Policy Brief Series # 107

Research And Development Solutions

FROM POLICY CONSENSUS TO AN EVIDENCE-SCREENED, COSTED DELIVERY COMPACT FOR FAMILY PLANNING IN PAKISTAN

Introduction

Pakistan does not lack family planning and population policy. Recent documents - including FP2030 commitments, the National Population Stabilization Program, the National Health and Population Policy, the Planning Commission framework, and earlier CCI-linked recommendations – all converge around the same broad diagnosis: slow fertility decline, weak service access, commodity insecurity, inadequate and poorly protected financing, weak data use, need for better federal–provincial coordination, and insufficient accountability.

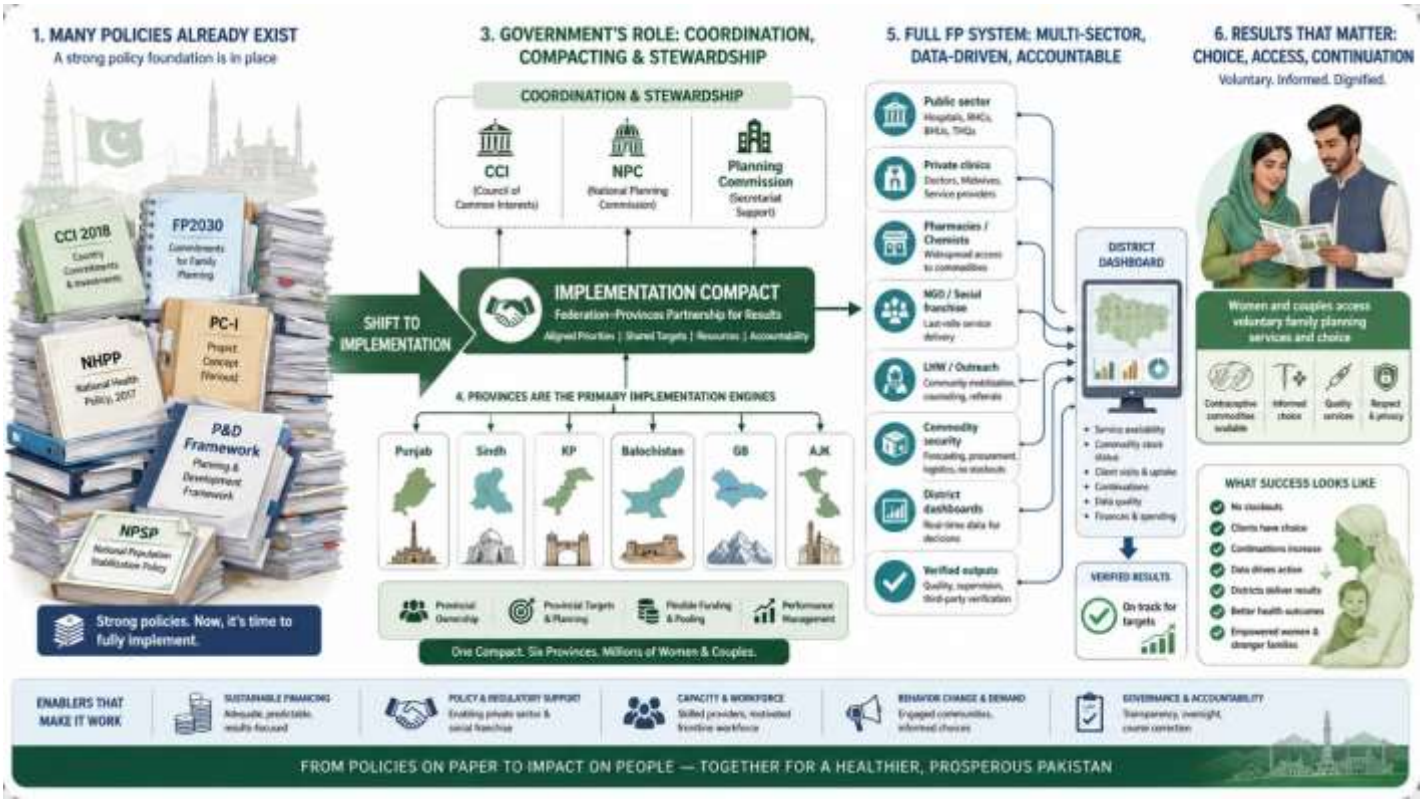
However, convergence must not be mistaken for evidence. CCI 2018 should remain the political foundation, but not the technical blueprint. Their tracking highlights the risk of process-based monitoring: Processes such as meetings were held, notifications issued, portals created, or committees formed led to high implementation scores, while CPR and mCPR stagnated.

Recommendations carried forward from CCI and later documents should now pass **four tests**: 1) Pakistan-specific evidence, 2) implementability, 3) cost, and 4) measurable contribution to CPR/mCPR, continuation, commodity security or fertility-related outcomes.

Pakistan's FP and population documents broadly agree that the next step is not another strategy. It is an evidence-screened, costed and market-aware **implementation compact**: that is provincially owned, federally facilitated, commodity-secure, independently verified, and delivered through the full public–private–community FP market.

POLICY TAKEAWAYS

- Pakistan has enough population policy. It now needs an evidence-screened, costed and market-aware **implementation compact**: provincially owned, federally facilitated, commodity-secure, independently verified, and delivered through the **full FP market**.
- No recommendation is carried over without review of its need and grounding in **local evidence**.
- National Population Council compact specifies sharing for data sharing, regulation and commodity security, leaving implementation details to provinces
- A total market approach that builds the dominant role of the private sector through chemists and clinics by reducing unnecessary regulatory and administrative barriers while maintaining safeguards for safety, quality, informed choice and equity.
- Commodity security through forecasting and ensuring at least 12 months of supply.
- Monitoring based on results such as CPR/mCPR, supplies dispensed etc. rather than processes such committees formed or meetings held.
- Funding decisions based on a national Value for Money assessment, rather than historic accounting.



Analysis

Pakistan continues to **mistake process for progress**. Meetings held, task forces notified, portals created, modules drafted and campaigns launched are not success unless they lead to commodities available, providers active, women counseled, methods dispensed, follow-up completed, stockouts avoided, budgets spent, and CPR/mCPR improving.

Implementation planning remains too public-sector-centered. Government is essential as steward, regulator, purchaser and guarantor of equity, but it is not the main – or even dominant - FP service channel. Public sector accounts for around 35% of annual FP services and reaches only about 5% of MWRA each year, showing very low use of public capacity. PWD facilities averaged less than one FP client per day, and LHWs served less than 10 FP clients a year on average.

This means government should stop financing structures alone and start purchasing verified delivery across the **whole market**: public facilities, PWD outlets, LHWs, private GPs, LHVs, CMWs, pharmacies, shops, chemists, social marketing networks, NGO/social franchises, BISP-linked providers and urban outreach workers.

The **private sector needs to be understood as a market**, not just as an implementing partner. Most women using private channels obtain short-term methods from shops, chemists or pharmacies. Yet Pakistan has **not developed a strong for-profit FP model**. Poorly targeted subsidies may crowd out commercial provision where clients are willing and able to pay, while unclear or burdensome rules on import, registration, clinic licensing, pharmacy participation, provider authorization and reporting may discourage legitimate private participation. These risks should be tested through a market and subsidy map, but they are too important to ignore.

Public provision and subsidies remain essential for poor, underserved and high-cost users; the problem is not subsidy itself, but poorly targeted subsidy that may crowd out sustainable provision where users can pay. The state should shape the market: protect poor users, target subsidies, remove unnecessary barriers, ensure quality and informed choice, secure commodities, simplify reporting, and make room for sustainable commercial provision where feasible.

Key Recommendations

1. Treat CCI 2018 as the political foundation, not the technical blueprint

Inherited recommendations must be screened for evidence and applicability. They should be classified as: retain and scale, redesign, pilot and evaluate, defer, or remove. No new PC-I, strategy or program may be approved without a crosswalk showing what has already been proposed, funded, implemented, and what failed to produce outcomes.

2. Use the NPC Compact to Agree on Common reporting, progress tracking modalities and Regulations, Leaving Implementation Details to Provinces, with most services in the private sector.

The NPC should support a voluntary federal–provincial compact focused on data sharing, interoperability, and commodity security. Government may remain the steward, (a light touch) regulator and guarantor of equity and rights, but public financing should increasingly purchase verified outputs across the full FP service market.

3. Build a Total-Market FP Strategy.

Government should remain the guarantor of equity, safety and rights, but rapid gains require a functioning FP market. This means targeted subsidies may be reserved for poor and underserved users, strategic purchasing from public and private providers, simpler accreditation and reporting, pharmacy and business friendly rules, predictable import and tax treatment, and space for viable for-profit models, including a predictable, proportionate and risk-based regulatory regime.

4. Treat Commodity Security as the First Operational Priority.

Without contraceptives, demand generation collapses. Each province needs a 12-month buffer stock, quarterly forecasting, exchange-rate-indexed commodity budgets, simplified imports, tax/duty relief, emergency procurement rules, district stockout scorecards, and inclusion of private/social-marketing demand in forecasting.

5. Replace Process Monitoring with Outcome-Linked Monitoring.

A green dashboard of meetings, notifications, portals and committees is not success. Future dashboards should track commodities available, providers active, women served, methods dispensed, follow-up completed, stockouts avoided, budgets released and spent, users continuing, and if CPR/mCPR are improving.

6. Funding Decisions must be based on an Updated National Costing and Value-For-Money Exercise.

Pakistan needs a current costing model by delivery channel including public and private sector, that includes estimated cost per user, cost per CYP, cost per additional modern user, cost per continued user, and cost per CPR/mCPR gain.

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