ATTACHMENT H: GENDER ANALYSIS
Building Healthy Families Activity

Introduction

The Building Healthy Families Activity aims to expand access to and utilization of essential health care in Pakistan, namely quality family planning (FP) and maternal, newborn, and child health (MNCH) services, in order to improve health outcomes for some of its most vulnerable populations. The activity aims to increase utilization of quality voluntary FP/MNCH services primarily among young and newly married couples in order to improve healthy timing and spacing of pregnancies. The activity also has a focus on social and behavior change interventions to engage men and boys. Challenges in FP/MNCH brought on by the COVID-19 pandemic, notably disruptions in service provision, contraceptive supply chain and staffing, are also critical components of this activity. The geographic focus of the proposed activity will be limited to the federal level and two provinces, KP and Sindh, with the possibility of extending coverage nationwide.

Gender integration and inclusiveness are integral to the success of this activity. Keeping this in perspective, in accordance with the guidance set forth in the ADS 201[1], ADS 205[2], and USAID's Gender Equality and Female Empowerment Policy, 2020[3], the following gender analysis has been conducted to better understand the gender dynamics and to inform the activity design accordingly. This gender analysis presents findings from a desk review with specific recommendations for the Building Health Families Activity to address gender disparities in health outcomes of interest.

Annex 1 in this document shows key findings across the five domains of the gender analysis: Laws, Policies, Regulations and Institutional Practices; Cultural Norms and Beliefs; Gender Roles, Responsibilities and Time Use; Access to and Control Over Assets and Resources; and Patterns of Power and Decision Making.

Country Context

Pakistan is challenged with gender inequalities across all sectors and despite efforts, a wide gap exists in access to health services and outcomes between men and women, boys and girls. According to the *Global Gender Gap Report 2021* published by the World Economic Forum (WEF), Pakistan ranked 153rd out of 156 countries on the gender parity index. Pakistan's gender gap has widened by 0.7 percentage points in 2021 compared to 2020. The WEF used four sub-indexes that include economic participation and opportunity, educational attainment, political empowerment, and health and survival. Pakistan ranked 153rd in health and survival.

Due to institutional, cultural and social norms, women are at a disadvantage from birth and are subject to discrimination throughout their lifetime. Starting at birth there is a gender preference for boys. Early marriage of adolescents further deepens the inequality as it predisposes women to early pregnancy and high fertility, placing women and newborns at risk of death from birth complications. Additional social

[1] https://www.usaid.gov/sites/default/files/documents/201.pdf
[2] https://www.usaid.gov/sites/default/files/documents/205.pdf
[3] https://www.usaid.gov/sites/default/files/documents/USAID_GenderEquality_Policy_MT_WEB_single_508.pdf

dogmas further limit women's rights and access to reproductive health services. It is not uncommon for women to have a limited role in family-decision making, relying on the husband and mother-in-law to make decisions on important matters including health care seeking behaviors, particularly those related to reproductive health and FP.

While the country has made considerable progress in reducing maternal mortality, FP/MNCH access and quality issues remain rampant across the country. Access to critical health services, including the provision of antenatal and postnatal care, safe delivery, availability of contraceptives, FP counseling are ongoing challenges, particularly in rural areas. Public institutions responsible for the provision of basic health services including Rural Health Centers (RHCs) and Basic Health Units (BHUs), often do not have the adequate resources, staff, medicines, or equipment to serve the population.

COVID-19 has exacerbated these challenges. Women are disproportionately impacted as the pandemic has further limited access to essential services such as FP commodities, counseling, antenatal and postnatal care. Lockdowns and travel restrictions caused severe shortages of life saving medicines and vaccines, including a reported stockout of 48 percent of contraceptive commodities, a 30 percent decline in routine FP services and a 52 percent disruption of immunization services.[4]

GOPs commitments

Pakistan Vision 2025[5] promotes the importance of health to economic and social development. The GoP has subsequently made a number of health commitments related to reproductive, maternal, newborn, adolescent and child health (RMNACH) including its 10x10 RMNACH Agenda[6] and implementation of a basic package of universal health care. In addition, Sindh and KP also have developed their own Provincial Health Plans. The GoP's Current Council of Common Interests (CCI) has also committed to achieving ambitious FP goals, including increasing CPR from 30 percent to 46 percent by 2025 and to 56 percent by 2030; and decreasing the Total Fertility Rate (TFR) from 4.1 to 3.6 by 2025 and to 3.2 by 2030. These measures will contribute to the larger objective of reducing the Population Growth Rate (PGR) from 2.8 to 1.8 percent by 2025 and further to 1.7 percent by 2030.

FP & Maternal Child Health

One in six women in Pakistan has an unmet need for contraception according to the PDHS 2017–2018[7]. Contraceptive prevalence, though slightly increasing from the last three surveys, does not reflect the expressed desire of women and couples who want to limit or space births. Further, demand indicators such as ideal family size and total fertility, despite considerable funding and resources have remained largely unchanged.

[4] Measuring impact of mitigation measures during COVID-19 pandemic in Pakistan : Maternal, Newborn and Child lives lost and save

[5] Pakistan Vision 2025 https://drive.google.com/file/d/10X8nVGVCInkOCpm01eRrsn0xdrqIw1NB/view

[6] Improving Maternal, Newborn and Child Health Outcomes in a Decade https://www.countdown2030.org/wp-content/uploads/2021/02/Pakistan-CD-report-2020.pdf

[7] PDHS 2017-2018 https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf

Pakistan also has one of the highest abortion rates in the world with 48 percent of pregnancies unintended, of which 54 percent are terminated, mostly in an unsafe way[8]. Low utilization of FP/MNCH services can be attributed to socio-cultural barriers, high discontinuation rates for modern contraceptives, poor quality FP counseling, lack of integration of FP services with MCH services, minimal public sector investment in FP/MNCH, and weak health systems. COVID-19 has aggravated the situation by decreasing access to these services and impacted commodity supply chains.

This larger context, coupled with patriarchal social norms, emphasize the need to engage men for not only increasing uptake of FP services but also as users themselves, and as agents of change in their communities. Engaging adolescent boys in sexual and reproductive health (SRH) programming will be key as gender perspectives, knowledge, attitudes, and skills acquired in early years set the stage for future health behaviors and relationship dynamics[9]. Proven approaches include social marketing, outreach with male motivators while promising interventions include clinic provision of information and services, outreach through peer educators/mentors, mass media, community dialogue, and life skills-based education. Emerging interventions including engaging men through social media, mHealth, hotlines, and engaging religious leaders can also be considered[10].

The challenging environment for FP also links to Pakistan's devastating maternal, child, and infant mortality rates, which constitute the largest share of preventable deaths. While the country has made considerable progress in increasing skilled birth attendance and health facility deliveries, challenges remain in areas like high stillbirth rates, quality and lack of respectful maternity care, lack of knowledge among women on the pregnancy danger signs and lack of integration of FP counseling in postpartum care[11]. Evidence suggests these FP/MNCH indicators fare worse among women in rural areas and those with lower socioeconomic status.

The Government has deployed more than 96,000 Lady Health Workers (LHWs) in the country, mainly to support Basic Health Units (BHUs) which are also the first point of interaction between clients and the service providers on health issues in the rural setting. LHWs visit door-to-door to ensure that health services reach women, children and the marginalized communities. It is critical to ensure that outreach workers including Lady Health Workers and social mobilizers are trained to provide counseling to young people on reproductive health matters including connecting them to the nearest health facilities for essential services.

Gender-Based Violence & Early Marriage

Gender-based violence and violence against women continues to be a concern in Pakistan. PDHS showed that 28 percent of women aged 15 to 49 had experienced intimate partner violence in their lifetimes. The highest physical violence in Khyber Pakhtunkhwa (KP) (57%), followed by Balochistan (43%), Punjab

[8] Improving Maternal, Newborn and Child Health Outcomes in a Decade https://www.countdown2030.org/wp-content/uploads/2021/02/Pakistan-CD-report-2020.pdf

[9] Best Bets for Accelerating Family Planning in Pakistan https://www.popcouncil.org/uploads/pdfs/2020RH_BestBetsFPPakistan_Men.pdf

[10] Best Bets for Accelerating Family Planning in Pakistan https://www.popcouncil.org/uploads/pdfs/2020RH_BestBetsFPPakistan_Men.pdf

[11] Improving Maternal, Newborn and Child Health Outcomes in a Decade https://www.countdown2030.org/wp-content/uploads/2021/02/Pakistan-CD-report-2020.pdf

(29%), and Sindh (25%). Given the stigma, incidences of violence, particularly intimate partner violence, are likely grossly underreported. Pakistan also ranks 6th highest in the world in child marriage where 21% of girls are married before the age of 18[12]. Women living with abusive partners fear their partners' negative reaction on discussions on FP or the use of contraception. In instances of sexual violence, women have a greater likelihood of experiencing unplanned pregnancies, poor antenatal care, frequent abortions, and an overall poor reproductive health. In early and child marriages, girls are vulnerable to sexually transmitted diseases, including HIV and AIDs and early pregnancies and childbirth related complications mainly due to lack of sexual and reproductive health knowledge and limited or no access to contraceptives and essential healthcare.

COVID-19

Pakistan continues to be affected by COVID-19 both in terms of the primary and secondary effects of COVID-19 on the health and development sectors as well as resource shifting due to the focus on fighting the pandemic. As variants affect the country's health infrastructure, backsliding of routine services including childhood immunization, MNCH, and FP services has occurred[13]. Women have been disproportionately impacted as the pandemic has limited access to essential services because of state regulations like stay-at-home orders, financial concerns, or a higher perception of COVID-19 related health risks. As vaccines are administered, it's important to note that gender-related factors have a strong influence on vaccine hesitancy, confidence, and acceptability.

Evidence suggests that in crisis situations, women and girls are also more vulnerable to and likely to suffer from food insecurity. Globally, women, adolescent girls, and young children are at heightened risk of malnutrition, which may increase their susceptibility to infectious diseases. In populations where women are responsible for food security within the household, increased food insecurity places them under heightened pressure and could expose them to intimate partner violence or reliance on negative coping mechanisms, such as transactional sex. Women's poor nutritional status and delays in seeking health care are amongst the many reasons making them an easy target for infectious diseases.

Role of the Private Sector in FP MNCH Service Delivery

Non-governmental organizations (NGOs) and the private sector provide approximately 65 percent of FP services, 90 percent of birthing, and 80 percent of medical outpatient services to people[14]. Private pharmacies, health service providers, and NGOs have an important role to play in FP service provision. With the demand for services unmet, there needs to be a shift in how the public and private sectors respond jointly to achieve universal FP/reproductive health (RH) coverage. The private sector has the advantage of much larger numbers of service delivery points than the public sector and is generally perceived to provide more client-centered care, but its services are less affordable, especially for poorer segments of the population. Despite widespread concerns about cost and clinical quality, patients often bypass public facilities to use private providers, frequently citing reasons of convenience and

[12] Time to End Child Marriage in Pakistan https://www.hrw.org/news/2018/11/09/time-end-child-marriage-pakistan

[13] IHME COVID-19 Result Briefing
https://www.healthdata.org/sites/default/files/files/165_briefing_Pakistan_4.pdf

[14] Pakistan Bureau of Statistics. 2019. Contraceptive Performance Report 2016-2017. Government of Pakistan, Statistics Division, Pakistan Bureau of Statistics, Islamabad.

responsiveness. Likewise, for reproductive health needs, women largely rely on the private sector hospitals and clinics. However, seeking healthcare from private facilities involves large out of pocket expenses for many families thus limits women and children's ability to access quality healthcare services resulting in increasing health inequities. The Sehat Sahulat Program [15]of the recent government is a huge step towards Universal Health Coverage in Pakistan. This social welfare initiative is expected to reduce large out-of-pocket health expenditures of poor families while seeking healthcare from the private facilities.

Learnings and Recommendations

Based on desk research and findings of previous gender analyses presented in this document, the Building Healthy Families activity should consider the following recommendations:

1. At a minimum, any data collected and reported on should be disaggregated by sex and age to understand gender disparities. For example, gender disparities in COVID-19 vaccination rates and accessibility, perceived negative side effects of vaccines and contraception, etc.
2. Youth friendly and gender-sensitive approaches should be applied in all health services that are provided to young people, regardless of marital status or parity. The health and social benefits of contraceptive use for healthy timing and spacing of pregnancy for young women and their children need to be well understood among (young) couples, first time parents, extended family, and the community, to include the community health system as well as key influencers, such as traditional and religious leaders.
3. Support expansion of vaccine coverage with a focus on women, children including pregnant women while promoting vaccine uptake in underserved communities including ethnic minorities, internally displaced persons, and refugees. Engage men through social media and community mobilization efforts to promote awareness of vaccines, equitable distribution of household responsibilities, dispel myths and misconceptions about the vaccine.
4. Examine and address the gap between couples' fertility intentions and contraceptive decision making and behaviors. Address individuals and couples concerns on perceived and actual side-effects of contraception through counseling and so that people can make appropriate decisions for their FP needs.
5. Explore opportunities either before marriage or as newly married couples, to establish positive couple communication on FP choices, joint decision-making, conflict management and financial implications of children.
6. Apply male engagement approaches across FP and MNCH programming and continuum of care. The Recipient should consider how to go beyond engaging men as merely supporters of their partner's contraceptive choice and use, but as users themselves (condom use, vasectomy as well as primary health care) and also as agents of change towards positive and equitable gender norms and attitudes in their communities. Incorporate approaches - proven, promising and emerging - to work with and reach young men and adolescent boys.
7. Regional specificities in access to and barriers to FP/MNCH services as well reaching underserved and minority such as refugees and internally displaced persons need to be carefully considered while engaging communities in participating in activity. This intersects with audience

[15] https://www.pmhealthprogram.gov.pk/

segmentation based on geographic differences (urban/rural), socio-economic factors and specific ethno-cultural considerations in the KP and Sindh.

8. Address harmful gender norms that lead to poor health-seeking attitudes and behaviors as well as outcomes by applying SBC approaches at the individual, community and facility levels. This may be done through community mobilization efforts, health worker capacity strengthening and provider behavior change at the facility level.
9. Prioritize the needs of female frontline workers to protect healthcare workers from COVID-19 infections and by ensuring access to personal protective equipment and menstrual hygiene products and flexible working arrangements to balance the burden of care.
10. Given the Government's explicit focus on increasing contraceptive prevalence and decreasing population growth rates, USAID and Implementing Partners must mitigate risk and implement appropriate approaches that take into consideration women, men and couples expressed fertility intentions, their informed consent and voluntarism.
11. The Recipient should consider reaching young people and newly married couples through creative channels including social media, mHealth platforms to normalize and initiate discussions around reproductive health, use of contraceptives and birth spacing.
12. Explore opportunities to integrate messaging around positive gender norms, and addressing attitudes and behaviors (ie. acceptance or justification of wife beating, child marriage) of intimate partner violence and violence during pregnancy. Examine ways to address early marriage and delaying the age of first birth to protect women and girls' health and overall wellbeing. At a minimum, include 1-2 gender specific indicators to track activity's work around attitudinal or behavioral change within the activity MEL plan.

Annex 1: Key Findings by Domain

Laws, Policies, Regulations and Institutional Practices	• Pakistan has adopted a number of key international commitments to gender equality and women's human rights – the Universal Declaration of Human Rights, Beijing Platform for Action, the Convention on the Elimination of all forms of Discrimination Against Women, and the Sustainable Development Goals. • The 18th Amendment to the Constitution commits Pakistan to educate girls and boys to 16 years of age • Pakistan Constitution provides a strong legal framework for many dimensions of women's equality but implementation of provisions is weak (ADB Pakistan). • National Commission on the Status of Women (NCSW), institutional actor tasked to examine the relevance and efficacy of all government policies, programs, and measures related to safeguarding and protecting the interests of women and achieving gender equality; monitor Pakistan's achievements against human and women's rights obligations under international agreements or conventions to which Pakistan is a signatory. Provincial councils on the status of women have also formed, or are forming, in KP and Punjab, with missions similar but tailored to provincial concerns. (ADB Pakistan) • KP passed new law on domestic violence against women passed by the KP Assembly declaring the abuse of women by family members an offence punishable with one-five years imprisonment and penalty. Under the bill, domestic violence against women includes economic, psychological and physical abuse. (Article: Dawn, Feb 2022) • FP & Govt. Commitment: Government has committed to increase contraceptive prevalence per the FP2030 commitments from the current 34% (PDHS 2017) to 50% in 2030.
Cultural Norms and Beliefs	• Studies show disconnect between couples' expressed fertility preferences for spacing or limiting, and their choices of methods. Couples' desires to space and limit childbirth have not been met by a corresponding uptake of FP methods. (Azmat et al., 2021). • Early marriage for girls is still an issue, but decreasing over time. Early marriage has physical, economic, and social implications including early pregnancy, financial dependence, and suppression by men and in-laws. **Gender based violence** • Gender-based violence and violence against women continues to be a concern in Pakistan. Majority of Pakistani women do not disclose or take action against GBV for fear of divorce. In the last PDHS, 79% of the violence was perpetrated by the husband, followed by in-laws (20%). For IPV, 52% of the women did not seek help or tell anyone. • PDHS states that 28% of women aged 15-49 report experiencing intimate partner violence, a slight decrease from 32% of women reported to have experienced physical violence from their partners in the 2012-2013 survey (PDHS, 2017). Given the stigma, incidences of violence, particularly intimate partner violence, are likely grossly underreported. • High profile cases of violence against women have been the center of mass protests in Pakistani society with women representing mostly upper or middle class urban classes (Aljazeera Op. Ed).

Gender Roles, Responsibilities and Time Use	• Social/patriarchal norms dictate that men are the breadwinner of their families, that women stay home and tend to the house. This applies to both rural and urban contact, across socio-economic status, while women of higher socio-economic status may have a slight advantage over mobility, it still applies. • Husbands and in-laws often make decisions on when to seek care as they have control of resources. This applies to health seeking behaviors and access to health services.
Access to and Control Over Assets and Resources	• Basic health services, including the provision of antenatal and postnatal care, safe deliveries, and contraceptives are often inaccessible to women. Rural Health Centers (RHCs) and Basic Health Units (BHUs) do not have the adequate resources, staff, medicines, or equipment to serve the population. • Since 2021, there has been a decline in the number of women who were visited by an LHW to discuss FP (29%-19%) since 2012. • Only 11% of women were given information regarding contraception during postnatal check-up (PDHS 2017-18). Increasing skilled birth attendance and facility deliveries is an opportunity for FP counseling and services. • Seventy-one percent of live births are delivered in a health facility, primarily in private sector facilities, while 3 in 10 births are delivered at home. Births to women with higher education and those in the wealthiest households are more likely to be delivered at a health facility (PDHS, 2017). • Women do not come to facilities for treatment of GBV directly for fear of retribution, reputational issues and discretion. • There has been a substantial decline in the number of women who were visited by an LHW to discuss FP (29 percent to 19 percent) since 2012. • HR shortages and services accessibility remain a critical issue. In Sindh, over half of women face challenges in accessing healthcare. Among women in rural Sindh, distance is a challenge for 68% of women and transportation is a challenge for 76% of women, highlighting the urgent need to make health services more accessible. Further, despite high regard for the LHW program, which is intended to provide basic health services, including FP, just over half of women are aware of LHWs in their area. • COVID -19 Access: In the early stages of vaccine delivery, vaccination figures were lower for women compared to their male counterparts likely due to access (GAVI.org).
Patterns of Power and Decision Making	• 2017-18 PDHS asked married women about their participation in three types of household decisions: her own health care, making major household purchases, and visits to family or relatives. Married women in Pakistan are most likely to have sole or joint decision making power about their own health care (51%) and visiting family or relatives (49%) and least likely to make decisions about major household purchases (44%). Overall, 36% of married women participate in all three decisions. Since 2012-13, married women's participation in decision making has steadily improved. • Forty percent of women need permission from a family member to seek or remain in paid employment, according to the 2019 Pakistan Social and Living Standards Measurement (PSLM) survey. Less than 10% of households say women can decide for themselves (CGDEV 2021). • Adolescent married girls have low decision making autonomy for contraceptive use and childbearing.

	• Child Marriage and Teenage Fertility: According the last PDHS, child marriage and teenage fertility in Pakistan remains a concern for overall health and development outcomes in the country. Teenage childbrearing has remained unchanged since 2012-2013 and 8% of adolescent women aged 15-19 are already mothers or pregnant with their first child. This is slightly different in wealthier households where 5% of adolescent women have begun childbrearing, compared to 10% of adolescent women in lowest wealth quintiles. • Intimate Partner Violence: PDHS showed that 28% of women aged 15 to 49 had experienced intimate partner violence in their lifetimes.The highest physical violence in KP (57%), followed by Balochistan (43%), Punjab (29%) and Sindh (25%).