



POLICY BRIEF

SLOW PROGRESS OF FAMILY PLANNING IN PAKISTAN AND POSSIBLE LEARNINGS FROM THE SUCCESSFUL EXPERIENCES OF IRAN, TURKEY AND BANGLADESH

1 BACKGROUND

Pakistan's population is estimated to be 220.9 million (mid 2020), growing at 2.1 percent per annum and with net annual addition of 4.3 million, it is projected to touch 263 million by 2030¹. The rapid population increase has several implications for the socioeconomic development of the country. As one of the few pioneer countries, Pakistan visualized this situation in the 60s and took a policy decision to address population issue by introducing voluntary family planning services in the country. However, with five-decades of investment in family planning program, only 25 per cent of women reported using modern contraception in 2017-18, the lowest amongst the Asian and neighboring Muslim countries. With family planning programme in place, Pakistan aimed to achieve replacement level fertility (2.2 births per woman by 2030). Fertility declined steadily from 4.9 births per woman (1990-91 PDHS)² to 4.1 births (2006-07 PDHS) and to 3.6 births (2017-18 PDHS). Surveys reveal that fertility decline generally remained slow after 2006. Pakistan is falling behind to achieve its own goals set for lowering fertility reflects inadequate investment and attention to raise contraceptive use rate.

According to population Policy 2002 Pakistan envisioned to achieve replacement level fertility by 2020. Pakistan pledged at the 2012 London Summit on Family Planning to achieve a CPR level of 50 percent by 2020. But both the goals

remained unattained. The existence of unmet need for contraception (17% of married women) and continued persistence of inequity among users reported by 2017-18 PDHS reflected in major difference of use of modern contraceptives between poor and rich segments of married women (13 point difference) points to weaknesses in the service delivery system. The non-use of contraception and high unmet need have resulted in high-risk births at times leading to unsafe abortions. A study undertaken by Population Council in 2012³ estimated that 2.25 million induced abortions were performed directly affecting the highly sensitive health indicator of maternal mortality ratio (MMR). Though this has declined over the last decade (from 276 to 186 for 2006-07 and 2019), but still much higher than neighbouring Muslim countries.

The Third Meeting of the Federal Task Force (held on August 6, 2020), Chaired by H. E. Dr Arif Alvi, President of Pakistan who took note of the unusual slow pace and low uptake of family planning in Pakistan desired to know the reasons of this situation and how Pakistan can take benefit from successful experiences of three Muslim countries – Iran, Turkey and Bangladesh. This brief provides a comparison of major features of four nations to show where Pakistan stands, what best practices were implemented by these nations to address high growth rate, and how Pakistan can take advantage from their successful experiences.

POPULATION - PAKISTAN



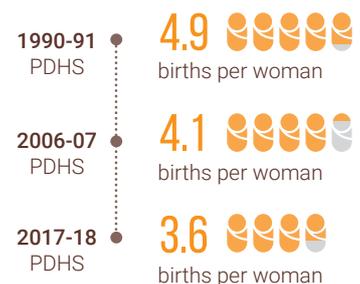
MODERN CONTRACEPTIVE METHODS



FERTILITY RATE - PAKISTAN

PAKISTAN AIMED TO ACHIEVE REPLACEMENT LEVEL FERTILITY

2.2
births per women by 2030



¹ Elaboration of data by United Nations, Department of Economic and Social Affairs, Population Division. [World Population Prospects: The 2019 Revision.](#)

² Prior to the 1990s, average fertility in Pakistan was approximately six births

³ "Induced Abortions and Unintended pregnancies in Pakistan, 2012" - Population Council

2 POPULATION AND FAMILY PLANNING PROGRAMMES OF TURKEY, IRAN AND BANGLADESH

INITIATION OF POPULATION AND FAMILY PLANNING PROGRAMMES



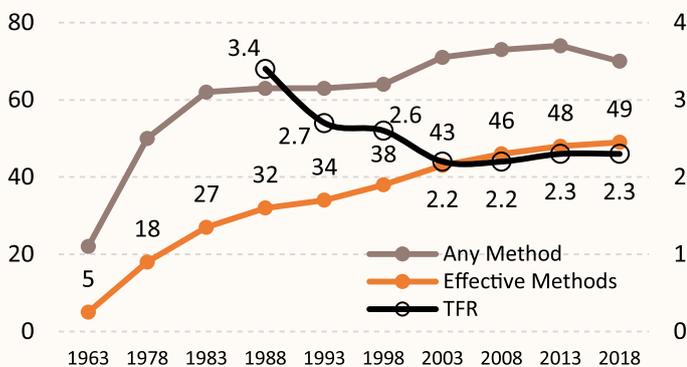
It is interesting to note that all three Muslim countries initiated their population and family planning programs almost at the same time or even later than Pakistan's policy declaration: Pakistan – 1965, Turkey – 1965, Iran – 1989, Bangladesh – 1976. The figures below present the trend of total fertility rate and contraceptive prevalence rate in each of these four countries. Turkey achieved 40 points increase in CPR in 2 decades (1963 – 83) but had high proportion of traditional method use complemented by abortion rate and by

late 1980s already had achieved TFR of 3.4 births. Iran's progress has been most dramatic in the increase of modern CPR – doubled from 27 to 56 in just 12 years (1988 to 2000). Iran's fertility declined by more than half in ten years, from an average of 6.2 births per woman in 1986 to 2.5 births per woman in 2000 particularly impressive in rural areas⁴. Studies show that 61% of the reduction in fertility rate in Iran was attributable to family planning⁵.

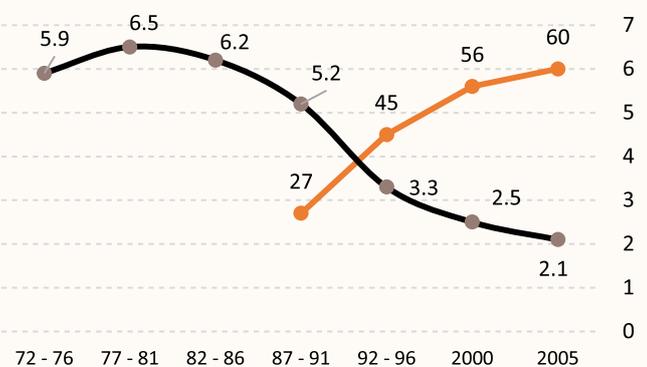
Bangladesh is a remarkable example of rapid increase in contraceptive use and fertility decline during mid-1970s to late 1990s when TFR declined from 6.3 to 3.3 births and modern CPR increased from 5 to 43 percent. The stalling of fertility in Bangladesh for a decade was taken as a challenge and addressed through series of programmatic modifications to achieve desired fertility level of 2.1.

TRENDS OF FERTILITY AND MODERN CONTRACEPTIVE USE IN TURKEY, IRAN, BANGLADESH, AND PAKISTAN

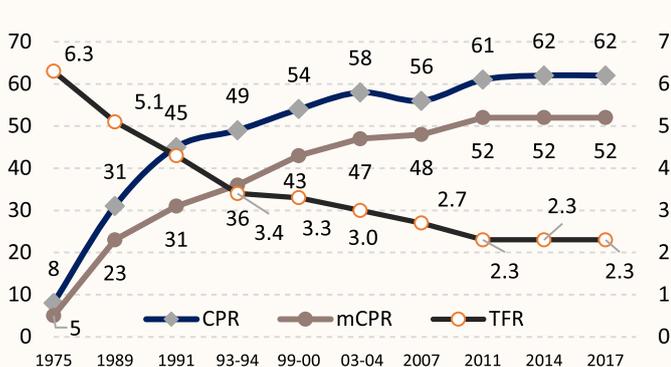
Trend of TFR and mCPR - Turkey



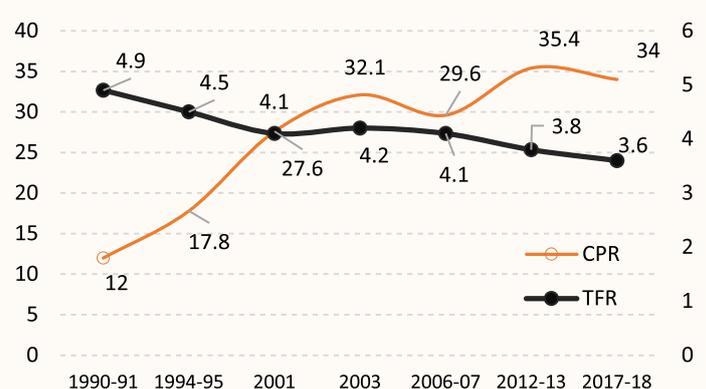
Trend of TFR and mCPR - Iran



Trend of TFR and CPR in Bangladesh



Trend of TFR and CPR - Pakistan



⁴ Farzaneh Roudi, Pooya Azadi, and Mohsen Mesgaran. *Iran's Population Dynamics and Demographic Window of Opportunity*. Working Paper 4, Stanford Iran 2040 Project, Stanford University, October 2017

⁵ Erfani A, McQuillan K. Rapid fertility decline in Iran: analysis of intermediate variables. *J Biosoc Sciences* 2008; 40:459-78.

The critical features adopted by the three countries to achieve success are:

1 LEGISLATION AND PARLIAMENTARY SUPPORT TO REFLECT POLITICAL COMMITMENT

Passing of a Law by Parliament in Turkey (in 1965 and 1983) and Iran (in 1989) laid the foundation of Population Planning and Policy pursuit. Open discussion among members and Politicians built ownership especially in Iran when senior religious leadership issued Fatwa and began to give Friday sermons, which produced tremendous acceptance of the concept of small families and use of contraception. The Law provided legal framework for funding and to take measures for nationwide family planning program, with focus on reaching out at doorsteps with modern contraceptive methods. In Bangladesh, Population Policy was formulated in 1976 and approved by the Cabinet as integral

part of development planning and social reforms. Firm political commitment upheld the establishment of long-term plans and to providing necessary funding to implement all aspects of the plans. Critical to their success was the 'open support and seriousness' expressed by the leadership towards the issue to convey determined message to program functionaries and people in general to pursue the goal. Leadership's unwavering support and clear understanding of population as a national cause on long term basis, and persistence with patience even with changes in political governments, were considered key factors for the results.

2 COMPREHENSIVE PLAN FOR UNIVERSAL COVERAGE AND AVAILABILITY OF SERVICES

Open political commitment, with firm and serious support of the leaders sustained over time was translated into a thorough Plan to ensure widespread availability of information and services along with a strong behavior change communications to educate and convince people. Commonalities among them also included: establishing a national program under the Ministry of Health responsible for implementing family planning initiatives; and all aiming at reaching women at their doorsteps: regional mobile teams in Turkey, community-based health workers and health houses in Iran; and family-welfare assistants in Bangladesh. The purpose in each case was to educate women regarding benefits of lower fertility, birth spacing, and giving them necessary information regarding

modern contraceptives, and addressing their misgivings and fears. The uniqueness regarding Iran's motivation and Program was their three objectives: encourage birth spacing for 3-4 years; discourage pregnancies before age 18 and after age 35; and encourage families for three healthy children. Bangladesh specifically evolved communication program to address desire for large family size and son preference, campaign also contributed to the success of the program. Strict program monitoring, use of operations research and evaluation to address program weaknesses contributed significantly. Innovative initiatives especially in Bangladesh during a decade of status quo in fertility, enabled the country to go back on track to achieve a TFR of 2.1 in the next decade.

3 PROVISION OF MODERN METHODS AND INTEGRATING FP SERVICES TO BROADEN MATERNAL AND CHILD HEALTH SERVICES

Provision of a comprehensive package of modern methods remained fundamental to ensure proper birth spacing and minimizing unintended or untimely pregnancies. Promotion of IUCD (in Turkey); and IUCD and vasectomy (in Iran); and tubal ligation and injectables and emergency contraceptives (in Bangladesh) made real difference in reducing fertility. Furthermore, the role of 'state taking the driving force' was essential to determine the direction and to maintain momentum ensuring needed contraceptive method mix is attained and is aligned with the fertility lowering goals while still ensuring client's choice. Common to all three countries was the proactive use of

public sector health personnel and facilities for the provision of FP services. Turkey used the 1965 Law on Population Planning to mandate and direct all health personnel of Ministry of Health to provide FP services and later in 1983 authorized trained non-physicians to provide IUCD that doubled IUCD use by 1988. Iran, besides expanding the network to reach out women also ensured primary health care setup to provide FP services. Bangladesh used maternal and child health framework post-approval of 2004 Policy whereby FP services were integrated with Primary Health Care for easy of accessibility to women.

4 PURSUIT OF FEMALE EDUCATION GOALS

Girls education works several ways to influence attitudes and behaviours especially when seen in context of female autonomy, social equity, understanding of family building and use of contraception for birth spacing. All three nations actively pursued girl's education

as development objective over the years, which not only helped in increasing age at marriage, but also promoted desire for smaller family and minimized son preference as a factor for more fertility.

Several major issues and missed opportunities may be noted for low uptake of family planning in Pakistan:

- 1 Rapid population growth though accepted as a barrier to developmental since 1960s but never openly discussed in the parliaments or legislation ever evolved. Furthermore, shyness of leadership towards open support and seriousness for sustained efforts with consistency and continuity marred all desired long-term gains. Absence of leadership's frontal public statements and guidance allowed conservative forces to establish confusions and fears among people, which were not allayed by direct contacts and education efforts.
- 2 High population growth was always seen as a competing priority against economic and development strides. Political leaders and programme managers lacked understanding and patience necessary to pursue the cause of population on sustained basis and wait for the result. Leadership and management also shied from progress review at the federal and provincial hierarchy reflecting lack of empathy.
- 3 Though service delivery and counseling at community level was given credence in mid 1990s but ever since year 2000 it is not taken with seriousness to be followed up for assurance and appreciation. Counseling women played a critical role in all three Muslims countries (Turkey, Iran & Bangladesh) to educate and encourage clients and address fears and myths of family planning and contraceptive technology. Unfortunately, it never received adequate attention by all stakeholders in Pakistan especially after dilution of the tasks of LHWs in year 2000 and beyond in support of other health programmes.
- 4 Provision of FP services within healthcare umbrella provided boost to service acceptability in all three countries. Unfortunately, delivery of FP services by the Population Welfare and Department of Health (solely and together) did not fully meet the needs of the people mainly because of silo approach and lack of coordination and collaboration. Merger of the two Ministries have been the agenda of several government's since year 2000 but it remained a difficult proposition because of differences in sources of funding, fund flows, hierarchical relationships, constitutional prerogatives and reluctance on part of functionaries⁵. Half-hearted response by all provincial Departments of Health never integrated or implemented FP services with MCH in real spirit of commitment.
- 5 Role of state towards 'policy review' and 'regulatory tasks' remained non-existent⁶ at federal and provincial levels. Good understanding and developing improved assessment of progress and coordination with partners are critical for timely reaching the goal.
- 6 Contraceptive method mix of Pakistan is acknowledged for its least efficacy and effectiveness towards lowering fertility since 1990s. Focus on tubal ligation and condoms have contributed least towards this goal. Though about half of all women reach out to private sector for services due to their easy access and active role in promoting contraception but remained limited to least effective methods.
- 7 Quality of services monitoring, and beneficiary feedback remained secondary and lacked intensity.
- 8 Performance Evaluation and Research was a Programme pillar but not given adequate institutional support to address and analyze substantive field problems. Inadequate support to the pillar led to decay of research institutions in terms of research capacity and its contribution to the sector.
- 9 The devolution of functions in 2010 diluted the national cause and has not improved but contributed to further neglect of the importance in real terms. The spirit of devolution in terms of building capacity and authorizing districts for planning, action and accountability lacked seriousness.
- 10 Female education though considered a critical pillar to social change and a major factor in fertility decline yet was not given carefully attention and to enhance investment since year 2000.

5 WAY FORWARD

In view of existing barriers and to achieve the goal to further decrease fertility rates by 2030 (as pledged at ICPD 25 and Nairobi Conference Nov 2019) and based on the successful experiences of the three Muslim countries, following key measures are outlined:

1. Political Commitment and voice needed to be raised in Legislation with persistence and continuity. Sustained engagement of legislators for championing and holding the executive accountable.
2. Population should remain a national cause and provincial contribution evolved by consensus and funds made available by provincial and federal government with understanding of long term need and patience to wait for the results being critical due to crosscutting effect of the population variable

on all socio-economic development sectors. We should sensitize and empower political leaders and the bureaucrats and follow up progress through a strong accountability mechanism.

3. All provincial Health Outlets must take on FP as integral service with full commitment. Strengthen LHWs and other CHW programme supplemented by other interventions such as male engagement, premarital counseling, encouraging female education and life skills based education for young people to learn benefits of family planning. Immediate high-level conversation and decision to come up with a more cost effective and expanded family planning programme by ensuring provision of family planning services as part of broader maternal and family health services by DoH.

4. Annual policy Review System must be established at national and provincial leadership levels. Implementation of CCI

recommendations must be reviewed and steps taken to realize it.

5. Investment and promotion of birth spacing methods like IUCDs and implants is overdue and needs greater attention.

6. Equity must be a key strategy in future plans to enhance access to the poorest segment of population and promoting a method mix that builds birth spacing and minimizes unintended pregnancies

7. Counseling and services go as a package – but private sector remained focused on services and sales. Media should actively promote FP messages.

8. Research and Evaluation by made essential part of policy revision. Strong M&E system supported by availability of reliable service coverage data and frequent representative surveys such as the Performance, Monitoring for Action (PMA) and operations research are needed.

⁶ Sania Nishtar, Saba Amjad. 2009. Pakistan's health-population mantra J Pak Med Assoc. Vol. 59, No. 9 (Suppl. 3), September

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