Investigating Barriers to Achieving Safe Motherhood in Pakistan:
A Study in Selected Sites in Rural Sindh and Punjab

Hilda Saeed
Rahal Saeed
Saman Y Khan
Acronyms

AJK  Azad Jammu and Kashmir
ANC  Antenatal checkup
BHU  Basic Health Unit
CPR  Contraceptive Prevalence Rate
CBO/s Community Based Organization/s
CSO  Civil Society Organization
D&C  Dilation and Curettage
EmONC Emergency Obstetric and Neonatal Care
FANA Federally Administered Northern Areas
FAO  Food and Agricultural Organisation
FATA Federally Administered Tribal Areas
FLCF First Level Health Care Facility
FGD  Focus Group Discussion
FP  Family Planning
FP/RH Family Planning and/or Reproductive Health
FPAP Family Planning Association of Pakistan
GDI  Gender-related Development Index
GEM  Gender Empowerment Measure
ICPD International Conference on Population and Development
IA  Induced abortion
IDI  In-depth interview
IUD  Intrauterine device
HIV/AIDS Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HDI  Human Development Index
LHW  Lady Health Worker
LHV  Lady Health Visitor
MDG  Millennium Development Goals
MoPW  Ministry of Population Welfare
MoH  Ministry of Health
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNA</td>
<td>Member of the National Assembly</td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MSS</td>
<td>Marie Stopes Society</td>
</tr>
<tr>
<td>NCSW</td>
<td>National Commission on the Status of Women</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental Organisations</td>
</tr>
<tr>
<td>NWFP</td>
<td>North West Frontier Province</td>
</tr>
<tr>
<td>PDHS</td>
<td>Pakistan Demographic and Health Survey</td>
</tr>
<tr>
<td>PMIPHC &amp; FP</td>
<td>Prime Minister’s Initiative on Primary Health Care and Family Planning</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
</tr>
<tr>
<td>PoA</td>
<td>Plan of Action</td>
</tr>
<tr>
<td>PRHN</td>
<td>Pakistan Reproductive Health Network</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>PRSP</td>
<td>Punjab Rural Support Programme</td>
</tr>
<tr>
<td>PV</td>
<td>Punjab Village</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RH/FP</td>
<td>Reproductive Health AND Family Planning</td>
</tr>
<tr>
<td>RHC/s</td>
<td>Rural Health Centre/s</td>
</tr>
<tr>
<td>SG</td>
<td>Shirkat Gah</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>SRR</td>
<td>Sexual and Reproductive Rights</td>
</tr>
<tr>
<td>SV</td>
<td>Sindhi Village</td>
</tr>
<tr>
<td>S&amp;P</td>
<td>Sindh and Punjab</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Introduction

This post-ICPD review of progress in Pakistan specifically stresses on contraception and abortion, with the cross-cutting themes of gender, social equality and equity; safe motherhood; sexual and reproductive health and rights, HIV/AIDS and STIs. Shirkat Gah has opted to address the need for Safe abortion services- including Post Abortion Care (PAC) and the unmet need for contraception in view of poor maternal health indicators and a high incidence of induced abortion, including unsafe abortion within the country.

Pakistan, situated in the South Asian subcontinent, is a large, complex country, divided into four provinces i.e. Sindh, Baluchistan, Punjab and Khyber Pakhtunkhwa and into three other regions viz. Federally Administered Tribal Areas (FATA), Federally Administered Northern Areas (FANA) and Azad Jammu and Kashmir (AJK) regions (Figure-1). Health is a provincial issue and the decentralization was recently initiated in 2011.

Figure 1: Map of Pakistan

1.1 Country Economic and Social Indicators

a. HDI, GDI and GEM

Fifteen years after ICPD, Pakistan’s total population stands at an estimated 180 million with an average growth rate of 2.2% per annum, ranking it 6th in the list of most populous countries of the world.1 It has receded from a record high growth rate of 3.7% per annum in the 1960s. According to the Pakistan Health and Demographic Survey 2006-07, 41% of the population is below 15 years of age, 55% are in the age group 15-64 and 4% are over 65. The overall sex ratio for all ages is 102 men per 100 women, which is considered implausibly high and attributed to a tendency to under-report women.2

2. Pakistan Demographic and Health Survey (PDHS) 2006-7.
Despite economic recession, militarization, significant religious extremism and internal displacement of people, all of which have had a severe, adverse impact on Pakistan’s development sector, Pakistan’s development status on the Human Development Index (HDI) has improved steadily; ranking 134th out of 177 countries in 2004, it now stands at 141 out of 182 countries, with a value of 0.572.³

Gender indicators have also gradually improved: the Gender-related Development Index (GDI) value is 0.532 with a ranking of 124 out of 155 countries and the Gender Empowerment Measure (GEM) value is 0.386 (99th rank out of 109 countries). Female life expectancy is now 66.5 years whereas male is 65.9 years.⁴ The adult literacy rate for females and males is 44% and 69%, respectively.⁵

Table 1: HDI, GDI and GEM trends in value and rank

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HDI Value</td>
<td>0.483</td>
<td>0.522</td>
<td>0.551</td>
<td>0.572</td>
</tr>
<tr>
<td>Rank</td>
<td>128</td>
<td>135</td>
<td>136</td>
<td>141</td>
</tr>
<tr>
<td>GDI Value</td>
<td>0.360</td>
<td>0.489</td>
<td>0.525</td>
<td>0.532</td>
</tr>
<tr>
<td>Rank</td>
<td>-</td>
<td>67</td>
<td>124</td>
<td>124</td>
</tr>
<tr>
<td>GEM Value</td>
<td>0.153</td>
<td>-</td>
<td>0.377</td>
<td>0.386</td>
</tr>
<tr>
<td>Rank</td>
<td>-</td>
<td>-</td>
<td>82</td>
<td>99</td>
</tr>
</tbody>
</table>


Pakistani women, have achieved some major milestones and significant amongst these is their political presence. At present, 24% of the National Assembly is composed of women (women on general seats are 15 and on reserved seats are 60 out of a total of 314 MNAs) and 17% of the Senate is women (total 99 Senators).⁶ At the district level (zila level), women councillors are a total of 27,703. Increasing literacy, the Protection of Women (Criminal Laws Amendment) Act 2006 and other related measures have aided women’s progress with reduction in social exclusion, poverty alleviation and healthcare. At least four women’s rights activists are now in the National Commission on the Status of Women (NCSW). The first female Speaker of the National Assembly of Pakistan was elected in 2008.

b. Human Poverty Index

Despite these improvements, poverty remains notable; the global economic recession, rapid devaluation of the rupee, escalating food and non-food inflation, compounded by lack of

---

⁴ UNHDR 2009. A GDI ranking lower than the HDI reflects the inequalities that persist between men and women. Social structures and discriminatory traditions have been increasingly identified as key elements in holding women back.
⁵ Pakistan Economic Survey 2008-09.
adequate governance and political stability have retained significant levels of poverty in Pakistan.7 Alarmingly, extreme poverty is leading to suicides.

The Human Poverty Index (HPI-1) value of 33.4% for Pakistan, ranks 101st among 135 countries for which the index has been calculated.8 The country’s Gross Domestic Product (GDP) for 2008 with regards to purchasing power parity was US$454.2 billion and as per official exchange rate Pakistan GDP was US$160.9 billion with an expected 2.0% growth in 2008-09 as compared to 4.1% in 2007-08; the per capita GDP of Pakistan with regard to purchasing power parity was US$ 2,600 in 2008. The poverty head count ratio has increased from 33.8% in 2007-08 to 36.1% in 2008-09 thus placing approximately 62 million people below the poverty line.7 The poor in Pakistan are disproportionately rural and female. 52% of Pakistani women suffer from poverty of opportunities, compared to 37% of men. The level of income inequality as defined by the GINI Index is 30.6. Socio-economic disparities are considerable: the poorest 10% survive on 3.9% of the national income, while the richest 10% have access to 26.5%.

c. Health Sector

In 2006, government spending on health as a percentage of the GDP was 0.51%. Though health expenditures in absolute terms have shown a steady increase over the years, government spending on health as a percentage of GDP remains almost stagnant, standing at 0.57% in 2007-08.10

Under-5 mortality rate for girls is 94 per 1000, while for boys it is 85 per 1000 births.11 The greater mortality rate for girls appears to be due to neglect in childhood and needs to be probed further. Disparities are high: under-5 mortality in the poorest 20% of the population is 121 per 1000, and in the richest 20%, is much less, at 60 per 1000.12

The ILO Maternity Protection Convention 2000 is applicable to, and enforced, for women employed in the government or corporate sector as registered workers; they are eligible for maternity benefits (cash, maternity leave, hospitalisation benefits), but it is not strongly enforced in other cases, e.g. agricultural workers or women in informal employment. So far, there is no legislation for paternity leave. Since few government offices or private organisations have crèches at the workplace, women are unable to bring their infants to work.

d. Literacy

The national adult literacy rate (age 15 years and above) is 54.2%. Gender inequalities are clearly apparent in adult education with the female literacy rate at 39.6% and male literacy rate at 67.7%. Literacy remains higher in urban areas than in rural areas. The combined gross enrolment ratio in 2007 is 34.4% for girls and 43.9% for boys.13

7. In 1990-2004 the National Poverty Line was 32.6%. According to the Pakistan Economic Survey 2007-2008 the percentage of people living below Poverty Line i.e. Rs. 944.47 (USD $16 approx.) per adult equivalent per month was 22% in 2005-06.
8. UNHDR 2009.
Resistance to girls’ education is decreasing; however, parental reluctance to send their daughters to school sometimes stems from safety factors, housework, or discriminatory factors. At times, child marriages and other traditional norms are a hurdle to girls’ education too.

e. **Labour Force Participation and Employment Rates**

Pakistan has a labour force of approximately 52 million people. The labour force participation rate for females is 19.6% while male is 69.5%. The number of women under the category ‘employed’ indicates a declining trend: from 31.2% in 2003-04 it has come down to 22% in 2007-08. 75% females are employed in the agricultural sector, 12.6% in services and 12.2% in industry. The overall unemployment rate remains unchanged at 5%.\(^{14}\)

f. **International Conferences, Declarations, Treaties and Conventions signed by Pakistan**

Pakistan ratified the Alma-Ata Declaration of 1978; it is a signatory to the International Conference on Population and Development (ICPD) Plan of Action, 1994, and to the Fourth World Conference on Women, 1995. It was also a signatory to the UN World Summit 2005, which was a follow-up to the UN Millennium Summit 2000 in New York.

Pakistan has signed and ratified the Universal Declaration on Human Rights 1948 and the Vienna Declaration and Programme of Action adopted at the World Conference on Human Rights in 1993.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1979, was ratified in 1996, but with a reservation on article 29(1), pertaining to disputes. A general reservation invoking the primacy and supremacy of the Constitution over and above the provisions of CEDAW was made. The government has submitted reports to the CEDAW Committee though all have not been shared publicly, and it has not yet signed the Optional Protocol.\(^{15}\)


g. **National Level Laws and Policies on SRHR; Women/Gender Equality; Young People’s SRHR; Violence Against Women, Rape, Sexual Harassment, Trafficking.**

The draft National Youth Policy 2006 was circulated widely amongst NGOs and the civil society. It was also reviewed by the Pakistan Reproductive Health Network (PRHN) members to address

\(^{14}\) *Pakistan Labour Force Survey 2007-08.*

\(^{15}\) Khawar Mumtaz. ICPD Ten Years On: Pakistan Report (Shirkat Gah 2005). Reservation on CEDAW: Any dispute between two or more states parties concerning the interpretation or application of the present Convention which is not settled by negotiations shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree on organisation of the arbitration, any one of the parties may refer the dispute to the International Court of Justice by request in conformity with the statute of the court.
SRHR issues. Suggestions included amendments to language to be proactive, gender sensitive, and rights-based; incorporate specific SRHR concerns, education, information, and access to safe and friendly youth services. These suggestions were forwarded to the Ministry of Youth Affairs. Unfortunately, the process has stalled and the draft policy remains pending.

The promulgation of the Protection of Women (Criminal Laws Amendment) Act (WPA) 2006 provides protection to women in cases of violence and false accusations of zina (adultery). The promulgation of WPA 2006 was the result of concerted struggle for more than twenty-five years by women’s and human rights activists and NGOs through research, advocacy, and lobbying with policy makers, parliamentarians, and linkages with the media.

A similar process has been followed for two more Bills; the Domestic Violence (Prevention and Protection) Bill and The Criminal Law (Amendment) Bill have both been passed by the National Assembly and tabled in the Senate in 2009. Both Bills have been prepared with inputs from the women’s movement, Human Rights Commission Pakistan and the legal fraternity. The Criminal Law (Amendment) Bill includes amendments to the Pakistan Penal Code and Criminal Procedure Code to enhance punishment for offences relating to harassment of women.

The National Plan of Action for Women 1998 and the National Policy for Development and Empowerment of Women 2002 are indicative of government commitment to implement institutional gender reforms. The Ministry of Women’s Development in collaboration with civil society organisations is revising the NPA in light of the developments of the past decade. Shirkat Gah is also deeply involved in this process. The revised NPA will draw upon the ICPD+15 and Beijing+15 review processes underway, and align Government’s priorities with emerging concerns. The National Policy for Development and Empowerment of Women is also currently under review.

In February 2012, National Commission on the Status of Women Bill 2012 to protect women’s rights against every sort of discrimination was passed. As a result the NCSW now has autonomous status with full financial and administrative powers. Its fundamental functions will be to examine policies, programmes and other measures taken by the government for women’s welfare and gender equality as provided in the constitution and “in accordance with international declarations, conventions, treaties, conventions and agreements relating to women, including the Convention on the Elimination of all forms of Discrimination against Women”.

1.2 Context of the country in terms of SRHR

Changes in the SRHR arena have been mixed in Pakistan. Women’s and girls’ increasing educational opportunities have contributed to their rising age at marriage; women’s age at marriage before age 15 has declined from 15% in the oldest cohort to 7% among women aged 20-24; mean age at first marriage has increased from 21.7 in 1990-1991 to 23.1 in 2006-2007.16

However, to date, there is no policy on SRHR: the National Health Policy refers only to maternal and child health. The government has continually shied away from any discourse on sexuality, except for STIs and HIV/AIDS with resultant inadequate public awareness of SRHR. The maternal mortality currently stands at 276 per 100,000 live births, with relatively low Contraceptive Prevalence Rate (CPR) at 30% and Total Fertility Rate (TFR) at 4.1. Currently, skilled care at

childbirth is available only in 39% cases.\textsuperscript{17} Optimal SRHR is impeded by limited access to FP/RH services, including outreach particularly to rural areas: LHWs provide coverage in the rural areas. Contravention of women’s SRHR is evident in some contraceptive practices, e.g. spousal permission is considered essential for female sterilisation, as a requirement of the Ministry of Population Welfare (MoPW). The converse, of spousal permission for vasectomy, is not required. This spells a clear violation of women’s right to contraception (interview with Dr. Laila Shah, Marie Stopes Society, Karachi, Pakistan).

Information on the legal and religious aspects of abortion in Pakistan is quite abysmal. Due to insufficient publicity regarding permissibility of abortion under certain circumstances, no government hospital will admit to any abortion case till the situation regarding it is clarified as part of Government Health Policy. Provincial health and population secretaries (interview with Kamal Shah, Chief Executive Officer, FPAP) admit to their confusion on this issue but state that this is in accordance with Government policy. A few NGOs working in the RH sector provide post-abortion care related services in accordance with the Pakistan Penal Code e.g. the Family Planning Association of Pakistan (FPAP) will provide services for rape survivors, or in case of contraceptive failure.

1.3 SRHR, STIs, HIV/AIDS

According to UNAIDS estimates, about 96,000 people were living with HIV in Pakistan at the end of 2007 (just over 0.1%). Despite the low prevalence there is evidence of local concentrated epidemics among Injecting Drug Users (IDUs) in major cities across the country; between 10-50% in Quetta, Faisalabad, Hyderabad, Karachi and Sargodha. Since majority of the IDUs are either married or sexually active,\textsuperscript{18} this constitutes a major threat of the spread of the virus to the general population.

Prevalence rate amongst antenatal women have not yet been estimated (interview with Dr. Sikander Sohani of Aahung, Karachi, Pakistan). However, PDHS 2006-7 reports that women between 15-49 years who have ever heard about AIDS were 44% and 51% of them knew at least one method of preventing it. Nevertheless, gender inequalities may contribute to the spread of HIV/AIDS in Pakistan; women’s low socioeconomic status, lack of mobility, less decision-making power as compared to men and issues of access are significant concerns.\textsuperscript{19}

1.4 Progress associated with ICPD

A National ICPD Plan of Action was never prepared. In 2000, a draft National RH Policy was prepared based on the ICPD definition of RH; however, this was never formally approved by the Ministry of Health or Population Welfare. The National Health Policy 2001 reflected the ICPD philosophy by addressing issues of RH with the inclusion of rights through primary health care. The policy builds upon a national vision for the health sector based on a ‘Health-For-All’ approach as defined in WHO’s Alma-Ata Declaration of 1978 and continues in the direction set by ICPD. The Pakistan Population Policy 2002 is a direct follow-up of the ICPD commitment.\textsuperscript{20}

\textsuperscript{17} PDHS 2006-7.
\textsuperscript{18} HIV/AIDS in Pakistan; http://worldbank.org/pk.
\textsuperscript{20} Population Assessment of Pakistan 2003 (GoP-UNFPA).
Monitoring of progress regarding ICPD commitments is regularly carried out by the government, though government reports tend to focus on achievements, not gaps.  

According to one expert interviewed for this study (Dr. Laila Shah, Marie Stopes Society, Pakistan) there is now an increased collaboration between the MoH and MoPW at the field level which has led to improved Primary Health Care (PHC), contraceptive facilities, safe abortion and Post Abortion Care (PAC). She further stated that the Pakistan Government plans to increase Lady Health Workers (LHWs), i.e. community based health workers, to 200,000 across the country.

1.5 Criticality of the issue

This study focuses specifically on contraception and abortion, since these two areas are crucially important for achieving progress not only in the population and development sector, but also for overall national progress.

As mentioned before, Pakistan has 41% of its population below 15 years of age; their future Reproductive Health (RH) needs promise to be significant. Also there exists an unmet need for contraception in the current population estimated at 36% (unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception). Meeting the current and future RH demands of its population is going to be an important challenge for Pakistan.

In the wake of the large unmet need for contraception, the fate of many unwanted pregnancies in Pakistan is induced abortion. About 890,000 induced abortions, with 196,671 of them being unsafe abortions, are estimated to take place in Pakistan each year. Unsafe abortion is sought in times of critical need, largely due to insufficient awareness of the law and public orthodoxy (interview with Dr. Laila Shah, Marie Stopes Society, Karachi, Pakistan). In Pakistan, under certain circumstances, abortion has been considered permissible since 1997, to save the woman’s life or to provide “necessary treatment.” Islamic law also permits abortion up to the first 120 days of pregnancy, prior to “ensoulment.”

Keeping these factors in mind and the threat of contraceptive commodity insecurity looming large in the near future, highlighting and advocating for these issues becomes critical for the health of its population and progress of Pakistan.

Objectives and Methodology

2.1 Conceptualizing the research

---

22. PDHS 2006-7.
25. Presentation by Dr. Sadiqua N. Jafarey at a Marie Stopes Society Seminar on Post-Abortion Care, November 2008.
Initial desk research and data analysis, with valuable contribution by key informants and stakeholders, provided the basis for the monitoring review, steered through the Pakistan Reproductive Health Network (PRHN). Media reports added topicality in Pakistan’s fast-changing political and economic scenario. Research locations were selected from Shirkat Gah outreach areas.

Two components of the RH Package were probed: **Comprehensive Family Planning (FP) services for women and men; and maternal health care, including safe motherhood and post-abortion care** (Contraception and Abortion). The finer facets studied were the availability of and hindrances to contraception at the grass roots level; people’s attitudes towards contraception, availability and accessibility to safe motherhood services and post abortion care. Where requisite facilities were unavailable, the reasons were investigated, including the prevalent situation in case of emergencies, or alternatively, in case of unwanted pregnancies. The study also obtained understanding of women’s daily health care needs, including difficulties encountered within the home (e.g. limited inter-spousal communication) and within Basic Health Units of the Government of Pakistan and other health facilities.

### 2.2 Overarching Research/ Monitoring Questions

Pakistan’s commitments at ICPD led to the introduction of the Pakistan Population Policy 2002: this was reviewed with **an overarching question to ascertain the impact of Health and Population policies at the community level**. For the FGD and IDI guides, different components of RH were probed:

- Maternal health care, including safe motherhood, pre & post abortion care for complications.
- Availability of RH/FP services/ facilities.
- People’s decisions regarding RH/FP by women/couples.
- Community awareness and support for RH/FP.
- Availability of new services/facilities.
- Source of provision: Government, NGO sector or individuals?
- Common complaints about services and facilities.
- People’s health-seeking habits.
- Knowledge of the use of ultrasound examination (this question was asked to establish uptake of modern health facilities i.e. awareness regarding it, accessibility and utilization; furthermore it was asked to probe possible prevalence of female foeticide).
- Availability of quality health care for women during pregnancy and delivery.
- Transport arrangements for emergencies.

**In Depth Interviews:**

- Women/couples’ responses to unwanted pregnancies.
- People’s/women’s feelings regarding abortion.
- Availability of safe/unsafe abortion facilities.
- Quality of availability (i.e. do facilities/services include doctor, nurse, LHV etc.).
- Generally observed post-abortion complications and service provision in such cases.
- Reasons for termination of pregnancy and related questions like who takes the woman for abortion etc.?

2.3 Methodology and Location

Two villages, Village Piyaro Lund in Sindh and Haft Madar in Punjab were selected for collecting information on the areas of interest to the study. SG has had a long presence in these locations and has developed trust with the community through its CBO partners – a fact which enabled rapport with villagers and facilitated answers to the sensitive questions of the study.
Findings and discussion

3.1 Characteristics of the Participants of the FGDs and the IDIs

The participants of the FGDs and the IDIs were residents of the villages of Piyaro Lund in Sindh and Haft Madar in the Punjab (as mentioned earlier). The FGDs of men in the Punjab were conducted on Christian (1 FGD) and Muslim (2 FGDs) communities and in Sindh all 3 FGDs were conducted with Muslim men. The FGDs and the IDIs of women were conducted only on Muslim women both in the Punjab and Sindh villages.

Of the 3 FGDs conducted with men in the Sindh village (SV), 47 men participated in total; 17 in the first one, 15 each in the 2nd and the 3rd group. One FGD consisted of men from the Nagore tribe who were mostly farmers; the 2nd FGD was conducted on men from the Lund Baluch tribe who were farmers, shop keepers and students and the 3rd was conducted on men from the Syed clan who were farmers, teachers and some students. Most of them were in the age group of 21-30 years (19) but their ages ranged from teenage to 70 years.

Of the 3 FGDs conducted with men in the Punjab village (PV), 35 men participated in all; 12 in the first one, 11 each in the 2nd and the 3rd group. One FGD consisted of Christian men who were mostly daily labourers; the 2nd FGD consisted of Muslim men from the Gujjar clan who were farmers and the 3rd consisted of Muslim men from the Rajput clan and (again) they were mostly farmers. Most of them were in the age group of 31-40 years (12) but their ages ranged from 20 to 70 years.

Of the 3 FGDs conducted with women in the PV, again a total of 47 participated. The ages ranged from teenage to 50 years but the average age group represented was that of 21-30 year olds (23) and 31-40 year olds (16). They were from the Gujjar and Rangher clans. Although these women had no specific profession yet their daily work included household chores, working in the fields next to the village etc.

Of the 3 FGDs conducted with women in the SV, a total of 59 women participated. Their ages ranged from teens to 70 years but the average age group represented was 21-30 year olds (17). There were 21 women in the first group, 20 in the 2nd group and 18 in the 3rd group. Their daily work was the same as that of the rural women in the Punjab.

A total of 4 female IDIs in the PV were conducted; one of a TBA who was a 60 year old with 8 children (5 boys and 3 girls), second of a 40 year old housewife with 7 children (3 boys and 4 girls), third of a 35 year old housewife with 3 children (2 boys and 1 girl) and the fourth was of a 24 year old Lady Health Worker (LHW).

In the Punjab, male IDI was conducted on a 55 year old man with 10 children (5 boys and 5 girls) who was an electrician by profession.

A total of 3 IDIs were conducted of males in the SV, all interviewees were residents of village Piyaro Lund, District Tando Allah Yar, Hyderabad, Sindh. They included a 30 year old shopkeeper who was educated upto 8th grade and belonged to a poor family (income 3000/- per month) and of the tribe Khaskheli. The second interview was of a 45 year old male, whose education was till 2nd grade and by profession he was a trader belonging to the Mirbahar tribe. The 3rd interviewee was a 40 years male, educated till the 8th grade, also a trader by profession belonging to the Lund Baloch Tribe.
Of the 3 IDIs conducted of females in the SV, one was of a TBA, another of a 38 year old housewife with 5 children (3 boys and 2 girls) and 3rd of a 35 year old housewife with 6 children (3 boys and 3 girls).

If one looked at the number of offspring in the PV focus group, the older Muslim men and the Christian men had on average 7-9 and 6-7 children respectively, whereas the younger Muslim men had 2-5 children.

3.2 RH services and the RH needs of the population

The study showed that there was a universal dissatisfaction amongst the respondents regarding the availability of the RH services at the level of the village and/or the community. This was particularly true of respondents from the SV, both men and women. Nonetheless, as regards improvement in the awareness regarding RH issues, women in the SV and both men and women in the PV reported an improvement in the last five years. However, men in the SV reported none/little improvement. According to them there had been little or no change in the RH/FP knowledge amongst men. They further added that the newly created cadre of LHWS needs to talk to men too because lack of proper knowledge prevents Sindh men from adopting new FP methods (more on this in the FP section). According to them, the current cadre of LHWS is young and unmarried, and they are hesitant and shy in talking to men about RH/FP related issues. They suggested that the Pakistan government needs to recruit married LHWS who would be more confident in talking to men in the community. In contrast to this opinion, younger and educated respondents in both study areas reported a greater awareness and better FP practice amongst their group and peers.

The universal dissatisfaction extended to the Government run health care delivery system particularly at the Basic Health Unit (BHU) level. A BHU was a First Level Health Care Facility (FLCF) established in the 1980s, by the Government, for providing Primary Health Care (PHC) at the village level all over Pakistan. BHUs have been usually located only 3-5 kilometres from the villages they serve. However, the field findings in both the villages in Sindh and Punjab show, that except for the very poor, BHUs were generally avoided by the respondents. Different reasons were given for this including: 1) BHU being a Government facility, shuts down at 2p.m. 2) it was invariably ill-equipped 3) and under-staffed or absent staff 4) had a poor supply and quality of medicines 5) the attitude of the staff was careless 6) and the staff charged a fee where there should be little or none. So going to the BHU was considered a waste of time and avoided. In contrast to this, the poor and the indigent in the village, who had little choice, were reported to utilize BHUs more regularly for their needs. However, even in this, women in the PV reported that the BHU staff provided facilities like medicine etc. to the people whom they were acquainted with and neglected the others.

Another strong and pervasive fact that emerged from the field findings was that nearly all respondents, except the poorer ones, in both villages, reported utilizing privately run health facilities, located in the nearest town (usually 10-15 km. from the village), for any/all of their RH needs. This was despite the fact that it entailed greater expense (usually out of pocket) and travelling a greater distance. Respondents reported a greater trust and satisfaction on the private sector health facilities. Unequivocally, the health service of choice for RH needs (and others too) of the respondents was the private health sector. In both villages, the husbands usually cooperated with their wives in seeking quality health care services from the nearest town. In some instances, the in-laws were supportive too.
Community support, in the form of money, or looking after the household when the woman was taken to the hospital or in providing timely transport, was reported to be usually present – occasionally the local leaders were not very cooperative. Also husbands tended to have/save an emergency fund when the wife got pregnant which was utilized at the time of need. However, the quality of the transport was very doubtful as women in the PV reported being transported in a tractor trolley and suffering severe injuries like placental tears and bleeding etc. and even delivering in the trolley because of the rough ride.

**Respondents in the PV reported a steady decline in the use of home remedies, saying it was now only 50% popular but in the SV it was still a common and a popular practice, with a reported prevalence of 80%. In the PV, if a home remedy failed, then the patient was taken to a hospital. However, in both the villages in S and P, home remedies were still practiced by the poor and some women in the SV reported that it caused death in extreme cases.** The practice of consulting traditional spiritual leaders, including the local pir, was still common and some men in the PV went so far as to say that they had prevented pregnancy through a taweez (an amulet).

The health service providers involved in the delivery of the RH services in the villages were quite a few and included (in decreasing order of popularity) 1) the (private) doctor (or hospital /maternity home) in the nearby town (very popular) 2) the spiritual healer (particularly for the poor) 3) the Dai (TBA) 4) Village Dispenser 5) the nurse 6) the Hakeem (traditional physician).

Amongst the minority group i.e. Christians studied in the PV, the situation seemed to be particularly bad. It seems that their only recourse to RH services were the private hospital/s in the nearby town of Bhai Pheru for even the Muslim Dai of the village was not ready to attend to the Christian women. There was a strong stigma attached to her visiting the Christian women and Muslim members of the community would taunt her with remarks like “have you become Christian too” if she did so. The Christians tended to go to a nearby town (again different from the town frequented by the Muslim community members) because it was where their relatives resided and they could stay with them for free. Also their level of awareness regarding FP was very limited.

### 3.3 Safe motherhood

Awareness and better practices regarding safe motherhood have greatly improved (as the PDHS 2006-7 data has also demonstrated). Women in both villages (in Sindh and Punjab) reported regular antenatal check ups (ANC), with tetanus toxoid immunization. The ANC, performed generally 3 times during the entire pregnancy, was usually done on the advice of a doctor and an ultrasound was performed at each visit. The **ultrasound** was definitely the new kid on the block and very popular. Whilst in the PV, men and women reported that the ultrasound was used to determine the health and the position of the foetus, in the SV, it was invariably reported that it was also used for determining both the position and the sex of the foetus. If it was a female foetus, the woman usually kept quiet and became sad. There was no report of sex-selective foeticide. The urge to know the sex of the child emerged very strong in the respondents from Sindh, where women went to a private health facility that charged Rs. 200/- per visit as compared to a government facility, where it cost only Rs. 50/- (1/3rd of the private fees) because the private facility revealed the sex of the foetus whereas the government one did not.
The behaviour regarding delivery seems to have undergone change over time as institutional deliveries are more popular now as compared to home deliveries. **Men and women in both villages reported a trend towards institutional delivery at a private health facility in the nearby town** as compared to home delivery in the village. This was truer for the well to do in the village *(as mentioned earlier)*. In both S and P villages, it was reported that the poor still use the services of the TBA (untrained Dai) for home based delivery. The TBA was assisted by the village dispenser who administered an/y injection that the woman may need. However, an interesting change reported in the behaviour of the Dai was that in case of a suspected complication, she referred a woman quicker to the health care provider as compared to before.

There seemed to be a limited trend towards post natal check up in both villages. Few women reported going for one. Again, this finding was in line with the findings of the PDHS 2006-7.

### 3.4 Family planning

In the PV, significant finding was that FP awareness was poorest in the Christian community *(as mentioned before)*. The Christian men reported no knowledge of any form of modern contraception. On the other hand, Muslim men reported that as women breast fed their babies for 2-2.5 years, natural birth spacing took place. Also in the PV, the religious leaders, generally considered to be against FP, were reported secretly practicing it. They kept it a secret because they did not want other people to think they were committing a sin. Most of the older Muslim men in the PV also considered FP to be bad.

The LHWs were particularly prominent in the field and were associated strongly with polio campaigns and distribution of FP supplies especially in the SV. In the SV, the FP supplies i.e. pills and condoms, which were distributed for free by the LHWs were reportedly discarded by the community. Some women even reported giving the condoms to their children to use as balloons. Women ascribed the discarding of FP supplies to the fact that they were distributed free of cost and people do not appreciate anything given for free. This was particularly ironic as the men in SV reported purchasing condoms from the local pharmacy for their use. The purchases of condom were not done openly but secretly as people were shy about it. In the PV, 6 grocery shops out of 12 (50%) stocked condoms but also sold them secretly for fear of detection.

The provision of FP services in the village through the LHWs, as reported in the SV, was not so in the PV. The LHW network had a patchy outreach in the PV with very limited FP service provision. The LHW in the PV reported that she had recently been given the injection Depo-Provera for administering to the women in the village. However, she reported that the village women felt that it may cause excessive bleeding during the monthly periods and/or also cause infertility, so they did not use it and the injection was not popular. Women in the PV preferred sterilization at the time of delivery and usually after 5-6 or more children. However, in the SV, the injection method was popular and frequently used. Women in the SV reported feeling more secure from unwanted pregnancy for 3 months with an injection and there was no hassle of remembering to take something daily *(as in the pill)*.

Women in both S&P villages reported frequent and disturbing side effects and failure of modern FP methods e.g. IUDs caused infection and increased bleeding and loss of breath and even cancer leading to death; use of oral pills resulted in obesity and leucorrhoea and menstruation becoming irregular. A constant refrain from the data was that after FP use, there was increased
bleeding, obesity, infection etc. The side effects produced a great deal of fear and discouraged FP uptake by women. It not only led to cessation of use of FP methods but also discouraged from using any other method and discouraged others from taking one up. Many women in the PV also reported frequent failure of FP methods and therefore preferred sterilization as it was trustworthy.

Some men in the SV reported to have undergone a vasectomy but men in the PV felt that this would cause impotence and therefore kept away from it. Male condom use was reported and disposal of condom was cited as a big problem; they had been disposed off in masjid bathrooms or local drains. In the PV, Muslim men felt that FP was more a responsibility of the woman.

Except for men in the SV, most people reported that the awareness about FP had increased manifold, and TV and civil society organizations were quoted as an important medium of information. Many people in the villages possessed a TV in their homes.

One significant finding regarding FP in both S&P villages was that it was particularly popular amongst the younger age group and used more by them. The small family norm seemed to be the preferred reality of the younger and/or more educated generation. Regarding preference for FP method, each area had its own preference, as outlined in Table-1 below:

**Table 1: Preference of FP method (in %)**

<table>
<thead>
<tr>
<th>Province</th>
<th>Preferred Family Planning methods (%)</th>
<th>Condom</th>
<th>Pills</th>
<th>Female Ster.</th>
<th>Male Ster.</th>
<th>Injection</th>
<th>Copper-T</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Punjab</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(for both males &amp; females)</strong></td>
<td></td>
<td>10</td>
<td>5</td>
<td>70</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td><strong>Sindh</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td>2</td>
<td>9</td>
<td>12</td>
<td>73</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td>43</td>
<td>20</td>
<td>4</td>
<td>33</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

The concept of using FP method through mutual consent (Table-2) was evident throughout the two areas studied, although secret use (meaning without informing the husband), opposition to the use - the husband stating why do you wish to use family planning when I am providing for the children - continues to persist. Also in some areas, although rare, yet the idea that FP was a sin also persists. Usually if husband and wife agreed, then the influence of the in-laws, particularly the mother-in-law, was reportedly reduced and in some places, the in-laws were reported being supportive of FP use by the woman.
<table>
<thead>
<tr>
<th>Province</th>
<th>FP-Mutual decision (%)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punjab (for both males &amp; females)</td>
<td>80</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Sindh</td>
<td>Yes</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td>80</td>
<td>20</td>
</tr>
</tbody>
</table>

A very interesting finding was that some men in SV stated that women are free to decide about FP, pointing towards a possible emergence of women empowerment and one lady councillor in the Sindh village reported using FP as her own decision and receiving complete cooperation from her husband. However, this was a minority opinion and still, by and large, women could practice FP only after getting permission from the husband.

As compared to older women (age group 40-50 years), the younger women (age group 21-30 years) in the PV, expressed a strong desire for limiting their family size but could not access FP services. The younger women felt that 2 children were enough whereas the women of the older age group reported a desire for larger families. The inability to access FP services had different reasons, e.g. the BHU did not offer FP services or because the services were too costly.

Thus, despite a potent (unmet) need for FP, the strong (rather very strong) deterrents to FP use and continuation were reportedly cost of buying FP supplies regularly, the reported side effects and lack of money to treat side effects. Other factors like effectiveness (as opposed to failure to prevent a pregnancy), accessibility and availability to good quality and cheap services for treating the side effects, were quoted as important factors too.

**Feroza (wife of Sagheer Hussain)***

**Village PLS**

**District Tando Allahyar**

**Hyderabad, Sindh**

Feroza is 38 years of age. Educated till primary, she was married 22 years ago, at 16 years of age. She has three daughters and two sons. Her husband is a government employee and she herself is a former village councillor. She lives independently, separate from her in-laws. She said that they have no health facility in their village but a Lady Health Worker (LHW) visits the village and distributes 1) contraceptive pills, 2) tablets for strength and sometimes 3) cold and fever medicine for children. She claimed that the injectable hormone is good and if we ask a doctor, they administer it.

---

1. Names have been changed to maintain the privacy of the interviewees
2. Village name has been changed
Feroza said that men voice strong opinions regarding family planning (FP). The opinion of in-laws on FP is not important because if the couple agree, then no one interferes. However, if a woman has an operation (contraceptive surgery or tubal ligation), some people in the street (Mohalla) may comment but now most women have started FP. The decision is mutual - a woman is like a leaf in the wind, she cannot decide on her own. The Dai is available for RH but now the LHW also visits the village. However, the Government has provided no services. Access to health facilities is possible because we call the local Dai (available in the village) for any (RH) ailment. It would be more satisfactory if there were health services available in the village and we would not need to go far for them.

In case of any emergency, her husband takes her to the doctor in the nearby District Hospital Tando Allahyar using hired transport. Feroza gave birth to her first two children at home. The third child was born in a hospital, and the fourth again at home. She had her last child at the hospital. As a home remedy, she asked the Dai to massage her. Fortunately, Feroza has never had any miscarriage.

She said that women go for an ultrasound when the doctor asks them to. The change in the last 5 years is that now men take their women for regular check-ups and follow the doctor’s advice. Also, the town of Tando Allahyar now has a lady doctor.

She mentioned that she had been practicing FP i.e. taking the pill and using hormonal contraception; but she conceived. She said that because she is an independent woman, she talked to her husband and said she did not want this child as she felt unable to raise a small child. Her husband agreed and she went to a Lady Health Visitor (LHV) and had a D&C. It hurt a great deal but she had no choice. The LHV was untrained because after recovery she consulted a Lady Doctor who told her she had developed a wound in her uterus and that was why there was constant bleeding and fever. She treated her for 3 months and now she was better.

The LHV charged her Rs. 2000 for the abortion. Feroza says that her family did not adversely react to her getting an abortion as it was a mutual decision of the couple. The couple are now careful in their use of FP so as to avoid going through another painful episode like that.

3.5 Unwanted pregnancy/ Abortion

In the absence of good quality FP services, women resort to induced abortion to limit family size. This trend seemed to come through far more so in the PV. Interestingly, on first questioning, most people denied this practice but on further questioning or questioning around it, it became clear that it was a common practice.

a) Men’s attitudes towards induced abortion: The constant response of men from the S&P villages, both for Muslim and Christian men, was that induced abortion (IA) was a sin (almost 100% response). In the SV men said that even amongst their Hindu friends, this was considered a sin and they insisted that it was not practiced in their area. However, further probing (discussed below) proved otherwise.

b) Women’s attitudes and induced abortion: Induced abortion seemed to be a common practice for women for FP purposes especially in the PV. Interestingly, as in the case of other RH findings, the richer women were able to get the services of a qualified medical doctor (even a qualified gynaecologist), usually at a private hospital in the town nearest to the village. The
poorer women used the services of the village Dai and had an abortion performed under very unsafe conditions, leading to severe complications and even death was reported. Apart from the medical doctor (in case of the rich) and the local Dai (in case of the poor), others who could be consulted for an induced abortion were the nurse and the local LHV. In fact, all range of female paramedics could be consulted in case of need, however, the LHW in the PV reported that she considered it a sin and would avoid the subject if any woman asked her advice. Also the LHW reported that the government had not given them any medicine for this.

c) Cost of an induced abortion: It was usually an expensive procedure and the cost was equivalent to the month of pregnancy. The fee that was charged was about Rs. 1000/- per month in case of a married woman/girl and much more expensive in case of an unmarried woman/girl.

d) Marital status of women seeking IA: Reportedly, pregnancies were not uncommon in unmarried girls and it was reported that they resorted to induced abortion to get rid of it, especially in the SV. A few cases of unmarried girls getting pregnant and seeking an abortion were mentioned by the Sindhi men. As regards the reaction to such an incident, men stated that no honour killing took place in such circumstances as it was the family's matter and Karo Kari (honour killing) was more common in upper Sindh and not here.

e) Side effects of IA: Secondary infertility following induced abortion in both married and unmarried girls was commonly reported in both villages. Another common complaint was continuous severe bleeding for 3 months and continuous severe pain. Death was also reported following an induced abortion in the PV by women.

f) Reasons for IA and husband's involvement: The reasons quoted for seeking an abortion were manifold and included 1) too many children 2) poverty 3) child too young 4) mother too weak 5) girl too young at marriage 6) newly wedded women who do not want a child immediately. If a woman felt that her husband would oppose induced abortion she went to her parent’s house and had it secretly done there. However, women reported that many times, the husband supported the wife in seeking termination of pregnancy and provided the finances for it too. Sometimes, pressure from in-laws stopped a woman from getting an abortion even when she wanted it herself.

g) Methods adopted for IA: The methods adopted for induced abortion included the traditional ones i.e. inserting something into the vagina which could be an herb or a piece of wood (which usually was quite effective but also dangerous and unhygienic) or ingesting some strong herbal remedy (which may or may not be effective). Modern methods used for abortion included invasive ones like D&C. The use of the MVA was not reported.

h) Post abortion care: Regarding post abortion care (PAC), when poorer women underwent a miscarriage, the local Dai administered methergin to the woman whilst the more well-to-do went to private facilities. However, what was tragic was that women reported that after going through the trauma of induced (unsafe or safe) abortion, usually conducted in the 3rd month, but 4th month pregnancy termination and beyond were also reported, the woman was not put on any FP method or provided any counselling on prevention of pregnancy and was soon pregnant again.
4.1 Conclusions

Data from the field reinforced the entire cross-cutting differentials demonstrated by the PDHS 2006-7 that affect the use of RH/FP and other services. Thus education, age group, income level, all affected the uptake of RH services and the use of FP.

This study also highlighted some hitherto unknown facts and pointed out many significant and challenging aspects of RH in Pakistan. It seems that whereas at one end, people in the community feel that there has been an improvement in the knowledge, awareness and practice (utilization) of RH/FP services, yet on the other hand, it is not the government but the private sector that seems to be fulfilling their RH needs and is more trusted by them.

Men and women nowadays are going towards institutional delivery, antenatal check-ups, ultrasound examinations and there is more FP use amongst the young and/or educated. However, the poorer and the marginalized, the ones who need good quality subsidized government sector services the most, continue to be denied that and depend on unskilled and unsafe health practitioners for fulfilling their requirements.

Media, particularly television, has played a significant role in raising awareness on RH issues and reinforcing desired behaviors, but services continue to lag behind, whereas it should be the opposite i.e. advocacy only after the services have been set up properly.

What has changed little includes post natal care and post abortion care (PAC). These services still remain elusive, patchily available and/or unknown and/or unpopular. Despite many private NGOs coming into the field of RH/FP service provision, and providing good quality PAC, their outreach and impact is still limited. This could be due to the size of the country and it will take a long time for them to reach the villages of Pakistan.

Opposition to FP use, though less, is still found in the community especially amongst the older and more religious minded.

Amongst the newer findings is the information on the needs of the unmarried youth and the ubiquitous (and iniquitous) use of the ultrasound. Unmarried girls/women need FP counselling and reliable services to prevent (unsafe) induced abortion and subsequent sequelae of secondary infertility with all its concurrent severe social problems. Although the ultrasound is amongst the best tools for monitoring the health of the pregnancy, but its use as a sex identifying tool is a dangerous phenomenon that needs further investigation.

An important unmet need that emerged from men was more reliable knowledge on RH/FP, especially in the Sindhi village. Whereas most LHWs are serving women of the communities where they are located, yet being young and unmarried and living in this conservative culture, they are embarrassed and reluctant to discuss issues related to sexual matters with men in the community.

Strong deterrents to FP use and continuation, despite strong (unmet) need that have emerged from the study were 1) cost of buying FP supplies regularly 2) the varied and frequent side effects; many believed that IUDs caused infection and increased bleeding; oral pills caused loss of breath, obesity and leucorrhoea and general FP use resulted in irregular menstruation,
increased bleeding, obesity and infection 3) lack of money to treat side effects, and 4) lack of effectiveness of FP i.e. oft reported FP failure (therefore preferred sterilization as being more reliable). These side effects produced a great deal of fear, and discouraged contraceptive use by women. Such opinions/experiences not only led to cessation of use of FP methods, but also discouraged women/couples from using other methods.

Inter-spousal communication appeared to be better than expected from the literature review, in that in several cases, the use of contraception was by mutual decision. However, there were also several cases where the husband frowned upon use of contraception, nor was his wife independently able to use contraception without his permission. Trends towards progressive change, with greater use of contraception, were particularly evident in younger community members.

Communities, by and large, are well-knit and cooperative towards each other in emergencies, or in times of financial need. However, most tend to remain within their own kind, and are reluctant to mix with people of a different community, as evidenced by the social isolation of the Christian community in the Punjab village.

Younger women appeared more attuned to inter-spousal communication (in that they reported greater use of contraception/fewer children). Some also reported independent decisions about contraceptive usage, though the majority still expected decisions by the husband.

In the absence of adequate RH/FP facilities, women tend to use induced abortion as a method of contraception. This appeared to be a common practice among women. In most cases, the husbands were cooperative and supportive, although there were cases when the wife was unable to share her decision with her husband, and had an induced abortion in secret.

An abortion law permitting abortion in specific cases is operative, but has not been sufficiently publicised. Under the circumstances, an anomalous situation prevails. Some NGOs (e.g. FPAP, MSS) provide safe post-abortion care (PAC) facilities with confidentiality, but neither MoH nor MoPW have made such facilities available to women, with the end result that a high proportion of unsafe abortions continue to occur.

4.2 Recommendations

a. Recommendations for the Government:

The government is signatory to the ICPD Plan of Action (PoA) and pledged in 1994 to provide accessible and affordable RH/FP services to all its citizens according to their need/s. That pledge was reiterated in 2005 and enshrined in MDG 5. However, it is a pledge that remains to be fulfilled. In order to ensure that it fulfils its commitment, following are some recommendations for the government emerging from our study:

i) The government needs to focus on good quality and affordable RH/FP services at the community level by reiterating the focus of the Prime Minister’s Initiative on Primary Health Care and Family Planning (PMIPHC & FP) or the Lady Health Worker (LHW) programme, as it is popularly known, towards this. The LHWs have become too involved in many other health initiatives of the government like polio eradication, malaria control etc. and their focus on RH/FP, for which this cadre was primarily created, has diminished with time.
ii) The public sector health delivery system at the First Level Health Care Facility (FLCF) level i.e. the Basic Health Unit and Rural Health Centre, whilst physically omnipresent and ubiquitous in all Union Councils of Pakistan, needs considerable reform in order to address the RH/FP and PHC needs of the community, particularly the indigent. Public sector health delivery system reform has been tried in different guises by the government i.e. the Public Private Partnership (PPP) model of the Punjab Rural Support Programme (PRSP); the tertiary care hospital adopting Government FLCFs like the Holy Family Hospital, Rawalpindi model etc. Successful models need to be studied and replicated or scaled up.

iii) Furthermore, the genuine need of the public/community to have a functioning public health delivery system needs basic changes in the current system too. These could be pertaining to greater resource allocation towards the public health sector in the national and provincial budgets and/or better career structures of the doctors posted in rural areas and/or on-the-job training on management, supplies and administration of the medics and paramedics posted at the FLCFs and/or a system in place of continuous medical education. Also, improvements in the service delivery can be ensured through standardization of services e.g. the separate system of selling of FP supplies by the LHWs and the Family Welfare Workers should be removed and a homogenous system created and/or enhanced EmOC facilities with 24-hour service provision in keeping with WHO guidelines. Last but not the least, tracking of financial disbursements at the health delivery level can ensure effective utilization.

iv) The concept of a male health educator/FP counsellor at the FLCF level or community level needs to be seriously explored in order for FP practice and uptake to improve in Pakistan.

v) The current provisions in the Pakistan Penal Code regarding abortion law need to be highlighted and the health sector informed on it so as to provide safe abortion services within the existing legal parameters.

vi) Furthermore, the government needs to acknowledge the high incidence of induced and unsafe abortion and initiate a dialogue on it. Also, it needs to make widely available safe abortion facilities as permissible under the law.

vii) The young in the villages of Pakistan are keen to adopt new RH ways. This desire needs to be cashed in and the government needs to focus on their needs and desires. The draft National Health Policy 2009 and the draft National Youth Policy 2006 must develop a greater focus on SRHR for the male and female youth of the country so that their emerging desires are adequately addressed and the current demographic transition becomes the demographic dividend. Each province needs to develop a clear health policy on this too.

viii) The misconceptions regarding FP, whether religious or cultural, need to be continuously and aggressively addressed through organizing dialogues with religious leaders and other stakeholders. The television has proved a popular medium for conveying public health messages, this should be optimally utilised in the future too.

ix) In some areas the minorities and marginalized people in the villages are being neglected. The LHWs can be trained to meet their needs too.
b. **Recommendations for the Donors:**

Donors are effective partners in any development process in a country. However, the important point is that donors work according to evidence-based national priorities and facilitate the change process. Some of the recommendations that emerged from this study which can be aimed at the donors include the following:

i) Initiate dialogues on public sector health delivery system reform, especially for SRHR.

ii) Provide technical support and encouragement to the government for integrated, holistic approach to health, maintaining focus on RH/FP.

c. **Recommendations for the Civil Society Organizations (CSOs):**

Civil Society Organizations (CSOs) or Non-Governmental Organizations (NGOs) have continued to prove that they are important accountability mechanisms for the country. Not only that, they provide the evidence required to change and act as agents of change. Thus they play an important role in keeping the countries development process on course. Of particular importance in this are NGOs like Shirkat Gah working on women’s issues and their resolution, as women continue to be denied their basic human rights. Some of the recommendations that emerged from this study which can be aimed at the NGOs include the following:

i) The NGOs need to remind the government of its obligations through a comprehensive advocacy plan. In this case, the NGOs need to advocate for the following:

   • Increased focus of LHW programme on RH/FP.
   • Introduction of male motivators at the community/facility level.
   • Meeting unmet need with special focus on emergency contraception and examining medical contraception.
   • Challenge the limited outreach of RH/FP services which have led to high rates of unwanted pregnancies, unsafe abortion, maternal morbidity and mortality, and chronically low CPR through advocating for provision of safe abortion services and improving post abortion care and post natal care.

ii) NGOs need to help achieve policy change, by pressurising the government to meet its commitments to the various United Nations conventions, protocols, and conference documents that it has signed, ratified and endorsed. Included in this is the responsibility of NGOs to monitor government compliance on international commitments.

iii) Create awareness about SRHR and SRR in the broader framework of women’s empowerment among women’s groups, NGOs, the media, political parties, and especially women parliamentarians for greater and effective advocacy.

iv) Create awareness among communities they work with to develop their own agency and mobilise to claim their due rights. Engage with duty bearers to deliver on their mandates.
Bibliography


*MDGs: Expanding the Agenda.* Shirkat Gah (2005).


