Evidence Based Policies for Improving Maternal Health in Pakistan

Improving Maternal Health in Pakistan: Meeting MDG-5 Targets

During the last few years numerous developments transforming the social, political, and economic landscape of Pakistan have taken place, all having an impact on the outcomes of Pakistan’s Millennium Development Goals. The Pakistan economy is in dire straits and an increasing number of people are falling below the poverty line. The burden of poverty is distributed disproportionately among families, with children and women affected most, the feminization of poverty being a well-recognized phenomenon. Demographically Pakistan is undergoing a ‘youth bulge’ with 60% of the population below 30 years of age and girls suffering a disadvantage in terms of education, health and employment. The following table gives a statistical overview of the status of women in Pakistan:

Table 1: Status of women in Pakistan

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Literacy</td>
<td>35.4</td>
</tr>
<tr>
<td>Gender Parity Index for primary education</td>
<td>0.84</td>
</tr>
<tr>
<td>Gender Parity Index for secondary education</td>
<td>0.8</td>
</tr>
<tr>
<td>Gender parity index for youth literacy</td>
<td>0.78</td>
</tr>
<tr>
<td>Women’s share of the labour force</td>
<td>26</td>
</tr>
<tr>
<td>Share of women in wage employment in the non-agricultural sector</td>
<td>10.64</td>
</tr>
<tr>
<td>Ave. age of marriage for women aged 25-49</td>
<td>19.7 (urban) 18.8 (rural)</td>
</tr>
<tr>
<td>Unmet need for contraception</td>
<td>37</td>
</tr>
<tr>
<td>Infant Mortality Rate (IMR)</td>
<td>78 (per 1,000 live births)</td>
</tr>
</tbody>
</table>


Table 2: The Gender Inequality Index 2011

Components of the Gender Inequality Index (GII)

GII—three dimensions and five indicators

The GII is a composite measure reflecting inequality in achievements between men and women in three dimensions:

i. Reproductive health is measured by two indicators: maternal mortality ratio and adolescent fertility rate.

ii. Empowerment is measured by secondary and higher education attainment levels and parliamentary representation.

iii. Labour is measured by women’s participation in the work force.

In Pakistan, women lag behind in each of these areas except parliamentary representation. Pakistan is ranked 115 out of 145 countries in the GII 2011.
With respect to MDG-5 the GOAL is to Improve Maternal Health

**Targets:**

a) *Reduce by three-quarters between 1990 and 2015, the maternal mortality ratio*

b) *Achieve universal access to reproductive health by 2015*

**Table 3: Current status of MDG-5 Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Latest available statistics</th>
<th>MDG-5 target by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio (MMR)</td>
<td>No. of mothers dying due to complications of pregnancy and delivery per 100,000 live births</td>
<td>276</td>
<td>140</td>
</tr>
<tr>
<td>Proportion of births attended by skilled birth attendants</td>
<td>Proportion of deliveries attended by skilled birth personnel (Medical Officers, midwives, LHV)</td>
<td>40%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Contraceptive Prevalence Rate</td>
<td>Proportion of eligible couples for family planning programmes using one of the contraceptive methods</td>
<td>29.6%</td>
<td>55%</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>Average number of children a woman delivered during her reproductive age</td>
<td>4.1 births per woman</td>
<td>2.1</td>
</tr>
<tr>
<td>Proportion of women 15-49 years who had given birth during last 3 years and made at least one antenatal care consultation</td>
<td>Proportion of women (15-49) who delivered during the last 3 years and received at least one antenatal care during their pregnancy period from either public/private care providers</td>
<td>56%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

This policy brief brings attention to the problem and provides research based evidence for considering policy options and recommendations.

**Monitoring the Implementation of MDG-5 in Pakistan: Action Research Project**

Shirkat Gah – Women’s Resource Centre is a leading women’s rights organisation of Pakistan. It undertook an action research project to assess the status of implementation of MDG-5 interventions in Pakistan (2010-2011). The findings confirmed evidence from other sources and reports that Pakistan is lagging behind and unlikely to achieve the MDG target set for 2015. It was also clearly shown that investments and interventions made in the area are not having the desired impact and have so far been unable to make a significant impact on the lives of average Pakistani women.

This is a crucial time to address this failure because of the current demographic status of Pakistan where over 60% of the population is below thirty years, and a very large number of women and girls are in child-bearing age (Framework for Economic Growth 2011, Planning Commission of Pakistan). The consequences of not adopting corrective measures at this stage will lead to a population explosion, increased maternal and neonatal morbidity and mortality, reinforcing of gender inequalities and a negative impact on economic growth.

Shirkat Gah’s research clearly shows that health is not only a medical problem, but also a socio-economic one deeply related to the status of women in society. In the social sectors, there are major gaps in service provision which are reflected in the various development indices as well as the Pakistan MDG Report 2010. In the absence of formal services, women resort to harmful practices and informal and inadequate social support networks. In many cases these practices and customs perpetuate inequalities or skewed power dynamics of caste, socio-economic class, feudal hierarchies and gender. Thus only a cross-sectoral approach can address these problems in a meaningful way.

Following is a concise summary of the findings of the research:

**Reproductive Health Needs: Services, Supplies, and Information**

- Isolated and/or vertical interventions in select areas/districts provide successful models (e.g. Family Advancement for Life and Health - FALAH and Pakistan Initiative for Mothers and Newborns - PAIMAN Projects) may have significant local impact but do not provide cover for all women in need. Shirkat Gah’s research, comparing districts where donor-supported interventions had been carried out with those where only routine public services were available showed that the plight of women in both categories was more or less the same. The only factors that made a difference were residence in an urban area where a wide choice of services was accessible; socio-economic status; and, education.

- Poverty is a key determinant of public health facility utilization. However Basic Health Units (BHUs) in investigation sites were inadequately staffed and stocked; where facilities were better they were not
conveniently located. Locations were seen to be based on political expediency rather than need or population, resulting in lack of accessibility and under-utilization of available services.

- Emergency Obstetric Care was not available and relevant BHU staff was absent in the specified duty time. Traditional Birth Attendants (TBAs) were the main local service providers for reasons of timely availability, costs and familiarity. Lady Health Visitors (LHVs) provided services but did not undertake field visits although their terms of reference require them to. The role of LHVs was generally appreciated in all sites; they were accepted and respected by the community. However, coordination between Lady Health Workers (LHWs) and LHVs was found to be poor.

- Unmet need for family planning among women was widespread. Inadequate services for contraception mean that many women resort to abortion as a means of family planning. No safe abortion or post-abortion care is available to them.

Reproductive Health Needs of the Youth and Adolescents

- Both male and female youth felt there is a lack of awareness on RH and strongly expressed the desire for information, counseling and services. No services cater to the young age/adolescent population and LHWs are not equipped to handle the needs of adolescents, as it is not part of their mandate.

Governance and Reproductive Health

- The minimum age requirement is not complied with at the time of marriage, and all marriages are not registered. Births, particularly of female children, are also not registered. These issues are directly linked to early marriages, increased fertility and poor health, social and financial outcomes.

- The absence of the local government system was voiced everywhere as that provides a sense of ownership and an accessible avenue for drawing attention to their needs. Without local government one sided patron-client relationships get nurtured, and corruption, nepotism and inefficiency seem to have freer reign.

- The Lady Health Workers program is well appreciated by the community; it empowers women and brings vital information and health services to their doorstep. Before the 18th Constitutional Amendment, it functioned as a vertical program, running parallel to the regular health system. Post 18th amendment, it has been devolved to the provinces and is in a state of transition with the issue of finances not fully settled and only partial ownership by provinces.

- While a whole range of informal and formal health services are available to the people in the public and private sectors, there is no regulation of the quality of care that is being provided. As a result there is widespread quackery, corruption, medical negligence and malpractice which go on unchecked.

Social Factors Influencing Reproductive Health

- There is a lack of participation and involvement of men in family planning services. Men reported not having enough information about family planning and contraceptives, being unaware of women’s reproductive health needs, and not sure of where to get this information. There are very few functional male mobilizers who could complement the work of the LHWS.

- Dual practice is a commonly prevalent problem where medical professionals in the public sector divert patients to their private practices for monetary profit at the expense of the public health sector.

- Nowhere was the huge potential of mobile phones, TV, radio and internet being used for developing innovative strategies for raising awareness, spreading information and providing services to remote areas and women confined to their homes. These vital means of communication and information remain under-utilized.

Encouraging Reproductive Health Responses: Ways Forward

- There is a correlation between secondary education and positive reproductive health outcomes. Girls entering secondary school tended to stay till completion of their schooling. This results in relatively late marriages, spacing of children and taking up employment.

- There is a widespread desire to educate daughters and limit family size.

- There was responsiveness of officials (Health, Population Welfare, Local Government) to community demands when community links and engagement were facilitated during the research. As a result in various sites BHUs were reactivated; LHWs and LHVs were appointed; a regular supply of medicine in BHUs was ensured; mobile health units were mobilised, etc.

- The research process built information, advocacy and communication capacity of local CBOs and their staff to monitor services and express their needs, and to engage with duty bearers.
Policy Implications

Women represent almost half of Pakistan’s population and are faced with critical barriers in the shape of high maternal mortality (276/100,000 live births), deeply entrenched discriminatory social structures that reinforce health inequities, deny women a say in decision making and deprive them of the benefits of development, growth and fulfillment. Pakistan’s reproductive health and gender development indicators hide the inequities within the averages.

The demographic ‘youth bulge’ and an exploding population, with estimates that if the current fertility rates continue, the population would exceed 500 million by 2050, means that this would have catastrophic effects on the already scarce resources of the country and an increase in poverty levels. Pakistan has already indicated that in the current circumstances, it is unlikely to achieve the MDG targets by 2015 (Pakistan MDG Report 2010). The window of opportunity that is currently available because of the youth bulge will close in a few years. If at this stage due attention is given to young people and women in terms of education, capacity building, health awareness and services, the potential of these youth can be harnessed and the crisis can be converted into an opportunity. This demands a wide ranging agenda of action.

Recommendations

• Adopt an integrated approach to women’s reproductive health that factors in women’s rights, gender equality, poverty, education and employment.
• Employ a continuum of care approach addressing needs of girls and women at each stage of their life cycle (infancy, childhood, adolescence, reproductive, menopausal).
• Increase quality and access of services delivered through regular health system rather than relying on vertical or limited donor funded interventions. Vertical programmes should be integrated into the regular health system to maximize coverage.
• Ensure BHUs are accessibly located and need and population based; that round the clock emergency obstetric care is available and accessible.
• Given that mid-level professionals (MLP) and local level providers are key to RH and FP delivery, fully integrate LHW program into provincial health systems and upgrade skills of TBAs with emphasis on referrals; establish mechanisms for monitoring all MLP; revitalize the role of male mobilizers.
• Improve availability of contraceptives with back up counseling and follow up services as well as provision of safe abortion and post abortion care.
• Re-structure the health and population welfare departments in the light of the 18th constitutional amendment for streamlined and coordinated, timely and effective services.
• Make adolescent reproductive health a part of the educational curriculum including adverse effects of early marriages. Given the demography of Pakistan and the huge proportion of people under the age of twenty there should be added emphasis on raising awareness and services to this group. Expand the ambit of LHWs to include Adolescent Reproductive Health.
• Focus on women’s education and improving their socio-economic status through provision of skills and opportunities.
• Ensure the right to education by enforcing Article 25-A under which “The State shall provide free and compulsory education to all children of the age of five to sixteen years in such manner as may be determined by law.”
• Make amendments in the Child Marriage Restraint Act 1929 to increase the minimum age of marriage to 18 years.
• Make birth registrations mandatory for determining age at time of marriage; and ensure compliance of minimum age by marriage registrars.
• Re-visit legislation regarding quackery and regulation of health care to make it more strict and effective.
• Increase awareness through media, SMS campaigns, (involving local general stores to include men) and expanding social marketing techniques.
• Utilize potential of the internet to provide awareness and tele-medicine on the pattern of the highly successful ‘Info-ladies’ of Bangladesh where local women are provided a laptop and a mobile phone (as well as a bicycle) and they go from house to house providing digital information on areas as diverse as farming and animal husbandry to health and nutrition.

Members of Parliament and relevant departments could use the evidence from this research to inform their policies and practices. The solutions are not difficult, nor are they resource intensive. They only require logical thinking, good governance, a commitment to the principle of social justice and a strong will. By considering the recommendations based on the findings of scientific research, the health and quality of life of millions of Pakistani women can be dramatically improved.
Evidence Based Cross-Sectoral Policies for Improving Maternal Health in Pakistan

During the last few years numerous developments transforming the social, political, and economic landscape of Pakistan have taken place, all having an impact on the outcomes of Pakistan’s Millennium Development Goals. The Pakistan economy is in dire straits and an increasing number of people are falling below the poverty line. The burden of poverty is distributed disproportionately among families, with children and women affected most, the feminization of poverty being a well-recognized phenomenon. Demographically Pakistan is undergoing a ‘youth bulge’ with 60% of the population below 30 years of age and girls suffering a disadvantage in terms of education, health and employment.

**Table 1: Current status of MDG-5 Indicators**

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

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

This policy brief brings attention to the problem and provides research based evidence for considering policy options and recommendations.

**Monitoring the Implementation of MDG-5 in Pakistan: Action Research Project**

Shirkat Gah – Women’s Resource Centre is a leading women’s rights organisation of Pakistan. It recently undertook an action research project to assess the status of implementation of MDG-5 interventions in Pakistan (2010-2011). The findings confirmed evidence from other sources and reports, that Pakistan is lagging behind and unlikely to achieve the MDG target set for 2015. It was also clearly shown that investments and interventions made in the area are not having the desired impact and have so far been unable to make a significant impact on the lives of average Pakistani women.

This is a crucial time to address this failure because of the current demographic status of Pakistan where over 60% of the population is below thirty years, and a very large number of women and girls are in child-bearing age (Framework for Economic Growth 2011. Planning Commission of Pakistan). The consequences of not adopting corrective measures at this stage will lead to a population explosion, increased maternal and neonatal morbidity and mortality, reinforcing of gender inequalities and a negative impact on economic growth.

The following matrix provides a concise summary of the findings of the research and the recommendations that came out of those findings:

**Findings**

**Recommendations**

**Select area/vertical interventions**

Isolated and/or vertical interventions in select areas/districts may have significant local impact but do not improve the overall situation. Shirkat Gah’s research, comparing districts where donor-supported interventions had been carried out with those where only routine public services were available showed that the plight of women in both categories was more or less the same. The only factors that made a difference were residence in an urban area where a wide choice of services was accessible, socio-economic status and education.

- Increase quality and access of services delivered through regular health system rather than relying on vertical or limited donor funded interventions.

**Health systems and equity issues**

Poverty is a key determinant of public health facility utilisation. However BHUs in investigation sites were inadequately staffed and stocked, where facilities were better they were not conveniently located. Locations were seen to be based on political expediency rather than need or population resulting in lack of accessibility and under-utilization of available services. This was compounded by pathetic conditions of roads and unavailability of timely public transportation.

- Ensure BHUs are accessible and on need and population based.

Emergency Obstetric Care (EmOC) was not available and staff was absent in specified duty time.

- Make round the clock EmOC to be made available and accessible.

Mid level professionals as well as TBAs were the main local service providers for reasons of timely availability, costs and familiarity.

- Upgrade skills of TBAs with greater emphasis on referral mechanisms.

LHWs provided services but did not undertake field visits although TORs require them to.

- Ensure safe round the clock public transport.

**Vertical programmes and post-18th amendment status of Health Departments**

The Lady Health Workers program is well appreciated by the community; it empowers women and it brings vital information and health services to the doorstep. However before the 18th Constitutional Amendment, it functioned as a vertical program, thus running parallel to the regular health system. Post 18th amendment, it has been devolved to the provinces and is in a state of transition with the issue of finances not fully settled and only partial ownership by provinces.

- Re-structure the Health and Population Welfare Departments in the light of the 18th Constitutional Amendment.

Coordination between LHWs and LHVs was found to be poor.

- Streamline field level coordination between the two departments for effective and timely services.

- Fully integrate LHW program into provincial health systems.

- Improve coordination between various mid-level professionals for effective service delivery.
Improving Maternal Health in Pakistan: Meeting MDG-5 Targets

Potential of these youth can be harnessed and the people and women in terms of education, capacity development, growth and fulfillment. Pakistan’s deeply entrenched discriminatory social structures that reinforce health inequities, deny women a say in their reproductive health related needs of adolescents nor is it part of their mandate.

Findings

**Regulation of health care: inadequate existing legislation**

While a whole range of informal and formal health services are available to the people in the public and private sectors, there is no regulation of the quality of care that is being provided. As a result there is widespread quackery, corruption, medical negligence and malpractice, which go unchecked.

**Dual practice: growth of private sector at the cost of the public one**

Medical professionals in the public sector divert patients to their private practices for monetary profit.

**Widenspread unmet need for family planning among women**

Inadequate services for contraception mean that many women resort to abortion as a means of family planning (FP). No safe or post abortion care is available to them.

**Adolescent health care**

There are no services catering to young age/adolescent population — both male and female. There is lack of awareness and strongly expressed desire for information, counseling and services. LHWs are not equipped to handle the needs of adolescents nor is it part of their mandate.

**Legislative and administrative lacunae**

The minimum age requirement is not complied with at time of marriage, and all marriages are not registered. Births are not registered particularly of female children. These issues are directly linked to early marriages, increased fertility and poor health, social and financial outcomes.

**Lack of involvement of men in family planning services**

Men reported not having enough information about family planning and contraceptives, being unaware of women’s reproductive health needs, and not sure of where to get this information. There were very few functional male mobilizers who could complement the work of the LHWs.

**Under-utilization of latent potential of media, mobile phones and internet**

Nowhere was the huge potential of mobile phone, TV, radio and internet being used for developing innovative strategies for raising awareness, spreading information and providing services to remote areas and women confined to their homes. It remains under-utilized.

**Positive findings**

Responsiveness of officials (Health, Population Welfare, Local Government) to community demands when community links and engagement were facilitated during the research: BRUs were reactivated, LHWs and LHWs were appointed, regular supplies of medicine in BRUs was ensured; mobile health units were mobilised, etc. The research process built information, advocacy and communication capacity of local CBs and their staff to monitor services, and express their needs, and to engage with duty bearers.

Policy Implications

Women represent almost half of Pakistan’s population and are faced with critical barriers in the shape of high maternal mortality (276/100,000 live births), deeply entrenched discriminatory social structures that reinforce health inequities, deny women a say in decision making and deprive them of the benefits of development, growth and fulfillment. Pakistan’s reproductive health and gender development indicators hide the inequities within the averages. The demographic ‘youth bulge’ and an exploding population, with estimates that if the current fertility rates continue, the population would exceed 500 million by 2050, means that this would have catastrophic effects on the already scarce resources of the country and an increase in poverty levels.

Pakistan has already indicated that in the current circumstances, it is unlikely to achieve the MDG targets by 2015 (Pakistan MDG Report 2010). The window of opportunity that is currently open because of the youth bulge will close in a few years. If at this stage due attention is given to young people and women in terms of education, capacity building, health awareness and services, the potential of these youth can be harnessed and the crisis can be converted into an opportunity. While this demands a wide ranging agenda of action, one specific area which deals directly with youth and women is that which comes under the purview of MDG-5. The Provincial Health Departments, being key players, can play a crucial role in this context.

What can the Health Departments Do?

- Adopt an integrated approach to women’s reproductive health that factors in women’s rights, poverty, education and employment.
- Improve availability and access to family planning services, and provide safe abortion and post abortion care.
- Increase awareness raising for reproductive health through mainstream and social media, and other communication tools.
- Ensure that health policies and services address issues of youth including male and female adolescent population and staff is sensitive to their needs.
- Ensure the formulation of a gender sensitive youth policy that includes reproductive health related needs of adolescents.

Written and edited by Dr. Narmeen Hamid and the Shirkat Gah team.
Evidence Based Cross-Sectoral Policies for Improving Maternal Health in Pakistan

During the last few years numerous developments transforming the social, political, and economic landscape of Pakistan have taken place, all having an impact on the outcomes of Pakistan’s Millennium Development Goals. The Pakistan economy is in dire straits and an increasing number of people are falling below the poverty line. The burden of poverty is distributed disproportionately among families, with children and women affected most, the feminization of poverty being a well-recognized phenomenon.

Demographically Pakistan is undergoing a ‘youth bulge’ with 60% of the population below 30 years of age and girls suffering a disadvantage in terms of education, health and employment.

### Table 1: Current status of MDG-5 Indicators

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

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

The issues encountered by female adolescents in particular, range from the practice of early and forced marriages, low levels of contraceptive use, spread of sexually transmitted infections (STI including HIV), and gender based violence among possible others. Existing policies and programmes for adolescents and young people do not adequately address most of the above issues and do not seem to be based on the needs of female adolescents within and outside marriage. Lady Health Visitors, Lady Health Workers and Population Welfare Centres are providing much needed services to women, but considering the fact that men are the ultimate decision makers, the lack of focus on them in terms of awareness raising, male mobilizers or recognizing their common sources of information, like the local general store, is an issue that needs to be addressed.

### Monitoring the Implementation of MDG-5 in Pakistan: Action Research Project

Shirkat Gah– Women’s Resource Centre is a leading women’s rights organisation of Pakistan. It recently undertook an action research project to assess the status of implementation of MDG-5 interventions in Pakistan (2010-11). The findings confirmed evidence from other sources and reports, that Pakistan is lagging behind and unlikely to achieve the MDG target set for 2015. It was also clearly shown that investments and interventions made in the area are not having the desired impact and have so far been unable to make a significant impact on the lives of average Pakistani women.

This is a crucial time to address this failure because of the current demographic status of Pakistan where 60% of the population is below thirty years, and a very large number of women and girls are in child-bearing age (Framework for Economic Growth 2011, Planning Commission of Pakistan). The consequences of not adopting corrective measures at this stage will lead to a population explosion, increased maternal and neonatal morbidity and mortality, reinforcing of gender inequalities and a negative impact on economic growth.

Shirkat Gah’s research clearly shows that health is not only a medical problem, but also a socio-economic one deeply related to the status of women in society. In the social sectors, there are major gaps in service provision which are reflected in the various development indices as well as the Pakistan MDG Report 2010. In the absence of formal services, women resort to harmful practices, solutions and informal and inadequate social support networks. In many cases these practices and customs perpetuate inequalities or skewed power dynamics of caste, socio-economic class, feudal hierarchies and gender.

Thus only a cross-sectoral approach can address these problems in a meaningful way.

The following matrix provides a concise summary of the findings of the research and the recommendations that came out of those findings:

<table>
<thead>
<tr>
<th>Findings</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select area/vertical interventions</strong></td>
<td>• Integrated approach to women’s reproductive health that factors in women’s rights, poverty education and employment.</td>
</tr>
<tr>
<td>Isolated and/or vertical interventions in select areas/districts may have significant local impact but do not improve the overall situation. Shirkat Gah’s research, comparing districts where donor-supported interventions had been carried out with those where only routine public services were available showed that the plight of women in both categories was more or less the same. The only factors that made a difference were residence in an urban area where a wide choice of services was accessible, socio-economic status and education.</td>
<td>• Increase quality and access of services delivered through regular health system rather than relying on vertical or limited donor funded interventions.</td>
</tr>
<tr>
<td><strong>Equity issue</strong></td>
<td>• Ensure population and health initiatives are need and population based.</td>
</tr>
<tr>
<td>The interventions, whether state or donor sponsored, were seen to be based more on political expediency rather than need or population, resulting in lack of accessibility and under-utilization of available services.</td>
<td></td>
</tr>
</tbody>
</table>
## Findings

### Post-18th amendment status

The Lady Health Workers program is well appreciated by the community, it empowers women and it brings vital information and health services to the doorstep. However, before the 18th Constitutional Amendment, it functioned as a vertical program, thus running parallel to the regular health system. Post 18th amendment, it has been devolved to the provinces and is in a state of transition with the issue of finances not fully settled and only partial ownership by provinces.

### Widespread unmet need for family planning among women

Inadequate services for contraception mean that many women resort to abortion as a means of family planning (FP). No safe and post abortion care is available to them.

### Adolescent health care

There are no services catering to young age/adolescent population – both male and female. There is lack of awareness and strong expressed desire for information, counseling and services.

### Legislative and administrative lacunae

The minimum age requirement is not complied with at time of marriage, and all marriages are not registered. Early marriages lead to increased fertility, poor health of mother and child, as well as social and financial repercussions.

Births are not registered, particularly of female children, making it difficult to comply with minimum age of marriage requirement.

### Lack of involvement of men in family planning services

Men reported not being enough information about family planning and contraceptives, being unaware of women’s reproductive health needs, and not sure of where to get this information.

There were very few functional male mobilizers who could complement the work of the LHWS.

### Under-utilization of latent potential of media, mobile phones and internet

Nowhere was the huge potential of mobile phone, TV, radio and internet being used for developing innovative strategies for raising awareness, spreading information and providing services to remote areas and women confined to their homes. It remains under-utilized.

### Positive findings

There is a correlation between secondary education and positive reproductive health outcomes. Girls entering secondary school tended to complete their schooling resulting in relatively late marriages, spacing of children and taking up employment.

Widespread desire to educate daughters and limit family size.

Responsiveness of officials (Health, Population Welfare, Local Government) to community demands when community links and engagement were facilitated during the research: BHUs were reactivated, LHWS and LHVs were appointed, regular supplies of medicine in BHUs was ensured; mobile health units were mobilised, etc.

The research process built information, advocacy and communication capacity of local CBOs and their staff to monitor services, and express their needs, and to engage with duty bearers.

## Recommendations

- Re-structure the Health and Population Welfare Departments in the light of the 18th Constitutional Amendment.
- Streamline and improve field level coordination between the two for effective and timely services.
- Revitalize LHWS programme.
- Improve availability and access to FP services.
- Establish quality FP services in all public sector health outlets (commodity availability, choice of methods, counselling, follow up, etc.).
- Provide safe and post abortion care.
- Ensure that provincial Population Welfare policies and services address issues of male and female adolescents.
- Expand the ambit of Population Welfare Centres to include Adolescent Reproductive Health.
- Considering the demography of Pakistan and the huge proportion of people under the age of twenty, there should be added emphasis on raising awareness about family planning services to this group.
- Promote making amendments in the Child Marriage Restraint Act 1929 to increase the minimum age of marriage to 18 years.
- Population Welfare Departments should advocate for making birth registrations mandatory for determining age at time of marriage; and ensure compliance of minimum age by marriage registrars.
- Revitalize the role of male mobilizers.
- Increase awareness raising through media, SMS campaigns, (involving local general stores to include men) and expanding social marketing techniques.
- Utilize potential of the internet to provide awareness and telemedicine on the pattern of the highly successful ‘Info-babys’ of Bangladesh where local women are provided a laptop and a mobile phone (as well as a bicycle) and they go from house to house providing digital information on areas as diverse as farming and animal husbandry to health and nutrition.
- Contribute Life Skills Based Education content to the Education Department for inclusion in school text books
- Share best practices from the field and encourage responsiveness among Population Welfare Department officials.
- Establish quality FP services in all public sector health outlets.
- Provide safe and post abortion care.
- Streamline and improve field level coordination between the two for effective and timely services.

## Policy Implications

The demographic ‘youth bulge’ and an exploding population, with estimates that if the current fertility rates continue, the population would exceed 500 million by 2050, means that this would have catastrophic effects on the already scarce resources of the country and an increase in poverty levels. Pakistan has already indicated that in the current circumstances, it is unlikely to achieve the MDC targets by 2015 (Pakistan MDC Report 2010). The window of opportunity that is currently open because of the youth bulge will close in a few years. If at this stage due attention is given to young people and women in terms of education, capacity building, health awareness and services, the potential of these youth can be harnessed and the crisis can be converted into an opportunity. While this demands a wide ranging agenda of action, one specific area which deals directly with youth and women is that which comes under the purview of MDG-5. The Provincial Population Welfare Departments are key players and can play a crucial role in this context.

## What can the Population Welfare Departments Do?

- Ensure that Population Welfare policies and services address issues of male and female adolescents.
- Ask for a re-structuring of the Health and Population Welfare Departments in the light of 18th Constitutional Amendment to streamline and improve coordination between the two for effective and timely services.
- Improve availability and access to family planning services to check unsafe abortion.
- Revitalize the role of male mobilizers.
- Increase awareness raising and health education through media, SMS campaigns.
- Utilize potential of the internet to provide awareness on reproductive health needs, services and rights.
Evidence Based Cross-Sectoral Policies for Improving Maternal Health in Pakistan

During the last few years numerous developments transforming the social, political, and economic landscape of Pakistan have taken place, all having an impact on the outcomes of Pakistan’s Millennium Development Goals. The Pakistan economy is in dire straits and an increasing number of people are falling below the poverty line. The burden of poverty is distributed disproportionately among families, with children and women affected most and, the feminization of poverty being a well-recognized phenomenon. Demographically Pakistan is undergoing a ‘youth bulge’ with 60% of the population below 30 years of age and girls suffering a disadvantage in terms of education, health and employment.

Table 1: Current status of MDG-5 Indicators

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

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

Pakistan ranks 115 out of 145 countries in the Gender Inequality Index 2011.

The positive relationship between female secondary education, employment, empowerment and health outcomes is an established one, yet the low level of educational achievement in women, has not been given the attention it deserves. Other issues encountered by female adolescents in particular, range from the practice of early and forced marriages, low levels of contraceptive use, spread of sexually transmitted infections (STI including HIV), and gender based violence among possible others. Existing policies and programmes for adolescents and young people do not adequately address most of the above issues and do not seem to be based on the needs of female adolescents within and outside marriage.

This policy brief brings attention to the problem and provides research based evidence for considering policy options and recommendations.

Monitoring the Implementation of MDG-5 in Pakistan: Action Research Project

Shirkat Gah – Women’s Resource Centre is a leading women’s rights organisation of Pakistan. It recently undertook an action research project to assess the status of implementation of MDG-5 interventions in Pakistan (2010-2011). The findings confirmed evidence from other sources and reports, that Pakistan is lagging behind and unlikely to achieve the MDG target set for 2015. It was also clearly shown that investments and interventions made in the area are not having the desired impact and have so far been unable to make a significant impact on the lives of average Pakistani women.

This is a crucial time to address this failure because of the current demographic status of Pakistan where over 60% of the population is below thirty years, and a very large number of women and girls are in child-bearing age (Framework for Economic Growth 2011, Planning Commission of Pakistan). The consequences of not adopting corrective measures at this stage will lead to a population explosion, increased maternal and neonatal morbidity and mortality, reinforcing of gender inequalities and a negative impact on economic growth.

Shirkat Gah’s research clearly shows that health is not only a medical problem, but also a socio-economic one deeply related to the status of women in society. In the social sectors, there are major gaps in service provision which are reflected in the various development indices as well as the Pakistan MDG Report 2010. In the absence of formal services, women resort to harmful practices, solutions and informal and inadequate social support networks. In many cases these practices and customs perpetuate inequalities or skewed power dynamics of caste, socio-economic class, feudal hierarchies and gender. Thus only a cross-sectoral approach can address these problems in a meaningful way.

The following matrix provides a concise summary of the findings of the research and the recommendations that came out of those findings:

<table>
<thead>
<tr>
<th>Findings</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select one/vertical interventions</td>
<td>• Integrated approach to women’s reproductive health that factors in women’s rights, poverty education and employment.</td>
</tr>
</tbody>
</table>

Isolated and/or vertical interventions in select areas/districts may have significant local impact but do not improve the overall situation. Shirkat Gah’s research, comparing districts where donor-supported interventions had been carried out with those where only routine public services were available showed that the plight of women in both categories was more or less the same. The only factors that made a difference were residence in an urban area where a wide choice of services was accessible, socio-economic states and education.
Improving Maternal Health in Pakistan: Meeting MDG-5 Targets

Role in this context. Departments are key players and can play a crucial role in this context.

MDG-5. The Provincial Women Development Departments are key players and can play a crucial role in this context.

Policy Implications

The demographic ‘youth bulge’ and an exploding population, with estimates that if the current birth rates continue, the population would exceed 500 million by 2050, means that this would have catastrophic effects on the already scarce resources of the country and an increase in poverty levels. Pakistan has already indicated that in the current circumstances, it is unlikely to achieve the MDG targets by 2015 (Pakistan MDG Report 2010). The window of opportunity that is currently open because of the youth bulge will close in a few years. If at this stage due attention is given to young people and women in terms of education, capacity building, health awareness and services, the potential of these youth can be harnessed and the crisis can be converted into an opportunity. While this demands a wide ranging agenda of action, one specific area which deals directly with youth and women is that which comes under the purview of MDG-5. The Provincial Women Development Departments are key players and can play a crucial role in this context.

What can the Women Development Departments Do?

- Focus on women’s empowerment through employment opportunities and skill development education and ensure removal of barriers to access and retention in educational institutions
- Ask for amendments in the Child Marriage Restraint Act 1929 to increase the minimum age of marriage to 18 years
- Promote domestic violence legislation and its implementation to ensure reproductive health and rights of women
- Promote making birth registrations mandatory for determining age at time of marriage; and ensure compliance of minimum age by marriage registrars
- Increase awareness raising and rights education through media, SMS campaigns
- Utilize potential of the internet and social media to provide awareness on women’s rights

Adolescent needs

Considering the demography of Pakistan and the huge proportion of people under the age of twenty. Adolescent needs are not adequately catered for there are no services catering to young age/adolescent population – both male and female. There is lack of awareness about rights and opportunities and strong expressed desire for information, counselling and services.

Legislative and administrative issues

The minimum age requirement is not complied with at time of marriage, and marriages and all marriages are not registered. Lack of decision making authority; violence, bride price were all indicative of the patriarchal context within which health interventions are made. Births are not registered, particularly of female children. These issues are directly linked to early marriages, increased fertility and poor health, social and financial outcomes.

Under-utilization of latent potential of media, mobile phones and internet

Nowhere was the huge potential of mobile phone, TV, radio and internet being used for developing innovative strategies for raising awareness, spreading information and providing services to remote areas and women confined to their homes. It remains under-utilized.

Absence of an effective and representative local government system

The absence of an elected local government system was voiced everywhere as that provides a sense of ownership and a system of drawing attention to their needs. Without local government one sided patron-client relationships are nurtured, and corruption, nepotism and inefficiency seem to have freer reign.

Positive findings

There is a correlation between secondary education and positive reproductive health outcomes. Girls entering secondary school tended to complete their schooling resulting in relatively late marriages, spacing of children and taking up employment. Widespread desire to educate daughters and limit family size. Responsiveness of officials (Health, Population Welfare, Local Government) to community demands when community links and engagement were facilitated during the research: BHUs were reactivated, LHWs and LHVs were appointed, regular supplies of medicine in BHUs was ensured, mobile health units were mobilized, etc. The research process built information, advocacy and communication capacity of local CBOs and their staff to monitor services, and express their needs, and to engage with duty bearers.

Policy Implications

Written and edited by Dr. Narmeen Hamid and the Shirkat Gah team.
Evidence Based Cross-Sectoral Policies for Improving Maternal Health in Pakistan

During the last few years numerous developments transforming the social, political, and economic landscape of Pakistan have taken place, all having an impact on the outcomes of Pakistan’s Millennium Development Goals. The Pakistan economy is in dire straits and an increasing number of people are falling below the poverty line. The burden of poverty is distributed disproportionately among families, with children and women affected most, the feminization of poverty being a well-recognized phenomenon. Demographically Pakistan is undergoing a ‘youth bulge’ with 60% of the population below 30 years of age and girls suffering a disadvantage in terms of education, health, and employment.

**Table 1: Current status of MDG-5 Indicators**

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

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

This policy brief brings attention to the cause of the problem, its implications for policy, a critique of existing options, and policy recommendations.

**Monitoring the Implementation of MDG-5 in Pakistan: Action Research Project**

Shirkat Gah – Women’s Resource Centre is a leading women’s rights organisation of Pakistan. It recently undertook an action research project to assess the status of implementation of MDG-5 interventions in Pakistan. The findings confirmed evidence from other sources and reports, that Pakistan is lagging behind and unlikely to achieve the MDG target set for 2015. It was also clearly shown that investments and interventions made in the area are not having the desired impact and have so far been unable to make a significant impact on the lives of average Pakistani women.

This is a crucial time to address this failure because of the current demographic status of Pakistan where over 60% of the population is below thirty years, and a very large number of women and girls are in child-bearing age (Framework for Economic Growth 2011, Planning Commission of Pakistan). The consequences of not adopting corrective measures at this stage will lead to a population explosion, increased maternal and neonatal morbidity and mortality, reinforcing of gender inequalities and a negative impact on economic growth.

The following matrix provides a concise summary of the findings of the research and the recommendations that came out of those findings:

<table>
<thead>
<tr>
<th>Findings</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select area/vertical interventions</strong></td>
<td>• Integrated approach to women’s reproductive health that factors in women’s rights, poverty education and employment.</td>
</tr>
<tr>
<td>- Isolated and/or vertical interventions in select areas/districts may have significant local impact but do not improve the overall situation. Shirkat Gah’s research, comparing districts where donor-supported interventions had been carried out with those where only routine public services were available showed that the plight of women in both categories was more or less the same. The only factors that made a difference were residence in an urban area where a wide choice of services was accessible, socio-economic status and education.</td>
<td>• Focus on women’s education and ensure the right to education by enforcing Article 25-A under which “The State shall provide free and compulsory education to all children of the age of five to sixteen years in such manner as may be determined by law.”</td>
</tr>
<tr>
<td><strong>Adolescent health care</strong></td>
<td>• Make Life Skills Based Education a part of the educational curriculum.</td>
</tr>
<tr>
<td>- There is lack of awareness and strong expressed desire for information, counseling and services.</td>
<td>• Institute school health system with reproductive health provisions and nutritional information.</td>
</tr>
<tr>
<td><strong>Under-utilization of latent potential of media, mobile phones and Internet</strong></td>
<td>• Increase awareness raising through media, SMS campaigns, involving local general stores to include men and expanding social marketing techniques.</td>
</tr>
<tr>
<td>- Nowhere was the huge potential of mobile phone, TV, radio and internet being used for developing innovative strategies for raising awareness, spreading information and providing services to remote areas and women confined to their homes. It remains under-utilized.</td>
<td>• Utilize potential of the internet to provide awareness and Life Skills Based Education.</td>
</tr>
<tr>
<td><strong>Positive findings</strong></td>
<td>• Increase the number of functioning secondary schools; ensure accessibility of girls to schools.</td>
</tr>
<tr>
<td>- There is a positive correlation between secondary education and reproductive health outcomes. A higher level of education resulted in relatively late marriages, spacing of children and taking up employment.</td>
<td></td>
</tr>
</tbody>
</table>
**Policy Implications**

The demographic ‘youth bulge’ and an exploding population, with estimates that if the current fertility rates continue, the population would exceed 500 million by 2050, means that this would have catastrophic effects on the already scarce resources of the country and an increase in poverty levels. Pakistan has already indicated that in the current circumstances, it is unlikely to achieve the MDG targets by 2015 (Pakistan MDG Report 2010). The window of opportunity that is currently open because of the youth bulge will close in a few years. If at this stage due attention is given to young people and women in terms of education, capacity building, health awareness and services, the potential of these youth can be harnessed and the crisis can be converted into an opportunity. While this demands a wide ranging agenda of action, one specific area which deals directly with youth and women is that which comes under the purview of MDG-5. The Provincial Education Departments, being key players, can play a crucial role in this context.

**What can the Education Departments Do?**

- Increase budgetary resources for women’s education and remove barriers to access and retention, so girls can stay in schools and delay age of marriage and child-bearing as well as empower themselves
- Make Adolescent Health Care a part of the educational curriculum
- Increase awareness raising and health education through internet, media and SMS campaigns
- Utilize potential of the internet to provide awareness and Life Skills Based Education.