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Gender Inequalities of Health: A Case Study of Pakistan

Waseem Hassan Malik

Thesis submitted in partial fulfillment of the requirement for the Masters of Arts
in International Development Studies at Saint Mary's University,
Halifax, Nova Scotia, Canada

July 28, 2000

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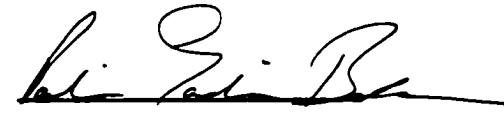

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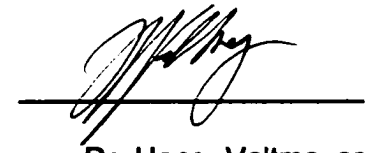

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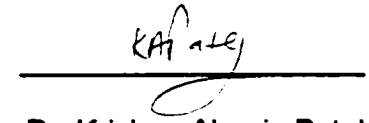

Dr. Krishna Ahooja Patel

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Abstract

Gender Inequalities of Health: A Case Study of Pakistan

Pakistan is one of the low-income countries in the world where the status of women in particular, is far lower than even in the South Asian countries. Low level of education, poor health and nutrition, limited access to resources and lack of decision making power are the main causes of low status of women. There is an immense need to provide social, economic, political and legal opportunities to three-quarters of Pakistan's population: women and children who are neither beneficiaries of or contributors to the development process and fall for short of realizing their human potential.

The study is based on the Gender and Development (GAD) approach to assessing and dealing with women's unequal position in society and it involves an analysis of gender disparities with regards to accessing health facilities. The study discusses the present health systems of Pakistan as well as the health status of women. Included are the issues of population growth and family planning policies implemented by the government. It also highlights the role of non-government and international agencies in providing health care services to people, the impact of these services and the barriers to accessing these services.

Until recently gender differences in health received little attention from the planners and policy makers. The focus has been more on the provision of health services. However, other socio-cultural barriers have been neglected. For example, social norms about female mobility, *purdah* and burden of family honor have increased women's responsibilities and caused them to neglect their own needs. It has been argued that patriarchy is the main cause of segregating women in accessing health care and that all interventions to increase women's health status are women oriented. In a society of male decision-makers, it's crucial to have an intense participation of men in the process of change to achieve the goal of gender equality in health.

July, 2000

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Chapter One

INTRODUCTION

Theoretical Overview

There is a strong link between health and social development, a fact that can not be denied for reasons which are apparent in human history. The allocation and provision of resources are determined by each society's distinct setup and among these resources health facilities are critical. An equal or equitable provision, allocation and distribution of these facilities are the key issues. Unfortunately, this distribution is well under the influence of the socially defined gender inequalities, which further leads to an increase in the differences in the life span of men and women. This neglect and ignorance is particularly complex in the context of women's health due to their different biological structures and needs. There is a need to understand the social, cultural, economic, political and religious barriers of society that inhibit access and utilization of health resources adequately and equally by both women and men.

Gender disparities in Pakistani society and culture are deep and extensive. Deeply rooted cultural and institutional constraints prevent Pakistani women from playing a fulfilling role in the development of their society. Their presence in the public sphere is condemned under the guise of cultural and religious values, thus making their contribution outside the home difficult if not impossible.

Institutionalized violence against women in Pakistan allows crimes of 'passion' and 'honor' to go unpunished and in the past two decades has become one of the biggest constraints to a widening of their role in the public domain.

Gender disparities are pronounced despite some gains over the past two decades, Pakistan's female health indicators compare unfavorably with both the averages for South Asia and with low-income countries as a group. Disparities in life expectancy at birth, the under-five mortality rates, the adult literacy rate and school enrollment ratios are wider for females than for males. Maternal mortality-at 27 per 10,000 live births-remains high. One measurable consequence of this in Pakistan is a maternal mortality rate of 340 / 100000 (UNDP 1999) and that complications related to reproductive health are among the first five causes of deaths for women aged between 15 and 44 years of age (Boerma 1987).

Health policies and programs have focused on biological aspects of diagnosis, treatment and prevention. Likewise, when considering the differences between women and men there is a tendency to emphasize biological or sex differences as explanatory factors of well-being and illness. A gender approach to health, while not excluding biological factors considers the critical roles that social and cultural factors and power relations between women and men play in promoting and protecting or impeding health. The World Health Organization (1999) defined health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity".

There has been a tendency to equate gender analysis with an analysis of the situation of women. The purpose of a gender analysis, however, is to identify and analyze inequalities that arise from belonging to one sex or the other, or from the unequal power relations between the sexes. These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health. They can also affect the access to and control of resources, including decision making and education, which protect and promote health and the responsibilities and rewards in health work. Since these inequalities most often disadvantage women a gender analysis will be used to explain and address women's health problems.

Pakistan is a male dominated society. Most of the time men hold decision making power and women are subordinated to them. This domination is clear in and outside the family. According to Coward (1983) patriarchy best describes this kind of male domination, it describes the political and social control of Pakistani women by men. "Patriarchy" is the concept that men hold power in all the important roles in the societies-in government, the military, education, industry, business, health care, advertising, religion-and that women are, in the main, deprived of access to that power. It does not imply that women are totally powerless, or totally deprived of rights, influences and resources; rather, that the balance of power is in men's favor (Mosse 1993). Varieties of patriarchy and its historical links are well illustrated by Lerner

> In all its forms a double sexual standard, which disadvantages women, was part of the system. In modern industrial states, such as in the United States, property relations within the family develop along more egalitarian lines than those in which the father holds absolute power; yet the economic and sexual power relations do not necessarily change.... Changes within the family do not alter the basic male dominance in the public realm, in institutions and in government" (Lerner 1986).

Focusing on patriarchy in the South Asian context, Bhasin (1993) defines its meaning in the Urdu language as *pidarshahi* and says "the word patriarchy literally means the rule of the father or the "patriarch" and originally it was used to describe a specific type of "male-dominated family" – the large household of patriarch which includes women, junior men, children, slaves and domestic servants all under the rule of this dominant male. Now it is used more generally to refer to male domination, to the power relationships by which men dominate women and it characterizes a system whereby women are kept in a subordinate position in a number of ways". Walby (1996) agues that it is not useful to tie anything else to patriarchy except gender inequality. She defines patriarchy as a system of social structures and practices in which men dominate, oppress and exploit women.

The focus of the thesis is on gender and health. However, the social construction of masculinity and associated male roles may also disadvantage men and some examples of this will be made.

Women in Development (WID)

Ester Boserup (1970) was the first to critically evaluate from a feminist perspective the West's attempts to modernize the Third World and was the first to systematically use gender as an variable in her analysis (Rathgerber :1989, 2). Her focus on the potentially adverse effect of modernization's (economic development's) on women stimulated the creation of development theories that focus exclusively on women. Her approach was referred to as women in development (WID) and it attempted to address the sexual division of labor by encouraging women's integration into the mainstream of economic, political and social life. This approach, however, did not challenge modernization's implicit assumption that there is a natural and universal sexual division of labor based on the biological differences between the sexes. This meant that the implementation of WID often served to increase women's workloads without addressing the gender-relations that served to subordinate them. The failure of WID projects to increase women's participation led to the creation of the Gender and Development approach (GAD) to women's issues in development. With a holistic focus, this approach attributed the subordinate position of women to social and cultural constructs that create a gendered division of labor and define women's contributions as secondary.

Boserup's argument woke up the development community to the possible negative impact of modernization on women and led to a women-centred form of

development in theory if not in practice. Her theories and their offshoot Women in Development (WID) were institutionalized in a liberal feminist approach to economic development in the 1970s and 1980s. Its structural approach to women's issues assumed that there was a 'natural' sexually based division of labor. WID then attempted to liberate women by sponsoring a shift in the division of labor to include women in productive work. The evolution of WID theory took three different approaches; equality, anti-poverty and efficiency. Women and Development (WAD), a conflict oriented Marxist approach to Third World women's issues, also evolved out of modernization theory. WID and WAD concentrate on increasing women's productive work and further multiplying their reproductive, productive and community managing roles, without considering their impact on the society. Ineffectiveness of these two development theories therefore is attributed to a lack of awareness in development communities.

Gender and Development (GAD)

GAD starts with the assumption that women in underdeveloped countries have disadvantaged and subordinate positions that prevent them from participation as decision-makers and beneficiaries in development (Moffat 1988). To deal with this deficiency, GAD attempts to include women in the development process. In this context, women are viewed as active agents of change (Rathgeber 1989). The focus is not only on women, however, but on the social structure itself: "[D]evelopment is viewed as a complex process involving the social, economic,

political and cultural betterment of individuals and of society itself" (Young 1988: 6). GAD uses "betterment" in this context to refer to the ability of the society and its members to meet the physical, emotional and creative needs of the population at a historically acceptable level. By focusing on the historical culture and experience of the indigenous populations it is assumed that the empowerment of women, in their local cultures, will improve their position relative to men.

In contrast to WID's liberal feminist focus on formal equality GAD uses a substantive definition of gender equality based on radical feminism. Instead of focussing on institutional differences, this definition of equality focuses on power (Mahoney 1996). It assumes that women and men start from an uneven playing field and concentrates on the end result- the good of the family and community. Equality in this context is viewed as justice and is a value statement concerning how people ought to be treated (Lummis 1992). It assumes that change needs to be precipitated through intervention in the basic social and cultural systems (especially the family). The only way to initiate this type change is by including women in the development process.

GAD proponents assert that there is no universal sexual division of labor, and that there are no natural predefined roles for women. GAD instead contends that gender roles are socially and culturally constructed by each society. The fact that the actual roles assigned to women differ from society to society indicates that the gender specific socially ascribed roles for women and men are relative to

particular situations and cultures. The socially constructed sexual division of labor involves value judgements as to the suitability of tasks for both males and females. The problem is that women have universally been assigned to inferior and/or secondary roles (Rathgeber 1989). The sexual division of labor therefore can be said to place primacy on the work of men. The cultural and social values, beliefs, opinions and attitudes of society then serve to reinforce the unequal sexual division of responsibility (Wilkens 1997). GAD attempts to reduce the inequalities that women face and thereby increase their participation with men. This will ultimately increase women's ability to become decision-makers within the community. By achieving a greater control over their lives, women can challenge their unequal sexual divisions of responsibility.

GAD focuses on addressing and ultimately changing the social constructs and the picture of unequal gender- based relationships and conditions. The focus is not on women per se, but on the relationship between women and men. The work of both women and men is viewed as essential, with both genders benefiting from the dynamic interdependency between women and men. GAD instead focuses on the "fit" between family and the organization of the economic and political spheres. This causes GAD to implicitly reject gender roles that devalue women's work. The local social constructs are based on the public / private dichotomy which GAD views as the means for undervaluing the work performed by women (Rathgeber 1989). The GAD perspective is that women should challenge these oppressive structures and situations simultaneously at

physical and social levels. This forces GAD to make an important conceptual distinction between the physical condition of women and the social position of women.

The physical condition of women refers to their immediate practical needs. These are short-term necessities that women identify in their socially acceptable roles in society (Moser 1993). These concerns concentrate on fulfilling the basic needs that are necessary for the day to day functioning of society and usually focus on physical inputs as a means of dealing with immediate problems. Practical needs are usually a response to a perceived necessity and relate to unsatisfactory living conditions and lack of resources (Moffat 1988). These physical necessities are attributed to women based on the gendered division of labor and are therefore responsible for preserving and reinforcing women's subordinate position in society (Moser 1993).

The social position of women relates to their long term strategic interests. It is these interests that GAD sees as essential to address in order to improve the position of women relative to men. These interests rise from women's awareness of their subordinate power relationships in society and they vary according to particular contexts (Moser 1993). "They relate to the gender divisions of labor, power and control and may include such issues as legal rights, domestic violence, equal wages and women's control over their bodies" (Moser 1993: 39). While GAD does not assume that women have a perfect

understanding of their position it is necessary for women to come to the realization that their position can and should be changed. This awareness is viewed as necessary if any long term gender development is to be sustained in a GAD context.

The household, as the basic social unit within a GAD framework, is presumed to be the primary source of women's subordination and power. Subordination results from the application of norms that set the parameters of permissible behavior. These kinship guidelines are reinforced in the house and focus on women's inferiority by emphasizing deference, subordination and submission to males. GAD focuses on how society devalues women's positions and how this causes women to internalize and accept their subordinate and inferior positions.

Women's work is undervalued in the house because of the perception that women's work does not contribute to the overall well-being of the family. A woman's ability to acquire power within the household is dependent on perceived notions of what she is entitled to (Wilkens 1997) and the lack of appreciation of a woman's role then gets transplanted onto the women herself. Sen (1990) points out that if a woman undervalues herself her position within the house will be weaker and she is more likely to accept inferior conditions. The norms and kinship systems that devalue women are then reflected in women's treatment outside the home as the household hierarchy is transplanted into the social organization of a society. GAD therefore attempts to improve women's

perception of themselves as a means of dealing with their subordination. The means of accomplishing this improvement in perception is "empowerment". By increasing their self-esteem and personal power, they will ultimately increase their status within the household and this can eventually be reflected onto society as a whole.

While GAD emphasizes the need for women to be active in promoting their needs and issues related to inequality, it does not focus exclusively on female subordination. It assumes that a shift in power relations will benefit any disadvantaged segment of the population. "It [GAD] leads, inevitably, to a fundamental re-examination of social structures and institutions and ultimately to the loss of power of entrenched elites, which will effect some women as well as men" (Rathgeber 1989: 13). In challenging the status quo there is the inevitable conflict with individuals who have a vested interest in maintaining the current paradigm. There is often a perception within these entrenched elites that the only means of achieving power is by controlling and manipulating outcomes at the expense of others. From this perspective there is a finite amount of power in the world and the only way to acquire more power is to take it from somebody else. The focus therefore is on having 'power over' somebody else. People without power are marginalised from the decision-making process and are unable to affect all aspects of their lives. It would be difficult to bring about a power shift in gender relations within this context, because this conflict oriented

interpretation of power ensures that the only way to protect and enhance an individual's interests is at the expense of somebody else.

GAD endorses a different perspective on power. Within a GAD framework, power is viewed as a personal increase in self-reliance and internal strength (Moser 1993). Power is a description of a relation, not a "thing" that people have (Nelson 1995). It assumes that there is an infinite amount of power in society for the taking. Accordingly the growth of one person does not necessarily have a negative effect on anybody else. The power shift is seen as an interactive process to which everybody can contribute and grow. The ability of the entire population is wrapped up in the definition of betterment as the ability of the society and its members to meet the physical, emotional and creative needs of the population at a historically acceptable level. GAD therefore tends to focus on how individual choices can benefit the entire community (Nelson 1995). There is an expectation that as Third World women are given control over their lives and decision-making process, the entire community benefits from the end result, a more equal share of societal goods.

GAD and Beyond: Recent Approaches to the issues of Gender

The GAD approach attributes gender inequality to socially created gender constructs that determine the sexual division of responsibility. This division is seen as devaluing the work that women perform despite the fact that it

contributes significantly to the development of their countries. GAD proponents argue that this dichotomy then alienates and subjugates women by creating a negative perception of their self worth. GAD attempts to provide women with a sense of empowerment, which creates an expectation that they be included in the community and household decision-making. A possible way to improve the GAD approach is then examined. GAD initiatives have been criticized as isolated initiatives that fail to address the language that defines women as inferior. The postmodern feminist approach uses the enlightenment model of objective and value free rational thought as a source of progress and as a means of criticizing the construction of identity for third world women. It assumes that the means to women's liberation is wrapped up in deconstructing and understanding the models that define females as opposite and inferior to man. Postmodernists argue that these binary models needs to be addressed in order to include everyone's unique and personal voices in development. The postmodern movement attempts to look beyond modernity by placing a negative value on the hierarchical and dualistic nature of Western thought (Parpart 1995).

Over the last three decades, women's issues have moved rapidly up the policy agenda of national governments and international organizations. In 1985, in Nairobi, participants at the Third World Conference on Women agreed to adopt a Forward Looking Strategy to improve the status of women and in the years that followed, policies in line with this approach were devised across the globe. Although these initiatives have been diverse in their origins and implementation

strategies, most have been loosely based on what is termed the 'Women in Development' or WID approach.

Central to this approach is the recognition that women are marginalised. They are excluded from the mainstream of economic and social life and as a result are likely to receive fewer benefits than men from whatever the development process has to offer. Post-Nairobi, the solution to these problems is seen to lie in improving the access of women to health and social services, to education, to credit facilities and to other resources that might enhance their own well-being, while at the same time maximizing their contribution to the wider community.

Research projects using the WID framework have brought some considerable benefits for women but they have been uneven. Evidence collected from many parts of the world has demonstrated that far from being on the margins of their communities, many women are now actually at the heart of them, carrying out much of the labor that makes the continuation of economic, cultural and social life possible (Boserup, 1970; Rogers, 1980). At the same time, a range of WID-policy initiatives were implemented and have achieved considerable success in bringing about practical improvements in women's lives. Across the world, women live longer than men, fertility rates have fallen by a third, maternal mortality rates have been halved and female literacy has increased from 71.1 per cent of the male rate to 84.3 per cent (UNDP 1999).

There can be no doubt that these have been very positive developments, often making a major impact on women's daily lives. However, they have done little to alter women's basic position in society. Women's economic, social and political status has remained largely unchanged and in some communities has actually deteriorated. This has led a growing number of observers to question the appropriateness of the WID approach as a means for meeting women's long-term needs (United Nations / INSTRAW 1993; Kabeer 1994; Young 1993).

The main criticism of WID policies is that they continue to define women themselves as 'the problem', as passive victims who need welfare and special treatment if their circumstances are to be improved. As a result, the reasons for women's plight remain largely unexplored. No explanation is given for the systematic devaluation of their work or the continuing constraints on their access to resources. In an attempt to fill this gap in the analysis, the focus of many planners and policy-makers is shifting from women themselves to the social divisions between the sexes-in other words gender relations, that is to a GAD approach.

It is now clear that most dimensions of economic and social life are characterized by a pattern of inequalities between women and men that routinely value what is 'male' over what is 'female'. Unless these divisions are taken seriously, policies designed to improve the situation for women's lot are likely to offer only limited and often short-term solutions. Kate Young in her book, Serving Two Masters

(1989) argues that as long as women are thought to be of a different order of being than men, limited to one aspect of their capacities then the obvious differences between men and women will not merely be interpreted and acted upon as differences but as inequalities. Supporting Kate Young's arguments (MacDonald 1994; Moser 1993; Canadian Council for International Cooperation 1991; UNDP 1999) say that in recognition of this reality, a growing number of developmental agencies and other organizations are now adopting the 'gender and development' or GAD approach as a more appropriate methodology for tackling the massive inequalities that continue to limit the potential of so many women around the world.

What Do We Mean By Gender?

According to United Nations International Research and Training Institute for the Advancement of Women (INSTRAW 1995), gender is all about reconciling growth with the equitable distribution of benefits among men and women, equality of power-relations between men and women and most of all to highlight the interdependence and partnership between men and women in any field of development.

Gender is not a synonym for the word 'women' nor is it an abbreviation for 'men and women'. As explained above it is a concept that attempts to look at and understand the differences between men and women that are externally

influenced and the conditions that are imposed on the naturally given biological sexes. Therefore, in my thesis gender has to deal with 'both' sexes in relation to each other and not 'either / or'.

According to the definition of gender by WHO (1999) Gender refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences.

Different groups within any culture may define masculinity and femininity differently according to sub-cultural definitions by race, age, class, sexuality, religion and region of the country. Biologically what distinguishes women from men is the difference between their reproductive systems. These anatomical and hormonal variations are the basis upon which individuals are allocated to a particular sex. However, they represent only a part of the complex set of criteria by which people adept to distinguish femaleness from maleness. Equally important are the socially defined characteristics that different cultures assign to those individuals defined as female and those defined as male that is, gender. These apparent differences are sometimes justified with reference to biology. Women are given certain sorts of jobs, for instance, because their biological capacity for motherhood is said to make them more 'caring'. In reality, however,

gender differences are social constructions that can potentially be changed in ways that most biological characteristics cannot.

Despite their diversity, all societies are divided along what we can call the 'fault line of gender' (Moore 1988; Papenek 1990). This means that women and men are defined as different types of beings, each with their own opportunities, roles and responsibilities. The most obvious illustration of this is the split between the public world of employment work and politics which is seen as 'naturally' male and the private arena of the family and the household which is seen as 'naturally' female. Thus women in most societies are expected to take the major responsibility for domestic tasks (if not for actually performing them) and care of children, the elderly and the sick. Men on the other hand, are allocated the primary responsibility for supporting the family (with women joining them increasingly in the labor market).

These gender divisions shape the lives of both women and men in fundamental ways. As individuals with particular identities and as actors in an infinite variety of social contexts, they are shaped and reshaped by their female and male socially defined characteristics. In one sense then, both women and men are constrained by their membership of a particular gender group. But these variations represent more than just difference. In most societies they are also used to justify major inequalities with those in the category of female having less access than those in the category of male to a wide variety of economic and

social resources. This inequality is most obvious in the distribution of resources including income and power. Around the world, women now make up about 70 per cent of those who are poor (UNDP, 1995). This "feminization" of poverty is found in both rich countries and in poor countries and reflects women's unequal situation in the labor market, their less favorable treatment in most social security systems and their low status within the household. Many have no access to independent income and those who do earn their own wag receive on average around three quarters of the comparable male salary (UNDP 1995).

As well as material discrimination, women's lives are also affected by the cultural devaluation of femaleness that is a significant element of everyday thinking in so many societies (Martin 1987; Ussher 1989). Work which is done at home for instance, is deemed to be of less value than waged work and those who perform it are treated accordingly. The relatively low value placed on women and girls by individual families and by society as a whole is evident in the global statistics on literacy. Although considerable strides have been made over the past two decades, women still outnumber men by two to one among the world's illiterate people and girls constitute the majority of the 130 million children without access to primary school (UNDP 1995).

Women's access to political and economic power is not commensurate with their numbers, their needs or their contributions as citizens. Some do exercise considerable influence within their own families and communities but many do

not and few have formal power in the arenas where important decisions are made. For instance, although women make up half the electorate, they hold only 14.2 per cent of ministerial-level positions and only six per cent of the seats in national cabinets (UNDP 1997). In some countries these gender inequalities in power continue to be reflected in the discriminatory nature of the law. Many women, for instance, are denied the right to manage their own property for instance, to travel abroad, or to control their own fertility and mobility to educate and health resources. In practice, the linkage between women's agency, activism and empowerment seems very unclear (Jeffery 1998).

Men versus Women

These examples demonstrate the complex and multi-faceted pattern of inequalities that still characterize the relations between the sexes. Even though progress has been made in some areas, widespread discrimination against women continues and it is recognition of this reality that lies behind the adoption of the gender approach to policy and planning. As many of the problems women face are closely related to their relationships with men, the lives of men must be also be considered. Gender inequalities in authority and power have to be identified and strategies sought for their amelioration.

It is not surprising that the development of gender analysis has been led by those concerned to remedy the manifest inequalities that currently disadvantage

women. However, it is also important to identify the ways in which gender stereotyping may damage men. Where societies expect men to be the 'breadwinner' for example, some men will feel obliged to work extremely long hours with resulting damage to their physical and mental health. Similarly, the social expectation of what it means to be a 'real' man may make it difficult for men who are ill to admit weakness and seek medical help (Sabo and Gordon, 1993). Again Sabo and Gordon (1995) write that "masculinity is not only a risk factor in disease etiology but it is also among the most significant barriers to men developing a consciousness about health and illness. "Real men" do not get sick and when they do, as we all do, real man don't complain about it and they do not seek help until the entire system begins to shut down[1]. Here primary concern will be also with the impact of gender inequalities on the health of women. However, I will also identify those areas where men's health may be put at risk by the ways in which gender roles are currently constructed.

Sex, Gender and Health

Patterns of health and illness in women and men show marked differences. Most obviously, women as a group tend to have longer life expectancy than men in the

[1] For further details on men's health and illness in the context of race, class, ethnicity and sexual reference, see "Men's Health and Illness" edited by Sabo and Gordon (1995). This volume is the combination of different author's contribution explaining gender to understand culturally defined patterns of men's health and in the result they face health risks. However, I found rare literature particularly on men's health with reference to South Asian region in general and Pakistan in particular.

same socio-economic circumstances as themselves. Yet despite their greater longevity, women in most communities report more illness and distress than men (Blaxter 1990; Rahman 1994; Rodin and Ickovics 1990; US National Institutes of Health 1992). The precise details of this excess in female morbidity and the factors that lie behind it will vary in different social groups, but the broad picture is one where women's lives seem to be less healthy than those of men (Macintyre 1996). The explanation for this apparent paradox lies in the complex relationship between biological and social influences in the determination of human health and illness.

Part of women's advantage in relation to life expectancy is biological in origin. Far from being the 'weaker sex' they seem to be more robust than men at all ages (Waldron 1986). In all societies significantly more male fetuses are spontaneously aborted or stillborn and in most societies this pattern of excess male mortality continues to be marked during the first six months of life. The reasons for this greater 'robustness' of girl babies needs further investigation but they seem to include sex differences in chromosomal structures and possibly a slower maturing of boys' lungs due to the effects of testosterone (Waldron 1986). In adult life too, women may have a biological advantage at least until menopause as endogenous hormones protect them from ischaemic heart disease. Overall, their innate constitution appears to give women an advantage over men, at least in relation to life expectancy. *When this female potential for greater longevity is not realised it is an indication of serious health hazards in*

their immediate environment. This is the case in Pakistan as chapter four makes clear.

Women have not always lived longer than men. In Europe and the United States of America the female advantage over males first became apparent in the latter part of the nineteenth century as the life expectancy of both sexes increased (Hart 1988). Ever since, this gap between the sexes has continued to widen, with the size of the female advantage being proportional to the life expectancy of the population as a whole. In Europe, Latin America and the Caribbean the gap is about seven years, in Sub-Saharan Africa three years and in South east Asia four years. Only in Southern Asia do women and men have one year life expectancy (UNDP 1999).

Gender Inequalities in Health Care

The status of women is considerably worse in South Asia than in most of the World. And within South Asia, Pakistan has one of the worst records in female health and education. Pakistan's fertility rate of 5.4 is considerably higher than that of any other large Asian country and as many as one in every 38 women die from pregnancy-related causes, compared, for example, with one in 230 women in Sri Lanka (Tinker 1998: 5). Viewed on a global scale, however, the most pressing concern is not too much medical attention for those who can afford it but lack of attention for those who are poor. Even in rich countries like the United

States, poor women find themselves without access to health care more often than men from the same social group (Zierler and Krieger 1997; Krieger and Zierler 1995). This is illustrated by the striking fact that although black women have a lower incidence of breast cancer than white women they also have higher mortality rates from the disease (United States National Institute of Health 1992).

It is in the poorest parts of the world that women's lack of access to health care is at its most acute (Jacobson 1993; Timyan, Brechin, Measham and Ogunleye 1993). In part this reflects the very low levels of expenditure on health care overall, which in many societies has been exacerbated by structural adjustment policies. While annual per capita expenditure on health care in the United Kingdom is about $1039, in Bangladesh the comparable figure is only $7 and in Mozambique $5 (WHO 1995). These severe constraints on public sector spending obviously affect both sexes, but in conditions of poverty it is usually women who face the greatest problems in acquiring adequate health care. Pakistan's public health expenditure for the period 1990-1997 was 0. 8 per cent of GDP as compare to its 6. 1 per cent of GDP for military expenditure (World Bank 2000).

We know that many households in certain regions of the world spend less on health care for women and girls (das Gupta1987; Papanek 1990; Sen 1988 and 1990; UNICEF 1990). This reflects both their lower social status and their lack of decision-making power. Often men control the cash, making it difficult for women

to pay for health care or for transportation costs if facilities are far away. Women are also more likely than men to spend what little cash they have on their children. The relationship between the cost of services and their rate of uptake is often complex, but in most cases increased costs lead to a decline in use and this trend is especially evident among women (Timyan 1993).

These financial constraints are reinforced in settings such as in Pakistan where customs and values deny women the right to travel alone or to be in the company of men outside their immediate family. In circumstances where female health workers are not available, treatment by a man may dishonor a woman and her family and she may need to go without care in order to avoid this. The opportunity costs of medical treatment may also be greater for a woman. If she becomes ill at harvest time for example, there may be no-one who will take her place either in the fields or at home so that the visit to a health worker might impose unacceptable burdens on the household as a whole.

As well as these economic, social and cultural obstacles, the emotional and cognitive capacities of women themselves may limit their access to health care. In many cultures women learn to believe that suffering is their lot (Papanek 1990). Problems such as backache or vaginal discharge may be so widespread that they are accepted as normal with no expectation that things could be any different (Bang and Bang 1992). Low self-esteem limits women's ability to make demands and this may be reinforced by embarrassment if the problem is one that

the community disapproves of. Lack of education contributes to this lack of self worth while also denying women the opportunity to understand their own bodies or to make an accurate assessment of their need for health care.

Traditionally, women's health services have focused on their reproductive needs, especially contraception and safe childbearing. This has an obvious logic in the face of the huge toll of reproductive ill-health that continues to affect some of the world's poorest women. However, it has also had serious limitations. First and most importantly, it has meant that millions of young women and those who are post-menopausal have been denied access to any health care at all during periods of great need in their lives. Second, women of childbearing age have not found it easy to obtain health care for non-reproductive problems. This gap is especially evident in the context of mental health. Very few services are available for women in developing countries yet there is growing evidence that their needs are very great (Desjarlais 1995; Paltiel 1987).

Knowledge Gap

Failure to provide a complete picture of women's health status stems in part from the fact that many developing countries lack a complete and accurate vital registration system. However, this is often compounded either by an official reluctance to recognize the importance of gender issues or by the complex social issues that surround so many women's health problems. Maternal mortality for

instance is often under-reported due to a variety of social, religious, emotional and practical factors such as the stigma of abortion, the desire to avoid an official enquiry and the failure to indicate pregnancy as a precipitating factor (Tinker 1994; WHO 1991). New methods have been developed for identifying these deaths but high level commitment will be required to ensure that the problem is taken seriously (WHO 1992).

Gaps in the availability of information on women's lives are now beginning to be filled, with the United Nations in particular leading the way (United Nations 1991; United Nations 1995; WHO 1992; UNDP 1995, 1997 and 1999). However, much remains to be done if the database for health-related policy-making is to be improved. In particular there is a need for the development of appropriate indicators combining biomedical, epidemiological and socio-economic data to monitor the changing state of women's and men's health around the world. A recent United Nations Human Development Report combines a number of indicators, such as life expectancy, educational attainment and income, adjusted for gender inequality, to provide a gender-related development index (GDI) and a gender-related empowerment measure (GEM) (UNDP 1997). These provide important tools for understanding the broader issues influencing women's health.

Domestic violence in particular represents a huge public health problem that has not yet been accurately documented. At a recent WHO consultation, participants stressed the need for international reporting criteria with culturally sensitive

definitions and standards (WHO 1996). They highlighted the difficulties of collecting information on gender-based violence and called for the dissemination of ethical and methodological guidelines for those working in the field (WHO 1996; Heise 1995). The concluding report requested a revision of relevant categories in the International Classification of Diseases (ICD) in order to provide a clearer picture of the diversity of violence against women. It also called for the creation of a global database to be co-ordinated by WHO (WHO 1996).

Donor pressure has also meant that the Pakistan government has been forced to alter priorities and directions in its health package, thus resulting in appropriate and relevant health research. Moreover, the government does provide the largest data-bank regarding health (and other) statistics which are used by others interested in research (Zaida 1995).

The above detailed theoretical arguments lead back to the question raised in the beginning of this chapter, namely is patriarchy the only source of segregation of women from men in accessing existing health resources? Women have additional needs for reproductive health care and more I have argued many face serious obstacles in their attempts to meet those needs. It requires commitment a coherent principle of equity to ensure that women and men have their different interests recognized. Women and men share many non-reproductive health risks; however, gender bias results in neglect of general health care for women and girls and sometimes mistreatment. The physical restrictions on women's

movements, combined with limited access to household resources, severely constrain women's ability to seek health care for themselves. In addition, health facilities often lack skilled female staff and do not provide adequate privacy and care for women, thereby discouraging women from using these facilities. All of these considerations leads to a reformulation of the research. In the remainders of the thesis I explain the problem: Is there a need to bring changes through intervention in the basic social and cultural systems (family, economic, political and religious) to initiate gender [health] equalities? Do recognition and awareness of women's particular health care needs enable them to participate fully in the overall development process? Much blame has been by feminists put on men or on patriarchy for causing this system of inequality and very little on the social, economic and political structures in which both men and women live (Zaida 1996). In order to improve the quality of health care for women and men according to their particular needs, those structures have to be understood carefully to alter them for equal access to health resources. In this regard Marxism and other forms of structuralism such as political economy, make points that should be compared-incorporated into feminist analysis, to some extent GAD does so.

Synopsis

This research is based on library research. To broaden the scope of this thesis, I have examined the contribution of scholars and institutions working on issues of

gender and health in developing countries. I have analyzed the published conclusions of research studies and apply a GAD analysis of the data collected and information obtained. The GAD approach utilizes gender analysis, which is the tool for analyzing the specific nature of gender differences by asking basic questions such as who does what, where, when, how often, with what resources and returns and who controls what? Such questions enable an assessment of gender differentiation in activities, resource ownership, use and control (Moser 1993). Library resources, including relevant research studies / reports by UN agencies including WHO, World Bank documents and journals and government policies of Pakistan related to the topic were consulted.

The aim of highlighting gender in this way is to document a movement towards a position of equality between women and men in main parts of the world including Pakistan. This does not, of course, mean that both sexes should be treated in exactly the same way since biological and social differences mean that each will have particular sets of needs. Instead it requires adherence to the principle of equity to ensure that women and men have their different interests recognized and their varying needs met with equality as the desired outcome. Nor does it mean that all women should receive the same treatment. A range of strategies will be needed to achieve equality for different groups and this diversity needs to be built into all policies designed to promote equality both between women and men and among women themselves.

In the context of a development process, gender is significant for two reasons. Firstly, women are found disproportionately among the most vulnerable population groups. Secondly, access to and utilization of health services are influenced by cultural and ideological factors such as low valuation of the health of girls and women as compared to that of boys and men. By highlighting some of the gender issues in health sector reform, the implications for vulnerable groups and the severe lack of information and understanding on the impact of health sector reform becomes evident.

This thesis will focus on health inequalities in gender with a particular focus on socio cultural values of Pakistan, a society dominated by a patriarchal setup. To provide some background knowledge, the second Chapter description of the social structure, kinship patterns and some information on linguistics and ethnic groups in Pakistan have been provided. It elaborates the social institutions like family patterns, marriage and the lineage system of Pakistani society, which play a very important role in determining women's status as well as cultural trends.

The third Chapter discusses the social and legal status of women in Pakistan, with a particular emphasis on religious issues and its politicized presentation in the community. As a Muslim country, it is generally believed that women's status in Pakistan is primarily based on Islamic teachings. However, most of the traditions have transformed, not only religious teachings but also legislative rights of women according to the interpretations of those in power. Also women's

struggle from the day of independence and before, have played a pivotal role in safeguarding their rights in the constitution of Pakistan.

In Chapter 4 key health issues in Pakistan are presented. A review of the literature shows the efforts of government, non-government and international agencies to provide health facilities to the nation. It discusses the contribution of these institutions in terms of the increase and decrease of maternal, child mortality rates and population growth over a certain time period. In relation to fertility, the weaknesses and strengths of Pakistan's family planning and population policies are also reviewed.

An effort has been made in chapter 5 to highlight the factors influencing women's health-seeking patterns. In this way we show that patriarchy is the main reason for the inaccessibility of women to existing heath resources. Indeed this is the thesis of this study. Therefore we conclude that to reach the goal of equal women's status it is important to take men in to confidence and to include their contribution and collaboration in these efforts. This conclusion is presented in Chapter 6.

Chapter Two

PAKISTAN: A MATTER OF CONTEXT

Introduction

'Pakistan' is both a Persian and an Urdu word. It means the land of the Paks-the spiritually pure and clean. It also symbolizes the religious beliefs and the ethnic stock of its people. Pakistan is officially the Islamic Republic of Pakistan and is situated in southern Asia; it is bounded on the north and northwest by Afghanistan, on the northeast by Jammu and Kashmir and China, on the east and southeast by India, south by the Arabian Sea and on the Southwest Iran. A rocky strip of Afghanistan in the north, about 30 miles wide, separates Pakistan from the former USSR. The status of Jammu and Kashmir is a matter of dispute between India and Pakistan. The area of Pakistan is 796,095 square kilometers (307,374 square miles), not including the section of Jammu and Kashmir under its control. Pakistan controls about 84,159 square kilometers of Jammu and Kashmir. This area consists of Azad Kashmir (11,639 square kilometers) and most of the Northern Areas (72,520 square kilometers), including Gilgit and Baltistan. The capital of Pakistan is Islamabad but the largest city of the country is Karachi. The federal government administers Azad Kashmir, Northern Areas and tribal territories.

Pakistan, the major home of most Muslims in South Asia, came into existence in August 14 1947. South Asia was divided into two countries- India and Pakistan. Geographic, political, linguistic and administrative differences within Pakistan divided the country in 1971 and East Pakistan (now Bangladesh), with 54 per cent of the population, separated. Pakistan was the first country created as an Islamic state. By law, the country's president must be a Muslim. The legal system follows both the Islamic codes of justice, or Sharia and old British laws.

Pakistan has four province, fifteen municipal corporations, four hundred and fifty seven municipal and town committees, forty cantonment boards, four thousands six hundred and eighty three union and district councils (World Bank 2000). Political representation of areas is categorized on the basis of population. In rural areas, for union councils, the number of members are determined on the basis of population of 1000 per electoral unit; for each district, there is a *zila* / district council, comprising such number of members as may be determined on the basis of population. In urban areas, a town committee as a whole may represent a population of 5000-30,000; municipal corporations are constituted in large cities (Choudhery 1988).

The United Nations Development Program (UNDP) in its 11th annual Human Development Report (HDR) 2000 ranked Pakistan 135th out of 174 on the basis of its Human Development Index (HDI). This compares to 138, year before, a slight improvement in status.

According to the UNDP gender-related development index, Pakistan ranks 115; well above human development ranking. Life expectancy at birth among females is 65.6 years versus 63.3 for males. Adult literacy for females (age 15 and above) is 28.9 per cent versus 58 per cent for males, GDP per capita income for females is $776 as compared to $1,594 for males, a major disparity, larger than the world average. Regarding gender empowerment measures, only 8 per cent of the total population of women are administrators and managers, while 25.1 per cent of women are professionals and technical workers. On the issue of human poverty in developing countries, the HDR ranks Pakistan at 68.

According to the UNDP 2000 the ratio of people that are not expected to reach the age of 40 is 14.3 per cent; 15 per cent have no access to health services; 44 per cent are living without sanitation services and the ratio of underweight children under age of five is 38 per cent. The adult illiteracy rate is 56 per cent. The Infant mortality rate has improved at 94 per 1,000 lives versus 118 in 1970. The country's health profile shows that 64,000 people between the ages of 1 to 49 are living with HIV / AIDS in Pakistan and the adult rate (15-49 years) is 0.09 per cent; cigarette consumption per adult annual average is 562; and there are 52 doctors and 32 nurses for 100,000 patients.

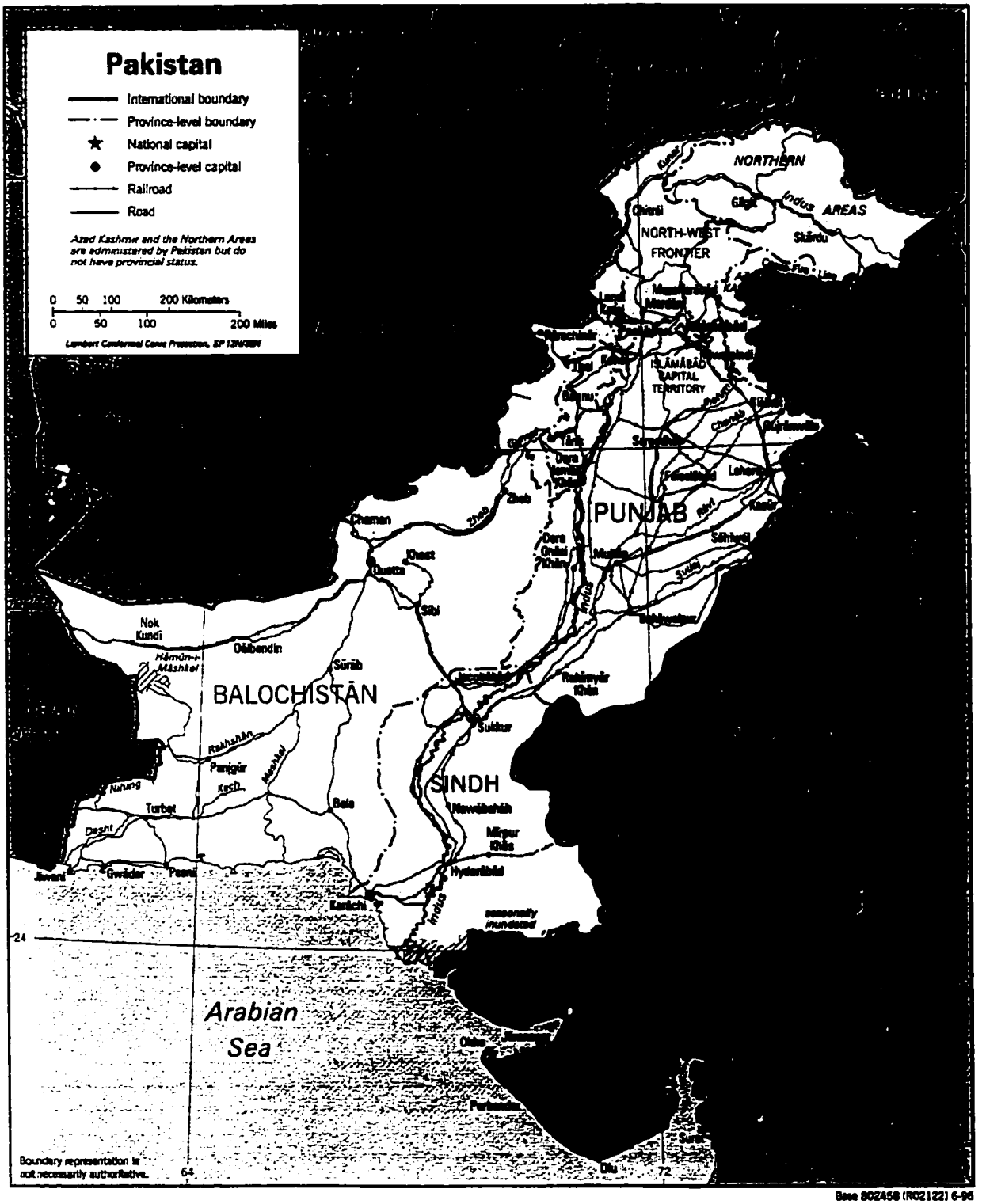
Provinces and Divisions:

Province	Capital Cities	Divisions
Sindh	Karachi	Karachi, Hyderabad, Sukkur
Punjab	Lahore	Lahore, Multan, Faisalabad, Rawalpindi, Gujranwala, Deri Ghazi Khan, Bahawalpur, Sargodha
North West Frontier Province (NWFP)	Peshawar	Peshawar, Kohat, Dera Ismail Khan, Malakand, Hazara, Tribal Areas (autonomous)
Balochistan	Quette	Quetta, Sibi, Kalat, Makran

Northern areas of Pakistan and Azad Kashmir are not divisions but districts that are controlled by Federal Government.

Territories	District Capital	Districts
Northern Areas (FANA) (Pakistan's Administered Northern Area)	Gilgit	Gilgit, Skardu, Ghizar, Diamar, Ghanche
Azad Kashmir (Pakistan's Administered Disputed Area)	Muzzafarabad	Muzzafarabad, Mirpur, Kotli, Bagh, Poonch
Federally Administered Tribal Areas (FATA)		
Islamabad Capital Territory	Capital	Capital

Map of Pakistan



Source: http://www.lib.utexas.edu/Libs/PCL/Map_collection/middle_east_and_asia/Pakistan_pol96.jpg

Social Structure

Unlike India's caste system and social hierarchy, people in Pakistan can be categorized by their ethnic background and the class they belong to. Different regionally based ethnic groups can be placed with and across the upper, lower and middle class as well as the military class, the civil bureaucracy, the capitalist or landlord.

There are serious 'structural' facts concerning ethnicity and class that tend to complicate otherwise simple issues of ethnic parity. While the bourgeoisie and the landlords are social classes by virtue of their control over key resources, the military and bureaucracy are wielders of power through their control of the state apparatus. At one level of analysis it is important to keep the two forms of distinction separate. However, while analyzing the class and power asymmetries in a multi ethnic society, it becomes useful to treat both these types together. For example, these relate to a common aggression. Therefore, while recognizing that higher officials of the military and civil bureaucracy may be drawn from any class the military and bureaucracy are best seen as various elements of the 'ruling class'. This usage is preferable to the term 'elite', in favor with many social scientists, because the latter becomes too broad and ambiguous by including social classes which may not be as economically or politically dominant as those holding military and bureaucratic power.

Demographically, the *Punjabis* comprise the largest single ethnic group (48. 2 per cent) in Pakistan's population, followed by *Pushtoons* (13. 1 per cent), *Sindhis* (11. 8 per cent), *Siraikis* (9. 8 per cent), *Urdu*-speaking (7. 6 per cent), *Baloch-Barohis* (4.2 per cent), *Hindko* Speaking (2.4 per cent). Although it would be safe to equate *Punjab* with *Punjabis* and *Saraikis* and NWFP with *Pushtoons* and *Hindko*-speaking *Pathans*, in *Sindh* and *Balochistan* the overlap between ethnicity and region is not so obvious (Ahmed 1998).

Pakistan is a country of linguistic as well as ethnic diversity in its four provinces and two territories. The estimated population was nearly 132 million in 1996 (Asian Development Bank 1997) and 140.0 million at the end of the year 1997 making it the seventh most populous country in the world, with 97 per cent of the population Muslim. The country will rank fifth in the world by the year 2020, when its population is projected to reach 262 million and third in the world in 2050 (Marble and Conly 1996). In its first fifty years of independence, Pakistan has experienced internal political instability and costly regional conflicts but has still achieved substantial economic growth and a considerable degree of economic development.

Pakistan has made progress on the scale of human development from the early 1970s to the early 1990s. The total fertility rate fell by 20 percent, life expectancy at birth increased by 23 per cent (by 26 per cent among women) and the infant mortality rate declined by one-third. The adult literacy rate has increased by 46

percent since 1977. Enrolment ratios for primary education have increased by 19 per cent (by 34 per cent among girls) and for secondary education by 62 per cent (by 160 per cent for girls) since 1974 (World Bank 1996).

But despite this progress, Pakistan still lags behind the average for low-income countries. Growing at a rate of about 3 per cent a year, the population is projected to double in the next two decades to about 260 million. Pakistan's fertility rate is about 65 per cent higher than the average for all low-income economies, its infant mortality rate is 30 per cent higher, its adult literacy rate is 25 per cent lower and its gross primary and secondary school enrolment ratios are not much more than half the average for all low-income economies. Malnutrition among infants, young children and women of childbearing age is also a major health concern (World Bank 1996).

Traditional Kinship Patterns

Pakistani social life revolves around family and kin . Even among members of the most Westernized elite, family retains its overarching significance. The family is the basis of social organization, providing its members with both identity and protection. Rarely does an individual live apart from relatives; even male urban migrants usually live with relatives or friends of kin. Children live with their parents until marriage and sons often stay with their parents after marriage, forming a joint family. Usually male elders are the heads of households even

after their retirements. Their consultation is important before taking any important family decision.

The patri-local household is the primary kinship unit. In its ideal, or extended form, it includes a married couple, their sons, their sons' wives and children and unmarried offspring. Sons establish separate households upon their father's death. Whether or not an extended household endures depends on the preferences of the individuals involved. Quarrels and divisiveness, particularly among the women (mother-in-law and daughters-in-law), can lead to the premature dissolution of a joint household.

Descent is considered patrilineally, so only those related through male ancestors are considered relatives. The *biradari,* or group of male kin (from the patrilineage), plays a significant role in social relations. Its members neither hold movable property in common nor share earnings, but the honor or shame of individual members affects the general standing of the *biradari* within the community.

Marriage is a means of allying two extended families; romantic attachments have little role to play. 'Marriage is typically the unification of two families and not two individuals. The husband and wife are primarily representatives of their respective families in a contractual arrangement, which is typically negotiated between two male heads of household. It is fundamentally the parents

responsibility to arrange marriages for their children, but older siblings may be actively involved if the parents die early or if they have been particularly successful in business or politics. The terms are worked out in detail and are noted by law at the local marriage registry.

Islam explicitly rejects social and spiritual distinctions among believers. The caste system among Muslims diverges from that of Hindus in its ideological content and symbolic expression; in social structural terms the two systems are quite similar. Castes in Muslim society are secular status groups rather then the expression of a spiritual hierarchy; as such, they lack the restrictions on personal association, exchange of food and common dinning that figure so prominently in the Hindu caste system. Indeed, an exchange of food on ritual occasions is an important element of social solidarity in Punjabi villages. Nevertheless, Muslim castes retain a high degree of endogamy. Marriage between castes, although sometimes grudgingly accepted as a fait accompli, generally causes disapproval and loss of prestige and social standing. Endogamy further means that over a period of generations families tend to remain in a roughly similar structural position toward one another.

In India and Pakistan, occupation is the single most reliable indicator of status, at least in the rural areas; it is more important than wealth. In the cities power and wealth, combined with concepts of ancestry, are the basis for social status and prestige. It is extremely difficult for an individual without family or of low social

position to expect any considerable upward mobility. Yet for those who have educational qualifications and the capacity and influence for maneuvering, there are possibilities for great advancement on a regional or national level (Nyrop, Benderly, Conn, Cover, Cutter, and Parker 1975).

Linguistic and Ethnic Groups

Language is an important marker of ethnic identity. Among the more than twenty spoken languages in Pakistan, the most common ones are: *Punjabi*, *Sindhi* and *Urdu* as well as *Pakhtu* or *Pashto* and *Balochi*. The *Sindh* province has 21 districts, which form five divisions-*Karachi*, *Hyderabad*, *Sukkur*, *Larkana* and *Mirpurkhas*. In Sindh 58.7 per cent people speak *Sindhi* while 21 per cent speak the national language, as revealed by linguistic data of the census. The census, now complete in *Sindh*, shows that out of the total population, 30,439,893, of *Sindh*, 59.7 per cent speak *Sindhi*, 21 per cent Urdu, 7 per cent *Punjabi*, 4.2 per cent *Pushto*, 2.1 per cent *Balochi*, one per cent *Saraiki* and five per cent speak other languages. The linguistic census was carried out for the first time in Pakistan in 1998 but only provisional results were announced.

Nearly half (48 per cent) of all Pakistanis speak *Punjabi*. The next most commonly spoken language is *Sindhi* (12 percent), followed by the *Punjabi* variant *Siraiki* (10 per cent), *Pakhtu* or *Pashto* (8 per cent), *Balochi* (3 per cent),

Hindko (2 percent) and *Brahui* (1 percent). Native speakers of other languages, including English, *Burushaski* and various other tongues account for 8 percent.

Although Urdu is the official national language, it is spoken as a native tongue by only 8 percent of the population. People who speak Urdu as their native language generally identify themselves as *muhajirs* (refugees from India). A large number of people from educated backgrounds speak *Urdu*, as opposed to their natal languages in their homes, usually to help their children, master it.

Instruction in the best schools continued to be in English until the early 1980s and after 1988. President Zia ul Haq officially supported the *Urdu* language and Islamic studies as a compulsory part of syllabus for grade 10 to grade 14 and in professional education institutions. Mastery of English is highly desirable because it facilitates admission to good universities in Britain, the United States and Australia.

The ethnic composition of Pakistan in the mid-1990s roughly corresponds to the linguistic distribution of the population, at least among the largest groups: 59.1 percent of Pakistanis identify themselves as *Punjabis*, 13.8 percent as *Pakhtuns*, 12.1 per cent as *Sindhis*. 7.7 per cent as *muhajirs*, 4.3 per cent as *Baloch* and 3 per cent as members of other ethnic groups. Each group is primarily concentrated in its home province, with most *muhajirs* residing in urban *Sindh*.

Chapter Three

THE STATUS OF WOMEN IN PAKISTAN

The Rural and Urban Population Context

The cultural understanding that women should remain within their homes so neighbors do not gossip about their respectability has important implications for their productive activities. As with public life in general, wage work outside the home appears to be the domain of men. Rural women work for consumption or for exchange at the subsistence level. Others, both rural and urban, do piecework for very low wages in their homes. Their earnings are generally recorded as part of the family income that is credited to men. Census data and other accounts of economic activity in urban areas support such conclusions. For example, the 1981 census reported that 5.6 per cent of all women were employed, as opposed to 72.4 per cent of men; fewer than 4 per cent of all urban women were engaged in some form of salaried work. By 1988 this figure had increased significantly, but still only stood as 10 per cent. Only 2 per cent of all women were reported as participating in the labor force (Population Census Bureau of Pakistan 1998).

Pakistan's people are not evenly distributed throughout the country. There is an average of 146 persons per square kilometer, but the density varies dramatically, ranging from scarcely populated arid areas, especially in Balochistan, to some of the highest urban densities in the world in Karachi and Lahore. About 68 per cent of the population live in rural areas in 1994, a decrease of 7 per cent since 1970. In contrast, the number of people living in urban areas has risen substantially, resulting in an urban growth rate of 4.6 per cent between 1980 and 1991. The population of urban dwellers is 35 per cent of the total (World Bank 2000).

A report of the commission on the status of women in Pakistan (1986) provides the figures. It says that more than half of Pakistan's population is below the age of fifteen and nearly a third is below the age of nine. For cultural reasons, enumerating the precise number of females has been difficult and estimates of the percentage of females in the population range from 47.5 percent in the 1981 census to 48.3 per cent in the 1987-88 labor force survey. Pakistan is one of the few countries in the world with an inverse sex ratio: official sources claim there are 111 men for every 100 women. The discrepancy is particularly obvious among people over fifty: men account for 7.1 per cent of the country's total population and women for fewer than 5 per cent. This figure reflects the secondary status of females in Pakistani society, especially their lack of access to quality medical care.

The Status of Women and the Women's Movements

It can be said that the current women's movement in Pakistan began with the formation of the Women's Action Forum (WAF) in 1981 (Mumtaz and Shaheed 1987). This organization began as an urgent effort to unite women and women's organizations to combat the attack on women launched by General Zia ul Haq's Martial law government during his tenure from 1977 to 1988 (Gardezi 1994).

Cultural patterns are not uniform across the whole country. They vary by such factors as the socio-economic status of the family in which a women is born and lives, the rural / urban setting, caste group, regional group and so forth. A redefining of the role and status of women must take these conflicts and patterns into account (Shah 1986: 27).

Much of the literature on women states that women are victims of the double oppression of class and gender. This is as true in Pakistan as elsewhere. What this means in the Pakistani context is that not only have women had to struggle hard to win concessions from a male dominated society, but they have also had a hard time maintaining themselves and their families in a socio-economic milieu in which the vast majority of the populace is victimized by social, political and economic deprivation. Women in Pakistan are the victims of various types of repression and oppression. Women as well as men suffer from being part of a socio-economic framework dominated by international capital in which their

contribution and status are often determined by forces external to themselves. Within this framework, however, women are further oppressed because they belong to the gender that is seen as being necessary for maintenance of the system but is relatively unrecognized and poorly rewarded for its contribution to that maintenance. Women are not only victimized by economic systems but also by social and political relations within it.

This is not to suggest that class and gender are the only factors responsible for women's situation in Pakistan today. Additional significant factors that affect the conditions of Pakistani women are those of religion, kinship, nationality (ethnicity) and access to education (Rouse 1988).

Muslim reformers in the nineteenth century struggled to introduce female education, to ease some of the restrictions on women's activities, to limit polygamy and to ensure women's rights under Islamic law. Sir Syed Ahmad Khan convened the Mohammedan Educational Conference in the 1870s to promote modern education for Muslims and he founded the Mohammedan Anglo-Oriental College. Among the predominantly male participants were many of the earliest proponents of education and an improved social status for women. They advocated cooking and sewing classes conducted in a religious framework to advance women's knowledge and skills and to reinforce Islamic values. But progress in women's literacy was slow: by 1921 only four out of every 1,000 Muslim females were literate.

As independence neared, it appeared that the state would give priority to empowering women. Pakistan's founding father, Mohammad Ali Jinnah, said in a speech in 1944:

> No nation can rise to the height of glory unless your women are side by side with you; we are victims of evil customs. It is a crime against humanity that our women are shut up within the four walls of the houses as prisoners. There is no sanction anywhere for the deplorable condition in which our women have to live. (Jinnah 1944)

After independence, elite Muslim women in Pakistan continued to advocate women's political empowerment through legal reforms. They mobilized support that led to passage of the Muslim Personal Law of Sharia in 1948, which recognized a woman's right to inherit all forms of property. They were also behind the futile attempt to have the government include a Charter of Women's Rights in the 1956 constitution. On March 2, 1961, the Family Law Ordinance saw the regulations of divorce and the restriction of polygamy by the President of Pakistan (Grover and Arora 1997). The 1961 Muslim Family Laws Ordinance covering marriage and divorce, the most important socio-legal reform that supported women, is still widely regarded as empowering for women.

In 1947, the Anglo-Mohammadan Law was in vogue in the urban areas while customary law prevailed in rural areas. The latter denied the rights of inheritance to women and even the basic ones relating to marriage and divorce. In addition, the *Jirga* system (a tribal council) was all supreme in the tribal areas that did not

take cognizance of the rights that Islam had bestowed to women. All women's organizations in Pakistan, under the leadership of the All Pakistan Women's Association demanded the setting up of a family law commission to study and recommend changes in laws pertaining to child marriage, polygamy, divorce, custody of children and inheritance. The government set up a commission in 1956. Five years later, the family law ordinance was promulgated. Women acclaimed the ordinance but some of the *ulema* were highly critical of certain provisions in this ordinance, including the one restricting polygamy. This provision disallows remarriage without the permission of the first wife. It is interesting to note that similar laws are already in existence in other Muslim states. In Syria and Jordan, for instance, the wife has the right of divorce if the husband wishes to remarry. In Iraq and Indonesia the consent of the court of law is required and in Turkey polygamy is totally prohibited (Siddiqi 1990).

Legal Status of Women

Despite Constitutional guarantees of equality, the Constitution itself carries provisions that negate the fundamental right of equality and equal protection under the law. Also laws exist and others are being enacted that are directly in conflict with the Constitution. In the name of religion are subject to different interpretations, thereby causing even more confusion. These include discriminatory laws like the Pakistan Citizenship Act (whereby the foreign wife of a Pakistani man is entitled to citizenship but the foreign husband of a Pakistan

women is not), areas of personal law, portions of labor laws, the *Qanoon-e-Shahadat* (that reduces the value of women's testimony to half that of a man's), the *Hadood* laws which oust the testimony of women altogether for the purposes of *hadood* punishment and all the Islamic laws (which for purposes of inflicting punishment consider a girl child who has reached puberty to be an adult, while a boy is considered an adult only at 18). Islamic laws moreover, can not be challenged as violating Fundamental Rights because of the Eighth Amendment to the Constitution that validates all ordinances, laws and acts made during the period of martial law and forbids their being questioned in any court of law anywhere.

The law creates insecurity in marriage and divorce since men have absolute right of divorce and need not assign any reason for divorcing their wives. As well, women have no right to maintenance after divorce, no right to share in marital property, nor the right to live in the marital home.

In practice, many of the laws favorable to women have been ignored and their implementation has been ineffective. While labor laws have some protective or beneficial provisions for women (probation against night work, certain types of work, matemity benefits, etc.), they also provide discrimination against them (Zia 1994).

According to Islamic laws, a husband is entitled to four wives at a time. This law of polygamy is interpreted differently in different regions of Muslim societies. In Pakistan, the practice of polygamy was slashed by law in 1961 when Pakistan's first martial law administrator General Ayub Khan took a decision to eradicate it. There were public demonstrations against this decision. People never accepted this law. In this particular case, *Ulema* (clergy) played an important role to lead ordinary man against it. They did not accept a forceful decision to end polygamy. Instead it became a vanishing practice afterwards, mainly because of financial constraints and social obligations. Also cumbersome were the requirements that a husband, first should get permission from his present wife to get married again; second there should be some solid reason for that; and third he should be able to provide equal rights to all his wives and children.

When a marriage dissolves, a Muslim woman is entitled to her "*haq mehr*", an amount stipulated under the marriage contract. It is an agreed right of women under Islamic Law in the event of divorce. It can vary on the basis of local customs and that can be either an equal amount of gold, silver or local currency. Besides that the husband is also responsible to provide support to the dismissed women for the period of "*iddat*", the period of separation (seclusion) three lunar months, to be observed on dissolution of marriage. The amount of "*haq mehr*" usually depends on the mutual understanding of the bride and bridegroom's families. A bride's male elders prefer to have a high amount of "*haq mehr*" so that it can also play as an economic pressure on the bridegroom to avoid

marriage dissolution or separation. Contrary to poor families, rich landlords fix a high amount of "*haq mehr*" to keep their status high in the eyes of people and other landlords.

The Muslim law of inheritance is based on inequality. The share of a male heir is twice that of a female. Thus the share of a son is twice that of a daughter and that of a brother is twice that of a sister of the same degree (Beteitte 1983:54).

The Pakistan experience as documented in the report of the commission of inquiry for women (1997) offers an illustration of this discriminatory aspect of the law. The law made during the martial law regime included offences of *zina* (enforcement of *hadood*) ordinance 1979. The narration in the Report about the *zina* ordinance is replete with instances of the victimizing of women through the use of law. *Zina* in translation refers to adultery with or without the complicity of the women. It is illegal or impressionable conduct without moral sanction. Prior to the *zina* ordinance being implemented *zina* was a crime in the form of adultery. The punishment was five years imprisonment or a fine or a combination of these two punishments. In 1979, the *zina* ordinance was promulgated and, the report records that a lot has changed for women in terms of victimization and the criminalisation of conduct those parents, police, husbands and others see as offensive has been witnessed. Prior to 1979, there were only a handful of reported cases of adultery (p 66). No sooner did the law include the women as a potential offender than the allegations of *zina* ran into thousands. In the women's

police station in Karachi, 80 per cent of the cases registered were under this law (Ramanathan 1997).

The inherent unfairness is that in a court of law a woman's testimony is worth half that of a man's. Many women at this very moment are rotting in jail with children that have been born within those walls. On what basis? Merely that the husbands have secured false testimony so they could have them put away and be free to probably marry again.

Since the Pakistani government proclaimed its intent to institute "*Nizam-e-Mustafa*[2]" women have been one of the key groups targeted by the regime of Zia ul Haq. In March 1983, the *Majlesi-e-Shoora*[3] passed a "Law of Evidence" whereby the status of a women is reduced to that of half a man in terms of her ability to bear witness in court. In cases of rape, a women's testimony is to be considered inadmissible[4] and the murder of a women does not warrant the same penalty as a similar crime against a man. Studying women's agency and

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[2] *Nizam-e-Mustafa* refers to the law of the Prophet (Mohammad) which is taken by many in Pakistan as the basis for a theocratic state.

[3] *Majlesi-e-Shoora* was the consultative body in Pakistan that today formulates its laws. From 1977 till 1985, there was no legislative body in Pakistan. The *Majlesi-e-Shoora* that was created by Zia, was essentially a non-democratic body, both in its selection and composition. It was entirely the creature of the military regime, design and created to rubber stamp its policies.

[4] It should be noted that, although the *Majlie-e-Shoora* passed this law, it was not signed into effect by General Zia until much later. This delay was in part a consequence of the strong mobilization of women against its passage. However, it should also be noted, that despite into not having been signed by the President, courts still tried and sentenced women, using this "law" as a basis for their so doing. Three cases have been made public whereby rape victims were actually sentenced and subjected to flogging because no male witnesses could be brought forward to testify on their behalf and their own testimony was not permissible. One of these three women included a blind women whom, after being raped, was charged with extra marital relations. This example of blaming the victim, particularly when the victim is a woman is rampant in today's Islamic Pakistan. It is also interesting to note that the women who was given the

political religion in South Asia, Jeffery (1998) says that the debate about gender issues in South Asia has been so indelibly overwritten by the agendas of politicized religion that it is extremely difficult for those concerned about gender justice to be heard, let alone be politically effective. Politicized religion casts its shadow over the whole region and has crucial implications for the attainment of gender justice.

A melding of the traditional social welfare activities of the women's movement and its newly revised political activism appears to have occurred. Diverse groups including the Women's Action Forum, the All Pakistan Women's Association, the Pakistan Women Lawyers' Association and the Business and Professional Women's Association, are supporting small-scale projects throughout the country that focus on the empowering of women. They have been involved in such activities as instituting legal aid for indigent women, opposing the gender segregation of universities and publicizing and condemning the growing incidents of violence against women. The Pakistan Women Lawyers' Association has released a series of films educating women about their legal rights; the Business and Professional Women's Association is supporting a comprehensive project inside Yakki Gate, a poor area inside the walled city of Lahore; and the Orangi Pilot Project in Karachi has promoted networks among women who work at home so they need not be dependent on middlemen to acquire raw materials and

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severest sentence out of the three came from the tribal areas; this indicates the even more oppressive conditions under which tribal women live.

market the clothes they produce. Several NGOs are also working in different regions to educate women about their rights.

Dowry

Dowry is a commonly practiced tradition. It has strong historical roots. On the other hand it is a un-islamic *rewaj* (custom) which is condemned by young generation and elders and at some level by some provincial government's efforts. Dowry has different characteristics and meanings in each province and in each locality. For example, in tribal areas of North West Frontier Province (NWFP) province and Balochistan, girls bring money to their fathers when they get married. They are literally sold and usually their fathers get money in return for their daughters. The "price" of a bride depends on her age, beauty and abilities to work and manage a home. Usually, a high price is paid when a girl is young, preferably less then nineteen, pretty and not disabled. If the bride is widowed disabled, or older, then the price is much lower. Depending on the bridegroom and bride's father's deal the price can also be paid in installments. Ideally the price should be spent on preparation of the dowry but practically fathers rarely do that. One can but imagine how women would be treated after their purchase. After marriage, the loyalty and expectations of sincerity from the groom and his family are extremely high. And women are so culturally entrapped that some kill their own siblings in cases of family enmity. They do so especially because they are exempted from some punishments as a "woman".

Having male children fulfills the prerequisite of huge dowries. Greed for a dowry leads to harassment and murder of brides and daughters-in-law (Anandan 1982). Greed could be seen as the main factor behind this social evil. Many young girls do not get married because their parents are unable to satisfy the huge list of dowry requirements that they get from bridegroom's family before the decision to marry is confirmed.

Usually a dowry consists of jewelry, furniture and cash. In some cases, cash and material items flow from the groom's family to that of the bride in far larger sums than the amount she brings as her dowry.

Female Education

There is a common saying of the Prophet Mohammed, "to seek knowledge is the duty of every Muslim man and woman". Such religious teachings are easily negligible by the society when facing economic hardships and other social barriers. The poor economic conditions of the man are the main reason for not sending children to schools where they not only spend time but also money. Instead they can work and help their parents at home or outside the home.

Comparison of data for men and women reveals significant disparities in educational attainment. By 1992, among people older than fifteen years of age, 22 per cent of women were literate as compared with 49 per cent of men. The

comparatively slow rate of improvement for women is reflected in the fact that between 1980 and 1989, among women aged 15 to 24, 25 percent were literate. United Nations sources say that in 1990 for every 100 girls of primary school age there were only 30 in school; among girls of secondary school age, only 13 out of 100 were in school; and among girls of the third level, grades nine and 10, only 1.5 out of 100 were in school. Slightly higher estimates by the National Education Council for 1990 stated that 2.5 per cent of students 3 percent of men and 2 percent of women between the ages of 17 and 21 were enrolled at the degree level. Among all people over 25 in 1992, women averaged a mere 0.7 year of schooling compared with an average of 2.9 years for men.

Studies show that Pakistan has made remarkable progress in raising its literacy rate by 45.4 per cent during the past 17 years, showing an increase of 19.3 per cent as compared to 26.1 per cent registered in the national census conducted in 1981.

According to the figures of the national population census (1998), the 1998 literacy rate has increased by 45.4 per cent over the past 17 years since 1981. This is a phenomenal upward trend in the literacy rate as compared to the period of ten years from 1971 to 1981 when the literacy rate was registered at 21.7 per cent in 1971 and 26.1 per cent in 1981. The latest data revealed the literacy rate in Punjab has increased by 47.4 per cent, while in Sindh, NWFP and Balochistan it has increased by 47 per cent, 37.3 per cent and 26.6 per cent respectively

(National Population Census 1998). Adult literacy rate is 55.2 per cent for males and 25.4 per cent for females (UNDP 1999).

In the comparative data on literacy rate, Pakistan still lags behind other countries of the south Asian region as well as the countries graded as having on average low-income. The ratio of enrolment of male students in Pakistan is recorded at 101 per cent as compared to 109 per cent of other regional countries and 113 per cent in the low average income countries. The ratio of female enrolment in Pakistan is registered at 45 per cent as compared to 90 per cent in other south Asian countries and 103 per cent in the low-income average countries. Pakistan's literacy level has been calculated at around 45 per cent, while real literacy that makes one functional, hovers around 10 to 15 per cent of the total population. Likewise, of those 10 years and above, among a population of about 90 million, only 21 million or 23 per cent have fewer than eight years of schooling and around 24 million were in schools in 1998-99. It would be imprudence to compare this situation with Pakistan's neighbors in the region. Illiterate persons do not have much comprehension of their rights and obligations; the uninitiated lose their direction and fail to determine the course of their lives.

In determining which variables most affect health status in low and high-income countries, Siddiqui and Mahmood (1994) conducted a research study that encompassed the years1960 to 1990. They show that literacy is the most

important and statistically significant variable. This variable correlates well with life expectancy and has a significantly negative effect on the infant mortality rate.

The conclusion that can be drawn from these data is that women's poor health status and high fertility rates can be substantially improved by increasing the number of schools and their access to education and income opportunities. It would give them confidence and decision making power for certain crucial health variables like marriage preferences, family size and family hygiene.

Woman in Islam

The role of women in Islam was explained in the *Quran* (Muslim's holy book) in the 7th century. The *Quranic* chapter "*Nisa*" (Woman) deals with issues of women's relations within the society. A new social order was laid down by defining the duties and functions of the sexes; marriages came to be regarded as a social contact; divorce was abhorred as an obnoxious practice; polygamy was limited and rights and obligations of men and women were clearly elaborated.

Islam does not impose polygamy as a universal practice. The Prophet himself was a monogamist for the greater part of his married life, from the age of 25 when he married Khadija until he was 50 when she died. A woman may not be married without being consulted and is able to obtain a divorce. A husband is required to maintain the divorced wife and children. The Muslim woman is

accorded full spiritual and intellectual equality with men and is encouraged to practice her religion and develop her intellect. In her relations with men a woman is expected to observe modesty of behavior and dress and a strict code of morality which discourages unnecessary mixing of the sexes. Her relations with her husband should be based on mutual love and compassion. He is responsible for the maintenance of the wife and children and she is to give him the respect due to the head of the family. She is responsible for the care of home and the children's early training. She may own her own property, run her own business and inherit in her own right as affirmed by the *Quran*. In her old age she is respected and shown every care by her children and by the society as a whole. The *Quran* says: "they are garments unto you and you are garments unto them". The Prophet suspended all distinction on the basis of caste, color, sex or status in his manifesto of *Hijatul – wida* (last address) and pronounced the high and low, man and woman equal as human beings. He said, "the world and all things in the world are precious but the most precocious thing in the world is a virtuous woman". The Prophet also gave supreme recognition to womanhood when he declared that paradise lies at the feet of mothers.

Generally, for the laws and social regulations regarding women consultation of the *Quran* and *hadith* (saying of Prophet Mohammad) are considered the most authentic sources. But sometimes the relevant quotations directly from the *Quran* and *hadith* at different times and in different places have been distorted, ignored or flouted. The present time of widespread rethinking of the role and rights of

women is perhaps the appropriate time to look with fresh eyes at the Islamic point of view, which has contributed to the formation of the social values in the vast area of the world. Feminists in Pakistan trying to develop alternative readings of the *Quran Sharif* and other key texts of Islam have found their theological credentials undermined by their male opponent (Jeffery 1998).

Ulema's (clergy) Response

Since the birth of Pakistan, religious extremists have played an influential role in legislation formulation and directing people in the country, provinces and within ethnic groups. Their participation in the political arena also directs national development polices at the state level such as family planning and women's rights. Jeffery (1998) argues about the barriers feminists face in Pakistan and says that the influence of politicized religion on the state and the centrality of gender issues in politicized religion in themselves create difficulties for feminists. A very good example of this can be seen in the women's section of *Jamaat-e-Islami*[5] Pakistan at the closing session of its two day workshop entitled "Dividing society on gender basis creates imbalances and hatred in the society: Contemporary challenges and responsibilities of Muslim Women" (1999). This was held in collaboration with the Pakistan Islamic Medical Association and it examined the documents concerning women viz. CEDAW (Convention on the

[5] The *Jamaat-I-Islami* (JI), the largest religious party in Pakistan, was founded in 1941 by Maulana Abul Ala Maududi as an ideological movement to promote Islamic values and practices in British India. Though they never scored in the polls to rule the country but still play important role in the upper and lower houses. How do they react to the international and government

Elimination of all forms of Discriminations Against Women) and the Report of the Commission on Women's Rights. It issued the following press statement consisting of the recommendations unanimously approved by all the participants: I quote it at length because of its importance.

> We Muslim Women reiterate our belief that Islam has its own, all pervading and comprehensive code for solving the problems of all human beings, whereas distributing humankind in small units, men and women and then trying to solve their problems separately causes hatred between them, confuses the issues and creates imbalances in the society. Therefore, we demand that all the problems be tackled in the light of Quran and *Sunnah*. For the solution of the problems of today, we must seek help from the *ijtahad* (interpretation and re-interpretation of Islamic law.)
>
> Having studied CEDAW thoroughly we draw the conclusion that it is a document in conflict with the sovereignty of Allah. It encourages mixed society and free social environment and it would amount to inviting the wrath of Almighty Allah if Muslim society accepts this document. Therefore, every Muslim country should forthwith reject this document. We disapprove any action taken in the light of it.
>
> Taking advantage of such a document some NGOs are conducting an organized campaign against Islamic social and marital system, *hudood* (Islamic limits) and punishments *qasas* and *di'yat* and for the elimination of Islamic law of evidence. We warn them if they continue challenging the modesty of Muslim society through such evil provisions, the envious women of the Muslim society as a whole shall resist these moves.
>
> We want to make it clear that we very vehemently condemn all such efforts as are being made with impunity to bring amendments to the law and constitution of the Islamic Republic of Pakistan in the name of elimination of discrimination against women and to enforce the recommendations of any commission or any Institution by our Media through mixed and vulgar society. We cannot tolerate nudity, immodesty and waywardness, disobedience of parents by children and revolt of wife against husband.

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agenda for women development is significant especially because of their ideological difference and with reference of Islamic interpretations of them.

> We demand that instead of forcing women in an undue manner to come to the economic field, men should be made to bear economic responsibility so that peaceful atmosphere of household is not de-stabilized. Heads of families should be reminded through media of their duties and responsibilities. We express our heartfelt pain in regard to the way women folk is subjected to forced labor and dishonor by *Jagirdari* (feudal land lords) oppression. We demand that the concerned agencies should take notice of this situation and come to the rescue of the oppressed womenfolk. Women should be helped to get their rights under the Islamic laws of inheritance. Lady judges should hear family disputes. Family courts should be separate from civil courts. Government should avoid adopting the Family Planning as a state policy, rather it should be left to the freewill of the individual and the advice of the doctor. Its publicity at state level should be stopped. Abortions should be banned".

This group of women belongs to a religious political party of Pakistan and are very influential because of the religious connotation they have attached to their party. They are very strictly in favor of women's *purdah* and concept of "*chadder and char dewari*" (for women to stay inside the four walls of house) . They are against the emancipation of women but want to deal with the issues of injustice with women with a firm commitment to men's dominant role in and outside the household. On the other hand there are many NGOs working on violence against women issues and who want the Government to make changes in the constitution to eliminate discrimination against women at the state level but because of the religious party's political influence it is very hard for other women's groups to advance their work.

Women's Rights in the Constitution of Pakistan

Right from those days when people started struggling for as independent Pakistan, Muslim women fought equally with men. They were very active politically as well as socially. This may well be termed the real beginning of women's movement in Pakistan. Their traumatic experience and unity during the independence struggle led them again to fight against the days of under dependence in a newly born Muslim country. They succeeded in many platforms such as to have the family ordinance and other laws in their favor in 1960s and 1970s. In 1973, the Constitution of Pakistan safeguarded the rights of women as equal citizens of the country for the first time. Following are the few articles of the Constitution, which are found the most relevant as to women's rights.

> Article 25
> All citizens are equal before law and are entitled to equal protection of law. There shall be no discrimination on the basis of sex alone. Nothing in this Article shall prevent the state from making any special provision for the protection of women and children.
>
> Article 27
> The citizen otherwise qualified for appointment in the service of Pakistan shall be discriminated against in respect of any such appointment on the ground only of race, religion, caste, sex, residence or place of birth.
>
> Article 34
> Steps shall be taken to ensure full participation of women in all spheres of national life.
>
> Article 35
> The state shall protect the marriage, the family, the mother and the child.

Article 37
The state shall:
Make technical and professional education generally available and higher education assessable to all on the basis of merit. Make provision for securing just and human conditions of work, ensuring that women and children are not employed in vocations unsuited to their age or sex and for maternity benefits for women in employment.

Article 51
The National Assembly shall consist of two hundred members to be elected by direct and free vote in accordance with law. ... ten seats in addition to the number of seats referred above shall be reserved for women and allocated to the Provinces in accordance with the constitution and law.

There is no doubt that law serves a purpose in promoting social change, but mere legislation can not change society overnight. It is obvious in the teachings of Islam which is the religion of 97 per cent people and in the Constitution that men and women have equal rights, protected against discrimination and have safeguards for their basic rights. It is society and its deeply routed traditions that mould the rules and regulations of existing gender practices and inequalities.

Women in Pakistan have been given representation at the national and local government level through the provision of reserved seats from 1947 until 1988. However, the proportion of reserved seats has never been more than 10 per cent at the national, provincial and local government levels. Women are always elected on these seats through indirect election. The insignificant number of seats reserved for women and the mode of indirect election to these seats fail to provide opportunities for women to play an effective role in politics. Currently, 20 per cent representation of women through indirect election at the district level is

proposed in the devolution of power framework of the present military regime. Because of the revolutionary potential of the proposal it has already come under attack by orthodox religious forces in the country.

For the first time in the history of Pakistan, the devolution of power framework proposes to give equal representation to women through creating multiple-member constituencies at the union council level. This proposal has the revolutionary potential to change the politics and governance of the country because of the following reasons. The presence of women candidates at each village and ward level to contest union council elections will be the beginning of a "cultural revolution" in Pakistan. The visibility of women in the politics of local government will fracture the ideology of the gender-based division of labor that confines women to the four walls of their homes. A large number of women entering the traditionally male arena of politics will change popular perceptions and enhance the acceptance of women in politics and hence in public affairs. Due to the direct election proposed for women at the union council level in the devolution of power framework, women candidates will learn quickly the art of politics. They will have to reach out to people, to mobilize public opinion in their favor. In the process, they will create constituencies and will be accountable to them after the election. Women councilors will clearly have their own constituency, as they will come into power through direct election. Therefore, they will work to fulfill the expectations and aspirations of their constituents. This

will most probably shift development priorities at the local level in favor of the social sector.

Government's Gender Health Policies, Planning and Development

Pakistan endorsed the Beijing Platform for Action (BPFA)[6] in 1995 and is bound to operationalise its National Plan of Action for women. Islamabad also formally ratified the Convention on the Elimination of All Forms of Discrimination against Women in 1996 but has avoided the implementation of its resolutions.
The Annual Plan approved by the government for 1998-99 pertained to the first year of the government's ninth five year plan (1998-2003) (The Planning Commission of Pakistan 1998). National self-reliance is the theme of the 9th Plan. Pakistan's ninth five-year plan made participation and community development major themes in social sector development. It also emphasizes a population policy, which focuses on reducing infant and child mortality on the assumption that the resulting increase in child survival will help reduce fertility. The target for the five-year period is to lower the crude birth rate by increasing contraceptive practices.

However, It is a different matter that the Annual Plan too has already undergone drastic cuts because of financial stringency that is attributed officially to

[6] The Beijing Declaration and Platform for Action was adopted at the Fourth World Conference on Women, Beijing (4-15 September 1995) by representatives from 189 countries. The Platform reflects a new international commitment to the goals of equality, development and peace for all women everywhere. It builds on commitments made during the United Nations Decade for

international sanctions imposed by Pakistan's creditors as a reprisal for its nuclear tests. The cuts forced by the domestic resource crunch have a roller coaster effect because these lead to the withholding of aid by foreign donors as well. Such aid often constitutes more than half of the development outlay in Pakistan.

Pakistan's economic performance ran off twice. First, following its nuclear tests. On May 28th, 30th 1999 Pakistan conducted six atomic bomb tests and faced subsequent imposition of sanctions by G-7 countries. Second, after a military coup in October 12, 1999 when Pakistan lost its commonwealth membership.

One of the important projects of Pakistan's Ninth Five-Year Development Plan is to set up a permanent commission on the status of women to protect their rights and ensure their equal participation in national development. The commission will consist of 10 to 20 members. The majority of members will be women. The government will appoint the chairperson and members of the commission for a period of three years. One member will be from the religious minority. The commission will be authorized to appoint advisers for assistance in accomplishing its task in various spheres of life. The federal cabinet has already approved the setting up of the commission, which is aimed to promote the socio-economic development of women in the country. The commission will have its own permanent secretariat in the Ministry of Women's Development. The

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Women, 1976-1985, including at the Nairobi Conference and on related commitments made in the cycle of United Nations global conferences held in the 1990s.

commission will serve as a permanent monitoring body to safeguard women's rights. It will formulate recommendations on rights of women. The commission will be authorized to take action for incorporating necessary amendments in existing laws for protecting the rights of women. It will also be authorized to take necessary action in case of violation of women's rights guaranteed to them under the Constitution.

The National Commission on the Status of Women (NCSW) will work for the emancipation of women, equalization of opportunities and elimination of all forms of discrimination against women. NCSW would act as a statutory body to investigate, examine and review legal safeguards provided to the women. In the light of the Beijing Conference, 1995 a National Plan of Action (NPA) has already been launched in the country. It seems that the commission will bring a major change in the overall development and empowerment of women. But in reality how far government's policies will be successful is very difficult to predict because the Pakistan's national assembly set up the same kind of commission on the status of women in 1975 after passing a resolution. The national assembly passed this resolution during the international women's year in 1975 and it can be seen as a result of persistent demand from women's pressure groups.

A number of steps in this direction have been taken for example the development of micro-credit facilities. The First Women's Bank (FWB) with a capital of Rupee 48 million for provision of loans to women on a 12 per cent markup has been

established and it is heartening to note that the total revolving credit of FWB has been increased from Rupee 48 million to Rupee 173 million. It is a successful experience for the ministry (Ministry of Women Development 2000).
So far government has taken some practical initiatives in different sectors, the ministry had also requested the Agriculture Development Bank of Pakistan (ADBP) to extend loans to women for the establishment of their businesses. The spokesman said the ministry had distributed Rupee 26 million to NGOs, working for the welfare of women in the country.

The National Plan of Action prepared by the Ministry of Women Development establishes a set of priority actions formulated to help achieve the agenda for the empowerment of women in Pakistan. The basic theme of the NPA is based on the principle of shared power and responsibility between women and men at home, in the workplace and in the community. The NPA covers all the important areas for the development of women in poverty.

Having ratified the UN Women's Convention and under its own Constitution, Pakistan is obliged to treat women equally and to protect their fundamental human rights. United Nations Development Program's (1996) project "Facilitating women's mobility" was very much part of the government's National Plan of Action (NPA) for women, which established a set of priority actions formulated to help achieve the agenda for the empowerment of women in Pakistan. The chapter on women and poverty in the NPA states as one of its

strategic objectives to extend outreach of ongoing programs to women, to overcome traditional socio-cultural norms that constrain women's mobility.

The government is preparing to launch a special package for women. Giving some key points of the package, government would give a daily meal to the female school children in villages in a bid to improve their nutritional status and thereby end emotional deprivation. Under the poverty alleviation program of the government, 20 women-friendly districts are being set up countrywide. Eight of these districts would be in the Punjab and four each in the three provinces. In order to address this situation 44,000 women health visitors are being appointed under the Health Ministry while another 12,000 village -based health workers are also being inducted. Some 66,000 women were being engaged as village health workers to promote immunization in rural areas and reduce the percentage of physically handicapped people (Asian Development Bank 1997).

Chapter Four

KEY HEALTH ISSUES

Health in Pakistan

In Pakistan, life expectancy at birth is 64 as compared to 62 in South Asia as a whole and 59 in low-income countries. The mortality rate under age 5 was 161 in 1980, which in 1997 improving to 136 per 1000 (World Bank 2000). The Asian Development Bank (1997) provides health statistics in its 1997 report for Pakistan. The report says that Pakistan's national network of health services consists of 823 hospitals, 4, 205 dispensaries, 4, 925 basic health units (BHUs), 856 maternity and child health centers (MCH), 498 rural health centers (RHCs) and 260 tuberculosis centers (see health systems structures in Pakistan diagram 1, page 82). There are 85,552 beds. In terms of health professionals, there are 69,694 registered doctors, 2,753 dentists, 22,531 registered nurses, 4,277 registered lady health workers and 20, 869 midwives (all of the above and following statistics are from the 1995-96 Pakistan Economic Survey).

In addition to the above, Pakistan has 11, 263 doctors in the private sector-4,000 in Punjab, 5,161 in Sindh, 1,533 in NWFP, 397 in Balochistan and 165 in Azad Kashmir and the Northern Areas. The popularity of the private sector is growing but no reliable statistics exist regarding the number of clinics and hospitals

operated by the private sector. Anecdotal evidence appears to indicate the predominance of the private sector in providing curative care.

Non-government organizations are very active in the health sector in Pakistan. In particular, numerous NGOs work in the area of mother and childcare and are especially experienced in assisting with basic health care, breast-feeding, preparation of weaning foods and identification of childhood diseases. In the Punjab, NGOs play a very important role in providing health care in remote rural areas where the Government does not have working facilities. It is the same in Sindh province. I have personally visited remote areas of Sindh where no Government officials have visited since Pakistan's independence. There was absolute absence of basic amenities. The National Rural Support Program (NRSP)[7], is a national NGO, imparts training of small enterprises and provided loans to both men and women of the area separately according to their particular needs. Large NGOs such as the Aga Khan Health Services (AKHS), the Red Crescent society, Edhi Welfare Trust, the Fatimid Foundation, Al-Shifa Trust Eye Hospital, Pakistan Retnitas Pegmentosa Society, Shokat Khanam Memorial Hospital, Apna Sehat and the T. B. associations tend to focus their activities more on Pakistan's urban areas only AKHS and Apna Sehat are also have activities in the rural parts of the country.

[7] National Rural Support Program (NRSP) is an NGO working in rural areas of Pakistan. This NGO is based on the design of Aga Khan Rural Support Program (AKRSP) which is only concentrating in Northern Areas of Pakistan. NRSP is working in almost all-rural areas of

Noman (1997) has analyzed well health resources and their availability in different parts of the country, as well as the demand for and production of medical professionals and their distributions within provinces, urban and rural areas. He says that there are regional disparities in addition to the obvious imbalance in rates of growth among various health resources. The ratio of nurses per hospital bed is substantially lower in Sindh and Punjab than in NWFP and Balochistan. The ratio of hospital beds to population has changed little in the NWFP and Sindh and has increased substantially in Balochistan. On the other hand, the Primary Health Care (PHC) facilities-population ratio in Punjab (13,399) is over twice the ratio in Balochistan (6457).

Another serious imbalance is the concentration of medical facilities and resources in urban areas. While around 65 per cent of the population is resident in rural areas, 83 per cent of employed physicians are working in urban areas. In addition, 85 per cent of all hospital beds, 82 per cent of all hospitals, 97 per cent of all TB centers and 58 per cent of all mother child health (MCH) centers were concentrated in urban areas in 1990. There is no formal structure to provide health services below the Basic Health Unit (BHU) designed to serve a population of 5 to 10,000 and thus it is estimated that 36 per cent of the population, approximately 39 million rural residents, have no reasonable access to basic health care. As a consequence, there is a strong relation between

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Pakistan except Northern Areas and NWFP. As a consultant anthropologist for monitoring and evaluation for NRSP, I have visited most of its filed working areas and conducted interviews.

distribution of resources and differential urban rural mortality rates (Pakistan Economic Survey 1995-96).

Development of medical schools increased in the past few years, however, far beyond the needs of the nation. Currently, there are 17 medical schools producing approximately 4000 doctors annually. The output of medical specialists is estimated to be about 135 per year while the demand is approximately 600 to 700 specialists a year. The government is providing essentially no cost medical education for an increasing surplus of doctors, many of whom will be unemployed and / or underemployed, pressuring the government for employment or capital resources.

While there are 47 nursing schools in Pakistan, the number of applications is low. Nursing remains primarily a female occupation and the problem of expanding the nursing staff is linked to the under supply of female health workers at all levels and in all categories. The problem is particularly severe in the rural areas. Efforts at recruiting and retaining female staff in rural areas are complicated by low rural female literacy, the low status of nursing and paramedical professions, regulatory rigidities which discourage re-entry to service, the absence of incentives for working in rural facilities and general cultural constraints on the employment of women. The cumulative result of these various factors is that there are many vacant posts for nurses and other female health workers.

In 1992 some 35 million Pakistanis, or about 30 per cent of the population, were unable to afford nutritionally adequate food or to afford any nonfood items at all. Of these, 24.3 million lived in rural areas, where they constituted 29 per cent of the population. Urban areas, with one-third of the national population, had a poverty rate of 26 per cent.

Between 1985 and 1991, about 85 percent of rural residents and 100 percent of urban dwellers had access to some kind of Western or biomedical health care; but 12.9 million people had no access to health services. Only 45 per cent of rural people had safe water as compared with 80 percent of urbanites, leaving 55 million without potable water. Also in the same period, only 10 percent of rural residents had access to modern sanitation compared with 55 per cent of city residents. This leaves a total of 94.9 million people hence without sanitary facilities.

In the early 1990s, the leading causes of death remained gastroenteritis, respiratory infections, congenital abnormalities, tuberculosis, malaria and typhoid. Gastrointestinal, parasitic and respiratory ailments, as well as malnutrition, contributed substantially to morbidity. The incidence of communicable childhood diseases was high; measles, diphtheria and pertussis took a substantial toll among children under five. Although the urban poor also suffered from these diseases, those in rural areas were the principal victims.

Despite these discouraging facts, there has been significant improvement in some health indicators, even though the population grew by 130 per cent between 1955 and 1960 and between 1985 and 1990 increasing from 50 million in 1960 to 123. 4 million in 1993. For example, in 1960 only 25 per cent of the population had purportedly safe water (compared with 56 per cent in 1992). In addition, average life expectancy at birth was 43.1 years in 1960; in 1992 it had reached 58.3 years.

In addition to public-and private-sector biomedicine, there are indigenous forms of treatment. *Unani Tibb* (Arabic for Greek medicine), also called *Islami-Tibb*, is *Galenic* medicine resystematized and augmented by Muslim scholars. Herbal treatments are used to balance bodily humors. Practitioners, *hakims* (traditional healers), are trained in medical colleges or learn the skill from family members who pass it down the generations. Now there are some registered medical colleges providing Islamic *Tibb* education. Some manufactured remedies are also available in certain pharmacies. Homeopathy, thought by some to be "poor man's Western medicine," is also taught and practiced in Pakistan. It is gaining popularity particularly because of its cheep consultation fee and medicines as compare to rising fees of western-trained doctors and their medicines. These traditional medical systems are practiced widely in Pakistan. According to 1995-96 statistics there are 39,559 registered *hakims* and 39, 108 homeopaths practicing in Pakistan. It is interesting to note that the total number of these two types of traditional practitioners is roughly equal to the number of doctors

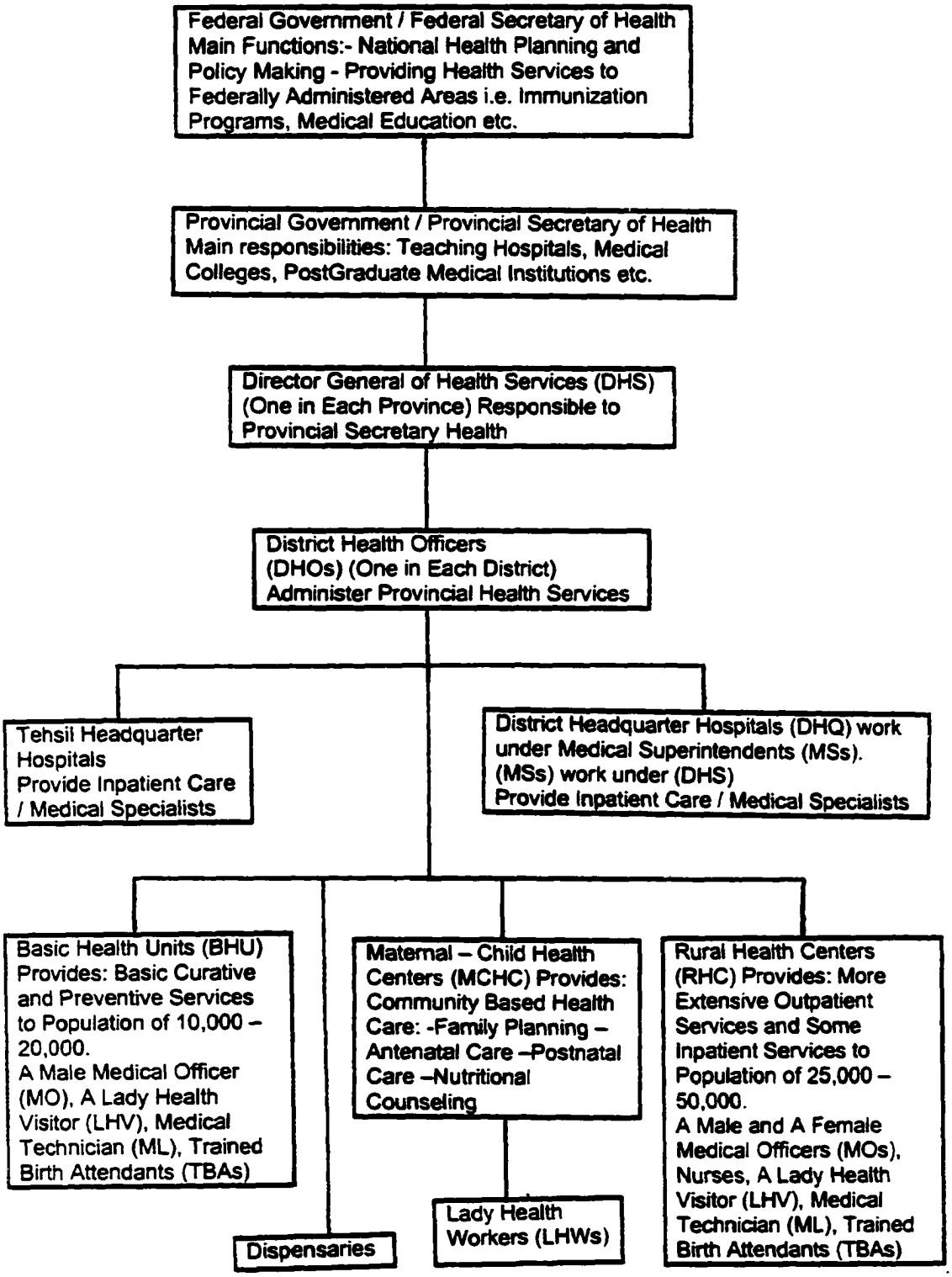
practicing Western medicine. However, traditional medical practitioners tend to be more common in rural areas and their services often cost considerably less.

Several forms of religious healing are common too. Prophetic healing is based largely on the *hadith* of the Prophet pertaining to hygiene and moral and physical health and simple treatments are used, such as honey, a few herbs and prayer. Some religious conservatives argue that reliance on anything but prayer suggests lack of faith, while others point out that the Prophet remarked that Allah had created medicines in order that humans should avail themselves of their benefits. Popular forms of religious healing thought to offer at least protections from malign influences that are common in most of the country. The use of *tawiz,* amulets containing *Quranic* verses, or the intervention of a *pir,* living or dead, is generally relied upon to direct the healing force of Allah's blessing to anyone confronted with uncertainty or distress. As this healing treatment is linked with people's faith and believe system, it is practiced in one way or another by many without any class, ethnicity or status differences, all over the Pakistan.

The amount of federal government investment in health is low by international standards and there is evidence that the funding is allocated in such a way as to be less effective than it could be. The government's investment in the health sector is minimal. The health sector share of Gross National Product (GNP) is only 0. 90 per cent for the financial year 1995-96, a figure which is low by any international standards. However, a variety of surveys indicate that private

sector involvement, primarily in urban areas, increases the total financing of the health sector to about 3.5 per cent of the GNP and this level of financing does not compare unfavorably with countries at the same level of development as Pakistan. Thus, non-governmental investments in health care are approximately 2.5 times that of the federal government (Noman 1997).

Health Systems in Pakistan



Maternal and Child Health

Pakistani women suffer from the highest maternal mortality rates in the region and only 29 per cent of women receive antenatal and childbirth care from trained attendants. Usually women's health facilities are available through maternal and child health services. These services generally, put more emphasis on child health and address only a restricted set of women's health needs.

The average age of marriage for women was 19.8 between 1980 and 1990 and, with the rate of contraception use reaching only 12 per cent in 1992, many delivered their first child about one year later. Thus, nearly half of Pakistani women have at least one child before they complete their twentieth year. In 1988-90 only 70 per cent of pregnant women received any prenatal care; the same proportion of births was attended by health workers. A study done by the National Institute of Population Studies (1992) covering the years 1975 to 1990 found that 57 per cent of pregnant women were anemic (1975 to 1990) and that many suffered from vitamin deficiencies. In 1988 some 600 of every 100,000 deliveries resulted in the death of the mother. Among women who die between the ages of 15 and 45, a significant portion of deaths are related to childbearing.

The inadequate health care and the malnutrition suffered by women are reflected in infant and child health statistics. About 30 per cent of babies born between 1985 and 1990 were of low birth weight. During 1992, 99 of every 1,000 infants

died in their first year of life. Mothers breast-feed for a median of twenty months, according to a 1986-90 survey, but generally withhold necessary supplementary foods until weaning. In 1990 approximately 42 per cent of children under five years of age were underweight. In 1992 there were 3.7 million malnourished children and 652,000 died. Poor nutrition contributes significantly to childhood morbidity and mortality. More than 49 per cent mortality among children under five years of age is due to diarrhea or malaria. Acute respiratory infection and diarrhea are still a the major killers of children below five years of age and remain a big challenge for the medical practitioners.

Apart from the dangers that women face as a result of deliveries by untrained persons under unhygienic conditions, induced abortion constitutes another significant health hazard for Pakistani women. Abortion is illegal in Pakistan. The 1930 Law of Crime (Section 312) in Pakistan states that whoever voluntarily causes a women with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the women, be punished with imprisonment. The Law therefore forbids qualified doctors to induce abortions except for saving the women's life. The law is more literally followed in general wards and when dealing with poorer patients. But in private wards and in dealing with private patients, the law is probably interpreted more liberally because induced abortions are performed therapeutically for patients who can afford the doctor's fees (Shah 1986: 191).

In a seminar on "Women and Mental Health" (2000), Dr Rizwan Taj while lecturing on the promotion of mental health for women, stated that emotional deprivation among the women also causes universal lactation failure. In his brief review on the topic he said that women constituted two-thirds of psychiatric patients since they faced more difficulties on account of gender discrimination, role stereotyping, male dominance and the misinterpretation of Islamic values.

Many women's premature deaths are due to a high rate of maternal mortality from hemorrhage, infection, toxemia[8], obstructed labor and primitive abortion methods. The majority of Pakistan's population lives in rural areas. Poor women in these areas where they have a variety of cultural barriers need more health care and nutritional food. Besides childbearing responsibilities, they also work in the fields for longer hours. Generally they eat last after other members of the family because it is expected that they be patient and sacrificial. They take it as a part of their motherhood, which causes them malnutrition and a lack of immunity against diseases. Then, consulting male doctors is another social barrier because of the custom of *purdah*; either they delay their consultations or seek health care at the stage when they are seriously ill.

[8] Toxemia is caused by high blood pressure and can lead to convulsions and death if not treated.

Fertility

Fertility is a universal human concern, as is anguish over infertility whatever its cause. Most cultures include a series of rituals or prayers or special precautions to help a woman successfully conceive and to carry her through a safe delivery. When a woman fails to conceive, a wide variety of cultural explanations is given and usually the blame is placed on the women. A barren woman is often a marganalized figure and seen as someone both personally unfulfilled and socially incomplete. In Pakistani society producing a child specially a son is considered to be very important for a family to continue its name and property.

According to the Population Reference Bureau (1992) the total fertility rate in Pakistan was estimated at 6.1 in 1991. In 1991, the crude birth rate estimated to be 43 per thousand, one of highest among South Asian countries. A third of married women of childbearing age interviewed in the national sample Demographic Health Survey in 1990-91, said they wanted more children National Institute of Population Studies (1992).

In terms of health, an Asian Development Bank report (1997) reveals, Pakistani women on average bear five to six children and many suffer from chronic malnutrition and anemia due to frequent childbearing and poor dietary intake. Maternal mortality is at 340 deaths per 100,000 live births (1993) and in 1995, 25 per cent of all babies born were underweight. Repeated pregnancies also effect

women's potential for participation in economic activities and leads towards poor health and nutrition. With a birth rate averaging between five and six children per woman and a high population growth rate of 2.8 per cent, the population will double again by the year 2020 unless significant and sustainable action is taken.

According to the 1999 Population Census report, almost 43 per cent of the population (both sexes) are below 15 years old. Most of them will be entering the job market soon. The report stressed that it is essential to attain a higher growth rate to absorb the workforce entering the job market. Furthermore, what is also essential is to invest in the social sector (education, health and training) so that this 43 per cent (children and youth) becomes a productive asset for the nation.

The overall male sex ratio, as obtained from Population Census 1998 is 108. The sex ratio is higher (112) in urban than the rural areas (106), probably due to male dominated migration from rural areas to urban areas of the country.

Pakistan's total population was 33. 8 million in 1951 and reached 65.3 million by 1972. Its growth rate was 3. 0 per cent in 1981 but decelerated to 2. 4 per cent during mid-1988 and further to 2.2 per cent by March 2000, when the country's population is estimated to be 137.5 million of Pakistan. There is a substantial unmet need for a contraceptive and to raise awareness about the advantages of proper child spacing and practicing family planning. However, the growth rate is projected to slowdown further to 2.0 per cent by the year 2003, according to

official statistics. It is important to note that agencies working for the control of population growth and family planning ignore the "value" attached to children by the society. The nature of their value can vary in different parts of the country but it is obvious that children are considered as assets more from economic point of view. A couple with many children, especially male children feel themselves to be privileged. Children are taken as economic manpower, no matter whether they work and bring revenue to homes, or stay at home playing role of mini-parents, taking care of young brothers and sisters. Family poverty restricts people's choice in accord with their particular economic needs.

Population Policy, Family Planning Policies and Problems

Pakistan's population growth rate is one of the highest in the world, particularly among the larger developing countries. Introducing family planning and access to its services was the initiative of NGOs in Pakistan. Public sector family planning services began in 1960 as part of the second five year plan, 1960-65 (Planning Commission 1960). A definite population policy, however, did not appear until the third five year plan, in 1965-70 (Planning Commission 1965).

> The improvement in living standards, as reflected in the earlier projections of per capita income, rests heavily on certain assumptions regarding growth of the population. With the planned improvement in health facilities and nutritional standards, the mortality rate is likely to decline fairly rapidly. Unless it is checked by the fertility rate, the population growth could easily be pushed beyond 3 per cent per annum. If this happens the population will double itself by 1985. Such an increase would defeat any attempt

> to raise per capita income by a significant amount. A vigorous and broadly based program of family planning is therefore an integral part of the strategy of the perspective plan". (Harddee & Satterthwaite 1970)

Implementation of this policy consisted of a national program to provide contraceptives, person-to-person family counseling by paramedical staff to couples of reproductive ages.

The country's current population growth is a major deterrent to socio-economic development. It's stated goal is to reduce fertility in order to control growth. The Ministry of Population Welfare is responsible for developing and implementing family planning policy and programs as an integral component of the national socio-economic development plan. The emphasis is on improving the standard of living and quality of life by promoting a small family norm. Implementation and organizational inputs have been subject to numerous financial and political constraints which have produced periods when relatively little family planning service was being provided.

The key to controlling population growth, according to activists in the women's movement, lies in raising the socio-economic status of women. Until a woman's status is determined by something other than her reproductive capabilities and especially by the number of sons she bears, severe impediments to lowering population growth rates will persist.

According to the National Institute of Population Studies' demographic and health survey (1992). Pakistan's extremely high rate of population growth is caused by a falling death rate combined with a continuing high birth rate. In 1950 the mortality rate was twenty-seven per 1,000 population; by 1990 the rate had dropped to twelve (estimated) per 1,000. Yet throughout this period, the birth rate was 44 per 1,000 population. On average, in 1990 each family had 6.2 children and only 11 percent of couples were regularly practicing contraception.

Family planning services are available to people through different channels. Government hospitals and clinics are the major source for female sterilization. The contraceptives provided include condoms, oral contraceptives, Intrauterine Devices (IUDS), injectables and sterilization, primarily female.

Non-governmental organizations also offer services but primarily to urban areas and on a limited basis. The Family Planning Association of Pakistan (FPAP) is the most active. Much of the NGO work, is intended to be guided by the NGO Coordinating Council (NGOCC) situated in Islamabad and overseen by the Population Council and National Trust for Population Welfare (NATPOW). The private sector also provides mass family planning services. These include pharmacies, private physicians, allopathic and indigenous medical practitioners and traditional birth attendants or *dais*.

In the last quarter of 1999 nearly one million couples have suffered as a result of the withdrawal of family planning services, following the stop in donor funds for population welfare funneled through the government. The National Trust for Population Welfare (NATPOW), which oversees family planning services at 479 centres nationwide-80 based in Sindh-wrote to the project managers of the service centres that they are discontinuing their funding since the World Bank has informed them that they have stopped funds beyond December 31, 1999 (DAWN International 2000). The Family Planning Association of Pakistan (FPAP) have begun writing to their respective heads that, having learnt that NATPOW has stopped funding from January 1st 2000, they are returning the rented premises and the equipment used for family planning.

. The effect of this winding up of reproductive health services after almost a decade is that women are deprived of contraceptives and follow up care. Funds were withdrawn when family planning projects were successful with 40 per cent contraceptive prevalence rate (CPR) increase. The NGOs maintain that the World Bank stopped the funding to NATPOW because of "mal administration"- including the failure to register the Trust, set up regional boards and appoint a professional chief executive. Besides administrative problems, at this stage where, the majority of the population is aware of the use of contraceptives, continued accessibility and availability is very important.

As noted in Chapter one, gender roles and relations are basically the difference in what men and woman do and the social implications of that. Here, the reproductive role of women plays a significant role. According to a study done by Bhassom (1991), females are the major targets of family planning programs. The reason for this focus is probably based on the idea that women are home-makers and child-bearing is the sole duty of women. The other reason can be that types of contraceptives available, in easy-to-use methods are for women, for men there is only condom or sterilization, while it is evident that contraception is a very important concern of both men and women. From the policy perspective, it is agreed that population policies must take into account all aspects of women and men's needs. Together with this, it is also important to integrate the social and cultural aspects of contraception in a given community. Considering, a patriarchal society like Pakistan, where men are the main decision-makers, it is necessary to encourage males to take more responsibility for improving women's reproductive health and to protect women's rights.

There is little doubt that the changes in population structure and quality have been at the centre of an economic and social surge in the developed countries in the world. The secret may be the control rate of population growth. Pakistan's population during the last five decades had increased by an average of three per cent per annum. The major rise was caused by rapid decline in mortality and a very slow fertility rate decline. International migration is taken as having a zero effect thus the population growth rate has been tremendous. However,

indications are that some breakthrough in fertility decline has been made in the 1990s. Projections have been floating around showing that the current growth rate is around 2.2 to 2.4 per cent. Other indicators, which usually decline with fertility, have not recorded much improvement. The situation as it prevails does not ensure a sustained fast decline in fertility. The population below 15 continues to be 43 per cent of the total; it was almost the same in 1951.

The figure for infant mortality has always been disputed in Pakistan; it was estimated to be 136 in 1962-65. By 1996-97, it had been estimated to be anywhere between 92-100. It is indicative of poor medical facilities, inadequate child health care and ignorance among family members. The maternal mortality rate was 340 per 100,000 live births in 1990. It is still the same, if not higher as reported by some organizations like UNICEF, WHO and UNDP. These very small samples of figures do not bode well for immediate relief from population pressure. Although there has been a decline in fertility in recent years, one main worry continues to be over-population when compared to Pakistan's resources.

What this thesis research confirms is that the strongest correlation between declining population and development comes out to be the improvement in the condition of women; their literacy, education, economic independence (empowerment), provision of equal opportunities, freedom from oppression and the guarantee of their full participation in the process of governance backed by the male population. Also needed is a change in attitudes, which would support

the small family norm and control the fast increase in population growth. People need to be reminded continuously of the dangers lurking behind rapid population growth and the need to conserve resources for use in development effort rather than consumption. They should also be made aware of the principle that the country can not achieve social and economic progress, including a decline in population growth, without improving the life of women.

For a woman it is important to recognize her health problems and assess their severity in order to make a decision to seek health care. However, it is not enough to have the knowledge and health care facility available as there are many other socio-cultural factors influencing the health-seeking behavior. This is the topic of the next chapter.

Chapter Five

FACTORS INFLUENCING THE ACCESSIBILITY OF HEALTH RESOURCES

The Role of Women to maintain Family's Honor

Women have biological advantages that normally make their life span longer than men. This is the fact described by many studies, however the role of other factors like environment and life style is still under research. Women's biological advantage is nevertheless being reduced by the discriminatory behavior towards women and is less apparent in economically developing countries. In a country like Pakistan, according to the World Bank's 1997report, women's life span is only two years longer than men's. Gender relations in Pakistan rest on two basic perceptions: that women are subordinate to men and that a man's honor resides in the actions of the women of his family. Thus, as in other orthodox Muslim societies, women are responsible for maintaining the family honor. To ensure that they do not dishonor their families, society limits women's mobility, places restrictions on their behavior and activities and permits them only limited contact with the opposite sex.

Women are under overbearing pressure to keep a family's honor. Pakistanis assume, often explicitly, that men and women are different kinds of creatures.

Women are thought to be weaker than men in mind, body and spirit, more sensual, less disciplined and in need of protection, both from their own impulses and from the advances of strange men. The honor of the family, which is easily damaged and nearly irreparable, depends on the conduct of its women, particularly of sisters and daughters; consequently, women are expected to be decorous, modest and circumspect. The slightest implication of unavenged impropriety, especially if publicly acknowledged, can irreparably damage the family's honor. Female virginity before marriage and fidelity afterward are essential to its maintenance. If they discover a transgression, men are traditionally bound to punish the offending women (Grover and Arora 1997).

This pressure ultimately, results in restricting the physical mobility and seclusion of women from men, which restricts their access to health care. Until recently women's health problems received inadequate attention by policy makers. The information available on women's health was scarce. Most of women's health problems were not recognized as serious and life threatening. In addition to that, women tend to suffer silently in order not to disrupt household organization. Available data shows that maternal mortality rate is so high because many women do not benefit from the health care system available to them. Particularly, the mobility of women is very closely related to the *izzat* of male members of her family.

> The mobility of women has strong cultural connotations in this patriarchal society. By restricting the mobility of their female family

> member, or more importantly being perceived as restricting their mobility, they are making a statement regarding their *izzat* (honor). The general perception is that if women's mobility is restricted, then their contact with other men is limited and so is the opportunity for sexual misdemeanor. The sex role socialization is such that women have internalized this issue completely and they do not question it." (Mumtaz 1999)

It is thus culturally unacceptable for women to go to the health centers without an escort. Young or middle-aged women have to ask another family member, preferably an elderly woman, man, son or younger brother to accompany them on their trip to a doctor.

In addition to this, the transport facilities available in both rural and urban areas are very poor. Use of this transportation system means a close contact with men outside the family in the form of drivers, or other fellow commuters. The attitude of these men is usually not very respectful and women have to hear many comments, which further demoralizes them stepping outside the house.

Purdah is another important social norm, which helps to restrict the mobility of female members of society. *Purdah* means "a veil"; women should hide themselves behind the veil and should not come out in public barefaced or without proper covering. Different forms of *Purdah* came into existence for example covering the full face with the sari, covering the head, shoulders and bust with a shawl. but this system restricted movements and caused sex segregation (Pandit 1985).

For their protection and respectability, women are traditionally expected to live under the constraints of *purdah* (*purdah* is Persian word for curtain), most obvious in veiling. By separating women from the activities of men, both physically and symbolically, *purdah* creates differentiated male and female spheres. Most women spend the major part of their lives physically within their homes and courtyards and go out seldom only for serious and approved reasons. Outside the home, social life generally revolves around the activities of men. In most parts of the country, except perhaps in Islamabad, Lahore, Karachi and wealthier parts of a few other cities, people consider a woman and her family to be shameless if no restrictions are placed on her mobility.

Purdah is practiced in various ways, depending on family tradition, region, class and rural or urban residence, but nowhere women meet unrelated men and mix freely. The extensive restraints are found in most parts of the North West Frontier Province and Balochistan, where women almost never leave their homes except they are provided an escort or when they marry. They may not be allowed contact with male cousins on their mother's side, for these men are not classed as relatives in a strongly patrilineal society. They have only very formal relations with those men they are allowed to meet, such as the father-in-law, paternal uncles and brothers-in-law. In rural areas, those courses from where women bring water are designated merely for women and called as "women areas". A male should always try to avoid using such areas. This form of restricted mobility and veiling result in the limited contact of women with the

outside world, which not only affects their medical treatment-seeking behavior but also limits their opportunities to know about basic health issues.

Poor rural women, especially in Punjab and Sindh, where gender relations are generally somewhat more relaxed, have greater mobility because they are responsible for both activities, within household and in the fields. However, this relaxation does not affect society's attitudes towards women's health problems. Going to a doctor is still a decision made by males and is only possible in the presence of an escort. When a family becomes more prosperous and begins to aspire to higher status, it commonly requires stricter *purdah* among its women as a first social change.

Among wealthier Pakistanis, urban or rural residence is less important than family tradition in influencing whether women observe strict *purdah* and the type of veil they wear. In some areas, women simply observe "eye *purdah*": they tend not to mix with men, but when they do, they avert their eyes when interacting with them. Bazaars in wealthier areas of Punjabi cities differ from those in poorer areas by having a greater proportion of unveiled women. In cities throughout the North West Frontier Province, Balochistan and the interior of Sindh, bazaars are markedly devoid of women and when a woman does venture forth, she always wears some sort of veil. In this situation mobility and *purdah* are not the main constraints to reach health facility. The permission of male members and affordability are the main concerns. As women's shoulders are burdened with

the concept of honor and mobility is very closely related to it, the decision of going or taking a sick female member of the household to a doctor is a major decision.

In this patriarchal society, the most important factor is that decision-making power remains in the hands of men, as a father, brother, husband or elder son.

> Most care of women and children takes place at home and the most important health care providers are mothers themselves and their relatives. The husband and the family of the husband and the village leaders have a strong say in the health care of village women. There may be delay in her case and referral in general or for special conditions such as pregnancy; for social, financial or other reasons. Women are mostly not prepared to challenge these decisions because of their upbringing and dependent situation. (Asian Development Bank 1999).

Particularly, in the case of a married women's sickness, the problem is first discussed by the elderly women of the family. Then the first intervention is always a household remedy and the second preference is folk sector treatment. If that does not work, only then is the problem brought to the knowledge of male members of the family. Who, by keeping in mind all the factors like mobility, cost and time make a decision to pursue medical treatment or not. However, men are very independent, their role is defined as breadwinners and final authority in a family unit. In the case of their sickness women are the primary care providers, but decision to seek treatment and to spend money remains with men. Although in men's sickness being male their health is very important for the household and

in case of sickness delays are made rarely. But traditionally men are in the masculine protector-provider role and are supposed to be tough, avoiding femininity, concealing emotions, the breadwinners, the respected and violent, and the adventurers. In these roles men are socialized to have self-control and express less emotions and to not ask for social support. They learn to avoid or refuse to admit pain, to not to ask for help and to try to appear strong. This behavior may cause delay in seeking help in case of their illness, however, in any case, the decision is taken by male members of the family.

Awareness and Practice

Women's overall status in society not only influences their physical condition but also curtails other opportunities like getting education, knowing about their rights and understanding their body needs. This reduced access to information results in a failure to accomplish what their body needs. Ultimately, they do not pay attention to the symptoms of sickness until and unless they develop a serious or non-curable disease. For example every year a considerable number of Pakistani women develop 'cervical cancer' (which is the commonest genital tract cancer) and breast cancer. These are the preventable cancers. Early diagnosis and treatment of precancerous lesions can prevent the disease from taking hold.

Particularly for genital tract cancer, women victims are from the villages. Predisposing factors are early marriage, multiparty and poor genital hygiene. The

most tragic aspect is that women come to hospital for treatment with advanced slopes of the disease because they are unaware of its symptoms. The treatment of advanced disease yields poor results. However, good results could be drawn if this cancer is detected early and treated appropriately.

The need for appropriate health education is vital. Recently, the health system of Pakistan is supplemented by several national programs of the Ministry of Health, including the Lady Health Workers program for family planning, primary health care, the expanded program of Immunization and the National Health Education program. These programs are very important for women, as most of their activities are directly targeting women and children's health. These programs are delivered at community level which also helps women to abide by their norm of having limited mobility. However, their coverage is still inadequate and needs to be expanded.

> About 80 per cent of rural people have access to radio and television and pamphlets are eagerly read in the village, reflecting the dearth of information in many rural areas. The public interest in all kinds of information provides good potential for increasing public awareness of self-care and of the health services that can be expected from public and private health facilities. The National Health Education program has been particularly strong in promoting child survival, family planning and HIV / AIDS control. However, more information needs to be provided on women's health-related topics such as nutrition during pregnancy, timely referral for obstetric emergencies, how to recognize quality care, respect for female staff and staff attitudes. Ministry of Health plans to expand the National Health Education Program, strengthen the capacity of provincial health education cells and develop province-specific programs (Asian Development Bank 1999).

Violence

Another cause of health problems is gender-based violence and because of the stigma attached to it medical treatment is not pursued. Limited data are available on this subject but it has started to receive attention as a serious health issue, as well as an issue of women rights. According to Ministry of Women's Development Pakistan, violence against women is rooted in the social relationships of patriarchy, which are based on a system of male domination and female subordination (see Chapter one). The Ministry has noted that wife battering is fairly common and that four rapes are reported in the country each day.

This is believed that these cases of domestic violence are highly under-reported because of the social stigma and the consequences of revealing these conditions. As a result most women suffer at home and never try to ask for medical help for their injuries.

The United Nations Development Fund for Women has defined violence against women as;

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Note: It encompasses, but is not limited to, physical, sexual and psychological violence occurring in the family, including battering,

> sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs. (UNIFEM 1994).

An other common form of violence against women in Pakistan is burning. The victims often died and their deaths are described as accidents or suicides. The president of a local NGO, Progressive Women Association (PWA), Shahnaz Bukhari (2000) said the Association had registered some 28 burn cases in Rawalpindi, Islamabad district in the month of May. She said most of the women who were victims of burns have succumbed to their injuries. She said five women died at Rawalpindi General Hospital of burn injuries. The president said, PWA has launched a campaign for burn victims since 1994 and so far data on 36,550 burn victims have been collected. Of which only 0.1 per cent had survived.

Honor killing is another severe violence against women. Dishonor of the family includes alleged or real sexual relations outside of marriage, seeking a divorce or simply choosing a marriage partner against parental wishes can lead to an "honor" killing. According to the Human Rights Commission of Pakistan Report (2000), over 1000 honor killings take place every year in Pakistan and in the Punjab province alone, at least 700 women are raped every year. The report of

the Human Rights Commission of Pakistan pointed out that women are killed solely because they use their right to marry the persons of their own choice.

Undoubtedly, this violence and harshness against women is becoming increasingly brutal, exploitative and harsh. The victims are threatened against reporting the crime, or face dire consequences. This is in spite of the fact that they have equal rights under the constitution of Pakistan. It says the criminal act of abusing and brutalizing women must be severely punished (Shikoh 1984).

Karo Kari, which translates as "blackened man, blackened woman", is a tribal tradition which decrees death for women suspected of adultery and is still practiced in Balochistan and Sindh. Men often make women their victims to resolve other disputes, often over land or family feuds, disguising the deaths as *Karo Kari*. Young girls who have not yet reached puberty, married women with children, even grandmothers are killed on charges of having sexual relationships with men they have often never seen. And those who survive the attacks live their lives as social outcasts.

The killers take pride in what they have done, the tribal elders condone the act and protect the killers and the police connive in the cover-up. Usually such cases are settled outside court by the *jirga* (a tribal council), which announces a verdict. Often the girl's family is compensated and pressurized not to make an official complaint. If tried in court the men often escape with lesser punishments

pleading the murders were committed in "sudden and grave provocation" rather than as planned murders.

The government has prepared a plan to strengthen institutions, provide a humane judicial-redress system and carry out legal reforms in vital areas to combat violence against women. However, the most important factor is to raise awareness among women to have substantial knowledge about their rights. They are not motivated to seek medical help in case of violence instead they insist to hide the incident and increase the chances of it happening again. They are not well informed about the physical, mental and emotional hazards of going through this violence repeatedly. Particularly in remote areas of Pakistan, where revealing these incidents means to face more violence. Both male and female awareness about these issues is important.

The Girl Child

A woman only begins to gain status, security and satisfaction in her husband's home when she produces sons. Therefore, mothers love and favor their boys and often nurse them longer then girls. In later life the relationship between mother and son remains very warm and intimate and the father is a more distant figure. Observers suggest that women compensate for the emotional lack in their often rather impersonal marriages and submerged adult lives through their relationships with their sons, who often remain in or near the parents' household.

The wife who enters such a home finds herself in a distinctly secondary position. Furthermore, parents are eager to marry girls off as soon as they reach puberty to forestall any mishap to their virginity (Grover and Arora 1997).

When a baby is born, it is the occasion for either congratulation or condolences- the former if the child is boy, the latter if a girl. Sons rather than daughters are desired since the family land passes down through the male line only and the political strength of the family depends on its men; a family with many sons will be more powerful than one with few. Although rivals individually for their father's land, the sons will unite against others whenever necessary. This property of a segmentary lineage system is nicely described in the famous Middle Eastern saying: "I against my brothers; my brothers and I against our cousins; my brothers, cousins and I against the world".

This son preference also reflects in discrimination against female children in households and it is very obvious in all spheres of life for girls such as inadequate food, limited access to formal education, lack of proper clothing, the burden of domestic chores, gender-biased health seeking patterns, as well as in other social, economic and political activities. Mothers always try to maintain their son's good health by providing them with good nutritious food. The mild ailment of a son secures a lot of attention from the whole family, while daughters are supposed to be more patient with their problems. This results in malnutrition in girl child, consequently in higher rates of female child mortality.

Girls who survive this situation can remain very weak and suffer from chronic anemia. When these girls become mothers they repeat the same behavior and nurture this vicious circle.

Poverty

> Pakistan is a low income country with a per capita gross domestic product (GDP) 458 American dollars in financial year 1997 / 98. However, the country ranks very low based on the United Nations Development Index: 138th out of 174 countries, which is well below what would be expected from its GDP if compared with other countries at similar income levels. About half of the population lives without safe drinking water, half the adult population is illiterate and half of all children under the age five are underweight. Its poor human development status reflects many years of serious neglect of the social sector and is increasingly impeding Pakistan's economic development in addition to causing largely avoidable human misery. The country's poor human development status is marked by inequity between rural and urban populations, income groups and women and men. (Asian Development Bank 1999: 1)

The inequity between men and women facilitates male control over all aspects of women's lives. Most importantly, in a nation of 45 per cent poor people, women become the poorest as they have no control over the economy of the household. In households where women work and earn cash income the hand over their salaries to the male members of the family, who decide where, when and how to spend this money. On a monthly or daily basis, women are given a limited amount of money to meet the kitchen or basic household expenses. Women have little access to money to meet costs for transportation and for going to a

health care center, or to pay for the medication. Ultimately they lack independent decision-making power and can not decide on their own to seek health care.

Gender biases are deeply rooted in Pakistan's social and cultural norms and are often not recognized by the women themselves. Even with some amount of money in hands women would always think about the necessities of male members of the household, or about the children, particularly sons. Their themselves or daughters are the last to get attention for their needs. "Women learn to internalize the male favoring perceptions and will likely pass them on to their own daughters" (Asian Development Bank 1999).

Keeping this situation in view, the government is paying a lot of attention to social services in the country. In the health sector the government's main focus is on primary health care with particular emphasis on women and children. Especially, to make women more independent, government has started micro credit schemes for women through it Social Action Program (SAP)[9]. This program provides small loans to women to start their own business at the household level to help them earn some money. Poverty, of course, affects the health of everyone, not just women.

> It would be hard to exaggerate the influence that poverty has on people's health, because poverty restricts choice in so many areas

[9] Social Action Program (SAP) started in 1993, is a social sector reform program in Pakistan. It aims to improve the performance of the social sector as the core strategy to advance human development. The SAP strategy gives to women and the rural poor in general. SAP is in its second phase (1997/98 – 2002/3) and its total cost is $ 7 billion.

> that are basic to good health. Being very poor usually means; not having enough food or the right kind of food; not having decent housing, sanitation and water supply; not being able to get health care when needed (even if the care is free, the cost of transport or medicine can put it out of reach); not being able to send children to school or take advantage of adult education opportunities; not being able to think or plan beyond today's crises; not being accorded your dignity as a human being. These are the consequences of poverty at individual or family level. (Smyke 1991: 26)

Patient-Healer Relationship

Several studies have been conducted to find the reasons why some people go to a doctor in case of illness and others do not. In some cases, the delay has serious consequences. There are several socio-cultural factors influencing the decision and one of them is the "provider". It is very important for the patient to know how a practitioner is going to react to his or her explanation of the illness. According to Klienman (1980) every patient and provider has his or her own explanatory model of the particular illness episode. These models provide explanation for five aspects of illness. 1) The aetiology or cause of the problem. 2) The timing and mode of onset of symptoms. 3) The pathophysiological process involved. 4) The natural history and severity of illness. 5) The appropriate treatment for the illness. For a successful consultation there must be a consensus between the two parties. Medical and lay models may differ greatly in how they interpret a particular episode, especially in cause, diagnosis and treatment. For example the medical doctor belonged to a different region and have difficulty understanding why women do not take bath or drink cold water

during the menstruation cycle, or why they insist on having some "warm medication" for their pains in that period.

There can also be problems of terminology. This problem can be seen on two levels; first is a lay man's everyday language and medical jargons; secondly patient and provider may belong to different language groups. Patients, particularly women because of their limited understanding of modern medicine, explain their problem by using the specialized folk terminology. For example, in different regions menstruation is explained in different terms such as "*kapray aana*", "*napaki kay din*", "*khas din*", "*kapray ganday hona*". Particularly in a country such as Pakistan where more than a dozen languages are spoken (see chapter 2), a health practitioner from one region can be complete alien for another. Whereas in the government health system, geographical transfers from one area to another takes place very frequently and practitioners and patients both face this problem to have understanding of each other's explanatory models.

Another very important problem area in the doctor-patient relation is played by the context. Helman (1996) explained two aspects of the context. First is the internal context of prior experience, expectation, explanatory models and assumptions that each party brings during the clinical the encounters. If a patient is not satisfied from his / her previous experience with a practitioner due to unmet expectations or difficult communication, that will create a barrier for the next trip.

Second is the external, context which includes the actual setting in which encounter takes place and the wider social influences acting upon the two parties. This includes socio-economic factors like poverty, class and gender, religious or ethnic division. For example, in a big hospital every patient wants to have the attention of a specialized doctor and on the other hand doctor's also determine the economic condition of the patient by his / her appearance and try to communicate and prescribe treatment accordingly.

By assessing the internal and external context the relationship and communication between patient and doctor can be understood in a better way. It also helps the clinicians to decide that who is in need of help the doctor may need to involve the whole family in order to improve the patient's condition. Positive interaction between patient and health provider lead to a patient's confidence and compliance with the prescribed treatment.

In conclusion, the presence of a health facility is not the only factor that can contribute to improve the health condition of people. There are various other socio-economic factors influencing the situation. In the context of Pakistan's diversified society, unless attention is paid to these factors it will be difficult to achieve gender-based health development. International health initiatives ignore the particularly socio economic conditions because of their financial constraints and time pressure. Yet, the cost-effective approach to health promotion must include attention to culturally meaningful interventions.

Suggestions

The most important of all development programs, education for girls and adult female literacy should be kept in the foreground for every component of the national development plan. Although, separate women dispensaries could not become in vogue, the health and reproductive health initiatives have helped generate almost a separate stream of health services catering exclusively to women. There is no doubt that improvement in women's health affects the entire society, the health of children, that of other members of the family and most of all, the inter-spousal relationship which can make or mar a family. But there are still considerable gaps in services common to both men and women.

Women's development goals are difficult to achieve in an orthodox society where well over half the population lives in the rural areas with strong tribal and clannish traditions. Female health workers should be appointed, particularly for those areas where *purdah* is strictly observed for example in NWFP, Balochistan and rural Sindh. Introducing a family planning component in rural health centers with a woman doctor or female paramedic whose duties include family planning, counseling and the provision of supplies to the rural areas to increase outreach and accessibility, will overcome cultural problem caused by male contacts for health care.

Sustainable development is only possible if it is broadly based, emphasizes labor-intensive growth and raises the status of women by developing strategies to allow more equal participation to contribute fully to socio-economic development. The objective of government's poverty-reduction strategy should be to bring the poorest sections of society into mainstream economic activities by creating employment opportunities, through the provision of small loans, particularly to women. Together with this, facilities like hostels for working women, daycare centers for children of working women and good transportation systems should be introduced to facilitate women's mobility, access to facilities and resources.

Gender awareness raising programs should be imparted to women so that they become conscious of their rights. Due to the lack of awareness, women have become victims of the atrocities of exploitative forces. A wide range of public awareness programs through the media, education system and public announcements should be planned to inform both men and women of women's equal rights. Together with other issues, special emphasis should be on social norms like the concept of *purdah*, *izzat* and decision-making power. *Ulema* (clergy) can play an important role to eliminate or reduce the severity of violence by publicly condemning violent incidents against women through the mosque to create awareness among the masses. Such inhuman behavior should be discouraged.

An awareness campaign should be launched for men so that they also became sensitized towards women's issues. Women in the urban areas are comparatively better informed than their rural counterparts regarding their rights, so more stress is needed for creating awareness among the rural womenfolk, who comprised the majority of the women in the country.

Although the religion and the constitution had guaranteed various rights for women, these have not been given to them due to the socio-cultural traditions prevailing in society. Power devaluation is necessary. The monopoly of political stalwarts should be ended in the local council elections and due representation should be given to women in local councils after the devolution of power.

In a majority of instances police do not register complaints regarding domestic violence and the women victims are asked to go back home. Criminal laws should be reviewed and revised to ensure equality before the law and the equal protection under law to women and girls. Police should promptly and without bias register and investigate all complaints.

Philanthropists and NGOs should come forward to help the government in the health sector. The government alone can not run all hospitals and health centres for providing better health facilities to people.

The authorities should be urged to implement the recommendations given by various commissions formed by the government to look into the issues faced by women. They should also observe the conditions and make local laws in conformity with the requirements of various international conventions regarding women's rights.

Chapter Five

CONCLUSION

Pakistan lags far behind most developing countries in women's health and gender equality. Women are found disproportionately among the most vulnerable population groups. Access to and utilization of health services are influenced by cultural and ideological factors such as low valuation of the health of girls and women as compared to that of boys and men. By highlighting some of the gender issues in health sector reform this thesis exposes, the implications for vulnerable groups and the severe lack of information and understanding about how their condition needs further reform.

Several primary forces contribute to the overall environment for women; age, culture-based gender biases, lack of awareness, lack of access to health facilities, socio-economic status class and the pressures of poverty. Each, in itself, is oppressive to woman. But their combination generates contradictions in women's lives. To these earlier problems are now added a new dimension: the further widening of the gap between the rich and the poor. According to the economic survey of Pakistan 1999-2000, the number of people below the poverty line has increased from 17.8 million to 43.9 million, in the last eleven years. It threatens to further intensify and make more intractable the existing inequalities.

Under these circumstances, further progress for the majority of women in Pakistan could be jeopardized.

Developments in the health sector that have taken place and the trends established so far, both at the provincial and national level and the rural and urban levels, help identify general areas of priority for intensification and concentration of efforts for women health and development in Pakistan. Among these are areas of critical importance to women where progress achieved so far still falls short of a minimally desirable standards, such as primary health care, availability and accessibility of health resources particularly in rural areas where majority of the population live, safe motherhood, nutrition and family planning and most importantly cultural attitudes that reinforce women's low social status.

Some health indicators, such as immunization rates and knowledge of family planning have increased in the last decade and are very positive developments. But even sol the main health indicators show a negative graph as compared to other developing countries. Use of contraceptives has increased but the fertility rate is high at 5. 3 continuous births per woman. Of every 38 women who give birth one dies. The mortality rate for children under age five is 136 per 1000 births and infant mortality rate is 90 per 1000. The population growth rate is 2.8 per cent, which is much higher than elsewhere in South Asia.

The key issues for women health and development in Pakistan are increased participation of women in decision-making in health system; involvement of NGOs, private sector and government in the implementation of activities for the improvement of women's socio-economic and health statuses; safe motherhood initiatives; self-care; adolescent reproductive health; health information and education; and development of women's leadership in the context of primary health care. Narrowing the gaps between enacted legislation and policies to assure women's basic rights and their implementation; gaps between acknowledgement of the critical importance of women's contribution to development and provision of support for the same; and, most glaringly, gaps between the scale of needs and allocation of resources are crucial for women's health and development.

There is also an urgent need to obtain essential, sensitive and region specific information, especially gender specific, desegregated information. Documentation of such information for sub-groups, particularly identified disadvantaged and vulnerable groups, is a prerequisite for the formulation of realistic plans of action for country level activities. It is impossible to offer solutions to problems. There is a need tc identify and understand regional problems in a local cultural context. A shift of action to the local levels, preferably the grassroots level is essential. This variation has critical implications for gender relations and women's location in different parts of the country.

Practical and sustained actions at policy and program levels covering social, economic and political dimensions is essential. Giving more attention to maternal health problems, the combat of preventable communicable diseases and the encouragement of efforts to lower birth rates is called for. Proportionate emphasis is also required to those issues which have received comparatively meager attention, such as AIDS, smoking and drugs.

Identification and provision of adequate solutions to the present challenges are vital for women health and development such as: How can sustainable development be achieved for all? How can everyone have sufficient clean water? How can population growth and resources be brought into balance? How can economics help reduce the gap between the rich and the poor? How can the empowerment of women be carried out to improve the human condition? How can women share the same political, economic and social rights as men do? How can cultural gender based biases be terminated. How can women's accessibility to health care be attained? How can Pakistan achieve its goal of making its population healthier?

All these challenges have special significance for women. Sustainable development is important as it includes environmental, economic and social sustainability. Literacy, awareness and poverty eradication are linked to health, population and democratic ideals. Improved literacy, reduced infant mortality and

effective family planning would help women to become builders of alternative societies.

Recent findings of government, international agencies and United Nation's Human Development report indicates that there is a rise of awareness at both the policy and public levels in Pakistan. Substantial numbers of women in urban areas have begun to participate in the improvement of their own condition in response to the stimuli for change brought into their lives. The empowerment of women offers tremendous hope for positive changes to be accomplished within reasonable time frames. Empowerment for women refers to the enhanced activity of women whose consciousness of social justice has been raised, to think and act together to come up with enabling solutions, to become equal partners in society. Women's empowerment cannot be achieved unless gender concerns are incorporated into national policies to promote the status and well-being of poor women. Women should be able to effectively gain access to and share in economic resources, services and opportunities. Although the religion and the constitution had guaranteed various rights for women, these are not given to them due to the socio-cultural traditions prevailing in society.

Pakistani women live within a patriarchal framework. Male domination, authority, powers and strength is visible in all classes and ethnic groups. In day to day life, women face these values in all areas of their life. It is fundamental to review patriarchy to analyze the health status of women and their socio – economic

factors, which account for the pitfall condition of overall health. Social indicators like infant mortality, maternal mortality and life expectancy reflect the double burden of oppression women face in Pakistan. The health of the vast majority of women particularly those residing in rural areas is adversely affected by this lack of decision making power, access to resources, mobility and socially required escort for mobility and their inherited discrimination due to the bias against them in differential feeding, education, work load, health care and the most obvious son preference / daughter negligence syndrome.

In Pakistan, rural women spend half their lifetime hauling water. Among people living below the poverty line, it is women who live in extreme poverty. Improving the status of women can have a positive effect in all areas of life. The thought that men are superior to women is a problem throughout the world. The key to the social liberation of women lies in universal literacy and education to help change the traditional value systems. The new millennium would come to full glory only if half of dormant humanity begins to play ifs rightful role.

Limits of Gender and Development (GAD) Approach

The Gender and Development (GAD) approach evolved from the Women in Development (WID) in the late 1980s using a holistic perspective and recognizing the importance of social, economic, and political factors in women's lives. It aims for full equality of women within the framework of economic development and

focuses on strengthen women's legal rights. GAD is concerned with the socially fabricated roles of gender, and welcomes the potential contributions of men, particularly who share their concern with gender equity and social justice. GAD affirms women as agents of change rather than as passive recipients of development services.

However, the GAD approach seems more applicable in the realm of research rather than in the everyday world because it proposes a re-examination of the way in which social structures and institutions effect women's oppression. GAD also ignores the approach that under global capitalism, women's oppression can not end. GAD also skips the fact that both the paid and unpaid labor of women, inside and outside homes is essential to development. In addition, GAD's effectiveness depends largely on the goodwill of men.

Women have had a long history of marginalization in all aspects of socio-economic life and exclusion from the process and benefits of development. Their access to political and economic power lags behind men at all levels including areas where they are the majority. Empowerment of women and gender equality is the key to women's liberation but it can not be achieved without sensitizing males in the society. In case of Pakistan it is extremely difficult if not impossible to bring radical change in basic social institutions including patriarchy. A slow process of change through women centered and men sensitized gender projects and policies can proceed. Empowerment and gender equality will enable women

to take an equal place with men and to participate equally in the development process in order to achieve control over the factors of production (The women's role as income earners, often in agriculture or the informal sector. In Pakistan productive role is often underestimated or ignored. The lowest indicator is that of labor force participation, the rate for female participation in 1998-99 was only 13.6 per cent as compared to 70.0 per cent for males), re-production (women's childbearing and child rearing role), and community roles (women's collective work at the community level) on an equal basis with men. Women have a constitutional right to lead and participate in development. If women play an active role at all levels of decision-making, different, alternative ideas and views can enrich the development process. The fact that women can make an equal and important contribution to the development process must be recognized.

Gender is defined by societal norms and practices, and supported by societal attitudes. This relationship is usually in favor of men. However, it does not negate the fact that men can also find themselves in a position of subordination, it recognizes that women are more often subordinated. It is important to note that this relationship as well as the roles men and women are expected to fulfill is defined by culture, religion, the balance of power within society, and other factors. This relationship is a difficult to change through policy, particularly if the policy environment is one that favors either or. Subordination and marginalisation can lead to a planning process, which does not consider the needs of men and women, nor their contribution made through the various roles they play. It is

premised on the assumption that changes made will have universal benefits, and it can occur in the household, in the community or in institutions. Men and women have different roles and responsibilities, they also have different gender needs in the society. If gender roles and gender needs are understood, planning is more effective. Policies are more clearly defined and programs and projects are designed with the different needs of the people who are supposed to benefit.

Gender roles determines people's gender needs. Such needs can be further broken down into "practical gender needs" and "strategic gender needs" (Moser, 1989). Practical gender needs refer those needs of men and women as defined by their existing engendered roles within society, in which, women must fulfill three roles while men usually fulfill one that is productive. Practical needs and practical policies are concerned with the effective fulfillment of these socially defined roles, that is, they do not seek to change the status quo. Practical gender needs are to do with what people need to perform their current roles more easily, effectively and efficiently. For example hiring and training female staff particularly for rural areas and provisions of health centres including facilities such as family planning services, child-mother health care and vaccination, child health education for women as a support to their child rearing role.

In contrast, strategic needs and strategic policies are directly concerned with changing the status quo: challenging socially defined roles and tackling gender subordination in society. For example, implementation of religious and

constitutional rights, and recommendations produced by National Plan of Action for Women. Change in legislation to deal with imbalances of power in the family such as domestic violence and unequal divorce settlements; and the encouragement of female membership of political bodies so as to enhance women's participation in decision-making. However, it is important not to treat women as a homogenous group, the experience of an individual woman will vary with respect to her class, race, ethnicity and geographic area, among other factors. As a result different men and women will express different needs; some may only express practical needs, while others may be more concerned with strategic issues.

Economic problems have led to the deterioration of the health care system in Pakistan, a system in which access is already limited and hinder women's accessibility to available resources. There are several important factors related to it. Women's capacity to access and use health information is limited by their gender roles and the circumstances, in which they live and work. Women face severe health problems, particularly in the areas of nutrition and maternal mortality. Women's health is determined to a large extent by their access to, as well as the quality of services, both of which have deteriorated substantially. There have been severe impacts on maternal and child health care (MCH), which should form one of the major focuses of national health policy.

In short, policy must recognize the fact that women have different needs in different regions of culturally diverse Pakistan. Policies should be designed to meet strategic needs and practical needs. To improve understanding and increase awareness of the situation of men and women, and develop sensitivity towards gender issues, not only within government but also within society as a whole is vital. There is a need to take initiatives not only from the State, but also from the private sector and civil society as a whole to accelerate the pace of change towards gender equality by improving the situation of women by keeping in view the essential role of men in Pakistan. The ultimate aim is to eliminate economic, political and social inequality between the sexes in both the public and domestic spheres.

Works Cited

Asian Development Bank (1999). Report and Recommendations of the President to the Board of Directors and a proposed Loan to the Islamic Republic of Pakistan for Women's Health Project 1999-2004. Manila: Asian Development Bank.

Anandan, Sujata (1982). "Marriage or Murder" Illustrated Weekly of India, 15-21 August. 1982, pp. 16-19.

Ahmed, Feroz (1998). Ethnicity and Politics in Pakistan. Karachi; New York: Oxford University Press.

Asian Development Bank (1997). Social Sector Issues in Pakistan: An Overview, Social Sector Profile, Manila: Asian Development Bank.

Ashraf, Javed and Birjees Ashraf (1993). Estimating the Gender Wage Gap in Rawalpindi City. The Journal of Development Studies. Vol. 29, pp. 365.

Bhassorn, Limanonda (1991). "Women's perspective in family planning and community participation, In NGO management and family planning from women's perspective", Proceedings of an international seminar, 10-18 Nov, 1991. Population No 12, Denish Planning Association.

Boerma, J. T. (1987). Levels of maternal Mortality in developing countries. Stududies in Family planning. Vol.18, pp. 213.

Boserup, Ester (1990). "Economic Change and the Roles of Women" in Irene Tinker (ed.) Persistent Inequalities: Women and World Development. Oxford University Press: Toronto.

Boserup, Ester (1970). Women's Role in Economic Development. London: George Allen and Unwin.

Bang, R. and Bang, A (1992). "Why Women Hide Them: Rural Women's Viewpoints on Reproductive Tract Infections", Manushi, A Journal About Women and Society, Vol. 69, pp. 27-30.

Beteille, Andre (ed). (1983). Equality and Inequality, Theory and Practice. Bombay / Calcutta / Madras, Delhi Oxford University Press.

Bhasin, Kamla (1993). What is Patriarchy? New Delhi: Kali for Women Raj Press.

Bhopal, Kalwant (1999). Gender, 'Race' and Patriarchy: A study of South Asia Women. Aldershot, Hants, England, Brookfield, Ashgate Press.

Chipp, Sylivia A. and Green, Justin J. (eds.) (1980). Asian Women in Transition. London. The Pennsylvania State University Press.

Coward, Rosalind (1983). Patriarchal Precedents: Sexuality and Social Relations, Padstrow / Cornwall: T. J. Press.

Currer, Caroline and Stacy, Margaret (eds.) (1986). Concepts of health, Illness and Disease, A comparative perspective. Berg / Hamburg / New York: Leamington Spa.

Clarck, Alice W. (ed) (1994). Gender and Political Economy: Explorations of South Asian Systems. Oxford / New York: Oxford University Press.

Coward, Rosalind (1983). Patriarchal Precedents: Sexuality and Social Relation. London, Boston: Routledge and Kegan Paul.

Chipp, Sylvia A. and Green, Justin J. (1980). Asian Women in Transition. University Park: The Pennsylvania State University Press.

Choudhury, Golam W. (1988). Pakistan: Transition from Military to Civilian Rule. Essax / England: Scorpion Publishing Ltd.

DAWN Lahore (2000). "28,000 women die during pregnancy every year", January 27, 2000.

DAWN Karachi (2000). "400 children die of vitamin deficiency", January 27, 2000.

Evans, Alison. (199-?). Gender and Third World Development. Module 1: Socio-Economic Statistics. University of Sussex, Brighton: Institute of Development Studies.

Gardezi, Fauzia (1994). Islam, Feminism, and the Women's movement in Pakistan: 1981-1991, in Kamla Bhasin and Ritu Menon (for India). Nighat Said Khan (for Pakistan) (eds.) Against All Odds: Essays on Women, Religion and Development from India and Pakistan New Delhi: Published by Kali for Women, in collaboration with Isis International and the South Asian Women's Forum.

Grover, Verinder and Ranjana Arora (1997). Pakistan: Fifty Years of Independence: A Chronology of Events-1947-97. New Delhi: Deep and Deep.

Green, Andrew and Ann Matthias (1997). Non-Government organizations and Health in Developing Countries. Houndmills / Basingstoke / Hampshire / London: Macmillan Press Limited.

Government of Pakistan. (2000). Economic Survey (1999/2000). Government of Pakistan Finance Division. Islamabad, Pakistan.

Gesler, Wilbert M. (1991). The Cultural Geography of Health Care. Pittsburgh, Pa.: University of Pittsburgh Press.

Government of Pakistan (1960). The Second Five-Year Plan, 1960-1965, Planning Commission, Karachi, Pakistan.

Government of Pakistan (1965). The Third Five-Year Plan, 1965-1970, Planning Commission, Islamabad, Pakistan.

Government of Pakistan (1998). Planning Commission of Pakistan, Islamabad, Pakistan.

Hunte, Pamela A. and Farhat Sultana (1992). "Health Seeking Behavior and the Meaning of Medications in Balochistan", Pakistan. Social Science and Medicine Vol. 34, pp. 1385.

Hardee, J. G. and Satterthwaite, A. P. (1970). "Pakistan", Country Profiles, The Population Council, New York.

Helman, Cecil G. (1994). Culture, Health and Illness: an introduction for health professionals, London: Butterworth- Heinemann.

Hart, N. (1988). Sex, gender and survival: inequalities of life chances between European men and women in A. J. Fox (ed.). Inequality in Health within Europe, Aldershot: Gower.

Inhorn, Marcia C. and Peter J. Brown (1997). The Anthropology of Infectious Disease, International Health Perspectives, Theory and Practice in medical anthropology and International health, Australia: Amsterdam, Netherlands: Gordon and Breach Publishers.

Jeffery, Patricia (1998). "Approaching Gender: Women's Activism and Political Religion in South Asia". Social Sciences Research Council. New York: Vol. 52, No.1.

Janovsky, Katja (1995). Health policy and Systems development: An agenda for Research. World Health organization, Geneva.

Justice, Judith (1986). Policies, Plans, and People: Foreign Aid and Health Development. Los Angeles: University of California Press.

Luitel, Samira (1992). Women in Development. Nayabazar: B P Luitel.

Kaufman, Michael (ed.) (1987). Beyond Patriarchy: essays by men on pleasure, power and changes, Toronto / New York / Oxford University Press.

Kabeer, Naila (1996). Reserved Realities: Gender Hierarchies in Development Thought, New Delhi: Pauls Press.

Kabeer, Naila (1991). Gender, Production and Wellbeing: Rethinking the Household Economy, Discussion Paper 288, Brighton: Institute of Development Studies, University of Sussex.

Kabeer, Naila (1994). Reversed realities: Gender Hierarchies in Development Thought, London: Verso.

Kleinman, A. (1980). Patient and Healers in the Context of Culture. Berkeley: University of California Press.

Lerner, G. (1986). The Creation of Patriarchy. Oxford: Oxford University Press.

Leslie, Charles (ed.) (1976). Asian Medical Systems: Comparative Study. Berkeley / Los Angeles / London, University of California Press.

Leonardo, di Micaela (ed.) (1991). Gender at the Crossroads of Knowledge: Feminist Anthropology in the Postmodern Era. Berkeley: University of California Press.

Midhet, Farid; Becker, Stan and Berendes, Heinz W. (1998). "Contextual Determinations of Maternal Mortality in Rural Pakistan". Social Science and Medicine Vol. 46, pp. 1587.

Mubarak, K., Shafqat, S., Malik, U., Pirzada, R. and Qureshi, A. F. (1990). 'Health, Attitudes and Beliefs of Working Women". Social Science and Medicine Vol. 31, pp. 1029.

Maguire, Patricia (1987). Doing Participatory Research: A Feminist Approach. The Center for International Education, Amherst, Massachusetts: University of Massachusetts.

Moore, Henrietta L. (1988). Feminism and Anthropology, Oxford: University of Minnesota Press.

Mathur, Indu and Sanjay Sharma (eds.) (1995). Health Hazards, Gender and Society. Jaipur and New Delhi: Rawat Publications.

Mettal, Mukta (ed). (1995). Women Power in India. New Dehli: Annul Publications Pvt. Ltd.

Moffat, Linda (1988). The Gender and Development Approach as an alternative to Women in Development Approaches. CCIS: Ottawa.

Moser, Caroline (1993). Gender Planning and Development: Theory, Practice and Training. New York: Routledge.

Mosse, Julia Cleves, (1993) Half the World, Half a Chance: An Introduction to Gender and Development, Oxford: Oxfam.

Ministry of Women Development (1997). Report of the Commission of Inquiry for Women Pakistan, Government of Pakistan, Islamabad, August 1997.

Mumtaz, Khawar and, Farida Shaheed (1987). Women of Pakistan: Two Steps Forward, One Step Back? London: Zed Books.

Ministry of Women Development (1997). Report of the Commission of Inquiry for Women: Pakistan, Government of Pakistan, Islamabad, August 1997.

Marble, Michelle and Conly, Shanti R (1996). "Pakistan's Population Program faces daunting challenges. Report on the result of a study conducted by Population Action International" Women's Health Weekly Vol. 11, pp.3.

Mumtaz, Zubia., Waseem, Muneeba., Usman, Nighat (1999). Women Working in Rural Areas of Pakistan: Constraints and Issues. Health Services Academy, Ministry of Health, Pakistan.

Nyrop, Richard F., Benderly, Beryl Lieff., Conn,Carry Corwin., Cover,William W., Cutter, Mellissa J., Parker, Newton B. (1975). Area Handbook for Pakistan. Washington, D.C.: American University.

Nichter, Mark and Mimi Nichter (1996). Anthropology and International Health. Asian Case studies. Theory and practice in Medical Anthropology and International Health. Amsterdam: Gordon and Breach Publishers.

Nichter, Mark (1989). Anthropology and international health. South Asian Case studies, Dordrecht / Bostob / London: Kluwer Academic Publishers.

National Institute of Population Studies (1992). Pakistan Demographic and Health Survey, 1990/1991, Islamabad, Pakistan.

Nichter, Mark (1991) "Recent Trends in Ethnomedicine, Medical Anthropology: cross-cultural studies in health and illness" Social Science and Medicine Vol. 13, No. 1-2

Nasim, C. M (ed.) (1979). Iqbal, Jinnah and Pakistan: The Vision and the Reality. Syracuse / New York: Maxwell School at Syracuse University.

National Census (1998). Population Census Bureau of Pakistan. Census Report of Pakistan, Islamabad, Pakistan 1999.

National Institute of Population studies (1992). Pakistan Demographic and Health Survey, 1990/1991, Islamabad, Pakistan.

Noman, Omar (1997). Economic and Social Progress in Asia: Why Pakistan did not become a Tiger. Karachi : Oxford University Press.
Noman, Omar (1992). Pakistan Political and Economic History since 1947. London / New York: Kegan Paul International.

Okojie, Christiana E. E. (1994). Gender Inequalities of Health in the Third World. Social Science and Medicine Vol. 39, pp. 1237.

Ostergaard, Lisa (199-?). Gender and Third World Development. "Module 3: Gender and Health". Institute of Development Studies. University of Sussex, Brighten.

Ostergaard, Lise (ed.) (1992). Gender and Development: A Practical Guide. London / New York: Routledge.

Penny and Esttenk, John Van (eds). (1982). Gender and Development in Southeast Asia. Proceedings of the twentieth meetings of the Canadian Council CCSEAS XX Vol. I for South East Asian Studies. York University, October 18-20, 1991. Ottawa / Montreal: McGill University.

Parpart, Jane L and Maranne H Marchand (1995). "Exploding the Canon: An Introduction/Conclusion" in Feminism Postmodernism Development. New York: Routledge.

Pakistan Institute of Medical Sciences (2000). A Seminar on Women and Mental Health at the Psychiatry Department, Islamabad, Pakistan, May 6, 2000.

Population Reference Bureau (1992) World Population Data Sheet, Washington D. C.: US Department of Health and Human Services.

Pandit, Harshida (1985). Women of India: An Annotated Bibliography. New York; Garland Publishers.

Progressive Women Association (PWA). (2000), Islamabad, Pakistan.

Pakistan Commission on the Status of Women (1986). Report of the Commission on the Status of Women, Islamabad, Pakistan.

Rouse, Shahnaz J. (1988). "Women's Movement in Contemporary Pakistan: Results and Prospects: in M. Francis Abraham and P. Subhadhra Abraham (ed.) Women, Development and Change: The Third World Experience. Bristol, U.S.A.: Wyndham Hall Press.

Ramanathan, Usha (1997). "Women and Law", Economic and Political Weekly, December 6, 1997, pp. 3117-3118.

Rathgeber, Eva (1989). WID/WAD, GAD: Trends in Research and Practice. International Development Research Centre: Ottawa.

Read, Margaret (1996). Culture, health and disease, Social and Cultural Influences on Health programs in developing Countries. London: Tavistock Publishers.

Shah, Nasra M. (1986). Pakistani Women: A Socioeconomic and Demographic Profile. Islamabad: Honolulu, Hawaii: Pakistan Institute of Development Economics; East-West Population Institute, East West Center.

Sabo, Donald and Gordon, David Frederick (eds.) (1995) Men's Health and Illness, Gender, Power and Body: Research on Men and Masculinities. Thousand Oaks / London / New Delhi: Sage Publications.

Seymour, Susan C., (1999). Women, Family and child care in India, A World in Transition. Cambridge / New York: Cambridge University Press.

Sen, Amartya (1988). "Family and food: sex bias in poverty", in T. Srinivasan and P. Bardham (eds). Rural Poverty in South Asia, New York: Columbia University Press.

Sen, Amartya (1990). "Gender and Co-operative Conflicts, in I. Tinker (ed). Persistent Inequalities: Women and World Development, Oxford: Oxford University Press.

Sabo, D. and Gordon, G. (1993). Men's Health and Illness: Gender, Power and the Body, London: Sage Publications.

Siddiqi, Bilqis (1990). "Socio – Economic Status of Woman in Pakistan" in Zaidi, A.M. The World of Islam Today (ed.) Islamabad, Pakistan: National Institute of Historical and Cultural Research.

Siddiqui, Rehana and Mir Annice Mahmood (1994). "The Determinants of Health Status: A Cross-Country Analysis", The Pakistan Development Review, 33: 4 Part 2, (1994). pp. 745-758.

Shikoh, Mirza Muzaffar (1984). The Constitution Of The Islamic Republic Of Pakistan: Its Historical Determinants, Constitutional Antecedent, Evolution And Major Problems. Ann Arbor, Mich.: University Microfilms.

Smyke, Patricia (1991). Women and Health, London / New Jersey, Zed Books Ltd.

Tinker, Ann, Daly, P., Green, C. Saxeman, H., Lakshminarayanan, R. and Gill, K. (1994). Women's Health and Nutrition: Making a Difference, Washington: World Bank.

Tinker, Ann G. (1998). Improving Women's Health in Pakistan. Human Development Network. Health, Nutrition and Population. The World Bank.

UNICEF (1990). The State of the World's Children 1989, Oxford: Oxford University Press.

United Nation's web address for Women Watch:
http://www.un.org/womenwatch/confer/index. html

United Nations (1995). Indigenous Women: Taking Control of Their Destiny. Department of Public Information, New York.

United Nations (1991). The world's women 1970-1990: trends and statistics, Social Statistics and Indicators, Series, K. no 8, New York: United Nations.

United Nations (1995). The world's women 1970-1990: trends and statistics, Social Statistics and Indicators, Series, K. no 12, New York: United Nations.

United Nations International Research and Training Institute for the Advancement of Women (INSTRAW) (1995). Gender Concepts in Development Planning: Basic Approach. Santo Domingo : United Nations International Research and Training Institute for the Advancement of Women.

United Nations International Research and Training Institute for the Advancement of Women (INSTRAW). (1993). "The Development of Thought on Gender and Women in Development (WID): Towards a New Paradigm" in R. Blumberg and B. Knudson (eds). Gender Training Portfolio, Santa Domingo: United Nations.

United Nations Development Program (1995). Human Development Report 1995, UNDP, New York, USA.

United Nations Development Program (1997). Human Development Report 1997, UNDP New York, USA.

United Nations Development Program (1999). Human Development Report 1999, UNDP New York, USA.

United Nations Development Program (UNDP) (2000) Human Development Report 2000 UNDP, New York, USA.

UNDP/World Bank/ WHO Special Program for Research and Training in Tropical; Diseases and Women's Health Project (1996). Health Workers for Change: A Manual to Improve Quality of Care, Geneva: World Health Organization.

United States National Institutes of Health (1992). Opportunity for Research on Women's Health (NIH Publication no 92-3457), Washington, D. C: US Department of Health and Human Services.

United Nations Development Program (1996). Facilitating Women's Mobility Project of the Government of the Islamic Republic of Pakistan. UNDP, Islamabad, Pakistan.

United Nations Development Fund for Women (UNIFEM). (1994). Declaration On The Elimination of Violence Against Women. New York, United Nations, 23 February 1994 (Resolution No. A/RES/48/104).

United Nations (1996) Statistical Yearbook (1996). United Nations Reproduction Section: New York.

Vlassoff, Carol (1994). "Gender Inequalities in Health in the Third World: Uncharted Ground". Social Science and Medicine Vol. 39, pp. 1249.

Van Wijk, Cecile M. T. Gijsbers; Van Vliet, Katja P. and Kolk, Annemarie M. (1996). "Gender Perspectives and Quality of Care: Towards Appropriate and Adequate Health Care for Women". Social Science and Medicine Vol. 43, pp. 707.

Web address for the map of Pakistan: http://www. lib. utexas.edu/Libs/PCL/Map_collection/middle_east_and_asia/Pakistan_pol96. jpg

Walby, Sylvia (1990). Theorizing Patriarchy. Oxford: Basil Blackwell.

Winkvist, Anna and Akhter, Humaira Zareen (1997). "Images of Health and Health Care Options among Low Income Women in Punjab, Pakistan". Social Science and Medicine Vol. 45, pp. 1483.

Waldron, Ingrid (1986). "What Do We Know About The Causes of Sex Differences in Mortality?", Population Bulletin on the United Nations, Vol 18, pp 59.

Waldron, Ingrid (1987). "Patterns and Causes of Excess Female Mortality among Children in Developing Countries", World Health Statistics Quarterly, Vol 40, pp. 1094-210

Waldron, Ingrid (1995). "Contributions of Changing Gender Differentials in Behaviour to Changing Gender Differences in Mortality" in Donald Sabo and David Gordon (eds). Men's Health and Illness: gender, power and the body. London: Sage.

Waldron, Ingrid and Jacobs, J. (1989). "Effects of Labor Force Participation on Women's Health: New Evidence from A Longitudinal Study". Journal of Occupational Medicine, Vol. 30, No 12, pp. 977-83.

Walby, Sylvia (1996). "The Declining Significance or the Changing forms of PatriarchY?", in Patriarchy and Economic Development: Women's Positions at the End of the Twentieth Century, Moghadam, Valentine M. (ed.) (1996). Clarendon Press, Oxford.

White, Sarah C. (1992). Arguing with the crocodile, Gender and class in Bangladesh. London / New Jersey, Zed books limited.

Weiss, Anita M (1985). Women in Pakistan: Implications of the Current Program of Islamization. Berkeley: University of California.

Weiss, Anita M (1991) Culture, Class, and Development in Pakistan: The Emergence of an Industrial Bourgeoisie in Punjab, Boulder, Colo.: West view Press.

World Bank (1993). World Development Report 1993: Investing in Health, Oxford: Oxford University Press.

World Bank (1989). Women in Pakistan: An Economic and Social Strategy. The Wold Bank, Washington D. C.

Wold Bank web site for Pakistan: http://wbln1018. worldbank. org/sar/sa. nsf/a22044d0c4877a3e852567de0052e0fa/52f84015f49ca343852567d800438bd0?OpenDocument

World Bank (1996). Country Profile: Pakistan. The Wold Bank, Washington D. C.

World Health Organization (1991). Maternal Mortality: A Global Fact Book, Geneva: World Health Organization.

World Health Organization (1992). The World Health Report 1995, Bridging the Gaps, Geneva: World Health Organization.

World Health Organization (1994). Health Population and Development (WHO Position Paper, International conference on Population and Development)., Geneva: World Health Organization.

World Health Organization (1994). Assessment of Fracture Risk and its Application to Screening for Post-Menopausal Women, Technical Report Series No 843, WHO Scientific Study Group, Geneva: World Health Organization.

World Health Organization (1995). Women's Health: Improve Our Health, Improve Our World (WHO Position Paper, Fourth World Conference on Women), Geneva: World Health Organization (in press).

Young, Kate (1993). Planning Development with Women: Making a World of Difference, London: Macmillan.

Young, Kate (ed.) (1988). Women and Economic Development: Local, Regional and National Planning Strategies, Oxford / New York / Paris: Berg Publishers Limited.

Young, Kate (ed.) (1989). Serving Two Masters: Third World Women in Development, Ahmedabad: Allied Publishers Limited.

Young, Kate (1988). Gender and Development: A Relational Approach. CCIS: Ottawa

Zaidi, S. Akbar (1996). "Gender Perspective and Quality of Care in Underdeveloped Countries: Disease, Gender and Contexuality", Social Science and Medicine. Vol. 43, No. 5, pp. 721-730.

Ziauddin (2000) Neither secure nor developed, The News International (daily). June 13, 2000.

Zaidi, Syed Akbar (1995). "Health Research in Pakistan". Economic and Political Weekly. No. xxx, pp. 307.

Zaidi, Syed Akbar (1985). "The Urban Bias in Health Facilities in Pakistan" Social Science and Medicine Vol. 5, pp. 473.

Zia, Shahla. (1994). Women, Islamisation and justice in Kamla Bhasin and Ritu Menon (for India) Nighat Said Khan (for Pakistan). (ed.) Against All Odds: Essays on Women, Religion and Development from India and Pakistan. New Delhi: Published by Kali for Women, in collaboration with Isis International and the South Asian Women's Forum.