# Status of women's health and well-being in Northern Pakistan

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## Summary

This paper is the result of an effort to fill the gap on the lack of information and related research regarding women's health and well-being specific to the northern areas of Pakistan, collected from agencies involved in health activities and relevant reports. The northern areas of Pakistan, consisting of the districts of Gilgit, Skardu, Diamer, Ghizer, and Ghanche, are spread over 72,496 sq km, with a population of about one million people. At the time of independence, there was no infrastructure and conditions were deplorable. Despite the building of the Karakorum Highway, and the work of NGOs and the government, the challenge of improving women's health and access to social sector services remains a daunting one.

Pakistan lags far behind most developing countries in women's health and gender equity. The sex ratio is one of the most unfavourable to women in the world as a result of female mortality during childhood and childbearing. The high number of deaths in childbirth (one woman in 38) and infant deaths (almost half) result from low nutrition and poor maternal health. Although high fertility rates are associated with a lack of adequate services to meet contraceptive needs, the preference for having large families, related to the traditional status of women, is a contributory factor too. The lack of mobility, decision-making power, and income present serious constraints to women accessing the limited services. More important, the inappropriate dietary patterns and nutritional deficiencies among women have serious implications on the quality of their life.

The northern part of Pakistan has an extreme climate. It is harsh and barren for several months of the year, with temperatures frequently dropping below

freezing. Whereas the low-lying areas grow crops twice a year, the high altitudes get only one crop a year. In subsistence farming, productivity depends largely on climate. In addition, the remoteness of the area makes the situation more difficult because the range of food available is limited and hinges on the storage of food during the summer season.

The total population is .93 million in the northern areas in comparison to 140 million in Pakistan. The sex ratio is 107 men to 103 women, suggesting a discriminatory trend against women. The number of female-trained professionals in the health services in the northern areas is appalling and can be taken as the reason for the high rate of maternal deaths in a society where women can seek advice only from women. On one hand, there is little knowledge about basic nutrition and the balanced intake of food; on the other hand, cultural backlash, religious taboos, and traditional habits aggravate the situation. Thus, socio-cultural factors play a part in creating and perpetuating these imbalances.

Because of the difficulty of delivering health care under these conditions, this part of the country has a maternal mortality of 600 per 100,000 live births and an infant mortality of 130 per 100,000 live births. The main causes of maternal ill health are related directly or indirectly to nutrition. Furthermore, the nutritional status is linked to the role of women and influences the health of the other members of the family as well. There is limited health facilities and the coverage in far-flung areas is low because of dilapidated infrastructure and limited funds. To tackle these problems, the Government of Pakistan is trying to foster partnerships with the private sector for the northern areas; one such venture is social marketing for delivery of family planning services and contraceptives.

Efforts are being made to address the immense problem by introducing programmes to improve the outreach of such activities and to increase the number of female health care providers by the Government of Pakistan and other agencies working in the region. Active stakeholders are Aga Khan Health Services (AKHS) and NGOs such as Family Planning Association of Pakistan (FPAP). AKRSP has been in the region for 20 years and is recognised internationally as a community-based organisation with the mission to alleviate poverty through promoting sustainable livelihoods of mountain communities. It has set up in five districts of the northern areas and Chitral a network of almost 4,000 local organisations which facilitate men's and women's participation in a range of collective development initiatives related to constructing and maintaining infrastructure, managing natural resources, and creating assets.

While improving the situation of men and women, the impact of these activities on the health status of women has not been evaluated. For one, AKRSP is not involved directly in delivering health services, and, two, there is

minimal research regarding this. So far, programmes supported by the government and Aga Khan Health Services have concentrated on delivering health services to vulnerable groups (especially mothers and children) to reduce the alarming health-related problems.

In Baltistan, one of the programme areas of AKRSP, the infant mortality rate is 207 per 1,000, whereas the national rate is 110 per 1,000. The training of Traditional Birth Attendants (TBAs) by AKRSP in Baltistan has been an important activity in the provision of social sector services. The TBAs are trained in antenatal post-natal care, childbirth, family planning, and childhood diseases. The local women now not only have access to increased supply of pregnancy-related services, such as vaccines and immunisations, but the TBAs have also found a profession and are able to earn an income.

Despite continuous efforts, the challenges posed by poverty, conflict, social instability, and preventable diseases have sabotaged the development of women. The level of existing health services, strategies employed to reach out, programmatic priorities, and the information needs are central factors in determining the health status of women in Pakistan. In addition to the technical aspects, the involvement of the community, mobilising its support, creating awareness about health issues, and the reach of health services are vital elements that need significant attention in health programmes. Here, greater emphasis may have to be paid to the nutritional status of women to help women carry out the designated roles and have an effect on the health of the family. Without doubt, poor maternal health, malnutrition, meagre services, and social issues exacerbate the poor health status of women in Pakistan.

"*Reproductive Health is a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life (WHO).*"

According to a World Bank report (1997), 'Towards a Health Sector Strategy,' the conditions related to reproductive health constituted one-fifth of the disease burden and results in disability. The causes of the poor health status of women can be attributed to the lack of information, appropriate services, excessive childbearing, and low contraceptive rates.

In Pakistan, 20% of the population are undernourished, and 41.3% of women residing mainly in rural areas suffer acutely from anemia, indicative of low calorie intake. Pregnancy and lactation place extra demands upon the woman. Furthermore, religious taboos and traditional habits add to low intake of food and result in low birth-weight of newborns. Discrimination against women begins soon after birth. Studies and research in Pakistan reveal that gender was the most significant determinant of malnutrition among children, with this being more evident in low-income families where food is scarce.

An indication of the government's priority is that less than 1% of the Gross Domestic Product was earmarked for health expenditure in 1998, comparing poorly with military spending and education. A considerable percentage being used for debt servicing is a macro factor that underlies the weak economic situation.

There is a paucity of health facilities in Pakistan. The population per hospital bed in the northern areas is 1,210. There is a dearth of trained health professionals. For instance, trained health personnel supervise only 20% of births in the northern areas. There are only 244 medical doctors and 2,745 para medical staff available to provide health services in the entire region.

## Conclusion

This paper argues that a cost-effective, comprehensive approach to reproductive health care is required. Priority must be given to increase community-based services to meet the need for family planning. Increased capacity and number of female health providers would help to counter the sociocultural barriers that women face in accessing services, with special attention given to women in the far-flung remote areas.

Due to the enormity of the task, the private sector, and especially NGOs and local development organisations, should be encouraged. AKRSP has fostered almost 4,000 social organisations (village and women's organisations) in the northern areas. The capacity of these organisations can be built around different health needs and can serve the communities by providing services on the doorstep. It may be noted that crucial for the effectiveness of these programmes is the participation of women in planning and implementation. These programmes can bring a change, but we need to review and identify approaches that reduce gender discrimination and improve the overall status of women. National strategies will have to give much more attention to health interventions for women, particularly during their reproductive years.

The actions stated above could reduce the burden of disease and associated costs. Institutions that permit the formation of policies targeted at improving the quality of life and standard of health for mountain women must be strengthened. There are no possible short cuts and ready-made solutions. The government's commitment, in the shape of the Northern Health Project and such programmes, needs considerable resources and must be aligned to community requirements and to women.