Socio-Structural Obstacles to Improve Female Health in Pakistan: Towards a Theoretical Model*

Muhammad Hafeez

Abstract: An ever-growing body of literature underscores the significance of socio-economic and cultural factors as underlying the health statuses of populations. Similarly, gender is increasingly being acknowledged as an important contributor of the health of males and females. Gender differences are socially produced and accordingly result in different health outcomes of both sexes. However, the correlation between gender and health of populations is not adequately understood. This paper represents an attempt to develop a model to explore the mechanisms through which poorer female than male health status is produced in Pakistan.

Keywords: gender, health, women, inequalities, Pakistan

Socio-economic Structure and Health

Although advances in medicine and modern clinical practices have been important to the health and well-being of both sexes, an ever-growing body of literature underlines the

* This paper is based on PhD research done at the National Centre for Epidemiology and Population Health, the Australian National University, Canberra, Australia during 1996-2000. The data and information were collected from urban and rural communities in Punjab, Pakistan in 1998.

significance of socio-economic and cultural factors as underlying the statuses of populations' health (Macintyre 1997, Marmot 1997, Chenet 2000, Graham 2000). Socio-economic, cultural, and biological factors are noted as important determinants of population health, but their inter-relationships are complex (McCarthy and McCain 1992). Health status in developed countries is much better than that in poor countries, but some developing nations, like China, Sri Lanka, and Costa Rica, record health indicators, and life expectancies at birth, nearly as good as those in developed countries (UNICEF 1998, World Bank 1993). Caldwell (1986) has identified nearly a dozen countries around the world achieving health statuses far beyond what their national levels of per capita income would predict. In other words, it is not just economic improvement that produces health. A conducive social environment may be equally important to good health outcomes in a population (Wilkinson 1998). While the correlation between socio-economic status and health is strong, the mechanisms through which the social environment effects on health are not adequately understood.

Along with age, gender is the most salient human attribute in almost all societies. The first piece of information to know concerning all human interactions is the sex of the individual concerned, because most following interactions are shaped on gender information. Although this gender basis of human interaction is now undergoing change, most inter-human dealings still reflect the gender of the actors and gender structures. To make interaction relatively easy, different dress codes are applied to men and women. The sex of an individual is clearly an important reproductive distinction, but that distinction has been overly highlighted in contemporary societies. Undoubtedly, a clear distinction between males and females is functional for society, but

stereotyping of males and females has gone too far, and a whole body of beliefs has accumulated around persons' sex. These beliefs and attitudes have a strong bearing on the comparative health of males and females (Stronks 1996).

Sex, Gender, and Health

After nearly three decades of work on gender and related issues, sex and gender are still confused, and are generally used to mean the same. Sex normally means biological differences between males and females. Gender, on the other hand, conveys "socio-culturally constructed components attached to each sex. Moreover, biological differences - whatever they may be - are basically constant across historical time and space" (Chafetz 1990:28), but gender systems change over time and differ across societies. As a consequence, the health of males and females varies.

All societies are divided into male and female domains and Pakistan is no exception. This dichotomy suggests that males are different types of creatures having varied roles, responsibilities, and entitlements (Charles 1993, Moore 1988). Although there is a great variation in roles and entitlements but certain consistencies are found around all societies of the world. For example, domesticity is the domain of females and public life is mainly occupied by men. The places or tasks associated with maleness are usually more valued than those linked with femaleness (Hess 1987, UNICEF 1990, Donnan 1997, Hakim 1998, Doyal 2000). It may be noted that these gender based inequalities impact the health of both men and women, but this paper focuses on female health.

Nathonson (1975:57) presented three theoretical explanations towards sex differences in illness. The first

argument suggests that women report higher morbidity than that among men because it is culturally appropriate and acceptable. Secondly, the sick role of women is more compatible with their other social roles. Thirdly, women experience more sickness because their socially assigned roles are more stressful than those assigned to men. These explanations have been criticized due to their partial focus on women and is suggested that these explanations have failed to explore in equal depth the social roles of men and women (Popay and Groves 2000:70).

Gender is increasingly being recognized as a major source of social and health disadvantage for females in almost all societies around the world (Denton 1999, Fischbach 1997, Furhrer 1999, Hafeez 1999, Hill 1995, Kronfield 1999). Females are systematically disadvantaged through socially produced differences between the sexes (Moghadam 1992, Sathar 1994, 1996, Mahmood 1995, 1996). Gender seems to permeate all aspects of individual and social life, shaping social processes at micro and macro levels of human activity. Gender is so pervasive in people's lives that its effects often go unnoticed. Our psyche, stereotypes, and pre-dispositions do not allow us to appreciate the dynamics of gender in shaping our attitudes, motives, and behaviours. And we just take these behaviour patterns as 'given' and do not see how they relate to differential health outcomes in populations.

Female status in Pakistan is low (Patel 1991, Weiss 1999) and this "low social, economic and legal status of women is intimately tied to the well-being of their children" (Agha 2000:199). To understand the role of gender in-health, one has to look in depth at local social processes through which the health of the two sexes is differentially influenced.

The role of wife/mother is a hard one, and to prepare girls for it they are socialized to attach high social value to altruism from childhood. Similarly, giving birth is a painful process and the image of painful mothering is applied to the whole of their lives. Although this socialization pattern may help prepare females for a tough wife/mothering role, it certainly contributes towards making their lives relatively uncomfortable as well (Lindsey 1994, Lorber 1997, Mathews 1999, Okojie 1994)

The analysis of health differentials between males and females is as complex as are gender systems themselves. Females are considered a sicker sex because of gender-based beliefs about the reproductive biology of women, and accordingly some complaints of illness among females are considered 'normal' and are attributed to their biology. Consequently, the threshold for labelling women as 'ill' is higher than that among men. Females in Pakistan are more likely to delay seeking medical help until an illness reaches an advanced stage (UNICEF 1990, GDFHS 2000, Vlassof 1994, WHO 1999, Hafeez 2000b). At times, these delays lead to medical complications and death. Medical complications emerge through lack of access to and use of available health care services, and accordingly the major reason for high maternal mortality is complications of obstetric problems (Midhet et al. 1998).

Women and Gender Studies in Pakistan

After nearly three decades of discourse on gender in developed world, the term gender is now becoming a buzzword in Pakistan. Although a lot of work is done on gender and gender-related issues, gender is still equated with the disadvantage of women. Accordingly, the Western academic discourses have shifted from 'Women Studies' to

'Gender Studies', but 'Women Study Centres' are even now being established in Pakistan. For example, at the largest and the oldest university of Paksitan (the Punjab University, Lahore), a Women's Study Centre was established as recently as 1998 (personal communication). Pakistani media, both private and public, and policy are increasingly heard talking about women and their social disadvantage. Apparently, Pakistani policy is yet to be sensitised about the impact of gender structures on men's and women's health. Given the continuing low status of Pakistani females, this paper deals with women's health disadvantage in Pakistan. The dominant framework of research on gender inequalities in health and illness has been, and to some extent remains, social role theory (Lennon 1987, Lindsey 1994, Popay and Groves 2000:69). Little attention has been given to develop theoretical models to explain structure based gender differentials in health.

The emphasis of gender literature from developed world is now on social construction of gender identities and on the relationships between the two sexes, the focus of this paper, however, shall be on the disadvantage of women because it is more pertinent to Pakistani social and economic situation. A closer examination of Pakistani policy on women suggests a lack of clarity about the road map of improving their social and health status. However, the mention of policy weakness is not aimed to undermine Governmental and Non-Governmental Organizations' actions to alleviate sufferings of women. For example, the efforts to enhance literacy and education among women and girls are laudable. The national endavours to enhance participation of women in politics and also increasing employment opportunities for women are appreciated. However, this paper makes an important contribution to highlight deep-rooted social and health disadvantage of women in Pakistani social structure.

From Pakistani perspective, the identification of the domains of social and health disadvantage of females is an important task in its own right and can potentially contribute towards improving their health and social status (Ahmed 1999, Kazi 2000, Khalid 2000). Aiming gender equity as a policy goal is an important pursuit and should remain so. But most Pakistanis would believe that the notion of "gender" overpoliticizes the "natural" differences between males and females, and hence become counter-productive. According to them, these gender differences are not avoidable. Rather they are considered natural and hence are desirable. Given the domination of this traditional perspective, addressing the gender-based structural conditions of women's social and health disadvantage becomes even more important to bring sustainable change in female health and social status.

Feudal Patriarchy and Shift in Change of Gender Structures

In the 1970s, liberal tendencies appeared to be occurring too fast, and to be beyond the absorption capacity of rigid structures. Normative and gender structures were stretched beyond their limits of flexibility. The change in gender structures coupled with the modernizing image of women did not fit well with the traditional ideology of orthodox feudal and religious-political elites. Patriarchal communities in Pakistan did not approve of women competing with men for employment, transport, and other public goods, although there was little competition for educational facilities because of segregated schooling. Knowing the patriarchal constitution of Pakistani society, the beneficiaries of patriarchal traditions (i.e. feudal landlords and the religious-political elite) converged into a powerful lobby to influence state policies to revive weakening age-old patriarchal gender

structures. The electronic media, especially television, were used to re-inculcate traditional values, behaviours, and attitudes. The popular TV serial '*Waris*' is a good example.

The feudal landlords, politicians, and industrialists had common interests in the maintenance of traditional structures. In the 1980s, they collaborated and joined forces with the government to work for the restoration of declining traditional control. The orthodox religious elite provided greatly needed legitimacy to their actions. The combination of these four forces, the state, feudal landlords, industrialists, and religious-political elites, produced the most powerful social coalition in the history of Pakistan. They systematically influenced social processes and the social psyche of the people, instigating a tradition-oriented 'social revolution'. To ensure revival of traditional control, they adopted a dual voluntaristic and coercive strategy. The voluntaristic measures included persistent acculturation through the media. Coercive actions included widespread violence against women and unjust implementation of *Hudood* laws.

In 1979, the *Hudood* laws, concerned primarily with gender and sexuality, were introduced. These laws were meant to protect and benefit women, but their unjust implementation resulted in restraining their rights in courts of law, and it became harder for women to seek justice against excesses perpetrated by men. A recent high profile government report concluded that these laws hampered women's social and legal status and constrained their rights to attain justice through normal court procedures (RCIW 1997). Recently, the Chief Justice of Pakistan has highlighted the need to review discriminatory laws against women in the country (*Nation* 1999).

Recent reports have suggested a growing trend of domestic and public violence against women (RCIW 1997; Fikree and Bhatti 1999; Human Rights Watch 1999). Violence against women ranges from mental torture to beating and murder. The incidence of stove burning is reported to have risen sharply in recent years (Human Rights Watch 1999). As there are no systematic data on violence against women, most studies are based on newspaper reports. According to the Human Rights Council of Pakistan, in an eight-month period during 1999, "of the 372 women who reported domestic violence, 272 died as a consequence of the battering" (quoted in Fikree and Bhatti 1999:196). Although these figures are alarming they represent only extreme cases coming to the attention of the Human Rights Council. Nevertheless, they do highlight the severity and intensity of the battering of some women in Pakistan.

The custom of *karo kari* (honour killings) is continuing unabated. During 1999, of 264 honour killings, 162 victims were women (*Dawn* 2000). Honour killing of a woman is still not treated as 'murder'. The judiciary looks at 'honour killings' as having mitigating circumstances (RCIW 1997) and takes a lenient view of them, which only encourages more of them. Honour killings may be functional in local social systems, but such killings, mostly of women, produce a critical negative image of females.

In the past several years, newspapers have given extensive coverage to stories of violence against women. They increasingly have reported stove burnings (kitchen accidents), *karo kari* (honour killings), abductions, and gang rapes. Although such coverage has enhanced awareness of the problem, it has had a serious negative effect on the Pakistani social mind. Such stories have produced social apprehension about the security, safety, and future of

females. Noting the significance of the negative contribution of the media, an Islamabad-based NGO called 'Sahil' requested media people to 'keep a low profile' while reporting such stories (*Nation* 2000). The suggestion was not to publish such stories prominently and sensationally, as many people were believed to have been influenced negatively by them. Pakistani media generally publicize stories about violence against women sensationally, and Sahil noted that such coverage might have encouraged some men to indulge in violence against women. Such sensational publicity also creates a negative and vulnerable image of females

Because the dominant social and gender structures are generally unfavourable to women, people seem to be more concerned about the futures of their daughters than of their sons. Their gender-based feelings are generally shared with relatives and friends, contributing to a cycle of growing discrimination against girls. First, they prefer that a girl should not be born in the first place. There may be implicit (praying) or explicit (sex-selective abortion in some cases) measures taken to avoid the birth of girls. Secondly, people may discriminate in providing health care to their children. According to the 1990-91 PDHS, for the 10-year period preceding the survey 22.0 boys and 36.5 girls per thousand live births died aged 1-4 years (NIPS 1992:118). The differential seems high, but consistent reporting of higher female than male mortality among children aged 1-4 years indicates the female mortality disadvantage (Arnold 1997, Hakim et al. 1998, Tinker 1998). This male-female child mortality differential is generally attributed to differential access to and use of health services. It is likely that the 66 percent higher mortality among girls than boys aged 1-4 years is largely the result of differential gender-based health care practices (NIPS 1992, United Nations 1996, Tinker 1998,

Wallerstein 1998). This gender differential in mortality appears dramatic, and some more conservative estimates report as little as 12 percent higher mortality among girls than boys aged 1-4 years (MHDC 1999). There may be a variety of degrees of gender differential in reports of child mortality, but the common factor is that girls' mortality is higher than boys'.

Consequences of Gender Structures for Females

In Pakistan, gender structures are pervasive at household and social levels (Donnan and Selier 1997). Gender structures, just like social structures, influence the health of males and females (Broom 1999). In the context of a low social valuation of female gender, girls from lower socio-economic strata experience particularly severe discrimination in education and health. In 1995, literacy among adult Pakistani males was 50 percent, compared with 24 percent among adult females. The adult female literacy rate in 1995 was thus 48 percent of that of males, even lower than in India and Bangladesh (see Table 1).

In terms of female primary school enrolment as a percentage of male enrolment, the 1995 statistics ranked Pakistan at the bottom among South Asian countries, below even Nepal. The picture for other levels of school enrolment was similar. Data for 1992 showed that female mean years of schooling as a percentage of the male mean was also the worst (23 percent) in the region. Widespread discrimination against girls and women underlies high levels of illiteracy among females (UNICEF 1998).

Table 1 Gender related profile of Pakistan in the context of South Asia

	India	**Pakistan**	Bangladesh	Nepal	Sri Lanka	South[b] Asia (Wtd Avg)	Developing Countries
Female population as a % of male							
1998	94	**97**	93	85	102	93	97
Male literacy rate (%) 1995[a]	66	**50**	49	41	93	63	79
Female literacy rate (%) 1995[a]	38	**24**	26	14	87	36	62
Adult female literacy as a % of male							
1970	41	**35**	35	12	80	40	NA
1995	58	**48**	53	34	94	57	78
Female primary school enrolment as a % of male							
1970	64	**37**	48	20	92	60	79
1993	81	**61**	82	67	99	79	88
Female mean years of schooling as a % of male							
1980	32	**25**	29	33	79	32	33
1992	34	**23**	29	31	79	33	55
Female life expectancy at birth as a % of male							
1970	97	**99**	97	97	103	97	103
1997	100	**103**	100	100	106	100	105

Maternal mortality per 100,000 live births 1990-96	437	**340**	850	1500	140	480	384
Total fertility rate							
1960	6.0	**7.0**	6.7	6.0	5.4	6.1	6.0
1997	3.1	**5.1**	3.2	5.0	2.1	3.4	3.1
% decline 1960-97	48	**27**	52	17	61	44	48
Contraception use by women aged 15-49 years (%)							
1970	12	**4**	22	1	8	12	18
1990-95	41	**18**	49	29	66	39	56
Earned income share of females as % of male 1995	34	**26**	30	50	55	33	48
Female economic activity rate as a % of males 1995	46	**36**	73	68	55	48	64
Gender-related development index 1997	0.424	**0.399**	0.342	0.327	0.700	0.415	0.564
Gender empowerment measure 1992	0.228	**0.179**	0.305	NA	0.286	0.226	NA

Source: MHDC 1999

a Source: UNICEF 1998

b The South Asian figures include Bhutan and Maldives.

Note: The Gender-related Development Index (GDI) adjusts the Human Development Index (HDI) for gender equality in life expectancy, educational attainment, and income. For more information on HDI, see MHDC 1999.

NA Data not available

The MHDC based in Islamabad has developed a 'Gender Development Index' (GDI) to compare women's situation across countries. The GDI is based on women's health and education status in relation to men's. Pakistan's record is not only poorer than those of most countries in the world, it is even worse than that of neighbouring relatively poor India, while Sri Lankan women enjoy the greatest emancipation in South Asia.

Another gender-related development measure constructed by the MHDC is called the 'Gender-Empowerment Measure'. This is based on statistics for variables such as schooling and income. Data for 1992 show that Pakistan was rated the poorest (0.179) among the countries for which data were available in South Asia, against a regional average of 0.226 (MHDC 1999:200). A more detailed comparison of the gender-related profiles of Pakistan, other countries in South Asia, and developing countries in general is given in Table 1. The data show that the maternal mortality rate in Pakistan was lower than in other countries except Sri Lanka. This may, however, reflect significant under-reporting of maternal deaths due to poor recording of causes of death. This argument receives some support from 1989 data, which estimated that there were 600-800 maternal deaths per 100,000 live births (NIPS cited in Mubarak 1990:29). According to the 1995-96 Pakistan Integrated Household Survey (PIHS) conducted by the Federal Bureau of Statistics (hereafter FBS) (1997:43), the MMR in Pakistan is around 650 deaths per 100,000 live births.

Effect of Gender Structures on Health Services Use

According to a 1996 United Nations report, *Too Young to Die: Genes or Gender*, the most important source of gender discrimination in health is differential access to health

services. Educational, nutritional and feeding discrimination is reported from South Asia, but these discriminations have had limited differential effect on the health of males and females (United Nations 1996). Gender-based discrimination in immunization is also reported to be minimal. It is argued that differentials in the use of curative health services are both larger and more widespread. The differential parental use of health care is the main mechanism through which boys survive more frequently than girls do (Booth and Verma 1992, United Nations 1996).

As noted earlier, in Pakistan, 1981-90 data show that 36.5 girls and 22.0 boys per thousand live births died aged 1-4 years (NIPS 1992), 66 percent higher mortality among girls than boys. According to Hakim et al. (1998), during 1992-96 mortality rates were 18 boy and 23 girl deaths per thousand live births in this age group, suggesting a gender-based mortality differential of 27 percent. The variation in the extent of differentials in mortality is understandable, but all surveys show higher female than male mortality among children aged 1-4 years. Such differentials are usually attributed to gender-based discrimination in child rearing practices and parental use of health care services (NIPS 1992, AVSC 1997a, Tinker 1998, Wallerstein 1998).

Hospital data from the Islamabad Children's Hospital show that nearly one-quarter fewer girls than boys were brought for health care between January 1989 and September 1990 (Mahmood and Mahmood 1995:701). If people from the relatively high literacy city of Islamabad discriminate against girls regarding health care, it is highly likely that people from other parts of Pakistan also use health services differentially for their sons and daughters. According to another recent report, statistics from large public hospitals in Pakistan reveal that a significantly larger proportion of boys

than girls are brought for care at government health care facilities, even after adjusting for the excess of 104 males per 100 females among children aged 0-4 years (United Nations 1996:15). Given this pattern of health services use, a significant differential in survival between boys and girls aged 1-4 years should come as no surprise.

From birth, a female child is considered a guest in her parents' house, because she will move to her in-laws' home after her wedding (Hakim and Aziz 1998). Girls come to know about their transient status at home when very young. Some parents prefer to invest in education and training of their sons, because it will add to their home in a variety of economic and social ways. On the other hand, some parents invest in their daughters' education, training, and health to improve their marriage prospects.

To sum up, the major reason for poorer female than male health is the inequitable use of health services. Although educational, nutritional, and feeding discriminations are reported, their differential effect on the health of males and females is limited. Discrimination among boys and girls regarding immunization is reported, but the differential use of curative services is emphasized. Parents are more willing to utilize all possible resources for their sons, when ill, than for their daughters.

Gender Inequalities and Female Health

A large body of literature shows a close relationship between gender inequalities and mental and physical health of men and women (Annandale and Hunt 2000, Doyal 1995, Stein 1997). These studies have not only looked at mortality but also at more qualitative aspects of life like illhealth and mental ailments (Ibraz. 1993). It is suggested that many

problems faced by women are not the direct product of their biology. Rather they are the product of social discrimination and because of gendered activities pursued by them in their daily lives (Belle 1990, Kitts and Roberts 1996). Anxiety and depression are much more common among women than among men (GDFHS 2000, Khalid 2000). Yet there is no concrete evidence to suggest that women are constitutionally more susceptible to such problems than their male counterparts (Busfield 1996).

Poverty

Poverty and income inequality are inversely related with population health (Rodgers 1999, Waldmann 1999). Poverty in Pakistan is reported to have increased during the past decade (Government of Pakistan 2000, 2001) and gender disparities of income and wealth make Pakistani women even more vulnerable. Pakistani women suffer more than men due to low nutrition levels and lesser access to health care (Tinker 1998). Acute gender division of labour in Pakistan often denies basic human needs like time for rest and recuperation (Bhatti 1999, Fikree 1999, Karim 1994,Winkvist 1997). Most Pakistani women have little social support and a large majority of them are being abused by men (HRW 1999, WHO 1996). The physical and psychological security needs of Pakistani females grow in a highly discriminated home and social environment whereby they are trained to belong to the less valuable group (female) and result in their low self-esteem which is linked with the state of mental health (Papanek 1990, World Bank 1989). These women are socialized to be altruistic and are encouraged to work for the well being of others at the cost of their own health.

Given the disadvantaged social circumstances for Pakistani females, their health is expected to remain poorer than that of their male counterparts (ICRW 1989. However, on certain important indicators, female health has improved in the last few decades (Hafeez 2000a). The life expectancy at birth is a good example. Pakistani women have now caught up and their life expectancy is at par with that of men at 63 years (UNICEF 1998) but their lives suffer from illhealth much more than their male counterparts (Tinker 1998, Hafeez 1999). Pakistani social structure provide unequal access to a large array of social, economic, political, and psychological resources to women having a direct/indirect impact on their health. A substantial proportion of their illhealth can be linked with their daily lives full of gendered routines whose social and economic value remains low. These gendered responsibilities obviously can be modified through adjustments in social policy and social structure.

Change in Gender Structures

Masculine and feminine behaviours are inextricably linked to either sex or female gender (Annandale and Hunt 1990). Being a traditional society, gender structures in Pakistan are rigid. There is a "need for policies to free up individuals from the constraints of rigidly defined gender roles" (Doyal 2000:937). It may be noted, however, that any change in gender relations is likely to challenge masculine identities of Pakistani men and they are likely to react. Machismo is an important and socially valued attribute. For example, to impress upon his peers, a young boy from a low socio-economic background carved burn marks of his name's initials with a lit cigarette (Personal communication with the person). To tackle this obstacle, it is imperative to address material, institutional, and structural inequalities in larger social structure. However, to improve female health, change

in patterning of gendered divisions in social structure is extremely important. At the same time, effort must be made to enhance and recognize the value of their domestic activities. For example, they may be paid for doing domestic work. Such a strategy demands significant changes in social and economic organization of Pakistan.

Gender-based Concerns in Pakistani Perspective

Recent scientific work has established both a theoretical basis and strong empirical evidence for a causal impact of social relationships on health (House et. al. 1999:161). Gender systems of a society provide a framework of social relationships and impact on people's health (Stronks 1998, Berkmann 1999). The question arises, how do gender systems come to influence health and health care behaviours? Gender stratification structures are so rigid, discriminatory, and important that people start thinking about the sex of a child even before conception. People pray for the birth of sons. The births of sons are celebrated and rejoiced, while female births are accepted quietly, or mourned if there are two or more living daughters already (Hafeez 2001).

The source of differential attitudes towards sons and daughters can be traced to gender-based concerns. Boys and girls raise their own types of concerns for their parents. These concerns relate to aspects of the children's future lives. Education, employment, security, and marriage are some of the major issues with which parents are usually concerned (Hafeez 2000). Educational and employment concerns arise more with sons. Parents like to invest in sons' education to improve their employment prospects. These concerns are more positive in nature because of their potential future rewards. As sons are expected to remain part of their

families, they are considered assets and worthy of investment. According to Hakim and Aziz (1998:729), "A son is regarded as a permanent part of the family and an asset who will reinforce the family power and status"

On the other hand, daughters are mainly associated with security (protection of female honour, chastity, and modesty) and marriage (Hafeez 2000). These twin concerns are more negative in nature. They are consumption, rather than investment, oriented concerns. Daughters consume and take resources away in the form of dowry and their moving to live with the families of their in-laws. In recent years, because of high dowry demands (Sathar and Kiyani 1998), concerns over daughters' marriages have probably intensified.

The concerns about sons are more economic in nature, while those about daughters are both economic and social in nature. Although economic concerns are usually more important than social concerns, households may have greater ability to adjust and adapt to economic realities. People can cope with a low standard of living, but social concerns are encompassing and stick in people's minds. At the same time, people have little control over concerns created by the larger society. For example, physical insecurity, especially of females, is perennial in Pakistan, and there are few measures individuals can take to improve the situation. Increasing incidences of abduction and rape have produced a worrying state (RCIW 1997), and parents are concerned over the security of girls and women.

Because people have greater adaptability to economic realities, they are not as anxious about material comforts as about social problems. Owing to lack of adaptability, social concerns are a potential source of tension and worry. In

other words, people are more worried about the futures of their daughters than about those of their sons. This gender difference has an adverse effect on the health of both parents and female children.

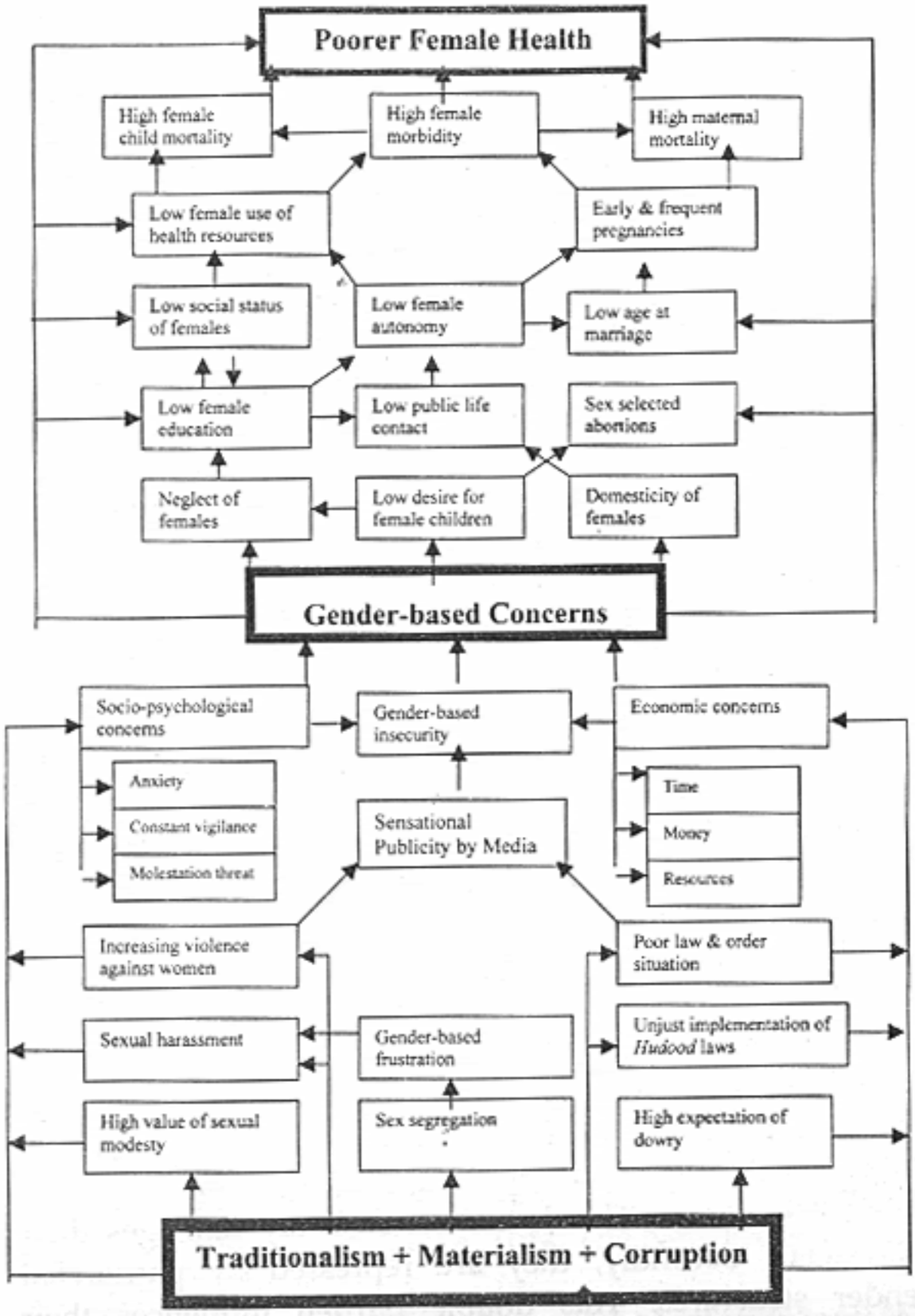
Figure 1 shows a model of female health in Pakistan. The model shows a typology of people's concerns and their impact on the health of females. It attempts to show that a resurgence of traditional social values and emergent materialism, coupled with lawlessness, has produced a social environment that has caused special concerns regarding females. People are unprecedentedly concerned with their daughters' security and marriage prospects. As most people lack resources to address these social issues, they remain anxious about them. Such gender-based concerns have a negative bearing on the health of both males and females, but more so on that of females.

There are two sections of the model. The lower section shows the typology of gender-based concerns. It suggests that the social system of Pakistan has re-embraced tradition and also acquired the norms of a material culture. The traditional values have reinforced sex segregation, and placed a high social value on female modesty. At the same time, corruption and political instability have produced a poor law-and-order situation, resulting in an increased incidence of abduction and rape (RCIW 1997).

The upper section of the model shows the mechanisms through which gender-based concerns affect health. Because people are more concerned about the futures of their daughters, they want to avoid concerns associated with female children.

One way of avoiding those concerns is to avoid the birth of female children in the first place. Praying not to conceive a female child is the first action. A small minority are able to indulge in sex-selective abortion after using ultrasonography to ascertain the sexes of unborn children, although rare in Pakistan. "In a hospital-based

Figure 1
Gender-based concerns and female health model



survey of 30 private and public hospitals in Pakistan, 11 percent of maternal deaths were attributed to induced abortion" (Fikree et al. cited in Tinker 1998:7). And finally, when a female child is born, some people mourn her birth. Once a female baby is born, she may not receive equal treatment from her family and society to a male baby. Some people discriminate in the allocation of food, health services, and leisure. Many parents do not provide adequate health services to girls. They are discriminated against in both the quantity and the quality of services made available. As a result, girls experience higher morbidity, leading to higher mortality among daughters than sons aged 1-4 years.

The overall social status of females, both parents and children, is a lot lower than that of males. Males enjoy much more autonomy and freedom to move around than females. Females are provided with fewer educational and training opportunities than males. Because people are more concerned about the futures of their daughters than of their sons, they like to relinquish responsibility for their daughters by arranging early marriages (Mahmood and Nayab 1998). This results in early and frequent pregnancies, leading to high fertility and contributing to a high maternal mortality rate (Sathar 1987, World Bank 1989, Mahmood and Nayab 1998, Midhet et al. 1998).

In summary, greater gender-based female than male concerns create psychosocial pressures for both sexes, but females are affected doubly. First, they learn very early in childhood that by virtue of being girls, they have a lower status than males. This lower status badly damages their self-esteem. Secondly, they are repressed by patriarchal gender structures. This double burden influences their health negatively throughout their lives.

References

1. Agha, S. (2000). The determinants of infant mortality in Pakistan. Social Science & Medicine **51**: 199-208.

2. Ahmed, S. (1999). Family, marriage and gender roles: an explanation of high fertility amongst Pakistanis in Pakistan and abroad. Journal of Research **33**(1-2): 37-50.

3. Annandale, E. & K. Hunt (1990). Masculinity, femininity, and sex: an exploration of their relative contribution to explaining gender differences in health. Sociology of Health and Illness **12**(1): 24-46.

4. Annandale, E. & K. Hunt (2000a). Gender inequalities in health: research at the crossroads. In E. Annandale and K. Hunt (Ed.), *Gender inequalities in health* (pp. 1-35). Buckingham: Open University Press.

5. AVSC (1997). Men as partners in reproductive health: working report. New York: AVSC International.

6. Belle, D. (1990). Poverty and women's mental health. American Psychologist **45**: 385-389.

7. Berkman, L. F. (1999). The role of social relations in health promotion. In I. Kawachi, B. P. Kennedy and R. G. Wilkinson (Ed.), *The society and population health reader* (pp. 171-183). New York: The New Press.

8. Bhatti, L. I. et al. (1999). The quest of infertile women in squatter settlements of Karachi, Pakistan: a

qualitative study. Social Science & Medicine **49**: 637-649.

9. Booth, B. & M. Verma (1992). Decreased access to medical care for girls in Punjab, India: the roles of age, religion, and distance. American Journal of Public Health **82** (2): 1155-57.

10. Broom, D. (1999). The genders' of health. Gender, Health and Healing: Reflections on the Public-Private Divide, Warwick, Canada.

11. Busfield, J. (1996). *Men, women, and madness: understanding gender and mental disorder*. London: Macmillan.

12. Caldwell, J.-C. (1986). Routes to low mortality in poor countries. Population and Development Review **12**(2): 171-220.

13. Chafetz, J. S. (1990). *Gender equity: an integrated theory of change*. London: Sage Publications.

14. Charles, N. (1993). *Gender divisions and social change*. Hemel Hampstead: Harvester Wheatsheaf.

15. Chenet, L. (2000). Gender inequalities in health. In E. Annandale and K. Hunt (Ed.), *Gender and socio-economic inequalities in mortality in Central and Eastern Europe* (pp. 182-211). Buckingham: Open University Press.

16. Dawn (2000). Honour killings. Dawn, March 24, 2000. Karachi.

17. Denton, M. & V. Walters (1999). Gender differences in structural and behavioural determinants of health: an analysis of the social production of health. Social Science & Medicine **48**: 1221-1235.

18. Donnan, H. & F. Selier (1997). *Family and gender in Pakistan: domestic organization in a Muslim society*. New Delhi: Hindustan Publishing Corporation.

19. Doyal, L. (1995). *What makes women sick: gender and the political economy of health*. New Brunswick, New Jersey: Rutgers University Press.

20. Doyal, L. (2000). Gender equity in health: debates and dilemmas. Social Science & Medicine **51**: 931-939.

21. Fikree, F. & L. Bhatti (1999). Domestic violence and health of Pakistani women. International Journal of Gynecology & Obstetrics **65**: 195-201.

22. Fischbach, R. L. & B. Herbert (1997). Domestic violence and mental health: correlates and conundrums within and across cultures. Social Science & Medicine **45**(8): 1161-1176.

23. Fuhrer, R. et al. (1999). Gender, social relations and mental health: prospective findings from an occupational cohort (White Hall II Study). Social Science & Medicine **48**: 77-87.

24. GDFHS (1998). Gender differences and female health in contemporary Pakistan. Canberra: National Centre for Epidemiology and population Health, Canberra, Australia.

25. Government of Pakistan (2000). *Economic Survey 1999-2000.* Islamabad: Finance Division, Economic Adviser's Wing.

26. Government of Pakistan (2001). Economic survey. Islamabad: Finance Division, Economic Adviser's Wing.

27. Graham, H. (2000). Socio-economic change and inequalities in health. In E. Annandale and K. Hunt (Ed.), *Gender inequalities in health* (pp. 90-122). Buckingham: Open University Press.

28. Hafeez, M. (1999). Magnitude and dynamics of domestic violence against women: evidence from rural and urban sites in Pakistan. Journal of Research **33**(1-2): 63-90.

29. Hafeez, M. (2000). Gender and other differences in health: findings from urban and rural sites in Lahore and Bahawalnagar, Pakistan. National Centre for Epidemiology and Population Health. Canberra: The Australian National University.

30. Hafeez, M. (2000a). Male-female health differentials in Pakistan (a review of improvement). Mother and Child **38**(3): 81-87.

31. Hafeez, M. (2000b). Determinants of immunization differentials: evidence from two districts of Punjab, Pakistan. Mother and Child **38**(1): 23-31.

32. Hafeez, M. (in press). Revisiting son-preference in Pakistan: evidence from a survey of rural and urban

communities in two districts of Punjab, Pakistan. Population Studies (NIPS): 1-12.

33. Hakim, A. & A. Aziz (1998). Socio-cultural, religious, and political aspects of the status of women in Pakistan. The Pakistan Development Review **37**(4): 727-746.

34. Hakim, A. et. als. (1998). Pakistan fertility and family planning survey (PFFPS) 1996-97. Islamabad: National Institute of Population Studies.

35. Hill, K. & D. M. Upchurch (1995). Gender differences in child health: evidence from demographic and health surveys. Population and Development Review **21**(1): 127-151.

36. House, J. S. et al. (1999). Social relationships and health. In I. Kawachi, B. P. Kennedy and R. G. Wilkinson (Eds.), *The society and population health reader* (pp. 161-170). New York: The New Press.

37. HRW (1999). *Crime or custom? Violence against women in Pakistan*. New York: Human Rights Watch.

38. Ibraz, T. S. & A. Fatima (1993). Uneducated and unhealthy: the plight of women in Pakistan. The Pakistan Development Review **32**(4): 905-915.

39. ICRW (1989). Strengthening women: health research priorities for women in developing countries. Washington , DC: International Center for Research on Women.

40. Karim, A. (1994). Pakistan: murder by neglect. In: Conveying concerns: women write on reproductive health, [compiled by] Population Reference Bureau [PRB]. Washington, D.C., PRB **16**: 16.

41. Kazi, S. (2000). Gender inequalities and development in Pakistan. In S. R. Khan (Ed.), *50 years of Pakistan's economy: Traditional topics and contemporary concerns* (pp. 376-414). Karachi: Oxford University Press.

42. Kitts, J. & J. Roberts (1996). *The health gap: beyond pregnancy and reproduction*. Ottawa: IDRC.

43. Kronenfeild, J. J. (1999). Gender and health status. (Ed.), *Handbook of the Sociology of Gender*. In J. Chafetz (ed.), (pp. 459-481). New York.

44. Lindsey, L. L. (1994). *Gender roles: a sociological perspective*. New Jersey: Prentice Hall.

45. Lorber, J. (1997). Gender and social construction of illness: a review. In E. Riska (Ed.), *Images of women's health*.

46. Macintyre, S. & K. Hunt (1997). Socio-economic position, gender and health. Journal of Health Psychology **2**(3): 3159-1053.

47. Mahmood, N. (1996). Gender differences in fertility desires and son preference in Pakistan: implications for reproductive behaviour. Paper presented at the IUSSP Seminar on Comparative Perspectives on Fertility Transition in South Asia.

48. Mahmood, N. & M. A. Mahmood (1995). Gender differences in child health-care practices: evidence from the Pakistan demographic and health survey, 1990-91. Pakistan Development Review **34**(4): 693-707.

49. Marmot, M. et al. (1997). Social inequalities in health: next questions and converging evidence. Social Science & Medicine **44**(6): 901-910.

50. Matthews, S. et al. (1999)..Social inequalities in health: are there gender differences? Social Science & Medicine **48**: 49-60.

51. McCarthy, J. & D. McCain (1992). A framework for analyzing the determinants of maternal mortality. Studies in Family Planning **23**(1): 23-33.

52. MHDC (1999). Human development in South Asia 1999. Islamabad: The Mahbub ul Hua Human Development Centre.

53. Midhet, F. et al. (1998). Contextual determinants of maternal mortality in rural Pakistan. Social Science & Medicine **46**: 1587-1598.

54. Moghadam, V. (1992). Development and women's emancipation. Development and Change **23**: 215-??

55. Moore, H. (1988). *Feminism and anthropology*. Oxford: Polity Press.

56. Mubarak, M. (1990). *Health coverage in Pakistan, an evaluation for future strategy, "health for all"*. Rawalpindi: The Army Press.

57. Nation (1999). Chief justice for reviewing discriminatory laws against women. The Nation. Lahore: November 29, 1999.

58. Nation (2000). Violence against women. The Nation, Lahore, March 13, 2000.

59. NIPS (1992). Pakistan Demographic and Health Survey 1990-91. Islamabad: NIPS and IRD/Macro International Inc., Columbia, Maryland, USA.

60. Okojie, C. (1994). Gender inequalities of health in the third world. Social Science & Medicine **39**(9): 1237-1247.

61. Papanek, H. (1990). To each less than she needs, from each more than she can do: allocations, entitlements and value. In I. Tinker (Ed.), *Persistent Inequalities: women and world development* (pp. Oxford: Oxford University Press.

62. Patel, R. (1991). *Socio-economic, political status and women and law in Pakistan*. Karachi, Pakistan: Faiza Publishers.

63. Popay, J. & K. Groves (2000). :Narrative" in research on gender inequalities in health. In E. Annandale and K. Hunt (Ed.), *Gender inequalities in health* (pp. 64-89). Buckingham: Open University Press.

64. Rodgers, G. B. (1999). Income and inequality as determinants. In I. Kawachi, B. P. Kennedy and R. Wilkinson (Ed.), *The society and population health reader* (pp. 5-13). New York: The New Press.

65. Sathar, Z. A. (1994). Intervening variables. In A. Iqbal and B. Dinesen (Ed.), *Fertility in Pakistan: a review of the findings from the Pakistan survey* (pp. 113-122). Voorburg: International Statistical Institute.

66. Sathar, Z. A. (1996). Gender perspectives in Pakistan's demographic transition. Gender perspectives in population, health and development in India, New Delhi, Unpublished paper.

67. Sathar, Z. A. & M. F. Kiyani (1998). Some consequences of rising age at marriage in Pakistan. The Pakistan Development Review: 541-556.

68. Stein, J. (1997). Factors effecting health. In J. Stein (Ed.), *Empowerment and women's health* (pp. 141-171). .

69. Stronks, K. et al. (1996). Behavioural and structural factors in the explanation of socio-economic inequalities in health: An empirical analysis. Sociology of Health and Illness(18): 653-674.

70. Stronks, K. et al. (1998). The importance of psychosocial stressors for socio-economic inequalities in perceived health. Social Science and Medicine **46**(4-5): 611-623.

71. Tinker, A. G. (1998). *Improving women's health in Pakistan*. Washington D.C.: World Bank.

72. UNICEF (1990). Gender differentials in access to health care for Pakistani children. Islamabad, Pakistan: UNICEF, Pakistan.

73. UNICEF (1998). *The state of the world's children 1998.* Oxford: Oxford University Press.

74. United Nations (1996). Too young to die: genes or gender (Draft). New York: United Nations, Population Division: 318.

75. Vlassoff, C. (1994). Gender inequalities in health in the third world: unchartered ground. Social Science and Medicine **39**(9): 1249-1259.

76. Waldmann, R. J. (1999). Income distribution and infant mortality. In I. Kawachi, B. P. Kennedy and R. G. Wilkinson (Ed.), *The society and population health reader* (pp. 14-27). New York: The New Press.

77. Wallerstein, C. (1998). Pakistan lags behind in reproductive health. British Medical Journal **317**(5 December 1998): 1546.

78. Weiss, A. M. (1999). *Women, civil society and politics in Pakistan*: Carfax Publishing Ltd.

79. WHO (1996). Violence against women: WHO consultation 5-7 February 1996. Geneva: World Health Organization.

80. WHO (1999). Gender and health: a technical paper. WHO Internet Site: World Health Organization: 39.

81. Wilkinson, R. G. et al. (1998). Mortality, the social environment, crime and violence. Sociology of Health & Illness **20**(5): 578-597.

82. Winkvist, A. & H. Z. Akhtar (1997). Images of health and health care options among low income in Punjab, Pakistan. Social Science & Medicine **45**(10): 1483-1491.

83. World Bank (1989). Women in Pakistan: an economic strategy. Washington D.C.: World Bank.

84. World Bank (1993). Investing in health: world development indicators. New York: World Bank.