

Financial Resource Flows for Population Activities

Report of a case study in Pakistan

The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.

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Preface

In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS activities;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analysing population data will cost US\$ 17.0 billion in 2000, and increase to US\$ 21.7 billion in 2015. Two-thirds should be paid by the recipient countries, one-third will be paid by the international donor community.

The case study in Pakistan was conducted from 17/05/1999 to 05/06/1999, and forms part of the UNFPA/NIDI project that measures global financial resource flows for population activities. For this purpose, questionnaires are sent annually to public and private donor organisations in developed countries, and to government departments and national NGOs in developing countries and countries-in-transition. Collecting all this information from a

broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. For better illustrations of the problems, eight country case studies have been carried out during 1997 to mid-1999. The case studies will complement our knowledge about financial flows for population activities that were obtained through the mail enquiry.

Data for this report were gathered in May and June 1999 by Mr. Masood Hayat, Director Operations Dataline services, Ms. Marja Exterkate and Ms. Marlies de Jager, both from the UNFPA/NIDI Resource Flows Team.

We want to express our sincere thanks to Mr. Francois M. Farah, UNFPA representative and Ms. Tahira Abdullah, assistant representative at the Pakistan UNFPA office. Many thanks go to all respondents who shared their time and information with us.

Due to the complexity of international and national resource flows in population assistance, and the relative short duration of the study, it is possible that this report contains significant omissions or errors. The authors will welcome any comments or corrections.

Marja Exterkate, Marlies de Jager and Masood Hayat

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1. Demography of Pakistan

The Islamic Republic of Pakistan is situated in South Asia, bordering Afghanistan, China, the Islamic Republic of Iran, and India. The country is divided into four provinces, Punjab, Sindh, North West Frontier Province (NWFP) and Baluchistan, and the Federally Administered Tribal Areas (FATA). Since independence in 1947, the country has experienced recurrent political upheavals, with frequent government changes.

According to the 1998 census, its population was over 130.5 million, which makes Pakistan the seventh most populous country in the world and fourth in Asia, after China, India and Indonesia. The majority of the population resides in rural areas (67.5 percent), whereas 32.5 percent lives in urban areas. Table one provides some basic national demographic indicators for Pakistan for the period 1951 to 1998.

Table 1. Basic national demographic indicators, Pakistan

	1951	1961	1972	1981	1998
Population (million)	33,74	42,88	65,31	84,87	131,51
Average annual growth rate	1.8	2.4	3.6	3.1	2.4
Per cent urban	17.8	22.5	25.4	28.3	32.6
Crude birth rate		51	52	37	32.7
Crude death rate		15	11 *	10.7	9.1
Total fertility rate		6.1 **	6.3	6.9 ***	5.1
Contraceptive prevalence rate					23.9% ****
Infant mortality rate *****	131	129	109	99	78
Life expectancy at birth Male	33.8	38.7	53.6		63.1
Female			47.6		63.0

* 1970; ** 1963; *** 1979; **** 1986/97; ***** figures relate to 1950, 1960, 1970, 1980, 1995 respectively.

- Sources :
- Population and Development Pakistan Country Report for ICPD+5, p. 5, 9
 - UNFPA CPA, draft 1999
 - Social Development in Pakistan, Annual Review, 1998, Social Policy and Development Centre, Karachi, 1998.
 - Kingsley Devis, the Population of India and Pakistan Princeton, New Jersey, Princeton University Press, in 50 Years of Pakistan, Volume 1, Summary, Federal Bureau of Statistics, Statistic Division, Gov of Pakistan Islamabad (June 1998).
 - Population Projections for 9th perspective plan period (1998-2023), Office Memorandum, Government of Pakistan, Planning and Development Division, Population and Social Planning Section.
 - Hakim, Abdul, John Cleland and Mansoor-ul-Hassan Bhatti. Pakistan Fertility and Family Planning Survey 1996-97, Main Report. National Institute of Population Studies, Islamabad & Centre for Population Studies, London School of Hygiene and Tropical Medicine, December, 1998
 - The State of Population in Pakistan, 1987. Abdul Razzaque Rukanuddin and M. Naseem Iqbal Farooqui, NIPS, November 1988.

The population has grown rapidly from 33 million in 1951 to over 130 million last year. The growth rate averages to 2.7 percent per annum, and is the highest compared to other populous developing countries (e.g. China 1.1

percent, India 1.9 percent and Indonesia 1.5 percent). According to United Nations projections, Pakistan's population will grow to over 380 million by the year 2050, surpassing the United States, Indonesia, Brazil and Russia to become the world's third largest country behind India and China (Rosen *et al.*, 1996, p.1).

The gap between economic growth and human development continues to widen, which manifests itself through unemployment (over 15 percent), poverty (40 percent of Pakistanis live below the poverty line) and illiteracy (60 percent). GNP is US\$ 490 for 1996/97.

Despite a long history of support for family planning, fertility rates are still high and contraceptive prevalence is still low, also compared to neighbouring Asian countries (see table 2).

Table 2. Total fertility rate and contraceptive prevalence in selected Asian countries, 1997

Country	Total Fertility Rate	Contraceptive Prevalence Rate
Pakistan	5.3	24
Bangladesh	3.2	45
India	3.1	41
Indonesia	2.6	55
China	1.8	83

Source: NIPS, Population growth and its complications on socio-economic development in Pakistan, July 1998, p. 30.

However there are indications of a beginning transition in Pakistan. Total fertility rates (TFRs) averaged approximately 6.5 children per woman during the past decade, but declined to 5.1 in 1998. Also the Crude Birth Rate (CBR), the Crude Death Rate (CDR) and the average annual growth rate declined to 32.7, 9.1 and 2.4 respectively in 1998.

The Contraceptive Prevalence Rate (CPR) increased from about 6 percent in 1975 to 23.9 percent in 1996/97 (Population Council, 1997, p. iii and p. 5). Contraceptive awareness and knowledge is nearly universal with 94.3 percent in 1996/97. The level of unmet need is found to be 37.5 percent of all the currently married women (PFFPS, 1996/97).

Maternal mortality is estimated to be very high in Pakistan, especially in the rural areas. Survey data for small areas give estimates ranging from 400 to 1,700 per 100,000 births (UNFPA, 1993, p. 9). The sex ratio (number of women per 100 men) is 93, due to high female mortality during the

childhood and childbearing years. Up to one year of age, mortality is slightly higher for boys than for girls. Between age one and fifteen, more girls than boys die.

Estimates of infant mortality rates (IMRs) vary between 80 and 120 per 1,000 live births, and there are likely to be wide variations in infant mortality by geographic and socio-economic groups (UNFPA,1993, p.10). The high infant mortality rates are due to low weight at birth, closely spaced children and various diseases.

2. Methodological issues

The specific objectives of the case study in Pakistan are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail inquiry;
- to use the findings of the study as benchmarks for studying the quality of data gathered through the mail inquiry in other countries;
- to investigate the roles of government, NGOs, private sector and the international community in the field of population activities;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programmes within the country? And how?

From 17/05/99 to 05/06/99 interviews were held with representatives from ministries, international donors (bilateral and multilateral), and national and international NGOs in Islamabad, Karachi and Lahore. Annex 1 provides a list of all persons and organisations contacted during the case study. With a few exceptions, the co-operation of all respondents was very positive.

To optimise the quality of the information, the team followed as much as possible a standard strategy:

- 1996 and 1997 financial data were collected through questionnaires during the last two years;
- questionnaires were controlled and internal and external quality checks were done;
- if necessary, information was corrected or adapted, in some cases a second visit was made to the organisation;
- in May and June 1999, in-depth oral information was gathered about various activities of the organisation such as: historical overview of funding, implementation of the ICPD Programme of Action, future plans and activities, et cetera.

The team is confident that the information obtained in the case study is of high quality.

During the case study it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years:

- In line with the ICPD PoA, more and more projects are integrated development projects. Therefore, expenditures for the four separate categories, as defined in paragraph 13.14 the ICPD 'Programme of Action' are often very difficult to distinguish, and are fairly often rough estimates. In line with this, there is the problem that the four population activity groups which are used to categorise financial flows are not completely mutually exclusive. Especially the lines between reproductive health and family planning are not always obvious.
- Many agencies, governmental and non-governmental, bring 'reproductive health' into their agenda whether or not it is in context. Sometimes the word 'family planning' is simply replaced with 'reproductive health'.
- Population and reproductive health activities are primarily carried out by two ministries: the Ministry of Population Welfare and the Ministry of Health. As the two ministries do not necessarily co-operate, this sometimes causes duplications or inconsistencies. However, in the upcoming five-year plan, more integration is being proposed. Other ministries involved with reproductive health/women's empowerment are the Ministry of Women Development, Social Welfare and Special Education, the Ministry of Education, and the Ministry of Labour and Manpower.

3. National Population Policy

3.1 | Population Welfare Programme

Private family planning activities started in the mid-1950s with the founding of the non-governmental organisation Family Planning Association of Pakistan. In 1960, the Ministry of Health and Social Welfare began providing family planning services in the public sector. The Population Programme in Pakistan was actually initiated in 1965 under the direct leadership of the President of Pakistan. The government articulated an explicit population policy, noting that high rates of population growth “would defeat any attempt to raise per capita income by a significant amount” (Rosen, *et al.* 1996, p. 9). The national population policy became an integral part in Pakistan’s 3rd five-year plan (1965-970), and has been ever since very much focussed on family planning activities as such.

During the 3rd plan period, the population programme was based upon the efficient distribution of supplies and the motivation of potential acceptors. The programme emphasised meeting specific annual targets regarding the number of acceptors (World Bank, 1995, p. 74). The government created a special infrastructure to provide contraceptive services, as the existing health facilities were already overloaded. Despite high political commitment, implementation of the programme faltered for a variety of reasons: the programme was introduced on a large scale without the groundwork which was needed to overcome cultural and social constraints, and it only focussed on demographic targets. In 1969, after 4 years, only 6 percent of couples used contraceptives (Rosen, *et al.*, 1996, p. 9).

In 1973, the *Continuous Motivation System* was introduced, shifting the focus from targets to client motivation and follow-up. This system involved a listing of all the fertile couples in the project areas, so that they could be visited by male or female fieldworkers for motivation and supply of contraceptives (PFFPS, 1998, p. 8). This was also never fully implemented and had little impact (Rosen, *et al.*, 1996, p. 9). One of the major problems of this phase was the unstable political climate (World Bank, 1995, p. 75).

With a change in leadership of the government and the family planning programme, a new *Contraceptive Inundation Scheme* was initiated in 1975 with assistance from USAID (*ibid.*). The objective of this scheme was to overcome any contraceptive supply bottle-necks and to allow supply to create demand (*ibid.*). All possible channels (e.g. shopkeepers, clinics,

fieldworkers) were utilised to distribute contraceptives. This was also poorly implemented, mainly due to inadequate distribution systems. Contraceptive use and knowledge were unchanged from 1969 levels.

During 1977-1980, family planning activities were suspended, due to the after-effects of the 1977 general elections and resulting transition to a military government. Family planning clinics tried to continue to function, but without promotional support.

Until the 1980s, the family planning programme was set up as a division in the Ministry of Health. During the beginning of the 1980s, important organisational changes took place. The *Continuous Motivation System* was discarded in 1981. The population programme re-started with a multi-sectoral approach, and was transferred to the Ministry of Planning and Development, where a separate Population Welfare Division was established. With the recognition that there was a relation between population and other development sectors, family planning became a partial responsibility of numerous government departments (UNFPA, 1993, p. 11).

Under the 6th five-year plan (1983-1988), the multi-sectoral approach was continued, and provincial population welfare departments were established, with implementation responsibilities. With this multi-sectoral approach, emphasis was put on MCH, female education, broad based IEC programmes in more rural areas and incorporating NGOs. In order to encourage NGOs to participate in the programme, a Non-Governmental Organisations Co-ordinating Council (NGOCC) was set up in 1985. But despite all this, the contraceptive use in 1985 was only 9 percent. Major problems were inadequate technical support, failure to clarify the division of responsibilities between federal and provincial governments, and lack of political support (World Bank, 1995, p. 75). In 1986, a social marketing project began subsidised retail sales of condoms with the assistance of USAID. To provide research and evaluation support, the National Institute of Population Studies (NIPS) was created in 1986. NIPS was set up as an autonomous research organisation within the Population Welfare Division to carry out research related to population welfare. The main areas for research are:

1. Research about the various components of the family welfare programme;
2. Issues affecting FP practices, e.g. perception of religious leaders;
3. Monitoring of on-going projects and programmes;
4. In-depth analysis of the findings.

During the 7th five-year plan (1988-1993), the policy and strategy of the 6th Plan were continued. Mobile service units were added to the programme to increase coverage (PFFPS, 1998, p. 9). The objectives of the 7th plan were:

- increase contraceptive use from an estimated 11 percent in 1987/88 to 23.5 percent in 1992/93.
- reduce CBR from 42.3 to 38.0.
- prevent 3.1 million births during 1988-1993.
- increase the number of acceptors from 2.1 million in 1987/88 to 3.7 million in 1992/93.
- provide reproductive health services to mothers and child health care services for children under five years.

The strategy for the 7th Plan is based upon active support and participation of relevant government departments, public institutions and the private sector in providing services and promotional programmes (UNFPA, 1993, p. 8). But also during the 7th plan period, the population programme only had a small impact: in 1990/91, contraceptive prevalence had slightly increased to a level of 14 percent. Services remained limited due to a shortage of funds, restrictions on the recruitment of staff, and lack of open political support up to 1990 (Government of Pakistan, PC-I, p. 12).

In 1990 the Population Welfare Division was given an independent status of the Ministry of Population Welfare. NIPS remained an autonomous research organisation under this Ministry. The population programme now received open political support from the government leaders. Allocation for the programme was exempted from budgetary cuts in 1991/92 (Government of Pakistan, PC-I, p. 12).

During the 8th Plan (1993-1998), efforts to increase the coverage continued, as it was realised that only 20-25 percent of the total population had access to family planning services, and only 5 percent of the rural population. Two of the major efforts are firstly, the establishment of the village based family planning workers (VBFPW) programme under the Ministry of Population Welfare, and secondly, the Prime Minister's Programme for Family Planning and Primary Health Care, which was launched in 1994 to extend outreach services to communities through the Lady Health Workers (LHW). This programme falls under the Ministry of Health.

Social marketing activities ceased after USAID's withdrawal in 1993, and recommenced in 1995, with two private sector organisations with funding of KfW and DFID. The Social Marketing Programme (SMP) has established a network of Green Star family planning outlets to provide contraceptives and

services to low income groups. Key Social Marketing (KSM) is working to increase access to hormonal contraceptives through the private sector, utilising a network of private sector chemists and doctors (PFFPS, 1998, p. 153). Currently, pills, injectables, condoms and IUDs are available for subsidised prices.

However, during the 8th Plan, the population welfare programme remained focussed on achieving demographic targets. The objectives of the 8th Plan were:

- increase contraceptive use from 14 percent in 1992/93 to 24.4 percent in 1998;
- reduce TFR from 5.9 in 1992/93 to 5.4 in 1998;
- reduce CBR from 39 in 1992/93 to 36 in 1998;
- reduce the rate of population growth from 2.9 in 1992/93 to 2.7 in 1998.

The objectives of the 8th Plan have been met. The VBFPW and especially the LHW outreach activities had an impact on the coverage, in addition to the two social marketing programmes.

During the current 9th Plan (1998-2003), some elements of the ICPD-PoA are incorporated, e.g. a reproductive health package through the MoH and MoPW, and more co-ordination and integration of activities at service delivery level. Efforts will be undertaken to bring the community based workers (VBFPWs and LHWs) of both sectors under one umbrella. The target oriented approach at the field level will be discontinued. However, targets at the federal and provincial level would be continued in the future.

The main demographic objectives in 9th Plan are:

- increase contraceptive use from 23.9 percent to 40.3 percent in 2003;
- reduce the annual population growth rate from 2.4 percent to 2.1 percent in 2003;
- reduce TFR from 5.1 to 4.2 in 2003.

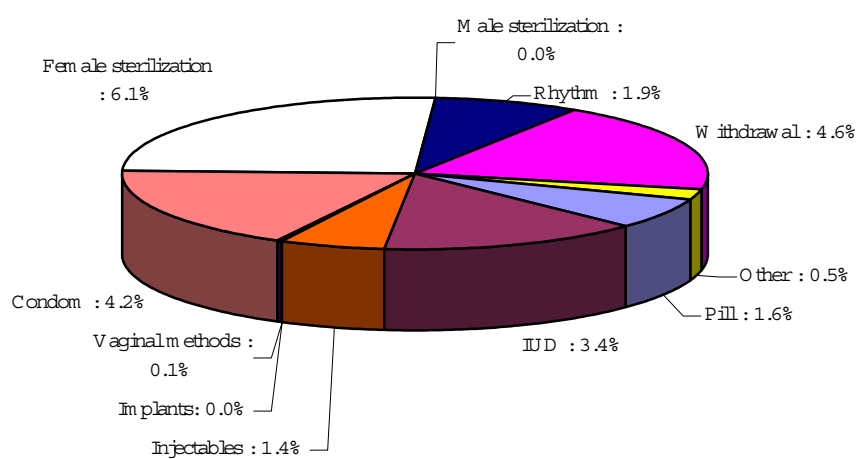
Contraceptive method mix.

One of the major objectives of the Population Welfare Programme is to enhance contraceptive use by increasing awareness of family planning and motivating couples to adopt a method (PFFPS, 1998, p. 131).

Awareness of family planning is widespread (over 94 percent of ever-married women), but only 24 percent of currently-married women were using contraception in 1996/97, of whom 17 percent a modern method (PFFPS, 1998, p.144/145). As can be seen in figure one, female sterilisation

(6.1 percent) is the most popular modern method, followed by condom (4.2 percent), and IUD (3.4 percent). Withdrawal is the most popular traditional method (4.6 percent).

Figure 1. Percentage distribution of contraceptive methods, 1996/97



Source: PFFPS, 1998, p. 146.

Management of the Population Welfare Programme.

The population welfare programme is a vertical programme, and has always been made and funded at the Federal Ministry of Population Welfare. The federal level is also responsible for most training, contraceptive procurement and distribution, social marketing, co-ordinating and funding of NGOs, research and evaluation, and national media campaigns. Provincial population welfare departments are charged with service delivery, administration and local promotion and supervision (Rosen, *et al.*, 1996, p. 24).

The Federal Ministry of Population Welfare has its own clinics and service delivery system, consisting of a network of approximately 1,520 family welfare centres, 220 hospital-based reproductive health service centres, 250 mobile service units, and about 12,000 village based family planning workers. Clinical training activities take place in 12 Regional Training Institutes. The MoPW network covers only a small part of the population (10-12 percent), compared with the general health system, which almost has a primary health facility in every union council.

Since 1990, when the Ministry of Population Welfare was created, the Ministry of Health's involvement in family planning have been limited. It always remained involved in basic activities like distributing contraceptives, providing delivery services and ante- and post- natal care. With the Prime Minister's Programme for Family Planning and Primary Health Care in 1994, the MoH's active involvement in family planning returned again. The Prime Minister's Programme is implemented by Lady Health Workers (LHWs) at the community level. These LHWs are trained and employed under the programme. Programme Implementation Units (PIU) have been established at federal, provincial, divisional and district levels. These PIUs plan, monitor and supervise the activities of the LHWs. To date, 47,000 LHWs are trained. So, the Ministry of Health is also implementing parts of the national population welfare programme. In contrast to the population welfare programme, health is a provincial subject. The federal government is responsible for health policy development and co-ordination; the provincial health departments are responsible for health service provision and funding of their share of the health system. The health delivery system consists of roughly 12,000 health facilities, with three layers through which contraceptives are supplied: basic health units, rural health centres, and sub-district hospitals.

Women's empowerment.

The general status of women in Pakistan is still very low. Maternal mortality is high, female life expectancy is lower than male life expectancy. The practice of seclusion (*purdah*) and limited decision making authority hamper

women's access to social services. Literacy and school enrolment for females are low as well.

Table 3. Education and illiteracy by sex, Pakistan

	female %	male %
primary enrolment	30	57
secondary enrolment	13	28
illiteracy	76	50

Source : UNFPA, the state of the world population 1998.

A women development wing was established in 1979 as a Division of the Cabinet Secretariat, to promote the integration of women in the planning and development process. It became the Ministry of Women Development in 1989. In 1996, social welfare and special education were merged with the Ministry, and it was renamed the Ministry of Women Development, Social Welfare and Special Education. The women development wing is responsible to undertake and promote projects for providing special facilities for women. The Ministry has developed linkages with some local NGOs. Filling the gaps in the development efforts of the federal and provincial departments, they fund women's related development projects. Since 1979, they funded more than 900 projects that are implemented through federal or provincial line departments and some NGOs. Some of the major activities undertaken are:

- Micro credit for women: The First Women Bank Limited was established in 1989. It operates a small credit scheme to help women earn their living;
- Export trade houses for women entrepreneurs have been established in Lahore and Islamabad;
- Separate enclosures for women in the open markets like the Sunday Bazaars have been set up;
- Establishment of crisis centres for women in distress;
- Visit to jails to monitor the situation of women;
- Research on the conditions and problems of women.

In 1998, the Ministry has formulated a National Plan of Action (NPA) as follow up of the Beijing conference on women, held in 1995. The NPA establishes a set of priority actions formulated towards achieving the agenda for the empowerment of women in Pakistan. It aims to facilitate women's participation and protection of women's rights. To facilitate these post-

Beijing activities, a Beijing Follow-Up Unit (BFU) has been established in the Federal Ministry of Women Development, and one in each of the provincial women development departments.

A Commission of Inquiry for Women was set up in 1994 to review the status of women. The report of the Commission was presented to the Prime Minister in 1997, but so far, no action has been taken.

Social Action Programme.

In 1990, when the poor performance of the social sector became evident, the government developed a Social Action Programme (SAP), which was launched in 1993. The programme was implemented primarily by the provinces, which are responsible for the social services. The SAP concentrated on improving the access to and quality of primary education, primary health and nutrition (at the basic health unit level and village based), population welfare, and rural water supply and sanitation. Four already running preventive programmes of the health sector were gradually brought under SAP: AIDS control, immunisation, malaria control, and the Prime Ministers Programme on primary health and family planning. Within SAP, 66 percent of the budget goes to primary education, 20 percent to primary health, 4 percent to population welfare, and 10 percent to rural water supply and sanitation. The first phase (1993- 1997) was supported by the World Bank, Asian Development Bank, DFID and the Netherlands under the SAP-project (SAPP I). Support included funding and technical assistance. The objectives of SAPP I were (Henn, 1998, p. 4/5):

- support the government's ownership and decentralised management of SAP by providing direct budget support for the programme;
- leverage an absolute and percentage increase in public sector allocations to the specific social sector areas of primary education, primary health, population welfare, and rural water supply and sanitation, by making only annual increase in targeted spending in these sector eligible for reimbursement;
- alleviate the most pronounced weaknesses in programme design and implementation through the provision of technical assistance.

The SAP succeeded in protecting the budget that was allocated for the social sector during the period 1993-1997 from the drastic cuts made in other public programmes.

The second phase (1998-2002) focuses on elementary education (till class 8), basic health and nutrition (up to the sub-district level hospitals), population welfare, and rural water supply and sanitation. SAP II

emphasises consolidation of the SAP sector services and more decentralisation of administrative and financial power to district level. There is a moratorium on construction of new health facilities. SAPP II is supported by the World Bank, Asian Development Bank, DFID, EU and the Netherlands.

3.2 | HIV/AIDS Programme

Pakistan began testing for AIDS in 1986 at the National Institute of Health. Until December 1998, 1,364 HIV infected, and 170 AIDS cases are reported to the National AIDS Programme. Most of these cases are male. Based on this, the WHO estimated the number of HIV infected persons between 50,000 to 80,000.

The Federal Committee on AIDS started functioning in 1987, and defined the broad policy guidelines for the control of AIDS in Pakistan. The programme was mainly laboratory oriented and technical support came through WHO. Until 1993, the distribution of AIDS messages through t.v. or radio was banned. In view of the behavioural implications, the programme was made more realistic through a long term plan, which was launched in 1994. Initially the programme was being planned until 1997, but is extended to 2002. Activities are being implemented in the overall health care infrastructure of the country. The main items are:

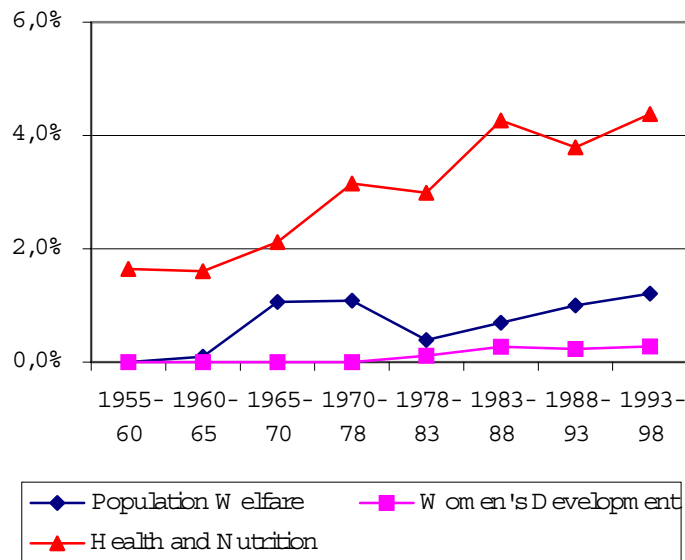
1. Creating awareness on HIV/AIDS;
2. Prevention of HIV transmission and reduce morbidity associated with HIV/AIDS;
3. Promotion of safe blood transfusion;
4. Prevention of STD-transmission;
5. Establishment of an AIDS surveillance and monitoring system;
6. Conduct training of various categories of health staff;
7. Conduct research and social behavioural studies;
8. Develop and strengthen a programme management structure at federal and provincial levels.

Some of the achievements include establishment of provincial implementation units, screening of blood, health education campaign on t.v., hotlines, establishment of 14 new surveillance centres.

4. Financial Flows

The population welfare programme is funded by the government of Pakistan, international assistance, and to a lesser degree, by the private sector. As can be seen in figure two, funding for population welfare activities as a share in the total five-year plans have been at a low level of 1 percent. As can be seen in the same figure, allocations to related-population activities were low as well: the share of women development-activities have been less than 0.5 percent, and health and nutrition activities have been fluctuating and are now hovering at a level of 4 percent of the total five-year plan allocation. Historically, Pakistan's public expenditure on population has been modest, at between 0.06 percent to 0.07 percent of GNP (World Bank).

Figure 2. Share of various sectors in the five year plan allocations



4.1 | Role of the Government of Pakistan

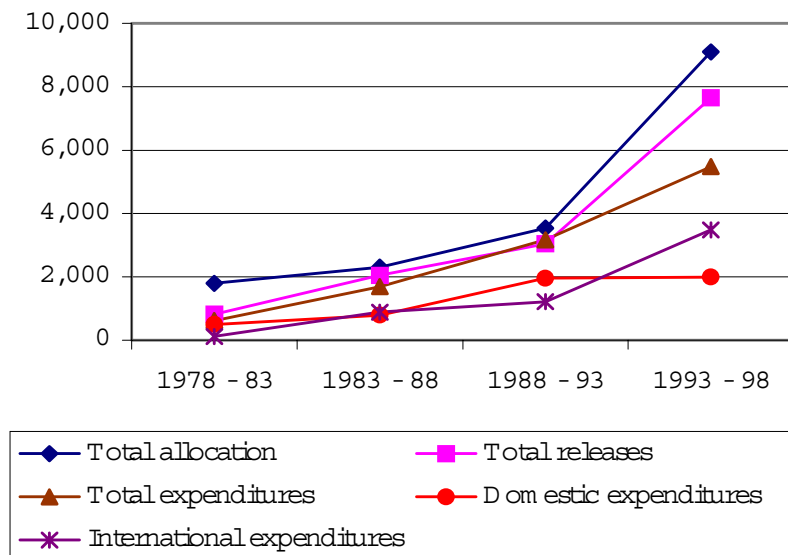
The national population and health programmes are implemented by several ministries, the main ones being the Ministry of Population Welfare and the Ministry of Health. They operate parallel systems for health and family planning service delivery, and have separate administrative systems.

Ministry of Population Welfare

In terms of funding, the federal Ministry of Population Welfare is responsible for the population welfare programme. The population programme is financed from the government's annual development budget, rather than the regular budget, with unfavourable implications on staff recruitment and development (World Bank, 1995, p. 77). Employees of the population programme are not on the regular budget, creating job uncertainty.

Since the inception of the population welfare programme, total funding for the Division of Population Welfare, and later the Ministry of Population Welfare has been rising slowly until the early eighties. A decline is noticeable during 1978-83, the period during which family planning activities were suspended. Since then funding is increasing from Rs 1.7 billion (roughly US\$ 182 million) to Rs 9.1 billion (about US\$ 288 million) during the 8th Plan, and is allocated for Rs.15.9 billion in the 9th Plan (US\$ 318 million). Although funding for population rose during the 5-year plans, actual releases, and final expenditures were much lower.

Figure 3. Allocations, releases, and actual expenditures of funds, Ministry of Population Welfare, during 5th (1978-83) to 8th (1993-98) plans, in Rs. million



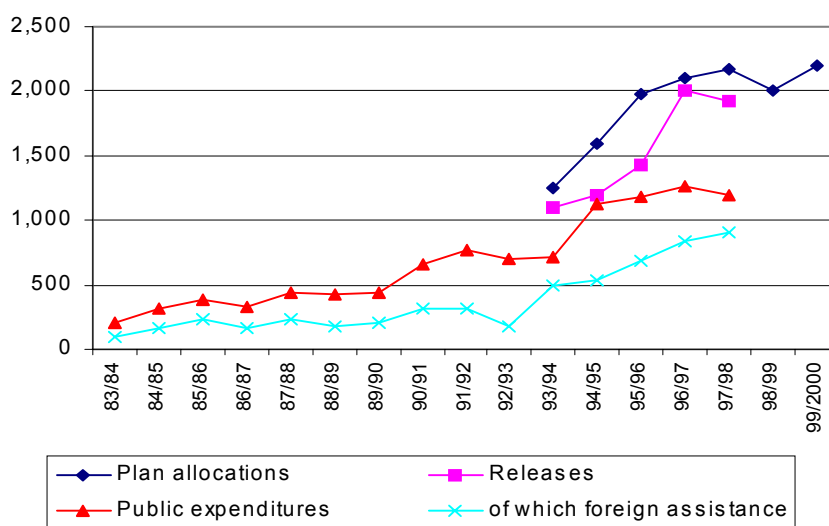
Releases are done on a quarterly basis, but due to a long bureaucratic process, finances are released at a very late stage. Figure three gives an

overview of allocations, releases, expenditures, and domestic and international expenditures during the last four Plan periods (1978-1998).

Expenditures as a percentage of the Plan allocation fluctuated from 34 percent during the 5th Plan, and increased to 90 percent during 7th Plan, but dropped again to 60 percent during the 8th Plan. The low rates of expenditure can be attributed to a number of reasons, among which the late release of the allocations, so one has simply not enough time to spend the money, and the ban on procurement or new recruitment at several levels, due to financial problems within the government. The share of international assistance in the above figures has been fluctuating, from 19 percent, 53 percent, 39 percent, and in the 8th plan 64 percent. The aim in the 9th Plan is that donor assistance will be reduced to around 40 percent, with a maximum of 50 percent.

Figure 4 gives an annual overview of allocations, releases and expenditures.

Figure 4. Annual allocations, releases, and actual expenditures of funds, Ministry of Population Welfare, since 1983, in Rs. million.



During the 8th Plan period (1993-1998), we can see that releases have been lower than allocations, with even a lower level of expenditures. In 1993/94 57 percent of the allocations were actually spent. This increased to 71 percent in 1994/95, but declined to 60 percent, and even 55 percent in 1997/98.

Public expenditures in the figure consist of domestic as well as international expenditures. The table below gives an overview of the expenditures by source.

Table 4. Public expenditures for the population welfare programme, Ministry of Population Welfare, 1983-1997 (Rs. Millions)

fiscal year	of which:		Percentage		
	Total public expenditures	Domestic	Foreign assistance	Domestic	Foreign assistance
5th Plan (1977/78- 1982/83)	617 (US\$ 62m)	501 (US\$ 51m)	116 (US\$ 12m)	81%	19%
1983/84	202	102	100	50%	50%
1984/85	321	160	161	50%	50%
1985/86	388	156	232	40%	60%
1986/87	335	171	164	51%	49%
1987/88	441	208	233	47%	53%
6th Plan (1983/84 - 1987/88)	1,687 (US\$ 106m)	797 (US\$ 50m)	890 (US\$ 56m)	47%	53%
1988/89	424	243	181	57%	43%
1989/90	444	232	212	52%	48%
1990/91*	653	341	312	52%	48%
1991/92*	763	444	319	58%	42%
1992/93*	703	529	174	75%	25%
7th Plan (1987/88 - 1992/93)	2,987 (US\$ 138m)	1,789 (US\$ 82m)	1,198 (US\$ 55m)	60%	40%
1993/94	711	211	500	30%	70%
1994/95	1,133	593	540	52%	48%
1995/96	1,181	491	690	42%	58%
1996/97	1,257	417	840	33%	67%
1997/98	1,194	282	912	24%	76%
8th Plan (1992/93-1997/98)	5,476 (US\$ 173m)	1,994 (US\$ 63m)	3,482 (US\$ 110m)	36%	64%

* estimated figures

US figures in brackets are in million of US\$, and are approximate figures.

Sources: World Bank: Staff Appraisal Report Pakistan, Population Welfare Programme Project, February 10, 1995, p.66; for figures after 1993/94: MoPW

The drop in 1992/1993 foreign assistance is due to the withdrawal of USAID, but this was soon balanced by support from other donors. The share of foreign assistance in the total public expenditures is, especially during the 8th Plan period high, and shows even an increasing trend. It should be noted that most of this external assistance since the early 90s consists of (World Bank) loans, rather than grants.

Ministry of Health

Health is a provincial subject. The Federal Ministry of Health is responsible for the developmental budget (PSDP or Public Sector Development Programme), whereas the provinces are expected to pay for recurrent costs out of their own resources, plus some additional developmental costs. Family planning and reproductive health activities which are provided at the Basic Health Unit and Reproductive Health Service levels, are funded by the provinces. In order to get the total picture for reproductive health activities which fall under the Ministry of Health, developmental costs made for RH at the federal level should be supplemented with the provincial recurrent and some provincial developmental costs for reproductive health activities. The major problem is that RH activities are included in the PHC programme, and are not a separate budget line. In order to estimate the share of RH expenditures, the percentage of time health workers spent on RH activities was applied to the recurrent costs in the PHC budget. This exercise was only done for 1997 expenditures, where estimates were made for all the four provinces. The outcome is given in the summary paragraph in this chapter.

In addition to these general reproductive health activities, two vertical programmes are being implemented under the federal Ministry of Health: the Prime Ministers Programme on Primary Health and Family Planning, and the National AIDS Programme.

The Prime Ministers Programme on Primary Health and Family Planning.

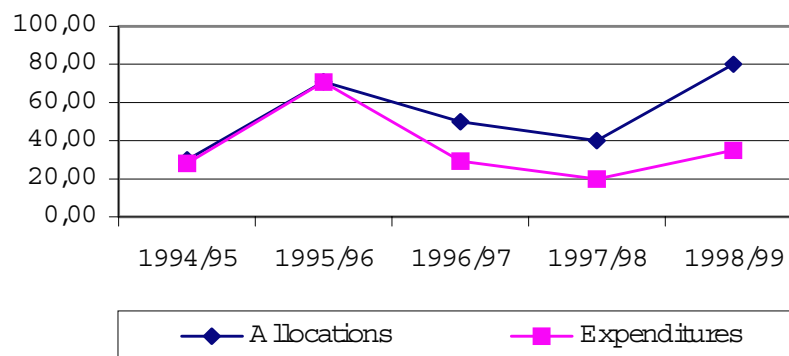
This programme was launched in 1994. During 1994/95 Rs. 402 million (US\$ 13 million) was allocated, of which Rs. 371 million (82 percent) was spent. For 1995/96 Rs. 1 billion (US\$ 32 million) was allocated of which almost 100 percent was spent.

During the 8th five-year plan, Rs 9.1 billion (US\$ 288 million) was allocated for this programme, of which Rs. 4.28 billion was released, with only Rs 3.7 billion or 41 percent actually spent.

The National AIDS Programme.

The AIDS programme (1994-1997) was allocated for Rs. 774.35 million (US\$ 24 million) by the government. The actual releases until 1998 came only to Rs. 271 million, of which Rs.183 million was spent. 40 percent of the budget goes to the media campaign.

Figure 5. Government allocations and expenditures of the AIDS programme, 1994-1999 (in Rs. million)



Since 1995/96, when 100 percent of the allocations were spent, expenditures are decreasing continuously. In 1998/99 only 44 percent of the budget was spent

In addition to government funding, the international donor community contributes significantly to the HIV/AIDS programme, especially through UNAIDS (US\$ 420,000 in 1999), WHO (US\$ 250,000) and UNICEF (US\$ 200,000 in 1999).

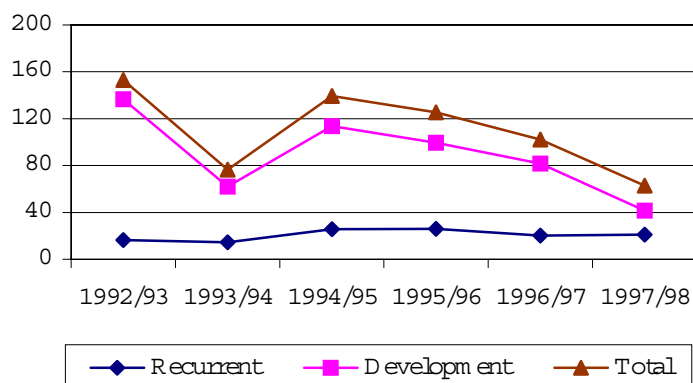
Ministry of Women Development, Social Welfare and Special Education.

Since 1979, the Women Development Wing in the Ministry funded more than 900 projects in the public and NGO sector for more than Rs 2 billion. All funding has always come from the GOP.

In figure 6 we see that the expenditures since 1992 have been decreasing with a steep decrease in 1993/94. This decline was due to overall decreasing budget allocations by the government.

Due to continuous decreasing government funding, additional future funding is to be looked for from provincial government departments or donors.

Figure 6. Expenditures of the Ministry of Women Development, 1992-1998 (in Rs. million)



Summary¹

In Pakistan, the Population Welfare Programme is a federal subject for which allocations are made in the federal budget. The Ministry of Population Welfare mainly implements the programme. However, certain components of the programme, like the Prime Ministers Programme on Primary Health and Family Planning, and the National AIDS Programme are being implemented by the Ministry of Health. Likewise, the provincial health departments are implementing many components of reproductive health. Health, at the provincial level is a decentralised subject for which resources are allocated in the provincial budgets.

Also the Ministries of Education and Labour and Manpower are involved in implementing the population education programme and workers' population education programme respectively.

The total budget for all the above referred population activities for the year 1997 and the distribution between the various government departments is given in the table below.

From the table on the next page we can conclude that funding for population activities implemented by the several ministries at the federal and provincial level originates for 23 percent from international sources, and for 77 percent from national ones. This seems to contradict the figures in table 4 in the Ministry of Population Welfare paragraph, where in 1996/1997 67 percent of funding originated from international sources, whereas only 33 percent came from national ones.

Table 5. Total government budget for population activities

¹ This paragraph heavily draws on the report on data collection of financial flows for population for the UNFPA/NIDI project in Pakistan, 1997.

by source and ministry, 1997

Total government budget in 1997	Rs. 3,998.5 million (US\$ 97 million)
	%
from international sources	23
from national sources	77
Percentage going to:	
Ministry of Population Welfare	50.00
Ministry of Health	22.70
Ministry of Women Development	0.50
Ministry of Education	0.01
Ministry of Labour and Manpower	0.24
Provincial Health Departments	26.60

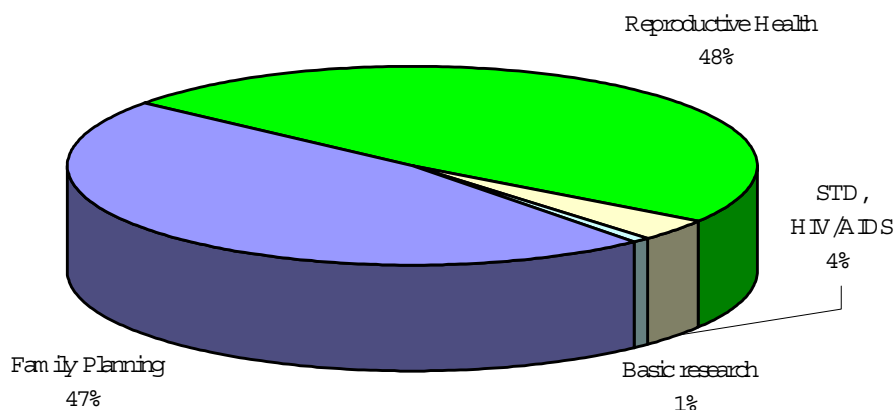
It is clear that when we look at population activities, the focus on the Ministry of Population Welfare alone would cause a very biased interpretation, and a strong underreporting. Of the population welfare programme, only 50 percent of the funding goes to the Ministry of Population Welfare. The other 50 percent goes to the Ministry of Health, of which the provincial health departments play a very important role. Almost 27 percent of the total budget for population welfare originates from the provincial health departments.

Total expenditures for population activities in 1997 (roughly Rs. 4 billion) comes to a per capita expenditure of US\$ 0.75, of which US\$ 0.57 is contributed by the government of Pakistan, and the remaining US\$ 0.17 from the international community. When one relates the expenditures in 1997 to GNP (of US\$ 490), it means that 0.20 percent of GNP is spent on population, of which 0.15 percent comes from national sources, and 0.05 percent from international.

95 percent of the government expenditures goes to family planning/reproductive health activities, 4 percent to STD, HIV/AIDS, and only 1 percent to research activities (see figure 7).

4.2| Role of the International Donor Community

The federal Economic Affairs Division (EAD) of the Ministry of Finance and Economic Affairs is responsible for the overall co-ordination and management of donor inputs. All donor money, which goes directly to the country, has to flow through the EAD. Exceptions are the WHO, which signs an agreement directly with the Ministry of Health, and donor money

Figure 7. Government expenditures by category, 1997

which is disbursed from international NGO-headquarters directly to their field offices in Pakistan. All donors fund projects or programmes through a re-imbusement process, usually quarterly.

International assistance has been important for the population welfare programme, as became clear in the previous paragraph. Assistance is in the form of financial or technical assistance, contraceptive procurement, equipment, training, research, etc.

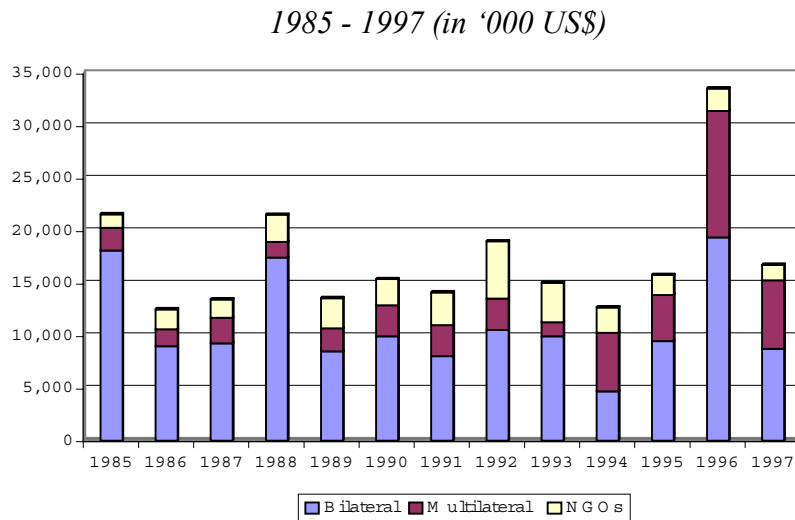
The programme suffered, when USAID (the largest donor to the population programme during the 1980s) cut off all bilateral aid to Pakistan in 1993 following a dispute over nuclear policy. USAID has been the most important donor for the population programme, accounting roughly 60 percent of total foreign assistance. Support from other donors, especially UNFPA and DFID tried to balance this cut.

Total international funding since 1985 by channel is given in figure 8.

As can be seen in figure 8, donorfunding for population activities in Pakistan has been fluctuating. Bilateral assistance has been the main channel, except in 1994 where bilateral funding was less than 37 percent. The peak in 1996 is due to high expenditures of UNFPA, DFID, and KfW.

Bimonthly, nine donors working in the field of reproductive health and population, together with the UNFPA meet in a donor taskforce. The main goals of these taskforces are to enhance donor co-ordination, share experiences, explore possibilities of collaboration, and funding issues. In addition there is a quarterly RH “forum” for interested donors.

Figure 8. Donor expenditures by channel of distribution in Pakistan,



Source: UNFPA, Global Population Assistance Reports.
1997 figures are preliminary

The major funders of the SAP (WB, ADB, EU, DFID, NL) also meet on a regular basis.

Currently, the main international donors for population activities are the Asian Development Bank, World Bank/IDA, DFID, KfW, and UNFPA.

4.2.1. Bilateral Donors

DFID

DFID has a substantial development programme in Pakistan. All support is provided on grant terms, and comprises both technical co-operation as well as financial aid. The programme is poverty focussed. DFID contributes a total of US\$ 34 million to the four population and health projects of the World Bank. All population activities, and most health activities fall under the SAP. They have also separate health activities:

- Key Social Marketing project, which started in November 1996 and is being executed by the Futures Group Europe (US\$ 11,5 million for 5 years);
- Evaluation of LHWs in 1999, a one year project of US\$ 1.6 million;
- STD prevalence survey by province (US\$ 1.1 million);

- Doorsteps project with the Family Planning Association of Pakistan, a four year project, expecting to end in December. It's objective is to increase contraceptive prevalence by establishing a static service outlet, doorsteps mobile services and by enlarging the outreach of static units. (US\$ 928,000);
- Community Based Family Planning project with PAVHNA (Pakistan Voluntary Health and Nutrition Association): provision of family planning services to women in their homes, supported by broader static services. Population Concern is the executing agency. A 5 year project (US\$ 1,8 million).

European Union

NGO co-financing projects. The following four projects are implemented through a European NGO, and executed by a local NGO:

1. After the ICPD, the Asia Initiative, a US\$ 25 million project for the Asian region, with US\$ 2.8 million for Pakistan for a four year period. It consists of four sub projects, executed through three European NGOs: World Population Foundation, Marie Stopes, and Population Concern;
2. Community based service delivery project, implemented through Population Concern with APWA Karachi (1994-Dec. 1999; US\$ 127,000). Non-clinical contraceptives (pills and condoms) are distributed at clients' doorsteps through trained community workers in North Karachi;
3. Community based family planning service delivery through Population Concern, with PAVNA Karachi (1994-Dec1999; US\$ 459,000). Provision of comprehensive health, birth spacing and child survival in East Karachi;
4. Karachi Reproductive Health Project (Dec 1996–Dec 2000; US\$1.3 million). The aim of this project is to test a model focussing on improving the reproductive health of women from low-income communities.

Bilateral projects:

- Rural Social Development Programme (RSDP) (US\$ 28 million) with the Ministry of Health, and 7 local NGOs. Hasn't actually started;
- Funding through SAP (US\$ 23 to 28 million for health, and especially reproductive health).

The EU is very centralised: all funding and decision making is done in Brussels, not Islamabad, which may cause lengthy procedures.

Germany (KfW)

KfW contributes a total of US\$ 40.3 million to three of the four population and health projects of the World Bank.

Germany has one main project in Pakistan, which is directly with SMP (Social Marketing Pakistan), a local NGO, created and registered in 1991 by the US based Population Services International. SMP is the executing agency for the KfW funds for social marketing, with PSI providing technical and management assistance. The project is allocated for approximately US\$ 26 million for the period 1994-1999. Before 1993, the project was funded by USAID, and focussed on social marketing of condoms. Since late 1994, KfW took it over and expanded the programme with the Green Star network, which focuses on family planning services, along with contraceptive products (condoms, IUDs, and since mid-1997 also oral and injectable contraceptives). The aim is to utilise private sector resources (distribution, communications, research, private medical practitioners) to expand the choice and increase the use of contraceptive methods and products among low income groups.

In addition to the SMP, KfW funds some smaller reproductive health projects, amounting to US\$ 86,500.

The Netherlands

Dutch population programmes focuses in the provinces of Baluchistan and NWFP. Most projects are implemented directly with local NGOs. Ongoing projects are:

- Rokhana Kor Family Health Hospital, Peshawar, NWFP, 1998–2001. Implemented by the Family Planning Association of Pakistan. The project is to improve health and well-being of low income families in urban, peri-urban and rural communities of Peshawar district. The allocation is over US\$ 512,000;
- Reproductive Health Programme, Baluchistan, 1998–2002. Implemented by the Marie Stopes Society. The project supplements services provided by the government's health and population welfare services in South Baluchistan. The allocation is over US\$ 2 million.

At the end of 1999, a 3 year reproductive health programme in Haripur District, NWFP is planned to commence, for roughly US\$ 2 million, and to be implemented by SCF/US. The aim of the project is to strengthen the capacity of the government's health and family planning departments to provide quality services, create awareness, and training of community workers.

In addition, the Netherlands contribute to the SAP- programme. Under SAP II, US\$ 18 million has been allocated for the education sector, and US\$ 2,6 million for reproductive health.

CIDA

In addition to bilateral aid to the Ministry of Health, the Canadian aid in Pakistan goes through two wings:

1. Canada fund for local initiatives (annually),
2. Women's development project (a 6 year project: 1996-2002; US\$ 2,9 million).

ad. 1.

This fund provides economic, technical, educational, and social assistance to small-scale, innovative development projects undertaken by community based NGOs and village groups. It emphasises projects aimed at improving the physical infrastructure in rural and semi-rural areas, delivering social services and enhancing the socio-economic condition of women. It finances a maximum of US\$ 36,000 per year per project.

ad. 2.

This project has a more strategic nature, and supports development by women and for women. Its focus is on human rights, health, education, and economic advancement. Initiatives include institutional strengthening, awareness raising, advocacy, applied research, training, and gender sensitisation. It finances a maximum of US\$ 72,000 for a partner for three years.

45 percent of CIDA's aid goes directly to local NGOs under these two wings. A few of the major ongoing projects are:

- Gender, reproductive health and sanitation programme in Hazara district, NWFP: an integrated development project implemented by Sungi;
- Aurat Foundation in Lahore: this is set up as a women resource information centre.

4.2.2. Multilateral Donors

UNFPA

UNFPA started its activities in Pakistan in 1970 with the first country programme. This programme, which was implemented to 1973, supported the family planning programme, with the main focus on procurement of contraceptives and clinical equipment. The second programme (1974-1981) emphasised training in maternal and child health and family planning services, strengthening the Regional Training Institutes, human resource development in family health. During the third (1981-1986) and fourth programme (1987-1993), the 1981 census was supported, training of field personnel in IEC continued, as well as procurement of contraceptives and equipment. Support was given to family planning services through government and NGO family welfare centres at the community level. The current programme, which has almost come to an end, supports the governments population programme according to the 8th five-year plan, and provides assistance in achieving Pakistan's population development objectives. 60 percent of the budget is allocated for MCH/FP services, 20 percent for IEC, 5 percent for population policy formulation, and population dynamics, 12 percent for women and development, and the remainder 3 percent is reserve. Out of the budgeted US\$ 30 million, US\$20 has to come from regular sources. The upcoming, 6th country programme will run from January 2000 to December 2003, with an expected budget of almost US\$ 40 million.

UNFPA is working with the Ministries of Population Welfare, Health, Education, Women's Development, and Labour and Manpower. Although in the past, UNFPA worked directly with local NGOs, they don't anymore, due to the size of the programme. Instead, UNFPA works through umbrella NGOs and other international NGOs, like NATPOW, AVSC, Pathfinder International, and Medicines du Monde. For some ad-hoc, one-time things, they do provide money directly.

*Table 6. Budget of UNFPA' country programmes
(in million US\$)*

Country programme	years	budget
First	1970 – 1973	1.76
Second	1974 – 1981	15.00
Third	1981 – 1986	11.00
Fourth	1987 – 1992	20.00
Fifth	1993 – 1999	30.00
Sixth	2000 – 2003	40.00*

*preliminary estimation.

UNFPA also co-sponsors UNAIDS. From 1997 to 1999, US\$ 200,000 was provided through UNAIDS for the National Aids Control Programme.

UNAIDS

From 1996 to 1998, UNAIDS allocated US\$ 420,000 to the National AIDS programme. The project focussed on six main activities:

1. involve and mobilise key influential men and women at district level in HIV/AIDS prevention;
2. promote safer practice among commercial sex workers in Lahore, Karachi, Rawalpindi, and Multan;
3. facilitate networking and information sharing with NGO participation regarding AIDS related issues;
4. strengthen counselling centres for HIV/AIDS patients and their families;
5. facilitate research endeavours related to HIV/AIDS;
6. facilitate training of national professionals on HIV/AIDS related issues in other Asian countries.

World Bank

The World Bank has four ongoing population and health projects:

Table 7. Budgets of ongoing World Bank population and health projects (in million US\$)

Name of project	dates	Total Budget	World Bank	Estimated amount of Bank financing for population and RH	Other donors	GOP
Family Health I	03/92 – 12/99	62.9	45.0	13.5	3.8	14.1
Family Health II	07/93 – 12/99	114.0	48.0	19.2*	34.4	31.6
Population Welfare	07/95 – 12/99	287.6	65.1	40.8	61.5	161.0
Northern Health Programme	07/96 – 12/2000	57.7	26.7	26.7	19.7	11.3
SAPP I	06/94 - 06/97	4,020.0	200.0	40.8	218.0	3,602.0
SAPP II	06/98 – 06/2003	10,056.1	250.0		1,760.3	8,045.8

*of which US\$ 6.7 million for contraceptives.

The Family Health I project operates in the provinces Sindh and NWFP, and aims to improve health services through the introduction of maternal services, including family planning, and the integration and expansion of communicable disease control. Comprehensive in-service training and institutional development components are included. The programme is implemented by the provincial governments with technical support from local NGOs and universities.

The Family Health II project operates in the provinces Punjab and Baluchistan, and aims at improving the health status of the population through assisting with the implementation of the provincial health development programmes. Emphasis is on primary health, preventive and promotional services.

The Population Welfare Project strengthens the supply of family planning information and services to meet the already existing demand. It complements the SAP. It is implemented by the federal Ministry of Population Welfare and the provincial Population Welfare departments, with technical support from local and international NGOs. The programme supports the entire national population programme.

The Northern Health project supports the GOP's programme in Northern Pakistan, comprising the Northern Areas and Azad Jammu and Kashmir to improve the health status.

Overlapping are the Social Action Programmes-projects (SAPP I and SAPP II), multi-sector investment projects to improve basic social services. These projects also include components of population.

Asian Development Bank

Besides the contribution to the SAPP, the ADB operates currently one population project, with a budget of US\$ 25 million (1994-1999). The aim is to increase accessibility and coverage of family planning services in rural and under-served areas, through community based approach. In addition the project strengthens institutional capacity for population welfare services through the support for programme planning, at the MoPW and provincial departments.

4.2.3. *International NGOs*

AVSC

AVSC International has been working in Pakistan since 1975. Early programme efforts concentrated on introducing female sterilisation through non-governmental organisations as well as in the public sector.

The aim of AVSC in Pakistan is to:

- increase access to sterilisation and clinic-based contraception through training doctors, nurses and other service providers;
- improve the quality of family planning service delivery including management, supervision and safety of services;
- increase male participation in family planning decision-making, acceptance of partner's reproductive health choices and willingness to use contraception.

AVSC is currently involved in two projects on reproductive health:

- The UNFPA project, which started in August 1994. The aim of the project is to set up training centres for strengthening training capabilities in counselling, infection prevention and clinical services. Five local NGOs (PAVHNA, FPAP, BEHBUD, APWA and MCHS) are playing a key role in the execution of this project. NGO facilities and trainers are assisting RHS training centres in conducting quality training activities. RHS staff are also attending courses organised by these NGOs as a part of the project. Up till now eight training centres were set up;
- The Man As Partner project, which is a global initiative, launched by AVSC International in 1996. The project is designed to help providers, policy makers, and donors create programmes that constructively involve men in reproductive health. The MAP initiative has three primary purposes:
 - to increase men's awareness and support of the family planning and reproductive health choices of their partners;
 - to increase men's awareness of the need to safeguard the reproductive health of their partners and themselves, especially through the prevention of sexually transmitted diseases;
 - to improve access to men's contraceptive methods for couples who are interested in using them.

In the past, AVSC Pakistan mainly received funds from USAID. Since USAID's withdrawal from Pakistan in 1993, funding decreased sharply. Currently, annual funding amounts to roughly US\$ 100,000, of which in 1997 US\$ 70,000 for IEC activities. The main donors are UNFPA (US\$ 40,000 UN projects with NGOs) and the Nippon Foundation (US\$ 30,000).

All funding goes through AVSC head office in New York.

The Population Council

The Population Council started research in Pakistan in 1957, and a permanent office was opened in 1992.

In the past decade, the Population Council has carried out research projects funded by a/o the Overseas Development Administration, USAID, UNFPA, the Rockefeller Foundation, the World Bank, the Asian Development Bank, AVSC, the Royal Netherlands Embassy, DFID and the Bill Gates Foundation.

Current major projects of the Population Council are:

- Technical assistance to the Ministry of Population Welfare. A project which started in 1998, funded by the World Bank for the amount of US\$ 2.8 million;
- Research in health and gender as related to reproduction in Pakistan. The project started in 1997 and is funded by the Royal Netherlands Embassy for the amount of US\$ 1.6 million;
- Assessing the impact of improving the quality of reproductive health care in Pakistan, funded by the Rockefeller Foundation for the amount of US\$ 395,761. The project period is from April 1999 to February 2002. The objectives of this study are to document the feasibility of improving the quality of government family planning services by training service providers in better ways of information exchange;
- Developing a research agenda for adolescents in Pakistan, funded by the Bill Gates Foundation with an amount of US\$ 15,000 for the first phase. The project started in October 1998 and is an ongoing project. Both qualitative and quantitative data is being collected to analyse the lives of adolescents in Pakistan.

This year, a DFID funded project commences on the Evaluation of the Prime Minister's Lady Health Workers Programme, for the Ministry of Health. The project will start in June 1999 until January 2000. The key aims of this project are the development of benchmark of capabilities necessary for the delivery of community based Lady Health Worker Services.

Futures Group-Europe

The Futures Group-Europe is implementing the Key Social Marketing project. This started in November 1996 and has a funding of DFID of US\$ 9.8 million for 5 years. The aim of the project is to increase national demand for hormonal contraceptives: oral pills and injectables. The main focus of the project is on IEC, through 2 strategies:

1. encounter trust with the service providers: design curriculum which contains contraceptive facts, counselling, side effects, communication skills, et cetera. Very little clinical. Training is for:
 - a. female doctors, gynaecologists, obstetricians, paediatricians (16 hour curriculum);
 - b. paramedics: LHWs (16 hour curriculum);
 - c. chemists/ shopkeepers (4 hour curriculum).

Roughly 10,000 people have been trained, distributed evenly over these categories.

2. TV spots: building awareness. What is the key, what to provide, and what to do next? Airtime for this is paid by the Futures themselves. In 1999, spending for airtime is estimated US\$ 491,000 (the GOP has other spots about the small and happy family).

In addition to this, airtime is available for documentary programmes. The Futures Group tries to develop programmes with information on family planning. This works two ways: the television programme makers do not have to develop a new programme and Futures does not have to pay for expensive airtime.

The project is quite successful: in 1998, 0.5 million pills (for 12 rupees a cycle) and 70,000 injectables (for 55 rupees) were sold.

Probably, the two keys to success are:

- a. The 15 minute audio cassette with detailed information on contraceptive pills and injections to help couples make informed choices on their contraceptive needs. It includes the instructions for use and is sold along with the pills and injectables. The first tape is for free. The tape has a question and answer (doctor and patient) formula in 5 local languages (urdu, punjabi, sindhi, pushto, baluchi). The Futures receives roughly 500 requests per month;

- b. *Mohalla Sangat*: an outreach programme which is aimed at overcoming a major social barrier to better health care, namely female mobility. The LHVs organise *Mohalla Sangat*, a small group consultations in homes where women listen to the cassette with a LHV.

Asia Foundation

The Asian Foundation was established in 1954, the year it opened an office in Pakistan, to promote U.S.–Asian understanding and co-operation. The Foundation's objectives are to encourage Asian-Pacific efforts to strengthen representative government, build effective legal systems, foster market economies, increase accountability in the public and private sectors, develop independent and responsible media, and encourage broad participation in public life.

The bulk of core funding comes from the head office in San Francisco, USAID, the Asian Development Bank and the World Bank. Other earmarked funding is coming from amongst others DFID, the Hewlett Foundation, UNICEF and John Hopkins.

The overall goal of the current programme of the Pakistan office is to assist in building commitment to addressing needs in social sector development, especially as such needs relate to women.

The population programme of the Pakistan office is a growing programme. In 1995 the Foundation helped to set up the National Trust for Population Welfare (NATPOW), by providing consultancy services to assist in strategic planning, organisational development, financial management, and management information systems for a programme that will support NGOs involved in family planning.

Current programmes are:

- Mother Care Project; a/o breastfeeding support groups and maternal & infant nutrition;
- Male involvement; a community based programme which focuses on increasing male involvement in family planning and reproductive health, funded by the Hewlett Foundation;

- Pakistan NGO Initiative (PNI); a social sector programme implemented in 1995 by the Asian Foundation, together with the Aga Khan Foundation, under a US\$ 10 million grant of USAID. Recently this programme was extended to September 2001 with another US\$ 6 million grant of USAID. The objective of the PNI is to strengthen community organisation, capacity building, coalition building and advocacy, girls' education, maternal, reproductive and child health, and credit and savings programmes for women. Only nongovernmental and community based organisations can be considered for support under the PNI;
- Baluchistan Safe Motherhood Initiative (BSMI); a research and intervention project in the Khuzdar district of Baluchistan. The objective of the programme is to develop and test community-based intervention strategies to reduce maternal mortality and morbidity. The project is funded by the MotherCare project (John Snow International), the National Institute of Child Health and Human Development and UNICEF.

4.3 | Role of National NGOs

Sustaining as a national NGOs in Pakistan is not easy, as the political environment is very harsh for local NGOs. Therefore, as of yet, the role of national NGOs is marginal in Pakistan. They serve less than 5 percent of the family planning services. There are only a few NGOs, which, although they deliver good work, still have a marginal impact. Most NGOs still work only in family planning as such, and have not adopted a holistic approach, or innovative work. This can also be seen figure nine, where it becomes clear that 72 percent of the expenditures is in pure family planning activities.

The technical and absorption capacity of national NGOs is low and they are very dependent from international donors. Their donor-dependency is very clear if one looks at sources of income (figure 10): 87 percent comes from the international donor community.

Although, in financial terms, national NGOs do not play a major role, their impact on a smaller scale is big: in a direct way, of course by serving disadvantaged groups, initiating innovative projects, but also in an indirect way, by training local women to become motivators or field workers who do most of the outreach work. Their life and attitudes have changed too.

Figure 9. National NGO expenditures by category, 1997

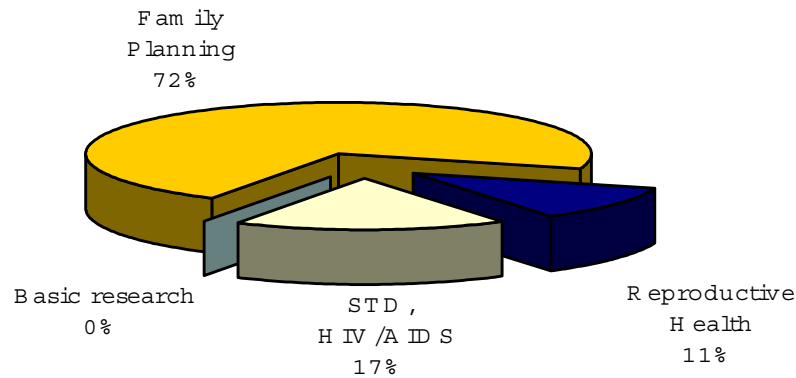
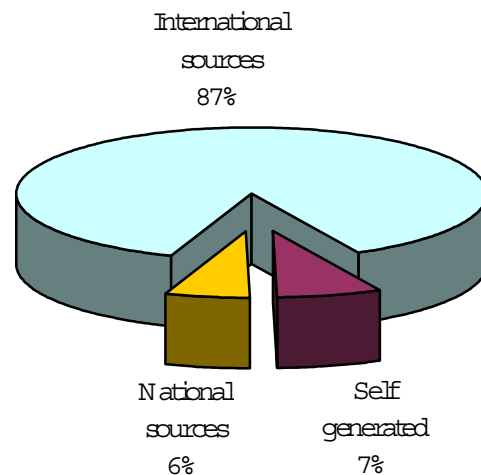


Figure 10. Sources of income of national NGOs, 1997



Especially in a traditional country like Pakistan, this impact should not be ignored.

The activities of some of the major national NGOs are described below.

NATPOW

NATPOW is an umbrella organisation, established in 1994, replacing the NGOCC (non-government organisation co-ordinating committee) which was established in 1985 by the MoPW. The aim of the NGOCC was to involve the NGO sector in population activities. The NGOCC channelled funds from the government and donors to NGOs, and provided technical support to NGOs involved in the implementation of family planning services. As a government organisation, NGOCC was not an independent organisation, and was disbanded in Nov 1994. It was replaced with

NATPOW (National Trust for Population Welfare), with the status of an autonomous NGO umbrella organisation with the initial government endowment of Rs. 104 million. NATPOW procures funds from international donor agencies and the government for NGOs engaged in population welfare, MCH and reproductive health care activities. Selected NGOs are provided both financial and technical support. NATPOW has been running eight field offices (Islamabad, Lahore, Faisalabad, Multan, Hyderabad, Karachi, Peshawar and Quetta. Currently, NATPOW is funding 153 NGOs. Funding for the project funds comes from UNFPA and World Bank. Before 1993, most funding came from USAID. Administrative expenses are met from the interest earned on the initial government endowment fund of Rs. 104 million. Both UNFPA's and the World Bank's funding for NATPOW will end at the end of 1999. Future financing of NATPOW is not yet secured, due to the fact, that although NATPOW is supposed to be an autonomous NGO, the reality is that it falls totally under the Ministry of Population Welfare, and is therefore not autonomous at all.

The Family Planning Association of Pakistan (FPAP)

The FPAP is the oldest and most important NGO in the area of family planning activities. Founded in 1953, the FPAP has more than 110 clinics and 1,286 non-clinical outlets for family planning information and services throughout the country.

The overall priorities of FPAP are to generate public support for the small family norm; pursue equity in development for all, with special focus on disadvantaged groups, including women; expand service delivery and strengthen the quality of services; and focus on lower parity couples.

The organisation is making real efforts to translate the Cairo agenda into action through its programmes in the areas of women's empowerment, male involvement in family planning, and adolescent health (Rosen et. al, 1996, p. 32).

In addition to its usual activities, FPAP runs programmes on empowerment of women, men as partners, reproductive rights, service delivery, advocacy and human resource development.

Prior to ICPD, as affiliate of IPPF, the FPAP had been encouraged to develop their governance and management structures on the assurance of the continuing expansion of traditional patterns of funding through IPPF. Currently however a reverse trend has set in due to a down slide in the IPPF core budget. In 1996 the annual IPPF grant was US\$ 2.3 million, in 1997 it was US\$ 2.2 million and in 1998 the grant further declined to US\$ 1.9

million. These financial constraints have brought about recognition of the fact that self-reliance is now essential. One of the components of sustainability addressed by FPAP is resource generation: locally looking into prospects of increase in bilateral funding; support for project funding through multi-lateral financial institutions; co-operation with the UN system and with private sector institutions.

Furthermore, the decision was taken to work towards financial stability by strengthening the cost recovery system at service outlets, and encouraging concerned community based organisations to set up community funds. Currently, the self generated income from the FPAP comes only to 4 percent of their total income.

All Pakistan Women's Association (APWA)

APWA was established in 1949 as an organisation working with refugees, mainly helping and assisting the women and children among them. Currently it is a non-political, voluntary organisation of which the fundamental aim is moral, social and economic welfare of the women and children of Pakistan.

APWA is active in the Population Welfare Programme with the assistance from UNFPA, who is the major donor after USAID withdrew in 1993. Other donor funding comes from CEDPA, SIDA, DFID, the Asian Foundation, European Union and Population Concern. Furthermore, they receive money from the friends of APWA, who raise funds through charity.

Projects funded by UNFPA are going through Pathfinder as the executing organisation. Projects funded by the European Union are executed by Population Concern.

APWA has provincial and district branches throughout Pakistan. They run 70 family welfare centres/service outlets, which are spread all over the country. The funding agencies for these centres are UNFPA, DFID, NATPOW, and the European Union. At the family welfare centres' multifaceted integrated programmes in health, family planning education, relief and social services are managed by volunteers and trained staff.

Originally, services provided by APWA were free of charges, currently they charge fees-for-services.

After ICPD the Health and Population Section of APWA strengthened and expanded its own programme. The methodology and activities employed are more broad based, integrated and participatory. Community based delivery approach, one to one counselling, integration with skill training, emphasis on primary health care, immunisation, antenatal care, treatment of

reproductive health, and involvement through male motivation, resulted in the ongoing projects achieving 80 percent to 90 percent of its objectives. New family planning projects were developed using innovative strategies:

- a) 4 family welfare centres with support funding from European Union / Population Concern through PAVHNA were established in the North Karachi area since January 1995;
- b) 5 small family welfare centres with support funding from NATPOW;
- c) 7 family welfare centres were established with support funding by UNFPA in October 1995 and in 1999.

APWA's main concern is to take primary health care including family planning and safe motherhood initiatives to women and girls in urban slums and rural areas. The basic strategy used at all APWA's centres is to approach family planning through MCH and other related activities like income generation, adult literacy, et cetera.

Some of the programmes concerning population activities that are currently running are:

- Adolescence programme for young boys and girls of underprivileged area of Karachi, in which the health, population, community development and youth section of APWA will be combined to implement the programme;
- Improving quality of life of the women and children in peri-urban areas of Karachi, by providing them PHC and RHC services and bringing about behavioural changes through IEC Campaign;
- Providing more facilities to the existing health care system, widening the scope of activities e.g. RTI, STD, AIDS awareness and treatment, child care, EPI, diarrhoea control, nutrition and primary health care.

Pakistan Voluntary Health and Nutrition Association (PAVHNA)

PAVHNA is a consortium of 32 NGOs, and was established in 1979. The objective was to improve the nutritional and related health and socio-economic status of women and children. Over time, the focus has shifted from nutrition to :

- promotion of working relations between NGOs and grassroots organisations;
- encouragement of activities in spheres of women's development, better nutrition, safe motherhood, child care and access to reproductive health services;
- assist member agencies in strengthening their capabilities through training and technical assistance;

- train NGO managers and FP/RH service providers;
- train young girls on life skills, and promote income generating activities;
- provide qualitative family planning/reproductive health services at the clinic and community level.

Until 1993, most funding originated from USAID. After they pulled out, UNFPA, DFID, and the EU tried to fill this gap.

PAVHNA has five main programmes:

1. Community Based Family Planning Programme: from DFID through Population Concern (1994 – 1999). Through the umbrella of PAVHNA, reproductive health care and family planning services are provided by 9 grassroot organisations in Karachi. The new phase of the project has been recently approved for 5 another years, with bilateral funding from DFID.
2. Human resource development: training of personal at all different levels, e.g. in contraceptive technology.
3. Two contraceptive surgical centres.
4. Gender-focus women's empowerment training programme.
5. Training of service providers in the Key Social Marketing Project, funded by the Futures Group International and DFID.

Behbud Association of Pakistan

Behbud is a national non-profit organisation, which started in 1967 as a small volunteer group, operating out of a member's home. Currently it is a national organisation with its head office in Rawalpindi and branches in Lahore, Karachi, Multan, Quetta, Peshawar, Gujranwala and Islamabad.

The aims and objectives of Behbud are:

- to provide basic health and education facilities to low earners;
- to give vocational training and provide employment to the jobless;
- to help in rehabilitation of national emergency victims;
- to spread awareness about an improved quality of life through self help.

Population activities are the main kind of activities (50 percent) of Behbud. Other activities are community development (29 percent), education (4 percent) and income generating services and setting up a micro enterprise (16 percent). The areas in which projects are being implemented are rural or slum areas.

UNFPA is the major donor for the population activities (85 percent). AVSC, Pathfinder and NATPOW are other important donors. Projects which are funded by donors are normally funded for a period of three years.

Besides the funding from donors, Behbud also generates its own income. They charge 6 percent fees for their contraceptive services, also because they follow a sustainability concept. Further industrial homes and craft centres have been set up. Boutiques at Lahore, Karachi and Islamabad are outlets for the products.

According to the ICPD, the focus on family planning is now shifted to the more extended area of reproductive health. Because of that, more services are provided, including antenatal care, pre-marriage counselling, male reproductive health package, postnatal care and nutritional classes.

At the headoffice in Rawalpindi four projects related to family planning and health are being implemented:

- national network for family centres;
- integrated population and women development project;
- reproductive health project;
- permanent method (training programme for doctors).

For the clinical services that Behbud provides, the branches have 31 service units, 27 family welfare centres, 1 reproductive health centre and 2 mobile units. Contraceptives are obtained from the government and as well as from Social Marketing Pakistan (Green Star).

Behbud is involved in HIV/AIDS information and education. They have no material available for testing/screening on HIV/AIDS.

Marie Stopes Society (MSS)

Marie Stopes Society started its activities in 1992, and is affiliated with the Marie Stopes International. They offer reproductive health services to low-income families, with a special focus on family planning. They have a focused mission to provide quality reproductive health care services to men and women in Pakistan, by:

- utilising innovative management and marketing techniques to consistently maintain the quality of service and to keep costs low;
- reaching more clients by providing services at their doorstep, in under-served areas through community-based reproductive health workers, an outreach mobile team and through appropriate information, education and marketing;

- ensuring sustainability of clinics by charging an affordable fee to clients, yet providing subsidised treatment to those poor clients who are unable to pay for the services;
- striving to continuously provide a new and broad range of reproductive health and family planning services and to introduce new contraceptive methods;
- aiming for capacity building through technical training of MSS staff and reproductive health workers in other organisations both within and outside Pakistan.

The head-office of MSS is in Karachi, and they operate 10 reproductive health clinics all over Pakistan, community based distribution projects in Karachi and Sukkur and mobile service units in Karachi, Sindh, Baluchistan, and NWFP.

Five of the clinics generate their own funds. All services at the MSS clinics have fixed prices, which are revised each year. MSS utilises a subsidised treatment fund (STF) which collects money through donations for clients who cannot pay and need a service immediately.

MSS is sponsored by the Netherlands through bilateral funding which goes through EAD. Funding from DFID and the EU goes through NGO-cofinancing schemes, through European NGOs.

4.4 | Role of Private Sector

When talking about the private sector, we mean the private for-profit sector. Like in many developing countries however, the distinction between the public and private health sector is a difficult issue. Many government doctors work from say nine in the morning to two in the afternoon and then accept patients in their private clinics, where they deliver the same services and drugs for much higher fees.

In Pakistan, roughly 75 percent of the people go to private for-profit health services. These are however curative based. Preventive health care, quality standards, and services for the poor and disadvantaged groups are not available (Futures Group, 1997, p. 9). In addition, 93 percent of drugs are purchased by the private sector and 65 percent of all health expenditures are private “out-of-pocket” household expenditures (ibid.).

The PFFPS revealed that 53.4 percent of the married women obtained a contraceptive method from a public sector outlet, 45.2 percent from the private sector, and only 1.4 percent from the NGO sector (PFFPS, 1998, p.

147/148). Considerable variations exist in the prices of contraceptives, not only between the different sectors, but also within. There is no uniformity in the pricing of contraceptives. It goes beyond the scope of the present study to measure the impact of the private sector on population activities.

5. Concluding remarks

Ever since its inception in the mid-60s, the population welfare programme has undergone many administrative and programmatic changes. Several approaches were taken, but none were successful, partly because of little demand for family planning, fluctuating political commitment, and inadequacies in design and implementation. The population welfare programme has been very much focussed on demographic targets, and has been very family-planning oriented.

ICPD made a change in Pakistan. Although directly after the ICPD, the term reproductive health was being used, it was rather a change in name (instead of family planning) than an actual change in activities. But now after 5 years, the concept is slowly gaining weight. In the ninth five-year plan, elements of reproductive health, as defined in the ICPD conference, are included. It needs to be kept in mind, that with the huge population and population growth (2.4 percent), family planning activities remain extremely important. Even so, with sustained high infant and child mortality rates, child survival programmes remain important. Room should be left for a flexible interpretation of reproductive health, as in Pakistan, malaria and TB control are very important items in the safe motherhood programme. Priorities need to be set within the context of the country.

In the Ninth plan period (1998–2003), the programme has incorporated elements of the ICPD, like a reproductive health package, integration of activities, decentralisation, and inclusion of NGOs.

The population welfare programme is being implemented by several ministries, the main ones the Ministry of Population Welfare and the Ministry of Health. More integration of the MoPW and the MoH is needed, as the different tasks are confusing and even overlapping. The distinction of the activities under both ministries is dissatisfactory. Population is still a highly centralised subject, and is still financed from the development budget rather than the regular budget. The centralisation causes lots of delay in the financial releases to the provinces, which has dramatic consequences for the implementation at lower levels. Family planning is part of health, being it MCH, PHC, or RH. The coverage of the MoH facilities is much wider than the MoPW facilities. Because health is provincial level, and some provinces (especially Punjab and to a lesser extent NWFP) have successfully started decentralising administrative and financial power to the district level, the health departments would be the most obvious counterparts to work with.

In chapter 4, we saw that of the 1997 budget for the population welfare programme, 50 percent originated from the Ministry of Population Welfare, 23 percent from the Ministry of Health, and 27 percent from the provincial health departments. In 1996/97, the Ministry of Population Welfare receives 67 percent of funding from international sources, whereas the total population welfare programme, implemented by the several ministries at the different levels receives only 23 percent from international sources. The main reason is the strong input of the provincial health departments. This suggests that the focus on the Ministry of Population Welfare is misleading, and more emphasis should be put on the provincial level.

As became clear from 1997 financial data, 95 percent of government and NGO expenditures goes to family planning/reproductive health services, 4 percent to STD, HIV/AIDS activities, and only 1 percent of to basic research activities. National data collection and analysis should be improved, emphasis should be laid on the interaction of population with development. Research institutes like the National Institute of Population Studies need to be strengthened, in order to conduct more impact and policy-oriented studies.

NGOs in Pakistan don't play the role they should play, partly because of the difficult situation they work in. In order to reach a broader coverage of the population of Pakistan (in the 9th year plan the goal is 70 percent for the rural areas, and 100 percent for the urban areas), NGOs need to play a bigger role in implementing the population welfare programme. In terms of financing, national NGOs depend on international sources (87 percent of their income comes from international sources). Withdrawal of the major donors in 1993 hit the NGO world tremendously. Only 7 percent of the income is self-generated. In order to be more sustainable, this percentage needs to be increased. More discussions are needed on cost-recovery and sustainability in very poor areas.

NGOs should play a role in pioneering projects or programmes, and work jointly with the government. They should be able to work freely, without government control and interference. No strategic planning exists of streamlining work of national NGOs, different government departments or donors.

In Karachi, it was found that four national NGOs were serving the same area with the same type of services. Funding can be used much more efficiently if a strategic framework exists, with clear tasks for every institution. NGOs need to co-ordinate their work, under an umbrella NGO that is truly autonomous. The capacity of NGOs needs to be built, more longer-term

goals need to be set, and less ad-hoc services. Long-term financing, like an endowment fund, could be an option.

All this is in line with the ICPD Programme of Action, which Pakistan signed in 1994.

Furthermore, government expenditures in the population welfare programme are much lower than allocations. The main reasons for this are:

- allocations may be released very late in the year, so not all funds are spent in the fiscal year;
- ban on procurement or new recruitment at several levels, due to financial problems within the government.

But although expenditures have decreased, the percentage share in the social sector has increased, which is an encouraging sign.

The Population Welfare Programme has survived the 1997 change in government. With the high population growth rate in mind, it is now realised that this growth is a serious issue. Both government and donors should increase the funding, as spending per capita is still extremely low (US\$ 0.75 per capita in 1997). Some impact of the programme is being noticeable: the increase of contraceptive prevalence to 24 percent, the development of a reproductive health service package, successful decentralisation in e.g. Punjab. With goals like more integration, decentralisation, and involvement of NGOs, the programme is on the right track, at least on paper. In order to really implement it, it is “now or never”: the current developments regarding the population welfare programme should be stimulated.

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