

POVERTY, GENDER INEQUALITY AND SOCIAL EXCLUSION AND THEIR IMPACT ON MATERNAL AND NEWBORN HEALTH IN PAKISTAN

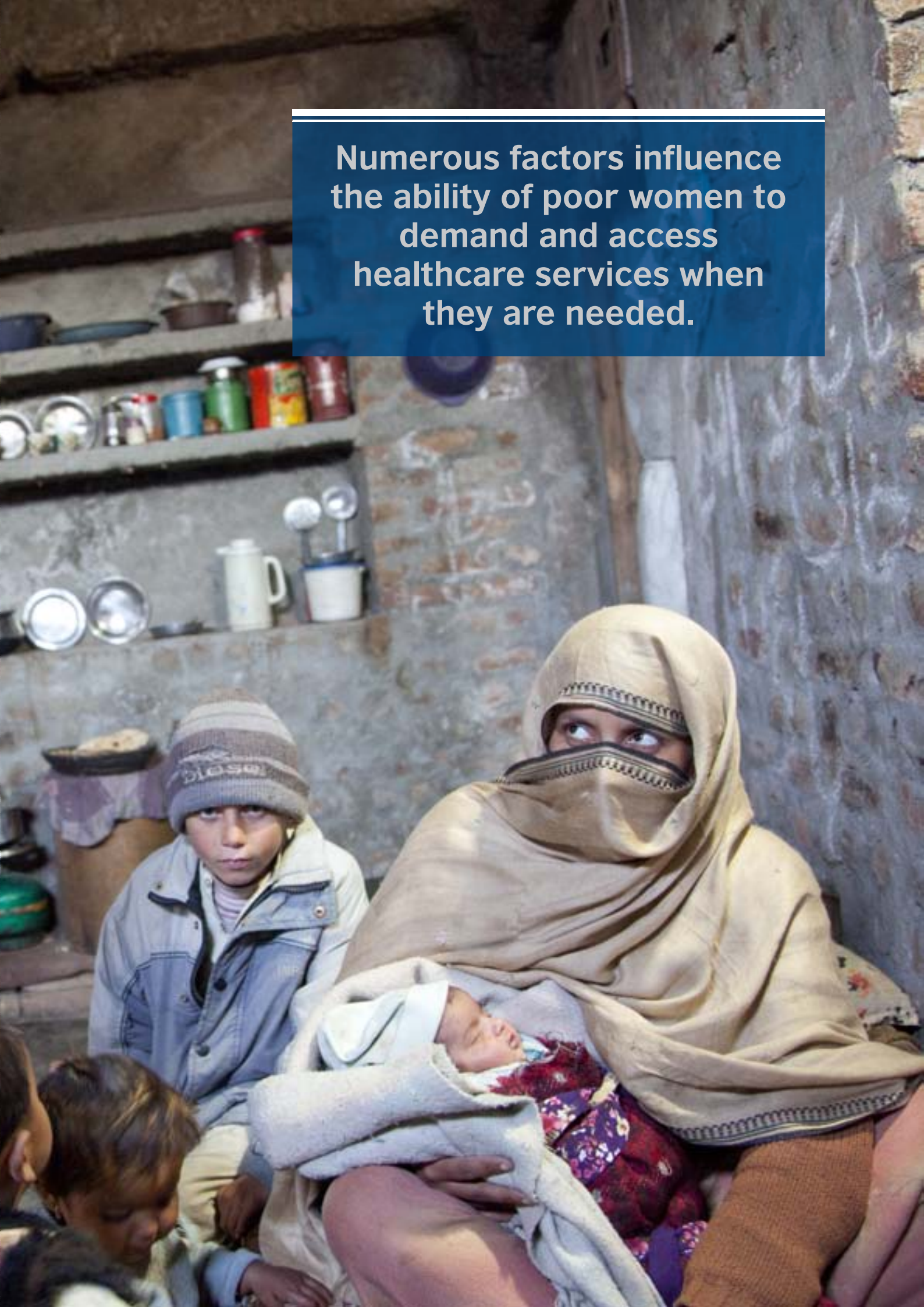
A Briefing Paper

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Numerous factors influence the ability of poor women to demand and access healthcare services when they are needed.



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URDU TERMS

<i>Biraaderi</i>	Extended kinship network
<i>Burqa</i>	A loose outer garment covering the entire body, worn by Muslim women in public places. Generally, the burqa is understood to include the Hijab (head covering) and the Niqab (a face veil with opening for the eyes only).
<i>Dai</i>	Traditional birth attendant
<i>Dunia dari</i>	Conforming with norms of society
<i>Hakeem</i>	Physician
<i>Napaak</i>	Impure
<i>Mard</i>	men conforming to the socially acceptable notions of hegemonic masculinity
<i>Mohalla</i>	Neighbourhood
<i>Purdah</i>	Seclusion of women from the sight of men or strangers,
<i>Sharam</i>	Shame
<i>Unani</i>	Greek (medicine)
<i>Zaat</i>	Caste

LIST OF ABBREVIATIONS

AusAID	Australian Agency for International Development
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BHU	Basic Health Unit
BISP	Benazir Income Support Programme
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMW	Community Midwife
DFID	Department for International Development
DHIS	District Health Information System
DHO	District Health Officer
DHQ	District Headquarter (Hospital)
EmOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunisation
FATA	Federally Administered Tribal Areas
FP	Family Planning
GDP	Gross Domestic Product
GEM	Gender Empowerment Measure
HMIS	Health Management Information System
IDP	Internally Displaced Person
KPK	Khyber Pakhtunkhwa
LHW	Lady Health Worker
LHV	Lady Health Visitor
LMO	Lady Medical Officer
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Newborn Health
MSDS	Minimum Service Delivery Standards
NGO	Non-governmental Organisation
NHA	National Health Accounts
OOP	Out of Pocket
PAC	Post Abortion Care
PDHS	Pakistan Demographic and Health Survey
RAF	Maternal and Newborn Health Programme Research and Advocacy Fund
RHC	Rural Health Centre
RMNCH	Reproductive, Maternal, Newborn and Child Health
RSP	Rural Support Programme
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
THQ	Tehsil Headquarter (Hospital)
TT	Tetanus Toxoid
UN	United Nations
UNDP	United Nations Development Programme
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHO	World Health Organisation



Executive Summary

The Maternal and Newborn Health Programme Research and Advocacy Fund (RAF) is a five year national programme funded by the Department for International Development (DFID) and Australian Agency for International Development (AusAID) to improve practices and supporting policies related to Millennium Development Goals (MDG) 4 (to reduce child mortality) and MDG 5 (to improve maternal health) with a focus on the poor and marginalised people in Pakistan. In order to do this RAF funds quality non-clinical research to generate evidence and effective advocacy initiatives. Poverty, gender and social exclusion constitute a central focus of the RAF and its funded projects.

This paper aims to build understanding as to why **gender and social exclusion ‘matter’ to maternal and newborn health**. Specifically, it aims to provide a brief overview of the gender and social inequalities in Pakistan; and explore how these influence health policy and planning; delivery of maternal and newborn health services; and women’s ability to exercise choice and control over the decisions that affect their well-being. The paper is based on a review of literature from Pakistan and, to a lesser extent, other South Asian contexts, and aims to present the evidence that illustrates the impact of the various social and political dynamics that affect maternal and newborn health.

Health service provision and coverage is uneven, and there are significant disparities in terms of access to healthcare and health indicators between the poorest and wealthiest quintiles, urban and rural areas, as well as between and within provinces. Pakistan’s health

budgets also remain extremely low compared to other countries in the region.

It is increasingly recognised that the lack of provision of adequate basic health services, trained staff, adequate medical supplies and equipment have a direct impact on maternal mortality. However, **underlying factors such as socio-cultural structures and dynamics which operate at the state, community and households levels to discriminate against women and girls, prevent them from accessing and utilising quality health services**. Social exclusion also keeps certain groups disadvantaged because of discrimination on the basis of their gender and/or social identity. Understanding the concepts of poverty, gender inequality and social exclusion helps to better understand the socio-cultural barriers and dynamics of the Pakistani society that contribute to poor health outcomes, especially for women and children.

There are significant differences between maternal and newborn mortality indicators for the poorest and richest households. Poverty can increase vulnerability to causes of mortality, such as maternal infections and under-nutrition. The poor are also materially excluded from accessing health services through cost—in terms of fees for services, travel costs, the cost of medication and the opportunity cost of having to take time off work.

Poor women’s utilisation of maternal health services is shaped by various factors. These include the overall governance of the health sector, and government planning, budgeting, and decision-

making; the actual delivery of affordable and quality services; and the existence of social and cultural 'demand-side' barriers which affect poor women's ability to demand healthcare. Poor women's lack of voice, policy makers' lack of attention to the needs

Pakistan has some of the worst maternal and child health indicators in South Asia.

of the poor, and poor women's dependent status and lack of decision-making authority at all levels characterise many of these factors, and affect the availability of, and poor women's access to, quality maternal healthcare services in various ways.

The type and quality of services available to poor women are largely dependent upon decisions made in central, provincial or district government regarding **prioritisation of women's health issues and allocation of resources to maternal health services.**

The allocation of resources to the health sector, and the management of those resources are shaped by various political and institutional factors, including centralised systems, corruption and poor accountability mechanisms. Reproductive health has relatively few champions, and is generally given a low priority in government planning and decision-making. In addition, politics as a whole, and therefore **election campaigns are not connected to social issues.** It is hoped that as a result of the devolution of the Ministry of Health, provincial parliaments will take greater responsibility for ensuring that budget making and spending is fair, transparent and accountable. However, questions remain about the actual impact of devolution in terms of service delivery to the poor, and reducing inequalities between groups.

Currently, the **participation of citizens - and particularly poor citizens - in decision-making and policy formulation is weak.** Formal horizontal accountability mechanisms are also weak. There

have been some initiatives to support monitoring and management at the district level (such as the PAIMAN's District Health Management Committees) however, there remain questions about their sustainability. There is also little evidence of client feedback mechanisms that enable patients' perspectives to be taken into account when evaluating services.

A key barrier to demanding accountability is the **lack of information and data on service delivery performance and health outcomes.** While there is a culture of reporting, performance monitoring and evaluation remain limited. The public health surveillance system is also fragmented and unable to generate the data required to make public health decisions, or hold service providers accountable.

Pakistan has a good network of primary health facilities and hospitals. However, **many facilities are in disrepair, damaged or destroyed by conflict or disasters or too far from remote communities.** At the facility level, there are significant problems with **insufficient numbers of health workers,** absenteeism and low motivation and quality. Both basic and comprehensive healthcare facilities often lack the **minimum levels of drugs and equipment** needed to provide effective maternal care. Two-thirds of births in Pakistan occur at home. Home births are more common in rural areas than urban areas. They are also more common among women with little or no education. The majority of births are not attended by skilled birth attendants and many women receive no pre-natal care at all.

Satisfaction with government health services is also low. Clinic staff and community workers are not trained to respond to patients' circumstances, to expand discussion beyond their immediate needs to their wider reproductive health concerns, and to engage them in discussion regarding reproductive healthcare solutions. Thus, even amongst poor communities, there is **widespread use of the private sector for health services.** However, the private sector is largely unregulated, and various negative practices such as overcharging patients, unnecessary prescription of drugs and advising clinical tests without indications have been reported.

Nearly all users of government facilities pay **out of pocket (OOP) costs**, which can expose families to large unexpected expenses. There is increasing evidence that OOP payments act as a significant financial barrier to essential healthcare and are a source of impoverishment. **Long-distance travel to healthcare facilities** is also a major barrier to accessing healthcare services, particularly for women who may have restrictions placed on their mobility or who may not be able to afford the transportation costs or the time needed for travel. **Access to emergency care** is, therefore, a particular issue for poor women.

There are various 'demand-side' factors which influence the ability of poor women to demand better services when they are needed. **Low levels of girls' education** limit women and girls' health-seeking behaviour by depriving them of the knowledge and tools to recognise symptoms of disease and make informed health decisions. Lack of education and access to information can also result in strengthening of **traditional beliefs and practices**, some of which can prove harmful to the health of women and babies. A low level of education is also an important factor in determining whether a woman bears children at a young age. Infant and child mortality rates are also lower among children whose parents are more highly educated.

Low levels of individual autonomy amongst women in Pakistan results in poorer health outcomes, as women are unable to make decisions regarding the need for care, and accessing healthcare services. As men control the household's resources, it is they and older family members who play a paramount role in determining the health needs of a woman, and deciding when and where she should seek healthcare. **Limitations on the physical mobility of women and girls** also impact their access to healthcare services.

There is **significant unmet need for family planning in Pakistan, particularly in the rural areas**. Levels of women's education are positively associated with low rates of use of contraceptive and antenatal care in Pakistan. Poor women's inability to exercise control over their own bodies and reproductive activity due to patriarchal cultural norms also affects the uptake of contraceptive

Factors such as socio-cultural structures and dynamics which operate at the state, community and households levels to discriminate against women and girls, prevent them from accessing and utilising quality health services.

methods. Unplanned pregnancies are the main reason why women seek induced abortions, and many poor women often resort to unsafe abortions, which carry serious risks to their health, and the risk of post-abortion complications.

Pakistan is subject to various forms of conflict and violence and over the past decade has experienced two devastating natural disasters - the 2005 Kashmir Earthquake and the 2010 Floods. **Many of the areas affected by the conflict and disasters in Pakistan were already experiencing significant health system failures and high maternal mortality and morbidity risks**. The onset of the conflict or emergency situations has served to further undermine maternal and newborn health in various ways. The immediate effects include the destruction of infrastructure, the exodus of health professionals (and particularly female health workers), and the diversion of resources away from health. Women's access to health services is also affected by the prevailing insecurity, and displaced women can experience particular difficulty in accessing safe delivery and emergency obstetric care. Conflict, disasters and displacement can also increase food insecurity, and affect nutrition levels and vulnerability to disease and illness. There is also the risk of increased levels of gender-based violence, and the sexual exploitation of young girls and women.



Introduction

Funded by the Department for International Development UK (DFID) and Australian Agency for International Development (AusAID) the Maternal and Newborn Health Programme - Research and Advocacy Fund (RAF) is a grant making fund with the aim to support research and advocacy initiatives to influence pro-poor policy and practice reform related to maternal and newborn health in Pakistan. Poverty, gender and social exclusion constitute a central focus of the RAF.

This paper aims to build understanding of the impact of poverty, gender and social exclusion on maternal and newborn health and their significance in RAF funded research and advocacy initiatives. Its particular objectives are to:

- Provide a brief overview of the gender and social inequalities in Pakistan and their implications for maternal and newborn health.
- Explore how social exclusion and gender inequalities manifest themselves in terms of health policy and planning, women's access to health services, as well as women's ability to exercise choice and control over the decisions that affect their well-being.

2.1 Methodology

This paper is based on a comprehensive desk review of recent published documents (donor reports, journal articles, book chapters) dating from 2000 onwards. As far as possible, the review looks at the social, economic, political and cultural barriers faced by women or groups excluded on the grounds of one or more of the following factors: ethnicity, race,

religion, caste, descent, age disability, HIV status, migrant status, region/place of residence. It focuses on the evidence (quantitative and qualitative) that illustrates the impact of the social and political dynamics that affect maternal and newborn health.

Whilst gender and social exclusion issues in Pakistan have received increased attention in recent years, there remains a paucity of research and data on their impact on health. Therefore, the paper also draws on insights from Pakistan's health sector in general, and to a more limited extent, from other South Asian contexts.

The paper is structured as follows:

- The context of maternal and newborn health in Pakistan;
- An overview of gender and social inequalities in Pakistan;
- A briefing on the interplay and impacts of gender inequality and social exclusion on maternal and newborn health in Pakistan; and
- A more detailed examination of how these affect policy making on maternal and newborn health; the provision of reproductive health services; and women's ability to access and use these services.



Context

Pakistan has some of the worst maternal and child health indicators in South Asia. Some of these are as follows:

- The maternal mortality rate in Pakistan is around 276 per 100,000 live births.¹
- An estimated 30,000 women die each year, the equivalent of one woman dying every 20 minutes.²
- Among women aged 12 to 49, complications arising out of pregnancy and childbirth are the leading cause of death and account for 20 per cent of all deaths for women of childbearing age.³
- For every mother who dies from pregnancy and childbirth complications, 20 women are left suffering severe injuries and lifetime disabilities such as obstetric fistula.⁴
- The infant mortality rate in Pakistan is 42 deaths per 1,000 live births.⁵
- One in every eleven children in Pakistan dies before reaching his or her fifth birthday, and more than half of these deaths occur during the first month of life.⁶

According to the 2006-7 PDHS, postpartum haemorrhage is the leading direct cause of maternal deaths, followed by puerperal sepsis and eclampsia. Obstetric bleeding (postpartum and antepartum haemorrhage) is responsible for one-third of all maternal deaths. A significant proportion (8 per cent)

of maternal deaths is attributed to treatment failure or complications of medical procedures.⁷ Obstetric embolism is another important direct cause of maternal mortality (6 per cent). Another 6 per cent of maternal deaths are attributed to complications of abortion (either sepsis or haemorrhage). All of these causes can, in the most part, be prevented.

While there has been progress in reducing maternal mortality and under-five mortality in Pakistan, this has levelled off over the last ten years, and Pakistan will not meet its targets for MDGs 4 and 5 by 2015.

Pakistan's health budgets remain extremely low compared to other countries in the region, and the recommended WHO levels of expenditure. Over the past ten years, the health sector's share of GDP had remained relatively static; at between 0.5-0.7 per cent. According to Planning Commission data, in 2011, this fell to 0.23 per cent of GDP.⁸ It is argued that the lack of investment in women's health and poor access to services is underpinned by gender inequality and limited recognition in practice of the rights of poor women to good quality maternal health services. However, there is very little analysis of how issues of poverty, gender and social exclusion influence healthcare policy formation, resource allocation, the design and delivery of maternal health services, and disadvantaged women's access to health services.

¹ PDHS 2006-2007

² Khan et al (2009)

³ PDHS 2006-2007

⁴ UNICEF (2008)

⁵ PDHS 2006-2007

⁶ Ibid.

⁷ In some instances, though, the reported delay in receiving care or inadequate care may not have been real but perceived to be so by the family. Nevertheless, the availability and quality of emergency obstetric care is a matter of great concern in the country; two other studies (one in Sindh and the other in Punjab) have shown similar results (Siddiqui et al 1999; Fikree et al 2006).

⁸ Pakistan Economic Survey 2010-2011



Health service provision and coverage is uneven, and there are significant disparities in terms of access to healthcare, and health indicators, between the poorest and wealthiest quintiles, urban and rural areas, as well as between and within provinces. These have been exacerbated by increased conflict and humanitarian disasters.

- Women living in rural areas are at double the risk of dying of maternal causes than women living in urban areas – a maternal mortality rate of 319 and 175 deaths per 100,000 live births respectively.⁹
- The maternal mortality rate in the province of Balochistan is 785 deaths per 100,000 live births.¹⁰
- Under-five mortality is 28 per cent higher in rural areas than in urban areas (100 and 78 deaths per 1,000 live births respectively).¹¹
- Infants are 1.6 times more likely to die in Balochistan than in Punjab.¹²

These indicators are a result of poor, rural women's limited access to the continuum of care required to ensure maternal and newborn health. Antenatal visits are significantly lower in rural areas, where only 20 per cent of women make four or more antenatal care visits compared with 62 per cent of women in major urban settings.¹³ The use of modern contraception is also fairly low and there is high

unmet need. Total fertility ranges from 4.3 children per woman in Khyber Pakhtunkhwa (KPK), 4.1 in Balochistan and 3.9 in Punjab.¹⁴

The difference in fertility rate between the lowest quintile and the highest quintile is 5.8 and 3.0. Contraceptive prevalence ranges from 15 per cent in Balochistan to 32 per cent in Punjab. An estimated 197,000 women are treated each year for complications resulting from unsafe abortions. Many unintended pregnancies result from ineffective use of contraception, lack of funds to pay for contraception, inaccessible family planning services and misconceptions about risks of contraception.¹⁵

The latest National Nutrition Survey (2011) indicates that childhood and maternal under-nutrition have either stagnated or become worse in Pakistan over the last ten years. Almost 43.7 per cent of children under the age of 5 in urban areas, and 46.3 per cent in rural areas are stunted. 15.1 per cent children are wasted and 31.5 per cent are underweight. 44.6 per cent of mothers in urban and 57 per cent in rural areas are underweight. 30 per cent of mothers reported subclinical vitamin A deficiencies. 58 per cent households nationally, 72 per cent in Sindh and 63.5 per cent in Balochistan reported facing food insecurity.¹⁶

⁹ PDHS 2006-2007

¹⁰ Ibid.

¹¹ UNICEF (2008)

¹² Ibid.

¹³ Ibid.

¹⁴ PDHS 2006-2007

¹⁵ Population Council (2004). A further RAF-funded research project is due to commence in April 2012

¹⁶ National Nutrition Survey (2011)

Poverty, Gender Inequality and Social Exclusion in Pakistan and their Impact on MNH

It is increasingly recognised that the principal barrier to achieving large-scale reductions in maternal and newborn mortality rates is the lack of attention paid to the broader, social, cultural and political factors at work in particular contexts which affect women's access to health services. A recent article in the *Lancet* notes:

“A medicalised and technological approach to MDGs 4, 5, and 6 has [...] marginalised the analysis of gender equity as a root cause and contributing variable to maternal and child health, and is reflected in the absence of a gender focus in public health policies and programmes. Technological fixes [...] will not by themselves achieve long lasting change for future generations [...] MDG 3 is not just a goal in itself but a driver for all the MDGs, and is intimately linked and causally connected to MDGs 4, 5, and 6.”¹⁷

The concepts of gender and social exclusion are ways in which to understand and account for these broader factors. And as Figure 1 (see page 22) shows, while the lack of provision of adequate basic health services, trained staff, sufficient medical

supplies and equipment has a direct impact on maternal mortality, the underlying causes of these deaths are socio-cultural structures, which discriminate against women and girls, and prevent them from utilising services.¹⁸ Gender-based inequities shape women's access to education, ability to travel, financial and social resources, participation, and decision-making authority in key aspects of their lives.

Poor women's lack of voice and their lack of representation in decision-making structures results in a social silencing of their needs. As a result their needs are inadequately reflected in policy-making and planning processes. The needs of women from socially excluded groups are even more invisibilised. In fact, a combination of poverty, gender inequality and social exclusion can contribute to the ‘three delays’ that most maternal deaths are attributed to. These are:

- Delays in deciding to seek medical care.
- Delays in reaching the appropriate medical facility.
- Delays in receiving adequate and appropriate treatment.

The Constitution of Pakistan upholds the principles of equal rights and equal treatment of men and women. However, as is the case in many developing countries, social exclusion in Pakistan keeps certain groups disadvantaged because of discrimination on the basis of their gender and/or social identity. Not only are these groups more likely to be poor,

¹⁷ The *Lancet* (2010), p.1939

¹⁸ These issues also make it harder for the poor to exit from poverty on a sustainable basis – because the “rules of the game” around gender and social exclusion kick in when external shocks occur, so that those on the borderline of poverty sink back into it. This is particularly important for external shocks due to the illness of a family member, particularly the main breadwinner.



exclusionary norms and practices can restrict them from benefiting from development, and render them invisible.¹⁹

Box 1.

Definitions of Gender and Social Exclusion

Gender: Sex refers to the biological and physiological characteristics that define men and women e.g. women can become pregnant, men cannot. Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

Social Exclusion: Social exclusion is a process by which certain groups are systematically disadvantaged because they are discriminated against on the basis of their identity, i.e. ethnicity, race, religion, sexual orientation, caste, gender, age, disability, HIV status, migrant status or where they live. Discrimination occurs in public institutions, such as the legal system or education and health services, as well as social institutions like the household.²¹ Social exclusion is a context-specific concept, which highlights how different deprivations (e.g. unemployment, lack of political voice) can compound each other and affect a particular group or groups of individuals through both formal and informal channels.

Gender inequality is a particularly prevalent form of exclusion. Significant gender disparities - which cut across all classes, sectors and regions of the country - exist in Pakistan. Gender disparities can compound other forms of social exclusion to trap people in poverty. Poor women²⁰ who are from ethnic, religious or caste minorities can be triply disadvantaged – by their poverty, gender and social status.

Societal perceptions of women as lower status dependents - which are reinforced by customary practices and existing laws - constitute the primary barrier to gender equality. The social exclusion of women is thus enforced by the (informal) institution of patriarchal power structures, which are entrenched in social, cultural and religious systems across Pakistan. The additional barriers described below serve to collectively deny women opportunity as well as access to health and other services.

The sections that follow outline the evidence on the impacts of poverty, gender inequality and social exclusion on maternal and newborn health. It is important to remember that the size and diversity of Pakistan means that there are significant socio-cultural differences between and within communities as well as provinces.

¹⁹ DFID (2008)

²⁰ While gender is about more than just women, the particular situation in Pakistan means that analysis of women's status is particularly needed. However, the role of men and how to engage with them to bring about change to women's health is also an issue that should be addressed in greater detail.

²¹ DFID (2005)

Gender inequality in Pakistan

Low prioritisation of girls' education. In Pakistan, overall literacy is only 44 per cent while adult female literacy is less than 30 per cent. There is a large literacy gap between men and women. In 2008, the gender parity index²² in primary, secondary and tertiary education was 0.83, 0.76 and 0.85 respectively.²³ The literacy rate for urban women is more than double the rate for rural women.²⁴ In Balochistan and FATA, the rural female literacy rate is less than 10 per cent.²⁵

Limited ability to enter waged employment. In 2007, only 13 per cent of those employed in the non-agricultural sector were women. In 2009, UNDP's Gender Empowerment Measure (GEM) - which measures the extent to which women participate in economic and political life through tracking the share of seats in parliament held by women; the number of female legislators, senior officials and managers; the number of female professional and technical workers; and the gender disparity in earned income - ranked Pakistan 99th out of 109 countries.²⁶

Lack of control over income and assets. Although there are no legal restrictions to women's ownership rights in Pakistan, discriminatory traditions and norms prevail. Women have the right to access to land, but data suggests that the share of female land ownership is very low. Women are also entitled to access bank loans and other forms of credit, and a number of credit institutions now target women. However, their access is limited by their inability to provide the required collateral²⁷ and restricted mobility. In addition, whilst women may inherit from their fathers, mothers, husbands or children, their share is generally smaller than that to which men are entitled. Daughters, for example, are religiously entitled to inherit half as much as sons.

Lack of decision-making powers in the household. Research shows that women's lack of decision-making power within the household results in poorer health outcomes, as they are

unable to make important decisions regarding the need for accessing healthcare services.²⁸

Limited mobility of women. Although women have the legal right to freedom of movement, traditions and customary practices (such as the tradition of male guardianship, and 'purdah', i.e. seclusion or veiling) limit their ability to exercise this right to various degrees in different regions. A survey conducted in rural communities in Punjab found that only 35% of women were allowed to go unescorted to a market in their village, only 28% were allowed to attend health centres unescorted and only 12% were allowed to visit neighbouring villages unescorted. On a mobility index with a maximum value of 5, the women of Punjab were assigned a value of 1.4.²⁹

Low levels of participation in public life. In 2010, only 22 per cent of seats in the national parliament were occupied by women.³⁰ Women's lack of representation in public life and their limited decision-making power at the societal level has an important impact on how discussions on gender issues are conducted and for the resulting legal and political implications.³¹

High levels of violence against women. Violence against women within marriage is widespread, and non-consensual and forced sex is part of the different forms of violence that women experience.³² Legal frameworks offer little protection for the physical integrity of Pakistani women.³³ Until very recently, there was no specific law covering gender-related violence, instead such crimes fell under the general Penal Code. However, in November 2011, the National Assembly passed the 'Prevention of Anti-Women Practices (Criminal Law Amendment) Act 2011' which proposes a minimum punishment for those involved in "anti-women practices" such as wanni, swara or budla-i-sulh, wherein women are traded to settle personal, family or tribal disputes.³⁴ As with many other legislative measures on women's issues, questions remain about the enforcement mechanisms.³⁵

²² The Gender Parity Index measures the relative access to education of males and females. In its simplest form, it is calculated as the quotient of the number of females by the number of males enrolled in a given stage of education.

²³ UN Statistics Division (2008)

²⁴ Choudhry (2005)

²⁵ Ibid.

²⁶ UNDP (2009)

²⁷ OECD/DAC (2005)

²⁸ Mumtaz and Salway (2009)

²⁹ Jejeebhoy and Sathar (2001)

³⁰ Inter-Parliamentary Union (2010)

³¹ WHO (2007a)

³² Fikree & Bhatti (1999); Fikree et al (2005)

³³ The National Assembly passed the Domestic Violence Bill in 2009. However, the Senate failed to pass it within the three months required by Pakistan's Constitution.

³⁴ <http://tribune.com.pk/story/292165/prevention-of-anti-women-practices-bill-unanimously-approved-by-na/Parliament> had failed to pass the Bill on two previous occasions, and it had remained pending in the Assembly for over three years

³⁵ OECD-DAC (2005)

4.1 Poverty

Poverty status undermines maternal and newborn health in several ways. It can heighten the incidence of direct causes of mortality, such as maternal infections and under-nutrition. The poor are also materially excluded through cost – in terms of fees for services, travel costs, the cost of medication, and the opportunity cost of having to take time off work. 22 per cent of Pakistan's population lives below poverty i.e. line under the \$1.25 a day. 51 per cent of the population suffers from multiple deprivations as calculated in the Multidimensional Poverty Index in the Human Development Report for 2010.³⁶ According to UNDP's 2010 Human Development Indicators, Pakistan's Gini coefficient³⁷ was only 32.7 in 2006³⁸-however, there are certainly high inequalities of access to healthcare between wealth quintiles.

Conflict and recent natural disasters in Pakistan have also had a profound effect on poor communities. Most visibly they have triggered large-scale displacements of residents seeking refuge and shelter in temporary camps.³⁹ During the 2010 floods, approximately 49 per cent of flood-related IDPs in Sindh were women; with the majority of female IDPs coming from severely affected and

Poverty can heighten the incidence of direct causes of mortality, such as maternal infections and malnutrition.

already impoverished rural areas. The death of household members of working age as a result of conflict can push previously vulnerable households into extreme forms of poverty (particularly households with widows, orphans and disabled individuals), which may well become permanent if the household is unable to replace labour.⁴⁰ The disruption in households' ability to access food, healthcare and education, often at key points in the life-courses of adolescents or pregnant women, can also contribute to the intergenerational transmission of chronic poverty.⁴¹

A recent study has shown that neonatal mortality rates are around 55 per cent higher for the poorest 20 per cent of households than for the richest quintile.⁴² Similar inequities are also prevalent for maternal mortality.⁴³ Comparative studies also

Table 1. Selected Indicators Showing Disparity in Coverage of Health Interventions Among the Wealthy and the Poor in Pakistan

Indicators	Coverage (%) by Wealth Quintiles Disparity Gap (%)		Disparity Gap (%)
	Lowest	Highest	
1 Proportion of pregnant mother who received antenatal care by any Skill Birth Attendant (SBA)	16%	77%	61%
2 Proportion of pregnant women who received two or more doses of Tetanus Toxoid vaccine during last pregnancy	32%	77%	45%
3 Proportion of women who delivered in health facility	12%	74%	61%
4 Proportion of mother who received professional postnatal care for last birth within first 24 hours	10%	58%	48%
5 Current use of modern contraceptives among the currently married women	12%	32%	19%
6 Proportion of fully immunised children between 12 and 23 months of age	26%	64%	38%

Source: Pakistan Demographic Health Survey, 2006-07

³⁶ MPI identifies multiple deprivations in the same households in education, health and standard of living. The education and health dimensions are based on two indicators each while the standard of living dimension is based on six indicators. All of the indicators needed to construct the MPI for a household are taken from the same household survey.

³⁷ This is a commonly used measure of inequality. The coefficient varies between 0, which reflects complete equality and 1, which indicates complete inequality, i.e. one person has all the income or consumption, all others have none (World Bank <http://go.worldbank.org/3SLYUTVY00>)

³⁸ <http://hdrstats.undp.org/en/countries/profiles/PAK.html>

³⁹ Pakistan has faced significant natural disasters in recent years including the 2005 earthquake and the floods in 2010. There has been an increase in sectarian killings in Balochistan and Sindh, while some north western regions in KPK, FATA and Swat have been facing continuous insurgency and foreign military operations.

⁴⁰ Justino (2006)

⁴¹ Orero et al (2007)

⁴² Alam et al (2010)

⁴³ Lawn et al (2006)



show that in countries with high maternal mortality ratios (MMR) such as Pakistan, there are systematic inequalities across wealth quintiles in terms of women's utilisation of skilled birth attendants, facility-based care for labour and delivery, and antenatal and post-partum services.⁴⁴

A 2011 study of the Benazir Income Support Programme's (BISP) impacts on women's reproductive health service uptake confirms that poor women use significantly fewer reproductive and maternal health services and less often than women of greater economic means. A 2007 study of tetanus toxoid (TT) vaccine coverage found that low immunisation levels were more common among younger and poorer women in semi-rural and rural areas of Punjab.⁴⁵

Poverty is closely interlinked with gender inequality, as both act as barriers or filters and can affect women's ability to translate demand for healthcare into effective utilisation. An analysis of the 2006-7 PDHS found that the overwhelming majority of women aged between 12 and 49 who had died in 95,000 sampled households had been poor. In 29 per cent of cases relatives cited lack of money as a major reason for delays in seeking treatment.

Lack of finances led to other consequences including: sending the woman back to her parents'

house; not buying prescribed medicines, or taking them irregularly; not seeking medical care; refusing hospital admissions, blood transfusions or surgery; and not travelling to bigger cities to seek a higher level of care when referred by local doctors.⁴⁶

Socially excluded groups in Pakistan can often be among the poorest (but not always, depending on the type of exclusion). Poor women and girls can also be subject to additional exclusionary informal norms such as discrimination based on ethnicity, religion, disability, age and location among others. Each of these deprivations compounds one another, heightening exclusion as well as deepening and sustaining poverty. In particular, the combination of poverty, gender inequality and social exclusion can entrench:

- A lack of information and knowledge;
- Inadequate maternal and newborn health practices and care seeking;
- Insufficient access to nutritious food and essential micronutrients;
- Limited availability of quality basic healthcare services and poor access to maternity services; and
- Limited ability to demand greater access to quality healthcare.

Analysis of poor people's access to healthcare services in Bangladesh⁴⁷ shows that their exclusion

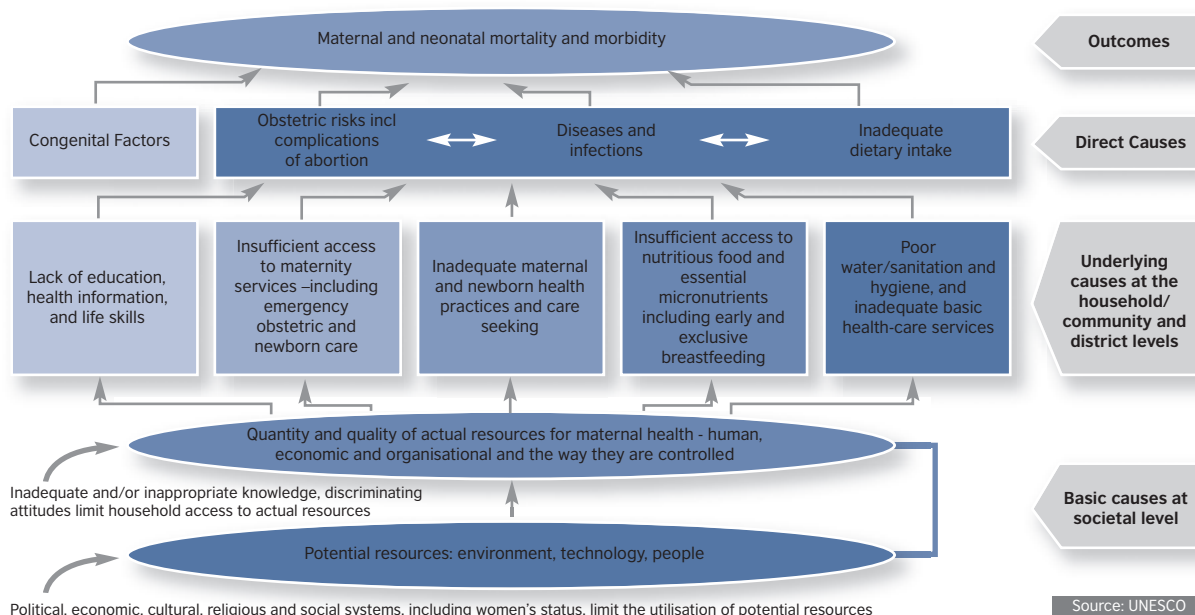
⁴⁴ Durand (2010)

⁴⁵ Hasnain and Shaikh (2007)

⁴⁶ Population Council (2010)

⁴⁷ Gardner and Subramaniam (2006)

Figure 1. Conceptual framework for maternal and neonatal mortality and morbidity



from healthcare is perpetuated through a combination of factors. These include lack of awareness of health issues, the services available, and how best to seek treatment. Poor people also believe that they will be treated in a humiliating way by clinic or hospital staff, or that access to services and their cost, depends on having a personal relationship with clinic staff or some other influential person/patron. This reflects a generally low level of trust in government services. Similarly, in the private/NGO sector, charges are often not standard or transparent, and private clinics are suspected of profiteering.

4.2 Gender inequality

In Pakistan, socio-cultural norms often determine that men control key assets and make decisions regarding women and girls' access to health services. Women are often not able to demand better access to healthcare services due to their lower status, lack of education, constraints on mobility and their ability to appear in public spaces. Those who are in strict *purdah* are often not allowed to physically access services without a male escort.

Research studies⁴⁸ have highlighted **gender discrimination in medical expenditures**; finding

that when ill - girls are less likely to be taken for a medical consultation and even when they are, less is spent on their medical care than for boys. Rural households are more likely to consult private doctors (are generally considered to be of higher quality) for boys than for girls. The choice of which healthcare provider an individual chooses is also strongly influenced by financial considerations, and women often use traditional healers - who are cheaper, easier to access and more culturally acceptable.⁴⁹

There remains a gender gap in terms of literacy rates in Pakistan, and this is particularly pronounced in rural areas. **Low levels of girls' education** are not only linked to poor maternal and newborn health outcomes, but also limit women and girls' health seeking behaviour. Uneducated women are less likely to use contraception and take decisions regarding their reproductive rights.⁵⁰ This is reflected in the high fertility rate for Pakistani women and the low contraceptive prevalence rate. Lack of education also affects women's employment prospects, and consequently their levels of autonomy, as well as household income (which in turn affects how much can be spent on education, health, food, etc.). Illiteracy is also a major barrier to accessing information about services.

⁴⁸ Cited in World Bank (2005)

⁴⁹ Shaikh and Hatcher (2005)

⁵⁰ PDHS 2006-2007



Early marriage is also common in Pakistan.⁵¹

Approximately 40 per cent of all women in Pakistan marry before the age of 18 while 13 per cent marry before the age of 15.⁵² Early marriage often leads to early childbearing and high total fertility,⁵³ higher rates of abortion, as well as higher rates of unfavourable pregnancy outcomes in not only the first pregnancy but in subsequent pregnancies as well. Teenage pregnancy can also have serious health implications for infants in terms of low birth weight and higher rates of stillbirth. In Pakistan, the infant mortality of babies born to women younger than 20 years is 116 deaths per 1,000 live births compared to 55 deaths per 1,000 births of women aged 40 to 49.⁵⁴ Infants born to teenage mothers are 1.5 times more likely to die than infants born to older mothers.⁵⁵ Early age at marriage is also likely to lead to less education, longer reproductive life, less articulated ideas about family size, less use of contraceptives and low status in the marital family.

Poor women often have **inadequate intake of nutritious food and essential micronutrients** due to limited access to food within the households and poor dietary habits. Low literacy levels, especially amongst adolescent girls and women, their lack of involvement in decision making, early marriage, lack

of birth spacing and poor access to healthcare are all factors determining child and maternal nutrition in Pakistan. Poor women's low nutritional intake and the poor quality of local diets can undermine their reproductive and maternal health. In the 2011 National Nutrition Survey 58 per cent of households nationally, 72 per cent in Sindh and 63.5 per cent in Balochistan reported facing food insecurity.⁵⁶ Nutrition status is also intrinsically interconnected with issues of gender and the inequitable distribution and allocation of food at household, community or regional levels. The National Nutrition Survey also found that 49 per cent of women of child-bearing age were anaemic. The risk of anaemia is often exacerbated by women's unequal or insufficient

Low levels of girls' education are not only linked to poor maternal and newborn health outcomes, but also limit women and girls' health seeking behaviour.

⁵¹ Women in Pakistan have very little legal protection in regard to family matters. Under the Child Marriage Restraint Act of 1929, the minimum age of marriage is 16 years for females and 18 years for males (OECD/DAC, 2010). However, The 2003 United Nations World Fertility Report estimated that 21 per cent of girls between 15 to 19 years of age were married, divorced or widowed. The PDHS 2006-7 finds that the median age of first marriage is increasing over time and now stands at 19.1 years. The median age at which a woman first gives birth is 21.8 years – an increase of half a year from the 1990-91 PDHS.

⁵² PDHS 2006-2007

⁵³ Paruzzolo et al (2010)

⁵⁴ PDHS 2006-2007

⁵⁵ Agha 2010

⁵⁶ National Nutrition Survey (2011)

Over 70 per cent of women in Pakistan face domestic violence.

Human Rights Watch (1999)

access to food resources, poverty and frequent child-bearing. Iron-deficiency anaemia is among the most prevalent forms of micronutrient deficiency among women of childbearing age in Pakistan.⁵⁷ Thus, maternal infections and under-nutrition are more likely when women are living in conditions of poverty.

Box 3

Violence during pregnancy in Pakistan

After being kicked repeatedly in the stomach by her husband, one young woman who was six months pregnant, developed severe bruising and pain. She did not receive any medical help for three days. Upon seeing a doctor only after a concerned neighbour called for one, the woman was told her unborn child had died and she needed immediate hospitalisation. Her husband agreed to hospitalisation, but threatened her with divorce if she divulged any information about his violent behaviour to hospital staff. A year later, she became pregnant again because her husband had refused to use contraception himself on religious grounds or to let her use it. By this time, the violence had escalated and now involved other members of her husband's family. While she was concerned about her own safety and the health of her child, she could not leave her husband because she was unsure about whether she would get support from her family. She also felt she would be judged by society and later by her children for walking out on her husband.

Source: Hussain and Khan (2008)

Societal perceptions of women also play a primary role in **violence against women** and the opportunities available to them to address the issue. Over 70 per cent of women in Pakistan face domestic violence.⁵⁸ Sexual coercion is also common in marriage and many women endure sexual assault.⁵⁹ The concept of 'marital rape' does not exist, as it is widely believed that men are entitled to demand sex within marriage. These ideas are given weight by some religious interpretations that see the primary purpose of women as being to fulfil the sexual needs of men and to bear children.⁶⁰

Nearly one-quarter of the postpartum women interviewed in a 2004 study⁶¹ reported that they had experienced some form of physical abuse during their pregnancies. If injured, few sought help. Most were uncomfortable discussing domestic violence with healthcare providers, who they felt were uninterested or unsympathetic. Healthcare providers are also limited in their ability to handle such issues. For example, where a nurse or midwife identifies that a woman has experienced domestic violence or abuse, they are not required to report it.⁶² A 2004 study⁶³ found that in Karachi, only 3 per cent of obstetricians routinely screened for domestic violence at antenatal visits, due to lack of training in domestic violence issues, lack of time, and not having a solution to the problem. The Pakistani legal system is also unable to provide support to women who may be experiencing violence.

Women living in conflict-affected areas, or **those displaced by conflict or natural disasters**, can also find their access to health services affected by prevailing insecurity, increased risk of gender-based violence, and sexual exploitation of young girls and women (see section 7.9 for more information on this). Displaced women can experience particular difficulty in accessing safe delivery and emergency obstetric care.

Sexual violence is directly linked to reproductive and

⁵⁷ As defined by the World Health Organisation (WHO), anaemia refers to blood haemoglobin levels of ≤ 11 g/dl. Iron-deficiency anaemia is one of the world's leading causes of disability and thereby constitutes a significant, yet also highly preventable, global public health problem. Variations in the prevalence of anaemia are correlated with women's socio-economic circumstances, their lifestyle and health-seeking behaviours (WHO: http://apps.who.int/rhl/pregnancy_childbirth/medical/anaemia/cfcom/en/index.html)

⁵⁸ Human Rights Watch (1999)

⁵⁹ Kapadia et al (2010)

⁶⁰ Hussain and Khan (2008)

⁶¹ Fikree et al (2004)

⁶² Ibid.

⁶³ Ibid.

sexual health issues, such as gynaecological problems, sexually transmitted infections (STIs) and unintended pregnancies. The extent to which domestic violence contributes to maternal mortality rates in Pakistan is not known. However, studies from India, Egypt and Uganda⁶⁴ have found a link between limited use of antenatal care and increased obstetric complications in women who experience domestic violence. Research from India also indicates that violence during pregnancy is associated with adverse birth outcomes and higher infant mortality.⁶⁵

4.3 Social Exclusion⁶⁶

Globally, evidence indicates that health outcomes for excluded groups tend to be worse than average – particularly in the case of indigenous and low-caste groups.⁶⁷ The available literature points to two main impacts of processes of social exclusion on maternal and child health:

- i. complete exclusion from access to health services; and
- ii. exclusion from fair or comparable treatment.

A 2003 study⁶⁸ of social exclusion in Pakistan identified various grounds for social exclusion: occupational groups (including bonded labour), class, caste, ethnicity, gender, religious minorities, youth, ethnicity and disability. Excluded groups in Pakistan also often live in deprived areas where there is limited health coverage, and where nutrition is poor – such as rural areas and slums.

A 2005 study⁶⁹ finds that:

- 46 per cent of the population are excluded on the basis of their occupation, or lack of access to land.
- Up to 40 per cent experience language-based exclusion.
- Up to 4 per cent are excluded on the basis of non-Muslim religious status.
- Allowing for overlap across categories, as much as 40-50 per cent of the population of Pakistan is socially excluded. Many key MDG indicators would improve by more than 10 per cent if the levels of deprivation of socially excluded groups were the same as mainstream society.

Poor women and girls can also be subject to additional exclusionary informal norms such as discrimination based on ethnicity, religion, disability, age and location among others.

Box 4

Impacts of social exclusion on access to health services

In India, 36% of Scheduled Caste and Scheduled Tribes women give birth in a health facility, as compared to 59% for higher caste groups. Dalit children in India can experience significant levels of discrimination in obtaining health treatment. One study found that 90% of the time, Dalit children are made to wait last or wait longer in line when receiving medicine from nurses or laboratory technicians.

For ethnic minorities in Vietnam, more than 60% of childbirths take place without prenatal care compared to 30% for the Kinh population, Vietnam's ethnic majority. A study of street children in Lima, Peru, showed that there is a clear dislike of going to the medical centre due to the treatment they receive: "It makes me sad because they humiliate you", reported one child. One qualitative study amongst the rural poor in China found that many women choose not to have a skilled birthing attendant present because they feel they possess enough knowledge of birthing from the elder generation. These women are largely uneducated and lack information about maternal health due to their rural location.

Source: Broadbent (2010)

⁶⁴ Ahmed et al (2006); Diop-Sidibe et al (2006); Kaye et al (2006)

⁶⁵ Ahmed et al (2006), see fn. above.

⁶⁶ The term 'social exclusion' has been used to describe: groups at risk of exclusion; what people are excluded from; the states associated with exclusion; the processes involved and levels at which they operate; and the actors involved. Some of these issues have been addressed in the preceding sections.

⁶⁷ Ohengo (2006); Nayar (2007) cited in Broadbent (2010)

⁶⁸ Hooper & Hamid (2003)

⁶⁹ Carraro et al (2005)



A study by Mumtaz et al. (2011) offers two case studies of women from a village in Northern Punjab who died during childbirth. One woman, Shida, did not receive the necessary medical care because her heavily indebted family could not afford it. The second woman, Zainab, was a victim of domestic violence, and did not receive any medical care because her marital family could not afford it, nor did they think she deserved it. Both women belonged to lower caste households, which are both materially poor and socially viewed as inferior.

“The stories of Shida and Zainab illustrate how a rigidly structured caste hierarchy, the gendered devaluing of females, and the reinforced lack of control that many impoverished women experience conspire to keep women from lifesaving health services that are physically available and should be at their disposal.”⁷⁰

There is however, relatively little empirical research focusing explicitly on the relationship between social exclusion and health inequalities in Pakistan. Data constraints have meant that to date systematic analyses of social exclusion in Pakistan have been limited to exclusion on the basis of gender. However, lessons can be derived from other country contexts.

A study on primary healthcare in Bangladesh⁷¹ found that ultra poor groups rarely left their villages, and had neither the knowledge nor the confidence to get themselves to healthcare centres, or to demand treatment. Only 18 per cent of the rural ultra-poor used government or NGO clinics or hospitals, and only 13 per cent used private qualified physicians. Of the rest, 23 per cent were treated by the kabiraj (traditional herbalists or spiritualists), 15 per cent used untrained allopathic (‘quack’) doctors and 30 per cent used semi-trained allopathic practitioners, including local drug vendors and rural medical practitioners. It is also argued that excluded groups, particularly those in rural areas, often do not have the capital, knowledge and social relationships needed to access privatised services, and may be discriminated against in the provision of such services.⁷²

⁷⁰ Mumtaz et al (2011). RAF has recently funded another study by this team to investigate the relationship between social exclusion and maternal health through ethnographic research in districts Jhelum and Layyah in Punjab

⁷¹ Gardner and Subramaniam (2006)

⁷² Freedman et al (2005), cited in Broadbent (2010)

Governance of the Health System

The type and quality of services available to poor women are largely dependent upon decisions made about prioritisation of and resource allocation for maternal and newborn health issues at the provincial level and implementation at the district level. The allocation of resources to the health sector - in particular to MNH, and their management is influenced by various political and institutional factors, including corruption, weak fund flow mechanisms, frequent staff transitions, and poor accountability.

In addition, health policy and planning processes pay insufficient attention to poverty, gender and social exclusion issues. These factors have a profound impact on the equitable distribution of service provision, and also undermine healthcare delivery.

Pakistan's health system is also fragmented and service delivery is hampered, albeit to different degrees in each of the provinces, by lack of good

leadership and management, inadequate HMIS and referral systems, and unsystematic and non-transparent procurement.

This section discusses the impact of poverty, gender inequality and social exclusion on the type and quality of MNH services provided, particularly to poor people, by the government (or privately).

5.1 Political Will and Prioritisation of Women's Health Issues

In 2001, the Pakistani Government committed itself to reducing maternal mortality by 70 deaths per 100,000 live births and infant mortality by 45 deaths per 1,000 births by 2010.⁷³ In October 2009, the Federal Ministries of Health and Population Welfare signed the Karachi Declaration, which committed the Government of Pakistan and international donor organisations to scale up maternal, newborn, child health and family planning best practices in the country.⁷⁴ Health policy changes introduced in the mid-1990s and the introduction of devolution reforms suggest that improvements are occurring.⁷⁵ The government launched the National Program for Family Planning and Primary Health Care (commonly referred to as the Lady Health Workers programme) in 1994, and the donor-supported Maternal, Newborn and Child Health (MNCH) Programme in 2007 which aimed to address maternal, neonatal and child morbidity and mortality, through improved health service delivery in communities.

Pakistan's health budgets are extremely low compared to other countries in the region and to the recommended WHO levels of expenditure.

⁷³ Rukanuddin et al (2007)

⁷⁴ Population Council (2009)

⁷⁵ World Bank (2005)

However, Pakistan's health budgets are extremely low compared to other countries in the region and to the recommended WHO levels of expenditure. According to WHO, a per capita expenditure of \$30-40 per annum is considered the minimum for quality basic health services. The per capita expenditure in Pakistan is \$25 per year, of which only \$5.40 is public expenditure.⁷⁶ There have been almost no changes in the total share of health spending as a percentage of GDP from 2002 to 2010, and on average total health expenditure has remained at 0.56 per cent. Thinking and planning for the expansion and development of the health sector has also generally been undertaken within the context of 5-or 1-year plans, and rarely on the basis of a long-term, strategic perspective. Governance of the health sector is also affected by frequent changes in government and corruption.⁷⁷

The allocation of resources to the health sector - in particular to MNH, and their management is influenced by various political and institutional factors.

Pakistan's government institutions and bureaucracy have, until recently, remained highly centralised, patriarchal and elitist.⁷⁸ Women also generally have less voice than men in Pakistan's patriarchal society. As a result reproductive healthcare – which is a greater priority for women, is given low priority in overall health policies. In addition, politics as a whole, and therefore election campaigns, are not connected to social issues. Currently health issues do not feature prominently in political manifestos or debate, and elected political leaders lack a health sector agenda.⁷⁹

Pakistan has made progress in terms of women's representation in governance.⁸⁰ At present, there are

78 female legislators elected in the 342-member National Assembly, and 18 female senators in the 100-member Senate of Pakistan. These women legislators are helping to shape a political agenda which includes pursuing women-specific legislation.⁸¹ However, the representation of women in cabinet, and hence their influence on policy making remains limited. There are no laws to ensure women's representation in decision-making committees and higher forums such as local government commissions, and finance, management and monitoring committees. In 2004, only 22 per cent of women councillors reported that they attended council meetings regularly, and less than 30 per cent had any knowledge of the council agendas of the last two sessions or of the council budget.⁸² Political initiatives on women's issues often meet resistance from religion-based political parties.

There is little analysis on the attention given to maternal health in policy-making processes, however it can be argued that women's lack of engagement in these processes has important implications for their ability to ensure that priorities such as maternal health service provision are kept on the agenda and are adequately addressed.

5.2 Corruption

The enforcement of Pakistan's regulatory systems is weak, primarily because regulations are often poorly specified, regulatory agencies lack capacity to enforce legislation, policy is inconsistent and there is a lack of transparency. Transparency International's Corruption Perception Index (CPI), for example, ranked Pakistan as the 143rd most corrupt country out of 178 in 2010, down four places in 2009, and nine places in 2008. Corruption remains an important factor affecting the delivery of services.

The most noticeable example of weak regulation in health care management systems is absenteeism of health care personnel, also termed as "ghost workers". This is particularly prevalent in rural

⁷⁶ UNICEF (2008)

⁷⁷ Dodani, S. and Chotani, R. (2012)

⁷⁸ Pappas (2009)

⁷⁹ TRF (2010)

⁸⁰ Women make up 22 per cent of the National Assembly and 17 per cent of the Senate (IPU, Parline Database). At the local level too their share in local government representation has increased from 10 per cent in 1993 to 33 per cent through reservation.

⁸¹ This includes the 2011 Prevention of Anti-Women Practices Act; the 2010 Protection Against Harassment of Women in the Workplace Act.

⁸² Asian Development Bank (2004)



areas. Recent health facility surveys found that in Balochistan, the absentee rate for all staff was 50 per cent, while for doctors it was 58 per cent and for female paramedics, 63 per cent. The situation was similar in Sindh where 45 per cent of the doctors were absent from Basic Health Units (BHUs) and 56 per cent were absent from Rural Health Centres (RHCs).⁸³ Another example of corruption is illegal user fees which are often charged to patients in some public sector facilities. In fact, a 2010 World Bank report shows that the cost of utilising public and private sector facilities is almost comparable.⁸⁴

Corruption in the pharmaceutical sector is also pervasive and lack of transparency in procurement processes remains an issue. Drugs and medical supplies are often stolen from central stores for resale in private practices or on the black market resulting in chronic shortage of medication in public facilities. Corrupt management and monitoring capacity also leads to poor quality of medication on the shelves including expired, counterfeit and harmful drugs.⁸⁵

5.3 Devolution

In 2010, the government passed the 18th Amendment to the Constitution of Pakistan, which

was implemented in 2011. The Amendment aimed to grant provincial governments greater autonomy in policy-making, planning, implementation and monitoring functions, and led to the devolution of 17 ministries from the federal to the provincial levels, including the Ministries of Health⁸⁶ and Population Welfare. Most of the responsibilities of the former federal Ministry of Health have been delegated to the Provincial Health Departments. This includes the management and oversight of the vertical programmes. However, the fund flow mechanism for the vertical programmes remained a federal subject with the Inter-Provincial Coordination Cell of the Planning Commission of Pakistan.

The federal government has also retained authority on issues such as regulating the medical and para-medical professions and medical research through the Pakistan Medical & Dental Council (PMDC), Pakistan Nursing Council (PNC) and the Pakistan Medical Research Council (PMRC).

In principle, devolution of health to the provinces will help ensure better delivery of health services to local communities, by enabling more context-specific planning and decision-making, which is better aligned with the needs of the people. However, given the limitations around financial resources, infrastructure and staffing at the

⁸³ World Bank (2010)

⁸⁴ Ibid.

⁸⁵ Pappas et al (2009)

⁸⁶ According to government data, the provincial share of the divisible pool would increase from 47.5% to 56% for the first year (FY2010-11) following the agreement and to 57.5% for subsequent years.



provincial level, devolution also presents numerous administrative and functional challenges. The question also remains whether devolution will in fact benefit the poor in terms of service delivery, and reducing inequalities. A study of the 2001 devolution process found that while the local government was indeed empowered, targeted biases towards the Nazim's village and village blocs headed by particular village influentials also emerged.⁸⁷ Increased allocations in provincial budgets will also place greater responsibility on provincial parliaments to ensure budget making and spending is fair, transparent and accountable.

A recent review⁸⁸ of Khyber Pakhtunkhwa's Annual Development Plan 2011-12 showed that Rs. 56.5 billion of its total development funds of Rs. 85.1 billion are categorised as unallocable or block funds. In other words, 66.4 per cent or two-thirds of KPK's total development budget remains under discretionary control. Similarly, a review of Punjab's budget for 2011-12 showed that 90 per cent of its education budget is kept as block funds, compared to 9 per cent maintained in 1999-2000.⁸⁹

5.4 The Vertical Programmes

Provincial public health systems function alongside the vertical programmes. At the district level, therefore, primary and secondary healthcare facilities are managed by the district health

authorities i.e. the Executive District Officer-Health (EDO-H), but the community-based health services operate, including the Lady Health Workers and Community Midwives operate under their respective provincial Vertical Programmes.

Provincial Departments of Health have been delegated responsibility for the management and oversight of the Vertical Programmes, including; the two main community based health service delivery initiatives– The Maternal, Neonatal and Child Health (MNCH) and the Family Planning & Primary Health Care (FP&PHC) Programmes; and the Population Welfare Department, that deal with essential maternal health issues like family planning and sexual reproductive health. However, with the fund flow mechanism remaining a federal subject, challenges around timely disbursement of funds continue and have resulted in considerable difficulties for the vertical programmes.

The disintegration of the management of the health services is further complicated by the introduction of the Peoples Primary Healthcare Initiative (PPHI) - a programme of the Rural Support Programme Network (RSPN), governed by the Cabinet Division of the Federal Government of Pakistan. PPHI is responsible for the administrative management of over 60 per cent of primary health care facilities in the country, while the responsibilities for technical oversight remain with the EDO-H.

⁸⁷ Cheema and Mohmand (2006)

⁸⁸ Omar Asghar Khan Foundation (2011)

⁸⁹ Faisal Bari, Pakistan Today, 29 August 2011 <http://www.pakistantoday.com.pk/2011/08/policy-disconnect/>

This fragmentation in the management and delivery of health services has created further inefficiencies in the health system, and has undermined the stewardship of the provincial health authorities.

5.5 Systems

5.5.1 HMIS/DHIS

There are a variety of standards and information systems in place in the public health sector in Pakistan. The main HMIS was developed during the early 1990s with a focus on first-level care facilities. However it was not developed into a credible tool used for decision-making. There is no standardised information system across public hospitals. The vertical programmes have set up their own information systems, leading to duplication of efforts in some cases and unbalanced resource distribution in others. No information is collected about the private sector.⁹⁰

Recently, both Punjab and KPK provinces have developed District Health Information Systems (DHIS) that aim to integrate data from the primary and secondary care facilities, information from the vertical programmes, as well as information on public health sector human resources, logistics and finance.⁹¹ However, the quality of data and under-reporting remain a significant problem. In particular, the DHIS does not collect information on population indicators, such as demographics and socio-economic status, which can be used to disaggregate trends. Currently neither the HMIS nor DHIS are being used for performance monitoring across the primary healthcare system.

5.5.2 Referral Systems

Referral systems are not fully functional or supervised and are hampered by a fragmented system of multiple, unregistered providers, contracted out facilities, vertical programmes and insufficient human resources to support and use efficient referral systems and processes. There remain many remote districts with serious transport problems for EmOC referrals.

A 2001 study suggests a poorly functioning referral system may be responsible for the inability to achieve expected improvements in health status, especially of rural population groups in Pakistan.⁹²

5.6 Voice and Accountability

Responding to Pakistan's MNH challenges requires change from above as well as pressure from below to promote the interests of poor and marginalised groups. Strengthening the engagement of citizens in planning, monitoring and accountability processes is thus critical for improving health service delivery in Pakistan, both in terms of ensuring that the design of health services reflects the needs of citizens, and enabling citizens to hold the government and service providers to account for their decisions and actions. Currently, the participation of citizens, and particularly poor citizens, in decision-making and policy formulation is weak. For example, the National Health Policies (NHP) that were developed in 1990, 1997 and 2001 were all conceived, directed, and implemented by a small group of technocrats at the Ministry of Health without the involvement of civil society organisations, professional bodies, consumer organisations, or members of parliament.⁹³ Formal horizontal accountability mechanisms are also weak. However, there is some evidence that the National Assembly Standing Committee on Health is willing to exercise parliamentary oversight over the health sector.⁹⁴

A key barrier to demanding accountability is the lack of information and data on health outcomes.

There have been some initiatives to support monitoring and management at the district level. In 1999, District Health Management Teams (DHMTs) were introduced with the aim of bringing together representatives from across the district to monitor and manage local health services. These DHMTs

⁹⁰ TRF (2010)

⁹¹ HLSP (2010)

⁹² Siddiqi S, Kielmann A, Khan M, et al. (2001)

⁹³ Pappas et (2009)

⁹⁴ TRF (2010)

were able to achieve broad-based membership and influence change in health budgets. However, the model did not prove sustainable.⁹⁵ RAF has recently funded an advocacy project to strengthen participation of CSOs and communities at grassroots level in district health management through institutionalizing DHMTs in District Manshera of Khyber-Pakhtunkhwa. The project builds upon earlier experience of working with DHMTs and the sustainability challenges faced by them in Pakistan.

One initiative that is being successfully implemented in Pakistan is that of Women Friendly Spaces (WFS). WFSs aim to bring women together with a view to providing them with increased public space, strengthening their collective identity and enabling them to develop the skills and confidence to engage with each other, as well as with issues that are important to them. After the 2005 Earthquake, Sungi Development Foundation initiated a WFS project in three districts of Muzaffarabad, which aimed to provide a space where women come together around organised activities, and obtain advice on issues related to women's and adolescent girls' general health, nutrition and reproductive health needs. Citizen monitoring by rights-based groups and the media also shows encouraging trends. Rights-based groups, many of which are linked to community-based networks, have been prominent during the past decade, advocating democratic transition, the protection of human rights, and better delivery of services.

More than 30 private television channels and many FM radio channels are also now operational. Many are raising important issues related to MNH through current affairs and entertainment programming. However, most of the media is commercially oriented; fiercely competitive for audiences; and has low investigative reporting capacity.

A key barrier to demanding accountability is the lack of information and data on health outcomes. The public health surveillance system is fragmented and unable to generate the data required to make public health decisions, or to hold officials accountable (see *section 5.5.1 for more information on this*).

Social accountability mechanisms – such as, for example, citizen report cards, social audits, participatory budgeting and public expenditure tracking – allow communities to influence service delivery by being directly involved in monitoring government performance, generating evidence and demanding accountability. These citizen-led monitoring mechanisms have proven successful in countries such as India, Brazil, India, Indonesia, Mexico and Uganda, in terms of improving governance institutions, their relationships with citizens, and service delivery.⁹⁶

In Pakistan, an experiment using report cards which aimed to provide information to parents and schools about the academic performance of their children both in absolute terms and relative to other children in other schools resulted in: an increase in children's test scores in both the public and private schools involved; improvements in learning indicators in private schools that scored below average; and a significant drop in fees by private schools that scored higher than average.⁹⁷ However, there is still limited understanding about why some mechanisms work in some contexts and not others. It is important that targeted efforts are made to include marginalised groups including adolescents, ethnic and religious minorities and the very poor, in such initiatives. Even where spaces for participation are made available, these groups can lack the skills, information or representation to have a voice amongst more powerful participants.

⁹⁵ Ibid.

⁹⁶ See Bjorkman and Svensson (2007) for information on Citizen Report Cards in Uganda

⁹⁷ Ringold (2012)





Service Delivery

Women's maternal health outcomes are contingent on the quality and scope of existing public and private sector services and the level and quality of facility- or community-based care they receive during pregnancy, childbirth and the post-partum period. Access to, and utilisation of, healthcare services is determined by the following factors:

- Physical access to/availability of services;
- Economic access or affordability of services; and
- Social access or acceptability of these services.⁹⁸

According to a 2008 survey, women in KPK who did not deliver in a health facility tended to either believe it was not necessary (48 per cent), it cost too much (31 per cent), it was not customary (12 per cent) or it was too far away (11 per cent).⁹⁹ In Balochistan 23 per cent of women said it was because the facility was not open, 40 per cent because it cost too much, 17 per cent because it was too far and 19 per cent because their husband or family did not allow it. This section looks at the issues around the delivery of MNH services delivery, particularly for poor and socially excluded groups.

6.1 Health Infrastructure

Women's maternal health outcomes are contingent on the quality and scope of existing public and private sector services and the level and quality of facility- or community-based care they receive during pregnancy, childbirth and the post-partum

period. In Pakistan, health services are less available, and utilisation rates are lower in rural than in urban areas. Antenatal visits are significantly lower in rural areas, where only 20 per cent of women make four or more antenatal care visits compared with 62 per cent of women in major urban settings.¹⁰⁰ The majority of deliveries, almost two-thirds, are conducted at home.

Social accountability mechanisms allow communities to influence service delivery by being directly involved in monitoring government performance, generating evidence and demanding accountability.

6.1.1 Public Sector Facilities

Pakistan has a good network of primary health facilities and hospitals. The public health system is made up of primary health care units called Basic Health Units (BHUs) and Rural Health Centres (RHCs), as well as Tehsil (THQ) and District Headquarters (DHQ) hospitals. BHUs and RHCs provide basic obstetric care as well as community outreach

⁹⁸ Ensor and Cooper (2004)

⁹⁹ PDHS 2006-2007

¹⁰⁰ UNICEF (2008)



programmes through Lady Health Workers (LHWs). The hospitals are staffed by specialists and are expected to provide comprehensive obstetric care.¹⁰¹

However, many facilities are in disrepair, damaged or destroyed by conflict or disasters or are too far from remote communities. Health facilities often have serious water and sanitation problems. A 2006 study found that only 46 per cent of first level healthcare facilities had a water supply, 72 per cent had electricity and only 33 per cent had toilets.¹⁰²

A 2005 survey¹⁰³ found that the distance to the government facility is also an important determinant of use. Most communities in Balochistan (66 per cent) and Sindh (52 per cent) were located more than 20 kilometres from a Rural Health Centre (see section 7.8 for more information on this). In Punjab, a relatively well-covered province, only 66 per cent of the rural population has access to a health facility that is located within half an hour of travel time. Access to

emergency care is thus a particular issue for poor women. A study on the provision of obstetric care in Multan district in the Punjab finds that the district falls short of the minimum number of comprehensive Emergency Obstetric Care (EmOC) facilities needed. The authors note that although the UN recommends that all women with obstetric complications deliver at EmOC care facilities, in Multan District, this has happened in only 23 per cent of cases.¹⁰⁴

Coverage of services in rural Punjab and KPK has expanded at a faster pace than in Sindh and Balochistan, where services in some cases have either stagnated or declined.¹⁰⁵ Such a trend can be seen in terms of tetanus toxoid immunisation of pregnant women, but less so in the use of antenatal services. Further, a national ranking of all districts in Pakistan shows that the top 20 districts in terms of five key health indicators¹⁰⁶ are mainly in Punjab, whilst the worst five performing districts are in Balochistan.

Table 2 . Inter-District Variation in Key Indicators - % Coverage

District coverage	Punjab		Sindh		KPK		Balochistan		Pakistan	
	Best	Worst	Best	Worst	Best	Worst	Best	Worst	Best	Worst
Immunisation	99	64	88	35	100	48	97	28	100	28
CPR	65	25	44	14	43	20	35	1	65	1
TT injections	87	19	75	29	63	16	63	2	87	2
Antenatal care	80	38	81	30	71	8	72	6	81	6

¹⁰¹ Fikree et al (2006)

¹⁰² World Bank (2010)

¹⁰³ Cited in World Bank (2010)

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

¹⁰⁶ These indicators are: a) CPR; b) %age of pregnant women receiving at least one tetanus toxoid injection during pregnancy; c) %age of women who visited a health facility for prenatal consultation; d) %age of women who visited a health facility for postnatal consultation; and e) immunisation rates.

6.1.2 The Private Sector

The private sector is expanding rapidly, but it has inadequate systems for accreditation, standards or enforcement mechanisms.¹⁰⁷ 64 per cent of rural Pakistani households use private providers for antenatal care. According to a 2010 report, in Sindh and Punjab 74.5 per cent and 67.1 per cent of service users respectively used private services, whilst in Balochistan only 44 per cent of services users tended to go to the public sector.¹⁰⁸ The private sector includes accredited clinics and hospitals, as well as many unregulated hospitals, medical general practitioners, homeopaths, hakeems, traditional/spiritual healers, Unani (Greco-Arab) healers, herbalists, bonesetters and quacks. There is a wide disparity between the quality of care provided by these different providers. The formal private sector is concentrated largely in urban areas and spread thinly in rural areas, while the informal sector is predominantly rural.

It is argued that the ease of access accounts for high utilisation rates of private facilities, as well as perceptions amongst women that they receive more attention and better quality services, and benefit from greater confidentiality, better behaviour and flexible payment arrangements.¹⁰⁹ However, the private sector is largely unregulated, and various negative practices have been reported including overcharging patients, unnecessary prescription of drugs, advising clinical tests without indications, etc.¹¹⁰

6.1.3 Public- Private Partnerships

In urban parts of the country, some public-private partnership initiatives exist through franchising of health outlets. Under the People's Primary Healthcare Initiative (PPHI) model in Punjab, District Governments contract the provincial Rural Support Programmes (RSP) to manage first-level care facilities in their district. PPHI has been implemented in over 60 per cent of districts in Pakistan. A recent PPHI evaluation¹¹¹ has shown that the contracted out BHUs have delivered improvements in utilisation and customer satisfaction – but there remain serious drawbacks and a lack of transparency. There is poor

Ease of access and the perception amongst women that they receive more attention, better quality services, greater confidentiality, and flexible payment arrangements accounts for high utilisation rates of private facilities.

Chatterjee et al. (2008)

coordination between contracted out facilities and the public health facilities and problems with referrals between different management units. There is also evidence that contracted out facilities are not supporting the LHW programme sufficiently.¹¹² In fact, the evaluation states:

“... (T)hese improvements are nowhere near enough. Utilisation of essential MNCH services is extremely low across PPHI and DDOH BHUs, and that for reproductive health services is simply abysmal, so the chances of making a substantial impact on MDGs 4 and 5 through the PHC network in Pakistan remain, at this point, improbable without substantial reform”.

Non-governmental organisations (NGOs) are also active in the health sector. For example, in Pakistan, the Family Planning Association of Pakistan, Marie Stopes Society and Aga Khan Health Services all have a wide presence and have achieved some success in raising the level of awareness about positive health behaviour, and particularly contraceptive use, amongst communities.¹¹³ However neither private nor

¹⁰⁷ HLSP (2010)

¹⁰⁸ World Bank (2010)

¹⁰⁹ Chatterjee et al (2008)

¹¹⁰ WHO (2007b)

¹¹¹ Martinez et al (2010)

¹¹² World Bank (2010)

¹¹³ WHO (2007b)



non-government providers work within a regulatory framework and so very little information is available regarding the extent of human, physical, and financial resources involved.

6.2 Human Resources

At the facility level, there are significant problems with insufficient numbers of health workers, absenteeism and low motivation and quality. A 2011 Review of the MNCH Programme found that implementation of the CEmONC and BEmONC components has been hampered by an inability to hire sufficiently trained personnel, absenteeism, high attrition rates due to inconsistent salary flows and overall poor management and monitoring. There is also a lack of trained health workers especially female staff, including doctors, nurses, midwives and skilled birth attendants - in some of the poorest areas.¹¹⁴ The majority of BHUs and RHCs in rural areas are unstaffed by Lady Medical Officers (LMOs), nurses, Lady Health Visitors (LHVs) or community midwives.¹¹⁵ In most provinces, health workers are disproportionately distributed between urban and rural areas. A recent survey found that in Balochistan, 57 per cent of LHV positions and 40 per cent of doctor positions remain vacant.¹¹⁶ Absenteeism is also rife - in Balochistan the absentee rate for all staff

was 50 per cent, with 58 per cent doctors, and 63 per cent female paramedics absent. In Sindh 45 per cent of doctors were absent from BHUs and 56 per cent from RHCs.¹¹⁷

Two-thirds of births in Pakistan occur at home. Home births are more common in rural areas (74 per cent) than urban areas (43 per cent). They are also more common among women with little or no education.¹¹⁸ The place of delivery is one of the most important factors affecting child mortality; births which occur at home carry a greater risk.¹¹⁹ Perinatal mortality (that is, stillbirth or death in the first week of life) is dramatically reduced by the presence of skilled birth attendants during delivery.¹²⁰ In 2007 only 38.8 per cent of births were attended by skilled birth attendants.¹²¹ According to the PDHS, 35 per cent of women receive no pre-natal care at all.¹²²

6.2.1 Community Midwives (CMWs)

The Community Midwives cadre was introduced in 2007 by the MNCH Programme to provide skilled birth attendance to women at or near their homes. Whilst the programme has resulted in some improvements in the availability of skilled birth attendance for home deliveries in some districts of Punjab, overall the Programme has experienced

¹¹⁴ Khan et al (2011)

¹¹⁵ WHO EMRO (2007)

¹¹⁶ World Bank (2010)

¹¹⁷ Ibid.

¹¹⁸ PDHS 2006-2007

¹¹⁹ Iram and Butt (2008)

¹²⁰ Rukanuddin et al (2007)

¹²¹ Data from <http://unstats.un.org/unsd/mdg/Data.aspx>

¹²² PDHS 2006-2007

significant challenges due to slow disbursement of funds and weak management. The 2011 Review of the MNCH Programme found that there have been delays in registering CMW colleges with the Pakistan Nursing Council, and in setting exams for those trained.

The Programme originally planned to train 11,996 CMWs. At the time of writing, 42 per cent of these have been trained. Out of those trained, approximately 60 per cent have been deployed. A further 2,000 are waiting deployment and there are fears that they may be lost to other positions or the private sector.¹²³ According to findings from a 2011 RAF-funded study, there was a gap of 20-22 months between training and deployment of CMWs in Sindh.¹²⁴ The same study also showed that while CMWs are accessing pregnant women in approximately two-thirds of the assigned areas in Punjab, a majority of those women who use CMW services for ANC go elsewhere for delivery (Dai, government facility or a private practitioner).

A majority of women who use CMW services for antenatal care go elsewhere (Dai, government facility or a private practitioner) for delivery.
Khan et al. (2011)

There are also important coverage gaps – in 2010, seven districts in Balochistan had no trained or deployed CMWs, and in KPK, three conflict-affected districts (Tank, Shangla and Kohistan) had no CMWs.¹²⁵ In Azad Jammu and Kashmir the findings of a recent RAF funded study¹²⁶ showed that the majority of CMWs are placed in peripheral rural

areas with some areas overlapping or in proximity to other covered areas while many areas remain unattended by the CMWs.

There are concerns that CMW training includes an insufficient focus on practical experience.¹²⁷ CMW's stipends are lower than those of LHWs, and they are also encouraged to charge for deliveries.¹²⁸ Supervision responsibilities are unclear and they are not adequately integrated with the LHW system. A RAF-funded study on 'Assessment of Community Participation in the CMWs Programme' conducted in KPK found that lack of linkages and coordination among CMWs, LHWs and LHVs was a key barrier to effective utilisation of CMW services.¹²⁹

6.2.2 Lady Health Workers (LHWs)

The Lady Health Worker (LHW) Programme is one of Pakistan's success stories. LHWs are members of the community who have received 15 months of training to deliver primary health care. Nearly 90,000 LHWs provide services directly to the households of around 77 million people and have consistently maintained high utilisation rates. In 2007, areas served by LHWs had a Contraceptive Prevalence Rate (CPR) of 42 per cent against the national average of 30 per cent, child immunisation rates of 80 per cent against a national rate of 47 per cent, and 51 per cent of deliveries attended by a skilled birth attendant (SBA), against 39 per cent nationally.¹³⁰ However coverage is uneven – in Punjab, LHWs only reach 80 per cent of villages. Those consequently Balochistan has the poorest coverage, in terms of health facilities and workers. In most cases, emergency obstetric care is only available at tertiary hospitals.¹³¹

LHWs are also supported at the community level by voluntary health committees, village health boards and women's groups, which are expected to mobilise demand for health services and improve knowledge of preventative care. A RAF-funded research study to assess the effectiveness of a 'community based intervention model to address the

¹²³ Khan et al (2011)

¹²⁴ Faisal, A., Imran, M., Manzoor, A., Shoaib, S. and Suleman, S. (2012)

¹²⁵ Khan et al (2011)

¹²⁶ Khan, S. A., Shehzad, M., Shams, B., Yaqoob, A. and Zaman, T. (2012)

¹²⁷ Dobson and Lalji (2011)

¹²⁸ Khan et al (2011)

¹²⁹ Akhtar, T., Rauf, S., Khan, Z., Wazir, S. and Raza S. (2012)

¹³⁰ Hafeez et al (2011)

¹³¹ Mumtaz and Salway (2007)

three delays and improve access to EmONC for non-LHW covered areas' in Dadu district of Sindh province is currently underway.

It is important to remember that female health workers are also subject to similar gendered norms as their patients. A 2003 study¹³² found that LHWs are subject to: abusive hierarchical management structures; disrespect from male colleagues; sexual harassment; lack of sensitivity to their gender based cultural constraints, including inconvenient and distant placements; restricted mobility; and conflict between domestic and work responsibilities.

6.2.3 Traditional Birth Attendants (TBAs)

The majority of deliveries in rural Pakistan are conducted by the dai, or Traditional Birth Attendant (TBA). TBAs are popular care providers, particularly amongst poor communities, and have important strengths. They are independent service providers rooted in their communities. As the recognised experts on childbirth in their communities, they are critical to providing essential messages about routine maternal and newborn care, such as initiation of breastfeeding, cleanliness at delivery, and cleaning and warming babies.¹³³ However, they often use unsafe practices which are harmful for both the mother and baby,¹³⁴ and many women develop complications during home births. Of those that do, only 1 out of 20 is taken to a health facility where emergency obstetric care is available.¹³⁵

As in other developing countries, there have been various initiatives to train TBAs in Pakistan - to teach them how to respond to minor complications and to recognise and refer major complications. These have been shown to have a significant effect on reducing perinatal mortality - that is, infant death within the first week - but little impact on maternal mortality. A 2005 study in Pakistan evaluated the effect of a three-day training programme for TBAs in the context of rural home births.¹³⁶ The study found reductions in death rates for newborns, but did not find a statistically significant decrease in maternal death rates.

The majority of deliveries in rural Pakistan are conducted by the dai, or Traditional Birth Attendant (TBA). TBAs are popular care providers, particularly amongst poor communities

The Population Council's Safe Motherhood Applied Research and Training (SMART) Project also demonstrated a 22 per cent decline in perinatal mortality attributable to the training of dais and community mobilisation in Southern Punjab. A follow-up study conducted 19 months after the training showed that the trained dais had better knowledge, skills, practices, and client responses than untrained dais. Trained dais were also more aware than untrained dais of danger signs during pregnancy, delivery, the postpartum period, and for newborns. Significantly, trained dais were found to be referring about 40 per cent more cases to the nearest health facilities than untrained dais.¹³⁷

6.3 Supplies and Equipment

Under-investment in maternal health services means that both basic and comprehensive healthcare facilities often lack the minimum levels of drugs and equipment needed to provide effective maternal care. A study on maternal healthcare provision in Multan found that even when women make it to healthcare facilities, supplies, drugs, and equipment are often lacking. Essential supplies such as ferrous sulphate and folic acid (to prevent anaemia in pregnant mothers) were not available. Two facilities that serve between 100,000 and 300,000 people did not have basic newborn equipment, including baby scales, foetal stethoscopes, or bulb syringes.¹³⁸ Another study in Sindh found that only half the BHUs and RHCs in Sindh had the necessary equipment to carry out proper deliveries. Even basic requirements

¹³² Mumtaz et al (2003)

¹³³ Population Council (2011)

¹³⁴ Mumtaz et al (2003)

¹³⁵ Ibid.

¹³⁶ Jokhio (2005)

¹³⁷ Population Council (2011)

¹³⁸ Fikree et al (2006)



for safe delivery, such as soap, sterilised scissors or new blades for cutting the umbilical cord and sterilised thread or clips for cord tying were available in only one RHC and two BHUs.¹³⁹ In Balochistan, contraceptives were available in only 15 per cent of BHUs and in Sindh antibiotics were available in only 12 per cent of RHCs and 22 per cent of BHUs.

District hospitals are relatively better-equipped and many pregnant women go there directly when they need care, bypassing basic healthcare facilities because they lack trained staff, medicine and equipment. This can result in the poorer families incurring greater cost, in terms of fees, travel time and fares. It also results in district hospitals being overloaded.

6.4 Quality of Care

Generally, factors that patients consider important in determining quality of care include: acceptable waiting times; convenient opening hours; confidential relationships; availability of gender-sensitive services; continuity of services; and being treated with dignity and respect.¹⁴⁰ The poor quality of existing public reproductive health services is widely recognised, and is considered a major explanatory factor for the underutilisation of

services and for poor reproductive health outcomes in Pakistan.¹⁴¹ Satisfaction with government health services is low, especially among vulnerable groups. For example, a 2005 survey¹⁴² found that among households that are current users of services only 62 per cent were satisfied with government health facilities as compared to 82 per cent satisfaction among users of qualified private providers and 76 per cent among patients of unqualified providers. Vulnerable households were significantly less likely to report satisfaction with available government services while urban residents, more educated respondents, and female respondents were more likely to express general satisfaction. A 2011 RAF-funded study of client satisfaction with antenatal care services in 10 districts in Punjab found that only 5 per cent of providers were considered to provide quality services in terms of assessment, 2 per cent for counselling and 44 per cent for treatment.¹⁴³

In a 2007 assessment and patient satisfaction survey of the quality of healthcare in KPK the key problems identified included: hygiene, staff availability, access, referrals, complaint management, equipment, toilets, affordability, treatment guidelines and the availability of information to patients.¹⁴⁴

¹³⁹ World Bank (2010)

¹⁴⁰ Eldis Health Key Issues: Universal Access to Sexual and Reproductive Health Services <http://www.eldis.org/index.cfm?objectId=2CFE67B1-BDCA-4E0B-7E098172942AA9EC>

¹⁴¹ Sathar et al (2005)

¹⁴² Cited in World Bank, Delivering Better Services to Pakistan's Poor (2010)

¹⁴³ Majrooh, M.A., Akram, J., Hasnain, S. and Siddiqui, A. (2011)

¹⁴⁴ Government of NWFP (2009)

It is argued that the public health system in Pakistan is not sensitive to the gender and familial constraints and dimensions of better reproductive health. Clinic staff and community workers are not trained to become aware of and respond to patients' circumstances, to expand discussion beyond patients' immediate needs to their wider reproductive health concerns, and to engage them in discussion regarding reproductive healthcare solutions.¹⁴⁵ Minimum Service Delivery Standards (MSDS), although available, are not operational across the country.¹⁴⁶ There is also little evidence of the existence of mechanisms that enable patients' perspectives and levels of satisfaction to be taken into account when evaluating services, and incorporated into policy decisions.

6.5 Out of Pocket Payments

Out of pocket (OOP) payments – that is, costs that have to be paid out of pocket at the moment of utilisation of services - are considered to be one of the largest sources of healthcare financing in developing countries. According to National Health Accounts (NHA) 2005-6, 75 per cent of Punjab's health expenditure is financed through (OOP) payments. 98 per cent of the private expenditure in Punjab is financed through (OOP) Payments. A 2010 World Bank report¹⁴⁷ highlights that nearly all users of government facilities pay out of pocket, and that the costs of using public and private services are comparable. Paying for healthcare can expose families to large unexpected expenses, as out of pocket costs of healthcare can include consultation fees, the cost of medicines, as well as travel fares. Poor households can thus incur (OOP) Payments as high as 76 per cent of the total amount spent on healthcare per annum.¹⁴⁸

A WHO study¹⁴⁹ also finds payments for healthcare in Pakistan are regressive; those least able to contribute pay proportionately more than the better off. There is increasing evidence that (OOP) Payments act as a significant financial barrier to

essential healthcare, are a source of impoverishment, and can exacerbate inequity. The requirement of (OOP) Payments is particularly hard on the poor, whose illness will either remain untreated or force patients into deeper poverty. It is estimated that OOP healthcare payments drive about 4 per cent of Pakistan's population into poverty every year.¹⁵⁰ In a context where there is evidence of gender discrimination in terms of medical expenditures, fees can present a particularly significant barrier to women's access to reproductive healthcare.

Even the recent CMW programme, that is designed to increase access to skilled birth attendance in communities, is providing inequitable access to poor women. The 2011 Annual Review of the MNCH Programme¹⁵¹ found that CMWs are allowed to charge Rs. 500 per delivery.

6.6 Transport

Long-distance travel to healthcare facilities is a major barrier to accessing healthcare services, particularly for women who may have restrictions placed on their mobility or who may not be able to afford the transportation costs or the time needed for travel. This is particularly true when accessing antenatal care services in emergencies.

In rural areas of Pakistan distances to the nearest health facility, combined with poor roads, are a particular problem. A 2005 survey¹⁵² found that households with a government facility within 5 kilometres were 1.5 times more likely to use government facilities irrespective of whether private facilities were also available. Most communities in Balochistan (66 per cent) and Sindh (52 per cent) were located more than 20 kilometres from a Rural Health Centre. Punjab was best served with the majority of communities having access to facilities within 20 kilometres or less. In Balochistan, only 26 per cent of facilities were accessible by road, followed by Sindh with 46 per cent.¹⁵³ There is also

¹⁴⁵ Sathar et al (2005)

¹⁴⁶ Khan et al (2011)

¹⁴⁷ World Bank (2010)

¹⁴⁸ Ibid.

¹⁴⁹ Ibid.

¹⁵⁰ Ibid.

¹⁵¹ Khan et al (2011)

¹⁵² Cited in World Bank (2010)

¹⁵³ PDHS 2006-2007

Long-distance travel to healthcare facilities is also a major barrier to accessing healthcare services, particularly for women.

evidence¹⁵⁴ that dissatisfaction with primary care services means that many people prefer to turn to higher level hospitals for primary care. However, the effect of distance is compounded by poor public transport and roads, and this contributes to higher costs of visits. Long distances are also a disincentive for women who may need to be accompanied for each visit. A 2005 study¹⁵⁵ also found that most hospitals in the study districts of Punjab and KPK did not have functional ambulances.

6.7 Impact of Conflict and Natural Disasters

Conflicts and recent natural disasters have had a significant impact on the delivery of health services in affected areas. Immediate effects include the destruction of infrastructure, the exodus of health professionals (particularly female health workers), and the diversion of resources away from health. Women and girls who are displaced¹⁵⁶ by conflict or natural disasters are particularly vulnerable to poor reproductive health. Women may also lack access to safe delivery services and emergency obstetric care.¹⁵⁷

It should be noted that in emergency healthcare provision in refugee/IDP camps can sometimes be considerably higher in quality and greater in scope than 'normal' services (e.g. increased accessibility of FP, abortion and post-abortion care services), and it is often remarked that this was the case during the 2010 floods. However, experiences vary. A 2010 assessment of IDP camp conditions in Dera Ismail Khan following the displacement of almost

Box 5

The impact of conflict on maternal health in Gilgit

Women's access to health services is adversely affected by ethnic, sectarian or religious conflict. Research into the uptake of maternal health services by Sunni women in Gilgit Town, in Pakistan's Northern Areas during the period of 2005 Sunni-Shia conflict found that following the Pakistani Army's January 2005 takeover of civil administration, governmental concerns with health service provision, physician safety and patient access were de-prioritised. Sunni physicians were purposefully targeted and killed in sectarian attacks - and as maternal health centres were located in Shi'a neighbourhoods (mohallas), and health services were mostly provided by Shi'a physicians and support staff - Sunni community members were profoundly impacted. By summer 2005, thousands of pregnant Sunni women were either denied access to services by the Army during curfews, or by family members unwilling to accompany patients to seek treatment in Shi'a mohallas. Comparative analysis of Gilgit's maternity clinic records between late 2004 and early 2005 shows an 80 per cent drop in the number of Sunni patients.

Sources: Varley (2010)

2.8 million people in the Swat/Malakand operation in 2009 found that over 57 per cent of people had no access to health services.¹⁵⁸

6.7.1 Impact on Infrastructure

Insurgent groups in KPK have engaged in frequent attacks against security personnel, teachers and health workers. Militants have targeted vaccination campaigns, NGOs and reporters, as well as education and health infrastructure.¹⁵⁹ A 2010 Amnesty International report estimates that in 2009 there were sixteen attacks on NGOs and health facilities in FATA and KPK - an increase from five attacks in 2008. In Malakand district, which has been particularly affected by violence, the estimated cost of damages to health infrastructure

¹⁵⁴ Fikree et al (2006)

¹⁵⁵ Ali et al (2005)

¹⁵⁶ Internally Displaced Women (IDPs) not living in camps and those in new emergencies are reported to be more likely to have poorer access to reproductive health services than refugees, largely due to the absence of a legal instrument that recognises IDPs internationally.

¹⁵⁷ Austin et al (2008)

¹⁵⁸ Save the Children (2010)

¹⁵⁹ Amnesty International (2010)



is Rs. 502 million. It is reported that the health facility network in FATA has deteriorated to such an extent that even those needing minor procedures have to travel to Peshawar.¹⁶⁰

6.7.2 Impact on Human Resources

Natural disasters and conflict situations adversely affect doctors and health workers. Ongoing sectarian tension in Karachi has resulted in the deliberate targeting and killing of nearly 75 Shi'a physicians by Sunni militants over the past decade. The deaths of physicians, often considered leading members of their respective communities are typically viewed as a means to destabilise or punish 'enemy' communities.¹⁶¹ In FATA there have been reports of abductions of health workers by insurgent groups and doctors being killed or injured by insurgents or as a result of US military operations. In areas such as Mardan in KPK and Dir-Bajaur districts in FATA, women health service providers have been routinely targeted for violent attacks or intimidated or threatened by militants. NGOs also report incidents of health workers being shot, taken hostage, threatened and kidnapped.¹⁶² As a result, many doctors, nurses and Lady Health Workers have refused to carry on working in FATA, either taking extended leave, or seeking transfers to safer facilities.¹⁶³ The loss of health staff can lead

to significant gaps in health service provision. The 2011 Annual Review of the MNCH Programme¹⁶⁴ found that DHQs in the districts of Tank, Battagram, Karak, Shangla, Hangu and Kohistan are not providing CEmONC services due to security reasons and being unattractive places to work. The LHW programme has been particularly affected by recent natural disasters - 72 per cent of LHW houses were partially or completely destroyed during the Earthquake¹⁶⁵ and in flood-hit regions, the LHW programme experienced more than 50 per cent staff shortages in the worst affected districts.¹⁶⁶

6.7.3 Government Spending

Conflict affects government spending on the health sector. Pakistan's government spends about 2.9 per cent of GDP on health – less than any of its neighbours.¹⁶⁷ Government expenditure is strongly tilted towards debt servicing and defence. While the former has reduced from 52.5 per cent in 2005 to 27.1 per cent in 2010, defence expenditure has remained stable at around 17-20 per cent. It is estimated that the conflict over the Siachen glacier costs India and Pakistan an average \$200 million annually, more than enough to meet the primary child health needs for several states and provinces in the region.¹⁶⁸

¹⁶⁰ Yusufzai (2008)

¹⁶¹ Varley (2010)

¹⁶² In 2009, a militant group seized a health unit operate by the International Medical Corps in the Buner district in KPK. Staff members were kept hostage for over an hour and clinic inventories stolen (Rubenstein 2010)

¹⁶³ Yusufzai (2008)

¹⁶⁴ Khan et al (2011)

¹⁶⁵ Ibid.

¹⁶⁶ Dar and Khan (2010)

¹⁶⁷ Gottret (2010)

¹⁶⁸ Bhutta (2004)

Demand-side Factors

In addition to the predominantly supply-side issues discussed above, there are various 'demand-side' issues which influence the ability of poor women to access and use maternal and newborn health services, but which are not directly dependent on service delivery. These include social and cultural issues which affect women's ability to demand better services and for these demands to be listened to by their families and health service providers. Pakistani women face a number of different barriers in accessing and utilising maternal health services. These include: poor levels of education; lack of decision-making power; lack of financial resources; fear of violence; and constraints to mobility. There is significant evidence that these barriers contribute to the 'three delays' (see section 4) that poor women can experience in accessing healthcare, particularly in emergency situations.

7.1 Literacy and education

Education has been shown to have a significant influence on female health outcomes. Low levels of girls' education, which are prevalent across parts of Pakistan, are not only linked to poor maternal and newborn health outcomes, they also limit women and girls' health seeking behaviour.

Education is also an important factor in determining whether a woman bears children at a young age, which may result in unfavourable health outcomes for both maternal and child health,

Women and girls' limited access to education also affects their health care-seeking behaviour.

particularly if the girl is young and physically and psychologically underdeveloped. In Pakistan, women with more than secondary education get married at a median age of 24.5 years, nearly six years later than women with no education (18.2 years).¹⁶⁹ Infant and child mortality rates are lower among children whose parents are more highly educated. In 2006-7 the infant mortality rate for babies of women with no education was 84 deaths per 1,000 live births compared to 50 deaths per 1,000 live births for babies of mothers with higher education.¹⁷⁰

Women and girls' limited access to education also affects their health care-seeking behaviour as it deprives them of the knowledge and tools to recognise symptoms of disease and make informed health decisions. Women's education levels are also positively associated with low rates of use of contraceptive and antenatal care.¹⁷¹

7.1.1 Traditional healthcare beliefs and practices

Lack of education and access to information can

¹⁶⁹ PDHS 2006-2007

¹⁷⁰ Ibid.

¹⁷¹ Saleem and Bobak (2005)



result in strengthening of traditional beliefs and practices, some of which are harmful to the health of women and babies. A 2004 study¹⁷² of women in low-income areas of Karachi found that women were more likely to seek treatment for high fever earlier than for heavy bleeding. This is because of the pervasive belief that postpartum bleeding is normal - and in fact desirable - as it releases the unclean menstrual blood retained in the uterus during pregnancy. Some women delay seeking treatment for heavy bleeding or discharge because they believe that it is a result of weakness caused by the rigours of labour and delivery. In addition, women often seek care from close relatives or traditional healers rather than from formal health care providers.

Traditional feeding and routine care practices of newborn babies can also prove harmful. For example, a 2005 study¹⁷³ found that 55 per cent of women fed their newborn traditional substances such as honey, ghutti (a herbal paste), water, green tea or other foods. Studies have shown that breast milk is the best first food for babies and that such pre-lacteals may be harmful to infants. Some women also applied substances such as mustard oil, coconut oil, surma (which contains antimony, a metallic element) or other traditional substances to newborn babies. When applied to an unhealed umbilical stump, these materials may lead to sepsis, a potentially deadly infection of the blood. Daily

massage with mustard oil is another common newborn care ritual that may induce sepsis.

7.2 Women's Employment

In the labour market, lower educational status coupled with social norms that restrict mobility confine Pakistani women to a limited range of employment opportunities and low wages.¹⁷⁴ As a result, they lack economic independence and have fewer economic benefits. This has implications for both their social status and their health. Adequate income is an important factor in being able to access healthcare services, particularly when these services are not freely provided by the state.

Women often perform unpaid work in the house or in subsistence agriculture or family businesses and are not registered in the statistics on female employment. As a result, their economic participation goes unrecognised officially, and their working conditions are unregulated.

7.3 Decision-Making Authority

It is argued that low levels of individual autonomy amongst women in Pakistan results in poorer health outcomes, in that women are unable to make decisions regarding the need for care, and accessing healthcare services. Men often control the household's resources and along with older family

¹⁷² Fikree et al (2004)

¹⁷³ Fikree et al (2005)

¹⁷⁴ World Bank (2005)

members such as the mother-in-law, play a paramount role in determining the health needs of a woman and deciding when and where she should seek healthcare. An analysis of data from the Pakistan Social and Living Standards Measurement Survey (PSLM) 2005-06¹⁷⁵ finds strong evidence that heads of households play a significant role in women's maternal health services utilisation in Pakistan. In the 2001 Pakistan Rural Household Survey, an overwhelming number of women reported that they needed permission to visit a health facility.¹⁷⁶ The low status of women can prevent them from recognising and voicing their concerns about health needs.¹⁷⁷

Pregnancy and reproductive issues are also considered part of the female domain, from which men are excluded. As a result husbands often have limited knowledge of the symptoms of danger in pregnancy¹⁷⁸: "So strong is this exclusion that it is incorporated into societal prescriptions regarding how an ideal mard (men conforming to the socially acceptable notions of hegemonic masculinity) should behave."¹⁷⁹ The same study also highlights that pregnancy is associated with sex, and therefore with sharam (shame). This has implications for the amount of interest a man will demonstrate in his wife's pregnancy as well as the mobility of pregnant women. Pregnancy is also associated with impurity. Women are considered napaak (impure) for 40 days following birth, during which time they may not say

their prayers, or touch the Qur'an. This leads to what the authors' term a 'metaphorical' separation from men.

Poor households with few educated family members often make decisions collectively. Research¹⁸⁰ amongst women in rural Punjab has found that in contexts of limited education and female seclusion, women from the biraaderi (extended kinship networks) are often seen as sources of reproductive health knowledge. Thus, experiences of contraceptive methods and antenatal care are often discussed within these networks, and this creates an environment which can either encourage or inhibit the use of healthcare services. However, the ultimate authority to make pregnancy-related decisions rests with a parent-in-law or husband.¹⁸¹ A woman's ability to influence this decision-making often rests on her ability to use her network of interpersonal relationships with her husband, marital family and natal family.

A study of antenatal care (ANC) in Punjab found that women who successfully claimed ANC did so not through direct challenges but by using existing gendered structures and channels of communication to influence authority figures.¹⁸²

7.4 Privacy

The inhibitions of women themselves are also an important factor preventing women from seeking healthcare. Many women are not comfortable discussing their sexual behaviour. This embarrassment causes some to turn to home remedies or dispensaries when they should be seeing a doctor, thereby delaying treatment. Their discomfort is exacerbated in the presence of doctors by the lack of privacy during consultations; poor provision of information regarding diagnosis; treatment and after-effects; and the "moralising, judgemental and sometimes callous" attitude of staff.¹⁸³

A woman's ability to influence this decision-making often rests on her ability to use her network of interpersonal relationships with her husband, marital family and natal family.

¹⁷⁵ Hou (2010)

¹⁷⁶ Cited in World Bank (2005)

¹⁷⁷ Shaikh and Hatcher (2004)

¹⁷⁸ Mumtaz and Salway (2007)

¹⁷⁹ Ibid.

¹⁸⁰ Mumtaz and Salway (2009)

¹⁸¹ Sathar et al (2005)

¹⁸² Mumtaz and Salway (2007)

¹⁸³ Gardner and Subramaniam (2006)

In addition, strong taboos around discussing sex and sexuality also keep women from talking about family size and the need for contraception. According to a 2008 study¹⁸⁴:

“Most young women felt they could not openly discuss sexual health issues with their husbands, partly due to sex and sexuality being a taboo and partly because of the fear that their motives may be misunderstood and they might even be accused of adultery.”¹⁸⁵

7.5 Mobility

Although women have the legal right to freedom of movement, traditions and customary practices (including purdah) limit their ability to exercise this right - and effectively access and use healthcare services - to various degrees in different regions. A 1997 study of women's mobility in Punjab finds that the issue of mobility has three dimensions: women have to seek permission to go to certain places; there are restrictions on going to certain places alone; and purdah has to be observed.¹⁸⁶ A study for World Bank's 2005 Country Gender Assessment finds that the majority of rural women are unable to travel to a health facility unaccompanied (see Box 2 and section 4.2 for more on this).

Unplanned pregnancies are the main reason why women seek induced abortions, and many poor women often resort to unsafe abortions, which carry serious risks to their health.

However, Mumtaz and Salway (2009) argue that it is the decision to access healthcare that is the key determinant of the uptake of reproductive health services and not women's patterns of mobility. Their study found that: “(O)nce a decision was made, women invariably travelled with company. Women sought company, for it protected them from potential accusations of sexual misdemeanour and ensured someone would look after their interests in the case of incapacitation in a usually hostile healthcare system.”

7.6 Use of Contraceptives

Contraceptive usage has important implications for reproductive and maternal health as unintended pregnancies may result in unsafe abortion. The lack of availability of contraception can also lead to multiple pregnancies which can have a detrimental effect on the health of mothers.

A 2000 study¹⁸⁷ also shows that a longer interval between births substantially decreases the risk of the newborn dying in infancy. Children born between 18-35 months of a sibling are 0.4 times as likely to die in infancy as children born within less than 18 months. Data from the 2006-7 PDHS shows that the average birth interval in Pakistan is 29 months but one-third of babies are born less than two years after the previous birth.

The 2006-7 PDHS finds that while the use of family planning has tripled since the 1980s, it has levelled off in recent years. The current contraceptive prevalence rate of 30 per cent is roughly the same as 2003 levels.

Poor women's inability to exercise control over their own bodies and reproductive activity due to patriarchal cultural norms affects the uptake of contraceptive methods. In Pakistan, the main barriers to using contraception are women's concerns about their husbands' or in-laws' views about family planning; the perceived social unacceptability of contraception; and the belief that family planning decisions are made by the

¹⁸⁴ Hussain and Khan (2008), p.473-4

¹⁸⁵ According to the Hudood Ordinance – a 1979 law enacted to implement Shari'a law – there is a maximum penalty for extra-marital and pre-marital sex as death by stoning and 100 lashes respectively.

¹⁸⁶ Cited in Mumtaz and Salway (2007)

¹⁸⁷ Agha (2000)



husband and fertility was determined by God's will.¹⁸⁸ A 2000 study¹⁸⁹ found that no village women admitted using contraceptives, even though half of them did not want any more children. The authors report:

“One woman explained that if women told their husbands that they wanted to use contraceptives, the husbands would harass them and ask who had brainwashed them. Another woman spoke of duniadari, the concept that you have to conform with the norms of the society”.¹⁹⁰

This highlights the importance of targeting secondary audiences such as mothers-in-law and husbands in family planning behaviour change campaigns.¹⁹¹

7.6.1 Son Preference

In Pakistan, sons are generally preferred to daughters as they are considered to carry on the family name, earn money and support their parents in old age. Conversely, girls have to be supported until marriage and families have to provide a dowry to get them married.

As a result, women with relatively more daughters than sons are more likely to want or are pressurised to have more children and are therefore less likely to practice contraception.¹⁹² A 2000 study¹⁹³ of urban and rural women from the low-to-middle-income groups in Punjab found that whether women had borne sons affected their ‘status’ within their families, and their access to healthcare. Women with many sons were considered to be better-respected than other women. The study also found that most urban women who had sons used contraceptives. A woman who produced only girls could be considered incomplete and her husband was encouraged to remarry. Mothers of daughters, particularly those from low-income households, experienced verbal and physical abuse. As a result, the women did not use contraceptives and planned to keep conceiving until they had a son.

This 'son preference' can also lead to relative neglect (as well abandonment) of girls compared to boys in early childhood.¹⁹⁴ In addition, women who have been discriminated against from birth have already experienced years of deprivation and in some cases malnourishment when they enter their childbearing years. Their health reserves are then further drained by repeated childbearing and inadequate care during maternity.

¹⁸⁸ Cited in Hussain and Khan (2008); Agha (2010)

¹⁸⁹ Winkvist and Akhtar (2000)

¹⁹⁰ Ibid.

¹⁹¹ Agha (2010)

¹⁹² World Bank (2005)

¹⁹³ Winkvist and Akhtar (2000)

¹⁹⁴ OECD/DAC (2005)



7.6.2 Abortions

There is significant unmet need for family planning, particularly in rural areas (almost 25 per cent according to the 2006-7 PDHS), as well as high abortion rates in rural, impoverished or conflict-affected communities. The risk of post-abortion complications is also unevenly distributed according to residence and income quintile. Wealthier urban women can afford hygienic abortions provided in clinical settings and by skilled providers. In rural areas, abortions are routinely provided by unskilled providers.¹⁹⁵ A 2002 study¹⁹⁶ estimated that, on average, only 7 per cent of poor rural women obtained their abortions from doctors, while 42 per cent went to dais. By comparison, an estimated 49 per cent of non-poor urban women had doctors perform their abortions, while only 9 per cent went to dais. One-half of all abortions are performed by providers who lack sufficient training and in unhygienic conditions.¹⁹⁷

Unplanned pregnancies are the main reason why women seek induced abortions. A number of studies¹⁹⁸ have reported high rates of morbidity amongst women admitted to hospital for complications of induced abortion. A 2004 study¹⁹⁹ finds that in 2002, 890,000 induced abortions were performed, and the annual abortion rate was 29 per

1,000 women aged 15-49. These figures indicate that the average Pakistani woman experiences one abortion in her lifetime. One in seven pregnancies is terminated by abortion, indicating that induced abortion is a widely used method of preventing unwanted births. An estimated 23 per cent of all Pakistani women who have an abortion are hospitalised for ensuing complications. Others who cannot access medical services die, or live with debilitating complications.

7.7 The Impact of Conflict and Natural Disasters

Women and girls from communities that are displaced²⁰⁰ by conflict or natural disasters are particularly vulnerable to poor reproductive health. The disruption of family and social support mechanisms and lack of access to livelihoods and community support can make them vulnerable to sexual violence. Evidence suggests that displaced women probably experience rape and other forms of sexual violence more often than women in settled populations,²⁰¹ particularly where lack of employment opportunities for young men in displaced settings lead to conflict and violence within the home.²⁰² Women may also lack access to safe delivery services and emergency obstetric

¹⁹⁵ Vlassoff et al (2009)

¹⁹⁶ Rashida et al (2003). This study drew together more than 100 health professionals from all four provinces to consider how women's economic status and residence influence access to formally trained abortion providers.

¹⁹⁷ Casterline et al (2004)

¹⁹⁸ Cited in Hussain and Khan (2008), p.478-9

¹⁹⁹ Population Council (2004)

²⁰⁰ Internally Displaced Women (IDPs) not living in camps and those in new emergencies are reported to be more likely to have poorer access to reproductive health services than refugees, largely due to the absence of a legal instrument that recognises IDPs internationally.

²⁰¹ McGinn (2000)

²⁰² Kottagoda (2008)

care. Lack of quality reproductive health services can lead to high mortality rates, an increase in unsafe abortions, and increased morbidity related to high fertility rates, poor birth spacing, and post-abortion complications.²⁰³

7.7.1 Violence against Women and Children

Rates of spousal and family violence are known to increase in response to widespread insecurity or hostilities and conflict. The stress of living in overcrowded conditions, the trauma of violence and loss compounded by the lack of employment can also contribute to domestic violence. In a study of gender-based violence (GBV) amongst Afghan refugees in Pakistan, 50 per cent of women reported experiencing physical or emotional violence. 60 per cent of husbands admitted to abusing their wives and 30 per cent stated that they had resorted to extreme abusive practices, such as punching or causing serious physical harm.²⁰⁴

7.7.2 Mental Health

Women have been found to experience severe mental health problems in conflict and disaster situations. Mental illness affects women's ability to cope with issues of reproductive health.

A recent study of women survivors of the 2005 earthquake found 63 per cent of the earthquake-affected women of reproductive age in Pakistan had anxiety and 54 per cent had depression.²⁰⁵ A husband's lower education, having a husband who lost his job or family business, having experienced gender violence, and being separated from a family member were highly associated with depression and anxiety. Having limited access to health facilities was also found to be a strong predictor for depression and anxiety.

Adolescent girls and women who are poor, socially excluded and experience marital instability or violence are especially likely to suffer from clinical depression and anxiety, which is correlated with reduced decision-making and self-care. Depression is directly linked to adverse premature labour,

decreased breast-milk, compromised neonatal nutritional status and poor rates of infant survival.²⁰⁶ It is also considered an underlying cause of inconsistent, low- or non-use of contraception, higher incidence of pre-menstrual dysphoric disorder (PDD), post-partum depression and psychosis.

7.7.3 Access to Services and Peace Building

Deterioration in the health status and human capital of women is also critical as they play an important role in promoting social cohesion and reducing conflict. The inclusion of women in peace processes is essential as their involvement contributes to promoting the norms of equal participation; allows for the articulation of different experiences and needs of women in conflict; and enables women to act as active agents in post-conflict recovery processes. Promoting maternal health allows women the opportunity to develop the human capital in order to participate fully in society.²⁰⁷

Conflict can also impact social capital by causing displacement, changing household composition, disrupting family networks, breaking down relationships of trust and closing off access to wider institutions of society. When combined with the breakdown in state service provision, vulnerable individuals and households who are dependent on local or family networks can be left with no support networks at all.

It is commonly argued that relative deprivation – i.e. when poverty is associated with perceived injustices, and exclusion between groups – is more strongly

Promoting maternal health allows women the opportunity to develop the human capital in order to participate fully in society.

²⁰³ Austin et al (2008)

²⁰⁴ International Medical Corps (2009)

²⁰⁵ IDMC/Norwegian Refugee Council (2011)

²⁰⁶ Rahman et al (2004)

²⁰⁷ In times of conflict, men and women's adherence to 'typically' male and female gender roles take on a greater symbolic/performative importance. As such, many women face pressures to uphold 'traditional' practices, such as purdah and social segregation, and forms of gender inequity at domestic and community levels

linked to conflict than poverty per se. Research has found that where culturally defined groups experience multiple forms of exclusion ('horizontal inequalities') in the political, economic, social and cultural realms, violence becomes more likely.²⁰⁸

In the case of Pakistan, inequalities are linked to ethnic, communal and class divisions. There are consistent regional disparities in Pakistan, across the economic, social and political spheres, and there is a wide disparity in health indicators between the provinces and between income groups (*please see section 3 for more information on this*).

State patronage of certain regions and ethnic groups fuels conflicts along regional and ethnic divides, as it causes resentment among those who consider that they are treated unfairly in terms of resource distribution, particularly in terms of social services. For example, a recent survey of FATA residents on issues that were "very important" to them, found that FATA residents overwhelmingly identified 'human services' (81.4 per cent identified lack of jobs, 67.3 per cent cited lack of schools and education, and 70 per cent cited poor healthcare). In contrast, while highly unpopular, only 60 per cent cited the US drone programme as "very important".²⁰⁹

Furthermore, states that do not fulfil a society's basic needs and expectations are seen to lack legitimacy. There are arguments that service delivery can improve the legitimacy of weak governments and that health service provision addresses group grievances that stem from the perception that government service provision is inequitable. However, there has been little research into the relationship between health and state-building. There are also few studies that look at the expectations of populations regarding healthcare provision by their government.

DFID's 2010 Practice Paper on Building Peaceful States and Societies argues:

"A population's trust in state institutions increases as it sees the state acting in the collective interest. Where the state

has the will and capacity to deliver its functions, meet public expectations and uphold its obligations to protect human rights, the population is more willing to pay taxes, accept the state's monopoly on legitimate use of force and comply with laws and regulations." Responding to people's expectations is thus considered a key component of efforts to build peaceful states and societies.

Where state capacity is weak, the impetus can be to deliver services quickly through non-state mechanisms, to meet urgent needs and address grievances. However, this may weaken state legitimacy. Conversely, premature attempts to deliver services through a weak state may overwhelm capacity and mean that basic needs go unmet.²¹⁰ The role of non-state actors must thus be carefully thought through. Whereas they can usefully provide basic services where the state is absent, visible services provided by non-state actors, whose primary accountability is to donors rather than to citizens, can undermine legitimacy. Quality in service provision is equally important for state credibility.

²⁰⁸ Stewart (2008); Kanbur (2007)

²⁰⁹ New America Foundation/Terror Free Tomorrow (2010)

²¹⁰ DFID (2010)





Conclusion

This paper has argued that the poor, rural and excluded women and children of Pakistan bear a disproportionate burden of maternal and newborn mortality and disability. A large number of these maternal and newborn deaths could be avoided if women had access to timely, appropriate, affordable and adequate care. Access to, and utilisation of, health care services is determined by factors such as physical access to services, economic access or affordability of services and social and cultural barriers which limit access to or acceptability of services. A 2010 DFID study highlights the ‘futility’ of strengthening the supply side of a health system without addressing the major demand side barriers that currently prevent many of the poorest women from accessing health services.²¹¹

For Pakistan to make meaningful progress, on maternal and newborn health, the issues of poverty, gender and social exclusion must be explicitly addressed and put at the centre of government policy making, planning and budgeting. Development interventions are unlikely to reach excluded people unless they are specifically designed to do so.

Research that focuses on gender and social exclusion can help to identify the processes and mechanisms that prevent women from accessing maternal healthcare services. It can identify which groups are excluded and help unpack the processes and structures which underpin the exclusion of women from access to quality maternal and newborn health services. These include the governance issues and barriers that result from exclusion from decision-

For Pakistan to make meaningful progress, on maternal and newborn health, the issues of poverty, gender and social exclusion must be explicitly addressed and put at the centre of government policy making, planning and budgeting.

making processes, assets and opportunities; and the social norms, cultural practices and informal institutions that lead to discrimination against women and excluded groups.

RAF recognises that poor women and socially excluded groups are often unable to influence decision-making in Pakistan and that differences in power often determine whose voice is heard. Advocacy strategies that are based on rigorous evidence collected through the participation of poor men and women can act as an important instrument for greater citizen’s voice and demands for improved state responsiveness.

This paper should thus be seen as a starting point, and its findings subjected to deeper analysis. It aims to provide a basis upon which actors involved

²¹¹ Hulton et al (2010), *The Evidence toward MDG 5: A Working Paper*, Paper commissioned by DFID and NORAD, Options, p.98



in research, advocacy and programming in maternal and newborn health in Pakistan can build further thinking about how to address poverty, gender and social exclusion issues. The paper has argued that this is critical if Pakistan is to make meaningful progress in addressing maternal and newborn mortality.

In addition, on the basis of this initial review of the available evidence, a tentative list of areas can be identified in which there are gaps in the data:

- Detailed case study research on the reasons why women find it hard to access healthcare in certain contexts, involving an investigation into the dynamics of household-level decision-making, the problems with the treatment women receive, and the perceived benefits of 'traditional' medicine and healthcare.
- Greater research and analysis of the impact of social exclusion on women's access to maternal and newborn health services.
- Analysis of the decision-making processes on budgeting and planning for maternal and newborn health in Pakistan. Who are the decision-makers, both at national and local levels? How are decisions made? What information is used? What are the mechanisms for oversight and accountability?
- Analysis of the role that women parliamentarians play in lobbying for greater attention to maternal and newborn health through, for example, through participation in decision-making committees and higher forums such as local government commissions, finance, management and monitoring committees.
- Research on the potential for citizens, community organisations and political leaders at the local level to influence planning, development, management and implementation of healthcare delivery at the district level.
- Research on the role of traditional governance institutions such as informal justice mechanisms, religious leaders, traditional leaders, etc. in reinforcing or challenging social norms around women and children's health.
- Greater analysis of how community health workers address pregnancy complications. Are they given and trained in using medical equipment that can address some issues? How do they ensure women's access to emergency obstetric care? How much authority do they have vis-à-vis the patients' family?
- An exploration of models through which women who live in areas uncovered by CMWs or LHWs can access maternal healthcare.
- Research on the adequacy of skills and knowledge amongst health visitors and hospital staff to address obstetric complications.
- Action research around the gender challenges faced by lady health workers/visitors in the health sector.
- Research on the role of health visitors as well as clinic and hospital staff in identifying and addressing violence against women.
- The role of social and kinship networks, as well as older women and men, in creating an environment which encourages utilisation of health services.

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Page 8

Wife of a local farmer from KHOO MITHIWALA- DG Khan; 27 year old Rubina is a mother of five. With not enough to eat and repeated pregnancies Rubina is acutely anaemic and looks much older than her age.

Page 12

Bibi jan stands outside her house with her twenty one year old daughter-in-law Samina and her four children. (Gilgit Baltistan).

Page 14

19 year old Hajra with her 5 day old baby boy Arsalan – her second child in 2 years of marriage.

Page 16

About to have mustard leaves with rotten tomatoes and roti (pita bread) for lunch; Nasrullah has three children and his wife is expecting the fourth. He is Imam (prayer leader) at a local mosque in a village (Swat) and also works as a daily wage worker at a local vegetable market.

Page 18

Aisha bibi, pregnant with her eighth child lies on the floor next to a charpai (bedstead) surrounded by her mother in law, daughters and a grand daughter

Page 21

Children of school going age play around in streets – village Khoo Mithiwala near Dera Ghazi Khan

Page 23

23 year old Sajida and her husband Adil Khan – a daily wage earner in Swat valley have 5 children, the youngest only 25 days old. With not enough money for rent, they live in a one room under construction house with the owner's consent.

Page 26

Traditions and customary practices limit women's mobility to various degrees in different regions. In most areas, women outside the home must be accompanied at all times by a male relative, even while she observes purdah.

Page 29

LHV doing prenatal checkups at a Basic Health Unit in Kot Chutta. As the only public health facility in the area the BHU sees an average of 200-250 patients every day. The BHU has also seen a rise in the number of women coming for deliveries since they have had a LHV on duty (24 hours) and an on call Lady doctor. The BHU also has the facility of a basic labour room.

Page 30

Patients and their relatives wait for their turn to see the Lady Doctor at BHU near Dera Gazi Khan.

Page 33

Seen here with his wife and grand children, Nizam is a retired bus driver and a father of 5 sons and 5 daughters. They all live in the same 2 room house. Two of his sons are married and do odd jobs to sustain the family. His daughters and Daughter-in-laws were not allowed to be photographed.

Page 34

Woman waiting for her turn to get her newborn immunised at a Public Vaccination Centre in Swat City

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Women wait to see the doctor in a basic health unit.

Page 38

Zarena with her just delivered baby boy at a BHU in D. G Khan District. While most deliveries are conducted by TBAs, the lady health worker had convinced Zarena's mother in law to take her to the BHU.

Page 41

A young mother brings her baby for vaccination at a Public Vaccination Centre in Swat City

Page 44

Girls are often given complete responsibility to take care of their younger siblings from a very young age. Five year old Sara and her friends carry their siblings all day long, while their mothers do household chores and go out to collect potable water, in the remotely located mountainous Forano Village, Gilgit Baltistan.

Page 46

Pakistan has a strong patriarchal society. Men are the bread earners, while women are supposed to stay indoors and manage the house. This picture shows Khuda Bakhsh (in orange turban) and his brother are brick kiln workers in a village near Jehlum. They support a large family of twenty-five members including their wives, children and grand children. Bakhsh's wife is pregnant with their eighth child.

Page 49

Karim lives with his wife and five children in a mud house shared with his six brothers and their families. The brothers work as farmers for a local land lord and support the family of fifty eight members. In this picture Karim is seen holding his newborn son, as his wife (in maroon shawl) and other members look on.

Page 50

The wife of a daily wage earner Aliya is 9 months pregnant with her first child. Her mother in law (in white burqa) insists she is 19 years old but the LHW conducting the prenatal checkup insists she is much younger, extremely malnourished and anaemic.

Page 53

An LHW checks the weight of the newborn while visiting Hajra after the birth of her second son, for a post natal check-up.

Page 54

15 year old Naila plays with her daughter – one year old Saima.

Page 56

27 year old Rubina shares a single plate of rice with her five children; three daughters and two sons – one of them four months old. With not enough to eat and repeated pregnancies Rubina is acutely anaemic and looks much older than her age.

