EDITORIAL

Prioritizing effective family planning programming through evidence use in Pakistan

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Pakistan is the fifth most populous country in the world. Its population is growing the fastest among the ten most populous countries worldwide.[1] This large population and its relatively low levels of human development pose many challenges to the country and its citizens such as poverty and vulnerability to climate change or terrorism.[2] A recognition of these concerns has renewed the focus on Family Planning (FP) to not only limit population growth but also restore reproductive health rights to families. This recognition is also reflected in high level commitments such as the Recommendations by the Council of Common Interest and as a key component of the Sustainable Development Goals, and has led to considerable pledges by the government and donors to enhance FP services. However, despite these, the use of family planning continues to be low in Pakistan. This special Supplement of the Journal of the Pakistan Medical Association explores gaps in current FP programming in Pakistan and also suggests some successful models of effective programming in the country.

While the population agenda cuts broadly across almost all domains of the nation's social life such as education, employment, human development and social safety nets, family planning is addressed through health services that are the purview of the Ministry of National Health Services, Regulation and Coordination (MoNHSRC), the provincial Departments of Health and Population Welfare. Pakistan pledged to achieve contraceptive prevalence of 50% by 2050.[3] fulfilling this commitment will require a holistic national response where the government plays a coordinating role by providing oversight, tracking and reporting on national progress; and fills in critical gaps in programming or funding.

Central to this role is data management and reporting. At the moment, the multiple sources of data that are available, include surveys by the government, from any other large surveys or research by other entities with tracking of supplies and services. The Ministry has a core responsibility to collate and analyze these, and report key information in real time, perform higher level synthesis of these data periodically to produce a coherent national picture of the state of family planning, for use in policy and programming decisions. These functions would best be housed in the upcoming Centres for Disease Control and the Health Data Centre that will be a part of a reformed National Institute of Health.

A key contributor to the low uptake of family planning has been the top-down application of programming. In a diverse country such as Pakistan, it is unlikely that fertility preferences and the need for contraception would be uniform across all communities. For e.g., preference for sons varies across demographic groups and is a key driver of fertility is some households.[4] Similarly, as contraceptive prevalence changes, types of methods used, access and intention to pay for contraception changes. Another key variable is the rapid urbanization that is associated with women's employment and higher acceptance of FP.[5,6] To address this, programmes will have to be locally contextualized to address community needs and norms. In particular, aspects of urban programming, prominently absent from much of FP programming until now, will have to be re-positioned as a core policy objective.

Currently most contraceptives coming into Pakistan are channeled through the government, which it then provides to public and private providers. This supply, and that of vaccines, is tracked through an online system. However, the system has many limitations. For e.g., it reflects mostly government provided contraceptives and only few from the private sector, even though the latter accounts for the bulk of FP services. More problematically, the database has large gaps such as entire districts showing no data for months. Incidentally, the vaccine system also shows the same gaps.[7] Part of the problem is limited ownership of such databases by the government. Although it is managed by an internationally accredited entity, lack of oversight of the data and its use by the government and very little feedback from either the public or the private sector means that data errors remain uncorrected. Ownership of these data and their analysis by the Health Data Center can address this major gap.

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Another key gap is the conduct and use of data from national surveys which are mostly funded by donors. This also means that their timing is uncertain, subject to availability of funds, and the use of their data in government planning is sporadic. The National Ministry of Health Services, Regulations and Coordination can institutionalize some of the routine surveys (through the Institute of Health Research) and their analysis at the Center for Disease Control, along with triangulation of survey data with other sources such as supplies and reconcile with other national studies etc. to arrive at an overview of the situation. These analyses must be reported to government, civil society, donors and other wider stakeholders routinely in the form of briefings and published annually as flagship reports. It can also fund research (through the upcoming Institute for Health Research) to promote better understanding of local contexts as they vary across the country and to innovate on the use of technology for service delivery and measurement of programming outcomes.[8]

The public sector has a key role in ensuring the availability of contraceptives which has been sporadic and inconsistent for at least two decades. Most contraceptives are imported in Pakistan, with the exception of some locally manufactured pills. Lately some Non-Governmental Organizations and private companies have started importing directly. In today's fast moving and competitive world, it is not feasible to manufacture all contraceptives locally. However, the government can fulfil its responsibility to ensure commodities by reducing regulatory hurdles and abolishing taxes on import or sale of contraceptives, which were declared emergency medicines by the Council of Common Interests (2019).[9] The MoNHSRC will also work with the Drug Regulatory Authority of Pakistan to expedite approval of new contraceptives that have received regulatory approval in other countries.

In Pakistan nearly two thirds of women avail their services from the private sector.[7] However, the services in the public sector serve a vital niche. As opposed to the private sector, government services, half of which are rendered by the lady health workers, are the only source of FP in rural and hard to reach areas; and therefore, are crucial in reaching populations that have no other recourse. On the other hand, this may contribute to the higher costs of public sector services.[10] Casting a wider net of government services made sense in the 1990s when the private sector had not yet developed. Today with a robust private sector, it's time that the government refocus its service delivery to mostly such remote or rural locations and let the private sector (through donor support or fee for service) serve the more urban locales.[5,6,11]

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