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An Analysis of Reproductive Health Issues in Pakistan

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1. INTRODUCTION

Population programmes in many developing countries have emphasised on family planning services driven largely by numbers and demographic targets. With the advent of the International Conference on Population and Development (ICPD) in 1994, it has been recognised to move beyond a narrow focus on family planning to a more comprehensive concern of reproductive health oriented towards meeting the needs of individuals and families.

This advocated shift in population and development strategy, especially in health emphasises that services be offered to women, men and adolescents with a special focus on fulfilling women's health needs, safeguarding their reproductive rights and involving men as equal partners in meeting the goal of responsible parenthood [United Nations (1995)].

In response to ICPD's mandate, Pakistan's population programme has increasingly been focussed on various aspects of reproductive health and is in the process of broadening the scope of services for a transition to reproductive health without losing focus on achieving fertility reduction goal. In this regard, the government has adopted a comprehensive population and development policy incorporating an array of reproductive health services and has integrated population and health departments and their activities in dealing with RH problems. Under the consideration that the revised programme can not simultaneously address all of the RH problems, an integrated National Reproductive Health Services Package has been developed to provide services to eligible women, men and adolescents [Pakistan (1999)]. The major components of RH package include:

- Services related to family planning for females and males;
- Maternal health care including safe motherhood and pre and post abortion care;
- Infant health care;

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- Prevention and management of RTIs/STDs and HIV/AIDS;
- RH problems of women and adolescents;
- Management of infertility;
- Management of RH related issues of men.

More recently, involvement of men as partners in supporting the reproductive health problems of their wives and as clients having their own reproductive health needs is recognised as an important component of the programme. Using the existing infrastructure and facilities in health and population welfare departments, it is planned that services will be provided through phasing of activities at different levels for raising reproductive health status of population.

Given the transitional stage of the population programme, this paper aims to examine the state of reproductive health in Pakistan on the basis of selected indicators and look into the issues related to RH status of both women and men in the socio-cultural context of the country.

Information on specific illness and problems related to reproductive health is very limited, particularly for men and adolescents in Pakistan. Data available from some national level surveys indicate selected aspects of RH including those on fertility, family planning, antenatal and postnatal care, delivery and infant health which provide a general and broad view of the state of reproductive health in Pakistan. However, specific information related to other RH problems such as sexually transmitted diseases, reproductive complications and infections, infertility, abortions, reproductive health education and healthy sexuality is scarce and not available on national and provincial levels. The present study, therefore, relies primarily on information available in the 1996-97 Pakistan Fertility and Family Planning Survey (PFFPS) for assessing the reproductive health issues of women, and on some micro-level independent studies to fill in the data gaps on selected RH issues of men.

2. REPRODUCTIVE HEALTH STATUS: A BROAD VIEW

In spite of gradual improvement in some of the health indicators over the past decades, the reproductive health status of population in Pakistan remains much below the desired level when compared with countries of similar socio-economic conditions. It is observed that family planning and health services and supplies have not been adequate to meet the needs and demands of fast growing population, resulting in severe health problems for young children and their mothers, especially those belonging to poor households and living in rural areas.

A general view of reproductive health status indicators reveals that fertility levels have remained high (TFR is around 5 births per woman) with low contraceptive use (24 percent in 1996-97), resulting in large family size with closely spaced children. Infant mortality rate, though declining, is estimated to be around

85–90 per 1000 live births, and excess mortality is evident among girl children than boys between 1–4 years of age, suggesting gender discrimination in child health care and nutrition.

Many women have high risk of dying due to pregnancy and childbirth complications, especially in rural areas. As such, maternal mortality rate remains high at 340 per 100,000 live births, but other sources give estimates ranging from 286 in Karachi's urban settlements to 756 in rural Balochistan [ADB (1997)]. Research evidence shows that almost 80 percent of maternal deaths are due to direct obstetric causes resulting from antepartum and postpartum hemorrhage, reproductive infections and edampsia, whereas hepatitis is the most frequently cited means of maternal death from indirect causes [Tinker (1998)]. A few community and hospital based studies in the city of Karachi have highlighted that delayed referrals is a key risk factor for high maternal mortality which relates to inadequacies in maternal services, problems in access to health facility, and delayed decision-making at the family level in case of emergency [Fikree (2000)].

Moreover, the unmet need for family planning remains as high as 38 percent resulting in substantial number of unwanted pregnancies and unsafe abortions with adverse implications for the health of mothers and children. Infants also have high risks of death from birth related complications and infections such as diarrhea, pneumonia and respiratory infections which are closely related to mother's health and quality of antenatal and postnatal care.

The prevalence of other reproductive health problems such as sexually transmitted diseases (STDs) and HIV/AIDS is relatively low in Pakistan as compared to other countries in the world. However, it is recognised that patterns of health behaviour which can rapidly facilitate an epidemic spread of HIV/AIDS infection are widespread among men. Most women have problems in discussing the issue with their husbands due to social and cultural barriers and have limited knowledge about the vulnerability of the problem [MoH/UNAIDS (2000)].

A number of factors have contributed to keeping the reproductive health status low in Pakistan. While poverty and an inadequate health care system in terms of supply and management problems underlie the poor health status of the population in general, women face peculiar additional risks because of their reproductive characteristics and low socio-economic status. Hence, provision of RH services need to be based on the socially-embedded gender dynamics in various stages of the life cycle, on the different and changing needs of both genders and their interaction, and on how decisions are made in the acceptance and utilisation of services. In this context, socio-cultural aspects that affect and shape reproductive health motivations and behaviour are important in understanding key issues in the utilisation of services more effectively and in assessing the gaps in knowledge, concepts and notions relating to RH. This will help to identify significant areas of programme intervention. The following sections of the paper will therefore focus on analysing

reproductive health issues of women and men in the socio-cultural context of Pakistan and their implications for reproductive health programme.

3. REPRODUCTIVE HEALTH ISSUES OF WOMEN

Women's reproductive health is not just confined to reproductive years of life (15–49 years), it is rather related to different stages of life cycle i.e., infancy and childhood; adolescence; adulthood; and older age; reflecting different RH needs and behaviour. The current estimate of women of reproductive age (15–49 years) is 28.5 million in Pakistan, nearly 46 percent of total female population [Pakistan (1998)]. This and a large magnitude of young adolescents about to enter their reproductive years would be exposed to pregnancy and childbearing problems unless quality of care and effective RH services are not offered within the realm of socio-cultural norms and affordable costs. In general, women's reproductive health issues can be divided into three major categories such as healthy sexuality; safe pregnancy and childbearing; and intended births [Tsui *et al.* (1997)]. Due to data limitations on sexuality and related issues, the present analysis will focus on the other two areas of concern.

(a) Safe Pregnancy and Childbearing

A women's health is said to be at risk if she gives birth to a child "too early, too late, or too frequently". The socio-cultural norms in Pakistan expose women to all of these risks. The social pressure to marry off daughters at an early age is still prevalent. Hence, many young women get married early, and are expected to bear a child soon after marriage and to continue childbearing in late years of life. Some of the issues related to women's marriage and childbearing behaviour are discussed below.

(*i*) *Age at Marriage*

Early marriage is still a norm in Pakistan. Evidence from 1996-97 PFFPS data shows that the median age at marriage for females (aged 25–49 years) is 18.3 years. Even in major urban areas, it does not go beyond 19 years (Table 1). Hence, there is not much variation in median age at marriage among urban and rural residents ranging from only 18.2 years in rural areas to 19 years in major urban areas.

It is interesting to note that there is virtually no significant difference between the median age at marriage for younger and older age groups as the median age at marriage remains 18.3 for women aged 25–29 years compared with 18.7 years for 45-49 years old. This supports the argument that the socio-cultural norm of marrying early is still strong and prevalent in Pakistan. However, education of women is the only factor contributing to increase in age at marriage. For example, with each increment in level of education, age at marriage is delayed by one year or more. Overall, age at marriage for above secondary education is four and a half-years higher (22 years) than for illiterate women (17.7 years).

Table 1

Median Age at First Marriage Among Ever-married Women Ages 25–49 Years

Characteristics	Current Age					
	(25-29)	(30-34)	(35-39)	(40-44)	(45-49)	All Ages 25-49
All Women	18.3	18.0	18.3	18.4	18.7	18.3
Residence						
Major Urban	20.2	18.2	19.0	18.4	18.3	19.0
Other Urban	18.4	17.9	18.2	18.3	18.3	18.2
Rural	18.1	18.0	18.2	18.4	18.8	18.2
Education						
None	17.2	17.2	17.8	18.3	18.2	17.7
Primary	19.3	18.3	19.1	20.2	19.9	19.3
Middle	18.7	20.3	19.5	17.8	19.0	19.2
Secondary	21.6	19.3	19.8	19.3	21.3	20.0
Above Secondary	22.3	22.9	21.6	18.7	22.8	22.0

Source: Adapted from PFFPS 1996-97.

Getting married at a young age exposes many women to face the biological and social demands of marriage and childbearing. The challenge is compounded further by lack of related knowledge, as discussing and seeking knowledge about sexuality and childbearing before marriage are generally considered a taboo in the society. It is usually with time and experience that women get the confidence and mobility to learn about RH issues. Young age and lack of awareness puts women in a disadvantageous position in relation to their husbands and in-laws to have some say in seeking appropriate health care.

(*ii*) *Teenage Motherhood*

A substantial proportion of women get married during adolescence (13–20 years) and are under societal pressure to produce an offspring. Hence, early marriages are generally followed by early pregnancies. Teenaged mothers and their children are at increased risks of social and health problems. The 1996-97 PFFPS data show that over 10 percent of the teenaged females have begun childbearing. Of these, 7.5 percent have already become mothers, while 2.6 percent are pregnant with the first child (Table 2).

Table 2

Percentage of Teenage Mothers Aged 15–19 Years and Those Pregnant with First Child

Characteristics	Teenagers who are	
	Mothers	Pregnant with First Child
All Women	7.5	2.6
Residence		
Major urban	4.6	0.8
Other urban	4.7	1.5
Rural	9.0	3.4
Province		
Punjab	6.0	2.2
Sindh	7.5	2.6
NWFP	12.7	3.2
Balochistan	10.6	5.1
Education		
None	12.5	5.0
Primary	6.9	2.3
Middle	1.9	0.7
Secondary	0.9	0.8
Above Secondary	1.9	0.2

Source: Same as Table 1.

Rural areas have a much higher incidence of teenage pregnancy (12.4 percent) as compared to major urban (5.4 percent) and other urban areas (6.2 percent). Among provinces, teenage fertility is the highest in the NWFP and Balochistan (16 percent), followed by Sindh (10 percent) and Punjab (8 percent). Education, as expected, is inversely related to the initiation of childbearing. Only 2.1 percent of women with above secondary education have started childbearing, while the proportion is 17.5 percent for illiterate women.

These data, thus show that teenage motherhood is more common among rural residents and those with little or no education. These sub-groups of women with lack of awareness about RH issues and limited experience of managing pregnancy related problems are most vulnerable to face the adverse effects of teenage motherhood. Efforts are, therefore, needed to develop IEC programmes for young mothers to increase their knowledge about the hazardous effects of early childbearing besides providing other social and economic opportunities for young women to uplift their status and prepare them for role of motherhood.

(iii) Antenatal, Postnatal Care, and Post-delivery Family Planning Advice

Regular and timely ante and postnatal care check ups are important to safeguard the health of women and the child during and after pregnancy. The data show that only 36 percent of women received antenatal care and 23.7 percent had postnatal care (Table 3). Age of mother shows an inverse relationship with antenatal care as higher proportion of younger mothers get antenatal care (38.9 percent) than older ones (29.8 percent), while the reverse is true for postnatal care where women beyond age 25 are more likely to go for postnatal care. This may be related to the fact that relatively older women with greater frequency of childbearing face greater maternal and child problems and realise the need to get postnatal care and also have lesser social barriers in mobility to seek such care. However, urban women show much higher antenatal and postnatal care received than their rural counterparts. As expected, the positive impact of education on receiving natal care is also evident in Table 3 as 80 to 96 percent of women with secondary or above education get this care. Considering that majority of women in Pakistan are still illiterate and live in rural areas, it is but logical that the country's female population is at much higher risk of suffering from maternal infirmities and related RH problems due to their neglected health seeking behaviour during pregnancy.

Table 3

Percentage of Births who Received Natal Care and FP Advice

Characteristics	% Receiving Antenatal Care	% Receiving Postnatal Care	% Receiving FP Advice within 3 Months of Delivery
All Women	36.0	23.7	11.0
Mother's Age at Birth			
<20	38.9	17.1	5.2
20–24	36.8	22.7	10.4
25–34	36.8	24.8	11.0
35+	29.8	26.2	16.1
Residence			
Major Urban	76.5	35.5	20.1
Other Urban	50.1	28.0	14.5
Rural	26.9	21.0	18.9
Education			
None	24.5	20.8	18.0
Primary	51.7	31.3	16.1
Middle	74.0	36.7	18.3
Secondary	79.7	29.8	29.3
Above Secondary	96.4	48.4	22.0

Source: Same as Table 1.

Seeking family planning advice within three months after delivery is considered important for the health of the mother and child. Figures in Table 3, however, show a dismal situation. Only 11 percent of women reported to have taken advice on family planning within 3 months of birth. Even in major urban areas and among the more educated women, the proportion seeking family planning advice remains very low (20 percent and 22 percent, respectively).

(iv) Place of Delivery

Health of the mother and that of the newborn largely depends on the conditions in which the birth is given. Lack of proper hygiene and medical care can give rise to complications that could be life threatening for both. In Pakistan, the age-old tradition of giving birth at home is still strong as majority of the births take place there. The evidence shows that 83 percent of the births take place at home in the country, while only 8 and 9 percent of deliveries occur in the government and private hospitals/centres, respectively (Table 4). In rural areas, about 98 percent of deliveries occur at home compared with 45 percent in major urban and 78 percent in other urban areas. Age and education of the mother show a positive relationship with the use of government or private hospitals and clinics showing lesser proportion of women giving birth at home.

Table 4

Percentage Distribution of Births by Place of Delivery

Characteristics	Home	Govt. Hospital/Centre	Private Hospital/Clinic
All Women	82.7	7.8	9.4
Mother's Age at Birth			
<20			
20–24	80.3	13.3	6.5
25–34	82.3	10.4	10.3
35+	82.7	7.3	9.9
	85.6	6.7	7.7
Residence			
Major Urban	45.1	21.6	33.4
Other Urban	78.8	9.6	11.6
Rural	98.9	5.2	4.9
Education			
None	91.1	4.5	4.4
Primary	77.1	12.5	10.3
Middle	55.8	23.5	20.8
Secondary	58.4	13.3	27.9
Above Secondary	15.9	18.9	65.2

Source: Same as Table 1.

Despite substantial increase in knowledge and positive attitudes towards using family planning services, figures in Table 4 show that a significant majority of women still resort to seeking traditional means of health care, especially among poor rural and uneducated families. This includes using Traditional Birth Attendants (TBAs) and mother-in-law as service providers for delivery. Childbirths assisted by untrained personnel in unhygienic and unsafe conditions increase the risks of many infections and delivery complications. The evidence shows that more than 60 percent of deliveries are assisted by untrained TBA and family members [PIHS (1996-97)]. The most common reasons cited for using traditional means of childbirth are being less costly, more convenient as it avoids travel costs and time and leaving home, and because of normative behaviour in the village.

(v) Infant Care: Neonatal and Post-neonatal Mortality

Neonatal and post-neonatal mortality is often caused by endogenous causes, the roots for which lie in the poor reproductive health of the mother. Complications of pregnancy and delivery are accompanied by health problems that affect the child, especially in case of neonates. Pakistan has very high infant mortality rate (around 90 per 1000 live births) with neonatal mortality having a major share in it (Table 5).

Table 5

Neonatal and Post-neonatal Mortality

Characteristics	Neonatal Mortality	Post-neonatal Mortality
All Women	54	40
Residence		
Major Urban	30	30
Other Urban	57	34
Rural	58	42
Education		
None	61	47
Primary	43	24
Middle	43	8
Secondary and Above	10	30
Maternal Care		
Only Antenatal	43	33
Antenatal and Postnatal	25	29
Only Postnatal	64	37
None	54	45

Source: PFFPS (1996-97).

As the table shows, positive impact of mother's education and urban residence on child survival is significant. Rural areas having less medical facilities and being more tradition bound have higher mortality rates as compared to urban areas. For example, neonatal mortality in major urban areas is almost half of that in rural areas (30 vs. 58 per 1000 live births). This fact can be related to earlier discussion which showed that the proportion of women receiving maternal care is much lower in rural areas, and most women deliver babies at home, thereby increasing the risks of neonatal mortality. These findings are supported by figures in Table 5 which show that women receiving both antenatal and postnatal care have the lowest neonatal and post-neonatal mortality (25 and 29 per 1000 live births, respectively) than those who receive no natal care at all (54 and 45, respectively).

(b) Intended Births

Women should only give birth when she is willing and have planned to do so. Unintended births form one of the main issues of reproductive health for women. Reducing unwanted pregnancies improve maternal health mainly by reducing the times a woman is risked due to pregnancy and childbearing in poor conditions [Tsui *et al.* (1997)]. In Pakistan, the total fertility rate (TFR) is as high as 5.4, the ideal family size is 4.3 children and the contraception prevalence rate (CPR) is not widespread (only 24 percent), it is but consequential that women would have high rate of unwanted births.

(i) Unwanted Births

Comparing the total wanted fertility rate (TWFR) with the actual total fertility rate (TFR), it becomes evident that 1.4 births, on average, are unwanted (Table 6). The magnitude of unwanted births by provinces shows that Balochistan and NWFP have almost twice number of unintended births (2.0) than that in Sindh (1.0). Level of education shows the smallest magnitude of unintended births, thereby reaffirming the fact that educated women are more likely to meet their reproductive goals than women with no education.

An important cause of large gap between intended and actual births is the low CPR in the country, the reasons for which have been widely discussed in a number of studies. All these studies show that despite supply related constraints, the socio-cultural values and gender inequality issues perpetuated in the society are important factors affecting the family planning behaviour and reproductive health status of women [Mahmood and Ringheim (1996); Sathar and Kazi (1997); Mahmood (1999); Agha (2000)].

Table 6

Total Wanted Fertility Rate and Total Fertility Rate

Characteristics	Total Wanted Fertility Rate	Total Fertility Rate	Unwanted Births
All Women	4.0	5.4	1.4
Residence			
Major Urban	2.7	3.9	1.2
Other Urban	3.5	4.8	1.3
Rural	4.5	5.9	1.4
Province			
Punjab	3.9	5.3	1.4
Sindh	4.0	5.0	1.0
NWFP	3.9	5.8	1.9
Balochistan	5.1	7.1	2.0
Education			
None	4.5	6.0	1.5
Primary	3.4	4.9	1.5
Middle	3.1	4.4	1.3
Secondary	2.3	3.1	0.9
Above Secondary	2.9	3.5	0.6

Source: Same as Table 1.

(ii) Abortion

Unwanted pregnancies and high unmet need among women in Pakistan lead many to resort to unsafe and illegal abortions. Such practices are a cause of concern for reproductive health of women due to increased risks of maternal morbidity and mortality. Being illegal officially, except under certain medical conditions, untrained and unqualified people generally carry out abortions, which is reflective of denying women their reproductive and sexual rights, and high prevalence of unmet need in Pakistan. The ever-increasing numbers of street-side clinics operated by untrained personnel or paramedics are conducting unsafe abortions adding to the severity of reproductive health problems especially for women belonging to lower income groups and low levels of education. In general, incidence of abortion among Pakistani women is considered to be high, but no precise estimates are available. It is believed that abortions are generally underestimated due to social stigma and guilt attached to the event.

The evidence available from various micro-surveys shows that the Induced Abortion Rate (IAR) is quite high in the country. One survey indicates it as high as 25.5 induced abortions per 1,000 women aged 15-49 years. Of these, an alarming 69 percent had post-abortion complications [Fikree (2000)]. Of all the maternal mortality

and morbidity reported by hospitals in a survey, 2 to 12 percent instances were contributed by induced abortions [Fikree (2000)]. Results of another study on RH indicate that although a significant proportion of women are aware about having abortions in case of mother's health at risk (65–70 percent), it is found that knowledge about side effects of abortion is not so high as only 27 percent of sampled women reported 'woman's life at risk' due to induced abortion [Hakim and Zahir (2000)].

This situation suggests that there is need to improve the management information system on RH to get an accurate assessment of abortions and their related effects on women's health. Moreover, information and education campaigns through mass media and other channels should be enhanced to raise levels awareness of women about the adverse effects of abortion in addition to providing quality of care.

4. REPRODUCTIVE HEALTH ISSUES OF MEN

As involvement of men in reproductive health and family planning is recognised as important component of Reproductive Health Services Package of Pakistan, it becomes important to examine their RH status and role in accepting and utilising those services.

Pakistan's population programme in the past has largely focussed on females with small and sporadic attempts made to provide services to men. The Continuation Motivation Scheme (CMS) in 1970s focussed on motivating men for family planning, but since its discontinuation in 1977, no other programme has specifically targeted men. Limited success of family planning programme without men's participation, and the threat about the spread of STDs and AIDS has raised concern about targeting men in RH policy and programme.

For analysing men's RH issues, very little information is available about their RH problems, needs, and their knowledge and attitudes. A couple of national level surveys provide data on husbands' family size preferences and family planning related questions. [PDHS (1990-91) and PSOMA (1994)]. However, considering the important role of men as partners in reproductive health and family planning, some micro-level studies and focus group discussions have been conducted by NGOs and some independent organisations which provide useful insights into men's RH issues and related behaviour [Douthwaite (1998); Ali (1999); Miller and Ali (2000)].

(a) Knowledge of Reproductive Health

Men's knowledge of reproductive health pertains mostly to family planning and related behaviour. The available evidence shows that there has been an increase in awareness about family planning methods among men from 79 percent in 1990-91 to about 85 percent in 1994 [NIPS (1992); Bhatti and Hakim (1996)]. While knowledge among women is almost universal, 10 percent of husbands are not aware

of any contraceptive method at all [Population Council (1997)]. Husbands tend to know about male methods more than women, but are less aware about female methods. Men report that the major sources of information on family planning and RH are friends and relatives (for condom and pills), their wives (for IUD and injectables), and health education messages through mass media. However, men's knowledge about specific RH issues such as RTIs/STDs, infertility, abortion, etc., is very low. Survey conducted on male attitudes towards RH indicates that a very small proportion (less than 10 percent) of men have a basic understanding of the conception process, the mechanism behind withdrawal and issues, related to sexuality. Most men have indicated a keen desire to learn more about RH and reproductive physiology [MoPW and Population Council (1996, 1998)].

(b) Attitudes and Practice of Family Planning

The commonly held view that men are generally against family planning and women often cite husband's disapproval as a major reason for non-use of contraception is not supported by the available data on men's attitudes towards family planning. The evidence shows that about 60–70 percent of men approve of family planning and this percentage is higher for those living in urban areas and with higher levels of education [NIPS (1990-91); Mahmood (1998)]. Information available from the Unmet Need Survey indicates that as compared to women, men appear to view contraceptive methods more positively as they perceive specific methods to be less expensive and are less concerned about their side effects (Table 7).

Table 7

Perceptions of Husbands about Contraceptive Methods among those who have Reported Knowledge

	Approves FP		Expensive to Obtain		Bad Effects on Health	
Method	Husband	Wife	Husband	Wife	Husband	Wife
Pill	42.9	39.5	11.5	21.0	30.7	48.9
Condom	48.7	44.6	6.5	12.5	14.4	18.4
IUD	37.8	33.1	16.3	41.0	38.7	73.0
Injection	43.3	48.2	20.2	38.2	19.7	42.2
Sterilisation	43.3	54.4	26.1	23.4	27.5	43.0
Withdrawal	61.2	83.1	–	–	2.4	2.4

Source: Adapted from Population Council (1997).

However, evidence from other studies suggests that men are more hesitant about revealing contraceptive use or sexual activity than women as they feel inhibited to discuss things openly due to socio-cultural norms and are more concerned about the moral and religious acceptability of family planning [MoPW and Population Council (1996; 1998)]. Regarding other reproductive health problems such as STDs, male potency and sexuality, there are many misconceptions and low level of awareness among men. Generally, males perceive that *hakims* and traditional healers understand their RH problems better and are more accessible, and less costly.

With increased knowledge and use of contraception in Pakistan, male methods are observed to contribute a significant and increasing share to the overall CPR. The gains in use of male methods, especially the condom and withdrawal are greater than any other method (Table 8). It is likely that the concerns about the adverse side effects of hormonal and clinical methods has contributed to increase use of male methods. Moreover, social marketing campaigns to promote condom supply and its use have also increased its popularity.

Table 8

Male Methods of Contraceptive Use

Methods	PDHS 1990-91	PCPS 1994-95	PFFPS 1996-97
Condom	2.7	3.7	4.2
Withdrawal	1.2	4.2	4.6
Vasectomy	0.0	0.0	0.0
Abstinence	1.3	1.0	1.9

Source: Same as Table 1, PDHS 1990-91 and PCPS 1994-95.

The widespread use of withdrawal as traditional method has contributed to a significant overall increase in CPR. It is believed that fear of side effects of modern methods and faith in the effectiveness and legitimacy of using traditional methods have increased its use. On the contrary, vasectomy remains a very unpopular and unacceptable method of contraception among men. Reasons given in the literature for poor utilisation and awareness of vasectomy are weak commitment from the government and NGO sectors and lack of availability of such services for men [Rosen and Conly (1996)].

(c) Other Reproductive Health Concerns of Men

With limited knowledge about specific RH issues, men tend to seek advice and treatment for their problems from traditional healers, *hakims* and homeopaths, especially in rural areas. Widespread advertisements publicising about ‘guaranteed’ treatment of male sexual problems by *hakims* and other clinics managed by quacks in cities and small towns attract many male clients who perceive those providers having

more privacy, knowledge, and are considerate towards the treatment of RH problems [Douthwaite (1998); Miller and Ali (2000)]. Evidence from other studies suggests that men express suspicion of overcharging by allopathic providers and complain about their unfriendly attitude or poor quality of care and medicines provided.

The dearth of information about men on STDs and HIV/AIDS limits the possibility of accurately assessing the prevalence of the disease. Poor social and economic conditions make the men highly vulnerable to these type of RH problems, who in many instances, resort to harmful and unsafe traditional treatment having adverse effects on their health. This situation calls for developing an advocacy/IEC strategy directed to men to avoid unsafe health seeking behaviour. Also, health education programmes through various channels of mass media and community based workers need to be initiated to raise awareness among men of RH risks and to promote responsible sexual and reproductive behaviour keeping into consideration the socio-cultural norms and gender relations in the society.

5. CONCLUSION AND IMPLICATIONS

This analysis has revealed that Pakistani women and men are faced with a number of reproductive health problems. Maternal mortality rate being one of the highest in the world, is primarily related to pregnancy and childbirth complications which arise because of their own neglect in seeking appropriate health care. Social and economic constraints in accessing services and inadequacies in health care system for obstetric emergencies, are additional causes of high MMR, especially in rural areas. To improve this situation, there is need to raise the level of awareness among women of the danger signs which indicate the need to seek emergency care immediately, and to inform them about the availability of such services at the nearest location. Moreover, reproductive health education programmes should be enhanced to raise the knowledge about RH issues.

Men's knowledge and attitudes regarding RH pertain mostly to family planning and related behaviour, with little information on issues such as STDs, male potency and sexuality. There are many misconceptions and low level of awareness among men about these problems which lead them to seeking unsafe and traditional means of health care. In this regard, information concerning different perspectives on sexuality, and appropriate health behaviour is required besides increasing awareness about the reproductive health risks of their wives. Hence, effective IEC and support programmes are needed for clarifying the commonly held myths and notions concerning RH, and for raising the level of awareness regarding RH problems among both women and men.

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COMMENTS ON

AN ANALYSIS OF REPRODUCTIVE HEALTH ISSUES IN PAKISTAN

Reproductive Health, in the light of 1994 International Conference on Population and Development (ICPD) held at Cairo, is an important emerging new area in Pakistan in the context of its comprehensiveness. The efforts of the authors, Dr. Noushin Mahmood, Chief Researcher and Durr-e-Nayab, Research Demographer, PIDE, are appreciated for presenting paper on this important area which I hope will generate interesting discussion. Although, the paper is mostly based on the narration of literature review, yet it has provided chance to share important findings about reproductive health from various studies, in particular, Pakistan Fertility and Family Planning Survey 1996-97. As a discussant, I am offering few comments and suggestions so that they can improve this paper.

Surveys with different methodologies and scope such as national level, provincial level, district level, or of purpose sample have been compared and inference drawn. This fact need to be reflected in the description There are contradictory statements about male attitude and behavior, which need to be supported with evidence.

No doubt, male methods, use of withdrawal and condoms have increased over the period of time, yet the proportion in condom use is not as high as that of overall national level rise in contraceptive prevalence rate, from 1990-91 to 1996-97. The statement that “gains in use of male methods, especially the condom and withdrawal are greater than any other method” is not based on facts. The factual position is that compared to condom, proportion increase in the use of Pill, IUD, Injectables, Female Sterilization has been higher from 1990-91 to 1996-97.

It appears that with an increase in demand for family planning, there has been an increase in the use of withdrawal. Another important aspect about the profile of users of withdrawal is that they are mostly living in urban areas and are comparatively educated. This suggests that there is to some extent shift from condom to withdrawal. Non availability of contraceptive may be another possibility for this change. The assumption

that side effects of hormonal methods might have contributed to rise in male methods cannot be considered true unless based on empirical evidence because there has been equally an increase in other methods over the period of time.

Few other important components of reproductive health, such as, infertility are missing which possibly could have been considered. Since the paper aims to examine the state of reproductive health in Pakistan, it need to include the current status of various reproductive health components covered in the service delivery infrastructure of both Ministries of Health and Population Welfare as well as by the civil society and the missing gaps need to be highlighted, in particular, quality, coverage and understanding major components of reproductive health package both by the service providers and clients.

There is cursory mention about population and development policy. In fact there is a RH Policy also which is being coordinated by Planning and Development Division of which authors may like to make reference.

While discussing safe pregnancy and child bearing, it is mentioned that a woman's health is said to be at risk if she gives birth to a child "too early, too late, or too frequently". It is true, but in Pakistani context I would like to add its "too early, too close and too frequent births", which put the health of both woman and her children at risk.

Finally, for such an important area, there is need to bring all important points in the conclusion and policy implications. I think policy implications need more elaboration and coverage. There is an important review available in the Ministry of Population Welfare and NIPS which was prepared for ICPD+5 in 1999; which authors may consult to update their paper.

Thank you.

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Director