GENDER-AWARE POLICY APPRAISAL

POPULATION WELFARE SECTOR

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with
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FOREWORD

The Government of Pakistan is fully committed for introducing gender responsive budgeting and this has been reflected in the key policy documents which include Poverty Reductions Strategy Paper (PRSP), Medium Term Development Framework (MTDF) and Gender Reform Action Plan (GRAP) which all explicitly advocate for instituting gender responsive budgeting.

The Ministry of Finance, Government of Pakistan with the technical and financial support of UNDP and its cost sharing donors has initiated the 'Gender Responsive Budgeting Initiative' (GRBI) project to promote policy and resource allocation with a gender perspective.

Gender Aware Policy Appraisal is one of the tools of gender responsive budgeting which analyses policies and programmes funded through the budget from a gender perspective by asking whether policies and their associated resource allocations are likely to reduce or increase gender inequalities. The project commissioned three appraisal studies for the sectors of Education, Health and Population Welfare as part of its planned activities. The studies undertook a sector-specific situation analysis to understand the needs and identify gaps from a gender perspective. The draft reports were shared with the departmental focal persons as well as other stakeholders in a workshop and a focus group discussion for feedback and inputs received have been subsequently incorporated in the final report.

The reports were supervised, with valuable inputs, by Ms. Deborah Budlender, founding member of South African Women's Budget and a leading international adviser on gender responsive budgeting.

I would also like to take this opportunity to thank UNDP and its cost sharing donors, namely Swiss Agency for Development and Cooperation and Royal Norwegian Embassy, for their continued support as well as the departmental focal persons, both federal and provincial, for their contribution.

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CONTENTS

	Foreword	
	Acronyms	v
	Executive Summary	1
1	**Introduction**	**4**
2	**Methodology and Limitations of the Study**	**5**
	2.1 Scope and Methodology	5
	2.2 Limitations	6
3	**Situation Analysis**	**7**
4	**Policy Analysis**	**21**
	4.1 Population Welfare Programme	23
	4.1.1 Family Welfare Centres	23
	4.1.2 Reproductive Health Services Centres	24
	4.1.3 Mobile Service Units	24
	4.1.4 Village Based Family Planning Workers-Male (VBFPW-Male)/ Male Mobilization.	24
	4.2 Relevant Developments in Health Sector Policy	25
5	**Budget Analysis**	**26**
	5.1 Budget Allocation (2005-08)	27
	5.2 Budget Allocation Trend (2002-06)	27
	5.3 Budget for Service Delivery	29
	5.4 Budget Utilization (2004-05)	29
	5.5 Sector Review (2004-05)	30
	5.6 Flow of Funds	31
	5.7 Expanding Coverage and Strengthening Services: Inconsistencies in Service Targets	31

6 Service Delivery and Impact Analysis **35**

6.1 Inconsistencies in Performance Targets 35

6.2 Contraceptive Performance 36

6.3 Performance by Service Outlets 38

6.4 Males Involvement and Performance in RH/FP 39

6.5 Issues and Concerns in Programme Implementation 39

7 Conclusion, Policy Implications and Recommendations **42**

References 46

ACRONYMS

ADB	Asian Development Bank
ADP	Annual Development Programme
AGPR	Accountant General Pakistan Revenue
AIDS	Acquired Immunodeficiency Syndrome
AJK	Azad Jammu and Kashmir
BCC	Budget Call Circular
BHU	Basic Health Units
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Surgery
CYP	Couple Years of Protection
DHS	Demographic Health Survey
EI	Education Index
EPI	Expanded Programme of Immunization
FATA	Federally Administered/Administrative Tribal Areas
FBS	Federal Bureau of Statistics
FPAP	Family Planning Association of Pakistan
FWC	Family Welfare Centres
FWW	Family Welfare Workers
GDI	Gender Development Index
GDP	Gross Domestic Product
GEM	Gender Empowerment Measure
GOP	Government of Pakistan
GRAP	Gender Reform Action Plan
GRB	Gender Responsive Budgeting
GRBI	Gender Responsive Budgeting Initiative
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HP	Health Personnel
HPI	Human Poverty Index
HRD	Human Resource Development
HWs	Health Workers
ICPD	International Conference on Population and Development
IMR	Infant Mortality Rate
IUD	Intra-Uterine Device
LHVs	Lady Health Visitors
LHWs	Lady Health Workers
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MICS	Multi Indicators Cluster Survey
MIS	Management Information System
MOH	Ministry of Health
MOPW	Ministry of Population Welfare
U5MR	Under 5 Mortality Rate

EXECUTIVE SUMMARY

Background, Objectives and Methodology

Pakistan is striving to achieve population stabilization in order to alleviate poverty, improve the status of women, bridge the gap in gender inequality and promote the quality of life of the people. The aim of the government is to achieve the Millennium Development Goals (MDGs), which the Government has incorporated in its Medium Term Development Framework (MTDF) and accelerate the process of sustainable development. The purpose of the study is to review and analyze the situation of male and female in the country, the relevant policy, budget allocation, releases and spending, and impact of the Population sector using a 'gender lens' so as to promote policy and resource allocation with gender perspective. The study covers the federal, provincial and district level with sub-national analysis confined to the Punjab province and two districts namely Gujrat and Rajanpur. The analysis relies mainly on secondary data such as Medium-Term Budgetary Framework (MTBF), MTDF, Population Welfare Programme's Federal and Punjab PC-1s, sector review expenditure, service statistics data and Federal Bureau of Statistics published data.

Situation Analysis

Despite government statements supporting family planning for nearly more than four decades, the fertility rate remains high. Pakistan has persistent high fertility and a high population growth rate among poor, illiterate and rural population where woman continue to bear more than 5 live births over the reproductive period. These births start too early, are spaced too close and too frequent, and continue too long into higher parities resulting in about 33 percent high-risk births. The contraceptive prevalence rate is low and there is high unmet need for contraception as one-third women do not want another child immediately or any time in the near future yet do not have either availability, accessibility and / or affordability to contraceptives. The repeated pregnancies result in one induced abortion for every five live births resulting in a high induced abortion rate of 29 per 1000 women in the country. These are mostly unsafe and clandestine abortions resulting in severe post-abortive complications and other health problems for women. Almost seven out of ten deliveries take place at home and only half of the women in the country get ante-natal care. Male involvement in responsible parenthood and reproductive health (RH) and family planning (FP) is very poor.

As long as the preference for two or more sons persists the total family size will, on average, be at least 4 indicating that the appreciable decline in fertility might take a longer time than visualized. If the perception of couples does not change in favour of a smaller ideal family size the fertility transition will not be achieved over a desired period of time.

Population Policy

The Population Policy of Pakistan envisages population stabilization by the year 2020 achieving replacement level by attaining a Total Fertility Rate (TFR) of 2.1 children per woman and contraceptive prevalence rate of 60 percent thereby reducing the growth rate of population to 1.3 percent per annum. The MTBF developed for the

years 2005-08 cover objectives and strategies, which have been incorporated in MTDF.

Budget Analysis and Performance

The programme budget allocation has increased two-fold over the period 2002-03 to 2005-06. The allocation for the Population Welfare Programme (PWP) has grown in real terms to address the programme's changing and growing demands. It has increased by 75% from Rs.2.6 billion in 2004-05 to Rs.4.5 billion in 2005-06. Of this 4.5 billion, Rs.3.0 billion is earmarked for provinces for implementing the PWP in their provinces/districts.

The sector review of the year (2004-05) indicates 88 percent utilization of the revised budget allocation. The shortfall in utilization of funds as well as in achieving physical targets of coverage has been, among other factors, partly due to non-approval of PC-1s and ban on recruitment for filling up of vacant posts. 97% of the PWP's budget is financed through Public Sector Development Programme (PSDP) development budget. Of the total budgetary allocation three-quarters is spend on service delivery components that is, Family Welfare Centres (FWCs), Reproductive Health Services (RHS)-A Centres and Mobile Service Units (MSUs), which mostly provide family planning services to women. Almost 80 percent of all the users of these outlets are women. Male involvement in responsible parenthood is very insignificant from the demand as well as supply aspect and needs to be given crucial priority.

The transfer of funds from the Federal Government to Provincial Population Welfare Department (PPWD) takes on average almost three months while it takes another one month to reach end users. This affects the morale of the employees and performance of the project. With the defederalization of the PWP, the problem of late releases of funds has become more serious. Like other social sector programmes such as health and education, it is suggested that the salary component of PWP should be transferred from development to non-development recurring expenditure in order to ensure timely payments and boost the morale of PWP employees. The provinces should be persuaded to start financing PWP activities in a phased manner from their own resources so that they may be made responsible for and own the programme.

Conclusions, Discussions and Recommendations

Pakistan's family planning programme faces severe constraints in a milieu in which women are circumscribed in their ability to become educated to work and to leave their houses unaccompanied. They lack autonomy and have restricted mobility and minimum discretionary access to economic resources. More generally, the low status of women, among others, is surely a major factor in the limited use of family planning methods in the country.

Specific outreach to improve maternal and child health, engage in community development efforts and create demand for family planning services has yet to start more effectively. Although implementation has been devolved to the provincial level, the programme still faces several bottlenecks in terms of policy and management shifts and collaboration with public health and private sector. The past experience indicates that the performance of public health outlets have been abysmally poor in implementing PWP activities. The Non-Governmental Organizations (NGOs) and the

private sector, including private medical practitioners, should be accorded more resources and encouraged more in PWP activities, as they could contribute substantially to the family planning programme. This would lead to more coverage, access and utilization of RH/FP services.

The prospects for future fertility decline will primarily depend on more effective implementation of population policy, particularly more effective IEC dissemination, increased coverage and accessibility, particularly widening of out-reach coverage and above all, improvement in the quality of care services. The demand for services has to be highlighted, programme management has to be strengthened and political and administrative support need to be ensured and sustained.

The problems and constraints discussed in the paper will continue to undermine the population related MTDF, International Conference on Population and Development (ICPD) and MDG targets unless the health department, NGOs, civil society and other stakeholders at all levels seriously cooperate, collaborate and rationalize their implementation activities to achieve population stabilization. In this regard, the population policy needs to be further broadened and modified by taking into consideration the growing aging of the population, migration, urbanization, environmental and ecological issues, poverty and gender inequality of rural and marginalized population.

The PWP needs improvement in programme management at all levels in order to monitor the laid down goals of Poverty Reduction Strategy Reports (PRSP), MTBF and MTDF regularly. Serious initiatives are required to focus on quality of care and client's satisfaction and continuity of use of contraception. In this regard, supervision to change the attitude and behaviour of service providers through the means of facilitators/helper rather than policing and faultfinding approach needs to be given serious attention. Follow-up of clients, maintenance of adequate record and Management Information System (MIS), functional integration of PWP outlets and primary health care outlets of health departments under one authority, which has been ignored, needs to be given top priority. The issues and concerns of the PWP require priority consideration from policy makers, programme managers and all stakeholders. The demand generation and awareness campaigns need to be rationalized and improved to meet the missing links between supply and demand. Interpersonal communication and communication strategy needs to be given priority and new direction to address the unmet need for contraception.

Top priority has to be accorded to human resource capacity building of the programme employees at all levels and for all cadres, which has become very weak over the years. Involvement of religious scholars, opinion leaders and elected representatives should be encouraged to speak openly on adverse consequences of population growth and it should be regularly monitored how far they are taking active involvement in this crucial effort.

1. INTRODUCTION

The Government of Pakistan is striving to achieve population stabilization in order to promote the quality of life of the people, alleviate poverty, improve the status of women and accelerate the process of sustainable development. This is being implemented in the light of the Programme of Action (POA) of the International Conference on Population and Development (ICPD) Cairo, 1994, which identified a series of priority issues, which included among others, population and development, gender equality and equity, adolescent and youths and reproductive health services to men and women and their rights (ICPD, 1994). Pakistan is a signatory to the ICPD – POA. The tenth anniversary of ICPD (ICPD + 10) in 2004 offered an occasion to assess the progress made so far and discuss the challenges being faced to implement the ICPD – POA. In addition to this, the government is also committed to implementing the recommendations of the 1995 Beijing Fourth World Conference on Women and Beijing + 10 goals, where it reaffirmed its commitment to bridge the gap in gender inequality. Along with these efforts, the aim of the government is to achieve the Millennium Development Goals (MDGs, 2000), which the Government of Pakistan has incorporated in its Medium Term Development Framework (MTDF), (2005-10) goals and targets

Gender Responsive Budgeting (GRB) was proposed for the first time in Pakistan by the Ministry of Women Development in 2001. The Government of Pakistan's Poverty Reduction Strategy Paper (PRSP) advocated the implementation of GRB to address gender inequality and the impact of budgetary expenditures on different groups and sub-groups of the population. The Gender Reform Action Plan (GRAP) also advocates GRB as a tool of gender mainstreaming.

The Planning Commission in the MTDF (2005-10) states that it will "work to sensitize properly the federal and provincial entities on the basic rationale and concept of Gender Responsive Budgeting (GRB) and required investments. It will encourage and support the use of GRB at Federal and Provincial budgets". Each line Ministry/Department and allied entities will be required to address gender when they submit their Public Sector Development Programme (PSDP), PC-1 and other budgetary demands This would help to determine the extent to which resources and budgets are allocated to address gender inequality and equity and the impact of the budget on males and females This would ultimately help to improve government's efforts in achieving the MDG gender equality targets In this regard careful analysis of budgetary allocations and expenditures would help to identify funding gaps which will help to adjust priorities to alleviate poverty and promote gender equality and development. It could enhance efficiency by ensuring that expenditure benefits those who are in dire need of it. In South Asia, India, Nepal and Sri Lanka have taken the lead in gender responsive budgeting activities. [UNFPA, 2005].

In spite of Pakistan's improved economic growth during the sixties to eighties, its social sector performance has been quite dismal. The Human Development, Gender Development and Education Indices have been very low (UN, HDR, 2005). Pakistan continuous to have a high population growth rate (1.9

percent), high fertility rate (average of four children born per woman), high infant mortality rate (77 infant deaths per thousand live births), and under five years child mortality rate (103 deaths per thousand live births) and very high maternal mortality ratio (400-500 per hundred thousand live births) and low contraceptive prevalence rate (36 percent). The unmet need for contraception is substantial (33 percent) and is one of the highest in the world. Reproductive health services can play a crucial role in reducing infant, child and maternal mortality and reducing unmet need for contraception. Close collaboration and coordination between the health and population sectors is very important and joint efforts could only help in achieving these indicators over a short time. It is further noted that education of parents, particularly of mothers, has a close association with mortality and fertility levels. Female education specifically plays an important role in determining population indicators. Similarly, gender inequality, status of women and rights are core element of population, women's empowerment, poverty alleviation and development policies. Women's empowerment and their inclusion in development are essential for the fulfillment of the population sector's objectives.

It is noted that considerable progress has been made in the country in integrating population issues into development planning. The Government has adopted multiple measures in this regard and has taken action to decentralize and integrate population with other sectoral plans at the grass root level. Efforts are further pursued on the linkages of population and poverty, women's advancement, education and health.

The purpose of the study is to review and analyze the situation prevalent in the country, analyze policy along with budget allocation, releases, spending and impact using a 'gender lens' and promote policy and resource allocation with a gender perspective.

2. METHODOLOGY AND LIMITATION OF THE STUDY

The population welfare programme of Pakistan mostly focuses on married females. The reproductive health and family planning activities focus mostly on married women of reproductive ages (15-49 years). However the policy papers also lay stress on male involvement in responsible parenthood. A complicating factor in analysis is that reproductive health issues overlap with the health sector, for example, pregnancy-related care (such as pre-natal, postnatal care) and health-related issues (such as high risk live births, infant-child mortality, maternal mortality, infertility, fetal loses), which mostly pertain to health sector domain, are also closely related to population sector. These activities potentially complement and supplement each other in achieving fertility reduction. The Health sector is the topic of a separate policy appraisal but cannot be ignored in this paper.

2.1 Scope and Methodology

The study covers the federal level, while the provincial and district level analysis is confined to the Punjab province and two districts namely Gujrat and Rajanpur, covering north and south regions of the Punjab province.

Punjab province is more advanced socio-economically than other provinces. Within Punjab Gujrat is more advanced than Rajanpur as southern Punjab is more backward in socio-economic development than central and northern Punjab.

The analysis relies mainly on secondary data such as Medium-Term Budgetary Framework (MTBF) (2005-2008) for federal level and its sector review report for the year 2004-05, expenditure study and Mid-Term Plan for the year 2004-05. The PC-1 of population welfare programmes' various components is also utilized for analysis. In addition to this, various other policy documents including the Poverty Reduction Strategy Paper (PRSP) and Statistical Bureau's publications are used. Interviews with relevant government officials at the federal, provincial and districts level and other stakeholders were conducted to identify issues, constraints and gaps in gender-responsive budgeting and gender-sensitization.

2.2 Limitations

Population Welfare is primarily a behavioral change programme through which couples are motivated to adopt the concept of a small family norm. The population welfare programme in Pakistan is established as an independent, vertical programme parallel to health, although it is closely inter-linked and crosscuts with other social sector programmes such as health, education and women development. The population sector programme has operated separately and independently alongside the health sector programme since 1965.

The population sector budget of the country (federal, provincial and district level) is completely financed by the federal government. Provincial government have until recently provided no funding for this activity. However, Punjab has recently contributed a token amount of money by funding its newly established Secretariat of Provincial Population Welfare Department. Moreover, almost all the budget (97 percent) of the population welfare programme is financed through the development budget, Public Sector Development Programme (PSDP). However, both the recurrent and non-recurrent (development) budgets are considered for the analysis. At functional level, the activities of the programme are closely inter-linked with health service outlets, which are also supposed to supplement and complement the family planning activities through their community-based workers that is, Lady Health Workers (LHWs).

Due to time limitation, it was difficult to carry out meaningful analysis of districts However, attempts are made as far as possible to do analysis up to provincial and district level where available data permit this

3. SITUATION ANALYSIS

The population of Pakistan grew from 33 million in 1951 to 155 million in 2005 ranking Pakistan from 14th in the 1950s to the 6th most populous country in the world today. The growth rate of the population has been the highest over 3 percent per annum. Although it has declined, still it is one of the highest (1.9 percent per annum) of all South Asian countries. Almost three million people are being added each year to the existing population, which means if no dent is made in the growth rate of population then it will increase to around 193 million by the year 2015. The youth population (aged 15-24) will increase to about 40 million and females in the reproductive age group would increase to around 46 million in 2015. The growing population will continue to adversely affect the already over-burdened social services in the country.

The imbalance of the population by sex and selected age groups is shown in Table 1 for the study area, that is, Pakistan, Punjab and its two districts namely, Gujrat and Rajanpur. The overall sex ratio in Pakistan is reported to be 108 males per 100 females in 1998 Census. In Punjab it is reported to be 107. In Gujrat and Rajanpur districts it is reported to be 100 and 111 males per 100 females. The age-specific sex ratio for selected ages indicates that the sex ratio increases with age. The age-specific sex ratio indicates greater imbalance of sexes in older age groups. This is prevalent more in Rajanpur than Gujrat district. The great gender imbalance of sexes indicates, among other things, sex-selective under- and / or over-enumeration, a high maternal mortality rate and higher female than male mortality particularly in old ages resulting in increasing sex imbalance in the country. [Rukanuddin, 1967, Sathar, 1987, Siddiqui and Rukanuddin, 2003, Mahmood, 2004]. This pattern is unusual in international terms. Biologically the sex ratio is always high at birth (105 males per 100 females on the average). One would expect males to exceed females at the very young and adolescent ages, but females generally outlive males unless there are interfering factors as mentioned above.

The Population Welfare Programme, which started on a nation-wide basis in 1965, was conceived realizing the future growth rate, if it is not timely checked, could dilute the gains of development. The Population Welfare Programme has a chequered history of ups and downs due to frequent shifts in administrative and programme strategies, lack of open and sustained political and bureaucratic support, widespread illiteracy, low status of women and poor health conditions resulting in high incidence of under-nutrition, and high infant, child and maternal mortality.

The country could not cash in on the advantages of the high economic growth rate of an average of six percent per annum during 1960s-1980s to achieve advancement in social indicators from low to high levels. The social indicators of Pakistan have remained abysmally low and have remained well behind its economic performance putting Pakistan at the tail end lagging behind in all social sector indictors when compared to other countries of the region. The Human Development Index (HDI) ranks Pakistan at 135 out of 177 countries. On the Gender Development Index (GDI) it is ranked 107 out of 140

countries On the Gender Empowerment Measure (GEM) Pakistan ranks 71 out of 80 countries. On the Education Index (EI) Pakistan is near the bottom with a value of 0.44 and ranks 167 out of 177 countries even lagging behind Nepal and Bangladesh. On the Human Poverty Index (HPI-I) its rank is 68 out of 103 countries [UN HDR, 2005].

Table-1: Population by Selected Age Group and Sex Ratio Pakistan, Punjab, Gujrat and Rajanpur Districts, 1998 **(Population in 1000)**

Population by Selected Age Groups	Pakistan		Punjab		Sex Ratio* of	
	Population	Sex ratio	Population	Sex ratio	Gujrat District	Rajanpur District
Total	132,352	1085	73,622	1072	2,048 (100.4)	1,104 (111)
Males	68,874		38,094		1,026	581
Females	63,478		35,527		1,022	523
Children <1	2,993	1045	1,771	1045	1050	1040
<5	19,118	1043	10,480	1043	1048	1020
<10	39,333	1070	21,707	1060	1059	1072
<15	56,064	1090	31,304	1073	1065	1118
5-24	61,934	1083	34,962	1065	1023	1149
Adolescents & Youth 10-24	46,863	1117	23,735	1055	1003	1163
Adolescent 10-19	30,131	1105	28,409	1080	1037	1235
Youth 15-24	24,978	1038	25,365	1051	956	1095
Reproductive ages Pop. 15-49	59,024	1061	33,584	1049	938	1075
Working population 18-60	60,374	1066	34,486	1059	945	1068
15-64	68,586	1073	39,356	1062	955	1091
Elderly population 60 +	7,162	1192	4,570	1188	1083	1292
65 +	4,525	1202	2,962	1208	1082	1324

* Sex ratio is based on male population divided by female population multiplied by 100.
Source: Government of Pakistan, Statistics Division, Population Census Office. Census Reports of 1998 Census: (i) Pakistan (ii) Punjab (iii) Gujrat and (iv) Rajanpur

Of specific interest for this paper is that HDR 2003 indicates that Pakistan experienced the lowest decline in infant, child mortality and fertility during the period 1970-75 to 2003-05 of all countries of South Asia, South East Asia and many of the Muslim countries Similarly, the increase in contraceptive use has been lower in Pakistan than the above mentioned countries of the region (Population Reference Bureau, 2003; UN, HRD, 2003).

These trends can be seen in following Figures 1 to 3:

Figure 1: Percent Decline in TFR in Selected Countries, 1970-75 to 2000-05

Source: UN, HDR, 2003.

Figure 2: Percent Decline in Infant and Child Mortality in Selected Countries, 1970-75 to 2000-05

Source: UN, HDR, 2003

Figure 3: Contraceptive Prevalence Rate in Selected Countries, 2003

Source: Population Reference Bureau, Population Data Sheet, 2003

In Pakistan the initial decline in fertility reduction may be attributed to increase in age at marriage, gradual social and economic changes coupled with urbanization and modernization. It is noted that population growth and fertility rates have remained high and stable, although among some groups such as educated women, working women and those who marry late, fertility has shown a decline in the country.

Major findings of various socio-economic, reproductive health and family planning (RH/FP) indicators at micro-household level obtained through various data sources are given in Table 2. The Table shows that various indicators such as literacy and education, environment, child health and nutrition, mothers' health, mortality, fertility and family planning, gender inequality in education show a better trend for Punjab than for the overall average of the country. Within Punjab, as expected, rural areas are lagging behind urban areas. Within urban areas "other" urban areas have low socio-economic indicators than major urban areas. Comparing the indicators of Gujrat and Rajanpur Districts, it is noted that Rajanpur district is at the tail end of almost all socio-economic indicators in the province. It ranked at the bottom of all districts of Punjab in literacy and education, skilled health personnel attendant at birth, antenatal and post-natal care, contraceptive use, infant and under-five mortality, household covered by LHWs indicators. Consequently, Rajanpur is ranked one of the highest in fertility rate in Punjab. Literacy and educational differentials are noticed between males and females, and are more pronounced in rural than urban areas particularly in Rajanpur.

The recently conducted Pakistan Demographic Survey (PDS) (2003) found an IMR of 76 (81 in rural and 67 in urban areas) per thousand live births. For males and females IMR was reported 81 and 71 per 1000 live births respectively for country as a whole. The PDS showed that 57 percent of all infant deaths comprise neonatal deaths. The decline in neonatal deaths has been slower than for post-neonatal deaths. Neo-natal deaths have remained almost constant over the past few years.

Table-2: Socio-economic, Reproductive Health/Family Planning and Gender-Equality Indicators for Pakistan, Punjab Province and Gujrat & Rajanpur Districts

Indicators	Pakistan	Punjab						
		Other sources	Multiple Indicators Cluster Survey (MICS) 2003-2004					
			Total	Rural	Urban			
					Major Urban	Others Urban	Gujrat	Rajanp-ur
Literacy rate 10+								
Total	45 (53)	47 (55)	54	47	75	67	65	34
Male	58 (65)	57 (65)	63	58	78	74	73	46
Female	32 (40)	36 (44)	44	35	71	59	57	20
Literacy rate 15+								
Total	49 (50)	(63)	51	47	65	63	64	33
Male	62 (63)	(40)	53	49	65	62	61	38
Female	35 (36)		49	45	65	62	67	28
Net attendance rate			51	47	65	61	63	33
Gross primary school enrolment								
Total	72 (86)	76 (95)	88	83	104	104	119	56
Male	83 (94)	84 (100)	93	89	105	105	116	64
Female	61 (86)	69 (89)	83	76	103	103	124	45
Net primary school enrolment								
Total	42 (52)	45 (58)	51	47	65	62	64	33
Male	46 (56)	47 (60)	53	49	65	62	61	38

Female	38 (48)	43 (55)	49	45	65	61	67	28
Housing								
a) Mean householdsize	6.8	6.8	6.6	6.7	6.4	6.6	6.4	6.9
b) Mean number of persons per room		3.0	3.4	3.5	3.1	3.3	2.7	4.2
c) Percent of Households with no utilities electricity etc.		-	17	23	1	2	1	41
Child Health & Nutrition								
a) Under weight children under 5 years	37	35	34	40	23	30	28	47
b) Exclusive breastfeeding rate 0-6 months	16	7	30	30	39	24	-	-
c) Breastfeed during infancy (0-11 months)	-	-	78	79	73	77	79	93
d) Ever breastfeeding (recall for children 0-2 years)	92	89	96	-	-	-	-	-
e) Proportion o f one year olds immunized against measles (EPI)	61		66	-	-	-	81	19
f) ORT use (ORS & ORT)	54	44	43	40	46	48	57	34
g) Population covered by HWs			35	38	18	41	48	8
Mothers Health								
a. Antenatal care by skilled HWs	34 (50)	40 (56)	44	37	73	55	53	29
b. Postnatal care by skilled health workers	9 (23)	10 (23)	30	23	60	40	40	8
c. Both care by skilled health workers	24	16	33	26	66	44	45	7
Mortality								
a. IMR/1000 live births	82	92	77	82	55	74	61	97
b. <5 MR/1000 live births	103	115	112	119	75	107	92	153
c. Maternal mortality ratio/100,000 LBs	533	-	300	-	-	-	-	-
Birth attended by skilled health personnel	23 (U.N)	(48)						
Fertility and Family Planning								
a. Total fertility rate per women	4.3	4.8	4.7	5.9	5.5	5.9	5.5	6.7
b. Mean No. of children ever born (15-49)	2.7	2.5	3.8	3.8	3.6	3.9	3.3	4.0
c. Completed fertility rate (45-49)		-	6.0	6.2	5.4	5.9	5.5	7.6
Family Planning								
a. Know how to avoid pregnancy		97	76	72	89	84	81	63
b. Ever use any method to avoid pregnancy		31	39	34	55	47	39	16
c. Current contraceptive use i. Any method ii. Modern method	28 19	30 22	36 27	32 24	52 38	43 32	35 22	12 11
Gender Equality and Female Empowerment (Ratio Males/Females)								
i. Gross enrolment ratio in primary education			0.89	0.85	0.98	0.99	1.07	0.71
ii. Net enrolment ratio in primary education	0.74		0.93	0.90	1.00	0.96	1.10	0.73
iii. Net enrolment ratio in secondary education			0.88	0.73	1.12	1.08	1.03	0.72
iv. Literacy (15-24 years old) adult literacy	(0.72)(0.57)		0.83	0.74	0.93	1.04	0.97	0.50
v. Women in wage employment % females to total			0.19	0.22	0.15	0.13	0.09	0.30

Source: (i) Govt. of Punjab, Planning and Development Department, Govt. of Pakistan, Federal Bureau of Statistics, United Nations, UNICEF, 2005, Multiple Indicators Cluster Survey (MICS) 2003-04. Figures in parenthesis are from PSLM 2004-05 (FBS, 2005)

A recent study shows a high induced abortion rate (29 per 1000 women) in the country. Around 0.9 million induced abortions occur annually in Pakistan. The ratio of induced abortion is 0.20, which means one abortion for every five live births equivalent to one out of six pregnancies terminated by induced abortion.

This shows that induced abortions are widespread and a significant means of fertility control in the country. These abortions generally occur to relatively older married women who already have several living children; have achieved their desired family size and want to avoid unwanted pregnancies. It is further estimated that around 200,000 women are treated every year for unsafe and clandestine complications of induced abortions in the public and private health facilities. These unsafe and clandestine abortions, inter alia, are one of the major factors of maternal mortality and serious post-abortive health complications. It is further noted that the in-depth interviews with women and their husbands who have experienced an induced abortion reveal great stress on the family (Population Council, 2004).

Punjab Multiple Indicators Cluster Survey (MICS) 2003-04 reported several socio-economic RH/FP indicators for Punjab and its districts Total Fertility Rate (TFR) per woman has been observed as being higher (5.9 children) in rural than urban areas (5.5 in most urban and 5.9 in other urban areas) of Punjab and is higher in Rajanpur (6.7) than Gujrat (5.5). Similarly the estimates for those who have ever used or currently use contraception is reported lower in rural areas. It is lower in Rajanpur than Gujrat. In 2001-2002 when the contraceptive prevalence rate was recorded as 28 percent for the country as a whole, a rate of 30 percent was reported in Punjab. In 2005 when the overall prevalence rate in the country is estimated at 36 percent, it is again expected to be higher in Punjab. (MICS 2003-04). The contraceptive prevalence rate is estimated at 36 percent for Punjab (32 percent in rural areas and 52 percent in major urban and 43 percent in 'other' urban areas) for the year 2003-2004 (Table 2).

The unpublished data obtained from the recently conducted NIPS survey on Status of Women, Reproductive Health and Family Planning Survey 2003-2004 indicate TFR as being 4.3 children per woman for the years 2001-2003. More than two in five (45 percent) women reported that they do not want any more children. It was further observed from the survey results that (71 percent) of the births were delivered at home (NIPS, 2004). NIPS' earlier study indicated that 83 percent births were delivered at home while 95% of those women who did not go for antenatal care delivered their last births at home (NIPS 1998). United Nations reported that slightly less than one-quarter (23 percent) of the births were attended by skilled attendants (UNFPA, 2005), whereas PSLM (2005) indicate that 48 percent births were attended by skilled attendants (GOP, 2005). Lack of antenatal care brings dangers to both the woman and the child. The resultant high mortality rates among children could be one of the factors increasing high fertility rates in the country.

More than half (52 percent) of the women received antenatal care during their last pregnancy, (36 percent from doctors, 8 percent from nurses/Family Welfare Workers (FWW)/Lady Health Visitors (LHVs) and rest from Traditional Birth Attendants (TBA) /Dais and FWW). Four-fifths (80 percent) of the women did not receive any postnatal care. One-fifth (21 percent) of ever-married women reported spontaneous abortions and two percent resorted to induced abortion. The maternal mortality ratio through an indirect estimate was reported as 441 per hundred thousand live births (NIPS, 2004).

Only 43 percent of women had ever used a family planning method whereas 32 percent of married woman reported currently using a family planning method in the country. The proportion in respect of current use was 44 percent in urban areas and 26 percent in rural areas in the country. Of all the current users, two-fifth (39 percent) women using contraception had three or less children while one-third (33 percent) had four or five children and remaining about over one-quarter (28 percent) had six or more children (NIPS, 2004). The demographic impact is expected to be minimal for women using contraception with six or more living children. Efforts need to be made to encourage younger and low parity women to adopt contraception.

According to PRHFP Survey (2000-01), the most commonly used form of contraception is contraceptive surgery, accounting for 34% of users. This followed by condoms (27%), IUDs (17%) and injectables (13%). Different forms of contraception offer different advantages and disadvantages to women and men. Intra-uterine devices, for example, generally afford women more control over contraception than condoms. They also do not rely on regular medication as the pill does

A common measure of demand for family planning is the total need or demand for services. This total demand is the sum of contraceptive prevalence (met need) and unmet need for family planning. Pakistan has one of the highest unmet needs for family planning services in the world. Total demand for family planning is reported as around 65 percent, which comprises 32 percent met need (contraceptive prevalence) and 33 percent unmet need. Of this met and unmet need (65 percent) 20 percent has been for spacing and 45 percent has been for limiting births. In Punjab, the total demand for family planning is reported as 70 percent (36 percent met need and 34 percent unmet need). Of the total demand (70 percent) 20 percent is reported for spacing and 50 percent for limiting births (NIPS, 2004). Higher unmet need has been reported (35 percent) among the uneducated. Among women with middle, secondary or more education it has been 28 percent and 23 percent respectively (NIPS, 2004).

As regards mobility, seven out of ten (69 percent) women reported that they had to seek permission of their husband or other senior persons for going outside their house. Four-fifth (80 percent) women reported having had their marriage arranged according to the choice of their parents, while 16 percent reported that they married with their own choice and with the consent of parents. The remaining 4 percent women reported to have married entirely on their own choice. These indicators suggest that most women might have limited choice in controlling their reproductive life (NIPS, 2004).

The recent Pakistan Social and Living Standards Measurement survey (PSLSM), 2004-05 provides recent data, among others, on antenatal and postnatal care for the country and Punjab. The data show that child delivery at home has declined from 82 percent in 1998-99 to 71 percent in 2004-05. The proportion of deliveries assisted by doctors/nurses increased from 18 percent in 1998-99 to 31 percent in 2004-05. The deliveries assisted by Dais and

TBAs were reported at 49 percent. This proportion declined from 59 percent in 1998-99 to 49 percent in 2004-05. The proportion was higher in rural area (53 percent) compared to 43 percent in urban area. Whereas the deliveries assisted by non-health personnel, that is, family members, neighbors, friends and others showed a slight decline from 23 percent in 1998-99 to 21 percent in 2004-05. Again the proportion was higher in rural area (27 percent) than urban area (9 percent). As regards households' satisfaction of facilities/services provided by government outlets, 36 percent reported satisfaction about Basic Health Units but only 10 percent reported satisfaction with family planning services (PSLM, 2004).

A study conducted by the Population Council (2001-2002) on Adolescents and Youth in Pakistan indicated that of all older youth of 20-24 years of age, 58 percent females got married before age 20 (28 percent in urban and 58 percent in rural areas). The corresponding proportion in Punjab was 42 percent - 20 percent in urban areas and 51 percent in rural areas. Early marriage usually results in early pregnancy. Pregnancy at a young age results in a high-risk birth and can have long-term consequences. Those who start early also have longer reproductive lives ahead of them and might thus be more likely to reach high parity. Among youths 15-24 of age, around one-sixth (16 percent) reported having used contraception at some point (29 percent in urban and 15 percent in rural areas of the country). The corresponding use among youth in Punjab was reported as 20 percent - 33 percent in urban and 17 percent in rural areas. The intention to use contraceptives in the future was reported by 57 percent for the country as a whole - 64 percent in urban and 56 percent in rural area. In Punjab, the corresponding proportion is reported as 69 percent in both rural and urban areas [Population Council, 2002].

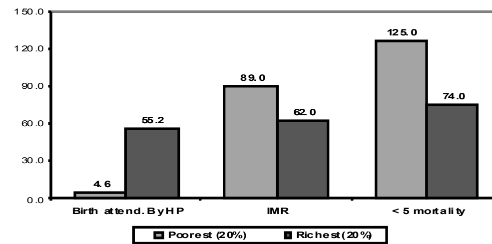
Socio-economic status is the most important factor in determining how much education girls receive in Pakistan. This is important because of the close links between education and fertility. Girls belonging to the lowest economic strata do not get a chance even to complete one grade, whereas their counterparts in the highest strata usually are able to continue their education beyond primary level. Moreover, girls' reasons for drop out are social, family/families' disapproval or access to school whereas boys mostly drop out of school due to economic reasons or due to their own lack of interest in studies.

It has been empirically observed that socio-economic status and demographic characteristics of the household are important factors, which affect infant, child and maternal mortality, contraceptive prevalence and fertility. Households with low income (poor women) suffer from weaker health, particularly maternal health, experience high infant, child and maternal mortality, experience a greater proportion of abortions, experience repeated pregnancies and higher proportion of high-risk births particularly in higher parities, have less knowledge of the source of family planning methods, have greater distance to travel to access RH/FP services, resulting in a much higher unmet need for family planning. Poverty is also a crucial factor in determining the chances of infant and child survival. Children under 5 years of age from poor households are twice as likely to die as those in the richest group.

The following figures (4a to f) show the inequalities in pregnancies, mortality, fertility, contraceptive use, unmet need for family planning by selected socio-economic and demographic characteristics in Pakistan. The figures show that among the poorest 20 percent households, only 5 percent of births were attended by health personnel compared to 55 percent among the richest 20 percent of households. The percentage of deliveries taking place at home is the highest in rural areas (87 percent) compared to 51% in urban and 39% in major urban areas. Ante-natal care has been found to be negatively related to the educational attainment and residential status of women. Similarly infant mortality and under 5 mortality rates are negatively related to birth intervals, residential status and educational status of women. The fertility level is also negatively related to women's educational attainment. Unmet need for family planning has been noted more in rural areas and among illiterate women (NIPS, 1998 & 2001).

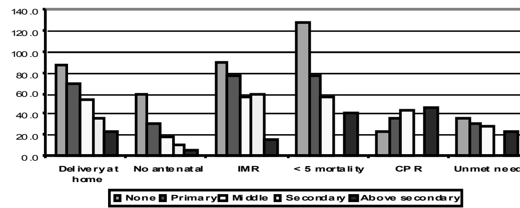
Figure 4: Inequalities in Pregnancy care, Fertility, Mortality by Selected Characteristics, Pakistan

a) Income of household:



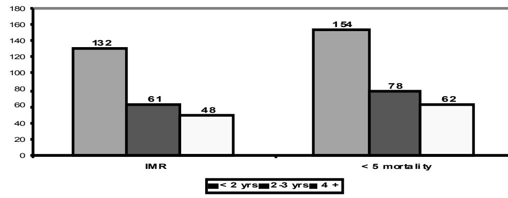
Source: UN, HDR (2005).

b). Education level of women aged 15-49 years:



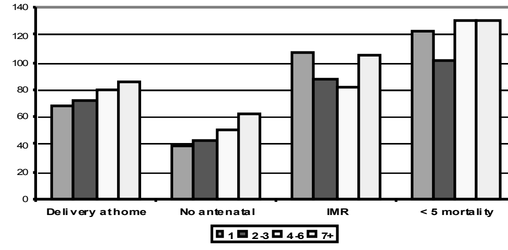
Source: NIPS, PRHFPS (2001)

c) Birth Interval:



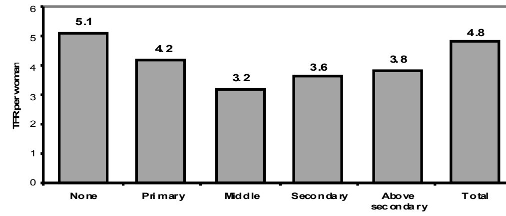
Source: NIPS, PFFPS(1998)

d). Birth Order:



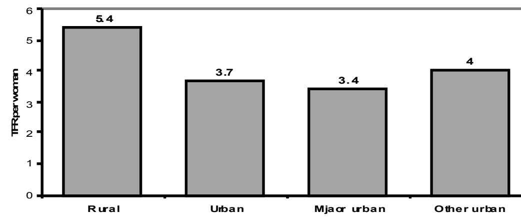
Source: NIPS, PRHFPS (2001)

e). TFR per Women



Source: NIPS, PRHFPS (2001).

f). TFR per Woman (by residence):



Source: NIPS, PRHFPS (2001)

In Punjab the IMR per 1000 live births is reported higher among illiterate mothers (87 per thousand live births) than among literate mothers (56 per thousand live births). Similarly the under-five mortality rate (U5MR) is higher (129 per thousand live births) among illiterate mothers than among literate mothers (76 per thousand live births) (MICS, 2003-2004). All these patterns call for special attention to the needs of poor women and poor families in the Population policy. They also emphasize the important role that education can play in addressing fertility issues, especially if those who are educated can substantially take advantage of meaningful opportunities in the labor market.

Few women in Pakistan work outside the home for wages in the formal sector. NIPS study indicates that 20 percent of ever-married women in the country were working for money. It has been found in many studies that educated and working women had lower infant and child mortality, lower fertility and higher contraceptive prevalence rates than uneducated and non-working women (Sathar, 1998 and Hakim et. al 1998).

A study in rural Punjab noted that changing parental aspirations for children's education are a critical turning point in decision-making regarding reproductive health and family planning behaviour and choices Research on determinants of reproductive health and family planning behaviour and schooling of children found, in particular, that the presence of a girls' primary school was associated with higher contraceptive prevalence rate [Sathar and Shahnaz, 1990]. The education-fertility link in respect of the mothers as well as father's level of education has been documented in several studies in the country and elsewhere. This link is found to be stronger for mothers' education than for fathers as it is found that mother's education plays a more significant role in higher contraceptive use than father's education (GOP, PCPS, 1986 and NIPS, DHS, 1992).

The NIPS study on Pakistan Fertility and Family Planning Survey (1996-97) showed that live births, which had a birth interval of less than 2 years faced at least twice the mortality risk of infants and <5 children's deaths for those who

had longer birth intervals of 2-3 years or more. The same trend has been noted for birth order and among younger women (20-29) compared to < 20 years of age and older women. Because high fertility is associated with closely spaced and high parity births, it is therefore directly linked to neonatal, infant, child and maternal health and mortality. Reducing fertility rates would be expected to improve the incidence of mal/under nutrition and anemia among women and reduce overall maternal mortality. This would also be promoted by encouraging women to have deliveries attended by skilled health personnel and at the health institutions and by reducing high risk births i.e. higher order births and births occurring to youths under 20 years. Births occurring to this group are riskier than births occurring to women in the age group 20-34 years of age.

The Pakistan Demographic Survey (2003) shows that more than one-fifth (22 percent) of the total births in the country occur to women under 20 (5 percent) and to women 35 years of age and above (17 percent). The corresponding proportion is 19 percent in urban and 23 percent in rural areas. In Punjab the corresponding proportion is slightly lower. Similarly, 34 percent of the births in the country 27 percent in urban areas and 37 percent in rural areas occur among women who have already given birth five or more times. These births are also considered high-risk, and contribute significantly to infant, child and maternal mortality.

Men's involvement in responsible parenthood is essential in achieving lower fertility, as they exercise a predominant role ranging from decisions related to size of family to other family decisions at micro and macro level. Motivating and educating men in RH/FP will be crucial so that their decisions change in favour of small family norm. This might also give more decision-making power to women and thus promote gender equality and equity. Men should be effectively assimilated in resolving various problems associated with unwanted pregnancies such as ineffective contraception, induced abortions. It is, therefore, essential to evolve men's critical and increasing role in reproductive health decisions-both in contraceptive decisions and decisions about induced abortions and its repercussions. It could be achieved through encouraging and improving better and increased interpersonal communication between men and women on RH/FP.

Son preference and an agricultural economy both encourage large families. Analyses of data collected in 1968, 1975, 1986 and 1990 from various surveys consistently show that son preference affects fertility preference and contraceptive use (Rukanuddin, 1975, Sathar, 1987, Rukanuddin, 1991, Sathar and Casterline, 1998). The Demographic Health Survey (DHS) of 1990-91 found that of the women who reported their ideal family size, 40 percent of them indicated 4 children with preference of an average of 2.2 sons (NIPS, 1992). The National Impact Survey data (1968) indicated that those women who experienced male infant deaths replaced the infant loss earlier than in the case of female infant deaths. When the sex of the dead child was considered, it was observed that those couples who lost their male offspring compensated for their losses more than did those with female losses which indicated again preference for sons. It was also noted that those couples who experienced high

infant and child mortality had higher fertility level than those who did not have infant and child mortality (Rukanuddin, 1975). In Pakistani culture, particularly, in rural areas and in poor families, the cost of rearing children is considered quite small requiring a few additional grains in the pot and no additional requirement for accommodation etc. Only when children are considered an economic burden rather than benefits will the ideal family size likely shift from large to small (Sathar, 1990 and Rukanuddin, 1991).

In a qualitative survey people indicated that the developmental changes, modernization and rising cost of living had made the upbringing of children more costly. This has driven down the demand of children and increased the perceived cost of unwanted birth (Sathar and Shehnaz, 1990, Sathar and Casterline, 1998). Moreover, in several field surveys field workers routinely pick up complaints that because of rising prices families cannot afford large families (Hakim and Miller, 1998). There is an opportunity for the PWP to cash in on these opportunities through meeting the demands of the couples through its community based workers that is LHWs and expanding the coverage and meeting the latent demand of couples who do not want any more children and want to space their births.

There is the danger, however, that the family planning activities will be given little emphasis in the Women Health Project by LHWs who are expected to do many health duties and that family planning will be assigned low priority by other ministries that are being required to offer family planning services. Moreover, as long as the service delivery outlets of PWP and health department work vertically without any functional integration at the grass root level, it would be difficult for the desired objectives of RH/FP and fertility reduction could be achieved. The need of the time is that all the service outlets of PWP and primary health care outlets of health departments and LHWs Programme should be brought under one roof and under one authority. The divided authority does not help in achieving the RH/FP targets, which has been experienced over the last two decades.

To conclude this situation analysis, it is noted that repeated pregnancy and the high fertility as prevalent in the country is seen to be highly correlated with early female marriages, early child bearing, high infant and child mortality, close birth intervals, birth continuing in high parities, high fetal losses and induced abortions. Malnutrition and under-nutrition, high levels of anemia among females, particularly among pregnant and lactating mothers, high unmet need for contraception, high ideal family size and gap between desired and actual number of children, preference for boys and desire for sons to survive until the parents' old age to provide security, preferential care and treatment of boys compared to girls, low literacy and educational attainment particularly among females, low mobility of females, low female economic activity, religiosity, ignorance, conservatism and socio-cultural norms and practices, indifferent attitude of males to RH/FP, persistent high incidences of poverty are still major obstacle in the way of gender empowerment, gender equality, high fertility and lower use of contraception in the country. These factors further get aggravated and compounded with poor and/or non-

availability, accessibility and affordability of services and limited use of health outlets services for FP/RH.

4. POLICY ANALYSIS

In this section an attempt is made to provide an overview of population policy, its linkages with other sectoral policies and the extent to which it addresses gender issues discussed in the previous section.

The first ever population policy in Pakistan was the outcome of a participatory process involving a wide range of stakeholders and concerned partners. With the approval of the federal cabinet, it was announced by the President of Pakistan on World Population Day, on 11th July, 2002 (GOP, 2002). The population policy is designed to achieve social and economic revival by suppressing the rapid population growth and reducing its adverse consequences for development.

Along with population policy, the government also launched the Population Sector Perspective Plan 2012. On the one hand the plan restructured the national population welfare programme which has been integrated into the government's Poverty Reduction Strategy Paper (PRSP). On the other hand, its strategies have been translated into operational programmes which have been decentralized from fiscal year 2002-2003 to the provinces and have expanded considerably through the involvement and partnership of private and public sector organizations, NGOs and civil society stakeholders along with the social marketing of contraceptives institutes and the active involvement and functional integration of Federal and Provincial Health services outlets.

The population policy is wide in scope. It identifies core issues such as gender inequalities and lack of access to quality services. It states a commitment to reduce the incidence of unwanted fertility (pregnancies), promote the small family norm, make an investment in the youthful population and focus on male involvement.

The Population Policy elucidates vision, goals, objectives and strategies. The overall vision of the Population Policy is to achieve population stabilization replacement level, that is, a total fertility rate of 2.1 children per woman by 2020 through expeditious completion of the demographic transition that entails a decline in both fertility and mortality rates. The goals of the Population Policy seek to increase awareness of the adverse consequences of rapid population growth at the national, provincial, district and community level, promote family planning as an entitlement based on informed and voluntary choice, attain a reduction in fertility through improvement in access to and quality of reproductive health services and reduce population momentum through a delay in the first birth, changing spacing patterns and reduction in family size desires

The policy objectives are to reduce fertility through enhanced voluntary contraceptive adoption, increase the contraceptive prevalence rate to 60 percent by 2020, reduce population growth rate to 1.3 percent per annum by 2020 and provide universal access to safe and modern family planning methods by 2010.

The major objectives and key targets of the population welfare sector under the MTDF (2005-10) which are in line with the Population Policy are to decrease the population growth rate from 1.9 percent in 2005 to 1.6 percent in 2010, increase the coverage from 75 percent in 2005 to 95 percent in 2010, to ensure that all service outlets of health departments will offer reproductive health services including family planning and make efforts to enhance involvement of NGOs/civil society organizations and social marketing projects in family planning. These combined factors will help to increase contraceptive prevalence rate (CPR) from existing 36 percent in 2005 to 51 percent in 2010.

The Population Policy enunciates the major strategies under PSRP and MTDF for achieving objectives of population growth reduction by 2010 and population stabilization by 2020. The Policy aims to facilitate in decentralizing programme management and service delivery to provincial and district level. It aims to develop and launch a well-designed advocacy campaigns to address targeted population. It focuses on provision of quality services particularly to the poor, under-served and un-served populations in rural areas and urban slums. The policy reiterates the importance of building strong partnership with concerned line ministries particularly health non-governmental organizations and private sector. The policy lays stress on making contraception accessible and affordable through social marketing of contraceptives (SMC). It also accords particular attention to expanding and strengthening service delivery, training, monitoring, evaluation and research. Most of these strategies are continuation of the ongoing activities of the PWP. However, Population Policy reiterates these activities in a more consolidated and effective manner.

Under the MTBF (2005-08) and MTDF (2005-2010) the Population Welfare Programme is expected to focus on new initiatives and priority programmes. It will involve women organizations and other groups working for women's needs in the planning, implementation and monitoring of reproductive health services and programmes. It will promote men's participation in reproductive health programmes through sensitization and creating awareness among them for responsible reproductive behaviour in relation to women's health benefits and overall improvement of quality of life and family welfare, information and services. The provincial government will establish family planning cell in all provincial departments of health and improved managerial and service provision capacity at different tiers of devolution with a view to improve performance of programme personnel.

The MTDF (2005-2010) aims to make the family planning activities part of RH package available at all health service outlets. This will address the fact

that the public health sector which has over 13000 service outlets is currently not offering family planning services on a regular basis as they do not have a mandate to cater unmet need for family planning (MTDF 2005-10).

It is expected that the newly constituted Population Commissions at the Federal level under the Prime Minister and at the provincial level under the Chief Ministers will ensure strong political and administrative commitment to the programme at all levels and close coordination and collaboration of population activities among different sectors of the government also between public and private sectors.

4.1 Population Welfare Programme

Pakistan's Population Welfare Programme is an ongoing programme since 1960 when it was introduced under the Ministry of Health and then in 1965 it was made an independent vertical programme parallel to health. Pakistan's Population Programme has been one of the most reviewed and evaluated public sector activities with fluctuating political and administrative support and priority, frequent shifts in policy programme emphasis, strategy and approaches and administration [Rukanuddin et. al, 1991, Hakim et. al, 1998 and Rukanuddin, 2000].

In 2001 a Review Committee on Restructuring of Population Welfare Programme highlighted that poor management, low accessibility, poor quality of services and lack of community participation were the major causes of slow progress of the programme and set out strategies, priorities, programme needs identified gaps recommended among others, that the service delivery be devolved to the provinces.

The recommendations were in line with the government's devolution plan. The process of review and decisions by the government led to the formulation of the Population Policy and Perspective Plan 2012. In terms of this Plan, the role of MOPW becomes that of a central coordinating body for population interests and objectives. Provincial PWDs after de-federalization receive their funds directly through the PSDP of the MOPW. The de-federalization of the PWP provides a new direction to population policymakers, managers, especially at the provincial levels to design strategies, allocate and spend funds according to their local need. Moreover, necessary administrative, financial powers have been delegated to PPWDs to implement the field activities.

The PWP under the devolved setup will continue to function and offer the family planning services through the following infrastructure in close collaboration with the outlets of health departments and other Provincial Line Departments (PLDs), Target Group Institutions (TGIs) and NGOs. PPWDs offer family planning services through their service outlets which are as under:-

4.1.1 <u>Family Welfare Centres (FWCs)</u>

The FWC is the backbone of the service delivery of PWP. It provides MCH and family planning services. It covers a population of around 20-25 thousand through its satellite clinics and outreach facilities. It is managed by

a Family Welfare Worker (FWW)/Family Welfare Counselor who, among other duties, inserts IUDs and dispenses other contraceptives such as oral pills, injectables and condoms.

4.1.2 Reproductive Health Services Centres (RHCs or RHS)

(a) *RHS–A centers:* These are hospital-based family planning service delivery units located in the district hospitals and other government hospitals. Each center is headed by Lady Medical Officer. It provides contraceptive surgery and treatment to females along with MCH and other health-related family planning services, treatment for infertility and side effects, prevention and management of RTIs/STDs. RHC–A is funded by PWP and falls directly under the administrative control of PWP.

(b) *RHS-B centers:* Hospitals having operating facilities and trained persons interested to perform contraceptive surgery are designated as B type centers. These are mostly located in the hospitals of PLDs and TGIs and NGOs. They get reimbursement for the costs of their contraceptive surgery services from the PWP.

4.1.3. Mobile Service Units (MSUs)

MSUs provide FP/RH services at the doorstep of un-served community in the rural and far-flung areas through their pre-determined camping schedule. Each MSU covers 15-20 villages in a tehsil. It undertakes 10-12 camps every month, The MSU in-charge is a Women Medical Officer trained in dispensing family planning services and IUD insertions and is funded by PWP.

4.1.4 Village Based Family Planning Workers - Male (VBFPW-Male)/Male Mobilizers

This cadre was introduced as a pilot project during the Ninth Five Year Plan (1998-2003) to enlighten and motivate males towards responsible parenthood and family health and advance gender equality for improving family planning. This cadre is being extended to all Union Councils. The VBFPW have been renamed as Male Moblizers and the initiative is funded by PWP (GOP, MOPW, PC-1).

The Ministry of Population Welfare (MOPW) transferred the administrative control of the provincial programmes to the provinces on 1st July, 2002. The provinces accepted the decision of the Federal government as a challenge and activated their service delivery infrastructure to further devolve it to the district level. Some of the provinces including Punjab completed the work for recruitment against the available approved vacancies In this regard, integration at grass-root level has been completed in the form of the transfer of MOPW's 12,000 VBFPWs to Ministry of Health (MoH) National Programme on FP/PHC to join the cadre of Lady Health Workers (LHWs). Efforts are also underway to strengthen functional integration between Family Welfare Centres (FWCs), Lady Health Workers (LHWs) and Mobile Service

Units (MSUs) to improve service delivery at the community level. [GOP, MTDF, 2005]

Under the revised set up, the specific role of MOPW has been confined mainly to policy, planning, financing PWP, advocacy and communication to bring behavioral change, monitoring and evaluation, contraceptive logistics and human resources development. Hence, the broad mandate of the Ministry is to strengthen policy and advocacy and monitor outcome indicators, whereas the service delivery has to be integrated with the health infrastructure under the devolved set up and the implementation of the programme would rest with the provincial population welfare developments (PPWD) (MOPW – PC-1, 2003-08). Government acknowledges that the overall performance of the programme under the new structure needs improvement in all areas. [GOP, MTDF, 2005]

4.2 Relevant Developments in Health sector policy

The national programme of family planning and primary health care (LHWs programme) will be devolved to the provinces and districts in two phases. Phase I includes consolidation and expansion of the programme to 100,000 LHWs during 2003-2005, which is now being delayed and is expected to be achieved during 2005-06. At the end of phase I, the programme will be evaluated by a 3rd party and the programme adapted in the light of evaluation report. The phase II pertains to development of a strategy for sustainability during 2005-2008 through capacity building and logistic support of the districts and provinces. The programme will be transferred to the 20 districts on a pilot basis. The districts will, among others, do family planning work also.

5. BUDGET ANALYSIS

The Poverty Reduction Strategy Paper (PRSP) recommended that the Government embark on a reform of public expenditure management under the Medium Term Budgetary Framework (MTBF), which is a multi-year approach to budgeting. It aims to link the Government's spending plan to its policy objectives. The MTBF reform commenced during 2003-2004 as a pilot activity in the two Ministries of Health and Population Welfare. In 2004-05 these Ministries worked according to a new MTBF Budget Call Circular (BCC) and guidelines. It comprised new instructions and proformas for MTBF and budget preparation with an attempt to link MTBF and budget proposals with activities, outputs and policy objectives The Ministry of Population Welfare (MOPW) carried out a detailed exercise of determining output indicators, setting of activity levels to achieve these indicators and costing of these activities in the medium term perspective.

In this section an attempt is made to analyze the population welfare sector budget with a view to investigating how far the budget has been gender-responsive in terms of contributing to gender equality. In Pakistan budgets are prepared at Federal level, at provincial level for each of the four provinces, and at each district level. Each budget is classified into current and development budget. The budget preparation provides object classification of budgetary allocation and revised estimates by various projects, activities and heads of expenditure. It includes public (government) as well as multilateral and bilateral assistance committed by donors for project- specific activities or overall support to programme activities.

Since 1965 and until today, the activities of the population welfare sector at federal, provincial, district and in other areas that is, Federally Administrative Tribal Areas (FATA), Northern Areas (NA) and Azad Jammu and Kashmir (AJK) are totally financed by the federal government from the PSDP. The population sector activities get almost 97 percent of their allocation from the development budget. The three percent budget obtained from current budget is mostly utilized in the Federal Secretariat for the administrative activities of the core staff of the Ministry of Population Welfare.

Like other social sector activities, the population sector activities get an insignificant (0.07 percent) allocation of the total GDP in the country. [GOP, PRSP, 2005]. For the population welfare sector, all the activities to be carried out have to be transcribed onto Planning Commission's PC-1 forms. Each PC-1 explains the activities to be executed along with the objectives, goals and strategies and proposed financial implications for accomplishing the activities. At present, there are 24 approved PC-1s for the period 2003-2008 sponsored / executed by the MOPW. The Government allocates an annual budget in the light of PC-1's financial approvals. The major PC-1 is for the Federal and four provincial governments' population sector activities, which share a large portion of development allocation.

5.1 Budget Allocation 2005-08

The three-year ceilings of Mid-Term Budgetary estimates in the MTBF (2005-2008) is linked to policy objectives enunciated in the Population Policy document and in the MTDF (2005-10), which focuses on reduction in fertility, growth rate of population and increase in the number of contraceptive prevalence rate by the terminal year, that is, 2008 of the MTBF (2005-2008).

The development: current budget ratio of 97:3 remains more or less constant over the period 2005-06 to 2007-08. The current budget increase is estimated at 8 percent in 2006-2007 and 5 percent in 2007-2008. The increase for the development budget is estimated at 10 percent and 2 percent respectively for the corresponding years. The Medium Term Budget Estimates are transformed into policy objectives. These are given in MTBF document (GOP, 2005).

The current budgetary allocation of 3 percent would be utilized on the employees related expenses of the population planning officers and staff, which includes pay, allowances, operating expenses, transfer, physical assets, repair and maintenance etc. This amount would be spent on the Population Welfare employees working at Islamabad Secretariat, Lahore (Directorate of Production and Printing) and Karachi (Directorate of Central Warehouse).

The development expenditure on revenue account for the year ending 2006 and the budgetary forecasts for fiscal year 2006-2007 and 2007-2008 would be spent mostly (83-85 percent) on salary and service delivery expenses and other operating expenses of the development expenditure related to population sector activities mostly related to service delivery to be incurred by the provinces/districts The PRSP support for population activities resulted in a substantial increase in the budgetary allocation since 2001. The budgetary allocation in the PSDP for PWP increased four-fold from Rs.1.1 billion in 1993-94 to 4.6 billion in 2005-06 and two-fold increase from Rs2.3 billion in 2002-03. Ahmed (2005) has mentioned that the allocation to PWP have grown in real terms to address PWP growing demands. Expenditures after controlling for 1992-93 prices have shown real increase in 2003-04, implying that after controlling for inflationary factors, the sector expenditures have increased from Rs.841 million in 2000-21 to Rs.1,021 million in 2003-04.

5.2 Budget Allocation Trend, 2002-2006

Table 3 shows the PSDP and revised budget allocation and expenditure on population welfare activities for the years 2002-2006. There is a 75% increase in the PSDP for the country as a whole and for Punjab in 2005-2006 compared to the previous year's allocation. In the revised allocation, the corresponding increase has been 88 percent for Pakistan and 80 percent for Punjab. According to MOPW's monthly expenditure statement, 24 percent (Rs.1112 million) of the total revised budget is allocated to Federal and the rest (Rs.3458 million) is allocated to the four provinces. Of the total provincial allocation of Rs.3458 million, 50 percent (Rs.1719 million) is allocated to Punjab

Table-3: Budget Allocation, Releases, Expenditure, Pakistan and Punjab, 2002-03 to 2005-06 (Rs M)

Budget	2002-03		2003-04		2004-05		2005-06	
	Pak	Punjab	Pak	Punjab	Pak	Punjab	Pak	Punjab
Allocation original (PSDP)	2,300	746	3,115	1,048	2,586	977	4,521	1,748
Percent increase over last year	-	-	35.4	40.5	-17.0	-6.8	74.8	78.9
Revised allocation	1,938	747	2,348	806	2,431	959	4,570	1,719
Percent increase over last year	-	-	21.2	7.9	3.5	19.0	88.0	79.3
Releases	1,916	646	2,341	806	2,430	959	870	352
Percent increase over last year	-	-	22.2	24.7	3.8	19.0	-64.2	-63.3
Expenditure	1,798	556	2,168	709	2,138	774	343	119
Expenditure as percent of releases	93.8	86.1	92.6	88.0	88.0	80.8	39.4	33.9

Source: Govt. of Pakistan, Ministry of Population Welfare, Directorate of Financial Management

Table 4 shows the budget allocation by head of expenditure for the provinces. For the four provinces combined and for Punjab the increase (in 2005-2006) has been 78 and 79 percent respectively. There has been 37 and 60 percent more increase for the administrative setup of all the four provinces and Punjab respectively. The increase is noted more for Tehsil set up. Table further shows that in case of service delivery components for the four provinces and Punjab, the increase has 97 and 89 percent respectively. Of the total allocation, almost three-quarters is earmarked for service delivery component. It could be further noted that of the total budget allocation for three major service delivery outlets of PWP (FWCs, MSUs, RHCs), 56-60 percent is earmarked for FWCs.

Table-4: Budget Allocation by Head of Expenditure for Population Welfare Programme, Pakistan and Punjab, 2004-06 (Rs.M)

S.No.	Head of Expenditure	Budget Allocation 2004-2005		Budget Allocation 2005-2006		Percent increase over the last year	
		4 Provinces Combined	Punjab	4 Provinces Combined	Punjab	4 provinces	Punjab
1	Administrative setup	450.8	156.0	615.4	250.3	36.6	60.4
	a. Provincial	149.3	25.9	129.5	30.3	-13.3	17.0
	b. Regional	21.7	12.1	6.2	-	-71.4	-
	c. District	220.2	93.2	340.9	142.3	54.8	52.3
	d. Tehsil	59.6	24.8	139.7	77.7	134.4	213.3
2	Family Welfare Centres (FWC)	851.5	450.9	1193.6	652.7	40.2	44.8
3	Mobile Service Units (MSUs)	178.9	105.6	409.3	190.3	129.3	80.2
4	Reproductive Health Services (RHS)	275.6	161.8	527.8	243.8	91.5	50.7
5	Village Based Family Planning Workers (VBFPWs)	100.7	42.3	287.5	171.5	185.5	305.4
6	Provincial Line Departments (PLDs)	3.1	0.5	5.7	2.5	83.4	400.0
7	Registered Medical Practitioners (RMPs)	4.6	1.0	5.6	2.0	21.7	100.0
8	Communication Strategy	72.2	41.0	55.5	21.9	-23.1	-46.6
9	Innovative	0.5	-	5.5	5.0	-	9.1
10	Establishment of RH-A Centre	-	-	245.0	150.0	-	-

11	ADB-RH Project	-	-	108.7	29.1	-	-
		1937.9	**959.0**	**3457.8**	**1719.1**	**78.4**	**72.2**
12	Total of service outlets (serial 2-7, 10 & 11)	1414.4	762.1	2783.2	1441.9	96.8	89.2

Source:Govt.of Pakistan, Ministry of Population Welfare, Directorate of Financial Management

5.3 Budget for Service Delivery

Most of the service delivery outlets cater to predominantly married women of 15-49 years of age. In 2005-2006, 80 percent of the total allocation (Rs.3458 million) in the four provinces and 84 percent of the total allocation (Rs.1719 million) in Punjab is expected to be spent on providing service delivery to clients (Table 4). In the federal budget the amount to be spent on service delivery component is estimated 35 percent, which is for Azad Jammu and Kashmir (AJK).

5.4 Budget Utilization 2004-05

The percentage of expenditure remained more than 90 percent of the released budget in 2002-2003 and 2003-2004. In 2004-2005 it declined to 88 percent. In the first quarter (July-September) of fiscal year 2005-2006 only 39 percent of the revised budget has been spent in the country whereas in Punjab the spending stands at 34 percent only (Table 3). In the federal capital the utilization of budget was 63 percent on the whole and almost the same proportion of utilization was reported for service delivery outlets. Serious focus has to be paid at the federal, provincial and district levels to increase the absorptive capacity.

Table-5: Budget Utilization as Percent of Allocation for Provinces, 2004-05

(Rs M)

S.NO	Heads of Expenditure	Punjab, Sindh, NWFP, Balochistan, 2004-05			Punjab 2004-05		
		Allocated budget	Exp.	% Utilization	Allocated budget	Exp.	% Utilization
1	Administrative Organization	450.8	459.5	101.9	156.0	176.7	113.2
	a. Provincial	149.3	156.3	103.4	25.9	37.9	146.2
	b. Regional	21.7	27.6	127.3	12.1	16.4	135.6
	c. District	220.2	217.0	98.5	93.2	95.6	102.5
	d. Tehsil	59.6	58.6	98.2	24.8	26.8	108.2
2	Family Welfare Centres (FWCs)	851.5	749.5	88.0	450.9	390.2	86.6
3	Mobile Service Units (MSUs)	178.9	93.4	52.2	105.6	44.1	41.7
4	Reproductive Health Services (RHS)	275.6	244.2	88.6	161.8	131.9	81.5
5	Village Based FP Workers (VBFPWs)	100.7	65.9	65.4	42.3	16	37.9
6	Provincial Line Departments (PLD)	3.1	2	64.5	0.5	0.5	100
7	Registered Medical Practitioners (RMPs)	4.6	2.3	50.0	1	0.5	49.9
8	Community Strategy	72.2	35.5	49.2	41	14.5	35.5
9	Innovative	0.5	0.3	60.0	0	0	0
	Total	1937.9	1652.6	85.3	959	774.4	80.8
10	Total of service Outlets (Serial 2-7)	1414.4	1167.3	82.5	762	583.2	79.7

Source: Govt. of Pakistan, Ministry of Population Welfare, Directorate of (FM)'s Exp. Statement.

Table 5 exhibits the spending under various heads of expenditures by all provinces combined and Punjab for the years 2004-2005. All the provinces combined and Punjab were able to spend 85 percent and 81 percent of their budget allocation respectively. The absorptive capacity of service delivery components was relatively low (81-83 percent). It is particularly noted that all the Mobile Service Units (MSUs) could only spend half (52 percent) of their allocated budget. In Punjab the corresponding proportion was only 42 percent. Most of the MSUs might not be operational due to logistic problems or concerned staff might not be fully recruited. This might be one of the reasons for low spending on MSUs. With almost a doubling in the budget allocation in 2005-2006, it is expected that the MSU's staff component will get expanded and will become operational in providing services. This would help to increase the absorptive capacity of MSUs. Their monitoring and supervision would also be effectively enhanced as the MSUs are expected to cater the remote and far-flung areas at the doorsteps of the villages, which will help to expand coverage, especially to poorer people.

Punjab was able to utilize four-fifths (81 percent) of its budget allocation. The lowest utilization was for VBFPWs males (38 percent), followed by MSUs (42 percent). The utilization rate of RHSs (82 percent) and FWCs (87 percent) was quite encouraging during 2004-2005. Efforts have to be especially devoted to expand efficient utilization of allocated budget for the service delivery outlets where the spending is quite low.

5.5 Sector Review 2004-05

Under the MTDF, the Ministry of Planning and Development carries out mid-term (half-year) and annual sector review immediately after the end of the second quarter and after the end of the fourth quarter of the fiscal year for all the development projects to see how far the budget releases are utilized by various heads of expenditures. The sector review for half year and the complete fiscal year 2004-05 is given in Table 6.

Table 6: Half Yearly and Yearly Sector Review of Budget Utilization, 2004-05, Pakistan and Provinces (Rs.M)

Area	Half yearly utilization (July 2004 to December, 2005)			Yearly utilization (July, 2004 to June, 2005)			
	ADP Allocation in Rupees	Utilization In Rupees	Percent utilization of ADP	Budget Releases In Rupees	Utilization/ Expenditure in Rupees	Percent of utilization of ADP	Percent of utilization of Budget releases
1. Pakistan	2586	9507	368	24301	21398	827	881
2. Federal	660	2901	440	5167	5027	762	973
3. Punjab	977	2927	300	959	7744	793	808
4. Sindh	451	2225	493	524	492	1091	939
5. NWFP	358	846	236	2604	2042	570	784
6. Balochistan	184	608	330	170	1664	904	979
(Total S.Nos 3-6 all provinces)	1970	6606	335	19134	1637	831	856

Source: GOP: MOPW Directorate of Financial Management.

The mid year review (ending second quarter of PSDP 2004-05) indicated the total utilization of the whole years' annual development plan budget was 37 percent. At the federal level the utilization was 44 percent and in the provinces it varied from 24 percent to 49 percent. The average of half yearly utilization for all the provinces combined was 33 percent. The yearly sector review indicates that 83 percent of ADP budget allocation. The details for the four provinces indicate utilization ranging from 78 percent to 94 percent (Table 6). Punjab spent 79 percent of ADP allocation and 81 percent of released budget. The reasons for low spending among other things have been cited as non-approval of PC-1s and ban on recruitment.

5.6 Flow of Funds

Smooth budget execution, among other things, is a crucial factor in achieving the key policy objectives and strategies, especially in a sector such as Population where the money is allocated by one level but used for implementation by different levels. Timely release of funds to the end users has a positive effect on the morale of the employees and their dedication to perform their assigned jobs more effectively. Time lag in release of funds from Federal Government to Punjab province during the four quarters of 2004-2005 took from a minimum of 53 days to 92 days with average delay in releases of 73 days in the last year. For other provinces the situation has been slightly better. In the first quarter of fiscal year 2005-2006 it took a total of 84 days from the day approval was accorded by the Principal Accounting Officer (that is, Federal Secretary) to reach the funds to the Punjab Population Welfare Department. For example, the breakdown of funds releases in the 1st quarter of 2005-2006 is 27 days for getting endorsement by Financial Advisor's office of Ministry of Finance. It took 15 days to send to Accountant General Pakistan Revenue (AGPR) Office and other 10 days to send the sealed authority to State Bank of Pakistan. Finally the Provincial Finance Department took 32 days to transfer the funds to Provincial Population Welfare Departments (PWD). Further it takes on average one month more to reach the end users of the service outlets from PWDs in all the provinces

The Punjab Provincial Finance Department takes the longest time to release the funds to the PWD. The time lapse ranged from 28 days to 54 days in the last four quarters and averaged 40 days in the last year. When the whole population welfare programme was federalized, there was not a serious problem in release of funds as AGPR could release the funds on routine basis. With the de-federalization of the programme, the problem of late release of funds has become more serious.

5.7 Expanding coverage and strengthening services: Inconsistencies in service targets

The MTBF (2005-2008) and MTDF (2005-10) have stressed expansion of service delivery outlets and staff to achieve operationalization of devolution plan and for making the programme management more efficient and effective in implementation. The MTBF and MTDF have given physical targets of service delivery components of the PWP for the periods 2005-08 and 2007-2010 respectively. These are given in Tables 7 to 9 for Pakistan and in Table 10 for Punjab.

Table 7: MTBF Physical Targets of Service Delivery, Pakistan, 2005-08

(Cumulative)

Service Components	2005-06	2006-07	2007-08
Family welfare centers	2436	2626	2803
RH centers	176	218	269
Vasectomy units	14	18	21
Mobile service units	294	298	302
Male mobilizers	5280	5980	6324

Source: Ministry of Finance, MTBF, 2005-08

There has been a shortfall in achieving physical targets of PWP's service delivery components when compared to MTBF physical targets for the year 2005-06 as shown in Table 7. The highest shortfall of 71 percent is noted for vasectomy clinics as only four clinics are in operation against a target of 14 to be established in 2005-06. It seems unlikely that the target of establishing vasectomy clinics would be achieved in the next six months of the fiscal year. Moreover, there is almost one-third shortfall in the establishment of RHS-A Centres and MSUs. Only 50 percent (2622) of the male mobilizers are working against the total target of 5280. It may be noted that minimum qualification of male mobilizer is graduation and they are appointed on contractual basis, which discourage them to accept the position. Even if they accept the offer, their retention rate is expected to be low, as they will try to get a permanent job. It seems that the male mobilizers whose main responsibility is to motivate males for the involvement of RH/FP services would suffer, if not recruited and/or on regular basis expeditiously.

Table 8: MTDF Physical Targets of Service Components, Pakistan, 2004-10

(Cumulative)

Components	2004-05 Benchmark	2005-06	2006-07	2007-08	2008-09	2009-10
Family welfare centers	2274 (2211)	2479 (2361)	2712 (2541)	2888 (2675)	3000	3000
Mobile service units	218 (207)	264 (241)	290 (257)	298 (275)	300	300
Reproductive health service centers	132 (117)	180 (124)	230 (133)	280 (143)	300	300
Male mobilizers	4085 (3840)	5802 (5377)	6610 (6031)	6700 (6061)	6660	6700

Note: Figures in parenthesis are from PWP, PC-1.
Source: (i) Govt. of Pakistan, Planning Commission, MTDF (2005-2010). (ii) Govt. of Pakistan, MOPW, Federal PC-1, 2003-08).

The physical targets given in the above tables show some inconsistency in terms of service delivery targets between MTBF, MTDF and PC-1. PC-1 targets are consistently lower than the others. However, these figures are also all different from the targets given in the Economic Survey, 2004-05. These figures need to be made consistent and realistic in terms of achieving the physical targets.

The Economic Survey's Physical Targets are as follows:

Table 9: Service Delivery Infrastructure, Pakistan, 2004-06

S.No.	Service Delivery Outlets	Planned 2004-05	Achieved as on 31-3-2005	Targets for 2005-06
1	FWCs	2054	1969	2350
2	RHCs 'A'	118	114	142
3	MSUs	214	177	290
4	Male Mobilizer	2849	1285	5309

Source: Govt. of Pakistan, Economic Survey of Pakistan (2004-05), Table-13.2

The Punjab Population Welfare Department (PWD) aimed at 100 percent coverage of the population for family planning activities with the following service delivery infrastructure as shown in Table 10.:-

Table 10: Family Planning Infrastructures, Punjab, 2002-08

Description	2002-03 Benchmark	2003-04	2004-05	2005-06	2006-07	2007-08
Programme outlets						
Family welfare centers		1060	1225	1300	1400	1500
RHS-A centers	51	54	57	60	63	66
Vasectomy units	0	3	6	9	12	15
Male Mobilizers	366	1000	2000	3000	3300	3300
Mobile Service Units	70	82	117	117	117	117

Source: Government of Pakistan, from Approved PC-1, 2005.

Like the national targets, the Punjab Population Welfare Department is also lagging behind in achieving its physical service delivery infrastructure targets even in the year 2004-05. For example, only 1185 FWCs have been established. Further, some of these are not yet functional. The number of RHS 'A' remains at 51 which was the benchmark figure for 2002-03. Similarly, so far none of the vasectomy units have been established. Their number remains at the three reported for 2003-2004. Only 105 Mobile Service Units have been established. So far only 274 male mobilizers are working which is less than the benchmark target of 2002-03. One of the main reasons cited for not achieving the infrastructure target has been given as delay in the PC-1, failure to get approval from the Finance Department and the ban on recruitment of employees for staffing these outlets as well as a ban on recruitment of male mobilizers for motivational activities. The same picture of under-delivery is expected to be prevalent for other provinces.

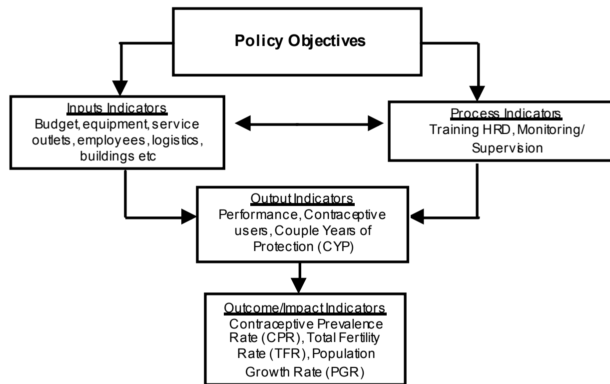
The population activities need to be expanded by the end of the MTBF period 2008 in the far-flung remote areas of the country so that the unmet need of the segmented and pro-poor people is met. This could be effectively achieved if the Public Health Sector, which has over 13,000 service outlets, is functionally integrated for providing family planning and RH services on regular basis, as at present, according to the MTDF, they "do not have a mandate to cater to unmet need for family planning" (MTDF, 2005-10).

The National Programme of Family Planning and Primary Health Care, which is commonly known as Lady Health Workers (LHW) Programme and is being

devolved at the grassroots level and further expanded, is responsible for primary health care along with family planning. These workers are employed by the Health sector, but are relevant in an assessment of government's performance in respect of family planning. In an evaluative study [NIPS, 2000] it was found that about 29 percent of VBFPW/LHW reported that they visited currently married women in the last 12 months and 48 percent discussed family planning and 83 percent had discussed health problems with the women. In another study, it was also noted that Trainer-cum-Supervisors were not regular in their supervisory visits as they were asked to perform other jobs in addition to their assigned work (Oxford Policy Management, 2002). Pakistan discontinued the service of midwives, which Bangladesh continued after separation from Pakistan. Bangladesh further strengthened this layer of workers through extensive training. This cadre until now is successfully providing family planning services in Bangladesh. In Pakistan this type of worker does not exist as a first referral system for the community based approach and thus constitutes a missing link between LHWs and skilled health personnel.

6. SERVICE DELIVERY AND IMPACT ANALYSIS

In Gender Responsive Budget Initiative (GBRI), it is important to bring out issues confronting the population activities. These issues need to be merged into policy objectives and have to be transformed and relate to budget allocation and service components targets as input indicators, which have to be further identified into process indicators and ultimately into output and outcome/impact indicators The link between objectives, inputs, process, outputs and outcomes are shown in the following chart:



6.1 Inconsistencies in performance targets

The objective according to the MTBF is to achieve 11 million contraceptive users by the end of year 2008 which will bring down the total fertility rate to 3.4 children per women, contraceptive prevalence rate to 45 percent and bring down the growth rate of population to 1.7 percent per annum (GOP, MTBF, 2005).

The prime objective of the government is to achieve ICPD as well as MTDF (2005-2010) and MDG goals, which would ultimately facilitate the population policy's vision of achieving population stabilization by the year 2020. The MTBF developed for the years 2005-2008, lists the objectives and strategies of the Population Welfare Ministry to be achieved by the end of year 2008.

In addition to the above performance measures, the recently published Planning Commission's Pakistan MDG Report 2005 (GOP, 2005) also show the PRSP, MTDF and MDG targets of infant, child and maternal mortality,

antenatal care, fertility and contraceptive use as shown in Table 11. Comparing the fertility and CPRs targets, it is noted that there is no consistency between the two when comparing PRSP, MTBF, MTDF and MDGs targets. The rates of TFR and CPR are inconsistent as international data and experience show that CPR level of at least 70 percent is required to achieve TFR 2.1 per woman (Ahmed, 2005). It is astonishing to note that Pakistan MDG Report 2005 shows that TFR of 2.1 per woman will be achieved by the year 2015 instead of 2020 with lower CPR of 55 percent instead of 60 percent (Table 9). This ambitious target of achieving TFR of 2.1 by the year 2015 seems absolutely unachievable. One has to even seriously think whether with our current performance replacement level will be able to be achieved even by 2020. These inconsistencies in achieving the demographic targets need re-visiting and rethinking as MTDF (2005-10) and MDG Report 2005 are both published by the Planning Commission.

Table-11: Goals of Achieving Targets under PRSP, MTBF, MTDF, MDGs & Population Policy, Pakistan, 2005-2020.

S.No	Selected Indicators	2004-05	Targets				
			PRSP 2005-06	MTBF 2008	MTDF 2009-10	MDG 2015	Pop. Policy 2020
1	Infant mortality per 1000 live births	73	63	-	65	40	-
2	Maternal mortality ratio per 100,000 LB	400	300-350	-	300	140	-
3	Total fertility rate per woman	3.9	3.7	3.4	2.7	2.1	2.1
4	Contraceptive prevalence rate (%)	36	42	45	51	55	600
5	Population growth rate (%)	1.9	-	1.7	1.6	-	1.3

Source: Planning Commission, Centre for Research on Poverty Reduction and Income Distribution, Pakistan Millennium Development Goals Report, 2005, September, 2005

6.2 Contraceptive Performance

The Management Information System (MIS) of the PWP produces service statistics showing contraceptive performance of various methods by various service outlets. It generates performance for districts and provinces and at national level. The physical performance in terms of number of users of contraceptives can be converted into Couple Years of Protection (CYP)[1] to indicate achievement of the programme. Table 12 exhibits the performance of contraceptive mix. The Table shows that there were 3.1 million persons who used a modern method of contraception in 2004-05. The MTBF shows performance of 7.7 million users by end of fiscal year June, 2005. This shows that only 60 percent of targets of contraceptive users have been achieved. One may also take into consideration that service statistics/figures are usually over reported. These users (3.1 million) produced 6.7 million CYP. Almost two-third of the contraceptive users were women and one-third (33 percent) were men. When the contraceptive users are converted into CYP, it is noted that 1.01 million (33 percent) users of condoms achieved 0.7 million (11 percent)

52

[1] For converting units of contraceptives into number of users and Couples Years of Protection (CYP), the MOPW uses the conversion factor as follows. One use 100 condoms, or 13 cycles of oral pills, or 5 injectables or one IUD or one sterilization. For converting contraceptive mix into CYP, 144 condoms, 15 cycles of oral pills, 5 vials of injectables are used. For one IUD 3.5 years and for one sterilization 12.5 years are used for conversion into CYP.

CYP whereas 0.16 million (5 percent) cases of contraceptive surgery achieved 2.0 million (29 percent) CYP. Similarly the IUD insertions of 0.9 million (28 percent) women are transformed into 3.1 million (46 percent) CYP.

The data of contraceptive performance by age and/or parity of users is not available, which otherwise could show how far various contraceptive mix particularly contraceptive surgery make a demographic impact on birth aversion. It is believed that most of the women who undergo contraceptive surgery are of high parity and have given birth to five or more living children, hence their demographic impact might be minimal. Unless the contraceptive surgeries are performed on women with 3-4 living children, demographic impact could be negligible on fertility reduction as they (high parity older women) have almost completed their family size (fertility).

Table 12 further shows that the highest share of CYP is reported by IUD (46%) followed by contraceptive surgery (29%). Of the CYP achieved 9 out of 10 is credited to females. This illustrates that women are bearing the main burden of responsibility for contraception, whereas population policy mentions that more men must also become responsible. The PWP's significant female bias is also evident from the procurement data. It is noted that the total value of contraceptive distributed/sold in 2004-05, was of Rs.195 million. Of this total amount, 79 percent was spent on contraceptives, used by females (52 percent on injectables, 16 percent on oral pills and 11 percent on IUDs) and 21 percent by males (condoms). Similarly the IEC programme, which is six percent of the total PWP budget of 2005-06 is expected to influence more females than males

Table-12: Contraceptive Performance, Number and Percent of Users and Couple Years of Protection (CYP). Pakistan and Punjab, 2004 -2005.

No.	Contraceptive Mix	Pakistan 2004-05			Punjab 2004 -05		
		Contraceptive Units	No. of users /(%)	CYP/ (%)	Contraceptive Units	No. of users/ (%)	CYP/ (%)
1	Condoms (units)	101,168,855	1,011,689 (32.7)	702,561 (10.5)	16,244,217	162, 442 (18.7)	112,8 07 (3.7)
2	Oral pills (cycles)	8,066,826	620,525 (20.1)	537,788 (8.0)	699,573	53,813 (6.2)	46,638 (1.6)
3	IUD (insertions)	872,302	872,302 (28.2)	3,053,053 (45.7)	462,311	462,311 (53.3)	1,618,088 (53.7)
4	Injectables (vials)	2,143,917	428,783 (13.9)	428,783 (6.4)	492,206	98,441 (11.3)	98,441 (3.3)
5	Contraceptive surgery (cases)	157228	157,228 (5.1)	1,965,350 (29.4)	90,711	90,711 (10.5)	1,133,888 (37.7)
	Total	-	**(3,090,527) (100.0)**	**(6,687,540) (100.0)**	-	**(867,719) (100.0)**	**(3,009,862) (100.0)**

Source Government of Pakistan, Ministry of Population Welfare (unpublished data)

In Punjab there were 0.87 million users of contraceptives which generated 3.0 million CYP. Only one out of five (19 percent) users were (male) condom users whereas remaining 4 out of 5 were female contraceptive users. The highest share of CYP is contributed by IUDs, (54 percent) followed by contraceptive surgery (38 percent). During the first quarter of July-September, 2005, the contribution of CYP is almost the same as noted during 2004-05 for the country as whole and for Punjab.

During 2004-05, 6 percent of the total contraceptive surgeries were male vasectomy operations (9,744 men were vasectomized). Of all these vasectomies, 94 percent were performed in Punjab. The rest were performed in Sindh (5 percent) and the remaining one percent was performed in NWFP and Islamabad. The conversion of 9,744 vasectomy cases gives 121800 CYP. If these are deducted from the total sterilization cases of CYP then the CYP for female sterilization case decline by 1.8 percent point from 29.4 percent to 27.6 percent indicating that males contributed 1.8 percent CYP of contraceptive surgery cases. This shows that males' involvement in contraceptive use is very insignificant compared to females.

6.3 Performance by Service Outlets

The contraceptive performance of various methods of contraceptive by service outlets shows that three-fifths (59 percent) of the total IUDs are inserted in the FWCs. The highest CYP is achieved by FWCs (33 percent) followed by RHS (28 percent). Almost all (89 percent) of the Contraceptive Surgeries (CS) in the country are done at RHS (66 percent in A Centres and 23 percent at B Centres). In the private sector 22 percent CYP is achieved by Social Marketing of Contraceptives (SMC). Of this 22 percent (35 percent is achieved through condoms, 32 percent through oral pills, 26 percent through IUD insertions and the remaining 7 percent through contraceptive surgery and injectables. NGO (FPAP) contribution of CYP is 8 percent of the total country's performance. Of this 8 percent, 62 percent is achieved through IUDs, 24 percent through contraceptive surgery, 12 percent through injectables.

In Punjab 75 percent of IUD insertions were performed by FWCs staff. All the contraceptive cases are performed by RHS (76 percent by A Centres and 24 percent by B Centres). The performance of public health departments has been insignificant in providing contraceptive and family planning services The CYP achievement by PLDs has been very low (0.3 percent). Efforts are being made for the last two decades to have functional utilization of health departments' service outlets in providing RH/FP services as they have more than 13,000 outlets But so far the outcome has been discouraging. In Gujrat and Rajanpur districts, 81 and 73 percent of the IUDs were credited to FWCs respectively. All the contraceptive surgeries cases were performed in the RHS-A Clinics in the districts.

When the contraceptive performance in terms of Couple Years of Protection CYP is related to budget allocation, it is noted that in 2004-05, almost half of the budget (54%) allocated to service outlets (FWCs, RHS & MSUs) of the PWP contributed two-third (65%) of CYP in the four provinces combined. In Punjab three-quarters (74%) of the budget was allocated to service outlets (FWCs, RHS and MSUs) and its contribution to CYP was 96 percent.

6.4 Males Involvement and Performance in Reproductive Health/Family Planning

Males' involvement from the demand side was briefly discussed in the Situation Analysis Section. In this section, it is being discussed from the point of view of supply aspect. As mentioned earlier only 12 percent of the total CYPs during 2004-05 are attributed to male contraceptives (10 percent from condoms and only 2 percent from vasectomies). This shows that only one out of eight CYPs is accredited to males, which is very low and insignificant performance.

It is further noted that a very low percentage (6 percent) of males were vasectomied of the total sterilizations performed during 2004-05. The PWP should refocus its priority of male involvement in RH/FP. The vasectomy clinics' scope needs to be widened from merely performing male surgical operations to awareness, counseling, referral and surgical treatment of infertility (obstructive azoospermia). In a Male Reproductive Health Study it is reported that the infertility among couples is more among males than females and suggested that government should focus on male involvement in RH/FP and treatment of male's infertility (Tahir, 2004). In this regard, it is crucial that the scope of vasectomy clinics could be expanded in order to prevent innocent infertile men falling prey to sex clinics of quacks spread in peri-urban and urban areas of the country. Its scope could also be broadened by creating awareness about sexually transmitted diseases, HIV/AIDS, hepatitis and RH/FP.

As males are the prime decision makers in the family, changing their psyche and mindset by widening the scope of these clinics would be very important for the PWP. These Centers could also raise awareness about reproductive health issues among adolescents and youths in high schools and colleges, as they are the most vulnerable group, which may fall prey to quacks. These clinics could also play a positive role in negating the adverse attitude of males towards RH/FP. These vasectomy centers can also be utilized to impart knowledge and training to young medical graduates (RMPs, NGOs) and trainee urologists who would be coming across males having problems of reproductive health. In the light of expanded role its name is also required to be changed from vasectomy clinics to RHS – males clinics and/or endocrinological clinics. Similarly, the scope of female RHS-A Centres needs to be broadened from infertility and RTIs to HIV/AIDs and hepatitis awareness, counseling etc.

6.5 Issues and Concerns in Programme Implementation

The PWP has had three strategic intervention areas as a focus. These are (i) awareness building and creating demand (ii) provision of services to meet the demand and (iii) quality assurance (Ahmed, 2005). But the PWP faces several issues and constraints to improve implementation/impact. As mentioned earlier in (Section 4.1) the Review Committee on Restructuring Population Welfare Programme pointed out that slow progress of programme has been, among other things, due to poor management, low accessibility, poor quality of services and lack of community participation. Hence attention needs to be

focused on the following issues and concerns for better implementation/impact:-

- PWP since its inception is being entirely funded by the Federal Government through PSDP allocations. Provinces have so far failed to contribute significantly in monetary terms towards PWP activities like other social sector programme and, as a result, provinces seem to feel lack of ownership, which hampers the programme implementation/impact.

- The PWP has traditionally suffered from the ban on recruitment and non-filling up of approved vacancies. Around 25 percent of the sanctioned posts are vacant in the PWP in the country. This proportion is higher in Punjab. The non-availability of suitable personnel hampers the execution of PWP activities particularly at the grass root level.

- Due to unwillingness of women staff to serve in the remote, far-flung and unattractive areas, the RHSCs and FWCs cannot be made fully functional. Political and administrative pressure is used particularly by women staff to be able to serve at their own choice of field station. Further, there is persistent political pressure on the administration in the transfer/posting of staff in the field.

- There is habitual absenteeism of some of the field staff from offices and service outlets (such as District/Tehsil Population Welfare Officers, FWCs, RHCs and MSUs), which adversely affects the programme impact.

- There is limited coverage, access and utilization of service outlets. The effective coverage of FWCs and public health delivery system is limited in relation to the ratio of service outlets to population and the distance of service outlets from the client's residence. There is a shortfall in achieving the physical targets of service components. Moreover, the existing service outlets are under utilized as the demand creation activities and follow-up of clients has been poor. Most of the FWCs facilities do not meet the desired quality standard services. Some of the FWCs have limited space for five staff members and their clients' accommodation.

- The programme management is quite weak. Since de-federalization provincial PWP needs to be strengthened in programme management and effective implementation of PWP activities. This will depend on timely release of funds to the end users. The element of supervision mostly appears on paper. Programme employees face an absence of performance incentives, adequate training and access to promotion.

- The monitoring and technical supervision has been particularly weak in the PWP. District Population Welfare Office is the focal point and hub of all the population welfare programme activities in the district. However, due to abolition of divisional/regional tier, they are not being properly supervised / monitored by the provincial office. In order to monitor governance-related issues, a mechanism is required to be devised for effective and regular monitoring and supervision and technical monitoring to ensure minimum service delivery standards.

- There is dire need to provide on-the-job training to PWP employees with a view to facilitate their efficiency not as a supervisor to find faults but as a

facilitator and helper to improve their performance. This would help to improve the quality of services of service outlets. In addition to this, a specific operational plan for a long-term requirement to be developed to train programme personnel at all levels and of all cadres for the next 10-15 years.

- High-risk births, high incidence of induced abortions and maternal mortality are highly inter-related. Its incidence/prevalence is high in rural, peri-urban areas and poor segment of the society. According to MDG 2005 Report, there has been, among other factors, the absence of an integrated and coordinated maternal health service and MCH programme implementation and the interventions in this regard have been fragmented and disjointed.

- PWP is considered a low priority programme. The senior bureaucrats try to avoid posting in the PWP. This results in high turnover of senior officials, which hampers smooth functioning of the PWP.

- The quality of service outlets leaves much room for improvement. Follow-up of clients, lack of supervision, guidance and on job training had a detrimental effect on the quality of standards and on staff morale. For achieving population stabilization and fertility transition, efforts have to be devoted towards continuity of use which could be achieved among others, by improving the quality of services, regular and uninterrupted supplies of contraceptives and medicines, enhancement of skill through refresher training and monitoring.

- It is noted that there are indications for improvement in knowledge and use of contraception through effective use of media in interpersonal campaign/ messages. IEC and interpersonal communication efforts by providing counseling skills needs to be given priority to help the illiterate couples particularly males who are decision makers in the household. It will help to change their beliefs and misconceptions towards practicing family planning.

7. CONCLUSIONS, DISCUSSIONS, POLICY IMPLICATIONS AND RECOMMENDATIONS

The fertility rate and growth rate of population in the country remain high when compared to most of the countries of South Asia, South East Asia and other Muslim countries. These rates are high among poor, illiterate and rural population where woman continue to bear more than 5 live births over the reproductive period. These births start too early, too close and too frequent continuing too long in higher parities. Almost half of the women have reported in several surveys, that they do not want any more birth and about one-third of the births in the country are considered high-risk births, which could be eliminated through effective supply-oriented strategies. More than one-quarter of contraceptive users are of high parity with 6 and more children indicating very low demographic impact on birth aversion as these women have almost completed their family size. The repeated pregnancies result in high-induced abortions, which are performed under unsafe and clandestine methods. This results in severe complications and other health problems of mothers. Almost 70 percent deliveries are carried out at homes. Only one quarter of the deliveries are attended by skilled personnel and about half of the women seek antenatal care in the country.

The PWP is totally funded through PSDP development budget. Like other social sector programmes, such as education and health, it is suggested that at least the salary component of PWP should be transferred to non-development recurring expenditure in order to boost the morale of PWP employees. Moreover, the provinces should be asked to start financing for PWP activities in a phased manner from their own resources, which will indicate that they have started owning the PWP.

As long as the service delivery outlets of PWP and health department work vertically without any functional integration at the grass root level, it would be difficult that desired objectives of RH/FP and fertility reduction could be achieved. The need of the time is that all the service outlets of PWP and primary health care units of health departments should be brought under one roof and under one authority for effective implementation of PWP. The divided authority does not help in achieving the RH/FP targets, which has been experienced over the last more than two decades.

Social and cultural factors, inter alia, mitigate against the use of contraception by couples in the country as infant mortality particularly neo-natal mortality and child mortality is still high. Moreover, low literacy and educational attainment rates among females compared to males still prevail and these also contribute to high fertility rates. Although the male-female gap in literacy and education has slightly narrowed, inequality is still quite high even when compared to countries of South Asia and other Muslim countries.

Various studies have consistently shown that son preference affects fertility preferences and contraceptive use. As long as the preference for 2 or more sons persists the total family size will, on average, be at least 4 indicating that

the appreciable decline in fertility might take a longer time as visualized. If the perception of couples does not change in favour of a smaller ideal family size the fertility transition will not be achieved over a desired period of time. This would require dedicated efforts and missionary zeal on all the stakeholders to work in close collaboration for achieving the MTDF & MDGs targets/goals.

Pakistan's family planning programme faces severe constraints in a milieu in which women are circumscribed in their ability to become educated to work and to leave their houses unaccompanied. They lack autonomy and have restricted mobility and minimum discretionary access to economic resources. More generally, the low status of women is surely a factor in the limited use of family planning methods in the country.

Social economic and cultural values are gradually changing with the process of urbanization, modernization, increase in literacy and educational attainment and income. Exposure to the mass media has further helped in changing the perceptions, attitudes and behavior of the population, particularly those who are decision makers. In Pakistan almost half of the population lives in nuclear family household. This would have resulted, among others, in more interpersonal communication and husband-wife discussion on family matters, which would play a positive role in accelerating the demand for contraceptive.

Access and utilization of PWP service outlets has increased gradually. However, specific outreach to improve maternal and child health, engage in community development efforts and create demand for family planning services has yet to start more effectively. Although implementation has been devolved to the provincial level, the programme still faces several bottlenecks in terms of policy and management shifts and collaboration with public health and private sector. The past experience indicates that public health outlets have been abysmally poor in implementing PWP activities. The NGOs and the private sector, including private medical practitioners, should be accorded more resources and encouraged more in PWP activities, as they could contribute substantially to the family planning activities. This would lead to more coverage, access and utilization of RH/FP services.

The prospects for future fertility decline will primarily depend on more effective implementation of population policy, particularly more effective IEC dissemination, increased coverage and accessibility, particularly widening of out-reach coverage and above all, improvement in the quality of care services. Male involvement in responsible parenthood particularly in RH/FP should be effectively incorporated in resolving various problems associated with unwanted pregnancies and induced abortions The scope of current vasectomy clinics need to be widened to cater the needs of adolescents, youths and men in removing their misgivings and negative notions about RH/FP and in creating awareness, counseling, referral about reproductive tract infection, HIV/AIDS and treatment of infertility among males. The demand for services has to be highlighted, programme management has to be strengthened and political and administrative support need to be ensured and sustained. These efforts need to be augmented by effective implementation of social services programmes particularly increasing mother and child survival, breast feeding,

promoting literacy and primary education (especially female education) and alleviating poverty and improving the status of women.
Repeated pregnancies and the high fertility as prevalent in the country is seen to be highly correlated with early female marriages, early child bearing, high infant and child mortality, close birth intervals, births occurring in high parities (high risk births)., high fetal losses and induced abortions, high unmet need for contraception, high ideal family size and gap between desired and actual number of children, preference for boys, desire for sons to survive until old age to provide security; preferential care and treatment for boys compared to girls, low literacy and educational attainment particularly among females, less mobility of females, low female economic activity, religiosity, ignorance, conservatism and socio-cultural norms and practices, indifferent attitude of males to RH/FP. These factors along with persistent high incidence of poverty are still major obstacle in the way of gender empowerment, gender equity and equality, high fertility and lower use of contraception in the country. These factors further get aggravated and compounded with poor supply side of family planning that is, poor and/or non-availability, accessibility and affordability of services and limited use of health departments outlets for RH/FP.

In the light of the several surveys and qualitative research and case studies conducted in the 1990s the notion prevails that there is no demand for family planning and that Pakistan's family planning programme has not succeeded. These impressions must be removed altogether. The primary need and focus should be to strengthen the management and supply side of family planning so that the unmet need of the population is effectively met. Until coverage reaches more than 80 percent and until reproductive health facilities, including family planning services, are regularly provided in a quality consistent with the wishes of the clients and unmet need and latent demand for contraception is met, it is premature to conclude that family planning will achieve the desired objective of fertility reduction and lessening of the growth rate of population in the country as visualized in the Population Policy document. The fertility transition has started late and will continue, but it all depends on alleviating poverty and status of women, bridging gap in gender equity and inequality, focus on pro-poor and deprived segment of the population.

The problems and constraints mentioned above will continue to undermine the population related ICPD, MTDF and MDGs targets unless health department, NGOs, civil society and other stakeholders at all level seriously cooperate, collaborate and rationalize their implementation activities to achieve population stabilization. In this regard, the population policy needs to be further broadened and modified by taking into consideration the growing aging of the population, migration, urbanization, environmental and ecological issues, poverty and gender inequality of rural and marginalized population.

Serious initiatives are required to focus on quality of care and client's satisfaction and continuity of use of contraception. In this regard, supervision to change the attitude and behaviour of service providers through the means of facilitators/helper rather than policing and faultfinding approach needs to given serious attention. For achieving the MDGs targets/goals, top priority has

to be accorded to build human resource development capacity building of the programme employees at all levels and for all cadres, which has become very weak over the years A specific operation plan needs to be developed to train personnel over a long period of time for the next 10-15 years. Follow up of clients, maintenance of adequate record and MIS, which has been neglected, needs to be given due attention Moreover, the issues and concerns raised, require priority consideration by policy makers, programme managers and all concern stakeholders, which will help to achieve ICPD, MTDF and MDGs and Population Policy goals and targets.

The demand generation and awareness campaigns need to be rationalized and improved to meet the missing links between supply and demand Interpersonal communication and communication strategy needs to be given priority to address the unmet need for contraception Success outcomes of others countries, NGOs and private sector needs to be replicated within our social-cultural beliefs and framework. MSUs need to be expanded in terms of their performance with regular monitoring and supervision Although PPWDs have become autonomous involving their own strategies and budgets, the Ministry of Population Welfare must closely interact frequently to assist in developing their weak capacity management and organization set up at all levels

Involvement of religious scholars, opinion leaders, elected representatives, pointing out to adverse consequences of population growth at micro and macro level and their group discussions on electronic media be encouraged. Religious scholars should be trained as master trainers for changing attitude of mid-level religious scholars in favour of RH/FP as successfully done in Bangladesh, Indonesia, Egypt and Iran

The whole budget to provinces and districts amounting to more than Rs.3.0 billion annually continues to be financed by the federal government despite the fact that this programme has been de-federalized and devolved to the provinces since July, 2002 The desired objective of PWP would be difficult to achieve unless the provinces make financial contribution and take ownership of PWP, which still remains a low priority area for the provinces. The objective of achieving ICPD, MTDF and MDGs goals/targets will remain a dream until, among others, budgetary allocations mechanism of regular flow/release of funds to end users, their expeditious utilization and audit of release funds are properly regulated/encouraged at all levels by all the stakeholders

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