Khawar Mumtaz

icpd

Ten Years On

Pakistan Report
The report is based on desk reviews by Ayesha Khan on women's empowerment, Sarah Javeed on sexual rights, HIV/AIDS and reproductive cancer, Rabia Khan on gender equity and equality, and Dr. Sarah Saleem on maternal mortality and morbidities; interviews by Hilda Saeed and valuable comments on drafts at different stages; assistance in the first draft by Ayesha Kariapper; PRHN members' feedback and inputs; and Rashidah Abdullah and Ranjani Krishnamurthy's comments and feedback on the first and second drafts.
Ten Years On: Pakistan Report

All Rights Reserved. No part of this publication may be reprinted or reproduced or utilised in any form without the prior written permission of the publisher, or without clearly acknowledging Shirkat Gah Women's Resource Centre as the resource of this information.

Acknowledgement

This publication has been published with the help of Asian Pacific Resource & Research Centre for Women (ARROW)
List of abbreviation 8

Chapter a:
Executive Summary 13
→ 1. Introduction and Methodology 13
→ 2. Country Context 14
→ 3. Findings on achievements 14
→ 4. Contrast with government reports 15
→ 5. Barriers and facilitating factors 16
→ 6. Challenges and recommendations 17

Chapter b:
Introduction and Objective 19
→ 1. Population policies and programmes: a brief history 19
→ 2. ICPD-Cairo and its influence 20
→ 3. ICPD monitoring 21

Chapter c:
Methodology and County Team 23
→ 1. Overall methodology 23
Chapter d:

Country Context

1. History of SRHR policies, legislation and programmes before ICPD

2. Preparations for Cairo

3. The impact of Cairo on policies

4. Donor funded programmes

Chapter e:

Assessing Progress in Achieving ICPD Goals and Objectives

1. Study Findings

2. Gender, social equality and equity

(a) Human Development Index and Gender Development Index

(b) Gender Empowerment Measures

(c) Labour Force Participation

(d) Literacy and Education

(e) Violence Against Women

(f) The Girl Child

3. Reducing maternal mortality and morbidity, promoting safe motherhood and safe abortion.

(a) Maternal Mortality and Morbidity

(b) Maternal Morbidity

(c) Antenatal Care

(d) Safe Abortion
4. Promoting and protecting sexual rights, safe contraception, preventing/ treating HIV/AIDS and reproductive cancer. 44
   (a) Family Planning Information, Education and Services 44
   (b) Access to Counselling/ Support and Clinical Services for HIV/AIDS and Reproductive Cancer 46
   (c) Reproductive Cancer 47
   (d) Male Involvement 47

Chapter f:
The Main Implementation Barriers and Facilitating Factors 51
1. The Barriers 51
2. Facilitating Factors 54

Chapter g:
Future Concerns 57

Chapter h:
Challenges and Recommendations 59
   (a) Challenges to Government 59
   (b) The World Bank, ADB, and donors 60
   (c) Challenges and recommendations to civil society 61

Chapter i:
Overall Conclusion 63

Appendix 1 67
Appendix 2 71
References 83
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AGHS</td>
<td>Aga Khan Health Services</td>
</tr>
<tr>
<td>AMDD</td>
<td>Averting Maternal Deaths and Disabilities</td>
</tr>
<tr>
<td>AYP</td>
<td>Adolescent and Youth in Pakistan</td>
</tr>
<tr>
<td>ARROW</td>
<td>Asian Pacific Resource &amp; Research Centre for Women</td>
</tr>
<tr>
<td>BHUs</td>
<td>Basic Health Units</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>COI</td>
<td>Commission of Inquiry on Women</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>ESR</td>
<td>Education Sector Reforms</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPAP</td>
<td>Family Planning Association of Pakistan</td>
</tr>
<tr>
<td>GDI</td>
<td>Gender Development Index</td>
</tr>
<tr>
<td>GRAP</td>
<td>Gender Reform Action Plan</td>
</tr>
<tr>
<td>GEM</td>
<td>Gender Empowerment Measure</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>GoP</td>
<td>Government of Pakistan</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HRCP</td>
<td>Human Rights Commission of Pakistan</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>ICPD-PFA</td>
<td>The International Conference on Population and Development-Platform for Action</td>
</tr>
<tr>
<td>IFR</td>
<td>Individual Fertility Rate</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IWHC</td>
<td>International Women’s Health Coalition</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intra Uterine Contraceptive Device</td>
</tr>
</tbody>
</table>
IEC: Information, Education & Communication
ILO: International Labour Organization
JICA: Japan International Cooperation Agency
LHW: Lady Health Worker
LHV: Lady Health Visitor
LB: Live Birth
MMR: Maternal Mortality Rate
MoPW: Ministry of Population Welfare
M&E: Monitoring and Evaluation
MoH: Ministry of Health
MDG: Millennium Development Goals
NWFP: North West Frontier Province
NGOs: Non Governmental Organisations
NIPS: National Institute of Population Studies
NCSW: National Commission on Status of Women
NACP: National AIDS Prevention and Control Program
NCMH: National Committee on Maternal Health
PRHFPS: Pakistan Reproductive Health and Family Planning Survey
PRHN: Pakistan Reproductive Health Network
PFFPS: Pakistan Fertility and Family Planning Survey
PoA: Programme of Action
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIHS</td>
<td>Pakistan Integrated Household Survey</td>
</tr>
<tr>
<td>PPAP</td>
<td>Pakistan Poverty Alleviation Programme</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>PCPS</td>
<td>Philippine Center for Policies Studies</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RHPP</td>
<td>Reproductive Health Project Pakistan</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infections</td>
</tr>
<tr>
<td>RR</td>
<td>Reproductive Rights</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Centres</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>STDs</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
</tr>
<tr>
<td>SAP</td>
<td>Structural adjustment Programmes</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>TBAs</td>
<td>Trained Birth Attendants</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>The United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nation Programme on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Aid for International Development</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>UNHDR</td>
<td>United Nations Human Development Report</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population and Development</td>
</tr>
<tr>
<td>VAW</td>
<td>Violence Against Women</td>
</tr>
<tr>
<td>WAF</td>
<td>Women Action Forum</td>
</tr>
<tr>
<td>WEDO</td>
<td>Women’s Environment and Development Organization</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
The programme received a major setback during the military government of General Zia-ul-Haq (1977-1988), when thousands of family planning workers were retrenched. Population welfare came back on the agenda, though with limited resources, following the introduction of Structural Adjustment.
Executive Summary

1 INTRODUCTION AND METHODOLOGY

Pakistan's population programme began in 1953; the first official population policy was introduced in the mid-'60s. The programme has been characterised by the demographic objectives of reducing the population and fertility growth rates. Initially it solely addressed women, and failed to reach its objectives.

The programme received a major setback during the military government of General Zia-ul-Haq (1977-1988), when thousands of family planning workers were retrenched. Population welfare came back on the agenda, though with limited resources, following the introduction of Structural Adjustment Programmes (SAPs) in the mid-'80s. The International Conference on Population and Development (ICPD) marked a turning point in the country's population programme, moving it from a narrow family planning framework to a more integrated health and reproductive health one. This report monitors progress on the country's ICPD commitments, and has been steered by Shirkat Gah with the involvement of the Pakistan Reproductive Health Network within the framework of the ARROW-developed guidelines. The desk review of
the interviews were carried out by a small team of researchers, and feedback and additional information was obtained from PRHN members.

## 2 COUNTRY CONTEXT

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

Unemployment is high, as is social disparity. Severe ecological problems have disproportionately affected the daily lives of the poor, adding to water scarcity and disease proliferation. The last ten years have been lean in terms of economic growth, with the GNP falling to 3% during 1999-2001, and the influence of the IMF and World Bank in its fiscal and social sector policies. Pakistan's inadequate success in reducing its population momentum is considered to be due to the low level of resource allocation to the social sector coupled with inadequate policies and procedures, lack of capacity, and poor socio-economic conditions.

## 3 FINDINGS ON ACHIEVEMENTS

The immediate impact of ICPD was the modification of policy (Eighth Five Year Plan, 1993-98) and a more integrated approach towards the health and reproductive health sectors. The impact was not only at the management level, with the advent of implementation guidelines and monitoring systems in family planning and population welfare activities, but also at the social level, in promoting the acceptability of issues related to reproductive health. National Health, Population and HIV/AIDS Policies were formulated; the latest version of each in 2001, 2002, and 2000, respectively. These helped emphasise a broader-based RH approach, maternal and child healthcare, rural outreach and improved service delivery. The emphasis on the quality of services, delivering services at the doorstep, and training family planning workers and national health workers was the direct result of translating into policy of Chapters VII and VIII of the ICPD POA. Greater coordination between the Ministry of Population and the Ministry of Health ensued, and the two ministries undertook the joint design of a Reproductive Health Package. The Health Policy of 1997

**Some significant basic indicators:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of population in rural areas</td>
<td>67%</td>
</tr>
<tr>
<td>TFR 1994</td>
<td>5.4%</td>
</tr>
<tr>
<td>TFR 2000-01</td>
<td>4.8%</td>
</tr>
<tr>
<td>CPR mid-'80s</td>
<td>18%</td>
</tr>
<tr>
<td>CPR 2000-01</td>
<td>28%</td>
</tr>
<tr>
<td>Literacy 1990-91</td>
<td>35%</td>
</tr>
<tr>
<td>Literacy 1998</td>
<td>45%</td>
</tr>
<tr>
<td>Female literacy increase from 1990-91 to 1998</td>
<td>20-30%</td>
</tr>
<tr>
<td>IMR</td>
<td>82 per 1000 (males 99 per 1000; females 71 per 1000)</td>
</tr>
<tr>
<td>MMR 1990 -2002</td>
<td>300-700 per 100,000</td>
</tr>
<tr>
<td>Poverty</td>
<td>34%</td>
</tr>
<tr>
<td>HDI (rank 142: UNHDR 2003)</td>
<td>0.499%</td>
</tr>
<tr>
<td>GDI (rank 120: )</td>
<td>0.469%</td>
</tr>
<tr>
<td>GEM (rank 64: )</td>
<td>0.414%</td>
</tr>
</tbody>
</table>

TFR: Total Fertility Rate; CPR: Contraceptive Prevalence Rate; IMR: Infant Mortality Rate; MMR: Maternal Mortality Rate; HDI: Human Development Index; GDI: Gender Development Index; GEM: Gender Empowerment Measure

---

According to Secretary, Ministry of Population, Punjab. Saeed, Hilda. Op cit p. 89

The package included family planning counselling, IEC and services; perinatal/ prenatal care, safe delivery and postnatal care; infertility prevention and treatment; prevention and treatment of RTIs, STIs and HIV/AIDS; and information and counselling on human sexuality and responsible parenthood.
primary focus on creating awareness

had earlier provided for male councilors and motivators in the government population programme. The Ministry of Health also elaborated a national HIV/AIDS policy for prevention and treatment, with primary focus on creating awareness. Awareness of HIV/AIDS grew from 4% in 1991-92 to 75% during 2000.³

From 1998 the population programme focused on rural outreach and improved service delivery with a broader reproductive health approach, with emphasis on mother and child care as its stated objective. Post-abortion services, RTI/STI prevention and treatment, infertility, and reproductive cancer detection and treatment are covered under gynaecological services in tertiary hospitals. For those who are in need of medicare. Since abortion is illegal, no formal services are available, except for complications, and then only at tertiary hospitals. There is no special provision for complications arising out of violence. We see the increase in CPR and the decrease in IFR and TFR as achievements deriving from following the ICPD commitments.

However, we consider the inability to achieve higher targets as a shortcoming in implementation and resource allocation.

4 CONTRAST WITH GOVERNMENT REPORTS

Government reports tend to focus on achievements, not on gaps. They may admit that results are not optimal, but do not include analysis or examination of the reasons underlying failure. Furthermore official reports, while rich in information, fail to make linkages, for instance, between the withdrawal of the government's role in providing basic social services and declining indicators; or the centrality of discriminatory attitudes and practices against women and the impact on women's reproductive health. Misplaced reforms, such as putting health services in the private sector and rendering them unaffordable to the poor, are not factored in the assessment.

Similarly, no reasons are provided for the government’s inability to ensure staff presence in government health facilities. The reports also ignore important issues outside the framework of current policies like the incidence of unsafe abortions, or the need for a sexual health and rights policy, adolescent sexual health, and sex education. On the other hand, this NGO report while relying on official sources for basic data, complements them with information from academics, activists, and field projects, and attempts analysis based on deeper insights and experiences from the local level.

5 BARRIERS AND FACILITATING FACTORS

The imposition of structural adjustment, the lack of resources for the social sectors, the reforms under IMF directions for macroeconomic stabilisation, and militarisation have hindered progress in the country. The rise of religious extremism, which began with the Soviet invasion of Afghanistan and US-supported resistance to it during the 1980s, received additional impetus following American action in Afghanistan. Constant political upheaval, including three changes of government since 1994, culminating in a military coup in 1999, helped bring extremist political parties into the political mainstream. These parties formed governments in two of Pakistan’s four provinces following the general elections of 2002. They are intolerant of the rights of women and minority communities, and do not hesitate to use violence to promote their agendas. This has been witnessed in the NWFP, where NGOs working for female literacy have been threatened and attacked.

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

6 CHALLENGES AND RECOMMENDATIONS

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

Effective formulation and implementation of policy to include maternal mortality, unsafe abortions, sexual health rights, bodily rights and adolescent SRH with strong M&E must be accorded high priority with focus on a life cycle approach to women’s health. Establishing basic maternal healthcare facilities and comprehensive EmOC centres at accessible distances with suitable transport is the other priority area. The existing infrastructure of public health centres need to be made fully functional with adequate personnel policies. The private sector should be allowed to operate only after mechanisms ensuring the quality, uniformity and accountability of services, and regulating the pricing system, are in place. It is also imperative that appropriate legislation be enacted to ensure the availability of safe abortion methods, and permit abortion for victims of rape and violence.

Women’s status in Pakistan is very low due to regressive customs worsened by discriminatory laws. On the statute books are the Hudood Ordinances 1979, that cover fornication and rape (which require the evidence of four adult male eyewitnesses for maximum punishment and exclude the evidence of women and minorities for the same level of punishment); the Qisas and Diyat Ordinance (dealing with retribution and blood money in cases of murder where the diyat of females is half that of males); and the Law of Evidence (1983), which seeks to reduce the evidence of women in business transactions to half that of men. Customary practices like killing in the name of honour, offering women to settle conflicts, and domestic violence are widespread in some parts of the country. Civil society organisations working for women’s empowerment are threatened and insecure.

To meet these challenges, the government must continue its affirmative action with the reinstitution of job quotas for women in government service, the repeal of discriminatory laws, and punitive action against those indulging in customary practices like honour killing. Civil society’s role as a watchdog over policies and programmes, coordination of action and strategies, particularly in the area of reproductive and sexual health and rights, is imperative. For this the government has to ensure a safe and enabling environment.

---

*Hudood Ordinances cover zina (adultery and fornication) without making any provision for the crime of rape. Furthermore the law provides for maximum punishment (hadd) for zina with the evidence of four male Muslim eyewitnesses. The evidence of women and non-Muslims is not admissible for hadd.
Cairo 1994, in many ways, was the turning point for population related activities in Pakistan. The ICPD-PFA was endorsed by Pakistan without any reservations. The run up to ICPD and after has seen a progressive realisation about the importance of reproductive health and rights among government and NGOs.
1 POPULATION POLICIES AND PROGRAMMES: A BRIEF HISTORY

Pakistan's population programme was established in 1953, and is perhaps one of the oldest in Asia. The first official population policy was introduced in the country's Third Five Year Plan (1965-70) under a separate chapter on family planning, and the first institutional steps were taken at the same time (1965) with the establishment of the Pakistan Family Planning Council and a Population Division within the Ministry of Health.

The programme focused exclusively on the motivation of women for fertility control. It expanded considerably over the next decade, but failed to impact fertility, as it did not take into account the social reality that women possessed little or no say in decision-making. The retrogressive military government of General Zia-ul-Haq (which forcibly took power from the...
elected civilian government of Zulfiqar Ali Bhutto in 1977) represented the gravest setback to the programme, due to its enforcement of extremist religious views. The programme was reintroduced in the 1980s under donor pressure, but aggressive antifeminist policies backed by legislation continued.

Following General Zia's death in 1988, IMF-led Structural Adjustment Programmes drastically reduced funding for the social sectors. In 1986 a programme for the social marketing of contraceptives began with financial support from USAID. The project was successful in promoting the use of condoms in urban and peri-urban areas and giving visibility to the family planning programme. But the abrupt stoppage of USAID funds in the wake of Pakistan's admission to a nuclear programme in 1986 slowed the project until it picked up again in 1995, with British and German funds.

In 1990 a separate MoPW (Ministry of Population Welfare) was established. This resulted in the compartmentalisation of women's health and family planning, and the creation of turf problems between the health and population ministries. Thus, at the operational level, "a hospital's Obstetrics and Gynaecology Department, was not equipped to offer contraception, while a family planning centre could not provide comprehensive reproductive healthcare."

The National Health Policy of 1990 therefore provided for trained birth attendants and expansion of mother and child healthcare (including antenatal and natal care), but had no mention of reproductive health. The Population Policy of 1992 introduced new family welfare centres offering family and child health services and service centres in hospitals to provide sterilisation and other family planning services. The contradictions in policies and intent contributed to the official inability to broaden the perspective from fertility control to women's health and rights - a key conceptual shortcoming in addressing the population issue in Pakistan, in the pre-ICPD period. A characteristic of the population programmes was their lack of gender sensitivity. Thus, for instance, they focused on women for family planning and female sterilisation, in a culture where often the sole determinant of a woman's worth is her reproductive ability. This allowed minimal male involvement, which is a problem that has not yet gone away.

## 2 ICPD-CAIRO AND ITS INFLUENCE

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

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

Nevertheless, after ICPD, a more integrated

---

* Balchin, Cassandra; Mumtaz, Khawar; Shaheed, Farida, Women not the Womb. Lahore. Shirkat Gah. 1994. p. 9
* NGO Coordination Committee for Beijing+5, Pakistan NGO Review; Beijing+5. Lahore. Shirkat Gah. 2000. p. 41
approach to handling the health and reproductive health sectors was introduced. The Population Welfare Ministry's Village-Based Family Planning Workers were merged with the Health Ministry's Lady Health Workers, with training in basic RH care, counselling, hormonal contraception, ante and prenatal care, information on infertility, STDs and HIV/AIDS. That these initiatives have had some impact, though not as far-reaching as desirable, cannot be denied. Treatment for infertility, STDs and reproductive cancer is available at tertiary public hospitals, some NGO service centres and from the private sector. HIV/AIDS treatment is not yet available.

3 ICPD MONITORING

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

The present collective review provides the opportunity to include a wider range of civil society actors working in the area of SRHR. The exercise is seen as helping in deepening the analysis and understanding of why policies fail in changing Pakistan's rather poor indicators. The monitoring, it is hoped, will help in strategising for better and more effective delivery. The cross country/region dimension provides for learning, and makes it possible to tackle external aspects that have an impact on achieving ICPD goals. ■
The report has used a wide range of sources including government-generated national-level data like the decennial Population Census; reports of regular national surveys by the National Institute of Population Studies (NIPS), the Population Council, and UN agencies (e.g., Country Population Assessment Studies).

Methodology
Shirkat Gah, having past experience of working on ICPD-linked issues, and as a member and secretariat of PRHN, undertook the responsibility of steering the monitoring process in Pakistan.

PRHN is a network initiated in 1995, after the Second Asia-Pacific Social Science and Medicine Conference in 1994. It currently has a membership of over 260, almost equally divided between organisations and individuals involved in RH, RR and RH delivery. It operates through seven focal groups located in the main cities of the four provinces, including the capital, and in two smaller towns of Sindh and the NWFP.

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

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

Some of the problems faced by the research team include lack of comparable data over comparable time periods, sporadic and disparate information regarding the implementation of policies, not enough qualitative studies, and the lack of reliable data on some critical issues like maternal health and morbidity, nutrition and so on. The time available for the study was not enough to collect requisite additional evidence. The modest target of 20 interviews, too, could not be achieved because of unavailability or lack of interest from policymakers and parliamentarians.
As a reaction to the government's discriminatory legislation and other repressive measures the 1980s saw the emergence of a vibrant movement for women's rights spearheaded by Women's Action Forum, a new platform to challenge the military government.
Country Context

Reproductive rights and reproductive health, as stated earlier, were not terms used in policy documents before ICPD. While population became a significant concern for policymakers during the military regime of General Ayub Khan (1958-1969), when the first family planning policy was introduced under the Third Five Year Plan, it failed to have an impact on the population growth rate.

The programme continued under the civilian regime of Zulfiqar Ali Bhutto. However, under General Zia-ul-Haq it received a setback with an unproclaimed moratorium that saw the firing of thousands of personnel from the family planning department, probably due to the opposition of religious groups to family planning. Officially reintroduced in 1980, the programme was supposedly based on a multisectoral approach, emphasising the enhancement of education and employment opportunities for women. These inter-linkages, however, remained
largely on paper as discriminatory legislation in the name of Islam (the Hudood Ordinances, the Law of Evidence, Qisas and Diyat Ordinance) introduced in the late ’70s and ’80s by the military government of General Zia-ul-Haq reinforced the low status of women in the country. These, combined with low government allocations to the social sector, and the separation of health and population sectors at the policy level, led to the further dilution of the family planning programme. This was the time that the military regime had full support from the US government because of its role in the proxy war in Afghanistan against the Soviet Union. It was also the time that the extreme politico-religious groups received official recognition and government patronage.9

During the Afghan war, Pakistan became the conduit for arms and drugs; it is still living with the violence engendered by those arms, and with the expansion of the drug trade: significant numbers are addicted to drugs, adding a further dimension to the population scenario. STIs, HIV/AIDS, and Hepatitis B are highly prevalent among drug addicts, with added proliferation from the sale of their blood (blood screening facilities are not yet available throughout the country) for more drugs, and through sexual encounters. This has led to further proliferation of both drug addiction and STIs. Further, the increasing poverty led to a corresponding increase in the number of street children: in Karachi alone these are estimated to be about 15,000,14 and paedophilia is reportedly rife among them.15

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

2 PREPARATIONS FOR CAIRO

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

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

3 THE IMPACT OF CAIRO ON POLICIES

ICPD had an impact on the population policy as indicated above. The modification of the population policy and the Eighth Five Year Plan (1993-98) itself included implementation guidelines and monitoring systems in family planning and population welfare activities. The emphasis on the quality of services, delivery of services at the doorstep, and the training of family planning workers and national health workers was the direct result of translating into policy of Chapters VII and VIII of the ICPD POA.16

In 1994 the National Committee for Maternal Health (NCMH) was created under the chairmanship of the Federal Secretary for Health.17 Initial efforts since 1996 yielded closer collaboration between the ministries of health and population, for improved provision of services. Under the country's Eighth Five Year Plan (1993-1998), greater coordination between fieldworkers of the two ministries was encouraged, and a reproductive health package was jointly designed.18 While there are no specific RH and SRH policies, an RH Package was jointly prepared by the two ministries. This comprised nine components, including STIs/RTIs, reproductive cancer, male involvement, gender equity and equality, prevention and treatment for HIV/AIDS, maternal and neonatal health, and EmOC. However, except for sexually transmitted illnesses, RR and SR remain unaddressed in the RH Package.

Positively, the 1997 National Health Policy provided for male councilors and motivators in the government population programme, and the Ministry of Health elaborated policies and programmes for the prevention and control of HIV/AIDS. The focus in this area, however, remained on creating awareness and enhancing facilities for blood screening (from 4% in 1991-92 to 75% during 2000).19 However, treatment is not yet available in the public sector. Pakistan’s Ninth Five Year Plan (1998-2003) built upon the directions and foundations of the Eighth Plan and focused on rural outreach and improved service delivery in a broader reproductive health approach, with emphasis on mother and child care as its stated objective. The latest National Health Policy (2001) continues the direction set by ICPD. The policy views health sector investments as part of the poverty alleviation plan, marks the shift from tertiary to primary and secondary health sectors, and focuses on health sector reforms. It also seeks to promote greater gender equity in the health sector.

Demographic targets remain the primary concern of Pakistan’s population policies as reflected in the latest Population Policy of 2002.20 However, the policy also strongly reiterates the importance of involving adolescents in the RH service delivery and advocacy programmes.21 Adolescents are not specifically targeted in public health services though married ones avail the same maternal/RH health facilities as adults.

---

16According to Secretary Ministry of Health, Punjab. Saeed, Hilda, Op cit p. 89
17NCMH is “the focal technical and advisory body for matters relating to women’s health in general and safe motherhood in particular”. It has representatives from all four provinces and has been active in creating awareness, formulating a national maternal and perinatal health policy and a national plan for action with funding from UNICEF-Pakistan. Dr Asma Fozia Qureshi and Dr Yasmeen Sabeen Qazi, Maternal and Neonatal Health in Pakistan: A Desk Review. Islamabad. 2003 (unpublished) p. 19
18The package included family planning counseling; IEC and services, perinatal/ prenatal care, safe delivery and postnatal care; infertility prevention and treatment; Prevention and treatment of RTIs, STIs and HIV/AIDS; information and counseling on human sexuality and responsible parenthood.
21The major goals of the Pakistan Population Policy include attaining a balance between resources and population within the broad parameters of the ICPD paradigm; increase awareness of the adverse consequences of rapid population growth at the national, provincial, district and community levels; promote family planning as an entitlement based on informed and voluntary choice; attain a reduction in fertility through improvement in access and quality of reproductive health services; reduce population momentum through delay in the first birth, changing space patterns and reduction in family size desires.
22The Population Policy of Pakistan, 2002

---
4 DONOR FUNDED PROGRAMMES

That the RH sector now has greater priority than before is apparent from the budget allocations for the population welfare programme in the Ninth Five Year Plan: at Rs 10,340 million it is substantially higher than the Rs 7,654 million allocated in the Eighth Plan, though as a percentage of GDP it remains the same. The budget utilisation has also been higher in the Ninth Plan (80.3%) than in the Eighth (71.5%). UNFPA-generated figures reproduced in the Pakistan Population Assessment 2003 indicate that external resources for population activities registered an increase in the post-ICPD period from US$12.7 million in 1994 to US$28.1 million in 1999, with the resource flow reaching the high point of US$33.5 million in 1996.

There are several major programmes underway across Pakistan since 1999, and yet more in the pipeline. The Asian Development Bank has committed US$47 million for the Women’s Health Project (2000-05) in 20 districts across Pakistan with the aim of improving the health of women, girls and infants, and another US$36 million for the Reproductive Health Project67 (2000-05) improving RH status of underserved communities in 54 districts. Northern Health Project with World Bank loan has a commitment of US$26.7 million for the Northern Areas and Azad Jammu and Kashmir, CIDA, USAID, Save the Children-USA, UNFPA, DFID, NEDA, JICA, Asia Foundation, and several donor-supported NGO projects are also underway covering different parts of the country.

However, projects to address RH through the rights perspective are the exception rather than the rule. One important initiative is the Bill Gates Foundation supported and Columbia University68 coordinated Women’s Right to Life and Health project in three districts of Sindh, and its counterpart in the non-government sector in Punjab and Sindh. The project is being implemented in collaboration with the provincial government and UNICEF, and focuses on averting maternal death and morbidity through provision of quality EmOC facilities. A smaller experimental intervention by Shirkat Gah is supported under the same programme, and looks at women’s mobilisation for reproductive rights. Significantly, PRHN, a post-ICPD information and advocacy network formalised itself in 2000, highlighting the issues of rights and gender inequalities with reference to reproductive health and ICPD PoA (see Chapter C.1. for details on PRHN).

The last five years have also seen effective contribution by donor-supported social marketing programmes complementing the efforts of the Population Welfare Programmes in providing conventional69 and hormonal contraceptives at subsidised rates to low and middle income groups in urban and peri-urban areas. Contraceptives supplied by the government are free of cost. The interim results have been quite encouraging and it is anticipated that donor support will continue.

---

66GoP-UNFPA. Op cit p. 74
67Ibid p. 80
68The ‘Reproductive Health Services Package’ includes: comprehensive FP services for females and males, maternal health care including safe motherhood and pre- and post-abortion care for complications, infant health care, prevention and management of RTIs/STDS and HIV/AIDS, management of RH related problems of adolescents, management of RH problems of women, management of infertility, detection of breast and cervical cancers and management of RH related issues of men.
69Qureshi and Qazi. Op cit p. 10-17
70Columbia University Mailman School of Public Health’s AMDD Programme. There are 86 such projects in 51 countries.
71Conventional contraceptives include condoms, diaphragms, spermicides, as well as intra-uterine devices.
72Dr Rehana Ahmed, Country Coordinator Green Star Social Marketing. Interview.
The most significant change has been parents wanting to educate daughters, though when resources are scarce sons get precedence and daughters are kept at home. While many steps have been taken towards realising lower MMR and safe motherhood in recent years, the reduction of maternal mortality and morbidity remains a challenge.
Achieving ICPD Goals and Objectives

1 STUDY FINDINGS

a The ICPD Cairo objectives being monitored are:

1 Gender, social equality and equity.

2 Reducing maternal mortality and morbidity, and promoting safe motherhood and safe abortion.

3 Promoting and protecting sexual rights, safe contraception, and preventing/treating HIV/AIDS and reproductive cancer.

The progress towards gender, social equality and equity has been marked with mixed results. Improvement in such indicators as female labour force participation, female life expectancy (63 years, or 99% of male life expectancy), and a reduced gender gap in education; is offset by rising poverty, deteriorating HDI and GDI, greater income disparity and the failure to repeal discriminatory legislation. The most significant change has been parents wanting to educate daughters, though when resources are scarce sons get precedence and daughters are kept at home. While many steps have been taken towards realising lower MMR and safe motherhood in recent years, the reduction of maternal mortality and morbidity remains a challenge and the issue of unsafe abortion remains unaddressed. Promisingly, however, there has been, over the past decade, a growing acknowledgement among policymakers about the magnitude of the problem, and the consequent focus on formulation of policies to deal with it. The only positive success, however, is the substantial rise in the percentage of women
receiving antenatal care: from 30% in 1990-91, with a 6% increase in 1996-97, to 51% in 2000-01; and the increase in the contraceptive prevalence rate, from 17.8% in 1994-95 to 23.9% in 1996-97 and 27.6% in 2000-01. Significant strides have been made in achieving awareness about HIV/AIDS and its prevention through persistent advocacy campaigns in the media to promote contraceptive use. Coupled with improvement in service delivery, there has been a sizeable rise in the contraceptive prevalence rate and a declining fertility trend: from 5.6 per woman in 1994 to 4.6 in 2000-01, and in urban areas, a decrease from 6.1 to 4. In addition, a number of institutional interventions to improve women's status and the reproductive health sector are also apparent.

2 \hspace{1cm} GENDER, SOCIAL EQUALITY AND EQUITY

a \hspace{1cm} Human Development Index and Gender Development Index

i | Country Status:

Pakistan stands at 142\textsuperscript{nd} in the world (up two notches from 2003) according to UNDP's Human Development Report 2004, falling much below India (127), Bhutan (134), Bangladesh (138), Sri Lanka (96) and Maldives (84). The HDI dropped from 0.508 in 1997 to 0.499 in 2000. Similarly the situation on gender indicators (GDI) deteriorated in the same period from .472 to .468.\textsuperscript{21} These figures record a marginal reduction in the gap between the HDI and GDI of .006, which implies that the gender gap may not have increased in Pakistan over these years.

Female life expectancy (at 63 years) as a percentage of male life expectancy has deteriorated to 99% after being equalised at a little over 63 years. The female population in Pakistan remains at 92% of the male - a figure lower than the weighted average for South Asia, but certainly an improvement from a decade ago.\textsuperscript{30} The relative improvement in the sex ratio and female life expectancy at birth implies that health coverage of the female population has improved.

b | Gender Empowerment Measures

i | Country Status:

The reporting on Gender Empowerment Measurement has been irregular.\textsuperscript{31} Available information indicates that GEM has improved since 1994 (0.153). Although information on GEM is not available after 2002, it will probably show an improvement as over 36,000 women have been inducted into government decision-making forums in recent years. Currently, there are 188 women in the National and Provincial Assemblies, of whom 72 are in the National Assembly. Apart from these, 17 have been nominated for the Senate on reserved seats. The local government Devolution Plan 2001 reserves 33% seats for women for the first time to be directly elected in local bodies. Earlier women's reserved seats used to be 2%.

Women activists see this increase as a direct result of their advocacy. Due to active government support and encouragement and national level mobilisation campaigns launched by NGOs, a record 67,512 women filed their nomination papers for the 35,963 reserved seats at all levels of the local government. Thus, a total of 35,963 women were elected as Union Councillors, Tehsil\textsuperscript{32} Councillors and District Councillors.

ii | Service Delivery Issues

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

\textsuperscript{21}Mahbub ul Haq Development Centre 2000

\textsuperscript{30}Human Development in South Asia 1993 to 2003, Mahbub ul Haq Development Centre. 2003

\textsuperscript{31}Human Development in South Asia 2000-2002, Mahbub ul Haq Development Centre. 2000

\textsuperscript{32}Tehsil: the middle tier in the three level local government system (union, tehsil, district)
legislatures, women members find themselves restricted by party priorities that do not necessarily converge with those of women.\textsuperscript{33}

iii | National Level Laws and Policies

Affirmative action while enshrined in the Constitution, had never been seen on the scale of the recent women's political participation in local bodies and parliament. This was made possible by the Local Government Ordinance 2001 under which the Devolution Plan mentioned above was implemented. The Legal Framework Order is an extra-constitutional law enacted by the present military government to amend the Constitution and has revived, among other provisions, reserved seats for women in the federal and provincial legislatures after a lapse of nearly ten years. An earlier reservation of twenty seats for women in the National Assembly was for a specified period, which had ended in 1993. Realising that most women inducted into government lack knowledge of policymaking mechanisms and the skills to participate in lawmaking, the government and NGOs took initiatives to orient and train women parliamentarians and councillors, with the support of multilateral/bilateral donor agencies.

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

1. The ratification of CEDAW by the government in March 1996 with a reservation on Clause 29 (para 1) pertaining to disputes was made.\textsuperscript{34} A general declaration invoking the primacy and supremacy of the Constitution over and above the provisions of CEDAW. The government has reportedly submitted its report to the CEDAW Committee but has not publicly shared it yet and has not signed the Optional Protocol.

2. The setting up of a high-powered Commission of Inquiry in 1997 to review all laws pertaining to women and recommend changes (though most of its critical recommendations have not been implemented).

3. The adoption in 1998 of a National Plan of Action to implement the Beijing commitments, developed through government-NGO collaboration to define annual development plans of provincial governments.

4. The establishment of the National Commission on the Status of Women (a longstanding demand of women's rights activists) in 2002, though with recommendatory powers only.

5. The National Policy for Development & Empowerment of Women announced in 2002, with the goal of empowering women, removing inequalities, ensuring participation as equals in national development, provision of equality of opportunity and space for the realisation of their potential.\textsuperscript{35} The promotion of gender equity is also one of the ten specific objectives stated in the new National Health Policy, but no mechanisms are spelt out for achieving it.

6. The development of the Gender Reform Action Plan in 2003 with the financial support of the Asian Development Bank for gender mainstreaming and reforming the political, fiscal and institutional systems, awaiting cabinet approval (provincial GRAP approved in Punjab).

7. A Gender Strategy of the Ministry of Environment, Local Government and Rural Development has been prepared, supporting the employment of women.

8. The government is a signatory to the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution.

\textsuperscript{33} The Friday Times, October 3-9, 2003. Interviews with women members of parliament from across the political spectrum, including the religious parties, in which they made this point repeatedly.

\textsuperscript{34} Reservation on CEDAW: Any dispute between two or more states parties concerning the interpretation or application of the present Convention which is not settled by negotiations shall, at the request of one of them, be submitted to arbitration. If within 6 months from the date of the request for arbitration the parties are unable to agree on the organisation of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the statute of the court.

\textsuperscript{35} GOP, National Policy for Development & Empowerment of Women. Islamabad. GoP. 2003
 Labour Force Participation

i | Country Status

Although the reported female labour force participation is very low (9%), and lags behind that of males (48%), it has registered a 1% rise rate (labour force participation rate) as opposed to the 2% decline in male employment. Women engaged in economic activity as a percentage of males has increased from 11% in 1970 to 42%. The labour force survey does not include women not working in the formal industrial sector and therefore does not adequately reflect women’s economic participation. While the unemployment level seems to be rising for both men and women, it is higher for women (17%) than for men (6%). However, official statistics fail to account for the vast number of women employed in the informal sector as domestic help or involved in income generating activities from their home, and women in the agricultural sector. The fact that 62% of women are reported to be contributing family workers as opposed to 17% of men, and that women as salaried workers constitute 25% while the self-employed make up 14%, reinforces the fact that women’s employment is often simply invisible. In agriculture according to one study rural women involved in agriculture constitute nearly 80% of the total rural men and women compared to rural men (60%).

ii | Service Delivery Issues

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

iii | National Level Laws and Policies

There is no official policy for the informal sector that employs the largest number of women and often exposes them to hazardous materials. Nor is there any policy regarding awareness on economic rights or for grievances and harassment. An NGO developed code of conduct (2002-2003) against harassment at the workplace has succeeded in being voluntarily adopted by over 100 private sector organisations. The affirmative action policy of a quota of 5% for women in government jobs (introduced by Benazir Bhutto post-ICPD) was discontinued in 2003 by the present military government. However, the government has ratified the ILO Convention 100 on equal remuneration for women. And given the inadequacies in gender disaggregated data the staff of the Federal Bureau of Statistics has been gender-sensitised through external assistance; the number of female staff in the Bureau has increased, and its female enumerators trained.

iv | Literacy and Education

i | Status

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

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

ii | Service Delivery Issues

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

iii | National Level Laws and Policy

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

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

Gender sensitisation activities among teachers and students (in particular boys) are not part of official policy. However, gender sensitisation programmes among both teachers and students are conducted by NGOs working in these sectors, but it is not possible to assess the extent of their reach or effectiveness nationwide. Even though school curricula and textbooks are gender-biased, there is no programme for gender sensitization of school teachers nor is there a serious initiative underway to correct this, despite NGO efforts to bring attention to this issue.

e | Violence Against Women

i | Country Status

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

Domestic violence is on the rise with some 70-90% of women facing some form of domestic violence according to HRCP.\(^4^5\) There is no documenting of domestic violence; most estimates are based on newspaper reports. Although killings in the name of honour are still widely prevalent, recent reports indicate that there is a sharper focus on the issue due to the removal of legal safeguards from those involved, the ruling of the Supreme Court against this practice, and consistent activism and awareness raising undertaken by NGOs such as Shirkat Gah, HRCP, AGHS, WAF, Aurat Foundation, etc.

The crime of rape goes unreported largely due to social taboos; there is concern that this crime as well as gang rape may be on the rise. Incest is also estimated by social workers to be high.\(^4^6\) In a study conducted by the Population Council in 2002-03, 1,000 doctors expressed concern about violence even during pregnancy. Marital rape is not legally recognised. Wife burning is frequently reported in the print media, but cases are hardly ever registered by the police. There has also been a rise in crimes of mutilation by throwing acid and cutting off women's noses.

Official data on suicide rates among women are not available, as in many cases families cover up such crimes. A survey conducted in May 1999 by HRCP confirmed that 65% of female suicides occurred from depression or despair caused by economic constraints. Almost all the others resulted because of mismatch in marriage, tyranny by husband and in-laws, or an unmarried woman's unwillingness to accept the match made for her.\(^4^7\) HRCP (2003) estimated from press reports that most women who took their lives were less than 50 years old, were school and college students, rape victims, housewives, working women and mothers of young children. No data is available on the number of suicides due to polygamy. FGM is not generally a problem in Pakistan except in one community (the Bohras) where it is stated to be symbolic.

### Service Delivery Issues

The most obvious barrier in checking crimes against women is the lack of availability of fair judicial recourse available to the victims. This includes the reluctance or refusal of police officials to register such cases, the biased judgements of the courts and the discrimination institutionalised within the judicial system by laws like the *Hudood* Ordinances, related to rape and adultery have served to further victimize women. Since the law does not make a distinction between rape and adultery there have been numerous instances of rape victims being adjudged adulterous and punished. According to a July 2002 UN report, of the 2,200 women in prison, most had been convicted under the *Hudood* Ordinances.\(^4^9\)

### National Level Laws and Policies

Despite the recommendations of the National Commission on the Status of Women (2003) and the earlier Commission of Inquiry for Women (1997), the *Hudood* laws have not been repealed, though an ordinance was passed in April 2000 declaring "honour killing" murder, and a crime to be treated under the penal code (PPC 302). The COI and NCSW recommendations have not yet been followed to enact a law on domestic violence that specifies violence by husband or in-laws, clearly defines cruelty and declares it a criminal offence, and directs the police to register all cases of domestic violence. However a private member's bill on domestic violence was tabled in 2003, by a woman member in the Punjab Assembly, and was awaiting discussion at time of writing. On the trafficking of women, the NCSW's recommendations were accepted and The Prevention and Control of Human Trafficking Ordinance 2002, was promulgated. As a result of activist/ NGO campaigns against violence against women (VAW) gender sensitisation training for police officers has begun and is also part of the proposed police reforms.\(^4^9\)

---

\(^4^5\) HRCP. *State of Human Rights* 2003. p. 247
\(^4^6\) The Review. Dawn, 8 July 2004
\(^4^7\) HRCP. *State of Human Rights* 1999. p. 182
\(^4^8\) HRCP. *Op cit* 2003. p. 237
There is now increased media awareness on the problem of violence against women, with greater coverage by both the print and electronic media. The government and independent television channels have aired donor-funded plays highlighting gender issues, such as violence, and also regularly run discussion programmes on sexual harassment at the workplace, violence against women, and other issues.

In the year 1999 six women’s crisis centres were set up by the government but none in any government hospital.50 Within six months of their establishment 780 women had approached the centres; of these 291 sought legal assistance, while 60 were looking for shelter and 55 needed medical aid.51 These are in addition to government funded and managed women shelters (Dar-ul-Aman) which operate more as sub-jails. Several shelters have also been set up by NGOs in view of their need among women.52

The Girl Child.53

Country Status

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

The age at marriage has increased for both males and females: from 26.3 and 21.6 respectively in 1991 to 27.1 and 22.7 in 2000.54 Rural females are more vulnerable to marriage before age 20 than their urban counterparts (58% versus 27%). 47% of females (as opposed to 14% males) married before the age of 20 and 14% of females (males: 7%) before the legal age.55 The increase in age at time of marriage is attributed partly to the desire of parents to educate daughters but mainly to the rise in poverty and the practice of dowry which has spread even to areas where traditionally it did not exist.

The girl child experiences discrimination in education as the persistent gender gap reveals. While more adolescent girls are enrolled in school now (54% as opposed to 84% boys) than at any previous time, the gap is still huge.

| Table 2 - Early and Late Childhood Mortality Rates by Sex, Pakistan: 1982-2000 |
|-----------------------------------------------|-----------------|-----------------|-----------------|
| **Sex and Period**                          | **Infant**      | **Child**       | **Under-five**  |
| **Mortality/1000 LB**                       | **Mortality/1000 LB** | **Mortality/1000 LB** | **Mortality/1000 LB** |
| Both sexes                                  | 113             | 25              | 136             |
| 1982-86                                     | 85              | 20              | 103             |
| 1997-2000                                   | 125             | 21              | 143             |
| Males                                       | 99              | 15              | 112             |
| 1982-86                                     | 102             | 30              | 128             |
| 1997-2000                                   | 71              | 24              | 93              |

LB: Live Birth
Source: Pakistan Population Assessment 2003: p.28

*In Islamabad, Karachi, Lahore, Peshawar, and the Punjabi towns of Sahiwal and Vehari.
*Shelters for women set up by NGOs include Panah in Karachi and Lahore; AGHS’ Dastak in Lahore and Aurat Foundation's Mera Ghar in Peshawar.
*An important study of adolescents in Pakistan that preceded the AYP and provides a rich profile of adolescents based on PIHSS data is Valerie L Durrant, Adolescent Girls and Boys in Pakistan: Opportunities and Constraints in the Transition to Adulthood. Research Report No 12, Population Council, Islamabad. 2000
*Sathar et al., Adolescent and Youth in Pakistan 2001-2. 2003. pp. 104, 87. The AYP is a survey of adolescents and youth aged 15-24 in a nationally representative sample across Pakistan. For a discussion of the legal age of consent, see discussion in chapter E.1.f.iii.
Figures vary across income groups, provinces and rural/urban areas, with the gap narrowest in the highest income groups and widest in the lowest income groups. The lowest income group has, however, experienced an increase in female school attendance over the last five years. Current enrolment levels for adolescent girls are low, with only 15% in school as opposed to 33% of male adolescents. Once again figures are lowest among rural females and those in the two lowest income groups. Completion of middle school eluded most girls, with only 24.4% of those surveyed nationwide achieving that goal, in contrast to 52% of males. Figures were highest for girls in the Punjab and in urban areas. 17.7% of girls, in contrast to 32.7% of boys completed high school.

**Service Delivery Issues**

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

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

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

**National Level Laws and Policies**

Pakistan has made multiple international commitments involving the welfare of the girl child. It has signed and ratified the Convention on the Rights of the Child (CRC), the Additional Protocols on CRC, CEDAW, and ILO Convention 182 for eliminating child labour, as well as programmes of action agreed to at the ICPD and World Conference on Women in Beijing 1995. It lifted its reservations to the Convention on the Rights of the Child in 1996. However government expenditure on child rights is low: 1% of central government expenditure allocations (1992-2002), compared to 18% on defence. Nevertheless, there has been some progress in addressing girl child issues. The National Population Policy mentions increased focus on adolescent and male reproductive health; the comprehensive reproductive health package outlines RH services for all stages in the lifecycle of females, and also highlights the importance of providing male RH services. Yet the Population Policy and the Interim Population Sector Perspective Plan 2012 do not follow the lifecycle approach.

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

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

Girls and boys do not have equal inheritance rights under existing Muslim personal laws in Pakistan. According to Shariah law, women inherit property in specified proportions, depending on the number of other heirs. Most inheritance cases do not go to court, although when they do the courts do uphold women's rights to inherit moveable and immovable property. Under customary practices in the four provinces, women rarely inherit anything, particularly if there are male heirs as well. There is no specific legislation against child pornography, despite the fact that child sexual abuse has been recognised through the work of NGOs as a problem for both boys and girls. Child pornography, however, could fall under the reach of the existing Hudood Ordinances that make sex outside marriage a crime. Forced marriages take place in Pakistan especially among Pakistanis living abroad and family courts dissolve such marriages when approached. In January 2003, British and Pakistani judges signed a protocol on child abduction because of the spate of incidents in the wake of broken marriages in England (See Appendix I).

3 REducing Maternal Mortality and Morbidity, Promoting Safe Motherhood and Safe Abortion

a Maternal Mortality and Morbidity

i Country Status:

Maternal mortality is often seen as the factor responsible for the "missing women" in Pakistan's population statistics. At 300-700 per 100,000 live births, maternal mortality has been more or less consistent over the past ten years. There is great variance between figures from hospitals and community based research. MMR figures also vary from 17 in a private tertiary care hospital to 2736 in a public tertiary hospital. Alarmingly there has been no significant reduction in the hospital based MMRs over the past several years. On average, as many as 50 mothers die each day from pregnancy and childbirth related complications, while 30,000 women die due to the same every year, according to the Pakistan Society of Gynaecologists and Obstetricians. Studies have shown that most of these deaths are due to direct obstetrical causes. Most are preventable, and whether these deaths occur in the community or in hospitals, the leading causes are haemorrhage, eclampsia, sepsis, obstructed labour and abortions.

ii Service Delivery Issues

Research shows that the high level of maternal mortality in Pakistan is due to the poor access to peripheral health facilities for women in rural areas and urban slums, and complications mishandled by TBAs during delivery. Even though the percentage of women delivering at home is gradually decreasing (from 85% in 1990-91 to 77% in 2000-01), this is often the only available option as just 54 percent of the rural population lives within 6 km of a primary

---

(a) Batchin (ed). 1996
(d) Hospital based studies from different provinces of Pakistan estimate MMR to range from 670-4,472 per 100,000 live births and community based research on maternal mortality have estimated MMR ranging from 261/ 100,000 live births in the urban slums of Karachi to 673 in rural Khuzdar district of Baluchistan.
(e) Qureshi and Qazi, 2003. Op cit p.8
healthcare centre. Only 20 percent of women giving birth have a skilled attendant at delivery. A public sector health delivery network was put in place as far back as 1970. It looked good on paper but was grossly under-funded (expenditure on health being less than 1% of GNP), and suffers from very poor management (e.g. high staff absenteeism); thus it is under-utilised. The private sector provides nearly 80% of all health care.\textsuperscript{67}

\textbf{iii | National Level Laws and Policies}

The allocation of free time on television for relaying public service messages helped considerably in publicising the need for contraception, safeguarding maternal health, and caring for the girl child. The National Health Policy 2001 has "promoting gender equity" as one of its ten areas of reforms.\textsuperscript{68} The issue of maternal mortality, while not addressed directly, is implicitly addressed through the national programme for immunising mothers against neonatal tetanus in 57 selected high risk districts, expanding the cadre of Lady Health Workers (LHW) and provision of EmOC facilities in twenty districts under Women Health Project (see also the discussion of maternal morbidity, below).

\textbf{b | Maternal Morbidity}

\textbf{i | Country Status:}

Information on maternal morbidity in Pakistan is fragmented. Most of the information is hospital based. Symptoms of pelvic inflammatory disease (PID) in a rural community of Jamshoro, Sindh, were found to be 9%. In another survey 45% of women reported menstrual irregularities, 19%uterine prolapse, 12.8% PID and 5.4% urinary infections.\textsuperscript{69} The significant predictors of pelvic inflammatory disease were IUCD use, age less or equal to 20 years, and an urban lifestyle.\textsuperscript{70}

Urinary tract infection (UTI) is an important but less investigated public health problem. In Pakistan Reproductive Health and Family Planning Survey 6.6% women reported burning. This is much less than what was revealed in a community-based study where prevalence of UTI was 17%.\textsuperscript{71} Lack of nutrition is also an important cause of maternal morbidity as women in Pakistan are malnourished and anaemic compared to men, with those of reproductive age belonging to rural low and middle income groups being more anaemic. The most recent National Nutrition Survey (2001-02) shows that 36.9% of pregnant women have moderate anaemia, down from 41.4% reported in the National Health Survey of 1990-94.

\textbf{ii | Service Delivery Issues}

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

\textbf{iii | National Level Laws and Policies}

As stated above the National Health Policy 2001 addresses the issue of maternal and neonatal mortality and some major public sector preventive and curative programmes have been enforced. These include the LHW Family Planning Workers Programmes (a total of 71,000 workers), IMCI and many donor-financed projects, such as the Family Health Project, Reproductive Health Project and Women Health Project. The NCMH was created in 1994 as the focal technical and advisory body for women’s health matters, particularly safe motherhood, and is taking the lead in using the media and

\begin{flushleft}\footnotesize{\textsuperscript{67}Qureshi and Oazi, 2003} \textsuperscript{68}The ten areas are communicable diseases, primary/secondary health care services, district health system, promoting gender equity, nutrition gap, correcting urban bias, regulating the private medical sector, improving the drug sector, and health policy monitoring. \textsuperscript{69}\textsuperscript{PRHPS} 2000-01 \textsuperscript{70}Sajjan F, Fikree F. "Perceived gynaecological morbidity among young ever-married women living in squatter settlements of Karachi, Pakistan". \textit{JPMJ}. Pak. Med. Assoc. 1999 Apr: 49(4): 92-7. \textsuperscript{71}Bhutt WA, Bozdar MN, Fikree F. "Prevalence and risk factors of presumptive urinary tract infection in a rural community." \textit{JCPSP} Jan 2000; 10(1): 16-19 \end{flushleft}
conducting workshops for advocacy. Recently the UNICEF-initiated RHPP funded by ADB with the Ministry of Health has taken initiatives to train health personnel to identify and deal with reproductive health issues including EmOC. The expansion of EmOC through the private sector to the poor who are willing to pay the minimal cost of the services near their houses is also under consideration. NGO programmes include Shirkat Gah’s pioneering project of training TBAs in selected districts of Punjab, Sindh and NWFP to enable them to refer complications arising in women during pregnancy and childbirth. Another valuable addition has been the introduction of the WHO Protocol for Tetanus Vaccination, at the household and health facility level.

c  Antenatal Care

i  | Country Status:

The percentage of women receiving antenatal care has improved over the years. In 1990-91 the Pakistan Demographic and Health Survey reported only 30% of women sought antenatal care, in 1996-97 Pakistan Fertility and Family Planning Survey revealed a 6% increase, and in the recently conducted Pakistan Reproductive Health and Family Planning Survey 2000-01, 51% of women reported seeking antenatal care. A considerable proportion (44%) of antenatal care in 2000-01 came from trained personnel. Of the 49% women who did not seek antenatal care in 2000-01, 64% felt there was no need for it, and 20% could not afford it. Government services are not available everywhere; where they are, they charge for antenatal care. Very few (7.2%) said that health facilities were too far.

d  Safe Abortion

i  | Country Status:

Legally induced abortion is not allowed in Pakistan except to save the life of the mother. In daily practice, few doctors are willing to take the responsibility of induced abortion for a mother in critical need. However clandestine abortions occur and add to the high maternal mortality and morbidity. The Pakistan Reproductive Health and Family Planning Survey of 2000-01 mentioned an induced abortion rate of 2.9%. On the other hand in a study from Karachi the estimated total abortion rate was 0.86 which means that on an average a woman will have at least one induced abortion by the end of her reproductive life. The reasons mentioned by women for having an induced abortion include birth spacing, limiting family size and economic impoverishment. Contraceptive failure, too many children, medical reasons, and premarital and extramarital affairs are also cited as reasons. The abortion rate for the past year (prior to survey) was estimated as 25.5 per 1000 ever married women of reproductive age. In another survey from Karachi, maternal deaths attributed to induced abortion were 8% and all were due to sepsis. The abortion providers identified were TBA, LHV/ nurses, and doctors. Bleeding and infection were found to be the two major complications of abortion. Most of the research done on abortions is by professionals, NGOs and academics.

ii  | Service Delivery Issues

The incidence of maternal death as a result of unsafe abortions is estimated to be high (11%) in the country. The main reason for this fact is that most of these abortions take place in unhygienic conditions and are performed by untrained TBAs and LHVs or nurses.

iii  | National Level Laws and Policies

As mentioned earlier, abortion is illegal in Pakistan except when necessary to save the life of a pregnant woman. Even for the exceptional case, the law requires the professional judgement of at least two qualified doctors to confirm that further course of the pregnancy would be fatal for the mother. Otherwise, it is considered a criminal offence under the Pakistan Penal Code XLV of 1860, and the Qisas and Diyat Ordinance of 1991. Even in cases of rape and incest, abortion is not

---

permissible under the law. While NGOs, like WAF, FPAP, PPAP and others have raised the issue of unsafe abortions it is still not a subject of public debate.

4 PROMOTING AND PROTECTING SEXUAL RIGHTS, SAFE CONTRACEPTION, PREVENTING/ TREATING HIV/AIDS AND REPRODUCTIVE CANCER.

a Family Planning Information, Education and Services

i Country Status

The total fertility rate in Pakistan is 4.8 according to PRHFS 2000-2001 (the Pakistan Demographic Survey 200 puts it at 4.3) down from 5.64 in 1994 (urban TFR 3.7; rural 5.4). The gap between the urban and the rural TFR figures has been quite significant during the last decade. The obvious reasons for the decline in urban areas are increased female education and higher age at marriage for females. Additionally, the urban areas have more access to family planning services and have been provided regular FP facilities by the government, NGOs and the private sector (through social marketing and commercial sales).

One of the major demographic factors for high TFR is considered to be the low age at marriage for females. However, both male and female age at marriage since 1990 has seen an increase with that of females from 21.6 in 1991 to 22 in 1996-97 and to 22.7 years in 2000-01. According to most recent data gathered from the Adolescent and Youth Survey in Pakistan 2001-02 women rural females are more vulnerable to marriage before age 20 than their urban counterparts (see section E.I.F.I).

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>44</td>
<td>83</td>
<td>65</td>
</tr>
<tr>
<td>20-24</td>
<td>227</td>
<td>249</td>
<td>211</td>
</tr>
<tr>
<td>25-29</td>
<td>307</td>
<td>278</td>
<td>258</td>
</tr>
<tr>
<td>30-34</td>
<td>243</td>
<td>215</td>
<td>206</td>
</tr>
<tr>
<td>35-39</td>
<td>179</td>
<td>148</td>
<td>128</td>
</tr>
<tr>
<td>40-44</td>
<td>92</td>
<td>75</td>
<td>61</td>
</tr>
<tr>
<td>45-49</td>
<td>36</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>TFR</td>
<td>5.64</td>
<td>5.36</td>
<td>4.77</td>
</tr>
</tbody>
</table>

Source: NIPS, Pakistan Reproductive & Family Planning Survey 2000-01
Note: Age Specific Fertility Rates are per 1000 women

ii Service Delivery Issues

According to PRHFS 2000-01 awareness of a modern method of family planning is widespread (95%) with 97.3% in urban areas and 93.9% in rural. The overall contraceptive prevalence rate (CPR) for all methods is 27.6% (up from 17.8% in 1994). The urban CPR is 39.7% and the rural 21.7%. The breakdown for this figure is 20.2% for any modern method (from 12.6% in 1994) compared with 7.4% for any traditional method (2.8% in 1994). Further disaggregated data is not available.

The highest usage in male methods is the condom, which has risen from 3.7% in 1994 to 5.5% of total contraceptive users in 2000-01, followed by withdrawal at 5.3% (from 4.2% in 1994). Among female methods, sterilisation is on top at 6.9% (from 3.5% in 1994) followed by IUD at 3.5% (from 3.4%) and the pill at 1.9% (from 1.6%).

According to PRHFS (NIPS 2000-01) nearly 45% of all acceptor couples rely on methods that require the initiative or compliance of husbands - a significant finding in terms of decision making at the household level regarding family planning and choice of contraception. The unmet need for family planning is high (33%) despite the fact that more than half the women in this category do not desire more than three children. Some surveys have been done to find the gap between desire and behaviour and it is assessed that husband's disapproval, lack of accessibility to services, fear of side effects,
Table 4 - Percentage of Currently Married Women Currently Using Specific Methods

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Method</td>
<td>11.8</td>
<td>17.8</td>
<td>23.9</td>
<td>27.6</td>
</tr>
<tr>
<td>Any modern method</td>
<td>9.0</td>
<td>12.6</td>
<td>16.9</td>
<td>20.2</td>
</tr>
<tr>
<td>Pill 0.7</td>
<td>0.7</td>
<td>0.7</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td>IUD</td>
<td>1.3</td>
<td>2.1</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Injectable</td>
<td>0.8</td>
<td>1.0</td>
<td>1.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Vaginal methods</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Condom</td>
<td>2.7</td>
<td>3.7</td>
<td>4.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Female Sterilization</td>
<td>3.5</td>
<td>5.0</td>
<td>6.0</td>
<td>6.9</td>
</tr>
<tr>
<td>Male Sterilization</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Any Traditional Method</td>
<td>2.8</td>
<td>5.2</td>
<td>7.0</td>
<td>7.4</td>
</tr>
<tr>
<td>Periodic Abstinence</td>
<td>1.3</td>
<td>1.0</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>1.2</td>
<td>4.2</td>
<td>4.6</td>
<td>5.3</td>
</tr>
<tr>
<td>Others</td>
<td>0.3</td>
<td>-</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>


poor state of women's sexual rights and lack of female decision making at the household level all contribute in fulfilling this unmet need.

Information on the cost of contraceptives is scant but affordability does not seem to be an issue as the public sector dominates the provision of contraceptives, which are sold at subsidised rates. In the private sector, which comprises NGOs and social marketing programmes, the price of contraceptives does not have major effects on the market.9

iii | National Level Laws and Policies

Population policies and the National Health Policy have been discussed in the previous section. Important to note here is that advocacy of RH agenda and improved service delivery seem to be the major initiatives focused on by the government with improvement of IEC material being an important component. Expansion of the service delivery was a major priority area in the Ninth Five Year Plan. Currently there is a country wide network of 1,911 family welfare centres, 106 Reproductive Health Centres, 151 Mobile Service Units, 500 outlets of Target Group Institutions, and 7,584 outlets of the provincial line departments. Before ICPD, in 1993 there were 1,347 family

welfare centres, 79 Reproductive Health Centres, 174 outlets of Target Group Institutions, and 5,029 Health Department outlets including 384 outlets from other departments,9 and no mobile service units. Despite this increase not much can be said about the level of effectiveness or the quality of services extended at these service delivery outlets.

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

The combined expenditure in the social sectors: education, water and sanitation, health and reproductive health, has remained at 8.2% for the overall public sector development and non-development expenditure in the last decade. The trend in increased public sector

9Handyside Alan, Javeed Sarah, 1998. Pricing of Hormonal Contraceptives in Pakistan Social Marketing Programmes, Options Consultancy Services on behalf of DFID
9Government of Pakistan, Economic Survey 2002-03
spending of 11-16%, between 1990-91 to 1996-97, became erratic from 1997 onwards due to external factors, such as IMF regulations, structural adjustments, and the nuclear tests which led to the withdrawal of international donors. Further breakdowns are not available.

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

<table>
<thead>
<tr>
<th>Country Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>As of January 2000 the total number of detected AIDS patients rose to 187 (the first case reported was in 1987), while for HIV infection it was 1,436 according to the National AIDS Programme. The estimated number of people living with HIV/AIDS at the end of 1999 has risen to approximately 74,000.60 Despite the visible commitment of the government regarding RTIs/ STIs and the spread of HIV/AIDS there is still a need to strengthen the treatment components. The government and NGOs alike have limited access to people living with HIV/AIDS in Pakistan. There are presently only two NGOs working specifically with people who are infected.61 However 70 NGOs are participating in AIDS related issues. These NGOs are working in all four provinces and both rural and urban areas but their main focus remains awareness raising and research rather than service delivery. Limited information is available regarding counselling in the private sector, but some NGOs provide pre- and post-testing counselling services.</td>
</tr>
</tbody>
</table>

### Service Delivery Issues

A centre for the provision of training courses in counselling and case management has been established at the Civil Hospital in Karachi. Master trainers have been trained by the National AIDS Programme are expected to carry training programmes for clinicians in their respective regions. But so far no follow-ups have been conducted on this intervention. Some antiretroviral drugs are available in the major pharmacies in big cities or the drug can be arranged on request. The cost of care at the government hospitals is partially shouldered by the government, but the main burden remains on the patient. However, diagnostic and laboratory facilities are generally available.62 Treatment Policy of the government is due to start in December 2004, when antiretroviral medication will be provided to patients in all the provinces.

UNICEF, UNAIDS and UNFPA are active in advocacy and service delivery issues, with UNICEF funding concentrating on school youth; UNAIDS targeting intravenous drug users in major urban centres; and UNFPA assisting an NGO in preventing HIV transmission among drug users on the street, and soon initiating a project with commercial sex workers.63

### National Level Laws and Policies

The Ministry of Health stewards the HIV/AIDS country programme with provincial implementation units and has formulated several programmes and strategies for its prevention and control. The National AIDS Prevention and Control Programme (NACP) under the Ministry has been operational since 1994-95, and has led to a significant increase in the awareness level from a low 4% in 1991-92 to 75% in the evaluation undertaken in 2000. However gender disaggregated information is not available. Extensive advocacy campaigns in the print and electronic media by the programme are one of the major public sources for creating awareness regarding AIDS.

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

---

60 At present Pakistan is a low prevalence country (<0.1% of the adult population), but it is considered to be at high potential risk because of its low literacy rate, socio-cultural barriers regarding sexual behaviour, lack of awareness, misconceptions and disinformation, poverty, and gender issues.
63 UNAIDS, Pakistan Country Profile, 1999
64 UNFPA, Government of Pakistan, Pakistan Population Assessment 2003
HIV from spreading among vulnerable populations and to the general adult population.

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

c Reproductive Cancer

Adequate data are not available to estimate the incidence and age-standard rates (ASR) for cancer among men and women in Pakistan. According to the Pakistan Reproductive Health and Family Planning Survey (PRHFPS) 2000-01, 1.4% of women noticed a lump in their breast; of these 1% were diagnosed with breast cancer. Treatment for reproductive cancer is listed as one of the nine components of the RH Package 1998, and is available at some major hospitals, but there are no nationwide facilities by the Ministry of Health for early screening by pap smear or other means. Similarly, regular breast self-examination is not promoted, although this alone would help provide an important diagnostic tool.

d Male Involvement

i Country Status

ICPD ’94 did trigger the beginning of research into male perspectives on RH issues. NGOs have initiated projects to achieve male involvement in RH goals and also to explore RH from the male perspective for the first time. The demand for RH services among men has also been borne out by a government-led appraisal study of Family Welfare Centres. The study found that women are the primary users of these centres, and most men interviewed said they had not been approached by FWC staff regarding its services; few thought the centres offered any services for men. Among male youth interviewed, none went to the FWCs to use any of its services, while more than half of the female youth did visit them. The boys did express a need for RH counselling and advice on homosexuality, so they would not be forced to visit quacks or hakims for help.84

Contraceptive prevalence rates and data on specific methods reveal that nearly a quarter of contraceptive using women are sterilised. The most popular temporary method is the condom, used by 20% of current users, followed closely by withdrawal (19%) and the IUD (13%). The increase in figures among withdrawal users may be due to new attention being paid by researchers to investigating use of this method after the PCPS findings. Nearly half of all couples practising contraception rely on methods that require male initiative or compliance85 of husbands which is a significant finding in terms of decision making at the household level regarding family planning and choice of contraception.

The trends among women visiting health facilities with or without men are positive. According to PRHFPS 2000-01, 71% of women surveyed had ever discussed their health problems (related to different symptoms of RTIs/STDs) with husbands. 57% of husbands had taken women surveyed to the doctor.86

ii Service Delivery Issues

The key service indicator to monitor male involvement after the ICPD commitments is gender sensitisation activities, particularly among healthcare service providers and teachers, and among students - in particular boys. Most teachers in Pakistan are men,87 whereas outreach health and family planning services are dominated by women. Gender sensitisation programmes among service providers and students are conducted by non-government organisations working in these sectors, and government policy documents do not include gender sensitisation training as part of their RH approach.

There is no research available which provides indicators on status issues pertaining to other

---

87 For example 65% of primary school teachers in Pakistan are men (1997-98). (Mahbub ul Haq HDC 2000: 105)
aspects of male involvement in reproductive health, such as the percentage of men in families who share domestic responsibilities, the percentage of men who avail paternity leave (not applicable in Pakistan's legal context), or the percentage of women who get adequate maintenance support from their ex-husbands.

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

iii | National Level Laws and Policies

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

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

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

---

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

*Aahung in Karachi, Family Planning Association of Pakistan, Marie Stopes, and Message to name a few.
The role of the World Bank and IMF in Pakistan has increased over the years, especially in the last decade. Given the dire straits of Pakistan's economy - a high fiscal deficit and debt servicing crisis - the World Bank developed a strong say in the country's health policies that resulted in the private sector providing 80% of healthcare services by the mid-'90s.
CHAPTER

1 THE BARRIERS

A combination of internal and external factors created barriers that affected the implementation of ICPD commitments, and are expected to pose challenges in the future. The limited periods of democracy and heavy militarisation have added to the country's debt-ridden status, leaving little for the country's development.

The role of the World Bank and IMF in Pakistan has increased over the years, especially in the last decade. Given the dire straits of Pakistan's economy - a high fiscal deficit and debt servicing crisis - the World Bank developed a strong say in the country's health policies that resulted in the private sector providing 80% of healthcare services by the mid-'90s (Pakistan Integrated Household Survey 1995-96). The high fiscal deficit and extreme dependence on foreign financial assistance led to debt servicing as a percentage of foreign exchange earnings reaching 40% in 2000. Given the economic situation the World Bank and IMF imposed Structural Adjustment Programmes beginning in 1986. These SAPs, however, "affected various segments of population disproportionately, accentuating both poverty and related socio-economic problems in the country, as well as resulting in rising levels of unemployment,"
especially among the youth."\(^{10}\) At the same time Pakistan's foreign exchange reserves declined rapidly, touching the all time low of about a billion dollars after the nuclear tests of 1998.

Under IMF direction Pakistan had to embark on reforms for macroeconomic stabilisation. These included reduction and final removal of subsidies (on energy, wheat, fertilisers), privatisation of public run enterprises (banks and industries) and some basic services (education, health, transport), and liberalisation of imports through reduction and removal of tariffs. One condition that was met with great resistance (and had to be withdrawn) was the imposition of a 15% general sales tax on all drugs including lifesaving ones in 2002. People from low income groups have been hardest hit by the economic reforms which have not ended the economic stagnation and generated employment; thus private healthcare and/ or education have become unaffordable.

In the same period the proportion of people living in poverty also rose from 26.1% in 1990-91 to the current 34% (38% by some estimates) with rural poverty even higher (35% in 1998-99). While poverty is declining in the urban areas,\(^{11}\) a significant 20.4% of the population remains vulnerable to poverty. The characteristics of poor households in Pakistan, according to the Federal Bureau of Statistics (2001), are high dependency ratios (many children); education as the significant distinguishing factor between poor and non-poor households; dependency largely on precarious jobs often as labourers; and poverty status in rural areas closely related to landholding per capita (the poor own 0.27 acres per capita, the non-poor 0.84 acres per capita).

In response to the reduced spending on social sector and rising poverty the World Bank-coordinated and donor-supported Social Action Programme was instituted to improve health, education, population, and water and sanitation. The two-phase programme was, however, assessed as ineffective, inefficient and poorly managed. With declining expenditures in the public social sector, the private sector took responsibility for the provision of family planning, preventive services and drugs. The 1997 Health Policy provided for the BHUs and RHCs to be contracted out and the tertiary hospitals to be made autonomous and permitted to charge user fees (including for childbirth), thus becoming even more unaffordable for the poor.

Rising poverty affects women and children disproportionately, given the social cultural norms rooted in patriarchy and feudal/tribal norms that supersede both law and religious tenets. Women are restricted in mobility, have no say in decision making and are seen as dependents. Hence they face greater hindrances in attaining education, receiving healthcare and accessing employment opportunities. Due to economic pressure, however, women in poor families are forced to assume a greater responsibility for contributing to household incomes. More and more are pushed into the exploitative and low-paying informal sector, especially in the Punjab.\(^{12}\) Poor families also resort to forcing their children to become wage earners. According to an ILO survey in 1996 about 3.3 million children, or 8.3% nationwide, were economically active in the labour market.\(^{13}\) Gender disaggregated data is not available.

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

\(^{10}\) Pakistan Population Assessment, 2003, p. 15
\(^{11}\) According to one think tank, Social Policy Development Centre, poverty may be as high as 40% with one in every third household being poor, 2001, p. 14
\(^{12}\) Pakistan Participatory Poverty Assessment, National Report. 2003, p. 108
\(^{13}\) Poverty Reduction Strategy Paper. 2004, p. 101
many parts of the country, and by discriminatory laws. Despite continuous struggle by activists, these discriminatory laws have retarded women's progress for 25 years.

While the National AIDS Control programme has taken several strides forward, blood screening facilities are still not available throughout the country. The Ministry of Health has no strict guidelines or M&E for doctors and dentists, rendering large sections of the population susceptible to HIV. However, Pakistan has taken no action so far to counteract the deleterious effects of the WTO, which became effective December 31, 2004 onwards; this is likely to compromise the availability of antiretroviral drugs due to their high cost.

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

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

The NGOs in Pakistan have proliferated to over 56,000 over the last decade. In 2000 the largest number of NGOs were in education (46.4%) - more than half imparted religious education, and a fair number allegedly provided militant training. Health accounted for 6.1% of the registered NGOs, with the overwhelming majority (over 90%) in urban areas, followed by civil rights and advocacy NGOs at 17.5%.

The majority of NGOs were in the Punjab followed by Sindh, NWFP and Baluchistan, with fewer than 3,000 NGOs in the latter two. There are a little over 200 middle to large NGOs in the country. Those involved in promoting human rights and particularly women's rights are an enigma to the religious organisations and political parties - the most vocal and strident opponents of NGOs. In NWFP NGOs working for female literacy and political participation, have been threatened with physical attack, including bombing, and closure. Successive governments have followed the duplicitous policy of espousing collaboration with NGOs on the one hand, and lashing out when NGOs are critical of their policies or actions (eg nuclear tests or anti-women legislation) on the other.

Politically, Pakistan has seen three changes of government since 1994, the last one being the military takeover after the overthrow of a civilian government in October 1999. The militarisation of administrative systems with the induction of active armed force officials has been institutionalised, as has been of the role of

the military in the political sphere with amendments to the Constitution. This was achieved after making compromises and conceding space to extremist religious parties who were supporters of the Taliban in the past, are opposed to progressive thinking, are intolerant towards women and minority communities, and do not hesitate to use arms to promote their agendas. The antagonism of the religious groups to human/ women's rights advocates, to female education and political participation, and repeal of discriminatory legislation presents a formidable barrier to achieving ICPD commitments and MDG goals.

2 FACILITATING FACTORS

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

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

The other important development is the emergence of NGOs looking at issues from the human rights perspective. The NGO sector has shown its ability to mobilise and advocate for policies and change. It has played a significant role in promoting initiatives for peace with India and represents a small but vocal anti-war lobby. In the last decade NGOs have developed communication mechanisms as well as built thematic and regional networks for information sharing, advocacy and solidarity. This enabled the provision of support, for instance, to organisations that were subject to physical attack for carrying out female education projects in NWFP. There is also greater cross-thematic interaction among NGOs; for instance PRHN and the Pakistan Micro Finance Network for organisations providing credit to organisations and individuals, including women.

The Pakistan NGO Forum is the largest network of NGOs for safeguarding the interests of the sector. Formed in the mid-90s following government steps to bring in restrictive and controlling legislation, it has managed to defer the passage of the law by successive governments through its mobilisation and active lobbying.

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

A more recent phenomenon that has gained momentum in the last five years is that of the growing peace lobby. Articulating the desire of citizens for peace in the region and in the country the peace lobby has been very active for better relations with neighbouring India and has found resonance in among peace activists in the region. The anticipated peace dividend is less expenditure on defence and more for the social sectors.
The law and order situation and the tensions between provinces over shared resources (water being the foremost) are obstacles in the revitalisation of economic activity so critical for generating employment and eradicating poverty.
Future Concerns

In the immediate future the influence of the World Bank and the neo-liberal agenda in health is expected to prevail.

Due to the influence of the USA on Pakistan, the country has closely aligned itself with the “war against terror” in Afghanistan and is now assisting in tracking down al-Qaeda operatives in the region. The fallout of the alliance is being experienced in the form of heightened terrorist activities in Pakistan. The aid flow that increased dramatically (current foreign exchange reserves are in the region of 12 billion dollars) is likely to be sustained as long as the current political dispensation is acceptable to the major donor countries and financial institutions (EU, DFID, USAID, ADB, World Bank, etc) with a possible positive impact on education delivery and health services.

The rise in religious extremism is also likely to consolidate and expand and manifest itself in social and political conflict, including between the shia and sunni communities, which can be expected to create insecurity among minorities and the emerging citizens sector. This will impact the peace process between India and Pakistan, and continue to be a hurdle in the way of removing discriminatory laws and practices. The law and order situation and the tensions between provinces over shared resources (water being the foremost) are obstacles in the revitalisation of economic activity so critical for generating employment and eradicating poverty. The economy, which is claimed to be taking off, will be negatively affected by all these factors.

From the women's point of view government policy of pacifying the religious extremist elements for its own political reasons will mean slow progress in implementing institutional and legal changes that flow from its international commitments (CEDAW, ICPD, Beijing, CRC, etc) and recommended by state appointed commissions (Commission of Inquiry, NCSW). These include the repeal of the Hudood Ordinances.
Specific challenges with reference to RH and RR are the absence of a SHRH policy; existing policies that fall short of addressing women's and adolescents' RH and RR needs; ineffective implementation of policies; the persistently high maternal mortality rate; and poor quality of public sector facilities to address MM and other RH needs.
Challenges and Recommendations

**Challenges to Government**

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

**Recommendations to Government**

i Give specific attention, with legislation, policies and strongly implemented programmes, to the improvement of the low status of women. Re-institute the quota for jobs for women in government service, implement the recommendations of the Inquiry Commission and the NCSW to repeal the Hudood Ordinances and other discriminatory legislation that contribute to the perpetuation of discrimination and violence against women. Take punitive action against those, such as tribal jirgas/ courts and panchayats, who sanction the giving of women to resolve conflicts, killing in the name of honour, and domestic violence.

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

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

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

v Acknowledge the incidence of induced and unsafe abortions. As the first step, enact appropriate legislation to ensure safe abortion and legitimise abortion for rape and violence victims.

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

vii Create an enabling environment for government-civil society partnership.

b The world Bank, ADB, and donors

Challenges to donors

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

Recommendations to donors

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

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

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

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

Challenges to civil society

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

Recommendations to civil society

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

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

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

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

v. Conduct independent research to investigate the underlying reasons for maternal mortality in order to recommend policy action to address the issue. Highlight through research and publications the impact on women’s health of discriminatory legislation and social practices like forced and exchange marriages, killing in the name of honour, etc. through research. Share the findings with policymakers and the media.

vi. Use both the mainstream and alternative print and electronic media, including the performing arts, to raise issues related to women’s health, RH and RR and women’s empowerment and counter the retrogressive position taken by the extremist groups and political parties.
Current policies, good on issues that they cover, are poor in implementation due to poor governance and administrative systems, and have failed to reduce maternal mortality (over 300 per 100,000), bring down infant mortality to levels comparable with the region, reduce gender gap in female enrolment and drop out rates, contain poverty and its feminisation, or eliminate violence.
Overall Conclusion

Pakistan has taken several key policy decisions towards the implementation of the ICPD commitments in the past ten years. These have been at the institutional level as well as programme delivery level.

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

Despite such efforts the measures have not achieved as the desired results. Current policies, good on issues that they cover, are poor in implementation due to poor governance and administrative systems, and have failed to reduce
maternal mortality (over 300 per 100,000), bring down infant mortality to levels comparable with the region, reduce gender gap in female enrolment and drop out rates, contain poverty and its feminisation, or eliminate violence against women. Public expenditure remains low (0.7% of GDP for the entire health budget). Moreover there is still no RH policy, and RR are not factored in under population welfare. Sexual health, an integral part of ICPD PoA is not addressed at all, nor is the issue of unsafe abortion. Adolescent sexual and reproductive health and rights are left unaddressed. Some of the policies in other sectors have been counterproductive for instance that of privatisation, especially of healthcare.

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

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

Thus there are both challenges and opportunities for both government and civil society. The challenges are of a structural and institutional nature: provision of equal rights to women and minority groups, entitlements and opportunities to the poor, especially women, efficient and effective service delivery, monitoring with potential and actual clients of programme implementation, and increased allocation of resources for the social sectors are essential components of forward looking policies and plans. It is equally essential to deal with retrogressive elements opposed to progressive change, and the demonstrated will to do so at the political level. Civil society has to be alert, organised, and vocal.
Protocol on Child Abduction

The President of the Family Division and the Hon. Chief Justice of Pakistan in consultation with senior members of the family judiciary of the United Kingdom ("UK") and the Islamic Republic of Pakistan ("Pakistan"), having met on 15th to 17th January 2003 in the Royal Courts of Justice in London, reach the following consensus:

WHERE AS:

⇒ i. Desiring to protect the children of the UK and Pakistan from the harmful effects of wrongful removal or retention from one country to the other;
⇒ ii. Mindful that the UK and Pakistan share a common heritage of law and a commitment to the welfare of children;
⇒ iii. Desirous of promoting judicial cooperation, enhanced relations and the free flow of information between the judiciaries of the UK and Pakistan; and
⇒ iv. Recognising the importance of negotiation; mediation and conciliation in the resolution of family disputes;

IT IS AGREED THAT:

⇒ i. In normal circumstances the welfare of a child is best determined by the courts of the country of the child's habitual/ordinary residence.
⇒ ii. If a child is removed from the UK to Pakistan, or from Pakistan to the UK, without the consent of the parent with a custody/residence
order or a restraint/interdict order from the court of the child's habitual/ordinary residence, the judge of the court of the country to which the child has been removed shall not ordinarily exercise jurisdiction over the child, save in so far as it is necessary for the court to order the return of the child to the country of the child's habitual/ordinary residence.

iii. If a child is taken from the UK to Pakistan, or from Pakistan to the UK, by a parent with visitation/access/contact rights with the consent of the parent with a custody/residence order or a restraint/interdict order from the court of the child's habitual/ordinary residence or in consequence of an order from that court permitting the visit, and the child is retained in that country after the end of the visit without consent or in breach of the court order, the judge of the court of the country in which the child has been retained shall not ordinarily exercise jurisdiction over the child, save in so far as it is necessary for the court to order the return of the child to the country of the child's habitual/ordinary residence.

iv. The above principles shall apply without regard to the nationality, culture or religion of the parents or either parent and shall apply to children of mixed marriages.

v. In cases where the habitual/ordinary residence of the child is in dispute the court to which an application is made should decide the issue of habitual/ordinary residence before making any decision on the return or on the general welfare of the child, and upon determination of the preliminary issue as to habitual/ordinary residence should then apply the general principles set out above.
vi. These applications should be lodged by the applicant, listed by the court and decided expeditiously.

vii. It is recommended that the respective governments of the UK and Pakistan give urgent consideration to identifying or establishing an administrative service to facilitate or oversee the resolution of child abduction cases (not covered by the 1980 Hague Convention on the Civil Aspects of International Child Abduction).

viii. It is further recommended that the judiciaries, the legal practitioners and the non-governmental organizations in the UK and Pakistan use their best endeavours to advance the objects of this protocol.

ix. It is agreed that the UK and Pakistan shall each nominate a judge of the superior court to work in liaison with each other to advance the objects of this protocol.

Dame Elizabeth Butler-Sloss, DBE
President of the Family Division
of the High Court of England and Wales

The Hon. Mr. Justice Sh. Riaz Ahmad
Chief Justice of the Supreme Court of Pakistan
Reproductive Health - Evolution
1. RH evolved in ICPD conference in Cairo September 1994
2. Delegates from 179 countries took part in negotiation/discussions
3. A POA on Population & Development for next 20 years was finalized

Strategic Emphasis of RH
1. New strategy emphasizes numerous linkages between Population & Development
2. Focus is on “meeting the needs of individual women & men” rather than on achieving demographic targets

Reproductive Health – The Concept
1. RH is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes
2. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce & the freedom to decide if, when and how often to do so

Reproductive Health – The essence
1. Mean to sustainable development as well as human rights
2. Investment in RH save & improve lives
3. It slows the spread of HIV/AIDS
4. Encourages gender equality
5. This helps to stabilize population growth and reduce poverty

Protecting Reproductive Rights
1. During 1990s, a series of important United Nations conferences emphasized that the well-being of individuals, and respect for their human rights, should be central to all development strategies
2. Particular emphasis was given to reproductive rights as a cornerstone of development, and to empowerment of women as being an important element in ensuring the exercise these rights
What are RH Rights?
1. Reproductive Rights are part of Human Rights. Their goal is that each person should live a fulfilling, risk free sexual life
2. Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents

Reproductive Rights
1. A fundamental shift from long-standing demographic focus of population program to a focus on health & women rights

Key Approaches to RH
1. Holistic
2. Client-Oriented
3. Life Cycle

Holistic Approach

Domestic Violence
Safe Motherhood
Child Health
Family Planning
Sexual Health

Client - Centered Approach Aims at
1. Assessing their needs
2. Addressing those needs

As opposed to
Meeting Provider's or Government Targets
**Life Cycle Approach**
Governments in collaboration with civil society should take necessary measures to ensure universal access, on the basis of equality between women and men, to appropriate, affordable and quality health care for women throughout their life cycle.

(Report of the Ad Hoc Committee of the Whole of the Twenty-First Special Session of the General Assembly, 1 July 1999)

---

**Life Cycle Approach to Reproductive Health**

---

**ICPD + 5**

1. In 1999, the United Nations General Assembly convened a special session to review progress towards meeting the ICPD Goals.
2. The special session known as ICPD + 5 added some global benchmarks for achievements in RH.
3. Of these five are operational benchmarks, one each for a major area of RH.

**Services**
Provision of universal access to a full range of safe and reliable family planning methods and to related RH services.

**Safe Motherhood**
Percentage of births to be assisted by skilled attendants globally: 80 percent by year 2005

**Family Planning**
Gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families to be reduced by 50 percent by year 2005

**Adolescents and STD/HIV/AIDS**
Reduce vulnerability to HIV/AIDS infection, 90 percent of young men and women...
aged 15-24 should have access to preventive methods such as female and male
condoms, voluntary testing, counseling and follow up by year 2005

**Gender**
Elimination of gender gap in primary and secondary education by 2005

**Millennium Development Goals**
At the Millennium Summit in September 2000 the member states of the United
Nations reaffirmed their commitment to working toward a world in which sustaining
development and eliminating poverty would have the highest priority. The goals have
been commonly accepted as a framework for measuring development progress.
These include:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

### ICPD + 5 Benchmark and Millennium Development Goals

<table>
<thead>
<tr>
<th>ICPD+5 Operational Benchmark</th>
<th>MDGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Services: Provision of universal access to full range of safe and reliable family planning methods and to related sexual and reproductive health services</td>
<td>1. Eradicate extreme poverty and hunger</td>
</tr>
<tr>
<td>2. Safe Motherhood: Percentage of births attended by skilled attendants globally 80% by year 2005</td>
<td>2. Reduce child mortality</td>
</tr>
<tr>
<td>3. Family Planning: Gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families to be reduced by 50%</td>
<td>3. Improve maternal health</td>
</tr>
<tr>
<td>4. Adolescents and STD/HIV/AIDS: To reduce vulnerability to HIV/AIDS infection, 90% of young men and women aged 15-24 years should have access to preventive methods such as female and male condoms, voluntary testing, counseling and follow up by year 2005</td>
<td>4. Combat HIV/AIDS, malaria and other diseases</td>
</tr>
<tr>
<td>5. Gender: Elimination of gender gap in primary and secondary education by 2005</td>
<td>5. Ensure environmental sustainability</td>
</tr>
<tr>
<td></td>
<td>6. Improve maternal rate</td>
</tr>
<tr>
<td></td>
<td>7. Eradicate extreme poverty and hunger</td>
</tr>
<tr>
<td></td>
<td>8. Reduce child mortality</td>
</tr>
<tr>
<td></td>
<td>9. Improve maternal health</td>
</tr>
<tr>
<td></td>
<td>10. Combat HIV/AIDS, malaria and other diseases</td>
</tr>
<tr>
<td></td>
<td>11. Ensure environmental sustainability</td>
</tr>
<tr>
<td></td>
<td>12. Combat HIV/AIDS, malaria and other diseases</td>
</tr>
<tr>
<td></td>
<td>13. Promote gender equality and empower women: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all level of education no later than 2015</td>
</tr>
</tbody>
</table>
Global Challenges and Opportunities

Mobilizing Resources
1. This will require advocacy, negotiation, public education, effective use of resources, reduce waste and duplication, and to enlist the private sector and NGOs as partners.

Political Will
2. The opportunities presented to build political support are many. Investments in ICPD implementation will have a ripple effect where health, education, economic status of women and girls will be improved increasing their potential to contribute to national development.

Economic Development
Poverty will increase in some countries while others will prosper deepening existing inequalities. Human development will lead to economic development. Universal access to education and RH care crucial steps to help eradicate poverty. Access to voluntary RH services will give users the choices that will change the repetitive cycles of poverty. Smaller families allow more investment in each child's education and health.

Health Sector Reform
Now underway in many countries, reform processes include decentralization of health system planning and management, encouraging privatization of service delivery, putting a premium on cost effectiveness and cost recovery. Policy makers and health providers work together to effectively ensure delivery of RH services through joint planning at national and district levels, involvement of communities, and on the introduction of fees and its impact.

Capacity Building
More and better skilled planners, managers and providers will be needed. Opportunities to transfer skills exists through agreement with donors, in-service training, mentor relationships and training of lower level staff to provide more services.

Social Norms and Gender Relations
Some families, communities, and legal, political and economic systems value women less than men resulting in discrimination. This ensures disempowerment of women who can not contribute to society according to their potential. The highest proportion of women’s ill health burden is related to their reproductive role. Universal access to RH care including family planning, care in pregnancy, during and after childbirth and emergency obstetric care would reduce unwanted pregnancy, unsafe abortion and maternal death, saving women’s lives and the lives of their children. (A healthy mother is the first step towards a healthy child). Women empowerment will enable women to address the social conditions that endanger their health and lives.
### Some Key RH Indicators: Comparative Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Malaysia</th>
<th>Indonesia</th>
<th>Pakistan</th>
<th>Iran</th>
<th>Bangladesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries attended by skilled attendant</td>
<td>96.20</td>
<td>55.80</td>
<td>20.00</td>
<td>n/a</td>
<td>12.10</td>
</tr>
<tr>
<td>Primary School Enrolment Gross % School age pop Female</td>
<td>102.38</td>
<td>109.71</td>
<td>116.71</td>
<td>89.40</td>
<td>119.93</td>
</tr>
<tr>
<td>Secondary School Enrolment Gross % School age pop Female</td>
<td>103.70</td>
<td>53.50</td>
<td>31.86</td>
<td>76.83</td>
<td>55.90</td>
</tr>
<tr>
<td>Proportion of population 15-24</td>
<td>18.90</td>
<td>19.80</td>
<td>19.40</td>
<td>22.60</td>
<td>20.40</td>
</tr>
<tr>
<td>Mean age at Marriage Female</td>
<td>23.50</td>
<td>21.60</td>
<td>21.70</td>
<td>21.10</td>
<td>18.00</td>
</tr>
<tr>
<td>HIV/AIDS Prevalence, 15-24 Lower Bound Female</td>
<td>0.09</td>
<td>0.05</td>
<td>0.03</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>HIV/AIDS Prevalence 15-24, Upper Bound Female</td>
<td>0.14</td>
<td>0.07</td>
<td>0.07</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Seats in Parliament Held by women</td>
<td>14.50</td>
<td>8.00</td>
<td>n/a</td>
<td>3.40</td>
<td>9.10</td>
</tr>
<tr>
<td>Labor Force Participation Rate 15-64</td>
<td>82.80M</td>
<td>44.70F</td>
<td>86.30M</td>
<td>53.20F</td>
<td>84.60M</td>
</tr>
<tr>
<td>Under Age 5 Mortality Female</td>
<td>11.00</td>
<td>43.00</td>
<td>135.00</td>
<td>45.00</td>
<td>97.00</td>
</tr>
<tr>
<td>Life Expectancy at Birth Combined</td>
<td>71.95</td>
<td>65.13</td>
<td>59.00</td>
<td>67.95</td>
<td>58.14</td>
</tr>
<tr>
<td>Life Expectancy at Birth Female</td>
<td>74.53</td>
<td>67.00</td>
<td>58.85</td>
<td>68.75</td>
<td>58.20</td>
</tr>
</tbody>
</table>

Source: UNFPA

### Key Notes From ICPD +10 Global Meeting

#### Background
1. An NGO meeting in 'absence' of UNFPA call to inter-governmental meeting
2. Major partnership between North American and European NGOs to organize the event [PAI, IPPF, FCE, CFFC]
3. Largest grant from EC and others from Foundation, Japan, DFID & UNFPA
4. Five regional meeting and 1 Global meeting in 2004

#### Goals
1. To revitalize and re-energize Cairo movement
2. To reach out to new constituencies, traditional groups and entities
3. To build greater public support for ICPD POA
4. To establish an agenda for going forward in next 5-10 year [move even beyond POA]

#### Major Observations
1. The benchmarks of success in reaching to new constituencies were the extremely successful outreach to the HIV/AIDS community and Youths. [in terms of content and attendance]
2. HIV/AIDS well integrated into every session and working group
3. Youths was the biggest success
4. Moderate success with Human Right groups
5. Participation of development community was rated weak
6. Parliamentarians, strong participation (75) from across the world in addition to DFID officials.
7. Asset was the new set of international links
8. Deficit was lack in planning and reaching out groups at country level by steering committee
9. Pakistan was represented weakly in absence of any parliamentarians, Govt. official and most major NGOs
10. Youths involvement was very visible and clear
11. Not just participants but partners
12. "Youth Day" was organized a day prior to global meeting i.e August 30th
13. Youth finalized a "Participation Strategy" to ensure Youth agenda is reinforced in all group discussions
14. Incredibly creative, collaborative, energetic and responsible
15. Reinforces and refocus the Youths / adolescents in development
16. Evaluation from individual countries pointed out "data gaps"
17. No measurement of equation of gender violence, women's empowerment and domestic violence etc.
18. From advocacy perspective these issues are very well received by press and parliamentarians
19. Wonderful reference with a five – year shelf life
20. Weak focus on Population Dynamics and Involvement
21. Great focus on “Rights” issues
22. Workshop framework was focusing more energy on issues Poverty, Culture, Politics, Science/Technology, HIV/AIDS and Youths
23. There was some discomfort on the absence of “Population” and “Environment” as being “US agenda

Substantive Achievements from Cairo and Cairo+5 Meeting
1. Abortion – A Stronger Statement of “Abortion rights” than any of global conference produced language which is helpful to advocacy groups moving forward
2. Reinforcement of SRHR and HIV/AIDS as one community instead of two separate
3. Youth involvement was re-enforced and became more focused and stronger
4. Set challenges over the next 10 years on the progressive end of agenda
5. Challenge to NGO community to stay on these issues and push them hard over next 10 year

All World Regions Excepts Europe Will Continue to Grow
Developing countries in Africa and Asia will account for about 90 percent of the increase in world population project by 2050, while the populations of most developed countries will decrease. Among the developed countries, only the United States is likely to see significant growth, a result of immigration and a birth rate higher than other developed nations.

![Population Chart]

2004 World Population Data Sheet
PRB Population Reference Bureau
Around the World, Birth Rates Range Dramatically From 1.2 to 8 Children per Women.
In some countries of Africa and the Middle East, women average about six to eight births in their lifetimes. In Europe, the average falls far short of two children. Such low rates will ensure population decline and, in many European countries, the annual number of births is less than the number of deaths.

![Bar graph showing average number of children per woman](2004 World Population Data Sheet)

Despite Improvements, Each Year an Infant is 13 Times More Likely to Die in Africa as in Europe and America.
The lack of prenatal and postnatal care, resulting from the lack of facilities, trained professionals, or ignorance of the need for professional care, are major contributors to high rates of infant mortality, the fact that high rates remain in many countries does mask the fact, however, that real progress has been made. In Africa, rates have been halved since 1950, showing that maternal and child health programs do work.

![Bar graph showing deaths under age 1 per 1,000 live births](2004 World Population Data Sheet)

Across World Region, Contrasting Age Structure Will Lead to Sharply Different Demographic Futures.
Developing countries will far outpace developed countries in population growth because of a young age structure as well as higher birth rates. High birth rates in the
past are falling but continued high birth rates for many developing countries, guarantee several decades of growth. In the more developed countries, very low proportions of youth and high proportions of older people are significant factors in the coming population decline.

Among Less Developed Regions, Latin America Leads in Contraceptive Use. Family planning use is becoming more widespread in developing countries to help women avoid unintended pregnancies and to lower birth rates. A clear prerequisite is the availability of modern contraceptive for couples with both the knowledge and desire to use it. This objective has been generally achieved in much of Latin American and the Caribbean, but often falls quite short in sub-Saharan Africa and parts of Asia and Oceania. In each region, contraceptive use varies broadly. Obstacle such as the lack of funds and supplies – and the lack of comprehensive programs to educate couples on their options—are significant barriers.

HIV/AIDS Is a Devastating Global Problem With a Few Beacons of Hope. The number of people now living with HIV/AIDS has reached 38 million, according to the United Nations. Sub-Saharan Africa has by far the largest number of people living with HIV/AIDS, just over 25 million. Out of the 6.5 million HIV/AIDS victims in South/Southeast Asia, 5.1 million live in India. It is estimated, however, that infection rates have begun to decline in a number of countries, so that the situation need not be hopeless.
## Population in millions

<table>
<thead>
<tr>
<th>Region</th>
<th>Population Mid-2004 (millions)</th>
<th>Infant Mortality Rate</th>
<th>Total Fertility Rate</th>
<th>Percent of Population of Age</th>
<th>Life Expectancy at Birth (years)</th>
<th>Percent of Married Women 15-49 Using Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;15</td>
<td>65+</td>
<td>Male</td>
</tr>
<tr>
<td>More Developed</td>
<td>1,206</td>
<td>7</td>
<td>1.6</td>
<td>17</td>
<td>15</td>
<td>72</td>
</tr>
<tr>
<td>Less Developed</td>
<td>5,190</td>
<td>62</td>
<td>3.1</td>
<td>33</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Less Developed (Excl. China)</td>
<td>3,890</td>
<td>66</td>
<td>3.5</td>
<td>36</td>
<td>4</td>
<td>61</td>
</tr>
<tr>
<td>China</td>
<td>1,300.1</td>
<td>32</td>
<td>1.7</td>
<td>22</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>India</td>
<td>1,086.6</td>
<td>64</td>
<td>3.1</td>
<td>36</td>
<td>4</td>
<td>61</td>
</tr>
<tr>
<td>United State</td>
<td>293.6</td>
<td>6.7</td>
<td>2.0</td>
<td>21</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Indonesia</td>
<td>218.7</td>
<td>46</td>
<td>2.6</td>
<td>30</td>
<td>5</td>
<td>66</td>
</tr>
<tr>
<td>Brazil</td>
<td>179.1</td>
<td>33</td>
<td>2.2</td>
<td>30</td>
<td>6</td>
<td>67</td>
</tr>
<tr>
<td>Pakistan</td>
<td>159.2</td>
<td>85</td>
<td>4.8</td>
<td>42</td>
<td>4</td>
<td>60</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>141.3</td>
<td>66</td>
<td>3.3</td>
<td>37</td>
<td>3</td>
<td>60</td>
</tr>
<tr>
<td>Nigeria</td>
<td>137.3</td>
<td>100</td>
<td>5.7</td>
<td>44</td>
<td>3</td>
<td>52</td>
</tr>
<tr>
<td>Japan</td>
<td>127.6</td>
<td>3.0</td>
<td>1.3</td>
<td>14</td>
<td>19</td>
<td>78</td>
</tr>
<tr>
<td>Iran</td>
<td>67.4</td>
<td>32</td>
<td>2.5</td>
<td>33</td>
<td>5</td>
<td>68</td>
</tr>
</tbody>
</table>

2004 World Population Data Sheet  
PRB Population Reference Bureau
The right of access to modern family planning is currently denied to over 350 million couples worldwide


Balchin, Cassandra; Mumtaz, Khawar; Shaheed, Farida, *Woman not the Womb*. Lahore. Shirkat Gah. 1994


*Economic Survey of Pakistan. 2002-03*


Handyside Alan, and Javeed, Sarah, *Pricing of Hormonal Contraceptives in Pakistan Social Marketing Programs*. Options Consultancy Services on behalf of DFID. 1998


*National Policy for Development & Empowerment of Women*. GOP. Islamabad. 2003


*Pakistan Statistical Year Book 2002*. GoP. 2003

*Pakistan Contraceptive Prevalence Survey 1994-95.*

*Pakistan Reproductive Health and Family Planning Survey, 2000-2001*

*Pakistan Contraceptive Prevalence Survey 1994*


Qureshi, Asma Fozia and Qazi, Yasmeen Sabeeh Maternal and Neonatal Health in Pakistan: A Desk Review. Islamabad. 2003 (unpublished.)

Sajan, F. and Fikree, F. “Perceived gynecological morbidity among young ever-married women living in squatter settlements of Karachi, Pakistan.” JPMA 1999 Apr: 49(4)


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


UNAIDS, *Pakistan Country Profile 1999*
The report is based on desk reviews by Ayesha Khan on women's empowerment; Sarah Javeed on sexual rights, HIV/AIDS and reproductive cancer, Rabia Khan on gender equity and equality, and Dr. Sarah Saleem on maternal mortality and morbidities; interviews by Hilda Saeed and valuable comments on drafts at different stages; assistance in the first draft by Ayesha Kariapper; PRHN members' feedback and inputs; and Rashidah Abdullah and Ranjani Krishnamurthy's comments and feedback on the first and second drafts.