Delivering a world where every pregnancy is wanted every childbirth is safe and every young person's potential is fulfilled

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Population Situation Analysis of Pakistan

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1. Executive Summary

This meta-analysis was envisaged as a light version of a UNFPA Population Situation Analysis, drawing from recent analyses, surveys and studies, and from consultations with interest groups, including the government and other stakeholders, both national and development partners, individually and as a group.

Overview of Pakistan's Population and Development Situation

Pakistan's economic growth over the period 1960-2010 has averaged 5.2% per annum, respectable but below Pakistan's potential. According to World Bank categories, Pakistan graduated from low income to lower middle income status in 2008. The major problem was summarized by Prof. Ahsan Iqbal, in his Prelude to the document Pakistan 2025: One Nation – One Vision, when he wrote "In terms of economic indicators, Pakistan is a middle income country but in social indicators it falls amongst the least developed countries". Pakistan ranks 147 out of 188 countries on the 2015 Human Development Index. In the World Economic Forum's Human Capital Index, in 2015 Pakistan ranked 113 out of 124 countries. All of the countries ranked below it were in sub-Saharan Africa, apart from Yemen. Educational statistics for Pakistan show a dismal picture; not only are enrolment rates low, but Pakistan's completion rates for primary education are amongst the lowest in the world.

The devolution of power to the provinces through the 18th Constitutional Amendment passed by the National Assembly in 2010 increased provincial authority and reshaped federal-provincial relations. The necessary adjustments are still taking place.

Pakistan was a signatory to the Millennium Development Goals (MDGs), and is a signatory to the new Sustainable Development Goals (SDGs). Progress was made in meeting the MDGs, but in 2013 it was on track to meet the targets for only 10 of the 34 indicators on which it reports progress. Aside from the lack of in-built robust frameworks for monitoring and evaluation, a more basic cause of failure was that many of the goals adopted in the first place were unrealistic. The Pakistan government is giving great importance to meeting the SDG targets. Other targets committed to by Pakistan include a pledge at the London Summit on Family Planning in 2012 to work towards achieving universal access to reproductive health and increase the contraceptive prevalence rate to 55% by 2020 (later revised downward to 50%).

Population Dynamics and Sexual and Reproductive Health in the Context of Economic and Social Processes

Among the major countries of Asia, Pakistan is an outlier in terms of demographic transition. Its transition was considerably delayed by the slow onset of fertility decline. Over a long period – from the late 1960s to the late 1990s – the rate of population growth was barely below 3% per annum. It is therefore not surprising to find that Pakistan's population grew by 3.3 times between 1970 and 2015, a considerably greater increase than India (2.4 times), Bangladesh (2.5 times) or Indonesia (2.2 times) over the same period. Between 1990 and 2015, the number of children aged 0-15 in Pakistan increased by 43%, compared with 14% in India, 6% in Bangladesh and 8% in Indonesia.

Pakistan's demographic disadvantages, stemming from its delay in reducing fertility rates, are of three kinds. First, a higher population growth rate, requiring expansion of infrastructure and services to serve a higher population. Second, a higher growth rate of the school-aged population, making it harder to achieve educational goals. Third, a less favourable age structure for economic development, with a

smaller share of the population in the working-age groups. To make matters worse, a low percentage of women in the workforce reinforces the disadvantage of the smaller share of population in the working-age groups.

Happily, once fertility finally started to decline significantly, Pakistan began to experience a demographic dividend, which will continue longer into the future in Pakistan than in countries where the fertility decline set in much earlier. This is hardly much compensation, however, for the greater burden of a large poorly educated cohort of young people in the early 21st century who will still be in the workforce in mid-century. Massive further population growth in Pakistan is certain, because of population momentum: an age structure conducive to further growth, irrespective of what happens to fertility. The official projections show an increase of 72.6 million in the 2015-2035 period, or 37.4 per cent.

The contraceptive prevalence rate in Pakistan was only 35% in 2012-13, far below the rates in Bangladesh, India, Iran and Indonesia at the same time, which were all 50% or above. This does not reflect a lack of need for contraception; the unmet need for family planning (measured as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception) is 20 per cent of married women of reproductive age, one of the highest in Asia. Unmet need is also indicated by the estimate that 2.25 million induced abortions were performed in 2012.

Pakistan has seen considerable improvements over time in the proportion of deliveries taking place in a health facility, and this is reflected in a decline in the maternal mortality ratio (MMR), though it did not reach the target level. The infant mortality rate remains disturbingly high – double the rate in Bangladesh and almost 3 times the rate in Indonesia. The health system's strategy in lowering maternal and infant mortality has been appropriate, except for one blind spot – lack of recognition of the important role of family planning in lowering infant and maternal mortality.

Adolescents and youth are very large groups in Pakistan, and face major problems and frustrations. They lack opportunities in two crucial areas: employment and education. The problem for young girls is particularly acute, as their participation in employment is limited by cultural, religious and traditional norms. Youth in Pakistan face particular problems in accessing sexual and reproductive health information and services.

Pakistan's poor record in the social sectors has a number of root causes. One is the low level of public expenditure on health and education. The ratio of health workers to population is well short of the minimum threshold according to the WHO, and the balance between doctors, nurses and midwives is skewed, with insufficient nurses and midwives. Bureaucratic structures have also played a negative role in preventing effective provision of reproductive health and family planning services, with parallel health wings and population program wings in the Ministry of National Health Services at the national level and separate Departments of Health and of Population Welfare at the provincial level. In the provision of health services, reproductive health has received insufficient attention; and in the provision of reproductive health services, family planning has received insufficient attention.

There is a long list of shortcomings in the family planning program in Pakistan, ranging across financing issues, contraceptive availability, programme management impediments, budgetary inefficiencies, poor program monitoring, diluted focus of community workers on family planning, and neglect of demand generation and social mobilization. Action needs to be taken on a number of fronts simultaneously if the momentum of the family planning program is to be stepped up.

A number of innovative approaches have been tried in Pakistan in efforts to find ways to increase the

contraceptive prevalence rate in areas lacking health facilities. Projects such as the FALAH project, the MARVI Programme an urban slums project in Karachi and demand-side financing projects show potential to raise contraceptive prevalence rates among unserved or under-served populations. The main issue is how to scale up effective small-scale programs into programs with a broader impact.

Settlement patterns and population mobility

Internal migration plays a key role in the nexus between population and development. Unfortunately, because of the failure to conduct a census since 1998, there is a serious lack of data for the analysis of migration patterns and trends. Migration trends in Pakistan are influenced not only by the universal desire to better a family's economic circumstances, but also by natural disasters and the effect of terrorism. There are 10 cities in Pakistan with populations exceeding one million, and such cities make up a larger share of Pakistan's urban population than is the case in most other Asian countries. While migration has contributed substantially to the growth of Pakistan's cities, it is important to note that even if there were no net migration at all, the very high rate of natural increase of urban populations would still be leading to the rapid growth of cities.

Pakistan is an important source of international labour migrants, predominantly males going to the Middle East. Recruitment procedures are frequently exploitative, and while labour migration contributes valuable foreign exchange, it entails considerable sacrifices of wellbeing of the workers concerned. The inability of Pakistan's economy to absorb its rapidly growing workforce is the root of the problem.

Emergency situations: natural disasters, armed conflicts, displacement

Natural disasters – floods and droughts – have set back development in Pakistan. Armed conflicts have displaced millions of people, particularly in KP, FATA and Baluchistan. Millions of refugees have entered Pakistan from neighbouring Afghanistan. All these crisis situations pose complex challenges in meeting the needs of those affected. Disasters normally have their biggest impact on the poor. In relation to reproductive health services, there is a need to prioritize a minimum initial service package. Preparedness is important if adequate responses are to be provided. In a situation of overall service deficiency across the country, difficult decisions must be made about the relative importance of overall service provision and emergency provision in crisis situations.

Inequalities and the exercise of rights

The trend in poverty appears to be one of Pakistan's "good news" indicators. Poverty levels have fallen substantially, the headcount poverty rate being 29.5 per cent in 2013/14. However, many people remain only slightly above the poverty line, vulnerable to falling into poverty. Pakistan's inequality of income is also very marked. When demographic and reproductive health indicators such as fertility rates, infant mortality rate, delivery by trained health personnel and unmet need for family planning are compared across population groups, there are typically sharp differentials according to urban-rural residence, geographic region, and educational and wealth status. The government of Pakistan sees public sector investment in health as a pro-poor endeavour, but government spending on health care is heavily tilted towards specialized hospital care, which is disproportionately utilized by the rich.

Pakistan ranks very poorly on the various indices giving a comparative picture of gender inequalities between countries. It is in second last place among 145 countries on the Global Gender Gap Index of the World Economic Forum. According to UNESCO's gender parity index in secondary education, it ranks ahead only of Afghanistan and Yemen among Asian countries. Gender-based violence is a serious issue in Pakistan. Happily, there have been some legislative advances in recent times, including anti-honour killings and anti-rape bills passed at the national level.

Enabling poor women to space and limit their births can be considered an important element of empowerment, benefiting their health, enabling them to raise their children in better circumstances, and giving them more opportunity to engage in economic activities.

HIV/AIDS and sexually transmitted infections (STIs)

HIV/AIDS levels in Pakistan are relatively low but are an increasing health concern. Pakistan's epidemic is primarily concentrated among two groups: injecting drug users (IDUs) with a national prevalence of 27.2% in 2011, and transgender (Hira) sex workers with a prevalence of 5.2%. The government's decentralized approach to HIV/AIDS control has become even more important since devolution.

Challenges

Among Asian countries, only Afghanistan, Iraq, Yemen and Timor Leste have higher fertility and rates of population growth than Pakistan. Pakistan's population has more than quadrupled since the initial implementation of family planning programmes and today, and human development indicators have been disappointingly slow to improve. The two are not unrelated. Low achievements in the reproductive health area have adversely affected Pakistan's ability to achieve its goals for human and social development.

Despite the initial recognition in the 1960s that rates of population growth were too high, and despite the massive population growth that has taken place, there has been little evidence of a sense of urgency in reducing population growth rates on the part of senior politicians or bureaucrats, at either the national or provincial level. The current Prime Minister has never stated publicly that lowering of the population growth rate is a priority area. Nor has any provincial Chief Minister or Chief of the Armed Forces. There are some small signs of change; in Pakistan 2025: One Nation – One Vision, the statement is made: "... other than oil-rich economies, no country has been able to break into the high-income club without a radical reduction in its population growth rate. ... (T)he need for lowering the growth rate of population in more urgent than ever." However, apart from that statement, there is no further attention to population issues in the document. Proof of serious intent must be the allocation of personnel and financial resources to the activities that will make a difference to population growth rates: in particular, education and health services, and family planning services. The Government has stated aims of drastically increasing the share of GDP going to both education and health (rising to 4% and 3% respectively, from recent levels of 2% and around 0.5-0.8% respectively). Time will tell whether these aims can be met.

The most desirable development scenario for lowering rates of population growth would be one in which the political, security and economic situation improved and a "virtuous circle" of developments including pro-poor economic growth; increases in the share of development expenditure on education and health, leading to rapid advances in child survivorship and in levels of education attained by young people; and expanded reproductive health services.

The population policies completed for KP and Sindh and nearly completed for Punjab, while they have an adequate focus on reproductive health and family planning, and on lowering population growth rates, do not set these within the broader human development and economic growth strategies that create the conditions conducive to having small families.

The reasons for very slow uptake of family planning in Pakistan are partly programmatic, but they include basic cultural and religious obstacles to the adoption of contraception. The message that there is no conflict between the practice of most methods of family planning, if done for the right reasons, and Islamic teachings, while widely recognized in most Islamic countries, has not been brought successfully

to the notice of ordinary people in Pakistan. A vibrant family planning program is hard to achieve in the face of hostility from much of the religious leadership and ambivalence among political and community leaders. However, the strength of these factors does appear to be weakening over time.

In terms of meeting unmet need for family planning, the following four areas seem particularly important:

1. Access to contraception is still a major barrier, particularly for the poor and uneducated, and those living in rural areas. More attention needs to be paid to delivery of family planning services by lower level service providers.
2. The family planning activities of Lady Health Workers need to be given higher priority in their work responsibilities.
3. Contraceptive discontinuation rates are disturbingly high, mainly because of method failure and side effects. Counselling about side effects is clearly deficient. The menu of contraceptives available through different outlets needs to be revised to enable wider choice, and more attention should be paid to male providers.
4. The role of the private sector needs to be promoted, by removing barriers to its effective involvement in supply of contraceptive advice and methods.

In reaching lower rates of population growth in Pakistan, educational development can be considered just as important as family planning programs. This is because there is a strong inverse correlation between women's education and their fertility rates. (The total fertility rate is 4.4 among women with no education, but 2.5 among women with higher education). But all levels of education are seriously lagging in Pakistan compared with its major competitor countries, and the male-female gap in primary and secondary education is particularly marked.

Opportunities

Despite the discouraging state of most indicators of human development in Pakistan, a strong drive to expand and streamline education and health systems could convert Pakistan's youth into a force for development as healthier and better educated young people are enabled to enter a labour market that offers them meaningful and remunerative employment. If real progress is made on these fronts, the specific aim of lowering fertility rates will to a large extent "look after itself".

What is needed now is a clear statement from the Prime Minister and Chief Ministers of the provinces of the need to lower rates of fertility and of population growth in Pakistan, in the interest of more rapid economic, social and human development. Technical capacity in the Planning Commission to conduct intensive analysis of population and development issues should be built up. Similar technical assistance should also be given to the provincial Departments of Planning. Demographic training and research needs to be built up in selected university centres and perhaps at PIDE. If the Population Census is successfully conducted in 2017, detailed analysis of migration patterns and of the situation of adolescents and youth in Pakistan should be conducted. If the Census does not take place, and even perhaps if it does, a major migration survey should be mounted, along with a survey on adolescents and youth. In order to focus attention on population-development linkages, a major study could be mounted, ideally under the auspices of the Planning Commission, entitled "Pakistan + 50", meant to emphasize that Pakistan's population is expected to increase by at least 50 per cent by the year 2050. Such a study would involve senior economists, demographers, sociologists and environmentalists.

As for programmatic developments to achieve population goals, these will need to involve focused targeting of increased health spending, following the ten-point priority agenda for Reproductive Health provided in the National Vision for Coordinated

Actions to Address Challenges of Reproductive, Maternal , Newborn, Child and Adolescent Health , and Nutrition, 2016-2025. Among other things, this priority agenda recognizes that family planning is one of the most cost effective interventions to reduce maternal and newborn deaths. The re-invigoration of the family planning campaign should focus on meeting the high level of unmet need for contraception. Meeting unmet need is an unambiguously positive and non-coercive way to link behavioural change that will benefit people as individuals and families with a broad macro-aim of lowering the fertility rate and the rate of population growth – which will also, through its positive macro-economic effects, benefit people as individuals and families. Specific recommendations for better meeting unmet need are given in the full PSA report.

The role of the UNFPA should be to take a strong advocacy role, constantly emphasizing to the government the importance of population-development relationships and stressing these to all agencies of government. It should assist the government to analyse population-development linkages, and assist in building up the capacity for quality research into these linkages. UNFPA should also take the lead role in coordination among donors in the population and development and RH/FP areas, helping to avoid duplication, linking the donors with government, and engaging in dialogue with government about the best way forward in the family planning area. Some specific suggestions for UNFPA involvement are listed in the full report.

2. INTRODUCTION: OBJECTIVES, BACKGROUND, GUIDING PRINCIPLES, SCOPE AND METHODOLOGY

UNFPA Pakistan is embarking on the development of the 9th Country Programme 2018-2022, which is expected to be aligned with the Third One UN Programme Pakistan (OPIII). As part of this preparation, it is considered that specific analysis is required of Sexual and Reproductive Health (RH) and population dynamics as they relate to development more broadly. This could be done in different ways. One would be to conduct a Population Situation Analysis, similar to those that UNFPA has prepared for many countries. These are massive reports, taking considerable time to produce (typically, between eight months and two years according to FAQs distributed along with the full Conceptual and Methodological Guide – see UNFPA 2013). UNFPA Pakistan took a different approach by commissioning a meta-analysis of the population and SRH situation in Pakistan. They opted for this approach because several thematic analyses of the relevant topics by various development partners already exist.

The primary purpose of the meta-analysis is (i) to assess the population and sexual and reproductive health dynamics, (ii) to analyse their inter-linkages with broad development issues and (iii) to provide a strong evidence-base for the development of a strategic and focused 9th Country Programme that responds to the needs, priorities and national development strategies of the country, within the framework of the UNFPA Global Strategic Plan. The intended audience and users of meta-analysis are the UNFPA Country Office, government counterparts in Pakistan, and other development partners.

The objectives of the Meta Analysis are:

- To synthesize the findings of existing assessments, reports and other documents and provide an integrated appraisal of sexual and reproductive health, population dynamics and their relationship with social, economic, political and cultural processes in the country.
- To examine, analyse and interpret from the existing assessments, key population and SRH challenges confronting the country, specifically on Adolescent Sexual and Reproductive Health (ASRH), Family Planning (FP) and Maternal Health (MH).
- To identify opportunities for action with strategies and programmatic recommendations for the 9th UNFPA Country Programme (CP9).
- To provide insights and specific recommendations on the strategic role UNFPA could play, taking into consideration UNFPA's niche and comparative advantage vis-à-vis other development actors.
- To make an analytical contribution from a population perspective to the upcoming OPIII.

The situation analysis was envisaged as a light version of what is outlined in UNFPA's Conceptual and Methodological Guide for Population Situation Analysis (UNFPA 2013). In terms of content and methodology, it therefore assumes the form of a meta-analysis, drawing from recent analyses, surveys and studies, and includes the following:

1. A meta-analysis of available assessments and surveys to provide a comprehensive overview of the situation in the country as it relates to PD and SRH (specifically FP, RH and ASRH), including progress in complying with international agreements and goals, particularly the MDGs and the ICPD Programme of Action.
2. An assessment of SRH and population dynamics in the context of economic and social processes
3. Assessment of existing mechanisms to

enforce/implement policies and decrees

4. Space for public-private partnerships and the role of the private sector and civil society organizations in service delivery
5. An assessment of inequalities based on socio-economic, geographical location, gender and ethnicity, demonstrating and contrasting situations that characterize these different groups in the country.
6. An analysis of the connections between population dynamics, gender and SRH (FP, RH and ASRH), and their actual or potential implications for public policies as they relate to reducing poverty and inequalities and guarantee human rights. This would include analysis at the micro level of how women's empowerment is linked to poverty reduction and to relevant SDGs demonstrating how RH and FP (e.g. through birth spacing and reduction of unwanted births) could contribute to poverty reduction. At the macro level, it would include analysis of how population growth, age structures and migration are linked to development and poverty reduction.
7. The identification and analysis of the main population and RH challenges confronting the country, including opportunities for action with strategies and programmatic recommendations (including actions in the short and medium term), taking into consideration the availability of resources, capacity and commitment.
8. Insights and recommendations for strategic interventions in the 9th CP, taking into consideration the strategic role UNFPA could play given its niche and comparative advantage vis-a-vis other development actors in Pakistan.

There were two broad steps to the process:

1. Meta analysis of various reports, documents, assessments and evaluations available in the country.
2. Consultations with interest groups, including the government and other stakeholders, both national and development partners, individually and as a group, to complement, validate and update the meta-analysis.

The exercise was conducted in close collaboration with the government and national stakeholders to ensure that the final product has the buy in of the government. A list of meetings attended by the consultant is appended to this report.

3. OVERVIEW OF PAKISTAN'S POPULATION AND DEVELOPMENT SITUATION

The economic context

The Pakistan economy is semi-industrialized, with the major centres of growth along the Indus River. The diversified economies of Karachi and Punjab's urban centres co-exist with less developed areas in other parts of the country, particularly in Baluchistan. Pakistan's estimated nominal per capita GDP in 2015 was USD1,513 and in PPP terms, USD4,744. According to World Bank categories, the country graduated from low income to lower middle income status in 2008.

Pakistan's economic growth since its inception has been varied. The average 5.2% economic growth over the period 1960-2010 could be considered respectable, but well below Pakistan's potential. According to Amjad and Burki (2015), the long-term problems have been high spending on defence, high population growth, neglect of human resource development, low savings rate and steady decline in governance. After the turn of the 21st century, a number of economic reforms took place, which lowered poverty levels, but the economy cooled again from 2007, and inflation reached 25% in 2008. Economic growth in 2009 and 2010 was very low, and though it has recovered to rates averaging slightly below 4 per cent per annum in the years 2011-2015, this relatively slow growth is certainly not high enough to provide good job opportunities for the massive numbers of young people entering the labour market. Pakistan's labour market is the 10th largest in the world, but many workers are forced to find work overseas, contributing an estimated USD15 billion to the economy through remittances.

The structure of the Pakistani economy is gradually shifting away from agriculture, which accounted for only 21% of the GDP in 2010. Even so, Pakistan produces more wheat than the whole of Africa. In terms of employment, agriculture employs almost half the labour force and is the largest source of foreign exchange earnings. Agricultural raw materials such as cotton (Pakistan is the world's 4th largest producer) and hides are an important component of the country's manufactured exports.

Manufacturing accounts for 19% of GDP and 13 per cent of total employment. Large scale manufacturing is dominant. The cement industry is growing rapidly, but the textile industry occupies a pivotal position, contributing 8% of GDP and employing about 15 million people or roughly 40% of the industrial labour force. Unfortunately, the textile sector has remained stagnant over the last decade. Textiles are sold mainly to China, USA and UK. China buys only cotton yarn and cotton fabric, whereas the USA imports mostly made up textiles. The services sector has a 58% share in GDP and provides a little over one third of total employment. It has emerged as the main driver of economic growth. Pakistan's IT sector is growing rapidly.

According to the World Bank (2016), “deep improvements in governance are needed to unleash Pakistan's growth potential”. Long-standing structural constraints continue to hinder economic growth, while the greatest emerging constraint on economic growth is massive cuts in availability of electricity (World Bank, 2014). Pakistan has not invested in electricity generation capacity to keep up with growth. Severe institutional shortcomings also constrain electricity supply. Large investments are needed in power generation, and the huge power subsidies must be cut. The government has initiated a plan to phase out these subsidies, targeting them toward the poorest and most vulnerable.

The security environment and the law and order situation in Pakistan remain volatile, discouraging private and foreign investment. Productivity at all levels is low; in agriculture, there is low water productivity, and the highly protectionist agricultural

trade policy stifles competition and innovation. Overall, Pakistan has the lowest labour productivity among its regional competitors, corruption is generally perceived to be widespread,[1] and the country is highly vulnerable to shifting climatic patterns.

Yet according to the World Bank, Pakistan also has several opportunities. Its rich natural resource base (massive reserves of coal and natural gas, and considerable unexploited hydroelectric potential) and strategic location can be exploited for development, particularly if regional economic cooperation can be increased. The large share of the informal economy in the national economy, while reflecting low productivity, does make for economic resilience. Large remittances from foreign workers raise consumption among the rural poor, help reduce income inequality, and contribute to housing improvements, primary school enrolment and investments by small businesses.

The socio-cultural context

Civil society in Pakistan is largely hierarchical, emphasizing local cultural etiquettes and traditional Islamic values that govern personal and political life. The extended family is the basic family unit, although there has been a growing trend towards nuclear families for socio-economic reasons. Consanguineous marriage is favoured, and in 2012 more than half of all marriages (56 per cent) were between first and second cousins. This is probably the highest rate of consanguinity of any major country. First cousin marriages are much more prevalent in rural areas (54 per cent) than in urban areas (38 per cent), among women with no education (53 per cent) than among those with more than a secondary education (33 per cent), and among those in the lowest wealth quintile. The proportion of marriages between first cousins has fallen slightly between 2006 and 2012.

Though many prominent women can be cited in Pakistani history, including Benazir Bhutto as Prime Minister, the status of women in Pakistani society remains highly problematic. In 2014, the World Economic Forum ranked Pakistan as the second worst country in the world in gender equality, ranking near the bottom of the world's countries on indicators such as women's health and survival, women's educational attainment and equal economic participation and opportunity. Pakistan's per capita economic output is held well below that of comparable (and competitor) countries by the fact that only 22 per cent of women participate in the labour force. Girls lag behind boys in educational enrolment ratios to a greater extent than in most South Asian countries (and of course South Asia lags behind other world regions in this respect). In Pakistani society as a whole, women are considered subordinate to men, and are assigned gender roles in the domestic sphere, while men are considered the breadwinners and decision makers in the family. While some changes are taking place, with some women in urban areas taking up professional roles and contributing to family economics, not only does the proportion of women working outside the home remain small but also the fields of work open to them remain very restricted.

Social and religious norms and traditions are powerful reasons for women's exclusion and lack of empowerment in Pakistani society, particularly in poor and rural areas. Lack of government resources for tackling the issues, high poverty levels and low levels of literacy all result in a society in which few women are aware of their rights, and where the implementation and enforcement of reforms required to improve their situation is difficult to achieve.

The situation of women in society is highly relevant to devising appropriate strategies for raising the low contraceptive prevalence rate and meeting the high

1. In 2015, Pakistan ranked 117 out of 175 countries covered by Transparency International's Corruption Perceptions Index. This was a considerable improvement over its average ranking of 138 for the same index over the 2006-2012 period.

level of unmet need for family planning in Pakistan. Strategies need to be found that will overcome the constraints on women taking independent action in matters such as visits to medical facilities and practice of contraception, and ways must also be found to raise the understanding of men and enlist their support for their wives and daughters in these matters that are so crucial for women's and family welfare.

The human development context

Pakistan's key dilemma was clearly stated by the Minister for Planning, Development and Reform, Prof. Ahsan Iqbal, in his Prelude to the document Pakistan 2025: One Nation – One Vision, when he wrote "In terms of economic indicators, Pakistan is a middle income country but in social indicators it falls amongst the least developed countries".

Table 1 shows a number of human development indicators for Pakistan, compared with its two large South Asian neighbours – India and Bangladesh – and Indonesia, another large Muslim-majority country. While Indonesia is considerably more prosperous, and scores well above these South Asian countries on most indicators, Pakistan, India and Bangladesh have similar per capita GDP. Even so, on most of the indicators in the table, Pakistan scores well below the other countries.

Pakistan ranks 147 out of 188 countries on the 2015 Human Development Index. Most indicators are lower than for most countries of South Asia; this is true for educational development. In the World Economic Forum's Human capital index, in 2015 Pakistan ranked 113 out of 124 countries. All of the countries ranked below it were in sub-Saharan Africa, apart from Yemen.

Table 1. Pakistan, Bangladesh, India and Indonesia: income, mortality, health and education indicators.

	Pakistan	Bangladesh	India	Indonesia	Vietnam
Per capita GDP (USD)	**1,429**	1,212	1,582	3,346	2,111
Human Development Index 2015 (rank)	**147**	142	130	110	116
Human Capital Index 2015 (rank)	**113**	99	100	69	59
Infant mortality rate	**66**	31	38	23	18
Maternal mortality rate	**178 (111-283)**	176(125-280)	174(139-217)	126(93-179)	54(41-74)
% of deliveries in health facility	**48**	37	39	63	n.a.
% of births attended by trained personnel	**52**	42	47	83	n.a.
% of children aged 12-23 months fully vaccinated	**54**	84	44	66	n.a.
Net enrolment rate, primary education, 2013	**72**	95	92	90	98
Net enrolment rate, secondary education, 2013	**41**	53	62	75	n.a.

Source: DHS surveys, around 2012, except for India (2005-6); per capita GDP from World Bank (for 2015); enrolment data from UNESCO; MMR estimates for 2015, from W.H.O. et al., 2015.

Educational statistics for Pakistan show a dismal picture; not only are enrolment rates low, but Pakistan's completion rates for primary education are amongst the lowest in the world. There are poor teaching and learning outcomes, infrastructure is inadequate, and gender imbalances are far from being eliminated. The latest official Pakistan Economic Survey mentions "stagnant allocations at 2.0 percent of GDP; shortage of schools especially for girls in remote and far flung areas; shortage and absenteeism of teachers; lack of trained teachers, especially female teachers; missing facilities such as water, toilets and boundary walls; weak supervision and monitoring; and a host of factors such as conservative and tribal culture; insecurity and lawlessness; and poverty, compelling a large number of children to work rather than to attend school".

In the 60-year period following 1950, Pakistan's literacy rate increased only from 16 per cent to 55 per cent. The majority of Pakistan's population was uneducated until the 21st century, and this was the case for two thirds of women as late as 2006. Of course, literacy rates for the entire adult population cannot be increased very rapidly, because of the high proportion of unschooled among older adults. Focus needs to be on educational progress among younger cohorts. Here, the picture is somewhat better. Educational attainment is considerably higher among adolescents and younger adults than at older ages, and it is rising over time. For example, according to the UNESCO statistical database, in Pakistan the gross enrolment ratios in secondary education rose between 2006 and 2010 from 36 per cent to 46 per cent for males and from 28 per cent to 33 per cent for females. Nevertheless, such improvements left Pakistan well behind major competitor countries, where on the whole, educational advances have been more rapid. Thus in Bangladesh, for example, the male enrolment rate rose from 45 per cent to 56 per cent over the same period, and the female rate from 47 per cent to 61 per cent; and in Indonesia from 62 per cent to 83 per cent for males and from 63 per cent to 81 per cent for females – an increase of roughly 20 percentage points for both, compared with Pakistan's 10 points for males and 5 points for females.

The educational attainment of Pakistan's working-age population has been gradually improving. In 1981, two thirds of males aged 20-64 had no education, and 88 per cent of females. By 2006-7, the proportion of males with no education had fallen to one third, and the proportion of females to 64 per cent. This improvement, however, left Pakistan with a workforce ill fitted for employment in the higher-productivity occupations that the country needs to foster as it seeks to raise economic wellbeing and compete effectively in the international marketplace. The economic burden of carrying so many poorly educated workers far into the 21st century is a heavy one.

In the field of public health, Pakistan's record is also poor. While more will be written on health services below, it is significant that when compared with other countries with much the same level of per capita income as Pakistan, the infant mortality rate is considerably higher in Pakistan. As shown in Table 1, though, Pakistan is ahead of both Bangladesh and India in the percentage of deliveries taking place in health facilities and attended by trained personnel (though the Indian data are for 2006-7, and indicators were probably considerably better by 2012). But although slightly ahead of India and Bangladesh on these indicators, it is still highly unsatisfactory to have only half of deliveries taking place in health facilities and attended by trained personnel.

The political and institutional context with special reference to the 18th constitutional amendment

The year 2013 was a landmark year in Pakistan's history, witnessing the first democratic transfer of power in 65 years upon completion of a full term by an elected government. A government led by the Pakistan Muslim League-Nawaz came to power at the national level. This party also retained control in the largest province, Punjab. This election brought a strong mandate for change, though many obstacles remain.

A second key political change was the devolution of power to the provinces. The 18th Constitutional Amendment passed by the National Assembly on April 8, 2010, increased provincial autonomy and reshaped federal-provincial relations. A total of 43 departments in 18 ministries were abolished in 2011/12 and transferred to the provinces, while a new resource redistribution formula shifted greater funding to the provinces. The provinces' taxing powers were expanded, including a sales tax on services; and internal and external borrowing by provinces was permitted. Devolution was brought in very quickly, with arrangements in areas such as education and health services being completed within 3-4 months, despite the complexities involved, which really required a longer lead time to sort out the issues involved.

In some other countries, devolution of power has proven to be a double-edged sword in terms of its effects on population-development planning and the development of reproductive health programs. The potential benefit of bringing planning and revenue raising closer to the people most closely affected can be eroded by a weaker planning infrastructure, less understanding of the issues that had been gradually understood and integrated into planning at the national level, and lack of evidence that corruption lessens in a devolved system.

Devolution of power in Pakistan has been too recent to have allowed time for all the necessary adjustments to take place. In the meantime, an attitude of suspicion and confrontation towards central government is observable amongst many politicians and bureaucrats from the provinces, which can prove to be a barrier to effective cooperation and the harnessing of the capacity of both federal and provincial governments in the interest of socio-economic development.

Progress in complying with international agreements and goals

Pakistan is signatory to many international agreements and goals: for example, it signed up for the Millennium Development Goals, and is a signatory for the new SDGs; and it was a signatory to the ICPD Programme of Action. It is of course easy for countries to state acceptance of objectives and targets as agreed in such documents, but the key proof of serious intent is to show evidence of significant progress toward meeting the targets. When the spotlight of evident progress is shone on Pakistan's commitments, the picture is a mixed one: progress has been made, but in 2013, Pakistan was on track to meet the targets for only 10 out of the 34 indicators on which Pakistan reports progress (Planning Commission, 2013). Most of the population-related targets were far from being reached. This applied to: the under-5 mortality rate; the infant mortality rate; full immunization of children aged 12-23 months; immunization of less than one-year olds against measles; the coverage of Lady Health Workers; the maternal mortality rate; the proportion of births attended by skilled birth attendants; and the contraceptive prevalence rate (a CPR of 55% was supposed to be reached by 2015!); and the percentage of women giving birth who had at least one antenatal consultation.

As noted in the Pakistan Millennium Development Goals Report 2013, there was a common thread of weakness in many of these policies and programs. Most of them lacked in-built robust frameworks for monitoring and evaluation during implementation. Any need for mid-way course correction and fine tuning of interventions from lessons learned became administratively and politically difficult. This general conclusion certainly applied to the policies and programs aimed at stabilizing the population growth rate.

But the failure of Pakistan to achieve the population-related MDGs has a much more basic cause than the inability to fine tune interventions as evidence of diversion of results from goals becomes evident. The key problem was that the goals adopted in the first place were unrealistic. As discussed by Akhtar (2015), Pakistan adopted the United Nations MDG goals as

national goals, without adaptation to Pakistan's human or financial capacity. While goals no doubt need an element of ambition and optimism in order to galvanize planning authorities, they need to be grounded in reality to some extent.

The SDGs are a far more complex set of goals than the MDGs, and there is considerable interaction between them. The Pakistan government is giving great importance to meeting the SDG targets. It has established an SDG unit within the Planning Commission, not only at the national level, but also within the provincial Planning Departments.

Examining the SDGs from a population policy perspective, it is clear that there is complex interaction between many of the variables targeted, and that these variables will, separately and in combination, impact population growth and in turn be impacted by population growth. For example, the targets in the health, education and women's empowerment areas are all likely to affect fertility rates. In the reverse direction, managing population dynamics effectively has positive sustainable development outcomes, in social, economic and environmental terms – outcomes which should assist in achieving targets in SDG 1 (poverty), SDG 11 (sustainable cities), SDG 7 (energy), SDG 8 (productive employment), SDG 10 (inequality), SDG 13 (climate change), and SDG 15 (sustainable ecosystems). (see Akhtar, 2015).

Another case where the Government of Pakistan made international commitments was at the London Summit on Family Planning in 2012. At this summit, Pakistan pledged to work towards achieving universal access to reproductive health and increase CPR to 55 per cent by 2020. Provincial Governments were not comfortable with targets as they considered them to be over ambitious given the level of resources available and therefore, revised the targets down which resulted in lowering CPR target from 55 per cent to 50 per cent by 2020. While this might be considered a back-down, it can actually be viewed positively in that it probably reflected a more considered judgement by the provinces about what they could achieve, rather than merely plucking a national figure out of the air, and hoping that the provinces would manage to achieve the CPRs required to make it happen.

4. POPULATION DYNAMICS AND SEXUAL AND REPRODUCTIVE HEALTH IN THE CONTEXT OF ECONOMIC AND SOCIAL PROCESSES

Fertility trends, projections of population growth and the demographic dividend

Pakistan's socio-economic development has been hindered in comparison with that of other Asian countries by its demographic trends, particularly the sustained high level of fertility for a much longer period than in most of its neighbouring countries. Briefly described, as elsewhere in South Asia, sharp declines in mortality rates after 1950 led to an upsurge in rates of population growth. Mortality rates continued to decline steadily in Pakistan after the 1980s, though infant and childhood mortality rates remain substantially higher than in countries such as India, Bangladesh and Indonesia, where fertility decline set in much earlier than in Pakistan. Concern by parents about child survival can of course be one factor delaying fertility decline, though the mortality differential with other countries was not enough to explain much of the delay in initiating fertility decline in Pakistan. In any event, the delay in the onset of fertility decline led to the gap between birth and death rates in Pakistan becoming very wide, and as a result, Pakistan has had to cope with much more population growth than these other countries.

The fact is that for a long period in Pakistan – from the late 1960s to the late 1990s - the rate of population increase was barely below 3 per cent per annum. A rate of growth of 3 per cent per annum doubles the population in 23 years. So it is not surprising to find that Pakistan's population grew by 3.3 times between 1970 and 2015, a considerably greater increase than India (2.4 times), Bangladesh (2.5 times) or Indonesia (2.2 times) over the same period. But the even more significant comparison is the more recent growth - between 1990 and 2015. India, Bangladesh and Indonesia had all experienced significant fertility declines by 1990, which served to dampen subsequent population growth, whereas Pakistan's TFR in 1990 remained at a very high level – 6 children per woman. (It then began to decline and the 2012-13 DHS showed it had reached a level of 3.8 children per women by around 2010-11.) So whereas Pakistan's population grew by 76 per cent between 1990 and 2015, those of India, Bangladesh and Indonesia grew by 51 per cent, 52 per cent, and 42 per cent respectively over the same period. And a country where fertility declined even earlier – Thailand - saw an increase of only 20 per cent between 1990 and 2015.

Pakistan's demographic disadvantages did not end there. Countries where fertility declined earlier experienced significant changes in their age structure, with slow growth in the number of child dependants and continuing rapid growth in the working-age population. This increase in the share of the population in the working-age groups is often referred to as a “demographic bonus”. If effective advantage is taken of this bonus, through emphasis on educating the more slowly growing number of young people and providing employment for the rapidly growing workforce, the benefits for economic development are substantial – explaining as much as 30 per cent of all growth in the case of the East Asian countries, according to some estimates.

Unfortunately for Pakistan, this demographic bonus was postponed because of continuing high fertility. Between 1990 and 2015, the number of children aged 0-15 in Pakistan increased by 43 per cent, compared with 14 per cent in India, 6 per cent in Bangladesh and 8 per cent in Indonesia. Pakistan found it difficult to educate this growing number of children; the primary and secondary school enrolment ratios increased only slowly in Pakistan, whereas Bangladesh and Indonesia achieved much faster increases. Thus the young people entering the workforce were on average more poorly educated in Pakistan than they

were in the other countries. These young cohorts in Pakistan also had difficulty in finding work; as noted by the Labour Force Survey, 35 per cent of 15-19 year olds, 52 per cent of 20-24 year olds and 58 per cent of 25-29 years olds are engaged in some form of employment but most of them do not have proper skills, opportunities and choices to opt for decent professions (Pakistan Bureau of Statistics, 2014).

There was one more adverse factor weighing on economic growth in Pakistan – namely, the very low participation of women in economically productive activities. Only 22 per cent of Pakistani women are in the workforce, so the overall labour force participation rate at ages 15-64 is well below that in many countries.

To summarize: Pakistan's demographic disadvantages, stemming from its delay in reducing fertility rates, are of three kinds. First, a higher population growth rate, requiring expansion of infrastructure and services to serve a higher population. Second, a higher growth rate of the school-aged population, making it harder to achieve educational goals. Third, a less favourable age structure for economic development, with a smaller share of the population in the working-age groups. To make matters worse, a low percentage of women in the workforce reinforces the disadvantage of the smaller share of population in the working-age groups.

A silver lining on this demographic cloud is that once fertility finally started to decline significantly, this began to usher in the era of the demographic bonus, which will continue further into the future in Pakistan than in countries where fertility decline set in earlier. This is hardly much compensation, however, for the greater burden of a large poorly educated cohort of young people in the early 21st century who will still be in the workforce in mid-century, still weighing negatively on overall productivity of the Pakistan economy.

How much is population expected to increase in Pakistan over the coming decades? An infinite number of projections can be carried out, with varying assumptions. The United Nations Population Division's medium projection for Pakistan in the year 2050 is 309.6 million. However, the Population Division now includes probabilistic projections amongst its projections of population for member countries. For Pakistan, the projected figure for 2050 ranges between about 270 million and 340 million if an 80 per cent confidence interval is used, or between about 260 million and 355 million using a 95 per cent confidence interval.

The official projections for Pakistan do not go as far into the future as 2050. The most recent set, prepared in 2016, end in 2035, while the previous set (prepared in 2009) ended in 2030. Because of slower fertility decline than had been expected, the recent projections had to adjust fertility trends and projections, and as a result the projected population in 2030 was raised by 15.1 million compared with the figure in the earlier set of projections. The new projections give a figure of 267.4 million in 2035, slightly higher than the United Nations medium projection figure for 2035 (262.1 million). The projected increase over the 2015-2035 period in the new official projections is 72.6 million or 37.4 per cent (see NIPS 2016).

What is certain is that Pakistan still faces massive population growth. Importantly, population momentum will drive growth forward, irrespective of what happens to fertility. By population momentum, demographers refer to the effect of the young age structure, which is the result of high fertility and rapid population growth in recent decades.

The effect of population momentum is shown in a projection by Bongaarts, Sathar and Mahmood (2013). In their standard projection, in which fertility declines gradually from 2010 onwards, the population increases from a baseline 174 million to 302 million by 2050. In the other projection, fertility is assumed to decline immediately to replacement level in 2010. This projection, which removes the effect of high fertility after 2010, still yields a population of 264 million in 2050. So even with an instant attainment of replacement fertility, the population would grow by 53 per cent over the four decades, or by 92 million. Well over half of all population growth over the period is attributable to the momentum inherent in the population's young age structure. **Population momentum is an unavoidable fact of life, indelibly imprinted on Pakistan's age structure.**

Determinants of fertility: marriage patterns and adolescent fertility, trends in contraceptive prevalence, unmet need for family planning.

While female marriage on average in Pakistan is not as early as in Bangladesh, it still adheres to the South Asian norm of very early marriage. According to the Pakistan Demographic and Health Survey 2012-13, 8 percent of women aged 15-19 are already mothers or pregnant with their first child; 35 per cent of women aged 25-49 were married by age 18. Early pregnancy is common among the early-marrying group, and it is correlated with poverty, illiteracy and lack of understanding of sexual and reproductive health matters. Use of any contraception is only 10 per cent among married women aged 15-19, and use of modern methods only 7 per cent.

The contraceptive prevalence rate in Pakistan has increased gradually over time – from 12 per cent in 1990-91 to 30 per cent in 2006-07 and 35 per cent in 2012-13. For modern methods, the rate has climbed from 9 per cent to 22 per cent to 26 per cent over the same periods. However, this is far below the rates for modern methods attained in Bangladesh, India, Iran and Indonesia at roughly the same time (2012) – 52 per cent, 49 per cent, 57 per cent and 58 per cent, respectively.

The low rates of contraceptive use do not reflect a lack of need for contraception. The proportion of women in Pakistan who have an unmet need for family planning (measured as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception) is one in five (9 per cent with a need for spacing births and 11 per cent for limiting births). This rate is one of the highest in Asia.

Another indicator of the need for contraception in Pakistan is the high rate of induced abortions. It is estimated that 2.25 million induced abortions were performed in 2012 (i.e. 50 per 1,000 women aged 15-49). A total of 623,000 Pakistani women were treated for complications resulting from induced abortions, the vast majority of which were performed by unqualified people or involved traditional methods. These are very disturbing figures, and given that resort to abortions of this kind is very much a “last resort”, they provide clear supporting evidence of high levels of unmet need for family planning. On the positive side, the availability of these estimates and publicity given to them undermined the tendency to avoid discussion of induced abortion, and forced government to take the issue more seriously.

The low contraceptive prevalence rate in Pakistan can be related to the low level of education. Throughout the world, highly educated women tend to be at the forefront of fertility declines. In Pakistan, the 2012 DHS shows that TFR decreases consistently and dramatically from 4.4 among women with no education to 2.5 among women with a higher education. The problem is that women with no education are a larger share of the population in Pakistan than in most Asian countries, indeed than in most South Asian countries. Raising levels of education, especially for women, can play a crucial role in the speedy reduction of fertility rates.

Changes in the situation of SRH; relationship between SRH and maternal and infant mortality

Table 1 gave some figures related to reproductive health: the percentage of deliveries taking place in a health facility, and the percentage of births attended by trained personnel. Interestingly, Pakistan scored better on these indices than Bangladesh or India, although the Indian data were for an earlier year, and the figures had no doubt improved considerably over

time. On the other hand, in Pakistan the percentage of children aged 12-23 months who were fully vaccinated is well below that in Bangladesh, and the 44 per cent prevalence of nutritional stunting among children under 5 is unchanged since 1965.

Pakistan has certainly seen substantial improvements over time in the proportion of deliveries taking place in a health facility. In 1990, such deliveries were only 13 per cent of the total, a figure that rose to 34 per cent by 2006 and to 48 per cent by 2012. Conversely, the percentage of deliveries that took place at home fell from 85 per cent to 65 per cent and 52 per cent over the same periods of time.

The usually expected differentials were evident in these variables: deliveries were more likely to take place in a health facility and to be attended by trained personnel if the mother was living in an urban area, was better educated and was in a higher wealth quintile. Younger mothers and those at lower birth orders were also more likely to deliver in a health facility and be attended by trained personnel. As for antenatal care (ANC), the differentials by wealth quintile are very sharp: ANC in the richest quintile is nearly double that in the poorest quintile (97 per cent versus 51 per cent).

According to the most widely accepted international comparative estimates, Pakistan's maternal mortality ratio (MMR) has declined from about 431 per 100,000 live births in 1990 to 178 in 2015, a decline of 59 per cent (WHO et al., 2015). The average annual change is 3.5% per annum, but given the uncertainty in measuring MMR, the confidence range for this latter figure is between 1.8% and 5.1%. While Pakistan has clearly been making progress, it did not reach the proposed target of 140 by 2015. An estimated 8,000 Pakistani women die every year from pregnancy-related causes. There are wide variations between provinces, with MMR being lowest in Punjab (227) and highest in Baluchistan (785), according to the 2006-7 DHS. As for infant mortality, as shown in Table 1, the rates remain disturbingly high – double the rate in Bangladesh and almost 3 times the rate in Indonesia.

The health system's strategy in lowering maternal and infant and child mortality has focused mainly on increasing women's access to antenatal and obstetric care, improving nutrition, expanding immunization, and ensuring treatment for two major child killers, diarrhoea and pneumonia. The introduction of community midwives in 2007-08 to increase access to safe delivery was an important initiative, though the numbers trained and deployed so far are too few to make a great deal of difference. To improve emergency obstetric and newborn care (EmONC) services at the community level, the Punjab government set the target of equipping 30 per cent of Basic Health Units and upgrading two Rural Health Centres in every district and currently 30 per cent of BHUs are functional and providing 24/7 basic EmOC services.

While these are all appropriate interventions, there has been one blind spot in the approach, which is the lack of recognition of the role of family planning in lowering infant and maternal mortality. It is estimated that between 1990 and 2010, contraceptive use has accounted for about 40 per cent of the reduction in maternal deaths in developing countries, and if all the unmet need for contraception in the world were met, a further 30 per cent reduction in maternal deaths would be achieved (Cleland et al., 2012). Specifically for Pakistan, Ahmed et al. (2012) estimated that family planning averted 42 per cent of maternal deaths in 2008. Birth spacing is one of the strongest interventions to improve child survival rates. According to Rutstein (2008), birth intervals of 33 months would reduce the under-5 mortality rate by 13 per cent, and in Pakistan, neo-natal, infant, and child mortality are almost halved when birth intervals are 4 years or more, compared to when they are less than 2 years.

It is important to understand the strong link between high maternal mortality and low utilization of family planning services. The exposure to an unwanted pregnancy exposes more women to the risks

attendant on childbearing. Not only this, but there is often a direct link between a woman's reluctance to undergo another pregnancy and a health risk from that pregnancy. The point is that the reason why the pregnancy was unwanted may frequently be the mother's lack of full recovery from a prior pregnancy, or her reluctance to face another pregnancy if she is experiencing health difficulties. If such women have to have to undergo the pregnancy because of the failure of reproductive health services to enable them to use contraceptives directly raises the risk of a maternal or infant death. Post-partum family planning services are greatly needed, both for this reason and also to improve health of mother and baby.

The evidence is clear: family planning, in particular meeting the unmet need for contraception, should be a key weapon in the armoury to fight maternal and infant mortality in Pakistan.

Emergence of adolescents and youth as a priority group

The discussion in this section will focus on adolescents (age 10-19) and youth (age 15-24 according to the United Nations; 15-29 according to the Pakistan government). The median age of Pakistan's population is 22, one of the youngest in the world. Following declines in fertility, the proportion of the youth population has recently begun to decline, though it is still growing rapidly in absolute numbers. Youth face unique issues in Pakistan. In a hierarchical culture where age seniority counts for much, the ability of youth to speak out on issues that concern them is limited. This is particularly the case for adolescent girls. Yet values and norms are not static among young people, who face multiple and often conflicting social identities. Youth must still contend with traditional pathways of transitioning to adulthood, limiting their empowerment.

Pakistan 2025: One Nation – One Vision clearly expresses the concerns that government and ordinary Pakistanis feel about the situation of youth in Pakistan, when it states (p. 37): "A large set of Pakistani youth is dissatisfied, frustrated and in a state of disarray due to low education levels and large scale unemployment. This has led to serious social problems including drug abuse, crime, mental disorder, terrorism and religious fanaticism. … The Government of Pakistan is committed to addressing this situation through major investment in youth".

Youth in Pakistan face a lack of opportunities in two crucial areas: employment and education. The rate of youth unemployment is not exceptionally high in Pakistan, but the numbers of unemployed youth are large because of the age structure. Pakistan's Planning Commission estimates that in order to productively absorb the large number of youth entering the labour market, Pakistan's real GDP need to grow at an annual average rate in excess of 7 per cent – considerably higher than has been achieved in recent times. For young people, access to employment opportunities has implications not only for improvement in their material situation, but also for their transition to adulthood and sense of belonging and of social cohesion. As for education, poor quality and low enrolment ratios limit opportunities for youth. The high proportion of Pakistan's young people who are uneducated and without vocational skills are unlikely to end up in other than elementary occupations, with little chance of raising their incomes or moving into more productive occupations. The problem for young girls is particularly acute, as their participation in employment is limited by cultural, religious and traditional norms.

The difficult competitive situation facing youth in Pakistan can be illustrated by comparing the net enrolment ratios at lower secondary school level between Pakistan and other countries which can be considered its competitors in attracting international firms and competing in export markets. Taking India, Bangladesh, Indonesia and Vietnam as key countries with which Pakistan has to compete, the enrolment rates from UNESCO data are all roughly the same in India, Indonesia and Vietnam (around 85 per cent),

slightly lower in Bangladesh (77 per cent) but much lower in Pakistan (52 per cent). Young people in Pakistan are simply not getting as much education as they are in the other countries. Quality of education is of course as relevant as enrolment ratios, and while there is little comparative evidence to go on, it is unlikely that Pakistan would stand up very well in this comparison either.

A British Council report (British Council Pakistan 2009) documented several concerns commonly expressed by young people in Pakistan. About 92 per cent believed improving the educational system is an important issue. Almost 50 per cent believed they lacked the skills needed by the modern labour market and many expressed their inability to find an opportunity to gain essential skills. Those who were qualified struggled to find decent employment while battling discrimination and corruption. There was a sense of injustice and hopelessness: only one in ten expected an improvement in the near future.

Youth in Pakistan face particular problems in accessing sexual and reproductive health information and services. Talking about sexuality and reproductive health issues is difficult in Pakistan's socio-cultural milieu, and although youth are included in health strategies, sex education or youth-friendly health services are rarely provided. NGO-led life skills-based education initiatives have received recognition in-country, but programmes could not be institutionalised in the education systems. Since progress on these fronts is likely to be slow, alternative strategies are needed. In focus group discussions with 377 young boys and girls, youth in Pakistan express the desire to be provided family planning information, if possible privately, preferably through the internet, social media and mobile voice messages including videos or pictures for the uneducated (Population Council, 2016: xvi).The internet certainly has great possibilities in this regard, and social media is increasingly used by young people, though boys tend to have readier access than girls (Sathar et al., 2016: 14-15).

Health systems and service delivery in relation to unmet need and family planning

Pakistan's poor record in the social sectors has a number of root causes. One is the low level of public expenditure in these sectors. This is certainly true of health. The low priority given by successive Pakistan governments to lowering mortality and improving health is indicated by the fact that over the past decade, on average only 0.51 per cent of public sector expenditure on Pakistan went to health (calculated from Government of Pakistan, 2015, Table 11.3). This is very low by world standards. Limited budgets mean limited funds to pay salaries, and hence lower than ideal ratios of health workers to population. It is estimated by WHO that a minimum threshold of 23 doctors, nurses and midwives per 10,000 population is necessary to deliver essential maternal and child health services. Countries that fall below this threshold struggle to provide skilled care at birth to significant numbers of pregnant women, as well as emergency and specialized services for newborn and young children. In Pakistan the ratio in 2009 was only 14 per 10,000 population, well short of the minimum threshold. The balance between doctors, nurses and midwives was also skewed, with 139,555 doctors, but only 69,313 nurses and 26,225 midwives (WHO 2009).

Public health expenditure needs to be raised significantly. It is indeed planned to raise this to 3 per cent by 2025, and this plan has been endorsed by the Chief Ministers of the various provinces. If achieved, there will clearly be scope for significant improvement in the coverage of health services – and if properly planned, significant improvement in FP services as well.

But there are other reasons as well for the poor performance of health systems in delivering services in Pakistan – both health services in general, and also family planning services. Part of the problem has been bureaucratic structures. At the Federal level, there were formerly separate Ministries of Health and of Population Welfare. These Ministries "worked in parallel and seldom in tandem" (National Vision …. ,

p.9), or as stated more colourfully by another observer, they were engaged in a "cold war". After devolution, these two Ministries disappeared, Health in 2011 and Population Welfare in 2012. In 2013, in order to facilitate coordination with the provinces, a Ministry of National Health Services, Regulation and Coordination was established, which has a health wing and a population program wing, and is responsible for national oversight of health and reproductive health programs. This is generally accepted by most players. On the population side, after the Bali FP2020 Workshop, the population program wing constituted a Country Engagement Working Group (CEWG) – with 28 members, including provincial secretaries, INGOs and NGOs, plus donors, which will meet quarterly. However, there still appears to be some jockeying around the issue of whether the national Ministry should be treated as a focal point for all family planning matters, thus necessitating agencies such as UNFPA to be going through them in dealing with the provinces, or whether it is more a matter of "keeping them in the loop" with regard to programs and work plans being developed with the provinces.

At the same time, the Ministry of Planning, Development and Reform has separate health and population wings among its various wings. This can of course lead to some overlap of functions with the Ministry of National Health Services, but anyway devolution of service delivery to the Provinces has shifted the main locus for action. In general, the federal Ministry of Planning has the respect of the provincial planners.

At the provincial level, separate Departments of Health and of Population Welfare were also established, which have limited capacity. At the provincial level, too, the Departments of Planning have oversight of the activities of the Departments of Health and of Population Welfare, and in general, are respected by them.

The key issue for family planning and reproductive health services is whether these will be given sufficient prominence in the programs of the Ministry of National Health Services, Regulation and Coordination, and perhaps more importantly, in the programs overseen by the Departments of Planning at the provincial level, consistent with the increased sense of urgency in lowering fertility rates as expressed in Pakistan 2025. Unfortunately, up to this point family planning activities have not been given very high priority in programs of the Ministry of National Health Services, Regulations and Coordination, or in programs of the Departments of Health at the provincial level. Ahmed (2013) notes a paradigm shift that has relegated family planning to a secondary position within the framework of reproductive health care, diluting focus and investment in family planning. There has been a lack of focus and audience orientation in family planning advocacy and interpersonal communication; and monitoring and evaluation of family planning has been weak and sporadic. The complex funding flow mechanism has led to delayed and insufficient release of funds, which has caught the family planning programme in a cycle of low performance, supply shortages and stock-outs. In addition, pricing of contraceptives is a contentious issue that remains unresolved, resulting in Departments of Health failing to request contraceptives for their outlets.

The situation is particularly problematic in relation to the role of Lady Health Workers (LHWs). These formed the backbone of successful delivery of family planning services in the 1990s, but their role has been significantly diluted by their involvement in polio immunization and other activities. Moreover, between 30 per cent and 50 per cent of the population in several rural districts, especially in the poorest and most remote areas, are without LHW cover. At present, LHWs are given no training on side effects, and are not permitted to give the first dose of injectable contraceptives. The community midwifery program has probably not changed the situation much, since the numbers of community midwives is quite small. Some of them have FP in their workplan, some of them do not.

As far as programmatic shortcomings in the family planning area are concerned, there is not space here to trace this historically. This discussion will focus on recent and current issues facing the family planning program, taking inspiration from a recent detailed analysis by Pathfinder International (Ahmed 2013). In that study, a catalogue of issues was treated in sequence, from financing issues to contraceptive availability, security and procurement, program management impediments, budgetary inefficiencies, and poor program monitoring. Organizational impediments include human resource management and staff morale problems. Programmatic impediments and issues include program coverage, quality of service, diluted focus of community workers on family planning, and neglect of demand generation and social mobilization. Major issues and shortcomings were exposed with regard to all these aspects, and need to be addressed seriously and systematically if progress is to be made in enabling the program to lower the high unmet need for contraception. It may be possible to prioritise between the urgent needs outlined in the Pathfinder report, but the clear need is for action to be taken on a number of fronts simultaneously if the momentum of the family planning program is to be stepped up. Happily, a recent analysis of the family planning situation in Pakistan, which became available just before this meta-analysis was completed, gives a somewhat more optimistic assessment of the state of family planning in most provinces (Population Council, 2016).

Returning to the key indicator of shortcomings in Pakistan's family planning program – the high level of unmet need for contraception – an evaluation by the Population Council (Sathar, Khan and Hussain, 2015) appropriately takes a broad view of the issues involved. Discussing the **"three faces of unmet need in Pakistan",** they argue that the first of these is religious and social barriers – including religious misperceptions, which retain a strong hold in remote rural areas, rejection by religious leaders of the economic basis for fertility limitation, men's preference for large families, and limited spousal communication. Doubts and misperceptions about the religious acceptability of family planning are also found among service providers, limiting their effectiveness in counselling clients. However, on the positive side they argue that the large expressed unmet need for family planning and the high level of induced abortion indicate that religious and social resistance is waning; that men are becoming increasingly supportive of family planning; and that religious scholars generally support birth spacing in the interests of maternal and child health.

The second face of unmet need, they argue, is the inability to access family planning services. Thus the need cannot be converted into effective demand. This issue, of course, has many aspects. A significant proportion of Pakistan's population lives in rural areas with neither static facilities nor health workers available to deliver family planning services in the vicinity. Many of these communities are very poor and financial constraints, cultural limitations on female mobility, lack or expense of transportation and heavy workloads that limit time available for health visits all limit the ability to reach and acquire family planning services. Even when the public health system's service delivery outlets are accessible, opportunities to deliver family planning services are often missed. The 2012 DHS found that 75 per cent of non-users had visited a health facility, but service providers had discussed family planning with only 6 per cent of them. So much for Pakistan's FP2020 commitment that all public and private facilities would offer birth spacing services – which should obviously include pre- and post-delivery counselling.

Users of public health facilities also frequently complain about negligent, unsympathetic and rude service providers, indicating the need for more serious attention to behavioural training of providers in client-friendly treatment, including the need to provide clients the information and counsel they need to understand their problem and properly implement the treatment. And while access to private sector providers and social marketing is increasing, the role of the public sector in family planning service

provision is crucial because it is the only provider in many parts of the country and the only affordable option for the poorest groups in the population, who tend to have the lowest CPR.

The third face of unmet need, the Population Council argues, is discontinuation and disillusionment. The 2012 DHS found that aside from desire for pregnancy, the two most important reasons for discontinuation were side effects or health concerns, and pregnancy through method failure. Better counselling, provision of better quality contraceptives, and ensuring availability of a range of methods, including longer-acting methods, could bring major benefits to women who are discontinuing contraception despite wanting to avoid or postpone another pregnancy.

One positive development since devolution has been a clearer and more efficient division of effort between donors. For example, USAID is focusing on Sindh, DFID on Punjab and KP – especially MCH but with a small component of family planning, the Gates and Packard Foundations are focusing on technical assistance in Punjab and Sindh. The Population Council is landscaping family planning in Pakistan, focusing on seven cities in Sindh, Punjab and KP.

What has been the effect on family planning activities of the very important devolution of governmental functions to the provinces? In some ways it is too early to say, because it will take more time for the full effects of devolution to work themselves out. It is also difficult to generalize. However, it does appear that in Sindh, the current Chief Minister is supportive of family planning, budgetary commitment is there, through a costed implementation plan, and an inclusive FP2020 working group is in place, chaired at a senior level. Punjab and KP, too, appear to have a reasonable level of commitment from the provincial government for family planning activities, as demonstrated through budgetary support, though no clear messages of support have been forthcoming from the highest officials.

Public-private partnerships for service delivery

A number of innovative approaches have been tried in Pakistan in an effort to find ways to increase contraceptive prevalence rates, especially in areas lacking health facilities. Some of them appear to have considerable potential. They have mostly been developed by NGOs and private entities to bring contraceptive services closer to the people who need them. What are some of these projects?

The most broad-based was the FALAH project (2007-2012) conducted by the Population Council to improve the wellbeing of families through increased demand and utilization of birth spacing and quality family planning services. It emphasized improving access to services in the public and private sectors through a multipronged approach stressing (1) Communications and mobilization. A paradigm of "birth spacing saves lives" was introduced in place of the small family norm that had long been advocated. Mass media, community media and interpersonal communication were used. (2) Improving the capacity of the public health system to offer high quality services, by facilitating the availability of contraceptives at the facility level and training providers of the health system to be more responsive to clients' reproductive health needs. (3) Helping the private sector expand its outreach. (4) Enhanced social marketing of family planning commodities (for details, see Mahmood, 2012).

The CPR in FALAH districts increased from 29.4 per cent to 37.9 per cent over the span of 5 years 2007-8 to 2011, considered to be the direct result of FALAH interventions. This could be judged to be a good though hardly brilliant result, although on the positive side, it is important to note that it was achieved across a broad spectrum of Pakistan's localities – covering nearly 20 per cent of the total population, as contrasted with results achieved in small intervention areas, where local circumstances and the influence of dynamic leaders can sometimes make for impressive but not easily replicated results.

Two important findings of this project might be noted. One was the key role of LHWs in influencing clients' family size preferences, husband's approval of family planning and current use and future intentions. This highlights the importance of ensuring that LHWs are enabled to give sufficient attention to their family planning responsibilities. Another important finding was the urgent need for better husband-wife communication. Wives often incorrectly perceive the views of their husbands on contraception. In the FALAH baseline data, a quarter of women reported that their husband disapproved of family planning, but the husbands' own reports showed that almost two thirds of these women incorrectly perceived husband disapproval.

The MARVI Programme of the Health and Nutrition Development Society (HANDS) has shown that the problem of access in the most remote and disadvantaged communities can be overcome by training local uneducated women in provision of basic family planning materials and services, and enabling them to provide this service on a commercial yet affordable basis, provided there is a back-up organization (NGO or private entity) to ensure contraceptive supply and resolve other issues. The experience of working with this model in Sindh, where in the target areas CPR rose from 9 per cent to 27 per cent in three years, gives confidence that CPR can be raised quickly with the right approaches (Marvi, 2014). After all, the high level of unmet need ensures a receptive audience for family planning if the right approaches can be developed.

In an urban slums project in Karachi, supported equally by the Gates Foundation, the Packard Foundation and the Aman Foundation, the aim is to raise CPR by 15 percentage points in three years. The strategy is to improve services in existing clinics, not to establish new clinics. While this project is just coming to its mid-point and a mid-term assessment has not yet been conducted, it appears to be doing well. When the focus is on removing misconceptions and providing services, progress can be rapid. In another project in rural Sindh, in areas not covered by LHWs, male-female "couples", after some training, are involved in provision of counselling. The couples may be husband and wife, brother and sister, father and daughter, etc. Although they receive no payment, their status in the community rises, and this (along with their interest and dedication) is expected to keep them involved over time.

Two demand-side financing projects aimed at improving FP uptake, especially among women of low socioeconomic status, in Punjab, were conducted by Marie Stopes Society and Greenstar Pakistan, financially supported by the Packard Foundation with technical support from WHO. These projects used a two-pronged approach combining rural social franchising (the training, accreditation and branding of service providers and provision of uninterrupted contraceptive supplies) with demand-side financing (in the form of vouchers) to raise demand for services (Sathar, Khan and Hussein 2015: 9. For a detailed assessment, see Ali et al., 2015). Study A was a low cost service model with vouchers for free services targeting extremely poor women; Study B was a subsidized voucher scheme for FP counselling, postnatal care and child immunization. Both projects aimed to effect a 20 per cent increase in the CPR between baseline and endline phases (2012 to 2015). Such an increase was indeed more than achieved, though the quite high increase in CPR among control groups in both studies raises issues: was there a strong secular trend towards increased CPR in these areas (which if so would make them unrepresentative of Pakistan more generally), or was there some kind of "spillover effect" from the intervention area to the control groups? Another problem was that, although designed to primarily target women from the two lowest socioeconomic quintiles, more than two thirds of clients in Study A did not fulfil the poverty criteria.

The issue with many experimental and demonstration programs of the kind reported in this section is how they can be scaled up from effective small-scale programs dependent on dedicated individuals and/or the involvement of NGOs or INGOs, to programs with a broader impact.

5. SETTLEMENT PATTERNS AND POPULATION MOBILITY, INCLUDING URBANIZATION AND INTERNAL MIGRATION

Population distribution and density over time

Large areas of Pakistan are desert, and smaller, but quite large areas, are mountainous. For this reason, population density figures do not reveal much about the pressures of population on the agricultural resource base. Of course, rapid population growth has resulted in rapidly increasing population densities overall – from 101 per sq. km in 1980 to 245 per sq. km in 2015, but Bangladesh is 5 times more densely populated. In Pakistan, most of Punjab and much of Sindh are densely populated, and these are connected by a densely populated belt along the Indus River joining Punjab with the Hyderabad area of Sindh, with a densely populated outlier in Karachi. By contrast, densities are very low in the largely desert areas of Baluchistan and the mountainous areas of Gilgit-Baltistan. These two provinces cover almost half the land area but contain only 7 per cent of the population. If the sparsely populated parts of Sindh are added to them, it can be concluded that well over half of Pakistan's land area supports less than 10 per cent of the population. Indicators such as population density per hectare of arable land are more important than overall density figures. In the case of Pakistan, using data for 2005, using arable land as the denominator raises population density from 204 per sq. km. to 834 per sq. km., reflecting the fact that only about a quarter of Pakistan's land area is arable.

Population mobility and urbanization

Internal migration plays a key role in the nexus between population and development. Economic development is inevitably associated with the movement of people to areas of greater economic opportunity. This can involve a shift from one region to another, and/or from one type of settlement to another. Normally, this involves rural-urban migration. The process of economic development involves movement of workers from lower-productivity activities to those with higher returns, and typically this means a shift from primary industries (agriculture, forestry, fisheries, etc.) to secondary and tertiary industries. While there is considerable employment in secondary and tertiary activities in rural areas, the key locus of such activities is in towns and cities, and the shift in the economy's centre of gravity towards these sectors is inevitably associated with the process of urbanization.

The wide differences in productivity between urban and rural areas in Pakistan is evident from the fact that the urban economy contributes 78 per cent to the country's gross domestic product (GDP) although it is home to only one third of the total population (World Bank, 2014), and roughly the same proportion of the labour supply. The wide rural-urban differences in productivity are to a considerable extent reflected in differences in earnings, thus providing strong economic incentives for urban-ward migration. For example, wages of casual daily labourers are said to range from around 40-50 rupees in southern Punjab to 150-200 rupees in Karachi or Lahore (Gazdar, 2009, cited in Mehmood and Syed, 2015: 11).

What is the evidence from Pakistan of migration and urbanization patterns? First, migration can be considered from the perspective of whether provincial or district boundaries are crossed. It can also be considered as consisting of four different possible origin-destination movements: rural-rural, rural-urban, urban-urban and urban-rural. It is also important to know the gender balance of migration. There is evidence on all of these. On gender balance, as elsewhere in South Asia, short distance migration tends to be dominated by females, because of the influence of marriage migration. However, it appears that long-distance movement of females has increased over time, as has family migration to cities.

Importantly, rural-urban migration is estimated to constitute 40 per cent of all internal migration in Pakistan (Arif, 2005).

As well as the "pull" of economic opportunities in urban areas, there is evidence that natural disasters and climate change may be contributing to migration. The floods of 2010 placed large numbers of farmers in a precarious position, and some of them moved to the cities. But drought may actually be the most important climate phenomenon through its significant impact on crop yields of wheat, rice, cotton and sugar cane. A detailed study linking climate change with migration in Pakistan (Mueller et al, 2014) found that extreme high temperatures in the winter season in semi-arid areas of Pakistan (which wipe out over one third of agriculture yields) is the climatic factor most strongly correlated with migration.

There is debate about the role of poverty in migration. The argument is often made that migration – especially rural-urban migration - tends to be selective of the reasonably well-off and those with some education, because they are more aware of opportunities, and are better able to afford the cost of moving to another locality. On the other hand, the study by Mueller et al., 2014 argued that the effect of disasters on migration is most pronounced for the land- and asset-poor, who may have more locational flexibility, as they are not tied to land or assets, which can be hard to sell and are at risk of loss if unattended. The highest numbers of severely poor rural people – both those directly engaged in agriculture and those who generate incomes by providing goods and services to landowners - are located in the arid and semi-arid areas of Punjab and Sindh provinces. These are also areas in which heatwaves are projected to increase substantially due to climate change (Saeed et al., 2016). Thus the impact of climate change on migration might be expected to grow.

The war on terror and cross-border terrorism has unfortunately had major consequences for internal migration, bringing instability affecting KP, FATA and Balochistan regions, poor regions where limited resources have had to be shared first with Afghan refugees and later with IDPs from Malakand division and now almost the whole of FATA. This displacement and conflict situation has played a significant role in internal migration from FATA to KP and other provinces. Many more people than desired locally have moved into Peshawar, DIK, Tank, Hangu, and Kohat, raising demand for facilities and services in health, education and accommodation with no planning and resources to cater to these migrants. Many displaced persons have also moved into other parts of the country like Lahore, Karachi and Islamabad, with more Pashto speaking people in these cities than before. Likewise terrorism in Baluchistan has led to the displacement of Punjabi speaking people living there for decades towards Punjab and specifically Lahore, Karachi and Islamabad.

As far as urbanization is concerned, the percentage of population recorded as living in urban areas has risen from 28.1 per cent in 1980 to 33.2 per cent in 2000 and further to 38.8 per cent in 2015. While this increase was not particularly rapid, the numbers involved increased spectacularly because of the massive increase in Pakistan's population over the same period. Thus from 22.4 million in 1980, the number of urban dwellers more than trebled to 72.9 million in 2015. Moreover, in international comparisons, South Asian countries – Pakistan, India and Bangladesh – are considered to underestimate levels of urbanization compared with most other parts of the world. Thus the estimate of 72.9 million urban dwellers in Pakistan in 2015 is probably on the low side.

There are ten cities with populations exceeding one million (nine if Islamabad and Rawalpindi are considered as one conurbation rather than as separate cities; eight if – more controversially – Lahore and Gujranwala, located only 74 km. apart, are considered as one bi-nodal mega-urban region). Karachi and Lahore are dominant, with estimated 2015 populations of 16.6 million and 8.7 million respectively. But the total population of all cities with one million or more population in 2010 amounted to 55.4 per cent of the total urban population of Pakistan, quite a high proportion compared with most other Asian countries (UN Population Division, 2014: 14).

Internal migration is contributing substantially to the rapid growth of the large cities in Pakistan. However, there is a tendency to exaggerate the influence of migration on urban growth. The fact is that in Pakistan, the very high rate of natural increase of urban populations would still be leading to rapid growth of cities even if there were no net migration at all. If the claim that net rural-to-urban migration accounts for one fifth of the annual rise in urban population (see Saeed et al., 2016: 23) is correct, then clearly this is an important component of urban growth, but it is far from being the crucial one. Policies to lower rates of urban population growth and to accommodate effectively the growing urban population need to give greater attention to continuing high fertility in urban areas, which is the prime contributor to rapid growth of urban populations.

Looking ahead, however, it can be anticipated that rural-urban migration may well make an increasing contribution to urban population growth in coming decades. This is both because rural populations – the population pool from which rural-urban migrants are drawn – are growing rapidly as a result of continuing high fertility in rural areas, and because the incentive for rural dwellers to migrate to urban areas because of both rural push and urban pull factors is likely to remain strong. Of course, eventually, as the urban proportion of Pakistan's population climbs ever higher, rural-urban migration's contribution to its growth is likely to diminish. But that point is still some way off; the proportion of urban population in Pakistan is not expected to exceed 50 per cent for another decade.[2]

International evidence demonstrates that large cities tend to be the drivers of economic growth, and if managed properly, urbanization is very positive for development. The cities are the focus of migration because of the opportunities they offer, but they are also the locus of many issues of poverty, inequality and violence. In Karachi, informal settlements are organized primarily along ethnic lines, which often coincide with religious-sectarian and political affiliations, which become intertwined with electoral politics. Armed defence against intrusion by competing forces is often the next step. "Karachi is increasingly fragmenting into ethno-religious enclaves controlled by private militias" (ESCAP-UN Habitat 2015: 99). Another negative consequence of the growth of large and intermediate cities in Pakistan is that they are encroaching on rural areas, exacerbating food security issues. Residential areas have increased by more than two and a half times during the last two decades, primarily at the expense of class one farm land and pockets of fertile agricultural land on the urban fringe. Peri-urban agriculture, which was a key source of vegetables and dairy products for city dwellers, has been badly affected (Ministry of Climate Change, 2015: 28).

External migration

It was estimated that in 2004, about 4 million Pakistanis were living/working/studying abroad. Almost 2 million of these were in the Middle East, another million in Europe (mainly in the United Kingdom) and almost a million were in North America. Pakistan is one of the major countries sending labour migrants overseas. Migration of Pakistanis to the Middle East is mainly in the form of contract labour migration. Unskilled workers are the dominant category, accounting for 35% of such workers in 2000 and 50% in 2007. Skilled, semi-skilled and professional workers make up the balance. Unskilled workers are less educated and more

2. This is according to official national estimates (Ministry of Climate Change, 2015). Projections by the United Nations Population Division show the figure reaching 50 per cent much later - in 2035. By contrast, according to the World Bank's agglomeration Index, the share of Pakistan's population living in urban areas in 2010 was already above 50 per cent (Ellis and Roberts, 2016: Figure 2.6).

vulnerable to exploitative recruitment practices (Arif, 2009: 6).

A number of aspects of Pakistani labour migration are important to note, because they have policy implications. First, such migrants are almost exclusively male. Second, the Middle East remains the dominant destination area for such migration. Third, the source areas in Pakistan are not evenly spread: a 2009 study found that more than 60% of migrating Pakistanis originate from only 20 of the country's 110 districts (Arif, 2009: xi). The province of Khyber-Pakhtunkhwa (KP) is particularly prominent as a source of labour migrants. Indeed, it is the only province that has a much larger share in the annual outflow of workers than its share in the total population (Amjad and Arif, 2014: Figure 1). Fourth, over three decades, there has been little change in the skill composition of Pakistani workers leaving for the Middle East. Fifth, the majority of migrants obtain their foreign employment contract either through private Overseas Employment Promoters (OEPs) or obtain a direct visa. It seems that most migrants managed to stay abroad on more than one contract. This is important from a welfare perspective, because a second contract improves the likelihood of savings building up once initial costs of migrating have been covered.

There are several issues regarding the exploitation of labour migrants. Recruitment procedures are frequently exploitative, especially when sub-agents are involved. The maximum fee for service charges is frequently exceeded, arrangements made for border crossing without legal documents, and re-signing of contracts in the destination country at a lower salary than the original contract shown in Pakistan. Withholding of salaries for the first three months, irregularity in payment of wages, unfair deductions and non-payment of overtime also occur.

A basic issue in assessing the contribution of labour migration is to balance the considerable contribution of remittances to Pakistan's economic growth against the human costs of sending such large numbers of labour migrants abroad. It is likely that, if suitable employment opportunities were available domestically, a large proportion of Pakistan's labour migrants would prefer to remain in Pakistan; therefore the benefits flowing to the Pakistan economy through remittances must be weighed against the sacrifices in wellbeing that labour migration entails for large numbers of Pakistanis. The inability of Pakistan's economy to absorb the rapidly growing workforce is the root of the problem, and that inability is closely related to failure of population policy in earlier times.

6. EMERGENCY SITUATIONS: NATURAL DISASTERS, ARMED CONFLICTS, DISPLACEMENT

Pakistan has been facing multiple emergency situations. A series of natural disasters – floods and droughts - has set back development. Armed conflicts have also seriously disrupted development, particularly in KP, FATA and Baluchistan. These conflicts have displaced millions of people, affected inflows of foreign investment and devastated Pakistan's tourism industry. Also, the unstable situation in neighbouring Afghanistan has resulted in millions of refugees moving into Pakistan. It is estimated that there are about 3 million of these, half of them unregistered, mostly living in poor rural areas.

Alternating flood and drought conditions are frequent, and farmers are used to dealing with them. However, extreme events are beyond the ability of either individuals or, frequently, the government, to cope effectively with them. The floods of July-August 2010 were particularly devastating, destroying homes, crops and infrastructure and leaving millions vulnerable to malnutrition and water-borne disease. Months after the floods had subsided, hundreds of thousands of people remained in temporary camps with inadequate sanitation and food supply. More than 10,000 schools and 500 clinics and hospitals were damaged or destroyed. Roads and bridges were washed away, and the loss of economic production was enormous. As for droughts, the extended drought of 1998-2002 - severest in Baluchisatan and Sindh Provinces - is considered the worst in 50 years.

Both floods and droughts tend to have their most serious adverse effects on the poorest members of the community, who have few resources to cope with such adversity. There is a high degree of consensus in the scientific community that the severity of extreme weather and climatic events is likely to worsen as human activities are contributing to climate change.

Urban areas of Pakistan are subject to a number of natural hazards, including floods, cyclones, earthquakes and landslides, as well as man-made hazards such as fires, industrial and traffic accidents, and unsound construction practices leaving dense urban populations vulnerable to seismic and flood hazards.

All of these crisis situations bring with them complex challenges in meeting the needs of those affected. Disasters normally have their biggest impact on the poor. In relation to reproductive health services, the needs of those affected by natural disasters, armed conflicts and displacement are out of the ordinary. Normal ways of providing these services are disrupted by the event concerned, yet the need is heightened by the difficulties faces by pregnant women and those with young children who are caught up in these events. Hence the need to prioritize minimum initial service package for reproductive health in emergencies is of critical importance. Complications that occur during pregnancy or childbirth can be fatal during disasters when health care services are disrupted. In the short term, those affected may wish to postpone pregnancies until more favourable conditions are re-established; those who are already pregnant or about to give birth require support in very trying circumstances.

Preparedness is important if adequate responses are to be provided. The difficulties are two-fold: first, the unpredictability of natural disasters and armed conflicts, and second, the tendency for such events to take place in areas where services are least well provided in the first place. In a situation of overall service deficiency across the country, difficult decisions must be made about the relative importance of overall service provision and

emergency provision in crisis situations. Prepositioning of RH Kits is an important action to support preparedness and build capacity of the health system to implement the minimum initial service package for RH in crisis/emergencies

7. INEQUALITIES AND THE EXERCISE OF RIGHTS

Inequalities in population behaviour and trends (including inequalities by poverty and trends in reproductive inequality, mortality and morbidity)

In this section of the report, various indicators of inequality will be used to analyse their relationship to population behaviour and reproductive health outcomes. Attention should first be given to the degree of inequality that is indeed measured in Pakistan according to some of these indicators.

A key way to differentiate a population is according to indicators of income or wealth, with poverty a key indicator, as well as the degree of inequality in the income distribution. How much poverty is observed in Pakistan? Poverty appears to have declined steeply in the period of high economic growth during the 1980s, but it increased sharply in the 1990s when economic growth and inflow of foreign remittances slowed. In the 21st century, however, the trend in poverty appears to be one of Pakistan's "good news" indicators. According to a new set of official figures announced by the Minister for Planning, Development and Reforms in April 2016, the headcount poverty rate has declined from 64.3 per cent in FY2001/02 to 29.5 per cent in FY2013/14.[3] This is a very substantial decline. Of course, the number of people close to the poverty line remains high, which means there is significant vulnerability to poverty, and there is considerable movement into and out of poverty over time (see Arif, 2013, Table 5.3). For those living barely above the poverty line, one catastrophic illness is all that is needed to push them into poverty. The World Bank notes that over 50 per cent of Pakistan's population is living below the poverty line if an income of 2 dollars a day is used as the cut-off.

As for inequality in the income distribution, this is also very marked in Pakistan. Over the period 1988-2005, income distribution worsened; the Gini coefficient increased by about 17 per cent or 6 percentage points from 0.35 to 0.41. The share of the lowest 20 per cent of households declined from 9 per cent to 7 per cent, while the share of the highest 20 per cent increased from 44 per cent to 49 per cent (Jamal, 2009). Non-income aspects of inequality cannot be ignored – in land ownership, in educational levels, and in uneven regional economic development. Studies in Punjab and Sindh show that land inequality is associated with higher levels of deprivation and poverty.

There is strong evidence that the nature of growth in Pakistan is "inequality-increasing". Many argue that it is unlikely that the goals for poverty reduction can be achieved without a reduction in inequality, requiring explicit distribution policies (though the trends in poverty reduction noted above raise some doubts about this argument).

General indicators that will be used in this section, then, are levels of income or wealth, rural or urban residence, regional location and level of educational attainment. What are the differentials in mortality, morbidity and reproduction according to some of these indicators? Then there are some other indicators of elevated risk of infant mortality etc. that will be used. The data are drawn from the Pakistan Demographic and Health Survey, 2012.

The DHS data on infant deaths in the 10 years preceding the survey (Table 8.4) found urban-rural differentials in the infant mortality rate (urban 63, rural 88) that were less marked than differentials by mother's education or by wealth quintile. The infant mortality rate ranged from 92 for mothers with no education, through 55 for those with secondary

3. Prior to that, the official poverty line in Pakistan was much lower, and showed poverty incidence declining from 34.7 per cent in 2001-02 to 9.3 per cent in 2013-14. The new definition uses the cost of basic needs method, to capture non-food needs better.

education to 30 for those with higher education. Likewise, the rate ranged from in the 90s for the lowest two wealth quintiles, 85 for the third quintile, 75 for the fourth and much lower – 44 - for the highest wealth quintile.

Another way to differentiate the survival chances of infants and children is according to the demographic and biological characteristics of their mothers. The probability of dying in infancy is typically much greater among mothers who are too young (under age 18) or too old (over age 34), children who are too closely spaced (born less than 24 months after the preceding birth) and children born to mothers of high parity (more than three children). The risk is higher when a child is born to a mother who has a combination of these risk characteristics. In Pakistan, 58 per cent of births are in an avoidable high-risk category. The largest group of infants at risk are those who are of a high birth order (20 per cent) and those whose preceding birth interval was shorter than 24 months (14 per cent). Eleven percent of births share both these risk characteristics: they occur after an interval shorter than 24 months and a birth order higher than three. Such births have a risk ratio that is almost four times higher than births not in any high risk group. This means that in Pakistan, infant and child mortality can be reduced substantially by using contraception to space and limit births.

Antenatal care from a skilled provider is important to monitor pregnancy and reduce the risk of morbidity for the mother and baby during pregnancy and delivery. While in Pakistan, 73 per cent of mothers receive antenatal care from a skilled health provider, there are sharp variations according to various background characteristics. For example, the percentage rises from 51 per cent in the lowest wealth quintile to 97 per cent in the highest quintile; similarly, it rises from 60 per cent for women with no education to 81 percent for those with primary education, and further to 97 per cent for those with higher education. By region, Baluchistan is well behind other provinces, with only 31 per cent of mothers receiving antenatal care from a skilled provider. In Khyber Pakhtunkhwa, the figure is 61 per cent, in Gilgit Baltistan, 64 per cent, and in other provinces considerably higher – 78 per cent in Punjab and 78 per cent in Sindh, rising to 94 per cent in ICT Islamabad. There are substantial urban-rural differences, both in Pakistan as a whole and within provinces.

Similar differences are observed for other indicators of effective antenatal care: the proportion of women who had their first antenatal visit during the first trimester of pregnancy, and the percentage who took iron tablets or syrup. Likewise, protection against neonatal tetanus, the leading cause of infant death, which did not increase much between the 2006 and the 2012 DHS, varied considerably by province (protection of the last birth from neonatal tetanus ranging from 23 per cent in Baluchistan to 74 per cent in Punjab and 86 per cent in ICT Islamabad). There was less sharp differentiation according to urban-rural residence, but sharp differentiation according to education (50 per cent for those with no education to 91 per cent for those with higher education) and wealth (41 per cent for those in the lowest quintile and 87 per cent for those in the highest).

As for place of delivery, a slight majority of births in Pakistan take place at home. There is a strong association between delivery in a health facility and mother's education and wealth quintile. Only 34 per cent of births to uneducated mothers occur in a health facility, as compared with 90 per cent of births to mothers with a higher education. Similarly, delivery at a health facility is markedly lower among births in the lowest wealth quintile (27 per cent) than among those in the highest quintile (84 per cent). Assistance by a skilled health provider is more likely when births occur in a health facility. In this respect, too, there are very strong differentials by education and wealth quintile, and quite strong by urban and rural residence.

Turning to contraceptive prevalence, some of the inequalities found in the 2012 DHS can be briefly noted. Married women in urban areas are more likely to use contraception (45 per cent) than their rural counterparts (31 per cent). Urban-rural differences within regions are most pronounced in Sindh; urban women in this region are two and a half times more likely than rural women to use any contraception (43 per cent and 17 per cent, respectively). Contraceptive use is also positively associated with education and wealth. In the case of education, the CPR increases from 30 per cent among women with no education to 41 per cent among women with a primary- and middle-level education and 44 per cent among women with a secondary or higher education.

While the catalogue of inequalities related to reproduction, morbidity and mortality could be lengthened, the key point to be made is that the correlates of inequality tend to be similar for most of the variables considered. There are strong regional differences, quite strong rural-urban differences, and strong differences according to education and wealth status. These differences need to be understood, though, at a provincial and not just a national level. For example, as just noted, urban-rural differences in contraceptive use are starkest in Sindh; the CPR in rural Sindh is even lower than in rural Baluchistan. It is only the higher CPR in Karachi that keeps the CPR in Sindh comparable to that in KP.

From a policy viewpoint, of course, while progress can be made through improvement of facilities and personnel serving the general health and reproductive health needs of Pakistanis, it can also be made through assisting the population to be more receptive to the services available. From this perspective, education is the variable most readily amenable to influence, and strong improvements in the educational level of the population are likely to flow through to lower morbidity and mortality, and better reproductive health outcomes.

If the discussion is phrased in terms of reproductive rights, it is worth recalling that the ICPD stressed the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of FP of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In Pakistan, the access to family planning information and services, and to prenatal and postnatal care, is considerably better for urban dwellers and the better off than it is for rural dwellers and the less well-off. Since only half of deliveries in Pakistan take place in a health centre, it is hard to talk of the right to deliver in such facilities; there are simply not enough facilities available. But there are other cases that relate more directly to rights. When the large numbers of pregnant women waiting for prenatal care at a hospital are poor, and there is nobody there to serve them, this may reflect sheer inefficiency, but it may also reflect attitudes towards the clients concerned (poor women) that would not be shown to better-off women. The situation of these poor women is inequitable; their reproductive rights can be considered to have been ignored, or abused.

The government of Pakistan sees public sector investment in health as a pro-poor endeavour and includes it in the government's Poverty Reduction Strategy Programme. In most countries, public health spending on primary health care is pro-poor whereas that on tertiary care such as hospital services is pro-rich, as measured by the proportion of this spending that is utilized by the rich, compared with their share in total population or even in total income. This also appears to be the case in Pakistan. One study found that in general in Pakistan, MNCH related public health services can help reduce income inequality. The problem is that government spending on healthcare in Pakistan is heavily tilted towards specialized hospital care while leaving little resources for basic health facilities. While maternal and perinatal conditions are prominent as causes of mortality in Pakistan, they attract only a meagre share of total budgetary allocations on health (Malik and Janjua, 2013).

Gender inequalities (the Gender Gap Index, Gender parity index, Gender-based violence)

A number of indices have been devised to give a comparative picture of gender inequalities between countries. One of these is the Global Gender Gap Index, updated each year by the World Economic Forum. It scores countries on a number of variables, under four heads: economic participation and

opportunity, educational attainment, health and survival, and political empowerment. Pakistan scores very poorly on this index. Out of the 145 countries covered in 2015, Pakistan was in second last place, as it had been in the previous three years as well.

The Gender parity index is used by UNESCO and other agencies to measure the relative access of males and females to education. It is a simple measure: the ratio of girls to boys in a particular level of education – for example, primary or secondary education. The scores are shown in Table 2. Although Pakistan has improved its scores on the gender parity index over time, in secondary education, it still ranks ahead only of Afghanistan and Yemen among Asian countries, although it is ahead of a number of African countries.

Table 2. Pakistan: trends in gender parity index

	1990	2000	2010	2013
Primary education	0.53	0.68	0.85	0.87
Secondary education	0.42	n.a.	0.77	0.73
Tertiary education	0.40	n.a.	0.84	0.98

Source: United Nations, Millennium Development Goals Indicators. (http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=9)

It is noteworthy that one indicator on which Pakistan scores well is on the gender balance in tertiary enrolment, because (as in many countries), females actually exceed males in tertiary enrolments.[4] In the case of Pakistan, this can be seen as a strength, promising more equal involvement of women in productive sectors of the economy, but also as a weakness, because it reflects a very class-based set of opportunities. Few students from disadvantaged social groups complete secondary schooling and even fewer enter tertiary institutions, so the gender-balanced opportunities reflected in tertiary enrolments are only open to any great extent to women from the upper and middle classes.

Gender-based violence is a serious issue in Pakistan. There is a need to address the religious and sociocultural factors that foster a culture of violence against women. In the 2012 DHS, 33 per cent of ever-married women aged 15-49 reported having experienced physical or emotional violence from their spouse in the last 12 months (Amad et al., 2016, Chapters 6 and 7). The incidence of physical violence was much higher in Khyber Pakhtunkhwa and Baluchistan than in other provinces, and it was higher among poorer and less educated couples than among educated and better educated couples. The DHS listed a series of circumstances in which it might be considered justified for a husband to beat his wife; interestingly, for every circumstance listed, a higher proportion of ever-married women than of ever-married men agree that a husband is justified in beating his wife in that circumstance. This appears to reflect the internalized subservient position of women and the unwillingness or inability of many women to challenge that position.

Crimes against women that generally go by the term "honour killings" are also frequently found in Pakistan. It is impossible to know just how many such crimes occur, because of under-reporting, but Pakistan's Human Rights Commission reported nearly 1,100 such killings in 2015. Such crimes stem from rigid ideas about women's roles, a particular view about what constitutes "family honour", and a sense of entitlement among men in controlling the behaviour of female members of their family.

4. The 2013 figure in Table 2 shows a slight male excess in tertiary enrollments, but Pakistan's own data show a very slight female excess in the year 2015.

There have been some legislative advances. The first was a bill on domestic violence passed by the Provincial Assembly of Sindh on 8 March, 2013. However, it only covers extreme forms of violence against women. Another landmark bill was passed in Punjab in February 2016 criminalizing all forms of violence against women. Additionally, anti- honor killings and anti- rape bills have been passed at the national level very recently. Conservative forces try to block such bills. In the case of the Punjab bill, more than 30 religious groups, including all the mainstream Islamic political parties, threatened to launch protests if the law was not repealed, arguing that it will increase the divorce rate and destroy the country's traditional family system. The Council of Islamic Ideology (CII), a constitutional advisory body, which recently declared that it is permissible for a man to "lightly beat" his wife "if needed", argued that by passing the bill without its consent, the Punjab Assembly had committed an act of treason. Despite such opposition, the passage of the law was widely praised.

It is observed that low contraceptive use is found among women and girls experiencing domestic violence, no doubt because domestic violence leads to women and girls (15-19 years) having limited control over their reproduction. Those charged with family planning service delivery need to be aware of cases of domestic violence through linkages with community workers, so that they can facilitate contraceptive use and birth spacing among abused women who want to practice contraception.

Other areas of legislative action include a child marriage bill, aimed to raise the minimum age at marriage for girls from 16 to 18. It has been rejected twice at the Punjab province and federal level, and has been opposed by CII. In Sindh, the Child Marriage Restraint Act 2013 has been adopted but implementation remains a challenge. Experience of other countries including Indonesia, India and Bangladesh indicates that minimum marriage age legislation is very difficult to enforce, if community attitudes are ambivalent about such legislation.

Women's empowerment takes many forms, and in the Pakistan situation the enabling of poor women to have more agency related to the number of their births, the circumstances under which births take place, and the prospect of raising healthy children should be considered a potentially very strong element of empowerment. At the same time, such enabling would have major effects on poverty. There are two-way relationships here. The close correlation between poverty on the one hand and unmet need for family planning, deliveries under unsafe conditions, higher infant mortality, and restricted possibilities for poor mothers to earn an income, shows the impact of poverty on these unfavourable outcomes. The likelihood that poor women will have left school early, if indeed they went to school at all, reinforces these negative impacts of poverty, since low educational attainment has an additional negative impact. In the reverse direction, giving birth to unwanted children, running the risks of unsafe deliveries, being more likely to experience child loss, and having more restricted opportunities to earn an income, are factors exacerbating poverty. For example, children with fewer siblings tend to receive longer schooling than those with many siblings. In Pakistan, increased household size increases the risk of falling into poverty or remaining chronically poor (Arif and Bilquees, 2006).

Wider spacing of births and reduction in number of unwanted births can benefit women's health, enable them to raise their children in better circumstances, give them more opportunity to engage in economic activities, and perhaps enable them to have a greater say in family decision making. Better survival and health of the children women give birth to also facilitates their later education and contribution to the family.

8. SITUATION AND TRENDS WITH RESPECT TO HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS (STI)

HIV/AIDS levels in Pakistan are relatively low (around 0.1 per cent of the population aged 15-49), but are an increasing health concern. Pakistan moved from "low prevalence, high risk" to "concentrated" epidemic in the early- to mid-2000s. Between 2005 and 2015, the number of deaths due to AIDS rose from 360 to 1,480. A report released in July 2016[5] states that the number of people living with HIV/AIDS rose from 8,360 to 45,990 over the same period, a rise of 17.6 per cent per annum, the fastest increase in the world over this period. However, since estimates of HIV prevalence in Pakistan differ widely, and UNAIDS estimated 97,000 people living with HIV at the end of 2009, this estimate needs further clarification.

Pakistan's epidemic is primarily concentrated among two groups: injecting drug users (IDUs) with a national prevalence of 27.2% in 2011, followed by transgender (Hira) sex workers with a prevalence of 5.2%. Prevalence among overseas migrant workers is also increasing. The epidemic is fairly concentrated in big towns and cities. Pakistan sits on one of the world's busiest drug trafficking corridors, and prevalence of HIV among injecting drug users has steadily increased from 10.8 per cent in 2005 to 37.8 per cent in 2011. IDUs are overwhelmingly male (98.4 per cent), with an average age between 25 and 40 years old. The high HIV prevalence among this population is consistent with their high risk injection behaviour, with 71.5 per cent reporting 2-3 injections per day and only 39 per cent reporting always using a new syringe for each act of injection. (For details, see National AIDs Control Program, 2015; and World Bank, 2016).

There is concern also about the risk of HIV spreading among some other groups – in particular, male sex workers, female sex workers (though the incidence of HIV among this group remains very low), men who have sex with men, long-distance truck drivers, and returned migrant workers, deported from the Gulf States when found to be HIV-positive.

The government's National Strategic Framework for HIV/AIDS was developed in 2001 through a broad consultative process. Based on this Framework, the Government launched the "Enhanced HIV-AIDs Control Program" for the 2003-2008 period, shifting to a more decentralized approach, stressing HIV preventive services delivered through NGOs for most at risk populations, particularly IDUs and sex workers. This decentralized approach has become even more important since devolution. The Government's HIV/AIDS strategy at the national and provincial level is coordinated by the National AIDS Control Program and currently Pakistan AIDS Strategy III (2015-2020) is being implemented which focuses more on providing treatment, care and support to key populations. Many NGOs and international agency and other donors are involved in the program; it is sometimes criticised as being donor-driven.

5. From a meta-analysis coordinated by the Institute for Health Metrics and Evaluation at the University of Washington in Seattle, reported in The Express Tribune, 20/7/2016.

9. CHALLENGES

Pakistan was one of the earliest countries in Asia to adopt policies designed to lower the rate of population growth, beginning in the 1955-1960 Five Year Plan. But today, it is one of the few remaining countries in Asia with a TFR above 3 children per woman. Among Asian countries, only Afghanistan, Iraq, Yemen and Timor Leste have higher fertility rates and rates of population growth than Pakistan. Pakistan should be aspiring to be grouped with a more promising set of countries than this. In the long interval between the initial implementation of family planning approaches and today, massive population growth has taken place (indeed population has more than quadrupled), and human development indicators have been disappointingly slow to improve. The two are not unrelated. The failure to meet aims in the area of family planning and reproductive health has multiple causes, including cultural and religious factors, economic and social structures at national and local levels, weaknesses in the areas of governance and administration, and lack of a unified understanding of the issues and the approach to dealing with them. And there is no doubt that the low achievements in the reproductive health area have adversely affected Pakistan's ability to achieve its goals for human and social development.

The delay in reaching moderately high levels of family planning practice led not only to a much higher population than would otherwise have been the case, but also to delay in benefiting from a more beneficial population structure. Thus until recently, Pakistan was still facing the kinds of explosive increase in the school-age population that countries such as Indonesia, Bangladesh and India were facing in the 1980s; in those countries, the growth of school-age population had shrunk to much lower levels in the 1990s and to almost zero in the 2000-2010 decade, greatly facilitating their attainment of universal or near-universal primary school education.

It is instructive to compare the demographic history of Pakistan and Iran since the 1980s. In the mid-1980s, both had very high fertility – a TFR around 6 – and a very young population. Then fertility declined extremely rapidly in Iran, and commenced a slow decline in Pakistan. Between 1990 and 2020, United Nations projections indicate a growth of 49% in Iran's population and of 94% in Pakistan's population. But the key story concerns the child and young adult populations. The number of children aged 0-14 fell by 25% in Iran, but grew by 55% in Pakistan. Young adults aged 15-29 grew by 23% in Iran and by 100% in Pakistan. Among other things, Pakistan faces a massive challenge in educating such a rapidly growing number of young people, in finding employment for such a rapidly growing number of young job seekers, many of whom have very low levels of education, and in meeting their sexual/reproductive health needs.

Yet despite the recognition back in the 1960s that population growth rates in Pakistan were too high, and despite the massive population growth that has taken place since then, there has been little evidence of a sense of urgency in reducing population growth rates on the part of senior politicians or bureaucrats, at either the national or provincial level. Indeed, during the decade of "Islamization" under the regime of General Zia ul Haq in the 1980s, the idea of family planning was firmly resisted in official circles. Change came in the 1990s, but without much sense of urgency. As for the present time, the Prime Minister has never publicly stated that lowering of the population growth rate is a priority area. Nor has any Chief Minister or Chief of the Armed Forces. There appears to be little interest in issues of population on the part of parliamentarians at either national or province level. And while some planners and administrators are well aware of the importance of the population issue, many others are not.

There are now some small signs of change. In Pakistan 2025: One Nation – One Vision, the statement is made (p.7): "… other than oil-rich economies, no country has been able to break into the high-income club without a radical reduction in its population growth rate. … (T)he need for lowering the growth rate of population is more urgent than ever." However, apart from that statement, there is no further attention to population issues in the document. Statements are easy to make, and the proof of serious intent must be in the allocation of personnel and financial resources to the activities that will make a difference to population growth rates: in particular, education and health services, and family planning services. The Government has stated aims of increasing the share of GDP going to both education and health (rising to 4 per cent and 3 per cent respectively). Time will tell whether these aims can be met.

There appears to be limited recognition in Pakistan that fertility rates have fallen sharply – in some cases dramatically - in many predominantly Muslim countries – Iran, Oman, Algeria, Tunisia, Bangladesh, Indonesia and Malaysia are some key examples (Eberstadt and Shah, 2012). But Pakistan's story has been very different. After a degree of success in raising the contraceptive prevalence rate from 12 per cent to 28 per cent during the 1990s, the rate has risen only very slowly despite high levels of unmet need for contraception, clearly measured in DHS surveys. Other countries reaching a CPR of 28 per cent typically moved upwards, many of them rapidly, to 50 per cent and beyond. Why did Pakistan not do so as well? Clearly, part of the answer must lie in supply-side issues. Unmet need for contraception of 20 per cent can be likened to a crop of fruit ready for harvesting. At least a third of that 20 per cent is low-hanging fruit that can easily be picked if a good network of family planning services is in place. Addressing these supply-side issues is crucial.

But addressing the supply-side issues immediately raises broader concerns about why in Pakistan it has not been possible to provide a strong network of family planning services. Viewed in this light, it is not just an issue of empowering the government agencies responsible for providing these services with more personnel, larger budgets and better planning mechanisms, but of creating an understanding through the whole community of the ways in which individuals, families and communities benefit when all births are wanted births.

One problem is that there are pro-natalist incentives built into the resource allocation from the central government level, as well as the allocation of seats in the National Assembly. This is because these allocations are made based on population. (This indeed is a problem for the Population Census – there have been threats of consequences if one province's recorded population is considered too low). In India, a similar problem was dealt with by "freezing" the relative populations used for resource allocation at a particular year's level. The political environment in Pakistan appears to rule out the possibility of a similar adjustment here.

Even if the resolve to lower rates of population growth is increasing, questions remain about the policies that will enable Pakistan to achieve this end, and the means to carry out such policies. What happens to population growth rates will depend mainly on what happens to fertility. What happens to fertility will depend on a whole range of factors – among other things, the trends in economic growth, and the extent to which it is pro-poor; the trends in educational development, particularly in female education; the trends in child survivorship; and the degree of success in meeting the unmet need for contraception. The most desirable development scenario for lowering rates of population growth would be one in which the political, security and economic situation improved and a "virtuous circle" of developments including pro-poor economic growth; increases in the share of development expenditure on education and health, leading to rapid advances in child survivorship and in levels of education attained by young people; and expanded reproductive health services, helping to meet the unmet need for family planning, were all playing a

role. Even in a less favourable scenario on the broader political, economic and human development front, more effective reproductive health programs could by themselves undoubtedly lead to a reduction in fertility and in population growth. But it would be far better – and more sustainable - if these improved reproductive health programs could be part of a broader development scenario in which forward movement was evident in a wide spectrum of activities.

The population policies completed for KP and Sindh and nearly completed for Punjab, while they have an adequate focus on reproductive health and family planning, and on lowering population growth rates, do not set these within the broader human development and economic growth strategies that create the conditions conducive to having small families (Population Council, 2016: 88-90). The successful implementation of the new provincial population policies will depend on how well they are integrated with the provincial development and growth strategies, and with the commitments toward meeting the Sustainable Development Goals (SDGs), as well as Pakistan's FP2020 commitments. Thus further efforts to develop and refine these population policies will be needed.

Turning specifically to the progress of sexual and reproductive health programs over time, the challenges Pakistan faces are immense. Deficiencies in MCH are clearly revealed by the statistic that IMR in Pakistan is roughly double its level in India and Bangladesh (see Table 1). There is an urgent need for more and better-trained community midwives; training of 18 months is insufficient. On family planning, despite decades of official support, the progress in raising contraceptive prevalence rates and in meeting unmet need for family planning was extremely slow, except in the 1990s, when contraceptive prevalence rates rose from a dismal 11.8 per cent in 1990-91 to 27.6 per cent in 2000-01.

While this is sometimes referred to as the "golden era" of family planning, and a rise in CPR of 15 percentage points in a decade is certainly substantial, it can hardly match the rise of 30 points in Indonesia (1973-1985) or 25 points in Bangladesh (1985-1996-7) in just over a decade in each case, the rise of 21 points in Algeria in less than a decade (1986-7 to 1995) or the remarkable half-decade increase of 21 percentage points in Iran (1989-1994). And the key point is that most countries that have succeeded in rapidly moving CPR upwards to the 30 per cent level have seen continued increases from that level to 50 or 60 per cent. But in Pakistan's case, the contraceptive prevalence rate has edged up only slowly to 35 per cent (26 per cent for modern methods).

"While wanted fertility (estimate of what the total fertility rate would be if all unwanted births were avoided) in Pakistan has declined from 4.7 to 2.9, unwanted fertility has increased from 0.7 to 0.9 children per woman between 1991 and 2013. About 70 per cent of women of reproductive age currently want to delay or avoid their next pregnancy, but a fourth of them are not using any form of contraception, and as many as 20 per cent of married couples express an "unmet need for family planning". (from Reinvigorating Progress …. p. 3).

The problems can be viewed from a programmatic perspective: what shortcomings in approaches and administration of family planning hindered progress? There are indeed many such shortcomings, to be summarized below. But the issues run much deeper than that, revealing basic cultural and religious obstacles to adoption of contraception. Among the reasons for not intending to use contraception in the PDHS of 2006-07, "up to God" (28 per cent), "husband opposed" (10 per cent), and "opposed to contraception" (8 per cent) ranked high, totalling 46 per cent of all reasons.[6] In the DHS surveys in some other predominantly Muslim countries, the equivalent reasons for not intending to use totalled 4

6. It is not possible to tell whether such reasons are becoming less important over time in Pakistan, because the 2012 DHS Report for Pakistan does not give information on reasons for not intending to use contraception.

per cent in Indonesia in 2012, 9 per cent in Bangladesh in 2014, and 9 per cent in Morocco in 2003-04. Pakistan, then, at least in 2006 was showing far stronger resistance to practice of contraception than these other Islamic countries. The message that there is no conflict between the practice of most methods of family planning, if done for the right reasons, and Islamic teachings has not been brought successfully to the notice of ordinary people in Pakistan.

There were estimated to be 2.245 million induced abortions in Pakistan in 2012 (41 abortions per 100 live births); this rather startling evidence brought the issue of abortion out in the open. Abortion is legally restricted in Pakistan, but it is clearly filling in some of the gaps caused by the failure of the family planning program to meet the high level of unmet need for contraception. These abortions carry huge costs; there were an estimated 622,600 women treated for complications resulting from induced abortion in 2012, about 62 per cent of them obtaining care in private facilities. There are extremely poor abortion and post-abortion care practices. The need is clear for doctor and mid-level provider training in safer management methods for post-abortion complications, and the provision of necessary equipment and medicines for dealing with post-abortion complications.

The underlying ambivalence of many people in Pakistan about the morality and religious acceptability of practice of family planning – both among the general population, among officials and power holders, among religious leaders, and even among some medical doctors and other health workers – has undoubtedly flowed through to the observed weaknesses of the family planning program at most periods in Pakistan's history. A vibrant programme is hard to achieve in the face of hostility from much of the religious leadership and ambivalence among political and community leaders. The contrast with Indonesia is striking. In Indonesia, although there was certainly opposition to family planning from some Islamic quarters, the two largest mass membership groups under Islam – the Nahdlatul Ulama and the Muhammadiyah – from the early stages of the programme were actively involved with the government in promoting family planning and providing support services. A number of other Muslim majority countries, including Bangladesh, were also much more successful in at least countering the opposition, and more positively, enlisting the support, of religious leaders.

The challenge, then, is not just to modify the way family planning services are delivered in Pakistan, important as that is, but firstly to create an environment, in the society, among politicians and bureaucrats, and among religious leaders, in which the need for effective family planning is recognized and supported. In such an environment those employed in the delivery of health and family planning services can be expected to have higher morale and enthusiasm to deal with the multifarious specific challenges in providing family planning services. In such an environment reforms in programmatic aspects can be expected to have more impact.

The urgent need for reform of reproductive health and family planning activities in Pakistan does appear to be increasingly recognized at fairly high levels of government. The National Vision for Coordinated Priority Actions... states that "Family planning (FP) is one of the most cost effective interventions to reduce maternal and newborn deaths; furthermore, the vicious cycle of continued high rates of population growth and poor RMNCAH outcomes and nutrition in Pakistan needs urgent attention". The Vision goes on to state "There is also an urgent need for declaring a population emergency", and recommends adoption of a national population policy framework to provide overall guidance and ensure national coordination and development of synergies between population and health sectors. Similarly, Strengthening health system response to adolescent health needs; capacity building of health care providers, standardization of adolescent friendly service provision protocols, improved easy access to primary health care and

family planning services for adolescents; focus on sexual & reproductive health education among adolescents, both boys and girls in school and out of school, are important steps that need to be taken in a culturally sensitive manner.

Given the catalogue of shortcomings in the family planning program, already outlined in section 4 of this report, what appears most urgent is to understand the key obstacles to progress and the interventions that are likely to make a difference. A shopping list of needs, while reinforcing the undoubted gravity of the task and the large number of unresolved issues, will fail to identify strategic entry points.

The key bureaucratic obstacle to progress in the family planning area would appear to be the lack of priority given to family planning activities by the agencies set up to plan and deliver health services: the Ministry of National Health Services, Regulations, and Coordination at the Federal level and the Departments of Health at the provincial level. Although there are parallel population wings and health wings in these Ministries or Departments, the population wings are limited in their capabilities: matters of procurement, running of health facilities, etc. are under the control of the health wings, which tend to give lower priority to family planning activities than to what are sometimes considered "real" health activities. This can also affect the work of the Lady Health Workers, as discussed below.

Out of all the areas of need identified in reports such as Ahmed 2013, the RAF Policy Brief, Reinvigorating Progress on Family Planning, Sathar et al., 2015, and Population Council 2016, five appear to be particularly significant:

1. Access to contraception is still a major barrier. Unmet need for family planning is highest among the poor and uneducated. It is highest in Baluchistan, where inhospitable terrain and scattered settlements makes access to services difficult; it is highest in rural areas, where poverty, travel costs, lack of knowledge and education, constraints on female mobility, and heavy workloads prevent people from accessing FP services. Even though the public health system has a large network of service delivery outlets, clients may be unable to benefit because of early closing times or irregular opening times, the absence of female service providers, stock out of contraceptives, or lack of equipment. When women visit a facility, service providers will not necessarily have a discussion on FP with them, or may not treat them with due respect. Provision of family planning in Pakistan has focused on doctors, primarily female doctors, and although broadened in the 1990s to more community-based provision of services, more attention to involving lower-level service providers (including male providers) is urgently needed (Population Council, 2016:115).
2. The Lady Health Worker (LHW) program is very important in bringing information and services to clients. In the 1990s, family planning was their main focus; but their family planning work has been diluted by their other responsibilities, particularly in polio vaccination. There are a number of obstacles to more effective service by LHWs. One is their multiple responsibilities. The National Vision recommends a review of the curriculum for LHW/CMW and TORs to align more closely with priorities for MNCH, family planning and nutrition. "This may necessitate elimination of unnecessary activities and appropriate time management". If indeed family planning is receiving renewed emphasis in government priorities, then the family planning activities of LHWs should be given higher priority. It appears that the number of polio cases has fallen considerably in the past 6 months, and this should enable LHWs to devote more time to family planning work. But they should be given clear directions to do so.
Other problems include bottlenecks in

contraceptive supplies, preventing LHWs from providing methods (especially injectables) to their clients on time; inadequate care of clients they refer to static facilities; and the need to identify underperforming LHWs and find ways to improve their performance. A Supreme Court ruling gave LHWs permanent positions with improved salary, and while generally this is a good thing, they can no longer be easily dismissed for incompetence. With budgetary responsibility falling to the provinces, there are real issues about whether the recruitment of additional Lady Health Workers will be supported by the provincial governments, and what priority will be given to reproductive health among the many activities LHWs are required to perform.

3. Contraceptive discontinuation rates are disturbingly high. The available evidence suggests that the main reasons are method failure and side effects. Counselling about side effects is clearly deficient. At the same time, the dynamics of method mix need to be changed, giving clients more effective access to long-acting methods. While sterilization is not an acceptable method in Pakistan's official program on religious grounds, other long-acting methods need to be made accessible to potential users, to minimize the burden of seeking re-supply on the part of users who may find a stock-out situation, or who have difficulty in accessing supply sources because of time or distance constraints. The menu of contraceptives available through different outlets needs to be revised to enable wider choice and better access to newer methods, and regulations on what is permissible for different categories of health workers reconsidered. For example, LHWs should be allowed to provide the initial dose of injectables. More attention should be given to male providers, not only doctors and paramedics, but also male dispensers, hakeems and homeopaths, who could dispense some basic methods during the occasions they see male clients.

4. The private sector is playing an increasing role in provision of contraceptives. The preference for private services is attributed to the relatively low quality of care provided at public facilities; inconsistency in supply of contraceptives in these facilities; and lack of integration of family planning services within basic health services. The private sector can and no doubt will play an increasing role; after all, it is active in selling medicines, delivering babies and conducting abortions; it is always ready to supply any goods for which there is a demand. Barriers to an increased private sector role should be removed, and over the counter availability of contraceptives ensured. The role of pharmacies in providing counsel and a wider range of methods should be promoted. Possibly this could include administering the injection of injectables (Population Council, 2016: 116). At the same time, however, it is important to improve the public sector's service provision, because it is the only provider in many parts of the country, and the only affordable option for the poorest segments of the population.

5. Flow of funds in the government program is complex; delayed and insufficient releases tie the family planning program in a cycle of low performance, supply shortages and stockouts. Every case of inability to supply a potential user with a suitable method because of a stockout is a minor tragedy. Contraceptive pricing is also a contentious issue, leading to failure to request contraceptives for their outlets on the part of provincial Departments of Health; it must be resolved if the family planning program is to move forward.

In reaching lower rates of population growth in Pakistan, educational development can be considered just as important as family planning programs, though of course educational development has many other positive outcomes as well. But the policy challenges in education are immense. The share of GDP spent on education in Pakistan was 2.1% in 2012 and 2013 – low by international standards. A new educational policy is expected to be approved in 2016; meanwhile, the Government states a determination to achieve the UNESCO target: educational expenditure of 4.0 per cent of GDP by 2018 (Government of Pakistan, 2015: 179). What has been happening in recent years is that private school education has been expanding to fill gaps in public education. Nearly one third of students, at both primary and secondary levels, are attending private schools – both elite schools catering to the high-income groups, more affordable schools catering to the middle-income groups and low-cost private schools serving low-income families. These schools mainly appear in areas where there are already public schools, so they may be reducing the public schools' share of enrolment but not necessarily increasing total enrolment (Aziz et al, 2014: 17).

All levels of education in Pakistan are lagging behind competitor countries. All levels need to be expanded, and a systems approach is needed to ensure that the development of the education system is appropriately balanced. Prior to 2000, the higher education sector was marginalized in favour of primary education. In the 2000s, though, policy shifted in favour of promoting higher education, with the creation of a powerful Higher Education Commission which, however, has come under great political pressures. One problem in Pakistan is that an emphasis on higher education results in outcomes favouring the elites; the upper income groups reap most of the benefits of the public subsidy of education, since children from poor families have great difficulty in completing secondary education, let alone entering tertiary institutions. One positive outcome of trends in tertiary education, however, is that there are now slightly more women than men in colleges and universities. If the labour force participation rate for females rises from 23% to 27% as expected, with a million well-educated and trained women joining the workforce every 3 years, many will take jobs in the modern sector (World Bank, p. 10).

To benefit from the demographic bonus that Pakistan is belatedly beginning to enjoy requires improvements in educational levels of the young people entering the workforce, and strong levels of labour-absorbing economic growth, so that jobs will be available for the burgeoning workforce. The challenges of raising educational levels in Pakistan have already been outlined, and the multifarious benefits of doing so discussed. Policies and programs to raise educational levels and achieve high levels of economic growth go well beyond what can be considered population policies, and they involve agencies of government that have no direct responsibility for population policy. But clearly a "whole of government" approach is needed in coming to terms with the population issues that Pakistan faces; indeed it could be argued that success in achieving high levels of broad-based education is likely to be even more influential in meeting the goals of reducing both mortality and fertility levels than will provision of specific health and family planning services.

INGOS have been playing an important role in family planning activities in Pakistan, particularly in pioneering and testing new approaches to providing counselling and services, including those reaching poor and isolated populations. However, INGOs are under scrutiny in Pakistan, and require security clearance. This is not a good environment for optimizing their contribution and increasing their activity. There are 132 INGOs in Pakistan, but so far, only 37 have been granted formal permission to operate. Some heads of these INGOs have had visa applications turned down for a short (1-2 week) visit. This can hinder the contribution of INGOs to family planning/RH programs in Pakistan.

In developing a comprehensive program to integrate population and development concerns with sexual and reproductive health planning, there are further challenges in the data area. While DHS surveys provide detailed data on reproductive health and related matters, and annual labour force surveys and

the Pakistan Social and Living Measurement (PSLM) Survey provide further important information, many data gaps remain. For example, nationally representative data on adolescents and youth, their diversity and the issues they are facing, is missing. Failure to conduct a population census in 2008 leaves a serious gap in information required for broader population and development planning – in particular, information on individuals and households down to sub-district level. The plan to conduct a Population Census in 2016 has not come to fruition, though it is now hoped that this will take place in April 2017; indeed, the Supreme Court has ruled that it must take place. The outcome appears to hinge on the readiness of the Army to commit the large numbers of personnel needed to ensure the security of the census operation. Failure to conduct the Census would symbolize a lack of urgency on the part of government in generating the up-to-date and geographically disaggregated data needed for planning purposes. Though there will be major challenges in conducting an efficient census, especially in less secure parts of the country, Pakistan urgently needs the Census.

10. OPPORTUNITIES

Opportunities for action: policy, strategy and programmatic recommendations

In discussing opportunities for action, it is necessary first to define: action to what ends? In the Pakistan population and development situation discussed throughout this report, the key needs are to move more quickly through the demographic transition to lower mortality and fertility rates, in order to more quickly achieve stability in population size and an age structure favourable to development. Other aspects of demographic trends also need to be taken into account in planning Pakistan's development: notably, migration and urbanization, about which the data base in Pakistan is very deficient. The broader picture must not be ignored: economic and social development is a mosaic that can be altered in an infinite number of ways, and through an infinite number of permutations between interacting factors. To focus on one very important need - the need to lower rates of population growth – it must be understood that many different factors will influence the prospects for achieving this aim, and in turn the effect of lowered rates of population growth will be many, including some that are well understood and perhaps others that are less well understood. One obvious point to make is that there are "upstream" stumbling blocks to development in Pakistan that, if not removed, exacerbate many of the "downstream" tasks, including that of lowering fertility rates. These "upstream" stumbling blocks include relatively slow aggregate economic growth, and limited labour absorption in the growth that has taken place. Bottlenecks in production and distribution of energy, challenges on the security front, and high levels of corruption are singled out by development agencies as all holding back Pakistan's development.

There is also unanimity amongst development planners that Pakistan must make a strong drive for human development if its low rankings in international development indicators – and the deficiencies these low rankings reveal - are to be redressed. Education and health expenditures must be increased drastically and education and health systems expanded and streamlined, so that Pakistan's youth bulge can be converted into a force for development as healthier and better educated young people are enabled to enter a labour market that offers them meaningful and remunerative employment without having to rely on the uncertainties of entering labour markets in the Middle East and elsewhere. Girls' opportunities for education must be lifted especially rapidly, and a wider range of employment opportunities must be opened for both well-educated and less educated women.

It can be argued that, if real progress is made on these fronts, the specific aim of lowering fertility rates will to a large extent "look after itself". The preconditions for rapid fertility decline will have been met. This, of course, does not obviate the need for specific attention to the policies that will directly influence fertility - notably, the meeting of unmet need for contraception.

Despite the absence of a sense of urgency observable among political leaders, planners, bureaucrats and religious leaders, opportunities to move ahead faster on a number of fronts than had been possible in the past appear to be opening up in a number of areas. What are the key opportunities?

Moving forward on the population policy front

If the Pakistan government is beginning to take population issues seriously, that will provide a major opportunity for more effective policies and programmes. There are indeed hints, though they are only hints, that a new era has dawned, beginning with the Pakistan Government's commitment at the

London Summit in 2012 to raise the CPR to 55% by 2020 (later revised downwards to 50%), followed by an unequivocal expression of concern for reducing the population growth rate in the document Pakistan 2025 – One Nation, One Vision. Among the proponents of a more vigorous family planning program, a strong need was felt to articulate a consensus on the issue across political, religious and government divides, and in particular, for endorsement of family planning by religious scholars and leaders (the ulema). Some success in this direction was achieved in November 2015 at the Population Summit, but it was only limited success. The Population Summit was not attended by the Prime Minister, as initially planned, or by the Chief Ministers of any of the Provinces. The President however, officially opened the Summit on behalf of the Prime Minister. There was some tension at the Summit between some of the provinces and the federal level as these provinces perceived the central government to be orchestrating something they saw as now falling under provincial control. But at least population issues were discussed in a forum where many senior and mid-level politicians and administrators were interacting with religious teachers, NGOs and INGOs active in the population field.

What of the attitudes and actions of provincial governments now that family planning is the responsibility of the provinces rather than the central government? Here as well there are some positive signs, though movement is not as rapid as might be hoped, since it has taken the provinces nearly six years to prepare their population policies. The province of KP has completed its policy document, which was approved by the provincial cabinet and launched in 2015, while Baluchistan and Sindh have nearly completed their policies and costed implementation plans (Population Council, 2016: 88). It is reported that in Sindh and Punjab some new policy developments have occurred, notably the inclusion of youth and elderly, and involvement of males in family planning. Representatives of the provinces made certain commitments at the Population Summit, and follow up activities are focused on realizing these commitments and developing specific programs. Support for such activities should receive high priority among donors.

What is needed now is a clear statement from the Prime Minister and Chief Ministers of the provinces of the need to lower rates of fertility and of population growth in Pakistan, in the interest of more rapid economic, social and human development. Without such a statement, the emerging signs of greater commitment to lowering rates of population growth – such as the statement in Pakistan 2025: One Nation – One Vision – will signal only tentative commitment of the leadership to this goal.

Strengthening of population policy analysis in the Planning Commission

If population issues are to be given a more central place in Pakistan's development planning, it would be highly desirable for the technical capacity of the Population, Planning and Development Department of the Planning Commission to be built up. This Department has varied responsibilities, including approval of provincial projects with budgets exceeding 60 million rupees. It has also been given responsibility for improving the population components of Vision 2025. This, along with the need for Pakistan to meet the targets and commitments under FP2020 and the SDGs, could provide the focus of more intensive analysis of population and development issues in Pakistan. (The Planning Commission has recently established an SDG Section). This is a point in time when the appointment of a dynamic economic demographer, with some support staff, to this Department, could help the Planning Commission focus on policy issues and data needs related to population, and bring important analysis of such issues to the attention of other agencies of government.

Assistance to the provinces in development of population policies

With devolution, the responsibility for development planning has shifted to the province level. While considerable work has gone into preparation of population policies in the three provinces of Punjab, Sindh and KP, it has been noted that their population plans are not really integrated into broader plans for economic and human development, nor are the targets identified in provincial health sector strategies in concurrence with provincial population policies (Population Council, 2016: 8-92). Although the Population Welfare Departments have been the focal points for the preparation of provincial population policies, over the longer run, technical assistance to provincial Departments of Planning could be a more strategic investment because of their broad mandate, greater prestige and ability to get the Departments of Health and of Population Welfare to work together.

Develop district level plans of action

The district level is really the locus of development activities. Unfortunately, planning capacity is variable at this level. If dynamic programs of family planning/reproductive health are to be developed at the district level, there is an urgent need for the development of district level plans of action, spelling out the aims and specific policy measures. For this and for other purposes, district-level population projections are badly needed, but it is not clear how such projections – which require complex assumptions about migration in particular – can best be done. Ideally, the Pakistan Bureau of Statistics – or possibly, NIPS - should prepare such projections for all districts, as they have more technical expertise in this area than any other agency, and the need for centrally-computed district projections to sum to the projected population of Pakistan would minimize the risk of unrealistic projections being carried out for individual districts.

Revival of demographic training and research in Pakistan

Pakistan needs serious research into demographic issues, underpinned by some strong centres of demographic training and research. But although university centres for demographic training and research were set up in the University of Agriculture, Faisalabad, University of Karachi, and University of the Punjab, the centre in Karachi has closed down and the other two have not developed into strong centres. In PIDE, when demographic training was offered, there was not much take-up. There needs to be at least one strong centre in each of the three largest provinces, ideally two. Developing strong centres of population training and research takes time, and substantial resources. Considerable numbers of graduate students need to be sent to leading universities abroad, bonded in some way to the sending institution when they return. Ideally, one or two leading overseas demographers should be recruited to spend periods of time with these centres, particularly when staffing is weak because of staff being trained overseas.

An alternative - or part-alternative – would be to rebuild the population research and training work at PIDE.

A major research project on migration and urbanization in Pakistan.

Serious research is needed into migration and urbanization trends in Pakistan. Given Pakistan's high rate of population growth, both rural and urban populations are increasing rapidly through natural increase. Earlier patterns of male-dominated migration to urban areas are thought to be changing in favour of more family migration. At the same time, large refugee movements are complicating the situation.

It does not take a very high rate of out-migration from rural areas to raise urban growth rates to alarming levels, and this is what appears to be happening, although data deficiencies make it difficult to measure exactly what is going on. A major “State of Pakistan Cities Report” is planned, spearheaded by the Ministry of Climate Change with technical

assistance from UN-Habitat and funded by the Australian Government. While this will meet some of the planning needs, a comprehensive study is needed of urban dynamics at all levels, including intermediate cities and small towns, and the way migration is influencing trends.

The long time lag since the last census has resulted in a lack of suitable data, and if the Census is indeed held in April 2017, the availability of some data by 2018 should form the basis for a major research project on migration and urbanization. It must be stressed that only a census can provide the kind of detailed small area information that is crucial for studies on migration and the dynamics of growth of Pakistan's urban areas, particularly the mega-urban regions surrounding its largest cities.

However, irrespective of whether the Census eventuates, systematic research on Pakistan's migration patterns is essential. Certain other sources of data could be used. For example, the Labour Force Surveys conducted every year do have questions on migration which can be used to measure inter-Provincial migration. The Pakistan Social and Living Measurement (PSLM) Survey – an annual survey covering 75,000 cases – is also representative at province level and every 3rd or 4th year, with a larger sample, it is representative at district level. If agreement can be reached that an appropriate question or questions on migration be included in this survey, an agency such as PIDS or NIPS could be given responsibility for conducting policy-relevant research into migration and urbanization patterns.

An alternative approach would be to conduct a major migration survey. The advantage of a customized migration survey is that, with more detailed questions, much richer data could be collected, including on short-term movement and commuting. The survey data could be analysed by different research institutions, with PIDE probably playing the main role.

Comprehensive research on adolescents and youth in Pakistan

Given the crucial role of adolescents and youth in realizing the "demographic bonus" over the next two decades in Pakistan, a great deal depends on how effectively the tremendous potential and enthusiasm of adolescents and youth can be harnessed to achieve the development goals that are within sight. In order for the bonus to be realized, and not turn into a disaster, young people must be given the best opportunities for health, education and satisfying work. Many problems beset youth, however, not least among which are their reproductive health needs. Youth in Pakistan express the desire to be provided family planning information, if possible privately, preferably through the internet, social media and mobile voice messages including videos or pictures for the uneducated. In order to understand the challenges and opportunities, a comprehensive youth survey should be mounted, representative of regions and rural and urban areas, from which the key problems and opportunities faced by youth can be detected.

More regular data on fertility trends

The only source of data on fertility trends in Pakistan, aside from the DHS, is the PSLM Surveys. However, fertility data are only collected every second year in this survey, the most recent estimates being those from the 2013-14 Survey. Given the need to carefully monitor fertility trends, particularly if family planning efforts are stepped up, fertility data need to be collected each year in this survey.

Major study – Pakistan + 50

In order to focus attention on the implications of demographic trends for economic and social development in Pakistan, a high-level study to examine likely trends in population until 2050 and their implications should be commissioned, probably under the auspices of the Planning Commission, though other possibilities would include PIDE or NIPS. This project would need to involve senior economists, demographers and sociologists. The title "Pakistan + 50" is meant to emphasize that Pakistan's population is expected to increase by at least 50 per cent by the year 2050. The study would emphasize the development implications of these trends, along with consideration of ways of modifying demographic trends.

Programmatic developments to achieve population goals:

(1) Lowering mortality

Infant mortality rates in Pakistan, though declining, remain unacceptably high, and further declines would not only be a fundamental step toward increasing wellbeing, especially of the poor, who suffer much higher rates, but would also contribute to completing the transition of fertility rates to population replacement level. As demographic theory emphasizes, lowering of infant mortality is an important prerequisite for reaching low levels of fertility, because it undercuts the "replacement" motivation for having more children.

While the limited resources available for the task of lowering mortality and improving the health of the population remains a great challenge for Pakistan, the opportunities are certainly there. The recent Lancet Commission on Global Health notes that investing in health has a huge payoff. Mortality reductions account for 11 per cent of recent economic growth in low- and middle-income countries. Health expenditure, then, should be seen not just as consumption or welfare expenditure, but as a key investment in the productive capacity of the economy. Similar economic payoffs have been noted for education, and educational expenditure should also be seen in the same light.

As noted earlier, public spending on health in Pakistan averaged only 0.51 per cent of GDP over the past decade - one of the lowest in the world. But the Ministry of Planning and Development plans to raise this to 3% by 2025, and this has been endorsed by the Chief Ministers of the provinces.

(2) Improving reproductive health

The National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child and Adolescent Health, and Nutrition, 2016-2025, presented a ten-point priority agenda for improving the state of R-MNCAH and nutrition. Serious attention to this agenda could be expected to have major impact on reproductive health, but some of the items on the agenda read like a "wish list" and progress in achieving many of the goals is likely to be slow. The document recognizes that federal and provincial government need to substantially increase funding for RMNCAH to enable many of the improvements proposed to be achievable, and that the political will must be generated to view RMNCAH and Nutrition as national priorities clearly understood by all levels of government. One important priority is to improve the access to and quality of community based services, emphasizing more effective utilization of LHWs and CMWs, to recruit and train young women as CHWs in areas uncovered by LHWs due to shortage of appropriately qualified and trained young women, and to cover urban slums in larger cities with community volunteer health workers. Other key elements include improvement of quality of care in district facilities including rural health centres and district hospitals; overcoming financial barriers to care seeking, perhaps through a mixed model of interventions including conditional cash transfers, health insurance schemes for the poorest and marginalized groups, funded by government, and subsidies to public providers; addressing social determinants of health; and strengthening district information systems.

The 10-point priority agenda recognizes that "family planning (FP) is one of the most cost effective interventions to reduce maternal and newborn deaths" and that "the vicious cycle of continued high rates of population growth and poor RMNCAH outcomes and nutrition in Pakistan needs urgent

attention".

(3) Re-invigorating family planning

It was argued earlier in this section that a key reason why fertility remains high in Pakistan is that the nation's broad socio-economic development goals have not been met, in particular those focusing on human development. Notwithstanding the crucial need for more rapid socio-economic development, however, there are also specifics that can be worked on, and the key specific is meeting the unmet need for family planning. This is because meeting unmet need is an unambiguously positive and non-coercive way to link behavioural change that will benefit people as individuals and couples with a broad macro-aim of lowering the fertility rate and the rate of population growth – which will also, of course, through its positive macro-economic effects, benefit people as individuals and families. **Positive micro- and macro-benefits come together when unmet need for family planning is met.** It is crucial, then, to find ways in which unmet need for family planning can be more effectively met.

The recommendations are, in principle, straightforward, requiring well-designed and focused interventions. Family planning services need to be brought more effectively to people's doorsteps; misconceptions about religious teachings and about side effects of methods need to be put to rest; referral facilities in the public health network need to be equipped to meet clients' needs; the private sector and community groups need to be brought more effectively into the provision of services; barriers to availability of contraceptives in private sector outlets need to be removed; the range of methods effectively available to clients needs to be widened. The rise in CPR in a number of projects discussed in the section on "Public-private partnerships for service delivery" shows some of the approaches that work; the urgent need is to scale up the more successful of these interventions so that they can have a more thorough impact on family planning practice across the country.

The major problem in putting many of these principles into practice is that Health Departments have not been giving enough emphasis to family planning. In the 2000-2010 period, the Department of Health at all levels "focused on the primary function of curative care, and considered FP as secondary in their role ... . FP required sustained time and efforts for motivation and counselling whereas the heavy burden of curative care consumes most of the time of an already understaffed health infrastructure" (Ahmed, 2013: 42). The leadership role of the Departments of Health is crucial for the provision of family planning and reproductive health services; family planning needs to be considered as a routine and regular part of its mandatory services. This needs to be addressed urgently. Happily, the developing provincial health strategies appear to be giving due importance to delivering family planning services (Population Council, 2016). Effective partnership between the Population Welfare Department and Department of Health could include expanded timings in the public sector and setting up of separate family planning service centres within all public health outlets.

One key issue appears to be the effective utilization of Lady Health Workers (LHW). If indeed family planning is receiving renewed emphasis in government priorities, then the family planning activities of LHWs should be given higher priority. The quality of services offered by the LHWs needs review and constant monitoring to ensure the trust of clients in their work. Clear agreement by provincial governments to fill positions of LHWs who leave is needed, to ensure that the numbers of LHW are maintained and ideally, increased.

Integrating family planning services into mother and child health services through a program focused on post-placental insertion of IUCDs (often referred to as postpartum family planning) has some real potential. It appears to have been institutionalized successfully at two major public hospitals. The advantage of a postpartum approach is that, if women make the decision to adopt family planning postpartum, they can be provided with the necessary method while still in the health facility. This obviates the need to reach them with a method once they have returned home, though of course they will still require follow-up care. In the Pakistan situation, though, there is a real danger that because of heavy workloads of hospital and health centre staff, women being advised to consider postpartum family planning will not be given enough information and counselling, with the result that they will be forced to make a decision based on limited information and limited discussion. An element of coercion could thus easily creep into such programs.

There is a misconception that men in Pakistan are not supportive of family planning and consider it to be a matter that only concerns women. DHS Survey findings do not support this belief. The increased use of condoms and withdrawal also indicate men's initiative, though unfortunately it also reflects poor service delivery that is resulting in more shifting to natural methods. The USAID-funded FALAH project raised CPR in the target districts, through a strategy of using male community-based volunteers to inform, educate and counsel men in remote communities not served by Lady Health Workers. Men's group meetings were held, ulema were sensitized to propagate the birth spacing message in Friday sermons and other occasions, community theatre performances were used to introduce birth spacing as a health and social issue, and birth spacing messages were spread through television and radio. While the independent effect of these different interventions is not easy to measure, the effect of exposure to television messages and the men's group meetings are considered to have been clearly influential in involving men more fully in family planning programs (Ashfaq and Sadiq, 2015).

One reason for optimism about the future prospects for family planning is that, based on many focus groups discussions with a total of 377 participants, the Population Council's Landscape Analysis found that young people have a very positive view of family planning and express unqualified readiness to adopt it regardless of gender, school status and rural or urban residence (Population Council, 2016: xvi).

From the available studies and reviews, the following approaches appear to have considerable potential in the Pakistan situation.

Communication initiatives:

- Engaging religious leaders as proponents rather than opponents of family planning.
- Shifting the focus of messaging from "smaller families" to "birth spacing", stressing that religious scholars generally support birth spacing in the interests of maternal and child health
- Involving men more directly in support of family planning initiatives
- Educating and training journalists, broadcasters and others in media to deal objectively and interestingly with issues of population and development, reproductive health and family planning.

Enhancing access to services:

- Shifting to a less doctor-centric service provision model, more focused on lower-level providers, including male providers, and a greater role for pharmacies, to ensure widespread availability of methods.
- Removing barriers to private sector involvement in distribution of contraceptives.
- Enabling LHWs to return to a stronger emphasis on family planning, and ensuring that community midwives also emphasize family planning
- Training service providers in client-centred care and Islamic perspectives on family planning
- Training local women in remote communities – as exemplified in the MARVI program
- Urgently addressing the chronic issue of contraceptive stockouts through better

logistics management – staff training and emphasis on monthly distribution of supplies by all district departments to facilities and LHWs

Recommendations on strategic partnerships

Many United Nations groups, national aid agencies such as USAID, KFW and DIFID, along with the World Bank and the Asian Development Bank, and international NGOs, are working on development issues in Pakistan. The key INGOs working in the areas of population and development, family planning and reproductive health are the Population Council, Pathfinder International and the Marie Stopes Foundation. Most of these agencies meet together in a semi-formal way in monthly meetings. However, more can be done to build more effective partnerships.

The World Bank, for example, explicitly emphasizes a focus on women, children and youth in its programs in Pakistan, addressing inequity in all shapes and forms (with special attention to lagging regions and vulnerable groups), and engaging with local communities. They are also doing some analytical work on population with provincial governments. Given these priorities, there should be a number of areas where partnership with UNFPA is possible.

The UNFPA has provided technical support to the provinces of Punjab, KP and Sindh in the preparation of their population policies. The Gates Foundation has supported the development of policy in Sindh and Punjab, and USAID is providing support for family planning in Sindh. Strategic partnerships should be fostered in continuing support of this kind for provincial governments.

Strategic roles of UNFPA with Government/UN agencies/other development actors/stakeholders

UNFPA's 8th Country Programme has four main programmatic areas: (1) Policy advocacy; (2) Sexual and reproductive health with a youth focus; (3) Family planning and maternal health in development and humanitarian contexts; (4) Population and development. Being an orange country, UNFPA in Pakistan focused on policy advocacy, on "demonstration" projects and building the capacity to produce and use data (Khan and Wazir, 2016: 30-1).
These emphases should be maintained in the 9th Country Programme, but with some modifications. UNFPA should be taking a strong advocacy role, constantly emphasizing to the government the importance of population–development relationships and stressing these to all agencies of government. UNFPA should be looking at the big picture, assisting the government in strengthening its capacity for policy formulation in the area of population and development, and being the "go-to" agency for all matters related to population and development.

There are a number of correlates of this advocacy role. One is the need to build knowledge of the demographic aspects of development, which requires attention to capacity building in demographic research, and particularly economic demography, since economic planners are more convinced by arguments with strong underpinning in economics. Another is ensuring that the necessary data are available and utilized effectively. UNFPA has supported relevant analytical studies by NIPS and the Population Council, and is supporting the National Transfer Accounts study at PIDE. This kind of focused support for quality studies should be continued. The forthcoming Census is crucial, as is the DHS planned for 2017, and UNFPA should support research flowing from these. Ideally, if the Government wishes it, UNFPA could also provide technical assistance to an appropriate arm of government – probably the Planning Commission – to develop its capacity to analyse population-development inter-linkages. If resources permit, UNFPA could support a major migration survey and a major survey on adolescents and youth, both much needed to underpin the development of policy in these crucial areas.

It is generally accepted among the development partners interviewed that UNFPA should take the lead role in coordination among donors in the population and development and family planning areas, helping to avoid duplication, linking the donors with government, and engaging in dialogue with government about the best ways forward in the family planning area. A number of those interviewed argued that UNFPA has had too many small projects, including some involving the provision of services in the family planning/RH area. This is not UNFPA's most effective role.

Principles for UNFPA involvement:

- Engaging with government in addressing broad population and development issues
- Focusing on the key areas of population-development interaction – high fertility, infant and maternal mortality, and migration patterns
- Productively engaging youth and women in development
- Focusing on assisting the poor and vulnerable
- Supporting innovative pilot projects to meet unmet need for family planning and improve ASRH

Specific suggestions for UNFPA involvement:

- Serving as the key focal point for donors in the population policy and RH/FP area, and the key liaison between donors and government in these areas. UNFPA has been playing such a role, including conducting coordination meetings, but should be more active in orienting the donors, helping avoid duplication of effort, and linking with government
- Providing technical assistance to government, ideally to the Planning Commission, perhaps linked to a specific project, such as Pakistan + 50. UNFPA has also been providing technical assistance to the Pakistan Bureau of Statistics in planning for the Census, and related assistance could be continued.
- Providing similar technical assistance to the Department of Planning in one or more provinces, since many planning functions have now moved to the provincial level. A team consisting of an economic demographer, a health economist and a family planning expert could greatly assist in the elaboration of provincial population policies. As part of this process, assistance with the development of district-level plans of action would be useful. These would overview the population trends in the district, the facilities and services available in the area of family planning and reproductive health, and the key challenges. They would develop CPR targets and action plans for meeting them and better deploying the resources available. Support for such district plans could start on a pilot basis.
- Advocacy – work on training journalists in the electronic, print and web-based media in better understanding of population and development, and family planning/reproductive health issues. Regular and systematic training is needed. This should be done by government, but a pilot program run by UNFPA in collaboration with an agency such as NIPS in one or more provinces could help government to see how this can be done.
- Helping build a cadre of researchers/policy analysts in the population field by supporting the development of population teaching and research programs in a number of key universities and/or in PIDS.
- Sponsor a major report on migration and urbanization in Pakistan. Lack of data is a difficulty, but the Labour Force and PSLM Surveys could supply some data if suitable questions were included. Later, analysis of migration data from the Census should be supported; if the Population Census does not eventuate in April 2017 as planned (and perhaps even if it does), UNFPA could support a major migration survey for Pakistan.
- A nationally representative survey on adolescents and youth in Pakistan is also of

high priority, and UNFPA may wish to support such a survey with particular focus on SRHR, and assist in analysis of its findings and application of these to policy development. The Population Council, which has recently launched a report on youth in Pakistan, could be a partner in such an activity.

Though the UNFPA should not be involved in regular service provision activities in RH/FP and ASRH, it should be strategically engaged in pilot projects and other demonstration activities with potential multiplier effects. The key objective must be to reduce the level of unmet need from the 20% registered in 2012 to 10% or below.

11. CONCLUSION

Pakistan has been left behind by all major Asian countries in stabilizing its population size through transition to low birth and death rates. This is partly because of the difficult political and economic circumstances it has faced, but largely because it has failed to prioritize education, health and other human development policies and has failed to provide adequate family planning services for citizens wishing to space or limit births. Pakistan ranks near the bottom of the world's countries in terms of human development indicators, gender equity and the rights and empowerment of women.

A country's international competitiveness is directly influenced by its population and human development situation. In this respect, Pakistan can be likened to a boxer fighting with one hand behind its back – through failing to educate its youth effectively, failing to raise health levels as quickly as possible, failing to provide family planning services to all who need them and failing to integrate women into the workforce. Pakistan has been left behind by a number of Muslim-majority countries which have been benefiting from slower population growth and the demographic dividend for quite some time.

The prospects for population growth are clear: Pakistan faces enormous population growth over the next 20 years – probably at least 74 million, or 37 per cent. And growth will continue well beyond that time, even if fertility rates fall to replacement level very rapidly. This is not to deny that the trajectory of fertility decline matters; the further into the future projections are taken, the wider the difference between the population size and structure resulting from alternative fertility trends.

The positive demographic news is that the demographic dividend has begun to be felt, and will continue to benefit development over coming decades. The more quickly fertility declines, the earlier and larger the potential benefit will be. Whether this potential benefit is reaped will depend on the degree of success in raising healthy and educated children, developing an economy in which they can find productive employment, and changing social attitudes so that women can play the role in the economy that befits their rising educational levels.

In the past, there has been a lack of emphasis by national leaders on the need to stabilize population growth, a suspicion in many quarters that family planning is a western-inspired plot, and uncertainty about whether family planning is consistent with Islamic teachings. The need for a slowing of population growth is now recognized in various official documents, but not driven by forceful support from the top national and provincial leadership. The key need is to move from words to action. There has been a remarkable lack of urgency in official circles with regard to health issues in general, and to family planning in particular. This is holding back development, not only in those crucial areas, but in wider aspects of development that are influenced by rapid population growth and poor health status.

The proponents of a more effective focus on population policy in Pakistan are looking for positive signs of official support; some signs are there, but not any evidence that national leaders see this issue as a basic problem underlying most of the other issues that Pakistan faces. There is insufficient recognition of the ways in which rapid population growth has held back economic development, and in particular, human development, in Pakistan.

The need to raise health and education budgets is clear, and recognized in official circles. If health expenditures are indeed raised from around 0.5% to 3% of government budgets, this will enable the appointment of more health workers at all levels, improving their salary and working conditions, especially for those working in difficult areas, and ensuring the availability of needed drugs and

equipment – as a simple example, ensuring that essential newborn equipment such as baby scales, foetal stethoscopes and bulb syringes are available at the lower level health facilities, which is often not the case at present (Mir et al., 2013: 120). Similarly, the allocation of twice as high a proportion of the GDP to education, as planned, will enable some of the glaring deficiencies in primary and secondary schooling in Pakistan to be addressed.

With devolution, population planning has become a provincial responsibility. Though the process has been slow, there are now promising developments in the preparation of provincial population policies and in taking over provincial responsibility for all aspects of planning in the health and RH/FP areas, including the preparation of costed implementation plans, which should ensure that the chain of supplies and commodities in the health and family planning areas is not disrupted. These developments need the support of the donor community.

Many opportunities have been identified in this report for initiatives that would facilitate more rapid movement in the population and development areas, and in FP/RH and ASRH in Pakistan. Many of these have to do with increasing understanding of population-development relationships. To summarize these, there is a need to strengthen population policy analysis, both within the Planning Commission and, now that so much planning has moved to the provincial level, in the provincial planning agencies. Also, district level plans of action now assume great importance, and modalities for preparing them better are needed. Some strong centres of population research and training need to be developed, to underpin the analysis of population change and its relationship with development. Analysis of the upcoming Population Census data on migration and youth, once available, should receive high priority. If the Census turns out to be further delayed (and perhaps even if it does not), there is a case for the conduct of a major migration survey and a major survey of adolescents and youth, both of which could enable much more detailed analysis of these important areas than is presently possible.

As for the re-invigoration of the family planning program, the emphasis should be on meeting the high level of unmet need for family planning. This is an unambiguously positive and non-coercive way to link behavioural change that will benefit people as individuals and couples with a broad macro-aim of lowering the fertility rate and the rate of population growth – which will of course, through its positive macro-economic effects, also benefit people as individuals and families. Some specific ways of doing this through communication initiatives and enhancing access to services have been outlined.

Up to this point, family planning has not been seen as a health imperative in Pakistan, much less as a broader development imperative through its effects on birth rates, rates of population growth and the status of women. The following statement from Dr. Babatande Osotimehin, Executive Director of UNFPA, deserves to be strongly supported:

Having children is an important life decision that should be made freely and from a position of empowerment. Access to sexual and reproductive health, including voluntary family planning, expands options for women and adolescent girls to shape their future and fulfil their potential. It leads to fewer births, fewer deaths and fewer injuries. It also allows women and girls to obtain more education, better employment, and greater equality, all of which help eradicate poverty and transform our world.

As far as UNFPA's role is concerned, it should be strongly stressing advocacy, constantly emphasizing to all possible agencies of government the importance of population–development relationships. UNFPA should be looking at the big picture, assisting the national and provincial governments in strengthening their capacity for policy formulation in the area of population and development. It should also serve as the key focal point for donors in the population policy and family planning/RH area, and the key liaison between donors and government in these areas. A number of specific recommendations for action by UNFPA are outlined in the report.

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