Lao PDR National Family Planning Costed Implementation Plan 2017 – 2020

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Abbreviations

AWP	Annual work plan
BCC	Behaviour Change Communication
CBD	Community based distribution
CIP	Costed implementation plan
DHIS2	District Health Information software 2
FP	Family planning
FP2020	Family planning 2020 global partnership
GDP	Gross domestic product
GoL	Government of Lao PDR
HC	Health centre
HF	Health facility
IEC	Information Education Communication
IUD	Intrauterine device
LAK	Lao Kip
Lao PDR	Lao People's Democratic Republic
LARC	Long acting reversible contraceptive
LMIS	Logistics Management Information System
LSIS	Lao Social Indicator Survey
M&E	Monitoring and evaluation
mCPR	Modern Contraceptive Prevalence Rate
MoH	Ministry of Health
NGO	Non-government organizations
OOP	Out-of-pocket expenses
RMNCH	Reproductive, Maternal, Newborn and Child Health 2016-2025
SAS	Stock availability survey
SDP	Service delivery point
SO	Strategic Objective
THE	Total health expenditure
UNFPA	The United Nations Population Fund
USD	United States Dollar
VHV	Village Health Volunteer
VHW	Village Health Worker
WRO	Women of reproductive age
YF	Youth-focused
YFS	Youth friendly services

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EXECUTIVE SUMMARY

In 2016 the Government of Lao PDR (GoL) joined the Family Planning 2020 global partnership and articulated its commitments to the principle of universal access and outlined key targets for contraceptive access to be achieved by 2020. The GoL in collaboration with UNFPA and the Track20 Project developed a family planning costed implementation plan, to describe the interventions and process needed to support the government's national and international commitments for family planning.

The Costed Implementation Plan (CIP) is grounded in the national Reproductive, Maternal, Newborn and Child Health (RMNCH) strategy, Strategic Objective 1 (SO1) intended to achieve 70% mCPR among all women of reproductive age by 2025. It is distinct from other CIPs in is use of modelling[1] to compare different scenarios to prioritize the most effective interventions within the existing context of coverage and resource envelope in Laos. Coverage data on existing interventions, available human and financial resources is examined along with the international evidence on the most effective interventions, to set realistic goals for mCPR growth. Modelling techniques were also applied to determine if, and when targets for mCPR are achievable. These showed that at current rates of mCPR growth the RMNCH target cannot be achieved. To achieve the highest likely impact in mCPR by 2020, and shift the trajectory of growth this CIP identifies that a new strategy of high impact interventions will be needed along with re-distribution of allocated resources and increased resources to fund such interventions.

By drawing on global evidence the CIP provides a costed plan with considerable detail to inform annual plans and budgets. Annual workplans are the main instrument for actualising programme interventions. Grounding the CIP within annual plans is an approach more likely to domesticate the interventions, making them more likely to be delivered.

There are two significant challenges that the CIP attempts to address. The first relates to intervention selection: the evidence shows that not all interventions are created equal, nor do they perform equally in different contexts. The current RMNCH strategy contains many interventions, multiple activities all of which are intended to be delivered at scale equally across provinces with different contexts for growth. The second, is the financing needed to achieve intended results. Laos is entering middle income country status, with plans for increasing government expenditures for health, while reducing dependence on external donors and a shorter window for external donor support[2]. There is therefore an urgency to consider the twin challenges of delivering targets both efficiently and equitably.

The family planning CIP uses modelling to address these issues by proposing that a limited number of high impact interventions are implemented in selected provinces. Further, that this implementation should be incremental. In this way, the CIP is advocating for the most effective use of limited resources by investing in only the interventions that have demonstrated results based on global evidence, and, information on the challenges and context in Lao PDR. These key interventions are: expanding access to LARC in both the public and private sectors, reducing stock-outs of contraceptive commodities, demand generation activities and youth-focused activities.

Recognizing that funding may be limited, the CIP presents a tiered approach with three potential scenarios, A, B and C: A represents the most constrained, focusing investments in the Provinces with the

[1] Track20. FP Goals. From http://www.track20.org/pages/resources/FPGoals

[2] "World Bank. 2012. Government Spending on Health in Lao PDR : Evidence and Issues. Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/13211 License: CC BY 3.0 Unported."

greatest need, while B and C present variants where efforts are expanded to a wider set of Provinces. In all scenarios, a minimum package is implemented everywhere, but the number of Provinces with more expanded investments varies across scenarios.

The costing and gap analysis findings highlight that with this approach, resource mobilization is strategically focused on these high impact interventions. The expected program and commodity costs of the CIP is approximately 15 million USD over 4 years, or an average of 3.75 million per annum. The alternative scenarios present a lower cost, of 14 million USD and 10.6 million USD in total. These allow for planning how resources can be strategically prioritized in the case that full funding is not available. Commodities make up a large proportion of the budget, 8.85 million USD (ranging from 57% to 67% of the total across the three scenarios)[3]. Ensuring commodity security will be critical to the success of the CIP.

Provincial budget plans for RMNCH interventions for 2017 are the main planning instrument for family planning in Laos. A 2017 gap analysis is based on budget allocations at the Provincial level to interventions that align with the identified priorities in the CIP. The key finding is that the gap in funding while significant, can be addressed. Within the current provincial 2017 budget allocations approximately $815 thousand USD is allocated towards priority CIP interventions. The total cost to implement the CIP in 2017 is 1.899 million USD (excluding commodities), resulting in programmatic gap in funding of 1.08 million USD in 2017. Looking at the two alternative scenarios, which have lower programmatic costs the gap is smaller, ranging from nearly 500 thousand USD to just under 900 thousand USD. The gap analysis focused on one year of funding due to the complexity and difficulty in obtaining project funding figures for the years beyond 2017. In addition, since commodities are not included in the Provinces budgets, the gap analysis only focuses on the programmatic costs. The family planning CIP supports the reallocation of committed program funding and other resources to the key interventions outlined in this document. Consequently, future budgeting and planning should also focus resource mobilization towards investing in high impact interventions on mCPR when feasible.

The modelling used for the CIP, illustrated that with full investment, the mCPR at 2020 for married women is expected to reach 58 percent and 43 percent for all women. While these rates do not achieve the expressed target of 65 percent mCPR (for married women) as committed with FP2020, the evidence s to suggests that these are achievable targets based on the implementation of five key interventions areas with costs that are feasible and reasonable to fund. Additionally, the family planning CIP incorporates a discussion on the institutional arrangements and provincial plans in recognition that the successful operationalization of the CIP is reliant on organizations, technical and human resources to coordinate, manage and implement the plan.

[3] Commodity costs were taken from the Government FP Quantification Forecast

INTRODUCTION

The family planning CIP is based on the National Strategy and Action Plan for Integrated Services on Reproductive, Maternal, Newborn and Child Health 2016 – 2025 (RMNCH). It was essential that the CIP developed from this foundation to ensure alignment with existing policy and current efforts nationally. For the family planning CIP to be applicable for the country context, there must be continuity and consistency with policy and program directions under the framework of the RMNCH Strategy and action plan.

The CIP builds on prior country level analyses. The 2015 Family Planning Situation Analysis[4] contributed to understanding the family planning landscape in Lao PDR. The situation analysis highlighted improvements in the policy and service delivery context for family planning alongside modest but tangible increases in mCPR. The report also identified specific challenges and recommendations to be addressed to improve access and delivery of family planning services and commodities. These challenges and recommendations are pertinent to the family planning costed implementation plan (CIP). These challenges centered around the disproportionate support for family planning funding by external donors, over reliance on short-acting contraceptives and lack of promotion and access to long-acting reversible contraceptives (LARC), continued issues with stock-outs at district and sub-district health facilities and lack of private sector provision of LARC. The recommendations from the report are in line with the key interventions contained in the family planning CIP for 2017 – 2020.

Another feature of the family planning CIP is that it proposes provincial level operational plans for 2017 – 2020. This is included to ensure that the CIP can be operationalized through national and provincial annual planning and budgeting. Throughout the development process, all stakeholders underscored the necessity for the CIP to be a feasible and manageable plan. To that end, the family planning CIP document comprises of three parts:

- Part I: Background to the National Family Planning CIP
- Part II: CIP development process provides an overview of the rationale
- Part III: National Family Planning Costed Implementation Plan
    - Purpose and strategic action areas and objectives
    - Key interventions, sub-interventions and projected mCPR
    - Activities and Costings
    - Gap analysis of CIP costs and Provincial budget for key CIP interventions
    - Institutional arrangements for coordination, management and implementation of the CIP
    - Proposed Provincial operation plan
    - Monitoring and Evaluation framework

[4] UNFPA. (2015). *Family Planning Situation Analysis Lao People's Democratic Republic*. Vientiane, Lao PDR.

PART I: BACKGROUND TO THE FAMILY PLANNING COSTED IMPLEMENTATION PLAN

The purpose of a family planning costed implementation plan is to make operational the country's broad vision and strategic priorities for family planning. It is undertaken to ensure efficiency and equity in the use of resources to implement the national strategy. By identifying interventions most likely to deliver on the national vision and the resource requirements these entail, a CIP provides government and donors with a clear roadmap for the entire programme. The National Strategy and Action Plan for integrated service on Reproductive, Maternal, Newborn and Child Health 2016-2025[5] (RMNCH) under Strategic Objective 1[6], (reproductive health services and information) is the guiding policy document for family planning in Laos PDR. It calls for increasing access and use of contraception and reproductive health and family planning information which is expected to result in an increase in the contraceptive prevalence rate and reduction in unmet need. In 2016, the Government of Lao PDR (GoL) made the following specific commitments to the global FP2020 initiative:

- Increase CPR for modern methods among married women from 42 percent to 65 percent by 2020;
- Reduce unmet need for contraception (married women of reproductive age (MWRA); modern methods) to 13 percent by 2020 (from 20 percent in 2012); and
- Expand coverage and method mix for family planning services in health facilities with a focus on long-acting methods, such as implants and IUDs.

There are risks to policy commitments which arise largely from the financing environment. The Ministry of Health's 7th Five-Year Health Sector Plan (2011 – 2015)[7], shows a funding shortfall of 86 per cent for projects in reproductive health (safe motherhood and family planning). Out-of-pocket (OOP) expenses constituted 48.6 per cent of the total health expenditure (THE) in 2011-2012[8], while external resources for health made up 21.8 per cent and domestic government spending on health was at 16.4 per cent of THE for the same year[9]. OOP and opportunity costs pose a potential deterrent to expansion of use. Additional and on-going external assistance will be needed to meet policy commitments. Provincial and national stakeholders identified that resourcing needs in technical capacity and for full implementation of actions in SO1 are significant and not feasible to achieve by all provinces.

To avoid ad-hoc partial implementation, which can be the path to poor performance, this CIP moves to achieve mCPR at near target levels with a full package of FP services in targeted priority provinces. In other words, it's not the interventions or actions that are selectively implemented but rather the locations and target groups that are prioritised. There is strong evidence that, in a context of limited financial and human resources, a mixed approach of prioritising interventions and locations is more efficient and effective[10].

[5] Ministry of Health (2016). *National Strategy and Action Plan for integrated service on Reproductive, Maternal, Newborn and Child Health 2016-2025*. (page 2). Lao PDR

[6] *Strategic Objective 1: Increase utility and acceptance of quality reproductive health information and services among all women and men of reproductive age, included adolescent, young people, and those living in poor or rural areas regardless of marital status.* RMNCH Strategy and action plan 2016-2025.

[7] Ministry of Health (2011), *The 7th Five-Year Health Sector Development Plan 2011-2015;* Vientiane, Lao PDR.

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[9] Ibid. Ministry of Health. (2016)

[10] Family Planning High Impact Practice Organisation. (2015) *Family Planning High Impact Practice List.* DOI https://www.fphighimpactpractices.org/sites/fphips/files/hiplist_eng.pdf (web access)

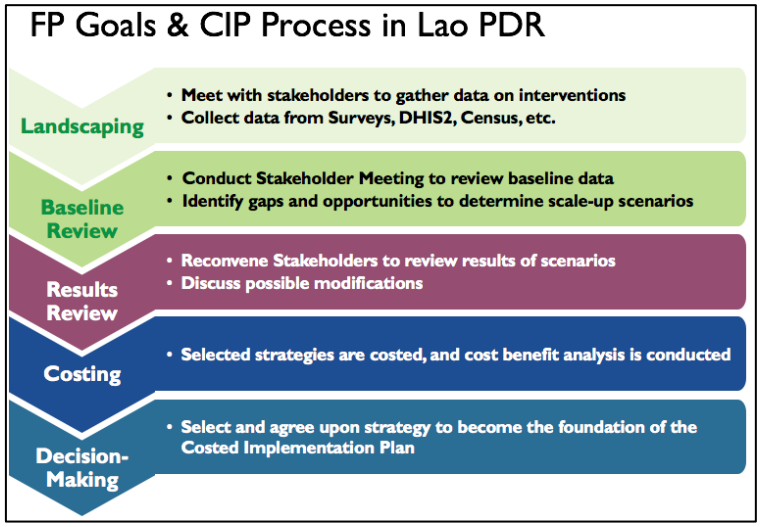
PART II: CIP DEVELOPMENT PROCESS

This section provides a summary of the process to develop the CIP and some of the data and results reviewed that informed the final document. The process was convened by the Ministry of Health, and led by the SO1 committee, with wide participation from experts in programme, financing within government, donors and NGOs. The CIP development process followed a five-step process as summarized in Figure 1, namely landscaping, baseline review, results review, costing and decision making. Detailed description of the consultative process on these five steps including complete data and results can be found in Annex 1.

At each stage of the process, stakeholders engaged in the review of data, provided guidance on interpreting data and data gaps, and guidance on the past performance, challenges and needs. The scenarios presented in this document were created by the technical group and all baseline and endline assumptions were vetted to ensure consensus. The group was convened for all five steps of the process so that each stage ended with agreement on both decisions and next steps.

The process to develop the family planning CIP was supported by an evidence-based model called FP Goals. Detailed information on FP Goals, including process and data requirements are given in Annex 2. Application of FP Goals requires careful vetting of assumptions, context, demographic and programmatic data by stakeholders to determine which package of evidence-based scenarios can be implemented in the given context. Of critical importance is that the model is not an optimizer tool, but in fact requires careful deliberation of intervention choices, scale by country stakeholders so that the final package of interventions of the CIP reflect choices made by stakeholders. This allows the evidence on the impact of specific family planning interventions to be part of the decisions-making process when deciding on priorities. Importantly, although impact is part of the conversation, applying the model within a consultative process allows for other factors, such as feasibility and government commitment, to also be part of the discussion.

Figure 1: CIP development process in Lao PDR



1. STEP 1: LANDSCAPING (September 2016)

The landscaping process was conducted in September 2016 with the primary purpose of understanding the context for developing the CIP. This includes close reading of the RMNCH strategy, Strategic Objective 1 (SO1) and interventions, review of data on service provision and logistics (DHIS2 and LMIS) and in-depth interviews with stakeholders[11] on priorities, existing and expected funding and resources. The landscaping identified SO1 as the base scenario, against which other options for growth and efficiency could be evaluated.

[11] Stakeholders who participated in the landscaping included experts from the Dept. of Hygiene and Health Promotion, MCHC, Food and Drug Department, CIEH, Providers, EPI, Vientiane Youth Center; from NGOs: PSI, CARE, PFHA, CHAI, LAOPHA; from MOH Statistics Division and the Statistics Bureau, and UNFPA and the World Bank.

The landscaping produced a series of tables and charts that highlighted potential areas of opportunities at the national and provincial level and led to the development of the three scenarios that would be produced to estimate impact and cost. The scenarios included: implementation of the RMNCH plan fully as well as partially, prioritization of provinces based on opportunity, and prioritization of high impact interventions.

2. STEP 2: RESULTS AND IMPACT REVIEW PROCESS (NOV 2016)

The Results and Impact Review phase was conducted in November 2016. This step was conducted to review the initial findings from the previously selected scenarios and finalize the scenarios based on feedback from the consultative group. The consultations evaluated the impact on mCPR from the different scenarios to identify opportunities to maximize impact by using geographical targeting and selective interventions. The results showed that selection of targeted locations for implementation with prioritisation, could achieve *comparable increases in mCPR with efforts that are within feasible parameters mCPR to the full implementation of the RMNCH strategy.*

3. STEP 3: COSTING (Nov-Dec)

Once the final scenarios and interventions were agreed upon, each sub-intervention and scale up of the implementation process was costed. The costs were determined as a unit cost and multiplied per the quantity of units (for example by number of facilities, sessions, visits, training or people). The costing was then presented to sub-committee members[12] for SO1 (reproductive health), SO8 (health personnel), SO9 (health financing) and SO11 (medical supplies, commodities and equipment) as well as members of the secretariat for the RMNCH Strategy and Plan. The same unit costs that were developed for the RMNCH strategy were used to ensure comparability.

4. STEP FOUR: DECISION-MAKING
Confirming scenarios (Dec 2016) and Funding gap analysis (Dec 2016 – Jan 2017)

The final stages of the process involved presenting the scenarios, impacts on mCPR and costings to the provincial stakeholders. This was completed during the *Review meeting for the RMNCH Strategy and Plan*[13]. The meeting also provided an opportunity to clarify and refine the unit costs for the sub-interventions. Lastly, an analysis of the funding sources relevant to the sub-interventions was conducted. The gap analysis examined the annual activity and budget plans for SO interventions for 2017 as well as a desktop review of development partner programs and funding. The analysis of scenarios, impact on mCPR and costings are presented hereafter.

[12] These meetings were called by the RMNCH Secretariat, of the Ministry of Health and took place on November 23rd, 2016

[13] Meeting was chaired by Dr. Kaisone Chounramany with SO1 committee members and Provincial heads of the Reproductive Health programme.

PART III: NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2017 - 2020

1. VISION

The overall goal of the RMNCH Strategy and Action Plan 2016 – 2025, is to improve reproductive health status and reduce maternal, neonatal and child mortality and morbidity including malnutrition. Within the Strategy and action plan, the first Strategic objective (SO1) "Reproductive health" calls for an increase in "the utility and acceptance of quality reproductive health information and services among all women and men of reproductive age, including adolescents, young people, and those living in poor or rural areas, regardless of marital status[14]."

The National Family Planning Costed Implementation Plan for Lao PDR commits to strategically increasing the mCPR among all women and married women in order to contribute to the reduction of maternal, neonatal and child mortality and morbidity.

2. OPERATIONAL GOALS

- Select FP interventions that have an evidence base as high impact interventions on the modern contraceptive prevalence rate among women (all women and married women).
- Develop specific and achievable costed implementation plans for provinces based on agreed prioritization criterion.
- Utilize the institutional arrangements under the RMNCH Strategic Objective 1 Committee and RMNCH Secretariat
- Ensure a feasible monitoring, review and evaluation framework to track progress of the CIP.

It is of note that the operational goals do not include a specific mCPR target. The mCPR target has already been established under the RMNCH Strategy and action plan (70 % mCPR, married women, by 2025) and the FP2020 Commitment by Lao PDR was established at 65% mCPR, married women, by 2020). Since there are two different targets the annual growth rates will be used to evaluate progress and monitor implementation of the CIP.

3. STRATEGIC PRIORITIES

The strategic priorities in the family planning CIP are the areas of focus for implementation and the allocation of financial resources. Throughout the consultation process with stakeholders to develop the CIP, these priorities were stated and reflect the concerns, experiences and lessons about the issues that must be addressed to improve the family planning programme and to have an impact on the mCPR. In other words, these priorities provide the CIP with a framework to ensure that the limited available resources are aimed at areas which have the highest potential to grow the mCPR in terms of unmet needs and high impact practices.

Three Strategic Priorities

[14] Ibid. Ministry of Health, (2016), RMNCH Strategy and action plan.

- ***Priority 1:*** Increase information and promotion of long-acting reversible contraceptives (LARC), namely implants and intra-uterine devices (IUD) and increase the number of midwives able to perform the procedures for insertion of LARCs in both public and private sectors.

- ***Priority 2:*** Improve the capacity at health centres to forecast, procure and distribute contraceptive commodities to ensure a reduction of stock-outs in these facilities.

- ***Priority 3:*** Ensure that demand generation is well-targeted priority population namely young people living in rural and urban areas, inclusive of men in promotion messages, events and campaigns for family planning services.

4. ALIGNMENT TO NATIONAL POLICIES

The family planning CIP is well integrated with Strategic Objective 1 in the RMNCH Strategy and action plan 2016 – 2025. Strategic Objective 1 focuses on increasing the mCPR, increasing availability of reproductive health and family planning information and services and improving and expanding current services. The CIP is also aligned with the Health Sector Reform program and Universal Health Coverage plans in which family planning is considered as part of the essential package of health services to be provided to all communities.

The key interventions selected for the family planning CIP have come from interventions already in the RMNCH Strategy and action plan. The CIP operationalizes these national strategies and action plans through i) providing key high impact interventions and sub-interventions ii) to be implemented in provinces that have the potential to grow the mCPR and iii) with multiple scenarios of scale up depending on funding availability.

Interventions selected for the CIP come from those already in the RMNCH strategy but made operational through **intervention** and **geographic** prioritisation applied through the lens of resource availability.

5. KEY INTERVENTIONS, SUB INTERVENTIONS AND PROJECTED CPR FOR MODERN METHODS

This CIP has three unique aspects. The first is intervention prioritisation based on both in-country expert opinion and evidence of impact in the current context. The second is a deliberate geographical focus for intervention, again based on evidence of highest impact. The third is scenario generation based on resource need and availability.

Intervention Prioritisation

A series of key interventions were identified within each of the three priority areas of this CIP for implementation **based on the FP Goals model analysis** of where the most opportunities for impact lie in Laos. *However, not all high-impact interventions were chosen by stakeholders and two interventions with low threshold of evidence were included based on stakeholder preferences relating to youth services.* Figure 2 outlines the relative contributions to mCPR growth by percentage increase in growth for interventions selected by the SO1 committee. Table 1 outlines each of the key intervention areas, sub-intervention and unit of measure accordingly. These elements form the basis for the full costing of this multi-year CIP for Lao PDR.

Figure 2a: Intervention prioritisation, Stock-outs. Evidence of High levels of primary methods

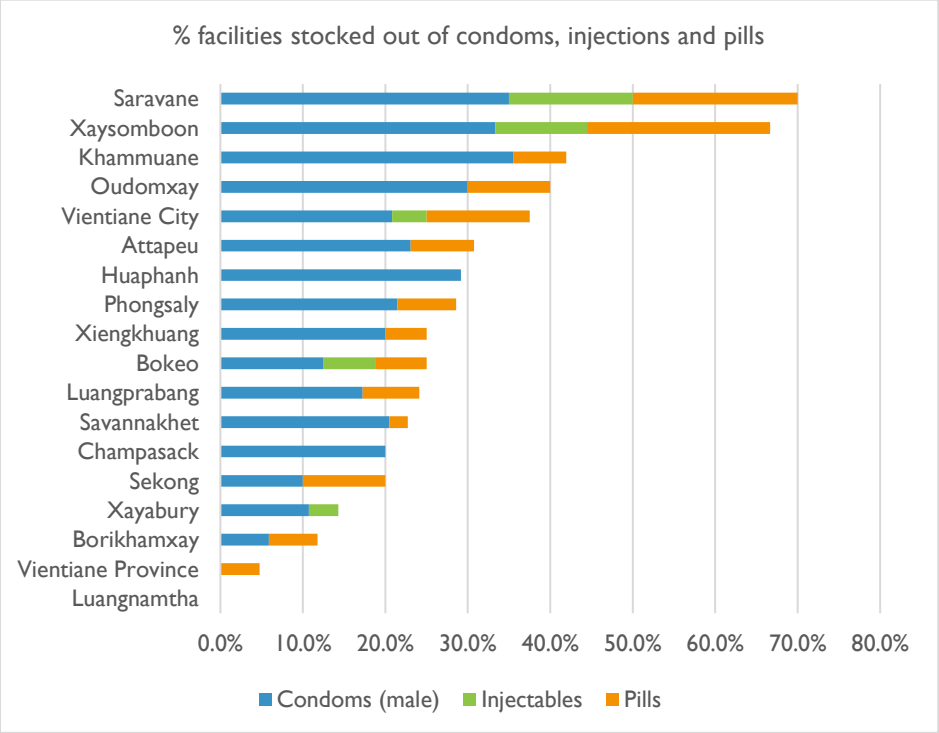
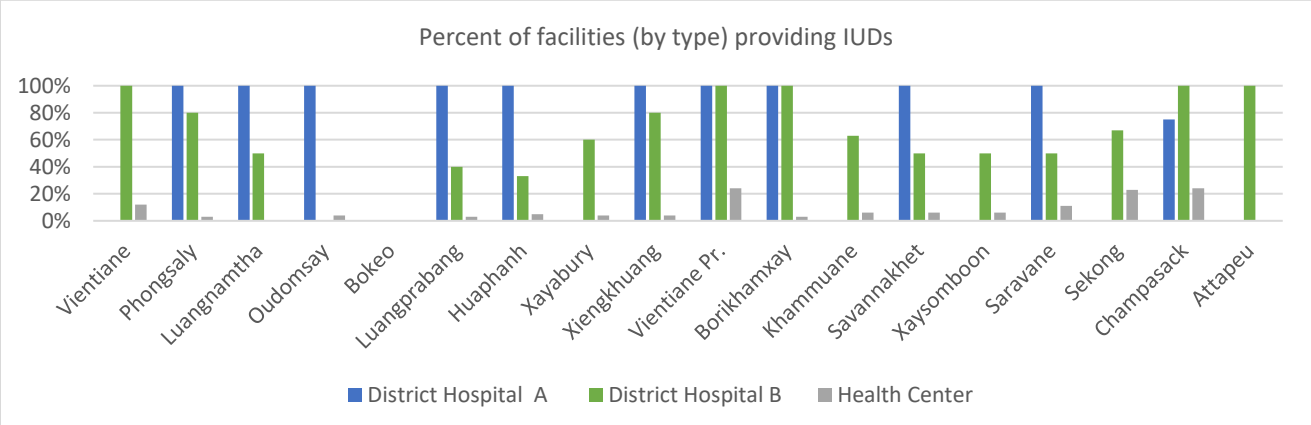


Figure 2b: Intervention prioritisation, LARCs. Evidence of very low levels of availability of LARCs at health centres



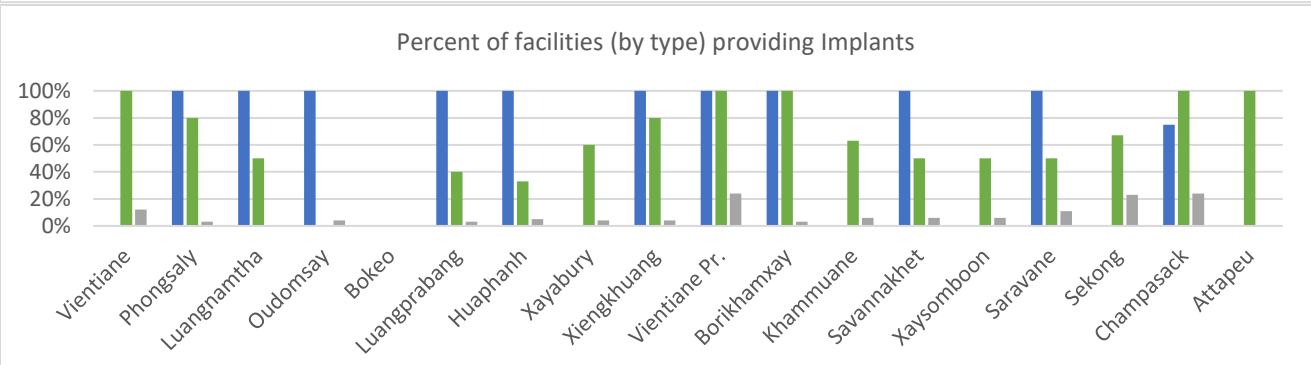
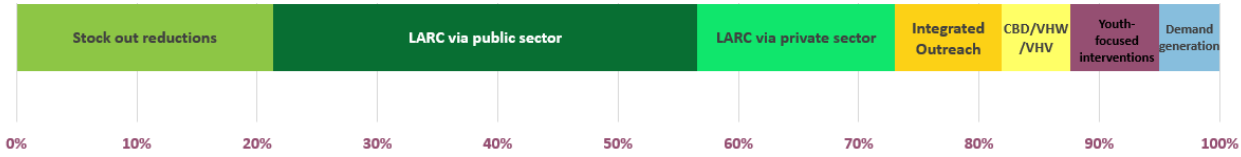


Figure 3: Relative contribution to mCPR growth by % of increase in growth



What are the drivers of impact?	% of increase	What will it take to achieve this?
LARC via Public Sector (Midwives)	35%	At least **956** midwives trained on LARC
Stock-Out Reduction to 2%	21%	Stock outs eliminated at **522** facilities
LARC via Private Sector	16%	**394** private facilities trained on LARC provision by 2020
Integrated Outreach	9%	**28,400** integrated outreach visits to take place annually
Comprehensive youth programming	7%	**183,400** young people reached by comprehensive youth programming- including access to YFS by 2020
CBD/VHV/VHW	6%	**1,850** CBD/VHW/VHV trained to deliver
Demand	5%	**135,260** people reached by FP days and group discussions by 2020

Table 1. Key Interventions & sub- Interventions , CIP Laos 2017-2020

Priority	Key intervention	Sub-intervention	Unit of measure for costing
Priority 1: Increase information and promotion of long-acting reversible contraceptives (LARC), namely implants and intra-uterine devices (IUD) and increase the number of midwives able to perform the procedures for insertion of LARCs in both public and private sectors.	Increase access to LARCs via public sector	• Train midwife in LARC	• # Health centers to be trained on LARC provision
		• Provide IUD insertion and implant commodities	• # Health centers needing medical supplies to insert IUD and Implants
		• Provide supportive supervision (Province to District)	• # Districts needing supervision (Province to District)
		• Health facility supervision (District to health center)	• # Health centers needing supervision (District to health centers)
		• Promote availability of services	• Promotion of services (# districts)
	Increase provision of LARC in private sector	• Train midwife in LARC	• # private facilities to be trained on LARC provision
		• Incentives for private providers*	• Financing for private providers
Priority 2: Improve the capacity at health centres to forecast, procure and distribute contraceptive commodities to ensure a reduction of stock-outs in these facilities.	Reduce stock outs	• Reduce stock-out in facility	• # facilities with stock outs to be eliminated

Priority 3: Ensure that demand generation is well-targeted priority population namely young people living in rural and urban areas, inclusive of men in promotion messages, events and campaigns for family planning *services*.	Demand generation activities	• FP community days	• # of FP community days held
		• FP discussion groups	• # of discussion groups held
	Youth-focused: Outreach activities to working youth	• Outreach events and activities to working youth	• # outreach events at provincial towns and Vientiane Capital
			• # outreach events at district towns
	Youth-focused: Outreach activities to youth in school	• Outreach events and activities to youth in school	• # outreach events at provincial towns and Vientiane Capital
			• # outreach events at district towns
	Youth-focused: train government staff to provide YF outreach activities	• Provide youth-friendly activities and outreach	• # trained from Provincial/Vientiane Capital
			• # trained from District
			• # trained from sub-district (based on #HF)

Geographical Prioritisation

Not all provinces benefit or benefit equally from the selected interventions. A set of criteria[15] were used to determine areas with the greatest need for these interventions where impact is likely to be strongest. Under the criteria, geographical areas with the greatest need for evidence-based interventions, received top priority. The criteria are:

- Provinces with the lowest provision of LARC per women of reproductive age (highest need for increased access to LARC)
- Provinces with highest number of private health clinic facilities (highest need for to increase private sector provision of LARC)
- Provinces with highest fertility rates (highest need to increase demand)
- Provinces with the most number of facilities with report stock-out of contraceptive commodities (highest need to reduce stock-out)
- Provinces with large youth populations either in rural or urban settings (highest need for youth-focused interventions)

Scenario Generation

From these criteria, three scenarios were then created:

- **A:** intensive scale up in top 5 provinces by need for each intervention, with minimum package everywhere else
- **B**: intensive scale up in *next* top 5 provinces by need for each intervention, with minimum package everywhere else
- **C**: intensive scale up in select additional provinces for each intervention (1-5 *additional* depending on intervention), with a minimum package everywhere else

[15] The criteria for selection draws from data collected and analyzed during the landscaping stage in the CIP development process. These included population demographics, the FP context, interventions being implemented and scale of implementation for each province.

The full RMNCH anticipated high levels of scale up for all interventions across all provinces. This is not feasible in terms of budgets or capacity, but also not needed since provinces are starting off in different places and therefore have different needs. The development of three alternative scenarios takes this into account as well as being realistic about budget constraints in the country. Scenarios are based on the feasibility of mobilizing financial and other resources to support the most important investments for each province, ensuring there is a clear starting point of focus in the context of likely having limited funding for implementation. This emphasis on provincial level implementation enables the CIP to be operationalized within existing provincial health planning structures and processes. This will be discussed in more detail in section **11. Operational Plans.**

Modelling identified a few high impact interventions that were not included in this CIP as stakeholders did not think these were feasible for implementation currently. Interventions included Post partum FP, social franchising and integrated outreach. In addition, youth outreach and demand generation activities have less impact empirically, but were considered to be important in the current context

Thus, each province is unique in the combination of key interventions to be implemented each year under each scenario. The prioritization has resulted in three different sets of activities, and three levels of budgets. In the case that funding for family planning is limited, the **priority** should be to deliver interventions as outlined in **scenario A**. This insures that limited funds are directed to those interventions and provinces that have the greatest need- while insuring a minimum package of services is provided everywhere. Should more funds be leveraged, investments can be scaled up to those outlined under scenario B, followed by scenario C. Table 2 lists all the provinces and identifies which interventions should be prioritized under each scenario (A, B, C) in each province.

Table 2. List of all provinces and priority interventions[16]

Province	PUBLIC SECTOR LARC	PRIVATE SECTOR LARC	DEMAND GENERATION*	REDUCE STOCK OUTS	YOUTH
Vientiane Capital	A	A	C	B	A
Phongsaly			A	B	
Luangnamtha	B	B			C
Oudomxay		B	B		
Bokeo	A		B		B
Luangprabang	B	A		A	A
Houaphanh	C	C	A	A	B
Xayabury	A	C		B	B
Xiengkhuang		B	B	B	
Vientiane Province		B			B
Borikhamxay		B			C
Khammouane	B	A	A	A	B
Savannakhet	A	A	B	A	A
Xaysomboun	B	C	B	C	C
Saravane	B	C	A	A	A
Sekong	C		A		C
Champasack	C	A	B	B	A
Attapeu	A	C	B	C	C

[16] For Demand Generation Scenario B, a total of 7 additional provinces were added rather than 5 since those ranked 5-7 all had the same TFR, so cutting it off at 5 was not possible.

SCALE OF IMPLEMENTATION FOR INTERVENTIONS

It is recognized that across all provinces a minimum package of support must exist to ensure that women have adequate access to high quality family planning information and services. The previous section describes how provinces were selected to receive 'intensive scale up' under scenarios A, B, and C. Table 3 below, outlines what "intensive scale up", versus the minimum package, would look like for each intervention.

Table 3: Description of scaling for priority and non-priority provinces

Key intervention	Scale up in priority provinces (A = top 5; B = next top 5; C = select additional provinces)	Scale up everywhere else (minimum package)
Increase access to LARCs via public sector	100% of health centers provide LARC	20% of health centers provide LARC
Increase provision of LARC in private sector	100% of private facilities provide LARC	20% of private facilities provide LARC
Demand generation activities	Roll out group discussions + community Family planning days (by district and per village)	None
Reduce stock outs	Reduce stock outs by 98%	Reduce stock outs by 20%
Youth-focused interventions	Outreach activities to working youth: 10 locations in urban districts of Vientiane city and large provincial towns; 5 locations district in district towns. Outreach activities in schools: 6 schools in urban districts of Vientiane city and large provincial towns; 3 schools in district elsewhere. Train staff: 3 staff members trained in each district of large Provincial towns and Vientiane City; 2 staff members trained per district, and 2 per Health facility.	Outreach activities to working youth: 5 locations in urban districts of Vientiane city and large provincial towns; 2 locations in district towns. Outreach activities in schools: schools in urban districts of Vientiane city and large provincial towns; 1 school in district elsewhere. Train staff: staff members trained in each district of large Provincial towns and Vientiane City; 1 staff members trained per district, and per Health facility.

Demand generation and youth-focused activities do not specify target districts. For these interventions, the Provincial Health Department and partners will determine the districts, villages, schools and work places to roll out the demand generation and youth-focused activities. The CIP provides the number of these outreach and promotion activities that need to be implemented to contribute to growth in the mCPR.

6. EXPECTED IMPACTS

By prioritizing scale up based on need, this CIP was able to obtain substantial impact within existing funds. Table 4 shows the expected impact in 2020 from intervention and geographical prioritisation through the tiered approach compared to the baseline scenario of full implementation of the RMNCH SO1 interventions, which is recognized to be unfeasible. It is expected that the annual average growth

in mCPR will be between 1.3 per cent and 1.9 percent. These rates in annual average growth of the mCPR will form progress indicators in the monitoring and evaluation framework for the family planning CIP. Under this CIP the expected mCPR in 2020 varies by scenario, with the highest increase in mCPR for married women of 59% under Scenario C, which is also the most resource heavy. In general, the expected impact from investing in the most promising interventions for Lao is likely to obtain an increase in mCPR between 7 to 10 percentage points in four years depending on resource allocation. This level of achievement is close to but under Lao PDR's FP2020 target of 65 per cent mCPR for married women.

Table 4: Expected per annum mCPR

	Baseline mCPR (2016)	2020 mCPR under each scenario				Average annual growth (% point) under each scenario			
		A	B	C	Full RMNCH	A	B	C	Full RMNCH
All women	35.5%	40.8%	42.4%	43.1%	45.2%	1.3%	1.7%	1.9%	2.4%
Married women	48.4%	55.6%	57.8%	58.8%	61.7%	1.8%	2.4%	2.6%	3.3%

7. COSTING

COSTING ASSUMPTIONS

In developing the unit cost and costs for the family planning CIP the following assumptions apply:

- Commodity costs will remain unchanged over the next 3 years (2017 – 2020) and have been taken from the government quantification report. This also assumes that maintaining consistent levels of commodity provision will also support efforts to reduce rates of unmet need, which influences mCPR.
- Costs associated with evaluation, policy changes, advocacy, human resources are excluded from the unit costs. These costs have been taken into account and are provided in *Annex 2: Additional Cost Summary*
- Programmatic costs could be reduced still further by decreases in: i) Average unit costs used (such as allocation for private financing); ii) Reducing recurrence/scope of activities in years (such as retraining) and iii) Realistic rescheduling activities in years would make the AWP budget more even.
- The final costing will be further refined according provincial and district annual work plans.

a. UNIT COSTS

The unit costs below were informed the initial data collection obtained during the landscaping gained from DHIS, departmental activity budgets and provincial stakeholder feedback on costs of implementing interventions at the provincial and district levels. In process of defining the sub-interventions and unit measures, high impact activities were selected. For instance, under 'youth', it should be noted that in the measure (and sub-interventions), the number of youth counselling rooms established are not included. This is because based on the modeling evidence, to establish and operate a youth counselling room requires significant resources with minimal if any impact on mCPR. Instead outreach actions in locations with high concentration of young people is a more effective strategy to engage young people rather than 'waiting' for them to access the youth counseling room. Table 5 presents the measures and unit costs used to calculate the costs by year of

implementation of the selected interventions (A, B, C) and by provinces. These measures also included in the M&E framework. The unit costs were multiplied by the number of facilities, days, events, districts to obtain the final costing for each intervention and sub-intervention.

Table 5: Units and Unit costs

Area	Measure	Unit Cost (LAK millions)	Unit cost (USD)	Unit cost
Stock out reductions	# facilities with stock outs to be eliminated	3.5	426.8	per HF
Public sector facilities: LARC	# Health Centers to be trained on LARC provision	5.5	670.7	per HF
	# HC needing medical supplies to insert IUD and Implants	2.8	341.5	per HF
	# HC needing supervision (District to HC)	0.7	85.4	per HF
	# districts needing supervision (Province to District)	2.4	292.7	per district
	Promotion of services	1.9	231.7	Per district
LARC via private sector	# private facilities to be trained on LARC provision	5.0	609.8	per HF
	Financing for private providers	4.0	487.8	per HF
Youth-focused: Outreach activities to working youth	Provincial towns and Vientiane Capital facilities	1.2	146.3	Per event
	District towns facilities	1.2	146.3	Per event
Youth-focused: Outreach activities to youth in school	Provincial towns and Vientiane Capital lower and upper secondary schools	0.3	36.6	Per district
	District lower and upper secondary schools	0.3	36.6	Per district
Youth-focused: train government staff to provide YF outreach activities	Provincial/Vientiane Capital	1.8	219.5	Per district
	District	1.2	146.3	Per district
	Sub-district	1.2	146.3	Per HF
Demand generation	# of FP community days held	5.0	609.8	per day
	# of discussion groups held	0.6	73.2	per group

b. ADDITIONAL COST CONSIDERATIONS

In addition to calculating direct program costs that resulted from scaling up the priority interventions, the CIP budget also takes into account two other sets of costs. First, other program costs that were included in the RMNCH SO1 that were considered to be important to maintain have been added- these costs are not Province specific, but rather relate to national level activities such as policy development. The costs included from the RMNCH SO1 budget are listed below, they totaled to 5,985 million LAK over the 4 years, or, nearly 730 thousand USD.

Table 6: Other Program Costs taken from RMNCH SO1

Key Activity	Detailed Activity	Total Cost (LAK) 2017 to 2020
1.1.2. Revise national clinical guidelines on FP, including task-sharing/shifting on IUD and injectables, and the adaptation and integration of international clinical guidelines on implants.	1.1.2.b. Orientation to Health provider in all provinces	116,802,000
1.1.3. Develop national IEC/BCC strategy on FP (based on national communication for health Strategy) with concrete implementation plans at field level.	1.1.3.a. Conduct workshop for development on national IEC/BCC strategy on FP	1,962,000
	1.1.3.d. Printing of new material	953,750,000
1.1.4. Revise national clinical guidelines on FP, including task-sharing/shifting on IUD and injectables, and the adaptation and integration of international clinical guidelines on implants.	1.1.4.b. Orientation to Health provider in all provinces	233,604,000
1.1.6. Establish national supportive supervision system to ensure regular monitoring and supervision to RH/FP staff at all levels across the country. Include RH/Family Planning in regular Monitor and supportive supervision	1.1.6.b. Conduct workshop to include new FP methods in the supervision form	101,970,000
	1.1.6.c. Conduct training on SOP of supportive supervise to the teams	3,405,600,000
1.1.14. Conduct formative research to inform the development / adaptation and field-testing of IEC materials in local ethnic languages.	1.1.14.a. Consultant to support conduction of research to inform the development / adaptation and field-testing of IEC materials	4,171,500
	1.1.14.b. Develop and finalize appropriate IEC based on research	8,343,000
	1.1.14.c. Printing IEC materials in local ethnic languages	1,158,750,000

In addition, commodity costs were taken from the Government Quantification Forecast. These costs are held constant in each scenario; however, it is recommended that each year the quantification request be refined based on plans, funding levels, and expected progress. The table below shows the annual commodity costs used in the CIP.

Table 7: Annual commodity costs (taken from Quantification Forecast)

	2017	2018	2019	2020	Total (2017 to 2020)
KIP (millions)	16,080	17,550	18,940	20,030	72,600
USD (millions)	1.96	2.14	2.31	2.44	8.85

c. COSTING SUMMARY

The full program and commodity costs for the FP CIP is calculated to be 125,881 million LAK, this is under **full implementation or Scenario C**. The USD equivalent is approximately 15.35 million USD ($1USD/8,200LAK) over the four years of the CIP. Table 8 provides a summary of the cumulative annual costs for the program implementing the above sub-intervention and commodities. This provides an overview of the program and commodity funding needed to implement the CIP in full. It should be noted that commodity costs, which are held constant across the three scenarios, represent a large proportion of the budget (57 to 67%). Table 9 provides the program and commodity costs for

each year. Annex 3, provides additional details on costing by sub-interventions by scenario, costs by province and cost effectiveness.

Table 8: Summary of programmatic and commodity costs (2017 to 2020) *

	A	B	C
	KIP (Millions)		
Direct program cost	29,278	41,621	47,297
Other program costs	5,985	5,985	5,985
Commodity Cost	72,600	72,600	72,600
Total Cost	107,863	120,206	125,881
	USD (Millions)		
Direct program cost	3.57	5.08	5.77
Other program costs	0.73	0.73	0.73
Commodity Cost	8.85	8.85	8.85
Total Cost	**13.15**	**14.66**	**15.35**

*Costs are cumulative from A to C. This document recognizes that the USD amount presented here is based on an exchange rate that for USD to LAK that is not the official rate. The USD rate for the CIP therefore is subject change depending on the official exchange to be used during implementation.

Table 9: Program and Commodity costs by Year

KIP (Millions)						
	2017	**2018**	**2019**	**2020**		**Total** (2017 to 2020)
Direct program costs: A	8,177	7,011	7,628	6,462		29,278
Direct program costs: B	11,598	9,985	10,826	9,212		41,621
Direct program costs: C	13,134	11,436	12,212	10,514		47,297
Other Program costs	2,439	840	1,819	887		5,985
Commodities	16,080	17,550	18,940	20,030		72,600
A (total)	26,696	25,400	28,387	27,379		107,863
B (total)	30,118	28,374	31,585	30,129		120,206
C (total)	31,653	29,826	32,971	31,431		125,881
USD (million)						
	2017	**2018**	**2019**	**2020**		**Total** (2017 to 2020)
Direct program costs: A	1.00	0.85	0.93	0.79		3.57
Direct program costs: B	1.41	1.22	1.32	1.12		5.08
Direct program costs: C	1.60	1.39	1.49	1.28		5.77
Other Program costs	0.30	0.10	0.22	0.11		0.73
Commodities	1.96	2.14	2.31	2.44		8.85

A (total)	3.26	3.10	3.46	3.34		13.15
B (total)	3.67	3.46	3.85	3.67		14.66
C (total)	3.86	3.64	4.02	3.83		15.35

8. FUNDING GAP ANALYSIS

Current funding for family planning includes funding by government, external sources and out of pocket payments. To understand the gap between available resources and what is needed to implement the CIP we examined the provincial budget plans and allocations for priority CIP interventions in 2017. At the time of drafting the CIP, it was understood that the SO1 interventions for 2017 of the RMNCH strategy and plan have provincial budgets confirmed. The process entailed reviewing the provincial budget plans for interventions that correlate with the key CIP interventions; government and development partner funding commitments for interventions and comparison with the costing developed for the CIP. The gap analysis compared funding commitments as overall program costs as well as by province.

There are two important reasons to focus the gap analysis on the provincial budget plan and allocations. First, both the provincial budget plans and the CIP have a shared framework, stemming from RMNCH strategy and plan and second, they provide provincial level comparison of what interventions are funded and what interventions are not. Being able to compare the interventions, funding allocated and CIP costs at a provincial level strengthens the analysis of where the actual funding gaps exist.

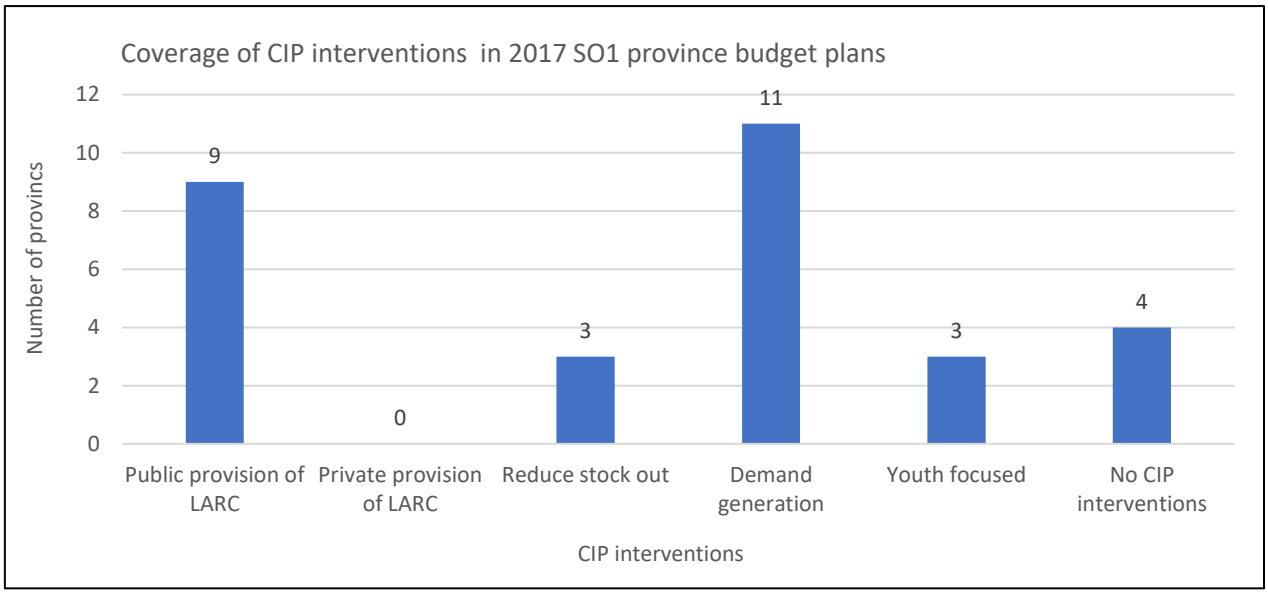
a. CIP-*aligned* INTERVENTIONS COVERED IN 2017 PROVINCIAL BUDGET PLANS

The interventions[17] identified in the provincial budget plans cover a wide range of sub-interventions. That is interventions funded fall under broad categories of the CIP but the actual activities being funded are not ones that are known to generate high impact. For example, there are 11 provinces planning to implement demand generation activities but these are not targeted but population-wide, which evidence shows poor return on investment. There are 9 provinces that plan to implement public sector provision of LARCs. Once again, the modality of implementation may not use high-impact actions. The remaining key CIP interventions relating to youth-focused interventions and reducing stock out are not as well covered. There are 4 provinces that do not include any CIP related interventions. Finally, private sector provision of LARCs is a high-impact CIP intervention that is not included in the SO1 budget plan.

Figure 4 describes the number of provinces that have allocated some budget for interventions that correlate with the CIP key intervention areas. It shows that the key interventions within the CIP will need both promotion and advocacy to increase the coverage of these interventions in provincial budget plans and allocations for the years ahead. To obtain the outcomes sought by the CIP and the broader RMNCH strategy, *it would be critical that there is flexibility in being able adjust the activities already funded* to match more specifically with the CIP.

[17] Current provincial budgets include training on reproductive health and family planning counselling, meetings, supervision, community outreach, training for skilled birth attendants, health centre staff, provincial and district staff, transportation, investigation into maternal deaths, promotion of services and incentives to public facilities to provide FP services.

Figure 4: Coverage of CIP-Aligned interventions in 2017 SO1 province budget plans



b. FUNDING ALLOCATED TO INTERVENTIONS THAT ARE ALIGNED TO THE CIP

For the interventions identified as aligned to the CIP priorities, a total of 6,687 million LAK or $ 815,462 was allocated across the provinces. We were not able to separate how much funding was allocated to each priority intervention- but rather only looked at the total amount allocated. Therefore, the allocated funding may not map to the CIP intervention plans and budgets. For example, a Province might have allocated 75% of their funding CIP-priority intervention funding to demand generation interventions, while in the CIP budget only 20% was allocated to these interventions. Therefore, gaps for particular interventions may exist even within the 'funded' portion of the CIP if there is not flexibility to reprogram funding.

There were 4 Provinces (Vientiane City, Vientiane Province, Khammuane, and Huaphanh) where no funding was allocated towards priority CIP interventions. Overall, most this funding is from external donors. Details of provincial budgets are given in *Annex 8*.

c. PROGRAMMATIC FUNDING GAPS FOR THE FAMILY PLANNING CIP

The gap analysis finds that although the government will require a significant amount of funding than what is being put forward through existing budget allocations, much of the gap can be addressed by re-directing available spending to interventions specifically identified in the CIP. The gap between available funding and need is based on provincial allocations in 2017[18]. The analysis assumes that allocations remain flat-lined for the period 2017-2020, since consistent data on budget projections related to costs specific to the CIP are not available. We examine two types of gaps. First, the overall gap in annual funding and second, gaps in funding specific to each province for the year 2017. An important cautionary note, is that gaps only include programmatic costs. Commodities are not

[18] These CIP costs presented here include costs for scaling-up each of the 5 key interventions to be implemented in that province. That is, if a key intervention has been prioritized for that province, then 100 per cent of that cost is included and all remaining interventions are costed at 20 per cent of the full cost. This allows an explicit amount for comparison of available funding and funding needed.

included in the gap analysis[19]. The costs for contraceptive commodities is taken to be constant throughout each scenario (A, B, C) in the CIP and have been aligned to the Government's Commodity Forecast. These costs constitute 72,600 million LAK or $8.85 million over four years (2017 – 2020). Funding for commodities will need to be assured as the CIP becomes operational and this matter is also addressed in the next section on resource mobilization. In addition, adjustments to the forecast may be needed each year in response to programmatic plans—for example, if fewer midwives are trained to insert implants than originally planned, implant consumption may be lower.

i. Overall funding gap of program costs in one year (2017 only)

The funding gap is shown relative to the budgeted interventions that are aligned with the 5 key priority areas of the CIP, compared with the CIP costs for scenarios A, B, and C. As expected, scenario C, which includes the most widespread interventions costs the most, and therefore has the largest funding gap. The programmatic funding gap for 2017 ranges from just under 500 thousand USD to just over 1 million USD. See table 10a for details.

Table 10: Overall funding gap of CIP costs for 2017 (without commodities)

		CIP budget in 2017 (excluding commodities)		
	Committed funds (Provincial budget allocations to CIP interventions)	Scenario A	Scenarios A and B	Scenarios A, B, and C
Total (LAK (millions))	6,687	10,616	14,038	15,573
Gap (LAK (millions))		*-3,929*	*-7,351*	*-8,887*
Total (USD)	815,462	1,294,633	1,711,905	1,899,206
Gap (USD)		*-479,171*	*-896,443*	*-1,083,745*

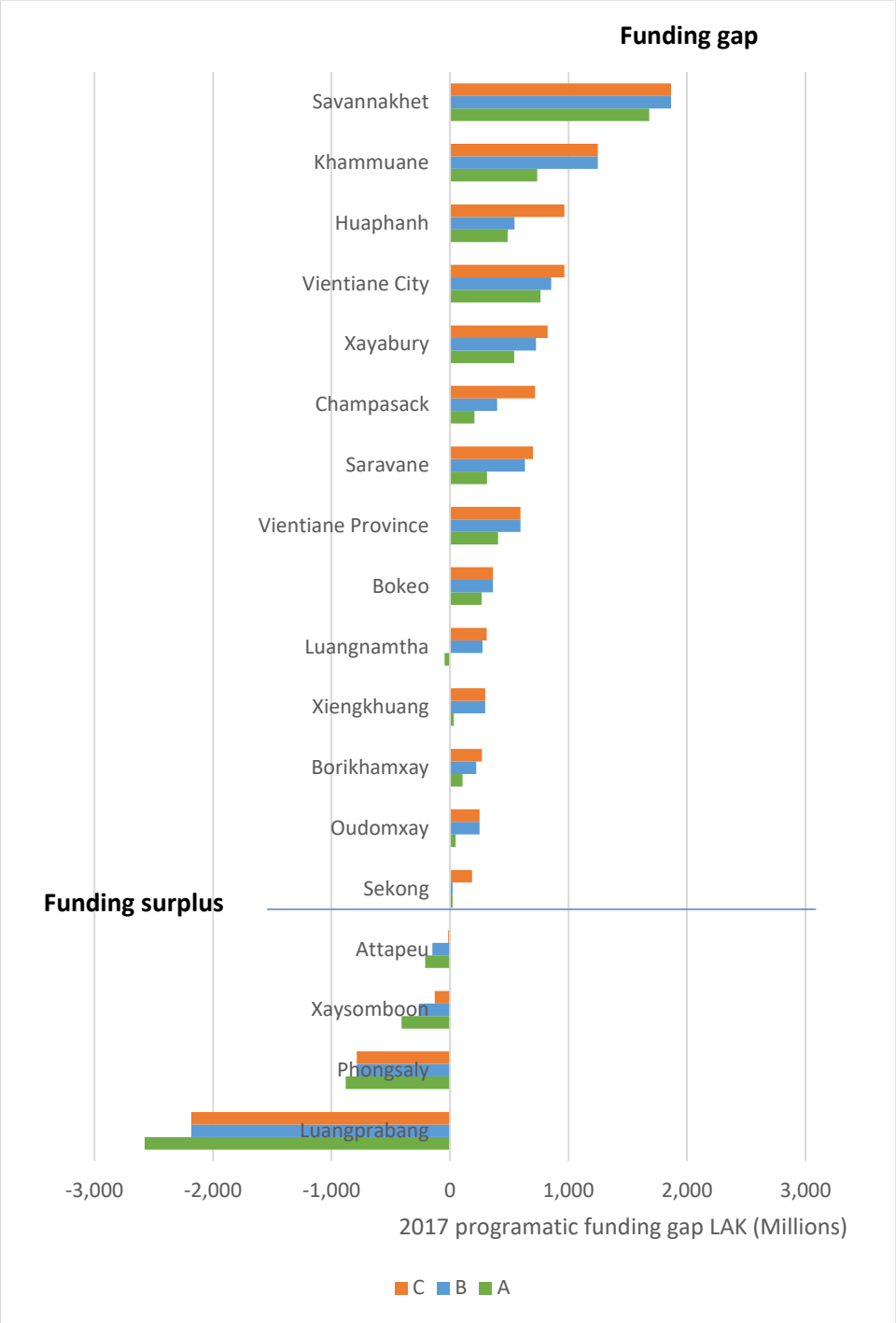
While this gap seems substantial, it is more surmountable when we look at this from the perspective of tiered in scenarios. Closing the gap to scenario A may be possible, while closing the gap to scenario C may be challenging. However, since scenario A was developed to get the most impact out of the most limited funding- implementing this scenario will ensure that benefits are maximized given funding constraints.

i. Funding gap of program costs by province

Figure 5 represents the funding gap by province. There are four Provinces where *more* money was allocated in 2017 budgets for CIP priority interventions than the CIP budgets for across all three scenarios (Luangprabang, Phongsaly, Xaysomboon, and Attapeu). If funding is flexible across province, it might be possible for some of these funds to be reallocated to the areas with the largest funding gaps. The provinces with the largest gap will clearly need to review their fund allocation to focus on the CIP interventions (Savannakhet, Khammouane, Vientiane Capital, Houaphanh and Xayabouly)—especially those with no 2017 funding allocated to priority CIP activities.

[19] Costs for contraceptive commodities are being evaluated separately by the Ministry of Health with logistics partners based on consensus during the Review phase of the CIP.

Figure 5: Gaps in funding family planning CIP program costs by Province



As noted earlier, gaps not only exist in financial resources but also in decision-making on the what interventions are being prioritized. Consequently, in addition to addressing gaps in funding all provinces will need to be well-orientated to the family planning CIP for impact to be actualized.

Table A7 in Annex 7 provides greater detail on the allocations, CIP costs and gaps by province.

i. Implications of funding gap

The first implication of the analysis above is that the extent of the funding gap depends on whether Maternal and Child Health provincial budgets are fungible – that is they can re-directed funding towards evidence-based CIP interventions. If they can be re-directed, then it is possible for the gaps to be filled within existing 2017 budgets. If not, filling the funding gap will require resource mobilization from government and external development partners. If we assume that only the CIP aligned budget can be allocated to planned interventions from scenarios A, B and C, the gap is ranges from nearly 500 thousand USD to just over 1 million USD, depending on which scenario is implemented. This finding has relevance not only for resource mobilization but should also inform the budgeting process and allocations for coming years. For Lao PDR to make progress on the RMNCH mCPR target (70% by 2025) as well as its FP2020 commitments, the government will need to fund more significantly than what is being put forward in 2017.

The funding gap also brings into question the dominance of revolving drug funds to cover operational costs at the health centre level and the package of benefits under insurance mechanisms especially health equity funds utilised by the poor. The success of proposed CIP interventions depends upon availability of services and commodities at the health centre level without resulting in high OOP costs for the end consumer. Expanding LARCs in the public sector will require not just trained personnel and commodities but addressing user fees and drug costs for the poor at the point of service. Currently, Health Equity funds have multiple payment mechanisms for services ranging from user fees in their benefit package. For those enrolled under the Social Health Insurance scheme, there are no co-payments for out-patient visits and drug costs but public sector providers are capitated, which may reduce provider incentives to provide time-consuming long-acting and permanent methods. There is need therefore to carefully review the benefits under different packages on offer, to determine if two major interventions within the CIP will be adequately financed at the point of service. Finally, expanding empaneled private sector and addressing reimbursements by type of method (case based versus capitation) for LARCs will be critical to ensure delivery of quality services, coverage of services by insurance schemes and likelihood that the private sector will be appropriately incentivized for their time.

While not assessed in this gap analysis, there may also be significant shortfalls in commodity funding-either now or in the future, that the Government will need to fill with its own resources. An important caveat is that provincial budgets do not include funding for commodities, hence the gap is analysed without commodities. Commodity costs in Lao PDR, per the Government quantification report is about $ 9 million USD over 4 years, which represents 57%-67% of the total need for CIP implementation. It is unclear if these costs can be reduced with greater efficiencies in procurement and distribution, refined based on planned implementation and expected mCPR achievement, or offset through greater use of the private sector. Annual processes to revise and update commodity forecasts should take the CIP interventions into account to ensure alignment.

Summary of key findings of funding gap analysis:

- External donor assistance comprises more than half of the financing for family planning interventions. However, there are a range of development partners supporting the sector.
- The CIP key interventions appear in some of the activities currently budgeted in provincial plans.
- 14 of 18 provinces have allocated at least some budget for interventions that align with the priority CIP interventions. However, the interventions in the provincial budget plans largely focus on demand generation activities so nay require refocusing.
- The overall gap in funding between allocated provincial budget plans and CIP program costs for 2017 ranges by scenario, from a modest 500 thousand USD to more than 1 million USD.

- The significant gap in funding is apparent upon examination of each provincial budget plan. This indicates that different assumptions have informed the decision-making process during budgeting stages for provincial SO1 financial planning.
- Through operationalizing the family planning CIP, it is then imperative that provincial, central and development partner decision makers accept and resource the high impact interventions that inform the family planning CIP.

9. RESOURCE MOBILISATION

The family planning CIP has been developed with an explicit focus on implementation of high impact interventions on mCPR. The emphasis on the use of evidence based modelling to inform decision making and planning is the foundation of the strategies for resource mobilization to ensure sufficient and on-going investment into family planning until the objectives and targets of the RMNCH strategy and action plan are accomplished.

The three broad strategies outlined in Table 11 are intended to guide the detailed development of action plan for resource mobilization.

Table 11. Strategies for Resource mobilization

Strategy	Rationale	Expected outcome
1. Accountability must be built in – whether as performance/results based funding with rigorous financial and performance reporting.	Fostering a strong reputation for achieving targets set with the committed resources for the CIP.	Results show an increase in mCPR as projected in the modelling.
2. Utilize evidence based modelling and the CIP monitoring framework to advocate for increased funding from Government, development partners and private sector.	Building an evidence base in the Lao PDR context to engage in policy dialogue and budget decisions.	The CIP is fully funded for the entire program timeframe and beyond.
3. Implementing partners recognize and prepare for changes in donor investment into FP. Seek transition funding of the CIP over the initial four years of this CIP.	Develop plans and engage early with stakeholders in government and with donors in anticipation of policy shifts and funding to FP.	Accomplish a smooth transition of funding sources over 4 years and beyond. That is the government to external donor financing of CIP over 4 years is: 1. Year 1 40:60, 2. Year 2 50:50, 3. Year 3 60:40, 4. Year 4 70:30

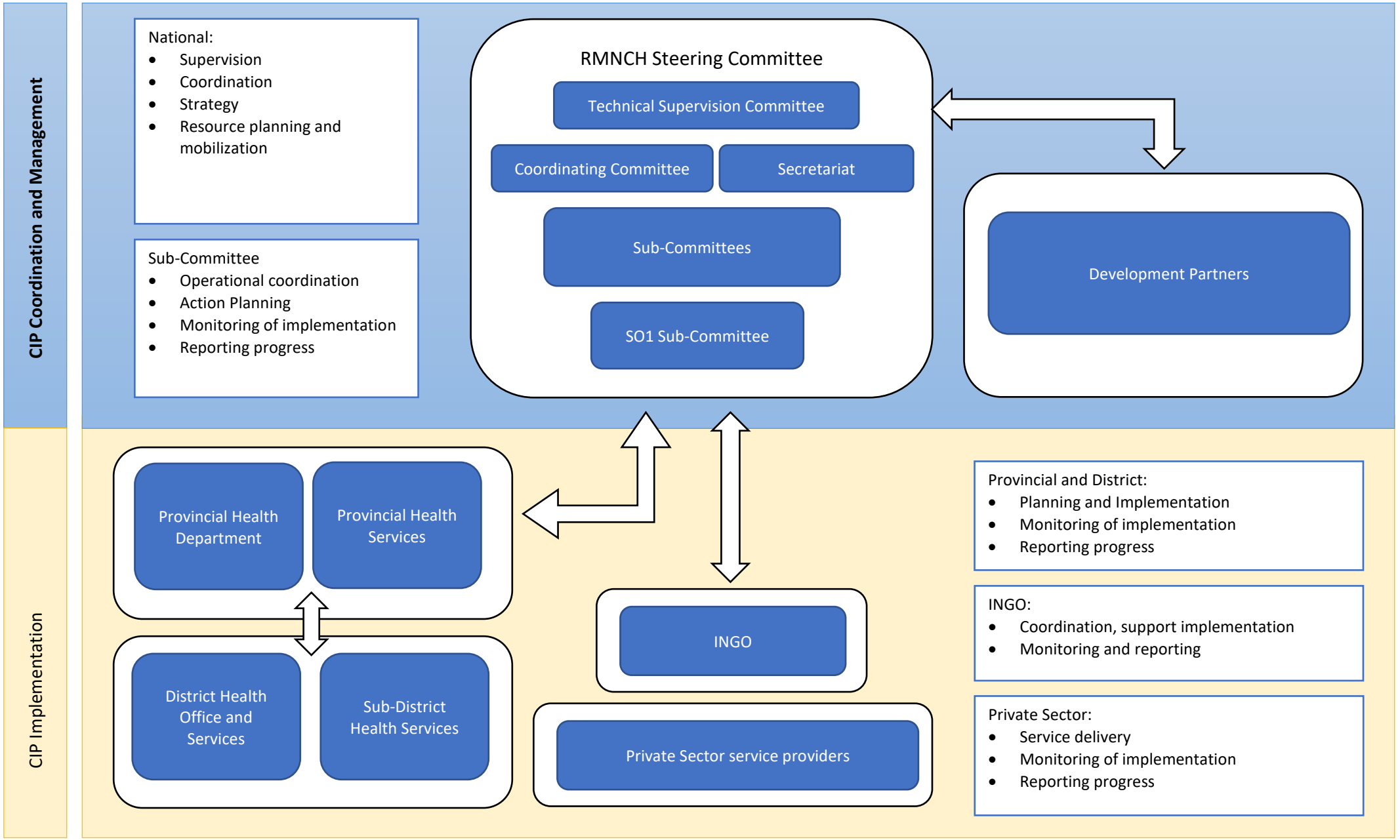
10. INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

In line with the RMNCH Strategy and Plan and the FO2020 commitment, the Government of Lao PDR remains firmly committed to prioritizing maternal, neonatal and child health. The family planning CIP is situated within a wider effort to promote an enabling environment for family planning and coverage of services to support the reduction in maternal, neonatal and child mortality and morbidity. At the policy and program level, the CIP recognizes that it is the Ministry of Health that will oversee the family planning CIP. With the focus of the CIP on increasing the mCPR, the management and coordination structure will require the involvement of national, provincial and district organizations and agencies and development partners (See Figure 6).

The management and coordination structure for the family planning CIP is proposed to be located within the current institutional arrangements for SO1 of the RMNCH strategy and action plan. That is, the management and coordination of the family planning CIP is appropriately placed within the

functions of the SO1 Sub-committee, which will coordinate with and be supported by the RMNCH Secretariat, Coordination Committee, Technical Supervision Committee and receive broad guidance and direction from the RMNCH steering committee. These Committees represent national administrative bodies to support the CIP, however in terms of implementation, the arrangements must also be inclusive of province and district administration. The coordination, management and implementation structure proposed for the family planning CIP is shown in Figure 5. The implementation structure is presented here to ensure that all stakeholders are represented. The CIP will require significant input from Provincial, District and the Private sector in the planning and implementation process. While annual planning and budgeting can be led by the Provincial Health Department, there will be a need for considerable engagement between national level partners and implementing organizations to ensure that sub-interventions are resourced both financially and technically.

Figure 6: CIP coordination, management and implementation structure



11. OPERATIONAL PLANS

This section presents proposed operation plans for each province. The purpose is to assist Provincial Health administrators to identify sub-interventions and required budget to inform annual planning for high impact CIP interventions. There are also a set of assumptions that must be stated here. The assumptions underlying the operation plans for each province are:

- GoL commitments to enable IUD and implant services in private clinics are actioned
- There are strategies in place for the development of a national information, education, and communication (IEC) and behavior change communication (BCC) strategy on family planning—based on the national communication IEC/BCC for health strategy.
- The continuation of the program for extending the training of existing community midwife students to become proficient in family planning counselling and procedures (IUDs, implants, emergency contraceptive)
- The continuation of efforts to increase coverage of family planning and maternal, neonatal, and child health services at the community level through the scaling up of existing, successful community-based interventions, such as the Community Based Distribution Programme
- The proposed budget allocation for the CIP reflect the health budget realities in which the current set of CIP sub-interventions are not currently budgeted.
- A tiered implementation (Scenarios A, B, C) ensures that investments are matched to need—putting the greatest effort into the areas with the largest need, and thus the areas where the largest benefit will be received.
- A tiered implementation (Scenarios A, B, C) allows for prioritization when funding is limited to fully implement all interventions.
- A tiered implementation provides greater scope for monitoring and evaluation to be planned and scaled.

PROVINCIAL OPERATIONAL PLANS FOR CIP INTERVENTIONS

The following tables have been extracted from the *Appendix 6. Summary of direct program costs by priority area, province and year (KIP (millions)),* which contains the summary of direct CIP program costs for each province by the key Intervention areas and year. As there are numerous provinces, each table containing annual costs for the CIP (2017 – 2020) is not presented here. Instead, the annual CIP costs by key interventions for four provinces are presented as examples of what the provincial budget plans would entail (Tables 12-15). These provinces are Vientiane Capital, Phongsaly, Khammouane and Saravane.

Table 12: Vientiane Capital Summary of direct program costs by priority area, province and year (LAK millions)

CIP Interventions	Vientiane City				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	23	0	23	0	46
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	0	0	0	0	0
Total Direct Program Costs	764	741	671	648	2,825
Scenario B	**Scenario B**				
Stock out reductions	113	0	113	0	227
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	0	0	0	0	0
Total Direct Program Costs	854	741	762	648	3,005
Scenario C	**Scenario C**				
Stock out reductions	113	0	113	0	227
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	110	110	110	110	439
Total Direct Program Costs	964	851	872	758	3,445

Table 13: Phongsaly Summary of direct program costs by priority area, province and year (LAK millions)

CIP Interventions	Phongsaly				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	23	0	23	0	47
Public sector facilities: LARC	79	79	79	79	315
LARC via private sector	10	10	6	6	34
Youth-focused interventions	37	37	37	37	146
Demand generation	85	85	85	85	342
Total Direct Program Costs	235	211	231	207	884
Scenario B	**Scenario B**				
Stock out reductions	115	0	115	0	230
Public sector facilities: LARC	79	79	79	79	315
LARC via private sector	10	10	6	6	34
Youth-focused interventions	37	37	37	37	146

Demand generation	85	85	85	85	342
Total Direct Program Costs	326	211	322	207	1,067
Scenario C	**Scenario C**				
Stock out reductions	115	0	115	0	230
Public sector facilities: LARC	79	79	79	79	315
LARC via private sector	10	10	6	6	34
Youth-focused interventions	37	37	37	37	146
Demand generation	85	85	85	85	342
Total Direct Program Costs	326	211	322	207	1,067

Table 14: Khammouane Summary of direct program costs by priority area, province and year (LAK millions)

CIP Interventions	Khammouane				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	172	0	172	0	343
Public sector facilities: LARC	153	153	153	153	612
LARC via private sector	220	220	135	135	711
Youth-focused interventions	69	69	69	69	275
Demand generation	122	122	122	122	488
Total Direct Program Costs	735	564	651	479	2,429
Scenario B	**Scenario B**				
Stock out reductions	172	0	172	0	343
Public sector facilities: LARC	593	593	593	593	2,372
LARC via private sector	220	220	135	135	711
Youth-focused interventions	141	141	141	141	564
Demand generation	122	122	122	122	488
Total Direct Program Costs	1,248	1,076	1,163	991	4,478
Scenario C	**Scenario C**				
Stock out reductions	172	0	172	0	343
Public sector facilities: LARC	593	593	593	593	2,372
LARC via private sector	220	220	135	135	711
Youth-focused interventions	141	141	141	141	564
Demand generation	122	122	122	122	488
Total Direct Program Costs	1,248	1,076	1,163	991	4,478

Table 15: Saravane Summary of direct program costs by priority area, province and year (LAK millions)

CIP Interventions	Saravane				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	161	0	161	0	321
Public sector facilities: LARC	114	114	114	114	458
LARC via private sector	17	17	10	10	55
Youth-focused interventions	108	108	108	108	432
Demand generation	98	98	98	98	390
Total Direct Program Costs	497	337	491	330	1,656
Scenario B	**Scenario B**				
Stock out reductions	161	0	161	0	321
Public sector facilities: LARC	434	434	434	434	1,738
LARC via private sector	17	17	10	10	55
Youth-focused interventions	108	108	108	108	432
Demand generation	98	98	98	98	390
Total Direct Program Costs	817	657	811	650	2,936
Scenario C	**Scenario C**				
Stock out reductions	161	0	161	0	321
Public sector facilities: LARC	434	434	434	434	1,738
LARC via private sector	85	85	52	52	274
Youth-focused interventions	108	108	108	108	432
Demand generation	98	98	98	98	390
Total Direct Program Costs	885	725	853	692	3,155

12. MONITORING AND EVALUATION

This plan is oriented broadly to achieve Laos goals set in National Strategy and Action Plan for integrated service on Reproductive, Maternal, Newborn and Child Health 2016-2025. The focus of the Costed Implementation Plan is on those elements in the strategy most likely to deliver the broad results sought and within the existing the resource envelope. As such, the strategy of the CIP is to obtain levels in mCPR achievement close to the target set in the RMNCH plan, through a deliberate focus on interventions and geographic areas that are most likely to respond to investments. Currently the RMNCH plan intends on scaling up a large package of interventions throughout the country and has set a target of 65% mCPR among married women by 2020.

Our analysis and modelling shows that even with full implementation of all interventions in the RMNCH, mCPR (married) will only reach 61%. Our modelling also shows that if Scenario C of the CIP is implemented, mCPR will only fall short by a few points, reaching 58%, which is within the uncertainty range for mCPR estimates. By better selection of interventions and a more targeted approach to province selection, with fewer resources a similar level of impact can be achieved.

Figure 7 describes the results framework for obtaining the increased mCPR of 58% by 2020 which is guided by investments in stock out reductions, in public and private provision of long acting and reversible methods, in demand generation and community mobilization to shift social norms and demand for children. We expect that investments in stock out reductions in 10 priority provinces by 98% and 20% reductions in other provinces will have an impact on utilization of all modern methods including long acting and reversible methods. Independent of the stock out effect we expect direct investments in training midwives in the public and private sector at 100% of health facilities in priority provinces and 20% of facilities in others, as well as investments in supportive supervision alongside incentives for performance in the private sector to deliver substantial shifts in women using these methods. Alongside stock- out interventions we expect from global evidence that targeted demand-side interventions through community mobilization to have an impact on modern method prevalence and long acting method prevalence in particular. Interventions targeting working and in-school youth are expected to generate both immediate and longer term impacts on all women contraceptive prevalence, with long term impacts generated through socialization effects of improved knowledge and use when sexual activity begins among this cohort.

Tables 16a and 16b describes the monitoring and evaluation plan for the CIP. We identify indicators that can track both at the output and outcomes level in the near term through routine service statistics and survey data respectively, while impact evaluation will be sourced through survey data. The monitoring and evaluation plan requires investments in personnel who will have to provide an annual report on these performance indicators to provide mid-course corrections

Figure 7: CIP Monitoring and Evaluation Framework

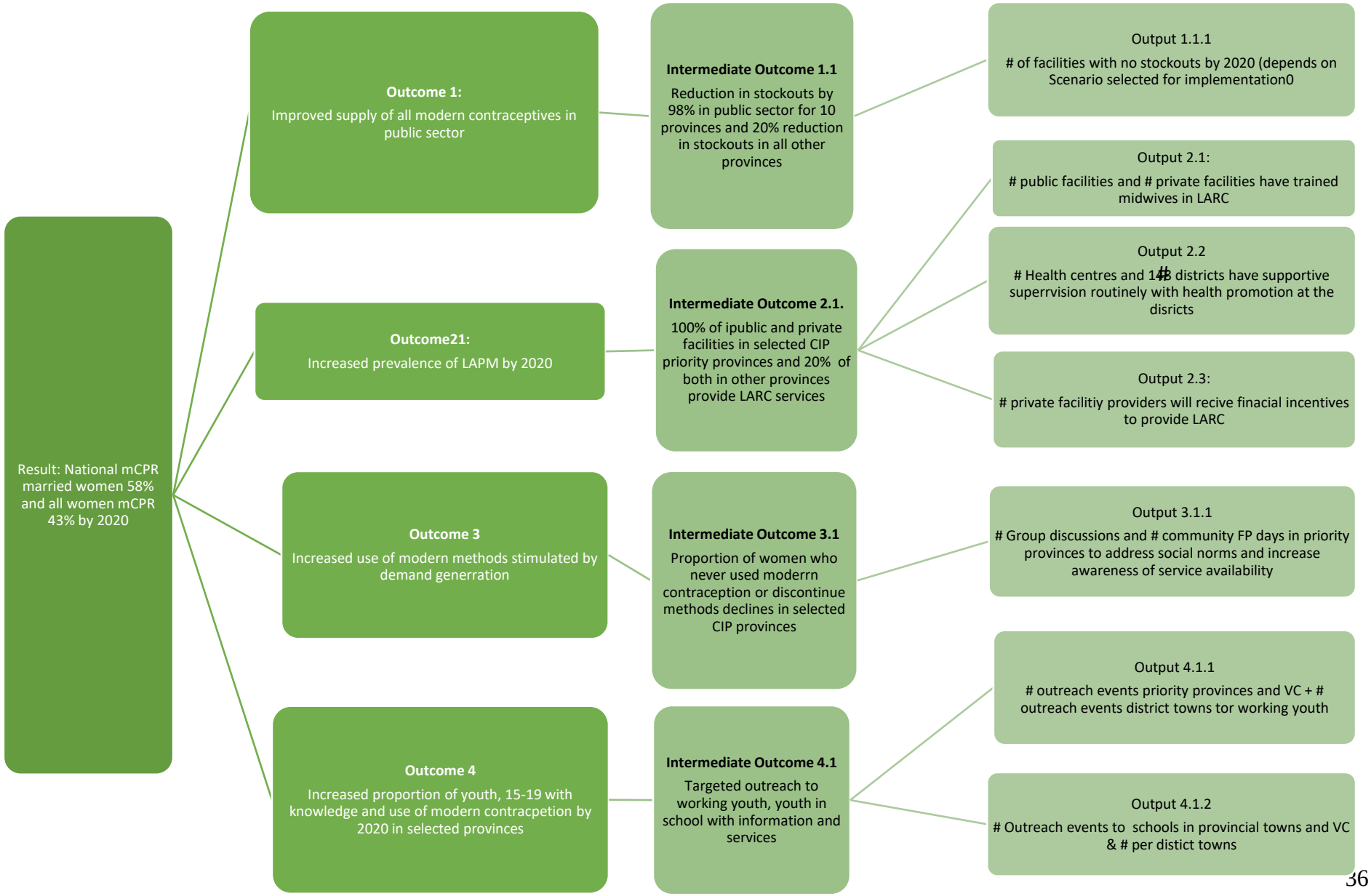


Table 16a: Monitoring Plan CIP, Outcome Level

Outcome	Indicator	Source of data	Baseline levels	Target
Stock outs of modern methods eliminated by 2020 in priority provinces and reduced by 20% in all others	Percentage of facilities stocked out by method, on the day of assessment, in priority provinces Percentage of facilities stocked out by method, on day of assessment or last reporting period, in all other provinces	LMIS/DHIS2 routine service statistics reports, and/or UNFPA SDP survey	Stock out rate for each method in priority provinces in 2016 (2012 LSIS and 2012 SAS[20] reports) Stock out rate by method in all other provinces in 2016 (2012 LSIS and 2012 SAS reports)	2% stock out rate for facilities in priority provinces 20% reduction from baseline for all other provinces
100% of facilities provide quality LARC services in priority provinces and 20% of facilities in other provinces	Percentage of facilities that have trained providers of LARC, by public and private, in priority provinces Percentage of facilities with full stock on the day of assessment or last reporting period Proportion of new adopters of LARCs who discontinue within 3/6 months of insertion of method (poor quality), for reasons other than desire for pregnancy	DHIS2 and LMIS DHIS2 and LMIS Supervision review reports from registers at facility	Province specific baselines in 2016 of facilities with midwives who currently offer LARC Province specific baselines in 2016 of health facilities are stocked with LARC methods n/a	100% of facilities in priority provinces, public and private with trained midwives by 2020 100% of facilities stocked adequately with LARCs by 2020
Increased number of new acceptors of modern methods in priority provinces who were previously non-users	Proportion of women who did not use contraception prior to the intervention in priority districts who identify community mobilization events as source of referral for adopting FP use	Periodic, based on survey and/or DHIS2	0% of WRA in selected villages	Increase in new acceptors of modern methods by source of referral

[20] Ministry of Health and UNFPA. SAS Report (2012) survey availability of modern contraceptives and essential life-saving maternal/RH medicines in service delivery points in Lao PDR.

Improved knowledge of modern methods of contraception among youth 15-19 who report that outreach as their main source of information	Proportion of working and in-school youth who can accurately report methods to prevent pregnancy, and have accurate knowledge of the fertile period by source of information Percentage of youth who know where to obtain methods including emergency contraception by source of information	Periodic, based on survey measuring knowledge among sexually active and inactive youth. Behavioral surveys	Lack data on Province specific baselines in 2016 of working youth and in -school youth with accurate knowledge of methods to prevent pregnancy and knowledge of fertile period Assume zero at baseline 2016 Lack data on Province specific baselines in 2016 of working and in school youth have accurate information on where to obtain methods of contraception Assume zero at baseline	Increase in % who reported accurate knowledge of methods to prevent pregnancy and knowledge of fertile period And % accurate information on where to obtain methods of contraception
Increased use of modern methods of contraception among sexually active youth, 15-19	Percentage of sexually active 15-19 married and unmarried who use modern methods of contraception	Periodic survey	Province specific Baseline from DHIS data	No target but will be evaluated periodically along with survey data

Table 16b: Monitoring Plan CIP, Output Level

Output	Indicator	Source of data	Baseline levels	Target
Procurement of adequate supply to support annual forecast requirements in 10 provinces and to support all other provinces Systems to maintain efficient inventory management in place by 2020 Incentives to providers to manage commodity stock levels	Quantification plan developed annually leading to zero gap in commodity requirements by 2020 for priority provinces and reduction in gap for other provinces Proportion of facilities that report using standard inventory management practices Proportion of facilities in priority provinces that have shifted to output based financing	LMIS/DHIS2 routine service statistics reports, and/or UNFPA SDP survey Logistics Master Plan annual report Health Financing annual report	Annual quantification plan gap 2016 in commodity needs in priority provinces 0% of facilities are using standard inventory management in 10 provinces 0% of facilities are using output based financing in 10 provinces to manage delivery of services	0 Gap in commodity needs in priority provinces per quantification plan by 2020, with 50% in 2017, 25% in 2018, 12.5% in 2018, 7% in 2019 and 2% in 2020 100% of facilities using standard inventory management practices in priority provinces 100% of facilities in priority provinces using output based financing for commodity management by 2020
Priority provinces have midwives trained in LARC in both private and public facilities Private facilities in priority provinces receive incentives to expand provision of LARC commensurate with level of effort required – strategic purchasing from the private sector of LARC services	Proportion of facilities that have trained midwives in place, of LARC, by public and private, in 10 provinces Proportion of private facilities that have strategic purchasing contracts to deliver LARC services	DHIS2 Health financing/donor reports	0% of facilities with midwives currently offer LARC 0% of private health facilities at provincial level have contracts to purchase LARC services	100% of facilities in priority provinces, public and private with trained midwives by 2020 100% of private facilities in priority participate in strategic purchase of LARC services
Health facilities in priority provinces receive routine,		Supervision reports by province	Baseline dHIS2 data from facilities and districts	100% of health facilities and districts in priority

scheduled supervision from district offices on quality and performance of LARC provision	Number of health facilities and districts in priority provinces trained in LARCs that have received a biannual supervision visit to review quality and performance standards, by public and private			provinces receive routine supervision on LARC provision by 2020
New community mobilization including FP days conducted in priority provinces per schedule	Number of community events including FP days conducted with accurate information on modern methods of contraception, fertility period and return to fertility post-partum by province Number of non-users reached by community events Number of non-users who cite mobilization as source of referral at health facility	Outreach – Community Health quarterly performance report by province Attendance registers community outreach by province by use Family Planning register – periodic analysis	Baseline provincial data in 2016 on community events with targeted information Baseline provincial data in 2016 on non-users reached Baseline provincial data in 2016 on non-users who cite community mobilization as source of referral for FP	Increase in community events held and FP community days held in priority provinces (coverage at Provincial, District and village level)
Outreach events to working and in-school youth completed on schedule Content of outreach events focuses on providing and testing accurate knowledge on preventing unintended pregnancies, knowledge of the fertile period and where to obtain modern methods	Number of outreach events conducted in priority provinces by in-school and working youth Number of outreach events with clear messages and completed tests on accurate knowledge on preventing pregnancy, on fertile period and source of contraception	Outreach coordinator reports Content analysis of outreach events	Baseline provincial data on outreach events to working and in school youth in priority provinces on FP knowledge n/a	Increase in outreach events in provincial towns and VC and district towns completed by 2020 Increase in outreach events in provincial towns and VC and outreach events in district towns completed by 2020 Increased knowledge based on of outreach events report before and after tests of knowledge

Annex 1: CIP DEVELOPMENT PROCESS, Detailed Description

This document was developed through a comprehensive, multi-sectoral process led by the Ministry of Health in Laos. The development process, which is detailed below, included formation of an overall advisory groups and technical working groups that focused on discussing different potential priorities. These groups were a mix of government, donors, implementation partners, and other relevant stakeholders. Initial discussions focused on current family planning priorities and a mapping of existing strategies and plans for all intervenors.

Coupled with this consultative process was the application of the FP Goals model, which estimates the impact of specific interventions on mCPR. Using the model within this type of process, allows countries to include impact, along with feasibility and government commitment, in discussions on programme priorities.

1. LANDSCAPING (SEPT 2016)

During this step a range of stakeholders participated in interviews from the Ministry of Health, Mass organizations, public health service provides, international non-government organisation, the World Bank and UNFPA. The information gathered formed the basis for understanding the investments and strategies of the GoL, various interventions being implemented by various government, non-government and development partners and program coverage, gaps and opportunities for growing the mCPR.

2. BASELINE REVIEW: DATA SETS AND CREATING SCENARIOS (SEPT 2016)

To establish the baseline data to be entered in the FP Goals, data was collected from DHIS2 as well as from various surveys and databases. The data sets collected included demographic data, total number of facilities, number of facilities that provided FP services by methods, average number of FP clients per facilities, community based distribution, stock-out, youth-focused interventions, FP integration with other services and health education, training. This data was presented to that were presented to Data, Program, Policy and Finance experts and other stakeholders to gain agreement on the data estimates.

With the baseline data, it was then possible to represent the FP landscape for Lao PDR and establish selected scenarios (containing FP interventions and activities) that could be entered into FP Goals to determine the estimated increase in mCPR. At the end of this process, a base scenario (Table A1) was selected based on the interventions for SO1. The subsequent scenarios were combination of interventions in SO1 that have proven impact on mCPR growth and being implemented in specific high need provinces.

Table A1: Interventions for the Base Scenario

What is in the RMNCH strategy and plan?	Interventions included in FP Goals
Policies, Strategies and Guidelines	Not included in model - no direct impact on mCPR (but indirect by allowing more access interventions)
Management, Monitoring and Supervision	Not included in model - no direct impact on mCPR (but indirect by ensuring quality services)
Reduce stock outs	Reduce stock outs (98% addressed by 2020)
Increase access to LARCs via the public sector	Retraining providers + midwife trainings → higher availability of LARC in public facilities (aim = all health centers offer LARC via midwives)

Increase provision of LARC via the private sector	Policy shifts (IUD in private sector) and training of providers → higher availability of LARC in private facilities
Scale up community-based interventions (CBD, VHW, VHV) and outreach	Scale up of FP provision via CBD/VHV/VHW, and scale up of FP through integrated outreach (aim: visit each village once every 3 months)
Demand generation activities	Roll out group discussions + community FP days in all districts
Youth-focused interventions: in-school curriculum, YFS, BCC	Scale up comprehensive youth programming with YFS (youth room at all district hospitals), and, scale up in-school RH education

3. RESULTS AND IMPACT REVIEW PROCESS (NOV 2016)

The base scenario was constructed from the interventions already in the RMNCH strategy and plan (2016-2025). An observation of the plan shows that many interventions are set to reach 100 percent coverage by 2020, making this scenario very ambitious. Once the base scenario was established, a set of conditions was established to inform the construction of the next scenarios to compare against the base scenario. There were two key rationale used to select the next scenarios. The first was to improve the mCPR in low prevalence provinces and the second was to include only the interventions that provided the most impact on mCPR growth. International research used to develop FP goals shows that there are key interventions that have proven impact on the mCPR. The consultation process also considered the experiences and comments of all stakeholders about which interventions should be priorities. A consensus was reached with regards which interventions should be used.

3.1 ANALYSIS OF SCENARIOS AND IMPACTS

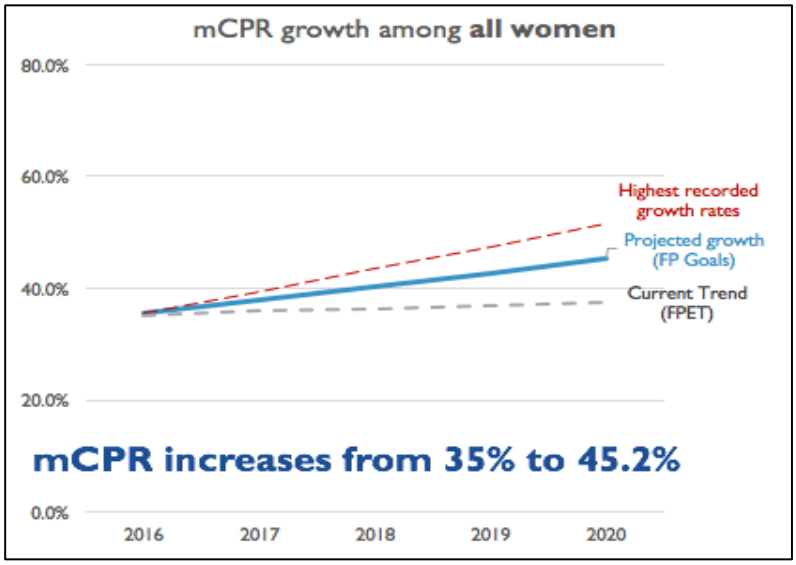
The Results and impact review process included the analysis of the base scenario, subsequent final scenario, impact on mCPR and costs for the sub-interventions and annuals costs for interventions. The analysis demonstrated that a substantial increase in mCPR can be achieved with a lower level of effort than through full implementation of the existing RMNCH strategy or the base scenario. The costing analysis will show that these investments or interventions are feasible with regards to funding and resourcing.

3.2 BASE SCENARIO AND IMPACT ON mCPR

The base scenario and impact on mCPR provided a comparison of the investments required to achieve similar impacts on mCPR to interventions and provinces that have been strategically selected in the subsequent final scenario. It should be noted here that the effort required to achieve an impact on the mCPR has cost implications. In other words, if less effort is required to obtain similar results then that scenario is more likely to a cost-effective choice.

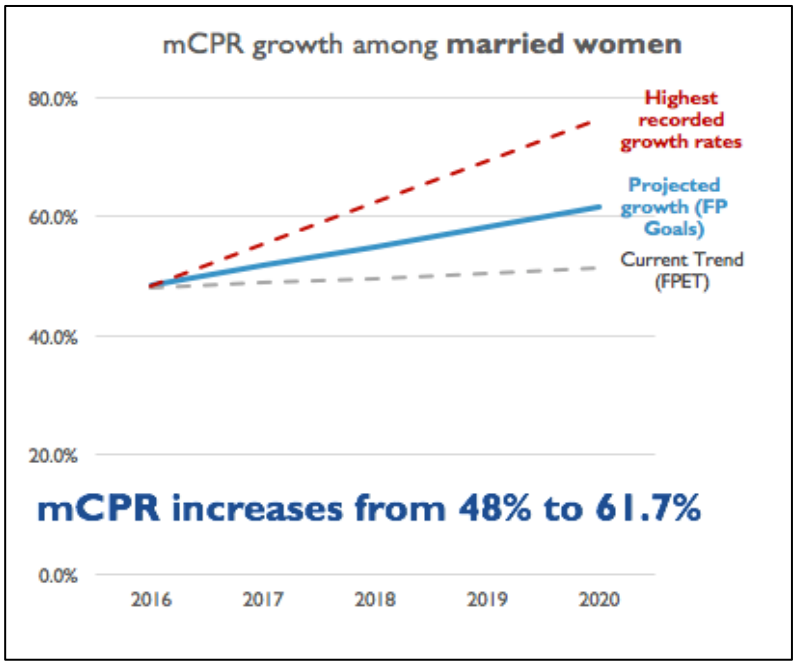
The SO1 actions for family planning in the RMNCH Strategy are the actions that form the base scenario an are listed in Table A1. These actions were entered into the FP Goals model. The impact on mCPR of the full implementation of these actions are presented in Figure A1 (mCPR growth among all women) and Figure A2 (mCPR growth among married women).

Figure A1: mCPR growth among all women, Base scenario



Based on modelling (through FPGoals) projected growth of mCPR, if interventions for family planning for SO1 are fully implemented, it is expected that the mCPR **for all women** by 2020 will be 45.2%. This represents is an increase of 10% from the

Figure A2: mCPR growth among married women, Base scenario



Modelling the projected growth of mCPR, if the interventions for family planning for SO1 are fully implemented, mCPR for married women by 2020 will be 61.7% an increase of 13% from current levels.

While these increases in mCPR are of interest, the mCPR among married women is just 4 percent points from the target of 65 percent by 2020. To achieve mCPR increases to 61.7% among married women by 2020, would require 100 percent implementation and coverage of the RMNCH interventions. 100% Implementation would translate into number of trainings, persons or activities as outlined in Table A2, which would require more resources then are likely to be available.

Table A2. Activity effort required for full implementation of RMNCH to achieve 61.7% mCPR among all married women

Intervention	Effort: Full RMNCH Implemented 2016 - 2020	Quantity (Total)	Unit
Stock out reductions	# facilities with stock outs to be eliminated	547	facilities
LARC via public sector	Min # midwives to be trained at Health Center	956	Persons
LARC via private sector	# private facilities to be trained on LARC provision	394	Facilities
Integrated Outreach*	# integrated visits to take place	28,434	Visits
CBD/VHW/VHV*	# CBD/VHW/VHV trained to provide FP services	1,854	Persons
Youth-focused	# young people reached by interventions in 2020	183,417	Persons
Demand generation	# women reached by demand generation in 2020	135,259	Person

* Integrated Outreach and CBD interventions were dropped as priority interventions by stakeholders during the development of the CIP

Table A3 presents a comparison of the investments and impacts on mCPR for married women between the base scenario and the subsequent scenario that priorities interventions and provinces. Through the selection of targeted locations for implementation, it is shown that this approach could achieve comparable increases in mCPR with efforts that are within feasible parameters.

Table A3. Comparisons of activities and impact on mCPR (married)

Intervention	Effort	mCPR in 2020 55.6%	mCPR in 2020 57.8%	mCPR in 2020 58.8%	mCPR in 2020 61.7%
		A: prioritize 5 province per intervention	B: prioritize 10 province per intervention	C: Prioritize additional interventions (above A, B)	Full RMNCH Implemented
Stock out reductions	# facilities with stock outs to be eliminated	333	461	485	547
LARC via public sector	Min # midwives to be trained at Health Center	483	713	838	956
LARC via private sector	# private facilities to be trained on LARC provision	219	309	369	394
Integrated Outreach	# integrated visits to take place	0	0	0	28,434
CBD/ VHW/ VHV	# CBD/VHW/VHV trained to provide FP services	0	0	0	1,854
Youth-focused	# providers trained on YFS	1,408	1,717	1,872	2,010
Demand generation	# group discussions held	468	1,116	1,224	1,776

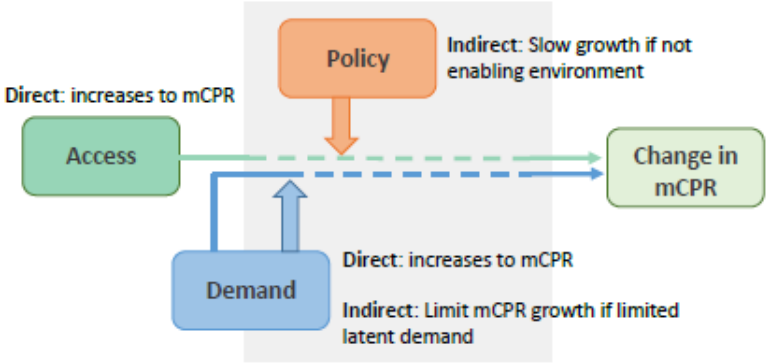
The mCPR result in prioritizing selected interventions in 5 high need provinces is expected to achieve a mCPR of 56 percent, only 6 percentage points below the full implementation of the actions in for SO1 of the RMNCH strategy and plan, but with much lower overall efforts as can be seen from the table above.

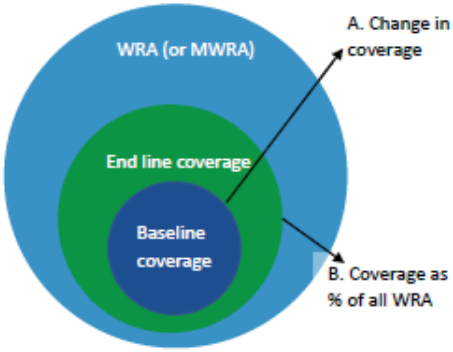
Annex 2: FP Goals Description

FP Goals: A policy tool for estimating the potential mCPR impact of FP interventions (Beta Version)

What it does. FP Goals is a model developed by Avenir Health that estimates the impact of introducing or scaling up various family planning interventions on the modern contraceptive prevalence rate in a country. The model is designed to work over a 5-year period, and requires the user to input data about the baseline situation in the country, as well as the planned intervention scale up. By comparing different mixes of interventions, countries can see what combinations can have the largest impact on mCPR growth. The model is tailored to the demographic situation in each country- meaning the impact of an intervention will vary country to country.

How it works. Each intervention has either a direct or indirect impact on mCPR (see diagram on left). For direct interventions, impact is determined based on the change in coverage (see diagram on right), and, the odds ratio for the intervention increasing mCPR (see table on back). For indirect interventions the mCPR growth projected from the direct interventions is slowed or capped when the policy environment is not enabling or when there is little latent demand for family planning.

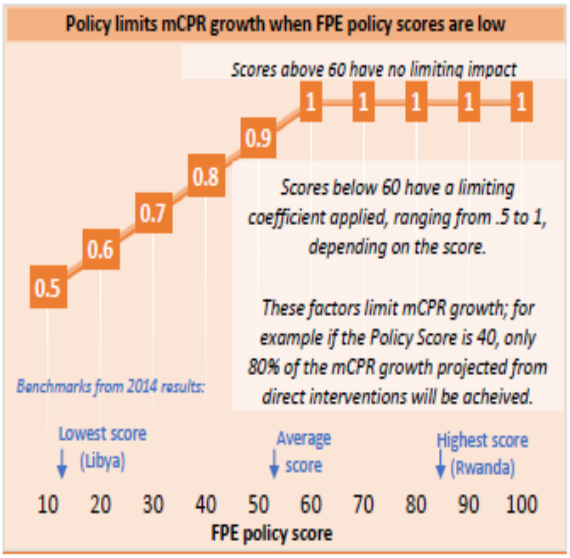


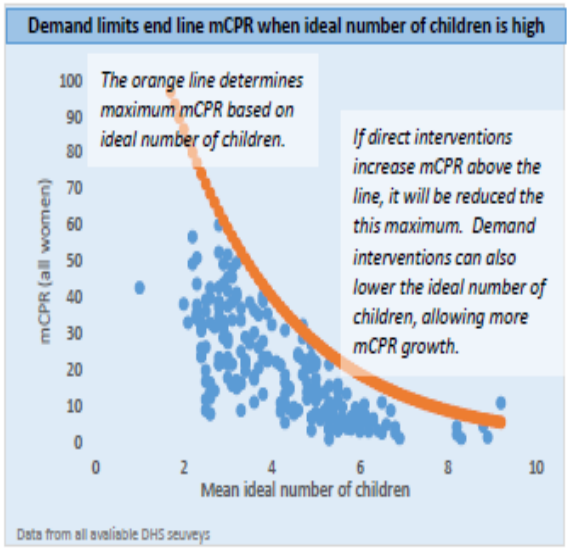


The evidence behind direct increases to mCPR. The odds ratios (OR) below are based on 77 results from 62 studies. The OR is the odds that exposure to the intervention will lead to an increase in mCPR. An OR of 1 means no impact, anything above 1 means there is a positive mCPR impact.

Intervention	Odds Ratio	Notes
Access		
Post-partum FP	1.72	*Based on intervention impact on PPFP uptake. Impact also calculated from increasing facility-based deliveries.*
Post-abortion and post-PAC FP	1.80	
Community-based distribution	1.52 to 1.61	*Range based on range of methods provided, and inclusion of community mobilization*
Mobile outreach	1.57 to 1.61	*Used CBD OR for full range of methods; range based on inclusion of community mobilization*
Social franchising	1.27	
Vouchers	1.22	
Social marketing	1.27	*Using social franchising OR until more evidence is available*
Stock out reduction	*calculated*	*6.5% pt increase for each method fully available, adjusted for method mix*
Introduce new method	*calculated*	*7.5% pt increase for each new method fully introduced, adjusted for prevalence, and similarity to other methods*
Demand		
Unmarried youth	1.56 to 1.58	*Range based on in-school versus out of school interventions*
Married youth	1.51	
Mass media	1.30	
Community mobilization	1.45 to 1.47	*Range based on type of intervention: comprehensive community engagement, individual-based approaches*

The evidence behind indirect limits to increases to mCPR. olicy and demand play an indirect role- limiting mCPR growth when these factors are not enabling. The mechanisms though which they limit mCPR growth are slightly different, as shown in the two graphs below.





Annex 3: Additional Details on Costing

a. Cumulative Costs and costs as functions of total CIP costs

The table below presents the sub-interventions that the reference group determined to be achievable in the country context. The table also provides the unit costs and the number of units used to calculate the costs for each sub-intervention.

Table A4: Cumulative costs by scenario and sub-intervention

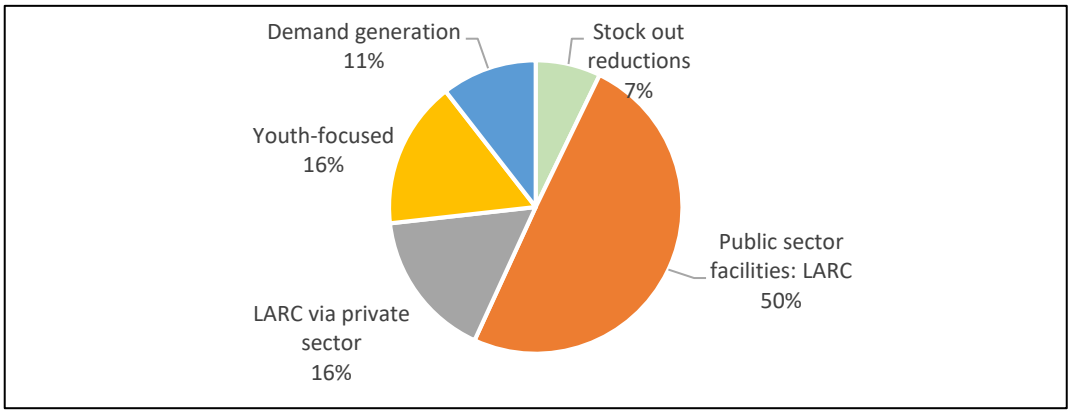
			A		A and B		A, B, and C	
Area	Measure	LAK millions	Units	Total Cost (LAK millions)	Units	Total Cost (LAK millions)	Units	Total Cost (LAK millions)
Stock out reductions	# facilities with stock outs to be eliminated	3.5	333	2,332	461	3,227	485	3,396
Public sector facilities: LARC	# Health Centers to be trained on LARC provision	5.5	483	5,315	713	7,841	838	9,216
	# HC needing medical supplies to insert IUD and Implants	2.8	483	5,412	713	7,983	838	9,383
	# HC needing supervision (District to HF)	0.7	483	1,353	713	1,996	838	2,346
	# Districts needing supervision (Province to District)	2.4	148	1,421	148	1,421	148	1,421
	Promotion of services (# districts)	1.9	148	1,125	148	1,125	148	1,125
LARC via private sector	# private facilities to be trained on LARC provision	5.0	219	1,097	309	1,545	369	1,844
	Financing for private providers	4.0	219	3,510	309	4,944	369	5,901
Youth-focused: Outreach activities to working youth	# outreach events at provincial towns and Vientiane Capital	1.2	270	1,296	305	1,464	335	1,608
	# outreach events at district towns	1.2	36	173	42	202	45	216
Youth-focused: Outreach activities to youth in school	# outreach events at provincial towns and Vientiane Capital	0.3	117	140	132	158	147	176
	# outreach events at district towns	0.3	203	244	285	342	327	392
Youth-focused: train government staff to provide YF outreach activities	# trained from Provincial/Vientiane Capital	1.8	52	187	62	223	72	259
	# trained from District	1.2	163	391	205	492	226	542
	# trained from sub-district (based on #Health facility)	1.2	1408	3,379	1717	4,121	1872	4,493
Demand generation	# of FP community days held	5.0	39	780	93	1,860	102	2,040
	# of discussion groups held	0.6	468	1,123	1,116	2,678	1,224	2,938
Total Program Costs (LAK millions)				29,278		41,621		47,297
Other Program Costs				5,985		5,985		5,985
Commodities (LAK millions)				72,600		72,600		72,600
Total Cost (LAK millions)				107,863		120,206		125,881

Table A 4 lists key CIP interventions and corresponding sub-interventions. It should be noted here that there were other key interventions which showed potential to increase mCPR but were not selected. These key interventions were postpartum family planning, support to pharmacies and mobile outreach. The rationale to exclude these interventions was that based on feasibility of implementation since there is limited country experience with these interventions. With exception of having a limited

number community based distributors for FP commodities, mobile outreach specific for FP has not been a discrete sub-intervention in the country context.

Figure A3 presents the CIP program costs disaggregated by the key intervention areas. It excludes commodity cost, which are assumed to be constant over the duration of the CIP timeframe. From Figure A3, it is apparent that public sector provision and access to LARCs comprises of majority of the program costs followed by private sector provision and access to LARCs, youth-focused interventions, demand generation activities and stock out reductions[21]. The focus on public provision and access to LARCs (implants and IUD) reflect the evidence base that supports the provision of LARCs as a high impact intervention on mCPR.

Figure A3: Cost of interventions as proportion of total program costs for CIP 2017 - 2020



In terms of the costs by province, Annex 5, provides a further breakdown of the costs by province, sub-intervention and year from 2017 – 2020. This is intended to assist all province and central planners to focus on high impact interventions and budget allocations accordingly. The CIP provides this level of detail in the appendix to ensure that all stakeholders have a shared understanding of the financial commitment needed to achieve the growth in the mCPR. A summary of the provincial costs is provided in table A5 below. The funding gap analysis that follows will discuss what the current total is for the funding short fall required to implement the CIP.

Table A5: Program costs 2017 – 2020 by Province (excludes commodities)

	Total Program Cost (2017 - 2020) KIP (millions)		
Province	A	B	C
Vientiane City	2,825	3,005	3,445
Phongsaly	884	1,067	1,067
Luangnamtha	529	1,711	1,859
Oudomxay	639	1,352	1,352
Bokeo	1,275	1,664	1,664
Luangprabang	2,468	4,048	4,048
Huaphanh	1,603	1,837	3,444
Xayabury	2,480	2,982	3,302
Xiengkhuang	666	1,497	1,497
Vientiane Province	1,588	2,249	2,249
Borikhamxay	627	998	1,196

[21] The stock-out reduction costs in figure 4, provide costs relating to systems strengthening costs and do not include commodity costs.

Khammouane	2,429	4,478	4,478
Savannakhet	6,427	7,159	7,159
Xaysomboun	332	916	1,305
Saravane	1,656	2,936	3,155
Sekong	577	577	1,232
Champasack	1,870	2,496	3,784
Attapeu	404	648	1,060
Other Program Costs	5,985	5,985	5,985
Total Program Costs	35,263	47,606	53,281

Annex 4: Additional Details on Cost-Effectiveness

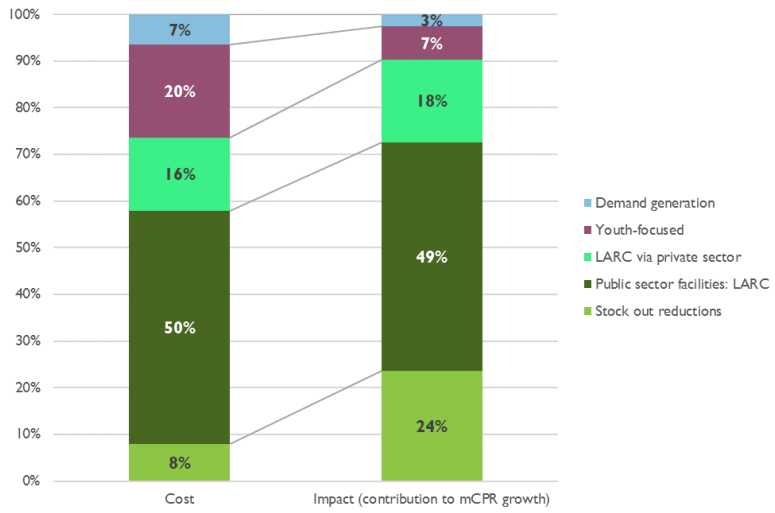
While a full cost effectiveness analysis has not been done, comparing the total program costs to the expected increase in mCPR under each scenario provides a look into the cost effectiveness of each of the three scenarios. As can be seen in table A6 below, the cost per percentage point increase in mCPR is lowest under scenario A, meaning this is the most cost-effective scenario. By prioritizing interventions to the provinces with the greatest need, a large impact can be achieved within a limited amount of funding. This gives reassurance that, in the case that funding is limited, focusing on the scale up specified under Scenario A will ensure limited funds are spent in a way that maximizes potential impact.

Table A6. Program cost (LAK millions) per % point increase in mCPR (all women) under each scenario

Family Planning CIP	Cost (LAK millions) per % point increase in mCPR
A	552,893
B	602,119
C	621,019

Further, it is useful to compare the cost of each priority area relative to the impact (measured here by contribution to increasing mCPR). The graph below shows results for Scenario A, results look similar in B and C. It should be noted that in this analysis, only the programmatic costs associated with stock out reductions are included (e.g. training and support), this does not capture the cost of the commodities. If we look at the cost to achieve impact (comparing the size of the box in the first bar to the second bar) it can be seen that demand generation and youth-focused interventions are most costly relative to their impact. However, from discussions it was clear that there was a strong feeling that these interventions are important investments, even if a short-term mCPR impact does not result. However, especially given the relative size of investments in youth focused programs, this could be an area to reduce programming in the case that the funding gap is not filled.

Figure A4. Share of cost compared to share of impact for each key intervention, Scenario A



Annex 5: Additional Details on Impact

The mCPR growth projected from the full implementation of the RMNCH strategy, versus CIP Scenarios A, B, and C is shown below. The first figure shows mCPR in 2016 (baseline) and the resulting 2020 mCPR under each scenario. The second figure looks at the percentage point mCPR growth from baseline to 2020, so that the changes can be more easily compared. Not only do the CIP scenarios help to maximize growth given resources, they also help to ensure more equitable increases by province. For example, in the full RMNCH (and to some degree under Scenario C due to increased interventions) Xaysomboon experiences significantly higher growth than any of the other provinces. Scenarios A and B have the most even growth across Provinces (a 7% point to 9% point gap from lowest to highest), while Scenario C and full RMNCH implementation has a gap of 17% points in growth across provinces- meaning the province with the largest increase is expected to grow by 17% points *more* than the province with the smallest increase.

Figure A5: mCPR (all women) at baseline and 2020

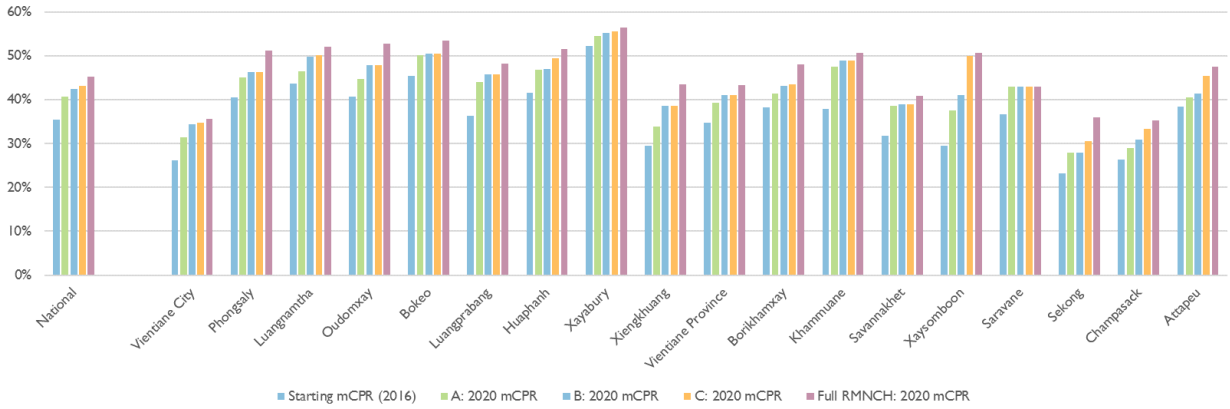
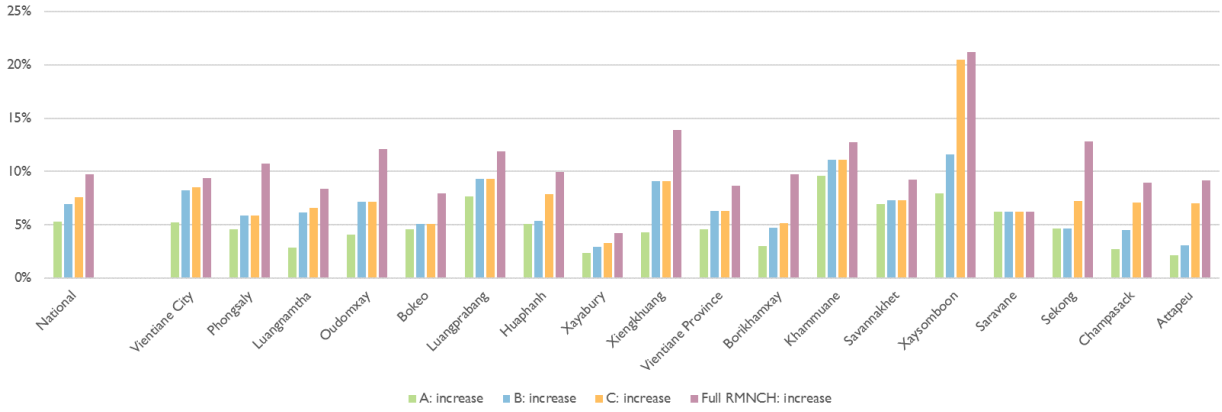


Figure A6: %point mCPR increase from 2016 to 2020



Using the FP Goals model, not only are results produced showing the overall projected growth in mCPR, but, results also show the expected contribution from each intervention area. This information can be used for further prioritize, by looking at the contribution of each key priority to overall projected mCPR growth both nationally, and by province (figures X, X and X)

Figure A7. Comparison of contribution to mCPR of each intervention under Scenarios A, B, and C

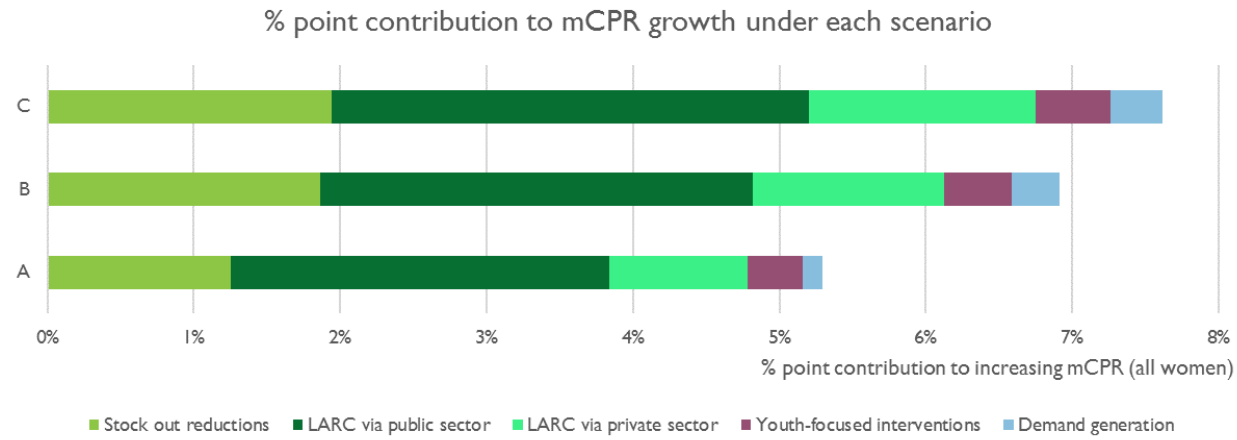
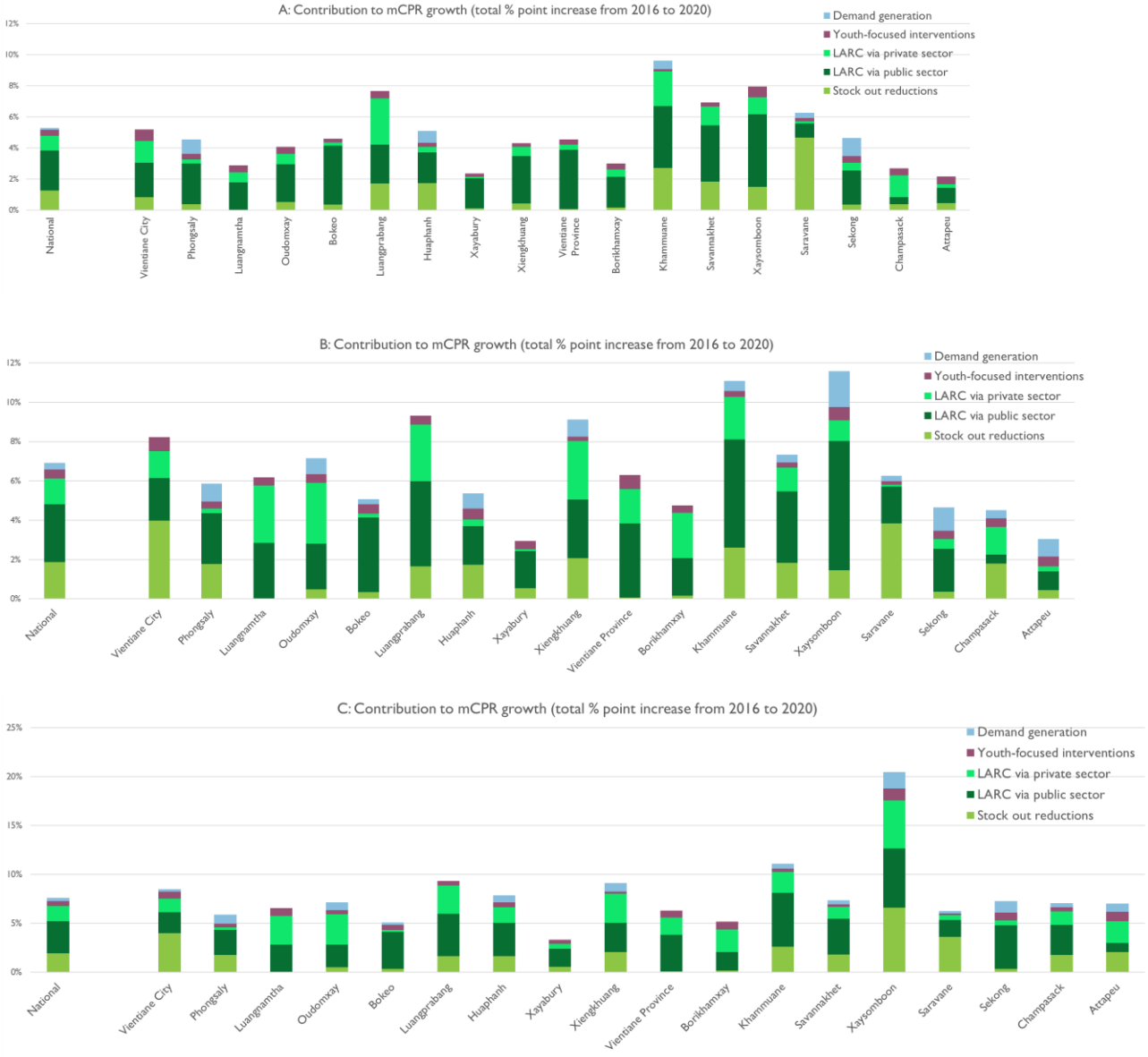


Figure A8. Comparison of contribution to mCPR of each intervention under Scenarios A, B, and C



Annex 6: SOURCES OF FUNDING FOR FP INTERVENTIONS IN 2017 PROVINCIAL BUDGET PLAN

It is noteworthy that 15 of 18 provinces source funding for SO1 interventions from both government and external donors (figure A4). In the provincial budget allocations, there were 3 provinces (Champasak, Khammouane and Vientiane Capital) that identified as having SO1 interventions being fully funded by government sources. This suggests that funding on family planning interventions rely significantly on external donor support.

Figure A9: Number of provinces by Government and external funding source

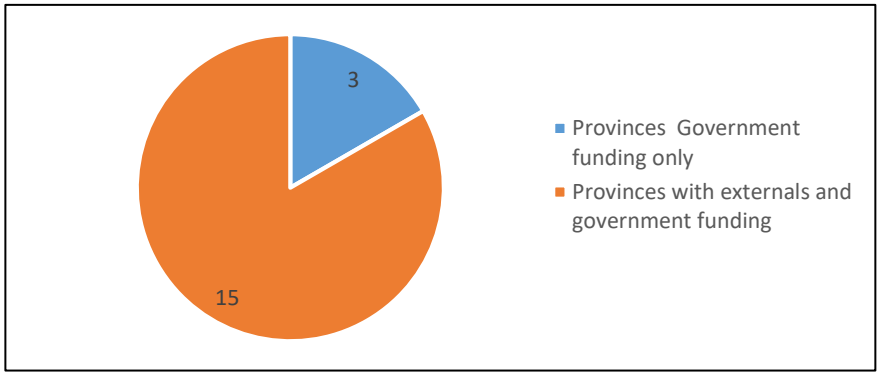
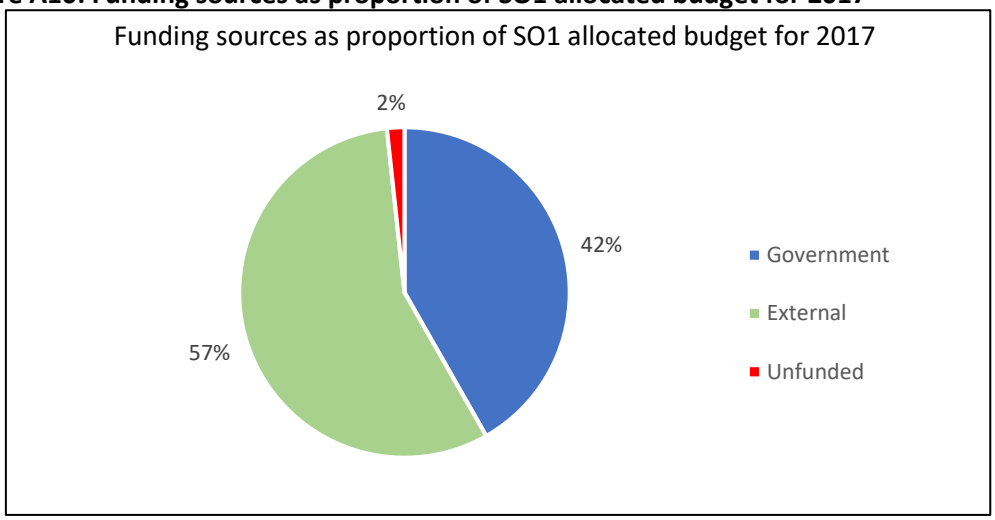


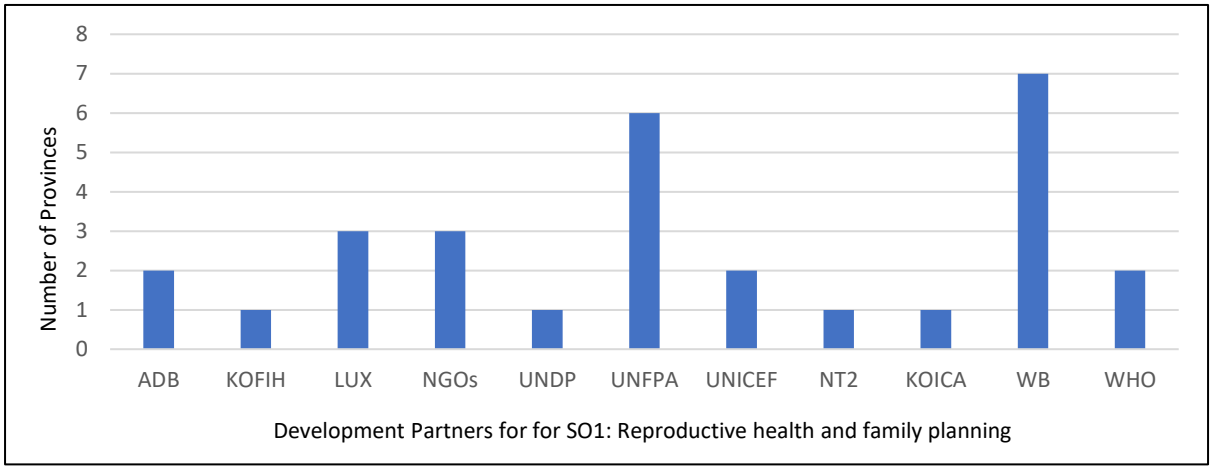
Figure A5, illustrates that government funding provides 42 percent of the budget allocated for all SO1 interventions and the 57 percent of funding comes from external donors. It is also of note that of the total budget needed for SO1 interventions, just 2% is unfunded. This suggests that provinces are developing activities and budget plans according to resources available and supports an understanding that current funding circumstances are limited.

Figure A10: Funding sources as proportion of SO1 allocated budget for 2017



Furthermore, the provincial budget plans also identify 11 different external donors (figure A6). The only donor, which was not individually specified were the non-government organizations and these were grouped as one donor under 'NGOs'. In some provinces, there are more than one external donor.

Figure A11: Number of province supported by development partners



This has implications for resource mobilization as there may be a greater opportunity to seek funding and other resources from government as well as from a range of development partners presently supporting FP initiatives. This also speaks to the scope and prominence to which FP is on the agenda for government and the development partner community.

Annex 7: Provincial Budget Allocations, CIP alignment and funding gaps, 2017

Table A7: Comparison of costs to determine gaps in funding for 2017

Provinces	LAK			USD
	SO1 interventions budgets aligned with CIP	CIP program Costs (Scenario A)	Funding gap/excess by province	Funding gap/excess by province
Vientiane Capital	0	764,100,900	(764,100,000)	(93,171)
Vientiane	0	406,640,400	(406,640,000)	(49,584)
Savannakhet	119,510,000	1,801,223,850	(1,681,710,000)	(205,061)
Saravane	183,960,000	497,460,400	(313,500,000)	(38,227)
Champasak	303,470,000	510,163,286	(206,530,000)	(25,183)
Khammouane	0	735,383,860	(735,380,000)	(89,669)
Sekong	125,904,436	149,470,815	(23,095,564)	(2,816)
Attapeu	317500000	107,129,300	210,500,000	25,668
Bolikhamxay	63,898,000	169,945,400	(106,052,000)	(12,932)
Houaphanh	0	485,705,650	(485,710,000)	(59,226)
Phongsaly	1,114,242,436	234,730,200	879,512,436	107,244
Luangnamtha	186,000,000	140,151,100	45,850,000	5,591
Oudomxay	119,000,000	167,607,300	(48,610,000)	(5,927)
Bokeo	65,100,000	331,330,400	(266,230,000)	(32,463)
Luangprabang	3,339,169,795	762,182,660	2,576,989,795	314,228
Xayabouly	99,000,000	639,902,000	(540,900,000)	(65,955)
Xiengkhuang	150,032,000	181,542,000	(31,508,000)	(3,842)
Xaysomboun	500,000,000	91,920,800	408,080,000	49,760
Other Direct Costs		2,439,400,500	(2,439,400,500)	(297,488)
LAK	6,686,786,667	**10,615,990,821**	(3,929,204,154.10)	
USD	815,360	1,294,633	(479,171)	

Annex 8: Summary of direct program costs, by total, province, priority area and year (KIP millions)

Table A8: National Requirements for the CIP: Direct Programme costs by priority area and year

	Total				
	2017	**2018**	**2019**	**2020**	**Total (2017-2020)**
Scenario A			**Scenario A**		
Stock out reductions	1,166	0	1,166	0	2,332
Public sector facilities: LARC	3,656	3,656	3,656	3,656	14,625
LARC via private sector	1,426	1,426	878	878	4,607
Youth-focused interventions	1,453	1,453	1,453	1,453	5,810
Demand generation	476	476	476	476	1,903
Total Direct Program Costs	**8,177**	**7,011**	**7,628**	**6,462**	**29,278**
Scenario B			**Scenario B**		
Stock out reductions	1,613	0	1,613	0	3,227
Public sector facilities: LARC	5,091	5,091	5,091	5,091	20,365
LARC via private sector	2,009	2,009	1,236	1,236	6,489
Youth-focused interventions	1,751	1,751	1,751	1,751	7,002
Demand generation	1,135	1,135	1,135	1,135	4,538
Total Direct Program Costs	**11,598**	**9,985**	**10,826**	**9,212**	**41,621**
Scenario C			**Scenario C**		
Stock out reductions	1,698	0	1,698	0	3,396
Public sector facilities: LARC	5,873	5,873	5,873	5,873	23,491
LARC via private sector	2,397	2,397	1,475	1,475	7,745
Youth-focused interventions	1,922	1,922	1,922	1,922	7,687
Demand generation	1,244	1,244	1,244	1,244	4,978
Total Direct Program Costs	**13,134**	**11,436**	**12,212**	**10,514**	**47,297**

Table A9: Direct Programme costs by priority area and year, Vientiane City

	Vientiane City				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	23	0	23	0	46
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	0	0	0	0	0
Total Direct Program Costs	764	741	671	648	2,825
Scenario B	**Scenario B**				
Stock out reductions	113	0	113	0	227
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	0	0	0	0	0
Total Direct Program Costs	854	741	762	648	3,005
Scenario C	**Scenario C**				
Stock out reductions	113	0	113	0	227
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	110	110	110	110	439
Total Direct Program Costs	964	851	872	758	3,445

Table A10: Direct Programme costs by priority area and year, Phongsaly

	Phongsaly				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	23	0	23	0	47
Public sector facilities: LARC	79	79	79	79	315
LARC via private sector	10	10	6	6	34
Youth-focused interventions	37	37	37	37	146
Demand generation	85	85	85	85	342
Total Direct Program Costs	235	211	231	207	884
Scenario B	**Scenario B**				
Stock out reductions	115	0	115	0	230
Public sector facilities: LARC	79	79	79	79	315
LARC via private sector	10	10	6	6	34
Youth-focused interventions	37	37	37	37	146
Demand generation	85	85	85	85	342
Total Direct Program Costs	326	211	322	207	1,067
Scenario C	**Scenario C**				
Stock out reductions	115	0	115	0	230
Public sector facilities: LARC	79	79	79	79	315
LARC via private sector	10	10	6	6	34
Youth-focused interventions	37	37	37	37	146
Demand generation	85	85	85	85	342
Total Direct Program Costs	326	211	322	207	1,067

Table A11: Direct Programme costs by priority area and year, Luangnamtha

	Luangnamtha				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	4	0	4	0	8
Public sector facilities: LARC	70	70	70	70	281
LARC via private sector	31	31	19	19	101
Youth-focused interventions	35	35	35	35	139
Demand generation	0	0	0	0	0
Total Direct Program Costs	140	136	128	124	529
Scenario B	**Scenario B**				
Stock out reductions	4	0	4	0	8
Public sector facilities: LARC	265	265	265	265	1,061
LARC via private sector	156	156	96	96	503
Youth-focused interventions	35	35	35	35	139
Demand generation	0	0	0	0	0
Total Direct Program Costs	460	456	400	396	1,711
Scenario C	**Scenario C**				
Stock out reductions	4	0	4	0	8
Public sector facilities: LARC	265	265	265	265	1,061
LARC via private sector	156	156	96	96	503
Youth-focused interventions	72	72	72	72	287
Demand generation	0	0	0	0	0
Total Direct Program Costs	497	493	437	433	1,859

Table A12: Direct Programme costs by priority area and year, Oudomxay

	Oudomxay				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A			**Scenario A**		
Stock out reductions	5	0	5	0	10
Public sector facilities: LARC	91	91	91	91	365
LARC via private sector	29	29	18	18	93
Youth-focused interventions	43	43	43	43	170
Demand generation	0	0	0	0	0
Total Direct Program Costs	168	163	157	152	639
Scenario B			**Scenario B**		
Stock out reductions	5	0	5	0	10
Public sector facilities: LARC	91	91	91	91	365
LARC via private sector	144	144	88	88	465
Youth-focused interventions	43	43	43	43	170
Demand generation	85	85	85	85	342
Total Direct Program Costs	368	363	313	308	1,352
Scenario C			**Scenario C**		
Stock out reductions	5	0	5	0	10
Public sector facilities: LARC	91	91	91	91	365
LARC via private sector	144	144	88	88	465
Youth-focused interventions	43	43	43	43	170
Demand generation	85	85	85	85	342
Total Direct Program Costs	368	363	313	308	1,352

Table A13: Direct Programme costs by priority area and year, Bokeo

	Bokeo				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	17	0	17	0	35
Public sector facilities: LARC	259	259	259	259	1,036
LARC via private sector	21	21	13	13	67
Youth-focused interventions	34	34	34	34	137
Demand generation	0	0	0	0	0
Total Direct Program Costs	331	314	323	306	1,275
Scenario B	**Scenario B**				
Stock out reductions	17	0	17	0	35
Public sector facilities: LARC	259	259	259	259	1,036
LARC via private sector	21	21	13	13	67
Youth-focused interventions	71	71	71	71	282
Demand generation	61	61	61	61	244
Total Direct Program Costs	429	411	421	403	1,664
Scenario C	**Scenario C**				
Stock out reductions	17	0	17	0	35
Public sector facilities: LARC	259	259	259	259	1,036
LARC via private sector	21	21	13	13	67
Youth-focused interventions	71	71	71	71	282
Demand generation	61	61	61	61	244
Total Direct Program Costs	429	411	421	403	1,664

Table A14: Direct Programme costs by priority area and year, Luangprabang

	Luangprabang				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	185	0	185	0	370
Public sector facilities: LARC	150	150	150	150	601
LARC via private sector	275	275	169	169	887
Youth-focused interventions	152	152	152	152	610
Demand generation	0	0	0	0	0
Total Direct Program Costs	762	577	657	472	2,468
Scenario B	**Scenario B**				
Stock out reductions	185	0	185	0	370
Public sector facilities: LARC	545	545	545	545	2,181
LARC via private sector	275	275	169	169	887
Youth-focused interventions	152	152	152	152	610
Demand generation	0	0	0	0	0
Total Direct Program Costs	1,157	972	1,052	867	4,048
Scenario C	**Scenario C**				
Stock out reductions	185	0	185	0	370
Public sector facilities: LARC	545	545	545	545	2,181
LARC via private sector	275	275	169	169	887
Youth-focused interventions	152	152	152	152	610
Demand generation	0	0	0	0	0
Total Direct Program Costs	1,157	972	1,052	867	4,048

Table A15: Direct Programme costs by priority area and year, Huaphanh

	Huaphanh				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	161	0	161	0	322
Public sector facilities: LARC	124	124	124	124	497
LARC via private sector	24	24	15	15	77
Youth-focused interventions	55	55	55	55	220
Demand generation	122	122	122	122	488
Total Direct Program Costs	486	325	477	316	1,603
Scenario B	**Scenario B**				
Stock out reductions	161	0	161	0	322
Public sector facilities: LARC	124	124	124	124	497
LARC via private sector	24	24	15	15	77
Youth-focused interventions	113	113	113	113	454
Demand generation	122	122	122	122	488
Total Direct Program Costs	544	383	535	374	1,837
Scenario C	**Scenario C**				
Stock out reductions	161	0	161	0	322
Public sector facilities: LARC	449	449	449	449	1,797
LARC via private sector	119	119	73	73	384
Youth-focused interventions	113	113	113	113	454
Demand generation	122	122	122	122	488
Total Direct Program Costs	964	804	919	758	3,444

Table A16: Direct Programme costs by priority area and year, Xayabury

	Xayabury				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	30	0	30	0	61
Public sector facilities: LARC	522	522	522	522	2,089
LARC via private sector	25	25	15	15	80
Youth-focused interventions	62	62	62	62	250
Demand generation	0	0	0	0	0
Total Direct Program Costs	640	609	630	600	2,480
Scenario B	**Scenario B**				
Stock out reductions	149	0	149	0	298
Public sector facilities: LARC	522	522	522	522	2,089
LARC via private sector	25	25	15	15	80
Youth-focused interventions	129	129	129	129	515
Demand generation	0	0	0	0	0
Total Direct Program Costs	825	676	815	666	2,982
Scenario C	**Scenario C**				
Stock out reductions	149	0	149	0	298
Public sector facilities: LARC	522	522	522	522	2,089
LARC via private sector	124	124	76	76	400
Youth-focused interventions	129	129	129	129	515
Demand generation	0	0	0	0	0
Total Direct Program Costs	924	775	876	727	3,302

Table A16: Direct Programme costs by priority area and year, Xiengkhuang

	Xiengkhuang				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	20	0	20	0	40
Public sector facilities: LARC	93	93	93	93	370
LARC via private sector	26	26	16	16	83
Youth-focused interventions	43	43	43	43	173
Demand generation	0	0	0	0	0
Total Direct Program Costs	182	162	172	152	666
Scenario B	**Scenario B**				
Stock out reductions	98	0	98	0	196
Public sector facilities: LARC	93	93	93	93	370
LARC via private sector	129	129	79	79	417
Youth-focused interventions	43	43	43	43	173
Demand generation	85	85	85	85	342
Total Direct Program Costs	448	350	398	301	1,497
Scenario C	**Scenario C**				
Stock out reductions	98	0	98	0	196
Public sector facilities: LARC	93	93	93	93	370
LARC via private sector	129	129	79	79	417
Youth-focused interventions	43	43	43	43	173
Demand generation	85	85	85	85	342
Total Direct Program Costs	448	350	398	301	1,497

Table A17: Direct Programme costs by priority area and year, Vientiane Province

	Vientiane Province				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	7	0	7	0	14
Public sector facilities: LARC	310	310	310	310	1,239
LARC via private sector	31	31	19	19	101
Youth-focused interventions	59	59	59	59	234
Demand generation	0	0	0	0	0
Total Direct Program Costs	407	399	395	387	1,588
Scenario B	**Scenario B**				
Stock out reductions	7	0	7	0	14
Public sector facilities: LARC	310	310	310	310	1,239
LARC via private sector	156	156	96	96	503
Youth-focused interventions	123	123	123	123	492
Demand generation	0	0	0	0	0
Total Direct Program Costs	596	589	536	529	2,249
Scenario C	**Scenario C**				
Stock out reductions	7	0	7	0	14
Public sector facilities: LARC	310	310	310	310	1,239
LARC via private sector	156	156	96	96	503
Youth-focused interventions	123	123	123	123	492
Demand generation	0	0	0	0	0
Total Direct Program Costs	596	589	536	529	2,249

Table A18: Direct Programme costs by priority area and year, Borikhamxay

	Borikhamxay				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	15	0	15	0	31
Public sector facilities: LARC	80	80	80	80	320
LARC via private sector	29	29	18	18	93
Youth-focused interventions	46	46	46	46	182
Demand generation	0	0	0	0	0
Total Direct Program Costs	170	154	159	143	627
Scenario B	**Scenario B**				
Stock out reductions	15	0	15	0	31
Public sector facilities: LARC	80	80	80	80	320
LARC via private sector	144	144	88	88	464
Youth-focused interventions	46	46	46	46	182
Demand generation	0	0	0	0	0
Total Direct Program Costs	285	269	230	214	998
Scenario C	**Scenario C**				
Stock out reductions	15	0	15	0	31
Public sector facilities: LARC	80	80	80	80	320
LARC via private sector	144	144	88	88	464
Youth-focused interventions	95	95	95	95	380
Demand generation	0	0	0	0	0
Total Direct Program Costs	334	319	279	264	1,196

Table A19: Direct Programme costs by priority area and year, Khammuane

	Khammuane				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	172	0	172	0	343
Public sector facilities: LARC	153	153	153	153	612
LARC via private sector	220	220	135	135	711
Youth-focused interventions	69	69	69	69	275
Demand generation	122	122	122	122	488
Total Direct Program Costs	735	564	651	479	2,429
Scenario B	**Scenario B**				
Stock out reductions	172	0	172	0	343
Public sector facilities: LARC	593	593	593	593	2,372
LARC via private sector	220	220	135	135	711
Youth-focused interventions	141	141	141	141	564
Demand generation	122	122	122	122	488
Total Direct Program Costs	1,248	1,076	1,163	991	4,478
Scenario C	**Scenario C**				
Stock out reductions	172	0	172	0	343
Public sector facilities: LARC	593	593	593	593	2,372
LARC via private sector	220	220	135	135	711
Youth-focused interventions	141	141	141	141	564
Demand generation	122	122	122	122	488
Total Direct Program Costs	1,248	1,076	1,163	991	4,478

Table A20: Direct Programme costs by priority area and year, Savannakhet

	Savannakhet				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	296	0	296	0	592
Public sector facilities: LARC	1,002	1,002	1,002	1,002	4,008
LARC via private sector	241	241	149	149	780
Youth-focused interventions	262	262	262	262	1,048
Demand generation	0	0	0	0	0
Total Direct Program Costs	1,801	1,505	1,708	1,412	6,427
Scenario B	**Scenario B**				
Stock out reductions	296	0	296	0	592
Public sector facilities: LARC	1,002	1,002	1,002	1,002	4,008
LARC via private sector	241	241	149	149	780
Youth-focused interventions	262	262	262	262	1,048
Demand generation	183	183	183	183	732
Total Direct Program Costs	1,984	1,688	1,891	1,595	7,159
Scenario C	**Scenario C**				
Stock out reductions	296	0	296	0	592
Public sector facilities: LARC	1,002	1,002	1,002	1,002	4,008
LARC via private sector	241	241	149	149	780
Youth-focused interventions	262	262	262	262	1,048
Demand generation	183	183	183	183	732
Total Direct Program Costs	1,984	1,688	1,891	1,595	7,159

Table A21: Direct Programme costs by priority area and year, Xaysomboon

	Xaysomboon				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	12	0	12	0	24
Public sector facilities: LARC	43	43	43	43	171
LARC via private sector	16	16	10	10	50
Youth-focused interventions	22	22	22	22	86
Demand generation	0	0	0	0	0
Total Direct Program Costs	92	80	86	74	332
Scenario B	**Scenario B**				
Stock out reductions	12	0	12	0	24
Public sector facilities: LARC	128	128	128	128	511
LARC via private sector	16	16	10	10	50
Youth-focused interventions	22	22	22	22	86
Demand generation	61	61	61	61	244
Total Direct Program Costs	238	226	232	220	916
Scenario C	**Scenario C**				
Stock out reductions	59	0	59	0	117
Public sector facilities: LARC	128	128	128	128	511
LARC via private sector	78	78	48	48	252
Youth-focused interventions	45	45	45	45	181
Demand generation	61	61	61	61	244
Total Direct Program Costs	371	312	341	282	1,305

Table A22: Direct Programme costs by priority area and year, Saravane

	Saravane				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	161	0	161	0	321
Public sector facilities: LARC	114	114	114	114	458
LARC via private sector	17	17	10	10	55
Youth-focused interventions	108	108	108	108	432
Demand generation	98	98	98	98	390
Total Direct Program Costs	497	337	491	330	1,656
Scenario B	**Scenario B**				
Stock out reductions	161	0	161	0	321
Public sector facilities: LARC	434	434	434	434	1,738
LARC via private sector	17	17	10	10	55
Youth-focused interventions	108	108	108	108	432
Demand generation	98	98	98	98	390
Total Direct Program Costs	817	657	811	650	2,936
Scenario C	**Scenario C**				
Stock out reductions	161	0	161	0	321
Public sector facilities: LARC	434	434	434	434	1,738
LARC via private sector	85	85	52	52	274
Youth-focused interventions	108	108	108	108	432
Demand generation	98	98	98	98	390
Total Direct Program Costs	885	725	853	692	3,155

Table A23: Direct Programme costs by priority area and year, Sekong

	Sekong				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	23	0	23	0	46
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	0	0	0	0	0
Total Direct Program Costs	764	741	671	648	2,825
Scenario B	**Scenario B**				
Stock out reductions	113	0	113	0	227
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	0	0	0	0	0
Total Direct Program Costs	854	741	762	648	3,005
Scenario C	**Scenario C**				
Stock out reductions	113	0	113	0	227
Public sector facilities: LARC	301	301	301	301	1,205
LARC via private sector	241	241	148	148	778
Youth-focused interventions	199	199	199	199	796
Demand generation	110	110	110	110	439
Total Direct Program Costs	964	851	872	758	3,445

Table A24: Direct Programme costs by priority area and year, Champasack

	Champasack				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	18	0	18	0	35
Public sector facilities: LARC	146	146	146	146	585
LARC via private sector	175	175	108	108	566
Youth-focused interventions	171	171	171	171	684
Demand generation	0	0	0	0	0
Total Direct Program Costs	510	492	443	425	1,870
Scenario B	**Scenario B**				
Stock out reductions	87	0	87	0	173
Public sector facilities: LARC	146	146	146	146	585
LARC via private sector	175	175	108	108	566
Youth-focused interventions	171	171	171	171	684
Demand generation	122	122	122	122	488
Total Direct Program Costs	701	614	634	547	2,496
Scenario C	**Scenario C**				
Stock out reductions	87	0	87	0	173
Public sector facilities: LARC	468	468	468	468	1,872
LARC via private sector	175	175	108	108	566
Youth-focused interventions	171	171	171	171	684
Demand generation	122	122	122	122	488
Total Direct Program Costs	1,023	936	956	869	3,784

Table A25: Direct Programme costs by priority area and year, Attapeu

	Attapeu				
	2017	2018	2019	2020	Total (2017-2020)
Scenario A	**Scenario A**				
Stock out reductions	10	0	10	0	19
Public sector facilities: LARC	60	60	60	60	241
LARC via private sector	7	7	4	4	23
Youth-focused interventions	30	30	30	30	120
Demand generation	0	0	0	0	0
Total Direct Program Costs	107	97	104	95	404
Scenario B	**Scenario B**				
Stock out reductions	10	0	10	0	19
Public sector facilities: LARC	60	60	60	60	241
LARC via private sector	7	7	4	4	23
Youth-focused interventions	30	30	30	30	120
Demand generation	61	61	61	61	244
Total Direct Program Costs	168	158	165	156	648
Scenario C	**Scenario C**				
Stock out reductions	48	0	48	0	95
Public sector facilities: LARC	60	60	60	60	241
LARC via private sector	72	72	44	44	232
Youth-focused interventions	62	62	62	62	248
Demand generation	61	61	61	61	244
Total Direct Program Costs	303	255	275	228	1,060