THE STATE OF FAMILY PLANNING IN PAKISTAN

Targeting the Missing Links to Achieve Development Goals

UNFPA
Pathfinder International
The State of Family Planning in Pakistan

Targeting the Missing Links to Achieve Development Goals

June 2013
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Targeting the Missing Links to Achieve Development Goals

For United Nations Population Fund (UNFPA)
June 2013

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Pathfinder International, Pakistan Office

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It is time to Act
Preface to the State of Family Planning in Pakistan

Rabbi Royan

From being the world’s 13th most populated country (37 million) in 1950, Pakistan is today the 6th largest (184 million). Based on current trajectories, Pakistan’s population stands to double by 2050. Latest data from the Pakistan Demographic and Health Survey 2012/13 confirms that the total fertility rate at 3.8 in 2013 remains high, with the rate highest among poorer women living in the rural heartland and with the lowest levels of education. Contraceptive prevalence rates (CPR) remains very low. The maternal mortality Ratios at 276 per 100,000 live-births, while has declined, remains high. More than 80 women die each day because of preventable complications during pregnancy. If only the huge unmet need for family planning could be addressed, CPR would increase significantly, and unplanned pregnancies (one in four) and unsafe abortions (one cause of maternal mortality) could be brought down, with its attendant positive effects on mother and child health in the country.

We will recall that at the Family Planning Summit organized in 2012 and held in London, the Government of Pakistan (GOP) made a commitment to achieve universal access to Reproductive Health by doubling Contraceptive Prevalence Rate from the current level to 55% in the year 2020 as part of its Family Planning 2020 (FP2020) vision.

It must be underscored that the following principles underpin the achievement of the FP2020 goal. First, that voluntary and universal access to family planning is applicable to all be it rich or poor, men or women, married, or unmarried. Second, it is imperative that young people, who account for 60% of the population in Pakistan, are better informed and are better able to exercise the right choice of family planning. Third, innovation in FP programme design, implementation and monitoring are encouraged, especially cultivating on the vast potential of the private sector and civil society under an enabling environment created and facilitated by the GoP. Last, it is important to learn the lessons from the past and focus more attention to programme sustainability, national ownership and above all, accountability for results, the lack of which was one of the major attributors to the lost decade of Family Planning in Pakistan.

In UNFPA’s view the broad strategy to achieve universal access to reproductive health in Pakistan thereby reaching Pakistan’s FP2020 goals has three pillars: first, a demonstrated political will and support to family planning; second, the health system owns and is strengthened to deliver family planning information and services; and third, the family planning programme attaches high importance to accountability, good governance, efficacy and results. We are at a historical junction where with the confluence of the 18th amendment and the new Government in power, strategic shifts towards addressing the population and family planning agenda is highly possible.

First, taking the momentum of the 18th Amendment, the provinces need to formulate rights-based, and equity focused Population Policies, family planning strategies, action plans and monitoring and reporting frameworks. These instruments help set up the provincial vision, targets and actions that are prerequisite to achieving national FP2020 goals. The Provincial budgetary allocations also need to be secured by the provincial government to support the family planning programme. As committed by
most of the political parties in their respective party manifestos prior to the last election, UNFPA would welcome a materialization of the commitment to allocate 0.5% of provincial budgets to population activities including the procurement of contraceptives.

Second, it is essential that all health facilities and service providers, especially those at the Primary Health Care (PHC) level, are equipped or provided with skills to deliver FP information and services. The country should invest in institutionalizing quality family planning training that comes across sectors and departments. The health system needs to own the agenda of family planning through laying out a clear division of labor between the Department of Health and the Department of Population Welfare, and removing verticality and “ilo” management between and within the health programmes and population programme.

To achieve such an objective, it is suggested that Departments of Population Welfare taking the opportunity of the 18th Amendment, re-look its mandates and consider steps that will aim to transform itself as the institution that will champion the important role of population dynamics in the national and provincial development agenda, will become competent to provide advisory services to the provincial government and sister departments on much broader population issues and challenges, leads in family planning technical standards, know-how, and last but not least, will ensure quality of family planning information and service across sectors and departments.

Third, it is time to revert the Lady Health Workers Programme back to its original mandate that is with a focus on providing family planning information and services in the communities. The benchmarks that were used to assess the performance of the Programme are now to be streamlined towards such a direction. On the other hand, the opportunity to establish a national marriage counseling system is to be grasped through which culturally sensitive information on family planning is provided to orient and prepare young couples for the prosperity of their family and life.

There are about 7 years to the Year 2020. For individuals, a period of 7 years is long enough to achieve many things; enough for a girl to complete her school, enough for a woman to bear several children, or to a family located in the riverbank many life-breaking flights from the ravages of monsoon rains. If we want change, we all will have to act now.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AKU</td>
<td>Agha Khan university</td>
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<tr>
<td>BHU</td>
<td>basic health unit</td>
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<tr>
<td>CBO</td>
<td>community-based organization</td>
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<tr>
<td>CEO</td>
<td>chief executive officer</td>
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<tr>
<td>CSM</td>
<td>contraceptive social marketing</td>
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<tr>
<td>CMW</td>
<td>community midwife</td>
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<tr>
<td>CPR</td>
<td>contraceptive prevalence rate</td>
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<td>CS</td>
<td>contraceptive surgery</td>
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<tr>
<td>CYP</td>
<td>couple years of protection</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>DHQH</td>
<td>district health quarter hospital</td>
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<td>DHO</td>
<td>district health officer</td>
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<tr>
<td>DOH</td>
<td>department of health</td>
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<tr>
<td>EDL</td>
<td>essential drug list</td>
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<tr>
<td>FATA</td>
<td>federally administered tribal areas</td>
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<td>FP</td>
<td>family planning</td>
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<td>FPAP</td>
<td>Family Planning Association of Pakistan</td>
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<td>FWA</td>
<td>family welfare assistant</td>
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<td>FWC</td>
<td>family welfare centre</td>
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<tr>
<td>HR</td>
<td>human resources</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IEC</td>
<td>information, education, and communication</td>
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<tr>
<td>IPC</td>
<td>inter personnel communication</td>
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<td>IPPF</td>
<td>international planned parenthood federation</td>
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<td>IRC</td>
<td>institutional reimbursement cost</td>
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<tr>
<td>IUCD</td>
<td>intra uterine contraceptive device</td>
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<tr>
<td>KP</td>
<td>Khyber Pakhtunkhwa</td>
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<tr>
<td>KSM</td>
<td>key social marketing</td>
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<tr>
<td>LHW</td>
<td>lady health worker</td>
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<tr>
<td>LMIS</td>
<td>logistics management information system</td>
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<tr>
<td>MCH</td>
<td>mother &amp; child health</td>
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<tr>
<td>MDG</td>
<td>millennium development goals</td>
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<tr>
<td>MM</td>
<td>male mobilizers</td>
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<tr>
<td>MNCH</td>
<td>maternal neonatal &amp; child health</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOPW</td>
<td>Ministry of Population Welfare</td>
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<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
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<tr>
<td>MSS</td>
<td>Marie Stopes Society</td>
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<tr>
<td>MSU</td>
<td>mobile service unit</td>
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<tr>
<td>MTBF</td>
<td>mid-term budget financing</td>
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<tr>
<td>MTDF</td>
<td>mid-term development framework</td>
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<td>MWRA</td>
<td>married women of reproductive age</td>
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<td>NATPOW</td>
<td>National Trust For Population Welfare</td>
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<tr>
<td>NFC</td>
<td>National Finance Commission</td>
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<tr>
<td>NGO</td>
<td>non-governmental organization</td>
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<td>NGO-CC</td>
<td>non-governmental organization coordination council</td>
</tr>
<tr>
<td>NIPS</td>
<td>National Institute of Population Studies</td>
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<tr>
<td>NRIFC</td>
<td>National Research Institute of Fertility Care</td>
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<tr>
<td>NWFP</td>
<td>North-West Frontier Province</td>
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<tr>
<td>P&amp;D</td>
<td>planning and development</td>
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<tr>
<td>PAIMAN</td>
<td>Pakistan initiative for mothers and newborns</td>
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<tr>
<td>PBS</td>
<td>Pakistan Bureau of Statistics</td>
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<tr>
<td>PC-1</td>
<td>Planning Commission-1 (form for preparation of development programs/projects)</td>
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<td>PDHS</td>
<td>Pakistan demographic and health survey</td>
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<td>PGR</td>
<td>population growth rate</td>
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<td>PI</td>
<td>performance indicator</td>
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<tr>
<td>PLD</td>
<td>provincial line department</td>
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<tr>
<td>PME</td>
<td>procurement of material and equipment</td>
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<tr>
<td>PoA</td>
<td>plan of action</td>
</tr>
<tr>
<td>POL</td>
<td>petrol, oil and lubricant</td>
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<tr>
<td>PPHI</td>
<td>peoples primary healthcare initiative</td>
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<tr>
<td>PPP</td>
<td>public-private partnership</td>
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<tr>
<td>PPSO</td>
<td>public-private sector organizations</td>
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<td>PPWD</td>
<td>Provincial Population Welfare Department</td>
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<td>PRHFPS</td>
<td>Pakistan reproductive health and family planning survey</td>
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<td>PRSP</td>
<td>poverty reduction strategy paper</td>
</tr>
<tr>
<td>PRSP</td>
<td>Punjab rural support program</td>
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<tr>
<td>PSDP</td>
<td>public sector development program</td>
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<tr>
<td>PTCC</td>
<td>provincial technical coordination committee</td>
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<tr>
<td>PWD</td>
<td>Population Welfare Department</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PWP</td>
<td>population welfare program</td>
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<tr>
<td>PWTIs</td>
<td>population welfare training institutes</td>
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<tr>
<td>RH</td>
<td>reproductive health</td>
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<tr>
<td>RHC</td>
<td>rural health centre</td>
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<tr>
<td>RHS-A</td>
<td>reproductive health services-A</td>
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<tr>
<td>RMPs</td>
<td>registered medical practitioners</td>
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<td>RSPN</td>
<td>rural support programs network</td>
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<tr>
<td>RTI</td>
<td>regional training institute</td>
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<td>SMC</td>
<td>social marketing of contraceptives</td>
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<td>SOP</td>
<td>standards of proceedings</td>
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<td>SRHR</td>
<td>sexual and reproductive health and rights</td>
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<tr>
<td>STD</td>
<td>sexually transmitted diseases</td>
</tr>
<tr>
<td>TAMA</td>
<td>technical assistance management agency</td>
</tr>
<tr>
<td>TFR</td>
<td>total fertility rate</td>
</tr>
<tr>
<td>THO</td>
<td>tehsil health officer</td>
</tr>
<tr>
<td>THQH</td>
<td>tehsil health quarter hospital</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States. Agency for International Development</td>
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<tr>
<td>VBFPW</td>
<td>Village-based family planning worker</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WMO</td>
<td>woman medical officer</td>
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Acknowledgements

The State of Family Planning in Pakistan is an assessment aimed at ascertaining the status of Family Planning based on operations, progress made and shortcomings covering the period 2000-11. Several quantitative studies done in the recent past missed the underlying system-wide issues causing the sector’s poor performance. This is basically a qualitative study using responses from in-depth interviews, selective statistics from secondary sources and extensive review of literature. The assignment was completed between October 2012 and April 2013.

I would like to express my gratitude to Pathfinder International headquarters for their endorsement to undertake the assessment by the Pakistan office and to the United Nations Population Fund- Islamabad for its principal support in commissioning and funding it along with guidance extended in the initial phase. Pathfinder had outsourced the exercise to a Lahore based establishment, Contech International. The firm under continued guidance and support of Pathfinder developed the tools, undertook the literature review, conducted in-depth interviews of many key respondents, produced a transcript of interviews and formulated a draft report. Pathfinder would like to thank and appreciate Contech International for the extensive work undertaken and for bearing some of the administrative costs through their own setup.

I am personally most grateful to all the respondents at the federal and provincial levels, representatives of NGOs and social marketing and development partners for giving valuable time from their busy schedules to provide important information bearing evidence on the findings of the study. I am equally thankful to those respondents who replied to the interviews as a group and to those who expressed an inability to participate in the assessment as it also reflects their stance in this regard. Lastly, I would like to express my sincere thanks to Candace Lew, Senior Technical Advisor for Contraception, Pathfinder International, and my own team at Pathfinder Pakistan especially Ghulam Rabbani and Abo Ul Hassan Madni for making timely and valuable contributions as the draft report had to be reviewed, recast and re-constructed in order to enrich with data analysis and pertinent quotes from respondents while giving a final shape to the report. Technical and editorial support from head office is acknowledged.

I trust that this assessment will enable the development world to take stock of the situation, consider the findings and recommendations at appropriate levels, and take the necessary action by charting a course which advances the objectives of population and sustainable development. This is vital for the well-being of the people and future of Pakistan. In fact, the future is today, as it is dependent on action taken today, sustained over time with understanding and conviction, duly charged with determination and concentration reflected in action.

Tauseef Ahmed PhD
Country Representative
Pathfinder International – Pakistan Office
Executive Summary

Pakistan has an estimated population of more than 180 million with an annual growth rate of 2.03 percent and if this trend continues the population of the country will double in the next 35-36 years. This has adverse implications for the socio-economic development pace and process. Pakistan has been conscious of the emerging population issue and introduced the concept of voluntary family planning in its First Five Year Plan 1955-60. The commitment to the cause was sustained by progressive growth in resource and programmatic expansion but no significant progress was made till the 1980s. The renewed emphasis and strong political support in the 1990s did register improvement when contraceptive use rose from below 12 percent in the early 1990s to around 28 percent in the late 1990s. However, the period 2000-11 did not continue the upward trend, rather the contraceptive prevalence rate (CPR) stagnated as revealed by surveys including the Pakistan Demographic and Health Survey 2006-07 (Sathar and Zaidi, 2010). The stagnation stunned planners and has raised several questions about the efficiency and effectiveness of efforts made by various stakeholders. This slowdown is not unique in the region as other countries are also presently experiencing the same phenomenon. However, challenges in Pakistan appear more systemic in nature both from demand and supply sides as identified in different reviews (Karim and Zaidi, 1999; Rukanuddin, 2001; TAMA, 2008). The sector as a whole and the Population Welfare Program (PWP) in particular, did not perform as anticipated (Sathar and Zaidi, 2010). The situation further aggravated with the enactment of the 18th Constitutional Amendment which allowed provincial programs to execute massive programs with limited funding, combined with a passive approach by the provinces and lack of pro-active coordination between the Population Welfare Department and the Department of Health (AKU, 2012).

Pakistan made efforts to address the issue with its own resources and with generous support by various donors, nongovernmental organizations (NGOs), and community-based organizations (CBOs). The United Nations Population Fund (UNFPA) in particular has remained a steadfast supporter of the program since 1969 and invested in its progress and attainment, commissioned this study through Pathfinder International to assess the program in view of stagnant CPR, high population growth, and unstable environment for FP. The study was outsourced by Pathfinder to a reputed research firm ‘Contech International’ under its guidance to collect information and undertake analysis and prepares an initial draft report. This was reviewed and reconstructed by Pathfinder on the basis of literature review and In-Depth Interviews (IDIs) to enrich and improve the study in the context of agreed Terms of Reference TOR with UNFPA. This has consumed considerable time and the efforts initiated in October 2012 have been completed in April 2013.

This report consists of nine units and examines the role and contribution of different stakeholders in detail. The first unit covers introduction and background information while the second explains the study design, approach, objectives, methodology and essentials of FP. The next four units concentrate on assessment and data analysis. The third unit explains inputs and outlines the stakeholders of FP, discusses policy atmosphere, recent changes, funding of the program and contraceptive security. The fourth unit brings out the processes and procedures followed in managing the program including planning, coordination and monitoring process.
Units five to seven look into outputs, target setting, coverage and access, demand generation and social mobilization, HR management and development and quality of services. The eighth unit focuses on devolution and the NFC Award. The final unit of the report brings out major findings as part of the conclusion and makes broad, salient recommendations.

The study brings out that targets and goals related to Family Planning have not been achieved due to lack of clear policies, planning, a governance mechanism and limited coordination among relevant stakeholders. Coverage and access was found lacking and the Departments of Health did not own the program and that LHWs’ focus was diluted due to over-emphasis on polio immunization. Serious inequity in service availability emerged due to the dilution of Lady Health Workers’ (LHWs) role in family planning (FP) and Health facilities not taking on family planning as part of their essential service delivery package. A complex funding flow mechanism with delayed and insufficient releases caught the program in a vicious cycle of low performance supply shortages and stock-out. It is unfortunate that neither the federal Ministry of Population Welfare nor the Planning Division evolved any strategy to remedy the issues, but rather remained at dragger drawn. The advocacy and interpersonal communication (IPC) remained less audience oriented and less focused, while monitoring & evaluation and research support was weak and sporadic. Focus on family planning took on a secondary position when it was introduced within the framework of reproductive health care. A paradigm shift towards reproductive health (RH) diluted focus and investment in family planning. Low contraceptive requirement assessments resulted in stock-outs while no resolution of contraceptive pricing continued to be a contentious issue for Health not to request for contraceptives for health outlets. Over-centralization by the federal Ministry of Population Welfare did not promote provincial ownership, especially their investment in family planning activities.

The devolution of the population subject to the provinces has had the mixed result of defocusing the population issue from the national perspective. At the same time, it provided an opportunity to the provinces to revisit the subject, considered within the provincial development framework and build on the collective strength of Population & Health to work for delivering integrated services duly backed by adequate resources as its own responsibilities and compelling need for sustainable development endeavor. These efforts are particularly relevant and important in translating Pakistan’s commitments made at the London Summit FP 2020 into practice. All this is needed to revitalize the Population Welfare Commission, revisit Population Policy 2010, rejuvenate Provincial Population Steering Committees, build ownership of family planning in Departments of Health and the Population Program by provincial Governments, revamp the planning process, ensure adequate allocation, improve coverage and access, overhaul monitoring and supervision system, tap the resources of public-private sector organizations (PPSOs), and maintain commodity security and active support of all stakeholders. This will need effective backup of advocacy & promotional campaigning with an effective system of monitoring including third party monitoring at regular intervals and feedback from beneficiaries built into the whole monitoring follow-up and evaluations system. Adopting a new approach based on birth-spacing and improving method choice, especially long acting methods are essential components. The existence of a large service provider and facility network needs to be optimally utilized along with gearing political support and acknowledgement that the
unprecedented high population growth is negatively impacting economic growth and the welfare of Pakistan’s people.

Family planning has been a missing link in the development process in the last decade. Investing in family planning is a major step towards claiming the ‘demographic dividend’ in the coming years. Investment in family planning will enhance investment in human capital in the coming years and would be a major step towards attaining the benefits of the demographic dividend. This investment directed towards building and revamping systems will benefit Pakistan and its people, especially the young mothers who are joining in millions every year. Hopefully, this will be given due consideration and will put the Family Planning program on the right track to deliver what is needed and strike a balance between overall population size enabling sustainable development and improving per capita access to goods and services, thereby affecting quality of life.
Unit One: Introduction and Background

1.1 Introduction

Pakistan, with an estimated population of over 180 million, is the sixth most populous country in the world and the second most populous Muslim country (FBS, 2011-12). The area that constitutes Pakistan today had a population of almost 50 million in 1960, and if current annual population growth rates remain unrestrained the population of Pakistan is expected to double in the next 36 years (UN, 2011). It is a compelling situation for policy makers and planners to take note of the effect and influence of such rapid population growth and visualize the adverse implications on the resources and the socio-economic development of the country. Pakistan has been conscious of the long-term effects of galloping population growth and adopted the philosophy of voluntary family planning in the 1950s, with the lead taken by NGOs. These persuaded the government and a series of gradual expanded efforts were made in a sustained manner to advocate and provide the means for family planning. These initial measures containing basic components were well-defined and carefully planned for execution by all stakeholders, taking into consideration the socio-economic and demographic perspective for meeting health and family planning needs of the population (TAMA, 2008).

All the programs and initiatives (including that of Department of Health, Population Welfare Program, NGOs and private sector) have attempted to contribute to improving maternal and child health, thereby having an effect on fertility decline by increasing demand, access and availability of family planning information and services. Nevertheless, the recent studies reveal that Pakistan’s progress has been slow and low in achieving its contraceptive prevalence targets and in managing the fertility decline (World Bank, 2010; Sathar and Zaidi, 2011). It is quite evident that Pakistan will miss the goal set at the International Conference on Population Development (ICPD) and Millennium Development Goals (MDGs) 4 and 5, especially universal access to Family Planning (FP), with glaring and continued high unmet need for contraception (UN, 2012). The recent devolution process through the 18th Amendment, crafting of population policy 2010 through participatory process and population perspective plan 2002-12, extended renewed commitment to revitalize the existing mechanism to sustain programmatic initiatives with visions required for a stable and better off populace. Hence, it is necessary to take stock of the situation to understand and explain the current state of family planning in Pakistan. It will bring into focus the overall situation during the last decade (2000-10), which is marked by a stagnation of the Contraceptive Prevalence Rate (CPR), an increase of ever users and drop-outs along with barriers and challenges that have resulted in discouraging feelings of letdown.

1.2 Background

Family planning in Pakistan has come a long way with visible successes witnessed during the 1990s. The ever users of FP have progressively increased from 20.7 percent in 1990-91 to 48.7 percent in 2006-07. Similarly, current users of family planning also increased from 11.8 percent in 1990-91 to 27.6 percent in 2000-01, touching around 30 percent in 2006-07. The stagnation in current use of contraception, though not unusual in countries like Pakistan, needs to be examined more closely to identify and understand the contributing factors. According to the
Pakistan Demographic and Health Survey (PDHS, 2006-07), the contraceptive prevalence rate (CPR) is 22 percent for modern methods, with eight percent couples opting to use traditional methods making the CPR for all methods 30 percent. Among modern methods of contraception, injectables (2.3 percent), IUD (2.3 percent), pills (2.1 percent) female sterilization (8 percent) and condoms (7 percent) are the most prominent methods. Focus on other methods (pills, injectables, IUD) temporary methods essential for spacing remained weak (PDHS, 2006-07). Use of modern methods increased from 9 percent to 20 percent (during 1990/91 to 2000-01) mostly constituted by a significant rise in the use of condoms (2.7 to 5.5 percent), IUDs (1.3 to 3.5 percent), injectables (0.8 to 2.6 percent) and oral pills (0.7 to 2.6 percent) during the same period. The rate of change was much slower since year 2000 for all methods except IUD and injectables, the proportion of which, however, showed slight decline. Tubal ligation doubled from 3.5 in 1990-91 to 7 percent in 2000-01, and increased marginally to 8 percent by 2006-07. Similarly, the contraceptive prevalence rate showed a slow increase during the comparative period of 2000-01 with 2006-07 wherein the increase was 2 percentage points, from 27.6 to 29.6 as given in Table 1.1.

The stagnation of current use of contraception during 2000-10 and a steady increase in ever use is marked by high drop-outs who increased from 12.6 percent (2000-01) to 19.1 percent (2006-07). The high contraceptive discontinuation rate was closely associated with poor follow-up care and resulted in stalling the CPR for several years (PDHS, 2006-07; Rahnuma, 2009).

Table 1.1: Trends in Knowledge and Use of Contraception

<table>
<thead>
<tr>
<th>Description of indicator</th>
<th>PDHS, 1990-91</th>
<th>PRHFPs, 2000-01</th>
<th>PDHS, 2006-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of contraception</td>
<td>77.7</td>
<td>95.7</td>
<td>95.9</td>
</tr>
<tr>
<td>Ever users of FP</td>
<td>20.7</td>
<td>40.2</td>
<td>48.7</td>
</tr>
<tr>
<td>Current users of FP</td>
<td>11.8</td>
<td>27.6</td>
<td>29.6</td>
</tr>
<tr>
<td>Modern method user of FP</td>
<td>16.2</td>
<td>20.2</td>
<td>22.0</td>
</tr>
<tr>
<td>Drop-outs</td>
<td>8.9</td>
<td>12.6</td>
<td>19.1</td>
</tr>
<tr>
<td>Unmet need for contraception</td>
<td>28.0</td>
<td>33.0</td>
<td>24.9</td>
</tr>
</tbody>
</table>

The trend in proportion of drop-outs increased over two decades and the highest drop-outs were noted since year 2000 i.e., 9 percent in 1990, 13 percent in 2000 and 19 percent in 2006-07 (as shown in Table 1.1). The highest dropouts are noted for condoms and pills (10 percent each) and injectables (9 percent). The IUD dropout only marginally increased during the last decade; it could possibly be due to decrease in ever users of this method. The decline in use of modern methods during these years is a serious matter, especially when users have shown interest and initiated the use of long acting methods. Constant current users of traditional methods (seven to eight percent), reflect the need to reach them for counseling and encourage access to modern methods. Significant drop-outs of traditional methods over the years (10 percent for 2000-01 to 17.6 percent 2006-07) appears to reflect users’ increasing dissatisfaction with the ineffectiveness of these methods. The primary question is: Where in the system are mechanisms to attract such users towards modern methods?

On the contrary, a strong desire to curtail or space pregnancies has continued to exist among Pakistani women over the years. The 25 percent of unmet need revealed in the PDHS (2006-07)
is evidence of where the focus needs to be in order to accelerate acceptance and improve the CPR. Almost 25 percent of women showed such a desire in PDHS 2006-07 across urban and rural areas. It is clear that easy access, better counseling and quality of services remain big challenges. A high level of unwanted pregnancies and induced abortion appeared to be a reflection of this dismal situation (Population Council, 2004).

Though client satisfaction is a key in decision making regarding contraceptive use and its continuity, reasons for drop-out and ‘no intention’ of using contraception seem to reflect linkages and impediments in the system for provision of quality services that would strengthen access and use of contraception. More than 43 percent of non-users desire not to use contraception (2006-07) in the future which also means that the other 57 percent of women, including 25 percent with unmet needs, need to be reached for counseling and services through focused approaches, and the 30 percent who are currently practicing family planning need to be supported with assurance and follow-up care as necessary. Service delivery systems are designed to address these reasons by building corrective actions to overcome these barriers. Essential to any future remedial measures is the women’s propensity for not intending to use contraceptives in the future (dropouts and non-users). The PDHS 2006-07 identified the most common reasons for not intending to use as: “up to God” (28 percent), “infertile/can’t get pregnant” (15 percent), “husband opposed” (10 percent), and “opposed to contraception” (8 percent). High demand for children and misperceptions regarding FP continued over the years, while neglect in reaching out to non-users appears to be a major missed opportunity, as noted by the PDHS. For instance, fieldworkers or Lady Health Workers (LHW) (12 months prior to survey) reached out to less than one-quarter (23 percent) of nonusers to discuss family planning issues and only 3 percent received FP supplies from them. The service delivery gap is definitely a major concern.

Service availability in the area of family planning has also witnessed change over the years. Both the public and private sector entities have been serving clients with a variety of methods. The dynamism between the public and private sectors and within the public sector needs to be elaborated by examining the changing contributions of various stakeholders. Increasingly, the private sector (Social marketing, NGOs and commercial entities) has been penetrating into the user’s market and establishing its space and credibility for services without challenging the public sector. A comparison of two household surveys (NIPS: PRHFPS 2000-01 and PDHS 2006-07) reveal that the public sector served 57% of users in 2000-01, declining to around 48% in 2006-07. Private sector entities that already had a major contribution in the condom market since the early 1990s also showed a significant contribution in serving injectables and IUDs by 2006-07 (Figure 1.1). The figure also reflects the efforts of the government to make space for the private sector in the provision of a surgical method. The enhanced role of NGOs and non-public sector bodies providing women with tubal ligation is well reflected in the two surveys and in the decline of tubal ligation users served by public sector entities.
The public sector provision of FP services is made by the Population Welfare Department (PWD) and Department of Health outlets. A comparison of two surveys reveals the dynamics of role sharing by Health facilities in the provision of family planning. Overall, the proportion of the population served by population welfare facilities declined significantly from 45 percent in 2000-01 to 35 percent in 2006-07, while the role of health facilities and lady health workers increased marginally from 11 to 13 percent over the same period. Surveys reveal that access to services by Population Welfare Department facilities declined more significantly in IUDs, injectables and oral pills (18%, 16% and 12% respectively). In contrast, only community-based workers filled the void and took an active role in 2006-07 to serve injectables, oral pills and condoms (Figure 1.2). The vast facilities network of the Department of Health: Basic Health Units (BHUs) and Rural Health Centers (RHCs), highlighted as important family planning sources during the late 1990s, could not deliver family planning services as needed during the years 2001-2006.
This decline in the DOH’s performance is a major setback to the availability of family planning services. The important point is that DOH needs to own FP and ensure that all its outlets commit to the delivery of FP services, particularly when FP is being positioned as a health intervention.

Client information regarding the side effects of contraceptive use and how to manage them are two key areas of counseling critical to maintain continuity in use of modern contraceptives. Clients served by Reproductive Health Services-A (RHS-A) centers show that a little more than a quarter of clients received essential information on both aspects (PDHS 2006-07). In contrast, clients reported a much higher proportion of counseling by lady health workers (LHWs).

1.3 Trends in Contraceptive Prevalence Rate: Targets and Achievements

Pakistan was one of the first countries in the world to not only recognize growing population as a development issue but also to formulate and design plans and measures to address it. Generally, Pakistan’s population issue has been tagged with economic development process in various forms. Pakistan’s first public acknowledgement of ‘demographic transition’ and anticipated rapid population growth as a threat to wipe out development gains was part of its First and Second Five Year Plans (1955-60 and 1960-65) attempting to address population growth through limited interventions. The Third Plan (1965-70) noted that rising population growth dilutes past economic advances, and proposed raising CPR to 34 percent by 1975 to tackle high fertility rates. The Fourth Five-Year Plan (1970-75) identified a significant rise in unemployment due to high population growth, while the Fifth Plan evolved around the concept ‘development is the best contraceptive’ and identified the development process as the main beneficiary. Its more realistic goal saw an increase in CPR from 6 percent to 18 percent by 1983. The Sixth Plan (1983-88) tied population welfare policies to elaborate objectives and highlighted multi-sectoral strategies with a focus on fertility management. The Seventh Five-Year Plan (1988-1993) incorporated the formal declaration by Mexico City World Population Conference 1984, to make FP services ‘universally available,’ and to increase CPR from an estimated 13 percent to 23 percent with an emphasis on clinical methods.

By the early 1990s, lowering the population growth rate and increasing the contraceptive prevalence rate had become permanent features of five-year plans. Unfortunately, both preceding and subsequent plans could not achieve the set targets for CPR and fertility related goals. With political governments in place, the early 1990s witnessed the seriousness of government commitment towards the population issue. The Eighth Five-Year Plan (1993-1998) continued to recognize the consequences of rapid population growth on social and economic development, and resolved to support the population programme to address poor performance and low coverage of rural areas. Pakistan also endorsed the ICPD Plan of Action 1994, which called for taking action to promote human development and stabilize population growth within the context of ‘comprehensive reproductive health care.’ The Ninth Plan focused on reducing the population growth rate and servicing unmet need for contraception. The innovative strategies in the provision for FP services and progress in contraceptive prevalence rate during the 1990s provided impetus to the government to maintain the momentum, but this did not
occur as progress was slow and the increase in CPR remained low as described in the previous section.

High population growth, low FP performance during the 1970s and 80s and the widening gap between targets and performance had built pressure on successive governments to be aggressive and results oriented. A closer look at more recent policy and planning documents reveals the increasing realization at the highest level to maintain CPR in the national economic and development framework. More recently, as part of Pakistan’s MDG commitment, CPR is considered central to fertility decline and population growth strategies. The interim Population Sector Perspective Plan 2012 envisioned and set an ambitious agenda to increase the contraceptive prevalence rate from 30 percent (2001) to 43 percent in 2004 and 53 percent in 2012. Furthermore, government publications produced in the 2000s consistently adjusted the CPR indicator and set a target of 36 percent in the Mid-Term Development Framework (MTDF, 2005-10), 45 percent for 2007-08 in the Federal PC-1, 57 percent for 2010-15 in the Poverty Reduction Strategy Paper (PRSP). The MTDF projected a CPR of 51 per cent for its terminal year (2009-10), while MDG-5b aimed at contraceptive prevalence of 55 percent for 2015 (Table, 1.3).

Though there is awareness of rapid population growth and the bulging population issue in Pakistan, macro growth documents by the Planning Commission including Vision 2030 and the New Growth Framework 2011. Do not focus on population issues. Rather they concentrate on the ‘demographic dividend’ in relation to growth strategies without taking into account the need for effective FP programming on which it hinges. In contrast, Annual Development Plans continue to emphasize control over the population growth rate and predict Pakistan will be the fourth most populous country in the world by 2050. Family planning services have not kept pace with the increased demand. The stagnation of CPR at 30 percent is a testimony to the fact that there remains disconnect between not only the demand and provision of services, but also the priority allocated to FP within development processes. All this is ample evidence of the concern of policy makers about the implications and consequences of rapidly growing population on the socio-economic development of the country. More importantly, it emphasizes that to achieve the desirable level of fertility, robust family planning services is imperative to regain (and sustain) the momentum in fertility transition and still remain in a position to avail the ‘demographic dividend.’

Table 1.3: Targets and Achievements of CPR: Widening Gaps (in percentages)

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>PRSP</td>
<td>--</td>
<td>37.2\textsuperscript{a}</td>
<td>39.4\textsuperscript{a}</td>
<td>42\textsuperscript{a}</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>57\textsuperscript{d}</td>
<td>55\textsuperscript{e}</td>
</tr>
<tr>
<td>MTDF 2005-15</td>
<td>--</td>
<td>36\textsuperscript{b}</td>
<td>38\textsuperscript{b}</td>
<td>41\textsuperscript{b}</td>
<td>45\textsuperscript{d}</td>
<td>48\textsuperscript{b}</td>
<td>51\textsuperscript{b}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population Perspective Plan</td>
<td>--</td>
<td>40\textsuperscript{c}</td>
<td>43\textsuperscript{c}</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>53\textsuperscript{d}</td>
<td></td>
</tr>
<tr>
<td>Actual Achievement CPR</td>
<td>27\textsuperscript{f}</td>
<td>32\textsuperscript{f}</td>
<td>--</td>
<td>26\textsuperscript{d}</td>
<td>29.6\textsuperscript{d}</td>
<td>27\textsuperscript{f}</td>
<td>--</td>
<td>27\textsuperscript{f}</td>
<td></td>
</tr>
</tbody>
</table>

Sources of information:

- Poignancy Reduction Strategy Papers
- Medium Term Development Framework
- Population Perspective Plan 2002-12
- Ministry of Population Welfare PC-1 2003-08
- MDGs 2015

1. PRHFPS 2000-01
2. PDHS 2006-07
3. SWRHFPS 2002-03
4. PLMS - PBS
5. Economic Survey of Pakistan 2010-12
The contraceptive prevalence targets have always been quite ambitious in the past and enhanced every year under various Programmes and Frameworks. Consistently, various assessments of the performance of FP programmes only revealed Pakistan’s inability to achieve the intended targets and goals. The Pakistan MDG Report 2010 categorically states that during 2001-2009 the MDG target for FP is unlikely to be achieved, as the reality is far from the target. The Annual Plan 2011-12 also depicts a gloomy picture of the Population Sector indicator (CPR). Under-achievement of the indicator has been consistently noted over the years, while corrective actions lagged far behind. This fact is at the root of this study.

Pakistan recognizes the urgent and dire need to thoroughly look into the current state of FP in the country. This entails an understanding of the impediments and challenges facing successful family planning methods in order to change course and re-invigorate efforts, especially at the community level which has the flexibility to address unmet need and evolve in whatever direction is needed.

Considering the rapid increase in CPR from 12 to 28 percent during the 1990s, continued high unmet need for contraception (defined as those currently married women who do not desire to have more births or like to space births, but are not currently practicing any contraceptive method) reflects programmatic problems (PDHS, 1990-91; PRHFPS, 2000-01). Users and potential users were unable to locate accurate information, the right type of services or exercise choice for suitable methods. While a slowdown in the contraceptive prevalence rate was seen across the board, there is serious variance in contraceptive prevalence and unmet need for contraception across provinces and urban-rural settings, highlighting imbalance in availability and access to services. In other words, inequity and variance in use rate is proliferating in the service system. Though a number of initiatives were launched to increase FP coverage, the public sector faced a series of implementation and management problems in fully reaching and benefiting the target group.

In the 1990s several commitments on the part of national and local government, the NGO sector and international donors created a very supportive environment for a robust family planning programme. The programme was given open political support, the initiation of an accelerated program in 1991, the government’s explicit commitments made at ICPD in 1994, increased budgetary allocations, the induction of a community-based workforce by the Ministries of Population and Health, and the involvement of a large number of NGOs in service delivery targeting rural areas, as well as greater donor assistance in social marketing to reach all urban areas. The UNFPA lent its support through a special project for field monitoring of all population welfare facilities, all of which resulted in some improvement in service delivery. These initiatives could have had more profound results if certain systemic issues and problems had been addressed. As it was, outcomes were diluted. Several assessments and studies of the sector brought to light evidence of core systemic issues including:

- Poor management, inadequate coverage and low quality of services encountered by family planning programme in Pakistan, even prior to the 1990s (Rukanuddin 2001);
Highly centralized decision making that reflected a lack of trust in the management system;

Inadequate oversight and governance measures affecting programme performance; direct supervisors lacked authority to carry out decisions for timely execution, or take disciplinary action for hiring and/or firing of low-grade staff. Though staff decreased overall, female supervision remained a weak area;

Sanctions imposed by the US following Pakistan’s nuclear testing in 1998, that seriously delayed funding to the population programme, apart from short releases of funds;

Withdrawal of USAID in 1994 created a vacuum in grant funds available for procurement of contraceptives;

Field staff continued pursuing a target-oriented approach even after the Federal Ministry had disclaimed it because of serious criticism from donors;

Staffing gaps in the population programme were quite significant, but no substantive action plan evolved to address the Human Resource (HR) crisis. High staff retirement and a ban on fresh recruitment especially to administrative posts during 1996-1999, resulted in large-scale vacancies that severely knocked-out the programme performance;

Poor human resource management by the Ministry resulting in frustrated and demoralized field staff with worries related to job security, promotions, career planning, etc;

Frequent changes in top management and provincial administrators and a ban on recruitment contributed to weakening management at all levels;

Inadequate coverage, particularly in rural areas where expansion was modest and lacked in quality of services (Hakim and Miller, 1998; Rosen and Conly, 1996);

Coordination with the MOH remained weak and could not translate into regular provision of family planning services through their health facilities, especially in rural areas;

Stocks of all contraceptives ran dry for months as the LHW programme experienced a major financial crunch during 1998-2000;

The Women’s Health Project depended on Ministry of Population’s contraceptive supplies. Distribution to twenty project districts could not be operationalized due to a minor pricing issue, thereby impeding the provision of contraceptives to target women.

Government health facilities failed to make family planning services ‘widely available’ while the issue of ‘quality of FP services’ in health facilities existed (The World Bank: 1998);

In addition to management issues, a number of programmatic constraints also persisted. The family planning programme, though charged with providing services in both urban and rural facilities, in fact tended to concentrate activities in urban centers and could not overcome the differential even with the help of the private sector and social marketing (Rahnuma, 2009). The outcome was a visible urban-rural total fertility rate (TFR) differential by the mid-1990s, with higher fertility in rural areas (Hakim et. al., 1998). Other issues included:

A lack of local ownership: what the Population Programme by design did not try to build was local ownership especially at provincial and district levels. Provincial governments
The performance of mobile service units was not improved over the 1994 level, its visualized expansion remained suspended and was further marred by the personnel selection process;

- Monitoring, research-support and evaluation were sporadic and lacked purpose-bound action plans and time-bound results to assess the efficacy of the programs (Rukanuddin, 2001);
- NGO involvement through the National Trust for Population Welfare (NATPOW) emerged strongly until the World Bank’s Population Project came to an end in 1999. While the UNFPA and European Union (EU) sought greater operational autonomy for NATPOW to commit additional support, no progress was made on this score, which halted NGO funding from those sources;
- The information, education and communication strategy developed in the 1990s with the support of UNFPA maintained focus on birth limitation and family size. The strategy was implemented through highly expensive electronic media, while the more effective medium of interpersonal communication (IPC) was ignored. The strategy could not address strong misperceptions regarding family planning and demand for large families continued in rural areas.

Up to this point, the supply and provision of services has not met the demand for them. Past problems included issues related to policy, management of the FP program, the politics surrounding FP, comprehension of FP by stakeholders, and of course external factors. With these issues and problems, the population sector entered the new millennium. In fact, some of these constraints and impediments are inherent and exist in the program today. Because there are several providers of FP in the system, their role in the supply process needs to be assessed. This study includes a close look into the complex mechanism of FP services provision by all stakeholders to identify problems and missed opportunities in order to improve availability and access.

1.4 Population Projections for Pakistan

Projections for Pakistan’s population change in step with demographic indicators, mainly-fertility and mortality. The decline in fertility and mortality rates captured by several surveys in Pakistan (including Pakistan Demographic Surveys and PDHS) were complemented by improved life expectancy over the years. Encouraging projections for the current years by the National Institute of Population Studies in 2005 were based on results from 2001 demographic surveys which still reflected the decline in the fertility rate seen in the 1990s. Because the decline in fertility due in large part to the FP programs slowed down, earlier projections for the current period do not reflect the reality. They estimated a population size of 142 million in 2001, 153 million for 2005, 167 million in 2010, 173 million in 2012 and 194 million in 2020. Projections were revised and presented by the Planning Commission for the 2010 Population Policy exercise. The result was to bring each projection forward by five years, expecting a population size of 174 million for 2010, 192 million in 2015, and 216 million in 2020. A decline in fertility rates is desirable and necessary to contain fast rising population size in Pakistan. The Planning
Commission’s population projections of 265 m in 2030\(^1\) were based on the assumption that conditions would remain the same and fertility decline would continue to be slow. In case fertility decline did not improve substantially, a population size of 294 million is expected by 2050\(^2\). It is also projected that 50 percent of Pakistan’s population will reside in urban areas by 2045. The seriousness of the matter needs to be realized and it is a good time for re-evaluating prospects for further fertility decline and the efforts required to achieve the same.

Low mortality and high fertility sustained over a long period of time has serious implications for the structure, composition and distribution of population. Pakistan’s population has more than quadrupled in just 50 years (1947 – 1998) with peak growth rates between the mid-1960s and late 1980s. The growth rate has, however, continued to appreciably decline since the late 1990s, yet the sheer size of the population has added new dimensions and brought along scores of challenges to be addressed. With the declining growth rate, the population under 15 has reduced in terms of overall proportion (from 43 percent in 1998 to 41.6 percent in 2007 (FBS: 2007), but has increased in absolute numbers tremendously. This is the largest proportion of adolescents Pakistan has ever had, and with the existing momentum in the population growth the numbers will continue to rise at least for the coming decades, thereby putting tremendous pressure on policy makers to make good decisions. The importance of this age group pertains to the proportion of expenditure made towards their education, skill enhancement and prospects for employment to avoid potential threats to security they could pose if frustrated by limited prospects. The proportion of youth (age 15-24 years) are the new entrants in productive ages, which rose to 22 percent in 2010 and is expected to gradually slow down to maintain a level around 15 percent by 2040. The proportion of reproductive age women (15-44 years) rose from around 23 percent in 2000 to 26 percent in 2010 and maintains the proportion for the next two decades till 2035. Understanding this group dynamics is vital to ensure adequate support and growth of programs by simultaneously targeting female empowerment and reduction in fertility. Since many population-related changes take time to have an effect, it is time to pay more attention now to arrest galloping population growth.

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\(^2\) U.S. Bureau of the Census, International Data Base (2011 midyear estimates)
Unit Two: Study Design and Approach

2.1 Study Objectives

Family planning has not progressed as planned and the PDHS 2006-07 has specifically revealed a number of deficiencies and shortcomings, in particular slower growth in the CPR and the notable devolution of population and health subjects to the provinces. As such, it was an opportune time to assess the situation and look into the reasons that led to an unstable environment for FP in the previous decade and the need to evolve necessary strategies for focused attention in the emerging context of complete provincial ownership. The UNFPA took the initiative by organizing a critical situation analysis to identify factors facilitating or impeding the achievement of sectoral goals, outputs and outcomes. Based on this assessment, the study will recommend doable innovative activities needed to overcome the slippage and put the program on a fast track for improved implementation.

The parameters of the study include: collection of information on the existing FP situation in Pakistan from all stakeholders to assess existing mechanisms, available resources, issues, gaps and challenges in FP availability and accessibility. Further, the study intends to analyze available secondary data on the subject to capture trends and reflect on commitments. This study will identify key issues at various levels to set the stage for informed interaction between federal and provincial governments and all FP stakeholders.

This assessment study includes the following steps:

1. Defining pre-requisites and essentials of family planning
2. Defining approach-framework to guide methodology and data gathering
3. Interview tool development and data gathering process
4. Identification of stakeholders and preparation of report

2.2 Pre-requisites and Essentials of Family Planning Services

Before focusing on in-depth measures to address the matter, it is important to define or set a standard of what family planning is and what services are required to ensure quality of life during demographic transition. FP is a preventive measure for voluntary spacing of births, intended to benefit maternal and child health and when adopted on a mass scale over a stretch of time, contributes to a decline in fertility, lowering population growth. It is equally significant to highlight family planning as human right, the value of which is rooted in the fact of treating individuals as full human beings in their own right, as active agents, not as passive beneficiaries and provided with full range of FP services as per their choice and need for their family’s health and well-being (UNFPA: 2012).

However, adoption of FP involves a complex behavioural change process that demands extended time and concerted efforts for motivation, counseling and interpersonal communication to address individual need in an environment of trust, with visible warmth and spirit. This has to be backed by easy access to services, with a full range of methods of the
client’s own choice, delivered by a competent and dedicated provider, with due post-acceptance assurance and follow-up care on a sustained basis.

In this connection, an outline of essentials for FP services has been formulated and placed below (The World Bank, 1993) for consideration and comparison with on the ground efforts (Text Box 1). It will enable each participant / stakeholder to reflect upon its approach, input and end-result to focus resources to address operational aspects of the social cause with understanding and care in a holistic manner. Major inputs to meaningful and successful service delivery include motivation, service provision and capacity building of the provider, an adequate supply, regular on-the-job guidance, effective monitoring and evaluation, and incentives for providers and the immediate supervisor. These elements must be implemented as a package to ensure continued practice of FP. The first four elements are supply-side issues and the rest are critical supportive features. Taken together, all are fundamental components of a ‘system’ that encourages women to evolve behavior based on voluntary choice rather than survival and compulsion.
Text Box 1: Standard of Family Planning Service Package

Devote sustained time and efforts to counseling and motivation for acceptance of family planning by clients. Pursue this as a teacher, successful motivator and accomplished listener. Follow the popular mnemonic GATHER:

- Greet clients in a polite and friendly way and encourage them to express their concerns (assuring confidentiality and privacy (audio and visual) would encourage the client to respond)
- Ask them about their family planning needs and explain the benefit for family health
- Tell them about method choices, the mode of action and minor side effects
- Help clients decide on the methods best suited to their conditions
- Explain how to use the chosen methods correctly and regularly
- Remind clients of the need for return visits and assure post-acceptance care

a) Create easy access to services, with a full range of contraceptive facilities delivered in a setting that fosters linkages for integrated service provision with maternal, neonatal and child health (MNCH)
b) Ensure service delivery by a technically competent provider who cares for the clients
c) Ensure a reliable and efficient supply system for contraceptives
d) Institute close supportive supervision that occurs frequently for effectiveness onsite
e) Record client history, contact, follow-up and status updates
f) Consider staff training needs to refresh their knowledge and skills, and learn how to deal with new developments
g) Monitor a few essential indicators, with regular evaluation built into the programme
h) Adopt a simple reporting system for monthly reporting at the primary level
i) Involve other service providers who are already dispensing services at different levels
j) Compensate providers with incentives for good performance
k) Make provision for operational research to obtain community feedback and improve programme implementation.
2.3 Approach and Methodology for the Assessment

The ultimate goal of an FP program is for beneficiaries to have easy access to services and continued demand; which is reflected in terms of high service and facility utilization, continuity of contraceptive use based on exercise of full reproductive rights by clients and resulting fertility decline. Obviously, any framework designed to get a picture of the existing situation will include elements necessary to achieve the above goal. Since fertility and demand for children has deep social and cultural roots, bringing any change to it requires consistent and continuous emphasis on behavioural change. Providing family planning services requires sensitivity, especially in communication, to the cultural demand for more children and large family size when it exists alongside unmet demand for FP services. The focus on beneficiaries in such a framework, therefore, becomes a constant opportunity for modification based on regular feedback and interaction with clients to improve access, quality, services, and choice of services. It is this interaction that differentiates FP ‘clients’ from ‘patients’--a distinction critically misunderstood by some stakeholders, ultimately resulting in poor performance. The acceptance of family planning services in the community also depends on the perceived image of the services – birth spacing should be emphasized, not birth limiting. Until recently, the image of FP as a birth limiting system, dominated in the minds of beneficiaries, affecting their choice and ultimately the impact on desired indicators (fertility and growth rate). In recent years, shifting the emphasis to birth spacing and its close linkage with maternal health has given a different image and acceptance level to family planning services among beneficiaries in countries like Pakistan, where resistance remained quite high due to its previous image. A framework that tracks demand for quality is vital instruments in helping the public sector meet that demand. This assessment uses a standard system’s framework involving inputs, processes, outputs and outcomes of FP activities by all stakeholders (see Figure 2.1).

External influences such as religion and socio-cultural values determine fertility related demands. The re-framing of FP measures as a health initiative, combined with economic pressure, has helped to alleviate the conflict in the minds of people regarding whether FP is an acceptable behavior. The government’s commitment to achieve international targets like the MDG compels it to commit resources accordingly. Further, public policy creates clarity of purpose, provides direction, defines the scope and nature of activities, influences choices of technology and people, establishes a framework for individual competencies, and creates space for other stakeholders--especially private sector entities. The private sector in turn seeks better infrastructure and services to contribute to the national goal. Choice of technology as an input is critical in determining the achievement of sector objectives and targets. Contraceptive method mix and technology choices allowed by a Program also determine the level of effort required towards fertility transition. Donor support acts as catalyst, promoting efficiency and effectiveness in administrative and organizational structure to achieve goals. These are taken as inputs in our proposed framework.

The “System’s” perspective (Figure 2.1) captures program-based interventions and involvement of various stakeholders; important elements are enumerated as part of the framework. “Inputs”, the first arrow at the bottom of the figure, refer to resources: human, financial and
material (physical facilities and products for services), research findings for policy direction, and leadership for explicit support and commitment for change towards the goal. From a larger perspective, creating space for and engaging with other stakeholders to complement public sector efforts in promoting FP, reflects creative thinking and the government’s commitment to targeting remote and poor areas. The public sector always looks to perform more efficiently and effectively due to limited resource availability.

The management Infrastructure is a critical part and forms the internal engine of an organization that essentially converts ‘Inputs to Outputs’. Management is essentially composed of Structure, Systems and Strategy (objectives and targets) and guides the operations towards production of intended outputs and reflects its dynamism.

“Process,” the second arrow at the bottom of Figure 2.1, refers to multiple activities that are carried out to achieve the objectives of the program. Planning and implementation are two critical aspects of the process. Normally, resource availability is seen by management as the key determinant of results. However, process is an important feature as it entails several facets of the decision-making mechanisms: financial management, HR, Information management systems, performance monitoring and reporting system, and client interface system (advocacy and motivation). The importance of each of these lies in how each system and mechanism is practiced to reach desired outputs and whether quality of services is assured equally at all facilities. Workforce deployment is equally important to governance issues to ensure presence of staff. In countries like Pakistan where the social sector do not receive due attention, leadership role is of paramount importance to acquire priority for direction/guidance to the sector to build its image for effective implementation and to ensure progress. Good governance involves merit selection, correct placement of facilities, and timely a procurement mechanism for all commodities.

Organizations do not work in isolation rather bound by over-arching rules of business and sectoral influences. Ban on recruitment by governing bodies leads to a vacuum in services due to unfilled positions – in administrative or service delivery. This measure has repeatedly been used over decades to meet overall national financial regulations sacrificing the work efficiency and of course program effectiveness. Financial flow mechanisms from the main source (Ministry of Finance) to executing agencies to implementing departments and finally to field organs have over the past been recorded as a process consuming time leading to delays and impinging on timely program implementation. Involvement of several offices in the approval and release process often creates cleavages between distant financial managers and district managers’ implementing programs. Bridge financing by provincial finance departments provides a relief only when federal commitments to transfer payments exist.

Planning is an essential step of converting program inputs into desired outputs. Planning Commission-I (PC-Is) are necessary format to give formal shape to development programmes for consideration and approval by different bodies to grant authority for allocation of resources and incur expenditure for the implementation of the programme whether initiated by the Centre or the Provinces. Population Welfare remained a federal subject since 1960s and was treated as a development project for which PC-Is laid down the policy, strategies, and scope of
work with a national coverage. PC-I identified various components along with inputs and outputs and detailing design, targets and time frame, governance matters and strategy to resolve issues. There are weaknesses in understanding the linkage and interdependent support of different components in the process including converting targets into financial implications. PC-I is also used as a tool for budget formulation and of course for release of funds as per plan by Technical Sections. These documents also spell out how monitoring is conducted, which is restricted to input monitoring with a focus on financial utilization and physical progress of project inputs as per work plan and against the scope of work given in PC 1; and Annual Work Plan and Cash Requirements to meet the plan activities, and project output monitoring undertaken only if outputs are defined and information gathered.

Output refers to results achieved at the program level. Normally outputs include number of service outlets, or services delivered or any product that results from the use of inputs and processes under the organizational flow. Outputs are generally under direct control of the agency and are designed to meet requirements. Output performance traditionally focuses on budget-driven operations and remains input-based. Service outlets and delivery fall under this section and raise the issue of coverage and quality of service provided. In a broader sense, output may also include community mobilization and participation, involvement of task-sharing roles, fulfillment of the basics of the FP package, engagement of more stakeholders and signing of MOUs to enhance service structure, role of leadership and champions in promoting FP messages, future commitments (especially financial) by stakeholders, fund releases and utilization, stakeholders coordination, conduct of evaluation studies and use of findings for program improvements. Staff turn-over may also be a part. Removal of hurdles, building of program ownership and supporting staff morale and boosting activities are also outputs that are needed to achieve the outcomes. Well-organized outputs will generate necessary conditions for effective outcome of access and quality of services.

This framework was used to evolve interview tools, gather hard data from various organizations in support of the analysis, and to sequence/prioritize elements that are the foundation for the process and produce the desired outputs of the program.

The data assessment and analysis part of the study is organized in four units:

- The first set focuses on inputs and outlines the stakeholders of FP in Pakistan, presenting their roles and the scope of work with respect to family planning. It discusses the policy atmosphere in Pakistan and more recent changes occurring in this realm, financing of family planning by public sector entities (to the extent data allowed the discussion), and contraceptive availability and security issues.
- The second set brings out the processes and procedures followed by the FP stakeholders covering management and organizational matters, planning processes, coordination with the health sector, and monitoring processes.
- The third set looks into programmatic outputs targeting matters of coverage and access, demand generation and social mobilization, HR management and development, quality of services, and dilution of work of LHWs.
The fourth and final set covers two major external influences: 7th National Finance Commission award and 18th Constitutional Amendment and their impact on the family planning sector in Pakistan.

Each of these segments is based on feedback received from the interviews intertwined with facts and figures from reports and documents and quotes from the interviews. The quotes are verbatim but the name of the respondent is not revealed for privacy purposes.
Figure 2.1: Conceptual Framework and Operational Features of Family Planning Activities

External Environment and Influences
- Donor Support (International Commitments)
- Domestic FP Program Inputs
  - Govt commitment to FP
  - FP policy and related matters
  - Leadership
  - Financing and allocations
  - FP and Health workforce
  - FP products and supplies
  - Research and information

Planning and Budgeting Process
- Implementation Process
  - Mechanisms in Place
    - Management system in place
    - Service delivery – placement, outreach and partnerships
    - Ban on recruitment and development of FP workforce
    - Information - advocacy and motivation
    - FP products procurement and distribution process
    - Financing mechanism
    - Governance / Accountability / Monitoring System

Service Delivery – Coverage and Quality
- FP workforce – Task sharing
- Information flow and Awareness Campaigns
- Community mobilization
- FP products and supplies
- Financing releases and utilizations
- Staff turn over and morale
- Financial commitments by stakeholders (increased)
- Ownership by stakeholders
- Use of evaluation for program improvement

Inputs

Processes
- FP Demand Generation
- Availability of FP Services
  - Access to FP Services
- Quality of FP services available
- Service Utilization

Outputs
- Access to Contraceptives and Use Rates

Outcomes

The State of Family Planning in Pakistan, 2013
2.4 Data Gathering and Analysis Plan

The situation analysis uses a system’s approach wherein the exercise focuses on tracing the components of progression including inputs, processes, procedures, and outputs that lead to outcomes. The method adopted aims at gathering important and necessary information about impediments, facilitating factors and resources from key players across all stakeholders regarding FP events, processes, mechanisms, and activities during the period 2000-10. In general, it is a qualitative retrospective study based on two methods including literature review and in-depth interviews (IDIs). In the past, the reviews mostly recorded implementation issues across Pakistan, but this exercise includes all stakeholders based on the framework shared above that covers policy and decision makers, donors, implementing managers, and private sector managers.

The key respondents were identified on the basis of their roles and responsibilities during 2000-2010 at various levels relating to the FP sector. Most critical information was expected from respondents of former Ministry of Population Welfare (now based in different organizations in Islamabad), while implementation issues were expected to be highlighted by provincial departments. This led to formulation of a list of key informants from the defunct Ministry of Population Welfare, the Planning and Development Division (P&D), Secretaries and Director Generals (DGs) from Provincial Departments of Population Welfare and Health. Keeping in view the expanded role of various stakeholders in FP, other stakeholders from donors, NGOs, social marketing and pharmaceutical companies were also included. These categories were selected with a view to capture a comprehensive picture from stakeholders involved in formulation and implementation stages of the policy and program. An exhaustive list comprising eighty (80) respondents was prepared. Keeping in view the protocol and the confidentiality of information from public servants, letters were sent to Chief Secretaries of all provinces to facilitate the interviews with senior officers.

In view of the level and scope of work by various positions included for interview, the tools and questionnaires were developed with intensive and extensive involvement of Pathfinder. Finalizing the questionnaires took a considerable time. Questionnaires were shared with the donor agency. Given the critical roles and responsibilities in the organization and departments, relevant questions were included regarding policy formulation, planning, procedures, coordination with other stakeholders, systems, barriers and facilitators, and current commitments. The finalized questionnaires were designed in a way to cross check various statements and draw on recollections on critical matters. These interviews sought qualitative information while three formats were developed to seek hard data from Population Welfare Departments on (i) HR matters, (ii) financial matters, especially salary and non-salary aspects of expenditures over the years, and (iii) pre-service and in-service training data from Regional Training Institutes (RTIs).

The data collection process was undertaken during October-November, 2012 in the federal capital Islamabad, Lahore, Karachi, and Peshawar. To access respondents especially those belonging to the defunct MOPW and other retired officials, difficulties were encountered for their location in different Ministries and Divisions but were accomplished ultimately. Each respondent was contacted in person and out of the planned eighty (80), 51 IDIs were
completed and twenty nine (29) IDIs could not be conducted. PWD Sindh did not agree to the interview and PWD Punjab gave an interview in a joint session wherein the Secretary responded to most queries. Three respondents were selected from Balochistan Province, but an interview could only be held with the Director General Health Services Balochistan. Participation in interviews reflects the interest of the officials and members of the private sector and their concern regarding the FP sector, qualified by reservations/hesitation in identifying hurdles and shortcomings in the program. The qualitative data collected was transcribed into interview notes.

Though efforts were made to overcome possible reservations, respondents from the public sector replied to the questions voluntarily and the interviewing team was advised not to insist on replies to all questions. Detailed interviews were conducted with stakeholders (as per respondents’ list in Annexure-1.1) on a set of 31 questions. Data on financial matters, human resource and trainings was also sought from the Population Welfare Department records but only some information was provided by only two provinces after repeated efforts (Table 2.2).

<table>
<thead>
<tr>
<th>Financial matters and details</th>
<th>PWD Punjab related information is included in the report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PWD Sindh did not agree to interviews at all or provide any information. However, the Secretary of Finance provided some information</td>
</tr>
<tr>
<td></td>
<td>PWD in KP refused to provide information</td>
</tr>
<tr>
<td></td>
<td>PWD Balochistan did not agree to interviews at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing position</th>
<th>PWD KP and Punjab did not provide details but informed that positions according to PC-1 are filled.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PWD Sindh and Balochistan did not agree to interviews or sharing of any information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trainings by RTIs</th>
<th>PWD Punjab reported availability of complete staff at the training institutions, but they didn’t agree on details as the training institutions were managed by the Federal Ministry.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PWD KP reported availability of complete staff at the training institutions but did not agree to share further information.</td>
</tr>
<tr>
<td></td>
<td>PWD Sindh and Balochistan did not agree to interviews or sharing of any information.</td>
</tr>
</tbody>
</table>

Limitations of the Assessment Related to Unavailable Information

Lack compliance in providing crucial data was definitely a constraint to this exercise. Financial matters are critical in implementing any program and the interest in gathering such data was to see how the budget is managed in earmarking resources, making releases and undertaking expenditures where non-salaried components could become a bottleneck to the program itself. Similarly, vacancies especially of service providers and district managers remained a serious problem during the 1990s and the exercise envisioned seeing this aspect too. Unfortunately, no department shared such vital information and as such this analysis remains devoid of the benefits of such data. Training of health staff by RTI has been a major support since the early 1990s. Provision of data on training of Department of Health staff (especially of female health visitors and doctors) in FP technology, particularly that of IUCD insertion skills would have given
ideas regarding the extent DOH benefited from RTIs and how many Health staff would need refresher training to undertake this responsibility professionally and proficiently. Unfortunately due to non-provision of this data the exercise will not be able to shed light on such critical aspects. Therefore, some data on selected topics was taken from secondary publications of the Planning Commission and others sources. In general, the exercise was a means to identify various bottlenecks in the system for FP.
Unit Three: Stakeholders of Family Planning in Pakistan

Family Planning involves a change in attitude and behavior that has to be adopted as an enduring norm. It is a social issue and warrants collective resolve to address it in a holistic manner and sustained over a long span of time to bear fruit. An organized framework and system is necessary to lead the effort, own it as a combined responsibility for promotion, service provision and for synergistic support due to its cause and effect relationship to the socio-economic development process of the country.

Provision of family planning services as per ‘Essentials of FP package’ requires a consistent policy framework and unified levels of effort by stakeholders. In a welfare state like Pakistan, the public sector is looked upon to provide basic support in this regard, which includes infrastructure, necessary information and services to meet public needs. The question is whether the existence of a stakeholder makes a difference to the sector’s performance. Over the years, the number of family planning stakeholders has been changing and so has the number of facilities and coverage by various stakeholders (Tables 3.1 and 3.2). Given below is a comparison over a decade.

<table>
<thead>
<tr>
<th>Year 2001-02</th>
<th>Year 2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Sector Stakeholders</strong></td>
<td></td>
</tr>
<tr>
<td>(no longer in existence after Nov 2010)</td>
<td></td>
</tr>
<tr>
<td>Provincial Population Welfare Departments (PWD)</td>
<td>Provincial Population Welfare Departments</td>
</tr>
<tr>
<td>Federal Ministry of Health (MoH)</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>(no longer in existence after May 2011)</td>
<td></td>
</tr>
<tr>
<td>Vertical Program – Lady Health Workers (LHW Programme)</td>
<td>Vertical Programmes – LHW Program and MNCH Program (transferred to provincial DOH in June 2011)</td>
</tr>
<tr>
<td>Provincial Departments of Health (DOH)</td>
<td>Provincial Departments of Health</td>
</tr>
<tr>
<td></td>
<td>People’s Primary Health Care Initiative PPHI/ PRSP</td>
</tr>
<tr>
<td><strong>Private sector Stakeholders and Entities</strong></td>
<td></td>
</tr>
<tr>
<td>Greenstar Social Marketing (GSM)</td>
<td>Greenstar Social Marketing</td>
</tr>
<tr>
<td>Key Social Marketing (KSM)</td>
<td></td>
</tr>
<tr>
<td>RAHNUMA / Family Planning Association of Pakistan (FPAP)</td>
<td>RAHNUMA / FPAP</td>
</tr>
<tr>
<td>Marie Stopes Society (MSS)</td>
<td>Marie Stopes Society</td>
</tr>
<tr>
<td>National Trust for Population Welfare (NATPOW) supported NGOs</td>
<td>NATPOW existed but lacked resources to support NGOs</td>
</tr>
<tr>
<td>Private sector manufacturers (Zafa Pharmaceutical)</td>
<td></td>
</tr>
<tr>
<td>Private sector importers and distributors</td>
<td>Private sector importers and distributors</td>
</tr>
</tbody>
</table>

A quick review shows that the situation of stakeholders has changed over the years both in the public and private sectors. The two federal Ministries (Health and Population Welfare) ceased to exist after the 18th Constitutional Amendment and responsibility transferred to PWD and
DOHs respectively. This has provided an opportunity to DOH and PWD to work together through a unified operational framework by bringing into play their respective strengths in delivering an integrated package of services and ensuring adequate resources required for the FP component. In addition, the management mechanism introduced through PPHI / PRSP has added a new dimension to the contracting-out of public sector facilities and services and has the potential to strengthen service provision for family planning. Private sector entities, most of which are donor dependent, have also changed with the discontinuation of Key Social Marketing in early 2000s, whereas the Marie Stopes Society (MSS) has emerged as a steady player in service delivery for family planning. The local NGOs supported by NATPOW, though minor in the early 2000s, have almost reduced to negligible state due to lack of funding. This institutional resource needs to be supported through operational autonomy as a Trust and provided funding to work as a conduit to associate and involve larger number of NGOs and CBOs in a whole range of FP-related activities as part of their existing community uplift programs.

**Table 3.2: Trend and Progress of Family Planning Infrastructure**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a. Family Welfare Centers (FWCs)</td>
<td>1,260</td>
<td>1,327</td>
<td>1,688</td>
<td>1,752</td>
<td>2,524</td>
<td>---</td>
<td>2,891</td>
</tr>
<tr>
<td>b. Mobile Service Units (MSUs)</td>
<td>130</td>
<td>130</td>
<td>131</td>
<td>131</td>
<td>286</td>
<td>---</td>
<td>292</td>
</tr>
<tr>
<td>c. Reproductive Health Services RHS-A</td>
<td>70</td>
<td>80</td>
<td>106</td>
<td>106</td>
<td>152</td>
<td>---</td>
<td>201</td>
</tr>
<tr>
<td>d. Reproductive Health Services RHS-B</td>
<td>---</td>
<td>202</td>
<td>169</td>
<td>---</td>
<td>135</td>
<td>---</td>
<td>133</td>
</tr>
<tr>
<td>e. Village Based Family Planning Workers</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>- Females Workers</td>
<td>1,561</td>
<td>6,329</td>
<td>11,570</td>
<td>Moved to M/O Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Male Mobilizers</td>
<td>---</td>
<td>---</td>
<td>707</td>
<td>996</td>
<td>4,195</td>
<td>4,195</td>
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</tbody>
</table>

**Health Service Outlets**

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>a. Department of Health Outlets + Provincial Line Department Outlets</td>
<td>2,984</td>
<td>5,332</td>
<td>7,299</td>
<td>7,299</td>
<td>7,012</td>
<td>7,012</td>
<td>7,839</td>
</tr>
<tr>
<td>b. Lady Health Workers (Ministry of Health/DOH)</td>
<td>---</td>
<td>19,949</td>
<td>43,000</td>
<td>70,000</td>
<td>96,000</td>
<td>96,000</td>
<td>100,000</td>
</tr>
</tbody>
</table>

**PRIVATE SECTOR Outlets**

<table>
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<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. NATPOW funded NGOs</td>
<td>580</td>
<td>342</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>b. Target Group Institutions</td>
<td>174</td>
<td>339</td>
<td>450</td>
<td>450</td>
<td>98</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>c. Social Marketing Outlets (KSM + SMP) (private health providers and retail outlets)</td>
<td>27,000</td>
<td>27,000</td>
<td>62,600</td>
<td>62,600</td>
<td>53,000</td>
<td>67,000</td>
<td>67,000</td>
</tr>
<tr>
<td>d. Registered Medical Practitioners</td>
<td>2,500</td>
<td>8,655</td>
<td>---</td>
<td>---</td>
<td>26,080</td>
<td>26,080</td>
<td>26,080</td>
</tr>
<tr>
<td>e. Hakeems and Homeopaths</td>
<td>4,000</td>
<td>8,899</td>
<td>---</td>
<td>---</td>
<td>26,550</td>
<td>26,550</td>
<td>26,550</td>
</tr>
</tbody>
</table>

**Sources:**


The changes in terms of facilities by various stakeholders have been recorded over the years, but a careful review is intended below to explore how various stakeholders not only increased their strength and coverage but also deviated to address the family planning objectives, thereby nullifying the very spirit of ‘Essentials of FP service provision.’ Discussion on progress
will be made in subsequent sections while reviewing the status of major stakeholders separately.

The stakeholders of family planning, as they exist with their contribution, strength / weakness and prospect for exploiting full potentials in the future field are summarized hereunder:

3.1 Ministry of Population Welfare (now Defunct) and Population Welfare Departments

The FP activities remained policy driven which was initially closely linked with economic development for over three decades and experienced paradigm shift after ICPD-1994 to adopt holistic reproductive health approach. Addressing rapid population growth has been a steady policy parameter ever since 1960s, but also witnessed a state of uncertainty dithering in its translation into implementation plans with resources and consistent administrative support. In fact, the institutional support to this firm policy drive has been stated to have a ‘chequered history’ with many ups and downs and alternating responses by planners and respondents over the long stretch of time that has lapsed. Initially a ‘Family Planning Wing’ was created and located within the Ministry of Health (MoH), Labor and Social Welfare, wherein Family Planning Council was constituted at federal level and FP Boards established at provincial and district levels. In 1970s with the abolishment of the Council, the MoH was charged with the responsibility of policy, planning and logistics pertaining to FP. Early 1980s witnessed the transfer of FP Program to the Ministry of Planning and Development as a Population Welfare Division. The management of the FP activities made another stride in early 1990 when the Population Welfare Division was given the status of a full-fledged Federal Ministry and moved out of the Ministry of Planning and Development. Ever since 1990 the Federal MOPW remained the custodian of Population Policy, Program and Plans. The Ministry was responsible for policy formulation, co-ordination of all population and family planning activities as well as overseeing implementation of National Population Policy in co-operation with other Ministries, Government and Non-Government organizations and civil society. In addition, it acted as the Secretariat to the “National Population Welfare Commission” that was constituted in 2005 as a high-powered apex body to provide direction, guidance and monitor progress of implementation of its policy decisions and foster inter-ministerial linkages for support.

Family Planning remained as the prime activity of Population Welfare Program PWP in order to enhance contraceptive prevalence and reduce fertility rate in Pakistan. Exclusive FP service outlets (Family Welfare Centers, Reproductive Health Service Centers, Mobile Service Units, and Village Based Workers) were launched in 1970s, 1980s and 1990s. The population program received strong political support from the highest levels in late 1980s, which included launching of Accelerated Program. The RHS-A Centers were all based in public sector hospitals at districts and/or tehsil levels, FWCs remained standalone family planning facilities, while the MSUs provided out-reach family planning services to remote areas and community linkage for door step service was established through these workers in early 1990s. In view of cost reduction and minimizing duplication, Cabinet decided (in 2002) to transfer around 11,000 Village-Based Family Planning Workers (VBFPWs) to the MoH’s National Programme for Family Planning and Primary Health Care (NP for FP and PHC). This transfer completely severed the community level linkage of PWP and the merger resulted in loss of attention to FP for which they were
specifically trained. Male mobilizers’ scheme was initiated in early 2000 with recruitment and placement to motivate males and address misperceptions among males regarding FP. Furthermore, the Cabinet Decision regarding de-federalization of the PWP in 2002 provided new directions to provincial programme managers to design strategies, allocate and spend the resources earmarked for FP in accordance with local plans.

The MOPW remained as the front organization leading the Program. The functions of federal Ministry included: Formulation of Population Policy, Financing, Coordination, Advocacy Information Education, Communications, Training, Contraceptive procurement and supplies, and Policy/Program Monitoring and Evaluation. The post de-federalization decision, the provincial Population Department functions included: Program Planning, Coordination at provincial level with other line departments, procurements of drugs and other items for districts (except KP), awareness campaigns through mass media, statistics, Monitoring and Supervision. Federal Ministry received exclusive budget for management, service delivery, promotional campaign, contraceptive procurement, capacity building, service statistics reporting system, monitoring and evaluation and research back-up. The population program was financed entirely with federal funds allocated to the Ministry of Population Welfare down to its service outlets in the districts.

Consistent focus on addressing the tall order of population growth remained the prime focus for the Ministry, but the institutional and organizational support given to the program remained weak and wobbly. The service delivery network consisting of around 3000 outlets/facilities was insufficient to cover the whole population and constituted a major weakness in its system (TAMA, 2008). Prior to year 2000, no significant investment went into enhancing service availability except for community based workers, and toward RHS-A Centers. The number of mobile service units increased significantly in mid-2000 while the number of RHS-A Centers rose from 106 (in 1999-00) to 152 by mid-2005-06. The program was also beset with a number of other constraints (to be discussed in detail in later section) such as staff vacancies due to recruitment ban, budget inadequacy, particularly for operations, delayed/short releases, weak monitoring and evaluation, low clientele at facilities, weak interpersonal communications, inability to muster support from health sector and PPSOs (Karim and Zaidi, 1999; TAMA, 2008). Above all, is the lack of regular feedback of beneficiaries about their perspective of need and satisfaction with the services that would have been useful for assessing investment and progress made in implementation to deliver services.

In the post devolution scenario, the PWDs now have the full responsibility to plan, execute and own FP activities. The PC-Is for the PWP was approved in 2008/09 thus providing a base for provincial Departments to evolve future programs. The 7th National Finance Commission Award (2010) passed prior to 18th Amendment makes available funding for FP activities to Provincial Population Departments till 2014-15. Some role/institutions of the defunct MOPW still exist and are placed under the Population Wing of Planning Division, some assigned to EAD and data collation entrusted to Statistics Division. Federal Government is also obligated to transfer funds committed to support implementation of Population Program till 2014-15. The Provincial Governments do not feel obligated to put an extra effort to focus on population program to support the essential operational costs as per need and remained dependent on the existing
funds being transferred by the Planning Commission. Unfortunately, the Federal MOPW never negotiated or held a dialogue with provincial governments to evolve ownership or build capacity to understand the dynamics of demographic transition and the benefits that would accrue to provinces in their socio-economic endeavor. The Provincial Population Departments are barely supporting their existing programs in view of constrained financial support.

### 3.2 Ministry of Health (now Defunct MOH) and Departments of Health (DOH)

Pakistan has a three-tiered health system in its public sector, comprising the primary health facilities, secondary care hospitals and the tertiary level teaching hospitals. In 2012, there were 972 hospitals, 4,842 dispensaries, 5,374 basic health units, and 909 maternity and child health centres in Pakistan. Pakistan’s Constitutional structure enables a system whereby the provinces are responsible for most of the health service delivery, while the federal government advances support through policy development and provides services through a series of vertical programs that are partly funded by provinces and development partners. The DOHs make their own programmes (without directions from the MOH), and similarly, the district governments are free to determine their own priorities without any reference to provincial priorities even if they exist. It was in this complex situation, in order to improve maternal and child health indicators and specific disease eradication indicators, that Federal Government launched several vertical Programmes including the National Program for FP and PHC (in 1994), and MNCH (in 2006). Both these programs, among other objectives, use family planning indicators to reflect progress and performance.

The National Health Policy (1990) acknowledged that FP services were not being offered through any health service outlet at the time and declared that health service outlets would be mandated to provide FP services at all levels. The policy stated that health departments would work in close collaboration with the Population Welfare Division and the PWDs (Nisher et al: 2009). The overall vision of the National Health Policy (2001) focused on “health for all” with attention directed towards primary and secondary levels of the health care system. Similar to previous policy declarations, the 2001 Health Policy too recognized “large family size as an important contributor to household poverty and vulnerability.”. Health policy was categorical to ‘ensure family planning services at the door step of the population through an integrated community-based approach’. These policies and FP strategies were also reflected in the development of a National Program for Family Planning and Primary Health Care (LHW Program launched in 1994) and the MNCH Program in 2006. The Health Policy 2001 accordingly focused to raise the LHWs strength to 100,000 by 2005 to cover all underserved population for primary level care and family planning needs. The emphasis was on all health facilities to be equipped to provide a full range of contraceptives and follow-up services; while strengthening all DHQs, THQs and RHCs and selected BHUs through staff training and improvements in logistics and management systems. The PC-Is were clear regarding collaboration with the MOPW to decrease the unmet need of FP and achieve the MDGs.

The unanimous adoption of the 18th Constitution Amendment on April 20, 2010 entailing removal of the concurrent list (27 years after the original commitment) was a highly popular political step. Pakistan’s health system had many problems before the devolution process, at
the same time the preparation for devolution was insufficient, as it did not look into the essential and continuing critical federal role and realities on the ground. The two vertical national programs that encompassed FP activities (LHW and MNCH Programs) were devolved to the provinces, although federal support appeared necessary to reflect national perspective.

However, the reality on the ground showed a different scenario with respect to translating and adopting policies into FP service availability by the Departments of Health. The establishment and subsequent strengthening of the LHW Program focused on linkage with the community for primary health services including family planning. Placing over 100,000 LHWs mostly in rural settings placed health as the most important stakeholder for service delivery in family planning in the country. A number of problems were recorded for the program relating to FP activities. Foremost, low outreach contact was identified in the Pakistan DHS (2006-07) as a barrier to use: fewer than a quarter of women have been reached by a LHW in the past 12 months, of those, only 9% received information on family planning, while 2% received supplies. Evidence shows that the program’s impact has been limited and the inefficiencies in the system resulted in missed opportunities for counseling and referrals. Furthermore, operational linkages between the Population Welfare Department and the LHWs program remained weak, which resulted in inadequate commodities and supplies for LHWs, a most obvious factor contributing to discontinuation rates. The Training of LHWs lacked focus on FP methods and proper counseling.

MOH created a new cadre called Community Midwives (CMW), of skilled birth attendants under the National Maternal Newborn and Child Health Program (NMNCHP) to meet the health needs of mothers and children at their doorstep. CMWs are rural women to serve a population of 5,000 to 10,000 and belong to the same community identified as an effective resource to provide FP/RH services at doorstep. CMWs are better educated and given 18 month training to enable them to provide antenatal, intra-partum, postnatal and newborn care in their communities. The CMW training program commenced in 2007/2008 was envisioned to train and deploy 12,000 CMWs in five years. The NMNCHP, among other objectives, envisioned raising the contraceptive use rate to 55 percent by 2015. To-date around 7,000 CMWs have been trained across Pakistan and less than half of them deployed in communities. Unfortunately, the CMW training included only 9 hours of class work in 18 months to provide them basic knowledge rather than skills in effective counseling and IUCD insertions. Due to delayed financial releases the program was unable to deploy a large segment of CMWs, who opted to work for private sector organizations including NGOs. The resource remains under-utilized; it is reflected in weak focus on FP services, lack of contraceptive supplies, and low receptivity of CMWs in the communities due to age factors and non-availability of FP services.

In contrast to the policy statement, most DOH health facilities did not provide FP services on a regular basis during 2000-2010. The basic reason was the primary health care service package was not modified to incorporate FP service provision as an essential service to be delivered by the BHUs and RHCs. The health staff, therefore, never assumed provision of FP as their responsibility. DOH, however, at all levels focused on the primary function of curative care, and considered FP as secondary in their role even though it was relevant to reduce maternal, infant and child mortality and for attention to Post Abortion Care. Nonetheless, FP required
sustained time and efforts for motivation and counseling whereas the heavy burden and load of curative care consumes most of the time of an already under-staffed health infrastructure (TAMA, 2008). In the same way, LHWs have been heavily burdened with polio-related activities since mid-2000 and not being able to concentrate on FP, while CMWs suffered from low receptivity in the community and for not having supplies.

The defunct MOH and DOH still do not have specific budget allocations for procurement of contraceptives (except for LHW Program); do not share their MIS for presenting a consolidated contraceptive performance picture, do not pay any attention to strengthening linkages with PWD and their service providers lack training in FP technology and counseling. Citing the presence of a specialized and parallel program for FP, the Department has not claimed ownership of FP and it did not figure in their targeted activities (Sathar and Zaidi, 2011). Nevertheless, their strength is the vast infrastructure and that post-devolution situation has provided an opportunity to craft an operational framework to work together with full force and clear vision, target and strategy to be pursued as a combined responsibility. The MOH and the DOH have always been well positioned to take a front-role in FP and RH services by creating demand and ensuring supply for efficient services. There is no doubt about the leadership role of the Departments of Health being crucial for the provision of FP and RH services and that the post-devolution situation provides full opportunity to revisit and regroup resources for accelerated efforts in order to make-up for lost time and address missed opportunities.

3.3 People’s Primary Health Care Initiative (PPHI) & Punjab Rural Support Program (PRSP)

The lessons learned from two “experiments” piloted in Lodhran and Rahim Yar Khan Districts of Punjab in 1999 and 2003 respectively, and evaluation undertaken by the World Bank showed positive results in increasing the utilization rates of the facilities. The replication of the Model was then taken up by the federal Government (in 2005) after a decision made by the then President and Prime Minister. This initiative is known as the People’s Primary Health Care Initiative - PPHI (formerly known as the President’s Primary Healthcare Initiative) for improving the health service delivery at first level care facilities (FLCFs). The aim of the initiative is to strengthen the curative and preventive services provided by FLCFs, by handing over the management and finances for operating the BHUs to the Rural Support Program (RSPs) in the respective provinces. The objective was to re-organize and re-structure the management of all the BHUs in the district with a central role for community-based support groups. Contractual agreements which outline the terms and conditions for services provided by the BHUs (preventive and curative) were signed between the respective PPHI/PRSPs and District Governments in Punjab, Sindh, Khyber Pakhtunkhwa and Balochistan. Currently the PPHI model is being implemented in 2,393 BHUs in 81 districts throughout the country. The management is regulated through two contracts: 12 districts of Punjab (covering 1,049 FLCFs) under the auspices of the Chief Minister’s (of Punjab) Initiative for Primary Health Care (CMIPHC), while PPHI is in other provinces and areas (see table below for details). The LHWs are generally associated with BHUs, but in the case of PPHI/PRSP no LHWs are linked or associated with BHUs, thereby de-linking close community feedback to facility staff relating to FP.
Districts/BHUs/HFs in all provinces and areas (including Punjab, Sindh, Balochistan, KP/FATA and the Gilgit Baltistan) managed by PPHI/PRSP are in Table 3.3 below:

<table>
<thead>
<tr>
<th>Province/Area</th>
<th>Total Districts</th>
<th>Covered Districts</th>
<th>BHUs Covered</th>
<th>Total HFs Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punjab</td>
<td>36</td>
<td>12</td>
<td>847</td>
<td>1049</td>
</tr>
<tr>
<td>Sindh</td>
<td>23</td>
<td>18</td>
<td>551</td>
<td>927</td>
</tr>
<tr>
<td>KP/FATA</td>
<td>31</td>
<td>14</td>
<td>424</td>
<td>424</td>
</tr>
<tr>
<td>Balochistan</td>
<td>30</td>
<td>30</td>
<td>554</td>
<td>558</td>
</tr>
<tr>
<td>Gilgit-Baltistan</td>
<td>07</td>
<td>07</td>
<td>17</td>
<td>140</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127</strong></td>
<td><strong>81</strong></td>
<td><strong>2,393</strong></td>
<td><strong>3,098</strong></td>
</tr>
</tbody>
</table>

The focus of PPHI and PRSP for service delivery remains an essential primary health care package and where FP doesn’t appear as a robust component. A third party evaluation (TRF: 2010) conducted in 2010 revealed that 35 percent of PPHI-BHUs do not attract consumers for family planning, as overall 85 percent of PPHI facilities serve fewer than one client per day for the purpose. The household survey indicated that contraceptive use to be slightly higher in catchment areas of DOH managed BHUs mainly on account of the services provided by LHWs (47 percent), than PPHI areas (40 percent). The evaluation emphasizes very low utilization of facilities for FP services, and of course reflects huge missed opportunities to capture clients for FP through the Primary Health Care Network. An important point to be noted is that PPHI/PRSP managements consider reporting to Federal Government (Cabinet Division) regarding its performance and has almost no linkage with the DOH or PWD. PPHI procured contraceptive supplies from open market, rather than availing supplies from Central Warehouse, Karachi, managed by the Population Program Wing of Planning and Development Division. Furthermore, the PPHI service providers are not adequately trained in FP service provision and the district managers have no formal training in assessing demand for their districts or facilities for contraceptive requirements. The total number of BHUs under PPHI/PRSP management (2,393 i.e. 45 percent of all BHUs in Pakistan) are underutilized for the provision of FP services to serve rural communities.

Overall, the working of the initiative is positive due to improved inputs and effective management whereas, thrust of program lacks pro-active efforts in family planning. In summary, it is facing problems of training, monitoring and evaluation, inadequate contraceptive supplies and of course linkage with family planning efforts led by the PWDs. The performance of the program is meager in terms of FP and not being taken into account in the consolidated performance reports. It has the potential to make solid and substantive contribution, but needs to align its work with PWD and DOH for better understanding of the dynamics and the process, which include substantive time devotion to motivation and counseling for acceptance and adoption of birth spacing for family health.

3.4 Social Marketing of Contraceptives (SMC)

Social marketing approach provides an additional stream of services through enlisted private health providers, drug stores and retail outlets to facilitate access to products and encourage increased use of family planning services amongst the lower-middle and low-income households. Social marketing strategy is the adaptation of commercial marketing techniques
for social goals. The two major components of social marketing for family planning contributed to improving the accessibility of essential products and services, and by undertaking promotional campaign to enhance the use. Using traditional commercial marketing techniques, social marketing makes available the needed products and services affordable to low-income people, while persuading for the adoption of healthier behavior. Social marketing was first introduced in Pakistan in 1985-86 with grant assistance of USAID and the launch of a socially marketed condom, SATHI. The project support continued till 1993-94 when USAID discontinued its assistance but the product continued to exist in the market. Further assistance from bilateral donors and private foundations initially helped in sustaining the operations, which resulted in the social marketing program expanding coverage in Pakistan and contributing through a whole range of contraceptive products. Key Social Marketing (KSM) - a social marketing firm supported by Future Group involved a local pharma firm to execute and promote hormonal contraceptives (oral pills and injectables). KSM adopted the 'manufacturer model', whereby the firm used products, resources, distribution system, and expertise of private sector manufacturer was supported by KSM in promotional and training interventions. Unfortunately, the KSM’s partner manufacturing company did not fulfill the terms of agreement and closed its business in mid 2000s. However, KSM had entered into an agreement with a local manufacturing concern (M/s. ZAFA), who started local production of affordable, but high quality oral contraceptive pill on behalf of social marketing. This has been accessed to by both the firm and enabled Pakistan to cater to its own demand of oral contraceptive, beside export of the surplus at the same time. Greater accessibility and ease of availability of variety of contraceptives is a major output and contribution of social marketing. Furthermore, acceptability of clients of priced products and willingness to pay for such services are significant influences on behavior change to internalize and own FP.

Socially marketed products account for about 60 percent of all condom use, alongside varying degree of contribution in all other methods through a national network of over 67,000 specially trained private sector doctors, paramedics, drug stores and retailers offering FP services. It has visible concentration in urban and semi-urban areas, with scant presence in rural areas. Social marketing program has pursued to evolve informal linkages with the community workers (LHWs and NGOs) to provide access to rural clients, but had not made any innovative in-road to reach out the rural market. Family planning products that were issued to network of providers and retailers were being reported as sold/disposed and calculated as CYP to reflect its contribution. The whole efforts are focused on distributing products, but is weak in interaction and follow-up with private providers to cover social aspects of social marketing (UNFPA, 2011; TAMA, 2008).

An important issue that inhibits social marketing in Pakistan remains its sole dependence on external funding to implement its programs. Even though social marketing took off with government’s policy support, the social marketing entities sell products like commercial businesses in many respects some stakeholders have started to assume that social marketing be able to pay for their interventions through sales revenues generation to some extent and should be making efforts in that direction by design. Furthermore, social marketing maintained a supply oriented approach, while demand generation remains subdued. A main challenge faced by social marketing pertains to the environment required to meet some of the 'essentials
of quality FP services’. Pakistan’s environment seeks close provider-clients interaction to ensure continuity of use addressing queries based on misperceptions and poor knowledge regarding technical aspects of contraceptives, which many social marketing outlets and providers (including drug stores and clinics) may not meet the essentials of privacy and FP trained staff to respond to client’s queries. Drug stores provide three methods (condoms, oral pills and injectables) while clinics provide IUCDs and injectables. The Social Marketing providers / clinicians certainly need training and orientation to acquire necessary communication skills to meet clients’ needs for counseling and motivation to encourage acceptance of FP, beside regular follow-up to observe their working and refresh their thinking and approach to continually contribute to FP as a valued contribution to important national cause. A new organization by the name of DKT is entering in the market to undertake social marketing of FP. It is hoped this would make up for the vacuum created due to closure of KSM and would spread its coverage to urban slums, outskirts and rural areas.

3.5 Public-Private Sector Organizations (PPSO)

Target Group Institutions (TGIs) as a component of PWP was introduced in early 1980s. It comprised major public sector organizations employing a workforce of around one million, having their own infrastructure of hospitals, dispensaries and mother and child health centers where FP services were introduced on informal basis. The TGIs had over 700 health outlets and assumed to contain vast potential for provision of FP services. Unfortunately, effective institutional arrangement could not be established, and little headway was made in their involvement during the 1990s. The overall performance was not encouraging due to fewer staff training and lukewarm interest in contraceptive distribution. Lack of interest of the participating organizations, casual state of interaction between the Ministry and TGI’s Managers, weak monitoring and supervision of motivators, low level of education and skill of motivators were identified as some of the main impediments in the way of effective implementation of this component (NIPS: 2001).

It was re-named as “Public Private Sector Organizations (PPSOs)” with a thrust to forge formal partnership with public and private corporate sector organizations through a better approach and target larger number of these entities. Provincial Coordinators were to interact with the PPSOs focal points and PWDs were made responsible to facilitate in training activities. The District Offices were linked for contraceptive supplies, IEC material and regular follow-up. The Ministry attracted a large number of organizations at a high profile event leading to signing of 243 Memorandum of Understandings (MOUs) during 2007-08 with different PPSOs and till 2009 439 MOUs were concluded. However, no substantive follow-up work was undertaken to reflect on progress of actual implementation. This was not taken seriously for improvements and reflected inbuilt weaknesses towards opportunity lost and that the management was not geared to manage and support the working of PPSOs. Even to-day this is a vital area laden with rich potential. It needs to be pursued with a better design and fuller program managed by an exclusively designated set-up for management, support and monitoring purpose (TAMA, 2008).

3 These organizations include Pakistan Army, Navy, Air Force, Fauji Foundation, Pakistan Railways, WAPDA, Pakistan Ordnance Factories, Karachi Port Trust, Pakistan Steel, Pakistan Telecommunication, Pakistan Postal Services Corporation, Pakistan International Airlines and Agricultural Development Bank of Pakistan.
3.6 Role of NGOs and NATPOW in Family Planning

The role of NGOs in supporting FP and RH care is spread over last several decades with expanding scope of work. Most family planning activities undertaken by NGOs over the years has been coordinated by an umbrella organization (NGOCC/NATPOW). The National Trust for Population Welfare-NATPOW is an autonomous organization established in 1994 under Charitable Endowment Act, 1890 mandated to create an effective partnership with government, donors, civil society and the private sector. NATPOW had focused on capacity building efforts, which resulted in the emergence of a large number of NGOs of various sizes in the 1990s in the field as partners in the development process. Their contribution to enhance CPR is well recognized in different impact surveys undertaken during the same era.

The funding support to NGOs working in the social sector witnessed variety of resources including SAPP, grant funds by UNFPA, DFID, EU and credit from World Bank during the 1990s. A large number of NGOs, particularly those working in health, RH and FP benefited from these funds that were channelled directly through NATPOW by donor agencies whereby 264 Partner Organizations were brought into the fold of program and who executed 479 service delivery points (SDPs) during 1994-99. However, no donor assistance was available to NATPOW after 2000 due to conditionality imposed by donors related to operational autonomy and independence of NATPOW, which has not been fulfilled even to this date. This restricted its work and almost defeated the objective for which NATPOW was established.

The Population Perspective Plan 2012 clearly called for revitalizing National Trust of Population Welfare (NATPOW) and outlined its important functions like: capacity building and sustainability of smaller NGOs, expansion of accessible and quality family planning services and, encourage NGOs to incorporate family planning into their existing community uplift program, devise and implement innovative pilot projects, and maintain a family planning performance database of the NGOs/CBOs. The program envisioned an expansion of service delivery through a network of grassroots level NGOs through an umbrella body as a dire need, which persists to this day.

NATPOW was instituted for the purpose to serve as a conduit to attract more NGOs and CBOs to participate in the programme, but its operations was affected due to control by the nodal Ministry (TAMA, 2006). It failed to take off and thereby the organizational objectives and its ultimate contribution to enhance family planning were not achieved. Other causes that can be elucidated include: excessive controls over the organization, lack of flexibility to operate as an autonomous body and absence of a professional head for a long time of its existence, put together, never allowed operational autonomy to work as a Trust. The immediate outcome was complete drying of donor funding since January 2000 for attracting NGO’s work in family

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4 The organization remained without a professional Chief Executive for 9 out of its 13 years of existence. Ministry of Population maintained a complete hold on the functioning of NATPOW and the NGOs supporting FP work.
planning targeting the remote areas. As such, it did not work substantively to coordinate and promote the working with NGOs and CBOs.

On the other hand, some major NGOs working for family planning, who received direct funding from international parent organization like IPPF, MSI have been extending services, but reported decline during early 2000 due to low financial commitments and shifting of focus to areas other than family planning. As a result, they too had to curtail and restrict their operational activities and limit the scope of work relating to family planning. However, in 2007-08 government had allocated a small amount of Rs. 5 million for NATPOW, of which Rs.3.9 million was released to support the affiliated NGOs. During the FY 2009-10, Government provided another tranche of Rs. 17 Million for establishing Public Private Partnership through Partner CSOs with which technical strengthening and financial assistance has been provided to 30 CSOs until June 2010. Similarly, during 2010-11, another 30 CSOs were provided support of Rs. 13.5 million to establish 30 Family Health Centres in rural areas and for low economic-strata communities to deliver family planning services. Nonetheless, transparency in the disbursement of grants to NGOs remains a major issue at NATPOW, which several donors have been seeking over the years. The small FP-NGOs in Pakistan have limitations of technical manpower and competencies, understanding of FP management, and funding for their community development programs.

NATPOW has also remained overshadowed by select large NGOs like FPAP or MSS who received international support to contribute towards national FP cause. Continuity in serious management problems of NATPOW also reflects on non-seriousness and lack of support by its parent organization (previously Ministry of Population Welfare). Pakistan, unlike all its neighbouring countries has not been able to use CSOs to help promote the coverage and access to family planning. This is a major gap and a huge untapped resource available in the country that need urgent attention.

“NGOs are not regulated by government.”
“NATPOW was never encouraged to remove its weaknesses. No autonomy was guaranteed to it; and there was no effective leadership to run its affairs with consistency.”
“Public-private partnership was approved in NATPOW but was never implemented. New ideas shattered without any gains. Now only salaries are paid in this organization.”

Comments by Senior Govt. Officers

NATPOW, being an established and recognized entity has the potential to serve as an effective conduit to garner support and involve NGOs and CBOs in a bigger way, but would need a professional CEO and operational autonomy to work as a Trust, with more endowment to generate resources to support and sustain its operations. It will have to evolve and maintain effective linkages in the provinces as a result of devolution of population subject and work very closely with the federating units and under guidance. The work and contribution of NATPOW against the stated objectives also need to be subjected to accountability process using third party validation at regular interval of 2-3 years along with a system of regular review and assessment of progress.
Over the years, Provincial Departments (Health and Population Welfare) had the mandate to evolve relationship with NGOs and promote their network. Unfortunately, this was not achieved due to lack of ownership of FP activities. It was considered a subject matter of federal program and no provincial authority came forward or took lead to harness this potential. The devolution process has now afforded this opportunity and that both the Health and Population Departments may consider the subject afresh as it is an important resource that can bolster efforts in the field.

3.7 Family Planning Association of Pakistan - Rahnuma/FPAP

Family Planning Association of Pakistan (FPAP) has been active since 1953 in promoting and undertaking FP related interventions in all provinces of the country. Rahnuma/FPAP is a pioneer in the FP movement in Pakistan especially in helping access to FP/SRH services for marginalized communities. Rahnuma/FPAP operates nationwide through an extensive network of Family Health Hospitals, Associated Clinics and MSUs working in partnership with government medical facilities, NGO clinics, more than 2,100 affiliated private medical practitioners, and more than 2,400 community-based distributors. The organization has provided SRH/FP services through its network since 1985, and the quality of services has been recognized. In partnership with other smaller NGOs, Community-Based Organizations (CBOs) and International Agencies, Rahnuma/FPAP has also nurtured relationships across the country with community leaders from all walks of life including religious scholars, Ulema and Khateeb; land-owners and other local “influential”; medical professionals, teachers, and many other community stakeholders to provide a platform for removing barriers to improve access to healthcare, particularly for women, girls and youth. The shift in IPPF’s framework in 2005 to 5 A’s within SRH – (Access, Adolescents, Aids, Advocacy, and Abortion) has resulted in a de-focus on FP.

3.8 Marie Stopes Society – MSS

Established in 1991, MSS is part of the Marie Stopes International (MSI) global partnership. Till 2012, MSS provided over 1.5 m couple years of protection (CYPs) to women and couples by offering a full range of affordable, voluntary, high-quality FP and RH services through a network of 82 MSS clinics in 73 districts, eight mobile outreach teams and over 3001 Suraj Social franchise private providers in more than 50 districts of Pakistan. Through the private-provider network, MSS has piloted demand-side financing for FP. MSS has 24 centers registered with Population Welfare Department as RHS ‘B’ centers, and 82 Behtar Zindagi Centers (BZC) provide FP services. These centers provide a complete range of reproductive health services, including information, counseling, maternal and child healthcare and facilitate couples in the healthy timing and spacing of pregnancies.

3.9 Summary of the Section

These are the major NGOs making visible and sustained contribution in providing family planning services as part of the community uplift programs in their respective areas of operations. RAHNUMA/FPAP’s contribution to national CYP achievement rose from 4.1 percent
(in 2006-07) to 7.1 % (in 2011-12) while that of MSS rose from 0.7 percent to 0.9 percent during 2009-10 to 2011-2012 (PBS: 2012). The focus on family planning has, however, been diluted after the emergence of broader framework of reproductive health and on account of non-availability of assistance for family planning as the same has been attracted by other programmes such as HIV/AIDS and abortion related activities (UN, 2012). Both these organizations have the strength and experience to contribute to the cause of family planning, but their contribution need to be recognized, encouraged and supported with guidance and essentials for their expanded operations. Nonetheless, the public and private sector as well as the civil society organizations, are found to be lagging behind in one or the other aspect of the essentials for family planning service delivery when compared with the outline of essentials for service referred to earlier. They may have to review their respective operational framework and adjust for renewed emphasis and actual work in the field to enhance receptivity, acceptance of birth spacing and for adoption of the same as an enduring norm in the reproductive cycle of life of normal living.
4.1 Policy Environment and Directions

Pakistan is amongst the first few countries that recognized the population issue and evolved policies and strategies to address the same. The section will address two distinct matters: the environment and the policy direction before highlighting the existing situation. The policy environment will cover the political and programmatic support given to the issues of population. The substance of the policy within Pakistani context by key stakeholders will be discussed subsequently.

There is no doubt that the UNFPA supported international conferences held in 1954, 1964, 1972, 1984 and 1994, and played an important role in gearing developing nations like Pakistan towards policy formulation and linking it with the development process. Each international conference presented varying perspectives towards the causes and solutions of the issue which were not readily adopted in the overall development process of Pakistan. Accordingly, political support for population focused policies and programs also reflect serious fluctuations overtime and can be identified in three distinct time-periods. First, major support was witnessed in 1960s during Ayub era followed by low key program period. Second period started in early 1990s with several Prime Ministers addressing the issue of population growth as a national priority at important public platforms and extended guidance to programmatic endeavor. The post-ICPD period marked an even greater active interest in population policies, but shift towards reproductive health issues also diluted the focus on family planning, resulting in decrease in donor attention and assistance to family planning. The Millennium Development Summit 2000 though focused on poverty, hunger, gender and equity, etc., and maintained priority on education, maternal and child health, but family planning received attention only around 2005. Common target year (2015) refreshed the attention to ICPD and MDGs for consideration to greater commitment of funds by international donors to meet development needs. It is interesting to note that early 2000s witnessed the initiation of PRSP formulation process within the overall MDG mechanism and interlinked Health, Population and Education policies in a common priority framework to ensure achievement of goals. The PRSP process provided ample funding for all social sectors to achieve their respective objectives, since 2003. The third term started around 2009 with the introduction of birth spacing initiative, which received significant focus and visibility at the London Summit on Family Planning (FP-2020) held in July 2012.

In addition to international commitments, three other factors kept FP in focus of key stakeholders: evidence from the field (during late 1990s and early 2000s) reflecting rapid increase in CPR and a smooth decline in fertility rates provided impetus to policy makers to revise and gear population policy more optimistically to advance towards aggressive objectives; address tremendous emerging challenges due to rapid population growth, specifically those relating to age structures, rising proportion of household living below poverty levels and weaknesses in public sector programs; and enhanced interest of Ministry of Health to contribute in raising the CPR through community based workers.
The Population Policy 2002 was pursued on the basis of approval of the Cabinet and was framed for building a national consensus towards striking a balance between population growth and development, and advancing towards achievement of long-term goals:

- Reduce fertility through enhanced voluntary contraceptive adoption to replacement level 2.1 births per woman by 2020; and
- Universal access to safe FP methods by 2010.

The policy contributed to consolidation of programme activities based on the fertility decline noted during the 1990s. It proposed a paradigm shift away from pursuing purely demographic targets towards improvements in the quality of life of the people. The policy attempted to develop consensus and to activate all stakeholders for the expeditious completion of the fertility and mortality transition in Pakistan. The strategies laid out in the document to reach these long-term objectives entailed, among others, reducing unmet need for FP and provision of services to poor and under-served population in rural areas and urban slums. One visible shift, at the policy making level, was increased recognition of the importance of the private sector in promoting and delivering family planning services. The policy document did receive support from various donors and development partners. The policy document, however, remained a rather technical piece and not easily understood by lay persons, including politicians. A former Secretary of defunct MOPW was categorical in expressing his concern regarding the Policy:

"Although policy was technically sound, but MOPW was never successful in conveying the message and motivating people, so much so serving Secretaries and Director General were not able to understand the policy. Bureaucrats are generally not motivated by FP. FP was not owned by the Minister and Secretaries and all took it as least priority and posting in MOPW and PWD has always been taken as punishment."

Absence of common perception in understanding the long term implications of population issue and the need for consistently sustained action over time for its solution persisted among key policy makers in the Government even when bureaucracy and technical staff evolved a sound policy.

"Our parliamentarians do not fully understand the requirements of a good population policy."

Secretary PWD

"FP has always been last on the priority list of both federal and provincial governments."

Secretary PWD

Provincial Population Welfare Departments too expressed concerns regarding the Population in the following words:
Population Policy formulation process did engage provincial stakeholders but the Federal Ministry did not gear itself to be able to attract and elicit necessary support from the defunct Federal Ministry of Health and Provincial Departments of Population and Health. Misperceptions exist among senior officers regarding the process and misgivings of neglect leading to lack of ownership of the policy, as is reflected by some interviewees.

Interestingly, only Population Policy 2002 highlighted linkages and coordination with the Ministry of Health and vertical programs. On the other hand, several Director Generals Health interviewed in this exercise unanimously stated complete lack of commitment during the decade of 2000-10 by Provincial DOH regarding FP services. Given that an elaborate Population Policy 2002 was fully endorsed by the Cabinet, but the defunct MOPW was unable to encourage the MoH to enlarge the scale of its support through the Provincial Health Departments outlets. Director General Health provided a different perspective to this weakness:

“PWD always remained in fear of merger with DOH, therefore expecting Department of Health to provide the services, and keeping itself dependent on PWD is not justified.”

Interestingly, the Population Policy or the Perspective Plans are not known to PWD officers and they are oriented to only the issuance of RH/FP contraceptive commodities (TAMA, 2008). Discussions with stakeholders, especially with the Health Managers show:

- Weak understanding of essentials of family planning service provision by health care providers
- Poor understanding of demographic transition and importance of population policy initiatives
- Complete absence of ownership of the issue and willingness to support FP as a necessary service even for their cause of health care.
- Interestingly, not a single health manager referred to FP component in Health Policy 2001

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- **Policies are good but are on paper only. These are not based on ground realities and difficult in operationalizing to meet local needs. Plans are prepared at federal level (in Islamabad) and have limited involvement of stakeholders to address ground realities.** Director General, Population Welfare Department
- **Policy was much ambitious, targets unrealistic and lacked government ownership.** Former Secretary of Defunct MOPW
- **FP was not mainstreamed in development processes.** Former Secretary Defunct MOPW
- **Population Department was not involved in policy making process.** Former PWD Director General

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- **FP was not mainstreamed in development processes.** Former Secretary Defunct MOPW
- **Population Department was not involved in policy making process.** Former PWD Director General

- **Policy design was top-down and this remained the main factor of failure in its ownership and implementation.** Former Secretary MOPW
- **Several Secretaries of Population Departments had no interest in the Policy due to frequent transfers.** Former Director General PWD
- **Policies are prepared in good faith and good understanding. The overall direction of these policies is OK. Information and data used in their preparation are always objective and most recent. It is the interpretation and implementation that creates problem.** Provincial Finance Secretary
The evidence from the PDHS 2006-07 came as a blow to high expectations for increasing contraceptive use rate as a major factor to decline fertility. Given the trends and the realization that the goals are unachievable target, revisiting population policy in 2010 to revitalize FP was quite rational and realistic. The draft national population policy was prepared and shared with large number of stakeholders across Pakistan in 2010 and submitted to Cabinet for endorsement. The draft policy document accounted for a fresh approach linking maternal and neo-natal health indicators with use of FP and thereby making FP as an integral part of health initiatives. Birth spacing, which was not taken seriously over the years, was now considered as the core of the new approach with much more appeal and support from religious and conservative segments, who previously opposed to the idea of FP. The fresh approach is now considered amenable by senior health managers who have started to see FP as a major intervention to achieve several health goals including maternal and neo-natal mortality, birth weight, etc. The approach was endorsed by the Federal MoH before its dissolution in June 2011.

The Federal MOPW presented the draft Population Policy to the Cabinet for approval, right when the 18th Constitutional Amendment was being passaged in 2010, and as a consequence of which both Federal Ministries of Health and Population Welfare stood dissolved. The draft Policy 2010 was sent to Council of Common Interests (CCI) for perusal and further consideration. This needs attention for reconsideration and sharing with the provinces to facilitate in setting their goal, and framework about family planning.

However, strong resistance by Parliamentary Group to take up matters of devolved Ministries has put the policy in cold storage. Serious vacuum exists today to present national picture of population issue and that provincial governments were caught unprepared for a huge task, which situation has been succinctly brought-out in the WHO report (WHO, 2012) specifically related to the Health Sector. The opportunity for evolving Provincial Population Policy needs to be explored, but the concerned Departments are currently facing serious cash flow issues and do not feel to be in a state of adequate preparedness for the purpose.

**Family Planning Support by Departments of Health**

Fortunately, Health Sector Reform Units (HSRUs) established in the three Provincial Health Departments have recently undertaken exercises to prepare and get formal approval of reform agenda for health sector. Post-devolution preparation for enhancing family planning appears to be receiving concentrated attention in the DOH in Khyber Pakhtunkhwa (KP), Punjab and Sindh. But no formal FP necessary component of reformed ‘Essential FP Service Package’ referred to for first level care facilities (FLCFs). Health Sector Reform Strategy papers prepared with the donors assistance place FP at various levels of importance as highlighted in Table 4.1. In the formulation of these strategy papers, joint exercise was undertaken only in Khyber Pakhtunkhwa province focusing on HR development and necessary operational schemes, while in Punjab and Sindh such efforts still need to be undertaken. The Strategy paper of Khyber Pakhtunkhwa focuses on results based strategy (setting a clear target for CPR with a timeframe, while Punjab strategy focuses on process indicators of provision for drugs and to minimize
stock-outs, and Sindh paper did not give any concrete targets for achievement within a reasonable timeframe.

Table 4.1: Health Sector Strategy Evolved by Provinces

**KP - Health Sector Strategy - 2017**
- At least 70% of the population will have access to the Minimum Health Service Package (MHSP) for primary and secondary healthcare services by 2017 (including FP services);
- Increase the contraceptive prevalence rate (CPR) to 55% by 2017;
- Revitalizing the delivery of family planning services in public sector health facilities with a mechanism for forecasting contraceptive requirements and ensuring the uninterrupted supply of contraceptives to the facility, LHWs and CMWs;
  

**Punjab - Health Sector Strategic for 2020**
- Develop Essential Health Services (EHS) Package encompassing infrastructure, workforce, information systems, essential medicines, supplies and equipment (contraceptives included as essential list);
- Provide family planning services through uninterrupted supply of family planning commodities to all the primary and secondary level health facilities and outreach workers;
  - Percentage of BHUs/RHCs provided with more than 75% of essential drugs - 100 % by 2015;
  - Percentage of lady health workers with stock-out of family planning commodities 80% (2012-13) to 5 % (2019-20);
  

**Sindh - Health Strategic Plan 2020**
- Formulation of a Minimum Health Service Package (MSDP) with required resource esp MNCH-Family Planning-Nutrition;
- Special Areas of Emphasis Polio Plus, Nutrition, MNCH, Family Planning, NCDs, Communicable Diseases, Disaster;
- Integrated contraceptive services with maternal care by 2016: Provision of free contraceptives and training by DOPW to all DOH facilities for birth spacing. Integration of services with pregnancy care to reach out to couples;
  - Integrating contraception with pregnancy care and ensuring provision of long acting and permanent contraceptive methods;
  

“Strategies in Health are impressive. There is no problem that Pakistan cannot figure out and knows how to solve. The real challenge is how to make resources reach the people involved in implementation.” A Donor Representative
These are important measures for service provision under DOH, but several areas including demand generation, HR development, enhancing coverage and access etc., need to be coordinated to evolve workable strategies in line with national commitment. Furthermore, the strategy papers are good initiatives, but lacked seriously in the reflection of the larger picture of coverage and inclusiveness of all stakeholders. This is, especially related to private sector and NGOs, for task sharing in order to reach-out to remote areas and unattended segments of population. The initiatives are valuable but the gaps need to be attended to address issues pertaining to unmet need of contraception with focused attention and effective approach.

The LHW Program has also been devolved to the provinces and the workers given a ‘regular’ status in DOH. This measure removes the uncertainty around their work status except that their role as FP service provider needs to be made more focused, re-vitalized and enhanced to achieve FP goal.

4.2 Firm Political Support and Renewed Commitment at London Summit

The conceptual framework identifies political commitment and support to family planning as pivotal and critical to programs and policies. This commitment is manifested in different forms and at various levels: political commitment, government’s commitment, private sector’s commitment, and civil society’s commitment. It has to be open, firm and sustained over the horizon of time. This needs foresight, sound and insightful understanding of the issue, its long term implications for socio-economic development, consensus on goals and solutions, knowledge of the fact that considerable stretch of time is required to execute the program for tangible results and undeterred resolve to initiate step-by-step action directed towards the vision to be achieved within the set timeframe.

The political support for FP is important for social acceptance and legitimacy of the cause to be adopted and supported as an integral part of organized efforts. It has to be reflected in public statements, resource allocation and direction/guidance through periodic reviews and on important events to lay emphasis on the population issue. This has to be done by policy makers, public representatives and senior government officials for administrative support. Key initiative has to be taken by the concerned Ministry and Department to execute the desired program with determination. Its ownership is reflected in making the cause as an integral part of the pursuit. It is brought-out in policy, priority, resource allocation and duly supported by an organization with suitably qualified staff to undertake various related tasks. The progress is reviewed invariably to assess growth and direct/guide further improvements, supported by periodic assessment for effect/impact that forms part of the operational framework.
Policies and plans pertaining to family planning covering the last two decades show some consistent commitment by the government. But did FP receive the commitment as required, necessary and was that adequate? The Accelerated Population Program in early 1990s, the launching of LHW Program in 1994, the Population Policy 2002 and the Perspective Plan 2002-12 are all reflections of commitment driven by political entities and actualized by state sponsored programs. Nevertheless, the question existing in high degree still to be explored is what level of commitment was required, is required now and would be required in the time ahead to achieve the goal? As said earlier, change has to be viewed from demand and supply perspectives because adoption of FP requires change in outlook and behavior based on accurate information for enhanced awareness and attitudinal change to overcome age old norms of large family and promote spacing in pregnancies for health of women and their offspring. The availability of services has to be accessible, affordable, regular, and in conditions conducive to clients to convert all efforts into solid results. This requires steady flow of investment and its growth as per need till the goal is achieved.

Pakistan has experienced series of problems in this regard as commitment and support for FP have been wavering and varying over time. The politicians made explicit commitments to promote and strengthen family planning, yet their commitments were ad-hoc and for a short period (as the politicians remained in office for short durations). Closely related issue pertains to large number of feudal, who on the face of political leadership agreed with the cause of program, but did not extend real support to program oriented initiatives at the grassroots level, where behaviour and habit formation is influenced and effected. Their support was just rhetoric and motivated to gain employment opportunities for their voters, rather than from a sense of understanding and contribution to an important national cause. The political leadership oversight and dedicated support remained missing for all FP programs, administrative support with understanding of population and programme dynamics totally lacking due to ad hoc arrangements in placement of senior officers, not based on merit of steering an important national endeavor as per need, but as a parking place used for varying purposes. This defeated consistency and continuity and did colossal damage to a behavioral and social change programme like FP, resulting in loss of irrecoverable time and missing opportunities. High turnover of senior management at federal and provincial levels is a clear reflection of low commitment to the Sector. The Secretaries were normally from District Management Group trained in execution and management but seriously lacking understanding of requirements of behavioural change programs, which need sustained efforts with determination over time to bear visible results. The peculiar lack of this understanding has been one of the major causes that could not address the seriousness of matter and aggravated the program short term and long term continuity in implementation. This is also reflected in delayed fund releases, curtailment of funds, ban on recruitment, weak operational systems including monitoring, supervision, and sporadic shortages of supplies.
Bureaucrats were not generally motivated. FP was not owned by the Minister and Secretaries and all took it as least priority and posting in MOPW and PWD has always been taken as punishment. Former Secretary MOPW

There was neither a political will and support nor understanding and support of bureaucracy. A Senior Officer PWD

Politicians do not understand the importance of family planning. Senior Officer HSRU

Our parliamentarians do not fully understand the requirements of a good population. Secretary PWD

Lack of political and administrative commitment may be considered major reasons for this failure. Prog Manager LHW Program

On the other hand, bureaucracy looks for a formal PC-I document that once prepared starts providing necessary funds for implementation. The system involved several key players starting with technical staff preparing development plans, overseen by managers of Planning and Development Division, Ministry of Finance, and of course Economic Affairs Division to coordinate for donor support. During the slack political support time, bureaucratic system continues to execute and look after resource availability based on approvals of annual plans and achievements of immediate (inputs) objectives. This short term approach adopted as available evidence cannot reflect substantive economic gains from fertility decline or increased contraceptive use, thereby, making FP investment unattractive and less attractive to compete for scarce resources, which were pulled by more immediate physical infrastructure projects and other social programs. In the absence of political commitment of understanding and vision, bureaucracy’s focus remains myopic, with a safe approach of ‘going by the book’ adopted, irrespective of national priority due to limited appreciation of the population growth phenomena and its consequences for sustainable development. Given that population sector plans were weak and experienced problems in implementation, the Planning and Finance too treated the cause of multiple benefits FP program like any other infrastructure development project, by controlling and curtailing its financing at various stages and through different mechanisms resulting in impediments for the future growth of the sector.

Public statements on electronic media, awareness raising measures through billboards, TV, radio ads, and discussion sessions on public forum all reflect strong political support and commitment for FP through organized communication campaign. However, the decade of 2000-10 witnessed gradual fading of this robust campaign. The anti-climax was recorded in late 1990s when restrictions was placed by the Ministry of Information on FP advertisements, which seriously inhibited the message to be conveyed on account of unfounded fears and misconceptions – an action taken at the behest of highest authority. No effort was made by federal or provincial authorities to explain and remove misperceptions among the politicians regarding FP and for its assumption as western inspired idea.

A quick and simple comparison with Bangladesh FP program reveals that even though grassroots workers made a difference in service delivery by engaging and involving educated women for motivation/counseling and supply of contraceptives at doorsteps, it was the hourly radio program that regularly discussed population issues and matters related to FP on daily basis since 1980 which brought the change and registered its effect on the performance and in
fertility decline. Effective supply chain can, therefore, address unmet need issues, if backed-up by regular and relevant information that would nurture and nourish thinking in the desired direction. Pakistan’s FP programs and activities remained fragile and less effective due to deficient funding and commitment. In contrast to Bangladesh, where one of the world’s most effective voluntary FP programs, using the experience and lessons from the Matlab experiment, was implemented and sustained for consistency and continuity for decades.

Pakistan still has low contraceptive use and people’s attitudes are uncertain or even antagonistic, in the absence of a strong and sustained political commitment, which is central to and essential for any population programs and policies for complementarity with overall development objectives and to galvanize support for popular mobilization. This, with the passage of time and through sustained efforts, will result in favorable setting for endorsement of elites (religious and local leaders, medical professionals, and so on) as they have followings, contacts and influence in different sections of the society. It will ultimately lead to acceptance of FP as an enduring norm and its adoption in the mainstream of normal living resulting in increased contraceptive usage.

Pakistan has made renewed commitments on July 11 2012 at the London Summit to revitalize FP in the country and cited specific target to be achieved by 2020. During the Summit, a neighboring country committed to deliver family planning 'absolutely free of charge' to 200 million couples by 2020, while Bangladesh declared its resolve to enhance CPR to 72 percent by 2015 and 80 percent by 2020. Pakistan too committed to advance toward achieving universal access to RH and raising the contraceptive prevalence rate to 55 percent by 2020. Contraceptive services will be included in the essential service package of all provinces by 2013, and that FP will be a priority of intervention by over 100,000 LHWs. This bring into focus to ensure necessary financial support to meet the growing requirement and for realizing the goal for which long term plan(s) are in place for all stakeholders. In this context, it is important and equally relevant to revitalizing the National Commission on Population Welfare with better technical support and consider NFC Award according to need including that of FP performance. These are some critical steps needed to march towards the commitment made at the London Summit. The slowing of population growth is a national commitment that needs to be pursued and impressed upon by national bodies and provincial governments by strengthening the mechanism to mainstreaming FP and by providing all necessary funds to sustain support for the next ten years. Once this commitment is reflected and translated into action, donor assistance is certain to flow into the cause as part of the support in the needed area and as required by Pakistan.

4.3 Public Finance and Support for Family Planning Programs

Financial commitment is the main driver for attention and action relating to population issue and a manifestation of seriousness of the government about the matter. This section will only review the trends and composition of financial matters pertaining to FP program during 2000-2010 especially focusing on non-salary aspects. These will cover overall allocations, releases for utilization and proportion of funds earmarked and expended on programmatic activities.
Similar to the policy initiative, allocation to this date has been reflected in the Development Scheme (PC-I) by the Federal Government and for the yearly budget this has been committed in the Annual Development Plans and remained funded by the Centre. The PC-I forms have integrally budget measures associated with inputs required to achieve the desired outputs of the program, wherein capital cost, operating and maintenance requirement figure with a set timeframe. The PC-I is approved by relevant authorities before project launching and then monitored for its implementation and progress. Changes in inputs including inadequate and delayed availability of funds do affect the performance and achievements of the programme. At the same time, it serves as a constant reminder that time is an essential component of the investment being made in the cause. Two points need to be noted here: first, population welfare allocations were made by the federal government continuously and regularly against several competing sectors including health, education, and other development sectors; and second, FP allocations were made by the Federal Government in parallel to two programs: PWP and LHW Program, managed by two different Ministries. The non-availability of data may not permit analysis of all public sector funds for FP especially that related to the LHW Program.

**Trends in Health Sector Financing**

Total health expenditure is the sum of public and private health expenditure and covers the provision of health services (preventive and curative), FP activities, nutrition activities, and emergency aid designated for health. Public finance in Pakistan needs to be seen within the context of several major events that have occurred during 2000-2010 including initiation of Poverty Reduction Strategy (PRS), followed by MTBF, diversion of development funds towards war on terror, two major floods, and changing political governments.

The Government of Pakistan signed the Poverty Reduction Strategy Paper in 2004 (with IMF), which provided at best a rough proxy for ‘true’ pro-poor spending. The PRSP process brought the population goals and targets under its domain to express enhanced commitment towards the agreed goals. The process thus strengthened the allocations and expenditures of the Ministries of Health and Population Welfare.

In general, the total health expenditure in Pakistan remained low relative to other countries within the context of the South Asian region and declined during 2001-10 (Figures 4.1 and 4.2). The low levels of public funding reflect weakening of the ability and system of the public sector...
to provide even basic essential services to a majority of the population. The government’s health budget has been progressively increasing over the last decade, but not enough to meet growing need and to neutralize the effect of inflationary factor. The share of health expenditure to total expenditures/GDP is the most significant variable affecting health status in a country.

The analysis of health financing of last decade 2000-10 indicates that the major share of the financial resources in the public sector are provided by the government. Total health care expenditure as a percentage of GDP has declined from 0.72 in 2000-01 to an estimated level of 0.23 in 2010-11. Health spending has dipped by 25 percent in 2010/11 principally due to a 70 percent fall in development spending while current spending dipped by 9 percent.

Since 2002 the service delivery of the PWP has been under the administrative control of the provinces. They were made responsible for implementation of the Programme, with a guarantee of federal funding for a following four-year period i.e. till June 30, 2015. The Federal Government allocated increasingly towards PWP over various Five-Year Plans. The Programme received an enhanced allocation of Rs.15.6 billion for 9th Five-Year Plan (1998-2003), compared to Rs.9.1 billion in the 8th Plan. However, the funds made available during the 9th Plan period were Rs.10.3 billion - 66% of the allocation. The Programme expanded Rs. 8.3 billion - 53% of the plan allocation and 80% of the funds released.

The support of PRSP process was critical to the sector, as it provided substantial raises in funding since 2001. The actual PSDP allocations have reversed the past trend towards a positive leaning. The original allocation for the year (2003-04) was Rupees 3.1 billion (41% higher than previous year’s allocation) and was based on the restructured Population Program (Table 4.2). For the 10th Five Year plan period 2003-08, the Government committed Rs. 21.0 billion for the Programme, but it provided only Rs. 14.5 billion (69 percent of allocations). Under the PRSP and MTBF/MTDF processes Population Welfare Program received substantial funding from the

![Figure 4.2: Public Sector Health Expenditure as % of GDP](source: Economic Survey of Pakistan 2011-12. Government of Pakistan)

Social sector expenditure in 2011 was the same as it was in 1990. Per Capita on health during 1990-2011 was the same. Population has grown up; its requirements are different, but you are allocating and expending same money. A Donor's Analysis
government for the 10th Five Year Plan period. Prior to 2004, the availability of fund was significantly lower and maintained a ratio of around 0.5 per cent of GDP. The Medium Term Budgetary /Development Framework (MTB/DF) prepared by the Ministry of Finance, in consultation with the Ministry of Population Welfare allocated Rs. 24.7 billion for a five year period, which was a mere 1.2% of the total public sector allocation for 2005-10. The allocations for Ministry of Population rose from Rs 2.2 billion in 2000-01 to Rs 4.3 billion in 2005-06 as shown in Figure 4.3).

Population Program faced tough choices in implementing the programme post 2006-07. During 2008-10, the Programme remained on extension with inadequate financial support that was capped at Rs. 6.5 billion against the required actual allocation of Rs. 9.5 billion (only 69 percent released). Enhanced availability of funding to Population welfare program during 2005-10 appears to be of little use to achieve program outputs and coverage targets, as huge funds remained unutilized and returned in the presence of low utilization capacity – more than 30 percent allocated funds remained unutilized. Delayed transfer of funds to MOPW was narrated as a major cause of under-utilization. The subsequent year’s allocation by the Ministry of Finance was made keeping in view the utilization capacity of the executing agencies. Furthermore, the programme was capped at Rs 3.6 billion in view of program’s utilization in the previous year. Although Government expressed its commitment towards Population Welfare Sector by providing necessary financial allocations, yet various programmatic constraints and other supporting

### Table 4.2: Total Yearly Allocations and Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocations Rs billions</th>
<th>Expenditures Rs billions</th>
<th>Expd % of allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>2,200</td>
<td>1,499</td>
<td>68.1%</td>
</tr>
<tr>
<td>2001-02</td>
<td>1,740</td>
<td>1,454</td>
<td>83.6%</td>
</tr>
<tr>
<td>2002-03</td>
<td>2,200</td>
<td>1,798</td>
<td>81.7%</td>
</tr>
<tr>
<td>2003-04</td>
<td>3,115</td>
<td>2,156</td>
<td>69.2%</td>
</tr>
<tr>
<td>2004-05</td>
<td>2,586</td>
<td>2,334</td>
<td>90.3%</td>
</tr>
<tr>
<td>2005-06</td>
<td>4,374</td>
<td>3,021</td>
<td>69.5%</td>
</tr>
<tr>
<td>2006-07</td>
<td>4,369</td>
<td>3,341</td>
<td>76.5%</td>
</tr>
<tr>
<td>2007-08</td>
<td>4,928</td>
<td>3,394</td>
<td>68.9%</td>
</tr>
<tr>
<td>2008-09</td>
<td>4,300</td>
<td>3,000</td>
<td>69.8%</td>
</tr>
<tr>
<td>2009-10</td>
<td>4,800</td>
<td>3,500</td>
<td>72.9%</td>
</tr>
<tr>
<td>2010-11</td>
<td>4,100</td>
<td>3,300</td>
<td>80.5%</td>
</tr>
</tbody>
</table>

5 In comparison, the health sector was allocated Rs. 88 billion or 4.3% of the total allocation.
6 The allocations made during 2003-04 to 2008-09 are much lower than worked out in the Population Perspective Plan 2012 (Ministry of Population Welfare 2002)
factors had slowed the pace of progress, the most important one is inconsistent financial support.

Under the 18th Constitutional Amendment, the Provincial Governments have to implement the whole PWP, for which the Federal Government has committed to fund the program till 2015. During 2011-12, Rs 4.1 billion was reserved for the federal program against the capped allocation of Rs 3.3 billion of previous year.

The average expenditure for population program relative to gross domestic product (GDP) remained below 0.06% for the period of 1992–2010 (Economic Advisors Wing: 2011). Two peak periods were witnessed during the last two decades: in 1998/99 followed by a lull till 2001–02; second peak took place during 2007-08, but encountered decline since then (as shown in Figure 4.3). Taking account of the peak during 1999-00 related to major expense made towards procurement of contraceptives (WB credit) generally a declining trend is witnessed for the period 1994–2005, but given the increased allocation for fiscal year 2005–08, the general level of 0.06% was maintained. The improvement in the national fiscal situation appears to have had a positive effect on financial allocations, but expenses remained inconsistent with allocations to meet program objectives. Accounting for the two peak periods, the overall status of the population program reflects the status quo. Rather than dealing with the impediments, a practice of restricting financial resources for the Population Program was pursued.

The performance of a program depends not only on funds released but more importantly on timely and adequate funding released by the government. The PWP was de-federalized in 2002 and provided new directions to federal and provincial Programme managers, to design strategies, allocate and spend in accordance with local needs. The implementation of the Population Policy remained with the Ministry along with Advocacy, IEC, Training and contraceptive supplies, while the Implementation of the PWP and its various components including Procurements of drugs and other items for districts (except Khyber Pakhtunkhwa), awareness campaigns through mass media, and Monitoring and Supervision, Provision of motivational services, and logistic and other supplies to the outlets was the responsibility of the PWDs. The District and Tehsil tiers of the Program are the main service delivery agents. According to the set-up, the progress of implementation to meet program objectives critically depends on how much funds are allocated and released for non-salary activities as against the requirement. In the post de-federalization era, provincial population programmes received their funds from the development budget of the PWP through the Provincial Finance Depts.

A quick analysis of Population Welfare financial data for two provinces presents ratios based on three elements: budget, funds released, with a breakdown of salary and non-salary components. Actual figures are not being presented, rather ratios are shown. The release of allocated funds to the provinces by the Federal Ministry has generally been around 90 percent for province A and more than 80 percent in Province B. Serious problems of released amounts are noted for 2002-03, 2007-08 and 2008-09 for province A. For province B, these are noted in 2007-08 and 2009-10. Under-utilization appears to be a chronic case in province A during 2000-2006 and to a lesser extent in province B. Beyond 2007-08, the provincial governments appear
to be active in providing bridge financing and also some funding to meet program financial requirements. The support appears to be substantial in province A, especially in recent years.

Non-salary expenditure on program activities including procurements, supervision and monitoring, awareness campaigns, provision of services etc., are essential element of service quality. Ratio of salary to non-salary should either remain constant or fall to reflect greater use of funds for non-salary aspects. Substantial increase in salary as against non-salary ratio after 2008-09 is alarming in both the provinces, reflecting significant decline in non-salary expenditures. The bridge financing is, therefore, being used for provision of salaries rather than execution of program activities. In sum, non-availability of funds for program activities appear to be a major impeding factor to program performance during the last few years. Review of a third province’s expenditures reflects more than 80 percent spent on salary only during the last four years (Table 4.3).

Table 4.3: Trend Analysis of Allocations, Releases, Expenditures and Non-Salary Component Funds

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Release to Budget</th>
<th>Expnd to Release</th>
<th>Salary to Non-Salary</th>
<th>Non-Salary to Total Expd</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>100%</td>
<td>75%</td>
<td>108%</td>
<td>48%</td>
</tr>
<tr>
<td>2001-02</td>
<td>87%</td>
<td>88%</td>
<td>160%</td>
<td>38%</td>
</tr>
<tr>
<td>2002-03</td>
<td>54%</td>
<td>88%</td>
<td>165%</td>
<td>38%</td>
</tr>
<tr>
<td>2003-04</td>
<td>94%</td>
<td>91%</td>
<td>132%</td>
<td>43%</td>
</tr>
<tr>
<td>2004-05</td>
<td>98%</td>
<td>83%</td>
<td>127%</td>
<td>44%</td>
</tr>
<tr>
<td>2005-06</td>
<td>100%</td>
<td>69%</td>
<td>99%</td>
<td>50%</td>
</tr>
<tr>
<td>2006-07</td>
<td>87%</td>
<td>99%</td>
<td>122%</td>
<td>45%</td>
</tr>
<tr>
<td>2007-08</td>
<td>75%</td>
<td>118%</td>
<td>136%</td>
<td>42%</td>
</tr>
<tr>
<td>2008-09</td>
<td>62%</td>
<td>138%</td>
<td>253%</td>
<td>28%</td>
</tr>
<tr>
<td>2009-10</td>
<td>94%</td>
<td>129%</td>
<td>246%</td>
<td>29%</td>
</tr>
<tr>
<td>2010-11</td>
<td>100%</td>
<td>113%</td>
<td>482%</td>
<td>17%</td>
</tr>
<tr>
<td>2011-12</td>
<td>100%</td>
<td>141%</td>
<td>426%</td>
<td>19%</td>
</tr>
</tbody>
</table>

The resources earmarked for non-salary component in the budget is equally low, and this is further tapered by short and delayed releases. Capping on overall budget by the federal government since 2008-09 implies no compensation for inflation to non-salary allocations even when federal government announced substantial increase in salaries since 2009. Reduction in non-salary allocations and expenditure to compensate for salary allocations appears quite obvious, but not attended by provincial governments. Of equal concern is low spending on non-salary component, which was further compounded by the control exercised through short and delayed release. With respect to financial management - delayed release of funds by Federal Ministry to Provincial Finance Departments to AG Offices for Population Departments (on quarterly basis), and procedural delays to transfer funds to the provincial offices and
subsequently to districts seriously hampered programme management and performance. A significant decline in non-salary allocations and releases affect adversely the output and performance, resulting in loss of time and missed opportunities. Provinces need to be approached to provide upfront funding covering the full requirement for salary and non-salary aspects, claim from the Centre the resources already committed and make-up the shortfall from their fund, as population welfare is now solely their subject for cause and purpose.

Resources are pressed for the social sectors generally once again, given that Pakistan is spending huge amounts on the war on terror and has other priorities at this point in its history. But the consequences of low priority to FP in the last decade is reflected in the stagnation of contraceptive prevalence rates which is known widely. More resources have to be directed and prioritized for this sector and for the program. Furthermore, as is the case for other social sector funding, the resources for the population program need to be protected against any cuts. Furthermore, in an atmosphere where major donors such as USAID did not operate in Pakistan to support FP for several years (1994 to 2004), the Government still committed scarce resources to family planning and reproductive health. A fundamental understanding of time lapse in investment in this sector and for visible tangible results needs to be comprehended and recognized for sustained support over time. This is often compromised in the rush to divert resources to infrastructure related projects. The multiple benefits of investment in FP for sustainable development and cross-cutting effect on almost all other sectors overlooked.

### 4.4 Contraceptive Availability, Security, Procurement and Stock Position

The need to ‘ensure a reliable and efficient supply system for contraceptives’ is a critical aspect of the population welfare program that must be present to ensure quality services and to achieve the intended objectives. In view of high knowledge regarding modern methods and growing unmet need for contraception in Pakistan, its provision at all service outlets is fundamental for the particular reason that all efforts in this regard are only converted into solid results when the means are available for adoption as per need and choice. Several studies have shown high correlation between induced abortion and unmet need for contraception, which is causing poor health status of Pakistani women (Population Council, 2004). Successful programs provide contraceptive security by ensuring that people are able to obtain, choose and use high-quality contraceptives whenever needed by them. Offering a full range of contraceptive options is also important as cited in the link [www.k4health.org](http://www.k4health.org); UNFPA 2012). To address the objective with success the FP programs of Pakistan needs an uninterrupted supply of all contraceptives to enable clients choose and use their preferred method for birth spacing. The country is faced with growing number of current and potential users of family planning, who need an easy access to supplies for spacing of births. A number of critical programmatic steps that need attention in this regard include:

- Provision of right quantity and combination of products at all facilities to meet clients' needs.
- Placement of a well-functioning distribution system to get supplies to the right locations and on schedule.
• Adequacy of budgeted funding (and assured donor support up to the time it is available) for acquisition of required supplies to keep the facilities operating with necessary provision.

To a specific query on the subject, a number of respondents from DOH raised the issue of non-availability of contraceptives at health facilities since 2008.

Pakistan was facing contraceptive security all along since year 2000. Contraceptive security requires planning and commitment at all levels (national, provincial, district, facility) to ensure that necessary commodities, equipment, and other supplies are always available. With many key stakeholders in family planning including PWDs (4), DOH (4), PPHI/PRSP (3), Social Marketing companies (initially two and now only one left), large NGOs (2), and small local NGOs, still comprehensive understanding of contraceptive security appeared lacking. The major steps for Contraceptive Security include (PRB: 2010):

• Planning - how a country or program can begin to develop strategies for contraceptive security (including contraceptive forecasting).
• Financing - how national governments are increasingly identifying ways to pay for the contraceptive requirement to meet growing need.
• Procuring - common regulatory issues that affect the use of public funds to purchase contraceptives and other health supplies.
• Ensuring High-Quality Supply Chains - importance of a well-operating supply and distribution system as a critical element of meeting people’s family planning needs.
• Enabling Policy Environment for Contraceptive Security - the importance of political support for achieving contraceptive security and to illustrates how civil society and the commercial sector can be involved in these efforts

In Pakistan, with increasing interest of all stakeholders in the provision for FP services, improved knowledge regarding modern contraceptives, increase in demand for quality services, and better access to services, contraceptive security has become a priority not only because of the health and economic benefits of family planning, but also because of changes in (a) demographic trends, (b) the demand for family planning (most of which is
unmet), (c) the way development assistance is administered, and (d) greater realization that FP is a health initiative. All major steps for contraceptive security need a comprehensive review.

Traditionally, the contraceptive requirements plan were formulated by the MOPW using recent past average distribution of various methods by all Programme outlets and agencies supported by the programme including NGOs, and provincial health departments. The methodology was updated late 1990s and started to use population of married women of reproductive ages, recent CPR and target to be achieved, contraceptive method mix and sources of availability. Annual budget allocation was reflected in PSDP by the Federal Ministry to meet the estimated demand for all public sector stakeholders and NGOs. The national LHW Program evolved its own contraceptive forecasting system based on existing CPR of catchment areas and actual consumption. The two systems existed in parallel and lacked consistency in the assessments. Social marketing projects worked-out their own demand depending upon availability of funds and method mix based on the performance and the methods to be promoted through their franchise clinics and retail outlets.

The Federal Ministry undertook annual contraceptives requirement assessments on the basis of consumption (off–take) and stock availability by applying the following forecasting factors:

- Existing stock level in the warehouse and field including pipeline;
- Requirement for requisite stock building at various levels, viz Central Warehouse, district stocks and service outlets;
- Annual consumption of various contraceptives; and
- Method mix in the CPR at different points of times.

The established system operated on ‘demand’ basis, implying that stakeholder fulfills the contraceptive requisitioning requirements and deposits ‘sale proceeds’ of stock earlier provided and consumed in the State Bank account. The system, however, was in conflict with all the provincial Health Departments who sought non-priced contraceptives (due to absence of budget allocation for the purpose) and, therefore, did not meet the actual requirements of Health Depts for provision of supplies to their outlets. The pricing factor was recognized as conflict between the two Ministries and Departments, but was never addressed decisively to resolve the matter. It resulted in cyclical decrease in placement of ‘demand’ with the Central Warehouse and effected adversely on ‘off-take’ of contraceptives of DOH outlets and related facilities. In general, the forecasting too computed much lower requirements of contraceptives than actual anticipated need and was biased in favor of lower off-take and conservative estimates pattern of use bearing on the increase/slide in CPR. Besides, there was greater focus on tubeligation, along with lower estimates of MWRA (Married Women of Reproductive Age) as the sub-population for contraceptive services among female population produced cumulative adverse effect on the supply situation against the actual need.

The MOPW led the national endeavor in this area and was, in principle, supposed to meet the contraceptive requirements of Provincial Health Depts’ facilities and outlets and accordingly allocated necessary resources for the purpose based on the forecasting. The Federal MoH, however, allocated funds for contraceptive procurement to meet the need of National LHW Program (which the LHW provided free of cost to the acceptors), but it did not cover the
requirement of Provincial Departments of Health. This incongruent policy resulted in ‘dependence’ of Provincial Depts for provision of contraceptives which was never addressed seriously.

The Federal MOPW maintained its responsibility and financed contraceptive procurement through its PC-I s over the years. It allocated Rs 1.72 billion during the 9th Five-Year Plan (1998-2003) for Contraceptive Requirement and Distribution, of which 92 percent was utilized by end of the Plan period. This spending by MOPW included only one time facility extended by the World Bank project credit of Rs. 606 million to procure contraceptives in 1998-99. The MoH allocation for its LHW Program contraceptive requirements has always remained separate. The MOPW in the 10th Five-Year Plan (2003-08), envisaged contraceptive procurement worth of Rs. 2.9 billion and accordingly procured and provided the same, but against an estimated national contraceptive requirement of Rs. 4.0 billion (72 percent of approved amount).

Keeping in view the rising demand for contraception in Pakistan, the expenditures over the years on contraceptive procurement by all stakeholders including social marketing companies has not kept pace and placed the programs in tight position to meet growing requirement. The release of funds for procurement by Planning Commission was based on stocks position at the central warehouse and the field, and distribution rate. The low demand for contraceptives by all the provincial Departments of Health turned into a reason for lower annual allocation, its approvals and releases of funds to MOPW. The expenditure by LHW Program too exhibits an inconsistent trend, even though the number of LHWs has increased and touched around 100,000 in 2006 (Table 4.4).

Table 4.4: Expenditure on Contraceptive Procurement in Pakistan

<table>
<thead>
<tr>
<th>Year</th>
<th>Total US$</th>
<th>Percent MOH</th>
<th>Percent Govt</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>6.7</td>
<td>18</td>
<td>50</td>
</tr>
<tr>
<td>2002</td>
<td>7.5</td>
<td>24</td>
<td>40</td>
</tr>
<tr>
<td>2003</td>
<td>8.4</td>
<td>24</td>
<td>71</td>
</tr>
<tr>
<td>2004</td>
<td>17.4</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>2005</td>
<td>12.6</td>
<td>33</td>
<td>65</td>
</tr>
<tr>
<td>2006</td>
<td>13.2</td>
<td>8</td>
<td>47</td>
</tr>
<tr>
<td>2007</td>
<td>14.1</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>2008</td>
<td>9.3</td>
<td>NA</td>
<td>67</td>
</tr>
<tr>
<td>2009</td>
<td>16.8</td>
<td>NA</td>
<td>29</td>
</tr>
<tr>
<td>2010</td>
<td>22.5</td>
<td>NA</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: JSI: DELIVER Project Reports and UNFPA Presentations.

Donor support for contraceptive procurement\(^7\) has been consistent over the years to meet growing requirements especially in view of serious financial crunch experienced since 2008. The overall financial estimate worked-out by DELIVER Project for growing contraceptive demand was around US $ 24 m for 2010 onwards, implying that contraceptive requirements and financial needs were much higher than that has been assessed by the MOPW\(^8\). Therefore, the actual procurements were lower by the Public Sector (as a whole) and the maintenance of stock at a certain level had created false impression of not ordering higher levels of stocks in subsequent years. On the average, US$ 10 m/year expenditure of contraceptive procurement (50 percent of

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\(^7\) SAPP mechanism supported contraceptive procurement by public sector till 2002, while DFID and UNFPA supported social marketing company in 2003-2008 and to MoH in 2005 and 2009. With the coming back of USAID support to contraceptive procurement and logistics in 2009, other donors are investing elsewhere.

\(^8\) Annual contraceptives requirements for MOPW for 2007-2008 were approved to the tune of Rs.187.8 m against allocation of Rs. 193.3 m, while the PC-I approved amount Rs 456.2 m (41 percent of PC-I).
which was Public sector) for 2001-2009, was absolutely insufficient to meet contraceptive requirements, especially when the country required around US$ 25 m/year, resulted in stock outs.

The contraceptives are stored in the Central Warehouse, Karachi from where these are dispatched to district offices of Population Welfare and Health Departments in the provinces throughout the country. The Central Warehouse is responsible for storing and dispatching the contraceptives to the district offices and various other outlets providing FP services. At present, contraceptives are being supplied directly from Central Warehouse to DPWOs; EDO (Health); limited PPSOs; and large NGOs. The Warehouse had dedicated space for storage of contraceptives procured for National LHW Programme.

However, several problems exist in the logistics and distribution system that interrupt supplies to facilities; (i) Fewer district Health offices were requisitioning contraceptives and with verification of ‘sale proceeds’ deposited, the time lag between dispatching of packages from CWH and finally reaching the facility was quite long; (ii) The PPHI/PRSP mandate in early years (2006–09) did not contain provision of FP and accordingly remained out of the loop to directly requisition and receive commodities from CWH, Karachi. Informally, district managers of PPHI procured limited supply of contraceptives from DPWO on payment of sale proceeds to dispense and show record of FP commodity stocks at their BHUs; (iii) In the absence of any formal understanding with LHW Program, the commodities procured by the Program were not used to barter and support as temporary loan to MOPW in case of shortages; (iv) In case of low stock

Suggestions to Remedy Issue

“To make the FP program successful, it is absolutely essential to secure contraceptives and maintain the adequate supply chain.” Provincial Manager PPHI

“There should be an uninterrupted supply of contraceptive commodities to the facilities and LHWs, and if this cannot be provided, then there should be a system to provide the same to the DOH, or DOH should be allowed to procure these commodities. The legal provision should be made available and Punjab DOH should purchase the FP commodities by itself as FP commodities have been declared a drug item like other drugs present in the approved list.” Former provincial DG Health, Punjab

“Either this commodity procurement budget be made part of the program, or DOH should assume the responsibility to procuring the FP commodities.” Program Manager MNCH
Contraceptive pricing introduced in 1990s by the MOPW was nominal and instituted for purposes of ownership, avoidance of wastage and introduce a degree of accountability in the management of supplies. This was accepted by the Federal MoH and asked the LHWs to charge for supplies distributed by them, but allowed to retain the proceeds. The problem started when the Departments of Health came-out that since they were providing (ignoring actual availability) all medicines free to the patients, it would be appropriate to provide contraceptives free of cost as well. This wrangle continued over years and service provision as well as delivery through all health outlets affected. Now that FP has been repositioned as health intervention and the provinces are sole master of both Departments of Health and Population, they may revisit the issue to provide FP products as part of essential drug, make specific provision in the budget as being done for other medicines and ensure its all times availability at all distribution points free of cost or at a nominal price it may like to levy. There is a need to assess the ground situation and validate the actual working.

There appears to be a lack of appreciation and understanding of net loss to family planning program endeavors by not ensuring availability of supplies through all available outlets, which is far weightier than the minor matter of pricing. Then there is the deficiency in not being able to reflect national picture of consolidated performance and distribution of contraceptive in the reports released by Pakistan Bureau of Statistics with conspicuous miss-out of the performance of health sector, particularly of LHW program. The devolution of health and population, provides an opportunity to revisit the subject for management; budgetary provision (including garner support from development partners); working-out holistic requirement for the existing program and future partners/entities for distribution at nominally agreed price or free and placement of the same on Essential Drug List (EDL); consolidating reporting system; working-out arrangements with CWH with the support of Planning and Development Division for warehousing, distribution and inventory control; and facilitating/supporting social marketing in acquiring commodity for their program with back-up for emergency situation by providing/lending stock to avoid disruption in the supply system and the cause of the program.

JSI - USAID|DELIVER Project is currently supporting contraceptive security and streamlining systems since 2009 to ensure product availability at all facilities. The key interventions cover warehousing rehabilitation and expansion, management of procurement, strengthening LMIS, commodity security, monitoring and transparency and capacity building in all related areas including procurement planning, automation of procurement system, supported by contraceptive procurement manual and forecasting. The project works with all stakeholders and is designed to improve availability of supplies to all 140 districts in the country by introducing modern technology in the supply chain based on the updated LMIS. Hopefully, this
consolidated distribution and performance to present a national picture in the report managed by PBS. This would be a basic resource for forecasting, earmarking resources and taking procurement action and visualizing arrangements for management of stock and the supply system. USAID’s support during 2009-2013 is quite substantive in improving the logistics system and improving the stocks and flow of contraceptives at the facilities. Sustainability will only come when the Government of Pakistan fully buys-in the system and supports with continuity of funding for contraceptive procurement, as current support under DELIVER would not be available beyond September 2014.

4.5 Shifting Paradigms by Donors

Pakistan is a signatory to ICPD 1994 Plan of Action, and committed to adopt, and follow the recommendations in its programs and initiatives. Pakistan’s Population Program and FP activities have received sustained support from UNFPA over the years including technical assistance, contraceptives and commodities, and programmatic support. However, the new framework propounded under ICPD recommendations brought to limelight RH that diluted focus and significance of FP, which needed specific attention in a country faced with high-fertility situation. The resources estimated for FP in the ICPD did not materialize even up to any significant level of what has been given in that document. Rather, the assistance for FP shrunk and went to other programs, particularly to HIV/AIDS. In the pursuit to align the program with the RH, much time was lost (until the time it regained attention at the London Summit on Family Planning through FP 2020), whereas pressing need for Pakistan was for sustained focus attention to FP. The MoH did not give due attention for a concrete RH based program as enunciated in the ICPD, rather there too FP was placed on the backburner—lacking in will and spirit to own and act decisively.

The shift made by UNFPA to divert major chunk of its assistance to the areas of health especially to LHW/MNCH Programs without consideration to bringing both population and health on a common framework to advance FP as a collective responsibility was a loss of opportunity. A
number of respondents noted that for a whole decade UNFPA, in Pakistan, did not work through the prevailing system, rather executing a parallel program in selected 10 districts was another departure from the overall program framework that has not benefited FP or even the health system, on the whole. Donor may like to assess its own program and apply the results to extend support through advocacy, technical assistance and in areas of dire need, within a framework that fills the gaps to make-up for shortfall in areas of critical need.

The Population Program has been seeking support from the DOH inherent in it was their own advantage and cause i.e. for improvement of maternal mortality and infant mortality rate, and in the long run contributing to creation of financial space for overall improvement of health facilities. The RH concept is relevant for taking holistic view of health care, but at the same time focus attention on FP is necessary, as accorded to other vertical health program such as TB, Malaria, EPI, HIV/AIDS. Rather, investment in FP is more important due to multiple benefits for family health, fertility management, population growth containment and in the ultimate to save resources for sustainable development and protection of environment.

The Health Sector has not owned FP in its assumption, design and actual execution, and implementation. More recent approach of using FP as health intervention (spacing pregnancies to reduce maternal and child mortality and improve health indicators) has appealed health professionals and managers to see FP as important support to achieve health indicators. The health managers have started seeing its importance, but have yet to integrate in its programs and operationalize in service delivery package with the needed resources. This must be reviewed and that the post-devolution situation provides the opportunity. It needs understanding, target setting, necessary agreed operational framework and sustained support in resource allocation for working together for a common cause.

Population Program – donor nexus in the recent years faced a stalemate. Government-donor dialogue on FP could not move forward due to lack of innovativeness in programmatic matters, lack of health sector’s interest and MOPW’s inability to get their necessary attention, and adoption of a static isolated model that could not attract donor’s attention especially during 2007-2010. Donors (USAID, UNFPA, DFID, etc.) attraction to maternal health issues reflected their support to community midwifery program (national MNCH Program) through PAIMAN project that also focused on strengthening service delivery only in 20 districts. Similarly, USAID supported FALAH project for FP, targeted fewer districts across Pakistan and thereby did not contribute much to build program activities to give a boost within the framework of holistic public sector program for efficiency and effectiveness. The inability of the former MOPW to negotiate and convince the donors for programmatic support reflected weak management, poor overall operationalization of perspective plan, absence of a strategic plan, low commitment to achieve targets, low funding made available, and above all lack of innovativeness to enhance program access and coverage especially for weaker segments of the society. The image of the Ministry remained low and said to be weak in intellectual foresight and long term vision regarding the future of the population of Pakistan. Furthermore, the public sector programme operated within a fixed format and pre-determined frame and nothing could be easily diverted to cater to emerging needs however pressing and genuine that might be. This rigidity blocked the ways to shared perception and caused neglect in due recognition and
support to other stakeholders, particularly in the private sector and for the efforts of civil society. The limited support was exhibited in the endorsement of projects for donor funding and moving cases for necessary exemptions. But monitoring for quality services and accountability was inadequate. The MOU signing was an important initiative to bring the PPSO into the fold of program, but those broad agreements should have been followed-up and pursued for action. This was missing and need to be taken up afresh and proper management established in the PWD to focus on this initiative. This will contribute to strengthening the coverage as well. Keeping in view the significance of growing population and inadequate FP services, donors-government dialogue need to be undertaken on a regular basis through a formalized forum to share and benefit each other for a common purpose.
Unit Five: Management Impediments to Family Planning

5.1 Program Management

Management in broad term encompasses authority, responsibility and accountability in advancing a cause through its execution. It is an organized schematic process that includes planning, setting objectives, committing resources, acquiring and positioning human and financial resources necessary to achieve the stated program goals and objectives, and measure results while keeping in view the aspect of quality. The success of program management becomes visible in the achievement of stated goals within a stated timeframe, and whether the goals are achieved within the estimated resources, which would credit the planning process and also termed as efficient. Nonetheless, management roles are not limited to managers and supervisors; rather every member of the organization has some management and reporting responsibility as part of the role to attain the overall organizational objectives.

The population welfare program though have made some progress (mostly in the 1990s) but have not effectively achieved its goals and objectives, in spite of the fact that human, material and financial resources were specifically committed for the purpose. It reflects a somewhat inefficient use of resources. Earlier studies and analysis attribute this to weak management, inadequate coverage, and poor quality of services as major causes for less than the desired level of performance. This section covers the issues that have not been highlighted in the above discussion. Major among these as pointed out by our respondents include planning, budgeting, and monitoring.

5.2 Planning Process and System

Planning has two dimensions, one is overall planning, which sets vision, goal, broad approach and strategy, provides broad management framework and earmark resources for organizing and undertaking the venture. The other dimension is operational planning, which is a process that visualizes in advance of what to do, how to do and who would do. The planning bridges the gap between the existing situation and where one wants to be in a specific time period to

- “There was no governance mechanism, to implement 2002 Population Policy. The policy of 2002-2010 was never implemented in its true letter and spirit.” A Donor Comment
- “Major flaws have always been in developing implementation strategies or implementation itself. Policies couldn't get translated into action as the government neither had the capacity nor the will to do so.” A Donor Comment
- “The second issue is the planning commission did make an effort to clarify the plan, if the stakeholders have looked at the document of planning commission the problem would have been resolved.” Former Secretary, MOPW
- “Policy design was top-down and this remained the main factor of failure in its ownership and implementation.” Former Secretary, MOPW
- “The quality of our planning is academic in nature.” Former Secretary, MOPW
- “Plan that had to convert in implementation was quite vague.” NGO Head
advance to the desired objective. It schemes-out details for future courses of action and is oft
rightly cited that a program that is ‘Well planned is half done’. The process encompasses
development of a strategy to achieve the intended objectives, to solve problems, and to
facilitate action. However, Public Sector planning and execution is somewhat complex as it
involves more than one agency in the make-up of things to undertake the execution. The
Planning Commission is responsible to pursue all development plans for the country, allocate
resources for development programmes and approve development schemes to authorize
expenditure. Population welfare being a development programme falls within this framework
(and more importantly for the cross-cutting effect on other socio-economic sectors) for its
linkage and support as referred to in the Five-Year Plans, Vision 2020 and the National Finance
Awards (for allocation and transfer of resources) from the Federal Divisible Pool.

All development programs use Planning Commission Form 1 (PC-I) which is simply a standard
format on which development schemes whether initiated by the Federal Ministry or the
Provincial Departments are designed, formulated, processed and approved to extend authority
and give cover for resource allocation and to incur expenditure. It is, however, dependent on
how well the requirement and process has been visualized in formulating the PC-I and the
requirement for coordination and the linkages necessary for vertical, horizontal and parallel
programming spelt-out. The PC-I format is necessary to give formal shape to development
programmes for consideration and approval by different bodies (CDWP, and ECNEC depending
on the size of the projects) to facilitate implementation of programs. It reflects
translation of policies into actionable plan/activities to achieve the targets laid
down in the objectives. After de-
federalization of the PWP in 2002, the sole
responsibility for initiation rests with the
provinces, while funding is committed and
provided by the Centre till 2015. The
implementation of the Population Policy,
communication strategy, procurement of
contraceptives, etc., rested with MOPW,
while the implementation of the
Population Welfare Program and its
various components was the responsibility
of the PWDs. Progress review of PC-I
implementation is conducted by technical
sections prior to approval of next financial
releases. The planning process generally
remained top-bottom, highly centralized
and static. A number of problems need to
be pointed out that have created vacuum and eroded the quality of Programs.

First: The Planning process has been based on a framework, which maintained a ‘supply’
orientation based on incremental changes in existing budgetary allocations, service delivery and

- “Whenever subject of service delivery expansion was discussed, Planning Commission jumped into the affairs and did not support.” Former DG, MOPW
- “Continued political governments change, different understanding re FP in provinces and at federal level, along with changes in program implementation strategies adversely affected the policy and plan implementation.” Provincial Secretary, PWD
- “PC-I even after approved by ECNEC was never fully implemented and releases always fell short of prescribed allocation. PSDP would always approve our demand but we were never issued releases accordingly.” Director Financial Management, PWD
infrastructure. This process restricted availability of financial resources and lacked consideration to and assessment of real need for services in various regions and segments of population. Even though the concept for ‘unmet need for contraception’ has been in existence for over three decades, it has not been applied to effect necessary changes in the planning process. The absence of ‘demand’ orientation involving need assessment surveys, seeking feedback from stakeholders and evolving plans and programs in consultation with users and beneficiaries, have been major missing elements. What is needed is testing and institutionalizing a participatory planning process and establishing effective linkage with the budgetary process. Unless this is done, top-down planning will continue to be an impediment in reaching people as per growing need.

**Second:** Inconsistency between planned inputs and required inputs to achieve the stated objectives and outcome contributed to elusiveness. Population program maintained limited facilities for service delivery and assumed that Health infrastructure, private sector and NGOs will complement the coverage. This has not been achieved to the desired extent due to poor coordination and lack of understanding between stakeholders about cumulative benefit of the interventions for the support, particularly coverage and related inputs (infrastructure, funds, staff, and supplies). And one major reason was limited financial allocation to the program.

**Third:** There was weak understanding of linkage and interdependent support of different components in the process of specific contribution to overall achievement and to measure the progress of each component. For instance, Ministry of Population Welfare had no clear assessment regarding ‘covered’ vs ‘non-covered’ areas. In the same way, clear signals were not given to RTIs regarding requirements of fresh workers in various provinces/districts. One may say that RTI output was at best a routine and expected to produce 25-30 workers annually. In view of ban on recruitment, most of the new graduating girls were not engaged by the program and they resorted to alternate avenues including the NGOs.

**Fourth:** The planning process suffered from lack of feedback about implementation and effect and more specifically absence of innovativeness to involve new partnership and tap new sources for financing and support in service delivery. This has been a single negative feature that was not addressed by the process in vogue.

**Fifth:** Planning Commission required evidence for modifications and improvements in the design of the program. The Ministry asked its technical arm - National Institute of Population Studies (NIPS) to conduct component evaluations and household surveys to track trend in outcome and impact indicators. However, the application of findings was selective due to general nature of recommendations and weak interpretation of results both by Ministry and the NIPS. MoH abstained from using the same source of data for their plans and availed other sources to reflect facts for their program design and the PC-I. Furthermore, PC-Is rarely made use of evidence of inter-relationships among influencing factors and overlooked to evolve evidence-based program approach. The lack of these resulted in poor community mobilization activities around FP and isolated focus on the role of men for family health. The lack of focus on birth spacing and resultant thrust on long-acting methods (rather use of CYPs to promote tubal ligation and rapid increase in the number of RHS Centres) misdirected investment in family planning.
Sixth: The Programme maintained major role for the public sector and on its promotion, not realizing scarcity of resources. The planning was not only centralized, but also highly isolated process wherein integrated effort with other sectors and private entities could not be entertained and lack of mutual understanding and common perception appeared to be the lingering root cause of disinterest and isolation.

Over the years Pakistan evolved several plans to implement FP program. The process though centralized was unable to generate necessary ownership of provincial authorities in the objectives and in relationship to cause and effect for their development programs. The limited role of Provincial Population Departments and lesser use of provincial data in designing program as per local needs deflected on generating necessary proprietorship of authorities especially that of Planning and Development Departments. Weak planning, coordination and linkage between Federal Ministry and the Provinces resulted in low understanding of the problem within local development process. Furthermore, the planning focused on public sector facilities and outlets, and did not build complementarity to gain support and minimize duplication of facilities and services. Nonetheless, capacity issue to evolve a good plan always existed at the level of Ministry and in the PWDs.

A good plan, however, requires a logical framework with necessary ingredients, which appeared to be missing in most of the previous plans and only select PC-Is prepared for a donor like ADB or World Bank had the requisites information. It is acknowledged that planning is a skill and learning process, which require professionals with relevant qualification, aptitude, mind-set and experience. The Ministry and Provincial Population Welfare Departments did not have staff with this background for undertaking assignment covering the overall planning process. They had limited orientation to complete/prepare PC-Is and could not address the need for a comprehensive planning process. Similarly, monitoring system evolved for the program focused on input monitoring and less on outcomes. In the same way and for the same reasons, the Technical Section of Planning Commission could not extend an over-arching support to enrich the planning and built technical staff capacity. The relationship between the two remained less than cordial and criticism on plans, field monitoring was not welcomed which was seen as affecting financial releases.

In a nutshell, the vision in the entire planning process acquires centrality as a foresight that looks into the future on the horizon of time with particular reference to population, its galloping rate of growth, the absolute size, age structure and its consequential effect and influence on the process of socio-economic development – its pace, process and resources to support increasing population at existing level and creating resource space for investment for improvement. And how to deal with the matter overtime and sustain step-by-step measures that would advance towards the vision and goal.

Since 1955-60 all the National Development Plans have recognized rapid population growth as an emerging problem and set perpetual alarm. The compelling need was to design, organize, resource, execute, monitor and assess impact of the intervention periodically and make
improvements for acceleration, without compromising consistency and continuity, which must be understood by the un-denying fact that fruit of effort in this area would take long time to bear tangible results. In turn, these required understanding, patience and resolve to sustain operations. Equally important is the understanding of the operational framework of the program that is linked together, promptly initiated and sustained for consistency, continuity and the challenge of growing need for resources.

The programme is linked through a hierarchy of sub-objectives to advance towards the overall objective. Intra-programme coordination and support with understanding and action is essential to progressively move forward. This has been weak and taken for granted without knowing the essential inherent in the relation between IEC and service provision/delivery and their interdependence. The same formulation is also applicable to the planning process for LHW program, with particular focus on commonalities, mutual support, referrals, monitoring and sharing of performance data for reflection in consolidated reporting to present national picture. The LHW PC-I and plans have been myopic in scope and never lend a coordinated hand to other stakeholders even after merger of villages based workers in 2002. The duplication of services and non-assessment of coverage implied inefficient use of public sector resources to address a critical problem. The devolution process has, on this score, made the task easier and need to revisit to regroup resources and advance the efforts in a unified framework.

5.3 Budgetary Inefficiencies

Financial flows have strong bearing on performance and on which hinges achievements of program objectives and targets, as witnessed in the previous section. The routine incremental budgeting process adds to inefficacious allocation of resources as per need and use of funds, resulting in acquisition of low value for money, which makes policy and priority almost irrelevant. Population Welfare Programs did not agree to sharing such information, instead in-depth interviews and findings of previous studies are used to substantiate the inefficacious use of scarce resources given to Population Welfare. Pakistan’s public expenditure management system maintains budgeting for almost all the resources under the recurrent budget in a strictly incremental manner and funds are not allocated / released to various ministries in accordance with Government priorities (TAMA 2008). The system has a built-in weakness that do not take long term view of the subject matter and policymakers simply places focus on short-term decisions about allocations within a program.

Pakistan is a resource scarce country and funds are earmarked on the basis of availability of resources. Population growth has been a priority concern over the years but funding has always been less than what was required. Population Welfare Program has had four service delivery facilities including Family Welfare Centres, RHS-A Centres, mobile service units (MSUs), and male mobilizers. Several studies over the past have shown family welfare centers to have, on

- “Mobile Service Unit (MSU)'s vehicles were not up to the mark.” Former DG Technical
- “Mobile Health Unit (MSU) was a good initiative but the vehicles purchased for this purpose were huge and were not fit to move in most rural terrains.” Former Director General PWD
- “MSU vehicles used for MSUs were unfit for travel in rural areas.” Former Director General PWD
average, 5-6 clients per day and maintaining very low annual performance in terms of CYPs. The mobile service units, which serve 10-12 rural communities on monthly basis, reported only twice the CYP performance relative to a FWCs but the declining trend was recorded as worrisome. A comparison of estimates of expenditure per CYP for various components (per unit cost) revealed family welfare centers as cost inefficient and expensive proposition for service delivery (Ahmed T. et al 2006). The population welfare programme over the past has expanded various components as per requirements assessed by the local managers. Unfortunately, the programme does not have any criteria to evolve an optimal combination of various components. The decision to increase the number of MSUs to 309 on a crash basis by 2005-06 did result in additional funding to meet the requirement and also reflected increase in fund utilization rate. The expansion of the component, however, has been adhoc and efficiency gains as one-off. The practice is based on all input costs, rather than linking expenditure utilization with output and gains made in the important process of behavioural change.

The investment on RHS centers attracted increased attention to ensure provision of, among other family planning methods, the tubal ligation services. This investment was maintained even when staffing was a major problem during early 2000s, which slowed the increase in performance and under-utilized nature of RHS Centres made it cost ineffective in the long run. In general, cost per client or cost of performance has never been undertaken to support expansion activities.

The introduction of a cadre of male mobilizers (graduate men tasked to motivate and encourage local men for adopting family planning) was a good initiative, but evaluation clearly showed their poor training, weak orientation to their tasks, with no support for local mobility, lacked of immediate supervision, which resulted in poor performance. Political influence in selection, serious absenteeism, and low morale added to low performance. The evaluations were hardly used by Program Managers to assess continuity of such components or to effect necessary changes in the component.

The Ministry of Population Welfare executed a Communication Strategy using basically electronic media, mostly television advertisement. All surveys revealed that the communication efforts missed out a very large segment of population who reported unmet need for contraception and required accurate information to cope with misinformation and fears regarding contraceptive methods. Pursuit of policy area is required to revisit for evolving strategies that are grounded in the need for improved access to accurate information to the poor and those residing in the rural areas. De-federalization of communication activities to provincial population offices was undertaken during the implementation of Ninth Five-Year Plan but weak understanding of communication needs and capacity to evolve innovative strategies impeded any major progress. There were thus inconsistencies between policy directives and actual implementation, which was rather ineffective and not justified to use a major chunk of expenditures of the Population Program. The increase in allocation and expenditure was more than three times in a period of five years, but remained ineffective to bring about the needed change.
The Population Welfare Program had a multi-tier monitoring system. Unfortunately, fund release restrictions since 1999 along with ban on recruitment led to large number of vacancies in management tiers and very low non-salary fund for monitoring. Prior studies have shown poor outreach activities of FWCs linked to non-availability of non-salary support to staff. Program faced serious quality of service issues negatively affecting the performance.

It is interesting to note that a ban on recruitment was partially lifted in 2003 but the hiring of high caliber and trained staff for Ministry’s Population Welfare Training Institutes (PWTIs) was given least priority and as such major portion of new recruitment (done in 2003) received its in-service management training at NIPAs. This was contrary to the requirement identified by the Policy 2002 for a ‘Human Resource Development Plan’ as a key to enhance skills and professional abilities of programme personnel. The shift of focus of Lady Health Workers away from family planning was never reviewed by the Ministry of Health in Program annual evaluation and as such performance of LHWs in terms of family planning never got due attention.

The budget making process under the Poverty Reduction Strategy Paper (PRSP) and as endorsed by the Mid Term Budgetary Framework (MTBF) 2005-09, proposed to include performance based budgeting (PBB) as an important requirement to justify performance. Performance based budgeting envisioned shifting of the focus of attention from detailed descriptions of expenditures (inputs) to the allocation of resources based on goals and measurable outputs (TAMA 2008). This was not adopted by the Population Welfare Program. Accountability for effective use of funds remained a weak area within the Population Welfare Program. This has been a major management flaw in most government programs.

5.4 Programme Monitoring

The Population Welfare Programme had a multi-tier monitoring and supervisory system shared by the technical and administrative staff at different level of the management set-up. The technical monitoring supervised ‘service standards’ which were to be undertaken on a regular basis but was not closely linked with the performance. Monitoring of governance related issues was the responsibility of administrative staff at provincial, district and tehsil levels and had many weaknesses. Population Management Information System (PMIS) was put in place to standardize and streamline information gathering about program implementation and performance against essential indicators for oversight and regular periodic review. This will facilitate to observe as to whether the entire program is progressing as planned and the whole...
hierarchy making visible contribution as per assigned roles and responsibilities. This system is a linchpin for programme management as design of program monitoring was comprehensive and multi-dimensional and included input monitoring, process monitoring, output monitoring, and impact monitoring.

The budgetary provision made for monitoring activities by the Federal Ministry was less than 0.01 per cent of the total budget (Ahmed et al. 2007), which was a meager funding for a major task. The M&S Wing in the Ministry, with an independent directorate and similar directorates in the provinces, were responsible to undertake selective monitoring on the basis of input indicators. The monitoring was limited to review of data and reported progress of performance against target. Thus, review of MIS and reported data (service statistics and progress reports) became the main action, while field visits and focus on quality indicators remained weak and unattended. Due to limited funds availability for the purpose, the monitoring was carried-out as routine inspection activities and did not look into the vital process of operations, nor supported by action in the field for improvement.

The service statistics evolved over the years basically focused on commodity distribution within the program and to other partners and emerged as the ultimate tool to monitor program progress on inputs, and outputs. Furthermore, estimation of couple of years protection (CYPs) based on distribution has become a major instrument to reflect progress and performance for all stakeholders. The intense focus on contraceptive distribution equated as ‘delivery of services’ resulted in significant changes in existing method mix of Pakistan. Tubal ligation not only figured much higher for CYP but was also associated with institutional reimbursement cost (IRC). In order to reflect improvement in trend, and greater market profile of PWP, social marketing and NGOs started pushing the method. The legitimization of tubal ligation as an output indicator was seen through the continuous publishing of the quarterly reports and absence of any corrective measure by the Ministry. The push for tubal ligation has pressed the program into promoting surgical cases, which overwhelmed focus on clients for birth limiting and can be seen closely linked with increased number of RHS centres across Pakistan. The monitoring which should have focused on the process of achieving ‘population replacement level by 2020’ evolved itself in misdirecting program focus resulting in less focus on birth-spacing methods and almost no attention to client segmentation to reach young mothers to space birth. This resulted in prolonging and delaying the achievement of ultimate goal of the program besides ignoring the clients who want to use contraception for other reasons than birth spacing and birth limiting.

The logic behind such a big push raised questions about the approach and strategy in this regard. The decision making authority heading the program was from the bureaucracy, while the implementation at different levels was pursued by program functionaries, who had no authority to divert or make any adjustments beyond what has been decided by the top management. There was no support to design comprehensive monitoring inputs which should have focused on the process and quality aspects except of quantified figures. Equally deficient was the staffing of proper professionals who had understanding of monitoring of a social change program and what need to be seen for progressive monitoring. The monitoring at the Ministry and Provincial levels lacked professional staff and did not have necessary resources.
and was affected by lack of appreciation of importance and support by the senior management. Reporting tubeligation cases was rather easy and linking it with IRC helped program in its expenditure levels. Increased vacancy rate, especially of management posts, in addition to less than required resources for POL, field monitoring and research added to the seriousness of the setback. Use of service delivery transport by district and Tehsil officers for field monitoring and supervision, is reported by several NIPS’ studies. Measuring availability of essential inputs is critical for provision of services and only highlights the necessity of transport dedicated to field monitoring.

The basic reason for poor monitoring was that the dynamics of FP, the process involved and sensitivities surrounding the subject were not given due attention. It lacked understanding profoundly in monitoring and was simply treated analogous to other projects of physical nature to produce immediate visible results once the work is completed. FP is a behavior change endeavor and has a long gestation period to produce tangible results, something which was seldom appreciated, less understood, and still less was the commitment to sustain the efforts over necessary longer timeframe. Two important related factors were; lack of support from top management to this time consuming extensive field work and the lack of proper professional staff to strongly plead for the same that is reflective in planning, execution and the expected outcome.

The most important missing tool was timely assessment of progress to serve as evidence and benchmark as well as regular and systematic feedback of beneficiaries. Similarly, unobtrusive observation of service delivery points and exit interviews must be effectively built into the monitoring framework. The feedback from the community has been the weakest in the whole set-up. This must now figure prominently as part of regular monitoring and during periodic assessment. It must be questioned in each and every review session and field visit must include this component and accordingly reported in field visit reports. There has been adjustments in subsequent PC I, but this has not been thorough and needs to be revisited.

The Population Program had evolved its own comprehensive MIS entailing related Performance Indicators (PIs) regarding input and output to facilitate Program managers. According to the organizational set up of population program, monitoring was a federal component, which was echoed by the provinces, with little contribution and the ownership found missing in the monitoring process. The Provincial Departments had allocated meager funds for monitoring purposes and that too was clubbed with the budget on administration. In summary, monitoring remained focused on inputs and not on outcome and process aspects, thereby the major component of policy monitoring was not paid much attention. According to a report (TAMA, 2008), there was hypothetical distortion of records related to specific contraceptive method acceptance to show better performance than actually achieved. This became evident from PDHS (2006-07) which showed absolutely different contraceptive mix than the one reflected in service statistics. The survey revealed that CPR remained stagnant while the CYPs based on
reported contraceptive performance portrayed growth. Thus, the qualitative process aspects have been neglected by the program (TAMA, 2008).

No stakeholders were brought together and no joint reviews undertaken to get feedback from concerned stakeholders on any aspect of monitoring. In general, weak Institutional set-up, poor funding provision, lack of proper indicators to monitor quality inputs and services, and validation against actual ground situation contributed to and compounded the deficiency and weakness in effective monitoring of the program. The lack of professional staff with understanding and commitment to design and execute effective monitoring of all vital phases of the program is a major cause of this shortcoming. The monitoring system did not give adequate attention to governance matters to improve staff presence or quality of service matters. Institutionalized staff accountability yet needs to be given a serious thought for a substantive systematic change.

The National Program for FP and PHC, interestingly, had its own monitoring and supervisory system and remained an independent entity managed by the MoH and supervised by the provincial and district LHW managers. The main supervisory and monitoring role was assigned to the Lady Health Supervisor (LHS) to oversee 25-30 LHWs in a Union Council. The LHS normally visits each LHW in the field, observe her work and reviews the performance based on reported data. She also holds a monthly performance review meeting and gather their monthly reports and discusses field problems. Even though the LHS was supposed to monitor FP work of LHWs but due to role dilution of LHWs, the supervisory role of LHS also tilted toward non-FP related activities over the last decade. Non-availability of POL funds for supervisory visits seriously hampered their work during 2010-2012. Furthermore, due to non-availability of funds for stationery and print material, the LHWs could not prepare and share monthly reports on their performance, and as such FP received a serious setback.

The National Program of FP and PHC maintained a distinct effort to be seen as an independent vertical program and evolved its own targets and objectives, which were not integrated in the national goals and objectives pertaining to CPR and fertility. This solo flight campaign may be seen as an impediment to a national cause that required integrated and concerted focus on a national level. Accordingly, the performance of the program never got reflected in consolidated picture of contraceptive contribution in the reports being brought-out by the PBS. This too will need consideration for consolidation and improvement within a unified framework that has been facilitated by the devolution process. As such, this need to be to revisited, reviewed and revamped and that the entire monitoring process and the mechanics wherein the critical and essential indicators are identified and agreed for regular monitoring including a strong component of perception of beneficiaries about their need and satisfaction with the services. Similar to the National Program’s solo efforts, the national District Health Information System (DHIS) developed in recent years did not fully reflect on FP dispensation efforts by the health system at all levels.
5.5 Coordination with Stakeholders: Ministry and Departments of Health

Family planning is a reproductive health right and contributes to voluntary interval between births and represents by exercising the choice for number of children and adopt the mean to space the same. It is important to build favourable environment to enhance social acceptance, contribute in its promotion and service delivery for synergistic support on account of cause and effect relationship. The most essential requirement for coordination is a set-up with authority over all stakeholders and a system to bring them together for direction to take responsibility with understanding of the long term effect of population factor. The existing outlook and inherent mind-set is a major blockage, as coordination is said to be everyone’s responsibility, which amounts to nobody’s responsibility.

Health sector policy statement recognized family planning as an important service to be provided by all its facilities / outlets including provision of contraceptives, training and skill development of its staff, removing duplication of services, and supporting demand generation activities; to be supported by the Federal Ministry of Population Welfare and allied bodies as necessary and required. Both the Ministries of Health and Population Welfare signed a Memorandum of Understanding (MOU), for effective coordination in identified areas. Strengthening coordination was, therefore, essential for allocation of resources, evolving necessary systems and mechanisms to promote cost-effectiveness and enhance program implementation efficiency of both the Ministries for family planning.

A three tier coordination mechanism was evolved: first, National Commission for Population Welfare (NCPW) was set-up in 2005 to form a central authority to provide direction, and guidance to the programme, undertake periodic review/assessment of progress and facilitate inter-sectoral co-ordination in advancing the cause of population welfare for synergistic support; second, Provincial Steering Committees were evolved to address operational matters at provincial level; and third, District Technical Committees were established to focus on district and facility level matters. The apex body met only once and took a number of decisions including shifting of FWCs to BHUs and RHCs to address the issue of duplication of services and enhance efficiency of FP service delivery.

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10 The “National Commission for Population Welfare” is the highest policy coordination body, chaired by the Prime Minister, with the Ministers of Health, Education, Social Welfare & Special Education, Chief Minister of Provinces, Chief Executive of NA, Deputy Chairman Planning Commission, Chairperson Senate, Chairperson NCHD, Provincial Ministers of Population Welfare & Parliamentary Secretary of MOPW. There are several members by invitation.
The Provincial Coordination Committee (PCC) established in each province for development planning and the Chief Secretary headed coordination. The PCC created a “Steering Committees on RH/FP” under Secretary PWD, with representatives of Health Department and the LHW Program. The Steering Committee had not been able to materialize the PPSO MOUs to promote FP in those institutions to the benefit of the people and as such added to missed opportunities of FP.

Similarly, establishment of District Technical Committees (DTCs) through notification were meant to focus on functional integration process at the district level. The District Population Officer is the Secretary of the Committee, which is headed by EDO (Health). The DTC was responsible to assess Health Dept’s contraceptive requirements and send necessary requisition to CWH, Karachi. Non-commitment and lack of action at district level is noted to have made the Committee non-functional. To-date not all DTCs have been operational, thereby contributing to nonfulfillment of its objectives especially contraceptive requisitioning which is a persistent issue. Hundreds of FWCs were shifted to BHUs/RHCs in all provinces in 2008-09, as instructed by the NCPW. The FP performance of those FWCs recorded deterioration over the period as they never received the basic necessary space and support from facility managers.

The problems were communicated to Provincial Offices, but neither the PCC nor the DTC evolved any effective strategy to address and overcome the same. Poor FP performance of the concerned FWCs and RHCs could not support the spirit of the shift also due to the indifference displayed by the management of PWDs to coordinate and engage Health Departments in dialogue. The apathy towards the performance continues even after the abolishment of the Federal Ministry and disinterest in convening second meeting of the NCPW or to hold a coordination meeting with the Federal Ministry of Health to resolve the matter. In summary, all Inter-Ministerial Committees remained ineffective to address almost all functions for which these were established. Several

- “Coordination between DOH and PWD remained weak.” Former Director General PWD
- “Steering Committees were formed and met regularly on a quarterly basis but it could not be institutionalized.” Former Secretary Population Welfare Department
- “PWD officers did not choose to call DTC meetings; there were personal clashes with Health personnel.” Former Director General MOPW
- “Donors were very keen to establish good coordination mechanisms between them to advance FP program, but due to the lack of leadership role of MOPW this could not be effectively achieved.” Donor Comment
- “The mechanisms and guidelines were never materialized and implemented for coordination with DOH by the PWD due to their own fears of merger, after losing VBFPWs to MoH.” Donor Comment
- “The Health Department was not taken on board. If they may work in coordination much quality based objectives could be achieved.” A Researcher
- “High turnover in bureaucracy could not institutionalize coordination efforts.” NGO Head
- “Until Public and private sector coordinate, it will not be effective.” Donor Comment
respondents reflecting apathy and poor coordination at provincial and district levels highlighted absence of accountability mechanism and proper performance monitoring.

Nonetheless, a central authority is needed to direct and demand action from provincial and district level managers about progress and to overcome constraints/impediments and enhance the spirit of working together for common goal. But the direction and demand would only be accepted if that central authority demonstrates its own seriousness through determined action. The priority was reflected in the creation of this central body, but importance should have also been demonstrated in holding regular meetings (once or twice a year). Keeping in view the importance of coordination for FP, serious neglect was noted. In view that the nodal ministry had not expressed the need, some higher authority – PM Secretariat, Cabinet Division and/or the Planning Commission should have taken the lead. Seriousness, concern and commitment to the cause remained missing. This needs attention to provide for a reflection on national level, enable to meet commitment on international level and follow-up the commitment in the country for compliance and necessary action as well to shoulder some of the basic tasks that falls on the shoulder of the federation for setting vision, goal, standardization, uniformity, capacity building and assessment of effect and impact of efforts.
6.1 Organizational Issue

The Population Welfare Program had four management tiers: federal, provincial, district and tehsil levels and that each tier had/has its own specific issues impeding the performance. In order to provide grassroots level support and coordination of family planning activities the tehsil tier was established under the district office (in 1992). Unfortunately, the tier has never been fully established and made functional for the intended support to the programme (TAMA, 2008), as two-thirds of all tehsil offices never got established, more than half of TPWOs never received formal training regarding their job and remained ill-equipped logistically and ill-prepared due to lack of administrative powers and financial support to perform effectively especially in monitoring absenteeism, support coordination, and even in reporting progress in efforts and achievements. The program had not been able to evolve an effective inter-departmental coordination mechanism at tehsil level.

The 2002 Population Policy of Pakistan identified community participation as a key strategy to improve the efficiency of the Program and this was dependent on tehsil tier and the Family Welfare Assistants (FWAs) to undertake the task at grassroots level. Unfortunately, the program did not develop the much needed necessary technical protocols and mechanisms to guide the efforts. As such community participation remained the weakest link in the program, thereby unable to build linkage with and within the community to attract them to visit the facilities and avail the services.

The PWP did not have District Offices in all administrative districts of Pakistan - a gap that was addressed in early 2000s when district set-up was established in all the districts. This tier too experienced numerous management constraints that impeded its optimal performance. Massive staff retirement towards the end of 1990s and ban on recruitment left a large number of administrative posts vacant and double charge approach was resorted to for many facilities for many months. This not only affected service delivery, but made monitoring and supervision still weaker to check absenteeism and assess performance for improvement and acceleration. Furthermore, over-centralization in areas of organizational matters remained a trade-mark of the population program that gave little leverage to field managers to pursue and maintain efficient field activities. Districts officers were not supported with necessary delegated powers and unable to take disciplinary actions against field staff thus making them less efficient as managers. The District Office posts were filled on limited scale and their training as district managers was weak especially in planning, budgeting and monitoring due to closure of one Population Welfare Training Institute (PWTI) and insufficient training staff at the other. The new batch of district managers also remained ill-equipped and ill-trained to meet task requirements. Furthermore, female staff posted in far-away facilities, i.e. female welfare workers and female

- “Frequent transfers of top management had been a big impediment to Program performance.” Former D G - PWD
- “Political pressures on the management and administrative system created implementation problems at district level.” Former DG (Technical) MOPW
welfare assistants (FWAs) affected their presence and ability to fully contribute to programme objectives through full time attendance at the clinics on a daily basis.

The provincial offices too experienced difficulties in filling-up vacancies and the necessary powers for disciplinary action, which affected the efficiency and effectiveness. Furthermore, the Provincial Secretaries and Director Generals invariably appointed by the provincial governments were mostly provincial civil servants with no orientation and experience about management of a social change program like family planning and understanding of its dynamics and the inherent process. Moreover their reluctance to join the provincial offices in view of their perceptions of a low-prestige program resulted in high turn-over, causing continuous gap in effective management for implementation of the program with understanding and determination (Rukunuddin, 2001).

The over-centralization of the program was inherent in the system, (built in the Rules of Business 1973) which did not delegate necessary powers to program managers to implement the given mandate to monitor and coordinate with other sectoral stakeholders at the provincial and district levels. The Institutional Management Review (Ferguson, 2000) identified lack of administrative powers to the provinces over the employees of the programme (as they came under federal government) as one of the constraints in the effective management and implementation of the programme. Furthermore, lack of service rules, delineation of functions, delegation of powers, lack of capacity for extension of service delivery network and lack of performance assessment evaluation system continued to weaken the institutional and management aspects of the programme (TAMA, 2008). In the absence of any accountability mechanism, inefficiencies were inevitable and no substantive effort was undertaken to improve the system.

6.2 State of Flux

Population Welfare Program experienced several changes from federal to de-federal state over the years first in 1983, and then again re-structuring exercise undertaken in 2001-02 which led to merger of VBFPWs with LHW Program of Health. Under the 2002 Local Government Ordinance good governance was the key to improve performance of public service delivery. This was to be achieved, among others, through decentralization of authority, de-concentration of management functions, and distribution of resources. The Population Program though de-federalized in 2002 was never devolved under the Local Government Ordinance to the districts, like other departments and as such did not benefit from the new scheme of management. The absence of a devolved office at district level never got the same attention or priority for the district management under the Nazim. The systems never received attention at the Federal
Ministry and as such monitoring, planning, budgeting, MIS, etc., all remained weak.

### 6.3 Human Resource Management and Development

Personnel management especially transfers and posting seriously hampered effective programme management and implementation. Frequent changes of the top management especially in the provinces impeded continuity of understanding and smooth implementation. Moreover, ban on recruitment imposed for an extended period (till early 2003) added to weakening of management at all levels. Population Welfare Program never had a thoughtful, well considered and visualized Human Resource Development Strategy or Training Plan to encompass training requirements, staff placements, critical training assessments, etc. Monitoring of training and quality of services remained weak areas. No substantive training was undertaken to build a meaningful monitoring system focusing on governance, service quality including counseling and built-in system for regular feedback from the beneficiaries.

The Department of Health though benefitted from trainings offered by the RTIs across Pakistan but no concerted effort was made to educate medical professionals at health facilities regarding importance of family planning and linking it with the nearest facilities. The Departments of Health acknowledged that investment in human development remained grossly deficient relative to massive amount that went for building infrastructure and equipment, and did not evolve or express interest in training plans for their facility staff to improve understanding of WMOs or female health visitors regarding counseling or demand generation for contraception. Therefore, facility based interaction with clients remained an ignored area for Health, and burden of client load in need of curative care on the understaffed facilities only compounded the situation further. Several missed opportunities are now emerging after discussions with managers at various levels. For instance, both the PPHI and PRSP desire to link with Population Departments to get their staff trained in IUCD and implant insertions, and for refresher/in-service training in family planning technology and birth spacing counseling.

The defunct Ministry of Population Welfare initiated a new program in 2007 for orientation of religious leaders in family planning and reproductive health. The Program was able to orient more than 25,000 male religious leaders across Pakistan till mid 2010 through the Population Welfare Training Institutes. The religious leaders were provided orientation on the assumption that they will spread the learning on their own thereafter. The religious leaders were convinced but no contacts were maintained with them to track their work or for extending the required support in the field and to sustain their interest in the endeavor. This half-hearted and weakly designed initiative did cost public exchequer in millions, but was not able to yield the desired result and link the same to enhance acceptance of family planning for availing services and demand generation.

- "Religious leaders should be taken fully on board as FP is not only an academic issue but also a religious issue." PWD Secretary
- "Involvement of Mullahs and males should be an ongoing process with proper follow up." Director RHS-A
6.4 Staff Morale

The staff of the Ministry and Departments of Population Welfare went through repeated spells of de-federalization of the Population Program (1983, 2002 and 2010, which affected their morale and motivation to work for FP. Rather they were on the run and remained engaged in protecting their positions and got involved in litigation to save their jobs—loss of time and loss of the spirit to serve with commitment and determination. Several respondents from Population Welfare Departments expressed ‘lack of commitment’ in service delivery and lower administrative staff related to these shifts and now due to ‘devolved’ nature of the program. Furthermore, lower salaries offered to doctors in PWD add to low motivation to stay and work for Population Departments. Delayed transfer of funds by provincial Finance Departments to provincial Population Departments over the years resulted in delayed payment of salaries to staff. Population Program’s motto has always been client-satisfaction, but low job satisfaction and morale has been a key impediment in the way to achieve their own satisfaction and for better performance.

The decision taken by the Federal Steering Committee for Health and Population with regard to the relocation of FWCs of the Population Welfare Program to BHUs basically meant to enhance accessibility to family planning services. Half-hearted commitment and inhibition on sides, plus low morale and poor planning were at the roots as serious programmatic, operational and management issues that resulted in damaging for advancing this initiative.
Unit Seven: Programmatic Impediments and Issues

7.1 Programme Coverage

The Population Welfare Program envisioned 100 per cent family planning service coverage by 2015, but has not undertaken any mapping exercise of geographical areas and that of family planning/ reproductive health services infrastructure. The coverage of the FW centers has remained low keeping in view the limited number of facilities. However, satellite clinics organized by FWCs to expand coverage has not been a regular feature due to weak training, lack of planning and poor financial support. Two parallel efforts eroded the coverage of the target population for family planning services: the relocation of the FWCs to RHCs/BHUs and the Provincial Government decision to entrust the management of BHUs to PPHI/PRSP in phases (wherein FP was not part of PHC Package). A systematic and calculated approach for coverage of the entire population as a whole and in proportion by each infrastructure outlet does not appear to have been visualized and projected even on a theoretical basis. This requirement need to be fulfilled through a detailed mapping exercise to come-out with a somewhat factual position on coverage through the efforts and contribution of all the stakeholders and how do one account for the contribution of social marketing and civil society so that their place, role and contribution is reflected in relation to geographical coverage. The role of “District Technical Committees” to coordinate coverage, and outreach, mutual support and implementation needs to be strengthened. There would certainly be overlaps and duplications, which may be treated as reinforcement for the present and relaxed like that of the spirit of working of market forces, which exist in juxtaposition for the same range of household and other products and there is no crib about duplication and overlaps, as efficiency and effectiveness is the main driving force to promote business and attract consumers. Inability of the Population Program to oversee family planning coverage issues, increased number of non-functional FWCs (relocated in health facilities), distant (urban) location of private sector outlets, or even NGOs, promoted inequity in service distribution and access to services especially for poor segments. These definitely contributed to increase ‘unmet need’ for contraception.

- “Population Program could not cover whole population as funding was available to cover 1/4 population; and rest not covered.” Former Secretary MOPW
- “If there are 70 Union Councils then only 30 LHWs are working there. How they would they cover all area?” A Researcher
- “LHW program needs strengthening for coverage to areas which are still not covered.” LHW Program Manager
- “No proper monitoring system was introduced to check whether they were well trained or not. Client Follow-up was also not present and no well-connected system was evident.” Researcher
- “Trained staff of health sector was not posted according to their capabilities and skills; so, the gap of proper service delivery was obvious.” Master Trainer
- “Due to lack of focus on counseling component, clientage on average was very low. It was a major flaw.” Former DG Technical MoPW
7.1.1 Constraints to Coverage

(a) Ours’ is a male dominated society who makes crucial decisions regarding family and about adoption of family planning methods, but ignored in the normal process. In this regard, religious leaders have been oriented, but still hesitant to support openly, and if they do, they focus on breastfeeding and withdrawal method only. This too adds to missed opportunities to cover male population.

(b) Establishment of large number of health facilities (under political schemes) have placed extra burden on the Departments to staff these facilities, but also resulted in many cases to duplication. Lack of availability of female staff to deliver services to women in such facilities rendered a fairly large number of Health facilities ineffective.

(c) Private sector social marketing projects are mainly restricted to urban/peri-urban centers as per their original design. The service provision of the social marketing projects also gets constrained by funding cycle and adjustments in focus on the deliverables.

(d) The involvement of local NGOs to complement public sector’s family planning activities remained weak. Absence of an operational system to involve small local organizations working in remote areas has been a pronounced weakness. The Departments have been unable to tap possible NGO resources for expansion of coverage to remote rural areas.

RHS-B Centres are authorized to non-program supported organizations including MSS, FPAP, and formal organizations like Pakistan army, WAPDA, Railways, etc. Almost all such facilities are urban and recent decline in the number of these facilities (due to stoppage of payments related to tubeligation) has also contributed to constraining coverage even in urban settings for the services previously offered.

Coverage and access is generally taken to have the same meaning, whereas coverage reflects availability of services in an area, while access implies reach of services by beneficiaries with easy approach and near-by/ neighborhood. Both elements need to be focused in the efforts to expand coverage and to improve access for easy reach. This is inherent in the concept of door-step services and community based approach, but needs forceful and sustained concerted efforts. Community and social mobilization efforts are to be undertaken with a missionary zeal and as a movement for national cause of health and better living. This is generally absent and only sporadically visible because of some dedicated individuals.

“With funding cut faced by IPPF during tenure of President Bush senior, FPAP also faced 49% cut in funding and FPAP had to leave half of country means half of its program. It was not a need base withdrawal rather a cost based withdrawal and eventually we had to leave southern Punjab, Swat and every area which was far from provincial headquarters and manage in tight budget.” Head of a Local FP NGO

Another important aspect in this regard is that all along the public sector has taken for granted that clients would throng to service delivery facilities if supplies are available. Program managers had insufficient realization that sustained efforts for demand creation have to go into community mobilization to make it a reality. The subject involved change in behavior and approach that it dealt with a personal and private matter and to what extent can motivation
and, counseling be undertaken – a subject that will need continued pondering for solution and to remain within the permissible socio-cultural limits.

7.2 Constraints to Access of Family Planning Services

(a) Almost all Population Program facilities have service provision but for female clients only, thereby restricting access to males in such service facilities.
(b) Health facilities with lack of female staff make those facilities inaccessible to female clients.
(c) Health outlets without residential accommodation in remote areas make it difficult for staff to be present for duty and thus make it non-operational for services on a regular basis and for full working hours.
(d) Placement of community based workers (LHWs) in well-to-do locations makes access to needy women in poorest and far off localities difficult.
(e) Provision of services for limited time period (9-2PM) at most public sector facilities makes access to services difficult to working women in rural areas. Consideration needs to be given to their convenience to avail the services for consultation, counseling and service provision.

7.3 Quality of Service

Quality of services in family planning means devotion of time and efforts to motivation and counseling in a caring atmosphere, easy access of services, with provision for choice from a broad contraceptive method mix to suit client needs that is delivered by a competent provider tempered by humane approach that ensures the information and services are accurate, up-to-date and evidence based. This must be supported by post-acceptance care, with an effective and close supervisory system that would valid the reported performance. All these were found lagging in substance and spirit to treat the cause as a long term commitment instead of dealing with the same as one-time customer. Quality of services by all service providers is generally lagging behind in all important facets of programme implementation. Training, provision of supplies and placement of technical staff at district level were the measures needed to improve infection prevention and quality of service. Vigorous follow-up by the RTIs to observe as to how the knowledge and skill acquired was being applied in real working was missing. This is important as a support to on-the-job learning and identifies areas for refresher and improvement of training program designed and managed by the RTIs.

“Side effects of pills, injections and IUCDs and poor follow-up have been the major reason for non-popularity of these methods in rural communities. There was unacceptably high rate of infection with IUCD insertion, partly due to poor personal hygienic standards.” Former Director General PWD

Client counseling has been the main stay of family planning program to promote and encourage clients to adopt a method after complete review of method mix and to pursue them for continuity. Counseling has been quite weak and not monitored vigorously to ensure its effective use. Lady Health Workers Program has a large force in the field but needs to be equipped with counseling skills to be effective field force. Furthermore, a complete absence of social mobilization activities at the field level has isolated the service centres to enhance acceptability of facility and to generate regular flow of clientele. Furthermore, the Program focus remained
vaguely on client profile – reaching out young mothers and promotion of long-acting methods, but was unable to translate the requirement into any operational measures to bring about any change in fertility level. This needs to be approached with understanding and a system designed to carefully conduct popular mobilization for ensuring regular contact with communities and groups of people.

7.4 Diluted Focus of Community Workers on Family Planning

The progress and performance in family planning by village-based family planning workers (VBFPW) and lady health workers (LHW) remain unmatched to-date by any other component. The prime task of Lady Health Workers was to enhance family planning services to women in rural communities. The prominence of their work and tremendous investment made by the Federal Ministry of Health invited other less performing programs within Health to benefit from the presence of this vast frontline workforce focusing on the communities. The inability of the Ministry of Health to foresee their contribution towards family planning (considered the task of another Ministry) readily accepted the initiative from WHO to engage and involve LHWs in EPI campaigns especially in giving polio drops to children under age 5. This de-focusing of family planning by LHW Program has severely eroded their roles and needs revitalization to achieve family planning objectives. Similarly, the LHW Program has in place an effective supervisory tier at the grassroots which needs training in supportive supervision to enable LHWs target visits to households on need basis and make their field time more effective and productive.

7.5 Missing Out Demand Generation and Social Mobilization

Pakistan Demographic Health Surveys (1990-91 and 2006-07) clearly identify high unmet need for contraception (implying that a significant proportion of women were not using contraception even when they desire to space or limit births). This behavior and resistance is reflected in their continued high misperception regarding contraceptive technology and socio-cultural religious barriers. Policy makers and population program managers were well aware of these facts, and that of the existence of universal awareness regarding contraceptive methods among women in Pakistan. Nonetheless, over the years, Pakistan continues to have low female literacy where socio-cultural norms predominantly prescribe behaviors regarding marriage, fertility, family size, and maternal health, together having bearing on decisions about acceptance of family planning. Role of men and religion is also noted as a serious challenge to these development programs. Results from two major national surveys reveal that more than half of all respondents (58 percent) never discussed the issue of family planning with any family
member or friends reflecting conservative attitude tabooed to discussion (PDHS, 2006-07; PRHFPS, 2000-01).

The PWP addressed these issues through strategies on advocacy and awareness campaigns consistently reflected in three policy documents: Population Policy 2002, Perspective Plan 2002-12, and PC-I for 10th Five Year Plan (2003-08). The Policy highlighted the need to address prevalent fears and misconceptions especially among illiterate for lack of pertinent knowledge and/or inhibitions to practice family planning. Policy refers to an advocacy campaign as integral part to build and sustain adoption of the small family norm, but no focus attention was given to demand generation for family planning or addressing how to reduce misperceptions that result in unmet need. The Perspective Plan acknowledged that past campaigns were general and meant for awareness building only, had urban focus, and relied heavily on electronic media. The Plan envisioned focus on rural population using local communication channels, and to enhance availability of accurate information at people’s doorsteps. Furthermore, the strategy encompassed capacity building, using research as evidence, focusing on men and adolescents, and of course decision makers to reach the targeted population in order to trigger the process of change. Decentralization of communication activities was undertaken during the Ninth Five-Year Plan, but weak understanding of communication needs and capacity of provincial staff to evolve innovative strategies impeded any major progress. De-federalization of the population programme in 2002 included all major component, but Federal Ministry maintained, among others, communication strategy and advocacy as its own function and gave a limited segment to the provincial departments.

The PWP at the turn of the decade (year 2000) had a strong focus on interpersonal counseling skills through village based workers to motivate and educate women regarding contraception. It was a big support to demand generation while Family Welfare Workers focused on providing technical knowledge to clients at the facility. With the transfer of village based workers to Ministry of Health (as LHWs in 2002), the focus on interpersonal communication and social mobilization for family planning was lost as the LHW Program did not maintain the same level of interest, rather the workers were absorbed in several other tasks apart from FP. MOPW did not persuade the Ministry of Health to emphasize the importance of IPC and could not provide necessary training to LHWs in this regard. The loss of FP clientele and referral cases to FWCs is thus quite obvious.

- “Women’s empowerment must be focused and FP should be taken as fundamental right like RH.” Former Secretary MOPW
- “LHW’s is a good and an effective program but selected young girls, who were mostly low educated and were unable to convince mothers re FP and raise social issues.” DG Health
- “Demand side requires lot of sensitization through behavior change communication as there are many barriers in accepting FP which need to be broken to fulfill unmet need.” A Donor Comment
- “Reach the women and families with unmet need.” CEO I-NGO
- “The DOH didn't have any mechanism to address demand generation as it had no post of social mobilizer.” DG Health
The MOPW also initiated activities focusing on educating and motivating men for family planning and promoting small family size. Male mobilizers (graduate men / local residents) at community level were introduced in selected union councils across all provinces. Evaluation of the component, however, revealed poor performance due to weak training, meager support for mobility, weak immediate supervision, and inadequate supplies for distribution to local couples and all these impeded their ability to penetrate into the communities. Two other concerns undermined their performance: political interference in selection, and judging performance by number of vasectomy cases generated. The component faced serious scrutiny by Planning Commission and received little support for its continuation. The persistent existence of misperception among women and men that Islam does not permit family planning was seriously addressed after an International Ulema Conference in 2005. The Ministry undertook an initiative in 2006 of ‘orienting religious leaders towards family planning’. The orientation program covered more than 25,000 male religious leaders across Pakistan but maintained an assumption that the religious leaders will carry forward the social mobilization work on their own, it was rather a simplistic theory, which could not be substantiated in reality. Furthermore, the focus of orientation remained on small family and promotion of all methods, not readily accepted by the religious leaders especially surgical methods. The approach was fine-tuned in 2010 viewing family planning as health initiative and promoting birth spacing and spacing methods only. The approach was acknowledged by senior religious leaders who extended support to family planning. At the Program level, the support by religious leaders could not be materialized due to lack of follow-up efforts to ensure and support their involvement. Due to lack of coordination between Health and Population Welfare Programs at all levels, the fruits of the initiative were not benefitted. The LHWs were not disseminated the religious point of view regarding family planning to respond to women in their communities while medical practitioners / staff were not shared to help overcome their misperceptions.

The communication programs remained the core federal function and the backbone of the Population Program’s motivational and educational campaign and received tremendous attention that is reflected in the growth of budget allocations. However, three areas of serious discrepancy have been noted in reassessing the outcomes of these strategies:

- The focus remained on electronic media including television and FM radio stations, catering to middle and upper-middle classes in urban and peri-urban settings. Efforts towards the weaker section and un-served segment of population through interpersonal communication to motivate and educate them about family planning remained unattended.
- The entire service delivery was managed by the provincial departments, but allocation to support their demand generation activities was negligible. The communication budget,

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- “There is illiteracy along with socio-cultural and religious barriers.” Former DG Health
- “Ulema were not involved from the start of program leading to misconceptions and resistance from the communities.” Former Secretary MOPW
- “Focus was very weak and programs had limited interaction with male community.” PC LHW Program
- “Positive response from religious leaders should support family planning.” Director General PWD
therefore, need to be enhanced and tailor-made to fill the gaps identified as part of expansion of services for the target audience.

- The Perspective Plan noted that communications was a specialized nature of intervention and required special skill, which was lacking in the Ministry to support growing needs of the sector. The Plan emphasized the need to further decentralize the communication activities to district offices. This remained unfulfilled and yet need to enhance focus on target population by building skills and professionalism of concerned staff.

Ministry of Population remained as the key stakeholder for demand generation activities in Pakistan. No other stakeholder emerged with any firm initiative to support family planning. Unfortunately, biased coverage and faulty assumptions that small family norm messages would penetrate into the culture of deep rooted values, but it was unable to bring about any significant attitudinal and behavioral change. Awareness and demand generation campaigns used ‘electronic media’ which was insufficient and inefficient mode as it was accessed by only less than half the households who owned TV or radio. Huge investment made through this media was actually inconsistent with ground realities and could not provide method specific information and address misperceptions, misinformation and fears regarding contraceptive methods, absence of which was causing dropouts and resistance to adoption of modern methods. Management of communication strategy was too centralized and too far away from people who needed the information. The support required to meet and address causes of unmet need for contraception did not exist at federal or provincial levels, and as such the efforts of demand generation could not address the variety of reasons prevalent in various segments of the population.

Advocacy for family planning and its linkages with development planning remained a weak area. The politicians and bureaucrats remained unmoved regarding its importance and did not see betterment in economic or social indicators. Therefore, understanding of the program among decision makers and their being vocal to attract attention also remained low. At the grassroots, interaction with communities and social mobilization is seen as role of Family Welfare Assistant, but was not well supervised or accountable due to low priority assigned to such matters. The origin, presence and interaction of LHW with the community is taken as social mobilization, but they were not adequately trained for the purpose. Similarly, mobile service units requires a local social mobilizer to inform and motivate women to attend the camp for services but absence of such a cadre could not help in making best use of this facility to women in remote areas. Private sector project initiated by Greenstar too had important social mobilization components but were short lived and limited in coverage.

Demand generation remains an important policy intervention area for family planning, but received weak and inadequate attention during the last decade. It has to be pursued by
advocacy and through promotional campaign, duly reinforced and sustained by inter-personal campaign. These have to be research-based, audience-specific, monitored and assessed at definite intervals and interventions improved and refined for appeal in the message built around areas that would attract interest and address issues inhibiting acceptance and continuation of family planning practices. The persistence of high unmet need for contraception and demand for large family size, only warrant much higher attention and technical support for demand generation and awareness campaign to be rationalized and improved to address the gap. Interpersonal communication in particular, needs to be given due attention to tackle issues related to unmet need for contraception and the social barriers holding the change to encourage behavior and norm in the desired direction. Communication plan needs to be evolved for family planning messaging in a uniform manner for all stakeholders.

7.6 Why Private Sector Maintained Status-Quo

The management information system of the program reflects large number of registered medical practitioners, hakeems and homoeopaths being enlisted as service providers, but their performance and contraceptive distribution through them was dismally low. The number of these service providers did increase over time, but their performance remained low and no concerted effort was imminent to revisit the same for improvement and how to tap the potential of this existing resource. They have vast influence and contact with the masses through their normal practice for medical care and can be useful in creating enabling environment, encourage interval in births during their interaction with the clients/patients, also serve as a point for service provision and as a resource for referral. This need to be revisited, perhaps districts population set-up may identify and prepare list of interested providers and propose to social marketing organizations to consider enlisting in their programs.

The government didn't even provide us any feedback or recommendations when we shared our plans and strategies. We can't lift anything without the support of the government, whatever donors do is for the government.
Comments by Executives of Social Marketing Company

Social marketing must be done through all possible measures like shopkeepers, and all other possible routes. Out of the box innovative thinking is required while remaining within social norms.
Former Secretary, MOPW

At the same time, social marketing approach managed to introduce a separate stream of service delivery by enlisting private health care providers and existing network of retailers to make wider availability of contraceptive products. The social marketing being executed by private organizations received strong support of the Ministry of Population Welfare during the 1990s in the form of Government-Donor dialogue to address the service gap and for their package of assistance. The initiative did enhance service coverage through social marketing projects and received good response from donors to sustain the operations, mostly in urban areas and to some extent in peri-urban areas. Nonetheless, limited financing was problematic for expanding the scope of work to include service outreach to remote locations, where the need for strengthening was more pronounce and necessary. Social marketing through private sector has tremendous potential to broaden and deepen its
contribution and donors normally are interested to consider supporting the same with inclusion of innovative elements.

The Public Sector acknowledged the contribution of the social marketing companies in enhancing CPR during 1990s but supportive actions to ensure contraceptive availability in the context of overall requirement of the program and in relation to set objectives still need to be fulfilled and addressed to avoid disruption. The Perspective Plan 2012 and Population Policy envisioned expansion of social marketing to reach out to rural areas. Social marketing has always been donor dependent initiative with no public sector financial support. The envisioned social marketing initiative has tremendous potential, but it could not be fully tapped if the target rural population remained underserved. A serious thought was needed to operationalize and translate policy directions in this regard. The devolution of population subject to the provinces provides an opportunity to revisit the matter for consideration and to draw a framework to encourage and support operations with deepening effect in urban areas and broadening approach for rural areas. The social marketing organizations need to interact with provinces pro-actively and objectively monitor and validate the presence and active participation by their enlisted network.

There was a need to work through a formal forum to discuss innovative social marketing interventions and to evolve trust in their work to achieve the desired outcomes of rural expansion of social marketing network. Furthermore, reliable reporting and evaluating system of sales by marketing companies being equated as used (for calculation of CYP) created doubt in public sector managers. In this regard, public sector could not provide guidance to address the bottleneck and remove a sense of ‘distrust’ prevalent in some areas. Ministry of Population’s inability to use available PDHS 2006-07 data to build understanding of the dynamics could not break the barriers and to evolve good working relationship with social marketing and private sector entities to benefit the people. Social marketing organizations need to face challenges to expand meaningful operations, instead of resorting to an easier way out by linking existing network of LHWs for supplying contraceptives, as this did not provide necessary impetus for expanding scope and network to rural areas.

The need exists for a programme that is innovative and dynamic that would extend outreach to rural areas where the need is pressing and services sparse. As such, new sustainable initiatives are required and need to be explored.
Unit Eight: External Influences: NFC Awards and 18th Constitutional Amendment

8.1 Fiscal Reforms to Enhance Resources for Family Planning

The constitution of Pakistan requires re-review and dialogue between national and provincial authorities at regular five-year interval to evolve agreement on National Finance Commission Award (NFC) for the subsequent five-year timeframe for distribution of national resources/revenues from the federal divisible pool. The consensus agreement in vogue and referred to as 7th NFC Award was reached between the Federal Government and the four provinces on December 11, 2009 and is effective from the fiscal year 2011 and will be in force till 2015.

The provinces agreed to distribute resources among themselves on the basis of a multi-indicator weighted index instead of the population based criteria used in all previous NFCs.

Two features of this Award make it discrete from earlier Awards as it has enhanced transfer of revenues from the Federation to the Provinces: first, federation’s share was much smaller than the previous awards i.e. 44% instead of 52.5% (in 6th award finalized in 1996/97), and second, a new formula was used to reach the revised distribution of 56% for the provinces’ to be shared among the provinces. Both of these formulas have impacted an improved financial position of all four provinces as reflected in the table 8.1 and 8.2.

<table>
<thead>
<tr>
<th>Table 8.1: Weights of Multiple Indicators under the 7th NFC Award</th>
<th>Table 8.2: Horizontal Distribution of Funds under the 7th NFC Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>82.0</td>
</tr>
<tr>
<td>Poverty/Backwardness</td>
<td>10.3</td>
</tr>
<tr>
<td>Revenue Collection/ Generation</td>
<td>5.0</td>
</tr>
<tr>
<td>Inverse Population Density</td>
<td>2.7</td>
</tr>
</tbody>
</table>

By virtue of the Award, Balochistan was to receive a guaranteed sum of Rs.83 billion from the pool as its NFC share during the first year of the award. Any shortfalls were to be made up by the federal government from its own resources, and this arrangement for Balochistan will remain protected through the life of the next award. KP is to receive one percent of the total divisible pool (so the burden is shared proportionally by all federating units) in addition to its NFC share to acknowledge its role as a frontline state in the war against terrorism. This amount is equivalent to 1.83% of the provincial pool and Sindh to receive an additional transfer of Rs.6

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11 Consensus was not reached earlier because Punjab insisted resource distribution on the basis of population alone whereas the other three province, namely KP, Sindh and Balochistan demand giving importance to the revenue generation by each province, level of poverty in smaller provinces and other related factors as well, while distributing the national resources among provinces through National Finance Commission. (http://en.wikipedia.org/wiki/National_Finance_Commission_Award)

12 The distribution formula of 6th NFC award remained in effect beyond the constitutionally mandated period of 5 years because subsequent successive NFCs could not reach consensus on a revised formula.
billion from the federal government’s share, which is equivalent to 0.66 percent of the provincial pool. This amount is in compensation for Sindh’s acceptance of allocation of an equal weight to generation and collection of revenue.

This increase in the provinces’ share was necessary as the responsibility of social sector spending was with the provinces and the lack of provincial resources was a major impediment to poverty reduction efforts and reaching the objectives. The index also included revenue collection/generation as one of the indicators and the impact of which is envisioned that richer provinces can generate more revenues, will be rewarded and allocated more divisible pool resources. This may increase disparity and offsetting the impact of using the poverty/backwardness indicator. The net transfer affected during the period 2003-2012 is given below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Net Transfer to Provinces</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>226.0</td>
</tr>
<tr>
<td>2004/05</td>
<td>244.6</td>
</tr>
<tr>
<td>2005/06</td>
<td>349.0</td>
</tr>
<tr>
<td>2006/07</td>
<td>381.5</td>
</tr>
<tr>
<td>2007/08</td>
<td>465.5</td>
</tr>
<tr>
<td>2008/09</td>
<td>587.3</td>
</tr>
<tr>
<td>2009-10</td>
<td>710.6</td>
</tr>
<tr>
<td>2010-11</td>
<td>1,022.8</td>
</tr>
<tr>
<td>2011-12</td>
<td>1,270.9</td>
</tr>
</tbody>
</table>

Source: Economic Survey of Pakistan 2011-12, Economic Affairs Division Islamabad

It reflects that net transfer to provinces rose from Rs 226 billion in 2003-04 to Rs 1,271 billion in 2011-12, which is a substantial increase in resource transfer, with major jump taking place in 2010-11, which is the first year of 7th NFC Award. As such, this need to accommodate the requirement of population welfare program in the true spirit of devolution under the 18th Constitutional Amendment.

The funding of provincial population programs was to be incorporated in National Finance Commission Award to enable provincial ownership of the Program, but sidelined the transfer of funds to provincial governments as the federal committed to fund the program with a fixed amount up till 2015. Nonetheless, it was assumed that after the Award the Provincial Government were better placed with enhanced resources and will provide more funding to social sectors and assume full responsibility of population program. But the Provincial Governments accorded priority to programs and projects that had greater attraction and those bore quick results like construction, water schemes, etc. The program has always been considered a federal entity and given marginal significance under provincial development plans and that additional resource given by the federation never allocated for family planning in time. The criteria used for

- “Criteria of NFC award are also conflicting with FP program; Balochistan government remains hesitant in implementing this program because their population is already less compared to its area and the NFC award is based on population.” PWD Team
- “During the NFC awards, provinces were not transferred the required resources, this system back lashed, and provinces lost the ownership and interest in the programme” Former DG MOPW
- “Finance is the serious constraint and NFC award is still not fully implemented; some donor support is sought till year 2014 but thereafter provinces will have to take over the responsibilities.” HSRP Director
distribution of federal funds remain a clear impediment to family planning especially in the province of Balochistan where politicians used the population size criterion of NFC Award to promote population size to get larger chunk of federal funds. The respondents noted this discrepancy quite seriously and stated it to be against national goal of bringing a balance between population and the need for sustainable development through voluntary moderation of fertility.

The implementation of NFC has been somewhat weak in the past, hopefully would improve due to larger chunk of resources allocated to the provinces and due to adoption of multi-indicator for its distribution. Provincial Governments were glad to see the 7th NFC Award and that the Provincial Finance Commission would consider the requirement of population welfare program as an integral component of their development framework, due to its cross-cutting effect on all development endeavors. The realization of this is vital and recognition of the fact that investment in family planning produces multiple benefits for socio-economic advancement and well-being of the society as a whole. The envisioned objective and importance of family planning with its derivatives in terms of demographic dividend did not take root in provincial development framework and resulted in lack of ownership of the program. This needs to be placed in proper perspective and explained, in order to attract attention and action, because of devolution of the population subject to the provinces as their holistic responsibility. The desired stability in approach also need to be linked to additional incentives to encourage and further nourish successful strategy in the implementation of family planning activities for bringing down fertility and to come-out of the vicious cycle of high fertility and high infant mortality that also contribute to entrap one in poverty. As a whole, Pakistan needs to address its development goals and meet international commitments and obligations which include: (i) achieving universal access to reproductive health (RH) and to increasing CPR by 55% by 2020; and (ii) ensuring that all health facilities cover birth spacing services, and (iii) increase budgetary resources in pursuance of Pakistan’s commitment in London Summit 2012 for FP2020.

8.2 Devolution: National Perspective and Provincial Ownership

Pakistan witnessed a major administrative development in 2010 with the unanimous and popular approval of 18th Constitutional Amendment by the Parliament. The Amendment abolished the concurrent legislative list of several functions of the federal Government and devolved the same to the Provinces with effect from July 1, 2011. By virtue of this development Population Welfare Program was transferred to provinces in Oct 2010 while the Health Programs met the same fate on June 30, 2011. As a result, both the Federal Ministries(Health and Population) were abolished and Provincial Health and Population Departments emerged as Masters and also accountable for all their service delivery outcomes with the assumption of multi-fold increase in fiscal space provided under 7th NFC Award and subsequent increase in their responsibilities. Under the 18th Amendment select functions were placed under new constitutional provisions of Federal Legislative List. Family planning is now their sole responsibility for management and regular funding, with a proviso of commitment of fixed allocation by federal government till June 2015. Similarly, with the transfer of all vertical health programs to provinces the mandate for provincial health departments for managing and financing expanded their role and scope.
The goal of devolution is to achieve improved access to quality services; greater efficiency; and improved governance at all levels. Even after the passing of 18th Amendment resolution by the parliament, there was no uncertainty about the devolution, the Federal Ministry of Population Welfare and the Ministry of Health kept asserting that their respective ministries may not be abolished. This did not come true, and as such the management at both ends (federal and provincial levels) had very little preparatory and planning work undertaken at the national and provincial level. Devolution, if carried out without adequate preparation, may render it ineffective and may not bring about the desired results (WHO: 2013). No planning could be done for the devolution of the population welfare and health functions and no guidance was provided to provincial departments to prepare for smooth process of devolution.

The 7th National Finance Commission (NFC) award was signed prior to the 18th Amendment, and could not factor in the finances relating to the ministries/divisions that were to be devolved in subsequent months. Provincial governments asserted genuinely for federal government’s continued financial support of the devolved functions till the end of the award in 2015, which was gracefully agreed to by the federal government, with particular reference to family planning as mentioned above. On the other hand, the additional resources that became available to the provinces under the 7th NFC were not visibly used for building ownership or financing priority sector like family planning to meet the requirement (particularly for essential non-salary items and contraceptive acquisition) beyond the level already committed by the Centre.

The absence of preparedness plan for provincial departments for the transition by the federal Ministries landed all provincial departments into serious difficulties especially in taking-over and managing many federal functions which were new to them. Furthermore, organizational restructuring and technical resource was needed to build their capacities to set vision and address emerging challenges. These definitely stalled their operations and impeded their performance.

The first major complaint from all provinces (including population welfare and health programs) pertained to the flow of federal funds to meet the emerging needs associated with the new responsibilities was deficient, especially for population welfare and LHW programs. Evidence shows that federal government used expenditures of 2010 to assess fund flows to provinces. The reason was that federal government had put a freeze on procurements and new recruitment and as such low expenditures were recorded relative to previous years. In the absence of provincial development plans, in most cases federal government released salaries only with serious delays. The matter was further compounded for the LHW Program, where a significant salary increase given by the Supreme Court exceeded all estimations done by the federal government based on 2010 expenditures. The non-availability of non-salary component seriously impeded program field activities especially supervision, printing of forms and registers, procurement of medicines for clients, undertaking of trainings (pre-service and in-service), transportation of contraceptives from central warehouse to districts and on to facilities by Dept. of Health, etc. Unfortunately, provincial governments did not pay much heed
to address urgent requests for funding and to support family planning programs except for the provision of bridge financing to meet the gaps in the salary components.

Prior to devolution, the Federal Ministry had clearly identified information flow requirements from all stakeholders necessary to formalize a national picture and identify operational problems that need to be coordinated for timely response. The division of various entities of the Federal Ministry of Population resulted in not lack of clarity but also confusion among stakeholders in provinces to share relevant reports and information. The issue continues to exist as the current authority at the federal level (PBS) has yet to take seriously the role of coordinating, collecting, and analyzing the data from all stakeholders.

Family planning has been a key sector of donor attention and support. The donors were somewhat concerned with the management of Federal Population Program and looked toward the devolution in order to work with the provincial governments under new arrangements. In other words, donors preferred working with devolved set up and were expecting to bring family planning under one umbrella to enhance focus and role of stakeholders. All major donors are evolving fresh strategies by focusing their work on the provinces in line with devolution. They look forward to provincial policy statements on family planning, set provincial targets to be achieved, and how they would like to bolster financing with added resource provisioned under the new NFC. The matter is stalled as all provinces are currently engaged in tackling day-to-day problems. Planning Departments are expected to engage and hold consultative meetings with the Population Welfare and Health Departments to arrive at a consensus. Legal matters of donor commitments have also to be clarified by Federal Ministries and Provincial Finance Departments.

The inclusion of population in concurrent list at federal level was based on the consideration that it is a national issue and that only a national body should formulate uniform policy, set targets to be achieved and coordinate with donors for assistance. Over the years even though program was de-federalized in early 2001 with management, planning and implementation handed over to the provincial departments, ownership was never developed, which worried federal level managers regarding the future of family planning in Pakistan. The fear came true in 2010 and the Program was considered ‘headless’ and ‘rudderless’ to achieve international commitments. There is no denial that unless family planning is uniformly accepted by all provinces and implemented, the overall objective and commitment will not be achieved. The importance of a National Commission on Population Welfare to guide, steer, coordinate, and represent the country at international forums become critical, which may be linked and associated with the Council of Common Interests (CCI) chaired by the Prime Minister and discusses inter-provincial coordination issues and takes policy level decisions. The issues of
information flow, international procurement of contraceptives, donor coordination, etc., yet needs to be addressed and may be undertaken through a professionally managed team of experts under what may be called ‘Population Coordination Unit’ and associated with EAD.

In the post-devolution period, the Health Sector Strategy work by Departments of Health in three provinces (Punjab, KP, and Sindh) categorically makes family planning outcomes important and as part of health agenda. This is definitely a first positive step for strengthening access to family planning and building ownership of such activities. The concern is close coordination with population Welfare Department and engagement with all stakeholders to make it more comprehensive for better coverage. This is a serious step and critical time to start long term planning in the context of provincial development framework (with understanding of cross-cutting influence and effect of population factor) in setting vision, goal/target, strategies and for adequate financing in the run-up period and for the forthcoming cycle of NFC Award (2015-2020) that cover full requirement for management (both salary and operational cost) and provision for contraceptive commodity.

“The process of devolution was initiated without proper planning and preparation.”
Secretary PWD

“The problem now faced after 18th amendment, is that the funds approved by Council of Common Interest are not being released accordingly.” PWD Team

Devolution has further affected implementation of FP program. Funding was the main reason for underperformance of program in past and this remained unsolved till now. - Former Director General PWD

Population Welfare remained the least priority agenda in provinces and post devolution scenario is no different, resulting into weak funding, which is barely enough to pay the salaries but not meeting operational needs. - Former Director General PWD
Unit Nine: Major Findings and Recommendations

9.1 Major Findings and Conclusions

Pakistan is facing a set of daunting challenges to meeting international commitments such as Millennium Development Goals (CPR of 55 per cent by 2015), and universal availability and access to FP services due to fast growing population. With estimated population of over 180 million and growth rate of 2.03 percent, Pakistan’s population will double in the next 36 years. This is a major cause for socio-economic under-development, an increasing burden of unemployment, poverty and adds to increasing literacy and health challenges. The ever rising population is undermining Pakistan’s opportunity to gain benefits from its ‘demographic dividend.’ Addressing this menace has been Pakistan’s focus since the 1950s, when FP was formally introduced in the National Five Year Plan (1955-1960). Nevertheless, efforts got a boost in 1990s with inclusion of a vast cadre of village-based FP workers (Population Welfare Program) and Lady Health Workers (Ministry of Health) as a community-based workforce with the active involvement of the private sector.

The surveys and reviews undertaken during this study show that the progress of programs and interventions over the last decade (2000-10) has been slow and even witnessed a meltdown given a host of stakeholders from the public and private sectors. At the same time, the devolution process through the 18th Constitutional Amendment brought a glitter of hope for renewed commitment to improving FP program effectiveness and the performance of all stakeholders, especially at provincial levels. This study is an attempt to identify major areas and systemic factors that impeded efforts whereas the country should have focused attention on the need for effective family planning/reproductive health delivery system and come up with major workable recommendations for consideration and thoughtful initiatives to carefully nurture and nourish program efforts.

This study makes it clear that insightful understanding of population issues is lacking, especially among politicians, policy makers and planners, resulting in persistent neglect of the subject. For population policy formulation, in-depth consultations with stakeholders--especially provincial governments and PWDs--were not done adequately. The program was implemented with federal funding to which the provincial governments and even PWDs remained less motivated and lacked ownership. Programme performance was badly affected due to frequent transfers and rapid turnover of staff, especially at senior management levels. In addition, non-technical or inadequately trained personnel occupying key management posts failed to steer program implementation. Moreover, there is no one at present to provide oversight and guidance in the national perspective related to population in post-18th Amendment scenario and that absence of effective central coordinating mechanism has created a vacuum.

The Ministry and Departments of Population Welfare lacked coordination with Health at all levels due to apprehension of the merger. Consequently, FP was not owned by Health and the readiness of health outlets to deliver FP services remained questionable. At the same time, the focus of the LHWs became diluted on account of over-emphasis on the EPI program. Moreover, health staff lacked adequate technical and programmatic capacities related to FP services.
Community level contact of PWDs, which was key to increasing the acceptability of FP methods during the 1990s through the VBFPWs, was lost with their merger with the LHW program. Furthermore, the provincial and district technical committees established to provide operational support took the tasks as routine and made no decisive contribution to overcome barriers or guide improvement.

The progress of the program was not monitored or supervised at higher tiers and the functional integration process failed to establish linkages and maintain interest between population and health. Monitoring and supervision tools were seldom used and no feedback mechanism was put in place. The MIS was not integrated with other stakeholders working for FP. It focused on indicators related to quantity of supplies only and did not consider processes or the outcome of services. The information collected is not seen as feedback or analysed as evidence to improve decision-making. The performance of the workforce was based on distribution of stock and by applying CYP formula which weighted in favour of sterilization. It undermined method mix that was necessary for contribution to birth spacing and intervals in births as per right and choice.

Generally, coverage and quality of the program to-date remained low, including poor physical access, which contributed significantly to unmet need. Issues related to service delivery were raised at all levels but were not adequately addressed. The FWCs shifted to and located at RHCs / BHUs, virtually proved ineffective as the assumption for relocation to fetch better clientele was defeated for want of necessary logistics support from DOH. The RHS-A centres could not deliver as expected due to weak support and collaboration with hospitals as SOPs for coordination remain undeveloped and establishing RHS-B centres in the private sector proved a wrong decision, as they resort to hypothetical reporting to claim re-imbursement of IRCs. Moreover, performance of RHS-A and B centres focussed on surgical contraception because of bias towards CYPs performance indicators.

The Ministry could not pursue public-private partnership as envisaged. NGOs could not deliver services in remote and underserved areas for lack of support by NATPOW, as it remained politicized and under the influence of the nodal ministry. The primary objective of building public-private partnership to increase coverage areas and improve services to underserved segments of the population could not be achieved.

De-federalization of the Population Program started in 2002, by virtue of which total administration and implementation was passed to the provinces, with responsibility for funding of the program remaining at the Centre. The funding flow mechanism was very complex and caused delays in financial releases and in most cases less than the allocated amount arrived, which put the program in a vicious cycle of low performance. In the post-18th Amendment period, the functioning of PWDs is still dependent on federal funding till 2015, but only staff salaries are being released. Donor contributions during the 2000s have been fluctuating and limited as their focus had shifted from FP to other health initiatives. Insufficient allocations led to supply shortages and stock-outs compounded by the limited capacity of staff in quantification and timely demand consolidation. The pricing issue couldn’t be resolved and affected the program seriously for a long time. The absence of an effective central coordinating mechanism has further created confusion about contraceptive procurement at provincial and federal levels, particularly when supplies available under the USAID-Deliver project are only
available till September 2014. This warrants government decisions for consideration and necessary allocation for timely procurement.

The support of development partners has faded overtime due to low priority being given to FP by governments. Further, the potential of PPSOs couldn’t be tapped for advocacy and service delivery due to low attention, understanding and the need for special management skill. The generous donor support that was extended to the program since its inception needs to be maintained and their interest sustained through programmatic approaches. The development partners too may like to evaluate their program and consider support in a broad framework for advocacy, technical assistance and grant assistance to fill the gap in areas of dire need.

The advocacy campaign seems to have not achieved the desired objective of convincing politicians and policy makers. Community mobilization and IPC efforts have not kept focus on rural areas. The staff lacked skill in client-centred counselling and neglected follow-up care, yet another deficiency in the programmatic approach. Awareness messages lacked appeal and did not carry conviction and power in promoting family planning. The program took on board social mobilizers, especially the Ulema through a series of orientations, but failed to follow up to garner their support. The program will have to address all the constraints and impediments and re-group resources to redouble efforts for accelerated advancement in the desired direction to achieve the objectives within a set timeframe.

9.2 Investing in Family Planning – Importance for Demographic Dividend, Women’s Rights and Health

The state of family planning in Pakistan is far from perfect, even in its attempts to meet its own sector objectives and international commitments reflected in the ICPD and MDGs. The assessment reveals that Pakistan faced a host of serious problems impeding family planning performance, including: incomplete coverage, poor and unequal access to services and poor quality of services. More attention to the following is also required: (a) contraceptive supply shortages, (b) social mobilization and (c) demand generation initiatives. These systemic problems were clearly identified in the assessment and need to be addressed urgently with sincere commitment.

Over the years Pakistan has made tremendous investment in establishing an extensive infrastructure based on community workers and facilities. Keeping in view this resource and the history of progress, Pakistan delegation made a serious commitment at London Summit meeting in July 2012 given in box below. For Pakistan, focused investment in family planning is the gateway to pave way for ‘demographic dividend.’ Meeting FP2020 commitments is a tall order but a significant step to respond to unmet need, ultimately contributing to lowering the population growth rate. Improving systems is critical to protect investments. Pakistan has tremendous opportunities to work and promote family planning to gain momentum and move fast towards achieving immediate and long-term objectives pertaining to contraception and fertility. The recommendations made herein emerge from the conclusions and major findings based on intensive interviews of key respondents, literature review and thoughtful suggestions made by stakeholders. The recommendations cover major aspects of the program including devolution, policy and planning, management, inter-departmental linkages, intra-sectoral
coordination, funding, untapped PPSO, working of NATPOW, NGOs, social marketing and role of development partners in advocacy, promotional campaigns, inter-spousal communication services delivery with adequacy of contraceptive product availability and robust monitoring, impact assessment and research back-up.

### Pakistan FP-2020 Commitments

Pakistan made the following commitments at the London Summit meeting in July 2012:

- Work toward achieving universal access to reproductive health and raising the contraceptive prevalence rate to 55% by 2020.
- Pakistan will continue its 2011 commitment with the Provinces for all public and private health facilities to offer birth spacing services.
- The amount spent on family planning, estimated at US $151 million in 2011/12 will be increased to nearly US $200 million in 2012/13, and further in future years.
- The federal government assesses the contraceptive requirement as US $186 million over the period 2013 to 2020, which will need to be provided for.
- Contraceptive services will be included in the essential service package of two provinces in 2012, with the others following in 2013. Supply chain management, training and communication campaigns will be strengthened.
- Family planning will be a priority for over 100,000 lady health workers, who cover 70% of rural areas.
- Public-private partnerships and contracting out mechanisms will help scale up access, and work with religious leaders and men to promote the benefit of birth spacing will continue.

### Need for National Leadership / Oversight and Translation of Devolution as an Opportunity to Enhance Focus on FP2020 Objectives

The devolution resulting from the 18th Constitutional Amendment created a vacuum from the national perspective as the central focal point for policy planning, coordination and implementation was shut down and made leaderless--as pointed out by an important study respondent. Uniformity and standardization for unified response to formulate policy and coordination for institutional partnership appeared lost. This is a continuing basic requirement to provide a national perspective supported by a high calibre professional setup with a background in development economics, demography, population studies, monitoring, technical/clinical expertise and management experience, duly supported with resources to meet growing need to cover salary, non-salary and constant availability of contraceptive commodity.

This is essential for national unity and oversight with role for coordination, assessment and international obligations in addition to setting national goals, overseeing resource allocation and coordinating contraceptive acquisition. Thus, there is a need for a national coordinating body or commission with equal participation of all the provinces and regions led by federal representatives with the mandate of policy and guidance, program evaluation, research, procurement and coordinating the program among the provinces. A relevant step would be to re-visit Population Policy 2010 (currently with Council of Common Interests – CCI) that was formulated through a participatory process. It may be shared with the provinces to facilitate
their work on a policy within the post-devolution context. It is relevant to advocate for the reviv
and restructuring of the National Commission for Population Welfare.

Nevertheless, the devolution provided an opportunity to the provinces to re-visit the program and consider measures to re-vitalize family planning under one umbrella with effective ownership to enhance an integrated approach which reflects vision, goal and strategy to invest collective strength in advancing the cause of Family Planning. For this purpose, an apex body similar to the center is needed at the provincial level for political support to accord priority to FP, guide, support and strengthen inter-sectoral linkages within the context of provincial development framework for implementation, periodic review and for synergy with other concerned development programs. The provincial development framework now needs to reflect population factors integrated with the development process. The provinces will have to enhance institutional capacity specifically for policy formulation, planning, implementation and monitoring; along with commodity forecasting, quantification, timely demand consolidation and submission. The pre-requisite in this regard is fund allocation by provinces to the integrated FP program on an as-needed basis.

Furthermore, the existing Provincial Steering Committees (PSC) should regularly meet to review the progress, identify gaps and direct actions to address the issues, and seek reports from district level Committees. It should meet preferably on a quarterly basis, having representation from all stakeholders including politicians / parliamentarians (who are champions of FP), P&D, PWD, DOH, DoE, Auqaf and Religious Affairs, PPSOs, Social marketing firms and NGOs/CBOs. In addition, technical committees should also be activated to deliver effectively in supporting operations in the districts and submit regular monthly performance reports to PSC. This in turn will require adequately trained and technical personnel assigned to management positions at all levels and allowed to serve for a minimum standard time period of THREE years. In the same context, District Committees headed by EDO Health should meet monthly and regularly, review the stocks of contraceptives, clientele situation, trends and facilities that can strengthen family planning service provision, number of staff needing training, number of private and corporate sector facilities needing help in providing services effectively, reviewing NGOs and private sector support to FP in the district, extent of functional integration being undertaken and finally actions needed to remove bottlenecks.

**Family Planning as a Human Right**

Who needs family planning services the most? Pakistan, by virtue of its international commitments (ICPD, MDG and FP2020), endorsed family planning as a human right. It values the rights of women by treating them as individuals and full human beings in their own right, as active agents, not as passive beneficiaries (UNFPA, 2012). As such it must be ensured that all women receive services with ease according to their choice and need. Equity has been a major issue in access to services which calls for the public sector proactively reaching out to the poorest of the poor through its infrastructure. The review strongly recommends political will for family planning, effective ownership of family planning by Health System, and strengthening accountability and governance structure for efficacious results to achieve FP2020 goals as committed by Pakistan.
Consolidation for Enhancing Access and Equity

Pakistan has a vast network of resources for family planning, which needs optimal utilization. Consolidation of family planning services is a prime requirement and a priority today. Family planning coverage and access need to be improved and streamlined to ensure full coverage for the entire target population residing in urban, rural and remote, hard-to-reach areas. The initial step is to undertake a mapping of infrastructure for service delivery already in existence. This is based on the consideration that health facility networks and community based-programs such as the LHW program, MNCH program and family planning service delivery network would all work collectively to provide FP services and also take into consideration the coverage and contribution being made by civil society and social marketing. In this regard, it is critical that Health and Population combine their strengths to prioritise the FP services by ensuring readiness and meaningful participation in service delivery. The efforts must take into consideration all the requirements for FP services as explained in the introductory section of the report.

In the post-devolution scenario, Departments of Health in all provinces hold the key to rapidly enhance FP through their network. Provision of family planning services by qualified and skilled staff must be made mandatory for all health outlets and is feasible with concerted efforts and reasonable a time-frame. What is needed urgently is the strengthening of provincial Health Sector Strategy papers aligned with enhanced family planning goals, especially FP2020 targets to be adopted by all stakeholders under provincial FP Policy. A formal emphasis needs to be given to family planning’s essential components under ‘Essential PHC Service Package’ at first level care facilities (FLCFs) and inclusion of FP commodities under essential drug/medicine lists.

This assessment categorically recommends the creation of a National Plan that integrates provincial plans to achieve FP2020 objectives. Furthermore, the Planning process (beyond PC-I), especially the operational planning that links on-the-ground realities with the objectives to be achieved needs a complete overhaul both in the Health and Population Welfare departments. The operational planning process, needs to be oriented to address ‘unmet need for contraception’ requirements with a commitment of required budgetary resources and by tackling the inconsistency between planned and required inputs to achieve the stated objectives and outcomes. Planning needs to be sector-wide for all stakeholders that closely links technical, infrastructure and commodities inputs with human resource development, monitoring and supervision and of course with financial requirements to achieve specific objectives. Intra-programme coordination and support with understanding and action is essential to progressively move forward. Provincial Health and Population Welfare Departments require operational planning as a skill and a process. Professional training on planning processes is earnestly needed to build aptitude, mind-set and experience. Such plans would also meet the requirements laid out by Finance Departments for budgetary releases and achieving short-term objectives. These plans need to be evolved at district, and provincial levels to be aggregated for a national picture. Technical assistance for a reasonable time period to provinces is critical to achieve this objective.

The provision of FP services through community-based workers is critical and needs revitalization to address unmet need and access to doorstep services. In this regard,
counselling, motivation, referral and attracting clients to visit service centres for family planning by all community-based workers including LHWs, CMWs, FWAs (Male & Female) in close coordination with other partners is important and necessary.

Making of health network (BHUs and MCH Centres) effectively operationalized under PPHI/PRSP management with additional resources needs acknowledgement and its great potential to equitable delivery of FP services, needs to be fully tapped. PPHI/PRSP needs to consider capacity building in FP services and technical supervision, provision of contraceptive supplies, integrating FP related performance, task sharing and a mechanism for regular interaction with them at all levels.

Recent efforts and developments in working out contraceptive requirements for all stakeholders is a comprehensive task taking into consideration target population size, targeted CPR, contraceptive need to achieve the same, contraceptive mix based on survey and service statistics and cost estimates based on that information. Contraceptive security needs to be budgeted and funded with the support anticipated from development partners. This important task needs to be coordinated by national oversight body for consultation and for seeking anticipated support from development partners who have an abiding interest in continuing their support for the health and well-being of the people. The support by development partner would be more forthcoming if it is based on our own initial investment. Their support in research, and capacity building through foreign trainings including short exposures to strengthen advocacy will have greater value added provided own investment is planned.

The CMWs’ role in FP should specifically be spelled out and her interaction with LHWs, CBOs, NGOs and health facilities should be explicit and implemented in true spirit which will require attention to age requirements to make them acceptable in the community as providers. CMW’s trainings, supplies, supervision and provision of services need proper review and strengthening. FWCs should continue operating and their accessibility and service delivery issues should be sorted and solved on a case-by-case basis. Health facilities and hospital resources should be used for providing FP services and public sector RHS Centres should be utilized as training centres. The role of mobile services should be reviewed and re-vitalized for coverage and outreach to identify remote areas in need instead of being completely abandoned. Special attention needs to be paid by DOH and PWD to put in place a mechanism promoting post-partum FP by focusing on efforts at the maternity wards in all major hospitals.

Active involvement of NGOs to extend awareness and service delivery to remote areas is critical. The absence of a coordinating body has been recorded as a serious impediment to its success. NATPOW could be made more effective by giving operational autonomy to ensure it functions according to its mandate and relocated to the Ministry of Interprovincial Coordination. A professional CEO, effective coordination with provinces, and a clear plan of action for its interventions in addition to easier access to resources for field initiatives are needed for NATPOW.

The Public-Private Sector Organizations initiative covers public sector organizations and private industrial concerns, private hospitals, nursing homes etc., whereas social marketing brings a separate stream of services through private healthcare providers. The vast potential to contribute yet remains untapped to the cause and objectives of family planning programs and needs to be pursued with understanding and care. A focused management team in the
provincial organization needs to review the MOUs already signed and prioritize important large organizations that have health infrastructure within their setup. Fulfilling their immediate requirements including training, essential equipment supplies, continuing contraceptive requirements and a mechanism for reporting on basic indicators and regular review are highlighted. A comprehensive plan to meet the requirements and bring them into the fold of program services is important. District support mechanism for PPSOs is seen as essential for an enabling environment.

Regular contact with social marketing and civil society needs encouragement and revival to support and strengthen their programs through periodic reviews regarding their geographical coverage, strategy and contribution, including guidelines to facilitate their operations within the provincial development framework. A Donor liaison for support and questions is an essential component of strengthening the social marketing process.

**Promoting Advocacy and Counseling**

Family planning in Pakistan has missed out in the recent past on advocacy and promotional campaigns with robust inter-personal communications as an integral element of the social change program. The importance of demand generation needs full recognition and needs to be sustained without interruption but with regular review of achievement and improvement to add fresh appealing messages. Advocacy of politicians and administrators is badly needed to gain their support for commitment, resource allocation and to back-up the cause through direction and guidance. Inter-personal communication is important for group and individual behavioural change to address their needs and respond to queries and inhibitions. This is fundamental for community-level support to increase acceptance and to increase the contraceptive prevalence rate which is central to the objective of FP2020, to which Pakistan committed in July 2012. Promotional campaigns have to be undertaken continually based on research with a target audience and supported by measures to assess outcomes and impact. Building and placing a professional management to take on advocacy challenges is critical.

**Accountability and Performance Monitoring**

The accountability of every stakeholder must be established at all levels. Policy makers, program managers, evaluators and researchers, technical directors and staff, and of course service providers must all be evaluated in the system and process on an annual basis. Accountability to commitments made towards FP2020 needs to be foremost. Furthermore, performance monitoring needs an overhaul and should be assessed against agreed essential indicators that focus on outcome and impact like behaviour change aspects, quality of service and follow-up care with a built-in system of beneficiary perspective. Regular assessment of knowledge and skill level of service providers of all stakeholders is critical to this monitoring system and should be linked with refresher trainings. In the past, supportive supervision was the area that received the least attention. Extensive supportive supervision of frontline workers, particularly Population Welfare and Health, needs to be facilitated and given a hand in doing the work effectively. The supervision and monitoring system needs a complete overhaul to replace inspection and fault-finding with support and confidence-building of workers.
The rapid assessment system needs to be introduced at all levels, especially in the district, as year-round activity supported by periodic assessment undertaken every third year. Third party validation needs to be included as an essential component of the monitoring system. Currently there is no management information system (MIS) to give a national or even provincial picture of performance. A comprehensive MIS needs to be evolved and maintained which reflect performance at district and provincial levels. Pakistan Bureau of Statistics (PBS) is currently providing a national picture of contraceptive performance and distribution, which is quite narrow in focus and needs to include process and outcome indicators for consolidation by PBS. Provinces have started seeking answers to questions at the local level that require a regular research program aimed at assessing the relationship between change in behaviour against birth spacing to facilitate evidence-based decision making. This is a great opportunity to enable linking of planning with fresh research. For a sustainable and effective system, international norms reflect 7 per cent of the budget dedicated to monitoring and evaluation.

Financial and Budgetary Efficacy

The review reveals the existence of inconsistencies between policies and strategic programmatic initiatives to address realities on-the-ground in addition to a lack of need-based financial allocations and non-salary expenditures. Programme management aspects remain critical to achieve sectoral goals. These problems will continue to undermine the achievement of population-related goals unless accountability is factored-in and rigorously pursued.

- Pakistan, though, has made major progress but requires a solid plan of action to accelerate the ‘scaling up’ process. Programmes must be aligned with local sectoral needs. The organization must deal with various components of its implementation program by closely associating the stakeholders at all levels. Disengaging from present planning and budgeting processes could involve initiating planning from the grassroots that should remain objective and unbiased by senior managers at the provincial level.
- Least productive components need to be evaluated by competent authorities and assessed for weeding out, while well-tested pilot examples like MSUs need to be supported. Causes of non-delivery also need to be identified and impediments addressed. This must be carried out through strict management review, with focus on performance indicators and must necessarily include beneficiary feedback.
- Monitoring and Accountability: field monitoring of service delivery must be taken seriously with necessary financial support and systems. Linkage between annual performance and feedback through monitoring and fund releases at all levels needs to be introduced for accountability. Moreover, supportive supervisory visits received by field workers and facilities need to be evolved together with community feedback to improve quality services.
- The allocations to the program should reflect the stated priorities of the population sector. The process of making notional allocations should be done away with. Furthermore, allocations being critical to a smooth implementation of the program, they should be made non-lapsable (in the sense that unutilized allocation in a fiscal year should be made available immediately in the following year).
Keeping the establishment costs at a minimum level, is therefore desirable, while the non-salary requirement should be provisioned as per need and protected from any cut during the fiscal year. Moreover, there is a need to undertake such exercises to keep management aware of costs added due to unproductive aspects of any programme. Reduction in management costs implies revisiting programme organization and evolving a lean management structure as a collective responsibility and pursuing the subject within a unified operational framework – an opportunity being offered by the post-devolution situation.

**Targeting Human Resource Development**

Equally important is a human resource plan needed to steer the long-term requirements of the sector. Attention is needed to evolve, review and refine human resource development plans to ensure appropriate capacity and skill development for management, service delivery and monitoring-related tasks. The RTIs should continue working according to their mandate but include health care providers for capacity building and continuous refresher in FP technology, skills and counselling. All dimensions of management aspects of FP activities including planning, monitoring, supervision, and contraceptive forecasting and logistics management need to be thoroughly revamped. Comprehensive training needs to be imparted regularly on specific and updated modules to all stakeholders. The PWTI may be re-equipped, improved and strengthened with high calibre faculty and support to achieve this objective. These training institutions should have an effective coordination mechanism with provincial departments (Population Welfare, Health and NGOs) to facilitate the needs of all the stakeholders on a continuing basis.

These recommendations should be considered thoroughly and in greater detail to convert them into a workable plan, translated into operational activity with support of adequate human resources. This is vital to advance towards achieving a balance between population and sustainable development for the better future of Pakistan. The future is today; it is essentially dependent on action taken today and sustained on the horizon of time with understanding and firm resolve.
## ANNEXURES

### Annexure-1.1: List of Identified Respondents with Status of Interviews

<table>
<thead>
<tr>
<th>Department / Designation</th>
<th>Stakeholders' name</th>
<th>Conducted (Yes/No)</th>
<th>Reason of not conducting interview</th>
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<tr>
<td><strong>Islamabad</strong></td>
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<tr>
<td><strong>Politician</strong></td>
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<tr>
<td>Parliamentarian</td>
<td>Begum Shahnaz Wazir Ali</td>
<td>No</td>
<td>Not available due to prior commitments</td>
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<tr>
<td>Parliamentarian</td>
<td>Dr. Attiya Inayatullah</td>
<td>No</td>
<td>Not available due to prior commitments</td>
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<tr>
<td><strong>Defunct MOPW</strong></td>
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<tr>
<td>Judge Shariat Court</td>
<td>Mr. Shahzado Shaikh</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Former Secretary</td>
<td>Mr. Shaukat Durrani</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Former DG Planning</td>
<td>Mr. Abdul Ghaffar Khan</td>
<td>Yes</td>
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<tr>
<td>Former DG Technical</td>
<td>Dr. Mumtaz Esker</td>
<td>Yes</td>
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<tr>
<td>Former Director Communication</td>
<td>Mr. Shahzad Ahmed</td>
<td>Yes</td>
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<tr>
<td>Former DG Program</td>
<td>Mian Muazzam Shah</td>
<td>Yes</td>
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<tr>
<td><strong>Planning and Development Division</strong></td>
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<tr>
<td>Former Chief Population Section, Planning Division</td>
<td>Mr. Amanullah Khan</td>
<td>Yes</td>
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<tr>
<td><strong>Finance Division Islamabad</strong></td>
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<tr>
<td>Joint Secretary Budget</td>
<td>Mr. Kamran Ali Afzal</td>
<td>No</td>
<td>Not available due to prior commitments</td>
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<tr>
<td><strong>MoH (defunct)</strong></td>
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<tr>
<td>National Coordinator LHW Program</td>
<td>Dr. Arshad Chandio</td>
<td>Yes</td>
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<td><strong>NATPOW Islamabad</strong></td>
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<tr>
<td>Former CEO, NATPOW</td>
<td>Mr. Iftikhar Durrani</td>
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<tr>
<td><strong>Partner/Civil Society Organizations</strong></td>
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<tr>
<td>CEO, Population Council</td>
<td>Dr. Zeba A. Sathar</td>
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<td>Did not agree for interview</td>
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<td>Director M&amp;E Pop Council</td>
<td>Dr. Arshad Mahmood</td>
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<td>Dr. Gul Rashida</td>
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<td>National Program Director, PPHI</td>
<td>Mr. Faruk Haroon</td>
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<td><strong>Greenstar Social Marketing Program</strong></td>
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<td>Resident Director Greenstar</td>
<td>Mr. Muzaffar Mahmood Qurashi</td>
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<tr>
<td>Technical Advisor, Greenstar</td>
<td>Ms. Shireen</td>
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<td>Dr. Isa Muhammad</td>
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<td>Health &amp; Population Advisor, DFID</td>
<td>Dr. Raza Zaidi</td>
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<td>Program Officer, UNFPA</td>
<td>Dr. Mobashar Malik</td>
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<td>KFW</td>
<td>Ms. Masuma Zaidi</td>
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<td>Senior Program Officer Health, WB</td>
<td>Dr. Inaam-ul-Haq</td>
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<td>USAID Deliver Project</td>
<td>Dr. Muhammad Tariq</td>
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<tr>
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<td>Mr. Anwar A Khan</td>
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<td>Dr. Muhammad Nizamuddin</td>
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<td>Mrs. Zarmina A. Hassan Khan</td>
<td>No</td>
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<tr>
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<td>Mr. Ijaz Munir</td>
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<td>Secretary</td>
<td>Mr. Altaf Ezid Khan</td>
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<td>Mr. Qaisar Saleem</td>
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<td>Dr. Attiya Maroof</td>
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<td>Dr. Bushra Amjad</td>
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<td>Dr. Asma Rana</td>
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<td>Capt (R) Arif Nadeem</td>
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<td>Dr. Nisar Ahmad Cheema</td>
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<td>Dr. Aslam Chaudhry</td>
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<td>Provincial Coordinator LHW Program</td>
<td>Dr. Akhtar Rashid Malik</td>
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<td>Dr. Tanvir Ahmed Shaiq</td>
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<td>Dr. Sabeeha Khurshid</td>
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<td>Mr. Rizwan Memon</td>
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<td>Mr. Jan Muhammad Shah</td>
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<td>Dr. Anisa / Ms. Razia</td>
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**Former PWD**
- Former PWD Director General | Mr. Akbar Bhutto  |

**Department of Health Sindh**
- Secretary | Mr. Aftab Ahmad Khatri |
- Former Secretary | Mr. Syed Hashim Raza  |
- Addl. Secretary (Dev) and Chief HSRU | Ms. Kirin Ali |
- DG Health (Hyderabad) | Dr. Feroz Memon  |
- Provincial Coordinator LHW Program Hyderabad | Dr. Saifullah Kaimkhani |
- Provincial Manager MNCH Program | Dr. Sahibjan Badar |

**Finance**
- Sindh – Secretary Finance | Mr. Arif Ahmad Khan |

**Partner/Civil Society Organizations**
- CEO-Marie Stopes Society | Dr. Mobsina Bilgrami |

**Greenstar Social Marketing Program**
- Ex-CEO, Greenstar | Dr. M. Navaid Ali |

**Central Warehouse Karachi**
- Manager CWH | Syed Ilyas Haider |

**PPHI**
- Incharge PPHI Sindh | Dr. Riaz Memon |

**Donors**
- CEO-Packard Foundation | Yasmeen S. Qazi |

**Private Companies**
- ZAFA Karachi | Manager Sale/Marketing |
- Hansel Pharma Lahore | Manager Sale/Marketing |
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<td>Mr. Ahmad Hanif Orakzai</td>
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<td>Mr. Muzaffar Ali Afridi</td>
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<td>Dr. Najma Sultana</td>
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<td>Mr. Hazarat Ali, Accounts Officer assisted by Dr. Najma Sultana</td>
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<td>RHS-A Training Centre Incharge</td>
<td>Dr. Sartaj Naeem</td>
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<td>Mr. Abdul Samad</td>
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<td>Mr. Sahibzada Saeed Ahmad</td>
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<td>Dr. Noor Qazi</td>
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Annex 1.2: References


