Family Planning in Pakistan: Applying What We Have Learned

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Abstract

Despite six decades of government and private sector programs, CPR in Pakistan is among the lowest in the region. This article reviews published and grey literature to understand why despite sufficient time and usually sufficient funding, CPR remains low in Pakistan. This paper looks beyond the usual factors of quality of services, coverage and supplies and management issues to examine how family planning may be improved in Pakistan.

Based on analysis of the Pakistan Demographic Health Survey 2006-7, the public sector provides around a third of FP services, while NGOs and private providers another 15%. More than half of all family planning users buy their methods directly from stores. Within the government, the services cost 5-8 fold more than the private sector. Nearly a fifth of pregnancies end in an abortion suggesting the role of abortions as a key FP method. This together with a high unmet need pose the question: why is there such low uptake of FP services in the country.

To explain this lack of uptake, we explore the limitations of the public sector in providing services, the lack of effect of religious beliefs, of abundant, yet misdirected funding and gaps in demand creation. The increasing role of NGOs and donors in filling the void left by the public sector is discussed. Suggestions are provided about improving public and private sector services including better information gathering and use in defining needs, measuring results and creating demand for FP.

Keywords: Family planning, CPR, Contraception, Utilization, Policy, Pakistan, Programming, Service delivery.

Introduction

With an estimated population of 180 million in 2012, Pakistan is the sixth most populous country in the world. Although Pakistan initiated Family Planning (FP) programs in the private sector in 1953 and in the 1960s in the public sector, the Contraceptive Prevalence Rate (CPR) has increased by only 0.25% annually until 1990.The CPR rose more sharply from 12% in 1990 to 33% in 2000; with much of this increase occurring in rural areas and in traditional methods(1-3). In the following decade, the CPR languished again and was 30% in 2006-7.[1] Of the nearly 24 million married women of reproductive age (MWRA) 17 million,do not use any FP including nearly 6 million (25%) that have an unmet need for FP and 300,000-850,000 women seek abortions every year, often as an FP method.

There is a sense that much of the success of the 90s, while perhaps galvanized by the initiation of public sector outreach FP program i.e. Lady Health Workers program, were due to secular trends and happened in spite of, rather than due to, the services being offered. As in much of health, over the last two decades the bulk of FP services have transitioned from the public sector to the private sector. Public sector Departments of Health and Population Welfare now provide 35% of all FP services nationwide, while the private sector now constitutes the majority of FP services nationwide and constitutes predominantly of direct self-procurement of commodities from stores or services from private clinics or NGOs by women/couples.

The magnitude of this transition and its implications on the role of the public sector, donor focus, funding allocations, quality assurance, and methods mix have yet to be seriously accepted or addressed in the national FP agenda, debates or planning. This overview discusses FP service delivery in Pakistan in terms of changing historical trends, shifts in policies, and the evolving roles of different stakeholders so that this information may guide decision makers to accelerate FP efforts for meeting MDG goals in Pakistan.

Methodology

A search of Medline®, Popline® and Google®, combining "Pakistan", "family planning", "contraception", "sterilization" and "public policy" yielded very few references, mostly in the grey literature;

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of which only about 15 were directly about aspects of Family Planning (FP) in Pakistan. These were supplemented by additional grey reports based on recommendations by experts and snowballing from the references provided in articles and reports. We included both published and unpublished studies which were relevant to the topic. This evidence base was supplemented by a series of analyses conducted by our group using national survey data bases such as Pakistan Demographic and Health Survey (PDHS) 2006-7, Pakistan Social and Living Standards Measure (PSLM) 2010-11 and the National Health Accounts (NHA) 2005-6 and published online in the form of policy briefs at www.resdev.org/e2pa. Since much of available data are unpublished, this review aims to make the rich data from these "grey publications" available in the scientific literature.

Family Planning At A Glance

The Historical Perspective

Pakistan Government initiated its FP programme in 1966, and allocated 10% of the total health budget to FP with emphasis on mass media to promote voluntary spacing and adopted a target oriented approach to FP programming while aiming to reduce birth rates from 50/1000 to 40/1000. The Population Welfare Programme and the National Family Planning Council (eventually the Population Welfare Division of the Health Ministry) were also initiated in this decade.

The 1970s and the 1980s saw very modest successes from the Continuous Motivation System — where motivation teams encourage clients to use contraceptives — and the Continuous Inundation Scheme — where the supplies were to be distributed nationwide to ensure a steady flow of commodities.[4] In the former, the pre-defined composition of teams was too rigid to allow nuances of local contexts and the latter failed due to absence of adequate logistics systems and feedback. These management issues were compounded by inconsistent political support, for e.g. in 1982 the cadre of district technical officers — "lady doctors" who also oversaw paramedics — was abruptly eliminated, leaving mainly male providers in FP clinics.[4] Another example of political interference was the separation of the Population Welfare Division of the Health Division into a full ministry in the 1980s that led to fragmentation of FP programming in the government. Reflecting these issues and despite formulation of ambitious plans — that were most lyrhetorical and without funding commitments suggesting a lack of firm political support — the 1980s saw little progress. By 1990, the CPR was 12%, up from 4% in 1966, or around 0.3% per annum.

Interest in FP revived in the 1990s. Public-private partnerships and social marketing of contraceptives — inauguration of Greenstar and Key Social Marketing NGOs — were promoted and strong political support ultimately led to the formation of the Lady Health Workers' (LHW) program which contributed to the rapid rise in CPR in rural areas. The CPR increased to 30-33% in 2000 with near quadrupling of rural CPR in the decade.

In 2001, population had increased to 144 million, encouraging the formulation of a new Population Policy in 2002 that sought to reduce the fertility rates by half by 2010. These targets were matched by near doubling of government funding from around USD 52 million annually in 2002 to an average of around USD 83 million annually between 2003 and 2010 (UNFPA, Pakistan). However only 6% (0-16% in any given year) of these funds bought supplies, while the rest paid for salaries and overheads. The decade between 2000 and 2010 saw stagnation or even a fall in CPR from 30-33% in 2000 to 30% in 2006-7.

CPR and Estimated Users

The national CPR was 30% in the PDHS 2006-7, the last available national survey, reflecting an annual increase of 0.5% since 1960s.This CPR is much lower than Pakistan's regional neighbours Iran (79%), India (56%) and Bangladesh (56%) and translates into some of the highest fertility rates (TFR: 4.1) in the region. In 2007, the year that PDHS was conducted, there were 24 million MWRA in Pakistan, 22% (5 million) of these were using modern contraception and 8% (2 million) used traditional methods.[1] A large proportion (17 million) of women did not use any FP including 5.7 million (25%) had an unmet need for FP. In any given year, less than 12% of MWRA — 2.9 million women or around half the number of women with an unmet need for FP — received any FP services by either the public or the private sector.

Method Mix and Service Mix

The method mix for modern contraceptives includes female sterilization (37%), condoms (31%), IUDs (11%), injections (11%) and oral contraceptive pills (10%). However, female sterilization and IUD are long term methods and women who receive these continue to be included in CPR for years even when they don't receive these services anymore. Adjusting the PDHS method mix for women who received FP services in the past 12 months gives the total number of women who received FP services in a given year. Thus, 2.9 million women

receive FP services each year in Pakistan, with 54% receiving condoms, 18% injections, 17% pills, 6% receiving sterilization and 3% IUDs.

Long terms methods have never really been consistently promoted or taken hold in Pakistan. Although female sterilization is the commonest method in the CPR mix, it is not a commonly availed FP service. It also happens too late — at a mean of 39 years of age or after bearing 6 or more children — to help in population stabilization or meaningfully limit fertility. Moreover, outreach workers (Lady Health Workers) or health providers rarely advocate it to women before the 4th child, further limiting its utility. Despite their ease of application and utility worldwide, a number of misconceptions abound among communities and providers in Pakistan regarding IUDs that have led to limited acceptance of IUDs in Pakistan.[5] Similarly, the Health Ministry/Departments introduced injections in their method mix in 2008. Altogether long term methods account for around 20% of all FP services in Pakistan and reach around 296,000 women annually. Short term methods such as condoms and oral pills are the mainstay of the LHW program and for those who buy contraceptive directly from stores, in part reflecting their ease of procurement and the control they grant the user over the method.[6,7] Patterns of service uptake also vary between rural and urban areas. Uptake of modern contraception is much higher in urban (30%) than rural (18%) areas, even though rural areas caught up somewhat during the nineties.[8] Condoms are more common in urban locations and compared to female sterilizations in rural areas.

Main Issues

Service Providers

Family planning services are available from the public and private sectors. In the public sector, services are provided by either the Family Welfare or Reproductive Health Services Centres (RHS) of the Population Welfare Department or the Basic Health Units (BHUs) and Lady Health Workers of the Health Departments. Together they accounted for around 35% of all services and reached just under 1 million women annually in 2007. In the last two decades FP service provision has transitioned away from the public sector leaving its facilities vastly underutilized. For instance, on average Population Welfare facilities serve two women with sterilization and one with an IUD every 2 weeks. LHWs devote 9% of their time to FP and serve approximately 4 women with FP services each every year.[9] Despite these issues, the public sector is the main provider of FP services for the poor.[7]

Nearly half of all FP users directly buy commodities from stores and chemists directly without advice or counselling from a health professional. The rest of the private sector — around 15% of all FP services in PDHS 2006-7 — includes clinics run by NGOs and individual private providers. However, the role of NGOs has expanded since 2008. For example, the Marie Stopes Society now serves around 1.1 million women with FP services annually, up from start of FP service provision in 2008 (MSS records, Azmat K, private communication). Other major FP NGO providers include the Rahnuma — Family Planning Association of Pakistan (FPAP) and Greenstar Social Marketing that serve an additional 0.3-0.5 million women annually (NGO websites and private communication).

Matching Service Delivery and Uptake

Nearly all FP commodities are imported. All imports first come to a central warehouse located in Karachi and are then supplied to different public and private sector providers. These supplies are reported annually by the Federal Bureau of Statistics, allowing for triangulation of supply of commodities, and therefore services, against uptake of these supplies from community based survey data such as the PDHS. With the exception of IUDs, commodity supply data provided by the central warehouse matches commodity uptake from the PDHS. It appears that approximately 1.14 million IUDs were supplied from the central warehouse compared to the actual uptake of 100,000 in the PDHS (Table-1). This discrepancy holds for the public as well as the private sector.[10]

Trends of Service Delivery over Time

The supply of FP commodities (and presumably the services) has remained unchanged or perhaps even declined (by 7%) between 2006 and 2011. The main decline was in the private sector (15%), while the public sector remained unchanged. If supply data are true, a drop of 7% in supplies represents a fall in CPR for

Table-1: Service delivery vs. uptake in 2006-07. (Persons served in millions).

	Services Delivered*	Service Uptake±	Difference
Condoms	1.61	1.61	0
Oral Pills	0.68	0.50	0.18 (27%)
IUD	1.24	0.10	1.14 (92%)
Injections	0.60	0.54	0.06 (10%)
Sterilization	0.18	0.17	0.01 (<1%)
Total Users	4.31	2.92	1.39 (32%)

* From Contraceptive Performance Report 2006-7.

± From the Pakistan Demographic Health Survey 2006-7.

Table-2: Trends in commodity/ service supply 2007 - 2011.

	2006-07	2007-08	2008-09	2009-10	2010-11	Difference: 2011-2006
Condoms	1.61	1.66	1.33	1.62	1.62	0.01 (0.6%)
Pills	0.68	0.51	0.41	0.44	0.45	-0.23 (-34%)
IUD	1.24	1.37	1.31	1.32	1.21	-0.03 (-3%)
Injections	0.6	0.62	0.56	0.64	0.6	0
Sterilization	0.18	0.21	0.19	0.18	0.14	-0.04 (-25%)
Total	4.31	4.36	3.8	4.2	4.02	-0.3 (-7%)

* Source: Contraceptive Performance Reports from the years 2006-07 to 2010-11.

Table-3: Public-private sector differences in service supply.

Persons served in millions	2006-07	2010-11	Difference: 2011-2006
Differences In The Public Sector			
Condoms	0.47	0.56	0.09 (20%)
Oral pills	0.19	0.25	0.06 (33%)
IUDs	0.91	0.80	-0.11 (-12%)
Injections	0.30	0.34	0.04 (13%)
Sterilizations	0.15	0.11	-0.04 (-26%)
Total	2.02	2.06	0.04 (2%)
Differences In The Private Sector			
Condoms	1.14	1.05	-0.09 (-8%)
Oral pills	0.49	0.20	-0.29 (-59%)
IUDs	0.34	0.41	0.08 (23%)
Injections	0.30	0.26	-0.05 (-15%)
Sterilizations	0.03	0.03	0 (0%)
Total	2.30	1.95	-0.35 (-15%)

modern methods to 18%, since MWRA have increased by an estimated 2 million during this period. On the other hand, survey data from different locations give mixed results and until results from the next PDHS become available in 2013 it is difficult to accurately discern the direction of change in CPR. Most likely, the commodity supply data are incomplete. For example, the Marie Stopes Society served 1.1 million women in 2010-11 whereas supply record attributes only 30,000 women to the NGO for that year. Lack of inaccurate supply data suggests the need for better system of record keeping and a means to use this data to improve services, which can provide feedback on data quality to ensure accurate records are maintained.

Abortions as FP

An estimated 250,000 - 890,000 induced abortions happen every year in Pakistan,[11,12] constituting around 10-20% of all pregnancies and nearly all occur among married women.[13] Punjab and Sindh that have the highest CPR, also have the lowest rates of abortions. Approximately 20% of all women seeking abortions cite contraception failure as a cause,[14] highlighting the need for better counselling even with short term methods. These contraception failures and the inverse relationship between abortions and CPR suggest that perhaps womenmay be using abortion to control fertility.[15,16]

Doctors, nurses, midwives, dais or other untrained providers conduct abortions that cost from USD 8-48. Estimates of abortions by untrained providers run from 7-49% and are higher among poor women or those living in rural locations.[17] Abortions are legal for a few narrowly defined medical reasons, provided they are conducted by doctors. While this narrow definition of legal abortions and providers does not deter women/couples from seeking abortions, it seriously limits access to safe abortions and legal recourse if the situation arises. Additionally, the controversy surrounding abortions has unnecessarily delayed adoption of newer and safer medical procedures such as manual vacuum aspiration and the use of the drug Misoprostol for abortions. Finally, even though most women seeking abortions are MWRA and often aborting to control fertility, post abortion family planning is almost unheard of in clinical care and ignored as a policy issue since policy makers fear religious backlash and feel that discussions on abortion would be a politically risky enterprise.

Policy Issues

A population policy ideally encompasses many aspects of enhancing the lives of populations by ensuring education, healthcare, employment and basic rights.[18] Family planning or limiting population growth is but one of the components of such a policy. A government may not (and in most cases cannot) may not do all directly, but rather promotes an enabling environment where private sector and other actors can contribute to this goal. In Pakistan population policies have perennially focused on FP to the exclusion of other aspects affecting the population such as the education, economy or about developing a productive work force. This stems in part

from the population policy being considered the purview of the Population Welfare Ministry rather than a broader government development document. Thus Health, Finance, Industry, Education and other relevant ministries were only invited to review the final drafts of policy documents and therefore had no substantial contributions to the population policies of Pakistan. This lack of engagement of wider array of complementary ministries and departments such as Planning, Finance and Education in population development suggests that the decision makers are not yet convinced of the benefits of population stabilization or its role in growth.

Even within FP, although the government has historically set ambitious targets and even provided political support and adequate funds, the content of funding was not matched to expansion of services or incentives for shifting the social paradigm for communities to have smaller families. For example, when funding doubled after the approval of the very ambitious Population Policy 2001-2, nearly all but 6% of this additional funding went to personnel. In part this reflects the fact that politicians see health and population welfare as a means to provide jobs to gain votes and senior government officials are obliged or feel pressured to agree with them.[19] Not surprisingly then, despite the government spending around USD 652 million on FP between 2001 and 2009, the CPR may actually have fallen.

Since the primary focus of the public sector is to provide employment, service quality and scale have declined, resulting in expensive public sector services that cost 5-10 times more than the NGO services and hardly meet the needs of the clients.[7] Consequently, the public sector's role has receded to about a third of all FP services with serious underutilization of its facilities. While, some of these stem from lack of or irregular supplies, a lack of focus on FP services, policies that limit counselling and the time allocated to FP services by providers also play a role.

Another issue that compromises public sector performance is the frequent transfers at top levels that seriously limit institutional memory and continuation for policies. The average tenure of Health and Population Welfare Secretary or Director General is 3-6 months. Middle management persists but due to a lack of emphasis on performance, there is little career incentive to achieve results or to seek reforms.

Finally there has been, and remains, a complete disconnect between Population Welfare and Health in delivering FP services. Health Department considers itself as the provider of medical curative services with only secondary responsibility for FP. Although the services that Health and Population Welfare departments provide hardly overlap, neither refers to each other. For example lady health workers seldom ask their clients about their FP needs and almost never about long term methods such as IUDs and sterilization which are provided at Population Welfare facilities. There are numerous instances where there are almost no referrals from health clinics to Reproductive Health Centres despite both being located in the same building.

The overall result of these issues is that policy has had little impact on practices or results as seen from the modest CPR of 30% and even fewer (12%) MWRA availing FP services annually, despite considerable unmet need. A major factor that promotes this situation is the public sector's inability to measure or discuss results such as number of women served or service quality. The result is a lack of accountability in an expensive and underutilized public sector. Since there are few if any mechanisms in the public sector departments to measure actual services, triangulate available service delivery and commodity data with surveys to understand the actual quantum of services being provided, bottlenecks and gaps in services are seldom identified feedback provided to policy and program makers. The national FP effort would benefit from a more robust research agenda that includes service implementation, efficiency, costs, innovations in scale-up, enhancing access of the marginalized women to services and piloting private sector and for-profit services.

Misconceptions about Funding

There is a pervasive belief among public health experts that there limited funding for FP in Pakistanthat is resulting in the persistently low CPR. Empirical evidence shows that the opposite is true. During the 2001-9 period, the Government allocated USD 652 million, providing FP services at USD 40 per woman per year or approximately 8-10 fold higher than some of the NGOs and regional costs;[20] since most of these funds paid for salaries and overheads at underutilized facilities or large management structures and government services cost. The issue therefore has been efficiency in using available funds rather than the absolute amount of funding. However since there are no institutional mechanisms to analyse cost or service data these inefficiencies are not recognized or discussed. The debate therefore remains focused on "under funding of Population Welfare Departments or of FP" without discussing right sizing, efficiencies, paying for performance or results based funding.

Misconceptions about the Role of Religious Beliefs

The common public, health decision makers and public health professionals mostly believe that religious beliefs and proscriptions limit the use of FP in Pakistan. However, the PDHS 2006-7 showed that among nonuser of FP religious reasons accounted for around 5% of non-use. While considerable efforts have gone into mobilizing religious leaders to promote FP at national and grassroots levels, one has to question their utility in terms of the benefit such efforts will yield in promoting FP in Pakistan. It would be worthwhile to critically study the efficacy and utility of previous efforts to overcome religious resistance in Pakistan and other countries.

Advocacy

While the public sector dominated demand creation and advocacy until the 90s, the private sector including NGOs have started playing an increasing role in advocacy to complement the central role they are assuming in service delivery. Some actors such as the David and Lucille Packard Foundation and the Rahnuma — Family Planning Association of Pakistan have played a particular role in driving the agenda for rights and advocacy and in leveraging RH and FP onto the national stage and bringing together NGOs, government and donors on one platform. Donors have had a significant role in promoting FP over the decades as seen by the knock-on effect the USAID support for a supply and logistic system had in steering the debate back to FP in the recent years as it had done in the 1970s.

Within the government, advocacy is seldom directed at politicians or bureaucrats from Planning and Finance ministries (or their counterpart in provincial departments) who make budgetary decisions or engaged the Education Ministry for a more cohesive development approach to population stabilization and growth. Neither Health nor Population Welfare departments have a policy, strategy or in-house personnel for advocacy.

Demand Creation

There has long been a heavy emphasis on creating demand for FP. The earliest efforts date back to the 60s. In the 70s and to some extent in the 80s, the slogan "Do Bacchay Khushhal Gharana" (two children, prosperous household) was promoted via television, radio and newspaper advertising. Considering the minimal change in CPR from the 60s to 90s, these campaigns failed to achieve their purpose. While there were also a number of issues with services, many factors limited the efficacy of demand creation. Foremost perhaps was the fact that government decision makers were always reluctant to openly discuss condoms and specific methods.[21] More importantly, there was considerable emphasis on a uniform message for all parts of Pakistan. The messages were produced centrally and then distributed to provinces, ignoring local contexts. Finally considerable efforts were expanded to gain consensus on the message, often resulting in delays in actual implementation of campaigns. Despite these limitations, while advertisements aired, they improved FP uptake, which then dropped off once the advertisements stopped airing[22] suggesting the importance of sustained messaging (and the availability of services). Furthermore despite the expense and efforts, there were no formal impact evaluations of messages or demand creation strategies. However, in the final reckoning, demand creation did achieve some of its goals since in the PDHS 2006-7, 96% of the women interviewed knew of at least 2 contraception methods and even as far back as 1970s, when services were provided, they were taken up.[23,24]

Effects of Devolution of Health and Population to Provinces

Health and Population Welfare were devolved from the Federal to Provincial Governments in 2010-11, shifting the responsibility for policy, financing and implementation to the provinces. Despite concerns[25] about the provinces' capacity to meet these challenges, preliminary observations suggest that Punjab, Sindh and Khyber Pakhtunkhwa may already have exceeded the performance that was achieved under the federal system. On a policy level devolution has achieved provincial autonomy and responsibility, which is what it set out to achieve. In addition, it has created a market place for ideas and has pit provinces in competition against each other to demonstrate results. Devolution — which in its true sense should devolve decision making to grassroots — also presents an opportunity for Donors to fund the private sector directly, while demanding greater accountability, results and performance, thus putting legitimate pressure that they had not been effective in exerting on the Ministries of Health or Population Welfare.

Lack of Policy Debate on Role of Commercial Services

The private for-profit sector, which provides 95% of birthing and around half of FP services, is poorly understood and its impact is under-appreciated even by experts and hardly ever mentioned in policy dialogue. This is largely because as opposed to a few discrete NGOs and two Government departments, the private

sector comprises of thousands of private providers with varying characteristics and practice patterns. However, as with free markets in other commodities and services, the private sector which already provides nearly all of healthcare needs of the people, can also provide FP services as well and at costs much lower than the public sector. Additionally, evidence abounds that as women enter workforce, their use of FP grows[26,27] and that fertility decreases as affluence increases.[28,29] The question then to ask is should the state subsidize FP services for those who can afford it.[30] After all, one of the lessons from social marketing and the experience of at least one commercial company, DKT International,[31,32] suggest that this is very possible. However, FP is a health promotion service and it is not clear if everyone who needs it will actually buy FP services and it is possible that that the current 1.5 million or so self-procurers represent nearly all those who will buy FP themselves. Motivation of clients to buy FP services and other aspects of contraceptive markets needs to be actively studied and debated at academic and national levels.

Conclusions

Experience suggests that FP policies and programs have definitely achieved some successes when quality services (in outreach or at facilities) and continuous supplies were ensured. However, contraceptive prevalence contributes to the larger canvas of development by impacting population stabilization and growth. On this canvas, individual and macro-level socio-economic realities along with political priorities play a pivotal role. Thus, to reduce unmet need and increase FP usage, beyond maximizing access, quality and demand of services, broader development goals such as educational attainment and economic opportunities for girls and women are crucial. Ideal family size will decrease only when women and families consider the economic cost of children rather than an ephemeral benefit. This will only happen when there are fewer restrictions on women to receive education, enter employment or even leave their houses unaccompanied. Until then, tackling fertility as an isolated service delivery issue will achieve limited success.[33]

Recommendations and Inferences

Policy Level

◆ High level firm commitment to stabilize the population and make it productive has been inconsistent and has resulting the shrinking role of public sector that has fortunately been balanced by an emerging private sector in FP services. Nonetheless, there is a need for clear Government commitment to promote services rather than political economy, regardless of who delivers services.

◆ Build capacity of provincial Health or Population Welfare Departments to advocate to Finance and Planning Departments for protecting funding for FP and RH. This should include the capacity to generate and use evidence for advocacy and to measure programs.

Implementation and Programming

◆ There is a need to institutionalize analysis and use of available information to describe and measure existing services for efficacy and costs and then validating these against survey data which depicts service uptake. NGO do some of this analysis, but it is also needed in the public sector. The government departments can develop this capacity in-house or collaborate/ contract with private sector or academia for this work.

◆ Beyond implementer-level analysis, institutional mechanisms are needed to analyze data from all providers to provide a national picture of FP and FP services that includes lessons learnt, gaps and costs; help implementers understand the analyses; and make this information available for debate. This may be done by a consortium of NGOs, academia and the public sector and should be financially and administratively independent of, but work closely with the government. It will also help if standardized national surveys such as the DHS are repeated frequently and predictably, to measure national progress and to provide a reference frame for analysis of program data.

◆ NGO and public sector programs should develop and follow standards of service delivery to ensure some basic quality. Only functioning, standardized and efficient programs in the public or private sector should be funded. Inefficient or underutilized programs or services in either public or private sector must be discontinued. To expand access to FP services and coverage, competition may be encouraged between public and private providers with the use of vouchers, incentives and other demand side schemes.

Development Approach to Demand Creation

◆ Demand creation for FP must be institutionalized in a broader development approach. Since the majority of women in Pakistan buy FP supplies directly, perhaps the most powerful means to improve CPR is to empower women by improving their economic status. This would include improving education (to catch the generation that are children now) and the overall economy to create jobs that women can avail.

◆ In contrast to the current practice of ad hoc advertising, application of mass media approaches including the principles and practice of marketing and market research to effectively market the FP concept and products and measuring the effectiveness activities to guide further implementation.

Evidence and Research

◆ Research is needed to understand why people seek FP, what factor influences buying decisions, what determines their ability to buy (or at what point would they stop buying), consequences of limited buying power, influences of income and the markets for FP commodities and services and to promote market based service delivery models. Other necessary topics include the costs and applicability and determinants of effective services, models or demand creation; how successes, lessons and experience of post-devolution management of FP services may be shared and guide each other.

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