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Assignment No. 1 (Units 1–5)

Total Marks: 100 • Pass Marks: 40

SOLVED ASSIGNMENT GUIDE

(For Study & Reference)

Note: This guide is prepared for study and reference purposes only. Students are advised to read the relevant units of the course book, understand the concepts, and write the assignment in their own words. Copying this guide word for word is discouraged.

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Question 1: The Definitional Shift in the Concept of Women's Health (20 Marks)

Discuss the definitional shift in women health definition process.

Introduction

The way women's health has been defined has changed profoundly over the last century, and this definitional shift is not a mere matter of words. A definition decides what counts as a health problem, whose suffering becomes visible, which services are funded, which professionals are trained, and which women are reached. When women's health was defined narrowly, health systems were built narrowly: they treated women mainly as mothers, measured success mainly by survival in childbirth, and ignored large parts of women's lives — adolescence, sexuality, mental health, violence, work-related illness, disability and old age. As the definition widened, the agenda of research, policy and services widened with it. This

answer traces that shift in stages: from a biomedical and disease-based view, to a reproductive and maternal view, to the broader World Health Organization (WHO) concept of complete well-being, and finally to the feminist, rights-based and life-course understanding that dominates contemporary discussion. It also explains the forces that drove the shift — medical research, the women's health movement, international conferences, and evidence about the social determinants of health — and considers what the new definition means in practice, especially for a country like Pakistan.

A useful starting point is to remember that "health" itself was long defined negatively, as the absence of disease or infirmity. Applied to women, this negative and purely physical definition produced an even narrower result, because the diseases that received attention were chiefly those connected with pregnancy and childbirth. The definitional shift in women's health therefore has two dimensions: a general movement from disease to well-being, and a specifically feminist movement from the womb to the whole woman, living a whole life in a particular social context.

The Traditional Biomedical Definition: Health as Absence of Disease

In the earliest phase, health was understood through the biomedical model. The body was treated like a machine, illness was a breakdown in one of its parts, and the task of medicine was diagnosis and cure by a trained expert. Within this model, women's health problems were recognised only when they appeared as identifiable pathology — infection, haemorrhage, obstructed labour, tumours and similar conditions. Feelings, relationships, poverty, workload and social status were considered outside the boundary of health altogether.

This definition had three serious consequences for women. First, it was doctor-centred: knowledge flowed one way, from the professional to a passive patient, and women's own accounts of their bodies were discounted. Secondly, it was episodic: a woman entered the health system when she was acutely ill and left it when the symptom was treated, with little attention to prevention or to the conditions that had made her ill. Thirdly, it was fragmented: the body was divided among specialities, so a woman's anaemia, exhaustion, depression and repeated pregnancies could be treated as unrelated events rather than as one connected story. Critics later described this as a definition that could pronounce a woman "healthy" while she was undernourished, overworked, frightened at home and unable to make any decision about her own treatment.

The Maternal and Reproductive Narrowing

The second phase did bring women into public health policy, but on restricted terms. From the early twentieth century, and strongly after the Second World War, governments and international agencies invested in maternal and child health (MCH) services. Women were now a recognised category in health planning, yet the definition of their health remained tied to their reproductive function. A woman mattered to the health system mainly as a pregnant woman, a delivering mother and a breast-feeding infant-carer; programmes were judged by maternal mortality, infant mortality and, later, by contraceptive acceptance.

This maternalist definition achieved real gains — safer deliveries, immunisation, tetanus protection and family planning services saved many lives — but its limits became increasingly obvious. Adolescent girls before pregnancy, unmarried women, women who could not conceive, women past menopause, and women with problems unrelated to reproduction found

that the system had little to offer them. Services were often designed around the needs of programmes rather than of women: a mother could be offered contraception but not treatment for anaemia, a back injury from water-carrying, or depression. Feminist scholars summarised the objection in a phrase that became famous in the field: women are more than mothers, and women's health is more than maternal health. The definition had recognised women, but it had recognised only one role in their lives.

Table 1: Main stages in the definition of women's health

Stage	Working definition	What it included	What it left out
1. Biomedical	Absence of diagnosed disease	Treatment of illness and injury	Prevention, feelings, social causes
2. Maternal / MCH	Safe motherhood and child survival	Pregnancy, delivery, family planning	Non-reproductive needs, older women, adolescents
3. WHO well-being	Complete physical, mental and social well-being	Prevention, mental health, quality of life	Power, rights and inequality (initially)
4. Reproductive health (ICPD 1994)	Well-being in all matters of the reproductive system, with choice	Sexual health, rights, safe and satisfying sex life	Implementation gaps remained
5. Feminist / life-course	Health shaped across the whole life by biology and social conditions	Violence, work, ageing, disability, rights, participation	Still an unfinished agenda in many countries

The WHO Definition and the Turn to Well-Being

The third stage came with the Constitution of the World Health Organization in 1948, which defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Although the definition applied to everyone, its effect on

women's health was revolutionary in principle. It legitimised mental health and social well-being as health concerns; it implied that a woman subjected to constant fear, exhaustion or humiliation was not fully healthy even if no disease could be named; and it supported prevention and health promotion, not only cure.

The WHO definition has been criticised as utopian – "complete" well-being is a state few people ever reach, and the definition is hard to measure. Yet its historical importance is undeniable. It broke the equation of health with the absence of pathology and opened the door to indicators of functioning, quality of life and subjective well-being. Later refinements added the idea of health as a resource for everyday life — the ability to realise aspirations, satisfy needs and cope with the environment — which is particularly meaningful for women whose daily lives demand heavy physical labour, emotional care work and constant adaptation to scarcity.

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The Feminist Redefinition: Rights, Power and the Life Course

The fourth and most far-reaching shift was driven by the women's health movement from the 1970s onwards and was consolidated at the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995). Cairo redefined reproductive health to include sexual health, informed choice, and freedom from coercion, and it placed women's empowerment at the centre of population policy rather than demographic targets. Beijing affirmed that women have the right to the highest attainable standard of health and to control over their sexuality and reproduction, free of coercion, discrimination and violence.

From this movement emerged the contemporary definition used across the course: women's health refers to the health of women across the entire life span — from childhood and adolescence through the reproductive years to old age — as shaped jointly by biological sex differences and by gender, that is, by the social roles, resources, power and expectations attached to being female. On this view, a health problem does not need a uterus to be a women's health problem: heart disease presents and is treated differently in women; depression is roughly twice as common in women and is linked to poverty, violence and caring burdens; occupational injuries in home-based work, indoor air pollution from cooking smoke, and the health effects of son preference and food discrimination all fall inside the definition. The definition also becomes participatory: women are not merely patients or beneficiaries but knowers and decision-makers, entitled to information, consent, privacy and respectful care.

- From disease to well-being: outcomes now include functioning, mental health and quality of life, not only survival.
- From the reproductive years to the whole life course: girls, adolescents, unmarried women, women with disabilities and older women are included by definition.
- From biology alone to biology plus gender: social determinants — education, income, mobility, violence, decision-making power — are treated as causes of health and illness.
- From patient to rights-holder: informed choice, consent, confidentiality and freedom from coercion become part of what "healthy care" means.
- From uniform services to difference-sensitive care: sex-specific presentation of disease, and the different needs of rural, poor and minority women, must be recognised.

Why the Shift Happened and What It Changes in Practice

Several forces pushed the definition outward. Research showed that the leading causes of women's ill health could not be explained biologically alone: maternal deaths clustered where women lacked education, transport, money and permission to seek care. The HIV epidemic demonstrated that women's vulnerability was socially produced — many women were infected within marriage because they could not negotiate protection. Studies of violence, notably the WHO multi-country study, established intimate partner violence as a major cause of injury, chronic pain, depression and adverse pregnancy outcomes. At the same time, women organised: self-help groups, feminist health collectives and women physicians documented experiences that official definitions had rendered invisible, from medicalisation of childbirth to neglect of menopause.

Practically, the wider definition changes measurement, services and accountability. Measurement expands from mortality counts to morbidity, mental health, violence prevalence, unmet need for contraception and women's reported experience of care. Services expand from antenatal clinics to adolescent health, screening for violence, mental health support, cancer screening, menopause care and geriatric care. Accountability expands too: if health includes rights, then a service that is technically available but humiliating, coercive or unaffordable is failing by definition. For Pakistan, where maternal services dominate the public offer to women and where lady health workers remain the main bridge to households, the definitional shift is a practical programme of reform: train providers in gender-sensitive and respectful care, record and respond to violence and mental distress, reach adolescents and older women deliberately, and judge facilities by women's experience as well as by clinical output.

Conclusion

To conclude, the definitional shift in women's health is a movement through five widening circles: from the absence of disease, to safe motherhood, to complete physical, mental and social well-being, to reproductive health and rights, and finally to a feminist life-course definition in which biology and gender together shape health from birth to old age. Each stage corrected a blindness in the stage before it, and none of the earlier concerns — safe delivery, disease treatment — has been abandoned; they have been relocated within a larger picture. The definition remains contested and incompletely implemented, but its direction is clear: a woman is healthy not simply when no disease can be found and not only when she survives childbirth, but when she can live her whole life, at every age, with bodily integrity, mental well-being, information, choice and dignity.

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Question 2: Adolescent-Friendly Health Services in Pakistan (20 Marks)

Write down in detail adolescent-friendly health services in Pakistan.

Introduction

Adolescents — young people aged 10 to 19 years — make up roughly a quarter of Pakistan's population, yet they have historically been the age group least well served by its health system. Children's services end too early for them and adult services are not designed for them, so adolescents fall through the gap at exactly the age when habits, risks and opportunities are being formed for life. Adolescent-friendly health services (AFHS) are the internationally recognised response: services that are accessible, acceptable, equitable, appropriate and effective for adolescents, in the words of the World Health Organization's quality framework.

This answer explains why adolescents in Pakistan need a distinct service approach, describes the health problems such services must address, sets out the recognised characteristics of friendliness, and then examines in detail how services are organised and delivered in Pakistan — through public facilities, lady health workers, school and community programmes, non-governmental organisations and digital channels — together with the barriers that limit them and the reforms now under way.

A central idea runs through the whole discussion: adolescents will not use services that embarrass, expose or judge them. A technically excellent clinic that a 16-year-old girl cannot enter without her family's permission, where the provider may inform her parents, where she must queue with adults from her own neighbourhood and where she expects a lecture instead of help, is in practice no service at all. Friendliness is therefore not decoration; it is the condition on which access, honesty and follow-up all depend.

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Why Adolescents Need Special Services: The Pakistani Context

Adolescence in Pakistan is shaped by early and rapid physical change, intense social control — especially over girls — early marriage for a significant minority, high rates of anaemia and undernutrition, and very limited accurate information about bodies, reproduction and mental health. A substantial share of girls marry before the age of 18, and adolescent pregnancy carries higher risks of obstructed labour, eclampsia, low birth weight and school dropout. Boys face different but serious risks: tobacco and other substance initiation, road traffic injuries, and pressure to work in hazardous occupations. Across both sexes, mental health problems commonly begin in adolescence, while stigma keeps them hidden; studies in Pakistani schools

and communities repeatedly find high levels of anxiety and depressive symptoms among teenagers, with almost no accessible counselling.

The information gap is structural. Parents often feel unable to discuss puberty or reproduction; schools largely avoid the topics; and the media and internet fill the vacuum with a mixture of useful information and myth. Myths about menstruation still restrict girls' mobility, diet and schooling in many communities, and menstrual pain or irregularity goes untreated because families consider it shameful or normal suffering. An adolescent-friendly service must therefore do far more than treat illness: it must supply trustworthy information, correct myths respectfully, protect confidentiality, and connect health with schooling and livelihoods. Pakistan's commitments under its national health vision, provincial adolescent health strategies and global frameworks such as the Global Strategy for Women's, Children's and Adolescents' Health all recognise this, though implementation remains uneven across provinces after health was devolved to the provincial level.

What Adolescent-Friendly Services Must Provide

The service package recommended internationally and reflected in Pakistani programme documents covers preventive, promotive, curative and referral care in one welcoming setting. Its main components are set out below, and Table 1 summarises how each component responds to a documented adolescent need in Pakistan.

- General health and nutrition: assessment and treatment of anaemia, growth monitoring, deworming, dietary counselling, and management of common illnesses and skin, eye, dental and ENT problems.

- Sexual and reproductive health information and care: puberty education, menstrual health and hygiene support, information about marriage and contraception for married adolescents, antenatal care for pregnant adolescents, and prevention and referral for sexually transmitted infections.
- Mental health and psychosocial support: screening for depression, anxiety and stress, supportive counselling, identification of self-harm risk, and referral pathways to specialist care.
- Substance use prevention and help: counselling on tobacco, gutka, naswar, betel nut and other drugs, with referral for dependence.
- Violence and injury care: sensitive first-line support for physical, sexual and emotional abuse, medico-legal referral where the adolescent consents and the law requires, and safety planning.
- Immunisation and screening catch-up: tetanus protection, HPV vaccination where programmes offer it, vision and hearing screening, and identification of previously missed conditions.

Table 1: Adolescent needs in Pakistan and the friendly-service response

Adolescent need / problem	Friendly-service response	Typical delivery point
Anaemia and undernutrition, esp. in girls	Screening, iron/folic acid, diet counselling	Facility, school health sessions
Menstrual myths, pain and absenteeism	Menstrual health education, pain relief, WASH-linked advice	School, LHW visits, youth centres
Early marriage and adolescent pregnancy	Counselling, contraceptive information for married adolescents, quality antenatal care	BHU/RHC, LHW, NGO clinics

Anxiety, depression, exam and family stress	Confidential counselling, referral for specialist care	Facility counsellor, helplines, digital services
Tobacco and substance initiation (boys)	Brief counselling, peer education, referral	Schools, community and sports programmes
Abuse and violence	Private consultation, first-line support, safe referral	Designated facility focal person

The Characteristics That Make a Service "Friendly"

WHO's standards, adapted in Pakistani training materials, describe friendliness through the experience of the adolescent user. Accessible services are located where adolescents can reach them, open at hours compatible with school and work, and affordable — ideally free at the point of use, since adolescents rarely control money. Acceptable services guarantee privacy (a separate room or screened space, no consultations overheard), confidentiality within clear legal limits explained honestly, non-judgmental and respectful providers, and the possibility of being seen by a provider of the same sex, which is decisive for many Pakistani girls. Equitable services do not turn away adolescents because they are unmarried, out of school, working, disabled or poor. Appropriate services offer the full package the adolescent actually needs rather than a single vertical intervention, and effective services are delivered by staff specifically trained in adolescent development and communication, following evidence-based protocols, with functioning referral links.

Two practical arrangements matter greatly in Pakistan. The first is a designated space and time: many facilities now experiment with adolescent corners or separate clinic hours so that young people are not queuing with adult neighbours. The second is a trusted intermediary: lady health workers (LHWs), lady health visitors, school teachers trained as focal persons, and peer

educators can introduce adolescents to services in language they understand. Where these arrangements exist, utilisation rises; where a facility simply declares itself "friendly" without changing privacy, timing or staff behaviour, adolescents quickly discover the reality and stay away.

How Services Are Delivered in Pakistan

In the public sector, adolescent services are delivered mainly through basic health units, rural health centres, tehsil and district hospitals, and maternal and child health centres, supported by the Lady Health Worker Programme, which places community-based workers in rural areas and urban slums. LHWs counsel mothers and, increasingly within their mandate, adolescent girls in the household on nutrition, hygiene, menstruation and the timing of marriage and first pregnancy; they also refer adolescents to facilities. Population welfare departments and their family welfare centres provide reproductive health information and services, including for married adolescents. School health initiatives, run jointly by health and education departments in some districts, screen children and older students, promote hygiene and nutrition, and refer problems found.

The non-governmental and private sectors carry a large share of explicitly adolescent-focused work. Organisations such as Rahnuma (the Family Planning Association of Pakistan), Marie Stopes Society, Greenstar Social Marketing, Aahung and Rutgers-supported programmes have run youth-friendly centres, school-based life-skills education, and helplines that offer the anonymity many adolescents require. Life-skills-based education — covering puberty, bodily changes, communication, decision-making, protection from abuse and respect in relationships — has been piloted in schools in several provinces, often facing negotiation with parents and

religious sensitivities, and evaluations generally show improved knowledge and more protective attitudes where programmes are sustained. Digital services are the newest channel: health helplines, social media pages in Urdu, and telemedicine platforms allow adolescents, especially girls with a phone in the home, to ask questions they could never ask face to face. During and after the COVID-19 period, these remote channels proved their value, though they raise their own issues of privacy, accuracy and safeguarding.

Barriers and the Way Forward

Progress is real but constrained. Social conservatism makes reproductive health information for unmarried adolescents contentious, and providers themselves often share community attitudes, lecturing or refusing unmarried young people. Confidentiality is fragile in crowded facilities and in communities where the LHW is a neighbour; adolescents reasonably fear disclosure. Girls' mobility restrictions, the shortage of female providers, transport costs and opportunity costs of clinic visits all reduce use, while out-of-school adolescents — a very large group, including working children and married girls — are missed by school-based programmes entirely. Funding is fragmented among short projects, monitoring rarely counts adolescents separately, and mental health remains the weakest component of the package.

The way forward follows directly from the barriers: train and supervise providers specifically in adolescent-friendly, non-judgmental care and protect consultation privacy physically, not only by policy; institutionalise separate adolescent hours or corners in larger facilities; expand life-skills education with careful parental and community engagement rather than confrontation; reach out-of-school adolescents through LHWs, workplaces, madrassas and community youth groups; strengthen confidential helplines and moderated digital services in Urdu and regional

languages; and disaggregate routine health data by age and sex so that adolescents become visible to planners. Above all, adolescents themselves should be consulted in designing services — the consistent lesson of successful programmes in Pakistan and elsewhere is that services designed with young people are used by young people.

Conclusion

To conclude, adolescent-friendly health services in Pakistan are best understood as a deliberate redesign of ordinary services around the realities of adolescent life: the need for information without shame, care without exposure and support without judgment. The package spans nutrition, general health, menstrual and reproductive health, mental health, substance-use prevention and protection from violence, delivered through public facilities, lady health workers, schools, NGOs and increasingly digital channels. The model is well defined in policy and demonstrated in successful local programmes; the unfinished task is scale and consistency, so that friendliness does not depend on a single motivated provider or a short-lived project. Investing in this age group is among the highest-return decisions a health system can make, because the anaemia corrected, the early marriage delayed, the depression treated and the habit prevented in adolescence shape the health of the adult woman — and of her future children — for decades.

Question 3: Perspectives on the Mental Health of Women (20 Marks)

Explain in detail the different perspectives on mental health of women.

Introduction

Women experience mental health and mental illness in patterns that differ measurably from men's: depression and anxiety disorders are roughly twice as common in women worldwide, eating disorders and post-traumatic stress following violence fall heavily on women, while completed suicide, substance dependence and some externalising disorders are more common in men. Explaining this pattern has produced several distinct perspectives — biological, psychoanalytic and psychological, sociocultural, feminist, and the integrated biopsychosocial perspective — each of which illuminates part of the truth and, taken alone, distorts it. This answer explains each perspective in detail: its account of why women become mentally unwell, the evidence for and against it, and what kind of treatment or social action it implies. The discussion keeps returning to a practical point that matters for students of women's health: the perspective a clinician, family or policymaker adopts silently decides whether a distressed woman is offered hormones, therapy, protection from violence, economic support — or blame.

It is also important to separate mental health from mental illness at the outset. Mental health is a positive state of well-being in which a woman can realise her abilities, cope with normal stresses, work productively and contribute to her community. Perspectives differ not only about illness but about what flourishing requires for women: adjustment to given roles, or freedom to question them. That tension runs through every perspective examined below.

The Biological and Medical Perspective

The biological perspective explains women's mental health in terms of genetics, brain chemistry, hormones and reproductive events. Its strongest evidence concerns timing: women's risk of depression rises at points of hormonal transition — the premenstrual phase for

a minority with premenstrual dysphoric disorder, pregnancy and especially the postpartum period, and the perimenopause. Postpartum depression affects a substantial minority of mothers (studies in Pakistan commonly report figures in the range of one in four to one in three mothers in some communities) and postpartum psychosis, though rare, is a psychiatric emergency clearly linked to the biology of the puerperium. Neurotransmitter systems, thyroid dysfunction (more common in women and able to mimic depression), anaemia and chronic pain are also part of this account, as is the heritability of major mental disorders.

The strength of the biological perspective is that it destigmatises illness by locating it in the body, and it delivers effective treatments: antidepressants, mood stabilisers, and thyroid or anaemia correction can be life-changing. Its weakness, feminist critics argue, is reductionism when used alone. Elevated female depression rates appear across very different hormonal environments but track social conditions closely; treating a woman's low mood with medication while returning her to violence, destitution or total exhaustion treats the signal and ignores the fire. The biological perspective also has a history of misuse — from the nineteenth-century diagnosis of "hysteria" to the over-prescription of tranquillisers to housewives — which explains continuing suspicion of purely medical accounts of women's distress.

Psychoanalytic and Psychological Perspectives

Psychoanalytic theory offered the first systematic psychological account of women's inner life, but classical Freudian theory explained femininity through concepts such as penis envy and a supposedly weaker female superego — claims later feminist psychologists, from Karen Horney onwards, rejected as reflections of the theorist's culture rather than discoveries about women. Horney proposed instead that women's psychology is shaped by cultural devaluation and by the

real power differences between the sexes, an early bridge from psychoanalysis to social explanation. Object-relations and self-psychology traditions added more useful ideas: the importance of early attachment, and the way girls are often raised to define themselves through relationships, which can make relational loss and conflict especially destabilising.

Modern psychological perspectives are more empirical. Cognitive theory points to thinking styles: women, on average, are more likely to ruminate — to dwell repeatedly on sad feelings and their causes — and rumination is a well-established risk factor for depression. Behavioural accounts emphasise learned helplessness and low rates of positive reinforcement: a woman whose efforts are routinely unrewarded or punished, and who has little control over her daily life, is in the classic experimental situation that produces passivity and despair. Developmental psychology adds the impact of early adversity, including childhood sexual abuse, which is disproportionately experienced by girls and strongly predicts adult depression, anxiety and post-traumatic stress. These psychological mechanisms are valuable because they identify treatable processes — rumination, avoidance, trauma memories — through therapies such as cognitive behavioural therapy and trauma-focused approaches. Their limitation is that they can individualise socially produced distress: a woman can be taught to think differently about an intolerable situation while the situation itself remains untouched.

The Sociocultural Perspective

The sociocultural perspective locates women's mental health in the conditions of women's lives: poverty, low education, heavy unpaid workloads, restricted mobility, early and forced marriage, son preference, dowry and inheritance discrimination, and above all gender-based violence. Its evidence base is now very strong. The WHO multi-country study and many

subsequent studies show that intimate partner violence is among the most powerful predictors of depression, anxiety, suicidality and medically unexplained symptoms in women. Poverty operates through chronic stress, food insecurity, debt and humiliation, and women form the majority of the world's poor. Role strain is another core concept: the modern woman may carry paid work, total responsibility for housework and care, and emotional management of the whole family — the "second shift" — while having the least authority to set the terms of any of it. Even the apparently protective role of marriage operates differently by gender in many settings: married women frequently report worse mental health than unmarried women where marriage brings subordination and violence, reversing patterns seen in men.

In Pakistan the sociocultural account has obvious explanatory force. A daughter-in-law in a joint family with little privacy or autonomy, a home-based worker earning piece rates while managing a household, a mother blamed for bearing daughters, or a woman observing strict mobility restrictions after puberty all face chronic, uncontrollable stressors of exactly the kind stress research links to depression. Community studies in Pakistan have repeatedly found very high rates of anxiety and depression among women — often between a quarter and a half of women surveyed in low-income urban and rural samples — with poverty, marital conflict, violence and lack of support as the recurring correlates. The sociocultural perspective therefore directs intervention outward: poverty reduction, girls' education, legal protection, shelters, and changing norms, alongside any clinical care.

Table 1: Five perspectives on women's mental health compared

Perspective	Main explanation of women's distress	Typical intervention	Main limitation

Biological / medical	Hormones, genetics, brain chemistry, reproductive events	Medication, physical treatment	Reductionist if used alone; history of misuse
Psychoanalytic	Early relationships, unconscious conflict, feminine development	Psychotherapy, insight work	Classical theory reflected male bias; weak evidence base
Psychological / cognitive	Rumination, learned helplessness, trauma, thinking styles	CBT and other structured therapies	Can individualise social problems
Sociocultural	Poverty, violence, discrimination, role strain	Social reform, protection, empowerment	Underplays biology and individual difference
Feminist	Patriarchal power relations; pathologising of women's resistance	Empowerment-based therapy, advocacy, consciousness-raising	Must still engage with severe biological illness
Biopsychosocial (integrated)	Interaction of body, mind and social context	Combined, stepped care	Demands resources and coordination

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The Feminist Perspective

The feminist perspective shares the sociocultural emphasis on conditions but adds two distinctive claims. First, it names the system: patriarchy — the structured subordination of women in family, economy and state — is itself a determinant of mental health, and distress is often a sane response to insane circumstances rather than evidence of individual defect. Secondly, it criticises the mental health system itself: diagnostic labels and treatments have historically pathologised women's anger, sexuality and refusal of prescribed roles, while normalising their suffering as natural feminine sensitivity. Feminist therapy therefore works differently in practice: it makes the power relationship in therapy more equal, validates the woman's account, connects personal pain to social conditions, builds assertiveness and material

options, and treats safety from violence as a precondition of recovery rather than an optional extra.

The feminist perspective also reframes help-seeking. Women are often described as "over-reporting" symptoms; feminist scholars reply that women may simply be more willing to name distress in a culture that forbids men to do so, and that services respond to women with medication where they would respond to men with investigation. At the same time, a mature feminist position does not romanticise distress or reject medicine: postpartum psychosis and severe depression are dangerous illnesses requiring prompt treatment, and denying women effective medication in the name of ideology would be another form of neglect. The feminist contribution is best understood as a discipline on all the other perspectives — a standing instruction to ask who benefits from a diagnosis, whose account is believed, and whether treatment returns a woman to the conditions that made her ill.

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The Integrated Biopsychosocial Perspective

Contemporary practice increasingly adopts the biopsychosocial model, in which biological vulnerability, psychological processes and social conditions interact. A woman may inherit a vulnerability to depression (biology), experience it first after childbirth (reproductive event), have it amplified by rumination and isolation (psychology), and be kept ill by violence, poverty and lack of treatment access (society) — while recovery likewise works on several levels at once: medication, therapy, support from other women, legal protection and economic help. This integration explains otherwise puzzling facts, such as why the same hormonal event leaves one woman well and another severely depressed (their social worlds differ), and why purely

clinical services in low-income settings achieve limited results unless linked to community and social support.

For Pakistan, the integrated perspective has a concrete service implication: stepped, collaborative care. Lady health workers and primary care doctors can be trained to recognise depression and anxiety, provide basic psychosocial support and follow-up, and refer severe cases — an approach tested successfully in Pakistan through the Thinking Healthy Programme, in which LHWs delivered a cognitive-behavioural intervention to depressed mothers and substantially improved recovery. Integrating mental health into maternal and primary care, protecting confidentiality, involving families constructively without surrendering the woman's autonomy, and linking clinics to legal aid and social protection together translate the biopsychosocial idea into a workable system for women who will never see a psychiatrist.

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Conclusion

To conclude, the different perspectives on women's mental health are best read as partial maps of one territory. The biological perspective explains reproductive-linked illness and provides indispensable treatments; psychoanalytic and psychological perspectives illuminate early relationships, trauma, rumination and helplessness; the sociocultural perspective demonstrates, with strong evidence, that poverty, violence and role strain manufacture much of women's distress; the feminist perspective adds the analysis of power and a critique of how services themselves can harm; and the biopsychosocial perspective integrates them into modern, stepped care. A student or practitioner who holds only one map will misread many women. The sound position is integration with a feminist discipline: treat the illness,

understand the mind, and change the conditions — because for most women, mental health is produced, or destroyed, at the meeting point of all three.

Question 4: Reproduction as Women's Right to Choose (20 Marks)

Discuss the perspectives on reproduction as women's right to choose.

Introduction

Few questions in women's health are as debated as whether, and in what sense, reproduction is a woman's right to choose. At stake are concrete decisions every woman faces: whether and when to marry, whether and when to bear children, how many children to have, what contraception to use, and how to respond to an unwanted or dangerous pregnancy. Different perspectives answer these questions very differently. The reproductive rights and feminist perspective treats choice as a fundamental human right grounded in bodily autonomy. The population-control perspective, historically powerful in policy, has treated women's fertility mainly as a variable to be managed for national goals. Religious and communitarian perspectives locate reproductive decisions within moral law, marriage and family duty. Medical and public health perspectives emphasise safe, informed, voluntary services, while a newer reproductive justice perspective insists that real choice requires social and economic conditions, not merely legal permission. This answer examines each perspective, the international settlement attempted at Cairo in 1994, and the situation of women in Pakistan, where law, custom and services together decide how much choice women actually have.

A clarification is needed at the start: "right to choose" in the reproductive health literature is broader than the abortion debate with which it is often identified in Western politics. It covers

the whole chain of reproductive decisions, most of which — delaying marriage, spacing births, choosing a contraceptive method, seeking care in pregnancy — are uncontroversial in principle yet remain outside many women's real control. Keeping that breadth in view makes the discussion both more accurate and more useful.

The Feminist and Reproductive Rights Perspective

The feminist perspective begins from bodily autonomy: because pregnancy is carried in a woman's body, at real risk to her health and life, the decision to undertake it cannot justly be made by another person — husband, family, community or state. From this premise flow the recognised reproductive rights articulated in international human rights law: the right to decide freely and responsibly the number and spacing of children (affirmed in the Convention on the Elimination of All Forms of Discrimination Against Women, Article 16), the right to information and means to exercise that decision, the right to the highest attainable standard of reproductive health care, and freedom from coercion, discrimination and violence in all reproductive matters. The 1994 Cairo Programme of Action expressed the settlement in famous language: couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

Feminist scholars add that choice must be informed and uncoerced to be real. A woman "choosing" a method she does not understand, under pressure from a provider meeting a target, or unable to discontinue it when she wishes, is not exercising a right. This perspective therefore demands a full range of methods, honest counselling about side effects, the right to refuse as well as to accept, confidentiality, and services for unmarried as well as married

people. It also insists on men's shared responsibility: contraception and child-rearing should not rest on women alone, and male methods and male engagement are part of the rights agenda rather than an afterthought.

The Population-Control Perspective and Its Critique

The population-control perspective, dominant in international policy from the 1950s to the 1980s, framed reproduction from the standpoint of the state: rapid population growth threatened development, food security and political stability, so fertility — in practice women's fertility — had to be reduced through organised programmes. This perspective built much of the world's family planning infrastructure and contributed to genuine fertility decline, and many women welcomed the services it funded. But its logic was target-driven, and where targets ruled, abuses followed in various countries: sterilisation camps with inadequate consent, incentives and disincentives that pressured the poor, provider bias toward long-acting methods women could not discontinue themselves, and neglect of women's other health needs and of side effects.

The feminist critique of this perspective is not opposition to contraception — women's movements had demanded contraceptive access for generations — but opposition to being treated as instruments of demographic policy. Cairo 1994 formally marked the shift: demographic targets for providers were repudiated, and reproductive health and rights were placed at the centre. The lesson retained in current teaching is that programme success must be measured by informed, voluntary use and by women's health, never by acceptors recruited against a quota. Pakistan's own programme history, with its separate population welfare stream, periodic target pressures and recurring community mistrust, illustrates both the

achievements of organised family planning and the damage done whenever communities suspect that services serve the state's numbers rather than the family's welfare.

Religious, Cultural and Communitarian Perspectives

Religious and communitarian perspectives start not from the individual but from moral law, marriage and the family as a unit of decision. In Islamic scholarship, the mainstream historical position permitted contraception within marriage with mutual consent of the spouses — classical jurists discussed withdrawal ('azl) and most contemporary scholars in Pakistan accept temporary methods for spacing births, especially to protect the mother's health and the upbringing of existing children, while permanent methods and abortion are more restricted and debated. Abortion is generally prohibited after ensoulment, commonly placed at 120 days, with exceptions to save the mother's life and, in Pakistani law, for "necessary treatment" in early pregnancy. Catholic teaching rejects artificial contraception while permitting natural family planning; other Christian, Hindu, Jewish and Sikh traditions range from permissive to restrictive. A serious discussion must represent this diversity honestly rather than treating "religion" as a single voice, and must note that within every tradition, scholars and women themselves interpret duties differently.

The communitarian emphasis contains an insight the purely individual account can miss: reproductive decisions in most of the world, including Pakistan, are genuinely family decisions, affecting a husband, existing children and an extended household, and many women themselves want consultation rather than solitary choice. The feminist reply is not that families should be excluded, but that consultation must not become veto: where a husband or mother-in-law can override a woman's decision about her own body — including decisions carrying risk

to her life — the arrangement ceases to be shared decision-making and becomes control. Practical programmes increasingly work with this tension rather than against it: engaging husbands and religious leaders, promoting couple communication, and building community support for spacing, while preserving the woman's final say over her own body and her right to confidential services.

Table 1: Perspectives on reproduction and choice compared

Perspective	Who should decide?	View of contraception / services	Key concern
Feminist / reproductive rights	The woman herself, informed and uncoerced	Full method range, right to accept, refuse and discontinue	Bodily autonomy, equality
Population control	The state / programme, through targets	Services as instruments of fertility reduction	Development, demographic stability
Religious / communitarian	Spouses within moral law and family consultation	Spacing generally accepted in mainstream Islamic view; methods and abortion restricted variably	Moral duty, family welfare, sanctity of life
Medical / public health	The client, with professional guidance	Safe, voluntary, quality services; informed consent	Safety, effectiveness, unmet need
Reproductive justice	The woman, within real social conditions	Rights plus income, safety, services and child-rearing support	Whether choice is actually exercisable

Medical, Public Health and Reproductive Justice Perspectives

The medical and public health perspective approaches choice through need and safety. Its central Pakistani statistic is unmet need: a substantial share of married women — roughly one

in six in recent demographic surveys — wish to space or limit births but are not using contraception, and unintended pregnancy remains common, contributing to unsafe abortion despite legal restrictions. From this perspective, whatever one's moral framework, a system in which women cannot obtain the spacing methods most traditions permit is failing on its own terms: the remedies are supply, trained providers, counselling quality, management of side effects (a leading reason for discontinuation), and reaching women at moments of contact such as postnatal and post-abortion care.

Reproductive justice, a framework developed by women of colour in the United States and now used globally, extends the rights perspective with a social test. It holds three connected rights: the right not to have a child, the right to have a child, and the right to parent children in safe and healthy conditions. A poor woman may have a legal right to contraception but no clinic within reach, a legal right to maternity care but no transport money, and a legal right to keep her child but no protection from the violence or destitution that make parenting unsafe. Choice without conditions, on this view, is a slogan; justice requires the material and social infrastructure — income, education, safety, services — that makes each option genuinely available. This perspective usefully redirects attention in Pakistan from debating rights in the abstract to building the conditions under which a rural woman can actually act on any decision she makes.

The Situation in Pakistan

Pakistani women's real reproductive choice is constrained less by any single law than by an accumulation of practical bars: early marriage, low female education and literacy, limited mobility, the need for permission and money to visit a facility, provider attitudes, method

stock-outs, fear of side effects fed by rumour, and son preference, which pushes couples to continue childbearing until the desired number of sons is reached. Contraceptive prevalence has risen only slowly and remains around one-third of married women for modern methods, with heavy reliance on female sterilisation and condoms and low use of long-acting reversible methods — a pattern suggesting that many women reach services late, after completing the family size their circumstances imposed, rather than spacing from the start.

Reform consistent with every perspective except pure control is nonetheless identifiable: enforce laws on the minimum age of marriage; keep girls in secondary school, the single strongest correlate of later, healthier childbearing; engage religious leaders, many of whom already support birth spacing for maternal and child health; provide couple counselling through lady health workers and population welfare centres; guarantee method choice, side-effect care and respectful treatment in facilities; and include men as responsible partners rather than gatekeepers. Such measures enlarge women's choice without requiring any community to abandon its moral commitments, which is precisely why they command the broadest support.

Conclusion

To conclude, the perspectives on reproduction as a woman's right to choose range from the feminist claim of bodily autonomy, through the discredited logic of population control and the moral frameworks of religious and communitarian thought, to the practical tests set by public health and reproductive justice. The international settlement at Cairo, and the weight of human rights law, support the core proposition: decisions about the number and spacing of children belong to the couple and, where they conflict, ultimately to the woman whose body and life are at stake, exercised freely, with full information and means. The Pakistani task is less to win the

argument in principle than to remove the practical bars — early marriage, ignorance, distance, cost, stock-outs and veto power — that decide the question in advance for millions of women. A right that cannot be exercised is not yet a right in any sense that matters to health.

Question 5: Issues of Aging Women Through a Feminist Perspective (20 Marks)

Discuss the issues of aging women through feminist perspective.

Introduction

Old age is a women's issue in a double sense: women form the majority of the old, and the disadvantages accumulated across a woman's life — less education, less paid work, less property, more unpaid care — come due in old age with interest. Feminist gerontology, the study of ageing through a feminist perspective, argues that the problems of older women cannot be understood as the natural result of growing old. They are produced by the interaction of ageing bodies with a lifetime of gender inequality and with social arrangements that devalue both women and the old. This answer examines the main issues of ageing women through that lens: longevity and widowhood, poverty and economic insecurity, health and chronic disease, care work that never ends, elder abuse and neglect, and the cultural invisibility of older women — before considering what a feminist response requires in policy and in everyday life, with particular reference to Pakistan, where family care remains the assumed welfare system and formal support for the elderly is thin.

Two feminist concepts organise the discussion. The first is the life-course or cumulative disadvantage perspective: small gaps early in life — a girl withdrawn from school, a woman without wages or title to land — compound over decades into large gaps in old age. The second

is the double (some say triple) jeopardy of ageing women: they face ageism and sexism together, and, where class, rurality or disability is added, a third layer of disadvantage on top of both.

Longevity, Widowhood and Living Arrangements

Women live longer than men almost everywhere — in Pakistan female life expectancy exceeds male by a few years — so the population above 60, and especially above 80, is disproportionately female. Longevity is an achievement, but it is longevity largely spent in widowhood. Because women marry older men and outlive them, and because widowers remarry far more readily than widows, a large proportion of older women are widows while most older men still have a spouse. Widowhood for a woman frequently means simultaneous loss of status, income, protection and home: in patrilocal systems a widow's place in the household was mediated through her husband, and her security afterwards depends on sons, on her natal family's goodwill, or on property she often does not legally control even where Islamic and statutory law grant her a share.

Living arrangements follow from this. The celebrated joint family does shelter many older women in Pakistan, and coresidence with sons remains the norm and a real source of support. But the feminist perspective asks about the quality and the terms of that shelter: an older woman may be housed yet expected to earn her keep through childcare and housework, may eat last, may have no money of her own for medicine or transport, and may be moved between children's households like a responsibility to be shared. Migration of adult children, urban nuclear households and rising costs are thinning the joint family in practice, leaving a growing

minority of older women living alone or with only an elderly spouse — a group almost invisible to Pakistani social policy, which still assumes the family provides.

Poverty and Economic Insecurity

Poverty in old age is feminised because paid work, pensions and property are masculinised. Most Pakistani women of the present elderly generation spent their lives in unpaid household and farm work or in informal, home-based paid work with no pension, no savings in their own name and no employment record. Social security and occupational pensions reach only the small formal-sector workforce, in which women are a minority; a woman may qualify, if at all, only as a dependant widow. Social assistance such as the Benazir Income Support Programme and provincial welfare schemes, zakat and bait-ul-maal support, and old-age benefits through the Employees' Old Age Benefits institution help some, but coverage of elderly women specifically is patchy, amounts are small, and access often requires documents, mobility and intermediaries that an illiterate widow may not command.

Property is the deeper issue. Islamic law gives daughters and widows defined inheritance shares, and Pakistani statute affirms them, yet customary practice across much of the country pressures women to surrender shares to brothers or sons, in exchange for continued family protection. The feminist analysis is precise about the consequence: a woman who signs away her land at 30 in the name of family harmony discovers at 70 that she owns nothing, can threaten nothing and must petition for everything. Economic dependence then disciplines her whole old age — she cannot leave a neglectful household, pay for private treatment, or even choose what to eat. Feminist policy therefore treats women's inheritance enforcement, joint

titling of homes, and pensions that recognise care work (through carer credits or universal social pensions) not as welfare extras but as the foundation of a dignified old age.

Table 1: Key issues of ageing women and their feminist interpretation

Issue	What older women experience	Feminist interpretation
Widowhood	Loss of spouse, status and income; dependence on sons	Insecurity produced by patrilocal marriage and property systems, not by ageing itself
Poverty	No pension, savings or assets in own name	Lifetime of unpaid / informal work unrecognised by pension systems
Chronic illness & disability	Arthritis, diabetes, hypertension, poor vision, untreated conditions	Health systems designed around mothers, not older women; care rationed by dependence
Continuing care work	Raising grandchildren, nursing spouses while frail herself	Care is naturalised as women's duty at every age
Abuse & neglect	Emotional abuse, financial exploitation, neglect	Dependence plus ageism and sexism removes power to resist or report
Invisibility	Absent from media, policy and data	A culture that values women for youth and fertility discards them afterwards

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Health Issues: Menopause, Chronic Disease and Neglected Care

The health profile of older women is dominated by chronic, often multiple, conditions: hypertension, diabetes, arthritis and joint pain, osteoporosis and fractures, cardiovascular disease, cataract and other sensory loss, dental problems, and cancers detected late. To these must be added the legacy of the reproductive years — pelvic organ prolapse and obstetric fistula in some older women, chronic anaemia and musculoskeletal damage from decades of

water-carrying, load-bearing and cooking over smoky stoves. Menopause itself, occurring around the late forties, is a neglected transition in Pakistan: symptoms such as hot flushes, sleep disturbance, mood change and bone loss are rarely discussed, almost never treated as a health topic, and frequently endured in silence because neither women nor providers have a language for them beyond embarrassment.

The feminist critique targets the structure of services. A health system organised for women almost entirely around pregnancy has no natural home for a 65-year-old: she is too old for the maternal clinic that defined "women's health", and general services are crowded, rushed and often physically inaccessible, with male providers she may be reluctant to consult and costs she cannot pay without asking a son. Her symptoms are also easily dismissed — pain attributed to "just age", depression to temperament, memory loss mocked rather than assessed. Feminist health practice demands geriatric care that is sex-aware: screening and treatment of chronic disease and depression in older women, menopause services, attention to nutrition and bone health, rehabilitation and assistive devices, and providers trained to take older women's reports seriously.

Care Work, Abuse and Invisibility

Ageing does not retire a woman from care work; it often intensifies it. Older women nurse ageing husbands, raise grandchildren whose parents work or have migrated, and hold extended households together — labour that sustains the economy and the family while remaining unpaid, uncounted and assumed. The feminist point is not that such care is worthless; grandmothers' care is frequently loving and chosen, and older women derive real status and satisfaction from it. The point is that it is compulsory in structure: a frail 70-year-old with

arthritis and failing sight has no socially approved way to refuse, rest or be cared for herself, because caring is defined as what women are for. Reciprocity — care given across a lifetime being returned in kind — is the moral claim feminist gerontology presses on families and states alike.

Where dependence is total and status is low, abuse follows. Elder abuse of women includes physical and emotional abuse, financial exploitation (pressure to transfer property or hand over pension and support payments), neglect of food, medicine and hygiene, and abandonment in hospitals or shrines and, in extreme cases reported in the region, accusations and violence linked to property disputes. Older women rarely report: the abuser is usually a son or daughter-in-law on whom she depends, shame attaches to admitting family failure, and police and courts feel inaccessible. Culturally, the feminist perspective also names a quieter injury — invisibility. Media, advertising and even health campaigns picture women as young; the older woman appears, if at all, as a problem of burden. Internalised, this message teaches older women to minimise their needs and apologise for existing, a psychological harm layered onto material ones.

The Feminist Response: Policy and Practice

A feminist response operates at three levels. At the level of the state, it requires pensions and social protection that reach women in their own right — universal or broadly targeted social pensions, carer credits, and simplified access for illiterate elderly women — together with enforcement of women's inheritance and property rights, protection legislation against elder abuse with usable reporting routes, and age- and sex-disaggregated data so that older women

become visible to planners. Pakistan's senior citizens' welfare legislation at provincial level is a beginning, but implementation, budgets and awareness lag far behind the text of the law.

At the level of services and community, it requires primary health care that deliberately includes older women (chronic disease clinics, menopause and mental health care, home visits by lady health workers for the housebound elderly), day-care and respite arrangements that support families rather than merely exhorting them, and self-help and peer groups in which older women gain information, solidarity and a public voice. At the level of culture and family, it requires revaluing the older woman: recognising her knowledge and lifetime contribution, sharing care work among sons as well as daughters and daughters-in-law, and teaching the young that how a society treats its old women is a measure of its justice. Feminist gerontology finally insists on agency: older women are not only victims of structure but actors — organisers, earners, voters and grandmothers shaping the next generation — and policy should work with their organisations and demands, not only on their behalf.

Conclusion

To conclude, the feminist perspective transforms the study of ageing women from a catalogue of decline into an analysis of a lifetime. Widowhood insecurity, pensionless poverty, untreated chronic illness, unending care work, abuse and invisibility are shown to be the compounded results of decisions and structures — girls' schooling denied, inheritance surrendered, care uncounted, services built only for mothers — rather than the unavoidable price of long life. That analysis is hopeful as well as critical, because what is socially produced can be socially changed: enforce property rights, pension the carers, build health care for women past reproduction, protect against abuse, and honour reciprocity for a lifetime of care. A society that

has been carried, fed and raised by its women owes its old women more than shelter on sufferance; it owes them security, health and dignity in their own right.

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