

## **Population Planning in Pakistan: How to Meet the Challenge?**

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### **INTRODUCTION**

The recent decline in the total fertility rate (TFR) borne out by recent surveys and supported by the results of the 1998 population census of Pakistan (see Table 1) indicates that onset of fertility transition has been made in Pakistan. However, still these rates (5.3 children) excepting Nepal (5.4 children) are the highest in this region. A high proportion of young population (43 percent under 15 years) resulting in population momentum has made the situation grimmer as the task of achieving zero population growth seems to be many decades away even after attaining replacement level fertility. As per United Nations projections, Pakistan in 2050, will leave behind United States, Indonesia, Brazil and Russia and will become the third most populous country of the world with a population of 380 million.

A very high rate of population growth in the recent past annihilated most of the developmental achievements and the country remained poor in terms of socio-economic indicators. For example, the average annual per capita income is \$460, 24 percent females and 50 percent males are literate, about 60 percent population has an access to safe water whereas, satisfactory sanitation is available to only 30 percent of population [Population Reference Bureau (1997)]. This situation warrants immediate need to accelerate the pace of fertility decline in Pakistan.

In this paper, we will present a review of the past population policies, their performance, achievements and failures. On the experience of the past performance, we will suggest some strategies, adoption of which could accelerate pace of transition in Pakistan.

### **PAST PERFORMANCE: A REVIEW**

Pakistan is among the first few developing countries where efforts were initiated to reduce the growth of population. Such efforts by a few public-spirited volunteers led

Table 1

*Trends in Intercensal Growth Rates and Total Fertility Rates*

Census Year/Year of Estimation	Population (in Millions)	Intercensal Growth Rate	Name of Survey	TFR
1951	33.74	1.8	—	—
1961	42.88	2.4	—	—
1962–65	—	—	PGE	8.0*
1968–71	—	—	PGS	6.0
1972	65.31	3.6	—	—
1970–74	—	—	PFS	6.3
1975–79	—	—	PLM	6.5
1981	84.25	3.1	—	—
1984–85	—	—	PCPS	6.0
1986–91	—	—	PDHS	5.4
1994	—	—	PDS	5.6
1993–95	—	—	PIHS	5.4
1994–95	—	—	PCPS	5.6
1996–97	—	—	PFFPS	5.3
1998	130.60	2.6	—	—

\*Based on indirect estimates.

to the formation of the Family Planning Association of Pakistan (FPAP) in 1953, a non-government organisation (NGO). Realising the need of regularising population growth, the government of Pakistan offered assistance of Rs 0.5 million to FPAP in its first Five-Year plan between 1955–60. During this period, FPAP established clinics in selected cities and started providing family planning services.

In the second Five-Year Plan (1960–65), the pressure of population growth on socio-economic development was realised to be strong. The population programme was made an integral part of the health sector with an allocation of Rs 15.5 million. At the end of 1964, there were 1589 family planning clinics functioning within the set up of health dispensaries, hospitals and maternal and child health centres.<sup>1</sup> The overall population policy recognised the need of a change in the attitudes of individuals towards small family size norms. Such a change could be brought about by increasing the standard of living of individuals and their children.

During the period, although some improvement in the standard of living was achieved [Pakistan (1965)], the impact of the family planning programme was far below expectations. A critical analysis of the programme revealed that inadequacy of its performance stemmed from:

<sup>1</sup>The programme was entirely clinic-based with no motivational or follow up service activity.

"lack of motivation in the general masses; unsatisfactory arrangements for the distributions of contraceptives; inadequate education and information of the masses in family planning, shortage of administrative personnel; the programme was administered as a normal function of the existing health services with the result that doctors and other health personnel running those services were over-burdened with clinical work, could not give adequate attention to family planning [Pakistan (1965)]".

Keeping in view the shortcomings in the implementation of family planning programme during the Second Five-Years Plan, the government came forward boldly and announced a comprehensive and detailed national scheme. An independent family planning council was constituted and a national board of family planning was formed to advise the government on policy issues. An allocation of Rs 148 million was made during the Third Five-Year Plan (1965-70).

For the execution of the programme a total of 20,000 village 'dais' (Traditional Birth Attendants) were employed (one 'dai' for two villages) and about 1200 part time family planning doctors at the rate of 6 for each Tehsil were registered and appointed for the purpose of IUD insertion and clinical sterilisation. In the programme, sub-urban and rural clinics were to be established. The scheme aimed at 1.5 million IUD insertions and 90,000 vasectomies/ligation during the plan period.

All these efforts were intended to bring down the crude birth rate from 50 to 40 per thousand population. Supply out-lets including private shops, pharmacies, clinics and health centres were established and supplied with all sorts of contraceptives at highly subsidised price. The scheme also provided for the establishment of a National Research Institute of Family Planning (NRIFP) for both clinical and socio-psychological research.

The scheme was vigorously launched and the programme gained considerable attention both at home and abroad. During this period, the subject of family planning became a matter for public discussion and generally frustrated any organised religious opposition [UN/WHO (1969)]. However, contraceptive use remained low and inadequate for achieving fertility reduction goals [Shah (1979)].

Towards the end of the plan period, the findings of the 1968-69 National Impact Survey (NIS) estimated contraceptive use rate at 6 percent only. However, success was noted in the spread of contraceptive knowledge as a majority (97 percent) of married women was found to have the knowledge of at least one method of family planning.

It was realised that the weakest aspect of the effort so far had been the use of illiterate, poorly trained part time and low paid 'dais' for the implementation of the programme. During the Fourth Five-Year Plan (1970-75), a gradual replacement of 'dais' by a new category of full time family planning worker was envisaged, so that by

the end of the Plan period [i.e. (1975)] there would be one worker for each union council. In view of the side effects such as bleeding, discomfort etc. of IUD insertion, major emphasis was given to vasectomy/ligation. The hormonal pill was also introduced on a large scale.

For the implementation of the programme, the budget allocation was raised to Rs 315 million. Likewise, the target for birth prevention was raised from 3 million in the 3rd Five-Year Plan to 9.6 million in the 4th Five-Year Plan. It was presumed that by 1970 about 18 percent of married women were practicing contraception and this rate was expected to go up by 34 percent by the end of the plan period. Consequently, the birth rate which was presumed to be already down by 5 per thousand persons i.e. from 50 to 45 per thousand by the end of 3rd Plan, was expected to fall further to 40 per thousand persons by 1975.

However, implementation of the family planning programme in the initial years of the 4th Plan remained disrupted because of a series of political crisis in Pakistan including the war with India and the separation of East Pakistan (which later became an independent country named Bangladesh). By 1973, normalcy had prevailed and the programme resumed.

The Continuous Motivation System (CMS) which was introduced in Sialkot district in 1969 as a pilot project was considered to be doing well [Osborn (1974)]. This programme was formally adopted for high-density areas in July, 1973 and in the beginning of 1974, its implementation was extended to cover the entire country. In pursuance of this plan, a male-female motivator team was assigned to each operational unit with a target population of 8000 to 12000 persons. This team was entrusted with the job of motivating couples for family planning practice and distributing contraceptives among them.

The family planning programme was reviewed by a special committee in 1975. This committee approved the CMS with certain modifications and additions. To revitalise the programme the inundation approach of contraceptive distribution was started. It aimed at making contraceptives (condoms and orals) available to the entire population by putting supplies in every village and every quarter of urban areas, through 50,000 shopkeepers and local agents as well as hospitals, clinics and full time motivators. However, the results of the 1975 Pakistan Fertility Survey (PFS) revealed that the programme fell short of expectations. The programme achievements in terms of acceptors did not surpass the levels estimated in the 1968-69 NIS (see Appendix Table 1). The programme was rated as one of the least successful in the world [Robinson (1978)].

In 1977, after the change in the political set up in the country, the programme met with severe criticism from the political and religious leaders, resulting in an unproclaimed moratorium on programme activities, which continued until 1979.

The 1978-83 Fifth Five-Year Plan endorsed population control but called for a

socio-economic strategy which would induce a desire to limit family size. However, in the earlier period of the plan nothing much had been accomplished and in fact the programme, with its new name as the Population Welfare Plan, 1980–83, was restarted in the early 1980s and was termed as the “New Beginning” in Pakistan’s family planning programme [Robinson (1987)].

Recognising the linkages between fertility levels and income, nutrition, health services, education and employment of women, the plan shifted its single purpose birth control approach to become a multi-faceted one, in which the delivery of family planning services was one of several programmes offered by the Family Welfare Centres (FWC). By this approach, the plan aimed at changing the attitudes and behaviour of individuals in favour of small family size norms. In view of this shift in the programme’s strategy, the Population Welfare Division was transferred from the Ministry of Health to the Ministry of Planning and Development. The reorganisation resulted in a reduction of staff (from 16000 to 8500), whereby field motivators were relieved of their jobs.

Although an allocation of Rs 824 million was made between 1978 and 1983, nothing tangible was accomplished during these years except for the restructuring and re-organisation of the programme. This provided the framework for the Sixth Five-Year Plan (1983–88) which was adopted with some modification. The field activities were transferred to the provincial governments.

A review at the end of plan period indicated that although the demographic objectives were not fully achieved, a great deal of progress has been made [Pakistan (1988)]. About two years after the start of the programme, the results of the 1984–85 Pakistan Contraceptive Prevalence Survey (PCPS) indicated visible improvement in the prevalence of contraception over the estimates at the beginning of this plan (See Appendix Table 1).

The seventh plan (1988–93) which was made a part of the overall perspective plan up to 2003 was an effort in continuation of the policy adopted in the early 80s. The broader aim of the population policy was to improve the standard of living and quality of life of the people by facilitating the process of socio-economic and human development. A multi-sectoral approach is followed by involving all ministries and departments in dealing with population related issues. The ministries and departments would play a vital role in communication strategy, population education and service delivery. The plan promised to reduce morbidity and mortality particularly among high risk segments of the population i.e. women in the reproductive age group and children under Five-Years of age. The Population Welfare Division is responsible for co-ordinating all efforts through 36 different projects.<sup>2</sup> To ensure the success of the population welfare programme. The implementation of population policy envisaged bringing about a positive change towards family size norms.

<sup>2</sup>For details of these projects see Pakistan (1988).

By the end of 7th Five-Year Plan, it was realised that although some improvement in the contraceptive prevalence rate has been made and fertility has also shown a little decline yet the demographic targets set in the 7th plan were not achieved fully. In view of the past performance and the lessons learnt, new strategies especially for the expansion of family planning services in rural areas were devised. It was envisaged to hire on contract basis a community based motivator cum service provider for villages with population of 1500 and above or for cluster of villages having a population of 1000. This Village Based Family Planning Worker (VBFPW) ought to be a married, preferably a matriculate, at least 18 years old and a resident of the village in which she is to be employed. By the end of 8th plan period, 12000 such workers would be working in the villages covering about 70 percent rural population [Pakistan (1993)].

In order to strengthen further the programme activities, special training in family planning would be imparted to lady health workers as well as staff of health outlets of other line departments. Unlike the 7th Five-Year Plan, the 8th Five-Year Plan makes it mandatory for the staff of health outlets of other departments as well as for lady health workers to provide family planning services. The essential equipment and IEC material were to be provided by population welfare departments. The District Population Welfare Officer, being a member of the District Technical Committee would be responsible to monitor progress against given targets on a monthly basis and coordinate activities at local level. In order to achieve the targets set in the 8th Five-Year Plan, various aspects of the programme were to be strengthened further, the details of which are provided in Appendix Table 4.

### How to Meet the Challenge?

The 1998 population census results and a recent decline in TFR as mentioned earlier, are reflective of a situation whereby it can be believed that fertility transition has begun in Pakistan. Nevertheless, in order to accelerate the pace of the transition concentrated efforts are needed to reach at replacement level as early as possible. Here we will suggest some strategies and modifications in the existing setup in order to achieve the goals in the shortest possible time period.

In view of large unmet need for family planning methods which seems to have increased between 1990-91 to 1997 [Hakim *et al.* (1998)], the need for very strong family planning programme with excellent outreach facilities and delivery system is imperative. Ahmed (1971) observed that contraceptive services initiate a fertility change even in a poor rural traditional population irrespective of the level of economic development.

The laid out strategy in the 8th Five-Year Plan for strengthening family planning programme looks impressive. However, the programme's performance with respect to the targets set for the delivery of various contraceptives was not up to the mark (see

Appendix Table 5). In fact, in the last Five-Years, delivery targets for various contraceptives were not met even for a single year and the worst performance was observed for oral pills and contraceptive surgery. In view of dismal programme performance, one needs to evaluate the programme delivery system. Other efforts for provision of family planning services by about 6000 health outlets also seems not to be bearing fruit to the extent it was expected. In fact, a modest increase in the contraceptive prevalence during the period might have been due to the efforts of various NGOs, social marketing and MSUs.

It is true that past experience of utilising health outlets for family planning purposes was not successful. The major cause of its failure was the inclusion of the family planning programme within the existing health programme. As a result, the health personnel who were already overburdened with clinical work, could not give adequate attention to family planning activities. Moreover, bureaucratic rivalries between the two programmes remained a constraining factor. The health personnel performing duties for other than their own department always resented doing so. In fact, present integration of the two programmes has already started showing such sentiments as many health workers reportedly refused to attend training courses on family planning, and even those who formally registered often did not show up. [Rosen and Conly (1996)].

In view of low coverage of the population programme by using its own means and sparsely located outlets, it is certainly a right approach to utilise health outlets for family planning services. However, in view of past and recent experience and criticism against using health personnel for family planning services, it may be advisable if health premises is used by the population welfare department in a way that a separate cadre of family planning personnel are posted there to provide family planning services. This will have a three pronged benefit. Firstly, it will be less costly to establish a family planning outlet on the premises already owned/rented by the government. Secondly, in Pakistan where, in some quarters, family planning is still considered a taboo, women by virtue of visiting a health outlet will feel free to simultaneously visit a family planning clinic based in the same premises. In fact, our argument is reinforced by the fact that in a survey when intended users were asked about their preferred place to obtain family planning supplies, 67 percent wanted the supplies from health centres [Shah and Ali (1992)]. Thirdly, independent working of the two departments at the same premises will lead to better efficiency as well as coordination between the two closely-knit programmes. A close liaison when maintained could help complement the performance of the two services and cases could be referred to each other easily. As per ICPD Conference in Cairo, 70 percent emphasis was given on providing reproductive health services. In such an arrangement this objective can also be met in a better way.

In return all FWCs should provide premises to health department as well, to set up their outlets in these centres. In fact a better suggestion would be that an outlet

housed by the personnel of the two departments should be renamed as "Family Welfare and Health Centre".

At the grass root level both VBFPWs and community based lady health workers are providing health as well as family planning services. However, their services are not up to the mark especially for those services rendered for other department. For example, lady health workers consider themselves as health workers only and are reluctant to provide family planning services because they consider that provision of family planning services is the job of family planning department and special cadre known as VBFPWs are already doing that job. Moreover, inadequate and untimely supplies of contraceptives also hamper their efforts. Rosen and Conly (1996) noted that there is no organised system for keeping the community-based lady health workers supplied with contraceptives. Likewise, the performance and behaviour of VBFPWs for provision of health services is also not quite supportive. Rosen and Conly (1996) contend that in order to be acceptable in the community, a VBFPW should not only provide services for contraception but also provide health related services to the community as a whole but in particular for children and women. In such a situation, it is advisable to integrate VBFPWs and community based lady health workers into one cadre and renamed as Village Based Family Planning and Health Workers (VBFPHWs). This new cadre now formed should work under the Prime Minister's programme. This renaming and arrangement will make them responsible to provide services for both family planning and health related matters without any distinction or priority of work.

Training of these workers should be provided by the personnel of both health and family planning departments at one venue. These workers will get family planning and health related supplies from the respective staff posted in a nearby family welfare and health centre (FWHC). These workers will also refer cases to these centres wherever need be. The staff posted at the FWH centre ought to supervise and coordinate the services of these village-based workers. These workers will be required to report to the staff posted at the centre for their work performance every month. And a record keeping will be done at the centre.

The past performance of TBAs as outreach workers was criticised by many [Gardezi (1967); Ahmed (1971); Mahmood and Ali (1997)]. In fact one wonders, why TBA's were inducted once again for the same job for which they were subjected to criticism and were ultimately relieved of their duties. Even today, the socio-economic position of TBA's in a village community has not changed much. Although their profession is useful, their position remained far from respectable in the hierarchy of the village community. The female literacy rate has not changed much at the country level nor has it amongst TBA's who are still illiterate in most cases. Thus, the information and suggestions made by an illiterate and socially inferior TBA has little impact. In view of these observations, TBA's may be relieved of their duties as an outreach family planning worker. However, in view of their usefulness as reproductive health worker,



they may be entrusted with the duties of reproductive health care and accordingly be imparted proper training for better results.

Pakistan is a male dominated society where a male member of a household takes most of the decisions particularly of vital importance. Many previous surveys have indicated "husband's objection" as being an important reason for not using family planning methods (see Appendix Table 3). In a study on Pakistani data, Sirageldin *et al.* (1976) observed that a latent demand for contraceptive practice may have existed among women, but constraints such as husband's approval prevented them from actually converting it into effective demand. In other parts of the world, where there are male dominated societies, studies have reported such constraints faced by family planning programmes. In a study on Taiwanese data, Cernada and Huang (1968) observed that motivation for family planning through wives in such societies might sometimes be considered as a challenge to the husband's authority and thus may have a contrary effect.

In a male dominated society it is advisable to have male motivators for husbands. If budget permits, it will be advisable to create a cadre of village male family planning worker on the lines of VBFPW. Such efforts are certainly going to bear fruit. In fact, a study of a male dominated society in Gilgit, Pakistan, mostly male field motivators/worker provided information and services about family planning methods. According to Fazil (n.d.) this was an extremely successful experience as family planning practice increased substantially. Motivation for the use of male methods may also prove useful. India, another male chauvinist society was able to check fertility to some extent by effectively persuading a large proportion of males to have sterilisation. Japan is another male dominated society where 69 percent of users use condoms—a male method [World Bank (1989)].

In order to accomplish good results of the family planning efforts in Pakistan, an overall improvement in the present socio-cultural and traditional set up has to be made. Today, examples abound where fertility had declined rapidly without having achieved economic progress but by achieving remarkable improvement in socio-cultural and traditional set up. In Pakistan, in the last three decades, rate of economic development was on an average 5 percent and in fact, our per capita income has also doubled but because of very slow development of socio-cultural indicators, efforts towards achieving small family size norms were not very successful. On the other hand, Sri Lanka, which realised its salvage in social development few decades back, is today socially and culturally quite developed and its fertility level is almost at replacement level.

Another example is India, where within one country there is a sharp contrast. Unlike North India, the southern part especially state of Kerala is socially and culturally quite advanced and the fertility levels there are almost half of that are prevailing in the northern India. In South East Asia, Indonesia and lately Thailand are among a few of

those countries where fertility has declined substantially without achieving any perceptible economic development.

On close observation, it can be noticed that the most common feature of these societies is the increased educational levels (females 87 percent, males 93 percent in Sri Lanka; females 78 percent, males 90 percent in Indonesia and females 92 percent males 96 percent in Thailand). Attainment of education at least up to secondary level, particularly of females, increases the age at marriage as the time involved in the pursuit of education delays marriage. This, in turn reduces the number of childbearing years in a woman's life. Moreover, an educated woman is likely to be more independent in decision-making particularly in deciding the number of children she wishes to produce. She may be more economically productive and thus busy and hence may decide to have fewer children. In fact a number of studies have shown a generally significant negative impact of education on fertility and family size preferences [Sather (1979); Alam *et al.* (n.d.); Afzal *et al.* (1994); Mahmood and Zahid (1993); Ali (1989); Ali and Rukanuddin (1992)].

## CONCLUSION

The low status of Pakistani women breeds a culture where she lacks control over her fertility. A recent study shows that even those women, who considered themselves to be independent in taking decisions such as going to health clinic or a hospital alone and about their ideal family size, were practically producing as many children as other women in general. [Ali, Siyal and Sultan (1995)]. Implying that presently, the socio-cultural influences are much too strong to have any effect on their fertility behaviour. This situation may improve only when education pervades the whole community and especially among females. The educational attainment will bring a change in women's behaviour towards rational thinking. Once such a thinking is developed, fatalistic and traditional attitudes about large family size will fade away and women will start exercising their rights at their own will. In order to achieve this goal we fully endorse social action programme, nevertheless, we suggest that in view of extensive advantages of education, much more efforts are needed to achieve universal education in this country in minimum possible time.

India and Bangladesh were able to control fertility to some extent by introducing effective family planning programme. The immediate salvage here in Pakistan also lies in a very strong and effective family planning programme. In this respect, whereas, on one hand we suggest continuation of present population policy in general, on the other hand, small changes as suggested here, if incorporated in the future population planning may bear fruit sooner than expected.

## Appendices

Appendix Table 1

*Percentage of Currently Married, Women Age 15-49 Who are Currently Using a Contraceptive Method, 1996-97 PFFPS, 1994-95 PCPS, 1990-91 PDHS, 1984-85 PCPS, 1975 PFS and 1968-69 NIS*

	1996-97 PFFPS	1994-95 PCPS	1990-91 PDHS	1984-85 PCPS	1975 PFS	1968-69 NIS
Any Method	23.9	17.8	11.8	9.1	5.2	5.5
Any Modern Method	16.9	12.6	9.0	7.6	3.8	3.8
Any Traditional Method	7.0	5.2	2.8	1.5	1.4	1.7

Appendix Table 2

*Comparative Statement Showing ADP Allocations for the Population Welfare Programme and Actual Expenditures during 1965-1998*

Plan Period	ADP Allocation	Actual Expenditure	(Rupees in Million)
			Percentage Utilisation
<b>Third Plan</b> (1965-70)	148.200	167.714	113.167
<b>Fourth Plan</b> (1970-75) Including 3 Years, i.e., 1975-78 of Non-plan Period	628.794	509.675	81.056
<b>Fifth Plan</b> (1978-83)	823.922	617.100	74.898
<b>Sixth Plan</b> (1983-88)	2044.300	1686.260	82.486
<b>Seventh Plan</b> (1988-93)	3535.000	3046.900	86.192
<b>Eighth Plan</b> 1993-94	1100.000	710.520	64.593
1994-95	1200.160	1132.985	94.403
1995-96	1433.000	1181.210	82.429
1996-97	2000.000	1256.896	62.845
1997-98	1920.891	1194.309	62.1

Appendix Table 3  
*Percentage Distribution of Currently Married Non-pregnant Women Between 15-49 Years of Age, By their  
Reasons of Non-Use 1975 PFS, 1979-80 PLM, 1984-85 PCPS, 1990-91 PDHS and 1994-95 PCPS*

Reasons for Non-Use	PFS 1975			PLM 1979-80			PCPS 1984-85			PDHS 1990-91	
	Total	Urban	Rural	Total	Urban	Rural	Total	Major Urban	Other Urban	Rural	Total
Religions/Allah will	-	46.1	51.1	25.3	26.3	25.1	30.29	21.47	29.46	32.44	13.2
Fear of Side Effects/Health Concern	-	15.8	16.6	1.2	2	1	13.27	16.23	16.7	11.88	4.3
Protected by Breast Feeding	-	-	-	-	-	-	8.49	7.05	7.93	8.93	-
Family Planning not Available	-	-	-	-	-	-	7.65	1.87	9.12	8.64	0.8
No Knowledge of Family Planning	-	-	-	2.2	1.8	2.3	0.82	0.55	0.47	0.96	10.5
Perceived Fertility	-	2.9	3.3	4	5.1	3.7	9.97	8.7	9.87	10.29	11.8
Post Partum Abstinence	-	-	-	-	-	-	1.67	1.65	2.28	1.54	-
Husband or Family Opposed	-	18.1	9.2	9.5	12.1	8.9	5.86	7.67	6.06	5.41	6.6
Just never done it	-	-	-	-	-	-	3.53	3.85	2.07	3.77	-
Natural Spacing	-	-	-	6.1	5.6	6.2	12.46	20.78	7.23	11.7	-
Other	-	13.6	10.8	2.9	2.2	3.1	3.74	7.36	5.18	2.62	8.2
No Information	-	-	-	2.3	2.5	2.3	2.25	2.82	3.63	1.82	1.9
Want Children/Son	-	1	5.8	46.2	41.9	47.4	-	-	-	-	42.7
Ineffective Method	-	2.9	2.6	0.1	0.2	0.1	-	-	-	-	-

Appendix Table 3A

*Percent Distribution of Never-Users by Main Reason for Never-Use of any Method, By Type of Area  
(PFFPS-1996-97) and PCPS 1994-95*

	Total	PFFPS 1996-97		PCPS 1994-95				
		Urban	Rural	Major Cities	Other Urban	All Urban	Rural	Pakistan
Reasons for Non-Use	51.9	51.8	51.9	57.2	60.9	59.0	67.9	65.9
Want more Children	-	-	-	26.9	30.3	28.6	43.2	39.9
Programmatic	6.4	4.5	7.0	-	-	-	-	-
Lack of Knowledge	6.0	7.5	5.6	22.0	12.1	17.0	10.3	11.8
Husband Opposed	0.8	0.4	0.9	-	-	-	-	-
Cost too Much	2.2	3.5	1.8	-	-	-	-	-
Worry about Side Effects	2.0	2.0	2.1	-	-	-	-	-
Health Concerns	1.5	0.8	1.7	-	-	-	-	-
Hard to Get Methods	9.8	8.5	10.2	21.8	20.7	21.2	20.2	20.4
Religion	1.3	1.1	1.4	26.2	20.7	23.4	15.5	17.3
Opposed to FP/Not Needed	6.2	3.5	6.9	-	-	-	-	-
Fatalistic	0.4	0.7	0.3	-	-	-	-	-
Other People Opposed	1.4	2.1	1.2	-	-	-	-	-
Infrequent Sex	5.1	7.4	4.4	-	-	-	-	-
Difficult to Get Pregnant	0.5	0.4	0.5	-	-	-	-	-
Menopausal/Had Hysterectomy	0.5	0.8	0.4	-	-	-	-	-
Inconvenient	3.5	4.2	3.3	2.8	3.4	3.1	2.5	2.6
Other	0.6	0.9	0.5	-	-	-	-	-
Don not Know	(4821)	(1045)	(3776)	(647)	(659)	(1306)	(4351)	(5657)
(N)								

Source: PFFPS, 1996-97, p. 49, Table No. 6.4; PCPS, 1994-95, p. 105, Table No. 6.20.

Multiple responses were permissible. The sum total of percentages may exceed 100.0.

Appendix Table 4

*Physical Targets Set during 1993-98, Eighth Five-Year Plan*

Name of Service Outlet	1992-93					
	Bench Mark	1993-94	1994-95	1995-96	1996-97	1997-98
<b>A. Programme Outlets</b>						
(i) Family Welfare Centre	1290	1290	1340	1420	1500	1500
(ii) Productive Health Service 'A'						
Centres	79	79	80	91	101	101
(iii) Mobile Service						
Units	130	130	185	251	251	251
Sub-total	1499	1499	1605	1762	1852	1852
<b>B. Line Department Outlets</b>						
(i) Health						
Departments	2824	5540	6023	6324	6649	6649
(ii) Other Line						
Depts.	160	168	195	226	262	300
(iii) Target Group						
Institutions	174	229	284	339	394	450
(iv) Traditional Birth						
Attendant	5000	7000	7000	7000	7000	7000
(v) Registered						
Medical Practitioners	2500	6500	111000	15950	22500	22500

*Continued—*

Appendix Table 4—(Continued)

(vi) Hakeems	2500	5150	7400	10050	12750	14800
(vii) Homeopaths	1500	2250	3020	3780	4550	4900
Sub-total	14658	26837	35022	43669	54105	56599
<b>C. Non-Governmental Organisations</b>	580	418	512	582	653	723
Total A+B+C	16737	28754	37139	46013	56610	59174
<b>D. Community-based Services</b>						
Family Planning Workers	1561	3000	5000	10000	12000	12000
<b>E. Social Marketing of Contraceptives (Sale Point)</b>	67000	67000	70000	70000	75000	80000
<b>F. Special Areas</b>						
<b>Programme (AJK, NA and FATA)</b>						
(i) Family Welfare Centres	6	6	9	12	15	18
(ii) Reproductive Health Services	—	—	2	3	3	3
(iii) Health Outlets	184	214	321	401	478	526
(iv) Traditional Birth Attendants	—	30	70	100	130	160
(v) Hakeem	—	150	200	200	200	200
(vi) Homeopaths	—	20	40	50	80	100
(vii) Family Planning Workers	—	—	23	47	47	47

Appendix Table 5  
*Summary of Service Delivery in Relation to the Achievement of Targets during the Eighth Five-Year Plan, 1993-98*

Method	1993-94		1994-95		1995-96		1996-97		1997-98						
	Target	Achievements %	Target	Achievements %	Target	Achievements %	Target	Achievements %	Target	Achievements %					
Condom (Units)	127.204	43.962	34.56	130.443	81.239	62.28	135.127	95.926	70.99	140.69	116.25	82.63	194.080	141.18	72.74
Oral Pill (Cycles)	3.468	0.844	24.34	4.526	1.017	22.47	5.528	1.236	22.36	6.264	1.478	23.59	8.570	2.467	28.79
IUD (Insertions)	0.808	0.543	67.20	0.888	0.714	80.41	0.912	0.692	75.88	1.086	0.633	58.29	1.193	0.873	73.18
Injectable	2.004	0.879	43.86	2.768	1.026	37.07	3.460	1.080	31.24	4.521	1.197	26.48	6.054	1.646	27.19
Contraceptives															
Surgery (Cases)	0.223	0.085	38.10	0.279	0.093	33.33	0.381	0.099	25.98	0.418	0.097	23.21	0.431	0.106	24.59
Foam (Bottles)	0.154	0.089	57.79	0.177	0.116	65.54	0.229	0.027	11.79	0.113	0.003	2.65	0.213	0.005	2.35



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