POST PREGNANCY FAMILY PLANNING (PpFP) POLICY GUIDELINES BALOCHISTAN

NO.SO/ (DEV :)II-3/PWD/2020/40845

GOVERNMENT OF BALOCHISTAN
POPULATION WELFARE DEPARTMENT

OUR FAITH FREE CORRUPTION PAKISTAN

Dated Quetta, the 20th October, 2023.

To,

1. Director General Health, Balochistan.
2. Director General PWD, Balochistan.
3. Chief Executive Officer (PPHI), Balochistan.
4. All Development partners.

Subject: - **IMPLANTATION OF POSTPARTUM FAMILY PLANNING AND POST-ABORTION FAMILY PLANNING GUIDELINES.**

This is informed all partners and stakeholders involved in Family Planning (FP) initiatives in Balochistan that a Postpartum Family Planning (policy) guidelines implementation is finalized and ready to be implemented. This final document of the Provincial Family Planning Policy (PPFP) for widespread dissemination to all relevant stakeholders.

Your active participation and cooperation in implementing these updated guidelines are highly encouraged to enhance the impact and effectiveness of FP programs in Balochistan.

Thank you for your dedication to the cause of family planning and for your ongoing support in improving the health and well-being of our community.

Secretary.

Copy to:

1. Deputy Secretary to Chief Secretary, S&GAD.
2. PS to ACS (Dev:) P&D, Balochistan
3. PS to Secretary Education, Government of Balochistan.
4. PS. Secretary Health Government of Balochistan.
5. PS. Secretary Government of Balochistan. Population Welfare Department.

Section Officer
Development

20-10-23

Message from Minister Population Welfare Department, Government of Balochistan

Access to sexual and reproductive healthcare services, including family planning is the right of every individual. The intentions have always been to provide the best of services to women of this province. The contribution of family planning to maternal and child health cannot be over emphasised.

The PDHS 2017-18 findings for Balochistan highlight that contraceptive prevalence rate (CPR), for (any method) has only increased by 0.3 percentage point (from 19.5 in 2012-13 to 19.8 in 2017-18). However, demand for family planning during this 5-year period decreased by 9.5 percentage points (from 38.4% in 2012-13 to 47.9% in 2017-18) which has resulted in a net decrease of 9.2 percentage points in unmet need.

A collaborative initiative on integrated services of reproductive healthcare and family planning services provided by the Population Welfare Department are much needed to overcome this increasing menace of maternal and child mortality across Balochistan. This initiative will increase efficiencies in how family planning services are delivered and increase affordability and coverage.

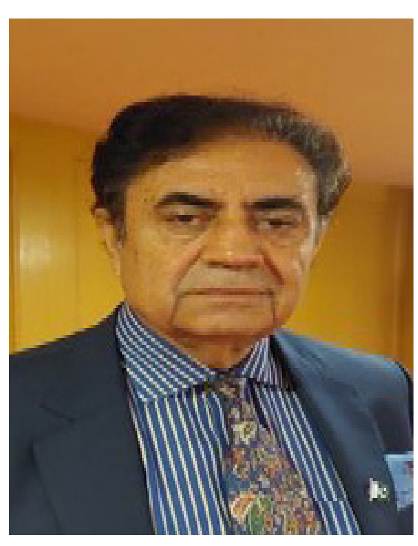
I have gone through the policy which covers every aspect of provincial family planning needs and I am hopeful that with further implementation we shall expect positive outcomes for the mothers and children of this province. I am confident the Population Welfare Department, Balochistan , in

partnership with the Department of Health and other stakeholders will play role to implement the Postpartum Family Planning(PPFP) Strategy with the objective to promote the reproductive health and family planning program for human capital development.

Sardar Ajaz Ahmed Jaffar

Minister Population Welfare Department, Balochistan

Message from Minister Health Balochistan



Post-pregnancy family planning refers to the process of making decisions and taking actions to prevent or postpone another pregnancy after giving birth. It is an essential aspect of reproductive health and plays a crucial role in the overall well-being of the mother, child, and family. There are several factors to consider when it comes to post-pregnancy family planning, including physical recovery, emotional readiness, contraceptive options, and future family goals.

First and foremost, allowing the body to heal and recover from the physical stresses of pregnancy and childbirth is of utmost importance. The uterus needs time to return to its pre-pregnancy size and strength, and the body requires adequate time to regain its energy levels. It is recommended to consult with healthcare professionals to determine when it is safe to resume sexual activity and engage in contraceptive discussions.

Emotional readiness is another vital aspect to consider. Adjusting to motherhood and nurturing a newborn can be challenging and overwhelming. It is essential for parents to establish a strong emotional bond with their child before considering another pregnancy. This time allows the parents to focus on the needs of their newborn and adapt to the new dynamics of their expanded family.

When it comes to contraception, there are various options available, including hormonal methods such as birth control pills, patches, or implants, intrauterine devices (IUDs), barrier methods like

condoms, and permanent solutions like tubal ligation or vasectomy. Each option has its own advantages and considerations, and what works for one individual or couple may not be suitable for others. It is advised to consult with healthcare providers to explore the different contraceptive choices, considering factors such as effectiveness, ease of use, side effects, and future fertility desires.

Furthermore, post-pregnancy family planning provides an opportunity for parents to discuss and evaluate their future family goals. It involves having open conversations and considering aspects such as the desired number of children, spacing between pregnancies, and financial considerations. This allows couples to make informed decisions and take proactive steps towards achieving their family planning goals.

In summary, post-pregnancy family planning is a comprehensive process that involves physical recovery, emotional readiness, contraceptive decision-making, and consideration of future family goals. By addressing these areas, individuals and couples can make informed choices regarding their reproductive health, ensuring the well-being of themselves and their families.

Dr Amir Muhammad Khan Jogezai

MInister Health, Balochistan

Message from the Secretary Population Welfare Department Balochistan

Recognizing the development needs of the province, the Population Welfare Department Balochistan is committed to provide an enabling environment to the communities where every pregnancy is wanted, every child is safe and the young people are provided with the opportunity to fulfill their potentials. Reproductive health and family planning services are the primary mandate of the department, which are being provided through the static and outreach services in the province. Moreover; the Population Welfare Department is working in close coordination with the department of health, PPHI and other national and international organizations for ensuring quality of care, with the focus to provide reliable access to modern contraceptives sufficient to benefit the communities.

The Population Welfare Department has , in technical support of the Pathfinder International, and in coordination with the Health Department, PPHI and other partners developed the Post Pregnancy Family Planning(PpFP) Policy Balochistan, to ensure family planning(FP) survives both during postpartum and post-abortion period, which is a low cost intervention that reduces maternal, infant and under-five child mortality. According to the WHO, Postpartum Family Planning (PPFP) is defined as the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth, but it can apply to an "extended" postpartum period up

to two years following childbirth. Moreover; studies suggest that the PpFP can be opted immediately after postpartum(IPPFP), during early postpartum(EPPFP), which is 48 hours up to 6 weeks and including extended postpartum(EPPFP), which is 6 weeks to one year after delivery.

The main objective of the policy is empowering females, especially maternal education, delivering adequate counseling, and strengthening existing integrated maternal and child health services in order to increase postpartum contraceptive use. Moreover; reproductive health and family planning need be systematically interweaved into the mainstream healthcare system for log lasting impacts. The Population Welfare Department is committed to integrated services at the Tertiary level hospitals, Secondary Level, the Primary and the Community level to have ensure maximum coverage for reproductive health and family planning services for development of healthy generation, balanced population growth and human capital for sustainable development of Balochistan.

Abdullah Khan

Secretary Population Welfare Department, Balochistan

Message from the Special Secretary Health

The postpartum period is a risk time for unintended pregnancies. A short inter pregnancy interval leads to a series of complication for both the mother and the fetus. Post-partum contraceptive knowledge helps women decide the time frame for future pregnancy and ultimately the better future of her family. Balochistan having multi-faceted determinants to control postpartum pregnancies i.e social and cultural norms hindrances. lack of education, lack of awareness on use of postpartum contraceptive methods, has a highest pregnancy related mortality ratio of 298 per 100,000 compared to the national ratio of 186 per 100,000 live births.

To bring about improvement in the overall indicators of postpartum family planning, the need of the hour is to put emphasis on the integration of reproductive healthcare services available either at Secondary level Hospitals or Tertiary level hospitals under the Health Department and Family Planning services at Family Welfare Centers under the Population Welfare Department. This initiative and collaboration would provide an opportunity to the mothers caregivers to receive counseling and services under a single umbrella. Additionally, private maternity centers should also be taken in loop to cover family planning needs u postpartum women.

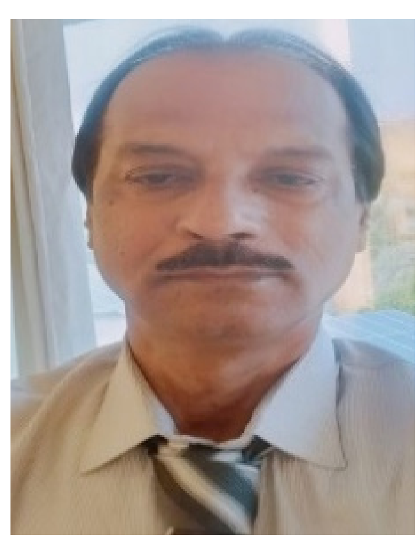
This policy has been devised fallowing extensive

technical discussions considering global evidence based guidelines. In my opinion implementation of the policy will drastically reduce maternal and child mortality rate of Balochistan and have an impact on maternal, newborn and child survival.

Muhammad Dawood

Special Secretary Health, Balochistan

Message from Director General Population Welfare Department Balochistan



Post-pregnancy family planning is a crucial aspect of maternal and child healthcare. After giving birth, it's important for couples to consider their future family goals and make informed decisions about contraception and spacing between pregnancies. One of the primary objectives of post-pregnancy family planning is to allow the mother's body to recover fully before conceiving again. Adequate spacing between pregnancies, typically at least 18 to 24 months, can reduce the risks associated with maternal and infant health, such as low birth weight and preterm birth. Health professionals often counsel women on various contraceptive options, helping them choose a method that aligns with their preferences, health considerations, and cultural beliefs. Effective family planning can empower couples to take control of their reproductive choices, promoting healthier outcomes for both mother and child.

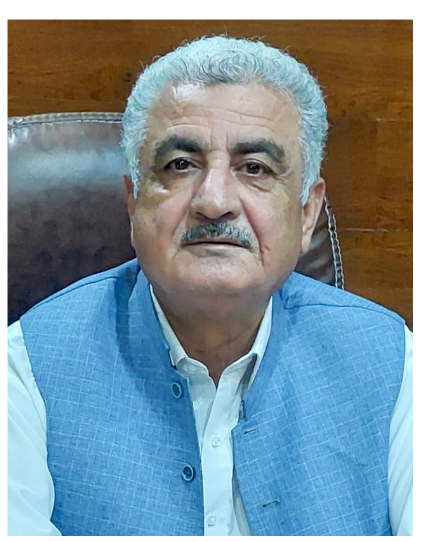
Furthermore, post-pregnancy family planning plays a vital role in achieving sustainable population control and reducing the strain on healthcare systems and resources. By allowing parents to plan the number and timing of their children, societies can better allocate resources for maternal and child health services, education,

and overall economic development. Access to a wide range of contraceptive methods and comprehensive family planning education is essential in ensuring that individuals and couples can make informed choices about when and how to expand their families. Governments and healthcare organizations must prioritize this aspect of reproductive health to promote the well-being of mothers and children and contribute to the overall social and economic progress of their communities.

Ghulam Mustafa

Director General Population Welfare Department, Balochistan

Message from Director General Health Balochistan



Post-pregnancy family planning is a crucial aspect of reproductive health that plays a significant role in ensuring the well-being of both the mother and the child. After giving birth, it is important for couples to carefully consider their future plans and make informed decisions regarding contraception and spacing of pregnancies.

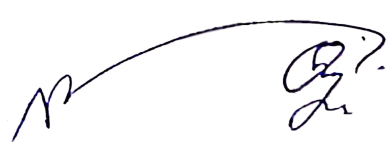
One primary consideration in post-pregnancy family planning is the choice of contraception. There are various methods available, including hormonal contraceptives, barrier methods, and intrauterine devices (IUDs). Each method has its own advantages and considerations, and it is important for couples to consult with healthcare professionals to choose the most suitable option based on their medical history, lifestyle, and future plans.

In addition to contraception, another essential aspect of post-pregnancy family planning is the spacing of pregnancies. Adequate spacing between pregnancies allows the mother's body to recover and replenish essential nutrients, reducing the risk of maternal and infant complications. It also allows parents to prepare for the arrival of another child emotionally and financially. Healthcare providers can provide guidance on the recommended spacing interval based on individual circumstances and maternal health.

Post-pregnancy family planning is a proactive approach that empowers couples to make informed decisions about their reproductive health. By considering contraception options and spacing pregnancies appropriately, couples can ensure a healthier and more fulfilling experience for both themselves and their children. Open communication and consultation with healthcare professionals are essential in making these decisions, as they can provide the necessary information and support to guide couples through this important phase of family planning.

Dr Noor Muhammad Qazi

Director General Health, Balochistan



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- Dr Ambreen Mengal, Director Technical PWD Balochistan

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LIST OF ABBREVIATIONS

CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
EBF	Exclusive Breastfeeding
FP	Family Planning
FWW	Family Welfare Workers
HCPs	Health Care Providers
HFs	Health Facilities
IUCDs	Intra-Uterine Contraceptives Device
LHWs	Lady Health Workers
LARCs	Long-Acting Reversible Contraceptives
MNCH	Maternal Newborn and Child Health
MICS	Multiple Cluster Survey
MMR	Maternal Mortality Rate
PDHS	Pakistan Demographic and Health Survey
PAC	Post Abortion Care
PAFP	Post Abortion Family Planning
PPFP	Post-Partum Family Planning
PpFP	Post-Pregnancy Family Planning
PPIUCD	Post-partum Intra utérine Contraceptive Device
SBAs	Skilled Birth Attendants
SDPs	Service Delivery Points

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Section 1:

Definitions

Post-Pregnancy Family Planning (PpFP):

refers to the provision of family planning (FP) services both during postpartum and post-abortion period. Policymakers are now accepting evidence that PpFP is a low-cost intervention that reduces maternal, infant, and under-five child mortality.

Postpartum Family Planning (PPFP):

is defined as the prevention of unintended pregnancy and closely spaced pregnancies throughout the first 12 months following childbirth.[1]

-The initiation and use of FP during the first year after delivery.[2]

The postpartum period starts immediately after childbirth and includes the first six weeks after delivery-during which the woman's body essentially returns to its pre-pregnancy state.

Postpartum family planning programs consider the extended postpartum period – one year after delivery to increase programmatic opportunities to reach families. Hence, one-year period can be classified as:

Post-placental – Within 10 minutes of delivery of placenta

Immediate Postpartum – After 10 minutes up to 48 hours of delivery

Intermediate Postpartum - From 48 hours up to 1 week after delivery

Late Postpartum – From one week to six weeks after delivery

Extended Postpartum – Six weeks to one year after delivery

1 Programming strategies for Postpartum Family Planning. World Health Organization 2013.
2 https://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/

Contraceptive methods during postpartum period

Lactational Amenorrhea Method (LAM

PPFP counseling consists of information on benefits of healthy timing and spacing of pregnancy (HTSP), return to fertility after birth, return to sexual activity, safe modern contraceptive options for postpartum women including those breastfeeding (based on WHO's medical eligibility criteria (MEC) for contraceptive use); lactational amenorrhea method (LAM), and transition from LAM to a modern contraceptive method.

Short-term contraceptive methods:

As shown in table below, both breastfeeding and non-breastfeeding women can safely use short-acting reversible contraceptive during postpartum period as per their eligibility (WHO medical eligibility criteria, 2015):

Table 1: Short-term contraceptive methods during postpartum period

For breastfeeding women	For non-breastfeeding women
Female sterilization	Female sterilization
Male sterilization	Male sterilization
Intrauterine device (IUD)	Intrauterine device (IUD)
Implants	Implants
Progestogen-only pills	Injectables
Lactational amenorrhea method (LAM)	Combined oral contraceptives (after 3 weeks of delivery/ childbirth)
Condoms	Condoms
Emergency contraception	Emergency contraception

Source: WHO Medical Eligibility Criteria for Contraceptive Use. 2015

such as PPIUCD and Implants are highly effective FP methods that can be initiated during the immediate postpartum in lactating and non-lactating women.

WHO medical eligibility criteria state that LARCs such as IUCDs and implants within the first 48 hours of postpartum is category one or safe. Both methods are cost-effective and PPIUCD can be inserted by a mid-level skilled birth attendant (LHVs and Midwives) while implants by medical doctors (male and female) and mid-level providers can also be trained, if policy allows.

WHO's Medical Eligibility Criteria (MECs) were updated in 2015 to allow for immediate postpartum Long term Reversible Contraceptives (IUDs and implants).

1) **Post-placental**: insertion within 10 minutes after placental expulsion

2) **Intra-cesarean**: insertion before closing the uterine incision

Pre-discharge: insertion from 10 minutes up to 48 hours postpartum

Postpartum Family Planning (PPFP):

Abortion refers to termination of pregnancy from any cause before the fetus is capable of independent existence. Family planning services is an integral component of post abortion care (PAC), provision of FP services during this period prevent unwanted pregnancies and future abortions.

After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy from WHO is at least six months in order to reduce risks of adverse maternal and perinatal outcome.

Informed choice and Volunteerism:

Informed choice in family planning means ensuring that clients have a variety of contraceptive methods from which to choose and the information needed to choose a method and use it successfully. The client must also be taught what to do if problems develop from method use. By informed choice, it is meant that a client chooses a method of her choice voluntarily without any force, and gets all the information related to FP methods. Women and their partners need accurate information to use a family planning method correctly. There are some key pieces of information that must be explained:

01 What the method is and how it works

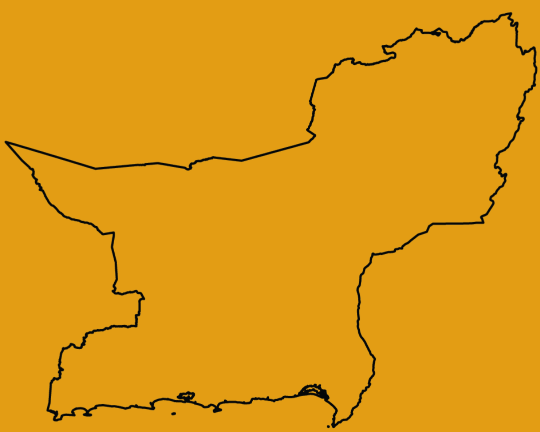
02 How effective it is at preventing pregnancy

The best way to check whether a woman knows how to use the method is to ask her to explain to you in her own words how to use the method.

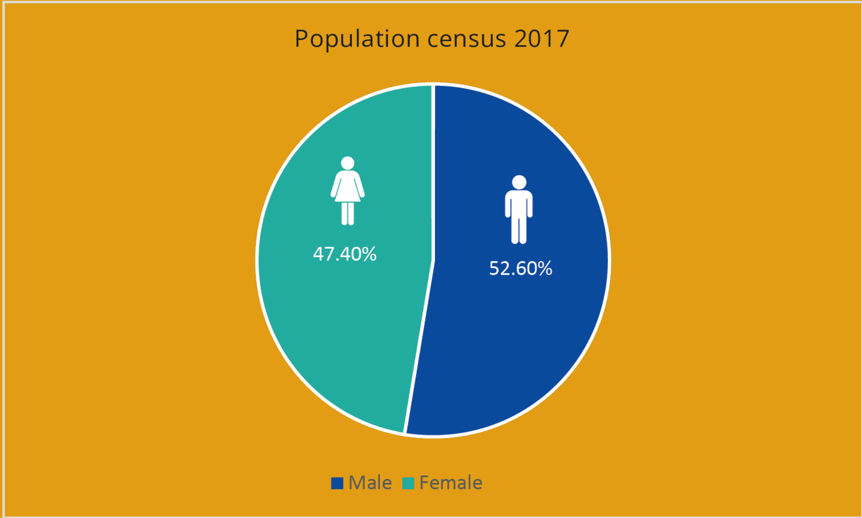
Section 2:

Situation Analysis

Balochistan is situated in the southwest of Pakistan and covers an area of **347,190 square kilometers** (134,050 sq mi). It is Pakistan's largest province by area, constituting 43.6% of Pakistan's total landmass.



According to population census 2017,
Balochistan total population is **12.344 million**, which constitutes **6.85%** of total population of the country,



The rural population constitutes **72%** of the total population, rest being the urban population.

The economy of the province is largely based upon livestock, agriculture, fisheries and production of natural gas, coal, and minerals. Outside Quetta, the infrastructure of the province is gradually developing but still lags far behind other parts of Pakistan. Limited farming in the east as well as fishing along the Arabian sea coastline are other forms of income and sustenance for the local populations. The rest of the rural economy and livelihoods is agro-pastoral derived from the ranges which provide a diversity of uses, including forage for livestock, wildlife habitat, medicinal plants, watershed, fuel wood, and recreational activity. With long travelling distances, low density of the population, and paucity of resources, it is not surprising to see low economic and growth indicators of the province, as compared to other provinces. Seeking healthcare is equally difficult, again, due to long distances and the lack of communication services, including transport.

According to the National Nutrition Survey (NNS) 2019 of Pakistan, 46.5 percent of under-five children are stunted, 18.9 percent wasted, and 31.0 percent are under-weight in Balochistan. The economic costs of malnutrition are high and persistent, with approximately 3 percent ($7.6 billion) of loss of GDP every year in Pakistan. PSLM 2018-19 revealed that almost 23.36 percent of households in Balochistan are experiencing moderate food insecurity while 3.55 percent households are severely food insecure. This figure is higher than the national figures.

Balochistan has the highest Pregnancy related mortality ratio in Pakistan, which is 298 per 100,000 live births[3] as against national ratio of 186 per 100,000 live births . As shown in the table 1 & 2, maternal health related indicators such as percentage of births attended by skilled health personnel (is the percentage of deliveries attended by health personnel trained in providing lifesaving obstetric care, including giving the necessary supervision, care, and advice to women during pregnancy, labour and the post-partum period and caring for newborns) has also improved between the last three PDHS-surveys. However, it still remains low of the required levels

3 Pakistan Demographic and Health Survey, 2006.

Table 2: Selected health and Family Planning indictors of Balochistan

Indicators	PDHS 2006-07	PDHS 2012-13	PDHS 2017-18
Maternal Mortality Ratio (100,000 live births)	785	Data not available	Data not available
Births by Skilled Birth attendants	23.0	17.8	38
Health facility deliveries	18.2	15.8	35
Family Planning (FP)			
Use of FP methods (any)	14.4	19.5	19.8
Use of modern contraceptives	13.4	16.3	14
Total Fertility Rate	4.1	4.2	4
Unmet need for FP	31.4	31.2	22
*Demand for FP satisfied	31.5	38.4	47.9

*Proportion of women of reproductive age (aged 49-15 years) who have their need for family planning satisfied with modern contraceptive methods

Table 3: Percent distribution of women age 15-49 years with a live birth in the last 2 years by person providing assistance at delivery of the most recent live birth, Balochistan, 2019-20 (MICS Survey)

Person assisting at delivery									
	Skilled attendant				**Other**				
	Medical doctor	**Nurse/ Midwife**	**Lady Health Visitor (LHV)**	**Community Midwife**	**Traditional birth attendant**	**Relative/ Friend**	**Other**	**No attendant**	**Total**
Total	38.6	4.6	3.2	3.5	45.6	2.9	0.5	1.1	100.0
Area									
Urban	58.9	3.7	2.7	2.0	30.9	1.0	0.0	0.8	100.0
Rural	31.3	4.9	3.4	4.0	50.9	3.6	0.6	1.2	100.0
Education									
Pre-primary or none	32.3	4.4	3.2	4.0	50.9	3.3	0.5	1.3	100.0
Primary	58.3	8.5	3.6	1.4	26.0	1.5	0.7	0.0	100.0
Middle	67.0	5.7	3.0	0.3	22.5	0.3	0.0	1.2	100.0
Secondary	73.9	1.3	2.1	1.4	20.1	1.1	0.0	0.0	100.0
Higher	74.6	6.1	4.2	2.0	12.5	0.0	0.0	0.7	100.0

Age at most recent live birth[A]									
Less than 20	43.7	2.9	2.4	1.6	44.1	3.2	0.8	1.3	100.0
20-34	38.5	4.7	3.2	3.5	45.7	2.8	0.4	1.2	100.0
35-49	36.9	4.8	3.6	4.2	46.0	3.1	0.6	0.7	100.0
Number of antenatal care visits									
None	25.1	4.0	2.0	4.1	57.7	4.5	0.6	1.9	100.0
1-3 visits	42.0	6.4	6.1	3.6	39.9	1.6	0.2	0.3	100.0
4+ visits	74.9	3.4	2.4	1.4	17.1	0.3	0.5	0.0	100.0
8+ visits	84.4	1.4	0.8	0.9	12.5	0.0	0.0	0.0	100.0
DK/Missing	(*)	(*)	(*)	(*)	(*)	(*)	(*)	(*)	100.0
Place of delivery									
Home	8.2	3.0	2.4	5.0	74.4	4.9	0.5	1.5	100.0
Health facility	83.2	7.0	4.5	1.4	3.7	0.0	0.0	0.1	100.0
Public	85.4	6.3	2.4	1.2	4.6	0.0	0.1	0.1	100.0
Private	79.4	8.1	8.2	1.8	2.2	0.0	0.0	0.2	100.0
Other/DK/ Missing	15.2	0.4	3.1	2.0	47.8	0.8	16.5	14.2	100.0
Wealth index quintile									
Poorest	11.6	3.7	2.5	6.4	68.2	5.4	0.7	1.5	100.0
Second	26.1	5.5	2.7	3.5	55.8	4.4	0.3	1.6	100.0
Middle	34.4	5.8	3.7	4.6	47.2	2.9	0.2	1.1	100.0
Fourth	49.9	3.9	4.9	2.1	36.0	1.5	0.9	0.8	100.0
Richest	72.0	4.2	2.4	0.8	19.6	0.2	0.3	0.4	100.0

The single most critical intervention for safe motherhood is to ensure that a competent health worker with midwifery skills is present at every birth, and, in case of emergency, there is a referral system in place to provide obstetric care at the right level of facility. The skilled attendant at delivery indicator is used to track progress toward the Sustainable Development Goal 3.1 of reducing maternal mortality and it is SDG indicator 3.1.2. In Balochistan MICS, the skilled attendants are medical doctor, nurse/ midwife, Lady Health Visitor (LHV) and community midwife .

Table4 below illustrates the deliveries taking place at health facilities and at homes:

As is evident that almost 60% of women from urban population go to health facilities for deliveries, whether public or private. In contrast, only 34% of rural women deliver at health facilities, most of them (21.2%) at public sector health facilities. More than 65% of women belonging to rural areas are delivered at home, as compared to 40.8% of urban women

Table 4: Percent distribution of women age 15-49 years with a live birth in the last 2 years by place of delivery of the most recent live birth, Balochistan, 2019-20:

Total	**Place of delivery**					
	Health facility					
	Public sector	**Private sector**	**Home**	**Other**	**DK/ missing**	**Total**
	25.9	14.5	58.6	0.6	0.3	100
Area						
Urban	38.8	19.7	40.8	0.5	0.2	100
Rural	21.2	12.7	65.1	0.7	0.4	100
Education						
Pre-primary or none	22.2	11.8	65.0	0.7	0.4	100
Primary	40.7	22.7	36.4	0.2	0.0	100
Middle	50.2	17.1	32.1	0.6	0.0	100
Secondary	49.6	23.9	26.4	0.0	0.0	100
Higher	27.8	50.7	19.5	2.0	0.0	100.
Age at most recent live birth						
Less than 20	25.2	15.7	58.2	0.4	0.5	100
20-34	25.6	14.9	58.6	0.6	0.2	100
35-49	27.2	12.4	58.9	0.7	0.8	100
Number of antenatal care visits						
None	15.9	8.0	74.6	0.9	0.6	100
1-3 visits	30.7	19.3	49.5	0.5	0.0	100
4+ visits	48.9	27.2	23.8	0.1	0.0	100
8+ visits	52.3	30.0	17.5	0.2	0.0	100
DK/Missing	(*)	(*)	(*)	(*)	(*)	100

The PDHS 2017-18 findings shown in table 5 point out that in Balochistan, contraceptive prevalence rate (CPR), for (any method) has only increased by 0.3 percentage point (from 19.5 in 2012-13 to 19.8 in 2017-18). However, demand for family planning during this 5-year period decreased by 9.5 percentage points (from 38.4% in 2012-13 to 47.9% in 2017-18) which has resulted in a net decrease of 9.2 percentage points in unmet need.[4,5]

Similarly, the methods mix figures of the province revealed that use of traditional methods such as withdrawal has increased from 0.5 to 5.8% from 2006-07 to 2017-18. Among the users of modern contraceptives, barrier methods (condoms) used by male (5.4%) and oral pills (2.7%) & female sterilization (2.4%) were the top 3 methods. Use of reversible methods (IUCD, injectables and implants) is very low as only 3.0 percent of MWRAs were using these three methods in 2017-18.

Method	PDHS 2006-07	PDHS 2012-13	PDHS 2017-18
	%	%	%
Any method	14.4	19.5	19.8
Withdrawal	0.5	3.0	5.5
Condom	1.6	3.7	5.4
Pills	5.3	2.4	2.7
Injections	1.4	1.7	2.3
Implants	0.0	0.0	0.1
IUCD	0.6	2.1	0.6
Female Sterilization	4.6	4.0	2.4
Male Sterilization	0.0	0.0	0.0
Others	0.5	0.6	0.9

Teen-age pregnancy

According to PDHS 2017-18, about 9% of women at the age of 15-19 years reported to have begun childbearing in Balochistan. Among them, 7% have had a live birth while 2% were pregnant at the time of survey. It was also reported that rural teenagers (10.4%) tend to start childbearing earlier than urban teenagers (6.7%). Additionally, those with low levels of education and wealth quantiles also tend to start childbearing earlier than those with 8 years or a greater number of years of education and high wealth quantiles.

4 Pregnancy related maternal mortality survey 2019
5 Pakistan demographic Health Survey 2017-2018

Family Planning service delivery

The Federal Bureau of Statistics collects contraceptives sale/ distribution data from DoPW, DoH and NGOs and estimates national mCPR based on the units sold/ distributed. According to Contraceptive Performance Report of 2016-17 estimated mCPR in 2016-7 was 39.2. Contribution of DoPW (14.1%) and DoH (12.8%) in mCPR was nearly 70% (26.9 out of 39.2). Obviously, improvement in population figures mainly depends on the performance of these two departments.

Both the DoH and DoPW are mandated to provide family planning services in Balochistan. The departments provide FP services through various levels of health facilities as well as outreach services. DOPW provides FP services only; while at DOH facilities, FP services are available as part of reproductive health services. The service delivery infrastructure of DOH is much more extensive than that of DOPW. A brief description of service delivery outlets of DOH and DOPW is attached at annexed A.

Major suppliers of contraceptive in the provinces are Department of Population Welfare (DOPW) and Department of Health (DoH) and NGOs. Lady Health Workers (LHWs) who work under DOH are the major supplier of reversible short-term contraceptive methods including injectables, pills and condoms. Over the years, it has been debated that functional and structural integration of the DOPW and DOH might help to make the delivery of FP services more effective. The Council of Common Interest (CCI) in its meeting dated 19th November 2018, based on the Recommendations of the CJ' Task Force on Population, has approved the integration of Family Planning in Health.

Section 3:

Progress on FP Commitments

At the Family Planning Summit 2012 held in London, Pakistan committed to increase its CPR to 55% (later revised to 50%) by 2020, which would have brought down its total fertility rate (TFR) to 2.8 children per woman. Accordingly, the provinces set provincial CPR targets to meet these goals. The Censes 2017 revealed that Pakistan Population was growing at an alarmingly high inter-censes growth rate of 2.5%. Similarly, PDHS, 2017-18 informed that the CPR was stagnant rather declined in some areas. Taking cognizance of this critical situation, the Chief Justice of Pakistan took Suo Moto Notice and directed the federal government to mobilize the provinces to introduce initiatives for reducing the population growth rate to a sustainable level. The federal government, with the help of other stakeholders, developed a set of recommendations to be implemented by the federal and provincial governments, which were approved by the Council of Common Interests (CCI) its 39th meeting held on 19th November 2018.

In all, the CCI recommendations include 30 items grouped under eight specific areas, including:

Establishing national and provincial Task Forces for steering and providing oversight, and taking critical decisions to reduce population growth, lower the fertility rate, and increase CPR

Ensuring universal access to FP/reproductive health services;

Increasing FP program financing

Enacting appropriate legislation for promotion of FP/reproductive health;

Improving advocacy and communication for FP

Improving FP curriculum and providing related training

Ensuring contraceptive commodity security

Generating support of ulema (religious scholars) for FP.

Balochistan has taken several initiatives, in response to implement the second group of recommendations, i.e., ensuring universal access to FP/reproductive health services, and more specifically, the sub-recommendation of mandating all public health facilities—including Family Welfare Centers (FWCs), Basic Health Units (BHUs), Rural Health Centers (RHCs), Tehsil Headquarters (THQ) Hospitals, and District Headquarter (DHQ) Hospitals—to deliver FP services as part of the Essential Package of Health Services (EPHS).

Prominent Initiatives in last five years

Balochistan has shown great political will and leadership's interest in improving health of the people. Several steps have been taken to improve the FP uptake, accessibility to quality FP services, and removing or minimizing the barriers to FP services.
In order for pursuing FP/RH agenda on a fast track, the Government of Balochistan, has constituted Balochistan FP2030 Working Group, headed by Secretary Population Welfare Balochistan, and having representation of all the stakeholders, working on Family Planning in the province of Balochistan. The members of this forum include high level officials of both departments, donor agencies, civil society representatives etc. The Group meets regularly and provides an excellent opportunity to review progress and highlight challenges, suggest solutions and bring synergy amongst various stakeholders. Both, DoH and DoPW fully appreciate the significance of this forum in harmonizing their activities and addressing challenges in implementation of CIP activities in the province.

Provincial Population and Health Policies and Plans

In recent years, the policy emphasis on improving access to quality FP services has increased in Pakistan. Since the devolution of health and population welfare programs from federal to provincial level in 2011, the provinces have developed their own policies and strategic plans for health and population.

Balochistan Health Sector Strategy

Department of Health Government of Balochistan (GoB) developed its Health Policy 2018-30 with the support of World Health Organization (WHO). The policy goal is to achieve Universal Health Coverage and the targets as set forth for Sustainable Development Goal (SGD) -3. The policy will provide vision, direction and guidelines for different components of health system and services as a long-term plan for Health System Strengthening. Balochistan Health Sector Strategy (2018–2022) has been revised and aligned with the Health Policy 2018-30 to serve as a vehicle for investment in the health sector.

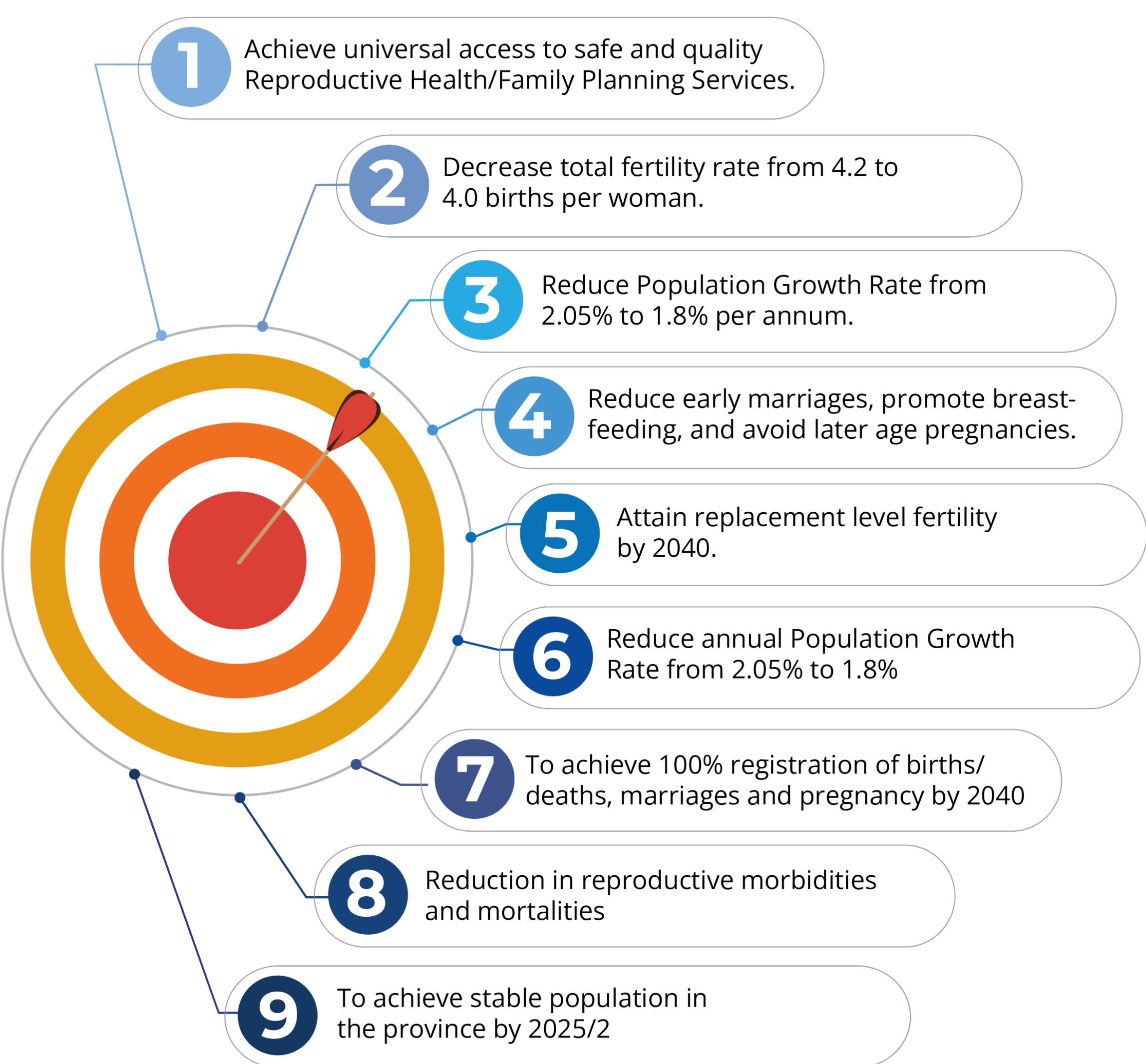
The strategy (2018 – 2025) has an action plan and monitoring mechanism to measure the progress of achievements of the provincial targets. The strategy includes FP as an integral part of sexual and reproductive health services, which are to be delivered at health facilities as well as by Lady Health Workers (LHWs) in communities.

The strategy explicitly mentioned to:

"Develop a Minimum Health Service Delivery Package (MHSDP) inclusive of MNCH-FP-Nutrition with required resource as per needs of rural disadvantaged districts. Develop a detailed Essential Package of Health Service (EPHS) for secondary care provision in under-performing districts, inclusive of following key priority needs: MNCH, Nutrition, FP, and provision of long-acting and permanent contraceptive methods.

Balochistan Population Policy 2015-2025

Balochistan Population Policy was finalized in 2015 with the main objectives of increasing the CPR from 20 percent to 25 percent in 2020 and to 25 percent in 2025. The other objectives of the policy include:



The policy mentions provision of a package of MNCH, nutrition, and FP services at DOH facilities.

Costed Implementation Plan (CIP):

The Costed Implementation Plan (CIP) is a document that provides a road map to work along the sectors on FP in a manner that it contributes towards overall population development. The CIP provides implementation mechanism and includes five-year plan (2020) in accordance with the population policy objectives. These include an implementation roadmap of the Policy, with multi-sectoral approach and have detailed list of activities, stakeholders' role to increase access and coverage for FP in order to specifically enhance CPR from current 20 percent to 36 percent by 2025 and to 46 percent by 2030.

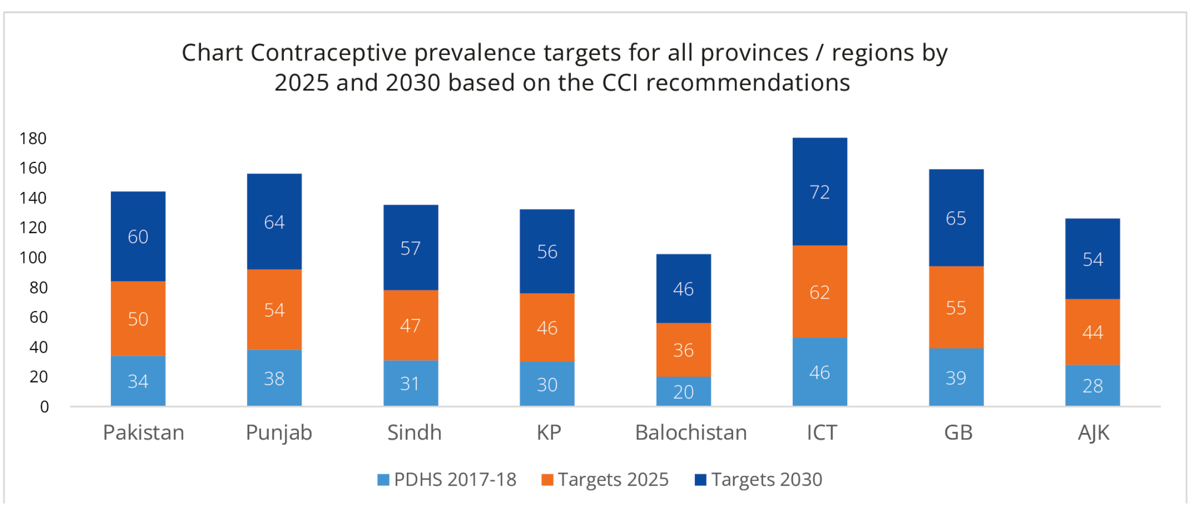
Unfortunately, after development of document for CIP, its implementation has been delayed due to some reasons, and it is hoped that provincial Population Welfare Department will soon start practical implementation of CIP in the province of Balochistan.

Postpartum Family Planning (PpFP) strategy has been endorsed by both DoH and DoPW in all the four provinces. The strategy provides a framework for provision of PpFP services at all levels of health facilities, and task sharing between the DoH and DoPW during antenatal, natal, and early and extended postnatal visits.

CCI recommendations for provinces

For the whole of Pakistan, the CPR should reach 50 percent in 2025 and 60 percent in 2030. The target level achieved by 2030 at the regional level depends on the starting CPR. It would be high in ICT (72 percent compared to 46 percent in 2017-18) and low in Balochistan (46 percent compared to 20 percent in 2017-18). The TFR of women in Pakistan would decrease from 3.6 children in 2017-18 to 2.8 in 2025 and 2.2 children in 2030. The TFR would be below the national level in 2030 in Punjab and ICT, with 2.0 and 1.5 children on average per woman respectively. The fertility in the capital city would be halved from the 2017-18 level. In Sindh, the TFR would reach 2.3 children in 2030 (same in AJK). It would be higher in the remaining provinces/regions, around 2.8-2.9 children in KP, Balochistan, and even GB where the starting value is high at 4.7 children per woman.

As shown in the table below, if the proposed provincial targets were achieved, this would translate into a CPR of 44 percent in 2025 and 50 percent in 2030 for the whole of Pakistan. Punjab and Balochistan have agreed on a 1 percentage point annual increase of the CPR to 2030.



If so, the CPR in Punjab would be 46 percent in 2025 and 51 percent in 2030. Whereas, in Balochistan, the CPR would be 28 percent and 33 percent in 2025 and 2030, respectively. Sindh, KP, and AJK have agreed on adopting a 1.5 percentage point annual increase of the CPR targets from 2017 to 2030: In Sindh, CPR reaches 43 percent in 2025 and 50 percent in 2030. The population growth in Balochistan would decline to 2.1 percent and 2 percent by 2025 and 2030, respectively, as the Govt. of Balochistan has agreed to increase yearly the CPR by 1 percentage point from 2017

Federal and Provincial Task Forces for Population

With the President of Pakistan as its chair, the Federal Task Force comprises of Provincial and Regional Chief Ministers, Provincial and Regional Chief Secretaries, and key Federal Ministers in addition to relevant officials. The FTF in pursuance of the CCI Recommendations is responsible for taking the FP/RH agenda forward and operates with the clear terms of reference.

A series of steps including enacting laws to restrain early/ childhood marriages, decentralization of family planning and reproductive health services to the local governments, strengthening the family planning programme and network through a public-private mix approach, resource mobilization, linking population programmes with social security and safety nets, promoting health literacy and engaging with key stakeholders and influencers were proposed

Like federal task force on population, the provincial task forces for population have also been established in all four provinces on the similar lines to implement recommendations of CCI and decisions of federal task force. The provincial task force is chaired by the concerned Chief Minister, with Chief Secretary, Secretaries Health, Population Welfare, Education, WDD, and representatives from civil society as its members.

Section 4:

Public Private Partnership (PPP) & Role of Development Partners

As per policy, Balochistan has actively worked on public-private partnership to increase access and coverage of health services, including FP. DOH has outsourced the Basic Health Units to PPHI, while rest of health facilities including RHCs and Secondary & Tertiary care hospitals remain under the administrative control of Department of Health Balochistan. The table below shows the existing health facilities in the province:

Table 7: Details of Health Facilities in Balochistan

Type of Health Facility	Number of the Health Facilities	Administrative Control
Basic Health Unit (BHUs)	735	PPHI
Rural Health Center (RHC)	105	Department of Health
Tehsil Headquarter Hospital (THQ)	10	Department of Health
District Headquarter Hospital (DHQ)/ Civil Hospital	23	Department of Health
Tertiary Care Hospital	04	Department of Health
Civil Dispensaries	541	Department of Health
Mother & Child Health Centers	91	Department of Health
Total	**1509**	

About 735 Basic Health Units are under administrative control of PPHI, whereas rest of health facilities are managed by Department of Health Balochistan. These include 105 Rural Health Centers (RHCs), 10 THQs, 23 DHQs, 04 Tertiary Care Hospitals and more than 540 Civil Dispensaries. The outsourced firms are required to provide FP services at the health facilities as part of the MNCH service package as well as to provide FP training to service delivery staff at the facilities.

Department of Population Welfare Balochistan manages around 258 static and mobile service outlets in the province, which provide FP services to the couples. In addition, PWD Balochistan has a field force of 450 Social Mobilizers, which mobilize the community for FP uptake as a volunteer informed choice and refer them to static PWD facilities, mobile units and outreach FP camps. The table below shows the details of PWD Balochistan managed FP service delivery points/outlets:

Type of Facility	Number of the Facilities	Administrative Control
RHS Center	11	Population Welfare Department Balochistan
Family Welfare Center (FWC)	191	Population Welfare Department Balochistan
Mobile Service Units (MSU)	56	Population Welfare Department Balochistan
Social Mobilizer	450	Population Welfare Department Balochistan
Total	**688**	

In addition to this, NGOs and private sector organisations, such as Family Planning Association of Pakistan (FPAP), Greenstar Marketing and Marie stopes Society also provide FP services to the community through their service delivery points, healthcare providers, community health workers and mobile units.

Development partners and key donors in the health sector can become instrumental in ensuring a stable, well concerted, and responsive improved state of affairs for the MNCH and FP programme. The international NGOs, NGOs and donor agencies have been providing technical assistance, mainly in the form of capacity development activities, provision of equipment, instrument and supplies to DoH & PWD facilities and logistics.

Section 5:

Human Resource Availability

Table 9: Human Resource availability at DOH Health Facilities

POST	TOTAL NO. OF POSITIONS	NO. OF FILLED POSITIONS	NO. OF VACANT POSITIONS (% OF TOTAL)
MEDICAL OFFICER/SMO			
	2076	NA	NA
WMO			
	822	NA	NA
GYNECOLOGIST			
		NA	NA
LADY HEALTH VISITOR			
	876	NA	NA
TOTAL OF ALL CADRES			
	3774	**NA**	**NA**

Table 10: Human Resource availability at DOPW Health Facilities:

POSITION	TOTAL NO. OF POSITIONS	NO. OF FILLED POSITIONS	NO. OF VACANT POSITIONS (% OF TOTAL)
WMO			
	56	33	23 (41%)
THEATRE NURSE			
	10	09	01 (10%)
FW COUNSELOR			
	63	52	11 (17%)
THEATRE TECHNICIAN			
	11	10	01 (9%)

FW WORKER			
	163	105	58 (36%)
FW ASSISTANT (MALE & FEMALE)			
	439	417	22 (5%)
FIELD TECHNICAL OFFICERS			
	56	38	18 (32%)
TOTAL FOR ALL CADRES			
	798	**664**	**134 (17%)**

Section 6:

PPFP Policy

Rationale

According to PDHS 2017-18, fifty-two percent (52%) of currently married women aged 15-49 in Pakistan have a demand for FP; 19% for spacing births, and 33% for limiting births. However only 34% of currently married women are using a contraceptive method either to space or to limit births, and therefore have fulfilled their need. The remaining 18% of currently married women have an unmet need for FP: 10% want to space and 8% desire to limit births but are currently not using any contraception. If all married women who want to space or limit their children were to use a family planning method, the contraceptive prevalence rate would increase from 34% to 52%.[6]

Balochistan figures shows that desire to limit childbearing increases with no of living children among both women and men, as highlighted in table 3. More women with two or more living children than men expressed to limit childbearing and higher with 2 and 3 children.

The table below shows the uptake of FP methods based on area, age, number of living children, education and wealth quantile. It very clearly shows that female sterilization is more common in the age group of 40 and above. Short term methods are more common in the women of below 40 years of age. Women from poorest wealth quantile have the lowest and from richest wealth quantile have the highest usage of any family planning method. Similarly, the FP uptake is lowest among women having no or only primary education.

Table 11: Use of Contraception: Percentage of women age 15-49 years currently married who are using (or whose husband is using) a contraceptive method, Balochistan, 2019-20

	No Meth-od	Fe-male Steril-ization	Male Steriliza-tion	IUD	Inject-ables	Implant	Pill	Male Condom	Female Condom	Dia-phragm/ Foam/Jelly
Total	79.9	0.6	0.2	0.7	4.5	0.4	5.1	4.0	0.2	0.0
Area										
Urban	72.8	0.8	0.0	0.6	5.5	0.2	7.1	4.5	0.2	0.0
Rural	82.3	0.6	0.2	0.8	4.2	0.4	4.4	3.8	0.2	0.0

6 PDHS 2017-18

Age										
15-19	92.1	0.0	0.0	0.0	1.1	0.1	2.8	2.5	0.2	0.0
15-17	93.3	0.0	0.0	0.0	0.0	0.0	4.3	2.0	0.0	0.0
18-19	91.8	0.0	0.0	0.0	1.4	0.1	2.4	2.7	0.3	0.0
25-29	79.6	0.4	0.1	0.5	4.3	0.3	4.7	4.7	0.1	0.0
30-34	79.2	0.4	0.1	0.7	4.3	0.3	4.9	4.6	0.3	0.0
35-39	75.8	1.0	0.1	1.1	6.0	0.2	7.0	4.1	0.2	0.0
40-44	79.3	1.3	0.2	1.1	6.2	0.6	4.5	3.5	0.2	0.1
45-49	83.1	1.1	0.4	1.0	4.1	0.8	4.9	2.4	0.1	0.1
Education										
Pre-primary or none	82.0	0.6	0.2	0.7	4.0	0.4	4.7	3.1	0.2	0.0
Primary	69.8	1.0	0.0	0.9	5.7	0.0	6.8	8.5	0.3	0.0
Middle	67.7	1.2	0.0	0.7	6.6	0.5	7.4	10.2	0.1	0.0
Secondary	68.1	1.0	0.1	1.2	8.0	0.0	7.7	8.4	0.0	0.1
Higher	70.8	0.8	0.1	0.3	7.3	0.3	4.6	7.9	0.0	0.0
Number of living children										
0	99.0	0.2	0.0	0.0	0.0	0.0	0.2	0.3	0.0	0.0
1	82.9	0.2	0.2	0.4	2.7	0.3	3.4	5.6	0.2	0.0
2	79.0	0.3	0.2	0.9	4.6	0.7	5.2	4.4	0.2	0.1
3	77.8	0.8	0.4	0.8	4.8	0.7	4.7	4.3	0.1	0.0
4+	74.9	1.0	0.1	0.9	6.2	0.2	7.1	4.3	0.2	0.0
Wealth index quintile										
Poorest	89.0	0.2	0.0	0.4	1.8	0.4	2.0	1.9	0.2	0.1
Second	85.7	0.4	0.1	1.1	3.8	0.3	3.8	2.3	0.2	0.0
Middle	82.2	1.1	0.3	0.9	4.9	0.5	4.9	3.1	0.3	0.1
Fourth	79.3	1.0	0.2	0.9	5.3	0.3	4.8	5.6	0.1	0.0
Richest	62.5	0.5	0.2	0.4	7.0	0.3	10.1	7.5	0.0	0.1

Table 12: Percentage of currently married women aged 15-49 in Balochistan who want no more children, by number of living children, according to background characteristics, Pakistan DHS 2017-18

Desire to limit childbearing, by no. of living children in Balochistan (PDHS 18)	Number of Living Children							Total
	0	1	2	3	4	5	6+	
Women								
Balochistan	0.5	3.5	13.1	15.5	30.3	50.9	68.9	31.1
Urban	2.3	5.8	19.5	21.8	41.4	60.1	67.3	35.1
Rural	0	2.7	9.3	12.8	25.1	47	69.5	29.4
Men								
Balochistan	6.0	3.1	18	8	20.2	25.8	35.5	19.2
Urban	(4.2)	(10.5)	(23.9)	(15.8)	(24.7)	(44.3)	44.4	26.2
Rural	(6.7)	(0)	(14.1)		(18.4)	(16.2)	32.6	16.

As shown in the table 13 below (MICS 2018), the unmet need is highest in the age group of 20-24 years (39.2%), and lowest among the women of 45-49 years of age (15.7). The same table demonstrates that unmet need is highest among women having no or only primary education, which is 33.4%. Looking at the wealth quantile, it is obvious that women of poor category are in more need of FP, than the others. It is therefore, very apparent that the policy makers and implementers need to focus more on poor, uneducated and youth to improve the FP indicators in the province.

Table 13: Percentage of women age 15-49 years who are currently married with unmet and met need for family planning, total demand for family planning, Balochistan, 2019-20 (MICS):

	Unmet need for family planning			Met need for family planning (currently using contraception)			Total demand for family planning		
	For spacing births	For limiting births	Total	For spacing births	For limiting births	Total	For spacing births	For limiting births	Total
Total	23.7	8.2	31.9	14.5	5.6	20.1	38.2	13.8	52.0
Area									
Urban	18.9	7.4	26.4	19.2	7.9	27.2	38.1	15.4	53.5
Rural	25.3	8.5	33.8	12.9	4.8	17.7	38.3	13.2	51.5
Age									
15-19	31.9	5.0	36.8	7.0	0.8	7.9	38.9	5.8	44.7
15-17	28.1	5.2	33.3	5.6	1.1	6.7	33.7	6.3	40.0
18-19	32.9	4.9	37.8	7.4	0.8	8.2	40.3	5.7	46.0
20-24	33.2	6.0	39.2	16.7	2.2	19.0	50.0	8.2	58.2
25-29	31.0	7.6	38.6	17.0	3.4	20.4	48.0	10.9	59.0
30-34	24.8	8.2	33.1	16.0	4.8	20.8	40.8	13.0	53.8
35-39	20.1	11.1	31.1	15.6	8.5	24.2	35.7	19.6	55.3
40-44	12.3	9.7	22.0	11.0	9.7	20.7	23.3	19.4	42.7
45-49	8.3	7.4	15.7	8.1	8.8	16.9	16.4	16.2	32.6
Education									
Pre-primary or none	24.5	8.9	33.4	12.8	5.2	18.0	37.3	14.1	51.4
Primary	22.9	4.8	27.7	22.5	7.6	30.2	45.4	12.5	57.9
Middle	20.5	4.2	24.8	23.8	8.5	32.3	44.4	12.7	57.1
Secondary	16.6	3.9	20.5	24.4	7.4	31.9	41.0	11.3	52.4
Higher	19.0	5.8	24.8	21.3	7.9	29.2	40.3	13.7	53.9
Functional difficulties (age 18-49 years)									
Has functional difficulty	18.3	8.5	26.9	9.8	9.7	19.5	28.1	18.2	46.3
Has no functional difficulty	23.8	8.2	32.0	14.7	5.5	20.2	38.5	13.7	52.2
Wealth index quintile									
Poorest	25.5	11.0	36.4	8.2	2.8	11.0	33.7	13.8	47.5
Second	27.4	8.7	36.1	10.0	4.3	14.3	37.4	12.9	50.4
Middle	25.6	9.0	34.6	12.6	5.2	17.8	38.2	14.2	52.4
Fourth	23.2	7.2	30.4	14.9	5.7	20.7	38.1	12.9	51.0
Richest	16.5	5.1	21.6	27.4	10.0	37.5	43.9	15.2	59.1

Data shows that unmet need for FP (spacing or limiting) is high during the first two years following a childbirth. Even though total unmet need decreases during this period from (73% to 52%), overall unmet need is still high. Sixty percent (60%) of all non-first births are spaced at less than the recommended 24 months birth to pregnancy interval, thus putting women and their infants at greater risk for poor maternal outcomes and perinatal outcomes.

Further the data shows that CPR among young age group of married women has declined during the period 2012-2018 in Pakistan. Table 4 presents CPR by age categories and showing CPR increase in only 40-44 years age category when women already had 6 or more children. There is a dire need to address the unmet need of young couples and first-time parents.

Table 14: Contraceptive Prevalence Rate (CPR) by age categories

Age Group	PDHS 2012/13	PDHS 2017/18	Change	
			% age Points	%
15-19 years	7%	6%	-1	-14%
20-24 years	15%	13%	-2	-10%
25-29 years	21%	21%	-	-
30-34 years	31%	30%	-1	-4%
35-39 years	37%	32%	-5	-11%
40-44 years	33%	34%	2.7	8%
45-49 years	26%	25%	-0.30	-1%

Source, PDHS 2017-18

Evidence shows that about 48% of sexually active women are at risk of pregnancy during the first six months postpartum; this risk increases to 75% from 6-12 months postpartum and to 76% from 12-24 months postpartum. Last three PDHS survey data show that facility-based deliveries are increasing, reflecting the need to strengthening FP counseling and FP services for women who come in contact with the health system/facilities during pregnancy, childbirth and postnatal period.

The antenatal period presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. For example, antenatal care can be used to inform women and families about risks and symptoms in pregnancy and about the risks of labour and delivery, and therefore it may provide the route for ensuring that pregnant women do, in practice, deliver with the assistance of a skilled health care provider. Antenatal visits also provide an opportunity to supply information on birth spacing, which is recognized as an important factor in improving infant survival. WHO recommends a

minimum of eight antenatal visits based on a review of the effectiveness of different models of antenatal care. Antenatal care is a tracer indicator of the Reproductive and Maternal Health Dimension of SDG 3.8 Universal Health Coverage.

One of the reasons of not capturing the low hanging fruits is very low ante-natal and post-natal check-ups and counselling for Family Planning. These are the areas, which can be game changer, if focused properly. If, we are able to counsel women during their an at-natal, natal and post-natal periods, the PPFP & PAFP uptake will rise dramatically. The tables below show the trends in ante-natal, post-natal care among different age groups, educational status and wealth quantile:

Table 15: Ante-natal coverage: Percent distribution of women age 15-49 years with a live birth in the last 2 years by antenatal care provider during the pregnancy of the most recent live birth, Balochistan, 2019-20

Status of Ante-Natal Care Balochistan. Source: MICS Survey								
	Medical Doctor	**Nurse/Midwife**	**Lady Health Visitor (LHV)**	**Community Midwife (CMW)**	**Traditional Birth Attendants (TBAs)**	**Others**	**No Ante-natal care**	**Total**
Urban	48.3	1.8	1.8	0.4	1.7	0.1	45.8	100
Rural	26.8	2.8	4.4	1.8	7.0	0.3	56.9	100
Education								
Pre-primary or none	26.4	2.6	4.0	1.4	6.2	0.3	59.1	100
Primary	54.3	3.1	3.4	2.2	3.8	0.0	33.2	100
Middle	55.4	3.5	2.0	2.3	3.9	0.0	32.9	100
Secondary	68.0	0.2	1.0	0.4	2.8	0.3	27.3	100
Higher	65.2	3.4	2.0	1.1	0.4	0.0	27.8	100
Age at most recent live birth[c]								
Less than 20	31.7	1.3	0.9	0.9	5.3	0.2	59.7	100
20-34	32.2	2.8	3.9	1.7	5.7	0.3	53.3	100
35-49	33.9	1.9	4.0	0.6	5.2	0.1	54.3	100
Wealth index quintile								
Poorest	10.9	2.4	3.5	1.4	8.1	0.3	73.3	100
Second	24.4	4.7	5.3	1.2	8.2	0.0	56.2	100
Middle	30.6	3.7	3.8	4.1	5.8	0.1	51.8	100
Fourth	38.7	1.5	4.1	0.6	3.6	0.7	50.7	100
Richest	58.7	0.6	1.9	0.0	2.1	0.2	36.4	100

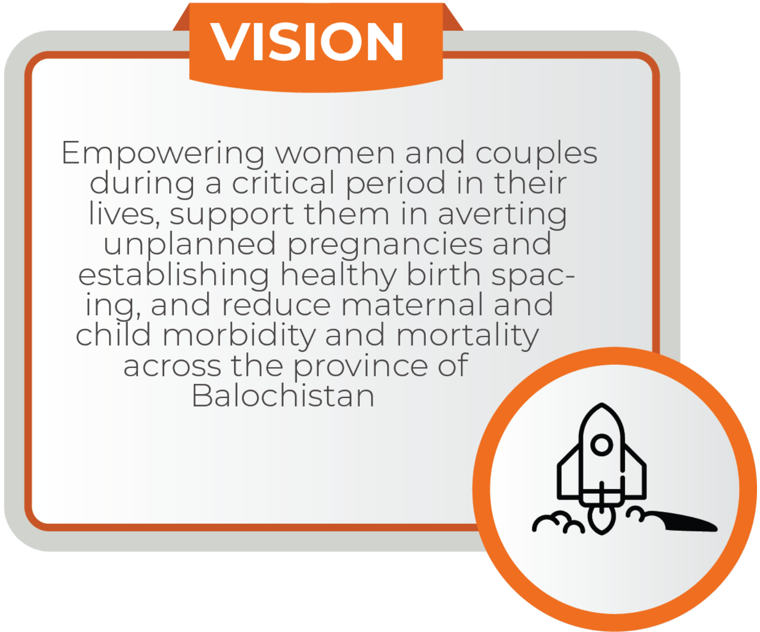
Table 16: Percentage of women age 15-49 years with a live birth in the last 2 years who for the most recent live birth received health checks while in facility or at home following birth, Balochistan, 2019-20

	Health check following birth while in facility or at home	PNC visit for mothers							
		Same day	1 day following birth	2 days following birth	3-6 days following birth	After the first week following birth	No post-natal care visit	DK/ Missing	Total
Total	37.5	5.8	1.0	0.8	0.8	1.4	88.9	1.2	100
Sex of newborn									
Male	36.3	5.3	0.7	0.6	1.1	1.5	89.6	1.3	100
Female	38.7	6.4	1.3	1.0	0.6	1.3	88.3	1.2	100
Area									
Urban	45.4	5.7	0.8	0.9	1.4	2.1	87.1	2.0	100
Rural	34.6	5.9	1.1	0.8	0.6	1.2	89.6	1.0	100
Education									
Pre-primary or none	33.5	5.4	0.9	0.6	0.5	1.2	90.2	1.2	100
Primary	56.9	9.5	1.4	1.4	2.7	2.3	82.4	0.3	100
Middle	44.6	2.9	1.2	0.0	0.6	3.8	91.0	0.4	100
Secondary	57.1	9.1	1.2	2.6	1.4	0.4	81.9	3.3	100
Higher	61.9	6.5	1.7	2.0	5.0	4.4	78.4	1.9	100
Age at most recent live birth									
Less than 20	30.1	3.9	0.6	0.2	1.0	1.9	92.2	0.3	100
20-34	39.3	5.7	1.1	1.0	0.8	1.5	88.7	1.3	100
35-49	33.3	7.1	0.8	0.4	1.0	0.9	88.5	1.4	100
Place of delivery									
Home	27.6	3.2	1.0	0.6	0.4	1.3	93.1	0.4	100
Health facility	52.4	9.8	1.0	1.1	1.4	1.6	82.7	2.5	100
Public	49.6	8.2	0.6	0.6	0.9	1.0	86.9	1.9	100
Private	57.4	12.8	1.7	1.9	2.4	2.5	75.2	3.5	100
Other/DK/Missing	11.8	0.0	0.0	0.0	0.0	2.9	96.9	0.2	100
Type of delivery									
Vaginal birth	35.1	5.6	1.0	0.7	0.6	1.2	90.0	0.9	100
C-section	77.1	9.8	1.1	2.3	5.0	4.4	70.3	7.0	100
Wealth index quintile									
Poorest	29.1	3.8	0.8	0.7	0.2	0.9	92.9	0.8	100
Second	35.1	5.8	1.3	0.2	1.1	1.8	87.6	2.2	100
Middle	35.1	6.9	1.2	1.4	1.2	2.0	85.6	1.7	100
Fourth	36.8	6.9	1.0	0.7	0.9	0.9	88.2	1.4	100
Richest	51.0	6.2	0.7	1.0	0.8	1.6	89.4	0.4	100

PPFP services and counseling during all maternal and child health contacts such as antenatal, during delivery, postnatal visit and other MNCH services can be effective for increasing awareness of demand for and use of FP during this critical period. Additionally, the above-mentioned hard facts demonstrate the need for increased community-based outreach and/ or referral services in rural setting with particular attention to women with young infant.

Keeping in view the above-mentioned facts and figures, there is need of full fledge PPFP policy in alignment with the Health Sector Strategy as Department of Health and its facilities throughout the province will be the main custodian of PPFP policy and its implementation. The role of Population Welfare Department is also very crucial, especially when it comes to, "Extended PPFP". It, therefore, becomes shared responsibility of both, the Population Welfare Department and Department of health to work closely to enhance the overall FP uptake in the province, with special focus on PPFP/PAFP, which can be a game changer in this regard

Vision



Mission

Integrating Family Planning (FP) as an essential component of Maternal Newborn and Child Health (MNCH) services at all levels of Health Facilities and FP-Service Delivery Points (SDPs[7]) to attain universal access to FP information and services in Balochistan

PPFP should not be considered a 'vertical' programme, rather as an integrated part of existing MNCH Services and FP efforts

Figure No.1: Post-pregnancy Family Planning Framework[8]

The post-pregnancy Family Planning Framework (figure 1) is adapted from Programming strategies of Postpartum Family Planning by WHO, 2013 which is based on learning experience of many countries including Rwanda, India, Bangladesh, and Egypt etc.

7 FP-SDPs are Family Welfare Centers (FWCs) and other Outlets providing FP services of Population Welfare Department (PWD)

8 Programming strategies for Postpartum Family Planning. World Health Organization 2013.

Section 7:

PPFP Policy

PPF Policy Objectives

01

To enhance demand for PPFP services by systematically integrating PPFP counseling during antenatal, labor and delivery, pre-discharge and postnatal care services at all health facilities and FP-SDPs of Balochistan

02

To provide full range of PPFP services during post-placental, immediate post-partum and postpartum period to women delivering at health facilities of Balochistan

03

To provide PPFP counseling during antenatal and postpartum period to pregnant and lactating women at home by Lady Health Workers and other community-based workers

04

To systematically integrate PAFP counseling in PAC services at all health facilities of Balochistan

Roles of Population Welfare Department & Department of Health:

Both the DoH and DoPW are mandated to provide family planning services in Balochistan. The departments provide FP services through various levels of health facilities as well as outreach services. DOPW provides FP services only; while at DOH facilities, FP services are available as part of reproductive health services. The service delivery infrastructure of DOH is much more extensive than that of DOPW.

Population Welfare Programme in Pakistan is being funded by the Federal Government since its inception (1966). Despite provincialization of Programme in 1983 and in 2002 the financing continued by the Federal Government through PC-I of Five Year Plan of Population Welfare Programme to all the Provinces. Last PC-I concluded in 2008. During 2008-10 programme was financed through lump sum anticipatory grant.

The issue of financing of Population Welfare Programm was considered by the Federal Government and the then Federal Minister for Finance Mr. Shaukat Tareen agreed for provision of Rs. 49 billion for Population Welfare Programme. This meeting was also attended by Provincial Finance and Population Welfare Ministers.

In pursuance of 18th constitutional amendment Regional Training Institutes and Multipurpose Services Centre of Ministry of Population Welfare were also devolved to Provinces in addition to Population Welfare Programme in December, 2010.

Balochistan, the largest of the four provinces of Pakistan, spreads over an area of 347,190 Sq, Kms., forming 43.6 per cent of the total area of Pakistan. It has clustered population and is smallest in proportion as compared to that of other provinces. Its population, according to 2017 census, is 12.344 Million with the growth rate of 3.37%. The CPR (Contraceptive Prevalence Rate) is 20%, having a low density per square kilometer. Physically, Balochistan is an extensive plateau of rough terrain divided into basins by ranges of sufficient heights and ruggedness. Broadly, Balochistan geographic area can be divided in to four distinct zones: Upper high lands, lower high lands, plains, and deserts. Population Welfare Department Balochistan is the main organization responsible to manage family planning and reproductive health (FP/RH) services in Balochistan. The functions of the Department have been set under Rules of Business, 1986 and in pursuance of the 18th Constitutional Amendment 2010. The responsibilities include policy formulation and implementation, legislation, financing, procurement, human resource development, information management, donor coordination, and monitoring and evaluation. As part of the Federation, the Department is bound to make contributions towards all international commitments including FP2020 and sustainable development (SDGs) goals, as part of Pakistan's commitment. It is expected that in the post-devolution scenario, financing of the

department and all its activities to be supported through its recurrent budget and the Public Sector Development Programs (PSDP).

The PWD facilities provide all modern FP services and commodities which are delivered through different static facilities and mobile/outreach services. Promotional efforts for awareness raising and counseling for FP services, including conventional and clinical methods, and male and female contraceptive surgeries are mandated by the Department, The Department has a network of facilities to provide family planning services in all districts of Balochistan.

Section 8:

Proposed Approaches

Experts Engagement

The existing PPFP sub-group may include and engage experts from the field, such as professors of OBGYN and midwifery in designing of the activities and implementation of the plan/activities for their technical input and addressing troubleshooting.

Integrated Approach

The approach for PPFP service provision will be based on an integrated model for ANC, during labor and delivery (L&D), and postpartum care (six weeks following birth of a child).

Over the years, it has been debated that functional and structural integration of the DOPW and DOH might help to make the delivery of FP services more effective. The Council of Common Interest (CCI) in its meeting dated 19th November 2018, based on the Recommendations of the CJ' Task Force on Population, has approved the integration of Family Planning in Health.

The greater contribution of chronic medical conditions toward maternal morbidity and mortality further underscores the importance of access to patient-centered family planning care, which includes assessment of reproductive goals as well as provision of preconception, contraception, and abortion care services. Women with chronic medical conditions need information about both how their disease (and any related medications) could impact the health of their pregnancy and how pregnancy might impact their disease state so that they can make informed decisions about family formation and pregnancy timing. For those who want to avoid or delay pregnancy, access to the full range of contraceptive methods and abortion services is essential, especially since unplanned pregnancies can increase the risk of adverse pregnancy outcomes by precluding optimization of health and medications before conception.

While access to family planning services is essential to health and well-being, it is currently delivered through a fragmented system. This may be particularly problematic for women with chronic medical conditions who are mostly likely to see primary care providers (or subspecialists) for their health management, but are then typically referred elsewhere (or simply expected to seek care elsewhere) for their contraception needs. Accessing abortion services may require yet another

transition of care. This fragmentation causes unnecessary hurdles to receiving comprehensive reproductive health care and leads to health needs going unmet, perhaps contributing to the higher rates of unintended pregnancy observed among women with medical and mental illness

While family planning care has traditionally been the domain of obstetrics and gynecology, increasing recognition that social and medical determinants of maternal health exist long before and after the index pregnancy underscores that primary care physicians are obligated to participate in ensuring the reproductive health of their patients. This means integrating family planning care into primary care practice, supporting efforts to tackle the deep social and structural inequalities that give rise to racial disparities in reproductive outcomes, and firmly advocating for reproductive rights and autonomy so that all people have the ability to build the families and lives they desire.

In this regard, the interaction and collaboration among the partners including DoH, PWD, and the officials of tertiary care hospitals will be improved through regular coordination meetings to review the FP services status and decision making based on the data available. These meetings will be conducted quarterly at provincial level, where policy and decision makers will be involved. For this purpose the existing forums, such as provincial population task force, FP2030 working group can be used or separate mechanism will be established, based on recommendations of the two departments; DoH & PWD. One of such proposed forums can be formation of a multi-stakeholders' coordination mechanism, comprising of representatives from health, education, Population Welfare, Social Welfare, PPHI, local bodies, donors, INGOs, NGOs, academia, UN bodies, and civil society organisations.

Similarly, at District level, the existing DHPMT/DHMT can be revitalized, which has representation of all the public and private stakeholders including DoH, PPHI and PWD. These forums at District level can be very crucial in addressing the commodity issues by re-locating the stock, where it is in abundance. Similarly, referral mechanism can be strengthened through this forum, and partners can share their progress and future plans to avoid any duplication of efforts.

Service strengthening:

As PPFP is to be provided in an integrated manner at the health facility and community level, the service delivery points need to be strengthened, especially to ensure that all women are effectively counseled and have time to make an informed and voluntary choice of contraceptive methods. For this purpose, the following actions/ inputs are to be in place:

Further, PPFP services provision requires that HCPs and SBAs have updated knowledge and skills on all methods of contraception and provision of LARCs such as PPIUCDs and PP-Implants. Furthermore, quality of PPFP services will be ensured through ongoing supportive supervision and monitoring of PPFP services through trained mentors/supervisors.

Service strengthening will include:

Informed and voluntary choice:

PPFP shall be provided within the context of volunteerism and informed choice.

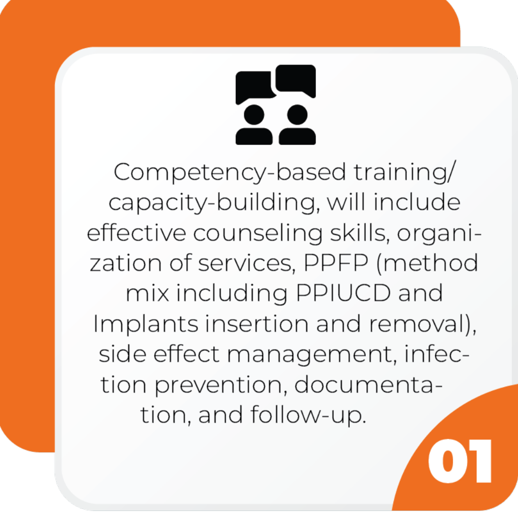
Preparing Training Sites:

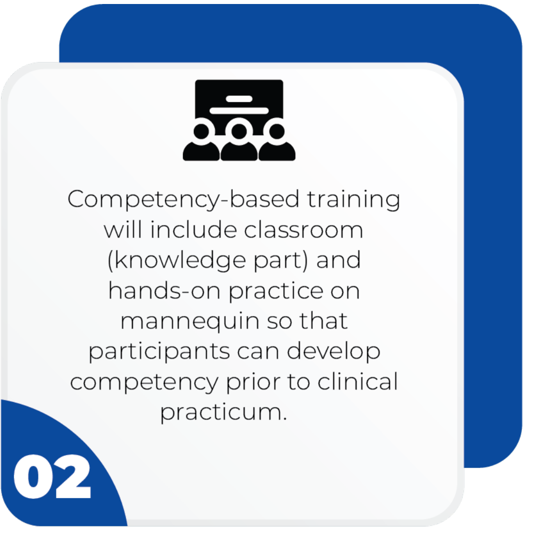
As a first step, a core provincial training/capacity-building team (well-respected teaching hospital faculty) would be selected and used as a master trainer for PPFP. Since the competency-based training require clinical practice on real clients to develop competency and confidence among HCPs. Therefore, all public sector tertiary level teaching hospitals (with busy labor room) will be upgraded as a clinical training site to initiate PPFP services. High delivery numbers will ensure that enough women accept a PPFP method based on Medical Eligibility Criteria (MEC).

The training staff who would actually care for the majority of the deliveries at the site will be identified to act as mentors/trainers/preceptors in future trainings.

The potential mentors/trainers preceptors would be assessed to see that they have achieved competency on PPFP services and are following the standardized guidelines.

Training and capacity building of HCPs





Supportive Supervision

Training as a one-time intervention is never sufficient. Master trainers and Trainers (to be included in JD) will make supportive supervisory visits to assist HCPs in implementing PPFP services, provide technical support and ensure the quality of services.
Head of the maternity unit should enroll in the first training. This will enhance

Quality of Care

Standards and guidelines are the foundation for quality of care. They provide the template for training/capacity-building of providers and for supervisors to assist staff to achieve high-quality services. The provision of PPFP services will be standardized with Balochistan provincial FP standards and guidelines to ensure that all women receive high-quality PPFP services.

Behavior change communication (BCC)

There are special considerations for PPFP women that should be focused while designing BCC interventions such as contraceptive methods choices must consider woman's breastfeeding status and postpartum period timing (refer to table in the definition section). In order to increase access, utilization and coverage of PPFP services, a wider approach using socio-ecological model at individual, community, health system and policy level will be adapted. The aim is to improve individual/couples' knowledge, attitudes and behavioral factors, supporting an enabling environment, providing access to quality health services level and influencing policies with overall system strengthening.

Figure 2: Socio-ecological model

Post partum Family planning policy environment

Quality health services and systems

Enabling environment (partner, family, community support)

Individual knowledge, attitudes and behavior

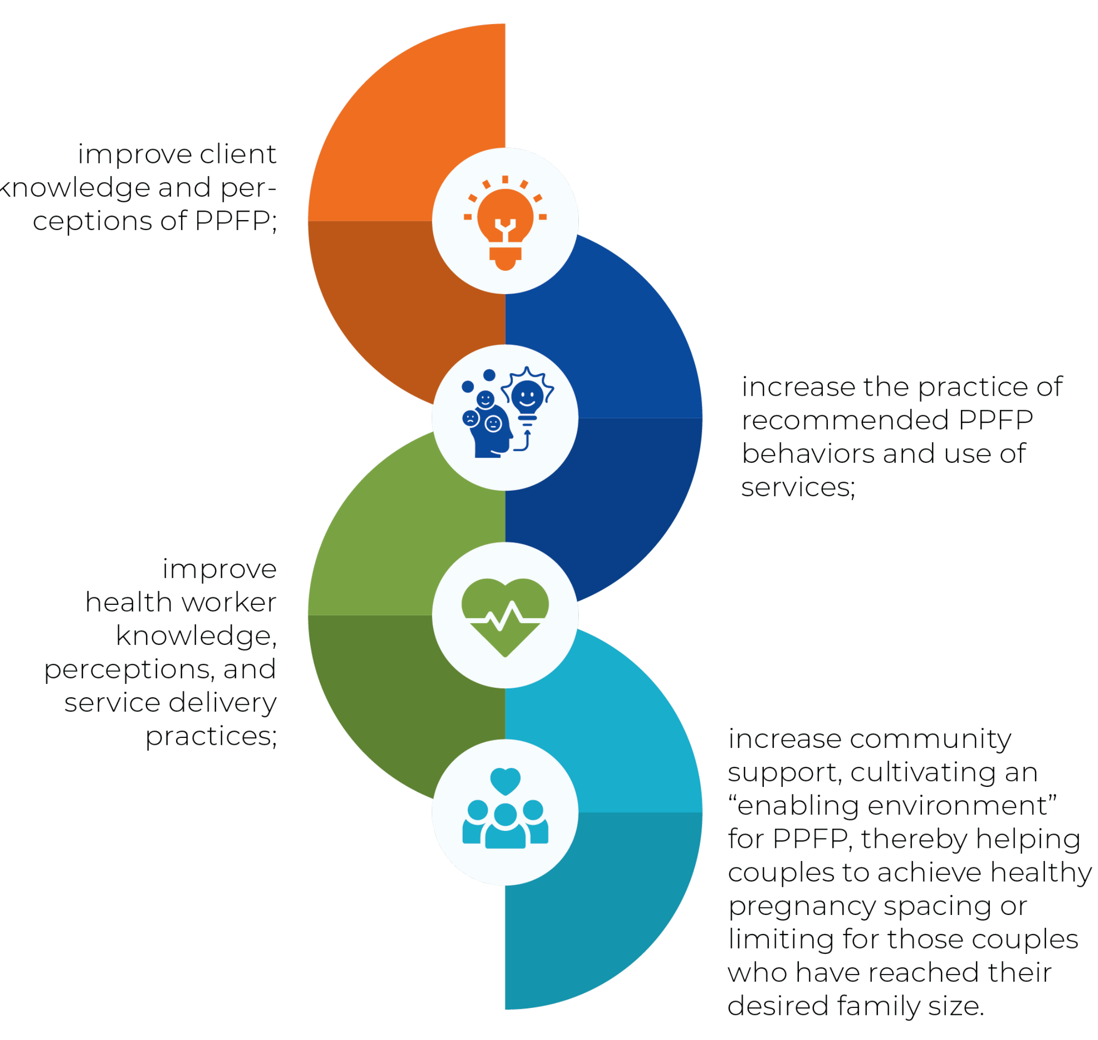
Increasing a woman's knowledge around HTSP, fertility and PPFP is necessary however not sufficient unless other decision makers such as husband and mother-in-law are engaged through various strategies.

Health workers' knowledge and attitude about PPFP will be addressed, as they can serve as barriers to effective provision of message and services. Further to promote more deeper and sustainable change special consideration will be given to critical areas related to FP such as political factors, gender status and reproductive health decision making, social norms related to sexual and reproductive health and use of family planning services including myths and misconceptions and rumors.

Social Behavior Change Communication (SBCC) for PPFP & PAFP:

SBCC is defined as “the use of communication strategies—mass media, community-level activities, and interpersonal communication—to influence individual and collective behaviors that affect health. Research shows that theory-driven, interactive communication that follows a proven design and implementation process can increase knowledge, shift attitudes and norms, and produce changes in a wide range of behaviors. Many implementers situate SBCC in a socio-ecological framework, which recognizes that determinants of health and health behavior exist on multiple levels and extend beyond the individual. Specifically, socio-ecological models acknowledge the influence of interpersonal relationships, community structures, and the broader environment. PPFP focuses on voluntarily initiating use of family planning (FP) methods soon after a birth and continuously through the first two years postpartum.

SBCC for PPFP aims to:



Section 9:

Objective 1

To systematically integrate PPFP counseling during antenatal, labor and delivery and postnatal care at all health facilities and FP-SDPs of Balochistan

Description:

PPFP Counseling during Antenatal Care (ANC)

refers to the health services that a woman receives to monitor the health and progress of her pregnancy and her well-being during her pregnancy. ANC provides an opportunity to encourage deliveries with a skilled birth attendant and to advice and counsel on the importance of FP and the contraceptive options available to her, including those that can be provided at the time of a facility-based birth (WHO 2006, WHO 2010b).

During ANC, women will be asked about their reproductive goals and encouraged to wait at least 24 months after delivery before attempting another pregnancy if they plan to have additional children.

Women will also receive counseling on HTSP & different PPFP methods during their ANC, including the lactational amenorrhea method (LAM), DMPA injections, condoms, LARCs such as implants, IUCDs, and permanent methods. Consent prior to labour can be obtained if a woman chooses any PPFP method for spacing.

Information and counselling about FP methods can also be given during postpartum period specially if a woman has not been counseled in the antenatal period and arrives in advanced labour. In public hospitals, most of the women do not come for antenatal care and are first seen during labour. For the couple or woman who does not desire future pregnancies (limit), ANC also provides a time when counselling about permanent methods can be offered, and voluntary informed consent can be obtained confirming the understanding that these methods are permanent options.

PPFP Counseling during Intrapartum Period (Labor and delivery [L&D])

Providers need to inform women and receive their voluntary consent before active labor, ideally during antenatal care (ANC).

The HCPs will ensure completion of PPFP counseling and the client's desired FP method before delivery/L&D. Women who do not receive ANC are screened on arrival to the labor room/Operation Theater (OT). Those who express interest in LARCs (PPIUCD and Implants) are screened for clinical conditions based on WHO medical eligibility criteria (MEC). PPFP counseling will be provided in early labor, if appropriate, and again in the postpartum ward. If the pregnant woman selected any LARC method, her choice is re-confirmed before childbirth. If it appears that active labor or other conditions would preclude an informed choice, the counseling is deferred until the first day postpartum.

PPFP Counseling during Postpartum Period

Post-natal Care (PNC) presents an opportune moment when women should be counselled on birth spacing and FP. WHO recommends that women who have delivered in a health facility should receive PNC at least 24 hours after birth. Contraceptive options should be discussed, and contraceptive methods should be provided, if requested (WHO 2010b, WHO 2013c).

Strategy	Activities	Sub-Activities	Responsible Department	Output
Strengthen awareness of and demand for PPFP during the ANC, L&D and Postpartum period at health facility	• Develop information, education, and communication (IEC) materials on PPFP and use by all type of facility providers for pregnant and lactating women to take home • Provision of counseling to women or couples on reproductive desires and the range of contraceptive options available using IEC materials and inclusion of husbands and other family members in ANC and PNC counselling session on PPFP	• Formation of a technical group to develop/adapt IEC material for facility and community HCPs • Review, pre-test, and finalization of IEC material • Printing and availability of IEC materials at all HFs and SDPs for PPFP counseling	DoH DoPW PPHI	• Notification of technical group on IEC material development and TOR finalized • Meetings minutes and drafts of IEC material • Availability of IEC material at the health facility

Strategy	Key Activities	Sub Activities	Responsible Department	Output
Integrate PPFP information and counselling with ANC and PNC services offered at HFs and SDPs	Provision of PPFP information and counseling by trained HCPs at Health Facilities (HFs) and Service Delivery Points (SDPs) during ANC and PNC visits at any time from childbirth till 6-week postpartum check-up, (in busy HFs, dedicated counselors working 24/7 specially in labour rooms) and are offered appropriate methods depending on their breastfeeding status and time since childbirth. Strengthening referral linkages between the various postpartum/ PNC providers and facilities, including FP clinics, to ensure continuity of care	• Mapping of HCPs for PPFP counseling training • Training of Trainers on PPFP counseling • Training of HCPs of HFs and SDPs on use of IEC materials and counseling • Referral and linkages between facility (including CMWs) and LHWs and FWWs for follow up of women during postpartum period	PWD DoH LHW and MNCH Programs PPHI	• Number of Trained trainers • Number of trained HCPs on PPFP counseling • Number of clients referred

Strategy	Activities	Sub-Activities	Responsible Department	Output
Improve the enabling environment for PPFP as a routine part of ANC and PNC services at HFs and SDPs	• Integrating PPFP within Essential Health Services Package (EHSP) for primary and secondary and tertiary care level facilities and as per service delivery standards and guidelines for quality-of-care and monitoring for ANC and PNC services • Improving knowledge, attitudes, and practices of tertiary care facility- HCPs towards PPFP so they support the provision of PPFP information and services e.g., Continuous Medical Education (CMEs) on PPFP (in-service training) • Integrating PPFP into pre-service education curricula of mid-level HCPs such as nurses, CMWs and LHVs and doctors	• Technical review and adaptation of PPFP service delivery package and counseling services into routine MNCH service at primary, secondary and tertiary care level HFs o Inclusion of PPFP into existing EHSP for primary and secondary and tertiary care level HFs and incorporating PPFP counseling into job description of various MNCH related HCPs such as MO, CMWs, LHVs, LHWs, FWWs, Obs. Gyn.	PPHI DoH DoPW Tertiary care/ teaching Hospitals	• Number/% of HFs and SDPs that have service delivery guidelines for PPFP • Number/% of HCPs trained to provide PPFP information and counselling to all ANC and PNC clients • Number/% of pre-service schools with PPFP included in curricula, service guidelines and protocols, and aligned with international MEC and national PPFP policies and strategy guidance • # /% of preservice tutors trained in teaching FP

Outcome Statement

All women and their families receiving quality PPFP information and counseling during antenatal, early labour and postnatal visits by trained HCPs at HFs and SDPs

Outcome Indicators:

- Number/percentage of HCPs competent in providing PPFP counselling
- Number/percentage of PPFP information and counselling sessions for pregnant women and number of pregnant women counselled Proportion of client records that are completed and have PPFP counselling and method choice, if any, documented
- Number/percentage of women attending ANC who received IEC materials about PPFP options
- Number of recently delivered women receiving counseling sessions during PNC on PPFP
- Number of counseling sessions with husband and other family members in ANC and PNC counselling session on PPFP

Section 10:

Objective 2

To provide full range PPFP services during post-placental, immediate post-partum, intermediate and extended postpartum period to women delivering at health facilities of Balochistan

Description:

A Labor and Delivery (LD) visit by women at HFs involves various points throughout the stay in the facility, including admission, early labour, delivery room, postnatal/ immediate postpartum ward and pre-discharge. Counselling on the importance of FP and available contraceptive method options, including LAM, is recommended during this period (WHO 2006, WHO 2010b). For women with limited access to health care in facilities, delivery at a facility affords a unique opportunity to address their fertility intentions and need for contraception: it does not require a return visit that may be prohibitively expensive or inconvenient. If a woman seeks to have an LARC method or a sterilization procedure immediately after delivery, special care must be taken to ensure that high-quality counselling has been done to verify the woman's choice. According to WHO's MEC guideline (WHO 2009), appropriate methods for FP service provision during the immediate postpartum period include: LAM, IUD, condoms, implants/ POPs, and sterilization (male or female). Progestogen-only injections are appropriate for non-breastfeeding women prior to discharge.

Strategy	Key Activities	Sub Activities	Responsible Department	Output Indicators
Physical infrastructure of HFs is adequate for providing high-quality PPFP services	• Select and/ or upgrading HFs to provide PPFP services, including availability of running water, electricity and space available for private counselling and surgical or procedure rooms • procurement is managed so that there is a continuous supply of FP commodities, equipment, instruments, and expendable supplies	• Mapping of all levels of HFs (primary, secondary and tertiary) and SDPs of DoPW • Repair and renovation of selected HFs for provision of PPFP services • Preparation of Annual Procurement Plan for PPFP services for the selected HFs • Procurement process for PPFP commodity, equipment and supplies for PPFP services	DoPW DoH PPHI	• Number of sites upgraded for PPFP services provision • Proportion of HFs that have on-site supplies, IEC materials, provider reference materials and job aids (protocols, standards and guidelines), FP commodities, including IUCD and Implants, equipment and instruments for PPFP services

Strategy	Key Activities	Sub Activities	Responsible Department	Indicators
• High-quality PPFP information, counselling and PPFP services are provided at HFs by competent, confident and committed HCPs	• Conducting competency-based counselling and clinical skills training in pre-service and in-service settings • Provision of job aids, up-to-date service protocols, guidelines, screening checklists and other reference materials such as MEC wheels • LAM counselling are routine components of pre-discharge counselling	• Training of Master trainers for PPFP services • Training of HCPs including OBGYN, medical officers, CMWs, LHVs • Supportive supervision to support HCPS including providing routine feedback and updates • Develop/improve the protocol for ensuring that informed and voluntary consent is obtained for all clients requesting PPFP prior to labour and delivery • Conduct other activities beyond one-on-one counselling to increase informed demand, such as group sessions in the antenatal clinics and postpartum ward, videos and posters, ensuring that messages resonate with clients and communities • Conduct training to ensure providers are competent to provide accurate counselling and messages regarding LAM	DoH DoPW PPHI	• Number of Master Trainers trained • Number of trainers trained • Number of clinical staff trained to competency in PPFP counselling and PPFP service provision • Number/% of HCPs who reach 80% of PPFP quality service delivery standards • Document consent properly for clients who adopted immediate PPFP • Proportion of lactating women who are counselled on LAM • Percentage of women adopting PPFP services who deliver at the HF.

Strategy	Key Activities	Sub Activities	Responsible Department	Output Indicators
Home-based PPFP services to be provided to postpartum women by community midwives (CMWs), counselling by LHWs and FWWs	• Strengthening linkages of CMWs and LHWs/FWW for follow up of postpartum women • CMWs, LHWs and FWW are able to provide short-term methods, such as pills, condoms and injections, to the postpartum woman in her home	• Regular monthly meeting/mechanism of LHWs and CMWs to exchange data/ information about ANC, PNC women in their catchment areas • provide PPFP messages and referrals for PNC and PPFP services, including HTSP, Exclusive Breast Feeding (EBF)/LAM, return to fertility, and contraceptive options for breastfeeding and non-breastfeeding women	PWD - FWW DoH MNCH Program LHW Program PPHI	• Proportion of LHWs and FWWs providing PPFP interventions (screening, referral, and method provision, where approved) confusing • Number of community mobilization activities conducted that include PPFP (including home visits, community meetings and health fairs) • Number/ percentage of postpartum women who started contraceptive use by 1st week & 6 weeks postpartum • Number of fathers reached with PPFP messages by LHWs and FWWs and male mobilizers

Outcome Statement:

Pregnant women consenting for adopting a contraceptive method after childbirth are receiving chosen appropriate method before discharge from HFs

Outcome Indicators:

- Proportion of women who select a method during ANC and who request and receive desired method prior to discharge from HF.
- Proportion of women/clients who request a method during early labour or pre-discharge counselling and receive their desired method before leaving the HF
- Proportion of women/client who receive/adopted a FP method after delivery or before discharge

Section 11:

Objective 3

To provide PPFP counseling during antenatal and postpartum period to pregnant and lactating women at home by Lady Health Workers and other community-based workers

Description:

ANC can be provided as part of home-based practices/service provided by LHWs or community-based workers. Thus, ANC helps support the essential link between health care services that are provided in the community and those provided in the facility. It also provides an opportunity to engage husbands and family members to support healthy pregnancy and postpartum behaviors.

If a birth is at home, the first postnatal contact should be as early as possible within 24 hours of birth by LHWs or Community based worker. Three additional PNC contacts are recommended on day 3, between days 7–14 after birth and 6 weeks after birth (WHO 2013c). It is important to reach women before they are at risk for an unintended pregnancy with information about return of fertility, their options to space or limit future pregnancies, and the benefits to their own and their newborn's health of doing so. Community-based interventions are critical during the vulnerable period when women return home from a facility-based birth, as well as for those women who do not give birth in a facility. Women should be counselled on birth spacing and FP during PNC contacts. Contraceptive options should be discussed, and contraceptive methods should be provided, if requested. Women should also be counselled on safer sex, including use of condoms.

Strategy	Key Activities	Sub Activities	Responsible Department	Output Indicators
Strengthen awareness of and demand for PPFP during the ANC period at community level	• Integrating PPFP information and counselling with ANC and PNC services offered at community levels	• Develop/adapt information, education, and communication (IEC) materials on PPFP to be used by LHWs and community-based workers (FWW) for counseling pregnant and lactating women • Printing of IEC/counseling materials on PPFP for LHWs and FWW • Training of LHWs and FWW in PPFP counseling during ANC and PNC • Availability of IEC/ counseling materials on PPFP with LHWs and FWW • LHWs and FWW providing counselling that includes discussion of a woman's or couples' reproductive desires and the range of contraceptive options available, including tubal ligation and vasectomy. • Conducting support Group meetings on PPFP as a topic in support group meetings including HTSP by LHWs • Promoting the inclusion of husbands and other family members in ANC counselling session on PPFP	DoH/LHW program, MNCH program DoPW PPHI	• Number/percentage of LHWs and Community based workers who are competent in providing PPFP counselling • Number/percentage of PPFP information and counselling sessions for pregnant women and other family members by LHWs and FWW • Proportion of client records that are completed and have PPFP counselling and method choice, if any, documented (at community level) • Number/percentage of women who received IEC materials about PPFP options by LHWs, FWW and CMWs • Number of husbands reached during counseling sessions with and in ANC counselling session on PPFP

Strategy	Key Activities	Sub Activities	Responsible Department	Output Indicators
Strengthen continuity of PPFP care linkages and referrals between facility and community	• Referral and linkages developed or strengthened between ANC services, labour and delivery, and PNC services whether they are located in the same place or in different facilities/ settings • Strengthen capacity of LHWs, and FWWs to provide effective PPFP counselling, including LAM, to women who deliver at home and, when requested, referred for PPFP services (within 48 hours, within one week or six weeks) to HF	• Technical consultation to build a mechanism, such as the client card, that accurately captures/records and communicates data about clients' health needs and immediate PPFP choices by LHWs and FWW • LHWs and FWWs ensure reinforcing PPFP counselling messages during pregnancy and postpartum period, when women go back to home after discharge from HF (from community to facility and from facility to community) • LHWs, FWW regularly identify, refer, and follow up pregnant women for ANC and PNC services and provide/reinforce PPFP messages to pregnant and postpartum and lactating women • Training of LHWs and FWW to provide effective PPFP counselling, including LAM, to women who deliver at home and on referral protocols for PPFP services (within 48 hours, within one week or six weeks) to HFs. • Provision of referral record materials such as referral slips and client record information	DoPW DoH PPHI LHWs FWWs	• Proportion of HFs with referral protocols that include documentation of clients referred by LHWs and FWW • Number/percentage of ANC clients whose client cards are filled in completely with pregnancy information and PPFP counselling and immediate PPFP method choice • Number/percentage of discharge cards and facility registers that are accurately completed and include data on •PPFP counselling, •contraceptive method selected, •services provided •follow-up care • Number of referred clients by each LHW and FWW for PPFP

Strategy	Key Activities	Sub Activities	Responsible Department	Output Indicators
Improve enabling environment for PPFP as a routine part of ANC, childbirth, and PNC services at community level	• Integrate PPFP within Essential Health Services Package (EHSP) for primary Health Care (PHC) and community • Integrate PPFP with pre-service education curricula of LHWs and FWW	• Develop/adapt PPFP training materials for LHWs and FWWs • Training of Trainers • Train LHWs on PPFP counseling during ANC, early PNC visits for home births to provide essential newborn care and EBF/LAM, (LAM as a gateway method to the use of other modern contraceptives), to discuss women's reproductive intentions for spacing or limiting and provide information on contraceptive methods and where to get them • Training of LHWs and FWWs to improve their knowledge, attitudes and practices to ensure they support the provision of PPFP information and services	DoH DOPW PPHI Development Partners	• EHSP for PHC with PPFP inclusion developed and in use • Number/percentage of HFs and SDPs that have service delivery guidelines for PPFP. • Number/percentage of HCPs who provide PPFP information and counselling to all ANC clients • Number/percentage of pre-service schools with PPFP included in curricula, service guidelines and protocols, and aligned with international MEC and national PPFP policies and strategy guidance • Number/ percentage of pre-service graduates competent in providing PPFP counselling during ANC

Outcome statement and Indicators:

Behavior change communication through LHWs and FWW to promote PPFP and inclusion of husbands and other family members in ANC counselling session; LHW and Community based workers (FWW) include PPFP as a topic in support group meetings including HTSP

Outcome Indicators:

- Proportion of women who received PPFP counseling during ANC and PNC by LHWs and FWW at home
- Proportion of women/clients who counseled by LHWs and FWW at home during ANC and PNC referred to HFs and received their desired method
- Number. of satisfied PPFP clients

Section 12:

Objective 4

To systematically integrate PAFP counseling and full range of PAFP services for women receiving PAC services at all health facilities of Balochistan

Description:

Post-abortion care (PAC) is a package of services provided to women who have had a threatened/incomplete/missed miscarriage or an abortion.
Receiving emergency PAC services may be one of the few points of contact with the health care system for many women. This is an important opportunity to provide contraceptive information and services that should not be overlooked.
Evidence suggests that offering FP and treatment for incomplete abortion services in the same place can result in more effective FP use, reduction in the repeated abortions and HTSP. In general, all modern methods of FP can be used immediately after emergency PAC, is provided: i) there are no severe complications requiring further treatment, ii) the client receives adequate counseling, iii) the HCP will screen for any precautions for using a particular contraceptive method. Natural FP methods can be used when a regular menstrual pattern returns. To prevent infection, women should not have sexual intercourse until post-abortion bleeding stops (usually 5–7 days) and any complications are resolved.

The role of PAC provider is a crucial link in helping PAC clients, as they can help in

- Recognizing the need for contraception,
- Overcoming possible misconceptions and fears regarding contraceptive method
- Gaining confidence and trust in the health care system

These behavior changes increase the likelihood of a PAC client accepting a contraceptive method and of following through on a FP referral. The above-mentioned objective would be achieved through the following strategies and activities.

Strategy	Key Activities	Sub Activities	Responsible Department	Output Indicators
HCPs (doctors, midwives, and nurses) are competent to ensure quality PAFP counseling and PAFP service delivery at HFs of Balochistan	• Equipping HFs with IEC materials on PAFP for counseling of PAC clients	• Review, adaptation of available PAFP IEC materials to local context and finalization	DoH DoPW PPHI Development partners	• Finalized IEC material • Number of PAC clients received PAFP counseling • Number of PAC clients consented to adopt any PAFP method • Number of consented PAC clients adopted any contraceptive method • Number of consented PAC clients adopted modern contraceptive method
	• Training of HCPs on quality PAC & PAFP counseling • Training of HCPs in provision of quality PAC & PAFP services • Training of HCPs on Value Clarification Attitude Transformation (VCAT) to address providers' biases towards abortion care	• Review and adaptation available PAC & PAFP training curriculum for HCP trainings and finalization • Developing pool of master trainers on PAC & PAFP counseling and PAFP service delivery • Training of Trainers on PAFP service delivery • Training of Trainers on VCAT • Training of HCPs on quality PAC & PAFP services • Training of HCPs on VCAT	DoH DoPW PPHI Development partners	• Finalized and endorsed training curriculum available • Number of trained trainers on PAC & PAFP • Number of trained HCPs on PAC & PAFP counseling • Number of trained HCPs on PAC & PAFP service delivery • Number of trained HCPs on VCAT

Outcome statement and Indicators:

All HFs offering quality PAFP counseling and services to all PAC clients regardless of the method of treatment for uterine evacuation (sharp curettage, manual vacuum aspiration) at HFs. As a result, the PAC clients are adopting PAFP methods and satisfied from the PAFP services.

Outcome Indicators:

- Number and Percent of HF regularly providing PAC services.
- Proportion PAC clients who agreed to adopt PAFP method to delay next pregnancy to six months
- Number. of satisfied PAFP clients
- PAFP refusal rate at HFs
- Client satisfied with PAFP services
- Decrease in unmet need for FP

Section 13:

Commodity Security

In Balochistan, DOH assess the annual requirement for contraceptives based on consumption in the preceding year. Data on consumption at health facilities and outreach programs are extracted from the Contraceptive Logistics Management Information System (CLMIS), District Health Information System (DHIS), the LHW Programme Management Information System (LHW MIS), and the MNCH MIS. Similarly, DOPW also follows the same rationale for assessing the annual requirement and uses data from the CLMIS for their SDPs and a margin for inflation added to the previous year's consumption. The utilization of PPFP services offered by the two departments will improve FP services and could improve utilization rates and hence the demand for contraceptives.

DOPW is responsible for joint procurement of contraceptives for both departments in Balochistan. Likewise, DOPW also distributes contraceptive commodities to all DOH facilities, including those managed by PPHI, as well as to the private sector.
Contraceptive procurement involves international bidding, an improved coordination between the two departments will result in early release of funds and hence timely procurement of contraceptives.

In Balochistan, DOPW monitors consumption of contraceptives based on information collected regularly from all HFs and SDPs twice a month; the provision of contraceptives to HFs and SDPs is based on this information. Distribution of contraceptives within districts is monitored by the District Management Team, with DHO (District Health Officer) being Chair and DPWO (District Population Welfare Officer) Co-Chair. This arrangement reflects collaboration between DOPW and DOH in the field. The contraceptive stock with LHWs is maintained by providing them a buffer stock, which is replenished on demand.

All PPFP commodity will be supplied free of cost to the clients.

Section 14:

Addressing adolescent and youth

Balochistan PPFP policy will focus on increasing awareness, information on healthy timing and spacing of pregnancy (HTSP), PPFP/PAFP/FP, exclusive breastfeeding, positive parenting, and related gender outcomes for young and adolescent, also their key influencers—especially husbands/partners and older women—and their communities, including a community- and facility-based HCPs, to achieve these outcomes:

- Increased voluntary contraceptive use
- Improved HTSP/FP knowledge, attitudes, and intentions
- Improved gender-equitable attitudes related to household roles and decision making
- Improved support from partners, families/households, and communities for FP use by young couples.

All PPFP commodity will be supplied free of cost to the clients.

Section 15:

Quality of services

Persistent quality and system gaps prevent many postpartum women from receiving effective FP counseling and services in low-resource settings. Improvement and health system strengthening efforts can overcome critical gaps in delivery of PPFP counseling and services to this group of women with high unmet need. Regular shared learning across sites and monitoring common quality measures at different levels of health systems (community, facility, district, regional, and national) can help accelerate improvements in the provision of PPFP services. Although still in initial phases, several countries and projects are implementing PPFP improvement and system strengthening efforts as part of the integrated RMNCH services. Learning from successful experiences to initiate, scale up, sustain, and institute PPFP best practices would reduce unmet need on contraception and contribute to end preventable maternal and child deaths.

Section 16:

Monitoring & Evaluation

The on- going monitoring of PPFP policy, strategy and activities will be informed by an effective and efficient monitoring and evaluation (M&E) system in Balochistan. Further, it is recommended by Community of Practice (CoP) for PPFP, those indicators that are routinely collected in a national HMIS are appropriate for monitoring of PPFP services.[9] They recommended that all HMISs should include an indicator for PPFP prior to discharge after a birth. Hence it is highly recommended to collect and aggregate the percent of women who deliver in a facility and initiate or leave with modern contraception before discharge for two reasons:

Feasibility: Requires minimal change to existing registers and proven feasible to aggregate and report to provincial level

Usefulness: Gives a snapshot of PPFP program performance, even if limited to women who deliver in facilities. In Pakistan and Balochistan, facility delivery rates are rising while few women return for postnatal care, so improving coverage of pre-discharge uptake is an opportunity to reduce extremely short and risky inter-pregnancy intervals

Indicator	Explanation	Source of information	Denominator
Percent of women who deliver in a facility and initiate or leave with a modern contraceptive method prior to discharge	Women who receive a method inserted by a provider (IUD, implant) or tubal ligation, women who start using the lactational amenorrhea method, and women who leave with a method (pills, condoms).	Delivery registers or Discharge Registers and antenatal records DHIS reports	Facility deliveries
Percent of women who delivered in a facility and received counseling on FP prior to discharge	Counseling should consist of information on benefits of healthy timing and spacing of pregnancy, return to fertility after birth, return to sexual activity, safe modern contraceptive options for postpartum women including those breastfeeding (based on WHO's medical eligibility criteria (MEC) for contraceptive use); lactational amenorrhea method (LAM), and transition from LAM to a modern method.	Delivery registers or Discharge Registers DHIS reports	Facility deliveries

9 Learn about the Maternal and Child Survival Program's experience collecting PPFP: https://www.mcsprogram.org/www.track20.org/pages/data_analysis/in_depth/PPFP/trends.php

It is NOT recommended to aggregate indicators on PPFP counseling during pregnancy and method choice in HMISs but documenting this information at the point of service gives useful clues to action for providers. Documenting of PPFP counseling is done during antenatal care reminds providers to start counseling early. Documenting if a woman has made a decision and her preferred contraceptive method can improve efficiency of counseling during subsequent visits and help providers ensure clients receive preferred methods as soon as possible after delivery. This information may be recorded in ANC visit registers or ANC card etc.

Governance and Accountability

FP Task force has been established at the provincial level in Balochistan and headed by the Chief Minister. The provincial Task Force meets regularly to guide and monitor implementation of FP related activities in the province.

In Balochistan, the Task Force is actively engaged and playing a leadership role: well-structured meetings chaired by Minister for Population Welfare are held on a quarterly basis. The forum systematically takes up implementation, technical, and monitoring issues and makes decisions. Representatives of both DOH and DOPW highlighted the significance of this forum in harmonizing activities and addressing challenges in working together.

All provincial health policies emphasize public-private partnership to increase access and coverage of health services, including FP.

As per policy, Balochistan has actively worked on public-private partnership to increase access and coverage of health services, including FP. DOH has outsourced the Basic Health Units to PPHI, while rest of health facilities including RHCs and Secondary & Tertiary care hospitals remain under the administrative control of Department of Health Balochistan. About 735 Basic Health Units are under administrative control of PPHI, whereas rest of health facilities are managed by Department of Health Balochistan. These include 105 Rural Health Centers (RHCs), 10 THQs, 23 DHQs, 04 Tertiary Care Hospitals and more than 540 Civil Dispensaries. The outsourced firms are required to provide FP services at the health facilities as part of the MNCH service package as well as to provide FP training to service delivery staff at the facilities.

Department of Population Welfare Balochistan manages around 258 static and mobile service outlets in the province, which provide FP services to the couples. In addition, PWD Balochistan has a field force of 450 Social Mobilizers, which mobilize the community for FP uptake as a volunteer informed choice and refer them to static PWD facilities, mobile units and outreach FP camps.

In addition to this, NGOs and private sector organisations, such as Family Planning Association of Pakistan (FPAP), Greenstar Marketing and Marie stopes Society also provide FP services to the community through their service delivery points, healthcare providers, community health workers and mobile units.

Institutionalization of PPFP

The first year postpartum has been identified as a crucial time to provide a wide range of contraceptive methods to women and addresses the needs of women and couples who wish to delay having children, as well as those who have reached their desired family size and wish to avoid future pregnancies. Provision of PPFP counseling and services to women prior to discharge from the facility after childbirth is a high-impact practice that can: raise awareness about the benefits of birth spacing, orient women and their partners about their contraceptive options and return to fertility and improve PPFP uptake among the increasing number of women delivering in health facilities.

The PPFP policy is comprehensive: it begins in the antenatal period with counseling at facility- and community-based antenatal care (ANC) visits and includes strategies for offering FP at various points of contact with the woman and her child up to 12 months postpartum. Within this context, strong emphasis is placed on the immediate postpartum period—while women are still in the maternity ward or within the first 48 hours after childbirth—as an opportunity to reach as many women as early as possible.

Both DoH and DoPW are aligned to provide FP services in Balochistan.

In Balochistan, the Task Force is actively engaged and playing a leadership role: well-structured meetings chaired by Minister of Health and Population are held on a quarterly basis. The forum systematically takes up implementation, technical, and monitoring issues and makes decisions. Representatives of both DOH and DOPW highlighted the significance of this forum in harmonizing activities and addressing challenges in working together. This policy document will further help institutionalization of PPFP activities in the province.

Section 17:

Annexure A

Brief descriptions of PWD and DOH outlets supplying contraceptive in Balochistan province are given below.

Population Welfare Department (PWD) FP-Service Delivery Points (FP-SDPs)

Family Welfare Centers (FWCs) operate in a rented building, in any BHU or RHC and each FWC serves a population of about 7000. While operating through its satellite clinics and outreach facility, a FWC covers a population of about 12000.

Reproductive Health Services (RHS) Centers: These are of two types: RHS-A Centers and RHS-B Centers. The RHSA centers are public sector, hospital-based service delivery outlets and provide full range of contraceptives. RHS-B centers are well-established private hospitals and clinics with fully equipped operating facilities and trained work force.

Mobile Service Units (MSUs) operate from specially designed vehicles which carry with-in them all the facilities of a mini clinic ensuring complete privacy for simple gynecological procedures and provide a package of quality Family Planning/ Reproductive Health (FP/RH) services to the people of those remote villages and hamlets where no other health facility exists.

Department of Health (DOH) health facilities

Basic Health Units:

Basic Health Units (BHUs) are located at Union Council level; each serves catchment population of up to 25,000. BHUs provide preventive, curative, referral and Outreach/ community-based services. Basic medical and surgical care, CDD, CDC, ARI, malaria, TB controls Maternal and child health (MCH) services are also part of services packages provided at Basic Health Units. BHUs also provide clinical, logistical and managerial support to Lady Health Workers (LHWs) and serves as a focal point, where community and the public sector health functionaries may come together to resolve issues concerning health.

MCH Centers:

Maternal and Child Health Centers (MCHCs) are also important part of the health system and together with BHUs and RHCs provides essential obstetric care through Lady Health Visitors (LHVs) and Community Based Midwives (CMWs).

Rural Health Centers:

Rural Health Centers: The RHCs have 10-20 inpatient beds, and each serves a catchment population of up to 100,000 people. The RHC provides promotive, preventive, curative, diagnostics, and referral services along with inpatient services. The RHC also provides clinical, logistical, and managerial support to the BHUs, LHWs, MCH Centers, and Dispensaries that fall within its geographical limits. RHC also provides medico-legal, basic surgical, dental and ambulance services.

Taluka/Tehsil Headquarter Hospitals:

located at each THQ and serves a population of 0.5 to1.0 million. At present majority of THQ hospitals have 40 to 60 beds. The THQ hospital provides promotive, preventive, curative, diagnostics, in patients, referral services and also specialist care. THQ hospitals are supposed to provide basic and comprehensive Emergency, Obstetrics, and newborn care. THQ hospital provides referral care to the patients including those referred by the Rural Health Centers, Basic Health Units, Lady Health Workers, and other primary care facilities.

Districts Headquarter Hospitals:

located at District level and serves a population of 1 to 3 million. The DHQ hospital provides promotive, preventive, curative, advance diagnostics, inpatient services, advance specialist, and referral services. All DHQ hospitals are supposed to provide basic and comprehensive EmONC. DHQH provides referral care to the patients including those referred by the Basic Health Units, Rural Health Centers, Tehsil Head Quarter hospitals along with Lady Health Workers and other primary care facilities.

Tertiary care and Teaching Hospitals:

Tertiary Healthcare hospitals are for more specialized inpatient care. Specialized Healthcare services usually for inpatients and on referrals from primary or secondary health professionals.

Lady Health Workers (LHWs):

LHWs work under DOH and play key role not only in distribution of contraceptives but also in creating awareness and bringing about changes in attitude regarding basic issues of health and family planning. One LHW is responsible for approximately 1000 people, or 150 homes, and visits 5 to 7 houses daily. The scope of work and responsibility of LHW also includes provision of family Planning products and service mainly condoms, pills and repeat dose of injectable.

Annexure B

List of illustrative indicators

Point of Contact	Outcome	Indicators
Antenatal Care	Increased PPFP counselling among ANC clients	Number/Percentage of ANC sessions that include PPFP information and counselling.
		Proportion of ANC client's records that are completed and have PPFP counselling and method choice documented, if any.
Labor and Delivery	Increased proportion of women who selected a method during ANC or during labor and delivery, received desired method prior to discharge	Number/percentage of client cards and facility registers that are accurately completed and include data on PPFP counselling, contraceptive method selected, services provided and follow-up care
Postnatal Care	Increased proportion of women who started using any contraceptive method by 6 weeks postpartum	Proportion of CHWs providing PPFP interventions (screening, referral, and method provision, where approved)
		Number/percentage of postpartum women who started contraceptive use by 6 weeks postpartum
		Number of fathers reached with PPFP messages
Extended Postpartum Care	Increased proportion of women who started using any contraceptive method within the duration of 6 weeks to 1 year postpartum	Number/percentage of postpartum women who started contraceptive use within the duration of 6 weeks to 1 year postpartum

<table>
<tr><td rowspan="4">Infant Care and Immunization Services</td><td rowspan="4">Increased number of women attending child health/ immunization visits who started using contraceptive method within the first year following a birth.</td><td>Number/proportion of mothers at immunization sessions screened for PPFP needs.</td></tr>
<tr><td>Number/proportion of screened mothers referred for FP services.</td></tr>
<tr><td>Number/proportion of mothers attending immunization sessions who accept an FP method the day of immunization services.</td></tr>
<tr><td>Number/proportion of women with a child 12 months of age or younger who are currently using a contraceptive method (by type of FP method used)</td></tr>
<tr><td>Principles of FP compliance</td><td>Followed principles of FP compliance at all facilities</td><td>100% of facilities providing PPFP services are adherent to principles of FP compliance</td></tr>
</table>