



USAID | **DELIVER PROJECT**
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Pakistan: Stock Analysis at Service Delivery Points for USAID-Supported Contraceptives

Final Report



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Abstract

In November and December 2012, the USAID | DELIVER PROJECT conducted stock availability assessments in selected districts of Pakistan. The assessment's overall objective was to estimate the contraceptive stock availability at service delivery points throughout Pakistan and to assess the contraceptive flow from the district stores to the facilities. This report presents the findings of the assessment, which includes comparative analysis of contraceptive availability at the facility- and district-level.

The report identifies and quantifies key elements in the supply chain that lead to stockouts at the facility level; e.g., poor requisitioning system, inadequate supplies to facilities despite sufficiency at the district store, and non-availability of transport.

Cover photo: Nasreen Munawar, a Lady Health Supervisor, counsels clients on using oral contraceptives in Lahore, Pakistan. Photo credit: Derek Brown.

USAID | DELIVER PROJECT

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Acronyms

AJK	Azad Jammu and Kashmir
BHU	basic health unit
COC	combined oral contraceptive
DPIU	District Project Implementation Unit
DPMA	depo-medroxy progesterone acetate (Depo-Provera)
DPWO	District Population Welfare Office
DOH	Department of Health
EDO	Executive District Officer
FWA	family welfare assistant
FWC	Family Welfare Centre
FWW	family welfare worker
IUD	intrauterine device
KPK	Khyber Pakhtunkhwa
LHS	Lady Health Supervisor
LHV	lady health visitor
LHW	lady health worker
LMIS	logistics management information system
MNCH	maternal, neonatal, and child health
NGO	nongovernmental organization
PDHS	Pakistan Demographic and Health Survey
PIU	Provincial Implementation Unit
POP	progestin-only pill
PPHI	People's Primary Healthcare Initiative
PRSP	Punjab Rural Support Program
RHC	Rural Health Centre
RSPN	Rural Support Programmes Network
PWD	Population Welfare Department
SDP	service delivery point
TA	technical assistance
USAID	U.S. Agency for International Development

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Finally, we must acknowledge the respondents, who are the health providers at the facilities, for sharing their time and for providing vital information for this study. Through this work, we have documented the information that will expand the availability of family planning services, which will definitely improve the quality of women's lives in Pakistan.

Executive Summary

The USAID-funded USAID | DELIVER PROJECT initiated activities in Pakistan in August 2009. From January 2010–November 2012, through the project, USAID has supplied contraceptives worth US \$52 million. USAID also committed to support the transportation, once a quarter, of contraceptives from the central warehouse in Karachi to all the district stores until March 2013. To assess the contraceptive distribution to service outlets and to identify system gaps for future decision-making, the Population Council conducted a rapid assessment of the stock analysis at service delivery points (SDPs) in 15 districts across the country.

In the public sector, the Family Welfare Centres (FWCs), health facilities (Rural Health Centres [RHCs] and basic health units [BHUs]), and lady health workers (LHWs) are the principal SDPs; therefore, they were selected for the study. Based on a suggestion by the project, a sample of 20 facilities (three RHCs, five BHUs, two FWCs, and 10 LHWs) in each district, comprising 15 districts in all the provinces, and Azad Jammu and Kashmir (AJK), were randomly selected. A checklist for stock analysis at SDPs was designed, in consultation with the USAID | DELIVER PROJECT. During the stock analysis survey, conducted in November 2012, contraceptive handlers—in most cases, providers—were interviewed.

This study's findings show that contraceptive availability varies by province and outlet type. In Punjab, specifically, FWCs offer the largest choice of contraceptives available, including all four required methods. Contraceptive availability at the Department of Health (DOH) outlets is better than at outlets operated by the People's Primary Healthcare Initiative (PPHI). In Khyber Pakhtunkhwa (KPK), FWCs, again, have all contraceptive methods at their outlets, followed by the DOH and PPHI. In Sindh, the DOH has the best stock position, followed by PPHI, and then the Population Welfare Department (PWD) outlets. In Balochistan, FWCs have the best stock, while PPHI can provide a full choice only at 10 percent of facilities; full choice is not available at any DOH facility. In AJK, where there is no PPHI, the PWD provides full choice at FWCs, while the same choice is available at 44 percent of the DOH facilities.

Overall, 78 percent of FWCs have all four mandated contraceptive methods, followed by 46 percent of the DOH facilities; only 35 percent of the PPHI facilities had all four. Only 21 percent of the LHWs had the three mandated contraceptive methods.

Stockouts vary considerably according to method. Condoms are most often out of stock—in 65 percent of LHWs, 49 percent of the PPHI/Punjab Rural Support Program (PRSP) facilities, and 29 percent of DOH facilities. Fifty-eight percent of LHWs and 33 percent of DOH facilities, 31 percent of PPHI/PRSP facilities, and 18 percent of FWCs were stocked out of combined oral contraceptive (COC) pills; 84 percent of PPHI facilities, 79 percent of DOH facilities, and 61 percent of FWCs were out of progestin-only pills (POPs). Likewise, DMPA was not in stock for 62 percent of LHWs and 42 percent of PPHI/PRSP facilities, and 25 percent of DOH facilities. Additionally, TCu 380A was not available at almost one-third of the DOH and PPHI/PRSP facilities. Eighteen percent of FWCs also reported that they did not have TCu 380As in their facilities.

Basic factors that affect contraceptive availability at static facilities—facility requisitioning systems, contraceptive distribution from districts to facilities, and supply according to demand—were all

examined. The requisitioning system is not fully functional; facilities usually collect contraceptives by visiting their respective district department stores. In many cases, facilities do not receive contraceptives according to demand. These factors do not appear to affect the basic availability of at least one contraceptive method in most facilities, especially at FWCs; there, procurement factors seem to have the least effect, at least for full choice availability. Supply issues are key issues to address at DOH and PPHI facilities.

The distribution system from district stores to facilities is weak, as most facilities (84 percent) procure contraceptives by staff visiting the district stores; or health facilities, in the case of LHWs.

Efforts from the USAID | DELIVER PROJECT ensured that contraceptives reach the district stores, but the system is not strong enough to sustain supplying contraceptives to facilities. This situation has two root causes: (1) a weak logistics management information system (LMIS) and (2) a weak facility-level distribution system. To ensure regular contraceptive supplies to facilities, the contraceptives management system needs to be strengthened, have a functioning LMIS in place, and ensure that districts completely fulfill the responsibility of delivering contraceptives to facilities. A relatively simple procedural implementation—for example, for prior requisitions, routinely collecting requisition forms during all facility deliveries—could help integrate the requisition and delivery operations within the procurement system. This would provide facilities with standard, relatively predictable waiting periods between orders and deliveries to enable them to manage their stock more accurately. All procedural decisions and changes, however, require proper discussion and well-managed implementation for uniform and successful operation.

Introduction

A 2012 USAID | DELIVER PROJECT (the project) report states that several factors caused Pakistan's low contraceptive prevalence rate (CPR), including an insufficient public sector supply of family planning services and inconsistent contraceptive availability. To ensure contraceptive supplies are available at service delivery points (SDPs) in Pakistan, the Government of Pakistan used a push system to all districts to provide a three-month buffer stock of contraceptives. The U.S. Agency for International Development (USAID) supplied the contraceptives and committed transportation support from the CWH to the districts; the health and population welfare departments distributed supplies to their respective facilities. During the final months of 2012, the Population Council received a contract for a contraceptive stock analysis at SDPs throughout Pakistan.

Contraceptive Security System

Within Pakistan's districts, service delivery networks, managed by different administrations, provide contraceptives to static health facilities: the Department of Health (DOH), headed by the Executive District Officer, (Health Executive District Officer [EDO]), and the People's Primary Healthcare Initiative (PPHI). Both facilities operate in the provinces of Sindh, Khyber Pakhtunkhwa (KPK), and Balochistan; and in Punjab province. A district support manager heads the Punjab Rural Support Program (PRSP). In some districts, basic health units (BHUs) have been contracted to PPHI or PRSP; while, in others, Health EDOs administer the Rural Health Centres (RHCs) and BHUs. The lady health workers (LHW) program's district coordinator manages the Health Houses of the National Program for Family Planning and Primary Health Care (LHWs), who report to the Health EDO. Providing family planning service is mandatory for health facilities and LHWs; they are required to provide advice, pills, condoms, and injectables to women of reproductive age, in their respective communities. Family planning is a primary mandate for Family Welfare Centres (FWC), which the PWD manages.

Contraceptives are stored at the Karachi CWH, which is currently headed by the federal government's Planning and Development Division. The CWH distributes the contraceptives, once a quarter, directly to the District Population Welfare Offices (DPWOs), PPHI/PRSP, and health department EDOs. DPWOs then deliver contraceptives to nongovernmental organizations (NGOs); and the health EDOs deliver to the LHW programs. The DOH, PPHI/PRSP, and LHW programs each have their own district warehouses and stores. The DOH and PPHI/PRSP issue contraceptives to their respective facilities monthly, while the LHW program supplies Health EDO or PPHI/PRSP health facilities quarterly. The LHWs are supplied from health facilities monthly. DPWO has a separate warehouse/store that supplies the FWCs monthly.

The DPWO's role is crucial. Each DPWO is responsible for determining the stock requirements for the DOH; PPHI/PRSP; LHW; and maternal, neonatal, and child health (MNCH) programs; and any NGO in the district. They then submit these requirements in a single requisition form (Contraceptive Logistics Report 6) to the CWH; each department (including DPWOs) is listed separately.

Lady health visitors (LHVs) from health facilities are expected to collect contraceptives from the DOH store during their monthly meeting at the health EDO's office, according to the *Manual of Contraceptive Logistics* (Government of Pakistan 2007). The family welfare workers (FWWs) or family welfare assistants (FWAs) from FWCs are also required to collect contraceptive supplies monthly from the DPWO stores. In exceptional cases, however, the DPWO can arrange for delivery to FWCs. In practice, PPHI/PRSP district offices deliver contraceptives to their health facilities. LHWs do not collect supplies from district stores directly; but once a month, from the Lady Health Supervisor (LHS)/health facilities to which they are attached.

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Health programs cannot operate successfully without a full supply of essential commodities. The project, supported by USAID, aims to improve essential health commodity supply chains by strengthening the logistics management information systems (LMIS), streamlining distribution systems, identifying financial resources for procurement and supply chain operations, and enhancing forecasting and procurement planning. The project encourages policymakers and donors to support logistics as a critical factor in the overall success of their healthcare mandate.

The project opened an office in Pakistan in August 2009 to support the coordinated goals of the Government of Pakistan and the USAID Pakistan's mission by using health system strengthening to improve the health of the people. The field office has been closely coordinating activities with the Provincial Population Welfare and Health departments and the LHW program. During discussions, priorities were jointly identified and developed; technical assistance (TA) was designed to strengthen the local capacity, which has focused on the—

- LMIS
- warehouse rehabilitation
- commodity security and procurement capacity.

To overcome the challenge of contraceptive security, from January 2010–November 2012, USAID supplied contraceptives worth U.S.\$52 million through the project, including—

- condoms
- combined oral contraceptive (COC) (Microgynon)
- progestin-only pill (POP) (Microlut)
- depo-medroxy progesterone acetate (DPMA)—Depo-Provera
- intrauterine device (IUD) (TCu 380A).

In addition, USAID committed to support contraceptive transportation from the CWH in Karachi to all district stores, quarterly, until March 2013. The project has also secured a commitment from all provincial and regional governments to—

- ensure transportation of commodities to SDPs, after district stores have adequate stock
- allocate sufficient budgets, through PC-Is, for transporting commodities from the CWH to district stores and service delivery outlets after March 2013.

In the public sector, three main SDPs provide family planning services to married couples of reproductive age: the Population Welfare Department (PWD) facilities, health facilities, and LHWs.

To assess the stock situation of USAID-supported contraceptives at SDPs, the project advertised, using this statement of work: *Rapid assessment of stock levels of contraceptives at SDPs in Pakistan*. The Population Council responded and was awarded the project.

Study Aims and Objectives

The objective of this study was to rapidly assess the contraceptive stock at SDPs throughout Pakistan and to assess the contraceptive flow from the district stores to the facilities. This was done by measuring the efficiency of the efforts made to support contraceptives security and their availability in facilities; including identifying system gaps and taking remedial measures.

Sampling Design and Methodology

A random sampling of the BHUs, RHCs, LHWs, and FWCs in 15 districts was selected as the methodology. For reasonable precision and accuracy, 300 facilities were selected, with 20 facilities per cluster (districts).

A stock analysis checklist at each SDP was designed, in consultation with USAID | DELIVER PROJECT. Data were collected from SDPs in face-to-face interviews with service providers.

Data Collection and Field Work

Seven experienced field teams, comprising one male and one female on each team, were trained in data collection in Islamabad. This was followed by field work from November 5–November 22. Data were entered simultaneous with field work; analysis was done immediately after the field work was completed (see table 1 and table 2).

Table 1. Number and Percentage of Facility Types

Facility	Number	Percentage (%)
Rural Health Centre	44	15
Basic health unit	75	25
Family Welfare Centre	30	10
Lady health worker health houses	151	50
Total	300	100

Table 2. Facilities and Their Departments

Department	Facility	Number
Department of Health	Rural Health Centre	44
Department of Health	Basic health unit (BHU)	19
People's Primary Healthcare Initiative/Punjab Rural Support Program	BHUs	56
Population Welfare Department	Family Welfare Centre	30
National Program for Family Planning and Primary Health Care (Lady Health Worker program)	Health House	151
Total		300

Contraceptive Stock Analysis at Service Delivery Points

The project has made a concerted effort to supply contraceptives, including—until March 2013—the quarterly transport of contraceptives from the CWH to all district stores. This is especially important because of the budget difficulties the Health and Population Welfare departments had when they attempted to transport contraceptives.

Contraceptive Availability at Facilities

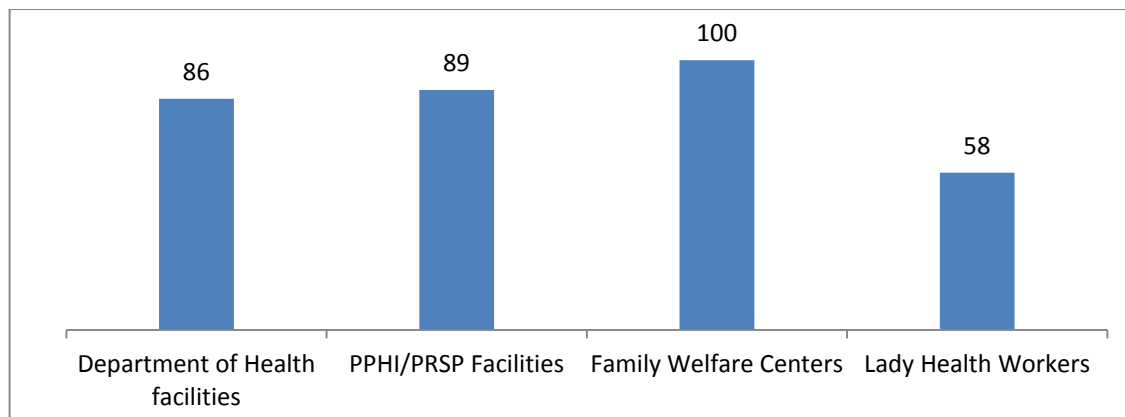
Figure 1 shows that at least one contraceptive method is available at all PWD outlets (FWCs); 58 percent of LHWs stock have a minimum of one, while 86 percent of DOH facilities and 89 percent of PPHI/PRSP facilities reported at least one method.

As identified in the FALAH project, before USAID contraceptive commodity support started in January 2010, the CWH had a limited supply of contraceptives and limited stock; distribution was being rationed and most facilities were stocked out. The Population Council's recent situation analysis (Mahmood, Arshad, and Sadiq 2012) includes details about the overall contraceptive availability in 68 percent of the health facilities (DOH and PPHI facilities). In PPHI/PRSP facilities, contraceptive availability is somewhat higher; in most cases, this may be because PPHI/PRSP district offices arrange their facilities' supply delivery. Limited availability in all FWCs shows their long-term family planning program involvement, because providing family planning services is their primary responsibility.

LHWs have the lowest contraceptive availability, which is a point of concern. Before USAID transportation support started in April 2012, the LHW program was having difficulty in transporting contraceptives from CWH to PPIUs and then onward to districts. The elimination of PPIU storage and direct quarterly shipments from CWH were intended to make the distribution system more efficient. Similarly, the requisition system was strengthened by developing an integrated requisition for all district level stakeholders, beginning in April 2012.

While contraceptives were available at the CWH, almost all districts were stocked out for all products. The transportation support did improve availability up to district level (see annex A). However, the availability up to the LHW level depends on the intra-district transportation mechanism. This assessment analyzes the facility-level availability and, also, compares it to the district-level availability.

Figure 1. Percentage of Facilities and Lady Health Workers with at Least One Contraceptive Method Available



Overall, the situation in Sindh (see figure 2) is much better than in other provinces. All DOH and PPHI facilities, as well as FWCs, had at least one contraceptive method at the time of the survey. This could be because the CWH is in Karachi; because of the relatively short distances, making a delivery in the province is easier. Sindh also fills out contraceptive orders better than the other provinces. However, contraceptive availability with the LHWs is far from ideal, even in Sindh; only 37 percent of LHWs had at least one contraceptive method.

In Punjab, 100 percent of FWCs, 90 percent of PRSP health facilities, 80 percent of DOH facilities, and 82 percent of LHWs reported having at least one contraceptive method during the survey. In Punjab, PRSP management appears to be more proactive in ensuring that they have contraceptives at their facilities. The Punjab LHW program also operates more efficiently than the other provinces' LHW programs.

In KPK, 100 percent of FWCs, 93 percent of PPHI facilities, 67 percent of DOH facilities, and 57 percent of LHWs reported at least one contraceptive method at the time of the survey. In KPK, PPHI management is efficient in ensuring contraceptive availability at facilities, whereas the DOH efforts are often weak.

Reported contraceptive availability is weak in Balochistan—70 percent of PPHI facilities, 50 percent of DOH facilities, and 33 percent of LHWs reported having at least one contraceptive. In Balochistan, only 25 percent of PPHI and FWC facilities each have contraceptives on the prescribed requisition form. Other PPHI facilities and FWCs make requisitions either verbally or on paper, or the District Office gives contraceptives to facilities without a requisition. The DOH does not make requisitions. The District Office provides contraceptives to all the sampled DOH facilities. This indicates a weak requisition and distribution system at the sub-district level; these factors contribute to a lack of contraceptive availability in Balochistan.

In Azad Jammu and Kashmir (AJK), all DOH facilities and FWCs had at least one contraceptive method; but there is no PPHI in AJK. LHWs' stock availability was low—only 55 percent of the LHWs had at least one contraceptive method available, which means 45 percent of the LHWs did not have any of the three contraceptive products they are expected to provide.

Figure 2. Percentage of Facilities and Lady Health Workers with at Least One Contraceptive Method Available, by Province, and Azad Jammu and Kashmir

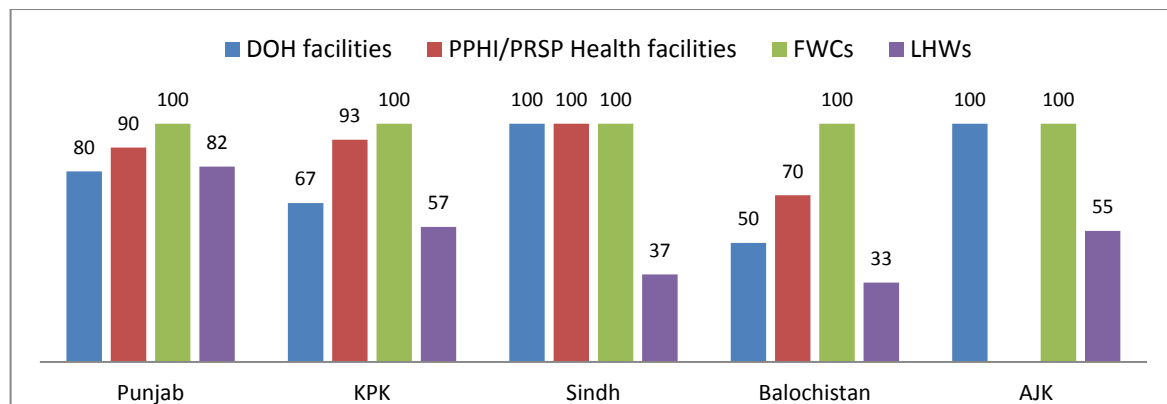


Figure 3 shows the availability of the individual contraceptive methods, by type of health facility or LHW. The overall availability of individual contraceptive methods is better in the FWCs, with 93 percent of FWCs reporting condom stocks, 86 percent with DMPA, and 82 percent for both COC and TCu 380A. POP was available in only 39 percent of the FWCs.

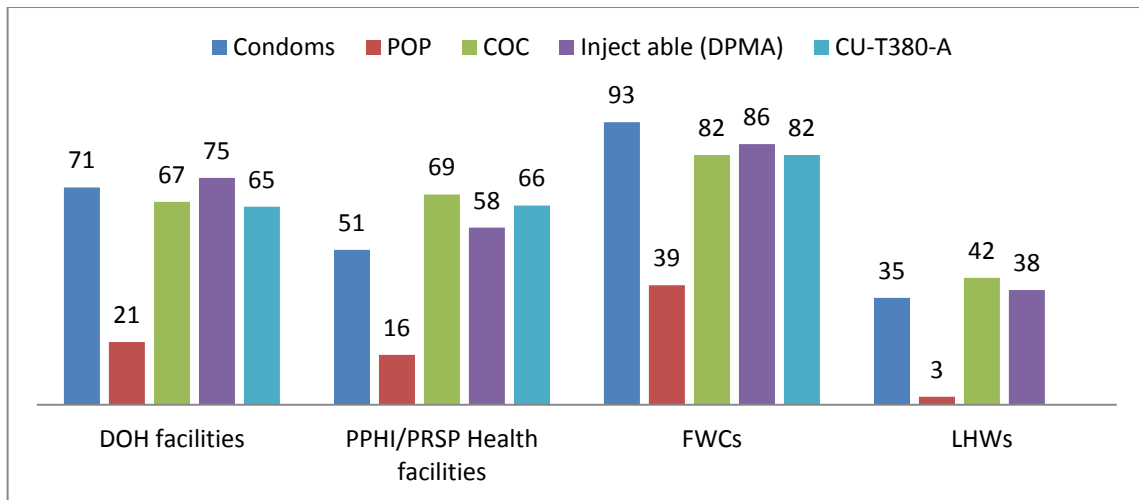
Seventy-five percent of DOH facilities reported DMPA stock, 71 percent reported condoms, 67 percent had COC, and 65 percent had TCu 380A. Only 21 percent of DOH facilities reported having POP available on the day of visit.

For PPHI/PRSP facilities, 58 percent reported DMPA stock, 51 percent reported condoms, 69 percent had COC, and 66 percent had TCu 380A. Only 16 percent of PPHI/PRSP facilities reported having POP on the day of visit.

Only 42 percent of LHWs reported COC pills, 38 percent listed DMPA, and 35 percent had condoms. Only 3 percent of LHWs reported having POP at the time of the visit.

POP availability is fairly low with all distributors, but especially the LHWs. Moreover, compared to facilities, LHWs have low contraceptive stocks. Condom and DPMA availability is lowest at the PPHI/PRSP facilities compared with DOH facilities and FWCS; only about half of the PPHI/PRSP facilities have condoms, while three-fifths have DPMA.

Figure 3. Percentage of Facilities and LHWs by Availability of Individual Contraceptive Method



Figures 4–7 show the availability of different contraceptive methods, by type of facilities, according to the provinces and AJK.

Figure 4. Department of Health Facilities by Contraceptive Method, Province, and Azad Jammu and Kashmir

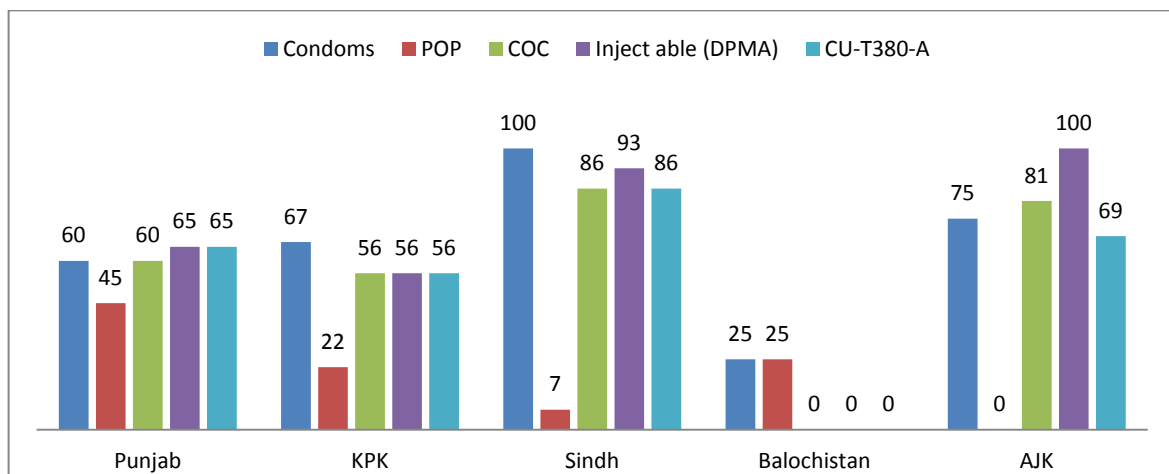


Figure 5. PPHI Facilities by Contraceptive Method, Province, and Azad Jammu and Kashmir

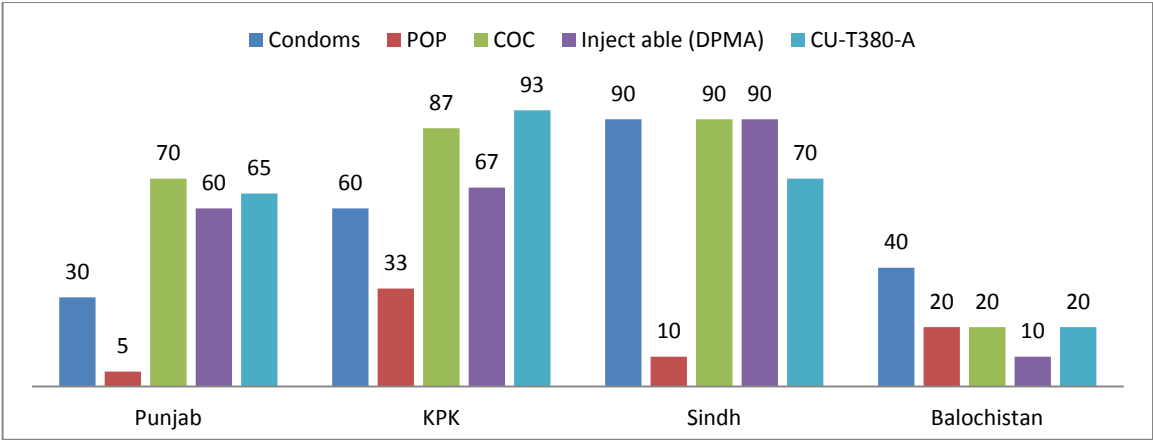


Figure 6. Family Welfare Centers by Contraceptive Method, Province, and Azad Jammu and Kashmir

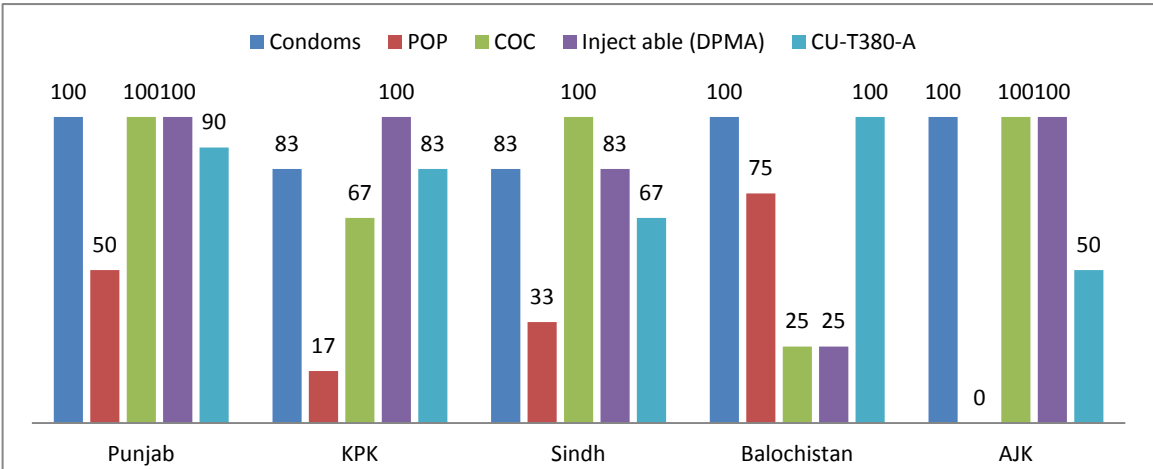
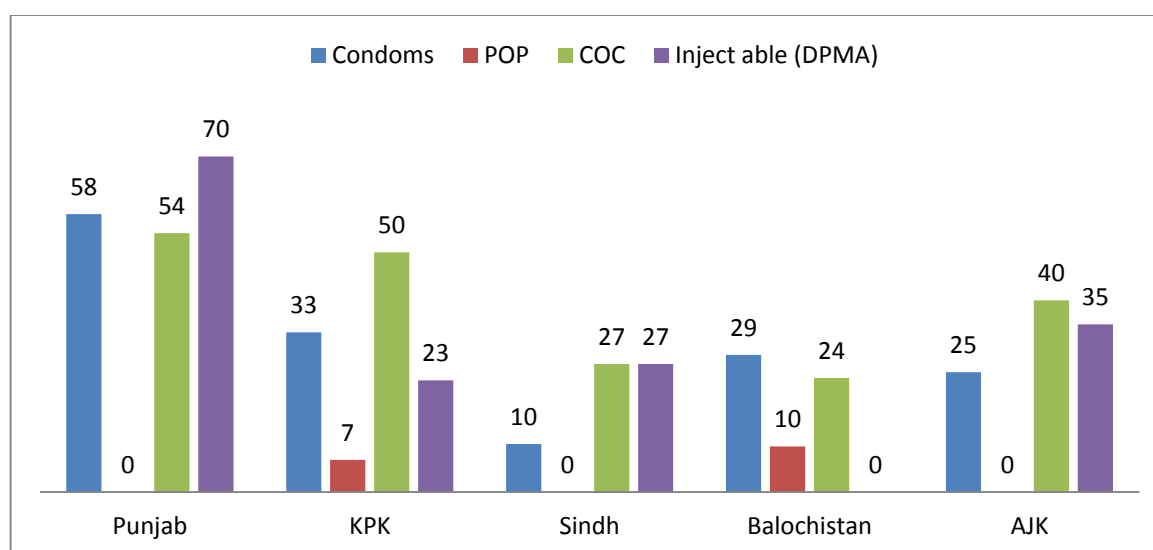


Figure 7. LHWs by Contraceptive Method, Province, and Azad Jammu and Kashmir



Freedom of choice in adopting a contraceptive method depends on the service providers' range of availability; ideally, all contraceptive methods should be available at SDPs. Four methods—condoms, pills, injectables, and IUDs—are expected to be available at all static facilities under assessment; while three methods (IUDs are exempted) are required for the LHWs. Table 3 shows that FWCs have all four methods available more often than the other facilities; this is followed by the DOH facilities.

Table 3. Percentage of Facilities and Lady Health Workers with Number of Methods Available

Facilities/Lady Health Worker (LHW)	No Method Available	One Method Available	Two Methods Available	Three Methods Available	Four Methods Available	Total
Department of Health facilities	14.3	6.4	3.2	30.2	46.0	100
PPHI/PRSP facilities	10.9	10.9	20.0	23.6	34.6	100
Family Welfare Centres	0.0	0.0	7.1	14.3	78.6	100
LHWs	42.4	17.2	19.2	21.2	0.0	100

PPHI/PRSP facilities lag behind in full method availability, with only 35 percent reporting a full range of contraceptives. What is troubling is that PPHI/PRSP facilities are also BHUs, and most of these facilities cannot provide clients the full range of methods for family planning. To ensure that clients have a valid choice, they should be counseled about all methods, and all the methods should be available. For LHWs, contraceptive availability is a serious concern: 42 percent reported having no contraceptive method in stock; only 21 percent of the LHWs reported having all three contraceptive methods they are expected to have, on the day of the visit.

Provincial contraceptive availability is shown in table 4 (Punjab situation), where all FWCs had four methods available; PPHI was weak in procuring all four methods (only 15 percent of facilities); only 40 percent of the DOH facilities had all four methods; likewise, with

LHWs—only 40 percent had their requisite three methods during the survey. However, the DOH facilities, with three to four methods, were best placed.

Table 4. Percentage of Facilities and LHWs with Number of Methods Available, Punjab

Facilities/Lady Health Worker (LHWs)	No Method Available	One Method Available	Two Methods Available	Three Methods Available	Four Methods Available	Total
DOH facilities	20.0	10.0	0.0	30.0	40.0	100
Punjab Rural Support Program facilities	10.0	15.0	15.0	45.0	15.0	100
Family Welfare Centres	0.0	0.0	0.0	0.0	100.0	100
LHWs	18.0	22.0	20.0	40.0	0.0	100

Table 5 shows that, in KPK, the FWCs' contraceptive stock position is relatively strong for availability of all four methods, compared to other facilities. Even so, only two-thirds of the FWCs had all four methods. More than 50 percent of PPHI facilities had all four, while 44 percent of the DOH facilities had all four on the day of the visit. Only 13 percent of LHWs had their required three methods. One-third of DOH facilities and 43 percent of LHWs had no method available. Compared to Punjab, KPK's family planning program is weak in terms of full method choice, although PPHI in KPK has a relatively stronger stock position.

Table 5. Percentage of Facilities and Lady Health Workers with Number of Methods Available, Khyber Pakhtunkhwa

Facilities/Lady Health Workers (LHWs)	No Method Available	One Method Available	Two Methods Available	Three Methods Available	Four Methods Available	Total
DOH facilities	33.3	0.0	0.0	22.2	44.4	100
PPHI facilities	6.7	0.0	20.0	20.0	53.3	100
Family Welfare Centres	0.0	0.0	16.7	16.7	66.7	100
LHWs	43.3	13.3	30.0	13.3	0.0	100

Table 6 shows that Sindh's DOH is ahead of all others in providing the four methods in their facilities (71 percent), closely followed by PPHI (70 percent), and then the FWCs (50 percent). Sindh's family planning program is weak; only 7 percent of the LHWs could provide three methods on the day of the visit. Up to 63 percent did not have any method available.

Table 6. Percentage of Facilities and Lady Health Workers with Number of Methods Available, Sindh

Facilities/Lady Health Workers (LHW)	No Method Available	One Method Available	Two Methods Available	Three Methods Available	Four Methods Available	Total
DOH facilities	0.0	0.0	7.1	21.4	71.4	100
PPHI facilities	0.0	0.0	20.0	10.0	70.0	100
Family Welfare Centres	0.0	0.0	16.7	33.3	50.0	100
LHWs	63.3	16.7	13.3	6.7	0.0	100

Table 7 shows that, in Balochistan, no DOH facilities had all four methods available; only 10 percent of PPHI facilities had all four. Two-thirds of the LHWs had none, and 50 percent of DOH facilities had none, which was also the case for 30 percent of the PPHI facilities.

Table 7. Percentage of Facilities and Lady Health Workers with Number of Methods Available, Balochistan

Facilities/Family Welfare Centre (FWC)	No Method Available	One Method Available	Two Methods Available	Three Methods Available	Four Methods Available	Total
Department of Health facilities	50.0	25.0	0.0	25.0	0.0	100
People's Primary Healthcare Initiative facilities	30.0	30.0	30.0	0.0	10.0	100
FWCs	0.0	0.0	0.0	25.0	75.0	100
Lady Health Workers	66.7	0.0	23.8	9.5	0.0	100

Table 8 shows that AJK's family planning program is as strong as Punjab's, with all FWCs having all four contraceptive methods in stock. Only 44 percent of the DOH facilities had all four methods available, and the same number of DOH facilities had three methods available. Forty-five percent of LHWs had no methods available, and 30 percent only had one. Only 20 percent of LHWs had all three contraceptive methods in stock.

Table 8: Percentage of Facilities and Lady Health Workers with Number of Methods Available, Azad Jammu and Kashmir

Facilities/Lady Health Worker (LHWs)	No Method Available	One Method Available	Two Methods Available	Three Methods Available	Four Methods Available	Total
DOH facilities	0.0	6.3	6.3	43.8	43.8	100
Family Welfare Centres	0.0	0.0	0.0	0.0	100.0	100
LHWs	45.0	30.0	5.0	20.0	0.0	100

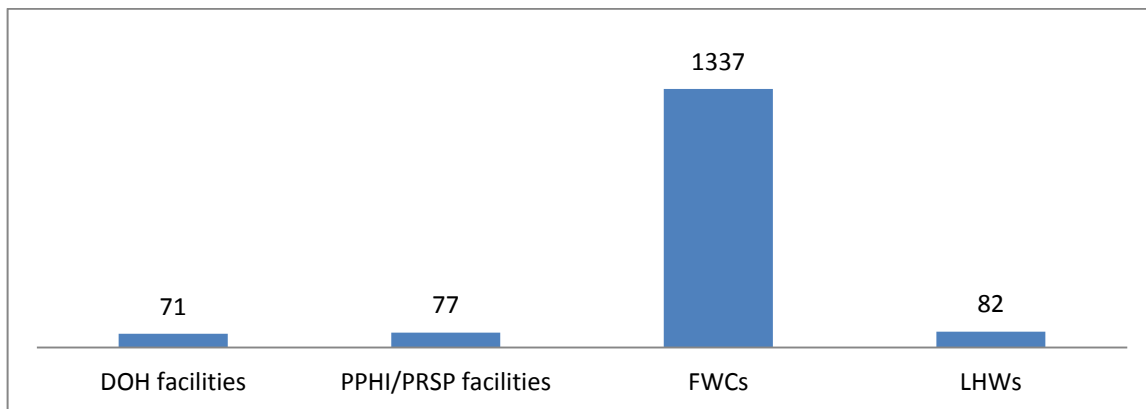
Average Monthly Contraceptive Use, by Method

Contraceptive method use varies by the type of facility. This section discusses the average use or the dispensing of individual contraceptive methods at different types of SDPs.

Condoms

Figure 8 illustrates the average distribution of condoms at the facilities and LHWs for the three months preceding the survey. The highest condom distribution was through the FWCs. Condom distribution was very low in other health facilities, as well as by the LHWs. The average distribution by LHWs, DOH, and PPHI/PRSP was similar—ranging from 82 units through the LHWs, followed by 77 units through PPHI/PRSP facilities, and 71 units through the DOH outlets.

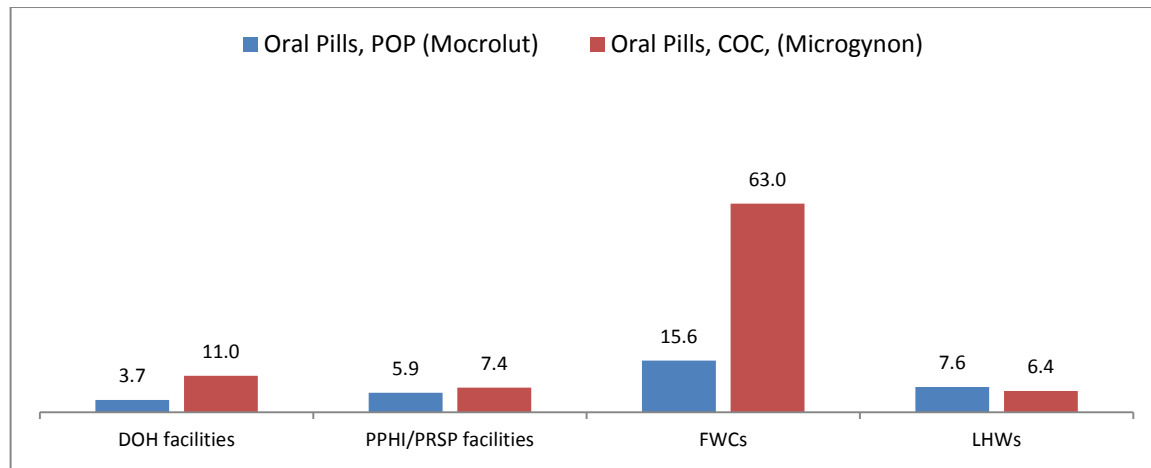
Figure 8. Average Monthly Distribution of Condoms, by Type of Facility and Lady Health Workers



Pills

Figure 9 shows that the average consumption of both categories of contraceptive pills, per facility, for the preceding three months was highest through the FWCs. Overall, at the FWCs, 79 cycles of pills were dispensed monthly, followed by 15 cycles through the DOH facilities, 14 through the LHWs, and 13 through the PPHI/PRSP facilities.

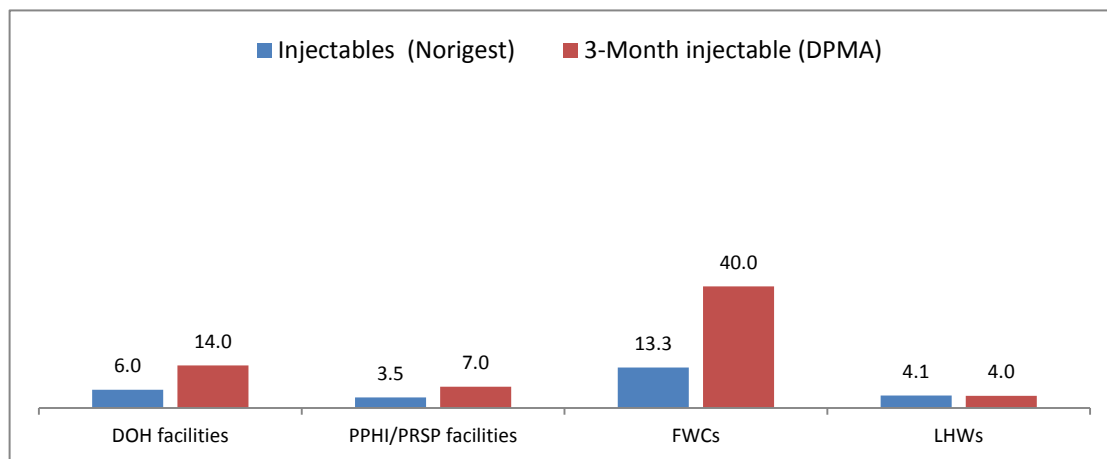
Figure 9. Average Monthly Consumption, by Type of Oral Pills, Facility, and Lady Health Workers



Injectables

Figure 10 shows that the average monthly consumption of both types of injectables is highest for the FWCs (40 DMPA and 13 Norigest). An average monthly distribution of 20 vials of injectables was observed for DOH facilities (14 DMPA and 6 Norigest), while PPHI facilities reported approximately 10 vials (7 vials of DMPA and 3.5 Norigest). The LHWs reported an average monthly distribution of four vials of DMPA and Norigest, each.

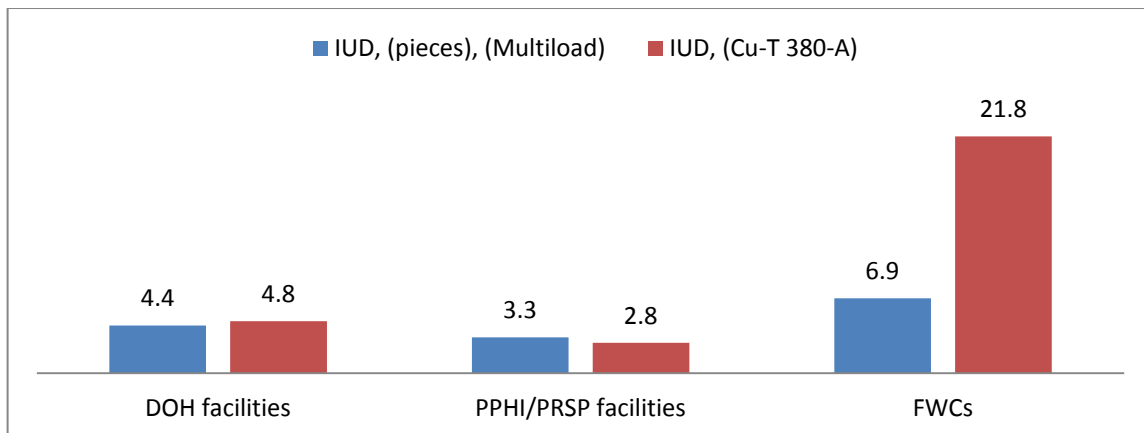
Figure 10. Average Monthly Injectable Use, by Type of Facility, and Lady Health Workers



IUDs

Figure 11 shows, on average, three months' use for both types of IUDs per facility, which was highest at the FWCs: TCu 380A was the most used. Average monthly performance reported by FWCs was for 22 TCu 380As and seven multiload clients. Average monthly consumption at DOH facilities was 4.8 TCu 380A; and at PPHI/PRSP facilities, was 2.8 TCu 380A.

Figure 11. Average Monthly Consumption, by Type of IUD and Facility



Contraceptive consumption from health facilities and the FWCs shows, overall, that the performance of FWCs is higher than the health facilities that work under health departments or PPHI/PRSP. Contraceptive availability, in general, is not an issue with FWCs, because their contraceptive availability is better than all the other facilities, excluding POP. Furthermore, the FWCs have contraceptives based on their demand for stock; their submission of prescribed requisition forms is higher than other facilities. These performance numbers, however, were obtained from progress reports submitted by facilities during the three months preceding the survey; their authenticity has not been validated.

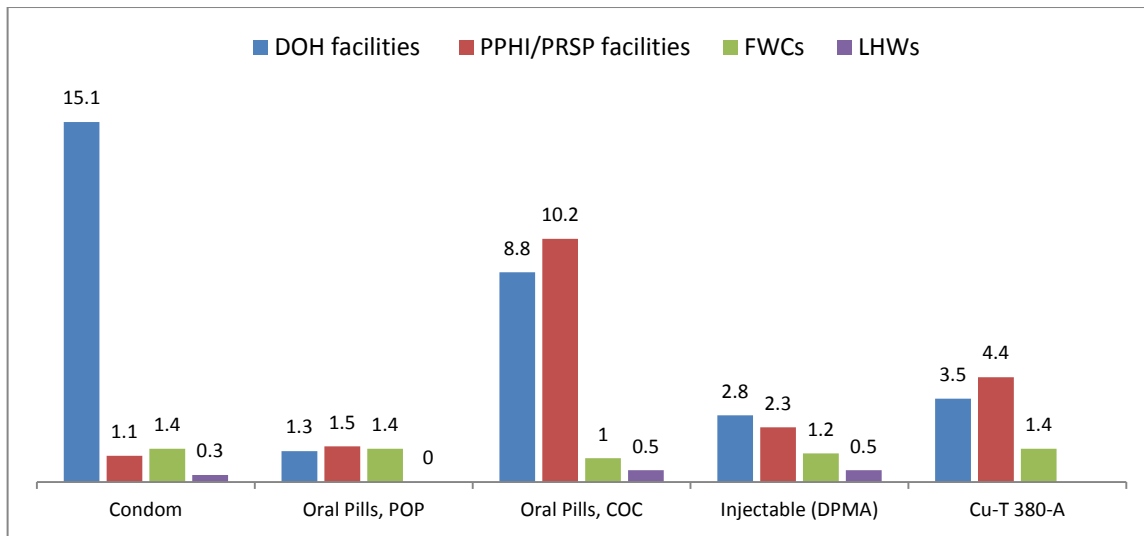
Availability of Buffer Stock

Stock position by month and method shows how many months of buffer stock the LHWs and facilities have available. Low levels or non-availability of buffer stock increases the likelihood of stockouts at facilities. Facilities are required to submit their requisitions based on their stock consumption. Because there is no buffer stock, the facilities stock often does last for the time between shipments, which sometimes exceeds several months; this leave the facilities without stock during this time.

Note: To calculate the number of months of stock available, add the total stock of a specific contraceptive method that is available at certain facilities and divide it by the average distribution of that specific method in those facilities. A stock average does not mean all facilities have the same number of months/days of stock.

Figure 12 shows that 15 months of condom stock and more than eight months of COC stock are available at the DOH facilities, while more than 10 months of COC stock is available at PPHI/PRSP facilities. LHWs have a few days of stock for all methods. All facilities are required to have a three-month buffer stock available. Figure 12 also shows that, for a number of contraceptives, buffer stock is below the desired levels, which ultimately leads to stockouts. The situation needs to be carefully examined to prevent stockouts in the future.

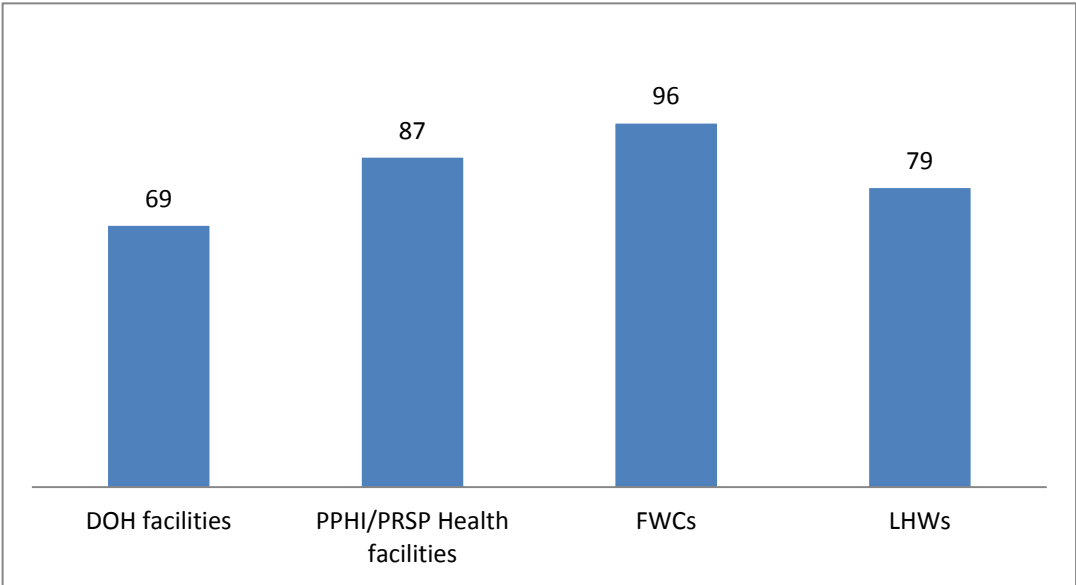
Figure 12. Months of Stock Available, Based on Average Consumption for Previous Three Months, by Facility and Lady Health Workers



Regularity of Contraceptive Supplies

Figure 13 shows the supply regularity from the district stores to the facilities and providers. The LHWs collect their contraceptives and other supplies monthly, after submitting their performance reports to their respective health facilities. More than 20 percent of the LHWs and 4 percent of the FWCs reported receiving no supplies during the last quarter. More than 30 percent of the DOH facilities and only 13 percent of PPHI/PRSP facilities reported no contraceptive supply renewal during the quarter. The supply problem is centered on the DOH facilities. Although 21 percent of the LHWs did not receive supplies during the last quarter, LHWs still had the highest shortage of contraceptives of all providers, implying that either they are not given their requisite contraceptive quantities or they do not request specific methods.

Figure 13. Percentage of Facilities and Lady Health Workers Receiving Contraceptives Supplies in the Last Quarter



System-Related Findings Affecting Contraceptive Stock at SDPs

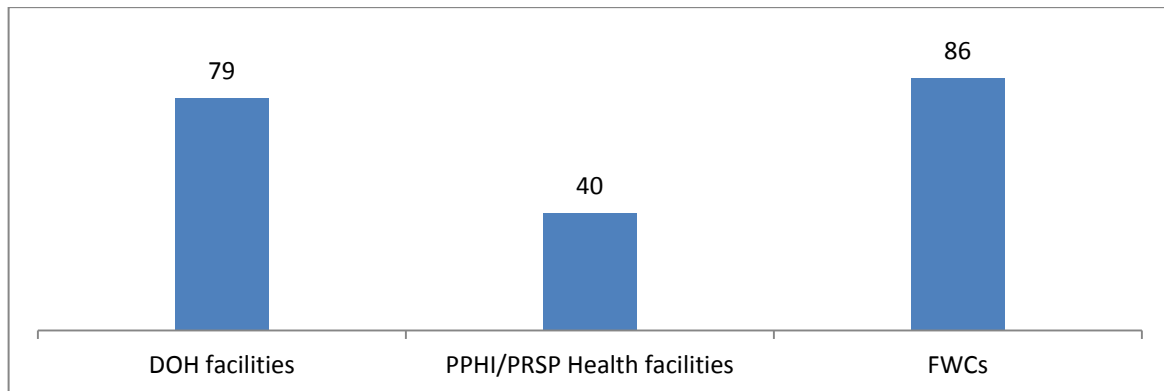
Contraceptive Distribution System

The contraceptive distribution system plays a critical role in the availability of contraceptives at facilities. The contraceptive manual, *Manual of Contraceptive Logistics*, (Government of Pakistan 2007) requires that health facility LHWs collect contraceptives from DOH district stores, and FWWs or FWAs collect contraceptives monthly from DPWO's district stores. The LHWs collect contraceptives from the health facilities where they are attached.

If the DOH/PPHI or PRSP and the PWD deliver contraceptives according to demand to facilities each month, this may help ensure contraceptive availability. Likewise, if contraceptives are delivered to the Health House of the LHWs each month, this may prevent stockouts there. A recent assessment (USAID | DELIVER PROJECT 2012) states that the weak distribution system, marked by inconsistency, both in timing and quantity, leads to erratic supply patterns at various levels of the supply chain.

Figure 14 shows that 79 percent of providers at the DOH facilities and 40 percent of providers at the PPHI/PRSP facilities reported collecting contraceptive supplies by visiting their respective district stores. The PPHI/PRSP's distribution system is satisfactory: the district office immediately delivers contraceptives to 60 percent of the facilities. For FWCs, the majority (86 percent of facilities) procure contraceptives from the district office on their own. All LHWs reported collecting their supplies from their attached health facilities.

Figure 14. Percentage of Facilities Where Staff Collect Contraceptives from District Stores at Their Respective Department

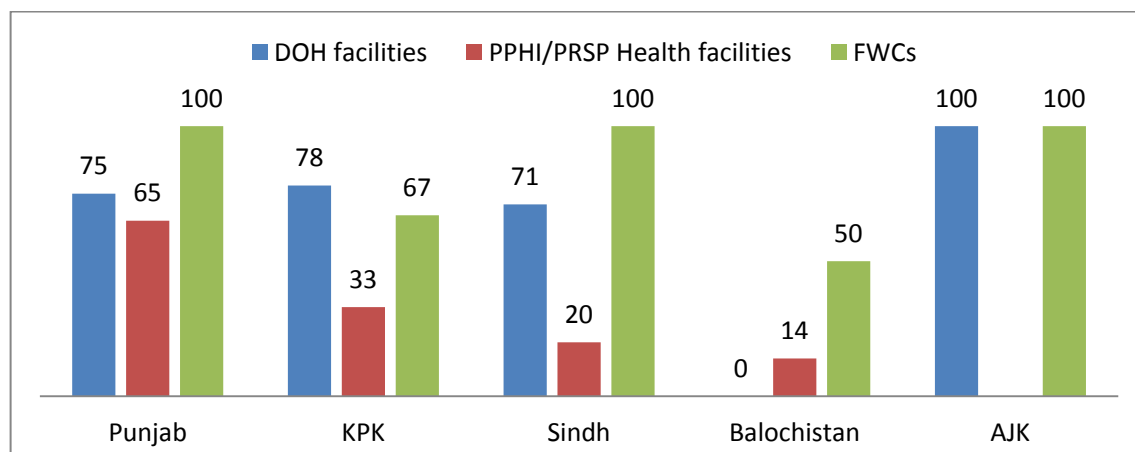


Contraceptive Distribution Systems in Provinces

Figure 15 shows how facilities of different departments, in each province, receive supplies from district stores. In DOH facilities, 78 percent in KPK, 75 percent in Punjab, 71 percent in Sindh, and 100 percent in AJK, collect contraceptive supplies by visiting their respective district stores. For Punjab, 65 percent of facilities seek their supplies from the district store, while the PPHI in Sindh and Balochistan primarily deliver the supplies to the facilities (80 percent and 86 percent, respectively). In KPK, however, one-third of the facilities must collect contraceptives from the district store.

All FWCs in Punjab, Sindh, and AJK collect contraceptives from the district store in KPK and Balochistan; this is the case for 67 and 50 percent of the FWCs, respectively.

Figure 15. Percentage of Facilities Whose Staff Collects Contraceptive Supplies from District Office



After contraceptive consignments are delivered to the district stores, commodities should then be delivered to all health facilities under the district health departments, or PPHIs/PRSPs, as well as LHWs. District departments are unable, however, to deliver contraceptives to their facilities, especially the Health and Population Welfare departments. The project has made transportation arrangements from the CWH to the district stores; their respective departments were to arrange for stock delivery from the district stores to the facilities, but this has not been completely successful.

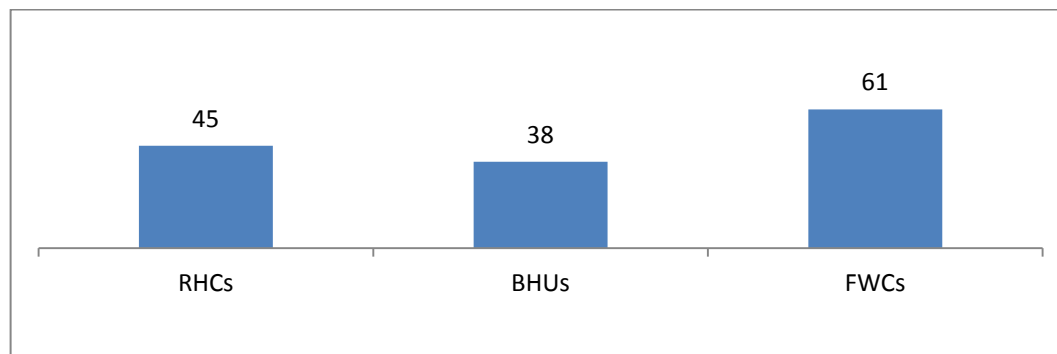
District managers and facility providers, and commodity handlers, need logistics management training; this will help establish the importance of commodity availability in facilities.

Contraceptive Requisitioning System

The contraceptive requisitioning system is the most crucial link in providing contraceptive. The SOPs outlined in the *Manual of Contraceptive Logistics* (Government of Pakistan 2007) has required, since 2002, that health facilities submit their requisition to their health EDO on the Monthly Contraceptive Stock and Performance Report for Health Outlets form (DOH 2). The PPHI/PRSP facilities are also required to submit requisitions on a similar form. Figure 16 shows that most FWCs use the prescribed form to make requisitions, but RHCs and BHUs lag behind.

The LHWs requisition system is weak, which results in all workers receiving equal numbers of contraceptives; it can result in under- or oversupply at specific SDPs. Oversupply often results in expensive contraceptives expiring; undersupply leads to frequent stockouts, depriving clients of protection against unwanted pregnancy. When the facility does not send requisitions, it is difficult for districts to procure the required supplies from the CWH—which requests the distribution records. If information is missing, or incorrect distribution is described on the district requisition form (Contraceptive Logistics Report 6), supplies are either not released from the CWH or they are delayed. This leads to facility undersupply, and the cycle continues. To ensure requisition on a *pull* basis, it is necessary to initially provide sufficient contraceptives to facilities or LHWs; then to ensure that they can report their performance on a prescribed form. Recent district supplies from the CWH have been using a *push* system; but to ensure regular flow and availability of stocks to facilities, a pull system needs to be fully in place. This will also help determine the required methods, as well as what quantity and where the stock is located.

Figure 16. Percentage of Facilities Requesting Contraceptive Supplies on Requisition Forms



Supply and Demand

A common complaint from providers during health facility assessments is that they do not receive contraceptives based on demand (Mahmood, Arshad, and Sadiq 2012). Since April 2012, the project has supplied contraceptives based exactly on the district demands. The project has ensured the transportation from the central- to the district-level. The critical concern to be addressed is the availability at the facility level. Figure 17 shows that two-thirds of the facilities at the PWD, (FWCs) and PPHI/PRSP are supplied based on demand. The PPHI/PRSP and PWD management appear to be more efficient in arranging sufficient supply based on facility demand. The DOH and LHW programs are behind in this respect—only 41 percent of the DOH facilities and 45 percent of LHWs received supplies, based on the requisition. The FWC requisitioning system is relatively stronger, compared to the DOH, which is rather weak.

The situation is of particular concern for the LHWs, who basically relay contraceptive demand for their communities. If LHWs do not have adequate contraceptives methods, there are serious repercussions for contraceptive continuity in communities.

Figure 17. Percentage of Facilities and Lady Health Workers Receiving Supplies According to Demand

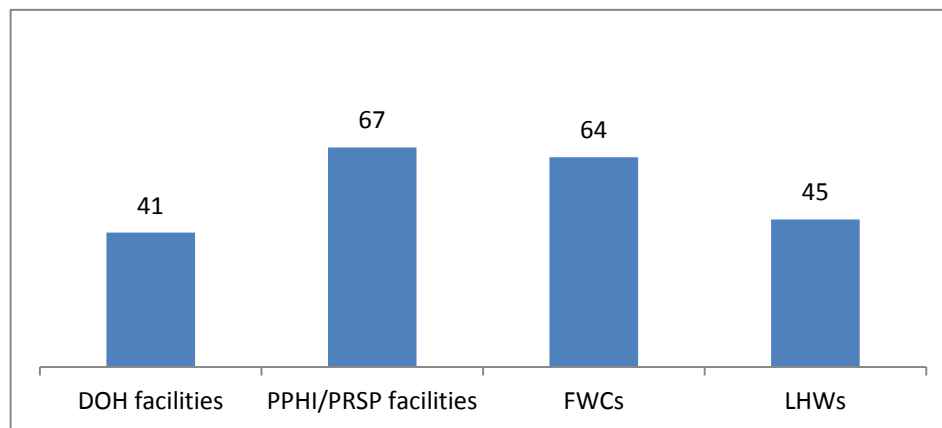
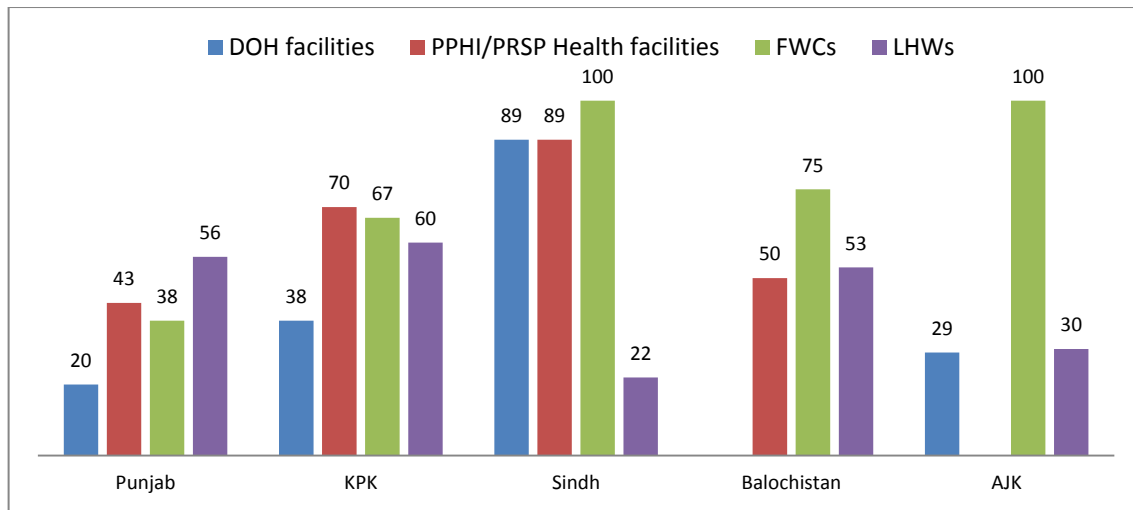


Figure 18 provides data on provincial demand and supply for facilities and the LHWs. The situation in Sindh is better than in the other provinces, where most facilities, in all departments, receive supplies based on demand—only the LHWs in Sindh are not receiving supplies according to demand.

Figure 18. Percentage of Facilities and Lady Health Workers Receiving Contraceptive Supplies According to Demand, by Department and Province, and Azad Jammu and Kashmir



Overall, most DOH facilities in all the provinces (except Sindh) and AJK do not receive supplies based on demand. In Balochistan, the DOH does not have a requisitioning system, so it is impossible to have supply by demand. The situation is slightly better for the PPHIs and FWCs: All FWCs in Sindh and AJK receive supplies by demand. The situation in Punjab is the worst; most providers in all departments do not receive supply based on demand.

In general, the LHW supply based on demand is poor; KPK has a relatively better situation, followed by Punjab, and then Balochistan. In Sindh and AJK, the LHWs' position is unsatisfactory.

Conclusion

Contraceptive availability of at least one method at a SDP varies by province. All static facilities (excluding LHWs) in Sindh have full availability of at least one contraceptive method; Balochistan lags behind all other provinces in availability. The DOH facilities in Balochistan have no requisitioning; almost half of its PPHI facilities receive fewer supplies than they need.

The LHW contraceptive availability is best in Punjab, where 82 percent of the LHWs had at least one contraceptive method available; this is followed by KPK (57 percent), Sindh (37 percent), and Balochistan (33 percent). In AJK, however, 55 percent of the LHWs had at least one contraceptive method, which shows that most LHWs have a scarce supply of contraceptives. Forty percent of LHWs in Punjab had all three required methods available, followed by 13 percent in KPK, 10 percent in Balochistan, and seven percent in Sindh. In AJK, 20 percent of LHWs had all three methods available. These numbers show the LHW program's current overall weakness in securing the full range of contraceptives.

Contraceptive availability was slightly better in the PPHI/PRSP facilities compared to the DOH facilities; the PWD is the exception because at least one contraceptive was available in all FWCs. The PWD's success compared to DOH is probably because they are focusing exclusively on the family planning program and providing family planning services in the field. The LHW program is lagging behind other programs in terms of contraceptive availability.

Seventy-eight percent of the FWCs provide full contraceptive choice for their clients, followed by 46 percent of DOH facilities; only 35 percent of PPHI facilities provide full choice. Only 21 percent of the LHWs had the full choice of three methods available.

In Punjab, specifically, the PWD provides the widest choice—all four methods at all the FWCs—while the DOH performs better than PPHI. In KPK, the PWD again is best at providing contraceptive choice, followed by DOH and PPHI. In Sindh, the DOH is doing the best job, followed by PPHI and then PWD. In Balochistan, PWD is performing best, while PPHI can provide full choice at only 10 percent of facilities; full choice is not available at any DOH facility. In AJK, where PPHI does not exist, the PWD provides full choice at the FWCs, while the same choice is available at 44 percent of the DOH facilities.

The basic factors affecting contraceptive availability at static facilities—including facility requisitioning systems, contraceptive distribution by districts to facilities, and supply by demand—were all examined. The requisitioning system is not fully functional, and facilities primarily collect contraceptives by visiting their respective department district stores; in many cases, facilities do not receive contraceptives according to demand. These factors do not seem to affect the basic availability of at least one contraceptive method at the facilities, especially at FWCs. Requisitioning factors seem to affect FWCs least, in terms of full choice availability; but supply issues are important to address for the DOH and PPHI/PRSP facilities.

Since April 2012, the CWH has used a pull system to provide contraceptives to districts (especially to DOH and LHW program). District departments send their integrated requisition every quarter, which reflects their consumption during the previous quarter. However, poor quality consumption data (especially of DOH and LHW program), leads to inaccuracies in requisitions and results in stockouts at facilities. Also, further down the pipeline, the district-level facilities are not receiving contraceptives based on their specific needs. Therefore, availability of at least one contraceptive is found at a wide range of facilities, but availability of a full choice for all four contraceptive methods is a matter of concern.

Stockouts would be greatly reduced if all district departments distributed supplies, without delay, to facilities each month. The budget must allocate adequate money for transportation. Not only in Pakistan, other countries also face this problem. For example, a USAID | DELIVER PROJECT assessment—*Uganda's Manafwa District: Contraceptive Logistics System Assessment and Action Plan: Covering the Last Mile to Ensure Contraceptive Availability*, 2008—in Uganda found, “One noteworthy challenge is the lack of a budget for transport and distribution. Contraceptive distribution is integrated with that of other products; sometimes contraceptives receive insufficient attention.” To ensure sustainability and to resolve the issue of contraceptive availability for the longer term, districts need to deliver contraceptives regularly to facilities/SDPs; it is imperative that sufficient allocations for this are included in the budget.

Briefly, to eliminate stockouts and undersupply at all levels, mainly focused on the facility/SDP level, a comprehensive and fully functional contraceptive requisitioning system is needed; as well as a distribution system that delivers contraceptives directly, without delay, to the SDPs.

References

Government of Pakistan. 2007. *Manual of Contraceptive Logistics*. Islamabad: Ministry of Population Welfare, Monitoring and Statistics Wing, Islamabad.

Mahmood A., J. Arshad, and M. Sadiq. 2012. *Situation Analysis of Health Facilities with Special Reference to Family Planning Services in Pakistan*. Islamabad: Population Council.

USAID | DELIVER PROJECT, Task Order 1. 2008. *Uganda's Manafwa District: Contraceptive Logistics System Assessment and Action Plan: Covering the Last Mile to Ensure Contraceptive Availability*. Kampala, Uganda: USAID | DELIVER PROJECT, Task Order 1.

USAID | DELIVER PROJECT. 2009. *Contraceptive Logistics Management System*. Report. USAID | DELIVER PROJECT in Nigeria.

USAID | DELIVER PROJECT, Task Order 4. 2012. *Provincial and District Supply Chain Management Situation Assessment*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 4.

Appendix A

Contraceptive Stock Availability at Facilities versus Supplies Provided at District Stores: September–October 2012

To analyze contraceptive availability, by method, at facilities and district stores, the stock position at facilities is compared to the contraceptive supplies¹. This information came by courier, through the USAID | DELIVER PROJECT, from the Karachi Central Warehouse (CWH), from September–October 2012. Facilities' stock positions were also compared with district stock positions, which district staff post in the electronic logistics management information system (LMIS).

Condoms: Data presented in table 8 show that condoms are not available at any Department of Health (DOH) facility in Sialkot and Loralai; the same position is noted in Abbottabad and Badin for lady health workers (LHWs). The courier record shows that condoms were supplied to DOH Sialkot and Loralai in the September–October 2012, but they were still at the district stores and were not distributed to the facilities. As reported by facility staff, distribution of supplies to facilities is primarily the facility staff's responsibility; they collect them at the district offices. Consequently, it can take time to notify facility staff that they need to collect their supplies.

Similarly, enough condom supplies from the CWH were made to the Punjab Rural Support Program (DPIU) Badin during September–October 2012, but these were not distributed to the LHWs in Badin. Contraceptive distribution to LHWs is through the respective Lady Health Supervisors (LHSs) at their facilities; therefore, supplies from the district to LHWs may take some time.

¹ A district-level analysis was not part of the *statement of work*. The country director from the USAID | DELIVER PROJECT asked that the analysis on the availability of contraceptives at the district stores be included and compared to the availability of contraceptives at the facility level. The USAID | DELIVER PROJECT provided the figures of contraceptive stocks for the district stores from their LMIS record and the courier delivery data for each district.

The LMIS shows that enough stock was available at the DPIU as of November 1, 2012, in Kallat and Loralai; but only 9 percent of LHWs in Kallat and 50 percent of LHWs in Loralai had condoms in their stock.

At DPIUs in Vehari, Layyah, and Nowshera, supplies were not distributed from September–October 2012, nor have any stocks in their district stores been reported through the LMIS. However, 30 percent of the LHWs in Vehari, 40 percent in Layyah, and 70 percent in Nowshera reported being stocked out of condoms during the day of the visit.

Overall, although condom stocks are available at the DPIU's district stores, not all LHWs had condoms available on the day of visit.

For condom availability at FWCs in Nowshera and Larkana, 50 percent of the FWCs were out of condoms, even though the supplies were available at their district stores; this was reported through the LMIS, as well as the courier record. See table 9.

No separate record is available for the People's Primary Healthcare Initiative (PPHI)/Rural Support Programmes Network (RSPN) for the courier and LMIS; therefore, an analysis is not provided.

Table 9. Availability of Condoms at SDPs Compared with Stock Availability at District Level (November 1, 2012) and Contraceptive Distribution Data (September–October 2012)

Condoms

District	Percentage of Facilities with Contraceptive Method				Stock Availability at District Stores (pieces) —USAID DELIVER PROJECT Courier Distribution			*Stock Availability at District Stores (pieces)—USAID DELIVER PROJECT-LMIS		
	DOH	PPHI/ PRSP	FWCs	LHWs	DOH	PWD	LHW	DOH	DPWO	DPIU/ LHW
Sialkot	0	20	100	70	6,000	0	33,000	...	149,300	...
Attock	88	NA	100	80	45,000	411,000	0	...	243,604	117,900
Vehari	67	0	100	70	0	18,000	0	...	104,398	...
Rahim Yar Khan	67	0	100	10	159,000	72,000	0	...	25,740	...
Layyah	33	100	100	60	0	0	0	94,038	88,800	...
Abbottabad	33	80	100	0	3,000	9,000	192,000	40,631	1,419	369,000
Nowshera	100	40	50	30	0	39,000	0	16,300	2,780	...
Mansehra	67	60	100	70	30,000	9,000	270,000	...	...	...
Badin	100	100	100	0	63,000	33,000	2,700,000	...	754,821	...
Benazirabad	100	NA	100	10	30,000	141,000	735,000	...	3,340	...
Larkana	100	80	50	20	0	90,000	642,000	...	29,661	...
Kallat	50	20	100	9	18,000	3,000	45,000	12,500	...	57,000
Loralai	0	60	100	50	3,000	6,000	0	...	...	89,000
Sudhnotti	75	NA	100	10	3,000	3,000	12,000	19,100	...	0
Bagh	75	NA	NA	40	0	18,000	0	...	...	3,000

*Data source: USAID | DELIVER PROJECT, Islamabad (NA = not applicable), (...) = information missing)

Progestin-only pills (POP): POP availability is weak at all facilities, in all the districts. None of the districts, except Sialkot and Attock, received POP supplies in September and October 2012.

In Layyah, LMIS data shows availability of enough stock at the DOH store, but no DOH facilities reported POP availability in their stocks on the day of visit.

For POP availability at FWCs, only Rahim Yar Khan and Kallat reported POP availability. Although the District Population Welfare Office (DPWO) LMIS reported POP stock availability in Attock, Vehari, Layyah, and Benazirabad, they were unavailable at FWCs. See table 10.

Table 10. Availability of POP at SDPs Compared to Stock Availability at District Store (November 1, 2012) and Contraceptive Distribution Data (September–October 2012)

Progestin-Only Pills

District	Percentage of Facilities with Contraceptive Method				Stock Availability at District Stores (pieces)— USAID DELIVER PROJECT Courier Distribution			*Stock Availability at District Stores (pieces)— USAID DELIVER PROJECT-LMIS		
	DOH	PPHI/ PRSP	FWCs	LHWs	DOH	PWD	DPIU/ LHW	DOH	DPWO	DPIU/ LHW
Sialkot	0	0	50	0	720	0	0	...	0	...
Attock	88	NA	50	0	720	2,880	0	...	1,727	...
Vehari	0	0	50	0	0	720	0	...	1,003	...
Rahim Yar Khan	67	20	100	0	0	720	0	...	590	...
Layyah	0	0	0	0	0	0	0	4,685	720	...
Abbottabad	33	60	0	0	0	0	0	713	22	...
Nowshera	33	20	50	0	0	0	0	0	0	...
Mansehra	0	20	0	20	0	720	0	...	...	...
Badin	0	20	0	0	0	0	0	...	48	...
Benazirabad	13	NA	50	0	0	720	0	...	325	...
Larkana	0	0	50	0	0	0	0	...	0	...
Kallat	50	40	100	9	0	0	0	0	...	...
Loralai	0	0	50	10	0	0	0	...	...	...
Sudhnotti	0	NA	0	0	0	0	0	0	...	...
Bagh	0	NA	NA	0	0	0	0	...	...	...

*Data source: USAID | DELIVER PROJECT, Islamabad; (NA = not applicable), (...) = information missing)

Combined oral contraceptives (COCs): COC availability in facilities is slightly better than for POP. All DOH facilities in Layyah, Abbottabad, Kallat, and Loralai are stocked out of COCs, although courier records show COC availability at the DOH district stores in Abbottabad, Kallat, and Loralai. The DOH Layyah did not receive supplies from September to October 2012.

Study analysis shows that in Kallat, the COC availability among LHWs is the worst; not one LHW reported availability on the day of visit. Only 20 percent of LHWs in Abbottabad, Benazirabad, and Sudhnotti, each; and 30 percent in Layyah, reported COC supplies in their stocks on the day of visit. However, couriers reported supplies provided in September and October 2012 to DPIUs. See table 11.

COCs were not available at any of the visited FWCs in Nowshera and Kallat, but their district offices had enough supplies, which were reported by courier and the LMIS.

Table 11. Availability of COCs at SDPs Compared to Stock Availability at District Stores (November 1, 2012) and Contraceptive Distribution Data (September–October 2012)

COC

District	Percentage of Facilities with Contraceptive Method				Stock Availability at District Stores (pieces)— USAID DELIVER PROJECT Courier Distribution			*Stock Availability at District Stores (pieces)— USAID DELIVER PROJECT-LMIS		
	DOH	PPHI/ PRSP	FWCs	LHWs	DOH	PWD	LHW	DOH	DPWO	DPIU/ LHW
Sialkot	33	60	100	50	7,200	0	78,480	...	10,600	...
Attock	88	NA	100	80	2,880	5,040	27,360	...	2,986	750
Vehari	33	60	100	90	2,880	10,080	0	...	4,520	...
Rahim Yar Khan	100	80	100	20	18,720	10,800	0	...	10,272	...
Layyah	0	80	100	30	0	720	9,360	0	4,245	...
Abbottabad	0	80	100	20	5,040	2,160	25,200	5,081	101	41,900
Nowshera	100	100	0	60	0	720	0	1,356	60	...
Mansehra	67	80	100	70	3,600	1,440	21,600	...	...	...
Badin	100	80	100	10	9,360	14,400	0	...	1,470	...
Benazirabad	88		100	20	5,040	3,600	72,000	...	0	...
Larkana	67	100	100	50	0	1,440	64,800	...	3,954	...
Kallat	0	20	0	0	1,440	7,200	2,880	1,000	...	7,480
Loralai	0	20	50	50	720	1,440	0	...	...	8,000
Sudhnotti	75	NA	100	20	0	1,440	72,000	72,240	...	0
Bagh	88	NA		60	0	1,440	0	...	...	10

*Data source: USAID | DELIVER PROJECT, Islamabad; (NA = not applicable), (...) = information missing)

Depo-medroxy progesterone acetate (DMPA or Depo-Provera): Table 12 shows that all the DOH district stores, except Layyah and Bagh, received DMPA supplies in September and October 2012; but health facilities in Abbottabad, Kallat, and Loralai did not report DMPA availability in their facilities.

For DMPA availability with the LHWs, all LHWs in Kallat and Loralai reported no stock, although supplies were available at their district stores. Although DPIUs in Abbottabad, Mansehra, Badin, Benazirabad, and Larkana were supplied, as reported by the courier; in September and October 2012, 90 percent of the LHWs in Badin and 60 percent in Larkana reported that they did not have DMPA supplies during the day of visit. See table 12.

Fifty percent of FWCs visited in Larkana and Loralai also reported stockouts of DMPA, even though stock was available at the Larkana district store.

Table 12. Availability of DMPA at SDPs, with Supplies Provided at District Stores, September through October 2012, and Stock Availability Reported by District Staff on LMIS as of November 1, 2012 at District Stores

DMPA

District	Percentage of Facilities with Contraceptive Method				Stock Availability at District Stores (pieces)—USAID DELIVER PROJECT Courier Distribution			*Stock Availability at District Stores (pieces)—USAID DELIVER PROJECT-LMIS		
	DOH	PPHI/PRSP	FWCs	LHWs	DOH	DPWO	DPIU/LHW	DOH	DPWO	DPIU/LHW
Sialkot	33	20	100	60	4,000	0	0	...	5,725	...
Attock	88	NA	100	80	3,600	1,200	0	...	608	5,261
Vehari	33	80	100	90	400	800	0	...	455	...
Rahim Yar Khan	100	80	100	50	6,800	3,600	0	...	3,639	...
Layyah	33	60	100	70	0	0	0	13	2,500	...
Abbottabad	0	80	100	20	2,800	2,800	1,600	3,377	2,174	21,440
Nowshera	100	60	100	20	400	3,200	0	680	1,450	...
Mansehra	67	60	100	30	3,200	3,200	6,800	...	...	...
Badin	100	100	100	10	4,400	2,000	800	...	1,182	...
Benazirabad	88	NA	100	30	2,400	3,600	73,600	...	200	...
Larkana	100	80	50	40	1,600	2,400	20,000	...	2,382	...
Kallat	0	0	0	0	400	400	0	1,000	...	1,200
Loralai	0	20	50	0	400	1,200	0	...	...	300
Sudhnotti	100	NA	100	40	4,000	800	4,000	0	...	0
Bagh	100	NA	NA	30	0	2,000	0	...	...	0

*Data source: USAID | DELIVER PROJECT, Islamabad; (NA = not applicable), (...) = information missing)

Intrauterine device (IUD) TCU 380A: LHWs are not trained to provide IUDs; therefore, they are excluded in this analysis. Table 13 shows that IUDs are available in all DOH facilities in Rahim Yar Khan, Nowshera, and Badin. Courier delivery data shows that stocks were delivered to district DOH stores at Sialkot, Attock, and Vehari; but only one-third of health facilities in Sialkot, two-thirds in Vehari, and three-fourths in Attock, reported IUD 380A stocks on the day of visit. Only one-third of health facilities in Layyah and Abbottabad reported IUD stock on the day of visit, although LMIS data shows stock available at the district stores. See table 13.

Fifty percent of FWCs visited in Sialkot, Abbottabad, Badin, Larkana, and Sudhnotti showed IUD availability on the day of the visit.

Table 13. Availability of TCU 380A at SDPs compared with stock availability at district stores (01 November 2012) and contraceptive distribution data (September–October 2012)

IUD TCU 380A

District	Percentage of Facilities with Contraceptive Method			Stock Availability at District Stores (pieces)—USAID DELIVER PROJECT Courier Distribution		*Stock Availability at District Stores (pieces)—USAID DELIVER PROJECT-LMIS	
	DOH	PPHI/ PRSP	FWCs	DOH	PWD	DOH	DPWO
Sialkot	33	0	50	3300	2400	...	125
Attock	75	NA	100	600	1500	...	1,210
Vehari	67	60	100	600	2100	...	1,262
Rahim Yar Khan	100	100	100	2400	2400	...	530
Layyah	33	100	100	0	3,000	1,490	2,975
Abbottabad	33	80	50	0	0	2,247	0
Nowshera	100	100	100	0	0	538	75
Mansehra	33	100	100	0	0	...	...
Badin	100	60	50	0	0	...	0
Benazirabad	88	NA	100	0	0	...	4,082
Larkana	67	80	50	0	0	...	44
Kallat	0	20	100	0	0	155	...
Loralai	0	20	100	0	0	...	...
Sudhnotti	50	NA	50	0	0	0	...
Bagh	88	NA	NA	0	0	...	...

*Data source: USAID | DELIVER PROJECT, Islamabad; (NA = not applicable), (... = information missing)

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