A Summary of the Costed Implementation Plan (CIP) on Family Planning for Sindh

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BACKGROUND

As Pakistan’s second-most populous province, with approximately 46 million residents in 2015, Sindh’s family planning commitments and outcomes have national importance. At current fertility levels, the province’s population is expected to rise to 50 million by 2020. In 2015, 13 million women were of reproductive age (ages 15–49), a number that could reach 15 million by 2020. Also, although general awareness of family planning in Sindh is high (96% of women know about at least one method), there is often a significant gap between knowledge and practice. Since 2000, the percentage of women of reproductive age using contraception in the province has held steady around 29.5 percent, with only 24 percent using modern contraceptive methods.1

Increasing contraception use in Sindh and reducing unmet need for family planning carry important implications for health and economic development, both in the province and nationally. Rapid population growth could result in a disproportionate number of young people relative to the total population, making it difficult to provide education and jobs and negatively impacting Pakistan’s economy. Over time, faster population growth increases pressure on energy consumption, employers and the economy, schools, healthcare providers and facilities, and the agriculture sector (Health Policy Plus, n.d.). Conversely, lowering fertility through the improved provision of family planning may lower population growth and can reduce the ratio of dependents to income earners.

In an effort to curb the country’s population growth, Pakistan was one of more than 20 countries at the 2012 London Summit on Family Planning that committed to address the many barriers faced by women when trying to access family planning. Under this coordinated commitment—referred to broadly as FP2020—countries set a number of goals related to contraceptive prevalence rate (CPR), family planning service provision and funding, supply chain management, and public-private partnerships. While Pakistan set national targets as part of FP2020, it had already (in 2010) devolved health and population to the provincial level. As a result, FP2020 targets are set at the provincial level with a view to contribute to Pakistan’s overall international commitments. Thus Sindh aims to increase its CPR to 45 percent by 2020, up from 30 percent in 2012/13 (National Institute of Population Studies and ICF International, 2013), in order to contribute to Pakistan’s national goal, which was recently 50 percent CPR by 2020.2

SINDH COSTED IMPLEMENTATION PLAN

A costed implementation plan (CIP) is a multi-year roadmap designed to help national and subnational governments achieve their family planning goals, thereby saving lives and improving the health and well-being of women, families, and communities (Family Planning 2020, n.d.). While most CIPs comprehensively address and budget for all aspects of a family planning programme, the Sindh CIP has costed additional activities along with projected routine family planning programme costs to be covered by government and donors. Therefore, total costs for ongoing routine and added CIP interventions have been calculated and included in the CIP (see Box 1). The Sindh CIP also serves as an advocacy tool for raising the visibility of family planning-related issues in the province.

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1 Except where otherwise noted, all data and information in this brief is drawn from the Costed Implementation Plan (CIP) on Family Planning for Sindh (Government of Sindh, 2015).

2 The interprovincial forum “Country Engagement Working Group” has decided to revise Pakistan’s CPR level of 50 percent to be achieved by 2020.
The Sindh CIP aligns with the province’s draft population policy and health sector strategy, and is intended to build on existing strengths of the Population Welfare Department (PWD) and the Department of Health (DOH). It functions as a blueprint to help both departments integrate the provision of family planning services, develop supportive supervision mechanisms, improve oversight, and increase stewardship.

**Strategic Areas**

According to the CIP, six strategic areas are considered critical for increasing access to and uptake of family planning in Sindh. These areas evolved through review and evaluation of the family planning situation in Sindh and were informed by feedback from stakeholders and partners.

**Strategic Area 1: Functional Integration**

Previous efforts to coordinate between the PWD and DOH were generally weak and left gaps in family planning service provision. Strategic area 1 focuses on enhanced strategic coordination and oversight between the population and health sectors at the provincial, district, and subdistrict levels.

Functional integration—i.e., integrating the subdistrict-level operations of family planning programmes run by either DOH or PWD—is both feasible and quickly implementable. Progress in this area may be measured through improvements to the referral process and the integration of family planning into maternal, neonatal, and child health programmes.

**Strategic Area 2: Quality of Care**

A number of issues contribute to low-quality family planning service provision in Sindh, including poor counselling services, insufficient use of long-acting reversible contraceptives (LARCs) (including IUDs and implants), weak mentorship and supervision, and inadequate focus on client satisfaction. Strategic area 2 aims to raise the quality of family planning services by better enforcing standards, improving providers’ skills, and ensuring client satisfaction.

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**Box 1: Sindh CIP’s Vision, Goals, and Objectives**

**Vision**

Sindh envisages promoting a prosperous, healthy, educated, and knowledge-based society wherein all citizens are provided with opportunities to access information and high-quality services around family planning and reproductive healthcare.

**Goals and Objectives**

The costed implementation plan for family planning is intended to help further this vision by enhancing CPR, reducing unmet need for family planning, and ensuring contraceptive security for the province’s citizens. Its primary goals include the following:

- Enhance CPR from 30 percent in 2012/13 to 45 percent by 2020
- Reduce unmet need for family planning from 21 percent in 2015 to 14 percent by 2020
- Ensure contraceptive commodity security up to 80 percent for all public sector outlets by 2018
PWD, DOH, and the private sector People’s Primary Health Initiative (PPHI) have indicated a strong willingness to promote a contraceptive method mix that includes LARCs. The effectiveness of this outreach, however, will depend on more rigorous quality standards and updated trainings for providers based on the Manual of National Standards for Family Planning Services, a document adopted by the Sindh PWD that can be used to help ensure high-quality services. Joint monitoring and supportive supervision to improve service quality can be provided through events like Family Health Days. These enable communities to benefit from services and/or referrals by trained providers that may not otherwise be available.

Strategic Area 3: Supply Chain Management

Support to Sindh’s contraceptive supply chain through the USAID│DELIVER project ended in 2015. In its absence, the government of Sindh assumes responsibility for procuring contraceptives and making them publicly available at service delivery points. Strategic area 3 focuses on improving contraceptive security to the last mile, including distribution and availability of contraceptives at service delivery points. The province’s well-developed public sector supply chain can be leveraged and strengthened through improved distribution and transportation to the last mile to ensure effective delivery of a contraceptive method mix that includes LARCs.

Strategic Area 4: Expansion of Services

Existing family planning service delivery mechanisms can be slow in responding to the needs of women of reproductive age and other hard-to-reach and/or vulnerable populations. This is partly due to financial constraints that include suboptimal allocations and delayed release of resources, large numbers of uncovered populations, and limited family welfare centres. Strategic area 4 aims to expand services with supply- and demand-side interventions for enhancing access—especially in urban slums, peri-urban, and rural areas—and to create space and linkages for public-private partnerships to reach vulnerable segments of the population, including the poor and youth.
Under this strategic area, the CIP focuses on expanding services and infrastructure, developing facilities as needed, hiring/training staff, operationalising guidelines, adopting task-sharing or public-private partnerships, and stimulating demand for LARCs through vouchers. Particular focal areas include expanded services to rural and remote areas, urban slums, and other low-resource areas, and the adoption of flexible facility hours and greater accommodation of cultural norms.

Strategic Area 5: Knowledge and Meeting Demand

There are currently two concerns involving communications around family planning services. First, the information available to the community about services offered at DOH and PWD facilities is often inadequate. Second, there is a trust gap stemming from concerns about the quality of family planning staffing and counselling. Strategic area 5 focuses on increasing knowledge and more effectively meeting the demand for family planning services by focusing on married women of reproductive age and emphasising male engagement and young people.

Community-based organisations and elders can reach out to males and the broader community to increase awareness of available family planning services, and of modern contraceptive methods in particular. Through the use of youth-friendly spaces, adolescents and young adults in educational institutions receive life skills-based education.

Strategic Area 6: Governance, Monitoring, and Evaluation

Certain systems-strengthening reforms are necessary to ensure successful implementation of Sindh’s CIP. Strategic area 6 aims to strengthen Sindh’s health and population systems by streamlining policy planning, governance, and stewardship mechanisms, and focusing on performance monitoring and accountability.

Recognising the importance of provincial structures in Pakistan’s devolved system, Sindh’s PWD and DOH are taking on crucial oversight, implementation, and data collection roles (see Monitoring and Accountability below).

Implementation of the CIP: Institutional Arrangements

Management and Coordination Structures

The Sindh CIP is implemented by PWD, in collaboration with DOH and PPHI, as well as development partners and local and international nongovernmental organisations. A number of dedicated units provide oversight and public sector stakeholder coordination (Oversight and Coordination Cell), implementation (CIP Cell), operations and technical support, and public sector reform.

The Sindh chief minister has established an FP2020 Working Group. This group will meet quarterly to oversee coordination between stakeholders and review progress—both on the CIP itself and towards achievement of FP2020 targets. In addition, intersectoral bodies such as the Social Sector Forum will be established to help enhance intersectoral linkages that can contribute to population and development sectors.

Framework for Functional Integration

Implementation is focused on an integrated model that brings together family planning services currently provided by the three implementing organisations (PWD, DOH, and PPHI) and development partners, and involves the provision of services through Family Health Days. The integrated model includes referrals and task-shifting between the public entities, ensuring commodity availability in facilities, capacity development and behaviour change communication, involvement from youth and males, public-private partnerships,
and monitoring and supportive supervision. A memorandum of understanding to be signed by the three implementing organisations would detail roles and responsibilities.

Roles and Responsibilities of Key Actors

Implementation of the CIP is defined by close collaboration between the three implementing organisations and the private sector. Private sector organisations—including domestic and international nongovernmental organisations, for-profit providers, and other development partners—have memoranda of understanding and standard operating procedures to define roles and contributions towards CIP implementation. Additionally, professional associations and research/academic organisations support the development of standard operating procedures; codes of conduct; and ethics, research, and training courses.

Monitoring and Accountability

Monitoring of CIP activities must measure implementation indicators, process indicators, and results and outcomes. Monitoring information will be drawn from a variety of official and unofficial sources and will inform cooperative efforts to foster accountability among healthcare providers and administrators. CIP accountability does not equate to top-down auditing; rather, accountability is perceived as strengthened organisational leadership and active participation of all stakeholders in decision making and management.

Costs

The CIP costing tool developed under the USAID-funded Health Policy Project was used to generate cost estimates for each of the strategic areas over the five-year implementation period. The data inputs for the tool were provided by the implementing departments and are based on documented evidence. Using this tool, implementing organisations and stakeholders in Sindh were able to calculate annual and overall costs for the CIP, as well as costs disaggregated by strategic area.

Overall, full implementation of the CIP from 2015–2020 will cost 79.12 billion Pakistani Rupees (PKR) (or US$781 million)—a figure that includes infrastructure upgrades and media outreach, but does not include family planning commodities. Currently, the government in Sindh has allocated PKR 890 million (US$8.8 million) to implement the CIP in 10 districts. Among the CIP’s six strategic areas, expansion of services is projected to carry the highest overall cost; costs for this area are expected to increase over the implementation period as a share of the annual total. Costs for monitoring, evaluation, and accountability are forecasted as lowest overall, and should remain relatively constant over the five-year implementation period. Annual CIP costs are outlined by strategic area and for the entirety of the CIP in Table 1.

Costs for implementing the CIP should be viewed within the context of more considerable overall expenses incurred by DOH, PWD, and PPHI. Total health and population spending by the government of Sindh is likely to exceed PKR 428 billion over five years (2015–2020), of which PKR 266.47 billion will be spent on hospital services and health facilities. Additionally, there are other costs associated with the provision of family planning in Sindh. The CIP does not account for routine costs for family planning-related activities, to either the provincial government or to development partners (see Table 2). Over the

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4 The exchange rate used within the text and tables of this brief is PKR 101.31 per US$1.00.
period of CIP implementation, the government of Sindh is projected to separately allocate PKR 51.24 billion for routine family planning activities and PKR 890 million towards CIP activities; development partners are estimated to contribute an additional PKR 10.29 billion to routine family planning activities.

**CONCLUSION**

Continued rapid population growth in Sindh may create additional pressure on the province’s economy and the well-being of its residents, a likelihood compounded by still-low contraceptive prevalence, persistent unmet need for family planning, and high fertility rates.

### Table 1: CIP Costs by Strategic Area, in PKR Billions (with % of annual total)

<table>
<thead>
<tr>
<th>Strategic area</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care</td>
<td>1.989</td>
<td>1.779</td>
<td>4.248</td>
<td>2.777</td>
<td>3.832</td>
<td>14.624</td>
</tr>
<tr>
<td>Supply chain management</td>
<td>0.266</td>
<td>0.405</td>
<td>0.428</td>
<td>0.485</td>
<td>0.509</td>
<td>2.093</td>
</tr>
<tr>
<td>Expansion of services</td>
<td>1.553</td>
<td>4.079</td>
<td>6.726</td>
<td>9.302</td>
<td>12.862</td>
<td>34.522</td>
</tr>
<tr>
<td>Knowledge and meeting demand</td>
<td>0.740</td>
<td>1.448</td>
<td>1.570</td>
<td>1.760</td>
<td>1.941</td>
<td>7.459</td>
</tr>
<tr>
<td>Governance, monitoring, and evaluation</td>
<td>0.292</td>
<td>0.136</td>
<td>0.156</td>
<td>0.165</td>
<td>0.224</td>
<td>0.973</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>7.873</strong></td>
<td><strong>11.185</strong></td>
<td><strong>17.680</strong></td>
<td><strong>18.544</strong></td>
<td><strong>23.838</strong></td>
<td><strong>79.120</strong></td>
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</tbody>
</table>

Expansion of services is the strategic area with the highest costs, as a result of the voucher scheme (PKR 19,961). Functional integration, quality of care, and expansion of services are the three largest categories. CIP costs do not include costs of routine family planning services currently provided by the government and development partners. These are costs in addition to routine family planning services and programmes.

### Table 2: CIP Cost, Compared to Sindh Government Allocations and Donor Funding to Family Planning

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<tbody>
<tr>
<td>Routine family planning costs, 2015–2020</td>
<td>PKR 51.24 billion (estimated allocation)</td>
<td>PKR 10.29 billion</td>
</tr>
<tr>
<td>PKR 61.53 billion</td>
<td></td>
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<tr>
<td>Total CIP Cost, 2015–2020</td>
<td>PKR 890 million, based on the PC-1 (actual allocation)</td>
<td></td>
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<tr>
<td>PKR 79.12 billion</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>PKR 52.13 billion</td>
<td>PKR 10.29 billion</td>
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<tr>
<td>PKR 140.65 billion</td>
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planning services, and difficulties in ensuring the availability of contraceptive supplies. Addressing these issues through implementation of the CIP will significantly impact Sindh’s health and demographic outcomes and its economy—and, as a result of Sindh’s high population, those of Pakistan as a whole. Through reductions in maternal and child deaths, unintended pregnancies, and unsafe abortions, Sindh could save over PKR 12 billion over the implementation period and generate nearly 4 million additional years of secure and effective family planning for couples.

REFERENCES


OTHER RESOURCES


A Costed Implementation Plan Resource Kit offering tools and guidance on developing and executing multi-year family planning plans is available at http://www.familyplanning2020.org/microsite/CIP.