

Rising to the Challenge:

An analysis of the implementation
of MDG-5 in Pakistan



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Compiled by
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شیرکت گاہ
Shirkat Gah

WOMEN'S RESOURCE CENTRE

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Acronyms

ARH	Adolescent Reproductive Health
ADO	Aurat Development Organization
BHU	Basic Health Unit
CBO	Community Based Organization
CCB	Citizen Community Board
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
D&C	Dilation and Curettage
FP/RH	Family Planning/Reproductive Health
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IUD	Intra-uterine Device
KPK	Khyber-Pakhtunkhwa
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MRDO	Movement for Rural Development Organization
PAC	Post-Acute Care
PAIMAN	Pakistan Initiative for Mothers and Newborns
PDHS	Pakistan Demographic Health Survey
PRHN	Pakistan Reproductive Health Network
SG	Shirkat Gah
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THQ	Tehsil Headquarters
UC	Union Council
UNICEF	The United Nations Children's Fund
UYWO	United Youth Welfare Organization

Glossary

Biradari: extended family

Dai: traditional untrained birth attendant

Dum: a special prayer said by holy person which is meant to have the power to heal

Ghee: clarified butter

Hakeem: a medical practitioner using traditional remedies

Hari: serf

Hikmat: traditional practice of medicine

Jinn: supernatural spirits

Jirga: a decision making assembly of male elders

Madrassa: religious school

Molvi: religious teacher

Murraba: measurement of land (equal to 25 acres)

Nazim: chief elected official of a local government

Panchayat: local conflict resolution committee

Parchi: doctor's prescription

Pir: religious soothsayer/holy man

Purdah: literally 'curtain'; the practice of secluding and segregating women; sometimes used for the veil

Safai: dilation and curettage (D&C) procedure

Shalwar: baggy trouser

Taveez: printed religious verses to be worn on the body to cure or prevent health and other problems, amulet

Unani: traditional healing system prevalent in the Middle East, India, Pakistan, and neighbouring countries

Waqfa: spacing between children

Watta satta: exchange marriage system



Executive Summary

As part of a larger Women's Empowerment and Social Justice Program, Shirkat Gah undertook a project to monitor the implementation of Millennium Development Goal-5 (MDG-5) in Pakistan. Among other planned interventions of the project, one was a qualitative research component. Initially the qualitative research was conducted at eight sites (4 rural and 4 urban) in four districts i.e. Multan, Charsadda, Dadu and Jaffarabad across the four provinces of Pakistan to identify and highlight gaps/obstacles in the implementation of programmes on achieving MDG-5, linking unsafe abortion to maternal health, accessing and claiming Family Planning/Reproductive Health (FP/RH) services, RH needs of adolescent females and linkages between positive RH/health outcomes and girls continuing secondary school. Later, for control purposes and increased credibility of the findings, Shirkat Gah added a rural site in four other districts, one in each of the four provinces, where no government/non-government project/programme, in addition to the regular services, existed, all the while maintaining the research methodology, research questions and focus of investigation.

Case studies of women in different age groups were also undertaken in all four provinces to contextualize the research with real life stories. The research generated four provincial reports. This is a synthesis of these reports with an analytical component highlighting critical questions raised by the research.

The significant findings of the research were that the defining factors for positive reproductive health outcomes were socio-economic status, education and to a lesser extent, residence in an urban centre. For those who were poor, uneducated or who lived in rural areas, the determinants were largely the same irrespective of which province they belonged to or whether their area had an intervention carried out in it or not.

It may be stated at the outset that from a purely factual perspective, the research does not add any new information to that which is already in the public domain. The problems have been repeatedly identified and the solutions are available. However, as demonstrated by this research yet again, the bridge between the problems and the solutions remains as wide as ever. The dilemma indeed is the failure to move beyond this impasse and the most important

finding of this research is perhaps just the fact that nothing has changed.

The added value of this research therefore lies in the fact that it draws attention from ‘content’ to ‘context’. Researchers, donors and policy makers often put too much emphasis on isolated interventions and programmes and fail to see the broader picture. This research has shown that while isolated interventions make a marginal difference, the quality of lives for the majority of the population remains unaffected. With the absence of meaningful support from the State people fall back to traditions, indigenous solutions and informal social support networks that have been serving them for generations. In many cases these age old traditions and customs are perpetuating inequalities or skewed power dynamics of caste, socio-economic class, feudal hierarchies and gender.

This research highlights the reality of women’s lives with a particular focus on issues related to reproductive health. It describes their support networks, their coping strategies and the harshness of their lives. It demonstrates that to make a meaningful difference the state will have to look at cross-sectoral reforms as well as consider specific measures identified in the report. It will have to assume its constitutional duty and responsibility to look after its citizens, particularly its weak and vulnerable ones who are being continuously exploited by the powerful in the society. Piecemeal interventions will only waste precious resources and not make a dent in the indicators which are not only stagnant but now beginning to show a dangerous negative trend.

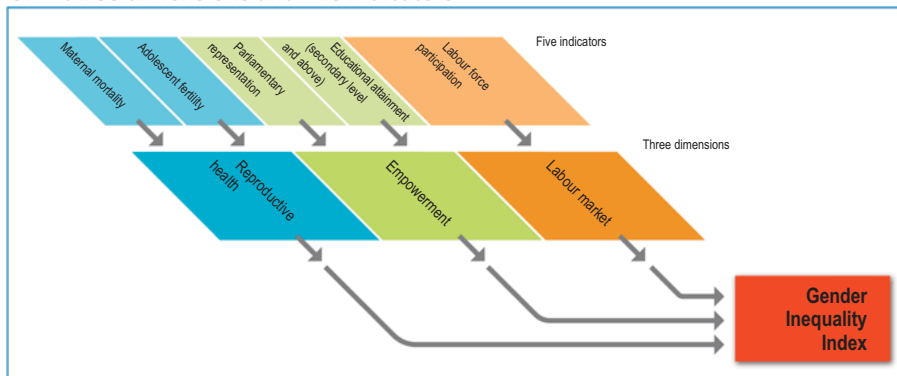
Introduction

Numerous developments have taken place over the last few years and contributed to the transformation of the social, political, and economic landscape of Pakistan, consequently impacting the outcomes of Pakistan’s Millennium Development Goals. The country’s economy is deteriorating and an increasing number of people are falling below the poverty line. The burden of poverty is distributed disproportionately among families, with children and women affected most, the feminization of poverty being a well-recognized phenomenon. Demographically, Pakistan is experiencing a significant ‘youth bulge’ with 60% of the population below 30 years of age. Among the young population it is girls that suffer a disadvantage in terms of education, health and employment. This inequality is reflected in the Gender Inequality Index in which Pakistan ranks 115 out of 145 countries.

Table 1: The Gender Inequality Index 2011

Components of the Gender Inequality Index (GII)

GII—three dimensions and five indicators



Source: Human Development Report 2011

Pakistan has aligned its poverty reduction strategy to the MDGs and is committed to meeting the targets by 2015. Already in the twelfth year of the MDGs, it is time to take stock of the progress made so far especially for MDG-5, since maternal health in Pakistan has been an important but difficult goal to achieve.

According to *Pakistan Millennium Development Goals Report 2010*, the key findings for the indicators of MDG-5 are as follows:

The maternal mortality ratio declined from 350 in 2001-02 to 276 in 2006-07.

The share of deliveries attended by skilled personnel, which was already quite low (48% in 2005-06) has gone down substantially to 41% in 2008-09.

The contraceptive prevalence rate (CPR) is given at 30%, considerably short of the MDG target. More worryingly, studies show that the trend may be becoming negative. The *Status of Women, Reproductive Health and Family Planning Survey* of 2003 showed an increase in contraceptive use among currently married women to 32 percent. However, the latest *PDHS 2006-07* indicates stagnation in contraceptive use with the CPR falling slightly to 30 percent. In the early nineties contraceptive use rose at a rate of 2% per annum, this rate fell by half to about 1% a year and has recently gone even lower.

The total fertility rate stands at 4.1 births per woman. According to a report on the status of family planning in Pakistan (Sathar and Zaidi, 2010), Pakistan has been the last among all its neighbours to experience fertility decline and continues to have the highest rates. At the time of its inception, Pakistan's total fertility rate (TFR) of 6.6 births per woman fell between India's TFR of 5.9 and Iran's TFR of 7 births per woman, and was the same as Bangladesh's TFR. All countries in the region experienced high fertility until the late 1960s, at which point India's fertility levels started a gradual but consistent decline. Bangladesh, with heavy investments in family planning programs, was the next to follow with the fertility rate beginning to decline rapidly by the early 1980s. Even Iran stepped up its family planning efforts by the late 1980s and started experiencing a very rapid decline in its fertility rate. Currently, Pakistan's TFR remains more than one birth higher than India's and Bangladesh's TFRs and around two births higher than Iran's TFR, which has reached replacement level despite starting just as late. Previous projections (Population Policy of Pakistan 2002) estimated Pakistan to reach replacement around 2020; however, given the current trends, these estimates have been revised and fertility is projected to reach replacement some ten years later than expected, according to the proposed Population Plan 2010.

The fifth indicator was regarding the proportion of women between 15-49 years, who had given birth during the last three years and had received at least one antenatal consultation. The figure stands at 58% with the MDG target being 100 percent.

The *Pakistan Millennium Development Goals Report 2010* admits that given the resource constraints and the slow growth of the economy it is unlikely the Pakistan would reach its targets on time.

Table 2: Current status of MDG-5 Indicators

Indicator	Latest available statistics	MDG-5 target by 2015
Maternal Mortality Ratio (MMR)	276	140
Proportion of births attended by skilled birth attendants	40%	>90%
Contraceptive Prevalence Rate (CPR)	29.6%	55%
Total Fertility Rate (TFR)	4.1 births per woman	2.1
Proportion of women 15-49 years who had given birth during last 3 years and made at least one antenatal care consultation	56%	100%

Source: The Pakistan Demographic and Health Survey (PDHS 2007)

To meet the target of reduction in maternal mortality ratio by 75% by 2015, global estimates reveal that the yearly required rate of decline is 5.5%; however, in Pakistan it has been less than 1% each year. Given the persistent negative ratio (105 males to 100 females) and falling CPR it is imperative to monitor the MDGs from gendered lens, especially the new target added to Goal 5 – ‘universal access to RH services’ – and its additional indicators of ‘unmet need for contraception’ and ‘age-specific fertility rate among 15-19 years old married adolescents’.

With this consideration, the project “*Monitoring the Implementation of MDG-5 in Pakistan*” undertook an in-depth look at issues of abortion, accessing and claiming of FP/RH services, RH needs of adolescent females and linkages between positive RH/health outcomes and girls continuing secondary school.

The current abortion law in Pakistan, which was amended in 1990, states that pregnancy can be terminated if carried out in good faith during the early stages of pregnancy in order to save the life of a woman or to provide ‘necessary treatment’ to her. There is ambiguity regarding the right of abortion in cases of contraceptive failure, rape and incest. Moreover, many providers are unaware that abortions are permitted to provide ‘necessary treatment’. Given the restricted nature of legal abortions, and the lack of publicity regarding the law, induced abortions are carried out clandestinely by unskilled providers in unhygienic and unsafe circumstances. The landmark Population Council study *Unwanted Pregnancy and Post Abortion Complications: Findings from a National Study (2004)* states that approximately one million abortions are performed annually with an abortion rate of 29 abortions per 1000 women of reproductive age and with one pregnancy out of six ending in abortion. The

study highlighted the fact that abortion is largely used as a means of family planning. In the absence of easily available contraceptives (inaccessible, financial constraints, objections by husbands, religious grounds) abortion, usually unsafe, is the usual recourse. Morbidity from unsafe abortion is very high and it is estimated to be responsible for up to 13% of maternal deaths (besides morbidity). The estimated number of women who experience serious health complications each year as a result of unsafe abortions is almost 197,000. In addition there are a high number of women having clandestine abortions who remain invisible because they do not present themselves at hospitals for treatment. This group is of rural poor women who suffer serious complications but who do not obtain hospital treatment mainly due to their lack of access to a medical facility and their inability to afford the costs of treatment. The situation is further compounded by the lack of proper post-abortion care (PAC) in the public and private sectors of the health care system for unsafe voluntary abortions, spontaneous (natural) miscarriages or risky abortions as a result of violence in an otherwise normal pregnancy.

According to the *PDHS 2006-07*, about half of the total female population is in the reproductive age group (15-49 years) and this segment has been growing over the past two decades, having an impact on overall population growth. Moreover, the current demographic trend points to a ‘youth bulge’, with approximately 50% of the population made up of people below the age of 20 years and the median age at marriage about 19 years (PDHS 2006-7). If these young people are neither educated nor informed on FP/RH they will not be equipped to realize their full potential on reaching adulthood. It is therefore imperative that simultaneous attention be paid to the RH needs along with educational ones of young people especially adolescent females.

Within the arena of adolescent reproductive health (ARH) the issues encountered by female adolescents range from the practice of early and forced marriages, low levels of contraceptive use, spread of sexually transmitted infections (STI including HIV), and violence, among possible others. Existing policies and programmes for adolescents and young people do not adequately address most of the above issues and do not seem to be based on the needs of female adolescents within and outside marriage. From communities, duty bearers, service providers to the youth themselves, all have inadequate information and/or knowledge of ARH problems or solutions. Lack of official interest in developing policies and schemes related to ARH undermines the ability of young people to claim rights and benefits, and obstructs the effectiveness of any positive measures.

The positive relationship between female secondary education and health outcomes is an established one, yet the low levels of educational achievement in women has not been given the attention it deserves.

The project in this context aimed to identify and highlight the gaps and obstacles in the implementation of MDG-5, linking unmet contraceptive needs to unsafe abortion, RH needs of adolescent females, documenting linkages between positive RH/health outcomes and girls continuing secondary school and mobilizing women to claim their rights for safe and quality services.

Along with the larger objective of awareness raising and capacity building at the micro and meso levels respectively, field research was undertaken in partnership with local CBOs at twelve sites (8 rural and 4 urban) across the four provinces to generate information regarding available services and good practices, the barriers in implementation and also the various social factors that obstruct/prevent the access of women and young women (both married and unmarried) to health services. Case studies of women in different age groups were also undertaken in all four provinces to contextualize the research with real life stories.

This report is a compilation of the four provincial reports generated from the field research undertaken in each of the four provinces. It attempts to bring all the information together as well as present a national overview and analysis of the situation regarding implementation of MDG-5 in Pakistan.

Added value of this report

It is perhaps safe to admit that this research does not reveal any new facts. Most health related statistics and information can be collected through a perusal of available resources on the internet or various previous reports. For the most part therefore it is a reiteration of already known facts regarding the status of health services, particularly those related to MDG-5. However, what it does add is valuable information regarding context, qualitative descriptions and indigenous coping strategies. Through an in-depth analysis it highlights the persistent inability to bridge the gap between the problems and the solutions. It illustrates the stark reality of an average Pakistani woman's life despite the millions of rupees being sunk into the health sector in her name and identifies specific areas for advocacy and policy change which can break the impasse, emphasizing the need for concerted political will to achieve change.

Structure of the report

The first section will provide a brief description of the geographical research areas and the methodology used. This will be followed by a section devoted to each of the main five themes on which the research was based, including a compilation and comparative analysis of information from the provincial reports. A lot of space is provided to case stories gathered from the field as they are direct testimonies and are a much more convincing evidence for the case put forward than any second hand analysis can be. The final section will consist of analysis, conclusions and recommendations.

The research process and its impact on CBO partners

Under the project, Shirkat Gah (SG) in collaboration with its 7 Community Based Organization (CBO) Partners working in selected districts in four provinces of Pakistan undertook several activities that strengthened their capacity. The project conceptualised as a participatory qualitative research envisaged the CBO Partners involvement from the very outset. For this purpose, the CBO Partners were given a two-week intensive training followed by a refresher session to enable them to conduct the research. The research findings once analysed were taken back to the communities along with the CBO Partners for sharing and subsequent development of advocacy plans in each site. CBO Partners were mentored in organising and participating in awareness sessions, theatre performances, and district policy dialogues with reference to the findings, as well as in engagement and consultations with relevant duty bearers with the objective of improving RH services and putting local concerns on the District planning and service delivery agenda. Their advocacy skills were built and further refined through advocacy campaigns. Most importantly, involvement in the process contributed to CBO Partners reputation as credible organizations working on RH in their respective districts.

The capacities of the CBO Partners were enhanced in the following ways:

- Improved Communication, Leadership Skills and Networking from community to UC and district level

It was reported by all the Partners that during the course of the project their

organization's networking especially with the Health, Population Welfare and Local Government Departments increased and this is something which is reflected by the presence of these departments in all the events organized by them. At the District Policy Dialogues most of the guest speakers acknowledged the fact that these organizations were in continuous liaison with them. Nisa Development Organization and Women's Resource Centre in Jaffarabad (Balochistan) said, *"Our communication skills have improved and we have had opportunities to interact with the varied, multi-level stakeholders."* Aurat Development Organization (ADO) in Nawabshah (Sindh) reported, *"Holding meetings with high profile district government officials and elected representatives and bringing them on board actually helped in elevating our leadership qualities."* A woman from Movement for Rural Development Organization (MRDO) in Mardan (KPK) who is also a Lady Health Worker (LHW) relates that, *"Now I am better able to communicate my messages to the women in my area and in motivating them to act on my advice."* Another female staff member belonging to United Youth Welfare Organization (UYWO) in Charsadda (KPK) shared her case by stating, *"During the course of implementing the project I have been recognized and whenever there was any problem related to FP or RH in the area people approached me and my popularity gained day by day. Seeing my acceptance among the masses different political parties offered their party membership to me. Now I am the Vice President of the Awami National Party Women Wing (Charsadda)."* Another case in point is of a CBO Partner in Multan (Punjab) - Roshni Organization - that took the initiative of opening up a new chapter of the Pakistan Reproductive Health Network (PRHN) and is acting as its focal point.

- Knowledge on RH and FP improved

Through awareness raising and capacity building sessions and theatre performances organized for the community, the knowledge of the staff of CBO Partners on RH and FP was enhanced whilst incorporating a rights based approach. Subsequently, ADO also requested for RH sessions for all its staff members. The District Social Welfare Council in Bhakkar (Punjab) shared that after the floods they succeeded in getting funds from US-Aid for a project on *"Improving Reproductive Health"* in six flood affected Union Councils of District Bhakkar. They acknowledged to SG staff that *"Our knowledge on RH that was built during the project helped us in implementing the activities of this particular project."*

All the Partners admitted that *it was through the project that they got the chance to know about the MDGs, more specifically what the goals and targets of MDG-5 are and the extent to which their provinces are lagging behind with respect to those targets committed by the government.*

- Credibility of the CBO Partners as organizations working on RH enhanced in their areas

In their respective districts, the credibility of the Partners as organizations working on RH has become stronger and on certain occasions they act as a resource for district data on RH issues for other organizations that are also working on RH. People from the community also approached them for solutions to their problems. *“Due to project activities especially that of research, our organization has been recognized in our district,”* said UYWO in Charsadda (KPK).

Change and impact: Communities

Given the findings that local women and men are poorly informed about RH, the awareness raising sessions (23) and theatre performances (11) organised covered the following areas:

The importance of pre and post natal check-ups; dangerous signs and complications during pregnancy; dietary requirements during pregnancy; myths about family planning; three delays in decision making processes leading to maternal mortality and morbidity; consequences of early marriages; puberty and the reproductive health needs of female adolescents; the concept of rights including reproductive health and rights; social determinants of health and the basic concepts of gender.

That these sessions including the medium of theatre touched local people may be gauged from the statements from various sites:

- Importance of post-natal care recognized

Acknowledging the importance of post-natal care and its connection with FP counselling a woman in Mardan (KPK) stated that *“women, at least once, must go for post-natal checkups as that is the time for planning the next child ... FP is better than abortion as the latter saps all the energy/strength from the mother’s body.”*

- Men in communities demonstrated greater support towards women’s RH issues

Becoming aware of women’s reproductive health issues they committed to taking care of women’s diet during pregnancy and viewing their pregnancies seriously by letting them go for ante-natal checkups and vaccinations. An elderly man in Bhakkar (Punjab) said that *he would send his daughter-in-law at least thrice for an ante-natal checkup*. During the District Policy Dialogue in Bhakkar the Deputy District Health Officer shared that the Government has funds for establishing a dispensary equipped and staffed for ante-natal checkups and vaccinations provided someone from the community donated space for it. In response, a local resident immediately stood up and announced his willingness to donate 2 kanals of his land which runs alongside the road for this purpose.

- Increased trend of institutional delivery; dispel the fear of C-Section

In a follow-up meeting of the awareness sessions, male members of the community in Bhakkar (Punjab) said, *“We learnt that in the case of an emergency we should be prepared beforehand for transport and save money in case of need for an operation. We should also stop relying on ‘Pirs’ or other spiritual healers.”*

- Theatre Performances: an excellent tool of learning and communication

UWYO in Charsadda (KPK) shared, *“Theatre proved to be an effective tool that assisted the community in initiating a discourse on sensitive issues such as FP and RH. These are the issues that people feel hesitant to talk about but nevertheless it was possible to mobilize them to work towards their solutions. It is a useful strategy for behavioral change.”*

The theatre performance in Bhakkar (Punjab) moved the community to such an extent, especially the male members, that they committed that, *“From now onwards we will give importance to girls’ education and marry them off at the right age with their consent.”* They

said, *“We have understood the consequences of early marriages and this was something we practiced earlier due to undue pressure from society.”* They further committed that *“We will not discriminate between daughters and sons as it is the root cause of such decisions.”*

A woman in Charsadda narrated, *“We have spent our lives aimlessly but our daughters have received a lot more information than us at this age from the theatre.”*

- Increased knowledge of males about different methods of FP

MRDO in Mardan (KPK) reported that after the session on FP and available methods for women and men their information was enhanced. A local husband decided to opt for FP and purchased contraceptives after consulting his wife.

- Apprehensions of mothers diffused and sessions with adolescents appreciated

Though separate sessions were organized for female adolescents in Mardan (KPK), mothers insisted on sitting with them as they were curious as to the content of the session. After the session their fears were allayed and they said, *“Everything was very useful and this information should also be shared with the mothers.”* The only disadvantage was that the daughters remained shy in the presence of their mothers and did not express themselves freely.

Research Methodology

Two districts were selected in each province - one in which an intervention in terms of services related to MDG-5 had been carried out and the other where only routine health services were present. In the intervention site further detail was sought by looking at an urban as well as a rural setting, while in the non-intervention site only a rural setting was selected.

The research carried out in each of the areas was qualitative in nature, using the life-cycle approach and Rapid Rural Appraisal tools like social mapping, well-being ranking, impact diagrams, as well as case studies, focus group discussions and interviews. Local CBOs worked as a bridge to the community and collaborated closely in conducting all the activities.

Table 3: Methodology details

Activity	Details
Duration of the study	Jan- May 2010
Overall sample	250 households for each site
Sampling technique	Households were selected by local CBO partners working in the area
Details of the participants	Married and unmarried, men and women (14-50 years old)
Methods of analysis	NVIVO and Manual
Ethical considerations	Oral consent was taken before each activity. Minutes reflect the consent
No. of FGDs conducted	(31 with men and 47 with women) = 78
No. of in-depth interviews conducted	(03 men + 126 women) = 129

Table 4: Sites selected for the research

Provinces	Intervention areas		Non-intervention areas
	Urban	Rural	
Punjab	District Multan		District Bhakkar
	Raza Abad	Garaywala	Nawan Gussu
Sindh	District Dadu Taluka Juhi		District Nawabshah
	Juhi Ward 1	UC Kamal Khan Sahib Khan Solangi	Nasri
Khyber Pakhtunkhwa	District Charsadda		District Mardan
	Muslim Mohalla	Nisatta	Khazano Dheri
Balochistan	District Jaffarabad		District Panjgur
	Gandakha city	Allah Bux Rahoja	Sorab



Sharing of research findings and developing advocacy plan. Village Sahib Khan Solangi, Taluka Juhi, District Dadu, Sindh.



Sharing of research findings and developing advocacy plan. Village Sahib Khan Solangi, Taluka Juhi, District Dadu, Sindh.



Well being ranking being carried out at Village Sahib Khan Solangi, Taluka Juhi, District Dadu, Sindh.



Women and girls enjoying themselves during an interactive theatre at Ward #1, Taluka Juhi, District Dadu, Sindh.



Social mapping exercise being conducted at Ward #1, Taluka Juhi, District Dadu, Sindh.



Women in District Charsadda, KPK, involved in an impact diagram exercise.



FGD on RH needs of adolescents female at Raza Abad, District Multan.



FGD on FP/RH services with women at Garaywala, District Multan.



Social mapping exercise being conducted at Nawan Gussu Village, District Bhakkar.



Programs for Achieving MDG-5: Availability, Accessibility and Quality

This chapter provides information on the status of implementation of programs for achieving MDG-5 in the selected areas. It also looks at the gaps and obstacles in the implementation of these programs and the various social factors that obstruct the access of women to health services.

A short summary of the situation in each province showed the following:

Khyber Pakhtunkhwa

	Nearest government facility	Nearest private facility	Informal health care providers	Interventions related to MDG-5
District Charsadda				
<ul style="list-style-type: none"> Muslim Mohalla 	<ul style="list-style-type: none"> -LHV -Dispenser (commonly known as doctor) -THQ hospital 15 mins away -MCH centre -Family Planning Centre 	<ul style="list-style-type: none"> Private clinics run by doctor who works at the THQ. A private hospital which is very expensive 		<ul style="list-style-type: none"> UNICEF opened temporary health centre in Nisatta for IDPs. Provided free medicines and referred patients to another health centre.
<ul style="list-style-type: none"> Nisatta 	<ul style="list-style-type: none"> BHU has a male doctor and closes at 1:00pm. Also has a nurse and LHV available 24 hours, much appreciated by community although men charged that she got condoms for distribution which she sold in the market 	<ul style="list-style-type: none"> Private clinics THQ hospital in Charsadda 		<ul style="list-style-type: none"> The centre was accessible for residents of Muslim Mohalla Duration of the project was 6 months.
District Mardan				
<ul style="list-style-type: none"> Khazano Dheri 	<ul style="list-style-type: none"> BHU, with a male doctor, closes at 1:00pm. Also LHV and one lady technician. 2 LHVs 	<ul style="list-style-type: none"> Private doctors 		

Sindh

	Nearest government facility	Nearest private facility	Informal health care services	Intervention in the area related to MDG-5
<ul style="list-style-type: none"> Juhi Ward 1 	<p>LHW who is mistrusted by men who say she sells the <i>ghee</i> tins provided by the govt. The women like her.</p> <p>Trained LHV at Taluka hospital but without lady doctor, ultra-sound machine, medicines, furniture or ambulance.</p>	<p>Male and lady doctors.</p> <p>The LHV in Juhi who also practices privately</p>	<p><i>Hakeem</i> who is very popular.</p> <p>Untrained <i>dais</i> one of whom admitted that three women under her care had died.</p>	<p><i>Dais</i> trained by PAIMAN. The men praised them but the women did not have any trust in them.</p>
<ul style="list-style-type: none"> Sahib Khan Solangi 	<p>BHU in UC Kamal Khan which has no doctor. An LHV comes once in 15 days. Not accessible at night because of transport problems and dacoits.</p> <p>No LHWs</p>	<p>Private doctor in Juhi city</p>	<p>Pir sahib</p>	<p>PAIMAN project run in UC Kamal Khan but nothing in village Sahib Khan Solangi</p>
District Nawabshah				
<ul style="list-style-type: none"> Nasri 	<p>BHU (non-functional, locked up)</p> <p>THQ hospital where there is no medicine and the lady doctor tells patients to come to her private clinic</p> <p>2 LHWs and 2 male CHWs for polio drops only</p>	<p>Private lady doctor in Qazi Ahmad (17kms from Nasri). Not easy to access at night.</p>	<p>General stores</p> <p>Dai, who is reportedly 100 years old and has to be carried to the patient.</p> <p>A local illiterate woman who gets men to buy contraceptive injections from the city and she administers them to the village women, without charging anything for her services</p> <p>Pir sahib</p>	

Balochistan

	Nearest government facility	Nearest private facility	Informal health care providers	Interventions related to MDG-5
District Jaffarabad				
<ul style="list-style-type: none"> Gandakha city <p><i>For complications nearest help is Larkana 150km, Jacobabad 170km or Shahdadkot 200km</i></p>	BHU with emergency ambulance (locals say it is used for shopping by relatives of doctor), male doctor, a lady doctor who comes twice a week from 9 to 2. LHV Trained dai 4 LHVs Family planning centre	Private clinics. Both BHU lady doctor and LHV have private practices	2 untrained dais, most sought after for home deliveries <i>Hakeem</i>	PAIMAN project: Rescue services for women in obstetric emergencies. Adolescent awareness activities.
<ul style="list-style-type: none"> Allah Bux Rahoja <p><i>For complications nearest help is Jacobabad 90kms and Shahdadkot 130km</i></p>	BHU, 2km away in Bagh Tel, with no doctor but 2 LHVs. Family Planning Centre	Compounder has a clinic	Untrained <i>dai</i>	
District Panjgur				
<ul style="list-style-type: none"> Sorab <p><i>For complications nearest help is Karachi which costs Rs.10,000 or Quetta in Rs. 5000.</i></p>	Civil Hospital Chitkan, 25 kms away, but doctors never present there. If they are there, they send patient to their private clinic	Private clinics in Chitkan run by government sector doctors	Untrained <i>dai</i> Religious/traditional healer	

Punjab

	Nearest government facility	Nearest private facility	Informal health care providers	Interventions related to MDG-5
District Multan				
• Raza Abad	2 LHWs. A dispensary 1 km away and Nishtar Hospital 4 km away	Two private clinics	A dispenser and a technician run practices as doctors. Two practitioners of black magic.	PAIMAN input in Nishtar hospital: labour room, ORT counters, well baby clinic, training room etc.
• Garaywala	2 LHWs and vaccinators BHU Binda Sandeela 6 km away. Has male doctor, LHV and support staff, but underutilized due to distance and transport. Nishtar Hospital 8kms away	Hospital run by welfare organization, which is partner of PAIMAN. Provides ante-natal, family planning and delivery services. Another private clinic, with LHV and on call doctor. Facility for C-sections.	Several quacks, untrained <i>dais</i> , <i>molvis</i> and Hafiz <i>sahib</i> for 'dums' and 'taweez'.	BHU upgraded by PAIMAN. Trainings of mid-wives and doctors. Provision of ambulances. Awareness raising activities.
District Bhakkar				
• Nawan Gussu	2 LHWs BHU Khansar 11kms away. Location inconvenient to majority of population but politically expedient. DHQ Bhakkar hospital 40km away	Private clinics located outside the village. Brig. Shafeeq Memorial Trust Hospital in Bhakkar city, blood test, C-sections.	4 homeopathic doctors, 2 <i>hakeems</i> , a dispenser and 3 untrained <i>dais</i>	

The determinants of utilization of reproductive health services

“All happy families are alike; each unhappy family is unhappy in its own way.” The opening line of ‘Anna Karenina’ by Leo Tolstoy.

Despite the different geographical locations, the picture in all the four provinces was quite similar. The gaps, obstacles and social factors affecting the implementation of programmes for achieving MDG-5 in each of the provinces were generally the same. **The determinants for positive RH/health outcomes were socio-economic status, education and an urban location, while province and the presence or absence of interventions did not seem to make any difference.** Thus women living in urban areas and those with a secondary education were marginally better off and in every area, the financially well off seemed to exist in a separate world.

This information ties in well with the fact that the poor mostly reside in rural areas and national data shows that RH facilities in rural areas are four times the distance in urban areas. The average distance to an RH facility in rural areas was 12 km in 2001. Moreover, the results from 2007 data show that the private sector, which is not free and seldom located in far flung rural areas, is increasingly becoming the source of method for users (Sathar and Zaidi, 2010).

For the majority of the population therefore, the main issues were those of poverty, lack of transport, as well as non-functional, under-staffed and under-equipped government facilities, which were rife with corruption and plagued with the problem of dual practice by government doctors, dispensers and LHVs, who ran lucrative private practices at the expense of their official duties. The private sector was expensive and unregulated. When formal services were found to be inadequate people resorted to indigenous coping strategies, falling back on traditional support mechanisms. Lack of awareness fed on illiteracy, superstition and belief in pirs. Traditional norms and religious beliefs worked in most cases to reinforce discriminatory practices affecting women and girls and further limiting their chances of getting good medical care.

In terms of social barriers, the status of women, their lack of decision making authority and patriarchal customs were the common factors deterring women

from using appropriate health services.

“Allah ki marzi hai, mard ki marzi hai, mard kehta hai ke aik subha paida karae aur aik sham paida karae. Us ko kisi baat ki fikar nahin hai, is ko takleef nahin hai.” (A woman from a control site, District Nawabshah, Sindh)

“It’s God’s will, men’s will. Men say we should bear one child in the morning and one at night. They have nothing to worry about, they bear no pain.”

“Mard to poochta nahi hain aurat ke jitney bhi bachay ho jaen, paida karti hain aur mar jati hain, roti peetti kaam karti. Mard ko apnay kaam se matlab hai.” (A woman from intervention site, Sahib Khan Solangi, District Dadu Sindh)

“Men don’t care how many children women have. They are just concerned with their own work. The women bear the children and die, they keep crying, but still they have to work and continue.”

Early marriages were the norm in all rural areas. Generally there was a large age gap between the husband and wife. In Punjab, the custom of *watta satta* or exchange marriages was common, while in Sindh, Balochistan and KPK, asking for a bride price was an oft quoted practice.

“Hamaray gaon mein wattay sattay ka riwaj hai. Agar main apni behen ko zameen ka hissa doonga to meri bivi bhi lekar aye gi, is liyay hum hissa nahin detay.” (A man in District Bhakkar, Punjab)

“Our village has the custom of exchange marriages. Only if I give a share of the inheritance to my sister will my wife bring it, therefore we don’t give shares.”

Education was a luxury few women in rural areas were provided. Primary schools were present in most cases and girls attended these where possible, but they dropped out as they grew older, because of distance, transport, security issues and social disapproval.

As far as satisfaction with the services was concerned, generally people were

dissatisfied but the sentiment varied in the four provinces.

KPK seemed to be the best as far as people's satisfaction was concerned. Even the rural areas had better government services and the private options were accessible and affordable. While the factors of *purdah* and physical mobility were more pronounced here the women seemed relatively better served than in the other provinces.

Sindh and Punjab were similar, in that issues of distance, transport and poverty were predominant in the rural areas. Balochistan painted a similar picture but district Panjgur had a unique aspect in that political sentiments for separation from Pakistan were rife there. This impacted on health services in several ways. The people preferred to use Iranian medicines and family planning products because Pakistani products were considered poor quality and the services provided to them inadequate and unfair. A respondent said there were only two lady doctors to cater to a population of 400,000 people and even these forced patients to come to their private clinics where they charged exorbitant fees. People felt that services would not improve until Balochistan seceded from Pakistan. Women refused family planning because they wished to have as many children as possible with minimum amount of gap in between so that they could grow up to be freedom fighters and go up into the mountains to fight for the freedom of Balochistan from Pakistan. One woman who had six children and wanted more said she was going to ask her husband to marry again, so that he may have more children with his second wife.

“Ham balochon ki nasal-kushi ki jarahi hai, agar hum khandani mansooba bandi karen to is ka matlab hum khud bhi baloch ki nasal-kushi kar rahe hain”.(Panjgur, Balochistan)

“The Baloch are being subjected to genocide. If we practice family planning, we would contribute to that.”

The law and order situation was a factor in Punjab too, but it was of a more serious nature in Sindh where the fear of dacoits was a major obstacle to accessing health services at night.

There were extreme cases where multiple factors combined to end in tragedy...

Panni, Sindh

Panni (Panah Khatoon) was a young mother who died soon after giving birth. This is her story as narrated by her mother, resident of Sahib Khan Solangi, a village in Dadu district. The village has no health services other than that of the local *dai*. There is a building for a government hospital but it is not functional. The landlords here own their private transport but the poor have none. They usually take paid rides on private trucks or cars to reach the nearest town. The security conditions of the town are very bad with frequent robberies at night and even cases of murders.

“Panni was married off the very next year after her menses initiated. She was married into a household with four brothers in law and three sisters in law. Her husband was a ‘*hari*’ and earned a total of Rs.150 as daily wages. The older members of the family worked on a regular basis and the younger ones herded cattle. Panni soon started to complain of intense headaches. We thought that she was under the influence of some *jinn* and we took her to many places for treatment but to no avail.

She became pregnant three years after her marriage. During her pregnancy Panni suffered from prolonged episodes of difficulty in breathing as well as headaches and she was taken to a private as well as a government hospital. There she was given various injections and medicines that provided some relief. At the time of delivery the family called in the local *dai* and Panni gave birth to a dead baby.

She did not conceive for another four years. During her second pregnancy she was initially fine and happily did all the household chores but as the pregnancy proceeded she started to feel extreme weakness. The second delivery was also conducted at home by the same *dai*. This time Panni gave birth to a baby boy who was healthy at the time of birth (he suckled milk). However, a few hours later Panni started to feel breathless, “I cannot breathe”, she complained again and again. At the same time her baby also became ill (reason not known) and died. Soon her condition worsened. It was night time and there was no doctor in the village. We tried to take care of her and managed to feed her some rice. She ate a little but could not go on and soon afterwards she lost the battle for her life. We had no means of transport and could not take her to the town hospital.

I still think that if there was a doctor in the village or a trained *dai*, we could have saved our Panni. Only if it was not night but day we could have taken the bus to the city hospital. But then she was also cursed with the *jinn*. We got her so many *taveez* (printed Quranic verses worn as a locket) but may be she was destined to die so early.”

Panni and her family were uneducated and poor. Her village lacked health services. During her second pregnancy major health issues were identified but the delivery still took place at home. Long distances, lack of transport and late hours all contributed towards this decision. Panni's young age at marriage was another factor that complicated matters for her physically as well as psychologically eventually resulting in her untimely death and the death of her baby. Her family was superstitious and blamed a jinn for her illness instead of getting prompt treatment.

Ayesha, Sindh

This is Basheeran's account of the life of her daughter, Ayesha.

Ayesha had not been well as a child. When she was about 6-7 years old she had been taken over by a spirit. Her arms and legs would contract as she would have violent convulsions that would make her scream. As her breathing became laboured and eventually stopped, she would lose consciousness. She was taken to a *Pir*, a spiritual guide, for a solution. He gave her *taweez* with Quranic verses inscribed upon them. These would fix her, he said. As far as Ayesha's family was concerned, this was no matter for a health professional, hence they never consulted a doctor on the subject. Her soul had been captured by a spirit and there was nothing any doctor could do about it.

At the age of 16, Ayesha became a part of her paternal uncle's household when she was married, on an exchange basis, to her cousin Shabbir, who worked as a peasant. Thus began a new life of undergoing torment at the hands of her in-laws. Not only was Ayesha made to do inhumane amounts of work by her mother-in-law, she was not allowed enough food to fill her appetite. Her husband's attitude towards her was lamentable. That he did not love her was blatantly obvious. He would routinely tell her to get out of the house and physically abuse her at the behest of his mother. However she would hide this from her parents and brother so as not to cause problems between the two families. He would not speak to her, accept meals from her or be intimate with her. Ayesha conceived a child for the very

first time, but there was no hint of their cruel behavior letting up. Her mother-in-law, Zainab, birthed the first child herself despite having no training as a *dai*. The child was dead at birth. That very month Ayesha became pregnant again. This child was also stillborn. All this time, no one took Ayesha to get medical help. Her own family members were poor and were not able to muster up the resources necessary to seek medical help. Her in-laws were just as poor, but additionally had no desire to do so. The people of the village claimed she did not even require medical help.

When Ayesha became pregnant for the third time, her in-laws threw her out of the house and told her to go have her child at her parents' house because they could not pay for the possible complications or for her treatment. Ayesha was indeed ill but could not get treatment. When, at her parents' home, she began to have contractions at night, her delivery was assisted by her stepmother Zainab, who was a *dai*. This time she gave birth to a stillborn baby girl. After delivery, unable to voice her complaints, Ayesha continued to groan in agony. Her family members desperately awaited dawn so they could arrange for transport, but she died waiting, in the course of the night at the age of twenty.

This case illustrates the lethal combination of poverty, illiteracy, faith in pirs, violence, lack of health services and lack of transport.

Ruqqaya, Bhakkar, Punjab

Ruqqaya died in childbirth at the age of 25. This is her story.

Ruqqaya was 20 when she got married. She had studied till matric. She did not conceive in the first couple of years of her marriage. Her husband's family took her to a *pir* for *taweez* and *dum*. She eventually conceived, but got no check-ups or immunization. She remained fine until the final month, when she started getting fits. She would fall unconscious, start trembling and foam would start coming out of her mouth. They took her to Civil Hospital, Bhakkar, which was 45 kms away and were told that she had high blood pressure. The baby was delivered at the hospital and they came back home and she was fine.

Three years passed and again she couldn't conceive, They went to get a *taweez* again. In the intervening years, Ruqqaya had undergone training to become an LHW and had started work at Khansar. So she regularly got herself checked by the LHV at the BHU and got the tetanus toxoid immunization. In the eighth month, she went to a

private doctor in Bhakkar to get her blood pressure checked and get an ultrasound examination. The blood pressure was high and the doctor gave her medicines and told her to reduce her salt intake. Ruqqaya followed her advice and felt better. Near the due date, one night she started feeling dizzy. A local doctor (quack) was called who checked her blood pressure and gave her a tablet to keep under her tongue. She vomited twice and her labour pains started. She was sweating heavily and her legs felt weak. Her husband hired a private car for Rs.700 and they reached Civil Hospital at around ten in the morning. The lady doctor came and checked her once. The nurses kept checking the blood pressure and saying it was okay and that there was still time for the baby. Ruqqaya was getting severe pains and sweating profusely. The nurses put her on a drip and gave her a few injections. The doctor who had come in the morning did not come again. She was in the hospital but whenever she was called she would say there was still time for the baby and she would come for the delivery. At around five in the evening the nurses shifted Ruqqaya to the labour room. The family members went to call the lady doctor but she said her duty time was over and they should call the doctor who would be replacing her. The nurses kept calling her, but she was late. About fifteen to twenty minutes later Ruqqaya passed away. The nurses had not touched her during this time. Another doctor whom the family forced to come and look at her, said her blood pressure probably went too high.

During her last few minutes, Ruqqaya had realized she was dying. She asked her family to take care of her daughter and said that during the last ultrasound examination she had found out that she was carrying a son but she hadn't told anyone because she wanted it to be a surprise. Her sister-in-law who was standing next to Ruqqaya when she was dying, said she could feel the movements of the baby even half an hour after she died. But then they stopped. She said if there had been a facility closer to home or the doctor had come on time, they could have saved Ruqqaya or at least her son. But it was not to be. May be that was God's will.

This story is one of lack of accountability and poor services in government hospitals, faith in pirs, unregulated private care where a large number of quacks practice unchecked, lack of proper antenatal care and failure to identify high risk cases.

Transport is a major issue in rural areas, as illustrated by the following case story:

Fatima, Allah Baksh Rahooja, Balochistan

“My name is Fatima and my husband’s name is Saifullah Rahooja. He is a relative of mine and works as a bonded labourer. I am uneducated and have lived in this village all my life.

A few months into marriage I conceived and had a baby girl. A year later I had another child who was born quite weak. My third and fourth pregnancies also went smoothly, although in the fourth pregnancy I lost much blood. I did not use contraceptives between any of my children. The fifth pregnancy was progressing smoothly until one day I began bleeding heavily. Unfortunately, it turned out that I had a miscarriage; therefore, I went to the doctor for *safai* (D&C procedure). There the doctor advised me to refrain from conceiving. We were not careful and two months later I was pregnant again. In the ninth month I went into labour and was having shooting pains so my husband went to fetch the *dai*. My case appeared to be complicated, so she refused and advised I should go to the hospital. It was late at night and there was no transport available in the village to take us to the nearest town. In this emergency, my husband and my mother-in-law helped me into the donkey cart and we were on our way to Bagh Tale. Since I was in labour and could not reach the hospital in time, I ended up delivering the baby en route. Sadly, my child did not survive by the time we reached the hospital. After receiving the necessary medical attention we later returned home and buried the child.”

Poverty is pervasive and one of the greatest determinants of utilization of health services:

Arbab, Jaffarabad, Balochistan

“My name is Arbab and I was born in this village. I was married at the age of fourteen and have seven children, five boys and two girls.

In our house both the men and women are labour workers and work on landowners’ farms. I too fully contribute in all the household chores. My day starts at about 6 a.m.; after I complete my household

chores I head out onto the farms. I return at about noon and feed the animals. After that I start preparing dinner for the evening. I have to work outside and inside the house like a machine. However, I am very thankful that my mother-in-law is quite supportive. She looks after the children when I am out working.

I wanted to give a *waqfa* between children, but we did not have access to family planning services nor did I have the money. All of my children were born through the assistance of the local *dai* because we can barely afford to eat twice a day, let alone afford a doctor's fee. Due to malnutrition my children often fall sick. Therefore, I am forced to ask others for help in obtaining medicine.

One day, during the ninth month of my pregnancy, while I was working on the farm I went into labour. My sister-in-law rushed to fetch the *dai*. By the time she arrived I had already delivered the baby. The *dai* only had to cut the umbilical cord and she still charged Rs.500. My last child is quite weak and his health is deteriorating quickly. Because we are poor my family is not able to afford to take him to a doctor. I fear for his life."

Lack of services, poverty and distances are common issues:

Abida, Sorab, Panjgur, Balochistan

"My name is Abida and my husband's name is Kifayatullah. I am thirty years old and I got married at the age of eighteen; I have four children. My husband is a *Molvi* in a local *madrassa*.

My first child was a boy who was born a year after our marriage. One year after his birth I had another son and then my third child was a girl. My first child was born in Chatkan under the supervision of a lady doctor. The remaining three children were all born at home. At the time of my fourth pregnancy I had become quite weak. In addition, my legs and back would ache constantly. I even asked my husband to take me to Chatkan for delivery; however, he said that he could not afford to. The transportation cost is Rs.2000 and the lady doctor's fee was between Rs.5000 and Rs.6000 for the delivery. As a result, I had my delivery at home and it turned dangerously complicated. The bleeding would not stop; therefore, my husband requested the neighbours' transport and we went to Chatkan. The doctor there even failed to stop the bleeding, so in an emergency situation I had to be rushed in an ambulance to Karachi's Jinnah Hospital. There I was able to get proper medical attention and the doctor was successful in

stopping the bleeding. I had turned quite pale from this ordeal and was not hopeful that I would survive. I am fine now, but occasionally my back aches. This incident occurred about three months ago and my child is fine now. The doctor mentioned that if the delivery had taken place at a hospital I would not have had to suffer in such a manner. Unfortunately, we do not have these facilities available here in the village. Additionally, we did not have transportation money to go to Chatkan. It would be a huge relief if proper health care facilities were provided to us in the village.”

Lack of decision making authority, violence, bride price: a reminder that the context within which health interventions are made cannot be ignored:

Haseena, Juhi, urban Sindh

Haseena was promised in marriage to an older man in exchange for Rs.20,000 when she was too young to even remember it. All she remembers of her own engagement is the joy of getting new bangles. Growing up, she remembers the elders whispering amongst themselves, saying she should be handed over to her in-laws since the money had been received. Getting her first period was a difficult time as she was too ashamed to tell her mother until there was excessive flow and she had no choice.

At a very young age (like many other girls there was no record of the year of her birth) her father married her off. She did not wish to leave but, like her other sisters, she had no choice in the matter. Soon after, her in-laws started pressurizing her to see midwives and doctors to ensure conception, indifferent to her pleas that she was too young to conceive. Seven months after her wedding she conceived for the first time. Her in-laws were content, but continued to mistreat her as they felt no obligation towards her because she was a bought “item”. Her husband was of no support to her either. He worked at a restaurant and earned Rs.400-500 per day out of which he gave her around Rs.30-40 every day.

During her first pregnancy she suffered severe backaches. She used to scream in agony and by her fourth month was almost paralyzed with pain. Since a female doctor was unavailable, she was taken to a male doctor, Dr. Hamid, in Dadu who diagnosed that the foetus was not developing normally. After several check-ups and ultrasounds, she gave birth to her daughter at a government hospital in Dadu. The child died after two days. Haseena was treated for forty days after which

she busied herself in household chores. After two months, she was pregnant again and after she suffered excessive pain for a month, the child died in her womb. Dr Najma at Civil Hospital, to whom she was referred by Dr Hamid performed a D&C.

Being physically weak, she is easily tired by work. In addition to household chores she sews clothes to supplement her husband's limited income. This gives her a constant backache but her husband refuses to take her to the hospital as it will be an additional financial burden. She cannot use her own money either because all of it has to be spent on the family.

She is now pregnant for the third time and despite the pain her husband is still not allowing her to go to the hospital. She consoles herself with the idea that he fears for her peace of mind and doesn't want her to get troubled because of potentially worrisome reports by the doctors. As he insists that he has left everything to the will of God, she too tries to make peace with her circumstances.

She finds temporary happiness when her in-laws treat her well. Mostly though, she wants to kill herself because they abuse her. She believes her life is not worth living. She has no independence or the power to make choices and feels that she has to beg for the fulfilment of even the most basic needs. She only visits her mother's family when her brother comes to pick her up because her husband never takes her, and then too she is not allowed to spend the night.

Her family gives no importance to the needs and wants of the women of the household. Her deteriorating health is disregarded. She lives in constant fear of losing her third child as well.

Social and cultural discrimination, early marriages, physical burden of work and a poor diet all combine to determine the health status of women:

Kausar, Bhakkar, Punjab

Kausar comes from a family who owned a *murraba* of land, so in a way they were slightly privileged. However, they did not have a tube well and so their crops were dependent on the rains. In the years when it rained their crops were good but in the ones that it didn't they faced hardship. In her family it was not the custom to give inheritance to girls. She said she knew that in Islam women got a share but in her family girls are not greedy and the brothers are not that well off.

Moreover, they had given all the sisters as much as they could when they got married so they had all voluntarily given up their right to inheritance in favour of their brothers.

Kausar was married at the age of 15 as part of a *watta satta* arrangement. After her second child, her husband married again and took away her children. Her parents then married her to another man with whom she had a further five children. All her children were born at home with no antenatal check-ups or immunizations. She tried contraception but she had to walk 20 kms to go to a *dai* recommended by women in her village. The *dai* inserted a tube (an IUD) which didn't suit her and she developed complications. She then had to walk all the way back to get it removed. Now she uses condoms which the LHW supplies.

She says the women in her village are overworked. They had to do all the housework, look after the children and the animals and also work in the fields. Whatever they earned from working in the fields was spent in day to day expenses. The women never got to eat a proper diet.

However, if one has money lives can be saved anywhere - irrespective of province or rural-urban status and despite the constant factors of illiteracy, traditional beliefs and lack of local services:

Gul Sultana, Khazana Dheri, Charsadda, KPK

"I am 25 years old and belong to Dir. I got married in Khazana Dheri, Charsadda. When I was 17, I got a proposal to which my father agreed. In our custom, the bride's family takes money from the groom's family and buys things for the dowry with it. I was the second wife of my husband. His name is Zahir Gul and he is employed in Saudi Arabia. He did not have any children from his first wife and she also used to live with us. When I did not conceive in the first two months, my mother-in-law told me I was infertile too and took me to a doctor in Mardan. He gave me some medicines which made me vomit a lot, but there was no pregnancy. Then they took me to another doctor in Charsadda. She was angry with my mother-in-law telling them there was nothing wrong with me. But my mother-in-law insisted that she give me some medicine so that I conceive quickly as my husband had to leave for Saudi Arabia soon. She just gave some pills which made me sleep a lot.

My mother-in-law used to quarrel with me all the time. Then my husband took me back to the same doctor in Charsadda. She did a

vaginal examination and said that the vagina was closed. She did a surgical procedure to open it and I conceived a month later. I had the baby in Mardan hospital and everyone was very happy because it was a boy. The delivery cost Rs.2000. When my husband came back next year, I conceived again and had another baby. At that time I had no information about family planning but then a LHW started visiting our homes and she told me the different options. I chose depot injections and started using them, but they are only effective for three months and I forgot my dates and did not get the injection on the required dates. As a result I got pregnant again and now I have three children. However my husband and I have decided that our family is complete and we don't want any more children. So now I intend to practice family planning carefully so that my three kids can get an education and lead successful lives."

Khursheed Bibi, Nawan Gussu, Bhakkar, Punjab

Khursheed is 22 years old and is illiterate. She was married at the age of 16 to her uncle's son as part of a watta satta arrangement. Her husband owns a poultry farm. She didn't conceive for a year and a half and her mother-in-law began taunting her, so her husband took her to Bhakkar to see a doctor. He took her on his friend's motor bike. The doctor took Rs.500 for parchi, Rs.250 for ultrasound and Rs.200 for an injection and medicine came for Rs. 500. She became pregnant five months later. During the pregnancy she went to the same doctor for check-ups about five times. Every time her husband would take her on a motorbike. She got her tetanus toxoid immunization for free from Khansar. Her daughter was born at home by a dai. She said she took care of her diet during her pregnancy. She used to eat meat and drink milk and even stopped doing household chores. Even for the first forty days after the birth she took special care of her diet.

After the birth her husband said she was very weak so they should have an interval before the next baby. So now she uses pills as well as condoms. The LHW comes home and provides the pills, condoms and also capsules for strength. She comes twice or thrice a month and if someone needs something in the meantime, they can go to her house and get it. She got pregnant again after three years. This time her husband took her on a motorbike to Munkeera which is 40km away. The doctor charged Rs.500 for the parchi and Rs.150 for the ultrasound. The medicines came for Rs.800. She got the immunization from Khansar. At the time of delivery, the pains continued the whole night. The dai finally said they would have to

take her to the hospital, so they hired a car (which cost Rs.1000) and took her to Civil Hospital. Another daughter was delivered there. The hospital didn't charge anything for the delivery but the nurses had to be given Rs.500 for mithai (sweets) and their medicines cost Rs.600/-.

Now she prays that God may give her a son next time because then she could get an operation to stop children, but if she got a girl, then they would have to continue having children till they got a son.

Zeba, Sorab, Panjgur, Balochistan

"My name is Zeba. I am twenty eight years old and have been married for six years. My husband is employed in Saudi Arabia. I have never been to school.

I didn't conceive for four years after my marriage. People in the village started to gossip and even my mother-in-law wanted my husband to marry again. I tried the local Balochi fertility treatment but it did not work. Then I decided to go to a doctor in Chitkan and she treated me for three months. I followed her advice and took the prescribed medication religiously. Thank God I finally became pregnant. During the pregnancy I regularly kept going to the doctor for check-ups. However, when my delivery date drew closer, the doctor said I would need an operation and she could not handle my case. She advised that I should go to some city hospital. Therefore I decided to go to Quetta for the delivery which is very expensive but thank God my husband could afford it. My child was delivered safely there. Now I am pregnant again and continue to have my check-ups with the same doctor in Chitkan.

I am so grateful to her because if I had not got the treatment, surely my husband would have married again. I just wish that we had a doctor like her in the village because so many poor women are not able to travel to Chitkan for treatment."

Linking Unsafe Abortion to Maternal Death

Abortion is a reality

In all areas surveyed the first response to a question about abortion was that it was a sin and an act to be avoided.

*“Bacha zaya karwanay ko qatl jaisa gunah samjha jata hai.”
(A woman from Village Garaywala, District Multan)*

“An abortion is considered a sin akin to murder.”

However, there were circumstances where it was thought to be acceptable, for example, to save the life of the mother. There also seemed to be an effort to obfuscate the issue, either to assuage the associated guilt or to rationalize choices by deliberately mixing spontaneous abortions with induced abortions. Women vehemently condemned abortion but said it was unavoidable when bleeding started or the baby died in utero.

“Khud se bacha zayah karwana gunah hai, laikin agar hamal khud se zayah ho jaye to who gunah nahin hai.” (A woman from Nawan Gussu, District Bhakkar)

“To deliberately induce an abortion is sin, but if it happens on its own then it is not.”

Practically, however, it was seen that induced abortion was a reality. It was used as a method of ending an unwanted pregnancy and it was being resorted to basically as a family planning measure, the usual reasons being poverty, too many children, domestic conflicts or the ill health of the mother.

Kalsoom, Nawan Gussu, District Bhakkar

Kalsoom belongs to Nawan Gussu which is a village 45 km from Bhakkar city. She is illiterate and is married to a shop keeper with whom she has four children: one daughter and three sons.

When her fourth child was just one, she conceived again. She didn't want another child just yet. She went to the LHV in Khansar which was 11 kms away, who said the pregnancy was one and a half months. She consulted her husband who agreed that it was still early so he took her to the LHV for an abortion. They didn't tell the mother-in-law and got an abortion. The LHV charged Rs.500. She had bleeding for a month after the abortion. After that she would get backache during menstruation but she didn't get any treatment for it.

Kalsoom says there are no facilities for an abortion in the village. They had to go to the LHV in Khansar who charged according to the duration of the pregnancy, the more advanced the pregnancy the higher the charge. They learned about the facilities from the LHW or other women. She said her husband had cooperated with her and taken her on his motorcycle.

The exception was in Balochistan where the research team could not elicit any information about induced abortion. The practice of abortions in unmarried women was not admitted but hinted at on several occasions. But this carried such opprobrium that even the mention of it was considered wrong. A public acceptance of a girl having indulged in pre-marital sex would have violent consequences. Thus any procedure to abort such a pregnancy would have to be conducted in complete secrecy.

Savera, Sahib Khan Solangi, Sindh

Savera was a young girl who herded cattle in the fields. She was unmarried and naïve and had no sisters. She met a boy from her neighbourhood in the fields and they began a relationship. Soon she became pregnant but when she confided in her lover he ran away from the village. She did not have the courage to face her immediate family. She contacted the *dai* who was her uncle's wife. The *dai* placed some medicines in her vagina but this failed to induce the abortion. Savera was in a state of panic. She knew her family would kill her without remorse if they found out. The *dai* contacted a TBA trainer named Zainab, who used to work for an NGO. Zainab told her to bring Savera to the health centre on some false pretext but the *dai* could not manage to get permission from the family. The next day Zainab along with a colleague went to Savera's house and told the mother that the centre was organizing a programme in Dadu and she should allow her daughter to attend. Zainab suggested that Savera's aunt, the

dai, could accompany her as a chaperone. However, the mother once again did not give permission.

Savera was now desperate. She knew her family would not help and all of Zainab's efforts had failed. The next day Zainab came to know that after being refused to go to the health centre, Savera went to the fields and ingested a large amount of pesticides in order to commit suicide. She did not survive. She was only thirteen when she died.

Awareness of laws relating to abortion

There was no knowledge at all about the legal position of abortion in the country. The perception that it was a sin led to the assumption that it was also illegal. This was perpetuated by health providers who, even in cases where it was legal, continued to give the contrary impression so that they could charge a higher amount for the procedure. Moreover it has been seen that many health providers too are unaware of the government policy on abortion. The current abortion law in Pakistan, which was amended in 1990, states that pregnancy can be terminated if carried out in good faith during the early stages of pregnancy in order to save the life of a woman or to provide 'necessary treatment'. The situation on the ground, however, is that every induced abortion is considered an illegal act and therefore performed covertly either in unsafe and unhygienic conditions or by unskilled providers or both. Spontaneous abortions or miscarriages are catered to in government hospitals but even for these, women reach there only after having exhausted all other options which are closer, more accessible or affordable to them.

Bakht Taja, Mardan, KPK

Bakht Taja is 30 years old and is married to Tariq who is a daily wage labourer. She has been pregnant ten times and has seven live children. She has attempted to get abortions several times. Relating her story she says when she conceived for the fifth time, she wanted to abort the baby as they could not afford another child. Initially her husband resisted but then he agreed. He consulted a paramedic who gave an injection and some pessaries. These induced labour and the water broke. It was as if something had fallen out. She rested for a few weeks because she felt very weak but her husband took her to a doctor who gave her multi-vitamins. Two years later, not having practiced any

contraception, she conceived again. Her husband forbade her to abort this child so she carried it to term. She then tried depot injections for family planning but these caused heavy bleeding so she discontinued. She conceived again and had another child. By now she said she had become very weak and after delivery there had been so much bleeding that she had passed out. Therefore, when she conceived yet again, her husband got a paramedic to give her an injection but this did not work; the pregnancy continued and she had the baby. The delivery was painful and afterwards every time she urinated, it felt as if something was falling out. A doctor in Mardan said she had a bladder injury which required surgery but they could not afford it. The next time she conceived a local woman told her about someone who was running a centre in Mardan. She did not know if she was a doctor or a quack. She did an evacuation and said the child had been aborted. Bakht Taja said she felt nauseated afterwards so she went back to the centre. A pregnancy test was done and it was found that the pregnancy was still intact. Another evacuation procedure was performed which was very painful and the 'doctor' said this time the fetus had been aborted. Bakht Taja returned home but the same symptoms remained, so she went back yet again and was given some injections after which she lost consciousness. The 'doctor' told her husband to take her to a hospital in Mardan as she could not handle the case any further. She also told him to not tell anyone what she had done, rather say that the waters had broken spontaneously. The doctor at the hospital after examination said that the baby was fine and an abortion was not advisable so she should go through with the pregnancy. She offered to deliver the baby and even keep it if they could not afford it, but when the time came they had no money to go to Mardan and she delivered a female child at home. Two years later she was pregnant again. This time she went to a BHU in Khazana Dheri and asked the LHV for an abortion. The LHV gave her some pessaries and said that they would cause bleeding and an abortion. She charged Rs.1200 and another Rs.500 for medicines. Two days later the bleeding started. Bakht Taja went to the LHV to confirm that the foetus had aborted as she felt nauseous. The LHV did a pregnancy test and said the abortion had been unsuccessful and she could not help any further. Bakht Taja came back home and her in-laws told her to give up the idea. She suffered for twenty days and then went to a paramedic who gave her an injection. The next day heavy bleeding started and she fainted. Her husband called her mother, who hired a private car and took her to a doctor in Mardan. This doctor carried out a procedure for which she charged a total of Rs.2500.

Bakht Taja says she knows that abortion is a sin but she was helpless and she begs God for forgiveness.

Awareness of services related to abortion

There was very little awareness regarding services for abortion and therefore all treatment sought was through references from other people who had had similar experiences or by trial and error. There was no post-abortion care.

At home too there was little sympathy, as such things were considered part of life and the natural events of a woman's life.

Niaz Pari, Charsadda, KPK

Niaz Pari belongs to Ozza Khail and is 45 years old. She said after her third child their families' financial situation was very bad and she was anxious not to have another child so she asked a lady who came to their house to sell cloth about it, and she advised depot injections. Niaz Pari tried them but they caused a lot of swelling and so she discontinued. Soon she conceived. She wanted to abort but there were no facilities in their area. She asked the same lady who was unable to help this time and so Niaz Pari gave birth to a daughter. She suggested family planning to her husband but he was not cooperative so she conceived again. She was really upset so her husband agreed to an abortion. Since there was no local facility available they did not know what to do. Meanwhile, she went to Nowshera for a family wedding and asked the other women there. One of the women who had recently had an abortion shared that a doctor had told her to insert an aspirin tablet in the vagina to induce an abortion. On her return home, Niaz Pari did just that and the next morning she felt severe pain. A little while later the baby was aborted. She felt weak but continued to do her house work. When she couldn't manage any longer she confided in her sister-in-law who got her some medicines from a doctor. Niaz Pari did not tell anyone else. She knew she needed rest and a good diet but also that she could afford neither.

However, it is essential to distinguish between spontaneous miscarriages and induced abortion. Miscarriages are frequent, they induce sympathy and their treatment is fairly straightforward in the sense that a D&C is carried out at government and private health providers without any issue, depending on the usual factors of availability, accessibility and affordability. However in these cases too there was no provision for follow-up care.

Allies

For married women who were opting for an abortion due to financial reasons the husband's permission and knowledge was usually present. In many cases the suggestion also came from him. When this was the case then he provided the logistic and financial support of taking the woman to the health provider and getting her the prescribed medicines and treatment. The same cannot be said for emotional support. A woman was expected to get back to her usual routine as quickly as possible and not treat this as an excuse to shirk her household duties. The attitude of the in-laws was also usually unsympathetic.

In cases where the reason for getting an abortion was the woman's health, the husband's support was grudging but present, however, if the reason was some sort of domestic dispute the attitude of the husband and in-laws could be downright hostile. Then the whole process had to be managed by the woman herself.

Her allies were friends, sisters or the local *dais*, LHWs or LHVs who were her confidantes as well as advisors and support network.

Qaima, Nawabshah

Qaima was Asghar's fourth wife. She had been married to him for five years and had borne him two daughters. She had run off and married him when her parents were forcing her to marry a ten year old boy who was her uncle's son.

When she became pregnant for the third time she decided to abort the pregnancy and flushed a stream of neem water (concentrate of boiled leaves from the neem tree) into her vagina for three consecutive days. On the fourth day she started bleeding. She then approached her local doctor with her neighbour whom she trusted. She told the doctor that she had not had her monthly period, concealing the fact that she was pregnant. The doctor gave her medicine and within four days the foetus was expelled. It was a male foetus. Qaima feels that at the time her daughter was too young and she was over-burdened and is confident that God will give her a son next time.

This chain of events was kept entirely secret from her husband and family. She covered up her visits to the doctor by saying she had bleeding for which she was on medication. Ten days later the bleeding

has still not let up. Qaima wants to start medication to put an end to the bleeding and also to get a D&C. But her next visit to the doctor is fraught with tension. She is terrified of going. Her husband's other wives have a grudge against her and she is forced to deny their accusations and maintain that she has had a natural miscarriage.

For unmarried girls the support network was smaller and the options very restricted. The mother and/or father of the child or a community health worker may try and help her if circumstances allowed, but sometimes none of these were possible and then the reaction from other family and community members could be violent and extreme with suicide becoming the only option left for the girl.

Series of actions for undertaking an abortion

There was a common sequence to the route used by the majority of women for ending an unwanted pregnancy. The first action was to try home remedies. These varied in the different provinces and ranged from simply jumping up and down, to inserting cloth soaked in salt in the vagina. These were usually done without the knowledge or consent of the husband.

If this did not work the local *dai* was called upon for help. She also tried traditional methods and sometimes gave medicines or administered injections to induce bleeding. In case of failure or complications, the woman then went to the nearest LHV, quack or private doctor of the area and if this too was unsuccessful then she ended up in a tertiary care hospital which may be public or private depending on the financial situation of the woman. At this stage the husband had to be in the picture as going to the hospital and paying for the services was not possible for the woman to do alone.

In areas where a family planning centre was available or an LHV was accessible to the community, women approached them directly too. In cases where the decision was the husband's and he had the resources, he might take the woman to a private doctor himself.

Consequences

Whatever the reasons for an abortion, it was a significant event in a woman's life with multiple consequences for her. The illegal and clandestine nature of

the abortion added to the gravity of the consequences. These were:

Physical

The physical consequences ranged from heavy bleeding, chronic backache, infections and weakness to uterine prolapse, urinary incontinence, secondary infertility and death. Other than these physical ailments, various perceptions about abortions also commonly prevailed. Women often associated abortions with complications like tumours, cancers, poor eyesight, memory loss, high blood pressure and weight gain.

Social

Women who are publicly known to have had an abortion were shunned in the community. There was a case of a woman who had gone without her husband's consent and when he found out he beat her and put black polish on her face as a sign of shame. Such a woman is also kept away from other pregnant women so that her shadow does not fall on these women and blight their pregnancies. Family members and religious leaders all criticize the act.

Financial

As with any other medical intervention, abortion too comes at a cost. The more advanced the pregnancy and the more illicit the arrangement, the higher the cost. When the abortion is being done as a joint family decision due to financial reasons, the family considers the one off cost of having an abortion against the long term financial repercussions of going through with the pregnancy. However, often the cost of treating complications which occur because of unsafe procedures is not calculated for and the family ends up paying much more than it had anticipated.

Emotional

Since all women spoken to considered abortion a sin, going through with it means they carried a burden of guilt which took its toll psychologically. They felt depressed, agitated and unhappy with the decision. If they were doing it secretly, the whole situation became fraught with physical and mental tension. Thus abortion was not merely a physical procedure but it had serious consequences on the mental health of women as well. Women in Sindh, Punjab and KPK recounted how after abortions they became irritable, they were unable to concentrate on household chores or look after their children and they got into fights with their husbands and in-laws.

Accessing and Claiming FP/RH Services

People's perceptions regarding family planning services

In all four provinces it was seen that there was a high degree of awareness regarding family planning. People were aware of what it was, its necessity and advantages. Both men and women seemed to understand the need for family planning due to financial constraints. However, there were mixed feelings about its legitimacy from a religious and social point of view and its efficacy from a health point of view.

The research revealed that any awareness came from LHWs, LHVs, family planning centres, radio and TV, the Green Star campaign and in some areas of KPK and Balochistan, from UNICEF and PAIMAN programmes. This awareness led to an understanding of what family planning was, the sort of options it could provide to a family and what advantages it could bring. However the message was received differently by men and women. For men the important factor was the financial one, whether they felt they could afford another child or not.

“Aaj kal mehngai ka daur hai, bachay utnay hi paida karne chaiyay jitney sambhal saken.” (A man in Raza Abad, District Multan)

“Everything is so expensive these days, one should only have as many children as one can afford.”

The health of the woman was not the determining factor. The physical burden that was imposed on women did not concern them as pregnancy and child birth were considered natural and routine matters and women continued to carry out all their duties inside and outside the house throughout the process.

“Sukh ho ya dukh, yeh aurat ka naseeb hai. Woh beemar ho ya hamal se ho, wo kaam karti rehti hai.” (A woman in Sahib Khan Solangi, Sindh)

“Joy or misery, this is every woman's fate. She has to keep working irrespective of whether she is sick or pregnant.”

On the average women got three to six days rest after childbirth. Neither were they given any special treatment during pregnancy.

“Hum thappar khatay hain aur kuch nahi. Maar kha kha ke hamari hadyan gal jati hain.” (A woman in Sahib Khan Solangi, Sindh)

“We eat slaps and nothing else. Our bones become weak from all the abuse we get.”

They were given regular food and were rarely taken for antenatal check-ups, so a woman’s pregnancy did not impose any financial or logistical change in men’s lives and thus that was not a reason for having less children. On the other hand, the advantage of having more helping hands, the social approval of *pirs*, certification of manhood and virility among men and that of fertility for their wives, and the appreciation if sons are being produced were only positives. In most cases these perceived advantages outweighed the possible financial disadvantage. For women however, the negative health implications of repeated childbearing on their bodies was an important factor but it was not translated into an actual demand because men were the real decision makers on the matter of the size of the family.

This resulted in the fact that while the awareness was definitely present it was partial awareness with not enough clarity on the advantages of spacing and less children on the health of women and the consequent benefits for the entire family which would include an economic benefit. This requires a targeting of men with a change in the content of the message. In this context, it may be mentioned that only the Punjab report had case studies of men who had opted for vasectomies. This is important information to follow up on as the factors which worked to inform, convince and then provide satisfactory services to these men need to be replicated and built upon. The absence of male mobilizers was conspicuous in all four provinces.

The other mental conflict was about the legitimacy of family planning. In some areas, particularly rural Sindh, Balochistan and KPK, the religious factor was still an important one. People felt that it was a sin to practice family planning, especially permanent methods. Some religious leaders actively preached against contraception. However, in Punjab and in most of the urban areas, this was not a strong factor. In fact the community religious leaders sanctioned and approved it albeit mostly for spacing.

Fehmeeda, Village Nasri, District Nawabshah, Sindh

“My name is Fehmeeda. I am twenty two years old and am married to a goat herder. We raise goats and cattle to sell for a living. I got married at the age of 17 and still don’t have any children, although I have conceived four times. The first time was about a year after my marriage. This ended in a still birth. The second time I delivered a healthy baby, but he died a month later due to a fever. Six months after this, I conceived again but this resulted in a miscarriage in the fifth month. I did not go anywhere for a D&C but later when I visited a doctor she told me I had jaundice. She told me to get proper treatment otherwise my children would not survive. My fourth child was born a year later with a C-section, but he too was a still birth. It has been nine months since that and I have yet to conceive again. I am not receiving any treatment as I want to let nature take its course. I am also not using any contraceptives as the doctor advised me to do, to improve my health. We believe the use of contraceptives is a sin in our religion.”

Socially, the norm was for a large family. Family planning was sought after the eighth or ninth child, some serious medical complication or very poor health of the mother. The need for sons also necessitated multiple pregnancies.

This in turn was linked to early marriages, low status of girls with limited education and employment options. Their role was limited to childbearing which they continued to perform till they were physically unable to do so anymore. A family planning campaign will only be effective if these aspects are addressed as well. For already married women, contraceptives remain an option of desperation, and often a clandestine activity, rather than a family decision involving long term planning and with the welfare of all its members in mind.

Panjugur district in Balochistan was an exception. Despite being a rural area there was a high awareness level and with many men working in Saudi Arabia, there was religious sanction as well. The majority used Iranian products but generally family planning was practiced to increase not decrease family size as men were being lost to the freedom struggle and there was a need to enhance the population. Thus political reasons dominated family planning practices.

The third factor regarding family planning was regarding its side effects. There were many fallacies and myths about the various methods. Oral pills, injections and IUDs all had stories associated with them of failure, excessive

bleeding, cancer, infertility, obesity, backaches etc. Condoms were well liked but dependent on the cooperation of the husbands which was not always there.

Nazeeran, Allah Bakhsh Rahooja, Balochistan

“My name is Nazeeran. I am forty years of age and have been married for twenty-two years. My husband has two wives. I am the first one. He has four children from me, three boys and one girl and ten children from his second wife, three boys and seven girls.

After receiving fertility treatment from Jacobabad I was finally able to conceive two years into my marriage. Unfortunately that baby died in my womb. My second pregnancy resulted in a miscarriage in the eighth month. I was very weak and not able to carry the child. I again conceived three months later but this time the miscarriage happened in the seventh month. After these three consecutive miscarriages, I went to Jacobabad to get treatment. Finally five years after my marriage I was able to conceive and then had four healthy children. My youngest child is now thirteen years old. I would like to have more children for which I am under treatment. It is Allah’s will if and when He gives me more children.

I have never used any contraceptives. I feel very weak and am not in the best of health. I also have a long history of leucorrhoea. The doctor says I will probably not be able to conceive again and that I should not lift heavy weights and should rest. But my children and husband would like me to have more children. Since I am unable to conceive further, I feel that my husband is not happy with me.”

People’s information about services and facilities of family planning

While awareness was high in all places where the message had reached this was different from being informed about services and facilities for family planning. A majority of men said they got their information from radio and TV (Green Star Campaign). Local *hakeems*, medical stores and shopkeepers were also a source of information.

“Jinsi taluqat kay liye log sanyasi aur hakeemon se malumat letay hain aur medical stores se bhi dawai le letay hain.” (A man in Village Garaywala, District Multan)

“People get information regarding sexual matters from hakeems (traditional non-allopathic practitioners) and they also get medicines from the local medical stores.”

The women got information from word of mouth, LHWs, or sometimes their husbands. They got some information from TV and radio as well but their access to these, as compared to men was less, especially in rural areas.

The level of awareness was therefore not seen to be matched by services. Awareness was being created and raising demand but a simultaneous increase in supply was not being made. This was leading to a high level of dissatisfaction among people. In this context too, the division was in the urban and rural areas and not depending on whether there had been an intervention in the area or not. The urban areas had more services, whether private or public and the people were aware of the services. In the rural areas the services were patchy.

Noor Shada, Village Usmania, Charsadda, KPK

Noor Shada belongs to a middle class family. Her father was a farmer and also owned a sugar cane machine which was an additional source of income. She got married at the age of 25 to Shad Gul who owns a dairy shop and keeps animals. They now have four children, two boys and two girls.

She says her area has both private and public health facilities, but she does not trust their quality. For medical problems other than those related to childbirth she goes either to Charsadda or Peshawar.

There is a Family Planning Centre and a BHU in her area. The BHU facilities are availed by both poor and rich, but unmarried girls do not go to the BHU. If a girl does go, she is thought of as having a bad character. Even married women first try home remedies. But the LHWs are very helpful and come to their homes to give advice.

She says all her children were born at home, which led to some problem in her bladder. She did not go to the hospital because of her shyness and the vulgar atmosphere there. With the advice of the local LHW, she has tried depot injections as well as pills and now that she feels her family is complete, she has consulted a doctor in Charsadda for permanent contraception.

The LHWs were well appreciated by the women because services at the doorstep were suited to cultural, social and financial constraints. However, their services were limited to pills and condoms. Beyond that the women had to step out of the house and then a host of factors, like distance, transport, cost, permission, escort and knowledge of options came into play. Obviously people chose the nearest and cheapest option. Also another important factor determining their choice was other people's experience. Information regarding services was passed on not through a formal way but through word of mouth and reputations were built in this manner. It may be mentioned that any good service was appreciated by the people and that the provider was almost guaranteed a flourishing business because people flocked to it. It is here that the conflict of interest between public and private sectors comes into play. People obviously prefer to go to the public sector facilities because they are either free or subsidized but the salaries of the health providers are low and there are hardly any incentives for them to serve in difficult circumstances. They, therefore, are tempted to increase their income by diverting public facilities, medicines, and their own time and expertise to the private sector. So even in areas where public sector facilities are present and staff and medicines provided, they are not functioning optimally because of lack of incentives, monitoring and regulation.

“Taluqa haspatal main her koi - incharge se ly ker nichly amlay tak - tamam log baiman hain. Hakoomat ke taraf se haspatal ke liye koi bhi cheez ati hai woh log khud hi kha jatay hain.” (A man in District Dadu)

“Everyone in the taluka hospital is corrupt, all the way from the incharge down to the support staff. Whatever the hospital gets from the government goes into the pockets of the staff.”

“Haspatal main jo khalayen hoti hain wo mareez ko thappar waghera bhi marti hain.” (A woman in District Charsadda)

“The female assistants at the hospitals often hit the patients.”

In many other areas, the facilities are simply absent or of low quality because of under-staffing and unavailability of medicines and equipment. The gaps in services left by the public sector are being filled by a variety of service providers who range from religious *pirs* and quacks to private doctors and clinics. Since there is no regulation of these services, there is no check on

unqualified persons administering family planning injections or inserting IUDs without follow up or counselling, perpetuating myths of side effects when things go wrong.

Women's access to family planning services

Women's access to family planning services was limited. Where home service was available it was appreciated and utilized. But men's compliance, financial situation, distance and transport were all factors which affected this access. Socio-economic status and urban location was more important than any other factor in limiting access and levels of utilization of good quality services.

Women's experiences about the quality of FP/RH services including emergency obstetric care

There was general dissatisfaction with the quality of family planning and RH services in all the provinces although it was the least in KPK where the services were relatively better. Women in urban areas and those who could afford it had better experiences. Even a single female doctor at a BHU working diligently and with a caring attitude for her patients, as in Gandakha city in Jaffarabad, Balochistan, was able to make the narrative a positive one for the people of that community, demonstrating that requirements are not fancy or necessarily expensive but simple straightforward systems, proper staffing, medicines and a referral network can make a significant difference to the quality of lives.

“Doctor Rahila bohat achhi hain. Un hone BHU me dawaion ka intzam karwaya aur degar staff ko rozana aane ka paband karwaya, aur hum aurton ke elaj ke liye mukhtalif masheen bhi mangwai. Woh asan aur bohat ache andaz me bolti hain, aur elaj sirf us sorat me nahin karti jub wo khud kehti hay ke filana machine mere pas nahin le haza aap log Shahdadkot chale jayen.” (A woman in Allah Bux Rahoja, Balochistan)

“Dr. Rahila is very nice. She has managed to get medicines at the BHU, ensured that the staff comes daily, and procured machines for our treatment. She explains things in a very kind

and easy way and if she feels she does not have the required machine or treatment, she refers her patients to Shahdaskot.”

As regards emergency obstetric care, the experience once again depended on the financial capability of the family. The poor majority often faced serious and tragic consequences because of lack of money, transport and accessible services.

Allies

Within their household, women were usually isolated when it came to matters of family planning. Their husbands supported them but only if and when it suited them. Mothers-in-law and sisters-in-law usually did not as family dynamics and politics were stronger than the shared bonds of womanhood. Other actors like fathers-in-law or other men would usually not speak in this matter. However, outside the home, women had allies in the form of mothers, sisters, friends, neighbours and other female relatives. This support was both emotional, in the way of sharing feelings, colluding in a secret activity and providing alibis, and practical, as in lending money, suggesting solutions or accompanying the women to wherever they needed to go.

Sameena, Village Garaywala, District Multan, Punjab

Sameena, belongs to a very poor household of village Garaywala near Multan. She is 24 years old. She got married at the age of thirteen to a man from her family who works as a labourer and earns Rs.3000 per month. They have six children.

Sameena is illiterate. She says in her family parents try to marry their daughters as soon as they reach puberty because they feel that with grown daughters there is a risk that something could happen to dishonour the family.

Sameena got pregnant for the first time, six months after her marriage. At that time she was unaware of family planning so just two months after delivering her first daughter, she became pregnant again and delivered twins. Then, without an interval, she had another daughter. It was at this stage that the local LHW came to her and advised her about family planning. She administered four injections

and charged Rs.5 each time. The injections didn't suit her because they caused heavy bleeding but at least she got an interval of two years. Then she had her third son. After that she had a 'tube' put in. The LHW brought an LHV from Multan to her house and she inserted the tube. But just four days after the insertion, she starting getting fits and felt really ill, so she got the tube removed. Her fourth son was conceived soon after. After his birth, the LHW advised her to start using contraceptive pills but she would forget to take them and also her abdomen started to swell, so she discontinued after four months. Her youngest son is now five years old and they only use the natural method where her husband ejaculates outside. Some women had told her about this method. Sameena says her husband is happy because this way she does not have to use all those methods that have such bad reactions. The natural method is the best because there is no cost, no side effects and they don't have to go anywhere for help.

Two of her children go to a home school, but she has not sent her eldest daughter to school because she thinks society is dangerous and people have dirty minds and they gossip.

The health workers too were allies and they were important because they were influential and they could provide practical support in the form of information, contraceptives and sometimes by physically accompanying the women to the health centre.



Adolescent Health

A community is made up of multiple hierarchies. These hierarchies are based on socio-economic status, caste, religion, profession and gender and they are all inter-linked. Thus some individuals may be high up on the hierarchy of one category but low on another. This can also be understood in terms of social exclusion. Taking the example of women, those belonging to high socio-economic group are socially included in terms of the privileges that come with wealth, but are often excluded when it comes to decision making and autonomy within the family. Within this framework, the adolescent female is excluded at multiple levels. Not only is she a girl in a patriarchal society, but she also does not have the leverage that women gain with age, marriage or production of sons. Deprived of education or opportunities for gainful employment, she is considered a burden and a constant threat to the honour of the family, thus the desire to pass her on as early as possible. While she is unmarried, she serves as another pair of hands in the household, but she possesses no rights. This is the backdrop against which the health status of adolescent girls needs to be considered.

Sexual and reproductive health issues of young unmarried girls

Adolescence heralds numerous changes in the physical and emotional make up of individuals and it can be a particularly difficult phase if the right information and support is not provided to them at the right time. While schools are a place where it is possible to impart life skills and comprehensive health education, in its absence as in our system, the responsibility naturally falls to the family. For girls then it is the mother who has the prime responsibility to prepare her daughter for this new phase in her life. We see the inter-generational transfer of knowledge and skills in other areas like the teaching of household chores e.g. cooking or sewing, looking after babies or caring for the old, social mores and etiquettes, dress codes and even beauty tips for skin and hair, but anything to do with sex, and thus reproductive health, is assiduously avoided and considered taboo. There is a concept of shame associated with this topic which may have its origin in religious teachings but the result is that everything related to it is considered ‘dirty’

and therefore something to hide.

The first manifestation of this attitude is seen when girls reach puberty and get their first period. It is something that they are never prepared for. They are only told that this is something normal once menstruation begins. The mother, or more commonly sisters, then explain how to manage this monthly event in a very discrete manner and often with very little support.

The research in all four provinces showed that girls get no sympathy or support if they complain of pain during menstruation. They are in most cases, told to bear the pain as it is normal. At the most they are given home remedies with different kinds of teas or sometimes pain killers like Buscopan or Ponstan.

“Jab larki ka seena bara ho jata hai aur mahina aney lagta hai to hum larki ka bahar nikalna band kar detay hain. Desi elaj kartay hain.” (A woman in District Nawabshah, Sindh)

“When a girl’s breasts develop and she starts getting her monthly periods, we stop letting her go out. We only give her home remedies.”

Shabana, Village Nawan Gussu, District Bhakkar

Shabana is 18 years of age and has been educated till primary level. Her father is a shop keeper. One of her brothers has done his FA and will soon be joining the army. Her elder sister is married and she helps her mother with the housework. She says in her family women don’t work in the fields. They just do the household chores and look after the animals. Her father keeps all the money and gives just a small amount to her mother.

She says there is a primary school in the village but the secondary school is 20 kms away in Digar Shad. Her father, uncle and uncle’s son - who is also her fiancé - have said she cannot go to another village to attend school. She says she has been betrothed to her uncle’s son as part of a *watta satta* arrangement.

Shabana says there are no facilities in her village for young girls. She was thirteen when she got her periods and she had no idea what was happening. Her mother then explained to her and told her how to use

the cloth during her periods. She says she gets pain in her back, legs and lower abdomen during her periods, but her elder sister says that is normal. She sometimes takes painkillers for it. She has never gone to the doctor because it is not considered a good thing for young girls of the village to be taken to a doctor. If an unmarried girl visits a lady doctor, people start gossiping that it is perhaps something to do with a pregnancy. However, if a girl gets a fever or cold, she may be taken to one of the two male doctors who sit in the village. Other than that they are given a mixture of fresh mint, cardamom, cinnamon and green tea to drink. She says she lies in bed for two days when she gets her periods and cannot do any housework. She feels very weak. The elderly women in the village say that she can get herself treated after she gets married.

Common complaints amongst adolescents in all four provinces were of menstrual pain and vaginal discharge (leucorrhoea). However going to the doctor with these complaints was not considered necessary. Even in extreme cases or for other related complaints, the mothers preferred to relate the problem to the doctor and get the medicine themselves, rather than taking the girls to the doctor. The overwhelming argument given for this was that people would gossip if a young girl were to visit a doctor (*“log batein kareinge”*) because they would suspect either that there was something wrong with her, thus spoiling her marriage prospects or that she had done something dishonourable thus tarnishing the family reputation.

Mahnaz, Allah Bakhsh Rahooja, Jaffarabad, Balochistan

“My name is Mahnaz and I am 19 years of age. I have completed primary education. Ever since my first periods, I have been having various problems. They are very painful but they are also irregular and the bleeding is very light. This worries me tremendously because the gap between the first and second menstrual cycle was six months. I keep telling my mother about it but she continues to insist that this is normal. However I am convinced that this is not normal because I know other girls in the village have them monthly. If I can go to a doctor when I have fever why can I not go for this problem? The reason is that the village women will start talking out of curiosity. Nothing remains hidden in our village; therefore questions will be asked e.g. why is a virgin girl not getting her menses? The assumption

will be that she is pregnant. Since I am engaged to be married, my mother really worries about the impression this will convey to my in-laws. Their knowledge of my condition would further complicate the situation and cause embarrassment to our family. It scares me that my medical condition may become a problem for me after marriage. Surely, if I am unable to conceive, it is possible that my husband will marry again.”

Without any physical or financial autonomy, young girls did not have the option to even go to the village store to buy medicine themselves. They were dependent on their mothers and if the medicine had to be procured from out of the village, then on the men in the family. Thus out of shyness and inhibition they would not mention that they had a problem and bear it as much as they could. They were told that the problems would go away with marriage and then it would be acceptable to visit a doctor. Poverty and discrimination combined to lead to a poor diet and a heavy work load which further affected their health.

Allies

Their natural allies were their friends and sisters. With them they would discuss everything and share their problems but being equally helpless, they could only provide moral and emotional support. The local LHWs and LHVs were helpful too but they were not really equipped or trained to provide the sort of support adolescent girls needed.

Rubina, Village Garaywala, District Multan

Rubina is 17 years old and has studied till class 4. She is unmarried. Her father has a donkey cart and on the days that he finds work he earns Rs.150-200. Her mother takes care of the animals. In her family children do not go to school. When her father sent her, her uncles and grandfather opposed it and said people will gossip. Her father gave in when she got to class 4. People in the village think that if girls learn how to read and write they will write letters to boys, but the truth is that those who want to do such things do them anyway. In her family *watta satta* marriages are the norm. The girls are married early and always within the *biradari*.

Rubina says there are no government health facilities in her village.

There are many private doctors but they charge a lot. Girls don't go to doctors themselves. If they have a problem, either the doctor is called to the house or their mothers go, describe the problem and get medicine. Some girls are just told to drink tea and eat a boiled egg. That sometimes helps. Some are advised a special tea with fennel, dried dates etc. which is also good. Most girls are too shy even to tell their mothers. They share with their friends because friends just guess that something is wrong and ask. If mothers were to ask they would even tell them. Sometimes when girls have problems like leucorrhoea, mothers don't take them to the doctor and say it will become alright by itself. If girls go to the doctor people start gossiping. They say 'why is this young girl going to a doctor' and suspect that something is wrong.

Rubina thinks there should be some programme that would tell young girls about these things, about the problems they may have and how to solve them. Even if one girl is told, she would tell all her other friends and lots of girls would be informed.

Services for adolescent health

It was very obvious from the evidence generated by the research that the regular health service options were not available to adolescent girls. The LHWs were accessible but were not trained to help them and the other service providers like the BHU, hospitals, both public and private where available, were denied to the girls because of social and cultural reasons. There was no provision to cater to this important section of the population keeping these cultural and social sensitivities in mind. Neither was there any service for health education or awareness raising.

Naeema, School Karuna, Charsadda, KPK

Naeema is 17 years old. She is fourth out of nine siblings. She is illiterate, because female education is not given any importance in her family. Her fiancé is illiterate himself and he doesn't allow her to go to school. In their culture, a girl who is confined to the premises of her house is considered good. Naeema says preference is given to boys for education and health. Even her mother does that. If she cooks chicken, she would ask Naeema to let her brothers have it. She says it makes her very angry. Her brothers are very strict regarding *purdah*

and don't allow her to go outside.

One day while washing clothes she felt her periods start. She felt like crying but controlled herself and told her sister. She felt a lot of pain. Her sister said it was because she carried heavy loads. She used to carry dung cakes on her head to the roof top. She now also has leucorrhoea, which embarrasses her. She feels she can't even tell her mother and even if she does she knows what her reply would be: it's normal, all girls get it, just bear it like the rest.

The area LHW comes to the house and notes down names for record keeping but never gives any advice or medicines. Her mother gives her home remedies but because of the nausea she can't take anything. There is a local BHU where there is a lady doctor also but that is considered only a place for married women. Unmarried girls are forbidden from going there. She says she can't even go to the hospital in Charsadda, because some people from the village work there and they would spread the news to the whole village. Once she talked to her fiancé on the mobile phone. Her sister-in-law found out and spread the news all over. Some days later she developed a pain in her ear and went to Charsadda hospital. There some people of the village saw her and spread the propaganda that she had talked to her fiancé so much that it had affected her ears. If even going for such problems can cause so much gossip then girls cannot even think of going for menstruation-related problems.

Zeenat, Parao Mulyan, Charsadda, KPK

"My name is Zeenat. I am 20 years old. My father is a barber by profession but he doesn't have a shop. He carries his instruments in a bag and goes to people's homes on a bicycle. He earns just enough for a hand-to-mouth existence. I have ten siblings and I am third in line. I was very fond of education so my father admitted me in a government school. I was very intelligent, but the teacher did not teach us well. She often asked us to bring money for various reasons like buying a water cooler etc. She would also often beat the children. Once she hit me on the head. I told my father and he told me not to go to school again, so I left and then would just help my mother with the housework.

I had my first periods during the marriage of my cousin while I was dancing. I was scared and told my sister who consoled me and told me what to do. She also told me not to eat cold and sour things during

periods. I get nausea and pain during my periods. My mother made many home remedies but none worked. My mother asked my father to bring a doctor for me. She lied to my father that I have a pain in my kidney. Later, my mother secretly told the doctor what the real problem was. He gave injections which helped relieve the pain somewhat.

Meanwhile I got a marriage proposal from my uncle's son. My parents agreed and we got engaged. Life was going on as usual but suddenly my periods became irregular. They would come after a gap of six or even eight months. My mother was very worried. She borrowed money from someone and took me to a lady doctor in Charsadda. There is a local BHU in our area but we didn't go there because people say it is only for married women. If a girl ever went there, people would comment on her character and point fingers of suspicion at her. The doctor did my ultrasound scan and told my mother not to worry as there was no problem and said I would get well. She told us that girls often get this problem. She gave us some medicines and said they would make my periods regular.

Now I am using those pills and it has been eleven days since. My mother is very worried because if these pills don't work then what option will we have left. We are taking precautions not to let my in-laws know about this as these are sensitive issues before a girl's marriage. Also, every step requires financial support and my father's earnings are not enough.

Now I wish I had continued my education. I could then have got a job and shared my father's burden. I pray to God that he brings prosperity upon us and that someday our family may also be happy.

Awareness of needs

Despite the neglect, girls understood clearly that they needed more than was being given to them. They showed an understanding that women's bodies had to bear the burdens of child-birth and a lot of physical labour so they needed nourishment, a good diet and care. But at the same time they were accepting of their fate and cultural norms. That was how women's life was supposed to be so they could not complain. They did, however, voice the need for better services and support, thus putting their expectations in the state rather than their own family and men-folk.

An interesting exercise that revealed the aspirations and needs of young women was where they were asked to define health. Varying definitions were

provided, which seen in the backdrop of their particular circumstances, showed how young girls thought. In one area the girls said good health was when a woman could perform all her household chores, she was fair, fat and beautiful to look at, gained weight easily and had a happy spirit. In another they defined health as the absence of mental stress. One definition made a good diet with milk, yogurt, meat, fruits and fresh vegetables, the condition for health and another qualified health as being disease free from the inside, not just from the outside, so a woman apparently fat to look at but eaten away with worries on the inside could not be termed healthy.

Early marriages

Early marriages were the norm in most rural areas. As soon as the girl reached puberty she was considered ready for marriage and parents thought it their religious and social duty to marry them as soon as possible after that.

“Hum shaadi kar detay hain, bhalay wo sukhi ho ya dukhi hamara is se koi wasta nahi hota.” (A woman in District Charsadda)

“We just marry the girls...whether they are they happy or miserable is not our concern.”

There was an underlying risk that young girls could pose a threat to the family honour and it was wise to marry them before they got into any trouble. Poverty, too, was cited as a reason. In KPK, money was taken from the boy’s family albeit to make the dowry for the girl, but in Sindh and Balochistan, girls were simply married for a price - younger the girl the higher the price.

“Aik larki ki qeemat 40,000 se aik lakh tak lagti hai agar larki jawan hai to uski qeemat aur bhi barh jati hai. Aur agar larki kisi dosray elaqay se lai jay tou phir uski qeemat 40,000 se bhi barh jati hai. (A girl from District Dadu, Sindh)

A girl is worth anywhere from Rs.40,000 to Rs.100,000, but if she is young then the price goes up. Some men even pay more than Rs.400,000 when the girl is from outside the community.”

In Punjab, the custom of *watta satta* or exchange marriages was common with children betrothed at an early age among families.

Hakeema, Sahib Khan Solangi, Sindh

Hakeema - one of five siblings - does not know her age. She did not even know about menstruation until she got her first period. Women in the area simply wear a *shalwar* with no cloth or pad. They keep staining their clothes and whatever they are sitting on, and so just keep changing clothes. Hakeema says she was married off to her cousin two months after attaining puberty. She guesses she must have been thirteen. Her husband deals in livestock and works in the fields. She was not consulted because it is understood that girls would marry whomever their parents choose.

She became pregnant six months after her marriage. She did not see any doctor during her pregnancy and her daughter was delivered at home by her grandmother. She now takes care of the family and cattle, does the housework, collects water and works in the field.

Consequences

Early marriages had consequences for the physical and emotional health of young women.

Physical

In terms of the effects on their bodies, the girls themselves were able to make the connection. They understood that they were unprepared for pregnancy because they did not know what precautions to take or what diet to eat. Many girls related experiences of how they had suffered miscarriages because they were carrying heavy loads or doing strenuous labour. Childbirth at an early age had its own hazards because the young bodies were not ready for it.

Ruqaiya, Sorab, Panjgur, Balochistan

“My name is Ruqaiya and I am thirty-two years old. I was married at the age of twelve and therefore I have been married for twenty years. My husband is also my cousin. I conceived a couple of months after my marriage and gave birth to a girl. Thereafter, I gave birth to eleven more children, each with a gap of one year. Now I have six boys and

six girls. Then my husband suggested I should use contraceptives in order to wait for a while before having more children. He brought me some Iranian family planning medicines which I used for four years. Then he brought Pakistani contraceptives from Green Star. These came from Chatkan, without a prescription. I am presently taking these but they cause my back and legs to ache. Another side effect has been heavy menstrual bleeding and them sometimes none at all. I also have swelling on my hands and feet, high blood pressure and a feeling of being bloated. However, I continue to take the medicines because I don't want to conceive yet.

We are mountain people and work as labourers all day out in the open. I have to walk a long distance to collect water and wash clothes. I make that journey thrice a day. Then I come home and cook for the family. The water we use is gathered rain water which is also used by the animals.

I believe that marrying at a young age and working in the open sky has ruined my health. But as per our Balochi tradition, the girls have to marry young and I am happy to be a Baloch. I love our traditional clothes and food. Our people have been living this lifestyle for decades.”

Emotional

More than the physical burden, early marriages also took an emotional toll. Young girls hardly out of their own childhood were not mature enough to handle the complex relationships and dynamics of married life. This led to tensions, fights, taunting and sarcasm by the in-laws for being incompetent in the ways of the world.

Yasmeen, Juhi, Dadu, Sindh

Yasmeen was sold in marriage to Ali Mohammad for Rs. 40,000. She was not consulted and was unable to voice her complaints to her family. She considers selling girls into marriage a shameless practice and resents that it was done to her. Ali Mohammad had been married to his first wife for 11 months when she fell ill and died. He had no children from her. Yasmeen had not even come of age when her prospective brother-in-law and also her sister's husband, began to frequent their house and hound her family into marrying her off. The

family finally relented. When Yasmeen got married she knew nothing of what transpired between a man and a woman and became frightened when she learned about sex from her husband, who was much older than her. She had also become very upset when she had menstruated for the first time and was suddenly overcome with pain. She had confided in her mother and had been told that it was a normal phenomenon which happened to all girls. Usually when she got her period, her feet hurt and her legs cramped up. All complaints to her mother would be met with silence.

Yasmeen is illiterate. She has been married 11 months and has not conceived yet. She and her husband want children. She has consulted the village *dai* and accepted medicine from her. She has not gone to the lady doctor because she knows her husband cannot afford the fees. Her in-laws treat her badly and even deny her food. She is terribly unhappy, but unlike complaints to her mother which are met with silence, when Yasmeen tried to communicate her unhappiness to her father, she received a single response: it must be her fault.



Linking Secondary Education with Better Reproductive Health Outcomes

Educational facilities were scarce in the rural areas in all four provinces surveyed. Primary schools were present but sometimes without teachers or other facilities. Secondary or higher schools were less common and often located out of the village. The lack of physical accessibility combined with the custom of not educating daughters led to most girls dropping out after primary school. Absence of public transport and poor security were also deterring factors.

However, there was a uniform expression of a desire to go to school and get an education. This was expressed in all the provinces.

Once again the socio-economic factor was a major determinant of whether a family educated its girls or not. If schools were easily accessible or transport, books and fees were affordable, then most families seemed to have no compunction about sending girls to school at least till secondary or even matriculation level. Beyond that cultural norms became dominant and the urgency to marry off the daughters overcame the desire to educate them.

Maryam, Jaffarabad, urban Balochistan

“My name is Mariam and I am 28 years old and I belong to the Jamali family. We are four sisters and three brothers. Our home does not lack for anything and we are all educated. I have done BA from Naseerabad, Jhal Magsi, and am now a teacher at Government Girls’ High School, Gandakha. I have been married for five months and my husband is also a teacher in Quetta.

I have had a miscarriage during the first month of my marriage. I feel it is because I made a tiring road trip to Quetta since my husband lives and works there, or it is possible that the cause could be all the soft drinks that I regularly consume.

I am now pregnant again and I take good care of myself by visiting the doctor regularly and taking the prescribed medicines. In the morning I teach at the school and am back by the afternoon. I then take a nap.

My mother-in-law is quite supportive and does not allow me to do any household chores as we have servants in our home. Traditionally, girls in our family get married at a much younger age. I not only married late but also married outside our family, even though I had several proposals from within the family. I refused them all as I believe that marrying within the family increases the chances of having abnormal children. Also at that time my body was not fully developed and ready to bear children. I think a girl should be at least 25 years old before getting married.

I'm quite happy with my marriage as my husband respects me and appreciates that I'm an educated woman. He understands that because of my education I am able to make responsible decisions regarding household matters. After my first child is born I plan to use birth control so that I can take proper care of my baby. I believe there should be at least a three year gap between children because a woman loses five years worth of energy per child."

In this context it was observed that education had a direct relationship with more awareness, more decision-making authority and better health outcomes. Although even women who were educated were often constrained by the same cultural norms, having to abide by strict customs of arranged marriages, not being allowed to work, or having to suffer the consequences of poor services when resources were not available but even then their attitudes were seen to be markedly different from those of illiterate women.

Sajida, rural Balochistan

Nineteen year old Sajida believes that a woman's opinion should be heard and she should be involved in all important decision making. This kind of thinking earns her ridicule from the other girls in the village, but she knows they are wrong. Of course, what can one expect from a group of uneducated young girls, she opines. The very idea is alien to them she knows. She herself gained such awareness from education. She is the proud holder of an intermediate degree. She has seven sisters and three brothers. One of her brothers is a school teacher and another is in the army. Her sisters are also pursuing their education.

Having completed her primary school education from her own village, she went to the town of Usta Mohammad to further her education

while staying at her maternal uncle's house. Her elder brother supported her in this pursuit as it was his wish also. Having attained her intermediate degree, she returned to her village because she missed her family. Her duties at home now include collecting water twice a day and cooking food in the evening.

Sajida will be married next year. It is customary for girls to marry young amongst her people, and the villagers already wonder why she isn't married. Her father, a teacher, is against early marriage. She was engaged to be married at six years of age to her uncle's son. He lives in Usta Mohammed, has acquired a bachelor's degree and now runs a medical store. However, Sajida maintains that marriage is an important decision in which the girl's opinion should be sought and as such, she is unhappy about the match. She questioned her father as to why he had betrothed her as a child, before she was in a position to express herself. He admitted that this had been a grievous mistake on his part but there was nothing to be done now. He had given his word and such promises had to be honoured.

Sajida hopes to have three children so she can remain healthy and take good care of her children. She intends to practice family planning and knows that in order to do so one must use condoms and pills that are promoted on television. Having a child every year is detrimental to a woman's health. Whenever she is ill she speaks to her mother about it. When she has periods and feels pain she takes Panadol, Buscopan or Ponstan for it. She changes her clothes two or three times a day. When she was in college she would use cloth pads, but stopped using them when she left because they made her feel uncomfortable.

In her village the men make all the decisions and the women are not consulted. She wishes fervently that they could be and her father agrees with her. He wants this to be the norm but he is constrained by their customs. But Sajida knows that one day the voice of women will be heard.

The need to produce a son was strong among educated women as well because of the prestige associated with it. It may need a few generations of educated women and positive role models to weaken this trend.

Asia, Village Garaywala, Punjab

Asia comes from a middle class family of village Garaywala, District Multan. She is 25 years old and has done FA. She runs a home school and her salary is Rs. 5000. She got married at the age of 19 to a person from outside her family, who now works as a librarian in Bahauddin Zakria University. They have two daughters; one is four years old and the other is almost three. Her father died when she was just nine and they faced a tough phase in their lives when money was very scarce and an uncle had to support them once in a while to keep things going.

She said in her family they did not believe in early marriages but since her father had died, when a good proposal came they agreed and she was married at an early age, even though it was her husband's second marriage.

Asia thinks educated girls are respected everywhere as they can make a significant contribution to the finances of a family. Regarding family planning, she and her husband have decided to use contraceptives. Her husband uses condoms because they have no side effects. The pills cause weight gain and irregular menses, injections cause continuous bleeding, while copper-T also causes weight gain and sometimes cysts as well. She says her youngest daughter is almost three years old and she tells her husband that they should try for a son, but he doesn't agree, so she doesn't insist, because she also realizes that the cost of everything is very high and it would be difficult to afford an additional child. Nevertheless, she does want a son and hopes that after sometime they will be able to try for one.

Secondary education combined with an ability to earn adds to the empowerment of women and better health outcomes. This empowerment will lead to the acceptability of educating women over the years.

Seema, Parao Khas, Charsadda, KPK

Seema is 28 years old. She is the eldest of eight siblings. When she turned five she was admitted to the primary school in Daguwal. It was close by and she used to go on foot. She completed her primary education and was then admitted to a high school in Charsadda as there was no high school in her village. People of the area didn't like

the idea of her going to the school but her grandfather, who was a frequent visitor to Lahore was influenced by the trend of girls education that he observed there and so he supported her to continue despite their criticism.

When she reached matriculation, a person told her father about LHW vacancies in the local hospital. He allowed her to apply and she was selected. Now she feels that education has really benefited her. It not only helped her get a job, whereby she can help her family, but it has also made her aware of how women should take care of themselves. She is continuing her education privately and hopes to do her BA.

Because she is educated, her opinion also carries weight. She has received many proposals and her opinion was asked each time. She rejected them as she did not like any of them but she says she will make her decision when the right man comes along.

Many people don't like the job of the LHW as it entails visiting homes and they think it is not suitable for girls, but her family is supportive and even though she gets disheartened sometimes, she carries on and her greatest ambition is to complete her training and then set up a private clinic to help the poor in her area. She also thinks that her example will encourage people to educate their daughters.

A woman from rural Punjab opined that for the illiterate life was simply about doing chores and bearing babies, so they neither questioned their fate nor complained, but educated women had an awareness about family planning, a balanced diet, when and what kind of help to seek during medical emergencies and how much more promise life held for them if they exercised their rights.

“Mera shohar aur saas kehtay thay ke aik beta (bazu) paida kar lo, lekin main ne kaha main ne bacha paida nahin karna, meri betyan hi bazu ban jayengi.” (A woman in Village Garaywala, District Multan)

“My husband and mother-in-law used to say I should bear a son as he would be my support, but I said no I won't have more children - my daughters will be my support.”

This made a difference in the quality of their lives, strengthening the already strong case for educating women.



Analysis

The critical issue raised by this research is to shift the focus of MDG achievement from isolated interventions, targets and quantifiable outcomes to a health systems approach, based on human rights and social justice. It has brought attention to context as opposed to content.

Examining the context, it may be instructive to look at some national statistics:

Poverty

Pakistan is ranked among the 43 countries most exposed to poverty risks according to the World Bank (<http://siteresources.worldbank.org/NEWS/Resources/WBGVulnerableCountriesBrief.pdf>). Poverty is widespread in Pakistan and is predominantly a rural phenomenon, even though with rapid urbanization urban slums are proliferating. Nevertheless, nearly two-thirds of our population lives in rural areas. Most of them depend on agriculture for their livelihoods. Many of them lack basic needs such as safe drinking water, primary health care, education and other social services. The World Bank's Task Force on Food Security in its report of 2008-09 put poverty in Pakistan to be at 36.1 percent. The latest assessments add at least 20 million more people to this club of have-nots, pushing almost 40% of the population below the poverty line. Another World Bank report titled '*Sparing lives, better reproductive health for poor women in South Asia*', among other statistics on poverty and women also states that 37.4% of Pakistan's children under the age of five are malnourished. The high poverty ratio has decreased Pakistan's spending on the social sector further, increasing poverty and reducing the standard of living in the country. High inflation, price hikes and shortage of commodities have added to the problem.

Considering the evidence showing the importance of socio-economic status to utilizing of health services, poverty alleviation has to be the foremost priority of the state.

Income inequality

The Gini coefficient is a statistical measure describing income inequalities, whereby a Gini coefficient of 0 would indicate an equal income for all earners and a Gini Coefficient of 1 would mean that one person had all the income

and nobody else had any. A lower Gini coefficient indicates a more equitable distribution of wealth in a society, while higher a Gini coefficient means that wealth is concentrated in the hands of a few people. The Gini coefficient is multiplied by 100 and expressed as a percentage (Gini Index).

According to the Human Development Report 2011, the Gini coefficient for Pakistan for the 2011 is 32.7. On the gender related development index (GDI) which looks at reproductive health, empowerment and labour market participation, Pakistan falls at 115 out of 145 countries.

Literacy

According to the Economic Survey of Pakistan 2010-2011, in 2009-10 the literacy rate in Pakistan was 57.4 percent. The male literacy rate stood at 69.5% while it was 45.2% for females.

Though *more than half of the rural population is illiterate*, the ratio improved by over half a percentage point to 49.2% by June 30, 2010 due to an increasing number of women and girls who can read and write. The female literacy ratio improved to 34.2%, a progress of 0.8% in a year. In rural areas, the 63.6% male literacy rate improved by only 0.4% in comparison. The *literacy rate in urban areas marginally declined due to a dip in the number of men who qualify as literate*. The urban literacy ratio decreased 0.1 per cent to 73.2 per cent, due to a fractional reduction in the male literacy rate. At present more than eight out of ten urban males are educated but the ratio is below that of 2008-09.

The provincial literacy rates also depict interesting trends. In Punjab and KPK the number of educated people increased, while it decreased in Sindh. The figure remained stagnant in Balochistan at 51.5 percent. Punjab turned out to be the most educated province, followed by Sindh, Balochistan and KPK.

In Sindh the percentage of educated people dropped by 1% to 58.2% in 2009-10. The declining ratios were witnessed across the divide, rural, urban, females and males. Contrary to that, in Punjab, the literacy rate increased to 59.6 percent. Over half of the rural population is literate and the urban literacy ratio stood at almost three-fourth in the province.

In KPK the literacy rate increased to 50.9%, a progress of almost one per cent. The rural literacy rate increased to 48.4% but the *urban literacy dipped by 0.4 percent*.

Population growth

While Pakistan recorded the lowest GDP growth rate (2.4%) among regional countries in 2010-11, the country's population swelled at a rate of 2.1%, the highest population growth rate in South Asia, adding more pressure on the country's already meagre resources.

Despite claims by successive regimes of allocating huge amounts over the years on 'population welfare' programmes, *the country has witnessed a decline of only 1.01% points in population growth rate during the last 30 years.*

Contraceptive prevalence

Comparative studies show that countries with higher contraceptive prevalence have lower population growth rates, therefore, it is not surprising to find Pakistan having the lowest contraceptive prevalence, at 30%, not just in South Asia but among major Muslim countries (Pakistan Economic Survey 2010-11).

The 1990s saw contraceptive prevalence more than double from a low 11% in 1991 to 28% by the end of the decade, with rural CPR increasing from 6 to 22% and urban from 26 to 40 percent. Since the new millennium, there has been little increase in contraceptive prevalence, with the national average only increasing to 30% by 2007. This stagnation in contraceptive use does not reflect the demand for family planning, which rose consistently from the 1990s. Unmet need for family planning rose from 33% in 2001 to 37% in 2007. This high and persistent unmet need explains the high proportion of unwanted pregnancies and induced abortions that take place in Pakistan (Sathar and Zaidi, 2010).

Iran, which has been under a conservative regime for decades, has a contraception prevalence of 74 percent. The average prevalence in Asia stands at 67 percent.

Youth bulge

Nearly 50% of Pakistan's population is below 20 years of age and over 60% below 30 years (Framework for Economic Growth Pakistan 2011, Planning Commission of Pakistan). With growing unemployment, these youths become disconnected from the country's economy and disaffected with its political

structure and are vulnerable to the blandishments of extremists. Demographic projections show this ‘youth bulge’ will continue to dominate the population for another 30-35 years.

Conflict

Yet another factor which is crucial to the discourse on ‘context’ is the fact that we are a country in the midst of a conflict. This important point is often not taken into account when discussing the failure to achieve targets like the MDGs.

In *‘Breaking the conflict trap: civil war and development policy’*, Paul Collier of the World Bank describes the economic and social cost of civil war. He says ‘..the costs to the active participants in combat bear account for only a trivial amount of the overall suffering. The damage from a war ripples out in rings. The inner ring is the displacement, mortality and poverty inflicted on non-combatants within the country. By the end of the typical civil war incomes are around 15% lower than what they would otherwise have been, implying that about 30% more people are living in absolute poverty. However the end of the civil war does not end the costs arising from it. Many of the economic costs such as high military expenditure and capital flight persist for years after the conflict. So too do heightened mortality and morbidity rates. Approximately half of the loss of disability adjusted years of life expectancy due to a conflict, arise after it is over. These economic and health costs of conflicts are not usually compensated by any post conflict improvements in economic policy, democratic institutions or political freedom. On the contrary, all three deteriorate. The typical civil war starts a prolonged process of development in reverse.’

Natural disasters

A series of natural disasters has uprooted communities and diverted resources and has contributed to slow progress. According to UNICEF, almost 100,000 pregnant women miscarried in the immediate aftermath of the devastating floods of 2010 in Pakistan. Seventy percent of those affected by the disasters have been women and children. The repercussions on the health system and the economy as a whole are still being felt.

Political and administrative collapse

The prevailing state of affairs is further aggravated by an unstable political situation and rulers who have failed to implement good governance. The

present governance crisis is reflected in the health sector as well, and it has much to do with the Local Government Ordinance of 2001 being held in abeyance. There is a loss of empowerment felt at the local level with the ending of the local government system and the councillors and nazims becoming non-functional. The 33% representation of women at the local level has also been done away with. The system is now returning to a more centralized mode and therefore less accessible, and people are once more resorting to the old *panchayat* system for a quick resolution of their problems. Forums like health committees where people had the possibility of being proactively involved in initiatives like transport and finances for obstetric emergencies or the formation of CCBs were potentially important mechanisms. The local government system also provided a better monitoring and accountability mechanism. It is widely accepted that the best governance model in today's world, is that of decentralization. We are moving in the opposite direction and a reversal of this trend is essential for better governance in the health sector, translating into better health care delivery and a more empowered, aware and proactive citizenry.

In this context, it is understandable that health overall, and reproductive health specifically, becomes a casualty of the system. It is not realistic to expect improvements in isolated health indicators when the whole governance system is under strain. However, every crisis offers an opportunity. The state has to recognize its responsibility towards the people; it was repeatedly seen in the research that people look towards the state for relief and support. Policies based on the principles of equity and social justice can improve the context within which specific interventions and goals like MDG-5 will stand a chance of success.

There are many issues related to sexual and reproductive health which are embedded in traditional biases and conservative norms but it has been observed that when interventions are initiated by the state and are institutionalized they can overcome these biases and norms and are readily accepted. A case in point is the way people accept lady doctors, teachers and lady health workers. When appropriate options are provided, people make the right choices even if they go against traditions, so women will opt to go to a doctor rather than an untrained *dai* for delivery if a lady doctor is available in their village. Young adolescent girls repeatedly stated that their families would not listen to or understand their problems but if the government were to provide facilities for them they would avail them. This underscores the responsibility of the state towards its citizens specially the

weak and vulnerable ones, because they depend on the state for protection and care. Thus the onus for change rests with the government. If it has the will to bring about this change, the way can be found.

Conclusions and Recommendations

Conclusions

Two definitive conclusions can be drawn from this research on the monitoring and analysis of MDG-5 implementation in the four provinces of Pakistan:

1. There was no significant difference between the districts where interventions had been carried out and those where they had not
2. The situation was generally the same in all the four provinces, particularly in the rural areas.

The differences that were seen were primarily related to socio-economic status, education and to a certain extent to the people's urban or rural status.

It was observed quite unequivocally that the programs for implementation of MDG-5 were not benefiting those who were living below or hovering close to the poverty line. As people moved up the social ladder and closer to the urban centres, the programs both public and private began to have an impact and their health care options increased and became more meaningful. A poor woman had choices too, but they were between an un-trained dai, and a pir which does not really translate into a realistic or beneficial choice but a slightly more affording woman could choose between going to the BHU in the next village or to a private doctor, in either case her chances for getting proper services became relatively better. These choices and the quality of service kept improving as people moved up the social scale. Women educated up to the secondary level were able to make more informed choices.

However an impact assessment of an intervention has to consider how much that intervention serves those that are most in need. No matter how good an intervention is, if it is serving only a limited number of people, it cannot be stated to be successful when the larger picture remains unchanged. With that parameter in mind, the interventions observed in the research could not be seen to have an impact.

It can also be concluded from the research that reproductive health cannot be reduced to targets and outcomes that have to be quantified and counted. This narrowing of the agenda does not even serve the purpose of reducing maternal

mortality as this depends on taking a human rights approach and looking at the underlying social and economic determinants of health. It was with this thought that this report deliberately avoided any statistical analysis of the data. The research had been undertaken with a qualitative methodology therefore rather than looking at numbers the report has tried to look at the social and economic context of the situation and place the issue of reproductive health and MDG-5 within that context. However even if considering purely quantifiable outcomes, the prospects of achieving the MDG targets are low according to the results of the current study.

Foremost among the negative factors is the persistent inferior status granted to women in the society. As many of the case studies illustrate, they are deprived of basic human rights of education, inheritance, decision making regarding their marriage, family size, physical movement, their right to dignity and the right to lead a life without violence and discrimination. All these factors have a direct impact on their health and thus they are denied this basic right as well. It is obvious therefore that without a human rights and social justice oriented approach, their health status cannot be improved.

The state of government run health services is generally poor. They are rife with corruption, often under-staffed and ill-equipped. The interventions in many instances are based on political expediency and not undertaken with consideration of need or equity. The menace of dual practice, with public sector doctors and paramedical staff running lucrative private practice at the expense of the public positions further erodes the trust and efficiency of public health institutions. On the other hand, the private sector is completely unregulated. From the quality of services, to the qualification of practitioners and the amount of fees charged, everything is working according to the principles of the free market but without any checks and balances. This leaves potential users at the mercy of the providers, with no protection from malpractice, exploitation or over-charging.

Other supporting infrastructure in terms of a public transport system, roads, schools or an efficient and representative local government system for political mobilization and voicing of demands at the village level is also absent or very weak. There is a governance crisis in all provinces.

This leads people to lose faith in the state and government institutions and fall back to their indigenous and traditional support networks. Thus castes, tribes and sects assume a lot of importance and a self-protective and survival

mentality takes over. In a patriarchal society, the old traditions and customs also means reverting to discriminatory and unfair practices for women. Therefore not sending girls to school, early marriages, taking a bride price, exchange marriages, *jirga* or *panchayat* systems to settle disputes or discriminating in food, all become the norm without the state stepping in to check or protect. Minimum age requirement is not complied with at the time of marriage, and most of the time marriages and the births of female children are not registered. Specifically in health, in some areas like the health of adolescent girls and abortion related care, the awareness and services are simply absent but in other more mainstream areas like family planning, antenatal and obstetric care, the state is guilty of negligence. For women this means finding allies in their limited social set up. Friends, neighbours, mothers and sisters are among these natural allies. They also then deposit a lot of faith in quacks professing healing powers, religious soothsayers and divine help. Thus there is a trend for an increasing superstition, religiosity and conservatism in the society.

The reproductive health needs of the youth and adolescents are being overlooked. Both male and female youth felt there is a lack of awareness on RH and strongly expressed the desire for information, counselling and services. There are no services catering to the young age/adolescent population and LHWs are not equipped to handle the needs of adolescents, nor is it part of their mandate.

Considering the fact that men are the ultimate decision makers, the lack of focus on them in terms of awareness raising, male mobilizers or recognizing their common sources of information, like the local general store, also needs to be highlighted. Men report not having enough information about family planning and contraceptives, being unaware of women's reproductive health needs, and not sure of where to get this information from.

On the positive side, the role of the LHW must be appreciated. This cadre of health workers is providing services even in the most remote areas. They are accepted and respected by the community, they become the sole link between women and the formal health sector, they provide services, information and most importantly they become influential allies for women who have no other support. The LHVs, from the static arm of the health service are also providing good service. A crucial area for consideration therefore, is the effective integration of the LHW program in the provincial health departments, in the post 18th constitutional amendment scenario. Further

effectiveness can be achieved by improving coordination between LHVs and LHWs needed improvement and ensuring LHVs undertook field visits as specified in their terms of reference and did not just restrict themselves to providing services.

Media in the form of radio and TV is playing a positive role and while this is still limited in many areas, the potential for growth in this area is immense. Social marketing as done by Green Star for instance is a good illustration of how awareness can be raised and need created in the community, if media is used in an innovative way. Another successful model that could be considered is that of the 'Info-ladies' of rural Bangladesh, where local women are provided a laptop and a mobile phone (as well as a bicycle) and they go from house to house providing digital information on areas as diverse as farming and animal husbandry to health and nutrition.

It is also very obvious from the research that even the limited access to education for women makes a significant difference in the quality of their lives. The research has documented the link between secondary education and reproductive health. This just adds to the already huge body of evidence that education of women will lead to improved health outcomes. Furthermore, there is a widespread desire to educate daughters and limit family size.

It is very clear that reproductive health has to be viewed as a social justice issue. The strategy to improve service delivery through vertical interventions, without making the link with empowerment at the individual level within families and communities, looking at considerations of equity and equality, or the State taking responsibility to protect the vulnerable and weak, a positive change in reproductive health outcomes will not be achieved.

Recommendations

The reforms needed to bring about meaningful change are beyond the scope of this report, however as explained in the previous section, it is impossible to prescribe policy recommendations for the health sector and specifically for the achievement of MDG-5, without considering the broader context of women's lives. In order to create an environment where the quality of lives of women can improve in a holistic way, multi-sectoral reforms are needed.

These reforms need to be in education to provide functional girls schools within physical access; in labour laws, ensuring women get adequate wages for labour; in water and sanitation so that potable water, proper toilets and a sewerage system is ensured; in roads, public transport and communication; in environment and agriculture, addressing issues of irrigation canals, pesticides; in local government systems and conflict resolution mechanisms so that women have a say; and in de-politicization of health and development initiatives, ensuring instead that they are need and population based.

More specifically, the following steps are recommended in the health sector:

1. Re-structuring the health and population welfare departments in the light of the 18th constitutional amendment. This could be done through proper ownership at the provincial level and the integration of reproductive health and family planning as a permanent part of the regular health system delivering at the grass roots.
2. Strengthening the role of lady health workers. Their program needs to be merged effectively with the regular provincial health departments so that issues of salaries, trainings and hiring can be localized and made more efficient.
3. Expanding the ambit of LHWs to include Adolescent Reproductive Health, as well as making Adolescent health a part of the educational curriculum
4. Making amendments in the Child Marriage Restraint Act 1929 to increase the minimum age of marriage to 18 years.
5. Making birth registrations mandatory for determining age at time of marriage; and ensuring compliance of minimum age by marriage registrars.
6. Revitalizing the role of male mobilizers who are currently almost non-functional and considering other actors like local shop keepers to spread awareness among men.
7. Enhancing coverage of and access to improved services for family planning, and reproductive health through providing improved PAC services and availability of medical and surgical treatment at primary/tertiary health facilities. Budgetary allocations for this by

provincial governments should be a key priority in the post-18th constitutional amendment scenario.

8. More innovative use of mass media like radio and TV to raise awareness. This is a unique window of opportunity because media and technology like mobile phones are reaching out to people irrespective of socio-economic class. In this context the concept of social marketing needs to be explored further as it has already been shown to be effective in the area of family planning.
9. Utilizing potential of the internet to provide awareness and tele-medicine on the pattern of the highly successful 'Info-ladies' of Bangladesh
10. Re-visiting the laws prohibiting quackery. The Prevention of Misuse of Allopathic Medicine Ordinance 1962 is the current legislation which deals with this issue but it may be pertinent to reconsider why its implementation is so weak and whether new legislation is needed to make it relevant. With regard to non-allopathic medicine as well, there is a need to re-evaluate the role of the various councils and mechanisms overlooking the practice of homeopathy, unani medicine, hikmat etc.
11. Re-thinking strategies to prevent exploitation of public health sector through the commonly prevalent problem of dual practice. For this other mechanisms of private public partnerships in the health sector need to be explored, whereby legal mechanisms for private practice can be provided to benefit both the doctors as well as the patients. One such option was the Rahim Yar Khan Model* but there are other possibilities e.g. through accreditation of private health care providers which can be considered.
12. Establishing an effective and representative local government system so that a system of accountability can be put in place.

Potential areas for future research

Two factors are of immense importance when considering future strategies for improving maternal health. The first is the demographic youth bulge and the opportunity it presents, while the second is the fast spread of the digital age

* In 1999, the Health Department Punjab considered improving management and expanding service delivery in BHUs with the involvement of the NGO sector. As a first step, the management of three BHUs in District Lodhran was outsourced to the National Rural Support Program, forerunner of the Punjab Rural Support Programme (PRSP). Since the initiative showed some potential, a pilot of the model was experimented in 2003 by contracting out management of all 104 BHUs in District Rahim Yar Khan to PRSP. This is known as the RYK Model.

of information. An innovative combination of the two may be the way forward for the future. It would thus be timely to carry out research looking at various options on how this could be done. The Bangladesh model of ‘InfoLadies’* is one example which could be piloted in selected districts. School health programmes, with schools being used as local resource and information centres could be another.

* *InfoLadies is an innovative program that aims at giving thousands of Bangladeshi women in remote areas access to information through various information and communication technologies (ICTs) to improve their chances in life. A typical Infolady is a trained rural young woman who cycles about five to ten kilometers a day and offers a variety of ICT-based and other services at the doorstep of the rural community she lives in. The Infolady carries a range of ICTs with her. These include a netbook computer with webcam, digital camera, mobile phone with internet connectivity and a headphone etc. She also carries a weight measurement machine, blood pressure machine, blood testing kit, pregnancy test kit, sugar test kit etc. It has proven to be an effective and sustainable business model empowering not only the people it is designed to serve, but also the women who deliver the services.*



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