



ISSN0030-9982

JPMA

Journal of the Pakistan
Medical Association (Centre)



Volume 59-No.09

September 2009

Supplement - 3

Page S-1 to S-40

Synergizing Health and Population in Pakistan

Heartfile

JPMA

The Journal of the Pakistan Medical Association (Centre)

Editorial Board

Chairman

Masood A. Sheikh

Editor-in-Chief

Fatema Jawad

Associate Editor-in-Chief

Huma Qureshi

Associate Editor

Qudsia Anjum Fasih

Sina Aziz

Editor, Students' Corner

Sajjad Raza

Statistical Reviewer

Aamir Omair

Members

Aamir M. Jafarey

Ali Yawar Alam

Amin A.M. Gadit (Can)

Afia Zafar

Anwar Ali Siddiqui

A.R. Jamali

Asad Pathan

Aiesha Mehnaz

Durre Samin Akram

Haider Ali Naqvi

Humaira Ahsan

Inam Pal

Iqbal Afridi

Javed I. Kazi

Manzoor Hussain

Mirza Naqi Zafar

Mohammad Wassay

Muhammad Hanif Shiwani (UK)

Nilofer Safdar (Can)

Najma Amjad

Rifat Rehmani (KSA)

Rumina Hasan

Sadia Ahsan

Salman N. Adil

Shahid Shamim

Shehla Siddiqui

Saeed Mahmood (USA)

Shaukat Ali

S.M. Mubeen

Suhail Anwar (UK)

Tasnim Ahsan

Yasmin Wajahat

Zohra Zaidi (UK)

International Advisors

Sub-Editor

Muhammad Kashif Riaz

Managing Secretary

Najum F. Mahmudi

Diaa Essam El-Din Rizk (KSA)

Gerry Mugford (Can)

M.B. Rokni (Iran)

Mubeen Fatima Rafay (Can)

Tanveer Azher (Can)

Farhad Handjani (Iran)

M.B. Heyman (USA)

Mehmood I Shafi (UK)

Rehman Siddiqui (UK)

Seerat Aziz (USA)

The Journal of Pakistan Medical Association (JPMA) is published monthly from PMA House, Aga Khan III Road, Karachi-74400, Pakistan.

All articles published represent the opinion of the author and do not reflect official policy of the journal. All rights reserved to the Journal of the Pakistan Medical Association. No part of the Journal may be reproduced, stored in a retrieval system, or transmitted in any form or by any other means, electronic, mechanical photocopying, recording or otherwise, without prior permission, in writing, of the Journal of the Pakistan Medical Association.

Price: Rs.300.00 (Single Issue), **Annual Subscription:** 3,000 in Pakistan and US\$110.00 for overseas countries (including air mail postage).

Publication Office: PMA House, Aga Khan III Road, Karachi-74400, Pakistan.

Telephone/Fax: (9221) 2226443 & 5418192, **E-mail:** jpma_jpma@hotmail.com

CONTENTS

Précis	S-1
Pakistan's health-population mantra Sania Nishtar, Saba Amjad	
Theme Report	S-3
Synergizing health and population in Pakistan Sania Nishtar, Saba Amjad, Sobia Sheikh, Mahbub Ahmad	
Comments on the Report	
Health-population nexus	S-24
Ishrat Hussain	
Institutional dichotomy between health and population in Pakistan—time to act	S-25
Yasmeen Sabeeh Qazi, Kathleen M. Toner, Huong Nguyen	
Improving reproductive health service delivery	S-27
Daniel B. Baker	
Coordination and collaboration—a win-win situation	S-29
Mumtaz Esker, Tufail Muhammad Khan	
Key elements for women's empowerment	S-31
William Conn	
Family planning is a life saver	S-32
Shahida Azfar	
Viewpoints related to the Report	
The imperative of functional integration for achievement of MDGs	S-34
Khalif Bile Mohamud	
Contraception, synergies and options	S-39
Rashid Jooma, Adnan A. Khan	

Pakistan's health-population mantra

Sania Nishtar,* Saba Amjad

Heartfile.

*Corresponding author

This special supplement of the Journal of Pakistan Medical Association is dedicated to reporting the findings of a study, which has been conducted by Heartfile to revisit a long-standing question and dilemma in social sector institutional restructuring in Pakistan, centred on merger of the ministries of health and population. The question has recently assumed importance in view of the conditionality stipulated by the International Monetary Fund with regard to reduction of unnecessary expenses.¹ As the result, the federal government has decided to abolish 13 ministries and departments and merge them with other ministries—the Ministry of Population Welfare is to be merged with the Ministry of Health. Whilst this is a valid approach from a fiscal and efficiency standpoint, the potential within ministerial mergers to achieve health and population outcomes—their key objective—must be clearly appreciated, particularly in view of the difficulties likely to be encountered while pursuing this course of action. Within this context, two considerations should be brought to bear.

First, that health and population are an inter-sectoral responsibility and that a number of factors are responsible for poor health and population outcomes in their own right. These include broader issues implicit in the social determinants—literacy, clean water, adequate sanitation, food security— and poor overall governance and conflict. Unless there are improvements in these domains, the desired level of progress in achieving population and health outcomes cannot be attained.

Secondly, with respect to the institutional determinants *per se*, many factors need to be taken into consideration. These include effectiveness of governance, current lack of separation between policy-making, implementation and regulation, health-related human resource discrepancies and poor accountability and transparency within the system. The present disconnect between the two ministries is just one of the many institutional factors that determine performance of a health system; health systems performance, in turn is dependent on many other factors in the individual domains of health systems. The authors are of the firm view that not much can be achieved by merging two institutional hierarchies that are plagued by numerous

challenges and have been unsuccessful in achieving their own objectives. Merger or functional integration of family planning and health service delivery should, therefore, be pursued as part of holistic reform of the health and population hierarchies. Furthermore, improvements cannot be expected without attention to broader measures, which centre on addressing fiscal space constraints on the one hand, and promoting transparency and efficiency in governance, on the other.

Within this context, the study's recommendations are being driven by three considerations. One, recognition of the challenges faced by both the institutional hierarchies and the need for reform. Second, an acknowledgment of the need to revisit the broader institutional mandate and scope of both the ministries, particularly the Ministry of Population Welfare, in view of the Programme of Action of the International Conference for Population Development;² the latter underscores the importance of linkages between population and development and envisages integration of family planning with maternal and child health in order to ensure that women and their families benefit from integrated systems of care. Third, a belief that coherence between the service delivery mandates of both the ministries could lead to improved services and ultimately better health, demographic and development outcomes. It is recognized that although this is not the only solution to the multifaceted issues faced by the health and population sectors, it is nevertheless necessary if not a sufficient step.

Before arriving at any conclusions, the authors have examined the rationale for merging the ministries and the challenges inherent in doing so. With reference to the former, there are many justifications for merger—the ICPD ethos and the envisioned inextricable linkages between health, population and development; current fiscal space constraints in view of the country's prevailing macro-economic situation and the need to rationalize costs, better integrate programmes and reduce duplication within that milieu; and poor service delivery performance of institutions in the current configuration. Examples of successful institutional mergers in the corporate sector also reaffirm the notion. The analysis has also taken stock of challenges involved in merger of the

institutional arrangements, on the other hand. Within this remit, although the federal and provincial structures of both the ministries are similar, differences in sources of funding and fund flows, coupled with differing hierarchical relationships—particularly with reference to the status of devolution—and reluctance on part of functionaries in both the institutional hierarchies pose significant challenges to merger.

The authors call for deep-rooted reform at several levels in both the institutional hierarchies.

The study recommends that within both sectors, reform of stewardship agencies should strengthen their policy-making, normative, regulatory and oversight role, with the Ministry of Population Welfare additionally assuming responsibility for development of linkages between population and development. The Ministry of Population Welfare has an untapped potential to assume a leadership role in the population-development paradigm; this role has remained unexplored. It is envisaged that if it is freed up from its service delivery task, it can play a more proactive role in policy and advocacy. Similarly, it is suggested that the Ministry of Health should assume a stronger normative role and oversight.

The authors recommend that both ministries should reconfigure their service delivery roles and focus on standard-setting, evidence-generation and provision of oversight. The normative role of the Ministry of Health and the departments of health should, in particular, focus on health systems management restructuring. Drawing lessons from existing prototypes of first level facility management restructuring by the health sector and capitalizing on the lessons learnt by the population sector in franchising, evidence-based options should be developed to contract out the delivery of essential health services.^{3,4} Contracting can be approached in two ways in the given context; one involves intra-organizational contracting within the health sector by assigning various levels of government to different purchaser-provider roles in an attempt to use decentralization of management to smaller administrative units and intra-organizational contracting as an element of competition and as an incentive for improving performance and quality. The other involves harnessing the outreach of private providers to deliver services and manage facilities. In restructured service delivery arrangements, a set of MDG+ essential health and family planning services can be grouped together and benchmarked as a yardstick for public delivery and as a basis for contractual relationships in new management restructuring arrangements centred on public-private partnerships. This can be a major step towards merger of the two ministries

from a service delivery standpoint, a level at which merger is needed. Such reorganization warrants a major shift in service delivery, financing, payment systems and governance and regulatory arrangements, with implications for changes in policies, laws and institutional frameworks. A long-term commitment and sustained action is needed to achieve this objective, which is why this approach has been outlined as the sustainable long-term solution to the health-population disconnect.

The proposed short to medium term strategies, which centre on a range of specific collaborative measures, have been articulated with a view to building capacity for the broader systems transformation. These include enunciation of a joint Health, Population and Well Being Policy, broadening the remit of the National Commission for Population Welfare, revitalizing the Joint Committee for Health and Population Welfare and exploring, where feasible, joint proposals for funding. Additional measures in the right direction include addressing governance issues at the level of requisitioning, procurements and supplies, where a significant collaboration is already underway and incorporating family planning into the mandate of the health sector; this can be done by further reinforcing family planning as a Lady Health Worker mandate, augmenting the field force through appropriate linkages with male mobilizers and mobile service units, mandating synchronous communication campaigns and fostering ownership of Reproductive Health-A Centres of the Ministry of Population Welfare by the health sector.

These steps, if taken in the medium term, have the potential to improve coordination and improve organizational efficiencies within the health and population sectors and appear to be the only options for maximizing synergies if the government does not take the needed steps to transform both the institutional hierarchies.

References:

1. Thirteen ministries to be abolished. The Frontier Star (Northwest Frontier Province, Pakistan) 2009 August 06. Free Online Library. <http://www.thefreelibrary.com/13+ministries+to+be+abolished.-a0205307771> (accessed Aug. 07, 09).
2. International Conference on Population and Development; Cairo, 5-13 September 1994. <http://www.un.org/esa/devagenda/financial.html> (accessed Jan. 22, 09).
3. Ahmad M. Thomas D. Population Welfare Programme Punjab-Situation Analysis Report, Technical Assistance Management Agency (TAMA) of the National Health and Population Facility, 2007.
4. Nishtar S. Choked Pipes-Reforming Pakistan's Health System. Forthcoming 2009.

SYNERGIZING HEALTH AND POPULATION IN PAKISTAN

Sania Nishtar,*¹ Saba Amjad,¹ Sobia Sheikh,¹ Mahbub Ahmad²

¹Heartfile; ²Ministry of Population Welfare, Pakistan.

*Corresponding author

ABSTRACT

The delivery of health and family planning services in Pakistan is the respective mandate of the Ministry of Health/departments of health and the Ministry of Population Welfare. This institutional separation creates issues due to marginalization of family planning and reproductive health as core health issues. The government of Pakistan has made several attempts in the past to merge both the institutional hierarchal arrangements. This study was conducted to examine if merger is a viable option and to explore a way forward to bridge the current population-health disconnect in the country. Qualitative survey methods, inclusive of review of published and grey literature, archival analysis, informant interviews and focus group discussions were used for the analysis. Findings outline both the imperatives for merging the ministries and the challenges inherent in doing so. Recommendations recognize that although not a sufficient step to improve health and population outcomes, creating synergies between the health and population sectors is an imperative. The sustainable long-term solution to the existing population-health disconnect centres on deep-rooted reform at several levels in both the institutional hierarchies, with transformation of the role of stewardship agencies and reengineering of service delivery arrangements as its hallmarks. Restructured service delivery arrangements are meant to allow the delivery of a set of MDG+ services, where family planning and reproductive health are grouped alongside and together with essential health services. The latter are envisaged to be a yardstick for public delivery of services and the basis of contractual relationships in new management arrangements, which involve a role for the private sector. The short to medium term strategies proposed in this paper centre on a range of specific collaborative measures with a view to building capacity for the broader systems transformation. Sustained political and institutional commitment will be needed to implement these recommendations.

INTRODUCTION, CONTEXT AND RATIONALE

Pakistan is the sixth most populous country in the world, with its current population estimated at 163.76 million.¹ Although the country's population growth rate has declined from over 3% in the 1960s and 70s to the present level of 1.8% per annum, it still remains unacceptably high compared to other developing countries. Findings from the largest household survey ever conducted in Pakistan also

show that although there has been a decline in Total Fertility Rate (TFR) from 5.4 children per woman in 1990-91 to 4.1 in 2006-07, TFR still remains high by international standards.^{2,3} Estimates project that if current trends continue, Pakistan will be the fifth most populous country in the world by 2050, with a population of 295 million.⁴

Population is a denominator for development. Increase in population size creates a number of challenges both for growth and development in the current macro-economically challenged environment, as well as security. The latter is relevant, not only to the demands that the rapidly increasing population places on the current situation with reference to water, food and energy security but also its impact on demographic security—the rapidly burgeoning base of the population pyramid being vulnerable to exploitation in the wake of rampant poverty, unemployment and illiteracy.

Increasing population size also has a number of implications for health and is likely to compound the existing situation with respect to poor health status of the people of Pakistan.⁵ Poor health status is evidenced by indicators reflected in a compendium of health statistics, which concludes by stating: ".....although there have been some improvements in the health status of the Pakistani population over the last 60 years, key health indicators lag behind in relation to international targets articulated in the Millennium Declaration and in comparison to averages for low-income countries.....".⁶ Findings from the aforementioned survey support this notion—the reported Maternal Mortality Ratio of 276 maternal deaths per 100,000 live births is high by international standards.⁷

Health and population have shared agendas, with maternal, child and reproductive health being shared core themes as well as common intervention paradigms. The government of Pakistan appears to regard both—health and population planning—as core elements of its development agenda; both are reflected in broader frameworks of planning,⁸⁻¹⁰ respective sectoral policies,^{11,12} and international commitments.¹³ However, despite stated commitments, successive governments have been unable to cascade policies and plans into concrete action, as a result of which health and population outcomes have remained intransigent.

There are many determinants of poor health status and poor population planning outcomes—socio-economic, biological, environmental, cultural and institutional. One of the many institutional impediments to achieving desired

goals in both these sectors relates to the design of the government's institutions in both these areas—health and population planning are served through separate ministries. The existence of health and population as separate ministries and provincial departments can, on the one hand, be viewed positively, as it gives population planning an additional concerted institutional focus. Nevertheless, it creates issues due to the lack of availability of both the services at the same place and the marginalization of family planning and reproductive health as core health issues. Family planning is not viewed as a health intervention in many rural and urban under-privileged areas and has been culturally and socially stigmatized. On the other hand, the provision of health is regarded as socially esteemed. It is, therefore, believed that if family planning and reproductive health services are provided through a recognized health service delivery network, better health and population outcomes can be achieved.¹⁴ Such a repositioning would also be in line with the paradigm shift in *family planning* from a *demographic target* to a *reproductive health end-point*.

Successive governments in Pakistan appear to have been cognizant of this gap, as is evidenced by many attempts to merge the two institutional entities. Family planning, in the context in which it is understood today, was not a core consideration at the time of Pakistan's inception, even though an emphasis was placed on reducing family size by the Bhole Committee Report, which laid the foundation of organized public health planning in Pakistan.¹⁵ As a result of this, a standalone ministry and provincial departments of health were created. It was only later, in the mid-fifties, that population growth was recognized as one of the major challenges for development and the Family Planning Programme was started nationwide, in earnest. The decennial world population conferences, particularly, the International Conference on Population and Development (ICPD), which was held in Cairo in 1994, provided a major impetus for family planning.¹⁶⁻¹⁸ The ICPD contextualized family planning to a much broader context; by emphasizing that the linkages between population and development go beyond demographic targets, it underscored the importance of meeting individual needs of men and women and empowerment, access and choice. Subsequently, most developing countries strengthened their institutional arrangements for population planning within the realm of existing ministries—health, public health or social development.¹⁹ In Pakistan, 'population' was also initially situated within the Ministry of Health, Labour and Social Welfare. Later, however, as a result of many changes, which have been described in this Report at various points and have been summarized in Table 1, population evolved into a

Table 1: Institutional status of population—watershed events.

Phase 1: Early 1950s

- ◆ Family planning initiated by resourcing the Family Planning Association of Pakistan.

Phase 2: Early 1960s-1985

- ◆ First Five-Year Plan (1960-65): The Family Planning Wing was housed in the Ministry of Health, Labour and Social Welfare. As part of this framework, the Family Planning Council was created at the federal level and Family Planning Boards were established at the provincial and district levels. Family Planning Clinics were also set up in the existing health facilities.
- ◆ Second Five-Year Plan (1965-70): The Family Planning Wing was given the status of a Division. The Family Planning Council and the Provincial Boards were given recruitment powers and resources to create their own field infrastructure.
- ◆ Third Five-Year Plan (1971-76): The Population Council was abolished. The Ministry of Health was charged with the responsibility of policy, planning and logistics. The Health Department was renamed as the Department of Health and Population with two directorates—one for health and another for population, at the provincial level. District level family planning activities were placed under the charge of District Publicity-cum-Executive Officer.
- ◆ Fourth Five-Year Plan (1977-83): The Family Planning Programme was transferred from the Ministry of Health, Labour and Social Welfare to the Ministry of Planning and Development. Family Planning Division was renamed as the Population Welfare Division (PWD). In the provinces, Director Generals were put in charge of the population infrastructure.

Phase 3: 1985-2001

- ◆ 1985: The Executive Committee of the National Economic Council decided to relocate Family Welfare Centres into Basic Health Units; the decision could not be implemented.
- ◆ June 1990: The Population Welfare Division was given the status of a full-fledged ministry. The Population Welfare Division and the Family Planning Programme moved out of the Ministry of Planning and Development.
- ◆ 1991: After a major appraisal, UNFPA recommended to the Prime Minister to adopt a multi-sectoral approach and to provide family planning services through health outlets.
- ◆ 2001: A Cabinet decision was taken to merge both ministries. The decision was largely reversed after one month; the only aspect of the decision implemented related to the transfer of 12,000. Village-Based Family Planning Workers of the Ministry of Population Welfare to the Ministry of Health's National Programme for Family Planning and Primary Health Care.

Phase 4: 2002-2008

- ◆ 2006: The National Commission on Population Welfare decided to mandate the creation of RH Centres in facilities owned by departments of health. The decision remained unimplemented.
- ◆ 2008: A Memorandum of Understanding was signed between the two caretaker ministers in an interim government to functionally integrate service delivery. Subsequently, an inter-ministerial task force was created.

Phase 5: August 2009

- ◆ 2009: A Cabinet decision was taken to merge the Ministry of Population Welfare with the Ministry of Health as part of a broader drive to maximize efficiencies in government and reduce institutional overheads and duplication in order to comply with IMF's conditionality for funding.
-

separate ministry. Table 1 provides a snapshot of key watershed events during this evolution, with reference to the institutional status of 'population' vis-à-vis 'health.' The events have been categorized into five phases. In phase 1, which spanned almost a decade, the government resourced and mandated an NGO—the Family Planning Association of Pakistan (FPAP)—to pursue family planning objectives. In phase 2, in the early 1960s, the Ministry of Health, Labour and Social Welfare was given responsibility for family planning and the importance of family planning was stressed in First and Second Plans, but with a limited scope. Later, the family planning programme was transferred to the Ministry of Planning and Development. In phase 3, which spanned from 1985 to 2001, there were many abortive attempts to merge the two institutional hierarchies. From 2001 onward, in phase 4, decision-makers appeared to be cognizant of the challenges posed by merger, and therefore, focused entirely on functional integration. However, most recently, as part of the International Monetary Fund-stipulated wider drive to cut down establishment costs, the Cabinet has decided to merge many duplicating ministries—folding in the Ministry of Population Welfare into the Ministry of Health is one of them.²⁰

THE ANALYTICAL DILEMMA—HONING THE QUESTION

In view of the background outlined in the previous section, the question of merging and/or functionally integrating the two ministries, and as a corollary, their respective departments in the provinces, has been a fundamental question in social sector institutional restructuring in Pakistan and a subject of institutional deliberations for over three decades now.

There are different perceptions and opinions on this issue and differing terms of debate. The term “functional integration” was coined by the United Nations Population Fund (UNFPA) in 1998 in relation to Pakistan's context, implying a physical merger of service delivery infrastructure, as a first step to the eventual merger of population and health as institutional entities.²¹ Many decision-makers, on the other hand, have inferred functional integration as being synonymous with structured cooperation and collaboration between federal, provincial and local government institutions in the health and population sectors and have not envisioned physical merger of institutional entities as an end-point.

As a result of this varied understanding, many efforts have been made over the last three decades both to merge as well as to facilitate collaboration between the two institutional entities. Table 1 provides a snapshot of attempts to date, whereas a detailed account summarizing the history of hierarchical relationships between the two institutional entities and the range of decisions that have sought to merge

and integrate them, have been appended to this Report.

This Report refers to two expressions; merger as conventionally understood is one of these; however, instead of functional integration, it chooses to use the expression “synergize” to denote the importance of collaboration, cooperation and supportive working for improving outcomes and emphasizes the need for addressing fragmentation and duplication in service provision. Synergizing literally means that the combined effect is more than the sum of individual components.

Within this context, this analytical study was undertaken with a two-pronged objective: firstly, to analyze if merger is a viable option, and secondly, to explore a way forward to bridge the current population-health institutional disconnect in Pakistan.

METHODS

Mixed methods were employed for the analysis. This included a review of academic and grey literature, semi-structured interviews, focus group discussions with key informants and expert consultations.

Review of academic and grey literature consisted of a Pubmed search; in order to review grey literature, the same search terms were entered into Google. Search was limited to English language articles published after 1947. A variety of mission reports, third party evaluation reports and internal programme monitoring documents were also reviewed as part of search of grey literature.

Semi-structured in-depth interviews were conducted with managers at various levels within the public and private sectors. A total of 45 interviews of varying lengths were conducted by the Principal Investigator (PI). The professional profiles of the interviewees ranged from clerical staff of the government and equivalent private sector employees, to Chief Executive Officers and Cabinet members. Gender, culture, language and social considerations were taken into account when planning interviews. The Principal Investigator also conducted focus group discussions with five to ten people on particular issues. A total of five focus group discussions were held. In-depth interviews, although not tape-recorded, were documented through comprehensive note-taking by the PI. In addition, three expert consultations were also held to deliberate on various drafts of the paper. Views with a consensual character were taken into consideration while framing the final recommendations.

RESULTS, THEIR INTERPRETATION AND DISCUSSION

This section of the Report presents findings of the study and narrates the authors' interpretations and discussion in relation to the findings. The question of the viability of merger has been addressed first. Both the

rationale and the challenges in doing so have been elaborated upon. The next question focuses on the importance of institutional mergers *per se*, in achieving desired outcomes, in an attempt to contextualize the issue to the broader health and population institutional domain. The authors subsequently elaborate on the long-term sustainable solutions to the population-health disconnect and lastly present short and medium term measures to maximize synergies at the policy, governance and administration, planning, service delivery and training levels.

1. Rationale for merger

There can be many arguments in support of merging the two institutional entities. First and foremost, the rationale for integration stems from the current emphasis on comprehensive reproductive health as opposed to standalone family planning, as coined by the ICPD. The ICPD Programme of Action endorses a new strategy, which emphasizes the importance of numerous linkages between population and development and focuses on meeting the needs of individual women and men rather than achieving demographic targets. The ICPD achieved institutional consensus on four qualitative targets and quantitative goals, two of which have relevance for reproductive health—reduction in maternal mortality and access to reproductive and sexual health services, including family planning.

The ICPD Programme for Action, to which Pakistan is a signatory, creates many imperatives for development in general and women's empowerment and broadening the approach to reproductive health and reproductive rights in particular. With the recent Resolution of the United Nations Human Rights Council on Preventable Maternal Mortality and Morbidity and Human Rights,²² the importance of the latter has been amplified. From an institutional standpoint, there are operational and conceptual dilemmas in separating maternal and child health from family planning within its framework—the reproductive health paradigm necessitates the integration of family planning with maternal and child health in order to ensure that women and their families benefit from integrated systems of care. In order to deliver on the reproductive health premise, the institutional configuration of the ministries should have been reconfigured. However, as opposed to this, the Ministry of Population Welfare has remained aligned on a pre-ICPD agenda with its focus on family planning service delivery; on the other hand, health has also not been proactive in taking the needed steps. In effect, therefore, the state institutional structures in health and population have not been optimally configured to deliver on the ICPD premise. This, by far, constitutes the strongest rationale for making a case for merging the two ministries. The conceptual

rationale is strengthened further in view of the general principle of efficiency and economy and prevailing practice in other developing countries.

Secondly, the performance of both the ministries and their respective departments in terms of impacting health and population outcomes should be brought to bear. As poor institutional performance calls for reform of service delivery arrangements in both the institutional hierarchies, it makes sense to merge the service delivery functions of both the ministries in any new service delivery arrangement. However, as the normative and oversight functions of both health and population are diverse and crosscut with different grounds, they can be retained respectively. This has been elaborated upon later in this Report.

Thirdly, it is important to contextualize any discussion on institutional reorganization to the context of Pakistan's recent macroeconomic downturn and the global financial crisis. Pakistan's macroeconomic situation is largely of its own making, as a result of issues of governance. Lack of integration of the country's financial markets with the global financial system had precluded earlier importation of the global financial crisis into Pakistan; however, the crisis is unfortunately, slowly permeating into the country, with resulting implications for trade and resource mobilization options. These factors are likely to accentuate existing fiscal space constraints, despite the expansionary fiscal policy the government has adopted in the Budget of 2009-10.²³

In view of the global financial downturn, cuts in Official Development Assistance (ODA) are also envisaged. Although the United States has recently made an exception by increasing rather than decreasing bilateral assistance,²⁴ and the Forum of the Friends of Democratic Pakistan has signalled forthcoming assistance,²⁵ these measures do not provide sustainable solutions for macroeconomic recovery and creating the direly needed fiscal space. Existing fiscal space constraints should, therefore, prompt efforts to improve returns on spending. Many approaches need to be pursued to achieve this objective—rationalizing transaction costs, better integrating programmes and merging duplicative structures should be part of this approach. Under this rubric and the broader paradigm of institutional reorganization in the country, the population-health disconnect stands as a core disparity and is a rationale for merger in its own right. Recently, the International Monetary Fund has stipulated merger of ministries as one of its conditionalities for continuing assistance to Pakistan. The federal government has therefore decided to abolish 13 ministries and departments and merge them into other ministries; the Ministry of Population Welfare is one of them.²⁶

Fourthly, the experience of corporate mergers can be instructive in the given context. Many corporate entities have successfully undergone institutional mergers with significant gains in efficiency and effectiveness. However, plans to merge institutional entities in the corporate sector usually pay careful attention to developing incentive structures as a pre-emptive measure and as a counter to organized resistance from staff and functionaries who, in most cases, strongly resist change that is likely to threaten their individual interests. Any successful attempt at merger of the two institutional entities—health and population—must therefore develop innovative solutions to address the issue of incentives at multiple levels.

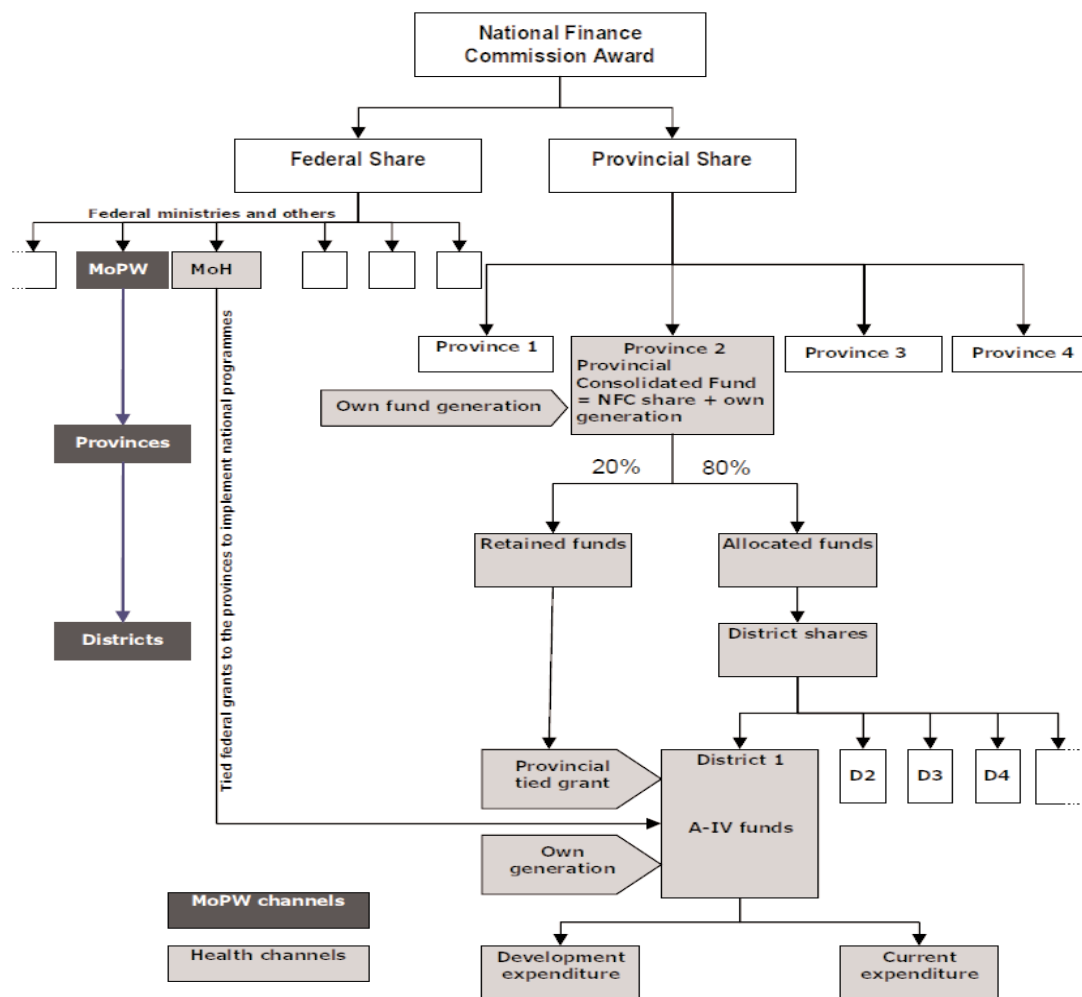
2. Challenges

Although the previous section of this Report has outlined a number of imperatives for institutional merger, pursuing that approach is by no means straightforward. Prima facie, the federal and provincial structures of both the sectors are similar. Both have ministries at the federal level;

both have provincial departments headed by Secretaries with Director Generals to oversee field operations; both have districts as the administrative unit and Tehsil (sub-district level) as the sub-administrative unit and both have their service outlets in the field—Health has hospitals, Rural Health Centres (RHCs), Basic Health Units (BHUs), Maternal and Child Health Centres (MCHCs) and dispensaries; there are 12,804 facilities in all.²⁷ Population, on the other hand, has 3,207 facilities comprising Reproductive Health Services A-Centres (RHS-As), Family Welfare Centres (FWCs), and Mobile Service Units (MSUs).²⁸ Despite this similarity, functioning of both the sectors is quite different, as a result of which merger can be fraught with many impediments.

First, the two sectors have different sources of funding and different channels of fund flows and controls (Figure 1). The population sector is financed entirely through federal funds from the Ministry of Population Welfare down to its service outlets in the districts. Flow of funds takes place through special channels different from

Figure 1: Flow of funds in the population and health sectors



the normal channels of the provinces and districts. Health, on the other hand, is funded by federal funds at the federal level, by provincial funds at the provincial level and by allocated provincial funds at the district level; local funds are also allocated at the district level. Unlike population, resource allocations in health at the provincial and district levels are independent of directives from the Ministry of Health. The funding mechanisms for health and population, therefore, follow separate channels with different arrangements.

Secondly, hierarchical relationships within each sector are different—population is federally funded, is not devolved and is only partially de-federalized, whereas health is both federally and provincially funded and stands decentralized. As a result, there is hierarchical continuity in population—from the Ministry of Population Welfare to Population Welfare Departments to districts in planning, programme formulation and implementation and monitoring. In the health sector, there is no such continuity. The Departments of Health make their own programmes without directions from the Ministry of Health, and similarly, the district governments are free to determine their own priorities without any reference to provincial priorities even if they exist. Both these complicated standalone arrangements can be an impediment to any efforts aimed at institutional merger.

Thirdly, a historical review of efforts aimed at merger and functional integration indicate reluctance on part of both population as well as health. Merger poses a threat to the careers of staff in the Ministry of Population Welfare, who are likely to resist if status quo is challenged. On the other hand, reluctance on part of provincial health departments is also evident; despite several high-level directives over the last three decades, significant progress has not been achieved. These directives include the Executive Committee of the National Economic Council's (ECNEC) decision of 1985,²⁹ the Federal Cabinet decision of 1991,³⁰ the Chief Executive Review Committee's recommendations of 2001,³¹ and the decision of 2006 by the National Commission for Population Welfare,³² which was presided over by the then Prime Minister. In addition to lack of will at the administrative level, there also appears limited political will to go ahead with mergers, as this would eliminate an additional slot for a minister—something political governments vie to create to oblige functionaries. Constitutional stipulations pose an additional difficulty; health is a provincial subject whereas population is in the Concurrent List.

Lessons from other developing countries can be instructive in assessing the impact of institutional impediments on any attempt that aims to merge institutional structures. The example of Bangladesh is particularly

relevant for Pakistan, given the institutional similarities. Bangladesh has a longstanding history of efforts aimed at institutional coordination and collaboration; however, so long as efforts did not threaten individual interests, they were not opposed. During implementation of the Health and Population Sector Programme (1998-2003), when merger was pursued as an institutional outcome and restructuring was envisaged to have consequences for respective staff and functionaries, efforts were strongly opposed and were eventually abandoned.

It must be appreciated that Bangladesh experienced difficulties even though it had more favourable conditions compared to Pakistan—unitary form of government and therefore no provincial level, continuous and identical hierarchical structures, same funding sources and similar channels of fund flows and no difference between the two hierarchies with respect to the degree of decentralization. This experience can provide useful insights into the dynamics of institutional integration vis-à-vis the countervailing forces and their determinants.

It is also important to note that in the case of many countries which have been successful in reducing TFR, such as Thailand and Bangladesh, success has been dependent on a combination of factors; these include improvements in social conditions and literacy levels, better access to healthcare, social mobilization and community involvement. Improvements have not been dependent upon ministerial structural changes. All these considerations should be carefully brought to bear in any future attempts aimed at merging institutional hierarchies.

3. How critical is institutional merger to achieving desired outcomes?

The ultimate objective of policies, plans, processes and outputs in the ministries of Health and Population Welfare is to improve health and demographic outcomes. The question of the importance of institutional mergers has to be contextualized to this paradigm as a starting point. Within this context, a number of factors merit attention.

First, it must be recognized that despite the efforts of many individuals and leaders, overall, both the health and population sectors have performed poorly; this is evidenced by intransigency of trends in health and population outcomes, both within the country as well as in comparison to other developing countries with similar levels of per-capita income and state of development.³³

The performance of a health system can be gauged by the extent to which it enables achievement of three end-points or goals; these include improving health status, financial risk protection and ensuring responsiveness. Although there has been no formal assessment of the performance of the health system in Pakistan, existing data

provide evidence of poor performance in relation to all the three end-points. The health status snapshot articulated in the compendium of health statistics referred to earlier, provides evidence of poor health status of the country's population;³⁴ lack of equity in health outcomes is additionally evidenced by inter- and intra-district disparities.³⁵⁻³⁷ Lack of fairness in financing can be illustrated by predominance of out-of-pocket payments, as a means of financing healthcare.³⁸ Even in the absence of formal measures to gauge responsiveness, management and performance issues discussed in the Section on Service Delivery provide evidence of gaps in this area.

Despite being relatively well-resourced, the Population Welfare Programme has also remained constrained in its ability to achieve desired goals; as a result of gaps in performance, both at the level of health as well as population, CPR currently stands at 30%, with evidence of recent stalling.³⁹ *Merger of two under-performing institutional hierarchies, which face difficulties in delivering on individual targets, against the background of reluctance on part of functionaries and possible turf wars if merger is pursued without caution, is likely to have its limitations.*

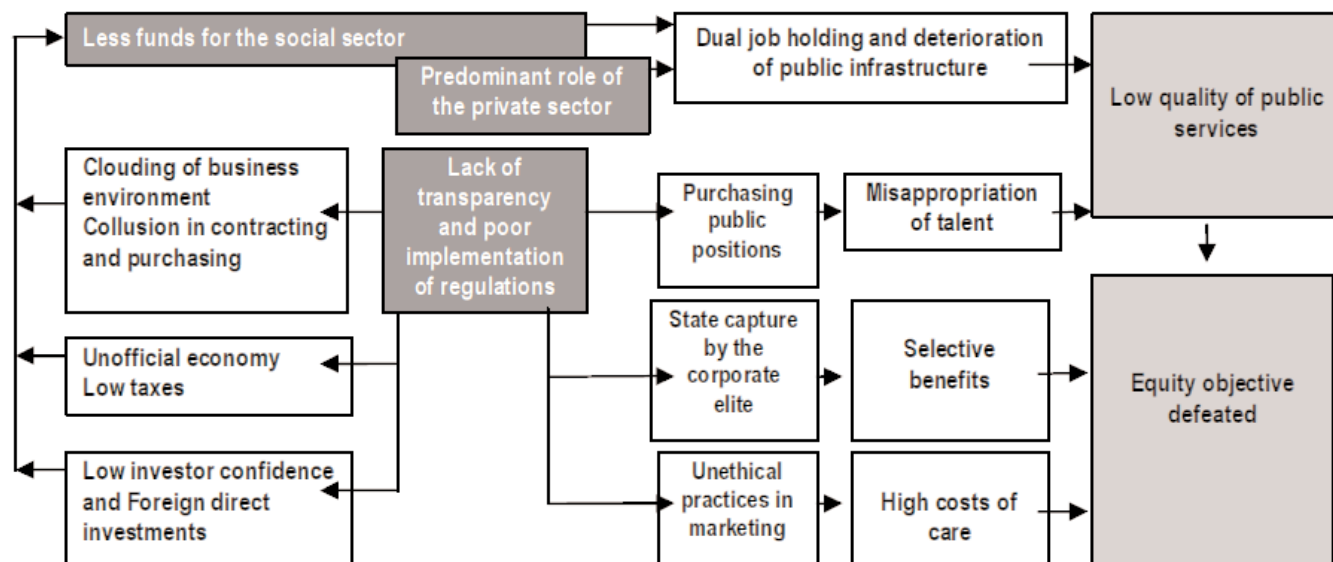
Secondly, it is important to recognize that health and population are an inter-sectoral responsibility and that a number of factors are responsible for poor health and population outcomes in their own right. These include broader issues implicit in the social determinants, poor overall governance, conflict and the general law and order situation; the latter is particularly important as it creates access issues in many parts of the country. Experiences of

many other countries have shown that a decrease in TFR has been dependent on a combination of factors in the inter-sectoral domain.

Thirdly, with reference to the institutional determinants *per se*, many factors need to be taken into consideration in terms of improving institutional performance. The effectiveness of governance is one; current lack of separation between policy-making, implementation and regulation is another; health human resource discrepancies is a third; poor accountability and transparency are other critical issues. And the list can go on. It must be recognized that the present disconnect between the two ministries is just one of the many institutional factors that determine performance of a health system. Other than institutional and governance-related factors, other pillars of the health system—for example, service delivery, financing and human resource—are critically important in determining health systems performance. It is also important to appreciate that the performance of the system is also just one of the many factors in the inter-sectoral domain influencing health and population welfare outcomes and that the other factors are diverse, ranging from socio-economic, environmental, behavioural and biological factors to political determinants. The importance of institutional mergers, which is sometimes blown out of proportion and is regarded as a priority within the health and population sectors, has to be contextualized to this understanding.

These considerations notwithstanding, the need to foster collaborative working between the ministries of health and population is an important institutional

Figure 2: The three governance-related determinants of weaknesses of mixed health systems



Source: Nishtar S. Politics of health systems-WHO's new frontier. Lancet 2007;370(9591):936-6.

consideration in working towards promoting efficiency. However, it must be appreciated that there are other, and perhaps more important determinants of institutional performance. One of the authors of this Report has recently alluded to a triad of determinants—insufficient funding for public facilities, poorly regulated private sector and lack of transparency in governance—as being responsible for the mayhem, which subsequently manifests itself as absenteeism, misappropriation of talent, collusion in procurements and pilferages from the system and stands responsible for poor public sector service delivery (Figure 2).⁴⁰ Addressing these systemic weaknesses calls for broad-based institutional reform and is beyond the remit of the present discussion. Furthermore, it must also be recognized that reduction in TFR and improvements in other related health outcomes are dependent on a number of other factors outside of the traditional purview of the health and population sectors. Unless Pakistan makes impressive improvements in social conditions, literacy rate and social mobilization and community empowerment, dramatic changes in TFR and related health outcomes are unlikely.

4. Sustainable long-term solutions to the health-population disconnect

The sustainable long-term solution to reforming population welfare and health institutions consists of a number of reform measures both within as well as outside of these institutions. The broader reform agenda, which entails recasting the roles of the Ministry of Health, the Ministry of Population Welfare and their respective departments and developing new service delivery and financing arrangements have been discussed in the first author's forthcoming publication entitled, '*Choked Pipes-Reforming Pakistan's Mixed Health Systems*.'⁴¹ This section should be read in conjunction with that publication. The following points are based on the vision articulated therein:

First, there is a need for better macroeconomic management so that the required fiscal space is created for both the sectors. This is important for resourcing public service delivery and bridging the incentive gap highlighted in Figure 2. Measures to enhance allocations should be paralleled with efforts to improve utilization, plug leakages and mainstream overall transparency promoting measures within both the sectors. Changes in civil service structures in order to enhance efficiency, improve performance and institutionalize accountability are critical in this regard. Predictable ODA should be channelled to strengthen state systems within this framework but with the view to ultimately transition away from donor support in the long-term.

Secondly, overall reform of the ministries Health and Population Welfare and their service delivery arrangements

is an imperative. As a first step, there is the need to define the mandate and scope of both the ministries. Both the ministries are meant to be stewardship agencies and are constitutionally mandated in a policy-making and oversight role. However, over the years, a number of factors—service delivery responsibilities, peripheral administrative and logistic tasks, responsibilities related to procurements and regulatory arrangements—have taken them away from their core normative role.

As a first step towards reorganizing the Ministry of Health and the Ministry of Population Welfare, a statement of purpose needs to be developed for each, which clearly articulates their role, mission and key deliverables and the set of outputs and processes that are needed overtime, to achieve these objectives. This exercise can help both the ministries envision a new future and is critical to reforming service delivery within the realm of reproductive health and more broadly Primary Health Care, of which family planning is a part.

Both the ministries should ideally focus on their core objectives, which are essentially normative and oversight in nature. The Ministry of Health should focus preferentially on policy-making, standard-setting, and planning and coordination and should be tasked with collating information and evidence, ensuring compliance with international regulations, providing oversight of autonomous and regulatory agencies and spearheading the broader legislative agenda. Additionally, it should also have the responsibility of establishing and garnering the consensus of all levels of government over the principles of *service delivery*, albeit while allowing the provinces and districts the flexibility to chose management restructuring options that are suited to their own respective needs. This role assumes importance in view of the ongoing management restructuring, especially of Primary Health Care facilities all over the country. One mode of management restructuring involves the role of non-state entities, in particular parastatal organizations and NGOs,⁴² whereas another entails intra-organizational contracting within government agencies.⁴³ In both, the role of the Ministry of Health and the departments of health should be to ensure that a set of MDG+ essential services—of which family planning is a part—are benchmarked as a yardstick for public delivery and as the basis of contractual relationships in these new management restructuring arrangements. This can be a major step in merging the two ministries—from a service-delivery standpoint—at a level where merger is needed.

The Ministry of Population Welfare's broader inter-sectoral mandate could be to develop linkages between population and development and focus on meeting the needs and rights of women in addition to achieving demographic

targets. Post-ICPD, the Ministry of Population Welfare was meant to transition from family planning to reproductive health; however, Pakistan's progress in fulfilling its commitments under ICPD have not been met as was evidenced by a review in 2003.⁴⁴ A new mandate, vision and role for the Ministry of Population Welfare should envision a stronger normative and oversight role for the Ministry in line with the ICPD framework. Major reconfiguration of roles should be paralleled with building capacity of both the ministries and adequately resourcing them so that they can focus on their core mandate.

Both the ministries should rationalize their operational service delivery responsibilities and reconfigure their service delivery roles so that they can provide oversight of service delivery through setting of standards and play a normative and market harnessing regulatory role as opposed to being directly involved in service delivery. The rationale for this approach becomes evident, through a review of the public-private mix in service delivery—79% of care in Pakistan is delivered by private providers.⁴⁵

Such a transformation necessitates a major reorganization of service delivery, financing and governance arrangements with implications for changes in policies, laws and institutional arrangements in the health and population sectors. It entails separation of policy-making, implementation and regulatory functions and mandating existing and new institutions in clearly defined roles. It also necessitates management restructuring in order to revitalize the existing Primary Health Care and Family Welfare infrastructures and place them under independent regulatory oversight. Achieving a fundamental consensus and clarity on the measures and means of delivering services with respect to the role of non-state actors needs to be part of this approach. Developing effective mechanisms to harness their outreach can clearly be the quantum leap in expanding outreach of public services, if appropriately structured.

5. Short and medium term measures to maximize synergies

The previous section of this Report has alluded to long-term structural changes and options that are needed to reform service delivery arrangements of both the institutional entities; these must be pursued as a priority. However, pending their institutionalization, short to medium term measures should be undertaken to maximize synergies between both the institutional arrangements. These measures can also serve as an entry point to broader reform measures.

Over the years, many efforts have been made to foster closer collaboration between the two sectors—by establishing combined structures of governance and administration, by articulating commitments in respective

sectoral policies and by developing collaborative models of service delivery. Recommendations to synergize health and population articulated herein have attempted to build further on these efforts.

5.1 Policy level commitments

Over the last 61 years, three successive health policies, the Population Policy of 2002, overarching planning instruments of the Planning Commission of Pakistan and other planning platforms and instruments have expressed a commitment to integrate health and population activities. A snapshot is summarized:

The National Health Policy 1990 acknowledged that family planning services were not being offered through any health service outlet at the time and stated that health service outlets would be mandated to provide family planning services at all levels. The policy stated that the health departments would work in close collaboration with the Population Welfare Division and the Population Welfare Departments. The policy devised three coordinating mechanisms in this regard—the District Health Board was made responsible for collaboration between population and health at the district level; the District Health Officer was given full responsibility of the Family Planning Programme; and training of Lady Health Visitors (LHVs) and public health nurses was meant to include family planning and birth spacing. Output-based targets of the policy included training of 500 LHVs, 500 public health nurses, 500 midwives and 500 health technicians in family planning methods every year.⁴⁶

The National Health Policy 1997 was more detailed than the policy of 1990; however, lack of attention to the inter-sectoral scope of health—including linkages with the Ministry of Population Welfare—stand as its key weaknesses. The policy framework also did not take into account, the socio-economic implications of increase in population size and did not adequately emphasize the value of increasing contraceptive prevalence.⁴⁷

The National Health Policy 2001 was centred on 10 key areas. One of the output-based targets of key area number eight, focused on imparting family health training to health workers. The policy recognized "...that large family size is an important contributor to household poverty and vulnerability, through its impact upon household savings and therefore expenditure available for health matters..."⁴⁸

The Population Policy 2002 explicitly expressed a commitment to collaborate with other ministries—especially health and education. It aimed to provide family planning services at the primary care level.⁴⁹ However, in doing so, the policy did not make explicit linkages with the health sector.

To date, there has been one provincial health policy—the **Health Policy for the Province of Sindh, 2005**.⁵⁰

While the policy overlooked specific actions aimed at collaboration, it acknowledged the importance of the multi-factorial causes of health and of collaborative working.

Overarching planning instruments of the government of Pakistan, such as the Poverty Reduction Strategy Paper (PRSP)⁵¹ and the Social Protection Strategy (SPS)⁵² also reiterate the need to unify provision of services. The SPS advocates for an integrated approach involving all government ministries, NGOs and other stakeholders, to support and protect those afflicted by poverty. In 2007, the Planning Commission of Pakistan formulated the idealistic Vision 2030⁵³. This document, to which many stakeholders have contributed, also envisages delivery of health and population welfare services through a fully collaborative and integrated approach.

Recommendation # 1: Although overarching policy instruments and respective health and population policies have acknowledged the need to dovetail health and population planning service delivery arrangements, a unified policy statement has not been enunciated to date. Greater and a more tangible commitment by the government of Pakistan is required to address this gap by enunciating a Joint Health, Population and Well Being Policy. The work initialized by the incoming government to formulate a new health policy and the current Zero draft of the Health Policy 2009 appears to be the right opportunity to embody population parameters in the health framework.⁵⁴ The collaborative health-population dimension has been reflected in the Gateway Health Policy Scaffold—an output of partnership agreement between Heartfile, Pakistan's Health Policy Forum, WHO and the Ministry of Health—and can be integrated in the framework.^{55,56}

5.2 Governance and administration

Several attempts have been made in the past to integrate the health and population sectors by creating combined structures of governance. At the broader governance level, the following initiatives are noteworthy:

In 2005, a **National Commission on Population Welfare** (NCPW) was created. This was a 33-member Commission headed by the then Prime Minister with representation both from health as well as population, as both the respective ministers were ex-officio members of this Commission. The Commission met once in 2006 and one of its recommendations was for the provincial health departments to establish family planning/reproductive health services in their outlets. However, none of the provinces initialized action subsequent to the enunciation of this pronouncement, as there were no incentives for each to collaborate.

Although the Commission can be an important platform, the potential within has not been tapped. Absence

of a mechanism to convene the Commission without the Prime Minister in the chair has been one of the factors, as a result of which it has been dormant. Additionally, the focus of the Commission has remained narrow and has not been aligned with the broader reproductive health agenda and development paradigm, as envisaged by the ICPD.

The Commission also mandated the creation of a **Joint Steering Committee**, which was to be co-chaired by the secretaries of health and population; although this was a step in the right direction, this structure too has not been fully operational and the secretaries have only met thrice since the establishment of the Committee.

In early 2008, the respective caretaker ministers of Health and Population Welfare, in an interim government signed a **Memorandum of Understanding** (MoU),⁵⁷ which outlined the parameters of envisaged collaborative working between the two sectors. The terms of the agreement also stipulated the establishment of a National Core Group involving all stakeholders. The Ministry of Health has followed upon this by creating an inter-ministerial task force.

At a downstream level in the administrative hierarchy, there are many joint institutional arrangements; these include the **District Coordination Committees, District Health Management Teams, Tehsil Committees and the District Technical Committees**; through these, some level of cooperation is in place even though many gaps remain to be addressed.

At the governance and administrative level, the level of coordination has been the key problem. This has either been too stratospheric—as in the case of the NCPW—or too downstream in the administrative hierarchy to have any sustainable impact as in the case of district and tehsil committees, referred to above. Although the latter have valuable experience and knowledge, they are powerless to influence policy change due to their position in the hierarchy.

A more effective forum to synchronize governance and administration would be a committee headed by the respective secretaries with active participation from the director generals. Such a forum, the Joint Steering Committee of Health and Population Welfare, already exists and has been created under the auspices of the NCPW, but has not been optimally functioning.

Recommendation # 2: The scope of the NCPW should be broadened to the National Population-Development Commission and the forum revitalized. Responsibility for convening this forum should be mandated to a focal point within the government's executive system, in case of non-availability of the Prime Minister, who currently chairs the Commission in order to ensure regular convening. The scope of the forum should be additionally defined,

particularly vis-à-vis the Joint Committee for Health and Population Welfare, which is mandated through the Commission.

The Commission should be mandated in an oversight and strategic role within the broader remit of population and development as opposed to the Committee, which should be used as a high-level operational platform to maximize synergies between the health and population sectors. The committee should continue to be co-chaired by the two respective secretaries and should be made operationally effective. The MoU signed between the caretaker ministers of health and population in early 2008 can be a starting point for defining the joint scope of work.

5.3 Planning instruments

The ministries and departments of the government of Pakistan seek funding for development projects from Public Sector Development Programme budgets by submitting project proposals entitled Planning Commission-1 (PC-1) documents. Currently, the Ministry of Population Welfare and the Ministry of Health and their departments submit standalone proposals for funding. A plausible option for synergizing activities could be to explore the feasibility of joint PC-1s, where appropriate and feasible. There is no example to date of a joint PC-1 having been submitted by respective ministries/departments. However, in Azad Jammu and Kashmir (AJK), where there is no Population Welfare Department, health and the Family Planning Association of Pakistan (FPAP)—a family planning NGO—have been working in collaboration since 1976 and have been funded through one PC-1.⁵⁸ Although strictly speaking this is not an institutional example of ministerial/departmental collaboration between health and population, it nonetheless demonstrates how both the sectors can come together to pursue common objectives.

A joint PC-1 can be feasible if service delivery arrangements are restructured in the health and population sectors, as envisaged in the 'Sustainable long-term solution to the population-health disconnect' and as outlined further under Primary Health Care, later in this Report. It might be useful to start to test this within one province or set of districts. Pilots and prototypes can build further on currently ongoing work. The USAID-funded Pakistan Initiative for Mothers and Newborns (PAIMAN) project has also attempted integration after an analysis of available options;⁵⁹ evidence from this experience should be taken into account while planning further in this area.

Recommendation # 3: The ministries and departments of Health and Population Welfare should actively explore the feasibility of collaboratively developing joint proposals—PC-1s—for funding, particularly when developing options to reengineer management and service delivery arrangements. They should also maximize

synergies by soliciting the participation of civil society stakeholders in these arrangements.

5.4 Collaborative working at the field level

Both the population as well as health sectors have service outlets and field functionaries performing similar or related tasks and providing services to the same clientele. They also have the same source of contraceptive supplies, have similar training needs, and potentially identical information-related and motivational messages to propagate through the same media. These similarities provide ample scope for collaborative working. Areas where cooperation is necessary and which lend themselves for synergistic efforts at the field level include procurements and supply, service delivery, training and communication.

5.4.1 Requisitioning, procurement and supply

There are two channels for procurement of contraceptives within the country. The larger amongst the two is the Ministry of Population Welfare's procurement channel through which the ministry, with the help of UNFPA, procures contraceptives in bulk for all of its own facilities as well as health facilities of the health sector, with the exception of the National Programme for Family Planning and Primary Health Care (NP-FP&PHC). The other procurement channel enables purchase of contraceptives directly by the NP-FP&PHC. Procured contraceptives are received in either case in a central warehouse in Karachi, owned and operated by the Ministry of Population Welfare. The Ministry of Health's NP-FP&PHC uses this warehouse for transit storage only and sends stocks to its provincial warehouses for onward distribution. Contraceptives are stored in the warehouse on a long-term basis; from here, district consignments are dispatched to District Population Welfare Officers (DPWOs) and Executive District Officers (EDOs) Health separately on a quarterly basis.

Overall procurement needs are determined by the Ministry of Population Welfare, based on computer-generated forecasts using consumption data from the field. For the health sector, the DPWOs and EDOs Health jointly determine the need for contraceptives and generate a request; the DPWOs are then responsible for requisitioning the requirement for their respective districts. In order to additionally ensure contraceptive security, a Reproductive Health Commodities Group has also been established. This group has broad-based representation from the health and population departments of the four provinces, NGOs, private sector and UNFPA. This arrangement represents another level of coordination and collaboration.

Thus, significant collaboration is already underway in the area of procurement and the distribution of

commodities. However, the system has many shortfalls. Consignments of contraceptives provided to the health sector are usually not necessarily those requested for, either in quantity or form; additionally, supplies are usually delayed with an average turnaround time of two months from request to delivery. The Ministry of Population Welfare attributes this to supply of inaccurate consumption figures. However, that clearly isn't the sole factor. The quality of contraceptives is also partly dependent upon warehousing and storage facilities, which are far from adequate at the district level. Moreover, buffer stocks are generally not maintained at district warehouses, as a result of which LHWs often exhaust stocks ahead of time—three months supply should be held at all times.

The LHW distribution chain appears to work better but problems have been encountered in streamlining supplies to the districts from the central warehouse. These issues indicate that there might be problems at both ends; in the health sector, health administrators may have problems in generating requests, requisitioning supplies and distributing consignments in the field, whereas at the other end, there may be problems related to requisitioning, procurement, disbursement and/or onward dispatch. There is much intra-district variation so problems cannot be generalized. Despite the existence of written protocols, procedures and sporadic trainings, these issues have not been resolved.

The existing system and procedure of supply of contraceptives was recently reviewed by the Ministry of Population Welfare in consultation with the departments of health and other stakeholders. Based on the inputs received, the 1987 edition of the Manual of Contraceptives Logistics has been revised and updated. The manual now has a dedicated section with guidelines and procedures for procurement meant specifically for EDOs of Health, who have the responsibility of managing health in districts; training has also commenced using these modules.

Collaborative channels and tools can only be effective in an environment where governance is effective, overall. There are many gaps in this connection. Specifically relevant to the subject under discussion are the frequent postings and transfers of EDOs and their support staff; this is both a de-motivational as well as a destabilizing factor, not just for the function under discussion but also with reference to effective functioning of any programme, at large.

The Health Management and Information System (HMIS) and its upgraded version the District Health Management and Information System (DHMIS) are also relevant to the discussion on requisitioning, procurement and supply, as many of the current gaps in this area prevail because of their limited use. Collation of accurate statistics

on use by the health sector can facilitate computation of precise requirements by the Ministry of Population Welfare, and therefore, streamline delivery.

Recommendation # 4: Governance challenges should be addressed in order to maximize synergies in requisitioning, procurement and supply of contraceptives—an area where collaboration is already underway. Use of HMIS and DHMIS should be capitalized to streamline supply and demand.

5.4.2 Service delivery

5.4.2.a Collaboration at the female community health worker level:

In Pakistan, over 93,000 community-based LHWs deliver preventive, maternal and child health and family planning services to women and children, covering approximately 55% of the country's total population in the rural areas.⁶⁰ Village-Based Family Planning Workers (FPWs) of the Ministry of Population Welfare were integrated with this programme in 2001. The family planning role of LHWs involves encouraging women to practice family planning and providing contraceptive pills and condoms. Recently, they have also been mandated to administer injectible contraceptives. They do not, however, have the training or equipment to insert or maintain intra-uterine devices nor carry out sterilization surgery, although they do recommend and refer cases for these procedures.

The programme is credited with positive independent impact on Contraceptive Prevalence Rate (CPR). A third-party evaluation of the project has shown that CPR is 10% higher in areas covered by LHWs compared to areas that are not covered by them.⁶¹⁻⁶⁶ LHWs are thus a valuable resource for promoting family planning practices; this further makes a strong case for synergizing population and health. However, a key issue in this regard relates to institutional impediments in the NP-FP&PHC itself. The programme's configuration has created many management issues, which undermine effectiveness of the programme. Overcoming these is an institutional reform imperative, much broader than the question currently under discussion.

The issue of inadequate incentives, lack of social support and mobility constraints are other important aspects of the programme, which need attention. With reference to mobility, many LHWs are placed in remote villages where they can typically only travel with male relatives, majority of whom do not encourage employment.^{67,68} Lack of social support and a number of other cultural factors, therefore, act as a barrier to recruiting LHWs where they are needed the most. As a result, LHWs do not cover 100% of the BHUs.⁶⁹ Therefore, in addition to a focus on the technical and

institutional aspects of the programme, attention to these social dimensions is an important aspect of integrating health and population services. Recently, a set of consensus-driven policy recommendations have been articulated by development partners to improve the social standing of LHWs and leverage their presence in communities as agents of social change rather than merely as health workers. Specific recommendations centre on changing their name from workers to activists, better incentives and remuneration and establishment of formal career paths for this workforce.⁷⁰ The current plan to train and equip 12,000 Community Midwives under the Maternal Neonatal and Child Health programme of the Ministry of Health offers an additional opportunity to strengthen the delivery of family planning services through the female health worker force of the health sector—a opportunity, which must be capitalized.

Recommendation # 5: The NP-FP&PHC should be further strengthened and the programme's systemic weaknesses should be addressed. The role of LHWs should be strengthened through appropriate and reconfigured career structures and better remuneration so that they can act as 'agents of social change' in the community within the reproductive health context, as opposed to 'workers' tasked with the delivery of basic health services. The field force of Community Midwives should additionally be used to deliver family planning services.

5.4.2.b Collaboration at the male community health worker level

Communication interventions targeting men are critically needed in Pakistan's male-dominated society in order to change beliefs, attitudes and behaviours. The idea of involving male community health workers into the field force of the Ministry of Population Welfare and creation of the Male Mobilizer Programme were therefore technically sound approaches. However, the Male Mobilizer Programme has been beset with many challenges since its inception and has not been as successful as was initially envisaged due to a number of cultural, political and administrative reasons. The programme offers inadequate incentives to attract personnel with the required competency and qualifications stipulated for the job. Political patronage in recruitments further weakens the impact of this programme. The programme, therefore, needs to be critically analyzed, given the questionable potential of male mobilizers in the current institutional arrangements. In any restructured arrangement, male mobilizers and motivators should work in close collaboration with the Lady Health Worker force, albeit with appropriate attention to cultural norms.

Recommendation # 6: A careful evaluation of the Male Mobilizer Programme of the Ministry of Population

Welfare is needed to explore options for maximizing its impact. Close collaboration should be fostered with the Lady Health Worker programme in any new arrangement.

5.4.2.c Clinical 'family planning services' within 'health territories' and in the field

Most public sector teaching and district headquarter hospitals house Reproductive Health Services-A Centres (RHS-As). The centres are staffed, equipped and administered by the provincial Population Welfare Departments. The service outlets are led by a female Medical Officer and are backed by a team of support workers, which consist of medics, family welfare workers, theatre nurses and technicians. The hospital gynaecologist is usually closely involved.

The RHS-A Centres often provide complete family planning services, including surgical procedures and information and counselling of infertility. Furthermore, many centres are also used as training facilities and provide basic and refresher courses to NGOs, off-site doctors and local personnel. RHS-As also hold Contraceptive Surgery Camps (CSCs) to provide services to clients in remote areas. These are usually arranged at Tehsil Hospitals and RHCs, which come under the purview of the health sector. Additionally, participation of LHWs in referring patients further strengthens the health-population collaboration in field service delivery.

In some districts, RHS-A Centres and CSCs function efficiently with an acceptable level of coordination between the two departments. However, in many cases, it is also otherwise. The question of institutional reconfiguration of these centres is interlinked with the agenda for reforming hospitals and should ideally be taken up within that context. However, in the interim, it appears feasible to pilot a model in which the Ministry of Population Welfare retains the role of training and capacity-building in RHS-A Centres and hands over service delivery responsibilities to the department of health. This approach can work towards ensuring that all hospitals, including Tehsil Headquarter and District Headquarter Hospitals, offer the entire range of contraceptive services as part of the portfolio of the health sector. In addition, the approach would also commensurate with the long-term plan to reconfigure the role of the Ministry of Population Welfare.

Recommendation # 7: Institutional reconfiguration of the RHS-A Centres should be pursued as part of broader hospital reform plans. It appears feasible for the departments of health to take ownership of the RHS-A Centres and for the MoPW to retain the role of training and capacity-building in an interim prototype arrangement. An in-depth analysis should inform hospital reform policy.

5.4.2.d Collaborative mobile service delivery

Mobile Service Units (MSUs) is an initiative of the Ministry of Population Welfare particularly designed to serve the needs of those living in remote rural areas. These units are based at the Tehsil headquarter level in the Tehsil Population Welfare Officer's office and are led by a female doctor and support staff, including Family Welfare Workers (FWWs). MSUs provide all the family planning services other than contraceptive surgery, as well as maternal and child care in far-flung areas. Although there are successful examples of MSUs, the full potential of the programme has not been actualized; additionally, there are gaps in linkages between this and the NPPF&PHC Programme.

Recommendation # 8: Cooperation between Mobile Service Units of the Ministry of Population Welfare and the National Programme for Family Planning and Primary Health Care of the Ministry of Health should be maximized in order to capitalize community linkages of the LHW workforce. In restructured Primary Health Care service delivery arrangements, mobile delivery of services can become part of the package of services to be contracted out.

5.4.3 Primary health care infrastructure

There have been three high-level decisions in the past to institutionally merge BHUs of the departments of Health and Family Welfare Centres of the Ministry of Population Welfare; these include the ECNEC decision of 1985, the Cabinet decision of 1991 and the decision by the Chief Executive in 2001. However, none of these has come to fruition. Taking past failures into account, the Prime Minister's Monitoring Committee instructed the Ministry of Population Welfare to conduct a study ".....to look into the possibility of accommodating 1,300 rural FWCs in BHUs...." in 2005. Findings of the study established that only rural FWCs could be incorporated into BHUs and that too if additional space was made available in the existing premises. The study also alluded to reluctance on part of both institutional arrangements to physically merge facilities. In view of this evidence, Secretary Population of the government of Punjab recommended that the notion of merging FWCs with BHUs should be abandoned.

Later that year, NCPW decided to enhance the outreach of family planning services. The Commission decided that ".....Provincial Health Departments will establish FP/RH service delivery outlets of Population Welfare Programme.....two rooms would be provided at all BHUs/RHCs/Health service outlets in the country....." Once again, the NCPW policy did not cascade into action and the matter has been at a standstill with no future plans of a re-launch. It is generally perceived that if attention was given to adequate staffing with requisite skills for family planning in BHUs and RHCs, as opposed to the focus on

merger, better results in terms of health outcomes could have been achieved. Future attempts aimed at restructuring should, therefore, learn from past lessons. It must also be appreciated that both FWCs and BHUs have critical management issues, which are more important to be addressed than attempts aimed at their merger. Institutional reorganization and reform of BHUs and FWCs should, therefore, be actively pursued; this can be taken up in the context of the current management restructuring of BHUs, which either involves out-sourcing/contracting management or incentivizing and resourcing directly managed services.

Recommendation # 9: Rather than merger of BHUs and FWCs, the focus should be on management reengineering. Any restructuring arrangement should group health and family planning into a set of services to be delivered by the agency mandated with service delivery responsibilities at the Primary Health Care level.

5.5 Pricing policy of contraceptives and Management Information Systems

The Family Welfare Centres of the Ministry of Population Welfare levy a nominal charge on contraceptives in an attempt to avoid pilfering and exaggerated reporting. A major proportion of the revenue thus generated is deposited back into the government's accounts. On the other hand, since the BHUs distribute medicines, free of cost to patients, levying a cost for contraceptives is a problem for them in the first place; secondly, maintaining accounts of the sale proceeds is an additional chore which the LHWs are not familiar with as opposed to their counterparts in the FWCs. In any event, the simultaneous existence of two pricing systems in the same community is a cause of discontent. This gap is also reflected in poor reported use of contraceptives in the HMIS and DHMIS. The issue of discordance of price has been pending resolution over two decades. It was on the agenda of the NCPW meeting in 2005 but was deferred.

Recommendation # 10: Pricing policy for contraceptives should be made uniform—Basic Health Units vis-à-vis Family Welfare Centres. User's charges should ideally be abolished in both the institutional arrangements.

5.6 Training and capacity-building

Training pertaining to family planning—both of inter-personal skills for motivation as well as provision of services—is an obvious area, which lends itself to collaboration between the two sectors. The health sector has personnel in over 12,500 service points and over 93,000 LHWs, all of whom need to be trained in family planning; the population sector, on the other hand, has a longstanding experience in this field, which can be capitalized. However, this potential remains untapped, as a result of which

healthcare providers in the health sector receive inadequate practical training in family planning.^{71,72} Although some level of collaboration does exist, it has not been fully optimized, particularly in the area of training LHWs, despite the existence of official training agreements. In 2004, the Ministry of Health and the Ministry of Population Welfare agreed that the latter will collaborate with NP-FP&PHC to develop a curriculum for LHWs and will train 66 master trainers in four provinces. There has been some progress in relation to this agreement, but the full potential within effective collaboration has not been capitalized.

The RHS-A Centres and the Population Welfare Training Institutes of the Ministry of Population Welfare offer additional opportunities to institutionalize training. The former imparts training in contraceptive surgery to doctors both from the health as well as the population sectors, whereas the latter is mandated in a capacity-building role with respect to motivational skills. Training of workers in counselling skills can be particularly important in this regard.⁷³ There is therefore the need to engage in joint yearly planning exercises to develop consolidated plans for training in order to fully realize the unutilized potential of collaboration in the area of training. Existing health provider continuing medical education programmes and capacity-building programmes for policy-makers and administrators should be additionally reviewed for appropriateness of content and curricula updated, where needed.

A specific human resource gap—this has implications for training—relates to the current professional status of Family Welfare Workers, who need to be brought to the same professional standards as Lady Health Visitors so that they could be accredited to offer the same range of reproductive health services. Currently, the FWWs are not accredited by any licensing authority; this gap can be bridged by bringing them under the licensing umbrella of the Pakistan Nursing Council.

Recommendation # 11: The Ministry of Population Welfare and the departments of health should proactively collaborate and jointly develop training and capacity building plans for all categories of service providers in the health and population sectors. In addition, practical family planning training should be incorporated into capacity-building and continuing medical education programmes of all categories of service providers. Managers and policy-makers should be sensitized to the policy formulation and implementation perspectives through the structured introduction of modules into mechanisms of ongoing training. In addition, FWWs should be brought under the regulatory umbrella of the Pakistan Nursing Council.

5.7 Social marketing

Recognition of the dominant role of private providers in health service delivery lent impetus to franchising of family planning services in Pakistan in the late nineties. The basic premise was to subsidize contraceptives, increase their availability by leveraging a network of private sector providers in poor urban areas and promote their use through advertising. Currently, one out of the two social marketing programmes initially rolled out—the Green Star Social Marketing programme—is fully in operation. Other NGOs also use social marketing though not to the extent of Green Star.⁷⁴⁻⁷⁵ This experience can be of value in informing policy and shaping new models of service delivery as is being recommended by this Report.

Recommendation # 12: Evidence from social marketing and franchising of contraceptive products should be carefully taken into consideration whilst reconfiguring service delivery arrangements within the broader ambit of institutional reform in order to leverage the outreach of private providers.

5.8 Communication strategies

While there is a perception that family planning does not conform to the teachings of Islam, another religious school of thought is of the view that Islam may be the only religion, which supports human free will such that a man can organize his affairs according to his own social and economic circumstances.⁷⁶ There have also been many *fatwas* (pronouncements by religious scholars) in support of family planning.⁷⁷ In 2005, the Ministry of Population Welfare organized the International Ulema Conference in Islamabad, which was attended by Ulema representing 21 Muslim countries.⁷⁸ The deliberations reaffirmed that Islam provides guidance on all aspects of life including issues relating to population planning and urged Muslim countries to formulate population policies in order to achieve population stabilization.⁷⁹ Although the Ministry of Population Welfare has been active in dispelling the myth—Islam does not allow family planning—through its communications, health has not done likewise and collaboration in this area has been minimal. It is therefore imperative that the Ministry of Population Welfare and the Ministry of Health/departments of health devise a common communication plan capitalizing religious arguments in support of family planning.

Synchronized communication between the health and population sectors is also needed in order to overcome social and cultural barriers to family planning and can reinforce messages in a male-dominated culture. Through synchronized Behaviour Change Communication (BCC), men and adolescent boys can receive appropriate information about sexual education, maternal health and the

advantage of family planning and can be educated about the potential risks and the advantages of vasectomies.⁸⁰ Other cultural norms such as marriages at a young age, preference for sons, the subordinate position of women and their general low health status, which contribute towards high population growth rates in Pakistan, can be included in coordinated communication campaigns.⁸¹⁻⁸² Coordinated communication can also better target other family planning opposing forces such as mothers-in-law.⁸³ The emphasis should be on healthy families rather than small families.

Recommendation # 13: Synchronized communication should be one of the core priorities of collaboration between the health and population sectors. Health and population need to work collaboratively to capitalize the religious argument and better target campaigns to overcome socio-cultural family planning bottlenecks. A shared campaign identity and common communication tools need to be prioritized for effective targeting and optimization of resources.

CONCLUSION

The question of merging the ministries of Population Welfare and Health has been one of the key social sector restructuring dilemmas in the country for over two decades now. This question has recently assumed importance in view of the conditionality stipulated by the International Monetary Fund to merge duplicating structures in an attempt to rationalize establishment costs, and hence merge the Ministry of Population Welfare with the Ministry of Health. Within this context, the conclusions of this study, which can be of relevance to informing policy can be summarized as follows:

- ◆ There are many considerations that underscore the importance of merger—notably, the shared agenda of reproductive health and family planning and current fiscal space constraints. However, merger will prove to be difficult because of differences in sources of funding, fund flows, hierarchical relationships, constitutional prerogatives and reluctance on part of functionaries.

- ◆ Not much can be achieved by merging two institutional hierarchies that are plagued by many challenges and each of which has been unsuccessful in achieving its own objectives. Merger/functional integration of family planning and health service delivery should therefore be pursued as part of holistic reform of both institutional hierarchies.

- ◆ Although there is the need for institutional overhaul of the health and population hierarchies, institutional improvements should not be expected without deep-rooted action within and outside of both the sectors. The needed broader measures should centre on increasing fiscal space on the one hand and promoting transparency in

governance, as a counter to institutionalized collusion, on the other.

- ◆ Within both sectors, reform of stewardship agencies should strengthen their policy-making, normative, regulatory and oversight role with population additionally assuming responsibility for developing linkages between population and development. Both ministries should reconfigure their service delivery roles so that they can provide oversight and pursue locally-suited management restructuring options with an emphasis on public-private partnerships. A set of MDG+ services—of which family planning should be a part—should be benchmarked as a yardstick for public delivery and as a basis for contractual relationships within new management restructuring arrangements. A long-term commitment to reform is needed to implement these changes, which is why the study conclusions project these in the long term.

- ◆ Over the short to medium term, a number of measures should be undertaken to build capacity for the needed long-term changes—these centre on enunciation of a joint Health, Population and Well Being Policy, broadening the remit of the NCPW, revitalizing the Joint Committee for Health and Population Welfare and exploring, where feasible, joint proposals for funding. Additional measures in the right direction include addressing governance issues at the level of requisitioning, procurements and supplies, where a significant collaboration is already underway and incorporating family planning into the mandate of the health sector; this can be done by further reinforcing family planning as a LHW mandate, augmenting the field force through appropriate linkages with male mobilizers and mobile service units, mandating synchronous communication campaigns and by fostering ownership of RHS-A Centres in the health sector. The potential to develop bridges through training should also be capitalized.

The short to medium term strategies proposed, which centre on a range of specific collaborative measures, can build capacity for the broader systems transformation. However, sustained political and institutional will be needed to implement these recommendations.

ACKNOWLEDGEMENTS

The authors would like to thank the following: Amina Katrina Ronis for help with reviewing literature; Yasir Abbas Mirza, Azhar Iqbal, Amjad Javed and Aamra Qayyum for logistic support; and Shahina Maqbool for editing the Report. The authors would also like to thank a number of experts who attended consultations, reviewed the manuscript and provided comments. In particular, constructive comments of Siraj-uddin, Kathy Toner, Yasmeen Qazi, Mobashar Malik, Saman Yazdani, Zeba

Sathar, Shahida Azfar, Babar Sheikh, and Saeed Shafqat are gratefully acknowledged.

This research has been supported by a grant from the David and Lucile Packard Foundation. The opinions expressed are those of the authors and investigators and do not necessarily reflect the views of the funder.

The authors declare no conflict of interest.

REFERENCES

- Economic Advisory Wing, Ministry of Finance. Economic Survey 2008-09. Islamabad, Pakistan; Government of Pakistan; 2009. <http://www.finance.gov.pk/> (accessed July 08, 09).
- National Institute of Population Studies and Macro International Inc. Pakistan Demographic and Health Survey 2006-07. Islamabad, Pakistan: National Institute of Population Studies and Macro International Inc, 2008.
- United Nations Population Fund. State of the World Population 2007, Unleashing the Potential of Urban Growth. New York, USA: United Nations Population Fund, 2008. <http://www.unfpa.org/swp/> (accessed Sep. 10, 08).
- Population Reference Bureau. Washington, DC, USA .<http://www.prb.org/> (accessed Jan. 17, 09).
- Nishtar S. The Gateway Paper: Health Systems in Pakistan-a Way Forward. Islamabad, Pakistan: Heartfile, 2006. <http://heartfile.org/pdf/phpf-GWP.pdf> (accessed April 07, 08).
- Nishtar S. Health Indicators of Pakistan-Gateway Paper II. Islamabad: Heartfile, Health Policy Forum, Federal Bureau of Statistics, Government of Pakistan, World Health Organization, Ministry of Health, Government of Pakistan; 2007.
- ibid ref no.02
- Ministry of Finance, Government of Pakistan. Accelerating Economic Growth and Reducing Poverty: the road ahead. Islamabad, Pakistan: Ministry of Finance, Government of Pakistan, 2003.
- Government of Pakistan. Medium Term Development Framework. Islamabad, Pakistan: Government of Pakistan, 2005.
- Government of Pakistan. Vision 2030. Islamabad, Pakistan: Government of Pakistan, 2007.
- The Ministry of Population Welfare. Population Policy 2002. Islamabad, Pakistan: The Ministry of Population Welfare, Government of Pakistan, 2002.
- Ministry of Health. National health policy 2001, The Way Forward. Islamabad, Pakistan: Government of Pakistan, 2001. <http://www.pakistan.gov.pk/divisions/health-division/media/NHP.doc>(accessed April 10, 09).
- United Nations Population Fund. Report of the International Conference on Population and Development United Nations, New York, USA: UNFPA, 1994.
- Ministry of Population Welfare. National Population Welfare Programme-Handing over note for Punjab. Islamabad, Pakistan: Government of Pakistan, 2002.
- Government of India. Health Survey and Development Committee Report (Bhore committee). Vol 1-4. New Dehli, India: Ministry of Health; 1946.
- World Population Conference; Bucharest, 19-30 August 1974. <http://www.un.org/esa/devagenda/financial.html> (accessed Jan. 22, 09).
- International Conference on Population; Mexico City, 6-14 August 1984. <http://www.un.org/esa/devagenda/financial.html> (accessed Jan. 22, 09).
- International Conference on Population and Development; Cairo, 5-13 September 1994. <http://www.un.org/esa/devagenda/financial.html> (accessed Jan. 22, 09).
- United Nation Population Fund. Programme of action of the International Conference on Population and Development; Cairo; 1994. <http://www.unfpa.org/icpd/summary.htm> (accessed March 26, 08).
- 13 ministries to be abolished. The Frontier Star (Northwest Frontier Province, Pakistan) 2009August 06; Free Online Library. <http://www.thefreelibrary.com/13+ministries+to+be+abolished.-a0205307771> (accessed Aug. 07, 09).
- United Nations Population Fund. How to address population issues during the Ninth Five Year Plan. Islamabad, Pakistan: UNFPA, 1998.
- 11th session of the United Nations Human Rights Council. Preventable maternal mortality and morbidity and human rights. Geneva, 2 - 19 June 2009. <http://www2.ohchr.org/english/bodies/hrcouncil/11session/> (accessed July 10, 09).
- Finance Division, Government of Pakistan. Federal Budget 2009-2010. Islamabad: Government of Pakistan; 2009.
- White Paper of the Interagency Policy Group's Report on U.S. Policy toward Afghanistan and Pakistan http://www.whitehouse.gov/assets/documents/Afghanistan-Pakistan_White_Paper.pdf (accessed April 28, 09).
- Ministry of Foreign Affairs Pakistan. PR. No. 126/2009. Date: 24/03/2009. http://www.mofa.gov.pk/Press_Releases/2009/March/PR_126_09.htm (accessed April 27, 09).
- ibid ref no 20.
- Economic Advisor's Wing, Finance Division, Ministry of Finance. Economic Survey 2007-2008. Islamabad, Pakistan: Government of Pakistan; 2008. <http://www.finance.gov.pk/survey/home.htm> (accessed July 30, 08).
- The Ministry of Population Welfare, Government of Pakistan. Year Book 2007-08. Islamabad, Pakistan: Government of Pakistan, 2008.
- Executive Committee of the National Economic Council (ECNEC). MOPW Working paper of 04 June 2004 on Interaction/Collaboration of the ministries and departments of Health and Population. http://www.mopw.gov.pk/publications/pplan/Chap6_7.htm (accessed Dec. 18, 08).
- Ministry of Population Welfare. Presentation to the cabinet for accelerating the population welfare programme. Islamabad, Pakistan: MOPW Government of Pakistan, 1991.
- Government of Pakistan. Chief executive review committee process and outcome. In: Interim: Population sector perspective plan 2012. Islamabad: Government of Pakistan, 2000. <http://www.mopw.gov.pk/publications/pplan/Default.htm> (accessed July 15, 09).
- Prime Minister's Secretariat. Office Order number 3(22)/ds(fa-1)/2004 dated 12th July 2006.
- Mahbub-ul-Haq Human Development Centre. Human development in South Asia 2007. Islamabad, Pakistan. Oxford University Press, 2008.
- ibid ref no 06.
- Fikree F, Karim MS, Midhet F, Brendes HW. Causes of reproductive age mortality in low socioeconomic settlements in Karachi. J Pak Med Assoc 1993;43(10):208-12.
- Midhet F, Becker S, Brendes HW. Contextual determinants of maternal mortality in rural Pakistan. Soc Sci Med 1998;46(12):1587-98.
- Federal Bureau of Statistics, Statistics Division. Pakistan Social and Living Standards Measurement Survey, 2007-08. Islamabad, Pakistan: Government of Pakistan, 2008.
- Nishtar S. Choked Pipes-Reforming health systems in Pakistan. GIII Islamabad, Pakistan: Heartfile. Forthcoming, 2009.
- ibid ref no 02.
- Nishtar S. Politics of health systems: WHO's new frontier. Lancet 2007;370(9591):935-6.
- ibid ref no 38.
- President's initiative on Primary Health Care. <http://pphinwfpata.com/about.php> (accessed May 08, 08).
- National Commission for Human Development. Strengthening and restructuring of Primary Health Care system and improving health of primary school students in eleven districts of Punjab. Islamabad, Pakistan: Department of Health, Government of Punjab; 2007.
- Pakistan and UNFPA country population assessment in 1999-2003. <http://www.unfpa.org/exbrd/2004/annualsession/dpfpa-2004-9.doc> (accessed April 27, 09).
- Federal Bureau of Statistics, Statistics Division. Pakistan Social and Living Standards Measurement Survey 2006-07. Islamabad, Pakistan: Government of Pakistan 2007. http://www.statpak.gov.pk/depts/fbs/statistics/pslm2006_07/pslm2006_07

- .html (accessed April 30, 08).
46. Government of Pakistan. National Health Policy. Islamabad, Pakistan: Ministry of Health, Special Education and Social Welfare (Health Division), Government of Pakistan, 1990.
 47. Ministry of Health. National Health Policy 1997. Islamabad, Pakistan: Government of Pakistan, 1997.
 48. *ibid* ref no 12
 49. The Ministry of Population Welfare, Government of Pakistan. Population Policy 2002. Islamabad, Pakistan: Government of Pakistan, 2002.
 50. Abbasi SH, Kazi GN, Mughal MJ. Health Policy for the province of Sindh. Karachi, Pakistan: Health Department, Government of Sindh, 2005.
 51. Finance Division, Government of Pakistan. Chapter 9 - Pillar VI: Human Development for the 21st Century. In: Poverty Reduction Strategy Paper-II. Islamabad, Pakistan: Government of Pakistan; 2009. <http://www.finance.gov.pk/admin/images/poverty/PRSP-II.pdf> (accessed May 25, 09).
 52. Ministry of Social Welfare and Special Education. Social Protection Strategy. Government of Pakistan, 2005.
 53. Planning Commission. Vision 2030. Islamabad, Pakistan: Planning Commission, Government of Pakistan; 2007. 202.83.167.93/pcportal/vision2030.htm - 51k. (accessed May 07, 08).
 54. Ministry of Health, Government of Pakistan. National Health Policy 2009. Stepping Towards Better Health. Islamabad: Government of Pakistan; 2009. <http://www.healthnwp.gov.pk/downloads/draft%20health%20policy.pdf> (accessed June 12, 09).
 55. MOU Memorandum of Understanding on developing the National Health Policy 2007. Ministry of Health, Government of Pakistan; World Health Organization; Heartfile and Pakistan's Health Policy Forum: Islamabad, 2007 <http://heartfile.org/>. (accessed Oct 19, 07).
 56. Nishtar S. Scaffold for the National Health Policy 2009. Heartfile: Islamabad, 2009. In press
 57. National Health Policy Unit, Ministry of Health, Government of Pakistan. Memorandum of Understanding between Ministry of Health and Ministry of Population Welfare, 2008. Islamabad, Pakistan: Government of Pakistan, 2008.
 58. Gardezi SMA. PC-1: Strengthening of reproductive Health and Family Planning services in Azad Jammu and Kashmir, 2002-05. Azad Jammu and Kashmir, 2001.
 59. United States Agency for International Aid and Pakistan Initiative for Mothers and Newborns. Functional Integration of Services, Rawalpindi District Pilot Study. Islamabad, Pakistan: JSI-PAIMAN, 2007.
 60. Economic Advisor's Wing, Finance Division, Ministry of Finance. Economic Survey 2007-2008. Islamabad, Pakistan: Government of Pakistan; 2008. <http://www.finance.gov.pk/survey/home.htm> (accessed July 30, 08).
 61. Douthwaite M, Ward P. Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Program. Health Policy Plan. 2005;20(2):117-23.
 62. Schmidt RL. Women and health care in rural Pakistan. Soc Sci Med. 1983;17:419-20.
 63. Upvall MJ, Sochael S, Gonsalves A. Behind the mud walls: the role and practice of lady health visitors in Pakistan. Health Care Women Int 2002;23:432-41.
 64. Islam A, Malik FA, Basaria S. Strengthening primary health care and family planning services in Pakistan: some critical issues. J Pak Med Assoc 2002;52:2-7.
 65. World Bank. Role of public investments in immunization converge. Innovative development strategies. World Bank: Islamabad; 2007.
 66. Federal programme Implementation unit. Field program officers' survey 2007 -Internal assessment of lady health worker programme. Islamabad, Pakistan: Ministry of Health, Government of Pakistan, 2007.
 67. Douthwaite M, Ward P. Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Programme. Health Policy Plan 2005;20:117-23.
 68. Amin S. The poverty-purdah trap in rural Bangladesh: Implications for women's roles in the family. Development and Change 1997;28:213-33.
 69. Mumtaz Z, Salway S, Waseem M, Umer N. Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. Health Policy Plan 2003;18:261-9.
 70. Personal communication. Packard Foundation and its partner's feedback on LHW Program.
 71. Walker G. Implementation Challenges of Reproductive Health, Including Family Planning and Sexual Health: issues concerning the integration of reproductive health components. United Nations Economic and Social Commission for Asia and the Pacific, 1998.
 72. Islam A, Malik FA, Basaria S. Strengthening primary health care and family planning services in Pakistan: Some critical issues. J Pak Med Assoc 2002;52(1):2-7.
 73. Lush L, Cernada GP, Ubaidur RA, Arif MS, Haque M., Ahmad MS. Operations research on the female village-based family planning worker program of Pakistan. International Q Community Health Educ 2007;26(2):189-210.
 74. Ahmad M. Thomas D. Population Welfare Programme Punjab-Situation Analysis Report, TAMA, 2007.
 75. Family Health International. Pakistan's Green Star trains "lady doctors" and others. Islamabad, Pakistan: The Network, 2000.
 76. Jullundri RA. Wisdom, insight and pragmatism: In the early days of Islam, Muslim society was familiar with the concept of the small family. Integration 1996;47:18-9.
 77. Ministry of Population Welfare. Khandani mansuba bandi Islam ki nazar mein. Islamabad, Pakistan: Government of Pakistan. <http://www.mopw.gov.pk>. (accessed May 10, 08) [publication in Urdu]
 78. Ministry of Population Welfare, Government of Pakistan. International Ulema Conference May 05. Abadi Nama. 2005;III(V):19-20.
 79. Ministry of Population Welfare, Government of Pakistan. International Ulema Conference on Population and Development. Islamabad, Pakistan: 2005.
 80. Faisal A. Core strategies for safe motherhood in Pakistan. Islamabad, Pakistan: The Futures Group International, Washington DC, 2001.
 81. Geary J. Liberating the shackled half. Family Planning in Pakistan. ORGYN 1995;(3):2-6.
 82. Winkvist A, Akhtar HZ. God should give daughters to rich families only: attitudes towards childbearing among low-income women in Punjab, Pakistan. Soc Sci Med 2000;51(1):73-81.
 83. Kadir MM., Firkee FF, Khan A, Sajjan F. Do Mothers-in-law matter? Family dynamics and fertility decision-making in urban squatter settlements of Karachi, Pakistan. J Biosoc Sci 2003;35(4):545-58.

APPENDIX

Population welfare: evolution of a separate sector

Pakistan has a long history of planning in the area of population welfare. The following account provides a snapshot of the evolution of population welfare as a separate institutional entity during each of Pakistan's five-year planning cycles. It must be noted that prior to the five-year planning cycles, directions articulated within the Bhore Committee Report guided social sector planning within the country. Relevant to the subject under discussion, the Report recommended increase in the age of marriage for girls, improving the standard of living and intentional limitation of the size of families.

First Five-Year Plan, 1955-60: The First Five-Year Plan recognized the potential negative socio-economic impact of increase in population size and signalled an intent to invest in family planning programmes by allocating half a million rupees to a voluntary private agency—the Family Planning Association of Pakistan (FPAP)—to support existing and future family planning projects. The FPAP used this funding to set up clinics and promote the idea of small families. It was thus the first NGO in Pakistan to have initialized family planning activities within the country.¹

Second Five-Year Plan, 1960-65: Family planning was institutionalized within the state system during the Second Five-Year Plan period. During this period, a Family Planning Wing was created in the Ministry of Health, Labour and Social Welfare; although a full-time Family Planning Commissioner was appointed, the Wing was headed by a deputy secretary. A Family Planning Council was also created at the centre and Family Planning Boards were established at the provincial and district levels.

During this period, the population programme evolved as a clinic-based initiative and Family Planning Clinics were established in hospitals, dispensaries, and maternal and child welfare centres. This enabled the creation of 2,683 Family Planning Clinics (FPCs) in the country, of which 1094 clinics were in East Pakistan—now Bangladesh. However, provision of contraceptives at health outlets proved to be ineffective as service outlets were reluctant to distribute them due to the attached stigma.

Third Five-Year Plan, 1965-70: During the Third Five-Year Plan period, the government's family welfare institutional arrangements were further consolidated. The Family Planning Wing was given the status of a Division and the Family Planning Commissioner was mandated as its head. Although a Division of the Ministry of Health, Labour and Social Welfare, it meant separation of the population programme from the health sector as the Family Planning Council and Provincial Boards were given recruitment powers

and resources to create their own field infrastructure for provision of services. During this period, the political leadership supported family planning and declared it to be in consonance with Islamic teachings; they also referred to population growth as an impediment to socioeconomic development.² During this timeframe, the National Research Institute for Family Planning was also created. The Third Five-Year Plan (1965-70) envisaged provision of contraceptives through male and female community motivators, who were supposed to be related to each other so that they could deliver contraceptives on bicycles. Bicycles were provided for the purpose; however, the plan to inundate the country with contraceptives through these teams was abandoned by the Planning Commission in view of objections raised by communities, given that those delivering the service were, in many cases, unrelated.

Towards the end of the Plan in 1969, the programme strategy was revised and the Continuous Motivation System (CMS) was introduced as a pilot programme. Unfortunately, due to political instability towards the end of the Five-Year plan, its operational structure began to crumble, especially at grassroots contact points.

No-plan period, 1971-76: During the no-plan period, the government decided to federalize the Family Planning Programme; however, this did not materialize. The first phase of the plan period suffered from financial setbacks, and therefore, a sub-plan covering 1973-76 had to be announced, during which major structural changes were proposed. The proposals included abolition of the Population Council; the Ministry of Health was to be charged with the responsibility of policy, planning and logistics. At the provincial level, the Health Department was to be renamed as the Department of Health and Population with two directorates—one for health and another for population. District level family planning activities were placed under the charge of a District Publicity-cum-Executive Officer.

Fifth Five-Year Plan, 1977-83: During the Fifth Five-Year Plan period, the Family Planning Programme was transferred from the Ministry of Health, Labour and Social Welfare to the Ministry of Planning and Development, and the corresponding Division was renamed as the Population Welfare Division (PWD). The PWD was now an independent body and could receive funds from government allocations and donors. By 1978, there were 16,000 sanctioned posts with about 13,000 employees in position. However, as part of major restructuring in 1981, total posts were reduced to 8,457 and services of 4,323 trained employees including 1,051 officers were dispensed with. This event was a major setback in terms of staff morale.

The programme in the field was placed under four provincial director generals, who reported to the Population Welfare Division.

Sixth Five-Year Plan, 1983-88: During the Sixth Five-Year Plan period, many institutional initiatives were undertaken. Provincial Welfare Departments were established and field activities were transferred to the provinces for implementation. The number of FWCs—establishment of which had commenced during the 1970's—was increased from 900 to 1,250. In an attempt to broaden the outreach of contraceptive delivery, collaboration was established with private sector organizations. The idea was to establish 50,000 contraceptive distribution points in the urban and peri-urban areas. Details about the eventual implementation and evaluation of this Plan are not in the public domain. During this plan period, an NGO Coordinating Council (NGOCC) was also established in Karachi to coordinate the work of NGOs. Furthermore, another initiative during this period involved the creation of the National Institute of Population Studies (NIPS). In 1985, ECNEC decided to relocate FWCs to BHUs but could not implement its decision.

Seventh Five-Year Plan, 1988-93: During the Seventh Five-Year Plan period, there appeared to be a strong political commitment towards family welfare. During this period, the Population Welfare Division was given the status of a full-fledged ministry and the PWD, along with the Family Planning Programme, moved out of the Ministry of Planning and Development. In addition, recruitment and training of 12,000 Female Village-Based Family Planning Workers (VBFPWs) and the Mobile Service Units Programme was initialized.

During this period, USAID ceased its support for the family planning programme; this change adversely impacted the supply of contraceptive commodities since 66% of all condoms were then being supplied through this programme. However, revival of assistance from 1994 onwards, as a result of support from the European Union and some other donors, was able to compensate for USAID's departure.

Eighth Five-Year Plan, 1993-98: The Eighth Five-Year Plan period was characterized by four institutional events. First, results of independent evaluations, which established under-utilization and inaccessibility of family planning outlets, lent impetus to creation of the franchised Green Star Project in the urban areas in an attempt to increase the availability and accessibility of contraceptives to low-income women. By the end of 1996, the Green Star Project was selling in excess of 80 million contraceptives annually, and approximately 5,500 Village-Based Family Planning Workers (VBFPWs) and 30,000 Lady Health Workers had been trained and were operational.³ In order to improve linkages between the government and the private sector, the NGOCC was also shifted from Karachi to Islamabad during this period; its charter was revised and it was renamed as the National Trust

for Population Welfare.

The second notable event during this period involved the establishment of the LHW Programme by the Ministry of Health; this programme employed the same recruitment criteria as Ministry of Population Welfare's VBFPWs, but expanded their mandate to maternal and child care in addition to family planning. The official name of the LHW Programme is now the National Programme for Family Planning and Primary Health Care. Since its creation, both the ministries have attempted to collaborate through this programme in order to prevent duplication of services and staff; however, many gaps remain to be addressed.

Creation of the Donors Task Force by UNFPA in 1997, with representation from bilateral and multilateral donors, represents the third important institutional event of relevance to the subject under consideration. The original scope of work of the task force emphasized the delivery of reproductive health services through collaboration between the ministries of population welfare and health.

During this plan period, the Social Action Programme Project 1 (1993-97) and later, Project 11 (1997-2002) also commenced. These projects were meant to accelerate improvement in the social sectors—four key areas of focus included primary health, primary education, population welfare and rural water supply and sanitation. The Social Action Project envisaged functional integration of service delivery arrangements of both the health and population welfare sectors in a decentralized arrangement; many decentralization reforms were introduced during this time; however, these were unsuccessful as a result of governance-related factors, but also because they attempted to decentralize health and population welfare within a centralized government system. Many of these issues remain unresolved even after radical decentralisation of the government system in 2001.

Ninth Five-Year Plan, 1998-03: The Ninth Five-Year Plan was characterized by efforts to merge both the ministries. The idea was initially mooted by UNFPA in a study report in 1998 but was not heeded to then. Subsequently, in 2000, the government constituted a committee to review the Population Welfare Programme and its interface with the health sector. The Review Committee held extensive consultations at the federal and provincial levels and came up with recommendations for merger of the two ministries with specific details and decisions regarding the status of the Population Welfare Programme, transfer of activities to the provinces and the status of funding arrangements, personnel and field activities in the new arrangements. In April 2001, the government decided to go ahead with merger. As per the stipulations of the decision, the Population Welfare Programme was meant to be retained in the Population Welfare Division at the federal level under the Ministry of Health, albeit with separate Population Welfare and Health Departments at the provincial level. The VBFPWs of

the Ministry of Population Welfare were meant to be transferred to the Ministry of Health. However, only a month after the announcement of this restructuring, the decision was reversed and it was decided to maintain status quo, whereby the Ministry of Population Welfare retained its independent status; the only aspect of this decision which could be implemented related to merger of VBFPWs with the field force of LHWs. It is not clear as to why the decision was reversed; however, according to anecdotal accounts, feedback about lowering of morale among employees of the Ministry of Population Welfare as a result of the decision and its likely fallout on the efficiency of the programme, played an important role.⁴

At the technical level, the Ministry of Population Welfare embarked upon expanding reproductive health services during this plan period, through the creation of community-based organizations, as well as by initializing development of the National Reproductive Health Services Package⁵—the latter was meant to be a joint venture between the Ministry of Population Welfare and the Ministry of Health and was supposed to be implemented over the next 10-15 years. Following this, in 2001, core strategies for joint collaborative work were recommended at the National Roundtable Meeting for Making Motherhood Safe and to Decrease Maternal Mortality.⁶

Medium Term Development Framework, 2005-10:

The chapter on population welfare in the Medium Term Development Framework (MTDF) 2005-10 has a separate section on functional integration. The section states that ".....linkages will be built between the community-based workers of Health i.e. LHWs and FWCs and MSUs of population departments. It will help to resolve the long-awaited issues of low clientele and missing linkage with the community of population programme and shortage of trained service providers at static service outlets of health departments. It will

be a major innovation in strengthening the functional level integration of Population Programme with Health sector. The functional integration of these services will receive priority under one coordinated programme."

The approach to functional integration as envisaged by the MTDF was a narrow interpretation of integration and did not take into account, important aspects of integration at several levels. This lack of clarity and lack of emphasis on specific areas of collaboration was, in all probability, a barrier to proactive efforts by both the ministries and manifested itself in failure on part of both to accord due priority to functional integration.

During the MTDF Plan period, however, some efforts were made to expand coverage of family planning services through health outlets. In its first meeting in 2006, the NCPW directed the provincial health departments to establish family planning/reproductive health services in health outlets; however, the decision could not be fully implemented. During this period, a Memorandum of Understanding (MoU) was also signed between the respective ministries to coordinate and further reinforce collaborative engagement in 2008.

References

1. Family Planning Association of Pakistan. Annual report 2006-Reemerging as Rahnuma. Lahore, Pakistan: FPAP, 2006.
2. No authors listed. Pakistan to Expand Population Control. JAMA 1972; 222(10):1320.
3. Sultan M, Cleland JG, Ali MM. Assessment of a new approach to family planning services in rural Pakistan. Am J Public Health 2002;92(7):1168-72.
4. National Population Welfare Programme. Handing over note for Punjab. Islamabad, Pakistan: Ministry of Population Welfare, Government of Pakistan, 2002.
5. Government of Pakistan. Reproductive Health Services Package. Islamabad, Pakistan: Ministry of Health and Ministry of Population Welfare, 1999.
6. Faisal A. Core strategies for safe motherhood in Pakistan. Islamabad, Pakistan: The Futures Group International, Washington DC, 2001.

Comment on the Report

Health-population nexus

Ishrat Hussain

Institute of Business Administration, Karachi.

Pakistan has lagged behind other developing countries of comparable income levels in its social indicators. Had it achieved the literacy rate of Sri Lanka and the health status of Thailand, the country's per capital income would quite conceivably have been at least twice the current level and the incidence of poverty much lower than what is prevalent today. So while we have, therefore, missed the boat, it is still not too late to regain lost grounds.

The well-researched study, 'Synergizing Health and Population in Pakistan,' highlights one of the avenues that can be capitalized to bring about an improvement in the delivery of health and family services, i.e., through synergy. Without shying away, I would move to the next logical step of merger. There are several cogent reasons to substantiate the argument that merger of the two services will translate into long-term gains. A fragmented governance structure is the key constraint hampering access to and quality of health and population services in Pakistan. While their target groups, intervention paradigms, instruments and core services are common, the rivalry between the two ministries and their counterpart departments in the provinces has led to greater problems than solutions in the approach to service delivery. Even though various coordination bodies exist in name and on paper at the federal, provincial and district levels, the attitude and behaviour of the functionaries of the two ministries show opposite trends. Turf preservation and inter-departmental fights dominate to the chagrin of the intended recipients and beneficiaries of these services.

It should also be recognized that the determinants of health status and population planning fall outside the narrow confines of the ministries in-charge of these two portfolios. Potable drinking water supply, sanitary environment, better nutrition, female education and social mobilization are the variables that influence outcomes. Both the ministries—if they are sincere in reaching out to the communities they serve—have to convey and disseminate the message with almost identical content. They have to work with those responsible for providing water supply, sanitation, nutrition, education, etc. Their own interventions are, therefore, highly limited.

It is quite cost-effective that the same Lady Health

Workers (LHW), who are engaged with families at the community level assigned to them, are able to convey the message in toto, rather than in an unnatural partition. Reproductive and maternal health, child care and family spacing—all are interwoven in the decision-making calculus of each family. Their needs should, therefore, be catered to by a single knowledgeable professional or para-professional of the government. The merger of family planning workers with LHWs at the field level in 2001 demonstrates the merits of this approach. On the same analogy, it is not clear as to why the Reproductive Health Services Centres at the hospital level are manned by the population welfare departments. Why can't these services be provided by a merged Health-Population Department within a single hierarchical organizational structure? Similarly, Mobile Service Units can cost-effectively be utilized, not merely for provision of family planning services but a whole package of health services. There is also perfect logic in the decision that has never been implemented that the Family Welfare Centres of the Ministry of Population Welfare should become part of the Basic Health Units. Separate training activities carried out by the respective ministries can be streamlined by a joint training programme, thus saving millions of budgetary resources that can be deployed for provision of healthcare services.

The International Conference on Population and Development (ICPD) had envisioned a paradigm shift from a demographic trend to a reproductive health point. But this shift has so far evaded Pakistan due to intransigence on part of our ministries. Unfortunately, the flow of funds from different external donors and international agencies organized on thematic grounds has made this transition difficult. The representatives of the respective agencies put their weight behind the sectoral ministry of their choice. But this is no reason as to why we should not take the right decision in the larger collective interest of the people of Pakistan.

On grounds of efficiency, cost-effectiveness, avoidance of duplication of efforts and ceaseless meetings and discussions forcing artificial coordination among recalcitrant partners, it is advisable to merge the two functions into a single Ministry of Health and Population Planning.

Comment on the Report

Institutional dichotomy between health and population in Pakistan — time to act

Yasmeeen Sabeeh Qazi,* Kathleen M. Toner, Huong Nguyen

The David and Lucile Packard Foundation.

*Corresponding author

The most recent Demographic and Health Survey in Pakistan confirmed persistently high rates of unmet need for family planning, low use of contraception and high rates of maternal mortality and unsafe abortion.¹ Despite significant public investment, a strong policy framework and many programmatic successes, rapid population growth and poor reproductive health indicators continue to impede development efforts in Pakistan.

Family planning has been demonstrated to be one of the most cost-effective health promotion measures for saving lives as compared to childhood vaccination and HIV prevention. There is a large body of evidence about the contribution of family planning to health and development outcomes. The Population Reference Bureau has documented the link between family planning and the health Millennium Development Goals (MDGs) in terms of reduction of maternal deaths and disabilities, neonatal and child mortality, and HIV transmission.²

The attached Report by Nishtar et al calls for integration of family planning with maternal and child health, HIV and AIDS and post-abortion care services. An expanding body of research, including a 2009 report from Population Action International,³ links population growth to climate change and suggests that investing in family planning, within the broader framework of reproductive health and rights, can make a meaningful contribution to addressing climate change and environmental degradation. Simply stated, unless Pakistan makes progress towards addressing rapid population and improving access to quality voluntary family planning and reproductive health services as essential health interventions, the country will miss a critical opportunity.

Fortunately, the government of Pakistan recognizes these priorities and has already demonstrated its commitment. One important step towards improving access to family planning and reproductive healthcare services and to addressing the broader population issues is to resolve the institutional dichotomy between the Ministry of Population Welfare and the Ministry of Health and to further maximize the capacity of both ministries.

The Report under review and its pathway of functional integration seeks to bring renewed attention and fresh ideas to this longstanding effort. It provides a number

of tangible and doable recommendations that can be taken forward in developing consensus and clarity on the complementary roles of these two critically important ministries.

While the Report is clear-sighted in identifying the many challenges to achieving functional integration, it provides sufficient rationale to inspire progress. It suggests how the Ministry of Population Welfare can be a leader on population issues, expanding its role in evidence-creation, capacity-building, policy development and population planning. This ministry can continue to broaden the view of population as an issue integral to development planning, poverty alleviation, environmental concerns and demographic security, beyond provision of family planning services.

Additionally, the Ministry of Health is well-positioned to take leadership for family planning and reproductive health services, creating demand and ensuring supply for stronger services. Whereas the role of the Ministry of Health remains crucial and its focus on provision of family planning and reproductive health services through its service outlets is not misplaced, the Report also recommends ways for the two ministries to move forward together and develop joint plans for implementation. These recommendations can help achieve breakthroughs in changing the dynamics of the current institutional arrangements. Development partners and the civil society must rally to the cause and support the consensus of the government to take meaningful action.

The recommendations offered by the Report are product of a transparent and participatory process, reflecting broad input from a range of stakeholders. They are informed by evidence and supported by strong analysis. Heartfile solicited feedback on its findings at critical junctures and remained appreciative of input, even of criticism. This process is worth emulating as stakeholders move forward with implementation, remaining open to input, relying on evidence and promoting accountability.

The recommendations reflect an underlying belief in the adoption of a patient-centred approach to promoting healthy behaviours and ensuring timely access to care. A study on the impact of patient-centred practices pointed to

improved health status and efficiency of care through reduced medical referrals and diagnostic testing.⁴ A system of delivering family planning in isolation from the broader set of maternal and other health services does not reflect a comprehensive approach that responds to the reality of multiple needs of patients. Focusing on the needs, priorities and capacity of the patient—in this case the woman and her family—can enable implementation of a comprehensive and effective approach.

Now is a critical and opportune time to hasten progress towards the MDGs, particularly in improving maternal health by investing in women's reproductive health, as these are critical to Pakistan's development. The government of Pakistan, and specifically the leadership in the Ministry of Health and the Ministry of Population

Welfare, has taken a forward-looking step in recognizing the power of collaboration. The challenge, however, is how to best maximize this synergy. Recommendations from the Heartfile Report provide strategic and concrete entry points to addressing this dichotomy.

References

1. National Institute of Population Studies and Macro International Inc. Pakistan Demographic and Health Survey, 2006-7. Islamabad, Pakistan: NIPS and Calverton, Maryland USA: Macro International Inc., 2008.
2. Smith R, Ashford L, Gribble J, Clifton D. Family Planning Saves Lives (Fourth Edition). Washington DC: Population Reference Bureau; 2009.
3. Young H M, Mogelgaard K, Hardee K. Projecting Population, Project Climate Change: Population in IPPC Scenarios. Population Action International, 2009; WP09(02).
4. Stewart Moira et al. The Impact of Patient-Centered Care on Outcomes, Journal of Family Practice, 2000, 49: 796-804.

Comment on the Report

Improving reproductive health service delivery

Daniel B. Baker
UNFPA, Pakistan.

The Report on “Synergizing Health and Population in Pakistan” by Nishtar et al is an important contribution to what has been an ongoing debate in Pakistan about merging or “functionally integrating” the reproductive health programs of the Ministry of Population Welfare and the Ministry of Health. The Report should be commended for laying out the dimensions of the controversy and taking an objective approach aimed towards substantive but, at the same time, realizable improvements in the current Pakistani programs for promoting family planning and better reproductive health. The proposals that are presented deserve the close attention of national policy makers in that, as the report emphasizes, successive governments have stated that these are priority areas for the development of the country.

As the Report documents, merger of the two ministries or functional integration of their service delivery networks has been on the table for a long time and various initiatives, more or less successful, have been undertaken to push such an agenda. There is certainly a rationale for such a merger, but there have been and remain a large number of obstacles. A major strength of this Report is that it moves the discussion away from what have become emotionally laden terms—“merger” and “functional integration”—in favor of “synergizing” and “synergies.” This is a terminology upon which all parties can and do agree, most likely because it means different things to different stakeholders. However, in order to facilitate constructive dialogue about concrete measures that would lead to such synergies, the Report makes a number of recommendations that should successfully frame a new approach to the old question.

Such attempts are not new. Indeed, the Report mentions that in one effort to square the circle without actually proposing physical merger of the two ministries, with all the attendant political ramifications, my own organization, UNFPA, in 1998 introduced the nomenclature of “functional integration,” which would look towards the merger of the service delivery infrastructure of the two ministries. Although the Fund would continue to support such an idea, this may not be on the table any longer. Functional integration has not taken place and seems to have been overtaken by other, less far-reaching proposals, many of which are outlined in this Report. We need to ask how improvements can be made in service delivery even if there

were to be no merger of the functions of the two ministries. Indeed, the health and population joint program of the United Nations in Pakistan calls for implementation of integrated maternal, neonatal and child health and reproductive health and family planning services.

The Report points out that the current delivery of services of both the Ministry of Population Welfare and the Ministry of Health does not fully meet the needs of the people of Pakistan in terms of improving reproductive and maternal health. Some of the reasons given include lack of a fully comprehensive approach to reproductive health within the Ministry of Population Welfare, given that its mandate is to look at the country’s population mainly in terms of supporting the small family norm through a nationwide family planning program. Similarly, the Ministry of Health has not fully adopted family planning as a necessary intervention in terms of protecting the lives of women and children, which should be a priority service of any national primary healthcare package. However, both ministries do recognize these limitations and are moving towards a wider view of their respective roles, and this will serve as the solid basis for greater cooperation and indeed “synergies.” These efforts should be commended and supported by the international development community as a whole and with technical and financial assistance by both bilateral and multilateral donors.

The issue of financing is addressed in the Report in that it calls for the “required fiscal space” for both sectors—health and population—in terms of both greater allocation of national resources and increased external assistance. UNFPA would certainly echo and, at every appropriate occasion, amplify such a call. There are two other macro-level recommendations in the Report: (a) a greater focus by both federal ministries on their normative and oversight functions while increasing the service delivery roles of provincial and district governments; (b) a reorganization of existing primary health care and family welfare infrastructures to better serve the population. Insofar as I am aware, such recommendations are entirely consistent with the thinking of the two ministries, but the devil will certainly be in the details of their implementation.

It is in making practical, immediate recommendations to achieve these shared overarching goals that this report has its greatest utility. These include using common planning instruments; instituting greater

collaboration, e.g., in training, at the field level; combining procurement and logistics operations for needed commodities; strengthening the Lady Health Workers' program; instituting an effective male community mobilizer program; turning management of RHS-A Centres over to the Ministry of Health; re-designing mobile service units to include services from both ministries; offering services of both ministries in all primary health care facilities; harmonizing payment policies for contraceptives between Basic Health Units and Family Welfare Centres; designing training programs for all types of primary health workers cooperatively; increasing the role of social marketing of

contraceptives; and synchronizing communication strategies and programs.

The common theme that runs through all of these proposals is that those who need reproductive health, including family planning services—that is all the women, men, couples and young people of Pakistan—should be able to access the full range of their needs in the simplest, most convenient, most affordable and most comprehensive manner possible. UNFPA wholeheartedly endorses such an end result.

Comment on the Report

Coordination and collaboration—a win-win situation

Mumtaz Esker,*¹ Tufail Muhammad Khan

¹Ministry of Population Welfare, Pakistan.

*Corresponding author

The manuscript 'Synergizing Health and Population in Pakistan,' articulates the rationale and the challenges that are likely to be encountered in the event of merger of the ministries of health and population. The Report reflects the meticulous work put in by the authors, provides insight into both the parallel programmes, and shows the way forward for the development of a framework for strengthening of linkages to achieve the Millennium Development¹ and the ICPD² goals. It also provides food for thought for the institutional hierarchies of both ministries in the direction of functional integration.

The functioning of the two ministries has, for many years, not only reflected gaps in service provision—as rightly pointed out—but also in mindsets. Any instability may exacerbate administrative issues and hinder the achievement of health targets. Functional integration, on the other hand, will enable removal of bottlenecks and revitalization of the common goal of improving the health and quality of life of the people of Pakistan.

According to the Pakistan Demographic and Health Survey 2007,³ nearly all Pakistani women are aware of at least one method of contraception and 85% know about contraceptive pills, injectables and sterilization. This is good news; the bad news is that family planning services continue to remain out of the reach of millions of Pakistanis. One-quarter of married women in Pakistan who want to end childbearing or space births, do not use contraception although 96 percent of them are aware of at least one modern method. Other reproductive health indicators like Maternal Mortality Ratio, Infant Mortality Rate, access to safe delivery, and postnatal and abortion services are equally dismal. Although the ICPD agenda has leveled the ground for all countries to ensure access to reproductive health through Primary Health Care, Pakistan has only made modest gains in the area of provision of essential reproductive health services.

The most pressing question is, "Why have comprehensive, voluntary family planning and reproductive health services remained out of the reach of millions of Pakistanis?" There are a host of complex factors behind this poor score card. One critical factor is the marginalization of reproductive health services and disconnect between the service delivery systems of the

ministries of health and population welfare; this has duly been highlighted by Nishtar et al in their Report.

An important collaborative step initiated by the two ministries in 1999 to achieve synergy was development of the Reproductive Health Service Package.⁴ This package was aimed at imparting necessary skills to Traditional Birth Attendants, midwives, Lady Health Workers, Lady Health Visitors, health technicians and medical doctors at the Basic Health Units and Rural Health Centres. Additionally, it also offered a framework for involvement of non-government organizations.

In 2001, the National Health Policy was presented with an overall national vision based on the Health for All approach. A year later in 2002 came the Population Policy of Pakistan,⁵ which explicitly identified issues related to the ever-escalating burden of population in the country. The Population Policy is anchored on the core mission of ICPD; its vision is "to achieve population stabilization by 2020 through the expeditious completion of the demographic transition that entails declines both in fertility and mortality rates."

Despite the existence of several policy frameworks, the critical challenge of poor linkages between health and population is yet to be bridged. Some attempts by donors and planners to achieve integration through merger of the two ministries met failure and led to a turf war between the two wings of the government, largely because of the absence of an appropriate strategy.

On the other hand, many opportunities still exist for establishment of linkages to improve outcomes through approaches that are less threatening and more acceptable to stakeholders on both sides. One way of doing this is through public-private partnership, where both ministries could join hands and pool resources for the achievement of common objectives. Similarly, family planning can be brought on the mainstream agenda of the Ministry of Health and integrated with, for instance, the Lady Health Workers' programme. The basic objective should be not to compete and confront, but to coordinate and collaborate.

References

1. Campbell-White A, Merrick TW, Yazbeck SA: Reproductive Health: The Missing Millennium Development Goal. Washington DC: World Bank Publications; 2006.
 2. UNFPA: United Nation Population fund. Programme of Action of the International Conference on Population and Development; Cairo; 1994.
 3. National Institute of Population Studies and Macro International Inc. Pakistan Demographic and Health Survey, 2006-07. Islamabad, Pakistan: National Institute of Population Studies and Macro International Inc, 2008.
 4. Government of Pakistan: Reproductive Health Services Package. Ministry of Health and Ministry of Population Welfare. Islamabad; 1999
 5. Ministry of Health. National health policy 2001, The Way Forward. Islamabad, Pakistan: Government of Pakistan, 2001.
-

Comment on the Report

Key elements for women's empowerment

William Conn

USAID, Pakistan.

I congratulate the authors on a thorough review and analysis of the health and population policy and systems related to the implementation of family planning and reproductive health service delivery programs in the public sector in Pakistan. The importance of having a solid framework to guide the implementation of family planning and reproductive health service provision is critical. As the authors have pointed out, family planning has been included in previous national health policy documents at least since 1990 and onward. It is again included in the new draft of the health policy document. It will be important for the government to approve the document and for donors and government to support and implement the programs outlined in the new health policy. This is an opportunity for the country to build a solid program and get closer to meeting the MDGs. Time may be running out for the 2015 deadline unless action happens soon. This paper outlines some critical steps that need to be taken.

The authors have discussed the complexities of implementing the family planning program in Pakistan, given the division of responsibilities between the two ministries.

There are many barriers to service provision that need to be addressed, including proper training in contraceptive technology, commodity procurement issues, warehousing and distribution, societal issues related to family planning, proper staffing of female healthcare providers, use of mobile units, pricing policies, social marketing and franchising, communication and behavior change, following best practices and international standards, a rigorous health information system that provides data for decision-making, and the political will to support all these program components. The authors have provided recommendations for overcoming each of these barriers, and likely others not mentioned in the article. Education, training and capacity-building in these areas will help to make improvements in program implementation at the

district and community level.

All of these program components combined are vital to the success of the family planning program for both ministries.

A clarification of the roles of each ministry may be useful to divide up the work plan. Family planning and reproductive health are an integral part of maternal child health and indeed a health intervention, and therefore clearly within the purview of the Ministry of Health. There are many economic and health benefits of contraceptive use and research has shown that timing and spacing of pregnancy has a positive effect on the health of the mother and baby. It is in the interest of health providers to inform their clients of all methods available, their benefits and possible side-effects, and let it to the couple to decide on their method of choice. If unmet need is met through the access to quality services, contraceptive prevalence will increase and the country will get closer to meeting the MDGs.

The responsibility of the government of Pakistan with leadership and guidance from the Ministry of Population Welfare, is to follow the Program of Action of the International Conference on Population and Development (ICPD) not only in written policy, but in action, particularly in the area of women's empowerment. This includes access to family planning and reproductive health services. The ICPD states that "...improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction. This, in turn, is essential for the long-term success of population programs. Experience shows that population and development programs are most effective when steps have simultaneously been taken to improve the status of women."

These two ministries obviously need to work closely together in a spirit of collaboration and caring for the families of Pakistan.

Comment on the Report

Family planning is a life saver

Shahida Azfar

Population Council, Islamabad.

The Report entitled ‘Synergizing Population and Health in Pakistan’ is very timely in view of the renewed concern and interest generated by recent data from the Pakistan Demographic and Health Survey (PDHS) showing that the contraceptive prevalence rate in Pakistan has not sustained the gains made in the 1990s, and that it has in fact, stalled and stagnated at 30%, with modern contraception showing a rate of 22% only. This has led to considerable soul-searching as to what needs to be done to address the huge unmet need as well as to achieve the MDGs 4 and 5, which are also lagging behind as shown by the PDHS.

The role of the Ministry of Health in delivering family planning services has, therefore, emerged as the need of the hour, which is also the subject of the Report under discussion.

The authors have made a commendable effort to comprehensively address an issue that has been on the agenda of policy-makers for several decades and on which very little progress has been made despite numerous efforts. This issue concerns the ‘functional integration’ of the health and population welfare programs in Pakistan. The authors have presented a cogent argument regarding why the term ‘functional integration,’ coined by UNFPA following the International Conference on Population and Development, is fraught with problems. Institutional integration or merger of the Ministry of Health and the Ministry of Population Welfare is generally perceived to mean merger of the two ministries into one, and has therefore met strong resistance, mostly by functionaries of the latter ministry. The real intention behind the concept—physical integration of service delivery of health and family planning services—could, therefore, never be realized. In view of the foregoing, the Report has instead selected the term ‘synergizing,’ which refers to the value added by the two ministries working in close cooperation and coordination.

While presenting a strong rationale for eventually having one ministry as the long-term sustainable solution to addressing the health and population program disconnect, the authors shelve it in favor of advocating short to medium term measures to increase operational coordination and cooperation between the two ministries at the federal, provincial and district levels. All

recommendations of the Report are actionable and should improve coordination and synergy between the two ministries and programs, if implemented as proposed.

While fully supporting the short to medium term measures identified for increasing synergy between the two ministries, I feel the Report has missed out on the paradigm shift that is needed to make the synergy work—which is internalization by the health establishment that birth spacing and family planning save lives, and hence it is the responsibility of each and every health worker—male or female, belonging to the public or private sectors—to promote birth spacing and family planning at every opportunity as part of their mandate and not on behalf of another ministry or cadre of workers.

The other element which needs to be further emphasized is ‘accountability’ by the public healthcare system for delivery of family planning services. The current lack of accountability by the Ministry of Health and the provincial health departments—in fact provincial governments as a whole—stems from the fact that the Constitution of Pakistan considers population welfare as a concurrent subject, meaning a joint responsibility of both the federal as well as the provincial governments, while health is considered a provincial subject. As a result of this difference, the entire structure of the population welfare program in Pakistan is set differently from health and from the way it is dealt with in other countries in the region and the world.

The question that arises is, what can be done to bridge the existing disconnect? The Report proposes several effective measures to this end. However, it would be pertinent to add that if status quo needs to be maintained, the focus should be not so much on bridging the gap but on what the Ministry of Health should—or rather must do—to deliver family planning services as an intrinsic part of its mandate and what is needed to enhance its capacity and accountability to perform this function. This leads to issues of training and capacity development of different cadres of the health system, commodity security, logistics and availability of contraceptives at all times at all service delivery points—static and outreach—effective supervision, reporting and recording, and monitoring and evaluation.

The next question then is, how can the Ministry of Health and the departments of health best coordinate and cooperate with the Ministry of Population Welfare to increase coverage of family planning services, considering that the former have more than 12,000 service delivery outlets in addition to over 100,000 LHWs delivering both primary healthcare and family planning services while the latter ministry has less than 2500 family welfare and other service delivery outlets. In this regard, the Report provides a comprehensive overview of different coordination mechanisms to ensure

complementarity and synergy between the health and population welfare programs.

In conclusion, it would be appropriate to suggest that after three decades of half-hearted attempts and despite numerous health and population policy directives, ECNEC and Cabinet decisions and reflections in Five-Year Plans—the last one being Vision 2030—it is time the Ministry of Health assumed full responsibility of and accountability for delivery of family planning services in Pakistan.

Viewpoint related to the Report

The imperative of functional integration for achievement of MDGs

Khalif Bile Mohamud
World Health Organization, Pakistan.

Abstract

Pakistan launched its Maternal, Neonatal and Child Health (MNCH) programme in 2006 in collaboration with the World Health Organization (WHO) and other partners to bridge gaps and upscale interventions aimed at reducing mortality and achieving the Millennium Development Goals (MDGs). The country will have an uphill task in meeting by 2020, the 2015 targets set for attainment of MDGs 4 and 5. The current Contraceptive Prevalence Rate (CPR) level of 30% is considerably below the 60% target set for 2020 and the current Total Fertility Rate (TFR), estimated at 4, is significantly higher than the set target of 2.1. Similarly, the Infant Mortality Rate (IMR) of 78 per 1,000 live births is lagging behind the MDG target of 40 per 1,000 live births, while the Maternal Mortality Ratio (MMR) of 276 per 10⁵ live births is higher than the MDG target of 140 per 10⁵ live births. With the rural population at an added disadvantage by reporting 82% and 40% higher MMR and IMR respectively—relative to the population of urban and major cities—reducing the current population growth rate of about 1.7% to 1.3% in the envisaged limited timeframe appears challenging.

To overcome these programmatic impediments, the existing fragmentation in implementation of MNCH/Reproductive Health (RH) and Family Planning (FP) services needs to be urgently addressed. To respond to this call, the ministries of Health and Population made a joint commitment at the end of 2008 to bring about functional integration by delivering the MNCH/RH/FP services in a unified manner and by setting up effective institutional, strategic and operational mechanisms that can enhance the implementation process. To significantly reduce IMR and MMR and improve RH/FP outcomes, the two ministries must challenge the status quo and promote the coordination of health and population policies, improve MNCH/RF and FP management practices including monitoring and supervision, deploy, train and motivate the health workforce and strengthen the health system. Functional integration must also aim at ensuring use of appropriate technologies and uninterrupted provision of supplies and equipment. This viewpoint, which is related to the Heartfile Report, aims at diagnosing outstanding challenges at the field level, as well as factors contributing to successful implementation of MNCH/RH and FP and their progress towards achieving Millennium Development

Goals (MDGs) 4 and 5.

Introduction

The government of Pakistan designed its MNCH programme, with a focus on RH and FP, in collaboration with WHO and other international health partners during 2006. The ongoing programme aims at scaling-up the implementation of high-impact and cost-effective best practices aimed at improving maternal and child health, reducing mortality and achieving the MDGs.¹ The pace of reduction in maternal, neonatal, infant and child mortality was reviewed and trends compared in relation to countries with similar socio-economic settings in the region. This analytical review clearly identified gaps within the domain of MNCH/RH and FP, underlining the need for establishing additional interventions to address this priority sub-sector of the District Health System (DHS). Accordingly, a five-year national programme was launched with an overall cost of US \$300 million. The programme has since been supported by a set of technical contributions including operational research activities in MNCH, development of a National Action Plan for Control of Micronutrient Deficiencies in line with WHO guidelines and recommendations; and structuring technical and management guidelines for making pregnancy safer, managing complications in pregnancy, child birth and newborns; these were subsequently incorporated into the programme's operational strategies. The programme has successfully attracted the much-needed financial support from a number of key international partners, with the expectation that universal access to MNCH/RH and FP services will potentially transform the current dismal rates of preventable maternal, neonatal and child mortality indicators and generate a reliable confidence towards the attainment of MDGs.²

The existing fragmentation and duplication in service delivery, however, poses a grave threat to these aspirations as certain RH and FP and limited MNCH programme components are managed by the Ministry of Population Welfare, with a nationwide mandate for the delivery of RH and FP services, while the programme itself falls within the jurisdiction of the Ministry of Health, which supports the provincial health departments in its implementation. The overlapping programmatic roles and failure to bridge service delivery gaps is causing inefficiencies and disorganization that constrain the

attainment of MDGs.³ During the course of a joint consultation held in December 2008, the two ministries agreed on a Memorandum of Understanding (MoU), stipulating the establishment of solid mechanisms for functional integration of MNCH/RH and FP services. The latter will enhance complementarities and synergies between the two ministries, and stimulate the effective and comprehensive delivery of these services, regardless of their managerial association with either of the two ministries. This was followed by the creation of a joint technical committee entrusted with designing the institutional mechanisms necessary for achieving the jointly set programmatic outcomes. This initiative corroborates the existence of a reliable political commitment willing to endeavour on this long-overdue operational reform.⁴ This review article aims at diagnosing the outstanding hindrances and challenges at the field level, as well as the factors that could contribute to successful implementation of MNCH/RH and FP services and accelerate their progress towards MDGs 4 and 5.

The intent and scope of functional integration

The desired functional integration is a process unifying and bringing together the MNCH/RH and FP methods, techniques and services, and enabling the delivery of an optimal mix of services in the right places. Functional integration denotes “The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.”⁵ It is a programmatic reform instituted in an environment where universal MNCH/RH and FP services—carried out separately by the two ministries—are integrated and jointly delivered without embarking on any significant structural adjustment or allowing the existing managerial systems to disrupt this essential undertaking. However, the desired programme acceleration will require a well-functioning workforce alongside effective and uninterrupted provision of medical supplies; equipment and necessary logistics to support the delivery of the MNCH/RH and FP package of promotive, preventive and curative health interventions; well-integrated monitoring and supervision, and procurement systems that generate better economies of scale within the existing resource limitation. In this context, integration will also imply actions focused on the health and family planning needs of vulnerable population groups, whereby a range of services incorporating the Integrated Management of Childhood Illnesses (IMCI), Emergency Obstetric and Neonatal Care (EMoNC), and Integrated Management of Pregnancy and Childbirth can be delivered under the same roof, promoting easy access to these services.

Such integration could also be envisioned through the establishment of management and oversight mechanisms that coordinate the different functions of MNCH/RH and FP in the DHS network, both at the primary health care (PHC) chain of facilities as well as at the referral level. The latter also highlights the need to ensuring continuum of care, with clarity as to which services are to be provided where, and the exact methodology that enables the timely and appropriate referral of complicated cases. Functional integration also recognizes the need to coordinate policies and strategic decisions relevant to organization of MNCH/RH and FP services and promotion of community participation in the planning and implementation of these services.

MNCH functional integration and the pursuit to MDGs: overcoming challenges

Although at the federal level, the two ministries have stipulated their solid commitment to functional integration of MNCH/RH and FP services in the framework of PHC and DHS, there are several challenges that need to be addressed:

1. The uphill task towards MDGs: The current CPR of 30% is considerably below the 60% target set for 2020, while the current TFR, which is estimated at 4, is significantly higher than the set target of 2.1. Similarly, the IMR of 78 per 1,000 live births, of which 69% are neonatal deaths, is lagging behind the MDG IMR target of 40 per 1,000 live births. Likewise, the MMR of 276 per 10⁵ live births is higher than the MDG target of 140 per 10⁵ live births. Furthermore, the rural population is at a significant added disadvantage, reporting 82% and 40% higher MMR and IMR respectively, as compared to the urban and major cities⁶. Moreover, reducing the current population growth rate of about 1.7% to 1.3% in a relatively limited timeframe appears to be an uphill task.⁶ The National MNCH programme, in tandem with other programmes, has to respond to these ambitious expectations, which can only be fulfilled through universal accessibility to a comprehensive and integrated package of essential MNCH/RH and FP services, coupled with a parallel development effort focusing on the key social determinants of health such as safe water, sanitation, education, poverty reduction and social harmony. The task at hand is further complicated by the growing number of married women of reproductive age related to the current demographic change, suggesting that unless effective programmatic interventions are expeditiously put in place, Pakistan will be confronted with a high population growth rate leading to unprecedented population doubling in 40 years and approaching 460 million by 2060.

2. Inter-ministerial coordination: In order to lend sustainability to the process of functional integration, the two ministries need to develop institutional, strategic and operational mechanisms that can support effective delivery of this priority programme. The latter will include the establishment of management coordination task forces at the federal, provincial and at the district levels, mandated to establish joint monitoring and evaluation instruments and assume shared accountability in achieving the MDGs.

3. Provincial and district level management: To sustain the benefits of functional integration, and given the constitutional responsibilities of the provinces in relation to health, the provincial health departments need to be actively engaged in the design and implementation of this operational reform process. Currently, the organization of MNCH/RH and FP services suffers from managerial fragmentation, whereby a senior officer is responsible for MNCH services while a similar high-ranking officer is managing MCH services in each provincial health department. This redundant additional position will constrain the desired unity of purpose in the planning, implementation and management of these services. This anomaly needs to be resolved by merging the two positions under a provincial manager of MNCH/RH and FP services. Furthermore, the weak provincial oversight of the district level management of RH and FP logistic supply systems needs to be rectified and technically developed.

At the district level, the Executive District Officer-Health (EDO-H) has to substantiate greater leadership by integrating RH and FP services into the MNCH programme in a sustainable manner. The perception of the Ministry of Population Welfare (MoPW) that the district level workforce of the provincial health departments does not pay significant attention to family planning services needs to be keenly addressed. The latter may be resolved by rendering MNCH/RH and FP services an integral priority component of the district supervisory and monitoring field activities, by enhancing the skill mix balance of the health workforce and by enforcing an accountability system based on achieving the results anticipated by the programme.

Moreover, many of the population welfare RH/FP Centres housed in facilities run by the health departments need to be officially supervised and supported by the management of these institutions to improve the quality of their services. A rapid mapping exercise of all MoPW and Department of Health (DoH) service outlets would identify the upgradation necessary to conform to the standards and norms envisaged for each level of care. Consequently, the Population Welfare Centers (PWCs), Basic Health Units (BHUs) and Rural Health Centers (RHCs) should function round-the-clock with medical staff, Lady Health Visitors (LHVs) and community midwives promptly answering the

on-call service needs of their catchment area population. Furthermore, the contractual terms of the nationwide outsourced and vertically managed BHUs—through the People's Primary Health Care Initiative (PPHI)—need to be revisited to formally guarantee comprehensive delivery of MNCH/RH and FP services both at the facility and community levels, with explicit accountability for achieving the desired programmatic outcomes of the MDG. The supervision of these facilities and their performance oversight should also become an integral part of the DHS to validate the concept of functional integration.

4. Commodity pricing: The existing variance in the pricing of family planning commodities needs to be removed. The MoPW-procured contraceptives are provided to clients at a nominal cost while the family planning supplies provided by the health facilities and Lady Health Workers (LHWs) are distributed free of cost.

5. Contraceptives, vaccines and essential medicines supply chain: The logistic management of contraceptive supplies, vaccines, syringes and essential medicines suffer from frequent stock-outs in many public health facilities due to logistic delays in the supply chain, weak managerial capacity and paucity of financial resources. An effective logistic management system would resolve these limitations in the implementation process.

6. Human resource training and motivation: Meeting MDGs 4 and 5 will largely depend on continued availability and effective deployment of a skilled and motivated workforce within the healthcare system network. The workforce in charge of the MNCH/RH and FP services delivery would require an adequate level of skill-mix including communication and social mobilization abilities and the skills to provide services that are permanently accessible to the target population. On the other hand, the workforce's livelihood and professional expectations, including better contractual terms and a predictable career development path, are essential for advancing the effectiveness of these life-saving interventions.

These accomplishments will defeat the assumptions that i) the current vertical family planning services will suffer if integrated; ii) the knowledge and motivation of the health staff is inadequate and hence unable to bring about sustainable improvements in RH and FP services, and iii) that programme performance will deteriorate due to the prevailing poor managerial conditions and lack of ownership of RH and FP services by the DHS. In addition to the district management and supervisory cadre, the programme requires a strong link with households and local community leaders to stimulate their participation. To substantiate this aspiration, the following three grassroots level health workers need to be mobilized as they significantly impact the success of MNCH/RH and

FP planning services in Pakistan:

i. Lady Health Workers (LHWs): The approximately 100,000 trained LHWs operating at the community doorsteps provide a unique opportunity to scale up the provision of MNCH/RH and FP services in the country. The retarded progress in raising the CPR among the LHWs' catchment area population during recent years needs to be rectified by enhancing their skills and motivation as being the most reliable care providers at the household level, they have an exceptional opportunity to deliver MNCH/RH and FP services.

ii. Skilled Birth Attendants (SBAs): A major challenge facing the programme is the shortage of SBAs, with only 20% being currently available out of the projected 50,000 required nationwide. The initial training of 12,000 Community Midwives (CMWs) planned by the National MNCH Programme, supplemented by 4,000 being trained by NGOs, is a step in the right direction. Along with the LHWs, the CMWs cadre will further enhance the current 65% delivery of family planning services by the public sector as against 35% provided by the private/NGO sector. However, the currently contemplated proposal of interrupting the government remuneration for CMWs after six months of internship following their graduation would have serious implications on the accessibility, reliability and quality of their services at the community level. Expecting a fee for service from the clients may force many expecting mothers to opt for untrained Traditional Birth Attendants (TBAs) despite the risk inherent to such an approach. Moreover, lacking the formal employment link with the DHS, it would be difficult for the district health management team to enforce the required level of monitoring and supervision, carrying out periodic mandatory capacity assessments or refresher trainings and/or providing regular supply of medicines, delivery kits and contraceptives and recording and reporting data to the district information system for planning and effective programme management similar to that of the LHWs' programme. Hence the comparative advantage of providing them a public sector contractual service, with a nominal stipend similar to the one offered to LHWs.

iii. Vaccinators of the Expanded Programme on Immunization (EPI): The recruitment, training, equitable deployment, logistic mobility and adequate remuneration of vaccinators is critical to the success of MNCH/RH interventions. Thus far, Pakistan has introduced eight vaccine antigens to combat polio, tuberculosis, tetanus, whooping cough, diphtheria, hepatitis B, haemophilus influenza type B and measles, while plans are currently underway to introduce new childhood vaccines along with improved injection technologies requiring professional capacity and strict adherence to the set quality and safety

standards. It is, therefore, critical to accelerate routine EPI services by rectifying prevailing gaps in the vaccine supply chain and by ensuring regular access to this life-saving intervention. The success of EPI would help MNCH/RH and FP services to gain acceptance at the community level and hence improve the care-seeking behaviour for maternal and childhood illnesses.⁷ The latter is corroborated by the Polio Eradication Initiative model in countries with Vitamin A deficiency, often resulting in blindness and preventable child mortality. Supplementary immunization activities against polio have enabled large-scale distribution of Vitamin A capsules and the control of this deficiency across the population.

8. Health Systems Strengthening (HSS): Health systems strengthening is a key strategy towards achieving the MDGs, which includes the delivery of MNCH services capable of bringing about a significant impact in the reduction of maternal, neonatal and child mortality. Access to quality health services, supported by implementation of an essential MNCH/RH and FP service package in the framework of PHC and by availability of appropriate technologies, supplies and equipment, will reduce the potential for duplication and have a positive impact on maternal and child health outcomes. Similarly, lack of deployment of female professionals at the BHUs and RHCs of many districts poses a real challenge to effective and equitable delivery of MNCH/RH and FP services and demands the development of medium and long term strategies to overcome this problem. The district management team and mid-level field supervisory officers have to be properly trained and assigned for implementation of MNCH/RH and FP services at PWCs, BHUs and RHCs in addition to EmOC referral support. The HSS process will warrant an adequate level of political support by the two ministries, substantiated by effective joint planning, strong logistic support and lack of competition as well as allocation of requisite financial resources.⁸

9. Enlarging the promotion and advocacy network for MNCH/RH and FP services: The various social sector ministries of the government such as Education, Youth, Religious Affairs, Social Welfare, Public Health Engineering and other relevant poverty-reduction institutions have to act in tandem and scale-up their interventions as they address critical social determinants of health that directly impact maternal, neonatal and child health outcomes. Engaging youth and leading religious leaders in the promotion of MNCH/RH and the use of contraceptives as a socially acceptable practice would bring about a positive transformation in knowledge, attitude and practice and enhance the pace of action towards the MDGs.⁹ The recruitment of 5,400 family planning male mobilizers by the MoPW and their subsequent deployment at the Union

Council, the lowest administrative level in a district, to promote family planning at the community level, is a major strategic undertaking. Similarly, the promotion of RH and FP through the training of 20,000 religious leaders on family planning can have a far-reaching impact in alleviating the skepticism and resistance often instigated by this dominant social group.

Comments and conclusion

The choice of family size is often determined by the level of contraceptive use, male child preference, and the income and education levels of a household. The current high level maternal, neonatal and child mortality and the high TFR and population growth rate mandate a change of paradigm in the MNCH/RH and FP service delivery.¹⁰ The two ministries have to create a solid commitment for achieving MDGs 4 and 5 through the delivery of an essential package that is universally accessible, acceptable and affordable by the target population. The process of functional integration should facilitate the availability of contraceptives and enable the use of these commodities as a socially acceptable practice, based on the effective role exerted by the LHWs, CMWs and other DHS service providers, and supported by aggressive community mobilization and social marketing interventions. Functional integration has the comparative advantage of delivering MNCH/RH and FP essential services package under the same roof and improving the scope and the quality of performance of the health workforce. MNCH/RH and FP services incorporate interventions that contribute to maternal and child survival, such as making pregnancy and delivery safer, encouraging child-spacing, averting unattended and unwanted pregnancies and delaying the maternal age of first childbirth.^{11,12} In Pakistan, mothers under 20 years of age are 54% more likely to experience an infant death, compared to those giving birth at a higher age, while those with a birth interval of less than two years have an 87% higher infant mortality risk, relative to those with higher birth intervals.⁶ Furthermore, delayed child-bearing among young women contributes to longer intervals between births, reduces maternal mortality and improves child survival, while the latter can increase demand for family planning.¹³ However, the entrenched protective attitude among the health and population workforce and their desire to maintain vertical operational accountability

may pose a direct challenge to functional integration. The creation of a joint oversight and technical committee that lays down the necessary institutional mechanisms will help regulate the integration process and build sustainable, shared accountability that can guarantee a promising reform paradigm for successful implementation of MNCH/RH and FP services.¹⁴ The above outlined brief programmatic review and analysis allows us to conclude that functional integration of MNCH/RH and FP services emerges as an ethical and equity driven socio-economic imperative encompassing the right to health, and enhancing maternal, neonatal and child survival opportunities and Pakistan's chances for achieving MDGs 4 and 5.

References

1. Mridha MK, Anwar I, Koblinsky M. Public-sector maternal health programmes and services for rural Bangladesh. *J Health Popul Nutr* 2009; 27(2): 124-38.
2. Sadik N. Reproductive health/family planning and the health of infants, girls and women. *Indian J. Pediatr* 1997;64(6):739-44.
3. Bryce J, Telleri N, Victora CG, Mason E, Dealman B, Bhutta ZA, et. al. Countdown to 2015: Tracking intervention coverage for child survival. *Lancet*. 2006; 23;368(9541):1067-76.
4. Nishtar S. The Gateway Paper – preventive and promotive programs in Pakistan and health reforms in Pakistan. *J Pak Med Assoc* 2006; 56(12 Suppl 4): S51-65.
5. Waddington C, HLSP and Egger D. Integrated health services-what and why? WHO Working Group on Service Delivery, Technical Brief No.1, May 2008.
6. National Institute of Population Studies and Macro International Inc. Pakistan Demographic and Health Survey, 2006-07. Islamabad, Pakistan: NIPS and Macro International Inc, 2008.
7. Clements CJ, Nshimirimanda D, Gasasira A. Using immunization delivery strategies to accelerate progress in Africa towards achieving the Millennium Development Goals. *Vaccine* 2008; 26(16):1926-33.
8. Martinez J, Paul VK, Bhutta ZA, Koblinsky M, Soucat A, Walker N, et al. Neonatal survival: a call for action. *Lancet*. 2005;365(9465):1189-97.
9. Khan LA. Posing a hidden political threat. Pakistan. No attempt has been made at the national level to evolve a religious consensus on the subject of family planning. *Integration* 1996;(47):28-31.
10. Shirmeen A, Khan MF, Khan KH. Assessment of fertility control efforts in a selected area of Karachi, Pakistan. *Ulster Med J* 2007;76(3): 144-5.
11. Potts M. Family planning is crucial to child survival. *Network* 1990;11(4):2.
12. Duan Y. MCH promotes family planning. *China Popul Today* 1992 ;9(3):14-6.
13. Roudi F. Iran's revolutionary approach to family planning. *Popul Today* 1999;27(7):4-5.
14. Lush L, Walt G, Cleland J, Mayhew S. The role of MCH and family planning services in HIV/STD control: is integration the answer? *Afr J Reprod Health* 2001;5(3):29-46.

Viewpoint related to the Report

Contraception, synergies and options

Rashid Jooma,* Adnan A. Khan

Ministry of Health, Pakistan.

*Corresponding author

Many countries that prospered in the later half of the 20th century did so only once their populations stabilized.¹ This is logical since limited resources can only be stretched so far and because strategizing for development and growth is difficult, particularly if the growth targets keep moving further away. Pakistan is the 6th most populous country in the world and is growing at 1.9% annually.² Although this rate is lower than it historically has been, it still means that the country is nearly 6 times as populous as it was in 1947. With Pakistan showing slow or negative growth on numerous human development indicators, and with crucial and worsening crises of water, power and food, it is imperative that population stabilization becomes an urgent priority of the government.

According to the Pakistan Demographic Health Survey 2007, only about 22% of married women aged 14-49 use a modern contraception method and another 25% feel that they will do so, provided these are available (the unmet need).³ In Pakistan, both the government as well as the private sector promote contraception, and within the government sector, both the Ministry of Health and the Ministry of Population Welfare provide contraceptives. The former does so at no cost to the public whereas the latter uses social mobilization methods, thereby shifting some costs to the public. There is considerable debate which approach is better, or whether both ministries should agree on a single approach.

Within this context, there are two larger questions. One is that of synergy between the efforts of the two ministries that are seeking to achieve nearly the same goal while the other is that regardless of the method for supply of contraceptives, only 1 in 5 married couples are using contraceptives, indicating a huge unmet need of about 25%.

The question of synergy between the two ministries plays out at both policy and implementation levels. At the implementation level, the Ministry of Health operates via Basic Health Units (BHUs) and Rural Health Centres where in-house personnel (physicians, nurses, LHVs) and the Lady Health Workers (LHWs) that visit families in the communities, promote contraceptives. The Ministry of

Population Welfare operates Reproductive Health Centres but mostly has mobile vans that visit communities twice or thrice a week. There are individual examples where the Ministry of Health and the staff of the Ministry of Population Welfare coordinate and work out of BHUs. In most other instances, the two teams operate in parallel. At the policy and planning level, the two ministries seized the opportunity arising from the circumstance of an ex-Secretary and an ex-Director General of Health becoming ministers of health and population welfare respectively, to set up a task force led by their respective Directors General to facilitate coordination between them. The technical teams, which have met thrice so far, commissioned a study to explore the potential and modalities for collaboration. The study described current linkages in a number of theme areas; it suggested strengthening of existing arrangements, improved training and supply chain management and increased institutional collaboration. In addition, formal curricula have been developed for training of nurses, paramedics and LHWs. The task force has recently constituted separate work groups to oversee and guide analysis in reproductive health outreach services, static services and commodities supply security to allow a coherent approach for synergies to be formulated and pursued.

The use of contraception by couples may be explained in the perspective of the Diffusion of Innovations theory that has been widely used to explain how ideas and new products are taken up by societies.⁴ According to this theory, ideas (or new products) are started by 'innovators' and then are taken up quickly by 'early adopters,' who are both highly receptive and good proponents of the new idea. The ideas or products are then slowly picked up by the 'early majority,' who need to be convinced of this change. More slowly, the idea is accepted by the 'late majority,' and there are always "laggards" that are difficult to convince. The theory was initially used in public sphere to explain adoption of new technologies by farmers but has since been extensively applied to explain marketing of new products. In all likelihood, the 22% of the married couples that use contraception and the 25% that would do so if it were

available, are the early adopters and it is telling that the combined efforts of the government and the civil society are insufficient to meet their demand.

This leads to the other crucial question of how public and private sector efforts fit into the overall needs scenario. Since all providers combine to meet only 22% of the need for contraception, with the unmet need being 25%, it is likely that only about half of those who are ready to use contraception (i.e., the early adopters) are being reached. For these people, the question is not so much of being convinced to use contraception but of contraception availability. Once contraception is available, they will use it. A supply chain that is inadequate to reach these suggests serious management issues. More difficult to penetrate will be the early majority—people who can be convinced to use contraception but require some efforts. The early majority may be convinced by emulating the early adopters among their contacts, but this will largely require behaviour change counselling via active outreach, contraception promotion and perhaps to some extent via creation of an enabling environment by virtue of advocacy and use of mass media. To date, efforts at reaching the late adopters have largely been inconsistent, disjointed and ineffective.

All of these suggest a crucial role for the inter-ministerial task force in overseeing the national effort to improve contraception uptake. The ministries recognize that they are not (or can be) the sole providers of contraception to all. Their role is more of coordination and to fill in gaps that are left out by the civil society. In this context, the role of the task force may be to coordinate approaches for both early adopters and the early majority. For the early adopters, the critical issue is ensuring ready

supply. The task force aims to do so by anticipating supply and demand, by addressing supply chain management issues in the public sector and by encouraging some supply from the civil society. The question of payments versus supplying for free is somewhat unimportant, given that the early adopters are the most likely to pay for contraception from amongst all groups. Once inroads have been made into the early majority, the question of paying for contraception will become crucial since there is some evidence that increasing cost detracts some people from availing these methods.

Once the supply of contraceptives is ensured, the next most important question for the ministries and the civil society is how to convince the early and late majorities. Surely some research should help to identify who these people are and what messages will work for them. However, there is considerable global and regional experience that can be brought to bear in our context. These include aspects of mass communication, facility-based approaches, focusing on men as key decision-makers for contraception, piloting family size reduction as a poverty alleviation measure, and perhaps most importantly, promoting outreach with individual families for interpersonal counselling. The main challenge for the task force, therefore, is to formulate a cohesive and executable plan that is grounded both in our national context as well as national and international evidence.

References

1. Economist, June 2000.
2. Economic Advisory Wing, Ministry of Finance. Economic Survey 2008-09. Islamabad, Pakistan; Government of Pakistan; 2009.
3. The Pakistan Demographic and Health Survey 2007.
4. Everett M. R. Diffusion of Innovations, Glencoe: Free Press. 1964.

This research has been supported by a grant from the David and Lucile Packard Foundation. The opinions expressed are those of the authors and investigators and do not necessarily reflect the views of the funder.