



Government of Pakistan

Birth Spacing Saves Lives

Strategy for Improving Delivery of Birth Spacing Services by The Public Health System

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1. BACKGROUND

Research in developing countries including Pakistan shows that healthy timing and spacing of pregnancies is important for the health of mothers and their children. Closely spaced pregnancies are associated with multiple adverse outcomes including the death of mothers and their newborns. Research also shows that pregnancy occurring within six months of a live birth increases the risk of induced abortion by 650 percent; risk of miscarriage by 230 percent; newborn death (<9 months) by 170 percent; maternal death by 150 percent; preterm birth by 70 percent; still birth by 60 percent; and low birth weight by 60 percent (Conde-Agudelo, et al, 2000, 2005, 2006; Da Vanzo, et al, 2004; Razzaque, et al, 2005; Rutstein, 2005). The WHO recommends an interval of 24 months from a live birth to attempting the next pregnancy in order to reduce the risk of adverse maternal, peri-natal and infant outcomes (WHO, 2006).

The Pakistan Demographic and Health Survey conducted during 2006-07 demonstrates that 1 out of 3 births are spaced less than 2 years apart. It also shows that 71 percent of currently married women have the potential for a higher-risk birth¹ with 29 percent falling into a single high-risk category and 42 percent in a multiple high-risk category. All such mothers and newborns are exposed to higher risks of adverse health outcomes. The survey also shows that unmet need for contraceptive uptake has remained persistently high. This leads to unwanted pregnancies that are often terminated through unsafe induced abortions resulting in adverse maternal outcomes. The scope for increasing contraceptive prevalence² and reducing fertility through wider access to family planning services holds huge potential for improving the chances of achieving the MDGs 4 and 5- reduce child mortality and improve maternal health.

The Ministry of Health is cognizant of the persistently high prevalence of peri-natal, infant and child mortality and maternal deaths and complications arising out of high fertility behavior in Pakistan. The high incidence of unintended and mistimed pregnancies is also resulting in almost a million abortions annually in Pakistan (Population Council, 2004). The health sector

¹ The single high-risk category includes women who are either less than 18 years of age or more than age 35 years or have a birth interval less than 24 months, or birth order greater than 3. The multiple high-risk categories include those women who have any two or more of the above characteristics.

² Currently less than a third of married women use any form of contraception. In fact, contraceptive use is merely 30% which is almost the same as it was in 2003. Further, there is a large gap between use and knowledge of birth spacing methods. Whereas 96 percent of married women know about modern methods, only 22 percent are using one.

recognizes that birth spacing is central to improving the health of mothers and their children and reducing peri-natal, infant, child and maternal mortality. The actualization of the MDGs-4 and 5 depends on reducing unacceptably high levels of unintended pregnancies and their health risks. The health system therefore, has chalked out a plan to reduce mistimed and narrowly spaced pregnancies by advocating birth spacing and providing essential services to achieve this coveted aim.

To help improve the effectiveness of a strategy to strengthen family planning/birth spacing services it is necessary to give a greater emphasis on advocating the benefits of birth spacing. As part of the strategy to save lives, the following objectives must be adopted by the MOH:

- Delay pregnancy until 24 months since the last birth
- Delay child birth until after the age of 18 years to avoid pregnancy related complications
- Avoid having children after the age of 35 to avoid pregnancy related complications

Service providers must be proactive advocates of birth spacing to their client and must provide comprehensive information on side effects of contraceptives and remove any myths and misconceptions the client may have. Further, advocacy programs must increase their focus on male involvement and promote inter-spousal discussion on birth spacing and choice of contraceptives to bring about positive behavior change.

The health system has a large structural base³ which has the potential to contribute substantially in reaching out to women in need of fertility regulating methods. The Ministry of Health at the federal level and Health Departments at the provincial level have resolved⁴ to deliver family planning services as mandated by the ECNEC in its meeting held in September 1985 and the National Population Commission, chaired by the Prime Minister, in its meeting held in July 2006. Their commitment will also contribute to meeting the huge unmet need for contraceptives that still exists in Pakistan.

³ There are more than 15,000 health service delivery outlets today which have potential for a rapid increase in services with little incremental cost.

2. PROCESS

An in-depth participatory process was followed involving both the Federal Ministry of Health and provincial health departments to define the operational plan and need for delivery of FP services by the Health System. As a first step, the DG (Health) established three task forces on Health Outreach Services, Static Health Centers, and Reproductive Health Commodities on July 30, 2009 to recommend comprehensive programmatic and operational measures that are required for improving maternal and child health outcomes and to examine the bottlenecks in the existing system at the district and provincial levels. A major concern of the group was for the Ministry and Departments of Health to deliver family planning services as a priority and integrate services with other programs while enhancing accountability at all levels. The three groups met several times and prepared their recommendations to present in a National Consultation Meeting held on September 14, 2009.

a) National Consultative Meeting

The consolidated recommendations of the task forces were presented in a briefing paper at a national consultation on September 14, 2009 (Annex-1) for the further deliberation by the Provincial DGs, Provincial Coordinators of the MNCH and the National Program for Family Planning and Primary Health care. The commitment of the Ministry of Health was enthusiastically endorsed by provincial population and health officials, including PPHI and international agencies/NGOs and there was a substantive discussion on bottlenecks faced by the different cadres. A report of the meeting is attached at Annex-2.

b) Provincial Consultative Meetings

The provincial health departments were further consulted in meetings held in Karachi for Sindh and Baluchistan (November 7 2009) and for Punjab and NWFP in Lahore (November 12 2009) to prepare provincial plans of action. Key issues at the district and provincial level for the delivery of family planning services by all tiers of the health system were also discussed.

The DG Health Services (Federal) emphasized the following key areas:

- Improved infrastructure for delivery of FP services and make it more client-friendly;
- Health officials need to be retrained and reoriented so that family planning services are considered essential services under the health service delivery package;

- The health system must have an independent guaranteed source for contraceptives and offer a full range of FP information and services.

Three working groups were constituted to focus on the following areas. They presented their recommendations after deliberation with the group members. The minutes of these provincial meetings are attached at Annex-3.

- Human Resources and Training Requirements
- Commodities Security- Availability, Storage, Distribution and Replenishment
- Accountability Mechanisms and Reporting Responsibility at the Federal, Provincial and District level

Following the initial meetings, further work was done in each province on financial estimates of training of the health staff, contraceptive requirements and accountability mechanisms.

3. PLAN OF ACTION

The purpose of this document is to outline steps to provide family planning/birth spacing services within the existing public health system in Pakistan. The document does not propose any new tasks or responsibilities for the health care providers, instead it outlines services that these providers are mandated to offer as part of their routine functions. Some major prerequisites and cross cutting issues the Health system needs to address to provide to family planning services are:

- i) Strengthen systems for obtaining Family Planning information and services in all public health care facilities at District Headquarters Hospitals (DHQs), Tehsil Headquarters Hospitals (THQs), Rural Health Centers (RHCs), Basic Health Units (BHUs) and MCH Centers. This will include a component of outreach through field workers such as Lady Health Visitors and Lady Health Workers;
- ii) Ensure delivery of quality services at all facilities through comprehensive training of health care providers, both male and female, in clinical and non clinical contraceptives techniques, counseling (Client Centered Approach) and contraceptive logistics management;
- iii) Enhance the capacity of Lady Health Workers to deliver FP services within their assigned communities through strengthening training and supply chains together with monitoring and supervision by the Lady Health Supervisors;
- iv) Develop a mechanism for procurement of all contraceptive commodities along with establishment of logistic, storage and distribution facilities to ensure an un-interrupted supply of commodities.

To move forward on the initiative of the Health department for the provision of family planning services, necessary prerequisites regarding capacity building, training, contraceptive security and monitoring and reporting systems are being finalized. Furthermore, in order to increase the CPR from that of 30 percent obtained from the PDHS, 2006-07 to 39% for the year 2013-2014, the capacity of health systems including the management issues will need to expand correspondingly.

A. Training of Health Service Providers

In the national and provincial consultative meetings the participants reiterated the need for improving the skills and capacity of static facility and community based providers in delivering family planning services. The areas that were highlighted included; providing an update on technology related to existing and new methods of contraception and enhancing interpersonal communication and counseling skills.

During the national and provincial consultations the types of trainings to be imparted, the contents, trainees, possible training venues were identified. The FALAH project has developed training packages for different cadres of the health department including LHWs and is implementing the trainings in 26 districts of Pakistan. These training resources may be used for developing the capacity of health providers at the different levels.

The training includes both Pre-service and In-Service Training.

1) Pre-Service Training

Pre-service trainings are aimed at revising the medical, nursing and paramedical curricula to strengthen the family planning component within the overall pre-service schooling syllabus. The rationale for institutionalizing the improvement in reproductive health teaching at the undergraduate level is based on an analysis carried out by the College of Physicians and Surgeons of Pakistan which showed that the curriculum is not comprehensive and does not address undergraduate reproductive health education needs.

The Ministry of Population Welfare with the support of FALAH project has already developed the syllabus for family planning for inclusion in the curricula of Medical Colleges, Nursing Schools and Public Health Schools. Once endorsed by the PMDC and the nursing council, the new curricula will be followed by the respective teaching institutions.

2. In Service Training

Based on a situation analysis on the provision of FP/Birth Spacing information and services by type of service delivery (Annex-4), and after thorough consultations with the provincial health departments and the federal Health Ministry, specific areas of training have been identified for different tiers of the health system. Five types of in-service training will be undertaken by the District Health Development Centers (DHDCs), the Public Health Schools

and Teaching Hospitals of the Health Departments. Wherever required, resource persons from the Population Welfare Programme would also be requested.

The following areas of training have been identified for specific cadres of service providers:

1. Orientation of managers on the importance of birth spacing and their role in improving access to services.
2. Client Centered Family Planning services, basic training for male doctors and paramedics
3. Client Centered Family Planning services, advance training for female doctors and paramedics
4. Competency based IUCD and implant insertion training for female doctors and LHVs
5. Voluntary surgical contraception for male and female doctors
6. Family Planning and client centered approach training for LHWs
7. Periodic refresher trainings

Training Contents:

All the trainings will have the following four generic thematic areas:

1. Counseling through Client Centered Training
2. Technical Contraceptive Technology Updates including Myths and Misconceptions
3. Government of Pakistan's Policy on Delivery of Family Planning Services
4. Islam and Birth Spacing
5. Skill Development

The degree of emphasis for each area will be adjusted according to the type of training and cadre of service providers.

Training Sites:

PHDC	Master Trainers – To be trained at the PHDC (possibly the existing FALAH trainers can be used)
Facilities (BHU's)	LHWs to be trained at the BHU
DHDC	Client Centered Family Planning Services Basic- for male providers Client Centered Family Planning Services Advance- for female providers
RHS-A Centers/RTI	Skill Based Training for IUCD and Implants for female providers
DHQ	Minilap and vasectomy trainings for selected male and female providers

a) Counseling through Client Centered Training

The training package includes sessions on how participants can raise self-awareness and recognize their roles and obligations to society, to improve their interpersonal communication skills and deal with clients with respect and dignity. The training will sensitize the providers to the influence of society in creating gender roles and explain how gender discrimination has detrimental effects on women's health. They will also be sensitized to the power dynamics within households that impact upon women's health. Furthermore, behavior formulation and its impact on service delivery will also be discussed. Participants will be taught to appreciate the importance of empowering clients through sharing information in a friendly and sympathetic atmosphere.

The training will introduce the SAHR Framework (originally developed and tested by the Population Council and now incorporated in the National Standards for Family Planning) which is an acronym for Salutation, Assessment/Ask, Help and Reassurance. The framework focuses on building rapport with clients, holistically assessing their needs, and offering help by providing a range of reproductive health options for the clients to choose from. Finally, the framework stresses providing reassurance to the client as well as referral information.

b) Technical Contraceptive Technology Update

The technical component of the training corresponds to the National Standards for Family Planning Services. This component emphasizes the concept of birth spacing as a health intervention by describing various positive health outcomes according to guidelines recommended by WHO. This concept is complemented by providing technical information on each birth spacing method. The training also provides a comprehensive overview of other family planning methods like No Scalpel Vasectomy (NSV) and minilap. The technical session

includes the following topics: Overview of available methods of contraception, including combined oral contraceptives (COCs), emergency contraception (EC), injectable contraceptives, intrauterine contraceptive devices (IUCDs), new methods such as the two rod Sino-Implant and 1 rod Implanon barrier methods such as condoms, modern natural family planning methods including fertility awareness methods such as Standard Days Methods, Lactational Amenorrhea and surgical contraception will be fully explained in terms of their mode of action, common side effects, management and eligibility criteria. Infection prevention practices will also be explained.

c) Government of Pakistan's Policy on Delivery of Family Planning Services

This component will emphasize the Government of Pakistan's policies related to family planning service delivery. During the session, following principles and values will be emphasized distinctly:

- No targets or quotas for any contraceptive method
- No denial of rights on non acceptance of birth spacing options
- No incentives for program personnel and FP acceptors
- Informed voluntary consent in case of sterilization
- Comprehensible information on method chosen is a must
- No promotion of induced abortion in any form

d) Islam and Birth spacing

This component will elaborate upon the Islamic viewpoint on birth spacing and family well-being in the light of the teachings of the Holy Quran and Sunnah as well as edicts issued by the Muslim scholars. This is necessary for helping providers and to better counter perceived religious opposition to birth spacing.

e) Skill Development

The competency based skill development trainings such as IUCD, minilap and NSV will put emphasis on gaining practical hands on experience in actual clinical settings.

f) Orientation of Managers

Orientation of managers on linkage of birth spacing and health outcomes, leadership concepts to think strategically and innovatively, improved monitoring and supportive supervision and fostering linkages and coordination mechanisms.

B. Contraceptive Security

(Availability, Storage, Distribution and Replenishment)

Currently, Executive District Officers (Health) procure contraceptive supplies from the DPWOs of Ministry of Population Welfare to provide to the Health Departments' service delivery outlets, such as, BHUs, RHCs, MCH centers etc. The DPWO has the responsibility to requisition contraceptives for the EDO on his request from the Central Warehouse and Supplies (CW & S), Karachi. It is then the responsibility of the EDO Health to dispatch these contraceptives to the service delivery outlets of DoH. Presently in most instances this system is not functioning optimally.

The Lady Health Worker's program procures contraceptives from their own budget with the assistance of UNFPA similar to the MoPW⁵. The contraceptives are stored in the MoPW's CW&S, Karachi. The LHW program employs a vertical distribution system, transferring contraceptives from the MoPW's central warehouse to Provincial Project Implementation Units (PPIU) stores, Basic Health Units, and to LHWs located at the village level.

While cooperation does exist between the MOPW and LHW's program at the national level for receiving, storing and distributing contraceptives to the PPIUs, there is room to improve the logistics system at the district level. In particular, the supply of contraceptives to health facilities by the MoPW and corresponding reporting back to MoPW does not work properly.

The objective of a logistics system is to ensure timely and uninterrupted flow of contraceptives to all service outlets and distribution points. The system aims to provide continuous availability of supplies and services to those who need them. To make all contraceptive methods available at all the service delivery outlets of public health sectors, the unanimous recommendation in both the provincial consultative meetings was that contraceptives should be included in the essential drug list and a new procurement process can be introduced.

Logistics begins with the accurate forecasting and timely procurement of contraceptive methods and ultimately includes delivery of supplies and services to the clients. In addition, there are some logistics support functions of extensive magnitude, i.e. recording, reporting,

⁵ The Population Welfare Program currently procures contraceptives through the assistance of UNFPA and receives contraceptive consignments at the MoPW Central Warehouse & Supplies (CW&S) in Karachi.

accountability, monitoring and supervision, which are essential to ensure that the primary logistics functions are carried out on a timely and efficient basis.

The primary and support activities of a contraceptives logistics management system are as follows:

- a) Contraceptive Forecasting
- b) Procurement of Contraceptives
- c) Warehousing and Storage
- d) Distribution of Contraceptives to Health Facilities

a) Contraceptive Forecasting

Contraceptive forecasting is the first step for any family planning program. Provincial meetings discussed forecasting and means of estimating the quantity of commodities needed to serve their provinces. During the provincial meetings it was proposed that contraceptive forecasting should be carried out at the district level. The four government departments providing family planning services at the district level (LHW program, Population Welfare Department, Peoples Primary Health Care Initiative (PPHI) for the BHUs run by them and the Health Department for all their other outlets should be involved. Two out of the four partners, the Population Welfare department and the LHWs program already provide family planning services at the district level. Therefore, to meet the contraceptive needs of all the married couples in a district, contraceptive forecasting will be carried out at the district level on the basis of available data from the district level surveys or the provincial level CPR obtained from the Pakistan Demographic and Health Survey (PDHS), 2006-7 with the reported contraceptive mix.

To implement the recommendation of the provincial consultative meetings, a four member contraceptive forecasting committee would be formed consisting of a DPWO, the district coordinator of LHW program, the representative of the PPHI and EDO-Health as the chair. The committee members would be trained in contraceptive forecasting techniques and dynamics of the contraceptive mix. The provincial level requirements would be the sum of the district level requirements.

The provincial level contraceptives requirement reflected in this paper have been estimated on the basis of the provincial CPR and the respective contraceptive mix obtained from the

PDHS, 2006-7. Based on current unit costs and aiming at the eventual target of around 39 percent CPR, the 5 year budget for commodities alone has been estimated to be around US\$ 111 million for the country for all partners. However, the cost of contraceptives for the health sector is around US\$ 46 million.

b) Contraceptive Procurement

Procurement means the whole process of acquiring goods and services from a third party which includes purchasing, transporting and delivering at the destination to meet the requirements of an organization.

Principles of Procurement:

- The procurement shall be conducted in a fair and transparent manner;
- The object of procurement brings value for money;
- The procurement process shall be efficient and competitive.

During the provincial level meetings, it was proposed that contraceptive procurement should take place both at the provincial or district level following the provincial procurement policy. Locally manufactured contraceptives such as oral pills and injectables may be procured at the district or provincial level based on the provincial health department procurement policy, whereas condoms and IUDs which are imported and bought from the international market may be procured according to the national/provincial procurement policy.

All the procurements should be undertaken by a designated committee; therefore, all the members of the procurement committee at the district/provincial/national level will also be trained on procurement procedures.

A detailed Contraceptives Procurement Manual will be developed for each province.

c) Contraceptive Warehousing/Storage

The guidelines for proper storage will be prepared to maintain an uninterrupted contraceptives supply to the clients.

Warehouses should be specifically designed or used for the storage of large quantities of commodities, whereas a “store” is a room which may be a part of building used for other purposes. The type, location, and size of warehouses/stores within the logistics system, all

play vital roles in meeting goals and requirements. Currently there are no such warehousing facilities available for the provincial health departments at the provincial level. Therefore, warehouses for the storage of required contraceptive quantities may be established at the provincial level to ensure safety of stocks and timely delivery of commodities.

Although there are storage facilities available at the district level, these are inadequate and in poor condition. In the consultative meetings, it was proposed that two years stock at the provincial warehouses and at least 6 months stock of each type of contraceptive should be maintained at the district level stores. Keeping in view the volume of the required quantities of these contraceptives, and the available storage capacity at the district level, existing facilities will have to be upgraded to house the required stocks. The concerned staff will be trained on the warehousing/storage procedures at the district/ provincial/national levels.

d) Distribution and Replenishment of Contraceptives

A logistics information system will be put in place to ensure an uninterrupted supply of contraceptives to clients. This will also ensure that there are no stock outs and no expired contraceptives on the shelf.

After the forecasting needs and initiating procurement requests are made, supply imbalances may still occur. Therefore, it will be essential for the provincial procurement committee to continually monitor the supply situation in the country and if necessary, reassess country needs and reschedule the delivery of order supplies. To maintain the desired surveillance over the country supply situation, the committee will maintain a Country/Provincial contraceptive Stock Position status for each contraceptive method. This will indicate the numbers of month stock in the provincial warehouse.

e) Instruments and Equipment for Provision of FP Services

Inventory assessment is essential in order to understand the magnitude of deficiency of equipment and instrument at each health facility. It is understood that all health facilities have some shortage of equipment and instruments to deliver a range of FP services. Therefore it is envisaged that all health facilities may be provided essential items such as IUCD insertion and removal kits, IUCD insertion table, Minilaparotomy kit and vasectomy kit (only DHQ Hospitals). These items will be provided as the service providers become available to deliver the particular method/s.

f) Capacity Development in Contraceptive Security

Training of specific staff engaged in contraceptive procurement will be carried out in the following areas at the DHDC's.

- Contraceptive forecasting techniques
- Data recording, reporting and feedback system.

C. Monitoring and Reporting System

(Accountability Mechanisms and Reporting Responsibility at the Federal, Provincial and District level)

Issues related to ensuring accountability and monitoring of the delivery of FP services through the health sector are major concerns for the provincial health departments. No new system needs to be developed for recording and reporting purposes as both the HMIS and DHIS systems report the progress on family planning activities from the facility level to the district level. The LHWs program also has a MIS to report the HR and their progress every month. However, an official would be designated to be responsible at the district level to ensure that the progress is reported by all health facilities every month and submit the consolidated report to EDO, Health. Innovative and pragmatic methodologies would be developed to lend credence to the current systems of monitoring.

a) Quality of Data

There are large gaps and inconsistencies in the family planning data reported by the facilities. One of the reasons for this discrepancy is that some districts are using the HMIS system and others the DHIS. Further, in the HMIS, DHQs and THQs are not reporting their progress to EDO, Health. Since they also provide Family Planning services, the lack of data from DHQs/THQs again represents a large gap in the data available to the EDO Health.

There is a gradual move from the current HMIS system to the DHIS which once fully introduced will help bring about a level of uniformity. A dedicated officer (Statistical Officer), at the district level, should be given the responsibility of collecting monthly progress reports from all the health facilities including LHWs program and present it to EDO, Health at the end of each month. The information will be used for improved decision making.

b) Data Reporting

The BHUs of majority of districts are run by the PPHI. Under the new system, all the PPHI representatives should submit their monthly progress reports to the EDO, Health who will make sure that all the FP activities are collated for further analysis. The progress reports will then be shared with District Health and Population Management Team (DHPMT) headed by the DCO.

All those who generate data will be trained on data recording, reporting and feedback system. Data reported would also be randomly validated, so that the quality of reported data is maintained.

c) Monitoring

There is still a need for monitoring and feedback regarding the quality of the data collected through the routine reporting system. At the district level, a EDO, health should be responsible for monitoring the quality of reported data. Similarly, at the provincial level, Director Public Health will be responsible for receiving the data and providing a critical analysis of the trends. The incumbent in turn would report to the office of the provincial DG (Health Services). Finally, the provincial progress reports on family planning/birth spacing would be submitted to Federal DG (Health Services). Following this, feedback will also be provided from the federal to the provincial level. The province will provide feedback to the district which will finally communicate with the service providers for the improvement of services.

d) Data Validation

The monthly reports submitted by the facility will be validated by the district level managers. The data will also be validated by a third party evaluation mechanism that includes special surveys. The national and provincial systems will use the analysis to obtain an assessment of the program annually.

e) Accountability

To ensure accountability, there should be a focal person at each level of the health system. At the federal level, Director General, Health Services to be overall responsible for ensuring family planning services at the national level. DDG (PHC) should be the focal person to ensure family planning activities are being carried out and the consolidated report submitted to the DG, Health Services.

Similarly, at the provincial level, the DG (Health Services), should have overall responsibility for evaluating the FP performance with the support of the Director RH who should be the focal person for consolidating the progress on Family planning activities.

At the district level, EDO (Health) will be ultimately accountable for all outcomes related to family planning service delivery by PPHI, LHWs and Health outlets. At each tier of the health system the reported information will be utilized for assessing accomplishments identifying weaknesses providing necessary feedback to the relevant staff.

D. Financial Estimates

Overall Summary of Financial Estimates for FP Activities in the Four Provinces, 2009-14

Activity	Punjab	Sindh	NWFP	Balochistan	Total in Pak Rupees	US \$
Trainings of Service Providers	216,140,523	92,893,760	110,425,245	61,437,208	480,896,735	6,011,209
Warehousing and Storage	821,000,000	437,000,000	251,000,000	101,150,000	1,610,150,000	20,126,875
Contraceptives requirement for DoH and LHW	1,978,899,000	932,930,000	582,582,000	177,091,000	3,671,503,000	45,894,000
Total	3,016,039,523	1,462,823,760	944,007,245	339,678,208	5,762,549,735	72,032,084

a) Summary Table of Training of Male and Female Service Providers, 2009-14

Activity	Punjab	Sindh	NWFP	Balochistan	Total Cost in Pak Rupees	US \$
Basic FP Training including CCA: (Male Doctors/Male Paramedics)	76,660,245	37,322,535	55,178,505	28,376,400	197,537,685	2,469,221
Advance FP Training including CCA: (Female Doctors/Male Paramedics)	32,240,805	16,146,870	12,924,375	11,217,495	72,529,545	906,619
IUD Skills Training: (Male Doctors/Female Paramedics)	13,393,448	5,034,630	8,285,265	4,796,963	31,510,305	393,879
CCA and FP-Birth spacing: Lady Health Workers -LHWs	56,694,100	19,505,400	17,575,000	6,068,600	99,843,100	1,248,039
Minilab and vasectomy (Male and female doctors and theater nurse)	27,478,800	9,294,300	8,351,400	6,061,500	51,186,000	639,825
Logistics and MIS Training: Managers and staff	4,165,125	1,318,775	3,648,200	326,250	9,458,350	118,229
Orientation of Managers	5,508,000	4,271,250	4,462,500	4,590,000	18,831,750	235,397
Total	216,140,523	92,893,760	110,425,245	61,437,208	480,896,735	6,011,209
Cost in US \$	2,701,757	1,161,172	1,380,316	767,965	6,011,209	

b) Summary Table of Warehousing and Storage at the District and Facility Level, 2009-14

Figure in Thousands

Activity	Punjab	Sindh	NWFP	Balochistan	Total Cost in Pak Rupees	US \$
Enhancing the Warehousing capacity at provincial level	490,000*	260,000	150,000	55,000	955,000	11,938
Enhancing the Warehousing capacity at district level	286,000	152,000	86,000	33,000	557,000	6,963
Enhancing the Warehousing capacity at facility level (one cabinet for each facility)	45,000	25,000	15,000	13,150	98,150	1,227
Total for Warehousing and storage at Provincial, district and facility level	821,000	437,000	251,000	101,150	1,610,150	20,127
Cost in US \$	10,263	5,463	3,138	1,264	20,127	

Based on PC-1 already prepared by the DoH Punjab

c) Total Contraceptives Cost by Province for the Period 2009-2014, All Programs including Private Sector

Figure in Thousands

Contraceptive Method	Punjab	Sindh	NWFP	Balochistan	Total Cost
Condom	2,409,179	1,152,917	519,077	150,591	4,231,763
Oral Pill	637,995	393,481	265,898	83,637	1,381,011
Injectable	1,635,600	693,640	567,050	174,409	3,070,698
IUD	123,462	27,170	17,220	6,083	173,936
Total Contraceptive Cost in Pak. Rupees	4,806,236	2,267,208	1,369,245	414,720	8,857,409
Total Contraceptive Cost in US \$	60,078	28,340	17,116	5,184	110,718

d) Total Contraceptives Cost by Province for the Period 2009-2014, DoH and LHWs Program

Figure in Thousands

Contraceptive Method	Punjab	Sindh	NWFP	Balochistan	Total Cost
Condom	867,304	415,050	186,868	54,213	1,523,435
Oral Pill	293,478	181,001	122,313	38,473	635,265
Injectable	768,732	326,011	266,513	81,972	1,443,228
IUD	49,385	10,868	6,888	2,433	69,574
Total Contraceptive Cost in Pak. Rupees	1,978,899	932,930	582,582	177,091	3,671,503
Total Contraceptive Cost in US \$	24,736	11,662	7,282	2,214	45,894

It includes an additional quantity for 12 months stock building

Annex-1: Briefing Paper for the National Consultation

Briefing Paper on Task force on Coordination of Ministry of Health and Population Welfare Reproductive Health Activities (Presented at the meeting on September 14, 2009).

Background

Pakistan has until 2015 to fulfill its commitment to providing complete RH services to the population as part of achieving MDG 5. Thus there is a strong resolution on the part of both arms of the Government of Pakistan, the Ministry of Health and Ministry of Population Welfare to provide reproductive health services and to coordinate their efforts for the best possible results. There is a renewed commitment on the part of the Ministry of Health to fulfill its commitment of delivering family planning services. The MoPW is already delivering services and is totally prepared to offer its training centers to the maximum of their capacity to help train LHW Master trainers, LHVs of BHUs; and for RHS and FWC centers to extend services to integrate with antenatal and postnatal care of DoH; extend mobilization activities to men through its male mobilizers; and to play its full lead role in ensuring contraceptive commodity security.

Three sub groups were set up on Health Outreach services, Static Health Centers, and Reproductive Health commodity security at the direction of the D.G. (Health) in a meeting held on July 30, 2009 (Annex 1) at the Pakistan Medical Research Council (PMRC) building to make recommendations for implementation of the Memorandum of Understanding (MoU) signed by the two ministries on February 14, 2008 (attached as Annex 2). The Director General in his opening remarks stated that there was a strong need to move on this front; that there was sufficient collective knowledge and wisdom about how to do so; and that he wanted a quick turnaround and feedback from the groups. In this spirit, the three groups have held their meetings and a joint meeting as well.

This paper attempts to consolidate the recommendations for further consideration of the Provincial DGs, Provincial Coordinators of the MNCH and the National Program for Family Planning and Primary Health care on September 14, 2009. Many of the recommendations involve policy shifts and particularly assignment of roles and responsibilities that require the involvement, endorsement and authority of provincial departments. This brief provides a background to the group work, described in more detail in the meeting minutes of the three groups (Circulated separately). The purpose of the groups was to find solutions to existing bottlenecks in the delivery of family planning services by the two main ministries that have

responsibility for the task, i.e. the Ministries of Health and Population Welfare. The groups focused their discussions on recommendations that would improve implementation at the district and provincial levels.

A major concern of the group was for the Ministry and Departments of Health to deliver family planning services as a priority and integrate services with other programs while enhancing accountability at all levels. This will be ensured by assigning family planning a higher priority at all levels through a clear directive from the Federal to the district level. This would ensure that systems work within their respective mandates.

Lady Health Workers (LHWs) are the main outreach mechanism and already mandated to provide family planning advice; supplies of condoms and pills, second and onward doses of injectables and referrals for clinical methods and further counseling. In the coming two years they are going to make family planning the highest priority, consolidate their work and are planning for not going into expansion. In this regard the recommendations of the group emanated from concerns about the consolidation, and highest priority being laid on family planning in the program. The male mobilizers of the MoPW are providing mobilization and the MSUs and FWC staff are providing outreach family planning services. Efforts will be made to coordinate the working of all outreach providers from both sectors.

The Department of Health and its outlets have the responsibility of securing contraceptives and their distribution; of training and overall coordination and mobilization. Family planning is an essential part of the mandate of the MNCH Program. The greatest challenge is to improve the functioning of the DoH in delivering family planning services through its static hospitals and outlets particularly RHCs and BHUs and to ensure that Lady Health Workers receive the full support for their family planning activities.

A summary of the consolidated list of recommendations follows:

General:

Policy

- Departments of Health should declare that they will ensure the provision of family planning services including contraceptives commodities through all their health facilities.
- The MoPW and PWDs should declare that they will ensure improved coordination of services between the two Ministries and Departments of Health and Population. In

- particular, coordination between two Ministries/departments at the district and provincial level will be strengthened.
- A dialogue needs to be initiated at the Federal and Provincial Levels to sort out the issue of PPHI, which has acquired majority of the BHU in the provinces and must cooperate with other programs for imparting trainings to the health care providers posted at the BHUs.
 - The different actors working in the health sector and all other partners should be taken on board for evolving a FP comprehensive strategy. The role of the development partners e.g. FALAH, White Ribbon Alliance (WRA), UNFPA, PAIMAN, DELIVER and DFID needs to be clarified.
 - Concrete areas where coordination is required are: Training, Mobilization, and Contraceptive Procurement and logistics.
 - All new expansion of services-whether by MoH or MoPW should ensure (using all available evidence; including GIS mapping of RH services) that the new service caters to un-served areas where there is no equivalent services within a 3 km vicinity.
 - The RHCS policy should be incorporated in the overall Health policy. The National Strategic Plan for RHCS should be devised involving all key stakeholders in order to meet the commodity requirements for addressing the unmet need in family planning
 - Financing mechanisms at the national level should facilitate more flexible and predictable financing and enables efficient procurement of contraceptives.
 - Contraceptive Forecasting should involve all the major players in the field of family planning and RH services and joint efforts should be made for resource allocation according to the size, capacity and performance of the Programme.

Responsibility and Accountability:

- District Health and Population Management teams (DHPMTs) can and must play an important role for *policy decisions and programmatic directions* between the two departments at the district level.
- DTCs⁶ should be the *vital organ for implementation of decisions* regarding family planning service logistics, and mobilization; MSU visits, location of services; and other

⁶ DISTRICT TECHNICAL COMMITTEE (DTC) is recommended as the key focal forum, where all the issues of Coordination/ Integration of Health and Population Welfare could be discussed. The DTC is chaired by EDO (Health) and DPWO is the member/ secretary of the committee. It may have representation of all the stakeholders offering Reproductive Health and Family Planning Services like District Coordinators of LHWs and MNCH Program, PPHI, NRSP, NGOs etc. DTC is considered as the vital organ for implementation of decisions regarding Family Planning Services. Contraceptive prevalence rate or some measure of family planning as one of the monitoring indicators to be reported by the EDO (H) to the provincial office. DTC should hold at

issues of coordination. The MoH needs to notify and amplify their duties and ensure regularity of meetings.

- The Department of Health *should have responsibility for the provision of Family Planning services from all health outlets i n the provinces and districts* and in particular, the Departments of Health must ensure the provision of Family Planning Services at all the Basic and Rural Health Centers.
- The *Population Welfare Departments should primarily have responsibility on issues related with availability, accessibility of contraceptives as well as coordination with DoH of training and mobilization activities*
- **At the federal level** the DDG Health (PHC) should be the focal person to ensure family planning activities are being carried out and report back progress to the DG. Health
- **At the provincial level**, the Director MCH should be the responsible focal person for family planning.
- **At the district level**, EDO (Health) will be ultimately accountable for all outcomes related to family planning service delivery.
- The District Public Health specialist should be nominated as the responsible person at the district level to ensure smooth coordination especially supply of contraceptives to the health facilities of DoH. Their TORs should be amended accordingly.
- The District Population Welfare officer should be responsible for the outlets and services of the PWD
- The District Coordinator of the National Program of FP&PHC should be responsible for the contraceptive availability and family planning service delivery by the LHWs.

Training and Mobilization

- Family Planning must be inducted more effectively in all pre-service trainings of health care providers.
- The RTIs will be utilized for enhancing the family planning skills including counseling of the health care providers particularly LHVs and Lady Doctors of the DoH.
- Refresher trainings of LHWs as well as Master trainers of National Program will be supported by MoPW
- Technical support for monitoring of step down refresher trainings on Family Planning will be provided by the MOPW

least one meeting in each quarter to sort out issues of contraceptive logistics, training of service providers on family planning, location of service outlets etc. Other issues of coordination could also be tabled in this forum.

- MSU camps will be organized in coordination with the District Coordinator of the National Programme. LHWs will refer clients to this camp and MSU camps will include LHWs referrals as a separate entity in their reports.
- RHS “A” Centers will hold monthly meeting of Hospital Management Committee and ensure that they provide FP counseling and services to antenatal/ post-natal OPDs of the Hospital.
- Family Welfare Counselors/ Workers of RHS “A” Centre will visit Gynae OPD regularly and a short-circuit TV (CCTV) would run videos in the waiting room on Health and Reproductive Health issues to integrate ANC and PNC services with family planning advice and counseling.

Contraceptive Security and logistics

- EDOs will fulfill his/her role of procuring contraceptives for the district
- Contraceptives should be included in the essential drug list of the Ministry of Health
- Existing contraceptives pricing policy which is causing hindrances in smooth supply of contraceptives –should be made uniform.
- The Social Marketing Program should be given due importance while making resource allocation by donors and government -Government should continue to make budget allocations for Social Marketing through MTDF.

Group 1 Specific Recommendation:

1. Family planning will be the major focus of refresher trainings of the National programme. A three day refresher training of all LHWs will be organized by the National programme in collaboration with MOPW comprising both, theoretical knowledge as well as enhancing practical skills such as counseling and contraceptive updates. These refresher trainings of LHWs as well as Master trainers of National Program will be supported by MoPW. Technical support for monitoring of step down refresher trainings on Family Planning only will be provided by the MOPW. Monitoring of trainings subcontracted to private sector may be considered.
2. Linkages with the DoH outlets have to be strengthened further
3. RHS (A) and RHS (B) to provide family planning counseling and services to OPD ANC clinics and post natal clinics. Short circuit TV to air educational videos in the waiting room.
4. RHCs and BHUs must deliver family planning services especially the ones with which LHW are linked.

5. Role of PPHI at the BHUs needs to be clarified.

Group 2 Specific Recommendations:

6. Focal points that are responsible for ensuring family planning commodities in place at the health facilities are required at the district level. The same person can make periodic assessments of the competencies of the Health Care Providers (HCP).
7. The District Public Health Specialist of the MNCH Program should be made responsible for the FP commodities and trainings for the static health facilities while the District Coordinator of the LHW Program can be assigned the responsibility of the community aspect of provision of FP Services.
8. Trainings of the HCP are the joint responsibility of the MoPW and the National Maternal, Neonatal and Child Health program.
9. The lack of warehouses is an issue both at the provincial and district level and in order to resolve this fundamental problem MoPW should ensure availability of warehouses for contraceptives, both at the provincial and district level.
10. Timely requisition for contraceptives to be made by the District health offices.

Group 3 Specific Recommendations:

11. The Health and Population Ministries should advocate for improving RH commodity security by engaging the support of Parliamentarians, Senior Policy Makers and Media Professionals.
12. Feasibility studies should be conducted for establishing condom and IUD/Cu-T manufacturing units in Pakistan. Testing laboratory to test locally produced contraceptives also needs to be established.
13. Contraceptives Logistics Management Systems must be further strengthened by improving logistics management information system. Important areas like warehousing, distribution/transportation and capacity building of relevant staff should continue to be addressed appropriately both by the government and donors.
14. Adequate storage facilities must be expanded from the Central Warehouse, Karachi to provide purpose built storage facilities at Provincial and District levels.

Annex-2: Report of the National Consultation

Report of the National Consultation on Birth Spacing, Islamabad, September 14th, 2009

In the meeting held on the 14th of September, 2009, the findings from the 3 task forces were discussed and the discussions were held on the following issues:

Policy

1. The MoH will take the responsibility for contraception and Birth Spacing and ensure the availability of supplies and personnel. This will be done in coordination between PWD and DoH at provincial and district levels (which are primarily responsible for implementation).
2. A national FP policy must be developed to chart out the role of all relevant partners. The policy will be consistent with the overall health policy of Pakistan. The policy will also ensure that the provision of FP funds should be part of routine budgets of government, with donors filling in occasional gaps. The audience expressed some concerns about the success of such a policy since the previous population policy has not been successful in addressing some of these issues.
3. Full coverage may be ensured via MoPW and MoH outlets. It is not clear how this is to be addressed since few people access these outlets (particularly the former), but it was agreed at least those who come to these outlets must be given or offered services.
4. The audience described that although there is a RH coordinator at districts, currently this person may have multiple responsibilities. There is a need for definition of an organizational structure to be established to ensure accountability of the FP services delivery
5. As commodities and services may be (and are) supplied through diverse means (MoPW, MoH, NGOs, development partners etc), there should be a central and common mechanism to track these and identify the gaps

Responsibility and Accountability

6. It is recognized that the main implementation of FP is at the district levels thus coordination must also be from the district level and cover the issues of supplies and services.

7. The system would work best with the organizational set up with a coordination person at each of the federal, provincial and district level who has full time responsibilities for these services. Planning, oversight and overall technical direction is the responsibility of the District Technical Committees which will make implementation decisions about FP including training, supplies management etc.
8. PWD is ultimately responsible for making available and conducting training and mobilization from the RTIs and related training facilities.

Training

9. It was suggested that FP should become part of curricula of HCW at all levels. Additionally, RTIs should be utilized for enhancing FP skills including counseling of LHVs and WMOs. Training and refresher training of LHW in FP may be by master trainers supported by the MoPW which may also provide technical support for monitoring of FP training.

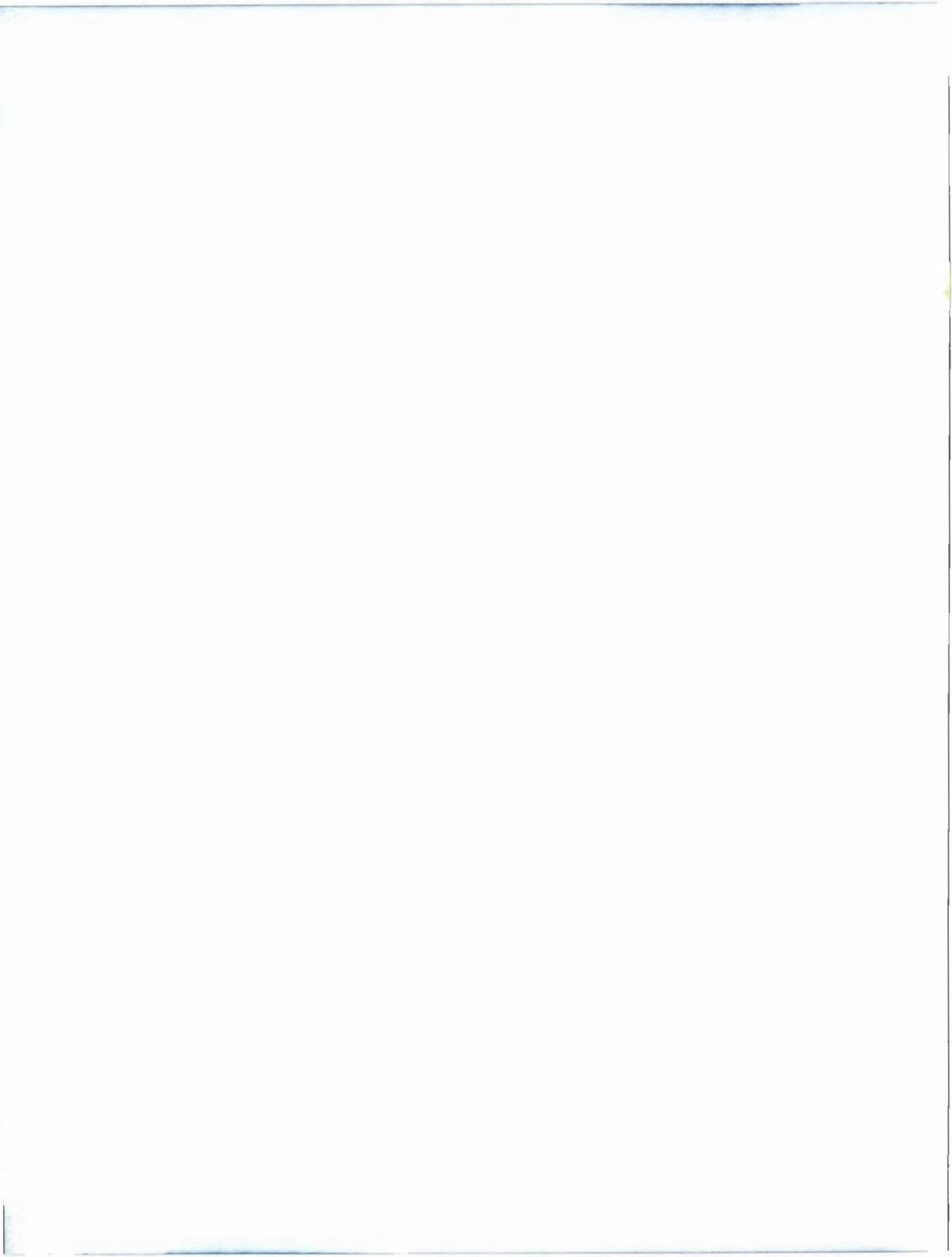
Mobilization

10. There is a role for male mobilizers from the MoPW. These should coordinate with LHWs from MoH. Other means of mobilizing the demand for FP are the doctors and nurses at health facilities who come in first hand contact with communities. They can thus be used to motivate their patients to use birth spacing. These efforts may include the use of RHA 'A' centers to liaise with OBGYN wards for FP counseling and services. Finally, MSU camps create outreach into communities; LHW may refer their clients to these camps.
11. Social marketing has been applied successfully to FP in Pakistan. This experience can be built upon to enhance the demand for FP services and to cover some costs.
12. There was discussion of a successful program of advocacy by FPAP to army recruits with services being provided for their wives.

Contraceptive Security and Logistics

13. This has been highlighted as the main gap in many discussions and analyses. The recent evaluation of the LHW program suggested that the main impediment for the LHWs to provide contraception were the supply of contraceptives to LHWs who then have to ration their supplies. There is a sense that a considerable portion of the current unmet need may be met by providing sufficient and timely supplies of contraception commodities to LHWs and 1st level facilities.

14. In order to do so, there is a need for forecasting the amount, method mix and overall costs of contraception commodities. Considerable work in this regard has been conducted by the UNFPA. Significant gaps have been identified in funding.
15. Other gaps are in the logistics of commodities including supply management and warehousing. There is an immediate need to understand where bottlenecks are and where the processes fail. The need for adequate storage facilities are required at provincial and district levels has been highlighted repeatedly. Such facilities must be complemented by adequate supply management issues including recruitment and training of personnel, adequate funds to cover these costs.
16. It was discussed that the government must allocate FP funds in regular budgets and ask donors to fill in funds to cover gaps. Government ministries should advocate for increased funds for FP from parliamentarians and other decision makers. This funding should be flexible to plug occasional gaps. Finally the role of social marketing in the supply system must be understood.
17. Evidence based forecast models may be developed to identify needs for the next several years. Some care must be applied to account for diverse scenarios so that different alternatives as well as sequences (ie saturation of the demand for one type of contraception) may be addressed. In the short term, it would be most useful to look at the current scenario of unmet need and first address that before even thinking of creating more demand, as only a third of the current demand is met. In order to do so, it is important to understand where the unmet demand is. This may be possible from looking at geographic distribution of services usage and unmet need but may also require additional research/ studies.



Annex-3: Report of the Provincial Consultations

Report of Provincial Consultations for Delivery of Family Planning Services by the Health System

Background

The Federal Ministry of Health as well as the Departments of Health of Baluchistan, NWFP, Punjab, and Sind have resolved to deliver FP services through all their health outlets; (static, outreach and MSU) in order to achieve MDG4 and MDG5 by 2015 as well as to contribute to meeting the huge unmet need for contraceptives that exists in Pakistan even today.

As a first step, the DG (Health) established 3 task forces on Health Outreach Services, Static Health Centers, and Reproductive Health Commodities on July 30, 2009 (Minutes of Task Force Meetings at Annex I) to recommend comprehensive programmatic and operational measures that are required and to examine the bottlenecks in the existing system at the district and provincial levels.

The outcome of these deliberations was presented in a briefing paper at a national consultation on September 14, 2009 which presents the consolidated recommendations of the task forces for the further deliberation of the Provincial DGs, Provincial Coordinators of the MNCH and the National Program for Family Planning and Primary Health care (Briefing paper at Annex II). The commitment of the Ministry of Health was enthusiastically endorsed by provincial officials and there was a substantive discussion on bottlenecks faced by the different cadres (Report at Annex III).

The consolidated operational plan for a concerted, coordinated and committed action for delivery of FP services by All Health Care Providers in the Public and Private Sector will be presented at a National Conference on December 15, 2009 by the Ministry of Health supported by FALAH to which international donors will also be invited. To prepare for this consultation provincial preparatory meetings were held in Karachi and Lahore.

Introduction

Following the national consultation of September 14 2009, provincial meetings were held in Karachi for Sindh and Baluchistan (November 7 2009) and for Punjab and NWFP in Lahore (November 12 2009) to prepare a provincial operational plan and examine the key issues at

the district and provincial level for the delivery of family planning services by all tiers of the health system (Agenda and list of participants at Annex IV).

The DG-Health in his opening remarks pointed out that efforts at promoting reproductive health/birth spacing and offering FP services were lagging behind the current requirements. He added that the Health sector needs to play a key role in preventive and curative services and the provincial consultation was a step towards getting the public health system geared to delivery of family planning services.

The DG stressed 3 key areas which need to be focused on primarily as follows:

- Improved infrastructure for delivery of FP services and make it more welcoming for clients.
- Health officials need to be retrained and reoriented that family planning services are essential services that are part of their mandate.
- The health system must have an independent guaranteed source for contraceptives and offer a full range of FP services.

The Chief of Party, FALAH in her presentation highlighted the need to promote birth spacing as a health intervention, which is beneficial for all concerned- mother, child, family and the community at large. Current global evidence and the PDHS 2006-2007 show the key role birth spacing plays in increasing child survival, improving maternal and child health outcomes. In Pakistan, 34% of the children are born less than 24 months after a previous birth, an interval perceived to be too short. Infant mortality in Pakistan could potentially be reduced by almost one-third from 78 per 1,000 to 52 per 1000 live births if all births were spaced by at least three years. Similarly, maternal mortality would also be reduced by one-third.

It is cost effective and a high impact health intervention-contributing to meeting MDG 4 and 5 goals.

She reiterated that the initiative taken by the MoH led by DG Health is most timely. Given the strong evidence on benefits of birth spacing, health care providers must promote and provide FP services. With the existing 15,000 FP delivery outlets, there is potential for a rapid increase in services with little incremental cost. Health facilities provide an appropriate environment where clients seek a range of health care.

In order for the health system to play a substantive role, working groups were developed around 3 themes:

- Human Resources and Training Requirements
- Commodities Security- Availability, Storage, Distribution and Replenishment
- Accountability Mechanism and Reporting Responsibility at Federal, Provincial and District level

The issues raised and the list of participants of each working group is attached at Annex

V. Key Recommendations of the Three Working Groups

I- Human Resources and Training Requirements

- 1 Male and female health providers who are concerned with providing Health Services at all tiers of the health system should be trained.
- 2 No facility should be without a provider while trainings are being conducted.
- 3 Existing training materials developed by FALAH and other relevant projects can be modified and utilized for conducting trainings.
- 4 A special monitoring and quality assurance mechanism should be developed to periodically reinforce training messages.
- 5 The training should not be of extensive duration.
- 6 Prior to imparting training, PHDC and DHDC need to be strengthened in terms of infrastructure and provision of material and staff.
- 7 Selected trainers of the FALAH project will be used to train PHDC staff to become master trainers.
- 8 It was recommended that all the trainings should be conducted at the Taluka /Tehsil level.

II- Commodities Security- Availability, Storage, Distribution and Replenishment

1. Contraceptives should be included in the essential drug list.

2. Personnel to be trained for contraceptive forecasting, procurement, warehousing/storage and distribution of contraceptives.

More specific recommendations to ensure quality, quantity, access and uniform pricing policy of contraceptives are as follows:

a) Contraceptive Forecasting

There are four government departments providing family planning services at the district level (LHW program, Population Welfare Department, Peoples Primary Health Care Initiative (PPHI) at the BHUs and Health Department at all other outlets of Health Departments). To meet the contraceptive needs of all the eligible couples in a district, it was proposed that the Contraceptive forecasting should be carried out at the district level on the basis of available data from the district level surveys or the provincial level CPR obtained from the Pakistan Demographic and Health Survey (PDHS), 2007-8 with the contraceptive mix.

It was proposed that a four member contraceptive forecasting committee should be formed consisting of a DPWO, the district coordinator of LHW program, the representative of the PPHI and EDO-Health as the chair.

The committee members should be trained in contraceptive forecasting techniques and contraceptive mix.

b) Contraceptive Procurement

Contraceptive procurement should take place at both provincial and national level on the basis of contraceptive forecasting carried out at the district level. The local manufactured contraceptives should be procured at the district or provincial level based on the provincial health department procurement policy. Condoms and IUDs which are procured at the international market should be procured according to the national/provincial procurement policy.

All the procurements will be done by a designated committee; therefore, all the members of the procurement committee at the district/provincial/national should also be trained on the procurement procedures.

c) Contraceptive Warehousing/Storage

Contraceptive warehouses should be established at the provincial and national level to ensure effective storage.

Although there are storage facilities available at the district level, these are very inadequate and in poor condition. It was proposed that at least 6 months stock of each contraceptive should be maintained at the district level. Keeping in view the volume of the required quantities of these contraceptives, and the available storage capacity at the district level, it was proposed that the existing facilities should be upgraded to house the district stocks.

It was also proposed that the concerned staff should be trained on the warehousing/storage procedures at the district/provincial/national level as applicable.

d) Distribution of Contraceptives to Health Facilities

A logistics information system needs to be put in place so that there is an uninterrupted supply of contraceptives to clients. It will also ensure that there are no stock outs, and no contraceptives should expire on the shelf. Hence, a contraceptive logistics management system needs to be developed at all levels.

III- Accountability Mechanisms and reporting responsibility at Federal, Provincial and District level

1. There was a clear agreement on the need to enhance existing monitoring and evaluation mechanisms ideally building on existing mechanisms rather than designing new systems.
2. Full time trained personnel are required for data management which is not the case at present.
3. It is critical to build linkages between PPHI and the EDO (Health) office to share data at the district level and ensure complete and accurate data for each district.
4. There should be a focal person at each level of the health system for accountability.
 - At the federal level, Director General, Health Services to be overall responsible for ensuring family planning services at the national level. DDG (PHC) should be the focal person to ensure family planning activities are being carried out and the consolidated report submitted to the DG, Health Services.
 - Similarly, at the provincial level, in the DG (Health Services), to be overall responsible for evaluating the FP performance with the support of the Director

RH who should be the responsible focal person for consolidating the progress on Family planning activities.

- At the district level, EDO (Health) will be ultimately accountable for all outcomes related to family planning service delivery by PPHI, LHWs and Health outlets.
5. District Health Information System (DHIS), should be implemented in all districts.

Annex-4: Situation Analysis of Provision of FP/Birth Spacing Information and Services by Type of Service Delivery

A situation analysis of the health service delivery system for providing family planning information and services is presented below:

a. Community Level-LHWs

At the community level, Lady Health Workers are mandated to provide family planning services. These services include provision of condoms and hormonal pills. Recently injectable contraceptives have been included and all LHWs have been provided training on their use. The program's Technical Committee on Innovations has also approved the provision of emergency contraceptive pills. In order to raise awareness regarding health issues the Lady Health Workers are expected to establish village health and women's committees. Most importantly, women's first line of contact is with LHWs regarding their intimate reproductive health problems. Therefore the LHW is a perfect medium for referral for family planning and other reproductive health needs. The LHW program evaluation results have shown that the workers need to enhance their focus on the provision of family planning services. For this improvement and fortification of family planning services the following are proposed:

- Lady health workers continue to provide basic counseling about family planning, to raise awareness about the health benefits of birth spacing and to provide oral pills, condoms, and injectables (SECOND DOSE) while referring women to the appropriate nearest facility for other contraceptive methods.
- Lady health workers' performance can be enhanced if their inter-personal communication skills are improved. Their counseling skills can become more client focused through increased home visits, using opportunities to meet several reproductive health needs, helping women cope with household decision making and doing better follow up of family planning acceptors so they continue using. Specific trainings in client centered approach (CCA) will catalyze a change in their competence and motivation to make household visits.
- LHWs have continuous available stocks of contraceptives including injectables and emergency contraceptive pills on a routine basis so as to avoid method discontinuation by clients due to stock outs. A proper logistic system can ensure this.

b. Basic Health Unit:

At the basic health unit the framework proposes that medical officers/medical technicians, dispensers (who act as providers in the absence of the medical officer) and lady health visitors provide a range of family planning services as part of the preventive health care package they are mandated to deliver described in their existing job descriptions. These services must include provision of information on benefits of birth spacing, range of contraceptive options available, provision of condoms, pills, injectables and IUCD insertion.

At present although these services are not being provided due to non-availability of contraceptives, it must be emphasized that providers do not consider family planning a part of primary health care. Further, their supervisors also do not stress upon providing family planning services.

The Ministry of Health plans to address these gaps drawing on the following strategies:

- In order to facilitate provision of FP services it is recommended that lady health visitors/women medical officers be trained in counseling and contraceptives technology -- FP advance including IUCD skills and client centered services and medical officers/medical technicians and dispensers be trained in FP basic and client centered services;
- Similarly BHU staff must vertically refer clients to secondary and tertiary level facilities for provision of surgical implants as well as minilap and vasectomy services. The referral system will provide priority care to the referred clients.
- A follow up mechanism must also be in place. The BHU will also be the first level referral facility for all clients referred to by the LHWs and be in a position to manage minor side effects as well as IUCD insertion.
- Furthermore, to ensure contraceptive availability a secure contraceptive logistic system will be put in place.

c. Rural Health Centre:

Rural Health Centers provide health care services to women and children, therefore they are ideal locations for post partum and post abortion counseling on family planning. A full range of family planning services must be mandatory at the RHC level.

Hence, the Ministry of Health plans to address these gaps as per the following strategies:

- In order to facilitate provision of FP services it is recommended that lady health visitors/women medical officers be trained in counseling and contraceptives technology -- FP advance including IUCD skills and client centered services and the medical officers/medical technicians and dispensers be trained in FP basic and client centered services;
- Similarly RHCs staff will vertically refer clients to secondary and tertiary level facilities for provision of surgical implants/minilap/vasectomy services. The referral system should provide priority care to the referred clients.
- A follow up mechanism must also be in place. The RHCs will be the first level referral facility for all clients referred by the BHUs/LHWs and should be in a position to manage side effects.
- Furthermore, to ensure contraceptive availability a secure contraceptive logistic system must be put in place.

d. Secondary and Tertiary Care Level:

A full range of services should be available at secondary and tertiary care level (THQ/DHQ) because the maximum number of clients are likely to access these for their reproductive health needs. Female staff is more likely to be present here. This level must be prepared for all cases of referral by LHWs, BHUs and RHCs. Service provision can be ensured through the availability of properly trained women medical officers and a functional operation theatre for reproductive health needs.

The Ministry of Health proposes the following:

- Additional availability of wider access to new contraceptive methods such as Sino-Implant and Implanon, minilap and vasectomy services, as well as management of major contraceptive side effects. While most staff will have basic training, only a few male medical officers and female staff have received trainings in vasectomy and minilap procedures.
- Furthermore, to ensure contraceptive availability a comprehensive contraceptive logistic system must be put in place.



Annex-5: Contraceptive Requirement by Method for the Period 2009-14

The Pakistan Demographic and Health Survey 2006-07 shows the overall contraceptive prevalence rate of 29.6 per cent and 22 percent for modern contraceptive methods. It means that during the year 2006-7 almost 7.5 million couples were practicing different contraceptive methods in Pakistan. During the period 2009-14, the number of contraceptive users will be increased from 8.298 million in 2009-10 to 11.456 million in 2013-14 in order to achieve demographic goals set for the period. The contraceptive requirements have therefore been worked out to provide family planning and birth spacing services to those who want to space their children or limit their family size to the number they already have.

The proposed requirement of contraceptives will be reviewed and adjusted annually on the basis of consumption, stock availability and service delivery expansion.

The following factors have been considered while projecting the requirements:

- i) Contraceptive mix obtained from PDHS, 2007-08;
- ii) Requirement for requisite stock building at various levels at the Provincial Warehouse, district stocks and service outlets;

The following tables show the Population Parameters and Contraceptive Requirement Indicators for each province and four provinces combined:

Contraceptive Requirement by Method for the Period 2009-2014, Pakistan

- a) Contraceptive Requirement by Method for the Period 2009-2014, PUNJAB
- b) Contraceptive Requirement by Method for the Period 2009-2014, SINDH
- c) Contraceptive Requirement by Method for the Period 2009-2014, NWFP
- d) Contraceptive Requirement by Method for the Period 2009-2014, BALOCHISTAN

A) Contraceptive Requirement by Method for the Period 2009-2014, Pakistan

Parameters	2009-10	2010-11	2011-12	2012-13	2013-14
Total Population (Million)	169.678	173.140	176.518	179.804	182.990
# of women of reproductive age (m)	27.148	27.702	28.243	28.769	29.278
Number of Births (m)	4.685	4.614	4.534	4.446	4.161
Number of Users (m)	8.298	8.936	9.588	10.253	11.456
Contraceptive Prevalence Rate (%)	30.6	32.3	33.9	35.6	39.1
Total Fertility Rate (TFR per woman)	4.1	3.9	3.8	3.6	3.3
Population Growth Rate (%)	2.04	1.95	1.86	1.77	1.60
Crude Birth Rate (births in 1000 p)	27.6	26.6	25.7	24.7	22.7
Crude Death Rate (deaths per 1000 p)	7.2	7.1	7.1	7.0	6.8
CPR- Modern Methods (%)	22.34	24.92	27.64	30.48	35.18
Contraceptive Mix (Expected)					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	23.23	23.55	23.87	24.18	24.50
Oral Pills	6.49	7.04	7.59	8.14	8.72
Injectable	8.15	9.64	11.12	12.60	14.20
IUD	7.67	9.14	10.61	12.08	13.66
Con. Surgery	27.56	27.89	28.22	28.55	28.83
Traditional Methods	26.90	22.74	18.60	14.46	10.09
Total	100	100	100	100	100
Number of Contraceptive Users by Method					
Figure in Thousands					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	1928	2104	2288	2479	2807
Oral Pills	539	630	728	834	999
Injectable	676	861	1066	1292	1627
IUD - Old and new cases	636	817	1017	1238	1564
Con. Surgery - Old and new cases	2287	2492	2705	2927	3303
Traditional Methods	2232	2032	1783	1483	1156
Total	8298	8936	9588	10253	11456
Contraceptive Quantity Required					
Figure in Thousands					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom (units)	277583	303024	329500	356986	404185
Oral Pills (cycles)	7006	8184	9463	10845	12988
Injectable (vials)	3381	4306	5330	6458	8134
IUD (units)	210	397	478	567	747
CS new cases	183	185	192	199	339

A.1: Contraceptive Requirement by Method for the Period 2009-2014, PUNJAB

Parameters	2009-10	2010-11	2011-12	2012-13	2013-14
Total Population (Million)	95.919	97.738	99.498	101.192	102.818
# of women of reproductive age (m)	15.347	15.638	15.920	16.191	16.451
Expected Number of Births (m)	2.494	2.443	2.388	2.327	2.159
Number of Users (m)	5.126	5.498	5.877	6.261	6.940
Contraceptive Prevalence Rate (%)	33.4	35.2	36.9	38.7	42.2
Total Fertility Rate (TFR per woman)	3.8	3.7	3.5	3.3	3.0
Population Growth Rate (%)	1.90	1.80	1.70	1.61	1.41
Crude Birth Rate (births in 1000 p)	26.0	25.0	24.0	23.0	21.0
Crude Death Rate (deaths per 1000 p)	7.03	7.00	6.97	6.93	6.90
CPR- Modern Methods (%)	23.23	26.16	29.27	32.54	37.55
Contraceptive Mix (Expected)					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	21.39	21.79	22.19	22.60	23.00
Oral Pills	4.22	4.91	5.61	6.30	7.00
Injectable	6.02	7.77	9.51	11.26	13.00
IUD	9.34	11.00	12.67	14.33	16.00
Con. Surgery	28.60	28.95	29.30	29.65	30.00
Traditional Methods	30.44	25.58	20.72	15.86	11.00
Total	100	100	100	100	100
Number of Contraceptive Users by Method					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	1096	1198	1304	1415	1596
Oral Pills	216	270	330	395	486
Injectable	309	427	559	705	902
IUD - Old and new cases	479	605	744	898	1110
Con. Surgery - Old and new cases	1466	1592	1722	1856	2082
Traditional Methods	1560	1406	1218	993	763
Total	5126	5498	5877	6261	6940
Contraceptive Quantity Required					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom (units)	157846	172501	187801	203735	229860
Oral Pills (cycles)	2810	3511	4285	5131	6316
Injectable (vials)	1544	2135	2795	3524	4511
IUD (units)	158	289	345	406	518
CS new cases	117	113	117	121	203

A.2: Contraceptive Requirement by Method for the Period 2009-2014, SINDH

Parameters	2009-10	2010-11	2011-12	2012-13	2013-14
Total Population (Million)	40.698	41.545	42.371	43.175	43.954
# of women of reproductive age (m)	6.512	6.647	6.779	6.908	7.033
Expected Number of Births (m)	1.140	1.122	1.102	1.079	1.011
Number of Users (m)	1.946	2.103	2.264	2.429	2.720
Contraceptive Prevalence Rate (%)	29.9	31.6	33.4	35.2	38.7
Total Fertility Rate (TFR per woman)	4.2	4.0	3.8	3.7	3.3
Population Growth Rate (%)	2.08	1.99	1.90	1.81	1.65
Crude Birth Rate (births in 1000 p)	28.0	27.0	26.0	25.0	23.0
Crude Death Rate (deaths per 1000 p)	7.20	7.12	7.03	6.95	6.50
CPR- Modern Methods (%)	24.30	26.81	29.44	32.19	36.74
Contraceptive Mix (Expected)					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	27.17	27.38	27.58	27.79	28.00
Oral Pills	8.68	9.01	9.34	9.67	10.00
Injectable	8.68	9.76	10.84	11.92	13.00
IUD	3.77	5.08	6.39	7.69	9.00
Con. Surgery	33.00	33.50	34.00	34.50	35.00
Traditional Methods	18.70	15.27	11.85	8.42	5.00
Total	100	100	100	100	100
Number of Contraceptive Users by Method Figure in Thousands					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	529	576	625	675	762
Oral Pills	169	189	211	235	272
Injectable	169	205	245	289	354
IUD - Old and new cases	73	107	145	187	245
Con. Surgery - Old and new cases	642	705	770	838	952
Traditional Methods	364	321	268	205	136
Total	1946	2103	2264	2429	2720
Contraceptive Quantity Required Figure in Thousands					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom (units)	76132	82916	89939	97194	109656
Oral Pills (cycles)	2196	2463	2749	3053	3536
Injectable (vials)	844	1026	1227	1447	1768
IUD (units)	24	58	74	91	121
CS new cases	51	56	59	61	103

A.3: Contraceptive Requirement by Method for the Period 2009-2014, NWFP

Parameters	2009-10	2010-11	2011-12	2012-13	2013-14
Total Population (Million)	24.100	24.666	25.227	25.782	26.330
# of women of reproductive age (m)	3.856	3.947	4.036	4.125	4.213
Expected Number of Births (m)	0.747	0.744	0.740	0.735	0.685
Number of Users (m)	0.949	1.029	1.112	1.196	1.407
Contraceptive Prevalence Rate (%)	24.6	26.1	27.5	29.0	33.4
Total Fertility Rate (TFR per woman)	4.7	4.5	4.4	4.3	3.8
Population Growth Rate (%)	2.35	2.28	2.20	2.13	1.95
Crude Birth Rate (births in 1000 p)	31.0	30.2	29.3	28.5	26.0
Crude Death Rate (deaths per 1000 p)	7.50	7.42	7.33	7.25	6.50
CPR- Modern Methods (%)	18.43	20.12	21.88	23.70	28.05
Contraceptive Mix (Expected)					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	24.70	24.77	24.85	24.92	25.00
Oral Pills	12.55	12.66	12.78	12.89	13.00
Injectable	16.19	17.15	18.10	19.05	20.00
IUD	6.88	7.91	8.94	9.97	11.00
Con. Surgery	14.57	14.68	14.79	14.89	15.00
Traditional Methods	25.10	22.83	20.55	18.28	16.00
Total	100	100	100	100	100
Number of Contraceptive Users by Method					
	Figure in Thousands				
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	234	255	276	298	352
Oral Pills	119	130	142	154	183
Injectable	154	176	201	228	281
IUD - Old and new cases	65	81	99	119	155
Con. Surgery - Old and new cases	138	151	164	178	211
Traditional Methods	238	235	228	219	225
Total	949	1029	1112	1196	1407
Contraceptive Quantity Required					
	Figure in Thousands				
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom (units)	33746	36708	39773	42941	50652
Oral Pills (cycles)	1548	1694	1846	2005	2378
Injectable (vials)	768	882	1006	1140	1407
IUD (units)	22	38	46	54	76
CS new cases	11	11	12	12	30

A.4: Contraceptive Requirement by Method for the Period 2009-2014, BALOCHISTAN

Parameters	2009-10	2010-11	2011-12	2012-13	2013-14
Total Population (Million)	8.961	9.191	9.422	9.655	9.888
# of women of reproductive age (m)	1.434	1.471	1.508	1.545	1.582
Expected Number of Births (m)	0.305	0.305	0.305	0.304	0.307
Number of Users (m)	0.277	0.306	0.336	0.367	0.389
Contraceptive Prevalence Rate (%)	19.3	20.8	22.3	23.7	24.6
Total Fertility Rate (TFR per woman)	5.2	5.0	4.9	4.8	4.7
Population Growth Rate (%)	2.57	2.52	2.47	2.42	2.40
Crude Birth Rate (births in 1000 p)	34.0	33.2	32.3	31.5	31.0
Crude Death Rate (deaths per 1000 p)	8.33	8.00	7.67	7.33	7.00
CPR- Modern Methods (%)	14.48	16.06	17.70	19.41	22.64
Contraceptive Mix (Expected)					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	24.70	24.75	24.80	24.85	25.00
Oral Pills	12.55	12.96	13.37	13.78	15.00
Injectable	16.19	17.11	18.03	18.95	23.00
IUD	6.88	7.74	8.59	9.44	14.00
Con. Surgery	14.57	14.65	14.72	14.79	15.00
Traditional Methods	25.10	22.80	20.50	18.20	8.00
Total	100	100	100	100	100
Number of Contraceptive Users by Method					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom	68	76	83	91	97
Oral Pills	35	40	45	50	58
Injectable	45	52	61	69	90
IUD - Old and new cases	19	24	29	35	55
Con. Surgery - Old and new cases	40	45	49	54	58
Traditional Methods	70	70	69	67	31
Total	277	306	336	367	389
Contraceptive Quantity Required					
Contraceptive Method	2009-10	2010-11	2011-12	2012-13	2013-14
Condom (units)	9859	10900	11986	13116	14016
Oral Pills (cycles)	452	515	583	656	759
Injectable (vials)	224	262	303	347	448
IUD (units)	6	11	13	16	32
CS new cases	3	4	4	4	4

B. Total Contraceptives Quantity* Required by Province for the Period 2009-2014, All Programs including Private Sector

Figure in Thousands

Contraceptive Method	Punjab	Sindh	NWFP	Balochistan	Total Quantity Required
Condom	1,204,590	576,458	259,538	75,295	2,115,882
Oral Pill	29,000	17,885	12,086	3,802	62,773
Injectable	19,471	8,258	6,751	2,076	36,556
IUD	2,286	503	319	113	3,221

It includes an additional quantity for 12 months stock building

B.1: Total Contraceptives Cost* by Province for the Period 2009-2014, All Programs including Private Sector

Figure in Thousands

Contraceptive Method	Punjab	Sindh	NWFP	Balochistan	Total Cost
Condom	2,409,179	1,152,917	519,077	150,591	4,231,763
Oral Pill	637,995	393,481	265,898	83,637	1,381,011
Injectable	1,635,600	693,640	567,050	174,409	3,070,698
IUD	123,462	27,170	17,220	6,083	173,936
Total Contraceptive Cost in Pak. Rupees	4,806,236	2,267,208	1,369,245	414,720	8,857,409
Total Contraceptive Cost in US \$	60,078	28,340	17,116	5,184	110,718

*It includes the cost of an additional quantity for 12 months stock building

C. Total Contraceptives Quantity* Required by Province for the Period 2009-2014, DoH and LHWs Program

Figure in Thousands

Contraceptive Method	Punjab	Sindh	NWFP	Balochistan	Total Quantity Required
Condom	433,652	207,525	93,434	27,106	761,717
Oral Pill	13,340	8,227	5,560	1,749	28,876
Injectable	9,152	3,881	3,173	976	17,181
IUD	915	201	128	45	1,288

It includes an additional quantity for 12 months stock building

C.1: Total Contraceptives Cost by Province for the Period 2009-2014, DoH and LHWs Program

Figure in Thousands

Contraceptive Method	Punjab	Sindh	NWFP	Balochistan	Total Cost
Condom	867,304	415,050	186,868	54,213	1,523,435
Oral Pill	293,478	181,001	122,313	38,473	635,265
Injectable	768,732	326,011	266,513	81,972	1,443,228
IUD	49,385	10,868	6,888	2,433	69,574
Total Contraceptive Cost in Pak. Rupees	1,978,899	932,930	582,582	177,091	3,671,503
Total Contraceptive Cost in US \$	24,736	11,662	7,282	2,214	45,894

It includes an additional quantity for 12 months stock building



**Annex-6:
Province-Wise Training Cost by Type of
Training**

Number of Service Providers and Cost estimates by Type of Training, Punjab

Sr. No	Designation	Type of Training	No. of Days Training Package	Criteria	Nos to be Trained (Sanctioned)	Name of Training Institution	Cost in Pak Rupees				
							Travelling	Perdiam	Stationary	Lodging	Total Cost
1	BPS 17 MO	CCFP -Basic TOT	6	4/district	144	PHDC	432,000	535,680	21,600	1,607,040	2,596,320
		CCFP - Basic Step Down	6	All Mos	4348	DHDC	13,044,000	16,174,560	652,200	24,261,840	54,132,600
2	BPS 17 WMO	CCFP -advance- TOT	6	4/district	144	RTI / TH	432,000	535,680	21,600	1,607,040	2,596,320
		CCFP - Step Down	6	All WMos	650	DHQ / RHS-A	1,950,000	2,418,000	97,500	1,607,040	6,072,540
		Minilap - Step Down	15	WMOs of THQ+RHCs	372	TH	11,160,000	3,459,600	55,800	10,378,800	25,054,200
		IUCD - TOT	6	2/District	72	RHS - As / TH	864,000	267,840	10,800	803,520	1,946,160
		IUCD - Step Down	3	All WMos	722	DHQ / RHS-A	1,083,000	1,342,920	108,300	2,014,380	4,548,600
3	BPS 18 SMO	CCFP - Step Down	6	All SMOs	430	DHQ / RHS-A	1,290,000	1,599,600	64,500	2,399,400	5,353,500
		Vasectomy - Step Down	15	1/Dist	36	TH	1,080,000	334,800	5,400	1,004,400	2,424,600
4	BPS 19 & 20	Orientation	2	DHPMT /12/dist	432	PHDC	2,592,000	712,800	64,800	2,138,400	5,508,000
5	LHV 9	CCA - TOT	6	4/district	144	PHDC	86,400	190,080	21,600	570,240	868,320
		CCFP - Step Down	6	All	3365	DHDC / RHS-A	2,019,000	3,129,450	504,750	4,694,175	10,347,375
		IUCD - Step Down	3	All	3365	DHQ / RHS-A	1,009,500	1,564,725	504,750	2,347,088	5,426,063
6	FMT - 14	CCFP - Step Down	6	All	462	DHQ / RHS-A	277,200	1,011,780	69,300	1,517,670	2,875,950
		IUCD - Step Down	3	All	462	DHQ / RHS-A	138,600	505,890	69,300	758,835	1,472,625
7	Disp - 6	CCFP - Step Down	6	All	2190	DHDC	1,314,000	2,890,800	328,500	4,336,200	8,869,500
		Logistics	2	All	2190	DHDC	438,000	963,600	328,500	1,445,400	3,175,500
8	MT - 14	CCFP - Step Down	6	All	455	DHDC	273,000	996,450	68,250	1,494,675	2,832,375
		Logistics	2	All	455	DHDC	91,000	332,150	68,250	498,225	989,625
9	Midwife - 4	CCFP - Step Down	6	All	3295	DHQ / RHS-A	1,977,000	3,954,000	494,250	5,931,000	12,356,250
10	LHW + LHS	CCA	6	All	59678	Health Facility	-	53,710,200	2,983,900	-	56,694,100
Total							41,550,700	96,630,605	6,543,850	71,415,368	216,140,523

Number of Service Providers and Cost estimates by Type of Training, Sindh

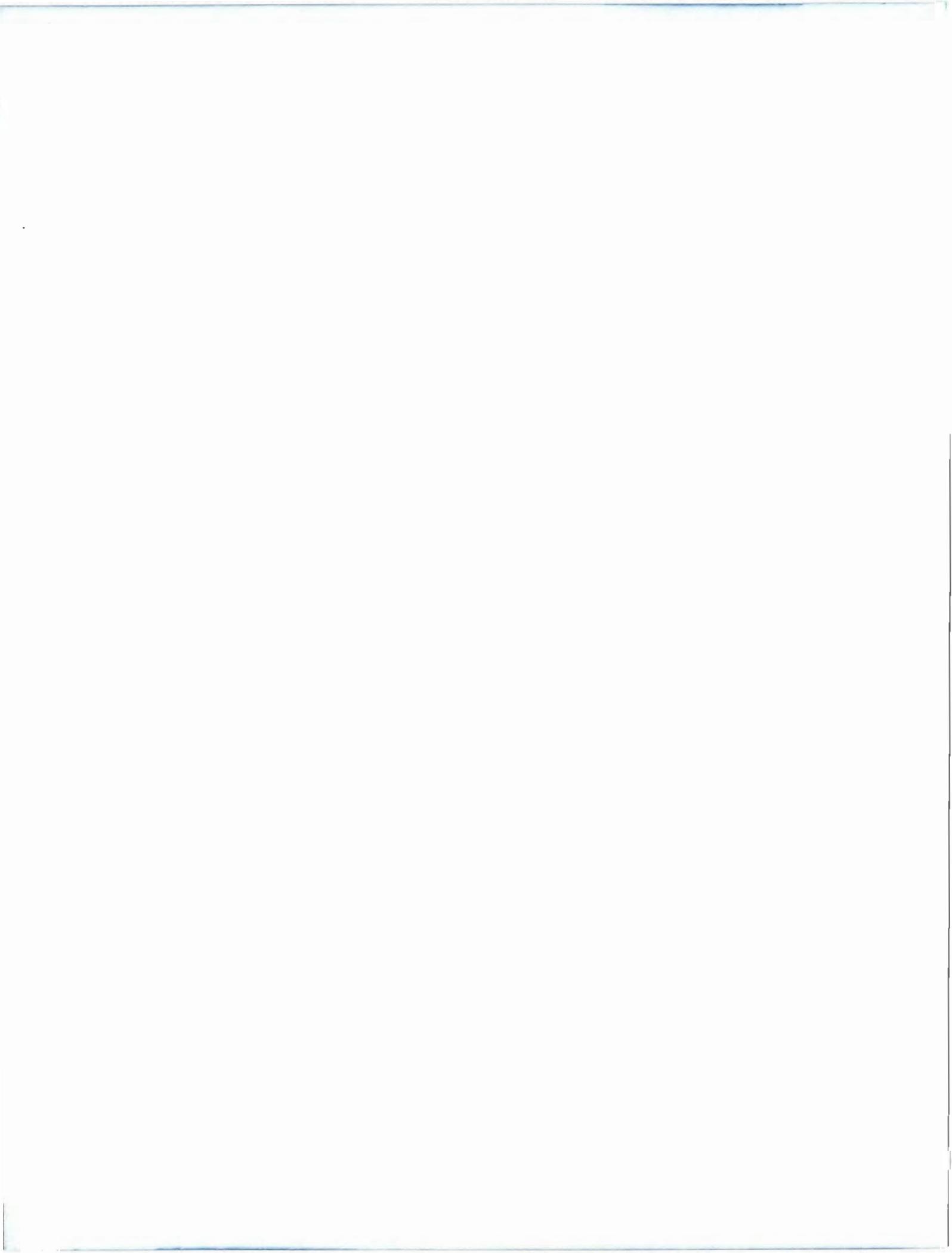
Sr. No	Designation	Type of Training	No. of Days Training Package	Criteria	Nos to be Trained (Sanctioned)	Name of Training Institution	Cost in Pak Rupees				
							Travelling	Perdiam	Stationary	Lodging	Total Cost
1	BPS 17 MO	CCFP -Basic TOT	6	4/district	92	PHDC	276,000	342,240	13,800	1,026,720	1,658,760
		CCFP - Basic Step Down	6	All Mos	2109	DHDC	6,327,000	7,845,480	316,350	11,768,220	26,257,050
2	BPS 17 WMO	CCFP -advance- TOT	6	4/district	92	RTI / TH	276,000	342,240	13,800	1,026,720	1,658,760
		CCFP - Step Down	6	All WMOs	944	DHQ / RHS-A	2,832,000	3,511,680	141,600	5,267,520	11,752,800
		Minilap - Step Down	15	WMOs of THQ+RHCs	92	TH	2,760,000	855,600	13,800	2,566,800	6,196,200
		IUCD - TOT	6	2/District	46	RHS - As / TH	552,000	171,120	6,900	513,360	1,243,380
		IUCD - Step Down	3	All WMOs	500	DHQ / RHS-A	750,000	930,000	75,000	1,395,000	3,150,000
3	BPS 18 SMO	CCFP - Step Down	6	All SMOs	335	DHQ / RHS-A	1,005,000	1,246,200	50,250	1,869,300	4,170,750
		Vasectomy - Step Down	15	1/Dist	46	TH	1,380,000	427,800	6,900	1,283,400	3,098,100
4	BPS 19 & 20	Orientation	2	DHPMT /12/dist	335	PHDC	2,010,000	552,750	50,250	1,658,250	4,271,250
5	LHV 9	CCA - TOT	6	4/district	92	PHDC	55,200	121,440	13,800	364,320	554,760
		CCFP - Step Down	6	All	414	DHDC / RHS-A	248,400	385,020	62,100	577,530	1,273,050
		IUCD - Step Down	3	All	200	DHQ / RHS-A	60,000	93,000	30,000	139,500	322,500
6	FMT - 14	CCFP - Step Down	6	All	242	DHQ / RHS-A	145,200	529,980	36,300	794,970	1,506,450
		IUCD - Step Down	3	All	100	DHQ / RHS-A	30,000	109,500	15,000	164,250	318,750
7	Disp - 6	CCFP - Step Down	6	All	449	DHDC	269,400	592,680	67,350	889,020	1,818,450
		Logistics	2	All	449	DHDC	89,800	197,560	67,350	296,340	651,050
8	MT - 14	CCFP - Step Down	6	All	307	DHDC	184,200	672,330	46,050	1,008,495	1,911,075
		Logistics	2	All	307	DHDC	61,400	224,110	46,050	336,165	667,725
9	Midwife - 4	CCFP - Step Down	6	All	242	DHQ / RHS-A	145,200	290,400	36,300	435,600	907,500
10	LHW + LHS	CCA	6	All	20532	Health Facility	-	18,478,800	1,026,600	-	19,505,400
Total							19,456,800	37,919,930	2,135,550	33,381,480	92,893,760

Number of Service Providers and Cost estimates by Type of Training, NWFP

Sr. No	Designation	Type of Training	No. of Days Training Package	Criteria	Nos to be Trained (Sanctioned)	Name of Training Institution	Cost in Pak Rupees				
							Travelling	Perdiam	Stationary	Lodging	Total Cost
1	BPS 17 MO	CCFP -Basic TOT	6	4/district	96	PHDC	288,000	357,120	14,400	1,071,360	1,730,880
		CCFP - Basic Step Down	6	All Mos	1992	DHDC	5,976,000	7,410,240	298,800	11,115,360	24,800,400
2	BPS 17 WMO	CCFP -advance- TOT	6	4/district	96	RTI / TH	288,000	357,120	14,400	1,071,360	1,730,880
		CCFP - Step Down	6	All WMOs	300	DHQ / RHS-A	900,000	1,116,000	45,000	3,348,000	5,409,000
		Minilap - Step Down	15	WMOs of THQ+RHCs	100	TH	3,000,000	930,000	15,000	2,790,000	6,735,000
		IUCD - TOT	6	2/District	48	RHS - As / TH	576,000	178,560	7,200	535,680	1,297,440
		IUCD - Step Down	3	All WMOs	300	DHQ / RHS-A	450,000	558,000	45,000	837,000	1,890,000
3	BPS 18 SMO	CCFP - Step Down	6	All SMOs	927	DHQ / RHS-A	2,781,000	3,448,440	139,050	5,172,660	11,541,150
		Vasectomy - Step Down	15	1/Dist	24	TH	720,000	223,200	3,600	669,600	1,616,400
4	BPS 19 & 20	Orientation	2	DHPMT /12/dist	350	PHDC	2,100,000	577,500	52,500	1,732,500	4,462,500
5	LHV 9	CCA - TOT	6	4/district	144	PHDC	86,400	190,080	21,600	570,240	868,320
		CCFP - Step Down	6	All	989	DHDC / RHS-A	593,400	919,770	148,350	1,379,655	3,041,175
		IUCD - Step Down	3	All	989	DHQ / RHS-A	296,700	459,885	148,350	689,828	1,594,763
6	FMT - 14	CCFP - Step Down	6	All	1099	DHQ / RHS-A	659,400	2,406,810	164,850	3,610,215	6,841,275
		IUCD - Step Down	3	All	1099	DHQ / RHS-A	329,700	1,203,405	164,850	1,805,108	3,503,063
7	Disp - 6	CCFP - Step Down	6	All	1766	DHDC	1,059,600	2,331,120	264,900	3,496,680	7,152,300
		Logistics	2	All	1766	DHDC	353,200	777,040	264,900	1,165,560	2,560,700
8	MT - 14	CCFP - Step Down	6	All	500	DHDC	300,000	1,095,000	75,000	1,642,500	3,112,500
		Logistics	2	All	500	DHDC	100,000	365,000	75,000	547,500	1,087,500
9	Midwife - 4	CCFP - Step Down	6	All	500	DHQ / RHS-A	300,000	600,000	75,000	900,000	1,875,000
10	LHW + LHS	CCA	6	All	18500	Health Facility	-	16,650,000	925,000	-	17,575,000
Total							21,157,400	42,154,290	2,962,750	44,150,805	110,425,245

Number of Service Providers and Cost estimates by Type of Training, Balochistan

Sr. No	Designation	Type of Training	No. of Days Training Package	Criteria	Nos to be Trained (Sanctioned)	Name of Training Institution	Cost in Pak Rupees				
							Travelling	Perdiam	Stationary	Lodging	Total Cost
1	BPS 17 MO	CCFP -Basic TOT	6	4/district	120	HRD Institute Quetta	360,000	446,400	18,000	1,339,200	2,163,600
		CCFP - Basic Step Down	6	All Mos	1188	DHDC /DHQ	3,564,000	4,419,360	178,200	6,629,040	14,790,600
2	BPS 17 WMO	CCFP -advance- TOT	6	4/district	120	RTI / TH	360,000	446,400	18,000	1,339,200	2,163,600
		CCFP - Step Down	6	All WMos	429	DHQ / RHS-A	1,287,000	1,595,880	64,350	4,787,640	7,734,870
		Minilap - Step Down	15	WMOs of THQ+RHCs	60	TH	1,800,000	558,000	9,000	1,674,000	4,041,000
		IUCD - TOT	6	2/District	60	RHS - As / TH	720,000	223,200	9,000	669,600	1,621,800
		IUCD - Step Down	3	All WMos	429	DHQ / RHS-A	643,500	797,940	64,350	1,196,910	2,702,700
3	BPS 18 SMO	CCFP - Step Down	6	All SMOs	207	DHQ / RHS-A	621,000	770,040	31,050	1,155,060	2,577,150
		Vasectomy - Step Down	15	1/Dist	30	TH	900,000	279,000	4,500	837,000	2,020,500
4	BPS 19 & 20	Orientation	2	DHPMT /12/dist	360	PHDC	2,160,000	594,000	54,000	1,782,000	4,590,000
5	LHV 9	CCA - TOT	6	4/district	60	PHDC	36,000	79,200	9,000	237,600	361,800
		CCFP - Step Down	6	All	293	DHDC / RHS-A	175,800	272,490	43,950	408,735	900,975
		IUCD - Step Down	3	All	293	DHQ / RHS-A	87,900	136,245	43,950	204,368	472,463
6	FMT - 14	CCFP - Step Down	6	All	15	DHQ / RHS-A	9,000	32,850	2,250	49,275	93,375
		IUCD - Step Down	3	All	15	DHQ / RHS-A	4,500	16,425	2,250	24,638	47,813
7	Disp - 6	CCFP - Step Down	6	All	1231	DHDC	738,600	1,624,920	184,650	2,437,380	4,985,550
		Logistics	2	All	90	DHDC	18,000	39,600	13,500	59,400	130,500
8	MT - 14	CCFP - Step Down	6	All	620	DHDC	372,000	1,357,800	93,000	2,036,700	3,859,500
		Logistics	2	All	90	DHDC	18,000	65,700	13,500	98,550	195,750
9	Midwife - 4	CCFP - Step Down	6	All	15	DHQ / RHS-A	9,000	18,000	2,250	27,000	56,250
10	LHW + LHS	CCA	6	All	6388	Health Facility	-	5,749,200	319,400	-	6,068,600
Total							13,884,300	19,522,650	1,178,150	26,993,295	61,578,395



References

World Health Organization 2006 Policy Brief on Birth Spacing-Report from a World Health Organization Technical Consultation. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safer.

Conde-Agudelo, A. and J. M. Belizan 2000 Maternal Morbidity and Mortality Associated with Inter-pregnancy Interval: a Cross Sectional Study. *British Medical Journal*, 321: 1255-1259 (November).

Conde-Agudelo, A. and J. M. Belizan, R. Breman, S. Brockman and A. Ross-Bermudez 2005 Effect of the Inter-pregnancy Interval after and Abortion on Maternal and Prenatal Health in Latin America. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1 (April), S34-S40.

Conde-Agudelo, A. Ross-Bermudez, and A. C. Kafury-Goeta 2006 Birth Spacing and Risk of Adverse Perinatal Outcomes: A Meta-Analysis. *Journal of the American Medical Association*, 295: 1809-1823

Population Council, Unwanted Pregnancy and Post-Abortion Complications in Pakistan: Findings from a National Study, October 2004. Islamabad, Pakistan.

Razzaque, A., J. Da Vanzo, M. Rehman, K. Gausia, L. Hale, M. A. Khan, A. H. M. G. Mustafa 2005 Pregnancy Spacing and Maternal Morbidity in Matlab, Bangladesh. *International Journal Obstetric and Gynecology*, Vol. 89, Supplement 1 (April), S41-S49.

Rutstein, S. 2005 Effects of Preceding Birth on Neonatal, Infant and Under-Five Years Mortality and Nutritional Status in Developing Countries: Evidence from the Demographic and Health Surveys. *International Journal of Obstetric and Gynecology*, Vol. 89, Supplement 1 (April), S7-S24.

2008 National Institute of Population Studies (NIPS) and Macro International Inc. Pakistan Demographic and Health Survey 2006-07. Islamabad, Pakistan.

