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DID MORE SUPPLIES INCREASE FAMILY PLANNING USAGE IN PAKISTAN

Introduction

Despite considerable funding of FP in the past decade, Pakistan' CPR rests at a meager 30%[1]. Only about 5 million out of over 25 million MWRA in the country use any modern contraceptive method and less than 3 million avail contraceptive services in any given year[2].

Previous experience had suggested that supply constraints were a key limitation in the uptake of FP services in Pakistan[3] and even as far back as the 1970s whenever FP supplies were made available, CPR increased dramatically[4]. Based on this, the USAID proposed to supply nearly USD 30 million worth of contraceptives and to help develop a Logistics Management System (LMIS) in Pakistan. This support was further expanded subsequently to provide contraceptives worth $89 million between 2010 and 2014. In the 2011 alone, it procured health commodities - mainly contraceptives - worth $23.2 million and was planning an additional supply worth $20 million during 2012[5]. This was timely since the overall supply of contraceptives had remained unchanged between 2006 and 2011[6] despite considerable funding for FP by the government of Pakistan.

The objective of this policy brief is to explore the lessons that have become available after introduction of sufficient contraceptive supplies and the impact they have had on services and their uptake.

Methodology

Data on service delivery from the year 2006-07 till 2011-12 was obtained from the Annual Contraceptive Performance Reports (ACPR)[7] compiled by the Pakistan Bureau of Statistics, which collect data from various governmental and private organizations. Commodity data from the ACPR were converted to give figures for the population served in one year using the criteria used by the Pakistan Bureau of Statistics, i.e. Condoms: 100 units, Oral Pills: 13 cycles of pills and Injections: 5 vials of injections. For this purpose, IUD and sterilization counted as 1 woman per year.

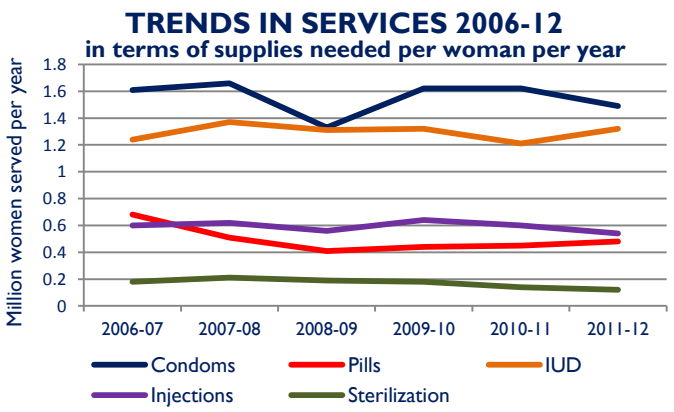
SALIENT POINTS AND RECOMMENDATIONS

- Over-reporting of IUD consumption persists in spite of a new and improved LMIS
- Increased availability of FP supplies did not result in their higher usage. This is in part due to limitation of these FP supplies to only one department in the public sector
- Availability of free FP supplies may have compromised existing markets of FP by shifting paying customers to free supplies
- Donors must demand accountability in the form of increased and better services from the public sector for the support they provide
- Reaching the urban poor with FP programming will likely achieve quick and welcome results among a key marginalized group that has generally been ignored previously

Data from the ACPR report were compared with data from the web-based Logistics Management Information Systems (LMIS) – an initiative taken by the USAID Deliver and the Government of Pakistan in order to strengthen in-country supply chains in the year 2011. The LMIS not only captures public sector supplies, but also records contraceptive information from national sales data from the private sector through web-based requisition and reporting forms. Data from the LMIS were also converted to the population served using the same criteria as above.

Results

According to the Annual Contraceptive Performance Reports (ACPR) by the Bureau of Statistics, the overall supply of family planning commodities has remained unchanged at around 4.067 million women in the past 5 years. This period includes USAID funded supplies worth USD 20 million since 2011. The LMIS showed that in June 2012, there were sufficient supplies in the central warehouse to serve 6.75 million women.



There have been some concerns about the accuracy of the ACPR. Since 2009, the USAID funded DELIVER project helped install and implement a Logistics Management Information System (LMIS) that tracks the delivery of contraceptives from the central warehouse in Karachi to the districts. As the table below shows that

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[1] Pakistan Demographic and Health Survey 2006-7

[2] Khan AA, Abbas K, Hamza HB, Bilal A, Khan A. From Contraceptive Prevalence to Family Planning Service Users: Implications for Policy and Programmes. *Journal of the Pakistan Medical Association* 2013;63:S-11-S-15

[3] The Third Party Evaluation of the Lady Health Worker Program. Oxford Policy Management Group. 2008

[4] Shelton JD, Bradshaw L, Hussein B, Zubair Z, Drexler T, McKenna MR. Putting Unmet Need to the Test: Community Based Distribution of Family Planning in Pakistsan. Int Fam Planning Perspectives 1999;25:191-195.

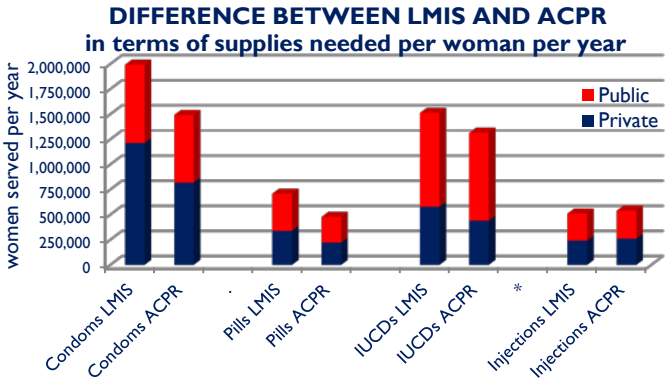
Osborn RW. The Sialkot experience. Stud Fam Plann 1974;5:123-129

[5] http://tribune.com.pk/story/357591/health-care-thanks-to-usaid-central-warehouse-enlarged/

[6] Research and Development Solutions Policy Brief #13: Family Planning service delivery and its uptake in Pakistan. July 2012. http://resdev.org/Docs/13fpsvcdelvsuptake.pdf

[7] The Federal Bureau of Statistics calls these reports "Contraceptive Performance Reports" or CPR. We have used the term ACPR to avoid any confusion with the more common use of the acronym CPR for Contraceptive Prevalence Rates

ACPR and LMIS show only 20% variation in data, reflecting the fact that both LMIS and ACPR use data from the Population Welfare Departments (PWD). As LMIS show, reports are complete for the PWD but remain incomplete for the health department and the private sector.



Issues Identified

IUDs Continue to be Over Reported

As note previously in RADS Policy Brief 13, IUD insertion record by public and private sector providers exceeds uptake figures based on the Pakistan Demographic Health Survey by approximately 1.1 million IUDs. The LMIS also shows the same level of IUD supplies suggesting that over reporting of IUDs happens after they leave the warehouse and likely at facilities. The question is: why do facilities over report IUDs that they don't insert and what they actually do with these IUDs.

Value Added of the LMIS over Previous System?

Another question is if the LMIS is reporting what ACPR has always reported, what would be the value added for this new system. One suggestion would be to institutionalize the use of data (LMIS or ACPR) for planning and for monitoring current services. For this to happen, the system must be willing to report under performance and be open to changes.

Lack of Impact of Sufficient Supplies on FP Use

Despite expectations, additional and adequate supplies have not resulted in increased usage. The one major difference between now and the previous experience (Shelton and Osborn) is that previously supplies were provided through the NGOs whereas in the current program, all supplies are in the public sector, specifically with the Population Welfare Departments. Anecdotes suggest that even Health Departments don't receive sufficient supplies while contraceptives languish unused in the warehouse. In fact it is unclear whether supplies even reach health and population facilities since the system only reports exit from the warehouse.

Since over half the users self-procure FP supplies, if the advent of USAID funded supplies did not increase FP users, it is highly likely these free supplies were simply taken up by users who had previously been willing to pay for their FP without creating a net increase in users. In other words, no new demand was created. This means that in its current form considerable additional support by the donors is unlikely to increase contraceptive usage in Pakistan and other means of programming must be considered.

Possible Solutions

Clearly the role of the private sector and NGOs is paramount. In 2006-7 self-procurements by users accounted for 40% of contraceptive use, NGOs for an additional 12% while both public sector departments combined to account for 35% of all FP services nationwide. Since then, the services of NGOs have expanded dramatically. Recent records from Greenstar Social Marketing and the Marie Stopes Society suggest that they each serve 1.5-1.7 million women each annually or roughly 3 times more than the total output of the public sector.

Many donors such as the USAID, DFID and KFW are already funding NGOs for providing FP services directly to consumers. This is a welcome trend that must expand. One major consideration is that while funding programs for remote and rural communities (which are highly marginalized) may seem equity-promoting, there is considerable unmet need and low CPR in cities as well and urban poor are seldom covered by donor funded programs or even the government's LHWs. Since they are closer to most service providers and urban services and live in denser groups, creating demand and providing services for them may be cheaper and more efficient than for more remote rural populations.

Since around half of the current FP users self-pay for FP supplies, there is an existing market for FP. USAID and DFID increased this market in the previous two decades by promoting social marketing and by formation of indigenous contraceptive manufacturing. These and similar initiatives that promote access and availability of FP supplies and services for those willing and able to pay for FP will serve to promote FP use far more than limited programming and possibly even working with government run FP programs.

Finally since consider funding is invested in the public sector in the form of commodities, capacity building and LMIS, should the donors hold the public sector responsible for some services. After all of these inputs were but a means to improve the uptake of FP by women and couples. If this is not happening, why this is so and what may be done to make services more effective in the public sector. Taking this further, if the public sector cannot deliver, should it continue to receive this support.

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