HEALTH DEPARTMENT
GOVERNMENT OF SINDH

IN SUPPORT OF
FP 2020
FAMILY PLANNING

POSTABORTION FAMILY PLANNING POLICY

Government of Sindh, Pakistan

February 2020

No. PHS (PWD)1-1/2019-20

GOVERNMENT OF SINDH
HEALTH DEPARTMENT

Karachi dated the 25th February 2020

To,

The Country Director
Ipas Pakistan
Islamabad

SUBJECT: ENDORSEMENT OF POSTABORTION FAMILY PLANNING POLICY AND SERVICE DELIVERY STANDARDS AND GUIDELINES FOR HIGH-QUALITY SAFE UTERINE EVACUATION AND POSTABORTION CARE FOR SINDH PROVINCE.

I am directed to refer to the subject cited above and to state that Department of Health is pleased to endorse the Postabortion Family Planning Policy (PAFP) and Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Postabortion Care for Sindh have been formally endorsed. As partners, we look forward to engaging productivity in improving the status of reproductive health of women in the Sindh province.

Public Health Specialist
(Public Health Wing)

A copy is forwarded for information to:

1. Technical Advisor CIP/Population Welfare Department Sindh, Karachi.
2. PS to Minister Health& Population Welfare, Government of Sindh, Karachi.
3. PS to Secretary, Department of Health, Government of Sindh, Karachi
4. PS to Secretary, Population Welfare Department, Government of Sindh, Karachi

Message from the Honorable Minister Health & Population, Sindh

Government of Sindh is making efforts for promoting better healthcare services in the Sindh province. A strong healthcare delivery system promotes effective delivery of health services and investment in healthcare leads to greater economic growth.

Government of Sindh is cognizant of high population growth rate and Unmet Need in family planning and barriers impeding contraceptive use. In this regard, the Departments of Health and Population, and FP2020/CIP secretariat are continuously working with coordinated approach to minimize the missed opportunities such as postabortion family planning. In this regard, Sindh government has developed the Postabortion Family Planning Policy to spell out clearly and re-emphasize the existing needs, and strategies for enhancing the postabortion contraceptive uptake and decrease deaths from unsafe abortions in the province. This postabortion family planning policy is guided by global best practices and considers local evidence in order to commit to improve the status of women`s health in Sindh. Furthermore, it will also bring Pakistan closer to achieve its commitment on global initiatives such as FP2020 and SDGs.

I thank all stakeholders who have contributed for the development of this document. I hope this document will be a source of guidance for high quality postabortion care and family planning.

Dr. Azra Fazal Pechuho
Minister for Health and Population
Government of Sindh

Date: 25 February, 2020

Message of the Secretary Health & Population Welfare, Sindh

The process for development of this policy document spans more than a year that involved a comprehensive consultative and consensus building process among the key stakeholders and extensive review of the existing scope of family planning covered in the current health and population policies. This postabortion family planning policy will help both Health and Population Welfare Departments in developing and implementing a coordinated intervention towards addressing poor contraceptive use and improve the health status of women in Sindh.

This document has identified some major areas which require our utmost attention and it also identifies and provides sustainable solutions based on evidence. This document shall be a driving force to strengthen the roles of both departments in terms of role and responsibility, and the linkage with each other for providing enabling environment to promote and practice postabortion family planning and accessibility and eliminate factors that may compel a woman to seek an unsafe abortion.

Mr. Zahid Ali Abbasi
Secretary Health & Population Welfare Department
Government of Sindh

Date: 25 February, 2020

Message from the Technical Advisor FP2020/CIP PWD

Sindh government has been at the forefront to develop and execute highly effective interventions that led to improved accessibility and high contraceptive uptake in the province. There are several success stories in health and population and FP that demonstrate high commitment of the health and population sector leadership- the worthy Minister Dr Azra Fazal Pechuho. The leadership is strongly committed to achieve high quality results with coordinated approach and improve the contraceptive uptake and sustain modern method use.

Postabortion family planning policy has been developed through a focused stakeholders consultative process involving key relevant technical experts working at the provincial and district level, CIP Secretariat, academia, professional bodies, development partners.

Sindh is a forward-looking province and it is the first province in Pakistan which is relentlessly working to achieve the FP2020 goals by devising and implementing a Costed Implementation Plan. It has shown progress in capacity building, capturing service delivery data and responding to postabortion care needs. Increasing access to family planning will contribute to reduce unwanted pregnancies and associated unsafe abortions.

Dr. Talib Lashari
Technical Advisor, FP2020/CIP PWD
Government of Sindh

Date: 25 February, 2020

ACKNOWLEDGMENTS

Department of Health, Government of Sindh would like to express its gratitude to CIP/FP2020 Secretariat and key stakeholders for their valuable support throughout the development of this document.

We are grateful to Ipas staff – both in Pakistan and the United States – for their technical assistance in drafting this document.

Since this Policy would not have been possible without the dedicated and painstaking work of the reviewers, apart from the authors and contributors, we are grateful to the several experts in the field with extensive experience in reproductive health especially in Postabortion Care and Postabortion Family Planning for providing their valuable inputs particularly acknowledging the valuable technical contributions by the following organizations/representatives of the Government, Development Sector, Donors, I/NGOs, Civil Society and Private Sector;

- Minister of Health and Population Welfare, Sindh
- Technical Advisor, FP2020/CIP PWD
- Naya Qadam project (Bill and Melinda Gates Foundation - Pathfinder International)
- Secretaries of Health and Population Welfare Department, Sindh
- Director General Health, Sindh
- Director General Population Welfare Department, Sindh
- Departments of Health and Population Welfare, Sindh
- In-depth Interview Respondents
- Key stakeholders of Consultative meeting and consultant who carried out the assessment of current PAFP policies
- Consultant who facilitated the consultative meetings
- Technical Working Group FP2020

We owe special thanks to Dr. Ghulam Shabbir Awan, Country Director Ipas Pakistan and Dr. Zakir Shah, Sr. Policy & Communications Advisor Ipas for their continuous support; Dr. Zainab Dawood and Ms. Kamyla Marvi for their facilitation and cooperation during the consultative process to draft this document.

LIST OF ACRONYMS

PAFP	Postabortion Family Planning
PAC	Postabortion Care
UE	Uterine Evacuation
CIP	Costed Implementation Plan
PWD	Population Welfare Department
TFR	Total Fertility Rate
MCPR	Modern Contraceptive Prevalence Rate
PIU	Plan Implementation Unit
TSU	Technical Support Unit
SDGs	Sustainable Development Goals
CMW	Community Midwife
IEC	Information, Education and Communication
IUD	Intrauterine Device
LHW	Lady Health Worker
LHV	Lady Health Visitor
MW	Midwife
MAP	Midwifery Association of Pakistan
SOGP	Society of Obstetricians & Gynecologists of Pakistan
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization
RH	Reproductive Health
MVA	Manual Vacuum Aspirator
OPD	Out Patient Department
LR	Labor Room
EmOC	Emergency Obstetric Care
FWW	Family Welfare Worker
BHU	Basic Health Unit
MLP	Mid Level Providers
HF	Health Facility
IDP	Internally Displaced Person

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1. Introduction

Sindh is the second largest province of Pakistan with a population of 47.9 million (Census 2017). The total fertility rate (TFR) of Sindh (3.6) corresponds with the national fertility rate (PDHS-2017-18) and it has the average annual growth rate of 2.41. With a low modern contraceptive prevalence rate (MCPR) of 24%, Sindh has an 18% unmet need for contraceptives.

Millions of women have no control over the circumstances under which they become pregnant and when faced with an unwanted pregnancy, many seek safe or unsafe abortion. Women who have an induced abortion often have had a previous abortion, yet many of these women do not have access to effective contraceptives and are not adequately counseled and/or offered immediate postabortion family planning services (PAFP), even though postabortion women are at risk of pregnancy almost immediately after the procedure[1]. Experience from other countries shows that abortion rates drop dramatically as the use of effective contraceptives increases and women who are offered PAFP services immediately after treatment have a much higher acceptance rate[2].

Pakistan Abortion Law

The law in Pakistan permits abortion to save a woman's life or to provide 'necessary treatment' to the woman with child whose organs have not been formed[3]. After organs are formed, abortions are permitted only to save the woman's life[4]. By virtue of amendment in the abortion law in 1997, an abortion to treat a woman for safeguarding her health is legal. Protection of the health of a human being is in accordance to the injunctions of the Quran and Sunnah. However, this new provision is not widely understood; meaning, implementation and use of this legal indication is often incorrect or inconsistent.

Unintended pregnancies and the complications that arise from unsafe abortions are tragically common experiences for many women and girls in Sindh province. Every year, there are approximately 600,000 induced abortions in Sindh with an abortion rate of 57 per 1,000 women aged 15 to 49 in Sindh province. Approximately, 175,000 of these women seek care for postabortion complications from public or private health facilities in Sindh[5]. In fact, modern contraceptive use (mCPR) has been

[1] Consensus Statement: International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), International Council of Nurses (ICN), the United States Agency for International Development (USAID), the White Ribbon Alliance (WRA), the Department for International Development (DFID), and the Bill and Melinda Gates Foundation. November 2013

[2] Assessment of existing PAFP policies through a desk review and key stakeholder in-depth interview. Ipas, July 2018

[3] United Nations Population Division, Abortion Policies: A Global Review, New York: United Nations, 2002.

[4] Pakistan Penal Code (Act XLV of 1860), Chapter XVI, Section 338(A)-(C)

[5] Sathar, Z., Singh, S., Rashida, G., Shah, Z. and Niazi, R., 2014. Induced abortions and unintended pregnancies in Pakistan. Studies in family planning, 45(4), pp.471-491.

stagnant in Sindh from 24.5% in 2012 (PDHS 2012-13) to 24.4% in 2017 (PDHS 2017-18). Under FP2020, Sindh is implementing the program to improve the CPR.

Costed Implementation Plan (CIP):

A Costed Implementation Plan (CIP) is a multi-year roadmap designed to help national and subnational governments achieve their family planning goals, thereby saving lives and improving the health and well-being of women, families, and communities. Goal of the CIP Sindh for family planning is intended to help further this vision by enhancing CPR to 45 percent by 2020. The implementation of CIP Sindh FP initiative is supervised by Sindh FP2020 Working Group led by Hon. Minister for Health and Population. A Plan Implementation Unit (PIU) has been setup to provide technical support and coordination between all stakeholders for implementation of CIP. The CIP (PIU) Secretariat is also been declared Technical Support Unit (TSU) to implement Council of Common Interest (CCI) recommendations in Sindh. CIP Secretariat has been providing active support in the implementation of postabortion family planning interventions in Sindh province.

According to WHO estimates, 20-30% of maternal deaths can be averted if family planning methods are correctly used (WHO). In Pakistan, 6-13% maternal mortality due to unsafe abortions could be effectively reduced by ensuring adequate counseling and providing postabortion contraception to the women.

Family planning saves lives by preventing unwanted pregnancies that might otherwise lead to maternal deaths associated with unsafe approaches and practices during induced abortion by untrained providers. Death from any unwanted pregnancy is a tragedy; but women with unwanted pregnancies are often those at the highest risk of dying in childbirth: older women, high-parity women & uneducated women. A cross national analysis of the actual effect of increased usage of family planning on maternal mortality between 1990 and 2005 showed that because of the fertility reduction caused by family planning, there were 22% fewer maternal deaths than would have occurred had both the fertility rate and maternal mortality ratio remained constant[6].

High-risk pregnancies are those that are spaced too closely together, that occur too often, or that occur when the woman is younger than age 18 or over age 35 (Brockman et al., 2003). Unwanted and high-risk pregnancies can result in unsafe abortions, medical complications, and maternal and neonatal death. Family planning seeks to reduce the proportion of women at risk of these complications by averting the number of unintended and high-risk pregnancies. Pakistan is a signatory of United Nations Sustainable Development Goals 2030 and Goal 3 – promoting good health and well-being- is directly related to maternal health. If the contraceptive needs of approximately 45.7 million couples

[6] Stover, J. & Ross, J. Matern Child Health J (2010) 14: 687. https://doi.org/10.1007/s10995-009-0505-y

in Pakistan were met, the country could prevent 7.3 million unintended pregnancies, 34 million induced abortions and 8,500 maternal deaths[7].

Overall, family planning efforts in Sindh province will allow couples/women to better plan for the number and timing of children they desire while also promoting healthy births and deliveries. In 2009, the historic Karachi Declaration endorsed adoption of high-quality postabortion care as among the selected MNCH-FP best practices and pledged[8] integrating and scale up of postabortion care best practice through policies, protocols and standards and guidelines for the health facilities at the provincial and district level.

The World Health Organization's model for PAC includes postabortion family planning (PAFP) as an integral part of the management[9]. However, PAFP is often ignored in the policies, protocols and clinical practice. Firstly, there is lack of a clear policy on PAFP in addition to the prevailing abortion stigma. This translates into lack of integration of FP services in healthcare service package and MNCH/emergency obstetric care (EmOC), Uterine Evacuation (UE)/PAC outpatient and inpatient service delivery areas and non-availability and /or stock outs of FP commodities. There are myths and perceptions about PAFP among women and service providers due to lack of awareness about postabortion fertility return, and the urgency of the need for postabortion contraception. Moreover, providers' biases, lack of capacity in counseling and inadequate use of long acting reversible contraceptives (LARC) undermines the PAFP. As a part of postabortion care, and to minimize missed opportunities for contraception, Government of Sindh places strong emphasis on the importance of postabortion contraception counseling and services, including the role of teaching institutions and facilities for bringing contraception services into UE/PAC procedure areas.

Following the Karachi Declaration, several policy frameworks and policy documents[10] have furthered the Sindh government's commitment to comprehensive PAC including PAFP. However, there is no explicit narrative for policy direction in this regard, especially regarding PAFP. Postabortion Family Planning counseling and service provision comes under the service delivery ambit of the Health Department (DOH) and the Population Welfare Department (PWD), Sindh. Currently both departments are providing emergency contraceptive pills bundled with contraceptive counseling and methods of choice.

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[7] Harris, S. and J. Gribble. 2018. 17 Reasons to Invest in Family Planning in Pakistan: Accelerating Achievement of the Sustainable Development Goals. Washington, DC: Palladium, Health Policy Plus

[8] Karachi Declaration was signed by the representatives of all Provincial Health and Population Welfare Departments, Government of AJ&K, FATA, Government of Gilgit Baltistan, donor agencies and development partners.

[9] Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review. Geneva: Inter-agency Working Group on Reproductive Health in Crises; 2010. 7, Comprehensive Abortion Care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK305158/

[10] Health Sector Strategy Sindh 2012, Sindh Population Policy 2016 and Post-Pregnancy Family Planning Strategy Sindh 2017

The Population Welfare Department provides services through Reproductive Health Services Centers (RHS-A type) generally for interval family planning. These clinics/centers are located within or nearby an obs/gynae ward at tertiary care teaching hospitals and District and Tehsil headquarter hospitals; however, they are almost always in a separate building or a dedicated unit that is away from other services. In addition, PWD also operates Family Welfare Centers (FWC) that actively promote voluntary family planning services, operating as a static facility for about 7,000 people in the catchment area/population around a rural health center or basic health unit. Mobile Service Units (MSUs) offer outreach general healthcare and family planning services in remote and underserved rural areas.

Women that have undergone an incomplete or missed abortion[11] will seek PAC services from the Health Department or from private sector hospital/clinic, in the outpatient/emergency department, labor room and/or operation theatres of secondary and tertiary level care facilities. Medical abortion is available at private pharmacies, and often patients purchase misoprostol tablets without proper counseling, prescription and/or knowing correct dosages[12].

Modern contraceptive method-mix and voluntary contraceptive counseling must therefore be available at the same time and in all the relevant places where women are being treated[13]. Ideally, postabortion care and postabortion contraception are provided in the same unit. Under suitable circumstances, information-sharing, contraceptive counseling and informed decision making about contraception are initiated prior to uterine evacuation if the patient is stable. Postabortion contraception should be offered as part of postabortion care. Almost all contraceptive methods can be started immediately following uterine evacuation. However, women have the right to decline contraception.

1.1. Rationale of PAFP policy development

Due to stagnated CPR and high unmet need for contraception, significant number of women have unwanted pregnancy in Sindh province. The stigma attached with abortion, ambiguity in understanding the abortion law of Pakistan and lack of knowledge among providers and people of the legal availability of safe UE services, many of the women with unwanted pregnancy resort to unsafe abortion every year with resultant morbidity and mortality. However, decreasing TFR (3.6) of Sindh

[11] Incomplete abortion: An abortion—whether spontaneous or induced—in which some pregnancy tissue passes out of the uterus, but some remains.
Missed abortion: A type of spontaneous abortion where the pregnancy stops developing normally but remains in the uterus and the woman has no symptoms.

[12] Sathar, Z.A.; Singh, S.; Shah, S.H.; Rashida, G.; Kamran, I.; Eshai, K. Postabortion Care in Pakistan: A National Study. Population Council, Islamabad, Pakistan (2013)

[13] http://www.pac-consortium.org/downloads/PAC-FP-Joint-Statement-November2013.pdf

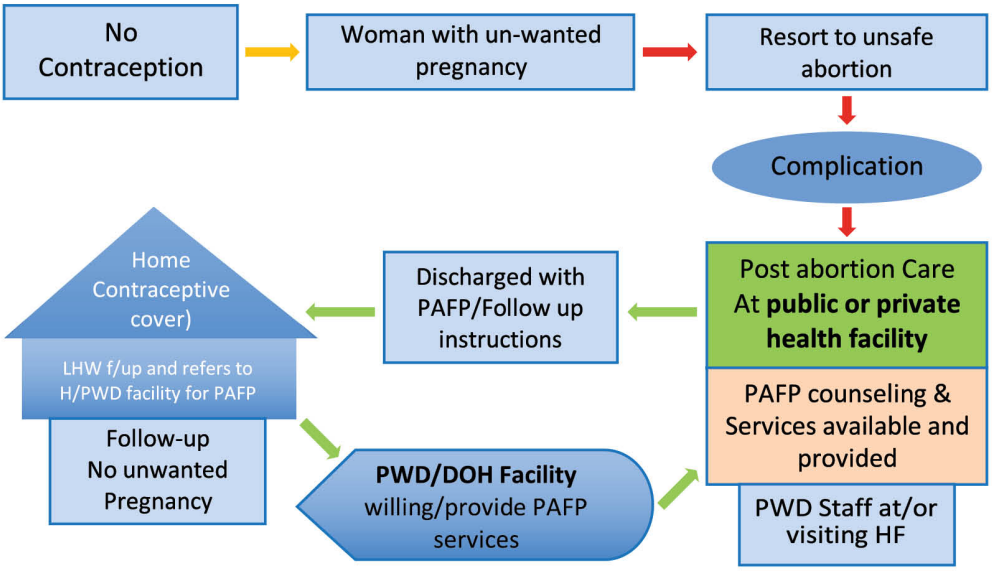
does not correspond with the low CPR; which possibly reflects the result of rising induced abortions and increased age at marriage.

Therefore, low use of postabortion family planning results in repeated abortion and indicates a 'missed opportunity' by the health system to better meet the needs of women and girls. Use of PAFP is essential to prevent a significant proportion of maternal mortality in Pakistan (6 to 13%) which is attributed to unsafe abortions, particularly in Sindh, where the abortion rate is 57 per 1000 women- this would be a major contribution in achieving the Goal 3 of Sustainable Development Goals (SDGs) – promoting good health and well-being. Provincial departments of Population Welfare and Health have the mandate to provide family planning services. However, PAC services are provided by the Health Department at health facilities and FP services are rendered by the PWD at their facilities (FWC, RHSC-A). The PWD facilities operate during the daytime and provide 'interval FP'.

When UE/PAC clients are referred to the PWD facilities for the PAFP services, usually there is a loss of potential FP clients from health facility to the PWD facility. Sometime, a woman may approach herself to a PWD facility for the postabortion counseling or services. It is a general observation and learning from interaction with some of the senior PWD service providers that PWD staff usually hesitate in attending postabortion woman/client given the abortion stigma and lack of skills of counseling and service provision to a PAC case and that PAFP is not part of their mandate or job description.

This warrants the development of a comprehensive provincial postabortion family planning policy to define the role of stakeholders in PAFP and, in turn, to provide the guidance to develop the provincial PAFP strategy and plans.

Figure 1: Pathway to Postabortion Care & PAFP- suggested settings



1.2. Process of PAFP policy development

In the above context, this draft provincial PAFP Policy document was developed through an extensive consultative process with stakeholders, including provincial Health and Population Welfare Departments, MNCH Program, development partners, professional bodies, NGOs/INGOs and private sector organizations to understand need and rationale, collect inputs and to define a common vision, clear policy directions and objectives based on existing reproductive health issues. The draft PAFP Policy is being submitted to the CIP Secretariat, Health Department and PWD, Sindh for review, feedback and approval.

2. Situation Analysis

2.1. Population and service environment

According to the 2017 Population Census, population of Sindh province is over 48 million, which ranks it the second most populous province of the country with a high fertility rate (TFR 3.6)[14]. The average annual growth of Sindh between 1998 to 2017 has been 2.41 (urban 2.46, rural: 2.36). Approximately, 48 percent of the population resides in the rural areas of Sindh. Slightly less than half of the population of Sindh constitutes females (46 percent) with a male to female ratio of 108.5.

According to NIPS-2008, about one in four births in Pakistan is unwanted, and a similar proportion is mistimed (National Institute of Population Studies 2008). Furthermore, an estimated 2.2 million abortions are performed each year in the country, many of them under unsafe conditions (Population Council 2013). These unwanted pregnancies contribute to population growth and are a major factor in maternal mortality where women and girls resort to unsafe abortion. About 6 percent of maternal deaths result from postabortion complications (PDHS 2007-8), and additional indirect deaths (anemia, hepatitis, cardiac disease) related to abortion raise this proportion to almost 10 percent (Jafarey et al. 2010). WHO's figures for Asia and developing countries denote the maternal mortality as 13% due to unsafe abortions.

Unplanned childbearing occurs because women encounter multiple obstacles to the use of contraception including lack of knowledge of contraception and sources of supply; low quality and limited availability of family planning services; cost of method, services, travel, and time; health concerns and side effects; objections from husbands or other family members and concerns about moral and social acceptability (Bongaarts and Bruce 1995; Cleland et al. 2006; Casterline and Sinding 2000; Casterline et al. 2001; Westoff and Bankole 1995). It is essential to strengthen the family planning program in Sindh province to address unwanted pregnancies through enhanced and effective counseling and voluntary measures by providing informed choices when it comes to family planning. Preventing unwanted pregnancies, reducing fertility and population growth could lead to a variety of health, social, and economic benefits.

One of the biggest challenges faced by youth in Sindh who are entering their prime working-age years is translating their productive employment into economic benefits for the province. Strengthening educational opportunities and enabling young women to direct their own reproductive lives by bringing the full panoply of reproductive rights and reproductive health services to them would be the two important steps to be taken by Pakistan in transforming demographic change into poverty

[14] Pakistan: 6th Population & Housing Census-2017

reduction and better lives for the great majority of Pakistanis[15]. Pakistan has a low literacy rate of 58 percent- (Economic survey of Pakistan, 2018) which has a strong relationship with population well-being (Bongaarts 2011; Sathar 2007). Literacy rate in Sindh is 62.2 percent with a substantial gender gap-male and female literacy rate in Sindh is 70% and 46%, respectively. Gender equity in education and employment would improve education rates. Women accounted only for 22 percent of the active labor force in the country (Labour Force Survey, 2010) which needs to be doubled at the very least to ensure that more than half of the working age population is employed.

2.2. Unsafe abortions and postabortion care

Unsafe abortion remains a neglected public health issue in Sindh and other parts of the country, even though thousands of women each year suffer, and sometimes die, from its consequences. The total fertility rate in Sindh has declined from about 5.1 children per woman in the mid-1980s to 3.6 in 2017–18; however, the rate of decrease has been slow and the TFR remains moderately high. The high level of unwanted childbearing and the slow increase in contraceptive use are reflected in a substantial unmet need for contraception in Sindh, estimated at 18 percent in 2017–18[16]. These factors place a large proportion of currently married women at risk of unwanted pregnancies[17].

Out of 2.25 million abortions in Pakistan in 2012, women in Sindh had an estimated 600,000 induced abortions. The abortion rate in Sindh is 57 per 1,000 women aged 15–49; which is the highest induced abortion rate among all provinces (Punjab: 51)[18]. The treatment of 175000 women suffering from postabortion complications imposes a heavy burden on the health system in Sindh and it involves a huge economic cost to manage the complications. This puts a significant financial burden on the already fragile and compromised health care systems, and therefore reduces their capacity to provide other much needed services[19]. Despite this heavy caseload, many women do not reach the kind of health facility surveyed in this study. Not knowing that such facilities exist, how to find them, how to get to them and the inability to pay for travel or take time off from work are probably some of the major reasons that women with abortion-related complications do not receive the care they need. This PAFP policy will lead to improvement on these challenges. Having a PAFP policy in place will mean that when women DO make it to the facility, they will not have to return later for contraceptive services; which avoids added costs related to traveling and/or getting time off work for a second visit.

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[15] Capturing the Demographic Dividend in Pakistan, Zeba A. Sathar, Rabbi Royan, and John Bongaarts, Population Council, 2013

[16] NIPS and Macro International 2008; Bradley et al. 2012; NIPS and ICF International 2013; NIPS 2018

[17] NIPS and Macro International 2008; Bradley et al. 2012; NIPS and ICF International 2013; NIPS 2018

[18] Sathar, Z., Singh, S., Rashida, G., Shah, Z. and Niazi, R. (2014), Induced Abortions and Unintended Pregnancies in Pakistan. Studies in Family Planning, 45: 471–491.

[19] Henshaw SK, Adewole I, Singh S, Bankole A, Oye-Adeniran B, Hussain R. Severity and cost of unsafe abortion complications treated in Nigerian hospitals. International Family Planning Perspectives.2008, March. 34(1): 40-50.

2.3. Postabortion family planning analysis

In 1994, the international health community identified postabortion care (PAC) as an important strategy to reduce maternal mortality by treating complications related to unsafe abortion, incomplete abortion and missed abortion, by providing postabortion family planning counselling and services to prevent repeat unplanned pregnancies and abortions. Contraception Service is an essential and integral element of PAC. Postabortion family planning is the initiation and use of family planning methods immediately after, and within 48 hours of an abortion, before fertility returns as soon as 8 days after uterine evacuation[20].

Following an abortion in the first trimester, or first three months of pregnancy, a woman's fertility usually resumes within two weeks. However, following an abortion in the second trimester, a woman's fertility usually returns more slowly, within four weeks[21]. Many health professionals interviewed in 2012 considered the counselling on a range of topics related to postabortion family planning to be inadequate (Population Council 2013).

Worldwide research shows that use of contraceptives for postabortion contraception was associated with decreased risk of repeat abortion[22]. Population Council's study in 2013 shows that while many facilities provide family planning services on their premises, there are some limitations in what contraceptive methods are offered (pills, injectables and IUDs, for example, are much more likely to be available than implants or sterilization). More importantly, in most facility types, only around half of clients leave with a method. A large number of facilities refer clients to other facilities to obtain contraceptives; however, there is lack of coordination and referral linkages between the public and private sectors, and between the health and population departments. But although counselling services are being provided in the facilities, the quality and extent of these is inadequate. Thus, one of the greatest opportunities for preventing unwanted pregnancies and, by association, unsafe abortions, is being missed: the provision of a contraceptive method to a much higher proportion of women leaving a health facility after receiving PAC treatment.

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[20] Family Planning: A Global Handbook for Providers; 2018 edition. Available from: http://www.who.int/reproductivehealth/publications/fp-global-handbook/en/
Clinical Practice Handbook for Safe Abortion. Geneva: WHO; 2014. Available from: www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/

[21] Postabortion Family Planning updates, Family Planning Division, Ministry of Health and Family Welfare, Government of India, March 2016

[22] Heikinheimo O, Gissler M, Suhonen S. Age, parity, history of abortion and contraceptive choices affect the risk of repeat abortion. Contraception. 2008. 78(2): 149-154 Curtis C, Huber D, Moss-Knight T. Postabortion family planning: addressing the cycle of repeat unintended pregnancy and abortion, International perspectives on sexual and reproductive health. 2010. 36(1):44-48.

3. Policy Direction

3.1. Vision

To achieve the highest attainable standards of health and family planning for all women and girls receiving uterine evacuation/postabortion care (UE/PAC) in Sindh Province.

3.2. Goal

To ensure that all women and girls in Sindh province have universal access to high-quality integrated postabortion family planning (PAFP) services in an equitable, efficient and sustainable manner.

3.3. Objectives

The PAFP Policy will provide a framework to:

1. To provide a rationale, direction and drive for developing/integrating and implementing woman-centered PAFP strategies and interventions.
2. To devise and implement strategies/mechanisms, SOP, expand job descriptions and content of capacity building activities (pre and in-service) of the regulation/accreditation bodies, teaching and training institutions, senior and midlevel managers and health care/FP providers, to integrate into the health system holistically so that the health/population staff at levels from community upwards are able to deliver quality, integrated and client friendly PAFP services.
3. To frame, implement, follow-up and monitor a harmonized, integrated and sustainable package of quality women-centered PAFP promotion, prevention and treatment interventions, commodities and evidence-based innovative technologies and interventions at facility and community levels and conduct research on the cost-effectiveness of interventions (Refer to 'Selected Practice Recommendations for Contraceptive Use; 3rd edition, 2016)[23].
4. To strengthen health systems towards universal coverage of PAFP services by paying attention to the deployment and retention of health and population staff and geographical access to PAFP services by under-served and vulnerable groups/beneficiaries and use the DHIS/HMIS & CIP database to monitor equity and inform decision making through a robust data collection system.
5. To expand ambit PAFP counseling and service provision and accordingly expand the providers' particularly midlevel providers' role and job descriptions, and address capacity building needs, formulate mechanism/arrangement to integrate the facilities at all levels including public and private for PAFP counseling and service provision.

[23] https://apps.who.int/iris/bitstream/handle/10665/252267/9789241565400-eng.pdf;jsessionid=5DD283A2F4D79556B4F271F7BB05E59C?sequence=1

6. Strengthen intersectoral/inter-departmental collaboration and coordination-especially between Health and Population Welfare Departments- and harmonize existing Population and Health policies to address the social determinants of poor postabortion family planning outcomes, and evidence generation to identify major obstacles and the most effective coordination mechanisms.

   6a. To strengthen supply side, commodity security, and equipment related to FP at all facilities, across public and private sector.
7. To highlight need for policy makers, managers and providers to examine their personal values and clarify the need for attitude transformation in order to fulfill their responsibilities of addressing abortion and postabortion health needs in a non-stigmatizing manner.
8. To intensify health/FP promotion efforts to increase community knowledge and awareness on PAFP interventions, to strengthen referral pathways and promote health/FP seeking behavior.
9. Strengthen governance systems and accountability (joint planning, implementation, monitoring, documentation and evaluation) of integrated PAFP interventions at provincial and district, including public-public and public-private partnerships.

3.4. Strategies to Achieve the Objectives

Strategy for Objective 1:

i. To develop the PAFP Strategies for translating the directions of the PAFP policy which will lead to the development of implementation plans with defined interventions.
ii. Pave the way for the development of clinical standards and guidelines on PAFP for assuring quality of services and operationalization at the service delivery level.

Strategy for Objective 2:

i. Seek assistance to build resilient systems to protect women and girls by fostering the principles of universal health coverage and human rights approach through health systems strengthening.
ii. Seek to achieve a strong, efficient, well-run health system that meets priority FP/PAFP needs through women-centered services that are universally accessible to the women and girls.
iii. Improve capacity and competency through developing an integrated FP/PAFP pre-service training and continuing professional development for health care and family welfare at medical educational institutions and training schools. This includes medical colleges, post-graduate medical institutions, teaching hospitals, nursing and midwifery schools, public health schools, regional training institutes (RTIs), Provincial Population Welfare Training Institutes (PWTI) and other training institutions.
iv. Seek to ensure high quality pre-service and in-service training for health care/population welfare providers to learn and implement the skills needed to provide integrated client-friendly and woman-centered PAFP interventions.

Strategy for Objective 3:

i. Integrate PAFP program management structures at provincial, district and facility levels.
ii. Support the institutionalization of a harmonized and standardized and integrated and sustainable PAC and PAFP essential packages/protocols that deliver a respectful woman-centered care.
iii. Support institutionalization of a harmonized quality assurance improvement model and mutual accountability mechanism. This would be achieved through the quality assurance institutions & guidelines such as provincial health care commission and Manual of Standards for Family Planning Services, Sindh.
iv. Mainstream rights-based approaches into PAFP programming, planning and implementation.
v. Establish and harmonize dynamic, sustainable and integrated health, family planning and population information systems to facilitate timely and evidence-informed decision-making.
vi. Promote sharing, documentation and application of effective and innovative PAFP practices.
vii. Ensure family planning interventions are integrated across the continuum of RH care in order to break the life cycle of unsafe abortions and complications of abortion that contributes to morbidity and mortality.
viii. Foster research and innovation on the adoption and scale-up of innovative PAFP service delivery models and technology. It will also encourage integrated innovations-such as Health and Population Welfare- which contribute to improved outcomes in PAFP.
ix. Support PAFP preparedness activities to strengthen the resilience of health systems during emergency humanitarian situations.

Strategy for Objective 4:

i. Promote research on access and utilization of UE/PAC and PAFP services with a focus on the poorest and most vulnerable groups in the population.
ii. Ensure access to cost-effective and safe PAFP products, commodities and appropriate infrastructure.

Strategy for Objective 5:

i. Review the existing ambit of PWD to include PAFP counselling and service provision in the job description of various cadres especially the midlevel providers.
ii. Encourage to develop the capacity building plan for service providers in PAFP counselling and service provision.
iii. Promoting to strategize the mechanisms to build the capacity of service providers of Health Department in Family Planning Counselling and service provision by PWD trainers and provision of counselling through dedicated counselors deployed in health facilities.

Strategy for Objective 6:

i. Focus on the role and advocate with other sectors/departments contributing to the causes of poor PAFP outcomes in women and girls.
ii. Develop multi-sectoral/inter-departmental strategies and mechanisms at provincial, district and community level to address key inter-sectoral/inter-departmental issues in PAFP, including reducing stigma, raising awareness, sensitization and capacity building for PAFP.
iii. Strengthen partnerships and coordination for PAFP service delivery at provincial, district and community level.
iv. Implement coordination structures to minimize overlap of activities at facility and community level.

Strategy for Objective 6a:

i. Identify the potential role of public-public and public-private partnerships to effectively address constraints of service delivery supply chain management and fostering innovations through research and development.

Strategy for Objective 7:

i. Aim to reduce the stigma towards abortion and Postabortion care by focusing on values clarification and attitude transformation (VCAT) of policy makers, managers and providers.
ii. Reduce the biases of providers towards abortion, PAC and PAFP by strengthening behavior change communication that will improve the behavior of providers towards the clients and strengthen provider's communication skills.
iii. Strategize and develop a coordination mechanism between various stakeholders especially between Health and PWD to improve and ensure quality service delivery and timely referral of PAC and PAFP clients.
iv. Develop the SOPs for Health and PWD to provide PAFP services to all clients receiving UE/PAC services.

Strategy for Objective 8:

i. Promote PAFP advocacy, health promotion, behavior change and social mobilization strategy (ies) that effectively reach all the key stakeholders and beneficiaries.
ii. Use woman-centered and client-friendly innovative mechanisms to reach women, girls, families and hard to reach groups, such as Internally Displaced Person (IDP) and refugees in humanitarian settings and women and girls with disabilities.
iii. Foster research into the effectiveness and quality of social mobilization messages and methods for increasing health seeking behavior.
iv. Promote harmonization and quality of social behavioral change messages across sectors and actors.

v. Address health system issues to facilitate access of the community in seeking FP such as privacy or confidentiality by strengthening the health system to be responsive in upholding the provider/facility obligations.
vi. Define revised roles and functions of health care/population welfare providers in view of provision of PAFP interventions including PAFP services.

Strategy for Objective 9:

i. Aim to strengthen the leadership and governance pillars of the health/population system to accelerate delivery of effective PAFP services and strengthen accountability for results.
ii. Promote harmonization of policies and procedures to ensure access to PAFP services by women and girls.
iii. Ensure effective integration of PAFP policy, strategy, programs and financing for improved service delivery at facility and community level.
iv. Harmonize and adopt enabling provincial PAFP policy in accordance with national, international and regional instruments ratified by the Government.

3.5. Activities to Achieve the Objectives

3.5.1. Requirements for the Interventions

The activities would require following interventions and management structures in place at the service sites

1. SOP/guidelines for PAFP in place for the PAFP counseling and high-quality service provision particularly ensuring privacy and confidentiality to the client.
2. Designating a shift focal person in each unit/site to ensure that PAFP counseling and services are provided.
3. Availability of a trained provider in PAFP counselling and service provision at/around the PAC service delivery points. Nurses and midlevel staff are involved in counseling and service provision.
4. Availability of method mix choice- ideally all modern contraceptive methods (full range of short term and LARC)- of at least 3 modern methods.
5. Record keeping system/reporting mechanism.
6. PAFP- IEC/SBC material availability and display in OPD and service delivery waiting areas.

3.5.2. Activities to implement the Interventions

Above mentioned interventions will require to arrange and place:

1. Whole site orientation in PAFP for all staff including support and cleaning staff, and Availability and compliance with SOP for PAFP and ensuring privacy and confidentiality to

the client at the time of counseling and service provision and offering full range of choice of method mix contraceptives.

2. Availability of shift designated focal person.
3. Capacity building of focal persons and providers including nurses and midlevel providers in PAFP counselling and service provision.
4. Contraceptive commodity supply and management system.
5. Monitoring, supportive supervision and evaluation system.
6. Development/updating FP IEC materials to include PAFP and screen display in waiting areas of the OPD and service delivery.
7. Take home messages/IEC should go with the clients receiving counseling & services.

4. Governance Framework

4.1. Organization and management of sectors to deliver results

After the 18th amendment in the constitution of Pakistan in 2010-11, Health and Population are provincial subjects and provincial governments are responsible for the formulation of health and population policies and implementation of programs and for the financial allocations. There are separate departments for Health and Population at the provincial level. In Sindh, Health and Population Welfare Departments are governed under the unified Provincial Health & Population Ministry.

4.2. Provincial Health Department

Overall, the Provincial Health Department is governed and managed by the Provincial Health Secretariat and Health Directorate; whereas, District Health is managed by the District Health Office. Maternal, Newborn & Child Health Program (MNCH) & LHW Program and other programs.

4.3. Provincial Department of Population Welfare (PWD)

The prime mandate of PWD is to provide family planning services to individuals and couples. The main structure of the Provincial Population Welfare Department comprises of the Secretariat, the Directorate General, Population Welfare Training Institute (PWTI), Regional Training Institutes (RTIs), RHS A, FWWs and District offices.

4.4. Suggested Mode of Services

Following mode of services will be included in the strategies:

1. PAFP interventions through providers of Health Department at the site of provision of UE/PAC services.
2. PAFP interventions through providers of PWD at the site of provision of UE/PAC services.
3. After UE/PAC services & counseling, referral of the client by the provider of Health Department to the PWD facility within the premises of the health facility and ensuring that client receives services from the PWD facility.
4. Follow up by the community based workers / outreach staff.

4.5. Management and Stewardship structures

This policy suggests that postabortion family planning should be provided at the site where UE/postabortion care is provided i.e. health facilities. In the health facilities following are the possible points where UE/PAFP services are provided:

a. Outpatient Department (OPD)
b. Operation Theatre (OT)
c. Labor Rooms (LR)
d. Emergency Department (ER)
e. Ward (Gynecology & Obstetrics/Female)

The women receiving UE/PAC services will be provided access to (24/7) PAFP services (counselling & provision of FP methods) at the sites mentioned above.

4.6. Roles and Responsibilities

Provincial Health Department and Population Welfare Department will take the ownership of provision of PAFP services in their respective roles. Other institutions and departments such as Provincial Health Care Commission, Midwifery Association of Pakistan (MAP), Society of Gynecologists and Obstetricians of Pakistan (SOGP), College of Physicians and Surgeons of Pakistan (CPSP) and others' role, as given in the following sections, will be further defined to strengthen the PAFP.

4.6.1. Role of Health Department

Postabortion family planning (PAFP) is a mandatory component of PAC services. Health Department will provide the counselling and PAFP services to all women and girls receiving UE/PAC services. The department will ensure the availability of trained service providers and full range of contraceptives are available at the site of provision of UE/PAC services. The Health Department in tandem with Population Welfare Department must ensure availability of choices of family planning methods at all service points. Specifically, for PAFP, commodities must be available at all PAC service points (operation theatre, labor room, gyne/obs ward and OPD) and an integral part of EmOC services. Commodity supplies, and equipment must be continually replenished, and stock outs prevented (Table 1). The intention would be that every woman receiving UE/PAC service is offered/counseled and has access to the family planning methods. Health Department would place a robust M&E system to record all the information of UE/PAC services including PAFP services.

4.6.2. Role of Population Welfare Department

Population Welfare Department is the prime department of the province working on family planning awareness raising, counselling services and provision of contraceptive services to the population. PWD will build the capacity of the Health Department in provision of PAFP services. This would apply to training of all cadre of service providers related to UE/PAC services, and in turn, to the PAFP services. The coordination between Health Department and PWD would be enhanced for the contraceptive supply management to ensure the availability of FP commodities at health facilities for

PAFP services. At the health facilities where RHS centers are located, PWD staff would visit the gynecology and obstetrics department for counselling and provision of PAFP until the capacity of health staff of the facility is built to provide the PAFP services (Table 1). Innovative research models will also be implemented where PWD staff would provide coverage for PAFP clients.

Table 1: Roles and Responsibilities- Health Department & PWD, Sindh

S#	Services	Health Department				PWD	
		Tertiary Care Facilities		Primary & Secondary Care facilities			
		C	S	C	S	C	S
1.	PAC Service Provision	√	√	√	√	X	√
2.	PAFP Counselling & Services at Health/ PWD facilities	X	√	√	√	√	√
3.	Procurement of FP Commodities	X	X	X	X	√	√
4.	Availability of FP commodities at Health & PWD facilities	√	√	√	√	√	√
5.	Capacity Building for FP Counselling and FP Service Skills	√	√	√	√	√	√
6.	Inter-departmental Referral	√	√	√	√	√	√
7.	Follow-up of PAFP Clients	√	√	√	√	√	√
8.	Record Keeping PAFP	x	√	x	√	x	√
9.	M&E PAC	X	√	x	√	X	√

C= Current performance/role; S= Suggested performance/ role in PAFP Policy

4.6.3. Role of other Departments and Institutions

Government of Sindh will ensure that PAFP is an integral part of service delivery and provide supportive supervision and mentoring through ongoing facility level and provider level clinical competency checklists. Furthermore, Government of Sindh will establish coordination with Health Care Commission, Midwifery Association of Pakistan (MAP), Society of Obstetricians & Gynecologists of Pakistan (SOGP), College of Physicians & Surgeons of Pakistan (CPSP) and private sector for capacity building and provision of services for PAFP.

4.6.4. Role of Public Providers

- **Community level and outreach providers**

Community level providers, including LHWs and FWAs male and female, must seek to identify women eligible for PAFP, counsel them for voluntary contraception, provide methods of choice if available or if required refer for family planning services.

- **Midlevel service providers (MLPs)**

MLPs, including CMWs, LHVs, Nurses and family welfare counselors (FWCs)/Family welfare workers (FWW) must have the capacity to counsel for voluntary PAFP, provide methods of choice or if required, refer for family planning services. The Pakistan Nursing Council also seek to expand the role of LHVs, community midwives and Nurses to include PA-IUCD and implants and will ensure competency- based training to ensure capacity for the same. PWD will expand the role and competency of FWC/FWW in implant insertion.

- **Public Sector Healthcare Providers in Obstetrics and Gynecology**

PAC cases are by and large dealt with in obstetrics and gynecology departments of public sector hospitals. The Health Department will ensure that PAFP is a mandatory component of the PAC services provided. This will include counseling for voluntary contraception, as well as provision of the service to all PAC cases. To ensure this, nursing staff will need to be trained and deployed at the obstetrics and gynecology/female departments, and commodity provision will be ensured at the ward level to allow for on the site choice of methods.

Table 2: Provider eligibility for the provision of postabortion contraception in Pakistan

Services	LHW		FWA		FWW		CMW		MW/N-MW/LHV		Doctor	
	C	S	C	S	C	S	C	S	C	S	C	S
Clinical Assessment of PAFP Client	x	x	x	x	x	√	√	√	√	√	√	√
Provide Confidentiality & Privacy to PAFP Client	√	√	√	√	√	√	√	√	√	√	√	√
Respect & provide support to Women's Informed & Voluntary Decision-Making & Autonomy	√	√	√	√	√	√	√	√	√	√	√	√
Community Linkages for Referral and Support	√	√	√	√	√	√	√	√	√	√	√	√
Counselling on PAFP	√	√	√	√	√	√	√	√	√	√	√	√
Provision of PAFP Services-Condoms, pills	√	√	x	x	√	√	√	√	√	√	√	√
Provision of PAFP Services-Injectables (2nd Injection)	√	√	x	x	√	√	√	√	√	√	√	√
Provision of PAFP Services IUCD	x	x	x	x	x	√	x	√	x	√	√	√
Provision of PAFP Services-Implant	x	x	x	x	√	√	√	√	√	√	√	√
Provision of PAFP Services-T. Ligation	x	x	x	x	x	x	x	x	x	x	√	√
Client Follow-up	√	√	√	√	√	√	√	√	√	√	√	√
Complications Referral	√	√	√	√	√	√	√	√	√	√	√	√
PAFP complications treatment	x	x	x	x	√	√	x	√	x	√	√	√
Maintain environmental Hygiene of PAFP services provision area & HF	√	√	√	√	√	√	√	√	√	√	√	√
Monitoring, Quality Improvement & Evaluation	√	√	√	√	√	√	√	√	√	√	√	√

C= Current provision of role; S= Suggested provision of role in PAFP Policy

4.6.5. Training and Capacity Building

- **In-Service Capacity Building**

Training including value clarification & attitude transformation (VCAT) of all cadres of health care providers at all levels of the health system including outreach workers, BHU, RHC, THQ, DHQ, FWC, RHS Centers and tertiary hospitals in PAFP will be assured. Capacity building of service providers must also address the stigma related to abortion to ensure comprehensive services, including family planning, are available to PAC clients. All government health care providers must be provided capacity building through competency- based certification on PAFP. For specialist providers, CPSP, SOGP, PMA and College of Family Physicians must promote PAFP amongst their membership.

- **Pre-Service Training**

PAFP must be a compulsory part of all health care and population welfare providers' pre-service curriculums. Where necessary Higher Education Commission (HEC) /PNC may be involved to ensure relevant approvals.

- **Additional measures**

The SBC strategies aimed at reducing stigma in the communities require working with local groups and/or training CBOs to support amplifying the messages and increase health seeking behaviors. The policy aims to strategize further in this direction.

4.6.6. Monitoring and Supportive Supervision of PAFP

Creating a safe culture through routine monitoring and evaluation of service statistics, contraceptive commodity availability and stock-outs, adverse events and removal of implants and IUDs should be used to inform and improve service delivery. DHIS indicators must track PAFP service provision through number of clients that were offered PAFP services and number of clients accepting PAFP. Furthermore, operational data on trained providers in the health system must be maintained in order to monitor access to PAFP services. Supervision and monitoring mechanisms of all health care providers must include supportive supervision for PAFP. Data will be shared with CIP through its proforma on monthly basis.

Annex.1. Instructions for Women about Postabortion Care & Contraception

As per Pakistan Abortion Law Section 338 Pakistan Penal Code 1860 (amended 1997), Abortion is legal in two conditions.

- To Save the woman's life
- To Provide necessary treatment

Safe Postabortion Care through Trained Health Care Providers:

Misoprostol: Misoprostol causes uterine contractions to expel out the remaining parts of procedure of conception/pregnancy tissues.

Manual Vacuum Aspirator: MVA is an instrument which is inserted into the uterus to remove remaining parts of products of conception/ pregnancy tissues.

Trained health care providers:

- Doctor
- Nurse
- LHV
- Midwife/community midwife

WARNING SIGNS (After PAC Procedure) TO SEEK IMMEDIATE HELP FROM A TRAINED HEALTH CARE PROVIDER

- **Excessive bleeding:** Soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, lightheadedness and increasing fatigue.
- **Severe abdominal pain:** Occurs any day after the day misoprostol is taken.
- **Fever:** A temperature of 38°C (100.4°F) that occurs any day after the day misoprostol is taken.
- **Unusual or bad-smelling vaginal discharge:** Especially if accompanied by severe cramps or abdominal pain.
- **Feeling very sick:** With or without fever, and persistent severe nausea or vomiting after the day misoprostol is used.

Postabortion Family planning- Contraceptive Methods Available to You

- You will be able to get pregnant again within 08 days after the treatment of an incomplete/missed abortion.
- If you would like contraception; it should be started immediately.
- Long acting reversible contraceptive (LARC) methods are more effective than the short-term methods in preventing an unwanted pregnancy.
- You can use any method after a complete and uncomplicated vacuum aspiration.
- You can use most methods when you take misoprostol, except for IUCD and sterilization. Those methods can be provided as soon as it is certain that the uterine evacuation is complete.
- Consider the effectiveness of contraceptive methods when choosing a method.
- Talk to your health care provider at the facility for more information about available methods.

When should you come back for a follow-up?

- If you have any concerns, return to the health facility at any time.
- If you would like to come back for a visit to receive more information on family planning choices, you can do so at any time.

Annex.2. List of Participants of the Consultative process – Draft PAFP Policy, Sindh

1. List of Respondents - Assessment of existing PAFP policies- key stakeholder in-depth interview (June – July 2018)

S. No	Name	Designation	Organization
1.	Dr Talib Lashari	Technical Advisor CIP/FP 2020 PWD	Population Welfare Department, Sindh
2.	Dr. Mahwish Mubarik	Deputy Director (Clinics)	PWD, Sindh
3.	Dr. Shama Iftikhar	Assistant Director (Clinics)	PWD, Sindh
4.	Dr. Tabinda Sarosh	Country Director	Pathfinder International
5.	Dr Azra Ahsan	Technical Consultant	National Committee on Maternal, New-born & Child Health (NCMNH)
6.	Dr. Noreen Zafar	President	GWHI, Lahore
7.	Dr Jamil Ahmad Chaudhry	National Program & Technical Specialist	UNFPA, Islamabad
8.	Dr. Lamia Mahmoud	MNCH Officer	WHO, Islamabad
9.	Ms. Clara Pasha	Vice President	Midwifery Association of Pakistan (MAP)
10.	Dr Ghulam Shabbir	Country Director	Ipas, Pakistan
11.	Dr Nasser Mohiuddin	DG Technical	Population Program Wing
12.	Dr Atiya Aabroo	Deputy Director, (Program III)	MoNHSR&C
13.	Dr Mumtaz Eskar	Technical Advisor	Marie Stopes Society (MSS)
14.	Dr Akhtar Rasheed	Additional Director (Operations)	Health Department, Punjab
15.	Dr Saadia Ahsan Pal	Vice President, SOGP	Aman Foundation
16.	Ms. Naureen Lalani	Manager -Sexual and Reproductive Health Management	AHUNG

17.	Ms Zofeen Ebrahim	Journalist	Freelance Journalist
18.	Dr Nadeem Ahmed	Project Director – Global Comprehensive Health Care Initiative	Rahnuma Family Planning Association of Pakistan (R-FPAP), Lahore
19.	Dr. Syed Khurram Azmat	Chief Technical Services	Green Star, Karachi
20.	Shazina Masud	CEO	Aman Foundation
21.	Dr. Noureen Asghar	Director PME	PWD, Punjab

2. Participants of Provincial Consultative Meeting- Sindh for the Development of Postabortion Family Planning Policy held on 24th September 2018 at Karachi

S.No	Name	Designation	Organization
1.	Dr. Khalid Hussain Bukhari	The Provincial Programme Director	MNCH Programme, Department of Health, Sindh
2.	Dr. Ghulam Shabbir Awan	Country Director	Ipas Pakistan
3.	Dr. Zakir Hussain Shah	Policy & Communications Advisor	Ipas Pakistan
4.	Dr. Zaib Dahar	Senior Technical Advisor	PPHI Sindh
5.	Dr. Javed Kakepoto	Additional Director	Health Department, Sindh
6.	Dr. Badar Munir	NPO MNCH Sindh	World Health Organization (WHO), Sindh, Pakistan
7.	Dr. Teerath Das	DPD	MNCH, Karachi
8.	Ms. Jenifer Younas	Provincial Coordinator	Pathfinder International
9.	Dr Qudsia Uzma	NPO MNCH	World Health Organization (WHO), Pakistan, Islamabad
10.	Dr Sara Salman	Head of Office	World Health Organization (WHO), Sindh, Pakistan
11.	Ms. Aliya Rifaqat	Consultant	Pathfinder International
12.	Dr. Marium Waqas	Head of Project Naya Qadam	NCMNH, Karachi

13.	Dr Yasmeen Qazi	Senior Country Advisor	The David and Lucile Foundation, Karachi
14.	Ms. Renuka Swami	GBV Analyst	UNFPA, Karachi
15.	Dr Nasser Mohiuddin	Director General Technical	Population Program Wing, Ministry of National Health Services, Regulations & Coordination, Islamabad
16.	Dr Atiya Aabroo	Deputy Director, (Program III)	Ministry of National Health Services, Regulations & Coordination, Islamabad
17.	Ms. Farhana Shahid	Technical Advisor	Jhpiego
18.	Dr. Tanweer Hussain	Team Lead	USAID
19.	Dr. Azra Ahsan	President	Association of Mother's & Newborns (AMAN)
20.	Prof. Dr Sadiah Ahsan Pal	VP SOGP/ Joint Secretary AMAN	OMI Hospital, Medicell Clinic & Concept Fertility Center, Karachi
21.	Ms. Ghausia Rashid Salam	SPO	Shirkat Gah
22.	Umair Aslam	Manager Programs	Aman foundation
23.	Ms. Naureen Lalani	Manager SRHM	AHUNG, Karachi
24.	Ms. Shahida Zaidi	Consultant	AMAN
25.	Dr. Mehwish	Deputy Director	PWD, Sindh
26.	Ms. Afshan Nazly	Director Nursing	PNC Sindh
27.	Ms. Kamyla Marvi	Consultant	Ipas
28.	Kiran Mahreen	Admin Associate	Ipas Pakistan
29.	Komal Murad	IT Administrative Coordinator	Ipas Pakistan
30.	Abdur Rauf Khan	Community Engagement Associate	Ipas Pakistan

3. List of PWD & Health Department, Sindh Officials – Meetings on PAFP policy (January 2019)

S. No	Name	Designation	Organization
1.	Mr. Zahid Abbasi	The Honorable Secretary, PWD Sindh	Population Welfare Department, Sindh
2.	Dr. Talib Lashari	Technical Advisor CIP/FP 2020	Population Welfare Department, Sindh
3.	Mr. Ashfaq Ali Shah	Director General, PWD Sindh	Population Welfare Department, Sindh