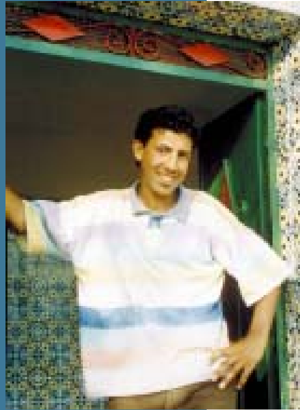

Adolescent and Youth Reproductive Health in

Pakistan

Status, Issues, Policies, and Programs

POLICY is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by Futures Group International in collaboration with Research Triangle Institute and the Centre for Development and Population Activities (CEDPA).

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ADOLESCENT REPRODUCTIVE HEALTH IN PAKISTAN

Status, Policies, Programs, and Issues

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March 2003

POLICY Project

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
CEDPA	Centre for Development and Population Activities
CRC	Convention on the Rights of the Child
FP	Family planning
FPAP	Family Planning Association of Pakistan
HIV	Human immuno-deficiency virus
ICOMP	International Council on Management of Population Programs
ILO	International Labor Organization
IPEC	International Program on the Elimination of Child Labor
JEAT	Join in Educating Adolescents and Teenagers
KAP	Knowledge, attitude, and practices (survey)
KRHP	Karachi Reproductive Health Project
LHRLA	Lawyers for Human Rights and Legal Aid
MMR	Maternal mortality ratio
MSS	Marie Stopes Society
NACP	National AIDS Control Program
NGO	Nongovernmental organization
NWFP	North-West Frontier Province
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PCPS	Pakistan Contraceptive Prevalence Survey
PDHS	Pakistan Demographic and Health Survey
PIHS	Pakistan Integrated Housing Surveys
PMS	Premenstrual syndome
PRHFPS	Pakistan Reproductive Health and Family Planning Survey
RH	Reproductive health
RTI	Research Triangle Institute
STI	Sexually transmitted infection
TFR	Total fertility rate
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAR	War Against Rape
WHO	World Health Organization

1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Pakistan is part of a series of assessments in 13 countries in Asia and the Near East.[1] The purpose of the assessments is to highlight the reproductive health status of adolescents in each country. The report begins with the social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Pakistan.

The concept of adolescence as a distinct period of human development is still fairly new in Pakistan. Most beliefs and practices in this multicultural society are still premised upon the assumption that the transition from childhood to adulthood is brief and marked by the onset of marriage, particularly for girls. But the reality of life in Pakistan is rapidly changing. One in three people lives in an urban center,[2] which means that Pakistan is unlikely to remain a primarily rural society. Access to electronic media is increasingly widespread, heightening the cultural influences of other areas and increasing access to information from the outside world. Educational levels and age at marriage are also increasing, lengthening the transition into adulthood.

The population ages 15–24 in Pakistan was estimated to be approximately 27 million in 2000, and it is expected to continue to increase, reaching 44.6 million in 2020 (Figure 1). This is an increase of 39 percent in just 20 years. This age group accounts for almost one quarter of the population in Pakistan and the peak number of youth will be reached in the year 2035.[3]

There is a wide gap in education between Pakistani boys and girls. Twice as many girls have no education (59 percent) compared with boys (31 percent) (Figure 2). Similar gaps are found for middle and secondary education. However, primary education levels are closer; 18 percent of boys compared with 14 percent of girls have a primary education (Figure 2).

Pregnancies and births will almost double among adolescent Pakistani girls in the next 20 years. Births will increase from almost 1.7 million in 2000 to 2.9 million in 2020 (Figure 3)—an increase of 41 percent. Between 1991 and 1995, unmet need declined slightly for 15–19 year-olds from 24.7 to 21.7 percent, respectively. However, it increased among older age groups (ages 20–24) from 24.5 percent in 1995 to 33.8 percent in 1995 (Figure 4).

The full range of implications that modernization and its attendant influences have on adolescents in Pakistan is unknown because research is still at a preliminary stage. Some research efforts are underway to piece together a larger profile of 10–19 year-olds, including analyses of essential existing data on employment and education.[4] There are some data, particularly from the Pakistan Demographic and Health Survey (PDHS) 1990–91, Pakistan Contraceptive Prevalence Survey (PCPS) 1994–95, and the

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[1] The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.
[2] Population Census Organization, 1998.
[3] Xenos, 1998.
[4] The Population Council in Islamabad is currently conducting analyses of Pakistan Integrated Household Survey 1990–91 data on adolescents in addition to preliminary research into their education and reproductive health requirements as part of an effort to prepare an integrated research agenda on this age group.

Pakistan Integrated Household Surveys (PIHS), that have enough age-specific information to assess some aspects of ARH status. Other aspects of adolescent health and development profiles are pieced together from medical research and nongovernmental organizations (NGOs), which provide insight into adolescent issues though this information is not based on nationally representative data samples. According to government figures, the population bracket 0–24 is twice as large as the population aged 25–60, which is considered to be the earning age bracket. This produces a high dependency ratio and fewer opportunities for the younger generation compared with their parents.[5]

This report reviews existing research on adolescents and reproductive health and identifies policy and program interventions, where available. Because planners are only just beginning to conceptualize adolescence and there are few ARH-specific laws, policies, or programs, a full exposé is not yet possible. Throughout the report, the reader will note gaps in available figures, research, and information. This is an inevitable result of the preliminary and limited nature of the research. Some of the findings have been extracted from more general research as part of an effort to build a preliminary reproductive health profile. This only underscores the need for more work in the area of ARH.

The report addresses adolescents ages 10–19. It is important to note, however, that the onset of puberty, which may start earlier or later than age 10, is a developmental milestone critical to understanding the period of adolescence. The needs and realities of 10 year-olds and 19 year-olds are different and they cannot be encapsulated by an overarching concept of "adolescence." Despite these limitations, however, the 10–19 year-old age parameter covers a general period of transition that is neither childhood nor adulthood and therefore has qualities that are uniquely its own.[6]

Two strong themes run through the report and assist in the task of conceptualizing what it means to be an adolescent in Pakistan today. First, adolescents in Pakistan are not exempt from the reproductive health problems faced by the adult population, particularly women. These problems include lack of information and access to services, maternal health burden, taboos on sexuality, sexual violence/exploitation, and the risks of exposure to sexually transmitted infections (STIs). However, adolescents are not adults. Therefore, they are more vulnerable and require additional information and protection than their older counterparts. Adolescents face the same issues as adults but with different emphases. For example, adolescent girls, even if married, are more often restricted than older women in their mobility and access to health and family planning services.

Second, the research conducted in Pakistan thus far reveals that there are particular biases against adolescents that have put adolescents at greater risk compared with adults in terms of reproductive health issues. Age discrimination is one such major bias; it generates barriers to adolescents accessing clinics and reproductive health care. Another factor that puts adolescents at risk compared with adults is greater risk of sexual violence. This is true for boys as well as girls. Finally, decisions and mistakes made during adolescence define and limit options for the rest of adolescents' lives. Therefore, if an unmarried girl experiences an unwanted pregnancy due to lack of adequate information and support, she is likely to suffer extreme consequences of punishment, which negatively affects her life as a whole.

[5] Azariah and Reichenback, 2001.
[6] This conceptualization of adolescence is based on Mensch et al, 1998.

Figure 1. Total Adolescent Population
(Ages 15-24)

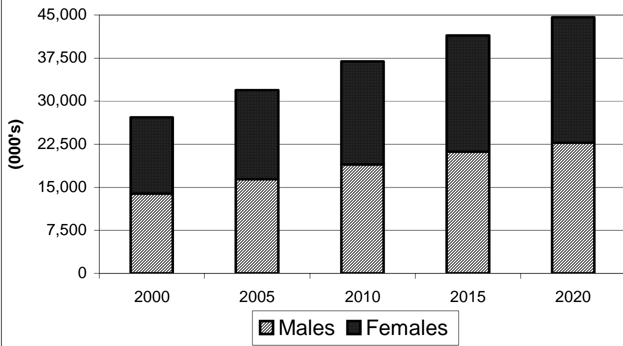


Figure 2. Years of Education Completed
(Ages 15-24)

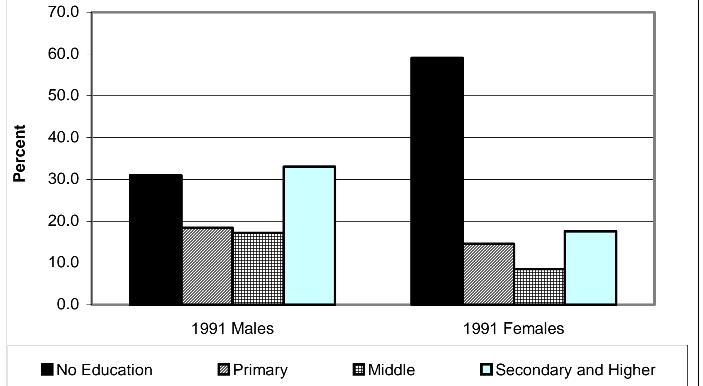


Figure 3. Annual Pregnancies and Outcomes
(Ages 15-24)

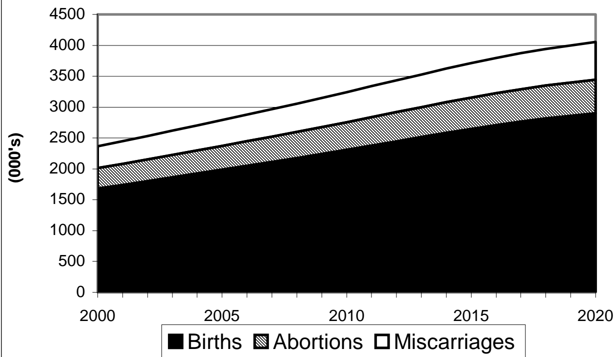
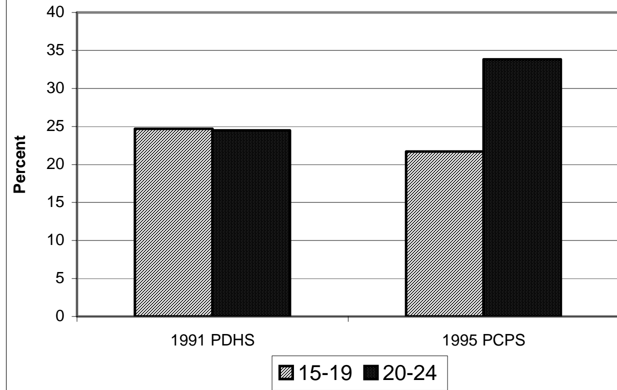


Figure 4. Total Unmet Need for FP
(Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 4

2 SOCIAL CONTEXT OF ARH

The differences between how girls and boys are socialized are quite profound in Pakistan. Numerous issues, such as their sex alone, age, class, and the culture, affect this socialization. In turn, their status—in terms of education, employment, and marriage, among others—and their knowledge of reproductive health issues are affected by these issues.

Education

The educational levels of adolescents, who make up one-quarter of Pakistan's population and are soon to be the adults and decision makers of society, are inadequate to equip them for their future responsibilities. An analysis of PIHS data reveals that nearly 30 percent of adolescents in Pakistan have never attended school.[7] The problem is more severe in rural areas, particularly in rural Sindh and rural Balochistan, and for girls. The gender gap in education is closing in urban areas, but huge gaps persist throughout rural Pakistan. Only one in three urban adolescents and one in six rural adolescents who ever attend school complete their schooling through grade ten. Parental attitudes are in favor of both boys' and girls' schooling, but the shortage of proximate schools and qualified teachers negatively affects girls schooling, particularly in rural areas and for education above the primary level. Only one in 10 adolescents has a literate mother, and four in 10 have literate fathers.

Table 1. Percentage of adults who ever attended school, by age and residence, 1991 and 1996–97

Region and Age	PIHS 1991			PIHS 1996–97		
	Male	Female	Both	Male	Female	Both
Urban areas (Ages 10–19)	75	49	63	78	57	68
10–14 years	88	75	82	90	80	85
15–19 years	85	71	79	86	79	83
Rural areas (Ages 10–19)	59	20	40	61	25	43
10–14 years	83	44	64	80	51	66
15–19 years	73	35	55	80	42	61
Pakistan (Ages 10–19)	64	29	47	66	35	51
10–14 years	84	53	69	83	60	72
15–19 years	77	46	62	82	55	69

Sources: PIHS, 1991; PIHS 1998:21.

During the 1990s, according to the PIHS, the percentage of adolescents who ever attended school did not show a steady increase. In fact, the 1996–97 PIHS figures suggest that the total number of adolescents who have ever attended school may be dropping, particularly for boys. In 1996–97, only one-third (35%) of girls ages 10–19 had ever attended school. Girls in rural areas are even further disadvantaged than their urban counterparts, where over twice as many females say they have ever attended school (57% in urban areas compared with 25% in rural areas). PIHS 1996–97 also reports that 16 percent of all adolescents (and 25 % of females in rural areas) drop out before completing primary school.

[7] Durrant, 2000.

Table 2. Adolescents who are literate, by sex and residence, 1996–97

Age Category	Urban			Rural			Overall Pakistan		
	Male	Female	Both	Male	Female	Both	Male	Female	Both
10–14 years	54	57	56	41	27	34	45	36	41
15–19 years	75	74	75	65	33	49	69	47	58
Total (Ages 10–19)	65	50	58	44	17	31	51	28	39

Source: PIHS, 1998:46.

There are numerous unanswered questions regarding the quality of education received by adolescents, the reasons why they do not remain in school, and the obstacles faced by girls in accessing the school system. While the government seeks to address these problems, there is still insufficient detailed research available to shed light on adolescents' educational experiences in Pakistan. From the information available, however, the profile of the Pakistani adolescent is one of disadvantage with regard to education.

Levels of education have been shown to exert a strong influence on adolescent fertility. In order to make accurate linkages between education, employment, and adolescent fertility and family planning, a clearer picture first needs to emerge of the issues they face with regard to schooling and work. The Population Council has studied the effects of school access and quality on family-building behavior in rural Pakistan. The study concludes that the number of primary girls' schools in a community and the ratio of girls' schools to boys' schools have a statistically significant effect on a woman's desire to stop childbearing and to use contraceptives.[8] Related research by the Population Council on women's empowerment and its impact on demographic indicators is another valuable addition to our understanding of how women's status is linked with positive changes in children's health and education indicators.[9]

Employment

According to a survey sponsored by the International Labor Organization (ILO) in 1996, 3.3 million (8%) of 40 million children ages 5–14 were economically active and 73 percent of them were boys.[10] However, figures will vary depending upon the terms used to define employment. An analysis of PIHS data from 1991 and 1995–96 reveals that 45 percent of adolescent girls in Pakistan are not in school, engaged in economically productive work, or married. The comparable figure for boys ages 10–19 is only 13 percent. Many of the adolescent girls in this group are working in the parental home, but it is unclear if this time is accounted for and what both boys and girls are doing in addition to this. Almost one-half of working adolescents (48%) do agricultural work. Further details about adolescents' work can be found in Table 3.

[8] Sathar et al., 2000.
[9] Durrant and Sathar, 2000.
[10] Ministry of Women's Development, Social Welfare, and Special Education, 1998.

Table 3. Percentage of Pakistani adolescents working one or more hours per week, by occupation type, gender, region, and age group, 1995/96

Occupation Type	All	Gender		Region		Age Group	
		Boys	Girls	Urban	Rural	Ages 10–14	Ages 15–19
Service	9.9	12.2	5.1	21.9	6.4	8.7	10.6
Agriculture	47.5	45.4	51.7	6.4	59.3	56.5	42.0
Production/labor	39.3	38.5	41.1	63.5	32.4	33.8	42.8
Clerical	0.6	0.7	0.5	1.4	0.4	0.1	1.0
Admin/managerial	0.8	0.5	1.5	2.1	0.4	0.1	1.3
Prof./technical	1.6	2.4	0.1	4.1	0.9	0.9	2.1
Sales	0.3	0.4	0.0	0.7	0.1	0.1	0.4
Unweighted n	8,165	4,915	3,250	3,222	4,943	3,535	4,630

Source: Durrant, 2000.

An analysis of PIHS data showed that about one-third of adolescents report working in either a paid or unpaid capacity and the nature of that work follows strict gender norms.[11] That is, boys are much more likely than girls to work for pay, work outside the home, be self-employed, and spend more hours per week working. Rural and urban differences are great as well, with rural adolescents doing more work—usually agricultural—than their urban counterparts and more often for no pay. Adolescent girls' median income from paid work is only 60 percent of that of boys. The majority of adolescent girls participate in housework activities (the same data is not available for boys), mainly cooking, cleaning, and laundry. This research poses some critical questions, one being whether housework prevents girls from engaging in other activities or whether they perform housework because they are not allowed to engage in other activities. Researchers are advised to further investigate this issue, and outreach programs need to work hard to reach the extremely vulnerable group of adolescents that is within the home, out of reach of other formal institutions.

An analysis of adolescent data in the third round of the PIHS (1998–99), covering 16,305 households across urban and rural communities in the country, explored trade-off patterns between adolescents' work and education.[12] Researchers found that "education is not being viewed as an investment in human capital that is expected to yield future returns in the form of enhanced labor market earnings."[13] In an unstable macroeconomic environment, the economic function of children/adolescents increases and that of adults decreases, thereby influencing parents to favor their child/adolescent working instead of studying. The link between work and education for children/adolescents is a complex one, as this and other studies bear out, and it is best to avoid establishing simple causalities. However, this study concludes that poverty, particularly the currently growing poverty in Pakistan, ensures that parents will view the investment in education as less beneficial than the economic rewards of their children's work, at least in the short term.[14]

Maturation and marriage

Various issues need to be addressed when talking about the effect of maturation and marriage on ARH in Pakistan. These include menstruation, marriage, marital relations, and early childbearing.

[11] Durrant, 2000.
[12] Khan and Shahnaz, 2002.
[13] Khan and Shahnaz, 2002:216.
[14] Khan and Shahnaz, 2002.

Menstruation. The onset of menstruation may mark an abrupt change to quasi-adult status in a girl's life in Pakistan, or it may mark the beginning of a long transition period to full adulthood. A girl's experience with menstruation will depend on her class, educational, cultural, and social background. Under Islamic laws, such as the Hudood Ordinances, the onset of menstruation is used to determine her adult status under the law, making a woman liable to severe punishment for sexual activity. While the age at marriage for girls has risen over the years, in some parts of the country girls are betrothed or married soon after their menses begin. In conservative and rural communities, menstruation usually marks a stricter enforcement of *purdah* (segregation of the sexes) norms, resulting in a girl covering her head, finding her mobility outside the home restricted, and causing her withdrawal from school.

In a study on the transfer of health and reproductive knowledge in a southern Punjab village, menstruation was "the watershed between being a girl child and becoming a woman."[15] A girl was immediately expected to observe purdah and wear a *burqa* and would be married within two to three years of her first period. Although such dramatic changes in a girl's status do not occur in all communities in Pakistan, particularly in urban centers, the social silence maintained around menstruation can be observed across class and cultural divides. Girls in the study relied on elder sisters or sisters-in-law for information about menstruation and its practical management.

Some practices related to menstruation are worrisome from the health and hygiene point of view. For example, the aforementioned study found that women were considered unclean while menstruating.[16] Some were made to sleep on a mat on the floor, forbidden to bathe, and advised to avoid certain foods so they would not grow ill. Existing research studies confirm repeatedly that girls' knowledge of and information about menstruation and hygienic practices during menses are inadequate. Examples abound throughout available research material.[17] For example, in a focus group discussion in DG Khan, some girls admitted that when they first began to menstruate they thought they had acquired a dangerous disease.[18] In a school-based survey in Karachi, the misconceptions among adolescent girl respondents in one public and one private school were similar—90 percent thought menstruation was harmful to health, and the figures remained extremely high for those who believed it was harmful to exercise or bathe during menstruation. A simple series of educational workshops with these girls in the school setting resulted in these figures dropping to insignificant levels in a follow-up test questionnaire.[19]

While a variety of home remedies and traditional therapies are used to manage menstrual cramps, premenstrual syndrome (PMS) was not recognized as a problem until a few years ago. However, in a study of 1,600 women in Karachi,[20] the total prevalence of PMS was 33.3 percent. The figure was slightly higher for married women (33.6%) than unmarried women (32%). It was inversely proportional to the number of pregnancies. PMS was most frequent among the lower socioeconomic groups and among women who lived in parts of Karachi most affected by ethnic and drug-related violence.

More research needs to be done on customs and restrictions, particularly in terms of the health dimensions, surrounding menstruation.[21] In a country with an ethnic and cultural mix, such as Pakistan, there is a need to understand in more detail how girls from different tribes and regions manage the practical and health dimensions of menstruation. While anthropological and development literature

[15] Mumtaz and Raouf, 1996.
[16] Mumtaz and Raouf, 1996.
[17] See also Arain, 2003 [upcoming]; PAVHNA, 2000; Aahung, 1999.
[18] Javeed, 2003.
[19] Masood, 1999.
[20] Shershah et al., 1991.
[21] Mensch et al., 1998.

includes limited information on practices surrounding menstruation among different tribes, the subject has not been the focus of sustained or comparative research.

Age at marriage. According to PIHS data since 1991, less than one-quarter of adolescent girls in Pakistan reported having ever married, and the proportion seems to be steadily declining (see Table 4). Rural girls are at a disadvantage compared with their urban counterparts, with PIHS 1996–97 figures showing 18 percent of rural girls ages 15–19 having ever married compared with only 8 percent of their urban counterparts. Married adolescent girls reported almost negligible numbers of children ever born. Once girls enter the 20–24 age group, there is a dramatic, more than four-fold increase in the proportion of those married, and the mean number of children ever born to women ages 20–24 is 0.9.

Table 4. Selected demographic characteristics for Pakistani women younger than 25, PIHS 1996–97

Characteristics	PIHS 1991			PIHS 1996–97		
	Urban	Rural	Total	Urban	Rural	Total
Percent Women Ever Married						
15–19 years	14	26	22	8	18	14
20–24 years	58	74	69	47	66	60
Total (Ages 15–24)	68	76	73	62	71	68
Mean Number of Children Ever Born						
15–19 years	0.1	0.1	0.1	0.0	0.1	0.1
20–24 years	0.9	1.3	1.2	0.7	1.0	0.9
Total (Ages 15–24)	3.0	3.3	3.2	2.6	3.0	2.9
Age-specific Fertility Rates (ASFRs)						
15–19 years	68	118	102	32	55	47
20–24 years	266	285	279	200	238	226

Source: PIHS,1998.

The proportion of adolescent males married is far less than that of married adolescent females. The PCPS found that only 5.3 percent of the males ages 15–19 surveyed were married, sharply contrasting with the figures of 23.4 percent given for females of the same age.[22] Calculations based on PIHS data show that more than one-half of women currently in their twenties were married during adolescence, while the corresponding figure for men is less than one-fifth.[23]

In Pakistan, the average age at marriage is increasing for both men and women, although at a faster rate for the latter. The mean age at marriage according to the PCPS 1994–95 is 26.1 for men and 22 for women. While men's age at marriage has risen by only about one year since the 1981 census, women's age at marriage has risen from 20 to 22 in that same period. The difference between men's and women's age at marriage is shrinking the traditionally large age gap between spouses. However, more recent data released by the Pakistan Reproductive Health and Family Planning Survey (PRHFPS) 2000–01 show that the estimated mean age at marriage is 27.1 for males and 22.7 for females, indicating that the rise in age at marriage is continuing but the gap between male and female figures is not narrowing.[24] Age at marriage is slightly higher for both men and women in urban compared with rural areas and is substantially higher, particularly for women, with increased levels of education.[25]

[22] Population Council et al., 1998.
[23] Durrant, 2000.
[24] Hakim et al., 2001.
[25] Population Council et al., 1998.

Table 5. Percentage of married adolescents ages 15–19, by sex, 1990–91 and 1994–95

Sex	PDHS 1990–91	PCPS 1994–95
Male	3.5	5.3
Female	18.4	23.4

Sources: Population Council et al., 1998; National Institute of Population Studies and Demographic Health Survey, 1992.

Adolescents, particularly girls, who marry when they are young do not necessarily wish to do so. A study of female autonomy and relations within marriage in Egypt found that among girls who married before age 16, only one in 10 chose their husband, while 40 percent of those who married after age 25 selected their spouse.[26] Arranged marriages are still the norm and females' status is significantly lower than that of males. In this context, girls' decision-making power with regard to timing and choice of spouse is certainly limited, but further research is required to determine under what circumstances early marriage is against the will of the adolescent girl.

A series of focus group discussions with adolescent boys and girls in rural Punjab revealed that they have different approaches to the question of marriage timing and choice.[27] While boys felt the ideal age at marriage was between 18 and 29, girls limited the range to 20–25—outside of the adolescent years. Interestingly, boys said that the choice of spouse should rest with both the boy and girl and that they express their own views on the matter. Girls generally felt that parents should be trusted to find them a suitable match, though girls ought to be consulted. A recent Sindh-based study conducted by Marie Stopes Society (MSS) similarly found that girls were more conservative; 94 percent of the girls surveyed said spousal selection should be made by parents compared with 59 percent of boys. But 41 percent of boys and 31.4 percent of girls also felt that both they and their parents should be involved in spousal selection.[28]

Table 6. Percentage of women ages 15–19 by marital status, 1990–91 and 1994–95

Survey and age	Never married	Currently married	Divorced/ separated	Widowed	Total percent	(N)
PCPS 1994–95 15–19 years	75.6	23.4	0.3	0.7	100	2,506
PDHS 1990–91 15–19 years	75.1	24.3	0.2	0.3	100	1,720

Sources: Population Council et al., 1998; National Institute of Population Studies and Demographic Health Survey, 1992.

Almost one-fourth of women ages 15–19 surveyed by the PCPS 1994–95 and the PDHS 1990–91 were currently married. Therefore, if 23.4 percent of women ages 15–19 surveyed in the PCPS 1994–95 are currently married, what do we know about them? Married adolescent girls are more likely to be found in certain pockets of Pakistan. Roughly three-quarters of girls in rural areas of Sindh and Balochistan and adolescent girls with no education marry before age 20.[29]

Married adolescent girls are likely to find motherhood the sole focus of their lives at the expense of development in other areas, such as formal education, training for employment, work experience, and

[26] Mensch et al., 1998.
[27] Population Council, 1999.
[28] Arain, 2003: Table 3.2.
[29] Durrant, 2000.

personal growth.[30] By Singh and Samara's (1996) analysis, the fact that Pakistan still has a substantial number of married adolescent girls implies that these girls have not had the education or employment opportunities associated with delayed marriage and reside predominantly in rural areas. This is supported by the analysis in the PCPS report, which shows that age at marriage is lowest in rural areas and increases with education.[31] This is also supported by Durrant, who finds that married adolescent girls are under great pressure to become mothers early, and as a result they have little spacing between marriage and childbearing and low levels of contraceptive use. Therefore, one-third of adolescent girls become mothers in their teens. Married adolescent girls are in great need of knowledge about reproductive health and access to relevant services.[32]

Marital relations. While sexuality is recognized in Pakistan as a healthy part of married life and is even encouraged by religious teachings, it is still subject to extreme legal and social controls. That is, sex outside of marriage is a crime against the state.[33] Suspicion of such sexual relations is cause for women in particular to be immediately killed by customary law (e.g., *karo kari* in Sindh[34]) or at the least, for a family's reputation to be tarnished and a girl's future prospects ruined. Whereas women's sexuality and the control of it by male elders or husbands is a foundation of social values and norms in Pakistan, men are understood to have sexual desires that may or may not be satisfied by their wives. Possibly for these reasons, there exist only a few more research findings on male compared with female sexuality. The question of whether sex within marriage is always consensual, particularly when one partner may be considerably younger and less empowered than the other, has barely been examined.[35] In Pakistan, the possibility of rape within marriage is not recognized. A large group of young women are sexually active and at the same time vulnerable to exploitative power dynamics with their husbands.

One pioneering research effort by Aahung, a Karachi-based NGO, is based on qualitative interviews with married men and women to explore existing norms and values pertaining to sexuality in low- and middle-income communities in Karachi. The study revealed that both men and women suffer from a lack of accurate and adequate knowledge about their reproductive anatomy and related reproductive health issues and that prevalent values and beliefs, characterized by shame, fear, and guilt surrounding sexuality, inhibit in particular women's comfort with their sexual relations.[36] Further qualitative research by Aahung exploring issues of sexuality, terms of negotiation between couples, and belief systems regarding sexuality is still underway. One can only extrapolate from findings such as these that married adolescents, particularly girls, will be only more vulnerable to unhealthy sexual practices and belief systems due to their lack of information and sufficient negotiating power in their relationships.

Knowledge of reproductive health issues

Knowledge about reproductive health is quite limited on the parts of both boys and girls, and the issues involved and reasons for this lack of knowledge differ for boys and girls.

Out of the 520 married female respondents ages 15–19 surveyed in PCPS 1994–95, 75.5 percent had knowledge of at least one contraceptive method, with 17.3 percent knowing of at least one traditional method (see Table 7). Fifty-nine percent knew the source of at least one modern method. Knowledge of

[30] Singh and Samara, 1996.
[31] Population Council et al., 1998.
[32] Durrant, 2000.
[33] Chohan, 1996.
[34] *Karo kari*, or the killing of a man or woman by a community on the suspicion that they have committed adultery or had sexual contact without being married, is prevalent in Sindh and Balochistan. For a discussion of the traditional form of settlement that includes the practice of karo kari, see Shah, 1998: 227–252.
[35] Mensch et al., 1998.
[36] Premjee, 2002.

at least one method increases slightly with age, peaking at 94.8 percent for married women ages 35–39. In contrast, 83.6 percent of married women ages 25–29 knew of a source of at least one modern method.[37] This means that adolescent respondents had somewhat less contraceptive knowledge than older women in addition to less knowledge of how to access a modern method.

Table 7. Contraceptive knowledge and practice among married female adolescents ages 15–19 (percentage), 1994–95

Knowledge of at least one contraceptive method	Knowledge of at least one traditional method	Knowledge of the source of at least one modern method	Ever used any traditional or modern contraceptive method	Want a child soon	Unmet need for contraceptives
75.5	17.3	58.8	4.7	74.1	21.7

Source: Population Council et al., 1998.

According to the PCPS 1994–95, only 4.7 percent of married women ages 15–19 had ever used any contraceptive method, traditional or modern, while the figure jumped to 17.1 percent for women ages 20–24. The survey establishes that ever use is higher in urban than in rural areas and is highest among provinces in the Punjab. Women with secondary education were nearly three times as likely to have ever used family planning as women without schooling. Out of the women ages 15–19 surveyed in the PCPS, 74.1 percent wanted a child soon compared with 52 percent of those ages 20–24. The unmet need for contraceptives was calculated at 21.7 percent for the women ages 15–19.

The PRHFPS 2000–01 covered 7,411 ever-married women ages 15–49 to assess the efficacy of the current national program in terms of a range of reproductive health indicators. When ever-married women were asked to recall puberty, 86 percent recalled facing problems at their first menstruation. Figures suggest that mothers, elder sisters, and other relatives or friends provided the most assistance at that time. When asked if they had discussed with their daughters the problems faced at the time of puberty, the mothers reported that they educated their daughters about menstruation, but less about other issues such as hygiene practices, nutritional education, breast development, and psychological problems. The proportion of women who discussed these issues with their daughters was higher in urban compared with rural areas. About 57 percent of women did not consider it important to educate their adolescent daughters about body and emotional changes.[38]

In an effort to assess the sexual and reproductive health needs of adolescents, the Pakistan Voluntary Health and Nutrition Association (PAVHNA) conducted a survey of adolescents (ages 13–21) in four provincial cities of Pakistan.[39] It interviewed 177 girls and 133 boys through random selection. Respondents demonstrated basic awareness of bodily changes during puberty, menstruation, sex, pregnancy, and contraceptive methods and had heard of AIDS. Findings showed that premarital sex was still not common in Pakistan. Parents were not considered reliable or common sources of information about sex, and teachers also lacked adequate rapport with their students to discuss these issues. Adolescents said they turned to peers and media sources for information, which researchers said led to tremendous misinformation.

Boys and young men may have more access to the outside world and exposure to diverse sources of sexual information but nevertheless, they seem to be deeply concerned about elements of their own sexuality. The prevalence of misinformation, perpetrated by so-called sex clinics which seek to “cure”

[37] Population Council et al., 1998.
[38] Hakim et al., 2001
[39] PAVHNA and Raasta Development Consultants, 2000.

men of unwanted sexual habits, and traditional and religious taboos exert a powerful hold on males. Since they seem reluctant to discuss their concerns and questions about their own sexuality with peers, it may be only when they marry and develop intimacy with their wives that they can lay some anxieties to rest.

Certain small studies venture into the unexplored territory of young peoples' attitudes toward sexuality. Although they do not represent a wide sample of respondents, their findings can be used in developing future research.[40] For example, young men seem particularly anxious about masturbation, homosexuality, nocturnal emissions, and infertility. In a study conducted among 188 male patients (ages 18–30) presenting at Aga Khan University in Karachi, 80.3 percent said they had masturbated at some point in their lives.[41] Their misconceptions include the belief that masturbation causes impotence (22.3%), physical illness (31.4%) and weakness (62.8%). Strong feelings of guilt remained with 68.6 percent of respondents. The misconceptions were more prevalent among respondents from lower- and middle-income groups. Their concerns were often exploited by sex clinics, where they would pay thousands of rupees for treatment for infertility prior to getting married simply because they had masturbated.[42]

Aangan, a community program to raise awareness about child sexual abuse, analyzed 45 letters received from young people (75% from young males) requesting information on sexual health.[43] Masturbation was the most commonly expressed concern (46%). Letter-writers feared that their future sexual performance would be negatively affected and that physical weakness, infertility, reduction in penis shape, loss of virginity, or related health problems may result from masturbation. These misconceptions are so deep-rooted in culture and traditions that researchers may be amazed to discover the hold of some extraordinary myths. For example, male child prostitutes interviewed in the North-West Frontier Province (NWFP) believed that among all the sexual practices they knew of, including sex with girls, sex with men or boys, sex with animals, and masturbation, the latter was by far the most sinful. In fact, they believed that if someone masturbated, God would get a fever.[44]

Young men are also concerned about nocturnal emissions (or "wet dreams"), though possibly to a lesser extent than masturbation. In the study conducted at Aga Khan University, 94 percent of respondents admitted to having them and 15 percent considered them a cause of physical illness.[45] Respondents associated dark circles around the eyes with the consequences of masturbation and nocturnal emissions.

A series of focus groups with adolescents in Chanessar Goth, a low-income, multi-ethnic community in Karachi, were conducted by Aahung (part of the Karachi Reproductive Health Project) in preparation for developing an AIDS awareness program within the local schools.[46] The discussions with both boys and girls attending the Urdu-medium secondary schools revealed that the main factors that contributed to poor sexual health among adolescents were a general lack of confidence and ability to be assertive, and inadequate information about the body. Child sexual abuse, sexual harassment, drug use, and shame and guilt associated with the body were identified as key concerns that inhibited their health-seeking behavior. In-depth interviews conducted with 71 boys ages 11–19 revealed that 18.3 percent said one should not talk about his body and 11.3 percent would not tell anyone if they experienced discomfort in their genital area. Most boys believed that masturbation endangered one's health and most commonly associated it with causing the penis to become crooked or loose.

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[40] See also World Population Foundation, 2002: 233–245 for research findings that support attitudes and awareness levels described in the other research studies in this section.
[41] Qidwai, 1996.
[42] Qidwai, 1998.
[43] Aangan, 1998a.
[44] Discussion with Anusheh Hussain, Sahil, December, 1998.
[45] Qidwai, 1996.
[46] Aahung, 1999.

The MSS of Pakistan, in its assessment of a youth awareness program on reproductive health in DG Khan, found that in this locality there are great misconceptions on reproductive health issues, lack of awareness, and a wide gap between attributes and actual behavior. Puberty is rarely discussed in the households, and young people suffer anxiety and stress when changes—even menstruation—occur for which they are entirely unprepared. When girls do get guidance from their mothers or older sisters on reproductive health issues, the information is often inaccurate. While the community and youth were supportive of greater awareness on reproductive health issues, social practices did restrict the openness of participation and discussion.[47] Another MSS knowledge, attitudes, and practices (KAP) survey in rural and urban Sindh gathered a wide range of data on adolescents' views on reproductive health issues, including their knowledge about puberty, pregnancy, reproduction, intercourse, masturbation, menstruation, contraception, and STIs.[48] While the final findings have yet to be published, studies such as these help to add depth to our understanding of adolescents' perspectives.

A study in Punjab of male needs and attitudes regarding reproductive health[49] found that men, women, and service providers all feel that men lack awareness and knowledge of reproductive problems and hold certain misconceptions about sexuality. These issues include infertility, weakness, sexual "debility" and masturbation. Service providers suggested that information and education begin to be provided to boys at age 14 and that services also need to help prevent the spread of homosexuality and prevent frequent masturbation—recommendations that probably reflect their own misconceptions.

Yet, since so little is known about female sexual attitudes and behavior and open discussion is so strongly discouraged, it is impossible to determine the real sentiments and activities of girls in Pakistan. Where field workers have access to adolescent girls and enjoy their confidence, as in the Family Planning Association of Pakistan (FPAP) Girl Child Project, findings have formed an important part of the knowledge base of the staff but have not been formally compiled for others to access. We cannot confirm, for example, if the rise in age at marriage has had any bearing upon premarital sexual activity among unmarried adolescents.

A study on reproductive health awareness in adolescent girls was conducted with 300 students in Peshawar high schools.[50] This city is more patriarchal and restrictive of women than other major cities in Pakistan. A questionnaire was distributed to these girls in classes IX and X, presumably ages 14–16. The researcher concluded that teenage sexuality was not a major issue for the students but that there was still a great need for multidisciplinary educational programs in schools to give adolescents "the right answers at the right time."[51] However, students clearly articulated their demand (88%) for sex education in schools, which belied the low level of expressed curiosity about sex. Another finding was that girls were shy to discuss menstruation and felt that virginity was a virtue.

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[47] Javeed, 2003.
[48] Arain, 2003.
[49] Raoof Ali, 1999.
[50] Majid, 1995.
[51] Majid, 1995.

In in-depth interviews conducted with 80 girls ages 11–19 in Chanessar Goth, Karachi, most girls felt it is inappropriate to talk about their bodies, although almost all said they would tell their mothers if they experienced discomfort in their genital area.[52]

[52] Aahung, 1999.

3 ARH ISSUES

A number of specific issues should be considered in a discussion of ARH. These include early, high-risk pregnancy, unwanted pregnancy and abortion, STIs and HIV/AIDS, awareness and prevention issues, and sexual trafficking and other abuse.

Early, high-risk pregnancy

Only 20 percent of women are assisted by a trained provider during delivery. Pakistan ranks third in the world for numbers of infants who die of neonatal tetanus, and the maternal mortality ratio (MMR) is 340 per 100,000 live births.[53] There is limited information on the consequences of early childbearing among young Pakistani women and what is available comes only from general maternal morbidity and mortality studies, which do not focus specifically on adolescents.

First, infant mortality is strongly linked with the mother's age at first birth, with younger mothers associated with the highest mortality figures. The PDHS 1990–1991 found that there are 70 neonatal deaths per 1,000 births for mothers younger than 20 and 51 post-neonatal deaths per 1,000. The figures drop as the age of mother increases and only climbs again for mothers age 40 or older.[54]

Additional research shows that adolescents figure prominently in numbers of deaths associated with child-bearing. In a survey of 30 hospitals and private clinics across Pakistan covering 104,551 live births, there were 703 maternal deaths, making the maternal mortality rate 670 per 100,000 live births.[55] Ten percent of those mothers were ages 15–20. The deaths were primarily from direct causes such as hemorrhage, hypertensive diseases and sepsis, which were mainly suffered by patients who were not enrolled in regular antenatal care. Jafarey (n.d.) identified that social, economic, cultural, and logistical factors prevented women from seeking medical advice even though they were urban residents.

As expected, the data imply what may be severe and unaddressed problems for adolescents. In a four-year review of maternal deaths in a Quetta hospital, 10 women ages 16–20 (7.8%) died due to the same triad of disorders mentioned in the Jafarey study.[56] Seventeen deaths (approximately 13.3%) were primigravida and six died of induced septic abortion. Another study examined the causes of delay that resulted in mothers being brought dead to a hospital in Karachi between 1981 and 1990.[57] Out of the 150 pregnant or recently delivered women who were dead on arrival at the hospital, 10 were younger than 20. Twenty-two (14.6%) of the women were primigravida; this number likely included most, if not all, of the adolescent girls.

The researchers found that most of the deaths were preventable had health services been accessed in time. The most disturbing finding was that the all but five of women brought dead lived only 5–10 km away from the hospital, but a combination of social and economic factors delayed their access to the facility. Reasons for delay included lack of available transport and finances, family's reluctance to bring a woman to the hospital, husband's absence from the house, and inadequate maternal services that failed to refer the patient to the tertiary care facility in time.[58]

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[53] Tinker, 1998.
[54] National Institute of Population Studies and Demographic and Health Survey, 1992.
[55] Jafarey, n.d.
[56] Ashraf, 1996.
[57] Jafarey and Korejo, 1995.
[58] Jafarey and Korejo, 1993.

Although all of the studies reviewed show the risks of death increase with higher parity and that the causes of death were easily preventable, the specific reasons for mortality among adolescents who have little or no history of previous births need to be identified. Adolescent girls' restricted mobility and access to health care could be explored further in research to ascertain causes of adolescent maternal deaths in hospital. For example, it is important to establish whether adolescent girls who are pregnant have more difficulty than older pregnant women simply seeking regular antenatal care and reaching the hospital in time and to then develop interventions to overcome these restrictions.

Unwanted pregnancy and abortion

The prevalence of induced abortion in Pakistan is difficult to determine with any accuracy because research into the practice has been limited and there is an obvious reluctance among the public to admit to illegal activity when questioned. However, community and hospital-based studies are increasing and some basic information has become clear. According to a recent study of abortion clinics conducted by FPAP in three major cities, those Pakistani women who seek abortions are generally married (91.4%), older than 30 (63.3%), and multiparous (61% had parity of 5+). Their reasons for seeking abortion were too many children (64.4%) and contraceptive failure (43.3%).[59] In an earlier Karachi community-based study, 11.7 percent of the women said they had had an induced abortion,[60] and the percentage of maternal deaths due to induced abortions in one Karachi hospital alone was 11 percent.[61] The profile of women who seek induced abortion, as identified in other research mentioned in this section, corroborates the profile of the FPAP study mentioned above.

Reasons for induced abortions include contraceptive failure or an unwilling husband combined with children born too often and with too little spacing for the mother to handle[62] or economic reasons.[63] While both men and women interviewed in a recent Karachi community-based study conduced by the Aga Khan University and Population Council did indicate that they had some level of religious-based concern about induced abortion, it was overcome by those who wished to maintain a small family norm when an unwanted pregnancy took place. Nonetheless, despite high levels of knowledge about family planning methods, knowledge of appropriate use and efficacy for specific contraceptive methods was poor, as was awareness that death could result from a postabortion complication.[64]

Medical practitioners often informally share the opinion that more than one-half of the work of gynecologists in hospitals is the treatment of complications caused by induced abortions, although women are reluctant to admit that they sought back-street abortions.[65] The risks and exploitation experienced by women who seek an illegal abortion have been the subject of some press articles and a limited amount of in-depth discussion among women's groups.[66] The contribution of induced abortion to the overall MMR is unknown. A large public hospital in Karachi estimated that 10 percent of maternal deaths in 1981–1990 were due to abortion (either spontaneous or induced, but the latter being the majority). A community-based study in a Karachi squatter settlement reported that 8.8 percent of all maternal deaths were due to induced abortion.[67]

[59] Rehan, Inayatullah, and Chaudhary, 2001.
[60] Fikree et al., 1996.
[61] Jafarey, n.d.
[62] Saleem, 1998.
[63] Fikree et al., 1996.
[64] Fikree, Saleem and Sami, 2002.
[65] Rana, 1992; Khan et al., 1996.
[66] Shirkat Gah, 1996.
[67] Fikree et al., 2002.

Although research on induced abortion has little to no specific discussion or findings pertaining to adolescents, findings such as those quoted can enhance our understanding of what would be the needs of adolescents seeking induced abortion. For example, adequate information and counseling for adolescents of both sexes (married as well as unmarried) on how to avoid unwanted pregnancy, use contraceptives effectively, and understand the risks of induced abortion can lead to a lifetime of better-informed decision making among couples. In the FPAP study, 3.3 percent of 452 interviewed women who sought abortions were age 20 or younger. Almost 9 percent of respondents said they had chosen induced abortion due to premarital affairs. The FPAP study found that nearly two-thirds of the abortions were induced by inadequately trained persons, and the most common procedures used to terminate the pregnancy was dilatation and curettage, not manual vacuum aspiration.[68]

In a hospital-based study in Karachi, two groups of women were studied in 1977–78 and 1990–91.[69] Out of a total of 3,462 women, 81 (2.3%) gave a history of induced abortion. Although data for women younger than 20 is not analyzed separately, it is revealing that 34 of these women were aged 15–25, nine had no children, 35 had 1–4 children, and five were unmarried. Such data establishes that younger women, including those who are not married and those with less than four children, seek abortions. It should be noted that hospital-based studies cover only those patients who seek care for postabortion complications and their figures are not representative of induced abortion patterns among women.

In Lahore, a study of 125 abortion cases found that 20 percent of the patients were ages 15–19 and 10 percent were unmarried.[70] Although most of the induced abortions took place among older women (ages 30–40) who were grand multipara and belonged to a lower socioeconomic group, this study clearly establishes that adolescents in Pakistan seek abortions. The findings of a Karachi hospital-based study of 37 cases of induced abortion are similar—more than 78 percent were among women ages 25–34 and over 75 percent were multiparous.[71] However, with six of the patients between ages 15 and 24 and three with no previous children, the data again suggest a small but potentially significant adolescent component of the induced abortion problem. Adolescents may be over-represented in studies such as these because of the increased risk among younger abortion patients of sepsis and other related complications, which are possibly caused by delays in seeking medical care.[72] This makes it difficult to correctly estimate the proportion of adolescent abortion patients.

For those women and adolescents who seek medical care after an induced abortion, there are few options other than going to large urban hospitals. Family welfare clinics do not treat abortion complications and, in fact, lack surgical facilities. The scarcity of medical services in the rural areas means that an undetermined number of women never access medical treatment for abortion-related complications. The difficulties of accessing urban-based services is even greater for adolescent girls, most obviously unmarried ones, whose decision-making power and physical mobility is so restricted by their social environment that seeking any medical help outside of the village is fraught with barriers.[73]

STIs and HIV/AIDS

The threat of an HIV/AIDS pandemic has prompted Pakistan's policymakers, donors, and development workers to attempt an initial exploration into high-risk sexual behavior with a view to controlling the spread of serious STIs. Because any research into sexual behavior patterns, as well as open discussion of

[68] Rehan et al., 2001.
[69] Zaidi et al., 1993.
[70] Rana, 1992.
[71] Tayyab and Samad, 1996
[72] Mensch et al., 1998.
[73] Khan, 1998.

how to reduce high-risk behavior, is fraught with social taboos, available research is limited to small-scale studies and does not represent any solid national sampling. One major weakness in available data, which also exists in research on other areas of reproductive health, is a lack of clear age breakdowns within the sample population. Thus, the limited data on AIDS and STIs in Pakistan, although more available than general information about sexual behavior, do not give us specific information about high-risk behavior among adolescents.

However, we know that some adolescents are exposed to high-risk behavior through sexual abuse, commercial sex, homosexual relations, and life in jails. They are also relatively powerless compared with adults in exploitative circumstances. It is reasonable to assume, then, that adolescents do figure into the high-risk groups for such diseases, although we cannot say in what proportion. Adolescents at risk, especially girls, are likely to be even more vulnerable due to their young age and lack of decision-making power.

HIV/AIDS. Pakistan is fertile ground for an AIDS epidemic because of its low social indicators, economic status, and apparent changes in increasing risks of transmission.[74] The reported number of HIV-infected cases has been low—until August 1997 the figure was 1,232. By September 2001 there were 1,699 officially reported HIV cases. The most frequent modes of transmission is heterosexual contact (37% of reported HIV cases) and infection through contaminated blood and blood-related products (18%), followed by intravenous drug use, homosexual/bisexual sex, and mother-to-child-transmission.[75]

Only 20 Pakistani children (up to age 19) have been reported to be HIV-positive, but the World Health Organization (WHO) estimates the total figure to be anywhere between 2,000 and 100,000. Since children and adolescents are often not tested out of the mistaken belief that they cannot be sexually active and most screenings are done only for groups labeled as high-risk, the real level of infection among them is not known.[76]

Ahmed (1998) points out other aspects of the disease pattern that impact children. Male migration, particularly between Pakistan and Gulf countries, has been a source of AIDS transmission and social ostracism for wives who become infected. Women and girls are physically more likely to contract HIV from men than vice versa. Women's lower social status and the high rate of rape in Pakistan further limit their ability to protect themselves from HIV transmission.[77] Changing social patterns and urbanization have increased the number of children affected by sexual abuse, prostitution, and homelessness. These children are all at high risk of contracting HIV and other STIs, although prevalence rates are not available. Finally, young people are also at risk because of contaminated blood transmitted through blood transfusions and the increasing use of needles for drug use in the region. While the prevalence of HIV/AIDS among high-risk groups in Pakistan may still be low, there are strong bonds among high-risk groups (i.e., transvestites, intravenous drug users, sex workers), indicating the increased likelihood of transmission within these groups.[78]

Age-specific data for adolescents is not available for studies done with high-risk groups because adults have been the focus of research. However, these studies do mention that high-risk behavior is seen among adolescents. For example, a study of the trucking industry—a potentially important conduit for

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[74] Hyder and Khan, 1998.
[75] Ministry of Health and UNAIDS, 2001.
[76] Ahmed, 1998.
[77] To date, among the reported cases of HIV and AIDS, there is a 5 to 1 ratio of men to women, not reflecting the fact that women are physically more vulnerable to the disease (Hyder and Khan, 1998). However, the future pattern of the disease may reflect the higher risk for females.
[78] Action Aid, 2003.

the spread of HIV/AIDS—found high rates of male-to-male sexual contact and contact with female sex workers, as well as a significant rate of drug use among the 35 truck drivers and truck cleaners surveyed.[79,80] The cleaners were younger than the drivers and included adolescent boys, whose practices were found to be similar to those of older men. More than one-half of the drivers had been cleaners first, which establishes how they were initiated into this line of work and high-risk behavior.

Another survey of sexual behavior among 300 truckers in Lahore found that truckers commonly engaged in high-risk sexual practices. Nearly one-half of all truckers surveyed reported having had sex with a man, 34 percent with a female sex worker, and 11 percent with a *hijra* (transvestite or eunuch). Despite high levels of AIDS knowledge among truck drivers, knowledge did not translate into a fear for their own risk level. Among those surveyed younger than 30, a lower proportion (26%) had ever had sex with a sex worker or a hijra (7.9%), but a higher proportion (54.3%) had ever had sex with a man.[81] In a larger study mapping the high-risk behavior of 821 truckers and cleaners (age 15 or older) across Pakistan, findings showed that drivers were more aware than the cleaners of at least two ways to prevent HIV and had more detailed knowledge of HIV transmission.[82] But younger respondents and those with more schooling tended to report more that they believed condoms were effective for preventing HIV infection. Among those who reported ever having had sex (81% of total sample), 42.3 percent had done so before age 21, with the younger respondents much more likely to have done so.

The sex industry, also a high-risk group in Pakistan, has been the subject of a number of HIV/AIDS prevalence and awareness studies.[83] One study found that the average age at first intercourse for the female sex workers interviewed was 14–15 and 11 for the male transvestites.[84] Condom use by sex workers was low. In the Lahore red light area, daughters inherit the profession from their mothers;[85] in another study, almost one-half of sex workers reported they began selling sex at the onset of menstruation.[86] A rapid assessment conducted in begging communities revealed that families who beg for a living in urban centers supplement their incomes by putting their daughters, as young as 12 years old, into sex work. These girls frequent truck stops, where their clients are truck drivers and shopkeepers, and religious shrines, where their clients are arranged through shopkeepers.[87] This is yet another example of how the young are set on the road to high-risk behavior in an environment in which knowledge about HIV and others STIs is low and the use of condoms is inadequate.

A study of 3,392 male prisoners (ages 11–81) in Sindh jails found that they reported symptoms of STIs and sexual intercourse with multiple partners (male and female).[88] They also reported past experiences with sex workers (26%), blood donations (22%), and injected drugs (3.6%). The study concluded that "prisons in Sindh are potential reservoirs of sexually transmitted diseases"[89] and recommended that the Sindh government control the spread of STIs in prisons if it wished to limit the problem among the general population.

There are only two juvenile jails in Pakistan. As a result, children find themselves in adult jails, albeit in separate cells, where they experience the same deprivation as older prisoners. According to a survey

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[79] While the sample is small, the implications are nevertheless underlined. Additional research is needed.
[80] Ahmed et al.,1995.
[81] Agha, 2000.
[82] Greenstar Social Marketing, 2002.
[83] Baqi et al., 1998; Khilji, n.d.; Manzoor et al., 1995; SOCH, n.d..
[84] Baqi et al., 1998.
[85] SOCH, n.d.
[86] Manzoor et al., 1995.
[87] Collective for Social Science Research, 2003.
[88] Khan et al., 1995.
[89] Khan et al., 1995.

conducted by the Society for the Protection of Child Rights in 1997, out of a total of 72,714 prisoners in Pakistan, 3,480 were juveniles. Most of them were languishing in jail awaiting trial, while only 282 were convicted.[90] Juvenile prisoners are therefore likely to be exposed to similar high-risk behaviors as their adult, particularly male, counterparts and thus at great risk of contracting STIs.

Exclusive focus on high-risk groups and behaviors obscures the reality that all citizens of Pakistan, including even those who are not sexually active, are at risk of contracting AIDS. For example, everyone is vulnerable to transmission through contaminated blood at hospitals or contaminated needles used in injections, regardless of age. The risk increases because bad health care practices have resulted in an excessive use of blood transfusions and injections in treating patients.[91]

The Karachi Reproductive Health Project (KRHP) undertook a survey to establish baseline STI prevalence among women in a low-income community in Karachi.[92] The study involved testing 601 married women between ages 14–45 for syphilis, gonorrhea, chlamydia, trichomoniasis, and candida in accordance with standards set by WHO and the National AIDS Control Program. The study found the prevalence of STIs to be extremely low (the highest prevalence was candida at 5.8%). There was no age breakdown of the survey data.

Data from surveys on reproductive tract infections and STIs show a general pattern of women complaining of back pain, vaginal discharge, and menstrual pain. In the PRHFPS 2000–01, for example, 37.4 percent of all women complained of back pain, 16.7 percent of hip pain, 25.5 percent of any vaginal discharge, and 10.4 percent of irregular or painful menstruation. Other complaints, such as colored (4%) or smelly (6%) discharge, were significantly lower.[93] Unfortunately, the data with age break-downs were not available.

Awareness, knowledge, and prevention of STIs and HIV/AIDS. While many aspects of reproductive health discussed herein are becoming accepted areas for research in Pakistan, sexual awareness and behavior is probably the least studied. The threat of HIV/AIDS worldwide has prompted attention to be given to it and other STIs (see discussion on commercial sex workers and HIV/AIDS) but this research is highly selective in favor of small, high-risk behavior groups in Pakistan. Available studies conducted among the high-risk groups susceptible to STIs and HIV/AIDS, such as commercial sex workers, drug users, prisoners, truck drivers, and blood recipients, show a generally low level of knowledge about HIV/AIDS and its transmission.[94]

The PRHFPS 2000–01 found that 42 percent of ever-married women had ever heard about AIDS, with their major source of information being television or radio. Among the 15–19 year-olds in this group (married adolescents), 38.1 percent had ever heard of AIDS and their major source of information was television or radio (34.3%). For ever-married women who had heard about AIDS, 77 percent reported that it spread through sexual activity, 60 percent through blood transfusion, and 55 percent through contaminated equipment. Among 15–19 year-olds, the figures were about 6 percent lower for each of the categories above. For women of all ages, there was lower awareness that the disease could be spread from mother to child, with 33.4 percent 15–19 year-olds and 40 percent of all women expressing an awareness of this.[95]

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[90] Fayyazuddin et al., 1998.
[91] Khawaja et al., 1997.
[92] KRHP, 1997.
[93] Hakim et al., 2001.
[94] Khwaja et al., 1997.
[95] Hakim et al., 2001.

A study of 188 men ages 18–30 in Karachi reveals that lack of awareness and information is not confined to high-risk groups of men.[96] Forty-one percent of respondents did not know that condoms can protect one from STIs and 30 percent did not know that a healthy person can transmit an STI. Ignorance levels were higher among respondents with lower socioeconomic and educational levels.

There was an interesting gender differential in the another study's findings regarding knowledge about general STIs, with 43.7 percent of the 71 males interviewed saying that sexual activity was a mode of transmission while only 11.3 percent of the 80 females interviewed could correctly state the same.[97] Similarly, twice as many boys as girls knew that sexual activity was a mode of transmission for HIV.

Among adolescents (151 male and female respondents ages 11–19) interviewed in Chanessar Goth, Karachi, most had heard of HIV/AIDS and knew it was fatal but only 23 percent knew that sexual activity was a mode of transmission.[98] Only 31 percent knew that using a condom reduces the chances of acquiring AIDS. Findings from 37 discussion groups with men in rural Punjab for another study also confirm that there is lack of knowledge and information about STIs, particularly regarding the role of condoms in protecting against infection.[99]

The low level of awareness and information regarding AIDS in Pakistan has been attributed to a complex set of factors, including urbanization, migration, exploitation of women, and the legal framework surrounding marriage and sexuality.[100] These are the same factors that put people at risk for contracting the disease, particularly the young and disempowered.[101] The stigma of STIs and taboos surrounding sex education have caused and reinforced the current ignorance.

Sexual abuse and forced sex work

Preliminary findings suggest that both adolescent boys and girls are vulnerable to exploitation and that the prime age for entry into the business may be the teenage years. The problems of sexual abuse and children forced into sex work have been addressed not by policymakers or national programs, but by small NGOs involved in protecting the rights of women and children in particular. Therefore, the research is modest but it is born of first-hand experience with victims and their rehabilitation.

In its *Overview of Child Sexual Abuse and Exploitation in Pakistan*, the Islamabad-based NGO Sahil argues that existing research is enough to demonstrate that child sexual abuse is, in fact, widespread in Pakistani society but that walls of silence prevent communities and the government from speaking out.[102] Worse, child prostitution and trafficking enjoy police protection because police earn financial compensation from the pimps who run the business.

Male child prostitution. In Pakistan, male prostitutes are believed to be cheaper for clients than female prostitutes. The prime age for male prostitutes is between 15 and 25.[103] It is likely that even less is known about their working environment and specific problems because the social taboos against boys admitting to sex with male clients are even greater than they are for girls.

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[96] Qidwai's, 1996.
[97] Aahung, 1999.
[98] Aahung, 1999.
[99] Raoof Ali, 1999.
[100] Hyder and Khan, 1998.
[101] Ahmed, 1998.
[102] Sahil, n.d.
[103] Fayyazuddin et al., 1998.

A small, but nonetheless pioneering, study by the Islamabad-based NGO Sahil of male child prostitution at a bus stop in the Punjab covered 20 children and 87 other community members. It found that the youngest child prostitute was 8 years old and the oldest was 18. Most were uneducated and came from severe poverty conditions in the northern areas. Ninety percent were runaways, fleeing home due to physical abuse, tribal disputes in which their safety was at stake, and extreme poverty. Runaway children were easily identified by a community member and inducted into the trade. This study challenges notions of masculinity and sexuality in the Pakistani context and reveals that sex between men and boys is more widespread than commonly believed. It also shows how runaway boys are particularly vulnerable to sexual abuse, drug dependency, and a life of sex work.[104]

The children surveyed by Sahil allege that police and army soldiers are a significant portion of their clientele. Children as young as eight were found working as male prostitutes. Although they are supposedly free to leave whenever they wish, the financial compensation (a child prostitute can bring in up to Rs 12,000 per month) and lack of alternatives usually condemn them to stay and eventually grow up to be pimps themselves.

Another Lahore-based study of street children was based on a series of focus group discussions in parts of the city where such children congregate and 140 in-depth interviews with street children ages 6–14 years of age. Seventy-five percent who had come to Lahore from rural Punjab. A key insight into the lives of these children is how they defined themselves; respondents agreed that a child was someone who had no sexual contact with older people, but someone who was sexually exploited no longer remained a child.[105]

The vulnerability of homeless children to disease transmission through high-risk behavior, sexual abuse, and drug addiction is obvious, and research bears out that this is the reality among street children in urban Pakistan. Among those surveyed in the Lahore-based study, 80 percent had experienced commercial or forced sexual contact, 50 percent had experienced the latter along with STIs, and 30 percent had been cut with sharp weapons by their so-called guardians among the drug addicts and police officers in the community. More than one-half had experienced gang homosexual sex when they were newcomers to the city. The children had low awareness levels about the use of condoms to protect against STIs and exhibited low health-seeking behavior, particularly for problems related to sexual activity.[106]

Another practice, common in the NWFP, but not yet the subject of much formal research, is *bachabazi*—older men keeping boys as their sexual partners. A man who wishes such a partner will select a boy, usually with fair skin and in his early teens. He will slaughter a goat in front of the boy's house to publicly demonstrate his choice. From that point on, the man is responsible for the education, clothing, and general care of the boy in return for sexual favors. The boy himself lacks decision-making power in this institutionalized and socially accepted form of sexual abuse.

A survey in NWFP found that out of 1,710 adult male respondents in communities throughout the province, about 83 percent said they knew about bachabazi.[107] Almost one-half of those who knew about it thought the practice was either common or very common. Similarly, almost 81 percent of the respondents said they knew that some boys in their own communities sell sex for money. The places from which boys could be procured for sexual services included hotels, schools, workplaces, markets, bus stations, and video shops. The study concluded that there was a high prevalence of male sexual abuse and commercial sexual exploitation of children in NWFP and that social norms such as bachabazi helped to perpetuate the widely tolerated practice of adults keeping young boys for sexual services.

[104] Hussain, 2001.
[105] Ali et al., 2002.
[106] Ali et al., 2002.
[107] NGO Coalition on Child Rights – NWFP/UNICEF, 1998.

Trafficking of women and girls. It is common knowledge that girls from Bangladesh, Burma, and other regions of South Asia are trafficked into Pakistan for sale to pimps, but the issue is particularly embarrassing for the Pakistani government because its solution would require regional collaboration and acknowledgement of each country's role in perpetrating the problem. Since India, Pakistan, and Bangladesh do not enjoy relations of mutual trust, there has been no progress made on a problem that has been highlighted in the press and by activists for years.

The trafficking issue has been most consistently addressed and publicized by a legal aid service in Karachi that handles women and girls who have been arrested for prostitution and are languishing in local jails without passports or the means to return home even if they were freed. Lawyers for Human Rights and Legal Aid (LHRLA) publishes updated reports on the "flesh trade," which include comprehensive figures from its own surveys. LHRLA estimates that up to 150 Bangladeshi women and children are trafficked into Pakistan each day, coming through an elaborate network of pimps and corrupt law-enforcement agents that covers the region.[108] Women and young girls are auctioned off at sales reminiscent of the slave trade during the 19th century, and each "sale" brings the pimp more than 200 dollars. The buyer, to whom the woman or girl is married off, may be a pimp himself or a man who uses her as a laborer. The occasional runaway or victim of a rare police raid finds herself in jail, charged with illegal sex outside of marriage under the Hudood laws or with illegal entry into the country. Their only hope for release and rehabilitation, even if only within Pakistan, is free legal aid offered by a limited number of NGOs in the country and refuge at one of the Edhi Welfare Trust charitable homes for the destitute.

Pakistani girls are also trafficked for use as prostitutes abroad, particularly in the Gulf. The problem is increasing and LHRLA alleges that authorities are paying insufficient attention to the issue.[109]

In addition, Pakistani girls work in brothels within the country. Pimps will pick up destitute or runaway girls and women from the streets and persuade or force them into the profession. Other victims are sold into the business by their own family members or even kidnapped from their own homes. Auctions of girls have been reported in small towns, where they fetch Rs. 30,000–40,000 for their "owners."[110]

Girl child prostitution. One early study[111] identified four broad categories of prostitutes: dancing girls, society ("call") girls, students or nurses earning additional income through prostitution, and full-time prostitutes in brothels. In a small survey of 40 full-time prostitutes (10 from each province), it emerged that most of them were between 20 and 35 years of age and had been sold and married off to their pimps by their families. This was particularly common in northern parts of the country such as Swat and Parachanar, from which girls would end up in brothels in other regions. Within the category of dancing girls, or kanjars as the community in the red light districts is known, further subcategories have been identified within a hierarchy.[112] It is possible that adolescent girls predominantly occupy one of these sub-categories, although age breakdowns are not always available. In another study of 100 sex workers in Lahore, 47 were ages 15–25.[113]

The Human Rights Commission of Pakistan has documented numerous reported incidents of the kidnapping and sale of women within Pakistan, as well as the trafficking of Afghan women in

[108] LHRLA, 1996.
[109] Ghaus, n.d.
[110] HRCP, 1996.
[111] Abbas et al., 1985.
[112] Khilji, n.d.
[113] SOCH, n.d.

Peshawar.[114] Accurate figures on the proportion of trafficked women who are adolescents are impossible to obtain, but the fact that young girls are sold into prostitution and that mothers and daughters are sold separately demonstrates that the business values the young independently. Further, those who find themselves bought and sold are invariably victims of poverty and lacking the support and protection of their families. [115]

It must be emphasized here that while research has provided us with evidence that the trafficking and prostitution of boys and girls exists, we still need to know much more about the magnitude and dynamic of this social problem. That is, to what extent are families and communities complicit in facilitating the commercial sexual exploitation of young people, how do children and adolescents experience their options within the trade, and how can policymakers realistically approach reintegrating into society those who wish to leave the trade?

Sexual abuse. Other types of sexual abuse are prevalent in Pakistani society, including the violence and abuse endured by the young within their own homes or communities, where perpetrators are often well known to their victims. Sahil argues that child sexual abuse is rooted in mainstream culture and strengthened by the power imbalance encouraged between children and adults. The problem is reinforced by society's refusal to acknowledge a child's rights over his or her body and the right to live free from violence. Children lack a voice in society, and thus are unable themselves to break the silence surrounding child sexual abuse.[116] However, despite the "walls of silence" surrounding these crimes and the difficulty in exposing and prosecuting the perpetrators, NGOs have made steady progress in documenting and publicizing the extent of the problem, and the press has begun to report incidents more frequently.

PAVNHA, a leading NGO in Pakistan that is addressing adolescent reproductive health issues, conducted a survey to explore trends in reproductive and sexual health of adolescents.[117] Three hundred and ten adolescents and 110 parents were interviewed through questionnaires. The survey found that physical and sexual abuse affected girls more than boys. About 19 percent of girls said they were sexually abused by family or others, the latter being mentioned in the majority of cases. Fourteen percent of boys reported sexual abuse, with the majority saying the abuse had taken place by a family member or someone not living with them. Girls in urban centers were found to be more vulnerable to sexual abuse because they were mobile and had outside exposure and interaction. The study cautions that findings on domestic violence and incest indicated these problems were rooted closer to home.

A study of child sexual abuse among children in Islamabad and Rawalpindi shows that from among 300 school children (ages 11–20, 155 female, 140 male), 17 percent were abused themselves—one in every five boys and one in every seven girls.[118] The abuse took place at young ages, and types ranged from verbal sexual abuse to rape and anal sex. More boys (17 in number) were victims of verbal sexual abuse than girls (7 in number), and more boys (12 in number) were victims of rape or anal sex than girls (5 in number). The most common place of abuse was the child's home. Respondents reported feelings of guilt, shame, anger, and frustration.

In a related study Aangan conducted to explore mothers' views about child sexual abuse, 100 mothers from upper-middle and lower-middle socioeconomic backgrounds were administered a questionnaire. More than one-half the mothers believed that both boys and girls were vulnerable to sexual abuse, but only 9 percent were willing to accept that family members could be potential abusers. Mothers

[114] HRCP, 1996; HRCP, 2001.
[115] Ghaus, n.d.
[116] Sahil, n.d.
[117] PAVHNA. 2000.
[118] Safdar et al., 2002. For more research findings see also Aangan, 1999.

overwhelmingly agreed that the child cannot be blamed for abuse and that the trauma would have serious effects on a child's life. However, mothers displayed a need for guidance as to how to discuss the issue with their children, although they understood that parents are the appropriate source of information.[119]

Figures reflecting the number of reported cases of child sexual abuse in a Sahil survey of Pakistani newspapers are noted in Table 9. These data are limited by the reality that police and subsequent newspaper reporting of cases is rare and represents only a fraction of all cases. Details of the cases may be sensationalized or inaccurate,[120] and boys may be even more reluctant than girls in some social settings to report sexual abuse. A study among 151 adolescents ages 11–19 in a low-income community in Karachi[121] suggests that while the majority felt that touching someone without their consent is wrong, a significant proportion nevertheless felt that the victim is at fault. The study suggested that this attitude contributed to the underreporting of incidences of abuse.

Table 9. Child sexual abuse by type as reported in Pakistani newspapers, January 1997–December 1998

Crime	Male	Female	Total
Abduction	13	124	137
Sodomy	171	(not reported)	171
Molestation	55	114	169
Rape	(not reported)	359	359
Gang Rape	114	287	401
CSA and Murder	46	81	127
Total	**399**	**965**	**1,364**

Source: Sahil Fact Sheet, January 1997–December 1998.

The figures indicate a widespread problem of sexual abuse. In 1997, for example, one child every day was reported to be gang raped, raped, murdered after a sexual act, or abducted for purposes of sexual fulfillment.[122] Females are twice as likely as males to be the victims of abuse. This reflects the fact that these crimes are most likely to attract police and press attention. Seventy-three percent of the abusers identified in connection with the cases in Table 9 were acquaintances of the victim. The second largest category of abusers was strangers (19%), followed by relatives, teachers, police, and *maulvis*.

The most vulnerable age group for female victims was between ages 10 and 18, with 77 percent of the victims distributed evenly between the age groups 10–14 and 15–18. Adolescent girls were particularly vulnerable to rape, gang rape, and abduction. Boys ages 15–18 were most often targets of sexual abuse (58%), followed by boys ages 5–10 (32%). These two age groups accounted for most of the reported crimes of sodomy and gang rape. The age distribution of victims in these reported crimes indicates that child sexual abuse increases as girls enter adolescence while boys may become victims at an even earlier age.

War Against Rape (WAR), a small organization with offices in Lahore and Karachi, has conducted a similar exercise based on newspaper reports of sexual abuse cases of girls in Punjab between 1991 and 1993. These findings confirm that adolescent girls are particularly vulnerable to sexual abuse. Out of 149 press cases analyzed, 85.2 percent were girls ages 10–20. Rape and gang rape were, again, the most commonly reported types of sexual abuse. Most of the girls came from lower or lower-middle income groups, which may simply indicate that girls from higher socioeconomic groups either do not report cases

[119] Aangan, 2000.
[120] Khan, 1994.
[121] Aahung, 1999.
[122] Sahil, n.d.

as often or else manage to avoid press coverage of cases. Since 4,200 child sexual abuse cases were registered with the Punjab police between 1991 and 1993, an analysis of these cases would probably reveal with more accuracy the class distribution of victims.

The Punjab study provides valuable insight into how sexual abuse is conducted. For example, in one-half of the cases in which the duration of abuse could be determined, cases were evenly distributed in the ranges of 24 hours, two to 29 days, and one month to one year. There were even six cases of reported abuse lasting longer than one year. In 89 percent of the cases, the abuse was also accompanied by abduction/attempted abduction and physical abuse. The abuser was most often identified as an acquaintance. Only 33 abusers (22%) were confirmed as arrested.

Findings from a small Karachi survey[123] of medical legal incidents recorded at the Police Surgeon-General's Office between January–August 1998 confirm again that adolescents are at high risk for rape and sexual assault. Out of 95 cases of reported rape, gang rape, sodomy, sexual abuse, rape and abduction, and incest, 43 involved victims ages 12–18 and 41 were between the ages of 19 and 40.

Fears of sexual violation underpin adolescent female mobility, which is particularly restricted compared with the mobility of older women.[124] The figures on sexual abuse and rape suggest that these fears are not baseless, and that the perception of the outside world as a potentially violent place for young girls in particular is not incorrect. Nonetheless, the unhealthy and morbid fear of assault that pervades social norms limiting girls' movement[125] is still likely to be exaggerated and manipulated. For example, scant attention is paid to acknowledging the problem of incest, which takes places within the home (see section on incest). Further, sexual assault and abuse also affects boys but their mobility is not restricted as a result nor is there a sense of constant threat that pervades their perception of the outside world. The threat of sexual assault serves most to restrict the movement of girls rather than boys and, in so doing, reinforces restrictive purdah norms.

Incest. Incest, defined as a form of child sexual abuse in which the abuser is a close relative of the child by blood or by law, is arguably the most taboo of the many forms of sexual exploitation of the young. Out of the cases Sahil monitored in 1997, 6 percent involved incest, which does not reflect the true extent of the practice since most such cases are unlikely to be reported.[126] In the WAR study, 5 percent of the 149 cases analyzed involved incest committed by step-fathers and uncles, but the author warns that the problem is more common than widely believed because it rarely makes it to the press.[127]

Another Islamabad-based project to tackle child sexual abuse, Aangan, analyzed a randomly selected pool of 100 confidential letters it received from victims/survivors of child sexual abuse. Forty-seven were incest cases (see Table 10).[128] This figure is dramatically higher than the number of incest cases monitored in press reports, possibly because the letter writer is a self-selected and anonymous figure who knows that his/her information will be shared in a safe environment.

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[123] WAR, 1998.
[124] Khan, 1998.
[125] Khan, 1998.
[126] Sahil, n.d.
[127] WAR, 1998.
[128] Aangan, 1998b.

Table 10. Major findings of Aangan study on incest

Incest Cases	
Number	47 out 100 surveyed
Survivors (incest stopped)	76 percent
Victims (incest continuing)	17 percent
Survivors as well as abusers	4 percent
Abusers	2 percent
Incest Victims	
Average age	8 years
Sex	66 percent female, 34 percent male
Abusers	
Sex	88 percent male, 8 percent female, 4 percent not identified
Relationship with victim Older cousins Real uncles Real brothers Fathers Aunts Other relatives Grandfathers	 32 percent 28 percent 19 percent 6 percent 6 percent 6 percent 2 percent

Source: Aangan, 1998b.

The study found that all the abusers identified in the study had been victims of child sexual abuse themselves.[129] Abuse may not only begin at a young age (6–8, on average) but it is also known to last for years, particularly because the abuser is usually a close relative. Findings suggest that girls are more likely to be victims compared with boys and abusers are more likely to be male than female. The most common reported psychological effects suffered by the victims were negative self-esteem and problems in relationships, followed by sexual difficulties, and fear of marriage. Finally, incest is not confined to one social class, rather it has been reported across classes in Pakistan.

Pornography. There is almost no research on child pornography and the exposure of children to pornographic material in Pakistan. However, in the NWFP it was reported that the showing of pornographic movies to children was on the rise[130] and the practice is linked to the sexual abuse of young boys in particular and subsequent exploitation of them for prostitution.[131] Further, children who are victims of sexual abuse are known to be blackmailed by their abusers, who threaten that they will, or have, publicized photographs of the abusive acts.[132]

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[129] Aangan, 1998b.
[130] NGOs Coalition on Child Rights – NWFP/UNICEF, 1998.
[131] Sahil, n.d.
[132] Khan, 1994; Fayyazuddin et al., 1998.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

As noted, policy planners are only just beginning to conceptualize adolescence and research is in preliminary stages. Therefore, a full exposé and discussion of issues and policies is not yet possible. Nevertheless, there is new political support to focus attention on adolescents. The available information with regard to laws and policies related to ARH is presented below.

Legal barriers

Education and media are good ways to reach adolescents and equip them with the information they need to protect themselves. Unfortunately, use of both approaches is limited by an official refusal to inform the public about sexual issues. This refusal and other barriers arise from fear that is rooted in a combination of traditions and religious interpretations and is reflected in state structures and institutions throughout the country. The result is that reproductive health information is made available only through a small number of NGOs or health practitioners with limited outreach. Ignorance helps maintain the various legal barriers with regard to providing information and services related to ARH. The government ban on the use of television and radio for AIDS awareness raising, for example, stalled the airing of the first condom advertisement until March 1994, only after the official stance was changed.[133]

Existing ARH policies

Generally, adolescent needs are not yet recognized as specific and valid enough to ensure major program and policy interventions. A few existent policies address some aspects of ARH and the government notes that others are planned.

Population policy. The National Health Policy[134] states that reproductive health as well as health education will be among the Health Ministry's priority programs. Its discussion of reproductive health mentions that all aspects of the reproductive system and its functions will be taught, but the document does not mention sexuality. Activities will be undertaken to empower the community to work for the promotion of its own health but one wonders how that is possible without basic sex education taught to young people. This gap in curricula, combined with the fact that young people do not rely on their parents for information on sexual issues, means that sources of information are often unreliable and exploitative.[135]

Pakistan launched its first-ever population policy in July 2002.[136] In addition to emphasizing the demographic targets for reduction of population growth and increase in contraceptive prevalence rates, which have been the mainstay of the population program since it was officially launched in 1965, there are some new initiatives. In particular, the defederalization of the program will transfer its fiscal and administrative responsibilities from the federal government to individual provinces. Of particular relevance to adolescents and youth in Pakistan, the new policy promises to address "adolescents through population and family life education in the formal and nonformal education sector and reach out to young couples with appropriate media, interpersonal messages, and services."[137] The policy document, in a separate paragraph on youth and adolescents, also says, "Youth are the future generation and need to be

[133] Khawaja et al., 1997.
[134] Ministry of Health, 1997.
[135] Qidwai, 1996.
[136] Ministry of Population Welfare. 2002b.
[137] Ministry of Population Welfare. 2002b:13.

sensitized about the wide-ranging consequences of rapid population growth for the individual, family, and nation and, therefore, the need to build a mindset for responsible parenthood."[138]

This review of existing research, though, has shown that adolescents face a wide range of reproductive health issues beyond the need to limit the size of their future families. Their vulnerabilities begin with the social development context, which ill prepares them for the reproductive health burden ahead, including early marriage, sexual abuse, lack of adequate awareness and prevention regarding STIs and HIV/AIDS, and so forth. It appears that the policy commitment made at the highest political level fails to acknowledge the full reproductive health burden faced by adolescents and continues to emphasize family planning and demographic targets despite the conceptual strides made by the international community at the ICPD 1994.

Since the core of the policy remains family planning and demographic targets, the ambitious Interim Population Sector Perspective Plan 2012 that arose out of the new policy retains the same programming focus. The 2012 plan outlines a comprehensive strategy for achieving the family planning goals that are required to bring Pakistan's population growth rate to stabilization level, and it seriously addresses issues of public-private collaboration, administration, effective outreach and advocacy, and improved service delivery that have haunted the program since its start.[139] Within this strategy, there is no detailed attention paid to adolescents other than the intent to include them in outreach and advocacy, and to include adolescent males in the efforts to involve men more in family planning.[140] Even if one takes into account the difficulty of addressing the needs of unmarried adolescents in a conservative society, the proportion of married adolescent girls and the pressures they face to produce children early in their marriage, as discussed above, still merits particular programming efforts to meet their needs.

Abortion. Policymakers in Pakistan are slowly recognizing that women practice induced abortion in this country, often in unsafe environments, posing a public health problem. However, Pakistani law does not allow abortion unless it is for the purpose of saving the life of the woman or providing her necessary medical treatment.[141] Efforts are underway in women's groups to change the abortion law, but it is not clear how such change would affect adolescents.

Sexual exploitation. Since the problems of child sexual abuse and the definition of a child as being younger than 18 have been slow to be accepted in Pakistan, little is being done at the national policy level to protect young people. Although there do exist legal provisions that partially protect children from sexual exploitation, no law exists that specifically prohibits child sexual abuse. For example, the 1979 Hudood Ordinances prescribe severe punishments of imprisonment and whippings for unlawful sexual intercourse with a child. However, a girl child is defined as someone younger than 16 or prepubescent, a definition in violation of the Convention on the Rights of the Child (CRC) and too vague to protect many adolescents. Further, provisions in the Pakistan Penal Code 1860 make the act of seduction of a girl younger than 18 punishable by imprisonment or fine, and the Sindh Children Act 1955 prohibits a child

[138] Ministry of Population Welfare. 2002b.
[139] For a review of the population program's policy history, see Khan et al., 1996.
[140] Ministry of Population Welfare, 2002a.
[141] The Pakistan Penal Code originally stated that if someone causes a pregnant woman to miscarry for a reason other than to save her life, that person would be punishable with fine, imprisonment up to three years, or both, and the woman herself could be imprisoned up to seven years and also be liable to fine. This law was amended in 1991 by a presidential ordinance that became law in 1996. This law differentiates between abortion caused to a child whose limbs have been formed and whose limbs have not been formed. The former is punishable with imprisonment provided it is not caused "in good faith for the purpose of saving the life of the woman or providing necessary treatment to her," and the latter is punishable with imprisonment as well as financial compensation to the victim's heirs. It includes a provision that allows for a more favorable interpretation of an act of a woman who has had an abortion (Shirkat Gah, 1996).

older than four from living in or frequenting a brothel.[142] However, the Provincial Suppression of Prostitution Ordinance 1961 comprehensively forbids the practice of prostitution, including encouraging the seduction or prostitution of a girl younger than 16.[143]

There is a bias in the law born of cultural and religious censure against homosexuality. Under the Pakistan Penal Code (Section 377), sodomy (i.e., "carnal intercourse against the order of nature with any man, woman, or animal") is punishable by up to 10 years in prison, whereas vaginal or oral penetration or any other sexual violence to a child is punishable only up to two years. As Sahil points out, the legislation reflects a greater interest in differentiating between acceptable or unacceptable sexual conduct than protecting children from sexual violence per se.[144]

These weaknesses in the law, which may not create the problem of child prostitution but arguably facilitate its continuation, remain despite Pakistan's commitment to the CRC. Under Article 34 of the CRC, state parties commit to take all appropriate national, bilateral, and multilateral measures to prevent the inducement or coercion of a child in unlawful sexual activity, the exploitative use of children in prostitution, or other unlawful sexual practices and pornographic performances.[145] Particularly with regard to the trafficking of women and children in the region, such bilateral and multilateral measures are not being taken by Pakistan.

The National Commission for Child Welfare and Development has begun a project with ILO IPEC (International Program on the Elimination of Child Labor) to conduct research and "establish administrative measures" to combat child trafficking in South Asia.[146] Meanwhile, the recommendations made by the Working Group on Youth Development in preparation for the Ninth Five-Year Plan (1998–2003) do not mention the need to combat child sexual abuse/exploitation or trafficking by addressing the underlying causes of this social problem. In fact, the report lists "problems in maintaining traditional moral values" as one of the major issues "afflicting" Pakistani youth. It is unclear, therefore, whether sexual exploitation of adolescents is being encouraged by default at the policy level.

One reason for inaction with regard to sexual exploitation is that legal complexities need to be unraveled in order to provide full protection to those younger than 18. Although there are laws that clearly forbid prostitution, trafficking, seduction of minor girls younger than 18, and sodomy, the laws are nonetheless inconsistent. For example, the Pakistan Penal Code (Section 366A) makes the seduction or forced intercourse with a girl younger than 18 punishable by imprisonment, but does not mention boys. In Sindh, the law pertaining to seduction and trafficking defines a minor as younger than 18, whereas in Punjab, the girl child is defined as younger than 16.[147]

The Hudood Ordinances 1979, which apply to rape and sex outside of marriage, cause the most damage of all. Under Hudood (Offence of Zina Ordinance, Clause 6), a woman or man is considered to be able to commit the act of rape with someone if: he/she is not validly married, it is against the will or consent of the victim, the victim is put in fear of death, or the victim believes him/herself to be married to the offender. Further, under the Zina Ordinance, sex committed with a nonadult girl younger than 16 is considered rape, but if the girl has attained puberty then the accused is to be awarded a lighter sentence. The law is even more complicated, however. Both boys and girls are considered adult if they are ages 18 or 16, respectively, or have attained puberty. An adult can be charged with adultery and awarded

[142] Fayyazuddin et al., 1998.
[143] Jillani, 1989.
[144] Sahil, n.d.
[145] Jillani, 1989.
[146] Ministry of Women's Development, 1997.
[147] Sahil, n.d.

maximum punishments of whippings and death.[148] Most intolerably, if a victim charges rape and cannot prove it, he or she can be charged with illegal sex outside of marriage and receive the maximum punishment. Hence, it was not out of any misinterpretation of the law that Sahil discovered a boy of age 12 in a Punjab jail, convicted under the Hudood Ordinances.[149]

The Hudood Ordinances enjoy specific ideological protection since they were the first laws enacted under Pakistan's process of Islamizing its social and legal system, which began under military rule in the late 1970s. Although it would take only a majority of votes in the National Assembly to repeal these laws, as recommended by the latest Report of the Inquiry Commission for Women 1997, governments avoid taking a stand on these discriminatory laws for fear of a backlash from the religious right.[150]

[148] Chohan, 1996.
[149] Sahil, n.d.
[150] Saeed and Khan, 2000.

5 ARH PROGRAMS

Compared with some other developing countries, Pakistan has done little with regard to ARH programming. As was noted, the country remains in the initial stages of information gathering and planning. Thus, little is currently available in the way of youth campaigns, peer education, and the like. Nonetheless, some programming has been instituted and should be mentioned. There is also a growing partnership between public sector and nongovernmental or private organizations in activities and programming for adolescents. Since it is a new area for programming and advocacy, the government has much to gain from the pioneering experience of NGOs, particularly those such as FPAP and PAVHNA, which are leading in the field of reproductive health service delivery in Pakistan and have included adolescents as a focus area.[151]

The public sector

Some ARH-related programming has begun in the public sector. Such programs are discussed below.

STIs and HIV/AIDS. The National AIDS Control Program (NACP) was established in 1987. It has established blood-screening centers across the country and held a media campaign to increase awareness, but misconceptions and ignorance prevail among the population nonetheless. Further, the problem of organizing the health sector to screen blood across the country and educate health practitioners about reducing risks to patients remains in the hands of separate provincial governments because health is a provincial, and not national, subject.

School-based health education. The formal education curriculum, including medical training, does not include sex education. Sexuality, apart from reproductive biology or contraception taught in specific settings, is a taboo subject. While the Education Policy states that curricula at the secondary stage of learning will include additional subjects such as awareness about drugs, AIDS, and environmental issues,[152] it still falls short from recommending a basic introduction to the facts of life. Even this is a limited effort and reproductive health education is further limited in impact because only a small proportion of all adolescents actually complete secondary school. (See also the section on the nongovernmental sector.)

There are some projects underway to begin the process of sex education, although they are tentative and introductory. While the family planning programs and objectives in Pakistan were never incentive enough to inspire service providers into discussing sex education, the threat of an HIV/AIDS epidemic has forced those tackling the issue to discuss sexual relations in unprecedented detail with their target communities. For example, Aahung, the AIDS awareness program run at the Reproductive Health Project in Karachi is trying to develop a curriculum for secondary schools, for both males and females, in which sexuality and reproductive health can be taught. They are currently experimenting with modules in selected secondary schools in Chanessar Goth—a low-income and multi-ethnic community in Karachi.

Aahung was also involved in a collaborative effort with the Ministry of Social Welfare and UNICEF, Islamabad, to provide sexual health education to adolescents from July to December 2001.[153] Using a life skills curriculum in Urdu developed by Aahung *Aware for Life (Adolescents),* in workshops with

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[151] For an overview of organizations and projects pertaining to youth development in Pakistan, including reproductive health, see Azariah and Reichenback (2001).
[152] Ministry of Education, 1998.
[153] Aahung. 2001.

adolescents in selected communities around the capital city, Aahung trained trainers to facilitate these workshops and implement the curriculum. Aahung monitored the effectiveness of this program, and found that changes beyond an increase in knowledge regarding sexual health could be found, as indeed was the program's intent. Improved health seeking-behavior, confidence and self-esteem, consciousness of rights and responsibilities, and desire to further disseminate their learning were found among the adolescent learners. Aahung strongly recommended that this program continue beyond the selected pilot communities.

Community-based interventions

RH Awareness-Raising Efforts. Innovative small-scale efforts are taking place around Pakistan to begin the process of imparting RH information and services to adolescents. A few of them are discussed below. It is interesting to note that efforts are not necessarily coordinated, and organizations or groups are to some extent working in isolation from one another, unaware of whether or not they are replicating efforts.

PAVHNA has completed a pilot project on adolescent reproductive health in four cities of Pakistan. The "Adolescent Reproductive Health Policy and Program Advocacy, Development of Youth Leadership, and Grassroots Level ARS Organization Capacity Building in Pakistan" project was supported by UNFPA through the International Council on Management of Population Programs (ICOMP) and began in 1999. Its aim was to create a common vision among major stakeholders in reproductive health policy through experience sharing and grassroots feedback and develop a core group of youth leaders and program managers in the process. The effort culminated in a workshop held the following year in which PAVHNA discussed the findings of its preliminary research on adolescent reproductive and sexual health and shared its experiences training youth in reproductive health issues. While those involved in the project were positive about the training and the need to continue it, the members of the press who were invited to the event were more skeptical. In an article in a leading women's magazine, one journalist suggested that western values were being imposed on Pakistani society and the United Nations was collaborating in the dismantling of its traditions and value system through the project by imparting ARH information and training.[154]

The medical staff of a government-run maternity hospital in Karachi developed a questionnaire and teaching models to give basic RH information to 80 girl students ages 13–16 from two schools, one private and the other public.[155] Before the teaching sessions, the medical staff conducted a pretest with the students. Girls in the elite, private (English-medium) school scored lower than girls in the public school (Urdu-medium) for correct responses that checked their basic information levels on menstruation, AIDS, and leucorrhoea. The reason for this was possibly that the private school students collected more incorrect information due to their greater exposure to media. Common misconceptions included the belief (90% total covering both schools) that menstruation was harmful to health. After the teaching sessions, responses to the same questions were almost 70 percent correct in both schools.

Sexual exploitation. Sahil is currently the only NGO devoted solely to the task of raising awareness about child sexual abuse and handling crisis cases. Based in Islamabad, it conducts small research studies, runs seminars, and publishes educational information on the problem. Sahil offers immediate medical and psychological aid to victims, referral services to those who need long-term care, and free legal aid through a team of volunteer lawyers.[156]

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[154] Nadeem, 2002.
[155] Masood, 1999.
[156] Sahil, n.d.

Another ongoing project tackling child sexual abuse in Islamabad is called Aangan, formerly a project with the community-based organization Bedari and now a part of a new organization called Rozan. Aangan's activities also include awareness raising through press and seminars and counseling victims and survivors. Its program of self-growth workshops with children in communities throughout the capital area has helped to bring the issue to the attention of teachers and students.

Like Aangan, which grew out of an organization devoted to the empowerment of women, WAR's work with victims of child sexual abuse grows out of its experience with violence against women. WAR handles individual cases of sexual abuse and provides legal help to survivors in Lahore and Karachi. It also conducts research and awareness-raising activities and works in close collaboration with legal aid services and human rights organizations.

Members of these small organizations, along with legal aid services (most notably LHRLA in Karachi and AGHS, a legal aid firm in Lahore) have a history of collaborating with the government in efforts to address the range of human rights problems faced by women and children. So far, no specific progress has been made at the policy level on sexual abuse of minors. There is a commitment to conduct a national survey to assess the scale of the problem and a national report on the trafficking of girls and women by the National Commission on Child Welfare and Development.

The nongovernmental sector

Some ARH issues are being addressed by the nongovernmental sector. These are discussed below.

Reproductive and sexual health. The FPAP, the largest NGO in this sector, has stated, "Reproductive health care also includes sexual health, the purpose for which is the enhancement of life and personal relations."[157] Although FPAP has targeted young people in a number of other projects, it is currently preparing the groundwork for a new initiative. Join in Educating Adolescents and Teenagers (JEAT) is directly aimed at addressing the knowledge and attitudes of young adults toward reproductive and sexual health with a view to influence their behavior in favor of the small family norm and responsible parenthood.[158] The project has multiple components, which include establishing baseline information on adolescents' existing level of information on sexuality and reproduction, establishing a resource and information base on adolescent sexual health, developing modules on reproductive and sexual health for youth, sensitizing staff on youth issues, and training counselors to work with youth. The program will work with adolescents already participating in youth activities.

Abortion. A few NGOs have begun to offer treatment for postabortion complications. The efforts were pioneered by Marie Stopes Society (MSS) in Pakistan. FPAP and the Behbud Welfare Association have recently equipped some of their urban centers across the country to perform simple dilatation and curettage and provide other treatments for complications. These services are provided in addition to a range of traditional family planning services that also include tubal ligations and vasectomies. Although the largest client demand at MSS is for tubal ligations and injectables, there is a consistent stream of clients presenting with incomplete abortion. MSS estimates that 15–20 percent of all their clients are adolescents; the assumption is that they are married.[159]

STIs and HIV/AIDS. The United Nations (UN) in Pakistan, led by UNAIDS and including UNICEF and UNFPA, is including education and awareness about STIs and HIV/AIDS in its programs. UNICEF

[157] FPAP, 1995.
[158] FPAP, n.d.
[159] Marie Stopes Society, 1998.

gives youth, in addition to high-risk groups, special attention in its current program cycle and trains nongovernment and government health workers in prevention and counseling techniques.[160]

The nongovernmental sector has taken up the challenge of raising awareness about STIs and HIV/AIDS among various groups in society, which include adolescents to a limited extent. For example, the AIDS Awareness Program run by KRHP in Karachi works in secondary schools to educate male and female students about sexuality and reproductive health issues. FPAP's Girl Child and Male Youth Programs include modules about STIs and HIV/AIDS in their workshops with adolescents, and more comprehensive information on these issues will be shared during the upcoming JEAT program. BAIA, a small NGO based in Islamabad devoted to the issue, has developed a comprehensive training manual for raising awareness about HIV/AIDS among communities and schools. Other IEC material produced by organizations working on reproductive health issues, including an upcoming reproductive health manual to be used in UNICEF programs, contains HIV and STI information, but this material is not being specifically used for young people and does not necessarily address their immediate concerns.

[160] UNICEF, 1998.

6 OPERATIONAL BARRIERS TO ARH

Inability to obtain services

Adolescent girls, even if married, are more often restricted than are older women in their mobility and access to health and family planning services. Social and economic factors typically delay access. Transport, finances, family's reluctance to bring a woman to hospital, husband's absence from the house, and inadequate and inappropriate referral services all contribute to an inability to obtain services.[161] For those women and adolescents who seek medical care after an induced abortion, for example, there are few options other than large urban hospitals. Family welfare clinics do not treat abortion complications and, in fact, lack surgical facilities. The difficulties of accessing the urban-based services are even greater for adolescent girls, most obviously unmarried ones. Girls' decision-making power and physical mobility is so restricted by their social environment that seeking any medical help outside of the village is fraught with barriers.[162] Girls in rural areas are even more desperate.

Research conducted in Pakistan confirms a strong gender bias in access to health care. Exploring gender differentials in access to health care in the NWFP, one study found that the female child's access to urban-based health facilities was half that of the male child.[163] The continuation of this bias has serious repercussions for the health of women, particularly adolescents and married women, whose access to services is curtailed by their low decision-making power in the household, limited mobility, and strict purdah norms.

Through interviews with mothers at out-patient departments of the Islamabad Children's Hospital, another study found that adolescent girls faced more difficulty in accessing health care than do adolescent boys.[164] While the boys could travel on their own to a care facility, parents had to hire a wagon to transport a girl or summon a doctor to their home. Both mothers and fathers felt that purdah norms interfered with the access their adolescent daughters had to treatment and that the presence of a lady doctor was essential. In a rural area with a female physician present at the health center, the number of adolescent boys and girls seeking health care was roughly the same.

A small survey of adolescents in a low-income community in Karachi echoes this gender bias that limits female access to services.[165] Out of 80 girls ages 11–19 interviewed in in-depth sessions, 77.5 percent said they could not go to the doctor without someone's permission. Out of 71 boys interviewed, 32.4 percent said it was necessary for women in their homes to get their permission to go to the doctor.

Similar findings emerge from rural-based studies. Adolescent girls in a qualitative survey conducted in three northern Punjab villages complained that they only troubled their parents to go to a doctor if they were severely ill.[166] The mobility of unmarried girls was severely restricted by their families and communities, limiting their access to education and employment opportunities most dramatically, out of a fear that their honor (or chastity) would suffer as a result of contact with the public, male sphere. This fear is a major factor in favor of girls marrying young as a means to ensure that their virginity and sexuality will not be lost. The fear of whether villagers would suspect sexual misconduct, as well as the difficulty in

[161] Jafarey and Korejo, 1993.
[162] Khan, 1998.
[163] Akhtar, 1990.
[164] Ahmed, 1990.
[165] Aahung, 1999.
[166] Khan, 1998.

locating a female doctor in the vicinity, was enough to prevent girls from actively seeking health care when ill.

A study in Southern Punjabi communities found that women were more restricted in their freedom of movement that those in the more developed villages of Central Punjab, where almost one-half of the women can visit a health center alone.[167] However, on the whole, women younger than 25 were the most restricted in their freedom to go to a health center alone (13.3%), while 46 percent of older women could do so. Married adolescent girls in particular require access to the full range of health and family planning services, including information on sex and family planning, treatment for ailments associated with sexual activity, and, of course, care during pregnancy and childbearing. However, the bias against their young age continues to restrict their access to services even when they are married.

In the field of traditional medicine in Pakistan, sex clinics run by *hakims* (traditional health practitioners) provide an alternative source of information, counseling, and treatment that is often preferable to the allopathic health and family planning services provided in the public and private sectors. In order to find out how much adolescents can learn from these sex clinics, Sahil carried out a small study of 15 sex clinics in Rawalpindi. Researchers found that most adolescent clients visited hakims for reproductive health problems or perceived sexual problems. The study reported that both hakims and clients had misconceptions about sexual and reproductive health (e.g., hakims said that masturbation can cause infertility and impotence), but that adolescent clients nonetheless felt satisfied with the medicines prescribed by the hakims. The treatment was costly and sometimes dangerous, but clients possibly had a closer rapport with the hakim than with medical doctors who have less time and are not part of the community.[168]

Limited information available to adolescents

There is some level of demand for sex education among young people.[169] Boys and girls are concerned not only with their own developing sexuality, but they also request more information about the other sex. Boys may be more open in demanding information, while girls are generally more inhibited about expressing their concerns. [170] In a survey by MSS of adolescents' KAP regarding reproductive health that covered 151 boys and 160 girls of predominantly Seriaiki or Sindhi ethnicity, the respondents overwhelmingly confirmed that they were in favor of reproductive health knowledge provision to adolescents. Boys and girls had different areas of interest, with more boys wanting to know about masturbation and more girls interested in pregnancy and childbirth information.[171]

However, the mainstream media and education system do not offer adolescents the information they need. Parents are also not a source of sex education for their children.[172] The tacit assumption among adults and policymakers, as well as health and family planning service providers seems to be that young people will get whatever information they need when it is proper—that is, when they are married. In fact, community and school-based programs have encountered resistance to sexual and reproductive health training among adolescents, particularly due to lack of information sources, government policies that restrict sex education in the curriculum, school authorities, teachers, and parents.[173]

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[167] Kazi and Sathar, 1997.
[168] Rafiq, 2001. For more research on hakims and sex clinics, see PROBE and FOCUS, 2000 and Raoof Ali, 2001.
[169] Raoof Ali, 1999; Qidwai, 1996; Aangan, 1998a; Masood, 1999.
[170] Aangan, 1998a.
[171] Arain, 2003. [upcoming]
[172] Qidwai, 1996.
[173] Javeed, 2003; Lal, 2002; Masood; 1999.

The reality of adolescents' lives, which includes sexual abuse and rape, misconceptions and anxieties about their developing sexuality, lack of information about the other sex, pregnancy risks, and STIs, is being denied out of fear that information will lead to an increase in premarital sex. As a result, even adolescents who are married and in need of sex education have no source of neutral information to protect their health and improve their sexual relations.

Adolescent girls are more likely to get their sexual and reproductive knowledge from women within their families. Unfortunately, even this hypothesis is difficult to verify through research because unmarried girls and young women are often forbidden from giving interviews to outside researchers.[174] This information is likely to be related to menstruation, while information about sex itself may only be passed on to a girl from a female relative on the wedding day itself.[175] There is no formally researched information available on unmarried girls' concerns about sex or reproduction prior to marriage. However, research findings among married couples have established that women's need for sexual satisfaction within marriage is accepted by couples, and it is not necessarily the case that women always subsume their sexual needs in deference to their husbands, as is sometimes assumed.[176]

[174] Khan, 1998; Mumtaz and Raouf, 1997.
[175] Mumtaz and Raouf, 1996.
[176] Ministry for Population Welfare and Population Council, 1998.

7 RECOMMENDATIONS

The preceding discussion has shown that adolescents in Pakistan, particularly girls younger than 20, are not exempt from the reproductive health burden that they share with their older counterparts. This includes burdens of maternal health and morbidity, risks of exposure to STIs, vulnerability to sexual violence, restricted access to health and family planning services (adolescent girls, whether or not they are married, face the greatest social restrictions in accessing health care, resulting in serious implications for their sexual and reproductive health), and a lack of adequate information on reproductive health issues. Adolescents' incomplete ability to make decisions due to their age, inexperience, and lack of decision-making power due to their status make them particularly ill-equipped to handle the reproductive health burden they face. Adolescents also have specific vulnerabilities and biases within the reproductive health issues they tackle (this is particularly true for girls—for example, discrimination in the laws will make an adolescent girl liable to adult prosecution for illegal sex if she has attained puberty—but adolescent boys also appear to be prime targets of sexual abuse, through a type of servitude, or bachabazi, and male child prostitution).

Laws, policies, and programs do not currently protect either girls or boys from exposure. If adolescents cannot enjoy the environment and protection they need now in order to function as adults with a full capacity for independent decision making, then certainly the task of making reproductive health a reality for men and women in Pakistan will remain impossible. The following are broad, initial recommendations that need to be carried out to ensure the health and well being of adolescents in Pakistan:

- Adolescents must be thought of and treated as a distinct segment of the population with specific developmental needs. This understanding must be shared and discussed with relevant public and nongovernmental institutions to work toward the development of a framework on ARH.

- Much more research needs to be conducted on the ARH-related health topics outlined above, including premarital sex, through national sampling as well as in-depth qualitative work. To date, the bias in findings lies in favor of information regarding married adolescents only and research on violence and high-risk behavior categories. We need to both fill in the major gaps in information regarding the remaining vast majority of adolescents in this country and further address those areas in which there has been research.

- Policies and programs need to be especially designed to meet the needs of adolescents, protect them, and help them to grow into informed, healthy adults. Planners and policymakers need to recharacterize and address the needs of adolescents in Pakistan if they wish for the population to enjoy a future filled with possibilities.

- Adolescents must be given access to reliable information on reproductive biology and sex through various programmatic interventions. Issues such as menstruation, masturbation, and general sexuality are fraught with misconceptions and taboos. As a result, young people exhibit an anxiety level about their own sexual development and sexuality that is unhealthy and unnecessary.

APPENDIX 1. Data for Figures 1 through 4

1. Adolescent Population (15–24) (000's)	2000	2005	2010	2015	2020
Males	13,950	16,431	18,996	21,205	22,756
Females	13,208	15,477	17,949	20,235	21,872

2. Level of Education (%)	1991 Males	1991 Females
No Education	31.0	59.1
Primary	18.4	14.6
Middle	17.2	8.6
Secondary and Higher	33.0	17.6

3. Pregnancy Outcomes (000's)	2000	2005	2010	2015	2020
Total Pregnancies	2,368	2,792	3,242	3,711	4,054
Births	1,682	1,986	2,307	2,649	2,899
Abortions	330	387	449	506	547
Miscarriages	355	419	486	557	608

4. Unmet Need (%)	1991	1995
Total Unmet Need (15–19)	24.7	21.7
Total Unmet Need (20–24)	24.5	33.8

Assumptions and Sources:

Figure 1. Adolescent population projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1991 was taken from the 1991 Pakistan DHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. The total fertility rate (TFR) and ASFR for the base year were taken from the Pakistan 1994–95 CPS report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 25 per 1,000 (Profiles estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 4. Levels of unmet need were taken from the 1991 Pakistan DHS report and the 1994–95 Pakistan CPS report.

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