Research and Development Solutions Policy Brief Series #53

What would it take to raise CPR to 50% by 2025 in Pakistan?

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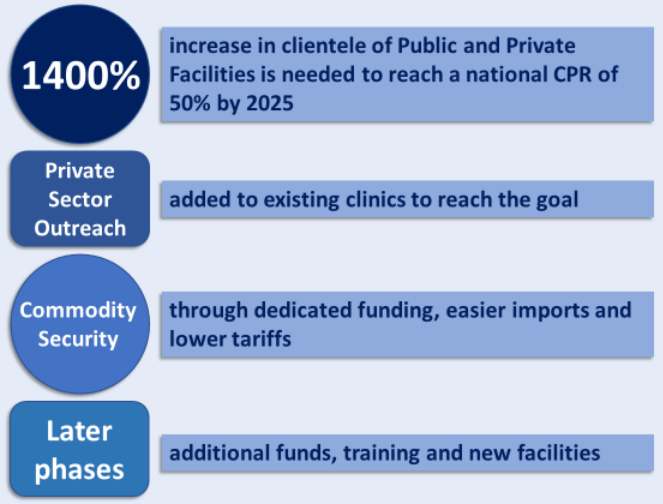
The Challenge

Pakistan is the fifth most populous country in the world and is one of the two countries (along with Nigeria) that have a growing population among the 10 most populous countries worldwide. Despite considerable political will - including a commitment to raise CPR to 50% by 2025 at the London Summit, that was reiterated by the President of Pakistan and the Supreme Court and then finally adapted by the Council of Common Interests (CCI) - funding and donor support, CPR has stagnated around 30-35% since 2007.



50% CPR means that 20 million MWRA use FP by 2025

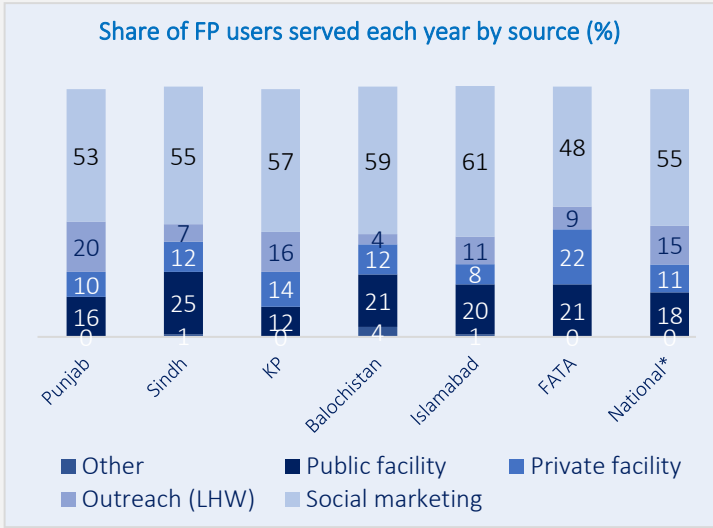
The current CPR of 34% translates into 11 million family planning users, of which 9 million use a modern method, but only 4.9M married women of reproductive age (MWRA) avail FP services each year. Pakistan's goal of 50% CPR means that around 20M MWRA must be using FP by 2025. Hence the current quantum of services must expand to include an additional 9M users.

Table 1. MWRA to be served by CCI Targets

	Current CPR	CPR targets for 2025 recommended by CCI	MWRA (in millions) that must be served to reach 50% CPR
Punjab	38%	54%	11.47
Sindh	31%	47%	4.45
KP	31%	46%	2.86
Balochistan	20%	36%	0.84
ICT	46%	62%	0.30
National	34%	50%	20

Sources of FP Services

Sources of family planning methods as described in the Demographic Health Survey 2017 can be condensed into four main channels: 1) *public sector clinics*, 2) *private (or NGO supported) clinics*, 3) *Outreach by lady health workers* and 4) *self-bought commodities promoted via social marketing*. Among these, it is likely that outreach by lady health workers (LHW) and social marketing have been maximally utilized, and therefore any additional FP users will have to be served from either public or private sector clinics. We explored the extent to which these channels must expand in each province to meet their own targets for 2025.



Discussion

This analysis departs from the conventional dialogue of increase in CPR by a 1-2 percentage points, by discussing the *actual number of MWRA or users that must be served and the channels from which this can happen*. Using actual numbers of users is important to estimate number of commodities to buy, number of clinics or personnel to deploy or the amount of funds needed for these.

Need for Efficiency. A 1400% increase in users (Table 2) does not mean that clinics (or providers) must also increase by that much. At present, over 3,300 population welfare and many departments of health facilities provide FP services to approximately 900,000 clients each year – or an average of 20-25 clients per facility per month. Even accounting for repeat visits, this is massive underutilization of facilities that have fixed costs for salaries and other overheads. This is reflected by the fact that only 6% of public sector funds pay for commodities (UNFPA-NIDI study, the Population Council 2021). Furthermore, even when funds are allocated, typically, their utilization is only around 30-50%.

Table 2: Total users served in past year by source

	Punjab	Sindh	KP	Balochistan	Islamabad	National
Public facility	0.44	0.27	0.11	0.04	0.01	0.88
Private facility	0.26	0.12	0.13	0.02	0.01	0.55
Outreach (LHW)	0.53	0.08	0.14	0.01	0.01	0.76
Social marketing	1.44	0.58	0.51	0.11	0.05	2.70
MWRA currently availing FP services each year	2.67	1.05	0.89	0.18	0.08	4.89
Total MWRA to be served to reach CPR: 50%	11.47	4.45	2.86	0.84	0.3	20
Additional users to be served to reach 50% CPR	8.8	3.4	1.97	0.66	0.22	15.11
						population in millions
Increase needed to reach 50% CPR	425%	425%	322%	450%	399%	409%
Increase needed if only considering public/ private facilities	1627%	1134%	1212%	1325%	1448%	1398%

Departure from Conventional Solutions. These facts suggest that any increase in family planning will require a *radical rethinking* of how to address this problem. Surely, the conventional asks such as more funds, more facilities and more trained personnel do little if funds are under spent and personnel or facilities are not visited by clients. It also highlights that there is considerable scope for scaling up in both the public and private sector without incurring additional resources.

Private sector outreach. A key consideration in public or private sector is whether more clients can be attracted. All successful FP programs in Pakistan – the LHW program in the 1990s, HANDS Marvi, Sukh Initiative in Karachi and the AHKRC Aapis Initiative in Rawalpindi – had a component of outreach in them. In this regard, the current costs of the LHW program make it prohibitively expensive. Instead, *low cost private and community-based outreach* such as the Aapis in Rawalpindi – at Rs. 200 per MWRA reached and 1200 per user - may be considered to complement fixed public or private facilities.

Ensuring Commodities. Availability of FP commodities has been inconsistent. The lack of contraceptives leads to uncertainty among clients and negatively impacts the demand for FP. If population and family planning are considered emergencies, this would allow contraceptives to be imported from any country and would lower tariffs and regulatory barriers to such imports. While some of these rules exist, they must be consistently enforced. Additionally, the public sector can earmark allocations for commodities, and even consider volume procurement of contraceptives, that it may sell to the private sector if needed.

Recommendations

1. To reach 50% CPR by 2025, Pakistan will have to increase its quantum of services from public or private facilities by 14-fold.
2. This increase will have to be supported by outreach that refers clients to public or private sector clinics, many of which are underutilized. There is less indication to make new clinics or to train additional providers.
3. Community-based, low-cost private sector outreach solutions may be more cost-effective than the government's LHW program which now has high costs.
4. Government can ensure commodities supplies through additional and ear-marked funding for contraceptives and by lowering tariff or regulatory barriers to import or local manufacture of contraceptives.
5. Increased funding, training additional providers or opening new facilities are least likely to help add additional users in the initial phases, where optimization of existing resources is more warranted.

For more information, please contact
Dr. Adnan Khan, MBBS, MS.
www.resdev.org
Phone: +92 51 843 6877
adnan@resdev.org
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