Contraception
The Unclaimed Right

The Invisible Victim

At 35, Sultana Bibi is a mother of eight, six boys and two girls – the eldest an 18 year old son and the youngest, twin daughters aged three. But she looks almost 55! Pale and exhausted, the physical strain on her is unmistakable. Her husband Mehtab Amir is a 45-year old daily wage earner.

Sultana, born to a poor family was just 17 when she got married to Amir. Belonging to the same village, his family was as poor as hers.

Like her, he, too, is completely unlettered. Both, however, can read the Holy Quran, but without understanding the meaning of the holy words in Arabic. This is the common practice in their village.

Their village is around 1,000 acres in area, a population of about 2,000 people, of which 60 percent comprise women. It has two mosques, two schools that have recently been made functional (one higher secondary school for girls and one primary school for boys) but no health facility.

There are days when Amir does not bring home any money as life of a manual laborer is full of uncertainties. Starving has assumed a normative status in their lives.

All six of Bibi's sons go to a public school but are often sent home due to non-payment of the nominal fee. As for her daughters, the mother thinks that it not necessary to educate them. Getting married early and becoming the mother of sons is considered lucky in Punjab province.

Bibi is considered lucky as she has been blessed with six sons. All deliveries took place at home through dais (untrained delivery assistants).

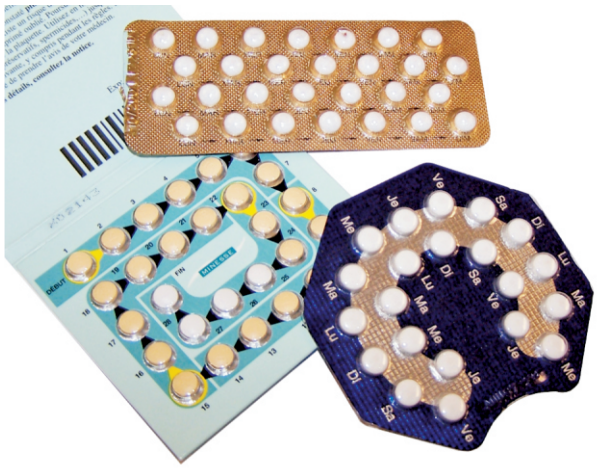
While she admitted that she did not have a clear idea about family planning (FP), she had heard of a doctor "who stops kids". She would often ask other women about ways of spacing pregnancies but never quite received a satisfactory answer.

Myths Abound

Whatever little Bibi knew about contraception is what she learnt through word of mouth. "Everybody told me that if I adopt a contraceptive method, I would not be able to do housework or lift heavy objects. Many said I would even end up getting cancer as a result of it," she said.

Bibi got scared because, according to her, if God forbid something should happen to her, the "kids are too young and need my care". She reminisced, "If my mother-in-law had been alive, she would have guided me."

After the birth of her six sons, Bibi was becoming weaker as she continuously suffered from menorrhagia (an abnormally heavy and prolonged menstrual period), backache and anemia (one of the more common blood disorders, where the number of healthy red blood cells decreases). In addition, the sky-rocketing food prices made it impossible for them to make ends meet. She was desperate to take some form of family planning. Bibi tried to



discuss it with her husband but in vain. Her sister-in-law, who lived in the urban periphery and had completed ten years of schooling, encouraged her to adopt some FP method.

But it was her twin daughters' birth that brought the real change. Her husband became scared – scared of more daughters. What if she now starts producing girls, he feared. So they began looking into FP more seriously for the very first time.

By then, other family members got actively involved in their very private matter.

Looking at this cash-strapped family, other family members also encouraged her to use a suitable family planning method. Upon consulting a doctor in the nearby city who ran a clinic with support from a non-governmental organization (NGO), she was advised to go for tubal ligation, informally known as getting one's tubes tied. Ligation or TL, as it is called, is a form of female sterilization, in which the fallopian tubes are severed and sealed to prevent fertilization.

Hesitantly she broached the subject of FP and asked her husband if she could get her 'tubes tied'.

Woman Denied Choice and Autonomy

His was an instant no to TL but he agreed for her to try some other form of contraception. "I believe TL is not allowed in Islam," said Bibi, adding, "Allah naraz ho jaein ge (God will be angry)."

According to Bibi, "We have observed that whenever women got TL done, something bad happened to their family like an accident, a disability, a fight between brothers etc. This is because those women went against nature and did not obey Islamic rules."

A little probing revealed that initially Bibi herself was interested in adopting a more permanent method, especially after the sixth child, but due to common misconceptions regarding birth control, her husband refused because he thought that his wife would be unable to carry out household chores.

However, when his brothers got involved and convinced him to adopt some birth control method, he changed his mind but still did not agree for TL.

Finally, Bibi went to a FP clinic where "a medicine was put in my uterus". That 'medicine' was the Intra Uterine Contraceptive Device (IUCD), about which she was given no proper information. "I have absolutely no problem with this and best of all, I can do all the housework. I haven't been to the doctor for the last three years," said Bibi with satisfaction.

Who Is The Victim? Who Victimized Her?

In Bibi's case, the woman who is a victim has suffered a lot and is still suffering. She did not get the contraceptive method when she needed it most. Finally what she got was not her first and required option. In addition, the health service provider did not bother to invest some time on counseling and provide her the method with her informed consent. The most poignant aspect is the complete absence of the recognition that it was a gross violation of the rights of a woman and her health.

On the face of it, the husband can be held responsible for the violation; however, a critical examination of the socio-cultural processes makes him appear to be a victim too. However, the greatest brunt of this torture is borne by a woman's body and soul.

The Path Taken...

A complex blend of economic hostilities, cultural taboos, social pressures, patriarchy, illiteracy and absence of basic health facilities gives rise to issues like cultural, geographical and financial inaccessibility to a low cost health service like contraception.

The general approach adopted by most couples is that of fatalism and complete surrender to the prevailing norms and value systems. This can be verified by their expression of conventional wisdom and popular interpretation of religion that entitles a superior position to sons, them being seen as earning hands. Compared to them, daughters are relegated a lower social status because they are perceived as mouths to be fed and a burden to be offloaded with dowry.

Bibi believed sons were "more important than girls as they will help alleviate our poverty, whereas for daughters we have to arrange money to spend on their marriage."

The Decision Maker

Her husband kept on producing children and violating not only the human and health rights of his wife but his children as well. He could not buy for them the clothes they needed, the food

they should have and schooling that was their right. Instead, he got them employed.

Yet, Amir alone cannot be held guilty as his decisions were influenced by his own illiteracy, lack of skills to earn comfortably and cultural concepts of masculinity that compelled him to maintain control over the body and life of his wife by keeping her pregnant and preventing her from opting any birth spacing method. He was the key decision maker.

Contraception – Where It All Began

An excerpt from Dr M F Fathalla's "Contraception and Women's Health", published in BMJ (1993), Vol 49, No1, PP245-251 states, "Contraception, a natural need, has been practiced but in an undocumented manner since time immemorial. However, family planning as we know it today came much later. The family planning movement started as a movement by women for women."

"Dr Marie Stopes, who wrote "Wise Parenthood" in 1918 and opened the first clinic in London in March 1921, was not a physician. She had her doctorate in Palaeobotany. Margaret Sanger, her sister, Ethel, and a social worker Fania, opened the fist clinic in Brooklyn. It was soon raided and the three women got arrested. Released on bail, they reopened the clinic, were rearrested and charged with maintaining a public nuisance."

Empowerment – A Distant Dream for Women in Pakistan

The Islamic Republic of Pakistan located in the patriarchal belt of South Asia is still characterized by selective modernity and perpetual patriarchy. Adding to the complex spectrum of patriarchy is the fact that there is no one Pakistan.

Pakistan of the masses is entirely different from that of the classes. Similarly, women are not homogenous. The rural and poor women of Pakistan are still endorsing centuries old subjugation and are treated as cultural minors.

Marriage, in spite of increasing divorce rates[1], is an important and a must follow institution. Getting married early[2] and becoming the mother of sons are still considered preferred choices and a mark of good fortune. The social confusion is strong and breeds in silence on a very private matter like contraception.

Empowerment and emancipation have different interpretations for a common rural woman, and these are distant dreams even for a middle class urban woman in a country that twice elected a woman as its prime minister[3].

A study on women's autonomy, fertility and livelihood conducted in rural Punjab, Pakistan, found spousal communication on FP to be the strongest determinant and predictor of contraception among all women's status indicators. The same study demonstrated that FP, followed by the number of children, is among the least discussed topics among the spouses where husbands appear more articulate than their wives (Zeba and Kazi, 1997).

According to Pakistan Demographic and Health Survey 2006-07, 25% of currently married women in Pakistan have an unmet need for family planning services, of which 11 % have a need for spacing and 14 % have a need for limiting. As far as the knowledge of contraceptive methods is concerned, the percentage of ever-married and currently married Pakistani women (ages 15-49) who know any contraceptive method, is 95.7 and 95.9 respectively. Overall, 55 % of Pakistani women have a demand for family planning. In other words, only just over half of the demand for contraception is currently being

[1] Presently, 62 % of women of childbearing age are married, one-third (35 %) are not married and the remaining 03% are divorced, separated, or widowed. Divorce and separation are socially discouraged, and hence are uncommon. Source: DHS 2006-07

[2] Though teenage marriages are on the decline, one out of six women age 15-19 is already married. The median age at first marriage has increased by about half a year in the last 16 years, i.e., from 18.6 years in 1990-91 to 19.1 years in 2006-07. Important differentials in median age at first marriage are found on the basis of educational level and wealth quintile. Source: DHS 2006-07

[3] Mohtarma Benazir Bhutto (1954-2007)

satisfied. (Pakistan Demographic and Health Survey 2006-07).

Research has repeatedly demonstrated that the contraceptive use increases with education and economic status. The gap between rich and poor is particularly striking in Pakistan.

A Comparative Data on Selected Indicators				
Country	Indicators			
	HDI Rank	GEM Rank	GDI Rank	Population in M
Pakistan	141	99	124	173.2
Afghanistan	181		154	26.3
Bangladesh	146	108	123	157.8
China	92	72	75	1329.1
India	134		114	1164.7
Indonesia	111	96	93	224.7
Iran	88	103	76	72.4
Nepal	144	83	119	28.3
Sri Lanka	102	98	83	19.9
Thailand	87	76	72	67
Source: Human Development Report, 2009. Overcoming Barriers: Human Mobility and Development, UNDP, Pakistan, 2009				

The document "Sparing lives" by the World Bank, in 2008, reported that the use of contraceptives is four times higher in the richest 20 % of households in Pakistan, compared to the poorest. The situation is reverse in Sri Lanka where women in the poorest fifth of the population have higher (80.3 %) use, than those in the richest (69.5 %). Denial of access to FP or adoption of any contraception by women and/or dependency on spouse's approval is seldom seen as a violation of human rights.

The poor and powerless women with no access to contraception are perhaps the most neglected and forgotten victims in the discourse and activism on HR including RHR. There is little discussion in Pakistan of the right-based perspective, or life-saving intervention, or the premise of women's rights.

Noted activist and advocate, late Rashida Patel (2000), considered it a blatant denial of women's rights to life, as health technology is now available to bring maternal mortality rate (MMR) down.

To date, there is no legislation on the issue of contraception. A woman has to seek the consent of her husband for TL, whereas the husband is not at all bound to do the same if he opts for vasectomy. This is the standard operating procedure for all health service providers across the country in public, private and non-profit sector.

Many NGOs and donors have worked and are working on RHR but the traditional area of FP seems forgotten and the critical issues of rights seem to be neglected, if not forgotten.

While religious scholars and political maulvis (clerics) are still divided on the "legitimacy" of contraception, there are some liberal voices among the religious sector.

One such voice is Dr Farooque Ahmed, primarily a psychiatrist from Khyber Pukhtunkhwa (KP) province, who has extensively supported family planning in his research and talks. The irony is that despite an emerging feminist political culture in Pakistan, the patriarchal consensus on such issues is still very strong with little or almost no space for powerful voices on contraception rights as a women's rights issue. The questions remain: Can the people, including women, claim health as a human right in Pakistan? What are the contraceptive options for a woman who is currently married and lives in a remote village which may be under the radar of public led and donor-funded projects, or has yet to be accessible to mushrooming private television channels and their fearless reporters? The saga and dilemma of these women are not documented in HR reports or project performance charts that chase numbers and are not interested in needs, as these do not fit into the academic definitions and technical framework.

For an effective understanding, that is bound to be indicated by a policy and set of policy actions that reflect empathetic understanding of the concerned issues, of FP and contraception in Pakistan, it is vital to identify, understand and analyze these issues in the context of Human Rights[4]. The change in perspective would bring a change in practices at policy level, and it is hoped that it would then be manifested in subsequent programmes, projects and activities.

Some Contraceptives Methods In South Asian Countries (in terms of %age)					
Method	Bangladesh	India	Pakistan	Nepal	Sri Lanka
Pills	28.5 (2007)	3.1 (2005-06)	3.1 (2003)	1.6(2001)	6.7(2000)
Injectables	7 (2007)	0.1 (2005-06)	3.4 (2003)	8.4(2001)	10.8 (2000)
IUCD	0.9(2007)	1.7 (2005-06)	4.4 (2003)	0.4 (2001)	5.1 (2000)
Condom	4.5 (2007)	5.2 (2005-06)	6.4 (2003)	2.9 (2001)	3.7 (2000)
Tubal ligation	5 (2007)	37.3 (2005-06)	7.5 (2003)	15 (2001)	34.14 (2000)
Vasectomy	07 (2007)	1 (2005-06)	0.2 (2003)	6.3 (2001)	1.89 (2000)
Traditional Method	8.3 (2007)	7.8 (2005-06)	6.9 (2003)	3.9 (2001)	20.5(2000)
Source: Sparing lives: Better RH for Poor Women In South Asia: The World Bank, DC, 2008. PP.16					

From the Mouth of Experts

In a country that possesses one of the oldest FP programmes in the developing world, and where representative research[5] suggests that more than 95% of women know of at least one method of contraceptive, it is deplorable that family planning

[4] By the end of the 1980s,the concept of RH was integrated into population discourse. According to which reproductive rights are human rights which are inalienable and inseparable from basic rights such as the right to food, shelter, health, security, livelihood, education and political empowerment.

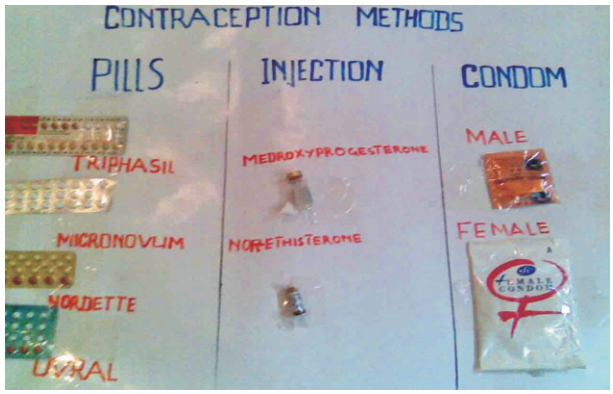
programmes cannot reach to a village a few kilometers from Islamabad, the federal capital. The urban bias in the planning and anti-poor policies is not strange to any student of state machinery and apparatus.

Dr Tariq Rahim, an experienced development practitioner and the first Pakistani who was trained in non-scalper vasectomy, is the founder and managing director of RH-Aid Consultancy. According to him, "The national FP programmes have provided many poor women with contraceptives and the ability to limit family size; but they have rarely given women genuine choice and control over their bodies, or a sense of self empowerment. The focus of FP has been on population stabilization and the meeting of targets rather than on the means or the processes to achieve its ends. With universal awareness about birth spacing, all that couples need is accurate information and affordable quality FP services at their doorstep". He added that, "the right of access to safe and affordable FP services must be the foremost agenda of the Ministry of Population Welfare (MOPW).

His thoughts are seconded by the communities that stress on the importance of creating awareness about family planning. According to them, the myths surrounding FP are difficult to sever. FP clinics must be opened in the villages because while one hears about the Lady Health Worker (LHW) programme of the government, they are never seen raising awareness in villages. Also there need to be regular programmes on the television and radio, because while majority of the people are illiterate yet they have radios and can listen and get information about such issues, the effects of FP measures and their permissibility in Islam."

Karachi-based independent consultant, Rahal Saeed, a gender and sexual and reproductive health and rights expert, said, "Overall from a policy perspective, I would say that the reason for RH rights not making inroads into policies is that inadequate attention is paid to rights per se. Many NGOs are finding that a rights-based approach to their work is unsuccessful because the rights do not exist in the first place. Therefore, for RH rights to get due position, we need concerted advocacy to ensure that the state gives us the rights in the first place, after which we can advocate for achieving those rights. If you notice, the policies, by and large, tend to focus on service delivery rather than on advocacy or rights."

"Pakistani CSOs are not enthusiastic about contraception as a right," said Hilda Saeed, a senior journalist and rights activist. From her experience of working in this field, Saeed said, "People in katchi abadis (informal settlements) and rural villages, alike, are keen to use FP. At times such people may be associated with CSOs, at other times they speak independently, but the majority is keen to practice FP. They may complain of lack of services, or fear of side effects, or prefer sons, or husband's may be reluctant to practice FP, but rarely are people or CSOs disinclined towards



FP. These needs (or understanding people's fears /reluctance) and addressing them, remain to be translated into practice with greater knowledge, and with focused advocacy aimed at inclusion of reproductive rights in a wider array of rights."

Saeed said a feasible entry point for CSOs would be to address needs first and "advocacy can follow". She said, people may be illiterate, but they're very intelligent, and we've learnt a lot from them," she added.

Iftikhar Durrani chief executive of the National Trust for Population Welfare (NATPOW) observed that: "Pakistan due to its socio-religious posture has been less sensitive on issues such as FP." Therefore FP has never been a priority in the national agenda. However, the draft Population Policy, 2010 does spell out a few actions for legislation for FP.

"I believe legislation is a must for FP services; however separating men and women on the issue will be counter-productive, since children are a common concern for both."

The Solution: Political and Civic Will

Any sensitive soul may ponder upon the question: What should and could have been done differently? If one has a magic wand or a time machine that can take one back to the past to undo the wrongs one wonders how many things one need to undo. A set of coordinated "wonders" would be needed at the macro level that would include:

- State policy - loud and clear on rights
- A legislation - that enables a woman to exercise control over her body
- An efficient system of service delivery points for health and FP
- Education for all - men and women

At the household level, frank and fair spousal communication on the number of children, spacing and contraception would yield positive results. These practical steps can prevent unrecognized tragedies from happening. The most shocking aspect is the invisibility of this tragedy and silence on this 'violence'.

[5] Source: DHS 2006-07

The Challenges Ahead

The affected party, the woman, is a unique type of victim as her victimization can neither be made public nor public leaders can go to console her. This owes its existence to not only the unawareness by the woman but also to the taboos, social norms and concepts of social shame associated with this very matter. This victim and all those women in Pakistan who are suffering from the unmet need of contraception can only be supported if an ambitious agenda to tackle several priorities is adopted at the state level by engaging concerned public, private sector and voluntary organizations with people and communities at the centre of the agenda.

The main challenge herein is how to materialize the recognition of the human rights aspect of contraception for a woman in Pakistan.

In this respect an all-inclusive approach that is based on visible and equitable participation of all stakeholders should be adopted to develop and adopt a policy on such issues. Further, there should be legislation that reflects equality between men and women by allowing women to have control over their bodies and they can use the FP method of their choice.

Men in their capacity as policy makers, controller of resources at various levels, husbands and religious leaders have to play a central role in these issues.

At the same time, women from masses and not only the women from elite NGOs must be included in such a policy dialogue and their voices must be heard.

Last but not least, the medical curriculum, deficient in contraceptive technology content must be re-examined and doctors must be trained adequately in obtaining RH history, equipped with counseling skills and imparting health education.

A Ray of Hope

The following statement by a federal minister may be seen as a ray of hope and a source of renewed optimism that silent screams and sufferings of the invisible victims may come to an end in our country.

Syed Mumtaz Gillani, Federal Minister for Human Rights, said: "Population issues, health issues and specially family planning are issues of the people and must be addressed at the grass roots. Health of women directly affects our national economy. It is sad and unfortunate that in spite of having a well established family planning programme, many Pakistani women to date suffer because of being unaware or unable to exercise contraception as a right...As the minister and elected representative of my people, I strongly believe that a lot of awareness is needed to be created among men as husbands and policy makers to establish an enabling environment where women in Pakistan, can access family planning services and adopt the method/s of their choice without any fear."

This case study has been authored by Dr. Rakhshinda Perveen. During its compilation expert opinion on the subject was sought from Syed Mumtaz Gillani, Federal Minister, Ministry of Human Rights; Mr. Iftikhar Durrani, CEO, National Trust for Population Welfare; Dr. Tariq Rahim, Managing Director, RH-AID; and Mr. Moazzam Shah, DG Public Private Partnership, Ministry of Population Welfare.