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Bottleneck Analysis on Factors affecting Scaling Up and Sustaining Gender Responsive Postpartum Family Planning/Postabortion Family Planning, Task Sharing Sharing/Shifting and Social and behaviour Change Communication (SBCC) in Family Planning

Pakistan Report 2025

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SPHERE
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Contents

Abbreviations

CHW	Community Health Worker
cLMIS	Contraceptive Logistics Management Information System
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
DOH	Department of Health
EBP	Evidence Based Practices
FP	Family Planning
HCE	Health Care Establishment
HMIS	Hospital Management Information System
HTSP	Healthy Timing and Spacing of Pregnancy
ICT	Islamabad Capital Territory
IEC	Information Education and Communication
LAM	Lactational Amenorrhea Method
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMIC	Low- and Middle-Income Country
OCP	Oral Contraceptive Pills
PAFP	Post Abortion Family Planning
PPFP	Post Pregnancy/ Post Partum Family Planning
PPIUCD	Postpartum Intrauterine Contraceptive Devices
PPW	Population Program Wing
PWD	Population Welfare Department
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
TFR	Total Fertility Rate
VCAT	Values Clarification for Action and Transformation
WHO	World Health Organization

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Executive Summary

Pakistan, the fifth most populous nation globally, faces considerable challenges in scaling up and sustaining gender-responsive Postpartum Family Planning (PPFP) and Post-Abortion Family Planning (PAFP) services. This report conducts a comprehensive bottleneck analysis to identify key barriers and offers evidence-based recommendations to strengthen family planning services, with a particular emphasis on Task Sharing/Shifting and Social and Behaviour Change Communication (SBCC).

Post-Pregnancy Family Planning (PPFP) encompasses a comprehensive approach to addressing family planning needs during the postpartum period, focusing on the prevention of unintended pregnancies and ensuring adequate spacing between births. It encompasses both Post Partum Family Planning (PPFP) and Post Abortion Family Planning (PAFP).

Task Sharing/Task Shifting in family planning focuses on optimizing the roles of various health worker cadres to improve access to contraceptive services, especially in resource-limited settings. This approach is essential for addressing workforce shortages and enhancing the efficiency of health systems in Pakistan.

Social and Behavior Change Communication (SBCC) in family planning focuses on using evidence-driven approaches to improve and sustain changes in individual behaviors, social norms, and the enabling environment to support the adoption of healthy family planning practices.

Since the 1960s, the government has initiated various family planning programs aimed at reducing birth rates and expanding access to services. A pivotal advancement was the introduction of Lady Health Workers, who deliver contraceptive counselling and services directly to rural women. Public sector initiatives, along with the efforts of national and international NGOs, bilateral organizations, and private sector social marketing ventures, have played a significant role in promoting contraceptive use.

Despite early achievements in raising awareness, the actual uptake of family planning methods has remained abysmally low. While 98.1% of women report being aware of modern contraceptive options, the modern contraceptive prevalence rate (CPR) is only 25% (PDHS 2017-18), with rural populations consistently showing lower usage than their urban counterparts. Fertility rate stands at 3.6 children per woman in 2023 according to World Bank estimates, with rural regions exhibiting significantly higher fertility levels.

As Pakistan approaches its FP2030 commitments, it is crucial to analyze existing data to better understand the shortcomings within the health system and to identify actionable strategies for scaling and sustaining family planning initiatives across the country.

This report applied the Bottleneck Analysis (BNA) framework, based on a global standardized protocol defined by WHO, to identify barriers hindering the scale-up of Post-Pregnancy Family Planning (PPFP), Post-Abortion Family Planning (PAFP), Task Sharing, and Social and Behaviour Change Communication (SBCC) interventions in Pakistan.

The findings reveal a critical lack of meticulous data collection, with population-level surveys conducted infrequently by national agencies such as the Pakistan Bureau of Statistics and the National Institute of Population Studies. This results in limited availability of reliable, up-to-date information, making it difficult to track progress or inform effective policy. National-level data repositories do not comprehensively reflect changes, and there is minimal documentation of implementation experiences or case studies—leading to a missed opportunity for institutional learning and policy improvement. Fragmented efforts and parallel policies further exacerbate the challenge of scaling up FP services in Pakistan. Key bottlenecks identified include:

Family planning services are being provided in Pakistan by both department of health and department of population welfare. While the population welfare department is receiving contraceptive stock from the MoNHSRC, the health department which deals with postpartum family planning (PPFP) in the obstetrics units receives none. Data sharing between the two departments needed for planning for FP and achieving the targets is also being done independently. While efforts are ongoing, the need for an integrated approach by both departments at the provincial level has been highlighted. Family planning although integrated into maternal and newborn health services, limited political commitment and lack of intersectoral coordination has reduced its visibility and prioritization within the broader health agenda.

Frequent stock-outs and uneven contraceptive availability, especially in Balochistan and Khyber Pakhtunkhwa, hinder consistent access, despite some progress in provinces like Punjab and Sindh.

A shortage of trained staff for counselling, combined with cultural barriers and provider biases, limits the effective promotion and uptake of PPFP services, especially long-acting methods and for vulnerable populations. Although institutional delivery rates are relatively high, many facilities fail to offer counselling or PPFP services during this critical window of care.

Frontline health workers often lack knowledge of existing FP policies, resulting in inconsistent messaging and missed integration with postpartum care. This has highlighted the need for refresher trainings from community health workers to obstetricians and gynaecologists.

Ambiguity around task sharing and shifting has led to confusion over provider roles, underutilization of services, and limited support from higher-level staff about quality assurance and role boundaries.

Current SBCC efforts do not adequately address entrenched cultural norms, misinformation, or social taboos around contraception. The lack of tailored messaging, community mobilization, and strategic stakeholder engagement has limited both demand for PPFP and broader community and political support.

Based on the activity aligned with the WHO BNA framework, here are plausible and actionable strategies for scaling up and sustaining gender-responsive Post-Pregnancy Family Planning (PPFP/PAFP), Task Sharing/Shifting, and Social and Behaviour Change Communication (SBCC) in Pakistan:

Short-term recommended action

- Lead the creation of a unified national FP framework aligned with FP2030 commitments through MoNHSRC, ensuring alignment across provincial policies while allowing contextual flexibility. The strategy must prioritize equity, integration, and scalability of PPFP and task-sharing approaches.
- Ensure functional health-population integration across provinces to eliminate duplication, improve service coverage, and ensure a unified, efficient FP service delivery structure. Institutionalize family planning counselling and method provision during ANC, delivery, postnatal care, child immunization, and post-abortion care, through a formal directive by MoNHSRC and provincial health departments.
- Finalize and officially notify the provincial task sharing implementation plans already drafted for Sindh, Punjab, KPK, Balochistan, and ICT. Clearly define roles, scope of practice, and ensure accreditation and supportive supervision of mid-level and community health providers (e.g CHWs, LHWs, and LHVs).
- Develop national SBCC guidelines with culturally adapted, gender-equitable messaging across multiple channels. Engage male partners, youth, and community influencers to promote shared responsibility and informed decision-making for FP.
- Improve procurement and supply chain management systems by establishing buffer stocks, decentralized distribution protocols, and integration with existing maternal and child health logistics systems.
- Implement standardized recording and reporting tools for FP at all service delivery levels including public and private sectors, across provinces/areas
- Strengthen digital health infrastructure to track disaggregated FP indicators (age, gender, geography), align data flows across HMIS/DHIS platforms, and enable timely, evidence-based planning and decision-making.
- Expand the use of DHIS2 modules for real-time data entry and stock monitoring. Link FP counselling and follow-up data in LHW mobile dashboards to reduce dropouts and enable timely replenishment of supplies to LHWs.
- Establish with provincial consensus facility-specific targets pertaining to utilization of FP services linked with the monitoring and evaluation systems of the respective provincial health department.

Medium term

- Direct resources—financial, human, and logistical—towards underserved and high-unmet-need populations. Streamline fund disbursement processes and align donor support with local budgeting cycles.
- Update training curricula and launch modular, ongoing professional development or Continuous Professional Development (CPD) programs focusing on FP service delivery, respectful care, gender responsiveness, SBCC competencies, and competency-based CPD programs for community-based and mid-level providers for effective task-shifting/task-sharing.
- Conduct periodic sessions for improving attitudes and reducing provider bias at the district and facility levels using available in-person or virtual training resources to facilitate task-sharing/task-shifting.
- Family planning was highlighted as an intersectoral intervention requiring collaboration between health, population welfare, education, communication, local government, and civil society to ensure a holistic and synergized response to FP needs. A platform that brings these sectors together should be established.
- Develop and monitor key performance indicators (KPIs) for both health and population welfare departments to enforce policy adherence through transparent audits and integrate community feedback systems to ensure quality and equity in FP service provision.
- Establish public-private partnerships to expand access points for contraceptive services, integrate private provider data into national systems, and engage private pharmacies, clinics, and e-commerce platforms as FP service partners/providers.

Introduction

Purpose

In the dynamic landscape of global health, ensuring equitable access to family planning services is paramount for the well-being of communities. Pakistan, a country with a burgeoning population, recognizes the pivotal role that family planning plays in fostering sustainable development, improving maternal and child health outcomes, and empowering women. Despite concerted efforts to advance FP initiatives and the adoption of various policies and programs, progress in key family planning indicators has remained stagnant over the years. While Pakistan has embraced globally recognized family planning approaches their implementation at scale has faced persistent challenges due to a range of structural, operational, and socio-cultural barriers that need to be thoroughly explored and addressed.

In response to these challenges, a comprehensive Bottleneck Analysis (BNA) is being undertaken to systematically identify and address the key barriers hindering the scaling up and sustainability of family planning initiatives. This study focuses on three areas: 1) gender-responsive Postpartum Family Planning (PPFP) and Post-Abortion Family Planning (PAFP), 2) the implementation of Task Sharing/Shifting and 3) Social and Behaviour Change Communication (SBCC) strategies in the family planning landscape of Pakistan. Recognizing the importance of engaging communities and empowering women in decision-making processes, the study aims to generate recommendations to create an environment that is not only conducive to family planning but also addresses the broader issues of reproductive health service delivery.

Objectives

The objectives of the bottleneck analysis include:

- Systematically analyse and identify bottlenecks in the scaling up and sustaining of gender responsive PPFP/PAFP services, task sharing/shifting, and SBCC strategies in family planning in Pakistan.
- Review the impact of existing policies, programs, and interventions on family planning outcomes, with a focus on gender equity and community involvement.
- Provide consensus-driven recommendations to overcome identified bottlenecks and enhance the effectiveness of family planning initiatives in Pakistan.

Situation Analysis

Situation Analysis

According to the 7th Population and Housing Census conducted in 2023, Pakistan's population has reached 241.49 million, making it the fifth most populous country globally. The census data indicates a current population growth rate of 2.55%, the highest in the South Asian region.[1] If this growth rate persists, projections suggest that Pakistan's population could double by 2050. This surge in population presents a hurdle for the nation's development, manifesting resource scarcity, environmental degradation, and increased unemployment rates.

Pakistan Population and Annual Growth Rate Snapshot						
Admin Unit	**Population (mil)**			**Annual Growth Rate (%)**		
	1998	**2017**	**2023**	**1998**	**2017**	**2023**
Pakistan	132.35	207.68	241.49	2.69	2.40	2.55
KPK	20.92	35.50	40.85	2.72	2.82	2.38
Punjab	73.62	109.98	127.68	2.64	2.13	2.53
Sindh	30.44	47.85	55.69	2.80	2.41	2.57
Balochistan	6.57	12.34	14.89	2.47	3.37	3.20
Islamabad	0.81	2.01	2.36	5.19	4.91	2.81

Table 1 - Pakistan Population and Annual Growth Rate Snapshot

Source: Pakistan Digital Census 2023

To tackle these multifaceted challenges, the country has implemented a series of family planning initiatives spanning several decades. Despite these efforts, Pakistan has a persistently high total fertility rate (TFR) of 3.6 children per woman in 2023, surpassing the replacement level of 2.1.[2] A complex interplay of factors contributes to this demographic trend, notably early marriages and childbearing practices. The median age of marriage for women, set at 18.6 years, extends their reproductive lifespan, impacting the overall fertility rate.[3] The interpregnancy intervals were also consistently short. Unequal access to contraception and limited information on family planning amplify these disparities, particularly in rural areas and among marginalized communities.

Beyond these structural challenges, Pakistan faces significant social and cultural barriers that increase misconceptions surrounding family planning. These obstacles are further compounded by religious objections and widespread gender inequality, which collectively hinder access to essential services and influence preferences for larger family sizes. In an

[1] https://www.pbs.gov.pk/sites/default/files/population/2023/Press%20Release.pdf
[2] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=PK
[3] Pakistan Demographic and Health Survey 2017-18

environment already constrained by limited resources, the perception of large families as a source of labor and security serves to reinforce higher fertility rates, perpetuating a cycle that hampers sustainable population management.

Addressing these challenges demands a multidimensional approach encompassing improved access to comprehensive reproductive health services, targeted education initiatives to dispel myths, and the elevation of women's status to mitigate early marriages. Apart from the implementation of robust monitoring and evaluation, scaling up of existing family planning initiatives through the implementation of Post Pregnancy Family Planning (PPFP), task sharing/shifting, and Social and Behaviour Change Communication (SBCC) emerges as a pivotal strategy.

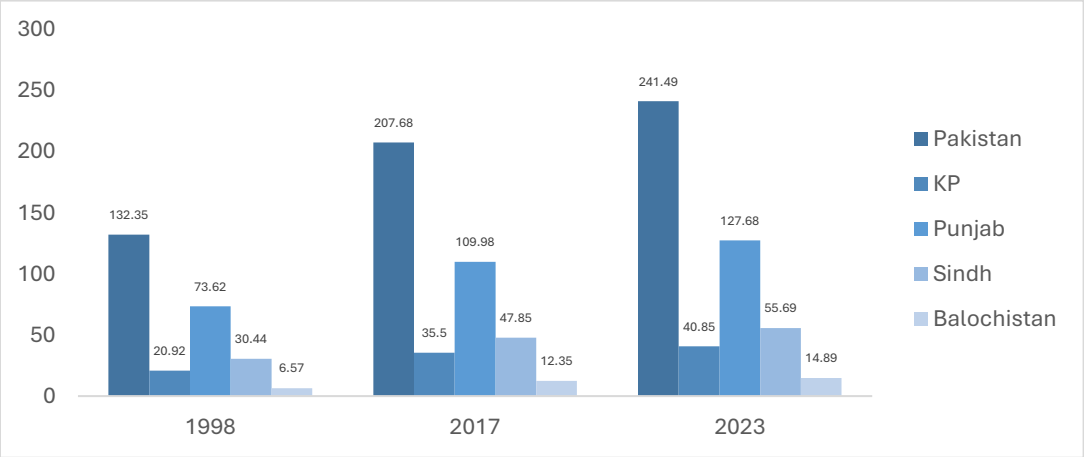

Figure 4- Breakdown of Population by Province, in millions.

Source: Pakistan Bureau of Statistics, 2023[4]

PPFP and PAFP recognize critical windows for intervention, capitalizing on the postpartum periods to offer family planning services and information. Task sharing/shifting involves delegating certain healthcare tasks to non-physician providers, expanding the reach of family planning services. Additionally, SBCC focuses on changing societal norms and behaviours related to family planning through targeted communication efforts. These approaches are integral to achieving commitments outlined in initiatives like FP 2030, a global partnership aimed at expanding access to voluntary family planning.

[4] Pakistan Bureau of Statistics. ANNOUNCEMENT OF RESULTS OF 7TH POPULATION AND HOUSING CENSUS-2023.

Pakistan's FP commitment for CPR at ICPD25 Nairobi Summit			
	PDHS 2017-18 (%)	**Target 2025**	**Target 2030**
Pakistan	34.2	50	60
KPK	30.9	46	56
Punjab	38.3	54	64
Sindh	30.9	47	57
Balochistan	19.8	36	46
Islamabad (ICT)	45.7	62	72
Gilgit Baltistan (GB)	39.0	55	65

Table 2 - Pakistan's FP commitment for CPR at ICPD25 Nairobi Summit

Source: Pakistan's FP2030 Commitment for CPR

FP 2030 recognizes the importance of these strategies in achieving its goal of enabling an additional 120 million women and girls in the world's poorest countries to access voluntary family planning by 2030. The commitment to task sharing, SBCC, and targeted family planning interventions aligns with the broader vision of FP 2030 to empower individuals and communities in making informed choices about their reproductive health.

Role of Post Pregnancy FP in Family Planning in Pakistan

Post Pregnancy Family Planning (PPFP) refers to prevention of unintended pregnancy and closely spaced pregnancy up to 12 months after culmination of gestation due to childbirth or abortion.[5] The World Health Organization (WHO) promoted the Healthy Timing and Spacing of Pregnancy (HTSP) of two years and above following the culmination of gestation, and at least six months after receiving post abortion care.[6] The role of PPFP is significant in preventing postpartum complications due to insufficient birth spacing and improving mother's health and existing children.[7] It is also important because it helps achieve Sustainable Development Goals (SDGs) by reducing poverty and hunger, improving health, supporting economic growth, and promoting a sustainable environment.[8] Therefore, PPFP merits investment and scaling up of evidence-based practices (EBP) to meet national and global SDGs.

[5] Nabhan A. Implementation strategies, facilitators, and barriers to scaling up and sustaining post pregnancy family planning, a mixed-methods systematic review. BMC Women Health. 2023 July.
[6] Organization WH. Institutional Repository for Information Sharing. [Online].; 2005. Available from: https://iris.who.int/handle/10665/69855
[7] Anita Makins SC. Post pregnancy contraception. In Best Practice and Research Clinical Obstetrics and Gynecology.: Elsevier; 2020. p. 41-54.
[8]Ellen Starbird MNRM. Investing in Family Planning: Key to Achieving the Sustainable Development Goals. Global Health: Science and Practice. 2016 June; 4(2).

The process of scaling up promotes health interventions to multiple communities that have successful results during experimentation in a pilot setting.[9] This process outlines nine steps for developing and implementing a successful scaling-up strategy. These steps cover planning of scalability, capacity building of organizations, capacity building of resource teams, environmental considerations, strategizing, institutionalization (vertical scaling up), expansion/replication (horizontal scaling up), diversification, spontaneous scaling up, and finalization.[10]

The need for scaling up of PPFP also derives from the high prevalence of unmet needs for family planning in low-and-middle income countries (LMIC).[11] Global contraceptive use for any method is estimated to be 65% in 2022, whereas the current contraceptive use in the most populous region of Pakistan stands at 34% accompanied by a total fertility rate of 3.6 births per woman and average population growth of 2.4%.[12,13] PPFP has a vital role in reaching a total fertility rate of 2.1 children per woman for a stable population.[14]

It is vital to understand the components of PPFP to further investigate the challenges of implementation and promotion. PPFP is initiated during the first year after childbirth or miscarriage/abortion. Furthermore, it can be divided into post-placental (within ten minutes of after delivery of products of conception), immediate postpartum (within 48 hours), early postpartum (48 hours to four weeks) and extended postpartum (four weeks to 1 year).[9] PPFP comprises of various contraceptive methods for individuals which range from counselling, medication, barrier methods and intrauterine contraceptive devices.

An important component of PPFP is the access to family planning counselling through integration of services with other healthcare visits. PPFP needs to be provided during antenatal care, childbirth, postpartum care, child immunization visits, infant care and post abortion care. Health visits and outreach programs serve an important opportunity for PPFP delivery with existing health services.

Barriers to PPFP need to be identified through the lens of WHO health system building blocks. These blocks are human resources, service delivery, governance, financing,

[9] WHO. IRIS. [Online].; 2021. Available from: https://iris.who.int/handle/10665/44432.
[10] WHO. iris.com. [Online]. Nine Steps for Developing Scaling up Strategy.
[11] Moore Z PAGRCEELCT. Missed opportunities for family planning: an analysis of pregnancy risk and contraceptive method use among postpartum women in 21 low- and middle-income countries. Contraception. 2015 March; 1.
[12] Ministry of National Health Services R&CoPPW. Year Book 2021-22 Islamabad: MoNHSRC; 2022.
[13] WHO. WHO.com. [Online].; 2022 [cited 2023. Available from: https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception.
[14] OECD. data.OECD.org. [Online].; 2023 [cited 2023. Available from: https://data.oecd.org/pop/fertility-rates.htm#:~:text=Assuming%20no%20net%20migration%20and,of%20economic%20and%20social%20developments.

information, and medicines & technology. By addressing the challenges of each area, we can formulate an effective scaling up strategy for PPFP.

The WHO supports values clarification for action and transformation (VCAT) training for abortion provider, which can control healthcare provider bias. WHO has also launched an online training course on ABC (attitudes, behaviours and compassion) to address health workers biases. Values clarification exercises minimize personal values to influence providers while interacting with women seeking abortion. Despite providers' attempts at objectivity, negative beliefs about abortion influence professional judgement and the quality of care. [15]

PPFP intervention has a role in reducing postpartum complications among mothers.[16] Sections of health system building blocks have to be addressed for coherence and promoting facilitating factors identified according to Pakistan's health care system for effective implementation of scaling up efforts. Sustainability can be ensured by formulating a contextualized guided long-term plan developed in consultation with stakeholders, keeping in view financial and budgetary constraints. Hence, a long-term plan should be developed for scaling up, capacity building, implementation, and procurements that is also costed for the next 5-10 years. Partnership development with local/private/NGOs organizations for social mobilization and demand creation allows the public sector to focus on the delivery of quality services, ensuring supplies and regulation.[17]

Role of Task Sharing and Task Shifting in Family Planning Programs in Pakistan

Many countries, especially low-and-middle income countries (LMIC) are dealing with a shortage of trained healthcare providers, especially for provision of contraception and family planning. This acts as a barrier for women in need of access to reproductive health and hampers efforts to achieve SDG targets for health promotion, reducing hunger and poverty.[18,19] In lieu of this problem, the WHO suggests the strategy of Task Sharing/Shifting. It is the delegation or transfer of tasks from highly trained health professionals to less-trained healthcare providers, i.e., nurses, lady health workers, community health workers, pharmacists etc.

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[15]WHO. International repository for information sharing. [Online].; 2012. Available from: https://iris.who.int/handle/10665/70914

[16] Maternal and Child Health Integrated Program (MCHIP), 2012, Statement for Collective Action for Postpartum Family Planning

[17] UNFPA, 2020, Task Shifting and Task Sharing for Family Planning in Pakistan: Progress, Challenges and Way Forward.

[18] WHO. iris.who.int. [Online].; 2022 [cited 2023. Available from: https://iris.who.int/bitstream/handle/10665/259633/WHO-RHR-17.20-eng.pdf

[19] Barbara Janowitz JSBB. Task sharing in family planning. Study in Family Panning. 2012 March; 43(1).

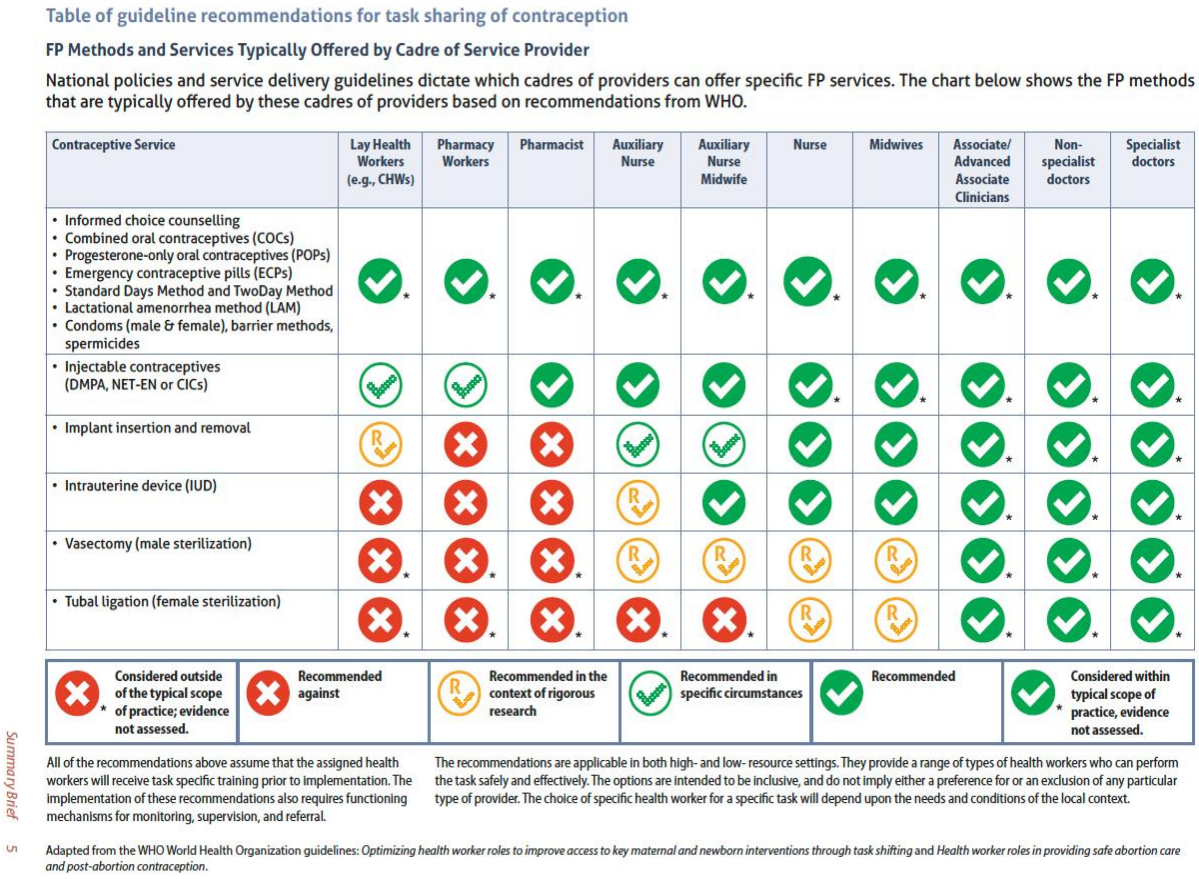


Table of guideline recommendations for task sharing of contraception

FP Methods and Services Typically Offered by Cadre of Service Provider

National policies and service delivery guidelines dictate which cadres of providers can offer specific FP services. The chart below shows the FP methods that are typically offered by these cadres of providers based on recommendations from WHO.

Contraceptive Service	Lay Health Workers (e.g., CHWs)	Pharmacy Workers	Pharmacist	Auxiliary Nurse	Auxiliary Nurse Midwife	Nurse	Midwives	Associate/ Advanced Associate Clinicians	Non-specialist doctors	Specialist doctors
• Informed choice counselling • Combined oral contraceptives (COCs) • Progesterone-only oral contraceptives (POPs) • Emergency contraceptive pills (ECPs) • Standard Days Method and TwoDay Method • Lactational amenorrhea method (LAM) • Condoms (male & female), barrier methods, spermicides	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*
• Injectable contraceptives (DMPA, NET-EN or CICs)	✓	✓	✓	✓	✓	✓*	✓*	✓*	✓*	✓*
• Implant insertion and removal	R	✗	✗	✓	✓	✓	✓	✓*	✓*	✓*
• Intrauterine device (IUD)	✗	✗	✗	R	✓	✓	✓	✓*	✓*	✓*
• Vasectomy (male sterilization)	✗*	✗*	✗*	R	R	R	R	✓*	✓*	✓*
• Tubal ligation (female sterilization)	✗*	✗*	✗*	✗*	✗*	R	R	✓*	✓*	✓*

✗* Considered outside of the typical scope of practice; evidence not assessed.

✗ Recommended against

R Recommended in the context of rigorous research

✓ Recommended in specific circumstances

✓ Recommended

✓* Considered within typical scope of practice, evidence not assessed.

All of the recommendations above assume that the assigned health workers will receive task specific training prior to implementation. The implementation of these recommendations also requires functioning mechanisms for monitoring, supervision, and referral.

The recommendations are applicable in both high- and low- resource settings. They provide a range of types of health workers who can perform the task safely and effectively. The options are intended to be inclusive, and do not imply either a preference for or an exclusion of any particular type of provider. The choice of specific health worker for a specific task will depend upon the needs and conditions of the local context.

Summary Brief 5

Adapted from the WHO World Health Organization guidelines: *Optimizing health worker roles to improve access to key maternal and newborn interventions through task shifting* and *Health worker roles in providing safe abortion care and post-abortion contraception.*

Figure 5-WHO Recommendation for Task Sharing/Shifting

The strategy of delegation/transfer of family planning tasks aims at increasing availability and access to contraception. Additionally, it creates an environment which allows more time for healthcare providers to practice specialized skills and services. This has emerged as a promising strategy to address the shortage of healthcare workers and expand access to essential family planning services. Pakistan faces a significant shortage of healthcare workers, particularly in rural and underserved areas, posing a major challenge for accessible and quality family planning services. Thus, task sharing and shifting presents a viable solution to address this workforce gap and expand access to family planning services.[20].

Task sharing occurs in two main forms: sharing within a health care establishment (HCE) and sharing across different types of supply outlets such as Pharmacies, Lady health visitor (LHV) and community health workers (CHW). In the first type, HCE oriented, responsibilities are delegated to lower-cadre providers within HCE for example, when nurses and physician assistants/surgeon assistants carry out tasks conventionally performed by physicians. In

[20] UNFPA. unfpa.org. [Online].; 2021 [cited 2023]

family planning, high demand and overworked providers are merits for task sharing, aiming to increase the time physicians and other high-level providers extend to routine procedures while access to family planning is extended to all.[21]

The concept of task sharing in such a setting is not novel and has been employed since the 1980s. The second task sharing is through various supply outlets such as in the case of CHWs who make home visits, travel time is eliminated for clients, and uptake and continued contraceptive use is facilitated. This positive outcome was one of the rationales behind household distribution of contraceptives in Asia.[22] It is also worth mentioning that task shifting and task sharing are mutually exclusive concepts, while task sharing is the expansion of cadres that can perform a particular task, the term task shifting is used to describe the provision of authority to perform a task from one cadre to another, conventionally from highly trained to lesser trained.

Research has consistently demonstrated the effectiveness of task sharing in family planning programs across Pakistan. A cross sectional study of married women of reproductive age (MWRA) found that lady health workers (LHWs), trained through task sharing initiatives, were effectively providing a range of family planning services, including counselling, contraception provision, and referrals to higher-level care.[23] Similar findings were reported in a study in Pakistan, which indicated that LHWs played a crucial role in increasing contraception uptake and improving reproductive health outcomes.[24]

Task sharing has been associated with positive impacts on family planning outcomes in Pakistan. A study revealed that task-sharing interventions led to a significant increase in modern CPR among women in rural areas.[25,26] Similarly, another study demonstrated that task sharing contributed to a decline in the unmet need for family planning and improved maternal and child health indicators.[27]

[21] Akin A, Training auxiliary nurse midwives to provide IUD services in Turkey and the Philippines. Studies in Family Planning. 1980; 11(5).
[22] Phillips JF, The long-term demographic role of community-based family planning in rural Bangladesh. Studies in Family Planning. ; 27(4).
[23] Syed Khurram Azmat . Assessing predictors of contraceptive use and demand for family planning services in underserved areas of Punjab province in Pakistan: results of a cross-sectional baseline survey. Reproductive Health. 2015 March;(25).
[24] Ashraf r,mk,kma,aa,&gh. Task-sharing for family planning services in Pakistan: An effectiveness evaluation. Journal of the Pakistan Medical Association. 2018; 68(7).
[25] Naz F,IF,AS,SMS,mSFT. Impact of task-sharing intervention on modern contraceptive prevalence rate in rural Sindh, Pakistan. Pakistan Journal of Medical Sciences,. 2019; 35(5).
[26] Shahana Nisar 1 MK2UN. Impact Of Lady Health Workers On The Contraceptive Prevalence Rate In District Mardan. Journal of Ayub Medical College Abbottabad. 2020 JANUARY; 32(1).
[27] Gul H,AA,KMA,MK,&AR. Impact of task-sharing on unmet need for family planning and maternal and child health indicators in Pakistan.. Journal of Pakistan Medical Association. 2020; 70(9)

Effective implementation of task sharing in family planning programs requires a comprehensive approach that encompasses training, supervision, and support for less-trained providers. Training modules should be carefully designed to ensure that providers acquire the necessary skills and knowledge to provide quality family planning services such as counselling on contraception, provision of barrier methods (condoms) Standard days method, Two-day method and Lactational Amenorrhea Method. Other services may be incorporated such as Intramuscular injectable contraceptives and insertion and removal of Intrauterine Contraceptive Devices (IUCD), though pharmacists and LHWs are not recommended for this task sharing. Regular supervision and ongoing support are essential to maintain provider competencies and address any challenges that may arise. Despite its demonstrated effectiveness, task sharing faces certain challenges in the context of family planning programs in Pakistan. One challenge is ensuring that less-trained providers have access to adequate resources and supplies to provide services effectively. Additionally, there is a need for stronger monitoring and evaluation systems to track the impact of task sharing interventions and identify areas for improvement and barriers. The need for highly trained healthcare providers will not be diminished by task sharing as there will be need for procedures like vasectomy and tubal ligation conducted under their supervision.

Task sharing has been in effect practiced in various countries of Asia and African regions prior to WHO's acknowledgment to remedy staff shortage and access to health needs. Research has consistently demonstrated the effectiveness of task sharing in improving family planning outcomes, particularly in underserved areas. Policy and governance are tools that can help in accreditation of less trained healthcare providers in providing a larger portfolio of services to individuals seeking family planning and contraception services.

Healthcare commissions in Pakistan, at provincial levels, are responsible for the accountability, accreditation and standards development of healthcare establishments and healthcare providers. These commissions are essential for collaboration to promote task sharing/shifting guidelines for Family Planning. By addressing the challenges and implementing effective strategies, task sharing can play a pivotal role in achieving Pakistan's family planning goals and improving the reproductive health of women and their families.

Role of Social and Behaviour Change Communication in Family Planning in Pakistan

To advocate and improve enrollment of individuals for family planning, an evidence-based approach is required to promote health seeking behaviour in communities and address the key determinants of behaviour that act as barriers and facilitators. Interventions that propagate to change behaviours through addressing key determinants such as knowledge,

attitude, beliefs, practices and self-efficacy are cumulatively termed SBCC interventions. SBCC is a multi-disciplinary evidence-based approach to raise awareness, dispel myths and address barriers that inhibit the utilization of FP and contraceptives.[28,29]

SBCC interventions address diverse factors influencing the adoption of contraceptives, including social norms, partner communication, method-specific barriers, and fertility preferences. SBCC enhances client-provider interaction, perception of service quality, and trust in the health system, creating a supportive environment that complements service delivery for robust family planning programs.[30] SBCC is focused on socio-ecological models of behaviour that identifies intervention at individual, interpersonal, organizational, community and environmental levels. Thus, the workflow of SBCC starts with defining and design of intervention, testing and evaluation of impact, refining of methods and finally adoption for broader application.[31]

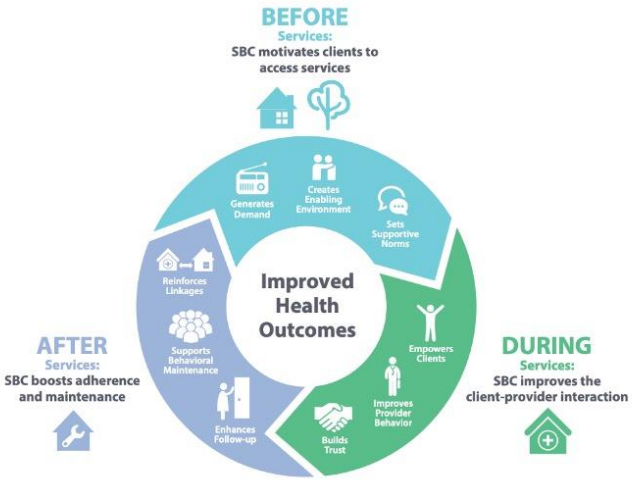


Figure 6 - SBCC Circle of Care

[Source: Breakthrough Action]

Family planning faces many barriers that inhibit the informed and educated consent of individuals to partake in family planning for the desired reproductive health outcomes. Among these barriers are myths, misinformation and lack of accurate knowledge of sexual health, contraception and family planning. Individuals that are knowledgeable about fact-

[28] Evaluation M. measureevalution.org. [Online].; 2018 [cited 2023. Available from: ww.measureevaluation.org/resources/publications/fs-18-278b/at_download/document
[29] Planning HIPF. fphighimpactpractices.org. [Online].; 2022. Available from: https://www.fphighimpactpractices.org/briefs/SBCC-overview/
[30] Planning HIPF. fphighimpactpractices.org. [Online].; 2022. Available from: https://www.fphighimpactpractices.org/briefs/SBCC-overview/
[31] Research BAa. breakthroughactionandresearch.org. [Online].; 2022 [cited 2023. Available from: https://breakthroughactionandresearch.org/SBCC-flow-chart/.

based information regarding contraception and its side effects are more favorable towards family planning and more likely to partake in family planning.[32] Coupled with myths about negative impact on fertility, there is strong indication for future discontinuation of contraceptive methods.[33] Societal bias towards contraceptive methods, inequality of decision making roles among couples acts as barriers and affects confidence of an individual to use family planning. These include examples of discontinuation of contraceptives due to disapproval of partner and family members.[34,35] Similarly, attitudes of influencers like mother in law along with other family members , community and religious leaders can also impact use of contraceptives.[36,37]

SBCC can assist in overcoming barriers to FP through knowledge-driven designing of messaging delivered through multi-level intervention (mass media, digital health services, community group engagement). This is achieved by engaging individuals and communities via electronic media, focus group discussions conducted by health counselors, couples counselling, digital tools and interactive published material.

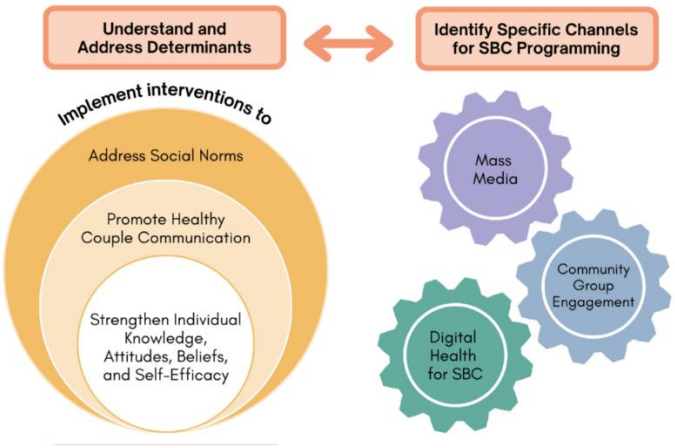


Figure 7- Social and Behaviour Change High Impact Practices/ SBCC HIP

SBCC programs are most effective when they use a multi-channel approach, and there is consistent evidence that shows the greater the exposure to SBCC campaigns through

[32] Ochako R MMASea. Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. BMC Public Health. 2015; 15(118).
[33] Gueye A SICMOC. Belief in family planning myths at the individual and community levels and modern contraceptive use in urban Africa. Reproductive Health. 2015; 41(4).
[34] Malalu PK AKTRCA. Determinants of use of modern family planning methods: a case of Baringo North District, Kenya. Science Journal Public Health. 2014; 2(5).
[35] Bajwa SK BSGGSKSN. Knowledge, attitudes, beliefs, and perception of the north Indian population toward adoption of contraceptive practices. Asia Pacific Journal of Public Health. 2012; 24(6).
[36] Adedini SA BSICOOAAOM. Role of religious leaders in promoting contraceptive use in Nigeria: evidence from the Nigerian Urban Reproductive Health Initiative. Global Health Science Practice. 2018; 6(3).
[37] S. A. Intentions to use contraceptives in Pakistan: implications for behaviour change campaigns. BMC Public Health. 2010; 10(450).

different channels, the greater the odds of behaviour change (known as a dose-response relationship). The first step to these interventions is to design the information of FP in lieu of existing levels of knowledge, belief, attitude and self-efficacy of the audience, focused upon dispelling misinformation and promoting the idea of benefits to health. Primary concerns of females of childbearing age in Pakistan, is the view of partner on harmful effects of contraception i.e. quality and standards of contraceptives as well as trust in healthcare services available for family planning.

Geographical Scope

The study covered 16 districts across Pakistan. These include 2 districts from Balochistan, 4 from Punjab, 3 from Sindh, 2 from Khyber Pakhtunkhwa, 1 from ICT, and 2 from Gilgit-Baltistan, along with 1 from Azad Jammu and Kashmir. The selection of districts was guided by criteria ensuring representation from urban and rural settings, capital districts, major urban centers, and rural areas. This geographical diversity aims to capture variations in family planning practices influenced by different demographic and cultural factors.

Initially, the study aimed to cover fifteen districts, but two districts in Punjab (Nankana Sahib and Bhawalnagar) were added on the recommendation of the Population Welfare Department. Further districts were also added from Balochistan to assess the bottlenecks.

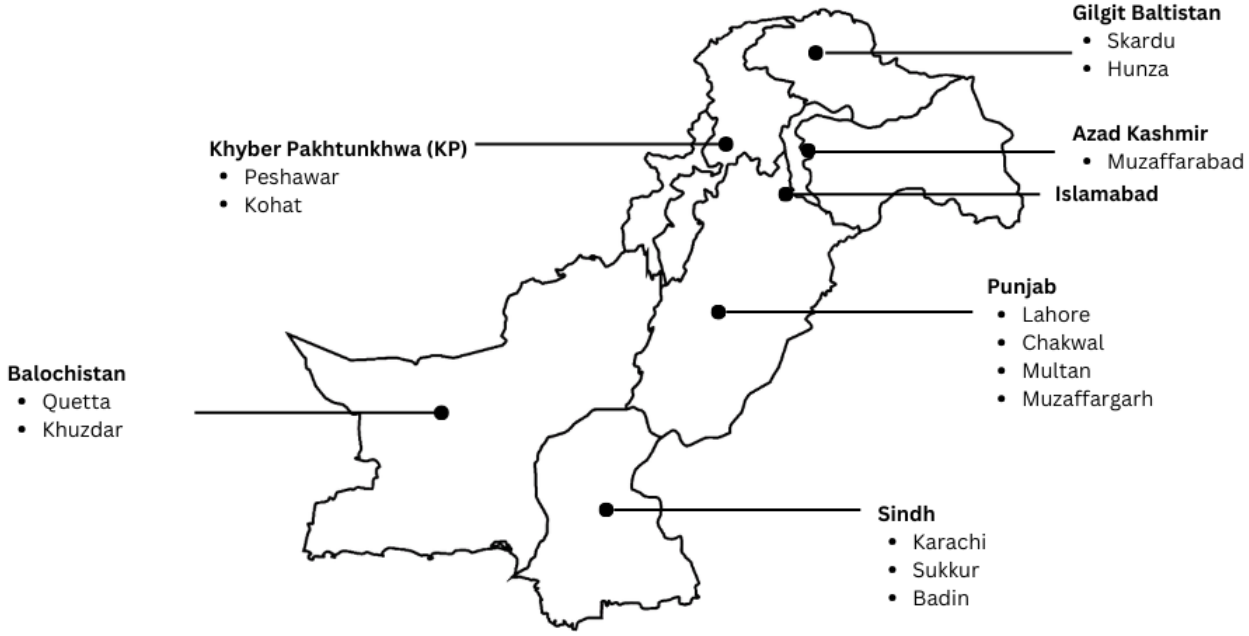


Figure 8- Geographical Scope of the Assignment

Conceptual Framework

Conceptual Framework

Figure 9 - Conceptual Framework

Gaps in Implementation

Gaps in Implementation

This section focuses on gaps in implementation of Postpartum Family Planning (PPFP) and Post-Abortion Family Planning (PAFP), along with Task Sharing/Shifting and Social and Behaviour Change Communication (SBCC) strategies. This report, under the Family Planning-Bottleneck Analysis Project, will provide an overview of the existent data obtained through various surveys that have been conducted in Pakistan and identify gaps that are essential for the scalability and sustainability of PPFP/PAFP, Task Sharing/Shifting and SBCC initiatives.

This analysis is based on a thorough examination of national data, obtained from the sources outlined below. This methodology is based upon the "Gaps in Coverage" component of the WHO FP Accelerator Plus guidelines. This component specifically focuses on a desk review of existing indicators, to be used for background information on the current state of EBP coverage.

The data sources which provided the indicators available for Pakistan are listed in Table 3 (Annexure 1).

Common Indicators

Based on Annex A outlined under the WHO FP Accelerator Plus bottleneck assessment guidelines, indicators common to PPFP/PAFP, Task-Sharing and SBCC were obtained from the sources identified in Table 3 (Annexure 1). This information is summarized in Table 3:

Indicator	Value	Source
Married women currently using any method of contraception	34%	DHS
Married women currently using any modern method of contraception	25%	DHS
Current users most recent supply or information from a public source	44%	DHS
Current users most recent supply or information from a private medical source	43%	DHS
Believes fertile period is middle of the cycle	8%	DHS
Unmet need for family planning	17%	DHS
Met need for family planning (currently using), total	34%	DHS
Total demand for family planning	52%	DHS
Demand for family planning satisfied by modern methods	48.6%	DHS
Future use of contraception: In next 12 months	33.3%	DHS
Users informed about side effect or problems of method used	35.3%	DHS
First-year contraceptive discontinuation rate due to method failure	4.7%	DHS
First-year contraceptive discontinuation rate due to all reasons	30%	DHS

Table 3 - Gaps in Implementation Data Sources

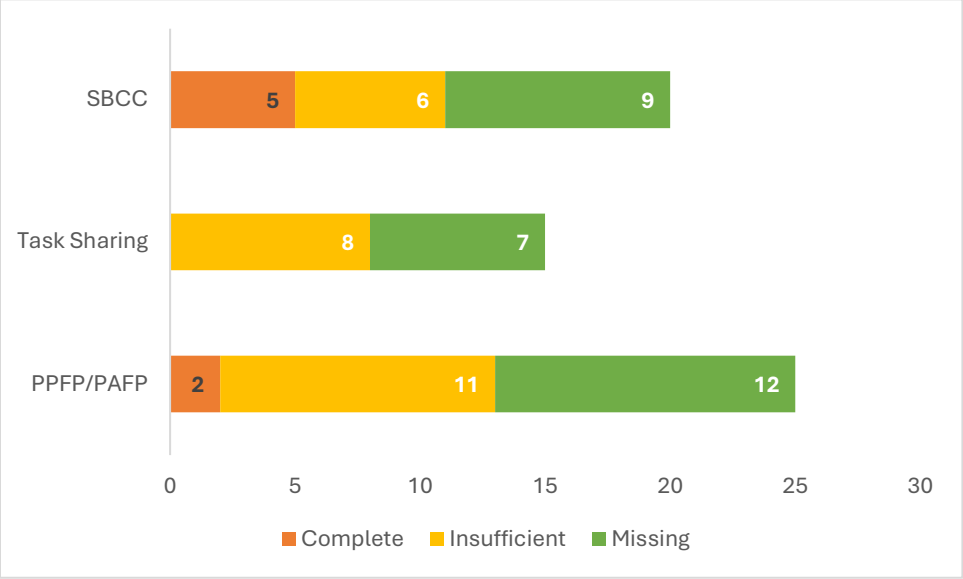
Specific Indicators

The specific indicators for PPFP, Task sharing/task shifting and Social behaviour Change communication that were extracted from the data sources available show that for postpartum family planning 12 out of 25 recommended indicators were available for Pakistan although the age disaggregation was found only for 2 indicators; rural urban break up is available for all the indicators that are available (12 out of 25).

For task sharing/task shifting only 7 out of 15 specific indicators are being reported on by the data sources available.

For SBCC, out of 20 only 9 indicators could be obtained from the available data sources and among these only 5 indicators provide disaggregation for age and rural urban distribution.

The number of indicators for which no data could be obtained are illustrated in Figure below, along with indicators which have insufficient data. Indicators for health workforce and task-sharing are crucial for understanding gaps in implementation of FP initiatives, and the non-availability of data can make this process more challenging.



Number of Complete, Insufficient and Missing indicators

Through this desk review of family planning indicators in Pakistan under the WHO FP Accelerator Plus Program, this report has highlighted several key areas of progress as well as persistent challenges that need to be addressed to improve family planning outcomes.

Despite notable achievements, such as a relatively high awareness of modern contraceptive methods among women of reproductive age (98.1%) and a significant portion of family planning services being accessed through both public and private sectors, the overall contraceptive prevalence rate remains modest at 25%. This rate reflects that there is a pressing need to delve deeper to understand these disparities and their root causes.

One of the most pressing issues identified is the unmet need for family planning, which stands at 17.3%. This indicates a considerable gap between women's reproductive intentions and their access to effective contraceptive methods. Addressing this gap is critical for improving maternal and child health outcomes and advancing gender equality.

Health concerns and fears of side effects are significant barriers to the uptake of family planning methods. Nearly 19.2% of women report not using family planning due to these concerns. This highlights the need for enhanced counselling and support services to ensure women are fully informed about their options and can manage any side effects effectively.

The review also underscores the importance of strengthening health service delivery, particularly in postpartum and rural settings. Increasing the availability of family planning counselling and methods at critical points, such as during antenatal and postnatal visits, can significantly improve access and usage rates.

Community engagement and tailored outreach programs are essential for addressing socio-cultural barriers and reaching underserved populations. Involving men in family planning discussions, leveraging digital platforms, and employing community health workers can create more supportive environments for women to make informed choices about their reproductive health.

In conclusion, while progress has been made in family planning in Pakistan, significant efforts are still required to meet the needs of all women, particularly those in rural areas and those facing health concerns. By implementing targeted interventions to enhance information dissemination, address health concerns, and improve service delivery, Pakistan can make substantial strides toward achieving its family planning goals and improving overall reproductive health outcomes.

Gaps in Guidance

Gaps in Guidance

Post Pregnancy Family Planning

For postpartum family planning, most of the policy documents provide clear guidance on PPFP. However, some related documents allude to PPFP without giving clear details. For example, Immunization policies, guidelines and tools recommend counselling on FP during child health checks/immunization visits

Some provide partial guidance for example, Infant feeding/nutrition policies, guidelines and tools clearly state the 3 criteria for Lactational Amenorrhoea Method (LAM)

Task Sharing and Shifting

For task sharing and shifting, the relevant policy documents provide only partial guidance for Task Sharing/Shifting. The only exception are the policy statements for KP, Sindh, Balochistan, Punjab and ICT for task sharing to improve access of Long Acting Reversible Methods. However, these are all draft documents.

Social Behaviour Change Communication

On SBCC, the policy documents provide partial guidance on use of mass media and digital health to promote FP and on how to involve men and promote health couple communication, there is clear guidance but poor implementation. There is lack of clarity in the documents regarding indicators for success of SBCC and community engagement for FP.

In SBCC, appropriate guidance is lacking in policy documents which advise on mass media such as guidance on formative research, pre-testing messages, targeting of communication, selection of appropriate channels, audience segmentation, working with local community platforms or infrastructure, and the need to address equity in SRH.

More details can be found in tables attached as Annexure 2.

Case Studies

Case Studies

Case Study 1: Engaging the Missing Link: Evidence from FALAH for Involving Men in Family Planning in Pakistan

Category	Details
Title of project or programme with short description	FALAH (Family Advancement for Life and Health) project, focusing on involving men in family planning in Pakistan. It also emphasized birth spacing, as opposed to limiting family size, as the primary purpose of contraceptive use.
Where was the project or programme implemented?	The project was first implemented in 20 districts across four provinces of Pakistan. In July 2009, 11 additional districts were added and five were dropped due to security concerns. During the last year of the project, the activities were limited to only 15 districts. The project was therefore implemented for all five years in 10 districts and for fewer than five years in 21 districts. Overall, the FALAH project districts cover 37 percent of Pakistan's total population
Who implemented it?	Consortium of NGOs led by Population Council, including Greenstar, HANDS, JHPIEGO, RSPN, Save the Children. Collaborated with provincial Departments of Health and Population Welfare.
Achievements	• CPR increased by 8.5 percentage points in intervention districts • Unmet need for spacing decreased by 4 percentage points • Significant male engagement and more supportive attitudes • Improved health provider capacity • Effective framing and behaviour change communication
Health Systems Success Factors (based on bottlenecks)	• Improved service delivery (access, quality, public/private sectors, mobile units) • Trained human resources (various levels, including male workers) • Effective information dissemination (mass media, community events, interpersonal) • Improved commodity security (contraceptive supply logistics) • Supportive leadership & governance (government collaboration, policy integration, and religious endorsement) • External financing

Challenges	• Socio-cultural barriers (women's mobility, fear of side effects, social disapproval) • Traditional exclusion of men in family planning • Issues with access to services, especially in rural areas • Low literacy levels requiring diverse communication • Ensuring sustainability.
Other Relevant Info/Lessons	• Reframing to "Birth Spacing Saves Lives" was effective • Religious endorsement crucial • Multi-pronged communication strategy worked well • Engaging men is essential • Focus on sustainability and evidence-based messaging.

Case Study 2: Deployment of Community Midwives (CMWs) as Providers of Family Planning Services

Category	Details
Title of project or programme with short description	The project is a collaborative effort to broaden government support for the deployment of Community Midwives (CMWs) as providers of family planning services in rural Sindh province, Pakistan. The aim is to generate evidence for the Sindh government to consider involving CMWs in the delivery of comprehensive reproductive and safe motherhood services, including quality family planning.
Where was the project or programme implemented?	The project was implemented in the rural Sindh province of Pakistan, with a pilot site in Hala, a sub-district of the Matiari district
Who implemented it?	The project was implemented by Pathfinder International-Pakistan, in collaboration with the Departments of Health and Population Welfare in Sindh, with support from Advance Family Planning (AFP)
Achievements	• Established a coordinating body to advance task-sharing. • LHW program adopted a protocol to support CMWs in community mobilization. • MNCH program agreed to revise CMW training to include IUD insertion. • Initiated training, developed manuals, deployed CMWs, and set up data collection systems.
Health Systems Success Factors (based on bottlenecks)	• Service Delivery: Expanded CMW roles, improved training, task-sharing with LHWs • Health Workforce: Strengthened CMW capacity, recognized CMWs as key providers • Health Information Systems: Implemented monitoring and evaluation • Medical Products, Vaccines, and Technologies: Ensured steady supply, expanded contraceptive options • Health Financing: Secured financial and programmatic support • Leadership / Governance: Established coordinating body, built partnerships, engaged champions

Challenges	• Delays in federal funding for CMW deployment. • Turnover in key positions in the Health Department. • Competing health priorities, such as polio vaccination campaigns, which made it challenging to schedule CMW meetings with the LHWs
Other Relevant Info/Lessons	• The importance of building partnerships early and often among various stakeholders. • The value of targeted advocacy planning. • The need to plan for transitions in government officials' positions. • The critical role of champions in positions of influence. • The significance of aligning the project with existing systems and structures to inform policy change.

Questionnaire Analysis

The initial overview of the responses to the questionnare provides a consolidated analysis across all levels showing a general sense of bottlenecks across all levels. Across all three service areas, most bottleneck categories fall within the minor bottleneck range (light green). This suggests that while obstacles exist, they are generally not critically hindering progress when considering all levels together. Notably, human resources for task sharing/shifting, and implementation, governance, and information for SBCC, as well as Implementation for PPFP/PAFP, were identified as having no bottlenecks (dark green).

The subsequent analysis reveals important distinctions in the perception of bottlenecks at different administrative levels. A key finding is that bottlenecks are generally perceived as more severe at the national and sub-national levels compared to the district and frontline levels. Several categories that are identified as important bottlenecks (light red) at the national and sub-national levels are often perceived as minor bottlenecks (light green) or even no bottlenecks (dark green) at the district and frontline.

Financing and people consistently emerge as important bottlenecks across all three service areas at the national & sub-national levels. This highlights potential systemic issues related to resource allocation and human resource management at higher administrative levels. **Information and governance** also present as important bottlenecks for multiple service areas at the national & sub-national levels, suggesting challenges in data management, communication, and leadership/oversight. **Medicine and technology** shows as an important bottleneck specifically for PPFP/PAFP at the national & sub-national level.

At the district and frontline levels, most bottleneck categories fall within the minor bottleneck range. Several areas, particularly implementation, governance, and information for SBCC, as well as implementation and governance for PPFP/PAFP, and implementation and human resources for task sharing, are identified as having no bottlenecks. This suggests that **operational aspects and immediate human resource availability at the service delivery level** are generally functioning more smoothly compared to the systemic challenges faced at higher levels.

The analysis indicates a disparity in the perceived severity of bottlenecks across administrative levels. While challenges exist across all levels, they appear to be more pronounced and potentially systemic at the national and sub-national levels, particularly in areas of financing, people, information, and governance.

This suggests that interventions aimed at addressing bottlenecks need to be differentiated based on the administrative level. Strategies focusing on policy, resource allocation, and systemic improvements might be more relevant for the challenges identified at the national and sub-national levels. Conversely, efforts at the district and frontline levels could focus on addressing the less severe, more localized obstacles to further optimize service delivery. The areas identified as having no bottlenecks, particularly at the frontline, represent strengths that could be leveraged and learned from.

Root Cause Analysis

Root Cause Analysis

A root cause analysis, using the 'Why-Why-Why' technique, was conducted during the stakeholder workshop to identify the underlying factors contributing to the challenges in family planning service delivery. This participatory approach allowed stakeholders to systematically explore and uncover the root causes behind key bottlenecks, ensuring a deeper understanding of the issues and informing targeted solutions.

PPFP

Governance and Financing

***Effect**: "There are no financing mechanisms and policy actions in place to ensure equitable scale-up of PPFP access in Pakistan."*

Question 1: **Why** is there a lack of financing mechanisms and policy actions for equitable PPFP scale-up?

Answer 1: Because there is a lack of political will and prioritization of PPFP within the government.

Question 2: **Why** is there a lack of political will and prioritization of PPFP within the government?

Answer 2: Because PPFP is not seen as a high-priority issue compared to other health and development concerns.

Question 3: **Why** is PPFP not seen as a high-priority issue compared to other health and development concerns?

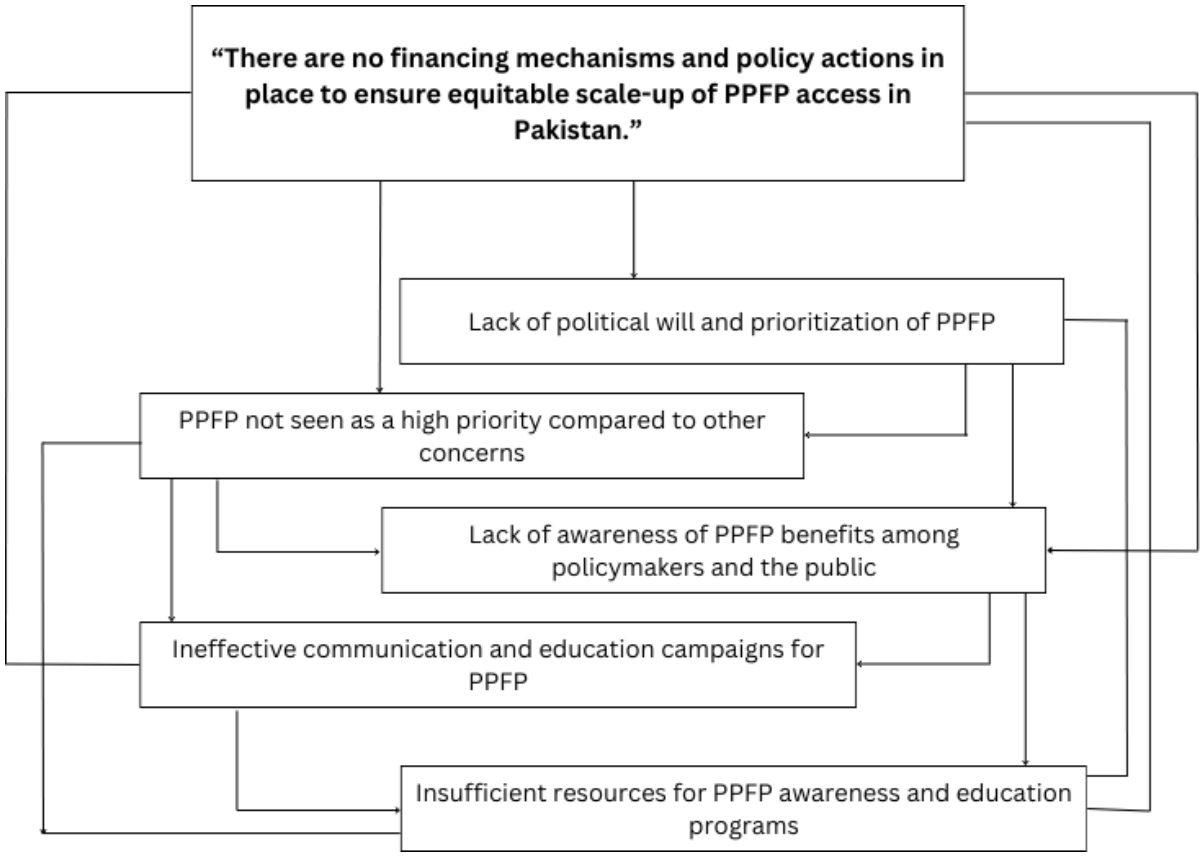
Answer 3: Because there is a lack of awareness and understanding of the benefits of PPFP among policymakers and the general public.

Question 4: **Why** is there a lack of awareness and understanding of the benefits of PPFP among policymakers and the general public?

Answer 4: There is a lack of effective communication and education campaigns to promote PPFP.

Question 5: **Why** is there a lack of effective communication and education campaigns to promote PPFP?

Answer 5: Insufficient resources are allocated for PPFP awareness and education programs.



Effect: *"There is a lack of strong accountability for postpartum and post-abortion family planning (PPFP and PAFP) across institutional structures and among policymakers and program managers."*

Question 1: **Why** is there a lack of strong accountability for postpartum and post-abortion FP across institutional structures and among policymakers and program managers?

Answer 1: Because there are no clearly defined accountability frameworks or performance metrics for PPFP and PAFP in place within institutional structures

Question 2: **Why** are there no clearly defined accountability frameworks or performance metrics?

Answer 2: Because PPFP and PAFP services are often integrated into broader maternal and child health programs, making it difficult to isolate specific accountability measures for family planning services

Question 3: **Why** is it difficult to isolate accountability measures for PPFP and PAFP within broader health programs?

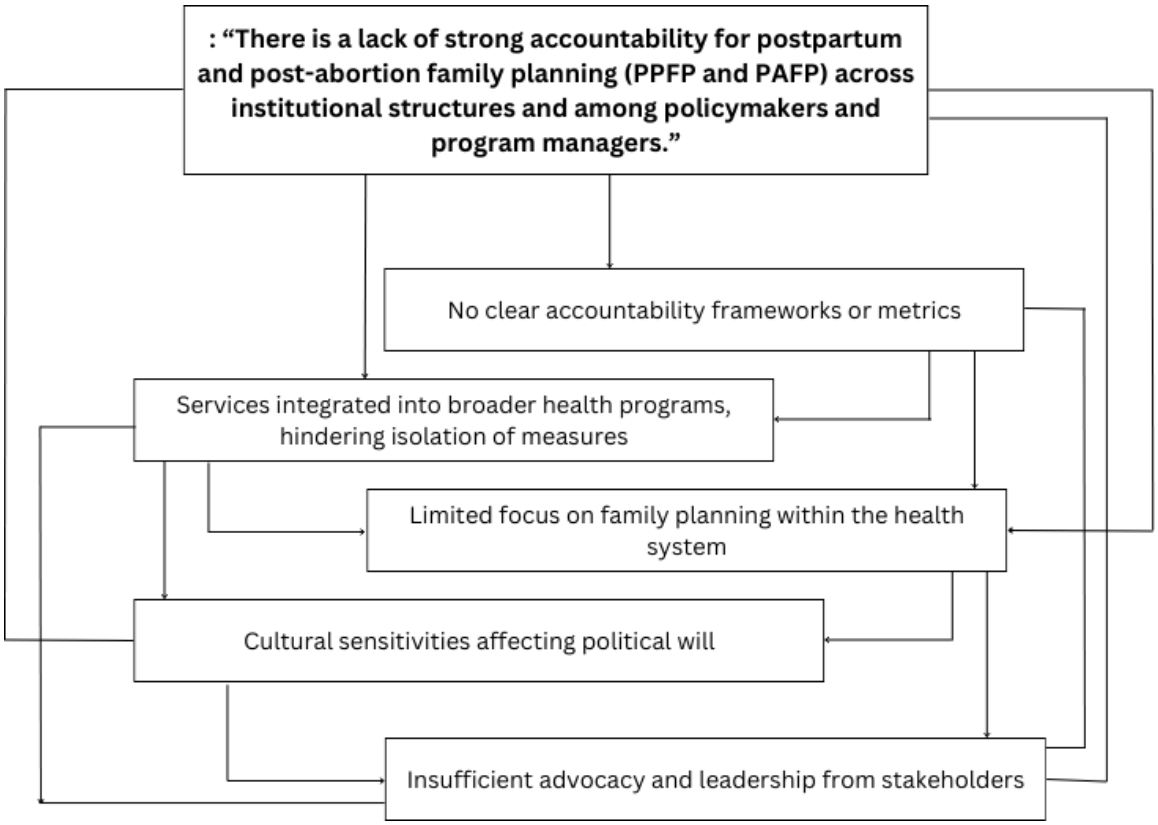
Answer 3: Because there is a lack of political and institutional focus on family planning, especially PPFP and PAFP, as priority areas within the health system.

Question 4: **Why** is there a lack of political and institutional focus on PPFP and PAFP?

Answer 4: Because there are cultural, religious, and societal sensitivities around family planning, especially post-abortion, which limit political will and institutional commitment.

Question 5: **Why** are cultural and societal sensitivities affecting political will and institutional commitment to PPFP and PAFP?

Answer 5: Because there is insufficient advocacy and public awareness about the importance of PPFP and PAFP, as well as a lack of leadership from key stakeholders such as the Ministry of Health, the Ministry of Population Welfare, and civil society organizations.



Effect: "There is no strong regulation to ensure access to postpartum and post abortion FP in Pakistan."

Question 1: **Why** is there no strong regulation to ensure access to postpartum and post-abortion FP in Pakistan?

Answer 1: There is a lack of clear policies and guidelines for PPFP services.

Question 2: **Why** is there a lack of clear policies and guidelines for PPFP services?

Answer 2: There is a lack of coordination and collaboration among different government agencies involved in PPFP.

Question 3: **Why** is there a lack of coordination and collaboration among different government agencies involved in PPFP?

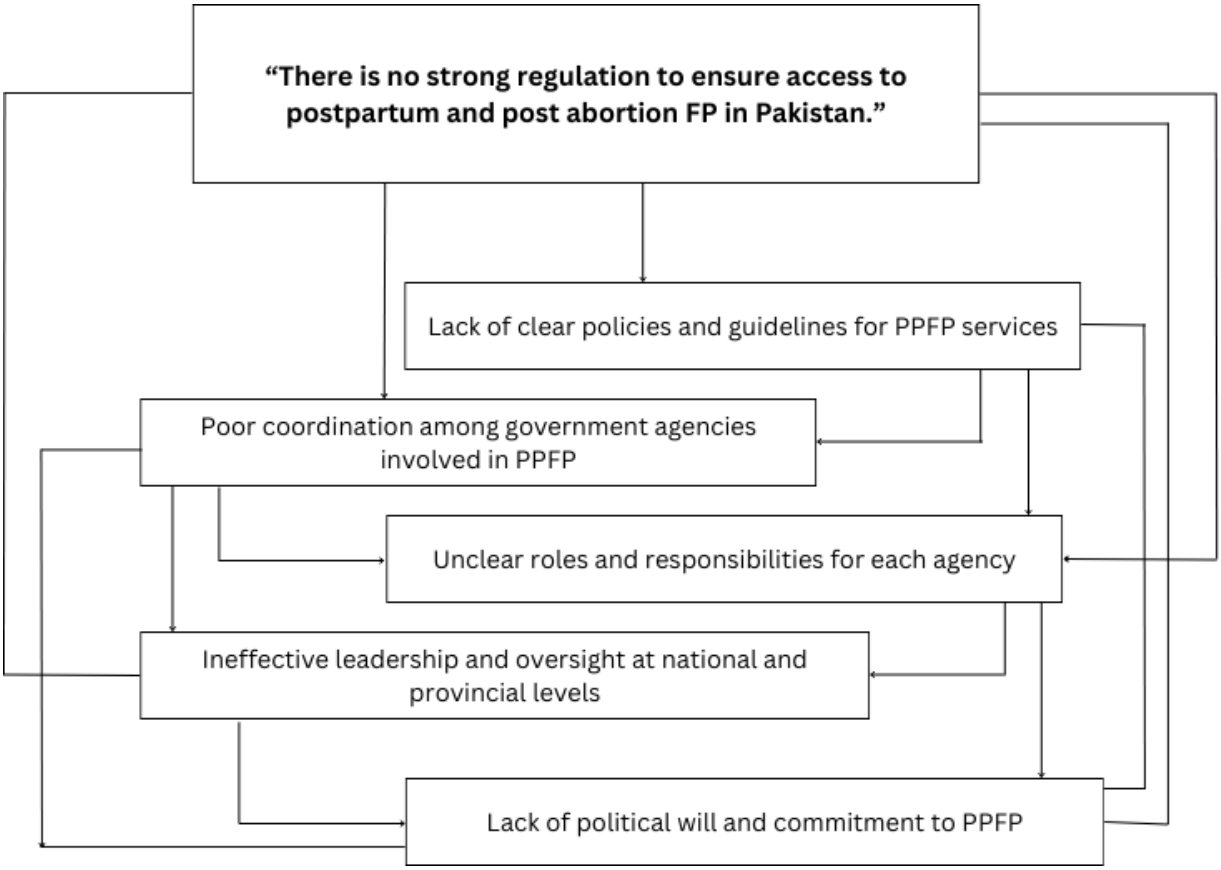
Answer 3: There is a lack of clear roles and responsibilities for each agency.

Question 4: **Why** is there a lack of clear roles and responsibilities for each agency?

Answer 4: There is a lack of effective leadership and oversight at the national and provincial levels.

Question 5: **Why** is there a lack of effective leadership and oversight at the national and provincial levels?

Answer 5: There is a lack of political will and commitment to PPFP.



Task Sharing and Shifting

Governance and Financing

Effect: "There is no coherent national plan for tasking sharing for FP scale up"

Question 1: **Why** is there no coherent national plan for task sharing for FP scale-up?

Answer 1: Because there is a lack of policy directives and strategic planning at the national level to incorporate task sharing into the family planning framework.

Question 2: **Why** is there a lack of policy directives and strategic planning for task sharing?

Answer 2: Because decision-makers have not fully recognized or embraced task sharing as a viable solution to address workforce shortages in family planning services.

Question 3: **Why** have decision-makers not fully recognized or embraced task sharing?

Answer 3: Because of limited awareness and understanding of the benefits of task sharing, combined with limited support from certain professional groups that fear loss of authority or dilution of their roles.

Question 4: Why is there limited awareness and support from professional groups?

Answer 4: Because there has been insufficient advocacy and capacity-building efforts to demonstrate the effectiveness of task sharing in other contexts, and to engage stakeholders (e.g., doctors, nurses, midwives) in the planning process.

Question 5: Why has there been insufficient advocacy and capacity-building for task sharing?

Answer 5: Because task sharing has not been prioritized as part of the broader health system strengthening agenda, and there is fragmented coordination between ministries, donors, and health organizations in promoting this approach.

SBCC

Governance and Financing

Effect: "There are no financing mechanisms and policy actions in place to ensure equitable scale-up of SBCC for FP in Pakistan."

Question 1: **Why** are there no financing mechanisms and policy actions for equitable SBCC scale-up?

Answer 1: Because family planning and social and behaviour change communication (SBCC) have not been fully integrated into national health and development priorities.

Question 2: **Why** have FP and SBCC not been fully integrated into national health and development priorities?

Answer 2: Because of fragmented governance, with limited coordination between health ministries, population departments, and other stakeholders responsible for policy and budgeting.

Question 3: **Why** is there fragmented governance and limited coordination?

Answer 3: Because there is a lack of clear leadership and accountability structures for driving comprehensive FP and SBCC strategies across government and non-government sectors.

Question 4: **Why** is there a lack of leadership and accountability?

Answer 4: Because SBCC for family planning is not consistently seen as a priority by political leaders, which affects institutional capacity and resources devoted to it.

Question 5: **Why** is SBCC for family planning not seen as a consistent priority by political leaders?

Answer 5: Because of competing national priorities, social resistance, and insufficient advocacy efforts to highlight the long-term benefits of family planning and SBCC interventions for sustainable development.

Effect: "There is a lack of strong accountability for SBCC for FP across institutional structures and among policymakers and program managers."

Question 1: **Why** is there a lack of strong accountability for SBCC for FP?

Answer 1: Weak monitoring and evaluation systems in place to track progress and identify accountability gaps.

Question 2: **Why** are monitoring and evaluation systems weak?

Answer 2: Insufficient resources allocated to monitoring and evaluation activities, leading to limited data collection and analysis.

Question 3: **Why** are resources for monitoring and evaluation limited?

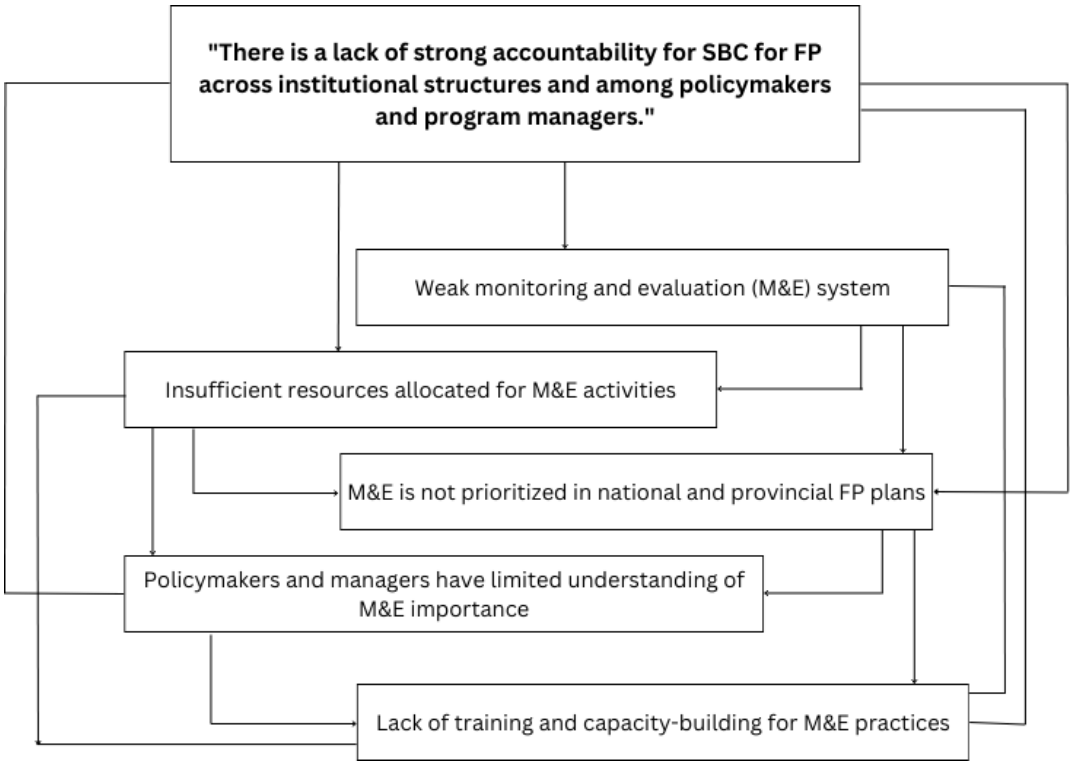
Answer: Lack of prioritization of monitoring and evaluation within the national and provincial FP priorities, resulting in inadequate funding allocation.

Question 4: **Why** is monitoring and evaluation not prioritized?

Answer 4: Limited understanding of the importance of monitoring and evaluation data for improving program effectiveness and accountability among policymakers and program managers.

Question 5: **Why** is there a limited understanding of the importance of monitoring and evaluation?

Answer 5: Lack of capacity development and training opportunities for policymakers and program managers on monitoring and evaluation methodologies and best practices.



Effect: "There is inadequate budget available at all levels for scale up of SBCC for FP"

Question 1: **Why** is there inadequate budget for scaling up SBCC for FP?

Answer 1: Because family planning and SBCC interventions are not prioritized in the national and provincial health budgets.

Question 2: **Why** are FP and SBCC interventions not prioritized in health budgets?

Answer 2: Because policymakers and budget planners perceive other health issues (e.g., maternal health, communicable diseases) as more urgent, leading to limited allocation of funds for FP and SBCC.

Question 3: **Why** are other health issues perceived as more urgent?

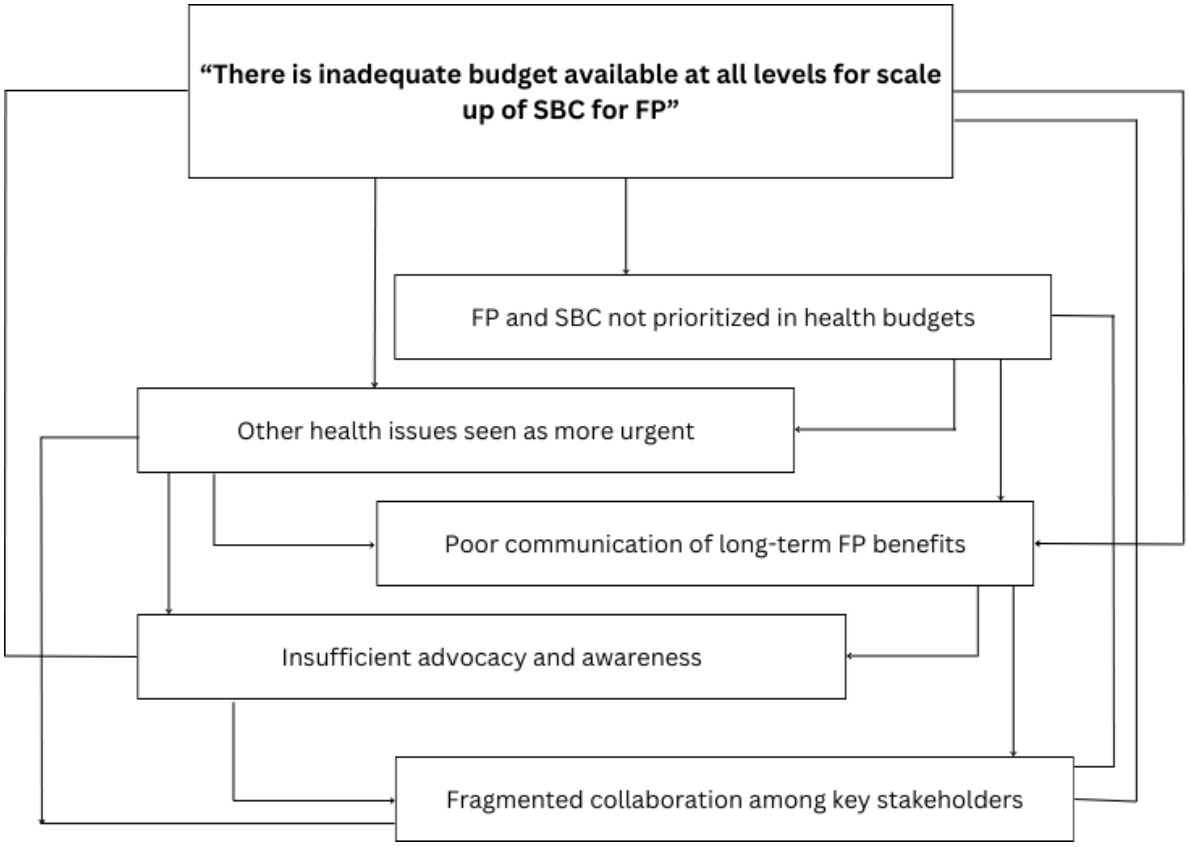
Answer 3: Because the long-term benefits of FP and SBCC interventions are not well-communicated, and there is insufficient advocacy to demonstrate the critical role they play in improving overall public health and development.

Question 4: **Why** is there insufficient advocacy for the importance of FP and SBCC?

Answer 4: Because stakeholders (civil society, NGOs, and government) lack coordinated efforts to effectively raise awareness and influence decision-makers about the need for sustained investment in SBCC for FP.

Question 5: **Why** is there a lack of coordinated advocacy efforts?

Answer 5: Because there are fragmented approaches and weak collaboration among various actors, including the health sector, population welfare departments, and non-governmental organizations, leading to ineffective advocacy for FP and SBCC funding.



Identified Bottlenecks

Identified Bottlenecks

The identified bottlenecks have been derived and consolidated from gaps in implementation, which were analyzed through the collected data; gaps in guidance, identified through a comprehensive policy analysis; a bottleneck questionnaire; and the findings from a stakeholder workshop, which brought together and synthesized all the insights.

Post Pregnancy Family Planning (including Post Partum and Post Abortion)

Lack of unified policy framework in provinces/federating areas

The Ministry of Health has long included family planning in its mandate, yet there remains a significant gap between policy formulation and actual service delivery. This disconnect has been exacerbated by the devolution of family planning responsibilities to the provinces following the 18th Constitutional Amendment. As a result, each province has developed its own strategies, often in isolation, leading to fragmented service delivery with unclear standards and ambiguous role definitions.

At the core of the issue is the absence of a single cohesive national post-pregnancy family planning (PPFP) policy being followed by the departments of health and population welfare in the provinces/regions. Without a unified framework, provinces lack consistent guidance, further contributing to inconsistencies in family planning services. This lack of coordination undermines the quality and scale of these services, limiting progress toward FP2030 commitments, creating silos in the health and population welfare departments. The smooth transition of the patient receiving services from the health department during pregnancy to the population welfare department after delivery is often lacking leading to poor continuity of care for a potential FP client which is a missed opportunity, hence the importance of postpregnancy family planning.

FP guidelines should also include how to ensure functional integration between the departments of health and population welfare to ensure that all women have a plan for family planning after each pregnancy, thereby improving maternal as well as newborn health and survival.

Existing draft policy frameworks have often failed to engage influential community members, particularly men, who play a critical role in decision-making regarding family size. The absence of strong political commitment and integration of family planning into broader health services further exacerbates this issue, leaving many women without necessary support to access contraceptive methods.

Lack of FP Commodities

Access to contraceptive methods is severely limited by frequent stock-outs and inadequate availability of supplies at health facilities. Many areas lack health clinics that provide family planning services, which restricts women's ability to obtain contraceptives when needed. This scarcity not only discourages usage but also perpetuates the cycle of unmet need for family planning, as women are unable to find reliable sources for contraception.

Pakistan's family planning commodities landscape varies significantly across its provinces, influenced by factors such as government policies, funding, and the effectiveness of supply chain management. Even though the availability of contraceptives has improved since 2009, however, certain provinces still experience stockouts, particularly Balochistan and Khyber Pakhtunkhwa (KPK). In contrast, Punjab and Sindh have managed to maintain lower stockout rates.

Punjab has seen a significant increase in contraceptive availability and has implemented a comprehensive policy framework to enhance service delivery. Sindh's health and population welfare departments are key consumers of family planning commodities. The province has also engaged in efforts to improve logistics and data visibility through the digital contraceptive logistics management information system (cLMIS), which has enhanced forecasting and inventory management.

Khyber Pakhtunkhwa (KPK) faces challenges similar to Balochistan regarding stockouts and availability of contraceptives. Efforts to improve access and reduce unmet needs are ongoing but face logistical hurdles. Balochistan struggles significantly with commodity availability, often reporting the highest stockout rates among the provinces. The region's remote areas complicate remote areas complicate supply chain logistics, impacting access to family planning services.

The Government of Pakistan, with support from international partners like USAID and UNFPA, has initiated various programs aimed at improving the supply chain for contraceptives. These efforts include establishing a web-based logistics management system to monitor inventory levels and facilitate better distribution practices across provinces.

Punjab leads in both total expenditure and per capita spending on family planning commodities, followed by Sindh and KPK. KPK has made notable progress in increasing its budget allocations recently, while Balochistan continues to lag behind.

The funding gaps for family planning across Pakistan's provinces are driven by a combination of lower overall spending, supply chain challenges, socioeconomic inequities,

and varying prioritization of family planning by provincial governments. Addressing these disparities will require targeted interventions tailored to the specific needs of each province.

Lack of Capacity

The lack of capacity in Pakistan's health system significantly exacerbates the challenges of scaling up PPFP services.

A critical issue is the lack of trained personnel capable of effectively counselling patients on contraceptive options. This deficiency leads to misinformation and a lack of confidence among users, which ultimately hampers the uptake of family planning methods. Cultural norms also play a significant role in limiting the effectiveness of family planning services in Pakistan. Many healthcare providers face societal pressures that discourage open discussions about contraception. As a result, patients may feel uncomfortable seeking advice or may not receive accurate information about available options. This cultural stigma can deter women from utilizing family planning services altogether.

The service side integration of family planning with maternal and child health (MCH) services is often inadequate in Pakistan. While various programs aim to provide comprehensive care, there are persistent gaps in coordination between departments responsible for maternal health and those focused on family planning. Efforts to integrate family planning into MCH services have shown promise; however, challenges remain at both inter-facility and intra-facility levels. Issues such as poor communication among departments, inadequate logistics management, and insufficient governing bodies hinder effective service delivery.

Healthcare provider biases

Healthcare provider bias is a significant bottleneck in scaling up post-pregnancy family planning (PPFP) in Pakistan.

Many healthcare providers hold personal beliefs that conflict with the promotion of family planning, particularly post-pregnancy methods. In conservative regions of Pakistan, providers tend to discourage women from using contraceptives due to cultural or religious norms, reinforcing misconceptions about birth control being harmful or inappropriate after childbirth. Healthcare providers, particularly at lower levels of the health system, have limited knowledge or misconceptions about the safety and effectiveness of modern contraceptives. This leads to reluctance in recommending post-pregnancy family planning methods, especially long-acting reversible contraceptives (LARCs), due to myths about side effects or complications.

In some cases, providers exhibit paternalistic attitudes, assuming that women should prioritize childbearing and family duties over their health and autonomy. This leads to

providers withholding information about family planning options or making decisions for patients based on what they believe is best, rather than supporting informed decision-making.

On the other hand, some providers also exhibit bias against young mothers, unmarried women, or women of lower socioeconomic status, assuming they are less suited or less deserving of family planning services. This bias further marginalizes vulnerable populations, reducing access to post-pregnancy contraception.

Provider bias often results in selective counselling, where some family planning methods are favored over others. For example, healthcare providers tend to be more inclined to recommend short-term methods, such as oral contraceptives, over long-term options like IUDs or implants, believing that the latter are not suitable for postpartum women. This limits women's access to a full range of contraceptive choices, undermining their reproductive autonomy.

Some providers prioritize immediate postpartum care, such as immunizations or maternal health checks, over family planning counselling. As a result, opportunities to introduce and promote PPFP are missed during key interactions with new mothers, reducing uptake and contributing to high unmet need for family planning.

Many healthcare providers are not adequately trained to deliver comprehensive PPFP services, leading to a lack of confidence in offering these methods. This gap is compounded by insufficient support and follow-up mechanisms for providers, making them less likely to initiate conversations about family planning or provide effective counselling.

These biases create significant barriers to scaling up PPFP in Pakistan, as they reduce access to information, limit contraceptive options, and undermine trust between providers and patients. Addressing provider bias through comprehensive VCAT training, culturally sensitive counselling, and stronger support systems is essential to overcoming this bottleneck and expanding the reach of PPFP services.

Quality of Care and Missed Opportunities in Institutional Deliveries

Institutional deliveries play a vital role in ensuring that mothers receive essential healthcare services, including antenatal care (ANC), skilled birth attendance, and postnatal care (PNC). Currently, institutional delivery rates in Pakistan are relatively high, with 66% reported in the Pakistan Demographic and Health Survey (PDHS) 2018 and 71% in the Pakistan Maternal Mortality Survey (PMMS) 2019. However, despite these encouraging figures, significant gaps remain in the quality of care provided at health facilities, leading to missed opportunities for PPFP interventions.

A key challenge is ensuring that women who deliver in health facilities receive comprehensive counselling and access to contraceptive options during their hospital stay. The lack of systematic integration of family planning services within maternal healthcare settings results in missed chances to provide women with the necessary information and resources to make informed decisions about their reproductive health. Addressing these service delivery gaps is critical to enhancing the impact of institutional deliveries on PPFP uptake.

While efforts should focus on improving the quality of care in existing facilities, it is also essential to further increase the proportion of institutional deliveries beyond the current levels to meet the Every Woman Every Newborn Everywhere (EWENE) target of over 90%. Expanding institutional delivery coverage, coupled with strengthened service delivery frameworks, can help reduce the unmet need for family planning, which currently stands at 17%, and prevent unintended pregnancies estimated at 4 million annually. Strengthening postpartum care services within facilities will contribute to improved maternal and child health outcomes and support the scaling up of PPFP initiatives.

Inadequate Knowledge of Existing Policies Among Frontline Healthcare Workers

When frontline workers, such as Lady Health Workers (LHWs), Lady Health Visitors (LHVs), nurses, and midwives, are unaware of or inadequately informed about PPFP policies, they fail to offer comprehensive and accurate family planning services. This leads to missed opportunities to counsel postpartum women on available contraceptive methods, contributing to unmet needs for family planning.

A lack of understanding of policies among frontline workers results in inconsistent or incorrect messaging about PPFP. Since these workers are unclear about the guidelines on contraceptive options, eligibility criteria, or the importance of postpartum family planning, they tend to give conflicting advice, which can confuse patients and discourage them from using contraceptives.

Inadequate knowledge of policies prevents frontline workers from recognizing and addressing the high unmet need for family planning, particularly during the postpartum period. As a result, they do not prioritize family planning counselling or offer methods that are appropriate for new mothers, such as long-acting reversible contraceptives (LARCs) or lactational amenorrhea method (LAM). Without clear knowledge of PPFP policies, they also do not integrate family planning into routine postpartum care effectively. Policies often emphasize the importance of integrating PPFP into maternal and child health services, such as immunization visits or postnatal care. When workers are unaware of these directives, family planning discussions are often overlooked during key health service interactions, limiting opportunities to offer contraception.

Policies often include provisions for ongoing training and capacity building. When frontline workers are unaware of these policies, they may miss out on training opportunities that could improve their knowledge and skills in delivering PPFP services. This knowledge gap can perpetuate poor counselling practices and reduce the quality of care offered to postpartum women.

Policies also outline referral mechanisms to higher-level facilities for women who require specialized family planning services. Without knowledge of these systems, frontline workers fail to refer postpartum women appropriately, limiting access to more advanced methods such as IUDs or implants, particularly in rural or underserved areas.

Task Sharing/Shifting

Unclear policy guidance for criteria and roles

Unclear policy guidance for criteria and roles is a significant bottleneck in scaling up FP task sharing and task shifting in Pakistan. It creates uncertainty at multiple levels of the health system, undermining the potential for effective FP task sharing/shifting and hindering broader access to essential FP services.

There are task sharing policies, but they lack operational and implementation clarity and have created uncertainty among health workers at various levels as they are unable to fully understand their specific roles and responsibilities in FP service delivery. This has led to further confusion about who is qualified to perform certain tasks (e.g., providing contraceptive counselling or administering specific contraceptive methods). As a result, essential FP services are underutilized or improperly delivered. This also leads to concerns about legal liabilities and regulatory compliance due to which health workers hesitate to take on new tasks if they are unsure whether they are authorized to do so, which slows down the implementation of task sharing.

Without well-defined roles and tasks, it also becomes difficult to monitor the performance of healthcare workers engaged in task sharing and shifting. This lack of accountability results in poor service delivery and missed opportunities to improve FP outcomes.

Limited support from higher cadres of healthcare providers

Limited support from higher cadres of healthcare providers, such as doctors and specialists, creates obstacles for scaling up FP task sharing and shifting by slowing down the acceptance and implementation of these models. Many higher-level providers view these reforms as a threat to their professional status and control over patient care. They resist delegating tasks, such as contraceptive counselling or IUD insertions, to lower-level providers like LHWs and LHVs, fearing a compromise in care quality and safety. Concerns about skill gaps and inadequate training further fuel this opposition, as senior providers doubt the ability of less-experienced workers to manage complex FP services effectively.

Additionally, there are financial disincentives, with higher cadres perceiving task sharing as a reduction in their involvement in profitable services. Professional norms and cultural expectations in Pakistan often reinforce the notion that specific medical tasks should remain the domain of doctors, making reforms that challenge these norms more difficult to implement. Lastly, the lack of involvement of higher-level providers in the policy-making process heightens their resistance, as they feel excluded from decisions that affect their practice.

Limited Continued Professional Development (CPD) Opportunities

For healthcare workers to effectively take on new roles in FP service delivery, especially through task sharing and shifting, they require continuous training to enhance their skills and knowledge. However, inadequate CPD programs hinder this process.

First, due to the absence of regular, updated training, lower-level healthcare providers like nurses, community midwives, and community health workers like LHWs and LHVs lack the skills necessary to safely perform advanced FP tasks, such as administering long-acting contraceptives or providing comprehensive counselling. This skill gap leads to reduced confidence among healthcare providers and potentially compromises the quality of services provided.

Additionally, the absence of structured CPD opportunities compromises the quality of care as health workers are ill informed about the latest FP guidelines, protocols, and innovations. CPD opportunities ensures that healthcare providers are well-equipped to address evolving FP challenges and deliver quality care. Moreover, the absence of continued development opportunities also reduces motivation and retention among healthcare workers. This ultimately stifles efforts to expand FP services, particularly in rural or underserved areas where skilled providers are already in short supply.

It also affects supervision and mentoring, which are crucial for supporting healthcare workers in newly expanded roles. Without ongoing professional development and mentorship, lower-level providers continue to struggle to navigate challenges and provide high-quality FP services, hindering the broader scaling-up efforts.

Existing Regulations on The Scope of Practice

Existing regulations or restrictions on the scope of practice in Pakistan often limit the roles that lower- and mid-level healthcare providers, such as nurses, midwives, and community health workers, can perform, especially in specialized areas like FP. By restricting who can administer contraceptives or provide counselling, these regulations prevent healthcare systems from efficiently distributing tasks to meet the growing demand for FP services.

For example, current regulations in Punjab require that only doctors can administer the first dose of injectable contraceptives, even though lower-level providers have the training and expertise to perform these tasks safely and effectively. This creates an unnecessary bottleneck, especially in rural and underserved areas where doctors are in short supply.

Moreover, restrictive regulations also discourage innovation in healthcare delivery by preventing the introduction of flexible, evidence-based models for task sharing and shifting. This rigidity reduces the capacity of the healthcare system to respond to workforce

shortages, limits access to FP services and leads to inefficiencies in service delivery. Additionally, regulatory barriers often slow down the process of updating laws to allow for broader scopes of practice, further hindering the scaling-up of FP services.

Divergent Policies Across Provinces

Since the 18th Constitutional Amendment in 2010, healthcare, including FP services, has been devolved to the provincial level, leading to varying policies and approaches across provinces. This lack of uniformity creates several challenges.

First, the absence of a standardized, national approach to task sharing and shifting means that healthcare workers in different provinces face inconsistent guidelines about what tasks they are allowed to perform. For example, LHWs in Sindh are permitted to administer the first dose of injectable contraceptives, while in Punjab, the cadre is not authorized to do so due to provincial regulations.

Second, divergent policies have complicated the creation of a cohesive training and capacity-building framework for healthcare workers across the country. Without a unified policy, provinces have adopted different training protocols, which has led to unequal skill levels and disparities in the quality of FP services offered. This lack of standardization has also hampered efforts to scale up successful models of task sharing from one province to another.

Social and Behaviour Change Communication (SBCC)

Unawareness of the National Population Narrative

Pakistan's national population narrative, known as Tawazun, is based on the idea of striking a balance between population and resources. It was introduced in 2017 to emphasize the urgency of addressing Pakistan's rapid population growth and the critical role of FP in improving health and socioeconomic outcomes. However, if key stakeholders, including policymakers, healthcare providers, community leaders, and the general public, remain unaware of this framework, several challenges arise.

It provides a unified vision and goals for addressing population growth through FP initiatives. Without awareness of this narrative, FP SBCC campaigns lack consistent messaging. This has led to fragmented communication efforts, where different regions and programs promote conflicting and incomplete messages, reducing the overall impact of FP initiatives.

The narrative highlights the importance of FP in improving maternal and child health, economic development, and gender equality. Since several advocacy groups, healthcare providers, and policymakers are unaware of these connections, they tend to fail to advocate effectively for FP, resulting in lower political will and reduced funding for FP programs. This weakens the momentum needed to scale up SBCC campaigns nationwide.

Parallel and Fragmented SBCC Efforts by Public and Private/NGO Sectors

Since the public sector and private/NGO organizations run separate FP SBCC campaigns without adequate coordination, they disseminate inconsistent and often contradictory messages. As a result, this confuses the target population about FP services, benefits, and methods, undermining the overall effectiveness of the campaigns. For instance, varying tones in communication have diluted the intended impact of SBCC efforts.

Parallel SBCC initiatives have also resulted in the duplication of efforts, where multiple organizations are focusing on the same geographical areas, demographics, or health facilities. This inefficient use of resources has led to over-saturation in some areas while leaving other regions underserved. Duplication also reduces the potential for optimizing resources, such as funding and personnel, that could be better allocated through coordinated efforts.

Public sector FP SBCC efforts are focused on broader population goals and policy objectives, while private and NGO initiatives tend to be driven by donor priorities, specific project goals, or niche target audiences. These conflicting priorities result in misaligned campaigns, further reducing the effectiveness of FP messaging and leading to fragmented service delivery.

Since public and private/NGO sectors do not collaborate, it becomes difficult to assess the overall effectiveness of FP SBCC campaigns, track progress, and identify gaps in coverage. This lack of data integration also prevents timely adjustments to communication strategies and contributes to inefficiencies in scaling up efforts.

Inadequate Data on SBCC Coverage and Outcomes

The absence of reliable, comprehensive data hampers effective decision-making and limits the ability to design and implement targeted SBCC interventions.

Without data on SBCC coverage and outcomes, it is challenging to measure the effectiveness of current FP SBCC campaigns. Policymakers and program managers lack insights into which messages are resonating with the target population, which communication channels are most effective, and whether there is any improvement in FP knowledge or acceptance. This hinders the ability to refine and adapt strategies to maximize their impact.

SBCC interventions are most effective when tailored to the specific attitudes, cultural norms, and needs of the target audience. Without detailed data on FP knowledge and acceptance trends, it is difficult to customize SBCC messages for different segments of the population, such as rural vs. urban communities, young vs. older individuals, or men vs. women.

Data on SBCC coverage and outcomes is essential for efficient resource allocation. Without this data, resources such as funding, manpower, and time is being directed toward areas that are already well-served or toward ineffective communication strategies. The trends also provide a way to track progress toward FP goals, including increased use of contraceptive methods and shifts in public attitudes toward FP. Inadequate data prevents program managers from monitoring progress over time, making it difficult to identify whether SBCC campaigns are producing the desired outcomes. This also complicates reporting to donors and stakeholders who expect measurable evidence of impact.

Cultural Limitations on Promoting Contraception in Mass Media

In Pakistan, discussions about contraception and reproductive health are often considered taboo, particularly in conservative communities. Cultural and religious sensitivities make it difficult to openly promote FP methods in mass media without facing backlash. As a result, mass media campaigns are toned down or avoid directly addressing key FP messages, which dilutes the impact of SBCC efforts. Without clear and direct messaging, the population remains uninformed or misinformed about contraceptive options.

Religious and cultural leaders, who have significant influence over public opinion in Pakistan, oppose mass media campaigns that promote contraception. This lack of cooperation results in censorship, limited airtime, and the need to frame FP messages in a way that avoids conflict with cultural and religious values. This compromises the ability to scale up SBCC efforts and reduces the potential reach of FP messaging through widely consumed platforms like television and radio.

Youth, especially adolescents, are a critical demographic for FP messaging, but cultural norms often discourage discussions of contraception and sexual health for this group. Mass media campaigns are often restricted from targeting young people with FP information due to concerns about promoting "immoral behaviour." This leaves young people uninformed about FP, contributing to high rates of unintended pregnancies and unmet contraceptive needs.

Proposed Strategies

Proposed Strategies

Developing a Comprehensive National Family Planning Strategy

Developing a comprehensive national FP strategy would provide a unified framework to address the barriers hindering the scaling up and sustainability of gender-responsive Post Pregnancy Family Planning (PPFP) and the implementation of Task Sharing/Shifting and Social and Behaviour Change Communication (SBCC) strategies. Since provinces in Pakistan are responsible for creating their own policies after the 18th Amendment, a national strategy will serve as a guiding blueprint to ensure alignment across provincial policies while addressing region-specific challenges. This strategy would help streamline efforts, avoid duplication, and ensure coherence in FP service delivery, while allowing provinces the flexibility to adapt it to their unique contexts.

An essential aspect of overcoming challenges in FP service delivery is addressing the long-standing dichotomy between the health and population welfare sectors. Achieving true functional integration between these sectors is a prerequisite for driving meaningful change in FP indicators. A well-integrated approach will enhance service delivery efficiency, optimize resource utilization, and ensure a holistic response to the population's reproductive health needs.

The parties responsible would include;

- Federal Ministry of National Health Services, Regulations, and Coordination (MoNHSRC) will lead the development of the national strategy in consultation with stakeholders.
- Provincial Health Departments will adapt the national strategy to provincial needs while ensuring alignment with its core principles.
- Professional Bodies and Regulatory Councils such as the Pakistan Nursing Council (PNC) and Pakistan Medical and Dental Council (PMDC) will ensure the guidelines are aligned with professional standards and ensure adherence, while the Technical Working Groups (TWGs) including representatives from federal and provincial governments, private sector, and civil society, these groups will help harmonize policies.

Equitable Allocation of Resources and Timely Releases

One of the critical steps to scaling up and sustaining gender-responsive FP is ensuring the equitable allocation of resources for all provinces. This involves distributing financial, human, and logistical resources in a way that ensures underserved populations—such as rural women, adolescents, and marginalized communities—have equal access to FP

services. The current urban-rural divide in healthcare delivery, where rural areas often lack the same level of infrastructure and healthcare personnel, needs to be addressed.

The delays in fund releases also stall the roll-out of FP programs and can limit the availability of resources needed to maintain momentum in scaling up these initiatives. Therefore, the increased and timely allocations and releases of funds are essential to implementing and sustaining effective PPFP, PAFP, task-sharing/shifting, and SBCC strategies.

The strategies would include;

- Identifying areas with high unmet FP needs, particularly in rural, underserved regions, and allocating resources accordingly. This would include providing additional healthcare workers, increasing the availability of contraceptives, and enhancing outreach services.
- Ensuring that national and provincial budgets are designed with a gender perspective, making sure that resources are directed toward programs that address the specific FP needs of women, especially postpartum and post-abortion services.
- Investing in the training and capacity building of healthcare providers, particularly in rural settings, so that they are able to implement PPFP and PAFP services effectively, and are equipped to take on task-sharing or task-shifting roles.
- Simplifying bureaucratic processes that delay the disbursement of funds, particularly at the provincial and district levels and establishing mechanisms to fast-track releases so that programs can respond more effectively to emerging needs or service gaps.
- Working with international donors to align their funding timelines with local budgeting cycles, ensuring that donor resources are available when needed and do not overlap or disrupt ongoing national FP efforts.
- Engaging the private sector, including NGOs, in the equitable distribution of FP resources, ensuring they supplement public sector efforts in regions where government services are limited.

The responsible parties would be;

- The Ministries of Health and Population Welfare at both the federal and provincial levels will play a key role in overseeing the equitable distribution of resources, particularly in rural and underserved areas.
- District-level health personnel will be responsible for ensuring that resources are distributed effectively at the local level, reaching the facilities that need them most.

- Private healthcare providers and NGOs will be involved in supplementing public sector efforts by providing services in hard-to-reach areas and ensuring resource availability.
- International donors like USAID, UNFPA, and other partners will provide technical and financial support to ensure equitable allocation through capacity building, supplies, and infrastructure development.
- FP programs, particularly through joint funding or programmatic agreements.

Strengthening Commodity Security

Adequate and reliable access to contraceptives is a foundation for successful FP programs, and stockouts can undermine the effectiveness of FP service delivery efforts.

The proposed strategies include:

- A streamlined supply chain management system would be developed to ensure a continuous and reliable flow of FP commodities. This would include demand forecasting, procurement, distribution, and tracking of stock levels.
- Implementing decentralized approaches to commodity distribution at the provincial and district levels will help address local stockouts and delays, ensuring availability at health facilities.
- FP commodities will be integrated into the supply chain systems of other healthcare programs (e.g., maternal and child health) to streamline logistics and improve availability.
- Establishing emergency stockpiling and maintaining buffer stocks at various levels (national, provincial, district) to prevent disruptions in the supply of FP commodities.

The responsible parties would be;

- MoNHSRC in coordination with Provincial Health Departments would oversee the national and provincial supply chain systems, ensuring timely procurement and distribution of FP commodities
- Both PWD and DoH will collaborate on logistics and ensure that both departments have aligned procurement and distribution strategies.
- Development Partners and Donors (WHO, UNFPA, USAID) will provide technical assistance and financial support for supply chain management improvements and ensure alignment with international best practices.
- District Health Offices (DHOs) will monitor stock levels and manage the distribution of FP commodities at the local level.

Development of Accountability Mechanisms

The development of accountability mechanisms is crucial for ensuring that PPFP, PAFP, and SBCC strategies are effectively implemented, and that task-sharing and shifting models are adhered to without compromising service quality. Accountability systems can monitor the allocation and use of resources, ensure adherence to FP policies, and track the performance of FP service providers.

The strategies for accountability mechanism of FP services would include;

- Establishing a transparent system for reporting on the allocation and use of FP resources at national, provincial, and district levels. This would involve regular audits, public reporting, and dashboards that track financial disbursements and service delivery outputs.
- Developing key performance indicators (KPIs) to measure the effectiveness of PPFP and PAFP services, including provider performance in task-sharing or shifting roles. Regularly monitoring and evaluating healthcare workers' adherence to gender-sensitive FP service delivery protocols and ensure SBCC strategies are reaching intended audiences.
- Engaging communities, including women's groups, in monitoring FP service delivery. Community-based accountability mechanisms would include complaint redressal systems and feedback loops where users of FP services can voice concerns or provide input on the quality of care they receive.
- Strengthening enforcement of existing FP policies and regulations, ensuring that healthcare providers, both public and private, adhere to the standards set for gender-responsive services and task-sharing/shifting protocols.
- Using independent third-party organizations, such as civil society groups or external auditors, to conduct periodic reviews of FP service delivery, particularly for government-run programs. These reviews can ensure objectivity and foster public trust in the accountability mechanisms.

The responsible parties would be;

- National and provincial health regulatory bodies will develop and enforce guidelines for the provision of PPFP and PAFP services, task-sharing, and SBCC strategies.
- Ministry of Health and Population Welfare will be responsible for creating and maintaining transparent reporting systems, performance monitoring, and financial accountability for FP services.
- Independent third-party auditors and CSOs will be tasked with conducting regular reviews of FP service delivery, ensuring transparency, and evaluating the quality of

care. Their oversight will also ensure that government agencies are accountable for resource allocation and service delivery.

- At the local level, community health committees will be engaged to monitor service delivery and provide feedback on the quality of FP services, with a focus on gender-sensitive approaches.
- Healthcare Providers at all levels (public, private, and NGO) will be held accountable for adherence to FP policies and service protocols. Monitoring systems will track their performance in implementing PPFP, PAFP, and task-sharing/shifting strategies.

Capacity Building

Capacity building is essential for scaling up gender-responsive PPFP and PAFP services, task-sharing/shifting, and SBCC strategies in Pakistan's family planning landscape. A capacity-building strategy will equip healthcare providers at all levels with the skills and knowledge to deliver comprehensive FP services, address gender-sensitive issues, and implement innovative FP approaches, such as task-sharing/shifting.

Updating training curricula for healthcare workers, including doctors, nurses, midwives, and LHWs, is also crucial for ensuring that FP education reflects the latest evidence-based practices, gender-responsive approaches, and task-sharing/shifting models. Since in-service training is cost intensive, the focus would be on pre-service curricula of the health workers. However, capacity building needs to be ensured through continued professional development programmes.

The proposed strategies include;

- A nationwide standardized training program with provincial components to strengthen the capacity of healthcare providers, especially in rural and underserved areas. The plan would include training on modern contraceptive methods, respectful care, and addressing cultural and gender-sensitive issues.
- Training would target mid-level providers, such as nurses, midwives, Lady Health Visitors (LHVs) and Family Welfare Workers (FWW), enabling them to take on additional FP roles under task-sharing/shifting models. The focus will be on improving clinical skills, quality of care, and ethical considerations for FP service delivery.
- Curricula at medical and nursing schools to be updated to include comprehensive modules on PPFP, PAFP, and gender-sensitive approaches to FP. This will enable future healthcare providers to offer FP services that respect the needs and rights of women and couples.

- New curricula to include content on task-sharing/shifting models, where mid-level providers like nurses and LHWs are trained to take on expanded roles in FP service delivery.
- SBCC strategies to be incorporated into the curricula for healthcare providers at all levels, equipping them with skills to effectively communicate with communities, address misconceptions, and promote positive FP behaviours.
- Ensuring that updates to curricula are aligned with CPD programs, requiring healthcare professionals to regularly update their knowledge and skills in FP and gender-responsive care.
- Another training component would be strengthening management and leadership skills at the district and provincial levels to ensure effective oversight and implementation of FP programs.

The responsible parties would be;

- Ministry of National Health Services, Regulations, and Coordination (MoNHSRC) will lead the development and rollout of national capacity-building programs.
- Provincial Health Departments will ensure implementation and roll out at the provincial and district levels, ensuring alignment with national standards.
- Healthcare Professional Bodies (PMDC, PNC) will ensure training curricula for doctors, nurses, midwives and community workers (LHVs, LHSs and LHWs) incorporate task-sharing/shifting and gender-responsive FP services.
- Medical and Nursing Schools/Universities for updating the curricula in line with national FP guidelines and best practices for PPFP, and task-sharing/shifting.
- Development Partners and Donors (WHO, USAID, UNFPA and others will provide financial and technical support for the design and implementation of capacity-building initiatives.

Streamlined Communication Messages

Streamlining communication messages for family planning (FP), particularly in the context of gender-responsive Postpartum Family Planning (PPFP), Post-Abortion Family Planning (PAFP), and Social and Behaviour Change Communication (SBCC), is vital for ensuring consistency, clarity, and cultural appropriateness. Given the diverse socio-cultural dynamics in Pakistan, it is essential to deliver targeted, uniform messages that resonate with various audiences and are sensitive to local contexts. This strategy ensures that FP messages are clear, effective, and widely accepted, helping to reduce misconceptions and promote positive FP behaviours.

The proposed strategies include;

- Development of a national FP communication framework that outlines key messages for PPFP, PAFP, and SBCC strategies. These messages would be gender-sensitive, evidence-based, and adaptable to provincial and local contexts.
- Communication campaigns to be tailored to address cultural and gender norms, focusing on the benefits of PPFP for maternal and child health while challenging misconceptions about contraception. Special attention to be paid to engaging men and communities in family planning.
- Public health institutions, NGOs, and private healthcare providers would align their communication strategies to avoid conflicting messages and ensure that all communication efforts support the same core FP goals.
- FP messages would be disseminated through a variety of platforms, including mass media (television, radio), digital platforms (social media, SMS), community-based outreach, and interpersonal communication through healthcare providers. This multi-channel approach ensures broader reach and engagement.
- Training programs for healthcare workers and FP outreach staff will include components on delivering streamlined FP communication messages, ensuring that they can effectively communicate and counsel on PPFP and PAFP services.

The responsible parties include;

- Ministry of National Health Services, Regulations, and Coordination (MoNHSRC) will develop and oversee the national communication framework for FP messaging.
- Provincial DoH and PWD to customize and implement the communication framework in line with local socio-cultural norms.
- The development Partners (UNFPA, USAID) will provide technical support in developing communication strategies and campaigns.
- NGOs and Private Sector to collaborate with government efforts and ensure that private sector communication aligns with public sector messaging.

Reporting Systems with Required Disaggregation and Data Sharing Mechanism

A robust and well-designed reporting system is essential for tracking progress in FP initiatives, and for effective implementation of task-sharing/shifting models. A reporting system that includes necessary disaggregated data (e.g., by age, gender, geographical area) enables decision-makers to monitor service uptake, identify gaps, and target resources more effectively. Additionally, an efficient data-sharing mechanism across sectors and levels of government enhances coordination and responsiveness.

The proposed strategic plan includes;

- A standardized, nationwide reporting system would be developed for FP services that include data on PPFP, PAFP, and task-sharing/shifting. The system should capture disaggregated data on key demographics (age, gender, socio-economic status) to identify trends and service gaps.
- The FP reporting system would be integrated with existing health information systems (such as the DHIS-2) to ensure coherence and streamline data collection processes.
- Data would be collected and reported in a disaggregated manner to allow for gender, age, and geographical analysis. This will help identify areas with low FP uptake and those needing targeted interventions, particularly for vulnerable and underserved populations.
- A formal data-sharing mechanism will be established between the MoNHSRC, provincial health departments, Population Welfare Departments (PWDs), and other key stakeholders. This will facilitate real-time monitoring and evaluation of FP programs and allow for timely course corrections.
- Leveraging digital tools and mobile-based reporting systems will ensure real-time data entry and reporting, improving the accuracy and timeliness of FP service data.
- Training healthcare providers and program managers in data collection, reporting, and analysis is crucial for ensuring the quality and reliability of the data being reported.

The responsible parties include;

- MoNHSRC to develop the national reporting framework, ensuring alignment with national health information systems.
- Provincial Health Departments and PWDs to implement the reporting system at provincial and district levels, ensuring that data is collected and reported as per the national standards.
- District Health Offices (DHOs) to ensure accurate data collection and reporting at the district level, and collaborate with provincial and national authorities on data sharing.
- Development Partners (UNFPA, WHO) for providing technical assistance for designing and implementing the reporting system, as well as capacity building in data management.
- Healthcare Providers and Field Workers for ensuring accurate and timely data collection, reporting disaggregated data, and contributing to FP service evaluation.

Consolidated Findings		
Thematic Area	**Bottleneck**	**Proposed Solution**
Governance and Financing	Equity	Equitable allocation of resources
	Budget	Increased and timely allocation of resources
	Accountability	Develop accountability mechanism for all FP service delivery
People and Information	Coordination	Strengthen coordination between different stakeholders ensure effective scale-up of task-sharing for FP
	Community Engagement	Ensure community engagement and participation particularly young boys, men, and community leaders to support scale up
	Reporting Mechanism	Implement reporting standards, key performance indicators and data sharing across all FP themes
Med/tech, Service Delivery and HR	Capacity	Ensure supportive supervision of mid-level and community health providers
	Supplies	Strengthen commodity security across all provinces
	Training and education	Update curricula and develop CPD pathways for all providers
	Referral System	Develop referral mechanisms and strengthen linkages

Table 4 – Consolidated Findings

Lessons Learned

Lessons Learned

At the midpoint of data collection, we have encountered and proactively addressed a number of challenges. This has led to the valuable development of a set of lessons learned that will inform the remainder of the project.

Questionnaire Design and Communication

The complexity and information density of the questionnaire led to difficulties in comprehension. Complex concepts hindered participants' ability to comprehend and respond, potentially affecting the accuracy and reliability of their responses.

Iterative improvements in questionnaire design were necessary. Our team learned the importance of using clear and straightforward language to elaborate on questions, ensuring that respondents can easily understand and provide accurate responses.

Piloting and Pre-testing Importance

Unforeseen challenges arose during the mid-way data collection phase. Our team recognized the importance of thorough piloting and pre-testing. This realization highlighted the need for rigorous approach to questionnaire refinement, ensuring that issues were identified and addressed before the actual data collection process began.

Mitigating Response Fatigue

The length of the questionnaire contributed to respondent fatigue, which could have resulted in incomplete or rushed responses, affecting the overall quality of data. Recognizing the impact of respondent fatigue, our team prioritized key questions, streamlining the questionnaire. This approach aimed to reduce the overall time required for participation, fostering sustained respondent engagement and improving the overall quality of responses.

Stakeholder Engagement and Time Constraints

Policy-level stakeholders were hesitant to participate due to the perceived time-consuming nature of the questionnaire, potentially impacting the study's support and cooperation from these key players. Challenges in gaining compliance from policy-level stakeholders highlights the need for advocating the importance of research. To address stakeholder concerns, our team focused on providing a clear outline of the time commitment required. Emphasizing the study's importance and potential impact helped garner support.

Stakeholder Collaboration for Streamlined Processes

Gaining compliance from policy-level stakeholders required strategic collaboration. Collaborative efforts involving open communication, highlighting mutual benefits, and addressing concerns were pivotal and emphasized the importance of stakeholder engagement in streamlining processes and ensuring ongoing support.

Adapting to Respondent Preferences

Respondents varied in their preferred modes of data collection. Recognizing this diversity, our team adopted a flexible approach by offering online, phone, and in-person data collection modes. This not only accommodated respondent preferences but also increased participation rates, ensuring a more representative and inclusive dataset.

Technology Integration

Respondent preferences for different data collection modes required technological flexibility.

Integrating technology into data collection processes, including online surveys and phone interviews, provided a solution to varied respondent preferences. This approach not only improved compliance but also proved to be time and resource efficient.

Continuous Training and Support for Data Collectors

Ongoing challenges faced by data collectors indicated a need for continuous training and support to address issues in real-time, improving their understanding of the questionnaire. Our team provided regular training sessions with field data collectors to include discussions on common challenges, clarification of complex questions, and strategies for handling difficult situations. Providing feedback for data collectors to share their experiences and seek guidance for all studies contributes to improved data collection.

Conclusion

The BNA highlights the urgent need for systemic realignment to address critical bottlenecks in Pakistan's family planning ecosystem. While the high awareness (98.1%) of modern contraceptive methods offers a foundation for progress, the persistently low CPR (25%) and high unmet need (17.3%) reflect an implementation crisis more than an informational one. This analysis confirms that fragmented service delivery, weak policy coherence, underutilized human resources, and culturally entrenched biases collectively inhibit the uptake and continuity of contraceptive use.

Rather than relying solely on new programs, the conclusion emphasizes optimizing existing platforms—like immunization visits and CHW outreach—for integrated PPFP/PAFP counselling and method provision. Furthermore, real-time data feedback loops, stronger decentralization mechanisms, and provincial harmonization of task-sharing policies are vital to bridging policy-practice gaps.

The report closes with a call for renewed political commitment and investment in FP2030-aligned strategies that empower frontline providers, involve communities, and systemically address the constraints mapped through this analysis.

The following table synthesizes the evidence-based recommendations and bottleneck analysis findings from Pakistan's family planning landscape, emphasizing gender responsiveness, integration, and sustainability across PPFP, PAFP, task sharing/shifting, and SBCC strategies

Strategy Area	Short-Term Strategies (0-1 year)	Medium-Term Strategies (1-3 years)	Long-Term Strategies (3+ years)
Post Pregnancy Family Planning (PPFP)	• Institutionalize FP counselling and method provision during antenatal care (ANC), delivery, postnatal care, immunization, and post-abortion care through formal directives by MoNHSRC and provincial health departments • Improve contraceptive supply chain management to reduce stock-outs, especially in underserved provinces • Train frontline health workers in gender-responsive counselling and PPFP/PAFP service delivery.	• Scale up integration of FP services with maternal and newborn health services across all provinces. • Strengthen data collection and monitoring systems (e.g., DHIS2 modules) to track PPFP/PAFP uptake and quality. • Expand public-private partnerships to increase access points for contraceptive services.	• Sustain universal access to integrated PPFP/PAFP services with equitable coverage, especially in rural and high-need areas • Institutionalize continuous professional development (CPD) programs focused on respectful, gender-sensitive FP care • Maintain robust supply chains with buffer stocks and decentralized distribution integrated into maternal health logistics systems
Task Sharing / Task Shifting	• Finalize and officially notify provincial task sharing implementation plans with clearly defined roles and scope of practice for mid-level and community health	• Scale up task sharing models across provinces with accreditation and supportive supervision systems for mid-level providers	• Institutionalize task sharing/shifting as a standard practice within the health system, ensuring sustainable

Strategy Area	Short-Term Strategies (0-1 year)	Medium-Term Strategies (1-3 years)	Long-Term Strategies (3+ years)
	providers (CHWs, LHWs, LHVs) • Conduct sensitization and values clarification (VCAT) sessions to reduce resistance from higher cadres and clarify quality assurance mechanisms • Update training curricula to include task sharing competencies and gender responsiveness.\	• Strengthen health workforce capacity through modular, ongoing CPD programs emphasizing competency-based FP service delivery • Integrate task sharing roles into national HRH policies and workforce planning	financing and policy support • Foster professional acceptance and inter-cadre collaboration through continuous education and quality assurance frameworks • Expand task sharing to include digital tools for supervision and performance monitoring
Social and Behaviour Change Communication (SBCC)	• Develop and disseminate a national SBCC toolkit with context-specific, gender-sensitive key messages validated by provincial stakeholders • Launch targeted SBCC campaigns engaging male partners, youth, and community influencers to	• Develop a comprehensive national SBCC framework with culturally adapted, gender-equitable messaging across multiple communication channels • Strengthen community mobilization and stakeholder engagement to address social taboos	• Sustain community-driven SBCC initiatives that normalize FP use and gender equity in reproductive health decisions • Institutionalize SBCC within health system planning and budgeting to ensure ongoing support and innovation

Strategy Area	Short-Term Strategies (0-1 year)	Medium-Term Strategies (1-3 years)	Long-Term Strategies (3+ years)
	promote shared responsibility in FP decisions • Establish provincial and national coordination platforms involving health, education, local government, and civil society for synergized SBCC efforts.	and misinformation around contraception • Monitor and evaluate SBCC interventions to refine messaging and approaches based on community feedback and impact data	• Leverage digital and social media platforms for continuous engagement and behaviour reinforcement at scale
Cross-Cutting System Strengthening	• Lead creation of a unified national FP framework aligned with FP2030 commitments, clarifying roles between Ministry of Health and Ministry of Population Welfare • Direct resources strategically to underserved and high-unmet-need populations with streamlined fund disbursement • Strengthen digital health infrastructure for disaggregated FP data	• Replicate successful integration of health and population welfare models across the country to eliminate duplication and improve service coverage • Enhance procurement and supply chain systems with buffer stocks and decentralized distribution protocols integrated with maternal and child health logistics • Establish transparent performance monitoring	• Achieve a fully integrated, equitable FP service delivery system with sustained political commitment and multi-sectoral coordination • Maintain long-term financing mechanisms including international co-financing aligned with national priorities • Foster a culture of continuous learning and adaptation through documentation of implementation

Strategy Area	Short-Term Strategies (0-1 year)	Medium-Term Strategies (1-3 years)	Long-Term Strategies (3+ years)
	collection and timely decision-making	systems with community feedback loops and policy adherence audits	experiences and institutional knowledge sharing

Annexures

Annexures

Annexure 1: Methodology

The report on the Bottleneck Analysis carried out in Pakistan based on WHO BNA protocol aimed to identify and address barriers that hinder the scaling up and sustainability of evidence-based family planning practices. The BNA Protocol which was grounded in WHO's building blocks for health system strengthening: (1) service delivery, (2) health workforce, (3) health information systems, (4) access to essential medicines, (5) financing, (6) leadership/governance (stewardship), and (7) people. The protocol built upon existing systematic reviews to identify bottlenecks that hindered the scale-up of EBPs.

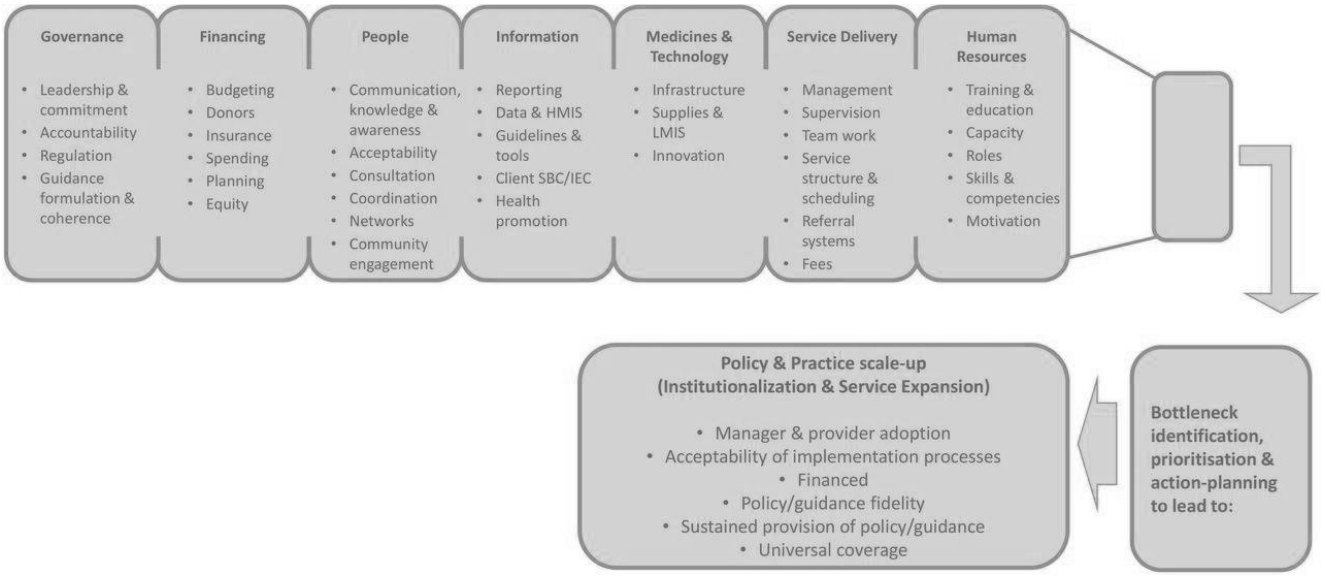


Figure 1- BNA Framework

The generic BNA protocol included a core assessment guide outlining methodological steps and was complemented by three specialized modules, each focused on a specific thematic area: post-pregnancy family planning (FP), task sharing, and social and behaviour change (SBCC). Each module contained tailored tools for assessment.

The BNA followed a structured three-step process:

1. Preparation,
2. Data Collection, and
3. Consensus Workshop.

This structured approach ensured a systematic analysis aligned with WHO's health system building blocks, using data triangulated from desk reviews, case studies, and key informant interviews (KIIs).

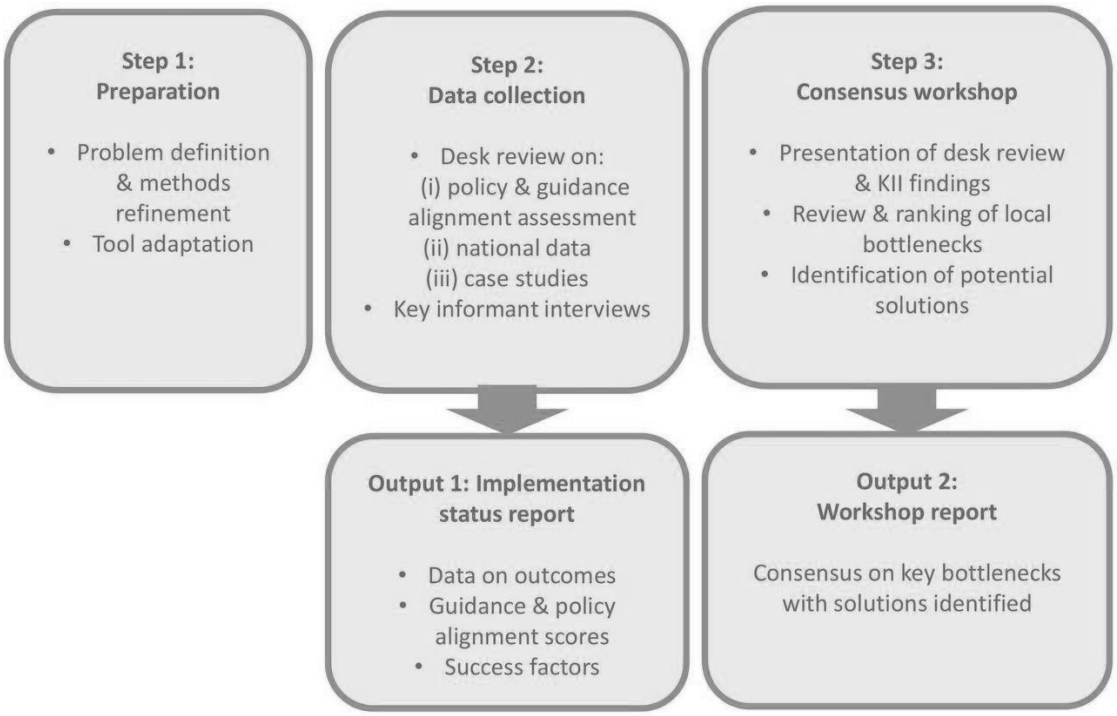


Figure 2 - BNA Structured Process

The preparation phase was facilitated by the WHO Headquarters and Country Office. During the data collection phase, two key methods were used: desk reviews and KIIs.

The desk review involved examining national and provincial-level family planning data, focusing on both outcome indicators and service delivery processes. It also included policy and guideline documents and selected case studies on the implementation or scale-up of EBPs related to each module (post-pregnancy FP, task sharing, and SBCC). One to two case studies per module were reviewed to understand existing efforts and extract relevant learnings.

Key Informant Interviews were conducted with a purposive sample of 10–20 stakeholders for each thematic area. These included policymakers and program managers from the Ministry of Health and implementing NGOs at national, provincial, and where needed, district levels. Additional respondents included health facility supervisors, professional association representatives involved in policy formulation or clinical guidance, and civil society stakeholders. The KIIs aimed to capture their views on critical bottlenecks affecting the scale-up of EBPs.

A structured Likert scale questionnaire was used to assess participant agreement with statements related to each health system factor. Interviewers also employed and used probing questions to explore each domain in depth. The results were entered into a data summarization sheet to facilitate visualization and interpretation using mean scores per bottleneck. These scores could also be categorized and displayed using bar charts,

disaggregated by respondent type (policy/programme, clinician, civil society), to highlight differences in perspectives.

Following the data analysis, a national consensus workshop was convened. The objective of this workshop was to discuss the findings from the data collection phase, validate the identified bottlenecks, and reach a collective agreement on priority challenges and actionable solutions. A modified Delphi technique and root cause analysis (including the "five whys" approach) were employed to guide discussions and formulate strategies to address the systemic barriers impeding the scale-up of family planning EBPs in the country.

Figure 3 - BNA Process Illustrated

Annexure 2:

Gaps in Guidance:

Data Source	Year of Publication	Overview
Pakistan Demographic and Health Survey (PDHS)	2017-18	It is a nationally representative household survey that provides data on a wide range of population, health, and nutrition indicators. It is conducted periodically to monitor progress and inform policy decisions.
Multiple Indicator Cluster Survey	Variable	It is a household survey conducted in Pakistan that focuses specifically on the situation of children and women. It is part of a global initiative coordinated by UNICEF and aims to monitor progress towards international development goals, particularly the Sustainable Development Goals (SDGs)
Pakistan Maternal Mortality Survey (PMMS)	2019	It is a nationwide survey conducted to assess and monitor maternal health in Pakistan. It is carried out periodically to gather data on various indicators related to pregnancy, childbirth, and postpartum care.
National Health Accounts Pakistan	2019-20	It is a comprehensive report that provides detailed information about the financing and expenditure on health in Pakistan. It is compiled by the Pakistan Bureau of Statistics (PBS).
Pakistan Population and Family Planning Yearbook	2022	It is published by the Population Program Wing (PPW) under the Ministry of National Health Services, Regulations and Coordination (MoNHSRC). It provides data and analysis on various aspects of population and family planning in Pakistan, including population size and growth, fertility and mortality rates, contraceptive use and family planning practices, maternal and child health, population projections and population and development issues, among others.
National Population Fact Sheet	2020	It provides a valuable snapshot of the country's population dynamics. Understanding these trends is essential for planning and implementing effective policies and programs that promote the well-being of all citizens.
National Nutrition Survey	2018	It is a comprehensive nationwide survey conducted by the Government of Pakistan with the support of UNICEF and other partners to assess the nutritional status of the population, with a primary focus on children under five, adolescent girls, and women of childbearing age (including pregnant and lactating women). It was designed to provide policymakers, program managers, and academicians with a unique set of nutrition-related data, including environmental, anthropometric, and biochemical indicators
Population and Housing Census 2017	2017	The Population & Housing Census 2017 was the 6th national census conducted in Pakistan since its independence. It was carried out by the Pakistan Bureau of Statistics (PBS). The main objective of the census was to collect accurate and up -to -date data on the population and housing conditions in the country. For reference to data missing in the 2023 version
Population and Housing Census 2022-23	2023	The first digital census of Pakistan

FP2030 Indicator Summary Sheet	2022	The FP2030 Indicator Summary Sheet for Pakistan provides an overview of the country's progress towards the goals of the Family Planning 2030 (FP2030) initiative. FP2030 is a global partnership that aims to ensure that by 2030, all people have access to the voluntary family planning information, services, and supplies they need.

Table 5 – Gaps in Implementation Data

Sources

PPFP/PAFP Indicators

Background: Current FP status	Module	Potential Data source	Suggested breakdown	All WRA	Rural WRA	Urban WRA	<20 WRA	>=20 WRA
% of FP accessed in the public sector	All	DHS	Rural/urban, <20/>=20	43.1	0.8	N/A	N/A	N/A
% of FP accessed in the non-profit private sector	All	DHS	Rural/urban, <20/>=20	42	N/A	N/A	N/A	N/A
% of FP accessed in the for-profit private sector	All	DHS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS or PMA	Rural/urban, <20/>=20	25.0	22.8	28.8	N/A	5.8
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20	0.4	2.1	2.2	N/A	0.3
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A
% of women with unmet need for FP	All	DHS or PMA	Rural/urban, <20/>=20	17%	19	15	17.9	N/A
% of women with unmet need for FP for spacing births	All	DHS or PMA	Rural/urban, <20/>=20	9.5%	10.1	8.5	16.8	N/A
% of all WRA who are < 12 months postpartum and not using modern contraception	PPFP	DHS or MICS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A
% of women who give birth in facility who are <12 mo postpartum and not using MC	PPFP	DHS or MICS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A
% women < 2 years postpartum who discontinue contraception within 3 months of use	PPFP	DHS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A

(may require analysis of DHS calendar data)								
% of women who receive ANC from a skilled provider	PPFP	DHS or HMIS or DHS	Rural/urban, <20/>=20	86.2	82.1	94.3	84.8	N/A
% of women with recent birth who have a post-natal check up within 6 weeks	PPFP	DHS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A
Median duration of exclusive breastfeeding	PPFP	DHS	Rural/urban, <20/>=20	1.6 months	2.0 months	N/A	N/A	N/A
Median duration of partially exclusive breastfeeding	PPFP	DHS	Rural/urban, <20/>=20	3.5 months	3.6 months	3.3 months	N/A	N/A
Median birth interval and/or % women with birth to pregnancy interval of at least 2 years	PPFP	DHS	Rural/urban, <20/>=20	28.2 months	27.6	29.8	19.7	24.1
% of women who give birth with a skilled attendant	PPFP	DHS or MICS	Rural/urban, <20/>=20	69.3	62.6	83.8	68.2	70.4
% of women who give birth in a health facility	PPFP	DHS or MICS	Rural/urban, <20/>=20	66.2	59.2	81.1	65.9	N/A
% ANC visits where FP counselling occurs	PPFP	HMIS or facility surveys	N/A	N/A	N/A	N/A	N/A	N/A
% of women delivering in facility who receive FP counselling before discharge	PPFP	HMIS or facility surveys	N/A	N/A	N/A	N/A	N/A	N/A
% of women delivering in facility who receive FP method before discharge	PPFP	HMIS or facility surveys	N/A	N/A	N/A	N/A	N/A	N/A
% of women attending for post-abortion or abortion care who receive FP method before discharge	PPFP	HMIS or facility surveys	N/A	N/A	N/A	N/A	N/A	N/A
% of post-natal care clients (usually 2-6 weeks postpartum) who receive FP counselling	PPFP	HMIS or facility surveys	N/A	10.9	9.2	14.2	5.0	N/A
% of immunization clients who receive FP counselling	PPFP	HMIS or facility surveys	N/A	N/A	N/A	N/A	N/A	N/A
% of women delivering in facility who receive breastfeeding counselling before discharge	PPFP	HMIS or facility surveys	N/A	N/A	N/A	N/A	N/A	N/A

Table 6 -PAFP/PPFP Indicators

Task Sharing Indicators

Background: Current FP status	Module	Potential Data source	Suggested breakdown	All WRA	Rural WRA	Urban WRA	<20 WRA	>=20 WRA
% of FP accessed in the public sector	All	DHS	Rural/urban, <20/>=20	43.5	0.8	N/A	N/A	N/A
% of FP accessed in the non-profit private sector	All	DHS	Rural/urban, <20/>=20	42.5	N/A	N/A	N/A	N/A
% of FP accessed in the for-profit private sector	All	DHS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A	N/A
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS or PMA	Rural/urban, <20/>=20	25	22.8	28.8	N/A	5.8
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20	0.4	2.1	2.2	N/A	0.3
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20	0.4	2.1	2.2	N/A	0.3
% of women with unmet need for FP	All	DHS or PMA	Rural/urban, <20/>=20	17.3	18.8	14.8	N/A	17.9
% of women with unmet need for FP for spacing births	All	DHS or PMA	Rural/urban, <20/>=20	9.5%	10.1	8.5	16.8	N/A
National Family Planning Effort Index	All	Track20		48.5	N/A	N/A	N/A	N/A
Number of health workers (all reported cadres) national/subnational	Task-sharing	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Doctors per 1000 population	Task-sharing	National/state Health info stats	Rural/urban or by state	1.239	N/A	N/A	N/A	N/A
Nurses per 1000 population	Task-sharing	National/state Health info stats	Rural/urban or by state	0.53	N/A	N/A	N/A	N/A
CHWs per 1000 population	Task-sharing	National/state Health info stats	Rural/urban or by state	N/A	N/A	N/A	N/A	N/A
% of workforce that are CHW	Task-sharing	National/state Health info stats	Rural/urban or by state	N/A	N/A	N/A	N/A	N/A
Ratio of unfilled posts to total number of posts, by cadre	Task Sharing	National/state Health info stats	Rural/urban or by state	N/A	N/A	N/A	N/A	N/A

Table 7 – Task Sharing/Shifting Indicators

SBCC Indicators

Background: Current FP status	Module	Potential Data source	Suggested breakdown	All WRA	Rural WRA	Urban WRA	<20 WRA
Modern contraceptive prevalence (% among women of reproductive age)	**All**	DHS or PMA	Rural/urban, <20/>=20	25%	22.8	28.8	N/A
% all women of reproductive age relying on Long Acting or Permanent methods of FP	**All**	DHS or PMA	Rural/urban, <20/>=20	8.8	N/A	N/A	N/A
% all current contraceptive users relying on Long Acting or Permanent methods of FP	**All**	DHS or PMA	Rural/urban, <20/>=20	0.4	2.1	2.2	N/A
% of women with unmet need for FP	**All**	DHS or PMA	Rural/urban, <20/>=20	17.3	18.8	14.8	17.9
% of women knowing any modern methods	**All**	DHS or PMA	Rural/urban, <20/>=20	98.1	97.9	98.6	90.5
% of FP users with full method information index (informed of side effects, told what to do if experience side effects, informed of other methods of FP)	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	18.8	N/A	N/A	N/A
% of women intending to use FP in the future (or next 12 months)	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A
% of women practicing covert FP use	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A
% of women not using FP due to health concerns or fears of side effects	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	19.2	N/A	N/A	N/A
% of female non-users intending to use FP in the future	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	33.3	N/A	N/A	N/A
% of women FP users making decisions about FP on their own or jointly with their husband	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	86.9	85.9	88.0	83.0
% of women FP non-users making decisions about FP on their own or jointly with their husband	**SBCC**	DHS or PMA	Rural/urban, <20/>=20	69.8	67.1	75.3	70.4
% of FP clients involved in decisions about their care during FP consultations	**SBCC**	DHS SPA FP exit	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A
% of women exposed to different FP messages (via different channels: radio/TV, newspapers, mobile phone, online)	**SBCC**	DHS	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A
% of women exposed to different media in the population (in past month or year) **-TV** **-radio** **- online/digital**	**SBCC**	KAPB or media surveys	Rural/urban, <20/>=20	N/A	N/A	N/A	N/A
% of women with access to phones: **- mobile phones** **- smart phones**	**SBCC**	KAPB or communication surveys	Rural/urban, <20/>=20	39.2	29.8	55.4	19.5

% of facilities with available visual aids for FP (flip charts, leaflets)	**SBCC**	DHS SPA Inventory	N/A	N/A	N/A	N/A	N/A
No. or % of districts with active health promotion teams	**SBCC**	HMIS	N/A	N/A	N/A	N/A	N/A
No. or % of health facilities with community outreach for RMNCH *	**SBCC**	HMIS	N/A	N/A	N/A	N/A	N/A
No. of organisations (NGOs, media, faith-based organisations) implementing SBCC activities related to FP (either nationally or in selected regions (illustrative).	**SBCC**	Estimate from reports	N/A	N/A	N/A	N/A	N/A

Table 8 – SBCC Indicators

Postpartum Family Planning

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	ANC policies, guidelines and tools recommend counselling on FP during at least one of the routine ANC visits		Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan (WHO and MoNHSRC)
2	Maternity or immediate post-natal care policies, guidelines and tools recommend counselling on FP in the immediate postpartum period		Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan (WHO and MoNHSRC)
3	Post-natal care policies, guidelines and tools recommend counselling on FP at the first post-natal care check-up		Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan (WHO and MoNHSRC) • IMNCI Guideline to Counsel the Mother WHO 2019

4	Immunization policies, guidelines and tools recommend counselling on FP during child health checks/immunization visits		None	Unclear Guidance	• National Immunization Policy, Pakistan. 2022. • National Health Vision 2016-2025
5	MNH policies, guidelines and tools clearly state the 3 criteria for Lactational Amenorrhea Method (LAM)	LAM criteria are: <6 months postpartum; fully or nearly fully breastfeeding; no return of menses	Full		• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan WHO 2019
6	Infant feeding/nutrition policies, guidelines and tools clearly state the 3 criteria for Lactational Amenorrhoea Method (LAM)	LAM criteria are: <6 months postpartum; fully or nearly fully breastfeeding; no return of menses	Partial	Ad hoc Evidence of Implementation	• IMNCI Guideline to Counsel the Mother WHO 2019 • Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan WHO 2019
7	MNH policies, guidelines and tools provide guidance on how to reach women who did not have a facility delivery with FP		Partial	Ad hoc Evidence of Implementation	• Caring for Newborn (Participant Manual) 2016 • Post-Pregnancy Family Planning Services f
8	MNH policies, guidelines and tools encourage women to transition from LAM to another method of contraception at 6 months postpartum		Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan 2019 (WHO-MoNHSRC)

9	Do policies, guidelines and tools align precisely with WHO's latest PPFP compendium and Handbook for postpartum and post-abortion FP?	Does guidance allow immediate initiation of progestogen-only pills & implants after birth? And do they allow initiation of combined and progestogen-only methods immediately post-abortion (both surgical and medical))?	Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan 2019 (WHO-MoNHSRC)
10	FP policies and guidelines align with WHO Selected Practice recommendations and WHO Handbook on initiation criteria for breastfeeding amenorrhoeic women <6 months postpartum.	Breastfeeding amenorrhoeic women less than 6 months post-partum can initiate POPs and implants at any time without need for a backup method. They can initiate DMPA between 6 weeks and 6 months postpartum without the need for a backup method.	Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan WHO 2019. MNHSRC

11	FP policies and guidelines align with WHO Selected Practice recommendations on initiation criteria for post-abortion women.	IUD/IUS can be initiated immediately after 1st and 2nd trimester abortion. All progestogen-only methods and combined hormonal method can be initiated immediately post-abortion.	Full	Clear Guidance	• Guidelines for Essential Practice for Pregnancy Childbirth Postpartum Pakistan WHO 2019. MNHSRC
12	PPFP and PAFP Policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services	Review WHO Human Rights for Contraceptive Services framework	Full	Clear Guidance	• Standardized Training Package on Family Planning

Table 9 - PPFP/PAFP Gaps in Coverage Indicators

Task Sharing/Shifting

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	There is a national task-sharing policy for RMNCH including FP		Partial	Ad-hoc evidence of implementation	• National Vision 2016-2025 for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition • LHW Strategic Plan 2022-28 • UNFPA Pakistan Task Shifting & Task Sharing Policy Brief • FP 2030 National Commitments
2	National FP guidelines have been updated with the 2017 WHO *FP Task Sharing guidance*	Record date of publication or last update, or if date of publication/update not available.	Partial	Adhoc evidence of implementation	• FP 2030 National Commitments
3	National FP / TS policy and guidelines includes *"who can provide"* table.		Partial	Adhoc Evidence of Implementation	• Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft)

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
					• Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft)
4	National FP and TS policies and guidelines use clear and consistent definitions and labels/terms throughout for CHWs and auxiliary nurses/midwives		Partial	Conflicting Guidance	• Human Resource for Health Vision 2018-30 • Annual Contraceptive Performance Report • Population Welfare Department documents • Department of Health documents
5	National FP and TS policies and guidelines provide clear and consistent requirements for CHWs and auxiliary nurses/midwives, specifying education & training, residency etc.		Partial	Conflicting guidance	• LHW Strategic Plan 2022-28 • Pakistan Nursing and Midwifery Council website

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
6	Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that **Community health workers** can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; and hormonal injectables, **under targeted monitoring and evaluation.**		Partial	Conflicting Guidance	• Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft)
7	Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that		Full	Clear Guidance	• Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft)

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	auxiliary nurses and auxiliary nurse midwives can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms, hormonal injectable, and contraceptive implants; and (for auxiliary nurse midwives) IUDs				• Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft)
8	TASK-SHARING policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of	Review WHO Human Rights for Contraceptive Services framework	Partial	Adhoc Evidence of implementation	• UNFPA Pakistan Task Shifting & Task Sharing Policy Brief • FP 2030 Commitments • Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft)

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services				• Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft) • Standardized Training Package on Family Planning
9	There are national-level/subnational policies that support the development and deployment of CHW programs		Partial	Policies exist but implementation remains a challenge	• National Health Vision Pakistan 2016-2025 • New Family Planning 2019-2024 National Action Plan • LHW Strategic Plan 2022-28 • Human Resource for Health (HRH) Vision 2018-30 • Punjab Population Policy 2017
10	There are national/subnational policies that explicitly refer to CHWs, with a formal governance structure, funding support, training agenda, job description, and appropriate support from public health facilities.		Partial	Policies exist but implementation remains a challenge	• National Health Vision Pakistan 2016-2025 • LHW Strategic Plan 2022-28 • Human Resource for Health (HRH) Vision 2018-30

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
11	There are national and/or subnational standards on the duration and content of CHW/health workforce education and training		Partial	Ad hoc evidence of implementation	• Pakistan Nursing and Midwifery Council • Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft)
12	There are national and/or subnational mechanisms for accreditation of CHW/health workforce education and training institutions and their programmes		Partial	Adhoc evidence of Implementation	• Pakistan Nursing and Midwifery Council Website • Population Welfare Department documents
13	There are national education plans for the health workforce, aligned with the national health plan		None	Unclear Guidance	• National Health Vision Pakistan 2016-2025 • Human Resource for Health Vision 2018-30

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	and the national health workforce strategy/plan, which match health worker competencies with population/health systems/labour market needs				
14	There are national systems for continuing professional development		Partial	Unclear guidance	• Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft) • National Vision 2016-2025 • LHW Strategic Plan 2022-28 • UNFPA Pakistan Task Shifting & Task Sharing Policy Brief
15	Clinical regulations, including licensure		Partial	Not adequately implemented	• UNFPA Pakistan Task Shifting & Task Sharing Policy Brief

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/ none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	regulations, stipulate that implants can be provided by auxiliary nurses and injectables can be provided by community health workers.				• FP 2030 Commitments • Task Sharing to Improve Access of Long Acting Reversible Methods – Policy Statement for Khyber Pakhtunkhwa (Draft) • Plan of Action to Implement Task Sharing Approach for FP Service Delivery in Sindh (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Punjab (Draft) • Plan Of Action To Implement Task Sharing Initiative For FP Service Delivery In Balochistan (Draft) • Plan of Action to Implement Task Sharing Approach For FP Service Delivery In Islamabad (Draft)

Table 10- Task Sharing/Shifting Gaps in Coverage Indicators

Social and Behaviour Change Communication (SBCC)

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	FP/RH policy & guidance documents recommend scale-up of SBCC interventions	Full	Clear Guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK

				• Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh
2	FP/RH policy & guidance documents recommend use of community health workers for RMNCH health promotion, including FP	Full	Clear Guidance	• National Vision 2016-2025 • LHW Strategic Plan 2022-28 • UNFPA Pakistan Task Shifting & Task Sharing Policy Brief
3	FP/RH policy & guidance documents recommend use of mass media to promote FP	Partial	Conflicting Guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program
4	FP/RH policy & guidance documents recommend use of community engagement, including interpersonal communication and groups, to promote FP	Full	Clear Guidance	• National Vision 2016-2025 • LHW Strategic Plan 2022-28 • UNFPA Pakistan Task Shifting & Task Sharing Policy Brief
5	FP/RH policy & guidance documents recommend use of digital health to promote FP	Partial	Conflicting Guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh

				• A roadmap to engaging the media more effectively by: Pathfinder International – Pakistan Country Program
6	FP/RH policy & guidance documents aim to address social and gender norms that may inhibit use of FP	Full	Clear Guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning
7	FP/RH policy & guidance documents aim to involve men and promote healthy couple communication	Partial	Clear Guidance but poor implementation	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program
8	FP/RH policy & guidance documents aim to strengthen the knowledge, attitudes, beliefs and self-efficacy of individual women and girls	Full	Clear Guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program

				• Standardized Training Package on Family Planning
9	FP/RH policy & guidance documents recommend community engagement, including working with community leaders, religious leaders, or other trusted opinion leaders, to promote FP	Full	Clear Guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program
10	FP/RH and SBCC policy & guidance documents adhere to recommended and evidence-based principles for SBCC (see Annex 1) including: - adherence to rights-based programming principles - community participation -adaptation to local context and target population - use of evidence-based structured design processes - monitoring, evaluation and learning of interventions	Partial	Adaptation to local context found in Media Engagement Strategy but evidence-based structured programming found only in Punjab and KPK documents	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program
11	FP/RH and SBCC policy & guidance documents advise on effective approaches for SBCC in family planning, along with strength of evidence in the local context	Partial	Adaptation to local context found in Media Engagement Strategy	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK

				• Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning
12	There are clear indicators for success for SBCC in policy and guidance documents	Partial	Evidence found in Media Engagement Strategy, Punjab FP Strategy, Post-Pregnancy FP Policy-Sindh, Advocation and Communication Strategy, KPK	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning
13	Policy & guidance documents advising mass media include guidance on formative research, pre-testing messaging, targeting of communication, selection of appropriate channels, audience segmentation, working with local community platforms or infrastructure, and the need to address equity in SRH.	None	Lack of evidence or guidance	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning
14	Policy & guidance documents advising community health groups empower participants for collective action and promote community agency	Partial	Ad hoc evidence of implementation	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh

				• LHW Strategic Plan 2022-28 • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning
15	SBCC materials produced by MOH (national, state/regional, district) align with recommended principles of SBCC (Annex 1): • Mass media materials (including radio/TV campaigns, advertising campaigns, influencer campaigns etc.) • Community engagement materials (including leaflets, training guides, etc.) • Digital materials (including SMS campaign content, videos, apps, social media, etc.)	Partial	Ad hoc evidence of implementation	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning
16	SBCC materials produced by NGOs (health implementers, community organisations, faith-based organisations etc.) align with recommended principles of SBCC (Annex 1): • Mass media materials (including radio/TV campaigns, advertising campaigns, influencer campaigns etc.)	Partial	Ad hoc evidence of implementation	• Family Planning Media Engagement Strategy For Punjab, 2024 • Advocacy and Communication Strategy, PWD, KPK • Communication Strategy Balochistan, PMCT Directorate • Advocacy & Communication Strategy, PWD AJK • Post-Pregnancy Family Planning Policy Sindh • A roadmap to engaging the media more effectively By: Pathfinder International – Pakistan Country Program • Standardized Training Package on Family Planning

	• Community engagement materials (including leaflets, training guides, etc.) • Digital materials (including SMS campaign content, videos, apps, social media, etc.)			

Table 11 -SBCC Gaps in Coverage Indicators

Questionnaire Analysis

As part of this comprehensive study, a pre-designed structured questionnaire was administered to a total of 182 unique participants, representing diverse regions across the country. The total responses (all three questionnaires combined) were 474.

Category & Level of Respondents	Task Shifting & Sharing	Social & Behaviour Change	PFPP/ PAFP	Total for all three questionnaires
Government	**134**	**128**	**112**	**374**
• **Community Providers**	44	39	42	125
• **District**	64	69	57	190
• **National**	7	3	2	12
• **Other**	2	2	-	4
• **Sub-national or regional**	17	15	11	43
NGO or civil society	**22**	**19**	**22**	**63**
• **Community Providers**	1	1	2	4
• **District**	7	5	5	17
• **National**	6	6	8	20
• **Sub-national or regional**	8	7	7	22
Private Sector	**12**	**10**	**11**	**33**
• **Community Providers**	1	2	3	6
• **District**	3	1	1	5
• **National**	4	2	3	9
• **Other**	1	2	2	5
• **Sub-national or regional**	3	3	2	8
Professional associations	**0**	**1**	**0**	**1**
• **NA**	0	1	0	1
Others / Unclassified	**1**	**1**	**1**	**3**
• **National**	1	1	1	3
Grand Total	**169**	**159**	**146**	**474**

Table 12 – Questionnaire Respondent Breakdown

The questionnaire covered all three thematic areas of focus, ensuring a holistic understanding of the key issues. After the data collection phase, the responses were carefully analyzed using a designated analysis tool, which facilitated a systematic and detailed examination of the findings. This approach allowed for insights into each of the themes.

The key provided uses a color-coded scale to indicate the severity of bottlenecks based on the mean scores.

- A mean score between **4.0 and 5**, represented by **dark red**, signifies a **very important bottleneck**, meaning there are significant challenges that critically hinder progress in that area.
- A mean score of **3.0 to 3.99**, marked in **light red**, indicates an **important bottleneck**, reflecting issues that are still impactful but less severe.
- Mean scores between **2.0 and 2.99**, shown in **light green**, represent **minor bottlenecks**, where obstacles exist but are less pressing.
- Finally, a mean score between **0.1 and 1.99**, depicted by **dark green**, suggests that there is **no bottleneck**, indicating that processes are functioning smoothly in that area without major impediments.

Summary of Mean KII Scores (All levels combined)			
Bottlenecks category	**Task Sharing/Shifting**	**SBCC**	**PPFP/PAFP**
Implementation	**2.01**	**1.46**	**1.93**
Governance	**2.38**	**1.72**	**2.06**
Financing	**2.36**	**2.80**	**2.41**
People	**2.18**	**2.36**	**2.17**
Information	**2.32**	**1.93**	**2.23**
Medicine and Technology	**2.15**	**2.07**	**2.23**
Service Delivery	**2.16**	**2.05**	**2.10**
Human Resources	**1.98**	**2.03**	**2.01**

Table 13 - Summary of Mean KII Scores (All levels combined)

Summary KII Scores National & Sub National			
Bottlenecks category	**Task Sharing**	**SBCC**	**PPFP/PAFP**
Implementation	**2.85**	**2.30**	**2.77**
Governance	**3.22**	**2.56**	**2.90**
Financing	**3.20**	**3.64**	**3.25**
People	**3.02**	**3.20**	**3.01**
Information	**3.16**	**2.77**	**3.07**
Medicine and Technology	**2.99**	**2.91**	**3.07**
Service Delivery	**2.98**	**2.89**	**2.94**
Human Resources	**2.82**	**2.87**	**2.85**

Table 14- Summary KII Scores National & Sub National

Summary KII Scores District and Frontline			
Bottlenecks category	**Task Sharing**	**SBCC**	**PPFP/PAFP**
Implementation	**1.95**	**1.40**	**1.87**
Governance	**2.32**	**1.66**	**1.99**
Financing	**2.30**	**2.74**	**2.35**
People	**2.12**	**2.30**	**2.11**
Information	**2.26**	**1.87**	**2.17**
Medicine and Technology	**2.09**	**2.01**	**2.17**
Service Delivery	**2.10**	**2.01**	**2.04**
Human Resources	**1.92**	**1.97**	**1.95**

Table 15 - Summary KII Scores District and Frontline Workers

The analysis considers bottlenecks at two levels: (1) All Levels Combined and (2) National and Sub-National levels versus District and Frontline levels to identify potential variations in perceived challenges.

Annex 3: Individual Ranking Tool for Group 1

Group 1: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(10 is the most important bottleneck, 1 is the least important)

Color each number only once

Governance	**Leadership & commitment** 1 2 3 4 5 6 7 8 9 10	**Accountability** 1 2 3 4 5 6 7 8 9 10
	Regulation 1 2 3 4 5 6 7 8 9 10	**Guidance formulation & coherence** 1 2 3 4 5 6 7 8 9 10
Financing	**Budgeting** 1 2 3 4 5 6 7 8 9 10	**Donors** 1 2 3 4 5 6 7 8 9 10
	Insurance 1 2 3 4 5 6 7 8 9 10	**Spending** 1 2 3 4 5 6 7 8 9 10
	Planning 1 2 3 4 5 6 7 8 9 10	**Equity** 1 2 3 4 5 6 7 8 9 10

Annex 4: Individual Ranking Tool for Group 2

Group 2: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(11 is the most important bottleneck, 1 is the least important)
Color each number only once

People	**Communication, knowledge & awareness** 1 2 3 4 5 6 7 8 9 10 11	**Acceptability** 1 2 3 4 5 6 7 8 9 10 11
	Consultation 1 2 3 4 5 6 7 8 9 10 11	**Coordination** 1 2 3 4 5 6 7 8 9 10 11
	Networks 1 2 3 4 5 6 7 8 9 10 11	**Community engagement** 1 2 3 4 5 6 7 8 9 10 11
Information	**Reporting** 1 2 3 4 5 6 7 8 9 10 11	**Data & HMIS** 1 2 3 4 5 6 7 8 9 10 11
	Guidelines & tools 1 2 3 4 5 6 7 8 9 10 11	**Client SBC/IEC** 1 2 3 4 5 6 7 8 9 10 11
	Health promotion 1 2 3 4 5 6 7 8 9 10 11	

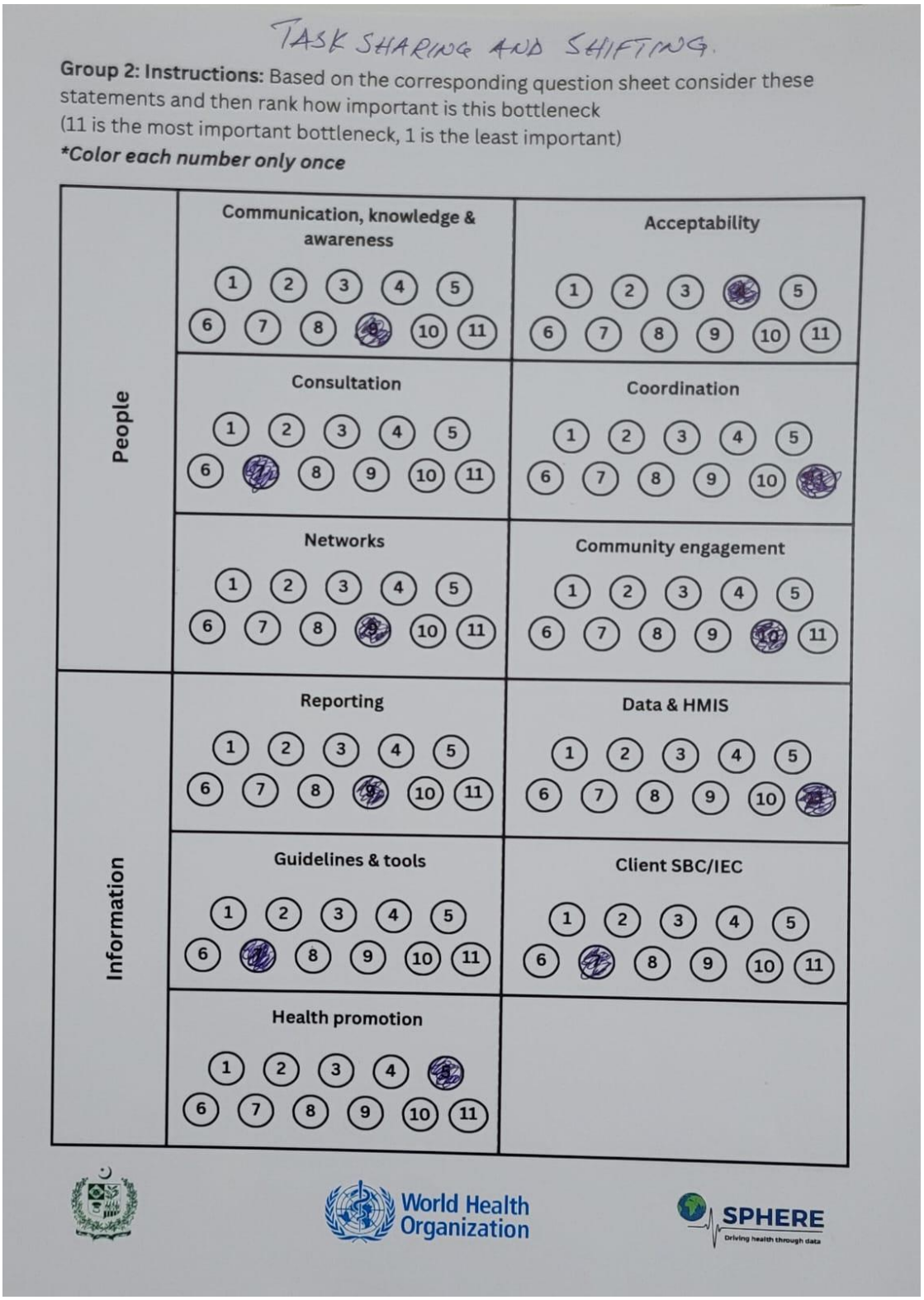
Annex 5: Individual Ranking Tool for Group 3

Group 3: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(14 is the most important bottleneck, 1 is the least important)

Color each number only once

Medicines & Technology	**Infrastructure** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Supplies & LMIS** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Innovation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	
Service Delivery	**Management** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Supervision** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Team work 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Service structure & Scheduling** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Referral Systems 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Fees** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
Human Resources	**Training & Education** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Capacity** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Roles 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Skills & competencies** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Motivation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	

Annex 6: Marked Individual Ranking Tools



TASK SHARING AND SHIFTING.

Group 2: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(11 is the most important bottleneck, 1 is the least important)
Color each number only once

People	Communication, knowledge & awareness	Acceptability
	Consultation	Coordination
	Networks	Community engagement
Information	Reporting	Data & HMIS
	Guidelines & tools	Client SBC/IEC
	Health promotion	

World Health Organization

SPHERE
Driving health through data

SBCC G.II

Group 2: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(11 is the most important bottleneck, 1 is the least important)
Color each number only once

People	**Communication, knowledge & awareness** 1 2 3 4 5 6 7 8 9 10 **11**	**Acceptability** 1 2 3 4 5 6 7 8 9 10 **11**
	Consultation 1 2 3 4 5 6 7 **8** 9 10 11	**Coordination** 1 2 3 4 5 6 7 8 9 10 **11**
	Networks 1 2 3 4 5 6 7 8 9 **10** 11	**Community engagement** 1 2 3 4 5 6 7 8 9 10 **11**
Information	**Reporting** 1 2 3 4 5 6 7 8 9 10 **11**	**Data & HMIS** 1 2 3 4 5 6 7 8 9 **10** 11
	Guidelines & tools 1 2 3 4 5 **6** 7 8 9 10 11	**Client SBC/IEC** 1 2 3 4 5 6 7 8 9 10 **11**
	Health promotion 1 2 3 4 5 6 7 8 9 **10** 11	

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SPHERE
Driving health through data

Shaista farooqui.

Group 3: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(14 is the most important bottleneck, 1 is the least important)
Color each number only once

SBCC

Medicines & Technology	**Infrastructure** 1 2 3 4 5 6 7 8 9 10 11 12 13 **14**	**Supplies & LMIS** 1 2 3 4 5 6 7 8 9 10 11 12 13 **14**
	Innovation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	
Service Delivery	**Management** 1 2 3 4 5 6 7 8 9 10 11 12 13 **14**	**Supervision** 1 2 3 4 5 6 7 8 9 10 11 12 13 **14**
	Team work 1 2 3 4 5 6 7 8 9 10 11 12 13 **14**	**Service structure & Scheduling** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Referral Systems 1 2 3 4 5 6 7 8 9 10 11 **12** 13 14	**Fees** 1 2 3 4 **5** 6 7 8 9 10 11 12 13 14
Human Resources	**Training & Education** 1 2 3 4 5 6 7 8 9 10 11 **12** 13 14	**Capacity** 1 2 3 4 5 6 7 8 9 10 11 **12** 13 14
	Roles 1 2 3 4 5 6 7 8 9 10 11 12 13 **14**	**Skills & competencies** 1 2 3 4 5 6 7 8 9 10 11 **12** 13 **14**
	Motivation 1 2 3 4 5 6 7 8 9 10 11 **12** 13 14	

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Group 3: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(14 is the most important bottleneck, 1 is the least important)

Color each number only once

Medicines & Technology	**Infrastructure** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Supplies & LMIS** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Innovation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	
Service Delivery	**Management** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Supervision** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Team work 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Service structure & Scheduling** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Referral Systems 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Fees** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
Human Resources	**Training & Education** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Capacity** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Roles 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Skills & competencies** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Motivation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	

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PPFP

Group 3: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(14 is the most important bottleneck, 1 is the least important)

Melvin

Color each number only once

Medicines & Technology	**Infrastructure** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Supplies & LMIS** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Innovation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	
Service Delivery	**Management** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Supervision** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Team work 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Service structure & Scheduling** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Referral Systems 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Fees** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
Human Resources	**Training & Education** 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Capacity** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Roles 1 2 3 4 5 6 7 8 9 10 11 12 13 14	**Skills & competencies** 1 2 3 4 5 6 7 8 9 10 11 12 13 14
	Motivation 1 2 3 4 5 6 7 8 9 10 11 12 13 14	

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Group 1: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(10 is the most important bottleneck, 1 is the least important)

***Color each number only once** Dr Sabina. PFP and PATP

Governance	**Leadership & commitment** 1 2 3 **4** 5 6 7 8 9 10	**Accountability** 1 2 3 4 **5** 6 7 8 9 10
	Regulation 1 2 3 4 5 6 **7** 8 9 10	**Guidance formulation & coherence** 1 2 3 4 5 6 7 **8** 9 10
Financing	**Budgeting** 1 2 **3** 4 5 6 7 8 9 10	**Donors** 1 2 3 4 5 **6** 7 8 9 10
	Insurance 1 **2** 3 4 5 6 7 8 9 10	**Spending** 1 2 3 4 5 6 7 8 **9** 10
	Planning 1 2 3 4 5 6 7 8 9 **10**	**Equity** **1** 2 3 4 5 6 7 8 9 10

SBCC.

Group 1: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(10 is the most important bottleneck, 1 is the least important)

Color each number only once

Governance	**Leadership & commitment** 1 2 3 4 5 6 7 8 9 10	**Accountability** 1 2 3 4 5 6 7 8 9 10
	Regulation 1 2 3 4 5 6 7 8 9 10	**Guidance formulation & coherence** 1 2 3 4 5 6 7 8 9 10
Financing	**Budgeting** 1 2 3 4 5 6 7 8 9 10	**Donors** 1 2 3 4 5 6 7 8 9 10
	Insurance 1 2 3 4 5 6 7 8 9 10	**Spending** 1 2 3 4 5 6 7 8 9 10
	Planning 1 2 3 4 5 6 7 8 9 10	**Equity** 1 2 3 4 5 6 7 8 9 10

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TASIC SHAZIN

DR ANILA BACHA
MCH/RH DG Health Services KP

Group 1: Instructions: Based on the corresponding question sheet consider these statements and then rank how important is this bottleneck
(10 is the most important bottleneck, 1 is the least important)

Color each number only once

Governance	**Leadership & commitment** 1 2 **3** 4 5 6 7 8 9 10	**Accountability** 1 2 3 4 5 6 7 **8** 9 10
	Regulation 1 2 3 **4** 5 6 7 8 9 10	**Guidance formulation & coherence** 1 2 3 4 **5** 6 7 8 9 10
Financing	**Budgeting** 1 2 3 4 5 6 7 8 9 **10**	**Donors** 1 2 3 4 5 6 7 8 **9** 10
	Insurance **1** 2 3 4 5 6 7 8 9 10	**Spending** 1 **2** 3 4 5 6 7 8 9 10
	Planning 1 2 3 4 5 6 **7** 8 9 10	**Equity** 1 2 3 4 5 **6** 7 8 9 10

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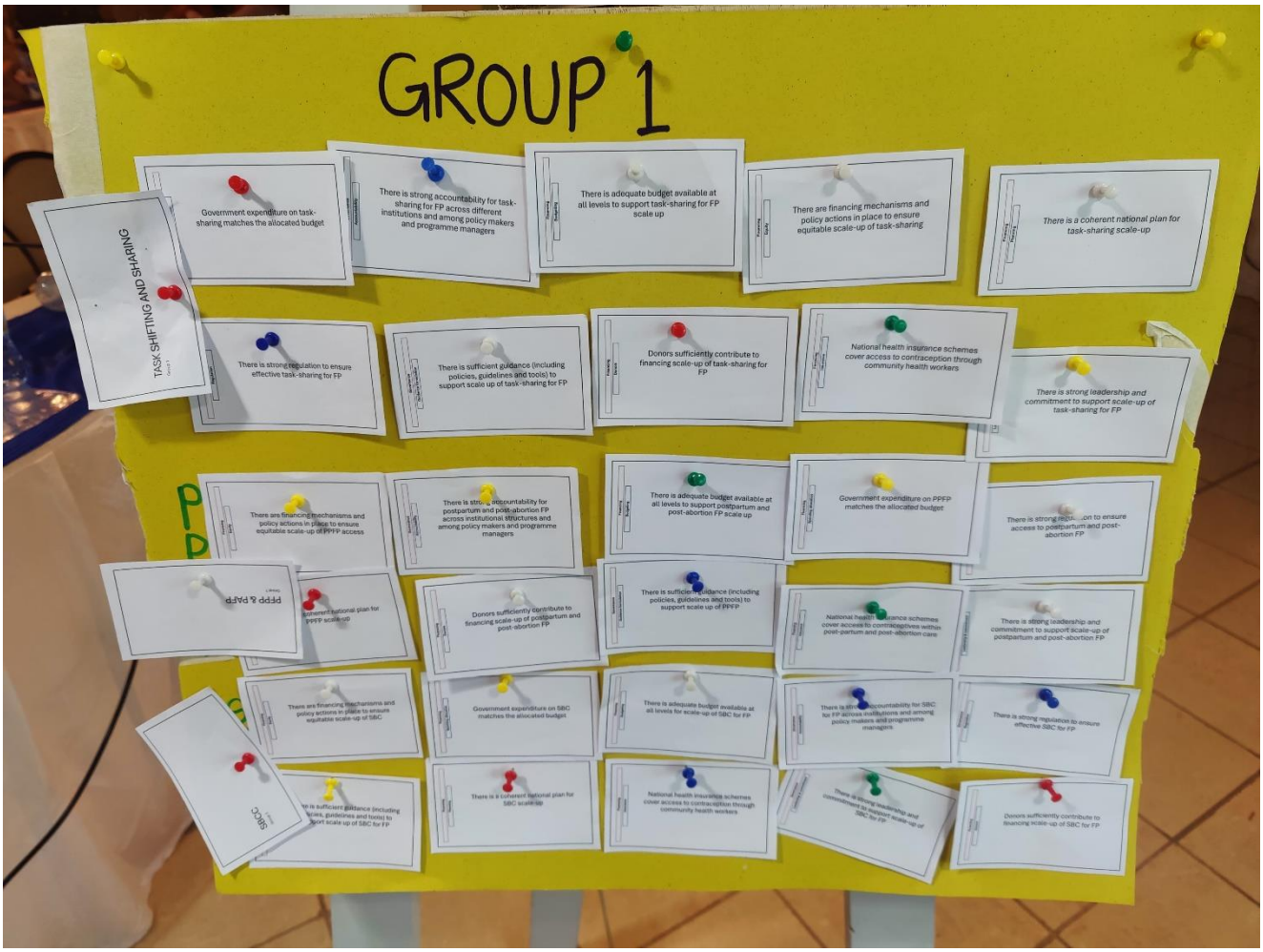
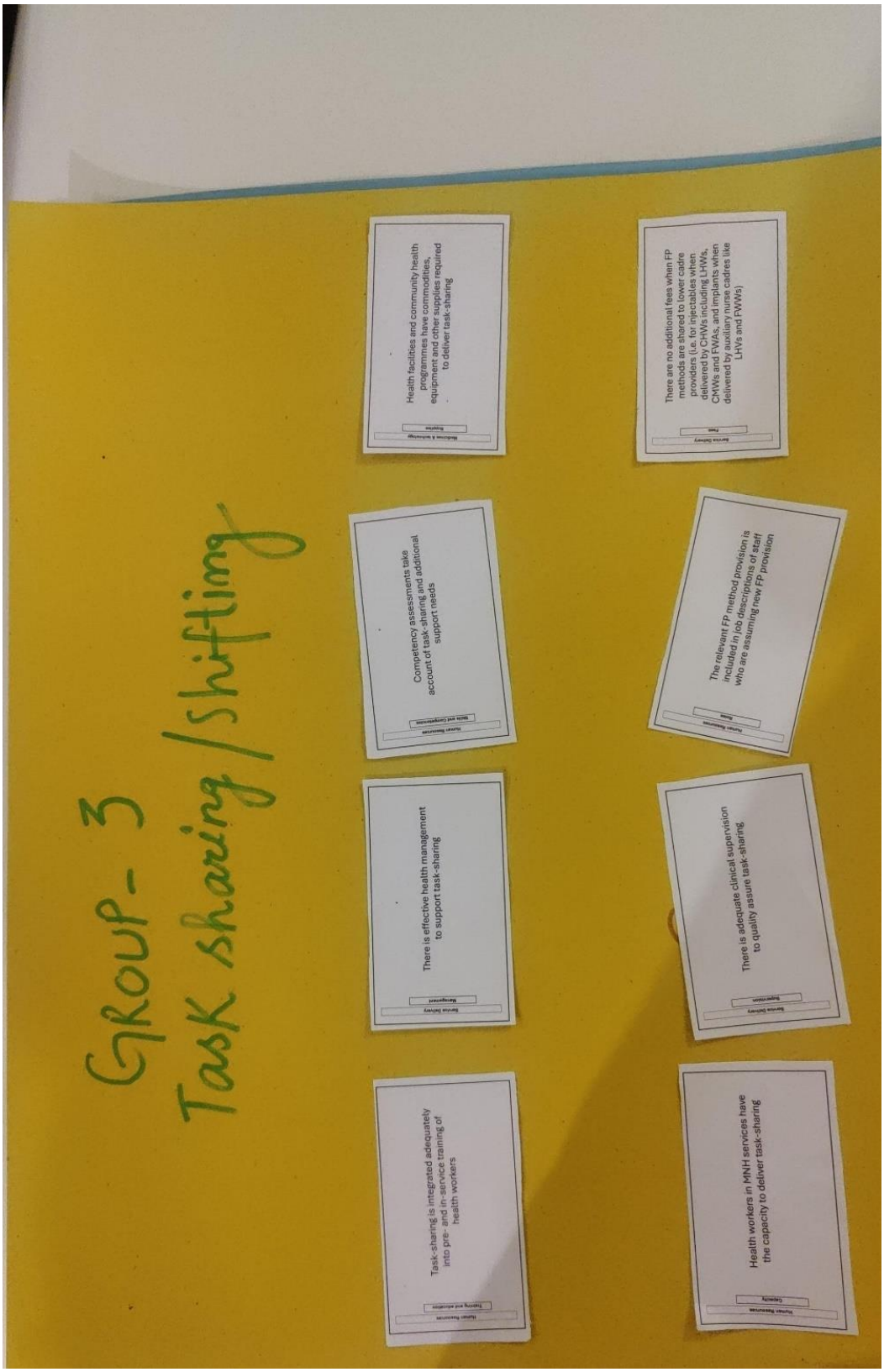
Annex 7: Group Ranking Exercise for Group 1



Annex 8: Group Ranking Exercise for Group 2

Annex 9: Group Ranking Exercise for Group 3



SBCC - GROUP 3
District health/population welfare teams, facilities and community programmes have commodities, equipment, tools and other supplies required to deliver SBC for FP
There is adequate supervision to support SBC
Community health/ population welfare teams and CHWs work in a coordinated way with health facilities
FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches for SBC
Health workers/population welfare involved in SBC have positive attitudes towards the policy
SBC is included in the relevent provider and manager job descriptions
There are effective referral systems between community outreach workers/ SBC agents/ CHWs and static health/ population welfare facilities
The organization of services makes SBC feasible
Staff working on FP across the health/ population welfare system have capacity to deliver SBC for FP
There is adequate training on SBC for FP
There is adequate health/population welfare infrastructure to deliver SBC for FP
There is effective health management

PPFP
Group 3
3
MNH staff have the requisite skills and competencies to deliver PPFP
Effective innovations to support implementation of PPFP are rapidly disseminated and utilized
Pre- and in-service training of health workers is adequately supporting PPFP provision
There is adequate clinical supervision to support PPFP
There is effective health management to support delivery of PPFP
Health facilities have commodities, equipment and other supplies required to deliver PPFP
Referral systems between different health facility units effectively support access to PPFP
Maternal health services are structured and scheduled to ensure access to PPFP
There is adequate infrastructure to deliver PPFP
Different teams involved in PPFP work together to ensure its delivery
MNH staff (working in ANC, maternity, PNC, infant care, abortion care) are motivated to provide PPFP

Annex 10: Short, medium and long term strategies