

Family Planning in Pakistan 1955 - 1977: A Review

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There is a general feeling that the population planning programme in Pakistan has reached a critical turning point. Despite almost 20 years of vigorous effort and the expenditure of about one billion rupees and some 70 million U.S. dollars, family planning has achieved no tangible decrease in fertility rates. Pakistan has a population of about 75 million today and this is expected to double by the year 2000. To put the matter quite bluntly, the family planning effort has not succeeded. Discouragement, disillusionment and recrimination threaten to replace the earlier enthusiasm and optimism among supporters of the programme. But while such emotional reactions are understandable they are not helpful. What will be useful is a careful review of these years of experience to learn whatever is there to be learned, for population planning in Pakistan will go on.

The present article reviews family planning in Pakistan, 1955 to 1977, to see what has been learned which can be of value to future planning. Since nearly all phases and aspects of the programme have been written up elsewhere [3, 4, 9, 20], no attempt is made to undertake an exhaustive descriptive or historical documentation of the programme's evolution. Rather, we focus on the main assumptions, strategies and organizational changes through which the programme has passed.

EARLY "PRE-PLANNING" PERIOD

Positive government policy towards family planning in Pakistan goes back as far as does economic planning itself. The First Plan (1955-1956) to 1959-1960) endorsed the philosophy of family limitation and disbursed about one million rupees, in grants to private associations and family planning clinics

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[15]. The Second Plan (1960-1961 to 1964-1965) took a more forthright position on the impact of unchecked population growth and spent some 15 million rupees for extending services, for training of medical and paramedical personnel, for educational work and for contraceptive research [16]. The mid-plan review (in 1963) claimed impressive statistical achievements including extension of family planning services to over one thousand existing health centres, and the training of several thousand health visitors and village level workers. A training-cum-research project by the name of Medical Social Research Project (MESOREP) was also established in Lahore with the cooperation of the Population Council (New York USA) and the Johns Hopkins University (USA). The Medical Social Research Project (MESOREP), continued to operate for the next ten years [17].

However, after this apparently promising beginning, the 1965 review of these efforts was more critical. The achievements were judged to have fallen below expectations due to: Lack of motivation in the general masses; unsatisfactory arrangements for the distribution of contraceptives; inadequate education and information of the masses in family planning; shortage of administrative personnel; the programme was administered as a normal function of the existing health services with the result that doctors and other health personnel running those services were over-burdened with clinical work and could not give adequate attention to family planning [12, p. 36].

THE NATIONAL COMPREHENSIVE FAMILY PLANNING SCHEME

The major effort at family planning in the public sector dates from 1965 when a comprehensive, detailed scheme was adopted as part of the Third Five Year Plan. The original scheme called for spending 160 million rupees but considerably more was actually spent as the programme developed [12, 22].

The scheme set as its five-year target a reduction of the birth rate from 50 per thousand to 45 per thousand, or nearly 20 percent.¹ The scheme was to reach the entire nation in a three year start-up period and was to provide services to some 20 million couples in the country.

The Scheme made clear its fundamental assumption that family planning can be approached as an administrative function. "It should be recognized that family planning is essentially an administrative and not a clinical programme." Success of the programme was thought to depend upon: efficient distribution of supplies; and motivation of the people.

An elaborate administrative apparatus was created to undertake these tasks. There was a Family Planning Council at the Centre and Family Planning Boards at the Provincial and District levels. All the Union Councils were associated with the programme. The family planning work at the local level was looked after by a Family Planning Officer (one for 3 Union Councils). At the bottom of the hierarchy was the village *dai*. She performed such functions as motivating the people and distributing contraceptives. At the national level the programme was supervised by the Family Planning Commissioner who headed a new Division in the Ministry of Health, Labour and Social

¹This birth rate of 50 was based on early results from the Population Growth Estimation Study (PGE). It now seems clear this figure was too high, as a result of a methodological error. See: [2].

Welfare called the Family Planning Division. The commissioner also served as secretary of the National Family Planning Council, chaired by the Health minister. The scheme provided for 1,000 Family Supervisors who worked with the Union Council Secretaries. A total of 20,000 village *dais* were employed, at the rate of one *dai* for two villages. About 1,200 part-time family planning doctors, at the rate of 6 for each Tehsil, were registered and appointed for the purpose of IUD insertions and clinical sterilization.

The key people in the programme thus were: the Publicity-cum-Executive Officer at the district level; the Family Planning Officer (one for three Union Councils), and the Publicity-cum-Executive Officer was equipped with a jeep and designed to be the "trouble-shooter" for the programme in his district; the Family Planning Officer at the local level, in the words of the Scheme, was to "tour in the villages, disseminate information and motivate the public on this programme, and guide, supervise and assist the village *dais* in their work". One jeep per tehsil was provided for the officer. The village *dais* were the local level motivators and also contraceptive supply agent.

Supply outlets were established at the local level for conventional contraceptives including village shopkeepers, stores, pharmacies, medical houses and other public or private, local bodies. The goal was one "agent" per 1,000 population and in practice this was usually also the *dai*.

Within this rather elaborate apparatus, relatively few of the personnel were actually full-time salaried persons. The secretariat of the Family Planning Council and the research and evaluations units were staffed by whole-time persons. In the provinces whole-time personnel include the administrator attached to the Provincial Family Planning Board, and the Family Planning Supervisors. The Union Council secretaries received a small salary for working with the Family Planning Officer. The selected village *dais* received a small salary in addition to their referral fees.

On the more purely clinical side outside the urban areas there was no whole-time staff. The Plan called for six doctors, lady health visitors or registered midwives per tehsil. These were mostly government doctors or private practitioners paid retainers of modest amounts in addition to the fees they could earn for operations or IUD insertions.

In the urban areas, there were established 21 whole-time clinics and 318 part-time clinics. The part-time clinics were housed in existing health facilities (health centres, hospitals and the like). The clinics, whole and part-time, concentrated on IUD insertions and vasectomies-tubeligitations.

The Plan aimed at widespread coverage and participation. Rather than emphasizing clinics and health centres as the means of reaching the people, the Plan used the local village *dais* as the chief agents, the regular political (District and union council officials) as the administrative apparatus, and medical, para-medical and lay personnel as the implementers of the programme. Most of these part-time or paid on an incentive basis. Indeed, the Plan placed strong emphasis on monetary incentives to all the part-time personnel connected with the programme.

For each vasectomy both doctor and the client will be paid Rs. 25. Insertions of IUDs will be free for the client. For each insertion doctors will be paid Rs. 7.50 and other Rs. 2 for referring cases leading to an insertion. A 50 percent rebate on the cost of contraceptive will go as commission to the sellers [12, p. 268].

The scheme provided for a National Research Institute for Family Planning (NRIFP) pursuing both clinical and socio-psychological research. The existing demonstration project in Lahore, MESOREP, was continued and several Training-cum-Research Institutes were created. Funds for both domestic and foreign training of staff were also provided.

This scheme was launched as planned. Drawing upon the Lahore-based Medical Social Research Project, Population Council and USAID advisors, the programme quickly trained and put in place the administrative organization. A flow of progress reports and data were generated, published and analyzed. MESOREP, the National Research Institute for Family Planning (NRIFP), The Pakistan-Sweden Family Welfare Project and other groups undertook surveys and related field research. A new journal was started (*The Pakistan Journal of Family Planning*, 1967-1971) and a series of Biennial Seminars were sponsored to discuss and evaluate the progress of the programme.

The speed with which the programme was launched impressed everyone, as did its size and scale of operation. The Pakistan programme received considerable attention abroad and a steady stream of visitors came to see at first hand what was called by some as an administrative 'model' of how to build family planning programme. Most observers judged it to be one of the first successful national programmes. The Pakistan programme trained its own staff at the leading population centres abroad and, in turn, provided a training ground for numerous foreign experts. The famous "couple-year of protection" notion was developed for use in Pakistan [5, 24]. USAID and other foreign donors involvement grew and budget was expanded greatly over the original allocation. (Table 1 presents summary of financial inputs to the programme). The Family Planning Council became the Population Planning Council, an autonomous agency. Some even attempted to 'explain' why the Pakistan programme had succeeded so much better than had the Indian programme right next door [8].

To be sure, there were some discontents about abuses in the incentive payment system and some doubts expressed about the accuracy of the performance data. But, such problems were viewed as "growing pains" and most observers remained quite favourable. A high-level UN/WHO advisory mission evaluated the programme in 1968-1969 and found generally positive things to report. An AID evaluation in this same period and also numerous world Bank reviews reached similarly positive conclusions [21].²

² In 1968, a USAID report said glowingly: "at the midpoint of the Third Five Year Plan there are ever-increasing indications that Pakistan's ambitious family planning targets will be achieved" [21, p. 128]. The UN/WHO report did have some quiet reservations. "The success in making family planning widely known and even favourably viewed by many people does not unfortunately ensure that the practice of family planning will be widely adopted but . . . it is in itself a considerable achievement" [21, p. 125].

In spite of its apparent record of success this first phase came to a rather abrupt end in 1969. Top leadership in the programme changed and the new commissioner and secretary, quickly unveiled his own revised programme.

In assessing what he felt were the weaknesses of the first scheme, the new secretary noted several points:

- (a) the key roll played by the largely illiterate, poorly trained part time *dais*.

In 1965 we attempted to form a field organization by employing 'dais' (mid-wives) as part-time field workers in the localities where they were deployed. Most of the women were illiterate, and many had no previous experience as midwives. They were not required to keep any record of their effort or achievement. The training they received never went beyond what an illiterate middle-aged village woman, working part-time for a very small income, could or would acquire. The programme executive in a local area (the Family Planning Officer) usually worked with 50 to 70 *dais*. His involvement in the effort of his field staff often remained limited to pressuring them to achieve prescribed targets in clinical service and contraceptive sales. If a *dai* failed to refer the required number of clients to a clinic over a period of time, she would be replaced by a new recruit. The replacement rate, at times, as high as 40 percent a year, often presented an additional problem in training [3, p. 6].

He went on to point out that as late as 1970 some 20 percent of the field positions of *dais* and Family Planning Officers were not filled. In short, the key "grass-roots" organizers had not succeeded in their tasks. The intended role of the other local persons—union council secretaries and local outlets had never materialized at all.

Table 1

Funding of Population Planning in Pakistan, 1960-1976

Source	Cumulative Total	
	Rupees	Dollars
Government of Pakistan	783,379,170	
U.S. A.I.D.	215,000,000	37,315,809
N.F.P.A.		7,429,639
Other Donors		20,023,000
Total:	998,379,170	64,768,448

Source: [22, Appendix II].

- (b) an emphasis on "methods" and devices not clients.

Under our present approach, the field worker's achievement has been measured in terms of the number of acceptors of clinical and nonclinical contraceptive devices the worker recruits. The Programme has focused on initial acceptance of a method by a client rather than on the subsequent continuity and regularity of use or on the ultimate aim of keeping a client nonpregnant by effectively employing a method or any combination of methods. Concentration on "input" targets—such things as insertions, supplies, and personnel activities—curtails the attention that needs to be paid to the fundamental output goal: the limitation of fertility. The field worker must accept the client as a lasting commitment and not as a onetime customer. We cannot possibly promote this attitude as long as we continue to define targets in terms of, and pay incentives on the basis of insertions and sales. We must reorient our programme to emphasize the goal of fertility reduction, *i.e.*, keeping an increasing number of women nonpregnant, for longer intervals, in an assigned target-group [3, p. 7].

- (c) lack of an adequate and reliable statistical base on which to judge results.

We have depended largely on sample surveys for programme evaluation. Sample surveys are, however, no substitute for a complete record system of field work. Sample surveys can provide information about the appropriateness of a policy for the programme as a whole, but they do not serve as indices of the efficiency and effectiveness of the programme in a specific community or district. They cannot measure the achievements of programme functionaries or identify problems of local importance. A continuous built-in process of evaluation for each "operational unit", or geographical subdivision, is essential for making comparisons from place to place and over a period of time and for taking quick corrective measures at relatively low administrative level [3, p. 8].

- (d) almost exclusive use of female field workers and motivators was also noted.

All primary workers enlisted in the field organization in 1965 were women and the family planning scheme as originally envisaged did not call for recruitment of male workers at "grass roots" level. The field organization is still almost entirely female (98 percent).

The predominance of women in the field organization is perhaps based on the assumption that the husband is less motivated for family planning than the wife. There are no *a priori* reason for this assumption. It is possible to argue that the male might be equally, if not more, inclined to accept a small family norm [3, p. 9].

- (e) Inadequate wage structure for workers especially the field workers.

The monthly wage of Rs. 15.00 (\$3.10) that we pay to a *dai* is about what a village woman might earn by keeping a few chickens or a goat, and the low wage has been justified on the ground that it is payment for part-time work. It is assumed that a *dai's* earnings from family planning form an increment over a basic source of livelihood. A large number of *dais* do not, however think that their job is part-time, presumably because they have no other source of assured income [3, p. 10].

We have quoted at such length from these criticisms of the 1965-1970 Programme because they were, even in retrospect, judicious, insightful and probably correct. The gamble on the use of *dais* and other part-time local field staff had not paid off. The answer was to move to an entirely different approach to local motivation and delivery system.

The basis of the existing structure is a massive corps, of illiterate, poorly trained, lowpaid female carriers of the family planning message, staying with the programme for short intervals, directing their efforts toward recruiting new acceptors rather than maintaining a high level of family planning, operating unsystematically and without adequate yard-sticks for measuring what they achieve. The new proposals are for a somewhat smaller organization, full-time and paid as such, literate enough to keep the records needed for supervision and evaluation, and oriented toward providing family planning care as a regular and continuous service rather than as a single exposure [3, p. 10].

The plan [13] called for dividing the area covered into operational units of roughly 8,000 to 12,000 and assigning a male-female motivator team to each such area (in practice the areas were Union Council or Town Committee areas). The teams were ideally to be composed of local residents, married to one another or otherwise closely related, literate with good handwriting, mature, persuasive and good at meeting people. These teams were trained to construct a household register of all couples in their area, recording particulars of age of both spouses, number of children and other pertinent data. From this register the target couples still in the fertile ages and still fecund, were selected and contacted. It was judged that each worker could contact 20 couples per day and that each couple could be visited once in every three months. The initial visit was for motivation to acceptance; subsequent revisits were for resupply of acceptors or further motivation work. The register on eligible couples was kept up-dated on what method was adopted or why no method was adopted to guide subsequent activities. The goal was for the team to become friendly enough with their clients to be able to persuade reluctant couples to try a method. Group meetings and various communications approaches were also attempted. Clinical acceptors-sterilizations or IUD—were referred to the nearest clinic and transport arranged. The teams were supervised by Family Planning Officers, one to each six teams.

The base salary per motivators was fixed at 100 rupees per month with incentive payments also available for performance. Thus, all

supplies were sold at nominal prices by the workers and these funds deposited in a special incentive account. Payments were then made out of the fund to the worker on the basis of the number of acceptors who, according to the register, had no birth for one year. The incentive payment varied according to the method, and for especially successful teams a bonus was added. The incentive payments were divided equally between the male and female in a team, subject to a maximum of such payments of 300 rupees per worker per year. The Family Planning Officers made periodic visits to each team and were supposed to check the accuracy of the register maintained. Further, special programme audit teams were established for each district and were to check on one in four of the acceptors registered by the teams.

Thus, the new programme aimed at contacting on a continuing basis all eligible couples in the country using literate, full-time local male-female teams, who maintained a permanent record of their activities, who were paid on an incentive basis, and who were subject to constant checking from above.

This CMS "continuous motivation system", as it came to be called, was put into operation in Sialkot District, Punjab Province, in July 1969. This was often called a test of the system before it was extended to the rest of the country. But no real evaluation of the first district's experience as compared to other non-CMS Districts was done for some years and by that time the programme was firmly committed to going to CMS throughout the country as quickly as staffing allowed [10]. (By 1975 CMS still only covered about one-fourth of the districts.)

In fact, before the system was fully operational, a series of political crises, culminating in the civil war in East Pakistan 1971 and in the subsequent war with India, disrupted all regular government operations. By 1973 normalcy had returned and the programme resumed, once again under new leadership. A special committee, appointed by the President (the Aslam committee) reviewed the programme in 1974 and gave the CMS approach its approval, while also recommending some changes [14].

The "Expanded" Population Planning Scheme (1973-1977)

The CMS approach was continued when activities were resumed, but some significant new features were added including some proposed by the Aslam Committee. These included converting the clinic-based Lady Family Planning Visitors into Family Welfare Visitors (a proposal already made much earlier) operating from clinics in the CMS areas; mobile clinics in the non-CMS areas; redefining the CMS areas to include all areas with population density of 300 per square mile; and finally, the "contraceptive inundation" system, an effort to distribute conventional contraceptives—chiefly condoms and orals—throughout the country through a network of 50,000 shopkeepers and local agents as well as hospitals, clinics and full-time motivators. This "inundation" aimed at making contraceptive devices available to the entire population by putting supplies in every village and every quarter of every urban area. It was viewed as supplementing the CMS and clinic systems. Experimental efforts to explore so-called "Beyond Family Planning" approaches the use of incentives of various sorts to increase acceptance and/or continuation—were also authorized, and a Demographic Policy Action Research Centre (DPARC) charged with research on "Beyond Family Planning" approaches was created. From 1973 various

"reforms" in the management of the programme, were also attempted including more rapid analysis of performance data and feedback of these results to the field, (the CR or Client Record System) and greater control over contraceptive supplies as they moved through the pipe-line (the Information System on Contraceptive Movement, or ISCM). Both these systems were computer-based, long over-due internal control schemes [6, 14, 22, 23].

This expanded CMS plus "innundation" can be said to have functioned until 1976 when leadership of the programme again changed and a new "integrated" approach was announced.

Regarding the CMS approach, both the original Sialkot Model and the Expanded CMS plus "innundation" seem to have fallen far short of expectations. One fundamental difficulty of evaluating programme results has been the lack of a consistent fertility series overtime. A series of sample surveys—PGE, PGS, The Impact Study [1, 7, 11, 17] and others—have been largely non-comparable and thus one could argue that fertility had risen, fallen or remained unchanged with equal plausibility. Finally, in 1976 the publication of the results from the Pakistan Fertility Survey (undertaken in conjunction with the World Fertility Survey) [19] showed that fertility is high (a crude birth rate of 41), current contraceptive usage is low (5 percent of eligible couples), both essentially unchanged since the Impact Study almost ten years earlier (See Table 2). Several recent outside reviews have also been undertaken which agree in an essentially negative judgement. These reports document the failure of CMS and "innundation" [6, 22]. It appears that family planning as a concept is more widely known than in earlier years. There also appears some interest in it by women but actual use rates are low and fertility remains high.

Table 2

Various Estimates of the Birth Rate in Pakistan, 1962-1975

	Crude Birth Rate
1962-1965 PGE	
Combined Estimate (adjusted for numerator only)	52
Registration data	42
Survey data	38
1968-1971 PGS	37
1968-1969 National Impact Study	39
1974-1975 Pakistan Fertility Survey	41

Source : [6, Table 1].

It is reasonably clear what went wrong. The original CMS concept was based on recruiting literate, dependable male-female teams who lived in the area where they were to provide service. Ideally, they were to be a young married couple. This proved unworkable. It proved impossible to recruit in a reasonable length of time such teams and from this fact a host of other results followed. The motivators actually recruited were young women, often unmarried, from some nearby urban area, who took the job for want of anything

better to do. Even using more lenient standards, it became hard to fill all the female motivators posts and at any one time never more than 75 percent were on the rolls, and much less in many areas. These, were recurrent suggestions that many motivators, especially male, were hired for and used in political ways, and that educational qualifications were falsified. Staff turn-over was high.

The motivators who did not live in their areas faced transport problems, since they had to journey from town to the countryside and return each day. Transport allowances were inadequate and the amount of time spent in the areas was thus reduced. The original quota of visits per team made no allowance for bad weather and poor rural roads and transport.

Thus, in a real sense, the CMS system never got of the ground. Most eligible couples were never contacted by a motivator and when they were it was by an "outsider" with no ties with the village. The CMS idea as it was conceived of in the plan proved impossible to implement. The result is that CMS had only slightly more impact than the system it replaced.

The contraceptive "innundation" scheme also, in the same sense perhaps was never properly implemented. USAID, which was actually responsible for the idea to begin with, saw to it that more than adequate supplies of condoms and oral pills were brought into Pakistan. But it even after "innundation" level of stocks were in the country—the end of 1975—these stocks were not reaching the distribution points. Studies have shown that many of the listed establishments were not in fact "outlets" and had no desire to be. Some did not exist and while many retailers refused supplies, others who wished them did not receive them. In short, the logistic and supply system proved inadequate to the task of handling "innundation" and the availability of a large number of outlets was overestimated.

To the original "innundation" idea was added a proposed computerized Information Systems on Contraceptive Movement (ISCM) but this system has not been proved workable even yet, and came too late to affect the outcome of "innundation".

In sum, the logic of "innundation" appears to have been simplistic. It gave in sufficient thought to the planning and logistic aspect and to the control of the massive supplies. Perhaps it assumed that the off-take at retail would spur the distribution but in practice this did not materialize. This built-in short-coming to the scheme is all the more remarkable since logistic control over supplies has been a chronic problem of the Pakistan programme ever since 1965, and this was wellknown.

The programme entered its last (and present) phase officially in 1978 with the decision to "integrate" it into the health programme. The Population Planning Division has again become the Population Division, under the Secretary, Health, thus losing its autonomy. The field staff have been converted into multi-purpose health workers and "innundation" is abandoned. Clinical functions, which had been Federal, are now provincial, with a greater emphasis placed on these methods. Only planning, evaluation research and motivation are left directly to the Population Division. Field operation were suspended

in September 1977 and at present the programme is awaiting new orders and new direction [6].

OVERALL SUMMARY AND ASSESSMENT

It is important to understand that in spite of the several reorganization and apparent changes in philosophy of the family planning programme in Pakistan, there has also been a great deal of continuity. That is to say, all variants of the programme were, in fact, still derived from the same set of underlying assumptions.

First, the plans and schemes have all been animated by the spirit expressed well in the 1965 scheme: "Family Planning is essentially an administrative matter." The changes in the schemes as time has passed have largely been administrative reorganizations. If part time, untrained, illiterate field workers proved inadequate then educated full-time workers should be substituted. If evaluation by the provincial units proved unreliable then centralizing it would solve the problem. This assumption that *some* organization would work had no foundation in fact or experience.

By focussing on administrative aspects, the programmes have downplayed clinical methods, including sterilization. Yet this is precisely the method that other countries in the region have had some success with in their programmes (India, Sri Lanka, Bangladesh). This has also meant that, by and large, the medical practitioners have remained aloof if not hostile.

Second, the plans were assuming (at least in retrospect) that a deep, unfilled demand for family planning services existed on the part of the potential clients. No consistent communications or propaganda strategy was ever developed in any of the schemes and demand was taken for granted. The programme has always been a "supply-oriented" one and the "innundation" scheme was in a real sense the logical culmination of all its previous efforts.

Third, the planners judged that the programme had to be a nation-wide programme to be acceptable politically and to have any impact. The programme has assumed that it was possible to create quickly such a programme, involving a relatively sensitive area of human behaviour, capable of reaching into the remote rural areas in spite of the fact that no other public sector programme—except perhaps the police and the postal service—have succeeded in doing so. Problems of logistics, transport and supervisory control have thus tended to be ignored. Yet no programme seems to have found a way of insuring the timely distribution of contraceptive supplies, on the effective monitoring of activities of field workers. Logistics has remained a problem and the very size of the programme has tended to swamp the headquarters with data. Get only in 1976 were efforts made to shift to a computer-based evaluation or supply control system—the CRS and ISCM—far too late to affect the outcome.

Four, the programme has lacked (and still lacks) a consistent, detailed set of fertility estimates for the population covered by the programme. The first plan assumed the population growth estimation (PGE) project or some version of it would continue. But, it did not, and, in any case, more detailed fertility data, permitting impact analysis, by districts was (and is) needed and

these have never been available. This has had the effect of forcing the programme leaders to use exclusively programme statistics—clients contracted, orals distributed or “couple-years”—as their basis for evaluation. These data were, in fact, not a good substitute since the underlying reliability of the programme statistics was one of the things the evaluation in terms of measured impact on fertility should have been checking on. Without such an independent data—based check on the programme, evaluation became circular and always showed that the programme was successfully working. The targets set for the lower-level field workers guaranteed that.

What is our summary? we conclude that the chief missing link has been not on the supply side but rather from demand side. In principle, *any* of the several field-worker programmes (*dais*, CMS, Innundation) *could* have succeeded. If they did not it was not only because of administrative problem or supply inadequates but also because of inadequate effective demand. Numerous studies indicate clearly a strong latent demand for family limitation but the programmes have failed to convert this into effective demand. Thus, it becomes difficult to separate demand unsufficiency from administrative inadequacies.

What determines demand for family planning services? Modern theories of fertility predict that contraceptive usage rises with income and education. There is a configuration of factors—income, female employment, literacy, infant mortality—which are clearly linked to fertility through contraception. Where these setting variables are negative, results of any programme will be uncertain. In 1965 we noted this:

This totality of socio-economic—psychological barriers, the combination of poverty, ill health and deprivation with strong religious and social values in favour of high fertility and strong resistance to any change, probably make the “setting” in Pakistan one of the most difficult in the world for the successful introduction of a sudden large scale family planning scheme. One might say that the Family Planning Scheme in Pakistan represents a good test of whether family planning can take hold in a situation in which the setting is basically adverse [20, p. 281].

The heartening yet puzzling thing is that the recent surveys (Pakistan Fertility Survey and others) do show a large percentage of couple now have some knowledge of family planning and furthermore that a large percentage of married females do not wish to have more children. This would suggest a latent demand. But it seems evident that the socio-behavioral dynamics are more complex than had been realized. Perhaps the men feel very differently; perhaps the women have no control over such decisions; or perhaps the “cost” of another child is still not great enough to warrant any real trouble or possible embarrassment to the female. Nearly 20 years of research on family planning in Pakistan have left us uninformed on this crucial point.

THE SHAPE OF THE FUTURE

It is beside the point to criticise the past programmes—approach, organization, advisors or leaders. Our analysis here has aimed at understanding what happened. In 1965 it appeared to many that the only viable option open to policy makers was to create (attempt to create) a mass contraceptive

service-generating network reaching into the rural areas which did not require large inputs of highly trained clinical personnel or massive capital infrastructure. This is what the programmes, in all their variants, have attempted to do. With the advantage of hind sight we can now say that this was probably beyond the administrative feasibility of the Pakistan government, in the total absence of any other basic social services. It is also clear that the programme never "caught on" with clients and that it provided services to a relative small percentage of strongly-motivated high-parity females. A real motivation towards family limitation simply does not seem to be yet present in most of rural Pakistan.

The apparent shape of the next phase has already been indicated and it seems that "integration" (with health) is now the watchword. Perhaps a few cautious suggestions can close out this essay.

Present plans call for a gradual expansion of meaningful government health services into the country so as to cover 50 percent of the population by 1981. Family planning should move along with this "package" as an integral part. But, this must be part of a consistent long-run strategy, not a new approach which is then changed in two years.

The urban areas are changing rapidly with health and education levels improving. In these areas, an expanded clinic-based programme stressing sterilization and IUDs will almost certainly yield good results. The private associations and all hospitals and doctors must be brought into this drive using whatever financial and administrative arrangements seem workable.

The government must firmly endorse the concept of voluntary family planning services on demand and not let the programme become a "between election" operation. Perhaps a series of national seminars involving top leaders and public officials as well as leading private citizens to discuss frankly the issues could be a useful step in Pakistan as it has been in other countries.

"Crash" programmes have not been productive. Future efforts should be carefully planned, pretested and then slowly and gradually put into place. Had a carefully phased programme, beginning in the urban areas and then slowly spreading to the countryside, been adopted in 1965, would not the overall family planning effort in Pakistan be at least as well off and for much less cost and effort?

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