# Pakistan

PAKISTAN

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# EXECUTIVE SUMMARY

## Introduction and Methodology

Pakistan's population programme began in 1953; the first official population policy was introduced in the mid-sixties. The programme has been characterised by the demographic objectives of reducing the population and fertility growth rates. Initially it solely addressed women and failed in reaching its objectives. The programme received a major setback during the military government of General Zia-ul-Haq (1977-1988) when thousands of family planning workers were retrenched. Population welfare came back on the agenda but with limited resources following the introduction of structural adjustment programmes in the mid-eighties. ICPD marked a turning point in the country's approach to population, moving it from the narrow family planning framework to one more integrated with health and reproductive health. This report monitors progress on the ICPD commitments, and has been steered by *Shirkat Gah*, (Women's Resource Centre, literally, a place of participation) with the involvement of the Pakistan Reproductive Health Network (PRHN) within the framework of the ARROW developed guidelines and framework. The desk review of literature, policies, programmes and interviews was carried out by a small team of researchers, and feedback and additional information was obtained from PRHN members.

## Country Context

Pakistan is the sixth most populous country of the world with an estimated population of 14 million with a sex ratio of 108 men to 100 women (*Economic Survey of Pakistan, 2001-2002*) and an annual population growth rate of 2.1 percent.

Unemployment is high, as is social disparity. Severe ecological problems have disproportionately affected the daily lives of the poor, adding to water scarcity and disease proliferation. The last ten years have been lean in terms of economic growth with the Gross National Product (GNP) falling to three percent during 1999-2001 and the influence of IMF/World Bank in its fiscal as well as social sector policies. Pakistan's lack of adequate success in reducing its population momentum is assessed to be due to poor governance and mismanagement, particularly of funds, lack of capacity at the concerned levels, and poor socio-economic conditions.

### Table 1. Some Significant Basic Indicators

| % Population in rural areas | |
|---|---|
| TFR 1994 | 5.4% |
| TFR 2000-2001 | 4.8% |
| CPR mid 80s | 18% |
| CPR 2000-2001 | 28% |
| Literacy 1990-1991 | 35% |
| Literacy 1998 | 45% |
| Female literacy increased from 1990-1991 to 1998 | 20-30% |

| % Population in rural areas | |
|---|---|
| IMR | 82 per 1000 (males 99 per 1000 Female 71 per 1000) |
| MMR last decade | 300-700 per 100,000 |
| Poverty | 34% |
| HDI (rank 142: UNHDR 2003) | 0.499% |
| GDI (rank 120: " ") | 0.469% |
| GEM (rank 64: " ") | 0.414% |

## Findings on Achievements

The immediate impact of ICPD was the modification of policy (Eighth Five Year Plan, 1993-1998) and a more integrated approach towards the health and reproductive health sectors. Not only at the management level with implementation guidelines and monitoring systems in family planning and population welfare activities, but also at the social level for the acceptability of issues related to reproductive health. National Health, Population and HIV/AIDS policies were formulated (the latest in 2001, 2002, and 2000 respectively), with emphasis on a broader-based Reproductive Health (RH) approach, maternal and child health services, rural outreach and improved service delivery. The emphasis on quality of services, delivery of services at the doorstep, training of family planning workers and national health workers was the direct result of translating into policy of Chapters VII and VIII of the ICPD PoA.[1] Greater coordination between the Ministry of Population and the Ministry of Health ensued and joint designing of a Reproductive Health Package by the two ministries was undertaken.[2] The Health Policy of 1997 had earlier provided for male counsellors and motivators in the government population programme. The Ministry of Health also elaborated a national HIV/AIDS policy for both prevention and treatment with primary focus on creating awareness (of HIV/AIDS from four percent in 1991-92 to 75 percent, during 2000). [3]

From 1998 the population programme focussed on rural outreach and improved service delivery in a broader reproductive health approach with emphasis on mother and child care as its stated objective. Post abortion services, RTI/STI prevention and treatment, reproductive cancer detection and treatment, and infertility are covered under gynaecological services in tertiary hospitals. Since abortion is illegal no formal services are available except for obstetric complications and also only at tertiary hospitals. There is no special provision for complications arising out of violence. The increase in Contraceptive Prevalence Rate (CPR), decrease in IFR and Total Fertility rate (TFR) are seen as achievements in following the ICPD commitments. However, not managing to achieve higher targets is seen as a shortcoming in implementation and resource allocation.

## Contrast with Government Reports

Government reports tend to focus on achievements and not so much on gaps. They do admit lack of optimal results but do not include analysis or examination of the reasons underlying failure. Furthermore official reports while rich in information fail to make linkages, for instance, between the withdrawal of the role of the Government in providing basic social services and declining indicators; or,

the centrality of discriminatory attitudes and practices against women and the impact on women's reproductive health. Misplaced reforms like the one putting health services in the private sector and thus rendering them unaffordable to the poor are not factored in to the assessment. Similarly no reasons are provided for government inability to ensure staff presence in government health facilities. They also ignore important issues outside the framework of current policies like the incidence of unsafe abortions, or the need for a sexual health and rights policy, adolescent sexual health and sex education. On the other hand, the NGO report while relying on official sources for basic data, supplements these with information generated by academics, activists, and from field projects and attempts analysis based on deeper insights and experiences from the local level.

## Barriers and Facilitating Factors

The imposition of structural adjustment, the lack of resources for the social sectors, and the reforms under IMF directions for macro economic stabilisation, and militarisation have hindered progress in the country. The rise of religious extremism (that began with the Soviet invasion of Afghanistan and US-supported resistance to it in the decade of the eighties) received additional impetus following American action in Afghanistan. Political change, three times since 1994 ending with a military coup in 1999, has been turbulent, bringing into the political mainstream extremist religious parties. Forming governments in two of Pakistan's four provinces following the general elections of 2002, these parties are insensitive to and intolerant of the rights of women and minority communities, and do not hesitate to use arms for promoting their agendas as has been witnessed in the North West Frontier Province (NWFP) where NGOs working for female literacy have been threatened and attacked.

Among facilitating factors at policy level is the recognition of women's social exclusion, poverty, and poor social sector delivery systems, especially of women's health services, and the abysmal Human Development Index (HDI) and Gender Empowerment Measures (GEM). These issues are now on the agenda of government reforms. On the non-government side, the women's movement has been the driving force in placing women's issues on the national and political agenda and the enactment of policy and institutional measures. Over the last two decades it has contributed to the emergence of NGOs and advocacy organisations/networks that have influenced policymakers to recognise the human rights perspective. These have demonstrated their ability to mobilise and advocate for policies and change. The growing peace lobby has opened up the potential for changed priorities in social spending.

## Challenges and Recommendations

Inadequate policies that fail to address women and adolescents' needs for Reproductive Health (RH) and Reproductive Rights (RR) are a major challenge for the Population Ministry. The persistently high maternal mortality rate and poor quality of public sector service delivery are also serious challenges. The private sector (including multinational pharmaceutical companies) has registered virtually unimpeded profitability keeping medicines out of reach of the poor. Officially unrecognised unsafe abortions are estimated to contribute 11 percent to total Maternal Mortality Rate (MMR) and pose a continuous challenge.

Effective formulation and implementation of policy to include maternal mortality, unsafe abortions, sexual health rights, bodily rights and adolescent SRH with

strong M&E (Monitoring and Evaluation) must be accorded high priority with focus on a lifecycle approach to women's health. Establishing basic maternal health facilities and comprehensive Emergency Obstetric Care (EmOC) centres at accessible distances with suitable transport is the other priority area. The existing infrastructure of public health centres needs to be made fully functional with adequate personnel policies. The private sector should be allowed to operate only after mechanisms that ensure the quality, uniformity and accountability of services and regulate the pricing system are in place. It is also imperative that appropriate legislation be enacted to ensure safe abortion and abortion for rape and violence victims.

Women's status in Pakistan is very low due to retrogressive customs worsened by discriminatory laws. On the statute books are the *Hudood* (Islamic laws) Ordinances 1979,[4] that cover fornication and rape (requiring the evidence of four adult male eyewitnesses for maximum punishment and which excludes the evidence of women and minorities for the same level of punishment); the *Qisaas and Diyat* Ordinance (dealing with retribution and blood money in case of murder where the diyat of females is half that of males); the Law of Evidence 1983 seeks to reduce the evidence of women in business transactions to half that of men. Customary practices like killing in the name of honour, offering women to settle conflicts, and domestic violence are widespread in some parts of the country.

For these challenges affirmative action by government needs to be continued with the reinstitution of job quota for women in government service, repeal of discriminatory laws and punitive action against those indulging in customary practices like honour killing. Civil society's role as watchdogs over policies and programmes, coordination of action and strategies, particularly in the area of reproductive and sexual health and rights is imperative. For this the Government has to ensure a safe and enabling environment.

## Introduction and Objectives

### Population Policies and Programmes: A Brief History

Pakistan's population programme established in 1953 is perhaps one of the oldest in the Asian region. The first official population policy was introduced in the country's Third Five Year Plan (1965 – 1970) under a separate chapter on family planning, and the first institutional steps were taken at the same time (1965) with the establishment of the Pakistan Family Planning Council and a Population Division within the Ministry of Health.[5] The programme, focussing exclusively on motivation of women for fertility control, expanded considerably over the next decade but still failed to impact on fertility as it did not take into account the social reality of women possessing little or no say in decision making. The retrogressive military government of General Zia-ul-Haq (that forcibly took over power from the civilian elected government of Zulfqar Ali Bhutto in 1977) represented the gravest setback to the programme, with enforcement of extremist religious views. The programme was introduced in the eighties under donor pressure, but aggressive anti-women policies backed by legislation continued.

Following General Zia's death in 1988, IMF-led structural adjustment programmes drastically reduced funding for the social sectors. In 1986 a programme for social marketing of contraceptives began with the financial support of USAID. The project was successful in promoting the use of condoms in urban and peri-urban areas and giving visibility to the family planning programme. But the

abrupt stoppage of USAID funds in the wake of Pakistan's admission to a nuclear programme slowed the project until it picked up in 1995 with support from British and German funds.

In 1990, a separate Ministry of Population Welfare (MoPW) was established that resulted in compartmentalisation of women's health and family planning and creation of turf problems between the health and population ministries. Thus, at the operational level, 'a hospital's Obstetrics and Gynaecology Department, was not equipped to offer contraception, while a family planning centre could not provide comprehensive reproductive healthcare.'[6] The National Health Policy of 1990 therefore provided for trained birth attendants and expansion of mother and child health care (including antenatal care, natal care), but had no mention of reproductive health. The Population Policy of 1992 introduced new family welfare centres offering family and child health services and service centres in hospitals to provide sterilisation and other family planning services. The contradictions in policies and intent contributed to the official inability to broaden the perspective from fertility control to women's health and rights -- a key conceptual shortcoming in addressing the population issue in Pakistan, in the pre-ICPD period.[7] A characteristic of the population programmes was their lack of gender sensitivity, e.g. the focus on women for family planning and female sterilisation (in a culture where often the sole determinant of a woman's worth is her reproductive ability); continuing minimal male involvement, etc. (a problem that has not gone away yet).

## ICPD-Cairo and its Influence

Cairo 1994, in many ways was the turning point for population related activities in Pakistan. The ICPD-PoA was endorsed by Pakistan without any reservations. The run-up to ICPD, and after, has seen a progressive realisation of the importance of reproductive health and rights among government and NGOs, as well as the centrality of RH and RR in determining the lives of the people. Initially, even if rhetorically, reproductive health found a place in official (and non-official) documents. At the same time, the link between population, development and women's empowerment began to gain currency. The 1992 population policy was modified after ICPD to ensure a reproductive health focus by emphasising safe motherhood, treatment of reproductive tract infections and STDs.

Despite the fact that Government's high level of commitment suffered a setback due to frequent political changes, the structural adjustment programme, inflation and lower social sector allocations (0.7 percent of GNP in 1998-99)[8], the momentum continued at the policy level under the Ninth Five Year Plan (1999-2003). A draft National Reproductive Health Policy was proposed in 2000 using the ICPD definition of RH including the ensuring of reproductive rights and women's empowerment for participation in 'all aspects of reproductive decision-making on a basis of equality with men.' The policy, however, was never formally approved. Pakistan thus has neither an RH policy nor a SRH one. Sex and sexuality are areas of silence in official discourse. Whereas the issue of RR is raised by women activists and medical practitioners the rights discussed are of access to facilities, choice of contraceptives, spacing children, freedom from violence and to choose marriage partners. SHR unfortunately are not yet part of the dialogue on RR and RH.

Nevertheless, post-ICPD a more integrated approach to handle the health and reproductive health sectors was introduced. The Population Welfare Ministry's Village Based Family Planning Workers were merged with the Health Ministry's

Lady Health Workers with training in basic RH care, counselling, hormonal contraception, ante and prenatal care, information on infertility, STDs and HIV/AIDS.[9] That these initiatives have had some impact, though not as far reaching as would be desirable, cannot be denied (see sections below). Treatment for infertility, STDs, and reproductive cancer is available at tertiary public hospitals, some NGO service centres and by the private sector. HIV/AIDS treatment is not yet available.

### ICPD Monitoring

Pakistan's progress in fulfilling its commitments under ICPD was reviewed through the joint Government of Pakistan (GOP) and UNFPA country population assessments in 1999 and 2003. The review of Beijing commitments after five years (Beijing+5) by NGOs in Pakistan provided the additional opportunity to visit progress on ICPD goals.[10] In both instances of GOP/UNFPA assessment teams of experts from the Government, private sector and select non-government organisations were brought in. In 1999 a broad spectrum of leading activists and service delivery NGOs were invited to undertake the exercise. In 2003 only three to four large service delivery NGOs were sent questionnaires for eliciting comments and included in formal consultations. The report however has been widely shared.

The present collective review provides the opportunity to include a wider range of civil society actors working in the area of SRHR. The exercise is seen as helping in deepening the analysis and understanding of why policies fail in changing the rather poor indicators in the case of Pakistan. The monitoring, it is hoped will help in strategising for better and effective delivery. The cross country/region dimension provides for learning and makes it possible to tackle the external aspects that have an impact on achieving ICPD goals.

## Methodology and Country Team

### Overall Methodology

Shirkat Gah, having past experience of working on ICPD-linked issues, and as a member and secretariat of PRHN, undertook the responsibility of steering the monitoring process in Pakistan. PRHN is the network triggered by the ICPD process in 1994. It currently has a membership of over 260 almost equally divided between organisations and individuals involved in RH, RR and RH delivery. It operates through seven focal groups located in the main cities of the four provinces including the capital and in two smaller towns of NWFP and Sindh.

The report is a combination of desk research, interviews of key informants, and the experiences from the field of PRHN members. A four-member committee was formed to review the objectives and indicators developed in the ARROW coordinated planning meeting; this committee decided on the methodology for inputs and feedback from members through a specially devised format; and proposed a drafting committee in the areas of the ICPD objectives to be monitored. On the basis of desk reviews the experts were to produce papers in each of the areas to be monitored with reference to the essential indicators. Shirkat Gah finalised the report after the presentation and discussion of the papers in PRHN national working group and national members' meetings.

The report has used a wide range of sources including government generated national level data like the decennial Population Census; reports of regular national surveys of National Institute of Population Studies (NIPS), Population Council, and UN agencies (e.g. Country Population Assessment Studies). Secondary sources like research and survey reports by various private and semi-autonomous institutions, as well as research reports and case studies produced by NGOs, were also used. To fill in gaps, eleven interviews with parliamentarians and non-government service providers were carried out. Unfortunately, no government official was available for interviews despite several attempts. Besides those directly involved in putting together the report a total of over 260 PRHN members (132 NGOs besides individuals) directly or indirectly also participated in the exercise. These included both men and women. Participation, however, was varied.

Some of the problems faced by the research team include lack of comparable data over specific time periods, sporadic and disparate information regarding implementation of policies, not enough qualitative studies, and lack of reliable data on some critical issues like maternal health and morbidities, nutrition and so on. The time available for the study was not enough to collect requisite additional evidence. The modest target of 20 interviews too could not be achieved because of non-availability/lack of interest of policymakers and parliamentarians.

## Country Context

### History of SRHR Policies, Legislation and Programmes Before ICPD

Reproductive rights and reproductive health, as stated earlier were not terms used in policy documents before ICPD. While population became a significant concern for the policymakers more pointedly during the military regime of General Ayub Khan (1958-1969) when under the Third Five Year Plan the first family planning policy was introduced, it failed to have an impact on the population growth rate that it was trying to address. The programme continued under the civilian regime of Zulfiqar Ali Bhutto. However, under General Zia-ul Haq it received a setback with an unproclaimed moratorium that saw the firing of thousands of personnel from the family planning department, probably due to the opposition of religious groups to family planning.

Officially reintroduced in 1980, the programme was supposedly based on a multisectoral approach, emphasising the enhancement of education and employment opportunities for women. These interlinkages, however remained largely on paper as discriminatory legislation in the name of Islam (the *Hudood* Ordinances, the Law of Evidence,[12] the *Qisas* and *Diyat* Ordinance ) introduced also in the late seventies and eighties by the military government of General Zia-ul-Haq, reinforced the low status of women in the country. Combined with low government allocations to the social sector and separation of health and population sectors at the policy level, these led to the further dilution of the family planning programme. This was the time that the military regime had the full support of the US Government because of its role in the proxy war in Afghanistan against the Soviet Union. It was also the time that the extreme politico-religious groups received official recognition and government patronage.[13]

During the Afghan war, Pakistan became the conduit for arms and drugs: it is still living with the violence engendered by those arms, and with the expansion of the drug trade; today significantly large numbers of the population are addicted to drugs, adding a further dimension to the population scenario. STIs, HIV/AIDS,

and Hepatitis B are highly prevalent among them, with added proliferation via sale of their blood (blood screening facilities are not yet available throughout the country) for more drugs by drug addicts, and through their sexual encounters. This has led to further proliferation of both drug addiction and STIs. Further, the steadily increasing poverty led to a corresponding increase in the number of street children: in Karachi alone these are estimated to be about 15,000 (UNICEF news reports in early 2004), and paedophilia is reportedly rife among them (paedophilia information given to Hilda Saeed in an interview by Dr. Sharaf Ali Shah, Sindh AIDS Control Programme, March 2004.)

As a reaction to the Government's discriminatory legislation and other repressive measure the 1980s saw the emergence of a vibrant movement for women's rights spearheaded by Women's Action Forum, a new platform that challenged the military government. Vociferously championing for women's rights and mobilising against the new laws, WAF demanded that abortion be a legal right available to rape victims and advocated the woman's right of control over her body. The WAF campaign put women's rights on the agenda of national politics and succeeded in forcing successive governments to address issues of women's inequality and its consequences. The largely positive pressure from international donors including the World Bank also contributed to refocussing of policies towards health and social sector reform. Juxtaposed with this was the relentless lobbying of the religious obscurantists for a narrow religious-based political and social dispensation. The ensuing tensions between women's/human rights advocates and the politico-religious forces in the period 1979 onwards continue to date.

## Preparations for Cairo

Preparations for ICPD marked the fusion of family planning/population advocates with those of women's rights as women activists came together with the family planning organisations to form the Pakistan NGO ICPD Committee. The Committee was responsible for sharing the ICPD Prepcom debates with other NGOs and civil society actors as well as briefing government officials at the provincial and federal levels (especially those attending the Cairo Conference) with the status of negotiations and the politics of the conference. The official delegation was led by a woman minister and included population secretaries in the federal and provincial governments besides a number of NGOs, including women's rights organisations, who connected with their counterparts for effective lobbying at the Conference. The Committee was not conceived as a permanent one and felt it had succeeded in what it had set out to do i.e. mobilising for ICPD, initiating debate and influencing policy.

The preparation and the high level participation at ICPD for both NGOs and officials were possible due to generous donor support from UN agencies (particularly UNFPA, UNICEF) and other bilateral donors. NGOs received support through various international NGOs/networks (e.g. WEDO, IWHC, IPPF, PANOS) besides international donors. The Pakistan NGO ICPD Committee followed up with the Conference by organising TV talk shows, sessions/press conferences with the mainstream print media and a number of meetings including several post Cairo meetings with government officials, NGOs and others to determine the future role of the government and that of the NGO sector.

## The Impact of Cairo on Policies

ICPD had an impact on the population policy as indicated above. The modification of the population policy and the Eighth Five Year Plan (1993-1998) itself included implementation guidelines and monitoring systems in family planning and population welfare activities. The emphasis on quality of services, delivery of services at the doorstep, training of family planning workers and national health workers was the direct result of translating into policy of Chapters VII and VIII of the ICPD PoA .[14]

In 1994 the National Committee for Maternal Health (NCMH) was created under the chairmanship of the Federal Secretary Health.[15] Initial efforts since 1996 yielded closer collaboration between the ministries of health and population, for improved provision of services. Under the country's Eighth Five Year Plan (1993-1998), greater coordination between field workers of the two ministries and joint designing of a reproductive health package by the two ministries were undertaken.[16]While there are no specific RH and SRH policy, the joint RH Package comprised of nine components including Sexually Transmitted Infections/ Reproductive Tract Infections (STIs/RTIs), reproductive cancer, male involvement, gender equity and equality, prevention and treatment for HIV/AIDS, Maternal and neonatal health, and EmOC. However, except for sexually transmitted illnesses, RR and SR remain unaddressed in the RH Package.

Positively, the 1997 National Health Policy provided for male counsellors and motivators in the government population programme and the Ministry of Health elaborated policies and programmes for the prevention and control of HIV/AIDS. The focus in this area, however, remained on creating awareness and enhancing facilities for blood screening (from four percent in 1991-92 to 75 percent during 2000).[17] However, treatment is not yet available. Pakistan's Ninth Five Year Plan (1998-2003) built upon the directions and foundations of the Eighth Plan and focussed on rural outreach and improved service delivery in a broader reproductive health approach with emphasis on mother and child care as its stated objective. The latest National Health Policy, 2001 continues in the direction set by ICPD. The policy views health sector investments as part of the poverty alleviation plan, marks the shift from tertiary to primary and secondary health sectors and focusses on health sector reforms. It further seeks to promote greater gender equity in the health sector.

Demographic targets remain the primary concern of Pakistan's population policies as reflected in the latest Population Policy of 2002.[18] However, the policy also strongly reiterates the importance of involving adolescents in RH service delivery and advocacy programmes.[19] Adolescents are not specifically targetted in public health services though married ones have the same maternal/RH health facilities available as the adults.

## Donor Funded Programmes

That the RH sector now has greater priority is apparent from the budget allocations for the population welfare programme in the Ninth Five Year Plan: Rs 10,340 million, substantially higher than the financial allocations of Rs 7,654 million in the Eighth Plan (though as a percentage of GDP it remains the same). The budget utilisation has also been higher in the Ninth Plan (80.3 percent) than in the Eighth (71.5 percent).[20] UNFPA generated figures reproduced in the *Pakistan Population Assessment* 2003, indicate that external resources for population activities registered an increase in the post ICPD period from US$ 12.7 million in1994 to

US$28.1 in 1999 with the resource flow reaching the high point of US$33.5 million in 1996.[21]

There are several major programmes underway across Pakistan since 1999 and several others in the pipeline. The Asian Development Bank has committed US$ 47 million for the Women's Health Project[22] (2000-2005) in 20 districts across Pakistan with the aim of improving the health of women, girls and infants and another US$ 36 million for the Reproductive Health Project (2000-2005) improving RH status of underserved communities in 54 districts. The Northern Health Project with a World Bank loan has a commitment of US$ 26.7 million for Northern Areas and Azad Jammu and Kashmir. CIDA, USAID, Save the Children-USA, UNFPA, DFID, NEDA, JICA, Asia Foundation, and several donor supported NGO projects are also underway covering different parts of the country.[23]

However, projects to address RH through the rights perspective are the exception rather than the rule. One important initiative is the Bill Gates Foundation supported and Columbia University[24] coordinated Women's Right to Life and Health project in three districts of Sindh, and its counterpart in the non-government sector in Punjab and Sindh. The project is being implemented in collaboration with the provincial government and UNICEF, and focusses on averting maternal deaths and morbidity through provision of quality EmOC facilities. A smaller experimental intervention by Shirkat Gah is being supported under the same programme looking at women's mobilisation for reproductive rights. Significantly, PRHN, a post-ICPD information and advocacy network formalised itself in 2000, highlighting the issues of rights and gender inequalities with reference to reproductive health and ICPD PoA .

The last five years have also seen effective contribution by the donor supported social marketing programmes complementing the efforts of the Population Welfare Programmes in providing conventional [25] and hormonal contraceptives at subsidised rates to the low and middle income groups in the urban and peri-urban areas of the country. Contraceptives supplied by the Government are free of cost. The interim results have been quite encouraging and there is anticipation of continued donor support in this regard. [26]

## Assessing Progress in Achieving ICPD Goals and Objectives

### Study Findings

The ICPD Cairo objectives being monitored are:

1. Gender, social equality and equity.
2. Reducing maternal mortality and morbidity, and promoting safe motherhood and safe abortion.
3. Promoting and protecting sexual rights, safe contraception, preventing/treating HIV/AIDS and reproductive cancer.

The progress towards gender, social equality and equity has been marked with mixed results, as improvement in such indicators as female labour force participation, female life expectancy at 63 years, which is currently at 99 percent of male life expectancy, and the reduction of the gender gap in education; however, these positive indicators have been offset by rising poverty, deteriorating HDI and GDI (Gender Development Index), greater

income disparity and failure in repealing discriminatory legislation. The most significant change has been parents wanting to educate daughters, though when resources are scarce sons get precedence and daughters are kept at home. While many steps have been taken in recent years towards realising lower MMR and safe motherhood the reduction of maternal mortality and morbidity remains a challenge and the issue of unsafe abortion remains unaddressed. Promising has been the trend over the past decade of the growing acknowledgement among policy makers about the magnitude of the problem and the consequent focus on formulation of policies to deal with it.

The only positive success, however, is the substantial rise in the percentage of women receiving antenatal care from 30 per cent in 1990-91, with a six percent increase in 1996-97 to 51 percent in 2000-01 and the increase in the contraceptive prevalence rate, 17.8 percent in 1994-95, 23.9 percent in 1996-97 and 27.6 percent in 2000-01. Significant strides have been made in achieving awareness about HIV/AIDS and its prevention through persistent advocacy campaigns in the media to promote contraceptive use. Coupled with improvement in service delivery, there has been a sizeable rise in the contraceptive prevalence rate and a declining fertility trend (4.6 in 2000-2001 from 5.6 per woman in 1994; in urban areas down to 4 from 6.1). In addition, a number of institutional interventions are also visible for improving women's status and the reproductive health sector.

## Gender, Social Equality and Equity

### Human Development Index and Gender Development Index

Pakistan stands at 142nd position (up two notches from 2003) according to UNDP's latest Human Development Report 2004 falling much below India (127), Bhutan (134), Bangladesh (138, Sri Lanka (96) and Maldives (84).) The HDI dropped from 0.508 in 1997 to 0.499 in 2000. Similarly the situation on gender indicators (GDI) deteriorated in the same period from .472 to .468.[27] These figures record a marginal reduction in the gap between the HDI and GDI of .006, which implies that the gender gap may not have increased in Pakistan over these years.

The life expectancy of females at 63 years as a percentage of males appears to have deteriorated to 99 percent after being equalised at a little over 63 years. Women in Pakistan continue to remain 92 percent of the male population - a figure lower than the weighted average for South Asia but an improvement from that a decade ago.[28] The relative improvement in the sex ratio and female life expectancy at birth implies that health coverage of the female population has also improved.

## Gender Empowerment Measures

The reporting on Gender Empowerment Measurement has been irregular.[29] Available information indicates that GEM has improved since 1994 (0.153). Although information on GEM is not available after 2002, it would show an improvement as over 36,000 women have been inducted into a number of government decision-making forums in recent years. Currently, there are 188 women in the National and Provincial Assemblies, out of which 72 are in the National Assembly. Apart from these, 17 have been nominated for

the Senate on reserved seats. The local government Devolution Plan 2001 reserves 33 per cent seats for women for the first time to be directly elected in local bodies. Earlier women's reserved seats used to be two percent. Women activists see the increase as a direct result of their advocacy. Due to active government support and encouragement and national level mobilisation campaigns launched by NGOs, a record 67,512 women filed their nomination papers for the 35,963 reserved seats at all levels of the local government. Thus, a total of 35,963 women were elected as Union Councillors, *Tehsil Councillors* (for revenue) and District Councillors.

The affirmative action policy to include women in the local government was not welcomed equally everywhere, and was met with strong resistance and opposition in the NWFP (including from the mainstream and left of centre political parties) where currently a fundamentalist political party is in the seat of provincial government. Here women were prevented from contesting as well as voting, resulting in the highest number of vacant women's seats. Even where elected, women in these forums have been facing severe gender bias from male colleagues who are not comfortable dealing with females in public. In national and provincial legislatures, women members find themselves restricted by party priorities that do not necessarily converge with those of women.

Affirmative action while enshrined in the Constitution has not been taken on the scale as witnessed recently regarding women's political participation in both local bodies and parliament. This has been possible due to the Local Government Ordinance 2001 under which the Devolution Plan mentioned above was implemented. The Legal Framework Order is an extra-constitutional law enacted by the present military government to amend the Constitution and has revived (among other provisions) the reserved seats for women in the federal and provincial legislatures after a lapse of nearly ten years. Earlier reservation of 20 seats for women in the National Assembly was for a specified period, which ended in 1993. Realising that most women who have been inducted into government lack the knowledge of policy-making mechanisms and skills of participating in law-making, initiatives have been taken to orient and train women parliamentarians and councillors by the government and NGOs with the support of multilateral/bilateral donor agencies.

Among other measures taken at the policy level to address the issue of women's empowerment are:

1. The ratification of Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) by the Government in March 1996 with a reservation on Clause 29 (para 1) pertaining to disputes. [30] A general declaration invoking the primacy and supremacy of the Constitution over and above the provisions of CEDAW. The Government has reportedly submitted its report to the CEDAW Committee but has not publicly shared it yet and has not signed the Optional Protocol.
2. The setting up of a high powered Commission of Inquiry in 1997 to review all laws pertaining to women and recommend changes (though most of its critical recommendations have not been implemented).

3. The adoption (1998) of a National Plan of Action to implement the Beijing commitments, developed through government-NGO collaboration to define annual development plans of provincial governments.
4. The establishment of the National Commission on the Status of Women (a longstanding demand of women's rights activists) in 2002, though with recommendatory powers only.
5. The National Policy for Development & Empowerment of Women announced in 2002, with the goal of empowering women, removing inequalities, ensuring participation as equals in national development, provision of equality of opportunity and space for the realisation of their potential.[31] The promotion of gender equity is also one of the stated ten specific objectives in the new National Health Policy, but no mechanisms are spelt out for achieving this.
6. The development of the Gender Reform Action Plan (GRAP) in 2003 with the financial support of the Asian Development Bank for gender mainstreaming and reforming the political, fiscal and institutional systems, awaiting cabinet approval (provincial GRAP approved in Punjab).
7. A Gender Strategy of the Ministry of Environment, Local Government and Rural Development supporting the employment of women has been prepared.
8. Government is a signatory to SAARC Convention on Preventing and Combatting Trafficking in Women and Children for Prostitution.

## Labour Force Participation

Although the reported female labour force participation is very low (nine percent), and lags behind that of males (48 percent), it has registered a one percent rise as opposed to the two percent decline in male employment. The number of women engaged in economic activity as a percentage of males has risen from 11 percent in 1970 to 42 percent.[32] The labour force survey does not include women not working in the formal industrial sector and therefore does not adequately reflect women's economic participation. While the unemployment level seems to be rising for both men and women, it is higher for women (17 percent) than for men (6 percent).[33] However, official statistics fail to account for the vast number of women employed in the informal sector as domestic helps or in other income generating activities from their home, and women in the agricultural sector. The fact that 62 percent of women are reported as contributing family workers as opposed to 17 percent men, and that women as salaried workers constitute 25 percent while those self-employed make-up 14 percent, reinforces the invisibility of women's employment.[34] In agriculture according to one study, rural women constitute nearly 80 percent of the total rural men and women compared to rural men (60 percent.)[35]

Women have limited formal employment opportunities, especially if they belong to poor and rural households. In the formal sector, where the labour laws are by and large gender neutral, in practice women get discriminated against by being hired as temporary workers and denied benefits like maternity leave, earned leave, etc. Similarly the statutory requirement of crèches in workplaces is sidestepped by hiring unmarried workers. Women are also usually confined to the low paying menial tasks in factories. In government jobs a very small percentage reach higher positions.

There is no official policy regarding the informal sector that employs the largest number of women and often exposes them to hazardous materials. Nor is there any policy regarding awareness on economic rights or for grievances and harassment. An NGO developed code of conduct (2002-2003) against harassment at workplace has been adopted by over 100 private sector organisations. The affirmative action policy of a quota of five percent for women in government jobs (introduced by Benazir Bhutto post ICPD) was discontinued in 2003 by the present military government. However, the Government has ratified the ILO Convention 100 on equal remuneration for women. And given the inadequacies in gender disaggregated data the staff of the Federal Bureau of Statistics has been gender sensitised through external assistance, the number of female staff in the Bureau has increased and its female enumerators have been trained.

## Literacy and Education

Although the female literacy rate (38 percent) remains much lower compared to males (63 percent), this gap has shown a declining trend over the past ten years. Female primary school gross enrolment as a percentage of males reportedly at 70 percent has risen by 13 percent from the pre- ICPD period (1991-92). But the female gross enrolment ratio as a percentage of male drops to 50 percent at the secondary level reflecting a higher dropout rate for girls as they go beyond the primary school age (attributed to cultural and school availability factors)[37.] This is corroborated by the literacy rate of females aged 15 years and above (28 percent) compared to males of the same age (58 percent).

Class and economic status are important determinants in female literacy as the highest 20 percent per capita income group has three times the number of literate females present than in the lowest 20 percent. This disparity is less for males in the same categories (1.7 percent). The rural-urban divide is yet another variable as female literacy in rural areas lags behind urban areas with the highest inequality in literacy reported for females in rural NWFP (4 percent).[38] This in great part is seen to be due to the lack of access to public schools for girls beyond middle school (class eight) in rural areas. Similar to the rest of the educational system, there is a gender gap in women's access to technical and vocational training institutes. According to government records the number of women in commercial, industrial vocational and polytechnics totalled 9,604 in 2000-01 compared to 54,998 males in the same year. Adult literacy programmes are run largely by NGOs, the majority of whom (46.4 per cent in 2000) are concentrated in the education sector.

There are a number of issues involved in the gender gap in education and the low level of literacy generally. These include the quality of education and of availability of accessible schools especially for girls. With the expansion of the private sector in education, the enrolment rates for boys in government run primary, middle and secondary schools have dropped due to the low standard of education offered there, as parents prefer to send their sons to private institutions. However, female enrolment has risen at all levels in state schools as more girls' schools are set up and prejudice against education for girls has decreased. In addition incentives where provided have led to more girls attending school. Quality seems to be the factor in the gradual fall over the years in the number for both males and females in commercial, industrial vocational and polytechnics and better facilities available in the private sector institutions.[39]

Achieving universal primary education and reducing the gender gap have been high on the agenda of successive governments in Pakistan and the target was to achieve it by the end of the Ninth Five Year Plan (1998-2003). Towards this the policy change over the past ten years has been of shifting resources from the tertiary to the elementary level and allocating more to primary schools and opening at least one primary school in every village. Currently under the Education Policy (1998-2010) and the subsequent Education Sector Reforms, the shift amounts to 48 percent of the total education budget and according to the Planning Commission of Pakistan is not enough for achieving the target.[40] The budget allocation for education over the decade has been at an average of 2.5 percent of the GDP.

Incentives like nominal fees, free books and nutrition for female students have also been introduced and have contributed to raising the enrolment level of girls. One initiative in this direction has been the Girls Rural Stipend Programme entailing a stipend of Rs 200 for rural school-going primary school girl students under ESR. Tawana Pakistan, a multi-donor funded programme coordinated by the Aga Khan University and implemented jointly by the Government and NGOs, was initiated in September 2002 to run up to mid-2006 as a nutrition package for schoolgirls (5-9 years) in 26 high poverty districts all over the country. The total number of schools to be covered is 5200 and expected beneficiaries are expected to be 520,000 girls.

Gender sensitisation activities, among teachers and students (in particular boys) are not part of policy. However, gender sensitisation programmes among teachers and students are conducted by non-government organisations working in these sectors, but it is not possible to assess the extent of their reach or effectiveness nationwide. School textbooks are gender biased and again no serious initiative is underway to correct the situation in spite of NGO efforts at highlighting the issue.

## Violence Against Women

Macro data on violence against women is not readily available and one has to rely on sample studies and press reports. Documentation by NGOs like the Human Rights Commission of Pakistan (HRCP), Human Rights Watch and Amnesty International, reveals that violence against women is on the rise, especially that related to customary practices e.g. verdicts by local adjudication systems (jirgas, panchayats) leading to brutal action against women ranging from vani (whereby woman/women including girl child/ children may be handed over to an adversary to settle a conflict) to death. Retrogressive social attitudes supporting customary violence are prevalent among members of the feudal classes, law enforcement agencies, lawmakers and the judiciary.

Domestic violence is on the rise with some 70-90 per cent of women facing some form of domestic violence according to HRCP.[41] There is no documenting of domestic violence; most estimates are based on newspaper reports. Although killings in the name of honour are still widely prevalent, recent reports indicate that they may be on the decline as a consequence of the removal of legal safeguards provided to those involved in such crimes, the ruling of the highest court in the country, the Supreme Court, against this practice, and the consistent activism and awareness raising undertaken by NGOs (Shirkat Gah, HRCP, AGHS Legal Aid Cell, WAF, Aurat Foundation, etc.)

The crime of rape goes unreported largely due to social taboos, there is concern that this crime as well as gang rapes may be on the rise. Incest is also estimated by social workers to be high. (The Review, Dawn, 8.7.04). A thousand doctors, in a study conducted by the Population Council in 2002-2003, have expressed concern about violence even during pregnancy. Marital rape is not legally recognised. Wife burning is another form of violence that is frequently reported in the print media, but the police hardly ever register cases. There has also been a rise in crimes of mutilation by throwing acid and cutting off women's noses.

Official data on suicide rates of women are also not available as in many cases families cover up such crimes. A survey conducted in May 1999 by HRCP confirmed that 65 percent of female suicides occurred from depression or despair caused by economic constraints. Almost all the others resulted because of mismatch in marriage, tyranny by husband and in-laws or refusal of an unmarried woman to accept the match made for her.[42] HRCP (2003) estimated from press reports that most of the women who took their lives were aged less than 50, were school and college students, rape victims, housewives, working women and mothers of young children. No data are available to indicate numbers of suicides due to polygamy. FGM is not a problem in Pakistan generally except in one community (Bohras) where it is stated to be symbolic.

The most obvious barrier in checking crimes against women is the lack of fair judicial recourse available to the victims. The reluctance and refusal of the police officials to register such cases, the biased judgments of the courts and the discrimination institutionalised within the judicial system by laws like the discriminatory Hudood Ordinances, related to rape and adultery. Since the law does not make a distinction between rape and adultery there have been numerous instances of rape victims being adjudged adulterous and punished. According to a July 2002 UN report, of the 2200 women in prison, most had been convicted under the *Hudood* Ordinances.[43]

The *Hudood* laws have not been repealed despite the recommendations of the National Commission on the Status of Women (NCSW) 2003 and the earlier Commission of Inquiry for Women (1997) though an Ordinance was passed in April 2000 declaring 'honour killing' as murder and to be treated under the penal code (PPC 302.) The Commission of Inquiry (COI) and NCSW recommendations have not yet been acted upon to enact a law on domestic violence that specifies violence by husband or in-laws, clearly defines cruelty declaring it a criminal offence, and directs the police to register all cases of domestic violence. However a private member's bill on domestic violence was tabled in 2003, in the Punjab Assembly by a woman member, and is awaiting discussion. On trafficking of women, the NCSW's recommendations were accepted and The Prevention and Control of Human Trafficking Ordinance 2002 was promulgated. As a result of activists/NGO campaigns against Violence against Women (VAW) gender sensitisation of police officers has begun and is part of the proposed police reforms too.

Media awareness has increased on the problem of violence against women, with greater coverage by the print and electronic media. The government and independent television channels have aired donor-funded plays highlighting gender issues, such as violence, and also regularly run discussion programmes on sexual harassment at the workplace, violence against women and other issues.

In the year 1999 the Government set up six women's crisis centres but none in a government hospital.[44] Within six months of being established 780 women had approached the centres, of these a major number of 291 were seeking legal assistance, while 60 were looking for shelter and 55 needed medical aid.[45] These are in addition to government funded and managed women shelters (Dar ul Amans), which operate more as sub-jails. A number of shelters have also been set up by NGOs in view of their need among women.[46]

## The Girl Child[47]

Pakistan's population structure is heavily weighted towards the younger age group with women below the age of 15 years forming 43.3 percent of the total population (males 43.5 percent), according to the Census of 1998. Those between 15 and 29 years are 19.8 percent of the total (males 19 percent). Gender differentiated data are not available for most indicators, where available as for under-five mortality rates, they show that fewer female children under five die compared with male children.

**Table 2. Early and Late Childhood Mortality Rates by Sex, Pakistan: 1982-2000**

| Sex and Period | Infant Mortality/1000 LB | Child Mortality/1000 LB | Under-five Mortality/1000 LB |
|---|---|---|---|
| Both sexes | | | |
| 1982-86 | 113 | 25 | 136 |
| 1997-2000 | 85 | 20 | 103 |
| Males | | | |
| 1982-86 | 125 | 21 | 143 |
| 1997-2000 | 99 | 15 | 112 |
| Females | | | |
| 1982-86 | 102 | 30 | 128 |
| 1997-2000 | 71 | 24 | 93 |

The age at marriage has increased for both males and females (27.1 and 22.7 respectively in 2000 from 26.3 and 21.6 in 1991.)[48] Rural females are particularly vulnerable to marriage before they are 20 than their urban counterparts (58 vs. 27 percent) with 47 percent of females (as opposed to14 percent males) married before the age of 20 and 14 percent of females (seven percent males) before the legal age.[49] The increase in the marriage age is attributed in some part to the desire of parents to educate daughters but mainly to the rise in poverty and the spread of the practice of dowry even to areas where it traditionally did not exist.

The girl child experiences discrimination in education as the persistent gender gap reveals. While more adolescent girls are enrolled in school (54 percent as opposed to 84 percent boys) than at any previous time the gender gap is still huge. There are variations in figures across income groups, provinces and rural/urban areas, with the gap being narrowest in the highest income groups and widest in the lowest income groups. The lowest income group however has experienced an increase in female school attendance over the last five years.

Current enrolment levels for adolescent girls are low with only 15 percent in school as opposed to 33 percent of male adolescents. Once again figures are lowest among rural females and those in the two lowest income groups. Completion of middle school eluded most girls, with only 24.4 percent of those surveyed nationwide achieving that goal, in contrast to 52 percent of males. Figures were highest for girls in the Punjab and in urban areas. A total of 17.7 percent of girls, in contrast to 32.7 percent of boys had completed high school.[50]

Specific RH programmes catering to the special needs of adolescent girls and boys are few but growing due to the effort of non-government organisations working in the fields of family planning and reproductive health to address the needs of the young population, although outreach remains limited.[51] These are few and located mainly in urban areas. The Family Planning Association of Pakistan has been involved in work with youth for several years, and currently conducts a Girl Child project in addition to its work with male youth under which it offers guidance to adolescent girls, life skills training and RH education. The well-established network of Girl Guides and Boy Scouts in the country is being used to provide counselling and training, particularly under the auspices of the Girl Guide Shield Programme.

Only one out of ten ever-married women reported their mothers having ever discussed bodily changes of puberty with them and over half the women did not consider it important to educate their adolescent daughters about body and emotional changes (Pakistan Reproductive Health and Family Planning Survey 2000/01). The demand for sex education among adolescents has been well documented by NGOs.[52] Organisations such as Aahung (harmony) in Karachi have made major efforts to disseminate material on RH and sexual health. Other NGOs across the country have taken up sexual health issues, particularly due to the available support and funding for HIV/AIDS awareness and prevention projects. Sex education is not integrated into school curriculum.

Shortage of schools, health centres, social discrimination, and poor nutrition all militate against better indicators for the girl child and later women in Pakistan.

Pakistan has made multiple international commitments involving the welfare of the girl child. It has signed and ratified the Convention on the Rights of the Child (CRC), the Additional Protocols on CRC, CEDAW, and ILO Convention 182 for eliminating child labour, as well as programmes of action agreed to at the ICPD and World Conference on Women in Beijing 1995. It lifted the reservations to the Convention on the Rights of the Child in 1996. However government expenditures remain low for child rights, at one percent each of central government expenditure allocations between 1992-2002 (compared to 18 percent expenditure on defence.)[54] Nevertheless there has been some progress in addressing girl-child issues. The National Population Policy mentions an increased focus on adolescent and male reproductive health; the comprehensive reproductive health package outlines RH services for the full stages in the life cycle of females, and also highlights the importance of providing male RH services. Yet the Interim Population Sector Perspective Plan 2012 does not retain the life cycle approach.

The National Health Policy outlines key areas of action with possible positive impact on the girl child, such as expanded immunisation, increased number of female health workers, and promotion of gender equity in the health sector. Among the targets is an increase in nurses from 23,000 to 35,000 by 2005. Implementation strategies for key action areas include increased use of the mass media for awareness on health, particularly nutrition.[55]

There are conflicting laws pertaining to the age of marriage. The legal minimum age for marriage is 16 years for girls and 18 years for boys under the Child Marriages Restraint Act 1929 (a marriage below this age remains valid unless it is rejected through the option of puberty). The Muslim Family Laws Ordinance 1961 stipulates the age of consent for a girl as 16, while the Majority Act 1875 states that a girl under age 18 is a minor, except in matters of marriage, dower and divorce.[56] Under the 1979 *Hudood* Ordinances, a girl who has reached puberty can be prosecuted for unlawful sex outside of marriage.

Girls and boys do not have equal inheritance rights under existing Muslim personal laws in Pakistan. According to *Shariah* (God's law) law women inherit property in specified proportions, depending on the number of other heirs. Most inheritance cases do not go to court,[57] although when they do the courts uphold women's rights to inherit moveable and immovable property. Under customary practices in the four provinces, women rarely inherit anything, particularly if there are male heirs as well.

There is no specific legislation against child pornography, despite the fact that child sexual abuse has been recognised through the work of NGOs as a problem for both boys and girls. Child pornography, however, could fall under the reach of the existing *Hudood* Ordinances that make sex outside of marriage a crime. Forced marriages[58] take place in Pakistan especially among Pakistanis living abroad and family courts dissolve such marriages when approached. In January 2003, British and Pakistani judges signed a protocol on child abduction because of the spate of incidents in the wake of broken marriages in England.

## Reducing Maternal Mortality and Morbidity, Promoting Safe Motherhood and Safe Abortion

### Maternal Mortality and Morbidity

Maternal mortality is often seen as the factor responsible for the "missing women" in Pakistan's population statistics. At 300-700 per 100,000 live births maternal mortality has remained more or less consistent over the past ten years. There is great variance between figures from hospitals and community-based research.[59] MMR figures also vary from 17 in a private tertiary care hospital to 2,736 in a public tertiary hospital.[60] Alarmingly, there has been no significant reduction in the hospital-based MMRs over the past several years. On average, as many as 50 mothers die each day from pregnancy and childbirth related complications every day, while 30,000 women die due to the same every year (Pakistan Society of Gynaecologists and Obstetricians). Studies have repeatedly shown that most of these deaths are due to direct obstetrical causes, that most are preventable and that whether in the community or hospitals, the leading causes are haemorrhage, eclampsia, sepsis, obstructed labour and abortions.

Research shows that the high level of maternal mortality in Pakistan is due to the poor access of women in rural areas and urban slums to peripheral health facilities, and due to complications being mishandled by Traditional Birth Attendants (TBAs) during delivery. Even though the percentage of women delivering at home is gradually decreasing (77 percent in 2000-2001 from 85 percent in 1990-1991) it is the only available option as just 54 percent of the rural population lives less than 6 km from a primary health care centre. Only 20 percent women have a skilled attendant at delivery. A network of health delivery systems in the public sector was put in place as far back as 1970, good on paper but grossly under-funded (expenditure on health being less than one percent of GNP), it suffers from very poor management (e.g. high staff absenteeism) resulting in its under-utilisation. The private sector provides nearly 80 percent of all health care.[61]

Allocation of free time on television, for relaying public service messages, which have helped considerably in publicising the need for contraception, in safeguarding maternal health, and caring for the Girl Child. The National Health Policy 2001 has 'promoting gender equity' as one of the 10 areas of reforms.[62] The issue of maternal mortality while not addressed directly is implicitly addressed through the national programme for immunising mothers against neonatal tetanus in 57 selected high risk districts, expanding the cadre of Lady Health Workers (LHW) and provision of EmOC facilities in 20 districts under Women Health Project (see also next section).

### Maternal Morbidity

Information on maternal morbidity in Pakistan is fragmented. Most of the information is hospital-based. Symptoms of pelvic inflammatory disease (PID) in a rural community of Jamshoro, Sindh, were found to be nine percent. In another survey 45 percent of women reported menstrual irregularities, 19 percent[63] uterine prolapse, 12.8 percent PID and 5.4 percent urinary infections. The significant predictors of pelvic inflammatory disease were IUCD (intra-uterine contraceptive device) use, age less or equal to 20 years and urban life style.[64]

Urinary tract infection (UTI) is an important but less investigated public health problem. In Pakistan's Reproductive Health and Family Planning Survey 6.6 percent women reported burning micturition. This is far less than what was revealed in a community-based study where prevalence of UTI was 17 percent [65] Lack of nutrition is also an important cause of maternal morbidity as women in Pakistan are malnourished and anaemic compared to men and those in the reproductive age group belonging to rural low and middle income group being more anaemic. The most recent National Nutrition Survey (2001-2002) shows that 36.9 percent of pregnant women have moderate anaemia, down from 41.4 percent reported in the National Health Survey of 1990-1994.

The health infrastructure in the country lacks the basic requirements to deal with the problem at all levels i.e. at primary, secondary and tertiary levels of care. The private and particularly the government health centres not only lack necessary medicines and equipment but also hardly have any qualified and trained gynaecology/obstetrics doctors and related paramedical staff in them. The former are unaffordable for the majority and there is no system of health insurance to cover reproductive health services of the poor in the country for deliveries or any other ailment. The public transport system is also very poor especially in the rural areas.

As stated above the National Health Policy 2001 addresses the issue of maternal and neonatal mortality and some major public sector preventive and curative programmes have been enforced such as the LHW Family Planning Workers Programmes (a total of 71,000 workers), IMCI (Integrated Management of Childhood Illnesses) and many donor financed projects mentioned above (Family Health Project, Reproductive Health Project and Women Health Project). The 1994-created NCMH (as the focal technical and advisory body for women's health matters, particularly safe motherhood) is taking the lead in using the media and conducting workshops for advocacy. Recently UNICEF-initiated RHPP, funded by ADB with the Ministry of Health, has taken initiatives to train health personnel to identify and deal with reproductive health issues including EmOC. Expansion of EmOC is also under consideration through the private sector to the poor and needy who are willing to pay the minimal cost of the services near their houses.[66] NGO programmes include Shirkat Gah's pioneering project of training TBAs in selected districts of Punjab, Sindh and NWFP to enable them to refer complications arising in women during pregnancy and childbirth. Another valuable addition has been the introduction of the WHO Protocol for Tetanus Vaccination, at household and health facility level.

### Antenatal Care

The percentage of women receiving antenatal care has improved over the years. In 1990-91 Pakistan Demographic and Health Survey reported only 30 percent of women seeking antenatal care, in 1996-97 Pakistan Fertility and Family Planning Survey revealed a six percent increase in antenatal care and in recently conducted Pakistan Reproductive Health and Family Planning Survey 2000-01, 51 percent of women reported seeking antenatal care. The sources of antenatal care in the year 2000-2001 were mainly trained personnel (44 percent). Of 49 percent women who did not seek antenatal care, 64 percent believed that there was no need of it and 20 percent could not afford the care. Government services are not available everywhere; where they are, they charge for antenatal care. Very few of the women (7.2 percent) mentioned the health facility as being too far.

### Safe Abortion

Legally induced abortion is not allowed in Pakistan except to save the life of the mother. In daily practice, few doctors are willing to take the responsibility of induced abortion for a mother in critical need. However clandestine abortions occur and add subsequently to high maternal mortality and morbidity. Pakistan Reproductive Health and Family Planning Survey of 2000-01 have mentioned an induced abortion rate of 2.9 percent. A study from Karachi, however, estimated that the total abortion rate was 0.86, which means that on an average a woman will have at least one induced abortion by the end of her reproductive life. The reasons mentioned by women for having an induced abortion include birth spacing, limiting family size and economic impoverishment. Contraceptive failure, too many children, medical reasons, pre-marital and extra-marital affairs are also cited as reasons. The abortion rate for the past year (prior to the survey) was estimated as 25.5 per 1000 ever-married women in the reproductive age group.[67] In another survey from Karachi, the maternal deaths which were attributed to induced abortion were eight percent and all were due to sepsis.[68] The abortion providers identified were TBA, LHW/nurse, and doctors. Bleeding and infection were found to be the two major complications of abortion. Most of the research done on abortions is by professionals, NGOs and academics.

The incidence of maternal death as a result of unsafe abortions is estimated to be high (11 percent) in the country. The main reason for this fact is that most

of these abortions take place in unhygienic conditions and are performed by untrained TBAs and LHWs/nurses.

As mentioned earlier, abortion is illegal in Pakistan except when necessary to save the life of a pregnant woman. Even for the exceptional case, the law requires the professional judgment of at least two qualified doctors to confirm that further course of the pregnancy would be fatal for the mother. Otherwise, it is considered a criminal offence under the Pakistan Penal Code XLV of 1860, and the *Qisas* and *Diyat* Ordinance 1991. Even in cases of rape and incest, abortion is not permissible under the law. While NGOs, like Women's Action Forum (WAF), Family Planning Association of Pakistan (FPAP), and others have raised the issue of unsafe abortions it is still not a subject of public debate.

## Promoting and Protecting Sexual Rights, Safe Contraception, Preventing/treating HIV/AIDS and Reproductive Cancer

### Family Planning Information, Education and Services

The total fertility rate in Pakistan is 4.8 according to PRHFS 2000-2001 (the Pakistan Demographic Survey 2002 puts it at 4.3) down from 5.64 in 1994 (urban TFR 3.7; rural 5.4). The gap between the urban and the rural TFR figures has been quite significant during the last decade. The obvious reasons for the decline in urban areas are attributed to increased female education and higher age at marriage for females. Additionally, the urban areas have more access to family planning services and have been provided regular FP facilities by the Government, NGOs and the private sector (social marketing and commercial sales).

One of the major demographic factors for high TFR is considered to be the low age at marriage for females. However, both male and female age at marriage since 1990 has seen an increase with that of females from 21.6 in 1991 to 22 in 1996-97 and to 22.7 years in 2000-01. According to most recent data gathered from the Adolescent and Youth in Pakistan Survey 2001-2002[69] rural females are particularly vulnerable to marriage before age 20, more than their urban counterparts (58 vs. 27 percent).

An overall downwards trend in TFR is apparent from the data in age specific and total fertility rates as shown in the table below. The most active reproductive years for women are ages 20-39 years

**Table 3. Trends in Age Specific and Total Fertility Rates**

| Age | PCPS (1994) | PFFPS (1992-96) | PRHFPS (1997-2000) |
|---|---|---|---|
| 15-19 | 44 | 83 | 65 |
| 20-24 | 227 | 249 | 211 |
| 25-29 | 307 | 278 | 258 |
| 30-34 | 243 | 215 | 206 |
| 35-39 | 179 | 148 | 128 |
| 40-44 | 92 | 75 | 61 |
| 45-49 | 36 | 24 | 26 |
| TFR | 5.64 | 5.36 | 4.77 |

**Source:** NIPS, Pakistan Reproductive Health & Family Planning Survey (PRHFPS) 2000-01

According to PRHFPS 2000-2001 awareness of a modern method of family planning is widespread (95 percent) with 97.3 percent in urban areas and 93.9 in rural. The overall contraceptive prevalence rate for all methods is 27.6 percent (up from 17.8 percent in 1994). The urban CPR is 39.7 percent and the rural 21.7 percent. Further breakdown is 20.2 percent for any modern method (12.6 percent in 1994) compared with 7.4 for any traditional method (2.8 percent in 1994). Further disaggregated data are not available.

The highest usage in male methods is the condom that has risen from 3.7 percent in 1994 to 5.5 percent of total contraceptive users in 2000-2001, followed by withdrawal at 5.3 percent (from 4.2 percent in 1994.) Among female methods, sterilisation is on top at 6.9 percent (up from 3.5 percent in1994) followed by IUD (3.5 percent) and pill (1.9 percent) both up from 3.4 percent and 1.6 percent respectively in 1994[70].

According to PRHFPS (NIPS 2000-01) nearly 45 percent of all acceptor couples rely on methods that require the initiative or compliance of husbands -- a significant finding in terms of decision-making at the household level regarding family planning and choice of contraception. The unmet need for family planning is high (33 percent) despite the fact that more than half the women in this category do not desire more than three children. Some surveys have been done to find out the gap between desire and behaviour and it is assessed that the husband's disapproval, lack of accessibility to services, fear of side effects, poor state of women's sexual rights and lack of female decision making at the household level all contribute in fulfilling this unmet need.

Information available on cost of contraceptives is scant but affordability does not seem to be an issue as the public sector dominates the provision of contraceptives that are sold at subsidised rates. While in the private sector, which basically comprises NGOs and Social Marketing programmes, prices of contraceptives do not have any major effects on the market.[71]

Population policies and the National Health Policy have been discussed in the previous section. Important to note here is that advocacy of RH agenda and improved service delivery seem to be the major initiatives focussed on by the Government with improvement of Information Education Communication (IEC) material being an important component. Expansion of the service delivery was a major priority area in the Ninth Five Year Plan. Currently there is a countrywide network of 1,911 family welfare centres, 106 Reproductive Health Centres, 151 Mobile Service Units, 500 outlets of Target Group Institutions, and 7,584 outlets of the Provincial Line Departments.[72] Before ICPD, in 1993 there were 1,347 family welfare centres, 79 Reproductive Health Centres, 174 outlets of Target Group Institutions, and 5029 Health Department outlets including 384 outlets from other departments; while there were no mobile service units. However, not much can be said about the level of effectiveness or the quality of services extended at these service delivery outlets.

Similarly, the NGO sector is quite active in promoting the ICPD agenda and improving the RH sector through various programmes and grassroots interventions at the community level. A number of prominent NGOs run permanent clinics and operate community based contraceptive distribution programmes, which provide family planning and reproductive health services. While the quality of all services cannot be checked nor are appropriate data available, the usage patterns indicate that except for tertiary hospitals lower level government services are poor and inadequate and most patients prefer private or non-government facilities.

The combined expenditure in the social sectors of education, water and sanitation, health and reproductive health has remained only at 8.2 percent for the overall public sector development and non-development expenditure in the last decade. The trend in increased public sector spending of 11-16 percent between 1990-91 to 1996-97 became erratic from 1997 onwards due to external factors e.g. IMF regulations and structural adjustment and testing of nuclear bombs that lead to pulling back of international donors.

### Access to Counselling/Support and Clinical Services for HIV/AIDS and Reproductive Cancer

As of January 2000, the total number of detected AIDS patients went up to 187 (the first case reported was in 1987) while for HIV infection it was 1,436 (National AIDS Programme). The estimated number of people living with HIV/AIDS at the end of 1999 has increased to approximately 74,000.[74]

Despite the visible commitment of Government regarding RTIs/STIs and the spread of HIV/AIDS there is still a need to strengthen the treatment components. The Government and NGOs alike have limited access to people living with HIV/AIDS in Pakistan. There are only two NGOs currently working specifically with people who are infected.[75] Seventy NGOs however are participating in AIDS-related issues. These NGOs are working in all four (Pakistan has four provinces and four federally administered territories) provinces and both rural and urban areas but their main focus remains awareness raising and research rather then service delivery. Limited information is available regarding counselling in the private sector, but some NGOs provide pre and post testing counselling services.

A Centre for the provision of training courses in counselling and case management has been established at the Civil Hospital in Karachi. Master trainers trained by the National AIDS Programme are expected to carry training programmes for clinicians in their respective regions. But so far no follow-ups have been conducted on this intervention. Some anti-retroviral drugs are available in the major pharmacies in big cities or the drug can be arranged on request. The cost of care at the Government hospitals is partially shouldered by the Government, but the main burden remains on the patient. However, diagnostic and laboratory facilities are generally available.[76] Treatment Policy of the Government was due to start in December 2004, when anti-retrovirals were to be provided to patients in all the provinces.

UNICEF, UNAIDS and UNFPA are active in advocacy and service delivery issues, with UNICEF funding focussing on school-going adolescents; UNAIDS funding is directed toward intravenous drug users in major urban centres; UNFPA is assisting an NGO for the prevention of HIV transmission among street drug users and is soon to initiate a project with commercial sex workers.[77]

The Ministry of Health (MoH) stewards the HIV/AIDS country programme with provincial implementation units and has formulated several programmes and strategies for its prevention and control. The National AIDS Prevention and Control Programme (NACP) under the Ministry has been operational since 1994-95, and has led to a significant increase in the awareness level from a low four percent in 1991-92 to 75 percent in the evaluation undertaken in 2000. (No gender-disaggregated information is available.) The NACP conducts extensive advocacy campaigns in the print and electronic media and these are one of the major public sources for creating awareness regarding AIDS.

The Government has also drafted an expanded National HIV/AIDS Strategic Framework for Pakistan for 2001-2006, in collaboration with UNAIDS. The framework defines the priority areas. The Ministry of Health has drafted an Expanded Response Programme of about US$ 40 million, to be implemented over the next five years, with the assistance of World Bank and other funding agencies to prevent HIV from spreading among the vulnerable populations and to the general adult population.

Similarly, the Ministry of Population Welfare's National Population Policy includes active interventions in areas of reproductive and sexual health, with reduction of RTIs and STIs for improving the reproductive health of the population. The Pakistan Reproductive Health Services Package includes prevention and management of RTIs and STIs and HIV/AIDS, as well as management of reproductive health related problems of men and women. The service delivery components are being covered by the ADB-funded Pakistan Reproductive Health Project (RHP) launched in 2003.

### Reproductive Cancer

Adequate data are not available to estimate the incidence and age-standard rates (ASR) for cancer among men and women in Pakistan.

According to the Pakistan Reproductive Health and Family Planning Survey (PRHFPS) 2000-2001, 1.4 percent of women noticed a lump in the breast, and of this, 1 percent were diagnosed as having breast cancer.

Treatment for reproductive cancer is listed as one of the nine components of the RH Package 1998, and is available at some major hospitals, but there are no nationwide facilities by the MoH for early screening by the Pap smear, or other means. Similarly, regular breast self-examination is not promoted, although this alone would help provide an important diagnostic tool.

### Male Involvement

ICPD 1994 did trigger the beginning of research into male perspectives on RH issues. NGOs have initiated projects to achieve male involvement in RH goals and also to explore RH from the male perspective for the first time. The demand for RH services among men has also been borne out by a government-led appraisal study of Family Welfare Centres. The study found that women are the primary users of these centres, and most men interviewed said they had not been approached by Family Welfare Centre (FWC) staff regarding its services, and few men thought the centres offered any services for men. Among male youth interviewed, none went to the FWCs to use any of its services, while more than half of the female youth did visit them. The boys did express a need for RH counselling and advice on homosexuality, so they would not be forced to visit quacks or hakims (traditional doctors of unani medicine) for help.[78]

Contraceptive prevalence rates and data on specific methods reveal that nearly a quarter of contraceptive-using women are sterilised. The most popular temporary method is the condom, used by 20 percent of current users, followed closely by withdrawal (19 percent), and the IUD (13 percent). The increase in figures among withdrawal users may be due to new attention being paid by researchers to investigating the use of this method after the Primary Care Partnership Scheme (PCPS) findings. Nearly half of all couples practising

contraception rely on methods that require the male's initiative or compliance,[79] which is a significant finding in terms of decision making at the household level regarding family planning and choice of contraception.

The trends among women visiting health facilities with or without men are positive. According to PRHFPS 2000-01, 71 percent of women surveyed had discussed their health problems (related to different symptoms of RTIs/STDs) with husbands and 57 percent of husbands had taken women surveyed to the doctor.[80]

The key service indicator to monitor male involvement after the ICPD commitments is gender sensitisation activity, particularly among health services providers and teachers, and among students – in particular boys. Most teachers in Pakistan are men, [81] whereas women dominate outreach health and family planning services. Gender sensitisation programmes among service providers and students are conducted by non-government organisations working in these sector and government policy documents do not include gender sensitisation training as part of their RH approach.

There is no available research to provide indicators on status issues pertaining to other aspects of male involvement in reproductive health, such as the percentage of men in families who share domestic responsibilities, the percentage of men who avail of paternity leave (not applicable in Pakistan's legal context)[82], or the percentage of women who get adequate maintenance support from their ex-husbands.

Those NGOs working on issues of sexual and reproductive health conduct studies and awareness-raising sessions with boys and men in informal and school settings.[83] Social Marketing Pakistan (SMP) provides family counselling as part of its work and also conducts research on male involvement in RH.

At the policy level male involvement is recognised as worthy of programmatic effort, if not priority. Pakistan Population Policy currently includes a focus on male involvement as one of its main objectives, along with reducing unwanted fertility and demand for large family size, and greater investment in youth, it does not however reflect the broader view of linking gender equity with reproductive health. Nonetheless, the promotion of gender equity is also one of the stated ten specific objectives in the new National Health Policy.

The Population Perspective Plan 2012 includes the strategy of encouraging males as partners in the programme and promoting responsible fatherhood. A supporting programme initiative is to increase and strengthen the male cadre of motivators from district to union council levels to close the gender gap in female-directed programmes and for the promotion, provision and strengthening of male contraceptive surgical procedures.

The National Aids Programme, through its work with the media, promotes the use of the condom as protection against STDs and HIV/AIDS, but in the Population Policy of Pakistan there is no mention of broader RH goals beyond reduction of population growth rate, reduction of fertility and universal access of safe family planning methods.

## Main Implementation Barriers and Facilitating Factors

### Barriers

A combination of internal and external factors created barriers that affected the implementation of ICPD commitments (and are expected to pose challenges in the future.) The limited periods of democracy and heavy militarisation have added to the country's debt-ridden status, leaving little for the country's development. The role of the World Bank and IMF in Pakistan has expanded over the years, especially in the last decade. Given the dire straits of Pakistan's economy-- a high fiscal deficit and debt servicing crisis—the World Bank developed a strong say in the country's health policies that resulted in the private sector providing 80 percent of health services by the mid 90s (Pakistan Integrated Household Survey 1995-96.) The high level of fiscal deficit and extreme dependence on foreign financial assistance led to debt servicing as a percentage of foreign exchange earnings reaching 40 percent in 2000. Given the economic situation the World Bank and IMF imposed Structural Adjustment Programmes (SAPs) beginning in 1986. These SAPs, however, 'affected various segments of population disproportionately, accentuating both poverty and related socio-economic problems in the country, as well as resulting in rising levels of unemployment, especially among the youth'.[84] At the same time Pakistan's foreign exchange reserves declined rapidly touching the all time low of about a billion dollars after it tested its nuclear devices in 1998.

Under IMF directions Pakistan had to embark on reforms for macro economic stabilisation. These included reduction and final removal of subsidies (energy, wheat, fertilisers), privatisation of public-run enterprises (e.g. banks, industries) as well as some of the basic services (education, health, transport), and liberalisation of imports through reduction and removal of tariffs. One condition that was met with great resistance (and had to be withdrawn) was the imposition of a 15 percent general sales tax on all drugs including life saving ones in 2002. People from the low income groups have been the hardest hit with the reforms in the economic sector - these have not ended the stagnation in the economy or generated employment, leaving the poor helpless as private health services and/or education have become increasingly unaffordable.

In the same period the proportion of people living in poverty also rose from 26.1 percent in 1990-91 to the current 34 percent (38 percent by some estimates) with rural poverty even higher (35 percent in 1998-99). While poverty is declining in the urban areas,[85] a significant 20.4 percent of the population remains vulnerable to poverty. The characteristics of poor households in Pakistan, according to the Federal Bureau of Statistics (2001), are: high dependency ratios (many children); education as the significant distinguishing factor between poor and non-poor households; dependency largely on precarious jobs often as labourers; and poverty status in rural areas closely related to land holding per capita (poor own 0.27 acre per capita; the non-poor 0.84 acre per capita).

In response to the reduced spending on the social sector and rising poverty the bank-coordinated and donor-supported Social Action Programme (safety net measure) was instituted for improvement in the areas of health, education, population and water and sanitation. The programme, in two phases, was however assessed as ineffective, inefficient and poorly managed. With the declining expenditures in the public social sector, the private sector took over responsibility for the provision of family planning, preventive services and drugs. The 1997 Health Policy provided for the BHUs and RHCs to be contracted out and the tertiary

hospitals to be made autonomous and permitted to charge user fees (including for childbirth), thus becoming more unaffordable for the poor.

Rising poverty affects women and children disproportionately, given the social cultural norms rooted in patriarchy and feudal/tribal systems that supersede both law and religious tenets. Women are restricted in mobility, have no say in decision-making and are seen as dependents. Hence they face greater hindrances in attaining education, receiving health services and accessing employment opportunities. Women in poor families, nevertheless, have experienced the need to assume greater responsibility of contributing to household incomes due to the economic pressure. More and more are pushed into the exploitative and low paying informal sector especially in the Punjab.[86] Poor families also resort to forcing their children to become wage earners. According to an ILO survey, in 1996, there were about 3.3 million or 8.3 percent of children nationwide who were economically active in the labour market.[87] Gender disaggregated data are not available.

Particular stress needs to be placed on women's health care: while there have been several policies and initiatives, many of them are largely on paper; they suffer from inadequate implementation and thus fail to have effective impact. Little concrete action has been taken to reduce the consistently high figures for maternal morbidity and mortality, which are believed to have added substantially to the country's negative sex ratio. The current policy of privatisation of health care negates the constitutional promise of Pakistan being a welfare state. The policies themselves continue to be silent even on abortion for victims of rape or incest: women therefore do not even have this basic right over their bodies. It is a well-known fact that many husbands and mothers-in-law frown on contraception, coercing women to have more children than they desire, thereby adding to Pakistan's population growth. Such women are denied both the right to contraception and to abortion, leaving them no alternative except unsafe abortion. The situation is worsened by the severely obscurantist climate prevailing in many parts of the country, and by discriminatory laws. Despite continuous struggle by activists, these discriminatory laws have negated women's progress for 25 years.

While the National AIDS Control programme has taken several strides forward, blood screening facilities are still not available throughout the country, the MoH has no strict guidelines or M&E for doctors and dentists, rendering large sections of the population susceptible to HIV. Treatment is presently unavailable, but has been promised December 2004 onwards. However, Pakistan has taken no action so far to counteract the deleterious effects of the WTO, which becomes effective December 31, 2004 onwards; this is likely to compromise the availability of anti-retroviral drugs due to high cost.

Militarisation is an important factor that impacts on where a country's resources are spent. In Pakistan's case tensions with India nearly brought the two countries to a full-scale war in 2002 and earlier led to the testing of nuclear devices, first in India and retaliatory ones in Pakistan in May 1998. This was followed in Pakistan with most bilateral donors freezing their financial support to the Government. Given its cash strapped situation Pakistan found itself on the verge of being declared an international defaulter (for not meeting its debt payment commitments) with dire consequences for the people. The military coup in October 1999 made Pakistan's external relations worse as world governments expressed their disapproval and unwillingness to provide financial support. However Pakistan's decision to align itself with the US in Afghanistan has brought benefits in the form of rescheduled debts from international financial institutions, aid pledges by bilateral donors, and stronger foreign exchange reserves.

With the centrality of security concerns in policy making, public expenditures are skewed as defence has historically been assigned the largest chunk of national resources. Pakistan's proximity to Afghanistan, the housing of millions of refugees following Soviet attack on Afghanistan in 1979, the rise of religious extremism and ready availability of arms has had a deep impact on the economic and social fabric of the country intensifying in the last decade. September 11 has had a critical fallout for Pakistan at the social and political levels with the increase in the incidence of terrorist activities, breakdown of law and order and consolidation of the militant religious elements in the country. The latter pose a direct threat to NGO workers, particularly those working on women's issues and services, in the two provinces bordering Afghanistan where governments led by religious political parties are in power. Religious assertion going hand-in-hand with militarisation of society manifests itself in the shape of violent sectarian conflict in the major cities, south Punjab and Baluchistan with target killing and suicide attacks as principal hallmarks. That it creates insecurity for the school going, sick and employed goes without saying.

NGOs in Pakistan have proliferated to over 56,000 over the last decade. In 2000, the largest number of NGOs was found to be in education (46.4 percent) --- more than half imparting religious education, and a fair number allegedly providing militant training. Health accounted for 6.1 percent of the registered NGOs with the overwhelming majority in urban areas (over 90 percent), and civil rights and advocacy NGOs were 17.5 percent.[88] The majority of NGOs were in Punjab followed by Sindh, NWFP and Baluchistan, with less than 3000 NGOs in the latter two. There are approximately a little over 200, middle to large NGOs in the country. Those involved in promoting human rights and particularly women's rights are an enigma to the religious organisations and political parties -- the most vocal and strident opponents of NGOs. In NWFP NGOs working for female literacy and political participation, have been threatened with physical attacks (including bombs) and closure. Successive governments have had a duplicitous policy of espousing the desire for collaboration with NGOs on the one hand, and lashing out at them when NGOs are critical of their policies or actions (e.g. nuclear tests, anti-women legislation).

Politically, Pakistan has seen three changes of government since 1994, the last one being the military takeover after the overthrow of a civilian government in October 1999. The militarisation of the administrative systems with the induction of active armed force officials has been institutionalised as has been of the role of the military in the political sphere with amendments to the Constitution. This was achieved after making compromises and conceding space to extremist religious parties who are opposed to progressive thinking, are intolerant towards women and minority communities, and do not hesitate in using arms for promoting their agendas. The antagonism of the religious groups to human/women's rights advocates, to female education and political participation, and repeal of discriminatory legislation presents a formidable barrier to achieving ICPD commitments and MDGs.

## Facilitating Factors

Important in the Pakistani context is the realisation by policymakers that measures have to be taken to address women's social exclusion, to deal with poverty and improve social sector delivery systems, especially if women's status and healthcare, and the abysmal Human Development (HDI) and Gender Empowerment Measures (GEM) are to be transformed.

However, there are a number of policies and initiatives in place. Some of the micro-level initiatives include rural support programmes, provision of vocational training to youngsters, micro-credit/micro-finance schemes such as those provided through the Khushali Bank, the Khushhal Pakistan Programme and the Zarai Tariqiati Bank for the provision of agricultural loans.

The other important development is the emergence of NGOs looking at issues from the human rights perspective. The NGO sector has shown its ability to mobilise and advocate for policies and change. In the last decade NGOs have developed communication mechanisms as well as built thematic and regional networks for information sharing, advocacy and solidarity. This enabled the provision of support, e.g., to organisations that were subject to physical attacks for carrying out female education projects in NWFP. There is also greater cross-thematic interaction among NGOs, for instance PRHN and the Pakistan Micro Finance Network (providing credit to grassroots organisations and women).

The Pakistan NGO Forum is the largest network of NGOs for safeguarding the interests of the sector (estimated membership: 2500). Formed in the mid-nineties following government steps to bring in restrictive and controlling legislation it has managed to defer the passage of the law by successive governments through its mobilisation and active lobbying.

The women's movement has been the driving force in placing women's issues on the national and political agenda including, more recently, that of killing in the name of honour. A number of policy and institutional measures of the Government have been the result of research, monitoring and advocacy of women's groups. The reservation of 33 percent seats in the local government and substantial increase in women's representation in legislatures is seen as a direct result of the activism by women over the past decade. The National Commission on the Status of Women too was formed following the relentless campaigns of women's organisations and activists.

The more recent phenomenon that has gained momentum in the last five years is that of the growing peace lobby. Articulating the desire of citizens for peace in the region and in the country the peace lobby has been very active for better relations with India and has found resonance among peace activists in the region. The anticipated peace dividend is less expenditure on defence and more for the social sectors.

## Future Concerns

In the immediate future the influence of the World Bank and the neo-liberal agenda in health is expected to prevail. The country's alliances with USA have had fallout in the form of heightened terrorist activities in Pakistan. The aid flow that increased dramatically (current foreign exchange reserves in the region of 12 billion dollars) is likely to be sustained as long as the current political arrangement is acceptable to the major donor countries and financial institutions (EU, DFID, USAID, ADB, World Bank, etc.) with possible positive impact on education delivery and health services.

The rise in religious extremism/xenophobia is also likely to consolidate and expand and manifest itself in social and political conflict, including between *shia* and *sunni* communities, which can be expected to create insecurity among the minorities and the emerging citizens' sector. This will impact on the peace

process between India and Pakistan and will continue to be a hurdle in the way of removing discriminatory laws and practices in the country. The law and order situation and the tensions between provinces over shared resources (water being the uppermost) are obstacles in the revitalisation of economic activity so critical for generating employment and eradicating poverty. The economy, stated to be on the take off stage, can be negatively affected by the above factors.

From the women's point of view the Government's policy of pacifying the religious extremist elements will mean slow progress in implementing institutional and legal changes that flow from its international commitments (CEDAW, ICPD, Beijing, CRC, etc.) and recommended by State-appointed Commissions (Commission of Enquiry, NCSW). These include the repeal of the Hudood Ordinances.

## Challenges and Recommendations

### The Government

#### Challenges to Government

Among general challenges to the Government, with far reaching implications, is that of poverty and of women's low status in society. Specific challenges with reference to RH and RR are: the absence of a SRHR policy; existing policies that fall short of addressing women's and adolescents RH and RR needs; ineffective implementation of policies; the persistently high maternal mortality rate; and poor quality of public sector facilities to address MM and other RH needs. Availability of medicines at affordable prices to the poor, and the issue of unsafe abortions also pose a continuous challenge. Ensuring the meaningful engagement of civil society in these issues is also a challenge for the Government; policies provide for NGO involvement but bureaucracy creates hurdles and criticism is unwelcome.

#### Recommendations to Government

i. Merge the MoPW and MoH for effective formulation and implementation of policies to include maternal mortality, unsafe abortions, sexual health and rights, bodily rights and adolescent SRH with strong M&E and a focus on a lifecycle approach to women's health. Make adequate information available; create awareness and infrastructure for the diagnosis of STIs, RTIs and reproductive cancers integral to health and RH policies. Develop trained staff, including doctors for counselling and treatment and set up systems of community based cancer registry.

ii. Make existing infrastructure of BHUs and RHC fully functional in all districts, tehsils and union councils to provide basic maternal health services with necessary conditions, incentives and personnel policies put in place for qualified and trained personnel. Establish comprehensive EmOC centres at accessible distances with suitable transport. Mobilise elected local body representatives for efficient delivery of quality services with relevant information and budget allocations.

iii. Ensure availability of affordable essential and non-essential drugs through mechanisms that regulate the quality, uniformity and accountability of services and pricing system of the private sector.

iv. Acknowledge the incidence of induced and unsafe abortions. Enact as the first step appropriate legislation to ensure safe abortion and legitimise abortion for rape and violence victims.

v. Give specific attention, with legislation, policies and strongly implemented programmes, to improving women's currently low gender status. Reinstate the quota for jobs for women in government service, implement the recommendations of the Inquiry Commission and the NCSW to repeal the Hudood Ordinances and other discriminatory legislation that contribute to the perpetuation of discrimination and violence against women. Take punitive action against those sanctioning (tribal *jirgas*/courts and *panchayats*) the giving of women to resolve conflicts, killing in the name of honour, and domestic violence.

vi. Take urgent multi-pronged nationally effective action with awareness raising for the public, counselling skills and enhanced ability of doctors to detect signs of violence and abuse, crisis centres, strong reporting system and forensic analysis. Simultaneously, the suffocating degree of conservatism, which governs women's lives, needs to be seriously analysed and eliminated, and the recommendations of the NCSW followed.

vii. Create an enabling environment for government-civil society partnerships to function.

## The World Bank, ADB, and Donors

### Challenges to Donors

The challenges to donors are of supporting policies and programmes that are appropriate and beneficial for the target populations, are efficiently managed and implemented, and are sustainable in the long run. As an endemic reason for deprivation addressing/eradicating poverty is a fundamental challenge. In the area of RH and RR, to keep a programme/policy focus on gender discrimination, wider gender and development framework and space for decision making by women.

### Recommendations to Donors

In order to meet the above challenges the donors need to:

i. Support people-centred economic and social sector reforms that remove/reduce income inequalities, secure livelihoods and improve the quality of life of the poor. Discourage policies that make essential services unaffordable. Encourage and support policies that remove structural causes of inequality and injustice (e.g. land reform, fair sharing of resources). Coordinate efforts to pool resources, and ensure genuine participation of local people in prioritising, planning and monitoring of development and service delivery related activities.

ii. Support the Government for putting in place mechanisms for regulation, monitoring and ensuring of quality services to the poor and reinforce government's primary role in social sector service delivery. Factor-in the negative impact of privatisation and liberalisation on the poor in accessing basic social services in donor supported policies and programmes.

iii. Put in place mechanisms and measures for the management of projects financed by donors to prevent mismanagement and corruption by setting up joint monitoring committees with local people and institutions, jointly agreed upon resettlement and compensation plans, etc.

## Challenges and Recommendations to Civil Society

### Challenges to Civil Society

The first major challenge to civil society, especially women's organisations and activists is that of averting maternal mortality. The second is of the absence of SHRH and RR policies. Next is that of implementation of existing policies and programmes in both letter and spirit. Others include that of organising/ strengthening civil society and its networks for influencing policy; to identify ways through which women can know their rights and exercise them to overcome obstacles in the way of accessing appropriate RH services and decision making.

### Recommendations

i. Lobby for a RH policy as a first step to be followed by SRHR policy to achieve ICPD goals. The lead may be taken by PRHN as the emerging platform for RH consisting of all major RH and population welfare organisations. Actively collaborate with women's rights organisations (some of whom are PRHN members) and networks to bring women's reproductive and sexual health needs on their agenda for women's empowerment. Already there is convergence on issues of violence against women, of abortion rights for victims of rape and sexual violence and for greater symbiosis needs to be created. Join the campaign to repeal discriminatory legislation and practices against women and minorities.

ii. Create awareness about RH and RR in the broader framework of women's empowerment among NGOs, women's groups, media, political parties, and especially women parliamentarians.

iii. Act as watchdogs of government policies and programmes. Highlight the gap between stated intent and implementation. Monitor government's compliance on international commitments.

iv. Use opportunities for inputs to government in conceptualisation and planning of RH programmes and policies. Recognising that NGO outreach will remain limited and that it is primarily government's responsibility to provide RH, STI/RTI services to the poor and the marginalised, those working in service delivery create models of efficiency and sensitivity to service seekers that may be taken to scale or replicated by government departments. Work in partnership with government without compromising on quality and the needs of the poor, setting standards of transparency and accountability. Use opportunity of dialogue and discussion whenever possible.

v. Conduct independent research to investigate the underlying reasons for maternal mortality in order to recommend policy action to address the issue. Highlight through research and publications the impact on women's health of discriminatory legislation and social practices

like forced and exchange marriages, killing in the name of honour, etc. through research. Share the findings with policymakers and the media.

vi. Use both the mainstream and alternative print and electronic media including performing arts to raise issues related to women's health, RH and RR and women's empowerment and counter the retrogressive position taken by the extremist groups and political parties.

## Conclusion

Pakistan has taken several key policy decisions towards the implementation of the ICPD commitments in the past ten years. These have been at the institutional level as well as at the programme delivery level. The recognition and identification of the problems has been candidly done. Some appropriate policy decisions like those of integrating the working of the Ministries of Health and Population welfare, collection of data, formulation of the national health, population, HIV/AIDS and national youth policies, and improvement in delivery of family planning services have all had some impact. There is greater usage of contraceptives; condom use has increased manifold; fertility rate and population growth rate have declined; awareness of family planning is almost universal; women's life expectancy has increased; the age of marriage has gone up for both males and females; there are a greater number of girls in schools in urban areas, in particular, among others. Pakistan has ratified CEDAW (albeit with reservations) and the Child Rights Convention and its Protocols. It has a National Plan of Action for implementing the Beijing commitments and a National Women Development and Empowerment policy in place, besides a National Commission on the Status of Women and a large number of women in the local government tiers and in the provincial and federal parliaments.

Despite the above efforts the measures have not achieved the desired results. Current policies, good on issues that they cover, are poor in implementation due to poor governance and administrative systems, and have failed to achieve reduced maternal mortality (over 300 per 100,000), bring down infant mortality to levels comparable with the region, reduce the gender gap in female enrolment and dropout, contain poverty and its feminisation, eliminate violence against women. Public expenditure remains low (0.7 percent of GDP for the entire health budget). Moreover there is still no RH policy and RR is not factored in under population welfare. Sexual health, an integral part of ICPD PoA is not addressed at all, neither is the issue of unsafe abortion. Adolescent sexual and reproductive health and rights also do not receive attention. Some of the policies in other sectors have been counterproductive for instance that of privatisation, especially of health services.

Moreover governments in the past decade while publicly committing themselves to women's empowerment have not yet repealed discriminatory laws that reinforce women's secondary status in society. Women remain dependent even when they contribute to household incomes, they are subject to domestic and public violence and harassment, and they have little or no say in decision-making regarding education, marriages or employment. Those in public office have to struggle against male biases and attitudes. The religious extremists have resisted women's participation in the political process in several areas of Pakistan. In all this successive governments have dragged their feet.

On the other hand, civil society organisations have become more active. ICPD succeeded in putting RH in a broader framework of rights. There is greater awareness, concern and advocacy on RH and RR. PRHN was created and became active and operational as *the* RH network. While it still needs greater recognition in policy-making circles many of its members sit in government committees and policy forums, thus bringing the network perspective to policy. Its ICPD+5 review workshops and seminars were attended by government officials and ministers and viewed extensively due to media coverage.

Thus there are both challenges and opportunities for both government and civil society. The challenges are of a structural and institutional nature: Provision of equal rights to women and minority groups, entitlements and opportunities to the poor, especially women, efficient and effective service delivery, monitoring with potential and actual clients of programme implementation, increased allocation of resources for the social sectors and dealing with the retrogressive elements opposed to progressive change and to demonstrate the will to do so at the political level. Civil society has to be alert, organised, and vocal.

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– *The Population Policy of Pakistan*, GoP, Islamabad. 2002.

– UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, February, 2000.

– UNAIDS, *Pakistan Country Profile 1999*.

## Abbreviations / Acronyms

| | |
|---|---|
| AGHS | AGHS Legal Aid Cell |
| BHUs | Basic Health Units |
| CEDAW | Convention on the Elimination of All Forms of Discrimination |
| CIDA | Canadian International Development Agency |
| COI | Commission of Inquiry |
| CPR | Contraceptive Prevalence Rate |
| CRC | Convention on the Rights of the Child |
| DFID | UK Department for International Development |
| EmOC | Emergency Obstetric Care |
| FPAP | Family Planning Association of Pakistan |
| FWC | Family Welfare Centres |
| GEM | Gender Empowerment Measures |
| GNP | Gross National Product |
| GOP | Government of Pakistan |
| GRAP | Gender Reform Action Plan |
| HDI | Human Development Index |
| HIV | Human Immuno-deficiency Virus |
| AIDS | Acquired Immuno Deficiency Syndrome |
| HRCP | Human Rights Commission of Pakistan |
| ICPD | International Conference on Population and |
| IEC | Information Education Communication |
| IFR | Individual Fertility Rate |
| ILO | International Labour Organisation |
| IMCI | Integrated Management of Childhood Illnesses |
| IMF | International Monetary Fund |
| IPPF | International Planned Parenthood Federation |
| IUCD | Intra-uterine contraceptive device |
| IWHC | International Women's Health Coalition |
| JICA | Japan International Cooperation Agency |
| LHW | Lady Health Workers |
| M&E | Monitoring and Evaluation |
| MDG | Millennium Development Goals |
| MMR | Maternal Mortality Rate |
| MoHRHP | Ministry of Health Reproductive Health Project |
| MoPW | Ministry of Population Welfare |
| NACP | National AIDS Prevention and Control Programme |
| NCMH | National Committee for Maternal Health |
| NCSW | National Commission on the Status of Women |
| NEDA | National Economic and Development Authority |
| NGO | Non Government Organisation |
| NIPS | National Institute of Population Studies |
| NWFP | North West Frontier Province |
| PAVHNA | Pakistan Voluntary Health and Nutrition Association |
| PCPS | Primary Care Partnership Scheme |
| PID | Pelvic inflammatory disease |
| PoA | Programme of Action |
| PPPA | Pakistan Participatory Poverty Assessment |
| PRHFS | Pakistan Reproductive Health & Family Planning Survey |
| PRHN | Pakistan Reproductive Health Network |
| RH | Reproductive Health |
| RHCs | Rural Health Centres |
| RHPP | Reproductive Health Project Pakistan |

| | |
|---|---|
| RR | Reproductive Rights |
| RTI | Reproductive Tract Infection |
| SAARC | South Asian Association for Regional Cooperation |
| SAP | Structural Adjustment Programme |
| SHR | Sexual Health and Rights |
| SRHR | Sexual and Reproductive Health and Rights |
| SMP | Social Marketing Pakistan |
| SRH | Sexual and Reproductive Health |
| STDs | Sexually Transmitted Diseases |
| STI | Sexually Transmitted Infection |
| TBA | Traditional Birth Attendant |
| TFR | Total Fertility rate |
| TFR | Total Fertility Rate |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency in International Development |
| UTI | Urinary Tract Infection |
| VAW | Violence against Women |
| WAF | Women's Action Forum |
| WEDO | Women's Environment and Development Organisation |
| WHO | World Health Organisation |

# Annexures

## List of Persons Interviewed

1. Dr. Rehana Ahmed, CEO, Green Star Social Marketing.
2. Ms. Rehana Rashdi, Director, PAVHNA.
   (Pakistan Voluntary Health and Nutrition Association).
3. Dr. Qayyum, Project Director, PAVHNA.
4. Dr. Jabeen Abbas, Asst. Project Director, PAVHNA.
5. Dr. Sharaf Ali Shah, Sindh AIDS Control Programme.
6. Prof. Dr. Sadequa Jafarey, President, NCMH
   (National Committee on Maternal Health).
7. Ms. Imtiaz Kamal, Secretary, NCMH.
8. Ms. Nighat Said Khan, Administration Manager, NCMH.
9. Ms. Fauzia Wahab, Member National Assembly.
10. Ms. Sherry Rahman, Member of the Senate.
11. Muhammad Ashraf Chatha, CEO, FPAP.

## Notes

[1] According to Secretary Ministry of Punjab. Saeed, Hilda. Opcit.p.89

[2] The package included: family planning counselling and services; Perinatal/prenatal care, safe delivery and postnatal care; Infertility prevention and treatment; Prevention and treatment of RTIs, STIs and HIV/Aids; Information and counselling on human sexuality and responsible parenthood.

[3] GoP-UNFPA, *Pakistan Population Assessment 2003.* Islamabad. 2004. p.42

[4] Hudood Ordinances cover zina (adultery and fornication) without making any provision for the crime of rape. Furthermore the law provides for maximum punishment (hadd) for zina with the evidence of four male Muslim eye witnesses. Women and non-Muslim's evidence for hadd is not admissible.

[5] The Council was disbanded in 1976 and a Population Welfare Division was created under the Ministry of Planning and Development until it was upgraded to an independent Ministry of Population Welfare.

[6] Saeed,Hilda, "Country Study of Pakistan", ARROW, Taking up the Cairo Challenge. ARROW. Kuala Lumpur. 1999. p.85

[7] Balchin, Cassandra, Mumtaz, Khawar, Shaheed, Farida, Women not the Womb. Lahore. Shirkat Gah. 1994 p.9

[8] NGO Coordination Committee for Beijing + 5, *Pakistan NGO Review; Beijing+5.* Lahore. Shirkat Gah. 2000. p. 41

[9] Ibid. p.42

[10] Ibid.

[11] The Law of Evidence, 1983 reduces the evidence of women in economic transactions to half that of men (two women equal to one man)

[12] Qisas and Diyat Ordinance. This law covers all crimes other than those under Hudood Ordinances. Under this murder is a crime against the person (not state) and the criminal can be acquitted if he obtains pardon from the victim's family and payment of diyat (blood money). Furthermore the diyat of a woman is half that of a man's.

[13] See for detailed discussion Mumtaz, Khawar, Shaheed, Farida, *Women in Pakistan; Two Steps Forward One Step Back?* London. Zed Books/Lahore. Vanguard Books. 1987

[14] According to Secretary Ministry of Punjab. Saeed, Hilda. Op cit. p.89

[15] NCMH is "the focal technical and advisory body for matters relating to women's health in general and safe motherhood in particular". It has representatives from all four provinces and has been active in creating awareness, formulating a national maternal and perinatal health policy and a national plan for action with funding from UNICEF-Pakistan. See Fozia Qureshi, Asma and Yasmeen Sabeeh Qazi, *Maternal and Neonatal Health in Pakistan: A Desk Review.* Islamabad. 2003 (unpublished.) p.19

[16] The package included: Family Planning Counselling, IEC and Services; Perinatal/ prenatal care, safe delivery and postnatal care; Infertility prevention and treatment; Prevention and treatment of RTIs, STIs and HIV/Aids; Information and counselling on human sexuality and responsible parenthood.

[17] GoP-UNFPA, *Pakistan Population Assessment 2003.* Islamabad. 2004. p.42

[18] The major goals of the Pakistan Population Policy include attaining a balance between resources and population within the broad parameters of the ICPD paradigm; increase awareness of the adverse consequences of rapid population growth at the national, provincial, district and community levels; promote family planning as an entitlement based on informed and voluntary choice; attain a reduction in fertility through improvement in access and quality of reproductive health services; reduce population momentum through delay in the first birth, changing space patterns and reduction in family size desires.

[19] The Population Policy of Pakistan, 2002.

[20] GoP;UNFPA. Op. cit p.74

[21] Ibid. p.80

[22] The Reproductive Health Project intends to cover: comprehensive FP services for

females and males, maternal health care including safe motherhood and pre and post abortion care for complications, infant health care, prevention and management of RTIs/STDs and HIV/AIDS, management of RH related problems of adolescents, management of RH problems of women, management of infertility, detection of breast and cervical cancers and management of RH related issues of men.

[23] Qureshi and Qazi. Op. cit.p.10-17

[24] Columbia University Mailman School of Public Health's AMDD Programme. There are 86 such projects in 51 countries.

[25] Conventional contraceptives include condoms, diaphragms, spermicidals, as well as intra-uterine devices

[26] Dr. Rehana Ahmed, Country Coordinator Green Star Social Marketing. Interview.

[27] Mahbubul Haq Development Centre 2000

[28] *Human Development in South Asia 2000-2002*. Mahbubul Haq Development Centre. 2000

[29] *Human Development in South Asia 1993 to 2000*., Mahbubul Haq Development Centre. 2003

[30] Reservation on CEDAW: Any dispute between two or more states parties concerning the interpretation or application of the present Convention which is not settled by negotiations shall, at the request of one of them, be submitted to arbitration. If within 6 months from the date of the request for arbitration the parties are unable to agree on the organisation of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the statute of the court.

[31] GOP, *National Policy for Development & Empowerment of Women. Islamabad. GOP. 2003*

[32] *Human Development Report 2000-2002*. Mahbubul Haq Human Development Centre. 2003

[33] Labour Force Survey of Pakistan 1986-2000.

[34] Mahbubul Haq Human Development Centre. Op. cit 2002. p.112

[35] Mahbubul Haq DC. 2000. pp 107, 110

[36] Pakistan NGO Review, Beijing +5. NGO Coordinating Committee for Beijing +5. 2000. p. 61

[37] Mahbubul Haq HDC.2002

[38] SPDC. 2002. p.66

[39] Pakistan Statistical Year Book. 2002.

[40] Opcit. *Pakistan Population Assessment 2003*. p.18

[41] HRCP, *State of Human Rights 2003*. p. 247.

[42] HRCP, *State of Human Rights 1999*. p. 182

[43] HRCP, Op. cit. 2003. p.237

[44] In Islamabad, Karachi, Lahore, Peshawar, Sahiwal and Vehari.

[45] HRCP, The State of Human Rights in Pakistan. HRCP. Lahore. 2000. p. 175

[46] Shelters for women set up by NGOs include Panah Karachi and Lahore; AGHS' *Dastak* in Lahore and Aurat Foundation's *Mera Ghar in Peshawar.*

[47] An essential study of adolescents in Pakistan that preceded the AYP and provides a rich profile of adolescents based on PIHS data is Valerie L. Durrant, *Adolescent Girls and Boys in Pakistan: Opportunities and Constraints in the Transition to Adulthood*. Research Report No. 12, Population Council, Islamabad. 2000

[48] PRHFPS 2000/01 Preliminary Report: 12.

[49] Sathar et al, *Adolescent and Youth in Pakistan 2001-2*. 2003. pp.104; 87. The AYP is a survey of adolescents and youth ages 15-24 in a nationally representative sample across Pakistan.

[50] Ibid. pp 58;45;51;149

[51] For details see Ayesha Khan, June, 2000. *Adolescents and Reproductive Health in Pakistan*: *A Literature Review. Islamabad*: UNFPA/Population Council.

[52] See ibid, pp. 17-26

[53] For examples, see Aahung, 2002 *Promoting Holistic Management in Sexual Health,* Karachi; Aahung Annual Report, 2001; Shireen Issa, ed., 2001, *Body, Mind and Spirit in Sexual Health: National Conference Report,* Karachi, Aahung.

[54] www.Unicef.org, September 2003. Figure taken from International Monetary Fund (IMF).

[55] Ministry of Health, June 2001. National Health Policy 2001. Islamabad: Government of Pakistan.

[56] Balchin, Cassandra, (ed). Time to Speak Out. Lahore SG. 1996

[57] Arif, Kamran and Shaheen Sardar Ali, "The Law of Inheritance and Reported Case Law Relating to Women", in Shaheed, F. et al (eds). 1998. Shaping Women's Lives: Laws, Practices & Strategies in Pakistan. Lahore: Shirkat Gah. P. 171

[58] See "Match Manufacturers", by Beena Sarwar, *The News*, September 28, 2003.

[59] Hospital based studies from different provinces of Pakistan estimate MMR to range from 670- 4,472 per 100,000 live births and community based research on maternal mortality have estimated MMR ranging from 281/100,000 live births in the urban slums of Karachi to 673 in rural Khuzdar district of Balochistan.

[60] Qureshi and Qazi, 2003. Op.cit. p.8

[61] Qureshi and Qazi. 2003.

[62] The ten areas are: communicable diseases, primary/secondary health care services, district health system, promoting gender equity, nutrition gap, correcting urban bias, regulating the private medical sector, improving the drug sector, health policy monitoring.

[63] PRHFPS 2000-2001

[64] Sajan F, Fikree F. "Perceived gynecological morbidity among young ever-married women living in squatter settlements of Karachi", Pakistan. *JPMA (Journal of Pakistan Medical Association)* 1999. Apr: 49(4): 92-7.

[65] Bhurt, W.A; Bozdar M.N; Fikree, F. "Prevalence and risk factors of presumptive urinary tract infection in a rural community," JCPSP Jan 2000; 10(1): 16-19.

[66] *Reproductive Health Project Pakistan*. Final Report .ADB TA NO.3387. Government of Pakistan Ministry of Population Welfare, Asian Development Bank

[67] Saleem, S and F. Fikree . "Induced abortion in low socio-economic settlements of Karachi,Pakistan: rates and women's perspectives". JPMA. No.51.Vol.8. 2001. pp. 275-279

[68] Fikree F, Gray HR, Berendes HW, and Karim SM. "A community -based nested case-control study of maternal mortality." *International Journal of Gynaecology and Obsterics*.No.47. 1994. pp. 247-255. This should be footnote 69

[69] Sathar et al, *Adolescent and Youth SurveyPakistan, 2001-2002. 2003.* pp 104; 87-88

[70] Pakistan Contraceptive Prevalence Survey 1994-95; Pakistan Reproductive Health and Family Planning Survey, 2000-2001

[71] Handyside Alan, Javeed Sarah, 1998, Pricing of Hormonal Contraceptives in Pakistan Social Marketing Programs, Options Consultancy Services on behalf of DFID

[72] Government of Pakistan, *Economic Survey 2002-03*

[73] At present Pakistan is a low prevalence country (<0.1 percent of the adult population), it is considered to be at high potential risk because of its low literacy rate, socio-cultural barriers regarding sexual behavior, lack of awareness, misconceptions and disinformation, poverty, and gender issues.

[74] UNAIDS/WHO Working Group on global HIV/AIDS and STI Surveillance, February, 2000.

[75] Lahore based New Light AIDS Control Awareness Group, and Peshawar based NGO, Orphan Refugees and Aid International.

[76] UNAIDS, *Pakistan Country Profile 1999*

[77] UNFPA, Government of Pakistan, *Pakistan Population Assessment 2003*

[78] Ministry of Population Welfare, December 2002. pp. 37-38

[79] Hakim et al, 2002. p. 62

[80] PRHFPS 2000-2001. pp.36-37

[81] For example 65 percent of primary school teachers in Pakistan (1997-98) are men. (Mahbub ul Haq HDC 2000: 105)

[82] Exceptionally a few NGOs have adopted a policy of paid paternity leave for their male employees.

[83] *Aahung* in Karachi, Family Planning Association of Pakistan, Mary Stopes, and Message to name a few.
[84] *Pakistan Population Assessment*, 2003. p.15
[85] According to one thinktank, Social Policy Development Centre, poverty may be as high as 40 percent with one in every third household being poor. 2001. p.14
[86] *Pakistan Participatory Poverty Assessment, National Report*. 2003. p 108
[87] *Poverty Reduction Strategy Paper. 2004*. p. 101
[88] Ghaus-Pasha, Ayesha. Jamal, Haroon and Iqbal , M. Asif. Dimensions of the Nonprofit Sector in Pakistan. SPDC. 2002. p. 12