Advancing Reproductive Health from a Human Rights Perspective
A Brief for Parliamentarians and Policy-makers

Executive Summary
Issues related to human reproduction and reproductive health traverse multiple domains from medicine and technology to morality, law and culture. On the one hand they relate to most private and intimate aspects of an individual’s, especially that of a woman’s life. On the other, they connect with very broad social phenomena, such as sustainable development and the role of men and women in society. The present brief is an attempt to unravel some of these issues, including those related to family planning, abortion and maternal health, in the context of Pakistan. The brief advocates a human rights and ‘life-cycle approach’ to reproductive health as a means to making technically and ethically sound choices about future strategies and actions.

Introduction
The International Conference on Population and Development (ICPD) held in Cairo in 1994 turned out to be a conceptual watershed in the struggle for reproductive rights in as much as it established a holistic definition of reproductive health from a human rights perspective and mapped out a broad plan of action agreed to by 179 nations. The Conference defined reproductive health as:

“a state of complete physical, mental and social well-being and not merely absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulating fertility which are not against the law, and the right to access appropriate health care services that will enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant”.

International women’s rights organisations and health agencies such as the United Nations Population Fund (UNFPA) and the World Health Organisations (WHO) are avowedly committed to following the ICPD agenda. Globally, the HIV and AIDS pandemic and persistently high rates of maternal mortality are recognized as the most serious challenges the world faces. Many developing countries, including Pakistan, have made important strides in reducing fertility rates and enhancing maternal health services in the past few decades. However, the enormity of the reproductive health challenge and a vast array of underlying moral and social issues call for more robust policy responses.

Conceptual Framework
Reproductive rights are not explicitly mentioned in major international human rights treaties, such as the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). However, these documents which Pakistan has signed up to, provide for the right to health that inter alia includes right to reproductive health. The 1973 Constitution of Pakistan under the chapter on Principles of Policy calls upon the state to ‘provide basic necessities of life’, including ‘medical relief’. The Principles of Policy cannot be a direct cause of action in a court of law in Pakistan. However, they hold persuasive value when read with Fundamental Rights and provide benchmarks to evaluate state policy.

In the context of the International Covenant, the right to health, like other socio-economic rights, imposes upon state parties positive obligations to respect, protect and promote that right. The obligation to respect the right to health would require state parties...
Reproductive rights began to get articulated as a subset of human rights at the United Nation’s 1968 International Conference on Human Rights. The resulting non binding Proclamation of Teheran was the first international document to recognize one of these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children". The ICPD expanded the right to family planning to include the right to better sexual and reproductive health and the right of women to have safe pregnancy and childbirth. In recent years, a number of countries, including South Africa, Kenya and Bolivia, have explicitly incorporated reproductive and sexual rights in national constitutions.

Analyses of international proclamations and court decisions also bring into sharp relief the conceptual links between reproductive rights and other human rights. These include the right to life, the right to security, the right to non-discrimination, the right to privacy and family life and the right to dignity, all of which are guaranteed by the Constitution of Pakistan. To elaborate, a maternal death, when it results from an undue delay in the provision of emergency obstetric care at a health facility, is prima facie, a case of the infringement of the right to life. Similarly, to force a woman to carry a foetus to term even when she is likely to suffer negative physical or emotional consequences may constitute a violation of her fundamental right to dignity.

A human rights approach to reproductive health is partly an attempt to counteract the traditional focus in public health and population policy on using women’s reproductive capacities instrumentally to advance demographic and economic targets. A rights-based approach establishes the importance of processes at par with intended outcomes. If reproductive health is a matter of rights, it is not a hand-out, and the women who receive services are not objects of charity or targets of demographic transition. The right to health in the ICESR is envisaged to be achieved progressively, the states are required to ensure that there is no discrimination in the exercise of the right and that a minimum core of the right is ensured, for example, through the provision of free emergency obstetric care.

Reproductive rights began to get articulated as a subset of human rights at the United Nation’s 1968 International Conference on Human Rights. The resulting non binding Proclamation of Teheran was the first international document to recognize one of these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children". The ICPD expanded the right to family planning to include the right to better sexual and reproductive health and the right of women to have safe pregnancy and childbirth. In recent years, a number of countries, including South Africa, Kenya and Bolivia, have explicitly incorporated reproductive and sexual rights in national constitutions.

Analyses of international proclamations and court decisions also bring into sharp relief the conceptual links between reproductive rights and other human rights. These include the right to life, the right to security, the right to non-discrimination, the right to privacy and family life and the right to dignity, all of which are guaranteed by the Constitution of Pakistan. To elaborate, a maternal death, when it results from an undue delay in the provision of emergency obstetric care at a health facility, is prima facie, a case of the infringement of the right to life. Similarly, to force a woman to carry a foetus to term even when she is likely to suffer negative physical or emotional consequences may constitute a violation of her fundamental right to dignity.

A human rights approach to reproductive health is partly an attempt to counteract the traditional focus in public health and population policy on using women’s reproductive capacities instrumentally to advance demographic and economic targets. A rights-based approach establishes the importance of processes at par with intended outcomes. If reproductive health is a matter of rights, it is not a hand-out, and the women who receive services are not objects of charity or targets of social engineering. A human rights approach asserts that the state has moral and legal responsibility for the issues regarding sexual and reproductive health. Not only should the rights be guaranteed in law and practice, but there should be mechanisms and procedures in place for women to vindicte their rights in the event of violations.

While a human rights approach may help reform laws, policies and practices, it has to be borne in mind that wider issues of gender and regional inequalities as well as predominant values and cultures might divest reproductive rights of all meaning and practical import. Social and economic conditions that give rise to demand for more children and encourage early marriages, for instance, need to be transformed if individuals and women are to exercise their reproductive rights. Contextual issues and barriers constrain the exercise of the rights in many other areas of reproductive and sexual well-being. For example, cultural taboos against openly discussing sexual issues prevent many victims of HIV/AIDS and sexually transmitted diseases from seeking timely help.

The conceptual approach we are advocating thus requires a human rights approach to be supplemented with a broad transformative vision that is sensitive to how reproductive rights are located within social and economic conditions. On this approach, reproductive health policies and programmes are to be supplemented by and synchronized with measures in other social sectors. For instance, education system should be geared toward removing gender stereotypes parallel to family planning programmes that encourage men to take up their share of responsibility in planned parenthood. Similarly, labour laws requiring employers to provide maternity benefits could supplement pre-natal and ante-natal health care services by allowing women the care and support they need for healthy child bearing.

In the context of reproductive rights policy and planning, a very useful conceptual tool is what is known as Life-Cycle Approach. The approach posits reproductive health as a lifelong concern for both men and women from infancy to old-age. As such, it helps broaden policy and programming horizons to address issues of gender-based discrimination and violence at an early age, specific physical and psychological problems that appear with the onset of puberty, issues of maternal health, birth spacing and STDs during adulthood, and finally, reproductive problems in old age.

**Salient Substantive and Policy Issues**

With an estimated population of 170 million, Pakistan is today the 6th most populous country in the world. While, annual population growth rate at 2.05 per cent is still higher than other countries in the region, the country is going through a demographic transition. Fertility rate has decreased to 4 per woman from over 6 in 1970s. Discussing what they believe to be a potential demographic divided, researchers at the Pakistan Institute of Development Economics (PIDE) have shown in recently published papers

---

8 In fact, population control programmes in many developing countries, including India and and Puerto Rico, often at the behest of Western donors, were known to include serious human rights abuses in the form of forced sterilizations. For a detailed discussion on such population control programmes, see Kalir 1994, pp 197-222.
9 Prostate related problems among middle-aged and elderly men are a case in point.
11 Ibid, p 236.
that the working-age population is bulging, the proportion of child population is declining and so is the dependency ratio. Because of a decline in the proportion of child population, the youth (15-24 years) share rose from 18.4 per cent to 20.9 per cent between 1995 and 2003. Pakistan’s peak youth size, the PIDE research shows, is projected to be 21 per cent around 2015 after which it will start declining. Thus the period of opportunity or a potential demographic dividend in the form of a largely young population is to last no later than 2045. As well as presenting opportunities for economic uplift, the higher share of the youth and working age cohorts in the overall population mix also requires appropriate policies dealing with education, employment and health.

According to the Pakistan Democratic and Health Survey (PDH) 2008, fertility is still considerably higher in rural areas (4.5 children per woman) than the urban areas (3.3 children per woman). Contraceptive prevalence rate (CPR) is still low in the country at 26 per cent, meaning that majority of married couples do not use a birth spacing method, this despite the fact that 96 percent of married Pakistani women are aware of at least one modern contraceptive method. Women in urban areas are more likely to use contraceptives (41 percent) than those in rural areas (24 percent). Contraceptive use increases with women’s level of education, from 25 percent among currently married women with no education to 43 percent among those with higher education. Similarly, women in the higher income quintiles are much more likely to be using some form of contraceptives compared to those belonging to poorer income groups. Opposition by husbands is cited as a reason for not using contraception by over 20 percent married women.

An alarming dimension of persistently low levels of contraceptive use is the dramatic increase in the incidence of abortion, mostly in unsafe environments, leading to serious health complications and deaths. Research shows that most Pakistani women who induce abortions are 30 years of age or above and already have three or more living children. The pattern only suggests that abortion is being used as a family planning method and there is an unmet need for safer birth control and birth spacing methods.

While abortion law in Pakistan allows for pregnancies to be terminated in early stages if there is a risk to a woman’s life or health, lack of awareness among health professionals about the law lead them to turn away even those women who are at a serious risk if they carry the pregnancy to the term (See Box). This, together with poverty, is leading increasing numbers of women to opt for backstreet abortions conducted by unskilled practitioners. The PDH puts the proportion of maternal deaths due to complications of abortion at 6 percent but admits a possibility of under-reporting since the survey did not include direction questions about abortion.

**Abortion Law in Pakistan**

Abortion is now legal in Pakistan if carried out for the medical treatment of a pregnant woman in the early stages of pregnancy. Previously, the Pakistan Penal Code allowed for abortion only if it was required to save the life of the pregnant woman. Section 338 of the Penal Code amended by Criminal Law (Amendment Act No. 1 of 2005) now reads: “Whoever causes a woman with child whose organs have not been formed, to miscarry, if such miscarriage is not caused in good faith for the purpose of saving the life of the woman, or providing necessary treatment to her, is said to cause Isqat-i-haml.”

The inclusion of the clause ‘providing necessary treatment’ provides greater legal latitude for an abortion and makes it difficult to obtain a conviction for isqat-i-haml or abortion before the limbs are formed.

Women do not receive skilled prenatal care or full protection against tetanus. Almost two in three births occur at home and 60 percent of births are not assisted by skilled medical attendants. Delays in seeking medical care for obstetric complications are common due to lack of transport, family support, non-availability of anesthetists at health facilities, and so on. Neglected childbirth involving prolonged obstructed labour sometimes results in obstructed fistula, leading to incontinence and continual vaginal discharge. Women who develop fistulas are often abandoned by their husbands and rejected by their communities. An estimated 5000 cases of fistula occur in Pakistan every year.

As a signatory to the Millennium Development Goals (MDGs), Pakistan’s targets for MDG-5 related to maternal health are to reduce the MMR to less than 140 and to increase skilled birth attendance to 90 percent by the year 2015. To achieve these targets, the government has recently launched a large-scale national maternal, neonatal and child health program. The public sector health infrastructure already includes over 5000 Basic Health Units, over 550 Rural Health Centres (RHUs), more than 4500 Dispensaries and over 900 Mother and Child Health Centres. The efficiency and utility of these facilities are seriously compromised by staff absenteeism, difficult access in rural areas, poor quality of care, lack of female staff and absence of strong referral links between primary health care and rural health centres.

A positive change to have occurred in Pakistan’s demography is the increase in maiden age at first marriage from 16 years to

---

2. Contraceptive use among currently married women is highest in Punjab province (33 percent), followed by Sindh province (27 percent) and NWFP (25 percent), and is lowest in Balochistan province (14 percent).
4. UNFPA: www.endfistula.org/highlights.htm
slightly over 19 years in 2006-7. However, among the poorest and least educated, girls’ maiden age at marriage is still lower than the national average. Overall, one out of six women aged 15-19 is already married. Marriage at an early age is associated with high risk pregnancies and higher incidence of infant mortality. Adolescent girls are also likely to have limited knowledge about sexual issues and reproductive choice and sexually transmitted diseases (STDs). Additionally, these girls are more often restricted than older women in their mobility and access to health and family planning services. Married adolescent girls are likely to find motherhood the sole focus of their lives at the expense of development in other areas, such as education, vocational training, work experience, and personal growth.

Sexual and reproductive health concerns and issues abound with regard to adolescents in general and not just married adolescent girls. Various misconceptions about sexuality, reproductive functions and human anatomy result in unhealthy practices with negative physical and psychological consequences. A series of focus groups with adolescents in a low-income community in Karachi as part of an AIDS awareness programme revealed that the main factors contributing to poor sexual health among adolescents were: a general lack of confidence, inability to be assertive, and inadequate information about the body. Misinformed and confused, many young men resort to visiting quacks or untrained health professionals. They often end up taking harmful substances in an attempt to cure perceived or actual sexual dysfunction.

To quote the Demographic and Health Survey again, only four in ten ever-married women aged 15-49 in Pakistan have heard about HIV/AIDS. According to an official estimate, approximately 97,400 people are currently living with HIV in Pakistan. Limited data suggest that infection is common among commercial sex workers and injecting drug users (IDUs). Other high risk groups include homeless children and adolescents, and mobile workers, such as truckers. Married women are susceptible to catching HIV and other STDs from their husbands given the lack of choice and say over sexual matters in marriage. Male migration, particularly between Pakistan and Gulf countries, has reportedly been a source of AIDS transmission and social ostracism for wives who become infected.

The issues highlighted here point to complex relationships between individual reproductive rights and broader socio-economic context. They also demonstrate the breadth of issues that go under the broad rubric of reproductive health and challenge the simplistic preoccupation with population control and provision of family planning services.

In terms of existing policy response, the cabinet approved a new National Population Policy earlier in 2010 while a new National Health Policy is available in draft form. With regard to the Population Policy, it is creditable that the document takes note of the demographic shift and acknowledges the limitations of current family planning programmes, including a lack of behavioral change and increasing incidence of unsafe abortions. Creditably, the policy envisages a greater engagement with men for planned parenthood. However, the policy document is short on addressing reproductive health issues from a human rights perspective and life-cycle approach. For instance, it is silent on early marriages and sex education for adolescents. The linkage with National Education Policy 2009 would have been desirable also in the light of evidence suggesting a positive co-relation between contraceptive use and women’s education levels. It would be desirable that such omissions are avoided when provinces come up with provincial policies to replace the existing national ones following the 18th Constitutional Amendment.

Similarly, the Draft National Health Policy acknowledges demographic transition and youth bulge occurring in the country. However, rest of the document does not specify measures targeting adolescents and youth, such as contraceptive and sexual education. The draft policy obliquely mentions high risk groups, including migrating populations, with regard to HIV and AIDS but is weak on specific policy measures or cross linkages with other relevant policy documents, such as National Emigration Policy or Labour Policy. Social determinants of women’s reproductive and sexual health, such as early marriages, domestic violence and gender stereotyping, seem to have fallen through the policy cracks. While the policy acknowledges the need for rationalizing health infrastructure across regions, it does not specify a roadmap or strategic directions to accomplish that goal.

Finally, with regard to legislators’ oversight role a clear intent of purpose on the part of Committees in the National and Provincial Assemblies and an understanding of reproductive and sexual health issues could go a long way in holding relevant departments accountable. This could also facilitate corrective measures in policy, planning and implementation.
Recommendations
Based on the preceding discussion and the conceptual framework elaborated in the brief, we now present a set of general, cross-sector recommendations followed by more specific recommendations with regard to policy areas highlighted in the brief.

General Recommendations

- Incrementally increase the health budget from the current level of less than 1 percent of GDP to at least 5 percent of GDP;
- The federal government should work with provinces and districts to develop mechanisms so that a certain percentage of development expenditures in the districts are spent on the delivery of health, particularly reproductive health;
- Encourage greater openness in parliamentary debates on issues related to sexual and reproductive health;
- Audit all reproductive health and family planning programmes and plans with a view to ensuring targeted coverage of high-risk groups, such as street children, adolescent girls and boys, prisoners, commercial sex workers, injecting drug users (IDUs) and truckers;
- Introduce a comprehensive anti-discriminatory legislation to end discrimination in employment and access to public services on the basis of pregnancy, marital status or HIV/AIDS status;
- Ensure inter-departmental coordination at federal, provincial and district levels to ensure linkages and cross-referencing between all social sector policies;
- Revitalize the Standing Committees on Health and Population Control in the Federal Parliament and Provincial Assemblies with personnel support for research provided.

Sector-Specific Recommendations

Recommendations presented in this section are by no means exhaustive and they do not cover the entire range of issues even within the selected sectors. However, they are meant to provide some illustrative examples of legislative, policy and administrative measures that are required to make reproductive rights a reality.

Child and Adolescent Issues

- Review the implementation status of Early Marriages Restraint Act 1929. Under the Act the minimum age of marriage for a male is 18 years whereas the minimum age of marriage for a female is 16 years. In much of rural Pakistan, girls are married off at a younger age. Evidence suggests that such unions are not rendered invalid and the offence is non-cognizable;
- Incorporate reproductive health and life skills training in school curricula at secondary and higher levels;
- End gender stereotyping in school curricula and teaching methods.

Contraceptives and Family Planning

- Evaluate population control programmes to make sure there is an adequate focus on behavior change communication activities with youth, married men and women, and opinion-makers, as distinct from mere information dissemination activities;
- Re-orient public health campaigns and social mobilization activities with a view to involving men as responsible partners in family planning and reproductive health;
- Review the implementation of the National Population Policy 2010, especially with regard to improvements in communication between men and women on issues of sexuality and reproductive health through LHWS and male mobilizers;
- Provide incentives for the manufacture, distribution and sale of contraceptives;
- Remove the legal requirement for a woman to have a written permission from her husband to undergo tubal ligation. The law is discriminatory in that a man does not need his wife’s permission if he wants a vasectomy.

Abortion and Maternal Health

- Issue notification directing public and private health sector facilities to provide safe abortion services to women in accordance with criteria set out in the amended law on abortion (Amendment Act No. 1 of 2005);
- Put in place a complaint mechanism and legal aid cells at district and sub-administrative units for women to hold health staff accountable for not providing adequate antenatal, post natal and emergency obstetric care;
- Prioritize emergency obstetric care and fistula repair facilities as part of new health infrastructure development.
Bibliography


Disclaimer

This document is an output from a project funded by the British High Commission aimed at bringing to light the issues of human right victims among the policy makers. The assertions, opinions and recommendations in this brief do not necessarily reflect the views of LEAD Pakistan or British High Commission and can therefore in no way be taken to reflect the official position of either of the organizations. No warranty (expressed or implied) is given as to the accuracy or completeness of the information contained in this brief and to the extent permitted by law, LEAD Pakistan and British High Commission and the advisors, authors, editors and distributors of this brief do not accept or assume any liability or responsibility for any consequences of anyone acting or refraining to act, in reliance on the information contained in this brief or for any decision based on it.