THE WOMAN NOT THE WOMB

Population Control
vs.
Women's Reproductive Rights

For Shirkat Gah

Cassandra Balchin, Khawar Mumtaz, Farida Shaheed
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Women living under muslim laws
نساء في ظل التشريعات الإسلامية
Femmes sous lois musulmanes

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Women Living Under Muslim Laws
is a network of women whose lives are shaped, conditioned or governed by laws, both written and unwritten, drawn from interpretations of the Koran tied up with local traditions.

Generally speaking, men and the State use these against women, and they have done so under various political regimes.

Women Living Under Muslim Laws
addresses itself
to women living where Islam is the religion of the State, as well as to women who belong to Muslim communities ruled by minority religious laws,
to women in secular states where Islam is rapidly expanding and where fundamentalists demand a minority religious law, as well as to women from immigrant Muslim communities in Europe and the Americas,
and to non Muslim women, either nationals or foreigners, living in Muslim countries and communities, where Muslim laws are applied to them and to their children.

Women Living Under Muslim Laws
was formed in response to situations which required urgent action, during the years 1984-85

The case of three feminists arrested and jailed without trial, kept Incommunicado for seven months, in Algeria, for having discussed with other women the project of law known as "Family Code", which was highly unfavorable to women.

The case of an Indian Sunni woman who filled a petition in the Supreme Court arguing that the Muslim minority law applied to her in her divorce denied her the rights otherwise guaranteed by the Constitution of India to all citizens, and called for support.

The case of a woman in Abu Dhabi, charged with adultery and sentenced to be stoned to death after delivering and feeding her child for two months.

The case of the "Mothers of Algiers" who fought for custody of their children after divorce.

amongst others...

The campaigns that have been launched on these occasions received full support both from women within Muslim countries and communities, and from progressive and feminists groups abroad.

Taking the opportunity of meeting at the international feminist gathering "Tribunal on Reproductive Rights" held in Amsterdam, Holland, in July 1984, nine women from Muslim countries and communities : Algeria, Morocco, Sudan, Iran, Mauritius, Tanzania, Bangla Desh and Pakistan, came together and formed the Action Committee of Women Living Under Muslim Laws, in support of women's struggles in the concerned contexts.

This Committee later evolved into the present network.

The objectives of Women Living Under Muslim Laws are
• to create links amongst women and women's groups (including those prevented from organising or facing repression if they attempt to do so) within Muslim countries and communities,
• to increase women's knowledge about both their common and diverse situations in various contexts,
• to strengthen their struggles and to create the means to support them internationally from within the Muslim world and outside.

In each of these countries till now women have been waging their struggle in isolation.

Women Living Under Muslim Laws aims at
• providing information for women and women's groups from Muslim countries and communities
• disseminating this information to other women from Muslim countries and communities
• supporting their struggles from within the Muslim countries and communities, and make them known outside,
• providing a channel of communication amongst women from Muslim countries and communities.

These objectives are fulfilled through
• building a network of information and solidarity
• disseminating information through "Dossiers"
• facilitating interaction and contact between women from Muslim countries and communities, and between them and progressive and feminists groups at large.
• facilitating exchanges of women from one geographical area to another in the Muslim world.
INTRODUCTION

Pakistan’s population, estimated at 120.8 million\(^1\) and growing at one of the fastest rates in the world (about 3 percent), has long been identified by development planners and policy makers as a major concern. Yet, after decades of planning, by 1978 there was a general feeling that the population planning programme in Pakistan had reached a critical turning point. Despite almost 20 years of vigorous effort and the expenditure of about one billion rupees and some 70 million US dollars, family planning had achieved no tangible decrease in fertility rates.\(^2\) Sixteen years and millions more rupees and dollars later, the situation is much the same.

Implications in terms of density (1591 persons per 1000 hectares compared to an average of 541 for developing countries) and urban population growth rate (4.6 percent) have induced a ‘population’ debate of sorts in the country. Unfortunately the debate is confined largely to official circles, and centred on the dismal failure of population planning programmes. While women’s reproductive capacities have been the object of discussion and the target of policies, their voices, concerns, desires and priorities have never been taken into account.

Various actors on the development scene: policy makers, international donors and some non-governmental organisations, have been exasperatedly grappling with the ‘population problem’. Seeing it as a failure of people to comprehend the benefits of small families, of women to respond to the family planning messages, of official agencies’ inability to provide adequate information, the preoccupation has been with devising campaigns and strategies for controlling family size. Today, doomsday scenarios of how many millions of Pakistanis will crowd the land by the year 2010, and of how far these millions will eat into health and education sector growth are the focus of both government analysis and media coverage of population issues. The result is a panic-stricken call for control. Recent TV and newspaper advertisements promoted contraception with slogans such as "Stop the flood: use family planning".

The ongoing level of debate and the failure of the population discourse to widen beyond the macro-development perspective lies behind Shirkat Gah’s decision to formulate a paper examining population policy in Pakistan. The two-fold objective of the exercise is to challenge the hitherto largely unquestioned premise that population planning = family planning = fertility control; and to effect a paradigm shift for focusing on people not on numbers, on the woman not on the womb.

The paper goes back into history to trace the genesis of official thinking. It highlights conceptual problems and shortcomings in the policies adopted, reviews women’s status in
Pakistan, their reproductive health and rights, and concludes with the identification of contemporary challenges and recommendations for addressing them.

The paper's main concern is not statistical information. This is not to say that data have not been referred to in this paper, and whenever national level data is used, the source is one of the following: Government of Pakistan; World Bank; or UNICEF. However, as far as possible the paper avoids statistics primarily because the major factors which affect women's daily lives, their immediate socio-economic conditions and ultimately their reproductive choices are phenomena which when reduced to quantification fail to fully reflect their realities. (How can one quantify, for example, the impact a threat of polygyny has on the number of children a woman chooses to have - a factor that may be significant in the lives of many women in monogamous marriages). Secondly, official data on population and demographic trends is frequently self-contradictory and now increasingly outdated in the absence of a national Census since 1981; independent data is invariably on only a very small scale. Thirdly, data on demography is extremely vulnerable to manipulation since the topic is fraught with implications for domestic policies as well as for Pakistan's international relations (where progress in population control has become an undeclared aid condition). Fourthly, sweeping generalisations based on statistical data obscure the individual realities of a woman's life and assist policies of control:

'The use of seemingly objective scientific evidence to justify, in the guise of improving health, measures designed to regulate the behaviour of individual women whose lives -- whether by choice or by necessity -- defy conventional norms of wifehood and motherhood, has a long tradition in law and policy.' (3)

POLICIES AND PERSPECTIVES

The Colonial Experience

Like policy in most other sectors in Pakistan, post-Independence population planning too is a continuation of policies developed in colonial times. Initially, the colonial regime's primary preoccupation with population was from the labour resource perspective. In the 1890s a policy of colonizing newly irrigated areas was adopted "with the objectives of relieving congestion in the settled agricultural districts north of Lahore and of developing new sources of revenue, surplus foodstuff and exportable crops" (4). While population fluctuations, including birth and migration rates, were recorded in the official Gazeteers, this
information was not acted upon; there was in effect no attempt to manipulate fertility or longevity patterns.

When population (in the narrower sense of fertility policies) eventually became a focus for the colonialists, the issue was not one of health but of ‘development’: ‘Demographic trends in the areas that now comprise Pakistan initially attracted attention in the late 1920s and early 1930s...Colonial authorities feared sustained population growth would undermine the agricultural prosperity that had been achieved in canal colony schemes.’(5) One colonial official, F.L. Brayne who served in the 1930s as a deputy commissioner in several districts of Punjab, conceived of a ‘general attack’ upon the multiplying hordes which bears remarkable resemblance to present population policies:

‘An initial campaign at publicity and mass instruction regarding the problems, means, and goals of rural development was envisioned, to be followed by regular and frequent visits by trained agents -- specializing in agricultural extension, credit, cooperatives, panchayat affairs, health, women’s welfare, and so forth -- who would guide and motivate counterpart individuals and village organizations.’ (6)

Though this grandiose plan was never implemented due to political, financial and manpower constraints facing the colonial regime in its final years, the basis for conceiving population control as a question of development (as defined by the government) and of a unidirectional attempt by the authorities to change the attitudes of the masses, had been laid.

**Post-Independence Population Policy in Pakistan**

Pakistan has one of the longest standing population programmes in Asia. Family planning activities began as early as the 1950s through the auspices of a non-governmental organisation, the Family Planning Association of Pakistan established a mere 6 years after Independence in 1953. Official concern in Pakistan regarding the country's population growth significantly predated the World Bank's identification of population as a major international issue. Addressing the World Bank Board of Governors in 1969, some four years after Pakistan's population policy had already been initiated on the same conceptual grounds, World Bank President and US Defence Secretary Robert McNamara declared, ‘The single greatest obstacle to the economic and social advancement of the majority of peoples in the underdeveloped world is rampant population growth’(7). Since Pakistan's population policy is today entirely donor-dependent (overwhelmingly on the World Bank, UNFPA and USAID) and to a great extent donor-driven, this perception underlying the population policies of multilateral agencies dominates the national policies. The Family Planning Association of Pakistan, the major non-governmental organisation (NGO) concerned with population issues shares this perspective. It speaks of the ‘economic benefit of each birth averted’.(8)

In the First Five-Year Plan (1955-60) population focus was purely on the resettlement of 10 million refugees from India. The Second Five-Year Plan (1960-65) took over from where the colonialists had left off, and emphasised the dangers of increased population growth as a threat to the benefits of economic development(9). However, it was not until the Third Five
Year Plan (1966-70) that the country's first population policy was outlined under a separate chapter on family planning. In 1965 the Pakistan Family Planning Council was established along with a Population Division within the Ministry of Health.

For the first decade the entire emphasis of the country's population policy was on the supply of contraceptives, information and motivation under splendid titles such as the 'Continuous Motivation Scheme' and the 'Contraceptive Inundation Scheme'. The saturation of the market that was the end goal of these schemes failed precisely because the factors affecting the decisions couples and women make were never given importance. For example, population policies were almost exclusively addressed to women, ignoring the fact that specifically in the family and generally in society structural inequalities ensure women have little or no decision-making power. Moreover, the identification of dais (traditional birth attendants) as motivators did not take into account the operation of social hierarchies and the realities of whom couples consult in their fertility decisions.

In the late 1970s during General Zia-ul-Haq's martial law rule, Pakistan's family planning programme experienced an unproclaimed moratorium. The programme was officially reborn in 1980 and was for the first time based upon a multisectoral approach, emphasising the incorporation of Maternal & Child Health Care into the programme and the enhancement of education and employment opportunities for women(10). Such interlinkages, however, have remained largely on paper and are rarely incorporated into actual interventions(11).

Nearly half a century after Independence there has been no widening of population discourse beyond a macro-development perspective, initially cultivated by colonial rulers and subsequently pursued by Pakistan's population planners and the funders of its programme. The population programme's goals have remained unchanged: fertility control is the objective and any circumstantial improvement in women's daily lives is simply a means to this end. Brayne's 'general attack' has in many ways been realised: 'the population programme in Pakistan has expanded considerably from a modest beginning as a non-government organisation to a substantial government enterprise covering the entire nation'(12), yet the impact on fertility and improved quality of life has been negligible.

**The Impact of Development**

The 1974 World Population Conference in Bucharest coined the slogan 'Development is the best contraceptive'. This view has been supported by historical analysis revealing that fertility declines in the developed countries only followed as a consequence of a reduction in poverty, where conditions guaranteed women and their families greater economic security and improvements in life expectancy, particularly the lowering of child mortality rates.
Official analysts in Pakistan claim this has been refuted: while the country is said to have witnessed development since Independence, fertility has remained unchanged\(^{(13)}\). The question that is not asked is who is benefitting from this supposed development:

' Economic growth in Pakistan has failed to transmit benefits to the poorest sections of society and has created sharp income inequalities. Upto 40% of households receive only 18% of total expenditure (1984-85) and consume on average less than 1/3 of what the better off consume. Poverty in the countryside is particularly widespread with the average income of agricultural workers having fallen to one-third of the urban average where most of the development has taken place. At the same time the pattern of growth has proven to be unsustainable, damaging and depleting natural resources on the one hand and not succeeding in improving people's quality of life on the other.'\(^{(14)}\)

The correlation between poverty and population is illustrated by a study undertaken in Pakpattan District, Punjab. The study found that the landless (poorest) have more children than those with large landholdings; that households with children contributing to labour had more children than those without; and, that while the total fertility rate of the village was 6.1, the average number of living children was 3 \(^{(15)}\).

The definition of development also needs to be made gender-sensitive; 'development' is invariably defined in androcentric terms while real improvements in the quality of life have passed women by. Rather than the assumed 'trickle down' benefit of household development for women, development in practice has intensified gender inequalities. Kerala State in India, where poverty is widespread but where a concerted effort to ensure greater social equality was undertaken ensuring a significantly higher status for women than in other parts of South Asia, is a good example of the direction of the causal linkage between population growth and women-sensitive development: it has a notably lower population growth rate.

In the era of Structural Adjustment there must also be a clear recognition of the negative impact of adjustment policies on women's health in general and reproductive rights in particular:

'By definition, structural adjustment entails a major overhaul of the systems by which a country organises the allocation of its human, financial and natural resources. Thus, theoretically at least, structural adjustment programmes could present opportunities at the national level for addressing gender and class inequalities as decision-makers are challenged to re-evaluate the rules that govern the distribution of society's resources. However, structural adjustment programmes that focus solely on macro-level social and economic indicators while diregariding the equally powerful rules operating at the micro level where households - and particularly women - must devise strategies to cope with the enormous upheaval caused by these programmes, are prescriptions for disaster; such programmes threaten the already precarious health of vast numbers of the world's population because they impose additional burdens on women while ignoring the structural constraints that prevent women from effectively redistributing or managing those burdens'. \(^{(16)}\)

Pressure to align the national and provincial budgets has invariably led to cutbacks in real outlays on health and other social services as well as general infrastructure, increasing the burden on women as they struggle to maintain their own health and that of their families. Pressure to devalue the national currency, lower trade barriers and remove
subsidies has led to rising prices and plummeting real incomes, pushing even basic commodities and foodstuffs out of the reach of ordinary people, again increasing the burden on women as they struggle to keep their families going, often sacrificing their own nutritional needs and health concerns in the process.

Conceptual Problems

A key problem in the formulation and pursuit of policy has been the failure to develop an indigenous perspective that takes into account both local community concerns on population and the wide range of factors influencing the choice made by individual couples regarding the number of children they have.

The social and political context in which women decide about the number of children is omitted and needs or desires of women are decontextualised... For example, a poor and black Brazilian woman may not want to bring her child into a desperate economic situation and a political environment where the child may be killed on the street by vigilantes. If the situation were different, she may love to have children. The question of whether she wants children or not is contentless if abstracted out of the real life situation. (17)

It must be emphasised that population planning per se is not to be rejected; there is clear evidence that communities have always planned themselves. What is being questioned, however, is the failure to research and understand why communities, families and individual women have adopted particular population and family planning strategies in particular circumstances.

Decontextualizing population issues, policy makers have never felt it necessary to discuss policies with the community and women in particular. Demographic surveys have
singly failed to ask women their points of view and there has been no attempt to establish which possible factors determine women's reproductive choices: problems of access and quality of services, inadequate information, son preference, need for economic security, absence of old age security, children as a source of status within the family - to name a few possibilities. Instead, surveys have been content to only ask about women's fertility and to accept explanations of high fertility such as 'do not want to use these (contraceptive) methods', 'family objects to family planning', 'religious beliefs', or 'wants children'.

With respect to regulating birth rates, within both the government and NGO population policy hierarchies (which include women at the policy-making level), there appears to be an inherent resistance to shifting the focus of 'population planning' from fertility control to reproductive health, to say nothing of women's reproductive rights. From our perspective a definition of reproductive rights must include women's economic, political, legal, educational, and general health rights. It is only when these rights are recognised as forming an integral part of women's reproductive rights and as having a focal role in their reproductive choices that population and demographic patterns can be properly understood - and then policies formed which may have some hope of success.

The intersecting influences that affect reproductive health are recognized in Agenda 21, the recommendations arising out of the UN Conference on Environment and Development (UNCED) process: 'Reproductive health programmes and services should, as appropriate, be developed and enhanced to reduce maternal and infant mortality from all causes and enable women and men to fulfill their personal aspirations in terms of family size, in a way in keeping with their freedom and dignity and personally held values.' Survival strategies devised by communities, families and specifically women to get through their daily lives may be in complete contradiction to the strategies perceived as 'correct' by actors at a different level due to:

'...a conflict between national and local goals. In fact people's strategies to make a living are such that demographic or environmental concerns are at best marginal and at worst in direct opposition with what is needed for success and survival.

'The immediate cause of this growing opposition is the uncoupling of local communities from their village environment... since the decision to have children will be considered with respect to access to external rather than local resources, large families should be seen as development strategies.'

Critiques of the country's population policy have invariably side-stepped or overlooked the status of women as a factor, and have preferred to focus on administrative and management weaknesses: organisational problems; faulty communication strategy; inadequate evaluation procedures; unrealistic targets; lack of commitment. These weaknesses are no doubt important constraints with consequences such as: a general unwillingness to guarantee attractive working conditions for female staff especially in the rural areas; lack of accessible outlets in rural areas and urban slums; a bureaucratic tussle between the Health and Population Welfare Ministries jealously guarding their domains.
This supply-side analysis is unable, however, to explain why in urban low-income and slum areas, where access to contraceptive services is far better, fertility levels have generally been found to be higher than in rural areas. Evidently, such an analysis suffers from the failure to go beyond quantitative evaluation to assess the impact of poor quality contraceptive and reproductive health services, to say nothing of the multiple realities of women's lives. These realities have led to some reassessment such as that by demographer Zeba Sathar, according to whom: "The low contraceptive use rates found in Pakistan reflect not just a failure of the programme to provide contraception in an acceptable and accessible form (which may perhaps be an easier issue to tackle) but also the general desirability of high fertility in this society."[21]

In addition even those who acknowledge the total failure and misdirection of policies to date, still focus on elements other than women's lives (such as child survival) as determining factors in fertility behaviour. While other factors undoubtedly intervene and should not be ignored, the approach is again woman as womb and conduit for policy. In such an approach, literacy, for example, is regarded as an element 'in terms of the resistance based on ignorance of the programme's efforts' and not as a factor increasing women's range of life options, their self-confidence, and their ability to make autonomous choices.

Essentially population policies that aim at reducing ('controlling') birth rates appear to be based on at least two false premises: first that it is possible to divorce the biological function of reproducing from the social context in which it takes place, and second that because it is women who become pregnant they are the primary actors responsible for producing children. Based on such premises policies ignore male attitudes and desires for numerous children, and instead seek to control women's fertility preferably through methods which are beyond her control such as sterilisations, injectables and insertions of IUDs. It is the womb that is the object of policies, the woman is only incidentally its location. The physical health of a woman is only tangentially a subject of concern (deterioration in consequence of early, frequent and unspaced pregnancies). It is indeed ironical that women who are enmeshed in a web of forces operating at all levels and in all spheres should then be expected to cut through all these strands and assert their autonomy in the reproductive sphere. It is our contention that independent decision-making in one sphere is conditional upon loosening all these strands and women's active participation in rearranging the fabric of society.
CONTEXTUALIZING WOMEN'S HEALTH AND REPRODUCTIVE RIGHTS

The constraints under which Pakistani women make their choices flow from an entrenched patriarchal structure (the values of which are internalized by women as well as men) that predetermines options. The hierarchies of this system are such that women's access to resources and decision-making powers in the family tend to increase with age and the number of male progeny. As women cross the threshold of their reproductive cycle, there is an easing of social restrictions, and a possibility of increased mobility and interaction outside the family. At this stage older women become more self-assertive and take more decisions but during most of their reproductive lives, women are subject to decisions taken by others: fathers, mothers, brothers, husbands and in-laws.

For their part, state policies have failed to provide women with the support systems or incentives required to break out of the cycle of control. Women continue to be viewed by society and the state as economically unproductive and dependent members whose primary function is to physically reproduce the community. The lesser importance given women is clearly reflected in all major "development" indicators.

Women form 48 percent of the country's estimated 120.84 million people (82.77 million rural and 30.07 million urban). This is one of the lowest sex ratios in the world, and illustrates women's low status. Recent statistics claim a change: starting in the mid-1980s women's life expectancy is said to be equal to that of men (59 years according to Economic Survey 1992-93) suggesting that Pakistan may be moving towards global patterns where women have a longer life expectancy and outnumber men. The implication is that gender specific problems in health care are being ironed out and that there has been a dramatic improvement in women's overall status. Not all are convinced of the validity of these statistics, especially in the absence of a national census. Even accepting these statistics, numerical change will be slow. The Economic Survey of 1991-2 reports an estimated population of 48 percent females and 52 percent males, a change of a mere 0.5 percent from 47.5 percent:52.5 percent in the 1981 census.

Education

Total literacy in Pakistan stands at 35 percent; female literacy at 22.3 percent\(^{22}\). Girls studying at the university level constitute only 0.8 percent of the total female population\(^{23}\), while the rural female literacy rate in 1990 stood at an abysmal 11.3 percent (having improved from 7.3 percent in 1981).

Emerging positive trends have failed to overcome gender inequalities. Thus, while there is a demand for primary schools for girls, articulated particularly strongly in rural areas\(^{24}\), the gender gap between male and female enrollment has in fact widened to 31.1 percent from 26.7 percent in 1951 (currently female primary school enrollment = 53.7 percent; male = 84.8 percent).

The existing education system reinforces stereotyped gender roles and supports structural inequalities\(^{25}\). From the perspective of reproductive issues the most important
aspect is the glaring omission of scientific information and instruction about the human body. The lack of sex education for girls and boys has ensured that even the 'educated' middle and upper classes are ignorant about biological processes which dominate their lives and health.

While there is little detailed research on the actual linkages between improved female education and reproductive health, a woman's educational level has been identified as the single most important factor affecting the Total Fertility Rate. Women with no education experience on average 5.7 births. In contrast the figure for women with at least a secondary education, plummets to 3.6, per woman(26). Significantly there is little variation in fertility levels by husband's education.

It remains uncertain, however, whether fertility is affected more by education or by the age at marriage. There is a significant correlation between educational level and median age at marriage: on average women with no education marry four years earlier than women with secondary or higher education(27). The later age at marriage may account for their lower TFR implying that fertility preferences have changed little. Research into the exact relationship between female education and fertility needs to be expanded given the apparent importance of this factor.

**Economic Participation**

Despite cultural constraints limiting their acquisition of knowledge and their mobility, the majority of women in Pakistan contribute substantially to the rural economy and are active in the urban service and industrial sectors. However, women's employment in remunerated activities is negatively valued and it is widely acknowledged that women's economic contribution is grossly under enumerated. For instance, the 1981 census reports a scant 3 percent of the female population as working, whereas the Agricultural Census of 1980 shows a female participation rate of 73 percent in the rural areas alone(28). A conservative estimate of women's labour force participation, across the various sectors, would be closer to 30 to 40 percent (29).

This invisibility has had a direct impact on the benefits women derive from their economic activity. Examples include: the failure of technological innovations to reduce drudgery and time spent by women in daily activities; development opportunities aimed exclusively at males; lack of access to productive resources and information, training and education(30); the confining of women to the informal sector where they face poor remuneration, appalling work conditions and insecurity; a failure of statutory law to cover the informal sector, where the majority of female workers are concentrated; and discriminatory conditions of employment in the formal sector. Under such conditions economic activity, carried out due to necessity, may damage rather than promote women's health.

Above all, women lack control over financial and other resources derived from their economic activity. The average rural woman will receive no compensation or recognition for the 16-hour days she works and will likely be regarded as an economic burden. Women's lack
Left behind to cope alone

Women's health is also affected by migrations. According to the 1981 Census, 5.2 million Pakistanis were internal migrants, moving within or between provinces. Many millions more are migrant workers abroad. This has direct implications for women, an increasing number of whom are being left behind to head households, or who are being uprooted from their homes and familiar support systems and placed in the invariably hostile and alienating environment of the inadequately serviced urban slum, with understandable repercussions for their health. Yet no attention has been paid to the impact of migration on women's physical and mental health.

Under circumstances of extensive labour migration both internally and abroad as well as polygamy, AIDS has to be acknowledged as an issue. At present in the absence of sex education and given health workers' failure to advise women on the impact of certain contraceptives on AIDS prevention, it cannot be assumed that AIDS will not flourish in Pakistan.

of economic autonomy reduces their decision-making powers within the family with implications for population and health programmes. At the most immediate mundane level women often need to request and account for expenditures on health and contraceptive services (including transport to the service-centre).

A large number of micro-studies indicate a possible increase in women's entry in the labour force, largely due to the pressures of growing poverty. This trend may also contribute to the significant development of women's marriage age inching up from 17.5 to 20.2 years. An additional factor in delaying marriage in certain communities may be the practice of jehez (dowry) which in times of economic crisis places a particular burden on families.

In the final analysis however, it is not so much whether women work but the extent to which they exercise control over their incomes, derive benefits from this, and acquire decision making power that will enhance their ability to exercise choices in all spheres of their lives, including reproduction.

Legal and Political Status

The patriarchal tendency to divide the public and the private spheres has been recognised as detrimental to women's human rights and, by extension, as detrimental to reproductive rights. Documents define human rights as civil and political liberties with regard to what governments can do...However by definition, UN legislation cannot deal with actions in the private sphere, including family relations, domestic violence, sexuality and reproduction.
Women's legal position in Pakistan, both according to statutory law and its practice, has always been poor. In recent years the social atmosphere created by General Zia-ul-Haq's politically expedient 'Islamisation' and the passage of a number of discriminatory laws had disastrous implications for women's legal status. For example, the 1979 Hudood Ordinances covering adultery and rape (besides drunkenness, theft and false testimony) have been used to reinforce control over women and further limit their autonomy in marriage: women who have married against the wishes of their families have found themselves indicted under this law as have divorced women who have remarried. Additionally, the seeming protection given rapists under this provision has increased women's insecurity, negatively impacting women's self-confidence.

The Hudood Ordinances and other Laws promulgated subsequently like the Qisas and Diyat Ordinance (1991) and Qanun-e-Shahadat 1984 (Law of Evidence), allowed an anti-woman agenda to flourish in all areas of discourse at the same time that the 1961 Muslim Family Laws Ordinance - which provides women a bare minimum protection of their rights within the family - came under strong attack. Starting in 1988, successive democratically elected governments have failed to repeal any of the discriminatory laws.

The Population, Labour Force & Migration Survey of 1979-80, conducted precisely during the initial stages of the legislatively retrogressive period for women, recorded a fall in contraceptive knowledge levels and reported intended future use. Either knowledge (and thereby use) had really dropped, or respondents were concealing their knowledge, or field data was manipulated, all carrying equally worrying implications for women's reproductive health.

Early marriage is identified as a health risk and is undoubtedly exacerbated by the legal system's failure to protect women. Inadequacy of birth records and respect for the 'privacy of the family', allow the minimum legal age for marriage to go unenforced, especially as courts have ruled that marriages of girls below 16 but past the age of puberty may be valid. The Pakistan Demographic and Health Survey (PDHS) 1990-1991 reports 7.3 percent of women currently in the 15-19 age group were married at the early age of 15.

The failure of legislative measures to provide women security in the family is further illustrated in the case of sterilization services. The staff at such centres explain that they request the husband's authorisation prior to sterilizing women to preempt the husband later divorcing the wife on the claim that she is barren as can easily happen in Pakistan.

Although the protection of the woman's rights is given as justification for this clause (because the law fails to protect her against such arbitrary divorce), it raises the question of whether recognizing prevailing social practices does not in fact inadvertently reinforce them. This is particularly so since no amount of signed papers regarding the husband's acceptance of his wife's sterilisation will, under local legal and social conditions, prevent him from obtaining a divorce if he actually seeks one.
Given that accepted expressions of female sexuality in Pakistan lie uniquely within the structure of a marriage, women's poor legal and social status within marriage restricts their ability to determine their own sexuality.

In the political and policy-making spheres, women continue to be grossly underrepresented, while their right to sit and participate in the political and administrative bodies continues to be questioned by orthodox elements. The limited presence of women in decision-making bodies, therefore, does not allow women's perspectives to be adequately reflected in government policies. In addition authoritarianism and a top-down approach in policies have led to an inherent mistrust of state-run programmes and facilities, and may be an additional factor in women's wariness of government family planning clinics.

Finally, the tendency in official circles to delink development from rights and status impedes the long term success of policies related to women. Consequently, even the country's most recent population policy which theoretically recognises the need for integration with a comprehensive development strategy, is unlikely to succeed since demographers and population planners have ignored the impact of women's legal status on reproductive rights and health(38).

**Shifting the Discourse**

A concept of reproductive health and rights that includes the context of individual women's lives must also include domestic violence and violence against women. Apart from exacerbating women's feelings of personal and bodily insecurity, mounting violence against women is frequently a direct attack upon their reproductive lives: for example rape leading to pregnancy or to the impossibility of future marriage. The assumption that it is the woman's duty to provide sexual satisfaction to her husband, backed by the law of restitution of conjugal rights, leaves little room for consideration of the woman's own sexuality. Failure to fulfill the husband's needs can lead to repudiation, polygamy and/or domestic violence.

Attempts to alter male attitudes towards family planning and encourage a recognition of their responsibilities towards women's health are welcomed as essential components of any population programme. But attempts to change these attitudes in a vacuum, and failing to recognize the societal atmosphere created by the overall discrimination against women, may lead to a marginal increase in contraceptive take-up but will not improve women's overall reproductive rights.

It is not only attitudes among men that need changing. Equally influential in decisions regarding family planning are extended family members, particularly mothers-in-law, and family planning service providers. Frequently the latter's class or social circumstances may be very different from that of the woman, and there is a failure to correctly perceive the needs of those seeking family planning services.
WOMEN'S HEALTH: STATUS AND SERVICES

The current population discourse in Pakistan appears to overlook the obvious: that a woman's reproductive capacities are shaped by her general health conditions long before she first becomes pregnant; that "safe motherhood" is significantly dependent on a healthy childhood and adolescence. A lifetime of discrimination in health and nutrition means women entering their reproductive years and the immense physical demands of pregnancy and birth have a very poor start, guaranteeing high maternal mortality (at 5/1,000 live births).

The prevalence of low birthweight babies across the maternal age groups and perinatal mortality (reported at 200.81 per 1,000 conceptions at risk\(^{(39)}\)) is an indirect indicator of Pakistani women's generally poor health; 90 percent of pregnant and lactating women are anaemic\(^{(40)}\). Although official analyses suggest that the expansion of tetanus toxoid coverage and the training of traditional birth attendants have contributed to lowering maternal and perinatal mortality, this is largely a supposition, unbacked by detailed investigation into factors impacting on women's life expectancy and maternal mortality.

Women's general health is greatly determined by their level of access -- both physical and social -- to health services. UNICEF estimates that only 55 percent of the total population and 35 percent of the rural population lives within 5 kilometres, or half an hour's walk, from any fixed health facility\(^{(41)}\). This shocking estimate may nevertheless be overoptimistic as it overlooks the realities of women's lives.

Physical mobility is a crucial issue for both female users and communicators. Analysing women's problems of access, one writer illustrated the social restriction on longer distance travel for women: 'the males have to go to work and the females do not like to go to the health centres or dispensaries alone', leaving them to rely on unscientific practices and untrained practitioners immediately available in their village\(^{(42)}\). Further the burden of daily chores leaves few Pakistani women a spare hour for travelling to a health facility (except in dire emergencies), let alone the time consumed waiting at, invariably understaffed, facilities.

Social barriers to women's mobility extends to adolescent girls and is a significant factor in the commonly reported gender differentials in access to health care for Pakistani children. A UNICEF study reported that some mothers felt family honour is threatened if adolescent girls are taken out of the home for treatment, their concern was that others may speculate as to the reasons for treatment. Disaggregating sex ratios by age group tends to support the observation that it is adolescent girls whose health is most endangered. Females outnumber males well beyond the supposedly most vulnerable under-5 age group and it is only in the 10-14 age cohort that the ratio of females suddenly falls\(^{(43)}\).
Percentage population by age group 1981

<table>
<thead>
<tr>
<th>Age</th>
<th>male</th>
<th>female</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>14.39</td>
<td>16.36</td>
</tr>
<tr>
<td>5-9</td>
<td>15.81</td>
<td>16.25</td>
</tr>
<tr>
<td>10-14</td>
<td>13.59</td>
<td>12.69</td>
</tr>
</tbody>
</table>

The Pakistan Demographic and Health Survey 1990-1991 reports that a countrywide average of 70 percent of women do not consult anyone for antenatal care. It should be noted, however, that the figure varies widely (from 14.6 percent among women with at least secondary education to 83.0 percent among rural women)\(^{(44)}\). Another survey revealed women's poor use of general health care facilities. Only 21.5 percent of women who judged themselves to be really sick visited a doctor. In 72.9 percent of cases no treatment whatsoever was sought and in 6.3 percent traditional or spiritual healers (pir) were consulted\(^{(45)}\).

One of the primary factors restricting women's access is that, all too frequently, what facilities do exist are devoid of the services of female health workers: less than a quarter of all doctors are women, reflecting little change since the 1950s, and few urban-born women doctors are willing to work in the rural areas. Apart from physical inaccessibility, this may go some way to explaining the low levels of doctor-assisted births\(^{(46)}\); 7 percent of all births, 21 percent in urban areas and a mere 2 percent in rural areas.

Physical access to family planning services is equally poor, and based on the false assumption that accessibility is an

![Balochi girl, Nasrollah Kasraian, NOVIB calendar, 1994](image_url)
entirely one-way process in which women will themselves seek out services. This presumption continues in spite of local evidence that outreach services, which help overcome women's problems of mobility and work pressures, can significantly improve coverage\(^{47}\). Programme outlets are also concentrated in urban areas with a clear negative impact on rural women\(^{48}\): 24 percent of urban married women knew of Family Planning Clinics and had met FP service staff compared with only 12 percent of rural women.

**Contraceptive Prevalence and Reproductive Health Services**

Total Fertility Rates in Pakistan are among the highest in the region, and higher than for other South Asian countries\(^{49}\). However, the PDHS argues that total fertility rates have fallen from a TFR of 6.0 births per woman reported in the 1984-5 Contraceptive Prevalence Survey down to 5.4 lifetime births per woman.

This apparent change in fertility - disputed by other observers - may have little to do with contraception. The International Planned Parenthood Federation states that total contraceptive use (married women aged 15-49) is a tiny 9.1 percent, a figure only slightly improved by estimates of an additional 7 percent of her users\(^{50}\). There is also a vast gap between stated desire and actual use. The Pakistan Contraceptive Prevalence Survey estimates a 55 percent unmet need for contraception.

Extended family structures tend to be strong supporters of high fertility. The role of the mother-in-law as a buttress of the male right of veto and of her son's general legal superiority in his marriage has not been assessed as a factor restricting women's access. Women who want no more children but who are not using contraception cited family (not husband specific) objections as the second most common reason after the rather vague 'do not want to use these methods', which may also reflect internalised social taboos against family planning\(^{51}\). Health workers, who must be viewed within their social context, are also prone to exaggerating the husband's social superiority, thereby indirectly curtailing the woman's health rights.

Reasons for low contraceptive prevalence and unmet contraceptive needs must be viewed in the context of women's subordinate social position and programme inadequacies, as well as the quality of reproductive health services.

A growing body of data supports the view that programmes that fail to respect a woman's ability to assess the entire range of circumstances affecting her own life and her need to make reproductive choices in accordance with her own calculus of relevant factors are, in the long run, destined to fail. Indeed, it is increasingly clear that the problem in family planning programmes is not lack of demand -- women want to be able to control their fertility. The shocking number of deaths from clandestine abortions certainly attests to this fact. The problem in family planning is poor quality programmes. Experience has shown that where family planning programmes are driven by goals unrelated to the health of women and where services are delivered in a manner that is dismissive or disrespectful of women's views of their own health and wellbeing, women will ultimately refuse to comply with providers' 'recommendation' about what is 'good for them.' Conversely, numerous studies demonstrate that family planning programmes that are oriented to the realities and pressures of women's lives -- that make physical access easy, provide usable information, offer multiple
methods and treat women and their choices with respect — will be used by women.\(^{(52)}\)

In Pakistan, too, there is a desperate need for offering women maximum informed choice about and control over their reproductive health and general health. Women need to be able to weigh up the entire range of risks and benefits for each contraceptive method allowing them to make a choice which is most appropriate to their personal circumstances. Instead, they are offered little choice and inadequate information. Programmes have also failed to provide a variety of strategies which cater to women of different ages and hence differing reproductive health needs.

Even within the limited framework of population control and focus on women the programme has lacked sensitivity. As the goals of the country’s population programme became more ambitious (as pressure from the World Bank increased and evidence of the programme’s failure mounted), there appears to have been a perception that the only way to achieve these goals was permanent contraception. The 1991-92 Economic Survey, for instance, outlining the steps taken by the Population Welfare Programme, only mentions female sterilisation. Prevalent among 2.6 percent of married women aged 15-49, it is the most common form of female contraception. Apart from the longer term impact of sterilisation on women’s health, only now beginning to be scientifically monitored (a number of negative effects have been noted in other countries such as a higher prevalence of hysterectomies and menstrual complaints), sterilisation may be less of a factor in improving women’s health than temporary contraceptives. The health of women seeking sterilisation is invariably already damaged by high parity and short birth intervals. Sterilisation, by permanently terminating a woman’s reproductive abilities — often the sole determinant of her worth — may also expose her to greater insecurities within the family than other forms of contraception.

**Enough to drive one mad**

The lack of opportunities for healthy exercise illustrates the direct impact socio-cultural restrictions on women’s mobility has on their health. Particular categories of women, notably the urban middle and upper classes and all strictly purdah-oberving women both in the rural areas and the cities, face the virtual non-existence of facilities and opportunities for exercise, compounding women’s overall poor health.

The link between women’s mental and physical health particularly noticeable in Pakistan, where women’s mental health needs are totally ignored; mental health problems among adolescent and teenage girls are regarded as damaging their marriage prospects and are hidden from public knowledge. The result is the manifestation of mental problems through psychosomatic, but more socially acceptable, gynaecological problems and the widespread abuse of psychotropic drugs.

Condoms remain by far the most popular form of temporary contraception in Pakistan\(^{(53)}\). Not surprisingly the only contraceptive to have been socially marketed is the condom, the clearest indicator yet that “facilitation of user’s access” is a term understood within a strictly limited context that excludes women’s reproductive autonomy. Equally, the forms of contraception now being most vigorously promoted involve little active participation by the woman and great dependence on health facilities: sterilisation, IUDs, and injectables.

An additional problem stems from inadequate quality of services and failure to provide women proper counselling leading
to side-effects. This is particularly important given that the frequency of side-effects associated with certain contraceptive methods has been a significant factor in discouraging users and prospective users alike. The population programme has witnessed often hasty swings from promotion of one "widely untested method" to another without any effort to find out what methods women want and what methods will suit Pakistani couples best(54).

An appropriate contraceptive method mix is absent in Pakistan where:

'The demand aspects of potential clients have been comparatively neglected. These demand factors may be grouped as sociobehavioral and health. Sociobehavioral characteristics include reproductive preferences, partner relationships, and coital patterns - all operating within specific cultural milieus. Most knowledge, attitude and practice type surveys have been biased towards reproductive intentions of 'idealised' families, without a systematic approach to human sexuality and human reproduction. Also neglected is the health status of client populations -- such as menstrual bleeding, breastfeeding, the prevalence of sexually-transmitted diseases (including AIDS), nutritional status, and the prevailing risk factors for anaemias.' (55)

It is impossible to devise an appropriate contraceptive method mix and appropriate health services - central to improved reproductive health - without a greater understanding of the divergencies of community-level attitudes and practices. While it is only feasible for state research institutions to conduct large-scale national-level macro studies, micro level data, providing a qualitative insight into population and health trends and practices, are best conducted by non-governmental research organisations which must be encouraged to take up such studies.

No research has been conducted to determine the quality of contraceptives available to the public either through official, NGO or retail outlets. The possibility of outdated and spurious drugs being passed on to users cannot be dismissed, especially since these practices are widely prevalent in other areas of Pakistan's pharmaceutical sector. Notably, 4.81 percent of surgical contraception acceptors stated their reason as being contraceptive failure and another 6.92 percent listed side-effects of previously used methods(56).

Non-allopathic Health Knowledge and Practices

Particularly among rural women, but even among middle class urban women, a variety of non-allopathic health care systems are highly popular. Attempts by allopathic doctors to refute as unscientific the practice of ascribing a specific taseer (a quality of 'hotness' or 'coldness') to individual foodstuffs has totally failed to prevent modern generations of women from avoiding specific foods or food combinations at various points in their life cycles. Recent country-wide research(57) reveals that in situations where a pregnancy is perceived to be proceeding normally, women rarely consult or interact with the allopathic health care system; hospitals and doctors are only resorted to when 'complications' arise, otherwise the traditional system of dosis, trained and untrained, are consulted.

Given the high cultural acceptability, technologically appropriate nature, low cost and greater accessibility of non-allopathic health care systems for Pakistani women (and also growing rejection of allopathic health care practices in view of their irrational application),
research to establish the scientific efficacy of the diverse non-allopathic health care systems and practices - not just in reproductive but in general health - is vital.

**New Reproductive Technologies (NRTs)**

A new element since the 1984 Mexico Second World Population Conference and the first Global Women's Health and Reproductive Rights Meeting has been the rapid expansion in availability and variety of new reproductive technologies, raising many questions for women's health rights. While nothing on the scale of the problem found in India, the abuse of amniocentesis to determine the sex of unborn children is a growing issue in Pakistan. Quite apart from other health implications, since abortion is only legal on the grounds of saving the mother's life, sex determination can only further increase the number of women who face the risks of backstreet abortion.

More widely available are new reproductive technologies used for overcoming infertility. Estimates suggest that as many as 15 percent of couples face primary or secondary infertility\(^{(58)}\). The social and medical burdens of infertility (real or perceived due to ignorance of biological processes) invariably land upon the woman, who, if not promptly divorced, is then at the mercy not only of hakims and piris but also of allopathic practitioners who liberally prescribe dangerous hormonal treatments and of the handful of private clinics now offering highly expensive services to overcome infertility.

Although NRTs are only within the reach of the very wealthy, the considerable publicity the clinics have generated has served to confirm the stereotype that married women must have children at all costs. NRTs, and their high-tech interventionist and woman-focused approach, have also diverted attention from the root causes of infertility among the vast majority of couples: male sterility, pelvic infections in women especially following the birth of the first child, non-allopathic attempts to treat imagined infertility, and a lack of sex education, all symptoms not of women's biological inadequacy but of the poor health service infrastructure and women's low status.

**Legal Restrictions on Reproductive Rights**

The Convention on the Elimination of Discrimination Against Women (CEDAW), (to which Pakistan is not a signatory, but which Prime Minister Benazir Bhutto's Pakistan People's Party has pledged to ratify in its recent election manifesto) includes the following reproductive choice related principle: 'State parties shall take all the appropriate measures to...ensure on a basis of equality between men and women the same rights to decide freely and responsibly on the number and spacing of their children.'\(^{(59)}\) Some have argued that the ambivalence of these principles makes it enormously difficult to identify reproductive rights abuses in circumstances where coercion is not explicit\(^{(60)}\). This, thus, strengthens the argument that reproductive rights have to be viewed as a largely unquantifiable issue that covers the entire gamut of girls' and women's life experiences.

Except in the case of abortion, in Pakistan there are no laws directly limiting reproductive rights\(^{(61)}\). That the popular perception, even amongst a number of family
planning service providers, is that laws regulating access do exist, indicates the strength of the other factors - largely social, cultural, religious attitudes - which restrict women’s access to health care and contraceptive services in the country.

Pakistan inherited anti-abortion laws from the colonial Penal Code of 1860 (Act XLV) which became absorbed as the Pakistan Penal Code, amended by the Qisas and Diyat Ordinance in 1991. The punishment in instances where the abortion is not carried out for the ‘purpose of saving the life of the woman or providing necessary treatment to her’ extends from three to seven years.

Facilities for Abortion

Induced and illegal abortion is officially recognised as a factor responsible for maternal morbidity and mortality(62). A 1971-72 study by Asghari K. Awan of a gynecology ward in a Lahore hospital found more than one third of admissions for miscarriage were linked with attempts at illegal induction; the general abortion rate was estimated at 54 per 1,000 conceptions. Awan pointed out:

‘These figures are of limited value since women usually seek hospital admission only in case of complications associated with abortion. Women who experience abortions without a mishap do not go to hospitals. Those who die during the process of abortion are of course not accounted for anywhere’. (63)

A high rate of illegal abortions is the direct consequence of denying women reproductive autonomy, the high percentage of unmet contraceptive needs and legal restrictions on abortion. A study of oral pill acceptors revealed one third had had 1-9 abortions. Only 13 percent of husbands were using condoms in spite of this history(64), indicating that abortion is regarded as a contraceptive option.

The 1976 Pakistani Women's Rights Committee set up by the Government of Pakistan stated:

‘There is a general feeling that it is time that abortion should be legalised as a similar demand is being made by women all over the world.

‘There are a good many reasons for narrowing down the scope of the offence of abortion. It has been noticed that in actual practice illegal abortions are resorted to by paying exorbitant amounts to incompetent medical practitioners and semi-trained midwives. In such cases abortions are caused under unhygienic conditions which either prove fatal for the women or seriously affect their health.’

Apart from improvements in contraceptive delivery services, the tragedy of backstreet abortions can be averted by widening the scope of grounds on which a woman can legally seek menstrual regulation to include the flexible sanction of ‘preventing serious danger to her physical or mental health’ (as recommended by the 1976 Report of the Pakistani Women's Rights Committee) as well as specifying abortion as a legal right available to rape survivors.

Women's organisations and family planning NGOs have not taken up the plea for menstrual regulation (up to 10 weeks since the last menstruation). In Bangladesh which
shares a South Asian and Muslim culture with Pakistan, menstrual regulation (MR) is widely and unconditionally available.

However, the Women's Action Forum (WAF) has demanded that abortion be a legal right available to rape survivors; a vote on a similar demand at the 1982 Triennial of the All Pakistan Women's Association, the country's oldest social work oriented women's group, was only narrowly defeated.

On the whole reproductive rights have hardly figured in rights discourse among women's organisations in Pakistan who have focused largely on the discriminatory aspects of the so-called Islamisation of laws. However, in 1984 when the Council of Islamic Ideology presented a draft of the Qisas and Diyat Ordinance containing stringent anti-abortion amendments, WAF successfully lobbied against this tightening of the law. It remains a matter of contention among women activists whether a public debate on the issue of abortion would be beneficial to women given the continuing weight even liberal politicians ascribe to the conservative religious lobby.

CONCLUSIONS

Women alone bear the entire burden of reproductive labour in a society through the process of pregnancy, birth and rearing of infants. This is not to argue that women should solely be defined by their reproductive roles, but merely to recognize their unique contribution to society. Even women who choose not to or are unable to have children may face health issues that are defined by their gender and biology: for example contraceptive choice, use of new reproductive technologies, breast and cervical cancer, menopausal problems, inadequate diet due to social conditioning, restrictions on mobility and therefore access to health care. It is critical therefore that the discourse on population and reproduction takes women's lives as a starting point and is guided by their concerns, priorities and perspectives.

This has notably not been the case of Pakistan's population programmes, all of which have been based on the premise that:

Population planning = family planning = fertility control

Clearly a failed model, this has neither benefitted women nor lowered the country's population growth rate.
An alternative model, one that is neither linear nor restricted in focus, and emphasises the centrality of women within a framework of reproductive rights needs to be developed. The very term 'rights' implies an expansion of possibilities, opportunities and choices for women, focusing on women's needs rather than the state's perception of the country's needs.

It is imperative that the focus of analyses falls simultaneously on the circumstances under which women are locked into high fertility patterns and the programmes of fertility reduction in which women's needs and choices are not taken into consideration. There can be no clearer illustration of the impact of this double bind than the vast gap between contraceptive knowledge and use. While the majority of women know of at least one contraceptive method (more in the urban than in rural areas: 74 percent in urban areas and 60 percent in rural areas) only a small 16.1 percent use contraceptives. In the Pakistan context, reasons for high fertility patterns include the social and economic insecurity of the family and of the woman within the family; elements that are ignored by the country's population policies.

Similarly, there is a widening imbalance between women's economically, socially and legally marginal status, and the increasing burden in their daily lives: within the family and society, women have many responsibilities and few rights. While emphasizing women's responsibility to lower their fertility, existing population programmes offer women little support in attaining their reproductive health rights, and may end up reinforcing an already oppressive situation.

The current policy of promoting the two-child family norm is effectively asking women to surrender a factor in their lives - often the only one - which guarantees them social status and economic security: their ability to produce children. This demand is made without offering women any alternative source of status and security. Small wonder then that a very large number of Pakistani women continue to want more than two children: 44.1 percent of women with two living children want more and a further 17 percent are undecided or believe it is 'up to Allah'.

Evidence that the total fertility rate has declined slightly while marital fertility preferences have remained stable, indicates that the socio-economic factors affecting a couple's fertility choices have changed little. High fertility choices that are perceived by population planners as 'irrational' and 'uneducated' may in many circumstances be a rational response. Clearly, a number of initiatives are required both at the conceptual level as well as that of intervention.
In Pakistan where present political arrangements impel the government to implement World Bank policies and its vision of human resource development, the country's feminists must develop an unambiguous position regarding development policies, particularly in the fields of women's health and education.

On the one hand policies of structural adjustment have already, as described above, had a direct impact on women's health and ultimately on their reproductive rights. On the other hand, many multilateral agencies, including those funding Pakistan's population programme, have begun to emphasise women's status as a programme focus, highlighting the need for increased female education, lowered maternal mortality rates, etc.

Not all are convinced that this programme focus will ultimately be beneficial to women:

"Women's womb is presently the most strategic object in this world...women never received so much attention until their womb was identified as the producer of something 'undesirable' for the earth ruled by white and rich people...A woman should earn some cash income so that her status within the family is raised to a level to make her accept a contraceptive method without the 'permission' of her husband. The precise objective is to cut individual women from their social and familial ties. In the process, women's bodies are displaced from the existing social nexus to be at the disposal of the population controllers, multinational companies, medical establishments and other related interests." (67)

While feminists must be careful not to take what may ultimately be a rejectionist stand, the concerns articulated in the above comment indicate just how clearly the focus must remain on the goal of improved women's health and their right to decide about matters affecting their bodies and lives as an end in itself.

There is at present an artificial delivery, planning and policy division between health and reproductive health services available to women. Since women's reproductive health cannot be isolated from their overall health status, this bifurcation must end. The Population Division should also focus on advocacy and the Health Ministry incorporate delivery and policy/planning of reproductive health services within other health activities. However, it must be noted that reproductive health services are largely preventative in nature whereas the health care system is predominantly curative. It is therefore essential that reproductive health services not be subsumed in the general health care system so as to retain their priority on preventive aspects.

To date the overwhelming focus both of national health plans and critiques of policy has been on raising the numbers of women having doctor-assisted/hospital births. There has, however, been no attempt to assess the impact of the quality of care in hospitals (both private and state) on women's reproductive health. For women from the lower classes who do not have the financial or social resources to ensure proper care, the hospital setting can prove at best insensitive and at worst downright dangerous. The women who suffer most from the on-going conflict between allopathic and traditional health systems are those in the urban slums where traditional knowledge and practices have been lost or abandoned, while physical and economic access to allopathic health care facilities is limited.

An increase in the numbers of Lady Health Visitors and paramedics must be combined with training and infrastructural improvements in obstetric emergency referral - now
regarded as the major preventive factor in maternal mortality rather than risk screening(68). The absence of effective emergency obstetric care facilities is illustrative of the population programme's objectives: fertility reduction rather than improved reproductive health.

Meanwhile the absence of widely accessible facilities for breast and cervical cancer screening, counselling regarding menopause, treatment of sexually transmitted diseases, and of infertility advisory services is again indicative of the tendency among health and population planners to view women's health needs as purely related to fertility control. What is perhaps most striking is that decades of failed programmes to curtail birth rates in Pakistan have not yet led to a questioning of the basic premises and top-down approach of such programmes. From our perspective, it is clear that as long as the womb - abstracted from the bodies of women and their lives - continues to be the focus of intervention, population policies will fail. To effectuate change, not only does the state have to make a strong political commitment to improving women's access to reproductive health services, this commitment must extend to expanding women's options and respecting their choices in all spheres of their lives.

The importance of viewing population as a broad social issue and not just a health issue cannot be overemphasised. Population planning is not simply a matter of controlling fertility nor is reproductive health simply a matter of preventing disease. Both are dependent upon the crucial link between women and society:

'A woman's biological ability to bear children is linked to the survival and continuity of families, clans, and social groups; the devolution and control of property; the interaction between human communities and their environment; the relationship between men and women; and the expression of sexuality.'(69)

The primary recommendation is therefore for looking at the 'population' issue as a rights issue and not as that of control. In both the North and the South, scholars and activists are presently developing new frameworks in which collective responsibilities and holistic analysis are central. However, since bodily and personal dimensions are at the core of any scrutiny of the 'absence or existence of reproductive rights,' the challenge here is to expand the framework without demolishing its original conceptual cornerstone(70).

Secondly, in view of the widespread and growing recognition in Pakistan that population planning is not a question of information and availability of contraceptives alone; a more comprehensive and humane understanding of people's lives and survival strategies is strongly recommended. When the scope of reproductive labour is broadened to include overwhelming responsibility for child rearing and maintaining the health of family members, it becomes clear how central to population issues women in fact are and how central to planning they should be. This 'holistic understanding' must therefore particularly focus on the lives of women. The strategies for survival devised by them, often in conditions of extreme oppression and adversity, must be the starting point.
OH, SWEETIE, YOU CAN TELL ME.
WAS IT POOR, SEX ED?
LACK OF IN-SCHOOL COUNSELING?
NO CONTRACEPTIVES?

HECK, NO, MA.
IT WAS JOEY.

Reproductive Freedom News, Vol.11 No.22, Dec 1993

NOTES & REFERENCES

1 Economic Survey of Pakistan 1993, Government of Pakistan
3 Deborah Maine, Lynn Freedman, Farida Shaheed, 'Risk, Reproduction and Rights: the uses of reproductive health data', draft October 1993
4 Samuel S. Lieberman, 'Demographic Perspectives on Pakistan's Development' in Population and Development Reviews 8, No.1 (March 1982) pp85-120
5 ibid
6 ibid
7 Quoted in People's Perspectives: No.2 Sept. 1993 p.22
8 The FPAP has extraordinarily calculated this to be equivalent to US $1,200 or Rs 29,520. Thus it concludes that FPAP's 'contribution to the national economy' in the 12 years 1979-90 was US $394,810,000.
9 Zeba A. Sathar, Population Policy and Demographic Change in Pakistan, Seminar on 8th Five-Year Plan, Planning Commission, GOP, December 1991, p.13
10 Zeba A. Sathar op. cit., p.15
For a sound analysis of critique of this argument see Nadia Haggag Youssef, 'Women's status and fertility in Muslim countries of the Middle East and Asia', paper presented at the American Psychological Association Annual Meeting, New Orleans, Louisiana, 1974


Farida Akhter, 'The Focus of Population Control on Women: Critical remarks', People's Perspectives: No.2 Sept. 1993 pp.9-12

Agenda 21, Chapter 5, 5.49

'Population, Environment and De-Responsibilization: Case Studies from the Rural Areas of Pakistan', eds. Franck Amadri & Tariq Banuri, UNRISD, 1992

Here there is a clear association between health and attitudes: in the villages Lady Health Visitors are rarely accepted as lodgers in people's houses while female teachers who have no housing are always welcomed.

Zeba A. Sathar, op. cit.

Economic Survey 1993


There is evidence that a substantial number of girls are in fact being educated in boys schools. In the more conservative provinces of Baluchistan and NWFP it was found that between one-third (Baluchistan Primary Education Development Programme) and one-fifth (Survey of Primary Education Development Project in NWFP) of all primary school girls attend boys schools.


Pakistan Demographic and Health Survey 1990-1991, NIPS, p.39

ibid, p.87

Farida Shaheed & Khawar Mumtaz, op. cit.

ibid

ibid

According to the Seventh Five Year Plan, half of the rural and one-fourth of the urban population cannot meet their basic requirements.
Statistics on the exact average age at first marriage are inconsistent: the 1981 Census stated 20.8 years while the 1990-91 PDHS places it at 21.7, a rise that not all regard as possible.

See Women's Action Forum position and suggestions for changes to the Universal Declaration of Human Rights.

Adrienne Germaine, in Rosalind Pollack Petchesky and Jennifer Weiner, Global Feminist Perspective on Reproductive Rights and Reproductive Health,' a report on the Fourth International Interdisciplinary Congress on Women, Hunter College, New York City, June 1990

See Khawar Mumtaz and Farida Shaheed, 'Women of Pakistan: Two Steps Forward One Step Back?', 1987; and Asma Jahangir and Hina Jilani 'The Hudood Ordinances: A Divine Sanction?', 1990

'Situation Analysis of Children & Women in Pakistan', UNICEF, GOP, 1992 p.97

a figure which is not adjusted for the inevitable underreporting.

Shahla Zia, 'The legal and political status of women: a critical factor in development', 8th Five-Year Plan Shadow Group working paper, 1992

from 28 weeks gestation to 1 week after birth.

Shaheen Attiqur Rehman, Minister for Social Welfare and Women's Division Punjab, 'Women's Development in Punjab', 1984

'Situation Analysis of Children & Women in Pakistan', UNICEF, GOP, 1992 p.60

Dr Razia Latif Ansari 'Problems of access of women particularly rural women to various services for health', paper presented at National Conference Health: Problems & Prospects for Women, Women's Division, GOP, 1980

Economic Survey 1991-92

PDHS, p.126

Kishwar Ejaz, op cit. This is the adult aspect of gender discrimination in access to health care that begins from birth, with out-patient department attendance and hospital admissions generally distributed as two-thirds male children and one-third female children although disease patterns are roughly equal. (See Dr Ambreen Ahmed, Dr Tasleem Akhter, Shagufta Alizai & Asma Zia, Gender differentials in access to health care for Pakistani children, UNICEF Pakistan, November 1990).

'Situation Analysis of Children & Women in Pakistan', UNICEF - GOP, 1992, p.60

Mike Semple & Yameema Mitha, 1986


Study of Male Motivation for Family Planning, FPAP, 1980, p.10

those using contraceptives but unwilling to confirm use to surveyors

Study of Male Motivation for Family Planning, FPAP, 1980, p.10

Deborah Maine, Lynn Freedman, Farida Shaheed, 'Risk, Reproduction and Rights: the uses of reproductive health data', draft October 1993

'Situation Analysis of Children & Women in Pakistan', UNICEF - GOP, 1992, p.58

Zeba A. Sathar, op. cit.

Dr N. Rehan, FPAP contraceptive surgery client profile, Paasban, 1991, p.19

(1992) First report of findings for the Women, Religion and Social Change project which was part of a regional research effort initiated by the International Centre on Ethnic Studies to identify the relationships between women, religion and social change.

Comment by senior FPAP official

This expands upon the foundational principle laid out at the 1968 International Human Rights Conference held in Tehran: 'Couples have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect.'


As for example in some countries where it is illegal to provide contraceptive information to certain categories of women.


Study of Male Motivation for Family Planning, FPAP, 1980, p.10

Correa, op. cit., p.13

Ghulam Yasin Soomro & S. Mubashir Ali 'Prevalence of knowledge and use of contraception in Pakistan', PIDE, Islamabad

Farida Akhter, op.cit.

Deborah Maine, Lynn Freedman, Farida Shaheed, op. cit.

ibid

Correa, op. cit., p.20