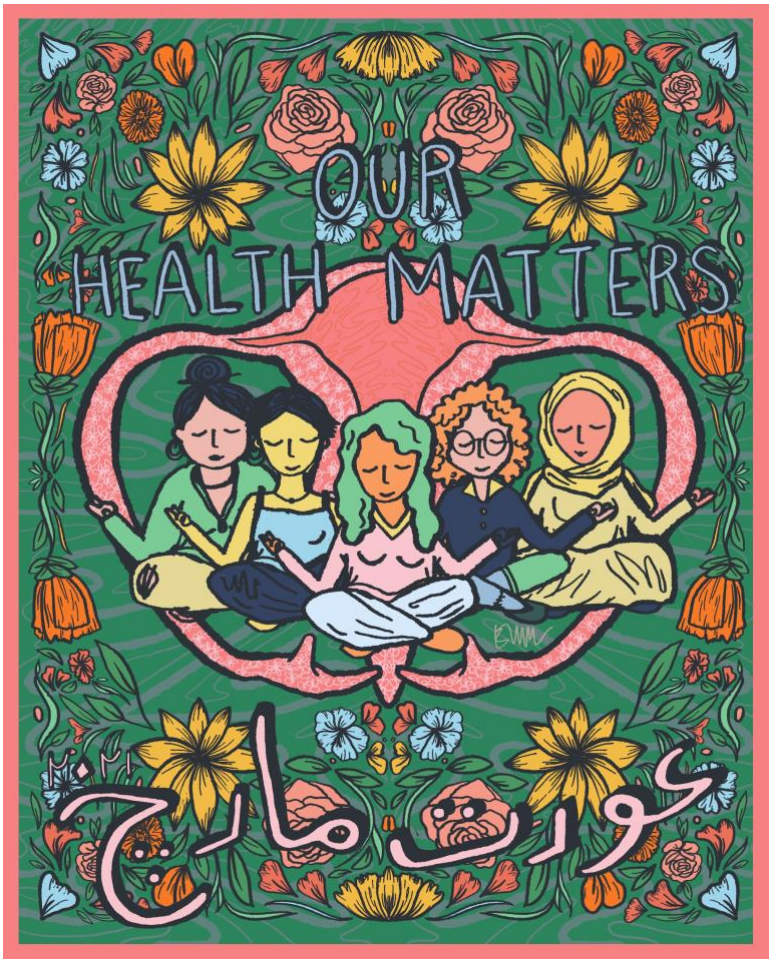
Feminist Manifesto on Healthcare - Aurat March Lahore 2021



Artwork by Emil.

The COVID-19 pandemic laid bare the stark inequalities in our society. Oppressions were amplified. Domestic violence ran rampant. The spectre of death and ill-health loomed over us all. Globally, we found the heart of society to be diseased. Diseased with injustice and inequality, with patriarchy and violence on gendered bodies, with vast class inequalities and capitalism, and with the dehumanisation of races and ethnicities. Our collective body was in pain.

Women everywhere experience the pandemic of patriarchy. Our bodies are crushed under the weight of unpaid labour. Patriarchy is a ravaging illness,

killing women every day. It is a femicide. The sickness of oppressive gender norms is slowly suffocating us. It is a violence. Keeping us scared in our homes, workplaces and motorways. This illness is systemic, it is structural, and our state is complicit.

In light of the cruelties wrecked on gendered bodies over the past year, the theme for this year's Aurat March Lahore is women's health. This issue is massively ignored at both an individual and structural level.

NOTE: In this document when we say women or *aurat*, we include everyone who self-identifies as a woman, regardless of their assigned sex at birth. We also include and advocate for non-binary identities, working to deconstruct these oppressive binaries and any identity oppressed by patriarchy.

1. Physical Health

1.1 Access to universal health care for every person regardless of gender identity, financial/social class, religion, sexual orientation, race, ethnicity, dis/ability and citizenship. **Universal health coverage** should cover prevalent issues in women's health, including reproductive and maternal health care.

> 1.1.1 We demand that the state fulfil its own constitutional obligations: Article 38 of the Constitution of Pakistan states that the state shall "*provide basic necessities of life, such as food, clothing, housing, education and medical relief, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment*".

1.2 We are **concerned** by the systematic reduction in the total health budget over the years; health expenditure as a percentage of the GDP went down from 1.2% in 2017-2018 to 1.1% in 2018-2019. This reduction is a direct result of the privatisation of the health sector and we are alarmed at the state's effort to package it as an 'effective economic solution'. This privatisation is symptomatic of the neoliberal policies of the state, outsourcing essential services to the 'market economy', turning healthcare into a for-profit business rather than a public service. The increased cost of health services results in women's health

concerns being further deprioritized and it also increases the burden of care work on women.

1.2.1 We demand that the **health budget be increased to 5% of the GDP in the 2021-22 fiscal budget** with specific information on allocated for women's, transgender, reproductive, mental and rehabilitative health. We demand that **all provincial governments release information regarding health budgets dedicated to reproductive health by March 8, 2021**, and **make public a plan for addressing COVID-19 specific challenges faced by women and gender minorities**.

1.2.2 The incumbent government has taken steps, such as the medical teaching institution (MTI) ordinance and the Sehat card, to move essential healthcare services towards a neoliberal model which treats hospitals like a corporate body with a board of governors, consisting of members from the private sector, that is guided by a profit logic rather than public welfare. We **resist efforts to privatise the health sector** as it will widen the yawning gap of access between the haves and have-nots.

1.2.3 The privatisation of healthcare results in decreased attention to health at the cost of increased focus on billing and profits. There has been a rise in unnecessary operations and procedures to serve the profit bottom-line, leading to an **over-medicalisation of healthcare services**. The most recent report of Pakistan Demographic and Health Survey (PDHS) shows a rapid increase in the rates of C-Section deliveries, from 14% in 2012-13 to 22% in 2017-18. Women who deliver at private health facilities are more likely to have a C-Section than women who deliver at public health facilities.[1]

1.2.4 While we welcome moves to expand coverage of the Sehat Sahulat Program/Card to differently abled persons (in AJK, GB, ICT, Punjab) and the transgender community. The program only caters to those registered with NARDA and have a CNIC. In Pakistan, marginalised populations such as women, transgender folks, refugees, and minorities such as the Hazara community are under-represented in the NADRA database and thus excluded from health coverage. Furthermore, the Khyber-Pakhtunkhwa

[1] https://pide.org.pk/blog/the-c-section-epidemic-in-pakistan/.

card **imagines and recreates patriarchal notions of how society should be structured** by issuing cards only to family units and not individuals, excluding individuals who don't fall into these neat categories.

1.2.5 As the government seeks to move into a public-private model for healthcare, there are **no mechanisms in place to regulate or monitor the quality of private healthcare**. Albeit the purpose of the Sehat cards has been to make healthcare accessible to low-income households, this seems unworkable in the absence of regulations to ensure quality and accountability in private health units. Lack of oversight and regulation leaves the door open for discrimination in care provided to Sehat card holders and regular patients as well as low quality and life-threatening healthcare provided those looking to profit off the system.

1.3 We recognise **gender-based violence and violation of our bodies as a healthcare issue** since it disproportionately harms the physical and mental capacities of survivors, and their loved ones. The healthcare system is first-responder in cases of physical and sexual violence, and therefore, have multiple opportunities to responsibly intervene and reduce harm. The trauma, which is an important concern for health practitioners, is disproportionately experienced by gender and sexual minorities due to structural patriarchal reasons that inevitably make the violence a health concern too.

1.3.1 Survivors of abuse need access to **mental as well as physical care within a rehabilitative framework** in order to adequately manage the long-term effects of the violence visited upon them. Health practitioners require training and autonomy to sensitively and efficiently handle the needs of the survivors.

1.3.2 We are painfully aware that healthcare settings become a primary **site of violence themselves**, especially for transgender people and differently-abled women. Unnecessary medicalisation of bodies not considered 'normal' and gatekeeping lay bare the rotting ambitions of a failing system that seeks to dehumanize what it does not understand. 92% of transgender people report facing discrimination or harassment in

healthcare settings in Khyber Pakhtunkhwa.[2] Another study in Punjab reported that 74% transgender persons prefer not to go public hospitals.[3]

1.3.3 Medicalised interventions to prevent sexual assault, such as physical and **chemical castration** of those who commit sexual offences, is a short-term solution that perpetuates that the faulty notion that rape is a crime of sexual desire rather than power. There is not enough medical evidence to suggest that chemical castration results in rates of recidivism. We state that in light of lack of medical evidence and an imperfect justice system, chemical castration is a cruel and unusual punishment and should be removed from the Anti-Rape Ordinance 2020 and assented by Parliament with the necessary amendments.

1.4 We demand introduction, and effective execution, of **educational programs centered on women's health**; issues that are considered taboo because of the sexualisation of women's bodies. This is particularly problematic when it comes to issues such as breast cancer, treatment for which requires early detection. Pakistan has the highest incidence of breast cancer in Asia, 1 in 10 Pakistani women are likely to develop breast cancer in their lifetime.[4]

1.4.1 We believe this is a feminist issue, the **stigma and shame associated with gendered bodies** prevents necessary interventions for mitigation and prevention. There is a dire need for public awareness campaigns for breast cancer prevention for the general population of Pakistan.

1.4.2 Apart from the essential information about the disease, these programs should include the method and importance of **breast self-examination for early detection of cancer**. We demand that the state actively work on increasing facilitation and wide access to screening to identify breast cancer in women even when they do not have visible symptoms, e.g., Mammography.

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[2] RHRN Young Omang (2017), "Health and Access to Care and Coverage for Transgender Individuals in Pakistan: A Call for Action", Peshawar, pp. 3-4.
[3] Good Thinkers Organization (2016). "Recognition of Third Gender: Realizing the Plight and Rights of Transgender Community in Punjab", Kasur, p. 18.
[4] https://hospitals.aku.edu/pakistan/campaigns/Pages/breast-cancer-awareness-2020.aspx, https://www.bbc.com/news/world-asia-50103088.

1.5 Women's health is regularly dismissed within the family, considered secondary to that of others in the household. Women are less likely to visit the hospital or seek treatment in case of illness. Furthermore, women's pain is often devalued by medical practitioners, drawing on stereotypes of women being the 'weaker sex'. We have to believe women when they say they're in pain. Due to the **'gender pain gap'**, illnesses specific to women are under-/mis-diagnosed and under-treated by medical professionals.[5] We demand gender bias training to be a mandatory part of doctor's education and regular measures be undertaken to unlearn these biases. We demand greater representation of women and gender minorities in clinical trials and sex-based research to ensure that the impact of drugs and treatments take into account needs of women (Also see section 6).

1.6 Increase the number of gender-sensitised **medico-legal officers** and the number of hospitals fulfilling medico-legal requirements. Medico-legal officers should have a dedicated space for examination, proper equipment, SOPs for privacy, a conducive environment, more security, and trauma sensitive training for handling cases of sexual assault and violence.

1.6.1 We demand the archaic **two-finger 'virginity' test** be banned across the country and de-facto discontinued in line with the judgement of the Lahore High Court. We agitate SOPs be developed immediately to ensure the test is not conducted by medico-legal officers. Effective equipment to collect evidence in cases of sexual assault, such a rape kits, must be made easily and widely accessible by the state.

1.6.2 We are deeply disturbed by the news that the Forensic Department of Khyber Medical College University has proposed **charging for its forensic services**, which includes medical examination of rape victims will cost Rs25,000 and the charges for autopsy will be Rs5,000 for the local residents of Peshawar.[6] This is indicative of privatisation of the healthcare system, turning patients and victims of sexual assault into 'customers'. Barriers to reporting sexual assault are already very high in our society

[5] https://www.nytimes.com/2013/03/17/opinion/sunday/women-and-the-treatment-of-pain.html.
[6] https://tribune.com.pk/story/2284972/1?fbclid=IwAR3Dv7Jx3XhDl81gT5I9-zdkI-43RjXvvM6ipl176kje7pvsYA9Gew2l1Ps.

and conviction rates are under 3%[7] and 0.3% according to other estimates.[8] It is the state's responsibility to reduce harm for a victim and survivor of sexual violence, not to retraumatise them by fleecing them for cash when they turn to the justice system for assistance.

1.7 The **number of HIV-positive people has nearly doubled** and there has been a 369% increase in deaths, per UNAIDS.[9] in Pakistan from 2010 to 2018. This is due to the reuse of syringes, inadequate blood transfusion practices, unsafe intercourse practices and unhygienic barber utensils as well as roadside dentists using unsterilized equipment. We demand public awareness on the spread of HIV and resources to prevent the formation of epicentres as was seen in Ratodero in 2019.[10]

1.7.1 People diagnosed with HIV are often treated as pariahs within their community and mainstream healthcare settings. There are misconceptions that sharing food, or touching HIV-positive people causes the spread of the disease. This leads to social ostracism and, in extreme cases, deadly violence. Educational campaigns must **debunk misconceptions about HIV**, so that the affectees can live and work with dignity and safety. Access to antiretrovirals must be made easier and affordable.

1.7.2 **Access to free medicines** is one of the biggest barriers to curbing the HIV epidemic. According to the Punjab Health Department only 11,000 patients had access to free medicines while around 90,000 patients in Punjab were not getting any medicines.[11] Pre-exposure Prophylaxis (PrEP) is a method of prevention of HIV used globally by populations with a high risk of exposure. When taken as prescribed, it significantly reduces the risk of contracting HIV. We demand PrEP medication to be locally available and covered by universal healthcare for the at-risk population of Pakistan.

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[7] https://www.geo.tv/latest/308019-less-than-3-rapes-in-pakistan-lead-to-conviction.
[8] https://www.thenews.com.pk/print/743228-only-0-3pc-rape-suspects-convicted-in-past-6-years.
[9] UNAIDS. (2019). Country Snapshot: Pakistan.
[10] https://www.nytimes.com/2019/10/26/world/asia/hiv-aids-pakistan-ratodero.html.
[11] https://tribune.com.pk/story/2285107/control-programme-fails-to-contain-hiv-in-punjab.

1.7.3 We demand that the vulnerability of gender and sexual minorities to HIV/AIDS be compassionately understood and the devastating impact that the pandemic has had on the community be recognised, that any attempts to weaponize the disease against marginalized communities be immediately throttled. We also demand that community-based organizations working with 'key populations' be made an equal part of the consultative process for legislation on HIV/AIDS in Punjab and adequate provisions be added in the Bill to address the needs of these communities.

1.8 We assert the **rights of differently-abled people** to live life with freedom, dignity and respect, without discrimination in attaining education, healthcare or employment. We recognise that differently-abled women face multiple oppressions from an ableist and patriarchal society. They are more vulnerable to violence, 77% of differently-abled women and girls face physical violence and among them, 72% never complained to anyone.[12]

1.8.1 We demand the adaption of the **ICT Disabilities Rights Act of 2020**[13] in all provinces at the earliest opportunity and be implemented with immediate effect. The National Council for Disabled Persons must be established as recommended in the Act, for the advancement of issues specific to disabled people.

1.8.2 We assert that specific measures be taken to **make hospitals, medical facilities and community health programs accessible** to differently abled people, particularly women and gender minorities. Doctors must be sensitized to the particular needs of differently-abled persons, and hospitals and clinics must be structurally redesigned to account for different abilities. We understand that accessibility to healthcare for differently-abled women requires an ecosystem and infrastructure of accessibility, not just limited to the healthcare system itself, including accessible transportation.

[12] https://www.thenews.com.pk/print/453585-77-disabled-women-girls-face-physical-violence.
[13] https://www.sightsavers.org/news/2020/01/pakistan-disability-act-becomes-law/.

1.8.3 We encourage the implementation of the *Rd. Shahnawaz Momani & Others* judgment[14] ordering for the inclusion of differently-abled people in public life and the *Malik Obaidullah* judgment which posits that the 'medical model' to be discontinued and the **adoption of the 'social model'** which "requires the transformation of societal attitudes and state policies".[15] Additionally, we demand that **less visible disabilities**, particularly mental illness, also be recognised as disabilities both at a societal and legal level.

1.9 We demand for transgender persons and the *Khawaja Sira* community's right to equitable access to and experience of health services. We reaffirm the section 4(d) of the Transgender Persons (Right of Persons) Act 2018 which states that "the denial or discontinuation of, or unfair treatment in, healthcare services" is prohibited.

1.9.1 As per the Transgender Persons (Protection of Rights) Act, 2018, we assert that every person must have the right to be **recognised as per their self-perceived gender identity**. The state should allocate more resources vis-à-vis sensitization training to ensure that the normative practice of misgendering within the medical community is corrected. **Misgendering** and the fear of being misgendered within the health system can often lead to inadequate healthcare provided to individuals as well as traumatisation.

1.9.2. We would also remind the state of its obligations under section 12 "to **review medical curriculum and improve research** for doctors and nursing staff to address specific health issues of transgender persons in cooperation with PMDC… to facilitate access by providing an **enabling and safe environment for transgender persons** in hospitals and other healthcare institutions and centres [and] … to ensure transgender persons access to all necessary medical and psychological gender corrective treatment." Currently, the PMDC's 'Code of Ethics of Practice for Medical and Dental Practitioners' includes no specific guidelines for providing care to transgender patients. Even after the passage of the 2018 Act, **no guidelines or policies have been developed** by the government. Although 78% HCPs claimed to be familiar with the Code, they completely lack

[14] https://www.supremecourt.gov.pk/downloads_judgements/const.p._64_2013.pdf.
[15] https://www.supremecourt.gov.pk/downloads_judgements/c.p._140_l_2015.pdf.

knowledge of any ethical guidelines when dealing with transgender patients. When asked if their medical education adequately prepared them to provide care for transgender patients, 46% said they were unprepared or 34% said they were only partially prepared.[16]

1.9.3 Even though **medical assistance during transition** is an essential need of the transgender/*Khawaja Sira* community, the provision of these services is severely neglected. Few doctors agree to perform the sex reassignment surgeries due to the patriarchal stigma attached to asserting the right over our *jams*. Most of the transgender community has to resort to self-medication and dangerous back-alley operations. We demand for the **institutionalization of accessible, competent and non-discriminatory hormone therapy treatment for the transgender/*Khawaja Sira* community**.

1.9.4. There is deep mistrust of the healthcare system within the trans/*Khawaja Sira* community due to the historical mistreatment, leading to a general reluctance to being open about sexually transmitted diseases and accessing healthcare.[17] It is the **onus of the state to rebuild that relationship** through outreach programs, and greater accountability measures for prejudiced treatment.

1.9.5. The COVID-19 pandemic has adversely affected the transgender/*Khawaja Sira* community that has suffered a **collective loss of income**. The community has been pushed into a **dire 'hunger crisis' during the pandemic** with the usual sources of earning livelihood having dried up.

- In Khyber Pakhtunkhwa, 75% reported being unable to manage their finances; some having been driven to debt and homelessness. There is a dire need for ensuring access to relief especially in remote areas, including the newly merged KP districts.[18]
- Existing socio-economic marginalization and health conditions mean more trans persons live in a state of invisible multi-

[16] RHRN Young Omang (2017). "Health and Access to Care and Coverage for Transgender Individuals in Pakistan: A Call for Action", Peshawar, p. 7.
[17] https://www.dawn.com/news/1472414.
[18] Blue Veins (2020). Differently Similar: A research on impact of COVID-19 on Transgender Community in Khyber Pakhtunkhwa, Peshawar, p. 20.

dimensional vulnerability and compromised health. Transgender and non-binary persons living with hostile families under COVID lockdown have to deal with added stress and trauma.[19] The state must take responsibility for implementing no-discrimination policies and gender-affirmative healthcare solutions across the board that ensure special grievance redressal mechanisms for transgender persons.

- Only 60% have **access to clean water** and 30% do not have **access to functional toilets**.[20] Relocations due to income loss and residence in congested quarters have made it practically impossible for a majority to follow SOPs. For 83%, their line of work puts them **more at risk of contracting the virus**.[21] The elderly with underlying health conditions are even more vulnerable now. Understanding specific vulnerabilities of marginalized groups is crucial to providing them with much needed relief. Policymakers must ensure equitable and meaningful representation of transgender individuals in designing interventions for COVID-19.
- The NCOC must ensure that data on COVID-19 is segregated to identify transgender persons and it is publicly available.

1.10 Aurat March demands that the **COVID-19 vaccine rollout** policy by the National Command Operation Centre (NCOC) and Ministry of National Health Services take into account accessibility for all classes, genders and racial and religious minorities. Gender, racial and religious minorities, especially from financially disadvantaged classes, do not have ready access to healthcare facilities due to familial restrictions and problems of mobility. The vaccine rollout must be conducted with mobile health teams, with a countrywide educational program on inoculation benefits. The vaccine must be **equitable** and **free of cost**, with strict adherence to medically ordained priority levels.

[19] https://www.pk.undp.org/content/pakistan/en/home/stories/social-inclusion-of-vulnerable-transgenders-in-times-of-covid-19.html.
[20] Blue Veins (2020). Differently Similar: A research on impact of COVID-19 on Transgender Community in Khyber Pakhtunkhwa, Peshawar, p. 16.
[21] Dareecha Male Health Society and Dostana Male Health Society (2020). The Forgotten Humans: Effects of COVID-19 on Transgender Community and Key Population in Pakistan, Islamabad, p. 23.

1.11 We demand the implementation of the measures outlined in the 2020 report published by the Ministry of Human Rights on the **conditions of female prisoners in Pakistan**.[22] The presence of only 24 female health workers to cater to the needs of female prisoners across the country is a travesty.[23] Globally the spread of COVID-19 has been rampant in prisons, and the report finds that Pakistani prison officials have also failed to observe measures like social distancing and mask wearing to curb the spread of disease. We demand the implementation of the Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the "Bangkok Rules") in female prisons nationally. Currently around 12% of women have children with them in prison who are as old as 9 or 10 years old. This is clearly against international laws which recommend non-custodial arrangements for pregnant women or women who are the sole caretakers of their children. Chronic contagious diseases such as HIV, tuberculosis and hepatitis were rampant with inadequate supplies of medical equipment and ambulances. These issues must be addressed at the earliest opportunity.

1.12 We strongly assert that **addiction and usage of drugs be treated as a public health issue** rather than through a carceral approach which disproportionately criminalises addiction among the most marginalised sections of society. Drug usage among women,[24] transgender people and gender non-conforming individuals[25] is often ignored as it may be less communal or less open as compared to men's. The stigma of drug usage is experienced acutely at the intersection of marginalised identities, with women and trans folks often denied medical care and welfare services because of their addiction. We demand that the state use a **rehabilitative approach to drug use**, with investment in public infrastructure that makes rehabilitative services available to the entire population. There is a dearth of affordable rehabilitation facilities in Pakistan, the ones which are available are often operating under unhygienic, unscientific and inhumane conditions.[26] Rehabilitation facilities must be regulated to ensure their practices are humane, and in line with modern medical advances.

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[22] http://www.mohr.gov.pk/SiteImage/Misc/files/Prison%20Report_1pbleed_pq.pdf.
[23] https://www.hrw.org/news/2020/09/07/pakistan-poor-conditions-rife-womens-prisons.
[24] https://tribune.com.pk/story/552830/anti-anxiety-pills-mamas-little-helper.
[25] Dareecha Male Health Society (DMHS) (2019). A Silent Battle: Bullying and Harassment of Sexual and Gender Minorities in Pakistan, Islamabad, p. 25.
[26] https://www.aljazeera.com/features/2016/7/4/my-mothers-battle-with-drug-addiction-in-pakistan.

1.13 We demand an **immediate end to early underage marriage**, which is a manifestation of the lack of control women and young girls have over their own bodies. Nearly 2 million girls in Pakistan were married or in a union before the age of 18,[27] which is the sixth highest absolute number in the world. Early marriage leads to early pregnancy, which is one of the factors contributing to maternal mortality and long-term health problems.

1.13.1 This issue intersects with that of **forced conversions of girls from minority religions** culminating in marriage. The Centre for Social Justice (CSJ) found that 162 cases of forced conversions were reported in the media between 2013 and 2020, and 46% of them were minors (32.7% aged between 11-15 years).[28] Forced conversions and marriages are often condoned by local police and union councils who turn a blind eye, often complicit in falsifying documents. We demand that clear and direct legislation be passed in all provinces to criminalise forced conversions, but also recognise that these legal interventions are not enough without political and societal will to take on this issue.

1.13.2 Child marriages have devastating consequences, with girls dropping out of school at a higher rate, being more likely to face pregnancy-related complications as well as being more likely to be victims of domestic violence. We demand an overarching structural reform to intervene in child marriages.[29] It is not enough to simply outlaw the act, however **raising the minimum age of consent for girls** from 16 to 18 would be a vital step through amendment of the Child Marriage Restraint Act. Alleviation of poverty, focus on education, and campaigns to change the mindset of decision makers such as local leaders, imams, and local officials are necessary to make laws meaningful.

1.13.3 However, it is important to draw distinctions within the law between forced marriage and self-arranged early marriages, the

[27] https://www.girlsnotbrides.org/child-marriage/pakistan/.
[28] https://www.dawn.com/news/1592945.
[29] https://www.globaldev.blog/blog/child-marriage-pakistan-evidence-three-development-programs.

criminalisation of the latter would put girls at greater risk and expose them to the carceral system.[30]

1.14 We recognise the toll and impact **physical labour in industries such as agriculture and garments has on women's health**. Industries frequently exploit women's labour with low wages, unsafe working conditions and long working hours. Many factories regulate toilet breaks, meaning that menstruating women have to wear the same sanitary pad/napkin for hours and often develop infections. Women are more likely to work in informal, cottage industries where regulation and accountability for poor working conditions is less likely. We demand that **humane and non-exploitative working conditions be recognised as a public health issue**. We demand that the ban on labour inspections instituted by the government is cruel and is resulting in the exploitation of the most vulnerable workers.

2. Reproductive Health

For far too long, women's reproductive health has been framed under the narrow understanding of "population control" and "family planning", which tends to reproduce colonial-era and racist structures that strengthen patriarchy rather than dismantling it. We want to re-centre the idea of bodily rights into the healthcare system. We, as Pakistani feminists, demand that the patriarchal grip over our bodies be dismantled to allow women and gender minorities to control and decide what happens to their bodies and health.

2.1 All individuals should have **rights over their bodies and the power to make decisions regarding health.** We recognise that women and gender minorities have systematically been denied autonomy and control over their own *jism*. This right is denied to us by our partners, families, communities, and the state. We

[30] https://www.dawn.com/news/1600526.

march for autonomy over our own bodies. Reproductive health has been long neglected by the state, part of the larger neglect of women-centric issues.

> 2.1.1 We demand that all provincial governments **release information regarding health budgets dedicated to reproductive health by March 8**, 2021 and make public a plan for addressing COVID-19 specific challenges faced by women and gender minorities.
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> 2.1.2 Denial of reproductive rights is intricately tied to power structures within the family, within which women's bodies are seen as an extension of the family's property, reputation and honour. The fight for women's health, and that of gender minorities, is part of this larger struggle for **dismantling power structures within the patriarchal family**.

2.2 **Forced gender reassignment medical procedures**, particularly against intersex individuals in order to make them conform to a gender binary, should be recognised as a form of sexual and gender-based violence. These procedures are often performed on individuals who are too young to give consent or make informed decisions regarding their biological and gender identity.[3132] The ICJ notes that procedures are often irreversible and cause permanent "infertility, pain, loss of sexual sensation and lifelong mental suffering, including depression"[33] and recommends **adding "additional provisions [in Transgender Persons (Protection of Rights) Act, 2018]** to ensure the respect, protection and fulfillment of the rights of intersex people, such as the prohibition of medically unnecessary hormonal treatment, surgical and other procedures, including "sex-assignment surgeries", on intersex children and adolescents, unless and until they are performed with their full, free and informed consent.[34] **Strict guidelines and oversight** of such procedures need to be formulated, placing the consent of individuals at the centre of such procedures.

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[31] Note: These coercive surgeries are being regularly performed in Pakistan mutilating hundreds of children every year: https://www.thenews.com.pk/print/287739-100-infants-with-birth-defects-rehabilitated.

[32] https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us.

[33] https://www.icj.org/wp-content/uploads/2020/03/Pakistan-Transgender-Advocacy-Analysis-brief-2020-ENG.pdf.

[34] https://www.icj.org/wp-content/uploads/2020/03/Pakistan-Transgender-Advocacy-Analysis-brief-2020-ENG.pdf, P. 12.

2.3 We reaffirm the **rights of children and adolescents over their own bodies**, to be secure from non-consensual contact, and their right to a comprehensive education that will allow them to assert control over their own bodies. Given the high prevalence of child abuse in the country,[35] **consent-based, Life Skills Based Education (LSBE)** needs to be part of the primary and secondary school curriculum. This education is mandated by many local policies, the National Education Policy 2009, National Youth Policy, Sindh Reproductive Health and Rights Act 2019, the Single National Curriculum, National HIV and AIDS Strategic Framework 2007–2012, and international conventions such as UN Convention on the Rights of the Child (UNCRC), Sustainable Development Goals (SDGs), Ottawa Charter for Health Promotion, and the Jomtien Declaration on Education for All.

2.3.1 We demand access to information regarding reproductive health through nation-wide public awareness campaigns, localised and disseminated through all available mediums. Awareness campaigns should also seek to de-stigmatise conversations around reproductive health. We agitate for investing resources in local and community-based health infrastructure to change attitudes around women's reproductive health.

2.4 Pakistani women have very limited **access to birth contro**l, with only 23.6% women use any method of contraception (World Fertility and Family Planning 2020, UN) resulting in high fertility rates (3.5% in 2019) that can cause long-term medical conditions ranging from urinary incontinence, maternal depression and in more extreme cases, infertility and death. This is a health emergency and we demand greater state investment in the provision of free and accessible contraception.

2.4.1 We recognise that **wilful denial of contraception or access to health services by partners and families is a form of domestic violence**. We demand that provincial Acts must include this denial within their definition of domestic violence.

2.4.2 We demand universal access to family planning for all. We call for an end to the divide of access to family planning and healthcare professionals, such as doctors and midwives, between rural and urban environments. Any such program must recognise the needs and

[35] http://sahil.org/cruel-numbers/.

challenges of single mothers, divorced mothers, aging mothers, differently abled mothers, mothers engaged in sex work, transgender parents and parents/caregivers in non-normative roles in the provision and access of maternal and reproductive healthcare.

2.4.3 This access includes availability of effective, modern and affordable methods of family planning. Women who are already shouldering an **economic burden** should not have to worry about finances in trying to obtain contraceptives that will meet their needs and their budgets.

2.4.4 The **rural-urban divide** in the quality of healthcare professionals and services is criminally negligent, contributing to rising negative maternal and child health indicators. We recognise that the government needs to prioritise bridging this gap, and ensure access to safe medical and family planning services to all rural areas. Currently, there are an estimated 14.5 physicians and 7.6 midwives per 10 000 population in urban areas to 3.6 physicians and 2.9 midwives per 10 000 population in rural areas. The government must address this rural-urban divide.

2.4.4 There needs to be a vast improvement to the supply chain and stock of contraceptives. It is estimated that in the next 6 months, Pakistan will face a shortage of contraceptives due to logistics disruptions caused by COVID-19.[36] This will exacerbate an already worsening situation, as Pakistan has seen a general reversal of positive trends in maternal and child health indicators in recent years. We strongly urge the Government to ensure availability of contraceptives on the market, in health care facilities, to Lady Health Workers and mobile health clinics.

2.5 We demand widespread educational campaigns on **family planning** that are inclusive in nature. In Pakistan, one-quarter of married women want a gap between childbearing or do not want to continue childbearing,[37] but are not using a family planning method. Women report a large unmet need for contraception. Some common impediments are opposition by family, concerns

[36] http://familyplanning2020.org/sites/default/files/COVID/UNFPA-Pakistan-Brief-COVID-19-Impact.pdf.
[37] https://pai.org/wp-content/uploads/2012/01/pakistan.pdf.

about health and side effects. Women with secondary school education are more likely to use modern contraceptives at a rate of 26% compared to the 19% of women with no education.[38]

2.5.1 The government must ensure that women are **aware of their rights, options and the potential health effects** in reference to childbearing and family planning. This can be done with media and school campaigns, increased mobilization of Lady Health Workers and mobile health units.

2.5.2 We reiterate our demand for an education that informs children about their rights and options regarding their own bodies and reproductive health through Life Skills Based Education (LSBE).

2.6 All individuals should have **access to safe abortion facilities and information**. Health professionals must be trained to provide information regarding abortion, regardless of their personal biases.

2.6.1 SOPs must be developed to read the provisions in the law regarding "necessary treatment" to include the economic, social and psychological welfare of the mother.

2.6.2 **Post-procedure care** should be provided as a matter of right for everyone who seeks an abortion. According to reports, 48% of pregnancies in Pakistan are unplanned and women are often forced to access unsafe abortions due to denial of legitimate services by medical practitioners due to social stigma and criminalisation, resulting in back-alley or self-inducted abortions which cause deaths and long-term health complications. Reports indicate that 13% of maternal mortality is attributed to unsafe abortions.

2.7 We demand that emergency measures be taken to address **maternal health**, particularly the **high rate of maternal mortality** among Pakistani women; most of these deaths are entirely preventable. Poor nutrition during pregnancy stems from dehumanisation of women within the household, i.e., women are often the last to eat within the family and there is a lack of attention given to the specific dietary requirements during pregnancy. 52% of the reproductive mothers in Pakistan are anaemic (Global Nutrition Index).

[38] https://pai.org/wp-content/uploads/2012/01/pakistan.pdf.

2.8 Access to **health facilities and health care workers** (such as doulas or midwives) during birth should be a basic right. More than 60% of women categorized as poor do not have access to basic sanitation, while 70% do not have a skilled health professional available at childbirth. We demand that the state invest in these services and take steps to bridge the rural-urban divide therein.

2.9 Women should have unhindered **access to resources for detection, treatment and prevention of reproductive cancers**. For example, breast and cervical cancer.

2.9.1 The Human Papillomavirus (HPV) is responsible for 90% of cases of cervical cancer, 70% of vaginal and vulvar cancers, and 60% of cases of penile cancers.[39] A *simple vaccine* is available which can be administered to children as young as 9 and adults as old as 45. The state must pay urgent attention to the distribution of this vaccine, nationally and free of cost.

2.9.2 Women must be provided basic **education about self-examination for breast cancer.** They must be made aware of the need for regular screenings by a medical professional, and their access to such screenings and information must not be hindered by the patriarchal concepts of shaming conversations around gendered bodies.

2.9.3 The **hormonal irregularities** and the health complications that arise with them are a major source of physical and mental distress for women. Gynaecological healthcare is inextricably linked to fertility, weight and marriage and is used as **a regular tool of body shaming and enforcing normative sexuality on young women**. Women are regularly subjected to medicines with harmful side effects in order to make them fit ideas of desirability. Women suffering from ovarian disorders, even cancer, have to navigate the cruel healthcare spaces in silence and shame by denying their own bodily truths. They have to become someone else in order to get the help they need. The reproductive healthcare for women reproductive should be disassociated from child bearing ability,

[39] https://health.mil/News/Articles/2020/01/14/HPV-vaccine-now-recommended-for-those-up-to-age-45.

matrimonial success and heteronormativity. The examination table should not be a site of shame.

2.10 Reproductive rights include the **right to privacy** of one's body, gender, sexual expression, and health history. The right to privacy includes control and choice over our bodies. We demand that the necessary legislative and structural reforms be made to ensure the privacy of all genders seeking health care.

2.11 **Sex-selective abortions** are part of a larger femicide against women. It is estimated that from 2000-2014, 219 pregnancies were terminated daily in Pakistan on the basis of sex (female foeticide), and around 90-95% of babies abandoned at birth are girls (female infanticide).[40] Economic constraints, social norms, and a patriarchal society have combined to have created a skewed sex to birth ratio of a 110 male births to a 100 female births. The practice of sex-selective abortions is an extension of patriarchal attitudes towards women within the household; the preference for sons places pressure on women to produce male offspring and the taboo placed on abortions forces it to happen in the shadows. Widespread educational campaigns aimed at changing this patriarchal mindset must be implemented. Providing safe abortions in a transparent and gender-sensitive manner along with SOPs in place for doctors will help curb this practice, while according dignity to mothers and the unborn child.

2.12 We demand the provision of health facilities to sex workers who are discriminated against within the healthcare system, stigmatised and often denied healthcare because of the nature of their work. We assert that **sex work is a form of work** and any regulation of it should be outside the carceral system. We assert that antiquated criminal laws targeting sex workers, that prevent reporting of violence, such as trafficking, sexual assault, rape and blackmail and extortion, be repealed. During the COVID-19 pandemic, sex workers are particularly vulnerable to the virus given their financial precarity and the inherent unsafe environment created by their job. We demand that the state **develop SOPs to ensure that sex workers are not discriminated against when accessing healthcare**, which includes non-judgmental treatment by medical staff, and specific resources made available that cater to the particular medical issues that they face, including screening and prevention for sexually

[40] https://www.dawn.com/news/1352104.

transmitted diseases (STDs), access to modern contraception, and safe abortion facilities.

2.13 The state must tackle issues attached with **menstrual health** in our country that are significantly compromising women's safety and wellbeing: lack of knowledge around menstrual health and safe sanitation. The issue largely intersects with class given inaccessible, unaffordable menstrual products and lack of latrine facilities.

2.13.1 **Lack of feminine personal hygiene is a major health risk**. Despite being a natural process, menstruation is a taboo which impedes it being discussed openly. Menstruation is thus shrouded in secrecy and around **66% of women in South Asia do not know about menstruation before their first period**.

2.13.2 Lack of latrine public facilities **disproportionately impact menstruating women, forcing them to miss school, work, curtail mobility and public participation when they're menstruating**. According to a UNESCO official survey, 46% of the primary schools have no latrines and there is no proper provision of water in 51% of schools. One-third of girls drop out of school before completing primary education due to lack of proper menstrual sanitation facilities in schools. We demand access to safe toilet facilities in all schools, places of work, public transportation and public places.

2.13.3 It has been estimated that around 79% of women in Pakistan are unable to manage their menses in a hygienic manner.[41] Unhygienic menstruation practices may lead to issues such as UTIs and various pelvic inflammatory diseases. The lack of sanitation facilities, knowledge and access to hygiene products leads to substantial anxiety and stress for menstruating women.

2.13.4 We call for **an end to the unequal access to sanitary products and hygiene** between rural and urban environments and demand for the provision of sanitary products to all rural areas across the country. Prices

[41] https://tribune.com.pk/story/1418055/79-pakistani-women-dont-manage-periods-hygienically.

of female sanitary napkins and other products should be heavily subsidised to be made easily accessible to all women.

3. Mental Health

3.1 We demand that patriarchal, environmental, and structural stressors that lead to adverse mental health in women, gender and sexual minorities be recognized as a health emergency, and for treatment to be prioritized as a need rather than a luxury. We demand that the state make good on its Nation Health Vision 2016-2025 which recognises that "Poverty, low literacy, unemployment, gender discrimination, and huge treatment gap have led to an invisible burden of mental health problems in the society."[42]

3.2 We assert that **emotional and psychological abuse be recognised as a form of violence**. The state must also recognise that societal, structural and institutional practices against women such as karo kari, satta wata, 'honour' killings, marital rape/abuse, harassment, forced childhood marriages, gendered violence, forced conversions, religious and ethnic discrimination traumatise women and gender minorities. This is both an individual and collective trauma. It is crucial to recognize the damage these practices cause and utilize structural mechanisms to eliminate them from our society.

3.2.1 Gender and sexual minorities face **'minority stress' due to the prejudice, emotional and physical abuse they suffer every day**, particularly from their own families. Four out of every five such persons face psychological health issues and two out of five take refuge in drugs of different kinds. Only a small fraction is able to consult psychologists and

42 https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/pakistan/national_health_vision_2016-25_30-08-2016.pdf.

psychiatrists and half of them say that they found their consultants not trained or sensitized in dealing with their needs.[43]

3.2.2 Women and gender and sexual minorities have faced **a crisis of mental health due to COVID-19 associated lockdowns and isolation**. For around 35 percent of persons belonging to gender and sexual minorities, consumption of addictive substances increased in the first six months of the pandemic. This was a direct result of exclusion and abuse and only 19% had access to professional psychological support for mental health ailments. Nearly two-thirds reported facing conflict with family during this time and in one-third cases, they were subjected to intimate partner violence. Social exclusion has invariably exacerbated for marginalized groups in the pandemic and a majority continue to suffer in silence and invisibility.[44]

3.2.3 We recognise the **second-hand trauma that patriarchal violence** can take on those of us who inhabit vulnerable bodies. This trauma impacts families, communities, first responders, law enforcement officers, medical staff and the public at large.

3.2.4 We understand that digital spaces are accessed and navigated in different ways based on gender, class and minority status. Given the increased use of social media during the pandemic[45], it bears repeating that **persistent cyber harassment and targeted online abuse against women and minorities impacts the health and wellbeing of vulnerable individuals**. It needs to be said that COVID-19 advisories and guides are not equally accessible for everyone in online spaces.

3.3 The **feminisation of mental illness**, association of women's emotional reactions with hysteria need to be de-linked and de-stigmatised. The stereotypes of masculinity prevent many from seeking mental health services; **our struggle seeks to ensure everyone receives these services** regardless of

[43] Dareecha Male Health Society (DMHS) (2019). A Silent Battle: Bullying and Harassment of Sexual and Gender Minorities in Pakistan, Islamabad, p. 25.
[44] Dareecha Male Health Society and Dostana Male Health Society (2020). The Forgotten Humans: Effects of COVID-19 on Transgender Community and Key Population in Pakistan, Islamabad, pp. 24-29.
[45] https://digitalrightsfoundation.pk/wp-content/uploads/2020/06/Covid-19.pdf.

their gender identity, financial/social class, religion, sexual orientation, race, ethnicity, dis/ability and citizenship.

3.4. We demand assignment of **mental health facilities as part of gynecological/ postpartum treatment**. A large number of women suffer through postpartum depression as it goes undiagnosed and unrecognised. It is vital for our state to acknowledge its treatment as an essential part of post-pregnancy treatment. We demand active de-stigmatization of postpartum depression, recognizing that it is deeply interwoven with the patriarchal burden of care work on mothers, and reduction of their purpose to that of being mothers.

3.5 We demand **trauma-training of legal professionals** for more informed responses to cases of abuse, sexual assault and harassment. We must recognise the inadequate response and neglect towards victims/survivors of abuse, sexual assault and harassment and actively work towards justice system reform that responds to the lived experiences of victims and survivors.

> 3.5.1 Medical officers dealing with rape and other kinds of gendered violence must be **trained in psychological trauma and trauma informed first aid**.
>
> 3.5.2 Women's lives do not end when violence happens, the health system must work towards **harm-reduction** when cases of violence are brought forward. We demand that all anti-rape and violence against women legislation should include **provisions for rehabilitation of victims and survivors**, with resources dedicated for **psycho-social care at all institutions tasked with dealing with victims/survivors**.

3.6 We assert that physical illnesses take an additional mental toll. This is particularly true for stigmatised illnesses which result in isolation from society.[46] The National Health Vision recognises the 'double burden' of **mental health components of infectious diseases** such as TB, HIV/AIDS and Hepatitis B and C. We demand psycho-social care be a significant part of public programs to address these diseases.

[46] https://www.himalmag.com/aids-in-pakistan-medical-issue-web-package/.

3.7 It is high time for the **silence around eating disorders and body image** to be broken. The 'beauty myth' continues to ravage the lives of young women through advertisements, entertainment media and popular culture. We carry the inter-generational weight of shame around our bodies. We are punished and tortured for embracing our bodies. We are reminded of our so-called imperfections in parks, on streets, in homes, in bathrooms and online spaces in order to keep us in control and under wraps. The dietary regimes represent ritualistic trauma in the lives of women, young and old, deemed undesirable. Skin whitening injections are a regular staple in the *rishta* industry. The discourse on mental and physical healthcare needs to acknowledge the gendered war waged on bodies of women and the systematic way in which such regimes of healthcare intersect with 'beauty' ideals. The silence around eating disorders and co-occurring mental health issues is not coincidental; it is deliberate and criminal.

3.6.1. The haunting presence of eating disorders in the lives of women who have undergone sexual trauma, especially with PTSD, needs to be seen and treated with the seriousness it deserves.

3.6.2. Numerous studies indicate that women of transgender experience suffer an increased risk of developing eating disorders due to the exclusion and abuse they are systematically put through. In their hypersexualized visibility, they are made complicit in their own erasure - which is bodily, psychological, emotional and spiritual. The healthcare systems need to acknowledge the trauma that trans bodies are put through on a daily basis and address their needs in a holistic manner.

4. Harassment and violence faced by women health workers

4.1 **All female health workers have the inalienable right of working in a safe environment**, where their colleagues and seniors do not subject them to verbal, physical and sexual harassment, affecting their mental well-being and ability to give care. We demand a work environment which is supportive of the safety, dignity and diversity of all its workers.

4.1.2 Despite mandatory provisions in the 'Protection against Harassment of Women at the Workplace Act, 2010', **most hospitals do not have**

functional sexual harassment committees. We urgently demand for these committees to be constituted, and call for greater checks and balances to ensure that the inquiry committee is bias-free, transparent and accountable. The process of investigation should be victim-centric and the right to privacy and dignity of the victim/survivor should be recognised.

4.1.3. We demand that the Workplace Act 2010 should be amended to include harassment by patients and clients. Furthermore, the law should be amended to clearly state that public and private areas outside of the workplace also come within the law's ambit.

4.2 We recognise the **immense burden Lady Health Workers carry in upholding the precarious health system in this country**, often working long hours and covering vast distances to the detriment of their own health. The labour of Lady Health Workers is devalued because of their own gender and the gender of the population they serve. The discrimination is apparent in the pay scale discrepancy applied to them compared to their male counterparts.

4.2.1 We demand the **reinstatement of the National Programme of Family Planning in its original capacity**, with the service structure that guaranteed standardised pay to Lady Health Workers from all provinces. We condemn the norm of delaying salaries to Lady Health Workers, and demand for their **incremental bonuses to be institutionalised**.

4.2.2 We recognize that the Lady Health Workers face consistent verbal and physical violence from the communities they serve as well as threats to their lives. They are routinely shamed for the assistance they provide in birth control and abortions. We demand for the government to **ensure their safety**, and actively work on changing these narratives. The government should hold the community leaders accountable who incite violence and abuse towards them.

5. Environmental/Community Health

5.1 We demand the state **recognize air pollution as an environmental hazard** that risks our collective health, particularly the health of the marginalised communities exposed to it. It is important to recognise the **impact on women's maternal health**, as well as risks to their children in the prenatal and breastfeeding stage. A Lancet medical journal study estimates that nearly 350,000 pregnancy losses a year in South Asia (7% of annual pregnancy loss) were linked to high pollution levels between 2000 and 2016.[47] Emergency measures should be executed to prevent deterioration of air quality.

5.1.1 **Air pollutants can be two to five times higher indoors than outdoors**. The relegation of women to the domestic sphere, tasked with domestic duties, exposes women who still cook using solid fuels (such as wood, crop wastes, charcoal, coal and dung) and kerosene in open fires and inefficient stoves, to an environmental risk as well damages to their health.[48] Household tasks, commonly allocated to women due to the unequal distribution of house and care work, can expose them to a variety of toxic substances used in cleaning & laundry products, pesticides, foods & solvents. We demand that women be given a safe working environment inside the home through cheap provision to clean, environmentally friendly fuels and technologies.

5.1.2 Women exposed to chemical pollutants can pass chemical toxins to their children both prenatally and through breastmilk. Therefore, it is important to **address and eliminate chemical pollutants to protect maternal health and the health of future generations**.[49]

[47] https://mobile.reuters.com/article/amp/idUSKBN29C31Z.
[48] https://www.who.int/news-room/fact-sheets/detail/household-air-pollution-and-health.
[49] https://www.justforhearts.org/environmental-factors-affecting-womens-health/.

5.2 We demand the government take **immediate measures to improve sanitation conditions and access to water**. Pakistan ranks third in the world in terms of countries facing acute water shortage.[50] Environmental policies must consider the **negative impact of climate change on women** in particular and present tangible structural solutions.

5.2.1 Poor sanitation infrastructure is one of the many sources of water pollution. Polluted water can transmit diseases such as diarrhoea, cholera, dysentery, typhoid, and polio. A large number of women in Pakistan work domestically as cooks, cleaners and carers, making them more vulnerable to water-borne diseases. By 2016, surface water availability per capita had fallen close to 1000 cubic centimetres and is expected to decrease even further. We demand for a proper irrigation and sewage system ensuring universal access to clean water and sanitation facilities all across the country.

5.2.2 The threatening **water scarcity impairs the lives of Pakistan's rural women**, who bear the responsibility of collecting and providing water for their households. The shortage of safe water at or near their homes — and the resulting need to walk up to 4 km or more to get water each day — has aggravated the burden of women's duties in many ways, making them vulnerable in terms of both their health and personal safety.[51]

5.2.3 With droughts prevailing, sometimes several years at a stretch, in various regions of Pakistan, one of the major challenges faced by the population is that **of malnutrition and deteriorating health as a result of the consumption of polluted water**, which has been for the most part a result of the shortage of water and the increased competition over it for use. The quality of water currently available to the masses has never been this low (UN Environment, 2019). Water stress has been taking a toll on women's health, and has been the cause of undernourishment in children.

[50] https://www.dw.com/en/water-crisis-why-is-pakistan-running-dry/a-44110280.
[51] https://blogs.worldbank.org/water/women-in-water-in-pakistan-shows-the-way.

6. Gender bias and medical research

Basic research is the foundation for clinical studies, for decades scientists have looked through the white male lens and these gender stereotypes have resulted in clinical studies and treatments that do not work for the female body. ***Access to clinical research and trials is a social justice and an equity issue.*** *Developing and designing studies without including sex as a variable is only going to add to the ongoing health crisis and will eventually lead to rise in mortality rate among women and people who are more susceptible to these illnesses. The assumption by the researchers, without any data to back this assumption, that all bodies - women's, intersex and trans - behave like men is dangerous.*

6.1 We demand that all preclinical research must have **an equitable inclusion of all gender subjects**, and must consider sex as an important biological variable[52]. Furthermore, it is important to understand that sex and gender are not fixed, immutable categories--this complexity must be the bedrock of medical research and clinical trials, otherwise medical research will fail more than half of the population. As the application of the experimental results obtained by using only one sex in research, to all sexes without any justification leads to fatalities and unwanted complications and adverse reactions.

6.2 The notion that males are the reference population, and all other bodies are the ones that are odd is inherently patriarchal. The notion that female bodies are more complex subjects because of their fluctuating hormones is baseless, and cannot be used as an excuse to exclude them from the clinical studies[53].

[52] Lee SK. Sex as an important biological variable in biomedical research. *BMB Rep.* 2018;51(4):167-173. doi:10.5483/bmbrep.2018.51.4.034.
[53] Lee SK. Sex as an important biological variable in biomedical research. *BMB Rep.* 2018;51(4):167-173. doi:10.5483/bmbrep.2018.51.4.034.

6.3 There is **rampant gender bias in HIV studies**. Women make up over 50% of the 35 million people living with HIV worldwide. Pakistan also faces a concentrated HIV epidemic, and the virus is the leading cause of death among women of reproductive age, but the clinical trials rely on the participation of men e.g., a median of 11 %, 19% and 38 % of the participants in cure, antiretroviral drugs and vaccine studies respectively were women (AMFAR study)[54]. We demand an equitable participation of women in HIV cure, antiretroviral drugs and vaccine studies[55] especially in publicly funded studies.

6.3.1 All research stakeholders must realize that designing trials with recruitment quotas, context specific planning and engaging local community advocates is the path toward adequate gender participation, sex balance and gender-based analysis in research.

6.3.2 Reviewers of applications and journal editors must adopt a strict policy to ensure appropriate female participation in funding applications and articles respectively.

6.4 **An end to male bias in physiology, pharmacology and neuroscience**[56] and more inclusion of women in neuroscience studies, as women are more likely to suffer from mood or anxiety disorders[57]. We, as a feminist movement, want to draw attention towards the stark difference in participation that is prevalent in neuroscience studies where males outnumber females 6 to 1.

6.5 We call on investigators developing and testing therapeutic and prophylactic **approaches for COVID-19 to design studies that include sex as a biological *variable***, and are inclusive of male versus female differences in drug responses, immunotherapies, vaccines and nonpharmacological interventions[58] as the lack

[54] https://www.nytimes.com/2019/05/28/health/women-hiv-trials.html; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2840955/; https://journals.lww.com/jaids/Fulltext/2016/02010/A_Systematic_Review_of_the_Inclusion__or.8.aspx.

[55] Curno, Mirjam J. PhD*,†; Rossi, Samuela MSc*,‡; Hodges-Mameletzis, Ioannis DPhil*,§; Johnston, Rowena PhD‖; Price, Matt A. PhD¶,#; Heidari, Shirin PhD*,** A Systematic Review of the Inclusion (or Exclusion) of Women in HIV Research, JAIDS Journal of Acquired Immune Deficiency Syndromes: February 1, 2016 - Volume 71 - Issue 2 - p 181-188, doi: 10.1097/QAI.0000000000000842.

[56] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008499/.

[57] https://www.nytimes.com/2019/05/30/health/gender-stereotypes-research.html

[58] https://www.jci.org/articles/view/139306

of consideration of sex biases in drug efficacy and reactivity may lead to increased adverse reactions. **It is our demand that *sex-disaggregated* COVID-19 data be provided by NCOC.**

6.6 We demand the **incorporation of gender data into evidence-based medicine**, so that the guidelines for disease management can be more gender specific[59]. Effects of drugs are different on men and women. Women are 1.5-1.7 % more likely to have adverse reactions to medications. We demand that the **product descriptions must include information about sex differences in adverse reactions to drugs**[60].

6.7 We demand legislation and establishment of a **public national clinical trial registry in Pakistan**, as recommended by ICMJE (International Committee of Medical Journals Editors), WMA and also mandated by section 20 of *Bio Study Rules* 2017, which meets the WHO's criteria of Primary registries[61].

6.8 The Pakistani state must take concrete steps to **ensure more involvement of women in clinical studies of medications and practice,** and to make sure there aren't any socio-economic difficulties for women who want to join these studies. This inclusion, however, should be done under a transparent and strict mechanism as it should not become an excuse to test dangerous treatments and medicine on women and vulnerable groups.

7. Inequitable care burden and the pandemic

[59] Holdcroft, A. (2007) 'Gender bias in research: how does it affect evidence based medicine?', Journal of the Royal Society of Medicine, 100(1), pp. 2–3. doi: 10.1177/014107680710000102.

[60] Beery AK, Zucker I. Sex bias in neuroscience and biomedical research. *Neurosci Biobehav Rev.* 2011;35(3):565-572. doi:10.1016/j.neubiorev.2010.07.002

[61] Its absence leaves room for reporting bias and other research misconducts by researchers, raising a question on the quality of research being produced. Trial registration has been marked as the single most valuable way to ascertain unbiased research reporting.

7.1 Patriarchal setups around the world are built on and sustained by the **unpaid labour of women**. It is estimated that girls and women are responsible for 75% of unpaid care and domestic work around the world. The care economy is a complex system that pins the burden of caregiving solely on women, and because of patriarchal gender roles, women are expected to offer free physical, mental and emotional labour to support households and communities. Pakistan is no different. The scales were already tipped before the onset of pandemic but COVID-19 aggravated the plight of women. As schools and businesses shut down and entire families isolated themselves at home, the care burden on women increased sharply and began affecting their well-being.

7.1.1 We demand that **domestic work be recognised as work**. We demand that women's contribution to the care economy through home-making and caring for families be recognised as unpaid labour that is equal to other types of work.

7.1.2 We demand that prompt **steps be taken to address the increasing care burden on women**. There is a strong need to recognise that parenting, caregiving and domestic chores are vital tasks that require collective attention and involvement of men.

7.1.3 Even in cases where care work is outsourced, there is exploitation of women and young girls who are tasked with this work, subject to low wages, poor working conditions, long hours, lack of dignity and violence. We demand that these **members of the 'informal economy' of domestic work be given a living wage, labour rights and protection from harassment/violence through the expansion of the definition of 'workplace' under the 2010 Workplace Harassment Act**.

7.2 We call for **more resources, assistance and support for women who bear the burden of caregiving** in times of crisis in the form of day-care facilities, maternity leaves and flexible working hours.

7.3 Women and minority human rights defenders face increased threats, harassment and violence due to the nature of their work. A reported 60% of women human rights defenders receive continual threats due to the nature of

their work[62]. Amnesty International has raised concern over recent incidents in which the oppressive laws being used to target artists, human rights defenders and journalists, besides the marginalised sections of society.[63] The state is silent or complicit in this slow strangling of advocates for justice. And such repression takes immense toll on the health and wellbeing of journalists, activists and human rights defenders.

7.3.1 Recognising that **human rights defenders face a crisis of wellbeing.**

7.3.2 Recognising that activists perform the labour of caring for each other and the most vulnerable segments of the society with little or no help.

7.3.3 Recognising that activists and **first-line responders handling cases of violence suffer from secondary traum**a and C-PTSD are not provided the care they need.

7.3.4 Recognising that the labour of women, trans and gender non-conforming people in building spaces of nurturance, care and healing, with little to no resources, remains invisible or taken for granted. **We do the work of birthing and sustaining movements. We deserve love and support.**

[62] https://www.dawn.com/news/1292335.
[63] https://www.dawn.com/news/1578583.

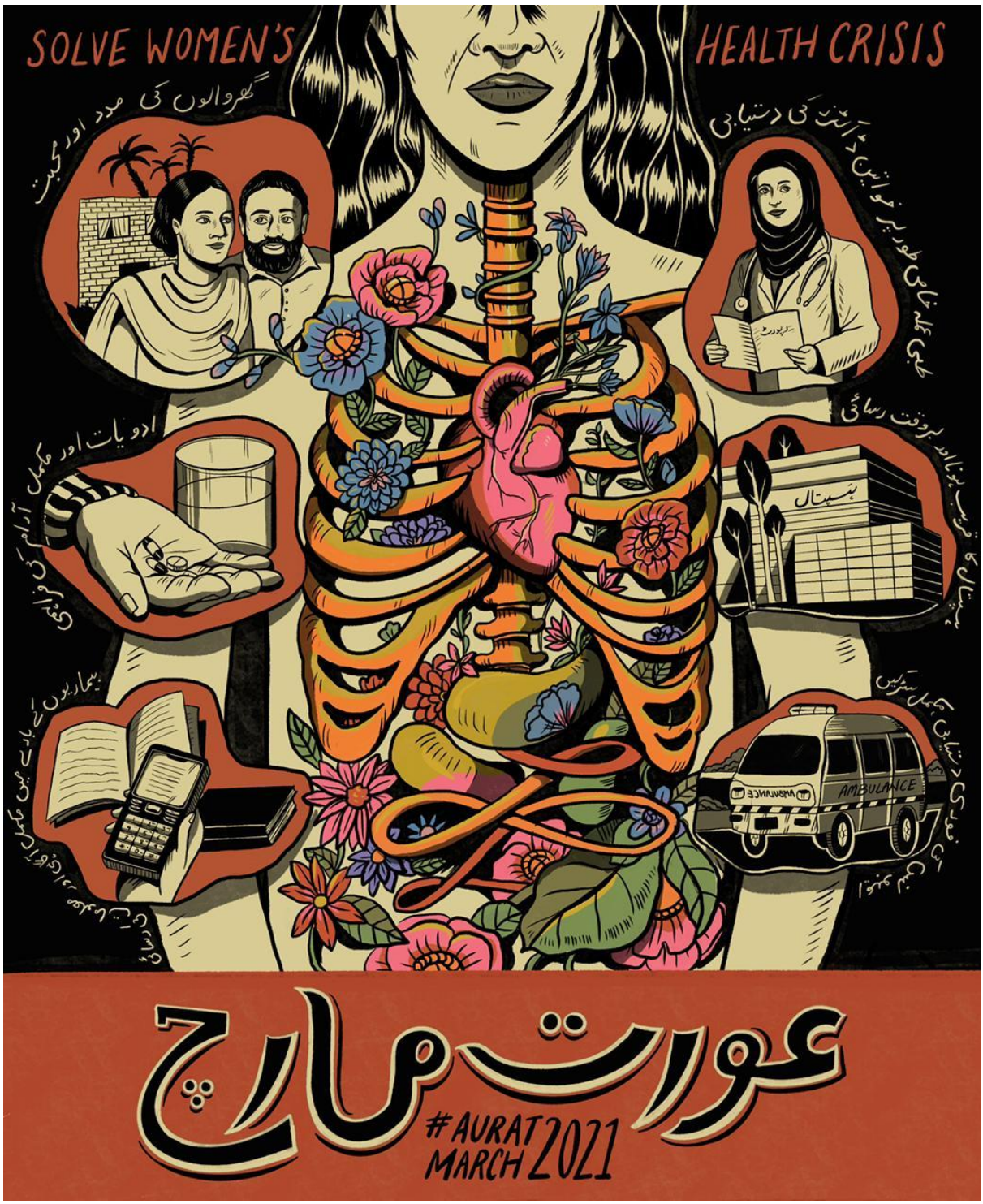
Postscript

Aurat March Lahore is a feminist collective consisting of women, transgender and non-binary folks who stand against patriarchal structures which results in sexual, economic and structural exploitation.

We work towards putting together the Aurat March every year on International Working Women's Day on March 8th, as well as working throughout the year to build a feminist movement. We stand in solidarity with our sister marches across the country.

Aurat March Lahore's three core principles are:

1. No NGO funding or affiliation
2. No corporate funding or affiliation
3. No political party alliance or affiliation



Artwork by Shehzil Malik