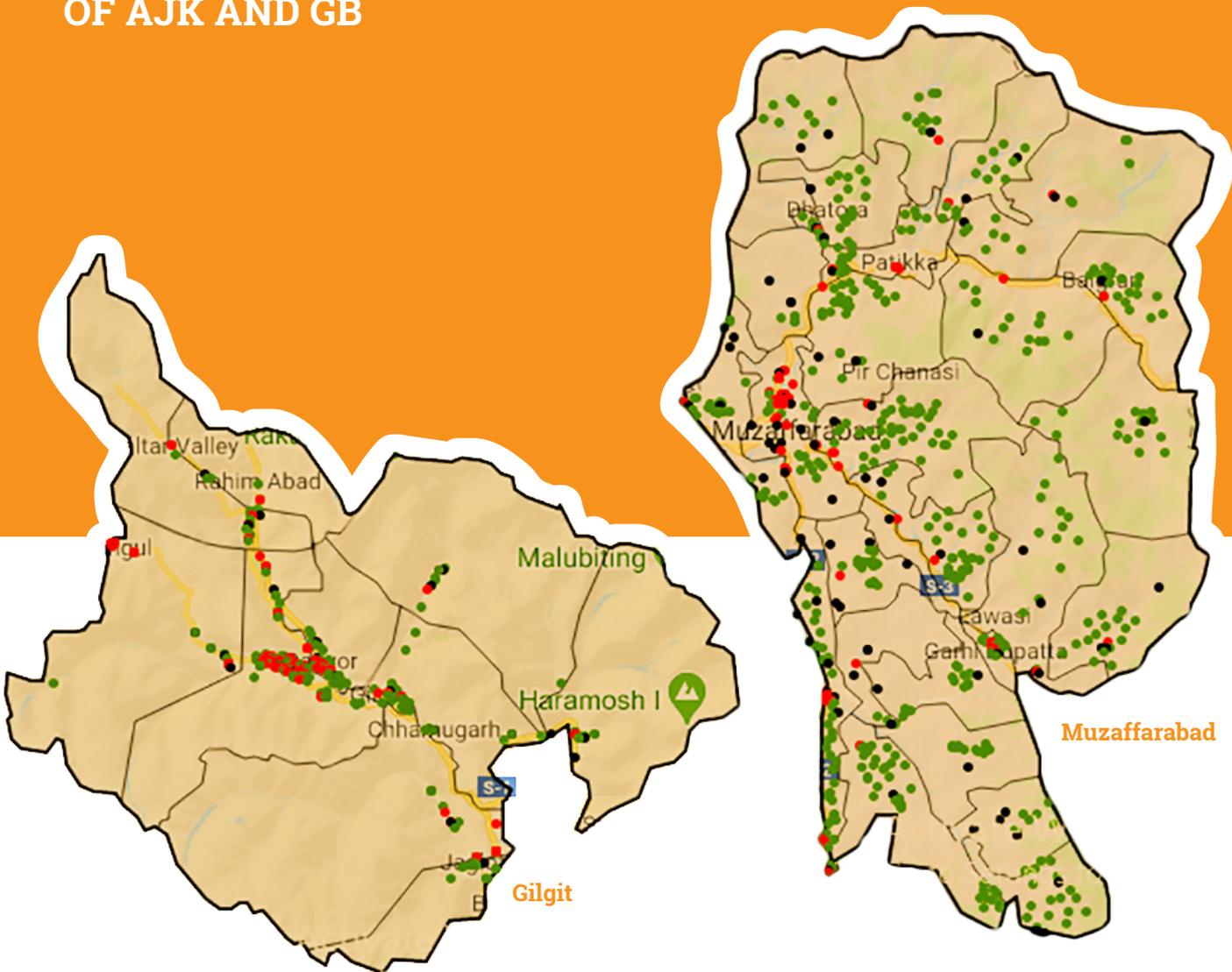


MAPPING OF PUBLIC AND PRIVATE SECTOR FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

IN THE SELECTED DISTRICTS OF AJK AND GB



- PRIVATE FACILITY
- PUBLIC FACILITY
- LHW

2020

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ACKNOWLEDGMENTS

We would like to acknowledge the United Nations Population Fund (UNFPA) Country office Pakistan for commissioning this study titled "Mapping of Public and Private Sector for Family Planning services in the selected districts of AJK and GB". We would also like to thank the Foreign, Commonwealth & Development Office, UK (FCDO) for its generous financial support.

The team would like to thank Ms. Lina Mahmoud Mousa, Country Representative, UNFPA Country office Pakistan, for her dynamic leadership and supervision throughout the study process.

A very special appreciation is reserved for Dr. Yilma Melkamu, International Advisor, Family Planning, UNFPA Country office Pakistan, for his continued support and comprehensive guidance throughout the process. Esteemed colleagues from UNFPA including, Dr. Bakhtior Kadirov, Deputy Representative, Dr. Jamil Ahmed, Program Specialist, Dr. Naila Yasmin, and Mr. Ghulam Abbas, have our thanks and appreciation for their guidance and involvement during the Mapping exercise and finalization of this report.

Dr. Anjum Javed, Director, Health Planning System Strengthening & Information Analysis Unit (HPSIU), Ministry of National Health Services, Regulations and Coordination took the lead to facilitate the coordination between population and health departments in Gilgit and Muzaffarabad districts for mapping the public and private sector with regard to Family Planning, Maternal Neonatal and Child Health Services. Finally, this report has greatly benefitted from the technical inputs shared by Dr. Ahsan from the HPSIU unit.

The scope of the study, covering all types of health facilities including district hospitals in public sector, pharmacies and homeopaths in private sector, required involvement of a wide range of stakeholders. It would not have been possible to accomplish it without the leadership and support extended by Population Welfare and Health Departments of Gilgit-Baltistan and Azad Jammu and Kashmir. We are thankful to these departments for working with us shoulder to shoulder from the very start till the end of this project. We are also grateful for the cooperation by private sector including clinics, hospitals and pharmacies for sharing the needed information. Our special thanks to lady health workers and their supervisors who coordinated to ensure visits to all health facilities despite their prior engagements.

We are obliged to the whole project team who worked hard, even during the harsh winters of the north to collect data within the specified time period. The team was cognizant of the challenges and handled them well. Their technical capabilities proved vital in translating the quality data into actionable dashboards for managers and policy makers. We are also very grateful to our Technical Advisory Group members for their insight in finalizing the survey tools.

This study was completed by Dr Khurram Shahzad (Consultant), Dr M. Asif Wazir and Dr. Yilma Melkamu from UNFPA Country Office Pakistan. For any correspondence or queries regarding the report please contact Dr. Asif Wazir at wazir@unfpa.org.

MESSAGE FROM THE GOVERNMENT OFFICIALS

Pakistan being the sixth most populous country in the world with a population of 207.8 Million growing at an inter-censual growth rate of 2.4 percent per annum (between 1998-2017), has prioritized family planning and reproductive health (FP & RH) as most important area under CCI Recommendations dated November 19, 2018. At current growth rate, the population of the country is projected to increase to 285 million by the year 2030. Such a high level of population growth is unsustainable and has already eaten into the modest gains made in terms of socio-economic development. The rapidly growing population has negative impact on climate change, environment degradation, deforestation and above all the decline in water availability per capita putting Pakistan in water stress situation. It will exacerbate food security and threaten the country's sustainable development prospects. Therefore, Pakistan is in dire need of harnessing all resources together and give their maximum access to married couples to responsibly decide the size and spacing of their family ensuring a balance (tawazun) between their resources and family size. Department of Population Welfare and Department of Health are encouraged to make use of the mapping exercise to strengthen health systems to meet urgent reproductive health needs of the people. The findings identify vast opportunity for private sector investment in enhancing reproductive health services complementing public sector efforts.

This Mapping report was coordinated by the Health Planning System Strengthening & Information Analysis Unit (HPSIU), Ministry of National Health Services, Regulations and Coordination, Govt. of Pakistan, with the support of United Nations Population Fund (UNFPA). It also reviewed status of existing facilities being operated by different partners to highlight their role in service delivery in the area of FP & RH

We would especially like to thank the staff involved from both Population Welfare Departments and Department of Health of Muzaffarabad and Gilgit for their support in collection of essential data. Similarly, District Administration of both Districts (Muzaffarabad AJK & Gilgit GB) equally deserve our appreciation for their prompt facilitation.

It is hoped that this report will be useful for program managers, researchers, policymakers and will act as springboard for evidence based planning and policies for integrated healthcare system included reproductive health and family planning under the ambit of Universal Health Coverage in AJK and GB regions.

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FOREWORD

The “Mapping of Public and Private Sector for Family Planning services in the selected districts of Azad Jammu & Kashmir and Gilgit Baltistan” reflects the United Nations Population Fund (UNFPA) commitments to support efforts by Pakistan in evidence generation to strengthen integration of reproductive health and family planning into the development strategies and plans. Since 1969, UNFPA has been actively working in Pakistan with the Government and both national and provincial counterparts to advance women’s and young people’s ability to exercise their sexual and reproductive health rights and expand the possibilities for them to lead healthy and productive lives.

The Action Plan for CCI Recommendations directed to conduct a mapping of all general registered private sector practitioners and hospitals that provide FP services in the country to help enhance the role of the private sector in FP services delivery. In response to this important recommendation, UNFPA in collaboration with Ministry of National Health Services, Regulations and Coordination conducted a pilot mapping study in two largest districts in the two regions including Muzaffarabad in Azad Jammu and Kashmir (AJK) and Gilgit in Gilgit-Baltistan (GB).

The private sector plays a critical role in family planning (FP) and can contribute substantively to a total market approach to providing contraceptive services. Information on current sources of modern contraceptive methods is critical for planning and programme implementation. However, there are no comprehensive, spatially referenced mapping of public and private health facilities that provide overall maternal, child health and family planning services in Pakistan. This is the first exercise that maps out public and private sector facilities to enhance district level coordination, minimize duplication and be a part of overall referral system.

The findings from the study show that there is a need to boost the provision of modern contraception through the private sector, particularly pharmacies and private hospitals. Achieving family planning goals largely depends on greater partnership and cooperation with the private sector and improvement of decisions around funding streams of countries with large populations and high unmet need such as Pakistan. This mapping exercise is an initial step towards developing an integrated healthcare system including reproductive health and family planning under the ambit of Universal Health Coverage in AJK and GB. Departments are encouraged to make use of the mapping exercise to strengthen health systems to meet urgent reproductive health needs of the people. The findings identify vast opportunity for private sector investment in enhancing reproductive health services complementing public sector efforts.

The time is favorable now for taking forward the recommendations presented in this report for the effective engagement of private sector to meet and complement the family planning goals and objectives. This could make availability of contraceptives equitable by reaching underserved and vulnerable segments of the population and meeting their family planning needs.

I offer my sincere appreciation and gratitude to the officials of the Health and Population Welfare departments of the AJK, and GB as well as the Ministry of National Health Services, Regulations and Coordination, for their valuable support and facilitation during the process. Finally, I also greatly appreciate FCDO for their generous support to implement this important study.

Shukriya

Ms. Lina Mahmoud Mousa

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EXECUTIVE SUMMARY

A high population growth rate and stagnant CPR have highlighted the struggles faced by Pakistan's population welfare and family planning programs. Unlike other areas in health, where private sector has stepped up to fill the gaps in service provision, the private sector's role in family planning services has remained limited. This has compounded the problems, as most Pakistanis are relying on private sector for their health needs. It is very common for people even from developed urban areas to have difficulty in accessing quality FP services; reflected through the most recent evidence of high unmet need observed in the Pakistan DHS 2017-18.

Under the ambit of Council of Common Interests, Govt. of Pakistan (CCIs) recommendation, it was proposed to conduct the mapping of all general registered private practitioners to provide FP counselling, information, and services to male & female clients in the provinces and ICT including AJK and GB. UNFPA planned to focus on the capital districts of AJK and GB, while mapping in ICT was being conducted under the auspices of the Ministry of National Health Services, Regulations & Coordination.

This mapping in AJK and GB aimed to cover all public and private facilities to enumerate the type of FP services and providers along with their geographical location. The project team used structured questionnaire to glean information from more than 1,200 facilities from both districts, including BHUs, RHCs, clinics, pharmacies, nursing homes, in-patient hospitals, Lady Health Workers and Community Midwives. Data were managed through online web-based system, producing digital web-based maps and dashboards as an output.

Even with ubiquitous provision of FP related counseling in public sector, only some facilities went beyond providing more than just counseling services. The inability of facilities to provide services was evident through their contraceptive availability, which was generally very low. Out of all the various types of public sector facilities in Muzaffarabad only small proportion of BHUs (15%), CMWs birthing and FP stations (23%), and dispensaries (40%) reported having at least three contraceptive products, the others reporting 0% for at least three methods. For Gilgit, dispensaries (8%), FWCs (22%) and public hospitals (29%) reported at least three methods being available. Only 1% and 5% of LHWs in Muzaffarabad and Gilgit respectively, reported having one or more than one contraceptive method available. The overall situation for MNCH services availability was relatively better compared to FP services, highlighting the need to link these services through policy and legislation to ensure wider access to FP services.

The overall performance for both public and private sector was far below optimal. Moreover, the private sector was mainly limited to densely populated areas. Both sectors did not utilize their full potential of FP counseling and services provision. Scaling up services would be an input towards long term sustained improvements in CPR but achieving 100% service provision from current public and private set up is critical to ensuring short term gains. The population planning must be dealt as an emergency, with all stakeholders playing their due role.

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LIST OF ACRONYMS

AJK	Azad Jammu and Kashmir
ANC	Antenatal Care
BHU	Basic Health Unit
CD	Civil Dispensaries
CMW	Community Midwives
COC	Combined Oral Pill
CPR	Contraceptive Prevalence Rate
DHQ	District Headquarter
DMPA	Depo-Medroxyprogesterone Acetate
DOH	Department of Health
ECP	Emergency Contraceptive Pill
FAP	First Aid Point
FP	Family Planning
FPAP	Family Planning Association of Pakistan
FWC	Family Welfare Centre
GB	Gilgit Baltistan
GIS	Geographic Information System
IMR	Infant Mortality Rate
IUCD	Intrauterine contraceptive Device
LAM	Lactational Amenorrhea
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMIS	Logistics Management Information Systems
MCH	Mother and Child Health Centre
MIS	Management Information System
NGO	Non-Government Organization
PBS	Pakistan Bureau of Statistics
PDHS	Pakistan Demographic & Health Survey
POP	Progestogen Only Pill
PWD	Population Welfare Department
RHC	Rural Health Centre
RHSA	Reproductive Health Service Centre A
THQ	Tehsil Headquarter
UMR	Under five Mortality Rate

**MAPPING OF PUBLIC AND
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HEALTH SERVICES**

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OF AJK AND GB**

Introduction





Pakistan has one of the highest fertility rates in South Asia, second only to Afghanistan. The fertility rate has only shown meagre decline from 3.8 births per women in 2012-13 (Pakistan Demographic & Health Survey, 2012) to 3.6 in 2017-18 (Pakistan Demographic & Health Survey, 2017). In comparison, other regional countries like India, Bangladesh, Nepal and Sri Lanka have reported a Total Fertility Rate (TFR) of 2 to 2.3 births per women (World Bank Open Data, 2017).

As a result of high fertility for the previous few decades, Pakistan ranks among countries having relatively younger population; a total of 38% population is younger than 15 years (Pakistan Demographic & Health Survey, 2017). While this poses a challenge for education, health and employment requirements, at the same time, if tapped appropriately, is a huge opportunity in terms of improved labor market and human capital and resultant economic growth.

The high fertility, in addition to its core impact on population growth, is strongly linked to maternal and child health as it exposes the mother to lifetime risks related to pregnancy and childbirth and also influences health of new-born and infants through multiple factors. Countries having uncontrolled population are likely to face challenges in expanding the access and quality of services. Pakistan's progress in family planning indicators presents an adverse picture. Contraceptive Prevalence Rate remained unchanged; 34.2% (compared to 35.4 in 2012-13); for modern

INTRODUCTION

methods it is 25% (compared to 26% in 2012-13). The situation is likely to counterpoise improvements in child survival, immunization and antenatal services observed in PDHS 207-18. Pakistan lags far behind other regional countries in terms of CPR; India and Bangladesh are doing much better as their CPR (for modern methods) is close to 50%.

Use of Modern Methods of Contraception in Regional Countries

Percent using contraception among women aged 15-49 who are married or in a union

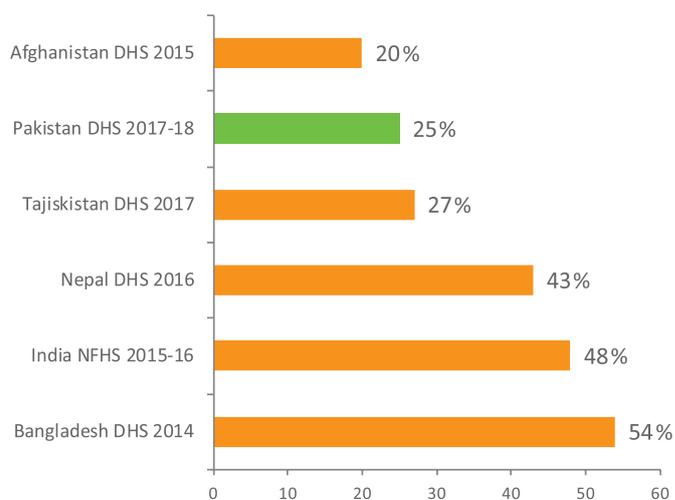


Figure 1. COMPARISON OF REGIONAL COUNTRIES IN TERMS OF CPR

The contraceptive method mix has not changed much from PDHS 2012-13 to PDHS 2017-18. The use of modern method has rather declined by 1%. There has been no or minimal change for almost all methods (Figure 2).

Almost half (52%) of married women aged 15-49 in Pakistan have a demand for family planning; 19% for spacing and 33% for limiting births. Out of the 52% having demand, only 34% are using contraceptives and

remaining (17%) have unmet need. Thus, almost 66% of the currently married women aged 15-49 have their demand for family planning satisfied. The unmet need for FP is the highest in younger age groups; almost 20%

in 25-29 & 30-34 year age brackets. It is moderately high in 15-19 & 20-24 year age groups (18%) and lowest in 40-44 & 45-49 year age groups (11%).

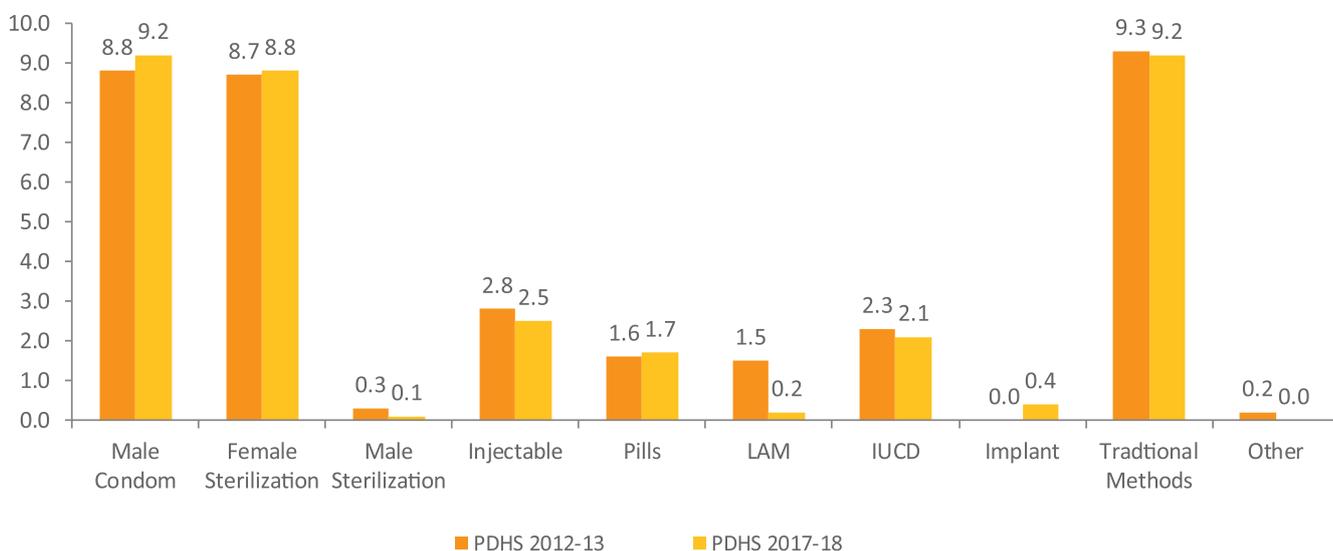


Figure 2. COMPARISON OF METHOD MIX (PERCENT OF CPR BY METHOD) BETWEEN PDHS 2012-13 AND PDHS 2017-18

Use of long-term methods such as IUCD and implants is very low in Pakistan compared to short term methods. Among current users of contraceptives, condom use (27%) is most common; followed by traditional methods (27%) and female sterilization (26%); while proportional contribution by pills (5%), IUCDs (6%) and Implants (1%) is very low (Figure 2). Pakistan needs to move towards more modern and long-term methods for effective birth spacing and planning. A recent analysis of method mix of 123 low and middle income countries shows that out of all the current users, the use of pills, injectable and IUCDs was 22.3%, 16.7% and 12.5% respectively (Ross et al., 2015); which is quite high compared to Pakistan. Conversely, the use of male condoms is 27% in Pakistan compared to 11.1% reported on an average for other countries (Ross et al., 2015).

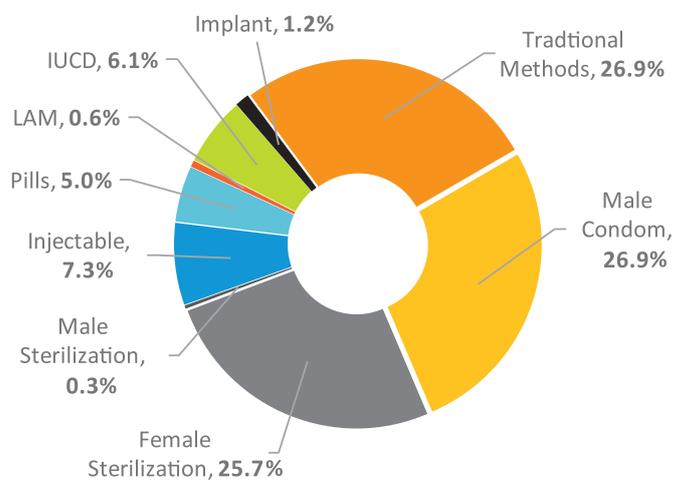


Figure 3. CONTRACEPTIVE METHOD MIX; PROPORTION OF METHOD TYPE USED FOR ALL THE CURRENT USERS AS PER PDHS 2017-18

The private sector involvement in FP has remained a challenge in Pakistan. The growth of private sector fills the healthcare services gaps. However, the flip side of the coin is that the growth is rampant, unregulated and most of the times is expensive and of low quality (Shaikh, 2015). The private sector contribution in terms of service delivery is around 70% of the total population served in Pakistan (Akbari et al., 2009). The proportion of those seeking care for diarrhea was reported to be as high as 73% from private sector; and only 17% cases were catered by public sector (BHUs and RHCs contributing only 5%) (Pakistan Social and Living Standards Measurement Survey, 2014). The situation, however, is different for FP service provision; with only 43% of women citing private sector as the source of contraceptives. The share of the private sector in GB was highest (even from the national average) around 48%. Whereas, around 30% of the total modern contraception methods were availed from the private sector in AJK (Pakistan Demographic & Health Survey, 2017).

The lower contribution in FP services by private sector compared to services for general ailments, shows the lack of private sector involvement due to various factors. There are huge missed opportunities of counselling and uptake of FP through private sector; from where masses are seeking healthcare.

Regarding antenatal care (ANC), 86% of women who gave birth in the 5 years preceding the survey received ANC from a skilled provider, this a 13% increase from 2012-13 (see Figure 4). However, proportion of women having at least four ANC visits was much lower (51%).

Trends in Antenatal Care Coverage

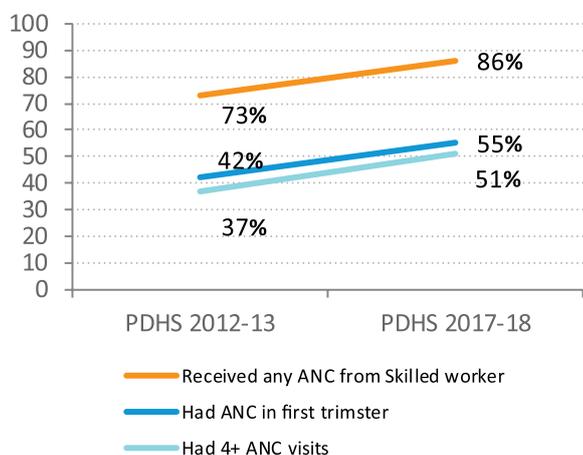


Figure 4. TRENDS IN ANTENATAL CARE COVERAGE

The proportion of women dwelling in urban areas (94%) were significantly more likely to receive ANC than those in rural (82%) areas. Similarly, in 2017-18, proportion of urban women receiving ANC (83.7%) was more than that of rural women (59.6%). Younger women (aged 15-35) were more likely (85% to 88%) to use ANC services compared to older women aged 35 to 49 (78%).

Women in highest quintiles (98%) and the highest education category (99%) were significantly more likely to receive ANC services from a skilled provider, compared to women in lowest quintile (67%) and with no education (76%). The difference highlights the challenges faced by women in disadvantaged communities and emphasizes the importance of focusing on development from a holistic perspective.

Another important parameter of ANC services are their quality, assessed by various studies. Despite increasing coverage, the quality of services remains relatively poor; as evidenced by a large scale survey in Sindh reporting only one third of women (out of total who received some antenatal care) receiving at least three elements of care (out of total seven) (Agha & Williams, 2016). The quality of services from the perspective of assessment, counseling and treatment was reported to be poor in a study conducted in Punjab (Majrooh et al., 2014).

Trends in Place of Birth

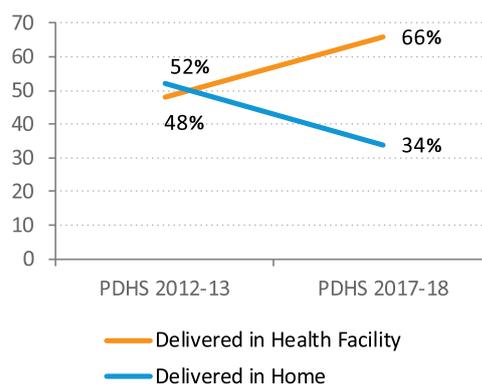


Figure 5. TRENDS IN PLACE OF BIRTH DELIVERIES

Quality of care was identified to be a significant and strong predictor of likelihood of institutional delivery in Sindh. In addition, a dose response relationship existed between number of elements of quality and the resulting institutional delivery; with one element

of quality increasing odds of institutional delivery by 1.7 times, three elements by 3.8 times and all seven elements by 10.6 times (Agha & Williams, 2016).

There has been great improvement over time in the percentage of deliveries at health facilities; institutional deliveries increased from 13% to 66% between 1990-91 and 2017-18. In the last 5 years, between 2012-13 and 2017-18 the proportion has increased by 18 percentage points from 48% to 66% (see Figure 5).

Provision of post-partum family planning counseling remained low (11%), for women who had given birth five year prior to PDHS 2017-18. The likelihood, however, increased with education and wealth quintiles, e.g. women with higher education were most likely to be counseled (16%) compared to women with no education (8%). Thus, the potential expansion in access to FP services through increase in ANC services has not been achieved in Pakistan (Pakistan Demographic & Health Survey, 2012).

OVERVIEW OF MUZAFFARABAD

GEO-DEMOGRAPHY

Muzaffarabad is the capital and the largest district of Azad Jammu & Kashmir (AJK). Geographically it is located on the banks of the Jhelum and the Neelum rivers. It has a very hilly terrain and is bounded by Punjab in the west and to Kupwara and Baramulla districts of the Kashmir in the east. To the north is Neelum District; the fall on the northeast of the district and Bagh District forms the southern boundary (Figure 6). The total area of the district is 1,642 square kilometers. The total population of Muzaffarabad is almost 650 thousand as per 2017 census; which is almost 16% of the total population of AJK.

CHILD HEALTH

The infant and under five mortality rates (Figure 7) in AJK are 47 and 53 per thousand live births respectively; which are close to that reported for Pakistan (62).

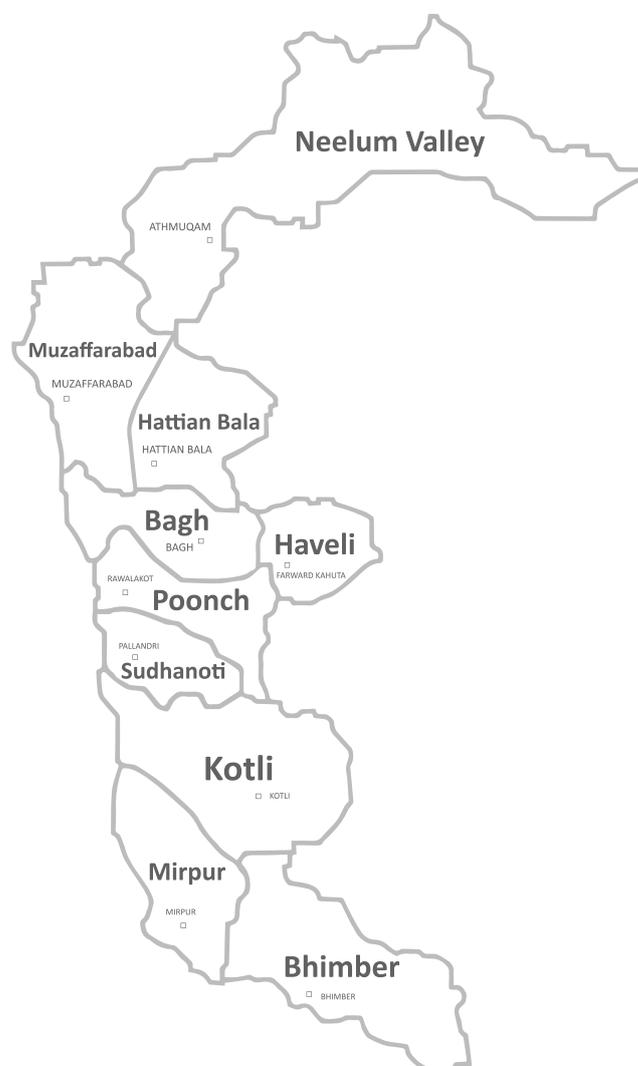


Figure 6. AZAD JAMMU & KASHMIR MAP

Infant & Under five Mortality Rates Pakistan and AJK

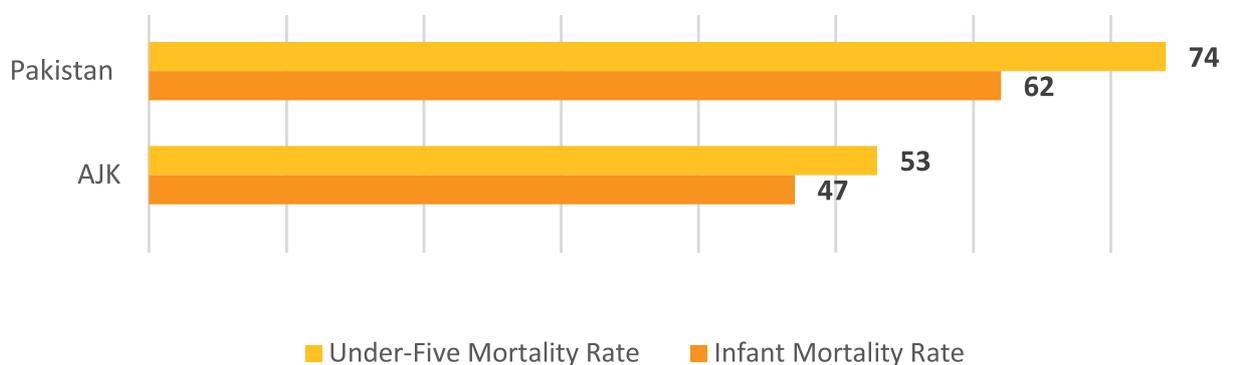


Figure 7. CHILD MORTALITY IN PAKISTAN AND AJK, SOURCE: PDHS 2017-18

HEALTH WORKFORCE

The doctor population ratio is one doctor per 5,507 individuals, which is well below the national figure of one doctor per 1,000 population. Similarly, nurse to population ratio is even poorer (1:12,102). Number of beds per population (1:1,690) are also lower compared to national criteria (1:1,000) (District Health Profile: Muzaffarabad, 2015).

REPRODUCTIVE HEALTH AND FAMILY PLANNING

The contraceptive prevalence rate reported for Muzaffarabad is 31% (District Health Profile: Muzaffarabad, 2015) which is a slightly higher from the CPR of 27.6% reported for AJK. Unmet need is quite high in AJK; reported to be 22% compared to the national figure of 17% (Pakistan Demographic & Health Survey, 2017). The contraceptive method mix is shown in Figure 8; which is quite similar to that of Pakistan in general.

Type of contraceptive method used among current users in AJK

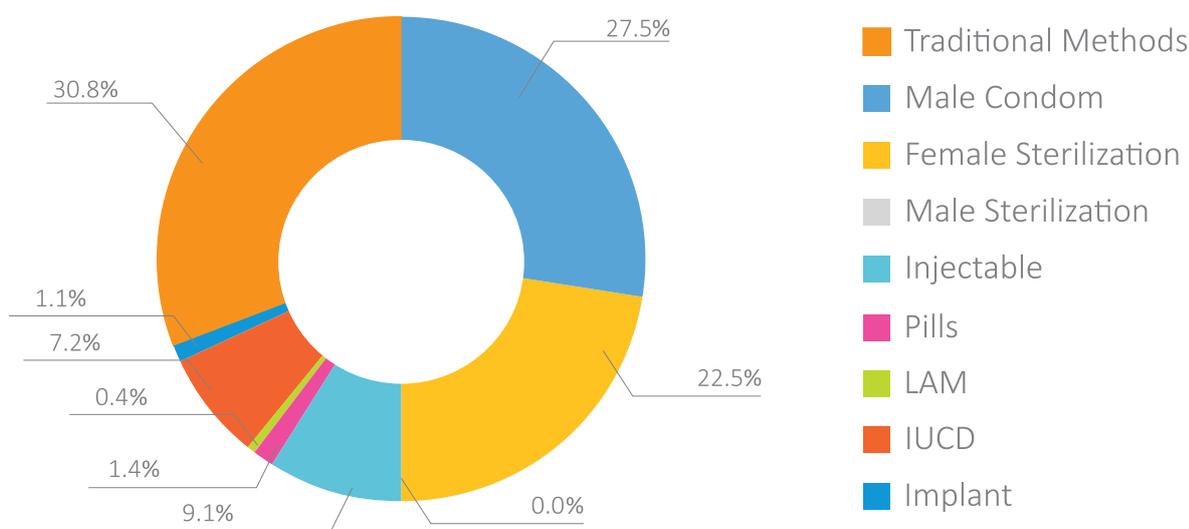


Figure 8. CONTRACEPTIVE METHOD MIX IN AJK, SOURCE: PDHS 2017-18

OVERVIEW OF GILGIT

GEO-DEMOGRAPHY

Gilgit District is one of the largest districts of the Gilgit–Baltistan territory in northern Pakistan. It was formed in 1970 when Gilgit–Baltistan was federally administered as the “Northern Areas”. It is bounded by the Wakhan Corridor (Afghanistan) to the north; Xinjiang (China) to the northeast and east; Skardu, Astore and Diامر to the south; and Ghizer District to the west (Figure 9).

The town of Gilgit is the capital of Gilgit District. The total population of Gilgit district is estimated to be almost 243 thousand as per projections from the 1998 census¹. Thus, Gilgit constitutes almost 19% of the total 1.3 million population of Gilgit-Baltistan.



Figure 9. GILGIT BALTISTAN MAP

CHILD HEALTH

Infant mortality rate (IMR) in Gilgit District is reported to be 45.9 per 1,000 live births; and under five mortality rate (UMR) is 54 per 1,000 live births (Multiple Indicator Cluster Survey: Gilgit Baltistan, 2017). Both IMR and UMR are lower in Gilgit District compared to overall figures for GB and Pakistan in general (Pakistan Demographic & Health Survey, 2017).

Infant & Under five Mortality Rates in Pakistan, GB and Gilgit District

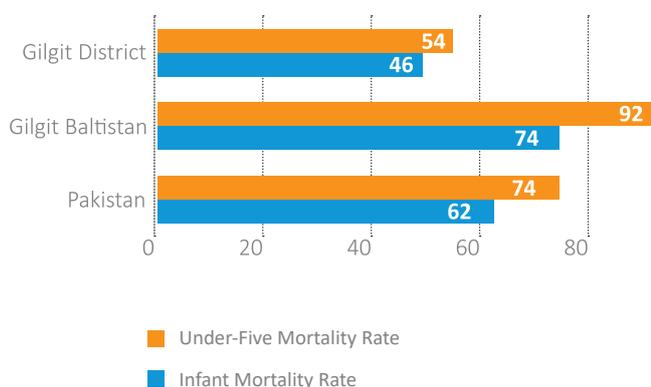


Figure 10. CHILD MORTALITY IN Pakistan, GB and Gilgit District
Source: PDHS 2017-18 and GB MICS 2016-17

REPRODUCTIVE HEALTH AND FAMILY PLANNING

The contraceptive prevalence rate in Gilgit is reported to be 46.5% (Multiple Indicator Cluster Survey: Gilgit Baltistan, 2017) ; which is better compared to the national statistics. The unmet need, however, is relatively higher (21.5%) compared to the national figure (17%) (Pakistan Demographic & Health Survey, 2017). Gilgit Baltistan² also had a unique method mix compared to remaining Pakistan. The use of injectable and IUCD are quite higher in GB compared to national statistics (Pakistan Demographic & Health Survey, 2017).

Type of contraceptive method used among current users in Gilgit Baltistan

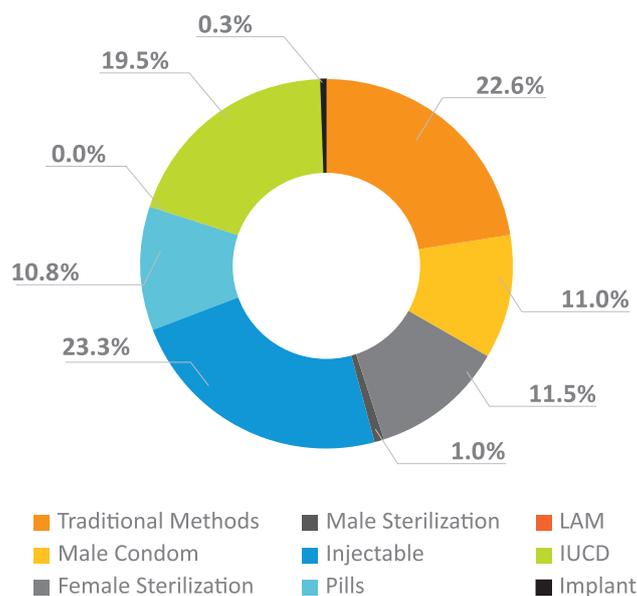


Figure 11-A. CONTRACEPTIVE METHOD MIX IN GB,
SOURCE: PDHS 2017-18

¹ Statistics from 2017 census yet not available for Gilgit
² No data for Gilgit specific method mix was available

WHY TO TAP THE PRIVATE SECTOR FOR DELIVERING FAMILY PLANNING SERVICES?

The private sector plays a critical role in family planning (FP) and can contribute to a total market approach³ to providing contraceptives. Information on current sources of modern contraceptive methods is critical for planning and programme implementation. The latest Pakistan Demographic & Health Survey 2017-18 captured the source of modern contraceptive methods (all methods) in AJK and GB. Government hospitals have the highest share in both AJK and GB (around 32%). The share of the private sector in GB was highest (even from the national average) around 48%. Whereas about around 30% of the total modern contraception methods were availed from the private sector in AJK.

PILLS: The main source of injectable is the public sector (81% in AJK and 55% in GB), primarily the government hospitals (21%) and other public sector including LHWs (58%). About 20% all injectable users in AJK and 45% in GB used the private sector as their source.

FEMALE STERILIZATION: The public sector has a large network to provide female sterilization in AJK (53%) and GB (60%); also, the private sector has improved service offerings in AJK (47%) and GB (40%).

IUDS: Almost two-thirds of all users of IUDs obtained their method from a public sector source (63% in AJK and 60% in GB). The private sector, as a source, remained at 37% in AJK and 40% in GB) in PDHS 2017-18.

INJECTABLE: The public sector provides the lion share to provided pills to 89% in AJK and 82% in GB of the method users. Government hospital and other public sector including LHWs are the main source of pills for users. The private sector has very limited role, stood at 11% in AJK and 18% in GB.

MALE CONDOMS: The private sector has always been in front as a source provider of this method. An enhanced role is evident in AJK (61%) and GB (73%).

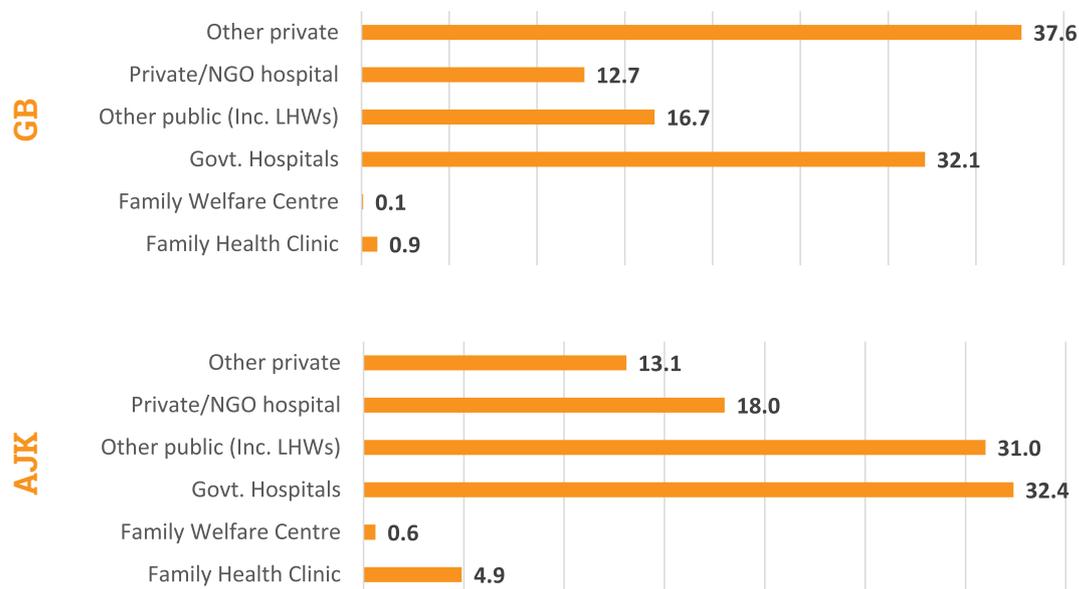


Figure 11-B: PERCENT DISTRIBUTION OF USERS OF MODERN CONTRACEPTIVE METHODS AGE 15-49 BY THE MOST RECENT SOURCE OF THE METHOD, AJK & GB. SOURCE: PDHS 2017-18

³ A total market approach is a lens or process that can be applied to develop strategies that increase access to priority health products in a sustainable manner. This approach helps grow the market for health products by better targeting free or subsidized products, reducing inefficiencies and overlaps, and creating room for the private sector to increase its provision of health commodities.

The 2017-18 PDHS results show that 76% of women in GB and 89% of women in AJK who gave birth in the 5 years preceding the survey received antenatal care from a skilled provider at least once for their last birth. Doctors were the major service providers. Survey data show that both in GB and AJK, 62% of the births in the 5 years preceding the survey were delivered in a health facility. Assistance from a skilled birth attendant during delivery is considered a key factor in reducing maternal and neonatal mortality. In GB, 64% of deliveries are conducted by a skilled provider. The proportion of births

assisted by skilled birth attendants in AJK stood also at 64%.

The postnatal period is important for mothers, as evidence has shown that they are more likely to develop life-threatening complications such as postpartum haemorrhage during this period. The 2017-18 PDHS shows that 40% in GB and 58% of women age 15-49 who gave birth in the 2 years preceding the survey reported having a postnatal check in the first 2 days after the birth.

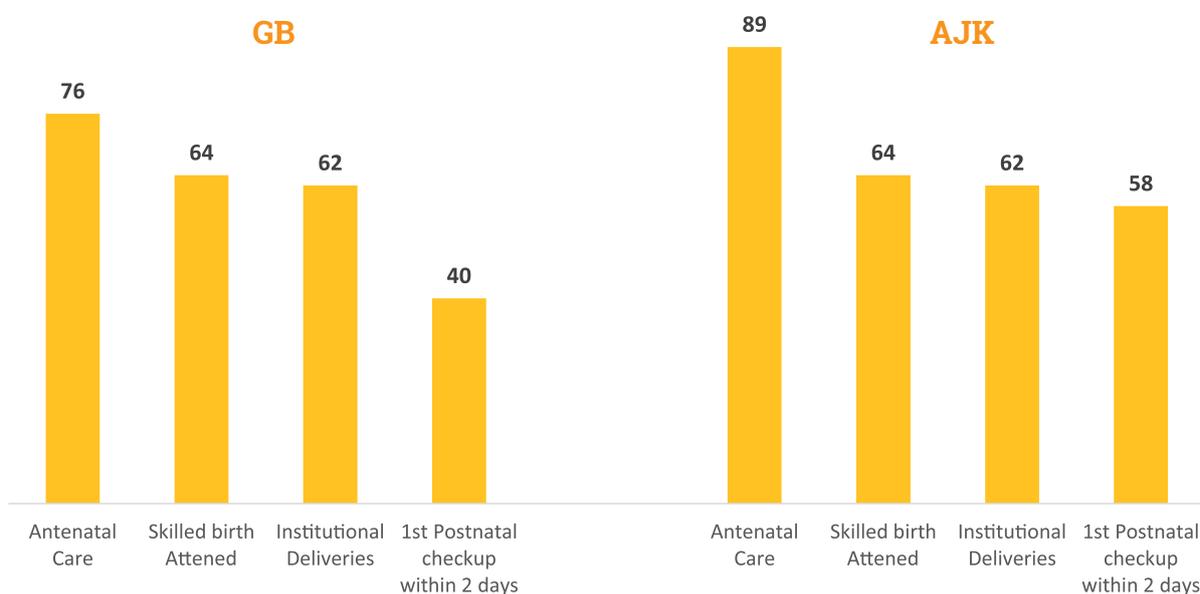


Figure 11-C: PERCENTAGE OF DISTRIBUTION OF WOMEN USING SPECIFIC REPRODUCTIVE HEALTH COMPONENTS IN GB AND AJK
SOURCE: PDHS 2017-18

2

OBJECTIVES

- 1 The mapping aimed to conduct an enumeration exercise that enlists the types of FP services and provider's geographic location for all public- private health facilities and major pharmacies in the two largest districts of AJK (Muzaffarabad) and Gilgit-Baltistan (Gilgit) regions that provide the family planning counselling, information, services, referrals, and contraceptive methods or distribute them free of charge. The study intended to cover LHWs/LHVs, private/NGOs hospitals, private doctors, and health facilities in the mapping exercise.
- 2 To Identify the bottlenecks and propose interventions to enhance the role of private sector in delivering the family planning services.

3

METHODOLOGY

DESIGN

This assessment was essentially a census of all the health facilities providing FP services in Muzaffarabad and Gilgit. All public and private sector health facilities were visited. The study intended to cover various types of private sector health facilities including informal private healthcare providers (hakeems, homeopaths, etc.). The overall goal was to not only map the current FP services provision but also identify potential for future engagement of private sector for expansion of services and improvements in CPR.

The project team initially collected and reviewed all the available data of facilities in both Muzaffarabad and Gilgit. List of government facilities were obtained from DOH and PWD. NGOs such as GreenStar and FPAP were approached to obtain information regarding their facilities. Some selected private sector facilities data was available through Department of Health AJK. However, no private sector information from Gilgit was accessible. The project team did not solely rely on listing of facilities available through various sources but planned to capture/verify all facilities through actual physical mapping.

MONITORING FOR QUALITY ASSURANCE

A project team lead each for Muzaffarabad and Gilgit was appointed; having requisite experience and qualification to lead the data collection and quality assurance processes. In addition to training and on field support, the team lead verified approximately 5% of facilities by rechecking the completed forms to ensure data quality. The errors were reported to be minimal (less than 1%).

End to end validation of data entry was also done. Once data was imported into the web-based system, all forms were rechecked to compare online form with paper form; to ensure no errors were introduced during data entry and import.

DATA MANAGEMENT & ANALYSIS

One of the fundamental objectives of the data management was to make accurate and quality data available to stakeholders for the purpose of data analysis. Data entry is prone to errors, omissions, and other inconsistencies hence a data editing form was developed online, where initial data which was entered in excel was imported and edited into a bespoke automated MIS designed on open source Linux operating system, the Apache HTTP Server, MySQL relational database management system, and the PHP programming language (LAMP) stack web-platform. Field supervisors initially received the forms and reviewed them for completeness and quality. Errors were rectified during daily meetings or repeat visits if required. Forms were entered into an excel based tool after initial data quality check. The data was imported into a web-based platform from the excel files. As mentioned earlier, as further quality check; a project team member was assigned to re-check all the online forms to ensure end-to-end validity (from physical form to electronic database). This application also had the provision of uploading of images and location of the facility.

The web portal was developed in open source PHP Laravel framework, while the backend database was maintained in MySQL. In the portal, there were different types of presentations adopted. In one presentation the data is shown in tabular and charts, with data filters so that the user can dig down to the required analyses and actions can be taken accordingly. This front-end chart layer is built through open source Apex Charts JavaScript library.

Other analyses presentations are district maps drilled down to facility location; these maps are the critical component of this portal. As it was not possible to collect coordinates data physically in the field due to legal restrictions, we adopted a modified approach. We identified the facilities through their addresses and nearest landmarks on Google Maps (enumerators helped district team lead on this). Then we extracted the GIS coordinates from Google Maps. These coordinates were approximate/nearby locations rather than pinpoint locations. We inserted these coordinates into the ArcMap to develop the maps. Electronic demarcations for UC boundaries were not available from any authentic source. Vector maps were developed from available local paper maps (received from DOH) and were used for demarcation of union councils.

The maps created in ArcMap 10.5 were then converted into GeoJSON files to develop web-maps. Leaflet JS library was used for dynamic presentation of web-maps. Thus, the web-maps are dynamic as per available data from the current assessment. Choropleth maps visualizations were used to display spatial patterns of data, indicated by color shades, for UC level comparisons.

The dashboards provide the users with drill down capability to filter data by facility type, facility ownership (private-public), and facility locations. User can also find details (type of services available etc.) about any specific facility along its picture and location on the map. Each facility was rated as per the elements of FP services availability; these ratings are visualized in terms of one to three-star on the geographical maps.

MAPPING OF PUBLIC AND PRIVATE SECTOR FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

IN THE SELECTED DISTRICTS
OF AJK AND GB

Results



4

RESULTS

A total 783 facilities were covered in Muzaffarabad and 413 in Gilgit. For Muzaffarabad, out of the total 266 static⁴ facilities, 28% (74) were from public sector. Major proportion of facilities among public sector were BHUs (39), followed by First Aid Points

(12) and Family Welfare Centers (8). Majority of private facilities were pharmacies (95), followed by clinics (58). The breakdown of facilities covered in Muzaffarabad are given in Table 1.

Summary of Public/Private Health Facilities - Muzaffarabad

Type of Facility	Number
Public Sector facilities	
Basic Health Unit (BHU)	39
Public Hospital	1
First Aid Point (FAP)	12
Civil Dispensaries (CD)	5
Rural Health Centre (RHC)	6
Reproduction Health Services Centre A (RHSA)	1
Mother and Child Health Centre (MCH)	2
Family Welfare Centre (FWC)	8
Sub-total	74
Private healthcare /NGOs clinics/Pharmacies/Informal healthcare providers	
Family Planning Association of Pakistan (FPAP)	2
Private Clinic	58
Nursing/Maternity Homes	18
Private Hospital	8
Pharmacy	95
Hakeem	8
Homeopath	3
Sub-total	192
Public Sector Outreach Programs	
Lady Health Workers (LHW)	504
Community Midwives (CMW)	13
Sub-total	517
Total	783

Table 1. TYPE OF FACILITIES IN MUZAFFARABAD

⁴ Static facilities include all facilities; excluding community outreach workers LHWs and CMWs

Out of the total 413 facilities covered in Gilgit, 209 were static facilities. The majority of public sector static facilities were civil dispensaries (26), followed by public hospitals (7) and family welfare centers (9).

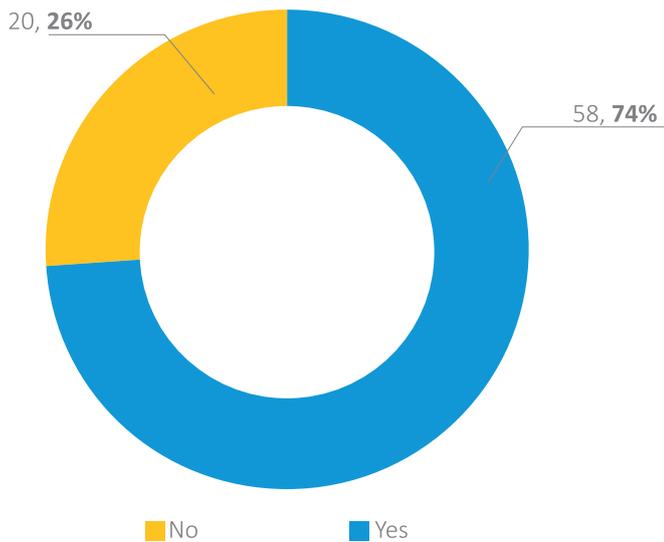
Pharmacies constituted the major proportion of private facilities (128), followed by private clinics (23). Detailed breakdown of facilities is provided in Table 2.

Type of Facility	Number
Public Sector facilities	
Basic Health Unit (BHU)	2
Public Hospital (DHQ, THQ)	7
Civil Dispensary (CD)	26
Rural Health Centre (RHC)	0
Family Welfare Centre (FWC)	9
Sub-total	44
Private healthcare /NGOs clinics/Pharmacies/Informal healthcare providers	
Dhanak Clinic	1
Private Clinic	23
Private Hospital	6
Pharmacy	128
Hakeem	7
Sub-total	165
Public Sector Outreach Programs	
Lady Health Workers (LHW)	202
Community Midwives (CMW)	2
Sub-total	204
Total	413

Table 2. TYPE OF FACILITIES IN GILGIT

In Muzaffarabad, among public and private sector static facilities, a total of 20 (26%) and 76 (39%) were not providing any FP services respectively (see Figure 12)

FP Service provision in public sector



FP Service provision in private sector

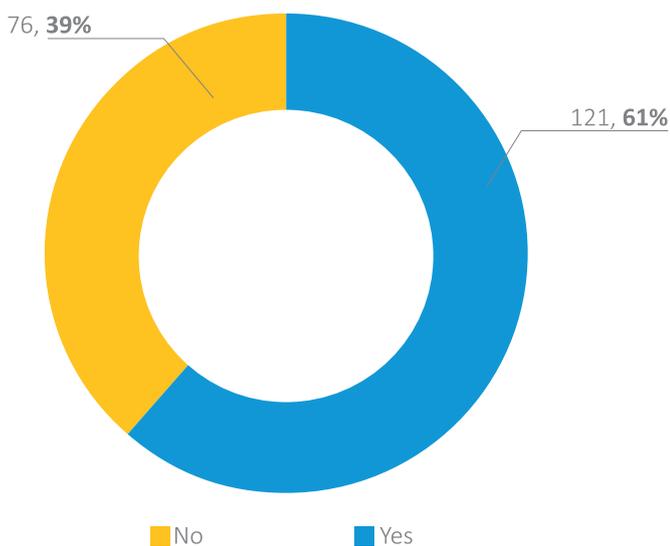
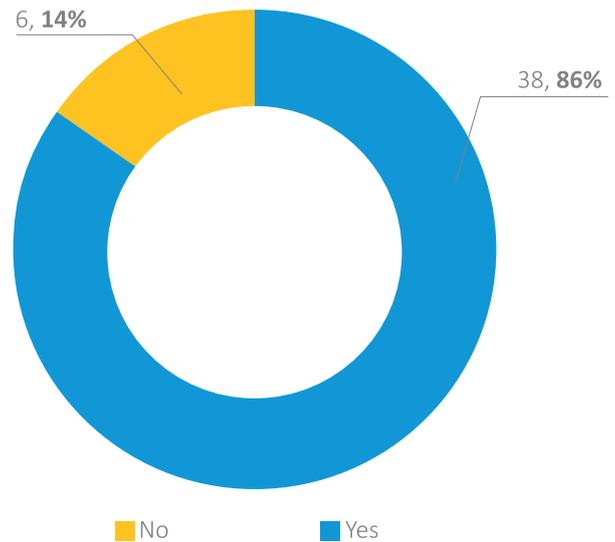


Figure 12. PROVISION OF FP SERVICES FOR PUBLIC AND PRIVATE SECTOR IN MUZAFFARABAD

In Gilgit for static facilities, among public sector only 13% were not providing any FP services compared to 15% in public sector (see Figure 13). Thus, overall provision of FP services in Gilgit was relatively higher in comparison to Muzaffarabad.

FP Service provision in public sector



FP Service provision in private sector

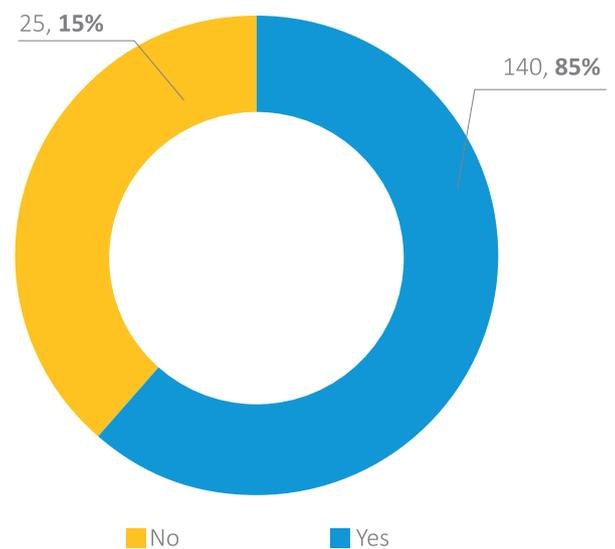


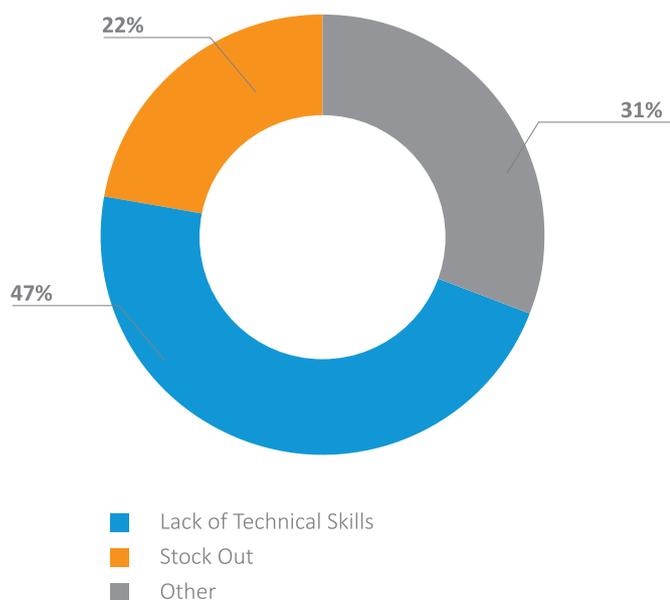
Figure 13. PROVISION OF FP SERVICES FOR PUBLIC AND PRIVATE SECTOR IN GILGIT

REASONS FOR NOT PROVIDING FP SERVICES IN MUZAFFARABAD

In Muzaffarabad, reasons were inquired from those who reported they were not providing any FP services. Figure 14 below provides the various reasons separately for public and private sector. Lack of technical skills was the most cited reason in public sector (47%). Lack of time (60%) was the most cited in private sector, followed by lack of technical skills (21%) and lack of incentive (12%). It is quite apparent that FP

service provision in private sector is limited mostly by their priorities of utilizing their time for other services; it is likely that they consider investing time in FP as inefficient use of their resources. For public sector, the lack of technical skills may potentially mean absence of trained human resource (e.g. for counseling, IUCD or implant insertion).

Public sector - Reasons for not providing FP services



Private sector - Reasons for not providing FP services

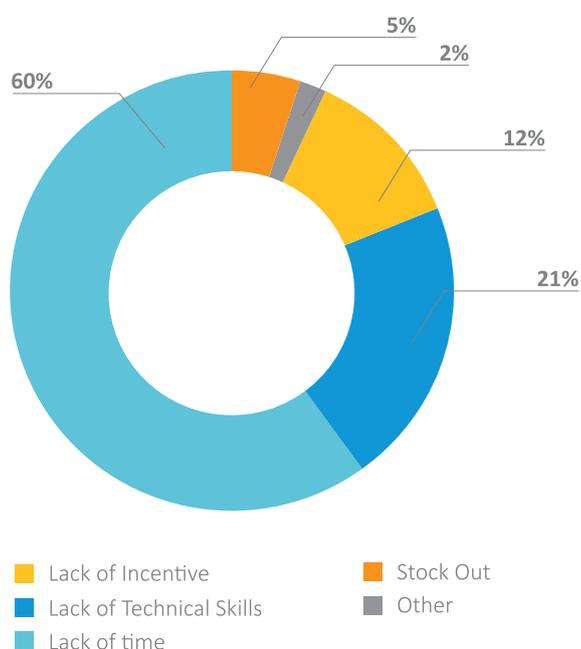


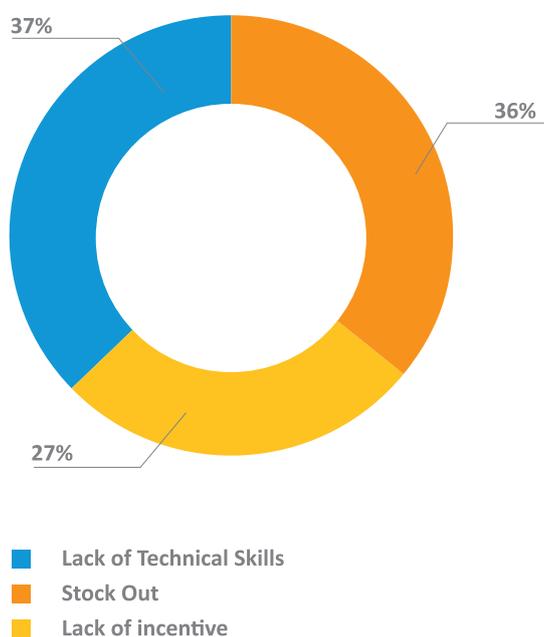
Figure 14. REASONS FOR NOT PROVIDING FP SERVICES BY PUBLIC AND PRIVATE SECTOR IN MUZAFFARABAD

REASONS FOR NOT PROVIDING FP SERVICES IN GILGIT

Similarly, the reasons for not providing FP services for Gilgit are given below in Figure 15. Lack of technical skills (37%) and incentive (27%) stand out to be the

major reasons in public sector. For private sector, similar to the Muzaffarabad, lack of time (35%) is the major reason, followed by lack of incentive (18%).

Public sector - Reasons for not providing FP services



Private sector - Reasons for not providing FP services

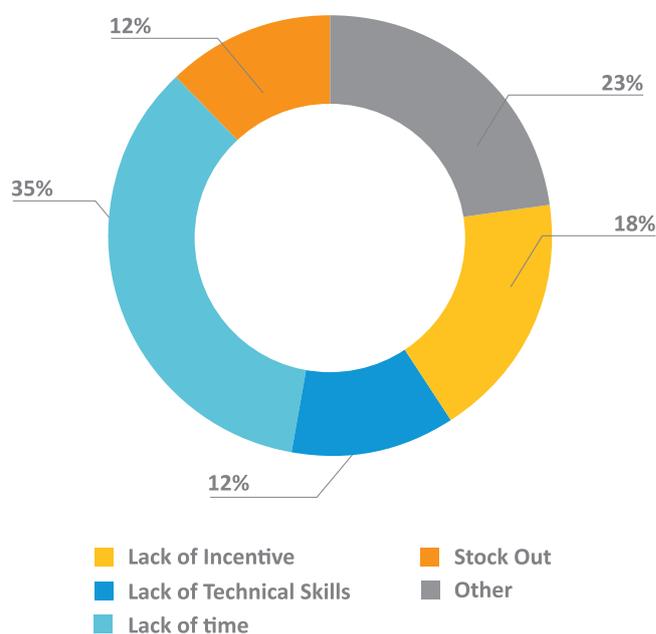


Figure 15. REASONS FOR NOT PROVIDING FP SERVICES BY PUBLIC AND PRIVATE SECTOR IN GILGIT

CONTRACEPTIVE STOCK AVAILABILITY IN MUZAFFARABAD

The stock availability was assessed at each of the facility including outreach workers. The availability for one-month injection, two-month injection and Implants (Femplant, Implanon & Jadelle) were negligible (less than 1%), hence they were not included in final analysis. The following table shows the percentage of facilities who reported to have the stock availability for a particular product at the time of site visit for Muzaffarabad. The availability was defined as having at least one dispensable product. The percentage was measured against all those facilities eligible to hold the stocks (based on facility type or their own policy of providing that particular method).

	Stock availability for private sector	Stock availability for public sector
Condom	82%	20%
COC Pill	17%	11%
EC Pill	16%	3%
POP	16%	7%
DMPA (3-month injection)	14%	11%
IUCD	2%	24%

Table 3. SUMMARY OF CONTRACEPTIVE AVAILABILITY IN MUZAFFARABAD

The overall availability of contraceptives was very low in both public and private sector; very clear from the fact that the availability of each and every product was reported to be less than 20%, except IUCDs in public sector (24%) and condoms in private sector (82%). Condoms were the highest available method for private sector (82%), followed by COC (17%). The high

availability of condoms in private sector was mainly being contributed by pharmacies.

Figure 16 below summarizes the availability of contraceptive products in Basic Health Units (BHUs). Out of total of 39 BHUs a total of 11 reported to have IUCDs or condoms, the availability for Injectables and pills was even poorer.

Stock Availability - Basic Health Units in Muzaffarabad

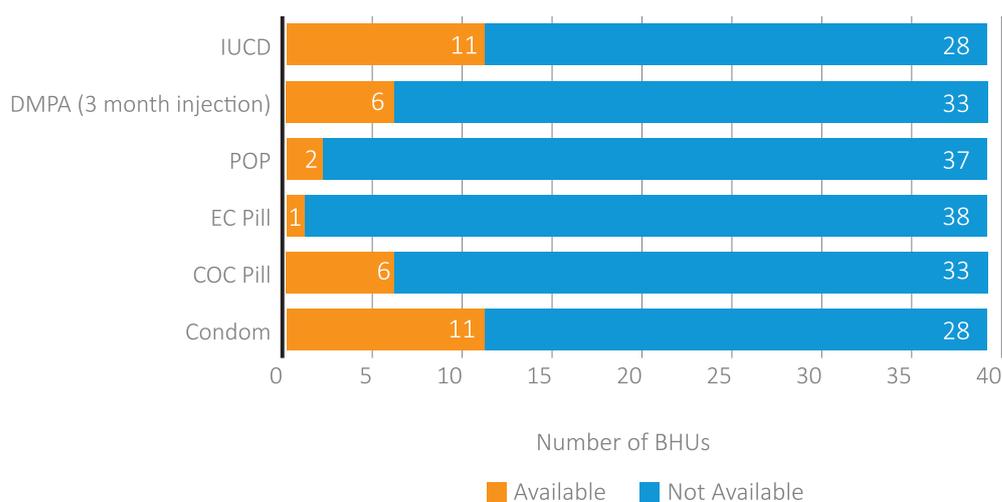


Figure 16. STOCK AVAILABILITY IN BASIC HEALTH UNITS IN MUZAFFARABAD

In FWCs, only three reported to have availability of IUCDs out of total of eight. No other product was reported to be available (Figure 17).

Stock Availability - FWCs in Muzaffarabad

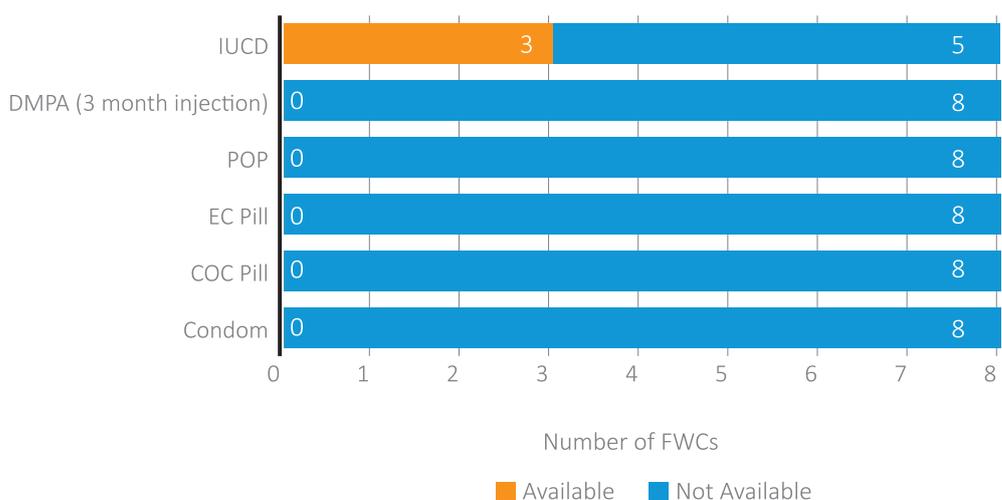


Figure 17. STOCK AVAILABILITY IN FAMILY WELFARE CENTERS IN MUZAFFARABAD

Availability of condoms was relatively higher in private sector as shown in Figure 18 below. The contribution by private clinical services providers for IUCDs, pills and injectables was almost negligible.

Stock Availability - Private Clinics / Hospitals & Nursing Homes

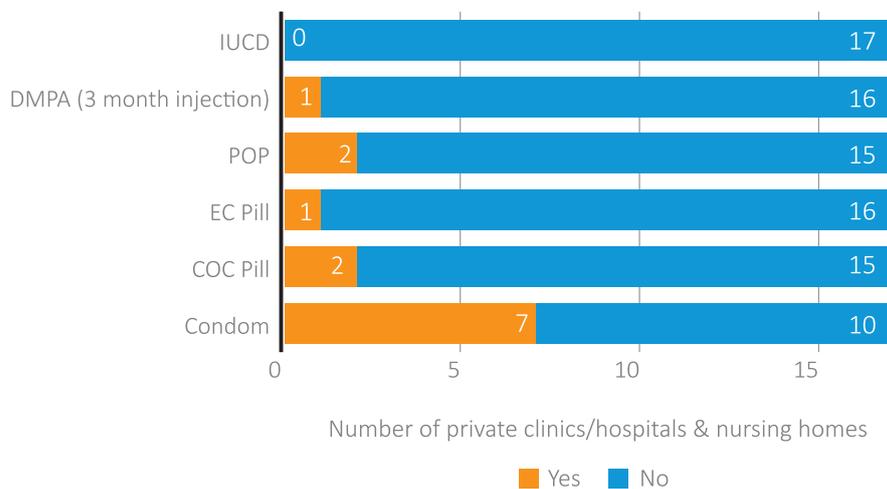


Figure 18. STOCK AVAILABILITY IN PRIVATE CLINICS/HOSPITALS AND NURSING HOMES IN MUZAFFARABAD

Pharmacies almost had a universal availability for condoms. However, no pharmacy was dispensing IUCDs. The availability of pills and injectables was also very low (Figure 19).

Pharmacies

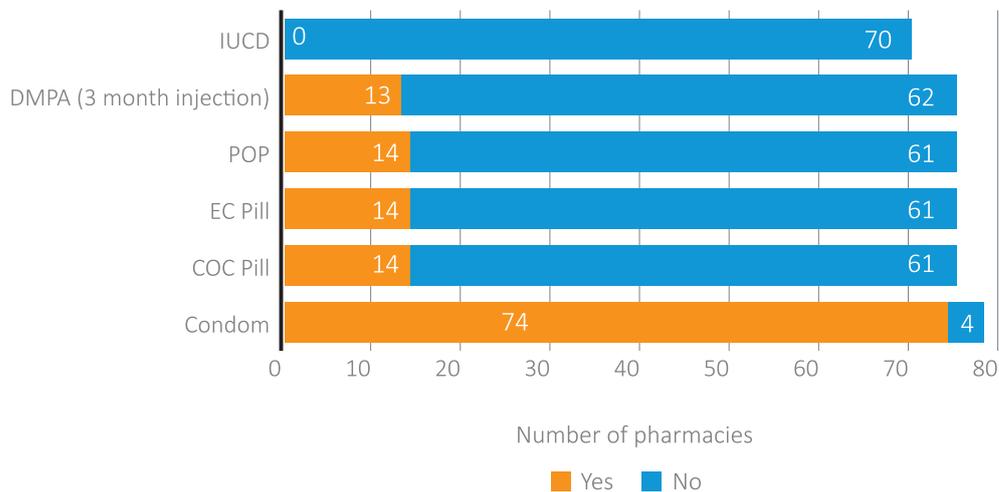


Figure 19. STOCK AVAILABILITY FOR PHARMACIES IN MUZAFFARABAD

The availability of stocks with Lady Health Workers was very low. Only three LHWs had at least one contraceptive available, which means out of the total of 504, only three had any product available to dispense to clients, and the remaining did not even have one method.

Looking at stock availability from another perspective of counting number of methods available at a facility at the time of visit provides insight into the available method mix at the facility. At least one contraceptive was available in 50% of MCH centers, 41% of BHUs and 40% of dispensaries. Only 40% of dispensaries, 23% of CMWs and 15% of BHUs had at least three contraceptives available. The availability of five or more methods was even rare as shown in Table 4.

	BHU	CMW	Dispensaries	FWC	LHW	MCH	RHC
At least one contraceptive available	41%	23%	40%	25%	1%	50%	33%
At least three contraceptives available	15%	23%	40%	0%	0%	0%	0%
At least five contraceptives available	3%	8%	0%	0%	NA	0%	0%

Table 4. CONTRACEPTIVE METHOD MIX AVAILABILITY AT MUZAFFARABAD

CONTRACEPTIVE STOCK AVAILABILITY IN GILGIT

Similar to Muzaffarabad, the availability for one/two month injection and implants (Femplant, Implanon and Jadelle) were negligible, hence these products were not considered for the current analysis. The availability was generally very poor; with IUCD (23%) being most commonly available in public sector, followed by Condoms (20%). The availability of condoms (85%) was the highest in private sector (mainly contributed by pharmacies), followed by DMPA (30%) and EC pills (29%). Overall availability in private sector was relatively higher compared to that in Muzaffarabad (Table 5).

	Stock availability for private sector	Stock availability for public sector
Condom	85%	20%
COC Pill	17%	10%
EC Pill	29%	8%
POP	14%	10%
DMPA (3-month injection)	30%	8%
IUCD	8%	23%

Table 5. SUMMARY OF CONTRACEPTIVE AVAILABILITY IN GILGIT

There were only two BHUs in Gilgit and both did not have availability of any contraceptives. Among FWCs, the availability of IUCDs and Condoms was almost 50%, while other methods were almost universally stocked out (Figure 20).

FWC

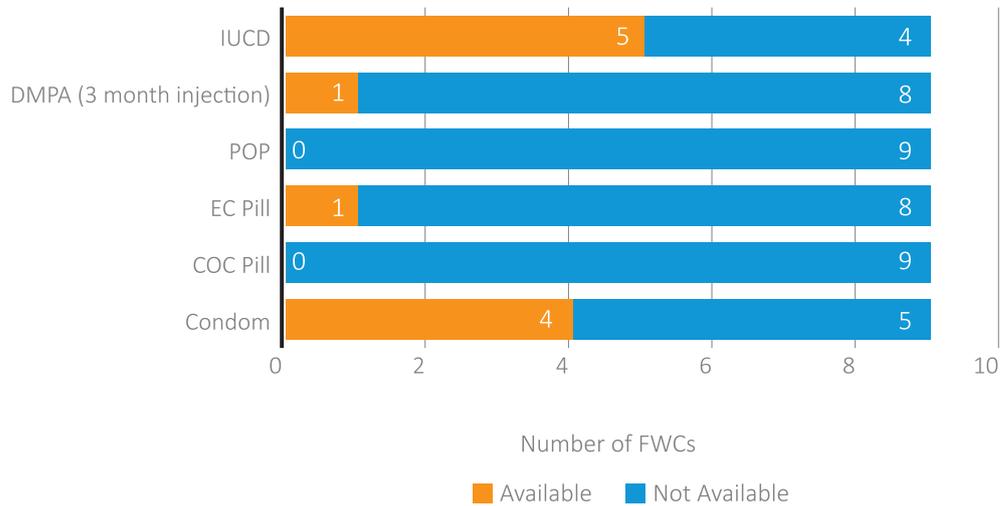


Figure 20. STOCK AVAILABILITY FOR FWCS IN GILGIT

The contraceptive availability in private clinics, nursing homes and private hospitals was generally approaching 50% for all key products. Almost two thirds of facilities reported having DMPA and Condoms (Figure 21).

Stock Availability - Private Clinics / Hospitals & Nursing Homes

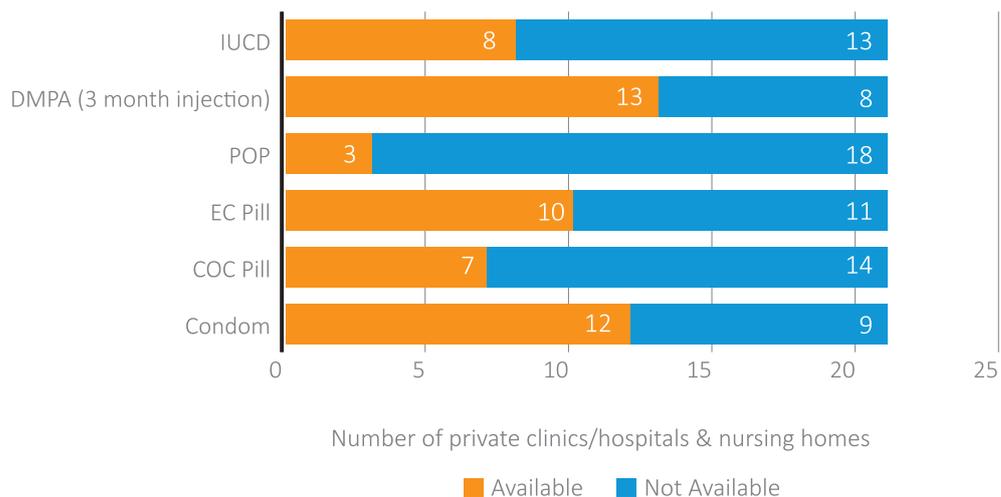


Figure 21. STOCK AVAILABILITY FOR PRIVATE CLINICS/HOSPITALS AND NURSING HOMES IN GILGIT

Among private pharmacies, the availability of condoms was almost universal, with only 11 reporting not having condoms out of a total of 121. The availability of other products was generally poor, with DMPA and EC pills being most commonly available (Figure 22).

Pharmacies

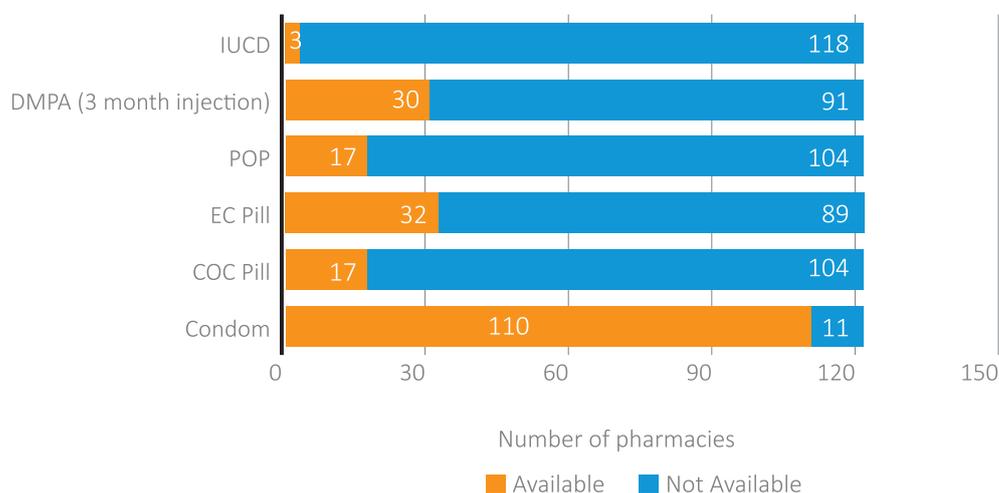


Figure 22. STOCK AVAILABILITY FOR PHARMACIES IN GILGIT

Among LHWs, out of the total of 202, only 9 had condoms available, two had COC and only one reported to have DMPA. Method mix availability in Gilgit is shown in Table 6 below. FWCs and Public hospitals in 67% and

29% of cases respectively had least one contraceptive available. Similarly, for at least three methods FWC and public hospitals performed relatively better. However, the availability of five or more methods was rare.

	Dispensaries	FWC	LHW	Public Hospital
Product				
At least one contraceptive available	8%	67%	5%	29%
At least three contraceptives available	8%	22%	0%	29%
At least five contraceptives available	4%	11%	NA	0%

Table 6. CONTRACEPTIVE METHOD MIX AVAILABILITY IN GILGIT

SPECIALIZED FP SERVICES IN MUZAFFARABAD

IUCD insertion was the mostly commonly available service in Muzaffarabad, with 60% of public sector facilities providing the services. Almost two thirds of BHUs were providing the service. Female sterilization and IUCD insertion were commonly available in private

sector as shown in Table 7 below. However, facilities offering female sterilization in public sector was very low (4%). The services for male sterilization was non-existent in either public or private sector.

Type of specialized services	Private	Public
Female Sterilization	37%	4%
Implants Insertion/removal	32%	3%
IUCD Insertion	30%	60%
Male Sterilization	0%	0%

Table 7. SPECIALIZED FP SERVICES IN MUZAFFARABAD

SPECIALIZED FP SERVICES IN GILGIT

IUCD insertion was the most offered specialized FP service; almost half of both public and private sector facilities offering this service. Implant insertion/removal and female sterilization were also available

in private sector in reasonable numbers compared to negligible availability in public sector as show Table 8 below.

Type of specialized FP services	Private	Public
Female Sterilization	17%	5%
Implants Insertion/removal	30%	8%
IUCD Insertion	43%	46%
Male Sterilization	9%	3%

Table 8. SPECIALIZED FP SERVICES IN GILGIT

FP COUNSELING IN MUZAFFARABAD

FP counseling was more prevalent compared to product availability. All LHWs reported to be counseling for FP, similar was the response for nursing homes, MCH centers, FWCs, CMWs. Almost 10% BHUs

reported not doing even counseling for FP. Almost 70% of private clinics reported doing counseling (Figure 23).

FP Counseling - Muzaffarabad

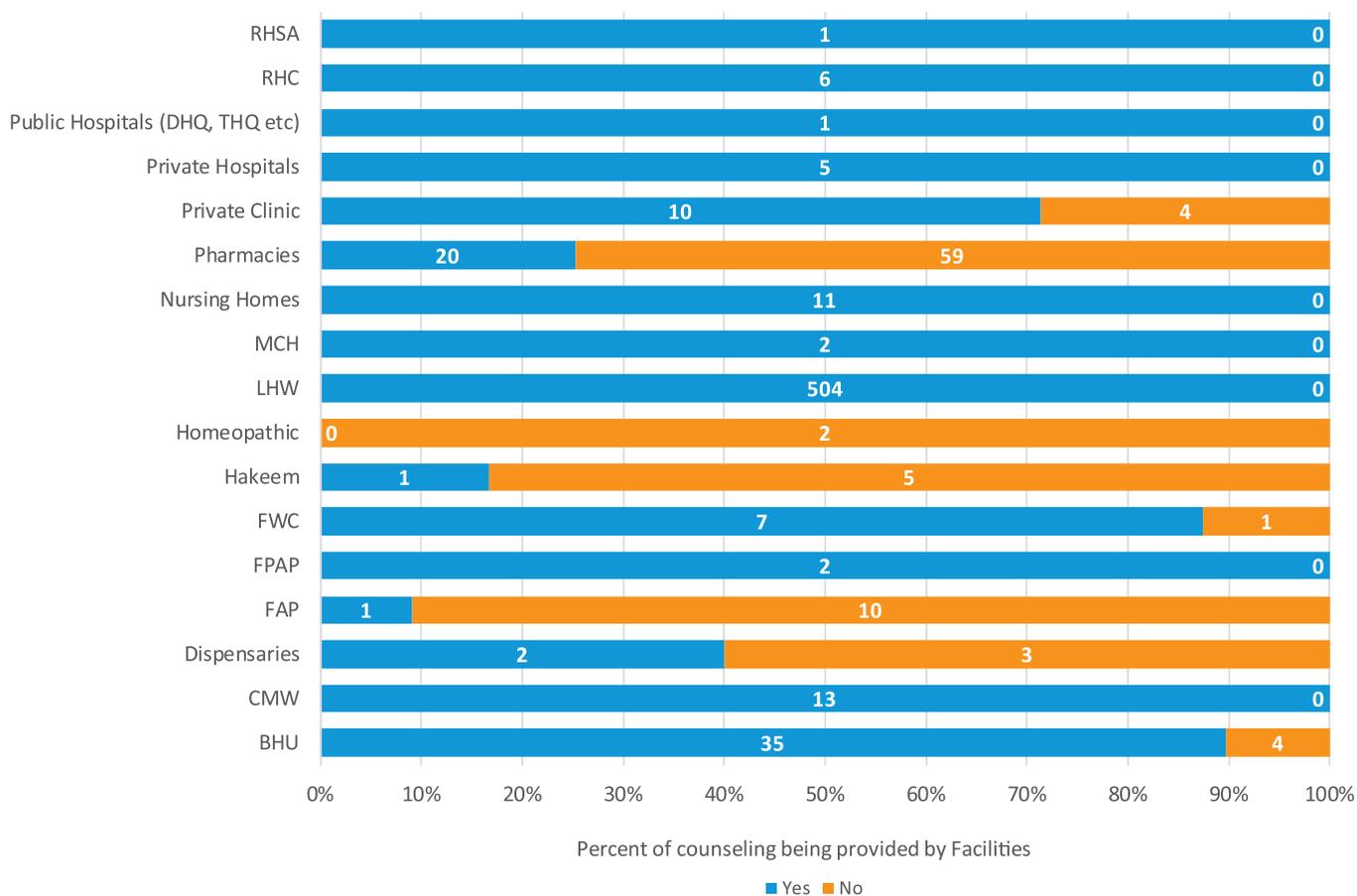


Figure 23. FP COUNSELING IN MUZAFFARABAD

FP COUNSELING IN GILGIT

All LHWs reported doing FP counseling. Most of the public sector facilities were performing well in terms of FP counseling including public hospitals, BHUs,

CMWs, dispensaries and FWCs. However, only almost 30% private clinics reported doing counseling.

FP Counseling - Gilgit

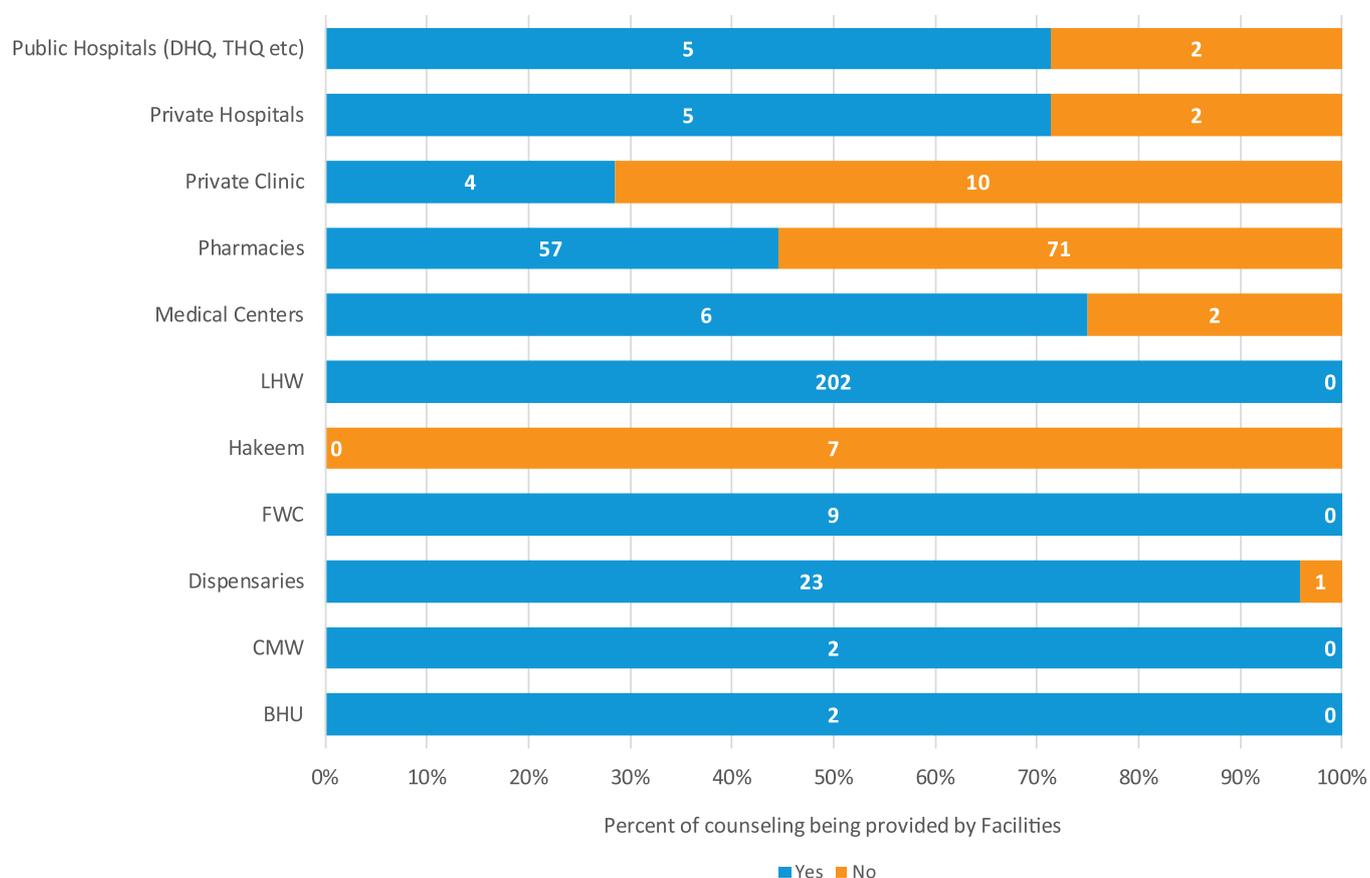


Figure 24. FP COUNSELING IN GILGIT

AVAILABILITY OF TRAINED STAFF IN MUZAFFARABAD

Availability of trained staff is critical to provision of FP services, specifically some specialized FP services for modern methods. Implants uptake has risen sharply after their introduction few years back, especially in Sindh and Punjab. Implants trained providers have gradually increased in number in both public and private sector. However, the situation of Muzaffarabad is different where there are only few (6%) trained for implant insertion and removal. No trained staff was available for male sterilization. Staff for IUCD insertion were available in 48% of facilities. Some facilities, although assigned to provide IUCD insertion by policy, were unable to provide the service due to absence of trained provider.

Staff Category	Public sector
IUCD insertion	48%
Female sterilization	5%
Male sterilization	0%
Implants insertion & removal	6%

Table 9. PUBLIC SECTOR AVAILABILITY OF TRAINED STAFF IN MUZAFFARABAD

AVAILABILITY OF TRAINED STAFF IN GILGIT

Almost 41% of facilities in Gilgit had staff for IUCD insertion. The numbers for female sterilization, male sterilization and implants insertion and removal were low (Table 10).

Staff category	Public sector
IUCD insertion	41%
Female sterilization	5%
Male sterilization	2%
Implants insertion & removal	11%

Table 10. PUBLIC SECTOR AVAILABILITY OF TRAINED STAFF IN GILGIT

ANTENATAL CARE SERVICES IN MUZAFFARABAD

The landscape of availability of antenatal care services was relatively better. Most of the BHUs, FWCs and FAPs were providing the service. Two thirds of the private facilities including nursing homes and clinics were also providing the service (Figure 25).

ANC Services in Public Sector- Muzaffarabad

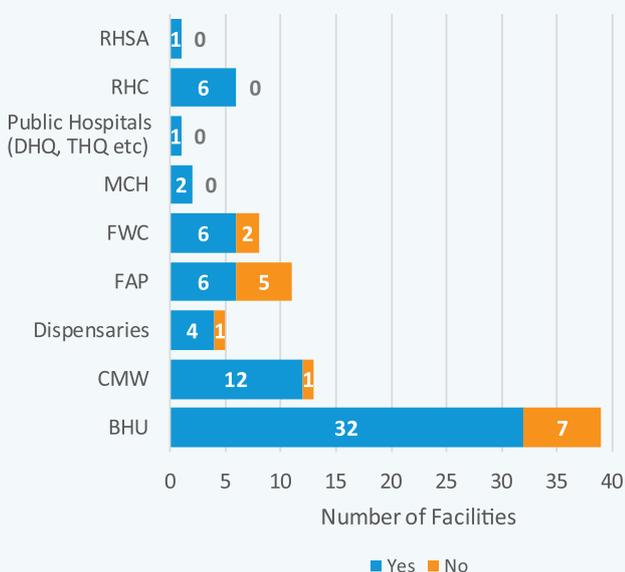
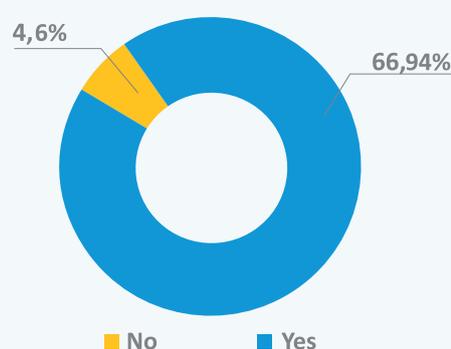


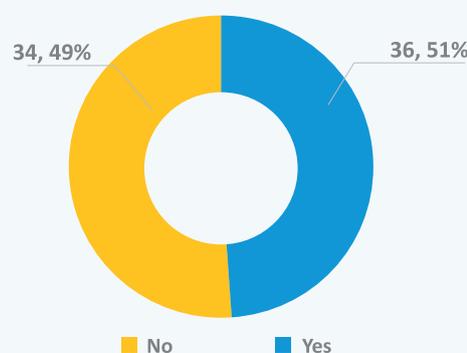
Figure 25. PUBLIC SECTOR ANC SERVICES IN MUZAFFARABAD

In terms of type of antenatal services, urine examination was less frequently available, i.e. in almost half of the facilities. The availability of tetanus vaccination was 81%, while iron supplementation product/advice was available from almost all facilities (Figure 26).

Received or told to buy iron supplements



Urine examination



Received tetanus vaccination

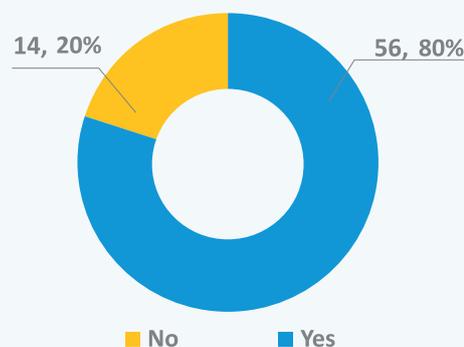


Figure 26. TYPE OF ANC SERVICES IN MUZAFFARABAD (PUBLIC SECTOR)

AVAILABILITY OF ANC SERVICES IN GILGIT

The situation in Gilgit was similar to that of Muzaffarabad, with almost universal availability of ANC services (Figure 27). Fifty percent of the private sector (15 facilities out of total 30) were also providing ANC services.

ANC Services in Public Sector - Gilgit

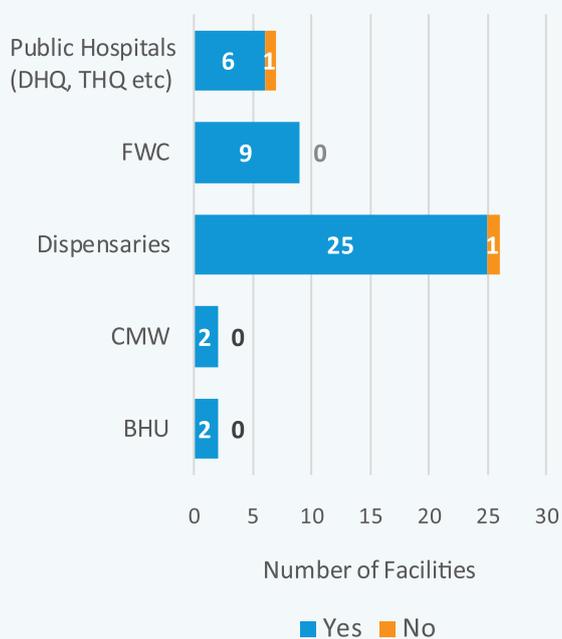
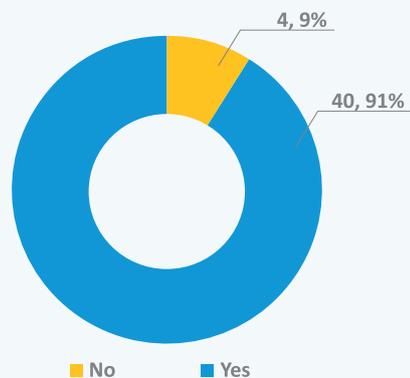


Figure 27. ANC SERVICES IN PUBLIC SECTOR IN GILGIT

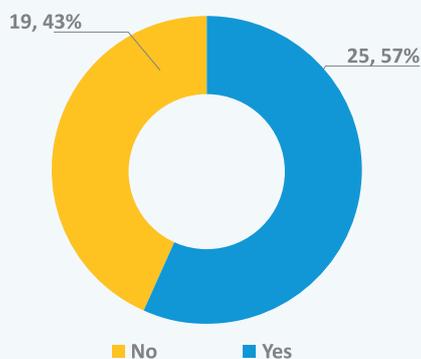
In terms of type of services, iron supplements or advice to use iron supplements was available in 91% of facilities. Urine examination and tetanus vaccination was available in 57% of facilities.

Received or told to buy iron supplements



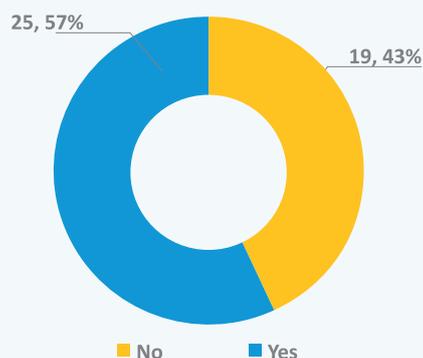
■ No ■ Yes

Urine examination



■ No ■ Yes

Received tetanus vaccination



■ No ■ Yes

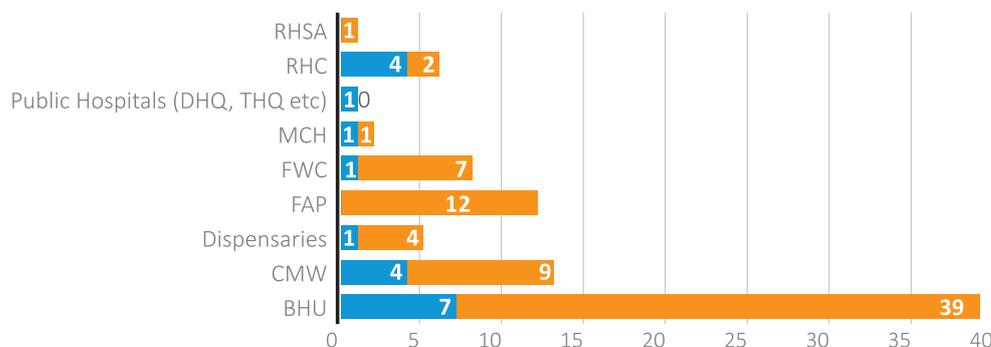
Figure 28. TYPE OF ANC SERVICES IN GILGIT (PUBLIC SECTOR)

BASIC OBSTETRIC CARE IN MUZAFFARABAD

The availability of basic obstetric care was relatively less frequent in Muzaffarabad. Only 22% of public sector and 10% of private sector facilities had basic obstetric care available. Seven BHUs had basic obstetric care available out of 39 (Figure 29).

Basic Obstetric Care - Muzaffarabad

■ Yes ■ No



Basic Obstetric Care - Private Sector Muzaffarabad

■ Yes ■ No

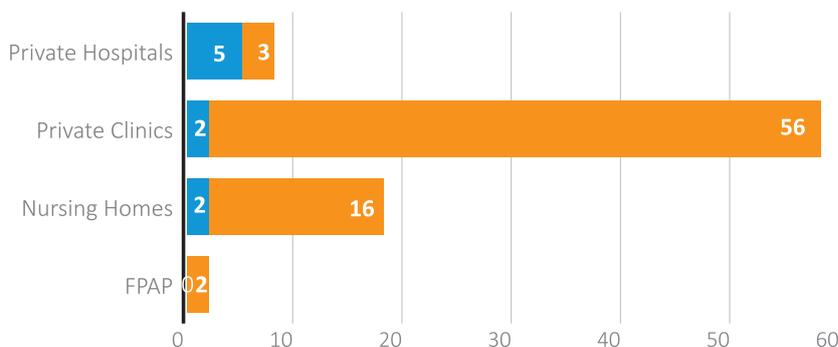
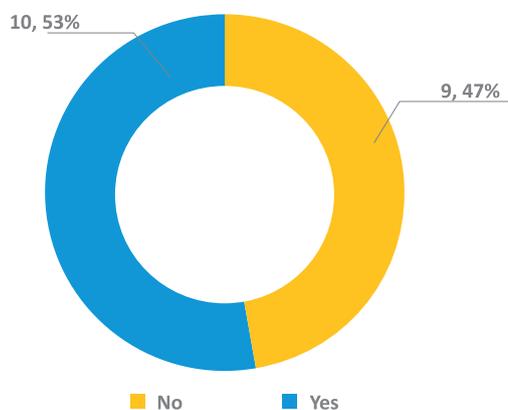


Figure 29. AVAILABILITY OF BASIC OBSTETRIC CARE IN MUZAFFARABAD

For public sector, among those who reported to have basic obstetric care, almost 50% had injectable oxytocic drugs and injectable anticonvulsants (Figure 30).

Availability of injectable anti convulsants for pregnancy induced convulsions



Availability of injectable oxytocic drugs

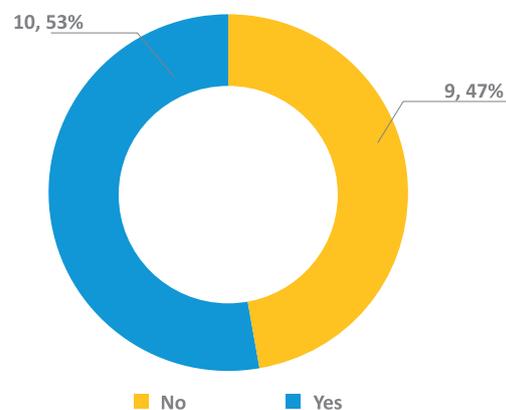


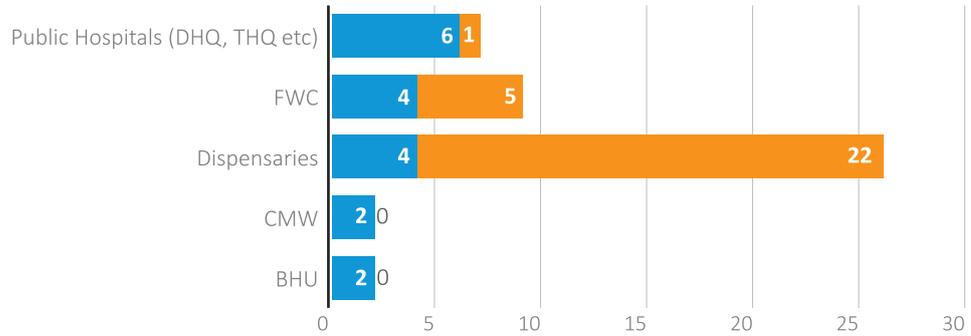
Figure 30. AVAILABILITY OF DRUGS TO MANAGE OBSTETRIC COMPLICATIONS - MUZAFFARABAD

BASIC OBSTETRIC CARE IN GILGIT

Almost 40% of public sector and 37% of private sector facilities had basic obstetric care available, which is relatively better compared to Muzaffarabad. Almost, 50% of FWCs had basic obstetric care available.

Basic Obstetric Care - Public Sector Gilgit

■ Yes ■ No



Basic Obstetric Care - Private Sector Gilgit

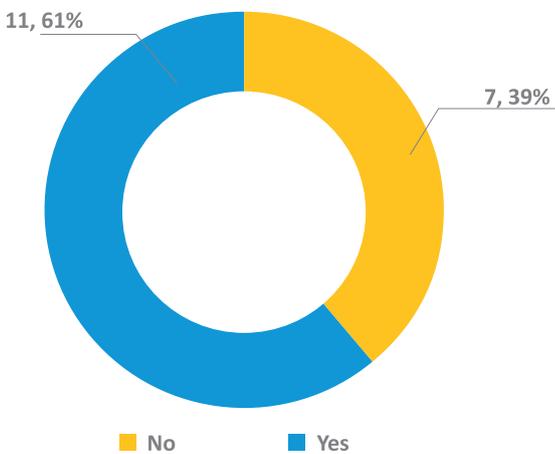
■ Yes ■ No



Figure 31. BASIC OBSTETRIC CARE IN GILGIT

For public sector facilities having obstetric care available, all reported to have injectable oxytocic drugs. However, only 61% reported to have injectable anticonvulsants

Availability of injectable anti convulsants for pregnancy induced convulsions - Gilgit



Availability of injectable oxytocic drugs - Gilgit

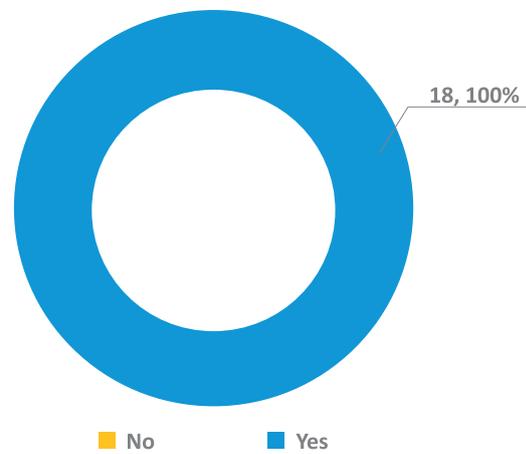


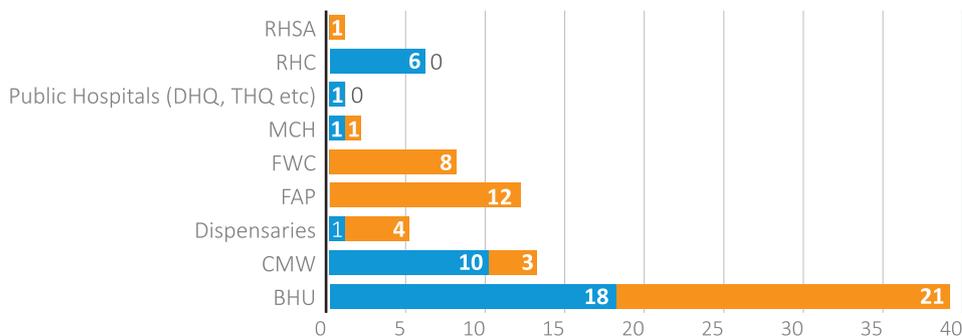
Figure 32. AVAILABILITY OF DRUGS TO MANAGE OBSTETRIC COMPLICATIONS IN GILGIT

NEONATAL CARE SERVICES – MUZAFFARABAD

All rural health centers and almost 50% of BHUs had neonatal care services available. The availability was much lower in private sector, with only two out of 56 clinics and 2 out of 18 nursing homes providing the service (Figure 33).

Neonatal Care - Public Sector Muzaffarabad

■ Yes ■ No



Neonatal Care - Private Sector Muzaffarabad

■ Yes ■ No

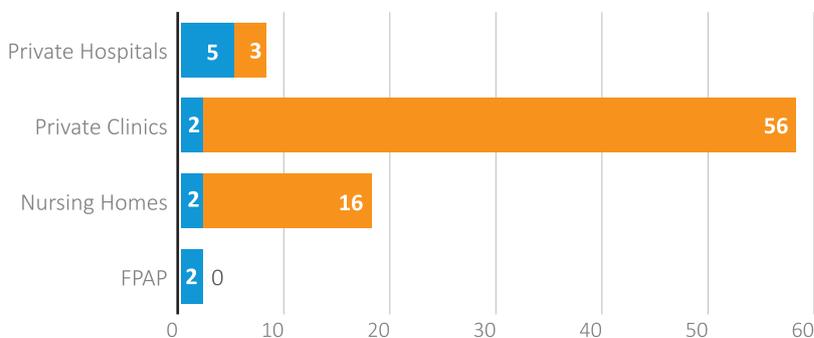
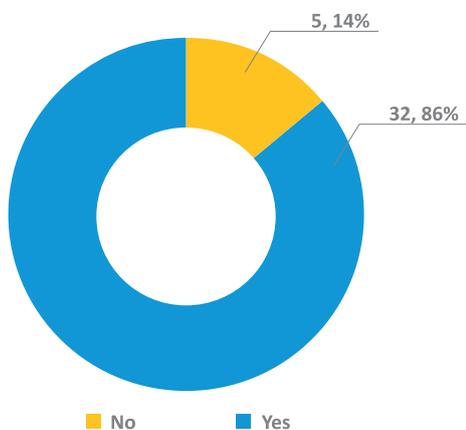


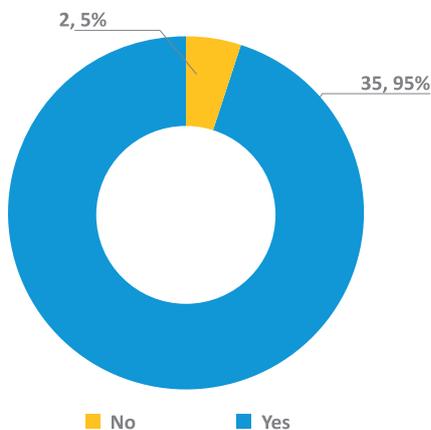
Figure 33. NEONATAL CARE SERVICES IN PUBLIC AND PRIVATE SECTOR IN MUZAFFARABAD

The breakdown of type of neonatal care services available in public sector is given below (Figure 34). Almost all facilities providing clean cord care, while 86% were providing warmth (skin to skin) and newborn resuscitation.

Basic newborn resuscitation Public Muzaffarabad



Clean cord care Public Muzaffarabad



Warmth (drying skin to skin contact) Public Muzaffarabad

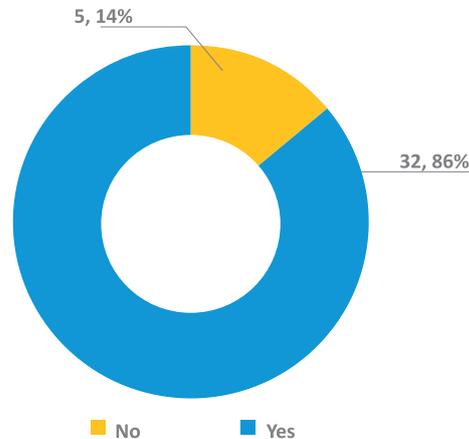


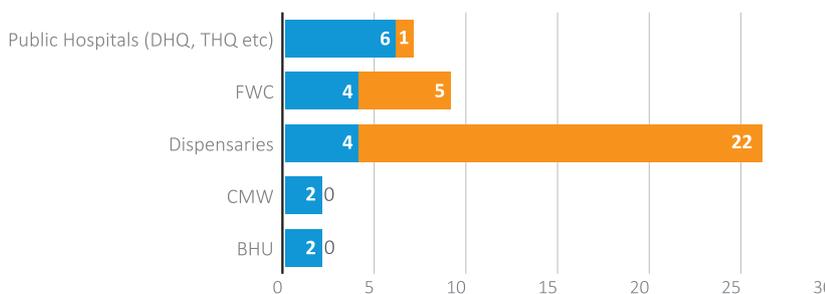
Figure 34. TYPE OF NEONATAL CARE SERVICES - MUZAFFARABAD

NEONATAL CARE SERVICES – GILGIT

The following graph shows availability of neonatal care services in public and private sector. Most of the public hospitals and almost 50% of FWCs had neonatal care services available. Newborn resuscitation and clean cord care were available in 100% of public sector facilities reporting to have neonatal care services. However, warmth through skin to skin contact was available in 87% of facilities.

Neonatal Care - Public Sector Gilgit

■ Yes ■ No



Neonatal Care - Private Sector Gilgit

■ Yes ■ No

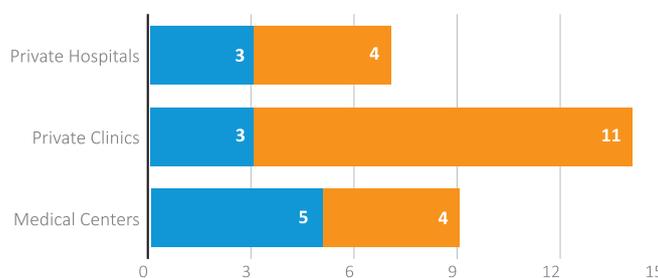
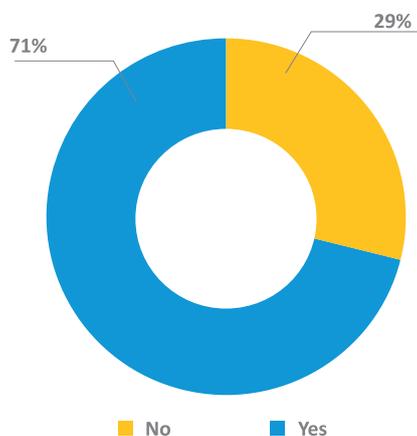


Figure 35. NEONATAL CARE SERVICES IN PUBLIC AND PRIVATE SECTOR IN GILGIT

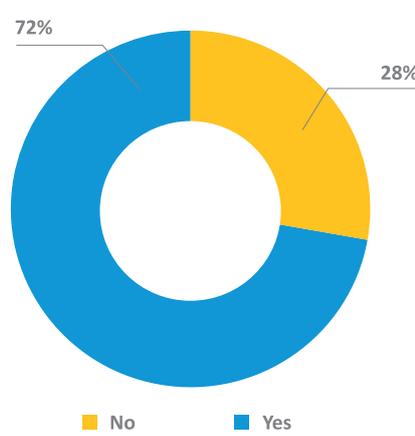
FP MANAGEMENT INFORMATION SYSTEM IN MUZAFFARABAD

Paper based information system is regularly being used in public sector. Almost 88% facilities reported using paper based LMIS. Electronic MIS was not being used at any facility. Facilities from department of health and population use registers for recording, inventory, issuance and client records. Almost 70% of facilities were recording and reporting these elements.

Contraceptive Inventory Management



Contraceptive Issuance



Contraceptive Client Record

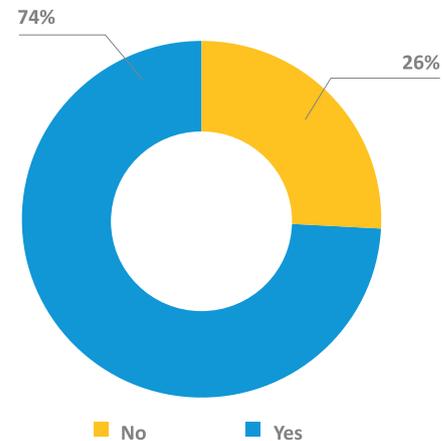


Figure 36. FP MIS COVERAGE IN MUZAFFARABAD

FP MANAGEMENT INFORMATION SYSTEM IN GILGIT

Almost 60% of the public sector facilities had paper based LMIS available. Contraceptive client record was maintained in only almost two thirds of facilities (Figure 37).

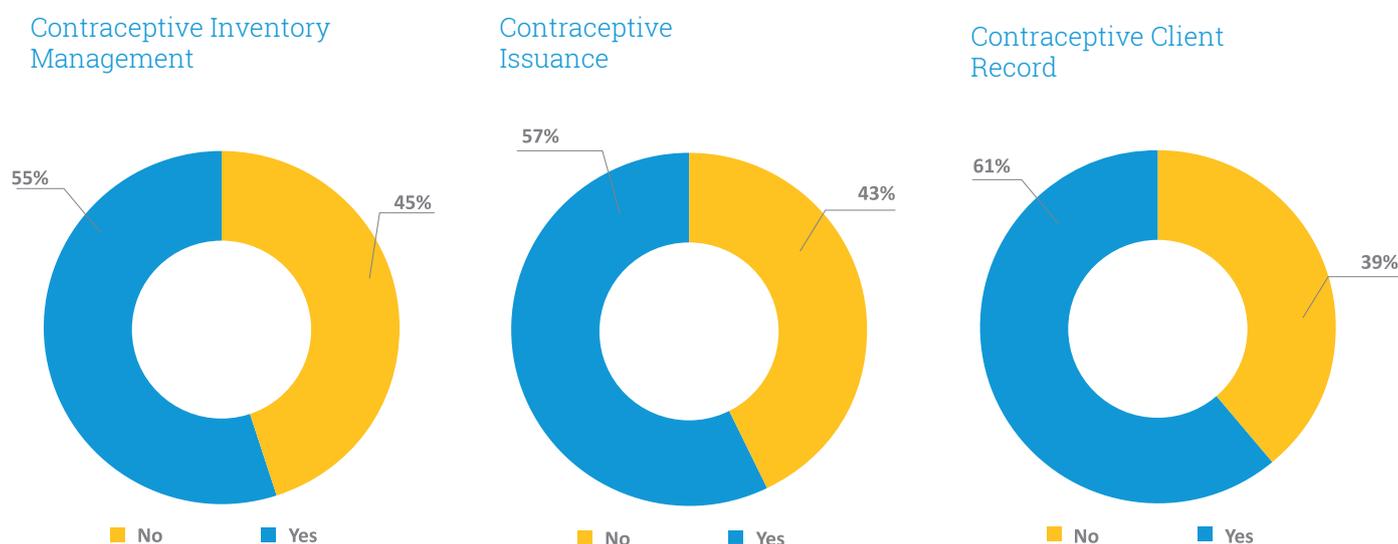


Figure 37. FP MIS COVERAGE IN GILGIT

HUMAN RESOURCE AVAILABILITY IN MUZAFFARABAD

Lack of key staff in various types of health facilities is obvious from Table 11 below. Only one third of BHUs had qualified doctors, and half of them had dispenser and LHVs. The availability of trained nurses and midwives was even lower.

Human Resources	BHU	Dispensaries	FAP	FWC	MCH	RHC
Dispensers/Technicians	51%	40%	58%	0%	100%	17%
Doctors (At Least MBBS qualified)	38%	0%	0%	0%	0%	0%
LHVs	51%	40%	0%	75%	50%	0%
Midwives	28%	40%	0%	13%	0%	33%
Nurses	5%	0%	8%	0%	50%	0%

Table 11. AVAILABILITY OF STAFF IN MUZAFFARABAD

HUMAN RESOURCE AVAILABILITY IN GILGIT

Family welfare centers in Gilgit had relatively better availability of qualified doctor and LHWs. Almost half of the dispensaries had at least one dispenser available. However, the availability of other staff was severely lacking (Table 12).

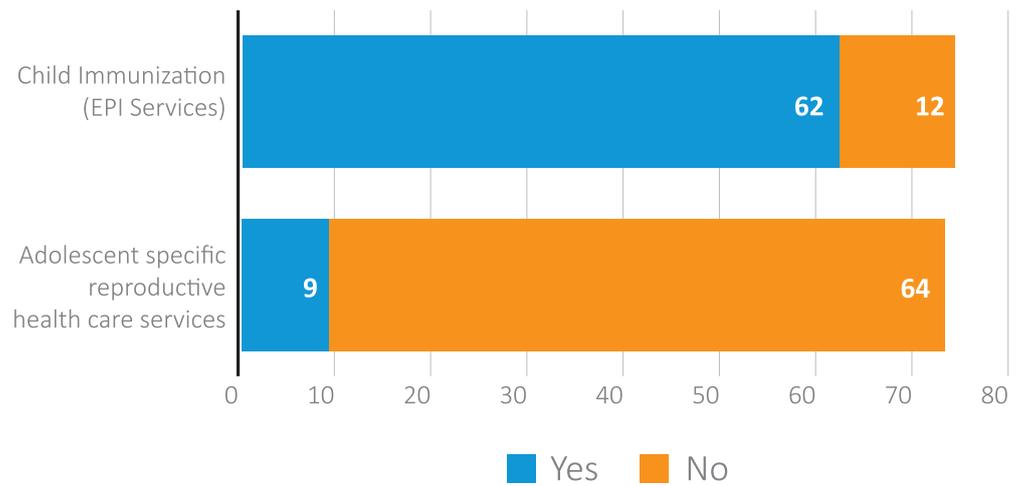
Human Resources	BHU	Dispensaries	FWC
Dispensers/Technicians	0%	42%	11%
Doctors (At Least MBBS qualified)	50%	8%	56%
LHVs	100%	15%	56%
Midwives	0%	0%	11%
Nurses	0%	12%	33%

Table 12. AVAILABILITY OF STAFF IN GILGIT

OTHER SERVICES

The project team also inquired about other services in addition to FP and MNCH in public sector facilities. A closely linked thematic area was adolescent related reproductive health services, which are very important in Pakistan's context; having a large proportion of young population. The availability of adolescent specific services was reasonably high in Gilgit, while it was less than 10% in Muzaffarabad. The proportion of services having child immunization was high in both district (Figure 38).

Other Services - Muzaffarabad



Other Services - Gilgit

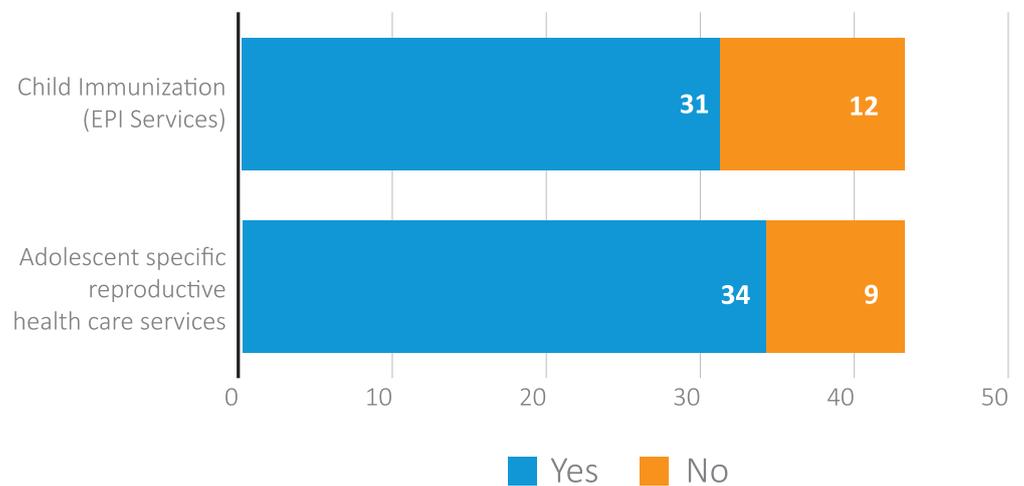


Figure 38. ADOLESCENT SPECIFIC REPRODUCTIVE HEALTH SERVICES AND CHILD IMMUNIZATION

**MAPPING OF PUBLIC AND
PRIVATE SECTOR FOR FAMILY
PLANNING AND REPRODUCTIVE
HEALTH SERVICES**

**IN THE SELECTED DISTRICTS
OF AJK AND GB**

**Geographical
Information System
Analytics**



5

GEOGRAPHICAL INFORMATION SYSTEM ANALYTICS

GIS mapping was aimed at producing district and union council level maps for location-based performance assessment. The maps provide a visual overview of comparison among UCs in both Muzaffarabad and Gilgit. Figure 39 shows the population volume by UC. MC Muzaffarabad has the highest population, followed by Muzaffarabad, Gojra and Danna.

UC WISE POPULATION - MUZAFFARABAD

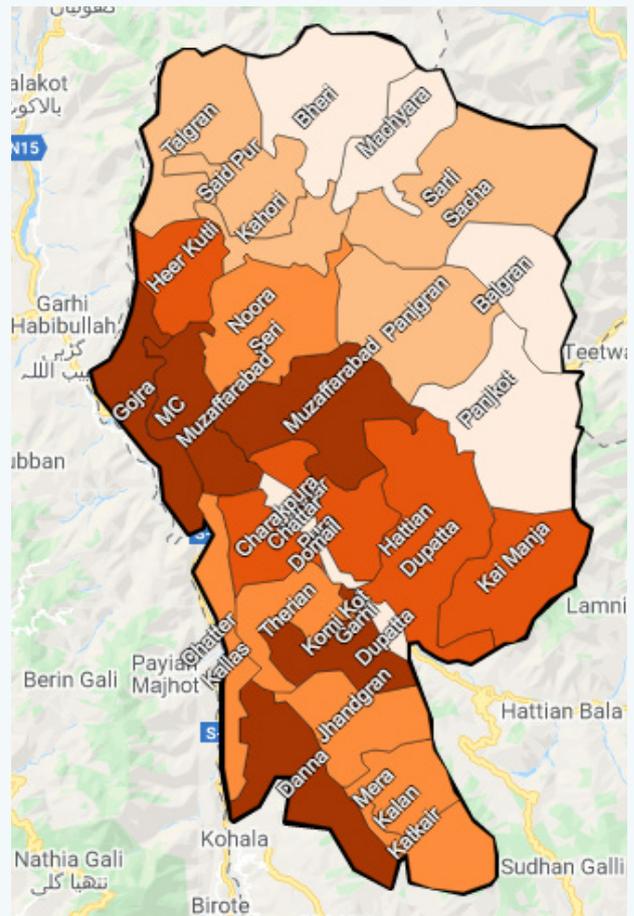
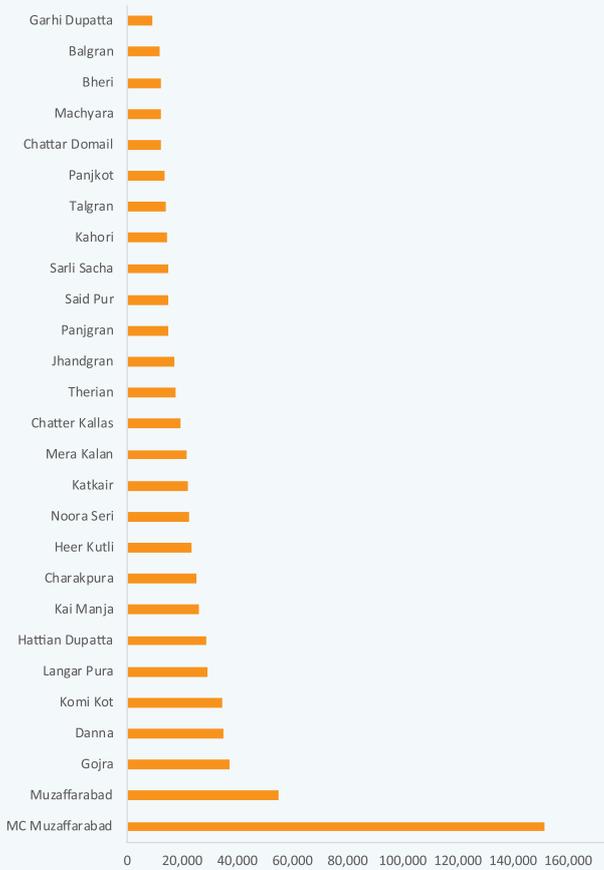
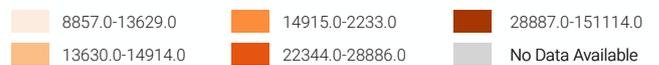


FIGURE 39: POPULATION NUMBERS BY UCS IN MUZAFFARABAD



Most of the Gilgit population is concentrated in Gilgit town and Danyore

UC WISE POPULATION - GILGIT

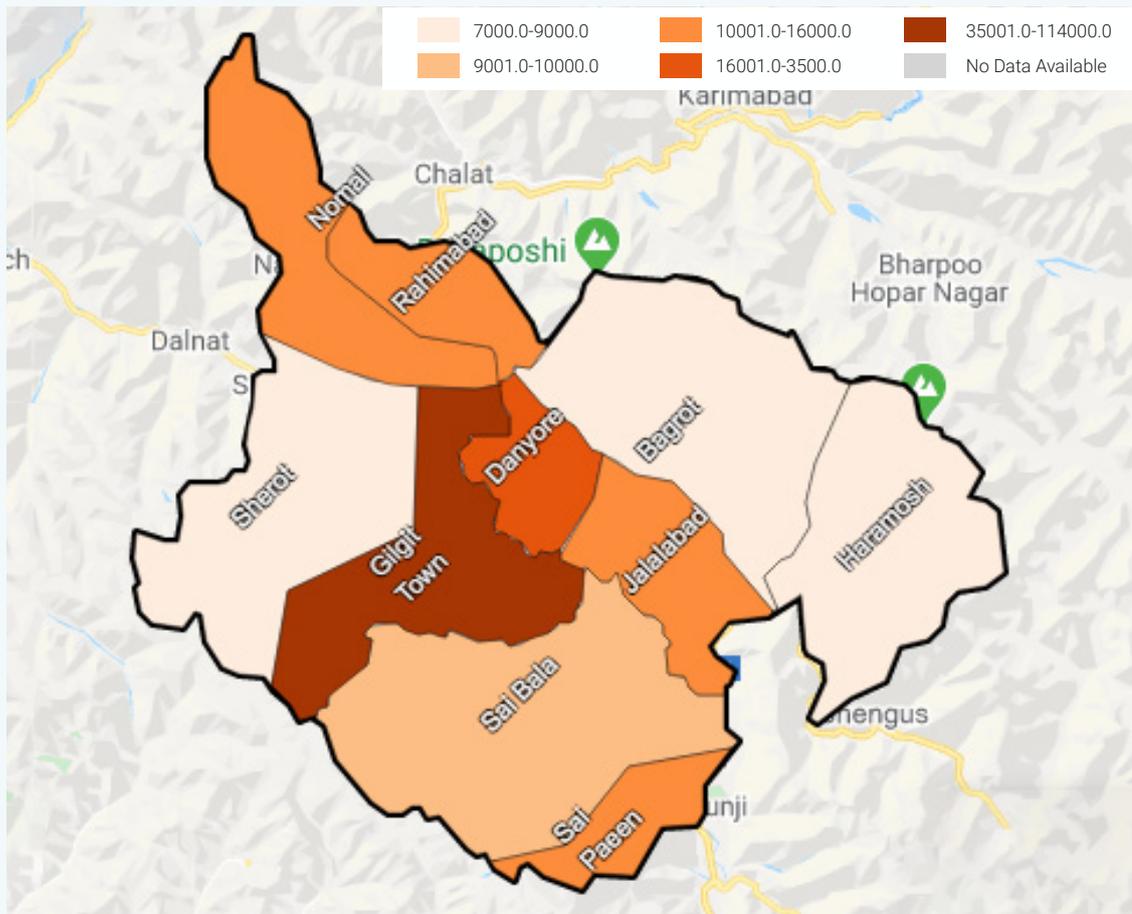
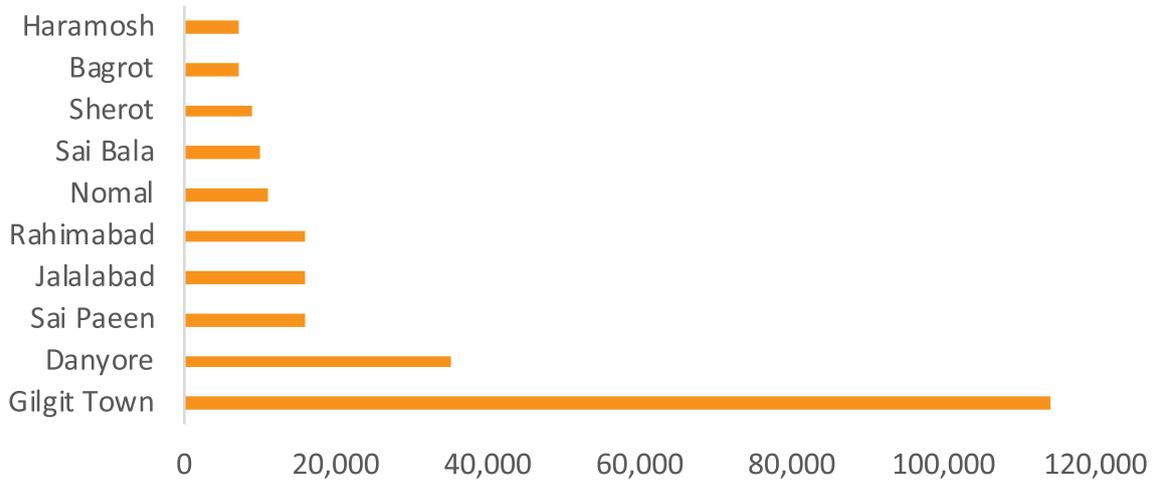


FIGURE 40: UC WISE POPULATION FOR GILGIT

LHW clientele was assessed by dividing the Married Women of Reproductive Age (MWRA) by the number of LHWs operating in a UC. For Muzaffarabad, the highest number of clientele per LHW was found in MC Muzaffarabad, followed by Komi Kot. However, the clientele figures are more or less consistent across UCs and there is are no major differences.

MWRA PER LHW - MUZAFFARABAD

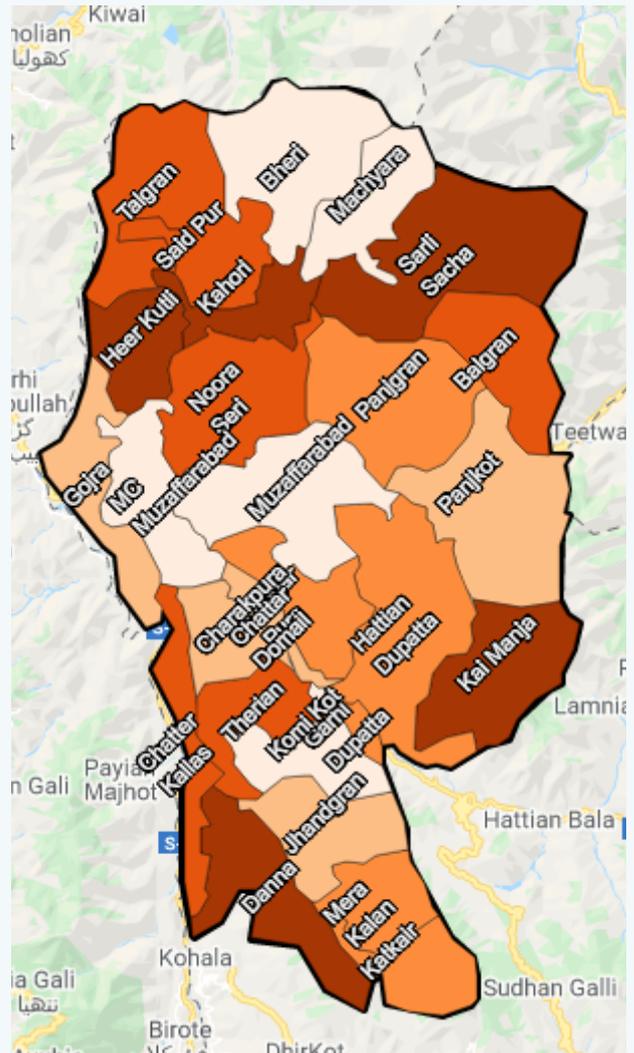
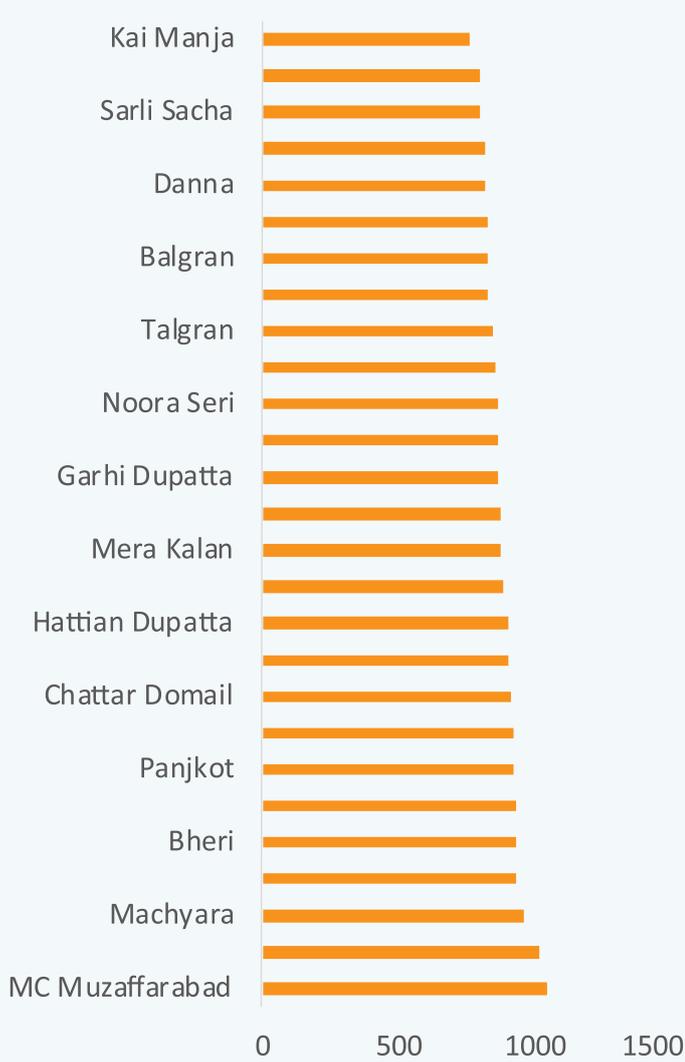
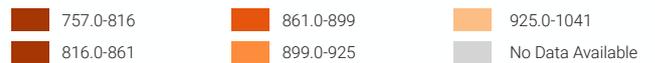


FIGURE 41: LHW CLIENTELE FOR MUZAFFARABAD



For Gilgit, the LHWs from Danyore and Rahimabad are relatively assigned more population compared to LHWs in Sherot and Sai Paeen. However, as per the overall geographical terrain of Muzaffarabad and Gilgit the LHW numbers cannot be harmonized, as only local LHW can reach some hard to access areas.

MWRA PER LHW - GILGIT

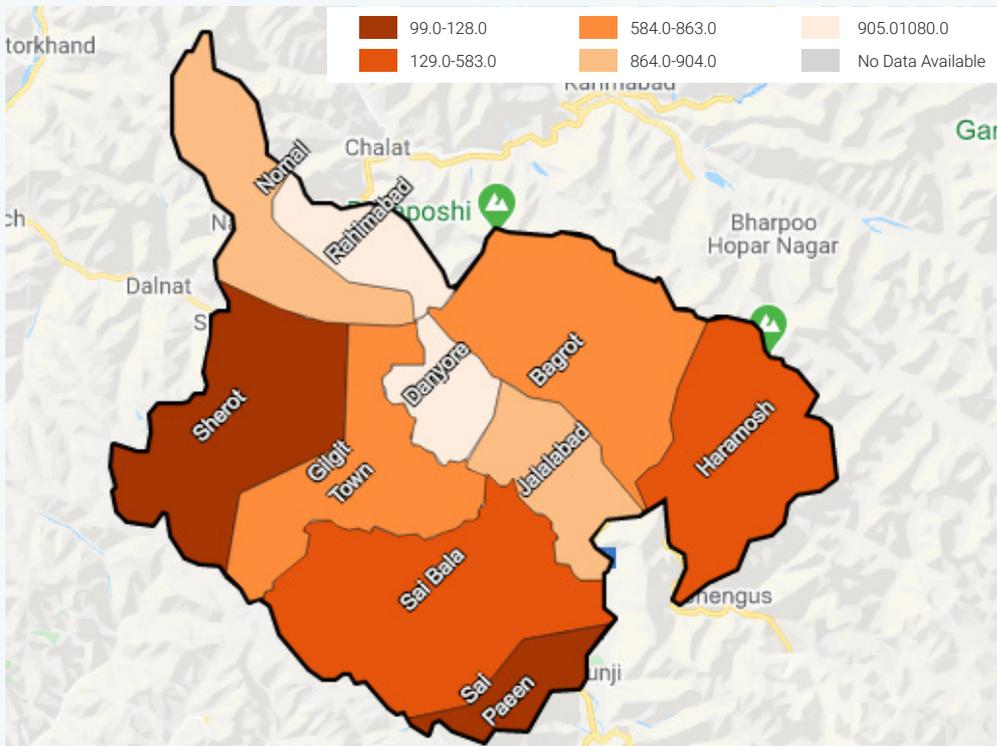
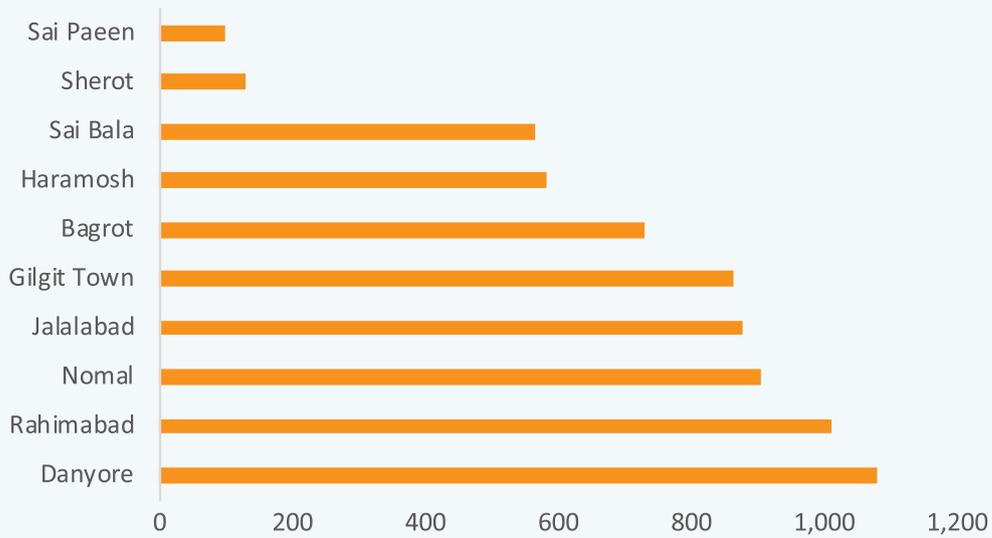


FIGURE 42: LHW CLIENTELE FOR GILGIT

The product availability was also assessed by UCs and mapped on GIS. Figure 43 below shows the percentage of facilities who have COC available (inclusive of LHWs). Apart from almost 25% availability in Garhi Dopatta and Chattar Domail, the availability in other UCs was no or minimal

UC WISE PERCENTAGE OF FACILITIES HAVING COC AVAILABILITY - MUZAFFARABAD

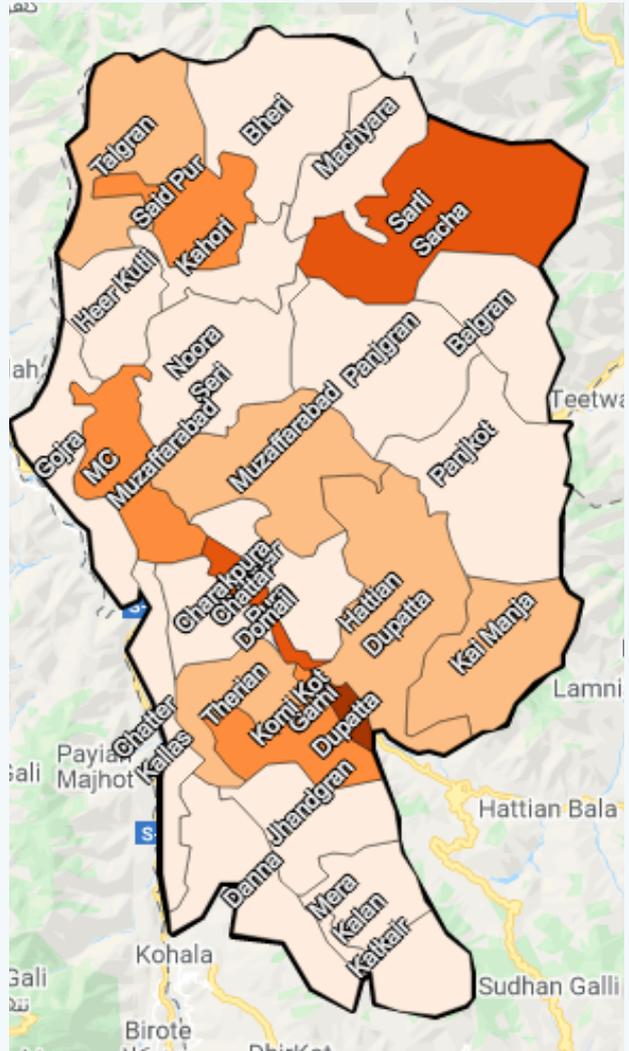
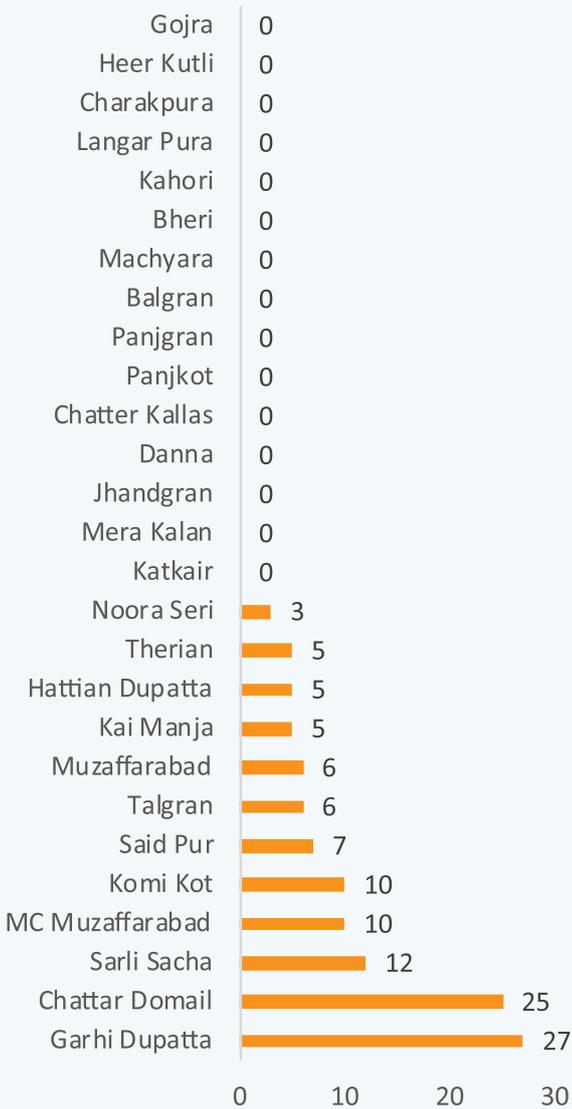
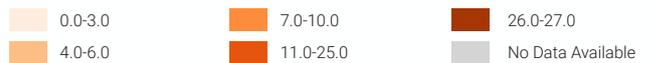


FIGURE 43: COC AVAILABILITY BY UC FOR MUZAFFARABAD



Similar pattern was observed in Gilgit, with minimal to no availability in almost all the 10 UCs (Figure 44).

UC WISE PERCENTAGE OF FACILITIES HAVING COC AVAILABILITY - GILGIT

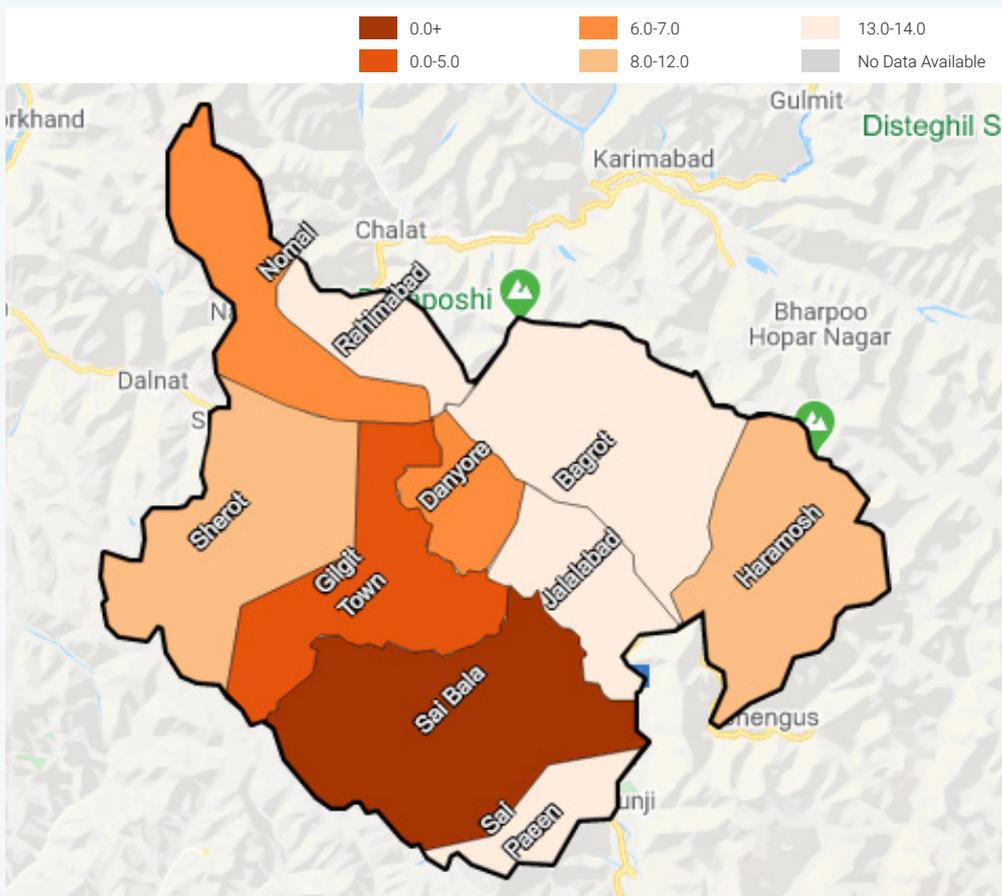
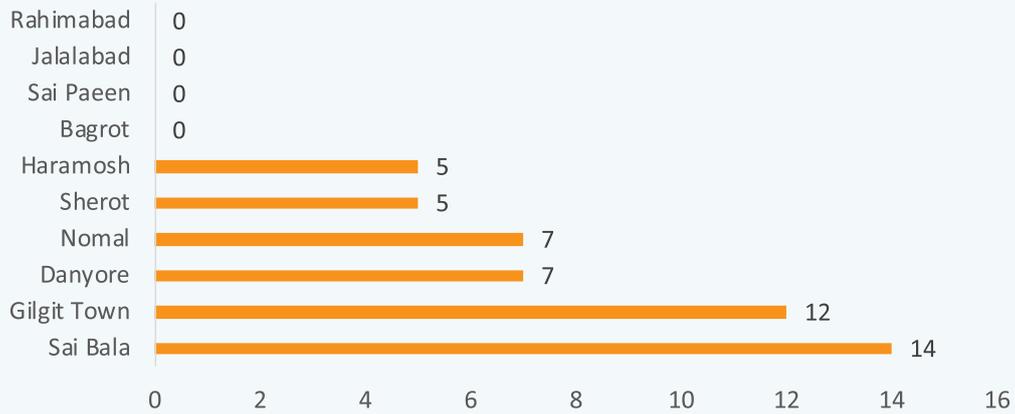


FIGURE 44: COC AVAILABILITY BY UC IN GILGIT

IUCD availability was similarly assessed, Chatter Domail had only one facility and it was stocked with IUCD. Talgran had three facilities and two were stocked. For remaining UCs, the IUCD availability was relatively low, being 0% for 14 UCs.

UC WISE PECENTAGE OF FACILITTIES HAVING IUCD AVAILIITY IN UC - MUZAFFARRABAD

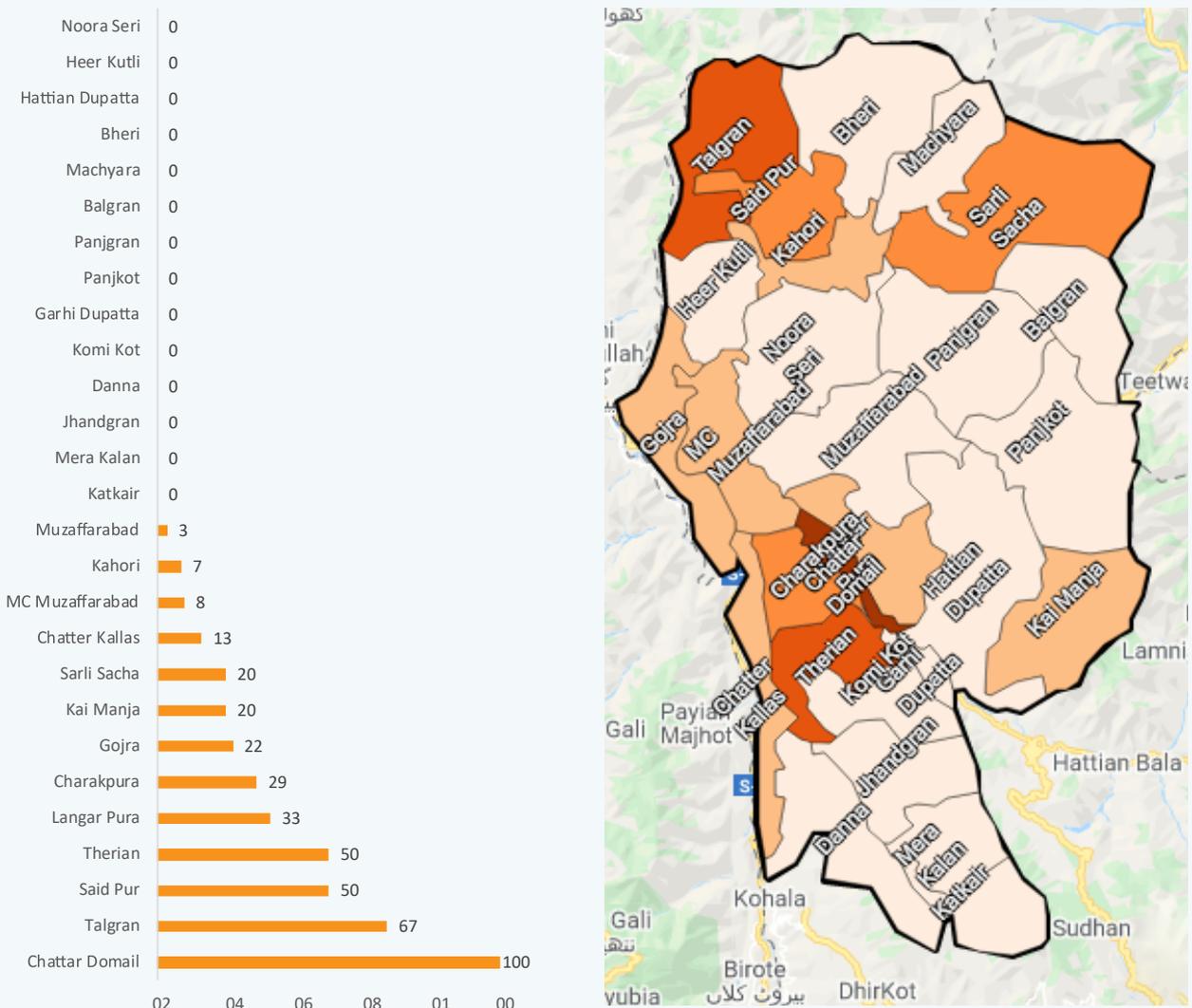
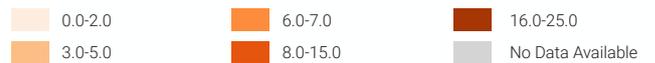


FIGURE 45: IUCD AVAILABILITY BY UC FOR MUZAFFARRABAD



For Gilgit, two UCs had 0% availability for IUCD. Sai Bala had the highest availability, followed by Bagrot

UC WISE PERCENTAGE OF FACILITIES HAVING IUCD AVAILABILITY IN UC - GILGIT

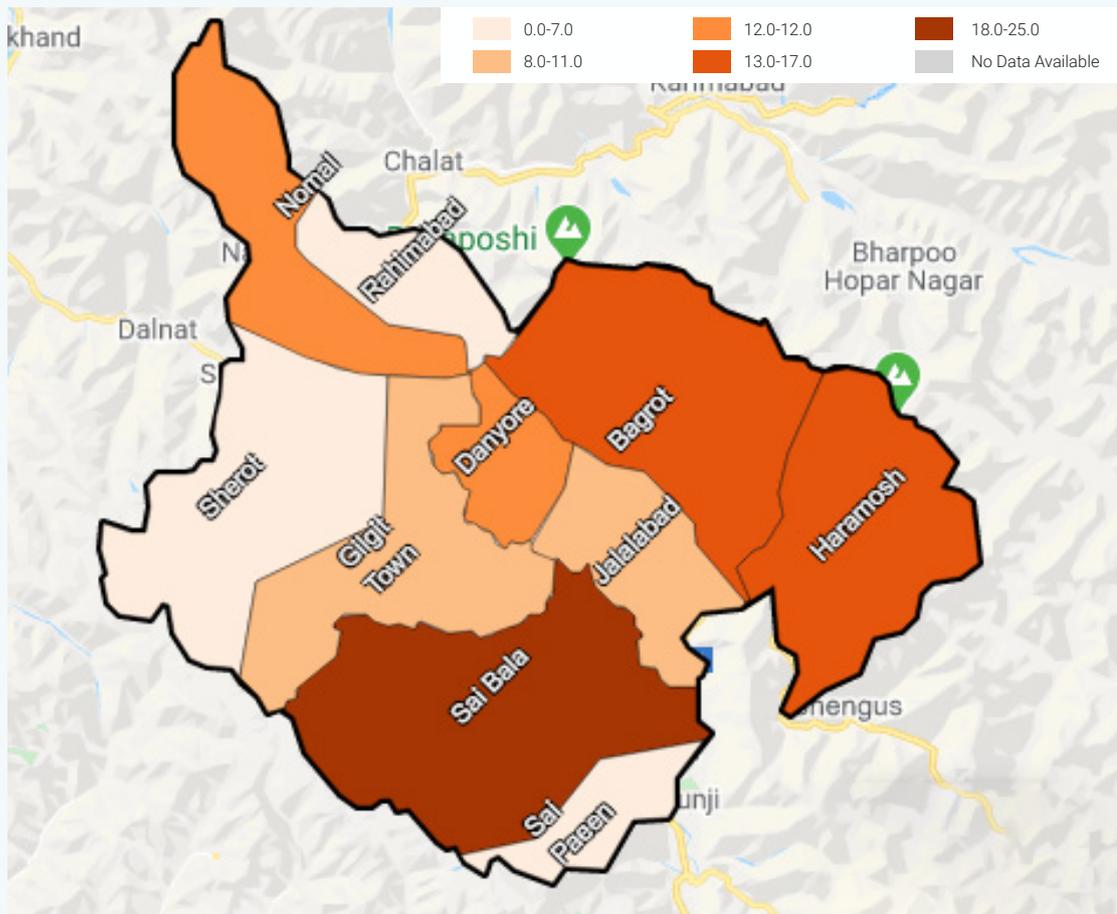
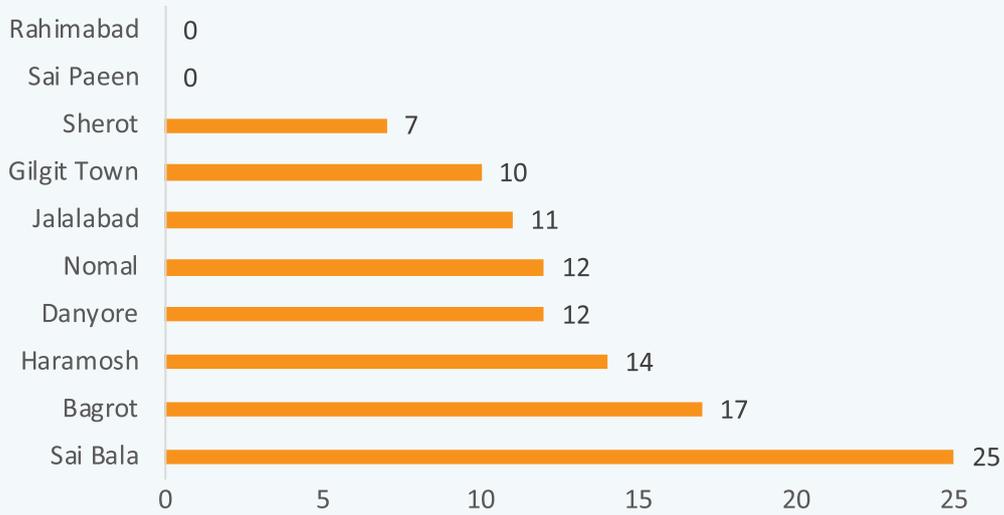


FIGURE 46: IUCD AVAILABILITY BY UC FOR GILGIT

Total number of individuals trained in FP in the past three years were counted by UC. Most of the UCs in Muzaffarabad, as shown in Figure 47, do not have even one staff trained in FP in last three years. Hattian Doppata and Langar Pura had reasonable number of trained staff mainly due to training of LHWs.

NUMBER OF TRAINED FP STAFF IN UC - MUZAFFARABAD

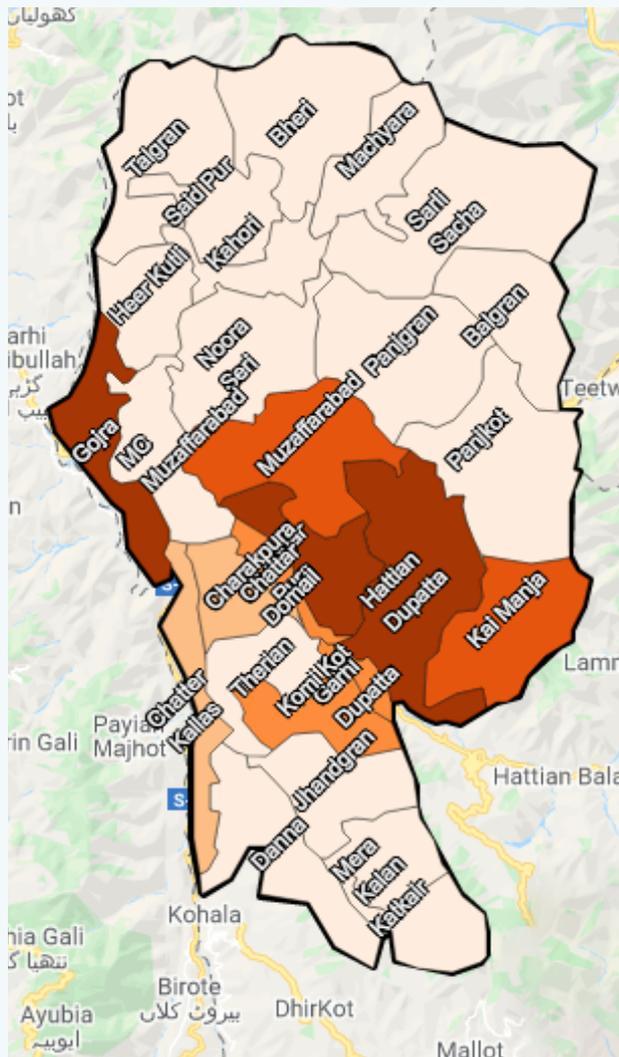
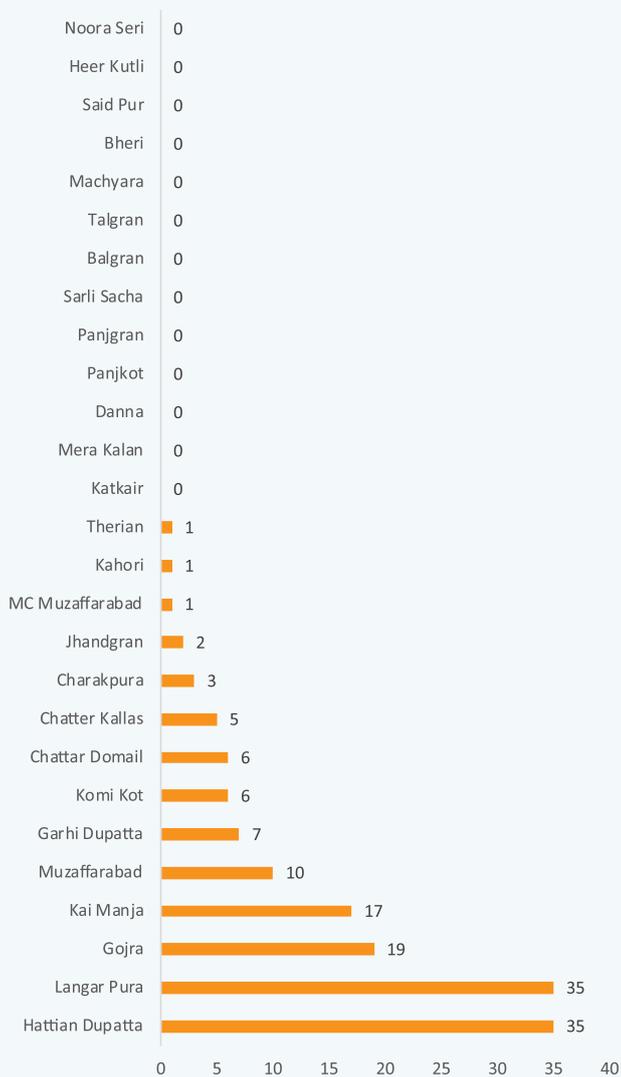
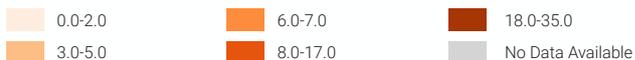


FIGURE 47: NUMBER OF STAFF TRAINED IN FP IN MUZAFFARABAD



Similarly, in Gilgit, the numbers were very low generally, except the high number (79) in Gilgit town (Figure 48).

NUMBER OF TRAINED FP STAFF IN UC - GILGIT

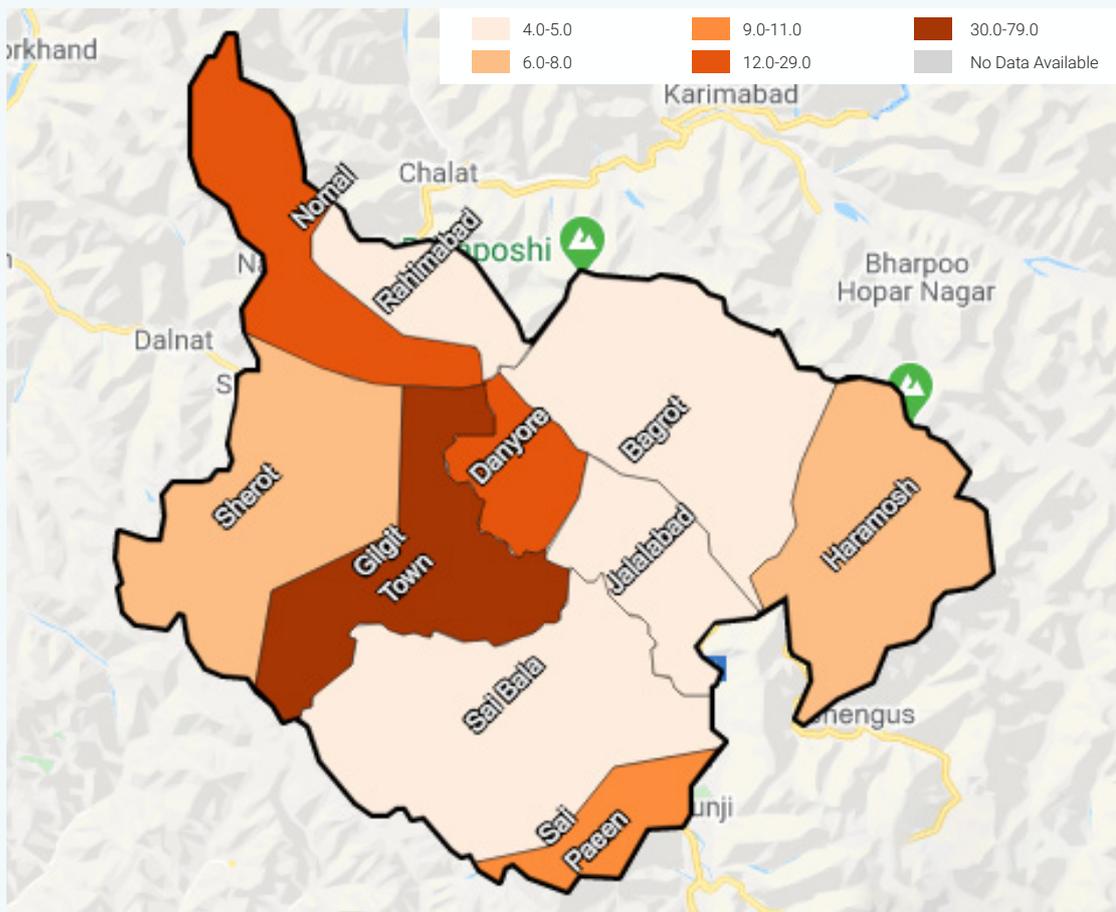
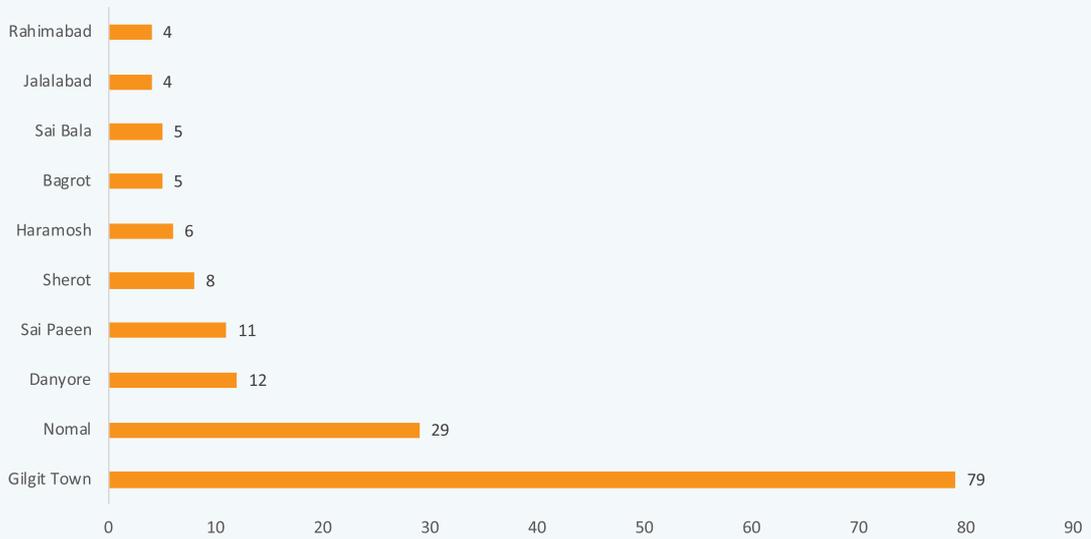


FIGURE 48: NUMBER OF STAFF TRAINED IN FP IN GILGIT

Facility coverage was assessed by dividing MWRA with the number of public sector facilities in a UC. The indicator pointed towards the adequacy or lack of facilities in a UC. MC Muzaffarabad had the highest number of MWRA being catered by a facility on an average; meaning having a smaller number of facilities compared to high population. However, the situation was better and relatively consistent for other UCs in Muzaffarabad as shown Figure 49.

PUBLIC FACILITIES COVERAGE UC WISE - MUZAFFARABAD

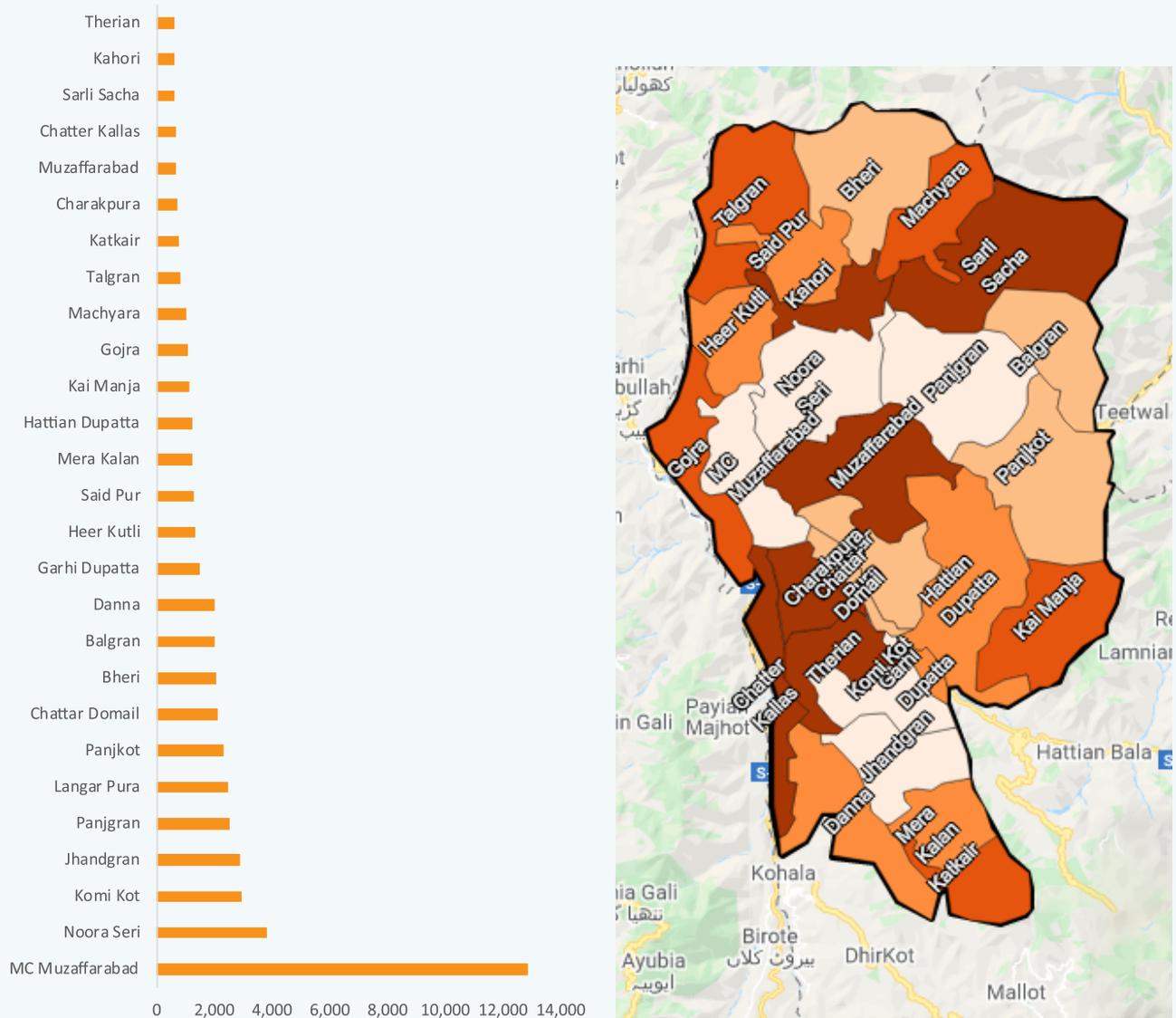
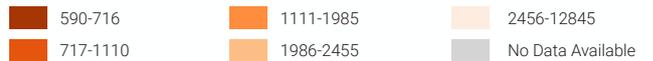


FIGURE 49: FACILITY COVERAGE IN MUZAFFARABAD



Similarly, in Gilgit, the numbers were very low generally, except the high number (79) in Gilgit town (Figure 48).

PUBLIC FACILITIES COVERAGE UC WISE - GILGIT

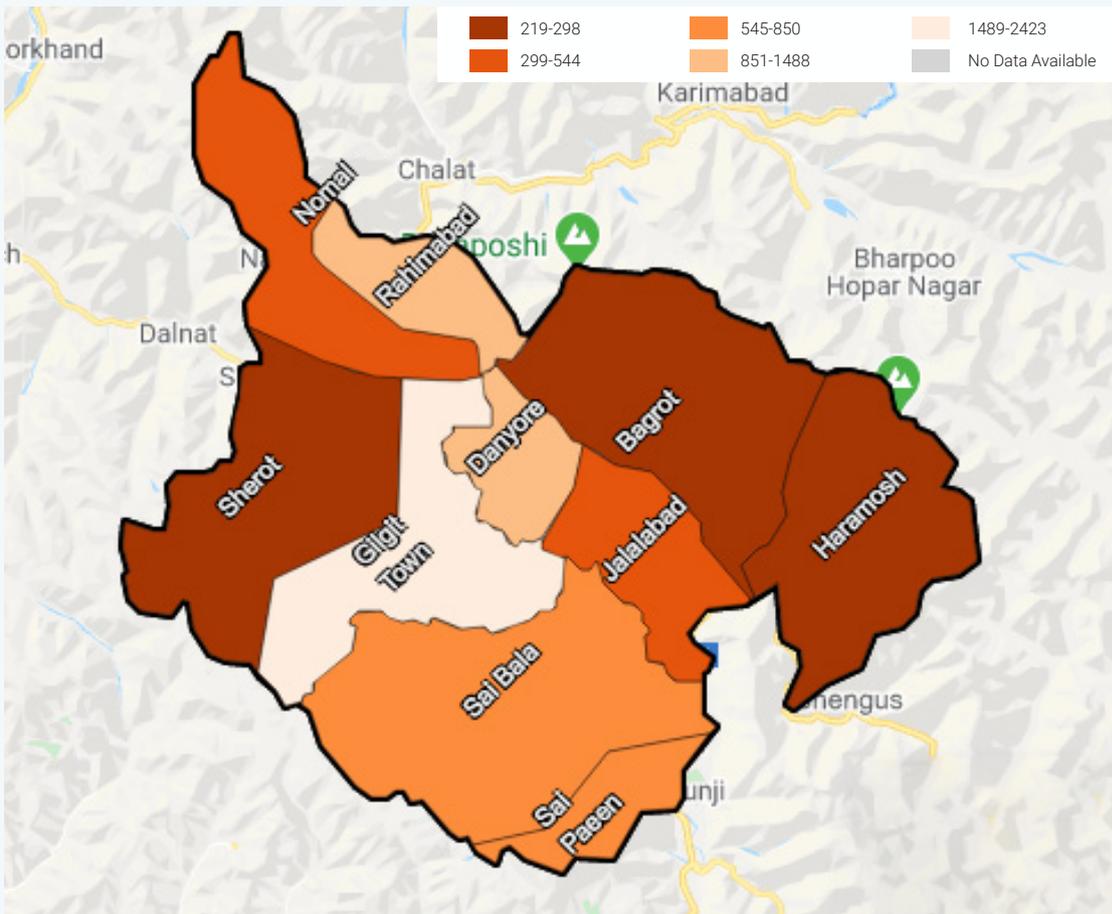
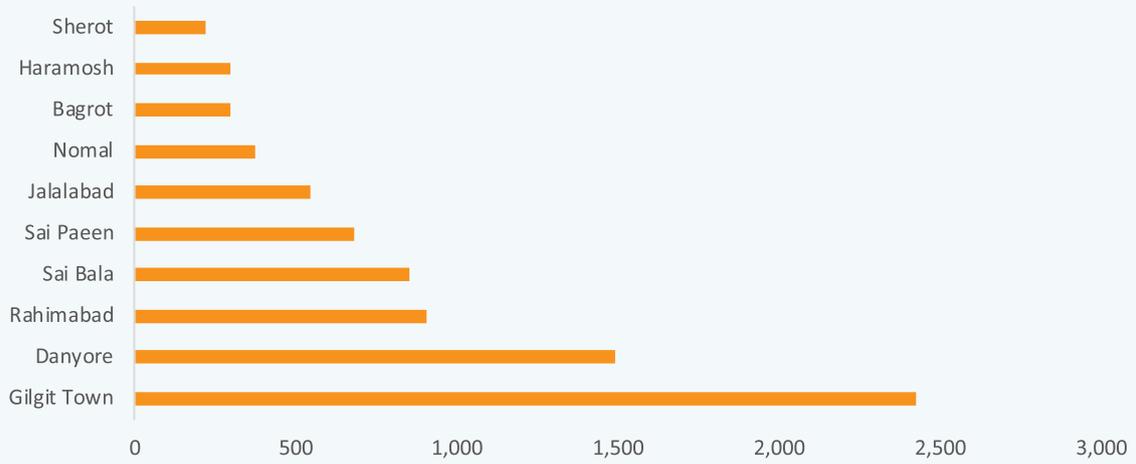


FIGURE 50: FACILITY COVERAGE IN GILGIT

Distance was used as a parameter to measure the spread and proximity of facilities in order to correlate it with potential access. Euclidean distance was used to measure distances between facilities, which measures the shortest possible distance of two locations on earth, thus the actual distances might even be greater as they require commute through streets/roads. It is pertinent to understand the proximity of public to private facilities to identify the areas where there is significant overlap of public and private sector and areas where either one of them is not present or located far away. The distance of each public sector facility was measured with the nearest private sector facility, and the average of distances was computed for a UC. The geographical proximity data in kilometers is shown in Figure 51 below. No private sector facilities were present in UCs shown in grey below. The distance on an average was 2.7 km in MC Muzaffarabad, while it was much higher for Sarli Sacha and Panjkot. The Figure 51 below shows that private sector facilities are few and sparse outside MC Muzaffarabad and Muzaffarabad.

PUBLIC PRIVATE FACILITY PROXIMITY - MUZAFFARABAD
Average distance of public facilities with private facilities in UC (in KM)

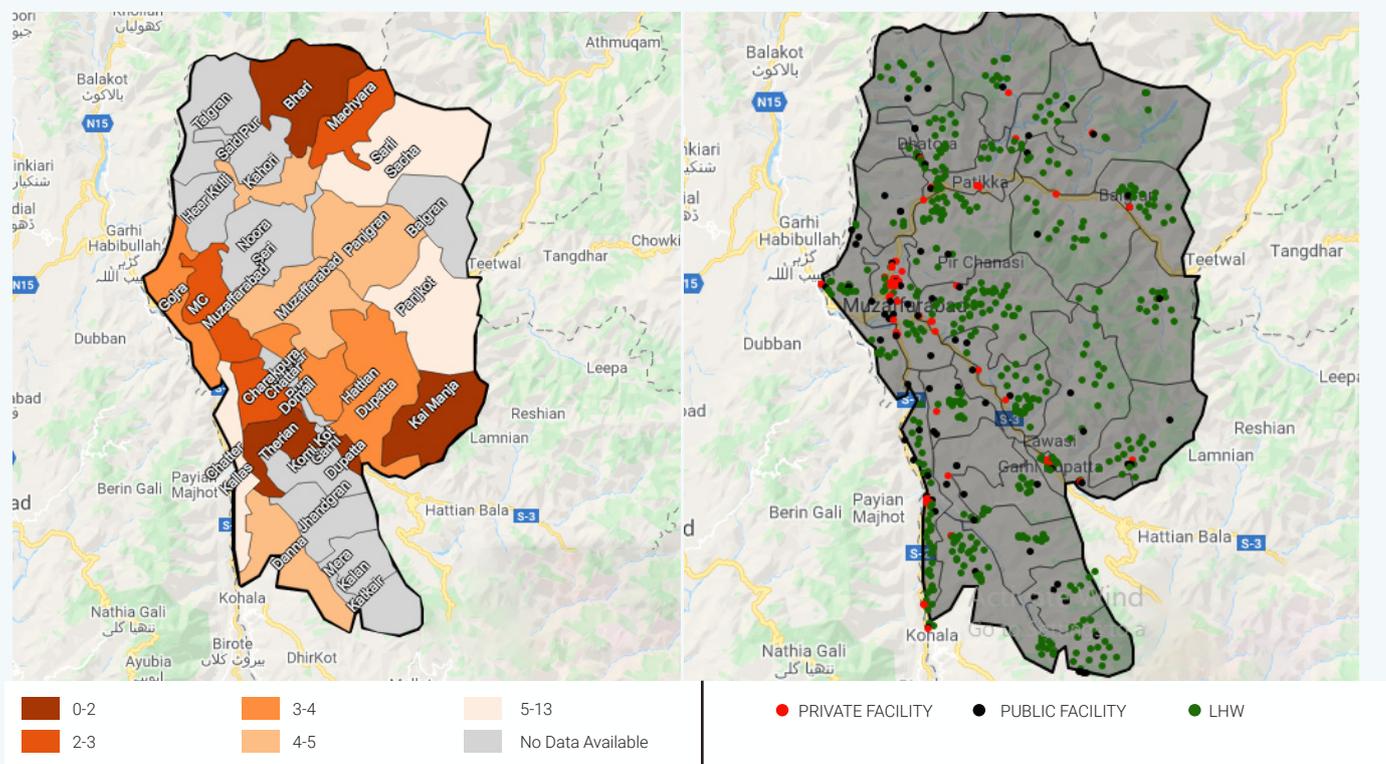
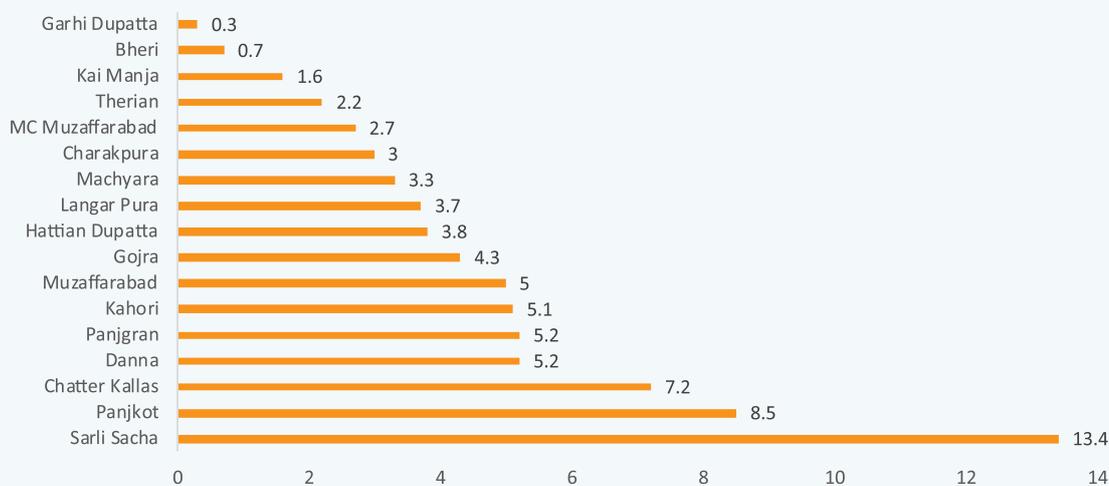


FIGURE 51: PUBLIC TO PRIVATE FACILITY PROXIMITY IN MUZAFFARABAD

Gilgit map clearly shows a crowding of public and private facilities in Gilgit town and Sai Paen. The private facilities are sparse and far away in Rahimabad and Sai Bala. Most of the spread of facilities is driven by the population spread.

PUBLIC PRIVATE FACILITY PROXIMITY - GILGIT
 Average distance of public facilities with private facilities in UC (in KM)

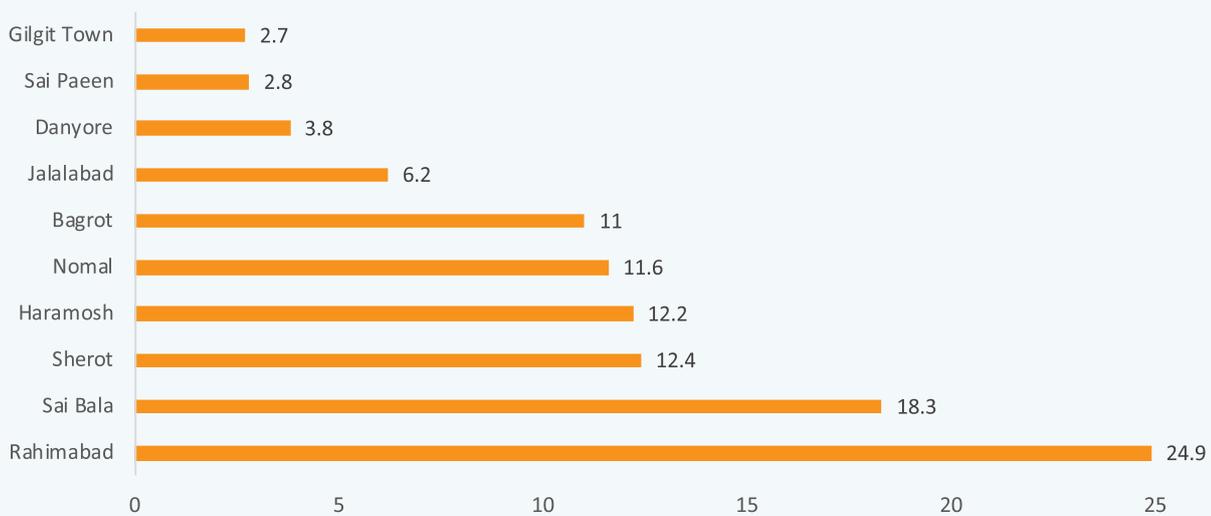
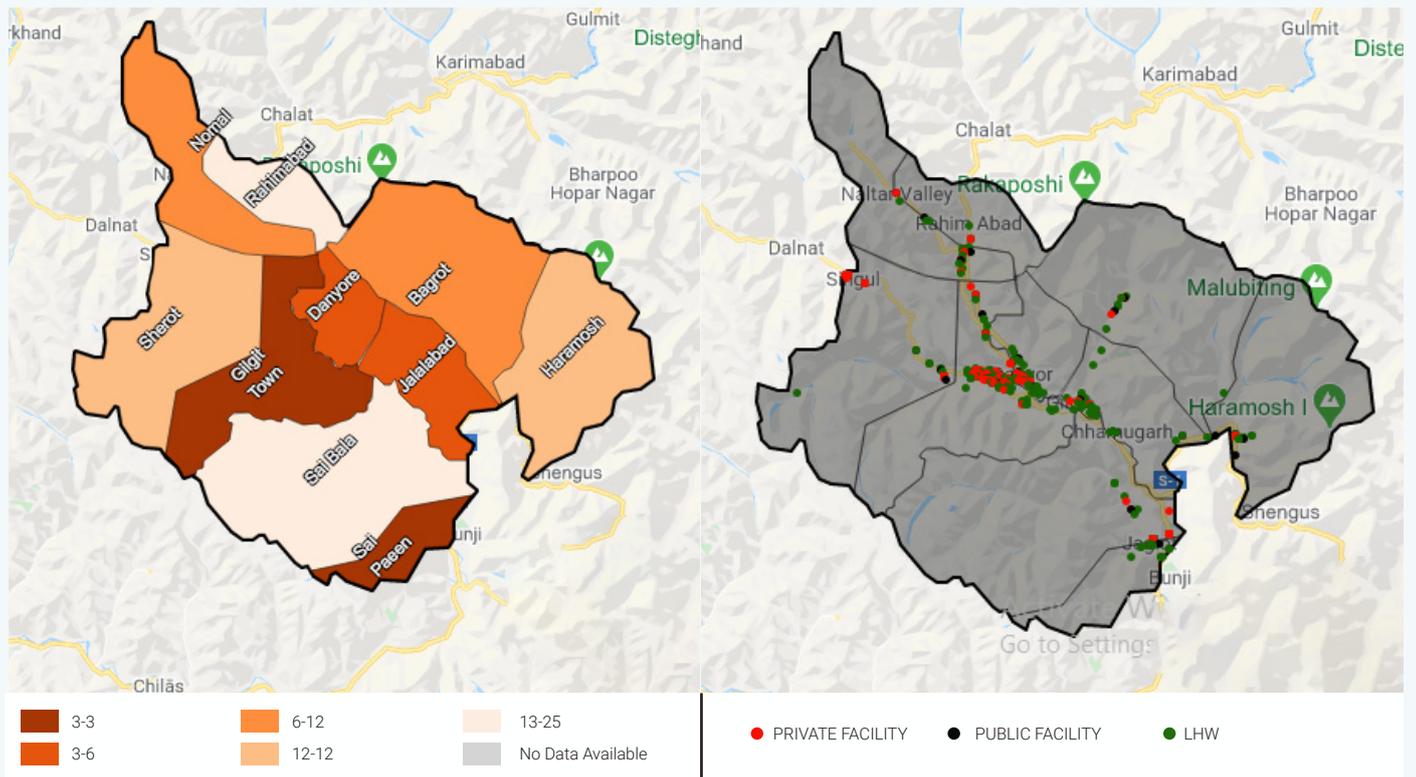


FIGURE 52: PUBLIC TO PRIVATE FACILITY PROXIMITY IN GILGIT

Another measure of coverage and access to communities is the distance from primary (FLCF) to referral (secondary/tertiary facilities e.g. RHC/THQ/DHQ) level facilities. Approximate distance for each of the primary facilities (BHU and Civil Dispensaries) was measured for the nearest secondary/tertiary facility. The average of distances was computed and shown below. Katkair had the highest on average distance, followed by Mera Kalan and Panjkot. Distances were quite short for MC Muzaffarabad, Balgram and Ghari Dupatta

DISTANCE OF PRIMARY TO SECONDARY/TERTIARY HEALTH FACILITY IN UC (IN KM) MUZAFFARABAD

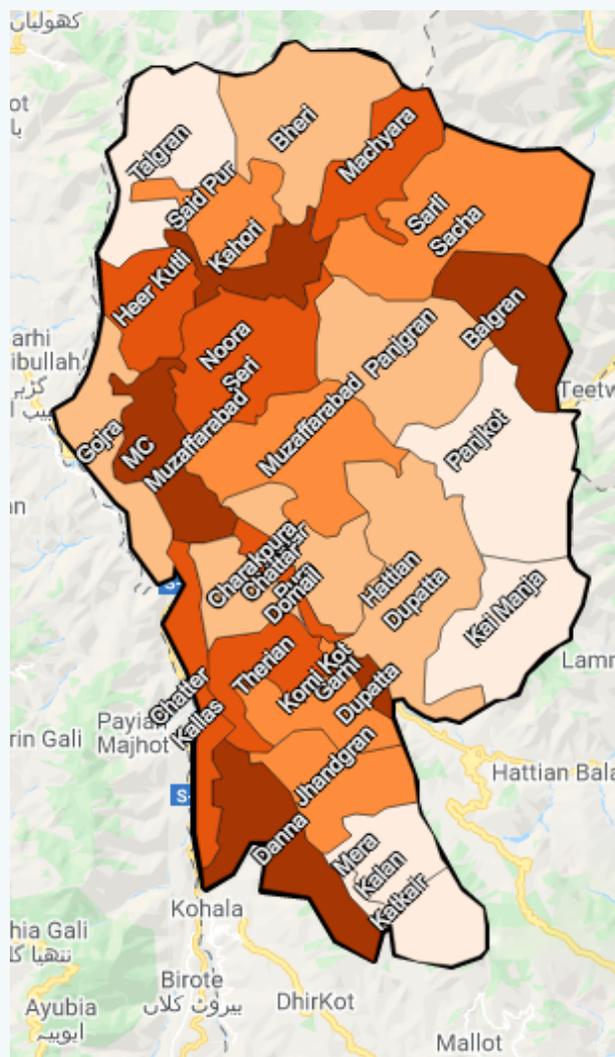
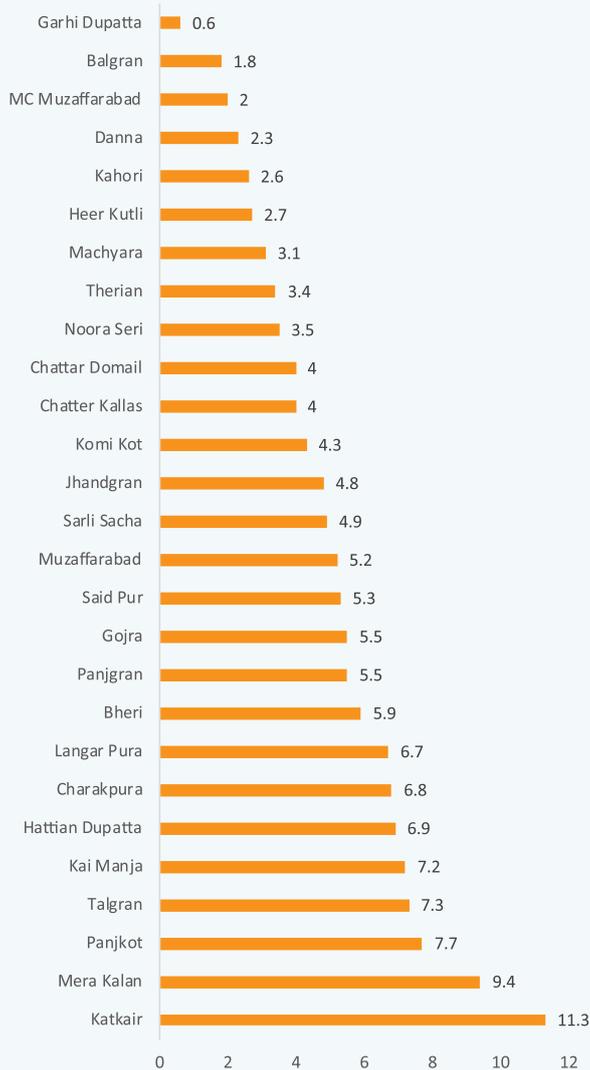
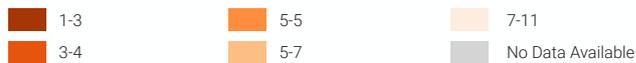


FIGURE 53: PRIMARY TO SECONDARY/TERTIARY CARE FACILITY PROXIMITY IN MUZAFFARABAD



In Gilgit, the Gilgit town, Haramosh and Danyore had the shortest average distances; while Nomal, Bagrot, Sherot and Rahimabad has distance of more than 10 km on average from primary to secondary/tertiary facility.

AVERAGE DISTANCE OF PRIMARY TO SECONDARY/TERTIARY HEALTH FACILITY IN UC (IN KM) - GILGIT

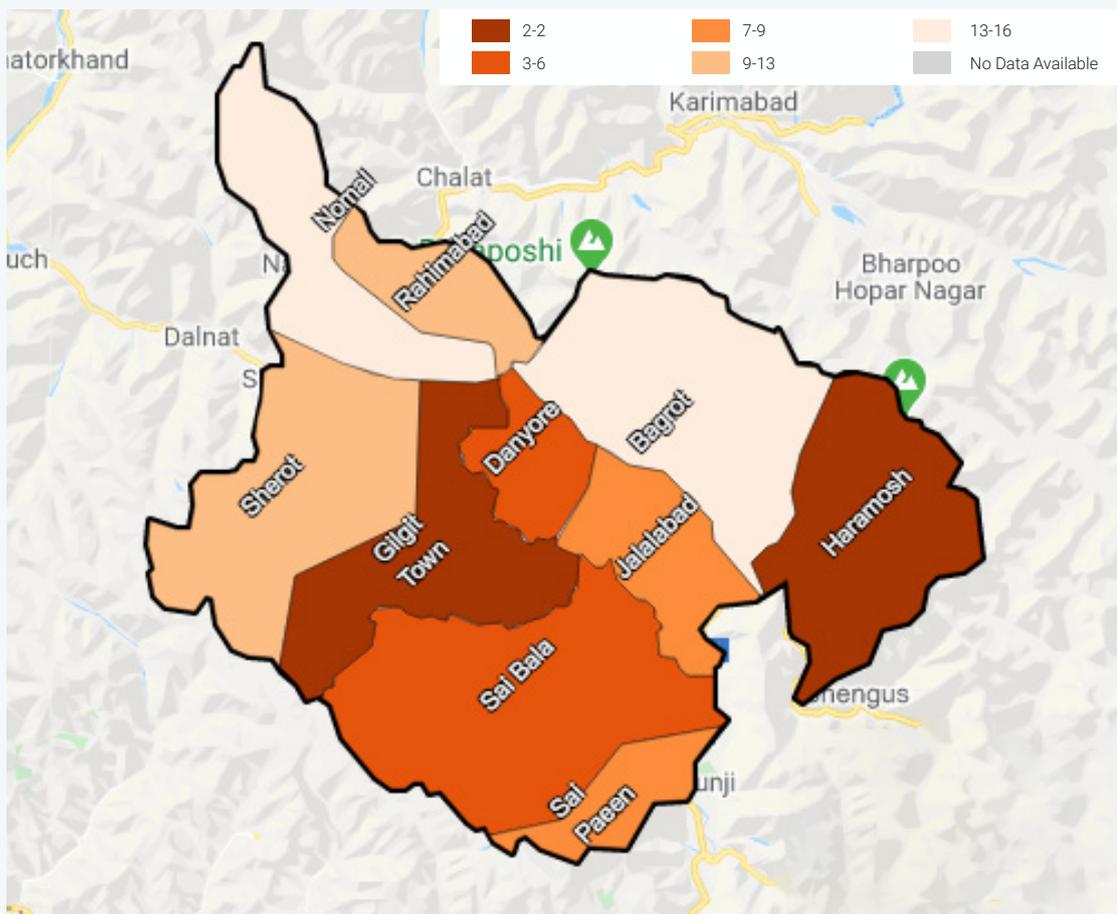
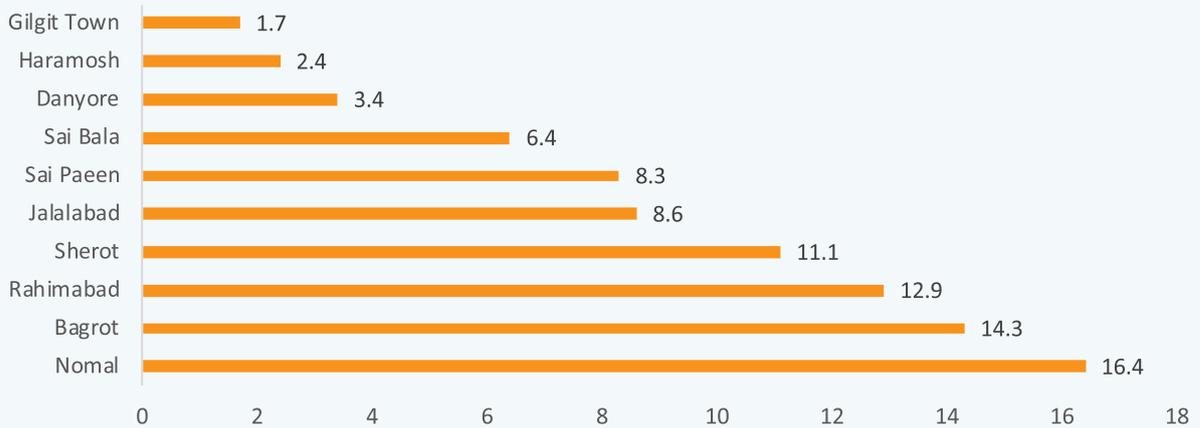


FIGURE 54: PRIMARY TO SECONDARY/TERTIARY FACILITY PROXIMITY FOR GILGIT

6

SUMMARY OF FINDINGS

Table 13 below provides a summary of key indicators and a comparative account of Muzaffarabad and Gilgit. District Gilgit performed consistently better for FP services and product availability except product availability in public facilities, in which Muzaffarabad did marginally better. Availability of at least one contraceptive in private facilities was much higher

compared to public facilities for both districts; mainly because pharmacies almost always had stocks of condoms available. Most of the public sector facilities were providing FP counseling, while private sector performance was lower in it. The availability of HR was relatively better in Muzaffarabad overall.

Key Performance Indicators	Muzaffarabad	Gilgit
FP Services and Product Availability		
Provision of FP Services - Public	52%	86%
Provision of FP Services - Private	61%	85%
At least one contraceptive available - Static Public Facilities	38%	24%
At least one contraceptive available - Community Workers	1%	5%
At least three contraceptives available - Static Public Facilities	13%	14%
At least three contraceptives available - Community Workers	1%	1%
At least one contraceptive available - Private Facilities	44%	78%
At least three contraceptive available - Private Facilities	9%	22%
FP Counseling		
FP counseling provided – Public	80%	59%
FP counseling provided – Private	7%	18%
Availability of HR - Public Sector		
Dispensers/Technicians	44%	33%
Doctors (At Least MBBS qualified)	21%	21%
LHVs	41%	29%
Midwives	22%	3%
Nurses	5%	16%

Table 13. COMPARISON OF KEY INDICATORS FOR MUZAFFARABAD & GILGIT

7

RECOMMENDATIONS

Following are the set of recommendations based on the mapping data for both Muzaffarabad and Gilgit

1 Almost 40% of private sector facilities were not providing any FP services in Muzaffarabad; means not even FP counseling was provided by these facilities. Situation in Gilgit was relatively better, with only 15% of private sector facilities not providing FP service. Considering the volume of private sector facilities (more than two times that of public sector), this is indeed a missed opportunity. Most of the private sector facilities cited lack of time or technical skills as the major reasons for not providing FP service. As mentioned earlier, the FP service provision is not seen as a measure to improve clientele/revenue in private sector. This obvious challenge can be converted into an opportunity by properly incentivizing private sector through various means.

The private sector does not see lack of FP service provision as the core of the health issues engulfing the community, which may be largely due to a curative approach towards health rather than preventative. The attitude needs to be changed by a systematic involvement of private sector. A collaborative planning is likely to be more impactful. Policy should be formulated to systematically involve private sector for provision of services at the existing facilities and expanding to rural and hard to access areas. A five-year roadmap aiming to achieve universal and comprehensive FP services provision at all facilities should be developed. The roadmap should include a legal framework and strategies to incentivize involvement through e.g. provision of free contraceptives. In order to increase and maintain demand for contraception for most in need populations incentives may be provided

by covering contraception costs through income support programs. Public private partnership could be extended further from just product provision to lending technical support from public to private and in-turn receiving 'space' and 'access' to clients/patients for FP counseling and service provision.

A conspicuous role can be played by pharmacies due to their high numbers and geographical reach. The method mix at pharmacies should be increased beyond condoms, alongside provision of counseling and distribution of communication material. Potential tax rebates can be offered to pharmacies allocating space for counseling and reporting clients counseled and products dispensed on monthly/quarterly basis. Government may encourage larger chains of pharmacies and hospitals or even other corporate entities to invest in FP services as part of their corporate social responsibility.

2 The contraceptive stock availability presented an abysmal picture both in Gilgit and Muzaffarabad. The stock availability was less than 30% for all products in both districts, except availability of condoms in pharmacies (which was more than 80%). Almost all LHWs in both districts were stocked out of all three products. It is imperative to note that even the current low level of CPR cannot be maintained at this level of availability. The availability at district stores and central warehouse (as accessed from Pakistan's web-based Logistics Management Information System) during the time mapping was conducted was also low to negligible. The federal government urgently

needs to build a mechanism for procurement and supply management for AJK and GB. Expediting development of PC-1 and release of funds is critical for urgent procurements. A joint procurement mechanism has been long been overdue for efficient and cost-effective buying of contraceptives. Systems have been placed in other provinces vis-à-vis district and sub-district levels distribution and monitoring, from which AJK and GB need to take benefit, to build a coherent and robust contraceptive supply chain.

- 3 Use of modern methods like implants have gained popularity in other provinces like Sindh and Punjab. The success has been built on public-private collaboration in training of resources and provision of products. Almost one third of private sector facilities in Muzaffarabad and Gilgit have trained providers for implants insertion and removal, which is quite significant considering the newness of this method. However, it has not translated into uptake of implants, primarily due to non-availability of products. There is indeed a huge potential for the future uptake. Apart from IUCDs, the services provision for other services in public sector was severely lacking in both Muzaffarabad and Gilgit. However, service provision for services like female and male sterilization, IUCD insertion were relatively better in private sector overall. Public sector needs to step up efforts for universal provision of these critical services in order to improve CPR.
- 4 Proper FP counseling forms the basis of behavior change towards appropriate birth spacing. The overall provision of counseling was good for both Muzaffarabad and Gilgit. However, the translation/manifestation of counseling into use/adoption of FP methods gets limited once the products and services are not available. Moreover, the quality of counseling in terms of how much it is translated into actual behavior change needs to be gauged in future assessments.
- 5 Better availability of MNCH services in Muzaffarabad and Gilgit show the disconnect between FP and MNCH. While, the districts can prioritize and provide much more complex and wider ranging MNCH services, the simultaneous provision of relatively less complex FP services remains very low. In order to expand FP services, they need to be bridged with MNCH services in both public and private sector; this may require policy/legislative measures from the higher levels of government.
- 6 Our data revealed that there was severe lack of trained providers for FP services. Apart from reasonable number of IUCD providers, the other providers for female and male sterilization and implant insertion/removal were very low. Only few of the LHW and other staff had received FP capacity building in the past three years. There must be some institutional structure to expand the current skilled providers for a range of services (counseling, surgery, logistics management, reporting, M&E etc.) This could be achieved through engaging public/private sector academia to train master trainers and providers on regular basis, and by expanding the workforce base through task shifting.
- 7 GIS analytics clearly show that private sector is mostly concentrated in high population density areas. Private sector should be incentivized and/or regularized to reach out to hard to access areas and prioritize provision of FP services. The distances of referral facilities in most areas was too high for clients to seek services comfortably. The government needs to consider providing all modern methods and specialized FP services at all primary facilities in order to improve the access.



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Ministry of National Health Services,
Regulations & Coordination
Government of Pakistan



MAPPING OF PUBLIC AND PRIVATE SECTOR FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

IN THE SELECTED DISTRICTS
OF AJK AND GB