[Review Article]

Women’s Rights Equal Women’s Lives: The Case of Pakistan

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Abstract

Objectives

The Constitution of Pakistan offer guarantees regarding women’s rights, but unfortunately some laws and also customs violate the above commitments seriously affecting the health of women and even endangering their lives. The purpose of the study is to describe various aspects of women’s health in Pakistan vis-à-vis human rights.

Methods

Review of available literature was undertaken. The scientific electronic database (such as PubMed, Science-Direct & Pakistani database) was searched for women health issues in Pakistan, covering a period from 1980s to present. Published government reports have also been included as sources of information for this paper.

Results

In Asia, Pakistan’s maternal mortality ratio is among the highest; more than half of the women are anemic. Access to health services is deprived whether be it economic, geographical or social. Majority of women are illiterate. Pakistan is among the countries with low gender indices and where female life span is less than men, and men outnumber women. Government spending on health and particularly women health is low compared to other countries.

Conclusion

Women’s disproportionate poverty, low social status, gender imbalances, and inadequate maternal services at the community level play a significant role in contributing to maternal deaths. In view of the fact that given accessible, quality health services, many maternal deaths can be avoided, demonstrates maternal mortality is clearly an issue of human rights.

There is a strong need that health sector spending is increased, role of women health care providers in rural areas be expanded (such as LHW) and involvement of private and NGO sector to fill gaps in service delivery, be ensured. In order to meet the targets of MDGs, the gender dimensions of demographic and social change need to be stressed further in all policies and development plans, which may result in narrowing of gender disparities and improving women lives.

Keywords: Maternal health, human rights, gender discrimination, violence, Pakistan
Introduction

Behind every death in pregnancy and childbirth is a personal tragedy. That tragedy can be understood and approached in many different ways. It is a biological or medical event. It is a health system malfunction. Sometimes it is family or community responsibility\(^1\). It is estimated that throughout the world half a million women die of pregnancy-related complications every year\(^2\). It is widely known that much remains to be done to ensure that women have safe and healthy pregnancies. Especially in Africa, Asia, Latin America, and the Caribbean (where 99% of maternal deaths occur), many women continue to die during labor and delivery because they lack timely access to quality health care. In the developing world, complications during pregnancy continue to be the leading cause of maternal death and disability for women of reproductive age (15 to 49 years)\(^3\) and overall, they account for more than one-quarter of deaths among women\(^4\). Life-threatening complications of pregnancy are generally not preventable or predictable, but when nothing is done to avert maternal death, then natural mortality is around 1000 to 1500 per 100,000 births\(^5\). Hence reduction of maternal mortality by quality service provision is a human rights issue for women and their children\(^6\).

Poor women face greater maternal mortality and morbidity, suffer continuous violence because they lack access to adequate reproductive health services, and are more likely to resort to unsafe, inaccessible, and/or unaffordable abortion services\(^2\). This ultimate tragedy of maternal mortality reflects the cumulative denial of women’s human rights\(^7\).

In the last 20 years, a human rights-based approach has been consciously interwoven with reproductive health care. From HIV treatment for pregnant women in MTCT (maternal-to-child-transmission) prevention programs, to issues of sexuality and maternal mortality\(^8\), human rights principles increasingly inform health policy making and programming\(^9\).

Health situation in Pakistan

Pakistan has a population of approximately 151 million, 67% of whom live in rural areas; 43.4% are under age 15; 21.6% are women of reproductive age.

The crude birth rate is 27.3 per 1000; the death rate 8 per 1000, life expectancy 63 years, and the annual population growth rate 2.4%\(^10\). The maternal mortality ratio is estimated at 350-43510\(^{10}\) to 500\(^{11}\) per 100,000 live births. In 1996, it was noted that communicable diseases and reproductive health problems accounted for more than 50% of total burden of disease\(^12\).

In Pakistan, during the period 1990 to 2002, three National health policies (1990, 1997 and 2001) have been announced. Though all policies and programs have emphasized maternal health, safe motherhood, and availability of female staff, ensuring the provision of emergency obstetric care has received inadequate emphasis\(^13\). Reports indicate that in NWFP and Punjab, most tertiary, secondary and first referral facilities do not provide EmOC (emergency obstetric care services) a key to save maternal lives, or meet the minimum acceptable level set by WHO\(^14\). It is also reported that many people prefer private-sector health services as they consider government hospitals to be of low quality as regards services and care\(^15\). Critical areas of maternal and child health where government investment has not increased include enhancing the availability of 24-hour emergency obstetrical care, interventions for improving mothers’ nutrition, management of reproductive tract infections, and development of referral systems for emergency care\(^13\).

The status of women in Pakistan is not homogenous because of the interconnection of gender with other forms of exclusion in the society\(^16\). It is recognized that in Pakistan, as in many other member states, many women do not enjoy many of the rights laid down in the Universal Declaration of Human Rights. Despite the efforts of the government, many NGOs, CBOs and other women’s organizations, there remains a significant disparity between these statements of principle and day-to-day reality.

There is considerable diversity in the status of women across classes, regions, and the rural/urban divide due to uneven socioeconomic development and the impact of tribal, feudal, and social formations on women’s lives. However, women’s situation vis-à-vis men’s are one of systemic subordination, determined by the forces of patriarchy across classes, regions, and the rural/urban divide. A comparison of some of the
basic health indicators among regional countries is shown in the Table 1.

Study objective: The objective of the paper is to illustrate the various aspects women’s health (i.e. morbidity, mortality), highlight the issues of gender discrimination and access to health services in Pakistan vis-à-vis human rights.

Methods and materials

A methodical review of available literature was undertaken and data was collected for women health issues globally and in particular, Pakistan. The scientific electronic database (such as PubMed, Science-Direct & Pakistani database) was searched using terms such as “Pakistan and women health”, “Pakistan and maternal health”, “Pakistan and women rights”. All published articles which focused on Pakistan and maternal health and human rights issues were reviewed. The articles publication date ranges from 1980s to date. In addition, published documents including government reports have been included as sources of information for this paper.

Result

Health: National Constitution and International commitments

Internationally, human rights have been enshrined in a number of treaties and conventions designed to give legal force to the Universal Declaration of Human Rights7. Pakistan has also adopted several of the national and international commitments to protect human rights and gender equality.

First and foremost, the constitution of Pakistan (1973)17) guarantees equality between women and men. It has the following provisions for affirmative action for women. The constitutions Article no 25 states: “All citizens are equal before the law and are entitled to equal protection before the law; there shall be no discrimination on the basis of sex alone; nothing in this Article shall prevent the state from making any special provision for the protection of women and children”. Other clauses such as Article no 34 states government commitment to ensure the full participation of women in all spheres of national life. Similarly Article no 35 affirms that state shall protect the marriage, the family, the mother and child. Article no 38(d) also insists government commitment on providing basic necessities of life, such as food, clothing, housing, education and medical relief for all citizens, irrespective of sex, caste, creed or race.

In addition, Government of Pakistan has also made various national and international commitments18) with reference to women and gender equality, over fifty years of its existence. These include the International Covenant on Civil and Political Rights (the Political Covenant), the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant), Vienna Conference on Human Rights Conventions and charters on human rights. In addition, there are international treaties directed at the relief of injustices that individuals may suffer on account of an innate characteristic. These include the International Convention on the Elimination of All Forms of Racial Discrimination (the Race Convention), the Convention on the Elimination of All Forms of Discrimination against Women (the Women’s Convention), Convention of education for All (Educational Convention), Vienna Conference on Human Rights (Rights Convention), and the Convention on the Rights of the Child (the Children’s Convention). Moreover, Pakistan is also a signatory to MDGs19), which aims to promote gender equity and equality and focus on interventions to improve women health care.

Women’s health in Pakistan

Gender indices

Pakistan ranks low in terms of gender related human development indicators when compared with countries of similar level of development. It is generally observed that gender discrimination starts earlier in a
woman’s life cycle. Females both as children and growing adults have greater incidence of malnutrition, child mortality, and lesser opportunities in access to education and employment than males. There appears to be a continuation of past trends as females get less education than men, and are discriminated by law as well as socio-cultural traditions and practices in the society such as, their marriage, political rights, or reproductive rights.

Gender disparity can be seen, for example, through the lens of gender related development index (GDI) and the gender empowerment measurement (GEM). In 2004, Pakistan GDI ranking is 120 out of 144 countries, while its GEM ranking is 64 out of 78 countries.

**Population Share and Sex Ratio**

In Pakistan, between the first census conducted in 1951, and the latest census in 1998, the population of Pakistan has increased about four times from 33.8 million to 132.4 million. Recently in 2004, the population of Pakistan is approximately 151 million making it sixth most populous country in the world. Due to the sharp decline in death rate since the 1950s driven by improvements in medical fields unaccompanied by a corresponding change in fertility laid the basis for population growth since 1950s. The population growth rates increased from about 2 percent in the 1950s to 3 percent or over until the 1980s. With the accelerated efforts of national population planning program and other socio economic changes, a decline in fertility and birth rates occurred during the 1990s, there by reducing the birth rate to 2.6 in 1998.

Women form 48% of the total population. Pakistan is one of the few countries in the world where men outnumber women, a result of excess female mortality during childhood and childbearing. The sex ratio frequently is used as an indicator of gender inequality in a society because it reflects gender differentials in mortality. The 1981 Census showed a ratio of 111 males to 100 females, one of the worst in the world. The comparatively low number of women as a percentage of the total population is an indication of precarious living condition. The greater level of deprivation of women and girls is reflected in their lower nutritional status, higher mortality and lower levels of education.

A high sex ratio indicates premature death of females, the source of which could include poor female access to health inputs or social factors resulting in sheer neglect. Pakistan’s recent sex ratio of 105 males per 100 females indicates excessive female mortality. Indeed, female child mortality exceeds male child mortality in Pakistan. In South Asia, apart from Bangladesh, Pakistan has the second highest ratio of preference for sons over daughters. Many women also believed that bearing sons bring them prestige in society. A substantial body of evidence shows that there is discrimination against daughters with regard to food allocation and access to health services and they suffer from high mortality especially during first four years of life. Most recent estimates of mortality ratio is reported to be 1.7 times higher for girls (24 per 1,000 births) than for boys (15 per 1,000 births) between the age group of 1-4 and mortality rate for women between the ages of 20-29 about double to that of men.

**Indicators of Mortality and Life Expectancy**

Generally, the female fetus has higher survival chances than the male fetus in industrialized countries. In addition women usually live longer

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1 The GDI attempts to capture achievement in the same set of basic capabilities included in human development index (HDI) — life expectancy, educational attainment and income — but adjusts HDI for gender in equality.
2 The GEM measures gender inequality in the key areas of economic and political participation and decision-making.
3 The sex ratio also can be influenced by sex ratio at birth, migration, and under-enumeration of females.
than men, for hormonal reasons in most countries. Yet in some developing nations, such as India, Nepal, Bangladesh, and parts of the Middle East life expectancy for males is significantly higher than their female counterparts [36,34,35].

An estimated 400,000 infant deaths and 16,500 maternal deaths occur annually in Pakistan [37]. Thus, infant mortality is still 75 per 1,000 live births and that is one of the highest in Asia [38].

In assessing health status, life expectancy is one of the most useful measures of well-being. Sex disaggregated data on life expectancy data reveals the following trends over the past three decades: (see Table 3)

The above data clearly shows that Pakistan is among those few countries where female life expectancy is less than that of men.

Gender and Prevalence of Anemia

Anemia is also among the leading causes of high maternal mortality [32]. Iron deficiency anemia, often associated with folic acid deficiency, is a major public health issue associated with adverse health outcomes and decreased work productivity. Evidence from Pakistan’s national health and nutrition survey reveals that a significant proportion of women suffer from malnutrition, Vitamin A and D deficiency and anemia in pregnancy [39]. Anemia is more prevalent among females than males in each age category. Particularly in the 15-24 and 25-44 age groups, there is a clear pattern of anemia among women then men. This high prevalence in childbearing ages is of particular concern, since anemia is one cause of low-birth-weight babies [39].

Trends in Maternal Mortality

Pakistan has high maternal mortality ratio (MMR) [40]. An estimated 16,500 maternal deaths occur annually in Pakistan [37]. During the 1990s, Pakistan Fertility and Family Planning Survey [41] gives estimates of 533/100,000 live births. A multi-year population based study reported in 1994 MMR varying from 286 per 100,000 live births in Karachi to a maximum of 630 per 100,000 live births in Balochistan province. Recent national estimates (2005) of MMR are 500 per 100,000 live births [11]. This translates into a lifetime risk of dying, that is, it is estimated that one of every 38 women dies due to causes related to childbirth [33].

Many factors contribute in aggravating maternal mortality. Evidence shows that almost 80% of maternal deaths are directly due to obstetric causes and result from hemorrhage, infections, eclampsia, obstructed labor, and unsafe abortions [5]. While hepatitis being the most frequent indirect cause of maternal death [33].

Table 3: Life expectancy in Pakistan (1970s-2002)

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
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<tbody>
<tr>
<td>1970s</td>
<td>53</td>
<td>52</td>
</tr>
<tr>
<td>1980s</td>
<td>59</td>
<td>59</td>
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<tr>
<td>1985-6</td>
<td>59</td>
<td>60</td>
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<tr>
<td>1990-1</td>
<td>60</td>
<td>61</td>
</tr>
<tr>
<td>1995-6</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>2002</td>
<td>63.7</td>
<td>63.4</td>
</tr>
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Domestic violence, rape & abortion issues

Few countries have reliable estimates on the prevalence of domestic abuse [43]. Gender violence generally encompasses physical, sexual or psychological harm or suffering to women including threats and coercion. In Pakistani setup women are encouraged to be subservient and wife battering, conflict with spouse and in-laws are common problems. In few studies almost 1/3rd of women had experienced physical violence; most common causes of abuse were financial constraints, presence of in-laws or children [45,42].

Hudood ordinance; is a series of Islamic decrees, refers to punishments in the Quran for adultery and fornication; enforced in tandem with the country’s secular legal system which derives from British common law [46], that were passed in 1979. One of the most controversial provisions of the Hudood ordinance states that a woman must have four male witnesses to prove rape, or else face charges of adultery herself. Criticisms of Hudood have been many and severe, as it adversely affect the most marginalized sections of Pakistan’s society - women and minorities [47]. The HRCP Report cites official government statistics according to which about 1,000 women were murdered last year in honor killings, another 10,000 were raped, and thousands more were victims of domestic violence, including 42 women...
who were attacked with acid and 19 flogged. Some surveys have indicated that 78 per cent of women workers have suffered harassment of one kind or another.

The right of women to safe abortion services is also a basic reproductive health right. Women should have access to quality services for the management of complications arising from abortion. In Pakistan abortion is allowed under special circumstances to save mothers life, due to fetus genetic malformations or in case of rape. Reliable national data is not available; a hospital study showed induced abortions rates up to 13.5%. Many unwanted pregnancies are result of high unmet need and ineffective use/failure of contraceptives. Thus driving many women to unsafe and illegal abortions by untrained persons causing further risks to life and even death.

Access and utilization of health services

Complex social, economic and cultural factors are barriers to access and utilization of health care for women. In Pakistan, Gender inequalities restrict women’s access to health care as they face social constraints in managing their own health and that of their children.

Women’s in ability to travel alone, as and when they wish is viewed as an important barrier to improving their health. Majority of women report they are unable to go to a health facility unaccompanied; especially family male members accompany them to health facilities. Access to reproductive health (RH) care is a major critical factor in determining outcomes for Pakistani women. The available evidence shows that a significant number of women have no access to modern health services particularly during pregnancy and childbirth. Studies concluded that family planning/RH clinics are accessible to only 10 percent of the population, with only 5 percent living within easy walking distance, only 50% received antenatal care at last birth and those who had their delivery attended by a skilled health attendant was lower still, more so in rural areas. Another important issue is that many women also feel uncomfortable to discuss reproductive health issues with male doctors and demand female doctors.

Most notable change to increase access and empower women, was introduction of Lady Health Workers (LHW) program in mid-1990s, based on the concept of doorstep, community based services and referral systems thus circumvent the proscriptions against woman’s movement; covering 60% of population. The workers may particular be effective if they can provide high quality information and encourage ideational change, as well as being source of services. The employment of female fieldworkers, who visit women in their homes had increased uptake of, services specially family planning and immunization.

Education & Women

Education is a human right and is central to development, social progress and human freedom. Education makes women more productive both inside and outside the household. An educated mother can plan the size of her family, ensure the well-being of her children, and make better use of community services. Outside the home, a women’s education is associated with higher productivity in wage employment and in agriculture. Educated women are also more likely to participate in the political process; illiteracy is a major obstacle in accessing relevant information and dealing with electoral procedures and political issues.

The experience of the 1990s is far from desirable in Pakistan, but some trends provide evidence for cautious optimism. The overall literacy rate in Pakistan has been improving albeit at a very slow pace, at the rate of 1% or even less per annum. It is alarming to note that share of female illiterate adults has been increasing over the years, from 52% of 28 million to over 60% of 48 million today. Of the 151 million Pakistanis, unfortunately, of the illiterate population in Pakistan, 47% are males and 71% are females. It is unfortunate that education of women is not considered a mean for social change or a process by which they can learn to question, think and become agents of change. Statistics indicate there has been under-investment in human capital. Pakistan ranks 142nd out of 177 countries in the human development rating. The Government expenditure on Education remains only 1.7% of GDP.
Maternal Health Related Public Spending

Expenditure in the health sector in general, and Maternal and Child Health (MCH) in particular is not well documented. The World Bank estimates that MCH services account for a share of total cost at primary level ranging from 6 to 17%, and 1 to 3% at secondary care level\(^2\).

Estimated total expenditure on health in Pakistan is US$ 18 per capita of which the total government health expenditure (GHE) is US$ 4 per capita. This compares unfavorably with the figure of US$ 34 per capita\(^{69}\) for a package of essential health services as proposed by WHO\(^{70}\). As a percentage of GDP, GHE was 0.7% in early and mid 1990s, decreasing to 0.5% in early 2000s\(^{71}\). For comparison, the corresponding figure for all low-income countries between 1990 and 1998 was 1.3% of GDP.

Discussion and conclusion

Gender discrimination is a global concern for women and all those who provide health services to them. The link between health and the lack of basic human rights is vivid throughout the life cycle of girls and women. Maternal mortality in developing countries is a major tragedy of inequity and social injustice. It should not be considered simply as a health problem. It is a human rights issue on which countries should be held accountable\(^{5}\). Several years ago, Rebecca Cook\(^{72}\) noted that the continued alarmingly high number of maternal deaths throughout the world is a result of years of inattention to the basic human rights of women with regard to safety and security of person.

For years, women in Pakistan have been disadvantaged and discriminated against. They have been denied the enjoyment of a whole range of rights-economic, social, civil and political rights and often deprivation in one of these areas has entailed discrimination in another. Gender is one of the organizing principles of Pakistani society. The values embedded in local traditions and culture predetermines the social value of gender. An artificial divide between production and reproduction, created by the ideology of sexual division of labor, has placed women in reproductive roles as mothers and wives in the private arena of home and men in a productive role as breadwinners in the public arena. This has led to a low level of resource investment in women by the family and the State. Thus, low investment in women’s human capital, negative social biases, and cultural practices; the concept of honor linked with women’s sexuality; restrictions on women’s mobility; and the internalization of patriarchy by women themselves, becomes, the basis for gender discrimination and disparities in all spheres of life.

Women, who have been denied social rights including the right to education are also often, denied the right to decide in matters relating to their marriage and divorce. Decision making role of women has been nominal due to their lack of access and control over resources including finances, lower educational and skill levels, limited mobility due to cultural restrictions and heavy requirements of domestic roles.

The fact that more than 16,500 women in Pakistan are estimated to die every year from pregnancy and child-related causes reinforces the importance of ensuring that all pregnant women receive adequate medical care during pregnancy and deliveries.

Beyond the medical causes of death, several factors play important roles leading to maternal death. A number of socioeconomic and health factors put women at high risk of death during childbearing and these include age (too young, too old) poor nutrition during pregnancy, too many births, high unmet need for family planning, poor access to health services, low status of women, illiteracy and over all poverty.

In order to increase access of these women to reproductive health services the policy makers need to take evidence based decisions. For example, to increase social access, in the current societal setup there is a due demand for female doctors and nurses in rural areas, there is also a demand to increase access to abortions services to women with unwanted pregnancies occurring due to unmet need or method failure, who, if quality services not provided, will access unqualified workers and many of them would die due to complications.

Health and Education is a basic human right and is central to development, social progress and human freedom. It should be promoted by governments at priority basis irrespective of gender, caste, creed or race.

Pakistan ranks low in terms of gender related human indices and life expectancy of women are less then
men, an uncommon observation. There is a strong need to change the mindset and develop a societal vision; where education for women should be considered a mean of social change, where access to health care is not an issue, where women have rights over their own lives and bodies. Initiatives such as LHW program can increase the access to health and empowerment of women.

It is also a requisite that principles of human rights should be incorporated at all levels of programming and policy making regarding reproductive health. Rights include non-discrimination and equality, a focus on the dignity of the person, freedom of information, and protection of physical integrity. The Hudood ordinance, most criticized for making it exceptionally difficult and dangerous for women to prove an allegation of rape, needs to be amended and revised to offer appropriate legal protection to women and minorities.

Gender equality is considered a necessary, though not sufficient, condition for social and economic development. In present times, where women make half of the population, if due attention for capacity building and attention to their health issues is not done, then in the coming decades the country will be increasing facing the social and economic burdens. As development remains an incomplete process unless we include both men and women at all levels of social, economic and political functioning.

Improving women’s health requires a strong and sustained government commitment, a favorable gender sensitive policy environment, resolute advocacy from the private sector activist and civil society, recognizing their right to safe motherhood and well-targeted resources. Long-term improvements in education and employment opportunities for women will have a positive impact on the health of women and their families.

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