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Status of Family Planning in Pakistan

**Zeba Sathar
Batool Zaidi**

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by Zeba Sathar and Batool Zaidi

Executive Summary

This report is mainly a review of the status of family planning and the efforts to promote contraceptive use through the Population Program, and the supporting roles of other sectors and players. It is divided into three sections: the first on how the program has evolved since its inception; the second on the trends in family planning outcomes over the last two decades; and the third on explanations for Pakistan's poor performance, and recommendations on how to make the population program more effective. Both analysis of secondary data, mainly taken from fertility surveys conducted over the last two decades, as well as primary data collection, through interviews with key stakeholders, inform the discussion in this paper.

When we had almost finished writing this report, the 18th Amendment to Pakistan's constitution was passed by the parliament. As a result, the Ministry of Population Welfare was dissolved on December 1st, 2010 and by March next year the Ministry of Health will also cease to exist. Although the implementation of the family planning program was already primarily done at the provincial level, the abolition of MoPW will severely impact program funding in the coming years. While we have tried to include the effects of this amendment in our report, much of the discussion is based on the situation before it.

Our discussion on the evolution of the population program begins from when family planning services were first introduced in the government's First Five-Year Plan 1955-1960 through the Family Planning Association of Pakistan (FPAP) and other voluntary organizations. Over the next two decades the major achievements included: the creation of an independent family planning set-up, a mass-scale information, education and communication (IEC) campaign, and the establishment a service delivery network in the 1960s; and the introduction of the "Continuous Motivation Approach" in the 1970s. Over the next decade, the program operated at a low key due to re-organization, political unrest and suspension of IEC activities. The only major achievements during this time included devolution of field activities to the provinces, institutionalization of the role of non-governmental organizations through the NGO Coordination Council (NGO CC) and the establishment of the National Institute of Population Studies (NIPS).

Much of the focus of our study is on the period starting with the 1990s when Pakistan started experiencing fertility decline. This period corresponded with the end of the Zia regime and renewed political support from the highest levels for the population welfare program, and the establishment of the federal Ministry of Population Welfare in 1989-90. The 1990s also saw the change that came with the ICPD conference; before, population was almost wholly left to the purview of the Ministry of Population Welfare and a few organizations doing social marketing and research formulation. The ICPD brought population, packaged as part of reproduction health (RH), to the forefront of the development arena. Prime Minister Benazir Bhutto's, active participation at the ICPD and strong commitment to population issues led to the initiation of the Lady Health Workers (LHW) program and the creation of the National Trust for Volunteer Organizations, a successor to the similar NGOCC.

The post-ICPD period was marked by even greater active interest in population policies and issues of reproductive health and recognition of the need to collaborate with other public institutions on the part

of the Ministry of Population Welfare, and with the private sector and NGOs in government plans and policies. In 2000, the Government initiated an assessment of the program, which led to formulation of the Population Policy in 2002, setting the long-term vision for the population sector. However, the ICPD, which centered on RH, resulted in taking some focus away from family planning; this was reflected in the shift in donor funding to other aspects of RH. This shift in funding was exacerbated by the political atmosphere in the country in which major donors, such as USAID, did not operate in Pakistan for several years, so the government committed its own scarce resources to family planning and reproductive health.

Despite the scarcity of resources, the 1990s saw contraceptive prevalence more than double from a low 11 percent in 1991 to 28 percent by the end of the decade, with rural CPR increasing from 6 to 22 percent and urban from 26 to 40 percent. Since the new millennium, there has been little increase in contraceptive prevalence, with the nation average only increasing to 30 percent by 2007. This stagnation in contraceptive use does not reflect the demand for family planning, which rose consistently from the 1990s. Unmet need for family planning rose from 33 percent in 2001 to 37 percent in 2007. This high and persistent unmet need explains the high proportion of unwanted pregnancies and induced abortions that take place in Pakistan; a study by the Population Council estimated a high abortion rate of 29 per 1000 women for the year 2002.

These issues of low contraceptive prevalence and high unmet become even more problematic when looking at the inequalities within them. Women from the poorest households experience significant change in their fertility desires with more than half of them expressing the desire to control their fertility; their desires now very closely match the fertility desires of women from the richest households. However, contraceptive use for the poorest women remains very low – 14 percent compared to 45 percent for women from the richest households. This explains the sharp increase in unmet need, a combined outcome of preferences and use, experienced by poor women who increased their demand to limit childbearing without much change in contraception use.

The low CPR among the poorest women can be in part explained by poor access to services. We know that the poor mostly reside in rural areas, and national level data show that RH facilities in rural areas are four times the distance in urban areas. The average distance to an RH facility in rural areas was 12km in 2001. Moreover, results from 2007 data show that the private sector, which is not free and seldom located in far-flung rural areas, is increasingly becoming the source of methods for users. In 1991 the government was the source of method for 56 percent of users, in 2007 its share went down to 48 percent, whereas the private sector's share increased from 30 to 40 percent over this time period.

Of course, access is not the only factor for the stagnating CPR. Poor quality of service provision and services is another important obstacle; fear of side effects and health concerns are increasingly become the reason women cite for not using contraception, particularly in the urban areas. This is also reflected in the high dropout rates, with a widening gap between ever-use and current use of contraception.

With all these factors at play it is not surprising then that the targets of the Population Policy 2002, of providing universal access to FP services by 2010 and for reducing the fertility rate to replacement level of 2.2 by 2020, have become glaringly unachievable in the planned time. In fact, current trends in fertility, if extrapolated, indicate the replacement fertility target will not be achievable even by 2030. Although slow to come, there has recently been recognition that Pakistan is off course with its objectives of the earlier 2002 policy. There is some awareness that Pakistan has strayed from prioritizing family planning, and that the high levels of unmet need for family planning and their general stagnation are a primary responsibility of the state. This led to the strong move toward the formulation and

preparation of a new Population Policy 2010; however, this has been put at the back burner due to the abolishment of the federal ministry. It is critical that the provincial governments take ownership of this policy document and take forward its agenda.

Once there is ownership at the provincial level, several steps need to be taken to make the provision of family planning more effective. The two main priorities need to be: first, the increase and guarantee of allocation of funds to the program, which at present are under serious threat due to the abolishment of the federal ministry who was responsible for providing the provincial programs with resources; second, strengthening integration with other sectors, including the health department, the NGOs and the private sector. The lack of integration and cooperation has meant limited outreach, limited consensus, lack of innovation, and, therefore, extremely minimal impact.

The program can significantly improve its service delivery components by a successful integration and coordination with the health departments. It can also be greatly strengthened if the NGO sector is brought in more actively into the fold. NATPOW offers some hope that a strong umbrella organization can make grants and strengthen the capacity of the NGOs, particularly the smaller organizations located in areas where neither the public nor private sector is willing or able to provide services. Moreover, the private sector has yet to be tapped fully but has to be approached with some parameters about the quality and range of services that would need to be provided by different cadres. A strong regulatory mechanism may need to be in place for uniformity of standards of service delivery at the national and even provincial levels; such a board has been formulated in Punjab already.

Even if all these programmatic issues were effectively addressed and remedied, the universal provision of services alone cannot fully achieve the targets; it will only take care of the immediate need for family planning. Investing in women's education is imperative, not only for increasing women's participation in the labor force, and society in general, but also for bringing about the ideational change needed for reaching replacement fertility. More widespread education, especially among women, women's increased participation in the economy, greater prosperity in general, and a more profound transformation from Pakistan's current primarily agrarian structure to industrialized society will be necessary to transform values about ideal family size from the current level of 4 children to 2 children.

Lastly, all this can only be achieved if there is strong political commitment (which has thus far been seriously lacking) to putting population issues at the center of Pakistan's development planning, by economic and finance departments, health officials, and donors alike. In order to convince these stakeholders that family planning needs to be repositioned in the development and policy dialogue as a means for healthy birth spacing, which is so closely linked to maternal and child health, and as a critical tool in realizing the demographic dividend and reducing poverty.

1. Introduction

This assessment is being carried out at a critical time in Pakistan's history. The 18th Amendment to the Constitution calls for all programs, including health and population, to be the sole responsibility of the provinces and, therefore, the Ministry of Population Welfare (MoPW) will not exist beyond December 1, 2010. While the Ministry of Population Welfare has been carrying the responsibility of providing family planning services for over four decades, the drastic change will be that the sole responsibility will now rest with the provincial departments of health to provide services. There will be huge challenges as this takes place because the provinces are cash strapped and have not made provisions for providing family planning services so suddenly. Services are likely to be further disrupted when the responsibilities of the federal Ministry of Health are also shifted to the provincial level in 2011.

This paper is mainly a review of the status of family planning and the efforts to promote contraceptive use through the Population Program, and the supporting roles of other sectors and players. Both analysis of secondary data, primarily taken from fertility surveys conducted over the last two decades, as well as primary data collection, through interviews with key stakeholders, inform the discussion in this paper. While discussing the past and present, the paper will point out areas that need corrective action or need to be abolished, as well as others that have been overlooked and need urgently to be brought into the program's fold.

2. Program Evolution

2.1. History of the Program

Making the connection between the wellbeing of the population, the country's resources and its size, General Ayub Khan was the first leader to announce emphatically in 1965 that Pakistan had a population issue that needed attention. He then assigned an important individual at the helm of the population program. This was ironic given that the first Pakistan census in 1961 yielded a total population size of only 30 million, which preceded the real spurt in growth that occurred between 1972 and 1981. Civil society was more advanced in their thinking, recognizing even earlier, in 1958, that an active family planning program was the need of the moment. The Family Planning Association of Pakistan (FPAP) started its own voluntary non-governmental program at that time and has probably had a huge imprint on the government program operating by its side for many years. Pakistan's First Five Year Plan (1955-60) introduced family planning activities through the FPAP and other voluntary organizations.

In the Third Five Year Plan (1965–70), an independent family planning set-up was created and mass-scale information, education and communication (IEC) activities were launched, and a service delivery network was established. The next plan introduced the "Continuous Motivation Approach" by employing male-female teams of workers at the union council level. Over the next decade, the program operated at a low key due to re-organization, political unrest and suspension of IEC activities. Major achievements during this time included devolution to the provinces of field activities, institutionalization of the role of non-governmental organizations through the NGO Coordination Council (NGO CC) and the establishment of the National Institute of Population Studies (NIPS). With the end of the Zia regime in

1989, the population program saw strong political support from the highest levels. However, since the Eighth Five Year Plan (1993-98) was finalized before the ICPD conference, the reproductive health (RH) framework was not reflected in it.

2.2. Impact of ICPD

Population was almost wholly left to the purview of the Ministry of Population Welfare and a few organizations doing social marketing and research formulation for at least a few decades, but then the ICPD period and its preparation seemed to mark some stir within the population arena. The ICPD 1994 conference was attended by the late Benazir Bhutto and her important statement, *“I dream of Pakistan, of an Asia, of a World, where every pregnancy is planned and every child is nurtured, loved, educated, and supported,”* led to the initiative of the Lady Health Workers (LHW) program. The launching of the Lady Health Workers program, a huge public-sector program mandated to provide family planning and primary health care in remote rural areas and in urban slums, was one of the two major innovations of the early nineties. The second was setting up the National Trust for Volunteer Organizations, a successor to the similar NGOCC.

The ICPD gave you ways of reaching men and women in a broader, more development-oriented way, and, therefore, made family planning more acceptable. From an NGO perspective, women’s rights activists started looking at contraception as a right. ICPD provided ways of looking at the availability of contraception within the larger issues of women’s space and mobility.

Advisor, Shirkat Gah (Women’s Rights Organization)

2.3. Post-ICPD

In the Ninth Five Year Plan (1998–2003), the population program was realized with a post-ICPD Plan of Action. In March 2000, the Government initiated restructuring and right-sizing of the public sector; an assessment of the Population Welfare Program was also undertaken, wherein it was noted that the program was moving in the right direction and that fertility transition had set in and had to be sustained. The process led to formulation of the Population Policy in 2002, setting the long-term vision for the population sector.

The post-ICPD period was marked by even greater active interest in population policies and issues of reproductive health. While reducing population growth rates remained the primary concern of the Government of Pakistan, and part of the Population Policy 2002, there was greater emphasis on providing accessible and better-quality services to meet the needs of individuals. Furthermore, the need to collaborate with other public institutions on the part of the Ministry of Population Welfare, and with the private sector and NGOs, now appeared in all government documents and plans. Other achievements during this period included establishing the National Population Commission and the Population Summit held in 2005.

Since 2000, health outlets were also mandated to provide family planning services. However, a major obstacle has been the limited delivery of family planning services by the health sector, in general, and the departments of health, in particular. The Lady Health Workers (currently employing close to 100,000 women with basic education) were found to be very effective in delivering family planning services in 2001 (Oxford Policy Management 2002), but were found in this year’s third party evaluation to be faltering in providing these services because of the overload on them for other duties, especially polio vaccines (OPM forthcoming).

Even though the provision of family planning is first in their mandate, the LHWs are busier providing primary healthcare (polio drops). That is why the latest third party evaluation shows that the LHWs have not succeeded in bringing up CPR. The program is fine – nothing is better than door-to-door service; the implementation and M & E (which should belong to MoPW) are the problem.

Director General Technical, Ministry of Population Welfare

2.4. National Population Policies

The Population Policy 2002 has several notable targets of broadening responsibility for service delivery, for amassing resources, providing universal access to FP services by 2010 and for reducing the fertility rate to replacement level of 2.2 by 2020. However, this is under serious review precisely because these targets are glaringly unachievable in the planned time. In fact, current trends in fertility, if extrapolated, indicate this target would not be achievable even by 2030.

By the end of 2009, there was a strong move toward a new Population Policy 2010, which is in the process of gaining Cabinet approval and comprises the latest projections incorporated by the Planning Commission. This was instigated by several shifts on the ground, such as the new National Finance Commission Award, the 18th Constitutional Amendment, and, most of all, the slow recognition that Pakistan was off course with its objectives of the earlier 2002 policy. There is some awareness that Pakistan has strayed from prioritizing family planning, and that the high levels of unmet need for family planning and their general stagnation are a primary responsibility of the state. Resources are pressed for the social sectors generally, once again, given the huge amounts being spent by Pakistan on the war on terror and the other priorities at this point in its history. Some corrective actions are underway: the most recent development is renewed realizations about family planning and a renewed commitment to provide family planning services through the LHWs and the departments of health, which is bound to make a significant difference to service delivery in the next few years.

2.5. Contraceptive Commodity Security

Contraceptive procurement and distribution have remained an uncertainty over the years, since Pakistan imports the bulk of its contraceptives. The Ministry of Population Welfare has been procuring contraceptives for more than three decades. For this purpose, there is a full-fledged Directorate of Procurement Material and Equipment (PME). There is a central warehouse in Karachi, from where contraceptives are distributed throughout the country, mainly through government channels. Unfortunately, adequate purpose-built storage facilities are not established at provincial and district levels.

Pakistan is dependent on donor funds to procure contraceptives; in fact, the major share of donor funding has been going toward procuring contraceptives. The main bulk of the overall outlay of 14 million dollars in 2007-2008 (rising substantially from previous years) went to social marketing (\$6.7 million), then to health (\$4.6 million), and last to MoPW (\$2.7 million). Various donors have contributed funds to obtain contraceptives that are purchased as one single order by UNFPA for the Government of Pakistan. Presently, the contraceptives are being procured by UNFPA (on payment basis) through international bidding; UNFPA receives 5 percent in services charges from MoPW.

At the moment, the government is facing a crisis, as it is unable to come up with the funding for the huge demand for contraceptives. Contraceptive commodity forecasting is based on the expectation of

raising the level of current contraceptive practice from 30 percent (2008-09) to 37.5 percent by 2015. Users are expected to increase from **8.4** million in 2008-09 to **10.8** million in 2014-15.

The status quo of how contraceptives are procured and distributed is most likely going to change. Discussions are underway: first, for the government to procure directly; second, for increased local manufacturing and self reliance; and, third, for changes in the lines of distribution. Local manufacturing of pills and injectables is already underway. Feasibility studies are under consideration for establishing IUD/CU-T manufacturing units in Pakistan. The pharmaceutical firms could be encouraged, facilitated and given incentives to manufacture contraceptives.

With the drastic changes anticipated with dissolution of the federal functions of the MoPW, resource mobilization, forecasting national contraceptive requirements and procurement of the national requirement will have to be taken up at the national and sub-national level by one of the arms of the government, such as the Planning Commission. Warehousing is likely to continue in Karachi, but distribution is likely to be through three or four distinct channels. Most likely, there will be different streams for the LHW program, the departments of health, social marketing, NGOs and others in the private sector, such as hakims and homeopaths.

On the effects of the 18th amendment: The money for family planning was coming from the federal budget and now that the ministry is being dissolved it needs to come from the NFC award, which has already been allocated for this year (none was given to family planning because that was coming from the federal government). Now for next year, the provinces will actually have to reallocate funds from another department to family planning, which will be very difficult and will be met with resistance from the heads of other departments. There is a need for huge advocacy at this moment targeting provincial governments and legislators to convince them of the importance of FP to ensure reallocation to the department.

CEO, Family Planning Association Pakistan

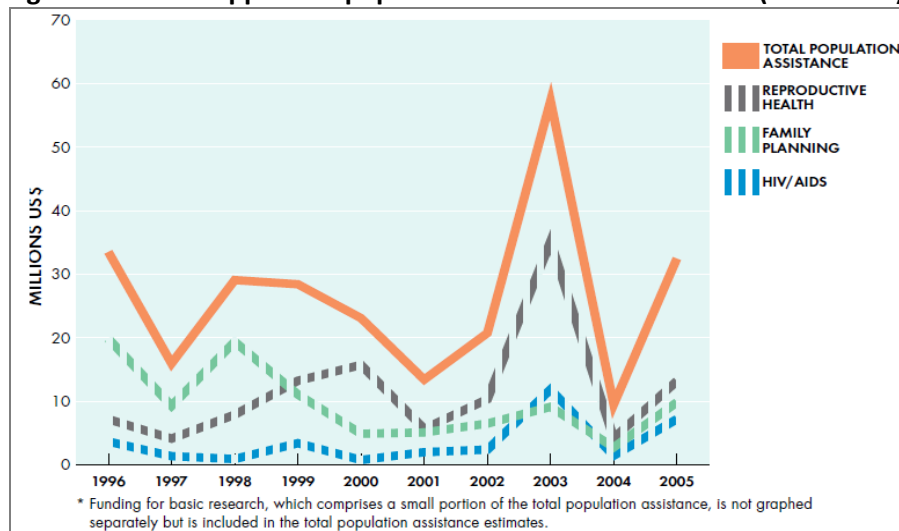
2.6. Funding Streams

In an atmosphere where major donors, such as USAID, were not operating in Pakistan for several years, the government committed its own scarce resources to family planning and reproductive health. Funds for population welfare are released at the federal level and then disbursed to the provinces, AJK and FATA. The total outlay has risen from Rs. 3.1 billion in 2003-04 to 4.2 billion in 2005-06 and remained fairly stagnant until 2008-09 at Rs. 4.3 billion (roughly US\$ 50 million). The ask for 2009-10 was much higher at Rs. 5.2 billion, but the releases were much lower than that, remaining at Rs. 3.4 billion.

This trend of limited donor funds, largely used to fund contraceptives, became even more exacerbated with international donor funds shifting very much in favor of reproductive health, in general, and HIV/AIDS, in particular, and away from family planning.

Since 2003, the funding flows have begun to increase from USAID, KFW and UNFPA, with DFID providing budgetary support through the Ministry of Finance. The chart below (Figure 1) shows a major spike in donor funding for RH, but it is quite evident that this addition was for maternal health and not for family planning, which remained flat until the recent past.

Figure 1: Donor support for population assistance to Pakistan (1996-2005)¹



2.7. Public/Private Partnerships

Social Marketing

Social marketing, starting in the mid 1980s, concentrated in urban areas and was expected to intensify its efforts to the periurban areas and extend its outreach to rural areas. It was to broaden the scope of services through new interventions in order to enhance the contribution of social marketing in raising prevalence and expanding markets. Increasingly, the private sector, through social marketing, has taken greater responsibility for dispensing, advertising and training in family planning, and also broadening its reach to other areas of reproductive health, including maternal health and HIV/STI prevention. Although the private sector is playing a very vital role in providing FP/RH services in the country, social marketing still continues to be concentrated in urban areas.

NGOs and CBOs

Historically, NGOs have played a pioneering role in establishing family planning in Pakistan and in setting the reproductive health agenda. NGOs have provided important clinical services, including contraceptive surgery. Apart from service delivery, there has been a considerable role for NGOs and CBOs in advocacy, BCC and community mobilization, where they have advantages. It is surprising that the contribution and performance of NGOs are neither fully reflected nor acknowledged in the reports compiled by the program.

Unfortunately, the NGO sector in Pakistan is probably the one most affected by the shortages in funding for FP, and NGOs have moved into newer reproductive health research areas, such as HIV/AIDs, where funding was available. As a result, funding channels for NGOs working on FP and RH have been limited, except by the very large NGOs, such as FPAP, Marie Stopes Society, etc.

The NGOCC, which was active in the 1980s, was transformed into The National Trust for Population Welfare (NATPOW), which has been fairly dormant from 1994 to 2008. NATPOW was established under the Charitable Endowment Act in 1994 as a statutory “Apex Body.” It creates an effective partnership between GoP, donors, NGOs and private-sector organizations for promoting small family norms, and arranges funds and provides technical assistance for the smaller NGOs working in the fields of reproductive health (including family planning and mother and child health). The organization remained

¹ Source: Hardee and Leahy 2008

ineffective for almost two decades until 2009, now a full-time chief executive officer and new board of directors have been appointed who have operationalized the organization to deliver its functions and mandate, especially coordination with its affiliated NGOs and making grants to them. This opening up of a grants-making channel should revitalize the role of the NGOs in service delivery. Even more current is the move to transform NATPOW from a trust to a not-for-profit company under the Companies Act 1984. This will presumably make the organization more independent and a better conduit of funds for greater involvement of NGOs and civil society organizations, including social marketing projects.

Public-Private Sector Organizations (PPSOs)/Target Group Institutions (TGIs)

Select target group institutions (TGIs) have been a part of the federal population welfare program. These institutions include Pakistan Water and Power Development Authority (WAPDA); the Pakistan Army, Navy, Air Force; Pakistan Ordnance Factories (POF); Pakistan Railways; Karachi Port Trust (KPT); Pakistan Steel; Pakistan Tobacco Company (PTC); Postal Service Groups; Pakistan International Airways (PIA); Zarai Taraqati Bank Ltd (ZTBL); and Fauji Foundation, etc. The target group institutions (TGIs) were renamed as PPSOs in 2005 with the aim to involve all public, private and corporate sector actors for the provision of family planning/reproductive health through their health outlets and to involve them for the propagation of the Population Welfare Program. Until 2009, 439 Memorandum of Understanding (MoUs) have been signed with them but with virtually little implementation.

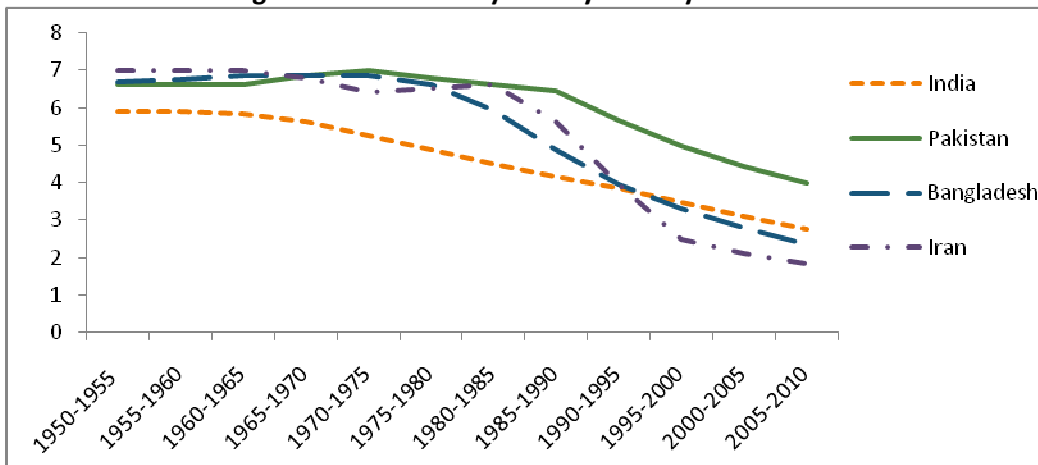
Some efforts were made, through the federal, provincial and district chambers of commerce, to involve the maximum number of service outlets of PPSOs to provide FP and RH services and establish RHS “B” centers. They were to be provided with technical support, contraceptives and trained staff. The respective provincial population welfare programs were to pay the salary of the staff. Generally, this is a greatly overlooked area, and there is untapped potential of organizations like: Combined Military Hospitals; Family Welfare Centers of Pakistan Army; health outlets of Pakistan Navy and Air Force and Pakistan Ordnance Factories, Fauji Foundation, Pakistan Railways, PTCL, PIA, WAPDA, KPT, Pakistan Steel, Oil and Gas Development Company Ltd. (OGDC); the Pakistan Atomic Energy Commission hospitals; and the outlets being run by NGOs, CBOs and the private sector to be involved in the provision of FP/RH services.

3. Trends

3.1. Fertility Decline

The weak population program is reflected in Pakistan’s fertility decline trajectory: Pakistan was the last among all its neighbors to experience fertility decline and continues to have the highest rates. At the time of its inception, Pakistan’s total fertility rate (TFR) of 6.6 births per woman fell between India’s TFR of 5.9 and Iran’s TFR of 7 births per woman, and was the same as Bangladesh’s TFR (Figure 2). All countries in the region experienced high fertility until the late 1960s, at which point India’s fertility levels started a gradual but consistent decline. Bangladesh, with heavy investments in family planning programs, was the next to follow with the fertility rate beginning to decline rapidly by the early 1980s. Even Iran stepped up its family planning efforts by the late 1980s and started experiencing a very rapid decline in its fertility rate.

Figure 2: Total fertility rate by country over time



Estimates of Pakistan’s fertility rates have been the source of much disagreement and debate, with reported TFRs diverging by almost one birth per woman for a given time period (Sathar and Zaidi 2009). Despite issues regarding exact levels of fertility, it is now widely accepted by demographers and government officials alike that Pakistan’s fertility decline began as late as the beginning of the 1990s. Currently, Pakistan’s TFR remains more than one birth higher than India’s and Bangladesh’s TFRs and around two births higher than Iran’s TFR, which has reached replacement level despite starting just as late. Previous projections (Population Policy 2002) estimated Pakistan to reach replacement around 2020; however, given the current trends, these estimates have been revised and fertility is projected to reach replacement some ten years later than expected, according to the proposed Population Plan 2010.

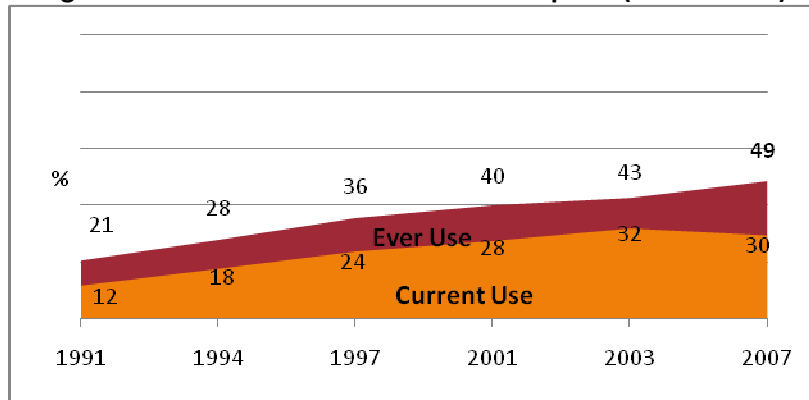
3.2. Fertility Regulation

Contraceptive Prevalence

Not surprisingly, there was hardly any fertility control within marriage before the late eighties and marital fertility in Pakistan did not experience a significant decline. Contraceptive prevalence rates (CPR) remained below 10 percent throughout most of the seventies and eighties, and only reached 12 percent by 1991 when the fertility transition began (Sathar and Zaidi 2009).

The nineties saw a distinct departure from this trend, with the CPR doubling to 24 percent in a six-year period (PFFPS 1996-97) and reaching 28 percent by the end of the decade (PRHFPS 2001). The Status of Women, Reproductive Health and Family Planning Survey (SWRHFPS) of 2003 showed an increase in contraceptive use among currently married women to 32 percent. However, the latest PDHS 2006-07 indicates stagnation in contraceptive use with the CPR falling slightly to 30 percent (Figure 3). In the early nineties contraceptive use rose at a rate of 2 percent per annum, this rate fell by half to about 1 percent a year and has recently gone even lower.

Figure 3: Current and ever use of contraception (1991 – 2007)



It is important to note that unlike current use of contraception, ever use of contraception has increased steadily over the last two decades (Table 1). Ever use increased from 21 percent at the start of the transition in 1991 to 34 percent in 2001 and finally to 49 percent, indicating a higher per annum increase since the turn of the century (2.5 percent per annum vs. 1.3 percent per annum in the 1990s).

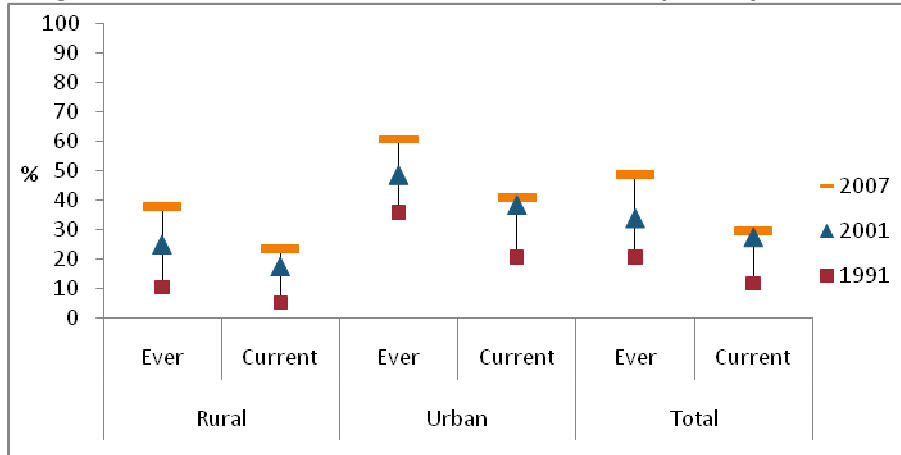
Table 1: Percentage of contraceptive use among currently married women 15-49 over time by residence

Variable		1991	1994	1997	2001	2003	2007
Overall	Ever use	20.7	28	35.7	40.2	42.8	48.7
	Current use	11.9	17.8	23.9	27.6	32.0	29.6
Current use by residence	Rural	5.8	11.0	ni	21.7	26.5	23.9
	Urban	25.7	31.9	ni	39.7	43.5	41.1

ni = no information

The stagnation in CPR is more apparent in the urban areas since the differential between urban and rural CPR has gone from 1:5 in 1991 to 1:2 in 2007. During the nineties, contraceptive use in urban areas increased more rapidly than in rural areas, but this trend reversed, and, since 2001, the rate of increase in rural contraceptive use has surpassed that in urban areas. Despite the consistent increase in rural CPR, absolute levels of contraceptive use in rural areas remain extremely low and still need to almost double to reach current urban levels, from 24 to 42 percent (Figure 4).

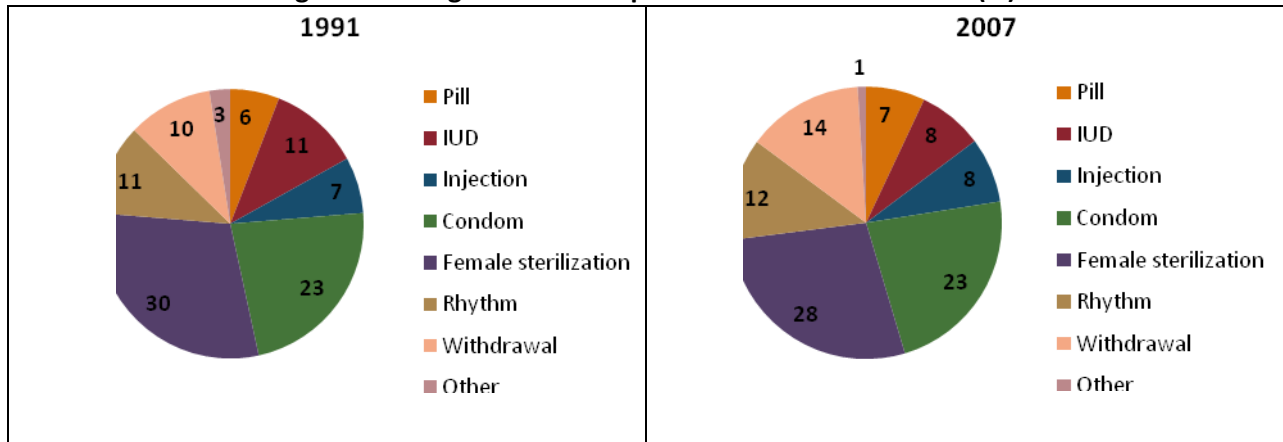
Figure 4: Trends in current and ever use of contraception by residence



Contraceptive Mix

At the beginning of the fertility transition, among the small percentage of contraceptive users, the most common type of family planning method was female sterilization (30 percent of users), followed by condom (23 percent of users). Out of the other half of current users, a quarter reported practicing a traditional method of contraception (PDHS 1990-91). The remaining quarter of women currently practicing fertility control were using the IUD, pill or injectables. Over the subsequent 16 years, Pakistani women’s choice of contraceptive methods has not changed substantially (Figure 5). Female sterilization continues to be the most popular method among current users, with only a 2 percentage drop in its share of method choice. The proportion of current users choosing condoms also saw no change over this period. While IUD’s share in method choice fell from 11 percent to 8 percent, the rest of the modern methods saw slight increases in uptake. The practice of traditional methods of contraception also saw a small increase; withdrawal was the more preferred of the two traditional methods, with 14 percent of current users choosing this method of birth control.

Figure 5: Changes in contraceptive method mix over time (%)



Trends in methods ever used are slightly different; while condoms, rhythm and pills (in that order) were the top three methods to have ever been tried by women back in 1990, condoms, withdrawal and rhythm are now the three most popular methods to have been ever used by women. Over the years, the

ever use of withdrawal saw the largest increase, from 20 percent of ever users in 1990-91 to 35 percent in 2006-07 (data not shown). The proportion of women trying injectables also increased substantially.

Overall, the trends in choice of method indicate that a quarter of women use traditional methods of family planning and another quarter use condoms, meaning that half are using couple-methods of family planning. The other half use female-methods, with around a quarter of these choosing permanent methods and the remaining quarter using other modern female methods.

Source of Methods

Back in 1991, when fertility decline had just come into play and contraceptive prevalence was at a low 11 percent, the government was the major supplier of modern contraceptive methods: 56 percent of users received the method from a government supplier (including government hospitals, doctors, clinics, family welfare centers, etc.), while only 30 percent received methods from the private sector (Table 2). By 2007, while the government remained the supplier for almost half of all contraceptive users, at 48 percent, the share of the private sector increased by more than ten percentage points to 41 percent, indicating that more and more users were paying for contraception.

Table 2: Source of modern method over time

Source	Pill		IUD		Injection		Condom		Female sterilization		All modern methods	
	1991	2007	1991	2007	1991	2007	1991	2007	1991	2007	1991	2007
Government	34.9	46.1	81.1	52.4	53.0	51.2	11.7	16.9	85.1	72.4	55.7	48.2
Private	56.2	39.6	15.8	47.6	42.0	44.6	47.6	58.0	13.7	25.8	30.0	41.4
Medical	49.7	31.2	11.3	41.0	42.0	41.7	33.2	27.3	13.7	25.8	25.5	30.1
Other shop	6.5	7.2	0.0	0.0	0.0	1.6	13.1	30.5	na	na	4.4	10.3
TBA	0.0	1.2	4.5	6.6	0.0	1.3	1.3	0.2	na	na	1.0	1.0
Other	5.2	5.3	0.0	0.0	4.7	1.3	11.5	0.8	na	na	4.3	0.9

na = not applicable

Looking at source of method by specific method type, two trends stand out. Over the 16-year time period, the government's share in the supply of the pill increased and it replaced the private sector to become the biggest supplier. On the other hand, IUDs, which in 1991 were primarily supplied by the government (81 percent), were now being equally provided by the private sector as well. Among the other methods, the private sector saw slight increases (corresponding to slight decrease in the government's share) in the share of injections and female sterilization, while both the public and private sector saw increases in the market share of condoms. Within the private sector, the supply of condoms by non-medical stores was responsible for the increase in market share.

Induced Abortions

Despite the fact that induced abortions are illegal in Pakistan except when performed to save women's lives, a study carried out by Population Council estimated 890,000 induced abortions a year for 2002 and an abortion rate of 29 per 1000 women aged 15-49 (Population Council 2004). This is a medium estimate, the low and high estimates were 25 and 31, respectively. The abortion rate of 29 is most likely an underestimate of the true abortion rate despite being moderately high by world standards. A majority of such abortions are taking place among married women with more than three children. Studies based on these data also find that a considerable proportion of women who have induced abortions have tried some method of contraception and some even reported using contraceptives (albeit ineffectively) when they became pregnant (Arif and Kamran 2006).

Sathar, et al. (2007) estimated measures of total pregnancy and unwanted pregnancy to portray the broader context within which induced abortion is occurring and to measure both the absolute level of unwanted pregnancy and the probability that women who experience an unwanted pregnancy would seek an abortion. Results yielded an unwanted pregnancy rate of 77 per 1000 women, which was almost two-fifths of all pregnancies. Abortions accounted for almost two-fifths of these unwanted pregnancies.

3.3. Unmet Need

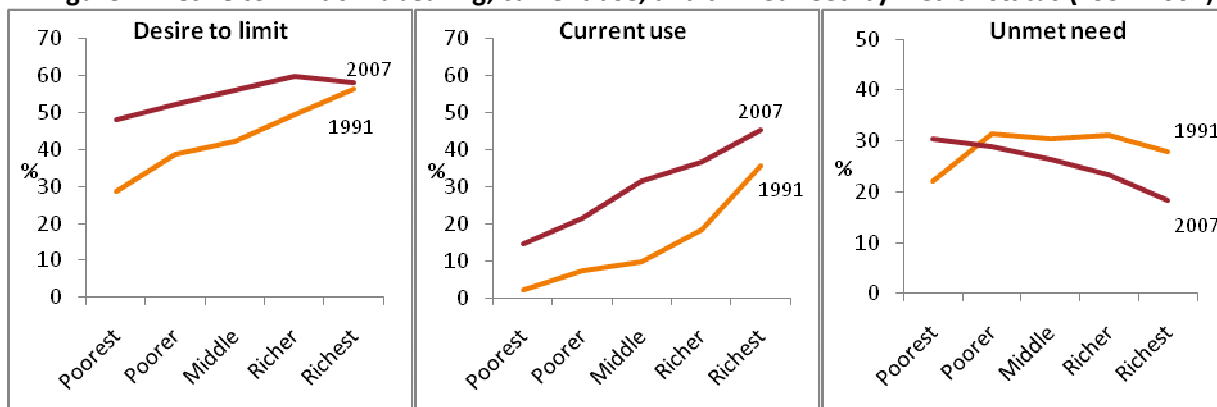
Despite the low use of fertility regulation, more and more women in Pakistan are expressing the desire to limit or postpone childbearing. In 1991, 40 percent of women surveyed wanted no more children, this increased to 52 percent in 2007. Regional differences in the desire to limit childbearing have been decreasing steadily over time since more and more rural women want to have no more children. These trends indicate that there is increasing demand for family planning among Pakistani women, particularly in rural areas. However, although more than 50 percent of women wish to limit childbearing and around 20 percent wish to space their next birth, only 30 percent are using contraception (PDHS 2007) – supporting a high rate of unmet need for Pakistani women.

Unmet need – the percentage of currently married women who are fecund and do not want to be pregnant yet are not using contraception – increased from 33 percent in the PRHFPS 2000-01 to 37 percent in the PDHS 2006-07. Unmet need in rural areas, which was initially lower, is now more than urban unmet need, suggesting that the availability and affordability of family planning services is an obstacle and limitation to fertility change, which applies more so in rural Pakistan. In line with these findings is the trend in unplanned childbearing (the combination of unwanted births and mistimed births): the proportion of recent births that are unplanned rose from 21 percent in 1990-91 to 24 percent in 2006-07. Unmet need for contraception and the proportion of births that are unplanned and the high rate of abortion suggest that a large fraction of currently married women in Pakistan are at risk of an unwanted pregnancy and potentially an unsafe abortion.

3.4. Vulnerable Group – Poor Women

Fertility rates in Pakistan vary by women’s education and household wealth status. These inequalities can also be seen in the unmet need for family planning. However, unlike total fertility, the relationship of unmet need with these background characteristics has changed over time. In 1991, women from the poorest households had the lowest unmet need; over time unmet need among these women rose substantially, and they now have the highest unmet need (Population Council 2009). The change in the relationship between unmet need and wealth can be understood by looking at the changes in the relationship between preferences and contraception and wealth (Figure 7).

Figure 7: Desire to limit childbearing, current use, and unmet need by wealth status (1991-2007)



The graphs show that the demand for family planning, as represented by the percentage of women wanting no more children, rose more dramatically for women from the poorest quintile. In fact, the figure that shows the proportion wanting to limit childbearing has almost converged at a level of around 50 percent or more for all wealth quintiles unlike the earlier period where it bore a sharp positive association with wealth. This is in stark contrast to differentials in contraceptive use that appear to be almost as sharp across rich and poor women as they were in the earlier period. Current use differentials (in absolute terms) between the poorest and richest women were 34 percent in the earlier period and 32 percent in 2007, indicating a negligible leveling of contraceptive use, unlike the dramatic leveling seen in fertility preferences.

Ultimately, this explains the sharp increase in unmet need, a combined outcome of preferences and use, experienced by poor women who increased their demand to limit childbearing without much change in contraception use. This is in contrast to the sharp fall in unmet need of the rich women who increased their contraceptive use in conjunction with their demand for it. The situation of relatively richer and poorer women has changed in these last two decades: the differential of unmet need by wealth is significant - practically nonexistent for the rich and over 30 percent for poor women (Population Council 2009).

3.5. Lack of Access

While access costs are not the primary determinant of contraceptive use at present, studies have shown that increasing service outlets and outreach programs can lead to a reduction in unmet need, i.e., increase contraceptive prevalence (Fikree et al. 2001; Shelton et al. 1999). Data from various national surveys show that access to a health or FP facility varies greatly between rural and urban areas of Pakistan. According to the 1991 DHS, getting to a reproductive health facility took an average of 40 minutes in urban areas, while in rural areas it took more than twice that time (96 minutes). By 2001, urban-rural disparities in availability of RH facilities still remained significant; distance to facilities was 3.4 km. and 12.6 km. in urban and rural areas, respectively (Population Council 2009). The 2003 data also show that the inequality in access remains strong. Since rural areas tend to have more poor people, it is not surprising then that the figure above shows a negative relationship between wealth and distance to nearest FP facility.

3.6. Quality of Services

The role of quality of family planning services and methods in the uptake of contraceptive use demonstrates yet another failing of the supply of family planning. In their analysis of DHS data, Zaidi (2009) found that over time increasing numbers of women have reported fear of side effects and health concerns as their primary reason for not intending to use contraception in the future (Figure 8). In urban areas, health-related issues have replaced religious prohibition as the most commonly reported non-fertility reason for not intending to use a method in the future. Even in rural areas, health related issues are the second most common non-fertility related reason for not intending to use contraception. The fear of side effects and health concerns are known to be hugely related to the quality of services and choice of methods available. The increase in the number of women trying contraception but not using it -- as demonstrated by the difference in current and ever use -- also suggests that health concerns and, therefore, quality of services are likely a significant factor in deterring contraceptive use.

Figure 8: Non-fertility related reasons for not intending to use contraception in future (1991-2007)



4. Understanding the Current Situation

4.1. Socio-Economic Factors

Economic Growth but Low Education

While Pakistan has experienced economic growth consistently since its inception, the prevalence of smaller family norms has yet to fully take place. A possible reason behind the divergent trends in fertility decline and economic growth is that social development has not been commensurate with economic progress; in Pakistan’s case, the two are not necessarily related. Firstly, despite persistent economic growth and a rapid increase in urbanization, the majority of Pakistan remains an agrarian society. Agriculture continues to provide more than 40 percent of employment; its proportion has only slightly decreased from 48 to 44 percent. There has been little change in the proportion of employment provided by the other sectors, with marginal increases in wholesale and retail and services sectors.

Secondly, the periods that saw a rise in economic growth rates did not see substantial progress in the social sectors and vice versa. Educational attainment saw little improvement over the period of the fertility transition, with gender inequalities in education remaining high throughout. It is only very recently that children’s enrollment rates have risen at the primary level from about 49 percent for boys and 38 percent for girls in the 1990s to 59 percent for boys and 52 percent for girls in the recent decade. There are wide urban-rural disparities: enrollments are 70 percent in urban areas, but they still lag far behind in the rural areas. Secondary school enrollments are even lower, not rising beyond 33 percent even for 10-14 year old boys. Less than half the population (around 47 percent) continues to be illiterate and reside in rural areas where illiteracy is even more severe. Education has been a largely neglected sector in past decades and few resources have been allocated to it until recently.

Low Participation of Women in Society

Moreover, women’s low mobility and autonomy remain obstacles to participation in politics, economic life and basic access to services. According to the Status of Women, Reproductive Health and Family Planning Survey 2003, one in three women was not allowed to leave her home alone and 42 percent of women who were able to go to health centers on their own were using contraception compared to half that proportion, 21 percent, who were not allowed to go to these facilities at all. Similarly, the proportion of women with high decisionmaking power within the household using contraception was twice the proportion of women with low decisionmaking power practicing family planning.

Women are more visible in Pakistani society, they are certainly participating more in politics, public life and education, and an increasing proportion of women are entering the labor force especially in urban areas. Yet, it is still questionable whether this has led to an increase in their status within the household and within society. Despite the recent increase in female labor force participation from 13 percent to 19 percent over the last 18 years, female participation remains low compared to male labor force participation, which has remained at around 71 percent across this period. Pakistan has the highest gender gap in labor force participation rates among the South, East and Southeast Asian countries (Arif 2008).

Even the minor increase in female labor force participation is offset by the trends in the types of work women are taking up. Trends in employment status show that women are replacing men in unpaid and agricultural work; the proportion of women engaged in unpaid family work has increased from 57 to 65 percent. The proportion of women working in the agriculture sector is double the proportion of men, 75 percent and 37 percent, respectively. However, the small but notable proportions of women who are educated and engaged in economic activity are likely to comprise an important influence on women's empowerment and on fertility change. Recent expansion in waged work for educated women in rural areas, such as the Lady Health Worker scheme and the hiring of female teachers and paramedics on contract basis, may be pivotal to further change (Sathar et al. 2005).

4.2. Explanations for Program Shortcomings

The Population Policy, initiated in 1998 and passed in 2002 by the Cabinet, was a statement supporting a commitment to population issues. The principles were strong but implementation details were weak. Essentially, elements of the policy underscored the need for an expeditious completion of the fertility transition, good inter-sectoral links and intertwinement with development programs. Unfortunately, while tackling the fertility decline, not much attention was devoted to how exactly this would happen and the resources it would require; once more, much was left to doing things the way they were done with some expansion in numbers of outlets and workers. Very little attention was given to details of coordination between the two mainline ministries of health and population welfare, with their respective provincial departments that are mandated to deliver services, or with the overall health system and LHWs. There has also been insufficient heed and concern about supply of contraceptive commodities and on the role of the private sector through social marketing, which was expected to expand to rural areas but remained restricted to urban areas, through organizations like Key and Greenstar Social Marketing.

Since then, there have been spurts of activity, such as the Population Summit 2005 and the formulation of the National Population Commission in one stroke, which meant that the kind of debate that preceded the formulation of such commissions in Indonesia and Brazil did not happen.

Lack of Understanding of Population Issues

While demographic issues are brought out periodically as a topic of deliberation when doomsday scenario forecasts are recognized, these issues are sidelined when times are economically good or when other more pressing issues are at hand. Population issues are not generally understood across bureaucratic or political circles, much less among wider sections of society. This is because at no point has serious attention been devoted to studying Pakistan's large population numbers, their distribution, and the implications they hold for the country's development, politics and ultimate stability. In fact, the demography of Pakistan and population policy have largely been only the responsibility of a particular ministry and a handful of professionals and organizations, with virtual state denial, apart from occasional statements from state leaders on World Population Day or other similar occasions. No

serious debate has taken place either in the parliament, the senate or, for that matter, in any of the think tanks and universities, or by the media, which is quite vibrant and free and usually responsive to issues close to the public's hearts and minds.

While politicians may find population issues contentious and sensitive for religious reasons or for reasons to do with national award for resources, it is curious that the economists and planners are guilty of neglect of this important parameter that is here to haunt them now, and certainly will haunt them even more a few decades down the line. Undoubtedly, the Third Plan onwards had mentioned population growth impinging on resources, but the inter-linkages and the reasons why Pakistan's population continued to multiply were not seen as central to development planning (Sathar 2010).

Even now, FP is not seen as a national priority. With the 18th amendment MoPW will be one of the first federal programs to be slashed, even though all high population countries have a national/federal level ministry. Director General Technical, MoPW

Role of International Politics

International population movements and politics have definitely affected the twists and turns of Pakistan's policies. The International Conference in 1965 was a confirmation of the role of family planning but only to be upturned by thinking in 1975 in Belgrade regarding development as the best contraceptive, which stalled the focus on family planning programs, only to be reversed in Mexico in 1984. The real landmark was the ICPD 1994, when the best possible balance was sought between population and development, laying out all its possible dimensions. Ironically, this took the biggest toll on family planning programs, instead of FP penetrating and permeating to all aspects of development, ranging from education, women's development, environment and health to mention a few.

The main message of the ICPD 1994 was the evolution of the term reproductive health, which was a holistic concept encompassing many aspects of family planning, safe motherhood and gender-based violence, etc. The diffuse and large set of programs to be implemented, combined with the dip in US support for family planning, led to a dramatic reduction in international resources for both reproductive health and, especially, family planning. Furthermore, the AIDs epidemic caught the world's attention and international funding for HIV/AIDs increased several-fold, and funds for RH, especially family planning, dipped radically, falling to their lowest levels in the early years of this decade.

Due to ICPD, the development agenda was broadened. Even though other relevant elements, such as rights, male involvement and poverty, entered the agenda, FP lost some of the focus. Even the MDGs ignored FP until the introduction of 5b, which is still universal access to reproductive health broadly, and not FP specifically. In 2005, there was a shift in IPPF framework to five A's within the area of SRH – Access, Adolescents, Aids, Advocacy, and Abortion. Since Rahnuma/FPAP is a member association of IPPF, it had to address all the A's and, therefore, in our performance FP was also a little de-focused.

CEO, Family Planning Association Pakistan

Naturally, Pakistan, a country largely dependent on international funds for social spending, in particular, suffered financially. To the credit of the Pakistan government, it did not allow funds to the population program to suffer; in fact, the entire funds have come from the public exchequer for the last ten years. However, in the very recent past, development funds have been more scarce and population issues somewhat lagging in the long priority list.

4.3. Linkages and Integration with Health and Other Sectors

One of the main constraints of the population program in Pakistan has been the lack of linkages with other sectors. Family planning has been as a standalone responsibility of the Ministry of Population Welfare and not of the Ministries of Health, Education or Social Development. The lack of integration and cooperation has meant limited outreach, limited consensus, lack of innovation, and, therefore, extremely minimal impact.

MoPW has tried to rope in other social sector ministries. However, the frequent change of government and secretaries means efforts need to be repeated over and over again.

Director General Technical, MoPW

It is being seriously felt that the actual partners who were the main players expected to contribute toward full coverage have failed. The Ministry of Population Welfare continued with its own service delivery, including 3,853 Family Welfare Centers, which are community based, 182 Reproductive Health Services A-Centers located in DHQ/THQ hospitals, 104 Reproductive Health Services B-Centers located in private hospitals, 292 Mobile Service Units for extension camps, and 4,835 social mobilizers at the union council level, have all been operating mainly as standalone, and they are now expected to integrate with provincial health departments.

The strong inter-linkages and reinforcing relationships between education and population have not been capitalized upon, with the exception of some small efforts at introducing population education in schools and colleges. Several opportunities for joint programs have been overlooked, and this has impeded gains in both sectors. In short, if education problems were to be improved, family planning programs would get a big boost, and, conversely, with lower fertility the school-age population would shrink, reducing challenges for the education sector.

There is a need to link education and population behavior. Schooling can delay age at marriage. Linkages between fertility, education and female employment need to be promoted together. 'Healthy educated girl who can do productive work.'

Advisor, Shirkat Gah (Women's Rights Organization)

Another major loss is the link with environment. As the recent floods have clearly demonstrated, the most unsustainable settlements, particularly those on riverbanks, were the ones to be most adversely affected. Scant attention has been paid to environmental issues since the comprehensive efforts at the National Conservation Strategy developed in the 1980's and the preparation prior to the Rio Summit in 1992. This is barring some narrow approaches, which certainly do not take population movements and distributions into account. Environment and population are both marginalized sectors. They would certainly have stronger lobbies and more funds if they saw themselves in partnership.

Most serious is the failure of the Ministry of Health and the health establishment in owning any share of responsibility for outcomes in population. The evidence is striking and abundant of how closely linked health indicators, particularly MDGs 4 and 5, are to fertility decline and family planning use. And yet, apart from the National Program for Family Planning and Primary Health Care, the Lady Health Worker programs, where 100,000 women are providing family planning services in their rural communities, the sector has largely abdicated responsibility for family planning. In particular, the large spread of the health service delivery network (at least 15,000) and additional allied hospitals has not prioritized family planning, nor even considers it its essential duty. It is hard to explain whether this is because of the reliance on the Ministry of Population Welfare and its departments for family planning services or the

lack of trained providers, the erratic supply of contraceptives and now uncertain funding associated with population.

As trends in source of methods show, the private sector is increasingly enhancing its share in the health sector. While social marketing is playing a role in family planning, there is a huge private sector beyond that comprised of private health providers, chemists, homeopaths, the commercial sector, and more. Fifty to 80 percent of healthcare is believed to be sought through private-sector providers.

Thus far, there is little recognition nor coordination between the main players in the family planning program and the representatives of this private sector. Associations, such as Pakistan Medical Association, the Society of Gynecologists and Obstetrician, the Pakistan Pediatric Association and Association of Homeopaths, can be brought into the umbrella of the program to elicit the support of these large groups of potential providers and counselors and their influence.

5. Recommendations

The year 2010 will most likely prove to be a defining one for family planning programs in Pakistan. While the Ministry of Population Welfare was actively working on a Population Policy 2010 and its inputs into the Tenth Five Year Plan on Population, decisions were made to take population off the concurrent list and to effectively discontinue the role of the ministry altogether. While consideration may be given to the reformulation of the Population Commission, it is now certain that on December 1, 2010 the provinces will hold all responsibility for delivery of family planning services. The fate of population welfare departments is not clear; but training and other institutes of the ministry are to be handed over to the provinces.

This represents an opportunity and a challenge. Resources for family planning may not be available in the provinces, or at least mechanism of resource flows may not be clear for a while. However, at the same time, services will become a responsibility of the provinces, thereby increasing accountability at the provincial level. The program is at a stage of huge upheaval, but it can at least improve its service delivery components by a successful integration and coordination with the health departments. Certain functions, such as formulation of policy, monitoring and research, and setting minimum standards will have to remain a national responsibility for the sake of uniformity. Much will now depend on the role of all the players other than the MoPW, particularly the health sector, to rise to the challenge of using its wider service network to incorporate family planning as a priority.

Two other actors who have underperformed are the NGOs and private sector. The program can be greatly strengthened if the NGO sector is brought in more actively into the fold. NATPOW offers some hope that a strong umbrella organization can make grants and strengthen the capacity of the NGOs, particularly the smaller organizations located in areas where neither the public nor private sector is willing or able to provide services. The private sector has yet to be tapped fully but has to be approached with some parameters about the quality and range of services that would need to be provided by different cadres. A strong regulatory mechanism may need to be in place for uniformity of standards of service delivery at the national and even provincial levels; such a board has been formulated in Punjab already.

5.1. Strengthening the Program

In sum, the program can be strengthened through the following means:

- Strong monitoring and oversight role at the center but with full participation of provinces;
- Service delivery of family planning services at all health outlets; with population welfare outlets playing a complementary and specialized role;
- Strong body to steer, assist and coordinate the role of the private and not-for-profit sector;
- Maximum number of NGOs and CBOs providing services in areas where underprivileged, hard-to-reach populations are located;

5.2. Expanding the Role of Stakeholders

The role of stakeholders is critical. It goes without saying that the responsibility of population issues and family planning programs has been too narrow, and this has been largely to blame for the failure in inclusion of other important stakeholders. There is a long list of parties that need to be convinced of the importance and the imperative of providing family planning services. Among that list, three sets of partners are critical.

First are the economic, finance and development planners at the Planning Commission and the Ministry of Finance who need to be aware of the huge impact of high fertility on all indicators of growth, poverty reduction and employment demands, etc.

The second is the health establishment starting from the Ministry of Health, which really needs to give its full endorsement and support and priority to family planning, with the full realization of how closely this is linked to its own priority of reducing child and maternal mortality. This has to extend to pre-service training for all medical and paramedical personnel and has to seep into actual in-service training. Family planning is an important health intervention that is not being adequately provided by both public and private sectors– this realization has to be advocated.

Thirdly, the donors and international community need at this point to make up for lost time for their neglect of family planning issues as a lost priority for almost a decade. They have to provide assistance financially and technically to ensure that Pakistan does not miss this opportunity to improve its family planning record.

In order to convince these stakeholders that family planning needs to be repositioned in the development and policy dialogue as a means for healthy birth spacing, which is so closely linked to maternal and child health, and as a critical tool in realizing the demographic dividend and reducing poverty.

5.3. Investing in Female Education

Increasing access and improving quality of family planning services will take care of the immediate need for birth control and even if, miraculously, unmet need can be completely eliminated by investments in supplying family planning services, contraceptive prevalence in Pakistan will still be around 55 percent, bringing fertility down to around 3 births per woman. While this will be a remarkable achievement, this CPR will still be significantly lower than international standards and insufficient for reaching replacement level fertility. Investing in women’s education is imperative, not only for increasing women’s participation in the labor force, and society in general, but also for bringing about the ideational change needed for reaching replacement fertility. More widespread education, especially among women, women’s increased participation in the economy, greater prosperity in general, and a more profound transformation from Pakistan’s current primarily agrarian structure to industrialized society will be necessary to transform values about ideal family size from the current level of 4 children to 2 children (Population Council 2009).

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Appendix 1: Interviews with Stakeholders

INTERVIEW GUIDELINES:

Past Achievements

What have been the major achievements made in FP and RH in Pakistan over the last few decades?

Who was responsible for these achievements? National Program? NGOs?

What impact did Cairo have on the status of family planning and relevant programs in Pakistan? (Positive or negative)

Current Issues

In your opinion what is the status of fertility decline across the country, and what are the consequences of high fertility?

What is your opinion on the current national program for FP – how has it evolved, how is it currently structured, how is it dependent on political \ commitment, what is the level of integration with other programs?

Is FP seen as a national priority among other host of health issues?

Are the appropriate financial and human resources in place now in 2010 to seriously address unmet need?

What are the socio-cultural and program challenges to providing FP in Pakistan today?

Who (adolescents, poor) is at risk? How does this relate to the Cairo objective?

Recommendations

Which areas does FP need to be linked with? How can these linkages be effectively established?

How can the national program be made more effective?

What are the ways forward if we want to achieve the Cairo objectives and meet the MDGs?

MUMTAZ ESKER – DG (Technical), Ministry of Population Welfare

Impact of ICPD

Before that it was number based – “Do bachay hi achay”. Benazir played a big role in making the ICPD plan a priority. Over all approach changed to be more rights-based, encouraging informed choice and voluntary use of family planning.

During the ICPD conference each country, including Pakistan, made its own Plan of Action. Pakistan’s Action Plan was drafted by both Ministry of Health (MoH) and MoPW but MoH did not deliver. MoPW cannot provide universal FP services; it can only cater to 25 percent of the population even when performing at full capacity. It cannot do it without MoH.

Moreover, internationally funding for FP decreased (went to HIV/AIDS) and FP only gained recognition in the MDGs around 2006/07.

Past achievements

Fertility declined like in the rest of South Asia, but did so at a much slower rate. The 1990s saw a gearing up of advocacy campaigns and a consequent increase in knowledge of FP. Maternal and Child mortality rates also declined.

No one entity alone has been responsible for the increase in FP use and fall in fertility. The ICPD, MDG 2000 meeting, and inclusion of contraceptive use as MDG 5b all contributed to the increase in commitment to providing family planning.

LHW program

Even though the provision of FP is first in their mandate they are busier providing primary healthcare (polio drops). That is why latest third party evaluation shows that the LHWs have not succeeded in bringing up CPR. The program is fine – ‘nothing is better than door to door service’; it is the implementation and M & E, which should belong to MoPW, that are the problem.

Program evolution

1965 FP program came to the government but lacked ownership and was never a priority (not in any party’s manifesto). So the program turned to other stakeholders and finally came to rest with the Planning Commission. During Benazir’s time it had the highest political commitment but otherwise never received any status and received no interest in the Parliament (most people shy away from it).

Even though abortion is high no one is talking about it in the public sector. Maternal deaths need to be auditable. The NGOs have done a good job in being vocal about FP and abortion issues. The media needs to take a more active role.

Integration

MoPW has tried to rope in other social sector ministries. However, the frequent change of govt. and secretaries means efforts need to be repeated over and over again.

Current status

Even now FP is not seen as a national priority. With the 18th amendment MoPW will be the one of the first federal programs to get slashed, even though all high population countries have a national/federal level ministry.

The provinces have not yet taken ownership and there are not enough financial or human resources, especially at the provincial level (Sindh and Balochistan). Another problem is that the NFC award is linked with population size of the province so provinces like Balochistan are encouraged to increase their population to get more money.

High risk groups

poor, rural, illiterate women.

Ways Forward

Economic development; poverty reduction; bringing women into the labor force; and female education a MUST.

Program – increase in financial resources for FP; recognize the special needs of youth; greater involvement/commitment from Health and private sector; national population policy to be included in the mandate for all political parties; expand choice of FP; pay greater attention to quality of service delivery, i.e., counseling.

KHAWAR MUMTAZ – Advisor, Shirkat Gah (Women’s rights organization)

Achievements

CPR of 30 percent. The private sector and Greenstar through social marketing took up contraceptive supply. NATPOW was setup to improve delivery but went through terrible breakdown due to lack of funding and contraceptive supply and revived itself much later. ICPD created synergy between the government and NGOs.

NGOs play an important role in promoting FP but government has to be the primary actor. Supply needs to come from government.

Issues

Budgets don’t represent increase in contraceptive demand.

Overall, yes the direction is still there. Needs to be linked with two things:

1. Accessibility – catering to women who have limited access. Moreover, access should be followed up...there is provision but no follow up visit on side-effects etc. Not all methods are available – there needs to be both knowledge and availability of all methods so women can decide what suits them best.
2. Youth bulge – need awareness regarding this group.

Impact of ICPD

Before FP was looked as at a technical process. The ICPD gave you ways of reaching men and women in a broader more development oriented way and therefore made family planning more acceptable. From an NGO perspective women’s right activist started looking at contraception as a right. The ICPD provided ways of looking at the availability of contraception within the larger issues of women’s space and mobility.

Program evolution

The Population Program has never been taken seriously; it has always suffered from lack of funds and ownership especially at the provincial level. It is not so much about what is wrong with the program itself, but the lack of recognition and budgetary allocation it gets. The program should be housed in the Health Department or the Planning Commission.

High risk group

Adolescent females – policies and programs look at the girl child and the married woman but ignore adolescent females. Marriage laws on minimum age need to be changed. Ways to ensure that girls do not get married early is by keeping them in school – for which there is demand. The approach needs to be integrated with other social sectors and cannot just be FP alone; it cannot be done without education. The ICPD provided such linkages.

We evade reproductive health issues of young people when there is a need to focus on young girls, especially from poorer households. As NGOs and Civil Society we should not feel like we need to look from the government's point of view; we should not ridicule SRH counseling and can perhaps package it as communication.

Political commitment

There has been an increase in political commitment and voice for women's rights in general, with greater acceptance of women in the public arena. However, there is a lack of political commitment to FP – this commitment was there at the time of ICPD and even led to the creation of LHW program. But the LHWs are burdened with providing other health services even though they were initially introduced for the primary objective of increasing FP. The LHWs need to be better monitored by the communities themselves.

Ways forward

Make available a wide arrange of contraceptive methods with follow ups for side effects.

Contraceptives should be made available in all health centers. The private sector is not interested in providing to poor people, so the public sector needs to focus on this group. A BHU is an ideal place for supplying contraceptives as health centers are more acceptable than family welfare centers.

Mobile Units for maternal and child health (particularly post natal checkups) provide a good opportunity for delivering FP.

Mass campaign to involve all doctors. Doctors should be mandated to do community service with a sufficient stipend.

Youth health needs to be integrated in all plans.

Allocate more resources to FP.

Mobilize NGOs for service delivery, monitoring and advocacy.

Link education and population behavior. Schools can delay age at marriage. Linkages between fertility, education and female employment need to be promoted together. 'Healthy educated girl who can do productive work'.

Administrative measures include improving birth registration system.

KAMAL SHAH – CEO, Family Planning Association Pakistan

Impact of ICPD

Due to ICPD the development agenda was broadened. Even though other relevant element such as rights, male involvement and poverty, entered the agenda, FP lost some of the focus. Even the MDGs ignored FP until the introduction of 5b, which is still universal access to reproductive health broadly, and not FP specifically.

In 2005 there was a shift in IPPF framework to 5 A's within the area of SRH – Access, Adolescents, Aids, Advocacy, and Abortion. Since FPAP is a member association of IPPF it had to address all the A's and therefore in our performance FP was also a little de-focused.

Now once again there has been renewed focus on FP but this has come at a very precarious time for Pakistan.

18th Amendment

There are two aspects – funding and program implementation. Since the program was run provincially it is not hugely impacted. The money however, was coming from the federal budget and now that the ministry is being dissolved it needs to come from the NFC award which has already been allocated for this year (none was given to FP because that was coming from the federal government). Now for next year the provinces will actually have to reallocate funds from another department to FP which will be very difficult and will be met with resistance from the heads of other departments. There is need for huge advocacy at this moment targeting provincial governments and legislators to convince them of the importance of FP and ensure reallocation to the department.

People are saying that Balochistan and KP are thinking of getting get rid of their population welfare departments. And if the ANP in KP willing to get rid of the FP program then what will happen if a more conservative party comes into power.

Even if NGOs do a lot they cannot work at the scale of government. They provide best practices for the government to replicate and scale up. FPAP is biggest FP NGO and even its reach is only 10 percent.

Current situation

Many studies (Pop Council, DHS) show that barriers to use have decreased; religious opposition has come down as a barrier. Knowledge has increased and there is high unmet need. Even if we just address this need we will make huge progress. But no one has contraceptive supplies. This year is going to be a very critical year for FP in Pakistan. I don't see political commitment. That is what will make the difference.

Political commitment was the main cause of increase in CPR in the 1990s. Even if you look at other Muslim countries that have experienced fertility decline there has been political commitment along with financial backing.

Programmatic challenges

Tension between Health and Population departments. FP delivery has to be a one-point service; across the globe the programs/countries that used an integrated model were the ones that succeeded. With the 18th amendment it seems that by default it might be integrated because there is pressure to decrease the number of ministries.

Huge health department sector is under-utilized. BHUs, RHUs, DHQs are all under-utilized. FP needs to be provided at all health centers. This will need initial investment for capacity building in health dept because FP is a specialized service. Meanwhile there is chaos in the population department; they don't have the funds to pay salaries even.

This is the right time to bring the two together. Even if one province can agree to integrate the two and implement the model then the rest can follow. Punjab secretaries of Health and Population Welfare both show willingness, we need to chalk out a model for Punjab and share it with donors to fund. This is a time when some donors are interested - USAID is a big donor, DFID is interested. But if we take too long to sort out the logistics they might lose interest.

Where can that money come from? It is in the NFC – need to work with legislators, Chief Minister, advocating for reallocation. It is about political will – we need to make FP a priority and in cabinet meeting have them prioritize funding FP.

Access is still an issue but we need to prioritize right now. No point generating demands when there is no supply. Right now we are worried if we will have contraceptives next month even.

Even if you just look at Punjab we know the pop is 9 crore and the FP program allocates money to only cater for 65 lakh if performing at full scale and right now it isn't even performing at half. Number one priority is to get FP on the agenda at the highest political level. Then we can go talk to them about programmatic issues like access, HR, etc.

High-risk groups

Mobility issues for women in rural areas. Poverty is restricting them further.

Information for adolescents is lacking; we assume that once married a 16 year old will start acting like a grown woman. We need specific services for adolescents. There is nothing for them at present; we don't cater to this demographic group.

IJAZ MUNIR – Secretary Population Welfare, Punjab

Major achievements

Awareness of FP increased substantially, for which NGOs were a major contributor.

The program is still running despite the serious lack of political commitment; people might not go but they know about FP service centers.

Issues

Have not been able to match awareness with uptake of services, and this gap continues to increase. A major reason behind this is that everything was left to MoPW, which even at full capacity only covers 14 percent of the population. Major political ups and downs are another reason.

Impact of ICPD

It was not very good for FP because it took some focus away from it, but RH benefited and in our cultural environment it is easier to sell FP as RH.

Integration

There is no integration between health and population welfare, with resistance from top management on both sides. Having vertical programs also impedes cooperation.

There is also a lot of disconnect between various policies and action plans. The MDG Plan advocates for facility-based services while the MNCH program advocates for home-delivery.

Not many countries in the world have an independent ministry for population. It is not necessarily about integration but about the need for a united, clear purpose/goal to provide family planning and

manage fertility. For example the LHW program has been overtaken by the health ministry to provide primary healthcare. Family planning needs to be a priority for all.

Programmatic recommendations

The program needs total overhaul. It is currently under staffed and not monitored properly. Couple Year Protection (CYP) monitoring is not effective because of contraceptive surgery/ permanent methods. We need to focus back on temporary methods for spacing.

We need to work with religious leaders at an institutional level, think about making religious leaders function as male mobilizers. Also need to pay current male mobilizers more. At present the program is stuck in a situation where they cannot fire the mobilizers and cannot pay them more.

Need to resolve management issues in Family Welfare Centers. They are a good concept but not implemented well.

Effect of 18th Amendment

The federal ministry will be abolished and we (provincial departments) will get the money directly. Training institutes will shift along with the budget to the provincial level. So at the programmatic level it will not make any difference – the program was already quite devolved.

The problem will be funding, which was coming from the federal government. They had promised us funding for 5 years, it has only been one year and now that the ministry is dissolving so we will not get funding for the next 4 years.

The funding for next four years will be decided by the Council of Common Interest and the issue will be amount of funds, which are at present negligible.

Contraceptive procurement will not be such a huge issue. The central warehouse is in Karachi and the four provinces just need to sit down and chalk out a plan. In my opinion we should continue with the arrangement with UNFPA.

Way forwards

We need to advocate for funds for family planning. We need to get the other ministries on board, convince them of the importance of population issues. And finally, we need to make sure that the provinces take forward the draft of the 2010 Population Plan.