CULTURAL BARRIERS AMONG PAKASTANI WOMEN RELATED TO HIV/AIDS DETECTION, PREVENTION, AND TREATMENT

By

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CULTURAL BARRIERS AMONG PAKASTANI WOMEN RELATED TO HIV/AIDS DETECTION, PREVENTION, AND TREATMENT

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Abstract

The AIDS epidemic may become the most devastating health disaster in human history; an estimated 40 million people are living with HIV/AIDS around the world (Lamptey, Johnson, & Khan, 2006). Developing countries have been particularly affected by the emerging HIV/AIDS global epidemic. Pakistan, the sixth largest country in the world, and the second most populous Muslim nation, is a developing country with limited resources and a soaring population of 189,000 million people.

Until recently, Pakistan was categorized as a low prevalence, high-risk country for HIV infection with an estimated 85,000 persons or 0.1% of the adult population, infected with HIV (The World Bank, 2005). Heterosexual transmission (52%) and contaminated blood or blood products (12%) are the most commonly reported modes of transmission for HIV/AIDS in Pakistan (Haider, Zohra, Nisar, & Munir, 2009). Other modes of transmission include injection drug use (2%), male-to-male or bisexual relationship (4.5%), and mother to child transmission (2%); the mode of transmission in 27% of the reported HIV/AIDS cases could not be established due to incomplete data (UNAIDS, 2008). This would suggest the number of reported cases of HIV is still relatively low or unreported. Social taboos and lack of knowledge among the general population and Pakistani health care providers prevent patients from reporting their affliction (Haider et al.).
In Pakistan, very few studies have been conducted regarding the knowledge of AIDS among women. Women comprise 48.5% of the Pakistani population, with an alarmingly high illiteracy rate of 72%. The life expectancy of females at birth is 61.6 years; however, the percentage of total life expectancy lost due to poor health in females is 15% (Government of Pakistan, Federal Bureau of Statistics, 2005). It was determined that identifying key barriers such as gender inequality, violence against women, unstable government and inconsistent law enforcement, greatly influences access, diagnosis, and treatment for HIV/AIDS infection. Women’s inequality emerges as a common theme that restricts their rights to preventative medicine and education.

The purpose of this paper was to identify cultural barriers leading to ineffective detection, prevention, and treatment of HIV/AIDS and sexually transmitted disease among women living in Pakistan. More specifically, how does the suppression of women’s rights and gender inequality contribute to detection, education, prevention and treatment of HIV/AIDS for the women of Pakistan? The intended goal of identifying key barriers is to increase societal, cultural, and governmental awareness and to facilitate constructive change.
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CULTURAL BARRIERS AMONG PAKASTANI WOMEN RELATED TO HIV/AIDS DETECTION, PREVENTION, AND TREATMENT

Introduction

Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which is spread through blood, semen, vaginal secretions, and breast milk. The most common method of transmission is unprotected sexual intercourse with an HIV-infected partner. Other routes of exposure include transfusions of HIV-infected blood or blood products, tissue or organ transplants, use of contaminated needles, syringes, or other skin-piercing equipment, and, mother to child transmission during pregnancy, birth, or breast feeding. HIV is an extremely fragile virus. It cannot survive long outside the body’s fluids and it cannot penetrate unbroken skin (UNAIDS, 2003).

AIDS was first identified in the 1980s, public health officials assumed its spread could be halted by informing people how to protect themselves from infection and by safeguarding blood supplies. This approach has been successful in politically organized communities with access to information and resources. However, populations in less developed countries have had little access to accurate information, treatment, or effective prevention programs (UNAIDS, 2003).

HIV was first detected in Pakistan in 1987. As the epidemic surged and shifted from people with high-risk behavior to the general population, public health professionals realized they needed to better understand the causes of individual infection and the forces driving the epidemic. AIDS has quickly become a disease of global importance. Lamptey et al. (2006) found HIV transmission was linked to specific behaviors such as
having multiple sex partners, commercial sex, and injection drug use, but they also
realized that these behaviors were influenced by political, economic, social, cultural, and
environmental factors including poverty, illiteracy, military conflict, powerlessness, and
gender inequality. Vermund et al. (2006) suggested the most urgent concern was the need
for education and aggressive risk reduction campaigns in those high-risk populations in
which the virus spreads most quickly.

**Statement of Purpose**

The intent of this literature review was to closely examine the cultural barriers leading
to ineffective detection, prevention, and treatment of HIV/AIDS and sexually transmitted
disease among women living in rural and urban Pakistan. How does the suppression of
women's rights and gender inequality contribute to detection, education, prevention, and
successful treatment of HIV/AIDS within the Pakistani culture? The intended goal of
identifying key barriers within the culture is to increase societal and governmental
awareness, and provide an opportunity for change of existing practices that are currently
unsuccessful in detection, management, and treatment of the HIV/AIDS epidemic in
Pakistan.

**Literature Search Strategies**

A comprehensive literature search was conducted using PubMed, Social Sciences
index, Google Scholar, the Cochrane Library, and the Library of Congress databases.
Key words used in the search included: female, Pakistan, HIV/AIDS, STI (sexually
transmitted infections), education, prevention, social stigma, condoms, discrimination
and violence against women. Other terms included: women's civil and cultural rights in
Pakistan and Islamic influence. The search was limited to female subjects in Pakistan,
and journals written in English. A total of 53 articles were retrieved and 38 articles were utilized for this literature review. Four textbooks were also requested from the WSU Library and included in this literature review. In addition, two video segments filmed in Pakistan, were reviewed. Credible information was retrieved and analyzed to respond to the question of scientific inquiry: How does the suppression of women’s rights and inequality contribute to detection, education, prevention, and successful treatment of HIV/AIDS within the Pakistani culture? The intended goal of identifying key barriers within the culture is to increase societal, cultural and governmental awareness, and provide an opportunity for change of existing practices that are currently unsuccessful in identification and management of the HIV/AIDS epidemic.

**Barriers to the Detection, Prevention, and Treatment of HIV/AIDS**

**Civil Rights of Women in Pakistan**

Women in Islamic countries live under dual legal systems: civil law, which is derived from Western legal systems, and family or personal status law, which is mainly built upon Sharia, Islamic religious-based law (Library of Congress, 2005). Islamic family law, which addresses marriage, divorce, child custody and inheritance, has long been a target for reform. Many have pressed for family law reform to further the states interest by removing hindrances to women’s full participation in the labor force and politics (Library of Congress-Women in Islamic Societies, 2005).

Pakistani women also live under a criminal code of law. The Pakistani Zina Ordinance (Hudood Ordinances) of 1979, is based extensively on Islamic Sharia Law (or legal code of conduct), this ordinance is a collection of five criminal laws including rape,
adultery, theft, robbery, and the prohibited use of narcotics and alcohol (Mirsky & Radlett, 2000).

The Ordinance criminalizes intercourse between a man and a woman that are not married. The criminal code requires that the act be witnessed by at least four Muslim males. If there are less than four male witnesses, criminal prosecution will not be enforced; and, the female accuser could be imprisoned if the alleged rape is not corroborated (Pakistani Criminal Code Human Rights Watch, 1992:34). The Protection of Women Bill (2006), reversed many of the Zina ordinances, but still made it a crime for a man and woman who are not married to have intercourse. Fornication may result in imprisonment for up to five years (Criminal Laws Amendment Act, 496(b), Dec 1, 2006).

Delayed and mishandled processing of complaints for women who report rape, sexual assault, or domestic violence are widespread; women encounter a police system that is incompetent and sometimes outright abusive (Human Rights Watch, 1999). Amnesty International (2004) has documented testimonies of bribery and corruption among police officers and of failure to follow up on cases involving violence against women. There are virtually no effective safeguards to protect women in custody.

The United Nations Development Fund for Women (UNIFEM) began to coordinate a working group on violence against women in 2004. The group was created to facilitate and coordinate various intergovernmental organizations (IGOs), non-governmental organizations (NGOs) and government bodies on gender-based violence. UNIFEM also funds the Ministry of Women’s Affairs to pursue legal research development, education, and advocacy for women of Pakistan (Amnesty International, 2004). Lack of support by government and judicial officials to uphold the rights of women continue to severely and
adversely affect education, prevention, and treatment of HIV/AIDS, and sexually transmitted disease among the women of Pakistan.

**Literacy/Education**

Seventy-four percent of Pakistanis have reportedly heard of HIV/AIDS, less than 30% are aware that the virus can be transmitted by intravenous drug use and tainted blood transfusions (Terzieff, 2003). According to UNICEF (2010), only 55% of Pakistani 15 year olds and greater can read and write. Thus approximately 14 of 30 million adolescents are illiterate. Worldwide, young people 15-24 years of age, account for an estimated 45% of new HIV infections (Farid-ul-Hasnain, Johansson, & Krantz, 2009).

Rai, Waraich, Ali, and Nerurkar (2007) reported the illiteracy rate for Pakistani women over 15 years old was 72%, according to UNAIDS 2001. The overall availability or access to education for Pakistani women largely depends on their economic and social background. Those from a wealthier family may have better access to formal or advanced education.

Shaikh and Shaikh (2005) examined the attitudes of Pakistani teachers regarding AIDS and preventive health education in classrooms. A cross sectional survey of secondary school teachers in Islamabad and Rawalpindi gave insight into personal views and perceptions of teachers who educate students about AIDS. Sixty five percent of teachers thought that AIDS education should be started in either 8th grade or above, while 30% thought it should start earlier. When asked, “Do you think teaching students about AIDS is irrelevant in the cultural setting?” an alarming 58.7% thought it was irrelevant. However, 75% of teachers did agree that AIDS is a major health concern in Pakistan.
Mashao (2008) proposed that HIV/AIDS education and awareness is related to inequality, empowerment, and level of literacy. Qualitative analysis obtained from 8 participants revealed that women are among those most infected with HIV and have the highest rate of illiteracy at the community level. Illiteracy and gender inequality are major factors fueling the rapid spread of HIV/AIDS in Pakistan (Mashao, 2008).

Farid-ul-Hasnain et al. (2009) completed a population-based, cross sectional study assessing knowledge and awareness of HIV/AIDS epidemic among youth, aged 17-21 years, in Karachi, Pakistan; this study focused on modes of transmission and prevention. Of 1,650 respondents, 24% had not heard of HIV/AIDS; those with increased lack of knowledge were younger males, those with less than six years of schooling, and those with no computer in the home. Among female respondents, identified risk factors for poor knowledge were young age, low socio-economic status, lack of enrollment in school or college, and being unmarried. Farid-ul-Hasnain et al., concluded young adults require education and skills to enable them to protect themselves from HIV/AIDS. Social and cultural taboos surrounding public discussions of sexuality remain key constraints to preventative education (Anderson, 2004).

Gender Disparity

In Pakistan, there are cultural norms, beliefs, and practices that undermine women’s autonomy and contribute to gender disparity (Verma & Mahendra, 2004). Rural Pakistani women suffer oppression, while urban Pakistani women are more similar to women of developed countries. At birth, a baby boy is rejoiced and celebrated, while a baby girl is mourned and is a source of guilt and despair in many families. Boys are given priority over girls for better food, care and education. Women are taught to be subservient
Women are restricted in mobility regarding education and work opportunities, which further confines women to their homes. Social life for a woman generally revolves around the activities of men (Islam for Today, 1994). Gender relations in Pakistan rest on two basic perceptions: women are subordinate to men, and a man’s honor resides in the actions of the women of his family (Islam for Today).

Chumil, Rodriguez and Boyd (2009) provided a brief cultural overview of the challenges that Pakistani women face living in an Islamic faith based country. In 1947, India gained independence and Pakistan was created as a refuge for Muslims. Lamptey et al. (2006) reported that of the 172 million inhabitants of Pakistan, 97% are Muslims who adhere to the Islamic faith. Due to Islamic religious beliefs and family customs, women experience various forms of human rights abuses, such as domestic violence, selling of young pubescence girls to married men, half rather than full share of the family inheritance and various tribal codes that allow honor killings when family dishonor is suspected. Advocates for women’s rights must start at the micro level to learn personal perspectives on culture and religion to facilitate empowerment among women (Chumil et al).

Verma and Mahendra (2004) examined the gender framework that defines the manner in which masculinities are constructed and manifested that impact women’s health and well being in the Indian society. Young men in India mature and develop in a male dominated context, with little contact in the post-pubertal period with female peers. They receive minimal sex education that could provide an opportunity for improved gender relations; much in the same way, the Islamic and Pakistani culture promotes male sexual dominance. Boys enjoy privileges reserved for men such as autonomy, mobility,
opportunity and power, while girls experience restrictions when their parents prohibit mobility, and withdraw them from school. Restriction of women is seen as a measure to protect family honor. In contrast, boys are encouraged to be active, aggressive, and assume leadership. A “real man” should be able to prove his masculinity. Verma and Mahendra (2004) validated the difficulties women face in attempting to follow HIV/STI prevention recommendations. Masculinity and sexuality are linked through sexual health anxieties, coercive sexual behaviors and sexual control over women.

**Violence Against Women**

Violence against women has become one of acceptance whereby, men exercise their culturally constructed right to control women (Naiz, 2004). In Pakistan, fifty percent of women are physically battered and ninety percent are mentally and verbally abused by their men (Verma et al., 2004). Domestic violence takes place in approximately 80% of households (Pakistan. National Commission on the Status of Women, 1997). In Baluchistan and Sindh provinces, Karo Kari is practiced openly, a woman suspected of adultery or infidelity faces the death penalty at the hands of her husband or in-laws. Usually the killer is not held criminally liable as he has retrieved the lost family honor (Naiz, 2004).

The Hudood Ordinance was first introduced in 1979 by the former military dictator Muhammed Zia-ul-Haq (HRW, 1999). This ordinance is derived from interpretations of the Qur’an’s divine teachings that judge offenses like rape and premarital sex as a fault of the woman for which she is then punished, rather than her perpetrator.

Andersson et al. (2009) conducted the first national survey of violence against women in Pakistan (2001 to 2004) that included approximately 23,430 eligible women greater
than 14 years of age. Qualitative interviews were conducted by random sampling in the homes of Pakistani women, great efforts were made to ensure privacy and safety of participants in their households. At least two interviewers entered each home, which proved to be very effective. Interviewers explained to eligible women respondents that this survey was about experiences of women and their responses would be kept confidential. Men were not present during the interviews so that women could speak freely. Data revealed that a woman was more likely to have experienced violence if she or her husband had no formal education, she was from a very poor household, she was married without her consent, or if there was family history of violence.

A New York Times editorial by N. Kristof (2004), documented the rape of a young woman who still today is seeking justice. Mukhatran Mai was a victim of gang rape at the order of a tribal council in the eastern province of Punjab in 2002 to punish her family for her brother’s alleged affair with a woman from a higher caste family. Many rape victims in Pakistan face severe social stigma of dishonoring the family. The punishment is suicide by swallowing either a pill or pesticide rather than disgrace family honor. Ms. Mukhatran pressed charges against her attackers, and enlisted the help of the Pakistani government. The case continues today. Ms. Mukhtaran currently runs a school in Meerwala, Pakistan as a refuge where she provides education to young girls and boys to increase awareness of women’s rights.

Mai, Cuny, Coverdale, and Kristof (2006) also addressed this concern in their book titled: In the Name of Honor: it documents the courage, pain and suffering of Mukhtar Mai and her fight against rape, illiteracy, and the repression of women. “Educating little girls is rather easy, whereas boys, who are born into this world of brutes and learn from
their elders' behavior, present a more difficult challenge. The justice dispensed to women must educate them with each passing generation, since suffering and tears teach them nothing” (Mai, p. 166).

Khan and Hussain (2008) explored the ecological framework of domestic violence in Pakistan, from 2002-2003. Cultural beliefs, and perceptions such as family honor being linked to the chastity of women, the practice of dowry, and discriminatory civil and criminal laws with an overall theme of structural disadvantage perpetuated by the state, make the issue of domestic violence more complicated and the victims more vulnerable. This qualitative study, in Karachi, explored middle and lower middle class women’s perspectives on domestic violence and coping mechanisms. Their perceptions of violence were consistent with those reported by human rights groups and NGOs (non-governmental organization); there has been an increasing trend of violence against women in Pakistan, especially since the introduction of the retrogressive Hudood Ordinances in 1979. One common theme during group discussions included the issue of gender and power imbalance between couples and other family members. Young women emphasized that cultural and social norms reinforced male power and dominance throughout their lives. Alarming data revealed that all of the participants talked about domestic violence (Khan et al., 2008).

Currently, there is no effective mechanism for investigation of crimes against women and no confidence building measures that have been successfully implemented to encourage women to come forward and report abuse (AI, 2004).
**High Risk Population/Risky Behavior/Lifestyle/Exposure**

Hasnain (2005) published a paper discussing the extent of the HIV/AIDS problem in Muslim countries; he outlined the major challenges to HIV/AIDS prevention and treatment, and discussed the concept of harm reduction, with a cultural approach, as a strategy to prevent further spread of the disease. The current course of the HIV epidemic is unlikely to change unless those at risk and the people affected make an effort to adopt preventative measures. Harm reduction is a philosophy that aims to reduce risks to the individual and community for those that are more often stigmatized, antisocial, or engage in illegal and risky behaviors. The biggest challenge in Muslim countries is lack of support politically and financially; government officials deny knowledge of the current HIV epidemic. Successful harm reduction will include reducing social stigma associated with AIDS, and integrating social, cultural, and religious frameworks in Muslim countries (Hasnain).

Emmanuel, Akhtar, Attarad, and Kamran (2004) found that chronic heroin abusers approach 500,000 in Lahore, Pakistan. A nationwide survey in 1993 reported less than 2% of injection drug users (IDU), were infected with HIV. The World Bank (2006), reported an estimated prevalence of 15% of IDUs infected with HIV, suggesting an increasing trend. Emmanuel et al. performed a cross sectional study to estimate prevalence of injection drug use and assess level of HIV knowledge among male heroin addicts in Lahore, Pakistan. Of those 664 respondents, 97% had heard about HIV/AIDS, and 54% of the respondents knew that HIV/AIDS exists in Pakistan. Participants reported friends were the primary source of knowledge (45.8%), followed by Radio/TV (27.5%), NGO’s (14%) and, other forms of print media, posters, and newspapers accounted for
The authors concluded that realization of the personal risk of getting infected with HIV was low (30%), and only 18% thought that they needed to be tested for HIV. Eighty-two percent of respondents admitted to injecting in groups; while 78% of injectors admitted to using old syringes, but only half attempted to clean syringes before reusing them. More than two thirds had no formal schooling (n=447); 55% of the respondents were married, 33.6% were unmarried, and only 11% were separated, divorced, or widowed. Eleven percent of the respondents reported regular ongoing extra-marital sexual relationships, 40% reported casual heterosexual, and 11% reported homosexual relationships. Of the subjects, 20.4% had sexual relations with commercial sex workers (CSW), and 80% admitted not wearing a condom in their last sexual encounter with a regular sex partner. Findings confirmed that IDUs have regular sexual contacts with CSWs, both heterosexual and homosexual; however, due to the extreme social and moral stigma attached to this information, surveillance and recording data are skewed, or not reported. Condom use is more consistent in casual sexual relationships with sex workers, rather than among regular sexual relationships. Respondents reported use of condoms primarily to avoid pregnancy rather than to protect themselves against various forms of STIs and HIV/AIDS (Emmanuel et al.). While homosexual encounters were reported, condom use in such encounters was minimal.

The government recognized the critical need to measure the prevalence and risk behavior of IDUs, male sex workers (MSW’s), Hijras (transgender), female sex workers (FSWs), and male truck drivers in the two largest cities in Pakistan. Bokhari et al. (2007) completed a six-month cross sectional study of 400 individuals with high-risk behaviors in Lahore and Karachi, Pakistan. HIV seroprevalence for IDUs in Karachi was highest at
23%, 45-74% respondents did not have formal education, 26% of IDUs were married, and 15% of male sex workers were married. Long distant truck drivers were also a very important subgroup; 57% were married, and 49% reported having sex with another man (commercial sex workers) while traveling. Eighty three percent of female sex workers were married, while 2% of FSWs admitted to using intravenous drugs in the past 12 months. MSWs and Hijras reported selling anal sex to males 84% and 75% of the time respectively. Concurrently, they reported using condoms only 6% and 8.8% respectively during this same period of time. Results of this study were presented to the Pakistani Director of General Health in 2004, in the hopes of developing a collaborative effort between the government of Pakistan and the international community to increase education and prevention strategies (Bokhari et al.). Further education and prevention measures are needed to increase surveillance and to target populations with high-risk sexual behaviors.

Rajabali, Khan, Warraich, Khanani, and Ali (2008) reported that the prevalence of HIV among homosexual and bisexual Pakistani men is reaching alarming proportions. Seven times more men are infected with HIV than women; however, most sexual transmission of HIV results from unsafe heterosexual contact. Sex workers in Pakistan represent the second most serious threat for HIV transmission (Rai et al., 2007).

Saleem, Adrien, and Razaque (2008), conducted a cross sectional study on the vulnerable population in Rawalpindi, Pakistan, which included FSWs, MSWs, Hijras, and IDUs. Among this population 136 (67%) FSWs were illiterate, 145 (71.4%) were married and entertained on average 23 clients per month. Consistent condom use was reported by 34 (17%) FSWs. One hundred thirty-three (66%) FSWs had knowledge of
STIs, 69 (17%) had STIs. Interestingly, FSWs were most frequently married (71.4%) which is consistent with the National Response to Intervention (RTI) study findings in Lahore and Karachi, Pakistan (Bokhari et al., 2007). The high percentage of married FSWs indicates the potential for rapid spread of HIV to the general population (Saleem et al.).

**Social Stigma/Family Honor**

A small minority of Pakistani women, who may want to disregard the social norms and redirect their lives from the traditional norm, often find themselves at a crossroads. Women are usually ignorant of the fact that violence against them is a crime (Khan & Hussain, 2008). The World Health Organization reported 55-95% of women in Pakistan are abused (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Women in Muslim countries who speak out face serious social stigma and shame. In Pakistan, the police are reluctant to get involved, judgmental and abusive towards the victim and protective of the accused. Khan (2006) investigated the legal system in Pakistan. He determined the law favors the perpetrators who commit violence against women by mitigating punishments and providing legal loopholes to escape from punishment. The legal system includes existing laws, judiciary, police officials, prosecutors and defense lawyers. For those women who do obtain justice, the consequences are still bleak. If the husband is convicted, the woman fears repercussion from his family, which may include bodily harm or murder. Women risk losing their children, and even if they keep them, few women of middle and lower class backgrounds can survive independently (Khan & Hussain, 2008).

In Pakistan, divorce continues to be a taboo and the fear of social stigma prevents women from reaching out for help. About 70% of abused women have never told anyone
about the abuse. Partner abuse may come in a variety of forms including, physical abuse, intimidation, humiliation, coercive sex, and isolation from friends and family (Hasnain, 2005). Many victims of domestic violence had thought through the consequences, and their decision not to leave their husbands was based on the realization that the strong social stigma associated with divorce could lead to minimal social support from their own families. One elderly woman commented, “A woman leaves her father’s house as a bride and her husband’s house when dead” (Khan & Hussain, 2008, p. 247).

**Pakistan: Islamic State or Federal Republic?**

Pakistan describes its government as a federal republic; however, it is heavily influenced by Islamic law. The gender disparity between men and women within Pakistan is demonstrated through government enforcement, interpretation, and execution of laws and social standards that breed fear, shame and silence. While constitutional rights are imbedded in Pakistani law, the Qur’an dictates justice or injustice, at least for women, and is left open for individual interpretation. Prior to 1979, Pakistan’s legal system had been a mix of colonial legislation, common law, and religious personal law (Mirsky & Radlett, 2000). Under the military dictatorship of General Zia-ul-Haq from 1977-1988, the constitution was heavily amended and laws not favorable to women were established. These changes created an atmosphere of fear, brutality, intimidation, and tension, which still exists today in modern Pakistan.

Women’s rights were almost exclusively the targets of the Hudood Ordinances Law. Even after the death of General Zia in 1987, and the return to civilian democracy, violence against women continues to worsen. Women experience discrimination and
inequality from birth, they have become silent victims of oppression and violence, which is commended as a virtue by their family and society (Khan & Hussain, 2008).

**Significance for Practice**

Access to universal screening, preventative medicine and education for all people in Pakistan is sub-standard. How does the suppression of women’s rights and gender inequality contribute to detection, education, prevention, and successful treatment of HIV/AIDS within the Pakistani culture? The country is faced with the challenges of the growing HIV/AIDS epidemic that is spiraling out of control. While all population groups in Pakistan may face increased risks of HIV, women and children are the most vulnerable and least able to protect themselves. The Islamic influenced government, the absence of women’s rights and the culturally approved violence towards women, compounded the situation. This is the environment in which advanced practice nurses, physicians and all health care providers must operate while caring for the people. Understanding the cultural, religious, and social norms that influence the people living in Pakistan is instrumental in developing a strategy for detection, prevention and access to health care.

The advanced practice nurse has a unique opportunity for initial universal screening of all clients to facilitate detection, and educational outreach in rural and urban Pakistan. Based on the evidence within this literature review, it is recommended advanced practice nurses act to: (a) control further spread of the epidemic in infants and young adults, (b) screen for early detection of HIV, (c) treat and care for the millions of people living with HIV, and (d) work to mitigate the epidemic’s impact on the millions of people affected with AIDS in underdeveloped Pakistan. The advanced practice nurse and other health care providers will need to work in conjunction with governmental agencies, non-
governmental organizations, churches, educators, religious leaders, policies makers, media (TV & radio), school based programs, and parents. Education is key to understanding and preventing the spread of HIV. Most challenging will be to address Pakistani cultural and religious norms in order to take steps to eliminate gender discrimination, decrease violence against women and effectively intervene to reduce the incidence of HIV/AIDS. These cultural norms have been in place for hundreds of years, the fact that the country became a Republic in 1947, has had little or no effect on the rights of women.

Summary

Women and children are innocent victims in the growing HIV/AIDS epidemic in Pakistan. Cultural barriers along with inequality of women’s rights contribute greatly to this escalating pandemic. Despite the alarming high incidence of rape and domestic violence in Pakistan, the government appears unable to limit impunity for these acts (Human Rights Watch [HRW], 1999). According to the Human Rights Commission of Pakistan, at least eight women are raped every 24 hours nationwide (1999). On August 2, 1999, the upper house of parliament refused to consider a resolution condemning the ritual practice of “honor-killing” that claims the lives of hundreds of women every year. Dismissive official attitudes towards violence against women reflect cultural and societal gender bias that dominates the country of Pakistan (HRW).

The United Nations has had a resident coordinator in Pakistan since 1979. More than a dozen U.N. agencies currently operate in Pakistan. In 1999, the World Health Organization recognized the critical role the health community plays in responding to violence against women: guidelines for health professionals were initiated (HRW, 1999).
The UNAIDS report (2009a) supported the implementation of the UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. The Action Framework was developed to address the persistent gender inequalities and human rights violations that put women and girls at greater risk of and more vulnerable to HIV (UNAIDS, 2009a). The UNAIDS Action Framework address three main areas:

1. Knowing, understanding, and responding to the HIV epidemic in women and girls. There is a need to utilize more quantitative and qualitative research of specific needs and risk behavior related to HIV in women and girls.

2. Assisting countries to increase political and governmental support in developing strategies and operational plans, and monitoring and evaluating the needs of women and girls in the context of HIV. There is a need to increase accountability and funding from local government and all relevant partners at the global, national, and community levels.

3. Increase advocacy, empowerment and leadership among women to transform social, and cultural norms while engaging men and boys to work towards gender equality.

The Agenda for Accelerated Country Action leverages growing political momentum for positive changes to the lives of women and girls (UNAIDS, 2009a). Despite the presence of several studies, additional research and development are required to combat this escalading disease, and to provide solution strategies for Pakistan and other developing countries. Understanding the cultural, religious, and social norms that influence the people living in Pakistan is instrumental in developing a strategy for detection, prevention, and access to health care.

Mukhtar Mai is a disturbing example of life for the women of rural Pakistan. This uneducated woman suffered unspeakable treatment at the hands of her village and
government, yet she fought back and became the leading activist in the struggle for
equality between the sexes and for women’s rights in Pakistan. Mukhtar Mai has
accomplished much more than her own equality, she has inspired a movement. A
movement to educate the young, “my little pupils, girls and boys, whose hard work at the
school inspires me to hope, I will see growth of a better educated generation.” (Mai, p.
172). Considered a hero by most, Mukhtar has used her notoriety to start a school in the
same village in which she was raped. The school is the beginning foundation for gender
equality and respect, at least in one village in Pakistan. There is indescribable irony in
Mukhtar humble lesson to her rapists, her religion and her government.
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