Bringing SRHR to the FOREFRONT in the post 2015 DEVELOPMENT agenda
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Written and Compiled by: Dr. Tabinda Sarosh

Shirkat Gah team and contributors

Presentations
Dr. Tabinda Sarosh, Ms. Tahira Abdullah (Senior Human and Women Rights Activist, Dr. Adnan Khan (Research and Development Solutions), Dr Ali Mir (Pop Council, Pakistan), Dr. Sarah Saleem (CHS, Aga Khan University), Mr Altaf Ezid (Secretary PWD, Punjab)

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P.O. Box. 5192, Lahore - Pakistan
E-mail: Lahore pubs@sgah.org.pk
                 Karachi shirkat@cyber.net.pk
                 Peshawar sgpesh@gmail.com
Website: www.shirkatgah.org

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Government Representatives

Ms. Mehtab Akbar Rashdi (MPA Sindh), Ms. Rahila Durrani (MPA Baluchistan), Mr. Shahzad Malik (Chief of Population, Planning Commission of Pakistan), Dr. Ghulam Asghar Abbasi (Chief of Health, Planning Commission of Pakistan), Mr. Altaf Ezid (Sect PWD, Punjab), Dr. Zafar Ikram (Provincial Coordinator MNCH, LHW and Nutrition for Children and Pregnant Mothers, Punjab)

Civil Society Endorsements and Input

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Preface

In view of the various regional and international processes that Pakistan has been a signatory to such as the ICPD Plan of Action and the MDG 5a&b, Shirkat Gah held a national consultation in Islamabad on December 30, 2013 with various government, media and civil society stakeholders.
The objective of the consultation was to:

- Review the progress of Pakistan in the terms of Sexual and Reproductive Health and Rights (SRHR) in the context of ICPD, MDG 5a&b and the recent APPC.
- Highlight the importance of prioritizing Sexual and Reproductive Health and Rights in the future development planning of the country.
- To collectively generate recommendations to improve the status of SRHR from the participants, for the CPD.
BACKGROUND & INTRODUCTION

In 1994, at the ICPD in Cairo, landmark decisions were taken by 179 countries across the globe to take notice of alarming indicators around sexual and reproductive health and the factors that contribute to maternal morbidity and mortality and their link with population and global development. Pakistan was represented by the, then, Prime Minister of the State, Ms. Benazir Bhutto and is a signatory to the ICPD Plan of Action (PoA).

The Plan of Action set out to:
- Provide universal access to family planning, sexual and reproductive health services, and reproductive rights;
- Deliver gender equality, empowerment of women and equal access to education for girls;
- Address the individual, social and economic impact of urbanization and migration;
- Support sustainable development and address environmental issues associated with population changes.

Shirkat Gah participated in the ICPD and was at the forefront in the civil societies’ advocacy efforts for progressive language and putting forward substantial recommendations that eventually shaped the PoA. This was followed by SG’s participation in the Beijing Conference (Fourth World Conference on Women) in 1995.

In addition, to the above SG contributed consistently towards shaping the CSO recommendations in various regional and international forums as a part of its advocacy for a human rights approach towards women’s issues including universal access to SRHR for all.

In 2010, Shirkat Gah carried out a 2 year long national qualitative research to track the progress towards achieving
MDG5a and b in Pakistan. On the basis of the findings SG did provincial and national level policy advocacy with the government representatives. SG designed and carried out a nationwide advocacy campaign including individualized policy briefs for Population, Health, Women Development and Education departments, policy dialogues at district, provincial and national level as well as regional and international level advocacy.

On December 30, 2013, Shirkat Gah organized a national dialogue on bringing SRHR to the forefront of the post 2015 development agenda for Pakistan. The consultation aimed to generate recommendations to prioritize SRHR in the post 2015 national development agenda.

There are two important international UN events that will be taking place in the context of population and development in 2014. The first is the 47th session of the CPD (Commission on Population Development) to be held in April and secondly in September 2014, the UN General Assembly will convene a special session on ICPD (International Conference on Population and Development) beyond 2014 in which CPD (Commission on Population and Development) delegates from 179 countries will sit together to review the progress and achievements towards the goals set out in the landmark International Conference on Population and Development. The CPD delegates of each participating country will also set out development agenda for the coming years.
KEY ISSUES IMPEDING PROGRESS IN SRHR IN PAKISTAN

Maternal Mortality Ratio in Pakistan is 276. Access to emergency obstetric and post-partum care is poor and only 56 percent women are able to access antenatal care. A host of factors such as distance, transport, cost, permission, escort and knowledge of options come into play.

The various service providers 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. The gaps in services left by the public sector are being filled by a variety of service providers who range from religious soothsayers and quacks to private doctors and clinics.

Unsafe Abortions: Hospital-based data (2013) show that 700,000 women in Pakistan have post abortion complications annually. SG’s research and experience indicates that most abortions take place in clandestine settings and this data is just a tip of the iceberg. Women often resort to unsafe abortion due to absence of reproductive choices and family planning services and commodities. Abortions account for 6% of maternal deaths (PDHS 2006-2007) and are often used for family planning. Reasons for resorting to an unsafe procedure include, but are not limited to, unavailability of appropriate health facilities in the vicinity, lack of awareness about how and where to access the appropriate health provider and the consequences of unsafe abortions, social restrictions on mobility and service providers who are biased and turn patients away.

Unmarried women are at higher risk of suicide and death and morbidity due to unsafe abortion resulting from social stigmatization.
Barriers to accessing family planning: Contraceptive prevalence rate in Pakistan is 30 percent and burden of family planning largely lies with women. Social norm is for large families, exacerbated by the social imperative to produce sons. Early age marriage, women and girls’ low status in society, limited female education and employment opportunities contribute towards low contraceptive use and high fertility rates. Family planning awareness is done through word of mouth, Lady Health Workers (LHWs), media etc., but increasing demand is not being met with an increase in supply. LHWs are appreciated because they provide services at doorstep, but are limited to pills and condoms, indicating a dearth of commodities and choices.

Inadequate Health Systems Governance: Evidence suggests that ill-equipped, under stocked and under-staffed facilities, lack of EmOC services and gaps in information dissemination, monitoring and accountability mechanisms as well as lack of continuous professional capacity building negatively affect the responsiveness, efficiency and effectiveness of services in Pakistan. According to a research by RADS, 96% of the funds utilized by the population department are directed towards administrative costs and only 4% are available to buy commodities, a finding that
points towards issues around funds utilization. Failure to ensure all birth and marriage (nikah) registrations is also a key governance issue that negatively impacts the SRHR of adolescent girls. The fairly recent ‘Devolution’ of departments is also clouded by a certain lack of clarity and a follow-up mechanism.

**Adolescent Reproductive Health:** RH services are not available to adolescents, especially in rural settings due to lack of trained providers and because of social and cultural barriers. No component of health education or awareness raising specifically addresses adolescents. Early age marriage has a high prevalence and data suggests correlation with maternal mortality. Shirkat Gah’s published research in Sindh (Jacobabad and Matiari) found the average age between 12-14 for girls. 18% of Pakistani women have had their first birth by age 18; 9% have begun child bearing between 15-19 years and 7% are already mothers between 15-19. Evidence shows positive correlation between girls’ secondary education and RH outcomes and yet 77 percent of girls drop out of schools after primary level.

**Marginalization of Women’s Rights in population and development discourses:** Population discourses often neglect the need for highlighting the marginalized status of women in a tribal, feudal and conflict-ridden society under the threat of religious fundamentalism in Pakistan. Legislated inequality of women, lack of decision-making and mobility opportunities, lack of access to information, lack of public services and public awareness about services, lack of access to justice, and feminization of poverty are huge barriers in achieving our ICPD commitments. Violence and fear of violence are key deterrents for women in accessing reproductive care and rights. Media reports reveal 65,316 cases between 2008 and 2011 but due to lack of data collection mechanisms and the stigma associated with openly sharing
and reporting domestic violence these figures grossly under represent the reality. Besides domestic violence, reports of sexual violence and harassment, honor killings, early and/or forced marriages, social and economic deprivation and psychological torture emerge every day and are documented in various SG research reports. Sexual minorities continue to suffer violence, social stigmatization and marginalization and remain deprived of opportunities and rights.

These alarming facts and statistics are among the worst in South Asia. Although the outcome document for the 6th Asia Pacific Population Conference (2013, Bangkok) endorsed by Pakistan has progressive language on Sexual and Reproductive Health and Rights but robust commitment and political will on the part of the government are required to bring about tangible changes in the current status of SRHR.

Based on the consultation the civil society agreed upon the following recommendations for the government and the civil society actors to ensure that SRHR remains a priority for the post 2015 development plans at national, regional and international level.
HEALTH SYSTEMS GOVERNANCE STRENGTHENING FOR QUALITY SERVICE DELIVERY

A strong political will, commitment and leadership from the government are the need of the hour to address the issues around health systems. Health and population policies and programs should take a cross-sectoral horizontal approach instead of a vertical and silo-ed approach to increase the quality and accessibility of services.

It is essential to not only increase funds allocation for health and population programs but also to ensure a mechanism for smooth funds release and utilization. Outreach programs like the Lady Health Worker Program are much appreciated and they along with other mid-level providers should be strengthened as a trained and responsive cadre. There should be support for safe delivery for all births at home and in institutions by an effective referral system including Emergency Obstetric Care through registered and trained TBAs whose presence on ground is a reality. Maternal death surveillance must be institutionalized along with effective monitoring systems and annual reporting. Considering the burden of maternal mortality attributed to unsafe abortion and complications related to post abortion care national and provincial policies need to be introduced. Private health sector and the pharmaceutical sector needs to be strictly regulated and monitored to ensure availability of affordable essential and non-essential drugs and regulate the quality, uniformity and accountability of services and pricing system of the private sector. In short Health Systems Governance must be strengthened to ensure accountability and transparency mechanisms at central and implementation level, by working in unison with the bureaucracy and technocracy, prioritization of principles of health equity, and evidence based decision making.
GOOD POLICIES FOR GOOD GOVERNANCE

Comprehensive rights based provincial policies for health and population must be implemented to ensure maintenance of facilities, equipment and human resource provisions with reservation of seats for women, supply chain management of a variety of contraceptives and other stocks and continuous training and capacity building of the staff. These policies should have as their foremost aim to create an enabling socio-economic and political environment for women within an equality and equity framework to enable women to access and exercise their sexual and reproductive rights fully. Also required is a comprehensive approach to ensure access to information and affordable and quality care at all stages of a woman’s lifecycle and across location (home, community and health facilities). The policies must entail a component of community participation for focused needs based services and facilities with emphasis on the needs of adolescents and youth. An effective information dissemination policy of Health and Population that ensures transfer of information to the doorstep of vulnerable women in need of services must be in place. The civil society is in consensus that the measures in this regard are to date insufficient and that a vigorous strategy which involves print and electronic media, social media and tools such as TV dramas should be employed.
WOMEN EMPOWERMENT AND SOCIAL DETERMINANTS OF HEALTH

It is a well-documented fact that women in Pakistan face discrimination in all walks of life which adversely affects their access to services. Most health and population programs continue to have a vertical approach towards the issue without the consideration of social determinants of health as outlined in the Alma Ata Declaration which states that, “Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.” Hence there is a need to adopt and implement policies an integrated and multi-sectoral approach to overcome viewing SRHR in isolation, including socio-economic and political factors, urbanization, migration and environment; ensure equitable sharing of benefits of sustainable economic development.

Pakistan is a signatory to CEDAW as well as the ICPD’s Program of Action. It is high time that Pakistan implements its CEDAW Plan of Action that looks at the needs of women from a rights perspective taking into account the root causes of gender bias: patriarchy, feudalism, tribalism, extremism and issues of food security, livelihood, fair distribution of labor and labor justice.
ADOLESCENT FRIENDLY POLICIES AND SERVICES

Adolescent SRHR is a neglected area and needs to be addressed keeping in mind various socioeconomic constraints that adolescents have to negotiate in the pursuit of accessing their rights. At policy level the foremost important action required is the standardization of age of marriage to 18, and implementation of the current law which states that the age of marriage is 16 for girls and 18 for boys. At implementation level, adolescent and youth friendly and quality services should be made available that are client centred and have a preventive, curative and rehabilitation component.

Implementation of Article 25 of the constitution that promises education for all Pakistani citizens till the age of 16 is also mandatory and schools should be equipped to provide a conducive environment for girls such as provisions of toilets, boundary walls etc. The curriculum should include Life Skills Based Education (LSBE) as schools provide a great opportunity for creating SRHR awareness as well as developing leadership and life skills in children.

Adolescents, both boys and girls need to be included in structured, culturally feasible discussions around their health and needs so that policies and programs are responsive and needs focused. This should go hand in hand with an effective information dissemination policy for the adolescents. A possible way is to include Adolescent Reproductive Health in the mandate of the LHWs as they provide door to door services and counseling. According to SG’s research, adolescent girls identified LHWs and traditional birth attendants as their confidantes and allies in terms of sharing of health issues.
COMMUNITY PARTICIPATION AND BUILDING OF MALE ALLIES

Men are the key decision makers and need to be sensitized and involved in community consultations, policy making and implementation of programs. Outreach services for men such as the Community Male Mobilizers need to be strengthened where they are functional and reactivated where they are non-functional. Community-level awareness-raising and health promotion, as well as Community Systems Strengthening (CSS), extending beyond the formal health system, play a crucial role, particularly in the areas of care and support. Conceptualization and policy framework development should be informed by direct feedback from the community in order to develop a needs specific and responsive program. Community consultations should prioritize the engagement with women girls and boys as well as other marginalized and vulnerable groups.
RECOMMENDATIONS IN THE CONTEXT OF DEVOLUTION OF THE MINISTRIES OF HEALTH AND POPULATION WELFARE

Provincial Population Policies should be developed and adopted within a stipulated time to ensure that the Programme continues without any setback after stoppage of Federal funding in June, 2015. The policies must be in line with the national ICPD commitments and should be the basis of a National Plan of action (NPA) for Reproductive Health. One possible mechanism for coordination could be the revitalization of Pakistan National Commission on Population as well as development of provincial commissions. To control population growth, family planning alone is not adequate and there is a need for a comprehensive plan which would provide access to information and development opportunities for individuals with focus on women empowerment and gender equality. The policy needs to adopt a multi-sectoral approach, set realistic goals and include a plan of monitoring and accountability. The policy needs to consider the youth bulge and the reproductive health needs of the youth. However, none of this can be efficiently carried out without carrying out the much delayed population census.

For clarity and consistency, one National Population Policy Framework should be designed; developed in consultation with the provinces, civil society, academia, private sector and other stakeholders that defines the relationship between Federal and the Provincial governments for execution and implementation of the Population Welfare Programme and the relationship between provincial components of the country-wide Population Welfare Programme.
OTHER ESSENTIAL COMPONENTS OF THE FRAMEWORK SHOULD BE

- Continuation of Population Welfare Programme as a priority at the Provincial levels
- Allocation of adequate resources for the recurrent and expansion costs
- Build upon the commendable work of the technical wing of the former Ministry of Population Welfare, the Directorate of Clinical/Non-clinical Training and its allied Regional Training Institutes, and Population Welfare Training Institutes to ensure a constant supply of skilled personnel, through competency based training.
SPECIFIC RECOMMENDATION FOR REGIONAL AND INTERNATIONAL FORA ON WOMEN’S HEALTH AND RIGHTS SUCH AS CPD

- Strong Pakistani delegation to continue the tradition of APPC (Asia Pacific Conference on Population) and endorsement of progressive stances on SRHR;
- CSOs and CSO platforms representation in the Pakistani delegation; CSOs continue to bring evidence-based, gender-disaggregated data to public & media and have been instrumental in minimizing the gap between the state and the citizens;
- Coordination and preparation of the delegation in forms of preliminary meetings and consultations among each other and various stakeholders such as the CSOs, youth groups, minority groups;
- Post CPD de-briefing meetings of the delegation with line departments and CSOs to ensure implementation of policies and introducing new policies in-line with the CPD and APPC resolutions;
- Devising follow up mechanisms/committee