To Assess the Status of Contraceptives Supply and Distribution in the Selected Areas of Uttarakhand

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I. INTRODUCTION

As per NFHS-4, the current fertility levels, a woman in Uttarakhand have an average of 2.1 children in her lifetime. The report suggested that condoms are the most commonly used spacing method (used by 22.7 percent of currently married women). The ninety-four percent of sterilized women had the operation in a government facility and almost equal proportion of IUD users had their IUD insertion in the public (46%) and private (45%) hospitals. More than half of pill users got their most recent supply from the private medical sector, which is also the most common source for condoms.

The NFHS-3 was also revealed that discontinuation rates for temporary methods are quite high. Thirty-seven percent of users of temporary methods discontinued use within the first year after they adopted the method. Nearly half of the users of pills (45%) and one-third of condom users (34%) discontinued use within the first year of use. Therefore, family planning programmes are challenged to reach and serve millions of women whose reproductive attitude resemble those of contraceptive users but whom, for some reason or combination of reasons, are not using contraception. Although family planning services have been a high priority in the delivery of health care to the Indian women of reproductive age for over 50 years, relatively little importance has been given to its quality. If services are not of high quality, clients do not receive the information and learn the skills they need to adopt and sustain successful contraceptive behavior. Quality services and access to a basket of contraceptive choices are essential to fulfill the unmet needs for family planning in India. Improving quality offers many benefits. Contraceptive use is safer & more effective. Information & services are more accessible. Clients make informed decisions & more satisfied. Providers find their work more rewarding. The public has a more positive view of health care & its providers. For improving quality client centre care needs to be provided i.e. respect, understanding, accurate information, competence, convenience & result. The best care helps clients achieve their own reproductive goals.

The supply and distribution of contraceptives play a crucial to ensure quality delivery of family planning services at each level. As per the discussions done at various levels of health systems in Uttarakhand, it was realized that supply and distribution is inadequate and many times clients are not getting contraceptive as their need or their choice. There are many loop holes in creating a demand list, supply mechanisms and distribution patterns. Its distribution process to various levels is varied, sometimes it is being given on demand and sometimes it is being sent as routine supplies. Further, it was realized that at various levels, officers are not able to establish systems of smooth flow of contraceptives supplies at various levels. The key objective of the study to understand the supply and distribution mechanism of contraceptives services at various levels within Doiwala block of Dehradun district in Uttarakhand. The study also analyzed the factors responsible for poor supply and distribution mechanism. Based on findings the study made recommendations for streamlining the supplies at various levels in the selected areas.

II. STUDY METHODOLOGY AND STATICALLY ANALYSIS

This study was cross sectional study and the project team developed the questionnaires for all the health providers at various levels. The study was conducted in three phases, at the first stage the study interviewed ASHAs, ANMs and Medical officers at various level within block, in second stage the study also reviewed the supply and distribution record at village, ANM centers and primary health centers level in the block and at the third stage the study also conducted

information regarding availability and challenges faced by clients of contraceptives at the community level directly from clients.

At the CHC level, study selected all 5 PHC and each PHC and from each PHC the study selected 2ANM centers. In each of ANM center the study also selected 5 ASHAs and from each ASHAs area the study selected 20 numbers of eligible couples on random basis. For this study we interviewed all selected health providers according to prescribed questionnaire and check their records regarding supply and distribution of contraceptives as per the standard checklist.

All the interviewers were done by area coordinators and similarly resource cell members and project manager review all the formats at PHC level. The resource cell members also play crucial role in development of various questionnaires and checklist. The study was started in month of 1April 2010 and field work was completed in month of 31 October 2010. After the completion of survey, for the outcome RDI used SPSS-17 for statistics analysis. The missing values were allowed for the analysis and frequencies were calculated from the univariate analysis. Bivariate analysis will be used to describe the relationship between different variables and the dependent variables.

III. Result

The study is pointed out that there were several lacunas in supply and distribution mechanism at various places in public health system at block level. The study revealed that supply from the district to block was not based on demand however CHC always received in various project wise family planning materials. Annually, few months it comes monthly however many times there is no fixed schedule; similarly it does not have any relation with demand. CHC received contraceptive from various programs such as family planning services, RCH services and HIV-AIDS control programme. The crucial point which study revealed that even today ANM Centers, PHCs and CHC getting target from district and district target is deciding by state. However, there is also no relationship between target and supply of contraceptives.

The ANMs were developing report based on target not on that what they are actually implementing. It becomes clearer when we resemble the CHC report with NFHS-3. As NFHS-3, CuT users in Uttarakhand was 2.6 however ANM, PHC and CHC achieving their target every year. In many ANMs and PHCs the target is higher than the actual number of eligible couples. The absence of actual list eligible couples at community level many, ANMs unable to make correct demand.

There is no proper schedule for demand generation at community level, ANM center as well as PHC level. Result of this, many place clients was not receiving adequate supply of contraceptive. More than 90% of ANMs were getting less than three month adequate supply of contraceptives, similarly only 30% of ASHAs receiving adequate supply of all contraceptives not more three month in a year. The ASHAs also not welling to promote basket of choice at community level because the supply of contraceptives do not contain all contraceptive thought out the year.

In the perspective of client view, the study revealed that more than 75% of male clients bought the contraceptive between 6PM and 8 PM however 90% of female clients bought the contraceptive between 10AM – 12 Noon. The study also pointed out that most of the male clients (84%) bought contraceptive from the private providers, however, majority of female clients (96%) received contraceptives from public health providers. The interesting point which study was revealed that at household level male (68%) mainly responsible for arrangement of temporary contraceptives in regular basis. The research also indicates that client is not receiving adequate supply from ASHAs or even many times they were not receiving from ANM center as well as PHC level.

Basis on the PHC procurement record, the study found that many time at CHC, PHC and ANM centers levels the distribution of contraceptives did not have any relationship with number of eligible couples or users. Many times they just divided by total available contraceptive by the number of PHCs at CHC level, number of ANMs center at PHC level and number of ASHAs at ANM center level. Which has also made difficult the task of ASHAs at community level to fulfill their actual demands? Similarly client also did not get adequate supply at ANM, PHC and CHC levels. The ANM center, PHC and CHC there was no mechanism to display the stock of contraceptive for public display.

IV. Conclusion

Study revealed that to establish contraceptive at least CHC to PHC, PHC to ANM center and ANM center to village level based on eligible couple or users based, secondly, can be outsource the public contraceptive materials for private providers and third the demand of contraceptive will made by CHC according the number of users. This can become a model for other block to ensuring client needs at adequately and help the health system to improve the RCH indicators significantly. To establish this system there is a need to develop an effective and efficient monitoring system at block level to ensure adequate supply at all levels.

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Reference

1 Ali, Disha, Mika Bwembya, Ethan Collins, David Papworth and Erika Ronnow. 2008. “Zambia: Family Planning Quantitative and Qualitative Logistics System Assessment, March 2008.” USAID Deliver Project, Task Order 1.

2 Angeles, G., D.K. Guilkey and T.A. Mroz. 1998. “Purposive Program Placement and the Estimation of Family Planning Program Effects in Tanzania.” Journal of the American Statistical Association 93(443):884–899.

3 Ashraf, Nava, Erica Field and Jean Lee. 2010. “Household Bargaining and Excess Fertility: An Experimental Study in Zambia.” under revision at American Economic Review . Bauman, Karl. 1997. “The Effectiveness of Family Planning Programs Evaluated with True Experimental Designs.” Public Health Briefs 87(4):666–669.

4 Bongaarts, John. 1994. “The Impact of Population Policies: Comment.” Population and Development Review 20(3):616–620.

5 Cochrane, Susan and Laura Gibney. 1991. “World Bank Working Paper: Does Better Access to Contraceptives Increase their Use? Key Policy and Methodological Issues.”.

6 Daniel, Elkan E., Rekha Masilamani and Mizanur Rahman. 2008. “The Effect of Community-Based Reproductive Health Communication Interventions on Contraceptive Use among Young Married Couples in Bihar, India.” International Family Planning Perspectives 34(4):189–197.

7 Debpuur, C., J.F. Phillips, E.F Jackson, A. Nazzar, P. Ngom and F.N. Binka. 2002. “The Impact of the Navrongo Project on Contraceptive Knowledge and Use, Reproductive Preferences, and Fertility.” Studies in Family Planning 33(2):141–164.

8 Desai, Jaikishan and Alessandro Tarozzi. 2011. “Microcredit, Family Planning Programs and Contraceptive Behavior: Evidence From a Field Experiment in Ethiopia.” Demography 48(1):749–782.

9 Gertler, Paul J. and John W. Molyneaux. 1994. “How Economic Development and Family Planning Programs Combined to Reduce Indonesian Fertility.” Demography 31(1):33–63. Hennink, Monique and Steve Clements.

2005. “The Impact of Franchised Family Planning Clinics in Poor Urban Areas of Pakistan.” Studies in Family Planning 36(1):33–44.

10 Kambo, Indra, R.N. Gupta, A.S. Kundu, B.S. Dhillon and H.M. Saxena. 1994. “Use of Traditional Medical Practitioners to Deliver Family PLanning Services in Uttar Pradesh.” Studies in Family Planning 25(1):32–40.

11 Katz, Karen R., Caroline G. West, Fode Doumbia and Fatoumata Kane. 1999. “Increasing Access to Family Planning Services in Rural Mali Through Community-Based Distribution.” International Family Planning Perspectives 24(3):104–110.

12 Johri L, Panwar DS, Lundgren R. *Introductionof the Standard Day Method in CARE-India’s Community-Based Reproductive Health Programs.* Washington, DC: Georgetown University, Institute for Reproductive Health; Available from: http://www.irh.org/sites

13 Georgetown University, Institute for Reproductive Health (IRH). *Lactational Amenorrhea Method (LAM)Projects in India.* Washington, DC: IRH; Available from: http://pdf.usaid.gov/pdf_docs/ PDACL.pdf