Research & Development
FORUM for Safe Motherhood Private Limited

Khyber Pakhtunkhwa Reproductive Healthcare Rights Act 2020

A FRAMEWORK FOR IMPLEMENTATION

February 2023

Table of Contents

List of Figures

List of Tables

Acronyms & Abbreviations

ASRH	Adolescent Sexual & Reproductive Health
CCI	Council of Common Interest
CMWs	Community Midwives
CPR	Contraceptive Prevalence Rate
DoH	Department of Health
DPWOs	District Population Welfare Offices
FP	Family Planning
FPI	Family Planning Index
FWCs	Family Welfare Centres
FWWs	Family Welfare Workers
GBV	Gender-based Violence
IDIs	In-depth Interviews
JDs	Job Description Statements
JDs	Job Description
KP	Khyber Pakhtunkhwa
MCH	Maternal & Child Health
MoNHSR&C	Ministry of National Health Services, Regulations, and Coordination
MSUs	Mobile Services Units
NGOs	Non-Governmental Organizations
NoC	No Objection Certificate
PPW	Population Planning Wing
PWD	Population Welfare Department
RH	Reproductive Healthcare
RHSC-A	Reproductive Health Services Centres-Type A
RTIs	Regional Training Institutes
SDGs	Sustainable Development Goals
SoPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
TPWOs	Tehsil Population Welfare Offices

1 Introduction

1.1 Background

More than half of the projected increase in global population up to 2050 will be concentrated in just eight countries – and Pakistan is among them.

At present, Pakistan is among one of the leading destination countries with highest asylum seeker refugees and displaced people[1]. It also has the third highest burden of maternal, fetal, and child mortality in the world. Its progress has also been slow in achieving the Sustainable Development Goals (SDGs) for addressing the common social determinants of health. In addition, the country has historically been facing huge challenges of political fragility, complex security issues, and natural disasters[2].

Reproductive health right is central to reducing poverty and improving long-term health. It is intrinsic to our right to life, freedom, health, choice, privacy, education and the prohibition of discrimination. Many women in Pakistan face barriers that prevent them from exercising this right. Major gaps remain at both service delivery and policy level, preventing adequate access to basic health facilities. Denying these rights have grave consequences that exacerbate poverty and inequality. It can lead to greater vulnerabilities to gender-related ill health, unintended pregnancies, maternal and child deaths.

Pakistan is fully cognizant of the impact of high population growth rate on its socioeconomic development and understands its linkages with rising poverty and disparity, high urbanization, urban migration, and climate change – all restraining investment in human development and improving lives of people. Consequently, reducing fertility rate has remained a key goal through provision of adequate family planning services, and women focused initiatives in health, education, social development, and legal sectors.

Recognizing the challenges posed by rapid population growth in the country, the Chief Justice of Pakistan in 2018 took a Suo Moto notice of the alarming situation. A Task Force was constituted to formulate a mechanism for addressing the unbalanced population growth, which helped evolve a set of eight key recommendations to accelerate efforts to increase the

[1] *UN Dept. of Economic & Social Affairs. World Population Prospects, 2022, Summary Results.*

[2] *Bhutta ZA, Hafeez A, Rizvi A, Ali N, Khan A, Ahmed F et al. Reproductive, maternal, new-born, and child Health situation in Pakistan: Challenges and opportunities. Vol 381, Issue 9884, p 2207-18.*

Contraceptive Prevalence Rate (CPR) and lower the Total Fertility Rate (TFR). These recommendations were reviewed and endorsed by the Council of Common Interest (CCI) – an inter-provincial highest-level decision-making body in November 2018 – which made it legally binding as the country's roadmap towards escalating the pace of Family Planning (FP) for all stakeholders, especially public sector entities to act together to achieve the objectives. The task force formulated an Action Plan (2019-30) in January 2019 for implementation of CCI approved recommendations. FP2030 was an international corollary which further supported and enhanced the positive developments at home. FP2030 envisages rights-based family planning commitments to support the vision of a future where women everywhere have the freedom and ability to lead healthy lives, and participate as equals in society and its development. Six strategic areas viz functional integration, postpartum and post-abortion family planning, adolescents, youth and family planning, advocacy and CSO engagement, emergency preparedness and response, and faith and family planning have also been indicated as priority areas for commitments under FP2030[3].

In pursuit of FP2030 Commitments over the years, Pakistan has witnessed several encouraging developments in the family planning and reproductive health arena. The Government of Khyber Pakhtunkhwa was among the first ones that pioneered the promulgation of Reproductive Healthcare Rights Act, 2020[4]. The Act is expected to act as a pathfinder for other provinces in significantly contributing towards promoting the reproductive healthcare rights, providing reproductive healthcare in an accessible and safer manner to people, and addressing the unmet family planning needs of the females, families, and communities.

The Government of KP's RH Act is committed to boost the RH service delivery in the province. It is expected to significantly contribute towards achieving the national CCI - FP (Council of Common Interests - Family Planning) 2030 commitment of the province, i.e., raising the Contraceptive Prevalence Rate (CPR) from 31% in 2017-18 through 46% in 2025 to 56% in 2030.

[3] *Government of Pakistan, Ministry of Health. FP 2030 National Commitments.*

[4] *Government of Khyber Pakhtunkhwa, Reproductive Healthcare Rights Act, 2020.*

KP AT A GLANCE

Figure 1: KP age specific birth rates and total fertility rates by education & wealth quintiles in urban versus rural (Source: MICS KP, 2019)

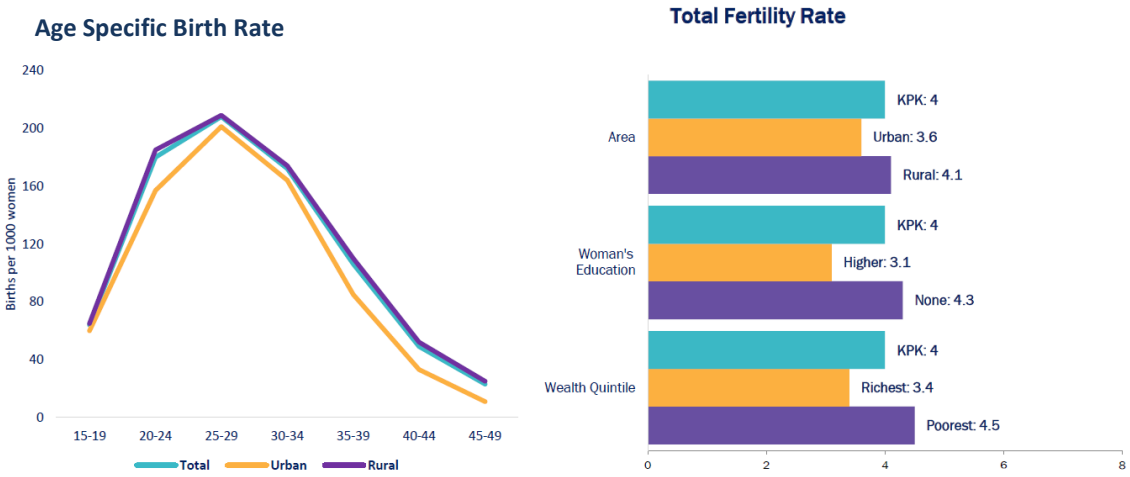


Figure 2: KP Population pyramid by age and sex including adolescents 10-19 years (Source: MICS KP, 2019)

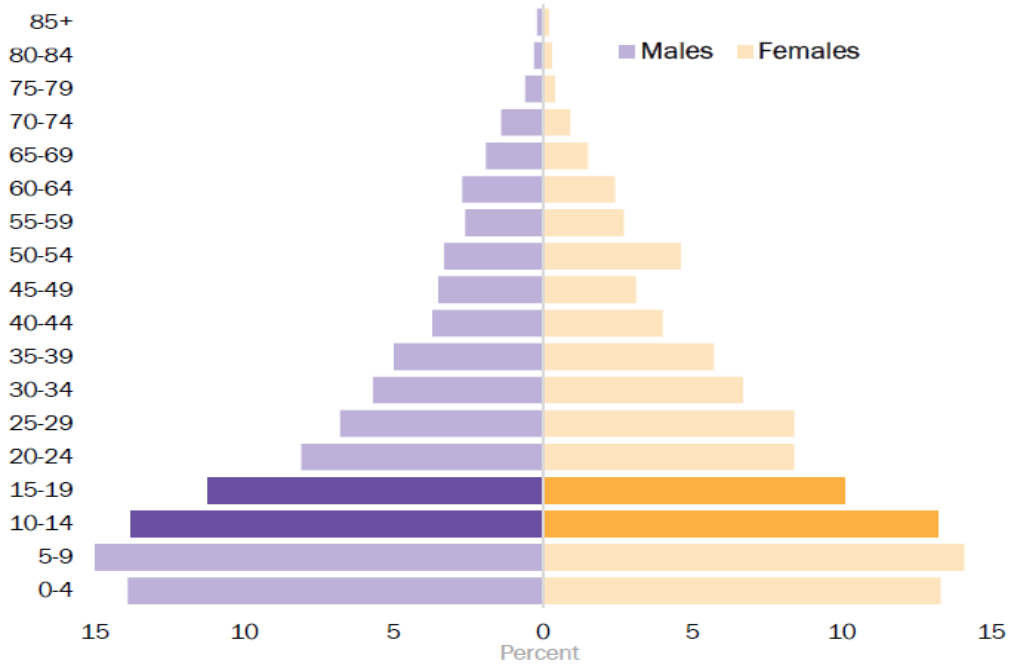


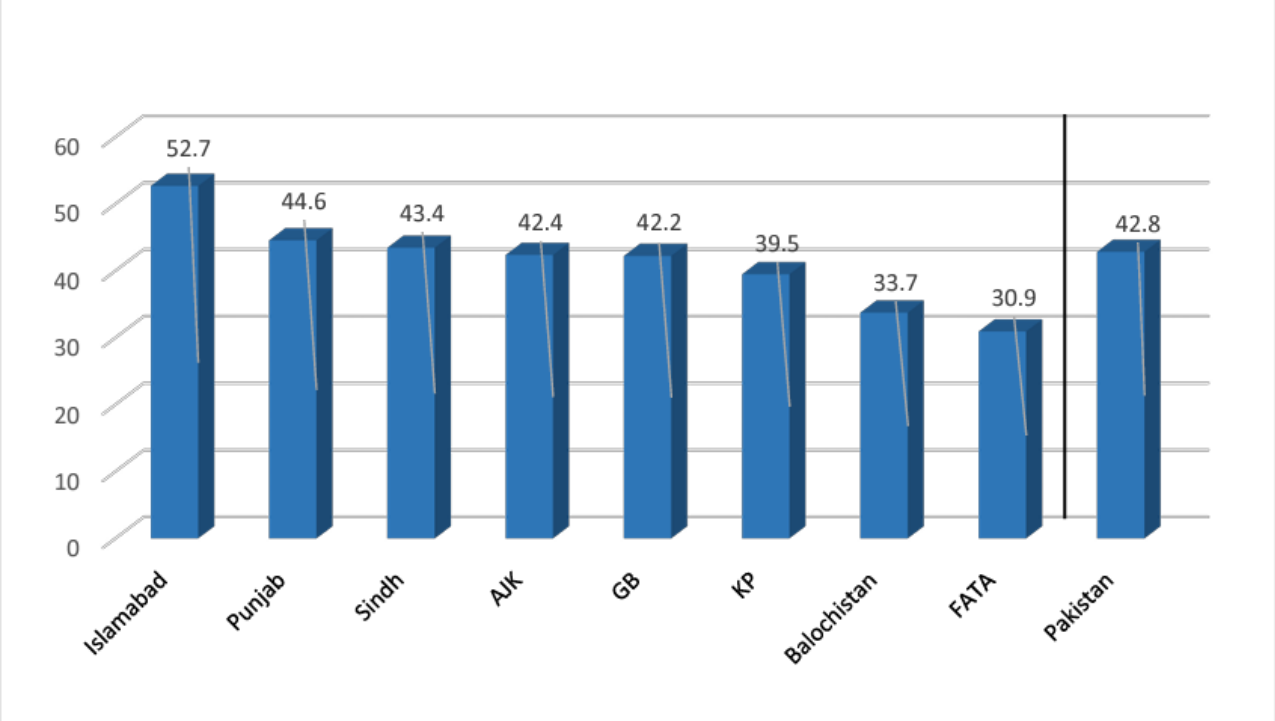
Table 1: FP Indicators of Pakistan and KP

S. No	Family Planning (FP) Indicators	Pakistan Demographic & Health Survey (PDHS) 2017-18	
		Pakistan	Khyber Pakhtunkhwa
1	Total Fertility Rate (TFR)	3.6	4
2	Contraceptive Prevalence Rate (CPR) (Both traditional and Modern Method)	34%	31%
3	Modern Contraceptive Prevalence Rate (MCPR)	25%	23.2%
4	Unmet Need for FP	17%	20.5%
5	Unmet need FP for Modern contraception	21%	23%

TRIBAL DISTRICTS AT A GLANCE

The situation of FP - RH is the lowest for erstwhile FATA (now merged tribal districts) of KP is among the lowest across the country due to host of reasons including low literacy and development, hard terrain, and the continuing volatile situation of the law and order in the area due to war on terror and its backlash. The figure 3 compares Family Planning Index (FPI) of the various regions of the country and FATA or merged districts are at the lowest FPI of 30.9 as compared to the national average of 42.8 and 39.5 of the KP settled area.

Figure 3: FPI of Pakistan including KP and FATA (Merged Districts)



Source: Computed from PDHS 2017-18

Table 2: FPI, FPI based ranking, CPR and Unmet Needs of Pakistan including KP and FATA (merged districts)

	FPI	FPI-based ranking	CPR	Unmet need
Islamabad	52.7	1	45.7	17.3
Punjab	44.6	2	38.3	15.8
Sindh	43.4	3	30.9	17.7
AJK	42.4	4	27.6	21.9
GB	42.2	5	39.0	26.0
KP	39.5	6	30.9	20.5
Balochistan	33.7	7	19.8	21.6
FATA	30.9	8	21.8	17.0
Pakistan	42.8	-	34.2	17.3

Source: Computed from PDHS 2017-18

1.2 Population Welfare Department, Khyber Pakhtunkhwa: An Organizational Assessment

The RH Act posits the responsibility of oversight and implementation on the Population Welfare Department (PWD) in the province, by empowering it to take actions at policy, programming and implementation levels. To better understand the department's role, a look into its existing structure is necessary.

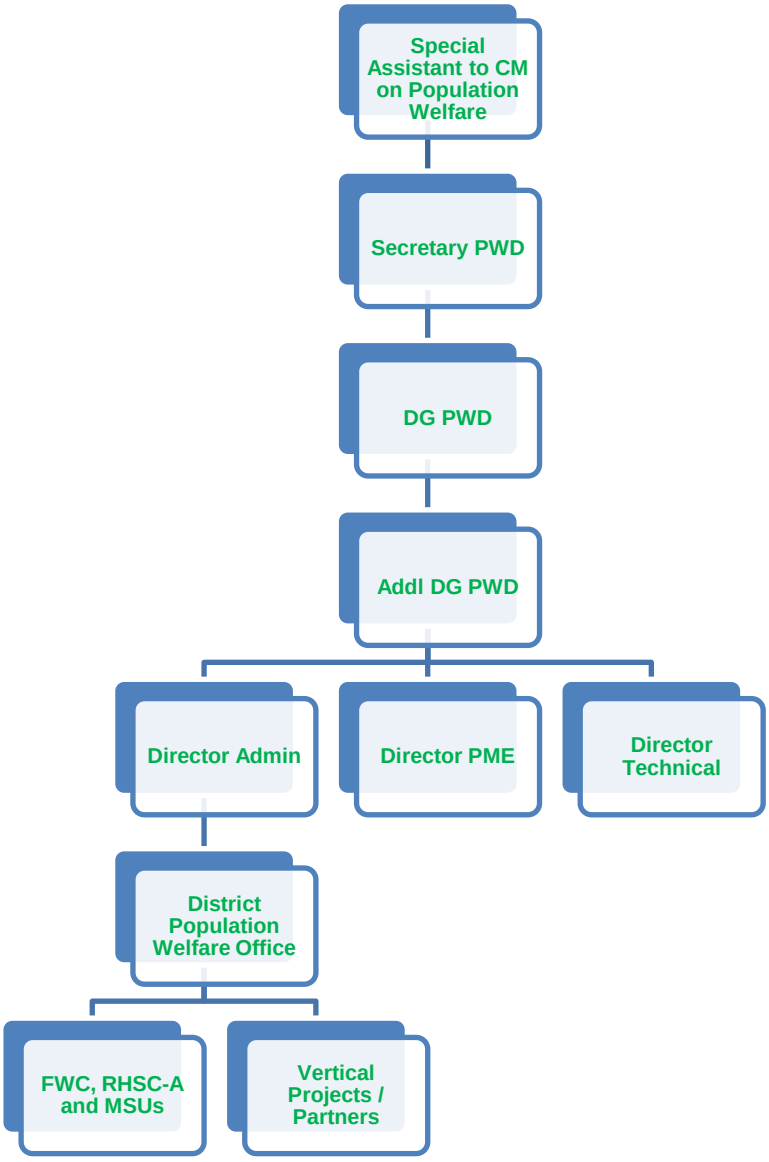
In KP, PWD provides Family Planning and Reproductive Health Services to married couples through static and out-reach services in the province. It is coordinated at the federal level with the Population Planning Wing (PPW) of the Ministry of National Health Services, Regulations, and Coordination (MoNHSR&C).

The department mainly focuses on birth spacing and bringing balance between population increase and socio-economic well-being. Government of KP recognizing the importance of population dynamics in the development planning, also acknowledges the need to reduce the rate and incidence of unwanted fertility through use of contraceptives, promoting balance between family size and available resources, and investing in youth by maintaining a focus on both genders.

Currently there are 35 District Population Welfare Offices (DPWOs) in Khyber Pakhtunkhwa including 7 in the merged tribal districts, but surprisingly there are only 18 Tehsil Population Welfare Offices (TPWOs) in the province. There are a total 632 Family Welfare Centres

(FWCs). Of them, only 50 are located in the merged tribal districts. It is expected that within a year time, their number will rise to around 1100.

The Reproductive Health Services Centres-Type A (RHSC-A) are public sector hospital-based service delivery units staffed by the Population Welfare Department. There are currently total 35 RHSC-As in Khyber Pakhtunkhwa including 4 in the merged districts. Apart from those, the department also has 40 Mobile Services Units (MSUs); out of which 7 units are performing in the merged tribal districts[5].



[5] *Population Welfare Department, KP. https://pwdkp.gov.pk/page/demographicIndicaTORs . Accessed on 17th July 2022 at 13:30 PST.*

After the promulgation of the KP Reproductive Healthcare Rights Act 2020, the department has endeavoured to take substantial steps towards its implementation. The steps taken since then include but are not limited to:

i. Notification of the KP Reproductive Healthcare Rights Rules, 2021.
ii. Notification of the KP Reproductive Healthcare Rights (Appeal) Rules, 2021.
iii. Notification of the DPWOs as FP RH Inspectors.
iv. Review of the Job Descriptions (JDs) of the PWD workforce to align them with the new roles and responsibilities
v. Development of elaborate procedures and templates for NOC processing, recommendation for cancellation of registration; checklists for inspection of the FP RH commodities and facilities, complaints processing and reporting etc., and review of the educational and informational material including their approval and rejection process.
vi. Training of the directorate staff, DPWOs and field managers about the RH Act, Rules, and the procedures, tools and templates for undertaking various key actions under the RH Act.

From the above, it is abundantly clear that the department has done the necessary spadework towards defining and implementing the immediate term minimum agenda in an organized, coordinated and smooth manner. At the same time, the department is keenly working towards developing a forward-looking futuristic plan that will pave the way for smooth sailing of the RH Act in the medium to longer term. This framework reflects a strategic move forward towards that high ambition of the department indicating a set of futuristic policy and program level undertakings.

1.3 Purpose & Objectives

To facilitate PWD in its role of implementing and overseeing the KP RH Rights Act 2020, a comprehensive framework for its implementation across the province needs to be developed. Consequently, the present report aims at:

1. Critically reviewing and analysing the KP RH Act with the aim of identifying its core elements and key action areas; and
2. Developing an implementation framework in each of the key action areas, and, where necessary recommending amendments to the Act, for its effective implementation.

2 Methodology

2.1 Approach

A two-pronged approach comprising of Desk Review and In-depth Interviews (IDIs) was adopted for the development of the framework.

During desk review, in addition to a thorough analysis of the RH Act, an extensive review of relevant documents as available on the websites of government departments, international organizations and non-governmental organizations (NGOs), was carried out. Where possible, these documents were downloaded for detailed review.

Qualitative inquiry was conducted into all key domains of RH Act by conducting IDIs with the policy, programming and district level operation executives of the PWD, as well as with seniors and experts in healthcare and development sector. A total of ten IDIs were conducted. Of these, six were conducted with senior executives of PWD, KP at the provincial and district levels. Of the remaining three, two were conducted with sitting civil bureaucrats having tremendous experience of government departments, while the third one was conducted online with a very senior population and development expert.

(A List of Interviewees is given at Annex-A).

2.2 Data Gathering Geared to Analysis of Objectives

For the IDIs, an interview guide was developed to inquire into almost each and every section and clause of the RH Act in critical terms by asking / exploring the following four key areas to help analyse the objectives in clear and lucid terms.

- *What was required by a section and / or a clause (s)?*
- *What was the situation on ground in relation to that?*
- *What were the actual or potential gaps? and*
- *What could be done to address those gap(s)?*

Transcribing was done for all the IDIs apart from automated recording of the one online interview in the chain of total ten IDIs. Paraphrasing was done from time to time to check on accuracy of the message received or recorded, especially those involving difficult or complex contextual, systemic or services issues.

(IDI Questionnaire is given at Annex-B).

2.3 Ethical Considerations

Qualitative Data Collection was preceded by formal appointment with each of the respondents to assure privacy as well as maintain confidentiality and focus during the interviews. The purpose and method of IDI was narrated in sufficient detail to each person. They were assured that the information will not be shared or disclosed with their name, nor will be used for any purpose other than the expressed one. Maintenance of interview notes/transcripts in safe personal custody of the interviewer, both during and afterwards, was also communicated to the respondents.

2.4 Data Analysis

Data extracted from the desk review and IDIs was analysed in a thematic manner. It was recorded and organized in the form of detailed notes against each clause in terms of policy recommendations and/or action points for implementation and service delivery.

3 A Roadmap for Implementation of RH Rights Act

3.1 Guiding Principles

Based on the findings of this assessment, some broad contours of the implementation framework are being proposed. Enactment of the Act should be guided by the principles proposed hereunder:

a) Reproductive healthcare rights being human rights are subject to the principle of non-discrimination, which guarantees that the rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, family status, health status, place of residence, economic and social situation. It is also important to eliminate financial barriers to access, especially for marginalized or disadvantaged populations and make services and supplies affordable to all.

b) In the context of family planning, a gender-responsive approach should be adopted. This approach will be informed by an understanding that in some societies it is not considered appropriate for women and girls to have information about contraception; and that decisions about whether, when and how many children to have is taken by the husband, at times, by members of the extended family[6]. This approach, once adopted, will ensure that the socially constructed differences and inequalities between women and men, their roles and responsibilities, norms related to appropriate behavior, opportunities and resources, and power and decision-making, are duly identified. Consequently, this approach will also ensure that measures are taken to address actively the harmful effects of these differences and inequalities to health and well-being.

c) A process needs to be initiated to review/develop/adapt contraceptive programs and clinic protocols to ensure that attention is paid to those from disadvantaged and marginalized groups, and particularly adolescents and young people. Development of guidelines on how health-care providers are to assess the competence of all the clients to take independent decisions on SRH, including contraception, is a must. Moreover, pre-

[6] *WHO. 2010. Gender Mainstreaming for Health Managers: a Practical Approach. Geneva: World Health Organization. Available from: http://whqlibdoc.who.int/publications/2011/9789241501071_eng.pdf.*

service and in-service training on these protocols should be provided to all relevant service providers.

In this context, faith and culture-sensitive, evidence-based advocacy and information, education and communication interventions targeting key stakeholders and policymakers to ensure their support for provision of comprehensive contraceptive information and services to disadvantaged or marginalized populations

should be supported.

d) Access to a secure, reliable and steady supply of a broad range of modern contraceptive commodities is an essential part of health care to a broad range of people: couples wishing to space the birth of their children; women who would die giving birth but whose lives could be saved if unintended pregnancy is prevented; married adolescents too young to be parents; people in need of protection from HIV and sexually transmitted diseases. Any service delivery point, including community-based ones, that provides contraceptive services should have available sufficient quantity of a broad mix of contraceptive methods. Contraceptive services, including the full range of contraceptive options, should be a part of the benefits package of all insurance schemes.

   If the bulk of a person's or family's income is spent on food and lodging, spending money on contraception is out of the question. Provision of free or subsidized access to contraceptives particularly for those with limited resources and from low-income groups is essential.

e) Estimates of need for contraceptive commodities should take into account the fact that women rely on different methods at different points in their reproductive lives, and may also switch from one method to another for health, personal preference and other reasons. As patterns of choice and preference become clear and as a province's total clientele for contraceptive information and services change in age, marital status, rates of STIs and HIV, the government needs to consider not only the number of methods provided but also how methods work, and ensure that its policies, supply chains and service

protocols take into account that women must be able to and will want to choose to switch methods[7].

f) In the provision of contraceptive information and services, studies show that where people feel they are receiving good-quality care, contraceptive use is higher, and that achieving higher standards of quality improves the effectiveness of sexual and reproductive health services and attracts people to use them. Elements of quality of care include: choice among a wide range of contraceptive methods; evidence-based information on the effectiveness, risks and benefits of different methods; technically competent trained health workers; provider-user relationships based on respect for informed choice, privacy and confidentiality; and the appropriate constellation of services (including follow-up) that are available in the same locality. The fulfilment of human rights requires that all healthcare facilities, commodities and services be respectful of medical ethics and of the culture of individuals, minorities, peoples and communities, sensitive to gender and life cycle requirements, and must be designed to respect confidentiality and improve the health status of those concerned. The principle of autonomy, expressed through free, prior, full and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law.

g) Engaging men for gender equality focuses on three specific potential areas (men as clients, as supportive partners in egalitarian decision-making related to reproductive health, and as agents of change in promoting gender equality) although it is not limited to these areas.

   Men as clients, often, underutilize reproductive health services or see no place for themselves within those services. Men should be encouraged to recognize that they too have sexual and reproductive health issues and needs; have the right to access reproductive health services themselves and those services should be available to them. Men may not consciously engage in decision-making about or support around reproductive health or family planning issues. They may see this as an area that is exclusively their spouse's responsibility. Or they may engage in a negative way either by preventing women from practicing behaviors or adopting family planning in ways that

[7] *Gribble J and Clifton D. 2010. Contraceptive Security: a Toolkit for Policy Audiences. Washington, D.C: Population Reference Bureau. Available from: https://www.k4health.org/toolkits/fp-logistics/contraceptivesecurity-toolkit-policy-audiences*

negatively affects women's sexual and reproductive health. Programs need to be developed that target men to involve them as supportive husbands in a variety of areas, including maternal health, family planning, neonatal care, and in prevention and management of HIV/AIDS and STIs[8].

h) Public sector procurement and supply is hampered by various factors including: restrictive legislation; special agreements with pharmaceutical companies; lack of capacity in management information systems and supply chain management; poor infrastructure (e.g., transportation and warehouses). To address this, regular monitoring of contraceptives distribution and stocks with attention to stock outs and method mix at all levels of service delivery points needs to be conducted. A system for regular review of information, forecasting, procurement and supply chain for contraceptives needs to be created or updated to ensure a steady supply of methods, in both the private as well as the public sector. In addition, advocating for and supporting the establishment of coordination mechanisms with partners; building capacity of logisticians, supply chain managers and specialists in forecasting and procurement; and engaging civil society and private sector in contraceptive supply, distribution and monitoring to strengthen the supply chain management, are some additional steps that can be taken in this regard.

i) Among the factors that contribute to unmet need for contraception are barriers to physical accessibility and mobility of women including geographical distance from services, poverty, and lack of access to insurance or high out-of-pocket expenses especially for migrants and adolescents. Other barriers include a number of gender-based disadvantages such as husbands' disapproval of contraception, or lack of information about how one gets pregnant. Features of facilities that may present a barrier include restricted opening times, lack of information in an appropriate language, and lack of health workers who are equipped to provide contraceptive information and services. Some of these barriers can be addressed through modifications in the way service delivery is organized, such as through Mobile outreach services which have emphasis on both supply and demand for contraceptive services, as they provide information, pills, condoms

[8] *UNFPA. 2013. Engaging Men and Boys: a Brief Summary of UNFPA Experience and Lessons Learned. New York, UNFPA. Available at: http://www.unfpa.org/resources/engaging-menand-boys-brief-summary-unfpa-experience-and-lessonslearned.*

and in some cases injectable, as well as generate demand for contraceptive services in their communities and provide referrals and follow-ups.

Other measures for increasing accessibility can include: having clear signs in the facilities on days and times in which services are available; ensuring that rooms have sign-boards so that clients can easily identify where to go; having a help desk at the reception with a facilitator who helps clients in negotiating the systems and procedures within facilities; having a facilitator who is able to communicate with marginalized and minority communities; ensuring there are separate rooms for women who want privacy for consultation and counselling; and having a process through which women can give inputs in setting up the services and feedback for services received. Ongoing competency-based training and supervision of care personnel on the delivery of contraceptive education, information and services will also help improve accessibility. Finally, experience in a variety of different settings has also shown that integrating contraceptive information and services into other SRH services also helps increase accessibility of such services.

3.2 Implementation Framework

For the implementation of RH Act, the following framework is being proposed. In the matrix given below all sections & clauses of the RH Act have been organized into four broad thematic areas:

a) Access to information & services by all (Non-discrimination)

b) Quality of care (Quality, Acceptability, Informed Decision-making, Privacy and Confidentiality)

c) Organization & regulation of health facilities

d) Others

Under each area, relevant sections and clauses are listed as requirements of the Act, along with existing situation, potential recommendations, responsibility, suggested time frame and outcome measures or deliverables for tracking. The department may look into creating Thematic or Domain Specific Technical Task Forces for guiding and managing the implementation in an organized, participatory and distributive manner.

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
THEME I: ACCESS BY ALL TO INFORMATION & SERVICES (Non-discrimination)				
3. a, b, c, u, x	Provide reproductive healthcare information; plan for and coordinate the dissemination of educational material; ensure that all men and women receive information for health and harmony among the family	The existing level of mass awareness about reproductive health and its various components ranges from borderline to low as we move away from settled to merged districts or from urban to semi-urban locations in KP. The reason being that it has only recently been brought into dedicated focus by the RH Act.	PWD has an approved communication strategy; the need is to implement that with provision of funds. Resources need to be mobilized for developing an audience specific multi-pronged strategy by exploiting the interpersonal, community, digital, social-media, electronic and print media platforms for engaging the decision-makers, mobilizing the agents for change, i.e., clerics, opinion makers; masses and clients. In doing so, it is worthwhile to keep in mind that: a) The demand created matches with the supply (or capacity) available with the department. b) It gradually transits or extends to RH domains of lesser challenge for the department, for instance, STIs, elderly care, adolescent care and GBV than full scale MCH or sub-fertility care.	An updated document of RH Rights Focused Communication Strategy is inplace and available that takes into account a transition from FP focus towards FP-RH as an integrated approach. Number of persons aware about reproductive healthcare information
3. e	Promote that all women have right to protection against discrimination in domestic, employment or social spheres due to pregnancy or motherhood	The women in Pakistan have seen discrimination in employment more than males. There are many factors behind female employment discrimination like low literacy rate, early marriages, and childbearing	Media and community-based campaigns about the rights of women at home, workplace and in the society by involving the key decision makers to create an environment where women are not discriminated due to pregnancy or motherhood and they are instead	# of media clips, advocacy events and community sessions around promoting the rights of women and protecting them against discrimination especially due to pregnancy or motherhood or on the basis of the gender of the baby.

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
		and the environment. Many females are not allowed to do job alongside males in Pakistani society, because it is considered inappropriate.	encouraged to get education and employment. Faith based sessions on the issue by involving the Ulama and Jirga Maliks might be of great help in the merged tribal districts. As per the Act the department has to oversight the overall implementation of the Act and shall give effect to the provision through all concerned public and private sector organizations. Correspondence to be made with concerned department (Social Welfare and Women Development deptt and Human Rights deptt) for implementation.	Listening and consulting sessions with the females in the community,
3. g	Protect women from being discriminated on the basis of gender of the baby	Most of the respondents viewed it as an issue of reasonable concern at the household level throughout the province especially merged districts again due to host of issues like lack of awareness, low literacy and poverty.	Most of the respondents ranked it as an issue of significant concern at the societal level especially in the merged areas where culturally male babies were preferred over the female. Awareness raising, BCC campaigns and involvement of the Ulama from Islamic standpoints were pointed out as potentially acceptable and effective strategic interventions. Correspondence to be made with concerned department (Social Welfare Deptt, Women & Development deptt & Human Rights deptt) for implementation.	
3. g	Protect women from discrimination for not being able to conceive		Apart from above mentioned interventions, the establishment of quality sub-fertility clinics (to start with in	• No. of sub-fertility clinics

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
			the regional headquarters or big cities) together with their publicizing for an appropriate utilization could be of significant help in addressing the problem. Correspondence to be made with concerned department (Health deptt, Social Welfare Deptt, Women & Development deptt & Human Rights deptt) for implementation.	
3. h	Facilities are visible to the communities	Visibility of the service outlets was an issue by and large in the province especially merged areas due to war on terror, anti-NGO sentiment and violence against healthcare workers till recent past. The situation has changed for better especially in the urban locations.	Visibility of the service outlets needs to be reviewed and improved on district and tehsil levels in the wake of specific security situation in the area.	Exit interviews with the clients about visibility of the facilities.
3. i, l, n	Reach the underserved by strengthening community-based RH services; and ensuring access and affordability of services	The existing workforce and service outlets in the public sector despite their placement in all the districts were inappropriate for reasonable population coverage. Together with partners in the public and private sector, they couldn't penetrate beyond the UC level.	Apart from the outlets' multiplication in pipeline, there was a dire need to have another three-to-four-fold increase (additional 3,000-4,000) in the outreach service outlets to reach the village council level. Green Star, GSK and a few NGOs like Rahnuma contributed a part only. Mapping and involving the Community Mid-Wives including those of the DoH in tribal districts, private practitioners, private sector hospitals and community-based NGOs is highly needed. However, the services by the non-government	Partnerships by type at the provincial, regional, district and sub-district level.

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
			sector need to be regulated by the department for access and affordability.	
3. k	Impart gender sensitive training to the service providers	The RTIs (Regional Training Institutes) impart gender sensitive training programs to various cadres of FP service providers.	RTIs may be requested to revisit the various training programs for gender sensitivity under the broader ambit of RH Act and accordingly redefine the programs' learning objectives, content, session delivery and assessment strategies.	Development of updated Training Programs with focus on RH rights and gender sensitivity.
3. w	Monitor service statistics to ensure reduction of unmet need for FP	At the moment, data gathering is in place at the district level that is reviewed periodically at various levels	The services of demographers and statisticians at the district level need to be optimally utilized for standardized data analyses in all the districts. The DPWOs / Deputy DPWOs need to be orientated about undertaking basic analysis / interpretation of the data for evidence-based decision-making with focus on analysis of the data concerning unmet FP needs. This will also help in maximally utilizing the under pipeline digitized information system/ dashboard.	Trend analysis of the unmet FP needs by district against a benchmark.
3. y	RH in primary and secondary curriculum	Some curricular initiatives are in pipeline under the notion of life skills education modules with the education department. The University of Peshawar has however introduced a module on population dynamics in collaboration with the Dept.	The initiatives in pipeline may be enriched and updated with appropriate content of RH in the light of RH Act together with expediting its finalization and implementation. Correspondence to be made with Education department for updation of curriculum.	An FP-RH rights based, culturally appropriate life-skills curriculum is available; # of district wise, high / higher secondary schools and colleges administering the curriculum.

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
3.o	Safeguard people against unethical trials regarding RH	There is a national bioethics committee at Pakistan Health Research Council. Likewise, there are a few other ethical review boards / committees in the public and private sector academia such as KMU and Peshawar Medical College. The Population Welfare Dept. don't have an entity of the sort at the moment.	Given that the department has a basic research infrastructure and medical, public health and technical human resource available with them at the provincial level, an Ethical Review Board can be easily constituted for reviewing of RH and FP related research trial proposals and accordingly granting the applicants ethical clearance or otherwise, as well as conducting need-based monitoring of the trials and binding them for periodic and end-term reporting. Members can be co-opted from local academia, if and where need be. TORs of the committee can be devised in accordance with the RH Act. Whereas, review capacity of the committee members can be built by observing the review process locally of other academia or completing free online certified courses. Designated PWD inspectors can report any irregularity observed to the Secretary PWD.	An Ethical Review Board is operational and meets as per requirement in the TORs.
3. u	Recommend educational courses for service providers	At the moment, an educational course of Associate Degree is reportedly in pipeline at the federal level for capacity building of the family planning workforce in delivery care.	Courses like Associate Degree and others of short to medium and longer duration need to be identified / introduced for capacity building of the RTI trainers, technical and managerial staff in the district, at subnational, national and international levels. The department may create a taskforce for the assignment or draft a project proposal document (PC1)	# of staff at the district and provincial level received a course or enrolled in a course. Establishment of an HRDIS (Human resource development information system).

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
			for the purpose, and / or coordinate with the development partners for sponsoring capacity building of the FP RH Workforce.	
3. a, c	Beneficiaries make all the decisions on the basis of fully free and informed consent	At service providers' level, the situation ranges between good to very good as we move from merged to settled districts in the province.	Desk-guides may be developed for service providers to maximize option for appraisal-based counselling than provider-led directive type. This is expected to further enhance or maximize free choice on the basis of informed consent. Already in practice guidelines need to be implemented in letter and spirit.	Listening sessions with the beneficiaries or exit interviews
7. a, b	Functions of RH Care Facility & Service Providers in promoting the RH and RH rights.	At the moment the type A and B RH centres are mostly only intervention-based clinics.	SOPs may be developed for quality assured RH care at various level of health facilities, including guidance about prominent display of the various RH Rights and selected sections of RH Act in a standardized manner. Apart from interventions, service providers need to be engaged in awareness raising among clients and their attendants about RH, RH rights, its legal character and contribute towards reducing the unmet need.	SOPs are available according to the RH Act; RH rights are prominently displayed in all the RH and FP clinics.
3. j	Provide full range FP services including MCH	The existing capacity and outlay of the department's services outlets is confined to antenatal and postnatal care provision. Although their Female Welfare Workers reportedly had a module of midwifery training, which was removed by Pakistan Nursing	In the given situation, during the transition period, referral pathways to recognized public and private sector maternity clinics / hospitals in each district, need to be properly mapped and strengthened via public to public and public to private MOUs for the purpose.	• No. of FWWs graduated • No. of FWWs conducting deliveries by district • No. of pregnant women referred to delivery care centres in the district (During transition phase)

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
		Council (PNC) when the FWW basic course module was revised for affiliation with PNC, Initiatives like imparting them HEC approved associate degree programs in pregnancy & delivery care were under consideration.		
3. m	FP workers detailed scope of work to be revised from time to time	The Department has detailed JDs for various cadres of FP workers. A revision was underway.	It is now high time to undertake a full-scale review of the JDs with a view to optimize these in the light of RH Act by redefining their roles and responsibilities including the tasks purported to be shifted or shared among the various members of the workforce. The exercise should regularly happen after a defined period of 3-5 years to dynamically align the workforce with the changing scenario of development in the sciences, services, technological and management approaches.	Revised JDs in the light of RH Act are available for various technical staff members
3. q,	Oversee forced pregnancy, sterilization, abortion or birth control	The department has the technical capacity for several of these, especially birth control and can easily complete the circle for oversight in coordination with other relevant departments such as Department of Health and Local Government	Coordination with relevant departments needs to be established for constituting and notifying an appropriate oversight with clear TORs to realize the purpose of the RH Act	An interdepartmental coordination and oversight committee is notified with clear TORs
3. s;	Receive complaints of its violation;	At the moment, DPWOs have been assigned as Inspectors to receive complaints about	The various options to address the issue are:	• RH Act dissemination on the mass media is undertaken.

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
8. 1, 2 (a), (b), and (c) 9. (1), (2), (3), and (4)	Appointment of Inspectors Quality Assurance	violation of the RH Act. Until now, no complaints have been received / registered by any of them. It appears to be an interim task shifting arrangement to a person who already has a plate full of the services planning & management agenda for the entire district. He has not been given any specific training of the new assignment nor are the people aware of the RH Act and the obligations it creates for the RH service providing entities in terms of safe storage, sale of the FP/RH supplies and commodities. It also creates an area of overlap with the role of district drug inspector of the department of health.	• Mass dissemination of the relevant sections/clauses on print and electronic media for awareness of the FP/RH product producers, distributors, suppliers and service providers so that they know beforehand and cooperate with the assigned inspectors. • Procedure of Inspection / investigation of reproductive health / Family Planning facility need to be devised. (Reported observations can be forwarded through proper channel to the concerned department). • Given that DPWOs are overworked, the department may create task sharing at the district level by notifying the Deputy DPWOs also as inspectors for better catchment coverage and providing need-based mutual relief to one another in the district regarding the assignment. • Inspection training events need to be arranged for the DPWOs/Deputy DPWOs together with developing a reasonably elaborate technical inspection checklist. The training should have sessions on ethical and polite conduct of the inspection. • Alternately in the medium term, create an expert cadre of regional inspectors, followed by recruitment of district wise expert cadre of inspectors in the longer run.	• PWTI train the DPWOs and their deputies specifically about the ethical conduct of inspection. • Checklists based comprehensive inspection of FP/RH commodities and supplies is in place. • Coordination is in place with the DoH and Local Government at all levels

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
3. t	Initiate investigation of cases against RH Act defaulting entities	The Inspectors have been notified but reportedly they need to be formally trained to effectively undertake this role. Standardized reporting templates and inspection checklists will also need to be developed.	The department on the analogy of HCC may look into creating a hierarchy of case processing as follows: • Report the quack FP/RH entities to the department for necessary action. • Communicate mild to moderate shortcomings to the genuine FP/RH entities and ask them for remediation within an appropriate time. In case of failure, may report to the dept. for initiating a case in coordination with the district government or liaise with HCC/concerned department for appropriate action in case the entity is registered with/ licensed by HCC / concerned department. • Report the major shortcoming(s) to the department for legal recourse or liaise with HCC for appropriate action in case the entity is registered with/ licensed by HCC /concerned department. • Investigation and filing of a case regarding the violation of RH Act shall be done in accordance with Section 10 of the RH Act. The cancellation of registration of an organization or an institution in the private sector shall be done in accordance with Section 11 of the RH Act. Detail of the penalties and appeal process has been illustrated in Section 12 and 14 of the RH Act respectively.	• No. of cases initiated/inspected per month in each district. • No. of feedbacks to the defaulting entities/inspector per month in each district.

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
4. (1), (2), (3) (i, ii, iii)	Oversight by the Dept.	There is a Provincial Technical Coordination Committee that was notified in 2005, which apart from PWD has representation of DoH, UNFPA and NGOs in it.	1. The Dept. shall be responsible for oversight of the Act. It may constitute an oversight body/board for the purpose, involving public and private sector stakeholders, such as, nominees of the DoH, Education, Local Government, Women & Social Welfare and Information Dept., public and private sector academia, prominent and credible RH NGOs. The TORs of the Board might be: • Review of the public policies and programs for optimizing the promotion of RH and RH rights • Directing the need-based updating and contextualizing the standards for FP and RH services to maximize people's access to quality RH services • Strategic directions to raise community awareness and involvement for RH and RH rights. 2. Existing FP2030 forum can be utilized in subject matter.	The Provincial Technical Coordination Committee is renamed as Provincial Oversight Committee for Reproductive Health & Rights; includes Education, Social Welfare, Home, Local Government and other relevant stakeholders into it with revised terms according to the requirements of RH Act. Opinion of the Higher ups.
6. (1), (2), (3)	Review of the IEC material developed by others	Existing focus of the department's IEC materials' review is on FP	The IEC material developed by FP and other stakeholders needs to be reviewed on a regular basis by an empowered permanent technical committee in the light of RH and RH rights in the Act for ensuring accurate and standardized messaging through all media platforms including formal and other ones, such as mini-clips, videos, and audios etc., developed in the private sector.	IEC Review committee is notified at all levels and meets regularly or need based

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
11. (1), (2), (3)	Obtaining and cancellation of registration of organization or institution in the private sector	The process needs to be elaborated while keeping in mind the role of HCC as a registering / licensing authority	A coordination mechanism needs to be set in place with the registering departments / authorities to create a database of registered entities followed by assessing them for NOC as well as assessing their facilities for quality assured services using the standard checklists developed by the department. Those without an NOC or violating the RH Act / Rules need to be reported to the relevant registering authority for cancellation of their registration.	# of cases reported for cancellation of registration.
3. p	Take stringent measures to prevent the testing and dumping of harmful contraceptives and pharmaceuticals in the province	Inspectors have been notified under the RH Act but there is no inter-sectoral coordination mechanism in place to prevent dumping of harmful pharmaceuticals (as the PWD inspectors are virtually laymen for inspection of the non-FP pharmaceuticals)	Capacity of the PWD inspectors for RH needs to be built together with setting in place an exchange of information mechanism with health department to prevent testing and dumping of harmful FP commodities and supplies. Under the Act the key requirements are to inspect the commodity or supply for: - its use in the country of manufacture - expiry, and - safe and secure storage - To report any irregularity if observed.	# of cases reported
15.	Removal of difficulties	The various areas identified for rephrasing need to be examined by the Department as to which ones can be tackled through this section and which one require legal opinion or amendment to the Act. Under Clause 3.e. the word 'protection' should be substituted with information, otherwise, it would require assigning to local government with developing reporting and referral pathways for the purpose. Alternately it may be shifted to inter-departmental oversight at the provincial and district levels for lead by the Home Department and District Administration, respectively.		

RH Act Reference	What is Required?	Current Landscape and Gaps	Potential Recommendations	Performance Measure / Deliverable
		Under Clause 3.d, f the expression 'ensure elimination' may be replaced with 'endeavour fully to eliminate or significantly minimize the discrimination against women in a phased manner….'		

4 Policy and Program / Field Level Recommendations:

The key findings and recommendations regarding an implementation framework for the RH Act have tentatively been categorized into Policy and Program / Field level as below. PWD may readjust any of them between the two categories as may deem appropriate:

Policy Level

1. Shift the focus from FP in a phased manner towards a broader undertaking for reproductive health and reproductive healthcare rights.
2. Improving the text of RH Act through legal review and rephrasing especially where it has words or phrasal expression in absolute terms, for example, replacing the word ensuring with maximizing or other suitable words.
3. The Dept. may constitute an oversight body/board for RH involving the public and private sector stakeholders, such as, nominees of the DoH, Education, Local Government, Women & Social Welfare and Information Dept., public and private sector academia, prominent and credible RH NGOs. The TORs of the Board might be:
    i. Review of the public policies and programs for optimizing the promotion of RH and RH rights,
    ii. Directing need-based updating and contextualizing the standards for FP and RH services to maximize people's access to quality RH services,
    iii. Strategic directions to raise community awareness and involvement for RH and RH rights.
4. Creation of an Ethical Review Board at the provincial level for examination and appraisal of RH research and trials proposals, and IEC Review Board for RH related IEC material, audios, videos etc. This is required because DRAP merely registers the drugs and supplies, and lays down guidance about how to conduct trials or get it registered with them and does not conduct ethical reviews itself. There is only one National Bioethics Board and the proposals have to wait for months and years to be cleared.

Program / Field Level

5. Reviewing and updating the communication strategy for raising mass awareness about RH and reproductive healthcare rights with FP from time to time in a faith and culture sensitive manner.
6. Complete the review and updating of the Job Description Statements (JDs) of PWD staff in the wake of new roles and responsibilities.
7. Involving the lost cadre of Community Midwives (CMWs) in provision of FP and Maternal and Child Health (MCH) services, through an approach focusing on building capacity and providing equipment & supplies.
8. PWD has an existing network of FPWWs, ASRH Centers, Type A and Type B RH Centers to cater for RH role. This can be further strengthened down the line through host of courses and capacity building initiatives.
9. Condensed courses and associate degree programs regarding the delivery care for the female family planning workers.
10. Adolescents education via life skills curricula about RH and RH rights.
11. Capacity building of the trainers and care providers about gender responsive training and programming.

5 Conclusion

By and large, the information gathered during IDIs has identified specifics for policy and programmatic action by various levels of the department for realizing in a short run, including those requiring task sharing or shifting within the department. However, those requiring a cross departmental or inter-sectoral coordination including those falling in the ambit of "Removal of difficulties" or requiring legal review or amendments to a smaller extent, may be addressed in a medium term.

The information in the desk review (as adjuvant to the IDIs) requires contextualizing and adaption by various theme based expert groups (proposed to be constituted for the purpose). This will innovate, enrich and enhance the existing policies, programs and service delivery models and align them in a befitting manner with the international community, given that they are evidence based and are universalised recommendations as advocated by WHO-UNFPA for various international settings and economies. This may be undertaken as an ongoing review and development process with short through medium to long term implications across the various domains and sub-domains.

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Annex A: List of IDI Participants

1. Mrs. Ayesha Ihsan, DG PWD, KP
2. Mr. Wali Muhammad, Additional DG PWD, KP
3. Mr. Farid Khan Marwat, Director PME PWD, KP
4. Mr. Hidayat Khan, Director Admin PWD, KP
5. Dr Farina Basit, Director Technical PWD, KP
6. Mr. Aleem Khan, DPWO, Peshawar
7. Mr. Abid Majeed, Former Secretary Health and PWD / Sitting Secretary Forest, KP
8. Dr Nadeem Akhtar, CEO HCC, KP
9. Dr Mumtaz Esker, Population & Development Consultant
10. Dr Anisa Afridi, Director MNCH Tribal Districts, DoH KP

Annex B: IDI Questionnaire

Unique ID:
Name: (optional)
Position: (Optional)
Category: Policy / Programming / Operations

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
3. a, b, and c.	Provide reproductive healthcare information.	What is the existing level of awareness in the province about reproductive healthcare? What is the existing level of awareness in NMDs?			In your opinion, what are the reproductive health areas that need to be specifically focused on for the purpose
3. a, c	Beneficiaries make all the decisions on the basis of fully free and informed consent.	What is the existing situation in the province about this? What is the existing situation about this in NMDs?			What are the most apparent or potential inhibitors or challenges in free choice among the women and men? - *At the client level?* - *At the family level?* i. From the spouse? ii. From the in-laws? iii. From others (specify) How can they be minimized?
3. e	Promote that all women have right to protection against discrimination in	What is the existing situation in the province about this?			What are the potential causes of discrimination against women on those grounds?

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
	domestic, employment or social spheres due to pregnancy or motherhood	What is the existing situation about this in NMDs?			i. at the domestic level ii. at the workplace iii. at the social level
3. f	Ensure elimination of all discrimination against women in healthcare services	What is the existing situation in the province about this? What is the existing situation about this in NMDs?			How do you feel about the word 'ensure elimination'? Do you think it needs to be rephrased? If yes, any thoughts about rephrasing it? How do you feel about the word 'healthcare services'? Do you think it appropriately expresses the mandate of the department? If not, would you like to rephrase it, and how?
3. g	Protect women from being discriminated on the basis of gender of the baby?	What is the level of vulnerability of women in the province due to being the mother of a specific gender baby? What is the level of vulnerability of women in the NMDs due to being the mother of a specific gender baby?			- Do you think that the department can protect them in significant terms, given that the provisions of RH Act are non-cognizable? - If not, what are your thoughts about realizing this in the given situation or you would like to redefine it? Any thoughts about redefining it?

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
3. g	Protect women from discrimination for not being able to conceive	What is the level of vulnerability of women in the province for not being able to conceive? What is the level of vulnerability of women in the NMDs due to not being able to conceive?			- Do you think that the department can protect them in significant terms, given that the provisions of RH Act are non-cognizable? - If not, what are your thoughts about realizing this in the given situation or you would like to redefine it? Any thoughts about redefining it?
3. h	Provide quality family planning services though a range of methods mix	What is the existing situation in the province about this? What is the existing situation about this in NMDs?			Is a category specific list of essential FP medicines & supplies available? Is an appropriate supply chain and LMIS (logistics management information system available throughout?
3. h	Facilities are visible to the communities.	Status in KP districts? Status in NMDs?			What are the branding mechanisms? How are the facilities promoted? Is the process risky anyway at some places? If yes, how the risk has been minimized? What else can be done?
3. i, l, n	Reach the underserved by ----- strengthening	Current status of the distribution of community-based FP / RH services in the province.			Type of services Acceptability & quality of services Partnerships:

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
	community-based RH services.				- *in the public sector* - *in the private sector* How about task shifting and share (if there is a dearth of resources and capacity)? Lessons learnt, challenges and way forward
3. j	Provide full range FP services including MCH				- Situation of full range FP services in the settled districts? - Situation of full range FP services in the NMDs? - Your take on MCH services? - How do you look at MCH, given that DoH has a full-fledged capacity and role about this? What are your thoughts about apparent duplication in this area, and how can that be avoided?
3. k	Impart gender sensitive training to the service providers	Current situation?			Current modalities and their reach in the public sector? Modalities in place or in pipeline for the partners in the private sector?
3. m	FP workers detailed scope of work to be				Do all the FP workers have detailed JDs?

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
	revised from time to time…				If yes, are they updated on a regular basis? If yes, how and after how much interval?
3. o	Safeguard people against unethical trials re RH				What are the current departmental / institutional mechanisms? Are there any ethical review boards or committees in the department? If not, what can be done in the short, medium or long run?
3. q,	Oversee forced pregnancy, sterilization, abortion or birth control				Is there any oversight committee in the department? If not, what should be the composition and TORs of such a committee? Do you anticipate any sociocultural issues? If yes, what are they? And how can they be overcome?
3. r,	Receive complaints of its violation				What is the mechanism for receiving complaints re RH Act violation, it's processing and redressing? Example(s)? Challenges? Way forward?
3. t	Initiate investigation of cases against RH				What's the process? If there is none? What are

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
	Act defaulting entities?				your thoughts and ideas around managing that?
4. (1), (2), (3) (i, ii, iii)	Oversight by the Dept.				Departmental Oversight Committee? Its composition & TORs? Defining the relevant public sector organizations? Coordination with the public sector organizations? Respective roles & responsibilities? Grey areas and their resolution? Mechanisms for community awareness and involvement? Alliances with and roles for CSOs / private sector? Roles for media? Advocacy & policy dialogues about RH?
3. u, x	Plan for and coordinate the dissemination of IEC material on FP & RH; ensure all men and women receive information				Existing coordination mechanisms for the purpose? If yes, how to enhance their effectiveness & coverage? If none, your thoughts about? Resources for IEC material development, printing & dissemination? Role of print, e and social media?

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
3. u	Recommend educational for service providers				Categories of service providers? Training needs assessment? Resources for different description courses development & administration? Phasing?
3. v	Frame policies for the promotion and protection of families?				Existing policies? How to review and update? Issues in protection of families? FP / RH services in SSP?
3. w	Monitor service statistics for reducing the unmet FP needs				What needs to be added? Are the services integrated and virtually surveilled at all levels? If not what needs to be done?
3. y	RH in primary and secondary curriculum?				Current state? Core needs of the growing teens in gender specific and culturally appropriate manner? Stakeholders' identification & onboarding for needs assessment, curriculum development, administration, monitoring and enhancement?
5. b, 3. p	RH commodities, proper sale, storage and marketing etc.				Issues & challenges? Capacity & training of the FP inspectors? Current strategies? What the inspectors can do or not do

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
					in the face of its non-cognizance? Ways to overcome? Gender specific inspecting? Areas of overlap with the DoH Drug Inspection System, rules and roles? How to agreeably review, redefine & resolve?
6. (1), (2), (3)	FP/RH material developed by others				Mechanisms of mutual coordination, review and approval?
7. a, b	Functions of RH Care Facility & Service Provider				Roles in RH Act? How to standardize / brand display of the key RH acts provisions at the facility?
8. (1), (2) a, b, c 9. (1), (2), (3), (4)	Appointment of inspectors Quality assurance				Are inspectors expert for the job as required by the Act? If not what needs to be done in terms of their capacity building & redefining their roles and powers? How to prevent duplication with DoH drug inspection, quality assurance & control? Legal issues? Remedies?
11. (1), (2), (3)	Obtaining and cancellation of registration of organization or				Issues in NOC for the private sector? Overlap with HCC? How to overcome? Coordination /

RH Act Reference	What is required?	What is existing situation / current landscape?	What are the gaps?	What could be done specifically to address the gaps?	Probe(s)/ Supplementary Question(s)
	institution in the private sector.				legal issues? Who needs to be notified as the relevant forum in case of non-compliance with NOC seeking / cancelling registration as recommended under 11(3).
15.	Removal of difficulties				Is the Department Head total or defined (partial) authority for the purpose? If not, who? Of the discussed above, which one of the legal or statutory problems with suggested remedies fall within purview of the department or the government? Which are the ones that may require legislative amendments?