

THE FAMILY HEALTH CARE REPORT

A Review of Pakistan's Expanded Population Planning Program

*Contract No. AID/afr-C-1138
Work Order No. 06*

*Family Health Care, Inc.
1211 Connecticut Ave., N.W.
Washington, D.C. 20036*

Submitted:

*Draft Report: November 30, 1976
USAID/Islamabad*

*Final Report: December 23, 1976
Agency for International Development
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I. SUMMARY

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SUMMARY

INTRODUCTION

The charge to the Family Health Care (FHC) team focused on the Pakistan Expanded Population Planning Program. In addition to the Scope of Work described in Contract No. afr-C-1138, Work Order No. 6, USAID/Islamabad had prepared a Logical Framework for the program with stated goals, purposes, outputs, and inputs. Both frames of reference were used by the team in the process of reviewing the program's effect on fertility regulation in Pakistan.

The FHC team arrived in Pakistan on November 5 and departed on December 2, 1976. During this time, many descriptive documents relating the details of program organization, budgets, and personnel were reviewed. In discussions with USAID/Islamabad, it was mutually agreed that there was little value in re-documenting the abundance of information already known to AID. For that reason, documents regarding the current organization of the program and similar materials are not commented upon further in this report. The interested reader will find these materials listed in the Bibliography.

The team's analysis of the Expanded Population Program attempts to transcend the minutia of program details, to

seek new or additional information regarding the conceptual design of the program, to investigate the validity of the assumptions upon which the program design is based, and to measure the fertility impact and the associated costs of the program. In order to accomplish the task listed in the Scope of Work, team members met with and interviewed knowledgeable authorities in the public and private sectors.

A list of institutions which were visited for interviews with concerned administrators and policy-makers can be found in the Appendix. Throughout its review of the population planning program, the team was given cordial assistance and timely counsel by members of USAID/ Islamabad and the Population Planning Division in the Federal Ministry of Labour, Manpower, Health, and Population Planning. A Demographic and Economic Profile of Pakistan is provided on page 7 of this section.

The Family Health Care Report is divided into five sections:

- I. Summary
- II. Conclusions and Findings
 - System Capacity to Affect Fertility Regulation
 - System Support Elements: Public Policy, Communication Strategies, and Program Management
 - Population Planning Goals, Program Assumptions, Impact, and Cost
- III. Issues Facing the Population Planning Program
 - Population Policy
 - The Position of National Leadership

- Village Socio-Economic Dynamics and Family Planning Strategies
- Program Planning and Management

IV. Recommendations

- The Role of the Prime Minister
- The Government of Pakistan's Population Planning Organization
- The Population Planning Division in the Interim
- The Agency for International Development
- Future Foreign Assistance

V. Epilogue

Appendix

Bibliography

The team members assigned to this study by Family Health Care were:

Jarrett Clinton, M.D., M.P.H., Team Leader, Director of Evaluation, FHC

Warren Robinson, Ph.D., Professor of Economics and Director, Population Issues Research Group, Pennsylvania State University

Petra Reyes, M.P.H., Consultant in Communications; Ph.D. candidate, Johns Hopkins University, School of Hygiene and Public Health

Jeremiah Norris, Director, International Division, FHC

A PRÉCIS OF CONCLUSIONS, FINDINGS, AND RECOMMENDATIONS

The lack of quantifiable success with the population planning program and its constant inability to influence significantly the population growth rate is reflected by the disillusionment among program staff and donors alike. The former attribute this state of affairs, in large part, to the donors, saying certain flawed elements of the program have been forced upon them. For their part, the

donors say there is a tenuous commitment by the government to the goals of the program and little accountability among program staff.

It was not FHC's charge to determine which, if any, of the parties is at fault. The fact that the program has failed to meet the goals and purposes agreed to by both the donors and the recipient government renders the probable assignment of blame a moot issue. It is interesting to note, however, that all through the review process the team encountered no criticism--even the suggestion of such--which attributed the inadequacies of the Expanded Population Planning Program to insufficient financial resource availability. If there is one point the government, donors, and private sector sources expressed consensus on, it is this: the problem is not resources, it is the effective management of those resources.

The reader will note in this report that the conclusions and findings of the FHC team have been stated before by others who have reviewed the population program during the past several years. Perhaps the FHC team has made the same case in a somewhat different manner, but the results are essentially similar: the population planning program in Pakistan is not working.

The team did not wish to use its moment with the reader to reiterate the past, but it did want to express a few statements which are based on the enclosed findings. The Government of Pakistan must accept full accountability for population planning and its attendant consequences if goals are not met. The resources have been made available and donors continue to demonstrate active interest in funding the program. Those resources must now be blended with a national commitment to population planning goals. This is a Pakistani issue; population planning can only be addressed within the societal value structure of Pakistan. The failure or success of the program is a Pakistani responsibility. For the Agency for International Development, the team recommends a thorough examination of its role as a powerful donor, and specifically suggests adoption of an assistance relationship that is more sharply defined and directed toward specific purposes and outputs.

Working together, the Government of Pakistan and the donors can establish a productive partnership on the recognition that the significance and value of past investments in population planning efforts lie less in their substantive accomplishments than in the impetus they can provide now to new forms of organization which can serve as the incipient forces necessary for an effective national program.

PAKISTAN DEMOGRAPHIC AND ECONOMIC PROFILE

September, 1976

Population	73.1 Million
Crude birth rate	44.5/1000
Crude death rate	14.5/1000
Annual population growth rate	3%
Number of years to double	23
Infant mortality rate	100-120/1000
Maternal mortality rate	7-8/1000
Population below 15 years of age	46%
Life expectancy at birth	48 years
Per capita GNP (current prices)	\$130
Labor force in agriculture	57.3%
Population in rural areas	74.6%
Average number of children born per couple	6.3
Literacy rate:	
Overall	20%
Male	30%
Female	9%
Children 5-19 years in school	30%
Eligible fertile couples	14 million
Percent eligible fertile couples contracepting (Summer 1975)	5-7%

SOURCE: USAID/Pakistan estimates based on best available data, including recent information from the Ministry of Finance.

II. CONCLUSIONS AND FINDINGS

- System Capacity to Affect Fertility Regulation
- System Support Elements: Public Policy, Communication Strategies, and Program Management
- Population Planning Goal, Program Assumptions, Impact and Cost

SYSTEM CAPACITY TO AFFECT FERTILITY REGULATION

CONCLUSION

The Field Motivator Team (FMT) staff now in service is largely inappropriate for the program's basic target through the Continuous Motivation System (CMS): village population groups. The CMS was designed to insure that FMT staff (locally recruited, married couples) visit 74 percent of all eligible couples* three to four times each year for the purpose of contraceptive motivation and acceptance of family planning practices. However, the CMS regularly affects only a small minority of couples. Patients who come to Family Welfare Clinics (FWCs) appear to be served more for episodic illnesses and other health needs than for family planning. The team noted in FWCs visited that the ratio of health visits to family planning visits is on the order of 4/1. The anticipated high use of oral contraceptives has not occurred in the program. Sterilization, though at low levels, is increasing as a method of contraception; abortion is not yet acceptable, yet increased demands are being made upon the system for this service.

* Approximately 10.4 million of the estimated 14 million couples of reproductive age.

FINDINGS

A. The Continuous Motivation System

1. The CMS would require a delivery capacity of 30-40 million home visits each year. Given the difficulties of recruitment, training, supervision, transport, and logistics, this objective was an unreasonable expectation on the part of program managers and beyond the scope of available resources.
 - a. Using the lower figure of three visits per couple per year, and an optimistic six (6) effective visits per day over a 280-day work-year, one FMT (male and female) could do 1,680 visits each year. A cadre of 18,572 FMTs (37,144 staff) would be required to perform 31.2 million home visits.
 - b. The resources required to support this number of FMTs, excluding transport and driver, supervision, supplies, selection and training, etc., is on the order of \$13.4 million at current salaries: $\$30/\text{month}/\text{motivator} = \360 per year $\times 2$ persons/team = $\$720/\text{year}$ $\times 18,572$ FMTs = \$13.4 million.
 - c. The entire family planning program, including Government of Pakistan and all other donor support, is projected at \$24.3 million in FY 1976-77. If (b) was fully implemented, the CMS would have consumed 55 percent of the projected budget to support direct FMT salaries. During FY 1975-76, the salaries of FMTs, Lady Motivators, and dais accounted for 26 percent of the expended budget. This is a high allocation when one considers their program output.
2. Field Motivators (FMTs), either male or female, have failed to increase significantly the delivery of oral contraceptives and condoms to new acceptors. Though the Client Record System (CRS) indicates that

approximately 90 percent of contraceptives sold are from the FMTs, that information is solicited by the FMTs themselves and may be biased considerably. Oral contraceptive off-take (distributed or purchased from system) has dropped below 400,000 cycles per month since early 1976; condom off-take remained essentially static during 1976.

3. A large percentage of female positions approved for FMTs are unfilled. Reports indicate that some experienced FMTs have been released because the validity of their 10th year graduation certificate was questioned.
4. There appears to be greater job stability and a higher proportion of older, more "life-experienced" FMTs in Baluchistan than in other provinces.
5. The contraceptive method preferred by the FMTs is the condom. This bias reflects that of their superiors. The FMTs' explanation of the common side effects of oral contraceptives is frightening to the villagers. Nevertheless, some villagers do buy, at nominal prices, the orals. Some say that this is done to insure that the "young person" would not lose his/her job. The buyer is a relative, or friend and assumes some obligation to "assist" the friend, or the relative of a friend.
6. There are persistent allegations that large quantities of condoms are purchased for balloons. Village children say "they are cheaper, stronger, and do not break as easily if they hit the hot brick or concrete".
7. Transportation for female FMTs faces enormous constraints. Bicycles are seen as totally inappropriate by both the female FMTs and the villagers they serve.

8. Though exceptions are noted throughout the program, FMTs are usually viewed as inappropriate role models by the villagers they are supposed to motivate; often FMTs are young, unmarried, and inexperienced. More importantly, since they do not reside in the village, they are alien to its traditional society and are effectively excluded from the role of change agent. In essence the current FMT staff represents a forced compromise from the original plan to recruit local married couples. The probability of obtaining larger numbers of appropriate FMT staff is apparently low.
9. Appropriate and sustained supervision of FMT staff by PPOs and SPPOs varies greatly. There are instances of high quality performance, yet there are also abundant reports of insufficient supervision by PPOs/SPPOs.

B. Family Welfare Clinics

1. Family Welfare Clinics (FWCs) are staffed by minimally trained Family Welfare Visitors (FWVs) who provide free services and medicines. For the most part, these clinics are used much more as sources of primary care for children and mothers than as providers of family planning services. In clinics visited by the team, 80-85 percent of the cases listed on the daily register were for rudimentary health problems, and the kinds of drugs dispensed by the FWVs seemed to be more closely associated with the varieties available in stock than with the types of drugs normally indicated for treatment of the illnesses seen.
2. New acceptor rates in clinics visited were minimal, ranging from 5-13 percent of the total case load on the daily register. New IUD acceptors are generally provided services through the FWVs. The monthly number of new IUD acceptors has not changed significantly over the past year.

3. Each clinic visited did have supplies of oral contraceptives and condoms, though rarely by the standards of "inundation". However, in the great majority of clinics the supplies available, particularly of oral contraceptives, were sufficient to preclude significant constraints on supply. More foam preparations and Sultan brand condoms were almost always requested. Supplies provided to acceptors were generally adequate.
4. The FWVs complain they have insufficient training for the clinical management of the diseases encountered; are provided refresher training only in family planning subjects; and have insufficient drugs for the treatment of the side effects of oral contraceptives. Vitamins C, B, and K are used for treatment of these side effects, though clinical evidence for efficacy is highly questionable. The vitamins do no harm and may exert a positive placebo effect.
5. FWCs are found side by side with Rural Health Complexes and MCH centers. There appears to be no collaboration between these units, and patients visit the FWCs because the clinics usually are stocked with medicines and drugs while the others are not. At the Federal level, there is the feeling that family planning services are being dispensed in FWCs under the guise of "health".
6. By 1980, the PPD plans to have 2,100 family planning clinics in operation (currently there are 890) and to be training 500 FWVs per year. In many cases, these clinics and personnel will be located in the same villages which have Basic Health Units and Rural Health Complexes. While there are discussions at the Federal level concerning collaboration and cooperation, there is no specific plan between the PPD and the Health Ministry to

integrate, even at a planning level, these costly and duplicative efforts.

7. When this subject was raised by the team at the Federal level, respondents on the "health side" said, in terms of eventual integration, that population planning staff "may be unfit to return to government service". Those on the "population side" said "there will be no integration of health and population planning programs".
8. As a corollary to the points above, USAID is the major donor to the population planning program, and is currently negotiating a Project Paper with the government to fund the Basic Health Services project in the Federal Ministry of Health. It has been explicitly mentioned to the team that AID bears responsibility for "imposing the CMS program on the Pakistanis". If both projects continue without being integrated, which would be likely only with major policy intervention from outside the Federal Ministry of Health, Labor, Manpower and Population Planning, then the stage is set once again for AID to be the convenient whipping post for government frustrations when the overly ambitious targets are not met.
9. There is a general program bias by FWVs toward the condom and IUD, and against the OC. Their convictions were more easily understood when the team heard a senior Federal-level clinician state, "The pill will not work in our setting".
10. FWVs claim their supplies of drugs are declining. The explanation provided them is that UNICEF is reducing their commitments of these consumable pharmaceuticals.
11. In only a few Family Welfare Clinics visited did the team find the English language text-manual provided FWVs at graduation. Similarly, no copies of the English language Treatment and Diagnosis Manuals, which are

provided were found. The Urdu language text-manuals have not been received.

12. Due to limited staff and transportation, supervision of Family Welfare Visitors is totally inadequate. The steps now being taken to create a cadre of Family Welfare Supervisors should begin to alleviate this problem while creating another: each officer is to be provided with a 4-wheel vehicle and driver. There are over 420 serviceable vehicles in the PPD fleet at this time and, if each FWV supervisor is to receive a vehicle, another 100-300 will be added to this total. The team has seen no cost figures for this transport, nor for logistic and maintenance requirements.
13. FWVs acknowledged that their commitment to the clinic limited their ability to follow-up IUD and oral contraceptive users who needed home visits. With only one worker per clinic, the individual cannot be in the clinic and the village each day. Transport or transport funds are limited and this creates an additional constraint against home visits. Clinical follow-up responsibility sometimes has to be given to motivators because the FWV cannot do it.

C. Contraceptive Sales Agents

1. Within each province, several sales agents were visited. However, the team was constrained by time and the arranged schedules from visiting random villages. Non-scheduled visits in the Quetta area were possible. In all large shops visited there were at least one gross condoms and one box (60 cycles) of OCs. In rural areas the supplies were generally lower. Recent field reports by USAID personnel suggest that supply levels are improving in some number but by no means all, districts. Sales volume was generally low, except for Quetta, which reported 40-60 cycles OCs and one or more gross condom sales per week. Other recent

surveys suggest that average shop sales are 20 cycles OCs and 1.5 gross condoms sales per week.

2. Review of survey data indicates that agents complain that villagers are sensitive to open display of contraceptives, that there are low profit margins associated with the government-supplied contraceptives, and that demand for contraceptives is low.
3. Point of sale information posters were nearly non-existent; contraceptives were displayed only in cities; many rural shops had no sign identifying them as sales agents; and rural shops' contraceptive stock containers were broken or non-existent.
4. Nearly all the English-speaking sales agents in the Quetta area indicated a consumer demand for foam preparations and Sultan brand condoms. One brand of condoms, due to a manufacturing error, created many complaints and furthered the development of a strong brand preference.
5. With regard to contraceptive sales agents, a front page article in a Karachi English language paper noted the high prices charged for government-supplied contraceptives. Reliable sources confirmed that condoms in the Karachi area are selling for as much as Rs. 4-6 per dozen, a price markup of approximately 20 times the standard.

D. Ministry of Health Facilities

1. Because the team concentrated on rural areas, it visited only a few maternity homes and hospitals. The record for postpartum acceptance of family planning is good, but the number of hospital-based deliveries is very small.
2. In a maternity hospital within Peshawar there were adequate supplies of all types of contraceptives, and surgical sterilizations were provided.

3. In all MCH centers, whether a training MCH clinic for Lady Health Visitors or a freestanding MCH center, the availability of family planning services was scant. Only one center of those visited had a reasonable supply of contraceptives. Most LHVs said family planning cases were referred to the nearest Family Welfare Clinic. While Lady Health Visitors received training in family planning motivation and in the provision of contraceptives, the team witnessed no significant field and clinical involvement of Lady Health Visitors in the program.
4. A MCH center associated with the Lady Health Visitor School in Peshawar reported they closed their family planning services under instruction from the local Population Planning Board. Another example of MCH disinterest in family planning was discovered while visiting a FWC located in a hospital outside of Hyderabad. The team was told there was one MCH center just down the hallway. The team asked for permission to visit the center but it could not be obtained. Over 85 percent of the cases on this FWC daily register were for minor illness.

E. Sterilization

1. Review of reports and discussions with program officials indicates that the demand for female sterilizations is growing and that the national program plans to provide rapidly additional surgical sterilization services. From the outstanding facility at Lady Wellington Hospital in Lahore to a modest maternity hospital in Peshawar, the mood of physicians toward female sterilization is positive and encouraging. Female sterilizations reached a high point of over 1,600 in October 1976, about double the number a year earlier. Vasectomy cases have averaged nearly 200 per month for the past two years.

2. There is ample evidence of increased awareness by professionals of new sterilization techniques, particularly minilaparotomy and laparoscopy.
3. Supply of laparoscopes is now approaching that of trained operators, but a reasonable maintenance and repair system for the laparoscopes has not been developed.
4. Instruments for minilaparotomy are manufactured in Pakistan at prices lower than available in the U.S.
5. Most physicians and officials believe that women are requesting sterilization, not because of the incentive money (generally US \$2 equivalent), but because they seek a safe means of permanent fertility control.
6. Those few patients seen on the wards visited were high parity, and of middle to lower economic class, i.e., the wives of shopkeepers, craftsmen, tradesmen, or middle income farmers.
7. The coordination between the Population Planning Division and the Health Ministry for implementing a rapidly expanding sterilization service program is still scant. At present there is no articulated plan for utilizing all private and public resources for sterilization, nor for incorporating appropriate sterilization messages into the field motivation activities.

F. Abortion

1. Abortion services are not legal within Pakistan and assistance for abortion service is precluded by AID legislative requirements.
2. The demand for abortion services within Pakistan appears to be moderately high. One private clinic reports as many requests for abortion as for contraceptives.

3. Abortion services apparently are available in major cities; the cost ranges up to Rs. 600 or more.
4. Some suction curettage apparatus is available in major institutions and could be used for menstrual regulation or abortion if the procedure was legalized.
5. In a meeting with 19 hakeems in Lahore, it was the consensus of this group that the rise in abortion demand may be due, in part, to improper contraceptive techniques.
6. A recent study indicates that there is a much higher incidence of induced abortion in Pakistan than what is usually suspected. The sizeable number of induced abortions by dais is directly contributing to the high rate of maternal mortality.

SYSTEM SUPPORT ELEMENTS: PUBLIC POLICY, COMMUNICATION
STRATEGIES, AND PROGRAM MANAGEMENT

CONCLUSION

There is little evidence to suggest the presence of a comprehensive government strategy to guide the magnitude of public investments necessary for implementing a coherent, fully accountable national population planning program in which the commitment of resources is consistent with the magnitude of the target to be achieved. Such guidance is not available, either within the Federal Ministry of Labour, Manpower, Health, and Population Planning, or across other ministries, i.e., Agriculture (which affects the target population more than any other ministry); Education; Planning; and Finance and Economic Affairs. The private sector remains, for the most part, an untapped resource for achieving the public goal. There appears to be adequate funding for the development and implementation of a communication strategy, yet there is a lack of management and technical expertise at the Federal level to appropriately utilize available funding from donors. The requisite management capacity and knowledge base to sustain a long term commitment to a "no-growth family" (the four-person family unit) is weak. At present, such a family is incompatible with the prevailing societal norms of the target population.

FINDINGS

A. Public Policy

1. While the Prime Minister has privately supported the population program, he has not publicly voiced his support to national leadership in a manner which permits them to understand that his authority is being invested in the goals of the program.
 - a. Donors and knowledgeable Pakistanis agree that the Prime Minister will not publicly lend his prestige to the program until after the election (June 1978 at the latest).
 - b. Often, at the village level, People's Party Chairmen are not aware of the Prime Minister's stated priorities for the program.
 - c. For the near future, the national goals on fertility regulation are in conflict with labor-intensive requirements for food production, a key element of Pakistan's overall development scheme.
2. The population problem is considered by policy-makers as a one dimensional government problem and one which can yield primarily to public solutions.
 - a. The prime target population--rural villagers--do not yet identify their lives and destinies that closely with the government.
 - b. The values of traditional village society are not shared by those who designed the national program.
 - c. Funding to private sector groups, either for project design, implementation or research, is extremely limited and tightly controlled.
3. The national goals are overly ambitious, largely unattainable with the resources which are available, and inconsistent with the social norms of the target population.

- a. Since 1965, none of the fertility regulation goals for the population program have been met. At this date, they continue to be set at unrealistically high levels. They remain national in scope rather than aimed at pre-selected targets of opportunity, e.g., salaried workers, in fixed-based establishments.
 - b. As a direct result of the setting of unattainable goals, staff morale has fallen as the targets proved to be unnecessarily ambitious.
 - c. Using the present program design and implementation strategies and assuming the present categorical breakdown of the budget (26 percent of this year's \$24.3 million expenditure toward salaries), fully effective coverage by 18,572 FMTs to motivate the 10.4 reproductive-age couples in the target population would require an annual operating budget of \$51.5 million--more than double the present outlay (see II.A.1., p. 10, for more detailed calculation of salaries projection). (This would be somewhat lower if full staffing of FMTs resulted in lower per capita overhead costs.)
 - d. Among program managers there are few illustrative role models for family planning. Those interviewed average four children, plus chowkidar, dhobis, ayah (house servants), etc. In rural societies, children often serve as surrogate chowkidar, dhobis, and ayah to the father and mother. The prime motivator staff (FMT) for family planning is often unmarried, young, inexperienced, and from outside the village.
4. Federal capabilities to undertake a coherent social effort in a policy area which cuts across traditional institutional lines are weak.
- a. Within the Federal Ministry of Labour, Manpower, Health, and Population Planning,

competition and divisiveness have surfaced between Health and Population Planning. Both Divisions are independently planning to increase physical plant capacity and staff for the extension of services to rural areas--in many cases to the same village.

- b. Recently, the Ministry of Education has cooperated with the Population Planning Division, and population planning concepts are to be incorporated into school textbooks. This cooperation should be continued and accelerated.
 - c. The Population Planning Division has approached the Ministry of Agriculture for the use of agricultural extension agents as motivators in villages. Nothing has yet been achieved and it is not known by us how effective these agents are in their primary job function. In most Integrated Rural Development Schemes, there have been no efforts to incorporate population planning services.
5. Federal capacity to systematically address the complex and changing relationships between policy and implementation are tenuous. The provincial capacity to link policy with implementation is constrained.
- a. Policy formulation for major initiatives is generally understood at the Federal level, but understanding diminishes as policy filters down to provinces and districts.
 - b. The team found no policy or regulations reference manual at the provincial or district levels which might facilitate the transmittal and orderly retention of Federal guidelines.
 - c. Field personnel occasionally complain that they were not informed promptly of policy or regulation changes.

- d. Federal level staff feel the need to "federalize" the program because their policy directives are not executed in the field; provincial level staff feel that they are being asked to implement policies in which they have not been active participants or supporters, and that they have no control over policy matters.

B. Communication Strategy

Judging the adequacy of communication efforts is considerably more difficult than measuring the adequacy of fertility control services. In our review of this program we are struck by the communication program deficiencies and inadequacies. Other national programs appear to have a more effective population/family planning communication program.

1. Conceptual Inadequacy

- a. The team notes from PFS and earlier surveys encouraging evidence that the rural population recognizes the population planning program and can identify modern means of contraception. On the other hand, the low prevalence of contraceptive use, despite increasing availability, testifies to the inadequacy of a communication strategy sufficiently incorporating personal and mass media education, persuasion, and reinforcement--all essential elements to the contraceptive use adoption process.
- b. The team was unable to identify within the PPD program a data base for understanding patterns of diffusion, adoption, or innovation at the village level. Regretfully we were unable to pursue this issue in the agriculture sector where pertinent information might exist.
- c. Communication activities are generally equated with mass media approaches of selling an idea like one might sell soap. Yet, even with the broad approach,

the specific discussion of contraceptive use is prohibited from radio, newspapers, and cinema by a currently established "code of ethics" established to protect the public's sensitivities.

- d. Motivation efforts are defined by program leadership as an umbrella-like concept for interpersonal contact, which includes registration, recruitment, and contraceptive supply. The CMS as originally conceptualized and tested in the Sialkot and pre-Sialkot demonstration projects may have offered promise. Yet the current FMTs are not the married couples of local origin who, with extensive training in interpersonal communication and the adoption process, may have been able to transcend the barriers to contraceptive use. Exceptions of outstanding FMT performance were noted throughout the country, but these exceptions are, in number, far from the magnitude necessary to accomplish the task through an unipurpose method of persuasion.
- e. Little evidence was found within the national program of the identification of specific population targets, e.g., farmers, tradesmen, government workers, union members, military personnel, etc., for specially designed communication efforts. The messages appear to be directed toward everyone in general and to no specific group in particular.
- f. The team found little evidence of a sufficiently designed strategy for group or community meetings. It is understood that this element of the communication program is to be strengthened, but the team is unaware of the specific details.
- g. In a program plagued with rumors regarding the side effects of oral contraceptives and IUDs and with popular confusion of sterilization with castration (associated

with animal husbandry), we found no evidence of plans to allay these fears and concerns either by mass media or personal communications.

- h. Neither the population planning program nor the senior religious leaders have interacted sufficiently for each to understand family planning in an Islamic setting. We are encouraged that a dialogue between PPD and the Ministry of Religious Affairs recently has begun.
- i. The team noted that this sector of the program has had considerable input by foreign donors: SIDA, Ford Foundation, Johns Hopkins, and USAID. The team could not identify the causal linkages between advisors, both foreign and national, and program conceptualization. It did appear, however, that these combined efforts, for the most part, have failed to transform the people's knowledge of family planning into the people's adoption of effective fertility control methods.

2. Communication Program Planning and Management

Deficient conceptualization has contributed to a lack of planning and integration.

- a. There is a lack of management capacity and direction at the Federal level to effectively utilize allocated donor funds. For instance, in FY 74-75, the PPD was unable to justify a \$200,000 communication component in the UNFPA grant. These funds were subsequently withheld from the PPD by the UNFPA's New York office with the proviso that they would be reinstated when the PPD submits a strategy for their implementation in communication. As of November 1976, no strategy had been presented to the UNFPA, nor was it known to the team whether one had been drawn up by the PPD.

- b. Communication schemes are launched without identifiable objectives.
- c. Communication budgets are allocated to various categories of media and activities. Program strategies and plans are then finalized according to these allocations.
- d. The few communication specialists in the program are not given authority to make final decisions regarding program strategies. Interference and decision-making by senior program officers lacking understanding of either communication or rural sociology has been and continues to be one of the most serious shortcomings of the communication program. Bureaucratic control results in an emphasis on quantifiable and visible, easily reportable outputs: signs, boards, pamphlets, number of film showings, number of advertisements, etc.
- e. The area of interpersonal communication has been left undeveloped while other enterprises with limited effectiveness--seminars, conferences, TV programs--have been emphasized.
- f. Implementation of strategies at the district level has left insufficient flexibility for modification. While there is need for some degree of uniformity, centralized communication planning is generally out of touch with the heterogeneity of local cultural norms and attitudes regarding fertility.

The PPD Communication Committee attempted to enhance management of and coordination between the central and provincial levels, but was ineffective due to its limited communication and behavioral science expertise, and its inability to affect communication expenditures.

- g. Lateral coordination of the communication strategy with the training programs for field functionaries and motivators appears to have been adequate through the organizational integration within TREC. However, the current restructuring of training and communication activities will require special organizational linkages to insure coordination.
- h. In the program's communication efforts, there has been minimal cooperation and coordination with the Family Planning Association of Pakistan, the health sector, and other governmental, non-governmental, voluntary or private sector groups. Present improvements in this area are, however, encouraging.
- i. The absence of ongoing evaluation has been, and may well continue to be, a serious deficit, particularly since 90 percent of the communication schemes are one-directional with no provision for feedback: TV, pamphlets, signs, billboards, films.

3. Technical Soundness

- a. Related to the inadequacies outlined above, messages are not clearly defined. When defined, they often are inappropriate. For instance, there is a tendency to load a radio spot, or pamphlet, with conflicting and inappropriate messages. The impact on the receiver is diffused and often confusing. One example: "Space, and you will be prosperous."
- b. The "spacing" versus "limiting" emphasis has been inconsistent and confusing. Illiterate people are said to associate contraception with limiting family size. There is a great deal of confusion about child spacing.
- c. More often than is prudent, the term "to limit" is used in population planning

messages. This casts a negative connotation onto the recipient's receptivity, especially since the message is generated through government sources. The imagery engendered by messages which promote spacing techniques are far more positive, but, to the team, did not seem to be in wide use.

- d. Broadcast House in Karachi in 1967 tested radio as a medium to motivate listeners toward clinics offering family planning services. The test was a success: 85 percent of the people who came to the clinics following the broadcast said they heard the message either directly or indirectly. This station now provides a five-minute family planning broadcast each day in cooperation with the Sind PPB. However, the PPB does not accept the advice of the Station Manager, who designed the 1967 messages. The current messages are unplanned, the format is unchanged, and the potential impact of the message is never tested.
- e. In general, target audience surveys are rare. Consequently, most messages are constructed from a professional, elite perspective rather than from the recipient's frame of reference. It has been suggested that the documentary films are on a level inappropriate for the audiences, and that pamphlet and radio message content leaves the audience without explicit instructions on when and where to obtain services. The message conveys excessive information that may be meaningful to the message designer, but frightening and rumor-producing to the audience, e.g., lengthy elaboration on all the possible side effects of the pill.
- f. In summary, exclusive use of mass media techniques--neglecting techniques of interpersonal communication, community organization, and group dynamics--wastes resources. This focus indicates

misunderstanding of the special and limited utility of each approach that must be skillfully integrated into a communication program.

C. PPD Program Management

1. The management capacity at the Federal, provincial, and district levels to execute agreed upon plans is consistently weak.
2. Broad review of program alternatives have been initiated, yet few recommendations have been officially accepted or implemented.
3. Program planning--the consideration and written documentation of discrete objectives, specified-time-period work plans, and resource allocations--is inadequate.
4. Authorities are infrequently delegated or redelegated. As a result, program initiatives are highly dependent on actions taken by a few high level officials. Further, the absence of authority delegation limits the degree to which specialized technicians, e.g., warehouse and logistic staff, can improve support systems.
5. Coordination between components of the program is insufficient. Some examples: a radio station announces clinic hours incorrectly; newly registered sales agents are never visited by distributors; research and evaluation are duplicated; training activities exist in three PPD directorates with insufficient interaction.
6. Personnel appointments are heavily influenced by family and political connections rather than by work and training experience. Some personnel dismissals appear to be based on lack of proper credentials in spite of a reasonable record of good field performance.
7. Standardized job descriptions have not been established and are not used in selecting new personnel. It is reported that the job descriptions for FMTs do not correspond with the staff's capacity to perform the tasks or with the task actually undertaken.

8. Components of the information feedback system for program managers receive only modest attention at high levels within PPD and little attention by field program managers. Both the Client Record System (CRS) and the Information System for Contraceptive Movement (ISCM) are relatively complex systems requiring continuing supervision, on the job training, and high level management support. As noted elsewhere, the ISCM is far from operational; the CRS is not yet viewed as a management tool. The team is encouraged by the recent decisive actions taken on the basis of feedback reports by one DPPO in the CRS areas.

D. Transportation and Logistics

1. The population planning program in Pakistan is dependent upon transportation, particularly for the CMS and its attendant supervisory requirement, and upon the "inundation scheme." An adequate transportation system to support a massive field program does not exist.
 - a. A significant portion of the 430 operable four-wheel vehicles are older than five years. Twenty-five percent of the vehicles were "off road" in July 1976. A FY 73 USAID-initiated procurement plan for jeep parts is still not operational. A repair system has not been implemented by the PPD, and financing for fuel and maintenance is constrained. High fuel consumption of U.S.-assembled jeeps creates additional cost burdens. A recently established, yet not implemented, policy of transferring some four-wheel vehicles from the DPPOs to FWCs will require concomitant adjustments in fuel and maintenance procedures and financing.
 - b. 125cc motorcycles are in increasing supply, yet more are needed. The 125cc model is of appropriate size and economy for male workers in the program. Previously procured 50cc scooters were insufficient for rugged field use, and rapidly deteriorated.

- c. The recent suggested, but not implemented, plan to assist male workers to purchase the program's motorcycles through 36 monthly time payments should elicit greater personal pride and care of vehicles.
 - d. The suggestions of prior USAID-financed transportation advisors have neither been implemented nor rejected.
 - e. A new training program has been started for Family Welfare Supervisors who will be assigned to supervise FWCs. The plan is to field 100-300 such officers in the next few years; each will be supplied with a four-wheel vehicle. The manner in which this 100-300 vehicle fleet is to be managed, along with the present inadequately managed 430 vehicle fleet, is not clear.
2. A coordinated logistical system for the orderly flow of consumable contraceptives does not exist. The significant flow of supplies from the over-stocked Karachi warehouses has ceased since July 1976, and new contracts for shipments have not been negotiated. (Note: On November 26, FHC was informed that 4,000 gross condoms were sent to each of 12 districts.) The suggested plan to ship contraceptives directly to the PPO level without passing through intermediate levels is awkward, unnecessary, and probably infeasible. Stock storage facilities at the district level vary from excellent to unsatisfactory. The orderly transfer of stock requires improved district warehousing and controls.
- a. Payment systems for shipping contraceptives from the district level to SPPQ and PPO levels do not function smoothly. PPOs who take the initiative to ship stock on commercial carriers have not always been reimbursed for costs incurred.
 - b. The recently implemented Information System for Contraceptive Movement (ISCM) is a step forward, yet considerably more PPD leadership, attention,

field training, field supervision, program simplification, and rapid data processing--combined with feedback-- must be effected to provide timely stock movement estimates and controls.

- c. In-country stock of oral contraceptives are estimated to be more than 10-15 millions monthly cycles (MC). Five million MCs are in Karachi warehouses. Until early November 1976, storage facilities in Karachi were totally inadequate. The oral contraceptive stock level represents approximately two to three years' supply at recent 12-month trend levels and would provide approximately one year's supply for ten percent of Pakistan's married women of reproductive age.
- d. The team estimates that in-country condom stock is approximately 1.0 to 1.4 million gross. Theoretically there should be 1.6 million gross, but this volume cannot be accounted for at present. At present, there are 0.9 million gross condoms in the Karachi warehouses. Shortages at the field level exist throughout the country, even within Karachi City. Reportedly, this situation was resolved during November 1976. Total available condom stock would last approximately 20 months at recent off-take levels of approximately 60-80,000 gross per month.
- e. IUD stock is barely ample for current usage levels and the quality of the IUDs is reportedly inferior. Foam preparation stock is nearly exhausted.

E. The Statistical System as a Tool for Program Evaluation

- 1. An effective statistical reporting system to provide managers with operational insights into the implementation of program plans has been initiated (the Information Feedback System), but requires some modification.

- a. There are still some "bugs" to be worked out in programming the feedback system. Absolute data values, as well as their rankings by district, are not provided on the same feedback page.
- b. There is some grass-roots apprehension about the effect of this system on "forced" reporting or cheating--by other districts, of course.
- c. The clients-by-method tables report an "other and no method" group which is often as high as 15 percent. This group is largely made up of women who have just given birth, expelled an IUD, or for some special reason discontinued. For whatever reasons, they have discontinued. Reporting them as "clients" is misleading.
- d. The report on (a) "clients entering the system," (b) "total clients," and (c) "clients resupplied" is also a bit confusing since (a) and (c) do not equal (b); as one might expect to be the case. This is due to the quarterly nature of the report. A new client can enter the system, be resupplied several times in the same quarter, yet only be counted as one "total" client. Thus, it is clients, not contacts, the system is really reporting. A clarification could be added to the format.
- e. The exact interrelationship among "household," "total couples," and "eligible couples" appears to create some confusion at the grass-roots level. The exclusion of couples from being considered "eligible" is based on being: (a) over 40 or having the youngest child over five, thus indicating sub-fecundity; (b) being pregnant; and (c) being without any children at all and currently not using a contraceptive method. The exclusions are not "wrong," but they foster confusion in the field. They create a situation in which the FMTs or the PPOs have to exercise judgment about who is an eligible couple. This is dangerous. The field

workers are not so pressed with clients as to make it necessary to so partition the market. The FMTs should simply consider all currently married females 15-49 as potential clients and proceed accordingly. Similarly, pregnant women are eligible in a long-run sense and should not be excluded from motivational efforts.

- f. It appears that the quality of information feedback system data is reasonably good. Every effort should be made to deal with the "not reported" problem and to keep a direct link between the FMT and the statistical office in Islamabad, thus preventing "cooling" of the data by DPPOs or SPPOs.
2. The planned, but not yet implemented, continual contraceptive prevalence survey represents a powerful tool for verification of the Client Record System and contraceptive off-take as measured by the Information System for Contraceptive Movement. With the diverse fertility control services now provided in this program, a periodic cross-check of current contraceptive users by contraceptive type, acceptor age-parity, and source of contraceptive supplies is critically needed for sound program management.

POPULATION PLANNING GOALS, PROGRAM ASSUMPTIONS,
IMPACT, AND COST

CONCLUSION

In the past decade Federal expenditures and donor expenditures have risen substantially. They are now approaching a level of \$24.3 million for FY 76-77. The prospect is that these expenditures, both under existing authorizations and under new project agreements, will continue to rise. Thus, not only the intended beneficiaries, but Pakistani society as a whole, have a major stake in the effectiveness and economy of this program. The continued inability of the program to meet its goals should be of paramount concern at the highest levels of government.

FINDINGS

A. The Program Goals and Assumptions

1. The program, at the time it was launched as a comprehensive national effort in 1965, was based on several assumptions about the actual socio-economic situation in Pakistan:
 - a. That there were substantial benefits to be reaped at both the micro and macro levels by reducing fertility. This was based largely on macro growth model simulations, including, most particularly, the well-known Coale-Hoover book on neighboring India.
 - b. That there existed a large unfulfilled interest in and demand for contraceptive means by the great bulk of the fertile population of Pakistan. This belief was partly intuitive but also found

support from the early action-cum-research projects of MESOREP in Lahore, CALHEP in Dacca, the Village Academy in Comilla, and the pioneering work of the private associations in Karachi and Lahore. These early KAP studies, and most since then, indicated a strong latent interest in family limitation.

- c. That the private sector, i.e., households themselves, private pharmaceutical firms, hospitals, and medical doctors, lacked the flexibility and capacity to meet this demand. Hence, it had to be a public sector (government) program to have significant effectiveness.
 - d. That it would be possible to create quickly a nationwide public sector contraceptive information and distribution network which could do the job and could also be effectively controlled, monitored, and evaluated from the top down.
 - e. That in the interest of equity and of political acceptability the program had to be national in scope, reaching to every corner of the then divided nation and, moreover, had to provide contraceptives free or nearly free to the acceptors.
 - f. That although objective base-line data on fertility were lacking, this situation would be corrected. The Population Growth Estimation project and various other demographic studies had been launched and it was assumed that, on evaluation of these data, the program could have an impact on fertility.
2. Since 1965, numerous reorganizations and changes in the administrative network have occurred. New methods have been added, new approaches suggested, integration with MCH

services attempted, and the CMS added. Yet, it is clear that nationwide acceptance rates have not risen and that expanding the magnitude of the program has meant a sharp rise in unit costs. The following conclusions are suggested as a result of these experiences:

- a. The micro benefits of family reduction may have been overrated in 1965 and still are. Children continue to be perceived as an asset by many rural couples. Perhaps overall economic and social development will change this, but that day is still ahead for most of Pakistani society. This is not a contradiction of the "economic model" of fertility: only a special case of its application. The latent demand for family planning, thus, may also be overrated. Interest in contraception is not the same thing as dedication to use.
- b. The private sector may be a better, cheaper, more efficient means of distributing information and supplies. Even in the avowedly socialist economies like China and the USSR, the private market's usefulness is recognized. To maintain a large, costly field staff to resupply clients with condoms is not justifiable. In particular, the rural area may well be left to the private sector.
- c. The idea of reaching the entire nation in a short amount of time is unrealistic. No government programs--except taxation, limited law enforcement, and the judicial system--reach out to all villages; family planning is not an exception. Recent studies indicate a falling fertility rate and a rising prevalence rate in the urban areas of Pakistan: 14 percent current use in 1974-75 compared to 10 percent in 1968-69. For perhaps the first time, a clear difference between urban and rural socio-economic conditions is emerging.

- d. Thus, a useful program strategy would be to place the emphasis on areas which have already demonstrated an interest in family planning, and which show the highest degree of modernization, education, and development. This strategy would not abandon the rural sector since family planning will be available to the villages through the growing network of Family Welfare Clinics, the expanded rural basic health scheme, and private sector outlets and personnel.
- e. Rural village economic and demographic dynamics must change substantially before mass acceptance of family planning will occur by couples--except for "crisis" high parity females. Health, education, and non-agricultural employment are growing but, for most of the population, may be below the threshold needed to trigger genuine family planning acceptance.

B. Program Impact

The Logical Framework created by USAID/Pakistan for the Expanded Population Planning Project PROP (391-11-580-393) establishes as its purpose: "A family planning program capable of widespread delivery of contraceptive methods and promotion of and counseling on contraceptive use operating and widely used." The conditions which would indicate achievement of the project purpose by the end of FY 78 (September 1978) are:

- "74 percent of the population reached by the Continuous Motivation Scheme (CMS) through Field Motivator Teams. Clinic-based services in non-CMS areas are to reach 17 percent of the population."
- "Ever users" are to represent 30 percent of all eligible couples.

- "Current users" are to represent 16 percent of all eligible couples with CMS areas having 20 percent "current users".

The FHC team's judgment on the attainment of those stated conditions includes the following:

1. CMS Outreach - The extent to which the population had been reached by the CMS is a difficult condition to verify. The team approached this evaluation component from several aspects.
 - a. A recent review of the 1968-69 National Impact Study reflects the status of program outreach prior to the CMS. At that time, 83 percent (80 percent rural; 91 percent urban) of currently married women aged 49 and under knew of a program method when the interviewers specifically mentioned the methods. Thirty-six percent knew about family planning; 32 percent knew of a family planning facility.
 - b. The 1975 Pakistan Fertility Survey (PFS) used a much more stringent series of questions to avoid, as much as possible, over-reporting.

Review of the PFS tables indicates that 88 percent of the ever-married women aged 49 and under stated they knew of means to delay or avoid pregnancy. Seventy-five percent of the same group of respondents were able to mention a contraceptive method without specific prompting. Thirty-two percent knew where they could obtain family planning advice and services. Of these, 95 percent could state specific methods. Only 65 percent who were unfamiliar with service facilities could state

specific methods. PFS data indicate that only 29 percent of all ever-married women aged 49 and under had been visited by or had met a population planning worker. Significantly, 97 percent of those who had been contacted knew of efficient methods of contraception. Even 66 percent of those who had no contact with program personnel could identify specific contraceptives, however.

- c. A review of the Information Feedback System (Client Record System) suggests that a higher percentage of couples has been contacted within those sample districts. The CRS itself requires house-to-house registration, as does the entire CMS. In those districts which have field data input of at least four quarters, i.e., Hazara, Sialkot, Lahore, Lyallpur, Hyderabad, and Quetta, the percentage of re-contacts of eligible couples (about 13 percent of the population) by program personnel decreases with each quarter. Based on 2nd Quarter 1976 data in Hazara, less than 30 percent of eligible couples were contacted within the past four months; in Lahore less than 45 percent; in Quetta, Sialkot, and Lyallpur, less than 60 percent; in Hyderabad, 66 percent. For all CRS districts combined, the percentage of total registered clients re-contacted within the past four months decreased from 72 percent of registered clients in 3rd Quarter 1975 to 60 percent in 2nd Quarter 1976. Concomitantly, the volume of consumable contraceptive supplies provided at the re-contact visit were sufficient, on the average, for only two months.
- d. While statistics from the Information Feedback System are more optimistic than PFS data, the team generally concludes that the present eligible

couples meaningfully contacted by CMS is considerably less than 100 percent of the total in CMS areas, or 74 percent of the eligible population.

- e. While the team was unable to visit non-CMS areas, it doubts that a significant portion of the population in those areas was reached by a clinical system. Distances are great, roads in poor condition, and educational levels lower than in the more densely populated areas. In most developing areas of Asia, the number of mothers and children reached by an efficient government health system is on the order of 20 percent. In Pakistan, it is estimated that five percent of the rural population has access to government health services.

In summary, many villagers know of family planning and the existence of program personnel. Meaningful contact, however, is much lower than the anticipated 74 percent achievement level established. In FHC's judgment, the principal factors contributing to this lack of accomplishment are: poor program management, an insufficient transport system, inappropriate field personnel, and a motivation message perceived as irrelevant.

2. The Trend in Fertility - The true level of fertility in Pakistan is obscured by the lack of reliable data. However, the team conducted independent efforts to assess recent trends in Pakistan's vital statistics and the impact of the family planning program on fertility in the last ten years.
 - a. Fertility and mortality can be known in several ways. Births and deaths can be registered so that the exact number and dates can be obtained from civil or religious records. The registration system in Pakistan is, in fact, recording only a small percentage of the total vital events.

The officially reported birth rate for Pakistan based on these registration data has been around 20 per thousand, and the death rate 9 per thousand. The registering of the events is the responsibility of the local (Tehsil) political authority, while the compilation is done by the Health Ministry. Various proposals have been made to improve the system but evidence suggests that the accuracy of the system has actually deteriorated.

- b. The government recently created a new Census and Registration Secretariat in the Home Affairs Ministry and has started a drive to issue identity cards to every person over 18 years of age. This apparently had an effect in the cities but the rural areas seem untouched.
- c. Another method of obtaining fertility data is through sample surveys. Cross-sectional survey data are collected from a sample of the total population. The Population Growth Estimation Project (PGE) was an example of this approach. PGE aimed at producing estimates of fertility and mortality rates for East and West Pakistan between 1962 and 1965. PGE was replaced by the Population Growth Survey (PGS), a regular operation of the Central Statistical Office, between 1968 and 1971. There have also been one-shot surveys: in 1968-69 The National Impact Survey by the Population Planning Council, and in 1974-75, the Pakistan Fertility Survey as part of the World Fertility Survey. These data all suffer from a variety of problems arising from the representativeness of the samples, sampling and non-sampling bias and error.

The PGE was a methodological study as much as it was a substantial data collection effort, and it produced results from a series of cross-sectional (CS) quarterly surveys, parallel data from a special registration system operated by the study (LR), and special estimates incorporating both surveyed and registered events plus an allowance for error in both systems (CD). The CD estimates were the highest of the lot and in the judgment of some observers, "too" high. The LR and CS tend to show different age-specific patterns but roughly similar overall fertility levels.

The PGS was a fairly straightforward series of cross-sectional surveys which probably missed, as most surveys do, enough births to end up a bit on the low side. The National Impact Study (NIS) 1968-69 was a carefully designed and executed study aimed at producing data on the impact of the family planning program up to that moment. The Pakistan Fertility Survey (PFS) in 1974-75 was the Pakistani contribution to the World Fertility Survey. Its direct comparability with earlier studies was affected by the decision to collect birth data for the 12 months prior to the survey date (November 1974), and a strong tendency developed in respondents for the inclusion of births from before the 12-month period. This, however, has been adjusted.

- d. Overall, there are no marked trends in the birth or fertility rates. Pakistan suffered considerable trauma during the partition period (1947-48). There is a distinct possibility this caused a temporary reduction in births, which in turn may have created an "echo" effect: reduction in births some

20 years later. Thus, a slight reduction in crude birth rates in the mid to late 1960's might be a purely structural effect. On the other hand, there is also some indication that the age specific rates may have been falling slightly in the late 1960's. The PGE and PGS data seem to indicate this trend from 1963 to 1969. Moreover, the movements shown in this index indicate small decreases in the age-specific rates in the lower age group (15-19). This would be consistent with the fact that marriage age for females has increased by approximately 2 years from 1961 to 1975. It would also account for slight decreases in the fertility rates at the upper age groups (30 plus). This is again consistent with the evidence which shows that the family planning program has tended to reach, for the most part, high parity females.

- e. Given the fact that all these data are sample survey-based and thus contain sampling error, it is difficult to make too much of slight, apparent declines. Yet, it is worth noting that prior to the PGE experiment most local, smaller scale surveys, including the "People of Karachi study" in 1959-61, found fertility higher still. The official crude birth rate for planning purposes at the time of the 2nd Five Year Plan (1965) was 50 per thousand and some estimates were higher. The LR or CS PGE rates were below this but the CD-adjusted PGE rate was also about 52 for 1963.
- f. After weighing this evidence, a technical subcommittee created by the Planning Division concluded in the 5th Plan that the crude birth rate declined from 48 in 1960-65

to 44.5 in 1970-75, roughly 8 percent. This seems the best guess available (see Table 1, p. 47).

- g. Important new confirmation of that interpretation comes from the first effort to derive fertility estimates from the 1973 Housing, Economic and Demographic Survey conducted by the Census and Registration Organization in Pakistan. This survey was basically a sample of the 1972 census, an enumeration which included virtually no data on fertility. The East-West Population Institute, in collaboration with the Pakistan Census and Registration Organization, has produced estimates for the NWFP Province. These estimates show a rise in total fertility from 1959-63 to 1964-67 followed by a fall in 1968-71. The 1968-71 levels were about 91 percent of the 1959-63 levels. The rise occurred only in rural areas, while urban areas of all sizes showed a continuous fall over the period. Thus, the conclusion that some decline in fertility occurred over the period of roughly 1965 to 1975 seems even more plausible, although these results are tentative.

3. Measuring Program Impact

- a. As noted above it is clear that no dramatic decrease in fertility has occurred in the last 10 years. The estimates of the crude birth rate were around 50 per thousand population for the period 1960-65. As the team's review of the trend in the rates will indicate, it is believed that the present (1976) rate is around 40-45 per thousand. Thus, if we assume the average decline was from 48 to 44 during the period 1965 to 1975, we can make an estimate of the number of births this decline implies. Using Planning Division estimates of midyear population,

TABLE 1
ESTIMATES OF CRUDE BIRTH RATES IN PAKISTAN

	<u>1962-65</u>	<u>1968-71</u>	<u>1968-69</u>	<u>1974 *</u>
PGE				
LR	42			
CS	38			
CD	52			
PGS		37		
NIS			39	
PFS				38

* Adjusted to calendar year

1965 and 1975, and assuming the decline in the CBR proceeded in a linear fashion, 1965 to 1975, one would conclude that the total number of births averted was in the vicinity of 2.4 million (1970 population of 60,610 thousands x 4 per thousand equals 242,000 x 10 years = 2.4 million). Those assumptions are extreme, however. The estimate of 48 for a CBR in 1965 is perhaps high; the decline may not be smooth and linear; the program can not claim credit for all this decline since age at marriage and other parameters were also changing. Thus, this figure of 2.4 million births which did not occur between 1965 and 1975 is an upper limit of the real impact (Table 2, p. 49). Due to other population dynamics, a more realistic estimate would be to attribute half of this change to the population planning program: 1.2 million births averted.

- b. Another approach to measuring program impact is via the program statistics themselves. The number of devices distributed can be linked to the apparent contraceptive coverage they afford and hence, to the number of births these can be assumed to have prevented. The key link is the concept of "couple-years-of-protection" (CYPs) which provide a common denominator for conventionals: condoms, foam, orals, IUDs, and sterilization. Specifically, 100 units of conventionals equal one CYP; 13 oral cycles equal one CYP; one IUD inserted equals 2.5 CYPs; and, one sterilization equals 7.5 CYPs. On this basis, the quantitative output of the program can be converted into CYPs. Traditionally, these coefficients have been felt to describe the Pakistan experience. Similarly, it has usually been assumed that 3 CYPs equal one birth prevented.

TABLE 2
PAKISTAN: POPULATION GROWTH 1961-1975

<u>As of July 1st</u>	<u>Population (in million)</u>
1961	46.92
1965	52.58
1966	54.10
1967	55.65
1968	57.26
1969	58.91
1970	60.61
1971	62.43
1972	64.30
1973	66.23
1974	68.21
1975	70.26

Based on population estimates for 1961 worked out by the Planning Commission. The estimates for subsequent years have been worked out by extrapolating the 1961 figures by the following growth rates:

1961-65	2.98 percent per annum
1965-70	2.98 percent per annum
1970-75	3.00 percent per annum

SOURCE: Statistical Division, Ministry of Finance, Planning and Development, as quoted in: Current Economic Situation and Issues in Pakistan, World Bank 658 PAK, March 28, 1975.

During the period 1965-66 to 1974-75 a total of about 15 million CYPs were "produced" by all methods, implying some five million births averted (Table 3, p. 51).

The CYPs stemming from the non-clinical methods (condoms and orals) are suspect on two grounds: (a) the use efficiency of these methods can vary widely; and (b) the data refer only to devices distributed and there is ample reason to doubt that all of them have been used. At the extreme, one could argue that only clinical-method CYPs (IUDs and sterilizations) represent hard data. If one looks only at clinical methods, then, in the same time period some 7.5 million CYPs were produced implying about 2.5 million births averted. This estimate is still high since there is growing, recent evidence which shows the 2.5 CYPs per IUD inserted and 7.5 CYPs per sterilization are high and also that the ratio of CYPs to births averted is closer to 4 than 3. If 4 CYPs are assumed per birth averted then the output becomes 1.6 million births averted.

Combining these two approaches to the calculation of program impact in births prevented, the following points can be made:

1. The average 1965-1975 reduction of the crude birth rate from 48 to 44 is an upper limit to the estimates and the real reduction is certainly lower.
2. The clinical CYPs and births prevented are probably the core of any real impact of the program. Even these are probably a slight overstatement, because of deficiencies in the program data, and because

TABLE 3

COUPLE-YEARS OF PROTECTION ACHIEVED AND BIRTH AVERTED ESTIMATED USING PROGRAM OUTPUT DATA

	Conven- tionals	Orals	IUD's	Sterili- zations	CYP Grand Total	Implied Births Averted *	Total CYP's from IUD's and Sterili- zations	Implied Births Averted from IUD's and Sterilizations *
1965-66	276,000	-	467,490	12,330	756,000	252,000	480,000	160,000
1966-67	627,000	3,451	844,710	13,680	1,489,000	494,000	859,000	286,000
1967-68	960,000	1,545	1,064,880	109,170	2,136,000	712,000	1,174,000	391,000
1968-69	1,020,000	413	1,095,870	438,300	2,554,000	851,000	1,534,000	511,000
1969-70	1,020,000	373	857,400	77,220	1,955,000	656,000	934,000	311,000
1970-71	684,000	345	593,880	35,753	1,314,000	438,000	630,000	210,000
1971-72	252,000	3,811	310,950	24,840	592,000	197,000	336,000	112,000
1972-73	288,000	12,537	267,150	23,760	592,000	197,000	291,000	97,000
1973-74	480,000	189,589	1,244,710	33,460	1,950,000	650,000	1,280,000	427,000
1974-75	828,000	195,438	343,740	58,050	1,425,000	475,000	402,000	134,000
					<u>14,763,000</u>	<u>4,929,000</u>	<u>7,902,000</u>	<u>2,639,000</u>

* Method of obtaining from CYP's explained in text;
3 CYP's equal one birth averted.

the CYP calculation yields accomplishment not current prevalence, and some of the accomplishment is still in the future, i.e., the births females sterilized in 1973-74 will not have several years from now which they might otherwise have had.

3. Not all the measured reduction in birth rates and births prevented can be attributed to the program since other socio-economic parameters were in the picture: changing age at marriage, private sector purchase of contraceptives, and changing underlying age structure.
- c. Still another way of measuring program impact is in terms of contraceptive use prevalence: the number of currently practicing couples or females related to the base or target population. Using the program output data presented above and also the same program linkage parameters (one IUD inserted equals 2.5 years of protection, one sterilization equals 7.5 years of protection) to convert the CYPs achieved into current prevalence, one concludes that as of 1974-75 some two million couples were current practitioners of family planning by all means. If the base or target population is all married females aged 15-49, this is about 11 million.* This program statistic-based estimate would then indicate that roughly 18 percent of the target population was being reached.
 - d. The data from such independent surveys as the Pakistan Fertility Survey (PFS) and the National Impact Study (NIS) suggest lower impact rates, however.

* This denominator may be as low as 10 million, as high as 14 million. Nevertheless, prevalence, therefore, could vary from 14-20 percent due to the uncertainties of the over-reported 1972 census and the understated 1961 census. The team believes that 11 million is the best judgment.

The NIS reveals in 1968-69 about six percent of all currently married females were practicing contraception and about seven percent had ever practiced. The 1974-75 PFS showed similar prevalence rates: six percent of all currently married females currently using contraception and ten percent ever-used.

There is some argument that these rates are low due to a reticence on the part of females to admit contraceptive use, and also to their unwillingness to admit a husband's use of condoms--a method traditionally associated with prostitution. No data are available on this point, but perhaps the survey prevalence rates can be conceded to be a bit low.

- e. Using program output data to calculate prevalence, and accepting a fourth of the indicated current CYPs from conventionals by considering only acceptor rates via clinical methods (as per the logic on these data in our earlier section on fertility impact), then some eight percent estimated prevalence of contraceptive use results.
- f. Yet another approach to measuring current contraceptive use prevalence is to use statistics produced by the new Information Feedback System (IFS) of the Pakistan program. In ten representative districts covered by the CMS system, the registered target population of couples (wife currently married 15-44, judged to be fertile but not pregnant) can be compared to the number of current clients in the same district. This average prevalence rate is 14.4 percent for the period roughly covering 1975.

This figure seems high, and there are, in fact, unresolved problems in the data which could affect it. Primary among these is the fact that some 15

percent of the clients are reported as using no method. This suggests they have been erroneously included as users. If eliminated, the apparent prevalence rate would be reduced to about 12 percent. These client data are based on females 15-44, unlike the Impact Study and most other surveys, which used 15-49 as the age group. This smaller age group range would reduce the target population and also affect the prevalence rate.

The ten districts covered also display a fairly wide prevalence range. Sialkot, the original demonstration district for the CMS program, shows a 22 percent rate; Lahore a 16 percent. Others, less-intensively covered, range as low as 8 and 9 percent prevalence.

g. Making the adjustments and qualifications suggested above, one might conclude that the program's own Information Feedback System supports a conclusion that current contraceptives prevalence is 10 percent or under.

h. In summary, it appears that official program output (distribution) data and statistical error in translating the data resulted in overstating the real demographic impact. Using the best available independent estimates of fertility changes 1965 to 1975 suggests a maximum program impact of 2.5 million births averted. A more realistic estimate is half that, or 1.2 million births averted. This figure is consistent with the impact implied by program data, once these data are "deflated" and adjusted to give a more realistic picture. It also appears, from both adjusted program data and independent surveys, that about 8 percent of the target group females are actually practicing family planning at present. This prevalence level is considerably less than the anticipated target established for FY 78 in the AID Logical Framework.

4. The Cost of Population Planning in Pakistan

The costs of the program may be looked at in a variety of ways:

- a. There are purely financial costs for resources. How much, in financial terms, has flowed into the program allowing it to reach the production level it has? Table 4, p. 56, summarizes the financial inputs, for Government of Pakistan and foreign donors alike, during the period 1965-66 to 1974-75. Of the total inputs, USAID accounted for about 40 percent, other donor groups 20 percent, and the GOP 40 percent. In per capita terms, this was not a large sum. If one takes the program-generated CYPs (including those based on condom use) seriously, then the cost per CYP is also well within expected international ranges. This, in fact, has been the usual approach to cost-effectiveness studies of the program in the past. As we have seen, however, there is reason to suspect the validity of the condom-based CYPs. Moreover, the real product of the program is births averted, not CYPs or other such measures of program activity. Adjusting for the loss of East Pakistan in 1971, the program has cost approximately \$84 million (US) from 1965 to 1975. According to the team's highest estimates, it has prevented 2.5 million possible births for a cost per birth averted of \$34. Using the most realistic and lower figure of 1.2 million births averted, the cost per birth averted becomes \$70.
- b. Second, what are the costs in lost opportunity? The use of these resources for population planning prevents the society from using them for any other purpose. In the private sector the wage level (factor price) would reflect this opportunity cost. But in a non-competitive

TABLE 4

FINANCING OF PAKISTAN'S POPULATION PROGRAM
(In Thousands of Dollars or Rupees)

Year	RUPEES (000s)		DOLLARS (000s)		Grand Total (in dollars)
	Government of Pakistan	USAID	USAID	Other Donors	
1965-66	25,000	10,000	232	1,820	3,503
1966-67	38,500	9,515	210	1,661	6,673
1967-68	41,400	19,750	1,030	2,780	9,925
1968-69	20,700	45,957	2,297	2,665	11,628
1969-70	60,800	16,400	2,000	2,282	12,002
1970-71	64,200	--	2,078	3,297	11,790
1971-72 *	26,700	--	282	115	3,067
1972-73	26,500	--	6,569	413	9,632
1973-74	35,000	28,280	2,611	392	9,331
1975-75	40,000	21,720	8,022	2,879	17,073
1975-76	75,000	35,000	3,389	5,505	19,894
TOTAL	453,800	186,622	28,720	23,809	114,518 *

(83,981) **

* Prior to 1971-72 then East Pakistan (now Bangladesh) is included in costs.

** Total adjusted to exclude East Pakistan [(now Bangladesh) (55% of expenditures 1965-66 to 1970-71)].

public sector program, lost opportunities are those programs which could have been launched but were not because funds were channeled into family planning. Related to this cost is using administrative people to manage the family planning program when they could have been used for some other program. Slightly higher salaries plus, for upper level personnel, the hope of receiving foreign training and experience, have definitely attracted people to family planning who might have sought other government jobs.

The population planning program has come to represent a very large share of the total Ministry of Health budget. Population planning and malaria eradication took the lion's share of the budget for most of period 1965-1970, leaving little else for development of new health projects. The result: only an estimated 15 percent of Pakistan's population is marginally covered by public health and primary health care; infant mortality remains very high.

- c. The population planning program's financial costs, while not excessively high, are considerably higher per unit of output than has usually been understood. More important, perhaps, has been the tilt the program given to the overall health infrastructure. Ironically, the program may well have slowed the creation of an adequate health infrastructure--one of the programs most urgently needed for population planning to succeed in Pakistan. Table 5, p. 58, provides greater budget detail and sources of financing from FY 73-74 through FY 76-77.

EXPENDITURES ON
POPULATION PLANNING
BY CENTRAL AND
PROVINCIAL GOVERNMENTS
(in rupees)

TABLE 5

1973/74-1976/77

	FY 73/74		FY 74/75		FY 75/76		(PROJECTED ALLOCATIONS) FY 76/77	
	RUPEES	%	RUPEES	%	RUPEES	%	RUPEES	%
Central Government	14,539	17	14,598	15	21,796	20	42,920	30
Provincial Governments								
Punjab	39,977	51	49,638	52	49,799	46	57,826	40
Sind	15,951	19	18,632	19	19,879	19	23,173	16
NWFP	7,828	9	10,142	11	12,617	12	15,243	11
Baluchistan	2,597	3	2,935	3	3,056	3	4,437	3
Provincial Subtotal	(68,848)	(82)	(81,348)	(85)	(85,352)	(80)	(100,680)	(70)
TOTAL	<u>83,387</u>	<u>100</u>	<u>95,946</u>	<u>100</u>	<u>107,148</u>	<u>100</u>	<u>143,600</u>	<u>100</u>
SOURCES OF FINANCING FOR EXPENDITURES ON POPULATION PLANNING PROGRAM								
GOP Budget	35,000	42	40,000	42	74,550	70	85,000	59
Other			11,406 (1)	12	4,447(2)	4		
USAID	48,387	58	29,893	31	--		35,000	24
UNFPA			14,647	15	24,613	23	14,800	10
NORAD					3,538	3	8,800	6
TOTAL	<u>83,387</u>	<u>100</u>	<u>95,946</u>	<u>100</u>	<u>107,148</u>		<u>143,600</u>	
Fx Commodities Received (rupees equivalent)	19,950		49,054		79,490		99,400	
GRAND TOTAL	<u>103,337</u>		<u>145,000</u>		<u>186,548</u>		<u>234,000</u>	
GOP as % of Total	34%		35%		42%		36%	

1 Attributed possibly to receipts from sales of contraceptives.

2 An amount, not contributed by GOP or donors; possibly sales of contraceptives.

3 All sterilization costs controlled by Central Government.

III. ISSUES FACING THE POPULATION PLANNING PROGRAM

Policy-makers identify the future of Pakistan with mercurial market forces outside its boundaries and call for increased production of foodstuffs, cotton, and export labor to earn critically-needed foreign exchange. The population in rural areas is being asked to increase agricultural production and concomitantly to reduce the number of children per family unit. Yet, historically the former goal was accomplished by the production by family units of more hands for the field. The national leadership has yet to make clear to rural people how and why high rates of population growth tend to constrain growth in per capita income; indeed, the government's attempts generally to establish in the popular mind how family planning promotes individual well-being as it promotes the national interest have been less than adequate, notwithstanding the fact that the dynamics of this equation are not well understood even in developed countries, or within the discipline of economics.

The significance of initial and current population planning efforts conceivably lie less in their substantive achievements than in the impetus they provide now to new forms of policy and organization. Significant numbers of staff are now engaged in a common, though uncoordinated, enterprise. The scale of the investment demands that

ISSUES FACING THE POPULATION PLANNING PROGRAM

A. Population Policy

The population planning program has grown rapidly in the past decade. The many questions now being raised about its effect on fertility stem, in part, from the rapid rate and haphazard pattern of its growth vis-a-vis public investment and goal attainment. The questions being raised concern:

1. The appropriateness of national fertility goals for a target population living in semi-feudal, subsistence-level conditions;
2. The assumption that national social values are shared by a largely illiterate target population, and that this group identifies its traditional societal norms with national aspirations;
3. The effectiveness of existing arrangements by which policymakers and program managers acquire and utilize relevant knowledge;
4. The capacity of the population planning program as presently organized to affect fertility rates; and
5. The opportunity to learn from this large-scale social program and to transfer this knowledge to an enhanced national capability for addressing the population problem.

Relevant, vigorous, and well-executed population programs are difficult to design and carry out. Experience is limited, particularly for a nation which emerged out of the chaotic partition of the sub-continent in 1947, endured two wars with its Indian neighbor, and lost East Pakistan in 1971.

policy-makers be involved in re-defining the problems to be investigated and resolved before investing national leadership authority in the pursuit of solutions. Without that, the population planning program will continue as before: an inadequate response to weak signals from the Federal government; national, elitist values at variance with the prevailing norms of a semi-feudal agricultural society.

B. The Position of National Leadership

Population policy is concerned with a variety of problems that tend to be socio-economic in nature, and considerable uncertainty attaches to most policies so far devised to resolve these problems. Policy-makers seek to cope with uncertainty in a number of ways, each of which has associated costs. First, they may seek additional objective information, at the cost of time-- a critical limiting factor. Second, they may narrow the definition of the situation and the number of factors to which they attend, at the risk of unanticipated trends or events overwhelming decisions. Third, the alternatives considered may be limited to those on which a sufficient consensus exists to provide a basis for action; the possible cost is that expenditures rise without a comparable increase in effectiveness. This last approach has been the Pakistani model in population planning.

In this third context, political consensus is important. Yet its importance to the population program diminishes in direct proportion to the extent to which policy-makers continue to rely upon that justification for spending and attracting funds rather than upon demonstrable achievements.

There is general consensus on the part of those interviewed by the team that Prime Minister Bhutto is interested in and supportive of the population program, but unwilling to take a strong, visible stand until after the election. Begum Bhutto's recent public involvement in program activities is read by many as an indicator of the Prime Minister's continued support during this period of political consolidation.

The most direct impact of a strong stand by the Prime Minister is thought to be on the government itself and on the Population Planning Council/Division--from where repercussions would then quickly reach the field level. On the other hand, some think the rural population would not be as greatly influenced by the Prime Minister's public stand as they would be if an admired person closer to their lives made such a declaration.

Still others believe a strong, supportive policy statement by the Prime Minister would strike responsive notes in the private sector, among voluntary associations, and in profit-making enterprises. They feel that latent

interest in the population program is widespread, and that numerous organizations would be willing to support its goal if asked to do so.

Yet, among the educated professionals, as well as within a broad segment of those who are less educated, conservative factions do exist. Some of these do not favor the population program because they feel a need for military strength and manpower development. This conservative opposition could be strong enough to make the Prime Minister cautious about expressing his views on population planning before an election.

While these positions all have some merit, the team believes that the more fundamental problem lies in the narrow bureaucratic focus of the population program, which reflects a perception among the national leadership that the population problem is solely a government responsibility. In its planning documents, the government acknowledges that rapid population growth constitutes a multidimensional problem requiring a multi-sectoral approach for solutions. Yet, the government's placement of population planning authority in the Ministry of Labour, Manpower, Health, and Population Planning--a ministry which has rigidly adhered to strict compartmentalization of program responsibilities--has inhibited population planners from implementing a broader, multi-sectoral approach. The population program should be the

responsibility of a ministry which has the authority both to communicate across inter-ministerial lines and to influence the lowest administrative unit of local government--the Tehsil Dar.

C. Village Socio-Economic Dynamics and Family Planning Strategies

The so-called economic model of fertility maintains that the family size decision is based on a fairly rational assessment by couples of expected future benefits and costs of various family sizes. This assessment includes decisions about work versus leisure, choice of agricultural technology, and so on. This model, carried to its logical conclusion, would deny the ability of a population planning program to change intended, or optimum, family size with mere publicity or educational efforts. In this framework, population control programs could increase the efficiency of couples already practicing contraception, but no more. This model is generally accepted in most countries as an adequate picture of the decision-making process, although the costs and benefits are complex and hard to quantify.

Some have argued that the economic model is refuted by rural farm households in Pakistan where the completed family size approaches natural (i.e., totally unchecked) fertility. It is important to see that, in fact, the very opposite is true. Under conditions prevailing in

most villages, the costs of children are low. For example, education is purely local and minimal, with no out-of-pocket expenses involved; pregnancy, birth, and infant care are totally household functions and almost free; children have no special diet and eat last in the household; frequent pregnancies are not inconsistent with female work routines and there is, thus, no "opportunity cost". Furthermore, labor services are rendered by children at very early ages. Where land is limited, applying more labor per unit of land to increase yields is a primary method of raising output. Children are also the only real opportunity to store capital for the future, either for economic security or for future productivity. Some, in particular, are also a very real source of physical security in a countryside where village feuds and occasional violence are not unknown. All these factors lead to the conclusion that rural villages in Pakistan may illustrate the continued villager perception that optimum family size is as large as possible to provide a human capital supply.

The only meaningful costs are the human psychic and physical costs of the repeated pregnancies to the females, and this begins to be important only at very high parities. Thus, with rare exceptions, the village women view family planning as a way of ending child-bearing

a little earlier than usual; but only after they have met most of the large demand for children by their households.

This picture is quite consistent with numerous socio-economic cross-sectional studies of village life in Pakistan. The picture is one of family units doing their best to cope rationally with the circumstances imposed upon them by nature and the larger economic and social system. This picture can change rapidly once these external forces shift, but perhaps not before. Changing the availability of key inputs--water, electricity, fertilizer--will affect their production decisions; changing the availability of education, health services, or off-farm employment will affect the picture also.

There is no reason to doubt, however, that there exists a critical threshold where enough changes lead to a reduction in the optimum family size. In urban areas, this has apparently already been reached for many households. In some prosperous, commercially-oriented rural areas, it is likely to be reached soon. But, for many rural areas, population control efforts may represent seed on stony ground for a long time. The people's expressed knowledge of family planning is far from sufficient to transcend the powerful pronatalist influences.

D. Program Planning and Management

Pakistan's transition from a government bureaucracy run by the elite and highly esteemed Civil Service of Pakistan (CSP) to one now including civil servants whose backgrounds and skills are varied and uneven has had considerable impact on the implementation of social sector development, including the population program. The record of high managerial expertise of the CSP officers was essentially unchallenged for many years. The British had convinced the some 100 retained Pakistanis--those who were members of the Indian Civil Service (ICS) prior to the 1947 partition--that their training was superior and appropriate, and their experience in the Civil Service of high tradition and national value. Those staff of the now discarded CSP continue to hold positions of critical importance to Pakistan's future progress. Many serve with distinction.

Parallel to the discontinuance of the CSP was the rise of government program managers who came from more common backgrounds. Some are trained in management, more learn from experience, still others profit from a combination of both. Their management characteristics and style, however, are different from the CSP group. This difference frequently creates interactive barriers between those previously with the elite CSP and those with a more indigenous background.

Many of the people interviewed, with notable exceptions, now question the planning and management expertise of public sector managers, whether previously associated with the CSP or not. Specific time-phased planning and programming techniques, such as PERT or Critical Path models, are not used. Budgeting procedures continue to rely upon outmoded presentation and utilization formats. Management decisions are more subjectively based than quantitatively derived. Management information systems are either non-existent or awkward and slow.

As noted by the team in the foregoing sections, authority and responsibility within the population planning program are seldom redelegated. Job descriptions are insufficiently defined or grossly exaggerated, frequently overlapping with other program units, e.g., training activities and research endeavors.

Aggravating the planning and management problem and contributing directly to program inefficiencies in considerable measure are nepotism, favoritism, and the politicization of the personnel system. While the team does not have direct evidence of this misuse of public trust, the issue has been raised by individuals within the Population Planning Division and the Provincial Population Planning Boards, and by the public at large. The team is led to believe that these allegations,

though unverified by us, do not serve the best interests of the program. To the extent they remain, the program's marginal effectiveness will dissipate further.

Further, the team notes with great concern the implicit assumption on the part of most population planning officers that they alone can solve the population problem in Pakistan. Such esprit de corps would be well-placed if the population problem could yield to a one-dimensional approach. But, this is the case neither in Pakistan nor in any other country of the world.

A comprehensive fertility control program, orchestrated by the national government, and one which should embody every private and public resources of the country, necessitates an unparalleled degree of program planning and managerial competency. The planning and management requirements of a malaria or smallpox eradication program pale when compared to the prerequisites for an effective population control program.

The current characteristics of program planning, management, and administrative systems will not change rapidly. Incrementally, however, improved concepts and techniques can be introduced to senior and junior staff. Basic quantitative programming and budgeting skills should be instituted--e.g., using rankings as in the Information Feedback System; programming skills like PERT;

improved budget presentations, combining or correlating specific expenditure inputs with program outputs and achievements; and improved principles of supervision, group dynamics, and personnel counseling.

Many of these techniques are relatively new concepts to the current program staff. Hence, resources outside the Population Planning Division, though within Pakistan, must be utilized if new levels of management and planning expertise are to be achieved.

E. Donor Assistance to Pakistan's Population Planning Program

The appropriate style and magnitude of foreign development assistance to any recipient government or agency is always a gnawing issue. What are the objectives of the assistance? Friendship, institutional development, improvement of human and capital resources, equity, national self-reliance, long-term financial independence, alleviation of guilt generating from the maldistribution of wealth and resources? Donor agencies endorse most, though not necessarily all, of this partial listing of objectives.

A related issue is the degree to which foreign assistance is contingent upon, or licenses, mutual collaborative planning and rights of program audit. Understandably, the donor expects a reasonable accounting

of that assistance and desires evidence of the program impact contributed by the assistance. At the same time, recipients of foreign assistance generally acknowledge responsibility to provide financial accountability and evidence of the impact resulting from the foreign-provided input.

A larger responsibility lies with determining the manner in which funds or assistance are used after, rather than before, an agreement for foreign assistance is mutually signed. Further, the appropriateness of alluding to larger future assistance, if a more immediate assistance program is accepted and utilized, is still another responsibility.

The team's review of the Pakistan population planning program indicates considerable concern, expressed by government officials and private groups, that foreign donors (implying AID) have played an overly prominent role in the design of Pakistan's population planning program. The creation of a vertically structured program separate from the health system, and the implementation of the CMS scheme are two major examples offered.

In many respects, the Pakistan population planning program is perceived as an AID program. Whether the charge that a vertical program structure and a CMS scheme were imposed by AID upon the government is true or not,

AID is nonetheless being held to this account by other donors and nationals alike.

This program has had a long association with U. S. advisory technical assistance and financial assistance, a history perhaps longer than that found in any other national population program outside the United States. The basic role played by AID in Pakistan is, nevertheless, consistent with many, though not all, AID Missions.

From this background there is now a growing conviction among the Pakistanis that the program must "nationalize". Currently expressed policies of the Population Planning Division suggest a powerful "Pakistanization" of the program, with a lessening role for foreign advisors.

AID's broad-based financial assistance to the emerging Expanded Population Planning Program of the mid-1970s in Pakistan was appropriate then. Though the output was not as great as anticipated, the process provided numerous lessons of experience.

Pakistani program leadership now states that modifications will be made, management improved, accountability increased, and fertility impact heightened. This has all been said before.

Population planning is a Pakistani problem; ultimately, it will yield to Pakistani solutions. The government must

bear the moral responsibility and accountability for its success or failure. Donors, like Alexander the Great and others who followed his path into the subcontinent, ". . . are mere birds in passage."

IV. RECOMMENDATIONS

RECOMMENDATIONS

A national population planning program of the magnitude described herein should contribute to the confidence of Pakistanis in their government. Yet, evidence has mounted over the past several years of a conflict between Federal policy and its implementation at the Provincial level, particularly as it concerns the intended beneficiaries. Many initiatives have been undertaken on both sides to reduce the incompatibilities and communication gaps. While some progress has been made, serious questions remain about the net value of the almost \$84 million public investment during 1965-75 and of the net effect of the estimated \$24.3 million investment for FY 76-77.

The need is urgent for the Government of Pakistan to recognize that the organization of and responsibility for the population planning program has critical implications, not only for the future well-being of Pakistani society, but also for the democratic values to which it purportedly adheres.

The following recommendations result from the FHC team's review of its findings during the month of November 1976, and from its consideration of the major issues presently confronting the population planning program. Obviously, the current program is in a significant transition period. The focal point for the major recommendations is, therefore,

directed toward the 1978-79 period. These recommendations are offered as long-term goals, not as short-term changes to occur within months. More importantly, the recommendations must be considered as interdependent variables. Acceptance or rejection of any will influence the others.

A. The Role of the Prime Minister

The Prime Minister, because of his paramount role as the single authoritative decision-maker for the government, is in a position to address the whole of society's problems. The advantages of office give him the potential capacity to relate a multitude of issues to a set of reasonably coherent national policies.

The Prime Minister should invest his authority in the formulation of policies to insure inter-ministerial support and cooperation for reduced fertility rates, and designate accountability throughout the administrative structure of the government, from Chief Minister of the Provinces to the Deputy Commissioners, for program compliance.

B. The Government of Pakistan's Population Planning Organization

Subsequently, policy implementation for population planning should be organized (1978-79) around a Population Planning Coordination Council (PPCC) as an integral unit of the Federal Ministry of Planning, Finance, and Economic

Affairs. Population planning policy would be established by an Advisory Council of Federal and provincial authorities representing the interests of civil administration, health, education, agriculture, social welfare, information, etc., plus representatives of the private sector (and quasi-governmental), e.g., health, social security agencies, industry, unions, and concerned, respected citizens. The PPCC unit should be administered by an energetic individual of significant esteem in society and of the highest managerial talent.

The Population Planning Coordination Council unit, considerably smaller in staff size than the current PPD, would have a highly talented senior level planning and administrative staff supplemented by a data systems, research, and evaluation unit. The unit would direct and coordinate allocations of all domestic and foreign assistance to extant government and private sector agencies. For example, the Health Ministry would assume responsibility for a large portion of clinical services and perhaps for logistical requirements: warehousing and transportation of consumable contraceptives and health-related equipment. Provision of motivational activities and contraceptive/sterilization services would be totally integrated with all rural primary care services provided by the rapidly expanding rural health auxiliaries program and the incorporated Family Welfare

Visitors and Clinics. Also, the Pakistan Institute for Development Economics (PIDE) might be asked, on a contract basis, to conduct major research or evaluation activities. Similarly, other agencies would assume major responsibility for coordinated implementation of population components within their technical jurisdiction, e.g., population education and information services through radio and TV, public and private social welfare institutions, agricultural extension workers, and integrated rural development staff.

At provincial and district levels, a smaller PPCC would serve a similar function as the technical coordinator for the Chief Minister of the Province and the Commissioner/Deputy Commissioner, each charged with responsibility for program compliance and success.

Current PPD managerial and technical staff would, therefore, be dispersed in part to the PPCC and in larger part to the current components of the broad government apparatus delivering social services.

Simultaneously, with a fully supported government apparatus, the Federal PPCC would enter into written agreement or contract with a variety of groups and individuals for the staff training and the additional delivery of information, persuasion efforts, and contraceptive/sterilization services. These groups and individuals might include private advertising and marketing agencies,

associations of health providers, physicians, hakeems, nurses, and private service agencies, e.g., Family Planning Association of Pakistan, Pakistan Medico International, Red Crescent, Social Security Administration, Trade Unions, industries, and corporations. All public and private institutions acting as implementors of the program would enter into written contracts with the Federal PPCC for specific PPCC-funded activities.

The team wishes to re-emphasize that these field integrative efforts are predicated on a vastly increased priority for population planning efforts by national leadership.

Prior to the establishment of the PPCC, a study group should be commissioned by the Ministry of Planning, Finance, and Economic Affairs to:

Determine the appropriateness of a pre-selected target population vis-a-vis cultural values, accessibility, receptivity, and costs. Most likely, these target groups will be found among salaried income families, and those who earn incomes from the rather steady sale of commodities. This should not suggest an abandonment of the present target population in rural, agricultural areas. The intent is to give the population planning program an opportunity to demonstrate impact and effectiveness in that portion of the population most amenable to, and most able to afford, change. A useful role model within the Pakistani context is badly needed by the present target population which may aspire to change as their socio-economic conditions warrant. Broad-based educational efforts should still be directed at this group; the priority for the allocation of resources toward the acceptance of population planning practices should be aimed at the groups most likely to alter their life styles.

In summary, a Federally-established coordinating agency within a broad, powerful ministry would control and direct domestic and foreign funds to a spectrum of public and private agencies capable of providing services. The full spectrum of fertility control services, with appropriate information, would be available through public and private health agencies, commercial outlets, and places of employment.

C. The Population Planning Division in the Interim

In the interim period, prior to the initiation of the PPCC (1978-1979), the team recommends that the Population Planning Division:

1. Identify one or more program-oriented Pakistani management consulting firms or management training institutes which, with the assistance of senior program officials and possible short-term consultative services of foreign health/population planners, can design and implement on-the-job management training programs.
2. Incorporate into population training programs provocative motivational concepts which will enhance staffs' attitudes toward their jobs and responsibilities.
3. Broaden the cooperation and collaboration of other public and private sector groups that are critically needed in the population planning program. Discussions should be followed by written confirmation of PPD's interest in their involvement. Enter into written agreements with public and private groups to provide designated activities for agreed-upon assistance from the GOP/PPD. To the greatest extent feasible, allow the private and public agencies to function independently in the implementation of their

agreed-upon work activities following written agreement between the particular agency and GOP/PPD.

4. Reconsider carefully the more immediate feasibility of field level integration of Family Welfare Clinics into the government's Rural Health Scheme, on the precondition that the government agrees to provide top priority to MCH/family planning within its developing primary health care system.
5. Enhance supervision by creating an atmosphere in which program managers personally assist in the resolution of field problems rather than merely "inspecting" staff during site visits.
6. Increase the project testing prior to implementation of field programs. Avoid precipitous actions which might create long-term problems. For example: (a) proceed carefully in the efforts to involve the hakeems; be extremely concerned with their particular practice biases so as to avoid any error which might alienate them, and (b) seek additional counsel from rural sociologists and anthropologists before testing the feasibility of identifying and incorporating influential village women into the program.
7. Accelerate the dialogue with newspapers, journalists, and the Pakistan Broadcasting Corporation. Plan for a national working conference to inform the mass media of the current and projected program.
8. Initiate a sustained dialogue with trade unions and private sector employers to elicit their support for the program. Discuss this strategy with ILO staff in Islamabad.
9. Consider posting an additional Family Welfare Visitor to each existing facility rather than create more singly-staffed clinics. With two FWVs per clinic,

professional dialogue can increase, the clinic can remain open and staffed while one staff member engages in home visits, and overhead costs of rent and maintenance will be minimized. Provide Urdu language medical diagnosis and treatment protocols (procedures) to each student and practicing FWV.

10. Enhance the development of the communication strategy by appointing an individual with community organization skills to a top leadership position. Mass media experts can reinforce the message, but the fundamental problem is the need to mobilize the village.
11. Initiate special analyses from CRS data to determine the acceptors' age-parity by specific contraceptive. This will provide further clues to weaknesses in prescribing "spacing" methods, i.e., condoms and OCs, for women who need more permanent fertility control.
12. Avoid insufficiently planned female sterilization programs. Incorporate male sterilization efforts into the feasibility and planning efforts. Restrain the emerging attitude that the sterilization program is the only effective means of fertility control.
13. Improve immediately the quality and quantity of locally manufactured IUDs. Use contraceptive sales-generated funds to procure new IUDs and injectable contraceptives not available from donors.

The team recognizes that most of these suggestions have been made by Pakistan and outside reviewers over the past few years. The government is encouraged to consider the suggestions offered and determine the appropriateness of implementing these recommendations as soon as possible. Within Pakistan, time means more births. The need is now.

D. The Agency for International Development

Under the assumption that the government improves the population planning structure and operations, and that AID seeks a lower profile assistance role in the program, the team would then recommend for the Agency's consideration the following future projects:

1. Population Research and Development

The team supports the current proposal for creating a Population Research and Development (R&D) project. Its purpose is as follows:

Selectively enlist the support of major employers, village organizations, public and private research organizations, and enlightened citizens in the development and implementation of well-planned innovative programs to encourage small families.

The proposed project assumes that Pakistani organizations exist to implement the research, that the government has the interest to coordinate and stimulate the specific activities, and that together with the private sector they will actively participate in meetings, conferences, etc., designed to disseminate and utilize research, pilot and demonstration project results.

This grant-financed project between the government and AID could fund, on a sub-project by sub-project specific basis, research, feasibility studies, innovations, and experiments. For example:

- a. Conduct a 1,000-household contraceptive distribution project to understand the degree to which free

and/or priced contraceptives available within the house will influence current use. The team believes that this experiment is critical to understanding the assumption that household availability will increase the prevalence of contraceptive use in Pakistan.

- b. Convene working conferences of hakeem educators, physicians, and population planners to develop appropriate population materials for Tibia Colleges and practicing hakeems.
- c. Test the feasibility of determining, identifying, gaining access to, and incorporating village "influential women" into the supply of information and contraceptive delivery scheme.
- d. Test various incentives and disincentives and their affect on fertility.
- e. Create and develop private sector family planning service programs, e.g., Pakistan Railways, WAPDA, etc.

This project, in summary, provides high-risk, high-gain funds to enlarge the innovation, adaptation, and basic knowledge of the population planning efforts.

2. Population Management and Services Project
(FY 79 forward)

The purpose of this project would be to increase the prevalence of contraceptive use through available and accessible family planning services supported by improved program management and logistics. The foreign exchange elements would include oral contraceptives and other U.S. available contraceptives as demand and reasonable supply levels warrant, and sterilization equipment not available at lower prices within Pakistan.

A rupees currency component would provide for jointly agreed-upon activities for in-country training and development to improve the managerial and logistical capability of the population planning agency at population planning units within public and private institutions at Federal, provincial, and district levels.

3. The team recommends that excess PL-480 currencies (Mondale rupees), if available, be used only for specific field activities or projects. For example:
 - a. Local procurement of medical instruments for minilaparotomy and vasectomy kits.
 - b. Payments of up to Rs. 50 to medical institutions on a per case basis for sterilizations. This money would be advanced to avoid immediate cash flow problems.
 - c. Local procurement of bicycles (for male workers) and motor vehicles appropriate for program needs.
 - d. Expansion of sterilization facilities in rural areas: district hospitals, rural health centers, etc.
4. In view of the U.S. Government's procurement constraints, AID is encouraged to discuss these limitations with UNFPA or other donors and participate in identifying donor assistance for Japanese-produced vehicles, Japanese AV equipment, Depo-provera, and other items required by the program but not yet available through USG procurement channels. AID should not procure paper or film stock but assist the Government of Pakistan in identifying other donors willing to provide these commodities.

While the above recommended projects require considerable documentation prior to authorization of funds, the team

recommends that AID seek approval for concentrating its assistance in FY 77 and FY 78 along the lines outlined above.

E. The Pakistani-Donor Community: Future Foreign Assistance

If the government continues to seek foreign assistance for population planning activities, the FHC team believes that both donor agencies and the government bear responsibility to further define the parameters of mutual collaborative efforts. Donor agencies must collectively decide who among the donors can best and most appropriately coordinate and speak for the donor community. While each donor agency might relate to the government independently, the team believes that this approach generally leads to misinformation, competitiveness, and redundancy resulting in unnecessary burdens on the government. No one's best interests are served.

Alternatively, the donor community--through frequent informal exchanges and less frequent "formalized" gatherings--can select a spokesman who can arrange for formal dialogues and assist the recipient government by informing them of the particular interest areas, constraints, distinct capabilities, and expertise of the component members of the entire donor community. The spokesman might further

assist by actively expanding the interest of the donor community so as to provide increased foreign assistance combined with a broadened endorsement and legitimization of the government population control efforts.

In recent years this leadership role has been increasingly assumed throughout the world by a multi-lateral agency: UNFPA, UNDP, or the World Bank. AID, the government, and other donor agencies should consider the option of the UNFPA acting as the senior spokesman for the population assistance donor community within Pakistan.

AID should take on a decreasing leadership role while encouraging broader donor assistance to Pakistan's population planning program. By confining assistance to more specific activities, AID and the government can better engage in the collaborative design and review of critical segments of the program. AID's rights of overall program review would be minimized. Rights of specific project activity through mutual collaboration should be enhanced.

V. EPILOGUE

EPILOGUE

On the day of FHC's departure from Pakistan, the team learned that the Population Planning Division was granted centralized authority over the entire population planning program field apparatus. This decisive federalization provides further evidence that the central government is genuinely concerned about the lack of program progress: it is willing to withdraw traditional provincial authorities despite the proximity of the general elections. According to Pakistani leadership, federalization may solve two of the more pressing problems: nepotism within the field personnel system and non-coordinated communication activities.

But, it may well create another problem which has been long festering within the Federal Ministry of Labour, Manpower, Health and Population Planning: the operational and programmatic failure to integrate Health and Population Planning. It has been explicitly stated to the team by senior authorities in the PPD that the Population Planning Division will coordinate and collaborate its activities with Health--but it will not integrate them. Unfortunately, AID is an active participant in these disparate, duplicative, and unnecessarily costly efforts which, for example, at the

field level, may well result in the siting of both a Family Welfare Clinic and a Basic Health Unit in a village having neither service at this time.

Further, the federalization decision may aggravate another longstanding problem: the sense of program alienation on the part of the other public and private agencies which, in our judgment, are of critical importance to a successful fertility control program. Authority and responsibility for nearly all other social services continue to be placed on the Provinces, not through a federally controlled apparatus.

Improvement in program outputs--increased new and current contraceptive acceptor rates--will, therefore, depend most immediately upon how successfully an increasingly powerful and centralized Population Planning Division can generate program participation of: non-federalized public agencies such as the Health Ministry; a profit-oriented private sector; and a heterogeneous semi-feudal rural society.

Providing for full and effective participation of these groups in the effort to reduce fertility will not be an easy task, but improvements in the program are dependent on the generation of new energies and resources at every level of Pakistani society and in every sector of its economy. The need for immediate progress in

APPENDIX

A LISTING OF
INSTITUTIONS INTERVIEWED
BY FAMILY HEALTH CARE, INC.

November 5-30, 1976

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INSTITUTIONS INTERVIEWED
BY FAMILY HEALTH CARE, INC.

November 5-30, 1976

Akhlaq and Owais Consulting Group, Lahore

All Pakistan Women's Association, Lahore and Karachi (APWA)

Australian Embassy, Islamabad

British Embassy, Islamabad

College of Family Physicians

Dawn, English Newspaper, Karachi

Family Structure and Fertility Outcome Project

Family Planning Association of Pakistan (FPAP), Karachi, Lahore

Ford Foundation, Islamabad

German Agency for Technical Cooperation, Population, Planning
Coordinator, Islamabad

Government of Pakistan

- o Federal Minister for Health, Population, Planning, Labor and Manpower
- o Population Planning Division, (including Directorates in Islamabad, Lahore, Hyderabad, Karachi)
- o Population Planning Board
 - Baluchistan
 - Sind
 - Punjab
 - NWFP
- o District Population Planning Board and Related Field Operations and Staff in:
 - Lahore
 - Karachi, South
 - Hyderabad
 - Peshawar
 - Quetta
- o Census and Registration Organization, Census Division
- o Prime Minister's Representative on Administrative Inspection

- o Provincial Health Offices Including Training and Service Facilities
 - Punjab
 - Sind
 - NWFP
 - Baluchistan
- o District Health Offices
 - Peshawar
- o Institute of Hygiene and Preventive Medicine, Lahore
- o Planning Division, Islamabad
- o Ministry of Religious Affairs
- o Pakistan Institute of Development Economics, Islamabad
- o Rural Development Directorate, NWFP
- o Institute of Manpower Development
- o Pakistan Broadcasting House, Karachi and Lahore

Government of Pakistan Authorities

- o State Life Insurance Corporation, Karachi
- o Employees Old Age Benefit Institution, Karachi
- o Employees Social Security Institution, Punjab and Sind

Hamdard Laboratories, Karachi

International Labor Organization

Lady Wellington Hospital and King Edward Medical College, Lahore

Lipton (Ltd) Pakistan

Pakistan National Federation of Trade Unions

MNJ Advertising Company

Muller and Phipps (Pakistan) Ltd

Nawi-e-Waqat (Newspaper), Lahore

Nursing Council of Pakistan

Pakistan Medical Association (PMA)

Pakistan Management Institute, Karachi

Pakistan Medico International (PMI), Saghrabi Millwala Hospital,
Karachi

Tibia Committee and Hakeem Board, Lahore

UNICEF Representative, Islamabad

United Nations Fund for Population Activities (UNFPA),
Islamabad

University of North Carolina, Population Intern

USAID, Bureau of the Census

USAID MIT Nutrition Project

USAID Mission to Pakistan

U.S. Embassy, Economics and Political Section

World Health Organization (WHO) Representative to Pakistan

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