# Population Stabilization: The Case for Pakistan


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PAKISTAN REPORT 2010

# Contents

# Population Stabilization:

## The case for Pakistan

## Pakistan Report 2010

"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"

***Mohtarma Benazir Bhutto Shaheed, former Prime Minister of Pakistan at ICPD, Cairo, September 13, 1994.***

# Acknowledgment

This Report has been commissioned by Population Communication, New York. The Report presents an updated demographic profile of Pakistan; an in-depth analysis of demographic trends and changes; a review of the efforts of the government of Pakistan; and an assessment of the outcome and impact of these efforts. The Report also suggests a policy direction and an action plan for the way forward. It includes discussion on demographic transition and its importance in Pakistan; determinants of fertility decline and reasons for fertility stagnation. Review of policy framework and Population Program is an integral part of this Report which concludes with a proposed population policy aiming at Population Stabilization by achieving early replacement level fertility.

This report brings together essential data from different sources, including the recently completed Pakistan Demographic and Health Survey 2006-07; Economic Survey of Pakistan 2009; Draft report of the Planning Commission's Working Group on Population Sector; and Report of MOPW prepared for Implementation Commission on 18th Amendment; etc. Besides, a number of reports and research studies have also been benefited from to make the arguments and to substantiate the statements made and conclusions drawn in the report. The Report also draws many references from "Demographic Transition in Pakistan" by Dr. Tauseef Ahmed and lays the basis of scientific and logical discussion for policy makers, social activists, government officials, professionals and International Development Partners working on population and development in Pakistan.

Meetings and discussions with researchers from National Institute of Population Studies (NIPS); the Planning Commission of Pakistan; the Population Council; National Trust for Population Welfare; Research and Advocacy Fund (RAF); and other professionals in Islamabad have also contributed towards the finalization of this report. A series of meetings for seeking clarifications and guidance from Mr. Shaukat Hayat Durrani, Secretary Ministry of Population Welfare (MoPW) requires special mention for substantial value addition in the report. I am greatly indebted to him for not only his guidance and support but also for the peer review. I am also grateful to following colleagues and friends for providing necessary information used for analysis and preparation of this report:

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Abdul Ghaffar Khan
05- 08- 2010

# Overview

The Pakistan is in the midst of an unprecedented demographic transition. While, on the one hand, population policies and programmes have contributed to a modest decline in fertility; on the other, the changing demographic scenario has brought into focus a host of emerging issues that need to be addressed in coming years. With the results from the Pakistan Demographic and Health Survey 2007 showing that the contraceptive prevalence rate is stagnant at about 30 percent and the unmet need for contraception still stands at 25 percent, it is clear that Pakistan is not going to meet its population stabilization goal on the time frame as set in the Population Policy of Pakistan 2002 until some extraordinary measures are adopted.

Sustainable human development is intrinsically linked with a healthy, skilled and well-informed population. Pakistan recognized as early as in the 1950s that high population growth was one of the major impediments to sustainable development. Despite this, the country's Population Welfare Programme, formally introduced in the 1960s and sustained over the years, has achieved limited success in lowering the total fertility rate (TFR) and population growth rate (PGR).

Pakistan's population 34.0 million in 1951 has increased from 132.3 million in 1998 (Census Report of Pakistan, 1998) to 173.5 million in 2010. Pakistan is the sixth most populous country of the world. The Pakistan Demographic and Health Survey (PDHS) 2007 and the Pakistan Demographic Survey (PDS) 2007 showed a much slower decline in fertility between 2001 and 2007, and practically no increase in the contraceptive prevalence rate (CPR) during this period. According to the latest projections by the Planning Commission, the country's population is currently growing at an annual rate of 2.05 percent, which is among the highest in the region and the world. According to United Nations Population Division' report 2008, Pakistan's PGR is 2.2 percent. The high PGR is attributed, on the one hand, to a rapid decline in the mortality rate and, on the other, to a slow decline in the TFR for the first 30 years of the Programme. The onset of the much-awaited fertility transition brought down the TFR from about 6.0 in the 1980s to 4.1 in 2001 (PDS, 2001). This trend encouraged the policymakers to formulate the Population Policy of Pakistan 2002, which optimistically projected to achieve replacement level fertility (2.1 births per woman) by 2020.

Various programmatic constraints and other supporting factors have slowed down the pace of progress; the important ones include: weak political commitment; inconsistency in population policies and programs; lack of provincial ownership of the program; weak capacity and commitment of program personnel; and inadequate allocation of resources. For example, during

the plan period 2003-08, the Government of Pakistan committed Rs. 21.0 billion for the Programme, but it provided only Rs. 14.5 billion. Similarly, for raising the CPR from 34 percent to 45 percent, as envisaged in the Five-year Population Welfare Plan (2003-08), contraceptives worth Rs. 2.9 billion were procured and provided against an estimated national contraceptive requirement of Rs. 4.0 billion. Moreover, during 2008-10, the Programme remained on extension with inadequate financial support of Rs. 6.6 billion against the actual allocation of Rs. 9.5 billion.

The impact of high population growth rate on social and economic development and vice versa is well documented. If Pakistan's population continues to grow at the present rate of 2.05 percent, it would double in the next 33 years and put severe stress on natural resources and the environment, besides dashing the hopes of improving the quality of life of the people. Population stabilization is, therefore, a pre-requisite for promoting sustainable economic and social development. However, it is as much a function of making reproductive health care accessible and affordable for all as of increasing the provision and outreach of primary and secondary education, besides empowering women and creating employment opportunities for the people, so that they could improve the quality of their lives and become productive citizens. It is therefore, necessary that the decline in fertility is accelerated, so that replacement level fertility (2.1 births per woman) could be achieved at the earliest. Moreover, it is important to address the emerging population and reproductive health issues, such as safe motherhood, sub-fertility, induced abortion, reproductive tract infections and sexually transmitted diseases, promotion of responsible adolescent and youth behavior, gender equality, health and welfare of the elderly, and migration and urbanization.

The global and national evidence points to the health benefits of pregnancy spacing in reducing maternal, neonatal and child mortality, as well as in increasing family wellbeing. It is, therefore, imperative to formulate a new population policy that fully reflects the benefits of promoting pregnancy spacing. The Policy should focus on addressing issues related to maternal health and contraception, while increasing outreach of a comprehensive package of family planning/reproductive health services by the public, private and corporate sectors. It should provide a platform for coordinated, concerted and effective action by all the stakeholders to achieve fertility transition as per the targets set by the Government of Pakistan, as well as to implement the Programme of Action of the International Conference on Population Development and achieve the United Nations Millennium Development Goals 4 and 5. It should ensure that the Ministry of Health and all public and private sector health care personnel and outlets provide family planning/reproductive health information, counseling and services as an integral part of their mandate; the potential of community-based organizations is harnessed to provide

information on the benefits of pregnancy spacing; referrals to service delivery points are made where needed; and religious and opinion leaders are mobilized with the media's support to actively promote pregnancy spacing.

In 2010, Pakistan stands at a crossroads, having reached a stage in the demographic transition where changes in age structure are potentially favourable for the society. For example, reduced dependency ratio, due to an increasing proportion of the young population in the labour force and a decreasing proportion of the children in the total population, can contribute to sustainable human development through enhanced opportunities for economic productivity and savings, and by putting lesser demands on household consumption patterns.

This transition places Pakistan ideally to reap a rich demographic dividend, as envisaged by the Planning Commission's Vision 2030 document. However, this necessitates putting in place an effective family planning/reproductive health (FP/RH) programme to speed up the fertility transition process and adopting human development policies that can help transform the young population into a skilled workforce. For Pakistan, supportive policies that lead to stable macroeconomic conditions conducive to the creation of productive jobs for both men and women are also crucial to benefit from the demographic transition.

# Chapter-1

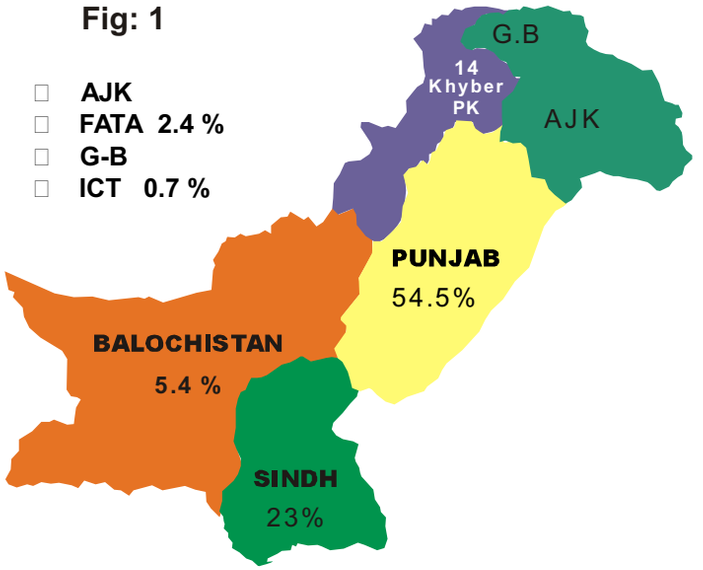
## Demographic Transition in Pakistan – A Description

# Chapter – 1

## Demographic Situation of Pakistan—A Description

1.1. Pakistan, with a population of 173.5 million is the 6th most populous country in the world. The male female ratio of Pakistan' population is 51.7% verses 48.3%. The proportion of population living in rural area is very high i.e. 63.7%. The geographical distribution of Pakistan' population is uneven as given in the figure below:

**Fig: 1**




- AJK
- FATA 2.4 %
- G-B
- ICT 0.7 %

| | |
|---|---|
| Population | 173.5 M |
| Male | 51.7% |
| Female | 48.3% |
| Urban | 36.3% |
| Rural | 63.7% |
| PGR | 2.05% |
| TFR | 3.6 |
| CPR | 30% |
| Unmet Need | 25% |
| MMR | 276 |
| IMR | 72 |

Source: Pakistan Demographic Survey – 2007; Pakistan Demographic & Health Survey – 2007
Projections by Planning Commission's Working Group on Population Sector, 2010
Economic Survey 2009-10

1.2. Population growth from 2007 through 2010 (projected) with male / female and urban / rural distribution along with the status of demographic indicators in these years is given in the table 1.1:

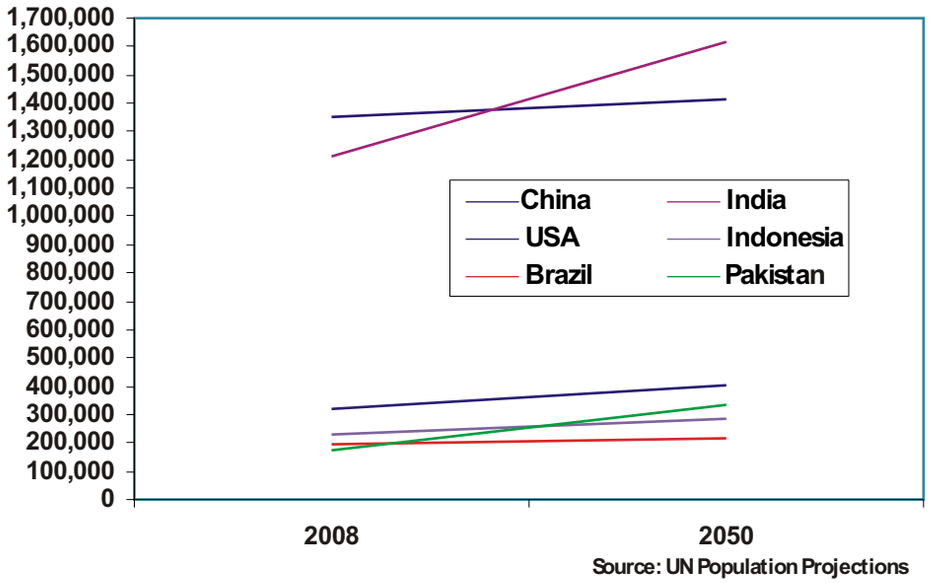
**Table -1.1:**

| Selected Demographic Indicators | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|
| Total Population (million) | 162.91 | 166.41 | 169.94 | 173.51 |
| Urban Population (million) | 56.82 | 58.74 | 60.87 | 63.05 |
| Rural Population (million) | 106.09 | 107.67 | 109.07 | 110.46 |
| Total Fertility Rate (TFR) | 3.9 | 3.8 | 3.7 | 3.6 |
| Crude Birth Rate (Per Thousand) | 29.1 | 28.7 | 28.4 | 28.0 |
| Crude Death Rate (Per Thousand) | 7.9 | 7.7 | 7.6 | 7.4 |
| Population Growth Rate (Percent) | 2.12 | 2.10 | 2.08 | 2.05 |
| Life Expectancy (Years) | 63.4 | 63.7 | 64.1 | 64.5 |
| Male | 62.7 | 63 | 63.3 | 63.6 |
| Female | 64.1 | 64.5 | 65.0 | 65.4 |

*Source: Sub Group II on Population Projections for the 10th Five Year People's Plan 2010-15.*

1.3. The demographic and health indicators of Pakistan are one of the highest in the region. TFR is 3.6 per women; CPR is 30 percent while the unmet need has been assessed at 25%. Maternal Mortality Ratio is 276/100,000 and Infant Mortality Rate is 72/1000. The annual population growth rate is 2.05 percent. If the population of Pakistan continues to grow at the present growth rate, it is expected that Pakistan will become the 4th largest nation on earth by 2050 after surpassing Brazil and Indonesia (Fig- 2).

**Fig-2 Pakistan's Population by 2050**




Source: UN Population Projections

## Total Fertility Rates (TFRs)

1.4. The level of fertility in Pakistan remained around 6.8 children per woman from 1961 through 1987. Fertility rate started declining after 1988; it declined rapidly in the last decade of 20th century (1991-2000). In the current decade, there has been a slow down in fertility decline, i.e. a fall from 4.8 to about 4.0 while the CPR initially rose to 32 until 2003 and then reversed to 30 percent (PDHS 2007). Trend in the rise and fall of CPR and TFR respectively from 1990 through 2007 is given in the table-1.2 and figure 3 and 4.

**Table -1.2: Total Fertility Rates and Contraceptive Prevalence Rates (1990-2007)**

| **Survey** | PDHS 1990-91 | PCPS 1994-95 | PFFPS 1996-97 | PRHFPS 2000-01 | SWRHFPS 2003 | PDHS 2006-07 |
|---|---|---|---|---|---|---|
| TFR | **5.4** | **5.6** | **5.4** | **4.8** | **4.4** | **4.1** |
| CPR | 12 | 18 | 24 | 28 | 32 | 30 |

Fig-3: Trend in the fall of TFR

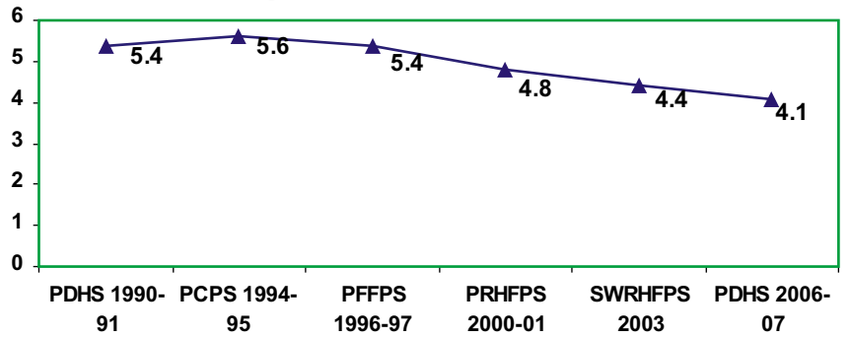
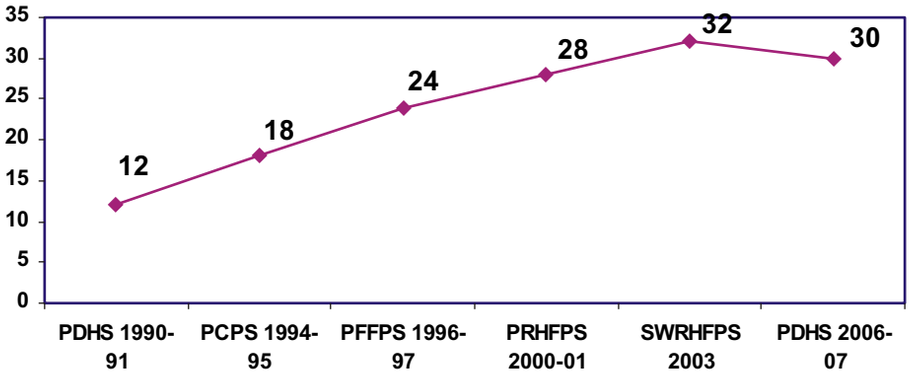



Fig-4: Trend in the rise of CPR




## Urban=Rural differential in TFR and CPR

1.5. There is a significant urban=rural TFR differential in Pakistan. The differential is more visible in mid 1990s, with higher fertility in rural areas. Estimates over a six year period indicate that urban fertility declined slowly from 3.6 (in 1998-2001) to 3.3 (in 2004-06), while rural fertility declined fast i.e. from 5.4 to 4.5 during the respective period. In urban areas the contraceptive use rate is reported at 41 percent against a CPR of 23.9 percent in rural areas (PDHS 2007). There appears to be some inconsistency between estimated TFR and reported CPR. According to the widely accepted correlation between CPR and TFR, a rise of nine percentage points in CPR should be accompanied by a fall of 0.64 in the TFR (Saha and Bairagi 2007, and Mauldin WP and Segal SJ, 1988). Induced abortion/ miscarriage may be at work but absence of data in the survey reports inhibits us to substantiate such links.

**Fig-5 (A): Urban Rural TFR 1970-2007**

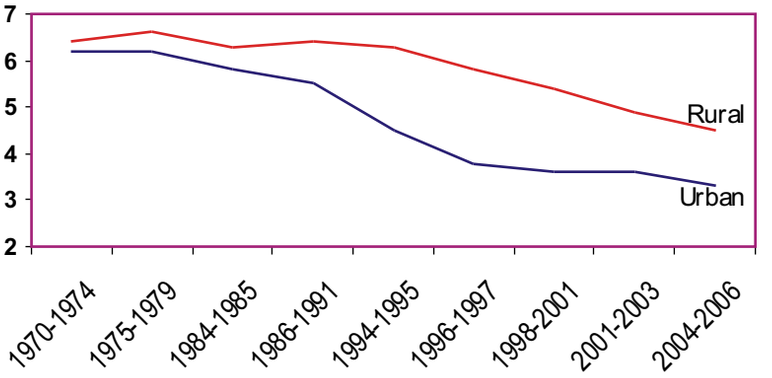
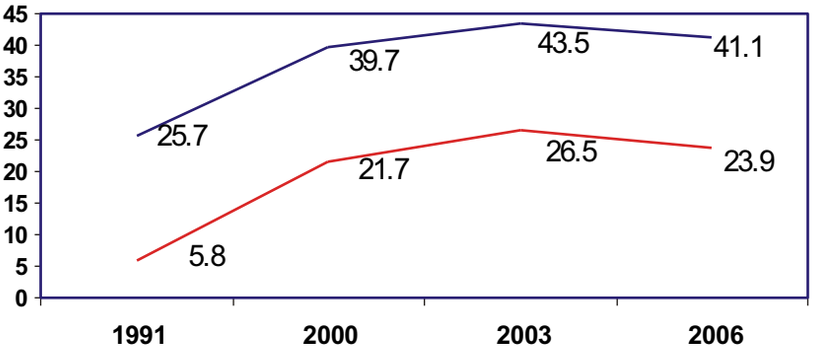



**Fig-5 (B): Urban Rural CPR 1970-2007**




## Comparative demographic picture of Pakistan among SAARC countries

1.6. The Asian Continent has a population of 4.12 billion with an annual growth rate of 1.1 percent and total fertility rate 2.4 per women. If we compare the demographic indicators of Pakistan with other countries of the SAARC region, Pakistan is found lagging behind in all indicators.

**Table 1.3**

| Country | TFR | CPR | PGR |
|---|---|---|---|
| Asia | 2.4 | 67 | 1.1 |
| Bangladesh | 2.8 | 58 | 1.7 |
| Bhutan | 2.2 | 31 | 1.4 |
| India | 2.8 | 56 | 1.5 |
| Maldives | 2.6 | 39 | 1.9 |
| Nepal | 3.2 | 48 | 2.0 |
| Sri Lanka | 1.9 | 70 | 0.5 |
| **Pakistan** | **3.6** | **30** | **2.05** |

## Comparative demographic picture of Pakistan among Muslim Countries

1.7. If we compare the Family Planning indicators of Pakistan with Muslim countries, we still see a dismal picture.

| Table -1.4: Country | TFR | CPR | PGR |
|---|---|---|---|
| Egypt | 3.2 | 59 | 1.8 |
| Morocco | 2.4 | 63 | 1.2 |
| Turkey | 2.1 | 71 | 1.3 |
| Iran | 2.0 | 74 | 1.4 |
| Indonesia | 2.2 | 58 | 1.2 |
| Malaysia | 2.6 | 55 | 1.7 |
| Bangladesh | 3.1 | 58 | 1.7 |
| **Pakistan** | **3.6** | **30** | **2.05** |

## Population Projections

1.8. **United Nation' Population Projections 2008:** Below are the population projections for Pakistan, 2010 through 2030. The term Medium variant means increase in population at a balanced pace while High and low variant mean if the change occurs at a high fertility or a low fertility pace. Constant fertility variant describes stable fertility change.

| Table 1.5: Pakistan Population 2010-2030 | | | | (Thousand) |
|---|---|---|---|---|
| **Year** | **Medium variant** | **High Variant** | **Low variant** | **Constant- fertility Variant** |
| 2010 | 184 753 | 184 753 | 184 753 | 184 753 |
| 2015 | 205 504 | 207 325 | 203 683 | 207 918 |
| 2020 | 226 187 | 231 276 | 221 098 | 234 354 |
| 2025 | 246 286 | 255 820 | 236 751 | 263 398 |
| 2030 | 265 690 | 280 054 | 251 345 | 294 812 |
| *Source*: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2008 Revision* | | | | |

1.9. **Projections by the Planning Commission of Pakistan, 2010:** In Pakistan, the last population census was held in 1998 when the population of Pakistan was counted as 145 million with an inter-censual population growth of 2.69 percent. Earlier, the Government of Pakistan, assuming fertility decline to continue at the pace of the 1990s, carried out population projections in 2005. Since the assumptions of these projections could not hold true and the next population census, due in 2008, was delayed; the Planning Commission had carried out the projections

afresh for framing the National Development Plan, 2015. Basically, the Planning Commission has made two sets of projections based on two different assumptions. Accordingly, two different scenarios of population growth up to 2015 and on to 2030 have been presented in Table 1.6:

i. Scenario-I assumes that the TFR and life expectancy would remain constant, and the population of Pakistan would continue to grow at its current rate of 2.05 percent per year.

ii. Scenario-II assumes that the Policy 2010 would be adopted and implemented and, as a result, the TFR would fall from its 2010 level of 3.6 to 3.2 in 2015, 2.8 in 2020 and 2.1 in 2030.

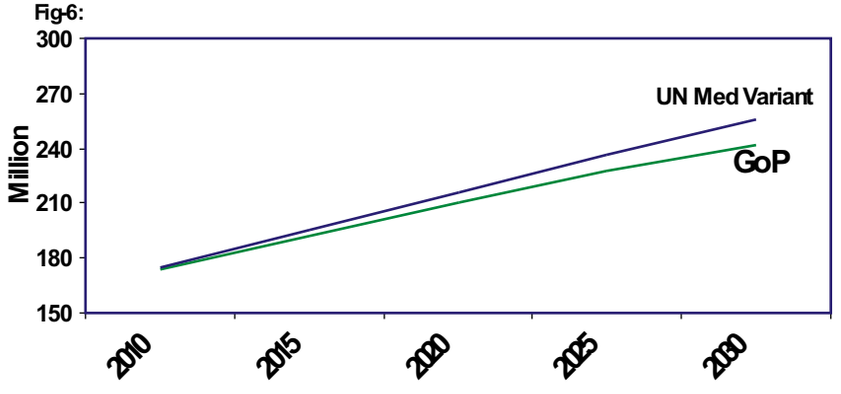
**Projected Population Growth Scenarios, 2010-2030 (in Millions)**

**Table 1.6**

| Scenario | 2010 | 2015 | 2020 | 2030 |
|---|---|---|---|---|
| **I. Policy Not Adopted and Implemented** **TFR:** 3.6 (2010) | 173.5 | 192.86 | 216.02 | 264.73 |
| **II. Policy Adopted and Implemented** **TFR:** 3.6 in 2010; 3.2 in 2015; 2.8 in 2020 and 2.1 in 2030 | 173.5 | 191.71 | 210.13 | 242.05 |

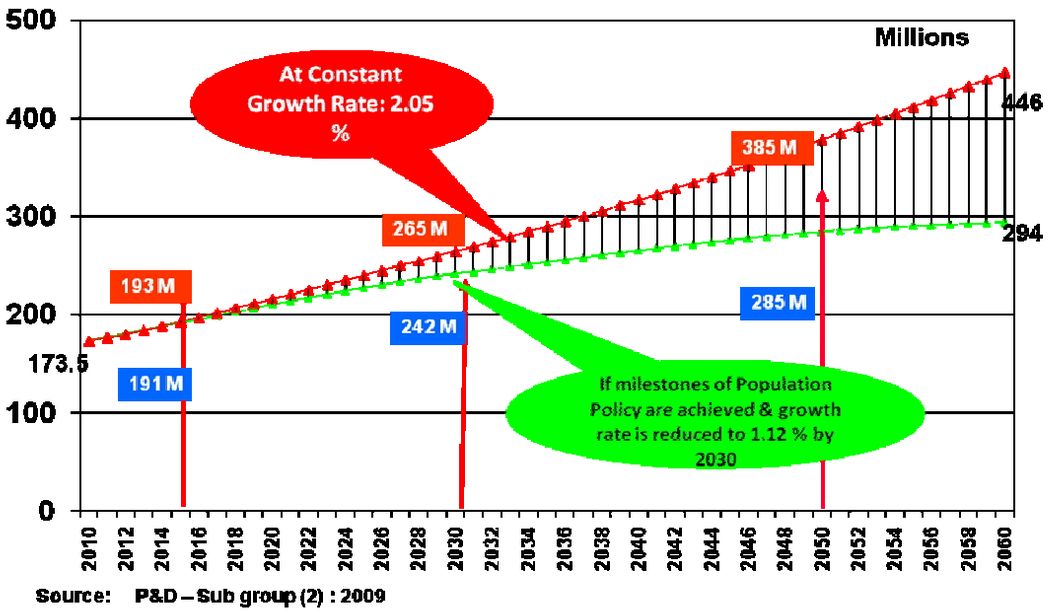
1.10. The projections by the Planning Commission are on the lower side compared to UN projections. The Planning Commission's projections assume that mortality will decline resulting in improved life expectancy at birth for males from 62.7 years in 2007 to 69.9 years in 2030, and for females from 64.1 years to 73.5 years for the same period. Assuming improvements in mortality and leaving international migration out of the calculus for the moment, the major determinant of population growth rates will be fertility.

Fig-6:



1.11. According to the Planning Commission's projections, if Pakistan is able to implement population program to achieve population policy goals, the population will be 242 million in 2030 as indicated in green, however, if it fails to do so and population grows at current constant growth rate of 2.05 percent, the population in 2030 will reach 265 million. If these projections are stretched further, the population would reach to 446 million in 2060 as indicated in red (Fig-7).

Fig- 7:-

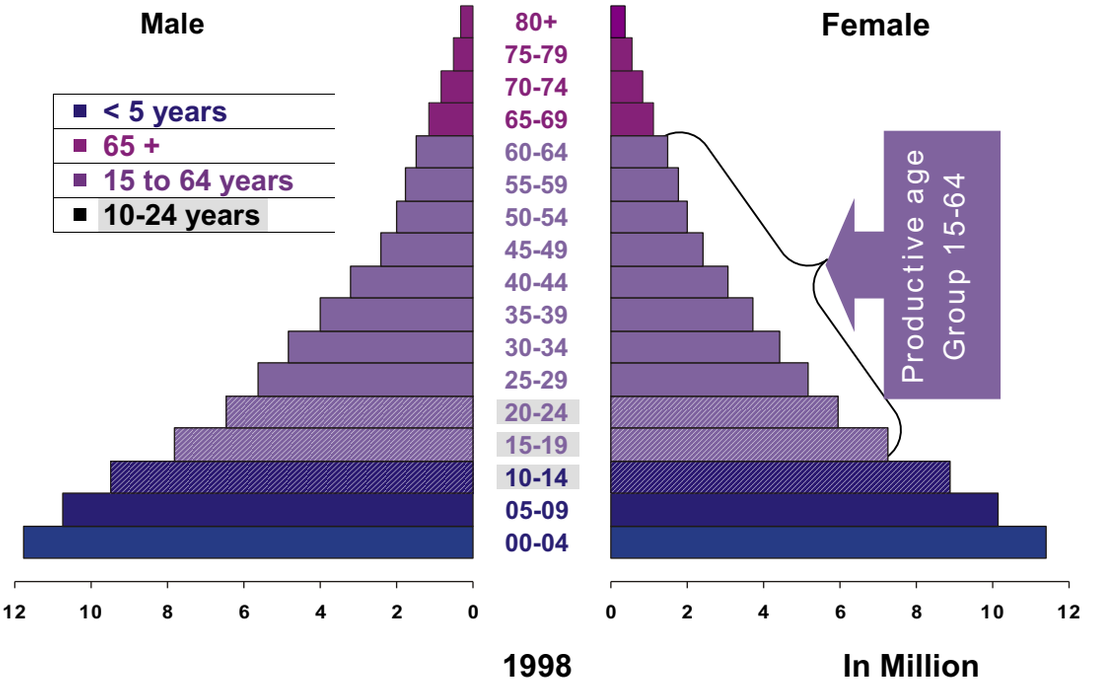



Source: P&D – Sub group (2) : 2009

## Age structure

1.12. Changes in age structure lie at the heart of fertility decline process. Four age groups are normally considered important: population less than age 5, population above age 65, proportion of population in productive age groups 15-64, and more recently the youth population (age 10-24).

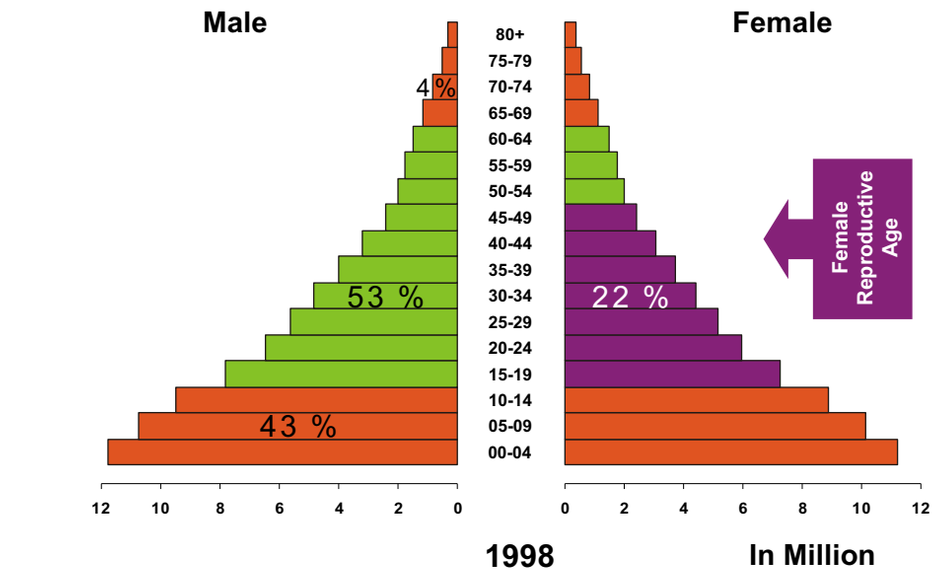
Fig- 8




## Comparative Picture of Age Group Distribution (1998 – 2010)

1.13. In 1998 Census, population under 15 years of age was 43 percent. This is the population which is dependent and requires to be looked after for health, education, clothing and other necessities. The population in the productive age (15-64) was 53 percent while the population in the age group 65 + was 4 percent. Population pyramid (See fig.9) shows that 22 percent of total population belonged to females of reproductive age group (15-49).

Fig- 9



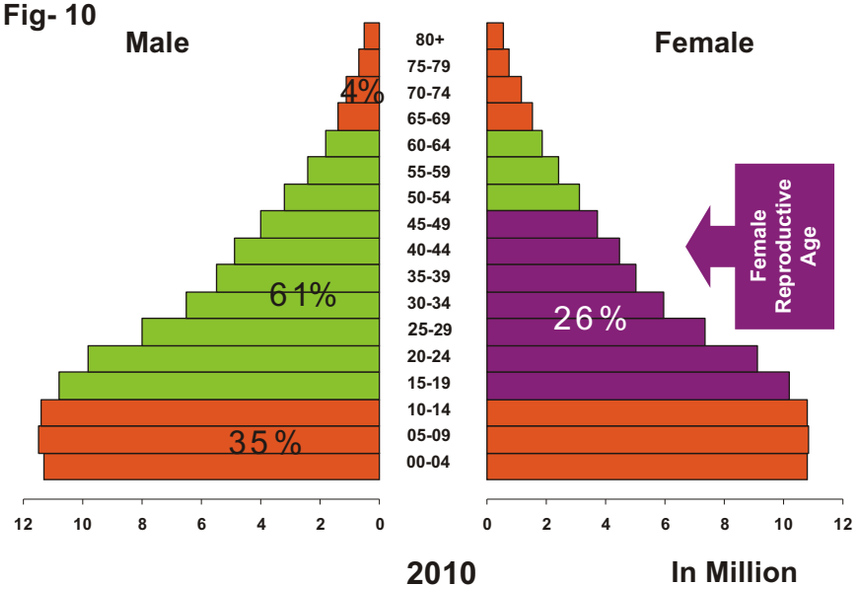
1.14. According to the projected population in year 2010, the proportion of population under 15-years has declined from 43 percent to 35 percent and resultantly the proportion of productive age groups (15-64) has increased from 53% to 61% (fig-10). This simply implies that:

i). the dependency ratio has decreased which is likely to lead to improved productivity and economic well being.

ii). the proportion of population in the reproductive age group (15-49) has increased (from 44% to 52%) which is likely to: a) create population momentum; and b) require additional access to family planning services.

iii). the proportion of youth population (15-25) has also increased which poses a challenge to Policy makers for providing adequate education and employment opportunities.

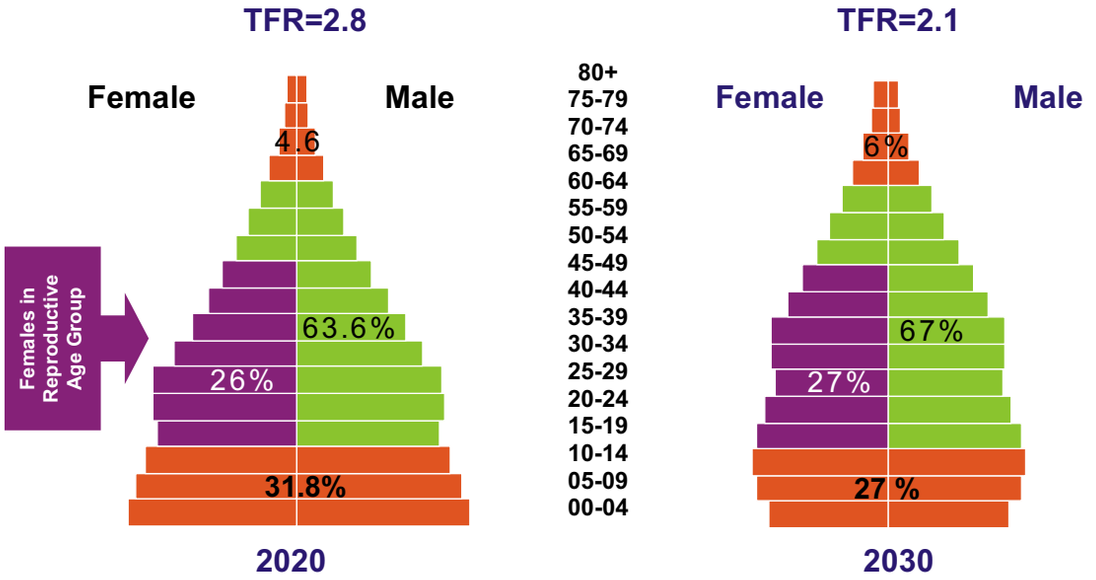
Fig- 10




## Comparative Picture of Age Group Distribution (2020 – 2030)

1.15. As envisaged, if the fertility level declines to 2.8 children per women by 2020, the proportion of population age group under 15 will further decline from 35% to 31.8% while enhancing the working age population (15-64) to 63.6%. By the year 2030, when we will achieve the replacement level of fertility, the proportion of population age group under 15 would further shrink to 27 percent and the working age population (15-64) will to 67 percent (Fig-11). If we are able to educate our youth today, we will be able to have an educated and skilled labor force tomorrow allowing us to avail the demographic dividend fully.

**Fig- 11 Population Pyramid, 2020 & 2030**

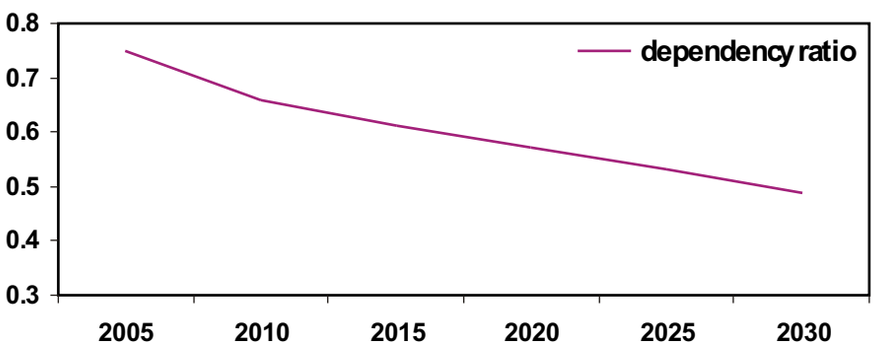



1.16. Another way of looking at the changes in age structure is to examine dependency ratios, i.e., the ratio of persons under 15 and over 64 to persons between 15 and 64. This ratio is an indication of an increase in young population and decrease in old population. The dependency ratio has already decreased from 0.86 to 0.75 in the fifteen years since fertility began to decline in 1990. The ratio will continue to decline for several more years even after 2030, mainly because of the reductions in the proportions of the population at the young ages of 0-14, and a continuing increase in the working age population.

**Table – 1.7**

| AGE GROUP | 2010 | 2015 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| TOTAL M+F | 173.51 | 191.71 | 210.13 | 227.35 | 242.05 |
| 0-14 | 0.36 | 0.35 | 0.32 | 0.30 | 0.27 |
| 15-64 | 0.60 | 0.61 | 0.63 | 0.65 | 0.67 |
| 65+ | 0.04 | 0.04 | 0.05 | 0.05 | 0.06 |

**Fig- 12:**



1.17. With a median age of around 21 years, Pakistan is a "young" country with a young population of 87 million aged = 21 years. It is estimated that there are currently approximately 104 million Pakistanis below the age of 30 years. This young population poses the challenge to the development planners; it also provides a hope for a better future of Pakistan. The median age, however is projected to increase to 26.4 years by 2030.

Table 1.8 : MEDIAN AGE

**Pakistan**
**Median age (years)**
**Medium variant 2010-2030**

| Year | Median age |
|---|---|
| 2010 | 21.3 |
| 2015 | 22.5 |
| 2020 | 23.7 |
| 2025 | 25.0 |
| 2030 | 26.4 |

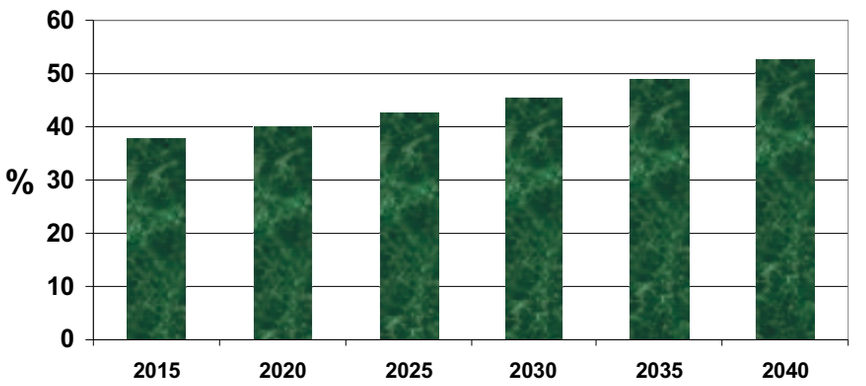
Source: World Population Prospects: The 2008 Revision

## Urban / Rural Population

1.18. During 1950-2008, Pakistan's urban population expanded over seven-fold, while the total population increased over four-fold. Dramatic but multidimensional changes have led to rapid urbanization and the emergence of mega-cities. Pakistan is the most urbanized nation in South Asia; continuing to urbanize @ 3%; with city dwellers making up 36% of its population, (2008).

1.19. It is generally believed that the rate of urbanization is associated with the pace of industrialization. The rate of urbanization was high in the formative years of Pakistan when industrialization was on fast track and the urban population had ample opportunities; the trend continued even in the eighties. The shift to urban areas is still taking place but is considered to be small as compared to that in many other parts of the world. According to base case projections, the year 2036 will be a major landmark in Pakistan's demographics since its urban population will reach to the level of 50% of the total population (fig-13).

**Fig- 13: Projections of Population in urban areas of Pakistan (%) (2015-40)**




Source: World Urbanization Prospects 2009

# Chapter-2

## Demographic Situation of Pakistan – An Analysis

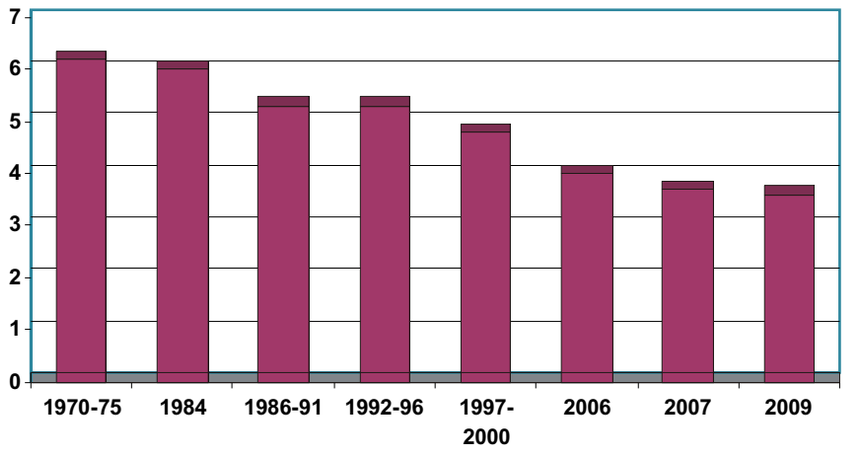
# Chapter – 2

## Demographic Situation of Pakistan—An Analysis

### Fertility Transition in Pakistan

2.1. A quick glance at total fertility rates (TFRs) since 1970s shows that the rate dropped below six births per woman during mid 1980s. The fast decline started around 1988 through 2000 with a reduction of approximately 2 children per woman. In the subsequent years after 2000, there has been a slow down in fertility decline (Fig-14). The Pakistan Demographic and Health Survey 2007, suggests that fertility has stagnated at around four births since the turn of twenty first century.

**Fig-14 Trend in Total Fertility Rate in Pakistan 1970-2009**




**Source: National Institute of Population Studies (NIPS)**

2.2. The data given in the table below also supports above assertion. It indicates that the level of fertility in Pakistan remained above 6 children per woman till 1985. Fertility rate declined rapidly during 1986-2000; falling from 6 to 4.1 children (See table 2.1).

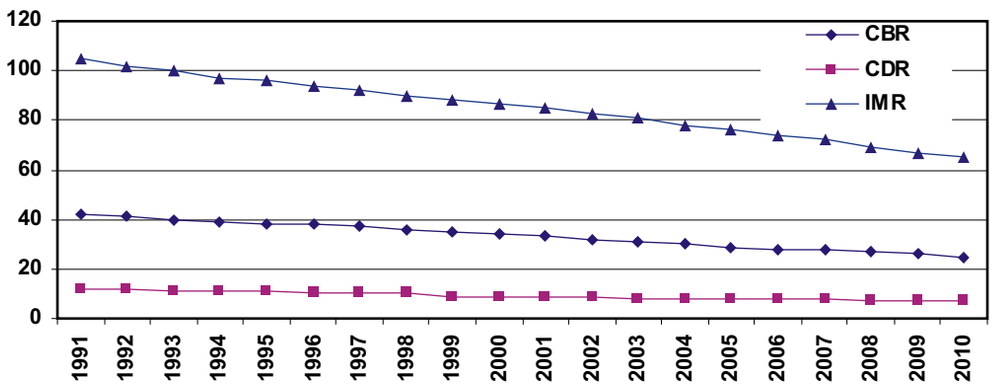
**Table-2.1: Trend in Total Fertility Rates as Reported by Various Surveys 1965 to 2007**

| Surveys | Years | Total Fertility Rate |
|---|---|---|
| Pakistan Fertility Survey | 1965-69 | 7.07 |
| Population Labor Force and Migration Survey | 1970-75 | 7.10 |
| Population Labor Force and Migration Survey | 1975-79 | 6.50 |

| | | |
|---|---|---|
| Pakistan Contraceptive Prevalence Survey | 1984-85 | 6.00 |
| Pakistan Demographic and Health Survey | 1986-91 | 5.50 |
| Pakistan Contraceptive Prevalence Survey | 1994-95 | 5.60 |
| Pakistan Fertility and Family Planning Survey | 1992-96 | 5.40 |
| Pakistan Integrated Household Survey | 1994-96 | 4.50 |
| Pakistan Demographic Survey | 2001 | 4.10 |
| Pakistan Reproductive Health and Family Planning Survey | 2000-01 | 4.20 |
| Status of Women, Reproductive health, and Family Planning Survey | 2003 | 4.20 |
| Pakistan Demographic and Health Survey | 2006-07 | 4.10 |

2.3. The population trends are best explained by CBR (Crude birth rate) and CDR (Crude death rate). These show the growth and decline of a population per thousand births while IMR (Infant mortality rate) is the number of newborns dying under one year of age divided by the number of live births during the year times 1000. The infant mortality rate is also called the infant death rate. All these indicators have improved if we see the pattern from the last census in 1998. CBR has declined by 20.32%, CDR by 12.79% and IMR by 17.73% during the time period from 1999-2009. This analysis confirms the juncture we are at, in terms of "demographic transition". Fertility and mortality both are on the decline which implies that the demographic transition has set and Pakistan has an opportunity to capitalize the widely acclaimed "Demographic Dividend."

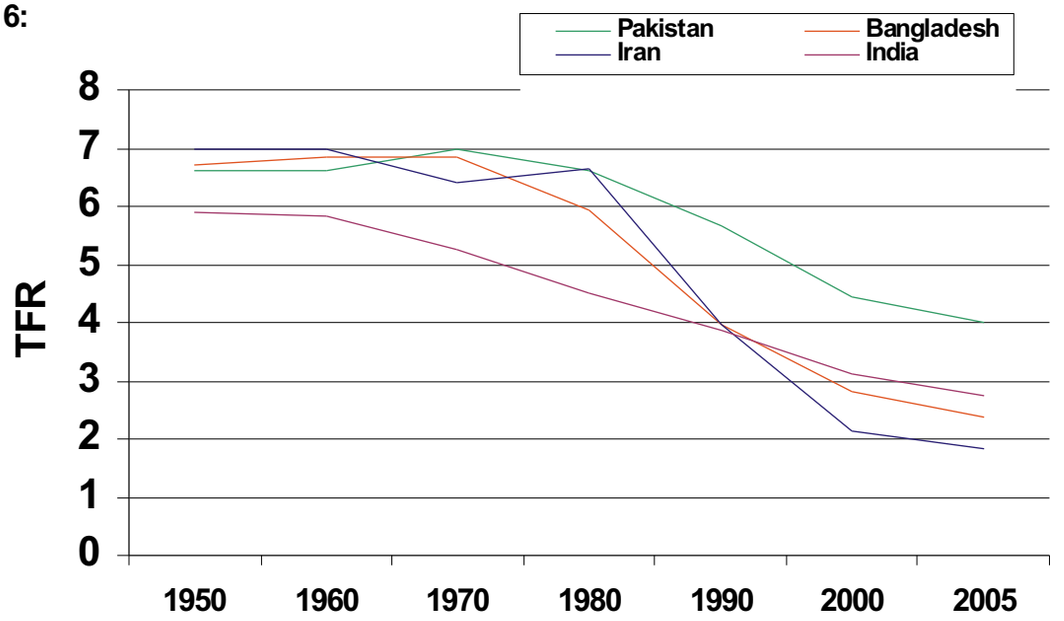
**Fig-15**




Source: US Census Bureau Internationl Database

2.4. The above analysis indicates that demographic transition has set though its pace is very slow. It started relatively late compared to other regional countries (fig. 16).

**Fig-16:**




2.5. The slower change in fertility rate maintained growth profile relatively high. The fast declining mortality resulted in enhanced life expectancy while a wide gap between declining mortality and high fertility turned the Pakistan's population profile a youthful' one. Proportion of population of less than 15 years age declined from 44.5 percent in 1981(Census 81) to 43.4 percent in 1998 (Census 98) and to 41.6 in 2005 (FBS: PDS 2005).

2.6. Population pyramids for 1998 and projected population for 2010, 2020, and 2030 (Fig-17 & 18) clearly indicate the beginning of 'bulge' at youngest age groups (less than 5, and 5-9 years). With further decline in fertility, the 'bulge' will become more prominent as the base population in these two groups gets smaller and smaller. This bulge has been described by some as a situation in which 20 percent or more of a population is in the age group of 15-24 years. It is the result of a transition from high to low fertility about 15 years earlier. The youth bulge consists of large numbers of adolescents and young adults who were born when fertility was high followed by declining numbers of children born after fertility declined.

Fig- 17

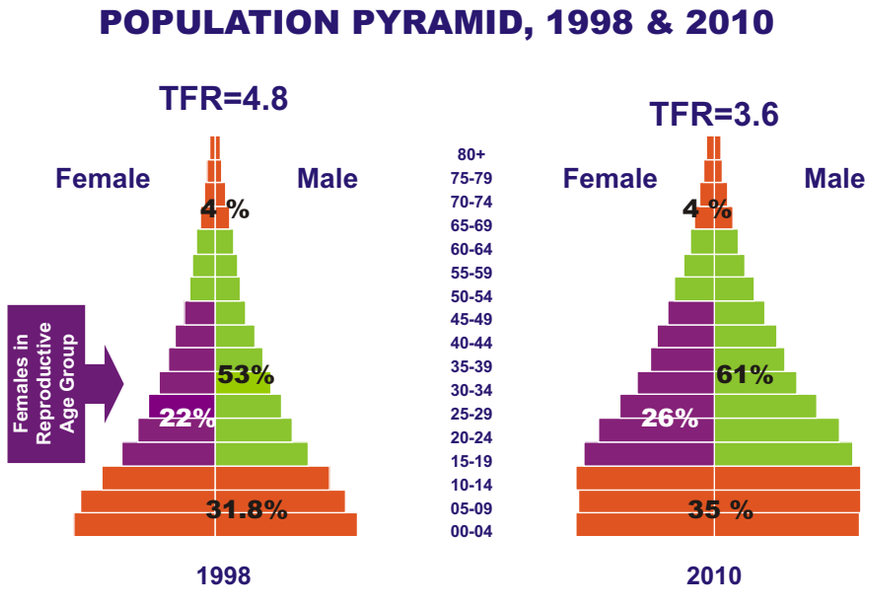
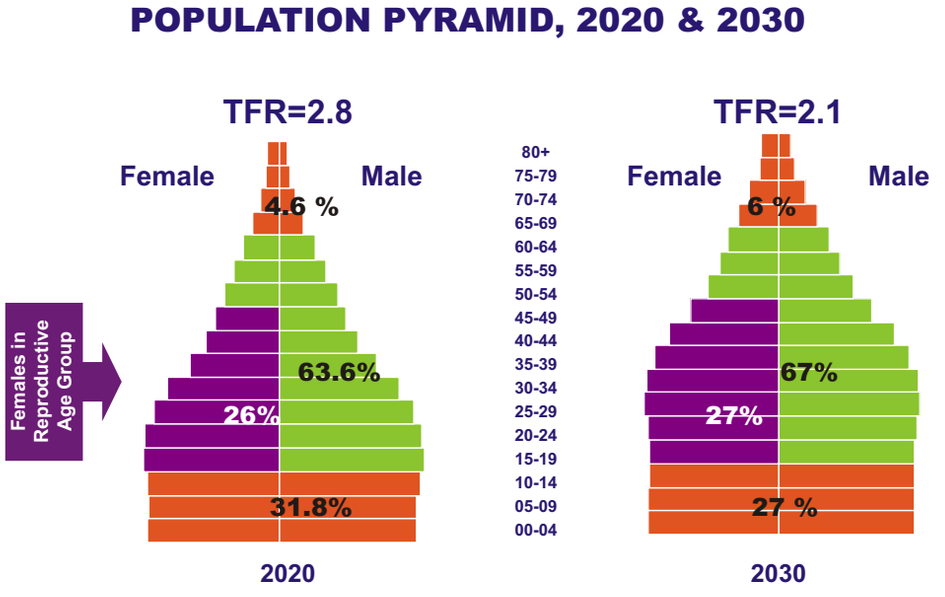
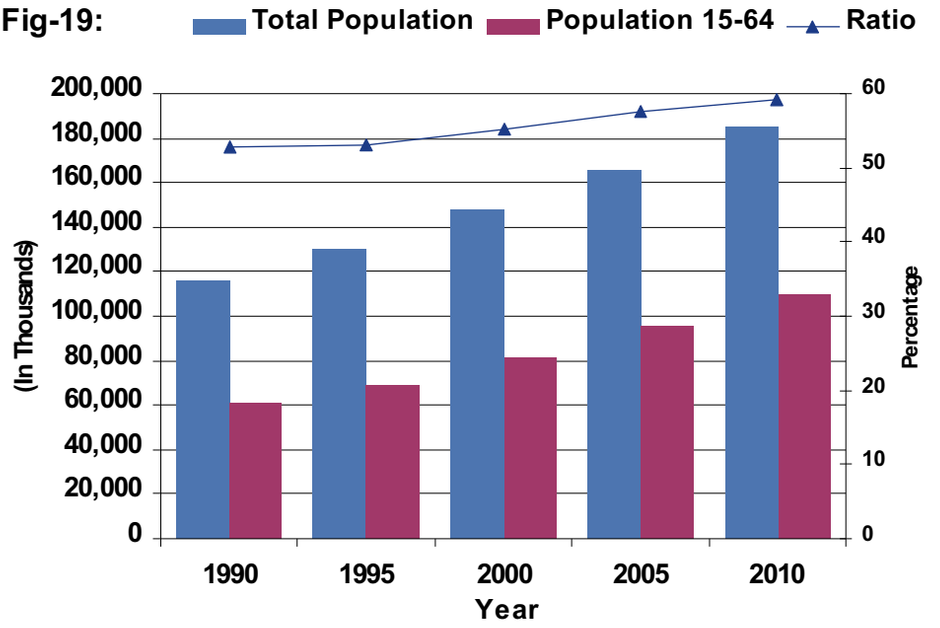



Fig- 18




2.7. The growing up of younger generation and entering into working age group (15–64 years) and consequently increasing the proportion of working age population from 52.9 percent in 1990 to almost 58.48 percent in 2000 and 59.3 percent in 2010 could provide a boost to economic development, if harnessed properly. At the same time, the youthful profile evolved as a result of sustained high fertility and sharply declining mortality over the past, is indicative of high momentum in population growth. This momentum is expected to result in the continuance of large addition of population over several decades even when fertility level gets reduced.

Fig-19:




2.8. However the growing up of the proportion of this age group (15-64) poses a challenge too since it contains within it two important segments: youth (age 15- 24) and women of reproductive ages (15-49). Youth are the new entrants to productive ages which call for enhanced proportion of expenditure towards their education and skill enhancement. On the other hand, proportion of reproductive age women, rising from around 23 percent in 2000 to 26 percent in 2010 and then maintaining this proportion for the subsequent years till 2030, warrants an understanding and attention of the government to formulate robust programs of fertility management, education, training and gainful employment targeting youth and women.

## Reasons for slowing down of Fertility Transition

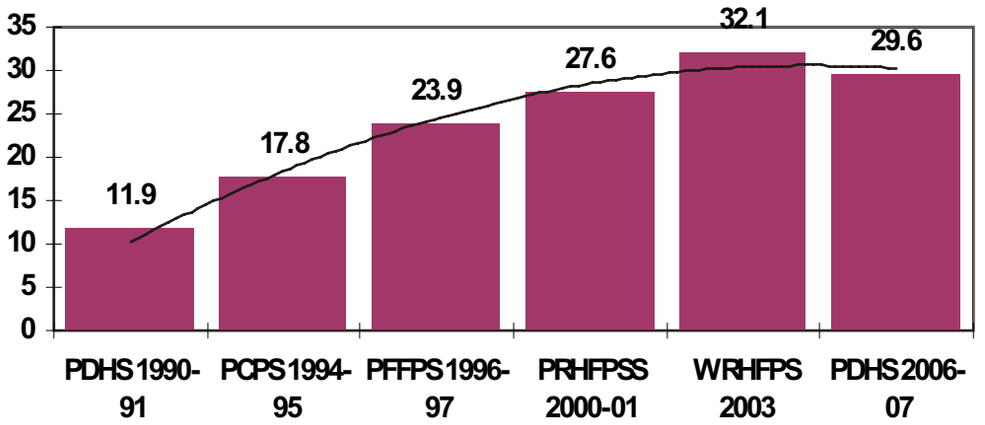
2.9. Evidence suggests that fertility decline in Pakistan has slowed down and it has added more population than projected for the years 2005 onwards, thus making achievement of ICPD goal of universal access to family planning and MDGs about health and education more difficult. In the ensuing paragraphs, a brief review of the factors related to fertility transition in Pakistan is presented:

### i). Use of Contraception:

2.10. The contraceptive prevalence rate (CPR), which is the most effective method to bring fertility decline, has increased marginally from 28 in 2001 to 29.6 percent in 2006-07 (PDHS 2007). This is the lowest among South Asia countries like Iran, Sri Lanka, Indonesia, and Turkey, which are close to or have achieved 'replacement level' fertility. Contraceptive use in Pakistan

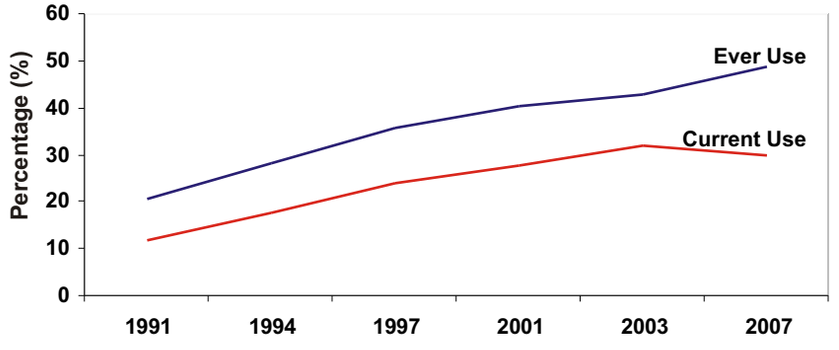
rose from less than 10% in late 1980s to nearly 30% by the turn of the twenty-first century. This rise in CPR had a distinct effect on fertility level in Pakistan and is attributed as the major contributor towards fertility decline in 90s (Sathar, 2007).

**Figure-20: Trend in Contraceptive Prevalence Rate in Pakistan, 1990-2007**



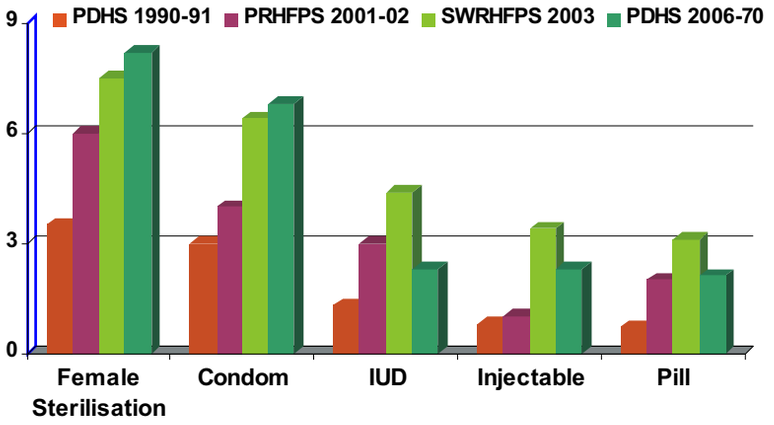

2.11. The most startling finding of the Pakistan Demographic and Health Survey 2007 is lowering of contraceptive prevalence rate, compared with 2003 level of 32.1 percent (WRHFPS 2003).What is alarming to note is the trend of widening gap between 'ever use' and 'current use' of contraception (Fig-21). The difference between the two is the proportion of women dropping out the contraceptive use for certain reasons. The survey (PDHS) assesses 20 percent difference between ever and current use which implies that a significant proportion of women does take an initiative but discontinue. Inadequate counseling, low quality of services, lack of follow-up, fear of side effects – especially of oral pills, injections and intra-uterine contraceptive devices (IUCDs) are reported as major barriers to contraceptive use. Moreover, low quality of services, irregular supply and non-availability of contraceptives at health facilities are other reasons for stagnation of CPR.

**Fig-21**



2.12. The survey also indicates that a segment of users (more than a quarter) employ inefficient traditional methods to control their fertility. What is more upsetting is the declining trend in use of birth spacing methods especially IUDs, injectables and oral pills. The use of female sterilization (to limit births) and condoms (male method for spacing) did increase but not enough to compensate for decline in others (Fig-22).

**Fig-22: Trend in Modern Method Mix Since 1990**




2.13. Use of different contraceptive methods appears to have an influence from the supply and quality of services of these methods. Supply and services of female sterilization and condoms did receive institutional support: female sterilization from public sector; while condoms through social marketing in urban areas and Lady Health Workers in rural areas while the supplies of injectables, oral pills, and IUDs remained inadequate, consequently dropping in their use rate. The Survey (PDHS 2007) suggests that the reasons for not using contraception mainly include the apprehensions toward fertility; fear of side effects; and the misperception that its use is against religion. Significant differentials between urban – rural areas exist for use of modern and traditional methods along with those for educational attainment, and wealth quintiles.

### ii). Induced Abortion:

2.14. Abortion is not legally allowed in Pakistan, however, induced abortion is practiced as a method to regulate fertility. It is hard to gather accurate information on the prevalence of induced abortion in Pakistan. According to the available data almost 20.4 percent pregnancies were unwanted in 1990, which increased to 28.4% in 1996-97 and to 35.6% in 2003. The unwanted pregnancies dropped to 24 percent in 2006-07. High unmet need for contraception (currently 25 percent of all married women) and the proportion of unwanted pregnancies (24%) reflect the potential risk of one million induced abortion each year (Mehmood, 2002; Sathar, 2007).

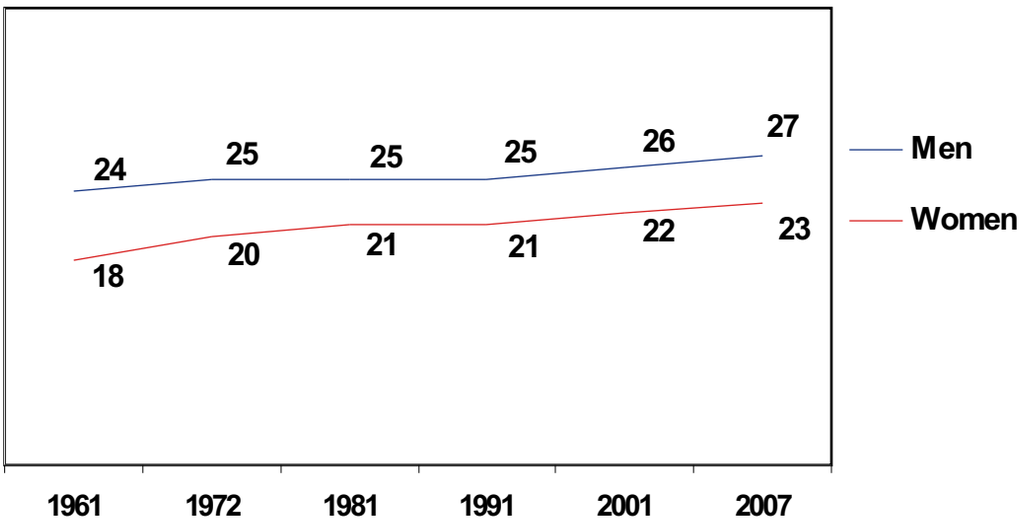
2.15. Household surveys indicate a quarter and about three percent among all ever-married

women reported spontaneous abortion (NIPS - PRHFPS 2001). A study conducted in 2002-03 found that there was one abortion for every five live births, implying that every Pakistani woman on an average have one abortion during her lifetime. The study undertaken by the Population Council estimates around one million (890,000) induced abortions occurring annually in Pakistan The study concludes that induced abortion is a significant means of fertility control in Pakistan (Population Council, 2004). The PDHS 2006-07 also reveals that about 10 percent women experienced a miscarriage or an abortion during five years prior to the survey.. This phenomenon, when examined in relation to high unmet need, demonstrates the health risks Pakistani women face during their reproductive life.

### iii). Age at Marriage

2.16. Family Planning Programme in Pakistan targets only the couples in the wedlock. Marriage as an institution for legal procreation and as a social contract for cohabitation is almost universal in Pakistan. In 1961, the female age at marriage in Pakistan was just 18 years which according to the recent estimates has increased to 23 years (Fig-23). This implies a reduction of more than five and half years in a woman's reproductive life. Rising age at marriage may result in fertility decline as a result of the "tempo" effect discovered nearly half a century ago by Ryder [see Bongaarts and Feeney (1998) for details and references].

**Fig-23:**

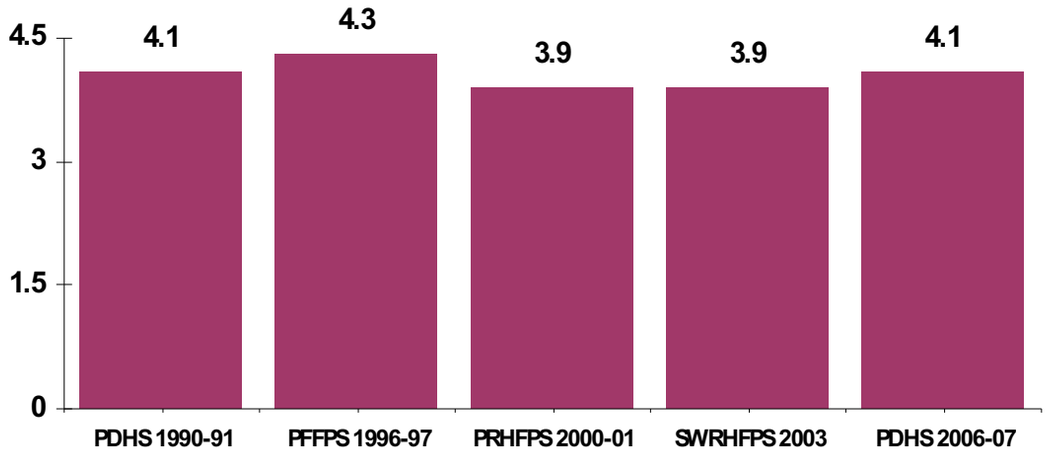



### iv). Desired Family Size

2.17. Desired family size is found to have had a strong direct effect on fertility while the desired fertility, in turn, is strongly affected by the level of development in a country. Families in agrarian societies find safety and strength in large family size, especially sons who also earn their

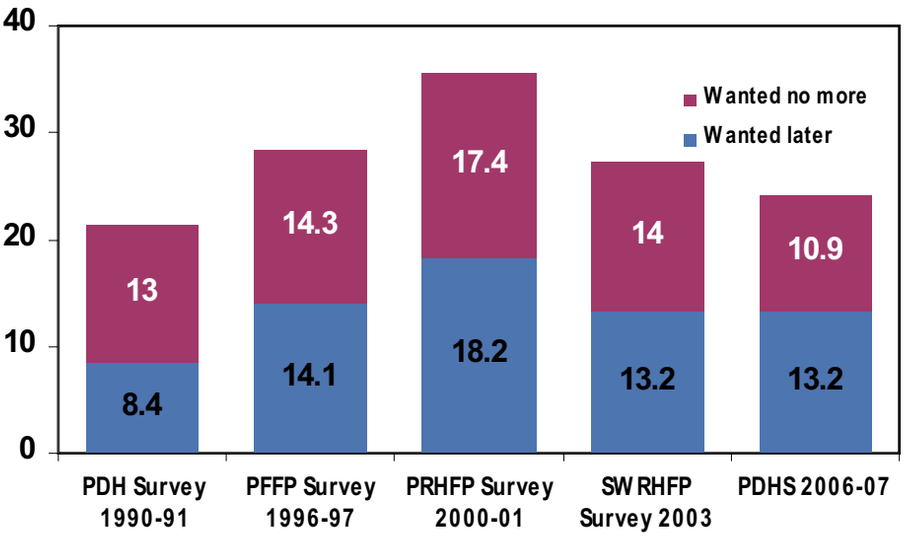
livelihood. Four factors are generally mentioned which contribute towards desired large family size in Pakistan, especially in rural areas - limited autonomy of women in fertility regulation practices; son-preference; state of economy; and social barriers to fertility control. With the increasing modernization, the social and cultural values have started changing, thus bringing down the desired family size (Fig 24). Enhancement in female education; improvement in child survival; and expanded employment opportunities for women are the critical areas which have contributed towards decline in desired family size.

**Figure-24: Ideal number of Children in Pakistan, 1990-2007**



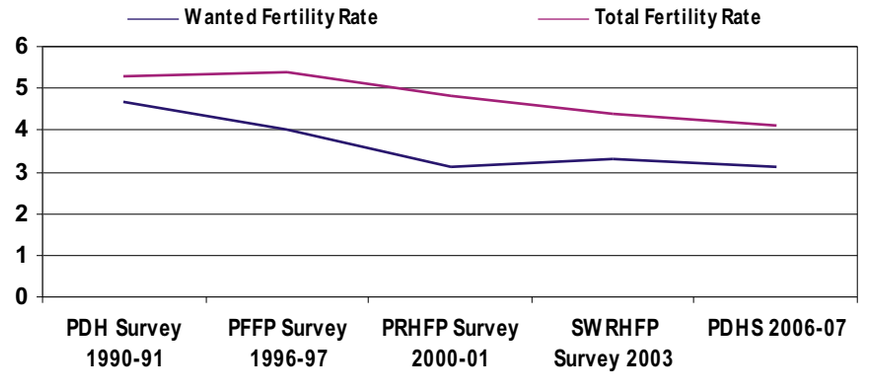

2.18. Pakistan in the last decades witnessed both a rise and a fall in proportion of unwanted pregnancies or the ones which women wanted to delay. This proportion was 21.4 percent in 1990 which went up to 35.6 percent in 2000-01. This significant increase in unwanted or untimely pregnancies indicates the large unmet need due to poor supply of services. The surveys subsequent to 2000-01 reveal a downward trend declining to 24 percent in 2006-07 (see figure 25). Surprisingly the proportion of women 'not wanting more children' increased from 13 % in 1990-91 to 17.4% in 2000-01 and then fell down to 10.9% in 2006-07, while women desiring delay increased significantly since 1990-91 (from 8.4% to 13.2% in 2006-07). This change in desires in recent years (2000-07) reflects a shift from 'family size' norms to birth spacing.

**Fig-25:**




2.19. The differences between total fertility rate (TFR) and total wanted fertility rate (TWFR) since 1990-91 indicates that the women are producing excess births than their desired levels (see figure 26). Pakistan has witnessed the 'wanted TFR' touching the level of 3.1 births as against TFR of 3.7 by 2006-07. This implies that better family planning services may reduce fertility rates much lower than the current level. The principal cause of unwanted childbearing is the unmet need for contraception.

**Figure 26: Gap between Wanted and Total Fertility Rates in Pakistan 1990-91 to 2006-07**

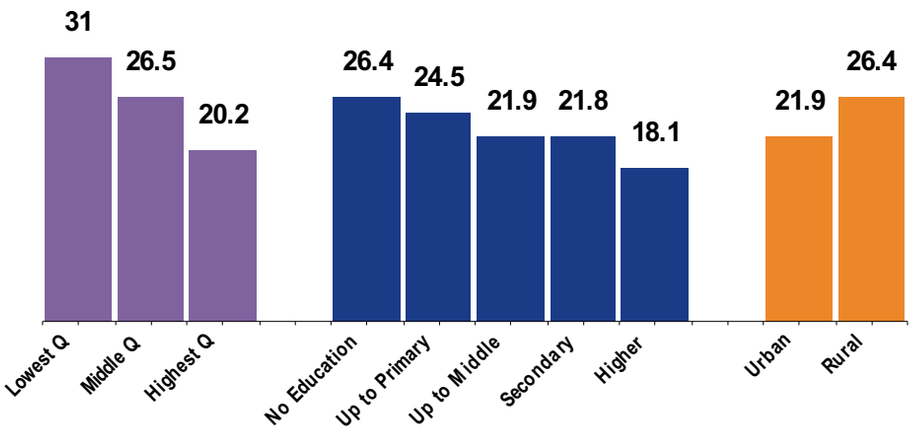


## v). Unmet Need

2.20. Unmet need for contraception at around 25% commensurate with the proportion of unwanted pregnancies at 24%. This refers to unfulfilled desire of women not to have pregnancy at all or to delay pregnancies due to lack of availability, accessibility and affordability of quality family planning services. In addition, personal reasons including self, or husband opposition, religious misperceptions and fear of side effects are also limiting factors in the use of contraception. Increasing proportion of drop outs (who had ever used) and those who experience contraceptive failure adds to already high unmet need for contraception.

2.21. Recent survey reveals that poor and middle class, rural and uneducated women or up to primary class experience high unmet need for contraception. PDHS 2006-07 also indicates that high unmet need has close linkage with induced abortion. High unmet need thus is a critical factor in stagnating fertility decline (Fig-27).

**Fig-27:**

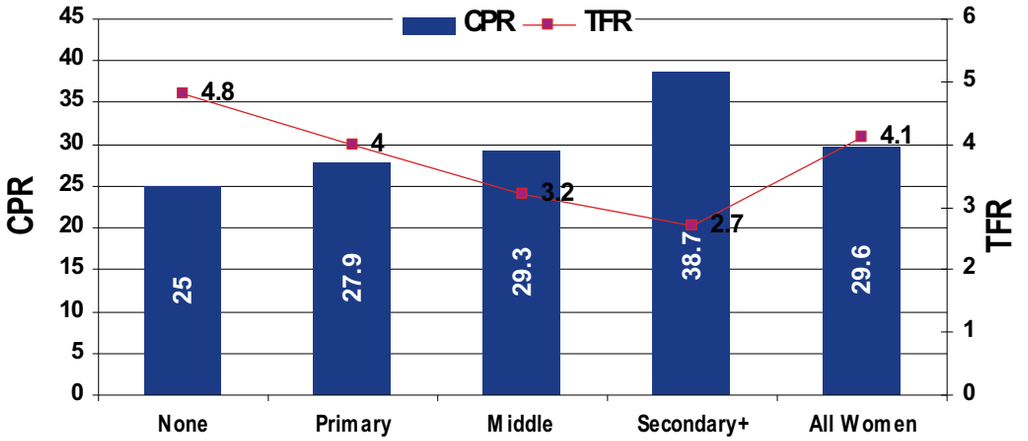



## vi). Female Education

2.22. The inverse relationship between education and fertility behavior is undisputed and also well established for Pakistan (Mahmood, 2005). The PDHS 2006-07 reveals that women with secondary or higher level of education bear less than three births (TFR 2.7) i.e. almost one birth less than their counterparts. Surprisingly, among highly educated women in Pakistan, there are 18 percent with unmet need for contraception, and another 11 percent use traditional contraceptives to regulate their fertility. The first segment calls for improved services while the second segment appears to be less informed or misinformed and needs information and education on fertility regulation.

| Table-2.2: Trend in Total Fertility Rate and Contraceptive Prevalence Rate by Women's Education Level, PDHS 2006-07 | | |
|---|---|---|
| **Education Level** | **TFR** | **CPR** |
| None | 4.8 | 25.0 |
| Primary | 4.0 | 27.9 |
| Middle | 3.2 | 29.3 |
| Secondary + | 2.7 | 38.7 |
| All Women | 4.1 | 29.6 |

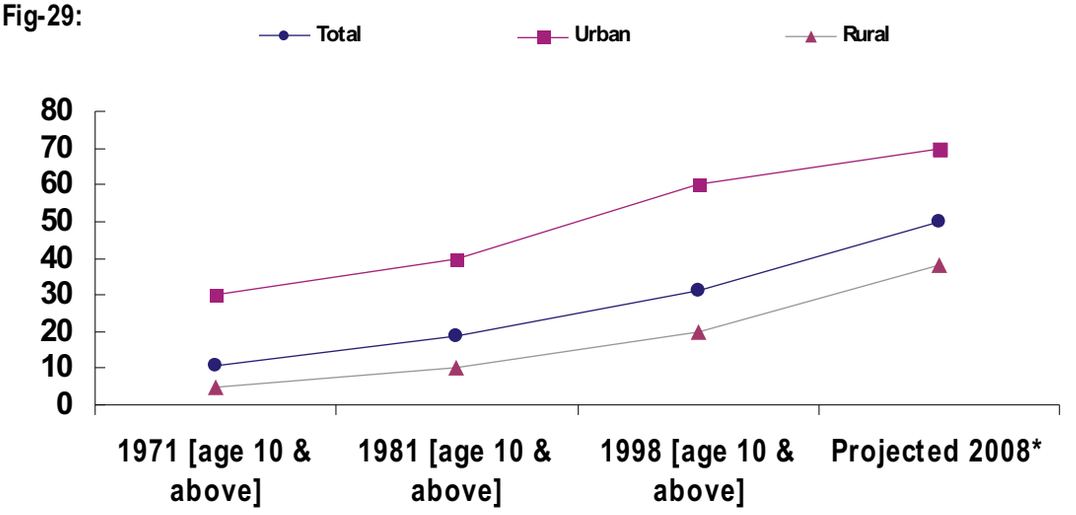
**Fig-28:**




2.23. The majority of female population in Pakistan continues to be illiterate; female literacy position is even worse in rural areas (Sathar, 2007). The rate of female literacy in rural areas was at an extremely low point of 7.3% in 1981 to another low point of 20.1% in 1998. Even if the rate of increase is kept constant, female literacy rate in rural areas is projected to be around 36 percent which is simply insufficient to sustain the fertility decline.

| Table 2.3: Trend in Female Literacy Rate by Region 1971-98 | | | |
|---|---|---|---|
| | **Total** | **Urban** | **Rural** |
| 1971 [age 10 & above] | 11.6 | 30.9 | 4.7 |
| 1981 [age 10 & above] | 16.0 | 37.3 | 7.3 |
| 1998 [age 10 & above] | 32.0 | 55.2 | 20.1 |
| Projected 2008* | 48.1 | 69.5 | 36.5 |
| * Projections based on the work of : Bogue, Donald J. (1969) Principles of Demography New York: John Wiley & Sons Inc. | | | |

Fig-29:




2.24. The PDHS of 1990-91 found 79.2% of ever married women between the ages 15 to 49 years to have no education – a proportion that came down to 74.9% in Pakistan Fertility and Family Planning Survey of 1996-97, 71.5% in Pakistan Reproductive Health and Family Planning Survey of 2000-01, 68.3% in Status of Women, Reproductive Health and Family Planning Survey of 2003 and finally to 65.0% in the latest PDHS of 2006-07. A Policy that focuses upon promoting women's education across the spectrum and allows greater investment in achieving universal access to primary education has to be adopted as an overarching strategy instrument for achieving replacement level fertility by 2030.

### vii). Women's Status and Empowerment

2.25. Education is the major force that breaks the resistance in the way of development. Education promotes enlightenment, innovation and inspiration to undertake new challenges. Education alleviates women status which in tern empowers them to take decisions about their fertility management. Status of women and their autonomy in decision making is a complex interplay of a large number of factors, mainly including educational attainment, gainful employment and economic wellbeing. The Pakistan Demographic and Health Survey (2006-07) revealed that fertility of women of low socioeconomic status is high [5.8] by two births than those who belong to upper strata of wealth [3.0]. Similarly, the differential in CPR is 15.6 percent verses 43.4 percent between these two groups of women.

2.26. Research studies in Pakistan have shown a strong negative relationship between fertility and female educational attainment. This relationship can be explained through behavioral changes like delay in marriage, desire for smaller family size, and women employment which are a consequence of education.

2.27. Contrary to this known phenomenon, female literacy and educational attainment could not become development priority. The Census of 1981 recorded merely 16% of women ages 10 years and above, to be literate, while this rate was only 7.3% in rural areas. The overall proportion of literate women increased two fold between Censuses 1981 and 1998 (see table 2.3). The access to female schooling could receive an adequate attention only in 1990s under the Social Action Program; female enrolment in primary education went to the highest point in late 1990s. Late 1990s also witnessed the highest female enrolment rate (22 %) at secondary level; it never rose to that level again even in 2000s. This trend is not conducive to the goal of fertility decline The National Education Policy 2008 though aims at universal, free and compulsory quality basic education for all children, especially girls by 2015; the target appears unachievable due to low investment in this sector (the World Bank).

### viii). Female Employment

2.28. The lesser the opportunity cost, the more the children a couple may have. The opportunity costs of children to their parents increases by enhancing parent's educational levels and by expanding women's job prospects in modern sectors. Women's formal sector employment and paid employment outside home has been recognized to have positive effect on fertility (Sathar and Kazi 2001). Some public sector initiatives to promote female employment in health and education since mid 1990s, though small when compared to overall increase in female work force, have shown signs of their enhanced participation in these sectors. Official statistics of this period show doubling of female participation from around 10 percent to 20 percent (in 2006-07). However, the highest and fast growing female labor participation is for women who have completed their desired fertility (age group 35-44 and 45-54) - their involvement has little effect on their age specific fertility. Participation of younger women (age 20-24 and 25-34) has risen only from 16 percent in late 1990s to around 22 percent in 2006-07. The decreasing trend in their participation rates during 2005- 06 onwards is an indication of some regressive forces at work.

2.29. Formal sector involvement of females does have negative influence on fertility. The capacity of Pakistani labor market to absorb increasing number of females completing higher education is quite limited; less than 13 percent females in labor market have secondary or more education. Only a marginal increase has been registered over last three years.

2.30. A study undertaken in Grameen Micro-Credit Schemes in Bangladesh concludes that access to micro-credit increases women opportunity costs and improves their status through alleviating poverty, thus lowering desired family size and increasing contraceptive use among clients (Harty 2007). Study results indicate that credit programs are an effective way of helping women in lowering their 'excess fertility' and facilitating them in achieving their desired family size. Short term micro-credit schemes, however, may not have the same effect on fertility as do the paid jobs.

### ix). Child Labor

2.31. Doepke (2004) found that education and child labor policies have large effects on fertility transition. In Pakistan, limited access to education, parental poverty, and cultural values like restrictions on girls' mobility make educational pursuit difficult and child labor an open option.

2.32. Pakistan has recorded a decline in child labor rates (age less than 15) during 1990s especially for boys. A rising trend in female child activity rates during 2002 onwards is disturbing in contrast to decline recorded for male children. A national child labor survey conducted by the Federal Bureau of Statistics (FBS) in 1996 found 3.3 million of the 40 million children (cohort of 5-14 years) to be economically active on full-time basis. Of the 3.3 million working children, 27 per cent (0.9 million) were girls (Ministry of Education 2005). Children's contribution to work in the rural areas is about eight times greater than that in urban areas because of agrarian nature of economy. Number of economically active children in age cohort 10-14 years is more than four times the children in age cohort of 5-9 years.

2.33. Studies reveal negative correlation between enrolment and involvement of children in economic activity in Pakistan. Compulsory schooling laws appear to be a more effective measure to reduce child labor than direct regulation and enforcing child labor regulation. The Ordinance for compulsory primary education was promulgated in 2002 in all provinces (except Balochistan and federal territory). An incentive package was also developed to meet the educational needs of poor students (early 2002) such as free textbooks, uniforms, stipends, fee waivers and nutrition.

2.34. Linking of education with labor market is critical for smooth flow from educational institutions to job market. Skill development of young population is a critical condition to transform expanding labor base into useful marketable professionals to derive the demographic dividend.

### x. Poverty

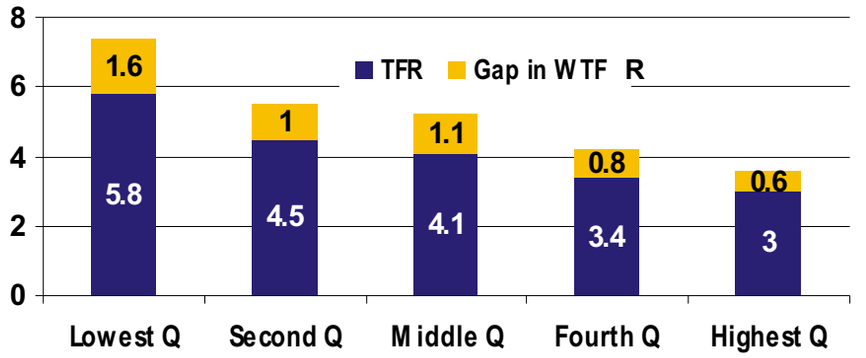
2.35. High fertility rate is a cause as well as a consequence of poverty. There are number of studies which suggest that fertility rate increases at low income levels but decreases at high income level (Dyson and Murphy, 1985; Kremer, 1993; Lucas, 1999).

**Table 2.4: Total Fertility Rates in Pakistan by Quintiles PDHS 2006-07**

| | Lowest Quintile | Second Quintile | Middle Quintile | Fourth Quintile | Highest Quintile |
|---|---|---|---|---|---|
| Total Fertility Rate | 5.8 | 4.5 | 4.1 | 3.4 | 3.0 |
| Gap in Wanted/Total Fertility Rates | 1.6 | 1.0 | 1.1 | 0.8 | 0.6 |

Source: Pakistan Demographic and Health Survey, 2006-07

Fig-30




2.36. Poverty limits one's ability to access information and family planning methods by which fertility can be regulated.

**Table 2.5: Met, Unmet and Total Demand for Family Planning in Pakistan by Quintiles PDHS 2006-07**

| | Lowest Quintile | Second Quintile | Middle Quintile | Fourth Quintile | Highest Quintile |
|---|---|---|---|---|---|
| Contraceptive Prevalence Rate | 15.6 | 20.8 | 30.1 | 36.8 | 43.4 |
| Unmet need for family planning | 31.1 | 27.4 | 26.5 | 19.9 | 20.2 |
| Total Demand for Family Planning | 46.7 | 48.2 | 56.6 | 56.7 | 63.6 |
| Teenage pregnancy | 15.8 | 11.6 | 7.8 | 8.0 | 4.0 |

Fig-31 (a)

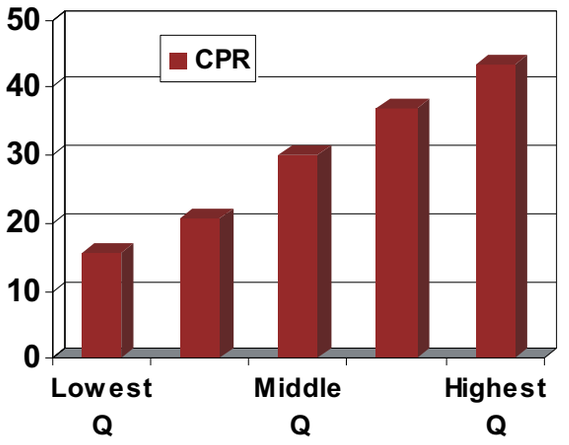



Fig-31 (b)

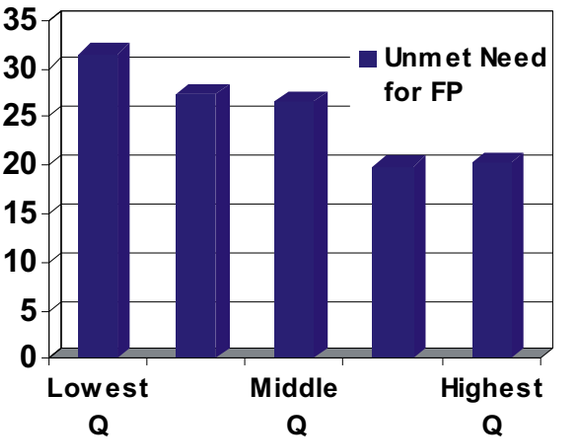


Fig-31 (c)

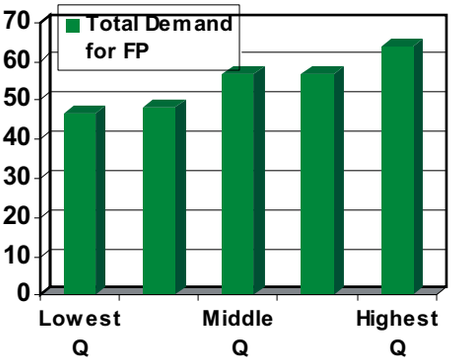
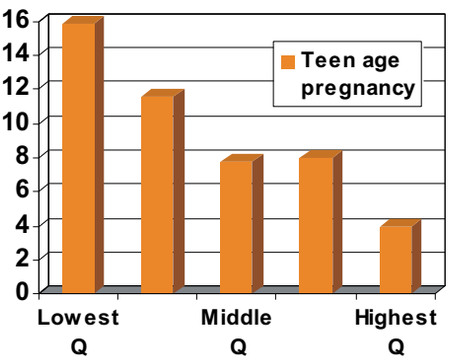


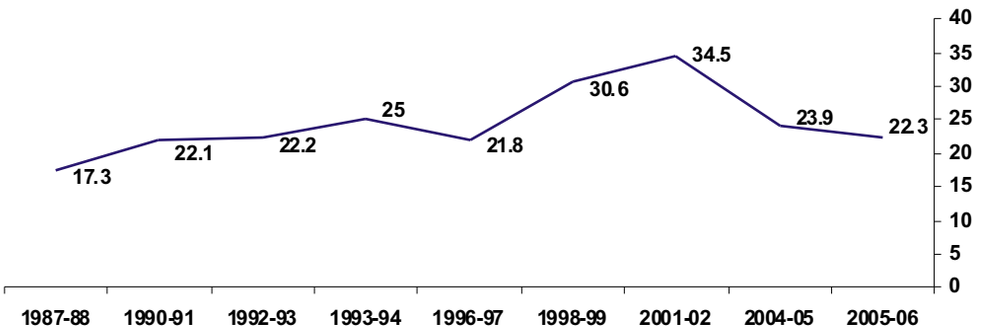

Fig-31 (d)




2.37. Besides, in low-income societies, wealth flows from children to households which may result in higher fertility among poor households who may even perceive unwanted or untimely pregnancies as desirable and wanted.

2.38. Poverty in Pakistan rose from around 17 percent in late 1980s to 34.5 percent in 2001-02 which declined to around 22 percent in 2005-06 (see figure 32). This decline was noted both in rural and urban areas: rural from 39.3 percent to 27 percent while urban from 22.7 percent to 13.1 percent. The urban poverty stood at less than half of the rural poverty. The PRSP process reports high correlation between poverty and household size, i.e. larger households and households with high dependency ratios are likely to be much poorer than smaller households.

**Figure 32: Trend in Poverty in Pakistan [Head Count Ratio], 1987-88 to 2005-06**




2.39. This analysis provides ample reasons to the policy makers to direct their attention towards rural, poor, un–served and underserved population in Pakistan through large-scale community mobilization and enhancing outreach of services at the doorsteps.

## Consequences of Slow Fertility Transition

2.40. Slow transition for low mortality and high fertility sustained over a long period has serious implications on the structure, composition and distribution of population. Since demographic transition creates an opportunity of 'demographic dividend'; stalling fertility is therefore seen as a threat to such prospects.

### I. Rapid Urbanization

2.41. Urban Population in Pakistan, which was less than 18 percent in 1951, increased to 28 percent in 1981 and to around 35.6 percent in 2005, reflecting high rural to urban migration. Census 1998 revealed that about 24 percent of the total urban growth was due to migration during 1981-98 (UNFPA: Pakistan Population Assessment 2003). The rate of urbanization, it is believed, is highest when industrialization takes place and the graph shows that in the formative years of Pakistan the rate was high since the urban population had ample opportunities and the trend continued even in the eighties.

2.42. Given the transition process, large proportion of 'youth bulge' is expected to relocate where job and education opportunities would be available to them. The distribution of population under demographic transition is expected to have an urban bias over the coming years as urban population will grow at a much faster rate (3.5 percent) than rural population. At this growth rate, the urban population is expected to double in less than 20 years. According to base case projections, the urban population in Pakistan will constitute 50% of the total in 2036. With a median age at 20, the profile of future urban population will continue to be 'young'. Urban centers will be highly congested as large and growing young population would reach there for education and skill development prospects as well as for seeking employment opportunities.

2.43. Urbanization is, therefore, an outcome of demographic transition, but the dividend can be realized only after converting increased youth force into an educated, trained and productive human capital through the creation of 'right environment' while using opportune policies, (Mason 2005). In the absence of such efforts and environment, the urban growth could turn in to a threat of demographic insecurity and social instability triggered by rising unemployment and pressure on demand for basic social services. Delay in fertility transition amplifies the fears that 'dividend' may turn into what Nayyab (2006) terms as 'threat' and insecurity.

### II. Dependency Ratio and Demographic Dividend

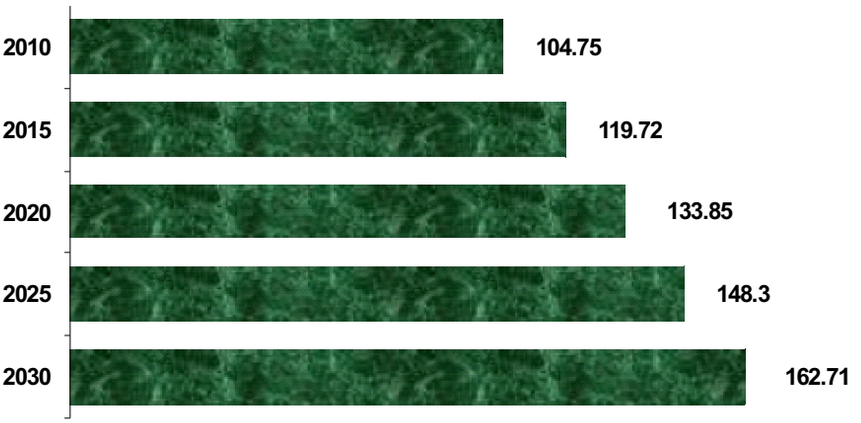
2.44. Fertility transition has its impact on population age structure and vice versa. Age structure determines the dependency ratio which is at the core of the demographic dividend process. The decline in dependency ratio can affect per capita output through several ways. Pakistan is experiencing a dwindling dependency ratio from as high as 98% in mid 70s to 81.5% in mid 2000s.

**Table 2.6: Declining Dependency Ratios**

| *Survey* | *Dependency Ratio* |
|---|---|
| PGS 1976-79 | 97.9 |
| **Census 1981** | 95.3 |
| PDS 1984 | 98.7 |
| PDS 1991 | 98.2 |
| **Census 1998** | 87.3 |
| PDS 2000 | 85.5 |
| **PDS 2005** | 81.5 |

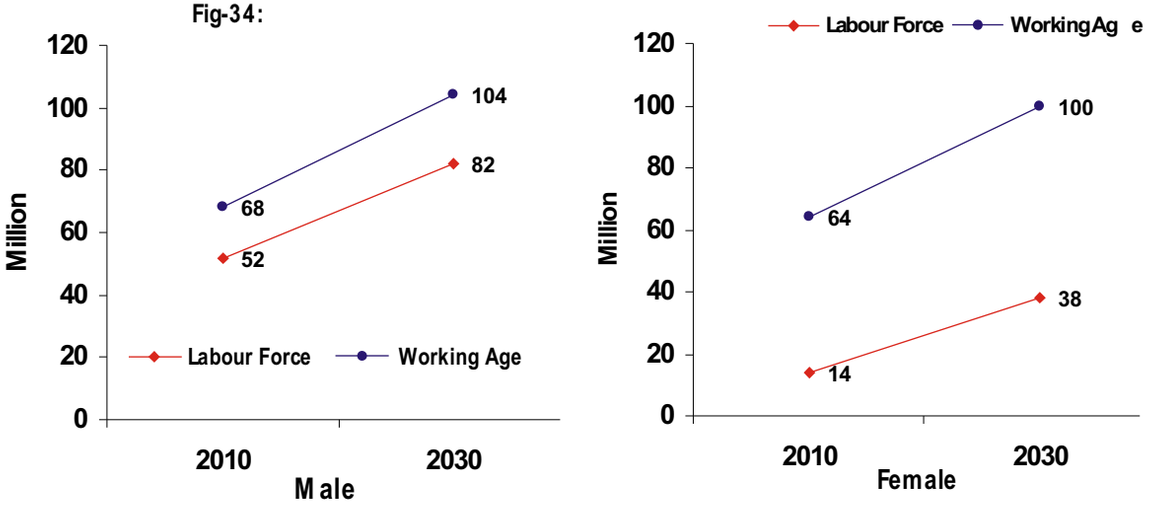
2.45. Reduced dependency ratios mean increase in the proportion of the working age population (15-64) and or a decrease in the proportion of young population (0-14) plus those in the older age (64+). The projected population of the working age group will increase from 105 million to 163 million during 2010-2030. However, the proportion of the older age population in the total population is also projected to show a substantial increase after 2025 (fig-33).

**Fig-33: Increase in Working Age group (2010-2030)**



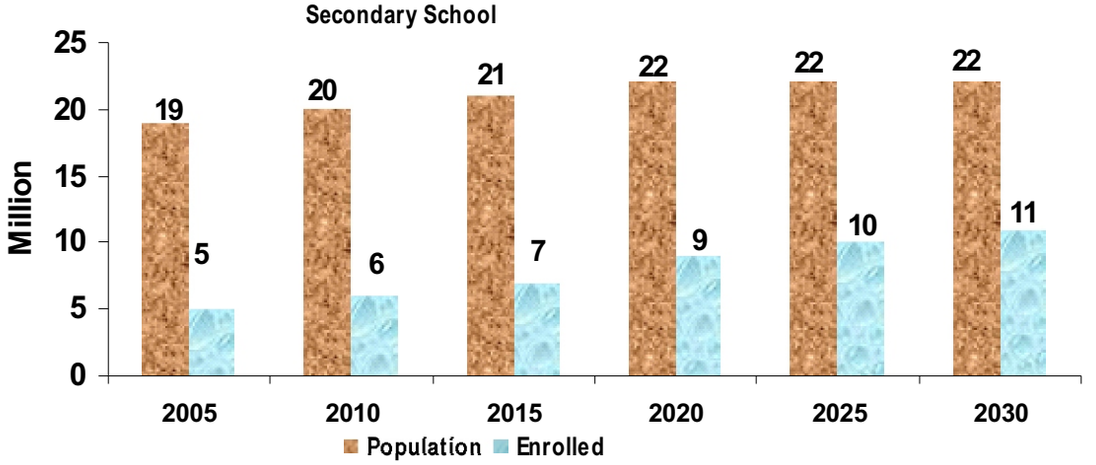

2.46. In view of limited expansion in the industrial base leading to a modest increase in employment opportunities plus the mis-match of the outcome of existing educational system vis-à-vis the requirement of the formal and informal employment sector, a huge gap is likely to emerge between the projected increase in the working age population and labor force (fig-34).

Fig-34:




2.47. The aforesaid situation would be further aggravated in view of low level of literacy and education. The fact that millions of young people who have missed school will be entering the labor force with a disadvantage.

Fig-35: Projected Population aged 10-14 year vs. the number of enrolled in Secondary School




2.48. The stagnation of fertility over a period of six years has added large number of births, pushing the proportion of children higher and thereby slowing down the decline in dependency ratio. This is challenging situation for Pakistan beside the fact that the proportion of old age population will start to exert its pressure on dependency ratio on time which is estimated to be around 2030. Therefore, the young profile of the population of Pakistan as in early 2000s (with a median age under 20) would certainly be different by 2030 when the median age is expected to rise to 33 years and the older age population to around 6 percent from 3.9 percent in 2005. It is important to note that an increase in either of the two elements – proportion of population in old

age or young population due to fertility stagnation, would reduce the scope and size of window of opportunity -- the demographic dividend. Old age population in Pakistan will exert its pressure starting 2030 and will make the overall dependency ratio rise again. Pakistan's window of opportunity, opened in 1990 for a period of fifty years, would come to close by 2045 (Nayyab 2006). Pakistan has already spent 18 years (a third of time available to it).

# Chapter-3

## Population Policy 2002 & Programme 2003-10
## (Review & Analysis)

# Chapter - 3

## Population Policy 2002 & Programme 2003-10
## (Review & Analysis)

## I. Evolution of Structure and Legal Frame Work

3.1. Pakistan is one of the first few countries which made a pioneering effort in the field of family planning. This initiative was taken by an NGO named 'Family Planning Association of Pakistan' in 1953. The Government of Pakistan, in the 1st Five Year Plan, 1955-60, endorsed the need for family planning and allocated Rs.5 million for disbursement to voluntary organizations for contraceptive advice and services.

3.2. Because of the limited reach of the NGOs to cover population on a large scale, family planning services were provided through the outlets of the health departments during the 2nd Five Year Plan, 1960-65. To oversee these activities, small independent units were established in the Ministry of Health and Provincial Health Departments. In addition, medical and social research projects were initiated through donors as a support activity.

3.3. In 1964, evaluation revealed that the services were not reaching the target population through the health outlets as these were overburdened with the existing health care needs of the people. Consequently, a full-fledged National Family Planning Programme was launched during the 3rd Five year Plan, 1965-70, and independent administrative structures in the shape of Federal councils, Provincial Councils and District Boards were established to run this activity. The prominent features of the programme were: involvement of "dais" as motivators, providers of conventional contraceptives and referrals for clinical services (IUD); family planning education and communication through mass media, etc.

3.4. In the 4th Plan period (1970-78), Continuous Motivation System was conceived under which "dais" were replaced by literate (Matriculate) teams of male and female motivators for each union council. These teams of motivators undertook registration of all households and fertile couples to ensure continuity of family planning services.

3.5. In the first half of the 5th Year Plan, 1978-83, the family planning programme (now renamed as Population Welfare Programme) underwent several organizational and structural changes. The programme was federalized in 1976 and Population Welfare Programme (Appointment and Termination of Services) Ordinance 1981 was issued to regularize the services of its employees through the Federal Public Service Commission. During this plan period, the

programme strategy was changed from the single purpose family planning approach to multi-sectoral and multi-dimensional approach that involved the relevant public sector organizations providing broad-based programme coverage. For effective coordination and implementation of this multi-sectoral approach, the Population Welfare Division was placed under the Ministry of Planning and Development.

3.6. During the 6th Plan period (1983-88), a major change in the Programme came in 1983 with the transfer of field activities of the Population Welfare Programme to the provinces, through the promulgation of "Transfer of Population Welfare Programme (Field Activities) Ordinance 1983. The multi-sectoral and multi-dimensional approaches, however, continued with renewed zeal for effective implementation during this period. Another major initiative taken during this plan period was the establishment of NGO Coordination Council, with representatives from NGOs of all the provinces. Setting up of National Institute of Population Studies (NIPS) to undertake research, evaluation and surveys to help the national programme to have an empirical basis in formulating its strategies and approaches was the third major initiative taken during this period.

3.7. The Population Welfare Programme received substantial political support during the 7th Plan period, 1988-93, when the status of the Population Welfare Division was raised to that of a Ministry and it received considerably enhanced allocation of funds. The multi-sectoral and multi-dimensional approach of the past Plans continued with emphasis on quality of services combined with intensified motivational campaigns.

3.8. In the 8th Five Year Plan, 1993-98, a village-based family planning workers (VBFPW) cadre was created for better IPC and extended outreach and door step service delivery in the rural areas. Under this scheme a VBFPW was posted in every village having a population of 1500 or more. To decentralize program management and monitoring, and supervision, divisional directorates and tehsil offices were created during this Plan to resolve day-to-day problems and establish close coordination with other related departments and NGOs at the field level. However it was during this period when the employees of the programme working under the Population Departments, who had been made provincial employees through an Ordinance in 1983 when the field activities were transferred to the provinces, were declared to be continuing as federal civil servants by a judgment of the Supreme Court announced in 1993.

3.9. The programme during the 9th Five Year Plan, 1998-2003, was developed on the positive elements of the strategies of the previous plans, ensuring continuity and consolidation of gains. The programme focused on strengthening of outreach through enhanced and improved service delivery strategy with special attention to rural areas. In the light of ICPD 1994 a broad-based reproductive health approach was adopted which included family planning, mother care and child health in the social context of the country.

3.10. In the year 2000, a Review Committee was constituted for Assessment of Population Welfare Programme. Extensive consultations with different stakeholders including four Provincial Governments were undertaken and a report was submitted in April 2001. Based on the recommendations of the review committee, the following decisions were taken:

i. The status of Population Welfare Programme shall be maintained as a separate Population Division and a stand-alone Ministry.
ii. There shall be separate Population Welfare Departments and Health Departments at provincial level.
iii. The VBFPWs of the Ministry of Population Welfare shall be transferred to the Ministry of Health w.e.f. 1st July, 2001.
iv. The Population Welfare Departments shall be funded through Federal PSDP up to 2003. After 2003, the funding shall be provided through NFC award. In case the award is not finalized, the funding shall continue through Federal PSDP.
v. The status of the Federal Civil Servants will be changed to Provincial Civil Servants through amendments in "Transfer of Population Welfare Programme (Field Activities) Ordinance, 1983".
vi. The administrative and financial control over the service delivery infrastructure (Family Welfare Centers, Reproductive Health Service Centers - A, Mobile Service Units) shall be transferred to the Provincial Population Welfare Departments along with their staff, equipment and funds.
vii. Family Health Workers shall provide contraceptives free of cost to the users.
viii. The Family Health Workers shall be trained in midwifery by conducting short course.

3.11. In pursuance of the decision at (v) above, an amendment to the Transfer of Population Welfare Programme (Field activities) Ordinance 1983 was issued on 25th July 2001 whereby the status of the federal civil servants in the Provincial Population Welfare Departments was changed to that of provincial civil servants. All the employees working in the PWDs were declared provincial civil servants.

3.12. Under the "transfer of Population welfare program (Field Activity) Ordinance 1983", the functions of Federal & Provinces have also been defined. The ordinance vests all powers and functions in respect of Field Activities in the Provincial Governments as under:

i. Provision of Population Welfare Motivational Services by establishing contacts with the clients at all levels;
ii. Provision of Family Health Service, Clinical and Non-clinical contraception through Family Welfare Centres and those Reproductive Health Service Establishments

located in the Provincial Government hospitals, and, particularly, provision of services for rural areas;

iii. Provision of Population Welfare motivation and services through line departments of the Provincial Governments;

iv. Supply of contraceptives and medicines to the desirous clients in urban and rural areas of the districts through the network of community distribution points, and other agencies involved in the programme;

v. Implementation of publicity and communication strategy;

vi. Promotion of community involvement and active participation in Population Welfare Programme activities;

vii. Coordination of Population Welfare Programme activities with other nation-building departments at district and local levels;

viii. Setting up of Advisory Management Committees at Family Welfare Centre level and Population Welfare Councils at district and provincial levels as provided in the Population Welfare Plan 1981-84; and

ix. Any other activity of the Population Welfare Programme that the Federal Government may specify.

3.13. The Federal Government continues to perform the functions pertaining to National Policy, planning and coordination, information, training, supplies, Statistics, monitoring and evaluation, research and foreign assistance.

3.14. Population Welfare Programme continues to be funded by the federal Government through PSDP and implemented by the Provincial Governments including Azad Jammu & Kashmir, Federally Administrated Tribal Area, Gilgit-Baltistan and Islamabad Capital Territory. One line budget of the Population Welfare Programme is transferred to the provinces by Ministry of Population Welfare through State Bank of Pakistan. Ministry of Population Welfare regulates the expenditure of Federal component only.

## II. Population Policy 2002

3.15. The "Program of Action" agreed at the International Conference on Population and Development held in Cairo in 1994 and Millennium Development Goals agreed during the UN Millennium Summit 2000 played important role in evolving the following policy framework:

- Pakistan Population Policy 2002;
- Population Sector Perspective Plan 2002-2012
- De-federalization of the Population Welfare Program with fiscal and administrative authority (July 2002)

- Poverty Reduction Strategy (PRSP) paper 2003
- National Health Policy (2001) - recognizing family planning as integral and essential part of its activities
- National Policy for Development and Women Empowerment 2002
- Education for all- Plan of Action 2003

3.16. Being signatory to the Programme of Action of the International Conference on Population and Development (ICPD), Pakistan adopted the National Reproductive Health Service Package in 2001, thus promoting family planning within the broader framework of reproductive health. The Population Policy 2002 had therefore a shift in focus from merely reducing population growth rate through Family Planning to a greater emphasis on providing broad based reproductive health services. This is said to have diluted the focus of the Program on population planning.

3.17. Fertility decline was very fast when the Population Policy 2002 was being formulated. There were expectations that this decline would continue with the same speed and the replacement level fertility would be easily achieved by 2020. But these hopes floundered when the contrary evidence came from the Pakistan Demographic and Health survey 2007.

3.18. The Policy though had a marked success in the revival of interest in population issue and it was able to underscore the need to collaborate with other institutions in the public and private sector and NGOs but predominantly it could not achieve its targets. The decline in total fertility rate from 4.1 to 3.7 has been largely a result of rising age at marriage and high abortion rates rather than changes in contraceptive prevalence. The ever use of contraceptive is almost 50 percent but current use is 30 percent, which indicates a large proportion of dropouts as a consequence of inadequate counseling and poor quality of family planning services.

3.19. Expansion in family planning services have also failed to keep up pace with the increased demand thus leaving an unmet need of 25%. Stagnating contraceptive prevalence rates at 30 percent from 2001-2007; the high levels of unwanted fertility and the large number of induced abortions are reflection of this reality. More than one out of three women want birth spacing, however not using contraceptives. These outcomes are largely a result of not having easy, accessible and affordable resort to means of preventing an unwanted pregnancy, which includes good quality information and services.

3.20. The Population Policy 2002 envisaged achieving universal access for FP/RH service by 2010 and the replacement level fertility (2.1) by 2020. Similarly, Population Perspective Plan (2002-12) targeted to achieve CPR at 57% by 2012. However, in the prevailing circumstances, with the existing CPR at 30% and TFR at 2.6 and with high unmet need of 25%, it does not look realistic to strive achieving these targets. In fact current trends in fertility if extrapolated, the

replacement level appears hardly achievable by 2020 as envisioned in population policy 2002. The situation, therefore, calls for rationalizing goals and objectives of the Population Policy, 2002.

## III. Population Program 2003-08 & 2008-10

3.21. As against the Contraceptive Prevalence Rate (CPR) target of 44.92% for the Year 2008, the CPR has even declined from 32% (2003) to 29.6% (PDHS 2007). Similarly, the Population Growth Rate (PGR) has stagnated at 2.05 percent against the target of 1.72 percent and the Total fertility Rate (TFR) has slightly declined to 3.6 against the target of 3.3 per woman. Unmet need for Family Planning and RH Services has been brought down to 25% as against the target of 20 percent.

3.22. The Programme has for the last many years focused on promoting small family norms through awareness and motivational campaigns. This strategy has been partially successful in raising the level of awareness about population issues, but it has not been able to bring about the desired change in attitudes and behavior. There are several reasons for this: first, the campaign has focused primarily on urban areas, while rural and semi-urban areas could not be targeted effectively; second, the majority of the rural population could not internalize the message due to low literacy rate; third, access to information and the quality of counseling remained poor, because the fear of side effects of contraceptives could not be taken out of the people's minds; fourth, the service providers, though given training on inter-personal communication (IPC) and information, education and communication (IEC) skills, lacked a professional flair to motivate and counsel eligible couples to adopt contraception; and fifth, religious and socio-cultural apprehensions about family planning could not be fully addressed.

3.23. The support from the health network, both at the federal and provincial levels, for the provision of FP/RH services remained modest since this area did not get the attention it deserved. The performance of lady health workers in providing FP/RH services was also found lacking (Third Party Evaluation: Oxford Policy Management, 2009). More importantly, the coordination between the MoPW and the MoH as critical partners and stakeholders was weak at all levels. As a result, the goal of achieving universal access to family planning services by 2010 could not be achieved.

3.24. The service delivery network of the Programme has expanded modestly over the years, but little attention has been paid to outreach services. Moreover, the combination of the network has not been worked out scientifically to address the issue of programme coverage and access in relation to settlement patterns, population density and geographical terrain. The neglect of service delivery points for men has also been noted. The weakness in the monitoring system,

superimposed by the target-oriented approach, prompted inflated reporting. Furthermore, evaluation studies of service components undertaken by NIPS reveal a number of operational problems impeding optimal performance.

3.25. The envisioned public-private partnership (PPP) initiative had tremendous potential, but it could not be fully tapped and the target population remained underserved. The same is true for social marketing companies (SMCs) though they have been an active partner of the MoPW in meeting the family planning needs of the people living especially in urban and semi-urban areas.

3.26. The Programme could not make an efficient use of the vast physical infrastructure of non-governmental organization (NGO), including national and provincial Rural Support Programmes (RSPs). Consequently the apprehensions about facilities providing family planning services continue to exist and the number of clients visiting the service centers remains low. Research indicates that more women want to space their next pregnancy, implying that the latent demand for family planning services is high but fragile, particularly among rural communities.

3.27. The service delivery of the Programme focused more on promoting sterilization and less on pregnancy spacing. The PDHS 2006-07 shows that a significant proportion of Pakistani women continue to conceive and give birth in serious health and life risk conditions, such as childbearing in teen ages; childbearing after age 34; short birth interval; and four or more births. The trend of contraceptive mix shows female sterilization and use of traditional methods as the major means of practice, but they have had a limited impact on the TFR. Over the years, four important issues have emerged: 1) decline in the use of three major methods of contraception (oral pills, injectables and IUCDs); 2) persistent unmet need for contraception; 3) widening gap between current and ever use of contraception indicating dropouts; and 4) high incidence of abortion (including induced).

**Governance Issues**

3.28. The poverty reduction strategy paper (PRSP) worked as a pretext for enhanced financial support to Population and Development over the following several year; the prerogative position assigned to MDGs over ICPD Plan of Action put the issue of addressing high fertility on the backburner and family planning went off government's priority radar. Following the myth of 1970s that 'Development is the Best Contraceptive', the senior politicians and planners, overemphasized achievement of economic growth at the cost of population sector priorities.

3.29. The situation became even more exacerbated with international donor funds shifting away from family planning and towards reproductive health in general and HIV/AIDS in particular. As a consequence, the Program could not keep pace in extending the services compatible with the emerging requirements. High level of unmet need for family planning (25%) and stagnation of demographic indicators provide sufficient evidence to substantiate this situation.

3.30. There is a tacit acceptance at the highest level that Pakistan has strayed from prioritizing population planning program and committed inadequate funds for Population Welfare Program. As against the overall approved cost of Rs. 21.02 billion for the plan (2003-08), the PSDP allocations were reduced to Rs.18.87 billion against which only Rs. 17.06 billion were released while utilization was allowed up to Rs. 14.54 million by the Finance Division during 2003-08. Similarly, against allocations of Rs. 4.709 billion and Rs. 14.162 billion for the Federal and Provincial Population Programs (2003-08), the Government was able to provide Rs. 3.207 billion and Rs. 11.349 billion respectively.

3.31. The Programme was de-federalized in 2002 with the financial, administrative and operational authority transferred to the Provincial Population Welfare Departments (PWDs). To give breathing space to the provincial governments to take over the Programme, the federal government agreed to continue its funding through the Public Sector Development Programme (PSDP) for the first three years or until the finalization of the next National Finance Commission (NFC) Award. Because of the delay in the finalization of the NFC Award and resource constraints of the provincial governments, the federal government continued to fund the Programme. Consequently, the provincial governments did not develop the desired level of ownership.

3.32. The funding of provincial Population Programs was to be incorporated in National Finance Commission Award to enable provincial ownership of the Program. Revision of NFC award sidelined the transfer of Population Welfare funds to provincial governments.

3.33. Under the Local Government Ordinance 2001, the whole administrative structure of Pakistan was devolved at district level with the creation of District Offices; the de-Federalized Population Welfare Program remained un-devolved in the district government.

3.34. Although family planning service delivery points increased and the prices of contraceptives remained unchanged over the last few years, access to services remained a problem area. The Programme's community-based service delivery model involving village-based family planning workers (VBFPWs) showed good results in 1990s, but the trend could not be sustained since this cadre was merged into Lady Health Workers (LHWs) cadre of Ministry of Health (MoH) in 2002. Consequently, the Programme lost its focus on community-based access to contraceptive services and the attention shifted to static facility-based services.

3.35. Ban on recruitment and vast vacant positions, especially of service providers in the service centers coupled with the absence of grassroots workers created a huge vacuum in service provision especially to rural masses. The position further worsened when the Ministry and Departments of Health, having endorsed revised National Health Policy 2002, did not give due priority to the provision of family planning services and as such the support needed to bridge the gap especially in rural and remote areas could not come forth. Limited role of non-governmental bodies to bridge the service delivery gap further aggravated the situation.

3.36. Other governance issues especially Program oversight requiring efficient feedback from the field including beneficiaries, with due periodic assessment, remained weak across all sectors responsible for family planning provision. Resultantly, the goals set during the ICPD or those of UN Millennium Summit remained no more achievable. It is felt that Pakistan has been unable to keep a balance between these two agendas and lost the track in finding ends of either of the two (Abrejo et al.; 2008). The realization of the growing population and political will to address this priority issue has remained confined to policy statements rather rhetoric.

3.37. The Population Policy 2002 has set for itself achievement of replacement level by 2020. The Perspective Plan 2002-12 identified TFR level of 2.8 for 2012 with a CPR of 53 percent. The most recent PRSP-II document (dated Nov 2008) rather sets TFR of 3.25 for 2010-11 with a CPR level of 37.5 percent, which does not appear to be internally consistent with the Perspective Plan. Pakistan has also committed to achieve the CPR target of 55 percent by 2015 to show its willingness to support sectoral development process. Keeping in view, inconsistency between 'what is required' and 'what is committed', the delay in achieving the policy goal (replacement level fertility) appears obvious.

3.38. A thorough exercise to revisit the Population Program policies, strategies, interventions, partnerships, and financial requirements is urgently needed to bring family planning to centre stage of all development activities. The focal point of all family planning activities should evolve from provincial commitment with dedicated support to enhance access, coverage to services and through functional integration. Outreach interventions including rejuvenation of male mobilizers and other innovative interventions to upscale useful practices needs urgent addressing of the problem leading to unmet need, and build strong partnership to achieve the same. Program would still need to be closely linked with the support of stringent social measures including compulsory education with increased pace in female education (till 10th grade), increasing opportunities of female work, and curbing child labor using legislation and regulation, which may hasten the achievement of replacement level fertility.

## IV. Conclusion

3.39. Pakistan's population, increasing annually by a little less than four million and making it the fifth most populous country in the world by 2015, poses a great challenge to its stability and prosperity. Political will to carry forward population agenda and to revitalize the family planning program is imperative and an urgent need of Pakistan. This calls for a serious realignment of population policy with the emerging realities. The prime focus of new policy should be to bring population at the centre stage of development process. Greater focus and investment in family planning in Pakistan is critical to achieving the lost momentum of fertility transition, and of course

the Millennium Development Goals. A robust FP/RH programme is, therefore, imperative to regain the momentum in fertility transition. It needs to give focused attention to the unmet need (25 percent) for contraception by addressing issues of misinformation and misperception, limited access to services, lack of client-focused care and quality services, and lack of choice of contraceptive methods. An aggressive communication campaign is required to enhance social acceptance for the programme. At the same time, vigilant and effective monitoring and regular evaluation is needed. This makes it all the more necessary that family planning be mainstreamed in the health policy, as well as into all other development initiatives.

# Chapter-4

## Way Forward

# Chapter - 4
## Way Forward

## I. Revitalizing the Imperative

### *a).* Population and Development

4.1. Rapid urbanization, technological advancement, increasing female literacy and better job prospects for women, proliferation of information through the media, and competitive market forces have set in the process of transformation in social values and lifestyles. As a result, the recent demographic surveys show that the TFR has declined in urban areas, while it is comparatively higher in rural areas, though finally declining.

4.2. The high PGR and TFR pose serious challenges to Pakistan's development as pressure on urban agglomerates is increasing, and an additional burden is being put on the already limited educational and employment opportunities for the youth. The changing age structure, resulting in an increasing number of youth entering the labour force, is further compounding the situation. The increase in population density, mushrooming urban slums, rapid depletion of water resources, deforestation and loss of arable land due to urban development are some of the manifestations of rapid population growth.

4.3. Reduction in poverty has been an essential part of all economic policies, particularly in the light of the Millennium Development Goals (MDGs), yet over one-third of country's population continues to live below the poverty line (BPL) with the absolute number of poor increasing. Regional variations in poverty are pronounced and well-recorded for Pakistan. The increase in poverty has a close relation to high fertility, especially among the lower strata of society.

### *b).* Reproductive Health and Family Planning

4.4. The Population Policy of Pakistan 2002 aimed at accelerating fertility transition to attain replacement level fertility by 2020 and the Population Perspective Plan (2002-12) envisaged CPR of 57 percent by 2012. It goes without saying that these were overambitious targets. The situation, therefore, calls for rationalizing goals and objectives of the Programme, as well as rearticulating roles and responsibilities of all the stakeholders.

4.5. Pakistan currently recognizes, more than ever before, the need to lower the PGR and TFR to be consistent with its development and welfare priorities. It also realizes that this requires strong political support; improvement in literacy rate, particularly of women; and reduction in poverty.

4.6. A new population policy with revised goals and rational targets is imperative to accelerate the fertility transition to reap the demographic dividend, besides focusing on the implementation of the Programme of Action of the ICPD and the achievement of the MDGs. The policy should provide clear guiding principles, a comprehensive strategy and a plan of action for all the stakeholders to realize a shared vision for the next at least 20 years.

# II. Proposed Pakistan Population Policy 2010

4.7. The proposed Population Policy should place the 'population factor' at the centre stage of national development planning. It should recognize reproductive health as a critical component of sustainable socioeconomic development having string linkages with the government's poverty reduction strategies. The Policy should reposition family planning as a health initiative, with a focus on maternal health and child survival, by making family planning services a vital component of the essential services package. Within this holistic perspective, and in the wake of emerging demographic realities, the proposed Policy should re-emphasize timely completion of fertility transition for stabilizing the population and reaping the demographic dividend.

4.8. Infused with this spirit, it is expected that the Policy would contribute meaningfully to the implementation of the Programme of Action of the ICPD and the achievement of the MDGs, particularly reducing the maternal mortality ratio by two-thirds by 2015.

## i). Vision

4.9. The Policy 2010 would promote a prosperous, healthy and skilled society where every pregnancy is planned; every child is nurtured and cared for; and every citizen is provided with choices to improve the quality of his or her life.

## ii). Goals

4.10. The Policy 2010 seeks to:

- Accelerate the completion of fertility transition for achieving population stabilization;
- Enhance human development for capitalizing on the unique opportunities offered by the emerging demographic scenario (demographic dividend); and
- Increase pregnancy spacing for improving the health of women and children.

## iii). Objectives

4.11. The short-term objectives of the Policy 2010 are to:

- Make available family planning services to the remotest areas of the country by 2015;
- Reduce the unmet need for family planning from the current 25 percent to 20 percent by 2015;
- Reduce the TFR from the current 3.6 births (Projections by the Planning Commission's Working Group on Population Sector, 2010) to 3.2 births per woman by 2015;
- Ensure contraceptive commodity security for all public and private sector outlets by 2015; and
- Improve maternal health by encouraging pregnancy spacing of more than 36 months, reducing the incidence of first birth among those mothers aged below 18 and discouraging the trend of mothers giving birth after age 34 and above, thus contributing to the achievement of the MDGs 4 and 5.

4.12. The long-term objectives of the Policy 2010 are to:

- Attain replacement level fertility by 2030;
- Achieve universal access to family planning services by 2030;
- Reduce the unmet need for family planning from the current 25 percent to 5 percent by 2030; and
- Increase the CPR from the current 30 percent to 60 percent by 2030.

## iv). Principles

4.13. The principles of the Policy 2010 are based on the Programme of Action of the ICPD, the MDGs and the Karachi Declaration 2009. These are to:

- Promote reproductive health as an entitlement, based on voluntary and informed choice;
- Address the population issue within national laws and development priorities, while considering the social and cultural norms;
- Ensure active, responsible and accountable participation by all the stakeholders; and
- Promote programmatic interventions on the basis of scientific evidence.

## v). Assumptions

4.14. The Policy 2010 is based on the following assumptions:

- Sustained political commitment at the federal and provincial levels;
- Full ownership of the Programme by the provincial governments by 2015 and programmatic interventions by them to reduce the unmet need;
- Enhanced resource availability for the Programme under the NFC Award;
- Mandatory provision of family planning services by the Provincial Departments of Health and adoption of family planning as an essential health intervention by the MoH;
- Centre staging of the population factor in national development planning for reaping the demographic dividend; and
- Broad-based multi-sectoral support.

## vi). Strategies

4.15. The Policy 2010 lays emphasis on reaping the unprecedented demographic dividend, as envisaged by the Planning Commission's Vision 2030 document. This necessitates adopting human development policies that can help transform the young population into a skilled workforce It situates reproductive health and family planning within the context of overall economic and social development, thus creating linkages with other developmental concerns, such as increasing the provision and outreach of primary and secondary education, empowering women and creating employment opportunities for the people.

4.16. The Policy 2010 also stresses upon putting in place an effective reproductive health programme that ensures the continuation and speeding up of the fertility transition process. It therefore, attaches special importance to achieving universal access to FP/RH information and services. The policy 2010 recognizes that achieving fertility transition is a collective national

responsibility of all potential providers in the public, private and NGO sector and provides for involving all the stakeholders in achieving the stated goals and objectives through the adoption of the following strategies:

**a) Mainstreaming Population in Development Planning**

4.17. The population policy impacts all spheres of economic and social life. It is evident from the inter-linkages between population and development that demographic trends are, on the one hand, determinants of socioeconomic development and, on the other, are determined by it. Broad-based sectoral and inter-sectoral support is, thus, critical to realizing the goals of the Policy 2010. This includes building strong linkages between population and other social sector areas.

4.18. Female education, in particular, is vital for achieving fertility transition. This is evident from the fact that the lack of emphasis on female education in Pakistan in the past has adversely affected the pace of fertility transition. Similarly, limited female employment has not allowed the country to accrue the benefits of women's positive association with fertility transition. Adequate investment in young people so that they could develop marketable skills has also remained an unattended area in Pakistan, limiting their productive involvement in the society.

4.19. In addition, rapid urbanization is putting an unprecedented pressure on the policymakers to cater to the growing need for services and amenities. The projected urbanization growth over the next two decades encompasses massive internal migration patterns and necessitates innovative population redistribution policies, such as building new towns and industrial zones. To address these issues, the institutions of the Programme would be strengthened, and all the stakeholders would be brought on one platform for reviewing the Programme and monitoring the progress made on goals and objectives. This would help evolve an integrated service delivery strategy to achieve synergy and facilitate reaping of the demographic dividend.

**b) Advocacy and Demand Generation**

4.20. The Programme has achieved a universal level of awareness, but there still exists a wide gap in the knowledge (of at least one method) and practice of family planning. The communication approach has to take this into consideration, and develop evidence-based, audience-specific and vibrant campaign to bring about necessary changes in attitudes and behaviour. The promotion of pregnancy spacing perspective of reproductive health needs special communication initiatives that emphasize its positive impact on maternal and child health. Pregnancy spacing is also in line with religious precepts and, thus, it provides a strong framework to solicit support of the religious community. The media with its fast growing role in disseminating information, building public opinion and shaping societal behaviour would be used to play a vital role in projecting and promoting voluntary adoption of small family norms and responsible parenthood. A strategy would also be devised to bring about positive changes in attitudes and behaviour towards the use of male contraceptives.

**c) Enhancing Access to and Improving Quality of FP/RH Services**

4.21. The Programme's service delivery network of 3,416 centers (2,853 Family Welfare

Centers, 271 Reproductive Health Service Centers and 292 Mobile Service Units) hardly covers 35.0 million people or slightly over 20 percent of the country's population of 169.9 million. The goal of achieving universal access to FP/RH services by 2030 and reaching out to the remotest areas of the country by 2015 cannot be realized through the efforts of the MoPW alone; it calls for collective resolve by all the stakeholders.

4.22. The Policy 2010, therefore emphasizes, filling the critical gap in access to FP/RH services through upgrading, expanding and integrating service outlets managed by the different stakeholders: the Ministry and Provincial Departments of Population Welfare, the Ministry and Provincial Departments of Health, the Planning and Development Division, the Ministry of Finance, provincial line departments, SMCs, private sector health professionals, population experts and civil society organizations (CSOs).

**d) Contraceptive Commodity Security**

4.23. Ensuring commodity security to cater to national needs for at least five years and uninterrupted availability of a complete range of contraceptives at affordable prices at all facilities is the lifeline of family planning services. In view of the projected increase in contraceptive uptake, additional contraceptive requirements are anticipated in coming years. Both commodity security and supply chain management system would be improved to avoid overstocking and stock outs at any level and any time.

**e) Training and Human Resource Development**

4.24. One of the major responsibilities of the MoPW under the Policy 2010 would be to implement the Programme professionally, so as to keep pace with other stakeholders and maintain national service standards while providing FP/RH services. This would require professional human resource to carry out a wide range of specialized functions. The Policy 2010, therefore, focuses on human resource development (HRD) in line with the emerging role of the Ministry and Provincial Departments of Population Welfare vis-à-vis other stakeholders.

4.25. Managerial inefficiency and low quality of care and services are often cited as the major reasons for ineffective implementation of the Programme. However, they are not the causes; rather, they are an outcome of the cause: lack of capacity. For capacity building, the Programme has Population Welfare Training Institutes and Regional Training Institutes, but the outcome leaves a lot to be desired by improving professional faculty, curricula and its relevance to counselling and care, teaching and training methodology, and learning environment. Measures ranging from revamping these institutes to revisiting their supervisory structure and control mechanisms are therefore a prerequisite for bringing about a positive change in this situation.

**f) Research and Evaluation**

4.26. Drawing on research on different aspects of reproductive health, family planning and fertility transition, the Policy 2010 recommends an evidence-based approach for the Programme. It also encourages institutionalization of research on reproductive health and family planning to enhance the knowledge base for improved policies and programmes. Future research would focus on how fertility transition could be accelerated in the shortest possible timeframe. Research on

improving access to services and addressing socio-cultural barriers would also be carried out to improve implementation of the Programme. Similarly, clinical and biomedical research would also be conducted to introduce new family planning methods. Furthermore, research on social mobilization, male involvement and innovative communications would be promoted.

**g) Public-Private Partnership**

4.27. Extending support to public-private partnerships (PPPs) is critical to expanding FP/RH services, both horizontally and vertically. The Policy 2010 envisages replacing the existing focus of the Programme on the private sector with an innovative approach, so that collaboration could be enhanced in those areas where FP/RH services are required. The approach would focus on extending outreach to rural areas and deepening efforts in urban slums. It would bring into its fold public sector organizations, corporate bodies, industrial concerns, private medical practitioners and CSOs/NGOs. Furthermore, the community-based service delivery model partnering with the community for setting up village-based service facilities would be adopted. Efforts would also be made to enlarge the social marketing network so as to encourage healthy competition. The vast social network of RSPs and other CSOs/NGOs would also be involved in social mobilization.

**h) Monitoring**

4.28. The Policy 2010 emphasizes adopting a joint monitoring framework to ensure effective implementation by all the stakeholders. It envisages adopting the results-based monitoring (RBM) mechanism to ensure that processes and outputs contribute to the achievement of clearly stated objectives. This approach would shift the focus of monitoring from outputs (number of contraceptives distributed, number of clients contacted and recruited, etc.) to outcomes (increase in the CPR, etc.). Putting emphasis on outcomes is also important for the MoPW to engage stakeholders and build partnerships to achieve shared objectives.

4.29. The monitoring framework would specify the indicators of input, service delivery process and output, which would be observed, reviewed and followed up regularly at the tehsil, district and division levels. Monitoring by the Provincial Population Welfare Departments would largely be a review of the district and tehsil level monitoring efforts. As a step towards activating the verification tool, the Provincial Population Welfare Departments would send their monitoring reports to the MoPW. These reports would be analyzed in regular review sessions on Programme implementation at the national level. The monitoring process, in order to be result-oriented, would also institutionalize the capacity to track and concurrently follow up the progress made in important aspects of the Programme. Since the operational monitoring would rest with the Provincial Population Welfare Departments, the MoPW would maintain supportive linkages with them, as well as enhance their professional capacity and skills.

## vii). Implementation Plan

4.30. In the wake of recent constitutional amendment (18th amendment), though, the population welfare program would be transferred to the provincial governments, policy making and its execution, in view to ensure continuity and consistency of national development priority, would

continue at the federal level through an apex body. This is also necessary to have an interface with United Nation's agencies; for forging bilateral and multi-lateral agreements and coordination with International Development Partners. This would necessitate restructuring of the ministry and redefining its role vis-à-vis the Provincial Departments of Population Welfare, the Ministry of Health, the Planning and Development Division, the Finance Division, other social sector ministries, CSOs/NGOs and the private sector.

4.31. In 2001, the Population Welfare Programme was defederalized through an ordinance 'Population Welfare Programme (2001). The Administrative and financial control over the service delivery infrastructure (FWCs, RHS As, MSUs) was transferred to the Provincial Population Welfare Departments along with the staff, equipments and funds.

4.32. Considering the crosscutting nature of the population issue, participation of all the stakeholders in implementation of the Policy 2010 would be encouraged and supported. In addition, necessary mechanisms and institutional arrangements would be put in place to seek the support of elected representatives and local leaders, opinion makers, religious scholars and organized communities for efficient and effective implementation of the Policy 2010. Furthermore, academic and research institutions would be involved in monitoring the progress made by the Policy 2010.

4.33. The implementation of the Policy 2010 would rest with the provincial governments who would do this in collaboration with the line departments, public and private sector organizations and NGOs/Civil Society Organizations in a way that conforms to social values and national and provincial development priorities. With the announcement of the 7th NFC Award, the provincial governments would have access to additional resources starting July 2010; therefore, it is expected that they would assume full ownership of the Programme.

## viii). Legal Framework

4.34. In 1981, Population Welfare Planning Programme (Appointment and termination of services) ordinance-1981 was issued regularizing the services of the personnel through Federal Public Service Commission and Departmental Selection Committee. In 1983, the Programme was De-Federalized (1983) through an ordinance namely Transfer of Population Welfare Programme (Field activities) ordinance to provide for the transfer of field activities of the Population Welfare Programme to Provincial Governments. The institutional arrangement of the program attained the status of an independent Ministry on 12th June, 1990.

4.35. In 2001, after an extensive review, the Population Welfare Programme was defederalized through an ordinance 'Population Welfare Programme (2001), the funding, however, was to continue through Federal PSDP up to 2003; thereafter the funding was to be provided through N.F.C. award. The Administrative and financial control over the service delivery infrastructure (FWCs, RHS As, MSUs) was transferred to the Provincial Population Welfare Departments along with the staff, equipments and funds.

4.36. The institutions of ministry of population welfare like National Institute of Population

Studies, National Trust for Population Welfare and National Commission for Population Welfare have been established through executive resolutions and need to be provided a legal framework. Partnerships with the private sector are without any formal legal cover which creates uncertainty among the Programme personnel and partners. Therefore, there is a need to develop a legal framework to strengthen and support the public private partnership.

### ix). International Cooperation

4.37. Pakistan is a signatory to the Programme of Action of the ICPD, as well as committed to achieving the United Nations MDGs. The Policy 2010, therefore, encompasses not only national development priorities but also international obligations. The MoPW envisages expanding the scope of its activities in accordance with the recommendations of the ICPD. Precisely against this backdrop, the Policy 2010 focuses on developing bi-lateral relations, especially with other Muslim and South Asian countries, and forging linkages with international development agencies, particularly for sharing best practices and seeking technical support.

4.38. The Policy 2010 seeks enhanced financial and technical cooperation from the international community, anticipating that it would understand and appreciate the population and reproductive health situation of Pakistan and its implications within and beyond boundaries. It also urges the international community to fulfill its obligations under the ICPD and the development partners to realize their commitments with Pakistan.

# Annex I: Programme of Action

The Policy 2010 would be implemented through Five-Year Population Welfare Plans, which would be part of the Five-Year National Development Plans. Every subsequent plan would be based on the evaluation of the previous one, as well as on the regional and global best practices. The 1st Five-Year Plan of the Programme under the Policy 2010 would be an integral component of the People's Development Plan 2010-15. The salient features of the Plan of Action to implement the Policy 2010 include the following:

## a). Mainstreaming Population in Development Planning

- Strengthening the National Commission for Population Welfare (NCPW) through an appropriate legal framework for creating synergies with other social sector ministries and departments;
- Bringing the population issue to the centre stage of development by emphasizing the implications and consequences of rapid population growth on different sectors of the society;
- Aligning different social sector policies (particularly those relating to education, health, social welfare, women's empowerment, labour, youth, employment, the environment and urban growth) and creating functional linkages between them;
- Sensitizing the decision-makers to mainstream the population factor in national development planning; and
- Formulating a joint action plan to synergize the human development initiatives of different government ministries and social sector organizations.

## b). Advocacy and Demand Generation

With a view to bridging the wide gap between knowledge (universal level of awareness: 97%) and practice, an aggressive communication campaign, which can bring about the desired change in behaviours and practice, would be adopted. This would entail:

- Bringing pregnancy spacing to the centre stage of programmatic efforts through appealing messages;
- Using multiple media channels with different thematic messages developed along scientific lines;
- Improving quality of counselling to emphasize benefits of family planning, and removing doubts and fears about side effects of contraceptives;
- Emphasizing mandatory counselling on pregnancy spacing during the antenatal and postpartum checkups and post-miscarriage;
- Utilizing the existing infrastructure of the public sector, as well as of CSOs/NGOs, for social mobilization to reach out to rural communities; and
- Using a multi-pronged approach to:

- Involve public representatives, opinion leaders, journalists, lawyers, academicians, etc., to solicit their support in promoting pregnancy spacing, safe motherhood and responsible parenthood
- Engage Imams and Khateebs at the village level to dispel socio-religious misconceptions about family planning
- Keep the media updated on the latest happenings in the Muslim world and in the region to promote the objectives of the Programme
- Promote male involvement in reproductive health and family planning through innovative community level initiatives, particularly in rural areas.

## c). Enhancing Access to and Improving Quality of FP/RH Services

- Increasing the number of service delivery outlets:
  - Family Welfare Centers (FWCs): from 2,853 to 5,255
  - Reproductive Health Service (RHS-A) Centers: from 271 to 321
  - Mobile Service Units (MSUs): from 292 to 346;
- Improving functional integration with service delivery points (13,000) of the MoH and the Provincial Departments of Health to:
  - Make available pregnancy spacing services at all the health centers where tetanus vaccination, antenatal and postnatal care, and child immunization are administered
  - Include contraceptives in the health essential drug list
  - Provide contraceptive services as part of primary health care
  - Include care for miscarriages /post-abortion in policies, guidelines, protocols and standards;
- Broadening networking with NGOs (500) for providing FP/RH information and services in the rural and remote areas through Family Health Homes (FHHs);
- Shifting the thrust of expansion of service delivery outlets from urban to semi-urban and rural areas, focusing on outreach and community-based service delivery under an institutional arrangement. While urban slums would receive priority, the bulk of services would be located in rural and remote areas;
- Developing partnerships with the national and provincial RSPs for social mobilization and expansion of service delivery;
- Expanding contraceptive choice and ensuring availability of quality family planning services and commodities, including emergency contraception, at all public and private sector facilities;
- Promoting pregnancy spacing methods at all facilities in line with the requirements of the clients;
- Focusing on the quality of service and client-centered training of the Programme personnel; and
- Carrying out analysis of Ministry and Provincial Departments of Health interventions for

family planning and primary health care to develop functional integration between service providers.

## d). Contraceptive Commodity Security

An estimated amount (at constant price) of Rs. 6.5 billion for national contraceptive commodity security would be required to raise the CPR from the current level of 30.0 percent to 38.0 percent by 2015; Rs. 9.6 billion to raise it from 38.0 percent to 45.5 percent by 2020; Rs. 12.8 billion to raise it from 45.5 percent to 54.0 percent by 2025; and Rs. 14.0 billion to raise it from 54.0 percent to 60.0 percent by 2030. Ensuring contraceptive commodity security, being a basic requirement for dispensation of family planning services, calls for developing an independent institutional arrangement (limited company) to carry out the following:

- Institutionalizing population projections while taking into account changing trends in contraceptive method mix, as well as forecasting future needs;
- Reviewing commodity requirements annually for adjustments against the consumption pattern and current stock position;
- Ensuring timely procurement and delivery of contraceptives;
- Managing warehousing, inventory control and proper distribution of contraceptive supplies to district stores/service delivery outlets managed by different stakeholders;
- Computerizing the contraceptive logistics management information system for effective monitoring and to ensure implementation of the standard operating procedures (SOPs) of storage and distribution, as well as avoiding pilferage and wastage;
- Upgrading warehousing facilities at the provincial and district levels, providing logistic support for the movement of stocks, and ensuring availability of trained workforce;
- Supporting and encouraging the pharmaceutical sector to establish contraceptive commodity manufacturing units in the country;
- Signing memoranda of understanding (MOUs) with the Ministry and Provincial Departments of Health and partners in social marketing for the purchase and distribution of contraceptives, medicines, equipment, etc; and
- Developing a joint data management mechanism of all projects of the MoPW, MoH, NATPOW, SMCs and NGOs/CSOs advancing the FP/RH agenda.

## e). Training and Human Resource Development

The following measures would be adopted to boost the human resource development (HRD) efforts for ensuring effective implementation of the Programme:

- Revamping and upgrading PWTIs and RTIs with modern facilities and professional staff, applying state-of-the-art methodologies and techniques;
- Adopting standard-based management and recognition (SBMR) to institutionalize the quality of care;
- Creating inter-linkages between research and training institutes to institutionalize

research-based planning and training-backed interventions;

- Incorporating reproductive health and family planning into the curricula of all medical colleges and universities; and
- Developing HRD plans, both short-term and long-term**,** to institutionalize the appointment of right person to the right job.

## f). Research and Evaluation

- Enabling NIPS and the NRIFC to provide up-to-date and reliable information to the policy planners, decision-makers and programmers in the field of population and development;
- Strengthening NIPS as an autonomous research arm of the MoPW through appropriate legal framework. It would continue to serve as a technical body for policy research covering major aspects of reproductive health, family planning, fertility transition, population and development;
- Upgrading the NRIFC to institutionalize research based-planning, and repositioning it to work on clinical studies, bio-medical research, and testing of the existing and new family planning methods;
- Encouraging collaboration of NIPS and the NRIFC with national and international academic and research organizations to support demographic and clinical research in Pakistan. NIPS would specifically focus on the analysis of the key interrelationships between determinants of fertility transition and critical indicators;
- Focusing on Pakistan-specific research in the areas that have a clear link with population: health, morbidity, mortality, etc.; and
- Conducting research on the socio-cultural determinants of fertility behaviour, especially at the household and individual levels, as well as the changing age structure, youth bulge, population ageing, urbanization and migration to reap the demographic dividend in the shortest possible timeframe.

## g). Public-Private Partnership

The focus of the strategy would be on extending the outreach of FP/RH services, to rural areas and urban slums through public-private partnerships (PPPs). Some of the activities to be undertaken include the following:

- Strengthening NATPOW to institutionalize and catalyze PPPs for broadening networking;
- Expanding cooperation for the expansion of FP/RH services through the network of about 13,000 service outlets of the Ministry and Provincial Departments of Health;
- Strengthening partnership with public sector organizations and corporate bodies:
    - Peoples' Primary Health Initiative: through the existing 3,000 outlets
    - Provincial Line Departments: through their existing health outlets (1,000)
    - Corporate Sector: through the existing 6,000 health outlets

- Establishing community partnership for setting up FHHs at the village level (1,000-3,000 house holds);
- Providing budgetary support to the SMCs working in rural areas and urban slums;
- Expanding the social marketing network to rural areas by franchising SMCs; and
- Establishing an independent body for regulating the resources and performance of SMCs and other private sector institutions working in the areas of reproductive health and family planning.

## h). Monitoring

- Creating a joint forum for carrying out strategic monitoring to ensure effective implementation of the Programme by all the stakeholders;
- Developing necessary indicators on the basis of priority monitoring and evaluation areas. Since the implementation of the Policy 2010 involves many ministries and departments, they would apply these indicators accordingly to track their progress;
- Compiling district profiles, and carrying out community need assessments, sample studies and client satisfaction surveys;
- Carrying out operational monitoring by the tehsil, district and divisional tiers and taking immediate remedial and follow up action at the monthly/quarterly meetings;
- Reviewing of the monitoring reports of the district and divisional tiers by the Provincial Population Welfare Departments; and
- Analyzing consolidated monitoring reports by the MoPW to carry out monitoring of the monitors and service delivery centers by a mixed team on 10 percent random sample basis.

## Bibliography

Abrejo, Farina G., Shaikh, Babar T. and Saleem S., 2008. "ICPD to MDGs: Missing Link and Common Grounds," Reproductive Health, Vol. 5, No. 4:

Ahmed, Tauseef (2009), "Demographic Transition in Pakistan"

Doepke, Matthias. 2004. Accounting for Fertility Decline During the Transition to Growth , UCLA and CEPR, May 2004.

Federal Bureau of Statistics 2007. Pakistan Demographic Survey Report 2005. Islamabad. Statistics Division, Government of Pakistan.

Federal Bureau of Statistics. (1987-2002). Pakistan Demographic Survey 1984-92, 1995 & 1996, 1997 and 2000, 12 reports total. Islamabad: Statistics Division, Government of Pakistan.

Harty, Jennifer 2007. Microcredit, Macro Change: The Impact of Credit Programs on Women's Fertility in Bangladesh. Honors Thesis.

Mason, A. (2005). Demographic Transition and Demographic Dividends in Developed and Developing Countries. United Nations Expert Group Meeting on Social and Economic Implications of Changing Population Age Structure. Population Division, Department of Economic and Social Affairs United Nations Secretariat. Mexico City.

Mehmood, N. (2002). "Trends and Variations in Unwanted Childbearing among Pakistani Women" In Pakistan's Population Stabilization Prospects (pp. 369 378) Islamabad: Population Association of Pakistan

Ministry of Education. 2005. The State of Education in Pakistan 2003-04. Policy & Planning Wing. Government of Pakistan Islamabad

Ministry of Population Welfare. 2002. Interim Population Sector Perspective Plan 2012. Planning Wing. Government of Pakistan Islamabad

National Institute of Population Studies (1998). Pakistan Fertility and Family Planning Survey 1996-1997 (PFFPS): Preliminary Report. Islamabad.

National Institute of Population Studies (2001). Pakistan Reproductive Health and Family Planning Survey 2000-01: Preliminary Report. Islamabad.

National Institute of Population Studies (NIPS) and Macro International Inc. 2008. Pakistan Demographic and Health Survey 2006-07.

National Institute of Population Studies, 2007, 'Status of Women reproductive health and family planning survey 2003, Islamabad.

National Institute of Population Studies. (1992). Pakistan Demographic and Health Survey 1990/1991. Islamabad: National Institute for Population Studies (with IRD/Macro International, Inc., Columbia, Maryland USA.

National Institute of Population Studies. (2008). Pakistan Demographic and Health Survey 2006-07. Islamabad: National Institute for Population Studies (with Macro International, Inc., Calverton, Maryland USA). June 2008.

Nayab, Durr-e, 2006. Demographic Dividend or Demographic Threat in Pakistan. Pakistan Institute of Development Economics, PIDE Working Papers No. 10

Planning Commission. 2007. Pakistan in the 21st Century: Vision 2030. Islamabad. Government of Pakistan. August 2007.

Population Council (2004) Unwanted Pregnancies and Post-Abortion Complications in Pakistan: Findings from a National Study. Islamabad: The Population Council

Saha, Unnati Rani and Bairagi. Radheshyam. 2007. Inconsistencies in the Relationship between Contraceptive Use and Fertility in Bangladesh. International Family Planning Perspectives: Volume 33, Number 1, March 2007

Sathar and Kazi 2001.

Sathar, Zeba A., Crook, N., Callum, C. and Kazi, S. (1998) "Women's Status and Fertility Change in Pakistan" Population and Development Review 14(3): 415 432

Sathar, Zeba. 2007. Stagnation in Fertility Levels in Pakistan. Asia Pacific Population Journal. Vol. 22. No. 2. Aug 2007.

UNFPA. 2003. Pakistan Population Assessment 2003. Islamabad.

United Nations (2008) World Population Prospects: The 2005 Revision. New York: United Nations.

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