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In this Issue

Assessing the future of family planning services in Pakistan after the 18th Amendment

By Safieh Shah

Restructuring Pakistan's Devolved Family Planning Services

In 2014, Pakistan's population was estimated at being over 188 million making it the world's sixth-most populous country. Since the census in 1951, the population has quadrupled while the urban population has increased seven times. Despite lowering fertility rates in the late 20th century, the country's growth rates are still the highest in the region, and are only exceeded by sub-Saharan Africa across the world. In 2014, the population growth rate of the country stood at 1.49% putting it within the top 35% globally.

Stagnant Family Planning (FP) policies during the 2000s and subsequent devolution

In the year 2000, the government of General Musharraf initiated an assessment of the Family Planning Programme (FPP), which led to the declaration of the first ever National Population Policy in 2002. This Policy set several long-term goals for the sector including the aim of providing universal access to FP services by 2010 with the aim to reduce the fertility rate to a replacement level of 2.2 by 2020.

The 2002 policy however, failed to achieve any of the goals it had set, as population figures for Pakistan continued to increase at levels, straining resources. One of the major issues remained access, particularly for poor women in rural areas as research points out, *"... (that) while access costs are not the primary determinant of contraceptive use... increasing service outlets and outreach programmes can lead to an increase (in) contraceptive prevalence"*[1]. Poor service provision was cited as another factor, as the acclaimed Lady Health Worker (LHW) programme suffered due to a lack of equipment provision, inability to retain staff – leading to high-turnovers and an overload of other duties, primarily polio vaccination programmes.[2] A fear of drug side-effects and other unexplored health concerns was also found to be an important deterrent from the usage of contraceptives.[3]

Coupled with these problems, low levels of female literacy, weak autonomy for women in society and high mortality rates from neonates all the way to children were all identified as reasons responsible for keeping fertility rates high.[4] In essence, what this implied was that the 'crystallising' of various socioeconomic factors from the previous decade had not been meaningfully sustained; leading to a stagnation in the implementation as well as outcomes of FP policies.

However, surveys showed that these declines have not been due to a lack of desire for FP, pointing to an unmet FP need. The percentage of women who did not wish to bear any more children rose from 40% (1991) to 52% (2007), with a further 20% expressing the desire to further space birth out. In 2007, it was also shown that 96% of Pakistani women were aware of some sort of

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contraceptive measure, yet only 30% of women were using contraceptives as recorded in 2007, further underlining the unmet needs gap for family planning options.

Demands of unmet needs for FP were also brought up during an evaluation of abortion practices in Pakistan. Research has repeatedly shown that despite laws restricting the access to legal abortion - the pregnant woman's physical or mental health has to be at risk in order for abortion to be allowed - the most common types of service users were literate women in their late 20s with several children. This strongly suggests that these women utilize abortion as a FP option, similar to what has already been identified in sub-Saharan religious countries. This further argues for the unmet need of contraceptive usage and other FP methods.

In 2010, the Pakistan Peoples' Party (PPP) government launched the new National Population Policy, which was created after an extensive round of discussions and planning with various stakeholders. However, this was also when the government had introduced the much-delayed devolution reforms to its functions, with many features of governance redistributing power from the centre to the level of the provinces. Consequently, the policy called for breaking up the Ministry of Population Welfare and devolving its functions to various organisations within the provincial governments' purview. Yet despite the long-held promise of the advantages of devolution, the breakup of the FP services was far from satisfactory. The functions for planning within the health sector, cooperating across provinces and liaising with international donors were all handed over to the Planning and Development Division of the federal government, which was meant to fund the Population Welfare Programme. Further functions related to FP and reproductive health were now being dealt by four separate ministries with four conflicting population planning priorities, based on their provincial assessments. There was a lack of consensus amongst the provinces due to diverging priorities. Baluchistan sought to increase its population, whereas Khyber Pakhtunkhwa was seen to be less public about its efforts in order to avoid a conservative, religious backlash: while Sindh and Punjab both expressed plans to develop programmes but have yet to announce any details.

The short-term impact of bureaucracy within the policy meant that many different ministries and organisations were in charge, which slowed down efforts. It was claimed that those responsible for population planning policies were unaware of practical issues and lacked the ambition as well as commitment required for implementation. Similarly, a lack of assurance towards improving the LHW programme was seen to be a significant issue since majority of Pakistan's population is rural where LHWs are the primary reproductive health service providers[5]. This is because, although the programme had been shown to be very effective, it suffered from inefficiency due to lack of sustainability.

The decision to devolve functions to various ministries was also criticised for further splintering a governmental function as Pakistan is one of two countries in the world, where the ministries for health and population are separate. Conversely though, it has been argued that *"health and population have shared agendas, a paradigm shift from FP being a demographic target to a reproductive health end-point."*[6]

FP Policies relative success in the 1990s

In comparison to the 1990s however, in the 2000s there was only a slight rise in the national average of contraceptive use to 30% by 2007.[7]

"Ladies and gentlemen, I dream of a Pakistan, of an Asia, of a world where every pregnancy is planned, and every child conceived is nurtured, loved, educated and supported," - Prime Minister Benazir Bhutto[8]

One of the watershed moments in the 1990s was the International Conference on Population and Development (ICPD). This precipitated an overhaul of how to approach family planning policies. A civil society activist described its impact as:

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"... (providing) you ways of reaching men and women in a broader, more development oriented way, and, therefore, (making) family planning more acceptable. From an non-governmental organizational (NGO) perspective, women's rights activists started looking at contraception as a right. ICPD provided ways of looking at the availability of contraception within the larger issues of women's space and mobility."[9]

The ICPD's approach demonstrated that the newly formed Ministry of Population Welfare (established in 1989) was not the primary institution responsible for family planning. Two major initiatives were shown to have a significant impact on population rates; the first of these was the establishment of the National Trust for Volunteer Organisations, which was instrumental in coalescing the efforts of NGOs and other civil society forces. The second was the initiation of the LHW programme, which saw numerous mid-level cadre health care providers in rural areas travel door-to-door to provide family planning awareness and teach its methods to both men and women.

An analysis of the programme showed:
"...use of reversible modern methods of contraception was significantly higher in localities having good access to literate, female community-based workers than in localities with little or no access. The availability of schools also exerts a powerful influence on contraceptive uptake, but the presence of other modern institutions, or proximity to a town, had no effect."[10]

One of the key aspects of the ICPD's redefinition of FP efforts was a focus on reproductive health that unwittingly led to a withdrawal of donor support for contraception and other family planning resources. However, the government continued to fund the programmes and the decade saw the usage of contraceptives increase from 11% in 1991 to 28% by 2000. In rural areas, the increase was from 6% to 22%, while in urban areas the corresponding change was from 26% to 40%.[11]

The beginnings of FP policies in Pakistan

Family planning in Pakistan began with the state's embrace of an NGO-led programme, now called Rahnuma in the 1950s, and the government's efforts in this field began in the 1960s under General Ayub Khan. His regime's "vigorous" family planning policies were initially hailed, but suffered from planning and design flaws that eventually led to little discernible impact.[12] The next two eras also saw negligible interest by the government in pursuing FP policies. For the Bhutto government, FP was far too closely identified with the previous era, while under General Zia-ul-Haq FP knowledge dissemination was actively opposed. In this regard, the government reduced expenditure on FPPs and banned public service messages on the issue.[13]

From a policy perspective, a quantifiable change came in the 1990s as this was a decade that also saw considerable changes in the country's fertility rates. Contraceptive usage doubled from the previous decade, and the country also underwent what is known as a 'fertility transition', i.e. when a society moves from high to low fertility rates. During this time, the governments of Benazir Bhutto in particular, as well as the ones headed by Nawaz Sharif actively invested in FP policies These were far more expansive and effective than previous eras. However, the policies were not solely responsible for changes. According to one researcher:

"...the fertility transition is argued to have occurred as a crystallisation of existing desires for smaller families along with a decline in family size desires and a reduction in the social, cultural and psychic costs of contraception."[14]

Similarly, others have argued that the achievement of declining fertility rates can be attributed to overall socio-economic development, increases in literacy particularly amongst females, and increasing awareness of the means and benefits of family planning.[15]
Irrespective of these developments, Pakistan continues to have some of the highest fertility rates in South Asia, and was the last major country in the region to achieve the fertility transition. Despite similar cultures and economic conditions as other countries in the region, Pakistan has consistently lagged behind in efforts to control its population. Pakistan's difficulties in this matter have been

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summed up as *"a reluctance or inability to translate reproductive preferences into appropriate behaviour."*[16]

Recommendations: a holistic approach to population planning

"Population growth is a developmental issue, not a clinical problem. No one denies today that top priority must be given to reducing high rates of population growth in the developing world. The differences are on strategies, not on objectives. Family planning must be regarded as an integral part of new models of sustainable human development. Divorced from such development models, and pursued as condom-distribution programmes with single-minded zeal to meet 'unmet demand' they will fail… We cannot slip a condom on poverty." – Mehboob-ul-Haq[17]

It has repeatedly been shown in other countries that successful population planning policies are achieved through a holistic approach to development, where lowering fertility rates end up as the symptom of several directives aimed at social change. There is strong empirical evidence to show that *"low fertility is determined mostly by economic, social, cultural, and educational improvements in a population and less so from the availability of family planning programmes."*[18]

Consequently, it has been put forth that an effective and sustainable population policy must be aimed at three major objectives, namely: reducing the rate and incidence of unwanted fertility; decreasing the demand for large-size families or increasing birth-spacing; and greater investment in the health education and employment opportunities, especially for young women.[19]

Translating these directives into the Pakistani context results in three broad areas for future policies to be pursued in. Firstly, the improvement of the quality of existing services; the inclusion of stakeholders at differing levels with coherent integration of disparate responsibilities; and concerted investment in health education, for the economy by enhancing autonomy for citizens, particularly women.

In terms of improving existing services, the prevalence of unmet FP needs is a major area that needs to be described using evidence-based research especially with regards to the majority of women already utilizing these services by identifying key gate-keepers. The high number of induced abortions and the rising gap between a desire for FP versus an ability to exercise that right, both suggest that there are a variety of reasons that women are not able to access birth-control measures. This ought to be explored, taking male power dynamics into account. Similarly, improving sustained investment by strengthening the LHWs' programme should be a top priority, owing to its proven ability to effect change not only within the context of FP but also with regards to other facets of reproductive and child health. Issues of overburdened employees, high turnovers and increasing inefficiencies due to a lack of resources need to be addressed in order to make the programme robust as well as sustainable in terms of quality of impact. The LHWs' and numerous other cadres from the most qualified Nurse Midwives (NMWs), all the way down to the Traditional Birth Attendants (TBAs) also known as *dais'* should be invested in as well as trained to further their knowledge and further their reach within communities, as most sexual, reproductive needs and child health are sought from women within their own communities due to varied ethnicities, cultures and degrees of beliefs Service delivery at various outlets has to be streamlined for efficiency by spreading health awareness with regards to the advantages of FP via different media and community and religious leaders; as well its benefits to the family as a whole, taking into account their preferences, source of livelihood, beliefs and attitudes.

The advent of devolution has increased the need for articulating policies that bring together the various ministries and governments entrusted with population planning, to ensure a greater ownership of responsibilities by role clarification within systems. Having standardized operating procedures in place which are monitored and evaluated, so that work is based on the objectives achieved rather than an individual are essential to measure achievements. Advocacy is required within the government, across the federal, provincial and district levels. This would be guided by medical research coupled with social development by liaising with countries' with comparable

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work done, to evaluate performances based on achievement of specific population planning indicators. Further, there is an urgent need to integrate or coordinate functions, with particular attention towards aligning population control policies with the health ministry's agenda for each specific province, and how these impact the national development goals. The importance of the private sector can also not be understated as it plays an important role in FP, since it is now the major source for contraception provision in the country and is flourishing very rapidly. The private sector has not been assessed especially in conjunction with the public sector, whereas the state-owned programmes have shown to be flagging in efficiency.

Finally, the most important aspect of successful population control can be achieved through investments in health education for women as well as female employment opportunities and career development. Much has been made recently of Pakistan's impending 'demographic dividend' whereby the majority of the country's population would be a young, working-age cohort that can be used to drive rapid development and growth. Without ensuring access to education for females and suitable employment opportunities for women however, Pakistan not only stands to lose out from this boon (by halving the potential) but also runs the risk of losing its young citizens of both genders to crime and opportunistic terrorism. There is strong empirical evidence linking female literacy and employment with decreases in fertility rates, family sizes as well as vertical propagation of knowledge regarding sexual and reproductive rights. Similarly, a more economically equitable society would also contribute to a reduction in fertility rates, reducing under-age marriages and change power dynamics with regards to the decision of FP within a joint family structure. These measures are the most effective ones for developing a coherent and successful population policy and y[20]et their purview lies well beyond the responsibilities of institutions as they currently stand. Consequently, it is imperative that population policies are made an integral component of social development efforts This can be achieved by synchronizing sexual and reproductive health education through a multi-pronged approach and by coordinating the priorities of differing institutions for a greater national interest.

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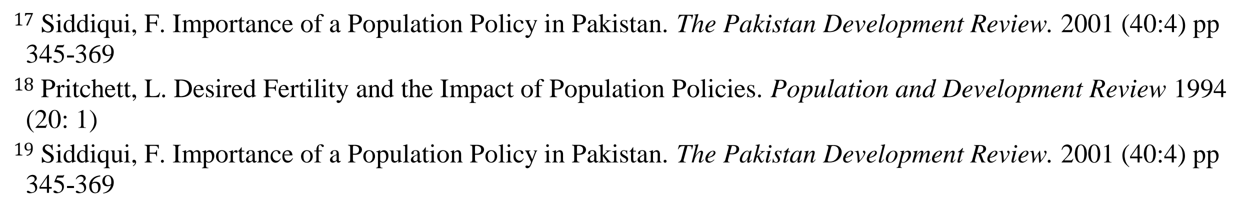

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