to operations, maintenance, medicines and sanctioned vacant positions will be shifted to the concerned NGOs. However, salaries of existing staff will not be shifted to those NGOs and instead will continue to be transferred directly to the accounts of concerned staff. Table 4.3 shows administrative details, roles and responsibilities at the DOH.

Table 4.3 | Department of Health (DOH), Sindh

Administrative level	Role	Responsibility
Provincial level	Office of the Minister for Health	Provides strategic vision and policy-level decision making for provision of health services in the province
	Secretary (Senior civil service officer)	Administrative head of the department. He/she is also the Principle Accounting Officer holding necessary financial powers
	Special Secretary and Additional Secretaries (civil service officer)	The Secretary is supported by a Special Secretary (Public Health); four Additional Secretaries each heading administration; development; public health; procurement; and monitoring and inspection wing
	Director General (civil service officer)	One of the roles of the Director General Health is to coordinate vertical health programmes. He/she is also responsible for monitoring the programme activities at each level of implementation
District	District health officer (DHO) or executive district officer (civil service officer)	District health system which is headed by the district health officer (DHO)/ in some districts called the executive district officer. There are four wings headed by DHO office i.e. medical and public health; admin and accounts; medical

Administrative level	Role	Responsibility
		superintendent; Taluka Health Office[37]
Subdistrict	Taluka Health Officer (civil service officer)	The Taluka Health Officer looks after his/her assigned areas in terms of monitoring and supervision and duties assigned through the district office

4.2 Population Welfare and Health Infrastructure

The province has a vast network of DOH and PWD facilities, with a combination of static facilities and mobile outreach services. PWD facilities have the mandate to provide FP services, while several facilities administered by DOH and PPHI include FP as one of the important functions, but not the primary mandate.

PWD infrastructure

As shown in Table 4.4, the PWD provides services through its six channels of static facilities and outreach services. These include reproductive health services (RHS-A) centres, FWCs, mobile service units (MSU), RHS-B centres, social male mobilizers, and no-scalpel vasectomy centres[38]. Table 4.4 provides details of the facilities. There are four types of RHS centres: RHS-A; RHS-B; RHS Master Training Centre; and RHS Training Centre.

RHS-B centres are certain type of facilities under a contract with the PWD. These include hospitals or clinics of other provincial departments, NGOs, private sector and charity hospitals having operating theatre facilities, trained staff with gynaecological and anaesthetic services. RHS-B centres are registered with PWD to augment services like contraceptive surgery (CS) and other FP and regional health services. However, due to resource constraints, this model of public-private partnership is not functional. In low-resource communities, the FWCs are the first line of PWD facilities to access FP[39]. The scope of work for FWCs includes provision of FP and MNCH services and treatment of minor ailments. In line with the International Conference on Population and Development, the scope includes safe motherhood, infant health care and management of sexually transmitted infections, including HIV/AIDS.

The Regional Training Institutes (RTIs) provide skills-based training in FP and reproductive health for doctors, medical students, nurses, LHVs and other paramedics. The RTIs also arrange orientation sessions for awareness of hakims, homeopaths, community health workers, teachers and college students.

[37] Health Sector Reforms Unit, Department of Health, Situation Analysis for Post Devolution Health Sector Strategy of Sindh Province.
[38] Population Welfare Department (PWD), *Population Welfare Programme Sindh PC-1, Five Year Plan (2010–2015)* (Sindh, Karachi: PWD, 2010).
[39] Personal correspondence with PWD, dated August 10. 2015.

Table 4.4 | Mapping of PWD and DOH Facilities and Human Resources Related to FP

Nature of Facility	Description	Department	Number of Facilities	No. of Human Resources	Population Covered
Static Units					
RHS-A	Hospital based units for provision of full range of reproductive health services comprising FP methods including CS (male, female); MCH care; prevention and management of reproductive tract infections and sexually transmitted infections including HIV/AIDS; management of reproductive health issues of adolescent boys and girls, men and women; infertility; early detection of breast and cervical cancers by promoting self-examination	PWD[40]	75	RHS-A - 11; RHS Master Training Centre 19; Training Centre 15	Population across a taluka
Family Welfare Centre (FWC)	FP information, counselling, follow-up for all methods except for implants CS; availability of contraceptives, medicines; MCH services, infant care including nutrition, growth monitoring, and common illnesses; referral of cases of infertility, HIV/AIDS; CS/implants	PWD	961	6 staff (male and female) led by Family Welfare Worker (BPS 8)	7000 (through satellite clinics/ outreach covers 12000)
No-Scalpel Vasectomy (NSV)	The five no-scalpel vasectomy (NSV) centres are situated at Karachi, Hyderabad, Larkana, Nawabshah and Moro. NSV is preferred method for male CS and is more simple and safe	PWD	5	Staff NSV Training Centre 7, NSV Centre 6	
Basic health units	A first-level care facility (FLCF) at Union Council level with preventive and basic curative services, referral, and FP modern methods i.e. implant, IUDs under PPHI	PPHI / DOH	783 (611 - PPHI)	Doctors/ specialists 21,042 Nurses 2628 LHVs 894 Paramedics 40,000	Union Council level (15,000)
Rural health centres	A First-Level Care Facility at town level with curative services, basic surgeries and referral, FP modern methods	DOH (recently outsourced)	125 (2-PPHI)		Cluster of Union Councils (50,000)
Taluka headquarters hospitals (THQ)	A secondary-level care facility at the taluka level with curative and surgery facilities with FP modern methods under emergency obstetrics and neonatal care (EmONC)	DOH (some of those outsourced)	44[41]		200,000
District headquarters hospital (DHQ)	A secondary-level care facility with specialties of medicine, surgery, Gynaecology , Paediatric facilities, and FP modern methods (EmONC)	DOH (some of those outsourced)	18		

[40]Population Welfare Department, Population Welfare Programme Sindh PC-1, Five Year Plan (2010–2015).
[41]Health Sector Reforms Unit, Department of Health, Situation Analysis for Post Devolution Health Sector Strategy of Sindh Province.

Nature of Facility	Description	Department	Number of Facilities	No. of Human Resources	Population Covered
Tertiary care and Specialized care Hospitals	Specialties in areas of medicine, surgery; FP methods, Specialized hospitals are dedicated to a certain specialty	DOH	9+27=36		
Outreach Facilities					
Mobile service units (MSU)	MSUs provide FP and reproductive health services to remote areas where other facilities are not available. The MSU operate from specially designed vehicles, which possess all the facilities of a mini-clinic. MSU ensures complete privacy for gynaecological procedures. Each MSU requires the organization of 10–12 outreach camps every month. Due to resource constraints MSUs are not fully functional.	PWD	10–12 outreach camps in a month	03 led by a Women Medical Officer or Field Technical Officer (FTO)	40,000
Social male mobilizers	Social Male Mobilizers are union council based workers. They are supposed to establish their office in their home. Two male mobilizers are to be recruited at each FWC. The mandate of Male Mobilizers is to increase acceptance of FP among the male population and use of male contraception methods. Male Mobilizers dispense condoms and pills. Most of the mobilizers are non-functional. In the wake of FP2020 goals, their role needs to be revisited.	PWD	Housed in each Union Council	1250	10,000
Lady health workers (LHWs) and lady health supervisors	LHWs are women from within the community who are educated up to class ten and are trained in delivering FP and maternal, neonatal and child health (MNCH) services; promotion of health education, nutrition promotion and basic sanitation etc.[42] They promote FP methods like condoms, pills, emergency contraceptive pills, and provide second injection to married women of reproductive age free of cost.	DOH/ National Programme on FP and primary health care	01 Health House in a population of 1000 (48 % covered area)	22575 770	1000
Lady Health Visitors (LHVs)	LHVs are placed at BHUs and rural health centres (RHCs) to provide primary health care services including FP to women.	DOH	Attached to public facilities/ private clinic	894	-
Community	CMWs provide skilled maternity care services at the community level.	DOH/MNCH Programme	Linked to public	1705	15000

[42]National Programme for Family Planning & Primary Healthcare, *The Lady Health Workers Programme, 2010–2015, PC-1* (Islamabad: Government of Pakistan, Ministry of Health, 2010).

Nature of Facility	Description	Department	Number of Facilities	No. of Human Resources	Population Covered
Midwives (CMWs)	Their skills in FP need to be improved.		facility/ NGOs clinic		
Training Institutes					
Regional Training Institute	Specialized training centres in family planning and reproductive health package	PWD	4	-	-
Provincial Health Development Centre (PHDC) and District Health Development Centre (DHDCs) (select districts)	Trainings centres of DOH to provide trainings to DOH doctors, LHVs and other providers on health sector and FP	DOH	PHDC 01; DHDCs; Training Schools 44	-	-

Department of Health infrastructure

The DOH manages nine vertical health programmes. FP services are the mandate of LHWs and MNCH programmes, with all static facilities providing these services. The implementation of CIP shall heavily rely upon the lady health worker cadre. Sindh currently employs 22,575 LHWs, each of whom covers a population of 1,000. These LHWs are supervised by lady health supervisors and are responsible for delivering primary health as well as FP services. Approximately 30 LHWs report to one lady health supervisor. LHWs are permitted to dispense pills, condoms, emergency contraceptive pills, and provide the second dose of injection in the community.

The MNCH Programme has a focus on basic and comprehensive emergency obstetrics and neonatal care (EmONC) services. The programme envisaged two to three facilities within a district to provide 24/7 comprehensive EmONC services and six to eight facilities to provide 24/7 basic EmONC services, while the remaining DOH facilities would provide safe delivery, preventive obstetric and neonatal/infant care services.

The Community Midwives (CMWs) are the backbone of the programme. The CMWs are based in the community and provide antenatal care and safe, normal delivery, in addition to postnatal care[43]. Current conversations are underway to determine if CMWs can provide postpartum IUD services and other FP services[44].

At the first-level care facility (FLCF), PPHI—as part of a public-private partnership model with the DOH for primary health care—also caters to the needs of FP users through provision of short- and long-term methods. PPHI entered into a contract with the DOH to manage BHUs in 22 districts of Sindh (except for 6 districts in the Division of Karachi and 1 Nawabshah district). BHUs are the first point of contact for communities. They provide an optimum space for FP services, as well as postpartum IUD, postpartum FP and post-abortion FP

[43]Health Department, *Strengthening of Maternal, Neonatal and Child Health Programme in Sindh PC-1, 2012–2015* (Karachi: Government of Sindh, March 2013).
[44]Comments received at the consultative meetings at the Oversight and Coordination Cell for Public Health Programmes and the MNCH Programme, Sindh, May 2015.

services, as they are operational 24/7. PPHI was initiated in 2007 in all provinces[45], with the DOH allocating all resources meant for the BHUs to PPHI for hiring staff, providing supplies and delivering services. PPHI was tasked with facility and health services management at the district level. These BHUs complement the DOH's layer of secondary and tertiary care in the districts and at the provincial level which provides short- and long-term methods. In some instances, under the Public-Private Partnership Act 2010, the DOH has outsourced its first- and second-level care facilities (RHCs, DHQs, THQs) in various districts to selected NGOs.

Working together for FP service delivery

Although the large infrastructure of the DOH and PWD addresses FP there remains a need for closer collaboration between both departments. Both departments work within separately set parameters for reporting, operating mandates and human resources. Although this allows for greater accountability for better performance of their respective facilities and human resources, there is a growing realization that for the improvement of FP outcomes, there is a need for functional integration at the district level. Functional integration entails the creation of a clear structure that will allow decision making about the division of tasks, responsibilities and recourse, as well as the distribution of financial resources needed to motivate stakeholders to coordinate their actions, while allowing each department to maintain its autonomy but share responsibility for collective action in addressing the challenges[46].

Implementation based on this collaboration is evident in the wake of inclusion of contraceptives in the Essential Medicine List of the DOH facilities such as BHU, RHC, THQ and DHQ[47]. Furthermore, during the CIP development process, both departments came together to jointly discuss FP strategies at length. The Population Welfare Programme, LHW, PPHI and MNCH have held several joint meetings, and more importantly, some of those have been co-chaired by both the respective secretaries to discuss joint interventions for the next five years. The level of commitment is so high that the Government of Sindh has already allocated resources under a joint programme for CIP for interventions.

As this relationship continues to strengthen in order to implement the CIP and meet FP2020 goals, there is a need for attention to the important areas for service delivery. Human resources availability, quality, referrals, supportive supervision and coordination need to be strengthened at the department level as well as within the Departments of Health and the Population down to the district levels—with an understanding of the commonality of the cause and the collective responsibility for change in voluntary societal behaviour for the health and wellbeing of the population.

[45] Personal correspondence with PPHI officials, October 28, 2015.
[46] André-Pierre Contandriopoulos, Université de Montréal. Groupe de richer recherinterdisciplinairsanté. *The integration of health care: dimensions and implementation*. (Montréal: GRIS, Université de Montréal, 2004).
[47] USAID | DELIVER Project, *Essential Medicine List (EML),* (Sindh: Department of Health, Government of Sindh, October 2014).

5 | Policy and Programming Overview

In the wake of devolution to better meet the needs of its population, the Government of Sindh is in the process of implementing policies and comprehensive programmes to provide a range of reproductive health and FP services. This section presents policies and programmes from the perspective of creating an enabling environment, satisfying existing demand, service delivery mechanisms, supply chain management, financing, and stewardship and accountability, with determination and sustained action to achieve the stated objectives of health and wellbeing of the population of Sindh.

5.1 Policy and Enabling Environment

Prior to the implementation of the 18th Constitutional Amendment, policies and plans in the social sector were developed at the federal level. However, after the Amendment, provinces became empowered to develop their own policies. In line with this strategic shift, Sindh has evolved its policies in the population and health sectors. It is important to note that the timing of the development of this CIP coincides with the formulation of the Sindh Population Policy, which is under review at the PWD, Sindh, and may conclude with changes in the approved policy document. However, and as proposed, the draft Population Policy's long- and short-term policy objectives are as follows.

Long term:

- Attain a decrease in fertility level from 3.9 (2013) to 3.0 births per woman by the year 2020.
- Raise the CPR from 29.5 percent in 2012–2013 (baseline) to 45 percent by 2020.

Short term*:*

- Increase access to FP and reproductive health services to the most remote and farthest areas of the province by 2017.
- Increase efforts to reduce unmet need for FP from 21 to 15 percent by 2020.
- Ensure contraceptive commodity security at all service outlets by 2018.
- Achieve universal access to safe and quality reproductive health and FP services by 2020.

The PWD's draft population policy 2015 asserts and reaffirms timely completion of fertility transition in the face of emerging demographic realities. The substance of the draft policy is based on voluntary character of the pursuit, equity and fairness in the provision of services, and the right to information with choice of methods to manage fertility preferences. This draft policy emphasizes an active pursuit of the birth spacing approach. In pursuit of its long-term fertility goals, the policy envisions improvements in the contraceptive method mix to increase access to long-acting reversible contraceptives (LARCs).

Complementing the PWD's Population Policy is the DOH's Health Sector Strategy (2012–2020). The specific objectives of the strategy include enhancing health outcomes in the province while improving cost efficiency and quality of service delivery; enhancing the stewardship role of DOH for steering the public and private sectors towards desired health outcomes; harmonizing the strategy with national policies and international

commitments while maintaining strong contextual relevance for Sindh; providing a financial framework for investment by government, private sector, UN agencies, and international partners; and providing a broad M&E framework for monitoring of the health sector strategy by DOH and partners.

Both policies emphasize the need for strengthening inter-departmental linkages to increasing FP uptake. The Population Policy defines the role of the DOH in provision of FP. It emphasizes the role of LHWs and CMWs as key mechanisms by which these goals can be achieved. The following excerpts from the draft Population Policy provide the parameters for this collaboration:

> **"The Department of Health will renew and re-emphasize its endorsement to family planning with mandatory provision of family planning services at all health facilities. The policy aims at harnessing the benefits of demographic dividend by making family planning a vital component of the essential health services package...."**

> **"The Department of Health will work closely with Population Welfare to impart IUCD insertionskills to CMWs at RTIs and ensure regular technical supervision and supplies. Furthermore, the Department will pursue the objective of increasing number of LHWs across Sindh."**

Likewise, the health sector strategy focuses on family planning under its "Special Areas of Focus" by redefining links with PWD, emphasizing FP services through district and urban primary health care systems (linkages with MNCH) and aiming at birth spacing in young couples.

Under the Strategic Actions, the Health Sector Strategy stresses integration of FP services with its MNCH services. It resolves to"provide free contraceptives and training by PWD to all DOH facilities for birth spacing, integration of services with pregnancy care to reach out to couples supported by community-based BCC."

5.2 Demand: Satisfying Existing and Creating Additional Demand

There are 1.747 million MWRA in Sindh who are current users of contraceptives. According to projections (presented in Sections 3 and 9), as a result of implementing the CIP, there will be an additional 1.2 million users of modern methods by 2020 (an estimated 74 percent increase in all users in five years and 66 percent increase in modern methods users). This increase will also include a large number of young people, requiring approaches that are sensitive to their needs. Therefore, in order to continue to meet existing demand and reduce unmet need, there is a need for both supply- and demand-side approaches to increase the annual rate of change in CPR which has remained at 0.4 percent for the last decade.

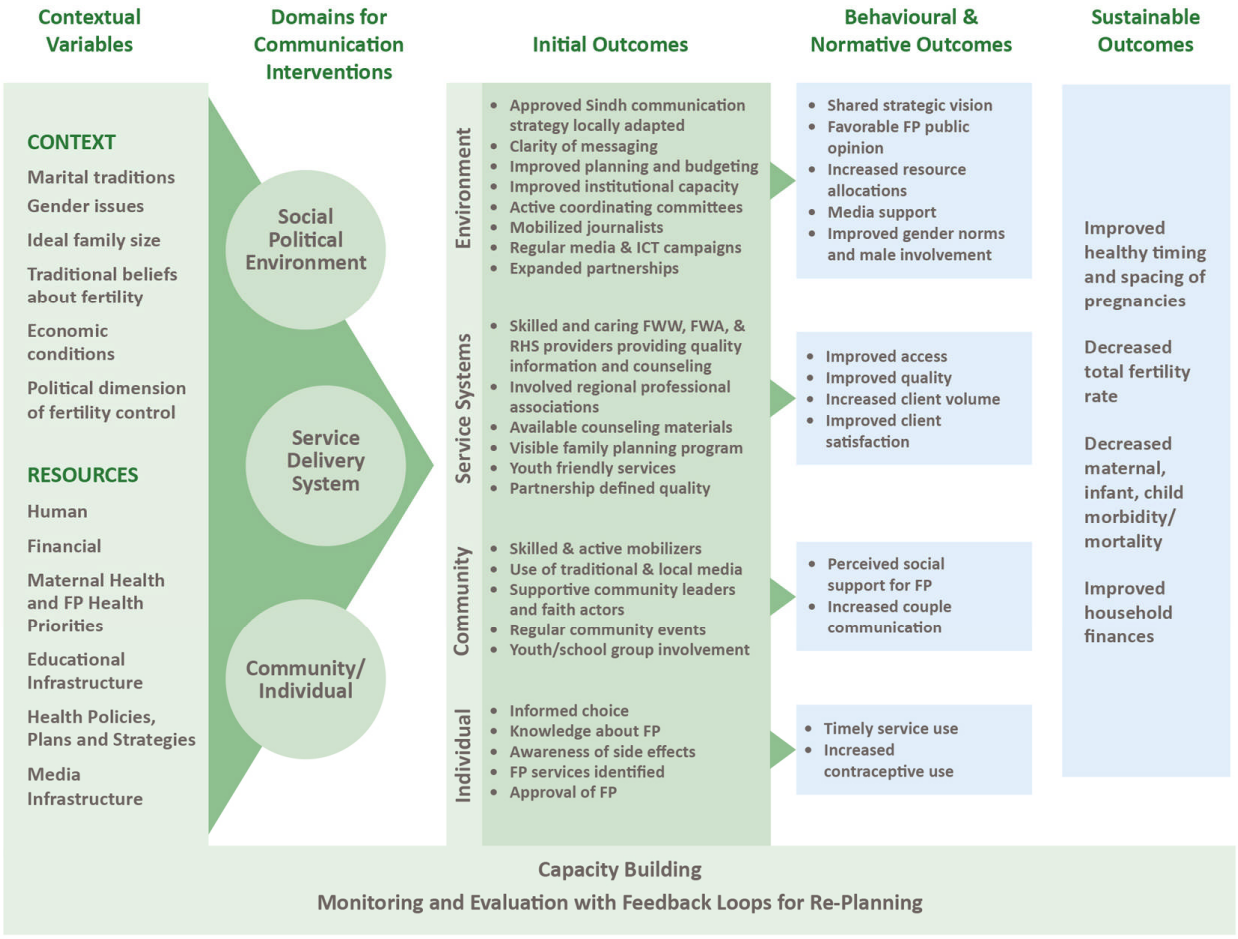
Currently, there are four programmes being implemented within the public sector, in addition to the private sector including NGOs initiatives to satisfy existing demands for contraceptives. However, any efforts at static facilities and outreach services in the public and NGO sectors need to be complemented with demand-generating approaches to facilitate behaviour change while creating effective awareness regarding location of FP facilities, awareness in the improvements in quality, and the types of services available. For example, PWD FWCs remain highly underused, with not more than three to four clients per day. Behaviour change approaches are necessary, as women in Sindh have restricted mobility due to economic access issues—poor women cannot afford to travel long distances to get services, and conservative social norms restrict their mobility.

To address these barriers in service uptake, PWD will build upon its existing efforts in collaboration with the Health Communication Component of USAID's MCH Programme, to facilitate behaviour change with a focus

on regular and repeated IPC in an environment of trust and care. PWD and the Johns Hopkins Center for Communication Programs are in the process of developing a communication strategy and 17 unified FP messages for Sindh. The purpose of this strategy is to unify, streamline and clarify the FP communication efforts of the PWD and its partners. The assumption is that by providing this framework, the collective impact of PWD and its partners on healthy timing and spacing of pregnancies will increase and thetotal fertility rate will decrease. This will lead to decreases in mortality and morbidity and potential improvements in household resources.

The Sindh Family Planning Promotion Pathway(Figure 5) demonstrates the PWD's approach and illustrates how a variety of interventions will work in synergy to enhance the health and wellbeing of families in Sindh through a systems approach[48].

Figure 5.1 | Sindh Family Planning Promotion Pathway



[48] Johns Hopkins Center for Communication, USAID funded communication component of MCH programme. *Communication Strategy for PWD, Sindh*, 2015.

5.3 Service Delivery and Access

As per PDHS estimates, in 2012–2013 the PWD RHS centre within the public sector were the primary mechanisms to provide FP services (34.9 percent), while the second main source was through LHWs who provide around 3.4 percent of FP services. The rest of the facilities within DOH and PWD provided 4.6 percent of FP services (Table 3.6). In terms of comparison, it is evident that RHS-A centres and LHWs are the relatively stronger elements, while RHCs, BHUs, FWCs and LHVs are the weaker elements in access to service delivery. Recently, PPHI has made concerted efforts to provide FP services at its outlets, but the assessment regarding achievements of those services can be conducted in due course. [49]

Service delivery mechanism barriers

- Uncovered areas.
- Underserved/underutilized centers.
- Identification of non-functional FP points. In many places, FP services are not up to the mark, either due to lack of motivational spirit of staff present at the service point, shortage of trained staff or lack of equipment.
- Staff strengthening of FP points. Existing points need training and supportive supervision at the field level.

During the CIP consultation process, low coverage of FP services, particularly in underserved areas in rural areas as well as peri-urban and urban slums, emerged as an area that needs focus and special attention. The LHW Programme covers only 46 percent of Sindh, most BHUs (under PPHI) do not provide FP services, and although 961 FWCs cater to rural areas, they have not been fully operational due to lack of essential equipment and necessary supplies. Additionally, there have been limited outreach camps and community-level services due to a lack of funds, thereby making it immensely challenging for women to avail services as per their need and choice.

With the increase in unmet need, it is evident that the demand for FP has been rising over the years, while actual utilization of services has been low and has not picked up pace—despite that FP stakeholders (both public and private) have designed and offered services mostly from static facilities. To reach underserved areas, more needs to be done to serve clients; there aren't strong outreach efforts.Instead, community-based health workers simply wait for clients to visit the static service units. This creates a missed opportunity for community-based health workers, such as the LHWs who often belong to the same community; their focus has been shifted away from FP services due to competing demands to complete other tasks. This missed opportunity has weakened outreach efforts to penetrate the community for FP contact, counselling, services and referrals related to birth spacing. Nevertheless, the LHW Programme has tremendous potential to advance to FP2020 objectives, provided the following concerns are addressed:

- The LHWs can be mobilized for FP if operational cost-related aspects are addressed. There are four concerns in terms of motivation of LHWs: salary, mobility cost, commodity security and effective supportive supervision that contributes to on-the-job skill development.
- The federal government has provided funding to vertical programmes including the LHW Programme. However, this support has not been sufficient to maintain the programme. During fiscal year 2014–2015 the federal government provided PKR 23 million[50], which was not sufficient to cover salaries; the LHWs

[49] Correspondence with PWD and PPHI, May 2015.
[50] Based on information from LHW Programme, May 2015.

did not receive their wages for the last three to four months in a number of districts. In the wake of lack of salary cost and resource constraints, the provision of operational cost has remained a low priority.

- Trainings on new techniques, as well as refresher trainings, have not been provided for the past few years. The LHW Programme can significantly contribute to FP if operational cost and salaries are provided on time and performance-related incentives are introduced to encourage mobility in the communities and interaction with the women based on strict monitoring at frequent intervals.

In some instances, human resources are functioning at a suboptimal level due to low utilization, as indicated by issues of access, awareness of services, affordability and quality. It has been noted that some of the workers are overworked and others are under -utilized. For instance, LHWs have been doing multiple tasks, while Social Male Mobilizers are not properly working due to different reasons such as appointments made under influences, lack of clear job descriptions and linkages within the system.

Another challenge shared by stakeholders is that providers, especially doctors and LHVs, need proper training in FP counselling and contraceptive technology. This is largely due to low investments in training and refresher courses over the years. For example, the functioning of FWCs was affected due to the PWD receiving lower non-salary funds during 2009–2014, thereby leading to neglect of equipment and lack of maintenance of service delivery outlets. In addition, the ban on recruitment over the last several years was a major barrier. Thus, FWCs also faced staff shortages, hindering smooth functioning.[51]

These human resource challenges have led to poor communication and counselling skills of service providers to address emerging misperceptions and myths regarding new technologies. This is coupled with poor treatment of clients, which has an effect on respectful care and addressing needs to satisfy clients and address discontinuation.

Although RTIs provide trainings, they also face resource constraints. Staff needs for trainings remain, and there is a need to invest in performance improvement and management mechanisms to improve staff motivation for better services. This can be ensured through incentives and timely payments. Historically, referral mechanisms have remained weak and less results-oriented. Although, there are different categories of community-based health workers supporting facility-based services, they are also short on supplies or lack necessary skills to offer a range of contraceptive methods. For instance, although CMWs get theoretical training on FP during their courses, they do not have a reliable source of supplies or hands-on training in counselling and IUD insertion management. Additional attention is needed to improve provision of youth-friendly services with respectful care based on sociocultural sensitivities.

Overall, there is a need to strengthen PWD and DOH service delivery points further. This requires financial resources for operations, properly trained human resources, better infrastructure, supplies and equipment. In this perspective, there are several challenges and gaps in service delivery mechanisms.

[51] Consultative meetings for CIP, May–July 2015.

5.4 Supply Chain Management

A client-centred, well-functioning logistics system is at the mainstay of FP service delivery. It can ensure "greater contraceptive access, higher quality of care, and more efficient use of resources."[52] By ensuring quality of services, these elements are critical to and "linked to greater contraceptive prevalence, higher continuation rates, and more client satisfaction."[53] The essential ingredients of the logistics system are forecasting, quantification, procurement, storage, distribution, waste disposal, monitoring and supportive supervision, and evaluation.This is to ensure continuous availability of the products at the service delivery point.

Supply chain barriers

- Management and logistics system issues in a systematic manner
- Availability of storage at various levels, especially at the facility level
- Reporting mechanism on utilization and linking with rising demand
- Capacity regarding contraceptive procurement
- Timely release of funds with required amount to operationalize the FP services as planned
- Maintenance of an online system for monitoring the supply situation at all levels.

Between 2009 and 2014, the United States government provided the government of Pakistan with support for contraceptives commodities through its USAID | DELIVER PROJECT. The support ended in September 2014, with the last shipment continuing through the end of 2015. In the wake of this discontinued support, supplies are being provided through buffer stocks. In response to the phase out of the USAID | DELIVER PROJECT, Sindh has made an allocation of PKR 5.4 billion for FP for the years 2014–2018. Assuming the current level of political commitment for FP in Sindh, it is anticipated that the government will continue its support for the procurement beyond 2018.

USAID support has provided supply chain management for procurement, transportation and availability at district-level stores, development of a web-based logistics management information system, province-specific procurement manuals, logistics manuals and the creation of the provincial Essential Medicines List. Support has also been provided to civil society, including the FP Association of Pakistan; Greenstar; and Marie Stopes Society. However, at the end of USAID support, the private sector programmes and NGOs are required to identify new sources for contraceptives, which will likely be an area of challenge in Sindh. This has been a topic of discussion during the CIP exercise.

5.5 Commodity Security

The Government of Sindh has committed funds for procurement of contraceptives for public sector stakeholders (PWD, DOH, LHW, PPHI). The procurement will be carried out under recurrent budgetary allocations of PKR 5.4 billion for the next five years. The forecasting of contraceptives has been made based on performance data of 2013–2014 from the Pakistan Logistics Management Information System website (www.lmis.gov.pk). All procurements will be made according to the Sindh Public Procurement Regulatory

[52]Knowledge for Health, "Logistic System Design & Supply Chain Management, Toolkits," accessed June 21, 2015, https://www.k4health.org/toolkits/fp-logistics/logistics-system-design-and-inventory-management.
[53]Ibid.

Authority rules and in accordance with the Sindh Contraceptive Procurement Manual, developed in collaboration with the USAID | DELIVER PROJECT. After receiving the contraceptives, the PWD, DOH, LHW and PPHI will provide services through their outlets, including RHS-As, FWCs, MSUs, BHUs, RHCs, THQs, DHQs, CMWs, LHW Programme and MNCH Programme. Distribution from district stores to the facility level will take place through the PWD. Table 5.1 shows the allocations for procurement of contraceptives for the next five years.

Table 5.1 | Allocations for the Procurement of Contraceptives (PKR in Millions)

Years					Total
2014–15	**2015–16**	**2016–17**	**2017–18**	**2018–19**	**2014–19**
688.131	887.097	1061.859	1268.978	1522.332	**5428.927**

The process of procurement of contraceptives has been initiated. As per the timeline of the process, the prequalification was conducted in October 2015. The shortlisted firms were asked to submit proposals within 20 days of shortlisting. The selection process was underway at the writing of this CIP.

The contraceptive commodities are now part of the Essential Medicines List of Sindh. Table 5.2 provides details on the contraceptives for different categories of facilities.

Table 5.2 | Essential Medicine List: Contraceptives for Different Categories of Facilities

Basic Health Unit	Rural Health Centre	Taluka Headquarters Hospital	District Headquarters Hospital
Condom	Condom	Condom	Condom
Combined oral contraceptive pills	Combined oral contraceptive pills	Combined oral contraceptive pills	Combined oral contraceptive pills
Progestin-only pills	Progestin-only pills	Progestin-only pills	Progestin-only pills
IUD	Emergency contraceptive pills	Emergency contraceptive pills 75 mcg (pack of 2)	Emergency contraceptive pills 75 mcg (pack of 2)
Injection 150 mg/ml	IUD	IUD	IUD
Injection 200 mg/ ml in lml	Injection 150 mg/lml	Injection 150 mg/lml	Injection 150 mg/lml
	Injection 200 mg/ ml in lml	Injection 200 mg/ ml in lml	Injection 200 mg/ ml in lml
		Injection 5 mg +25 mg	Injection 5 mg +25 mg
		Implant 2 rod 75 mg each	Implant 2 rod 75 mg each

Basic Health Unit	Rural Health Centre	Taluka Headquarters Hospital	District Headquarters Hospital
		(5 years)	(5 years)
		Implant 1 rod 68 mg each (3 years)	Implant 1 rod 68 mg each (3 years)

Source:Department of Health, Government of Sindh, Pakistan.*Essential Medicines List*. (Islamabad, Pakistan: USAID | DELIVER PROJECT, 2014).

The important aspects of the FP supply chain are discussed below in terms of gaps and challenges:

- **Procurement:** The PWD Sindh follows Sindh Public Procurement Regulatory Authority rules for the procurement of contraceptives. However, a process of capacity development in procurement, close monitoring and coordination is required to ensure timely procurement and release of funds.
- **Storage:** The central warehouse at Karachi provides state-of-the-art storage for the contraceptive commodities. A recent consultation between federal and provincial representatives concluded that in the post-devolution scenario, provinces need to join hands in pooling resources for joint management of the central warehouse.
- **Distribution:** At the district level, there are four stores each for PWD, DOH, LHW and PPHI. However, transportation to the subdistrict level to the last mile has remained a challenge since dedicated funds were not set aside for the purpose. Specifically, LHWs do not receive timely delivery of supplies[54]. A study conducted by the USAID | DELIVER PROJECTsuggests that commodities were available at 85 percent of the facilities surveyed[55]. However, more needs to be done, according to the PWD, particularly in the wake of DELIVER's departure.
- **Information system:** The USAID | DELIVER PROJECThas developed a web-based Contraceptive Logistic Management Information System (cLMIS). The cLMIS provides information on commodities' availability, consumption, stock-outs, expiry and demand for new supplies. Following the close out of USAID support, there is a need to strengthen the government's capacity to maintain the cLMIS through training of master trainers.USAID|DELIVER is currently working on these trainings, and it is anticipated that the cLMIS will be an integral part of the information system utilized by Sindh for CIP monitoring.

In conclusion, there are four main areas of focus to improve commodity security in Sindh:(1) availability of stocks at the subdistrict level; (2) M&E and supportive supervision; (3) subdistrict-level implementation and deployment of the logistics management information system, including trainings on logistics and storeroom management up to the BHU level; and (4) concerted efforts to invest in the sustainability of the logistics and supply chain management system following the close out of USAID support.

5.6 Financing

The Government of Sindh has shown greater commitment towards financing of FP and primary health care-related programmes. This is evident in the allocation of federal funding through the Public Sector

[54]Focus group discussion with LHWs in three divisions of Sindh for CIP, April 2015.
[55]AC Neilson, *Stock Assessment Survey* (Arlington, Virginia USA: USAID | DELIVER Project, 2014).

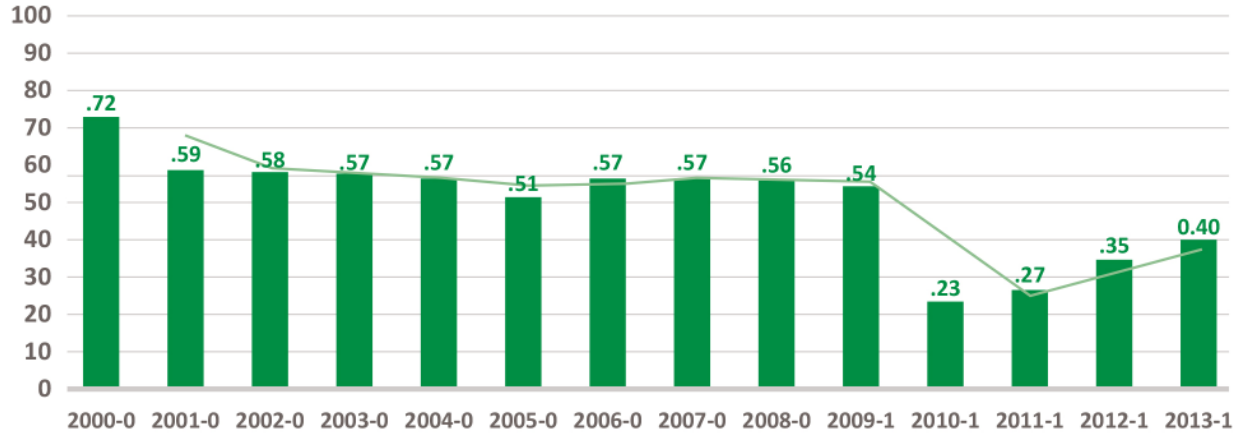
Development Programme (PSDP) and funds for FP-related programmes (i.e., LHW and MNCH in the provincial Annual Development Plan).

Financing is a crucial part of programmes. In general terms, inadequate financing is not only detrimental for programme implementation but it also causes inequities. In terms of FP, lack of fair financing affects availability of method mix, lack of trainings, monitoring and supportive supervision, thus leading to poor quality of services, and low morale and motivation of staff to devote special attention to addressing unmet need. Therefore, financing is a critical element for the effective implementation of FP.

Historically, the Population Welfare Programme has received federal funding through the development budget. For development projects, it is imperative to design a PC-1 (Planning Commission proforma 1). A PC-1 includes details of a project along with objectives, inputs, outputs, outcomes and how to measure those. The PC-1 dissects the inputs, outputs and outcomes in terms of capital, operating and maintenance costs with financial phasing on yearly basis.

The federal government has continuously provided funding for population welfare. The federal government has provided parallel funds to two programmes, including the PWD and LHW Programmes that were managed by two different ministries.[56] However, this financing mechanism is now transforming in the wake of the 18th Constitutional Amendment. The federal government has committed funds for the Population Welfare Programme and the LHW Programme for the next two to three quarters because it is anticipated that the new National Finance Commission Award will be declared by the end of the year[57]. The Government of Sindh has also allocated funds for the Population Welfare Programme, LHW Programme and other FP-related programmes.

Figure 5.2 | Health Expenditures as Percentage of GDP in Pakistan, 2000–14



Source: Ministry of Finance, *Economic Survey of Pakistan, 2013–2014*, Government of Pakistan, Islamabad (issued in June 2015).

In general, a declining trend has been witnessed in federal funding over the past decade. A quick look at Figure 5.2 suggests that there has been a decrease in federal financing, from 0.54 percent in 2009–2010 to

[56] UNFPA, *The State of Family Planning in Pakistan* (Watertown: Pathfinder International, June 2013).
[57] The National Finance Commission Award is a federal divisible pool of revenue. The provinces get their share of funds through that pool based on a multiple criteria. The Award is announced after every five years. Background information from Planning Commission of Pakistan, June 2015.

0.23 percent in 2010–2011. Though financing could not be raised to the level of 2009–2010, there has been a slow increase. By 2013–2014, the increase reached 0.4 percent. As per UN recommendations, health financing should be at the level of 2 percent of GDP by 2018 to achieve the desired policy objectives.[58]

In the wake of the 18th Constitutional Amendment, federal funding will end once the new National Finance Commission Award is finalized, in which case the provincial governments will have to allocate adequate financing to health and population programmes so as to achieve provincial policy objectives and international commitments.

An analysis of population programmefinancing through federal resources concludes that since 2006–2007 there have been lower allocations as compared to demand.[59] During that period, PKR 6.5 billion was capped by the Federal government, against the actual allocation of PKR 9.5 billion. Moreover, the increased levels of financing was met with low utilization rate. From 2005 to 2010, more than 30 percent funds remained unused. It has been argued that low utilization was due to delayed release of funds.

The average expenditures on the population programme in terms of GDP remained below 0.06 percent for the period 1992–2010[60]. USAID began providing contraceptive support in 2009, and therefore, no federal or provincial financing was required for the procurement of contraceptives from 2009 to 2015.

In the post-devolution period, provinces are expected to finance their own population programmes. However, financing needs to be assessed from the perspective of the ratio of salary versus non-salary components of allocations; there have been more funds available for salaries, whereas funds for operational costs remained low. Another concern has been delayed releases. Some conclusions can be drawn based on allocations and expenditures data for the years 2010–2011 and 2015–2016 of the PWD and LHW Programmes.

For achieving FP2020 targets, adequate financing of FP-related programmes is essential. Historically, fewer allocations are made against the demand or requirement of PC-1. These FP allocations are made with incremental changes based on the previous year's budget and utilization.

[58]Ministry of Finance, *Economic Survey of Pakistan 2014–2015* (Islamabad: Government of Pakistan).
[59]United Nations Population Fund (UNFPA), *The State of Family Planning in Pakistan* (New York: UNFPA, June 2013).
[60] Government of Pakistan, Ministry of Finance. *Economic Survey of Pakistan*. (Islamabad: Economic Advisor's Wing, Finance Division, Government of Pakistan, 2011).

Table 5.3 | Financing of PWD, 2010–2011 to 2015–2016 (PKR in Millions)

Year	PC-1 phasing		PSDP/ Annual Development Plan (ADP) allocation		Releases		Expenditure (expected up to June 2015)	
	TotalGovt. of Pakistan	Foreign Exchange (FE) /Loan/Govt. of Sindh	Total / PSDP	FE / Loan/ADP	Total/ PSDP	FE/Loan/ ADP	Total / PSDP	FEC/Loan /ADP
1	2	3	4	5	6	7	8	9
2010–11	1872.629		* 966.852	-	966.852	-	966.852	-
2011–12	2183.668	494.000	884.842	494.000	884.842	494.000	884.842	494.000
2012–13	2587.977	494.000	1259.415	494.000	1259.415	494.000	1259.415	494.000
2013–14	3021.653	1000.000	2082.373	1000.000	2083.373	1000.000	2083.373	1000.000
2014–15	3670.117	1610.000	2082.373	1000.000	2082.373	1000.000	2082.373	1000.000
2015–16	-	950.000	-	-	-	-	-	-
Total	13336.043	4548.000	7275.855	2988.000	7275.855	2988.000	7275.855	2988.000

Source: Population Welfare Department, Public Sector Development Programme2010–2011 to 2015–2016.

For the last five years, the population programme has continued to receive funding from federal as well as provincial sources. The provincial funding is bridge financing, which is basically to meet the shortfall in federal funding. A review of the financing for the last five years shows that allocations have been less than PC-1 phasing or demand. On average the allocations in federal PSDP have been 53 percent against the demand made in PC-1. Allocations have been 51.6 percent, 40 percent, 48 percent, 69 percent, and 56 percent per year, for the fiscal years 2010-2011, 2011-2012, 2012-2013, 2013-2014 and 2014-2015, respectively. The releases have been 100 percent of the allocated amount.

Over the last two decades, the PWD has set a price on contraceptives, except for tubal ligation and vasectomy. However, the DOH facilities do not collect these charges from clients. On average PWD collects an amount in the range of PKR 10–12 million per year through the sale of contraceptives. These proceeds usually were sent to the federal government, but in the post-devolution situation, PWD has sent a request to the Government of Sindh to keep that amount within the province. There is a need to consider the pricing of contraceptives during delivery of services. A decision was made at the Reproductive Health Commodity Security Committee meeting on September 14, 2015, that a summary (request) will be moved to the Chief Minister for devising a uniform pricing policy.

A review of PWD expenditure by component shows that no funds were released to some of the components (e.g., health education for youth and third-party monitoring).

The expenditures until June 2015 are in line with releases made. Hence, under-spending is not an issue. The communication strategy financing was in two parts. The Serial. No. 12 allocations are made through provincial resources while at Serial. No. 18 the federal share was allocated in the post-devolution period. The data regarding expenditures for federal financing on communication is missing in Table 5.4.

Table 5.4 | PWD Line Item Budget, 2010-2015

S #	Items (as per PC-1)	PC-1 Estimates			Actual Expenditure (Up till June, 2015)		
		Total	Local	FEC	Total	Local	FEC
1	Admin Organization	**2890.314**	**2890.314**	-			
2	a) Provincial Office	428.083	428.083	-	425.620	425.620	
3	c) District Office	1,184.443	1,184.443	-	1131.628	1131.628	
4	d) Tehsil/Town Office	1,129.743	1,129.743	-	748.170	748.170	
5	e) Regional Directorate	148.045	148.045		96.157	96.157	
6	PPSO	35.267	35.267		10.030	10.030	
7	Family Welfare Centre (FWC)	5284.742	5284.742		4586.923	4586.923	
8	MSU	556.586	556.586		527.885	527.885	
9	RHS-A	1549.462	1549.462		1312.397	1312.397	
10	Social Mobilizer (Male)	753.875	753.875		685.977	685.977	
11	Social Mobilizer (Female)	432.189	432.189				
12	Communication Strategy	429.707	429.707		206.429	206.429	
13	RMPs /H.H (New + Old)	74.703	74.703		2.832	2.832	
14	PLD	13.110	13.110		3.746	3.746	
15	Innovative	15.000	15.000		-	-	
16	Food supplement	85.440	85.440		-	-	
17	Health Education for youth	60.202	60.202		-	-	
18	Total	12180.598	12180.598				
	Contingency 2%	243.611	243.611		-	-	
	Third-Party Monitoring	121.807	121.807		-	-	
	Total	12546.016	12546.016				
	DEVOLVED INSTITUTION						
	PWTI / RTIs	607.383	607.383		139.970	513.725	
	MPSC	15.645	15.645		12.336	12.336	

S #	Items (as per PC-1)	PC-1 Estimates			Actual Expenditure (Up till June, 2015)		
		Total	Local	FEC	Total	Local	FEC
	Communication Strategy	167.000	167.000		*-	*-	
	Grand Total	13336.043	13336.043		10263.855	10263.855	

Source: PSDP, Population Welfare Department, Sindh. *Note:*FE = Foreign Exchange; H.H = Homeopath, Hakim; MPSC = Multipurpose Service Centre; MSU = Mobile Service Unit; PC-1 = Planning Commission proforma 1; PLD = Provincial Line Department; PPSO = Public-Private Sector Organization; PWTI = Population Welfare Training Institute; RMP = Registered Medical Practitioner; RTI = Regional Training Institute

The LHW Programme has been receiving funding through the federal PSDP under a decision of the Council of Common Interest that the provincial vertical health programmes shall be provided financing by the federal government until 2015 when the National Finance Commission Award is implemented. The programme mainly receives funding for salaries and operational costs (e.g., utilities; monitoring; petrol, oil and lubricants; TA/DA; maintenance; furniture and fixtures).

As a result of the decision of the Supreme Court of Pakistan, the services of LHWs have been regularized (made permanent). Therefore, the LHW Programme has been shifted to the recurrent budget from the development budget. In this regard, a Statement of New Expenditure of PKR 5,429 million has been submitted to the federal government; however, for the next fiscal year, PKR 1,540 million has been allocated which is insufficient for salaries and essential operational requirements. The contraceptive commodities have been provided by USAID; hence, the programme does not spend funds on procurement as yet. The programme purchased LHW kits a few years back and there is a need for dedicated resources to continue purchasing the kits, while also repositioning LHWs for FP services as their priority responsibility.

Table 5.5 | Expenditures Made by LHW Programme, 2010–2015 (PKR in Millions)

Financial year	Demand	Funds allocated	Funds released	Expenditure	Shortfall against demand
2010 – 11	1976,754	1976,754	1976,754	1895,308	0000,000
2011 – 12	3243,288	1680,000	1680,000	1679,608	1563,288
2012 – 13	3813,246	2310,528	2400,539	2400,000	1412.707
2013 – 14	4086,365	2310,000	2003,933	2003,888	2082.432
2014 – 15	4358,273	2310,000	2310,000	2309,876	2048.273

Source: Information collected from PSDP, Department of Health documents and through the LHW Programme, Government of Sindh.

According to the programme, 99 percent of the released funds are spent by the end of a fiscal year on average[61]. As a result of such an expenditure, there is need for an assessment to see whether outputs are comparable to inputs.

Table 5.5 above shows that allocations have been much less as compared to stated demand as per PC-1. A direct comparison of allocations versus requested funds for the fiscal years 2012, 2013, 2014, and 2015, showed that only 62 percent, 56 percent, 53 percent and 28 percent of the requested funds were released in each respective year.

During the budgeting process for 2015–2016, the Government of Sindh recognized the importance of CIP for FP2020 goals and allocated PKR 998 million for sustaining efforts to deliver FP services as part of implementing the CIP.

5.7 Development Partners, NGOs, Private Sector Including Corporate Sector Contribution

A significant percentage of services regarding FP are rendered by the private sector through different modes including social marketing, NGOs with development partners' funding, and their own facilities. The corporate sector is also another potential stakeholder to offer FP services. Achieving CIP targets would not be possible without streamlining NGOs, INGOs and private sector contributions.

The draft Population Policy of Sindh envisages a comprehensive framework for the engagement of private sector and civil society. The document states that "the Population Welfare Department will establish a mechanism of partnership with non-government voluntary organizations, the private and corporate sector, other government departments and the community (civil society bodies) to maximize coverage for improved access to quality services." The policy document stresses the need for private sector investments targeting urban slums and marginalized communities, social marketing and community-based distribution of contraceptives, adopting proven innovative interventions, and gender-specific career counselling[62].

As per the National Health Accounts Report 2014[63], 61.2 percent of the health and population sectors' financing is made through out-of-pocket sources; 1.04 percent through development partners; 12.06 percent through NGOs; an estimated 1.08 percent on social security jointly by corporate sector and the public sector; and 0.35 percent by autonomous bodies and corporations. Thus, the main contributors are the consumers themselves. Greenstar is also implementing social marketing in Sindh through more than 1,500 private providers. In addition, pharmacies and retail shops have been enlisted through social marketing techniques. DKT International, a relatively new partner, has established its Dhanak clinics—a social franchise initiative.

Donor funding is also channelled through NGOs. For example, USAID is implementing its MCH Programme (US$ 300 million) in Sindh through implementing partners that include INGOs and NGOs. Likewise, the David and Lucile Packard Foundation is supporting the Marvi workers' model of the Health and Nutrition Development Society (HANDS). The Bill & Melinda Gates Foundation, Aman Foundation and Packard Foundation are supporting the Sukh Initiative on FP in peri-urban areas of Karachi, the capital of the province of Sindh.

[61] Provincial Manager, National Program on FP & PHC (LHWs program), September 7, 2015.
[62] Draft Population Policy of Sindh for PWD, with technical assistance from Pathfinder International.
[63] Pakistan Bureau of Statistics, Pakistan national Health Accounts 2013-2014 (Islamabad: Government of Pakistan, Pakistan Bureau of Statistics, 2014)

Currently, NGOs have been working under a very flexible arrangement with the public sector. These arrangements include memoranda of understanding (MOUs) which are not strictly monitored for mutual implementation or compliance. All NGOs and INGOs do not necessarily enter into MOUs. The INGOs/NGOs are registered under different regulatory mechanisms including Economic Affairs Division, Securities and Exchange Commission of Pakistan, through Society Act at Sindh Social Welfare Department and the Cooperative Society Act.

In the above context, the role of NGOs needs to be streamlined. The work of NGOs/INGOs sometimes overlaps and duplicates the initiatives already in place by the public sector. Furthermore, sometimes the NGOs work in isolation.

Despite the challenges, as mentioned above, the contribution of NGOs and the private sector cannot be undermined. Rather, there is a need to tap the enormous potential of NGOs and private provision to complement public sector services for the broader goal of achieving FP2020 goals.

5.8 Stewardship, Management and Accountability

Stewardship

Stewardship involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability[64]. A successful stewardship mechanism depends upon how political and bureaucratic leadership is forthcoming and responsive to the needs of the population and health sector and their policy objectives. The programmes' stewardship and governance in FP is discussed in terms of:

- Policy and strategic opportunities.
- Oversight of public and private sector stakeholders including accountability of providers to policy makers and the users of services.
- Regulation (through rules, incentives, sanctions).
- Building coalitions and partnership.
- Aligning operational strategies and organizational structures.
- Accountability and responsiveness to the people[65].

Policy and strategic opportunities

The 18th Constitutional Amendment presents a strategic opportunity for the province of Sindh to move forward to build policy frameworks, institutional arrangements, poverty reduction strategies and medium-term budgetary frameworks. PWD is in the process of formulating the Population Policy. At the DOH, a Health Sector Strategy was formulated in 2012 which is deemed as the Health Policy document of Sindh. The roles and responsibilities of DOH and PWD are yet to be revisited in the context of the 18th Constitutional Amendment.

[64] World Health Organization, *World Health Report 2000* (Geneva: World Health Organization, 2000).
[65] A framework of stewardship and governance has been discussed in the Roadmap for Health Systems Strengthening in Sindh to Support USAID RMNCH Programme.

Oversight of public and private sectors

The departments need to revisit their role as service providers and move towards a strategic systems strengthening role, with a view towards commonality of the cause and collective action. Ensuring oversight with a broader leadership role will bring on board all public and private sector stakeholders to work together and ensure outcomes in FP. The DOH and PWD have endorsed creating functional integration at the grass roots level as well as mobilizing a huge number of LHWs for achieving FP2020 goals. It is expected that this closer collaboration at the provincial level will trickle down. The CIP presents a framework on functional integration and mobilization of LHWs. NGOs and the private sector will be required to complement this process. An outline of the contribution by NGOs/INGOs and the private sector has been described in Section 8.4.

The **standardization and regulatory mechanisms** play a critical role in developing and maintaining quality of services, streamlining private sector and NGOs contribution in informed choices, integrating data-gathering mechanisms like DHIS, and reviewing those to include private sector information.

There has been a lack of follow-up of protocols in service delivery, for example, weak implementation of the *Manual of National Standards for Family Planning Services*. There is a need for efforts to strengthen its implementation effectively.

Most recently, the DOH has outsourced its RHCs, some of the DHQs, and THQs to selected NGOs under the Public-Private Partnership Act 2010. The Oversight and Coordination Cell for Public Health Programmes held meetings to assess whether these NGO-managed facilities will continue to provide FP services or not. A need has been felt to consult these NGOs to bring them on board regarding the implementation of CIP.

Aligning operational strategies and organizational structures, protocols, manuals and standard operating procedures (SOPs)

The achievements of CIP targets as per FP2020 are possible if oversight and institutional mechanisms are in place, well-coordinated, and conclusive in decision making for effective performance. For example, functional integration at the subdistrict level is crucial for better performance. However, it is equally important that there are appropriate oversight mechanisms to ensure that such integration is actually working on the ground. There is a need to strengthen the district health and population management team (DHPMT) and district technical committee (DTC) at the district level, and the CIP Cell at the provincial level, to provide monitoring and supportive supervision. The overall mechanism of oversight will be supported through monitoring checklists, manuals, SOPs, IPC tool kits, data collection tools with FP indicators, procurement manuals and guidelines, and regular community feedback.

Accountability and responsiveness to the people

Accountability and responsiveness can be ensured through some forums in place. These forums and mechanisms are based on evidence[66]. For example, community-based organizations (CBOs) can serve a role in accountability of private providers and public sector services, and media can serve a role in creating awareness, advocacy and political will; enhancing general information about services; and engaging parliamentarians to support birth spacing.

[66]Technical Resource Facility (TRF), *Responsiveness and Accountability in the Health Sector, Pakistan* (Pakistan: Study Report for DFID and AusAID, September 2010).

In the above context, the CIP will focus on participation of CBOs and community elders for consensus-building on FP uptake within the community. Previously it was assumed that this role would have been played by social male mobilizers.

Currently, there are quite a few M&E mechanisms in place in the health and population sectors. These mechanisms include public sector facility-based monitoring including DHIS, and the management information systems of vertical programmes, tertiary hospitals and the PWD programme[67]. It is imperative to consolidate these vertical processes of data-gathering for comprehensive information analysis, feedback and decisive action.

6 | Key Concerns and Way Forward

The Government of Sindh has put various mechanisms in place to increase the uptake of FP services and to ensure that these mechanisms are optimally functional. However, there is still a need for further commitment to increase access to FP services, while being cost-effective and easy accessible.

Based on the situation analysis conducted during the CIP development process, the contextual background on FP in Sindh from stakeholder consultations has highlighted the need to take some immediate steps that include (1) revisiting the roles and responsibilities of the provincial health and population sectors in the context of devolution, including the process of defining functional integration which allows the DOH and PWD to come together with an understanding of the mutually beneficial cause of FP, while maintaining their autonomy; (2) functional integration with a focus on services with strong referrals for better impact, and the role of LHWs focused on FP; (3) addressing the needs of underserved and uncovered areas; (4) improving quality of services including capacity building of human resources; (5) addressing the needs of young couples and increasing male engagement by improving understanding about the benefits of birth spacing for family health and their role; (6) ensuring supplies to the last mile; (7) managing information thorough analysis, feedback for improved performance and information-based decision making; and (8) improving donor coordination, as well as private sector and civil society coordination and collaboration; and (9) developing strategic linkages to develop a long-term strategy for a more sustainable delivery of FP methods without losing focus on effective monitoring and rigorous evaluation duly backed by research.

These concerns will be addressed through robust and comprehensive strategies presented in Section 6. However, prior to outlining and detailing the strategies, the following three guiding principles serve as the basis for these strategies:

- **Strengthening existing services**, human and financial resources for higher impact in a cost-effective manner.
- **Accelerating interventions** by different stakeholders and mobilizing extra resources to implement those interventions.
- Introducing **innovative ideas, proven practices and modern technologies** to multiply the impact at both levels—existing services as well as accelerated interventions.

Critical areas needing investment are explained in the sections that follow.

---

[67] Health Sector Reforms Unit, *Sindh Health Sector Strategy 2012–2020* (Karachi: Government of Sindh).

6.1 Revisiting Roles and Responsibilities at the Provincial Level

After devolution, the rules of business of the PWD and DOH have been revised at the provincial level; however, there remains a need to streamline the rules of business with clearly defined functions and job descriptions that complement one another. The process of defining the working relationship of the two departments and their functional integration will allow for some clarity and cohesion, which will be imperative for effective implementation of FP programmes. The functional integration referred to here is the extent whereby the two departments will coordinate their functions and activities to achieve the FP2020 goal of 45 percent CPR.

6.2 Functional Integration of Services

There are two main areas that need to be invested in through functional integration. First, there is a lack of functional integration between different programmes related to FP. For example, there is weak coordination between the LHW Programme (under the DOH) and static facilities (run by the DPWO), with poor referrals and service delivery quality[68]. Second, there is a lack of integration of FP services with broader MNCH interventions at FLCFs as well as secondary-level care facilities like THQs and DHQs.

At the initial stage, strengthening of existing services and human resources would not require extra inputs except for minor adjustments. To facilitate this process, the major thrust in this regard would be improving the management perspective through improved data for decision making and supportive supervision of facility and community-based cadres. The PWD and PPHI have jointly made efforts in that direction that includes special camps at static facilities where staff from PWD, PPHI as well as DOH (LHWs and CMWs) joined hands to refer cases and thus, more clients are referred for implants in addition to ensuring continuing of existing users.

6.3 Refocusing LHWs on FP and Referrals

LHWs play a prominent role in expanding access to FP services at the community level[69]. LHWs have, over time, been made responsible for other primary health responsibilities, distracting from their FP mandate. Moving away from their focus on FG has led to more stock-outs, a lapse in the quality of counselling for side effects, and poor referrals between the LHW Programme and the FWCs, where most FP services are provided[70]. The focus on FP needs to be brought back and prioritized for attaining the health objectives as well as fertility for fertility-related objectives.

---

[68] Asad Hafeez et al., "Lady Health Workers Programme in Pakistan: Challenges, Achievements and the Way Forward," *Journal of Pakistan Medical Association*, (March 2011), http://www.jpma.org.pk/full_article_text.php?article_id=2633.

[69] Ibid.

[70] Ayesha Khan and Adnan Khan, "The Contribution of Lady Health Workers towards Family Planning in Pakistan," *Research & Development Solutions*, USAID Small Grants Program, Policy Brief Series no. 15 (August 2012). http://www.resdev.org/files/policy_brief/15/15.pdf.

6.4 Underutilized, Underserved, Uncovered Areas; Peri-urban Areas and Slums and Access to Poor

It has been noted that several service delivery mechanisms are underutilized, while specific areas like urban slums, the most remote poor areas, and peri-urban areas are underserved. This is partly due to lack of coordination between various programmes as well as between public and private sectors. There are issues of non-functional outlets and human resource shortages. There is also a low rate of contraceptive use among the poorest of the poor with high unmet needs.[71].

The first component of strengthening existing services will be aimed at mapping the gaps in the health system and targeting solutions, so service improvements plans can be made according to needs. However, for achieving FP2020 goals, an accelerated pace of service delivery shall be required. Therefore, a set of accelerated interventions will be implemented by adding new services as well as addressing gaps within existing services, using strategies of task sharing.

6.5 Quality of Care

The uptake of FP and satisfying unmet need have been slow due to lack of quality services, poor treatment of clients, discontinuation due to side effects, weak counselling skills, and poor system-level support for community-based providers and LHWs. In order to improve service quality, more investment is needed (at the financial and system levels) on refresher trainings, supportive supervision/mentorship, improved data for decision making, and quality assurance mechanisms, along with frequent close monitoring and persistent community feedback of their perspectives about the services.

6.6 Human Resources

Trained and motivated human resources are crucial for advancing the FP2020 agenda and policy objectives. In this regard, pre-service and in-service training will be a primary focus during implementation of the CIP. There is a need to equip all training institutes and bring on board the master trainers. Strategic Area 2 will focus on human resource development covering all management, motivational and monitoring aspects of programmes.

6.7Reaching Youth

Young people make up almost a quarter of the total population of Sindh, and a significant proportion of girls in the province are married before the age of 18.[72] Therefore, reaching this age group is essential to help them fulfil their parental responsibilities with an understanding of how to improve their lives. To effectively reach this group requires tailored service delivery and demand-side strategies, with a particular emphasis on creating strong linkages between supply and demand. Strategies may include comprehensive life skills education, community and facility-based counselling addressing their unique needs, comprehensive and non-judgmental contraceptive counselling and service provision, and engagement with key gatekeepers and community leaders to foster an enabling environment for service uptake.

[71]NIPS, Pakistan Demographic and Health Survey 2012–2013.
[72]Ibid.

Therefore, some of the critical areas to be covered in the overall strategy include life skills education, pre-marriage counselling, delaying first birth and later with adequate birth spacing by pursuing healthy timing and spacing of pregnancies. The approaches to operationalize youth engagement will include services and support through providers, academic institutions and the community itself. While implementing such approaches, lessons learnt and best practices within the country, as well as globally, will be adapted and carefully applied.

During the training of providers and community-based workers on FP, youth-friendly services and engagement will be added as a compulsory element of training (in-service and pre-service). Such an orientation of providers to the principles of youth-friendly services will allow existing facilities and community-based workers to incorporate ownership of providing services to meet the needs of young people. The providers will be encouraged to cater to young couples on a priority basis. In some districts, the PWD will also invite the private sector to assist in the rollout of youth-friendly services in selected districts. Moreover, universities and colleges will have youth spaces to impart life skills information for their future roles and responsibilities. PWD will work closely with the Sindh Text Book Board to finalize information packets for such spaces. In addition, use of mid-media (theatres, Melas, meena bazaars) and IPC will be two important tools to engage youth in a sociocultural and sensitive manner, in which CBOs, LHW, LHVs will have a significant role.

6.8 Availability of Contraceptives at Service Delivery Points

Contraceptives are available at the district level to PWD, DOH, PPHI and LHW[73]; however, the availability of contraceptives at the subdistrict and community levels has been identified as an issue of concern, particularly at the DOH facilities and for LHWs[74]. Some of the challenges include issues in transportation of commodities to the last mile; weak understanding and capacity for filing demands from the last mile to the district stores; maintaining inventory records; storage; and reporting on cLMIS through trained staff.

6.9 Information Management for Better Performance (Use of Modern Technologies)

The use of data for decision making is essential for the improvement of quality FP services. Information management systems are currently paper-based to a large extent; they lack analysis and effective use for timely feedback, and are therefore not utilized purposefully. There is a need to enhance the use of data for decision making through modern technologies of smart phones, dashboards and GIS, and client satisfaction surveys. This has been a weak area and needs more investment in necessary systems and staff training for comprehensive information management.

6.10 Donor Coordination and Need for Synergies

Given the amount of funds being invested by donors in Sindh, there is a need to synergize the support of development partners in consultation with the public sector, so that these interventions are complementary. Due to the lack of such a consultation process, most of the donor-supported projects overlap and duplicate public sector initiatives in addition to not being able to address areas of critical need.

[73] Reports and consultations at DOH, PWD, LHW, PPHI and USAID|DELIVER, May 2015.
[74] Consultations for CIP with DOH, LHW Programme, May 2015.

In addition to a need for enhancing donor coordination, strategic linkages with the private sector and civil society are also necessary to develop a long-term strategy for more sustainable delivery of FP methods and services, particularly as 54.4 percent of FP services are delivered by private sector entities.[75]

Based on the three guiding principles and key concerns listed earlier, six strategic areas are outlined and described in Section 7

Table 6.1 presents a selection of successful initiatives being piloted and scaled up in Sindh in collaboration with the public and private sectors.

Table 6.1 | Good Practices

Good practices	Implemented by	Description
Sanghar Model	PWD, Sindh	The FWAs, LHWs working in the community joined hands to hold FP camps. They were supervised by their respective district managers from DOH (LHW Programme) and PWD
Kasur and Khairpur model of integration	Pathfinder International	A Weekly Family Health Day was celebrated for which DOH and PWD workers worked in integrated manner to refer clients to the event of Health Day for information and use of FP methods. Joint monitoring was conducted by PWD/DOH
FALAH model	Population Council	A comprehensive model of integration, training, community awareness at the district level
Marvi Workers Model	HANDS	Low literate or illiterate young women were recruited from the community to serve as FP provider in areas not covered by LHWs
Use of smart phone/tablets	PPHI, Aman Foundation, Karachi	The use of mobile technology allowed for gathering of real time data forms used for performance management and information
Working with youth and adolescent	PWD/UNFPA and Aahung	This project engages youth in District Ghotki by developing their life skills

[75]NIPS, Pakistan Demographic and Health Survey 2012–2013.

7 | Costed Implementation Plan

The goal of this CIP is to increase the CPR to 45 percent of MWRA in Sindh, which would total approximately 3 million women by 2020. This entails the expansion of services to serve 1.2 million additional users through the existing infrastructure, as well as the expansion of facilities and staff accordingly.

The CIP is aligned with Sindh's draft Population Policy and the Health Sector Strategy. This implementation plan has been designed in a way that builds upon existing strengths of the PWD and DOH. The plan provides a road map to integrate services, develop supportive supervision mechanisms, improve oversight and increase stewardship as a common goal for both departments.

Based on existing systems and strengths, the plan shall expedite the process of implementation through the principles presented in Section 6. It will begin with strengthening existing services and implementing a set of accelerated interventions, complemented by the use of proven practices, new technologies and innovations.

Following are the vision, objectives, strategic areas and outputs of the CIP.

7.1 Vision for Population and FP

Sindh envisages promoting a prosperous, healthy, educated and knowledge-based society where all citizens are provided opportunities to access information and quality services about FP and reproductive health care.

7.2 Operational Goals and Objectives

1. Enhance CPR from 30 percent in 2015 to 45 percent by 2020.

2. Reduce unmet need for FP from 21 percent in 2015 to 14 percent by 2020.

3. Ensure contraceptive commodity security up to 80 percent for all public sector outlets by 2018.

7.3 Strategic Areas

Six strategic areas have been identified as part of the plan and are critical to reaching the goals and objectives. These strategies evolved based on a critical review and examination of the current FP situation in Sindh. Inputs were received during consultations with stakeholders and feedback from partners on the draft CIP. The information collected in this comprehensive consultative process was analysed using a Results Framework (Annex III). Recognizing that resources are limited, investments need to be directed towards interventions that have the highest potential to add new clients and rapidly reduce the unmet need for FP in Sindh. Therefore, the Oversight and Coordination Cell for Public Health Programmes, leading the process, has agreed upon six strategic areas based on urgency, importance and feasibility, and has ranked interventions as high, medium and low priority.

To some extent, the prioritization is reflected through the sequence of the strategic areas in this section. For more details on the phasing of activities, please refer to the implementation plan in Section 10.

- **Strategic Area 1:** Enhancing strategic coordination and oversight between the population and health sectors at the provincial, district and subdistrict levels regarding functional integration of services at the subdistrict level.
- **Strategic Area 2:** Ensuring quality of services by enforcing standards, improving providers' skills and ensuring client satisfaction.
- **Strategic Area 3:** Improving contraceptive security to the last mile, including distribution and availability of contraceptives at service delivery points.
- **Strategic Area 4:** Expanding services with supply- and demand-side interventions for enhancing access, especially to urban slums, peri-urban and rural areas, and creating space and linkages for public-private partnerships to reach vulnerable segments of the population including the poor and youth.
- **Strategic Area 5:** Increasing knowledge and meeting the demand for FP services by focusing on MWRA, emphasizing male engagement and young people.
- **Strategic Area 6:** Strengthening the health and population systems by streamlining policy planning, governance and stewardship mechanisms, and performance monitoring and accountability.

7.4 Intervention and Activity Mapping of Strategic Areas

Strategic Area 1

Enhancing strategic coordination and oversight between the population and health sectors at the provincial, district and subdistrict levels regarding functional integration of services at the subdistrict level

Rationale

Weak coordination between the DOH and PWD in the past has led to service delivery gaps in FP. Through the CIP development process, both departments have come together to work towards the Sindh goal of 45 percent CPR. During the CIP consultative process, they agreed upon the following mechanisms to facilitate FP service delivery:

- Functional integration of FP-related programmes at the subdistrict level.
- Refocusing the LHW mandate on FP.
- Strengthening referral mechanisms.
- Integration of FP into the MNCH Programme.
- Supportive supervision through oversight and coordination mechanisms existing at the provincial and district levels.

Functional integration is the operational integration of the programmes under DOH and PWD at the subdistrict (taluka and union council) levels, which includes clarifying roles and responsibilities, having LHWs work in partnership with the PWD and FWCs and by integrating FP into DOH vertical programmes such as MNCH.

At the subdistrict level, functional integration is feasible, immediately implementable, and with the potential to produce quick results. Over the past few years there have been certain approaches to functional integration in the public sector in Sindh that successfully generated additional users and satisfied the needs of the existing users, using strategies such as improving referrals between the two departments.

During existing experiences of integration, the DOH and PWD worked with LHWs working alongside FWCs, RHS-A centres, BHUs and RHCs to improve referrals and organize outreach camps. They also set up Family Health Days where trained providers delivered services that were not otherwise readily available in the community, such as implants and IUDs. These outreach camps and Family Health Days were supervised jointly by the PWD, DOH, PPHI and relevant programmes' district officials. With support through the CIP, it is envisioned that these activities under functional integration will be reviewed, scaled up, and brought to the attention of DHPMT and DTC meetings with regular feedback for progress assessment and improvement.

The model of functional integration described above will be notified jointly (agreed upon through an MOU) by PWD, DOH and PPHI, that include terms of reference specifying roles and responsibilities of each stakeholder. The notification will refocus the mandate of LHWs towards FP. The notification will also specify the role of the private sector and NGOs funded through development partners (see Figure 8.2: Diagram of Functional Integration). A referral mechanism shall be developed during meetings at the provincial and districts levels. These meetings will be held between the DOH, PWD, PPHI, LHW and MNCH Programmes and other relevant partners.

In addition, a basic component of functional integration is the improvement of referrals and integration of FP into MNCH services. A big contributor to this initiative will be the CMWs. However, given that CMWs are not regular employed staff of the MNCH Programme or DOH, different approaches will be adopted to maintain consistency of the CMWs' contribution under the CIP. For example, the MNCH Programme has planned to retain a number of CMWs for a certain period through DKT International's (an INGO) Dhanak clinics; CMWs will be engaged at 200 such clinics. The PWD also signed an MOU with DKT International that includes training of CMWs in IUD and post-abortion FP services.

In order to monitor performance at the provincial level, the Oversight and Coordination Cell for Public Health Programmes will provide support and coordination, and the CIP Cell and PWD will supervise the implementation (for more details on the mechanisms for managing implementation of the CIP, please see Section 8).

Key outputs

The following key outputs are expected:

- Model of functional integration implemented at the subdistrict level based on (but not limited to) community-based distribution of contraceptives, including setting up outreach camps and Family Health Days.
- Coordination and oversight mechanisms developed at the provincial and district levels (CIP Cell, DHPMT, DTC).
- Referral network for FP clients strengthened between DOH and PWD.
- LHW mandate refocused on FP through the functional integration approach.
- LARCs promoted for birth spacing.
- Utilization of services increased at the community level.
- Intersectoral collaboration developed at the subdistrict level (formalized through an MOU).
- LHWs motivated through recognition of their services through awards and transport cost support (i.e., on referrals).
- Operational costs released in the new fiscal year, enabling providers to work with motivation.
- FP integrated into basic and comprehensive EmONC services through the MNCH CMW Programme.

- FP services, including postpartum IUD insertion, postpartum FP and post-abortion FP and post-abortion care, integrated into MNCH services (i.e., basic and comprehensive EmONC at newly outsourced RHCs, THQs and DHQs of the DOH).

Strategic Area 2

Ensuring quality of services by enforcing standards, improving providers' skills and ensuring client satisfaction

Rationale

High dropout rates, poor counselling on side effects, inadequate competencies of services providers to provide LARCs, weak mentorship and supportive supervision, and poor focus on client satisfaction constitute the issues behind low-quality services in Sindh[76]. In order to bolster the quality of services, it was recognized that the PWD and DOH need to join hands to facilitate change.

There is a strong willingness among three key stakeholders (PWD, DOH and PPHI) to promote a method mix that includes LARCs (IUDs and implants). During 2014–2015, the PWD conducted outreach camps for implants in several districts of Sindh (including Sanghar district) and PPHI has expressed tremendous zeal to train and promote LARCs—steps which are consistent with the above commitment. NGOs/INGOs and the private sector are already playing their role in promoting and offering a method mix that includes LARCs[77].

To support the availability of LARCs, there also needs to be sufficient attention paid to quality. The PWD has adopted the *Manual of National Standards for FP*[78]*;* however, resources are needed to facilitate the rollout. Similarly, providers do not have the updated skills to administer the different long-acting methods being introduced. Therefore, there is a need to work with the RTIs of PWD and Provincial Health Development Centres (PHDCs), District Health Development Centres (DHDCs) of Department of Health, and other training facilities of both departments, so they can provide counselling on side effects of all methods and also safely and securely administer and remove IUDs and implants. Additionally, to reach the large number of youth in the province, youth engagement and modules specific to youth contraceptive services will be included in the trainings for providers and community-based workers.

It has been shown that investment in joint monitoring and supportive supervision mechanisms during outreach camps and Family Health Days, with participation from PWD, DOH, PPHI, LHW district offices, have been successful in improving service quality. The continued supervision, checks and balances through provincial and district officials have the potential to create an enabling environment and motivate providers to increase the number of cases and maintain service standards. This approach has been piloted and received good results, evident from reports of door-to-door validation visits by senior officials conducted during the Sanghar initiative[79]. Finally, client perspectives and experiences are an important indicator of the quality of

[76] Consultations with partners for CIP, April–May, 2015.
[77] Ibid.
[78] Government of Pakistan, *Manual of National Standards for Family Planning Services* (Karachi: Government of Pakistan, October 2007)
[79] Household visits by PWD senior officials from provincial office to rural areas of district Sanghar (shared during consultative process of CIP, April–May, 2015).

services. Therefore, monitoring and supervision visits will include client interviews, as appropriate and on a continued basis.

The achievement of the FP2020 goal largely depends upon staff competence to follow standardized procedures during services provision, while also being responsive to client needs.

Key outputs

The following key outputs are expected:

- Quality of services improved through follow-up of *National Manual on FP Services* and other protocols and guidelines.
- Skill development and training of providers offered at each level to enhance acceptability of services and improve quality.
- Providers trained in client-centred approach.
- In-service training provided for public sector providers on youth-friendly services.
- Client satisfaction measuring mechanism in place and functioning in all districts and clients satisfaction on availability of contraceptives at service delivery points captured.
- Capacity development strategized through training needs assessment on biennial basis.
- RTIs strengthened to support skills development.
- Renewed focus on FP through Continuing Medical Education and Continuous Professional Development to enhance knowledge of providers to ensure client satisfaction.
- Intensified monitoring at frequent intervals and surprise visits to validate reported performance by reaching the client at their home.

Strategic Area 3

Improving contraceptive security to the last mile, including distribution and availability of contraceptives at service delivery points

Rationale

Support from the USAID | DELIVER PROJECTends in 2015, which calls for the transfer of responsibility to the Government of Sindh to procure and make contraceptives available at service delivery points to the public sector. Therefore, implementation of the CIP for Sindh needs to focus on contraceptive security. The supply and distribution mechanisms need revamping and necessary budgetary support must be made, with special attention to delivery of contraceptives to the last mile.

Through USAID support, the public sector in Sindh has developed a well-coordinated supply chain management system at the provincial and districts levels that includes web-based cLMIS and its use for decision making; trained staff to continue reporting through cLMIS; supportive supervision to maintain inventory, storage and demand through a Contraceptive Logistic Report (CLR) 6. A CLR 6 includes the information regarding distribution and consumption of commodities at a particular facility or the area. These mechanisms will be sustained and further strengthened to ensure delivery of a method mix, with a focus on LARCs.

In lieu of the close out of DELIVER, Sindh has proactively dedicated PKR 5.4 billion for commodities until 2019. It is estimated that the contraceptives will be available by March 2016 based on the procurement process of the PWD[80].

Key outputs

The following key outputs are expected:

- Contraceptives procured and made available at subdistrict-level (taluka and union council) facilities through outsourced transportation.
- Uninterrupted availability of contraceptives ensured at provincial and district stores through timely procurement based on forecasting and quantification.
- Sustained reporting through trained staff regarding cLMIS so as to strengthen supply chain management.
- No reported stock-outs by LHWs in a minimum of seven districts during monitoring visits.
- Enhanced community distribution (including LHW Health House) due to better management of contraceptives inventory, storage and timely demand through CLR 6.

Strategic Area 4

Expanding services with supply- and demand-side interventions for enhancing access, especially to urban slums, peri-urban and rural areas, and creating space and linkages for public-private partnerships to reach vulnerable segments of the population including the poor and youth

Rationale

It has been noted that existing service delivery mechanisms are catering to the needs of MWRA at a slow pace. It is evident from slow progress on CPR that, on average, change remained at 0.4 percent annually over the past five years, partly due to financial constraints such as suboptimal allocations, delay in releases, a sizeable number of uncovered MWRA and a limited number of FWCs.

This strategy focuses on the expansion of services and the development of new RHS-A and FWC facilities where needed, hiring of additional staff to sustain and expand services, developing operational guidelines and launching a new cadre of community-based FP workers, adopting the strategy of task sharing/shifting where required, public-private partnerships and demand generation for LARCs through voucher schemes.

Through the CIP consultation process, a need has been expressed to enhance management capabilities through provision of appropriate office accommodations. The PWD head office and district offices have been working in hired buildings, resulting in periodic changes of location. In this regard, it was decided that the department should have its own buildings (i.e., Provincial Population House and District offices)[81]. Additionally, the department has stated a need to increase the number of its facilities due to administrative decisions of the government to form new districts and talukas, due to population growth and other factors.

[80] Based on background discussions with senior officials of the Population Welfare Department and the Budget Book, 2015–2016.
[81] Consultations at PWD, April–May, 2015.

In addition to the expansion of infrastructure and the presence of PWD, community-based FP workers will be introduced in selected areas not covered by LHWs. The rationale for a new cadre is that the public sector faces resource constraints to meet current financial needs, including the support of existing LHWs in the wake of their regularization under a court order including an enhanced salary package. Thus, a less costly and alternate approach of community-based FP workers is being piloted under the CIP, since it would be difficult to provide the same package to a huge number of new LHWs, if recruited. It is estimated that 6,586 community-based FP workers will be recruited during implementation of the CIP. They will be paid through support from development partners, keeping in view the complexities of recruitments within the public sector (i.e., a ban on new appointments, issues of regularization, and undue influences in appointments), these cadres may be appointed through private sector implementing partners.

Recognizing that clients turn to the private sector for service utilization, there is great potential for collaboration to address missed opportunities and service gaps. It is critical that the public and private sectors, particularly NGOs, collaborate to work on FP uptake to achieve FP2020 goals. According to the *PakistanNational Health Accounts 2009–2010*[82], 61 percent of households utilize private sector services. Apart from that, development partners mostly channel their funds through NGOs. The NGOs contribute 12 percent of the services, which also include NGO-run private FP facilities that complement public sector facilities. In addition, social marketing has been a useful mechanism to engage private providers in order to increase users. The services provided through the private sector and NGOs need to be streamlined. It has been observed that NGOs' interventions are often in duplication and overlap with the public sector due to a lack of communication for joint planning; on occasion, planning exercises are conducted, but these are carried out with relatively junior-level staff in the public sector with little recognition from top-level decision makers. As a result, the efforts made do not achieve shared objectives. The private sector, including general practitioners, private hospitals, maternity homes and chemists, is largely un-regulated, and thus, it remains unaccountable for primary health care and FP outcomes.

People living in low-resource areas have less access and cannot afford services with associated costs like transportation and opportunity cost of obtaining services while taking time off from their job.[83] . These inequities are quite visible in the use of contraceptives based on wealth quintiles, demographic differentials, lack of education and marginalized sections[84].

Aside from rural and remote areas, the phenomenon of urban slums has emerged. This phenomenon is a result of urbanization. There are slum dwellings in Karachi, Hyderabad, Sukkur and other big cities of the province. These slums are more concentrated in Karachi. Implementation of the CIP will include specific initiatives to address FP uptake needs in those areas. In order to increase access and reach the poorest of the poor and youth in urban slums and remote areas, the CIP includes a voucher scheme to increase access to LARCs, which are relatively new technologies in Sindh. To operationalize the voucher scheme, the corporate sector would be approached to assess how it can support FP initiatives under its corporate social responsibility. The voucher scheme will be materialized through working with the private/corporate sector and NGOs. It is envisaged that the private/corporate sector will mainly contribute in urban slums while NGOs will mainly contribute in rural and remote areas. Keeping in view the global experience that voucher schemes (including their cost-effectiveness) are still under review, any inclusion of voucher schemes or the

[82] Pakistan Bureau of Statistics, *Pakistan National Health Accounts 2009–2010* (Islamabad: Government of Pakistan, Pakistan Bureau of Statistics, 2010).
[83] Consultations at PWD, April–May, 2015.
[84] Hannah Tappis, Anis Kazi ,Waqas Hameed, Zaib Dahar, and Anayat Ali, "The Role of Quality Health Services and Discussion about Birth Spacing in Postpartum Contraceptive Use in Sindh, Pakistan: A Multilevel Analysis," *PLoS ONE* 10, no. 10 (2015).

introduction of vouchers will be based on an explicit learning agenda, standardization across voucher programmes and a cap on costs based on cost-effectiveness studies[85].

In order to adapt to the social norms context in Sindh, there is a need to adopt innovative ways to facilitate use of FP services. As men usually go to work, and they are often reluctant to allow their wives to go to a facility and obtain reproductive health services on their own. It is therefore suggested that FP facilities may start an afternoon or evening shift—a time when male members would be at ease to bring their spouses to FP services—which would enhance access for both young couples as well as increase male engagement in FP.

As part of expansion of services, one crucial area is task sharing/shifting. Health workers will receive training to carry out some of the tasks that are being carried out by medical doctors at facilities. For instance, LHWs administer second injections to MWRA, while the first is performed at a facility after recording blood pressure and a general examination. There is a need to provide the necessary training to LHWs to perform the first injection as well. Another example is Sayana Press—a new injectable to be administered by MWRA themselves. An LHW can distribute such injections after being provided initial training.

Key outputs

The following key outputs are expected:

- A cadre of an estimated 6,586 community-based FP workers pilot-tested and introduced in a phased manner in rural, remote and urban slums in areas not covered by LHWs.
- Services more accessible to young couples and male through evening facilities introduced.
- Task sharing and task shifting adopted to enhance access of all methods, including new methods/range of methods across all stakeholders to remote and rural areas in a phased manner.
- Enhanced collaboration between the public sector, private sector and NGOs under a framework for public-private partnerships implemented in urban slums, rural and the most remote areas in the least-developed districts identified in the CIP.
- Enhanced method mix of at least five methods (not variants of one method to be counted as new method), including LARCs.
- Services more accessible to the poorest of the poor through a voucher scheme initiated in underserved areas in collaboration with the private sector/NGOs.
- Inequities addressed through services for remote, rural, peri-urban and slum areas initiated under corporate social responsibility (e.g., vouchers).
- Improved provincial and district management by establishing Provincial Population House and District Population Houses in each district.

[85] Comments from partners during consultative process on CIP, October 2015.

Strategic Area 5

Increasing knowledge and meeting the demand for FP services by focusing on MWRA, emphasizing male engagement and young people

Rationale

Two major areas of concern exist in the area of communications: (1) Despite that DOH and PWD facilities are available in most areas, the catchment community has inadequate information about the services offered. (2) There is a deficit of trust due to issues of quality, staff behaviour and lack of providers' counselling skills. These issues further multiply in the wake of weak client follow-up mechanisms. Therefore, well-coordinated behaviour change communication interventions would be crucial to build awareness and regain trust of the communities. These efforts will build upon the work conducted to improve quality and respectful care and respond to client feedback as targeted in Strategic Area 2.

Family Health Days and outreach camps organized jointly by PWD, PPHI and DOH have shown that when communities are made aware of the availability of services through skilled providers, their level of trust increases. It has been noted that more clients utilize services at those outreach camps and Family Health Days.[86] Therefore, awareness campaigns shall be complemented by availability of services and based on choice of method as per desire and need of client.

During the consultative process for this CIP, unmet need was identified as an area of investment to make an impact on CPR. Therefore, there is concern regarding both the supply side and demand side. There is a need for attention to facilities carrying out FP services to be properly showcased so that the community knows where to seek services. As mentioned earlier, provider behaviour in certain cases can be an obstacle in services uptake. Over the period, providers have shown little interest in providing FP services or handling referrals.[87] Some feel that there are dedicated facilities where clients should go for FP services. It was also reported during an LHW focus group discussion that providers at several facilities do not take FP seriously, nor do they give priority to referrals.[88] Thus, there is a need to motivate providers and enhance their counselling skills and strengthen functional integration as highlighted under Strategic Area 1 and linking it to Strategic Area 2—quality of services. To facilitate this strategy, as well as contribute to the previous strategies, IPC for community workers and providers need to be paid particular attention. By spending quality time with MWRA, men and young couples, IPC allows for a dialogue around FP services. As part of the CIP conversations, PWD, DOH, PPHI and related programmes have shown an interest in shifting the focus on IPC and having more gatekeepers in the community, compared to the previous focus on MWRA only. In this regard, it is pertinent to mention that RTIs of PWD and trainings provided to LHWs will also contribute to an additional focus on effective communication through IPC, counselling and on-the-job guidance.

CBOs and community elders will be involved to engage male members and communities as a whole. A life skills approach for young people will be part of the communication interventions. The community voice will be reflected through CBOs to the district management, decision makers for improving the performance. The primary goal is to make the community aware of available services and motivate MWRA to obtain services. It is equally important that when couples approach service points through IPC sessions, providers should have

[86] PWD reports as shared during consultation on CIP.
[87] Focus group discussion with LHWs at Hyderabad, Larkana and MirpurKhas Divisions, May 2015.
[88] Ibid.

appropriate counselling skills and awareness on modern methods. In addition to IPC, there will be focus on mid-media (theatres, Melas, meena bazaars) and to some extent mass media.

In order to address the needs of youth and adolescent, youth-friendly life skills counselling spaces and clinics will be set up at different institutional levels. Skilled staff available at such spaces will impart life skills knowledge and support youth and adolescents with the exchange of information about parenthood responsibilities in the future.

Key outputs

The following key outputs are expected:

- Services improved due to better counselling skills of providers.
- Providers trained on counselling young people and young couples.
- Community awareness and accountability for services provision improved due to involvement of CBOs and community elders.
- Community made more aware through IPC, mid-media and mass media.
- Knowledge about life skills (including reproductive health) improved due to inclusion of such information at college, university and medical colleges level involving Department of Education and the Health Education Commission.
- Setting up youth-friendly spaces and clinics at universities.

Strategic Area 6

Strengthening the health and population systems by streamlining policy planning, governance and stewardship mechanisms, and performance monitoring and accountability

Rationale

Successful implementation of the CIP can be ensured through necessary systems strengthening reforms. It is assumed that, aside from emphasis on existing service delivery mechanisms, there would be an additional investment on accelerated and innovative interventions. In this regard, the provincial tier needs a more strategic role since the pre-devolution mode of roles and responsibilities would not be compatible with the newly emerging needs under CIP. The new role of the provincial tier requires more policy and strategic planning (which can be put in place through revisiting existing roles), hiring more skilled staff and re-organizing wings within the DOH and PWD in order to develop synergies. Such a re-organization will further ensure the stewardship and oversight role of PWD and DOH in their respective domains. Human resource management is a key element in the system strengthening process. During implementation of the CIP, the main focus in regard to human resources would be on quality improvement mechanisms, in-service trainings, refreshers, incentives and standardization of services. These elements are described under Strategic Priority 2.

In addition to oversight of programmes and services, the provincial tier will also look into the implementation of laws and regulations related to FP from the perspective of gathering data on implementation of those laws and regulations. For example, recently, the Sindh Assembly passed the Sindh Child Marriage Restraint Act, 2013. It would be useful to add an M&E indicator regarding implementation of the Act.

Furthermore, the monitoring, supportive supervision and information management system or a performance monitoring and accountability (PMA) system need to be in place to assess the pace of implementing the CIP. The PMA system will serve three purposes: utilizing data for decision making, enhancing the performance of staff and ensuring the quality of services. Therefore, a well-functioning PMA system is crucial for the success of the FP programme. Historically, performance monitoring and management has remained a weak area due to lack of funds, transportation (petrol, oil and lubricants), vehicles and properly trained and dedicated staff.

Although indicators for monitoring and established mechanisms (i.e., management information systems of PWD, PPHI, LHW, MNCH) are already in place, these mechanisms will be reviewed from the perspective of integrating them for monitoring and managing FP data. As part of the CIP implementation process, a PMA framework will be prepared using the table of indicators provided in Section 8 (Table 8.2) and the input, process, and output indicators provided in the implementation plan. This data will be reviewed on a quarterly basis, disaggregated by age, sex, socioeconomic status and geographical location.

An annual conference on FP shall also be held at the provincial level. This will be used as an opportunity for a sector review, whereby all FP stakeholders will gather to review sectoral performance. At this event stakeholders will share experiences and lessons learnt and review implementation of the CIP with policy makers, decision makers and managers so that course corrections are made and new approaches are adopted, in order to make the CIP a dynamic document.

Key outputs

The following key outputs are expected:

- A well-coordinated PMA framework prepared and a unit established for monitoring implementation of the CIP, with a lead role by PWD/CIP Cell, and DHPMT/DTC.
- Monitoring mechanisms improved with the establishment of a joint M&E Cell at PWD and use of new technologies (i.e., smartphones).
- Client satisfaction survey and exit interviews conducted in Years 1, 3 and 5.
- cLMIS integrated into health and population sectors' M&E mechanisms and reporting rate sustained and enhanced along with trained human resources.
- Dedicated resources available for M&E visits.
- Feedback system developed and decision making strengthened through district management which will be taking decisions on LHW reporting mechanisms.
- Monitoring visits in approximately seven districts during each quarter.
- Mechanisms for use of data for decision making for performance reviews established.
- Assessment of FP programme based on CIP context developed.
- Annual performance report on the state of FP in Sindh developed.
- Baseline established for CIP based on results of PDHS 2012–2013 and Multiple Indicator Cluster Survey Sindh Report 2014.
- Monitoring reports culminating into midterm assessment of interventions.
- Endline assessment of interventions will be conducted.
- Policy and plan prepared on governance and systems strengthening reforms in health and population sectors.
- A Forum of Social-Sector Departments on FP established and an Annual Meeting held.

- A Population Sector Reform Unit established at PWD to provide strategic support (see Section 8.1.3. for description).
- Implementation of Sindh Child Marriage Restraint Act, 2013 to be monitored.
- Clearly defined reporting lines and working relationship between PWD and DOH at the provincial and local levels.

8 | Institutional Arrangements for Implementation

It has been observed that policies and plans are seldom implemented in the absence of robust institutional mechanisms and in the spirit reflected during the design process. In order to implement the CIP in Sindh, a number of preliminary consultations have been held to discuss the implementation arrangements for the plan. Stakeholders recognize that implementation will require the adoption of multisectoral and decentralized approaches in coordination and management.

Implementation of the CIP will be taken up by the PWD in close collaboration with DOH and its LHW and MNCH Programmes and PPHI. In addition, the PWD will collaborate with international development partners, the private sector, INGOs and NGOs. The Oversight and Coordination Cell for Public Health Programmes will provide guidance and support in stakeholder coordination. The CIP Cell at PWD will oversee the implementation. Other forums at the provincial level (i.e., Provincial Population Council, Provincial Technical Coordination Committee and Reproductive Health Commodity Security Committee) will provide overall policy support and technical assistance through periodic reviews. At the district level, the district population welfare officer and the district health officer (DHO) office will work jointly towards implementation. These offices will also coordinate through DHPMT and DTCs. Following is a detailed account of how all these mechanisms will work under different policy approaches.

The institutional mechanisms are critical for advancing towards the FP2020 goal by implementing the CIP. It has been observed that policies and plans are seldom implemented in the absence of robust institutional mechanisms. Therefore, in order to implement the plan, the following mechanisms must be developed and put in place:

- Management and coordination structures.
- Roles and responsibilities of key actors.
- Coordination framework regarding functional integration.
- Performance monitoring and accountability.

8.1 Management and Coordination Structures

Implementation of the CIP shall take place under the supervision of PWD in collaboration with DOH and PPHI. The Oversight and Coordination Cell for Public Health Programmes will provide support in coordination between public sector stakeholders. The CIP Cell shall manage the operations while actual implementation shall be steered through a Plan Implementation Unit. The management, coordination and accountability structures will be based on the premise that all stakeholders shall work in unison.

The following parameters shall be followed at the provincial and district levels.

Provincial Level:

Oversight and Coordination Cell for Public Health Programmes, Sindh

Generally, policies and plans have been weak in terms of their implementation. Keeping that in view, it has been decided that a strong technical forum at the government level should supervise the implementation of the CIP and provide strategic guidelines for smooth functioning. It has therefore been envisaged that the **Oversight and Coordination Cell for Public Health Programmes, Sindh,** will play a supportive, guiding and coordinating role in the implementation. The Oversight and Coordination Cell has already been established to oversee vertical health programmes in Sindh including LHW, MNCH and Expanded Programme on Immunization and has provided a guiding and supportive role during the CIP process. Therefore, the Cell will continue to guide, support and coordinate with the stakeholders within the public sector and help remove bottlenecks at the highest level of the government to continue working for the cause of birth spacing.

CIP Cell and Technical Support Unit

Based on the fact that the **PWD** has dedicated resources and a mandate for FP, it will therefore spearhead the implementation while closely working with DOH, its programmes and PPHI. Implementation will include planning, financing and performance monitoring. However, there will be a broader representation of the public sector stakeholders in various forums for implementation. The PWD has already set up a **CIP Cell** for the purpose. This Cell will function for the duration of the CIP until 2020. The **DOH** manages the vast LHW health workforce, which will refocused its mandate on FP, as committed by Pakistan at the FP2020 Summit. Both Secretaries of Population and Health have been working closely regarding provision of their guidance on the process of CIP. For technical assistance, a technical team shall provide support to the PWD and CIP cell in the implementation including conducting analysis of the data, and preparing research reports and policy briefs.

Although the CIP Cell is set up at the PWD, it consists of senior officials already assigned to policy and planning functions;therefore, a dedicated unit is being suggested to support the technical aspects of implementation which will work in close coordination with the CIP Cell. A dedicated **Technical Support Unit**shall be set up to provide support to the Oversight and Coordination Cell, PWD and CIP Cell,for oversight, research, M&E, analysis, planning and other related areas. The Oversight and Coordination Cell is a policy-level supervisory body at the government level. While the CIP Cell is housed at the PWD to provide operational support at the design phase of CIP and later on its implementation,a Technical Support Unit shall be supported by the District CIP Coordinator. The Technical Support Unitshall work under the PWD during implementation of the CIP and shall be a dedicated resource assisted through newly assigned or appointed CIP Coordinators in the districts. The CIP Cell and Technical Support Unitshall work in cohesion—the former is responsible for operational guidance at the departmental level for necessary buy-in at the provincial and district levels, while the latter shall be a dedicated unit responsible for implementation of the plan.

Population Sector Reform Unit

One of the areas identified under Strategic Area 6 is strengthening the strategic role of the PWD in the post-devolution phase and enhancing its capacities for implementation of CIP. In this regard, a Population Sector Reform Unit shall be established to advise on strategic direction, policy planning, designing programmes/initiatives and research. The unit will provide an opportunity to invest in institutional strengthening, human resource development and management,and expanding and strengthening various wings and functions within the PWD. This strengthening is crucial in the wake of anticipated support needed for implementation of the CIP.

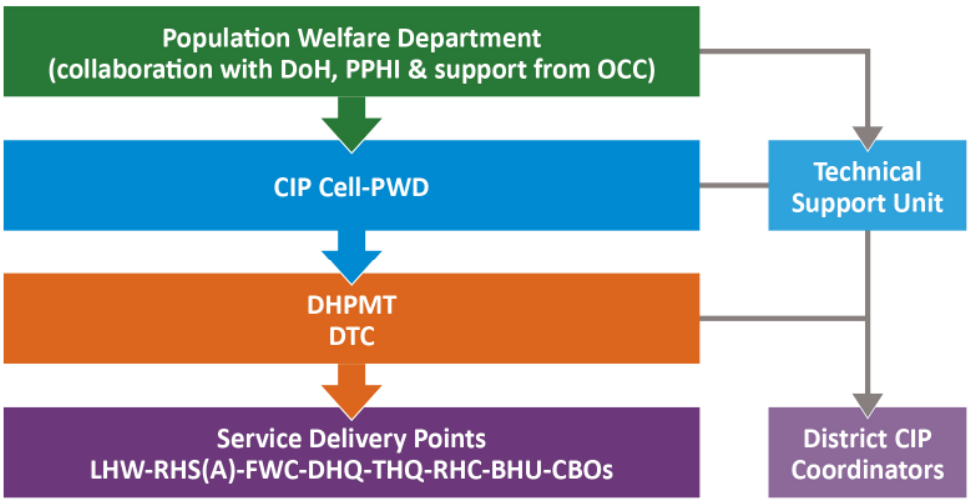
Important Stakeholders

Recognizing the need for representation of public sector stakeholders in various forums for implementation, the CIP management and coordination structure includes the **Sindh Population Council, Population Coordination Committee and the Provincial Technical Coordination Committee**. The Sindh Population Counciland Population Coordination Committee are multisectoral and chaired by the Chief Minister and Chief Secretary respectively; therefore, periodic reports will be submitted to each for review on progress. The CIP activities will be revised in line with the guidelines provided by the Sindh Population Council and Population Coordination Committee. The Provincial Technical Coordination Committee, already established, is chaired by the Secretary of the PWD. All stakeholders in the public sector are members while representatives from UN agencies, partners and NGOs are also part of the Committee. This Committee will review progress on implementationon a periodic basis.

Evidence suggests that FP is one way of improving lives and harnessing economic growth. Therefore, in addition to the DOH and the PWD, other relevant departments shall be involved in the process of implementation of CIP (i.e., Planning and Development Department, education, youth affairs, women's development and social welfare).

All stakeholders including the public sector, private sector, development partners, civil society (NGOS/INGOs), CBOs, research and academic organizations, and professional organizations will join hands in the process of implementation through a jointly agreed upon Framework on Public-Private Partnership.

Figure 8.1 |Management, Monitoring and Supervision of Implementation of the CIP



The following section describes the management, coordination and accountability mechanisms used to implement the CIP.

District Level

District Health and Population Management Team (DHPMT)

This is the highest forum at the district level where health and population managers and partners discuss issues related to both the departments and other partners. This forum will directly oversee the implementation process at the district and subdistrict levels and shall review progress on a monthly and quarterly basis.

District Technical Committee (DTC)

Already functioning, the DTC also works under joint leadership of PWD and DOH officials, DPWO and DHO/executive district officer for health. The DTC will review implementation more frequently and share the findings with DHPMT, ensuring decisive action on the decisions taken during their regular meetings.

A District CIP Coordinator shall be appointed to provide technical assistance to the public sector partners and monitor the implementation. A joint monitoring and supportive supervision mechanism shall be established. A proforma related to supportive supervision will be filled in the field through joint visits. The joint monitoring shall be conducted through PWD, DOH (LHW, MNCH), PPHI and other stakeholders. The monitoring indicators shall be synchronized with DHIS, in addition to reporting the data through CIP monitoring processes.

Subdistrict Level

At the subdistrict level, there are a number of static facilities under the administrative control of DOH, PWD and PPHI. In addition to those, there are community-based workers (LHWs, LHVs, CMWs and male mobilizers) working within communities. However, communities are either unaware about their services or they do not utilize these services at their optimal level. One of the major reasons is that the service delivery points and community-based workers work in vertical manner within their reporting mechanisms, despite that their objectives are identical. For example, LHWs, LHVs and FWCs provide FP services, as well as RHS-As, whereas BHUs, RHCs and CMWs have FP as one of their responsibilities. To achieve the CIP objective, it is imperative that the static units and community-based workers within a district work in an integrated manner in the spirit of mutual support to achieve their common goals.

8.2 Coordination Framework Regarding Functional Integration

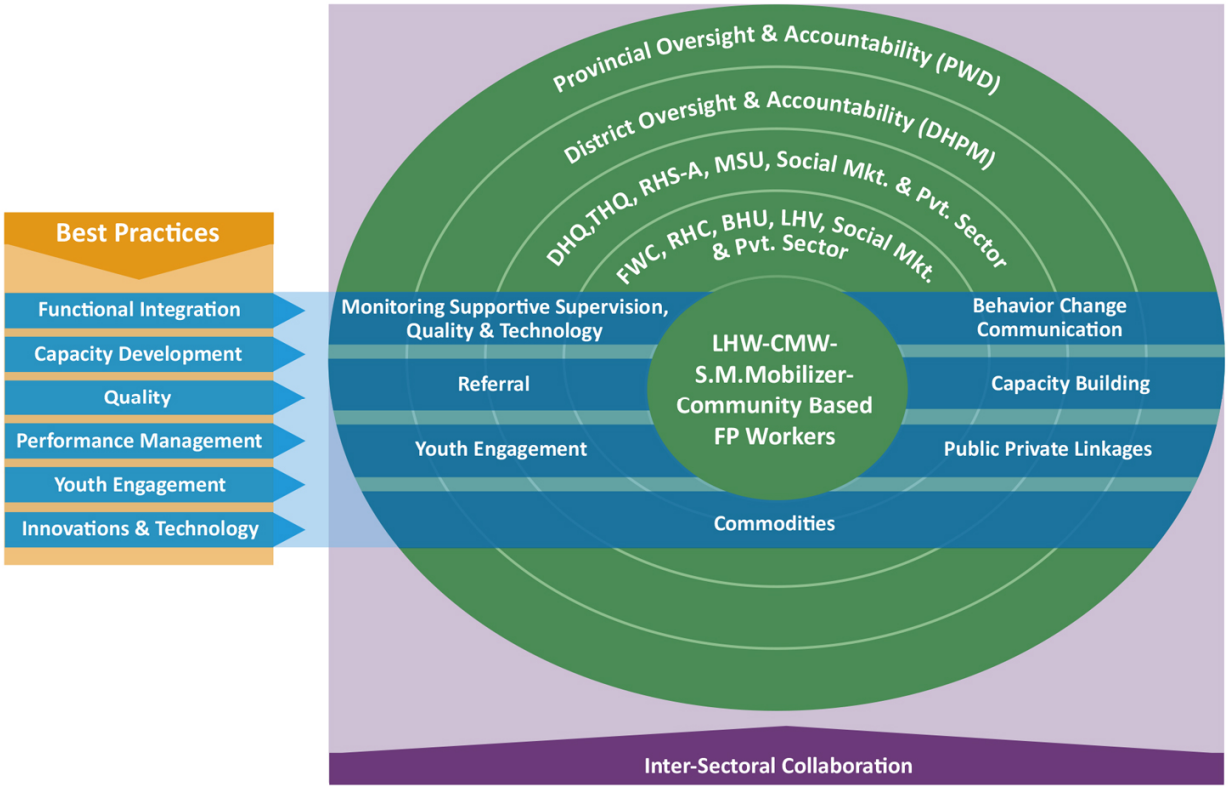
Through a consultative process, a model of functional integration has been developed so that all stakeholders (PWD, DOH including LHW and MNCH Programmes, and PPHI) will work in an integrated manner at the community level, first-level care and secondary-level care. The integrated implementation will be supported through community mobilization to be conducted by selected CBOs and dedicated influential community members.

The functional integration model was built on proven practices and models already existing in public, private and civil society—including functional integration, capacity development, quality, performance management, youth involvement and innovative technologies.

Through this implementation model, community workers at the grass roots level (e.g., LHWs) will work with other providers to promote FP uptake. A number of cross-cutting areas will be drivers for systematic and smooth implementation. These include referrals, capacity, commodities, communication, M&E, quality, supportive supervision and use of technology, youth involvement and public-private partnerships.

The Government of Sindh will issue an official notification to ensure ownership and recognition of this model. The implementation through functional integration will be supervised at district and provincial levels.

Figure 8.2 | Functional Integration Diagram



8.3 Functional Integration Under an MOU Between PWD and DOH

Implementation of the CIP will focus on an integrated model that brings together FP services provided by PWD, DOH, PPHI and other partners (see Figure 8.2). The model entails the PWD, DOH and PPHI coming together to organize Family Health Days. This approach has been piloted under the Sanghar model on functional integration, implemented by PWD along with DoH and PPHI. The main components of the integrated model as it relates to FP are:

- Referrals and task shifting between PWD, DOH and PPHI.
- Availability of commodities at the facility level.
- Capacity development.
- Behaviour change communication.
- Involvement of youth and male members.
- Linkages between public and private sectors.
- Monitoring, supportive supervision, quality and use of technology.

An MOU will be prepared and signed between the PWD, DOH and PPHI. The MOU will spell out details on each of the above areas. As per discussions with various stakeholders, Table 8.1 provides a road map for functional integration.

Table 8.1 | Road Map for Functional Integration

Areas of Functional Integration	Description	Roles and Responsibilities
Service delivery referral and task shifting, organizing outreach camps and Family Health Days	LHWs to refer implant and IUD cases to RHS-As, FWCs, rural health centres (RHCs) and THQs, and postpartum IUD cases to CMWs Joint outreach camps and Family Health Days will be organized to cater to FP users LHWs will be trained to provide some services regarding FP that are being provided at static units. For example, they would be prepared to administer first injections to married women of reproductive age (MWRA); at present they can only administer second injections onwards. This task shifting role can be initiated on a pilot basis. A new technology, Sayana Press, may also be promoted through LHWs and can be added into the LHW kit on a pilot basis	- DOH/PWD/PPHI to facilitate LHW referrals - Static facilities of DOH to refer cases to RHS-As , PPHI - Outreach camps will be organized at a nearby BHU, RHC, THQ or RHS-A and FWC
Commodities	The Government of Sindh has allocated PKR 5.6 billion for the procurement of contraceptives for the next five years until 2019	PWD to procure commodities for PWD, DOH and PPHI - PWD to distribute contraceptives - PWD to arrange transportation up to facility level for all three stakeholders
Capacity development	Trainings/refreshers for PWD, DOH and PPHI identified and details provided in Strategic Area 2	- PWD, DOH, PPHI to provide their respective training plans - PWD to undertake trainings for all stakeholders as per training plan approved at RTIs - DOH to undertake trainings as per plan at Provincial Health Development Centres (PHDCs), DHDCs
Behaviour change communication	IPC, counselling sessions and mid-media activities will be organized	- LHWs (DOH), CBOs/community influential (PWD) will undertake IPC - Providers at DOH/ PWD/ PPHI facilities to hold counselling sessions - CMWs, LHVs of DOH to hold counselling on postpartum IUD, post-abortion care FP - Joint Family Health Days by PWD, DOH and PPHI
Planning,monitoring and supportive supervision	Joint planning, monitoring and supportive supervision	- Joint plan by DOH, PWD, PPHI on Family Health Days - Reporting and data collection through respective department management information systems and DHIS - Joint M&E and supportive supervision visits

8.4 Roles and Responsibilities of Partners

This CIP has been the product of a joint partnership between the DOH and the PWD. However, the goal to achieve a CPR of 45 percent cannot be accomplished by the public sector alone. Therefore, it is envisioned that development partners would be forthcoming to support implementation of the CIP. At the time of the CIP development process, development partners working in Sindh were consulted, including USAID, The Bill & Melinda Gates Foundation and The David and Lucile Packard Foundation. It is anticipated that these partners would support specific areas under the CIP. UNFPA is also working with the PWD, and it is envisaged that it will provide technical assistance in terms of trainings and strategies. INGOs/NGOs working in the areas related to FP and reproductive health would also contribute to achieving CIP targets in the province. Through the ongoing consultative process of the CIP, including a review of the draft CIP for comments, most partner organizations have seen and expressed an interest in supporting the implementation of the CIP. In this regard, modalities for their involvement will be worked out through a Framework for Public-Private Partnership as referenced under Strategic Area 4.

Private Sector/Public-Private Partnerships

The PPHI manages BHUs across the province, except for the six districts of Karachi and the district of Nawabshah. PPHI has been instrumental in implementing the CIP agenda. It has made the commitment to work with LHWs (giving them space at BHUs to store their commodities and permitting them to hold monthly meetings) and organizing facility-based outreach camps and Family Health Days for increasing access to a wide range of methods, including LARCs. The private/corporate sector would be requested to work on CIP under social responsibility. Under the Public-Private Partnership Act 2010, the DOH outsourced its first- and second-level care facilities (RHCs, DHQs, THQs) in various districts to selected NGOs. The DOH is committed to play its stewardship role to ensure provision of FP services at recently outsourced facilities.

8.5 Role of the Private Sector Including NGos

It is envisaged that a public-private partnership mechanism will be developedfor the implementation of CIP. Such a mechanism will be governed through existing regulatory mechanisms within the public sector. These include:

- Sindh Public-Private Partnership Act No. V of 2010.
- Policy for Public-Private Partnership, Finance Department, Government of Sindh.
- Sindh Public Procurement Act, 2009 with Sindh Public Procurement Rules, 2020 (Amended 2013), Sindh Public Procurement Regulatory Authority, Government of Sindh.

In this regard, certain MOUs will be signed between public sector stakeholders and NGOs/private sector to be governed through above-mentioned regulatory frameworks. The Public-Private Partnership Act 2010 mainly deals with contracting services and joint ventures under an agreement, while Sindh Public Procurement Rules are related to a range of agreements that also includes management contracts, joint ventures and outsourcing.

Based on the above regulatory frameworks, SOPs will be developed in consultation with NGOs/INGOs and development partners and to be weighed by the Departments of Finance and Law. While developing SOPs it will be ensured that the professional contribution and value added by NGOs is not diluted and the procedures are of a facilitative nature and fully owned by NGO partners and the private sector.

Professional associations, research organizations and academia

The organizations under this category are expected to provide support in terms of developing SOPs, codes of conduct/ethics, research and certificate courses.

8.6 Performance Management, Monitoring and Accountability

Monitoring needs to occur at the following three levels: (1) implementation, (2) processes and (3) results/outcomes. This section describes a mechanism to track implementation and progress.

Implementation will be measured and recorded through administrative means, which includes collection and reporting of financial expenditures data on quarterly basis, including source of funds, geographical location and coverage of implemented activities, and which key stakeholder implements it. Output-level indicators focusing on number of facilities and outlets providing FP services through various means (static, outreach and mobile services) will be tracked at the district and subdistrict levels. In this case, youth-friendly services and programmes will be specially tracked and reviewed on a regular basis.

Measurement of process indicators remains vital to the overall progress of FP in Sindh. This covers all aspects of quality of service to clients including training imparted to new field workers, refresher trainings on counselling and competencies provided to in-service providers and community-based workers, occurrence of stock-outs for any contraceptive or other identified reproductive health commodities at facility or warehouse levels, actual annual expenditure of government funds on contraceptive procurement for the public sector, friendly and respectful environment at facilities, supportive supervision mechanisms in place and staff fully follow required quality protocols, number of awareness programmes aired/televised, statements made by champions and key personalities to support FP.

Finally, results/outcomes are normally drawn from information taken directly from FP users and clients, and include client satisfaction, continuity of use of method, discontinuation rates, shifting towards LARCs, trend in service utilization, CPR and related indicators.

The whole spectrum of monitoring will draw information from various sources: administrative records and registers, minutes of meetings, notifications issued, newspaper clippings, service statistics from health and population management information systems, and household surveys.

Accountability

Accountability is a crucial aspect within M&E. Therefore, during implementation of the CIP, measures will be taken to ensure accountability in collecting and reporting results by working with providers and administrators to create a culture of accountability and transparency. Rather than creating a culture of auditing, accountability will be perceived as organizational leadership strengthening rather than a top-down mechanism, and will encourage participation in decision making and management of workers.[89] To do this, the CIP will engage district managers, facility staff and the community to work together for better outcomes. The district managers would provide supportive supervision, facility staff will ensure quality of care, and the community will be engaged to support the facility staff for improved intake of services.

[89]Muhammad Abou Nar, Pathfinder International, "Strengthening Health and Community Systems: An Integrated Model of Transformational Leadership." Presented at Leadership Seminar by Pathfinder, Bhurban, Pakistan, October 2015.

In the above context, the CIP shall focus on accountability in terms of provincial oversight through the CIP Cell; district supportive supervision through DHPMTs and DTCs; more trained staff in modern methods, counselling and ensuring adherence to national standards; CBOs and community leaders to engage in community awareness about use of services as well as becoming part of supporting the facilities to improve quality of care.

8.7 Health Information Management

The health and population management information systems (i.e., health management information system [HMIS] and pharmaceutical management information system) are currently designed to provide user-and facility-level statistics on selected indicators applicable to FP. However, data on a number of important indicators is not always reported or entered into the system by health and population facilities. This is further complicated by handwritten reports that are sent to the district management, and data that is sometimes not entered into the system. There are several challenges in data management that need to be addressed to achieve a smooth monitoring process.

In addition to challenges on capturing service utilization data , collected data is not effectively used. It is not necessarily compiled, analysed and reviewed regularly for planning and progress monitoring, providing feedback or advocating for change. More notably, dedicated staff at the provincial and district levels have limited training in data handling, management and presentation for decision making.

Better systems are needed to improve coordination among partners and ensure activities are monitored as a harmonized provincial effort. The design of the CIP recognizes all these gaps in information management and considers coordination at all levels critical for the smooth implementation and achievement of targets set for Sindh's contribution to Pakistan's FP2020 goals. Therefore, the Provincial Technical Coordination Committee and district-level committees need to be proactively strengthened to take monitoring of implementation of activities seriously and regularly use inputs, process and output indicator reviews for decision making. The departments need to ensure that monitoring mechanisms evolve with updated tools supported by software to align with the needs of CIP. Though the Demographic and Health Surveys are undertaken every five years, interim arrangements are also needed for midterm assessments of outcome indicators for 2018. Quality of service measurement will be supported by increasing data for decision making use at the district level using dashboards, client exit interviews and competency checklists that will be put to practice by district officers (technical) by examining the skills of family welfare workers and LHVs in IUD and implant insertion and removal by doctors during supportive supervision and on an ongoing basis.

To assess progress and areas of corrective actions by enhancing the monitoring of FP activities, the following plan guides continuous monitoring with defined indicators and a mechanism for data collection, analysis and dissemination in an easily understood format for all concerned.

The PMA for results will be an essential part of the CIP. A well-organized framework on performance, management and accountability will be developed during implementation of the CIP, in consultation with relevant stakeholders. The framework will include the following:

- **Baseline study:** A baseline report will be prepared utilizing PDHS data.
- **Service utilization indicators:** This information will be gathered through routine DHIS and management information systems and cLMIS data tools. However, specific indicators will be included in the tools to capture the CIP-related data.
- **Input and process indicators through joint field monitoring and supportive supervision:** A mechanism of joint field monitoring and supportive supervision shall be devised. The input and process-related data will

be gathered through these visits. During such visits, tools like Lot Quality Assurance shall be used to assess quality of services and improve the same.

- **Output and key performance indicators:** Information will be collected and reported on dashboards.
- **Outcome indicators:** An analysis will be carried out on annual basis to show progress against outcome-level indicators. These would be reported through an annual report.
- **Annual joint review:** An annual joint review by PWD, DOH, PPHI and development partners shall be conducted to assess the pace of implementation and to take corrective measures where necessary.
- **Midterm evaluation:** A midterm evaluation will be conducted before the third year of implementation of the CIP.
- **Third-party evaluation:** A third-party evaluation will be conducted at the end of the CIP implementation process in 2020. In addition, a Demographic and Health Survey for Sindh will be conducted. This proposal will be further explored with relevant stakeholders for possibility of financing this activity.

Table 8.2 | List of Indicators and Sources for M&E

Actions areas	Indicators	Source	Key gaps and considerations	Frequency of data collection /analysis	Responsibility to collect data
Strengthen and encourage in-depth analysis of PDHS as well as conducting other surveys to assess status of FP / reproductive health indicators	*Indicators*mCPR[90]Contraceptive prevalence rate Percentage distribution of users by modern method Percentage of women with an unmet need for modern contraception Percentage of women whose demand is satisfied with a modern method Unmet need Method mix Teenage pregnancy rate	Demographic and Health Survey and Pakistan Living Standard Measurement SurveyHousehold SurveysMultiple Indicator Cluster Surveys	In-depth analysis of PDHS needed to review important relationships and factors affecting mCPR	After every five years	National Institute of Population Studies and Pakistan Bureau of Statistics Bureau of Statistics, Sindh
Strengthening existing data collection, supervision and monitoring mechanism	Review existing system and equip new tools for Reporting	Executive dashboard– linking with the DHIS dashboard to avoid creating parallel mechanisms	Tracking and monitoring progress on all key FP indicators by the CIP Cell/Plan Implementation Unit	After midterm plan review	Departments of Health and Population Welfare
Effective use of service utilization data with necessarily compilation, analysis and regular review	*Service statistics* Number of women receiving counselling or services in FP—new acceptors, and continuing clients Number of women discontinuing FP services Number of additional / FP users Number of women	HMIS, pharmaceutical management information system, and Pakistan Bureau of Statistics	The service utilization data needs effective utilization, compiled, analysed and reviewed regularly	Monthly, quarterly and annually	Department of Health and Population Welfare, private sector and NGOs

[90] Progress on CIP will be assessed on CPR.

Actions areas	Indicators	Source	Key gaps and considerations	Frequency of data collection /analysis	Responsibility to collect data
	receiving FP services, by method by age / parity Number of products dispensed, by method Number of youth receiving counselling services in FP—new acceptors and continuing clients				
Formalizing DHPMT and DTC FP working for district-level coordination among stakeholders for programmatic reviews	Working mechanism developed among partners Standard agenda formalized and tools developed to gather necessary data for regular review	Minutes of meetings (standardized schedule of meetings and list of meeting attendees)	Necessary coordination and work management among partners at district and provincial level	Annual and quarterly	PWD; DOH
Strengthen forums onFP to facilitate exchange of information, leverageresources, synchronize activities, and sharelessons	Meetings of various forums conducted, website up-to-date	Initiated revision/update of website	Annual and quarterly coordination meetings not conducted	Annual and quarterly	PWD, private sector and NGOs
Annual review of plan to determine the progress so far and determine how to adjust activities moving forward	Revision of objectives after the release of the Mid Term Assessment and Sindh district data from the Multiple Indicator Cluster Survey	Minutes of meetings	Existing plans need to be changed owing newly emerging needs and developments	Annually	Department of Health and Population Welfare, private sector and NGOs
Strengthen PWD district management	Evolve planning, monitoring and monitoring structure for FP implementation and timely reporting	District Reports	Monitoring of field activities implemented and reporting	Monthly	District management of PWD and DOH

9 | Projected Method Mix

9.1 Projected Method Mix and Contraceptive Needs

Implementation of the CIP will lead to an increase in the CPR to 45 percent by the year 2020. It is estimated that there will be on average a 2 percentage points increase in the annual rate of change in CPR. It is envisaged that the mCPR will rise from the current 26.5 percent to 36.5 percent by the year 2020, while traditional methods will be around 8 percent by that year. The disaggregated data regarding percentage increase in LARC users and other modern methods will be analysed and shown in the reviews regarding progress on CIP objectives. By adding both modern and traditional rates, CPR 45 percent will be achieved.

It is estimated that users of modern methods are projected to rise to 3 million by 2020. Therefore, the province of Sindh should expect 1.2 million additional users of modern methods (an estimated 74 percent increase in all users in five years and 66 percent increase in modern methods users) and a need to orient and accelerate efforts to deliver services to the additional users.

Table 9.1 | Population Trends and Required Number of Additional Users by 2020

Indicators	2015	2016	2017	2018	2019	2020
Pop of Sindh (M)	45.8	46.8	47.7	48.7	49	50.6
Women of reproductive age	13.5	13.8	14.1	14.5	14.8	15.2
Married women of reproductive age (MWRA) (million) *	8.4	8.6	8.7	8.9	9.0	9.2
All users (million)	2.3	2.6	2.8	3.1	3.4	3.7
Contraceptive prevalence rate (CPR) (%)	32%	34%	36%	39%	42%	44.5%
Modern CPR (%)	26.0%	27.0%	29.0%	31.0%	34.0%	36.5%
Unmet need (%)	21%	19%	17%	16%	15%	14%
No additional users (all methods)	236,250	214,881	215,668	310,163	284,848	329,684
Additional users required (modern methods)	116,375	125,555	203,633	216,318	276,584	272,845

***Based on PDHS. MWRA = 63% of all women in 2012**

Source: Pathfinder International estimates, based on discussions with PWD.

The projected contraceptive method mix for Sindh is presented in Table 9.2below. The projections assume a shift towards increased use of long-acting methods (i.e., IUD and implants) in Sindh from 1.1 and 0.2 percent to 3.0 and 2.0 percent respectively between 2013 and2020.

Table 9.2 | Projected Contraceptive Method Mix for Sindh 2014 – 2020

Contraceptive Method	2011-12	2013	2014	2015	2016	2017	2018	2019	2020
Oral Pills	1.8	1.8	1.9	2.0	2.2	2.5	2.7	2.9	3.1
Condoms	8.0	8.0	8.1	8.3	8.3	8.7	9.1	9.8	10.5
Injectable	3.3	3.3	3.4	3.7	3.9	4.1	4.5	4.9	5.3
IUCD	1.1	1.1	1.2	1.3	1.5	1.9	2.2	2.6	3.0
Implant	0.2	0.2	0.3	0.4	0.7	1.0	1.4	1.7	2.0
Tubal ligation	9.7	9.7	9.7	100	10.1	10.4	10.7	11.7	12.1
Vasectomy	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Others	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4
Total	**24.5**	**24.5**	**25.0**	**26.1**	**27.1**	**29.0**	**31.1**	**34.1**	**36.5**

Source: NIPS: *Pakistan Demographic and Health Survey (2012-2013),* for base year.

A targeted method mix has been projected for 2020 considering consumption, historical trends, growth rate and increase in the number of MWRA. The method mix projections are based on the overall trend of uptake of different methods; therefore, these should not be interpreted as reducing user choice for any method or emphasis on any particular methods. In this context, forecasting, quantification and procurement of the contraceptives need to be revised and adjusted on a regular basis.

As a result of consultations with stakeholders, the following assumptions have been used for projection of the method mix:

- The CIP will be implemented by the PWD, DOH (LHW and MNCH Programmes, Director General's office), PPHI, partner NGOs/INGOs, development partners and UN agencies, and will be reached with implementation of accelerated and innovative interventions, in addition to strengthening ongoing regular activities. In the CIP, areas not covered by LHWs, underserved communities in remote, peri-urban and slums will be covered with an emphasis on method mix by improving the availability and trained staff for those methods which are needed by MWRA (i.e., LARCs).
- It is assumed that due to improved quality, respectful care, enhanced counselling, and choices offered there will be shift from short- to long-acting methods.
- There will be an increase in LARCs as soon as more stocks and trained staffs are available to meet the users' expectations and choices. Additionally, there will be a rise in the use of condoms among short-acting methods due to the investments in community-based distribution of commodities through LHWs, community-based FP workers, and male social mobilizers (Table 9.2).

As per estimates, an additional 162,288 and 144,836 users of IUD and implants, respectively, are expected to be engaged based on informed choices across method mix by all stakeholders in 2020 (Table 9.3).

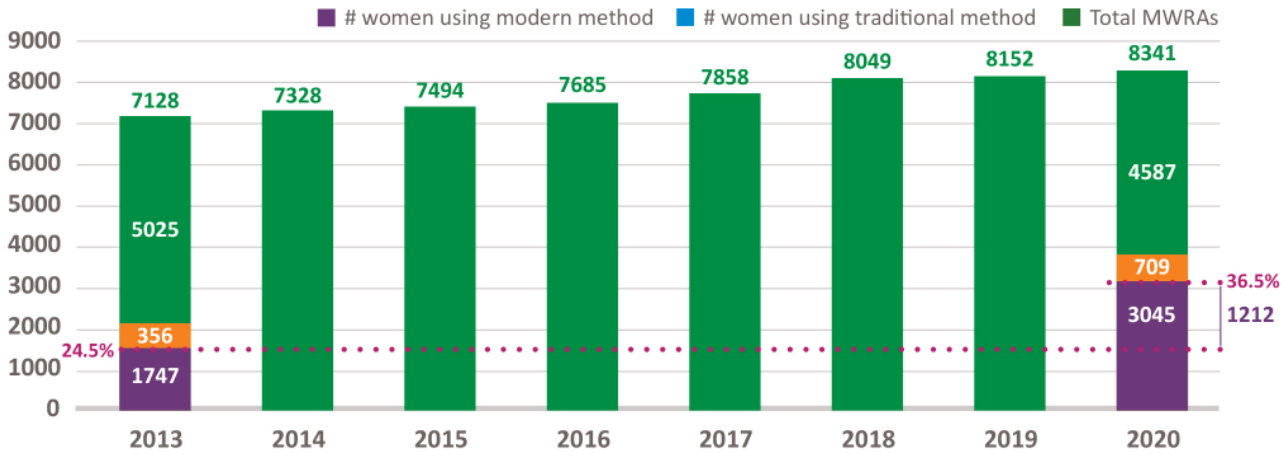
Table 9.3 | Overall Change Expected in Users (by Method)

	Base Year 2014	2020	2014–20	Percentage
All FP Users	2,161,996	3,753,506	1591,510	73.6
Modern Methods	1,832,200	3,044,510	1,212,310	66.2
Oral Pills	139,247	258,575	119,328	85.7
Condoms	593,633	875,818	282,185	47.5
Injectables	249,179	442,080	192,900	77.4
IUDs	87,946	250,234	162,288	184.5
Implants	21,986	166,822	144,836	658.8
Tubal ligation	710,894	1,009,276	298,382	42.0
Vasectomy	7,329	8,341	1,012	13.8
Others	21,986	33,364	11,378	51.8
Total	**1,832,200**	**3,044,510**	**1,212310**	

Source: Pathfinder International estimates reflecting policy directions (2015).

Based on projections presented in Table 9.3, the number of modern contraceptive method usersis projected to rise to 3.045 million by 2020. Therefore, the province of Sindh should expect 1.2 million additional users of modern methods (an estimated 74 percent increase in all users in five years and 66 percent increase in modern methods users).

Figure 9.1 | Trend of Number of Married Women at Risk of Pregnancy



9.2 Impact Assessment

The impact of implementing routine, accelerated and innovative/best practices interventions under the CIP until 2020 will have a significant demographic, health and economic impact. The data is used from PDHS and other reliable sources and projected based on implementation of CIP.

Impact 2software was used to calculate impact of the interventions and increase in CPR to 45 percent. The impact indicators include:

- Maternal deaths averted
- Child deaths averted
- Unintended pregnancies averted
- Unsafe abortions averted
- Abortions averted
- Couple years of protection generated
- Health care costs saved in PKR

The impact on different parameters by 2020 is estimated as follows:

- **Health impacts:** As a result of implementing the CIP, 1,848 maternal deaths and 29,470 child deaths will be averted.
- **Demographic impact:** As a result of implementing the CIP, a total of 1,774,367 unintended pregnancies and 193,332 unsafe abortions will be averted.
- **Economic impact:** An estimated PKR12.187billion shall be saved through implementing routine, accelerated and innovative interventions under CIP.
- **Couple years of protection generated:** A total of 3,963,090 couple years of protection shall be generated by implementing routine, accelerated and innovative interventions under CIP in Sindh.

Figure 9.2 | Estimated Child Deaths Averted Annually

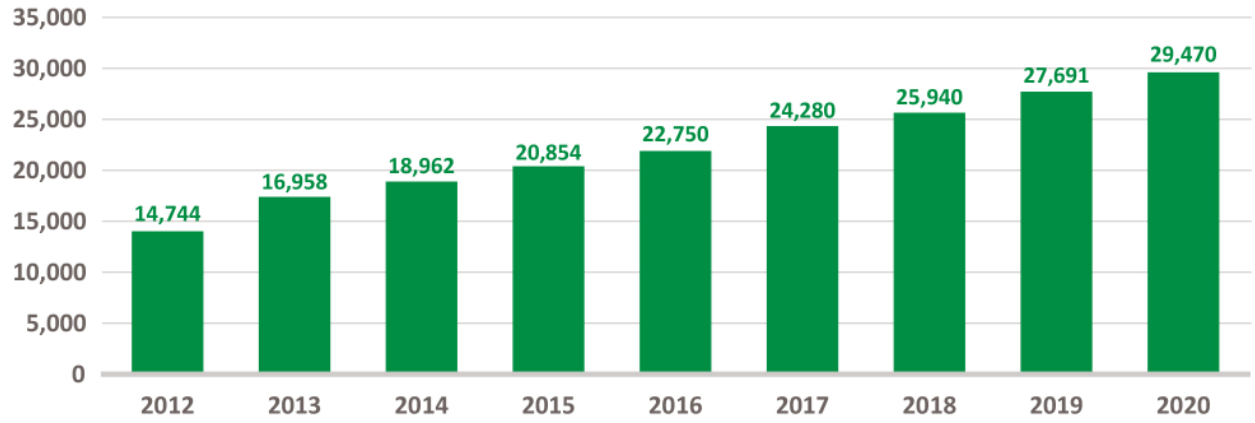


Figure 9.3 | Estimated Maternal Deaths Averted Annually

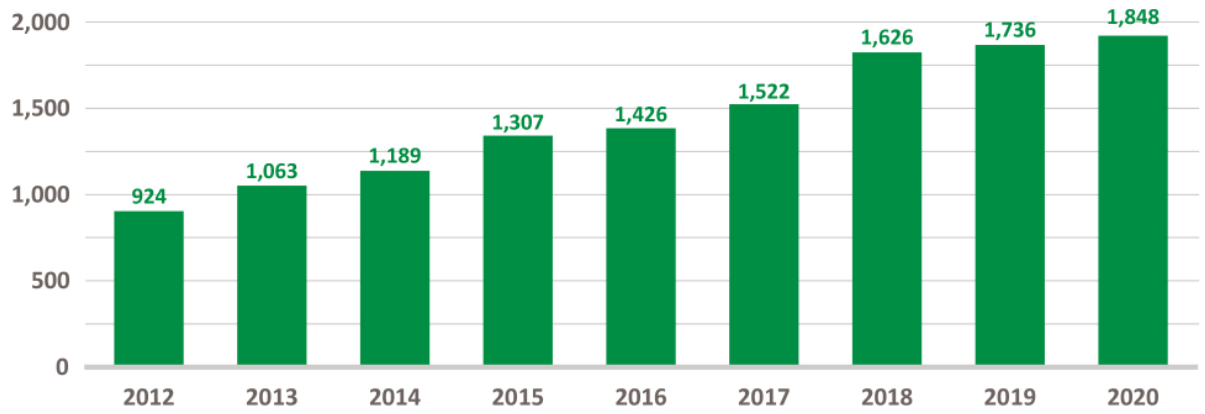
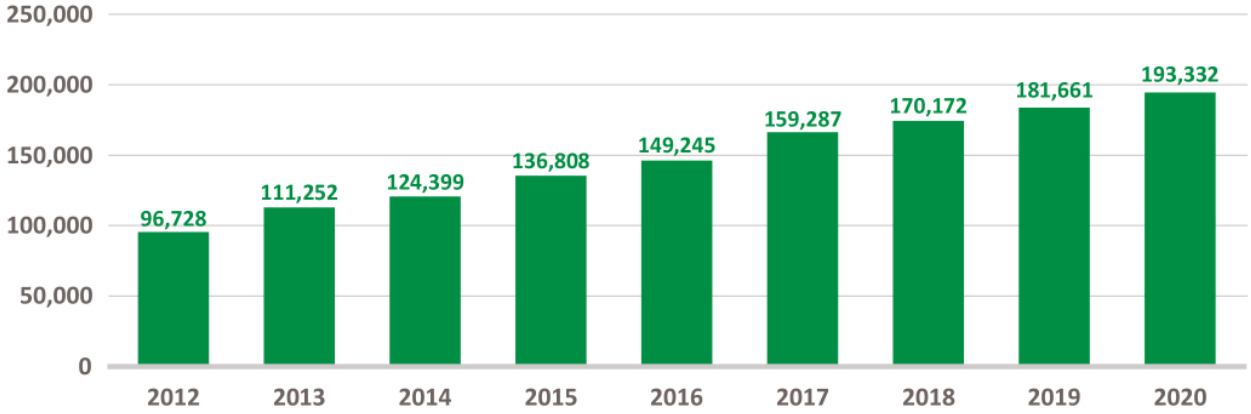


Figure 9.4 | Estimated Unsafe Abortions Averted Annually



10 | Implementation Plan

10.1. The Detailed Costed Implementation Plan for Family Planning in Sindh

This section presents the costed implementation plan strategic areas, and their corresponding activities.

Table 10.1| The Implementation Plan For Sindh

Strategic Area 1

Enhancing strategic coordination and oversight between the population and health sectors at the provincial, district and subdistrict levels regarding functional integration of services at the subdistrict level

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
1.1 A model of functional integration is implemented at the subdistrict level i.e., community-based distribution of contraceptives; setting up outreach camps and Family Health Days	1.1.1 Developed a functional integration model at the subdistrict level 1.1.2 Notification issued regarding the formal roles and responsibilities of each stakeholder regarding functional integration 1.1.3 Rollout of the model and ensuring participation of all stakeholders	1.1.1.1 Meetings held at the provincial level to formalize the model 1.1.1.2 Meetings held in each district to operationalize the model	Year 1, 2nd quarter and onwards	Notification of the functional integration model is issued	DOH, PWD, PPHI, LHW, MNCH	1.381
1.2 Coordination and oversight mechanisms are developed at the provincial and district levels (Oversight and Coordination Cell for Public Health Programmes; CIP Cell; DHPMT; DCT)	1.2.1 Meetings of Provincial Oversight and Coordination Cell 1.2.2 Meetings of CIP Cell, PWD 1.2.3 Meetings of DHPMT in each district 1.2.4 Meetings of DTC in each district	1.2.1 No. of participants in each committee and No. of meetings of each committee to be held in a year (total in 5 years)	Year 1, 2, 3, 4, 5	-Minutes of the meetings -Summary of decisions and implementation taken place (quarterly basis)	PWD, DOH (LHW, MNCH) PPHI	130.661

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
1.3 Referral mechanisms strengthened	1.3.1 Referral guidelines/ standard operating procedures (SOPs) to be reviewed	1.3.1.1 Guidelines/SOPs for referrals between LHWs, LHVs, CMWs, male mobilizers and static facilities to be reviewed 1.3.1.2 Meeting to finalize guidelines 1.3.1.3 Guidelines printed (5,000) 1.3.1.4 Distribution of guidelines	Year 1, 3rd quarter	-SOPs copy available -Orientation of workers on referral SOPs -Workers reports that referral network is working	DOH/PWD/PPHI	6.128
1.4 Maternal mortality and birth spacing conferences held	1.4.1 LHW Maternal mortality conferences (MMC) held on regular basis (provincial MMC on a yearly basis; district MMC on a monthly basis) 1.4.2 Linking the MMC with LHW FP focus; monthly number of FP referrals; DHPMT/DTC	1.4.1.1 Working papers, agenda, list of participants prepared 1.4.1.2 No. of participants 1.4.1.3 Venue 1.4.1.4 Per-head charges	Year 1, initiated from 2nd quarter and ongoing activity	-Reports from MMCs available -Summary of conclusions and implementation status (report to be shared at each conference)	DOH/PPHI	30.410
1.5 LHW mandate refocused on FP through functional integration approach	1.5.1 Mandate of LHW revisited 1.5.2 Availability of supplies to LHW 1.5.3 LHW kit 1.5.4 Monthly meeting at a BHU (PPHI to facilitate and medical officer to be involved) 1.5.5 Lady health supervisors provided necessary logistic support to monitor LHWs 1.5.6 Forms,	-Each district to discuss issues regarding refocusing LHWs on FP, and issues to be resolved on a priority basis	Year, 1st quarter	-No. of MWRA/couples an LHW visited during visit and discussed FP -No. of FP referrals by LHWs each month -Availability of contraceptives with LHWs in each month -LHWs kit available along with necessary medications -Notification	DOH, LHW	8,689.8

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
	stationary for LHWs 1.5.7 Ensure salary and operational cost provided on regular basis			regarding target setting on referral (one LARC); and by LHWs' own services		
1.6 Utilization of services increased at the community level	1.6.1 MWRA meetings by LHWs 1.6.2 Male mobilization through community elders; CBOs; male mobilizers 1.6.3 Coordination meetings between CBOs and LHWs	.6.1.1 No. of meetings held with MWRAs, males, community 1.6.2.1 Follow-up IPC meetings by CBOs and community influential with males/youth	Year 1 and onwards	-No. of MWRAs provided FP services by LHWs -No. of referrals by LHWs -No. of MWRAs received services from static units and outreach camps -No. of community meetings and follow-up meetings by CBOs and influential community -No. of and minutes from CBO/LHW meetings	LHW, PPHI, PWD, CMWs	912.754
1.7 Referral at FWCs	1.7.1 Referral of IUD cases at FWCs 1.7.2 Family Health Day	1.7.1 8 cases per month	Year 1–5	-No. of total cases in a month -No. of cases regarding side effect or follow-up cases	PWD	5,715.9
1.8 MSU functioning	1.8.1 MSU camps (2 camps/per MSU/per week) 1.8.2 Family Health Days	1.8.1.1 Referral of IUD and implant cases at MSU camps	96 cases per month (63 cases of implant; 33 cases of IUD)	-Mobilization sessions within community to utilize services at the camp -Cases referred by LHWs and other workers to the camp -No. of cases based on different methods	PWD	474.9
1.9 Enhancing service provision through	1.9.1 Family Health Day (2 in a	1.9.1.1 Once a week at RHS	Years 1–5	-No. of cases referred	PWD/DOH/PPHI	1,150.3

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
Family Health Days	week)	centre 200 cases referred monthly/RHS-A		-No. of cases conducted -Directions for follow-up		
1.10 Intersectoral collaboration at subdistrict level developed for planning Family Health Days and camps	1.10.1 Functional integration being implemented. 1.10.2 Camps being organized 1.10.3 Family Health Days being organized 1.10.4 Availability of long-acting methods and method mix ensured at the service delivery point level	1.10.2.1 Camps organized in districts 1.10.3.1 Detailed plan for camps and Family Health Days prepared on quarterly basis at DTC and review performance 1.10.3.1.1 Family Health Days planned and held	Year 1, 2nd quarter through Year 5	-No. of outreach camps held -No. of Family Health Days arranged --District reports sent to PWD	DOH, PWD, LHW, MNCH, PPHI	16.9
1.11 LHWs highly motivated through recognition of their services; services of LHWs/community workers recognized through awards, incentives	1.11.1 Referrals by LHWs and other community workers to be recognized by paying for travel, for client and herself (starting in 4 selected districts and then scaling up) 1.11.2 Selection criteria and Committee for selection of Award	1.11.1.1 Transportation cost for referrals PKR 700 per client 1.11.1.2 LHW best performance award in all districts of Sindh 1.11.1.3 Best performance award at provincial level	Years 1–5	-No. of LHWs provided recognition	DOH, CIP Cell, PWD, PPHI	1,367.5
1.12 FP integrated with MNCH services (e.g., basic and comprehensive emergency obstetrics and neonatal care [EmONC]) at newly outsourced Rural Health Centres, taluka headquarters hospitals (THQ) and district headquarters hospitals (DHQ) of the Department of Health	1.12 Newly outsourced facilities i.e., RHC, THQ, DHQ to ensure FP services provided all the time 1.12.2 Show case facilities for FP through a banner and brochure	1.12.1 Newly outsourced facilities provide FP as primary health service package 1.12.2 Banner placed at each facility 1.12.2.1 Brochures for distribution	Years 1–5	-No. of FP clients served by outsourced facilities and cases referred by LHW, LHVs and other providers --Facilities maintain contraceptive stocks and complete records in inventory register	NGOs managing the outsourced facilities and DOH	77.2

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
1.13 Operational cost released in new fiscal year enabling providers to work with dedication	1.13.1 LHW and other Programmes provided operational cost	1.13.1 Releases made during first quarter of fiscal year 2015–2016 and onwards	Years 1–5	-Total releases by the GOS to the Programmes	DOH and PWD through Finance and Planning and Development Department	-

Strategic Area 2

Ensuring quality of services by enforcing standards, improving providers' skills and ensuring client satisfaction

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
2.1 Quality of services improved through strict adoption of National Manual on FP Services and other protocols and guidelines	2.1.1 Notify each district that National Standards for FP will be enforced 2.2.2. Trainings and orientations on FP National Standards conducted at all district and facility level 2.1.2. Alignment of national standard-related monitoring with the M&E visits (please see 6.4)	2.2.2.1 Hiring of consultant for trainings 2.2.2.2 Provincial consultation on adoption of National Standards 2.2.2.3 Printing of National Standards in addition to use of technology for disseminating standards 2.2.2.4 Training of trainers on National Standards 2.2.2.5 Trainings on National Standards conducted at district and facility level for management and providers 2.2.2.6 A report prepared where and by whom the training on	Year 1, 4th quarter and onwards	--No. of trainings held -No. of facilities fully implementing the Standards -No. of copies printed and distributed	PWD, DOH, MNCH, and PPHI	193.143

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
		Standards has been completed				
2.2 Enhanced acceptability of services due to skill development and training of providers at each level	2.2.1 Training plan formulated for service providers 2.2.2 DOH doctors, and LHVs get trained in FP counselling and client-centred FP, healthy timing and spacing of pregnancies (HTSP), service provision for youth, competency-based training on LARC, postpartum IUD insertion, postpartum FP and post-abortion FP, including post-abortion care	2.2.1& 2 Trainings at RTIs, Provincial Health Development Centres (PHDCs) and DHDCs	Year 1, 4th quarter, through Year 5	No. of training per staff category; -Training areas and total trainings per areas	DOH/PPHI PHDC, District Health Development Centre	1,917.819
2.3 Promoting LARCs FP technology and infection prevention	2.3.1 Competency-based training of Women Medical Officers on LARCs at RTIs	2.3.1.1 Total 600 for 4 days (50 batches)	Year 1, 4th quarter, and onwards	-No. of training per staff category; -Training areas and total trainings per areas	DOH/PPHI/PWD/ RTIs	247.8
2.4 Refresher for outreach camps	2.4.1 Refresher training for MSU service providers	2.4.1.1. Total 144 participants for 6 days	Year 1, 4th quarter	No. of training per staff category; -Training areas and total trainings per areas	PWD/RTIs	68.363
2.5 Promotion of client-centred approach	2.5.1 Training of LHVs, CMWs on client-centred approach, and service provision for youth 2.5.2 Provision of IUD kits	2.5.1.1 Total 6 days, 520 total	Year 1, 4th quarter	No. of training per staff category; -Training areas and total trainings per areas	DOH/MNCH/PW D	214.763

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
2.6 Improving skills and competencies	2.6.1 Refresher of Family Welfare Workers on IUD insertion and removal, client-centred FP and infection prevention	2.6.1.1. 480 total, 6 days (total 961)	Year 1, 4th quarter and Year 3	No. of training per staff category; -Training areas and total trainings per areas	PWD/RTIs	146.953
2.7 Improving quality of pre-service training	2.7.1 Pre-service training of Family Welfare Workers at RTIs	2.7.1.1 2 Training course	Year 1	No. of training per staff category; -Training areas and total trainings per areas	PWD/RTIs	231.353
2.8 Availability of training material	2.8.1 Identifying training material	2.8.1.1. Printing of training material (manuals on LARCs; client-centred; counselling; HTSP; and infection prevention)	Year 1	--Copies of material	Relevant departments and PHDCs, RTIs	101.017
2.9 Improved training quality and human resources	2.9.1 Training of trainers of RTIs staff and teaching aids	2.9.1.1 No. of training of trainers 2.9.1.2 No. of participants 2.9.1.3 Per head charges	Year 1, 4th quarter	-Training of trainers report	RTIs/PWD	79.691
2.10 Increase training infrastructure	2.10.1 Establishment of new RTIs	2.10.2 1 New RTIs at Mirpurkhas and Benazirabad	Year 3	-Buildings completed and taken by PWD	PWD	1,557.4
2.11 Policy reforms related to staff of DOH oriented on FP approaches	2.11.1 Capacity development of HSRU and planning related staff in FP	2.11.1.1 No. of staff to be oriented	Year 2	Training report	DOH	1.801
2.12 Training of LHWs in HTSP and community mobilization	2.12.1 LHW refresher at the district level	2.12.1.1 FLCF 2, lady health supervisors 1770, FPOs/ Provincial Project Implementation	Year 1, 4th quarter and onwards	-No. of trainings and trainees -Categories of training	LHW Programme	784.5

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
		Unitmonitors (total 2,533)				
2.13 Refresher training for FLCF regarding LHW Programme	2.13.1 Refresher at FLCF level	2.13.1 .1 FLCF trainers 1,740, lady health supervisors 770, LHWs 22,576, FPOs and Provincial Project Implementation Unit monitors 23	Year 1, 4th quarter and onwards	-No. of trainings and trainees -Categories of training	LHW Programme	2,975.593
2.14. Refresher training for LHW Programme officials at provincial level	2.14.1 Refresher training at provincial level for DHOs, Provincial Project Implementation Unitof LHW, FPOs, district coordinator, regional coordinator and 3 participants from each district	2.14.1 .1 Coordination; technology updates; report preparation; supervision (92 participants)	Year 1, 4th quarter and onwards	-No. of trainings and trainees -Categories of training	LHW Programme	27.573
2.15 Enhance involvement of CMWs in FP	2.15.1 Building CMWs' capacities in FP, counselling and service delivery, with a focus on service provision for youth	2.15.1.1 PWD and MNCH collaborate for training	Years 2–5	-No. of trainings and trainees -Categories of training	MNCH and RTIs	130.679
2.16 Training for CMWs in clinical supervision	2.16.1 Strengthening of deployment and CMWs' capacities as clinical supervisors in 5 districts (Thatta, Badin, Tando Allahyar, Jacobabad, Shikarpur)	2.16.1.1 5 batches (20 each)	Year 2	-No. of trainings and trainees -Categories of training	MNCH and PHDC/RTIs	23.040
2.17 Building skills and competence on IUD insertion	2.17.1 CMWs training in IUD	2.17.1.1 No. of trainings (10 batches, 12 per batch)	Year 2	-No. of trainings and trainees	MNCH and RTIs	33.748
2.18 Postpartum IUD	2.18 Postpartum	2.18.1	-Year 2	--No. of trainings	MNCH and RTIs	29.291

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
training for CMWs	IUD training CMWs	5 batches, 12 per batch				
2.19 Post-abortion care FP promotion training for CMWs	2.19.1 Post-abortion care training (including FP), CMWs	2.19.1.1 5 batches, 12 per batch	-Year 2	--No. of trainings	MNCH	29.291
2.20 Strengthening FP through Continuing Medical Education and Continuous Professional Development	2.20.1 Provider skills enhanced through orientation seminars on latest FP approaches	2.20.1.1 Hiring of consultant for seminars for 440 days in a year 2.20.1.2 Seminar plan formulated 2.20.1.3 Seminar sessions conducted 2.20.1.4 An A 4 page brochure on new FP approaches	Years 2, 3, 4, 5	-No. of seminars held -No. of seminars with doctors as part of Continuing Medical Education and Continuous Professional Development	DOH, PPHI, PWD, RTIs	3,950.4
2.21 Clients satisfaction	2.21.1 Increased number of clients, contraceptives stocks at service delivery points, p-providers skills monitored for client-centred approach	2.21.1.1 Registration and records number of clients	Years 1–5	Report on service utilization (No. of clients; contraceptive availability; and skills of the providers)	All stakeholders	-
2.22 Capacity development strategized through training need assessment (TNA) on biennial basis	2.22.1 TNA	2.22.1.1 TNA tools prepared, -methodology finalized 2.22.1.2 Data collection 2.22.1.3 Analysis and report	Year 1; Year 3	-TNA report available	DOH/PWD/PPHI	11.954
2.23 Quality of care mechanism prepared per National Manual to ensure better quality of services	2.23.1 Quality assurance mechanisms (checklist; SOPs; supervision mechanisms) 2.23.2	2.23.1.1. SOPs on quality of care 2.23.1.2 Orientation of on quality of	Year 2, 1st quarter	-QOC indicators agreed -No. of supervisors	DOH/PWD/ PPHI	375.030

Output	Activities	Subactivities	Timeframe	Indicators	Roles and responsibilities	Cost for 5 years (PKR million)
	supervisors/CIP coordinator trained to monitor	care SOPs 2.23.1.4 Report writing on quality assurance				
2.24. Improved performance of male mobilizers and other service providers	2.24.1 Job descriptions revised for male mobilizers, LHVs and paramedics. 2.24.2 Performance mechanism developed to assess their performance	2.24.1.1 Male mobilizers working Mechanism finalized at facility and district levels 2.24.2.1 Conduct reviews to assess workers fully adopt their job descriptions	Year 1 and onwards	--Job descriptions of male mobilizers revised -No. of male mobilizers referring cases to facilities	PWD	97.669
2.25 Improved performance through use of new technologies i.e., GIS, smart phone, mHealth	2.25.1 Introducing smart phones for data collection and performance of the staff 2.25.2 GIS used for geo-mapping of facilities	2.25.1 Four districts selected to introduce the smart phone initiative 2.25.1.1 Staff trained on smart phone reporting 2.25.1.2 Generating report through server-based data sent through smart phones 2.25.1.3 Assessment of the success of the smart phone pilot 2.25.2 GIS use for analysis and decision making	Year 2, then scale up	-No. of reporting generated on smart phones -No. of decisions taken based on smart phone reports -No. of staff trained on smart phone reporting -Report of the assessment available	DOH/PWD/PPHI	1,395.4

Strategic Area 3

Improving contraceptive security to the last mile, including distribution and availability of contraceptives at service delivery points

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
3.1 Contraceptive procured and made available at subdistrict level through: -Regular means of transportation -Outsourcing distribution mechanism for selected districts (to pilot test mechanism)	3.1.1 Contraceptive forecasting and quantification exercise conducted 3.1.2 Procurement carried out as per procedures of Sindh Public Procurement Regulatory Authority 3.1.3 Contraceptives procured and stored at the central warehouse for future distribution 3.1.4 Contraceptives transported to district stores of PWD, DOH, PPHI and LHW 3.1.5 For subdistrict distribution, a contract finalized with a selected company to transport the commodities to facility and Health House level	3.1.4.1 Selection of a distributor and contraceptives transported to district stores 3.1.4.2 Commodities transported under supervision of district health management 3.1.4.3 Contraceptives transported to service delivery points on periodic basis 3.1.4.4 CLR 6 and inventory registers filled out properly Supportive supervision for storage, and consumption of contraceptives 3.1.4.5 Outsourcing of contraceptives for selected districts	Year 1, 2nd quarter, through Year 5	-Availability of contraceptives at service delivery points -Stock for the last 3 months -Consumption method wise -No. of CLR 6 and inventory registers filled per facility -No. of times commodities transported in a quarter -Quality of transportation checked through whether required number of commodities with proper care reached at service delivery points	PWD, DOH, LHW, MNCH, PPHI (NGOs may also report)	77.17
3.2 Strengthening of Provincial Logistic Cell --Contraceptive Commodity Security Committee (CCSC)	3.2.1 Provincial Logistic Cell will be made fully functional 3.2.2 Linking CCSC with the Oversight and Coordination Cell, CIP Cell and other overseeing bodies for CIP	3.2.1.1 Staff for PLC 3.2.1.2 Logistic and other support for PLC 3.2.1.3 Regular reporting mechanisms 3.2.1.4 Dashboards at	Year 1, 2nd quarter	-Reports of PLC generated -Decisions made based on PLC reports	PWD	0.937

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
		PLC using cLMIS data for decision making 3.2.1.5 Joint meetings of CCSC and CIP Cell				
3.3 Develop ownership for Contraceptive Logistic Management Information System (cLMIS) and sustained reporting through trained staff so as to strengthen supply chain management	3.3.1 Refresher trainings will be conducted on cLMIS 3.2.2. Trainings on forecasting and quantification 3.2.2.2 Monitoring the reporting rate at district and provincial level (at provincial level PLC will work and at the district level a focal point to be strengthened)	3.3.1.1. Refresher trainings on cLMIS planned and conducted (total 344) 3.3.2.1 Training on forecasting and quantification (10 provincial+ 1 from each district =30) 3.3.2.2.1 Monthly reporting on cLMIS to be shared at DHPMTs and Oversight and Coordination Cell/CIP Cell meetings for decisions	Years 2–5	-No. of trainings -No. of reports shared	PWD, DOH (Programmes), PPHI	334.4
3.4 Ensuring management of contraceptives availability, storage and consumption at facility level	3.4.1 Inventory of contraceptives maintained	3.4.1 Proper racks and palates per guidelines of PWD 3.4.1.1 Manage storage per manual	Year 1 for four districts and then scale up each year	-Quantity of contraceptives distributed to service delivery points and Health House -Quality of storage and record keeping	PWD, DOH, PPHI and relevant Programmes	468
3.5 Enhanced community distribution due to better management of contraceptives inventory, storage, timely demand through CLR 6	3.5.1 LHW, CMWs, LHVs having sufficient stock of contraceptives 3.5.2 Keeping record of contraceptives delivered within community	3.5.1.1 Checklist for monitoring of stocks	Year 1 and onwards	-Consumption of contraceptives method wise -Age, socioeconomic status of MWRA who receive contraceptives	PWD, DOH (LHW, MNCH)	1,212.6

Strategic Area 4

Expanding services with supply- and demand-side interventions for enhancing access, especially to urban slums, peri-urban and rural areas, and creating space and linkages for public-private partnerships to reach vulnerable segments of the population including the poor and youth

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
4.1 A cadre of an estimated 6,586 community-based FP workers (specific title may be decided) will be introduced in phased manner in rural, remote and urban slums in areas not covered by LHWs	4.1.1Recruitment of community-based FP workers in selected four districts as a pilot (also collaborate with HANDS to appoint Marvi workers in selected sites especially in rural areas)	4.1.1.1 Interviews in each district 4.1.1.2 Selections made 4.1.1.3 Trainings held	Year 1, 2nd quarter; replicate to other districts on yearly basis/in phases	-List of selected village-based health workers (VBHWs) available -VBHW training completed with deployment in Union Councils	PWD	8,060.569
4.2 Services more accessible to poorest of the poor through voucher scheme initiated in underserved areas	4.2.1 Voucher scheme finalized and implemented in selected four districts on pilot basis Under public-private partnership on pilot basis	4.2.1.1 Consultative meetings to finalize the procedure 4.2.1.2 Selection of service providers, quality checks mechanism 4.2.1.3 Selection of areas 4.2.1.4 validation Mechanism	Year 1, 3rd quarter; replicate to other districts in phased manner during Years 2–5	-No. of vouchers distributed -No. of vouchers redeemed - Percentage/number validated	PWD/ CIP Cell/ Private sector	19,961.138
4.3 Services enhance availability of all methods including new methods; range of methods across stakeholders through task sharing/shifting	4.3.1 Introducing methods such as Jadelle, Sayana Press, etc. 4.3.2 All methods to be ensured to be available with all stakeholders 4.4.3. Assessment of pilot testing	4.3.1.1 4Four districts selected for the initiative launch	Year 2, then scale up in following years	-No of facilities with at least two LARC available -Client feedback	DOH/PWD/PPHI	200.477
4.4 Services more accessible to young couples and males through enabling environment, training of providers and priority-based services for youth	4.4.1 Young couples getting more services	4.4.1.1.1 Staff to serve young couples on priority	Year 2	--Data on No. of young couples provided services -No. of staff trained in serving young		

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
				couples		
4.5 Enhanced collaboration between public sector, private sector and NGOs under a "Framework for Public-Private Partnership"	4.5.1 Partnerships built on FP with private sector/NGOs	4.5.1.1 Framework to be discussed and finalized with stakeholders 4.5.1.2 All partners to be listed and roles identified	Year 1, 2nd quarter	-A public-private partnership framework prepared -Copy of approved framework -List of NGOs to work under the framework -Target set for the quarter and report of implementation	DOH, PWD, relevant NGOs	1.269
4.6 Inequities being addressed through services for remote, rural, peri-urban and slum areas by expanding services through NGOs, corporate sector under social responsibility	4.6.1 Meeting with selected corporate sector 4.6.2 Meetings with selected NGOs held 4.6.3 Prepare a plan for services in urban slums and rural areas based on Human Development Index as per Pakistan Social and Living Standards Measurement Survey Report	4.6.3.1 Details of services that NGOs and private sector will provide (vouchers, community mobilization for availing services at facilities; organizing camps; meena bazaars; Family Health Days, etc.)	Year 1,3rd quarter, through Year 5	-No of facilities providing FP services through NGOs -Progress reports through corporate sector -No of monitoring visits	PWD	229.778
4.7 Establishment of new FWCs (215 in Year 1; then 100 each year)	4.7.1 Selection of Union Councils 4.7.2 Acquiring rented building 4.7.3 Putting facility in place 4.7.4 Recruitment of new Family Welfare Workers and other staff	4.7.1 5 staff at each centre 4.7.3 Purchase of equipment -Furniture -Fixture -Other amenities	Years 2–5	-Hiring of building -Staff hired -Goods procured and distributed	PWD	3,557.8
4.8 RTIs strengthening plan implemented	4.8.1 The plan for strengthening prepared 4.8.2 Faculty 4.8.3 Equipment 4.8.4 other material	4.8.2.1to 4 No. of faculty, equipment, resources provided	Year 1, 3rd quarter, through Year 5	-No. of new faculty appointed -New equipment provided -List of resource material (dummies) etc.	PWD	85.450

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
				provided		
4.9 New RHS-A Centres to be established	4.9.1 No. of new RHS-A in new THQs 4.9.2 Acquiring of land or space 4.9.3 In case of new building design prepared	4.9.1.1 Construction or hiring of space 4.9.1.2 Equipment 4.9.1.3 Staff hiring 4.9.1.4 Furniture and fixture	Years 2–3	-No. of new RHS-A established -No. of clients attending	PWD	670.449
4.10 Refurbishing of RTIs libraries	4.10.1 Libraries at RTIs	4.10.1.1 4Four libraries	Years 2–3	-Feasibility report prepared -No. of categories of books (digital and hard)	PWD/RTIs	11.709
4.11 Refurbishing of laboratories at RTIs	4.11.1 Need assessment with details of facilities 4.11.2 Funding sources	4.11.1.1. A total of four labs with dummies and skeleton -	Year 2	-Laboratories developed with list of facilities -Average use record (monthly) -Annual assessment report	PWD /RTIs	13.257
4.12 Vehicles for MSUs	4.12.1 Vehicles for MSUs at PWD 4.12.2 Repair and maintenance cost 4.12.3 Petrol, oil and lubricants 4.12.4 Drivers 72	4.12.1.1.Total of 72 vehicles to be purchased 4.12.1.2 Drivers	Year 1 and 2			271.711
4.13. Expanding facilities at CMWs schools	4.13.1 Skills labs in 23 CMWs schools established	4.13.1.1 Skills labs equipment purchased	Year 2 onwards	-No. of equipment purchased -Average use of new lab	DOH (MNCH)	30.912
4.14 Strategizing retention of CMWs	4.14.1 Retention of deployed CMWs in 23 districts (This excludes the 5 districts of Karachi Division)	4.14.1.1 Options prepared for retention 4.14.1.2 Financial resources mapping	Year 2 onwards	-No. of CMWs retained in each district -No. of cases of IUD and postpartum IUD being conducted by CMWs	DOH (MNCH)	1,427.882
4.15 Improved provincial and district management through	4.15.1 Funding sources identified	4.15.2 Offices to be set up at	Years 1–3	-Population House	PWD	873.8

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
establishing Provincial Population House and District Population Houses in each district	4.15.2 Acquiring land 4.15.3 Design of the building through an architect 4.15.4 Equipment, furniture and fixture	Population Houses as under: -PWD office -Research institute -Seminar halls -Library -FP-related programmes offices 4.15.2DPWO office in districts		constructed and set up -Relevant office setup		

Strategic Area 5

Increasing knowledge and meeting the demand for FP services by focusing on MWRA, male engagement and young people

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
5.1 Strategizing communication approaches	5.1.1 Communication strategy finalized	5.1.1.1 Consultative process held to finalize a draft strategy available 5.1.1.1.2 Integration of communication approaches into the CIP	Year 1, 1st quarter	-Copy of approved strategy available - Implementation report on quarterly basis	PWD, DOH, relevant INGOs	0.848
5.2 Services improved due to better counselling skills of providers	5.2.1 LHWs, LHVs, CMWs and other providers having regular counselling sessions with clients 5.2.2 IPC tools printed and made available with workers and providers	5.2.1.1. Counselling sessions with MWRA at facility and within community	Years 1–5	-No. of counselling sessions -No. of referrals as result of counselling -No. of IPC tools printed	PWD, DOH (MNCH)	1,980.573
5.3 Community awareness and accountability for services provision improved due to involvement of CBOs and community/local influential, professionals, religious leaders etc.) (working where male mobilizers are not functional or not available)	5.3.1 Selection of community elders/senior person in a village for those selected districts where male mobilizers are not available 5.3.2 Selection of CBOs to work within communities 5.3.3 Design of the programme how, CBOs and community elder will work within communities for awareness and accountability	-5.3.1 Stakeholder dialogue involving LHW, LHVs, FWAs, CMWs, BHU, selected CBOs 5.3.3 Developing a framework for elders and CBOs to work in communities	Year 1, 4th quarter	-No. of elders engaged -No. of CBOs in a district selected -No. of sessions held by elders -No. of sessions held by CBOs	PWD, DOH, PPHI	-
5.3 Community awareness improved	5.3.1 IPC sessions 5.3.2 No. of events under community media/mid-media (theatres, Melas,	5.3.1.1 Detailed mid-media plan chalked out at each district	Years 1–5	-No. of IPC sessions by each community worker	DOH, PWD,	43.247

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
	meena bazaars)			-No. of mid-media events -No of participants of mid-media events -No. of mass media episodes		
5.4 Knowledge about life skills improved due to inclusion of such information at college, university and medical colleges level	5.4.1 Consultations held with Department of Education, Health Education Commission, professional colleges to include life skills into the curriculum	5.4.1. 1 A consultant to design booklet; hold consultation; design assessment; and conduct assessment after one year 5.4.1.2 Booklet for life skills discussed through stakeholders dialogues and vetted by concerned department 5.4.1.3 Printing of life skills booklet 5.4.1.4 Distribution of booklet to selected institutions on pilot basis 5.4.1.5 Orientation of selected 30 teachers on booklet at concerned RTIs 5.4.1.6 Assessment of life skills after one year of distribution of booklet	Years 2–5	-No. of colleges, universities include life skills into teaching courses	Education, relevant colleges, universities	40.406
5.5 Branding of PWD	5.5 Branding PWD (change of name; logo; colour) 5.6 Developed 5.7 Scale up	5.5.1 All PWD facilities to be branded	Year 1	-No. of facilities branded -Increase in no. of cases since	PWD	263.698

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
				branding		
5.6 FWCs supported through community initiatives	5.6.1 Meeting with friends of FWCs committee on monthly basis	5.6.1 Total 961 meetings in a month	Years 1–5	-No. of meetings held -No. of members attended	PWD	957.5
5.7 Development/production of TV commercial (this is regular activity) for enhancing awareness on FP	5.7.1 TV commercial to be developed 5.7.2 TV commercial airing on selected channels	5.7.1.1 Two commercials a year	Year 2	-TV commercial aired -No. of times the TV commercial aired	PWD	1,153.694
5.8 Development and airing of music video	5.8.1 Music video 5.8.2 Airing of music video on Sindh channels	5.8.1.1 One a year (airing video for 3 minutes on mainstream channels) 5.8.1.2 Video prepared	Year 2	No. of times the music video aired -Pilot in selected areas asking clients whether they came after watching the TV commercials	PWD	1,193.654
5.9 Drama serial Sindhi	5.9.1 Drama serial Sindhi production PWD 5.9.2Discussions and selection of Sindhi channel for airing the serial	5.9.1 26 episodes -Liaison with the channel for logistic arrangements for the airing of the serial	Year 2	-No. of episodes the drama serial aired -No. of episodes aired -No. of cases increased due to airing of the serial a form to be filled as a pilot to assess whether clients came after watching the serial)	PWD	762.621
5.10 FP advertising in print media	5.10.1 Designing and printing of ads in newspapers	5.10.1.1 National/Sindh papers print the ads	Year 1	-No. of times the ads are printed	PWD	287.875
5.11 Installing billboards about FP	5.11.1 Billboards prepared	5.11.1.1 No. of places selected for billboards	Year 2	-No. of billboards erected -No. of places	PWD	282.725
5.12 Celebrating	5.12.1	5.12.1.1 Each	Years 1–5	-No. of events	PWD/ DOH/	38.033

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
international days on FP	International days	5.12.1.1 Each district (29) to hold International Day		at provincial and districts level	PPHI/ LHW/ MNCH	
5.13 A provincial FP conference for policy makers, decision makers, managers, partners providers to review FP initiatives in the province	5.13.1 Conference organized	5.13.1.1 Conference held on yearly basis	Years 1–5	-No. of conferences held	PWD /DOH/ PPHI	34.969
5.14 Media forum formed at provincial and district level	5.14.1 Media forum at provincial and district level established 5.14.2 Terms of reference of the forum prepared 5.14.3 Training of media persons on FP messaging	5.14.1.1. Meetings of media forum held at provincial and district levels 5.14.1.2 Trainings of media persons held	Year 1 onwards	-No. of meetings with media forum held -No. of media persons trained -No. of articles published and programmes aired	DOH, PWD, CBOs	419.588

Strategic Area 6

Strengthening the health and population systems by streamlining policy planning, governance and stewardship mechanisms, and performance monitoring and accountability

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
6.1 Developing management and technical support mechanisms for implementation	6.1.1 Establishment of Plan Implementation Unit (PIU) 6.1.2 M&E Cell within PIU 6.1.3 Strengthening Oversight and Coordination Cell/formation of Steering Committee 6.1.4 Strengthening CIP Cell	6.1.1.1 Terms of reference, hiring of staff plan finalized and hiring process 6.1.2.1 Arrangements made for M&E Cell 6.1.3.1 Details of support to Oversight and Coordination Cell finalized 6.1.4.1 Details finalized regarding CIP Cell	Years 1–5	-PIU established with staff, equipment -M&E Cell established at PIU -Details regarding Support to Oversight and Coordination Cell and CIP Cell -M&E Cell reports (data collection, analysis, report writing)	PWD (in collaboration with DOH, PPHI)	746.556
6.2 A well-coordinated PMA/M&E framework prepared	6.2.1 Consultative meeting of Technical Support Unit, CIP Cell and relevant stakeholders on developing framework 6.2.2 Draft framework shared 6.2.3 Meeting with Oversight and Coordination Cell/Steering Committee on the draft	6.2.1.1 Draft framework shared	Year 1	-M&E framework copies printed	DOH, PWD, PPHI, LHW, MNCH	0.656
6.3 cLMIS integrated into health and population sectors M&E mechanisms and reporting rate sustained and enhanced along with trained human resources	6.3.1 Mechanism developed to integrate cLMIS data into overall PMA mechanisms of data collection and analysis 6.3.2 Train demographers /CIP Coordinator and other staff in Programmes in	6.3.1.1 Meetings held with USAID DELIVER/PBS to integrate cLMIS into CIP M&E system 6.3.2.1 Deliver to train selected staff on integrated M&E	Years 1–2	-cLMIS integrated data reported and analysis available for decision making -No. of demographers /statisticians and other staff trained	PWD	3.142

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
	integrated M&E with cLMIS			-Reports through integrated system generated		
6.4 Dedicated resources available for M&E visits in the public sector	6.4.1 Resource allocations made within public sector allocations	6.4.1 Meeting held to dedicate resources	Year 1 onwards	-Budgetary allocations made -Copy of budget book		-
6.5 Joint M&E visits	6.5.1 Planning meeting for M&E visits at provincial level 6.5.2 District planning meetings for M&E visits 6.5.3 M&E visits in selected 6 districts in a quarter 6.5.4 Follow-up visits regarding supportive supervision	6.5.3.1 Seven districts selected 6.5.3.2 M&E visits along with all stakeholders 6.5.3.2.1 Data analysis 6.5.3.2.2 Report writing	Years 1–5	--No. of M&E visits per quarter -M&E Reports shared with Steering Committee and approved -Actions taken on M&E reports	PWD/ CIP Cell; DOH; PPHI	67.882
6.6 FP-related data separately reported for each stakeholder to know the contribution	6.6.1 Meeting held to decide mechanism 6.6.2 Reports of stakeholders separately prepared 6.6.3 Printing of the report	6.6.1.1 Implementation of mechanism initiated through Technical Support Unit	Years 1–5	--No. of reports available with disaggregated data by stakeholder	DOH, PWD, PPHI, LHW, MNCH, partners	12.710
6.7 Development of web portal of CIP Sindh	6.7.1 Selection of a firm to develop web portal 6.7.2 Web portal development and contents	6.7.1 Contents of web portal finalized and uploaded	Year 2	-Web portal developed -Hosting initiated		0.500
6.8 DHIS tools revisited and counselling data revised and added	6.8.1 Meeting held to review DHIS tool from FP perspective 6.8.2 Printing of revised DHIS tools to be distributed by relevant department	6.8.1 Counselling data included after review of DHIS tools 6.8.2 Report prepared based on revised tool	Year 1	-No. of reports covering indicators on FP counselling -No. of facilities with updated DHIS tools which include FP	DOH, PWD, PPHI, LHW, MNCH	4.140
6.9 Feedback system developed and decision making strengthened through district	6.9.1 Meetings of LHW, MNCH, PPHI held with district management on feedback	6.9.1.1 Discussions on feedback and decisions taken	Year 1 and onwards	-No. of meetings held with district management	DHO, DPWO, LHW, MNCH	2.208

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
management taking decisions on LHW reporting mechanisms				on LHWs and other workers reports -Main decision taken (Report) -No. of decisions implemented		
6.10 Baseline/assessment of FP Programmes in Sindh	6.10.1 A comprehensive assessment of FP Programmes in Sindh including SWOT [strengths, weaknesses, opportunities and threats] analysis	6.10.1.1 The tools for baseline developed -Methodology -Data collection mechanisms -Tools for data collection	Year 1	-Tools finalized -Data collection plan prepared	PWD / DOH/ PPHI	45.000
6.11Annual report on state of FP in Sindh	6.11.1 Annual report to be prepared on progress on CIP targets and shared with stakeholders	6.11.1Technical team to develop Annual report	Years 1–5	-Design and methodology of the report finalized	PWD/ DOH/ PPHI	18.403
6.12 Midterm evaluation of CIP interventions	6.12.1 Midterm will be conducted after 2.5 years of implementation of CIP	6.12.1.1 Tools for data collection 6.12.1.2 Methodology 6.12.1.3 Data collection 6.12.1.3 Plan for analysis	Year 3	-Design of midterm evaluation finalized -Tools, methods, data collection and analysis plan finalized -Report of the evaluation	PWD /DOH/ PPHI	3.093
6.13 End line evaluation of CIP interventions	6.13.1 End line evaluation will be conducted after 5 years of implementation of CIP	6.13.1.1 Tools for data collection 6.13.1.2 Methodology 6.13.1.3 Data collection 6.13.1.4 Plan for analysis 6.13.1.2 PIU to continue till end line evaluation and other close out activities are completed	Year 5	-Design of midterm evaluation finalized -Tools, methods, data collection and analysis plan finalized	PWD /DOH/ PPHI	37.588
6.14 Client satisfaction survey and exit interviews	6.14.1 Client satisfaction survey will be conducted	6.14.1.2 Tools for data collection 6.14.1.3	Years 1, 3, 5	-Design of the survey finalized	PWD /DOH/ PPHI	9.397

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
	at Year 1, 3, and 5 of implementation of CIP	Methodology 6.14.1.4 Data collection 6.14.1.5 Plan for analysis		-Tools, methods, data collection and analysis plan finalized -Surveys conducted in Year 1, 3 and 5 to be useful in making services accountable for results		
6.15 Annual joint review	6.15.1 Preparing for the review 6.15.2 Terms of reference of the Mission	6.15.1.1. Joint Review Mission finalized 6.15.1.1.1 Meetings of the mission for the review 6.15.1.1.2 Report of the mission as an annual report	Years 1–5	-Joint review report prepared	PWD / DOH/ PPHI	20.556
6.16 Plan prepared on governance and systems strengthening reforms in health and population sectors	6.16.1 A detailed plan on how both the departments will improve governance and the systems so that FP services are provided in effective manner	6.16.1.1 Consultation between both the departments held to finalize the plan 6.16.1.2 Plan implemented and report submitted to Steering Committee/ Oversight and Coordination Cell	Year 1 (3–4 quarter)	-Copy of plan -Report on implementation on periodic basis	DOH, PWD	0.500
6.17 A Forum of Social-Sector Departments on FP established	6.17.1 Forum notified at Planning and Development Department	6.17.1.1 Meetings of the forum held on 6-month basis	Year 1 (3–4 quarter)	-Minutes of the meetings	-DOH, PWD	0.736
6.18 Stakeholders allocating future funds in line with CIP	6.18.1 GOS allocated funds as part of funding for CIP 6.18.1.1 Development partners to fill in the gap to implement the CIP 6.18.1.2 NGOs set aside resources	6.18.1.1 Dialogue with donors on possible funding of CIP in Sindh	Year 1	-Allocations made by the government -Releases made out of allocations -Commitments from development partners	PWD/DOH along with consultants	0.398

Output	Activities	Subactivities	Timeframe	Indicators	Roles and Responsibilities	Cost for 5 years (PKR million)
	towards achieving CIP targets			-NGOs committing resources for FP plan		
6.19 A Population Sector Reform Unit (PSRU) was established at PWD to provide technical support reform process at PWD	6.19.1 Design of PSRU developed 6.19.1.1 PC 1 prepared 6.19.1.2 Approval of PC 1	6.19.1 Set up office for PSRU 6.19.1 Hiring of technical and non-technical staff	Years 1–5	-Concept paper -PC 1 -Approval -Allocations of funds -Hiring of staff	PWD	-
6.20 Sindh Child Marriage Restraint Act, 2013 is implemented	6.20.1 Developing certain indicators to report on implementation of the Act	6.20.1.1. Discussion with relevant departments regarding development of indicators and possibility of reporting and decisions on implementation of the Act	Year 1	-Indicators developed and integrated into CIP data-gathering mechanisms	PWD/ DOH/ PPHI	-

10.2Priority Activities to be Initiated During the First Year Onwards

The six strategic areas were discussed in-depth with the Oversight and Coordination Cell for Public Health Programmes, PWD and DOH, who collectively recognized the need to prioritize the strategic areas and activities of the CIP. As a result of these deliberations, the following 31 key activities have been prioritized through brainstorming at PWD with senior officials. A total of 19 activities are planned to be initiated during different quarters of year 1. The cost for these activities for year one is PKR 48 billion. The remaining activities will be implemented in subsequent years as part of the detailed implementation plan of the CIP, presented in this section.

Table 10.2 | Prioritization of Activities in Year One and Subsequent Years

No.	Activity	Starting Year	Starting Year	Starting Year	Starting Year	Starting Year	Responsibility	Cost for 5 yrs (PKR Million)
1	Functional Integration: MOU; refocus LHW; joint camps on FP	2015–16					PWD, DOH, PPHI	8,689.8
2	Trainings: FP techniques for DOH, PPHI, CMWs	2015–16					PWD, DOH	2,448.8
3	Orientation on National	2015–16					PWD	193.143

No.	Activity	Starting Year	Starting Year	Starting Year	Starting Year	Starting Year	Responsibility	Cost for 5 yrs (PKR Million)
	Standards on FP							
4	Improving performance by use of new technologies i.e. GIS, smart phone, mHealth		2016–17					1,395.4
5	Commodity procurement, distribution and availability at facility level: strengthening of cLMIS	2015–16						334
6	Community-based FP Workers	2015–16 Recruitment	2016–17 Training and placement					8,060.57
7	Voucher scheme (pilot based)		2016–17					19,961.14
8	Sayana Press (pilot)		2016–17					200.477
9	Public-private partnership framework for NGOs, private sector	2015–16						1.269
10	Retention of CMWs		2016–17					1,427.88
11	Male mobilization through selection of CBOs/community influential	2015–16						912.754
12	Counselling sessions by LHW, LHVs, CMWs, and printing of tool kits	2015–16						1,980.57
13	Mid-media: Melas, festivals		2016–17					43.247
14	Knowledge about life skills improved due to inclusion of such information at college, university and medical colleges level		2016–17					40.406
15	Branding of PWD		2016–17					263.698
16	Mass media: TV commercial		2016–17					1,153.69
17	Mass media: Talk show, print media, articles	2015–16						287.875
18	Media Forum at provincial and district		2016–17					419.588

No.	Activity	Starting Year	Starting Year	Starting Year	Starting Year	Starting Year	Responsibility	Cost for 5 yrs (PKR Million)
	level							
19	Developing management and technical support mechanisms for implementation: CIP Cell strengthening, Oversight and Coordination Cell strengthening, DHPMT/DTC strengthening at district level	2015–16						746.556
20	Comprehensive M&E Framework developed: Joint Monitoring and supportive supervision visits	2015–16						0.656
21	Development of Web Portal of CIP Sindh	2015–16						0.5
22	DHIS tools revisited and counselling data revised and added	2015–16						4.14
23	Baseline Assessment	2015–16						45
24	Annual Report on State of FP in Sindh	2015–16	2016–17	2017–18	2018–19	2019–20		18.403
25	Annual FP Conference	2015–16	2016–17	2017–18	2018–19	2019–20		34.969
26	Plan prepared and implemented on governance and systems strengthening reforms in health and population sectors: Population Sector Reform Unit	2015–16						0
27	A Forum of Social-Sector Departments on FP established		2016–17					0.736
28	Client Satisfaction Survey		2016–17		2018–19			9.397
29	Joint Annual Review	2015–16	2016–17	2017–18	2018–19	2019–20		20.556
30	Mid Term Evaluation			2017–18				3.093
31	End line Evaluation					2019–20		37.588
	Total							48,736

Source: Exercise conducted at PWD, Sindh, 2015.

11 | Costing

11.1 Costing Assumptions

The costing elements are outlined and costed based on data provided by the PWD and DOH programmes (i.e., LHW, MNCH and PPHI). The CIP Costing Tool developed by USAID Health Policy Project has been used by Pathfinder International to cost the strategic areas of the CIP. It is an Excel-based platform used to calculate the costs of the thematic areas. Costing inputs are provided as unit costs in order to facilitate and calculate the cost of activities and subactivities. Costing inputs are based on documentary evidence provided by the departments. The tool allows for a calculation of the overall costs of the plan, as well as a disaggregation of the costs by activity area and year. It includes both initial costs and costs for the duration of the plan.

This section presents the cost of each strategic area separately along with its relevant cost summary, timelines for different activities, method mix and commitments under FP2020. Regional/district splits could not be analysed due to non-availability of data at this stage.

Contraceptive costs are calculated from 2015 to 2020, using the information provided by PWD Sindh. The PDHS 2012–2013 was used to provide the baseline CPR and method mix[91]. The 2020 target CPR for all women of reproductive age was extrapolated for each subsequent year between 2014 and 2020, and verified by the PWD and DOH.

The calculations by PWD are based on consumption/distribution data; therefore, there is a difference between commodities costed under CIP software and the PWD. The number of IUDs and implants calculated in the CIP are also less as compared to the PWD. The reason being that these methods have been costed based on method mix in the CIP software. It is concluded that since the contraceptives will be procured by PWD hence, those calculations will be used for implementing the CIP.

A detailed costing analysis is available on the prescribed software. Some graphs are included in this draft from the results conducted through software.

11.2 Costing Summary

The total cost of the CIP during 2015–2020 is PKR 79.12 billion (US$ 781 million), which includes an infrastructure upgrade and mass media campaign[92].The Government of Sindh has already allocated PKR 998 million (US$ 98 million) towards implementing the CIP[93]. It would spend approximately PKR 52.238 billion (US$ 513 million) during 2015–2020 on FP-related activities through PWD, LHW, MNCH, PPHI and hospital services[94]. However, the overall outlay of DOH is quite considerable. For example, the DOH would spend roughly PKR 266.47 billion over the next five years only for hospital services and other facilities/prevention. The total projected outlay of the Government of Sindh in the health and population sectors would be more

[91] NIPS, *Pakistan Demographic and Health Survey 2012–2013.*
[92] An estimated amount of PKR 72 million will be spent on infrastructure and a mass media campaign.
[93] Annual Development Programme, 2015–2016, Planning and Development Department, Government of Sindh.
[94] Based on discussions at PWD, DOH (Development Wing), LHW, MNCH, PPHI, April–May and November 2015.

than PKR 428,433,626,324.7 (US$ 4.062 billion) over the next five years[95]. Assuming this trend of allocations in the past few years, the Government of Sindh spends around 12 percent of the total projected health and population outlay on FP-related activities.

Table 11.1 | CIP Cost, Sindh Government Allocations and Donor Funding

Total Cost for CIP (2015–20)	Government of Sindh estimated allocations (FP related)* (2015–20)	Development Partners (next 3–4 years)
PKR. 79.12 Billion (US $ 777.2 million)	PKR. 52.239 Billion ($513 million)	PKR. 10.2 billion (US $ 101 million)

*Projected allocations calculated based on DOH Development Wing of DOH and PWD.

On average, the per MWRA cost for interventions in all six strategic areas each year would be PKR 1,818 (US$ 18).The average cost per user for contraceptives comes to PKR 303 (US$ 3). This cost is less than US$ 4–4.20 in other developing countries[96].

11.3 Gap Analysis

The total estimated cost for CIP is PKR 79.12 billion (US$ 777.2 million). The Government of Sindh through PWD has initiated the process of procurement of contraceptives, for which PKR 5.4 billion have been allocated for the next five years. The cost of contraceptives for the CIP document has been estimated as per method mix at PKR 4.5 billion (US$ 821 million). The difference in the total cost of PWD documents and the CIP document is due to the fact that separate formulas have been used in both the documents. The PWD used distribution data for costing, whereas the CIP document used the method mix for costing. Since the Government of Sindh will procure the contraceptives, the cost of contraceptives calculated under the CIP has not been included in the total cost of the CIP.

An exercise was undertaken to calculate the projected cost of FP allocations by the Government of Sindh. The Health Secretary and Population Secretary were consulted for a policy decision in this regard. Detailed meetings with the Development Wing of the DOH and Finance Department were also held to calculate the FP cost of LHW, MNCH, PPHI and hospital services (tertiary, secondary, primary care health facilities).

Assumptions

The following assumptions were used in order to calculate the projected cost of FP:

- **LHW Programme:**The mandate of LHWs is to carryout activities regarding community awareness (5–7 hours each day to cover all households during one month), maternal health, nutrition, immunization, FP, minor ailments, health education and record keeping[97]. At present, LHWs spend 25 percent of their time

[95] The projected outlay does not include DOH-related financing for drug control; anti-malaria; chemical examiner & labs; EPI; administration. These allocations are PKR 10.327 billion (US$ 98,355,323) for the fiscal year 2015–2016. Source: Annual budget, Government of Sindh, 2015–2016.
[96] CIP of the Government of Uganda.
[97] PC-1 LHW Programme.

on FP[98]; however, under the FP2020 commitment it is planned to enhance their role related to FP. Therefore, in consultation with the LHW Programme and Development Wing of DOH, it was concluded that 50 percent of the allocations for LHW Programme would be dedicated for FP work.

- **MNCH Programme:** FP is one of the most important components of the MNCH Programme and CMWs under comprehensive and basic EmONC. As per the mandate as it relates to FP, the MNCH Programme provides postpartum FP, postpartum IUD, counselling and health education. The programme also conducted trainings on surgical FP methods through USAID MCH programme and UNFPA/UN agencies. Keeping that mandate in view, it has been estimated that 15 percent of MNCH allocations would be spent on FP-related activities[99].
- **PPHI:** The PPHI manages a total of 611 BHUs and 2 RHCs, except for two districts of Sindh, and is responsible for provision of curative and preventive services. The programme receives a grant in aid from the Government of Sindh on a yearly basis. The PPHI in collaboration with PWD has been providing services regarding FP methods including implants, Jadelle, IUDs insertion and other contraceptives to the clients who obtain services at BHUs and at dedicated outreach camps for FP. It has been estimated that the PPHI would spend 5 percent of its allocations on FP-related activities during the next five years[100].
- **Hospital services:** The DOH manages more than 393 tertiary hospitals, DHQs, THQ, RHCs, BHUs and other primary care facilities. These facilities are provided financing under the categories developmentandnon-development. For the purpose of this analysis, only allocations under the non-development category have been factored in. It is estimated that 2.5 percent of the allocations would be spent on FP-related activities over the next five years[101].
- **PWD:** The department manages 1,041 facilities, 1,250 social mobilizers and 4 RTIs. These facilities all provide a range of FP services/trainings. Thus, the department has the mandate regarding FP and population development. It has been concluded that the PWD would spend 100 percent of its allocations on FP and population development over the next five years[102].
- **Contraceptive procurement:** The Government of Sindh has allocated PKR 5.4 billion over the next five years for the purpose. This cost has been added into FP-related costs over the next five years.
- **CIP PC-1:** The Government of Sindh has allocated PKR 998 million for the next four years to implement CIP-related activities. This cost has been added into FP-related costs over the next five years.
- **Non-development costs:** As mentioned above, the costs related to developmentor capital cost has not been considered to calculate FP-related allocations. Only the non-development cost has been considered for the analysis which includes operations, services and salaries. In other words, these are direct (services related) and indirect (salaries and some operations) costs related to FP.
- **FP-related activities under CIP and by the Government of Sindh:** The CIP activities will be implemented by DOH, PWD and partners. The CIP activities are developed based on proven practices, new and accelerated activities. These are new as well as top-up or add-on activities in terms of interventions being undertaken by the Government of Sindh. Therefore, FP-related activities under CIP and routine FP activities under the government would not overlap or duplicate.

[98] LHW Programme and DOH (Development Wing), Government of Sindh.
[99] DOH, Development Wing, GOS
[100] Ibid.
[101] Ibid.
[102] PWD, Government of Sindh.

Financing Gap

Based on the above assumptions and available data it has been estimated that the Government of Sindh would spend PKR 52.238 billion over the next five years on FP. This includes PWD (programme activities and contraceptive procurement) = PKR 26.185 billion; government allocations for CIP = PKR 998 million; and DOH (LHW, MNCH, PPHI and hospital services) = PKR 25.054 billion. The development partners would spend PKR 10.287 billion over the next five years. The estimates for the CIP are PKR 79.120 billion over the next five years. Thus, a total amount of PKR 140.647 billion would be spent by all the above-mentioned stakeholders on FP over the next five years.

Keeping in view these figures, the financing gap is estimated at PKR 78.122 billion (US$ 767 million). The detailed estimates are provided in Tables 11.2a and 11.2b.

Table 11.2(a) | CIP Sindh GAP Analysis* (Estimates in PKR Millions)

Stakeholders and CIP	2015	2016	2017	2018	2019	Total Allocations (Projected)
Sindh Government	8,173	9,130	10,139	11,266	12,533	51,240
Development Partners	2,057	2,057	2,057	2,057	2,057	10,287
CIP	7,873	11,185	17,680	18,544	23,838	79,120
Total CIP (government, partners and CIP estimates): A	**18,104**	**22,372**	**29,876**	**31,867**	**38,428**	**140,647**
Current Allocations						
Sindh Government	8,173	9,130	10,139	11,266	12,533	51,240
Development partners	2,057	2,057	2,057	2,057	2,057	10,287
Allocation by government for CIP	250	250	250	250		998
Total current allocations: B	**10,480**	**11,437**	**12,446**	**13,573**	**14,590**	**62,525**
Financing Gap (A-B)	**7,624**	**10,935**	**17,431**	**18,295**	**23,838**	**78,122**

Table 11.2(b) | CIP Sindh GAP Analysis* (Estimates in US$ Millions)

Stakeholders and CIP	2015–16	2016–17	2017–18	2018–19	2019–20	Total Allocations (Projected)
Sindh government	80	90	100	111	123	503
Development partners (avg)	20	20	20	20	20	101
CIP	77	110	174	182	234	777
Total CIP (government, partners and CIP estimates): A	178	220	293	313	377	1,382
Current allocations						
Sindh government	80	90	100	111	123	503
Development partners (avg)	20	20	20	20	20	101

Stakeholders and CIP	2015–16	2016–17	2017–18	2018–19	2019–20	Total Allocations (Projected)
CIP allocations by Government of Sindh	2	2	2	2	-	10
Total current allocations: B	103	112	122	133	143	614
Financing gap (A-B)	75	107	171	180	234	767

*Calculation of allocations by the Government of Sindh was conducted focusing on the proportion of level of effort dedicated to FP.

Figures 11.1–11.6 below show the cost analysis as per each strategic area.

Figure 11.1 | Cost of Strategic Area 1: Functional Integration

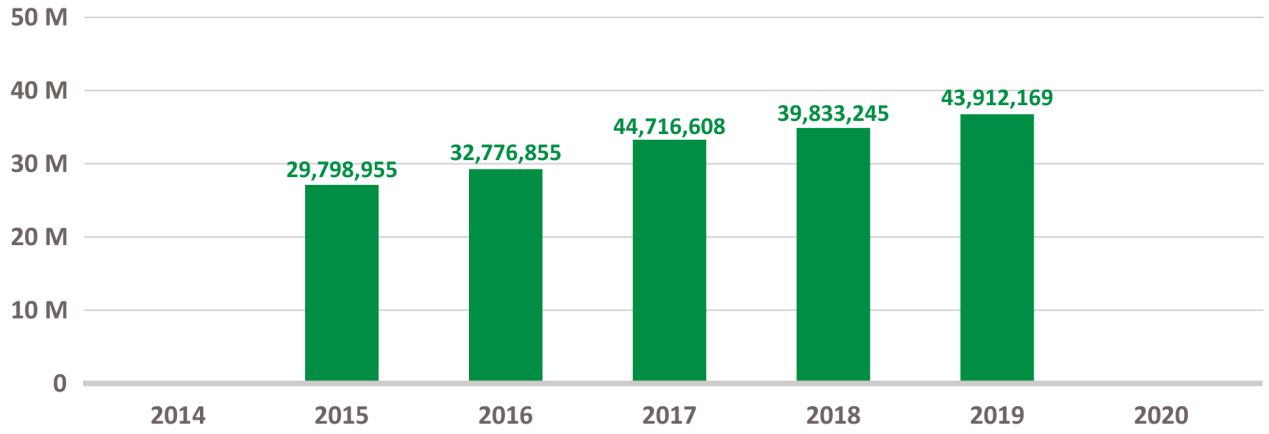


Figure 11.2 | Cost of Strategic Area 2: Quality of Care

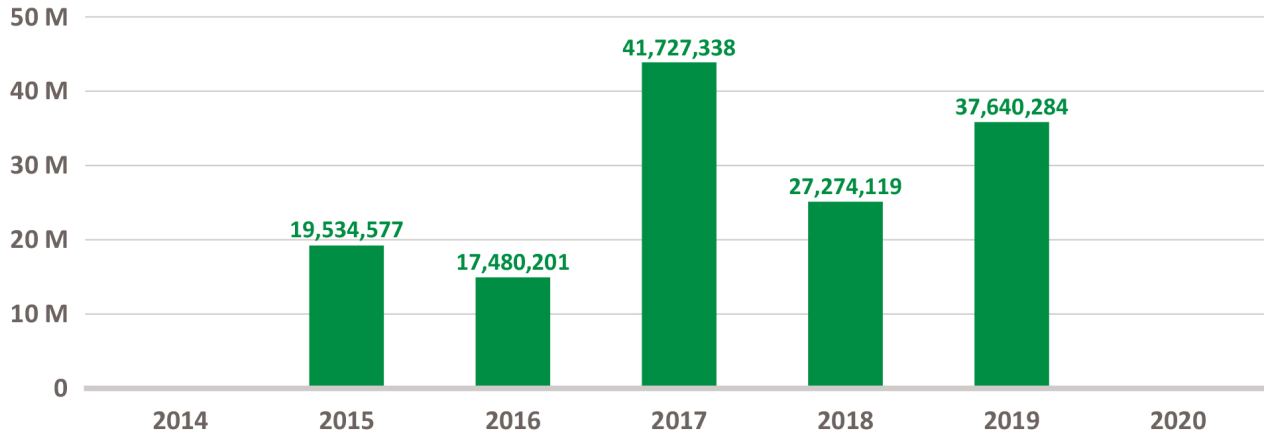


Figure 11.3 | Cost of Strategic Area 3: Supply Chain Management

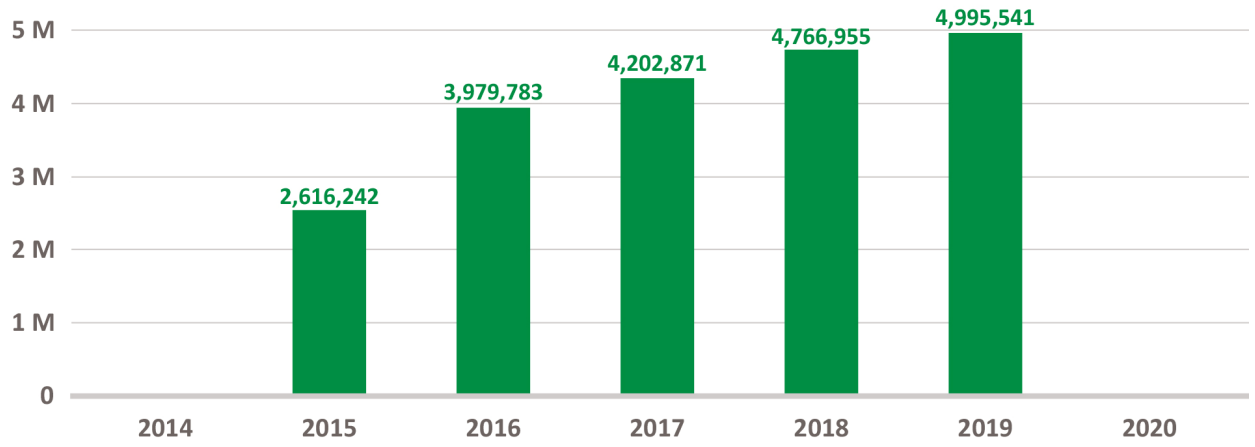


Figure 11.4 | Cost of Strategic Area 4: Expansion of Services

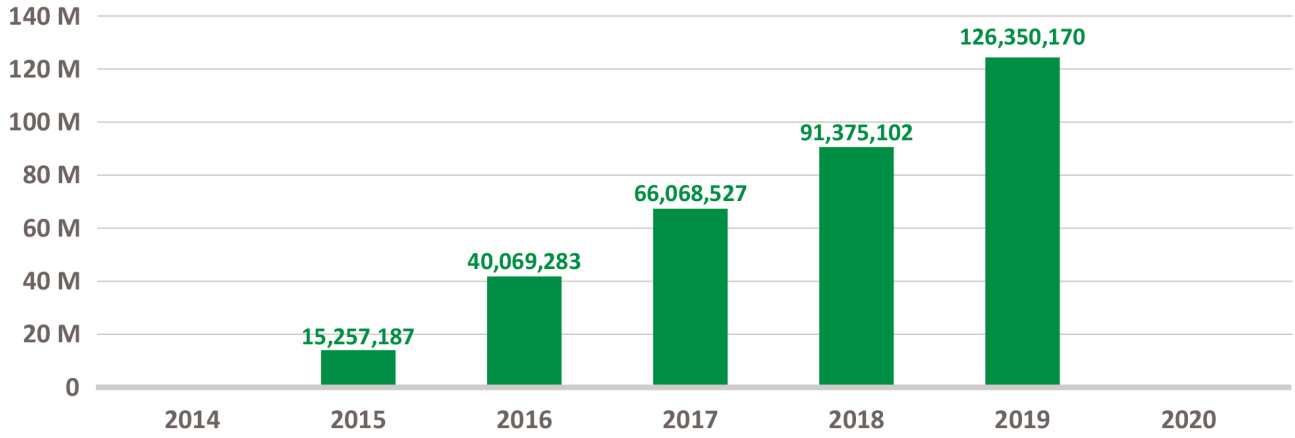


Figure 11.5 | Cost of Strategic Area 5: Knowledge and Meeting Demand

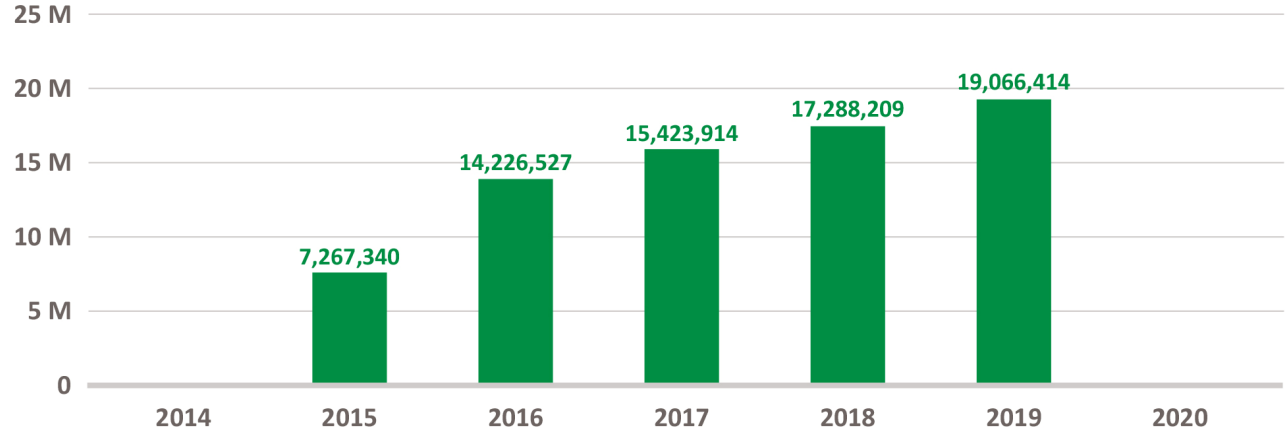
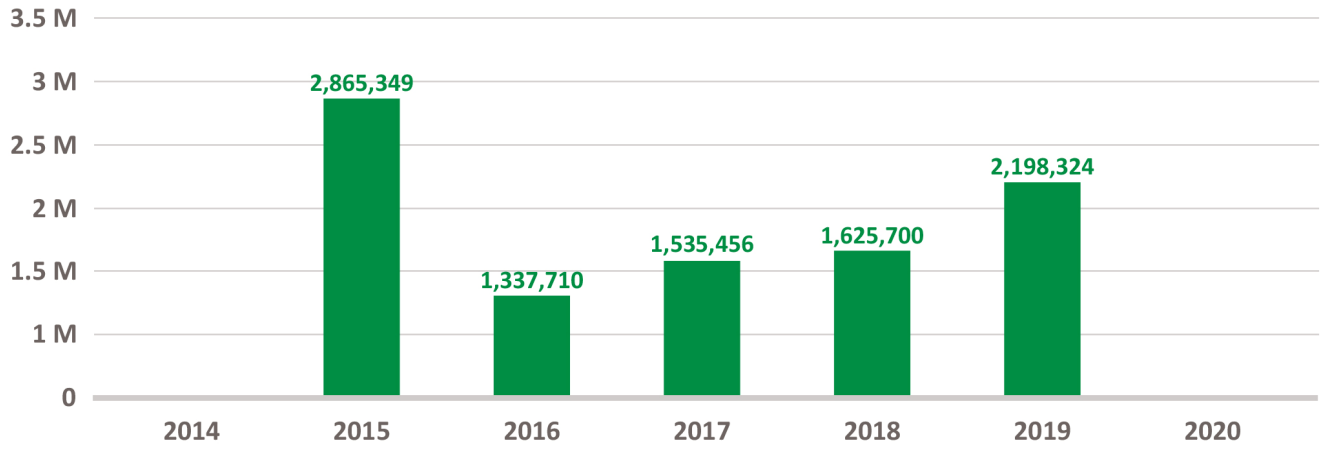


Figure 11.6 | Cost of Strategic Area 6: M&E



12 | Annexes

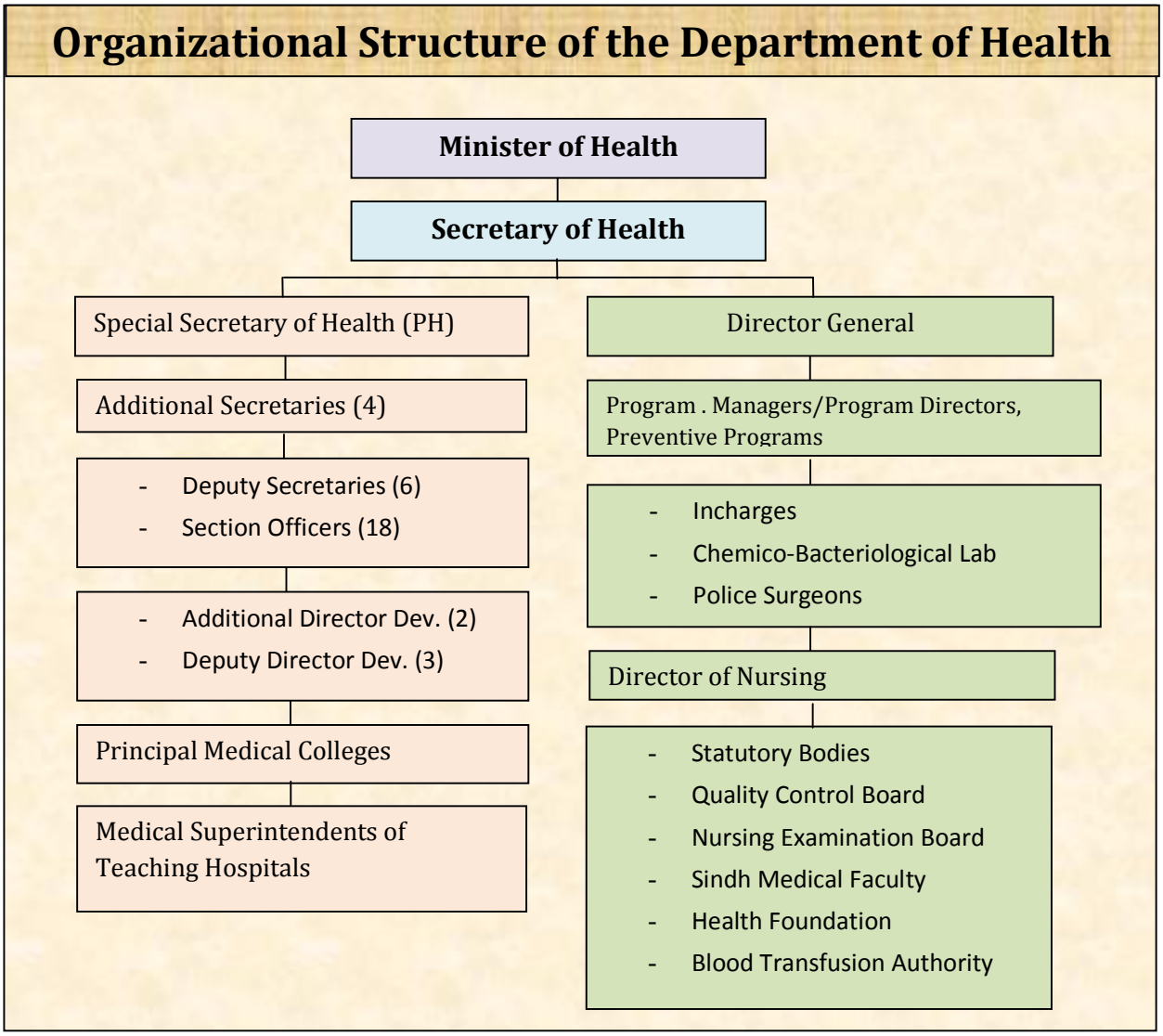
ANNEX I: Stakeholder Meetings

Public Sector		
1	Oversight and Coordination Cell for Public Health Programmes, Sindh	Dr. Azra Fazal Pechuho, Member National Assembly, Chairperson Ms. Shehnaz Wazir Ali, Provincial Coordinator
2	Population Welfare Department (PWD), Sindh	Mr. Mohammad Saleem Raza, Secretary Mr. Bashir Ahmed Mangi, Director General, PWD Syed Ashfaq Ali Shah, Additional Secretary, M&E Dr. Azmat Waseem, Additional Secretary, Medical Allah Dino Ansari, Additional Secretary, Communication, Training, Logistics and Supplies (C&TL) Syed Lakha Dino Shah, Deputy Secretary, C&TL
3	Department of Health (DOH)	Dr. Saeed Ahmed Magnejo, Secretary Dr. Hassan Murad Shah, Director General Health Dr. Khalid Shaikh, Special Secretary Dr. Mohammad Aslam Pechuho, Addition Secretary, Public Health
4	Costed Implementation Plan (CIP) Cell	Mr. Mohammad Saleem Raza, Secretary Mr. Bashir Ahmed Mangi, Director General, PWD Mr. Syed Ashfaq Ahmed Shah, Addition Secretary, M&E Dr. Azmat Waseem, Addition Secretary Allah Dino Ansari, Addition Secretary, C&TL Syed Lakha Dino Shah, Deputy Secretary, C&TL Mr. Zahid Baig, Section Officer Mr. Abdul Waheed Shaikh, PWD
5	People's Primary Healthcare Initiative (PPHI)	Dr. Riaz Memon, CEO Dr. Sattar Chandio, Public Health Specialist Dr. Zeb Dahar, Advisor, MCHIP Dr. Farah Sabeeh, Senior Technical Advisor, MCHIP
6	National Programme on Family Planning and Primary Health Care (including LHWs)	Dr. Jai Ram Das, Provincial Manager Dr. Pir Ghullam Hussain, Assistant Provincial Manager Mr. Shahid Zuberi, Accounts Officer
7	Maternal, neonatal, and child health (MNCH)	Dr. Sahib Jan Badar, Project Director Other team
8	HSRU	Dr. Nawab Mangrio, Chief HSRU
9	Regional Training Institute, Karachi	Dr. Shaheena Parveen, Principal, Regional Training Institute Najeeb Khan

10	Pakistan Medical and Dental Council	Dr. Imdad Khuskhk, Coordinator for Post-Graduate Education
11	Focus group discussion with lady health workers (LHWs), LHVs at Hyderabad, Mirpurkhas	Conducted by Dr. Ghulam Hyder Akhund in collaboration with Dr. Pir Ghullam Hussain
12	Focus group discussion with LHWs at Larkana	Conducted by Dr. Talib Lashari, Team Leader 25 LHWs from division (in collaboration with Dr. Pir Ghullam Hussain, Assistant Programme Manager and District Manager)
13	LHW Programme, Provincial Managers, Hyderabad	Dr. Talib Lashari with Senior Team of LHW led by Dr. Pir Ghulllam Hussain
14	LHVs at DHO Larkana office	Conducted by Dr. Talib Lashari with 7 LHVs
Donor/UN Agencies		
15	USAID Mission, Islamabad	Monica Villanueva (by phone)
16	United Nations Population Fund (UNFPA)	Shrutidhar Tripathi, International Programme Coordinator
17	Bill & Melinda Gates Foundation/The David and Lucille Packard Foundation	Dr. Yasmeen Sabih Qazi, Senior Policy Advisor on FP
International NGOs		
18	Pathfinder International	Dr. Tauseef Ahmed, Country Representative
19	John Snow Inc., USAID | DELIVER PROJECT	Dr. Muhammad Tariq, Country Director Inamullah Khan, Director Dr. Khurram Shehzad, Director
20	Population Council, Islamabad	Dr. Zeba Sathar, Country Director Dr. Ali Mir Dr. Gul Rashida Dr. Seemi
21	Population Services International	Jim Malster, Country Representative
22	Johns Hopkins Center for Communication Programs, Islamabad	Dr. Shuaib Khan, Chief of Party (COP) Dr. Zaeem ul Haq, Deputy COP Dr. Fatima, Social and Behaviour Change Communications Programme Manager
23	Jhpiego/Maternal and Child Health Integrated Program	Dr. Farid Midhet, Country Director/COP Kuyosh Kadrov, Deputy COP Dr. Farhana Shahid, Senior Technical Advisor

		Dr. Sohail Agha, Director, monitoring and evaluation (M&E)
24	John Snow, Inc. (JSI), Health Systems Strengthening	Dr. Nabeela Ali, COP Arshad Mahmood, Deputy COP
25	DKT International	Juan Enrique Garcia
Local NGOs		
25	HANDS	Dr. Tanveer Ahmed, CEO and team members
26	Aman Foundation	Mr. Altaf Musani Mr. Abdul Wahid
27	Marie Stopes Society	Dr. Shabnum Sarfaraz, Senior Technical Advisor/Deputy COP Dr. Shahnaz Shalwani Waqas Hameed Hassan Zaidi
28	Aahung	Dr. Sikandar Sohani
29	Greenstar Social Marketing, Pakistan	Amir Khan Zahid Memon

ANNEX II: Organizational Structure of the Department of Health



ANNEX III: Results Framework

The costed implementation plan (CIP) was developed following the *Guidance for Developing Technical Strategy for FP Costed Implementation Plan*, a resource kit prepared by FHI360 as part of the Knowledge for Health (K4Health) project, an initiative under FP2020 funded by USAID. The three main steps for developing the CIP included (1) situation analysis, (2) results formulation and (3) activity planning. The information gathered from stakeholders as part of the situation analysis was further analysed through the results framework to assess the key focus areas, causal factors and outcomes. Based on outcomes and results, the feasibility and impact was measured for prioritization. Finally, prioritized areas were identified and strategic areas were decided on. Following is the detailed results framework.

Technical Areas	Key Focus Areas / Causal Factors	Results	Impact and Feasibility
	Issues	Intermediate Outcomes	Prioritization
Policy, governance, enabling environment	1. Family planning (FP)-related programmes working in a vertical manner 2. Access: 46% of the rural areas are not covered by LHWs; uncovered areas a problem 3. Unmet need among young women (ages 15–24) for spacing is high; With unmet needs at 21%, and 51% women wanting no more births, the contraceptive prevalence rate (CPR) remains at 29.5%. A high proportion of women giving birth in Sindh are youth (8% as per Pakistan Demographic and Health Survey) 4. Side effects are a major factor for discontinuation (46%–76% for pill, IUD and injection) 5. A majority of women in Sindh are living with high-risk fertility behaviour (early pregnancy before age 18 = 20%, four or more pregnancies = 52%, too close pregnancies = 67%), enhancing the number of neonatal and under-5	1. Enhance number of users due to intersectoral collaboration 2. New village-based health workers (VBHW) recruited, replicating the HANDS Marvi workers' model 3. CPR raised to 45% as per FP2020 commitment by 2020 4. Percentage of discontinuation reduced significantly due to maintaining high-quality standards as per National Quality Standards for FP 5. Enhanced CPR; adherence to Prevention of Early Marriage Bill; and high-level awareness of healthy timing and spacing of pregnancies (HTSP) 6. Significantly increased CPR among districts with multiple deprivation (different types of deprivation, i.e., related to health, education, poverty, employment) and low-performing districts, shown through socioeconomic disaggregates and segments of population (i.e., young couples ages 15–24) 7. Contraceptive procured as per schedule set and distributed to last mile	

	mortality 6. Access: Poorest of the poor cannot afford (especially in 8 districts with multiple deprivation); young couples 7. Procurement of contraceptives requires timely completion 8. Over the period LHWs mandate for FP diluted 9. Introducing new technologies and innovations 10. Intersectoral linkages need to be established between Departments of Education, Youth, Women Development, Social Welfare, Information and related departments 11. Governance, policy, and systems strengthening reforms needed	8. Mandate of LHWs regarding FP revived and each LHW referred one case of long-acting methods in a month 9. CPR enhanced in districts with innovative approaches implemented 10. FP streamlined in all social-sector policies 11. FP uptake enhanced resulting in improved CPR due to better governance, and systems strengthening reforms at the provincial and district levels	
		Immediate Outcomes **1, 2, 3, 5, 6, 7**	
		Access of FP services enhanced due to functional integration at the subdistrict level; recruitment of VBHW; availability of services; services to poor 4: Trained staff available with quality FP services 8: Revitalized LHWs providing FP services at the door steps/homes 9, 11: Better governance, innovative and new technologies introduced that have improved effectiveness and performance of FP programmes 10. FP included in social-sector policies developed intersectoral collaboration 11. Stewardship indicators improved through Oversight and Coordination Cell for Public Health Programmes; Provincial Population	

		Council chaired by the Chief Minister; Provincial Population Coordination Committee chaired by the Chief Secretary; Provincial Technical Coordination Committee chaired by Secretary PWD strengthened	
	Causal Factors	**Outputs**	
	1–7: Horizontal coordination required; need to enhance access to quality FP services and counselling; need proper, adequate human resources trained in FP methods; lack of implementation of quality standards; lack of educated girls to be recruited as LHWs; lack of risk pooling mechanisms for poorest of the poor 11. Audiovisual van, supplies vans need maintenance, while insufficient petrol, oil and lubricants for M&E van 12. Mobile Service Units (MSU) and male mobilizers need to be fully functional	1. A model of functional integration at subdistrict level being implemented 2. A cadre of community-based health workers introduced and phased recruitments took place 3, 4, 5: Services improved in rural and remote areas to cover unmet needs, provide quality services 6. Vouchers scheme initiated in poor and underserved areas 7. Contraceptive procured and made available at subdistrict level 8. FP mandate of LHWs refocused 9. Innovative/new schemes implemented (e.g., smartphones, vouchers, outsourced transportation of commodities; injectable Sayana Press; recognition of referrals). 10. A Forum of social-sector departments on FP established 11. Policy and plan prepared on governance and systems strengthening reforms in health and population sectors -District managers capacities enhanced 17. Managers from same district with long-term posting 18. Intersectoral collaboration at subdistrict level developed 19. Coordination mechanisms at district and provincial level	1. Impact 1; Feasibility 1 (Q - A, PL - High) 2. Impact 1; feasibility 1 (Q- A, PL - High) 3–5. Impact 1, Feasibility 1 (Q-A, PL - High) 6. impact 1, feasibility 2 (Q-B, PL - Medium) 7. Impact 1, feasibility 1 (Q-A, PL - High) 8. Impact 1, feasibility 1 (Q -A , PL - High) 9. Impact 1, feasibility 1 (Q-A, PL - High) 10. Impact 1, feasibility 2 (Q B-PL - Medium) 11. Impact 1, feasibility 1 (Q , A - PL , High)

		developed (Oversight and Coordination Cell; CIP Cell; district health and population management team [DHPMT]; DTC 22. Social marketing techniques aligned with public sector service delivery 22. Corporate Social Responsibility Forum established to tap resources of corporate sector for targeted interventions like vouchers 3. National Standards of Quality in FP Services followed 7. Expansion of new facilities: Family Welfare Centres (FWCs), Reproductive Health Service (RHS) 8. Voucher schemes for poorest of the poor in selected districts and then scaled up 9. Service provider trainings conducted at Regional Training Institutes and Provincial health Development Centres (PHDCs) (e.g., on modern methods, side effects) 9. FP services made part of Essential Services Package and Minimum Service Delivery Package (MSDP) 10. Contraceptive procurement process expedited and procured during FY 2015–2016	
Service Delivery, Human Resources, Trainings	**Key Focus Areas/ Causal Factors**	**Intermediate Outcome**	
	1. Service provision to be strengthened, service delivery points with lower functioning a challenge 2. Despite high unmet needs services are underused 3. Weak supply chain management in terms of supply of contraceptives at	1–9: Family planning and reproductive health indicators improved due to enhanced and equitable access, availability and affordability of quality FP services through trained staff at static, outreach and mobile services and public-private sectors collaboration	

	subdistrict level is an issue 4. Weak outreach activities on FP due to LHWs multiple tasks etc. 5. Less focus on underserved areas, peri-urban and urban slums 6. Quality of services to be focused 7. Need to strengthen training institutes like Regional Training Institutes 8. Number, capacities of human resources, their incentives and job descriptions 9. Weak linkages between public and private partners		
		Immediate Outcomes	
		1–9: Indicators related to utilization, unmet needs, supply chain management, availability, affordability, quality of services improved	
	Causal Factors	**Output**	
	1. Due to lack of strengthening of facilities to make them properly functional 2. Due to issues of access, awareness about services, affordability; quality, acceptability and above all lack of proactive approach to reach out to clients instead of waiting for them to come to static unit 3. Due to inadequate transportation from district to facility level 4. Due to multiple tasks of LHWs; lack of motivation of Male Mobilizers; interrupted	1. MSU, FWCs, basic health units (BHUs), RHCs strengthened through timely supplies; equipment, petrol, oil and lubricants; community-based workers motivated through timely salaries; incentives; supplies FP uptake improved specially among young couples 2. All stakeholders worked in collaboration/functional integration to make services available, community-based distribution, camps, Family Planning Days, long-acting methods/method mix accessible with improved quality	1. Impact 1, feasibility 1 (Q-A, PL-High) 2. Impact 1, feasibility 1 (Q-A, PL High) 3. Impact 1, feasibility 1 (Q-A, PL High) 4. Impact 1, feasibility 2 (Q-B , PL -Medium) 5. Impact 1, feasibility 1 (Q-A, PL -High) 6. Impact 1, feasibility 1 (Q-A, PL

	supplies and material 5. Due to lack of initiatives for peri-urban and urban slums 6. Due to insufficient trainings for service providers (doctors and para medics) in counselling and methods; refreshers have not conducted for LHWs, LHVs, CMWs, FWAs. Social Male Mobilizers not functioning as per job descriptions 7. Due to bottlenecks related to trained faculty, equipment, material, incentives, lack of policy to hire faculty from market, the Regional Training Institutes are not strengthened 8.Due to lack of consensus based and trusted mechanism between public and private partners	-Strengthened referrals network - LHWs Maternal Mortality Conferences held on regular basis 3. Commodities reached at service delivery points through outsourced transportation 4. Male Mobilizers, LHWs, LHVs worked as per their mandate after revision of job descriptions of 1250 Male Mobilizers revised, LHWs focused on FP; supplies and material provided at service delivery points 5. FP services provided to peri-urban and slums through public-private partnership (PWD-HANDS-Sukh Initiative-Aman) 6. Service providers: doctors, LHWs, LHVs, trained in FP methods; job descriptions revised and refreshers conducted on counselling skills, client satisfaction, IUD/implant insertion and removal -contraceptive logistic management information system (cLMIS), forecasting and quantification, procurement (through the USAID | DELIVER PROJECT) -training need assessment on yearly basis conducted - Services of LHWs/community workers recognized through awards, incentives i.e. on referrals 7.RTIs strengthening plan implemented 8.More population covered through inducting new CMWs (currently 2000 to 6000 by 2020) 9. Partnerships built on FP with private sector such as corporate social responsibility initiatives like vouchers for remote, rural, peri-urban and slum areas initiated	High) 7. Impact 1, feasibility 1 (Q-A, PL High) 8. Impact 2, feasibility 1 (Q- C, PL - Medium) 9. Impact 1, feasibility 1 (Q-A, PL - High)

		-Newly outsourced health facilities to be aligned with FP2020 goals and CIP Sindh	
Financing	**Key focus areas/ Causal Factors**	**Intermediate Outcomes**	
	1. Adequate future funding for FP programmes in Sindh 2. Timely release of funds for salaries a challenge specially for LHW Programme 3. Financing mechanisms for underserved, marginalized population 4. Overlaps in public, private, donors and nongovernmental organizations (NGOs) financing	1–4: FP uptake and indicators improved	
		Immediate Outcomes	
		1: A clear road map in post-devolution scenario regarding financing roles and responsibilities of federal and provincial government 2: Performance of LHWs and other workers improved with timely salaries and dues 3: Improved FP services provision through financing mechanisms like vouchers 4. Streamlined services through enhanced coordination between public, private sectors, donors and NGOs	
	Causal Factors	**Outputs**	
	1. Due to limited federal funding, lack of the new National Finance Commission Award, provincial government could not prepare a plan for future funding 2. Due to non-availability of operational cost after	1. CIP provided a road map to all stakeholders in allocating future funds 2. Operational cost released in new fiscal year enabling all workers to work with motivation 3. Voucher scheme announced and	1. Impact 1, feasibility 1 (Q A, PL - High) 2. Impact 1, feasibility 1 (Q A , PL - High) 3. Impact 1, feasibility 2 (Q B, PL -

	regularization and limited federal funding, salary, mobility and medicines for LHWs kit, contraceptives not provided 3. Due to lack of risk pooling mechanisms poor, marginalized and young couples have less access to FP services 4. Due to lack of coordination mechanism	implemented 4. Framework for NGOs working	Medium) 4. Impact 1, feasibility 2 (Q B, PL , Medium)
Awareness and Advocacy	**Key Issues / Causal Factors**	**Intermediate Outcomes**	
	1. Advocacy and awareness 2. Myths and misconceptions, both on client's side as well as on services delivery side 3. Sociocultural barriers 4. Lack of awareness about facilities 5. Communication skills of providers an issue	1–5: Through effective communication, the uptake of FP increased with additional users specifically through community distribution	
		Immediate Outcomes	
		1–3: Effective communication strategy reduced level of barriers and enhanced awareness 4. More informed community about FP service delivery points 5. Communication skills of providers improved	
	Causal Factors	**Outputs**	
	1. A comprehensive and cohesive communication strategy lacks 2–3. Lack of awareness, ignorance, illiteracy, poverty 4. Communities lack information about FP services	1. Communication strategy developed 2–3. Community more aware through IPC, mid-media and mass media -Safe period during fertility made part of communication strategies	1. Impact 1, feasibility 1 (Q A, PL - High) 2–3. Impact 1, feasibility 1 (Q A, PL - High) 4. Impact 1,

	service delivery points, difficulties in access, issues of provider behaviour 5. Service providers lack skills in counselling, interpersonal communication on FP	-FP included into routine immunization campaign -Knowledge about life skills included at college, university and medical colleges level involving the Department of Education and Health Education Commission 4. Community started utilizing services -Media forum formed at provincial and district level -community-based organizations (CBOs) involved for community awareness and accountability for services provision in selected districts 5. More skilled providers offered FP services acceptable to community -FP included in Continuing Medical Education and Continuous Professional Development in collaboration with Pakistan Medical Association and Teaching Hospitals	feasibility 1 (Q A, PL - High) 5. Impact 1, feasibility 1 (Q A, PL - High)
Performance Monitoring and Accountability (PMA)	**Key Issues/Causal Factors**	**Intermediate Outcomes**	
	1. PMA is a huge challenge	1. Through better PMA governance, service, human resources indicators improved that improved FP-related indicators	
		Immediate Outcomes	
		1. Improved indicators of governance, services, human resources	
	Causal Factors	**Outputs**	
	1. Lack of cohesive, effective mechanisms for monitoring and evaluation (M&E) 2. Trained human resources, vehicles and lack of petrol, oil	1. A well-coordinated PMA/M&E Plan prepared and a Cell established for monitoring implementation of the CIP - cLMIS integrated into health and	1. Impact 1, feasibility 1 (Q A, PL - High) 2. Impact 1, feasibility 1 (Q A, PL -

	and lubricants to conduct monitoring and supportive supervision 3. A coordinated mechanism lacks regarding oversight, accountability for results 4. Feedback mechanism from district management to be strengthened such as LHWs in most cases do not get feedback from district 5. Data of stakeholders needs to be separately reported i.e. PPHI 6. Counselling data needs to be captured in the district health information system (DHIS)	population sectors M&E mechanisms and reporting rate sustained and enhanced along with trained human resources 2. Dedicated resources available for monitoring and evaluation visits 3. PMA mechanism developed at district and provincial level i.e. Oversight and Coordination Cell; CIP Cell; DHPMT; district technical committee (DTC) 4. District Management made bound to provide feedback 5. FP-related data separately reported for each stakeholder to know the contribution 6. DHIS tools revisited and counselling data revised and added	High) 3. Impact 1, feasibility 1 (Q A, PL - High) 4. Impact 1, feasibility 2 (Q B, PL Medium) 5. Impact 1, feasibility 1 (Q A, PL - High) 6. Impact 2, feasibility 1 (Q D, PL - Low)

ANNEX IV: FP2020 Core Indicators

FP2020 Core Indicators for Pakistan (adopted for CIP Sindh)	2012	2015
Indicator 1a. Contraceptive prevalence rate, modern methods		
Annual rate of change in mCPR		

Indicator 1a: mCPR-2013 disaggregation							
mCPR by wealth quintile	Lowest wealth quintile	Second wealth quintile	Middle wealth quintile	Fourth wealth quintile	Highest wealth quintile		
mCPR by residence	Urban			Rural			
mCPR by marital status	Married/union						
mCPR by education	None	Primary	Basic general	Middle/ Junior	Secondary	Professional Primary/ Middle	Higher

Indicator 1b. Percentage distribution of users by modern method of contraception	2012	2015
Pill		
Injectables		
Condom		
Lactational amenorrhea method		
IUDs		
Implants		
Female sterilization		
Male sterilization		
Standard days method		
Other modern methods *Includes emergency contraception, foam/jelly and diaphragms*		
Indicator 2. Number of additional users of modern methods of contraception	Baseline	
Indicator 3. Percentage of women with an unmet need for modern methods of contraception		

Indicator 3: Percentage of women with an unmet need, 2013 disaggregation							
	Lowest wealth quintile		Second wealth quintile	Middle wealth quintile		Fourth wealth quintile	Highest wealth quintile
Unmet need by wealth Quintile							
Unmet need by age							
Unmet need by residence	Urban			Rural			
Unmet Need by Education	None	Primary	Basic general	Middle/ JSS	Secondary	Professional Primary/ Middle	Higher

Indicator 4. Percentage of women whose demand is satisfied with a modern method of contraception	2012	2015

Indicator4: Percentage of women whose demand is satisfied, 2013 disaggregation

Demand Satisfied by Wealth Quintile	Lowest wealth quintile		Second wealth quintile	Middle wealth quintile		Fourth wealth quintile	Highest wealth quintile
Demand satisfied by age							
	Urban			Rural			
Demand satisfied by education	None	Primary	Basic general	Middle/ JSS	Secondary	Professional Primary/ Middle	Higher

Indicator 5. Annual expenditure on family planning from government domestic budget (not reported for 2012; reported for only four countries for 2013).	2012	2015
Indicator 6. Couple years of protection		
Indicator 7. Number of unintended pregnancies		
Indicator 8. Number of unintended pregnancies averted due to modern contraceptive use		
Indicator 9. Number of maternal deaths averted due to modern contraceptive use modern contraceptive use		
Indicator 10. Number of unsafe abortions averted due to use of modern contraceptive methods		
FP 2020 Core Indicators for Pakistan	**2012**	**2015**
Indicator 11. Percentage of women who were provided with information on family planning during their last visit with a health service provider		
Indicator 12. Method Information Index		
Indicator 13. Percentage of women who make family planning decisions alone or jointly with their husbands/partners		
Indicator 14. Adolescent birth rate		
Indicator 15. Percentage informed of permanence of sterilization		

ANNEX V: Facilities of Population Welfare and Health Departments

Population Welfare Department, Sindh

No.	Facility	Number
1	Family Welfare Centre (FWC)	961
2	RHS-A	70
3	Mobile Service Units	72
4	Social Male Mobilizers	1250
5	No-scalpel vasectomy	5

Source: Department of Population Welfare.

Department of Health, Sindh

Facility	(Department of Health) DOH Administered*	PPHI	Total
BHU	172	611	783
RHC	123	2	125
Dispensaries	100	370	470
MCH centres	10	29	39
Other (Unani etc.)	56	36	92
District headquarters hospital (DHQ)	18	-	18
Taluka headquarters hospital (THQ)	44	-	44
Major hospitals	27	-	27
Teaching hospitals and Institutes	9 (6+3)	-	9 (6+3)

Source: DOH; *Lately, all RHCs and some DHQs, THQs have been outsourced.

ANNEX VI: Conversion Formulae For Couple Year Of Protection[103]

144 Units of condom	=1 Couple years of protection (CYP)
15 Cycles of oral pills	=1 CYP
1 Insertion of IUDs	=3.5 CYP
5 Vials of Injection	=1 CYP
1 Case of contraceptive surgery	12.5 CYP

Contraceptive prevalence rate[104]

The contraceptive prevalence rate (CPR) is the percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception. It is usually measured for married women between the ages of 15 and 49. The CPR of Pakistan is calculated on the basis of consumption of contraceptive by converting number of units sold into users with the help of the formulae given in the following table:

Conversion formulae for users

100 Units of condom	= 1 User
13 Cycles of oral pills	= 1 User
1 Insertion of IUDs	= 1 User
5 Vials of injectables	= 1 User
1 Contraceptive surgery case	= 1 User

The number of users is divided by number of married women of reproductive age (MWRA), as per following formula:

CPR (%) = No. of Users/MWRA *100

[103]Pakistan Bureau of Statistics, *Contraceptive Performance Report 2013–2014* (Islamabad: Government of Pakistan, Pakistan Bureau of Statistics).
[104]Ibid.

ANNEX VII: FP2020: Rights and Empowerment Principles of Family Planning

Box 2: FP2020: RIGHTS AND EMPOWERMENT PRINCIPLES OF FAMILY PLANING

FP2020 Rights & Empowerment Working Group has developed principles on rights and empowerment. The fundamental right of individuals to decide, freely and for themselves, whether, when, and how many children to have is central to the vision and goals of FP2020. The international community has agreed that the right to health includes the right to control one's health and body, including sexual and reproductive freedom.

The working group has established a common understanding of rights principles as they relate to ten dimensions of family planning:

Agency and Autonomy: Individuals have the ability to decide freely the number and spacing of their children. To exercise this ability, individuals must be able to choose a contraceptive method voluntarily, free of discrimination, coercion or violence.

Availability: facilities, providers and contraceptive methods available so as to exercise full choice

Accessibility: Facilities, trained providers, and contraceptive methods are accessible without discrimination

Acceptability: facilities, providers and methods are respectful of medical ethics; sensitive to gender and life cycle requirements and confidentiality

Quality: appropriate, quality method mix, clear information, equipment and trained provider, respect for informed choice, privacy and confidentiality, client preferences

Empowerment: Individuals empowered to make decisions, can excuse through access to contraceptive information, services and supplies

Equity and non-discrimination: Quality, accessibility, and availability of information and services should not vary by non-medically indicated characteristics i.e. age, location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital or other status

Informed Choice: individuals' ability to access accurate, clear and readily understood information about a variety of contraceptives methods and their use.

Transparency and accountability: individual can access information on the design, provision, implementation and evaluation of contraceptive services, programs and policies; including government data. Individual can seek remedy when duty bearer have not fulfilled their obligations regarding information, services and supplies

Voice and Participation: Individuals/beneficiaries have ability to participate in the design, provision, implementation and evaluation of services programs and policies.

Source: FP2020: Rights & Empowerment Working Group

http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2014/12/FP2020_Statement_of_Principles_FINAL.pdf (accessed 18/06/15)

ANNEX VIII: Rural/Urban District Wise Data

Rural District Wise Data							
Serial number	District	Population	Union Councils	MWRAs	Uncovered MWRAs	LHWs	VBHWs required
1	Dadu	1,127,244	42	202,904	61,964	783	344
2	Badin	1,438,108	38	258,859	113,779	806	632
3	Ghotki	1,236,124	32	222,502	142,042	447	789
4	Hyderabad	345,802	11	62,244	62,244	0	346
5	Jaccobabad	624,232	28	112,362	44,502	377	247
6	Jamshoro	582,265	17	104,808	59,088	254	328
7	Kamber	847,090	32	152,476	38,896	631	216
8	Karachi East	487,185	12	87,693	-687	491	-4
9	Karachi South	51,873	1	9,337	8,257	6	46
10	Karachi West	151,290	3	27,232	26,512	4	147
11	Khairpur	1,441,260	52	259,427	88,787	948	493
12	Larkana	816,594	29	146,987	28,007	661	156
13	Matiari	406,821	12	73,228	8,068	362	45
14	Mirpur Khas	965,546	29	173,798	90,098	465	501
15	N. Feroz	1,150,691	39	207,124	57,904	829	322
16	Nawabshah	924,427	32	166,397	21,317	806	118
17	Sanghar	1,387,718	41	249,789	96,069	854	534
18	Sukkur	405,747	20	73,034	-4,006	428	-22
19	UmerKoat	790,631	21	142,314	68,694	409	382
20	KandhKoat	624,990	29	112,498	52,018	336	289
21	Mithi	1,162,574	40	209,263	110,083	551	612
22	Tando Allah yar	388,043	13	69,848	11,888	322	66
23	Thatta						
24	Tando M. Khan						
25	Shikarpur						
26	Central						
27	Malir						
28	Korangi						
29	Sijawal						
Total		**17,356,255**	**573**	**3,124,126**	**1,185,526**	**10,770**	**6,586**

Note: Separate data from serial number 23 to 29 not available

Urban District Wise Data							
Serial number	District	Population	Union Councils	MWRAs	Uncovered MWRAs	LHWs	VBHWs required
1	Dadu	317,563	10	57,161	-14,839	400	-82
2	Badin	321,840	8	57,931	8,611	274	48
3	Ghotki	310,557	8	55,900	17,560	213	98
4	Hyderabad	1,564,476	41	281,606	281,606	0	1,564
5	Jaccobabad	250,652	12	45,117	1,917	240	11
6	Jamshoro	384,900	11	69,282	27,342	233	152
7	Kamber	193,624	8	34,852	-6,188	228	-34
8	Karachi East	2,685,222	51	483,340	313,600	943	1,742
9	Karachi South	2,295,617	40	413,211	342,291	394	1,902
10	Karachi West	5,881,056	74	1,058,590	1,049,950	48	5,833
11	Khairpur	688,190	24	123,874	12,274	620	68
12	Larkana	544,960	17	98,093	31,853	368	177
13	Matiari	197,367	6	35,526	11,406	134	63
14	Mirpur Khas	335,695	12	60,425	-9,415	388	-52
15	N. Feroz	346,140	12	62,305	-8,075	391	-45
16	Nawabshah	488,157	19	87,868	11,728	423	65
17	Sanghar	448,004	14	80,641	24,841	310	138
18	Sukkur	495,913	26	89,264	-15,136	580	-84
19	UmerKoat	226,233	6	40,722	16,782	133	93
20	KandhKoat	84,393	4	15,191	-1,369	92	-8
21	Mithi	110,096	4	19,817	2,357	97	13
22	Tando Allah yar	212,777	7	38,300	-1,840	223	-10
23	Thatta						
24	Tando M. Khan						
25	Shikarpur						
26	Central						
27	Malir						
28	Korangi						
29	Sijawal						
Total		18,383,432	414	3,309,018	2,097,257	6,732	11,651

Note: Separate data from serial number 23 to 29 not available

ANNEX IX: District Ranking on Human Development, Pakistan Social and Living Standards Measurement Survey 2014

District	Literacy Rate	Rank	Fully Immunized Children (Recall +Record)	Rank	% Households with Flush Toilet	Rank	Overall Rank
Badin		23	64	16	21	22	20.3
Thatta		22	63	18	20	21	20.33
Jacobabad		21	57	22	26	6	16.3
Kashmore		20	70	17	36	14	17
Tharparkar		19	46	23	7	23	21.6
Shahdadakot		18	83	7	52	12	12.3
Umerkot		17	84	6	37	19	14
Ghotki		16	63	15	53	5	12
Jamshoro		15	91	5	35	16	12
Mirpurkhas		14	64	20	54	8	14
Shikarpur		13	79	8	44	9	10
Tando M Khan		12	43	19	32	20	17
Tando Allahyar		11	67	11	33	15	12.3
Matiari		10	81	9	46	17	12
Nawabshah		09	67	14	43	10	11
Larkana		08	85	4	72	3	5
Khairpur		07	73	12	33	13	10.6
Sanghar		06	58	21	42	7	11.3
Sukkur		05	71	13	61	4	7.3
Dadu		04	84	2	35	18	8
Noshahroferoz		03	62	10	43	11	8
Hyderabad		02	78	3	84	2	2.3
Karachi		01	91	1	97	1	1

ANNEX X: Sindh Child Marriage Act, 2013

The Sindh Child Marriage Restraint Act, 2013

The Sindh Assembly unanimously passed a law restraining child marriages by repealing an earlier law called Child Protection Act 1929.

Under the new law, the age of marriage has been fixed at a minimum of 18 for both males and females. The new law states that "the provisions of the Child Marriage Restraint Act, 1929, relating the Province of Sindh are hereby repealed. An offence punishable under this Act shall be cognizable, non-bailable and non-compoundable."

Under the law, in cases of underage marriage the parents, bride and groom can all be sentenced to three (3) years in prison and can be fined PKR 45,000. The Sindh Assembly is the first Assembly in the country to pass a bill of this kind.

As per the 1929 law, the age of a girl for marriage was fixed at 14 years. However, an amendment was made in 1965 fixing the age limit at 16 years. Under the 1929 law, the violator would be awarded three months maximum imprisonment and a PKR 1,000 fine.

References: 1. ActionAid Pakistan, "Child Marriage Restraint Act 2013," accessed June 14, 2015, http://www.actionaid.org/pakistan/what-we-do/womens-rights/child-marriage-restraint-act-2013.

2. Hafeez Tunio, "Singh Assembly Passes Bill Declaring Marriage Below 18 Punishable By Law," *The Express Tribune,* April 28, 2014. Accessed June 14, 2015, http://tribune.com.pk/story/701321/sindh-assembly-passes-bill-declaring-marriage-below-18-punishable-by-law/.

ANNEX XI: Proposed impact of changes in method mix and CPR

Sindh – Examining Impact of Changes in CPR and Method Mix

Changes in method mix									
Methods	**2011–12**	**2012–13**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Oral pill	1.8	1.8	1.9	2	2.2	2.5	2.7	2.9	3.1
Condoms	8	8	8.1	8.3	8.3	8.7	9.1	9.8	10.5
Injectables	3.3	3.3	3.4	3.7	3.9	4.1	4.5	4.9	5.3
IUDs	1.1	1.1	1.2	1.3	1.5	1.9	2.2	2.6	3.0
Implants	0.2	0.2	0.3	0.4	0.7	1	1.4	1.7	2
Tubal ligation	9.7	9.7	9.7	10	10.1	10.4	10.7	11.7	12.1
Vasectomy	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Others	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4
Total	**24.5**	**24.5**	**25.0**	**26.1**	**27.1**	**29**	**31.1**	**34.1**	**36.5**
				26	**27**	**29**	**31**	**34**	**36.5**

Methods	**percent users**	**percent users**	**percent users**	**percent users**	**percent users**	**percent users**	**percent users**	**percent users**	**percent users**
Oral pill	7.3	7.3	7.6	7.7	8.1	8.6	8.7	8.5	8.5
Condoms	32.7	32.7	32.4	31.8	30.6	30.0	29.3	28.7	28.8
Injectables	13.5	13.5	13.6	14.2	14.4	14.1	14.5	14.4	14.5
IUDs	4.5	4.5	4.8	5.0	5.5	6.6	7.1	7.6	8.2
Implants	0.8	0.8	1.2	1.5	2.6	3.4	4.5	5.0	5.5
Tubal ligation	39.6	39.6	38.8	38.3	37.3	35.9	34.4	34.3	33.2
Vasectomy	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3
Others	1.2	1.2	1.2	1.1	1.1	1.0	1.3	1.2	1.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

ANNEX XII: Process of Prioritization

The CIP is developed mainly following the *Guidance for Developing Technical Strategy for FP Costed Implementation Plan*, a resource kit prepared by FHI360 as part of the Knowledge for Health (K4Health) project, an initiative under FP2020. The three main steps for developing the CIP include: situation analysis, results formulation and activity planning.

The matter of prioritization of strategic areas and activities is critical. The CIP has been envisaged based on in-depth deliberations at PWD and DOH. A series of meetings was held with the programmes including PPHI, LHW and MNCH. The Oversight and Coordination Cell for Public Health Programmes, Sindh, provided continued and crucial guidance. Based on these continued deliberations, three guiding principles were set for the CIP as its fundamental approach. It was decided that to keep the cost-effectiveness and high impact as the top priority the first approach would be to build upon existing service delivery by strengthening those services. The second approach would be to add accelerated interventions based on existing services. The third approach would be to adapt innovative ideas and proven practices. There was consensus among all stakeholders on these principles during consultations held through the Oversight and Coordination Cell.

Qualitative data were gathered from 28 different stakeholders from the public and private sectors; development partners, INGOs, and NGOs. A structured questionnaire was used that was amended based on the nature of work of the particular stakeholders. The information obtained through individual and joint consultations was later analysed based on a standard CIP tool called “results framework.” (See Annex III). The prioritized activities have been reflected in the Implementation Plan.

Steps	Description	Main Conclusions and Prioritization
Situation analysis	-Information collected -Joint and individual consultations held -Evidence provided -Barriers discussed -Infrastructure of health and population described	-Trends in indicators -Use of contraceptives urban vs. rural -Reasons for discontinuation -Current use by wealth quintile (poor have less access) -Inequities regarding unmet need -Ranking of districts -Mapping of population and health sector facilities -1.2 million additional users required -Details on method mix -Barriers to service delivery; access (under-covered, underserved areas); commodity availability at facility level - Current level of financing
Results formulation	-Based on situation analysis, key issues identified	- Strategic role of provincial tier -Functional Integration of services -Refocus LHWs on FP -Underused, under-covered, and underserved areas - Quality of care/training of LHWs -Engaging youth, males -Availability of contraceptives -Accountability -Donor coordination
	Results framework (prioritization of strategic areas and interventions)	-Causal factors/ issues - Results/ intermediate outcomes

		-Immediate outcomes -Causal factors vs. outputs -Output measures for impact; feasibility; and priority level -Strategic areas prioritized as: -Functional integration -Quality/trainings -Commodities -Other strategies
Activity planning	CIP	- Measurable objectives -Strategic areas and key activities per results framework -Implementation Plan containing priority activities, costing

ANNEX XIII: Organization of Population Welfare Department