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Women Health in Pakistan: An Analysis of Millennium Development Goals (MDGS) Through Locally Constructed Indices

Abstract

The threats to instruments and strategies of women health and consequent empowerment in Pakistan are vivid as far as episodes of the past two decades are concerned. How far these potential threats proved detrimental to the Millennium Development Goals (MDGs) has been an un-answered question of the period. The main objective of this study was to evaluate women health in terms of Pakistan's achievement in MDG 5 and also in comparison with its neighboring countries (i.e. India, Bangladesh and Sri Lanka). Being a literature-based study multiple sources of secondary data were accessed through their websites. To double-check the results of the analysis made through locally constructed indices, the findings were triangulated by the In-Depth Interviews (IDIs) of 30 welfare personnel of the country as well as by the UN indices (GDI and GEM). The analysis leads us to the fact that women health in Pakistan is residual in nature.

Key words: Millennium Development Goals (MDGs), Women Health, Residual

Introduction

Prior to 1990, countries of the world had been improving their people's abilities without having a unanimously agreed upon set of activities. Everyone was beating his own trumpet. Absence of a standardized schema made it difficult for a country to measure her success or failure. And, hence, the audit of a country's performance was equally difficult. Although the UN Declaration of Human Rights emphasized welfare activities yet did not tell the *modus operandi* to do them. This problem was solved when in 1990 United Nations set forth Human Development Index (HDI) as a plea to help countries standardize their welfare efforts (Desai, 1991).

Afterward in 2000, Millennium Declaration was signed by the leaders of all the countries of the world gathered at the United Nations, New York. Through this Declaration, the year 2015 was set as the date to reach specific targets aimed at reducing poverty, improving healthcare, expanding education, protecting the environment, and promoting equality between men and women. These targets,

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which are 8 in number, had been named Millennium Development Goals (MDGs) (UNDP, 2015). Since 2000, every UN member has set specific targets and reports back to the United Nations on whether or not it is meeting these goals.

Of all the eight goals most of them are related to women. Regarding enhancement of women's status United Nations has been devising various instruments and strategies like the **Commission on the Status of Women (CSW), UN Division for the Advancement of Women (DAW), UN International Research and Training Institute for the Advancement of Women (INSTRAW),** UN Development Fund for Women (UNIFEM) and Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (UNO,2014) .And from amongst them, CEDAW is the main UN effort in favor of gender equality in the world (Charlesworth *et.al*,1991) . Around the world CEDAW is considered to be the Bible of women rights. Pakistan is a signatory to CEDAW (APWLD, 2006). Gender related Millennium Development Goals (i.e.MDG3&5) reflect the focal areas of CEDAW. Of these two goals, Goal 3 is concerned with gender equality and empowerment whereas Goal 5 is about improving maternal health. But it's a pity that none of the Pakistani government showed seriousness in proper implementation of this Convention in letter and spirit and henceforth these two goals. No doubt, she enjoys a better status than most of the women in the Islamic world (ADB, 2000), but it's yet to be ascertained whether she actually enjoys the status of good health or not.

Health has always remained on the periphery of the development landscape and women's health has always been considered as an important indicator of their status in a community. Therefore, Goal 5 is basic to all the gender-related goals. Also, it's high time to evaluate and take stock of what we have gained and what lost during the last 15 years.

The main objective of this study was to evaluate women health in terms of Pakistan's achievement in MDG 5 and also in comparison with its neighboring countries (i.e. India, Bangladesh and Sri Lanka).This article is an eye-opener which has been written in the light of latest UNDP report (i.e.2014). This piece of writing not only shows the plight of Pakistani women's health but also a comparison across-the-border (i.e. with India, Bangladesh and Sri Lanka).

Methodology

Following the statistical design of the widely-used Human Development Index (HDI), the indices using indicators of MDG5 were constructed to measure women's status of health (hereafter WSH) in Pakistan. The results were triangulated by the In-Depth Interviews (IDIs) of 30 randomly selected welfare personnel of the country. For this purpose an interview guide was used as a tool of data collection. These interviews were coded as 'SWPI' standing for 'Social Welfare in Pakistan Interview'.

The general formula for the construction of indices was:

$$\textit{Index} = \frac{\text{Given Value of the Indicator} - \text{Minimun Value of the Indicator}}{\text{Maximum Value of the Indicator} - \text{Minimum Value of the Indicator}}$$

In order to decide level of progress the researcher fixed cut-offs based on range of values as follows:

Range	0.000-0.166	0.167-0.333	0.334-0.500	0.501-0.667	0.668-0.834	0.835-1.000
Level	Lowest	Low	Low-to-Medium	Medium-to-High	High	Highest

The chief reasons of selecting the above neighboring countries are their similarities with Pakistan with regard to their political environments and norms concerning with WSH. The researcher has incorporated only those indicators of MDG5 which are unanimously adopted by all the four countries. As has been said earlier, the evaluation is based on United Nations Asia Pacific MDG Report 2014(Human Development Report 2014: Sustaining Human Progress, Reducing Vulnerabilities and Building Resilience). The reasons of making the Millennium Development Goals (MDGs) as basis of analysis are justified by the fact that (i)they address nearly all aspects of human welfare in terms of development;(ii) they do not represent abstract ambitions but are fixed and time-bound ; and (iii)they are basic to addressing poverty in its many dimensions. The Goals adopted by Pakistan are provided in Annexure-I. All the Eight (8) goals clearly advocate gender equality. But only two of them are directly related to women welfare which are:

MDG5. Improve maternal health: A mother's education, income, and empowerment have a significant impact on lowering maternal mortality.

MDG3. Promote gender equality & empower women: This central goal dedicated to gender equality and women's empowerment depends on the achievement of all other goals for its success.

We will confine our study to MDG5.

Analysis

(A) MDG5: Improve Maternal Health:

As has been said above, this goal and its underlying indicators are related to women health. This goal will be evaluated by constructing a Women's Health Index (WHI). The major indicators involved to construct this index will be:(i) Life Expectancy & Maternal Mortality Ratio; (ii)Ante-Natal Care (ANC) & Skilled Birth Attendance (SBA); and (iii) Contraceptive Prevalence (CP) & Fertility Rate (FR):

(i) Life Expectancy and Maternal Mortality Ratio: Maternal mortality is considered to be the major cause of women's death in the world. About 1500 women die daily in the world from pregnancy- or childbirth-related complications. A total of 99% of maternal deaths occur in the countries where 85% of the world's population resides. More than one third of these deaths occur in South Asia. Maternal mortality ratio in developing countries is 1100 maternal deaths per 100,000 live births versus only 2 in developed countries. Pakistan and Bangladesh led the region in Maternal Mortality Rate having 260 and 240 respectively during

the year 2014 whereas India and Sri Lanka had 200 and 35 respectively. The situation in Sri Lanka is, hence, very encouraging in the region (UNDP, 2015). The Maternal Mortality Ratio of Pakistan declined from 350 in 2001-02 to 276 in 2006-07. We have achieved MTDF target. However, in order to achieve MDG5, a dedicated effort will be required (GoP, 2013).

(ii) Ante-Natal Care (ANC) and **Skilled Birth Attendance (SBA):** MMR depends upon ANC and SBA, which are particularly neglected areas of health in South Asia (UNDP, 2010). Pakistan and Bangladesh lag in both of these indicators. In ANC Sri Lanka scores 99.4, India 74.2, Pakistan 60.9 and Bangladesh 54.6 whereas in SBA Sri Lanka, consequent upon the high ANC, tops the region with a percentage of 99, followed by India with 67.But both Pakistan and Bangladesh at 52 and 31 respectively.

The major reason of this fall is that majority of women reported that they are not allowed to go to a health facility unaccompanied and have to seek permission for that, typically from a male household member (Save the Children, 2009) who usually refuses.

(iii) Contraceptive Prevalence (CP) & Fertility Rate (FR): Fertility rate is defined as number of children born to a woman till her childbearing age. More contraceptive prevalence can reduce fertility rate. Pakistan and India are the countries with high fertility rates. Pakistan has very high FR in the region (i.e.3.2 births per women) (WHO, 2014) which is due to its very low CP (27 percent).FR of Sri Lanka is 2.3, of India is 2.5 and of Bangladesh is 2.2 respectively whereas CP of Sri Lanka 68, India55 and Bangladesh 61. A UNICEF Report had already warned that lack of trained and appropriately deployed health providers is an underlying cause of Pakistan's health problems (UNICEF, 2011).

The formula used for computation of WHI is:

$$WHI = \frac{\text{LE Index} + \text{ANC Index} + \text{SBA Index} + \text{CP Index} - \text{MMR Index} - \text{FR Index}}{6}$$

The comparison based on WHI has been shown in Table No. 1 below.WHI value of Pakistan is 0.4022.It is far less than that of Sri Lanka, slightly more than Bangladesh and fairly less than India. This is due to the two weak areas; low percentage of SBA and CP indices.(It should be noted that Maternal Mortality Ratio and Fertility Rate are negative indicators.)

Lankan health model is a success in the region with 63.55%. Among the rest India is at Low-to-Medium (49.13%) level, somewhat better than both Pakistan and Bangladesh showing progress percentages of 40.22 and 40.07 respectively. Pakistan's weak areas, as noted above, are low SBA, very low CP and the highest FR in the region. Bangladesh is deficient in nearly all the constituents. It is a country with a high MMR 240 per 100,000 live births, lowest ANC and SBA (i.e. 54.6% and 31% respectively).Although Pakistan is worse than Bangladesh in LE, MMR, CP and FR, yet it is better in ANC and SBA.

It can be concluded from this discussion that except Sri Lanka, the rest three countries possess a residual type of women health status. Lack of facilities as well as poor access to the available facilities has come out to be the major reasons

of the above weak areas. About the lack of facilities an officer is being quoted here verbatim:

"Best quality state-based health services must be available to every woman at her doorstep. But unfortunately this doesn't happen. In otherwise case, usually family or household takes this responsibility (Iqbal, 2013).

Defending the state another officer said:

State should not be blamed in this matter. Services are there. But it is due to the Pakistani culture that women are not allowed to avail them (Iqbal, 2013).

But state is responsible:

We spend only 0.8% of the GDP on health. Do you think this amount sufficient to provide good health cover for all the segments of society? Certainly not! The government fails to provide adequate health cover to the vulnerable segments of the society including the old-aged and the in-firm (Iqbal, 2013).

On the other hand, Sri Lanka, India and Bangladesh spend 2.0 %, 1.1% and 1.1% respectively. Per capita government expenditure on health (in US$) show nearly the same trend. Sri Lanka spends 105 US$, Bangladesh 26 US$, India 21 US$[16] whereas Pakistan is at the lowest with 8 US$. That is why a Pakistani family has to bear the brunt of purchasing private health services (i.e. out-of-pocket expenditures on services) for its member from its usually meager resources. Another official justifies the same in these words:

Household is handicapped in resources. How much can it afford for major surgery and chronic diseases. And if at all it does what will be left for the kids (Iqbal, 2013).

Except Sri Lanka, the level of women's health progress of the rest three countries (India, Pakistan and Bangladesh), as has been evaluated above, is low.

Generally speaking Pakistani women have to cope with the lack of public-level health facilities by purchasing for them from the private hospitals, clinics and medical centers. There they have to spend their resources saved in different forms such as reared animals, a patch of land, jewelry and a food grain stocks.

Confirming the Above Results by Gender-related UN Indices:

As a result of UN efforts, two indices to evaluate the state of women in a country had been constructed. Around the world these indices are frequently used to evaluate the state of women in a country. These indices are: Gender Development Index (GDI) and Gender Empowerment Measure (GEM).The details of these indices are:

1. Gender Development Index (GDI): It is an index of gender development. In 2010, GDI score of Norway was the highest of all countries. Very rarely GDI differs from the HDI (which is not gender-specific).Pakistan's ranking of HDI was 125 while GDI was 131 in 2010(UNDP, 2010).

2. Gender Empowerment Measure (GEM): It is an index of gender empowerment. With respect to the ratio of women in the parliament, nearly all the countries belonging to the Nordic model, especially Norway, top the rest of the world. In past and present no other country in the world has as many women in the legislature as the Nordic countries.GEM values of these countries is the highest in the world. On the other hand, Sri Lanka tops GEM values in the region while Pakistan and Bangladesh touch the bottom. (As shown in Table No. 2).It can be verified from the Table that GDI values fluctuate between 0.5 to 0.7 and 1.00 being the ideal value showing maximum gender development whereas GEM values fluctuate between 0.3 to 0.5 and 1.000 being the ideal value showing maximum gender empowerment. It means that level of gender development is higher in the world than gender empowerment.

However, in Nordic countries the GEM value is usually beyond the figure 0.900 and nearing 1.000.GDI is concerned with women's health, education and the matters related to their economic development while GEM is related to the enhancement of women's decision-making power pertaining to all matters of their lives. GEM, in this regard, is more comprehensive than GDI. It is very difficult for a country to GEM (or to gem) its women. That is why its value falls in the lower slots than that of GDI.

Seeing Table No.2, we once again see Sri Lanka leading the course while rest to follow. In GDI, however, performance of all the countries is dazzling. But in case of GEM we find all the four countries at residual level, India and Bangladesh somewhat deplorable.

Table No.2: Showing Women Empowerment in Pakistan and its Neighbors on the basis of GDI&GEM

HDI Rank 2014	**Country**	**GDI**	**Progress**		**GEM**	**Progress**	
			Level	**%**		**Level**	**%**
73	Sri Lanka	0.756	High	75.60	0.389	Low-to-Medium	38.90
135	India	0.594	Medium-to-High	59.40	0.308	Low	30.80
146	**Pakistan**	**0.532**	**Medium-to-High**	**53.20**	**0.386**	**Low-to-Medium**	**38.60**
142	B'desh	0.536	Medium-to-High	53.60	0.264	Low	26.40

Source: UNDP, 2009 (GDI + GEM)

The contents of this table also verify the claim that the women health in Pakistan and its neighboring countries, especially India and Bangladesh, is residual in nature. Differently put Pakistan exhibits very low progress in women development especially in women economic empowerment (as shown in TableNo.2).

Conclusion and recommendations

Results based on the self-constructed index namely Women's Health Index (WHI), values of GDI and GEM for Pakistan and its neighbors and the expert opinions of the welfare personnel indicate that WHS in all the three countries (India, Pakistan and Bangladesh) gives a residual look. And this residual shape of women health in all the four countries (Sri Lanka included) is due to low welfare spending. We conclude the discussion with this statement: A Pakistani woman's life is very miserable than those in the highly developed countries i.e. Sweden, Germany and USA, the best health models in the world. Besides low public spending, bad governance and regional norms are the main reasons of this residual progress. To avert the situation, we may recommend as under:

(1) Taxation is the only solution to the low public spending. We must cut down other unnecessary expenditures and give top priority to the health.

(2) For good governance the 'cross-evaluation' and 'in-built evaluation strategy' can be adopted but with the consensus of the stakeholders.

(3) To address the cultural constraints on women's access to out-of-home facilities of health, education, employment etc. it is strongly recommended that media, both electronic and print, should intervene the situation. Electronic media should play its role in highlighting the problems attached with ante-natal care, skilled birth attendance, and importance of contraceptive use as well .It should also play its role in changing the norms and values against women's education, training as well as their access to the labor market. Similarly the print media should play its role of a 'watch dog' to implement gender instruments adopted by the State.

(4) The Ministry of Social Welfare, as being focal machinery at federal level, should seek inter-ministerial partnership in implementing CEDAW, GRAP, Beijing Declaration and Platform for Action effectively.

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ANNEXURE-I

Millennium Development Goals (MDGs)

Goal 1:Eradicate Extreme Poverty and Hunger
Target 1. Halve, between 1990 and 2015, the proportion of people whose income is less than a dollar a day **Target 2.** Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 2:Achieve Universal Primary Education
Target 3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Goal 3:Promote Gender Equality and Empower Women
Target 4. Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015
Goal 4:Reduce Child Mortality
Target 5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Goal 5:Improve Maternal Health
Target 6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Goal 6:Combat HIV/AIDS, Malaria and Other Diseases

Target 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS **Target 8.** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
<u>Goal 7:Ensure Environmental Sustainability</u> **Target 9**. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources **Target 10**. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation **Target 11**. Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers
<u>Goal 8:Develop a Global Partnership for Development</u> **Target 12.** Develop further an open, rule based, predictable, non-discriminatory trading and financial system More generous ODA for countries committed to poverty reduction **Target 15:** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long run

(Goals and targets adopted by Pakistan, Sri Lanka, India and Bangladesh)