Birth Spacing/Family Planning
Costed Implementation Plan (CIP)

2018-2022

Table of Contents

List of Tables and Figures

List of Acronyms/Abbreviations

AfDHS	Afghanistan Demographic and Health Survey
ASMO	Afghanistan Social Marketing Organization
AMS	Afghanistan Mortality Survey
BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
BHC	Basic Health Center
BSC	Balanced Score Card
CBPHC	Community–based primary health care
CHC	Comprehensive Health Center
CHW	Community Health Worker
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CS	Contraceptive security
CSO	Central Statistical Organization
DH	District Hospital
DMPA	Depome Droxy Progesterone Acetate
EPHS	Essential Package of Hospital Services
FP	Family Planning
FHAGs	Family Health Action Groups
FHH	Family Health House
FPBS	Family Planning Behavioral Study
GDHR	General Directorate of Human Resource
HMIS	Health Management Information System
HSC	Health Sub-center
IUCD	Intra Uterine Contraceptive Device
KII	Key Informants Interview
LAM	Lactational amenorrhea method
LARCs	Long-Acting Reversible Contraceptives
LRP	Learning Resource Package
MDGs	Millennium Development Goals
MNCH	Maternal, Neonatal and Child Health
MoHRA	Ministry of Haj and Religious Affairs
MoPH	Ministry of Public Health
MSI	Marie Stopes International
NGO	Non-Governmental Organization

PPHD	Provincial Public Health Directorate
PLIS	Pharmaceutical Logistics Information System
PPHO	Provincial Public Health Office
PPPs	Public Private Partnerships
QA	Quality Assurance
RH	Reproductive Health
RHD	Reproductive Health Department
SBCC	Social and Behavior Change Communication
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rates
UNDP	United Nations Development Programme
UNFPA	United Nation Population Fund
WHO	World Health Organization

Foreword

The Government of Afghanistan recognizes that health is a basic human right. It believes in gender equity and equality, reproductive rights, and client cantered reproductive health care. The ministry of public health is committed to implement the right based approach for health, which is well-considered in this FP-CIP.

The MoPH believes that Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to the country highest maternal mortality rate.
Evidence suggests that a woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being. In the meantime family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. The MoPH also understand that Family planning can impact on the population size through enabling women who wish to limit the size of their families to do so.

The government of Afghanistan as outlined in the Global Strategy for Women's and Children's Health commits to adhering to the agreements made in the RMNCAH Strategy (2017-2021) and the Kabul Declaration for Maternal and Child Health (2015).
The MoPH makes efforts to achieve the committed national targets of reducing unmet need for family planning by 10 percent by 2020; and increasing the modern contraceptive prevalence rate to 30 percent by 2020.

The MoPH is committed to promote family planning – and ensuring access to preferred contraceptive methods for women and couples. We believe that is essential to securing the well-being and autonomy of women, while supporting the health and development of communities.

This CIP, which is developed in the light of national RMNCAH strategy will provide the MoPH with tools to assess the FP program progress and guide the MoPH in resource mobilization in the next five years.

Sincerely,

Ferozuddin Feroz, MD, MSc
Minister of Public Health, Afghanistan

I. Introduction

The Ministry of Public health (MoPH) is aiming to increase availability of high quality family planning services and ensure women and men have access to quality family planning services. Similarly, UNFPA Afghanistan supports the Ministry of Public Health to take steps to meet the family-planning needs and to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.

In July 2016 the government of Afghanistan made the commitment to developing a family planning national costed implementation plan (CIP) (2017-2020) as part of its commitments for program and service delivery.[1] This action plan helps to have a concrete, multi-year action plan for achieving the goal(s) of family planning program for Afghanistan.

The CIP is expected to strengthen the foundation for FP programming and service delivery at national and sub-national levels as well as to identify the activities to be implemented and resources needed for achieving the results.

The CIP will help government to achieve its family planning goals through indentifying and implementation of most effective interventions. The CIP will identify interventions and needed resources for key thematic and sub-thematic areas of a family planning program.

The CIP has been developed based on the following general objective and specific objective.

Objective:

To develop a 5-year costed Implementation plan for strengthening the national FP program to achieve its set goals and objectives, through extensive consultation with a range of key stakeholders.

Specific objectives:

1. To identify the most cost-effective and efficient interventions and activities for promoting access and utilization of FP information and services to the couples, especially those with high unmet needs, jointly with key stakeholders.
2. Define approaches, timeline and resource needs to implement these interventions, in an actionable work plan /implementation plan.

Afghanistan's health sector made some progress over the last decade, which translated in substantial decline in infant and child mortality and maternal mortality (1,291 deaths/100,000

[1] FAMILY PLANNING 2020. "COUNTRY ACTION: Opportunities, Challenges, and Priorities Afghanistan." January 2016. Family Planning 2020. 7 July 2017 <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Country_Action_Opportunities-Challenges-and-Priorities_AFGHANISTAN_FINAL.pdf>.

in 2015[2] compared to 1,600 deaths/100,000 in 2002[3]). The concerted efforts have enabled Afghanistan to stay on track in achieving MDGs 4 and 5. However the baseline indicators were extremely poor and until now remain high in regional and global comparison[4].
Despite conflict and poverty, Afghanistan has made reasonable progress in its reproductive, maternal, newborn, and child health indicators over the last decade based on contributions of factors within and outside the health sector. However, equitable access to health care remains a challenge and present delivery models have high transactional costs, affecting sustainability. [5].

Progress in Family Planning Programs

The Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. The knowledge of family planning methods is an important precursor to use. According to AMS 2010, about 91.6 percent of women of 15-49 ages have knowledge about any modern family planning method, but only 20 percent of women reported to use any modern method of family planning[6] suggesting a huge gap between knowledge and practice of family planning methods. Similar figure (19.8 Percent) of family planning use was reported by AfDHS 2015.[7]

Among those women who do use contraception, the most popular method is use of injectables (7 percent) followed by the pill (5 percent). [8,9] As indicated by AfDHS 2015, the contraceptive prevalence rate (CPR) is higher among married women in the urban areas than women in the rural areas (35 percent and 19 percent, respectively).[10]
The highest prevalence of contraception use is observed among married women aged 35-39 (29 percent), compared to 8 percent of married women aged 15-19 years, indicating that the contraceptive prevalence rate (CPR) among married women increases with age. [11]

There has been a marked increase in the use of a contraceptive method among currently married women with the increase more rapid between 2003 and 2006 than in the more recent years. [12] This is while the comparison of figures reported on the modern contraceptive use by AMS-2010 (20 percent) and AfDHS-2015 (19.8 Percent) indicates no improvement in the CPR in the past five years.

---

[2] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[3] Bartlett L., S. Mawji, S. Whitehead, C. Crouse, S. Dalil, D. Lonete, and P. Salama. 2005. "Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999–2002." The Lancet. March 5–11; 365 (9462): 864-70.
[4] World Health Organization (WHO). "country cooperation strategy." http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_afg_en.pdf. 02 12 2015.
[5] N. Akseer, Salehi A., Moazzem-Hossain S., Mashal M., Rasooly M., Bhatti Z., Rizvi A., Bhutta Z. (2016) Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study Lancet Glob Health 2016; 4: e395–413
[6] Ibid.
[7] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[8] Ministry of Public Health . "Afghanistan Mortality Survey." 2010.
[9] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[10] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[11] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[12] Ministry of Public Health . "Afghanistan Mortality Survey." 2010.

II. The CIP Development Process

The development of FP-CIP occurred through a participatory, inclusive, consultative and MoPH -led process. It involved a deep analysis of situation at the national, and regional level. The process was further supported through a series of consultation with individuals and groups of stakeholders. Likewise, meetings and dialogue was held with the MoPH senior officials, United Nations agencies, NGOs and other partners at national and provincial levels.

The CIP has been expected to strengthen the foundation for FP programming and service delivery at national and sub-national levels as well as to identify the interventions/activities to be implemented and resources needed for achieving the results. The CIP is intended to help government to achieve its family planning goals through identifying and implementation of most effective interventions.

The FP- CIP has focused on three key thematic areas of Family planning namely supply, enabling environment and demand/demand generation. These key thematic areas are further broken-down to sub-thematic areas.

The following table shows the key thematic and sub-thematic areas.

Table 1: Family Planning Thematic Areas

#	Key Thematic areas	Sub-thematic areas
1	Supply	- FP Service Delivery Modalities - Facilities providing FP - Skilled human resource providing FP services - Management, Supervision & Monitoring of FP services provision - FP services quality assurance and quality improvement system - FP methods availability - FP service integration with other health services - Referral system for FP methods/ services - Private sector involvement in FP service provision - FP counseling
2	Enabling environment	- FP program leadership and management - Supportive laws, policies, and guidelines for FP - Human and financial resources for FP - Evidence-based decision making for FP programming - Contraceptive security - Advocacy for FP program - Communities engagement in addressing barriers to FP use

		- Gender and social norms role and FP program
3	Demand/ demand creation	- Strategies to reduce cost of FP - Social and behavior change communication (SBCC) strategy (SBCC) strategy for FP - Commercial and social marketing to create demand. - Mass media and the FP methods/services - Communities and champions engagement in SBCC. - Peer education and the FP program

In order to develop the CIP, based on the standard guideline[13]the following three action steps were considered:

a) Situation Analysis
b) Result Formulation
c) Activity Planning

A. Situation analysis

The situation analysis involved the systematic collection, review, and analysis of information and data from various sources on the past and current status of the FP program. The situation analysis was used to generate key information needed to gain an in-depth understanding of the past and current FP program situation. The situation analysis focused on four elements: context analysis, policy analysis, program performance analysis, and stakeholder analysis.

- **Context Analysis:** The context analysis reviewed the demographic, politico-institutional, and socio-cultural context within which the FP program operates. Likewise, during contextual analysis, data on family planning trends, determinants and barriers of use was also reviewed.
- **Policy Analysis:** The policy analysis reviewed and analyzed the FP/RH policies; overall health, development, and relevant non-health sector policies, which have a direct impact on the FP.
- **Program Performance Analysis:** the program performance analysis reviewed how the program, including both public and private sector, was currently performing, to identify strengths and weaknesses of the program.
- **Stakeholder Analysis:** the stakeholder analysis reviewed stakeholders' role and contribution to the national FP program.

[13] Knowledge for Health- familyplanning2020.org/cip. Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans.

Approach of information gathering for situation analysis

a. Desk reviews/Literature review:

A comprehensive desk review/literature review was carried out to obtain evidence based snapshot of the status of FP key variables. The desk review focused to review the available literatures on the key thematic areas of family planning program namely supply, demand and enabling environment.
During the review the relevant national policy, strategy and guidelines on RMNCH/FP were reviewed. Likewise, RMNCH relevant research/data and recommendations from various studies to inform planning and programming was reviewed. In addition review of good family planning practices in region was carried out.
Furthermore, review of budget allocation trends and expenditure for FP programs, as well as working documents on RMNCH was considered during the review.
The desk review provided useful information on the key thematic areas of FP, program priorities, and current efforts on family planning program.

b. Consultative meetings:

The purpose of the consultative meetings was to expand on and supplement information found in the desk review.
A series of consultative meetings were held with key stakeholders in order to initiate a discussion on establishing a common understanding of the issue of FP, and on the process of developing the CIP. This provided a platform for multilateral and open discussions amongst MoPH technical departments, UN agencies, NGOs and other partners. Consultative meetings also discussed the efforts of partners in addressing FP program challenges and possible ways forward. It was understood that the views of stakeholders and partners on possible next steps would be particularly important in formulating the CIP.
During the consultative meetings information was collected on the key thematic areas of family planning program namely Supply, enabling environment and demand/demand generation.

c. Regional consultative workshops

Three regional consultative workshops were held as part of RMNCAH regional review workshop across Afghanistan by the RMNCAH department. In these workshops representatives of provincial public health directorate, BPHS implementer NGOs, regional representatives of UNICEF, WHO, HEMAYAT, UNFPA and other key RMNCAH stakeholders participated.
The consultative workshops were held in three regions including North region, south region and central region with the following breakdown:

#	Region	Province	Participants
1	North	Balkh, Saripul, Juzjan, Samangan.	BPHS implementers, Provincial Public Health Directorate staff Provincial RH officers, Regional representative of UNICEF, WHO, UNFPA
2	South	Kandahar, Helmand, Zabul Urozgan	BPHS implementers, Provincial Public Health Directorate staff Provincial RH officer, Regional representative of UNICEF, WHO, UNFPA
3	Central	Daikundi Bamyan, Kabul, Parwan	BPHS implementers, Provincial Public Health Directorate staff Provincial RH officer, Regional representative of UNICEF, WHO, UNFPA

A completely participatory approach was adopted at these workshops, and all participants interacted freely and voiced their opinions on problem/ shortfalls of FP. The workshops thus provided opportunities for sharing and learning in an open environment, in which participants from diverse categories interacted.

Presentations on the aim of FP-CIP and the process of developing FP-CIP were followed by lively discussion. To optimize efficiency and participation, discussions of potential interventions were held in small groups.

Participants brainstormed about the problem/ shortfalls of FP and the potential interventions on how to address the problem/ shortfalls of in groups around three thematic areas: Supply side, enabling environment and demand/demand generation.

The group work was shared during a plenary session and the outcomes fine-tuned collectively by the rapporteurs and facilitators.

d. National Consultative Workshop

A national consultative workshop on the draft of FP-CIP will be organized by RMNCAH- FP department with technical and financial support from UNFPA.

The aim of the national consultative workshop is to:

- Present the draft of FP-CIP;
- Collect inputs from stakeholders regarding the development, establishment and implementation of the CIP;
- Facilitate knowledge-sharing among stakeholders;
- Validate identified promising interventions.

The CIP draft will be presented to key stakeholders for final review, comments, and implementation planning, to ensure national consultation and involvement.

The workshop will bring together tens of key stakeholders from different sectors, working at provincial, regional and national levels. A completely participatory approach will be adopted

in which all participants interact freely and voice their opinions on the draft of the CIP. The opportunity of small group discussion will enable them to exhaustively discuss the presented potential interventions and propose additional interventions if any. The group work will be shared with all participants during the plenary.
The participants included high-level and senior governmental officials from concerned agencies/departments, UN agencies, NGOs, civil society, media and other partners.

B. Result Formulation

In the process of results formulation, we utilized the obtained information from the situation analysis to identify the strategic interventions and prioritize them in terms of being more effective and efficient interventions. At this stage of CIP development, the goal, expected outcomes, outputs and strategic interventions are defined.
The objectives of the CIP are in line with the objectives of the MoPH and Afghanistan government commitment for FP. The designed strategic interventions/activities are designed in a way to contribute achieving the MoPH objectives for FP.
The reflected interventions in the CIP are: those intervention identified by the RMNCAH strategy 2017-2021; those interventions identified and purposed during the consultative process; and those interventions suggested by the results of new available literatures on FP program.
The process of result formulation has been a participatory process and completed in close consultation and coordination with the MoPH - RMNCH department, National FP working groups and other stakeholders.

C. Activity Planning

Following the completion of result formulation, an implementation plan was developed in the form of matrix.
During the process of developing the activity plan, the required inputs and resources was estimated. The activity planning process will be completed in close consultation and coordination with the FP working group and FP-RMNCAH of the MoPH.
The core components of the implementation plan are the strategic outcomes, the key intervention activities, lead/partner agencies, performance indicators, timeline for implementation and cost.

D. Costing

In order to implement the planned interventions, and ensure the availability of necessary resources, a well estimated cost is considered for each planned intervention.
The costing process was completed in close coordination and consultation with the FP department and FP working group.

III. Situation Analysis

A. Context Analysis

In 2015 Afghanistan was ranked 169 of the 188 countries in the UNDP Human Development Index among the countries with low Human Development.[14] Afghanistan economic growth in 2013 was estimated at 3.6 percent, down sharply from strong growth of 14.4 percent in 2012. After a decade of strong revenue growth, domestic revenues declined to 9.5 percent of GDP in 2013 from 10.3 percent in 2012 and the peak of 11.6 percent in 2011.[15]
Life expectancy at birth has however increased by 5 year (s) over the period of 2000-2012 (from 55 - 60)[16], which could be the result of investment and subsequent improvement in public health. In the country, 35.2 percent of population is living under the national poverty line, while data on the percentage of population living on less than $ 1.9/ day is not available. Meanwhile the evidence shows that the literacy rate among adults age 15 and older is 38.2 percent.[17]
Afghanistan's population is among the fastest growing in the world. The annual rate of population change and growth is 2.03 percent annually. Afghanistan has one of the highest total fertility rates (TFR) higher than 5.3 children per women. Rural fertility is higher than urban fertility in every age group.[18] Sixty three percent of population is under the age of 25 and those between 15 and 24 years of age comprise17 percent of the population. With a projected population of 27.5 million people; 72 percent of whom live in rural areas.[19]

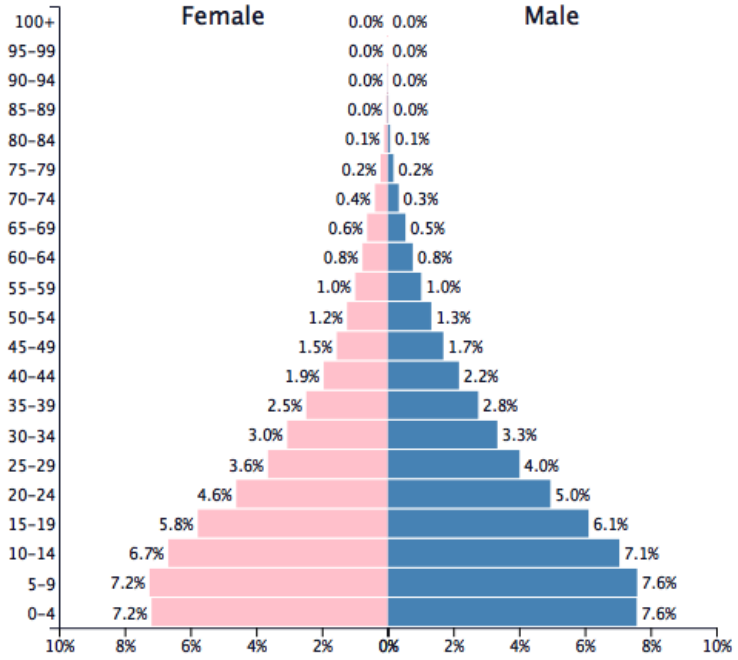
The recent data indicated that the neonatal mortality rate was 22 deaths per 1,000 births; the infant mortality rate was 45; and the under-5 mortality rate was 55 deaths per 1,000 live births. Similarly the data indicated that the Maternal Mortality ration was 1,291 maternal deaths per 100,000 live births. [20]

Afghanistan's health sector made some progress over the last decade, which translated in decline in infant and child mortality and maternal mortality (1,291 deaths/100,000 in 2015[21] compared to 1,600 deaths/100,000 in 2002[22]). The concerted efforts have enabled

[14] United Nation Development Program (UNDP). "Human Development Report ." 2016.
[15] Joya, Omar; Khan, Faruk. 2014. Afghanistan economic update. Afghanistan economic update. Washington DC: World Bank Group. http://documents.worldbank.org/curated/en/2014/04/19425195/afghanistan-economic-update
[16] World Health Organization. (2015, July 30). Afghanistan: WHO statistical profile. Retrieved from World Health Organization: http://www.who.int/gho/countries/afg.pdf?ua=1
[17] United Nation Development Program (UNDP). "Human Development Report ." 2016.
[18] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[19] Central Statistical Organisation (CSO). 2014.
[20] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[21] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[22] Bartlett L., S. Mawji, S. Whitehead, C. Crouse, S. Dalil, D. Lonete, and P. Salama. 2005. "Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999–2002." The Lancet. March 5–11; 365 (9462): 864-70.

Afghanistan to stay on track in achieving MDGs 4 and 5. However the baseline indicators were extremely poor and until now remain high in regional and global comparison[23].

Afghanistan Population Pyramid[24]- 2016



There has been a marked increase in the use of a contraceptive method among currently married women with the increase more rapid between 2003 and 2006 than in the recent years. [25] This is while the comparison of figures reported on the modern contraceptive use by AMS-2010 (20 percent) and AfDHS-2015 (23 Percent) indicates no improvement in the CPR in the past five years. As indicated by AfDHS 2015, the contraceptive prevalence rate (CPR) is higher among married women in the urban areas than women in the rural areas (35 percent and 19 percent, respectively).[26]
The highest prevalence of contraception use is observed among married women aged 35-39 (29 percent), compared to 8 percent of married women aged 15-19 years, indicating that the contraceptive prevalence rate (CPR) among married women increases with age. [27]

The knowledge of family planning methods is an important precursor to use. According to AfDHS 2015, about 94 percent of women of 15-49 ages have heard of specific modern contraceptive methods, but only 23 percent of women reported to use any modern method of

[23] World Health Organization (WHO). "country cooperation strategy." http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_afg_en.pdf. 02 12 2015.
[24] Population Pyramid .net “Afghanistan Population pyramid.” http://www.populationpyramid.net/afghanistan/2016/
[25] Ministry of Public Health . "Afghanistan Mortality Survey." 2010.
[26] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[27] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.

contraceptive method. Similarly 91 percent of men have heard of specific modern contraceptive methods, but only 3 percent of men use condom. The findings suggest a huge gap between knowledge and practice of family planning methods. Similar figure (20 Percent) of family planning use was reported by AMS-2010. [28]
Among those women who do use contraception, the most popular method is use of pill (7 percent) followed by the injectables (5 percent) and the male condom (3 percent).[29]

POLICY & POLITICAL COMMITMENTS

The government of Afghanistan—as outlined in the Global Strategy for Women's and Children's Health commits to adhering to the agreements made in the Reproductive, Maternal and Newborn Health Strategy (2017-2020) and the Kabul Declaration for Maternal and Child Health (2015). Through collaboration with the Family Planning 2020 Country Coordination Committee, the government pledges to increase access to reproductive health services by 2020. It also commits to ensure commodity security and increase method mix in Afghanistan, with a focus on long-acting and reversible methods and postpartum family planning. The Ministry of Public Health will finalize and operationalize the RHSC Strategic Action Plan. The government also pledges to ensure accountability through review of performance—led by the Ministry of Public Health—of the reproductive, maternal, newborn, and child health program using RMNCH quarterly scorecards. The Afghan Government also made the commitment to set and achieve national family planning targets as following:

- **Reducing unmet need for family planning by 10 percent by 2020; and**
- **Increasing the modern contraceptive prevalence rate to 30 percent by 2020.** [30]

B. Program Analysis

Program performance analysis reviewed how the program, including both public and private sector, has been performing, to identify strengths and weaknesses of the program. The program has been analyzed in three key thematic and sub-thematic area of supply, enabling environment and demand/demand creation.

1. Supply

- **FP Service Delivery Modalities**

Health services in Afghanistan operate at three levels through BPHS and EPHS, with a well defined referral chain from primary to secondary and tertiary care. At the primary care level, the BPHS is delivered through health posts, BHCs, CHCs and through HSCs and Mobile

[28] Ministry of Public Health . "Afghanistan Mortality Survey." 2010.
[29] Ministry of Public Health, Central Statistics Organization, ICF International. "Afghanistan Demographic and Health Survey 2015:Key Indicators Report." 2016.
[30] FAMILY PLANNING 2020. "COUNTRY ACTION: Opportunities, Challenges, and Priorities Afghanistan." January 2016. Family Planning 2020. 7 July 2017 <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Country_Action_Opportunities-Challenges-and-Priorities_AFGHANISTAN_FINAL.pdf>.

Health Teams in selected geographical areas.[31] Secondary care services are delivered through EPHS through District Hospitals (also included under BPHS) and Provincial Hospitals. Tertiary services are delivered through Regional Hospitals and Specialty Hospitals (included under EPHS).[32]
The BPHS has seven key elements, one of which is maternal and child health. FP is included within this element and interventions include counseling, screening for and treatment of STIs, advice on LAM, provision of condoms, pills, injectables, IUCD, and male and female sterilization. IUCDs are provided only where trained providers are available and sterilizations are only available in district hospitals. In recent years, postpartum IUCD and implants have been introduced. The EPHS also includes FP services and provides short-acting, long-acting and permanent methods of contraception.[33]

- **Facilities providing FP**

Evidence shows major gaps in the infrastructure of facility including non-availability of separate rooms for FP services and gaps in infection prevention. Furthermore non-availability of FP guidelines in all the facilities, particularly in the private sector, is a concern.[34,35] Evidence, also indicated that adequacy and appropriateness of communication, education and counseling materials has been a concern at a number of service delivery sites. [36]

- **Human resource providing FP services**

Well-supervised on- the- job training through follow up visits improve the staff skills in counseling and provision of contraceptives for instance IUD insertion/removal skill.[37]
While the evidence showed skills gaps in counseling, IUCD insertion and administration of injectables, which could be an indication possible, training gaps. In addition, there is no mechanism for trainee follow-up. The quality of training by regional training centres is not known.[38]. The findings also noted that a number of midwives were not able to confidently and accurately insert IUD. Furthermore, the evidence showed that the providers were not able to provide implant method, as they were not trained.[39] Meanwhile the evidence highlighted limited counseling skill and lack of skill for administration of injectable (DMPA) among CHWs. [40]

[31] The Ministry of Public Health (MoPH). "A Basic Package of Health Services for Afghanistan ." 2010.
[32] The Ministry of Public Health (MoPH). "A Essential Package of Hospital Services for Afghanistan ." 2005.
[33] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[34] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[35] Stakeholders' consultation, August 2017.
[36] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[37] B. Özek, et al. "On-the-job training through follow-up visits to improve the quality of family planning services." *The European Journal of Contraception & Reproductive Health Care* 3.4 (1998): 201-206.
[38] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[39] Stakeholders' consultation, August 2017.
[40] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.

- **Management, Supervision & Monitoring of FP services provision**

The evidence suggested lack of effective monitoring system for FP indicators. According to the FP department of RMNCH directorate, they are conducting monitoring and supervision activities at the national level, but due to limited number of staff they are not able to implement a comprehensive mechanism of monitoring and supervision.[41] At the provincial level the provincial reproductive health officer is responsible for conducting the monitoring and supervision activities independently or jointly with the BPHS implementing partners.[42] The implementation of FP through BPHS includes some monitoring indicators which includes contraceptives distributed as one of its utilization indicators (output indicator), CPR as an outcome indicator and fertility as an impact indicator.
The Balanced Score Card, a third party monitoring mechanism for BPHS implementation, has been used since 2004. In BSC the contraceptive methods are included under the indicator on Pharmaceuticals and Vaccine Availability Index.20 There is no indicator for monitoring the adequacy and quality of FP commodities.[43]

- **FP services quality assurance and quality improvement system**

The MoPH has invested heavily in improving quality of services in general, and this is a key component of the Balanced Score Card (BSC), which has been used since 2004 as a means to measure performance in the delivery of Basic Package of Health Services (BPHS) throughout Afghanistan.[44] Likewise, the national RMNCAH strategy considered the integration of quality as an essential aspect of the national strategy for RMNCAH services.[45]
The MoPH has established mechanisms for quality assurance and improvement which are being implemented systematically. The MoPH has developed specific quality standards for FP under the Harmonized Quality Improvement Program (HQIP) framework for different level of health facilities. [46, 47] While evidence showed the key health system gaps identified relate to poor quality of services with regard to informed choice and access to all methods of contraception and poor quality of commodities. Despite the MoPH's efforts to ensure client rights through Quality Assurance (QA) mechanisms and monitoring of quality through the Balanced Score Card, many of the rights of clients are not realized.[48]

- **FP methods availability**

The findings of a *Comprehensive Family Planning Needs Assessment* in 2015 showed that at least three FP methods (condom, pill and injectables) were available in more than 90 percent of facilities in the nine provinces, Kabul and the private sector. Only 80 percent of Basic Health Centres (BHCs) provided IUCD insertion, perhaps related to availability of

[41] Stakeholders' consultation, August 2017.
[42] Stakeholders' consultation, August 2017.
[43] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[44] Royal Tropical Institute (KIT). "The Balanced Scorecard Report." 2016.
[45] Ministry of Public Health (MoPH). "National RReproductive, Maternal, Newborn, Child, & Adolescent Strategy 2017–2021." 2017.
[46] Ministry of Public Health (MoPH). "Harmonized Quality Improvement Program (HQIP)- Family Planning Quality Standard for Health facilities." 2015.
[47] Stakeholders' consultation, August 2017.
[48] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

skilled providers. Tubal ligation facilities were available in less than 20 percent of district and provincial hospitals and in 66 percent of regional hospitals, perhaps related to availability of skilled providers.[49] Likewise the recent evidence shows that 70 percent of health facilities have 79 percent available modern contraceptives. It is lowest in Kandahar (42 percent) and Kabul (44 percent) and highest in Takhar (90 percent), Logar and Baghlan (89 percent).[50] Meanwhile, evidence highlighted some level of methods shortage at the service delivery points of public health facilities and private facilities, which hinders the optimal provision of contraceptive methods.[51, 52]

- **FP service integration with other health services**

Evidence suggested that FP is well integrated with primary care and maternal health but that integration with child health services is not strong.[53] At the policy and service levels, FP is not integrated with STI and HIV/AIDS services. While National FP Guidelines do mention screening for STIs and HIV, observations of counseling and IUCD insertion showed that the recommendation is not followed. The postpartum and post-abortion guidelines do emphasize FP. The focus of postpartum FP is on IUCDs. The impression gained from discussions with stakeholders is that FP is not actively promoted in the maternity wards.[54]

- **Referral system for FP methods/ services**

The evidence suggested that the referral system between BPHS facilities and between BPHS and EPHS facilities is not as effective as was envisaged and evidence also indicated that the referrals were very few in number. Reasons could be distance to a referral facility, lack of skilled providers at referral facilities.[55]

- **Private sector involvement in FP service provision**

Though the evidence highlighted that private sector's providers are not that much at the focus of the health system interventions, but the unique role of private pharmacies and other points of sale for birth spacing methods are evident. The evidence indicated that the provision of birth spacing services similar to fully fledged health facilities – female doctor based at private clinic provides prescription, or prescription guidance is provided by medicine dispensing staff. The evidence indicated that they stock the same range of birth spacing methods as available at public health facilities. In addition, evidence indicated lack of or limited capacity among private health workers in provision of some contraceptive methods. Furthermore, service cost especially for long term method such as IUD and

[49] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[50] Evaluation and Health Information System (EHIS) General Directorate. "EHIS First Quarter Report (2017)."
[51] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[52] Stakeholders' consultation, August 2017.
[53] Stakeholders' consultation, August 2017.
[54] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[55] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

Implant; weak counseling skills; and lack of standardized IEC materials highlighted as issues of concern in private sector.[56]

- **FP counseling**

The evidences highlight the limited counseling skill and skills gaps in counseling.[57] Evidence suggests that male involvement is crucial to a successful demand creation campaign and dispelling myths and misconceptions amongst men is important to ensuring their support of family planning.[58] This is while findings indicate that couple counseling is neither practiced nor perceived as a feasible family planning counseling approach by health workers working in public and private health care facilities. Counseling is conducted by female health workers (midwives, female doctors and female CHWs) with female clients visiting these health facilities or during home visits conducted by the female CHWs. The current design of family planning service provision especially at the public health facilities is not men (husbands) friendly. Males who accompany their wives to obtain family planning methods from the public or private sector are most often not directly included in the counseling process.[59] Furthermore, providing Family Planning counseling in a setting where confidentiality and privacy could not be ensured is an issue of concern.[60]

2. Enabling environment

- **FP program leadership and management**

The MoPH FP Unit falls under the RMNCAH Directorate and is affected by structural issues affecting the RMNCAH Directorate. These have an impact on its leadership role. In particular: overseeing and guiding the overall provision of FP services in the public and private sector appears weak; There is not much to report on the stewardship role of the Provincial Public Health Directorate (PPHD) as full transfers of administrative power and fiscal transfers have not taken place. There appears to be no active promotion or active monitoring of FP by provincial officers.[61]

Evidences indicate that the current institutional arrangement for coordination of family planning program at MOPH is not sufficient, and the human resource in place for this function are not adequate for the necessary coordination of the different actors in family planning in the health sector such as private sector services, reproductive health team,

[56] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[57] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[58] Adelekan, Ademola et al. "Male Involvement in Family Planning: Challenges and Way Forward," International Journal of Population Research, vol. 2014, Article ID 416457, 9 pages, 2014. doi:10.1155/2014/416457
[59] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[60] Stakeholders' consultation, August 2017.
[61] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

health promotion and health information teams, etc.[62] This central level weakness of structure and limited human resource at the FP Unit translates into limited operational linkage and technical support between the central MOPH leadership and coordination system for family planning, and the support systems at provincial, district and health facility levels.[63] This results in weak family planning services in areas of management, implementation of existing policies and guidelines, support supervision, capacity building and quality assurance.[64] Other areas of service support affected by such weaknesses include: a) ineffective coordination and inadequate quality assurance in branding and promotion of family planning products; b) inadequate resources mobilized and explicitly allocated for family planning support, and c) poor tracking of resources available and their efficient utilization to yield family planning results. [65]

- **Supportive laws, policies, and guidelines for FP**

Positive policies exist and could have been converted to reality if the leadership had been more supportive and adequate financial and human resources allocated.[66] The inadequacy of the government's financial support for promoting reproductive health and FP has implications for sustainability as donor support decreases. The commitment of political decision-makers across all sectors to manage Afghanistan's demographic growth and reap its potential dividend is not yet evident. [67]

After a long period of policy dialogue and drafting, the first draft National Population Policy for Afghanistan was completed in November 2016, and recognizes the strong interrelationship between population dynamics and socio-economic development. It calls for an increase in the use of family planning as a key measure to reduce the high fertility rates, including adolescent fertility, short birth intervals and the associated high reproductive risks.[68]

- **Human and financial resources for FP**

The RMNCAH Directorate is currently under-resourced and the adequacy of its human and financial resources should be reviewed.[69] The RMNCAHD posts are not fully filled and those filled are funded by donors. Rapid turnover of staff is another problem.[70, 71] The family planning unit within MoPH has a narrow institutional mandate and scope and limited human and material resources for the necessary coordination of the different actors in family

[62] Stakeholders' consultation, August 2017.

[63] Stakeholders' consultation, August 2017.

[64] Stakeholders' consultation, August 2017.

[65] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.

[66] Stakeholders' consultation, August 2017.

[67] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

[68] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.

[69] Stakeholders' consultation, August 2017.

[70] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

[71] Stakeholders' consultation, August 2017.

planning in the health sector (e.g., private sector services, reproductive health service actors, health promotion and health education, etc.).[72]
Furthermore at the program implementation level the evidence highlighted gaps in staff skills and experience in delivering some of the elements of birth spacing services,[73] especially with regard to provision of long term methods and provision of comprehensive counseling. It was noted that a number of midwives are not able to confidently and accurately insert IUD.[74, 75]

Financial allocation to a programme is an indicator of government commitment towards that programme. In 2011–2012, Afghanistan spent USD 246,744,339 on Reproductive health, which accounts for 16.4 percent of total health expenditures. International donors contributed a significant portion at nearly one-fifth of total health expenditures on reproductive health (USD 46,487,494).
Individual households financed more than three-quarters of the total expenditure on RH (USD 193,650,212) in 2011–2012. International donors also contributed a significant portion at nearly one-fifth of the total expenditure on RH (USD 46,487,494). The central government financed less than 3 percent (USD 6,577,377), while non-profit organizations serving households played a minor role, funding 0.01 percent of the total expenditure on RH. However, family planning services are typically considered under prevention and public health services, which account for just 3 percent of the total expenditure on RH. [76] Though as part of the United Nation's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), the Government of Afghanistan has committed to allocating 25% of its overall health budget to reproductive health.[77]
FP does not receive any funding from the government and is 100 percent donor funded. It is not clear if the allocations adequately meet demand, The RHD has no direct links to the MoPH Finance division as they are not administratively linked.[78]

- **Evidence-based decision making for FP programming**

Current attention to increasing access to family planning has increased focus on ensuring that policy, programming and practice are "evidence-based."[79] Currently the use of HMIS data has been limited and operations research has not been conducted before introducing new contraceptives or scaling up and introducing new service delivery mechanisms. Behavioural research studies of mothers-in-law and religious leaders have been carried out and the results are being used for training and to develop advocacy

[72] Stakeholders' consultation, August 2017.
[73] Stakeholders' consultation, August 2017.
[74] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[75] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[76] The Ministry of Public Health (MoPH). 2012. The National Health Account Report.
[77] FAMILY PLANNING 2020. "COUNTRY ACTION: Opportunities, Challenges, and Priorities Afghanistan." January 2016. Family Planning 2020. 7 July 2017 <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/11/Country_Action_Opportunities-Challenges-and-Priorities_AFGHANISTAN_FINAL.pdf>.
[78] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[79] Hardee et al. "Family Planning Policy, Program, and Practice Decision-making: The Role of Research Evidence and Other Factors,"Working Paper. 2015.
Washington, DC: Population Council, The Evidence Project

materials. Aside from a study on its role in reducing maternal mortality, few studies have been undertaken to illustrate the development benefits of FP.[80]

- **Contraceptive security**

Contraceptive security (CS) exists "when people have regular, reliable, and equitable access to a choice of contraceptive methods to meet their reproductive health needs.[81] The evidences show that stock-outs of method both in public and private sector are present, which hamper the regular access to contraceptive methods. [82] The data on stock-outs indicated that the levels of stock-outs were greater in lower level facilities located closer to the Communities. Similarly, compared to the nine provinces, Kabul reported a higher level of stock-outs including in district hospitals. The situation was worst in private facilities. [83]

- **Advocacy for FP program**

While efforts have been made to advocate with religious leaders, advocacy with parliamentarians and the adoption of multi-sectoral approaches has been limited. [84], [85] Some evidence suggests that program advocacy efforts were successful at the MoPH and Government level. Through collaboration with the Family Planning 2020 Country Coordination Committee, the government pledges to increase access to reproductive health services by 2020. It also commits to ensure commodity security and increase method mix in Afghanistan, with a focus on long acting and reversible methods and postpartum family planning. The government also commits to allocating 25 percent of the health budget specific to reproductive health and for creating a specific budget line in the Ministry of Public Health's annual budget for the promotion of family planning and procurement of contraceptives. [86] Anyhow, there is little documentation that shows that senior officials of MoPH publicly speak about FP. While the National Priority Programme and National Health Policy include FP, further high level multi-sectorial advocacy is required. Meanwhile, there are no systematic efforts to advocate with policymakers such as ministers, parliamentarians or other leaders at national and provincial levels.[87]

- **Communities engagement in addressing barriers to FP use**

Evidence indicates that efforts have been made to advocate with community leaders and religious leaders directly and through health shuras but the impact is not known.[88]

[80] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[81] EngenderHealth. "The SEED Assesment Guide for Family Planning Programming." 2011.
[82] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[83] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[84] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[85] Stakeholders' consultation, August 2017.
[86] FAMILY PLANNING 2020. "The commitment of Afghanistan Government." July 2016. Family Planning 2020. 7 July 2017 < http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/Govt.-of-Afghanistan-FP2020-Commitment-20161.pdf>.
[87] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[88] Stakeholders' consultation, August 2017.

Community engagement occurs through CHWs, health shuras, Family Health Action Groups (FHAGs) and through discussions between health facility managers and community leaders. It is not known whether FP is actively and regularly promoted through these channels.[89] Meanwhile, evidence revealed that the benefits of FP for maternal and child health and its economic benefits were known to various groups including community leaders. [90] Meanwhile, some evidence shows that the mobilization and engagement of religious leaders to promote and talk about contraceptives and birth spacing is limited and not widely practiced. [91]

- **FP program and Gender & social norms**

The Gender unit within the structure of the MoPH is playing an important role in mainstreaming the gender in the national health policies and programs. The department is aiming to improve the health and nutrition status of women and men equitably and to improve gender equity within the health sector.[92]
Similarly the National Reproductive, Maternal, Newborn, Child, & Adolescent Strategy 2017–2021, considers the gender equality as one of its strategic area. It aims to Increase gender sensitivity among health care providers; promote women empowerment; and promote strategies to prevent harm from gender-based violence and harassment in health facilities. [93]

- **Human Right Principles**

Evidence indicates that policies and strategies articulate human rights principles, equity, gender-sensitivity and socio-cultural dimensions. The Balanced Score Card that is used for monitoring of the BPHS includes six domains: client and community, human resources, physical capacity, quality of services, management and overall mission. Though not specific to FP, these domains cover all 10 areas of FP rights (accessibility, availability, acceptability, quality, agency/ empowerment/autonomy non-discrimination/ equity, accountability, informed choice, privacy and confidentiality, participation). [94, 95]

3. Demand/ demand creation

- **Strategies to reduce cost of FP**

Evidence suggests that interventions that support quality supply of services, while simultaneously addressing demand-side barriers such as service pricing, can successfully

[89] Stakeholders' consultation, August 2017.
[90] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[91] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[92] Ministry of Public Health (MoPH). "NATIONAL GENDER STRATEGY OF MOPH 2012–2016." February 2012.
[93] Ministry of Public Health (MoPH). "National Reproductive, Maternal, Newborn, Child, & Adolescent Strategy 2017–2021." 2017.
[94] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[95] Royal Tropical Institute (KIT). "The Balanced Scorecard Report." 2016.

create demand for a broad range of family planning services, even in settings with low contraceptive prevalence.[96]

Costs of FP services may be influenced by a variety of factors, including the choice of contraceptive methods, the channels of service delivery, and funding. Decisions about allocation of resources must emphasize the best interests of the client for a range of choices and safe, effective, and affordable services.

As literatures indicate the financial costs of FP services to clients include the official price of contraceptive products, supplies, and service provision. They may also include travel costs, the cost of lost work due to time spent seeking FP, and, in some cases, unofficial charges demanded by providers and/or staff.[97, 98] In Afghanistan the wide network of BPHS health facilities providing FP services free of charge addressed the issue of service cost to some extent, while the issue of travel cost and time spent seeking the FP still exist.[99] Evidence shows that women and children in the lowest wealth quintiles have the lowest usage rates of contraceptives, skilled birth attendance, antenatal care, and Penta-3 coverage.[100] Furthermore, in the private sector the high cost of contraceptives is an issue,[101] which requires control of service and product prices to ensure equity in access to family planning services to all.[102]

- **Social and behavior change communication (SBCC) strategy for FP**

A behavior change communication (BCC) strategy for reproductive, maternal, newborn, child and adolescent health is being developed and includes FP. However it is not known whether it includes key elements such as the identification of target audiences, barriers, communication channels appropriate for various audiences and strategies for dealing with rumors.[103]

- **Commercial and social marketing to create demand.**

Social marketing programmes run by the Afghanistan Social Marketing Organization (ASMO) and Marie Stopes International (MSI) are successful in urban areas but the rural penetration of such programmes is limited. Currently MoPH has no mechanism to continuously monitor responses to social marketing. [104]

- **Mass media and the FP methods/services**

[96] Gold, Judy et al. "Increasing Access to Family Planning Choices through Public-Sector Social Franchising: The Experience of Marie Stopes International in Mali." *Global Health: Science and Practice* 5.2 (2017): 286–298. *PMC*. Web. 22 July 2017.
[97] EngenderHealth. "The SEED Assesment Guide for Family Planning Programming." 2011.
[98] Ensor, T and S. Cooper. "Overcoming barriers to health services access: Influenceing the demand side." Health Policy and Planning 19.2 (2004): 69-79.
[99] Stakeholders' consultation, August 2017.
[100] The Royal Tropical Institue (KIT). "Afghanistan Health Survey 2015." Final Report. 2016.
[101] Stakeholders' consultation, August 2017.
[102] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[103] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[104] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

The evidence indicates that access to mass media messages increases the likelihood of the use of family planning[105],and exposure to FP messages in the media is associated with use of modern methods.[106]
Findings from literatures confirm that awareness and knowledge of contraception do not necessarily translate to use,[107] and evidence indicated that myths and misconceptions could be among main barriers to modern contraceptive uptake among women. [108, 109] Hence, mass media campaigns need to address key myths and misconceptions around contraceptives.[110]
In Afghanistan the radio and television were identified as sources of information on FP but an evaluation of the impact of mass media has not been carried out.[111] Currently, TVs are airing spots on contraceptive use, which are sponsored by ASMO.[112]
Furthermore, a youth phone line established by MoPH is popular and receives many queries related to FP. It provides counseling and also advises young women on how to contact health facilities in their respective provinces.[113]

- **Communities and champions engagement in SBCC.**

Community–based primary health care (CBPHC) and engaging with communities as valued partners can make to the improvement of maternal, neonatal and child health (MNCH). Stronger CBPHC programs can create entry points and synergies for expanding the coverage of family planning services.[114]
Evidence indicates in Afghanistan that the community engagement occurs through CHWs, health shuras, Family Health Action Groups (FHAGs) and through discussions between health facility managers and community leaders. It is not known whether FP is actively and regularly promoted through these channels. UNFPA and social marketing organizations have been supporting the involvement of religious leaders in FP in support of the strategic element of the National RH Strategy. These initiatives are implemented in collaboration with Ministry of Hajj and Religious Affairs (MoHRA). [115] Currently, there is no evidence to indicate the engagement of champions in the SBCC.

[105] Ajaero, Chukwuedozie K. et al. "Access to Mass Media Messages, and Use of Family Planning in Nigeria: A Spatio-Demographic Analysis from the 2013 DHS." *BMC Public Health* 16 (2016): 427. *PMC*. Web. 19 July 2017.
[106] Bajoga, Ummulkhulthum A. et al. "Media Influence on Sexual Activity and Contraceptive Use: A Cross Sectional Survey among Young Women in Urban Nigeria." African Journal of Reproductive Health 19.3 (2015): 100-110.
[107] Ochako, Rhoune et al. "Barriers to Modern Contraceptive Methods Uptake among Young Women in Kenya: A Qualitative Study." *BMC Public Health* 15 (2015): 118. *PMC*. Web. 19 July 2017.
[108] United Nation Population Fund (UNFPA). "National Family planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan." 2017.
[109] Stakeholders' consultation, August 2017.
[110] Stakeholders' consultation, August 2017.
[111] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[112] Stakeholders' consultation, August 2017.
[113] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[114] Black, Robert E et al. "Comprehensive Review of the Evidence Regarding the Effectiveness of Community–based Primary Health Care in Improving Maternal, Neonatal and Child Health: 8. Summary and Recommendations of the Expert Panel." *Journal of Global Health* 7.1 (2017): 010908. *PMC*. Web. 19 July 2017.
[115] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.

- **Peer education and the FP program**

This is well documented that peers in trained effective family planning can be a valuable addition to clinic staff in limited-resource settings. The utilization of peer mothers, improves health services uptake including family planning.[116] The implementation of a peer-led intervention model is likely to contribute to observed increases in self-efficacy, knowledge, positive attitude and use of modern family planning methods.[117, 118]
The evidence indicated that there is no strategy for utilizing peer educators for FP in Afghanistan. The Deputy Ministry of Youth Affairs peer educators intended to promote adolescent sexual and reproductive health programmes in urban areas are not active due to lack of support. [119]

- **Supply Chain Management of FP Commodities**

At the national level, there is no unique supply chain management mechanism for FP commodities such as projection, quantification, availability, procurement plan, actual procurement, storage and distribution of FP to address the country need for FP commodities as a whole.[120] Currently, at the national and provincial level the supply chain management system for the FP commodities from projection, quantification, availability, procurement plan, actual procurement, storage and distribution of FP is independently managed by involved parties and implementing partners including BPHS implementing partners.[121]

[116] Mudiope, Peter et al. "Greater Involvement of HIV-Infected Peer-Mothers in Provision of Reproductive Health Services as 'family Planning Champions' Increases Referrals and Uptake of Family Planning among HIV-Infected Mothers." *BMC Health Services Research* 17 (2017): 444. *PMC*. Web. 19 July 2017.
[117] Vu, Lung et al. "Increasing Uptake of HIV, Sexually Transmitted Infection, and Family Planning Services, and Reducing HIV-Related Risk Behaviors Among Youth Living With HIV in Uganda." Adolescent Health 60.2 (2017): 22-28.
[118] Wilson, Susan F et al. "Peer counselling for the promotion of long-acting, reversible contraception among teens: a randomised, controlled trial." The European Journal of Contraception & Reproductive Health Care 21.6 (2016): 380-387.
[119] United Nations Population Fund (UNFPA). "A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan." January 2016.
[120] Stakeholders' consultation, August 2017.
[121] Stakeholders' consultation, August 2017.

IV. Result Formulation

In the process of results formulation, we utilized the obtained information from the situation analysis to identify the strategic interventions and prioritize them in terms of being more effective and efficient interventions. At this stage of CIP development, the goal, expected outcomes, outputs and strategic interventions are defined.
The objectives of the CIP are in line with the objectives of the MoPH and Afghanistan government commitment for FP. The designed strategic interventions/activities are designed in a way to contribute achieving the MoPH objectives for FP.
The reflected interventions in the CIP are: those intervention identified by the RMNCAH strategy 2017-2021; those interventions identified and purposed during the consultative process; and those interventions suggested by the results of new available literatures on FP program.
The process of result formulation has been a participatory process and completed in close consultation and coordination with the MoPH - RMNCH department, National FP working groups and other stakeholders.

OBJECTIVES

The government of Afghanistan commits to:[122]

- Reducing unmet need for family planning by 10 percent by 2020; and
- Increasing the modern contraceptive prevalence rate to 30 percent by 2020

The strategic outcomes, outputs, and activities for FP- CIP are developed around the three key thematic areas of supply, enabling environment and demand/demand creation.

- Key Thematic Areas 1: Supply

Under this key thematic area the following strategic outcomes and strategic interventions/activities are addressed:

Strategic outcome A.1: Access to information and informed contraceptive choice is improved.

Strategic Interventions/Activities:

- Provide the CHWs and health care providers with client-friendly educational material to provide accurate and unbiased information, and orient them on the use of these materials.
- Provide client IEC-BCC materials in health facilities (public & private) and health posts.

[122] FAMILY PLANNING 2020. "The commitment of Afghanistan Government." July 2016. Family Planning 2020. 7 July 2017 < http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/Govt.-of-Afghanistan-FP2020-Commitment-20161.pdf>.

- Strengthen and maintain the provision of FP services and contraceptives through health facilities, which are not supported by donors.
- Strengthen and maintain the provision of FP services and contraceptives through EPHS, BPHS facilities.
- Include contraceptive implants in the BPHS and EPHS drug lists.
- Promote and support provision of LARC (IUDs, implants, and injectables) methods as a cost-effective, high-impact modern FP intervention at facility and community levels by community midwives.
- Strengthen and maintain the provision of FP services and contraceptives in emergency setting.

Strategic outcome A.2: Access to safe FP services is improved

Strategic Interventions/Activities:

- Strengthen Infection prevention including waste disposal at health facilities.
- Review and develop a better mechanism for infection prevention and waste disposal in health posts.
- Support PPHDs to ensure that IP standards for different types of facilities and health posts are met by implementing NGOs.
- Provide separate spaces to ensure privacy for FP services/counseling
- Design and implement appropriate quality improvement and quality assurance approaches to improve quality of FP service provision at facility and community levels.

Strategic outcome A.3: Continuity of care is strengthened

Strategic Interventions/Activities:

- Set up a follow up mechanism in health facilities to enable health service providers to follow up with clients.
- Introduce IT/Mobile technology for clients follow up
- Discuss regularly with CHWs during monthly meetings that the discontinuing clients in the community to be identified and counseled.
- Train the providers on the importance of continuity of care.
- Strengthen referral mechanism for FP services within the HF between different departments (such as EPI, Nutrition, and psychosocial counselors) and between HPs, HFs and among different level of HFs, so that clients get optimum level of FP services.

Strategic outcome A.4: Geographical accessibility is improved

Strategic Interventions/Activities:

- Conduct a mapping exercise to identify those areas where access to skilled providers, FP services and methods is limited.

- Improve access through different channels including training of female CHWs, community based distribution, mobile health clinics and establishing family health house (FHH).
- Use and adopt other successful programs such as EPI to improve access to FP

Strategic outcome A.5: Provision of FP services through private sector facilities is improved

Strategic Interventions/Activities:

- Strengthen and maintain the provision of FP services and contraceptives through private sector providers.
- Strengthen and maintain the provision of FP services and contraceptives through solo providers.
- Ensure private sector facilities provide FP services according to national standards and guidelines.
- Improve access through establishing public private partnerships (PPPs)
- Conduct regular coordination meeting with private sector HFs those have MoUs for FP/BS services.
- Expand the numbers of private facilities with which the MoPH has MOUs for FP services.

Strategic outcome A.6: Integration of services is improved

Strategic Interventions/Activities:

- Screen FP services clients for STIs and HIV
- Provide FP services as part of voluntary counseling and testing services for HIV
- Integrate FP counselling in EPI , Nutrition and psychosocial counselling in HFs

Strategic outcome A.7: Capacity/skill of human resource involved in the FP program is improved.

Strategic Interventions/Activities:

- Establish new FP national training centers at highly utilized national maternity hospitals.
- Decentralize the FP competency-based training through establishment of provincial FP training centers.
- Ensure all existing FP national and regional training centers are fully equipped with necessary commodities, supplies, and job aids for provision of quality BS/FP training.
- Establish FP centers of excellence at health facilities to be used for replication of FP training, FP services provision, and mentorship to nearby facility health providers.
- Map out the available capacity and resources of health facilities (both public and private) as potential training locations.
- Ensure that all national BS/FP Learning Resource Package (LRPs) and guidelines are up-to-date and aligned with international standards.

- Develop training materials that are appropriate in content and scope for other health care providers at health facilities
- Review the existing public and private medical and paramedical schools curricula and update the FP topics
- Promote the inclusion of BS/FP subjects, including LAM and postpartum FP counseling, into the pre-service curricula of physicians, Community Health Nurses, and other nurses in public and private institutions
- Train faculty of public and private medical and para medical school on FP
- Develop online FP resource center

a. Health service providers of public facilities

- Enhance the capacity and capability of in-service training institutions to provide competency-based training.
- Improve the skills of providers to administer/apply infection prevention and safety measures.
- Build the capacity of doctors in providing permanent methods of sterilization.
- Train FP providers in proper counseling skill.
- Train psychosocial and nutrition counselors on FP
- Initiate and sustain a post-training follow-up and supervision system for all BS/FP trainees, in collaboration with GDHR.
- Initiate mentorship for FP in the HFs

b. Community Health Workers

- Train female CHWs in appropriate administering injectables.
- Train CHWs, on appropriate counseling, referral, and provide job aids for CHWs.
- Enhance the capacity of community health supervisors in supervision for technical content and to develop their supervision skills.

c. PPHO staff, Supervisors and Managers of implementing NGOs

- Provide training on supportive supervision including FP to provincial reproductive health officers at the PPHO as part of the MoPH Quality assurance mechanism.
- Provide training on supportive supervision including FP to RH officer of implementing NGO.
- Build the capacity of NGOs program managers on FP services.

d. Private Sector

- Improve and build the capacity and skills of private sector providers in FP service provision.
- Strengthen of the counseling skills of private pharmacy staff.

Strategic outcome A.8: Rights-based Contraceptive provision is strengthened.

Strategic Interventions/Activities:

- Increase awareness of the facility, health post on clients' rights and right-based contraceptive services *(right elements: Accessibility, availability, acceptability, quality, empowerment/autonomy, non-discrimination/equity, accountability, informed choice, privacy/ confidentiality, and participation).*
- Increase awareness of the women shuras on women' rights and build their capacity to monitor the implementation of the rights.
- Increase awareness of the CSO, high school teachers, and CDCs on the FP as human right.
- Strengthen clients' feedback mechanism to facilitate regular feedback.

Strategic outcome A.9: Monitoring and Supervision mechanism for FP services is strengthened

- Conduct regular monitoring, supportive supervision of FP services implementation in Public health facilities by RH officer, RMNCAH staff and BPHS/EPHS implementing NGOs and provide regular feedback on findings
- Conduct regular monitoring, supportive supervision of FP services implementation in private health facilities by RMNCAH provincial and national staff and provide regular feedback on findings
- Conduct regular monitoring and supportive supervision of FP activities of CHWs, health Shuras and FHAGs by CBHC officer, CHSs and provide regular feedback on findings
- Conduct post training follow up from public and private health facilities

- Key thematic Areas 2: Enabling environment

Strategic outcome B.1: Evidence based policy/ strategy development strengthened

Strategic Interventions/Activities:

- Ensure implementation of FP/BS indicators reflected in RHMNACH strategy 2017-2021.
- Review and revise the procurement policy for quality assured procurement.
- Review of the HIV/AIDS and STI strategy to ensure FP services are provided in STI clinics and HIV/AIDS counseling and testing and care facilities.
- Develop specific strategies to provide FP to married adolescents for delaying first pregnancy in the cases of Early and Child Marriage in line with pre marriage counselling strategy.
- Initiate the pre-marriage counselling to target newly marriage couples.
- Develop Standard of Procedures (SOPs) for safe administration of contraceptives.
- Develop PPFP (Post Abortion) clinical protocols for antenatal and post abortion counseling and facility postnatal care to expand provision of IUD and implant services for postpartum and post abortion care.
- Promote community based PPFP counselling and referral mechanism and promote an integrated program of home visits for postpartum birth spacing, breastfeeding, infant and

young child nutrition, and immunization for community health workers, together with appropriate job aids and a training program.
- Establish healthy mothers group at the health facility level to encourage other mothers to use contraceptives as a BS or FP method.
- Introduce Sayana Press to CHWs
- Integration of FP/BS in citizen charter national priority program (CCNPP)

Strategic outcome B.2: Capacity for stewardship is strengthened at all levels of administration

Strategic Interventions/Activities:

- Strengthen the leadership capacity within the RHD, as well as the capacity to effectively plan, coordinate and communicate FP and RH programmes.
- Review the RHD in terms of the adequacy of its human and financial resources.
- Develop an advocacy plan to improve the visibility of FP programmes with a clear communication plan for national institutions such as Health committee of parliament, the Ministry of Economy, Finance and the President's Office as well as international institutions.
- Establish a Coordination mechanism with HEFD to track FP expenditures at all levels of tracking of expenditures for FP and RH by the Health Economics Division in collaboration with RHD (including at the provincial and district level)
- Consider performance-based incentives for CHWs on provision of FP services/ improving FP indicators.
- Strengthen the Capacity of RHD in conducting operational research on FP.
- Engage religious and community leaders and review ongoing activities by MoPH and MoHRA to identify best practices and gaps.
- Establish FP inter-sectorial collaboration and coordination mechanism and hold national FP inter-sectorial committee meetings.
- Integrate and promote postpartum FP counseling and services in maternal and newborn health services.
- Integrate and promote post abortion FP counseling and services in post abortion care services.
- Integrate Family Planning counseling services in immunization program.
- Integrate Family planning counseling services in nutrition program.

Strategic outcome B.3: Health Management Information System (HMIS) and Data on FP program is improved

Strategic Interventions/Activities:

- Strengthen the RHD's oversight mechanism through establish a central database for national data on FP and other RH services, linked with HMIS.
- Review and analysis HMIS to ensure the CYP data is collected quarterly.
- Modify the recording system of FP services to capture information on discontinuing clients.
- Consider FP/BS target setting at HF level

- Assess the HMIS review and feedback mechanism at various levels of services and take action based on findings.
- Build data quality assurance mechanisms at various levels of health care.
- Strengthen the capacity of program supervisors at various levels, and CHW supervisors based on the findings of HMIS reports.
- Conduct trainings on data for decision making for staff managing FP data at various levels.
- Strengthen the reporting system of private sector on FP.
- Conduct quarterly based FP data analysis on national level and present it to national forums.

Strategic outcome B.4: Contraceptive commodity security is improved

Strategic Interventions/Activities:

- Review/Revise contraceptive commodity security action plan to address the SEHAT project requirements.
- Strengthen supply chain management of FP commodities through proper forecasting, procurement, storage, distribution and reporting on family planning commodity.
- Develop standards for warehouses and storage place of FP commodity.
- Develop mentorship tools to gather and use information about the RH supply chain management system for use in supervisory visits.
- Monitor the implementation of standards for warehouse and storage place of FP commodity.
- Review and improve Pharmaceutical Logistics Information System (PLIS) to avoid stock-outs.
- Standardize inventory practices and records of RH Commodities
- Develop capacity building plans on RH commodity security (RHCS), PLIS and supply chain management, in collaboration with FP partners for warehouse managers and store keepers and implement the plan
- Advocacy for off budget resource mobilization
- Advocacy for provision of FP commodities

- Key thematic Areas 3: Demand/ Demand Creation

Strategic outcome C.1: Demand for FP and Birth Spacing services is increased

- Develop a comprehensive social and behavior change communication (SBCC) strategy for FP.
- Develop plan for orientation of the provincial health officers, implementing NGOs and private sector on SBCC strategy.
- Promote and monitor the incorporation of FP messages in Public and private health facilities and community level.
- Develop new messages around FP to address existing and emerging barriers, myths and misconceptions".

- Develop and implement a mass media campaign on family planning to promote FP and to dispel myths and misconceptions about contraception.
- Conduct round tables at national and provincial level on Islam and FP using of FP booklet.
- Promote FP messages through CHW, FHAGs and women's shura focusing on mothers-in-law and elderly women in the community.
- Encourage CHWs and FHAGs should focus on reaching out to poorer families, young married couples, and first-time parents with BS/FP information.
- Conduct orientation session on Islam and FP for Mullah and religious leaders.
- Include Islam and FP topics in in-service training curricula of health workers and CHWs.
- Include Islam and FP topics in pre-service curricula of midwifery, nursing and medical schools.
- Promote FP messages through religious leaders including promoting the distribution and use of existing booklets on FP and Islam, approved by the Ministry of Haj and Awqaf and Islamic Affairs.
- Distribute the IEC/BCC material on Islam and FP to religious leaders, civil society, health workers and school teachers, CHWs, during national and international days and health Shuras to dispel the myths, and misconception about FP.
- Develop orientation package and brochures on FP for civil society media and parliamentarians.
- Regularly review the reach of channels and impact of messages on FP.

Strategic outcome C.2: Male involvement in FP services is improved

- Train health service providers (both male and female) on male and couple counseling.
- Train and orient CHWs (both male and female) on male and couple counseling.
- Integrate FP services into male patient consultation and services.
- Develop and broadcast printed messages, radio and TV spots targeting males.

Strategic outcome C.3: Adolescents and young people are knowledgeable on FP services

- Develop pilot projects on premarital counseling, keeping cultural and religious sensitivity and technical accuracy in view.
- Train health workers to provide gender-sensitive adolescent and youth-friendly services for both girls and boys.
- Develop a training package for teachers in birth spacing (both knowledge and capacity building in conveying the information) and built into ongoing initiatives to involve teachers.
- Strengthen and expand mobile technology services such as youth phone line.
- Recruit and train peer educators to improve knowledge of youth on family planning.
- Include the importance of birth spacing/ FP and of delaying first birth in peer education program.
- Provide awareness on FP for adolescent and youth through Youth Health Corners and peer education program.

- Provide awareness on FP methods for adolescent and youths through Youth Help Line (YHL).

Strategic outcome C.4: Commercial and social marketing to create demand.

- Expand methods available through pharmacies and dispensaries through social marketing.
- Train Dispensaries and pharmacies on Family planning methods.
- Increase consumer awareness of social marketed products through promotional activities on demand creation through mass media, print materials, life-theater, and mobile-cinema.
- Increase consumer awareness of social marketed products through promotional activities on demand creation through national and traditional events.
- Increase consumer awareness of social marketed products through promotional activities on demand creation through organizing health gathering at the community level and religious gatherings.

V. Activity Planning

Following the completion of result formulation, an implementation plan is developed in the form of matrix.
The matrix defines the strategic outcomes, thematic areas, key interventions/activities, the lead & partner agencies, performance indicators, timeframe and indicative cost

- **Key interventions activities:**

In this section of the matrix, the action oriented interventions are reflected. The interventions describe what is needed to be implemented under several categories of family planning interventions. The key interventions and activities are developed based on the RMNCAH strategy 2017-2021; the evidence revealed by the new literatures and consultations with stakeholders in the form of individual and group consultations. The interventions/activities are finalized in close consultation with FP working groups.

- **Lead and Partner Agencies:**

In this section of the plan the lead and partner agencies are identified. This will help to understand, which organization has the stewardship role, which organization is providing technical and financial support. Likewise, this will help to recognize the implementing partners and the oversight body.

- **Performance Indicators:**

In order to be able to assess and track the implementation of CIP, some performance indicators (output indicators) are developed. These performance indicators are specific, measurable and time bound.

- **Timeframe:**

In order to ensure the implementation of the planned interventions and set indicators in a timely manner, a timeframe is set for each intervention.

- **Costing:**

In order to implement the planned interventions, and ensure the availability of necessary resources, a well estimated cost is considered for each planned intervention.

Methodology of Costing

The costing process was completed in close coordination and consultation with the FP department and FP working group. The components of costing including the number of units and unit costs were based on the data and information available with the FP department, the other technical departments of the MoPH, implementing partners and agencies involved in the family planning field.
In general the costing was completed in close consultation of partners who have a broad understanding and experience in the implementation of different components of family

planning. Although, during the costing process, it was revealed that there were some variability between activities implementation cost of different partners, but to address the variability, the team decided to accept average implementation cost.

For the costing of those activities, to be implemented for the first time, we benchmarked the activity costing with the previously implemented activities with similar nature, for instance some trainings.

The Microsoft excel program was used as calculating tool for details cost calculation. This could make the calculation easy, simple and editable when needed.

VI. Implementation Arrangements

The CIP will be implemented over a five-year period between 2018 and 2022 through the collaborative efforts of the MoPH, other concerned ministries and their departments at provincial levels, as well as NGOs, civil society organizations and development agencies in partnership with target communities and the wider public.

Governance and Coordination Structure

National

In order to develop a structure that ensures leadership, oversight, support and engagement at the highest political levels and across all levels of government for all aspects of the CIP, an inter-sectoral collaboration and coordination mechanism will be established. This mechanism will be managed by a national FP inter-sectorial committee. This committee will be led by the MoPH-RMNCAH department, which will meet quarterly.

The national FP inter-sectorial committee will be responsible for oversight of the implementation of the CIP and take all high-level decisions concerning its implementation. It will ensure that the CIP is implemented in an integrated and coherent way. Its membership will comprise representatives of key government ministries including MoPH, the Ministry of Women Affairs (MoWA), the Ministry of Education (MoE), and Ministry of Hajj and Religious Affairs (MoHRA), with decision-making power across all departmental areas of central government. It will be chaired by MoPH.

Provincial

In order to develop a structure that ensures leadership, support and engagement at the provincial level, a CIP management committee will be established to oversee implementation at the provincial level.

The members of each provincial CIP management committee will comprise representatives of the provincial departments of key government ministries (MoPH, MoWA, MoE, and MoHRA) with decision-making power at the provincial level. The provincial CIP management committee will be chaired by the Provincial Public Health Directorate (PPHD).

Implementation

Family planning requires work across all sectors and at all levels. Programmes will involve the health sectors, education, religious affairs, and include multiple approaches such as training, advocacy, and awareness-raising.

Roles of ministries and departments

The MoPH will take the leading role in implementing the CIP at the national level, providing leadership, coordination, monitoring and evaluation. They will also take part in the mobilization of resources for implementation.

In order to avoid confusion, and for more effective implementation of the CIP, a clear distribution of responsibility between different ministries, their departments and agencies is critical. This will be ensured through the establishment of specific working groups after CIP implementation is endorsed and initiated by the CIP inter-sectorial committee.

The PPHD at provincial and local levels will be responsible for following up on the implementation of the CIP within their respective areas. The role of other ministries at the national and provincial levels will be to implement sector-specific interventions in partnership with the MoPH.

Roles of NGOs and civil society

The involvement and participation of NGOs and civil society organizations at all phases of the CIP is crucial. These groups possess the knowledge, expertise and experience to effectively engage in the different stages of developing, implementing, monitoring and evaluating the CIP.
Partnering with diverse community leaders and networks, such as religious institutions, health institutions, and local NGOs can provide additional opportunities for the implementation of multi-sectorial approaches. In particular, engaging religious leaders in implementation will be an important strategy as they are well-known and respected in communities, and can influence attitudes and behaviour. Involving other key actors such as mass media and journalists, can bring widespread attention to, and encourage open discussion of FP program.

Role of development agencies

Development agencies[123] can play an important role in the implementation of the CIP by providing technical and financial support. Their role in creating an enabling environment for implementation is crucial. Through their direct collaboration with civil society organizations and NGOs, development agencies can provide an additional avenue to directly influence local and community level planning and implementation of the CIP. By working with civil society organizations and NGOs at the grassroots level, development agencies are able to encourage and promote the application of indigenous approaches and knowledge for behaviour change.

Risks and Mitigation Measures

The implementation of the CIP is always subject to influences beyond the direct control of its inter-sectorial committee. For this reason, the inter-sectorial committee will monitor the external environment to identify and mitigate potential risks where possible.
Table 1 presents a list of potential risks and mitigation measures.

Table 2: Risks and mitigation measures

Types of Risks	Risks	Mitigation Measures
Security risks	Deterioration of the political and security context (high risk)	Regular environment screening will be implemented to identify, assess, prevent, and control security risks. If security deteriorates the implementation strategy will be adapted accordingly. The main aim will be to avoid

[123] Development agencies aim to support projects in various countries by providing necessary resources and assistance. They may be multilateral (e.g. the World Bank, UNICEF, UNDP, UNFPA) or bilateral (e.g. USAID, AusAid, DFID, CIDA).

		the waste of resources, and to limit implementation to essential activities.
Financial uncertainty	Unavailability of funding to implement the CIP	The inter-sectorial committee will develop a comprehensive fundraising plan to ensure that the necessary financial resources are available to implement the CIP.
Social risks	Misinterpretation of interventions by the public and communities	Since the issue of family planning and contraceptive is very sensitive in traditional communities, the involvement of religious leaders, community leaders and local people will be ensured during implementation. Clear explanations of interventions will be provided in the light of civil law, religious legal systems and customary beliefs.

Dissemination Plan

The inter-sectorial committee has overall responsibility for disseminating the CIP at the national, regional and provincial levels through its member ministries and relevant departments and agencies. To ensure that the CIP reaches its target audiences, including government entities, NGOs, civil societies and development partners, a comprehensive dissemination mechanism using a range of media and approaches.

The first and most important step in disseminating the CIP will be its launch through a national event attending by all relevant governmental entities, civil society, NGOs and development partners. Information on the CIP will be disseminated through formal governmental channels to ministries, departments and agencies and through government-called official meetings, conferences and information sharing events. Printed copies of the CIP will be made available at such events.

VII. Monitoring, Evaluation and Reporting

Monitoring and Evaluation

Effective monitoring and comprehensive evaluation are essential elements of the CIP. By identifying successful initiatives and problem areas, implementation will be improved over time. For this reason, the CIP emphasizes on monitoring and project review as a core management component.

In general, the RMNCAH- MoPH as the government body leading the inter-sectorial committee, will have the overall responsibility of ensuring the monitoring and evaluation of the national action plan at the national level. Meanwhile, the provincial public health department, in its capacity as the head of the management committee, will have the responsibility of ensuring the monitoring and evaluation at the provincial level.
Other governmental entities, development partners, civil societies, NGOs and other stakeholders will fully participate in monitoring and evaluation.

As the lead agency the MoPH, with other members of the inter-sectorial committee, will establish a multi-sectorial mechanism to monitor the implementation of the CIP. This will involve the collection, analysis, communication and use of information on implementation progress and the achievement of clearly defined performance indicators that are closely linked with the CIP key interventions and activities.

The monitoring system will provide a mechanism by which relevant information is provided to the inter-sectorial committee and implementing partners in a timely fashion to help them make informed decisions. The monitoring mechanism will be implemented so as to be responsive, to highlight strengths and weaknesses in implementation, and to enable the responsible entities to deal with problems, improve performance, build on successes and adapt to changing circumstances.

The MoPH will lead evaluation, which will determine the relevance, efficiency, effectiveness, impact and sustainability of implemented interventions. There will be a mid-term and final evaluation of the CIP during its five-year implementation period.

The evaluation will be conducted at the project, programme and action levels using different methods including qualitative and quantitative data collection and analysis. It will provide information that is credible, useful and enabling to identify the strengths, gaps, and areas for further improvement. The evaluation process will provide the necessary evidence to define the need and make decisions on modifying interventions or identifying new interventions.

Reporting

Regular reporting will provide a framework for assessing the status of CIP implementation at any given time. The primary purpose will be to ensure that CIP interventions are properly implemented, and necessary actions and decisions are taken in a timely manner.

The MoPH, as the chair of the inter-sectorial committee, will have overall responsibility for developing these annual reports. It will receive monthly and quarterly progress reports from the relevant government departments, implementing partners, civil society organizations and other stakeholders which will form the basis of its annual reports.
The MoPH will make sure that progress on CIP implementation is reported to ministries, stakeholders, civil society and the general public through the dissemination of annual reports via different channels.

Impact

We used and Excel-based model to estimate the health, demographic and economic impact of family planning.[124] The model was fed with the data from Afghanistan Demographic and Health Survey (AfDHS 2015).
The following demographic, health and economic impacts were obtained, after running the model (see the table):

Table 3: Demographic, health and economic impacts of FP-CIP

	2017	2018	2019	2020	Total
Demographic impacts					
Unintended pregnancies averted	132,254	303,206	504,362	737,660	1,677,480
Abortions Averted	62,159	142,507	237,050	346,700	788,416
Health impacts					
Maternal deaths averted	278	596	922	1,249	3,045
Child deaths averted	2,346	5,378	8,945	13,083	29,752
Unsafe Abortions Averted	40,210	92,187	153,347	224,279	510,023
Economic Impacts					
Maternal & infant healthcare costs averted/saved (USD)	3,308,316	7,584,675	12,616,587	18,452,526	41,962,105

[124] Health Policy Project, United States Agency for International Development (USAID), and Marie Stopes International: http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubID=357

Family Planning Costed Implementation Plan (CIP) Matrix

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total (USD)
I-	**Supply**				
	Strategic outcome A.1: Access to information and informed contraceptive choice is improved.				
1.1	Provide the CHWs and health workers with client-friendly educational material to provide accurate and unbiased information, and orient them on the use of these materials	MoPH, UNFPA, WHO, HEMAYAT, BPHS implementers	30000 CHWs provided with educational materials.	2018-2019	**150,000**
			30000 CHWs oriented on educational materials.	2018-2019	**300,000**
			3000 HFs provided with educational materials.	2018-2019	**150,000**
			5000 midwives oriented on educational materials.	2018-2019	**1,000,000**
1.2	Provide client IEC-BCC materials in health facilities (public & private) and health posts.	MoPH, UNFPA, WHO, HEMAYAT, BPHS implementers	3000 public health facilities provided with clients IEC-BCC materials.	2018-2020	**60,000**
			200 private health facilities provided with clients IEC-BCC materials.	2018-2020	**4,000**
			15000 health posts provided with clients IEC-BCC materials	2018-2020	**300,000**
1.3	Strengthen and maintain the provision of FP services and contraceptives through health facilities, which are not supported by donors.	MoPH, UNFPA, HEMAYAT,	300 public HFs (currently not supported by donors) provided FP services and contraceptives (at least four contraceptives are available)	2018–2022	**4,770,000**
1.4	Strengthen and maintain the provision of FP services and contraceptives through EPHS, BPHS facilities.	MoPH,BPHS implementers	2700 public HFs provided FP services and contraceptives (at least four contraceptives are available)	2018–2022	**42,930,000**
1.5	Include contraceptive implants in the BPHS and EPHS drug lists.	MoPH, UNFPA, WHO, HEMAYAT,	Implant is included in the BPHS and EPHS drug lists.	2018	**1,000**

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
		BPHS implementers			
1.6	Promote and support provision of LARC (IUDs, implants, and injectables) methods as a cost-effective, high-impact modern FP intervention at facility and community levels by community midwives	MoPH, WHO, UNFPA, HEMAYAT, BPHS implementers	3000 of HFs promoted and supported the provision of LARC (specifically supply of Implant).	2018–2022	4,050,000
1.7	Strengthen and maintain the provision of FP services and contraceptives in emergency setting.	MoPH,BPHS implementers	34 Mobile Health Team (MHT)on average at least one MHT per province provide contraceptive at emergencies , to affecte population and IDPs	2018–2022	540,600
	Strategic outcome A.2: Access to safe FP services is improved				
2.1	Strengthen Infection prevention including waste disposal at health facilities	MoPH, UNFPA, HEMAYAT, BPHS implementers	3000 public health facilities utilizing infection prevention (IP) measures.	2018–2022	300,000
			3000 public health facilities implementing Health Care Waste Management Policy (HCWMP)-Procedure Manual.	2018–2022	150,000
2.2	Review and develop a better mechanism for infection prevention and waste disposal in health posts.	MoPH, WHO, UNFPA, HEMAYAT, BPHS implementers	15000 of health posts implementing infection prevention measures.	2018–2022	900,000
			30000 of CHWs trained on new mechanism of waste disposal.	2018–2022	300,000
			15000 of health posts implementing new mechanism of wastes disposal.	2018–2022	180,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
2.3	Support PPHDs to ensure that IP standards for different types of facilities and health posts are met by implementing NGOs	MoPH, PPHD, BPHS Implementers	680 supervision and monitoring missions to ensure the implementation of IP standards by implementing NGOs are conducted and reported by the provincial Public Health Directorate.	2018–2022	68,000
2.4	Provide separate spaces to ensure privacy for FP services/counseling	MoPH, PPHD, BPHS Implementers	3000 health facilities have/provide separate space for FP services/counseling.	2018–2022	30,000
2.5	Design and implement appropriate quality improvement and quality assurance approaches to improve quality of FP service provision at facility and community levels	MoPH, WHO	Revise and update HQIP tools as appropriate quality improvement and quality assurance approaches for FP service provision according to need program expansion.	2018	10,000
		MoPH, BPHS implementers	3000 HFs that implemented appropriate quality improvement and quality assurance approaches for FP service provision.	2018–2022	520,000
	Strategic outcome A.3: Continuity of care is strengthened				
3.1	Set up a follow up mechanism in health facilities to enable health service providers to follow up with clients.	MoPH, UNFPA	3000 health facilities implementing and reporting clients follow up mechanism for FP	2018–2022	972,000
3.2	Introduce IT/Mobile technology for clients follow up	MoPH	360000 clients received follow up text message from health facilities annually.	2018–2022	126,000
3.3	Discuss regularly with CHWs during monthly meetings that the discontinuing clients in the community to be identified and counseled.	MoPH	2040 monthly CHWs meeting conducted and reported as aggregated provincial report about FP discontinuing clients.	2018–2022	204,000
3.4	Train the providers on the importance of continuity of care.	MoPH, WHO	6000 of providers received training on the importance of continuing care, especially FP methods.	2018–2022	1,800,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
3.5	Strengthen referral mechanism for FP services within the HF between different departments (such as EPI, Nutrition, and psychosocial counselors) and between HPs, HFs and among different level of HFs, so that clients get optimum level of FP services.	MoPH, BPHS implementers	Referral protocol for family planning services is developed and distributed for referral (within HFs between departments) and different level of HFs and HPs.	2018	3,000
			6000 providers received training on referral protocol and referral mechanism.	2018–2022	600,000
			30000 CHWs received training on referral protocol and referral mechanism.	2018–2021	300,000
	Strategic outcome A.4: Geographical accessibility is improved				
4.1	Conduct a mapping exercise to identify those areas where access to skilled providers, FP services and methods is limited.	MoPH, WHO, BPHS implementers	A comprehensive mapping exercise is conducted in 34 provinces.	2018	34,000
4.2	Improve access through different channels including training of female CHWs, community based distribution, mobile health clinics and establishing family health house (FHH).	MoPH, BPHS implementers	13883 female CHWs trained on administration of FP methods.	2018–2022	138,832
4.3	Use and adopt other successful programs such as EPI to improve access to FP	MoPH	At least one successful program was piloted for improving access to FP.	2018–2022	100,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
	Strategic outcome A.5: Provision of FP services through private sector facilities is improved				
5.1	Strengthen and maintain the provision of FP services and contraceptives through private sector providers.	MoPH, Private sector association, Private providers	200 private HFs provided FP services and contraceptives	2018–2022	**2,575,800**
5.2	Strengthen and maintain the provision of FP services and contraceptives through solo providers.	MoPH, Private sector association, Private providers	250 solo private practitioners provided FP services and contraceptives	2018–2022	**960,000**
5.3	Ensure private sector facilities provide FP services according to national standards and guidelines	MoPH, WHO, Private sector association	1000 of private providers trained/ oriented on the MoPH standard guidelines for the FP services.	2018–2022	**500,000**
		MoPH, private sector association/ private providers	1000 of private providers following the MoPH standard guidelines on the FP services.	2018–2022	**6,000**
5.4	Improve access through establishing public private partnerships (PPPs)	MoPH,	1000 new Solo providers signed MoU with the MoPH for provision of FP services.	2018–2022	**960,000**
5.5	Conduct regular coordination meeting with private sector HFs those have MoUs for FP/BS services	MoPH, WHO, private sector association/ private providers	20 of coordination meetings are held with private sector association/ representatives	2018–2022	**2,000**

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
5.6	Expand the numbers of private facilities with which the MoPH has MOUs for FP services.	MoPH, private sector association/ private providers	200 new private providers/private facilities signed MoU with MoPH for FP services.	2018–2022	**20,000**
	Strategic outcome A.6: Integration of services is improved				
6.1	Screen FP services clients for STIs and HIV	MoPH, WHO, implementing partners	528 HFs screened their FP clients for STI and HIV.	2018–2022	**3,168,000**
6.2	Provide FP services as part of voluntary counseling and testing services for HIV	MoPH, WHO, implementing partners	540000 clients received FP services as part of voluntary counselling.	2018–2022	**cost covered und 1.3 & 1.4**
6.3	Integrate FP counselling in EPI , Nutrition and psychosocial counselling in HFs	MoPH, implementing partners	6000 HFs staff (2000 vaccinators, 2000 nutrition counselors, and 2000 psychosocial counselors) are trained on proper counselling skill.	2018–2022	**1,200,000**
	Strategic outcome A.7: Capacity/skill of human resource involved in the FP program is improved				
7.1	Establish new FP national training centers at highly utilized national maternity hospitals.	MoPH,	Two new FP national training centers were established at two highly utilized national maternity hospitals.	2018	**80,000**
7.2	Decentralize the FP competency-based training through establishment of provincial FP training centers.	MoPH,	5 provincial FP training centers is established.	2018–2019	**100,000**

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
7.3	Ensure all existing FP national and regional training centers are fully equipped with necessary commodities, supplies, and job aids for provision of quality BS/FP training.	MoPH, WHO	5 existing FP national and regional training centers are fully equipped with necessary commodities, supplies, and job aids for provision of quality BS/FP training	2018–2019	50,000
7.4	Establish FP centers of excellence at health facilities to be used for replication of FP training, FP services provision, and mentorship to nearby facility health providers.	MoPH	2 FP centers of excellence at health facilities are established.	2018–2019	10,000
7.5	Map out the available capacity and resources of health facilities (both public and private) as potential training locations.	MoPH	Mapping exercise was carried out to map the available capacity and resources of health facilities as potential training locations.	2018	9,000
7.6	Ensure that all national BS/FP Learning Resource Package (LRPs) and guidelines are up-to-date and aligned with international standards.	MoPH, WHO	10 BS/FP Learning Resource Package (LRPs) and guidelines are up-to-dated and aligned with international standards.	2018	18,000
7.7	Develop training materials that are appropriate in content and scope for other health care providers at health facilities	MoPH, WHO	5 set of new training materials are developed.	2019	31,250
7.8	Review the existing public and private medical and paramedical schools curricula and update the FP topics	MoPH	The existing public and private medical and paramedical schools curricula was reviewed and updated for FP topic.	2018	9,000
7.9	Promote the inclusion of BS/FP subjects, including LAM and postpartum FP counseling, into the pre-service curricula of physicians, Community Health Nurses, and other nurses in public and private institutions	MoPH, WHO	BS/FP subjects, including LAM and postpartum FP counseling is included in the pre-service curricula of physicians.	2019	10,000
		MoPH	BS/FP subjects, including LAM and postpartum FP counseling is included in the pre-service curricula of Community Health Nurses and other nurses.	2018	10,000
7.10	Train faculty of public and private medical and para medical school on FP	MoPH	500 faculty (5 faculty members from each of 100 schools) of public and private medical and para medical school are trained.	2018–2022	150,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
7.11	Develop online FP resource center	MoPH	Online FP resource center established.	2018	11,000
7.12	**a. Health service providers of public facilities**				
i.	Enhance the capacity and capability of in-service training institutions to provide competency-based training	MoPH, WHO	2 in-service training institutions those capacity was enhanced to provide competency-based training	2019	200,000
ii.	Improve the skills of providers to administer/apply infection prevention and safety measures	MoPH, WHO, UNFPA, HEMAYAT, BPHS implementers	3000 Midwives are trained on proper administration of injectable, IUDs, and Implant.	2018–2020	1,500,000
iii.	Build the capacity of doctors in providing permanent methods of sterilization	MoPH, WHO	160 doctors are trained on providing permanent methods of sterilization.	2019–2022	80,000
iv.	Train FP providers in proper counseling skill	MoPH, WHO	6000 of FP providers are trained on proper counselling skill.	2018–2022	1,800,000
v.	Train psychosocial and nutrition counselors on FP	MoPH, implementing partners	4000 (2000 nutrition counselors, and 2000 psychosocial counselors) are trained on proper counselling skill.	2018–2022	Covered Under activity # 6.3
vi.	Initiate and sustain a post-training follow-up and supervision system for all BS/FP trainees, in collaboration with GDHR	MoPH, WHO	200 post-training follow-up and supervision missions are held.	2018–2022	140,000
vii.	Initiate mentorship for FP in the HFs	MoPH	1360 mentorship visits are taken place in the public health facilities by implementing NGO RH Officer.	2018–2022	66,240
7.13	**b. Community Health Workers**				

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
i.	Train female CHWs in appropriate administering injectables	MoPH, BPHS implementers	13883 of CHWs are trained on proper administration of injectables.	2018–2022	**Cost is covered under # 4.2**
ii.	Train CHWs, on appropriate counseling, referral, and provide job aids for CHWs	MoPH, BPHS implementers	30000 CHWs are trained on appropriate counselling, referral.	2018–2022	**600,000**
		MoPH, BPHS implementers	15000 CHWs are provided with job aids.	2018–2020	**15,000**
iii.	Enhance the capacity of community health supervisors in supervision. for technical content and to develop their supervision skills	MoPH, BPHS implementers	1108 CHSs are trained on proper supervision skill.	2018–2020	**33,210**
7.15	**c. PPHO staff, Supervisors and Managers of implementing NGOs**				
i.	Provide training on supportive supervision including FP to provincial reproductive health officers at the PPHO as part of the MoPH Quality assurance mechanism.	MoPH, WHO	34 provincial RH officers trained on supportive supervision.	2019	**17,000**
ii.	Provide training on supportive supervision including FP to RH officer of implementing NGO.	MoPH, BPHS implementers	60 RH officers of implementing NGOs trained on supportive supervision.	2019	**30,000**
iii.	Build the capacity of NGOs program managers on FP services.	MoPH, BPHS implementers	50 NGOs program managers received training and capacity building support on FP.	2019	**25,000**
7.16	**a. Private Sector**				
i.	Improve and build the capacity and skills of private sector providers in FP services.	MoPH, WHO, private providers association	200 Private providers trained and received capacity building support on provision of FP services including counseling.	2018–2022	**100,000**

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
ii.	Strengthen of the counseling skills of pharmacy staff.	MoPH, WHO private providers association	200 Private pharmacy staff trained on proper counseling	2018–2022	60,000
	Strategic outcome A.8: Rights-based Contraceptive provision is strengthened.				
8.1	Increase awareness of the facility, health post on clients' rights and right-based contraceptive services.	MoPH, WHO, BPHS implementers	3000 health facilities' staff oriented on clients' rights and right based approaches.	2018–2021	900,000
		MoPH, BPHS implementers	30000 CHWs oriented on clients' rights and right based approaches.	2018–2022	300,000
8.2	Increase awareness of the women shuras on women' rights and build their capacity to monitor the implementation of the rights.	MoPH, BPHS implementers	500 women shuras oriented on women rights.	2018–2022	40,000
8.3	Increase awareness of the CSO, high school teachers, and CDCs on the FP as human right.	MoPH, BPHS implementers	51000 CSO members, Schoo teachers and CDCs members trained on FP as human right.	2018–2022	816,000
8.4	Strengthen clients' feedback mechanism to facilitate regular feedback.	MoPH, BPHS implementers	68 round of exit interviews were conducted to obtain clients feedback on implementation of clients' rights and right-based contraceptive services	2020–2022	340,000
		MoPH, BPHS implementers	2 reports on clients' feedback surveys are released.	2020–2022	10,000
	Strategic outcome A.9: Monitoring and Supervision mechanism for FP services is strengthened				
9.1	Conduct regular monitoring, supportive supervision of FP services implementation in Public health facilities by RH officer, RMNCAH staff and BPHS/EPHS implementing NGOs; and	MoPH, WHO	100 monitoring visits and supportive supervision are taken place in the public health facilities by National RH department.	2018–2022	70,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
	provide regular feedback on findings	MoPH,	120 monitoring visits supportive supervision are taken place in the public health facilities by Provincial RH Officer.	2018–2022	21,600
		BPHS implementers	120 monitoring visits supportive supervision are taken place in the public health facilities by implementing NGO RH Officer.	2018–2022	21,600
9.2	Conduct regular monitoring, supportive supervision of FP services implementation in private health facilities by RMNCAH provincial and national staff; and provide regular feedback on findings	MoPH, WHO	180 monitoring visits and supportive supervision are taken place in the private health facilities by National RH department.	2018–2022	7,200
		MoPH,	120 monitoring visits supportive supervision are taken place in the private health facilities by Provincial RH Officer.	2018–2022	14,400
9.3	Conduct regular monitoring and supportive supervision of FP activities of CHWs, health Shuras and FHAGs by CBHC officer, CHSs and provide regular feedback on findings	MoPH, BPHS implementers	2040 monitoring visits supportive supervision are taken place from CHWs, health Shuras and FHAGs by CBHC officer.	2018–2022	367,200
		MoPH, BPHS implementers	4080 monitoring visits supportive supervision are taken place from CHWs, health Shuras and FHAGs by CHSs.	2018–2022	204,000
9.4	Conduct post training follow up from public and private health facilities	MoPH, BPHS implementers	240 post training follow up are taken place from public health facilities	2018–2022	120,000
		MoPH,	120 post training follow up are taken place from private health facilities	2018–2022	60,000
	II. Enabling Environment				
	Strategic outcome B.1: Evidence based policy/ strategy development strengthened				

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
10.1	Ensure implementation of FP/BS indicators reflected in RHMNACH strategy 2017-2021	MoPH, WHO	20 review meetings on national FB/BS indicators are held	2018	2,000
10.2	Review and revise the procurement policy for quality assured procurement	MoPH, WHO	Procurement policy is reviewed/ revised	2018	6,250
10.3	Review of the HIV/AIDS and STI strategy to ensure FP services are provided in STI clinics and HIV/AIDS counseling and testing and care facilities	MoPH,	The HIV/AIDS and STI strategy is reviewed.	2018	2,500
10.4	Develop specific strategies to provide FP to married adolescents for delaying first pregnancy in the cases of Early and Child Marriage in line with pre- marriage counselling strategy.	MoPH, WHO	A strategy on provision of FP to married adolescent is developed.	2019	6,250
10.5	Initiate the pre-marriage counselling to target newly marriage couples.	MoPH, WHO	180000 couples pre-marriage counseling.	2018–2022	180,000
10.6	Develop Standard of Procedures (SOPs) for safe administration of contraceptives	MoPH, WHO	Develop Standard of Procedures (SOPs) for safe administration of contraceptives is developed.	2018	9,000
10.7	Develop PPFP (Post Abortion) clinical protocols for antenatal and post abortion counseling and facility postnatal care to expand provision of IUD and implant services for postpartum and post abortion care.	MoPH, WHO	PPFP (Post Abortion) clinical protocols for antenatal and post abortion counseling and facility postnatal care is developed.	2018	6,250
10.8	Promote community based PPFP counselling and referral mechanism and promote an integrated program of home visits for postpartum birth spacing, breastfeeding, infant and young child nutrition, and immunization for community health workers, together with appropriate job aids and a training program.	MoPH	2000 CHSs are trained on integrated program of home visiting.	2018–2019	90,000
		MoPH, BPHS implementers	30000 CHW are trained and provided with job aids on integrated program of home visiting.	2018- 2020	900,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
10.9	Establish healthy mothers group at the health facility level to encourage other mothers to use contraceptives as a BS or FP method.	MoPH, BPHS	500 health mothers' groups are established.	2018-2020	150,000
10.10	Introduce Sayana Press to CHWs	MoPH, BPHS	30000 CHW are trained and provided with job aids on Sayana Press.	2018-2020	750,000
10.11	Integration of FP/BS in citizen charter national priority program (CCNPP)	MoPH	Guideline and SOPs on the integration of FP/BS in CCNPP is developed.	2018	9,000
	Strategic outcome B.2: Capacity for stewardship is strengthened at all levels of administration				
11.1	Strengthen the leadership capacity within the RHD, as well as the capacity to effectively plan, coordinate and communicate FP and RH programmes.	MoPH,	24 RHD staff received training on leadership and management.	2018-2019	12,000
		MoPH,	24 RHD staff received training on planning, including budgeting.	2018-2019	12,000
		MoPH,	24 RHD staff received training on communication and advocacy.	2018-2019	12,000
11.2	Review the RHD in terms of the adequacy of its human and financial resources.	MoPH	RHD department is reviewed in terms of human and financial resources.	2018	6,250
11.3	Develop an advocacy plan to improve the visibility of FP programmes with a clear communication plan for national institutions such as Health committee of parliament, the Ministry of Economy, Finance and the President's Office as well as international institutions.	MoPH	An advocacy plan to improve the visibility of FP programme is developed.	2018	6,250

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
11.4	Establish a Coordination mechanism with HEFD to track FP expenditures at all levels of tracking of expenditures for FP and RH by the Health Economics Division in collaboration with RHD (including at the provincial and district level)	MoPH,	A coordination mechanism with HEFD to track FP expenditures with clear ToR and SOPs is established.	2018–2021	7,500
11.5	Consider performance-based incentives for CHWs on provision of FP services/ improving FP indicators.	MoPH, BPHS Implementing partners.	10 BPHS implementers initiated performance based incentive for CHWs.	2019–2022	48,600
11.6	Strengthen the Capacity of RHD in conducting operational research on FP.	MoPH, WHO	5 RHD staff received training on operational research.	2019	5,000
		MoPH, WHO	5 operational researches conducted by RHD, and technically supported by UNFPA & other partners.	2019–2022	250,000
11.7	Engage religious and community leaders and review ongoing activities by MoPH and MoHRA to identify best practices and gaps.	MoPH, MoHRA, WHO	20 consultation sessions conducted between the MoPH and MoHRA.	2018-2019	2,000
		MoPH, MoHRA,	20 consultation sessions conducted with religious and community leaders.	2018-2019	200,000
		MoPH, MoHRA,	one study supported to identify interpretations of religious teachings with regard to birth spacing and FP	2020	50,000
11.8	Establish FP inter-sectorial collaboration and coordination mechanism and hold national FP inter-sectorial committee meetings	MoPH, WHO	20 national FP inter-sectorial committee meetings are held	2018–2022	2,000
11.9	Integrate and promote Post-partum FP counseling and services in maternal and newborn health services	MoPH, WHO, BPHS implementers	Post partum FP counselling and services in maternal and newborn health services is integrated.	2019	1,000
11.1	Integrate and promote post abortion FP counseling and services in post abortion care services	MoPH, WHO, BPHS implementers	Post abortion FP counselling and services in post abortion care services is integrated.	2019	1,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
11.11	Integrate Family Planning counselling services in immunization program	MoPH, WHO, BPHS implementers	FP counselling and services is integrated in immunization program.	2019	1,000
11.12	Integrate Family planning counselling services in nutrition program	MoPH, WHO BPHS implementers	FP counselling and services is integrated in nutrition program.	2019	1,000
	Strategic outcome B.3: Health Management Information System (HMIS) and Data on FP program is improved				
12.1	Strengthen the RHD's oversight mechanism through establish a central database for national data on FP and other RH services, linked with HMIS.	MoPH	A central database for national data on FP and other RH services is linked with HMIS.	2018	3,750
12.2	Review and analysis HMIS to ensure the CYP data is collected quarterly.	MoPH, WHO	20 HMIS reviews conducted and documented	2018–2022	2,000
12.3	Modify the recording system of FP services to capture information on discontinuing clients	MoPH,	The recording system of FP services is modified during HMIS Review and update process	2018	Covered under # 12.2
12.4	Consider FP/BS target setting at HF level	MoPH,	64 people (NGOs and PPHO HMIS officers) are brieved and oriented on target setting at the HF level.	2018	12,800
12.5	Assess the HMIS review and feedback mechanism at various levels of services and take action based on findings.	MoPH,	20 sessions conducted with partners to provide feedback on HMIS review.	2018–2022	40,000
12.6	Build data quality assurance mechanisms at various levels of health care	MoPH,	A data quality assurance mechanism at various levels of health care is built.	2018-2019	1,000
12.7	Strengthen the capacity of program supervisors at various levels, and CHW supervisors based on the findings of HMIS reports.	MoPH,	1148 program supervisors and CHWs supervisors received capacity building support.	2018–2022	20,664

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
12.8	Conduct trainings on data for decision making for staff managing FP data at various levels.	MoPH,	40 program staff that managing FP data are trained on data for decision making.	2018-2019	4,000
12.9	Strengthen the reporting system of private sector on FP.	MoPH	340 people of private sector providers trained on HMIS reporting including FP.	2018	102,000
12.10	Conduct quarterly based FP data analysis on national level and present it to national forums.	MoPH	20 HMIS analysis and reviews sessions conducted and presented.	2018–2022	Covered under # 12.2
	Strategic outcome B.4: Contraceptive commodity security is improved				
13.1	Review/Revise contraceptive commodity security action plan to address the SEHAT project requirements	MoPH,	Contraceptive commodity security strategy is reviewed /revised.	2018	2,500
13.2	Strengthen supply chain management of FP commodities through proper forecasting, procurement, storage, distribution and reporting on family planning commodity	MoPH,	SOPs are developed for all stages of supply chain management.	2019	2,500
13.3	Develop standards for warehouses and storage place of FP commodity	MoPH,	Standards for warehouses and storage place of FP commodity are developed.	2019	2,500
13.4	Develop mentorship tools to gather and use information about the RH supply chain management system for use in supervisory visits.	MoPH,	Mentoring tools are developed.	2018	1,250
13.5	Monitor the implementation of standards for warehouse and storage place of FP commodity	MoPH,	20 monitoring mission conducted to ensure the implementation of warehouse standards	2018-2022	10,000
13.6	Review and improve Pharmaceutical Logistics Information System (PLIS) to avoid stock-outs	MoPH,	20 review sessions were held to review LMIS to avoid stock outs.	2019-2022	2,000
13.7	Standardize inventory practices and records of RH Commodities	MoPH,	A guideline for standardized inventory practices was developed.	2020	1,250

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
13.8	Develop capacity building plans on RH commodity security (RHCS), PLIS and supply chain management, in collaboration with FP partners for warehouse managers and store keepers and implement the plan	MoPH,	Capacity building plans for warehouse managers and store keepers is developed for both public and private sectors.	2018	1,250
		MoPH,	272 warehouse managers and store keepers trained in public sector.	2019–2020	27,200
		MoPH,	200 warehouse managers and store keepers trained in private sector.	2019–2020	20,000
13.9	Advocacy for off budget resource mobilization	MoPH,	60 high level advocacy meetings held with decision maker	2018–2022	6,000
13.1	Advocacy for provision of FP commodities	MoPH,	60 high level advocacy meetings held with decision maker	2018–2022	6,000
	III. Demand / Demand Creation				
	Strategic outcome C.1: Demand for FP services is increased				
14.1	Develop a comprehensive social and behavior change communication (SBCC) strategy for FP	MoPH	The SBCC strategy for FP is developed.	2018-20198	27,000
14.2	Develop plan for orientation of the provincial health officers, implementing NGOs and private sector on SBCC strategy.	MoPH	Orientation plan on SBCC strategy for FP is developed and implemented	2018	1,000
			102 provincial health officers and implementing NGOs are oriented on SBCC strategy	2018	51,000
14.3	Promote and monitor the incorporation of FP messages in Public and private health facilities and community level.	MoPH	120 missions are conducted to monitor the incorporation of FP message in Public and private health facilities and community level.		60,000
14.4	Develop new messages around FP to address existing and emerging barriers, myths and misconceptions"	MoPH	New messages are developed around FP to address existing and emerging barriers, myths and misconceptions"	2018–2019	6,250

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
14.5	Develop and implement a mass media campaign on family planning to promote FP and to dispel myths and misconceptions about contraception	MoPH, UNFPA	16320 of messages on FP aired through radios.	2018–2022	2,448,000
		MoPH	240 TV spot broadcasted.	2018–2022	67,500
14.7	Conduct round tables at national and provincial level on Islam and FP using of FP booklet	MoPH	680 round tables conducted at national and provincial level.	2018–2022	680,000
14.8	Promote FP messages through CHW, FHAGs and women's shuras focusing on mothers-in-law and elderly women in the community	MoPH, BPHS implementers	2040 information sharing and awareness sessions on FP is conducted by FHAGs.	2018–2022	102,000
		MoPH, BPHS implementers	240000 information sharing and awareness sessions on FP is conducted by women shura	2018–2022	1,200,000
14.9	Encourage CHWs and FHAGs should focus on reaching out to poorer families, young married couples, and first-time parents with BS/FP information.	MoPH, BPHS implementers	30,000 CHWs oriented to focus on focus on reaching out to poorer families, young married couples and first-time parents with BS/FP information.	2018-2019	Covered under # 1.1
14.10	Conduct orientation session on Islam and FP for Mullah and religious leaders	MoPH, UNFPA	680 information sharing and awareness sessions on FP is conducted for Mullah	2018–2022	680,000
14.11	Include Islam and FP topics in in-service training curricula of health workers and CHWs	MoPH	Topics on Islam and FP is included in the in-services training curricula of Health Workers and CHWs	2019	10,000
14.12	Include Islam and FP topics in pre-service curricula of midwifery, nursing and medical schools	MoPH	Topics on Islam and FP is included in the pre-services midwifery, nursing and medical schools	2019	10,000
14.13	Promote FP messages through religious leaders including promoting the distribution and use of existing booklets on FP	MoPH, MOHRA	680 information sharing and awareness sessions on FP is conducted by religious leaders	2018–2022	40,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
	and Islam, approved by the Ministry of Haj and Awqaf and Islamic Affairs	MoPH, MOHRA	1700 booklets on FP and Islam is distributed through religious leaders	2018–2022	5,100
14.14	Distribute the IEC/BCC material on Islam and FP to religious leaders, civil society, health workers and school teachers, CHWs, during national and international days and health Shuras to dispel the myths, and misconception about FP	MoPH, MOHRA, BPHS implementers	3060 sets of IEC/BCC material distributed during three National and international events.	2018–2020	61,200
14.15	Develop orientation package and brochures on FP for civil society ,media and parliamentarians	MoPH,	Orientation package on FP is developed for civil society ,media and parliamentarians	2019	7,500
14.16	Regularly review the reach of channels and impact of messages on FP	MoPH	20 annual reviews of the FP messages impact carried out.	2018–2022	6,000
		MoPH	10 annual reviews of the channels impact through which the FP messages broadcasted/promoted carried out.	2018–2022	3,000
	Strategic outcome C.2: Male involvement in FP services is improved				
15.1	Train health service providers (both male and female) on male and couple counseling	MoPH, BPHS implementers	3000 health services providers are trained on male and couple involvement in the FP counseling	2018–2022	900,000
15.2	Train and orient CHWs (both male and female) on male and couple counseling	MoPH, BPHS implementers	30000 CHWs are trained on male and couple involvement in the FP counseling	2018–2022	900,000
15.3	Integrate FP services into male patient consultation and services	MoPH, BPHS implementers	FP services is integrated into male patient consultation and services	2019	10,000
15.4	Develop and broadcast printed messages, radio and TV spots targeting males	MoPH	5 TV spot targeting males are developed.	2018	5,000
			240 TV spot targeting males are broadcasted.	2019-2022	14,400
			5 radio spot targeting males are developed.	2018	1,500
			8160 radio spot targeting males are aired.	2018–2022	1,224,000

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
	Strategic outcome C.3: Adolescents and young people are knowledgeable on FP services				
16.1	Develop pilot projects on premarital counseling, keeping cultural and religious sensitivity and technical accuracy in view.	MoPH	2 pilot projects developed and conducted on premarital counselling.	2019–2022	**100,000**
16.2	Train health workers to provide gender-sensitive adolescent and youth-friendly services for both girls and boys	MoPH	3000 health workers are trained to provide gender-sensitive adolescent and youth friendly services.	2019–2021	**900,000**
16.3	Develop a training package for teachers in birth spacing (both knowledge and capacity building in conveying the information) and built into ongoing initiatives to involve teachers.	MoPH, WHO	A training package for teachers in birth spacing is developed.	2019	**6,250**
16.4	Strengthen and expand mobile technology services such as youth phone line	MoPH	296,400 clients who used the youth phone line facilities.	2018–2022	**296,250**
16.5	Recruit and train peer educators to improve knowledge of youth on family planning	MoPH	494 peer educators recruited and trained on FP	2019–2020	**247,000**
16.6	Include the importance of birth spacing/ FP and delaying first birth in peer education program.	MoPH, WHO	Birth spacing/ FP and delaying first birth is included in the peer education program	2019	**10,000**
16.7	Provide awareness on FP for adolescent and youth through Youth Health Corners and peer education program.	MoPH	494 youth corners are established.	2019–2022	**247,000**
		MoPH	237120 adolescents and youth received awareness through health corners and peer education.	2019–2022	**474,240**
16.8	Provide awareness on FP methods for adolescent and youths through Youth Help Line (YHL).	MoPH	296400 adolescent and youth who were provided with awareness on FP through Youth Help Line (YHL).	2018-2022	**296,250**
	Strategic outcome C.4: Commercial and social marketing to create demand is strengthened				
17.1	Expand methods available through pharmacies and dispensaries through social marketing	MoPH, ASMO	1,150 newly established selling points under the social marketing.	2018-2022	**338,100**

	Thematic and sub-thematic areas Key Intervention/Activities	Lead Agencies and Partners	Performance Indicators (outputs)	Timeframe	Costing total
17.2	Train Dispensaries and pharmacies on Family planning methods	MoPH, ASMO	2,500 Dispensaries and pharmacies staff was trained.	2018-2022	37,500
17.3	Increase consumer awareness of social marketed products through promotional activities on demand creation through mass media and social/digital media	MoPH, ASMO	2,880TV spot targeting on FP methods are broadcasted under the social marketing.	2018-2022	282,240
		MoPH, ASMO	2,400 radio spot on FP methods are aired under the social marketing.	2018-2022	168,000
		MoPH, ASMO	Promote FP messages through social media and mobile messaging	2018-2022	50,000
17.4	Increase consumer awareness of social marketed products through promotional activities on demand creation through national and traditional events	MoPH, ASMO	30 national and traditional events used for consumer awareness and promotion of social marketed products.	2018-2022	22,500
17.5	Increase consumer awareness of social marketed products through promotional activities on demand creation through organizing health gathering at the community level. Expand methods available through pharmacies and dispensaries through social marketing	MoPH, ASMO	1,650 sessions for consumer awareness and promotion of social marketed products were conducted at the community level.	2018-2022	99,000
				Total	**93,922,226**

Summary of Cost for Family Planning Costed Implementation Plan (CIP)

		Cost per year (USD)					
Thematic and sub-thematic areas		Y1	Y2	Y3	Y4	Y5	Total
I- Supply							
1	Strategic outcome A.1: Access to information and informed contraceptive choice is improved.	10,359,320	11,415,120	10,484,920	10,848,120	11,148,120	54,255,600
2	Strategic outcome A.2: Access to safe FP services is improved	184,100	516,350	591,350	583,850	582,350	2,458,000
3	Strategic outcome A.3: Continuity of care is strengthened	255,000	1,126,000	1,164,000	754,000	706,000	4,005,000
4	Strategic outcome A.4: Geographical accessibility is improved	123,942	67,000	40,000	30,000	11,890	272,832
5	Strategic outcome A.5: Provision of FP services through private sector facilities is improved	136,600	1,221,200	1,221,600	1,222,000	1,222,400	5,023,800
6	Strategic outcome A.6: Integration of services is improved	873,600	873,600	873,600	873,600	873,600	4,368,000
7	Strategic outcome A.7: Capacity/skill of human resource involved in the FP program is improved	457,030	2,088,640	1,585,390	556,820	466,820	5,154,700
8	Strategic outcome A.8: Rights-based Contraceptive provision is strengthened.	251,200	961,200	536,200	241,200	416,200	2,406,000

9	Strategic outcome A.9: Monitoring and Supervision mechanism for FP services is strengthened	177,200	177,200	177,200	177,200	177,200	886,000
	II. Enabling Environment						
10	Strategic outcome B.1: Evidence based policy/ strategy development strengthened	594,400	1,047,650	396,400	36,400	36,400	2,111,250
11	Strategic outcome B.2: Capacity for stewardship is strengthened at all levels of administration	82,800	169,200	151,600	105,200	108,800	617,600
12	Strategic outcome B.3: Health Management Information System (HMIS) and Data on FP program is improved	88,282	72,732	8,400	8,400	8,400	186,214
13	Strategic outcome B.4: Contraceptive commodity security is improved	9,400	33,500	29,750	4,900	4,900	82,450
	III. Demand / Demand Creation						
14	Strategic outcome C.1: Demand for FP services is increased	804,770	1,181,020	1,173,520	1,153,120	1,153,120	5,465,550
15	Strategic outcome C.2: Male involvement in FP services is improved	366,300	1,192,950	578,550	458,550	458,550	3,054,900
16	Strategic outcome C.3: Adolescents and young people are knowledgeable on FP services	188,500	1,260,310	604,060	287,060	237,060	2,576,990
17	Strategic outcome C.4: Commercial and social marketing to create demand is strengthened	200,800	182,200	194,020	208,720	211,600	997,340
	Grand Total (USD)	**15,153,244**	**23,585,872**	**19,810,560**	**17,549,140**	**17,823,410**	**93,922,226**