What's Population Policy Got to Do With It?

Fertility Change in Pakistan

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Introduction

Making the connection between the well-being of Pakistan's population and the country's resources and size, General Ayub Khan was the first leader to announce emphatically and publically in 1965 that Pakistan had a population issue that needed attention. He then assigned an important individual to the helm of the population program. This was preemptive action given that the first Pakistan census in 1961 yielded a total population size of only 30 million, and it preceded the rapid spurt in growth that occurred between 1972 and 1981. Civil society was even more advanced in its thinking, recognizing in 1958 that an active family planning program was the need of the moment. The Family Planning Association of Pakistan (FPAP) started its own voluntary non-governmental program at that time and has probably had a huge imprint on the government program operating by its side for many years. That places Pakistan as one of the earliest countries to have *a* population policy. However, it also experienced one of the latest fertility declines in Asia, and its fertility levels appear to be settling at much higher levels than most of its neighbours. Fertility transition began just before 1990, about ten years later than in most of South Asia and at least 25 years after its clearly enunciated population policy.

But is a specific population policy, in the sense of setting demographic targets from time to time, enough to change families' reproductive behavior and diffuse ideas about family size and investments in children or are other factors far more important? There has been an absence of a host of policies that support such changes- for example, investment in the social sector, especially in education and most especially in girls schooling. Even in 2010 Pakistan ranks 125 on the Human development index despite some modest gains in per capita income which rank it as a middle level income country. Even given the fact that there have always been demographic targets on paper and in Five Year Plans, no serious attention has been devoted to studying Pakistan's large population numbers, their distribution and the implications they hold for the country's development, politics and ultimate stability, beyond a handful of persons. Population issues have not had an effective champion group that leads to population receiving the importance it deserves for improving human lives, particularly health, women's status and well being, and rights. In fact, the demography of Pakistan and population policy have largely been the responsibility only of a particular ministry – the rather minor Ministry of Population Welfare -- and a handful of professionals and organizations, with virtual government denial, apart from occasional statements from state leaders on World Population Day or other similar occasions.

Pakistan remains at the centre of debate regarding population issues, with more attention outside the country than within, with institutions like Population Action International, the World Bank, the United Nations Population division and even the White House calling for greater attention (Hardee and Leahy 2008, Ohno et al 2010, Lodhi 2010). This is because Pakistan remains an important and large contributor to world population; its growth rate exceeds most countries in Asia, and it has been steadily rising in the ranks of the world's five largest populations, from 8 to 6 to 5 and possibly moving to 4 in a relatively short time! But international donor attention to the topic has largely been absent, especially in the last few decades.

The question posed in the paper is whether there is any impact of Pakistan's policy and programmatic framework on Pakistan's fertility trajectory (apart from earlier declines in mortality in the 50's and 60's)? Conversely, can we conclude that the fertility transition in Pakistan has been disconnected from any policy framework? The development of population policy is described in the first section of the paper. In the next section we draw a comparative perspective with neighboring countries and in the third section seek explanations of aspects of policy that appear to have been effective, and those that remain disconnected with fertility behavior. This paper offers some suggestions for future change in Pakistan's looming population related issues.

1. Population policy - what's in it for fertility change?

In the very beginning we should define policy to include not only demographic goals, and provision of contraceptives and family planning services, but also policies that deal with how those goals are to be met, as well as those factors that influence wanted fertility such as girls' education, employment alternatives for women, reductions in infant mortality, and overall development (Jain 1998). The following is a synopsis of the course of population policy in Pakistan.

The first push (1965-76): The ten years after the First Five Year Plan (1955-60) saw the introduction of family planning activities through the Family Planning Association of Pakistan (FPAP) and other voluntary organizations. In 1965 the Government introduced an independent family planning set-up. Visible funds and directions were introduced into the population program through mass-scale information, education and communication (IEC) activities, and a service delivery network was established. In 1970 the government introduced the "Continuous Motivation Approach" by employing male-female teams of workers at the union council level. This was considered a more vigorous approach to distribution of contraceptives; the underlying assumption was that improved 'supply' would take care of demand for family planning. In 1975 the Pakistan Fertility Survey showed a flat curve in the uptake of contraception, which remained under5 percent, similar to the levels in 1968. In all likelihood the CMS with its total focus on supply of contraceptives without any visible demand for such services was a misplaced strategy (Robinson et al 1981). Unmet need for family planning services was negligible, and this earlier period may have been better utilized for creating a demand for smaller families, for child spacing and for gathering consensus for this policy. The strategy chosen and its misplaced priorities was a reflection very much of a top down decision to curb the rapid population growth rate. Infant mortality declined in this period, but girls' education did not rise dramatically.

The lost decade (1977-88): While these problems could have been rectified and a course correction could have been made, the coup in 1977 which brought General Zia-ul-Haq into power led to a reversal of any possible ground that policy may have achieved. Over the next decade, the program operated at low key due to re-organization, political unrest and suspension of IEC activities. The Zia regime more or less put a moratorium on family planning activities. This could be considered a lost decade where both demand creation and supply of services were largely absent and efforts to promote fertility change incurred a backlash which would take more efforts to resurrect than that required in the beginning of the program. Right-wing religious parties saw a rise in their popularity and Zia's own conservative views gave rise to the perception of conflict between family planning and religion.

Furthermore, negative attitudes towards women combined with low investment in the social sector, creating a huge swamp of factors dragging down any changes in attitudes and behaviors leading to fertility change. The Pakistan Contraceptive Prevalence Survey of 1984 reflected this downfall in gains made earlier, finding only 9 percent of women to be using family planning services. This was the decade

that set back Pakistan most visibly; having to restart a movement for change after this reversal was more difficult than starting anew. Further, any efforts at promoting fertility change were left with the stigma of religious disapproval. IMR and female literacy continued their gradual improvement.

The decade of success (1989-98). However, this was followed by a new beginning. With the election of Benazir Bhutto in 1988, the population program saw strong political support from the highest levels. Major achievements during this time included devolution to the provinces of field activities, institutionalization of the role of non-governmental organizations through the NGO Coordination Council (NGOCC) and the establishment of the National Institute of Population Studies (NIPS). Social marketing was introduced.

In 1993 the Government announced a policy to provide special attention and funding for the social sector through its Social Action Program. This was a policy response, largely donor induced, to correct course for Pakistan's lagging social indicators. Improvements were seen in these indicators but with some lag. Meanwhile, the International Conference on Population and Development in 1994 and its preparation seemed to mark some stir within the population arena. At that conference Ms. Bhutto made her important statement, *"I dream of a Pakistan, of an Asia, of a World, where every pregnancy is planned and every child is nurtured, loved, educated, and supported,"* leading to the initiative of the Lady Health Workers (LHW) program. This was a huge public-sector program mandated to provide family planning and primary health care outreach to 40,000 (later 100,000) communities, in remote rural areas and in urban slums. The National Trust for Volunteer Organizations, a successor to the similar NGOCC, was set up. The ICPD with its "beyond family planning" agenda, began to attract two significant groups into the gamut of actors concerned with population policy, health and women's organizations.

> *The ICPD gave you ways of reaching men and women in a broader, more development-oriented way, and, therefore, made family planning more acceptable. From an NGO perspective, women's rights activists started looking at contraception as a right. ICPD provided ways of looking at the availability of contraception within the larger issues of women's space and mobility.*
>
> Advisor, Shirkat Gah (Women's Rights Organization).

These ingredients, which included broadening efforts to incorporate women's issues, increasing efforts to invest in human development, addressing maternal and child health in rural areas, and diffusing responsibility of policy beyond the Ministry of Population welfare, augured well for a successful policy environment. Initial results were encouraging. The 1997-98 Pakistan Fertility and Family Planning Survey showed a doubling of the contraceptive prevalence rate from 12 percent in 1991. Changes in reproductive behavior were visible in rural areas, with prevalence rising to 19 percent in rural areas and to 36.5 percent in urban areas. Fertility decline was on a fast track, moving from 6.1 in 1991 to 4.8 in seven years. Feeney and Alam called this quick catch up the "fastest decline in Asia" (Feeney and Alam 2003). This was a period when services, institutional responsiveness to family planning needs, and a democratic government with fair commitment from both major parties came together to produce results for the population sector. Clearly the demand for family planning had been created and the improvement of services, especially in the rural areas, led to a surge in contraceptive prevalence. However, there was little change in mortality or female literacy.

Post-ICPD policy, little result (1999-2007): Things appeared to be well placed for rapid improvement when the formulation of a new Population Policy was initiated in 1998. The process that led to formulation of the Population Policy which was finally passed by the Cabinet in 2002 set a long-term vision for the population sector. There was every expectation that this rate of contraceptive uptake would continue and it was plausibly predicted that Pakistan would reach replacement fertility by 2020. While reducing population growth rates remained the primary concern of the Government of Pakistan, and was part of the Population Policy 2002, there was greater emphasis on rights and providing accessible and better-quality services to meet the needs of individuals. Furthermore, the need to collaborate with other public institutions on the part of the Ministry of Population Welfare, and with the private sector and NGOs, now appeared in all government documents and plans. The Population policy appeared to broaden scope and partnerships to achieve its goals. After the restricted statements of earlier plans, Pakistan finally had a policy that followed ICPD principles and extended beyond family planning.

There were, however, limitations. A policy announced in 2001 to transfer all family planning service responsibility to MOH was successfully resisted by MOPW, with the support of much of the population community. Also, once again broader development issues, including girls' education and status of women, were not included in population policy beyond general encouragement that such things should be attended to.

By 2006-07, the Pakistan Demographic and Health Survey and other sources provided some results. There had been significant if not dramatic improvements in health and education indicators, along with other development data. However, for fertility and especially family planning, the news was disappointing. At 4.1, the TFR was continuing to decline, but at a reduced pace. And contraceptive prevalence, having reached a peak in 2003 at 32 percent, had leveled off at 30 percent. Unmet need remained high, and desired family size showed little change.

Why was there so little progress? In part, there was a failure of implementation. The issue of how exactly services would be extended to meet the rise in demand and the gap in provision as seen in high unmet need was not closely followed through in any plan. Very little attention was given to details of coordination between the two main line ministries of health and population welfare, or with their respective provincial departments that are mandated to deliver services, or with the health system and lady health workers. The Policy emphasized intersectoral coordination, but hardly any was visible with education, youth, social welfare or women's development. The Lady Health Workers (currently employing close to 100,000 women with basic education) were found to be very effective in delivering

family planning services in 2001, but were found in the 2009 third party evaluation to be faltering in providing these services because of the overload on them for other duties, especially polio vaccines (OPM 2009).

Amidst the disappointment of lagging contraceptive prevalence and slower fertility decline, there was some surge of interest in population issues with the discovery of the possibility of the demographic dividend coming to Pakistan. The potential for this was laid out in the Vision 2030 document of the Planning Commission, which led to the Pakistan Development Forum 2007 declaring its theme as "reaping the demographic dividend". While signaling declining dependency ratios as an opportunity to reap economic benefits, demographers clearly pointed out the need to invest in a more rapid fertility decline, and in education and employment opportunities especially for youth (Sathar et al, 2007). Unfortunately, the good news was accepted in most circles without the accompanying provisos, so there was little understanding of what was required to reap the dividend. Nevertheless, the opportunity provided an occasion to focus on population issues more broadly as they relate to the economy, and across sectors especially education, youth and employment, providing some renewed focus. Political and economic events since 2007 have prevented continuation of this discussion of population as a development issue which began to stir interest in the Planning Commission and the Ministry of Finance.

The time of reckoning (2008-): As policy makers began to consider adjustments to these sobering realities, Pakistan was beset with a series of severe shocks. The effects of the world economic crisis of 2008-09, the disastrous floods of 2010, and the security situation related to resurgent terrorism severely restricted attention and budgets. Meanwhile, in March 2010 the Government passed the 18th Amendment to the Constitution, giving provinces full responsibility for many topics including population, health, education, and women's issues, and abolishing the relevant Federal ministries outright. The implementation of this measure is currently being worked out, but it clearly will require new approaches, concentrated at the provincial level, to providing social services of all types. National policies for population, health, and education, among other topics, will have greatly reduced salience beyond broad statements of intent.

Present status of major population and related indicators. Before going on to more detailed analysis, it is worth summing up what has happened. Since 1965, Pakistan has had a clearly stated policy of intent to reduce population growth through voluntary family planning (except for a hiatus during 1977-88). Initially that policy was narrowly focused on direct efforts to increase contraceptive prevalence and reduce fertility. Over time, especially after the 1994 ICPD, population policy became more focused on meeting the rights and needs of individuals. Throughout, primary responsibility for both implementation and the adjustment of policy itself were vested in the Ministry of Population Welfare, which had modest implementation capability and little influence on topics beyond family planning. Implementation was largely left in the hands of MOPW itself, and a relatively small group of supporting partners from among NGOs and scholars.

Some summary results are shown in Table 1. Most indicators have shown a slow but fairly consistent improvement over time, with improvements gaining pace over the last two decades (except for the plateau in CPR in recent years). Fertility is somewhat different: it remained consistently high until around 1990, when it began a rapid decline which has continued, although recently at somewhat reduced pace, to the present. But even that more impressive trend may have less significance in relation to population policy than it may appear. Casterline (2010) decomposes the influence of changes in wanted fertility, unwanted fertility and marriage composition. The conclusion of his analysis was that changes in marriage composition had the greatest influence on fertility in Pakistan in the period 1975-

2006, followed by changes in unwanted fertility and last of all by changes in wanted fertility. Whatever factors were responsible for the change at age at marriage had little to do with population policy.

Table 1: Selected population-related indicators for Pakistan, 1975-2007

Survey/Year	TFR	CPR	IMR	Literacy (MWRA)	GDP Per Capita (Current US $)**
1975- Pakistan Fertility Survey	6.3	55	--	11*	160 (1975)
1984- Contraceptive Prevalence Survey	6.0	9	106	14	338 (1984)
1990-91 Pakistan Demographic & Health Survey	5.8	12	91	21*	410 (1991)
1996-97 PFFPS	5.4	24	92	24	486 (1997)
2000-01 PRHFPS	4.8	28	--	--	551 (2001)
2003 SWRHFPS	4.4	32	--	28	561 (2003)
2006-07 Pakistan Demographic & Health Survey	4.1	30	78	35	881 (2007)

*Women with no schooling, **Source, The World Bank

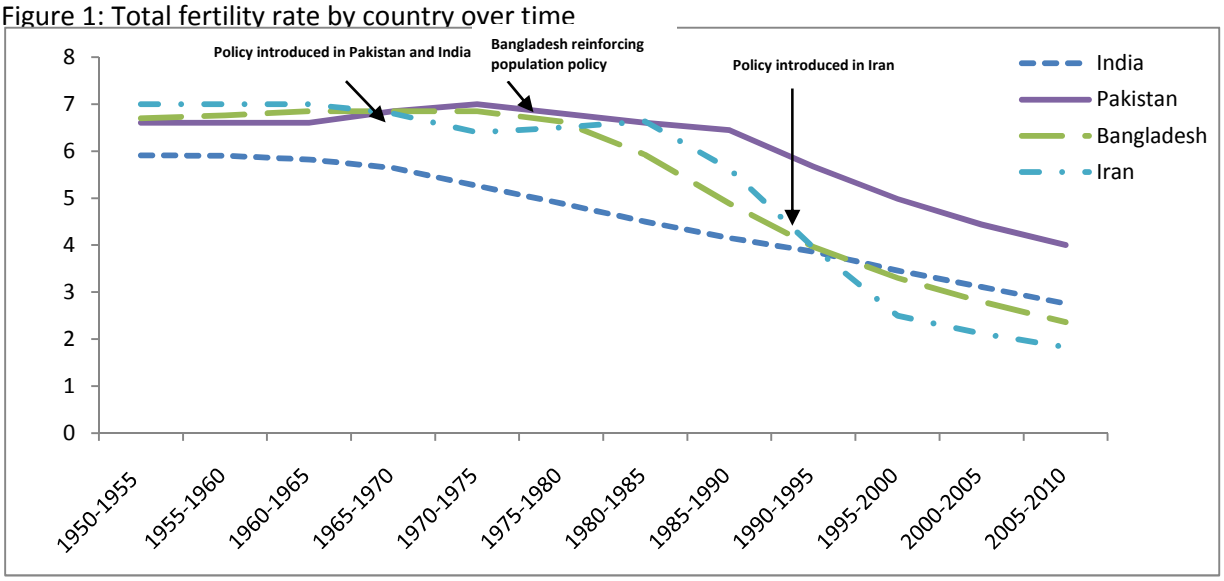
The question then remains, what effect has population policy had on these rather modest results, and what alternatives may have produced better results?

2. Pakistan - and its neighbours – a different scorecard?

It is interesting at this point to step out and assess the role of policy in Pakistan, against the experience of neighbouring countries. Instructive contrasts can be found in the histories of policy and change in neighboring countries, particularly Bangladesh, Iran and India. Pakistan was the last among all its neighbors to experience fertility decline and continues to have the highest rates. At the time of its inception, Pakistan's total fertility rate (TFR) of 6.6 births per woman fell between India's TFR of 5.9 and Iran's TFR of 7 births per woman, and was the same as Bangladesh's TFR (Figure 1).

Currently, Pakistan's TFR remains more than one birth higher than India's and Bangladesh's TFRs and around two births higher than Iran's, which has reached replacement level despite starting just as late as Pakistan . All countries in the region experienced high fertility until the late 1960s, at which point India's fertility levels started a gradual but consistent decline. Bangladesh, with heavy investments in family planning programs, was the next to follow with the fertility rate beginning to decline rapidly by the early 1980s. Even Iran stepped up its family planning efforts by the late 1980s and started experiencing a very rapid decline in its fertility rate reaching replacement in a remarkable period of barely 15 years.

Figure 1: Total fertility rate by country over time



Bangladesh offers a particularly tantalizing comparison since it was a part of Pakistan, with the same policies up until 1971. In fact much has been written about the comparative experience of the two countries (Cleland and Lush 1997, Caldwell et al, 1999, Kabeer 2009). In essence, while politically joined but geographically separated, the two countries had many differences in terms of ethnic mix, population densities, marriage patterns, land holding patterns. Reducing their different fates to mere differences in similar population policy but different implementation amounts to viewing major shifts in human behavior through a narrow lens. An important difference between the two countries was that the newly formed Bangladesh had a chance to view its resources in line with population size and recognized much more clearly and categorically that it had an issue of unsustainable population growth and went about dealing with it as a national priority. Pakistan in 1971 was in a different position having lost half the country; it did have at that point more resources, and other concerns such as a population fragmented across four provinces and multiple ethnicities.

It is important to point out that Bangladesh supported several other policies which strongly propped up population policy. Among the most important were the stronger economic role created for women and young girls and the priority given to providing primary education and onwards. Other important factors were the vigorous family planning program delivered through the Ministry of Health and Family Welfare to the doorstep (announced as a priority by the president) the neutralization of the religious groups, and the involvement of the women's groups. All these were important ingredients for policy impact and success. A rapid fertility decline was underway in Bangladesh by 1980, a decade in advance of Pakistan.

Perhaps even more intriguing is Iran, a seemingly conservative country where Ayatollah Khomeini announced a population policy only as late as in 1992, but which has found routes to achieve fertility reduction much more rapidly than Pakistan. Population policy in all practical terms followed a fertility decline in the case of Iran; perhaps the policy was a mere means to endorse behavior that had already started to take root. In fact the story of Iran's family planning program (UNFPA 2010) is an ideal one stating how various groups converged. Planners, economists, health specialists, etc., joined to create consensus on the issue, taking the powerful clergy on board slowly and surely. Was this just to ensure no obstacles being imposed, an endorsement sought and services made widely available? In any case, in Iran as in Bangladesh a policy supporting family planning was accompanied by supportive policies such as education of women, an excellent rural health system with neighborhood health houses, and

religious orientation counseling pre-marriage. This constellation of policies led to the very rapid decline shown in Figure 1.

Another interesting comparison is neighboring India, where the family planning program was instituted about the same time as in Pakistan. The demographic response in separate Indian states to supposedly the same program but implemented differently, was quite a stark contrast. States in the South such as Kerala, Tamil Nadu and Karnataka have reached replacement fertility levels, while states in the North such as Uttar Pradesh, Bihar, Madhya Pradesh and Rajastan have levels of fertility almost resembling Pakistan.

India is in some ways similar to Pakistan with multiple ethnic groupings, geographical expanse and heterogeneity in caste, economic and social terms. But the Northern states with slow fertility declines are also states with poor records in terms of educational attainment, weak status of women, poor health outcomes etc. Rates of fertility decline in the North are not seen to be very different to Pakistan. The lack of attention and progress in the accompanying factors may be a major factor for the weak policy impact, a mere symptom of weak commitment to social progress and thereby reduced impetus for changes in family reproductive behavior. In fact it is the Southern states, also economically poor but egalitarian and committed to social sector progress, that are reflected in the onset of India's fertility decline in the 1980's (Jain 2008). Politics and policy are just not enough. Development and literacy are important factors, and yet cultural differences between south and north India and resemblances of the latter with Pakistan seem to make an argument for factors beyond population policies driving the process of transformation from a high fertility to a low fertility regime.

In the regional comparison certain issues emerge as very important. The key elements of success in achieving fertility change according to this brief comparison appear to be the following:

- A large base of support for promoting the policy and seeking broad popular and religious endorsement
- Good quality, extensive health infrastructure for delivery of family planning services and outreach
- Improvements in women's status, such as promotion of female education and employment opportunities.

3. Unraveling the disconnect – where has policy worked and where has it not?

Based on the three criteria that appear to have supported the success of its neighbors, we can now look at Pakistan's population policy to see whether and how population policy might have contributed to Pakistan's long delay in bringing about sustained fertility decline.

a) Broad base of support for the policy.

With the exception of the period of Zia-ul-Haq in 1977-88, Pakistan has articulated a policy of reducing population growth through voluntary family planning, generally accompanied by forceful statements of the dire consequences to be visited upon Pakistan in the event of continued rapid population growth. The first question is, was that policy widely accepted?

In reality, for the most part concern with population policy was and remains limited to a few population ministry officials, researchers, academics and a handful of voices in civil society. Responsibility for periodic review of the policy was delegated to the Ministry of Population Welfare, which generally spoke

for itself and this relatively small population community. In these resulting policies, the other two main criteria for success –a strong health infrastructure and enhanced women's status – were given little more than lip service. Hence population policies prepared by MOPW and focused on this narrow base were periodically forwarded to the cabinet and duly approved, without troubling economic planners or requiring major changes in health or education, and things continued largely as before, with minor adjustments to suit the fashions of the day.

There have been no real champions that have gone about creating consensus on population issues. Politicians may understandably find population issues contentious and sensitive for religious reasons or for reasons to do with national awards for resources. More surprisingly economists and planners have been guilty of neglect of this important parameter, a neglect that is here to haunt them now and certainly will haunt them even more a few decades down the line. While from the Third Plan onwards there was mention of population growth impinging on resources, but the implications for economic and social sector policy were largely ignored.

Historically, NGOs have played a pioneering role in establishing family planning in Pakistan and in setting the reproductive health agenda. NGOs provided important clinical services, behavior change communication and community mobilization, research, and other inputs. Moreover, they have become increasingly vocal advocates for linking family planning and health, and for improved education and status for women. However, the NGO sector has had little direct influence on policy at high levels, so its influence has been largely through the limited channel of MOPW.

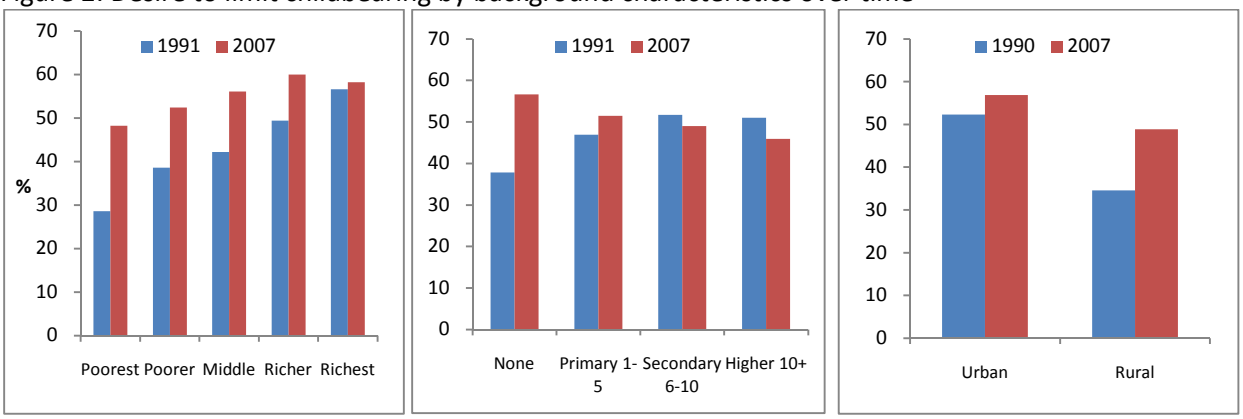
An important requirement for a successful population policy is the support, or at least lack of active opposition, of religious establishments. As we have seen, Bangladesh has effectively neutralized religious concerns, and Iran has strikingly gained the support of the religious establishment at the highest level. (In India, religious opposition has never been a major concern.) In Pakistan, despite many attempts, there remains substantial hostility to family planning from Islamic leaders, partly for reasons discussed below.

Donors have usually applied pressure in Pakistan to institute change in many areas. However, their support for family planning programs has fluctuated. International population movements and politics have definitely affected the twists and turns of Pakistan's policies. The real landmark was the ICPD 1994 when the best possible balance was sought between population and development laying out all its possible dimensions. Ironically, this took its biggest toll on family planning programs. Instead of having the impact of penetrating and permeating to all aspects of development, ranging from education, women's development, environment and health to mention a few, the main message of the ICPD was the evolution of the term reproductive health (RH) a holistic concept encompassing many aspects of family planning and safe motherhood, gender-based violence, etc. Responsibility for implementation cut across many ministries, NGOs and partners. The large and diffuse set of programs to be implemented led to a substantial dilution of attention and resources away from population and family planning, without effectively creating a health basis for family planning, or significantly improving women's status. In particular, the AIDs epidemic caught attention and international funding for HIV/AIDs increased several fold, at the expense of family planning. At the same time, the outreach structure of MOH became heavily preoccupied with polio eradication, to the detriment of family planning as well as other community-level health services. All this may change, with very recent turnaround in international rethinking about the priority for family planning. But until now, while donors have been broadly part of the support for population policy, their support has not been consistently focused on creating and supporting the policies that have been effective elsewhere.

To gain the support of the population, advocacy and communication strategies have long been part of the MOPW's agenda. Those strategies have largely been based on the idea of limiting family size. To elites, the benefits to the nation of lower population growth were stressed; to ordinary people, it boiled down to a "small family happy family" message. This was successful to the extent that for decades, more than 90 percent of Pakistanis have known about family planning. At the same time, it has caused a religious backlash, through the perception of family planning as a means of population control (which is perceived as against Islam) instead of as a means to improve maternal and child health (which Islam unequivocally supports). It has missed an opportunity to convince health officials and providers that family planning is an essential part of health care. And for elites, themselves often raised in successful large families, it has sometimes fuelled the perception that family planning is related to an outside agenda that has little to do with Pakistan.

Thus, universal awareness of family planning has not translated into high levels of use. However, whether directly a result of official advocacy and mobilization or an indirect effect of ideational change, the concept of limiting childbearing has permeated widely and is now apparent even in rural Pakistan and among the uneducated and across income groups. Figure 2 shows that the demand for family planning, as represented by the percentage of women wanting no more children, rose more dramatically for women from the poorest quintile. In fact, the figure that shows the proportion wanting to limit childbearing has almost converged at a level of around 50 percent or more for all wealth quintiles unlike the earlier period where it bore a sharp positive association with wealth.

Figure 2: Desire to limit childbearing by background characteristics over time



Nevertheless, levels of family planning use have remained disappointing. In part, this is because the strategy has targeted women but has not effectively convinced any of the groups influential in making decisions or been able to garner support for the policy publically. While women are the main beneficiaries, they certainly do not make decisions and were probably already prepared to be convinced of benefits of family planning; their main problem has been the absence of support for their desires within families – notably from their husbands -- and also in society. The most powerless were targeted while the most powerful remain unconvinced.

An alternative strategy that might have had more success in obtaining broad support for the program could have been to present family planning essentially as a health issue for mothers and children. A repositioning of family planning of birth spacing is a convincing strategy both from the point of view of health benefits of child and mother survival and also due to greater compatibility with and acceptability with religious values. Such a repositioning is underway; initial results seem to be strongly positive both within the public health community and in terms of the reception within families and communities.

However, whether it will be effective in gaining high-level political and budgetary support remains to be seen.

b) A strong health base for family planning services.

Unlike its more successful neighbors, Pakistan has not effectively placed family planning into the service structures of the Ministry of Health. The primary exception has been the Lady Health Worker program, but as we have seen, this has had limited success in supporting family planning. In part, this is because the LHW program is at the periphery of a ministry that is otherwise largely uninvolved in family planning.

Why is this so? For many years, MOH has, on paper, included family planning in its mandate, but that policy has not been translated into service delivery. To a considerable extent, this has been because of a long-running turf battle with the Ministry of Population Welfare. The MOPW consistently resisted giving major family planning service responsibility to the Ministry of Health, on the grounds that MOH could not be trusted to take its responsibility seriously. As long as responsibility lay with MOPW, MOH was unwilling to become involved. The result was that MOH, with a far stronger service structure than MOPW, was not available to the public as a source of family planning information and services. Moreover, getting across the point that family planning is good for health has remained difficult as long as the body responsible for the public's health was not supporting the concept within its primary health care system.

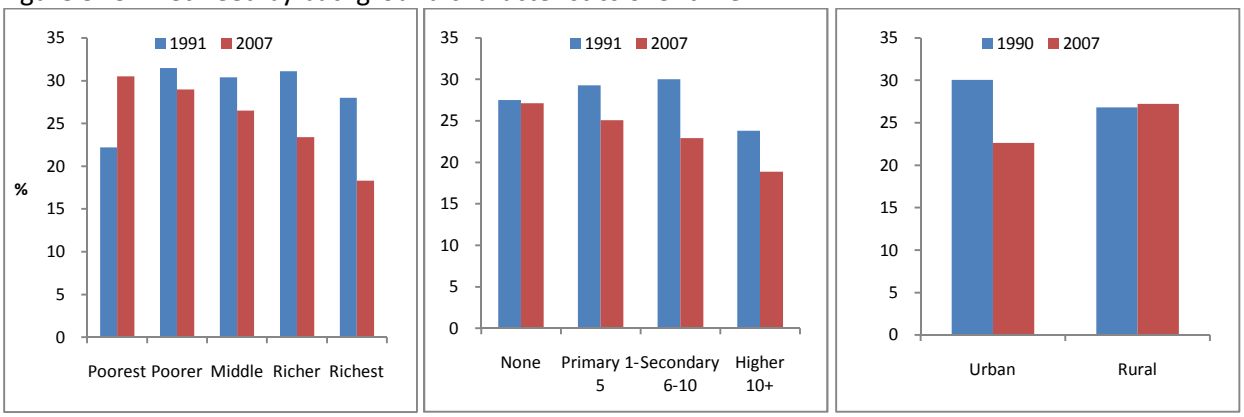
To understand why this failure is so important, it is necessary to look in more detail at the structure of demand in Pakistan. What is striking about the recent few years is the recognition and realization that family planning services have not kept pace with the increased demand. The high unmet need for family planning services, the high levels of unwanted fertility and the large number of induced abortions to avoid having and rearing an unwanted child are reflection of this reality. These outcomes are largely a result of women, couples and families not having easy, accessible and affordable alternatives to prevent unwanted pregnancies, such as good quality information and services. The stagnation of the contraceptive prevalence rate at 30 percent is a testimony to that fact and that there is a disconnect between demand and utilization of family planning services. More than one out of three women want to space or limit and are not using contraception. Furthermore on average, out of a fertility rate of 4, one child on average in unwanted.

Unmet need – the percentage of currently married women who are fecund and do not want to be pregnant yet are not using contraception – increased from 33 percent in the PRHFPS 2000-01 to 37 percent in the PDHS 2006-07. Unmet need in rural areas, which was initially lower, is now more than urban unmet need, suggesting that the availability and affordability of family planning services is an obstacle to fertility change, more so in rural Pakistan. In line with these findings is the trend in unplanned childbearing (the combination of unwanted births and mistimed births): the proportion of recent births that are unplanned rose from 21 percent in 1990-91 to 24 percent in 2006-07. In the case of Pakistan, one of the major failures is really the inability to deliver quality services, especially in the rural areas, beyond those provided by lady health workers. The Ministry of Health, which has the larger public service delivery network with around 14,000 outlets has not prioritized family planning. This is likely to change as a result of a recent commitment by the Ministry of Health to put family planning squarely as a priority in primary health care. Until now, however, the Ministry of Health static outlets were unable to fully deliver family planning services. This in brief was due to the refusal of health sector to take responsibility for family planning, prioritizing other services immunization, HIV AIDs and maternal health but not seeing its strong connection with family planning. A major factor was because

population welfare had the main responsibility for family planning, including controlling contraceptive supply chains.

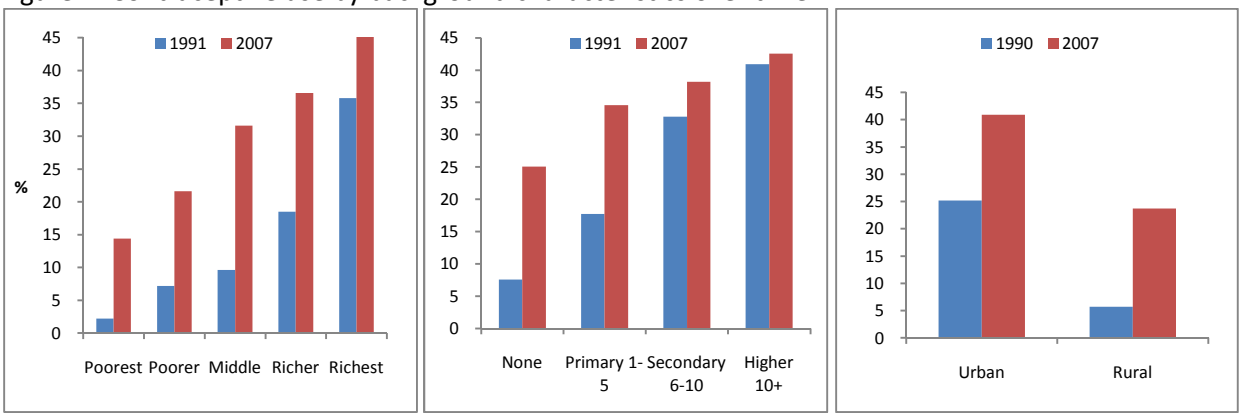
The relationship of unmet need with other background characteristics has also changed over time. In 1991, women from the poorest households had the lowest unmet need; over time unmet need among these women rose substantially, and they now have the highest unmet need (Population Council 2009). The change in the relationship between unmet need and wealth can be understood by looking at the changes in the relationship between preferences and contraception and wealth (Figure 4).

Figure 3: Unmet need by background characteristics over time



This is in contrast to differentials in contraceptive use that appear to be almost as sharp across rich and poor women as they were in the earlier period. Current use differentials (in absolute terms) between the poorest and richest women were 34 percent in the earlier period and 32 percent in 2007, indicating a negligible leveling of contraceptive use, unlike the dramatic leveling seen in fertility preferences.

Figure 4: Contraceptive use by background characteristics over time



Ultimately, this explains the sharp increase in unmet need, a combined outcome of preferences and use, experienced by poor women who increased their demand to limit childbearing without much change in contraceptive use. By contrast, there was a sharp fall in unmet need on the part of rich women, who increased their contraceptive use in conjunction with their demand for it (Population Council 2009).

Unmet need for contraception and the proportion of births that are unplanned, along with the high rate of abortion, suggest that a large fraction of currently married women in Pakistan are at risk of an unwanted pregnancy and potentially an unsafe abortion. Despite the fact that induced abortions are illegal in Pakistan except when performed to save women's lives, a study carried out by Population Council estimated 890,000 induced abortions a year for 2002 and an abortion rate of 29 per 1000 women aged 15-49 (Population Council 2004). The abortion rate is most likely an underestimate of the true abortion rate despite being moderately high by world standards. A majority of such abortions are taking place among poor, married women with more than three children. Results yielded an unwanted pregnancy rate of 77 per 1000 women, almost two-fifths of all pregnancies. Abortions in turn accounted for almost two-fifths of these unwanted pregnancies. So abortions are a clear response to the desire to limit and space births, but clearly operating outside of the population policy framework. (While post abortion care is considered a priority since 1994, as an essential part of RH, the provision of abortion is clearly outside publically supported services.)

Thus, by all measures there is substantial demand for family planning throughout the population. In addition to the public sector, increasingly the private sector through social marketing is taking on responsibility of dispensing, advertising and training in reproductive health, and is playing a very vital role in providing FP /RH services in the country. The Population Policy and the interim Population Sector Perspective Plan 2012 envisage an expanded role of social marketing in the pursuit of attaining population stabilization goal by increasing contraceptive use prevalence. Social marketing was expected to intensify its efforts to extend to the peri-urban areas and extend its outreach to rural areas. It was to broaden the scope of services through new interventions in order to enhance the contribution of social marketing to the national population goal. However, social marketing too has yet to fulfill its full role in expanding service delivery coverage especially beyond urban areas.

In sum, Pakistan's policy of vesting primary responsibility for family planning services in the Ministry of Population Welfare has led to a failure to establish a strong base for those services in the public health system. Partly as a result, for about two decades Pakistan has had one of the highest levels of unmet need for family planning in the world, and a golden opportunity both to meet the needs of the nation's people and to bring down its population growth rate has been squandered.

C. Improved women's status

While it is essential that Pakistan do a better job of meeting existing demand for family planning, it is evident from the data that desired family size is inconsistent with completing the demographic transition in Pakistan. The ideal family size in Pakistan has hardly changed. Meeting unmet need can bring the TFR down to somewhat below 4, but further progress will be more difficult because Pakistanis, on average, prefer over 3 children. This is unlikely to change unless there is a real transformation of society.

Clearly, many factors affect desired family size. Some are basically ideational, a self-reinforcing change in societal taste as the vision of a good life evolves. Perhaps more fundamentally, desired family size is a broad function of development in many areas, including income, education, health, etc. Even within the broad topic of development, however, there is much evidence that a central place in determining desired fertility is reserved for enhancing women's education and status. In studies in Pakistan as throughout the world, the primary social determinant of a variety of variables involving fertility and fertility preference is women's education. At the societal level, status of women – notably, but by no

means exclusively, participation in the labor force – is powerfully related to fertility. We have seen that for Pakistan's neighbors, improvements in women's education and status have been key factors in their success in reducing fertility. Bangladesh, and Iran especially, have an excellent record in making gains in female education. Iran, which has reached close to replacement fertility, has much greater proportions than Pakistan in higher secondary education and in high levels of female employment despite its conservative society in terms of hijab. The comparison between North and South India also reinforces the stark differences in investments in female education and the much lower status of women in the former (Janin 2008).

It was pointed out in the early 80's by the economist Lawrence Summers, in an address at the Pakistan Institute of Development Economics, that Pakistan had to invest in *all* of its people, not just some people, especially singling out the draw-down effects of under-investing in female education in particular (Summers 1992). In the subsequent decades, Pakistan made the recognition in the 90's that female education was lagging behind and some efforts were made to escalate enrollment through the Social Action Program. Education levels have improved in Pakistan, notably in the early years of the past decade, and improvements have been somewhat more rapid for girls than for boys. For example, net primary enrollment for boys has risen from 49 percent from1990-99 to 55 percent in 2000-2009, and for girls from 38 to 47 percent. The proportion of literate married women of reproductive age (a lagging indicator of education, since it reflects schooling levels in previous decades) has gone from 21 percent in 1990-90 to 35 percent in 2006-07. However, by comparison with Pakistan's neighbors, those changes are modest (see table 2).

Table 2: Literacy rates for married women of reproductive age for Pakistan, India, Bangladesh and Iran

Country	**Age Group**	**Female Literacy Rate %**
Pakistan	15-49 yrs	45.9
India	15-49 yrs	55
Bangladesh	15-49 yrs	55
Iran	15 + yrs*	77.2*

Sources:

1. Pakistan: PSLM 2008-9
2. India: National Family Health Survey 3 (2005-06)
3. Bangladesh: Bangladesh Demographic and Health Survey (2007)
4. Iran: United Nations Educational, Scientific, and Cultural Organization (UNESCO) Institute for Statistics (2006)

*Adult female literacy

Similarly, the participation of Pakistan's women in public space has made only modest progress, a fact somewhat obscured by the prominence of a small number of upper-class women. Female labor force participation rates have slowly inched up to 20 percent in 2009, a meager rise from 11 percent in 1991. Furthermore, labor force participation remain limited largely to uneducated or highly educated women. By comparison, the effect of the large volume of female employment in Bangladesh's garment workers has been well studied.

These results are clearly functions of policy, especially on the education side. As with population generally, a broadly articulated policy of education for all is important but not adequate. It must be supplemented with more specific implementation policies, and reified through budget allocations. Instead, Pakistan's education authorities have plodded on, building a certain number of schools and training a certain number of teachers each year with the budgets they are given. Plans are not in place to ensure, for example, universal primary education for all by a date certain. Budget allocations for education as a proportion of the budget have hardly changed ranging from 1 to 2 percent, not changes conducive to major achievement. Granted, increasing education for girls is not a population policy per se; but we would argue that a policy of reducing population growth is incomplete without an accompanying policy of universal education for girls.

Female participation in public space is perhaps less obviously a function of policy, in a free-market economy and a traditional social structure. In particular female mobility remains restricted in Pakistan in comparison with many countries and restrains women and girls from activities outside the home. Nevertheless, policies can help prepare women for labor force participation, can encourage gender equity in public sector hiring, can support economic sectors that require female participation, and can protect women who dare to venture into the labor market. Pakistan, while a signatory to various conventions on the status of women, has been limited in taking policy steps to make those commitments a reality.

4. Conclusions

In conclusion, Pakistan's population policy, per se may have been misplaced in its priorities though not altogether deficient in design. Creating demand for smaller family size, extending supply of services and emphasizing demographic targets for development may have been the ingredients of a successful approach if concomitant efforts had been made in these four decades to harness support for these measures, and if the policy had been broadened to address some broader issues. First, it is clear that the responsibility for and therefore support for the policy was restricted to a Ministry of Population Welfare that did not succeed either in forging productive partnerships, or in doing the job itself. The most glaring disconnect even today is that most educated Pakistanis, economists, planners and politicians remain unaware of how important the achievement of fertility transition is for Pakistan's development and how important family planning services are for achieving improvement in women and children's health. The base of support for the policy supporting fertility transition remained just too narrow and did not include women's groups, economists, and even donors, and consequently led to limited impact.

Secondly, the health sector, perhaps as a consequence, did not accept its responsibility in including family planning into its priorities, in the same vein as it did maternal mortality and child mortality reduction. The link between contraceptive use and improved maternal and child indicators was not capitalized on. The only exceptions are the Lady Health Workers whose extensive outreach in the rural areas has contributed to raising prevalence levels in those areas. Even today, the outlets of the health department are probably insufficient to extend services to most Pakistani women; the private sector will have to supplement the public sector, but the active contribution of the Health Departments would increase services in the public sector manifold.

Thirdly, and perhaps most importantly, there were few effective efforts or policies for improving the status of women. If indeed there had been dramatic improvements in female education, or in their economic participation, then the first two weaknesses of policy may have been mitigated as women themselves would have wanted fewer births and found the ways to achieve their reproductive

intentions. While Pakistan may have lost time in terms of the speed of its fertility transition, efforts in improving the gender indicators alongside the expansion of family planning services by the health sector can make a significant difference in making up for lost time.

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