

# COUNTRY PROFILE

## ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH: PAKISTAN



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## Introduction

Pakistan launched its family planning programme in mid-1950s. In 1990, the government launched a comprehensive Population Welfare Programme which became a major social action element in the provision of maternal and reproductive health services. Later, the government launched Family Planning and Primary Health Care programme (1994) and reached out to rural households through Lady Health Workers (LHW). In 2001, the cabinet approved a new National Health Policy which aimed to strengthen second and third tier health services and to promote the practice of good governance in health systems. In 2005, the federal ministry of health launched the National Maternal, Neonatal and Child Health (MNCH) program. This programme primarily aimed to reduce maternal mortality and infant mortality. Yet, a decade later, achieving the MDGs and ICPD Programme of Action (PoA) commitments looks like a distant dream for Pakistan. According to Pakistan Millennium Development Goals Report 2013, Pakistan still has a very high maternal mortality ration (276). The report also reveals that progress on indicators such as proportion of births attended by skilled birth attendants, contraceptive prevalence rate, and total fertility rate has been dismal. Internal and external challenges such as lack of a solid financial infrastructure to ensure universal provision of health services, poor monitoring and evaluation mechanism of existing systems, political changes and fading commitments by the governments plagued Pakistan's progress in the area of sexual and reproductive health services.

## The status of sexual and reproductive health in Pakistan

### Government Expenditure on Health

Pakistan's total health expenditure (THE) is 0.35 % of its GDP<sup>1</sup>. Private out-of-pocket or self-financing of healthcare is the largest source of financing for health care in Pakistan. The general government expenditure on health is 27% of the total health expenditure while the out-of-pocket expenditure is 63% of the total health expenditure which is a very high percentage<sup>2</sup>. Paucity of government funds leads to poor quality services in public health units and gradual emergence of private health service providers.

At present, the public health delivery system in Pakistan mainly comprises of outreach services at

the grassroot level and district level that provide preventive and curative health care. Government-funded tertiary care health services are only present in urban areas and big cities.

Informal and formal private health care providers are predominant part of the health care delivery system in Pakistan. The current health care delivery system is a result of a gradual privatization process which initiated in 1998, when the country faced a serious financial and foreign exchange crisis. This large-scale privatization has resulted in exclusion of lower-income quintile from access to cost-effective, optimal quality reproductive health care<sup>3</sup>.

The percentage distribution of health expenditure by the government for various sectors shows that general hospitals and clinic take up the maximum share (80.35% according to the latest PRSP progress report) and spending on mother and child care is the lowest<sup>4</sup>. The maternal mortality rates and infant mortality rates are very high in Pakistan, both comparatively higher for low and middle-income households (see the sections on maternal mortality and infant mortality). To improve these indicators and to ensure equitable access to quality and comprehensive reproductive health care, a rights-based approach is imperative. National budgets and public health expenditures needs to be reviewed in this context, and the state, as a duty-bearer, must fulfill its obligation to provide its tax payers equitable, non-discriminatory access to continuum of quality care.

## Contraception

The findings of a national study, Post-Abortion Care in Pakistan, issued by Population Council in 2013<sup>5</sup>, show that Pakistan has made strides of progress in the area of sexual and reproductive health (SRH). However, we still have a long way to go as a large proportion of women still have unmet contraception (as high as 20%, according to the latest PDHS) and safe abortion needs; a huge percentage of women are still experiencing post-abortion complications (as estimated 15 per 1,000 women of reproductive age<sup>6</sup>) and the contraception prevalence rate is still very low (approximate level of contraceptive use among married women aged 15-49 is as low as 30 percent), according to the Population Council study.

### Total Fertility Rates

According to Pakistan Demographic and Health Survey 2012-2013, the total fertility rate (TFR) in Pakistan has decreased during the last decade. During 1994-1996, the fertility rate was an average of 5.4 children. It must be noted that women who

had no education had an average of 2 more children than women who had received secondary level education. The fertility rates varied significantly by the education levels of the women<sup>7</sup>.

Between 2003 -2005, the avg. fertility rate decreased to 4.17 and the estimated TFR in 2006-2007 was 4.1. According to the PDHS 2012-2013, the total fertility rate has further decreased to 3.8 children<sup>8</sup>. TFR varies significantly in the rural and urban areas (4.2 births per women in rural areas as compared to 3.2 births per woman in urban areas). Factors such as better education system, higher status of women and better access to health system and family planning services contribute to this disparity between TFR in rural and urban areas. Fertility rate is highest in Baluchistan where the avg. TFR is 4.2 and lowest in the federal capital, Islamabad, where women have an avg. of 3.0 children. These regional disparities in TFRs are closely associated with regional differences in median age at marriage, age at first birth and the use of family planning methods. The survey also shows that fertility increases as the wealth of the household decreases. According to the PDHS 2012-2013, women in the poorest households have an average of 2.5 more children than women who live in the wealthiest households. Peak fertility occurs

at age 25-29 and it decreases sharply after age 30-34, a pattern which is same in both rural and urban areas.

### ... Pakistani women have about one child more than their desired number, implying that the current TFR is 31% higher than it would be if all the unwanted pregnancies were avoided (PDHS 2012-2013) ...

Overall, Pakistani women have about one child more than their desired number, implying that the current TFR is 31% higher than it would be if all the unwanted pregnancies were avoided<sup>9</sup>.

#### Contraceptive Prevalence Rate (CPR)

Knowledge of modern family planning methods and contraceptives is universal. According to the PDHS 2012-2013, 99% of ever-married women know at least one modern family planning method.

Table 1: Trends in fertility by background characteristics

Total fertility rates for the 1990-91, 2006-07, and 2012-13 PDHS surveys and percent change from the 1990-91 PDHS to the 2012-13 PDHS, by background characteristics

Background characteristics	1990 - 1991 PDHS	2006 - 2007 PDHS	2012 - 2013 PDHS	Percentage change during 1990-1991 to 2012-2013
<b>Residence</b>				
Urban	4.9	3.3	3.2	-34.7
Rural	5.6	4.5	4.2	-25.0
<b>Province</b>				
Punjab*	5.4	3.9	3.8	-29.6
Sindh	5.1	4.3	3.9	-23.5
Khyber Pakhtunkhwa	5.5	4.3	3.9	-29.1
Baluchistan	5.8	4.1	4.2	-27.6
<b>Education</b>				
No education	5.7	4.8	4.4	-22.8
Primary	4.9	4.0	4.0	-18.4
Middle	4.5	3.2	3.2	-28.9
Secondary	3.6	2.7	2.2	-38.9
<b>Total</b>	5.4	4.1	3.8	-29.6

Source: Pakistan Demographic and Health Survey, 2012-2013

The percentage of men who are knowledgeable about family planning methods is slightly lower than women. 95% of the ever-married men know at least one modern method of family planning. The desire to limit childbearing increases as the number of living children increases, from 2 percent among women who have no child to 91 percent among women with six or more children. Data also shows that generally men desire for more children than women.

According to the PDHS 2012-2013, more than 35 percent of married Pakistani women aged 15-49 are using contraceptives to delay pregnancies. Of these 35 percent women, 26 percent of women use modern contraceptives while 9 percent opt for traditional methods, which is a considerable number. The study also shows that among the modern methods, female sterilization and condoms are most commonly used methods (up to 9 percent of women using modern methods opt for condoms and female sterilization). Use of pills, LAM, and IUDs is still not very common among women (just 2-3 percent of women using modern methods go for these options). An interesting fact to note: use of withdrawal has increased significantly during last six years - from 4% in 2006 to 9% in 2012. It is also interesting to note that the percentage of women using pills is same in both rural and urban areas while percentage of women using other modern

contraceptive methods e.g. IUDs and LAM varies significantly in rural and urban areas. Married women of age 20-35 prefer condoms and injectable contraceptives while female sterilization is more common among older women. Use of female sterilization is also more common among women who have five or more children.

PDHS 2012-2013 also shows that CPR is closely associated with education. CPR increases from 31 percent among women who have no education to 41 percent among women who have primary or middle-level education and to 44 percent among women who have secondary or higher education. CPR also increases with an increase in household wealth, with 26 percent among women of poorest households to 46 percent among women of the wealthiest household.

The contraceptive prevalence rate in PDHS 2012-2013 shows that the percentage of women using contraceptives has increased over the time as in 2006, the contraceptive prevalence rate among Pakistani women was 30 percent<sup>10</sup>.

#### Unmet Need for Contraception

Unmet need refers to family planning needs for married women who want to postpone their next birth or limit childbearing but don't have access

**Table 2: Trends in the current use of contraception**

Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to several surveys

Methods	1990 - 91 PDHS	2006 - 07 PDHS	2012 - 13 PDHS
Any method	11.8	29.6	35.4
Any modern method	9.0	21.7	26.1
Female Sterilization	3.5	8.2	8.7
Pill	0.7	2.1	1.6
IUD	1.3	2.3	2.3
Injectable	0.8	2.3	2.8
Condom	2.7	6.8	8.8
Other modern method	0.0	0.2	2.0
Any Traditional Method	2.8	7.9	9.3
Rhythm	1.3	3.6	0.7
Withdrawal	1.2	4.1	8.5
Other	0.3	0.2	0.4
Not currently using	88.2	70.4	64.6

Source: Pakistan Demographic and Health Survey, 2012-2013

to contraceptives. Unfortunately, a large number of women's need for contraceptive has not been met. According to PDHS 2012-2013, 20 percent of currently married women have an unmet need for contraception. 9 percent of women have an unmet need for spacing while 11 percent have an unmet need to limit childbearing. Unmet need is highest among women from Baluchistan and lowest in ICT Islamabad. Also, unmet need is highest among women with no education and lowest in women who have secondary level of education.

**... women who participated in no household decision have a higher unmet need for family planning and contraception (22 percent) than women who participated in one to two or three decisions in their households (19 and 18 percent respectively) (PDHS 2012-2013) ...**

According to the PDHS 2012-2013, the unmet need for contraception has decreased from 25% in 2006-2007 to 20% in 2012-2013.

An interesting finding presented by PDHS 2012-2013 is the correlation of unmet needs for contraception with the women's ability to make decision inside the household and domestic violence. The unmet needs of contraception and family planning are also associated with women's decision-making capacity within the household. According to PDHS 2012-2013, women who participated in no household decision have a higher unmet need for family planning and contraception (22 percent) than women who participated in one to two or three decisions in their households (19 and 18 percent respectively). Unmet need is lowest among those women who agree with one or two reasons for wife beating (17 percent) and increases among women who agree with five to six reasons (25 percent).

## Maternal Health

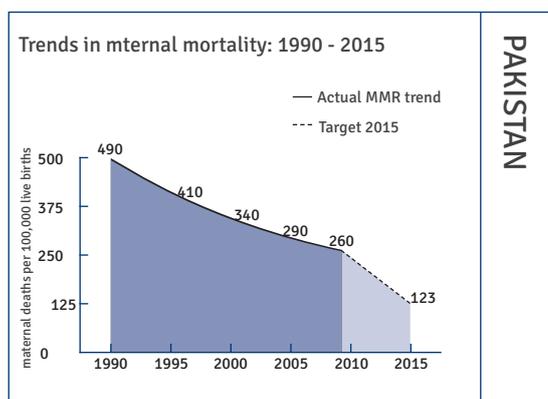
Like all other areas of SRH, Pakistan is making progress in maternal health area as well. But we still have a long way to go. Following facts and figures will provide a better, clearer picture of the ground situation in Pakistan.

## Maternal Mortality Ratio (MMR)

According to Trends in Maternal Mortality: 1990 – 2010 report<sup>11</sup>, Pakistan had a MMR of 490 in 1990 which decreased to 440 in 1995. The ratio decreased significantly over the decade. In 2005, the MMR was 310 and in 2010 it further decreased to 260. The percentage change between the MMRs of 1990 and 2010 has been 46%. And the ratio changed with 3% decrease every year in last two decades. (The latest PDHS (2012-13) does not mention MMR and have cited financial constraints and limited scope of the research as reasons.)

Sadly, Pakistan's MMR is highest in the South Asia region.

Figure 1: Trends in Mortality Rate between 1990 - 2015



Source: (Trends in Maternal Mortality: 1990 to 2008 - Estimates developed by WHO, UNICEF, UNFPA and The World Bank<sup>12</sup>)

There are many reasons that contribute in the alarming figure of MMR. Maternal mortality reflects the quality of healthcare provided to a woman and importance of a woman in her family and society. Lack of access to skilled healthcare for complicated pregnancies or for emergencies is often the leading cause of death. Obstacles can be physical delay in arrival to a medical care facility. Then delay in recognition of complication and then receiving adequate and comprehensive care once a woman reaches to medical facility in unrecognized/ untreated life threatening condition. Timely decisions are not made, inadequate facilities for the degree of the severity of disease, delay in referral to more specialized center in time. These social/cultural factors or practices contribute to the alarming increase in maternal death.

Social cultural aspect shows women needing to seek permission from family members before obtaining healthcare services as they have always been in the

subordination position. The lack of empowerment or decision making power has serious implications on health of women and child bearing. The low social status of women due to cultural values inhibits her access to health facilities hence leading to mortality and morbidity.

Another major reason that contributes to high maternal mortality rate is malnutrition, which affects 34 percent of pregnant women. Around 48 percent of lactating mothers have a calorie intake of 70 percent less than the recommended level<sup>13</sup>. Women in Pakistan suffer from deficiencies of several essential micronutrients such as iron, vitamin A, zinc, and iodine. This shows that mostly women have a poor or inadequate diet and due to the nutritional deficiency, which is harmful for both the health of the mother and baby

Poverty is also an underlying cause of the poor health system status of Pakistan. Pakistani women are trapped in the position of subjugation because

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**... significant gaps remain in Pakistan's millennium develop goal for infant mortality rate. The annual reduction in infant mortality rate in last two decades has been 2.5% which is extremely slow ...**

of their low social and economic status. In poverty stricken areas, majority of the times women suffer more than men. Poverty is widespread in the rural areas of Pakistan where people are in a state of deprivation with regard to access to healthcare services, sanitary facilities, human rights etc. Also, due to lack of education women in rural areas also have almost no knowledge on contraception or family planning methods which consequently leads to higher fertility rates. Lack of access to adequate medical attention (no transportation, long distance from healthcare facility) or due to extreme poverty, child is delivered at home without the assistance of skilled and trained medical health professionals which contributes to maternal mortality.

A strong correlation also exists between high maternal mortality rate and child marriage<sup>14 15</sup>.

### Perinatal Mortality Rate

Perinatal mortality rate is also very high. According to PDHS 2012-2013, the current perinatal

mortality rate is 75 per 1,000 births, while in 2006 this rate was 73 deaths per 1,000 births. Another disappointing finding is the slow progress in neonatal mortality rate. Pakistan's neonatal mortality rate has decreased by 7 percent only, according to the 2012-2013 PDHS (55 deaths per 1,000 live births in last five years. This rate was 60 deaths per 1,000 live births, according to PDHS 2006-2007).

### Infant Mortality Rate

Pakistan's infant mortality rate is the highest in South Asian region. According to UN's MDG Data<sup>16</sup>, between 2011&2013, Pakistan's infant mortality rate was 74. In 2002, the rate was 77, while in 1990-1991, it was 102 deaths per 1000 live births. Within Pakistan, Sindh province has the highest infant mortality ratio. Also, according to UN's MDG 2013 report, in Punjab and Khyber Pakhtunkhwa (KPK) province, the improvement in infant mortality rate has reversed.

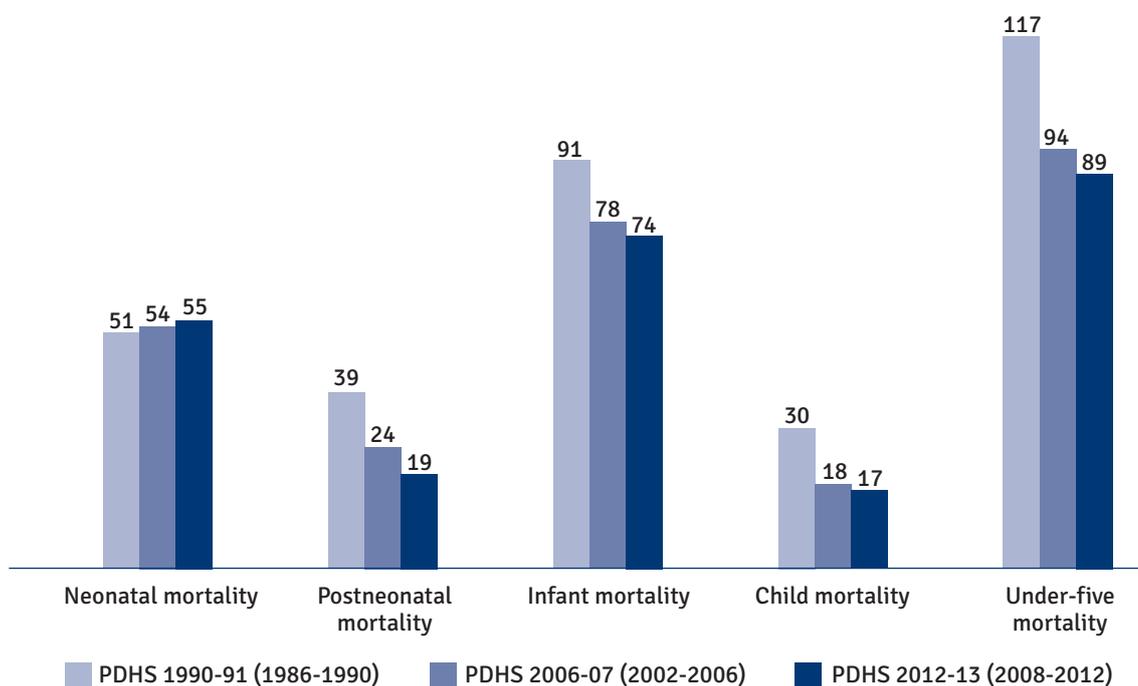
Significant gaps remain in Pakistan's millennium develop goal for infant mortality rate. The annual reduction in infant mortality rate in last two decades has been 2.5% which is extremely slow.

Poor health system and very low investment in child birth health care contribute to Pakistan's high infant mortality ratios. Government expenditure on child birth health care is very low. Also, in last few years, terrorist attacks and displacement of population in KPK and floods in many districts of Punjab have disturbed the health service delivery mechanisms<sup>17</sup>.

### Proportion of births attended by skilled birth attendants

According to the 2012-2013 PDHS, nearly half of the births occur in health facilities, primarily in private sector facilities. More than half of the births are assisted by skilled birth attendants and another 41% of the births are assisted by a traditional birth attendant. Health-facility based births are least common in Baluchistan (only 16%). Home births are more common in rural areas than urban areas (60% in urban areas as compared to 32% in rural areas). The percentages are closely connected to education and household wealth. Women with most education and women who belong to wealthiest households are most likely to receive assistance by a skilled birth attendant.

Figure 2: Trends in childhood mortality rate 1986-2012



Source: Pakistan Demographic and Health Survey 2012-2013

### Availability of Basic Emergency Obstetric Care and Comprehensive Emergency Obstetric Care

The availability of Emergency Obstetric Care (EmOC) services is far from universal. A 2008 study (conducted in Punjab and Khyber Pakhtunkhwa only) tells that only 60 out of 170 public health facilities in 19 randomly selected districts across Pakistan actually provided EmOC services<sup>18</sup>. It also revealed that 14% of those health facilities provided only basic EmOC services while 21.2% provided comprehensive EmOC services. The availability of EmOC services also varies by region and residence. For instance, 76% of the facilities in Khyber Pakhtunkhwa province did not provide EmOC services while 59% of the facilities in Punjab did not provide any EmOC services. At rural health center level, in Punjab only 25% of health facilities provided basic EmOC, while none of the RHCs in Khyber Pakhtunkhwa provided any EmOC service. The study also pointed out that there is dearth of female staff in district level, tehsils and rural level health centers making it difficult for local women to access the services as they prefer to be treated by female staff members.

Coverage of post-partum/post-natal care within 48 hours of delivery by a skilled health provider

The 2012-2013 PDHS survey shows that during 2011-2013, 60 percent of women received postnatal care within 48 hours of delivery. Among these 60% women, 54% received postnatal care within 4 hours of delivery, 5 percent received care within the first 4-23 hours, and 2 percent received 1-2 days after delivery. 38% of women did not get postnatal care. The survey also reveals that the percentage varies significantly by residence and women's education level. Mothers who live in rural areas or in the poorest households or with no education are less likely to have postnatal checkups. Provision of family planning counseling services during postnatal checkups is also not a very common practice, as evident from a study conducted in Karachi, Pakistan<sup>19</sup>.

### Antenatal care coverage

Like other areas of maternal care services in Pakistan, huge gaps exist in the provision of antenatal care (ANC) services. The 2012-2013 demographic and health survey reveals that only 67% of rural women received antenatal health care from a skilled health provider. The percentage varies remarkably across regions. For instance, in Baluchistan, only 31 percent of the women received antenatal care while in ICT Islamabad, 94% of the women received antenatal care. ANC coverage is

61 percent in Khyber Pakhtunkhwa while in Punjab and Sindh, it is 78 percent. Within regions, this percentage varied markedly by residence level. For instance, in Khyber Pakhtunkhwa, 85 percent of women in urban areas received ANC service from a skilled health provider as opposed to 56% of women in rural areas.

There are many factors affecting utilization of antenatal facility e.g. level of awareness regarding importance of antenatal care, distance from health facility, literacy level and socioeconomic condition.

## Adolescent and young people's sexual and reproductive health

### Adolescent Birth Rate

According to PDHS 2012-2013, eight percent of adolescent girls of age 15-19 are mothers or pregnant with their first child. Overall adolescent birth rate has decreased from 16% in 1990-91 to 8%; however, in some areas, it is still very high. For instance, in Khyber Pakhtunkhwa, adolescent birth rate is 10%, while in Gilgit Baltistan and Baluchistan, it's the lowest (7% each). Teenage girls with no education and those who belong to low-income households are most likely to have begun childbearing at an early age.

### Availability and range of adolescent sexual and reproductive health services

Adolescent sexual and reproductive health is an area where huge gaps exist in terms of rights and services delivery. Discussions around these issues are also not very common due to political and cultural conservatism, which leads to misconceptions and fears about the purpose of reproductive health services for adolescents and young people. Lady health workers' reluctance to talk to adolescent girls about reproductive health issues is also a matter of concern.

### Psychosocial Counseling

Youth friendly psychosocial counseling is not available in public health facilities. Some of the private practitioners do provide psychosocial counseling to adolescent mothers, but it's expensive and hence not accessible by majority.

### Contraception prevalence

Use of contraception is also not very common in

adolescent mothers, even though contraception service is available to adolescents in urban areas as well as in some rural areas at all levels. According to PDHS 2012-2013, the current contraceptive prevalence rate among ever-married adolescent mothers aged 15-19 is as low as 10.5%. The low CPR among young mothers can be attributed to many factors including general lack of information and lack of education.

### HIV/STI treatment

There are no mechanisms developed to reach out to young people who are seeking services for HIV/STI treatment. Young people can receive treatment and information about prevention mechanisms from tertiary level HIV treatment and care centers established across the country. Youth friendly awareness campaigns and services are not widely available.

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### Maternal health care

Basic maternal health care services are available to young mothers at all levels. However, comprehensive maternal health care services are only available at secondary or tertiary levels.

## Sexuality Education

Pakistan's national strategy framework on HIV/AIDS prevention and treatment does include provisions on incorporating reproductive and HIV education in the curriculum as well as in education institutes. However, due to political and cultural conservatism and general bureaucratic negligence, there has been no implementation in place as yet. There is a lot of stigma attached to sexual issues and HIV/AIDS which also explains why educationists and medical practitioners are hesitant

of talking about these issues in public. However, there are a few publications such as “Hamara Kal” (Our Future) which focuses on improving sexual and reproductive health of adolescents through education in order to raise awareness and create a conducive and enabling environment for young people. Several other interventions<sup>20</sup> taken up by civil society organizations also aim to provide basic education about reproductive health and rights to young people and adolescents.

## HIV and AIDS<sup>21</sup>

In Pakistan, the first case of HIV/AIDS was reported in 1986 in Lahore. Since then, the number of people living with HIV has been steadily increasing from 38,000 in 2001 to 98,000 in 2009. It's most prevalent among sex workers and injection drug users. Some prevalence has also been reported in returning migrants, refugees and truck drivers. Pakistan is facing the prevalence of HIV/AIDS in a concentrated segment of the community i.e. IDUs and sex workers with a 37.8% prevalence rate in IDU drugs users<sup>22</sup>. The prevalence of HIV/AIDS in general public is less than 0.1 percent. The epidemic is well established in Pakistan and can be defined as concentrated epidemic as the prevalence in traditional risk groups exceeds 5 per cent<sup>23</sup>.

### 1. Prevalence and burden

#### Percentage of young people aged 15-24 living with HIV

As mentioned before, the prevalence of HIV/AIDS in general public is very low. 0.1% of young people aged 15 -24 are living with HIV, according to the national data provided by WHO and Asian Development Bank<sup>24</sup>.

#### Percentage of sex workers living with HIV

According to a 2011 study “Sexual behavior, structural vulnerabilities and HIV prevalence among female sex workers in Pakistan”, the prevalence of AIDS in female sex workers was 0.63%<sup>25</sup>. In the 2008, the mean prevalence in 8 cities was 1.1% (range: 0 - 3%) among male sex workers and 4.3% (range: 0 - 27%) among Hijras<sup>26</sup>.

#### Percentage of men having sex with men living with HIV

The correct data estimates for this category is not available due to various social and cultural barriers.

But as mentioned above, according to the 2008 National Surveillance Report, the mean prevalence in 8 cities was 1.1% among MSWs and 4.3% among Hijras.

#### Number of HIV infected female adults

According to UNAIDS data, in 2012, Pakistan had approximately 85,000 adult women infected with HIV/AIDS<sup>27</sup>.

### 2. Availability of services for HIV and AIDS

#### Number of pregnant women living with HIV who received antiretroviral therapy (ART) for preventing mother-to-child transmission

As such, there is no data available on pregnant women who have received antiretroviral therapy. But according to a survey conducted in 2008<sup>28</sup>, 8.15% of HIV infected female sex workers have received HIV prevention treatment in last 12 months.

#### Reported number of adults on antiretroviral therapy

According to the data available through National AIDS Control Program of Pakistan, to date 1725 patients have received ART from the AID Treatment and Care centers established in various cities across the country<sup>29</sup>.

#### Whether HIV counseling & testing services are available with general outpatient care

HIV/AIDs testing services are available at outpatient care unit. But counseling services are only available at AIDS Treatment and Care centers. There are only 15 such centers in the country<sup>30</sup>.

#### Whether HIV counseling & testing is available as part of sexual and reproductive health services

No.

#### Whether ART is available as part of general outpatient service?

No, ART is only available at AIDs Treatment and Care centers.

## Availability of sexual and reproductive health services at different levels of care

The public health care system in Pakistan is a three-tier system i.e. primary of first level care facilities, secondary level health facilities, and tertiary level health facilities<sup>31</sup>. Primary level facilities include rural health centers, basic health units and community outreach programmes like Lady Health Workers and Community Midwives. Secondary level healthcare facilities comprise of tehsil headquarter hospitals and district headquarter hospitals. Tertiary level facilities are present in big cities only and they comprise of teaching hospitals.

Services for maternal health care, provision of contraceptives and counseling about family planning methods are available at primary, secondary and tertiary levels<sup>32</sup>. With the help of Lady Health Workers (LHW), these services are being offered to rural areas as well. In addition to that, primary care facilities such as dispensary and mother and child health care centers (MCHs) are also functioning across the country. But LHWs and MCHs only provide primary maternal health and family planning services. For gynecological services and secondary or tertiary level maternal health services, clients are referred to rural health care centers, or basic health units, or tehsil headquarter hospitals<sup>33</sup>.

HIV/STI prevention and treatment services are available at tertiary level only.

## Recommendations

We call on our government, international organizations, UN agencies, civil society partners and relevant duty bearers to take the following actions:

- Recognise that gender-equality and universal sexual and reproductive rights are integral to sustainable social and economic development and apply the human rights framework to address the stagnating SRHR indicators and proactively work to provide universal access to SRHR while upholding the rights and dignity of its citizens and addressing various inequities and inequalities.
- Unequivocally endorse, sustain and scale up State's resources to implement comprehensive intervention to ensure safe delivery for all births at home and in institutions by an effective referral system including Emergency Obstetric Care through registered trained TBAs, and to make information and affordable and quality care easily accessible for all women at all stages of their

lifecycle and across location (home, community and health facilities). Introduce national and provincial policies on post-abortion care.

- Review, amend and implement laws and policies to address the health needs of young people. Formulate adolescent-sensitive health programs and build awareness and capacity of service providers to meet young people's health needs such as client centered counselling and health care. Provide comprehensive sexuality and RH education to young people.
- Address the social determinants of health that impede women's access to quality reproductive health services. A strong patriarchal society, deep rooted discriminatory attitudes, violence and fear of violence, harmful traditional practices, parallel legal systems are all deterrents towards achieving the goals outlined in the ICPD PoA.
- Strengthen Health Systems Governance to ensure accountability and transparency mechanisms at central and implementation level, working unison of bureaucracy and technocracy, prioritization of principles of health equity, evidence-based decision making and weaknesses in policy, planning, health information and surveillance units to increase effectiveness.
- Institutionalize maternal death surveillance and institutionalize monitoring systems and annual reporting.
- Ensure availability of affordable essential and non-essential drugs and regulate the quality, uniformity and accountability of services and pricing system of the private sector.

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## About Shirkat Gah

Initiated as a small voluntary women's collective in Pakistan in 1975, Shirkat Gah (SG) has evolved into a leading women's rights organization that operates out of offices in Karachi, Peshawar, Lahore, and six field stations across all four provinces. SG's core strategies in its work with grassroots organizations in 44 districts, include research to generate evidence for capacity building and advocacy in the areas of personal status law matters; sexual and reproductive health and rights; a gendered perspective in sustainable development and promotion of peace, with violence against women traversing the four focus areas.

Nationally, SG has contributed significantly to the overall policy and legal framework and works with elected representatives and government functionaries to bolster an environment conducive for women to claim rights and to facilitate accountability. SG also engages regularly with international development organizations and agencies both for setting norms and standards as well as ensuring accountability on Pakistan's international obligations.

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