Sindh Population Policy 2016

Population Welfare Department
Government of Sindh
Karachi

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Message for the Chief Minister, Sindh

Rapid population growth has been a matter of great concern for my government in the pursuit of socio-economic development, that has been further compounded by the fast pace of urbanization and its concentration in certain areas, particularly that of Karachi. This situation warrants attention for visionary measures to strike a balance between population and resources. Although the government has visualized the need for moderating fertility long time back and family planning introduced by the federal government, some advancement and progress have been made over the years, but not adequately enough to achieve the desired objective, which remains a compelling and ever growing need.

The devolution of health and population subjects to the province have provided this opportunity to fully manage the population welfare programme.. The Sindh province is fully empowered to take stock of the situation, review the progress and identify the short comings, set the goal, formulate the approach and strategies based on broad consultation and develop framework to mount comprehensive effort drawing upon the commonality of the subject matter to address this immense challenge with all stakeholders in the loop.

I am pleased to note that a robust and comprehensive population policy will focus on this and provide direction for designing and organizing the efforts. My government stands firmly and formally committed to support the effective execution of the policy and will ensure that all the required inputs will be provided in this regard. Nonetheless, it is a big challenge, warranting time, efforts and sustained investments, More than that, It is a matter of societal behaviour, which makes it a collective cause and require contribution by all at individual, community and organizational levels to promote and support this important cause through their sphere of influence and contact by explaining the benefit of family planning for the family health and socio-economic well-being of the population of Sindh.

Syed Murad Ali Shah

Message for the Chief Secretary, Sindh

The Sindh province has been combating with the population growth phenomena as an integral component of federally sponsored public sector development programme for promotion and service provision of the means through voluntary adoption of family planning. These efforts have attained partial result, but have not been successful in bringing down the growth significantly for reasons of ownership and inadequacy of resources. This only raises the urgency to pay focused attention to the problem with improved understanding and determined action.

The post-devolution scenario has provided this opportunity in a holistic manner by making the province fully empowered to revisit and review the matter for quick and comprehensive sustained action as its sole responsibility. The Sindh Population Policy 2016 that has been formulated after lengthy and series of round of consultations with all stakeholders in the public and private sectors will advance the cause with accelerated pace. The launching of this policy and programmatic approaches and strategies stemming from this composite policy framework will go a long way to elicit broad support and accelerate promotion of voluntary family planning interventions. I assure that all administrative support will be extended towards achieving the objective of rational population growth as it the denominator for social and economic progress, and for the overall welfare and well-being of the population of Sindh to live a happy and contended life.

Mohammad Siddique Memon
Chief Secretary, Sindh

Message from the Minister for Population Welfare, Sindh

Fast population increase creates a drag on development, with ramifications on social services and economic growth. It has been a matter of concern for planners and this stems from unregulated fertility, which is dependent on individual and collective action to bear effect and impact for activities and intervention directed at improving the lot of the people of Sindh.

The design and framing of population policy specific to the province in the wake of devolution of the subject to the province represents both an opportunity and a challenge. It is an opportunity in term of being the sole master in managing the programme with hind sight of experience, better appreciation of the compelling need and how best to pool all institutional and human resources to support this vital cause. More important is the less understood problem of population variable's cross cutting effects and influences on almost all facets of development endeavour and being affected by the development factor in turn. This to a considerable extent neutralizes the investment needed for improving the socio-economic prospect for a better future and well-being of the people of Sindh.

I am confident that with the emerging consensus about the casual relationships between these two variables and the launch of this comprehensive population policy and the range of measures highlighted therein will serve as a solid basis to garner broad support for combined and continued efforts on the horizon of time to advance towards the desired objective, in order to ultimately achieve the goal of healthy and prosperous society for the province of Sindh.

MIR MUMTAZ HUSSAIN JAKHRANI
MINISTER FOR POPULATION WELFARE

Message for the Secretary, Population Welfare Department, Sindh

Population of Sindh Province estimated to be 42 million in 2011 is projected to increase to 62 million by 2030 if the trend of annual growth remained the same. The increase of this magnitude has many implications and consequences to meet the requirement for health, education, housing etc., and to conserve the natural environment. The planners have been mindful of this sprawling effect of growth, compounded by the unprecedented increase of urban population and multiplying effect of concentration in certain areas. The need for moderating the population growth through decline in fertility by way of voluntary family efforts was visualized visualized long time back and population welfare programme launched as public sector development undertaking sponsored by the federal government. Over the years, some progress has been made but not to the extent of attaining the desired level. and the reason being of lack of local focus and inadequacy of required resources. The need for active and sustained effort is ever more acutely felt to-day because of the accumulated effect of rapid addition of population in the past decades.

Consequent upon the devolution of the health and population subjects to the province, the subject being of cross cutting nature influencing and effecting all sectors and in turn being effected too, called attention as the sole and exclusive responsibility of the province. In the wake of this development, the population lead the efforts in the formulation of a comprehensive and composite Sindh Population Policy 2016 that has been finalized through a rigorous consultation process with all stake holder, in which being the natural partner due to commonality of the cause and the immediate beneficiary of birth spacing for improving the maternal and child, and avert the need for abortion which have separate effect and toll on maternal mortality and morbidity.

The population policy thus conceived and launched is built on the strong support and contribution of health sector of the public and private sectors as the natural partners in the cause and its effect on their endeavor for better health. The resolve is to reach-out to the communities in all urban, rural and far flung remote areas, beside the urban slums and squatter settlements with services through multiple service delivery systems and wide range of contraceptive methods. This will be backed-up by promotional and behavioral change interventions on extensive scale and in an intensive manner. Human development for different levels and various requirements for management, service delivery of quality, and full proof post-acceptance will be pursued vigorously. The programme of this dimension and volume will be adequately resources to meet salary and more importantly the operational requirements. A complete and real time result-bearing monitoring, reviews and assessments will be an on-going process, with regular feedback of client perspective about the services and satisfaction. The required set-up will be raised and strengthened starting from the ground level, going -up to the district, and provincial level.

Nonetheless, it is recognized that it is a long term endeavor as it involves societal behaviour change to adjust, adopt and patiently continue with use of family methods to register effect and impact. It is, therefore, highly significant that birth spacing be adopted as a lasting norm in the daily routine habit for the health of the family and well-being of population of Sindh. I hope and trust that the envisaged population policy and the measures proposed therein will be pursued with determined and sustained action. It will turn the immense challenge of containing the growth rate into a profoundly rewarding undertaking when the ultimate goal of welfare and well-being is achieved.

LAEEQ AHMED

Secretary, Population Welfare

Acknowledgment

After 18th Constitutional Amendment and Devolution 2010, when Ministry of Population Welfare and National Population Policy 2002 were ceased, there was a dire legal need that provinces may develop their Population Policies according to their socio economic structure. Population Welfare Department Sindh had taken rigorous actions to prepare Sindh Population Policy with common shared visions of all the public and private stakeholders.

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Vision of Population Policy 2016

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

Objectives of Population Policy 2016

The policy envisions to

- Enhance CPR from 30 % in 2015 to 45 % by 2020.
- Achieve the replacement level fertility i.e. 2.1 births per woman by 2035.
- Achieve universal access to safe and quality reproductive health/family planning services by 2020
- Increase access to family planning and reproductive health services to the most remote and farthest areas of the province by 2017
- Increase efforts to reduce unmet need for family planning from 21 to 14% by 2020
- Attain a decrease in fertility level from 3.9 (2013) to 3.0 births per woman by the year 2020
- Ensure contraceptive commodity security up to 80% at all public service outlets by 2018

1. Introduction

Pakistan, with a population of over 190 million is the 6th most populous country of the world. Its population is growing at an annual rate of 1.95 per cent, which is one of the highest in the region as well as in the world. At the current rate of growth, the population of Pakistan will double in the next 39 years compared to 79 years for SAARC Region. The fast population growth reduces the space and pace of economic and social development. Rather, more and more resources are required simply to cater to the need of additional population and meager resources left for improvement in per capita availability of goods and services. Thus, an obvious need was for sustained policy and programmes to maintain a balance between population growth and resource/economic growth for overall improvement in the living standard and wellbeing of the people.

Pakistan, as a policy matter, has recognized the need to lower population growth rate to be consistent with its welfare needs early in the 1960s. Nonetheless, a variety of factors impeded the process to achieve this goal and affected the decline in fertility. These included fluctuating political support to voluntary family planning efforts, continuing state of low literacy, particularly, among women, prevalence ofhigh poverty, persistence sense of insecurity and mounting cost of living.Nevertheless, the onset of much awaited fertility transition took place, (but with considerable time lag) that brought total fertility rate down from around six births in 1980s to around four births in late 1990s.Thisdeclining fertility trend encouraged policy makers to formulate the National Population Policy 2002 that projected optimistically to reach replacement level fertility by 2020.The fertility declined somewhat swiftly in the 1980s and 1990s,butremained on slowtracksubsequently.During this period,Pakistanalsoencountered complex socio-cultural, geo-political, economic and demographic situation that raisedconcernamongthe policy makers. The positive signal of fertility decline wasoverwhelminglyovertaken by increase in the absolute size of country's population.Itwas baffling the development planners and sharpening their concerns to attend to the matter.A major stride in this direction was the devolution of health and population subjects to the provinces in 2010, which provided them with the opportunitytoinvest time and efforts to evolve dynamic policies and pursue long term strategies to address population challengesfor achieving replacement level fertility, in order to reap the benefits of 'demographic dividend'.Thisbecame evident in the changing age structure (youthful population), reduced dependency ratio (fewer children and increased population joining labor force) to benefit development of Pakistan through enhanced employment opportunities, productivity and relatively reduced consumption pattern.However, the desired outcome is not automatic, rather linked to serious and sustained effective family planning program (to continue the fertility transition process), backed by accelerated policies of human development aimed at transforming theyouthful population into a knowledgeable and skillful productive workforce. This hinges upon policies and endeavors that would lead to stable macroeconomic conditions, associated with the growth of productive and rewarding employment opportunities for men and women alike.

The province of Sindh has a unique population structure among all provinces of the country and it is expected that the trends stated above will be followed.The population of Sindh grew from 19 million (1981 Census) to around 30 million (1998 Census) and estimated to have a population of 42 million in 2011 (based on recent past growth rates). It is projected to increase to46 million by 2015 and 61.7 million by 2030.Details of the projection exercise under three different scenarios, the assumptions applied, annual projections with further details up to 2050 and proportion of elderly population are given in Annexure-I.

The population of Sindhhasdoubled in less than 29 years (1981-2010) and projected to further escalate, with implications of constraining the development efforts. This rapid change emphasizes the need to focus on population variable as a dominant factor affecting and influencing socio-economic development goal and process in the Province. A dynamic and comprehensive provincial population policy emerges is an urgent need of the time to associate and involveall stakeholders to evolve shared perception of the prevailing situation and the need to focus attention to advance the cause of population welfare in unison towards common vision of a prosperous, healthy, educated, and enlightened society in Sindh.

2. Population and Development: An Overview

Population growth and development in Sindh areto be viewed closely in relation to dependency ratio(population under 15 years of age plus elderly population of 60 years and above), poverty, maternal health, malnutrition, child growth, educational attainment, and a number of otherassociated development indicators. Stabilizing population growth is to be considered in this context and it is a multi-sectoralendeavourthat requires continuous and real dialogue among diverse stakeholders to arrive at common points to address the issue throughcoordinationand collaboration at all levels of the government and civil society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at community levels, empowering women throughsocial cohesion including paid work participation, together with a steady, equitable improvement in family incomes, will facilitate early achievement of objectives outlined inFP2020 and enable advancement towards Sustainable Development Goals 2030.

The increase in population density, mushrooming urban slums and squatter settlements, rapid depletion of water resources, existing energy shortages, deforestation, and loss of arable land to urban development are all manifestations of the effect of immense population growth and points to further aggravation in the years to come if not firmly tackledwith vision and determination.This perspective has been in vogue since early days of the Population Programme. The particular increase in Sindh Population has two unique features: unabated high fertility trend, and migration both internal and international. These factors are dynamic and the impact grows over time,toimpinge on the pace of development efforts of the province due to availability of limited resources that get diverted to meet the emerging needs of increasing population and miniscule left for investment in development. These two factors are discussed below.

2.1 Population Growth

The Total Fertility Rate (TFR) declined from 5.1 births (in 1990-91) to 3.9 births (in 2012-13) as against the target of 3.37 births for the same period (2012-2013)in Sindh. The declining trend of fertility in the provincehas been slow due to low contraception, particularly in rural areas, perpetuated by high illiteracy, inadequate determined attention to promote birth spacing and on account of a number of barriers faced by the potential clients including social and cultural pressures.Thecause for tremendous rise in absolute population size during 1990s and 2000s is the outcome of previous high growth rate and this has neutralized most of the past investment in development. The contraceptive prevalence rate for Sindh, however, remained stagnant at 29.5 per cent (with only 24% modern methods) during 2001-2013along with a high discontinuation of contraceptive use particularly for reason of lack of follow up care. The unmet need in the province still remains at 21%, with 11% of women desirous to space and limit their family sizes. The trend of family planning indicators at different points of time based on the survey results present the following picture:

Trend in Family Planning Indicators for Sindh

S. No	Description of indicator	PDHS1990-91 (%)	PRHFPS 2001 (%)	PDHS 2006-07 (%)	PDHS 2012-13 (%)
1	Total Fertility Rate (TFR)	5.1	4.8	4.3	3.9
2	Contraceptive Prevalence Rate (CPR)	12.4	27.6	26.7	29.5
3	Modern Contraceptive Prevalence Rate	9.1	20.2	22.0	24.3
4	Proportion women want no more births	35.8	43.9	48.4	51.2
5	Unmet Need for contraception	23.9	- -	25.4	20.8
6	Percentage with teenage births (≤18)	12.0	8.3	8.3	7.9

There is a realization that family planning services have not kept pace with demand. Even though 96% of the population is aware of at least one method of family planning, the unmet need for contraception in Sindh is still at 21%, with a greater need for spacing future births among younger women (15-29) and those in need for limiting, particularly older women (30-49). As a result, women in Sindh, on average, have one birth in excess of their desired fertility (TFR of 3.9 as against wanted TFR of 3.0). The unmet need for family planning, high level of unwanted pregnancies and large number of induced abortions are a reflection of this situation. These outcomes are largely a result of lack of accessibility and affordable quality family planning information,comprehensive counseling and careorientedservices. Survey reveals that the proportion of women desiring no more births has risen from 36 percent to 51 percent (1990-2013) indicating desire among women to regulate their fertility. The inconsistency between desires to regulate fertility, yetnot availing contraceptive services at the same time, results in unwanted pregnancies or women who seek arecourse to induced abortion. Pakistan Demographic and Health Survey (2006-07) revealed that around 10 per cent women reported experiencing a miscarriage, or an abortion during the five years prior to the survey. This phenomenon when observed in relation with high unmet need, demonstrates the health risks a woman faces during her reproductive life period.

Socio-cultural pressures encourage large families and are a major barrier to family planning. Son preference remains strong and continues to influence reproductive behaviour especially in rural settings, as families favour male children because of labor and old age security because they also carry on the family lineage. Early marriages among girls remain a persistent practice even though average age at marriage has reached 20 in Sindh. High prevalence of adolescent marriages among poor segments of population is noted in several districts which are referred to as 'deprived' districts. Many districts, which have low female literacy or high poverty levels, also have high proportion of women giving birth in teenage. This high risk pregnancy behaviour (around 8% across three Demographic and Health Surveys – 2001-2013) puts health status of women at serious risk. Even though fertility shows a falling trend over the years, a large number of women continuing risky reproductive behavior areprevalent and not acceptable for family health. High risk fertility behaviours need to be addressed through effective communication efforts of advocacy, motivation, counseling and care through easily accessible services**.**

The modern communication technology especially spread of television channels, use of mobile phones, and social media are contributing to gradual modernization and ultimately empowering women to an extent with information to acquire decision-making potential and eventuallyhaving bearing on their fertility. Furthermore, women earning their own livelihood especially in urban areas, have better life chances as they get well-off and better informed to decide about family size and family wellbeing. Recent studies reveal that employment and economic autonomy at times is more important and encompassing than educational attainment in its effects on woman's autonomy.

2.2 Migration

The uniqueness of Sindh population is particularly reflected in its highest urban composition – 49 percent in 1998 (Karachi – a mega city, beside districts Hyderabad and Sukkur as the major urbancentres). The urban population continues to grow unabated because of employment opportunities and concentration of quality education facilities. The proportion of urban population is expected to increase in the coming years mainly by migration from other areas of the country. This has many ramifications - overstretching the existing facilities for social and economic living - and warrants urgent attention for sustained action to ease the situation, which provides relevant context to birth spacing alongside other measures to create separate poles of economic growth to contain the influx of population to the already crowded mega city of Karachi in particular. The mixture of urban population in Sindh, particularly that of Karachi with different socio-economic background and varying needs further compounds the situation and require special focus to reach, motivate and provide family planning services.

Sindh being the most urbanized and industrialized province of Pakistan have more than 50% of the industries, with concentration in Karachi. This is a strong pull factor for internal migration mainly from other provinces. The province faces influx of population from other provinces, urban districts to urban centres, and from the regular rural-to-urban migration in the pursuit of and for better livelihood opportunities. Besides, there is a throng of people (IDPs and flood affected) moving in distress, and further crowding the already densely populated localities. The total internal migration in the country increased from 1.397million in 1951 to 8.369 million in 1998, of which 68% moved within the Sindh province. As a result, squatter settlements in Karachi are estimated to be 6-8 million and that 61% of its population is living in informal settlements and kachiabadies. This situation has brought along numerous problems, with cause and consequences, not only for the socio-economic development, but also affected the social fabric of the society. Its result is visible in the inability to cope with the requirement of basic needs and services, environmental degradation and points to pressing requirements for focused efforts to reach the most vulnerable segment of the population for improved and easy access to all essential services including health and reproductive health care. It is, therefore, crucial that this be considered in the vision for urban planning and factored into the framework of development planning for actionon core issues with understanding and firm determination on a longer time scale to focus on service provision for the vast majority of the vulnerable population who are outside the range and reach of existing facilities for obviousreasons. This gigantic task is to be managed by a special institutional set-up under the Planning and Development Department. This challenge will require resolve, resources and regular research studies as well as to learn from global experience in the management of mega cities around the world.

2.3 Population and development dynamics

Rapid urbanization, technological advancement, progress in female education and employment prospects, proliferation of information through media, and competitive market forces have set and accelerated the process of transformation of social values, life style and raised the aspiration as well as expectation for improved living conditions. The changing age structure and increasing number of young population entering the labour force is further compounding the situation. The demographic and health surveys show that fertility level has significantly declined in urban areas, but remains comparatively high in rural areas, with the overall momentum regressing in the last few years.Withlarger number of married women entering the reproductive cycle of life every yearonlyraisesa query of why and what needs to be done and why that has not been done.

The number of children and fertility remains high among the poor segments of population and that recent statistics reveal that the absolute number of poor has increased dramatically during the decade 2000-2009. At the district level, many districts in Sindh show high level of most deprived population who are low on Human Development Index. The district indices of multiple deprivation for Pakistan 2012 (Research Report 82) reveals that districts Kashmore, Jacobabad, Jamshoro, Tando Muhammad Khan, Umar Kot, Badin, Thatta and Tharparkar of Sindh are in the high level of multiple deprivation. These districts will need special focus in efforts to pull them out of the deprivation status, in order to bring them at par with areas showing progressive trends in the acceptance of birth spacing and for the overall effect on the growth indicators of the province. The increase in poverty is more pronounced in rural areas and has close relation with high fertility especially among the lower strata of the society.

The preceding sections of this document has sketched the perspective and highlighted the population situation in Sindh, growth trends, its effect on the socio-economic development, portrayed the interrelationship between demographic variables and development variables.It reflects that the situation warrants the need for an encompassing population policy with realistic goals and rational targets that provides clear guiding principles and a comprehensive strategy to reinforce the efforts for service provision and support for favourable environment by all stakeholders as a collective endeavour to achieve shared vision of better future for almost all alike.The centrality of family planning in the pursuit for well-being of the people has been highlighted and efforts made thus far reviewed, with emphasis to strengthen and sustained future efforts.

2.4 Population Sector Review

Family planning services in Sindh have been launched since the inceptionof a national endeavour in the 1960s. The services are presently provided by several stakeholders that include: Departments of Population Welfare, and Health, Social Marketing firms, Private Sector Agencies and Non-government organizations. The population welfare programmethatwas launched in the 1960s to address population issues received overwhelming support from the NGOs. Social marketing initiative was launched in the 1980s and maintained its focus on urban centres, while the Health Department through the Lady Health Worker Programme laid the foundation in mid 1990s for doorstep services, but it took another decade to spread the coverage.The network of 22,575 Lady Health Workers and 770 Lady Health Supervisors still covers less than 50 percent of Sindh, to address the issue of access. These workers reach out women in their homes with family planning messages, providing them with effective temporary contraceptive methods, and referring to facilities for long-acting methods.However, the coordination between health and population welfare as critical partners and stakeholders (including civil society) remained weak at all levels. As a result, the program's impact has been limited and inefficiencies in the system resulted in missed opportunities to attract clients for counseling, services and referrals.

The service delivery network of population welfare programme Sindh as it exist consist of 961 static family welfare centres, 72 mobile service units, 70 reproductive health service-A Centers and 5 vasectomy centres, but service network could not achieve the desired effect that had emerged with the introduction of village based family planning workers, who were merged with the LHW programme.Moreover, the combination of the service network has not been worked out scientifically to address the issue of programme coverage and access in relation to the settlement patterns, population density and geographical terrain.A cadre of male mobilizers(1250)wasintroduced in 1998 to improve male involvement, provide accurate information and remove socio-religious misperceptions about family planning methods. The contribution of this cadre, however, remained negligible due to poor selection, inadequate training and weak monitoring. It was thus unsuccessful in bridging the gap in the

prevailing social mobilization, which was much in need, but remained unattended and neglected. The experience of shifting Family Welfare Centres to Basic Health Units/Rural Health Centres did not show any improvement as the Lady Health Visitors (LHVs) posted there did not fulfill their family planning responsibilities, rather the arrangements resulted in duplication of services, which needed attention. Highlights of past program and some additional features of future program are given in Annexure-III.

3. Population Policy Sindh, 2016

The Population Policy - Sindh 2016 drawn in the wake of devolution under the 18thConstitutional Amendment provides a landmark opportunity to Sindh to revisit and reflect upon the population matters for consolidation, reinforcement and expansion through enhanced collective resolvefor mutually beneficial outcome of wellbeing of its population.

3.1 Preamble

The urgent need to pursue family planning on the basis of province-specific population policy became self-evident and the Constitutional (18th Amendment) Act, 2010 facilitated the process. It has empowered the province of Sindh and provided the opportunity to formulate and implement policies, plans, programs and projects in population sector to execute the same as its sole and holistic responsibility. In this context, there is visible broad support of the provincial government to universally promote birth spacing as enduring norm for the health of family. The provincial government has demonstrated its ownership of the population program activities by transferring it on current budget; making budgetary allocation for procurement of contraceptives; and by developing a costed implementation plan (CIP) based on the guidelines of the draft population policy, in order to move into the implementation phase of renewed emphasis on family planning and as part of commitment of FP2020.Furthermore, based on the CIP a family planning training strategy and the communication strategy have also been developed. Prior to those contraceptive manuals were also developed. Thus, a set of these policy documents reinforce the level of preparedness of the population sector in Sindh regarding its strategic role in the post devolution period.

Family Planning products have been made part of Essential Medicine List and form part of the mandate of the health department service outlets. Thus, the Departments of Population Welfare, Health and all other stakeholders have resolved to work closely in promoting and making provision of family planning /reproductive health services through static facilities, outreach interventions and at the community and household levels.

3.2 Basic Principles of Population Policy

The foundation of population policy is based on voluntary character of the pursuit, equity and fairness in the provision of services and the right to information and services with choice of methods to manage the fertility. This policy at the very outset asserts and reaffirms timely completion of fertility transition in the face of emerging demographic realities. It dwells on the unanimous agreement among all stakeholders that 'Every Birth be Safe and Every Pregnancy Wanted'. This approach poses confidence in repositioning family planning within a holistic framework of socio-economic development of the province. It recognizes that fertility decline contributes to improvement in maternal health and child survival. It focuses on the concept of 'Healthy Timing and Spacing of Pregnancies' (HTSP) to revitalize family planning as birth spacing initiative – an approach supported by the religious scholars.

International Commitments and right based approach: Pakistan, by virtue of its international commitments (ICPD, MDG, FP2020 and now SDG 2030), is to end poverty in all its forms and to promote wellbeing in all ages and support reproductive health care including family planning as a fundamental right. It values the rights of women by treating them as individuals and full human beings in their own right as active agents (UNFPA, 2012). As such, it must be ensured that all women and men, who require services, receive it with ease, according to their choice and needs. Equity in access to services has been a major issue which calls for the public sector proactively reaching out to the vulnerable and poorest of the poor through its infrastructure. Pakistan has committed at the London FP Summit in 2012 to achieve universal access to RH and raise CPR to 55 percent by year 2020. Sindh will contribute towards national commitment by increasing its CPR by 45% by the year 2020.In the current post-devolution period, Government of Sindh fully acknowledges the importance of population growth issues and commit to contribute towards the main objective of offering and improving access to birth spacing services through all public and private health facilities. Increased investment in FP,is, therefore, an urgent need to be fulfilled and sustained with visionary understanding to reap the benefit of good health and wellbeing. The opportunity provides hope to rekindle the spirit that Pakistan had attained in late 1990s about fast progress of contraceptive use prevalence.

Political Will and Ownership: The gravity of the issue strongly demands firm political will and effective ownership of family planning by all stakeholders including the Health Department as the main partner to promote birth spacing, support coverage and accessibility, strengthen accountability and governance structure for efficacious results that would also meet various international and national commitments made by Pakistan.

Drivers of Change: The Population Policy 2016 Sindh will focus on three drivers of change:

(i) Sharing the Vision: The Population Policy pursues the vision, from the provincial level down to the district and lower levels for direct and determined action, coordination and collaboration with all stakeholders in promoting the universal concept of family planning for the welfare of the society as a whole. Population Welfare Department will be the prime organization in its lead role to take ownership of the policy, maintain an elaborate management and operational setup, align its implementationatall levels through: technical assistance on policies and guidelines; furnishing inputs on strategic initiatives,; formalizing and strengthening linkages between different tiers of the program to improve the referral system and eliciting support for objective assessment of effect and impact of the programme.

(ii) Informed Decision Making and Feedback Loops: PWD will improve its capacity to conduct operation research and analyze MIS data to inform Planning and mark the progress over time. It will partner with local research institutions in the province to train its staff in conducting exploratory and diagnostic research, with capacity for effective analysis. The policy also guides implementation of a meaningful program monitoring system that will use random follow-up visits to support delivery of its own programs by senior management to keep the field alert and instill realization of importance of the programme.

(iii) Prioritizing Community Needs: For synchronizing behavior change activities and demand creation for service uptake, the policy will emphasize concerted efforts to prioritize community needs in programs and view the community as partners and elicit their views about the services of the programme. The Population Welfare Department after identifying community concernswill provide guidelines to bring together community members, leaders, local health administrators and providers to suggest solutions for bridging the gap.

3.3 Vision

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

3.4 Objectives

- Enhance CPR from 30 % in 2015 to 45% by 2020.

- The policy envisions to achieve thereplacement level fertility i.e. 2.1 births per woman by 2035.
- Achieve universal access to safe and quality reproductive health/family planning services by 2020
- Increase access to family planning and reproductive health services to the most remote and farthest areas of the province by 2017
- Increase efforts to reduce unmet need for family planning from 21 to 14 per cent by 2020
- Attain a decrease in fertility level from 3.9 (2013) to 3.0 births per woman by the year 2020
- Ensure contraceptive commodity security up to 80% for all public sector service outlets by 2018

4. Imperatives for Implementation Mechanism

The strategic institutional framework for implementation of population policy will be reoriented and strengthened around following areas:

4.1 Firm and sustained Political Commitment

The population welfare is a development endeavour based on the recognitionof interrelationships between population variables and development variables. The centrality in the effort toward this cause is grounded in family planning, which is surrounded by deep rooted socio-cultural values and sensitivities. Its legitimacy for action needs the backing of firm and sustained political commitment from the highest level to enhance social acceptability and contribute to strategic planning for implementation of the programme. This will be pursued under the population policy and attained through open public statements, allocation of adequate resources, appointment of competent professional to lead and steer the programme, support the decision to provide adequate administrative set-up at provincial, district and operational levels, undertake periodic review of implementation progress, visit and witness operations at the grassroots level on selective basis to reflect importance and support to the cause. An apex body will be established in the Planning and Development Department for coordination, garner inter-departmental support and carryout watchdog function.In fact, Provincial Population Coordination Committee headed by Chief Secretary that stands notified will be revitalized to particularly focus on the progress against timed-goal and availability of resources/inputs. The Sindh FP2020 Working Group has been notified after due approvalof the Honorable Chief Minister. The Working Group is mandated to provide oversight and strategic guidelines for implementation of the CIP and related policy planning and programmatic issues.

4.2 Multi-Sectoral Approach towards Population and Development

The policy envisions coordinated and a multi-sectoral approach towards growing population issues in which population dynamics, poverty alleviation focused programs, and social development programs synergize to achieve overall goals and objectives of the policy. Achieving demographic dividend is the ultimate outcome and is possible only through active involvement of all key stakeholders and Departments working on female education, status of women, youth development, economic growth and employment generation, addressing regional inequities, conservative attitudes including male preference and young age at marriage, etc. The focus is to mainstream population factor in the development process to make way to achieve the overall vision of the policy. Within the multi-sectoral approach, the Population Welfare Department will steer the family planning efforts in Sindh and impress upon the need for multi-sectoral support to effectively implement the population policy and highlight well considered investment in youth and women to enable the province reap the benefits of demographic dividend. The Health Department being the main pillar of support under the renewed resolve and other stakeholders already mentioned will make significant contribution to advance the cause enunciated in the policy.

Population factor being a powerful universal denominator affects and influences the development, and in turn is influenced by it as well. Its dimensions are wide spread and impinges upon almost all sectors of human endeavor. The goals for improvement in goods and services pursued by various sectors within their set timeframe get affected and neutralized by the population increase phenomena. The efforts to slow down population growth through fertility moderation interventions, therefore, is recognized as central to the pursuit of socio-economic development process. This warrants backing and support by all sectors to facilitate the attainment of their respective goals and object and contribute to enhancing social legitimacy and mass voluntary acceptance of family planning as a collective social responsibility. The Population Welfare Department, as the prime frontal organization will advance, coordinate, collaborate, promote and pursue the family planning subject, but this cannot be achieved alone by the Department. It has to be supported, supplemented and complemented by all as a collective responsibility, in order to approach and deal with the matter from all dimensions and aspects due to its cross-cutting effect on all sectors and touching upon almost all facets of life. Broad features of the role, contribution, support and synergy expected of major key Departments and their affiliated organizations are outlined in Annexure II.

The Provincial Population Coordination Council led by the Chief Executive that already exists will play an active role for enhanced health involvement in the delivery of family planning services. The CC will meet at regular interval to conduct business, which include review of progress, direct efforts for improvement, foster linkages among different sectors for synergy and serve as the arm to support and protect the program in the acquisition of required resources. At the same time, similar committees already established in the district i.e. District Technical Committee (DTC) and District Health Management and Population Team (DHMPT) will be made fully functional to facilitate and support operational activities on the ground.

These committees will have the clients at the centre of their efforts and extend unflinching support to the frontline workers to meet the need and choice of clients for services. The committees will foresee mapping exercise of service delivery points, identify under-served or un-served communities, provide guidance for elimination of duplication, link the under or un-served communities with nearby family planning services, adjust location of the outlets for improved accessibility, enhance the role and scope of family welfare centres to include essential maternal and infant health care along with FP services.

The multi-sectoral approach is the basic premise for the costed implementation plan (CIP). The strategic areas require inter sectoral collaboration. The Sindh FP2020 Working Group includes representatives from different departments i.e. health, population, education, planning & development and finance. Such composition will ensure that the initiatives are implemented in relevant departments for ensuring the family planning contribution in social development.

5.0 Implementation Mechanisms

The Population Policy promotes comprehensive populationdevelopment which requires different initiatives in the sector in collaboration with relevant sectors. The PWD will work to develop required mechanisms. However, for the next five years the costed implementation plan (CIP) provides a road map to work along the sectors on family planning in a manner that it contributes towards overall population development.

The implementation mechanisms include five year plans in accordance with policy objectives. Thus, the CIP is the first five year plan to materialize the population policy. Subsequent five year plans will be prepared accordingly. The CIP was approved by the Honorable Chief Minister Sindh. The Government of Sindh has allocated and released funds against PC 1 of the CIP Phase-I. The CIP document is available on the website of the PWD and FP2020 Secretariat. Following are salient features of the CIP:

5.1 Salient features of Costed Implementation Plan (CIP)

Drawing upon the guidelines from the draft population policy, a robust and exhaustive follow-up exercise of Costed Implementation Plan (CIP) was undertaken by a team of experts based on the advice of political and administrative leadership and with the involvement of key professional staff. This was based on lengthy and repeated consultant process with all stakeholder and development partners and the outcome became to serve as implementation roadmap of the Policy that charts the way forward with comprehensive details and resource requirement for the first five years (2016-2020) of longer term Policy timeframe.The mechanism of CIP is expected to give a kick-start to the policy initiatives through multi-sectoral strategic plan that include interventions needed to realize priority goal of the province, associated cost requirement and comprehensive approach to monitor progress effectively on real time basis

This spelt-out the details, objectives/target to be pursued and output to be achieved based on noted activities and sub-activities, with timeframe, indicators, role and responsibilities by all at different levels and the cost worked out for a five-year time span under six (06) identified strategic areas listed below:

Strategic Areas

The objective of the CIP will be pursued by paying attention to following six Strategic Areas that is backed-up by a detailed Implementation Plan:

Strategic Area 1: Enhancing Strategic Coordination & Oversight between Population and Health Sectors at provincial, district and sub-district levels regarding integrated service delivery through effective Governance and Management

Strategic Area 2: Ensuring quality of services by setting up and adhering to standards; improving provider's skills; and ensuring client satisfaction through the network of public and private health sector,

besides the social marketing interventions and support of NGOs including specific package of assistance by development partners.

Strategic Area 3: Improving and sustaining supply chain management including distribution and availability of contraceptives at all Service Delivery Points (SDPs)

Strategic Area 4: Expanding services with supply and demand side interventions for enhancing access especially to urban slums, peri-urban and rural areas, also by creating space and linkages for public private partnerships to reach the larger segments of the population specifically the vulnerable groups and youth

Strategic Area 5: Increasing awareness and meeting demand for family planning services focusing on MWRA, male and youth through mass media, community level behavior change campaign with focus on sustained and repeated interpersonal communication.

Strategic Area 6: Strengthening health and population systems by streamlining policy planning, governance and stewardship mechanisms; and result-oriented Performance Monitoring and Accountability System

6. Areas of Programmatic Focus

6.1.1Enhancing Access to Family Planning Services

Enhancing access to family planning information and services as the mainstay of the Policy to advance the fertility transition goal. It will be undertaken and promoted as an overall collective social responsibility by all stakeholders. Efforts will be directed to persistently evolve consensus for commitment and support to attain widespread and easily accessible services by extending the same at the household level in the communities in urban areas and villages in rural areas. The services will be made client responsive to meet their need and choice, while adhering to the socio-cultural sensitivities and respecting their sensibilities. It will take cognition of the realities that clients' needs would be different at different point of time in their reproductive life cycle. The choice of contraceptive methods will be broadened to attract new clients and encourage continued use, which have equal impact for fertility moderation objective as against larger number of new acceptors who would use contraception for short duration. The services would be delivered by technically competent providers, who would devote time to maintain regular contact with the clients, listen to their concerns patiently in an environment of trust and confidence with assured follow-up care after initial acceptance of birth spacing. The services will be provided by the network of Population Welfare Department, infrastructure of Health Department, vast community based workforce consisting of lady health workers and community midwives and the Basic Health Units being managed by different organizations(such as PPHI), NGOs and Social Marketing Firms. Postpartum birth spacing programme will be especially targeted by the medical and paramedical staff of RHS Centres in attending to the clients visiting for post-abortion care, as these provide the context and condition of receptivity for counseling and acceptance of birth spacing.

Population Welfare Department will re-orient its network towards fulfilling RH services in addition to establishing direct close links with communities they serve and collaborate with the health staff to undertake mutually supportive activities, as has been demonstrated in selected areas. New protocols, checklists and guidelines will be drawn and functional requirements made available for promotion and

service provision by Technical Committee. The revitalized family welfare centres will be relocated in un-served neighborhoods based on the mapping exercise. The staff will be provided specific refresher on maternal and infant health matters, approaches to undertake social mobilization, ways for working with community, and techniques for effective client counseling. Enhancing and enriching the scope of work of these centres (social mobilization, counseling, etc.) will need additional support, close and intensive supportive supervision to aid and encourage the providers in the real work situation. The clientele attending the family welfare centres is currently low and warrants improvement to be effective service delivery points. To achieve this objective, a number of options will be pursued, which include entrusting some of the centers to local NGOs under Agreement, retraining the family welfare assistants for improved outreach work in the catchments areas, linking the Lady Health Workers and Community Midwives for referral of family planning clients for long acting methods to the nearby centers and placement of some centers/ selective staff in the RHCs or BHUs to attend to prospective family planning clients (including patients attending for post-abortion care) referred by health providers for counseling and service provision. The Health Department will consider inclusion of provision for Post Abortion Care in their service guidelines, protocols and standards for health facilities at all levels.

The population welfare has made heavy investment in establishing Reproductive Health Service Centres across the province. These include Centres located at the district and taluka hospitals, besides the ones managed by NGOs and para-statal organizations. These facilities will work closely with the Gynea-Obgyn Departments to promote family planning especially post-partum methods like IUCDs as earlier cited, for which guidelines will be developed and applied purposefully for conducive working relationship. At the same time number of RHSCentres will be rationalized and adjusted according to need and in view of existing financial situation. Population Welfare Department have the mobile service units, these too need re-orientation about their scope of undertakings and actual work in line with the original charter and also used as reinforcement team to visit and cover underserved areas in districts with low performance and low fertility. To address the fertility transition requirements, the providers will actively offer long-acting reversible methods especially IUCDs and implants.

The need for devotion of time and efforts to motivation and counseling will be impressed on all providers in the public and private sector as a linchpin to acceptance of birth spacing.Post-partum family planning services will be promoted through public and private sector facilities where deliveries are conducted so as to focus on this special group of potential clients for motivation and services– a point made earlier and reiterated for emphasis.

The Policy stresses upon all stakeholders including the private health sector to include and enhance provision of family planning services.This may include accreditation of non-program outlets, consolidation, up-gradation and relocation of outlets by taking those closer to the target population.The thrust of intervention will be directed towards potential clients who have indicated unmet need for family planning for spacing and limiting births. Since these women are halfway through to support birth spacing, but for some reasons were not resorting to any family planning method, they will be targeted by identifying the barriers through interpersonal communication to understand the cause, meet their specific need and choice, and persuade them to adopt contraception for birth spacing. This will make significant contribution to advance the objective of fertility decline.

Enhancing access to services remains the key policy focus to address family planning needs. The Policy looks forward to innovative undertakings by NGOs, private sector, in particular social marketing firms tostep-up support and complement demand generation, encourage motivational work, community

mobilization and contribute in selective service delivery to effectively complement public sector efforts. The social marketing firms mainly concentratedinurban areas, are encouraged to work in priority districts of the province to improve availability of quality services in line with government priorities and programme needs, including deepening their reach in urban slums and in katchiabadies. The Population Welfare Department will provide space and encourage:

(i) investment in family health and family planning by private sector, development partners and philanthropic bodies to target the urban slums and hard to reach communities;
(ii) expansion of networks for family planning services by increasing the number of family planning clinics and reaching out to unreached communities with community based distribution,and where necessary by deploying new workers in the un-covered communities;
(iii) Operations Research activities will search for proven innovative methodologies for service delivery and share with the partners ; and
(iv) Introduction of gender specific career counseling within the framework of existing counseling services.

The Department will especially establish a mechanism of partnership with non-government voluntary organizations; social marketing firms the private and corporate sector, other government departments and the community (civil society bodies) to maximize coverage for improved access to quality services. All these have tremendous experience and obvious potential to reach out to remote households in areas and vicinities where they are engaged in community uplift activities. External assistance would be required for selected public sector operational areas, the INGOs and NGOs framed in an equation that converge with keenness to support and requirement reflected by the program in an agreeable mode backed up by provision of regular review of progress ad utilization.

6.2Quality of Service Delivery

Adherence to quality of service standards will be emphasized and will address major problems faced by women with unmet need for contraception to increase use rate. Standards of quality FP service delivery entail following essential elements:

(i) choice among contraceptive methods; (ii) accurate information on method effectiveness, risks and benefits; (iii) technical competence of providers; (iv) provider–user relationships based on respect for informed choice, privacy and confidentiality; (v) ample supply of contraceptives; (vi) follow-up instructions; and (vii)the appropriate constellation of services.

The Population Welfare Department will be responsible for the development and promotion of quality standards protocols while taking into consideration the *WHO Medical Eligibility Criteria*. Strict adherence of these standards will be pursued to ensure all stakeholders follow service standards and protocols. The adherence is critical in the light of active promotion of long-acting reversible methods.

The primary requirement for improving quality of services is to keep the clients and their need in the fore front. Counseling support will be extended through regular and repeated contact with due care and respect to build confidence so that the clients share their concern and express their requirement in an atmosphere of trust. The provision of services needs to provide broad range of contraceptives to facilitate choice. The services to be dispensed by providers who are familiar with the local conditions and living pattern of the clients. The Department will strengthen the Training Institutions to improve management training, focus on quality of service and Client-Centered trainings. Technical supervision of service delivery is essential and integral to observe that prescribed quality standards and protocols are followed and applied. It has to be supportive in nature, intensive in form and frequent on time to aid

the providers in real work condition. This will be sporadically followed-up by client flow studies and other related instruments to assess quality and satisfaction with the given services. These will be backed-up with trainings and regular refreshers, alongside sustained availability of all essential inputs. All stakeholders providing family planning services will be brought together on a forum to adopt quality of service standards and ensure its strict adoption.

6.3Commodities

Continuous and uninterrupted availability of complete range of contraceptives at affordable price at all facilities is the lifeline of family planning and reproductive health services. An increase in the use of contraception with changing method mix including focus on long-acting methods is envisaged. It is, therefore, anticipated that due to increase in the target population in the coming years, budgetary provision will be ensured and enhanced to meet the need with readily available broad range of contraceptive methods. The supply chain management system that has been reviewed, improved and revitalized encompasses several measures and will be enforced and followed in letter and spirit initiated. For economy in cost and operational efficiency, Integrated Contraceptive Logistic Requirement-6 (CLR-6) is now generated on quarterly basis and fed into a province-wide contraceptive distribution plan for all districts. An effective Logistic Management System will be maintained on a regular basis by incorporating some additional specific measures as cited in Annexure III.

7. Special Areas of Attention

7.1Male involvements

Males remain the prime decision maker in the family setting due to the environment and practices prevalent in the fabric of the society. Their active involvement is, therefore, essential in supporting contraceptive use, birth spacing and family size, and in particular to ensure proper care during delivery to avoid the three delays(which are: delay in decision to avail medical services, delay in taking the client to the medical facility and delay in providing the needed services to the client at the facility) in seeking emergency obstetric support. The male community needs to be made to appreciate and sensitized to their role as household head and responsible fathers about the important and critical role of women in the health of the family and for maintaining the wellbeing of the family unit. Local activists, religious scholars and Ulema will be associated at all levels including at community level for regular communication with male community about the benefit of birth spacing for the family health and respond to their query/ apprehensions and misperceptions in this regard. This initiative has been tried and tested in the field and will be made a regular feature of the intervention for male involvement. Work place counseling sessions and awareness campaign will be actively pursued. Other male frontline workers, male mobilizers and motivators will be encouraged and persuaded to help mobilize male members for their support and for contribution to this cause. Provision for male contraceptive methods and procedures will be strengthened, and the method promoted to register increased acceptance.

7.2Focusing on Youth and Adolescents

The absolute size of youth population(age 15-24) in Sindh Province is estimated around 9.4 million which is expected to increase gradually to 10.1 in 2025 and 10.6 by 2030. The number of school going children would increasefrom10.2 million in 2016 to 11.1millionin 2025 and remain around10.9millionby 2030. Keeping in view the low age at marriage in rural communities and poor segments of population, Population Welfare Department will encourage concerned institutions to take initiative in promoting

delayed marriages and child bearing for the better health of women and the offspring. Similar move would be initiated to support education of adolescents as their reproductive health issues are significant in urban and rural areas. However, thiswill be approached within the acceptable socio-cultural framework of the province and in conductive settings. As such, thePolicy endorses that adolescents and youth may be equipped with knowledge about healthy and happy marital life leading to responsible parenthood. The Population Welfare Department will provide information, education and counseling on population issues and make available services for birth spacingto young married couples to minimize high risk fertility behaviours. Adolescent Counseling and Support Centers will be established to provide necessary guidance and services to adolescents. Pre-marriage counseling modules will also be developed for promotion of this practiceto serve as a voluntary guide for preparation of good parenthood life.

7.3Care of Elderly Population

The proportion of ageing population (aged 65 and above) in Sindh is increasing at unprecedented pace, with 3.8% of the total population at present, expected to increase to 5.6% in 2030, 8.0% in 2040 and would touch 11.2% by 2050. In absolute term, the population is estimated to increase from the current level of 1.8 million to 3.2 million in 2030, 5.2 million in 2040 and 8 million by 2050. This situation is both an opportunity and a challenge. An opportunity for the reason to have been blessed with longevity, wisdom of experience to contribute their usefulness to the society and in shaping the capabilities of younger generations. It is a challenge in the sense that the elderly population need support for income security, health care (against the non-communicable diseases to which they are vulnerable in this advance stage of life cycle) and the enabling environment, which include physical safety , care and respect , social cohesion, easy access to public services and re-energizing community commitment and support. This fast approaching reality needs to be recognized and policy realigned to include all dimensions of care and wellbeing for the elderly population. The population policy will impress upon and emphasize on this cause for support and timely action by all the stakeholders and for improvement of the measures already in vogues, in order to pursue progressive social welfare policies and practices that is inclusive and cover all people through all the life cycles with equity and fairness. There is also an urgent and continued need for research and data collection for analysis and monitoring of the progress on different aspects of lives of the elderly population. The Population Welfare Department will encourage Social Welfare Department to align its future development activities in line with the high growth of elderly population in Sindh.

8.0. Human Resource Development

Training is equated with institutional capacity building and that human resource development is the key to organizational efficiency and effectiveness for the cause of family planning. This is required on continued basis to impart and update knowledge and skill for carrying the assigned responsibility. It has to be adequate and repeated at regular interval for all types of staff and cover various types of areas as operationally required. Human resource capacity building for the programme falls under two broad categories: service delivery, where lies the bulk of programme manpower and those associated with it. This will be catered to by the Regional Training Institutes (RTIs) and the RHS training centers. For the service delivery training particularly through the RTIs, Population Department will support Pakistan Nursing Council in revamping RTIs examination system and strengthen the accreditation process to enable registration of FWW with the body. The RTIs/RHS Training Centres will setup formal linkages with hospitals for practical orientation of trainees especially in PPFP, PPIUCD and implants. The RTIs have also introduced e-learning courses – a facility that will be share and made available to the staff of department of Health as well. Some more specifics about this training are covered in Annexure-III.

Family Planning Training Strategy for Sindh(2016-2020)

A separate training strategy 'Pre and In service Family Planning Training Strategy for Sindh (2016-20) is being prepared by Population Welfare Department Sindh. The objectives of strategy are firmed as under:

Pre-Service: To include family planning components by revising existing curricula so that each related category of staff gets theoretical and practical training on method mix; counseling; rights based approach and communication skills

In-Service: Building upon per-service training and induction training, develop an integrated training mechanism that enhances skills based on standardized curricula in continuation of pre-service training. The training would maintain balance between theoretical and practical components; would include method mix; counseling; right based approach and communication skills etc.

Overall:

1. To enhance competency based skills through pre-service, in service trainingsto deliver quality services on equitable basis with rights based approach
2. To standardize the curriculum at pre and in-service stages within public and private sectors
3. To undertake impact assessment of trainings; conduct TNA based on findings of the impact assessment; and translate those results into Annual Training Plans
4. To strengthen monitoring, evaluation, supportive supervision and feedback mechanisms so that intended outcomes of trainings are ensured

9. Advocacy, IEC and IPC

Advocacy is aimed at the highest political and management hierarchy, policy makers, planners, community influencers and the public at large to trigger discussions on family health and population issues with respect to development goals.Advocacy campaign will be undertaken through various media channels to build, improve and support family planning and that inter-personal communication will be pursued as part of persuasive behavioral change efforts in the communities. Mass media and special events will be organized to invite attention and highlight the population growth issue as it has widespread reach, enables to transmit information quickly, reaches massive audience and can be repeated with the least of time. It is most appropriate and suitable for the province considering the vast proportion of urban population, particularly the concentration in the mega city of Karachi. However, the campaign has to be of high quality with appealing messages to attract and hold attention of the audience and evoke strong emotional response for enabling environment to adopt birth spacing norm as part of normal living. It is a time taking efforts due to long gestation period to produce results, but has to be sustained and repeated to bear effect and maintain/retain visibility of the programme.

The promotional campaign will focus on family planning, maternal and child health by drawing attention on the theme of HSTP, male involvement to recognize their role and support to family health, women empowerment through acceleration of education and increased employment opportunities, encourage spousal communication as brought out in surveys, awareness of youth towards their responsibilities as future leaders and different dimensions of topics relating to development variables

(such as urban population problem, environment, climate change, water and energy problem) as motivating factors in the context of birth spacing. To advance this component, creative talents in the public sector will be lobbied by reaching media decision makers, writers, producers, broadcasters, anchor person and editors for support including public service messages, placing inserts in on-going programmesinserting crispy and sharp tips in the entertainment-education programmes.The concept of Healthy Timing and Spacing of Pregnancies that has taken firm roots in Pakistan is a basis to move away from family size to maternal and child health related interventions. Its theme and advantages will be promoted on mass media as already mentioned, while the operational features and benefits will be elaborated in training sessions with providers and in the communities to emphasize family well-being through birth spacing.The advocacy/IEC campaign will be complemented and followed-up by interpersonal communication (IPC) through the network of frontline workers of population welfare and health departments, and massive community based workers. This will also be emphasized among other stakeholders including community organizations of rural support programme for the inherent importance of behavioural change. The IPC is crucial for a behavior change programme like family planning as it enables to address individual concerns, provides quick feedback and in-depth understanding to focus on individual needs and choice for services. The workforce will be given informatoryrefreshertraining and closely supervised to observe and support the actual performance.Some specific details particularly related to radio programme are given in Annexure III.

10.0 Role of NGOs, Civil Society, Private Sector and Public-Private Partnership

The population sector fully recognizes that the 'population development' is a shared responsibility where civil society, NGOs, INGOs and the private sector have to play their role so that publicpolicy objectives are achieved. Historically, development sector has been playing its role in provision of family planning services and creating awareness among the communities. There is need to streamline this role in terms of avoidingoverlaps, duplication and working in isolation. The NGOs role can be maximizedwith regard to community awareness. There is need to flourish the successful models like social marketing and encouraging private sector for provision of services as part of their social corporate responsibility (vouchers for poorest of the poor etc.). The role of philanthropywould also be taken into account. A recent policy instrument regarding streamlining the role of development sector and private sector has been the CIP that provides a framework for the next five years to work closely with this sector.

11.0Monitoring, Research & Evaluation

The programme will specifically adopt result based monitoring (RBM) mechanism, to ensure that processes and outputs contribute towards achievement of clearly stated programmatic objectives and integrate lessons learned into decision-making. Every component will clearly spell out its intended results which will enable toassessagainstthe outcomes. This approach will shift the focus of monitoring from outputs (number of contraceptives distributed, number of clients contacted and recruited), to outcomes (proportion of clients contacted, contraceptive prevalence rate, etc.). Putting emphasis on outcomes is important for engaging stakeholders and for building partnership to achieve shared objectives. This will facilitate to oversee the nature and quality of population sector activities by various stakeholders and add to investment efficiency, with desired effectiveness.

The focus of monitoring will be to compile district profiles, mapping of catchment areas, validation of clients, collate and analyze data for programme review and further necessary action. The data compilation will include community need assessments, sample studies and client satisfaction surveys and rapid assessment exercises for regular independent information, in addition to data from programme management information system. Two-way flow of information based on these measures

would be adopted to improve services. The monitoring will essentially include properly structured perceptions of the beneficiaries.This has been further elaborated with details in the Costed Implementation Plan (CIP) reflected as Annex-III.

Supervision is important and necessary to observe the extent to which staff actually carryout the assigned tasks with commitment, regularity, and adhere to the prescribed quality standards and protocols. Supervision will be frequent and of supportive type, focusing on the clients and frontline workers. It will serve the purpose of unobtrusive observation, contribute to guidance and support in normal work for improvement. The supervisory role will reinforce motivation, ensure application of acquired knowledge and skill in the real work and that enhanced contacts between the supervisors and workforce is expected to contribute to effectiveness. The supervisors will be appropriately trained and provided with necessary facilities including facilitation of mobility to undertake specified supervisory responsibilities. It will include announced and surprise visits to facilities, plus to the sites in the field and communities to follow the work schedules of grassroots workers.

All organizations will maintain functionally useful Management Information System to facilitate decision-making and gauge advancement and progress towards the stated goal and objectives. Monitoring is an essential instrument that review progress and share status upward and downward in the organizational stream. Monitoring is done initially by reviewing performance reports and followed-up in the field to validate the reported achievements. It is important for programming and making adjustments in the implementation. It is selective, yet effective by covering important and decisive elements of the process and end results of the efforts. The monitoring of population welfare will be enriched and amplified by a number of initiatives including exit interviews, simulated client/mystery clients approach and tracking individual clients in the field. This will primarily be an in-house endeavour, entrusted to qualified and competent staff, who are capable of undertaking the monitoring on qualitative and quantitative aspects of the programme, conduct analysis and make objective presentations for discussion and informed decision-making.

11.1Research

Research is important to expand the knowledge base about newer process and approaches to address population and development issues and better understand the inter-relationships of cause and effect over time as well as test and try new approaches particularly for assessing quality of services within the socio-cultural conditions. Operations research in particular concerned with strategic ways for improvingprogramme implementation, will note high impact practices understand micro-level determinants affecting and influencing fertility and improvement that can be brought about in service delivery. Demonstration projects and/or pilot studies that provide empirical evidence of viability to generalize positive findings for upscaling and replications will be pursued. The Research Section will be the focal point for management and coordination of this activity. Survey unit under Research Section is to be established on a priority basis.

Innovative techniques of data gathering and analysis including mobile assisted data and dissemination will be pilot tested and feasibility for scale-up undertaken. Furthermore, Citizen Report Card, and Community Scorecards, performance monitoring through innovative technologies and e-governance models will be tested to assess the benefits towards social accountability for improving efficiency and overall contribution to programme objectives. Scale up of innovations, however, will be weighed against gains to the programme.

ThePopulation Welfare Department Sindh will establish a regular forum to identify research agenda and to review research findings regarding RH/FP to understand the ground situation on continued basis and translate relevant findings for action to improve programmeimplementation. The forum will bring together researchers and planners especially from the field to develop their interest and analytical capacities for understanding, analyzing and interpreting research outcomes to link the same with implementation process. Higher education and training in research methodology and data analysis, and interaction among researchers will be encouraged to promote understanding of the policy makers, academicians, researchers, and programme managers including policy implementation process and assessment of progress. Education in demography, population, development economics, etc., will be encouraged and supported among young professionals. Capacity of existing staff will be built to conduct studies or Bureau of Statistics or Institute of Federal Government like NIPS will also be associated in research programme.

11.2 Evaluation

Evaluation is the final process of assessing the effect and impact of the programme to draw comparison of the extent to which the stated goal and objectives have been achieved. It facilitates to weigh the effectiveness of program for continuation, programming for the future and what improvements are required and where the thrust needs to be directed. Evaluation will be undertaken through formal reviews based on the service statistics, monitoring input, duly supported outcomes of focus group discussions, facility level surveys and district surveys to be undertaken on an annual basis as ongoing activity built into the operational system of the programme. This will be followed by provincial level Demographic and Health Survey after every Five-Year Plan, which will contribute to assess and evaluate programme achievements to chart course for the future. The evaluation will essentially be entrusted to external competent research organizations in the public and private sector. A comprehensive result oriented framework for M&E with pro-active approach has been chartered in the CIP and reflected in one of its strategic areas which deal with core and process indicators.

12.0Result-Oriented Governance

The Department will specifically promote voluntary acceptance of family planning by persuasion and by providing the means for contraception through its own service delivery network of family welfare centers, reproductive health service centres and mobile service units, with the district set-up as the core operating tier managing the work in the field.

Strategic direction and functional enhancement will be ensured and that all positions for management and service delivery will be filled-up on the basis of merit and placement made as per need to improve coverage and easy access to services by adhering to the laid down standard operating procedures, with all inputs made available for efficient and effective functioning. The staff will be provided regular training and refreshers in key areas to improve output, with ultimate focus on the client, service providers and their immediate supervisors. Co-ordination and collaboration with all stakeholders will be enhanced to harness their potential through mutually supportive space and operational framework. This will be especially pursued at the district level by strengthening District Technical Committees and provincial office monitoring their performance on a regular basis. The programme will be backed-up by an effective and sustained promotional campaign.

The Department will maintain an effective management information system (MIS) for evidence -based decision making and for vigorous oversight functions, with quick feedback mechanism to the field formulation. Real time assessment of performance will be reinforced by applying latest information technology such as mobile applications. Accountability checks will be built into the programme matrix through independent assessment and social accountability system with feedback from the beneficiaries.This is emphasized as performance management and accountability (PMA) in the CIP to be mainstay of institutional arrangements. The department will conduct regular quarterly review sessions to gauge the progress and implementation wherein partner organizations will be invited to brief about their efforts and contributions. An annual formal performance review at the highest level of the province will be a regular feature to assess achievement against the goal and objective for further guidance, improvement in implementation and expansion based on careful analysis of need. Nonetheless, the need for multi-sectoral support is underscored as an over-arching requirement for progress in this mutually beneficial pursuit.

13.0Outlays forImplementation of Policy and Programme

The programmes, projects and schemes focusing on the goals and objectives of the Population Policy 2016, and indeed all efforts to achieve replacement level fertility by 2035, will requireadequateand incremental fundingfrom the very initial five years plan phase in view of its critical importance to sustainable development for Sindh covering salary and non-salary cost plus provision for contraceptive procurement.Thepolicy followed-up exhaustive CIPexercise has worked-out and projected an ambitious financial requirementforthe initial five-year period(2016-2020). This may be seen and understood as explained in Annexure IV for assumption and logic to enable appreciate the parameters applied in drawing-up the projections and the conditionality of 'proviso' attached therewith. Beside, these will facilitate comparison of resource allocation process and system applied in funding commitment for public sector development programme.

ANNEXURE- I

DemographicProjectionsforSindh

In the absence of good statistics on in-migration to Sindh for the recent years, the population growth of Sindh is projected subject to the future course of fertility decline. Sindh's population growth can take three different settings and are based on three assumptions: the high variant assumes slow pace of fertility decline that results in rapid growth of population; the medium variant assumes moderate decline in fertility, and results in moderate increase in population; and lastly, slow variant which predicts relatively faster decline in fertility and a much slower increase in population. This exercise is undertaken to keep-up with the conventions and provide a choice to policymakers and planners to make a decision for an appropriate course of action that is sustained on the horizon of time to bear results. The medium and low variant reliance is developed on expected developments in the field of education and health together that would encourage signs of a higher proportion of women wanting no more children and substantially resorting to voluntary birth spacing. These desires are expected to be further strengthened with increase in education and improvement in health indicators.

Based on recent past fertility declining trends (PDHS 2006-07 and 2012-13) three distinct sets of projections are prepared (see Table 1 below). Moderate decline course envisions firm focus and decline in unwanted pregnancies as against allowing fertility decline on a natural slow course. The objective of these scenario is to present the momentum and speed, and the year when fertility replacement level (TFR=2.1) could be reached. Some small and consistent changes in the courses of fertility decline during the coming years will show major results in the size, structure, and distribution of population.

Table: 1 Change in TFR and Projected Population of Sindh for Three Scenarios[1]

	2011	2015	2020	2025	2030
Scenario I: High Variant (Slow decline) Total Fertility Rate	3.8	3.7	3.5	3.2	3.0
Projected Population(in millions)	42.2	46.0	51.1	56.4	61.7
Scenario II: Medium Variant (Moderate decline) TFR	3.8	3.5	3.0	2.6	2.3
Projected Population(in millions)	42.1	45.8	50.3	54.6	58.2
Scenario III: Slow Variant (Rapid decline) Tot Fertility Rate	3.8	3.3	2.7	2.1	2.06
Projected Population(in millions)	42.1	45.7	49.8	53.3	56.5

The population of Sindhisprojected to touch 61.7million by 2030 and 80.8 million by 2050, if the current slow course of decline is continued and replacement level fertility reaching in 2050. Adopting a moderate course, Sindh's population will touch 58 million by 2030, which means around 4million fewer population by 2030 (relative to slow decline), and 8 million fewer people by 2050, when the population is expected to reach 73.4million. However, with concerted efforts and measures to lower the growth rate (slow variant or a rapid decline in fertility) population would reach 57 million in 2030 and 66million by 2050. However, the level of effort will determine the extent to which Sindh's population is contained (see Figure-1 below). The moderate course for population change emphasizes the need to focus on it as a dominant factor affecting and influencing socio-economic development goal and progress of the province. The measures taken to reach replacement level fertility (2.1 by 2035) will address unwanted pregnancies and lower desired family size with focus on behavior change communications (moderate scenario).The possibility of realizing 'Slow Variant' is remote, thus not discussed.

[1] See Table below for detailed assumptions

The slowing of population growth and improving life expectancy in Sindh (moderate scenario) is expected to bring along fresh changes in age structure and giving way to new demographic trends over the next several years, including: proportion of school age children, youth, labour force, married women of reproductive age, and elder population.School age children (aged 5-14)represent about a fifth (23.5 per cent) of Sindh's population (Table A1). The current number of these children (10 million) will rise to 10.8million (by 2020) and continue to maintain the size by 2031 before leveling off and gradually falling in the subsequent years. These children need to be educated and properly nourished to become good productive citizens. Absolute number of youth population (age 15-24) is at 9.42million (20.2 percent of total population 2016) will rise to 9.63million in 2020 and 10.09 million by 2025 (18.5 percent of total population). The proportion and number of population in labour force (ages 18-60 years) will continue to grow over the years from current 24million (52 percent of total population) to 28million (in 2020 – 56 percent) and onwards to 34million in 2030 (60 percent of total population). The labour force will continue rising to 44 million by 2050. Youth of today and tomorrow is better educated than yesteryears, more conscious about political and personal matters, and have greater expectations from the state and society.Sindhneeds to recognize these potential trends and take necessary measures (invest in education and skill training) to produce skilled manpower for enhanced productivity. In order to reapthe*'demographic dividend'* during the period of transition to a low population growth regime of 2030s, educated and skilled labour force is essential, otherwise the population in productive age groups may not fully meet growing demands.

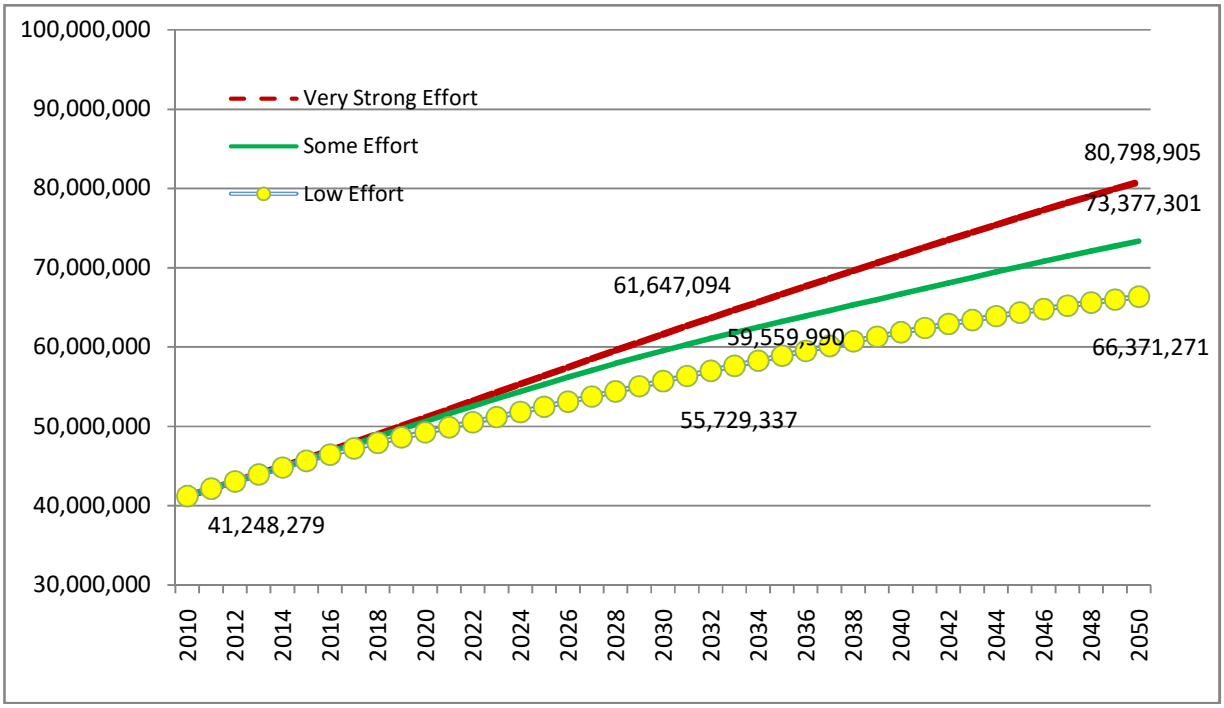
Assumptions for Population Projections, Sindh

High Variant (Low Effort and Progress)						
	2011	2020	2025	2030	2035	2050
Total Fertility Rate	3.9	3.5	3.2	3.0	2.8	2.1
Population Growth Rate	2.2	2.1	1.9	1.7	1.5	1.0
Life Expectation (M)	64.3	67.3	69.1	70.8	72.5	77.6
Life Expectation (F)	64.4	67.8	69.9	71.8	73.8	79.8
Sex Ratio	111.0	109.6	108.9	108.3	107.7	106.1
Medium Variant (Moderate Effort and Progress)						
Total Fertility Rate	3.8	3.2	2.8	2.5	2.10	1.9
Population Growth Rate	2.13	1.9	1.64	1.35	1.09	0.84
Life Expectation (M)	64.3	67.3	69.1	70.8	72.5	77.6
Life Expectation (F)	64.4	67.8	69.9	71.8	73.8	79.8
Sex Ratio	111.0	109.6	109	108.4	107.8	106.2
Low Variant (Very Strong Effort and Fast Progress)						
Total Fertility Rate	3.8	2.7	2.1	2.06	2.02	1.9
Population Growth Rate	2.1	1.6	1.18	1.13	1.07	0.67
Life Expectation (M)	64.3	67.3	69.1	70.8	72.5	77.6
Life Expectation (F)	64.4	67.8	69.9	71.8	73.8	79.8
Sex Ratio	111.0	109.7	109.1	108.5	107.9	106.2

Elder population in Sindh (age 65 and above) is expected to increase rapidly in the coming years. Sindh has currently an estimated 1.5 million elder population (3.7 percent), and is expected to increase to around 3 million (6.0 percent) by 2030, 5 million (8.3 percent) by 2040 and touch 8 million size (11.8 percent) by 2050. By turn of the current decade, Sindh should prepare itself for chronic diseases and

epidemiological changes starting with care for the elder population. The demographic change (small family units) along-with emerging disease pattern is expected to place enormous burden of care of this segment. These changes need to be acknowledged and foreseen to evolve policy with necessary social support, and health set-up required to address emerging issues of this segment of population.

Figure 1: Total Population Projections for three variants - Sindh



Low level of effort = Attaining TFR 2.1 by 2050 | ConsistentEffort = Attaining TFR 2.1 by 2035

Very Strong Effort = Attaining TFR 2.1 by 2025

Table A-1: **Projection Summary for Sindh's Population - 2010-50**

Based on Medium Variant (TFR 2.1 by 2035)

Year	Total Population	School going Children (Age 5-14)	Children age 5-24	Youth Population age 15-29 years	# of WRA 15-49 years	Labor force age 18-60
2010	41,248,279	9,701,543	18,323,885	12,084,662	10,154,257	21,326,783
2011	42,145,314	9,793,356	18,601,052	12,365,269	10,443,245	22,009,862
2012	43,056,133	9,885,115	18,859,702	12,628,366	10,726,325	22,694,369
2013	43,979,959	9,975,998	19,096,856	12,874,543	11,003,514	23,372,177
2014	44,914,996	10,063,902	19,308,600	13,105,695	11,275,460	24,040,439
2015	45,859,476	10,147,987	19,493,908	13,323,401	11,542,837	24,700,387
2016	46,811,370	10,254,137	19,678,364	13,529,861	11,806,115	25,352,827
2017	47,768,635	10,369,530	19,852,568	13,725,228	12,065,483	25,999,980
2018	48,729,022	10,493,200	20,023,404	13,906,396	12,320,946	26,643,695
2019	49,689,976	10,623,795	20,200,379	14,069,470	12,572,632	27,284,826
2020	50,648,678	10,758,582	20,389,603	14,213,247	12,821,155	27,923,440
2021	51,602,504	10,866,972	20,591,597	14,364,996	13,081,931	28,559,371
2022	52,548,648	10,984,708	20,802,906	14,490,045	13,335,164	29,192,624
2023	53,484,465	11,109,442	21,020,345	14,596,342	13,581,150	29,823,961
2024	54,407,300	11,238,307	21,239,009	14,694,786	13,820,415	30,481,720
2025	55,314,580	11,367,343	21,454,089	14,794,343	14,053,780	31,127,958
2026	56,204,776	11,466,948	21,661,632	14,924,167	14,304,259	31,762,431
2027	57,076,582	11,546,656	21,858,468	15,070,424	14,555,330	32,385,319
2028	57,927,578	11,604,652	22,041,812	15,231,162	14,806,565	32,997,444
2029	58,755,829	11,639,206	22,208,580	15,402,898	15,057,380	33,624,907
2030	59,559,990	11,649,219	22,354,962	15,581,916	15,306,848	34,254,680
2031	60,340,518	11,635,365	22,451,197	15,765,195	15,553,874	34,885,331
2032	61,098,271	11,598,330	22,533,514	15,950,420	15,797,256	35,515,467
2033	61,832,788	11,538,030	22,599,487	16,135,384	16,035,624	36,143,415
2034	62,543,657	11,455,188	22,646,975	16,317,311	16,267,397	36,767,508
2035	63,230,414	11,351,217	22,673,434	16,492,407	16,490,868	37,386,209
2036	63,919,510	11,229,417	22,652,724	16,629,468	16,705,215	37,997,626
2037	64,610,801	11,093,474	22,598,021	16,763,117	16,908,957	38,599,201
2038	65,304,231	10,945,634	22,509,771	16,890,467	17,098,968	39,187,788
2039	65,999,362	10,788,199	22,388,517	17,008,325	17,271,387	39,760,208
2040	66,696,095	10,623,464	22,235,453	17,112,733	17,423,554	40,313,483
2041	67,392,667	10,478,786	22,078,603	17,175,817	17,554,130	40,844,683
2042	68,087,143	10,355,453	21,919,929	17,208,550	17,664,194	41,350,815
2043	68,778,047	10,255,806	21,761,645	17,209,517	17,756,808	41,828,478
2044	69,463,986	10,181,649	21,606,267	17,177,985	17,836,672	42,275,964
2045	70,143,688	10,134,150	21,456,367	17,114,262	17,907,272	42,691,503
2046	70,815,104	10,111,120	21,313,046	17,020,798	17,970,106	43,072,402
2047	71,475,798	10,109,670	21,177,082	16,900,427	18,024,882	43,417,875
2048	72,124,121	10,128,997	21,049,921	16,754,872	18,071,187	43,726,410
2049	72,758,549	10,168,224	20,933,027	16,586,205	18,107,993	43,995,670
2050	73,377,301	10,226,527	20,827,859	16,396,694	18,134,251	44,222,634

ANNEXURE - II

Role of Different Departments in Carrying Forward Population Policy

Population Welfare Department

Population Welfare Department will be the prime frontal organization responsible for the management, coordination and collaboration relating to family planning and will maintain an elaborate implementation set-up for management and field operations in the province. Major specific functions are to:

a) Serve as the Secretariat of the Sindh Population Coordination Council;
b) Develop and articulate operational programs and plans related to population welfare activities;
c) Coordinate with sectoral agencies (governmental and non-governmental) relating to population and development activities at different administrative levels;
d) Ensure that the programs carried-out by different Departments and related agencies comply with the guidelines of the Council;
e) Reorganize the Population Welfare Department to fully address the Policy Vision and Objectives.
f) Monitor population activities, organize regular review sessions and evaluate the processes, outputs, outcomes and impact;
g) Promote and disseminate policy-oriented research programmes on population and development;
h) Establish multi-sector technical committees and special task forces as required to assist in the effective implementation of the Policy;
i) Work closely with Planning and Development, and Finance Departments to meet growing finance requirements.
j) Organize and conduct provincial level events (conferences, symposia, seminars, etc.) on population and development issues;
k) Ensure that inter-sectoral programs relating to population activities are effectively coordinated by instituting a sound information exchange system;
l) Facilitate the effective operation of existing family planning service delivery institutions;
m) Facilitate conditions that will promote the creation of domestic capacity for the production and distribution of materials and equipment to increase people's access to population and development information.
n) Establish effective working relationships with international agencies for the purpose of facilitation and acquisition of technical and material resources needed and useful for the programme;
o) Ensure smooth functioning of existing demographic data mobilization systems and supporting new ones including the vital registration systems like births, marriages, and deaths.
p) Encourage and strengthen capacity for demographic and population related research and problems by mobilizing internal and external resources;
q) Encourage and strengthen capacity for training demographic personnel by facilitating the mobilization of technical material and financial resources.

Department of Health

The Department of Health will be the main pillar of support to PWD based on the renewed emphasis to reposition family planning as health intervention in its programmes. It will contribute to the delivery of family planning services through the vast network manned by doctors and paramedics including the large scale community based workforce, and that with contraceptives provision included in the essential medicine list (EML) as part of primary health care. Major specific functions include:

a) Strengthen MNCH Programs by training of staff including the CMWs and make provision for family planning services
b) Make FP services mandatory at all levels of the health service delivery facilities including those under PPHI- a point reiterate for emphasis
c) Implement standards for the provision of family planning services including stock record
d) Coordinate and collaborate with Population Welfare Department in expanding coverage and avoidance of duplication
e) Strengthen reproductive health content in health teaching, training and education programmes
f) Strengthen and expand training of health personnel in collaboration with relevant institutions
g) Share contraceptive performance data for progress review and compilation of overall family planning performance report on regular basis and participate in review sessions.
h) Advise private health providers/hospital/clinics and the civil society organization registered with Health to include family planning in their services.

Department of Education (Primary, Secondary and Higher)

The DepartmentofEducation, in line with its policy and plan, will increase focus on education to accelerate overall literacy rate, with greater emphasis on female education. Some specific functions are as under:

a) Enhance investment in education especially for girls and in deprived regions.
b) Introduce population issues and family life education in curricula of secondary schools and in the higher institutions of learning, as permissible under local conditions and accord weight to include questions on population in the examination system.
c) Expand population and family life education and assist in basic training of IEC through the Teacher Training Programmes and academic institutions and raise the subject in Parents-Teachers association meeting geared to spread information about care and essentials for quality of life.
d) Encourage and support Universities to introduce courses on population dynamics, interrelationships of population and development and give weightage in thesis writing and assessment system
e) Undertake regular study of the factors influencing against female participation in the educational system and design plans and appropriate corrective measures.
f) Provide in-service training on issues related to population and development in collaboration with other agencies
g) Produce trained manpower in demography/population studies for managing various tasks related to implementation of the Population Policy
h) Engage in varied research activities in the field of population and disseminate findings through appropriate media
i) Facilitate in the monitoring and evaluation of programs designed to implement the Population Policy
j) Provide advisory services in data collection, research, analysis and dissemination related activities.

Department of Planning and Development

The Planning and Development Department while pursuing its role for overall development and progress of various sectors in the province is well placed to build and sustain political and administrative support for family planning. It will promote and strengthen effective inter-sectoral linkages for contribution as collective responsibility and undertake periodic reviews to highlight the effect of population variable on the progress and attainment of stated goal of different sectors as well as the CIP for family planning and health. Planning and Development Department will bolster efforts of Departments of Population Welfare and Health the Finance Department for increase in financial allocation according to growing requirements for accelerated efforts. Specific role include the following:

a) Incorporate activities related to the implementation of the Population Policy in the development plan.
b) Strengthen inter-sectoral linkages by extending support at the Coordination Council, during progress review of development sectors and in securing adequate allocation for family planning programme.
c) Encourage and extend technical assistance to sectoral agencies in the integration of demographic variables into the development processes.
d) Develop guidelines for incorporation of these variables at both micro and macro planning levels.
e) Monitor and review development planning activities in various sectors for the purpose of ensuring that the guidelines indicated above are taken into consideration in their respective activities.
f) Facilitate mobilization of external resources for the development and implementation of population programmes
g) Oversee measures taken to address service inequities and creating opportunities for female participation in development work

Women Development Department

The Department will pursue its specific goals and instill understanding about the advantages of women empowerment for family well-being and adulthood responsibilities as future leaders through a whole range of creative interventions and skill development trainings. Some specific function may include:

a) Awareness raising component be included in all projects being undertaken by the Department, plus provision for services wherever feasible
b) Promote birth spacing norm and adolescent health care through various agencies and women associations.
c) Discuss issues about maternal and child care in the context of birth spacing regularly in the meetings
d) Provision and promote joint training programmes at various levels for health, women and child development functionaries.

Information Department

The Information Department may allocate more free public service time in mass media to highlight population related issues and public service messages, subsidize advertisements and promotional programmes. Specifics may include:

a) Enhance visibility and sustain emphasis on population issues through public service messages, news and special event coverage, discussion sessions/panel talks and entertainment -educational programmes

b) Encourage producers, anchor person writers to include tips and crispy anecdote about population issues in the programmes
c) Promote Population Welfare Programme through cultural activities / art exhibitions and at public attracting events.
d) Promote family planning messages through stage dramas and participation of celebrities
e) Highlight population related issues and promote the concept of health and well-being through Arts councils.

Department of Youth and Sports

The Departments of Youth and Sports, while pursuing ITS specific goals instill understanding of adulthood responsibilities as future leaders through a whole range of creative interventions, skill development trainings, exercises and games. Some specific role may include;

a) Establishment of a "Youth Helpline" for counseling of adolescents on their health and reproductive issues
b) Consider initiating life-skills programmes for children and youth in schools
c) Undertake education and communication activities in reproductive rights at school level within cultural sensitivities of the regions.
d) Portrayal of equality of boys and girls for educationthrough all public messages and curricula
e) Encourage researches on the regional scale and depths of youth bulge in Sindh.
f) Devising sectoral strategies to turn youth bulge into a dividend for the Province
g) Run youth-led mass awareness campaigns for promoting family planning in the Province.

Social Welfare Department

The Social Welfare Department will raise awareness, environmental concerns and pre-requisites for healthy living through all its affiliated organizations, projects and activities. The specific contribution will include:

a) Encourage and ensure that all NGOs and welfare organizations registered with the Department include family planning component in their uplift activities for awareness raising and service delivery, wherever feasible.

Religious and Auqaf Department

The Religious and Auqaf Department would contribute to garner support of religious leaders as a whole, and Imam/Khateeb by specifically highlighting the health aspects of birth spacing, mother-offspring care and emphasize breastfeeding as part of natural nourishing and nurturing for healthy development. The specific contribution may include:

a) Coordinate and collaborate with religious associations and bodies for eliciting their support to birth spacing for family health, improvement in maternal health and child survival.
b) Arrange orientations of Imam and Khateeb to include in their JumaKhutabs the subject of mother and child health and that voluntary birth spacing is permissible and refer to various khutbas of religious scholars.
c) Serve as a coordinating and collaborating link with the Population Welfare Department in the promotion of enabling environment to enhance social acceptability of birth spacing at different for a and through mutual consultations.

Department of Labour

The contribution of Department of Labour needs to rest on the premises that health labour is necessary to optimize productivity of good quality and that the imbalance in the population growth is outstripping the capacity to generate the required volume of employment opportunities . This provides the context and relevance to promote birth spacing, and in particular to:

a) Involve labour union leaders in motivating their members regarding birth spacing norms
b) Strengthen FP and RH counseling services in all SESSI health outlets.
c) Include the topic of family health, birth spacing and support of male in the regular talk shows and organized gatherings of labour force.

Industries, Commerce and Investment Department

These establishments provide the forum to organize work place programmes to highlight the population issues, the need for birth spacing and wherefrom the avail services from the nearest place. The specific role may include the following:

a) Encourage industrial units to provide counseling and organize FP services under arrangements for their workers
b) Advise industrial units having well equipped health facilities to provide all services not only to their own employees, with provision for general population living in surrounding areas
c) Develop closer linkages between industrial units and government health facilities to provide FP and RH facilities
d) Coordinate with Chambers of Commerce and Industries to provide FP and RH services among their members

Department of Agriculture

The Department of Agriculture while promoting good farming practices through the extension workers may highlight population awareness and issues relating to land holdings, land fragmentation and the resources required to ensure improved availability, measures required for protection of agriculture land and cover concomitant issues of environment protection, deforestation and water requirement particularly that of safe drinking water. The specific role may include:

- Agriculture Extension Workers, during their interaction in the communities may contribute to awarenessand male involvement of birth spacing practices and their support for family health

XIII Un-specified Departments

The un-specified departmentsand their affiliated organizations not covered for specific role may base their support on the overall population situation visible to the naked eyes. This is seen in the urban crowding and rush for services at health outlets and schools; on energy and water shortages; reduction in land holdings; environmental degradation including deforestation etc. These may be considered in relation to the population issues with special reference to health for better productivity and the need for increased resources to creating infrastructure for greater employment. The Department in the pursuit of improving infrastructure and increased availability of transportation facilities point to the manifestation of population factor reflected in the congestions, crowds and pollution, which in turn demands greater resources for further investment to cope with the requirement of rapidly increasing population.The specifics for individual organizations can be drawn to face to face discussion between PWD and the concerned organization.

ANNEXURE-III

Some aspects of FP in retrospect and specifics of future efforts

The philosophy of family planning was conceived and translated into action in a modest way in the 1960s, but the programme expanded and continued overthe years. The programme did receive political endorsement (with spells of fluctuations and period of neglect too), policy support and specific financial allocations to address the emerging population issues.

Nonetheless, it remained supply-oriented and isolated from client's needs, with infrequent feedback of community perception. It was not engrained into the provincial development framework for support, synergy and holistic review. The programme though vertical in nature was managed by the Provinces including the Sindh Province for planning and implementation purposes. The need to promote family planning through enhanced access and to attain desired fertility levels was based on quality intellectual work and analysis, which resulted in the creation and establishment of a community based infrastructure of village based family planning workers in 1992. It was a significant innovative measure of intensive nature for social mobilization and service delivery at the doorsteps of the people. This service delivery model did produce good results in advancing the family planning objectives. During the same period (1994) the Ministry of Health embarked on another vertical programme in the form of lady health workers as a separate massive endeavor. To avoid duplication and uniformity in service package, the Government transferred and merged the village based family planning workers into the LHWs programme in 2002. This not only resulted in losing the focus on community based access to progress contraceptive services provided by the population welfare programme, but also seriously disrupted the positive trend in the increase of use rate witnessed during 1995-2000 period.

The support from health network for provision of family planning services was modest since it did not receive necessary focus as an essential part of its service mandate. The Department of Health committed to provide family planning services through the Basic Health Units and Rural Health Centres, as a large majority of women access these facilities for maternal and child health services. The de-federalization process of 2001 to district governments and subsequent handing over of all BHUs and Mother and Child Health Centers (MCH Centres) in the province of Sindh except Karachi and Sh. Benazirabad to People's Primary Healthcare Initiative (PPHI), remained deficient in attracting adequate attention to improve clientele commitment. To-date, the tremendous potential of these health facilities network could not extend effective support to the programme to meet the growing demand for family planning. Several missed opportunities have been recorded especially when increasing number of women are going for institutional delivery who could be encouraged to go for postpartum family planning, but no focused efforts were made to motivate them. Moreover, low outreach contact was identified in the DHS as a major barrier to use: one in ten rural women have received any care from a lady health worker in the past 12 months, and of these, only 3% received family planning supplies (PDHS 2012-13). The performance of lady health workers in providing family planning services was found faltering[2].

The claim by both important stakeholders (Health and Population) to be providing family planning services brought in a conflict of duplication and this has always been a major bone of contention between them. They agreed to minimize the duplication, but no concrete step was taken to remove/reduce the duplication. In general, the mix of all sources for service provision reflect a

[2]Third Party Evaluation: Oxford Policy Management, 2009.

comprehensive coverage in urban and rural areas, but information continued to be lacking on specifics about who is covering which area and with what type of services. The persistent high unmet need for contraception and generally accepted adequacy of coverage by the existing network only pointed to a situation that something crucial is not working somewhere, resulting in unwanted pregnancies and continued increase in the absolute population number. Deficiency in availability of services, non-availability and interrupted supplies of contraceptives at service delivery outlets remained as the re-occurring features that were observed, in addition to duplication (in some cases triplication) of services that defy logic and understanding. A quick review of facilities, staff placement and referral system noted several missed opportunities in the provision of family planning. Lack of coordination among stakeholders and absence of one key Department taking a lead role to facilitate, guide and bring together all stakeholders is a major flaw to be addressed and became a need of the time.

The Devolution process supported under the Constitutional 18th Amendment provided this opportunity, but it must also take note of the subsequent serious resource crunch that affect adversely the operational aspects of the programme. The problems need a system approach to reposition and rationalize service provision for family planning as a collective responsibility in Sindh, with foresight and conviction that lower fertility tends to increase survival rate of offspring and contributes to improvement of maternal health. The renewed commitment and emphasis expressed by all stakeholders including the Health during the consultation process of CIP exercise marks a sound beginning. The Department of Health has endorsed family planning as a health intervention as an essential component of MNCH and included contraceptives in the essential service package. Provision of family planning has been made mandatory through all the health outlets, in particular the BHUs and RHCs. The Policy that aims at harnessing the benefits of demographic dividend makes family planning a vital component of the essential health services package and when infused with all embracing spirit, it can contribute to attaining the Goals of International Conference on Population & Development (ICPD 1994), Millennium Development (MDGs 2000) FP2020 objectives and moving ahead towards Sustainable Development Goals 2030, particularly for reducing maternal mortality ratio and achieving universal access to reproductive health care.

The Department of Health has the edge and advantage of vast network of different types of static infrastructure and massive community based workforce consisting of Lady Health Workers, their immediate supervisors and community midwives, and can enhance the contribution significantly for its own cause of health care and for fertility decline too. Notwithstanding the past, it is to be recognized that Health has numerous functions, it is understaffed, encounters heavy load of clients/patients to look after the curative aspects with minimum time left for family planning potential users who require time and effort for counseling, motivation and to administer services. This reality do exist and will remain prevalent, but will be overcome to an extent by having a dedicated staff through additional arrangements or adjustment from within the existing strength by working-out on the options available through mutual resolve by Health and Population Departments. The community based workforce (LHWs and CMWs) of the Health can make-up for the short fall, but needs to be geared to actually interact in the community for counseling, service delivery and referral for clinical methods. The Department of Health will also work closely with Population Welfare to impart IUCD insertion skills to CMWs at the RTIs and ensure regular technical supervision and supplies. Furthermore, the Department will pursue the objective of increasing number of LHWs across Sindh especially in uncovered areas.

Public-Private Partnership

The envisioned Public-Private Partnership initiative though having tremendous potential could not be tapped and the target population that could have been covered remained un-served and insufficiently served. Social marketing has been an active partner in meeting the contraceptive needs of urban, semi-urban and to an extent of rural areas. Availability of family planning services through health outlets of Industrial Units and Corporate Sector remained unexploited. As a result, the delay to attain the goal of universal access to family planning services remains unachieved. The Department is , however, in a position to encourage others to harness their potential through liberal support in spirit and substance to advance the goal of fertility moderation and need to support PWD in this venture.

Nevertheless, mobilizing the private (profit and nonprofit) sector to serve public health goals raises governance issues of contracting, accreditation, regulation, referral, besides the appropriate division of labour between the public and private health providers, but will be addressed carefully on a case-to-case basis. Population Department, with the support of Health will make renewed efforts to facilitate their involvement and evolve a mechanism for regular interaction to review progress, monitor their contribution, exchange experience about the technical and administrative supervision in place to assure quality services. Social marketing already active and making significant contribution, and it is in recent years they have expanded their field work in rural communities by involving private clinics. They are encouraged to enhance their rural clientele, go deeper into the urban areas (slums and katchiabadies). Their contribution will be reviewed and acknowledged, and that a system for regular exchange of experience instituted.

Focus on service delivery training

The Regional Training Institutes and Reproductive Health Training Service Centers of Population Welfare Department are prime institutions to provide skills and competency based training for service delivery in family planning, and will provide pre-service and in-service training to **Programme and non-Programme** service delivery staff. The main features of the strategy impressed in the policy will include:

- Rationalize Regional Training Institutes with enhanced faculty to meet rising demand for training.
- Strengthen the training programme by improving its curriculum, training methodology, and other important aspects relating to requirements. These institutes, beside the training and refreshers for the programme personnel will conduct series of trainings for health staff especially in contraceptive technology, infection prevention, effective counseling, and social mobilization. The RTIs will also establish mobile training units to support on-job training and contribute to promotion of long-acting reversible methods.
- Develop capacity of front line workers by organizing short training courses on 'working with community' and approaches to mobilizing communities about Healthy Timing and Spacing of Pregnancies.
- Evolve comprehensive Training Plan for all RTIs for pre-service and in-service competency based training with particular attention to support all enlisted and interested stakeholders. Basic training of Family Welfare Workers (FWW) for NGOs to be arranged at RTIs with the training cost borne by Department of Health and respective NGOs.
- Supportive Technical Supervision will be given special attention by RHS Centers and RTI staff for technical monitoring and on-the-job observations to serve the twin purpose of observing application of the acquired knowledge and skill in real work and gather evidence for improving

training as well the focus required on refreshers. Transport will be made available through RHS Centres or Mobile Service Units for field visits.

- Crash training programme will be prepared and introduced by the RTIs and the RHS training Centres with content about management of family planning services including contraceptive surgery, motivation and counseling for the staff of Health, NGOs, enlisted Private Hospitals, Nursing Home, Health Set-up of Corporation and for the workplace programme of industrial concerns.
- Population Welfare Department will institute and support regular third party evaluation of RTIs to assess their achievements, improve and reinforce the facility and faculties in line with growing and emerging needs in all important areas of service delivery and its effective management by the programme, the health and other organizations participating in the cause. The CIP has stressed on this area with liberal resource provision and also highlighted the requirement for continued medical education and continued professional development focusing on different dimensions of family planning.

Commodities and Pricing of contraceptives:

This is a vital area of intervention and will be pursued on professional line as already mentioned in the text of policy document and that Provincial Reproductive Health Commodity Security Committee will be established especially to:

- Institutionalize population projections while taking into account changing trends in contraceptive method mix, its consumption and forecast future requirements with the support of qualified professional staff.
- Develop a comprehensive reproductive health commodity security strategy in consultation with all stakeholders
- Review commodity requirement annually for adjustment against consumption volume, pattern, and stock position.
- Manage warehousing, inventory control and proper distribution of contraceptive supplies to district stores/service delivery outlets of population programme, Health, provincial line departments.
- Computerize contraceptive logistics management information system for effective monitoring to ensure full implementation of standard operating procedures of storage and distribution to serve as check against leakage, pilferage and wastage.
- Up-grade warehousing facility, provide logistics support for movement of stocks and ensure availability of adequately trained manpower on the subject of efficient LMIS.

The Departments of Health and Population Welfare will together work with Planning Department for adequate provision of funds to facilitate timely procurement and delivery of contraceptive commodities on long term basis as has been carefully considered on professional lines, worked out, projected and costed in the CIP for an initial five year period. The Provincial Logistics and Procurement Cell will be activated to ensure uninterrupted availability of commodities and work out resource requirements and elicit allocations.

Pricing of Contraceptives

Reproductive health and family planning contraceptive services (birth spacing products) are offered on charge basis since early 1990s by both the public and private sectors in Pakistan. Population Welfare Department charges are nominal and have already established an environment of payment for services,

where as public health sector is reluctant to charge price of contraceptives. Government of Sindh will firm uniform pricing policy for both the departments of Population Welfare and Health and this will review in 2019-20 for future strategy.

Promotional campaign

The promotion of healthy timing and spacing of pregnancy through awareness and motivational campaigns remains a prime focus of the population welfare, as it includes addressing an intimate behavior of couples. Besides, there was a need to resonate the fact that fertility decline would accelerate improvement in maternal and child health. This essential and integral element of the programme could not move beyond just raising awareness and that desired change in attitude and behavior remained a far cry. It needs an intensive and a robust interpersonal communication at community and household level on a sustained basis. Moreover, the campaign maintained an urban focus and that majority of rural population was unable to internalize the message of small family norm due to high inherent demand for large family size and remained caught in the fertility-mortality trap, perpetuated by too early , too many, too close and too late pregnancies. Access to information and quality of counseling remained weak (fears of side effects of contraception were not explained); the service providers, though given trainings on IPC skills, lacked persuasive professional flair to motivate and counsel eligible women for maintaining sustained contact for acceptance of birth spacing and continuation with the usage of the adopted methods. Finally, religious and socio-cultural apprehensions that are deeply rooted into the society in general and about family planning in particular had not been addressed successfully with devotion and consistency. Several hundred religious leaders were oriented on Islamic perspective of family planning but not purposefully utilized to play an influencing role especially among the males.

Healthy Timing and Spacing of Pregnancies that has taken firm roots in Pakistan served as a basis to move away from family size to maternal and child health related intervention has been found receptive with the clergy. Community level initiatives that emphasize family well-being through birth spacing will be encouraged and promoted. Involvement of religious scholars and teachers at community levels will facilitate this process and provide a framework to elicit their support for birth spacing practices – a strategy that has been piloted and tested, with proven advantage. Different professional associations, women organizations, community based organizations (CBOs) and NGOs will be invited to participate in bridging the gap in mobilization and for promotion of birth spacing.

The private sector advertising and communication organizations will be involved and their expertise utilized. It will be ensured that the campaign is carefully designed, audience-specific, issue-focused and research-based with an in-built vigorous evaluation system to assess progress against objective of each communication intervention. Such a programme will be adequately resourced and managed by qualified and experienced professional staff.

The FM radio stations will be brought in and involved to keep the people fully informed regarding birth spacing and responsible parenthood, while due importance will be accorded to video programs as seeing have greater effect as stipulated in the CIP. Regular programs in collaboration with scholars and experts will be aired across Sindh. Family planning messages will be printed free of cost at top of all public sector advertisements as part of ownership and endorsement to the cause of population welfare as a universal theme. Special message services and cable network will be actively pursued to promote

birth spacing as part of public service message and educational tips included in the entertainment programmes.

A separate 'Population Communication Strategy' of Population Welfare department is being drafted, which is prepared on the following principle guidelines:

1. Communication is a process
2. Focus on quality of life and wellness and not just the absence of disease
3. Evidence-based decision making
4. Effective collaboration, coordination and partnership
5. No missed opportunity for integration and promotion of services
6. Gender equity and social inclusion
7. Voices of ordinary people and community participation should be prominent

The strategy focuses on the following areas:

1. Create a consolidated Province-wide communication strategy
2. Synchronize that strategy with local environment and needs. Create district action plans derived from the central strategy.
3. Create a rationalized budget for communication activities with simplified allocation and disbursement procedures.
4. Mount an intensive training program to orient actors at all levels of the "Pathways" system to their role in family planning communication.
5. Pursue partnerships with national, international and local agencies as well as a variety of sectors including public, private and NGO actors.

ANNEXURE-IV

Costed Implementation Plan for family planning

Drawing upon the guidelines from the draft population policy, a robust and exhaustive follow-up exercise of Costed Implementation Plan (CIP) was undertaken by a team of experts based on the advice of political and administrative leadership and with the involvement of key professional staff. This was based on lengthy and repeated consultant process with all stakeholder and development partners and the outcome became to serve as implementation roadmap of the Policy that charts the way forward with comprehensive details and resource requirement for the first five years (2016-2020) of longer term Policy timeframe.The mechanism of CIP is expected to give a kick-start to the policy initiatives through multi-sectoral strategic plan that include interventions needed to realize priority goal of the province, associated cost requirement and comprehensive approach to monitor progress effectively on real time basis

Service delivery figured as the main stay of the programme and important measures for improving overall service delivery was impressed, which included:

- Existing forum will be utilized to bring the stakeholders together to review programme and share goals / objectives for evolving an integrated service delivery to enhance synergy for the overall progress and for their respective institutional cause. Both the Health and Population Departments to play leading role in encouraging and supporting activities for family health to enhance mutually dependent object of health and wellbeing of the populace.
- Inter Departmental Technical Committee will revisit the Standard Operating Procedures (SOPs) / Term of Reference (TORs) for service delivery provision in line with integrated service delivery action plan for initial acceptance, continuation of practice of birth spacing and to maintain longitudinal record of clients once registered as acceptors.
- Mapping all FP facilities in the district both in the public and private sector by type of facility, extent and nature of service facility, and staffing pattern for geographical coverage and easy access.
- Reviewing and reinforcing the role of Social Marketing, private sector and civil society organizations specifically in urban areas, with special emphasis on the mega city of Karachi to ascertain their contributions, geographical coverage and institutionalizing a system for experience sharing and for further enhancing their support to the programme will be introduced. If required, necessary legislation would be considered to provide legal cover for their interventions.
- Spelt-out an elaborate M&E requirement covering the action and process and output indicators, with timeframe and included creation of CIP-oriented units within the existing institutional set-up to enhance priority for watchdog functions.
- Interacted with development partners and local affiliates and listed the role/contribution of each, areas of support/services, assistance committed with timeframe and prospect anticipated of existing commitment

Resource requirement and projection for the financial estimates for the first phase of implementation ending on 2020 were undertaken. This phase takes into account the cost of interventions in the entire public sector and aligned with the Policy goals and objectives. The total cost of routine FP program of PWD; DoH, PPHI and related programs has been estimated at Rupees 141.55 billion over a five-year plan period (2015-2020). This includes Rs. 52.23 billion by the Government of Sindh (Population Welfare Department; Department of Health (including LHWs, MNCH, secondary & tertiary hospitals etc.); PPHI projected allocations for family planning over the next five years; required financing of Rs. 79.12 billion for the Costed Implementation Plan (CIP) to meet FP2020 targets; contraceptive procurement; and development partners support through INGOs/NGOs estimated at Rs. 10.2 billion in family planning. Total funding gap in this projected outlay over the first five years has been estimated to be Rs. 78 billion after the estimated funding by the Government of Sindh worth Rs 890 million. The details are given below:

- **Estimated Cost of Phase I Implementation - CIP (2015-20)**

Stakeholders and CIP	Total Allocations (Projected)
Sindh Government	51,240
Development Partners	10,287
CIP	79,120
Total CIP (government, partners and CIP estimates)- A	**140,647**
Sindh Government	51,240
Development partners	10,287
Allocation by government for CIP	998
Total current allocations: B	**62,525**
Financing Gap (A-B)	**78,122**

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