Chapter 4

POPULATION

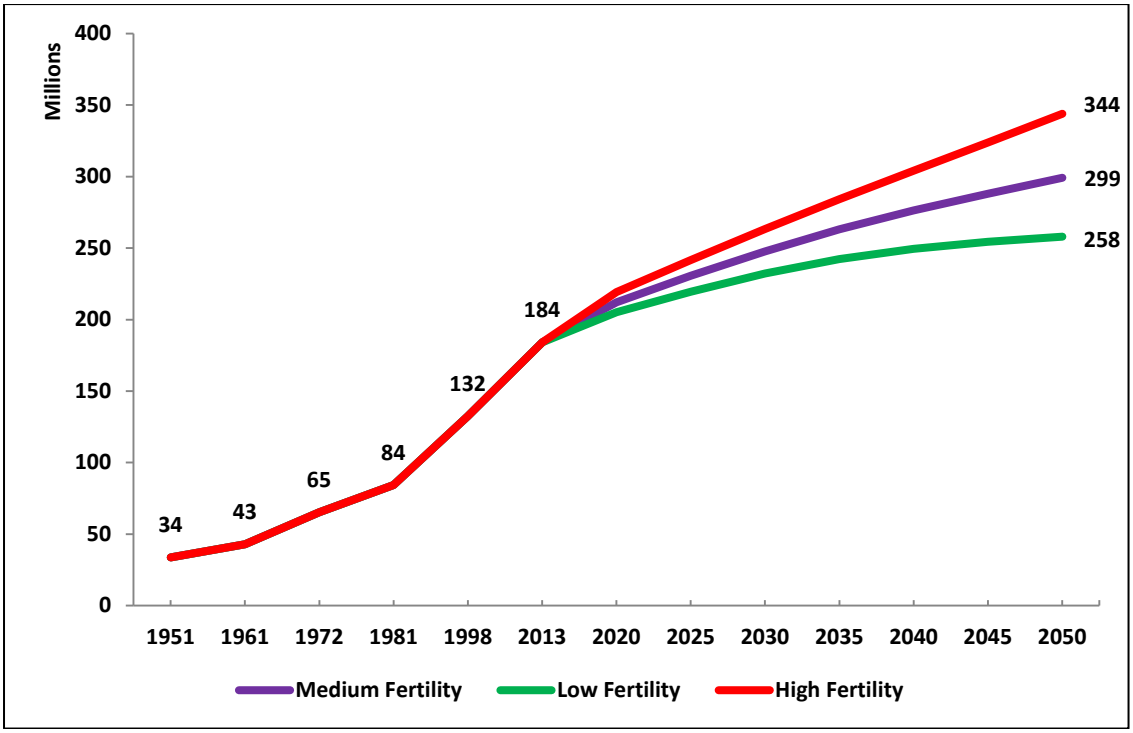
Pakistan is confronted with multiple internal and external challenges, including, financial and fiscal constraints, low literacy rates especially of women, poor quality of health and education services, high unemployment rates especially among the youth, energy crisis, water scarcity and food insecurity, terrorism and low status of women. While other countries are confronting some of the same challenges too, what segregates Pakistan from the rest is its continuing high-level of population growth rate. Almost all other countries of the region and other Muslim countries have been successful in curbing their high population growth rates through concerted efforts and by taking a position about population policy, which emphasised human development, particularly investment in education and health. These countries have come up with clear strategies to balance their population with resources. Consequently, their growth rates are closer to one per cent, while Pakistan continues to have a growth rate of about 1.9 per cent. The Plan will face a serious issue of matching resources with an almost unmanageable burgeoning population.

Pakistan has a chequered history regarding investments and priority accorded to population issues, and is far behind in its fertility transition. Resultantly, rapid population growth rate has eroded development gains and compounded the challenges of endemic poverty, social injustice, economic slowdown and environmental degradation. One of the most serious impediments to achieving success in school enrolment rates and in lowering maternal and child mortality, is high fertility, which directly increases the challenge of an ever-increasing schooling population of high parity and closely spaced births leading to high maternal and child mortality risks. As a result, neglect of this sector has contributed to Pakistan's failure in achieving its MDGs 3, 4 and 5.

In this Plan, Pakistan is effectively calling for greater investments in human development and clearly enunciated support for the population sector – both have lagged behind. Population is the hub of human development, while the spokes of the wheel are health, education, employment, gender, and youth sectors.

Given the lack of a population and housing census since 1998, future population-driven scenarios are based on projections. According to these projections, by 2050 the population can reach as high as 344 million if no further fertility decline occurs, and as low as 258 million if the fertility decline is more rapid (Figure 1). In this regard, a strong family planning programme is essential for achieving a more fast fertility decline and capturing benefits of the demographic dividend. At the London Family Planning Summit in July 2012, Pakistan set a target for raising its current Contraceptive Prevalence Rate (CPR) of about 35 per cent to 55 per cent by 2020, and reducing its total fertility rate from 3.8 per cent to 2.6 per cent by the same, and achieving replacement fertility by 2045.

Figure 1: Different kinds of fertility rates till 2050



While clearly ambitious in view of stagnation in impact of the family planning programmes in the last decade, where the CPR has barely changed from around 30 per cent in 2001 to 35 per cent in 2013, this is an achievable objective, as based on comparisons with other countries of the region. Furthermore, initiatives within Pakistan have succeeded in raising prevalence in a short period provided the intent to implement is there and resources are available. No obstacles will prevent Pakistan from accelerating an increase in its CPR, even in the rural areas, and among the poor and uneducated. New national population and development policy has to be framed in terms of meeting unmet needs, and encouraging birth spacing for the purpose of improving the health of mothers and children rather than for achieving demographic targets. This approach is consistent with the rights framework and the International Conference on Population and Development (ICPD) Programme of Action.

Developing population policies at the provincial level will be all the more challenging because each province must now highlight its own priorities. Two sectors, population and health, will have to contribute most immediately. In the post-18th Constitutional amendment scenario, these two sectors fall entirely within the ambit of the provinces. The provincial programmes will, therefore, have to revise their objectives and increase their efforts for achieving the desired results. The provinces will also have primary responsibility for ensuring coordination and monitoring of trends to track progress on policy implementation.

Changes in population size and growth rate in Pakistan from 1951 to 2015 are shown in Table 1 below.

Table 1: Population growth 1951-2015

Census year	Population (Million)	Average annual intercensal growth rate (%)	Percentage intercensal increase
1951	33.82	1.8	-
1961	42.98	2.5	27.09
1972	65.32	3.6	52.31
1981	84.25	3.1	29.01
1998	133.32	2.6	57.09
2003	147.69	2.03	-
2010	172.57	2.08	-
2011	176.20	2.06	-
2012	179.86	2*	-
2013	184.35	1.97*	-
2014	188	1.95*	-
2015	191.71	1.95 (P)*	

Source: *Population of Pakistan: An Analysis of Population and Housing Census, 1998, and Planning Commission Sub-Group-2 on Population Projections 2010-15.*
**Economic Survey of Pakistan 2013-14*

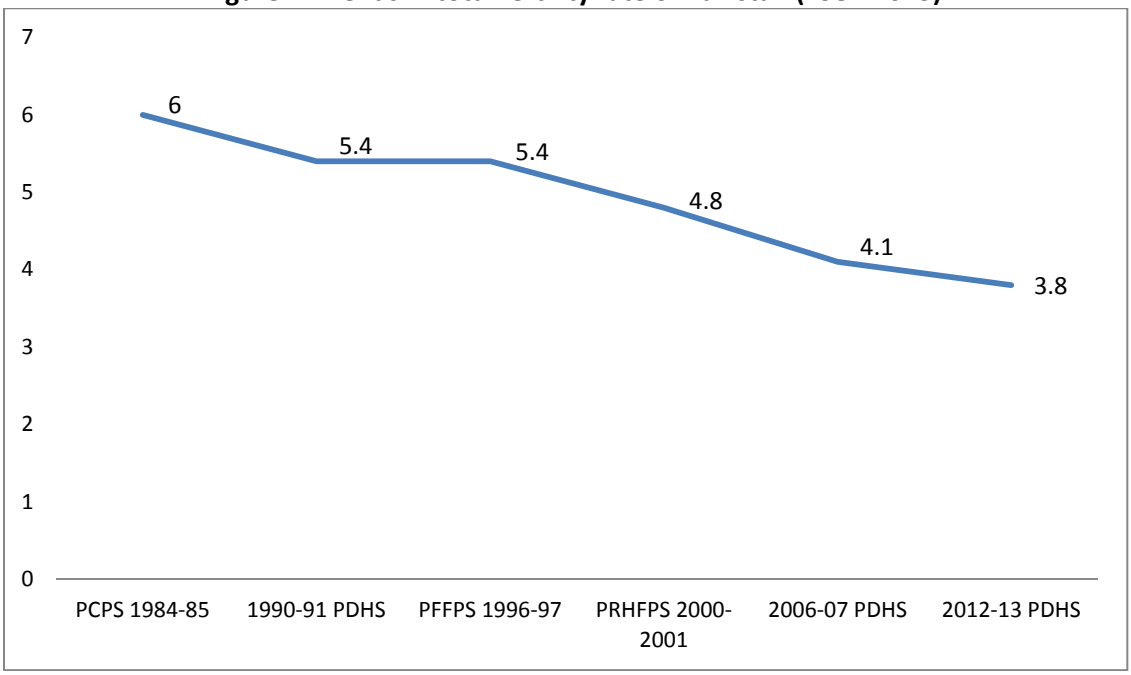
Thus far, the population growth has been eroding a part of the development gains. A decline in the fertility rate and lowering of the population growth rate can provide a major boost to development. It can be a key impetus for the economic growth, most importantly free resources for catering to the needs of growing numbers, and can be diverted to develop and mobilise human resources; thereby improving investments in human development. A strategy has been outlined for refocusing on population as a priority sector with a view to its important implications on population trends for every aspect of the Plan.

Current population estimates

As there has been no Census since 1998, the population is estimated to be at 188 million in 2014. Today, Pakistan is the sixth most populous country of the world. It has the highest population growth rate of 1.9 per cent and the lowest CPR of 35.4 per cent amongst the South Asian Association for Regional Cooperation (SAARC) countries. The crude birth rate (per 1000) in 2013-14 is at 26.4 (per 1000), and the crude death rate at 6.9 (per 1000), which are unacceptably high. This results in an annual addition of over 3.7 million people in its population size, which is projected to reach 219 million by 2020, and 344 million by 2050, when it is likely to attain the fifth position on the population table. It continues to lag behind with respect to other demographic indicators as well. An estimated 14,000 maternal and 400,000 infant deaths occur annually, a large proportion of which is linked to high fertility.

The total fertility rate, which is the average birth per woman, has declined sharply in the 1990s from about six to four children in 2001 (Figure 2). However, since then progress has slowed down and fertility is estimated at 3.8 children in 2012-13, according to the Pakistan Demographic and Health Survey with a CPR of 35 per cent, which is about half the level of other SAARC and Muslim countries. Goals, set earlier in the 2002 policy for Pakistan, were to achieve a Total Fertility Rate (TFR) of 2.1 by 2015, which has now been deferred to 2020. Pakistan has also committed internationally to a CPR goal of 55 per cent by 2020. This requires an acceleration of efforts for reducing fertility rates and increasing contraceptive prevalence.

Figure 2: Trends in total fertility rate of Pakistan (1984-2013)

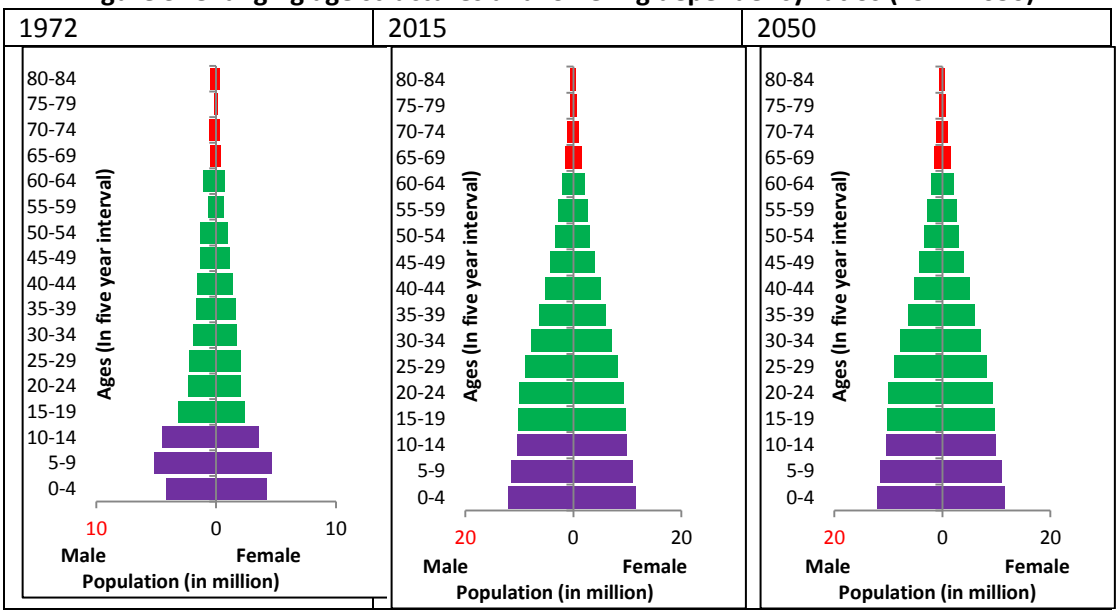


Some important demographic changes

A major change in the demographic profile as a result of the demographic transition, which began in the 1990s, is the changing age structure. In the past, population was much younger due to high fertility rate with the proportion of children under 15 outnumbering the working age population. This has begun to change in the last decade, and now the working-age population dominates and dependency ratios have begun to decline. Our working-age population of 117 million (62 per cent) and the youth (15 to 24 years) population of 41 million (22 per cent) present an opportunity for greater savings and economic growth provided they are skilled and employed. Translating this surge of the youth into the working-age population can translate into a 'demographic dividend' if the economy is able to create new jobs and productive opportunities. Historically, a demographic transition, like that of Pakistan, has provided unique opportunities elsewhere, particularly in the East Asia, for reaping dividend and progressing economically. Pakistan's economic prospects hinges on how it captures the demographic dividend through investments in education, health and skill development, and employment creation for its youth.

The population and development policy dialogue must make clear that the potential effects of the demographic dividend, even once fertility begins to falls more rapidly, are not automatic. The fact that countries in the East Asia and elsewhere experienced that the dividend does not guarantee that other countries will follow the suit (*Bloom and Canning 2004*).

Figure 3: Changing age structures and lowering dependency ratios (1972-2050)



Another major change of the past is that efforts were devoted to increasing demands for smaller families and family planning, but now the demand for family planning outstrips supply. Preferences of both women and men have changed and the majority want no more children or to space their next child. The latest evidence shows that there are about four million unwanted pregnancies in Pakistan, and half of them end in unwanted births. There is undoubtedly a considerable drive for lower fertility across the country and that is what couples want. This is the perfect opportunity for capturing the low-hanging fruit by providing quality affordance, and accessible services can raise the CPR from 35 per cent to 55 per cent by enlisting 20 per cent additional couples with unmet need. This will reduce fertility levels by at least one child to 2.8 children, closer to the wanted fertility levels.

PLAN

In the 1990s,a robust Family Planning and Reproductive Health (FP&RH) achieved lowering of the increased rate of population growth. With a very high unmet need for the FP&RH at 20 per cent, several barriers need to be overcome, including: misgivings regarding family planning methods, difficulties in accessing facilities and services, absence of client-focused quality services, as well as a disrupted flow of information and availability of contraceptive methods. In this regard, strict monitoring and evaluation, accountability and assurance of quality services at the individual level, have a critical role to play. The quality of services, which include provision of adequate information to the clients about the FP&RH, etc., technical competence of the service providers, and uninterrupted availability of medicines and contraceptives, need to be reviewed and accordingly addressed.

The broader objectives of the Plan include:

- Raising level of the current CPR from 35 per cent in 2012-13 to 49 per cent by 2017-2018, and to 55 per cent in 2020
- Increase the number of users from 11.9 million in 2013-14 to 16.1 million in 2017-2018
- Reducing the Crude Birth Rate (CBR) from 24.2 per thousand population in 2013-14 to 20.5 per 1,000 population by 2017-2018

- Bringing down the population growth rate from about 1.9 per cent per annum in 2013-14 to 1.87 per cent per annum by 2017-2018

For achieving the long-term objective of attaining the CPR of 55 per cent by 2020, the population programme will focus on new initiatives and priority programmes through the following focused interventions:

Firstly, population challenges need to be addressed through a coordinated and integrated approach, which requires involvement of all other sectors, cross cutting with the population issues. Since rapid growth of population affects all efforts being made in the sectors of health, education, women development and poverty reduction, etc., its objectives are virtually intertwined with all aspects of the Plan. Particularly, it emphasises the need to make a link with the health sector to increase access to services and with women empowerment for recognising females' role. Furthermore, there is an inadequate public-private partnership, and also non-existent mechanism for strengthening this partnership, while the private sector and NGOs are not fully involved in sharing the responsibility. At the moment, there is no mechanism of supporting and enlisting participation of the NGOs in service delivery and other programmes. This will be rectified as these organisations can contribute greatly, especially in non-serviced areas to meet unmet demand. A strong coordination will be established to rein in all potential synergies among all related sectors, and provide a mechanism of supporting the NGOs.

Secondly**,** since there has been little or no ownership and accountability of this sector, consequently attention and resources have dwindled. This will be reversed for a central development priority. Through the Vision 2025, the Plan will secure strong commitment and political will at the federal and provincial levels to make concerted efforts for improving results. While the provinces have full responsibility for implementation of programmes, and delivery of health and population services, there are some federal responsibilities, such as international coordination, provision of support to the provincial programmes, research and overall policy directives, including internal commitments. Strong oversight mechanisms will be enforced more stringently.

Thirdly, during the Plan period, the Ministry of National Health Services, Regulations and Coordination (NHSR&C) and the provincial health and population departments will address unmet need for the family planning with a renewed commitment. These will put the planning squarely as part of its priorities with population welfare, and extend maximum support. Since the health departments and Provincial Line Departments (PLDs) service outlets cover a wider outreach and are more numerous as compared to the service outlets of the Population Welfare Programmes (PWP), effective measures will be taken at the highest level to involve all the existing service outlets of the provincial health and line departments (Basic Health Units, Rural Health Centres and Tehsil Hospitals) and Special Areas (AJ&K, G-Band FATA) for provision of the FP&RH services. This is the only way to minimise the high unmet need for the FP&RH.

Fourthly, the population welfare departments will train doctors, paramedics and Lady Health Visitors (LHVs) of the health and PLDs in the FP&RH, clinical and traditional methods, and contraceptive technology at the Population Welfare Regional Training Institutes (PWRTIs), while taking proper remedial measures to increase their attendance and availability at the outlets. An adequate and regular supply of contraceptives will be made to the health and PLD service outlets through the public health contraceptive logistic system.

Fifthly, a well-directed and well-designed multi-channelled communication and media strategy will be developed by the PWP to convey the message that birth spacing saves lives. This approach has wide appeal across the board and full religious approval. More focused Interpersonal Communication (IPC) strategies will be pursued, where men will be as much focussed as women.

Sixthly, the progress will be monitored regularly. This will require improved population data on fertility and contraceptive prevalence trends, including urban and rural breakdowns. Household surveys will be conducted to measure changes in essential demographic behaviours. The newly-formed provincial branches of the Pakistan Bureau of Statistics (PBS) will coordinate this effort alongside the development of vital statistics systems.

It is important to collect fertility and contraceptive prevalence rates at the district and provincial levels as well as nationally through the Pakistan Social and Living Standard Measurement Survey (PSLMS). At the moment, there is no way of regularly monitoring annual progress in neither contraceptive prevalence rates nor fertility rates. Pakistan relies on the five-yearly evaluations of the demographic and health surveys, which are too late and infrequent to correct the course. The census, earlier postponed several times, is now scheduled to take place in March 2016, and will produce critical data for the entire planning process.

Financial review

An amount of Rs24.7 billion was allocated to the PWP in the Medium-Term Development Framework (MTDF). However, the utilisation was Rs16.5 billion due to delays in releases.

Physical review

The service delivery achievements remained satisfactory. The component-wise accomplishments made during the MTDF period (2005-10) are as follows:

(Cumulative)

S#	Service delivery outlets	Target	Achievement
1	Family Welfare Centres (FWC)	2,040	2,846
2	Mobile Service Units (MSU)	175	292
3	RHS-A	120	176
	Total	**2,335**	**3,314**

Key issues and challenges

Some of the major weaknesses, specific to the PWPs, are:

- For the last couple of decades, the PWPs are dependent on the development budget and funded through the federal Public Sector Development Programme (PSDP).
- The PWPs are being executed by the provincial governments, which have not picked up their recurrent financial liabilities to reduce the burden of the federal exchequer. There seems to be a lack of ownership of the Programmes by the provinces.

- Insufficient service delivery infrastructure, low coverage, and services are incompatible with demand. There is low quality of care and services, unreliable contraceptives methods and their detrimental side-effects and low turnout of clients at the Family Welfare Centres (FWCs).
- Lack of trained service providers, little emphasis on the need-base refresher trainings, lack of incentives to them and non-existence of their career planning
- Rampant absenteeism amongst the field functionaries
- Lack of commitment on their part and their lethargic attitude towards clients
- Weak, inadequate, irregular and inefficient monitoring and evaluation system for the health and PWP activities

Interventions to achieve desired goals

Financial Plan

For five years, a projected amount of Rs37 billion will be earmarked for the population welfare, and there is no foreign assistance for the programmes. The first six PWPs, in the Table 2 below, have been approved by the Executive Committee of the National Economic Council (ECNEC), while the remaining three have been done by the CDWP.

Table 2: Year-wise projected PSDP 2013-14 to 2017-18 for the population welfare sector

(Rs million)

Names of programmes	Allocations			Proposed		Total
	2013-14***	2014-15	2015-16	2016-17	2017-18	
PWP Punjab (2010-15)	4,060	3,789	2,715	2,663	2,692	15,919
PWP Sindh (2010-15)	2,327	2,171	1,629	1,526	1,543	9,196
PWP KPK (2010-15)	1,434	1,338	760	940	951	5,423
PWP Balochistan (2010-15)	900	840	326	590	597	3,253
Sub-total (provincial)	**8,721**	**8,138**	**5,430**	**5,719**	**5,782**	**33,790**
PWP AJ&K (2010-15)	250	233	243	74	58	858
PWP G-B (2010-15)	133	124	129	40	31	457
PWP FATA (2010-15)	88	82	86	26	20	302
**PWP, Islamabad	470	439	457	140	109	1,615
Sub-total (Special Areas)	**941**	**878**	**914**	**281**	**218**	**3,232**
Grand total:	**9,662**	**9,016**	**6,344**	**6,000**	**6,000**	**37,022**

Sources: *PSDP 2015, Year Book 2013-14, PIP Section*

* In the post-devolution period, the Federal PC-I stands abolished
** Transferred to the non-development budget
*** Funds were capped in FY 2010-11 after a decision of the CCI.

Physical targets and goals

The PWP envisages establishing service delivery outlets during the Plan period, which are enlisted in Table 3 below.

Table 3: Physical and contraceptive user targets and goals

(Cumulative number)

	2013-14 (Target)	2013-14 (Achievement)	2014-15 (Target)	2015-16 (Target)	2017-18 (Target)
Family Welfare Centres	3,427	2,891	3,000	3,200	3,427
Reproductive Health-A Centres	269	207	230	250	270
Mobile Service Units (MSUs)	300	292	325	350	380
Contraceptive users (Million)	10	8	12	13	14
RHS-B Centres	184	133	200	225	250
Registered Medical Practitioners(RMPs)	27,576	9,297	25,000	27,000	29,000
Hakeems and Homeopaths	14,009	8,071	15,000	16,000	17,000