CHAPTER 3

POPULATION

The proven connection between population increase and development has been globally emphasised and recognised. The population of Pakistan was 32.5 million in 1951, at which time it was the 14th most populous country in the world. Since then its population has since increased approximately 5.5-fold, reaching 184.5 million (projected as per 1998 census) in 2012-13. There is an annual addition of over 3.7 million people, which is projected to reach 219 million by 2020 and 344 million by 2050, when it is likely to attain the 5th position in the world if the population growth rate of 1.9 per cent continues unabated. This can be devastating for the country's already-scarce national resources. Also, this rate is undermining economic progress of the country, and this calls for a special focus on investing in the family planning to control the population growth rate.

Following the International Conference on Population and Development (ICPD), held in Cairo in 1994, the scope of family planning in Pakistan was broadened, and the right to reproductive health as an entitlement was made an integral component of the population programme. A perspective plan was devised with the goal of reaching replacement-level fertility by expanding the family planning coverage and high-quality services, reducing infant and maternal mortality, and instituting other programmatic and strategic measures

Administratively, Pakistan is composed of four provinces along with the Federally Administrative Tribal Areas (FATA) and the Gilgit-Baltistan region. The sparsely populated province of Balochistan (five per cent of the total population) in the South-Western part of the country, comprises 43 per cent of the land area of Pakistan. The Punjab is the largest province in terms of population, with about 56 per cent of the country's residents living there. Sindh is the second largest, with about 23 per cent of the total population, and Khyber Pakhtunkhwa is the third largest, with about 17 per cent. The FATA accounts for 0.5 per cent of the population. Gilgit-Baltistan comprises a total land area of 72,520 square kilometres, with a population of 883,799, and Azad Jammu and Kashmir, with a land area of 11,639 square kilometres.

At present, the population density of Pakistan is 231 persons per square kilometre, whereas 37.9 per cent people are living in urban areas. Although birth and death rates have fallen over the past several decades, decrease in the death rate is much more rapid than decline in the birth rate. Subsequently, life expectancy has increased, that is, from 63.4 years in 1981 to 66.5 years in 2013 for females, and from 62.4 years in 1981 to 64.6 years in 2013, for males.

The fertility rate has declined at lower pace in comparison to other Asian nations. Moreover, total fertility rate decreased from 4.7 in 2000 to 3.8 in 2013, but decline in population growth is comparatively modest, that is, from 2.1 per cent in 2000 to 1.9 per cent in 2013.

Performance review 2014-15

The population control programme has remained an important policy issue since 1960. Nevertheless, because of changes in various governments' population policies every five to 10 years, the desired results have not been achieved. Another major shift in population planning was made in 2010 by devolving the subject to the provinces.

Access to an improved source of drinking water is 93 per cent, but only eight per cent of households use an appropriate water treatment method and 59 per cent of households have an improved toilet facility, not shared with other households. About 94 per cent of households have electricity.

Overall, 87 per cent of households possess mobile phones (95 per cent of households in urban areas and 83 per cent in rural areas). The registered percentage of children under five years of age is 34 per cent, while 32 per cent have birth certificates, and 83 per cent of adults of 18 years and have been registered for the Computerised National Identity Card (CNIC).

About 53 per cent of women have no education, as compared with 34 per cent of men, the net attendance ratios are 60 per cent at the primary level and 37 per cent at the secondary level.

Employment is an important source of empowerment of women, especially if it puts them in control of their earnings. Measurement of women's employment can be difficult because some of the work that women do, especially work on family farms, in family businesses, or in the informal sector, is often not perceived by women themselves as employment and hence is not reported.

Out of the total population of women only 26 per cent of women were currently employed. The proportion of women, who were currently employed was lowest among 15-19 years of age (19 per cent) and increased to a peak of 33 per cent in the 35-39 age group. Women, who were divorced, separated, or widowed, were much more likely than married women to be employed. Similarly, women with three or more children were more likely to be employed than those with fewer children.

Migration, which may be seasonal, temporary, semi-permanent, or permanent, is an important demographic element that has far-reaching socioeconomic implications for both individuals and society, both in the place of origin and in the destination. Migration is usually related to opportunities for education and employment that motivate people to emigrate from their place of origin, culture and geographic hardships pushing people to a better or safer environment.

The migration from rural within country is 56 per cent of the total population who have migrated, followed by those migrating from cities and urban areas (43 per cent); the proportion of individuals immigrating from overseas is quite small (one per cent). Out-migration is more prevalent in Gilgit-Baltistan (30 per cent), Khyber Pakhtunkhwa (28 per cent), and Punjab (20 per cent). Only five per cent of households in Balochistan have an out-migrated member.

The median age for the first marriage among women between 25 years to 49 years is 19.5 years, while for men between 30 years to 49 years is 24.7 years. There is a close association between education and median age at the first marriage. The median age at the first marriage for women of 25 years to 49 years with no education is 18.3 years, as compared to 22.3 years for women with a secondary education. A similar pattern is observed between median age at

marriage and wealth quintile, with women in the highest wealth quintile marrying more than four years later than those in the lowest quintile.

Education and wealth are factors related to delayed marriage. The median age at the first marriage among men of 25 years to 49 years, and 30 years to 49 years shows patterns similar to that of women in relation to level of education and wealth quintile.

The minimum legal age at marriage in Pakistan is 18 years for males and 16 years for females. Women are considered to be exposed to the risk of pregnancy after marriage. Duration of exposure to the risk of pregnancy depends primarily on the age at which women marry for the first time. Women who marry early, on average, are more likely to have their first child at a young age and give birth to more children overall, contributing to higher fertility.

Knowledge of contraception is universal in Pakistan. More than one-third of the currently married women of reproductive age are using contraception, with most women (26 per cent) using a modern method. The two most popular modern contraceptive methods are the male condom and female sterilisation, that is, nine per cent each. The government sector remains the major provider of contraceptive methods, catering to the needs of nearly one in two users, that is, 46 per cent. 20 per cent of the currently married women have an unmet need for family planning services, with nine per cent having an unmet need for spacing, and 11 per cent having an unmet need for limiting.

The crude birth rate in 2013-14 is 26.4/1000 and the crude death rates 6.9/1000, both are unacceptably high. An estimated 14,000 maternal deaths occur annually and 4,00,000 infant deaths, a large proportion of which are linked to high fertility rate of the country.

The total fertility rate has declined from 4.77 in 2001 to 3.8 in 2013 with a contraceptive prevalence rate of 35 per cent (PDHS 2012-13). Pakistan has committed internationally to the CPR goal of 55 per cent by 2020. This requires an acceleration of efforts to reduce fertility rates and increase contraceptive prevalence in the coming five years. Population stabilisation, therefore, requires accumulative and unpunctuated efforts from all corners of society.

After devolution of the Population Welfare Programme (PWP), the main challenges include lack of ownership of the programme by the provincial governments, inability to create awareness regarding benefits of small family among the target population and demand generation for the family planning services, low investment in the population sector by the provincial governments and ineffective coordination between health and population welfare departments for provision of family planning and reproductive health services.

Physical targets

The PWP envisages establishing service delivery, which is presented in the table:

Physical and contraceptive user targets

	2013-14 (Target)	2013-14 (Achievement)	2014-15 (Target)	2015-16 (Target)
Family Welfare Centres	3,427	2,891	3,000	3200
Reproductive Health-A Centres	269	207	230	250
Mobile service units (MSU)	300	292	325	350
Contraceptive users (Million)	10	8	12	13
RHS-B Centres	184	133	200	225
Registered Medical Practitioners (RMPs)	27576	9297	25000	27000
Hakeem and homeopaths	14009	8071	15000	16000

Outlook 2015-16

The family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods, and this is facilitated through a programme for the FP&PHC; thus the Reproductive Health Service Centres (RHSCs) and hospital-based service outlets are major clinical components of the PWP.

The Mobile Service Units have been established to provide family planning services to remote areas with underserved rural populations. Moreover, the male mobilisers are responsible for encouraging programme advocacy among local community leaders, male teachers, shopkeepers, religious leaders, and community-based organisations. Other important components of the service delivery network include: registered medical practitioners, hakims and homeopaths, LHWs, public-private partnerships, and NGOs. The social marketing of contraceptives is a central component as well.

As a measure to develop ownership of the programme, the provincial governments will fund the programme during FY 2015-16 and onwards. However, being non-beneficiary of the NFC award, special area governments will continue to receive partial finding through the PSDP at the level of maximum release for FY 2010-11.

The accumulated socio-economic gains are largely diluted by the increase in population. Population size and growth have a strong bearing on all aspects of a nation's welfare, especially health, education, environment and poverty alleviation. It has been realised that if the population growth were greater than economic growth, then the country will never be able to meet people's needs for economic and social services. Arresting the population growth rate will, therefore, improve the per capita availability of goods and social services.

During the FY 2015-16, the PWP will continue with its 4500 service delivery outlets. As a policy measure, all 100,000 LHWs and 14,000 service delivery outlets of the health departments will be involved in extending family planning services.

An important indicator of the changing demand for the family planning is the extent to which non-users of contraception aim to use family planning in the future, which suggests targeting such part of the population for future objective setting.

Information on the level of public exposure to a particular type of media allows family planning programme managers to assess the most effective media for various target groups in the population and effort will be aimed at such directions. There is a sharp urban-rural contrast in exposure to the family planning messages through television and print media. For example, 34 per cent of women in urban areas are exposed to family planning messages through television, as compared with 20 per cent of rural women; the corresponding percentages among men are 60 per cent and 42 per cent, suggesting priority setting to be revisited when planning for the year ahead.

Particular focus will be made on creating awareness and education among the masses for small family norm; thereby creating demand for the family planning services among the target population.

Apart from the programme of population welfare that also needs to scale up its efforts in terms of coverage, execution and monitoring of its activities, some of the interventions for the citizens pertains to other sectors. Key areas, which need consideration in the year ahead, will be improving the provision of clean and safe water and provision of adequate sanitation.

There is also a need to register births of children under five years of age, reach MDG targets for educational attainment and school attendance, assess status of both in-migration (immigration) and out-migration (emigration), consider efforts in curtailing early (childhood) marriages.

The current trend in fertility and its preferences are unacceptable. The family planning services need to be improved and increased. Efforts are to be aimed at bringing the indicators for infant and child mortality down to the level suggested by the MDGs, reproductive health to be improved both for men and women, nutrition of children and women to be given priority through their related programmes.

HIV/AIDS-related knowledge, attitudes, and behaviour needs to be improved through better information sharing and treatment, while women's empowerment needs to be ensured to improve their demographic and health outcomes and a zero tolerance for domestic violence to be developed in the society.

Financial plan

Funds to the tune of Rs5,644 million will be provided through the federal PSDP for vertical programmes as per decision of the Council of Common Interests (CCI).

The physical targets set for 2015-16 have been tabulated on the next page.

Physical targets

	Target 2015-16
Family Welfare Centres	3,200
Reproductive Health-A Centres	250
Mobile Service Units (MSUs)	350
Contraceptive users (Million)	13
RHS-B Centres	225
Registered Medical Practitioners (RMPs)	27,000
Hakeem and homeopaths	16,000