POPULATION GROWTH IN PAKISTAN: A CONTENT ANALYSIS OF PUBLIC POLICIES

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Abstract

South Asia is the most populous region having three top ten largest population holding countries of world. Pakistan is one of them, having highest population growth rate in the region. However, the rate of growth and control of population in Pakistan has been behaving differently in comparison to other South Asian countries that instigate world's attention on why it is so, despite the continuous funding and implementation of population policies. Current study is intended to investigate the reasons behind its high growth rate in South Asia by exploring the policy shift and patterns of implementation in Pakistan during the last seven decades. This study investigates Pakistan's national five-year plans for the sections that particularly focus on population planning, and medium-term development plans, perspective plans and national & provincial population policies since 1950s to 2017. Qualitative content analysis technique was used to dig out the issue.Thoughfertility rate is continuously declining, but not up to the expectations of national and international planners. The study found that no serious efforts were made at the beginning when five-year plans began to be implemented in Pakistan. At the same time, Pakistan was unsuccessful to introduce specific population policies during the second half of the 20th century. The study concludes that non-Implementation of strategies and lack of monitoring and evaluation of the programs were main reasons behind unsuccessful population programs.

Key Words: Population Growth, Population Increase, Content Analysis, Plans and Policies, Pakistan.

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List of Abbreviations

CBR: Crude Birth Rate

CDR: Crude Death Rate

TFR: Total Fertility Rate

CPR: Contraceptive Prevalence Rate

FP: Family Planning

RH: Reproductive Health

MCH: Maternal and Child Health

CWFP: Concerned Women for Family Planning

IUD: Intra-Uterine devices

MSUs:Mobile Service Units

TBAs: Traditional Birth Attendants

GDP:Gross Domestic Production

IEC: Information, Education and Communication

UC: Union Council

KP: Khyber Pakhtunkhwa

AJK: Azad Jammu & Kashmir

FATA:Federally Administer Tribal Areas

KP: Khyber Pakhtunkhwa

MoPW: Ministry of Population Welfare

NHSR&C: National Health Services Regulations and Coordination

NIPS: National Institute of Population Studies

CIP: Costed Implementation Plan

JOICFP: Japanese Organization for International Cooperation in Family Planning

NGO: Non-Governmental Organization

FPAP: Family Planning Association of Pakistan

IWW:International Workers of the World

IPPF:International Planned Parenthood Federation

UN:United Nations

WHO: World Health Organization

UNFPA: United Nations Population Fund

FAO: Food and Agriculture Organization

ILO: International Labour Organization

WWW: World Wide Web

Chapter No. 1

INTRODUCTION

1.1 Background and Introduction

World population is increasing continuously. Today's world human population is morethan 7 billion, 200 years earlier it was less than one billion. For thousands of years, world population increases slowly but in recent century its growth goes up dramatically. It is predicted that today's world population is approximately equal to 7% of all the human ever lived in world history. From 1900A.D to 2000A.D, within a century, the world population increases 1.5 billion to 6.1 billion. This growth is three times greater than all human lived in the world (Roser, Ritchie and Ortiz-Ospina n.d.).

Rapid increase in population traced back through industrial and agricultural revolution in Britain, the living standard and health facilities were increased, life expectancy of children increased intensely. Under age five, (<5 mortality) infant mortality in the city of London was 74.5 % in 1730-49 which was decreased to 31.8 % in 1810-29. In eighteenth century, the population of Europe were doubled to almost 200 million. In the very next century, it was doubled again (Baird 2010).

During this period, English clergymen, Thomas Malthus wrote an essay on 'the principle of Population' and draw attention of scholars and state toward population increase.He claimed, population is growing exponentially, and the world resources are increasing geometrically. He predicted that if the population of earth would not be controlled, it leads to hunger and starvations (Malthus 1888). Malthus' essay proved as the first stone in the static water of population control debate.Contrary to Malthus predictions, in 19th century, advances in agriculture produced more food than the need of growing population[1].

[1]BBC. 2011. "Population control: Is it a tool of the rich?" retrieved February 12, 2019 https://www.bbc.com/news/magazine-15449959

Besides Malthus' attention toward birth control, it was an old fashion in human history through different methods. In 17th and 18th century, many new techniques including IUDs (intrauterine devices) and rubber condoms were introduced in Europe and later in other western countries. However, the phenomenon of population control is relatively a recent global development program. Its origin traced back to Francis Galton in 1883,who wrote a book "Inquiry into Human Faculty and its Development" which given upsurge social movements in Europe and United states(Hartmann 1997; Grimes 1994).

On the base of population growth rate, world human history can be divided into three phases or periods. First period associated as premodern, starts from the beginning of human history in which population growth was very slow. In second, modern period, medical, technological and agricultural revolutions became, and the standard of life becomes high. Population growth rate reached its peak in this period. Today, the third period of postmodernity is unfolding, and second period is over. Population growth rate is continuously decreasing and projected to stop at the end of this century (Roser, Ritchie and Ortiz-Ospina n.d.).

In the discourse of legitimization of population control includes many actors with their radical scripts. Neo-Malthusians favoured birth control to improve the life standard of poor through population control; socialists and feminists portray it as a woman right to control reproduction, is an individual freedom; eugenicists relate it with the quality of genetics. To control population, these actors, carried the germs of birth control in their drama as a liberating force. (Hartmann 1997).

Neo-Malthusians were the first advocators of radical birth control in British. they believed poverty caused by overpopulation and was in favour of contraceptive use to have fewer children, which helps to improve the life standard of poor class (Hartmann 1997). On the other hand, in the late

nineteenth century, Robert Dale Own carried radical neo-Malthusianism to United States.

Contrary to contraceptive plan in British, Own favoured birth control based on women right in United States through self-determinism. He supposed instead of overpopulation, unequal distribution of wealth is the cause of poverty. It is because overpopulation was not an issue in the new county of United Stated with abundant of land and opportunities. Social reforms were utopian, only possible through the individual reform and women rights with the right of reproductive control, were the basis of individual freedom (Hartmann 1997).

In the start of 20th century, Margaret Sanger, American advocate of birth control, become the organizer of International Workers of the World (IWW) who were socialist and anarchists. Later, she visits France and other European countries and to observe birth control activities. When she returned to America in 1914, wrote her own paper and have alliance with radicles. It puts key influence on the birth control movement (ibid).

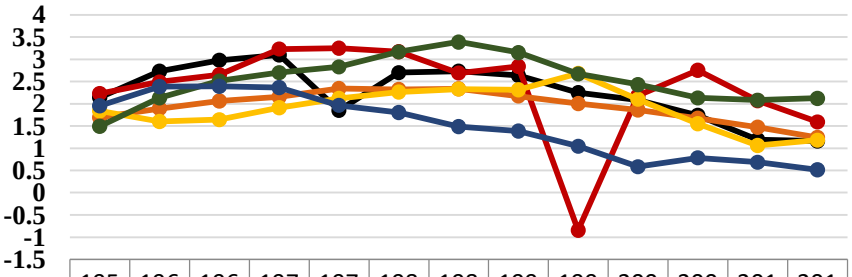
Later, many groups joined the eugenicists to promote voluntary birth control. Population Council and International Planned Parenthood Federation (IPPF) established by D. Rockefeller in USA, join eugenicists along other groups. The major aim of the birth control moment was to control the increasing population of Asia and Africa. However, United States was unable to restrict population of these countries through directly involvement. Later, it turned to the different organizations of United Nations (UN) like WHO (World Health Organization, established in 1948), UNFPA (United Nations Population Fund, established in 1969), FAO (Food and Agriculture Organization, established in 1945) and ILO (International Labour Organization, established 1919) (Grimes 1994).

Next to 1960s, The World Bank, United Nations and other different international organizations focused on the rapid growing population of third

world as a problem. They considered it as a factor of environmental degradation, political and economic instability. In 1966, US president Lyndon Johnson made US foreign aid for the countries who start family planning programme. Japan, UK and Sweden also spend on to reduce the fertility of third world[2].

To understand population change, population growth rate is more appropriate than total population. In human history, world reached its ever-highest growth rate after second world war to 2.1% annually. It is decreasing gradually and projected to reach at 0.1% at the end of 21st century (Roser, Ritchie and Ortiz-Ospina n.d.). Globally, Asia is the home of world's 60% population (United Nations 2017). In Asia, South Asia has highest population holding land of the globe. Out of top ten most populous countries of the world, three are in South Asia (India on 2nd, Pakistan 6thand Bangladesh on 8th).

Figure no. 1. 1 Population Growth Rate of South Asian Countries (1955-15)



	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015
Bangladesh	2.14	2.73	2.98	3.1	1.85	2.7	2.73	2.64	2.25	2.08	1.74	1.19	1.16
Bhutan	2.23	2.49	2.65	3.23	3.25	3.17	2.69	2.84	-0.8	2.18	2.75	2.07	1.59
India	1.69	1.89	2.06	2.15	2.34	2.32	2.33	2.17	2	1.86	1.67	1.47	1.24
Nepal	1.84	1.6	1.64	1.91	2.12	2.26	2.33	2.31	2.68	2.1	1.55	1.06	1.18
Pakistan	1.49	2.13	2.51	2.7	2.83	3.17	3.39	3.15	2.67	2.43	2.13	2.08	2.12
Sri Lanka	1.95	2.38	2.39	2.36	1.96	1.8	1.48	1.38	1.04	0.58	0.78	0.68	0.51

Source: World Population Review (2018b)

[2]BBC. 2011. "Population control: Is it a tool of the rich?" retrieved February 12, 2019 https://www.bbc.com/news/magazine-15449959

Within South Asia, Pakistan has highest population growth rate. The above graph indicates the population growth rate of South Asian countries starting from 1955 to 2015. To situate Pakistan, the growth rate in 1955 was 1.49 which increased to 3.39 in 1985[3]. Later, the graph reflected decrease in growth rate to 2.12 in 2015 but at this level, growth rate was still high among South Asian countries. Comparatively, rest of the countries have reduced their growth rate up to some extent. Sri Lanka continually reduced its growth rate from 2.39 in 1965 to 0.51 in 2015.

Pakistan and India got independence at the same time but both countries have different nature of population growth rate. Growth rate of India has gradually declined in every five years contrarily with Pakistan which is reflected in the graph. After 1955 Indian population growth rate has never reached to 3% while Pakistan crossed it. In 2010 India has 1.47% growth rate which reduced to 1.24% in 2015. In contrast, Pakistan has 2.08% in 2010 which increased to 2.12 % in 2015. Pakistan among South Asian countries shows increase in growth rate in past few years.

Similarly, before independence in 1970s, Bangladesh was part of Pakistan and known as East Pakistan. Its population growth rate was much higher than West Pakistan. Interestingly, after independence, Bangladesh control its growth rate shortly. However, the graph showed no remarkablereduction in Pakistan's population growth rate. In 1960s, Pakistan's population growth rate was 2.13 which was equal to 2005' statistics. After a little (0.05%) decline in 2010, it reached almost at the previous growth rate 2.12 in 2015.

Other than Pakistan, South Asian countries have achieved or nearby their set goals and set standards like India, Bangladesh and Sri Lanka. However, Pakistan was not successful to achieve its set targets. Intervening factors of

[3]The graph shows rapid increase in growth of Pakistan in 80s. It was because of the Islamic wave in the Zia period in which all population control programmes were stopped. Further, I will find all the explanations later.

population growth, GDP Per Capita Income, residence and literacy rate are discussed comparatively with South Asian countries to understand the population achieved variations.

Figure no. 1.1 GDP, Status of Residence and Literacy Rate of South Asian Countries

	Bangladesh		**Bhutan**		**India**		**Maldives**		**Nepal**		**Pakistan**		**Sri Lanka**	
GDP Per Capita Income ($)	1602		2903		1983		12527		834		1541		4085	
Residence	U	R	U	R	U	R	U	R	U	R	U	R	U	R
	36	64	40	60	34	66	48	52	19	81	33	67	18	82
Literacy Rate	61		65		72		99		65		59		93	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	65	59	73	55	81	63	99	98	76	55	71	45	94	92

Resource: PBS (2018); Statisticstimes (2018); WHO (n.d.-g); Countrymeters (n.d.)

The above table indicates three intervening factorsof population growth rate of south Asian countries. These factors are directly linked with population growth rate. GDP per capita income shows the economic condition of the country that how much people are stabled. It demonstrates the living standard of a nation. Stabled economic countries have good health, educational, employment, business and industrial opportunities for people. So, the economic condition of people effects on their family size. Wealthy people have less children than poor. According to National Institute of Population Studies (NIPS) and ICF (2018) and DHS (2012-13) women from highest wealth quantile have less fertility rate and less ratio of childbearing in early ages than lowerwealth quantiles. Fertility rate among highest, middle and lowest wealth quantiles in between 15-49 age groups of women were 2.7, 3.8 and 5.2 per women respectively.

As the above table shows, GDP have direct connection with literacy rate of country which ultimately linked with people decision making and have great impact on population growth rate. Higher the rate of GDP higher will be the literacy rate.For example, Maldives have highest GDP rate of 12527 while the literacy rate is 99.4 in 2017.On the other hand, if we see Pakistan among south Asian countries, the GDP rate is second lowest while the literacy rateis least 71.5(male) and 45.29 (female). So, literacy have direct impact on population growth rate.

Literacy rate is interlinked with population growth rate in general and female literacy rate specifically. Itseffects on growth and fertility rate(Saurabh, Sarkar and Pandey 2013). Higher education level reduces reproductive age of female. DHS (2012-13) survey shows, with higher education less women from 15-19 years of age starts child bearing. Women with no education who starts child bearing were 15.1%, women with primary education has 9.4%, middle 5.9%, secondary 4.1% and higher education had only 1.3%. Similarly, fertility rate with education level from no education to higher education was 4.4, 4.0, 3.2 and 2.5 per women respectively (National Institute of Population Studies (NIPS) and ICF2018).

However, besides these factors, Pakistan was the only country in the Asia who starts population control programs in the country. In 1950s Pakistan was on 13th number of most populated countries of world but now it becomes on 6th position. In the first census of the country, population was 33.7 million but now in 2017 it reached at 207.7 million people. In past sixty-six years, its population increased 516 %. It is projected that if current trends go on, it would be the 4th utmost populated country of the world after few decades (Countrymetersn.d.).

Pakistan's population growth rate was 2.3 in 1960 which reached its peak by 1983 at 3.4. Now, in 2016, its population growth was almost at 2.0%.

Although the growth rate of Pakistan is decreased to some extent, yet it was not successful to achieve its targeted goals. The fertility rate of Pakistan decreased from 6.6 per women in 1960 to 3.5 in 2016, which is almost half but it is not the case with population growth rate (World Bank n.d.-c). So, this study, explore the following questions and tried to reach its objectives that why Pakistan did not reach its desired set goals of population control and has highest population growth rate in South Asia.

1.2 Research Question

1. Were Pakistani policies and programs for population control successful to achieve its targets?
2. What reasons Pakistani policies and programs of population control were not successful up to the expectations?
3. What is population growth scenario of Pakistan?
4. Why Pakistan has higher population growth rate comparing to South Asian countries?

1.3 Objectives of the Study

The entitled study intends to enlist and investigate all population policies and plans of Pakistan and anticipates identifying focused areas in population control programmes. The study also aims to know the targets and trends of birth and contraceptive prevalence rate in different time epochs. In addition to it, theawareness strategies which provide grounds for spreading family planning and contraceptives programme to control population growth are proposes to identify.

1.4 Significance of the Study

Is population a resource or a burden? This question is the ‘point of tussle’ among academicians in demography from start. Many of them considered it as

a resource, however, for others, it is a burden. To understand this point, take China[4] as an example.

A population considered as burden, when the population of a country grows exponentially, and resources are lesser. As a result, the population density increased, and it burdens on the food and economy resources and on the facilities of health, education and job market. This situation leads to poverty, unemployment, miss management of proportionate population, health issues, and urban management.

Therefore, population growth is the important concern of international academia, governments, states and other non-governmental organisations' policies. Similarly, Pakistan ishaving 2.4% population growth rate[5] with limited resources in hand. It has plenty manpower but lack of job opportunities. It has 49% female proportion of population, but they did not have the same job opportunities as male. Pakistan has high unemployment[6], low literacy and miss management of manpower. However, its population is still increasing day by day.

Pakistan has a favourable geostrategic location which is the most populist region of the world. It is the world's most young population holding country. Its 2/3 population is below the age of 30 years.[7]Can Pakistan manage its manpower and use it as resource likewise China? If so,this region can be used

[4] China is the world most population holding country. In late seventies, they consider its population as a burden and decided and control its population through family planning of one child policy. At the same time, they take its population as a resource and managed its manpower. Therefore, today china is looked as most rapidly developing economy.

[5] UNFPA. 2018. "Pakistan." https://pakistan.unfpa.org/en/news/importance-family-planning-reiterated-world-population-day

[6] By CEIC report, in 2015 Pakistan' unemployment rate was 5.94, India 3.52 and Bangladesh 4.37. Pakistan has highest unemployment rate in South Asia. (https://www.ceicdata.com/en/indicator/pakistan/unemployment-rate)

[7] UNDP. 2017. "Pakistan National Human Development Report Unleashing the Potential of a Young Pakistan." Pakistan: Islamabad. https://www.undp.org/content/dam/pakistan/docs/HDR/NHDR_Summary%202017%20Final.pdf

as a consumer market. Before it, to be familiar with ground concerns of growth rate in Pakistan is the major focus of the study. Finally, this study would be helpful to enhance debate in the country between the two people who believed population as a resource and/or burden.

This study is focused on the reasons for relatively higher population growth rate in Pakistan compared to South Asian countries. To accomplish this task, this study intended to review all the programs and policies of population planning in Pakistan and analyse the evaluation reports of population programs of different organizations. This study also historically relates the higher population growth rate with intervening factors with entirely different geographic dichotomy. Identifying the gaps will help future proper planning of population.

1.5 Organization of the Thesis

The following study has total six main chapters. First chapter of the thesis is introduction followed by 2nd chapter of literature review, 3rd chapter of conceptual framework.Methodological framework is included as 4th chapter followed by results and discussion & conclusion as 5th and 6th chapter respectively.

First chapter, Introduction, just introduced the topic and discussed Research Questions, objectives of study and briefly discussed significance of the study. In the second chapter, literature review, focuses on the historical background of the population control and relate it with current population growth rate as a development strategy. Later, its emphasis on world population history and current situation in developed, developing countries particularly and South Asia and Pakistan specifically. Intervening variables of population growth also focused in the given chapter.

Chapter no. 3 relates the entitled study with already existing academic theoretical knowledge on population dynamics' chapter briefly describe the

research methodology of the study. Later in the 5th chapter entitled “Results” present all major results of the study. All the results are grouped under sociological and demographic themes. 6th chapter discussed the results with existing situation of the Pakistan and compare it with neighbouring South Asian countries.

At the last, conclusion and suggestions are discussed for detailed and extensive information about population planning in Pakistan. Annexures (including tables, graphs and figures) are provided at the end of this thesis.

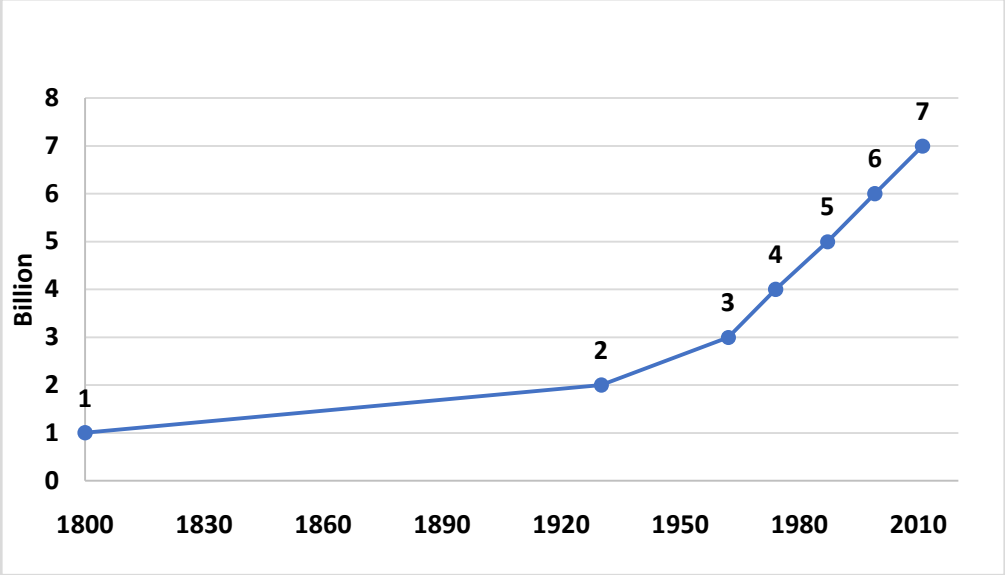
Chapter No. 2

LITERATURE REVIEW

2.1 Global Population Perspective

The population of world goes through different transitional phases. Before industrialization people of the world were facing hazardous diseases and starvations. They had high birth and death rate. The overall growth rate of the world was slow. After hundreds and thousands of years, world population reached its first milestone at 1 billion people, around 200 years ago. Life expectancy of all regions of the world were low. Only Europe and America comparative had high life expectancy which were 34 and 35 years than the average life expectancy of the world of 29 years. After the industrialization, early health transition started to begin in Europe then in America and Oceania and later in Asia after 1890s. Lastly, health transition starts in Africa in 1920. These transition leads to decreasing the mortality rate of the world and starts increasing average life expectancy (Roser n.d.-a).

Figure no. 2.1.1 Milestones of World Population

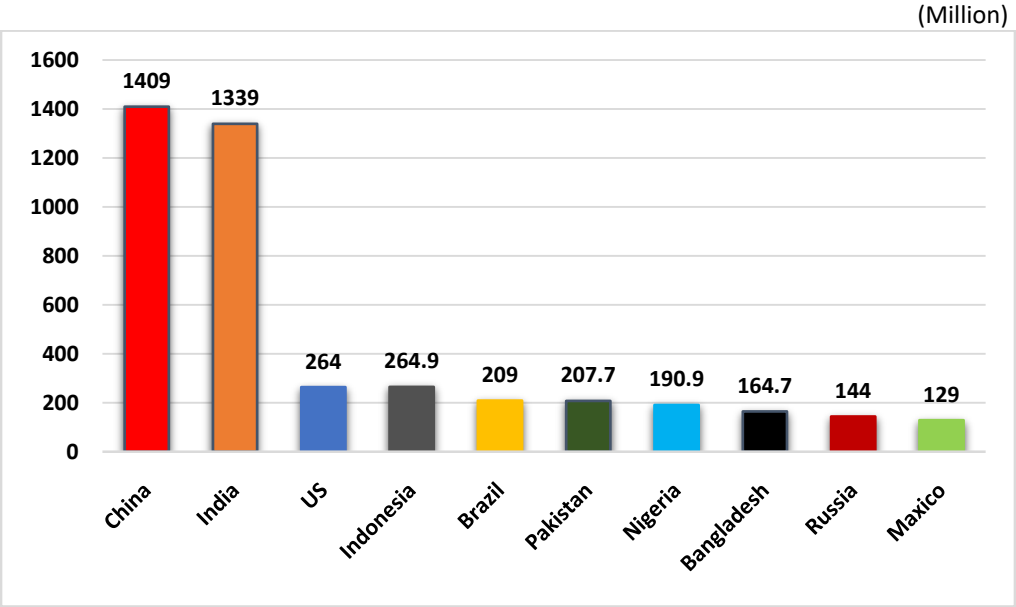


Source: Macionis 2012; Haub and Gribble 2011

To reach the 2nd billion, it takes more than a century in 1930. Advancement of medical field in 20th century decreases the death rate of the world and increases life expectancy. Within 32 years, in 1962, the world's population reached its 3rd billion (Macionis 2012). After first half of 20th century, during

post world war 2, due to the decrease in mortality rate and continuing high fertility rate with increasing life expectancy, world population growth rate was increased remarkably. As a result, world population growth rate reached its peak in 1962 at 2.1 (The World Bank n.d.-b). In 1974, world population reached at 4th billion people. Later, world population growth rate becomes slow, but its population reached at 5th billion in 1987 and 6th billion in 1999. Population quadrupled within 20th century. Today's it is approximately 7.6 billion (United Nations n.d.; Macionis 2012).

Figure no. 2.1.2Top Ten Most Populous Countries of World



Source: United Nations 2017; PBS 2017

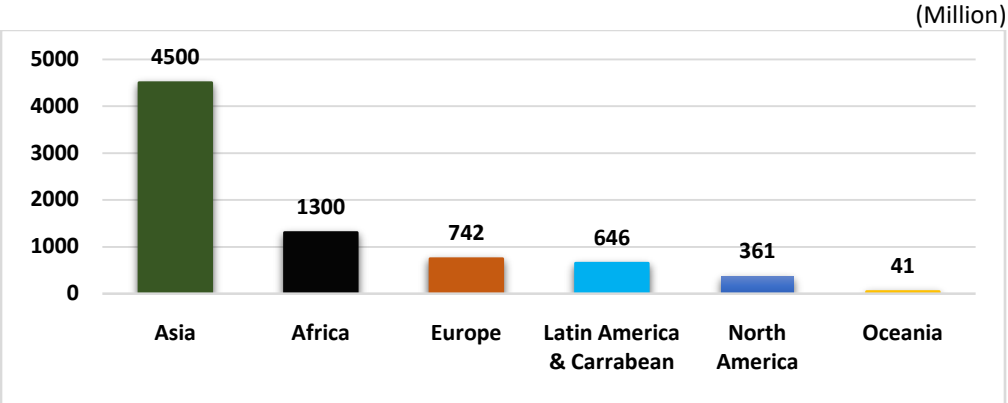
World population continuously increasing; however, its growth is slower than the recent past. Furthermore, the population growth varies by region to region and country to country. Asia is most populous region in the world which has sixty percent population globally. It has 4.5 billion of population. Within the top ten utmost populated countries of world, Asia having five countries including China, India, Indonesia, Pakistan and Bangladesh (from largest to smallest). Secondly, 1.3 billion, 17 percent people lives in Africa. The only African country in ten most populous countries is Nigerian with highest

growth rate in the world. Subsequently, Europe (742 million), Latin America and Caribbean (646 million) and North America (361 million) and Oceania (41 million) has 10 percent, 9 percent and 5 percent population respectively (United Nations 2017).

To understand the transitional fluctuation of growth rate, it is mandatory to historically look at the factors of growth rate like mortality, fertility and life expectancy. After industrialization, medical revolution came and with the passage of time more advancement comes in this field. Advancement in this field starts in today's advanced nations like Britain and America and then spread through the world. It decreases the average death rate of the whole world. As available data, just within 6 decades, crude death rate of the world decreased from 17.7 % in 1960 to 7.6 % in 2016 (The World Bank n.d.-e).

Life expectancy were started to increase with the advancement of medicine. Health transition began to start in Europe at first in 1770s and 1830s in America. Europe and America followed by Oceania in 1860s-70s, Asia in 1870s-90s, Former Soviet Union in 1890s-1900s and at last in Africa in 1920s. Life expectancy of the world, before health transition starts was almost 29 years. In 20th century, in increases rapidly. In 1913, it was reached at 34.1 year, 48 years in 1950 followed by 67.1 and 72 years in 2000 and 2016 respectively (Roser n.d.-a; The World Bank n.d.-f).

Figure no.2.1.3Regional Share in World Population



Source: United Nations 2017

Advancement of technology and development is faster than the non-material structure of human society. Human behaviour takes time to changed according with the developmental structure. As the death rate decreased and life expectancy was increasing consistently with the help of medical advancement, fertility starts declining. In 1960s, fertility rate was at its peak, 5.1 births per women. Afterward, it starts declining with sharp decline in 70s from 4.8 in 1970 to 3.7 births per women in 1980. The average total fertility of the world was reached at 2.4 in 2016 (The World Bank n.d.-d).

According to the future projections of United Nations (2017), the population of our world would increase 2.2 billion from 2017 to 2050. More than half of this contribution in the World population would be added from Africa with 1.3 billion. Second largest supplier would be Asia with the increase of 750 million people. Latin America and Caribbean, North America and Oceania would respectively come after Africa and Asia in future population growth contribution. Europe is the only continent whose population will be decreased than in 2017.

The highly projected growth in Africa is due to its high Total Fertility Rate (TFR) in the world with 4.4 children per women. Out of 21 high fertility countries, nineteen (19) are in Africa. Subsequently, Oceania has 2.3, Asia 2.2 Latin America and Caribbean 2, followed by North America and Europe with 1.9 and 1.6 respectively (Worldometers n.d.). Low fertility countries include, all the Europe and North American, only one in Africa, twenty in Asia, Latin America and Caribbean have nineteen and Oceania only three countries (United Nations n.d.).

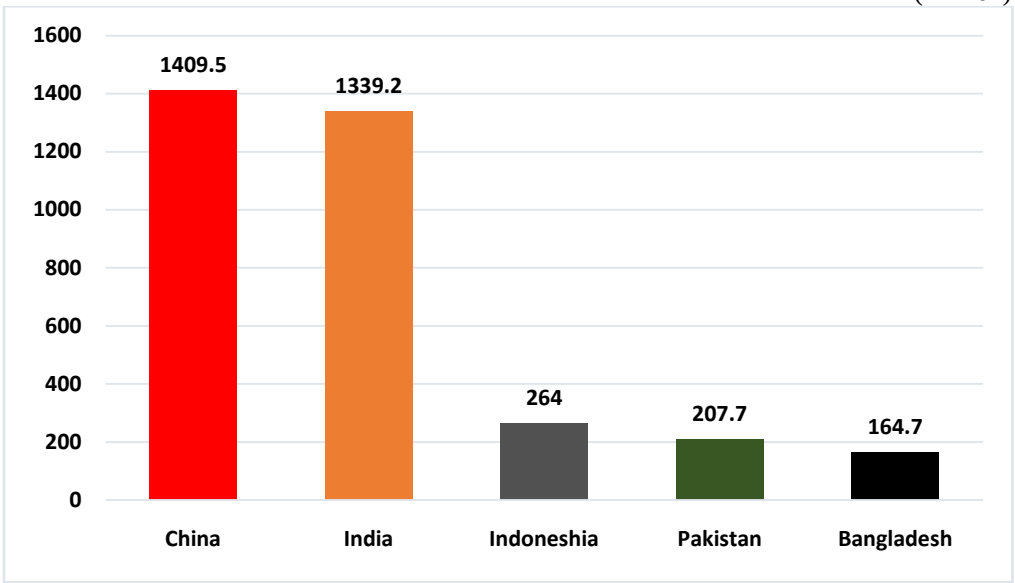
2.2 Population Growth of Asian Countries

Asia is the home of 60 percent population of the world with 30 percent of total earth land including China which was utmostpopulated country of the world with 1415 million people in 2018 (UNFPA n.d.-d) compared with 552 million

in 1950 (Trading Economics n.d.-b). During 1950s the government of China assumed population growth going outpace, starts promoting birth controlling. When in 1960s, China has highest growth rate of 2.7. Government starts family planning in late 1960s and in mid 1970s they give a slogan for family planning "late, long and few". When the population of china reached approximately 970 million, China announced one child policy to eradicate rapid growing population (Connet 2018).

Family Planning and one child policy resulted decrease in growth rate of China's population from 2.7 in 1971 to 0.5 in 2017 (The World Bank n.d.-b). One child policy was successful in lowering birth rate, but it caused aging in the country. So, in 2013, government emended the policy and relaxing one child policy on conditional basis. China has 83 percent contraceptive prevalence rate with on 4 percent of unmet family planning needs in 15 to 49 years old age women. It has 1.6 percent of total fertility rate/women with the life expectancy of 78 and 75 years for female and male respectively (UNFPA n.d.-d).

Figure no. 2.2.1 Most Populous Asian Countries in World's Top 10



Source: United Nations 2017; PBS 2017

Within Asia, South Asia is the hot spot of world's population. It has 24 % of total world's population (almost 1.9 billion) with only approximately 3% of land (Rodgers 2019). It is the denser subregion of the world. It has more population density than East Asia, Pacific and Sub-Saharan Africa. Where in 2017, it has 375 people/km^2, East Asia & Pacific has 96people/$km^2$and Sub Saharan Africa has 50 people/km^2 (The World Bank n.d.-a).

In world's top ten most populouscountries, three, India (1.34 billion), Pakistan (197 million) and Bangladesh (165 million) are in South Asia(United Nations 2017). India, Pakistan and Bangladesh followed by Nepal, Sri Lanka, Bhutan and Maldives has 29, 21, 0.8, and 0.4 million respectively.South Asia's population increasing with the growth rate of 1.27 per year (Trading Economics n.d.-a).

2.2.1 Population Growth in India

India is the utmostpopulated country in South Asia. Soon after its independence, India starts national programme for family planning in 1952 and becomes world first country in this concern. The population of India increases from 238 million in 1901 to 340 million in 1947 (Antony, Srinivasan and Saxena 1989) and reached at 1.35 billion in 2018 (UNFPA n.d.-a). After China, it is the second largest country in world and expected to reach China (1.41 billion) within few years in 2024, after that it would be the first largest country of the world. It is projected that its population will reach at 1.5 billion in 2030 and 1.66 billion in 2050 (United Nation 2017). Annual population change from 2010 to 2018 is 1.2 percent. Besides the population size, the average growth rate is slightly declining in India (UNFPA n.d.-a).

Historically, the growth was quite slow from 1901 to 1921, because of high mortality rate causes famine, ethnic conflicts and epidemics. The growth rate steadily increases till 1950. Afterward, a sharp increase took place in 1951-1961 and 1961-1971 with the growth rate of 1.98 and 2.28 respectively and

increases till 1982 at 2.3 percent (Antony et al. 1989). During and after 1980s, the population growth rate was started declining. In 2017, its growth rate was 1.13 percent. To decline growth rate, total fertility rate is the most influential factor. Since 1980s, total fertility rate declined almost half till 2018 from 4.97 to 2.3. Contraceptive prevalence rate from 15 to 49 year of age was 56 percent which highly contribute to control fertility rate (The World Bank n.d.-b; World Economic Forum n.d.; UNFPA n.d.-a).

In 1952 the government of India started population policy committee and make a family planning cell. From 1952 to 2017 India introduced twelve five-year plans. In its1st five-year plan which lasted till 1956, the government allocated 5 million rupees for family planning programs in which only one million were consumed. The term family planning was used as "family limitation and population control". Expenditures were increased, more and more money allocated for each next coming plan. The allocation for 2nd five-year plan (1956-61) was 50 million rupees. Similarly, expenditures continuously increased in 3rd, 4th, 5th, 6thand 7thplan with 270, 2858, 4974, 14292, and 32560 million rupees respectively. This trend continues till last plan (Antony et al. 1989).

2.2.2 Population Growth in Bangladesh

Bangladesh is the third largest population of South Asia and Seventh largest in the world. It has 165 million people (United Nations 2017). After Maldives, it has highest density in South Asia, which is 1265.04 people/km^2. After few years of its independence, in 1979 its growth rate goes on its peak at 2.82 percent (The World Bank n.d.-b). Population growth beyond a specific level considered as risk to the resources and the standard of life. It judged by government as too high and unfavourable for the economic development. To limit rapid population growth, government start to provide family planning services and introduced fertility control policies. To create balance between population and resources, government initiate and start national family

planning program since 1972. For this, Bangladesh introduced seven five-year plans yet (Karim 1989).

In 1976, first time officially nation population policy statement was approved. Family planning and population control programs integrated. Main concerns of the policy were to: a) door to door availability of contraceptives; b) start communication programs to change the outlook of rural living people; c) make a list of community support; d) reduce mortality rate (infant and child); e) through vocational programs, education and job opportunities, women's economic status decides to improve; f) make development in health and education. These programs were started to decline fertility (Ibid).

In the first five-year plan (1976-80), solid infrastructure and inputs were established for service delivery. Family planning targets starts as the second five-year plan (1981-85) in which all the ambitious goals were not accomplished but significant progress viewed. Contraceptive prevalence rate increased from 12.7% in 1980 to 29.7% by 1985 which reached at 35% in September 1987 (Ibid) and touched 64% in 2018 UNFPA n.d.-a). As a result, total fertility rate was declined inversely proportionately from 6.82 in 1975 and 2.1 in 2016 (The World Bank n.d.-d).

2.2.2.1 Strategic Steps for Population Control

Government adopted the policy in which NGOs were promoted to participate in family planning. Several projects started involving NGOs. In which, 'Integrated Family planning and Parasite Control Program' was started with the assistance of JOICFP (Japanese Organization for International Cooperation in Family Planning). JOICFP was in 7 unions with holding 100000 population. To increase the fertility limitation, MCH (Maternal and Child Health) based family planning project was started at Munshiganj under the assistance of German-Bangladesh technical Co-operation (Karim 1989).

Many Women's programs were started through different public and private organizations. Government also planned to increase the employment rate of females and reserved a specific quota for females in jobs at all levels with 50% jobs for females in primary schools. Further, at the rural level for every union of 20000 population, one clinic was opened by the PalliShishu Foundation (PSF) of Bangladesh. PSF has only 5 clinics in 1976 which increased to 100 clinics within 10 years. It was working without any national or international donors financial support. Additionally, the Concerned Women for Family Planning (CWFP) with the motto of 'serving women through women' has also served in rural areas for healthcare and FP (Ibid).

Within success stories of Bangladesh, MATLAB is one of the longest and most detailed population data sets holding program in developing countries. It sets examples in family planning. In the beginning, MATLAB started its experimental program in 149 backward villages of Bangladesh with 180000 people in 1977 where were no education and electricity with 88 percent of Muslim population, having fishing forming communities. The villages were divided into two groups, one group given access to MATLAB and others receive ministry of health services (Borgen 2014).

The program was started through door to door visits in the uneducated and conservative background families to adopt family planning methods. All the health services were provided on the doorsteps and were guided through lady health workers. It results lowering the fertility rate and increased contraceptive prevalence in the specific communities. Before the Programme started, contraceptive prevalence rate were 9.5 percent in treatment and comparison areas. After few years in 1984, contraceptive prevalence rate in treatment area was increased to 43.2 percent compared to comparison area only have 11 percent. Contraceptive prevalence rate reached at 57 percent in treatment area in 1990. Hence, government noticed the positive outcomes of

MATLAB program and began to train government workers and implement the MATLAB model (Nag 1992).

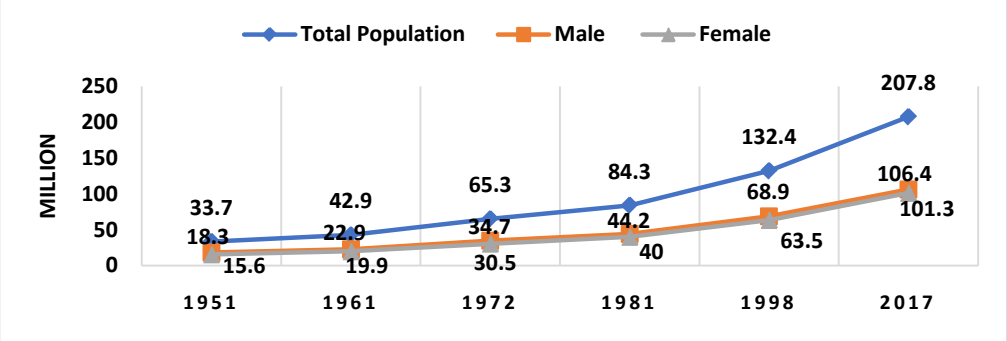
2.2.3 Population Growth in Islamic Republic of Iran

Islamic republic of Iran is the neighbouring country of Pakistan. It has 82 million population in 2018 with growth rate of 1.2 from 2010 to 2018. Iran revolutionized in population control after the saying of Ayatollah Ruhollah Khomeini in 1980s. He said that economy of the county could not bear the load of population. At the same time, on country level contraceptive strategies were utilized. Contraceptives were available at all government clinics; television programs and advertisements were run to inform about birth control. These strategies were useful which results as, in 1985 total fertility rate was 6.2, after a steep decline it becomes at 1.6 per women in 2018 (UNFPA. N.d.-b; The World Bank n.d.-d; Ebrahim 2015).

2.3 Population Growth in Pakistan

Pakistan get independence in 1947, it has two parts in different geographical locations, East and West Pakistan. After 1971, Bangladesh, the East Pakistan becomes an independent country. Today's Pakistan is the West Pakistan of that time. In the fourth year of its independence in 1951, Pakistan conducted its first census in country. In which total population of Pakistan was 33.7 billion and it was thirteenth most populous county of the world (Country Meters n.d.).

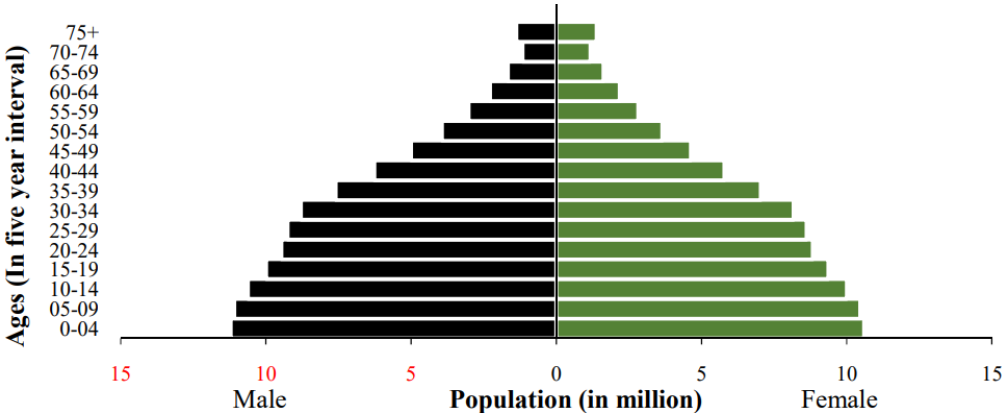
Figureno. 2.3. 1Population Census History of Pakistan



Source: PBS (2006) and Mahmood, Durr-e-Nayab and Mujahid-Mukhtar (1998)

Subsequently, in the sixth population census in 2017, its population boost up to 207.77 million people (PBS 2017). Within 66 years, its population increased 517 percent. It is projected that Pakistan's population will be reached at 307 million in 1950 and 352 million in 2100 (United Nations 2017). Population growth rate of Pakistan was started from 2.13 in 1960 and goes on its peak in 1985 at 3.39 percent. It was the only country in South Asia, which goes high at such level. After seventy-one years of its independence, it shows no remarkable decrease in its growth rate. In 2018, its population growth rate reached at 1.9 which were 2.08 in 2010 (World Population Review 2018c).

Figureno. 2.3.2 Age and Sex Composition of Pakistan



Source: Pakistan Economic Survey 2017

Population growth rate in Pakistan is unlike than South Asian countries. All these countries control their growth rate to some or greater level. Besides, Pakistan was not successful to control its population. The growth rate of Pakistan was shown as declined to some extend but it was not as the set standard of its goals.

Interestingly, Pakistan was the first Asian country who starts family planning, but its fertility declining was gentler in its region.In 1953, the first association which starts working on controlling fertility rate was the Family Planning Association of Pakistan which is now called RehnumaFPAP. In late 1950s the

military president Ayoub Khan take interest in the issue of increasing population and National Board of Family Planning was established for the federal government to devise policies for family planning (Khan 1996).

Pakistan' 1st population control program was part of its third five-year plan (1965-1970) which focusedonbirth control. According to the following plan, the goal was to decrease birth rate by 1970 from 50 to 40 per 1000. The main strategy which was used to achieve this goal was the use of condoms. Later, it replaced in 1966 by Intrauterine Device. In 1971, during Yahiya Khan' period family Planning commissioner focused on pregnancy reduction with contraceptive methods and introduce pills for women (Ibid).

In 1977, Zia-ul-Haq, chief of army, frozen all family planning programs and banned all the activities of publicity through martial law in the country. So, USAID's family planning fundingwas suspended. After Zia period, these programs of population control were given to under Ministry of Health Pakistan (Ibid).

Afterward the 18th amendment in 2010, Ministry of Population Welfare dissolved and once again it starts working under Ministry of Health. Through this amendment, population concerns shifted to provincial levels. Besides, Pakistan was not successful to achieve remarkable results. Some intervening variables are discussed which influenced on the way that Pakistan was not successful to achieve its targeted goals of population control.

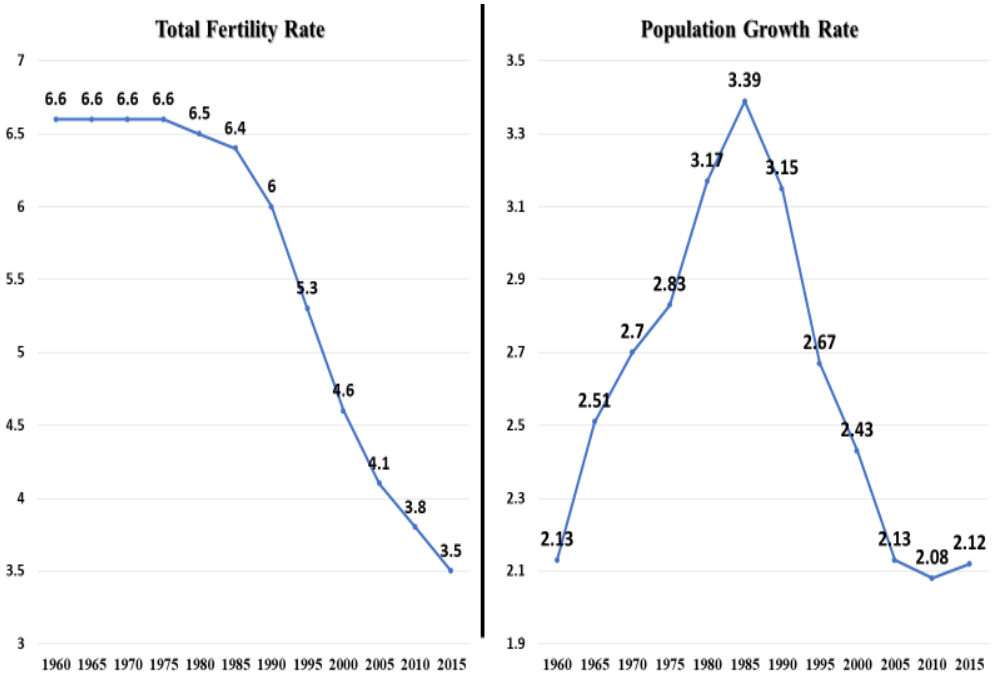
2.3.1 Population Growth Rate of Pakistani Provinces

Pakistan's population growth rate was not controlled successfully, however, a small change happens in it. To know the grounds of unsuccessful population growth control, at first it is necessary to looked at the share of administrative unit's growth rate. In last two censuses, the average growth rate of Pakistan was not declined remarkably. From 1998 to 2017, only 0.2 percent decrease was shown (Finance Division Government of Pakistan 2018a).

In these almost four decades, within Pakistan, three administrative units shown decline in growth rate which were Punjab, Sindh and Islamabad. However, the population growth rate of other administrative units was increased. Punjab showed remarkable improvement to control growth rate compared to other administrative units which was 0.5 percent followed by Sindh and Islamabad 0.3 percent. Besides, Baluchistan has reached 2.4 to 3.4 percent growth rate with one percent increase. FATA and Khyber Pakhtunkhwa have 0.3 to 0.1 percent increase respectively (Ibid).

This change in administrative level growth rate effects the overall percentage of Pakistan. Still increase in growth rate of half administrative units of Pakistan was the one of the reasons behind overall slow decline. Further, next, reasons of increase and decrease in growth rate of administrative units are discussed.

2.3.2Interlink between Population Growth and Total Fertility Rate in Pakistan



Source: The World Bank(n.d.-d); World Population Review (2018)

Besides, the family planning and population control programs started in 1953, total fertility rate (TFR) in Pakistan were almost 6.6 children per women from 1960 to 1980. The steadiness in fertility rate for two decades leads population growth from 2.13 in 1960 to 3.39 in 1985. After 1985, fertility rate declined sharply from 6.4 to 4.1 in 2005. In these two decades, 2.3 percent TFR declined. As fertility decline sharply, the same tendency shown in growth rate which declined 1.26 percent, from 3.39 in 1985 to 2.13 in 2005 (The World Bank n.d.-d; World Population Review 2018).

On the other hand, as total fertility rate declined, 6.6 children/women in 1960 to 3.3 by 2018 which was half, but population growth rate was not decreased at the same ratio. As the above graph shows, growth rate was 2.13 percent in 1960 which was 2 percent in 2018 (UNFPA n.d.-c). Which mean only 0.13 percent decreased in overall growth rate compared to the growth of 1960s.

2.3.3 Intervening Factors of Population Growth in Pakistan

Intervening factors of population growth rate in Pakistan are discussed under this heading. These factors are literacy rate, urbanization, gross domestic production, population density and migration of Pakistan. All the factors discussed briefly by province wise.

2.3.3.1 Literacy rate of Pakistani Provinces: Population Growth Rate

Literacy rate is on the key factor which effect on population growth rate, especially of female literacy rate. Punjab has overall high literacy rate among all provinces of Pakistan. It has 62 percent of overall literacy rate which was further divided in 72 and 54 percent of literacy rate by male and female respectively. After Punjab, Sindh has 55 percent of literacy rate, 67 percent male and 44 percent female. Punjab and Sindh followed by Khyber Pakhtunkhwa 53 percent and Baluchistan 41 percent, with 36 and 24 percent female literacy rate respectively (Finance Division Government of Pakistan 2018b).

Punjab has overall higher literacy rate than other provinces and has higher female literacy rate. This aspect lead Punjab to the reduction of population growth rate. As Sindh was next to Punjab in literacy rate, at the same way its population growth rate was decreased to some extent after Punjab. Khyber Pakhtunkhwa and Baluchistan has lesser literacy rate in general and female literacy rate specifically. So, it would be a one reason that their growth rate was increased from 1998 to 2017.

2.3.3.2 Urbanization of Pakistani Provinces: Population Growth Rate

Urbanization is one of the main factors which has inversely proportional impact on population growth rate. Higher the level of urbanization, lower will be the population growth rate. High population density, unavailability of residential areas, costliness and extra expenditures in Urban areas coerce to give birth less children. Rural women compared with urban women,give birth more children. Among rural and urban areas, fertility rate is high in rural than urban which is 3.9 and 2.9 respectively (National Institute of Population Studies (NIPS) and ICF 2018).

Pakistan is slowly urbanizing country in which Islamabad was highly urbanised territory with 50.6 percent of urban population. This rate was 16.1 percent decreased from previous two decades which is further discussable. Sindh was the highest urbanized province of Pakistan with 43.3 % in 1981 to 49 % in 1998 and 52 %by 2017 census. According to Kazmi (2018), urban trend in major ten cities of Pakistan increased 74.8% in between the last two nation census from 1998 to 2017. Karachi is one the top first city in them. It is the capital of Sindh Province. It was the 12thutmostpopulated city of the world and the largest city of Pakistan. Its population was 15.7 million. In its metropolitan area, 23 million people lived with the population density of 24000/km2. It has 5 percent growth rate annually (World Population Review 2018a).

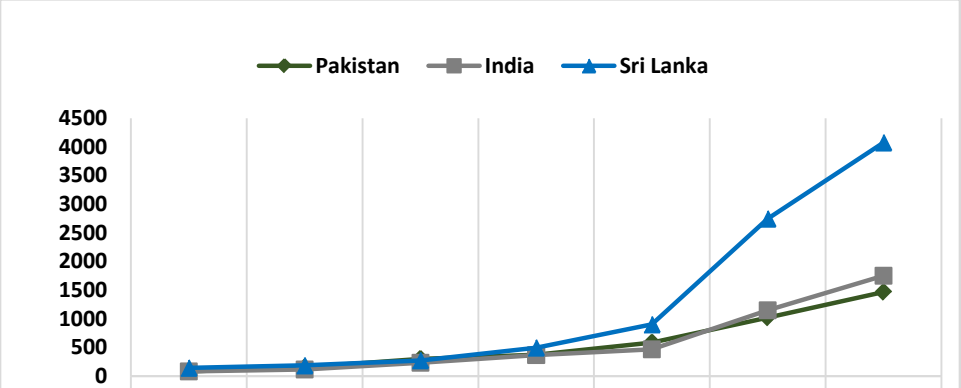
Subsequently, Punjab has 27.6, 31.3 and 36.7 percent urbanization in 19981, 1998 and 2017 respectively. Baluchistan was rapidly urbanizing province in Pakistan. It has 15.6 percent urbanization in 1981 and jumped to 27.6 percent in 2017. Khyber Pakhtunkhwa was least urbanized with only 19 percent of population in 2017 (Finance Division Government of Pakistan 2018a).

2.3.3.3 Gross Domestic Production of Pakistan: Population Growth Rate

Population growth and economic growth arelinked with each other of nation. The impact on one another is reciprocal. the relationship in between these two viewed in two way. First, population considered inversely proportion with the economic growth of a country. population growth considered as burden on country's economic growth (GDP). This view applied on developing countries. Second, population is directly proportional with the gross domestic production of a country. Labour supply increase with population growth with ultimate lead to the economic growth of the nation (Ahmad and Ahmad 2016).

Average population growth rate of Pakistan from 1951 to mid-1980s was 3% per year. Later, in the last one and half decade of 20th century it decreased to 2.6% per annum and reached to almost 2% in the start of 21st century. if Pakistan’s population growth rate grown at the rate of 2% since 1960s, its per capita income would be 64366 than 43748. Pakistan's population increased more than 4 times during last five decades, from 1951 to 2001. However, population of South Korea raises only 2.4 times. In the same period, Pakistan's per capita income increased only five times from $79 to $503 compared with South Korea where it increases 129% (Afzal 2009; Ali, Ali and Amin 2013).

Figureno. 2.3.3.3.1GDP Per capita



	1960	1970	1980	1990	2000	2010	2017
Pakistan	83	153	303	372	587	1021	1468
India	81	112	234	367	466	1149	1752
Sri Lanka	142	184	273	494	899	2744	4073

Source: CEIC n.d.

Within last 19 years from the census of 1998 to 2017, Population of Pakistan increased 57% with the average growth rate of 2.4% per year (Kazmi 2018). Comparatively population of India increased 32% with the average growth rate of 1.55% (The World Bank n.d.-b). During the same period, Pakistan's GDP per capita increased 312% from 470-1468 compare with India's 400% increase. However, Sri Lanka increased 463% GDP per capita in the same period to 4073 (CEIC n.d.).

As per the facts and figures discussed, it is concluded that the economic condition of country is highly dependent on the population growth of the country. Overpopulation burdened a country's economic condition.

2.3.3.4 Population Density of Pakistan

Generally, population density is looked that how much people lived in a countries specific area. It is described as "population density is number of persons per sq.km and is estimated by dividing midyear population with land area (Pakistan Economic Survey 2012-13)." As per by the Population Pyramid web site (2017), Maldives has the highest population density with 1267

people/km2 in the region of South Asia, followed by Bangladesh 1117, India 408 and Sri Lanka 318 people/km^2.

Pakistan has the population density of 247 people/km2 with diverse land (Ibid). It has uneven population density in different provinces and areas. Punjab is the highly populated province of Pakistan with 53% of total population with 25.8% land. It is most dense province. However, Baluchistan is the least populous region of Pakistan having only 6% of total population with 43.6% of total land (PBS 2017 and 2006). Karachi and Lahore are having highest density urban areas of Pakistan.

2.3.3.5 Migration

Migration has a significant effect on population growth of a country. Similarly, Pakistan has passed through different phases of migration in which country's population level increased significantly. It effects the economy, health and, labour market and population density of a country which are the factors population growth. Migration has several types which comes under external and internal migration. External migration mostly used the migration from one country to another. International migration also used in the context of one country to another country migration. Internal migration considered the migration within the territory of a country.

Pakistan has both external and internal migration history. Within external migration, Pakistan also has immigration and emigration history. In out-migration, there are three types of migrants. First, the migrant who use proper channel to go for developed world. Second, the students who go on scholarships but never comes after the finalization of their degrees. The third category are the migrants who goes outside specially in developed and Gulf countries for labour. They use illegal ways to go foreign. The last category is difficult to document. It was a rough estimate that almost 2-3 million Pakistani migrants are in developed countries. During the early years of

1980s, almost 2 million migrants move to the oil rich countries of Gulf from Pakistan. The main destination of emigrants was Saudi Arabia, Arab Emarat and Kuwait. Beside Iraq, Oman, Qatar and Bahrain were the destination for Pakistani Emigrants (Gazdar 2003).

Pakistan face three major immigration phases in history from 1947 to date. The first phase came after the independence of Pakistan in 1947. In which Muslim minorities migrated from India, Burma and Bangladesh to Pakistan. This migration was state supported. It was considered the largest mass migration the human history. In the second phase, after 1970s migrants from many Asian countries came to Pakistan. These migrations intensified in 1980s. Roughly estimated that 1 to 3 million people migrated in Pakistan, semi-legally and illegally. The third phase starts in 1980s, it was the longest period of migration in the region. During the Afghan civil war, Pakistan hosted 2.5 million of refugees which is the highest number of refugees hosted anywhere in the world (Ibid).

Chapter No. 3

CONCEPTUAL FRAMEWORK

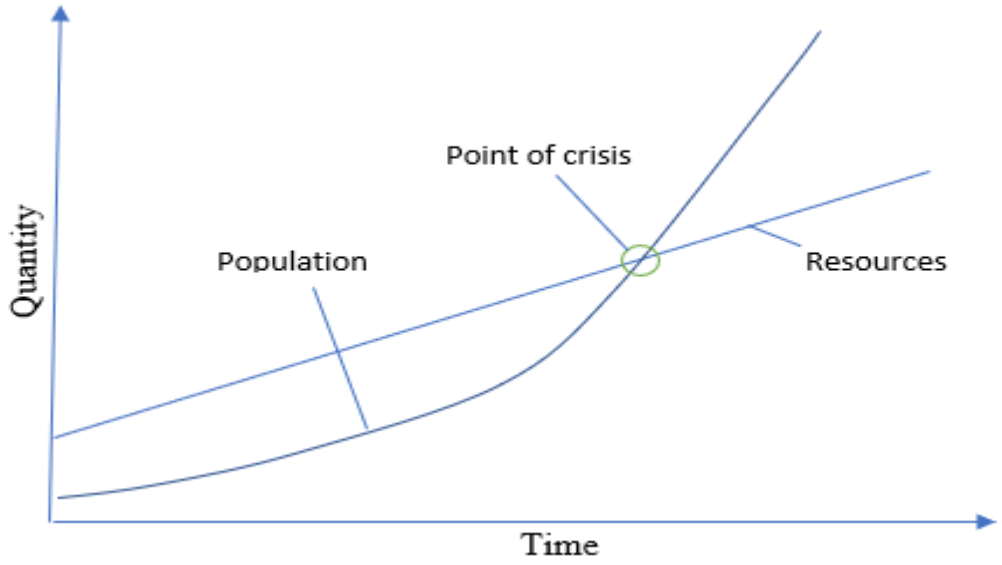
In the conceptual frame work, researcher relates his study with existing theoretical knowledge to validate its study.

3.1 Theory of Malthus

Thomas Robert Malthus (1766-1834) was an English clergyman. His book, 'essay on the principle of population' is considered beginning of the science of demography by today's demographers. He has a landmark in population theories with his publications. He wrote his perspective on population growth in 1798. In which he had two postulates, "First, that food is necessary to the existence of man. Secondly, that the passion between the sexes is necessary, and will remain nearly in the its present state (Weeks 2008)."

According to Malthus, food is necessary for man to survive and it is the nature. Besides, the power of earth to produce substance is weak than the power of population. Population is increasing geometrically (2, 4, 16…) however, substance increases arithmetically (2, 4, 8…). If the population goes unchecked, it surpasses substance and with the passage of time this gape continue to increase. So, both must be in balance (Ibid).

Graph No. 3.1. 1Model of Malthus Theory



Although food is increasing but not as population. If population will not be controlled, it would lead to famine and widespread sufferings. Malthus called them natural checks on population. He said the lack of food is the absolute check on population growth. However, he discussed positive and preventive checks.

Positive checks are those checks which control population growth beyond human interventions. Human have no control over positive checks. All-natural hazards and disasters are called natural checks. Tsunami, Earthquakes, Floods, Draughts are all positive checks. Even War considered as positive check by Malthus. Positive checks become the source to balance between food and population through mass killing.

Preventive checks are all those unnatural methods or means used by human through which births can be controlled. Such methods utilized and practiced consciously by human and they have full control over such techniques. Abortion, contraceptive methods, asceticism, late marriage are preventive checks. Malthusfavoured preventive checks. He said preventive checks should be adopted to escape from famine.

However, Malthus favoured moral checks and said it is the accepted way. Remain chastity, postpone marriage meant of favour small family size, all of these are moral checks. Other preventive checks were “improper means” for Malthus like abortion, sterilization, and contraceptive. He said if people control births through improper means then they expend their energies in non-economical ways.

As a consequences of population growth, Malthus believed that it leads to poverty. Urge to reproduce of people leads surpluses of labour in market. Which mean too much labourer available for limited works. As a result, unemployment increased, and wages goes down. Such low wages and surplus labour leads cultivators to cultivate more acres to increase substance. As

surplus increased, urge to reproduce leads more people for available resources which ultimately increase poverty. So, more people go under poverty with single increase in substance.

3.1.1 Application of the Theory

The population of Pakistan increasing rapidly by every passing day. Increasing population require more food, health facilities, and other facilities which considered obligatory.Pakistan's import and export's balance arenot well. Over all imports of Pakistan are much higher than exports. In 2017, Pakistan has negative trade of -35562.23 million US dollars. In which Pakistan's Import trade were 57440.01 million US dollars but exports were of 21877.79 million US dollars (WITS n.d.).

Pakistan is an agricultural country; besides, it imports food, fruits and vegetables including other resources. "Basic raw materials for food industries like palm and soya bean oil and consumer items like tea, powdered milk and pulses. Moreover, we now also import beef, mutton, chicken, eggs, butter cheese, curd, coffee, biscuits, chocolates, pickles, juices, jams, soft drinks, flavoured water, spices, dry fruit, nuts, honeyand even fish." [8]

"The veggies and fruits imported during the period included: potatoes, tomatoes, onions, shallots, garlic, leeks, cabbage, cauliflower, kohlrabi, kale, lettuce, chicory, carrots, turnips, cucumbers, gherkins, coconuts, bananas, avocados, dates, figs, pineapples, grapes, apples, pears, apricots, cherries, peaches, plumes and citrus fruits."[9]

Furthermore, resources of the country are limited and decreasing day by day. These resources are less to accomplish the demands of increasing population. Country's 44 % of children under five year of age are stunt and facing

[8,8] Aazim. Mohiuddin. 2018. "Appetite for food imports grows." Retrieved July 19, 2019. https://www.dawn.com/news/1394619

physical and mental health issues.[10] It is because of the malnutrition which is directly related to the food requirements. In last almost four years, on average five hundred children died in Thar, Sindh due to the food and health facilities unavailability.[11]

More people consume more resources of the country which leads to the shortage of resources, resulted as high prices in the country and poverty level started to increase. Population growth increases the market labour and wages get down due to surplus labour. Hence, people find less wages to run their life cycle and goes under poverty line. This condition increases the inflation rate in the country which leads to unemployment, increasing crime rate and lower medical facilities. Which ultimately leads to high death rate in the country.

3.2 Demographic Transition

Demographic Transition idea was given by Warren Thompson in 1929. This idea comes after Thompson's study of certain countries from 1908-27. The theory was basically a description of demographic variations of advanced nations, from high to low birth and death rates. Thompson discussed countries in three groups with the name of A, B and C (Weeks 2008).

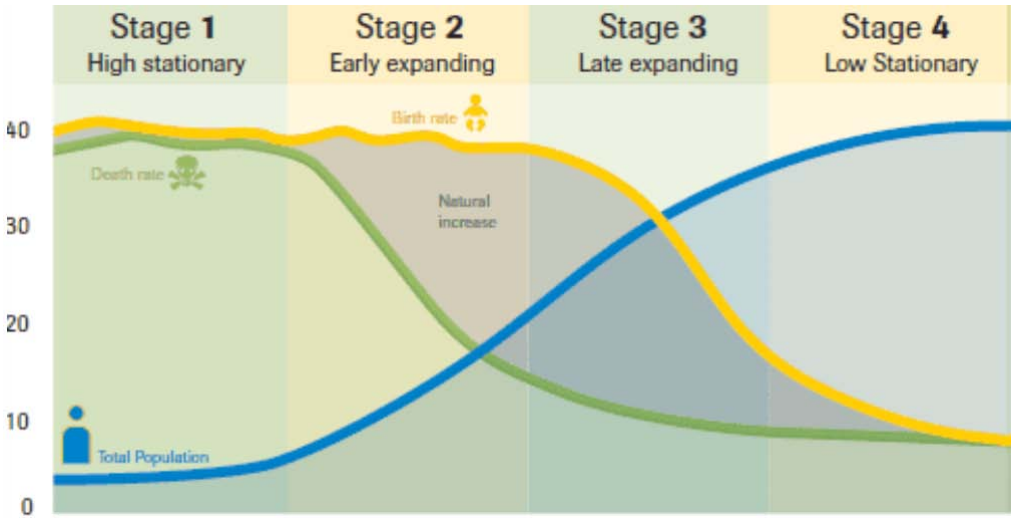
In group A, Thompson discussed United States and North and West Europe where these countries moved from high growth to low growth and becomes stationary. This transition happed from late nineteenth century to early twentieth century. In group B, Thompson listed Spain, Italy and Slavic of Central Europe where death rate decreases more rapidly than birth rate. Three to five decades before, group A passed the same situation. All the remaining world comes in group C, where birth and death rate were not controlled or little control. Consequently, Thompson assumed that the population of C

[10] https://www.pakistantoday.com.pk/2019/01/06/over-44-per-cent-children-under-five-year-are-stunted-in-pakistan-health-experts/
[11] https://www.dawn.com/news/1449385

group countries would increase which have 70 to 75 percent of total world's population (Ibid).

After Sixteen years of Thompson's work, in 1945 Frank Notestein work on it and gave labels to groups of A, B and C as incipient decline, transitional growth and high growth potential respectively. Later Davis termed transitional growth as population explosion and the term demographic transition born (Ibid). Besides, the theory of demographic transition has many versions. Karl Sex introduced the fourth stage and named the stages as "1) High stationary, 2) Early explosive Increase, 3) Late explosive increase, and 4) Low stationary."[12]

Graph No. 3. 2.1 Demographic Transition Model



First stage of high stationary: First demographic stage was the longest part of population increase. which start from human civilization to industrialization period. Birth rate and death rate was high in this stage and net population growth was slow because of unestablished nation, wars, economic instability and lack of medical advancement. Infant mortality rate was high in this stage.

[12]http://shodhganga.inflibnet.ac.in/bitstream/10603/11191/9/09_chapter%202.pdf

Second stage of early explosive increase: After the introduction of industrialization, second stage get started. Medical science and economic conditions were improved. Which causes to decrease the mortality rate. Life expectancy started to increase. However, it is difficult to change the human mind to reduce birth rate because it is slow process. Therefore, mortality rate starts decreasing and fertility rate remains same which results as high population net growth rate.

Third Stage,late explosive increase:As standard of living improved and death rate declines, after few decades birth rate also starts decline. However, its declining rate was slower than death rate because its lagging in people to recognize that death rate is actually declining. It is because institutions which favoured high fertility takes time to adjust new norms. Structure of family changed from large families to small families. Urban industrial states emerged with further economic development where compulsory education lower the value of child labour market. people get to know that lower infant mortality mean few children need to be born. Hence, with the lower mortality rate and declining fertility, net population growth slow downed in this stage.

Fourth Stage: Fertility and mortality, both are low and population growth in this stage is stabilizing. Countries in this stage have high literacy rate, rural to urban migration, highly employment opportunities for female, and advanced medical facilities for their citizens. fertility and mortality both are not always decreasing or constant, however, susceptible with circumstances. Example of stage four is China, Canada, Brazil, Australia and Argentina. Natural population growth is gradual in this stage, so considered as ideal (Grover 2014).

3.2.1 Application of the Theory

Within the country of Pakistan, population growth varies by different ethnic groups and region to region. Different administrative unites behave differently

in the sphere of population growth. On the macro level, the whole country as a single unite entered in the third stage of late explosive increase. Where population is still increasing but the growth rate becomes slow. Death rate decreased more rapidly than the birth rate because of advancement in medicine and urban industrial stage and of information technology.

It takes time to recognize that death rate is decreased for people and fertility institutions like family. Now changes are occurring in family institution and society is giving space for nuclear family, which was not acceptable before few decades. Literacy rate is continuously increasing and women rights movements getting their space in Pakistani societies specially in big cities. These factors are contributing in decreasing fertility. On the other hand, these transitional stages are varying by region to region.

Punjab is the most populous region of Pakistan having more than half population of the country. As a whole, it is in the third stage of transition but having two different behaviours. Central and upper Punjab are in the last phase of third stage where fertility and mortality are decreased, and population growth rate is steady. However, South Punjab is in the early phase of third stage where mortality rate decreased but the fertility rate still high and overall growth of population is high. Sindh is also in the third stage but Khyber Pakhtunkhwa (KP) just entered in the third stage. Female literacy and urbanization are low in KP and having high Population growth than Punjab and Sindh.

Besides, Baluchistan having totally different situation than other provinces. It is in the second stage of early explosive increase with high fertility and decreasing mortality rate. Population growth rate is high and increasing continuously. Health facilities are short than other provinces with lower overall fertility level. Baluch and Brohi ethnic people, lived in Baluchistan with majority, having high fertility rate than any other ethnic group in

Pakistan. Baluchistan have least developmental infrastructure and lower standard of living.

3.3 Critical View Context

Pakistan is a multicultural society which has different norms, values, customs and believes about fertility behaviour that eventually influence any country's population growth rate. These behaviours determine fertility patterns in Pakistan. Atif et al. (2012) stated that *"the fertility level appears to be the outcome of various demographic, economic, social and cultural variables, such as age at marriage, level of educational attainment, Socio-economic status, mode of living, active participation in the work force, exposure to contraceptive information and effect of conservative religious practices."*

In Pakistan, fertility is not only influenced by the factors of education, urbanization, employment, economic conditions and position of women but importantly by, believes and customs regarding fertility. Variety of ethnicities, or geographic areas have different fertility rate. It is because "*Socio-economic and cultural norms, value and belief systems of a society usually affect the attitude of the people(Ibid)."*

Muhammad (1996) concluded in his study that different ethnicities have different attitude toward fertility. It is because of diverse ethnic attitude, identification and perceived reproductive behaviour. People' ideas regarding family size, age at marriage, sex preferences, and fertility methods are highly influenced by their ethnic belonging. In this context, he said, Baluch and Brohi has higher fertility behaviour than other ethnicities in Pakistan. Sindhi and Pakhtoon has second higher fertility level. Punjabi speaking has lowest fertility level among Pakistani ethnicities.

Sindhi, Baluch and Brohi was recorded as lowest median age at first marriage. They were get married at only 15 years of age at first marriage, followed by Saraiki and Pakhtoon with the median age of 17 years. Punjabi and Urdu

speaking comparatively has highest age of 20 years. Similarly, they have different fertility and desired family size and diverse family planning knowledge, attitude and practice levels (Ibid). Furthermore, within different ethnicities, people have different believes, attitude and practices as by their geographic locality.

As per by conflict perspective in sociology, diverse attitude toward fertility patterns are because of un equal opportunities and resources which they have. People, communities or regions having high fertility rate is because of their lack of resources and marginalized position in society. Lack of poor economic conditions, education facilities and infrastructure direct people attitude and behaviour in a specific way. That's the reason, people of communities who belongs to poor or less resources have different attitude than the people with much resources.

Besides, functionalists looked society in different ways. They have the view that everything which happed in the society is good at some ways. Through their lenses, high fertility rate in specific areas but not in others is functional for the society. In Their perspective, it is not a problem but a resource. High fertility provides man power to a nation which can be utilized in a propriate manners.

Chapter No. 4

RESEARCH METHODOLOGY

Qualitative content analyses research design was used in the following study to understand the policy interventions contextually.

4.1 Universe

Universe of the study was Population wing under the Ministry of National Health Services Regulations and Coordination (NHSR&C): Government of Pakistan, Ministry of Planning Development and Reforms: Government of Pakistan, Population Welfare Department: Government of Punjab, Population Welfare Department: Government of Khyber Pakhtunkhwa (KP), Population Welfare Department: Government of Sindh, Population Welfare Department: Government of Baluchistan, Libraries of different institutions and online sources through world wide web (www).

4.2Unite of Analysis

Target population of the study was included, all the available national and provincial population policy documents of Pakistan since independence of the country, along with available five-year, perspective and Medium-term development plans and policies.

4.3 Time Period of Data Sources:

All the data sources used in the study spacing from 1950s to 2017. This period was selected because first plan was given in 1950s and the last policy for population given by Punjab population department in 2017.

4.4 Sampling Design:

Purposive sampling technique was used in the study. This strategy was used because all the secondary sources were not available. This technique was easier to access and collect available data than any other.

4.5 Sample Size

10 five-year plans, one perspective and three-year plan, one medium term development plan and two national and three provincial population policies were included in the sample.

4.6Tools for Data Collection

Data of the study was gathered in hard copiedform from Ministry of Planning, Development and Reforms: Government of Pakistan, Population wing under the Ministry of National Health Services Regulations and Coordination (NHSR&C): Government of Pakistan, and other provincial population departments through internet from their official websites.

4.7Technique for Data Collection

All the population related departments, institutes and Ministries were visited to know the availability of data. Different departmental libraries were also visited for data availability. Population plans were copied from photocopy machine through self-service. On the other hand, national policies were collected from population wing under Ministry of health, after many visits and meetings with director and deputy director. Provincial policies were downloaded from their provincial department's official websites.

4.8 Tools and Technique for Data Analysis

MS Excel used as a tool for data analysis. Snapshots of all plans and policies were made in excel sheets. All major points like targets, strategies, budget, organizational structure and physical targets were indited. Afterward, all the snapshots of data were compared and analysed. Researcher used triangulation method in analysis of plans and policies targets, budget and strategies.

4.9 Opportunities and Limitations

No any proper data source was available related to plans and policies in Pakistan. It took much struggle to visits multiple population departments, organizations, institutes and ministries for data collection. 9^{th} five-year plan

was missing and not available as by librarian of Ministry of Planning, Development and Reforms, the draft of 9th plan was not approved. All policies for Pakistan from international community were not existing. This thing limits the study to analyse Pakistani plans and policies. Review reports of all five-year plan were missing which were important for evaluation of the program. One-year plans were collected but not included because of too many missing one-year plan.

4.10 Field Experiences

In order to locate Pakistan's population policies and programs I face multiple hardships. The whole journey of locating data and collecting it for my study purpose consist upon so many scheduled and unscheduled visits to various ministries and departments. My visits revealed that it was really a tough task. However, I started my search for data collection from NIPS (National Institute of Population Studies). Authorities in NIPS told me clearly for having no data on National Population Policies and programs. They give me information regarding the availability of such data. I was suggested to visit Bureaus of Statistics and Ministry of Population.

In the next episode, firstly I get some basic information on phone call from bureau of statistics for their availability and concerned wing which deals with population statistics. Secondly, I searched the population ministry on google map to locate exact place. However, when I visit bureau of statistics, I met there with different staff members to tell them why I get here. They refer me to the Director general of the department. I then, visit his office but he categorically told me that we have no archival records of population policies and programs and that, we do not deal such things.

I then turn, towards ministry of population for which I search it on google map. When I reached there, shockingly I was told by some layman that we don't know about the new building location but this department for which you

came here has been shifted somewhere else. In some next days, my supervisor Dr Abida Shareef suggested me to visit National Archives Centre. We then, collectively with my supervisor visit National Archives Centre. When we get there, they inform us that the ministry of population has been dissolved after 18th amendment. And the respective departments have been shifted to each province. However, there is no central ministry of head ministry so that to deal with national populational programs and policies. It's very unfortunate, that Pakistan stands six most populous country of the world. However, there is no central department for it to deals with and inspect the whole population and its patterns of change.

In short, in the National archives we have been informed that with the dissolution of ministry the concerned archives have been shifted to provinces or it has been rolled out and make the food of dustbins. However, they suggested us to visit a Director rank officer in the Establishment Division of the Secretariat. With my supervisor, we visited his office. Interestingly, we have been informed there the data is available, but it needs some hard search of days in our own libraries. For the purpose of approval to visit, we meet up to Secretary level officers' number wise started from Director and Assistant Directors.

I then started visiting on daily bases to find out relevant data, but a major hindrance come in way. they told me if you are collecting the data from here you will have to search individually all the library for it. however, I decided to go for it. Soon, when I entered that library, I feel that I have been pushed to ghost house. There were books all around full of dusts. They, then informed me for paying back for if I found some relevant data. They told me if the data has been founded, we will scan it, and a soft copy will be given to you at 4 Rs per page.

However, I did not refuse to pay but, I search some documents there were no relevant data on population. In the next day, some member of the establishment division suggested me to visit the Planning Development and Reforms ministry for this purpose. One of my friends also advised me to visit Planning ministry. I then, scheduled a visit to that department and finally got some relevant data. However, I only collected all 5 years plans of populations. There were no evaluation reports of these collected 5-year plans.

In the last, phase of my field visits in the ministry of planning and development I was directed to visit health ministry and their population wing. After, collecting all 5 years of plans I then scheduled visit to health ministry. I visited there, and fortunately found the population policies there. The whole journey end here.

Chapter No. 5

RESULTS

In the following chapter, all findings and answers of research questions and objectives are presented and discussed briefly. Concerned research questions and objectives are mentioned in first chapter of the entitled study.The following study analysed Pakistan's five-year plans, national and provincial policies and other available mid-term and perspective plans. The study has some serious limitations regarding availability of evaluation reports of plans, which were impotent to analyse the plans achievement.

5.1 Population Plans and Policies of Pakistan: An Overview

First five-year plan (1955-60) did not have a chapter on population and neither discussed it. So, the first plan is not discussed in the following section.

5.1.1 2nd Five-Year Plan (1960-65)

In the second five-year plan, issue of population increase was recognized. So, a family planning program was started with the aim to change the people's attitude toward ideal of family and to motivate people for small family size and fewer children. For this, the major plan was to aware people about the program and motivates them for small family. To make people aware was considered more important than the use of contraceptives. In this plan, 30.5 million rupees were allocated for population.

5.1.2 3rd Five-Year Plan (1965-70)

It was the first comprehensive plan of population. Brief strategies were made to take bold steps for population control of the country. The financial allocations were increased from 30.5 million in the second plan to 280 million for third plan, which was 818 times greater than previous plan. Furthermore, the actual expenditures of the program were 356 million rupees. It was a well effort through the plan for structured system. The targets and the strategy of the plan were showing the serious intention to the issue of population. However, the targets of the plan were over-ambitious to reduce CBR from 50

to 40 per 1000 by 1970 and cover all 20 million couples to introduce FP practices at any cost.

In the strategy of implementation, it was planned to cover 36 districts in West Pakistan and 16 districts in East Pakistan and 2/3 districts will be covered in first two year of the plan. In which, 50,000 dais and health visitors were expected to hire as motivator, referrers and distributer of contraceptives. The major tool of contraception was sterilization, form and IUDs, 24,000 visiting family planning doctors were hired for the insertion of IUDs. Training would give all dais, health visitors, supervisors, and doctors. For the utility of the program 345 Jeeps were given. It was planned to give motivation at village and individual level and provide supplies at doorsteps at subsidies rates. Massive media would use for publicity. Planned evaluation system was derived for the program's success.

5.1.3 4th Five Year Plan (1970-75)

In the fourth plan the population budget were increased 150% than previous plan to 695 million rupees. This plan had three targets, 1) to decrease CBR from 45 to 40 per 1000 2) Prevent 9.6 million births and 3) 34% couples use contraceptives. In this plan, incentives on contraceptives were withdraw and introduce oral pills and emphases on oral pills and sterilization rather than IUDs. Replace dais into family planning workers and increase the number of family planning workers, lady FP visitors and clinics.

In the plan family planning clinics were likely to increase and rural clinics would have residents for staff. Health and family planning services integrated at UC level. It was decided to give priority of supplies to the areas which have more population pressure and contraceptive acceptance rate.

5.1.4 5th Five Year Plan (1978-83)

In the fifth five-year plan, it was planned to short family size and follow economic strategy. In this plan targets were focused on TFR, CBR,

contraceptive prevalence rate and contraceptive users. CBR was expected to decrease 26% and total fertility rate from 6.75 to 5 by 1983. It was aimed to educated and spread the knowledge of contraceptive from 75 to 100% and increase the CPR from 6% to 15.4%. 1800 million Rupees were given for the five-year program.

It was the first plan in which some external factors were intended to focus for long term control of the population and decrease the fertility and crude birth rate. So, it was intended to increase the age at marriage, spread the urban norms in rural areas and increase urban cities and areas. Increase literacy rate through education, particularly female education and increase the female entrance in secondary level education by 50%. Provide female employment. Through this, the female' fertile period would be short, and it helps to control population. By the growth strategy, major focus was expected to give poorer, rural and backward regions.

All the health and population programs were integrated and expected to merge all services as quick as possible. The need of 5000 new health outlets was derived. Hakeem, Homeopaths and other practitioners were expected to merge with the program and expend services through remote areas. For the betterment of program Information, Education and Communication (IEC) were given more emphases and give more choice of contraceptive. It was deliberate to provincialize the program. Research, monitoring and evaluation was planned to start for the effectiveness of program.

5.1.5 6th Five Year Plan (1983-88)

In the sixth five-year plan, the major emphases of the plan were on the reduction of fertility rate. Despite the struggle to decrease birth rate from last couple of decades, the issue is still identical. So, the plan had focused the issue through a development in strategy. Budget of the plane was increased from 1800 million rupees to 2300 million rupees. The targets of the plan were

to reduce CBR from 40.3 to 36.2 per1000 population by 1988, decline total fertility rate from 5.9 to 5.4 and population growth rate from 2.87 to 2.69% by the end of the plan. It was intended to increase contraceptive prevalence rate from 9.5% to 18.6 % through the continuation of current contraceptive practice from 6.8 to 13% by 1988.

In this plan, it was deliberate to develop multisectoral linkage and encourage local participants including NGOs to take active part in the family planning activities. New reproductive health centers, service outlets, clinics and training centers were established, increased and strengthened. The structure of the program of population welfare was deliberated to implement under federal, provincial and local level. Institutional research was stressed in the plan. Supply of all contraceptive methods was increased and to ensured availability, commercial marketing of contraceptive was utilized. The area of the program was broadened to AJK and Northern Areas where population education services were introduced and establish new 150 service outlets.

5.1.6 7th Five Year Plan (1988-93)

The seventh five-year plan was an extensional plan of the previous plan program. The budget of the program was same, and it was specifically focused on birth control to reduce fertility level. This plan was aimed to prevent 3.1 million births and reduce crude birth rate from 42.3/1000 to 38/1000. This plan was targeted to raise the family planning practice from 12.9 to 23.4 by 1993. To lesser fertility rate, the program was intended to increase the practice of breast feeding, give health care to under five-year children and decrease infant mortality. It was deliberated to improve maternal health through birth spacing.

Seventh Plan strengthened and extended the already existing structure or services and established 158 Mobile Service Units (MSUs). This plan tried to play bridge role between knowledge and practice. It focuses to educate the

people about population issues, replace the norms of family size to small family. Highlight the gap between population and resource and misgivings of program.

5.1.7 8th Five Year Plan (1993-98)

In the 8th five-year plan (1993-98), separate strategy was introduced for rural and urban areas. It seems more realistic because its targets and strategies were not too high but reachable. In the plan, it was planned to cover 100% urban areas through extended services with new outlets especially in low economic areas like slums and Kachi Abadie's. Similarly, 70 % percent of rural population was expected to cover through the coverage of 13060 high populated villages with the population of 2000 out of total 45000 villages. Reproductive health, Family Planning and Welfare programs were expected to extend. Population services were also devised to extend, strengthened and established in FATA, AJ&K and Northern Areas.

Like 6th and 7th five-year plans, multi-sectorial approach was continued in the 8th plan to expand population program coverage. NGOs were deliberate to more strengthen for service delivery to reach the targets. This Plan has targeted to decrease population growth rate from 2.9% to 2.7%, Crude birth rate was expected to decrease from 39 to 36 of 1000, and Total fertility rate expected to decrease 5.9 to 5.4 by the end of the plan in 1997-98. The targeted figures of fertility were same with 6th five-year plan's targets. Contraceptive prevalence was desired to increase from 14% to 24 percent through motivation.

To achieve the given targets, the budget was increased to 295 times than the previous budget of 2.3 billion to 9.1 billion rupees. Structural management of the program was at federal and provincial level. At federal level, ministry of population welfare has the responsibility to fund the budget, devise policies, monitoring and research, deal international assistance, training and

coordination. At provincial level, department of population were independent headed by secretaries. The entire population program was supported by political and administrative level through population welfare councils headed by Prime Minister at federal, Chief Ministers at provincial and Chairman at district levels.

5.1.8 9th Five Year Plan (1998-2003)

"The strategy during the ninth five-year plan (1998–2003) was guided by the principle of building on positive elements of the ongoing programme, ensuring continuity and consolidation of the gains. The scope of the programme has been enlarged to strengthen outreach through enhanced and improved service delivery strategies with continued attention to rural areas. A broader reproductive health approach has been pursued with emphasis on mother and child health care (Hakim 2001)."

5.1.9 10th Five Year Plan (2010-15)

In the 10th five-year plan (2010-15), it was assumed that the focus should not be on the population reduction only, however, to provide quality services to clients also. It was understood that there was need of paradigm shift in population planning and policies. So, the mechanism of policy and requisite infrastructure should be focused at first and then the interventions. It was assumed that rapid increase of population can be control through the serious efforts of provincial line departments to achieve goals. Partnership of different sectors of government, private and NGOs sector ware focused.

As all the provincial departments were independent, federal population welfare program was inclined to provide guidelines and different services to provinces to achieve the targets. The targets of 10th five-year plan were quite realistic and achievable. The objectives were to increase CPR from 30 to 37.5% by the end of the plan, reduce CBR from 24.91 to 21.03 per thousand

and decrease population growth rate from 1.88% in 2007 to 1.49% by 2015. The budget of the plan to accomplish the goals was set by 39.2 billion rupees.

5.1.10 11th Five Year Plan (2013-18)

Eleventh five-year plan was introduced after the devolution of Ministry of Population Welfare through 18th amendment in 2010. It has multi-targets of population control. In this program, it was intentional to increase the overall number of contraceptive users from 11.9% to 16.1% and its prevalence rate from 35% to 49%. Population growth was targeted to decrease 0.3% in five years form 1.9% in 2013 to 1.87% by 2018, which was quite short target and achievable. CBR was also intended to decrease from 24.2/1000 to 20.5/1000 by the end of the plan. The plan also set targets for 2020 of CPR and TFR.

In this plan, the existing clinics, services and practitioner were planned to increase. Strong mechanism intended to make for NGOs of their coordination. Population issues would be addressed through well designed and integrated interaction and communication through different sources. Political will needs to be gain at all levels. Unmet needs of FP and RH would be intended to address through population departments and health Ministry. Regulation monitoring was deliberate mandatory. This program was given 37 billion rupees of budget.

Provinces were independent to control population and health programs. They were free to make their own programs, plans and policies and to implement them. Federal government just deal the international community, give support and services for provincial programs and conduct researches.

5.2 Perspective Plan (2001-11) and Three-Year Plan (2001-04)

In 2001, Perspective plan were introduced with three-year plan. The intentional targets of services and strategies for these plans were not much different. Almost both were same except a few services. The same thing happened with objective targets of the perspective and three-year plan. The

targets for the first three years were larger than the remaining seven years. The targets of the plan were not specific. It has planned to reduce CBR, TFR, CPR, CDR, and population growth rate.

The plan was targeted to reduce population growth rate from 2.17% in 2001 to 1.82% in 2004 and 1.6 by 2011. It means the target for first three years to reduce 0.35% population growth rate and only 0.22% in the remaining seven years. Similarly, the target was to reduce fertility rate from 4.6 per women in 2001 to 3.5 in 2004 and 2.5 by 2011. Target of firth three month was to control 1.1 births/women to 1.0 for next seven years. This story remains with the other targets. The target was to increase CPR from 30% to 43% and 53% by 2004 and 2011 respectively. CBR were targeted to decrease 30.2 to 26 and 22.8 correspondingly.

The same development ratio depicts in all the services targets of the plan in which larger part of the target specify for the first three years and remaining for next seven years. This plan extended all the previous programs' services and structures which were carried out. The amount of Family welfare centers, Reproductive health services, mobile unite services, Hakeem and Homeopaths and private sector increased. In this plan, Provincial line department outlets were inclined to involve for FP services by 2004. Men's participation was promoted, and the area of research intends to strengthen.

5.3Medium Term Development Framework (2005-10)

During the fourth year of perspective plan and after national population policy 2002, medium term development framework given with the same goals given in the national policy 2002 to achieve reduction in fertility rate and create balance between the resources of the country and population increase. Propagate various population issues at national, provinces, district and local levels and spread awareness of population increase consequences. Further, promote family planning and attained remarkable reduction in fertility.

Finally, through small family, birth space and delay marriage break population momentum.

In this framework, all the previous aspects of perspective plan were focused with new targets to achieve goals by 2010. Population growth, CBR, CDR and TFR was targeted to reduce and increase CPR. All the targets were realistic and achievable.

On the road to reach program goals and targets, it was planned to strengthen public private partnership and integration between population and health services at federal, provincial and district level. Multi-sectoral approach was needed to enhance to deal with population issues. The personal skills and training were focused for professional level work. The provision of quality services of FP and RH in rural and poorer areas was focused. Awareness and IEC campaign were intending to increase in all the areas. A strong monitoring and evaluation strategy were fashioned in which third party would involve in the evaluation.

5.4 National Population Policies of Pakistan: An Overview

Summaries of all national population policy's and their focuses are discussed under this heading.

5.4.1 National Population Policy of Pakistan 2002

During the second year of perspective plan, ever first national population policy given with following goals; 1) achieve reduction in fertility rate and create balance between the resources of the country and population increase, 2) Propagate various population issues at national, provinces, district and local levels, 3) spread awareness of population increase consequences, 4) promote family planning and attained remarkable reduction in fertility. Finally, through small family, birth space and delay marriage break population momentum.

The policy had specifically two targets to achieve by 2004. Targets of policy were to reduce fertility rate by 1.9% annually and decrease fertility rate by 4 births per women. In this policy, future targets were also set to reach universal safe family planning services and decrease annual population growth rate and total fertility rate to 1.3% and 2.1 births/women respectively by 2020.

In this policy, specified strategies were devised to spread the family planning awareness to the people at all levels and promote small family norms. Men inclined to involve in this plan and spread population education in all levels. The major focus of the program was to spread the awareness and provide facilities to people. For this, advocacy campaign was planned to address special groups like policy makers and youth. It was strategic to build and strengthen relationship between line departments, line ministries, organizations, NGOs and media.

Coordination and monitoring were focused, and provision of family planning and reproductive health would be given priority to poor, rural and slum areas. All aspects of population and demography were inclined to Research.

5.4.2National Population Policy 2017

Pakistan's first population policy was introduced in 2002 and second national population policy draft was made in 2010 but approved in 2017. It was a general policy in which population control was not inclined directly. It has two goals, first, to achieve initial demographic dividend by 2015 and second, strengthen institution for effective date generation and its use. To achieve its first demographic dividend the plan intended to empower female, decrease fertility, increase child survival rate and provide protect good health facilities of people. Transform and develop education system to provide innovative and skilled labour. Develop necessary infrastructure and bring economic reforms and eliminate discrimination.

It was planned to develop a system through which data of population and development would be generated at regular basis. The data would be available for online open access. Monitoring system would be developed on result based.

5.5 Provincial Population Policies of Pakistan: An Overview

Under this heading, summaries of all provincial population policy's and their focuses are discussed.

5.5.1 Population Policy of Khyber Pakhtunkhwa 2015

After the devolution of nation population welfare, Khyber Pakhtunkhwa (KP) introduces its first population policy in 2015 with the budget of 4.032 billion for three years by 2018. In the policy, focus was given to the control of population growth through different ways. At one hand the policy focused to increase the contraceptive prevalence rate which was the part to reach London FP summit 2012 goals and decline fertility rate to decrease population growth rate. On the other hand, tries to change the image of birth control in the masses through inter-sectoral linkages, parliamentarians, local stakeholders, religious leaders and activists to create the environment of RH and FP.

In the policy, three variant assumptions were drawn on the bases of expected efforts and progress, high variant, medium variant and low variant. In all the variants, short term and long-term targets are given. The targeted years are 2020, 2025, 2030, 2035 and 2050. In the medium variant the CPR is expected to increase 28% to 42% by 2020, TFR is expected to reduce from 3.9 to 3.3 per women by 2020 and the population growth rate will decrease from 2.2 to 2.0. Increased investment for female education and empowerment is included in the long-term target policy for control the population growth. In the policy, male is focused to accomplish the target because of patriarchal society. They would be the motivators of FP. Contraceptive methods for male introduced.

5.5.2 Population Policy of Sindh 2016

It is the first population policy of Sindh province after the devolution of national MoPW. Pakistan was committed with London FP summit 2012 to achieve universal FP and RH services and increase CPR to 55% by 2020. Sindh population policy focused to achieve the international target of CPR and intended make its contribution of CPR from 30% to 45% by 2020. Like the KP government population policy, it was focused on to achieve universal safe FP and RH services by 2020. It was hoped to reduce the unmet need of family planning and gave security to contraceptive commodity. Targeted fertility rate to achieve by 2020 was 3.0 from 3.9 in 2013.

Similar with KP government strategies, it was hoped to achieve the targets through multisectoral approach, highest level of political commitment, and costed implementation plan (CIP). Male Involvement, advocacy complain, delay marriages and education of youth were part of the strategies.

5.5.3 Population Policy of Punjab 2017

The major focus of the Punjab population policy was on to the reduction of fertility level. Two different time bound target were set in the policy, short term and long term. Short term policy focused on security of contraceptive commodities and advocacy of FP through messages. Reduction of wanted family size set as a target. In long term policy universal availability of safe contraceptive methods and contraceptive prevalence rate was focused to reduce the fertility level by replacement level of 2.1 births per women by 2030.

This policy is also a part in following to contribute in achievement of the target of London summit 2012. All the strategies were common like Sindh and KP government. To fulfil the targets, 40 billion rupees were allocated for five year till 2020.

5.6 Evaluation of Budget Allocations for Plans and Policies of Pakistan

Every planning commission allocated a valuable amount of money for every plan period. In the first five-year plan when population planning program were not constructed yet, planning commission allocated 0.5 million rupees for population activities. It was not enough amount, but this amount shows their intention of population control. Even population planning, or control program was not introduced. In the second five-year plan which was introduced in 1960 had 6000% increased allocation of 30.5 million rupees. Even that was aimed to work on attitude of people and change family size definition. That program had not any physical target.

Table No. 5.6.1Outlay for Different Population Programs across Time

Plan/ Policy	Total Outlay	% Increase
1st Plan (1955-60)	0.5	-
2nd Plan (1960-65)	30.5	6000
3rd Plan (1965-70)	280 (expenditure 365)	818 (1097)
4th plan (1970-75)	695	60
5th plan (1978-83)	1,800	61.4
6th plan (1983-88)	2,300	22
7th Plan (1988-93)	3,535	35
8th plan (1993-98)	9,100	61
Perspective Plane (2001-11) and Three-year Plan (2001-04)	38,246 & 8.35	76.21
Population Policy 2002	N/A	-
Medium Term development plan (2005-10)	24,700	-35.42
10th Plan (2010-15)	39,200	59
11th plan (2013-18)	37,000	-5.6
Population Policy 2017	N/A	-
Population Policy of KP 2015	4,032 (3years)	-
Population Policy of Sindh 2016		-
Population Policy of Punjab 2017	40,000	-

Third plan was the first organized plan with planned structural objectives. Expected cost of the program was 280 million rupees but allocated 274 million. However, the expenditure of the plan was increase to 365 million rupees. Cost of the third plan was 1097 percent bigger than previous plan. Politically seriousness leads this plan to better direction and it accomplished remarkable success. Increasement in population programme' budget was continued in every plan. 4^{th}, 5^{th}, 6^{th}, 7^{th} and 8^{th} five-year plan had budget of 695, 1800, 2300, 3535 and 9100 million rupees respectively with increase of 60%, 61%, 22%, 35% and 61% compare each with their previous plan.

In the beginning of 21 century, perspective plan (2001-11) with three-year (2001-04) plan introduced which had allocated 38.2 billion rupees in which 8.35 million was allocated for first three years plan. After one year first population policy 2002 announced and three year later new plan presented by the name of medium-term development plan (2005-10). It had allocated 24.7 billion rupees. In 2010, tenth five-year plan allocated 39.2 billion rupees but three years later new 11^{th} five-year plan (2013-18) introduced with budget of 37 billion rupees. This amount of budget intended to distribute amount provinces and federal areas. Although provinces have their own budget, but they get share from federal government' population program. Khyber Pakhtunkhwa department introduced 4.03 billion of budgets for three years and Punjab has 40 billion rupees.

It shows that population programs in Pakistan don not have issue of money in any program. Every program has enough allocation for the program and each program has a valuable increasement in every budget.

5.7Evaluation of Population Programme: FocusedAreas acrossTime

Pakistan was the first country who starts family planning programme in Asia. The program was started by a private organization named RehnumaFPAP. At government level, in the first plan (1955-60), the increase of population

recognized and linked with economic growth of the country. In the second, separate chapter for population was included in the plan and the increase of population was recognized as issue for the long term economic and development meters of the country. Family planning program was started to create awareness and change the people' definition of family and change their attitude to assimilate small family norms. At this time of family planning, motivation was considered more important than contraceptive knowledge.

In the third plan, the problem was recognized seriously, and a comprehensive program of family planning was given. The need to control of population, birth control was the main focus in the plan. The programme was arranged to cover East and West Pakistan in a proper way and reach all the reproductive couple of the country. In the program, Intera Uterine Devices (IUDs) were introduced as the main contraceptive tool and government gave 50% subsidy in all methods. Dies were hired as a motivator and referrer and paid as IUD used by users. The same strategy was used in all level, doctors and lady doctors were give specific amount for each IUD insertion. The programme shows seriousness of government toward the issue of population growth. This programme had lack of monitoring system. It was difficult to analyses success rate, beside programme reduce birth rate by half of their target.

In the Fourth plan (1970-75), government cease subsidy on family planning methods and replace and convert dais into family planning workers and end their commission on referring clients for IUDs. The focus of family plan method was changed to oral pills. Priority for resources were planned to give on equality bases. Like on the bases of population density, contraceptive acceptance rate and on economic situation of the area. After the fourth plan, next plan delayed for three year.

In fifth plan (1978-83), Health and population sectors merged at all levels. Population planning council was decided to eradicate and make population

division under health and population ministry. Ministry of Population and Ministry of Health combined with the name of Ministry of Health, Population and Social Welfare. In this plan, population program focused that areas which have indirectly influence on population control. It planned to educate females and give them employment and spread urban norms in rural areas and increased urban units. These are the factors which effect on population growth lately. Health and population workers retrained, in which health workers provided with population-based training and population workers provided health-based training.

Population program focused to strengthen multisectoral linkages in the Sixth five-year plan (1983-88). Local participants are focused to encourage them in participation of family planning program. Research was intended to conduct. Special incentives for small family norms were introduced in the seventh plan. Monitoring and evaluation system were intended to develop and strengthened. NGOs were expanded and TBAs were involved for contraceptive distribution and motivation.

In eighth plan, Population Welfare councils were generated, prime minster was the head of federal population welfare council and chief ministers were the head of provincial councils. New strategy was stratified for rural and urban division. Family planning system was made of AJK and Northern Areas. Population departments were made independent headed by director general. In 2002, first population policy was introduced. In 2010, Ministry of population welfare devolved to provinces and federal level population division made under Health ministry. Provincial ministries are independent and free to make policies. Except Baluchistan, all provinces made their own policies. Population division at national level introduced its second policy in 2017 whose draft was made on 2010.

5.8Evaluation of Birth Control in Different Plans

Pakistan is the country with high resistance of birth control and fertility decline. Norms and patterns of the society are resistant to fertility decline. The major reasons of it are religious explanations, cultural patterns and less medical facilities and awareness to the people. So, it was hard to tackle this situation in all the epochs. It was the only reason that second five-year plan was only focused to change the attitude of people toward family planning and control population growth.

Table No. 5.8. 1Birth Rate of Pakistan across Different Plan Epochs

Plan/Policy	Present Level		Target	
	Date	Birth Rate	Birth Rate	Date
3rd Plan (1965-70)	1965	40	40	1970
4th plan (1970-75)	1970	45	40	1975
5th plan (1978-83)	1978	43.6	35.5	1983
6th plan (1983-88)	1983	40.3	36.2	1988
7th Plan (1988-93)	1988	42.3	23.2	1993
8th plan (1993-98)	1993	39	36	1998
Perspective Plane (2001-11) and Three-year Plan (2001-04)	2001	30.2	26	2004
			22.8	2011
Population Policy 2002	2004	-	-	2004
Medium Term development plan (2005-10)	2005	27.1	23.6	2010
10th Plan (2010-15)	2010	24.91	21.03	2015
11th plan (2013-18)	2013	24.2	20.5	2018

In the third and most detailed and organized plan (1965-70), births werespecifically targeted to reduce. Pakistan was the rapid increasing populating in the region. Ayoub Khan was the president of Pakistan and has the ideology development and high per capita growth and modern

industrialization. So, he was curious to control population growth because academicians of Harvard and government economists, who were assisted in first two plans, said that even 1.4% population growth is threat for economic growth (Khan 1996). Besides, he did not find any immediate solution.

In that scenario, birth control was recognized essential for economic development of the country. In the plan the main objective was to decrease birth rate from 50/1000 in 1965 to 40/1000 by 1970. Although it was an unrealistic target for the country that have newly building structured of family planning, but the high intentions of the government and strategy of the program make it possible to reach 45 per thousand births. However, the program did not successful to accomplish its targets but still it was a milestone.

In the fourth plan (1970-75), it was intending to reduce birth rate by 40 per thousand through increased contraceptive methods and number of users. It was not a high or unrealistic target, even the infrastructure was built initially in the earlier plan. Besides, Pakistan was ineffective to reach the targets. After the five years, the program was able to reduce only 1.4 births per 1000 population and birth rate of the country reached to 43.6 births per 1000.

After two decades of third five-year plan in which target of birth rate was to decrease by 40/1000, achieved in the end of 7^{th} five-year plan in 1993. Fourth, fifth, sixth and seventh five-year plan was abortive to achieve its targeted decrease in birth rate. In these four plans birth rate decreases just 5 by 1000. Stalled decrease in two decades caused political reasons. In President Ayoub period, population control programs were badly politicized by right wing religious parties and left-wing people party to overthrown Ayoub. After Ayoub, in 1971, Zulfiqar Ali Bhutto came in power and he did not give importance to family planning programs because he did not want to give opportunity to opposition to use same slogans against him (Khan 1996).

Unlike Ayoub and Zulfiqar Ali Bhutto who face religious right wings in their ideologies and development, Zia ul Haq made a strategy and use religious wings as his political ideology. He froze the family planning programs in 1977. Later, the program was started but its activities were not open. These political scenarios were caused of the abortive achievements of population program targets.

During and after the eighth plan, births rate started to decrease continuously. In the 8th plan, 4.66 million births were targeted to prevent. The program has different strategies for rural and urban areas. Is has future targets to reach 2.6 population growth rate. Political support of the governments was given to the program but unluckily in that period the governments were not stabled and were changing. The role of government in any program is crucial.

In the start of 21th century, perspective plane was introduced with short- and long-term targets. Short term targets were with the gape of three year;however, the next seven-year targets were not as long compared with firth three years. Just after one year of the perspective plan, ever first population policy was approved in 2002 and had targets of 2004. The policy was not just focused by2004; however, it has future targets to fulfil in 2020. It was quite successful policy in terms of its achieved targets.

In 2005, medium term development plan for five years was given which had targeted to decrease birth rate from 27.1 to 23.6 but the 10th five-year plan (2010-15) deliberate its targets of birth rate to decrease from 24.91 to 21.03. It shows that medium term development plan just decreases 2.2 births per 1000 in five year. In 2013, tenth plan was replaced by eleventh plan (2013-18) with the change of new government. 10th plan was abortive in decreasing birth rate up to the plan. In new plan, targets were set according to achieve Pakistan's commitment with international community.

After the devolution of Ministry of Population Welfare, all the provinces were independent to devise their policies and make strategies to implement. Through this, except Baluchistan, all other provinces make their own polices. Khyber Pakhtunkhwa makes its policy in 2015, Sindh in 2016 and Punjab introduced its policy in 2017. The major focus of their policies was to contribute to achieve the target given by international community in London Summit 2012. The target was to increase of contraceptive prevalence rate and decrease fertility rate by 2020.

According to the Pakistan Economic Survey of (2018-19), crude birth rate of Pakistan in 2018 was 25.2 births per 1000 population. Still it is very high, and it shows no remarkable decrease the last previous decade.

5.9 Evaluation of Proposed Contraceptive Methods

Contraceptives are one of the basic components of family planning projects to control population increase. Hence, it is not new in Pakistan. In the second five-year plan (1960-65), to control population growth, it was emphasised to focus on the change of people attitude and family size definitions rather than use of contraceptives. It was acknowledged that to spread awareness and knowledge is more valuable than contraceptives. However, in the next Third five-year plan (1965-70), this policy was totally changed.

In this new plan, major focus gives to contraceptives to reduce birth rate. Multiple strategies were planned of contraceptive use. In this first organised plan, IUDs were introduced and focused as major tool of contraceptives. It was intended to introduce family planning to all 20 million reproductive females to practice it anyway by 1970. Priority proposed to give more contraceptive accepting districts. Contraceptive sale at subsidised rates and 50% sale commission fixed for seller and gave monitory incentives to motivators and practitioners.

For every single IUD, lady doctor/dai/health visitor was proposed to give 25 rupees and on every insertion of single IUD doctor were given 8 rupees and dai/nurse 4 rupees. Besides, referral for every insertion, intended to give 2.5 rupees for dais and 2 rupees for others. 50,000 dais and 24,000 family planning doctors were intended to employ for IUD motivation and insertion.

In fourth five-year plan (1970-75), hormonal pills were introduced for contraception and IUD was replaced with sterilization because of its serious limitations. Over all quantity for contraceptives were also increased. IUDs were increased 3.0 million in third plan to 3.6 million in fourth plan. Similarly, sterilization from 0.9 million to 4.5 million, conventional contraceptives units from 1,152.5 to 1000 and include 39 cycles of oral contraceptives in fourth plan. Oppositely, fifth five-year plan (1978-83) mainly focused on spread of contraceptive knowledge and to increase number of users.

Fifth plan intend to increase contraceptive and encourage more secure form of contraception. Spread of contraceptive knowledge was planned to increase from 75% in 1977-78 to 100% by 1982-83 and increase the number of new users and continuous user from 13.6% to 27.2% and 6.0% to 15.4% respectively by 1982-83. Sixth five-year plan (1983-1988) also focused to increase all types of contraceptive techniques. IUDs cases were proposed to increase from 0.096 million in 1982-83 to 1.29 million by 1987-88. Similarly, Oral pills, condoms, contraceptive surgery cases and injectable were intended to increase from 0.571 million to 26.1 million, 43.2 million to 759.8 million, 0.044 million to 0.65 million and 0.061 to 0.76 million respectively by the end of the plan.

Seventh five-year plan (1988-93) continued the previous plan methods and targeted to prevent 3.1 million births. It had planned to expend social marketing of conceptive and proposed to increase contraceptive distributive

points from 50,000 to 72,000 by 1993. Next five-year plan (1993-98) was proposed to increase family planning coverage to 70% in rural and 100% in urban areas. Similar with seventh five-year plan, it was planned to expand social marketing of contraceptive and raise contraceptive prevalence rate form 14% in 1993 to 24.4% in 1998. Correspondingly, next plans focused on contraceptive prevalence rate and emphases on increased number of contraceptive users to some extend or greater extend.

Perspective (2001-11) and three-year plan (2001-3), Medium term development plan (2005-10), tenth five-year plan (2010-15) had their own specific targets and strategies to focus contraceptive use. Pakistan is the signatory of London summit 2012, so, in the 11th Plan (2013-18) and all provincial plans focused and proposed to achieve international commitment to increase contraceptive prevalence rate from 35% to 55% by 2020 and to provide safe family planning. That's why; all provincial policies focused on surety of contraceptives and proposed contraceptive increased plans to contribute in national achievement of international commitment. All provincial plans proposed to provide contraceptive commodity security.

Khyber Pakhtunkhwa, Sindh and Punjab proposed to achieve universal safe family planning and reproductive health services. Khyber Pakhtunkhwa proposed to increase contraceptive prevalence rate from 12% in 2013 to 42% in 2020 and 55% by2032, upsurge modern contraceptive means to 28% and decrease unmet family planning from 26% to 15% by 2020. On the other hand, Sindh and planned to increase contraceptive prevalence rate from 30% to 45% by 2020 and condense unmet family planning from 21% to 14% by 2020. Punjab proposed contraceptive security and rise CPR to 60% by 2030 respectively.

Besides, all the serious attempts by policy maker to increase contraceptive prevalence rate, raise number of contraceptive users and proposed multiple

contraceptive methods with increased number. Contraceptive did not increase up to the mark and every plan was unsuccessful to achieve its proposed targets. Because of cultural and societal norms prevail in Pakistani; it is difficult to access contraceptive programs. Contraceptive methods recognised as against the religious teachings and social norms.

5.10 Awareness Strategies in Policy Documents

Awareness strategies to make people aware about population growth issues and make grounds for population control programs were focused from starts of five-year population plans till now. Nature of such awareness programs were changed through different plans and policies. Some plans focused it on prioritized bases, however, others just ignored it totally. First strategy in population control program's history in five-year plans of Pakistan was started from awareness program in 1960. In start, awareness and motivation was considered more important than contraceptive means.

In 3rd plan, with physical targets, awareness and motivation was focused through monetary incentive to dais, media sources and mobile teams. It was an organized and systematic plan to reach and aware maximum people. However, 4th plan missed the awareness strategy in population program. In 5th plan, awareness program's effectiveness acknowledged for population control program. Hence, Information, Education and Communication strategy was started in the same plan. Furthermore, next all five-year, perspective and medium-term development plans, national and provincial policies included the strategy of awareness and motivation through different means except 10thfive-year plan, national population policy 2017 and provincial population policy of Khyber Pakhtunkhwa.

Chapter No. 6

DISCUSSION AND CONCLUSION

6.1 Discussion

Pakistan has highest population growth rate in South Asia, although it has first population program Asia. Besides, unfortunately, it takes more than a decade to include it in its national five-year plans. Pakistan include population chapter in 1960 in its 2nd five-year plan but its first organized population program was started from its third plan. In which strong strategy were devised to implement and decrease birth rate and control population growth. On the other hand, neighbouring India who get independence in same days with Pakistan, introduced its first five-year population plan (1951-56), a decade before than Pakistan, through population policy committee in 1952. According to Word Bank, it was ever fist national plan of the world for population control (Chaudhry 1989).

India introduced contraceptives in its firs plan in 1952. At this point Pakistan did not have any contraceptive base plan or clinics. It starts to change attitude through awareness in 1960 and introduced contraceptive after 1965. Pakistan introduced and implement its first precise population program in 1965. Through this program, basic structure of population program was spread in all over the country. India had its population family planning structure from its first five-year plan, but he achieves to decrease its birth rate from 41.7 in 1961 to 39 per 1000 by 1966. However, Pakistan decreased it birth rate from 50 in 1965 to 40 per 1000 in 1970 (ibid). Although Pakistan did not have any earlier family planning structure in the country but reduced 5 births in 5 years than India's 2.7 births per 1000 in 15 years. Though, both did not successful to accomplish their target, but it was a good attempt from Pakistan' population program.

As a whole, India was more successful to have 39/1000 birth rate in 1969 than 40/1000 in 1970 by Pakistan. After 1970s, both India and Pakistan face stalled decline in growth rate but still Pakistan was far behind India. India has 39 per 1000 birth rate in 1969 and decreased its birth rate to 32.6/1000 by 1985.

However, Pakistan has 45/1000 in 1970 to decrease it to 42.3 per thousand by 1988 and in 1993 it reached to 39 per thousand. It means Pakistan reach at the level of birth rate in 1993; India was at the same level in 1969.

On the other hand, Bangladesh, who gets independence from Pakistan in 1971, has recognized population growth as foremost problem in its first five-year plan (1973-78). Government of Bangladesh declared population growth as its first priority. Bangladesh introduced seven five-year plans starts from 1973 and will end by 2020. In the beginning, it was facing high fertility and population growth rate. Solid infrastructure and service delivery system were established from first plan. Multiple methods of contraceptives were introduced, and strong strategies were established.

Hence, second five-year plan (1980-85) achieves significant level of its targets and increases contraceptive prevalence rate from 12.7% on 1980 to 29.7% in 1985. Correspondingly, crude birth rate decreased from 27 to 23 per 1000 population (Karim 1989). These were massive achievements by a new country having high growth rate. Pakistan takes almost 70 years to reach this level of birth rate and 58 year for contraceptive level. Pakistan Increased its contraceptive prevalence rate from 6% in 1977 to 35% in 2013 (Planning Commission Government of Pakistan 2013-18).

Bangladesh delivers family planning services to the door steps through the collaboration with NGOs, different organizations with government throughout the country. Through this way, it increased its contraceptive prevalence rapidly. It has 8% contraceptive prevalence rate in mid 1970s and increased to 61.2% by 2011. Similarly, it decreased its fertility rate from 6.3 in 1975 to 2.3 per women by 2011 (Bangladesh Population Policy 2012). However, Pakistan still has its plan to achieve 55% contraceptive prevalence rate in 2020 and its fertility rate is still far from Bangladesh's fertility rate. Even its 2020s fertility target is far less than Bangladesh's 2011 position.

Currently, Bangladesh has 2.1 total fertility rates which is a stable population fertility rate. It means Bangladesh's population is not increasing nor shrinking. Pakistan is still very far from all South Asian countries and needs a valuable effort to stop its rapid population increase.

Table No. 6.1.1Outlay Comparison between Pakistan and Indian Plans

India		Pakistan	
Five-Year Plan	**Outlay**	**Five-Year Plan**	**Outlay**
1st FY Plan (1951-56)	6.5	1st FY Plan (1955-60)	0.5
2nd FY Plan (1956-61)	50	2nd FY Plan (1960-65)	30.5
3rd FY Plan (1961-66)	270	3rd FY Plan (1965-70)	280
4th FY Plan (1969-74)	2,858	4th FY Plan (1970-75)	695
5th FY Plan (1974-78)	2,856	5th FY Plan (1978-83)	1,800
6th FY Plan (1980-85)	13,090	6th FY Plan (1983-88)	2,300
7th FY Plan (1985-90)	32,560	7th FY Plan (1988-93)	3,535

In the domain of budged allocation Pakistan allocated a valuable amount compared with India because Pakistan is smaller than India, but their budget did not have much difference. In the first five plans of both countries comparatively with their population and Land area, Pakistan allocate more money than India. After the fifth plan of India (1974-78) and Pakistan (1978-83), India boost its population budget with high rate. Pakistan also increases its allocations, but India spends more money relatively. If allocation of Pakistan analysed individually, Pakistan spend a dear amount in each plan. It shows serious intentions of policy makers toward population programs.

Besides the seriousness of policy makers regarding population control, Pakistan takes more than a half century to introduced its ever first population policy in 2002. However, India and Bangladesh introduced their first population policy two and half decade earlier than Pakistan. India, gave its first national population policy in 1976 and second in 2000. Both of these

policies were before Pakistan's first policy. Similarly, Bangladesh officially approved its first national population policy outline in 1976.

These facts show that how Pakistan is behind South Asian Countries in its population growth control strategies

6.2 Conclusion:

Fertility control program was introduced in Pakistan at fist in Asia. Pakistan introduced multiple national five-year plans, policies, perspective plans and provincial population policies and program from 1950s to till date. Besides, Pakistan is having highest population growth rate in South Asia.

Issues in policy documents and their implementation caused Pakistan unsuccessful to accomplish its targets and goals. That's why Pakistan remains behind the countries of South Asian to control population growth at the desired level. Following are the main reasons behind this that Pakistan's unsuccessful progress to control population growth.

Pakistan recognized population growth rate as a problem for economic growth in the beginning but did not introduced any organized plan or policy for it till 18 years of its independence. It was ineffective to introduce any population policy in the second half of 20^{th} century. Ever first population policy was introduced after 55 years of its independence in 2002. Furthermore, it was also dormant to provide population program in the start. It takes years to present first organized population programme.

Targets and goals of different plans were illustrating that all time policy makers were aware of population issue and these plans show their intention toward population control. Besides,the plans were not going successful to achieve its goals and targets but still coming plans of population program were made similar in strategies. No paradigm shift made in program's strategies except continuous increasing in number of physical targets.

Overlapping plans and policies and non-implementation of programs lead Pakistan to the current state of high population and least successful in its region.

Suggestions

- A study should be conduct, to focused on the reasons of institutional lacks in achieving population growth targets or implementing policies and plans.
- A study must be conducted on transition of population control in different political eras and discussed that how different political periods effect on population programs.
- A study would be conducted to objectively evaluate the evaluation reports of plans and policies. It would be more helpful to identify loops in the study.
- In the contemporary age of media and 3G/4G internet, there is dire need of paradigm shift in family planning and population control programs. Government must initiate and do propaganda through electronic, print and social media campaigns to spread awareness of family planning.

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Annexures

Annexure 1

Annexure 1 provinces and organizational over view and give information about all national and provincial institute who deal population matters.

1. Governmental Institutes of Population

1.1 Ministry of National Health Services Regulations and Coordination Government of Pakistan[13]

Ministry of national regulation and services established in 2012 and its functions were expended later.

Minister of State of Health:Dr Zafar Mirza

Dy Director:Mr. Ahmed Nauman

Functions of NHSR&C

- National & International Coordination in the field of Public Health
- Oversight for regulatory bodies in health sector
- Population welfare coordination
- Enforcement of Drugs Laws and Regulations
- Coordination of all preventive programs, funded by GAVI/GFATM (TB, HIV/AIDS, Malaria, Hepatitis etc.)
- International commitments including attainment of MDGs
- Infectious disease quarantine at ports
- Coordination of Hajj medical mission
- Provision of medical facilities to the Federal employees in provinces

Attached departments of NHSRC are:

1. Pakistan Medical and Dental Council (PMDC)
2. Expanded Programme on Immunization (EPI)
3. Drug Regulatory Authority of Pakistan (DRAP)
4. National Institute of Health (NIH)
5. Pakistan Council for Nursing
6. Pharmacy Council of Pakistan
7. National Council for Homeopathy
8. National Council for Tibb
9. Directorate of Central Health Establishment
10. National Health Emergency Preparedness and Response Cell
11. Pakistan Medical Research Council
12. Health Services Academy
13. Central Warehouse Karachi
14. Tobacco Control Cell
15. National Institute of Population Studies (NIPS)
16. National Trust for Population Welfare (NATPOW)
17. Pakistan Red Crescent Society
18. Pakistan College of Physicians and Surgeons

1.2 National Trust for Population Welfare (NATPOW)[14]

NATPOW is administered by independent board of directors of federal, four provinces, AJK and Gilgit Baltistan, under the ministry of National Health Services, Government of Pakistan, National Trust for Population Welfare established in 1994. It established under the 'Charitable Endowment Act 1890'. It started as grant management form to create effective partnership between government and donner organisations, NGOs and civil society organizations. NATPOW's head and regional offices provides supports to its affiliated societal organizations

[13] http://www.nhsrc.gov.pk/

[14] http://www.natpow.org.pk/home.html

of financial and technical assistance for 'reaching the rural, marginalized & poor communities and rendering Reproductive Health & Family Planning-RH&FP Services/ Healthy Timing & Spacing of Pregnancy-HTSP and Safe Motherhood, Neonatal & Child Healthcare (MNCH) Services including Basic EmONC, Ante-natal Care, TT Vaccination, Safe Deliveries, Post-natal Care with Postpartum Family Planning-PPFP and Post-abortion Care-PAC, thereby improving Reproductive Health status of women, adolescents & men. In addition to the FP&RH and MNCH services, special emphasis is upon community mobilization & participation, advocacy & awareness raising, Research and HRD/ capacity building, to meaningfully contribute towards implementation of the National policies and development process in the Country.'

Additionally, NATPOW is inviting and collabourating with other organizations to increase its area of effects of development in the fields of 'community empowerment, social uplift of women, gender equality & equity, literacy & education especially the girls' education, human rights, citizen rights/ voice & accountability, counter extremism, sexual & reproductive health and-SRHR and empowerment of the marginalized/ deprived communities in term of their social rights and economic empowerment, skill development/ Technical & Vocational Training, research and other disciplines contributing to the development process/ services for the poor, rural and deprived communities and social groups in the Country.'

Offices:
NATPOW's head office is in Islamabad with other four regional offices in capital cities of every province, Karachi, Lahore, Peshawar and Quetta. The head office situated at "Block B, EPI Building, Near National Institute of Health (NIH) (Prime Minister's National Health Complex), Park Road, Islamabad, Pakistan. Contact number is 051-9216286."

Chairman NATPOW/ Director General, Population Wing: Mr. Abdul Ghaffar Khan
Population Program Wing (PPW), 10th Floor, Shaheed-e-Millat Secretariat; Ministry of National Health Services, Regulation & Coordination, Islamabad. Phone No. 051-9216286,83.
Chief Executive Officer NATPOW / Director (Admin & Coord), Population Wing: Mr. Ehsan-ul-Haq
Population Program Wing (PPW), 10th Floor, Shaheed-e-Millat Secretariat; Ministry of National Health Services, Regulation & Coordination, Islamabad. Email: ehsanddppw@yahoo.com. Phone No. 051-9216286,83.

Research
KAP Baseline Survey on WASH in 19 Flood Affected Districts of Sindh, KPK, Baluchistan, AJK and Gilgit-Baltistan (GB) (UNICEF-Plan International-NATPOW-NIPS-CSOs).
KAP Baseline Survey on WASH, in 17 Flood Affected Districts of Punjab, Sindh, KPK and Baluchistan (UNICEF-Plan International-NATPOW-NIPS-CSOs).

Services:
- Establishment of Basic Health Units (BHUs) and Family Health Units (FHUs).
- Awareness through Advocacy and Counselling.
- Research and Development (R&D).
- Community Mobilization.
- Strategic Communication.
- Policy Formulation.
- Capacity Building

1.3 National Institute of Population Studies (NIPS)[15]
Executive Director: Mr. Pervaiz Ahmed Junejo

[15] https://www.nips.org.pk/

Director (R&S):Ms. Azra Aziz

Established In:NIPS stablished as an autonomous organization through a Resolution in 1985 and it started functioning in April 1986, under the administrative control of the then Ministry of Population Welfare (MoPW). After the 18th Amendment to the Constitution of Pakistan in 2010, the Ministry of Population Welfare was devolved and issues relating to NIPS were transferred to the Planning and Development (P&D) Division on 03-10-2010. Subsequently, the status of NIPS was also declared as Subordinate Office of the P&D Division on 18-04-2012. Currently, NIPS has been placed under the administrative control of the Ministry of National Health Services, Regulations and Coordination (NHSR&C) since 04-05-2013.

Publications:

Pakistan Demographic and Health Surveys (PDHS)
Family Planning and Contraceptive Evaluation Studies,
Cross Sectional Surveys
KAP Surveys
Research Brief and News
Population Growth and its Implication (Rapid Booklets) etc

Objectives

- To conduct high quality research, surveys and evaluations in the field of demography, population & development and health;
- To disseminate the research findings to the policy and decision makers for policy formulation, strategic planning and improving quality of service delivery components;
- To provide technical assistance to the M/o NHSR&C, other governmental and non-governmental organizations by providing robust data in the field of demography, population & development and health;
- Continuous professional development of NIPS personnel through capacity building and training for concurrent human resource development;

1.4 Population Welfare Department (PWD), Punjab[16]

In 2010, because of 18th amendment, National Population Welfare Department was dissolved. All the welfare responsibilities go to provincial level and every province make independent Population Welfare Department (PDW). PDW of Punjab secretariat is headed by administrative secretory. Director general heads of provincial directorate run 36 districts and 121 tehsil welfare offices. Family welfare center, mobile service units, social mobilizer and family health clinics are working under these welfare offices.

The first population policy of Punjab approved by chief minister of Punjab in January 2017.

Minister of Population Welfare Department:Colonel (R). Sardar Hashim Dogar

Secretory:Bushra Amna (July 2018 to date)

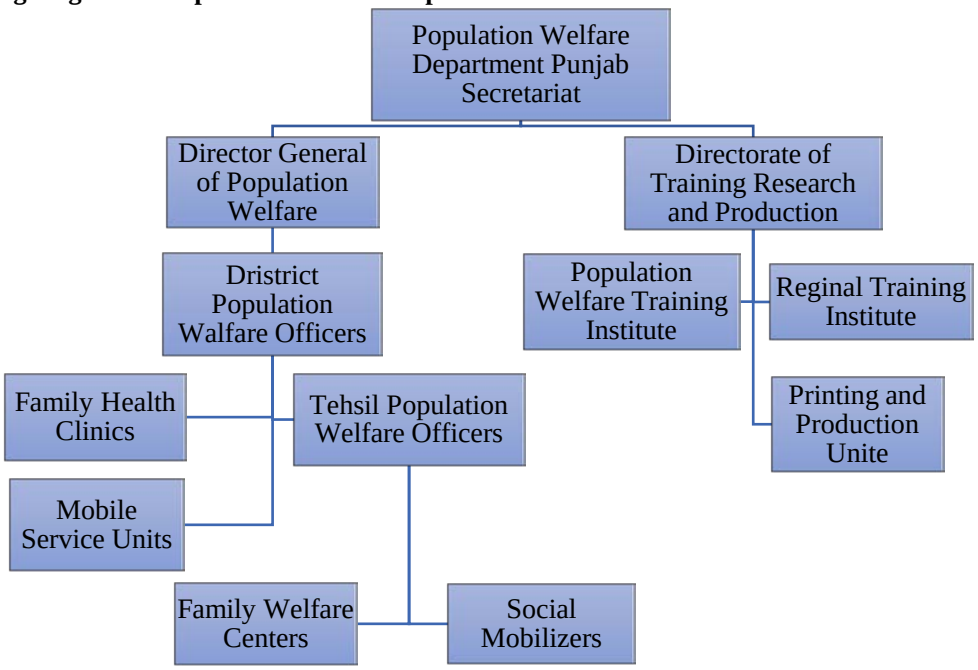
Functions of Population Welfare Department

- Population policy formulation, implementation, monitoring and evaluation
- Statistical analysis of demographic Indicators
- Mainstreaming population factor in development planning process
- Provision of family welfare services including family planning and general medical care
- Preparation of budget and development schemes
- Coordination with federal government, international agencies, NGOs and donors
- Procurement and distribution of contraceptives
- Training research and development of professional standards
- Information, education and communication services

[16] https://pwd.punjab.gov.pk/

- Promotion of population planning activities through private and other public sector institutions
- Budget, accounts and audit matters
- Purchase of stores and capital goods
- Service matters except those entrusted to Services and General Administration Department
- Matters incidental and ancillary to the above subjects

Organogram of Population Welfare Department



Affiliates of Population Welfare Department

Population Welfare Department of Punjab is having collabouration and partnerships with various governmental, non-governmental, national and international organizations to achieve the desired goals in various programmes. All the affiliates have collabouration in different work areas in "Capacity Building, Research and Training, Functional Integration of Services and Service Delivery, Supply of Commodities, Mainstreaming of Population Factors in Developing Plans and Information, Education and Communication Activities, Support in Advocacy of Programme." All the affiliates are as follow

Government Sector:

- Health Department, Government of the Punjab
- Maternal Neonatal and Child Health Programme, Punjab
- National Programme for Family Planning & Primary Health Care
- Provincial Line Departments
- Social Welfare Department
- Women Development Department
- Social Security (PESSI)
- Pakistan Railways
- Pakistan Army
- WAPDA
- Lahore University of Management Sciences (LUMS)
- Agha Khan University (AKU), Karachi

- Pakistan Institute of Development Economics
- Punjab Bureau of Statistics
- National Institute of Population Studies
- National Research Institute of Fertility Control
- Department of Health, Punjab
- Population Program Wing, Planning and Development Division Islamabad
- NATPOW
- Lahore University of Management Sciences

Non-Governmental Organizations:

- Marie Stopes Society
- Rahnuma (Family Planning Association of Pakistan)
- Green Star Social Marketing
- Punjab Rural Support Programme
- National Rural Support Programme
- Management and Professional Development Department (MPDD)
- Pathfinder International, Islamabad
- The David & Lucile Packard Foundation, Karachi
- JPHIEGO
- United Nation Fund for Population Assistance (UNFPA)
- ShirkatGah
- AAHUNG
- Rozan
- Population Council, Pakistan
- Health Services Academy
- USAID/ DELIVER Project

1.5 Population Welfare Department of Sindh[17]

Population Welfare Department of Sindh is also established after the devolution of National Population Welfare Department, because of 18th amendment. It is headed by the secretary. It has four wings which are headed by directors, named as 1. Admin and Finance Wing, 2. Monitoring, Evaluation and Planning Wing, 3. Medical Wing and 4. Communication, Training, Logistic and Supplies Wing. There are 629 Family Welfare Centres (FWCs) are working in 25 districts of the province. These FWCs are the main pillars of the department of Population Welfare. Sindh's first population policy was devised in 2016.

Address: Population Welfare Department Government of Sindh, N.I.C.L Building Survey No.183/4, 11th Floor, Cantonment Area, Abbasi Shaheed Road, karachi.99225641-2

Minister of Population Welfare Department:DrAzra Fazal Pechuho
Secretary of Population Welfare Department:Mr Zahid Abbasi
Director General: Allah Dinu Ansari

Functions of the Department:

- Coordination of programs with provincial and local levels
- Establishment of clinical and non-clinical contraception in rural areas
- Implementation of Strategies
- Motivate clients and establish friendly environment
- Ensure community involvement and supply medicine and contraceptive to people
- Establish the advisory management committees in all centres at district and provincial level

[17] http://pwdsindh.gov.pk/

1.6 Population Welfare Department of Khyber Pakhtunkhwa[18]

Population Welfare Department of Khyber Pakhtunkhwa has 25 sub-District population offices in every district. It has most detailed web site and was the first provincial department in Pakistan who develop provincial population policy at first. It develops the population policy in 2015.

Secretary:Mr. Asghar Ali

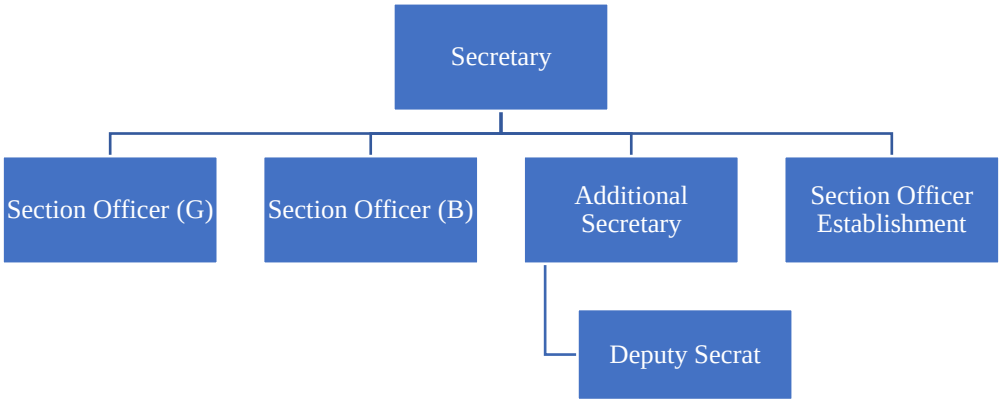
Functions

- Motivate clients through contact with them.
- Establishment of clinical and non-clinical contraception in rural areas.
- Through different agencies, supply medicine and contraceptives to clients in rural and urban areas.
- Implement different strategies for advertisement of the programs.
- Promotion of Population Welfare Motivation and Services and community involvement and activity.
- Coordination of programs with other departments at district and tehsil levels.
- Establish the advisory management committees in all centres Other specified programs of provincial government.
- Policy and Plans development for population welfare in the province.
- Monitoring and Evaluation of the programs.
- Mainstreaming of population programs at all levels.
- Promotion of population programs through different governmental or non-governmental organizations.
- Conduct research on different population aspects.

Achievements

1. 3.6 million couples assisted from unwanted pregnancies.
2. Child and other health care services provided to 0.54 million clients.
3. General ailments treatment given to 2.73 million parents.
4. Programs outreach expended through additional FWC, RHSC.

Organizational Structure



Annexure 2

Annexure 2 provides the list of population plans and policies document list .

[18] http://population_welfare.kp.gov.pk/

2. Data Sheet Source: Government Documents

2.1 Five-year National Population Plans Data Sheet

S. No.	Prog Name	Year	Concerned Content	Availability
1	1st Five-Year Plan	1955-60	Chapter /Page	Yes
2	2nd Five-Year Plan	1960-65	13:331-335	Yes
3	3rd Five-Year Plan	1965-70	15:261-268	Yes
4	4th Five-Year Plan	1970-75	15:235-242	Yes
5	5th Five-Year Plan	1978-83	13:391-401	Yes
6	6th Five-Year Plan	1983-88	21:449-471	Yes
7	7th Five-Year Plan	1988-93	32:271-277	Yes
8	8th Five-Year Plan	1993-98		Yes
	Missing	1998-2001		No
9	3-year and perspective plan	2001-04&2001-10		Yes
10	Mid-term development framework	2005-2010		Yes
11	10th Five-Year Plan	2010-2015		Yes
12	11th Five-Year Plan	2013-2018		Yes

2.2 Provincial Population Polices

S. No.	Prog Name	Year	Concerned Content	Availability
69	Population Policy of Pakistan 2002	2002	18	Yes
70	National Population Policy 2017	2017	20	Yes
71	Population Policy KP 2015	2015	23	Yes
72	Sindh Population Policy	2016	37	Yes
73	Punjab Population Policy 2017	2017	57	Yes

Annexure 3

Annexure 3, provides snapshot of all five year plans.

3.Five Year Population Plans' Snapshot

3.1 Second Five-Year Population Plan (1960-65)

The government recognize the rapid population growth and launched a family planning programme to change the values and attitude of people and replace the ideal of family with smaller family with few children than large family with many children.

Budget:

- 30.5 million

Objective:

- change the values and attitude of people and replace the ideal of family with smaller family

Strategy:

- First stage, the problem should be known by people.
- Motivation of fewer children is more important than knowledge of contraceptive means.
- Population growth will decrease gradually through employment and family earning.
- Vital statistics and demographic analysis to understand the clear picture of population

3.2 Third Five-Year Population Plan (1965-70)

Main Objectives:

- s where people give more acceptance.

Strategy

Motivation

Dai were the central figure of the program. Dai, who were already dealing sexual and sickness maters, were selected as motivator and dispenser for contraceptive.

Motivation also will be given through field supervisors and works. They will be given training for motivation and to stop the rejection of family planning.

Family planning programme ensure the enough supply of contraceptives and provide required medical and advisory services.

The programme gives monetary incentives to practitioners and motivators. Rs. 25 will be given to doctor/dai/lady health visitor for every sing IUDs (Intra Uterine Device) and free for clients. For insertion of every IUD, doctors and dais/nurses will be paid 8 rupees and 4 rupees subsequently. Additionally, for every insertion referring, dais will be paid Rs. 2.5 and other Rs.2.

Contraceptives will be sale at subsidized rate and 50 % of sales commission will goes to the seller.

Organization and Administration:

- There will be Family Planning Council at Centre, Family Planning Board's at Provincial and district levels. All union councils of west Pakistan and Thana councils of east Pakistan will be linked with the programme. In west Pakistan, a family planning supervisor will look after the programme at this level and will supervise 3 union councils. In East Pakistan, one Thana family planning officer will look at one Thana. In the programme hierarchy, under Health, Labour and Social Welfare ministry in Family Planning Division, Family Planning Commissioner will head at national and dai at bottom level.
- In West Pakistan, 1000 family planning supervisors will be provided to work with union council secretaries and 4000 Thana Family Planning Officers will be given in East Pakistan.
- one male and female assistant will be provided with each Thana officer.
- Total 50,000 dais will be employed, 30,000 for East and 20,000 for West Pakistan. Each dai deal two villages in both East and West Pakistan.
- For insertion of IUDs and clinical sterilization, 24,000 Visiting Family Planning doctors will be appointed with the average of 6 doctors for each tehsil in West Pakistan and 3 doctors for each Thana in East Pakistan.

Clinics:

- Establishment of 37 and 16 all-time urban clinics in West and East Pakistan subsequently with 718 part-time clinics, 318 in West and 400 in East Pakistan.
- IUDs will be main concentration of the clinics
- Each whole-time urban clinic will have 1 lady doctor, 1 health visitor, 1 family planning councillor and 1 female medical attendant.
- Part Time clinics housed in existing health institutions for use of family planning doctor.
- 1.5 million IUD insertion and 90,000 Vasectomies/ligations is the aim of scheme

Transport:

- For adequate utility, 345 jeeps obtained for the use of family planning units. One jeep for each tehsil and district headquarter in West Pakistan and one jeep for 2 Thana in East Pakistan.

Training Programme:

- 10 days training of family planning techniques will be given to 150 lady doctors, lady health visitors and trained midwives from each province and afterward, they will train other lady doctors, lady health visitors and trained midwives in their respective tehsil/districts.

- For Family Plaining Supervisors and Thana Family Plaining Officers, 14 days training programme will be given to train them in district headquarters in West Pakistan and Six suitable places will be opened in East Pakistan for training.
- They further train their male and female assistants and union council secretaries within 2 weeks, in their respective Thana and Union Councils.
- Three-week training will be given to dais in Thana and Union Councils.

Publicity:

- All publicity media will used for publicity.
- 52 mobile teams will be employed, and one projector will be provided to each mobile unit to show movies and slides for publicity.

Distribution of Contraceptives:

All kind of Contraceptives including foam tablets, condoms, jelly emko, diaphragms, durafoam will be provided and sold at highly subsidized prices and IUDs will be provided free.

Evaluation:

Two evaluation units will be constructed, one for each province having one director, medical officer, health education officer, tabulator, statistician and five interviewers. Units will review the programme and give further suggestions.

Future

- Birth rate halve in next 25 years.
- Growth rate expected to 2 till 1985

3.3 Fourth Five-Year Population Plan (1970-75)

Objective:

- Decrease birth rate from 45 to 40 per thousand.
- 9.6 million births will be prevented
- Married couples were expected to practice 34% contraceptives in 1975.

Budget:

- 695 million_____ (150% higher than 3rd plan).

Organization and Administration:

- Gradual replacement of dais with full time FP works_____ will be provided Rs.115/month
- Total 17,298 FP workers would be haired till 1975_____ 2 proposed for each Union Council (UC).
- Lady FP visitors will be increase from 1,200 to 2,883. (Rural clinics will be constructed with residential accommodation for staff).
- Service fee for doctors will be increased because of expected increase of sterilization. However, unite fee of sterilization of will be reduced.
- Post-partum and referral clinics will be increased
- Female worker must be fully trained as Lady Health Visitor_____28 months Training.
- Health and FP services will be integrated and services at UC level would be one establishment.

Clinics:

- Establishment of total 54 referral urban clinics, 18 in East and 36 in West Pakistan. Previous Plan's 37 full time clinics were re-designated as referral clinics.
- In rural areas 1230 full/part time family planning clinics would be established, 687 in East and 543 in West Pakistan.

- New 40 post-partum clinics will be established in 20 clinics each East and West Pakistan.

Strategy:

- Because of serious limitations of IUDs, it replaced with major focus on **Sterilization**. Also, **hormonal pills** will be provided for the first time.
- In 1970, 18% married couples were estimated as practicing contraceptives and expected to practice 34% in 1975.

Distribution of Resources/ Priority:
Distribution of resources will be provided in provinces or regions by their contextual situation of population pressure on land and other economic resources. The areas of higher population pressure and other such criteria will have greater amount of resources than less pressure areas. Family planning acceptance in areas would also be considered.

3.4 Fifth Five-Year Population Plan (1978-83)
Budget:

- Rs. 1,800 million

Objective:

- 26% decrease of birth rate from 43.6 in 1978 to 35.5 in 1983.
- Decrease Total fertility rate 6.75 in 1978 to 5 in 1983.
- Follow economic strategy and limit family size
- Contraceptive knowledge increases from 75% in 1978 to 100% in 1983
- Increase ever use contraceptives couples from 13.6% in 1978 to 27.2% in 1983.
- Increase all time contraceptive usage from 6% to 15.4% in 1983.
- Increase the share of contraceptive methods

Intentions:

- Through growth strategy, major focus will be given to poorer sections, especially in backward regions and rural areas.
- Upward age at marriage
- Provision of basic education to increase literacy rate, particularly focus on female education. Female education at secondary level expected to increase 50%.
- Provide necessary plate form for female employment
- Increase urban towns and cities and spread urban norms in rural areas.

Strategy:
Health Facilities and Population planning programme are integrated. So,

- All the activities would be merged as quick as possible.
- Through Federal, Provincial and District level organization, implementation and coordination would develop more effective.
- Total service outlets would increase manifold.
- 5,000 new health outlets will be requiring
- Program will cover wide range of area including remote areas
- Involvement of public and volunteer groups would be enhanced
- Hakeem, Homeopaths and other indigenous practitioners would be involved in the programme
- For program's effectiveness, more emphasis given to Information, Education and Communication
- Training, reporting and organization arrangements would be reorganized and strengthened.
- Programme would be Provincialized for unified delivery

- All Population and Health worker would be retrained (population worker get health bias training and health worker get population bias)
- Wide choice of contraceptives
- Worker train to cover all welfare services for Clint's confidence
- Voluntary and Public organization would be enhanced

Organization:

- Population Planning council would be abolished and Population division would be established under Ministry of Health, Population and Social Welfare
- Population Division headed by Additional Secretary
- Health department renamed with Department of Health and Population with two Directorates
- 4-6 officers would be in district level
- Beyond district level, Rural health clinics, MCH centers, basic health units and family welfare clinics would operate
- Community workers operate in villages

Evaluation:

- Research and Evaluation would be started
- Monitoring and evaluation of Activates

3.5 SixthFive-Year Population Plan (1983-88)

Budget:

- 2,300 million

Objectives:

- Reduce CBR from 40.3/1000 in 1983 to 36.2/1000 in 1988.
- Prevent 2 million birth in following plan
- Reduce Birth rate from 2.87% to 2.6%
- Reduce Fertility rate from 5.9 to 5.4 per women
- Raise current contraceptive practice from 9.5% in 1983 to 18.6% in 1988.
- Raise continuous Population Planning practice from 6.8% in 1983 to 13% in 1988.
- Provide reproductive care for mothers and child health care under 5 year of age

Supportive objectives:

- Develop and strengthen multisectoral linkages
- encourage local participants
- Provide infrastructure for training
- Motivate people of all areas
- Conduct research
- Undertake activities in domain of social and demographic research

Organization

- Population Welfare Programme will be implemented under three structure__ Federal, Provincial and Local
- Federal level, Population Division under the Ministry of Planning and Development would be responsible of Planning policies, evaluation, research, foreign assistance and NGOs projects
- Family Welfare Centers, Population Welfare Programme, Reproductive Health Services Project and other departments are under provincial responsibility.
- These activities carried out by Directors General in Provinces

Physical Targets:

A. Service Outlets

- 1500 Family walfare centers will be established
- 6 model clinics will be established
- 300 Reproductive Health Centers A & B will be established

- 1800 Hakim's matbs will be established
- Program through other Departments 5,000
- Azad Jammu and Kashmir and Northern Areas 150
- Target Groups 1,000
- NGOs service outlets 2,500
- Contraceptive Distribution Points 30,000

Selected Physical Targets (1983–88)

(Unit Nos.)

Description	Bench mark 1982-83	Targets 1983–88
A. Services Outlets :		
(i) Family Welfare Centres	1,081	1,500
(ii) Model Clinics	–	6
(iii) Reproductive Health Centres A & B Centres	75	300
(iv) Hakim's Matabs	500	1,800
(v) Programme through other Departments	500	5,000
(vi) Azad Jammu and Kashmir and Northern Areas	30	150
(vii) Target Groups	150	1,000
(viii) Non Government Organization (NGO) Services Outlets	250	2,500
(ix) Contraceptive Distribution Points	10,000	30,000
B. Training/Orientation : (Clinical Training) :		
(i) Programme Personnel : Refresher Training through FHMD.	3,000	15,000
(ii) Paramedics :		
(a) Family Welfare Councillors	306	750
(b) Family Welfare Workers	1,200	2,250
(c) Traditional Birth Attendants	1,000	8,000
(iii) Non-Clinical Training/Orientation through PWTIs :		
(a) Programme Personnel	2,419	7,000
(b) Personnel of Nation Building Departments	–	8,300
(c) Community Based Groups	2,506	45,000
(iv) Training of Teachers through AIOU	–	30,000
(v) Training of Teaehers through Workshops	2,600	14,000
(vi) Hakeems	561	2,000
(vii) Training of Adult Education Teachers	–	10,000
(viii) Social Education for Women	–	1,000,000

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Methods

- IUDs (cases) 1.29 million
- Oral pills (Cycles) 26.104 million
- Condoms (Units) 759.8 million
- Contraceptive Surgery (cases) 0.65 million

[19]Planning Commission Government of Pakistan. 1983. 6th five-year plan 1983-88. Islamabad.

- Injectables (Vials) 0.76 million

Strategy:

- Population Planning is a national responsibility
- favoring small family norms
- Involve NGOs and other target groups to expand coverage
- Integrate programme activities with other departments for diversification
- make women participants and beneficiaries
- devise a communication strategy
- Involvement of local leadership
- improvement of in-service training, Management training, management audit and operational evaluation
- Improvement of education specifically girls' school enrolment, women literacy and women participation in productive labour
- Strengthen programme structure
- Increase PF/MCH outlets from 1000 to 1500
- Integration PF into MCH
- Organize 1500 Family Welfare Centers Projects each center cover 15000-50000 people.
- 44.6% married women would be cover in Family Welfare Centers
- Need for strengthening Reproductive Health Extension Services
- Establish Population Study Centers in two selected universities
- Each province develops their own plan of implementation and service activities
- 4% newly married women of reproductive age will be attended through outlets
- Approximately 40% male of reproductive age will be reached through Institutional projects (i.e. Infrastructure Institutions, NGOs, District Distribution Point).
- Population Education and Services will be introduced in Azad Jammu and Kashmir and Northern Areas
- Evaluation and Research for effective improvement
- Population Development Center work for preprogramme' performance, evaluation and research.
- Timely, continuous and uninterrupted supply of clinical equipments
- Innovative Action____ explore more possible effective strategies for the programme

3.6 Seventh Five-Year Population Plan (1988-93)

Budget:

- 2.3 billion

Objectives:

- Increase family planning practice from 12.9% to 23.4%.
- Provide services of reproductive care for mothers and child health care for under age 5 children
- Reduce CBR from 42.3/1000 to 38/1000.
- Prevent 3.1 million births

Supportive Objectives:

- Develop and Strengthen field management via monitoring and supervision
- Expand clinical services by outreach and mobile units
- Emphasis on clinical methods
- multi-sectoral linkages
- local community participation
- training activities
- effective communication strategy
- Expand NGO involvement (925 separate service outlets)

- Involve Traditional Birth Attendants (TBAs) for motivation and contraceptive distribution
- involve registered private medical practitioners
- Expand contraceptives social marketing
- bio-medical and sociodemographic research
- evolve incentive schemes

Area:

- Federal District of Islamabad, Azad Jammu and Kashmir, and Northern Areas
- All Four Provinces

Organization

Federal Responsibilities

- Policy planning set national targets, Foreign assistance, contraceptive supplies, training, Information Education and Communication (IEC), monitoring, research, social marketing of contraceptives, NGO involvement, family planning facilities, services in AJ&K and Northern Areas.

Provincial Responsibilities

- Service Delivery, Field Supervision, monitoring and implementation

Physical Targets

- Family Welfare Centers (FWC) would increase from 1275 to 1347.
- 158 MSUs will be established
- For Reproductive Health Services (RHS), 'A' centers will be increased from 33 to 79
- 125 'B' centers, if satisfactory than upgraded as 'A' centers
- All Headquarters have at least 1 'A' center
- Total out of 5049 health department outlets 384 (224) outlets will be from other departments
- Hakim will be increased from 1156 to 2500.
- 1500 Homeopath will be sought to broad
- NGO Coordinating Council will have separate 925 service outlets
- 9,012 Traditional Birth Attendants will be involved
- 4,875 registered Medical Practitioners proposed to involve
- Contraceptive distribution points will be increased from 50,000 to 72,000
- In Northern Areas, MCH outlets will be increased from 50 to 90 with increased availability of lady doctor
- In AJK, Family Welfare Centers will be increased from 4 to 6 and all health outlets will provide family planning services

Strategy:

- Reinforce multi-sectoral approach for acceptance of small family norm
- Shifting to more effective contraceptive methods
- Design and implement effective communication strategy
- Strengthen field supervision from federal to gross-root level
- Introduce special Incentives for small family norms
- Provision of maternal and child health services
    - Narrow gape of awareness and contraceptive use
    - Increase breast feeding practice
    - Improve mother health through birth spacing
    - decrease infant mortality
- To Train Family Welfare Centers (FWC) staff, Mobile Service Units (MSU) proposed for every tehsil in four provinces headed by lady doctor/senior paramedic.
- Regional Training Institute (RTI) will be involved in training of trainers of multiple departments

- Institutionalized training will be broadened at Population Welfare Training Institutes (PWTI).
- This Plan will bridge the gap between knowledge and practice by
    - Replacing pro-family norms into small family norms
    - Dispelling erroneous notion that large family is economic asset
    - Removing miss giving of program
    - Minimize the gap between knowledge and practice
    - Highlight the gap between population and resources
- Mass media will be used to project breast feeding, location and weaning, late marriage, responsible parenthood, status of women, health of mother and child and nutrition needs.
- Population Study Centers (Uni. of Karachi and Agriculture Uni. Faisalabad) will continue to offer population study courses
- Construction of Central warehouse and National Research Institute at Karachi and five regional training centers will be continuing with construction of office accommodation for federal and provincial headquarters

Monitoring:

- For efficiency, all level close monitoring will be undertaken
- At Federal level M&S will collect data, conduct mini surveys, undertake monitoring of all aspects of programme

Research and Evaluation:

- To examine the factors effecting fertility
- contraceptive mix proposed to be followed

3.7 Eighth Five-Year Population Plan

Budget:

- 9.1 Billion

Objectives:

- Reduce crude birth rate from 39 in 1992-93 to 36 by 1997-98
- Reduce total fertility rate from 5.9 in 1992-93 to 5.4 by 1997-98
- Reduce population growth from 2.9 to 2.7
- Raise contraceptive prevalence rate from 14% to 24.4%
- Crude death rate 10 to 9

Supportive Objectives:

- Family planning coverage will be expanded to 70% in rural and 100% in urban area
- Multisectoral approach will continues and the number of outlets is being maximized
- Inter-ministerial committee has been set up for effective implementation
- Expand program coverage from 20% to 80% to improve implementation

Strategy:

Urban:

- Family Welfare Centers will be increased from 690 to 900, new established in low income areas
- RH centers ‘A’ type will be increased from 79 to 104, cover all district headquarter and selected tehsils
- RH centers ‘B’ type will be increased
- Health service outlets in Target Group Institutes (TGIs) will be increased from 174 to 450
- All health outlets would be involved in dispensation
- NGOs involvement will be strengthened
- All register medical practitioner will be effectively involved
- Hakeem and homeopaths will be involved as catalysts for motivational role
- Social marketing of contraceptives will be expanded

Rural:

Out of 45000 villages with 85 million population, 13060 villages have 70% of rural population

- 606 Family Welfare Centers covering 5% rural population will be relocated
- Coverage will be increased through effective involvement
- 130 mobile services in tehsils will be increased to 251
- Traditional Birth Attendants will be increased from 5000 to 7000
- Introduce Community based motivator-cum-service in village of 1000 population or above (will implement in 1561 villages, covering 60-70% population)
- Improving information, education and communication component
- All service outlets will display FP sign boards

FATA:

- FP services will be extended in FATA through existing 320 health outlets

Northern Area:

- Population cell will be established in Directorate of Health Services Northern Areas
- Service facilities would be expanded by establishing 2 RHS, 12 FWCs,238 health outlets, 23 health centers, 300 TBAs and 500 community health contraceptives.
- 23 lady doctors, 100 male doctors, 97 LHVs/FWCs, 976 paramedics and 3300 personnel of other categories

AJ&K:

- FP activities would be strengthened by existing structure

Organization:

Federal set-up:

- Funding, policy, planning, targets setting, training, coordination, negotiations for foreign assistance, monitoring, research and evaluation is the responsibility of federal government.
- FP services extends to AJ&K and Northern Areas.

Provincial Set-up:

- All four provinces have independent Population welfare departments headed by secretaries

Political and Administrative Support:

- Nation Population Welfare council headed by Prime Minister at federal level, Chief Minister at Provincial level and District/Municipal population welfare committee headed by chairman

Research and Evaluation:

- NIPS and NIRFC will continue the program's research pursuits

Future:

- Population Growth will be decreased to 2.6 in 2000.

3.8 Tenth Five-year Population Plan (2010-2015)

Budget:

- 39.2 Billion

Objectives:

- Increase contraceptive prevalence rate from 30% in 2008-09 to 37.5% by end of the plan
- Increase number of users from 8.426 million to 10.871 million
- Reduce CBR from 24.91 to 21.03 per thousand by 2014-15
- Bringing down population growth rate from 1.88% in 2007 to 1.49 by 2014-15

Supportive Objectives:

- Health outlets of provincial health department, AJK, Gilgit and FATA will be involved in provision of RH and FP services

- Training in contraceptive technology will be imparted to doctors and paramedics to health and other line departments
- Effective measures will be taken to involve all existing outlets of PLDs and Health departments
- Role of NGOs and CBOs will be strengthened and acknowledged

Research:

- NIPS will serve as a coordinating body to collect and disseminate research. To increase credibility, it will work in close contact with the UN population Division.
- National Research Institute for Fertility Care (NRIFC) will develop the capacity to test the rang of contraceptives produced by MoPW

Monitoring:

Monitoring will be strengthened, and joint monitoring visits carried out by MOPW and P&D Division.

3.9 Eleventh Five-Year Population Plan (2013-18)

Budget:

- 37 billion

Objectives:

- Increase contraceptive prevalence rate from 35% in 2013 to 49% by 2018.
- Increase number of contraceptive users from 11.9% to 16.1%
- Reduce CBR from 24.2/1000 to 20.5/1000.
- Decrease population growth rate from 1.9% in 2013-14 to 1.87% in 2017-18.

Organization:

Population and Health are under Provincial government, provinces have full responsibility for implementation of Programmes, and delivery of health and population services.

Federal responsibilities: International coordination, provision of support to the provincial Programmes, research and overall policy directives, including internal commitments.

Physical Targets:

Table 3: Physical and contraceptive user targets and goals

(Cumulative number)

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

[20]

Strategy:

- Population challenges need to be addressed
- population linked with Health sector and women empowerment
- Make mechanism to support NGOs for their strong coordination
- Secure strong commitment and political will at provincial and federal level

[20] Planning Commission Government of Pakistan. 2013. 11th five-year plan 2013-18. Islamabad.

- Ministry of National Health Services, Regulations and Coordination (NHSR&C) and provincial population departments will address unmet needs of FP&RH.
- Population Welfare Department (PWD) will train Doctors, paramedics, lady health visitors, clinical and traditional methods and contraceptive technology at PW regional training institutes.
- Adequate and regular contraceptive supply
- Well-designed multi channeled communication and media strategy will be devised to convey message of family planning

Monitoring:

- Progress will be monitored regularly
- Through PSLMS, Fertility and contraceptive prevalence rate at National, provincial and district level is important to collect.

Future:

- Pakistan's International commitment, Contraceptive Prevalence rate will be increased from 35% to 55% till 2020
- Total Fertility Rate will be decreased from 3.8% to 2.6% till 2020

Annexure 4

Annexure 4, provides snapshot of three-year and perspective plan.

4 **Three-year Population Plan (2001-04) & Perspective Plan (2001-11)**

2001-04	2001-11
Decrease Population Growth from 2.17% in 2001 to 1.82% by 2004.	Decrease Population Growth to 1.6% by 2011.
Increase coverage from 65% in 2001 to 76% by 2004	Increase coverage to 100% by 2011
Increase Contraceptive from 30% to 43% by 2004	Increase Contraceptive to 53% by 2001
12000 village base FP workers + 43000 lady health workers = 55000 family health workers	Merger of 58000 community-based worker of Health and Pop. Ministries
	Mid-wives will be created by upgrading the skills of lady health workers and family welfare workers
	Merge Ministries of Health & Population at Federal and Provincial level
Provincialize the operational activities & further decentralize to district level	Provincialize the operational activities & further decentralize to district level
	Existing Family Welfare centers and MCH of health department will be merged
Both ministries community workers become one cadre	Both ministries community workers become one cadre
All health department outlets will provide RH & FP services	All health department outlets will provide RH & FP services
Enhance involvement of NGOs/civil society organization and social marketing projects	Enhance involvement of NGOs/civil society organization and social marketing projects
	NATPOW will be restructured to run professionally and transparently

Physical Targets

Description	Existing in 2001	2004	20011
TFR	4.6	3.5	2.5
CBR	30.2	26	22.8
CDR	8.5	7.8	6.3
Growth rate	2.17	1.82	1.6
Contraceptive PR	30	43	53
Life Expectancy	62.9	64.4	68.7
Family welfare centers	1740	2100	2,500
Mobile Service units	130	130	130
Involvement of PLD+ H Service outlets	7,180	11600	20,000
RH service services	106	160	300
Target group Institutes (TGIs)	480	720	1700
Registered Medical Practitioners (RMP)	23,000	30,000	50,000
Hakeem and Homeopaths	21,000	31,000	40,000
Private sector	46,000	54,000	86,250

Strategy:

2001-04	2001-11
• Community based workers upgraded as midwives	• Implement RH package and improve its coordination with govt., NGOs, and other sectors
• Mobile Service Units	• Involve women organization and working group for women's need in planning, implementation and monitoring
• All service outlets of Population Line Departments will be involved by 2004	• Promote men's participation
• Demand of family Planning increased through mass media complain	• Assure high level quality of care in information and services
• Strengthen research in areas	• Provide constellation of linked or integrated services
•	• Make available as wide range as possible modern methods of FP
•	• Create better understanding of local context through quality of care

Future:

- Achieve a reproductive level by 2020

Annexure 5

Annexure 5, provides snapshot of Medium Term Development Framework.

5 Medium Term Development Framework (2005-10)

Budget:

- 24.7 billion

Goals:

- Attain balance between resources and population
- Address various dimensions of the population issues
- Spread awareness of adverse consequences of rapid population growth at all levels
- Promote family planning as an entitlement
- Attain reduction in fertility
- Reduce population momentum through small family, delay first birth and spacing

Objectives:

- Decrease Population Growth rate from 1.87 to 1.63
- Achieve replacement level of fertility in 15 years or earlier
- Increase coverage from 75% to 95%
- All service outlets of health department will of RH and FP services
- Increase CPR from 36% to 51%
- Enhance involvement of NGOs/civil society organizations and social marketing projects

Demographic Targets:

Year	2005	2006	2007	2008	2009	2010
TFR	3.5	3.28	3.13	3.0	2.85	2.7
CBR	27.1	26.1	25.5	25.0	24.3	23.6
CDR	8.4	8.2	7.9	7.7	7.5	7.3
Growth rate	1.87	1.8	1.76	1.73	1.69	1.63
CPR	36	38	41	45	48	51

Priority programs at Federal, provincial and district levels

- Strengthen integration b/w population and health sector services
- Ensuring Quality provision of RH and FP services especially to poor and rural population
- Strengthen public private partnership
- Improving institutional and management capacities
- to deal population issues, enhancing multi-sectoral and integrated approaches
- increase awareness and IEC campaigns
- Upgrade training and research skills

Strategies:

- Implement RH package and improve its coordination with govt., NGOs, and other sectors
- Involve women organization and working group for women's need in planning, implementation and monitoring
- Promote men's participation
- Assure high level quality of care in information and services
- Provide constellation of linked or integrated services
- Make available as wide range as possible modern methods of FP
- Create better understanding of local context of RH services through quality of care

Effective implementation of programme will focus on:

- Strong commitment and political will at all levels
- Close coordination among different sectors
- Collaboration between private and public sectors
- integration b/w Health and Population sectors and improving availability of RH services
- FP cell to be created at all provincial departments level of health
- Well directed communication and mass media policy
- Improve managerial and service provision capacity
- Improve programme personal's performance at all level

Monitoring and Evaluation:

- Third party involvement in evaluation
- Different sectors and programs interlinkage strengthened through regular monitoring
- District Coordinating Committee (DCCs) monitor availability and supplies with reporting
- Projects Wing and Technical Section of Planning and Development Division will monitor field activities

MOPW and P&D Division will prepare action plan for M&E activities

Annexure 6

Annexure 6 provides snapshot of all national population policies.

6 National Population Policies' Snapshot

6.1 Population Policy of Pakistan 2002

Goals:

- Attain balance between resources and population
- Address various dimensions of the population issues
- Spread awareness of adverse consequences of rapid population growth
- Promote family planning
- Attain reduction in fertility
- Reduce population momentum through small family, delay first birth and spacing

Objectives:

- Reduce annual population growth rate to 1.9% till 2004.
- Reduce total fertility rate to 4 births/women till 2004.

Strategies:

- Develop and launch advocacy campaigns to address special groups like policy makers, leaders, youth and adolescents
- Promote small family norms
- Increase ownership of population issues by stakeholders
- Reduce unmet need for family planning
- Adopt a shift from target oriented to people centered needs and services
- Ensure the provision of quality services especially to poor in rural and urban slums
- Coordinate and monitor a comprehensive network of family planning and RH
- Build Strong Partnership with line ministries, organizations, departments, NGOs, and private sector
- Strengthen coordination of population activities by civil society players, NGOs and media
- Expend the role of private sector
- Decentralized program management and service delivery to provincial and district levels
- Ensure availability of reproductive health package through nationwide service delivery outlets
- involvement of men in strengthening family as a basic unite of society and small family size decision making
- Ensure population and family life education

Research:

- NIPS will provide national data analysis and research findings. Research coveringall aspect of population.

Future:

- Reduce annual population growth rate from 1.9 in 2004 to 1.3 by 2020.
- Reduce TFR to 2.1 births/women by 2020.

- Universal safe access to family planning

6.2 National Population Policy 2017

Goal 1:

- Achieve first demographic dividend by 2015

Objectives:

- Accelerate demographic transition through rapid fertility decline, enhance child survival and improve education and general empowerment of women.
- Strive to fulfil and protect the right to health care for all
- Nurture a healthy and productive labour force
- transform education to develop a well-educated, skilled, and innovative labour force
- Implementation of economic reforms and development of necessary infrastructure
- Ensure social protection for vulnerable people at all stages
- Eliminate all forms of discrimination and exploitation

Strategies:

- Advocacy and policy dialogue
    - Relevant government sectors systematically mainstream population factor at all levels and within all sectors
    - Enhance capacity of staff in pertinent govt. institutes at all levels
    - Mobilizing and sustaining political will for investment in population issues
- Implementation through coordination
    - Support the development and implementation of coordination in designing and executing plans and programmes
    - Promote participation of civil society and private sector
    - Collabouration and linkages with international development agencies
    - strengthen partnerships
- Legal framework and governance
    - Support development
    - ensure effective management approach towards services provision at all levels
    - Provision of RH services including FP

Goal 2:

- Strengthening Institutes for Data Generation and its effective Use

Objectives:

- Strengthen system of data generation related to population and development
- Strengthen national and provincial governments to collect, analyze and disseminate data on national to district levels
- Develop regular basis online open access databases
- support the development of results-based monitoring and evaluation system

Strategies:

- Capacity development and training
    - develop appropriate structure for data generation
    - enhance the technical capacity of technical staff
    - expend interdisciplinary programs of training and practice
- Collabouration and mobilization of multi stakeholder partnerships
    - Foster private sector engagement
    - foster mechanisms to improve access widespread usage of data

Monitoring and Evaluation:

- monitoring and evaluation of performance
- Result Based Monitoring and Evaluation Framework (RBMEF) will be developed

Annexure 7

Annexure 7 provides snapshot of all provincial population policies.

7 Provincial Population Policies' Snapshot

7.1 Khyber Pakhtunkhwa Population Policy of 2015

Budget:

- Rs. 4032 million for 2014-15 to 2017-18 (3 years)

Objectives:

Medium term:

- Achieve universal safe access to RH/FP services by 2020
- Increase CPR from 28% in 2012-13 to 42% by 2020
- Raise modern CPR from 20% to 28% by 2020
- Reduce unmet FP from 26% to 15% by 2020
- Reduce TFR from 3.9 to 3.3 by 2020
- Reduce Population Growth rate from 2.2 in 2013 to 2.0 by 2020

Long Term:

- Increase CPR from 28% in 2012-13 to 55% by 2032
- Achieve replacement level of fertility (2.1 births/women) by 2032
- Decrease Population Growth rate from 2.2 in 2013 to 1.3 in 2032
- Encourage increased investment in female education and empowerment

Supportive Objectives/Strategies:

- Broad based support of parliamentarians, local champions, activists to create the environment of FP and birth control. Also develop inter-sartorial linkages to change the image of birth limits.
- Mobilizing of male for FP and use male contraceptive methods
- Supportive role of partners to motivate clients
- Availability of contraceptive at valuable price to all level

Monitoring and Evaluation:

- Population welfare will work to focus on monitoring from outputs to outcomes.

7.2 Sindh Population Policy 2016

Objectives:

- Enhance CPR 30% to 45% by 2020
- Achieve universal safe and quality RH/FP services by 2020
- Achieve replacement level of fertility i.e 2.1 births/women by 2035
- Increase FP/RH services in farthest and remote areas by 2017
- Reduce unmet need of FP from 21 to 14% by 2020
- Decrease fertility level by 3.9 in 2013 to 3.0 by 2020
- Contraceptive commodity security to 80% by 2018

Supportive Objectives:

- Political commitment at highest level
- Multisectoral approach
- Costed Implementation Plan (CIP) to work with FP sectors
    - enhance coordination of health and population sectors in provincial, district and sub-district level in integrated service delivery
    - Ensuring quality of services
    - improving sustaining supply chain management
    - Expanding services with supply and demand
    - increase awareness and meeting demand for FP Services
    - strengthening population and health system through policy, planning, monitoring and accountability

- enhance access to family planning services
- Quality FP service delivery
- Continuous and uninterrupted availability of contraceptive at valuable prices
- Male involvement
- Delay marriage age
- Educate youth and adolescents about population issues
- Pre and In-service FP training
- Advocacy complains through different channels
- NGOs, civil society, Public and private sectors involvement

Monitoring and Evaluation:

- Sindh population welfare department will establish regular forum for research
- Monitoring and evaluation system will be established

7.3 Punjab Population Policy 2017

Budget:

- 40 billion for five years (2015-20)

Objectives:

Short term:

- lower wanted family Size to 2.5 by 2020
- Actively promote three messages to every woman of Healthy Timing and Spacing of Pregnancy (HTSP) by 2020
- Ensure contraceptive security in all outlets
- Fertility level 3.3 by 2020

Long term:

- universal coverage and provide quality service of FP and RH to farthest and remote areas by 2025
- increase CPR to 60% by 2030
- Attain replacement fertility level of 2.1 by 2030

Strategy:

- all time service delivery
- contraceptive availability
- demand generation through advocacy
- motivation
- counselling
- Dedication and follow-up
- Multiple stakeholders
- political commitment

Monitoring Evaluation and Research