Leaving the Youth Behind: The Missing Demographic in Pakistan's SRHR Policies and Programmes

Pakistan's Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25)

NATIONAL REPORT

Leaving the Youth Behind: The Missing Demographic in Pakistan's SRHR Policies and Programmes

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LIST OF ACRONYMS

ACC	Adolescent Counseling Centres
AFC	Adolescent Friendly Centres
AHC	Adolescent Health Centre
AIDS	Acquired Immune Deficiency Syndrome
APPC	Asia Pacific Population Conference
ARROW	Asian-Pacific Resource and Research Centre for Women
CEAM	Child Early Age Marriage
CIP	Costed Implementation Plan
CMW	Community Mid-Wives
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
CSSP	Civil Society Support Program
FP	Family Planning
FGD	Focus Group Discussion
FHC	Family Health Centre
GBV	Gender Based Violence
GDI	Gender Development Index
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Managment Information System
ICPD	International Conference on Population and Development
IDI	In-Depth Interview
IT	Information Technology
KII	Key Informant Interviews
KP	Khyber Pakhtunkhwa
LHW	Lady Health Worker
LSBE	Life Skills Based Education
MHM	Menstrual Health Management
MHHM	Menstrual Health Hygiene Management
MOU	Memorandum Of Understanding
NGO	Non-Governmental Organisation
NIPS	National Institute of Population Studies
OOSC	Out-Of-School Children
PAC	Post Abortion Care
PBS	Pakistan Bureau Of Statistics
PDHS	Pakistan Demographic and Health Survey
PGR	Population Growth Rate
PoA	Programme of Action
PPFP	Post Partum Family Planning
PWD	Population Welfare Department
RH	Reproductive Health
SG	Shirkat Gah- Women's Resource Centre
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund

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EXECUTIVE SUMMARY

25 years since the International Conference on Population and Development (ICPD), Pakistan has made some progress in fulfilling commitments to ensure provision of contraception and family planning services to all. Health and population are now devolved subjects, with each province (Sindh, Punjab, Khyber Pakhtunkhwa (KP) and Balochistan) responsible for setting relevant policies and programmes in accordance to the federal guidelines and visions for health policy and programmes. Within these policies and programmes, however, youth representation and recognition of their needs, is missing. Despite being a large part of the current demographic of Pakistan, youth's access to health services, particularly those related to sexual and reproductive health (SRH), remains limited, and unsupported. While policy remains silent on their issues, social and structural barriers further exacerbate the lack of access to services, and perpetrate misinformation and myths related to SRH. Programmes rolled out for the youth focus on economic and educational development but disregard their specific SRH needs. The problem thus, remains that universal access to SRH information and services will remain unfulfilled until attention is paid to the different needs of young people, during the various life cycle stages, and the impact it has on their economic and education outcomes. The effectiveness of policies and programmes will only be seen if they are designed keeping in mind these specifications, and special consideration is paid to the impact of social and cultural practices on youth's access to SRH services and information.

Currently, there remains a huge gap between policies, budgets and implementation, with regards to youth issues overall. In the past few years, ministries and policies have been constituted and passed, but budget allocation and implementation structures and mandates have still not been rolled out. Small wins due to civil society efforts and collaborations with governments have been achieved, particularly with Life Skills- Based Education (LSBE), but has been gradual and slow.

Besides policy changes and implementation, there is resistance from communities to accept and recognise youth SRH needs, particularly of those that are unmarried. Unmarried young people are not expected to engage in sex, and therefore it is deemed unnecessary to provide them with information related to safe sex practices, Sexually Transmitted Infections (STIs) or Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS). Even discussing puberty with young girls and boys is a taboo, and thus, not encouraged or accepted. This is translated into service provision as well, where provider bias plays a huge role in restricting access to information and services.

The social and political environment has to be challenged through comprehensive state policy, clear directions and mandates as well as implementation of accessible and effective complaint mechanisms, to ensure availability and provision of services and information to the youth. Programmes must keep in mind economic barriers, social/cultural barriers as well as mobility restrictions, in order to provide solutions, while working on communication and awareness strategies to mainstream youth SRH issues.

INTRODUCTION

In 1994 at the ICPD, a historic Programme of Action (PoA) was developed by 179 governments which not only placed human rights at the heart of development, but most significantly recognised the significance of sexual and reproductive health and rights (SRHR) as being pivotal for improving quality of life for individuals as well as creating sustainable socio-economic growth. The vision of ICPD PoA is far from fulfilled globally, and as the ICPD nears its 25-year mark, Pakistan lags behind most significantly in terms of a neglected youth. It is pertinent to note that Pakistan was among the first countries to adopt the Sustainable Development Goals (SDGs) in which more than one-third targets refer to the empowerment or well-being of youth across different SDGs[1] and especially Goal 3 which focuses on health and well-being.[2]

YOUTH IN PAKISTAN: AN OVERVIEW

Pakistan is the 6th most populous country in the world[3] at an approximate 200 million population[4] with an average annual growth rate of 2.4 percent. Pakistan's Human Development Index (HDI) value has steadily increased from 0.404 in 1990 to 0.550 in 2014; however, it is positioned at 147 out of 188 countries and is in the medium human development category.[5] Gender disaggregated HDI values depict a sharp contrast – 0.452 for females and 0.610 for males – resulting in a Gender Development Index (GDI) value of 0.742.[6] Although, this has increased from 0.651 in the last five years, Pakistan still ranks substantively lower than both Bangladesh and India.

Presently, Pakistan is the second youngest South Asian country with 64 per cent of its population under 30, with 29 per cent between the ages of 15-29.[7] [8] According to the Pakistan Demographic and Health Survey (PDHS) 2012-2013 39 percent of the population is under 15 years of age, whereas 57 percent belongs to the 15-64 age group.[9]

The youth literacy rate reported for boys and girls aged 15 – 24 between 2008 and 2012 is 79 percent and 62 percent respectively.[10] According to National Institute of Population Studies (NIPS)[11] currently there are 22.84 million Out-Of-School Children (OOSC) aged 5 to 16, this constitutes more girls than boys.[12]

A significantly larger proportion of females have never been to school compared to males, 53 percent and 34 percent respectively. 28 percent of girls aged 10-14 have never been to school, this percentage increases in subsequent age groups.[13] Levels of education vary across rural/urban divides, and access to education is further influenced by wealth, which has been noted in PDHS and in a global context: 62 percent of poorest females aged 7-16 have never been to school in Pakistan, the 7th highest number in the world.[14] Youth (15-29) currently constitute 41.6 percent of the total labour force (15-64) and each year approximately 4 million youth become of working age[15] Youth unemployment has been on the rise, reaching 9.1 percent in 2015.[16]

Despite youth comprising a large chunk of the population, information regarding their development and social well-being is limited. Data collection is confined to comprehensive knowledge of HIV amongst female adolescents only, HIV/AIDs prevalence rates, school enrollment, marriage (again only females), and adolescent birth rates. National statistics do not reflect the needs of unmarried youth, nor do they look into health and social well-being of the 10-14 age cohort. There is little data available to assess mental health and puberty related anxieties and issues of the young group. The entire adolescent life transition cycle and the issues related to it remain unrecognised, which is a crucial element to adolescents' health needs.

Suffice to say, youth needs remain neglected in Pakistan, despite being a large population and the urgent issue of addressing their requirements; failure to recognise or meet youth needs has the potential to result in poor socio-economic outcomes for the country, due to a youth citizenry which is ill-equipped or unable to contribute towards national development.

It is important however to recognise the progress and development on SRHR outcomes overall. Considerable and commendable commitments and actions have been made to improve SRHR in Pakistan.

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[1] Sunyoung Hwang and Jiwon Kim, UN and SDGs: A Handbook for Youth, (UNESCAP, 2017), 10-11, https://www.unescap.org/resources/un-and-sdgs-handbook-youth.

[2] Target 3.7 reads, "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes."

[3] State of the world's Population 2017; Worlds Apart Reproductive Health and Rights in an age of inequality, (UNFPA 2017), https://www.unfpa.org/sites/default/files/sowp/downloads/UNFPA_PUB_2017_EN_SWOP.pdf.

[4] "Provisional Summary Results of 6th Population and Housing Census 2017", Pakistan Bureau of Statistics, accessed September 4th, 2018, http://www.pbs.gov.pk/content/provisional-summary-results-6th-population-and-housing-census-2017-0.

[5] UNDP (a), Human Development Indices and Indicators: 2018 Statistical Update Briefing note for countries – Pakistan, (UNDP 2018), http://hdr.undp.

PROGRESS ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN PAKISTAN

PROGRESS ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN PAKISTAN

Health		
	Maternal mortality ratio (3.1.1)	178 per 100,000 live births
	Proportion of births attended by skilled health personnel (3.1.2)	51%
	Under-5 mortality rate (3.2.1)	78.8 per 1000 Births
	Proportion of population with large household expenditures on health as a share of total household expenditure or income (3.8.2)	Data not available
	Proportion of the target population covered by all vaccines included in their national programme (3.b.1)	66%
	Proportion of the target population covered by all vaccines included in their national programme (3.b.1)	Adults and children newly infected with HIV:20 000 [18 000 - 21 000] Adults aged 15 and over newly infected with HIV 19 000 [17 000 - 20 000] Women aged 15 and over newly infected with HIV 5400 [4700 - 6000] Men aged 15 and over newly infected with HIV 13 000 [12 000 - 15 000] Children aged 0 to 14 newly infected with HIV <1000 [<1000 - 1100]

Table 1.1 Health Indicators Source Pakistan Demographic Health Survey and World Bank

Sexual and reproductive health, services and rights		
	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (3.7.1)	53.3%
	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that group (3.7.2)	37.69 births per 1,000 women ages 15-19, data not available for 10-14
	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1)	Data available for this states decision making alone OR jointly with husband - 92%
	Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (5.6.2)	Multiple legislations, international commitments policies and programs exist, but universal access is not gauranteed: youth (15-24) if unmarried, SRHR is largely ignored in policies pertaining to them, and even in practice

Table 2.1 Sexual and Reproductive Health Indicators, Source Family Planning 2020 (FP 2020) Pakistan

org/sites/all/themes/hdr_theme/country-notes/PAK.pdf.

[6] UNDP (b), Human Development Report Indicators – Gender Development Index (GDI), (UNDP 2018), http://hdr.undp.org/en/indicators/137906.

[7] This is the age group defined as youth, in Pakistan

[8] Adil Najam and Faisal Bari, Pakistan National Human Development Report 2017 - Unleashing the Potential of a Young Pakistan,(UNDP Pakistan, 2018), 2-3, http://www.pk.undp.org/content/pakistan/en/home/library/human-development-reports/PKNHDR.html.

[9] National Institute of Population Studies (NIPS), Pakistan Demographic and Health Survey (PDHS) 2012-2013,(Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International, 2013), 17

[10] 'Statistics", UNICEF, accessed September 4, 2018, https://www.unicef.org/infobycountry/pakistan_pakistan_statistics.html.

[11] The current population census was conducted in 2017, however, age-wise population figures are not yet published. As a result, all demographic calculations for subsequent years must use population projections based on the 1998 census. For the purpose of this report, projections of National Institute of Population Studies (NIPS) based on 1998 population census for the year 2016 have been used. For the enrolment, adjusted net enrolment figures have been taken.

[12] Academy of Education Planning and Management (AEPAM), Pakistan Education Statistics 2016-2017, (National Education Management Information

Adolescents and young people	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group (3.7.2)	37.69 births per 1,000 women ages 15-19, data not available for 10-14
	Proportion of youth (aged 15-24 years) not in education, employment or training (8.6.1)	29% have no education
		60% not working
		Data not available on training

Table 3. 1 Adolescents Health Indicators, Source UNICEF

The indicators given in Table 1.1, 2.1 and 3.1 are related to the SDGs and mark Pakistan's progress against international commitments. Especially relevant to youth, these targets encompass the commitments made during the ICPD conference. Pakistan is also State Party to the Convention on the Rights of the Child (CRC), which also stipulates the provision of SRHR information, services and care to the youth, including providing Comprehensive Sexuality Education (CSE) to all.

Pakistan has made significant progress in the realm of SRHR overall, with much credit due to advocacy efforts of the civil society at large. The government has also started to recognise the dire need to address reproductive needs of women, most likely due to the alarming rates of maternal morbidity, and population growth. In the past few years, Pakistan has successfully integrated Post Abortion Care (PAC) and Post Partum Family Planning (PPFP) practices in the overall health policies. Medicines such as Misoprostol were added to the National Essential Medicine List in 2016; guidelines for uterine evacuation were endorsed for uptake at provincial levels. A Reproductive Health and Rights Bill was introduced in 2013, but is still pending approval. The province of Sindh passed the Child Marriage Restraint Act in 2013, and increased the age of marriage from 16 to 18 for girls (at par with boys); advocacy efforts are underway in other provinces for replication. Sindh and Balochistan have both committed to incorporating LSBE at school levels, with commitments shown by Sindh under the Costed Implementation Plan (CIP):[17] the CIP Task Force has been working with organisations to pilot programs under LSBE, and plans are underway to implement the program across schools in all districts of Sindh. Rutgers WFP and Aahung in Pakistan tested a program enabling community youth to be champions and advocates for their own SRHR in 12 districts across Pakistan (Peshawar, Karachi, Matiari, Quetta, Pishin, Gujranwala, Lahore, Multan, Vehari, Dadu, Gilgit and Faisalabad). Considerable negotiations took place during the implementation phases of this project, and Sindh and Balochistan have committed to scaling up the work done by Rutgers and Aahung, through embedding LSBE curriculum in the education system. These are limited to certain grade years, and while the content has been diluted to be culturally appropriate (and limited in scope), it can be considered a step in the right direction.

The Chief Justice of Pakistan, taking notice of the distressing population growth rate, issued a Suo Moto Notice in 2018, *Human Rights Case No. 17599*, and initiated a task force specifically to expedite programs related to population issues. Recommendations of the Task Force pertain specifically to reducing Population Growth Rate (PGR) and Total Fertility Rate (TFR), while increasing Contraceptive Prevalence Rate (CPR). One of the specific recommendations of the Task Force is for the state to "Ensure Universal Access to Family Planning (FP)/Reproductive Heath (RH) Service", under which the Task Force has made the Federal and Provincial Governments responsible for: ensuring all public health facilities provide family planning services as part of their essential service packages; mandating private facilities to provide FP related counselling, information and services to both male and female clients; establishing the provision of FP, ante and post natal counselling and contraception as a priority service of the Lady Health Workers (LHWs) program; re-establishing the role of

System, AEPAM, Islamabad, 2016) ,23, http://library.aepam.edu.pk/Books/Pakistan%20Education%20Statistics%202016-17.pdf

[13] NIPS, PDHS 2012-2013.

male mobilisers to provide FP counselling to men; integrating civil society programs and efforts with the health departments to reach out to underserved and unserved areas; and federal/provincial financing schemes to be a part of FP schemes. The deadline given to both Federal and Provincial Governments to complete these tasks is 30th June 2019.[18]

Financing and legislation is a key part of these recommendations, with emphasis laid on the creation of a Special Fund for reduction of Population Growth, with a 5 year timeline. Health budgets are stressed upon, and recommendations for reallocations have been given; financial assistance from donor agencies (through Non-Governmental Organisations (NGOs)) and corporate sector is also mentioned. Under legislation, the task force recommends a FP/RH Rights Bill be legislated by 31st March 2019, and for the Federal and remaining Provinces to adopt the Early Child Marriage Restraint Act which Sindh currently has. Further, the task force recommends mandatory pre-marital counselling take place prior to officiating marriage, and the right to "promotive and primary health care" be recognised under the Constitution in addition to the extant right to education.[19]

While these recommendations are to be celebrated, it should be noted that these are specifically targeted at lowering population growth, and do not address the socio-cultural barriers youth confront in terms of access to services. There is also no recognition of CSE under these recommendations. Also of concern is the financing of these programs for execution. While the government has made these commitments, these are not reflected in the overall budgets, or even in the policies related to the youth. A closer look at the youth context of SRH reveals poor actual progress on the commitments made.

RESEARCH METHODOLOGY

In order to gauge and evaluate the state of SRHR for youth in Pakistan the study used secondary desk research, triangulated by Key-Informant Interviews (KIIs) with experts on the subject. The study was limited by lack of representative data on youth's SRH needs and their access to SRHR information and services, particularly for unmarried youth.

To compensate for these gaps, a two-tiered approach for in-depth analysis was adopted; desk research drew upon findings of both previous and current SG research projects which had worked with youth populations in multiple districts across four provinces in Pakistan on RH, child marriage, and safe abortions[20]. These projects employed interventional research and participatory action research methodologies. Existing project-based data sources were utilised for this analysis, which included policy briefs and research reports; unpublished transcripts of raw field data from Focus Group Discussions (FGDs) with male and female youth groups, older married women and men, and health practitioners; In-Depth Interviews (IDIs) with service providers such as LHWs, gynaecologists, nikah registrars, and police officers; in-depth case studies of young girls; and observation reports of SG's field researchers. The purpose of this research tier was to use on-ground research to inform analyses of systemic socio-cultural norms and practices which limit or otherwise restrict recognition of youth SRH needs, along with access to information and services.

The second tier of analyses consisted of external secondary data, to evaluate current policy context surrounding youth's SRHR. This involved analyses of external research on Pakistan's youth population; gaps in government statistical data; analysis of provincial youth policies from an SRHR perspective; and subsequent financial analysis of provincial budgets of Punjab, Sindh, KP, and Balochistan.

Seven KIIs were conducted to triangulate data with emerging insights from first tier of analysis. Informants from key international donor organisations and NGOs were selected based on their knowledge and expertise of, and involvement in SRH, particularly in policy-making processes surrounding youth demographic. Due to budgetary constraints as well as limited time and unavailability of people, interviews were conducted mainly with officials from Sindh. The purpose of these interviews was to enrichen analysis through expert opinions on representation of SRHR issues in policies and on-ground realities, particularly with reference to unmarried youth; analyse if challenges faced by the adolescent and youth population are translated adequately in government policies; assess progress and implementation of youth policies in Pakistan; and look at various challenges hindering implementation.

Shirkat Gah's community partners assisted in determining location and functionality of Adolescent Friendly Centres (AFC)/ Adolescent Counseling Centres (ACC). Cold calls were made to the identified AFC, and quick phone interviews conducted to assess the functionality of the centres. Questions regarding their timings, services, clientele were asked, and evaluated against the guidelines stipulated. KIIs conducted primarily for this report also informed the insight on AFCs/ACCs.

[14] State of the world's Population 2017.

FINDINGS

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN PAKISTAN

While initial analysis of 2017-2018 PDHS indicates that there has been some improvement in health indicators, overall health outcomes for youth still remain poor;[21] youth's access to SRHR services, information, and facilities is severely restricted due to a myriad of reasons, chief of which are socio-cultural and economic barriers; a lack of inclusion of youth's SRHR in policies and programmes, and weak implementation of existing policies and programmes.

To a large extent, it is the unmarried youth which remain the most disenfranchised; socio-cultural practices and beliefs impede unmarried youth (particularly girls) from accessing SRH facilities and services. Importantly, national indicators such as PDHS measure data such as TFR or age at first birth against married women, between the ages of 25-29. The lack of national records of SRH indicators for youth results in their exclusion in policies and programmes. Challenges confronting young people in terms of SRH which remain largely unaddressed include early marriage and pregnancy, low use of contraception, use of unsafe abortions, lack of relevant information and poor knowledge about bodily development including puberty and menstruation, sexuality, reproduction, and HIV.

A significant barrier to improving youth's health outcomes is that SRH remains a taboo subject for youth, particularly for girls. Combined with the absence of formal sources of knowledge, this obstructs access to vital SRH information amongst unmarried youth demographic as the expectation is that sex and sexuality are issues which young people will naturally understand after marriage.[22] Young people are expected to be sexually inactive before marriage, and programmes and policies thus neglect this demographic despite evidence which indicates that informing young people about their SRH such as puberty, dangers of unwanted pregnancies, FP, equality in marital relations, and communication and negotiation skills can result in improved knowledge and understanding of not just health issues, but also equal gender relations in society, and the importance of education and economic empowerment for girls.[23]

FP and contraceptive use has been found to be low in married youth too, due to lack of information but also lack of permission given by husbands or mothers-in-law, and misinformation about contraceptives,[24] creating a high rate of unmet need.[25] Interestingly, youth have been found to be more enthusiastic about adopting FP methods, particularly male youth who are more knowledgeable compared to girls about the importance of FP.[26] This can be attributed to greater mobility and independence enjoyed by male youth as compared to girls, multiplying avenues for gaining information. It is also important to note that, more often than not, available data on contraceptive use for youth relates to married youth; reflecting the assumption that unmarried youth do not have a need for contraception or family planning services.[27] This data gap is highly dangerous as it ignores on-ground realities.

A dire issue facing the country is the prevalence of Child and Early-Age Marriage (CEAM) which has an adverse impact on female SRH. The PDHS 2017-2018 reports that 4.9 percent women are ever-married for the age cohort of 15-29 years, suggesting continued high rates of early age marriage.[28] Pakistan Bureau of Statistics (PBS) reaffirms this suggestion through their inclusion of 15-year- olds in data collection of marital status in Pakistan. Early pregnancy and childbearing directly impact maternal and infant mortality rates and young mothers are more prone to health complications due to early pregnancy. Socio-cultural customs and traditions, steeped in patriarchy, are often the driving force behind early marriages,[29] manifesting in the form of harmful practices such as paith-likhi,[30] watta-satta,[31] vani/swara.[32] Furthermore, girls married at an early age have limited to no decision-making powers, which curtails their ability to exercise control over their own RH, including an inability to practice FP, use of contraception, access to pre-natal and ante-natal care, or access skilled birth attendants.[33] Additionally, early marriages and consequent early pregnancy has a direct adverse impact on the health of both the mother and child, and contributes to maternal mortality and morbidity.[34]

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[15] Najam and Bari, Pakistan National Human Development Report 2017, 2-3
[16] Ibid
[17] The Costed Implementation Plan is a 5 year program that Sindh has implemented to achieve its FP2020 commitments in the province.
[18] Recommendations Of The Task Force: Human Rights Case No.17599 Of 2018 – In The Matter Regarding Alarming High Population Growth Rate In The Country
[19] Ibid
[20] Humsathi, SAAF, HSGS, SMS – Where and how to describe these.
[21] NIPS, PDHS 2017-18 Key Indicators, (Islamabad, Pakistan, and The DHS Program, ICF Rockville, Maryland, USA, 2018), https://dhsprogram.com/pubs/pdf/PR109/PR109.pdf.
[22] Zeba A. Sathar, Iram Kamran, Maqsood Sadiq, and Sabahat Hussain, Youth in Pakistan: Priorities, Realities and Policy Responses, (Population Council, 2016), https://www.popcouncil.org/uploads/pdfs/2016PGY_YouthInPakistan.pdf

"When we go about our door-to-door visits, young girls have the opportunity to directly speak to us and are happy to see us; 'look, baji is coming' they say, but usually, their mothers interfere and scold their daughters for speaking up. young girls get a chance to speak to us, but their mothers often interfere or scold them for speaking up. So girls don't get to utilise this opportunity and later, their mothers come to us with their daughters' health issues! 'This is an issue with my daughter's health, but she's unmarried so how can we share this as long as her brother and father are in the house, what will they say'? They tell us."[35]

Important insights into the needs of unmarried youth in particular in terms of adolescent SRH are revealed through projects undertaken by SG on varied SRHR issues. Multiple projects have yielded consistent findings with regards to adolescent RH, which are further unpacked below.

Due to taboos surrounding RH, adolescent girls are not allowed to visit healthcare facilities alone, in many instances, even if escorted. Fear of social censure in small communities with little to no privacy is a powerful deterrent to youth seeking health services. Simultaneously, on the supply side, service providers struggle with young patients due to cultural norms and young people's inability to adequately express their health issues.[36] Such regressive views of adolescent health are also reflected in service provider bias, with service providers refusing to perform abortions on unmarried girls, [37] or failing to provide adequate care to rape victims due to personal bias/disbelief of rape.[38]

It is evident from field interventions across the country that unmarried youth have little to no information regarding their SRH. An assumption could be made that male youth would have accurate information due to their relative freedom of movement in comparison to girls; however, this is not the case according to SG's research. Raw data from various qualitative researches reveals that young boys lack information about puberty and sexuality. While greater mobility and higher education level than girls does, in some cases, provide boys with more sources of information as compared to girls, general trends in research indicate poor knowledge about puberty among male youth. They feel shame and fear approaching their fathers, and in turning to peers, often create a chain of misinformation.[39] They receive no information in their schools and have no access to service providers who can provide accurate SRH information.

Their confusion begins with nocturnal emissions, which they fear to be a sign of disease, and their main source of information is their peers or the Internet. Often, their only solution is to pressure parents to get them married.[40] In some cases, lack of sexual knowledge has taken harmful forms such as bestiality, with male youth reporting sexual initiation with household cattle,[41] but also child prostitution and rape; as well as 'dance-halls' which operate as brothels.[42] In such cases, unmarried male youth suffer from Sexually Transmitted Diseases(STDs)/STIs and turn to local pirs[43]/hakims[44] for medical treatment and due to shame or taboo on RH, resort to stealing money from their parents in order to get expensive, often ineffective treatment from local hakims,[45] which however, seems inadequate care as their health does not improve.[46]

"People in the community don't have the awareness that we ourselves have created harmful customary practices. The (socio-cultural) environment here is such that girls are attaining puberty at the age of 11 and 12 – they say that as soon as a young girl attains menarche, and 'becomes a woman', she should be married. They do not consider how young she is, or if she can manage an entire household. They only say 'this has been our rawaaj, our culture and practice for a long time, what will people say if we do not follow it anymore?' They don't have enough awareness to understand that their daughters' lives matter more than people's taunts."[47]

Young unmarried girls are largely ignorant regarding their RH. Mothers generally do not speak to their daughters about puberty, and silence daughters if they ask questions or, in the best case scenarios, direct them towards older sisters and mid-wives. This creates a culture of shame and secrecy around RH, undermining girls' health-seeking behaviour. Moreover, it creates severe misconceptions regarding ordinary RH topics such as menstrual health: girls report fear upon

[23] Aminah Jahangir and Neha Mankani, CASE STUDY: Aahung — Empowering Adolescents in Pakistan through Life Skills-based Education,(UNGEI, 2016), https://www.goodpracticefund.org/documents/Aahung-UNGEI-Final.pdf.
[24] Noureen Aleem Nishtar, Neelofar Sami, Sabina Alim, Nousheen Pradhan, and Farid-Ul-Hasnain, "Determinants of Contraceptives Use amongst Youth: An Exploratory Study with Family Planning Service Providers in Karachi Pakistan," Global Journal of Health Science 5, no. 3 (2013): 1-8, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4776775/.
[25] "Youth and Contraceptive Use" http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/06/FP2020 MeasurementAnnex_2015_Youth.pdf
[26] Population Council, Induced abortions and Unintended Pregnancies in Pakistan, 2012, (Population Council, 2014) http://www.popcouncil.org/uploads/pdfs/2014RH_PostabortionCare_Pakistan.pdf

reaching menarche because they believe they are sick or dying from disease. Girls have no source of information other than peers, and occasionally local Community Mid-Wives (CMWs). This lack of knowledge is debilitating for their emotional health, as their sense of identity and self-worth erodes due to a disconnection with their own bodies. In working towards providing girls with information regarding their RH, SG's on-ground interventions found that when girls' knowledge and capacity concerning their own reproductive health increased, it unlocked agency, giving them the confidence to advocate for themselves within their families and communities for their education, right to marry, and to speak up against sexual harassment.[48]

Deeply entrenched patriarchal norms that devalue girls means that their health does not receive importance within their homes and frequently, they resort to home remedies for menstrual pain or RH issues such as cysts, which may not be completely effective. These norms and subsequent imposition on girls of embodying family honour is another contributor to unmarried girls' inability to access health services. In small communities where gossip travels fast, it is considered inappropriate to take an unmarried girl to a doctor, particularly for RH issues, because there is an assumption that only married girls require medical attention. Consequently, any girl who seeks advice from a medical practitioner is subjected to social censure and character assassination. Fearing such consequences, parents refuse to take their daughters to the doctor especially when they suffer from RH issues. These can range from irregular periods, leucorrhoea, or painful periods. In cases where girls do visit health facilities, there have been complaints of sexual harassment and inappropriate behaviour by male staff[49] which becomes discouraging for health-seeking behaviour even further.

Programmes and policies fail to factor in adolescent health and focus instead on married couples. For example, the curriculum for LHWs, tasked with community outreach, repeatedly makes mention of married women when referring to end clients; unmarried girls are not perceived to have any RH needs. This is increasingly troubling as it completely isolates the youth bulge, which if left unaddressed, will have poor outcomes for the country: a sick population cannot support the country's socio-economic development, and if adolescent health needs continue to be ignored and side-lined, then there is a possibility that it can result in continuous health problems.

[27] Assessing Opportunities for Family Planning Programming among Adolescents and Youth in Pakistan", Pakistan Youth Opportunity Brief, TRACK-20, accessed September, 2018, http://www.track20.org/download/pdf/Youth%20Briefs/Pakistan%20Youth%20Opportunity%20Brief.pdf.

[28] NIPS, PDHS 2017-18 Key Indicators

THE NATIONAL VISION PAKISTAN, 2025

Being one of the 193 countries that have committed to advancing the 2030 Agenda for Sustainable Development, Pakistan developed a national visionary blueprint, the National Vision 2025. This blueprint was meant as a measure to align national health priorities to that of the global agenda.

The Global Agenda targets 3.7 and 5.6 emphasise universal access to SRHR services as pivotal to realising the overall Goals and Targets. While the first pillar of the National Vision endorses Goal 3 and 5 as part of its initiatives of putting "People First", a close examination of the document reveals that RH in general or SRH for the younger population hardly bear mention. The focus is on improvement of maternal health and infant mortality outcomes, with provisions of social safety nets through micro health insurance schemes, but the document fails to address the need to provide non-discriminatory and universal access to SRH service. Under Goal 5, the targets related to ending all forms of discrimination and violence against women, including harmful traditional practices and early and forced child marriage (5.1, 5.2 and 5.3) are addressed vaguely; universal access to SRH services (5.6) is not mentioned at all.

Recognising Pakistan's dismal social development performance, the Vision acknowledges strong social capital as pivotal to the country's growth, but in contradiction, suggests cuts in already low public spending for essential services. The focus on increasing youth employment and economic empowerment fails to make strong connections to health and SRHR both as an exacerbating factor and a direct result of poverty and high rates of unemployment. The Vision does not lay out any plans to address social norms and cultural practices that serve as the biggest obstacle to young people's access to information and services, particularly women and girls. The interlinkages of SRH to women's economic empowerment is neither recognised nor understood; yet this is crucial for an effective realisation of the National Vision.

THE NATIONAL HEALTH VISION, 2016-2025

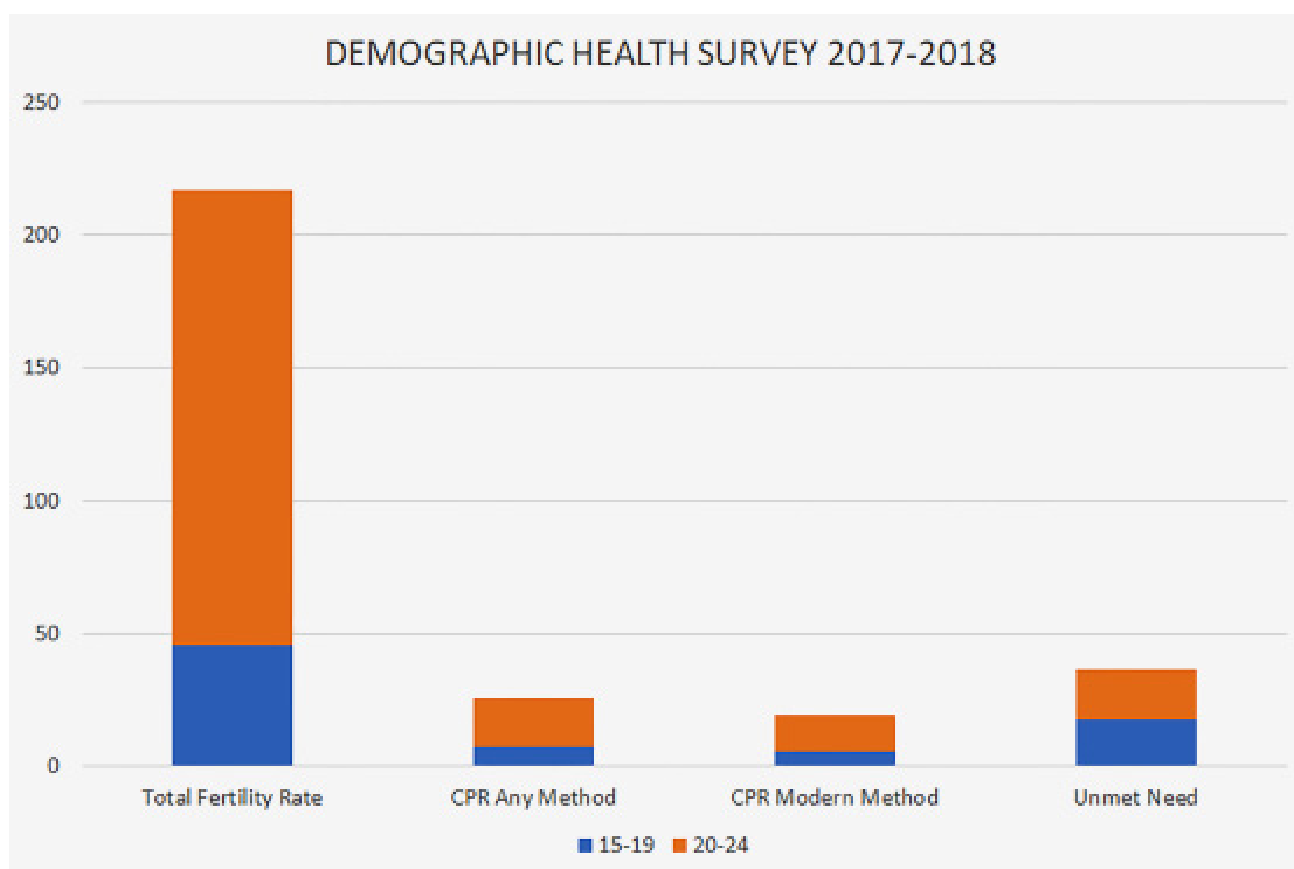

Figure 1 NIPS, PDHS 2017-18 Key Indicators.

Following the National Vision 2025, the National Health Vision 2016-2025[50] was launched. Formalising national health priorities, the document has three objectives, one of which is to create a common direction to consolidate national, provincial and interprovincial efforts.[51] The Policy is meant to serve as a guiding principle for developing and drafting provincial policies related to health. Despite a mention of non-communicable diseases, health access and inequities as well as the population explosion, the document makes no mention of adolescents and youth at all.

Similar to the National Vision, the words 'youth' and 'adolescent' do not feature at all in the National Health Vision (2016-2025) document.[52] The exclusion of youth and adolescents specifically with regards to SRHR is worrisome, suggesting a blind spot regarding youth's SRH and also indicating the government's inconsistency in formulating policy. There remain huge gaps in health and population policies, with youth being unaccounted for, creating a disabling environment for youth's access to SRH information and services. This is particularly concerning for Pakistan, considering the high fertility and low contraception rates amongst the young age cohorts.

With average age at first birth recorded at 22.8 years, it is imperative that the state focus attention and divert resources to youth groups, provide accurate, quality and comprehensive information regarding their reproductive health and rights, and quash misconceptions and myths regarding contraception.[53] The PDHS further reported that "8% of women age 15-19 had begun childbearing: 6% had had a live birth, and 2% were pregnant at the time of the survey". 19% of 19-year olds surveyed for the PDHS[54] in 2017 reported that childbearing had started, a significant increase from the 1% recorded at the age of 15.[55]

PROVINCIAL YOUTH RELATED HEALTH POLICIES

Under the 18th Constitutional Amendment, youth related issues, including health, are now provincial mandates. As part of their mandates, provinces are responsible for developing youth policies and establishing ministries focused on youth affairs. In 2015, four years post-devolution, a National Forum on Provincial Youth Policies was held in which representatives of the four provinces (Punjab, Sindh, KP and Balochistan) Gilgit Baltistan, and Azad Jammu and Kashmir presented their youth policies and status. For the purpose of this study, only provincial policies and budgets are reviewed for youth defined as the age bracket 15-29.

[29] "Child Marriages Around the World – Pakistan", Girls Not Brides, Accessed September 2018, https:/ /www.girlsnotbrides.org/child-marriage/pakistan/.
[30] Under SG's project Humsathi, findings indicate that the practice of pait-likhi i.e. betrothal at birth are most difficult to overturn as they are arrangements made at birth within families to strengthen or maintain kinship ties, and breaking such betrothals impact family and kinship ties.
[31] Exchange marriages.
[32] A form of forced marriage in which a girl is given away as punishment for crimes committed by her male relatives.
[33] Deepali Godha and Anastasia J Gage, "Association Between Child Marriage and Reproductive Health Outcomes and Service Utilization: A Multi-Country Study From South Asia," Journal of Adolescent Health 52, no.5 (2013), https://www.researchgate.net/publication/236265801/download
[34] Shahina Maqbool, "Rural teenagers in Pakistan start childbearing earlier than urbanites," The News, September 1st, 2018, https://www.thenews.com.pk/print/362338-rural-teenagers-in-pakistan-start-childbearing-earlier-than-urbanites
[35] Female health work, FGD, Jaffarabad (Balochistan), 2018.
[36] "Youth and Contraceptive Use", Measurement Annex FP2020, accessed September 10th, 2018, http://ec2-54-210-230-186.compute-1.amazonaws.

SINDH YOUTH POLICY

The Sindh Youth Policy[56] drafted in 2012, was officially launched and approved in May 2018. The delay in formal uptake of the law is unclear but speaks to the government's intention and prerogatives with regards to youth related issues.

The policy proposes short, mid, and long-term strategies to address youth issues. According to some experts, the consultative process involved many civil society members from the development sector. Other civil society actors interviewed for this report had been requested to provide expert input and review drafts, but were not involved with consequent consultative processes, and expressed concerns with the policy as it stands today.

The objectives outlined are to encourage economic, social, and political empowerment of the youth, with health being addressed under social empowerment.

Under this, emphasis is placed upon establishment of a "youth helpline" to serve as a counselling mechanism for adolescents on health and reproductive issues, culturally sensitive education and communication activities in reproductive rights at the school level, public service messages, accompanied with life skills based education curricula being used to stress upon gender equality, and increasing medical health literacy and awareness, with a focus on drug and tobacco use, HIV/AIDs, Hepatitis and other STDs. Violence against women, including early and forced marriages is brought up and consolidation of pro-youth legislation, and youth debates/essay competitions are proposed as solutions to these issues.

The focus on health is limited to the aforementioned subjects, failing to touch upon access to comprehensive SRHR and imparting information to the youth. Importantly, married youth is catered to under this policy, while the unmarried youth and adolescents are side-lined in terms of RH services. While not ideal, the mention of married youth's access to FP is important as service providers tend to deny young couples' contraception, due to their own personal biases, and instead, advise them to adopt contraceptive method after beginning or completing their families. Recorded across SG's raw data collection, service provider bias has been reported by most key players in the SRHR field. However, the policy fails to address service provider bias and does not provide solutions to young couples' obstacles to access.

The policy also fails to mention access to FP services for sexual assault survivors and does not recognise the link to FP provision to adolescents and youth to broader FP, health, or population welfare policies.

While not legally required, SG's researches found parental consent/necessary age or marital status plays a huge role in adolescents and youth access to FP. The policy neither acknowledges nor aims to eliminate this barrier. There is no recognition of social barriers to accessing services such as parental consent/necessary age or marital status, and neither is there a focus on maintenance of privacy of those accessing or expressing interest in access.

The policy mentions the development of a centralised information data collection system on youth development against progress indicators, but no details or mechanisms have been outlined since the launch of the Sindh Youth Policy in 2018 or since it was drafted in 2012, and no indicator development has taken place. Although a Commission for annual reporting is to be established under this policy, the budget speech and budgetary allocations of 2018-2019 do not mention any budgetary allocations under education or health to any of the youth programmes mentioned.

A CIP has been developed and was rolled out in Sindh in 2015, to bring up the CPR from 35% to 45%, and to address the FP commitments made in the London Summit. The youth needs regarding SRH are mentioned in the plan but are not the focus in terms of targets or indicators, nor has there been any movement in extending services to the youth. The Plan initially omitted any tangible initiatives to cater to adolescents. However, thanks to advocacy efforts of key stakeholders in Sindh, youth indicators were added to the CIP in 2017. The Population Welfare Department, overseeing the CIP implementation, committed to adopting and scaling up ACC in all 29 districts of Pakistan. This commitment is commendable but has shown no movement thus far.

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com/wp-content/uploads/2016/06/FP2020_MeasurementAnnex_2015_Youth.pdf

[37] Female Doctor, IDI, Swat (KP) 2016

[38] Female Doctor, IDI, Muzaffargarh (Punjab), 2016.

[39] Young Boys, FGD Shahdadkot (Sindh), 2016

[40] Unmarried Male Youth, FGD, Muzaffargarh, (Punjab) 2016.

[41] Unmarried Male Youth, FGD, Shahdadkot (Sindh) 2016.

[42] Married Men, FGD Jaffarabad (Balochistan) 2016.

[43] Spiritual leader.

PUNJAB YOUTH POLICY

One of the objectives of the Punjab youth policy[57] is to "create awareness on high risk behaviours such as HIV/AIDS and STIs and increase availability of integrated SRH information and services for adolescents and youth, especially the most marginalised and help prevent HIV/AIDS and STIs". The policy fails to meet this objective, however, as the outlined programmes to do not present a comprehensive or integrated guideline for the provision of comprehensive SRH related information or services.

The Punjab Youth Policy, approved in 2012, mandates the initiation of "culturally sensitive" life skill programmes, spearheaded jointly by the provincial education and health departments. However, further examination of sex education found this was limited to educative and communication activities. Topics to be addressed under life skills-based programmes are not identified in the policy, leading to the risk that information related to menstruation, safe sex practices, sexuality, etc. that are deemed inappropriate for a young and/or unmarried audience, may be omitted from the programmes. Moreover, this initiation ignores OOSC, which latest statistics approximate to be over 11 million children, as Punjab has been failing to meet its enrolment targets.[58]

The promotion of FP through widespread awareness campaigns, establishing a youth helpline for health and reproductive issues, is mentioned but there is nothing to ensure that provision of FP services to the youth would be accessible. Plans are expressed for establishing youth helplines, which would be limited to counselling on health and reproductive health.

The policy commits to creating Adolescent Health Centres (AHC), where youth can access services to discuss, and treat sexual, emotional and psychological problems. However, there are no ostensible guidelines present to stipulate the provision of services at these centres, including the equitable treatment of married and unmarried youth, provision of contraception, operation timings, location of these centres etc. The utility of these centres is still to be proven, which is further elaborated on later in this report.

Non-compliance with laws regarding early age and forced marriages was to be met with strict measures but no detail has been provided in the law, or otherwise[59] in terms of how this is to be met.

Different economic and education schemes have been discussed but no budget has been specified in the Punjab policy against the activities planned. The budget for 2017-2018 features a laptop scheme, scholarships (as part of the Punjab Educational Endowment Fund), orange cab scheme, sports (open ended) and Apna Rozgar (self-employment) as programmes for youth. Under healthcare, allocations have been assigned for maternal and neo-natal care, primary and secondary care, with no mention of an allocation assigned for youth specific programmes related to health, including those outlined in the policy. The budget does not take into account the activities and initiatives listed in the Punjab Youth Policy; there is no inclusions of programmes related to youth's sexual and reproductive health care services specifically mentioned and approved under the youth policy in 2012. The Policy proposes a Punjab Youth Endowment Fund while the budget allocates funds for the Punjab Educational Endowment Fund. While it is commendable that this funding is for the youth, it is not aligned with the youth policy in any way.

A monitoring and evaluation unit discussed in the Policy is responsible for assessing the impact and progress of the youth policy, but no clear mechanisms are outlined for this. The Policy also describes the creation of a Youth Commission responsible for executing and reporting progress on youth policy programmes, but no information is available on the establishment or existence of said commission.

Under the Integrated Reproductive Maternal Newborn Child Health & Nutrition Program of Punjab, maternal, new-born and child health is emphasised, with specific objectives to reduce morbidity and mortality, promote FP services, and improve the nutritional status of women and children. Once again, unmarried youth have been overlooked, despite the fact that this program could have had a promising impact on the youth health status.

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[44] Physicians practicing traditional medicine.
[45] Reproductive Health Needs of Adolescent Males in Rural Pakistan: An Exploratory Study.
[46] Unmarried Male Youth, FGD, Shahdadkot. 2016
[47] Unmarried Female Youth, FGD, Muzaffargarh (Punjab), 2018.
[48] Shirkat Gah (a), Ending Child and Early Marriages: Lessons of the Humsathi Intervention Study, (Policy Brief:Shirkat Gah, 2018), http://shirkatgah.org/shirkat/?p=14074.
[49] Ibid
[50] National Health Vision (2016-2035)," Accessed March 30th, 2017, http://www.nationalplanningcycles.org/sites/default/files/planning_cycle

KHYBER PAKHTUNKHWA YOUTH POLICY

The youth policy[60] adopted by the KP government in 2016 includes strategies to address the holistic health needs of the youth, protection, survival and development of children and the youth, education and communication activities related to RH, gender sensitive public messages and curricula, and drug addiction reduction projects. Pro-youth legislative measures include taking strict action and ensuring implementation of early and forced marriages laws; inclusion of religious leaders in debates; and essay writing competitions amongst students on early and forced marriages. Apart from the education and communication activities, there is no mention of the provision of RH services to the youth or adolescents, or ensuring that basic RH services are provided. Furthermore, as in other provinces, no budget or monitoring and accountability mechanisms have been detailed in this policy.

In order to implement the Policy, the KP government stated that jawan markaz (youth centres) would be established in towns as well as Union Councils across the province at an estimated cost of Rs. 1 billion (US $9.5 million). The town centres would comprise of data, Information Technology (IT), legal, job, literary, training and sports arts centres, while the Union Council centres would manage sports events, awareness sessions, community services and organisation. There is no indication of whether these centres will be providing additional services such as comprehensive RH services. The policy only mentions preventative health care awareness campaigns on basic health issues and emergency management as part of the services provided at these centres.

In 2016 the KP government announced that 2% of the annual budget would be allocated for youth development in line with the proposed Policy. However, as the 2016 budget released by the government did not reflect this, it is difficult to determine if the youth and adolescents are being catered to under a broader category. The current 2018-2019 budget too does not specify the allocation to youth projects under this policy.

BALOCHISTAN YOUTH POLICY

The youth policy[61] drafted by the government of Balochistan in 2015 has yet not been tabled by the assembly,[62] and therefore is yet to be approved and adopted. The draft policy aims to provide youth-friendly primary health care services, aligned with integrated health frameworks and practices, and specifically follow the commitments made under the CRC when addressing youth needs. Similar to all other youth policies, there is a multi-pronged approach to youth issues: social, economic, and political development.

For the improvement of youth health outcomes, the policy proposes collaboration with the private health sector to impart information and counselling to adolescents with regards to gender equality, relationships, violence, responsible sexual behaviour, responsible FP practices, family life, RH, and STDs (including HIV/AIDS and prevention). The policy, however, does not mention provision of FP services directly to youth or making contraception available to the youth.

Unlike the other policies, however, Balochistan policy specifically mentions the need to address puberty and bodily changes. It stipulates providing services in relation to sexuality, safe sex RH; contraception and protective method provision; STI diagnosis and management; counselling (and referral for testing and care); pregnancy testing and ante-natal and post-natal care; counselling on sexual violence and abuse (and referral for needed services); and PAC, etc.at certain facilities. This is commendable, however, the policy fails to mandate the non-discriminatory provision of these services while ethnographic research shows that provision of such services are limited to married couples and unmarried youth are not catered to. In order for these services to reach their full audience, it is imperative that the state specify these services are meant for all. Confidentiality should be practiced and emphasised on, to encourage unmarried youth to access needed RH services.

Building on the provision of services, the policy further proposes the use of ‘youth researches, events and debates on the scale and depths of youth bulge in the province and mass awareness campaigns for promoting FP in the province’. The promotion of ‘healthful practices and health services’, along with promoting healthy lifestyles, and highlighting harmful effects of drug addiction is stressed upon. There is a focus on the creation and implementation of education programmes

repository/pakistan/national_health_vision_2016-25_30-08-2016.pdf.

[51] The National Health Vision (2016-2025) provides an “overarching national vision and agreed upon common direction, harmonizing provincial, federal, inter-provincial and inter-sectoral efforts for achieving the desired health outcomes and to create an impact on health”

[52] “National Health Vision (2016-2035).”

[53] NIPS, PDHS 2017-18 Key Indicators.

on nutrition, anaemia, CEAM and RH, including a formal curriculum on LSBE, according to the policy. Youth cohorts and organisations are mentioned as groups to be collaborated with in the development of these initiatives.

The Balochistan policy is possibly the most comprehensive of all the policies mentioned, with a strong direction and understanding of reproductive health needs of the youth. Unfortunately, it is yet to be approved so no budget allocation or initiatives have been undertaken under this policy.

ADOLESCENT/YOUTH CENTRES PROGAMMES

Under the aforementioned policies, the emphasis laid on establishing youth/adolescent centres indicate these centres to be the main access point of information and counselling on reproductive health services and information. The United Nations Population Fund (UNFPA) in particular, had piloted a successful project in a few districts across Sindh, KP and Balochistan, with a strong model for youth centres for uptake.

"The program had a very strong component on social mobilisation which had further aspects on how parents and elders would be engaged so that they can facilitate and support the SRH centre we planned to establish within the government hospitals. Ghotki was our pilot site because we wanted to test it in a smaller district. So establishing the centre wasn't the hard part, it's just setting up the room essentially but how do you ensure that youth can access it. For that you need an enabling environment for them."[63]

However, since the project has ended, these youth centres have become non-functional. Recently the Sindh government has committed to adopting the established youth centres and creating new ones across all districts, but action on this is awaited.

In Punjab, AHC have been set up within the Family Health Centres (FHC). These fall under the mandate of the Population Welfare Department (PWD), and the staff is limited to a clinical psychologist. Of the 17 centres set up, six are non-functional as no staff has been appointed yet. It was found that the protocols and functioning of these centres were as per those stipulated by the National Protocols on ACC. The hours of operation are between Monday to Friday 9am-2pm, raising the question of how school-going children will access these centres.

The National Protocols for ACC proposed by the federal government for provincial adoption are guidelines that relate specifically to the Centres also mentioned in provincial youth policies. Non-clinical services have been outlined in the document and include counselling on emotional, SRH, mental health, Gender Based Violence(GBV) and PAC; information on SRH issues including FP, puberty, PAC, STDs (including HIV and prevention), maternal health (ante and post-natal) and GBV; and referrals to relevant departments, that would provide services needed (such as FP).

These Centres are not meant to provide clinical services to youth and adolescents however, and PWD are instructed to create a referral mechanism for clients accessing the ACC for treatment at the FHC (also known as the Reproductive Health

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[54] Key Findings PDHS Page 16: https://dhsprogram.com/pubs/pdf/PR109/PR109.pdf
[55] Ibid
[56] Government of Sindh, Sindh Youth Policy 2018, (Sports and Youth Affairs Department, 2018), https://www.unescogym.org/wp-content/uploads/2017/06/SIndh_Youth_Policy_2016_draft.pdf,
[57] Government of Punjab, Punjab Youth Policy 2012, (Sports and Youth Affairs Department, 2012), https://www.unescogym.org/wp-content/uploads/2017/06/Punjab_Youth_Policy_2012.pdf
[58] Over 11 million children out of schools in Punjab," Express Tribune, Februrary 19th, 2018, 'https://tribune.com.pk/story/1638478/1-11-million-children-schools-punjab/
[59] The age of marriage for a girl child in Punjab is 16 years
[60] Government of Khyber Pakhtunkhwa, KP Youth Policy 2016, (Department of Culture, Sports, Tourism, Archaeology & Youth Affairs, 2016)
[61] Government of Balochistan, "Balochistan Youth Policy 2015", (Environment, Sports & Youth Affairs Department, 2015), https://www.unescogym.org/wp-content/uploads/2017/06/Balochistan_Youth_Policy_2015_Draft.pdf
[62] Mir Behram Baloch, "Balochistan Youth Policy Hangs in Balance", Balochistan Point, March 24th, 2017, http://thebalochistanpoint.com/balochistan-youth-policy-hangs-in-balance/youth-policy-hangs-in-balance/
[63] Renuka Swami, UNFPA IDI, August 2018
[64] Saleem Shahid, "Skills-based education to be imparted in Balochistan schools", DAWN, May 14th, 2018, https://www.dawn.com/news/1407548
[65] Sindh approves life skills-based education for class 6 to 9, GEO News, January 17th, 2018 https://www.geo.tv/latest/177384-sindh-govt-approves-life-skills-

LIFE SKILLS BASED EDUCATION INITIATIVES (LSBE)

The proposed LSBE initiatives are intended to be a collaborative initiative between the education and health departments for implementation in schools and universities, suggesting a wide beneficiary group ranging from ages 12-19+.

Early in 2018, Balochistan signed a Memorandum of Understanding (MOU) with Aahung,[64] a not-for-profit organisation specialising in the designing and implementation of LSBE curriculum as a means of empowering adolescents and children to understand and know their RH rights. The content is related to children's nutrition needs, as well physical and sexual abuse. Aahung has also been an integral part of the LSBE initiatives in Sindh, Punjab and KP.

Sindh approved LSBE for grade 6-9 in 2018,[65] with content geared towards child protection against abuse, gender equality and human rights, hygiene and prevention from diseases such as Hepatitis. This initiative is to be launched in 8 out of 29 districts in Sindh.

While advocacy in KP and Punjab is on-going for the inclusion of LSBE in the formal curricula, currently, there is little progress on its approval and uptake. It is significant to note here there is no information related to RH puberty, and adolescent life cycle transitions as a part of this curriculum.

ANALYSIS

SG's review suggests while there may be some positive developments, much remains to be done to ensure provision of and access to comprehensive RH information and services. The focus of the policies seem to be on ensuring economic and political empowerment, with a minimal attempt to focus on better health outcomes for the youth. Officials from Sindh and Punjab claim to have undergone an extensive consultative process especially with the youth, during the development of their policies. This claim was met with scepticism from experts in the RH field.

Accessibility to quality information and services as an issue is neglected in the youth policies. Socio-cultural barriers, stigma and taboo related to RH for unmarried youth particularly girls, pressure to prove fertility and provider-bias deterring young couples' uptake of contraception and FP, and Menstrual Health Management (MHM) issues are not mentioned in the policies at all. While policies highlight the encouragement and improvement of school retention, in the absence of attention to the need to enhance school infrastructure for provision of clean safe water, private bathrooms for girls, and imparting comprehensive Menstrual Health and Hygiene Management (MHHM) information and products, this is fruitless.

"The first draft of the Sindh Youth Policy was made back in 2012 – 8 youth consultations were conducted in different cities in Sindh and about 20-25 in Hyderabad. Civil Society Support Program (CSSP) reviewed the draft to check how inclusive it was and found that it was more urban-centred and did not address issues faced by the rural youth." [66]

Glaring gaps in understanding the ground realities of the youth suggest that the consultative process may not have been representative, especially of the youth. The diverse needs of different youth groups are not catered to, especially the differentiated needs according to marital status, gender, religion, and age. The youth policies are criticised for not being entirely inclusive, as there is little reference to transgender and differently-abled youth. For these reasons, there is an appeal to the Punjab Government during a policy dialogue to revisit the youth policy, to amend the policy for increased inclusivity. This must apply to all the policies; all need to be revisited, as language, intention and outlines of all policies are similar in nature.[67]

"Provincial youth programmes are focused largely on skill development. Even in existing programmes, gender is not considered. We ignore women's needs and especially we do not disaggregate them by age or even schooling status. We did a study with United Nations International Children's Emergency Fund (UNICEF) on out of school girls – six million girls who are not married and between the ages of 15-19 are out of school. These girls are not working either so they aren't counted in productive activity either. This is a very important group, who is probably in dire need of RH services and they need to be focused on".[68]

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classes-for-secondary-students

[66] Noor Bajeer, KII, Civil Society Support Project (CSSP), August 2018

[67] *Call to review Punjab youth policy,* The News, March 16th 2018 https://www.thenews.com.pk/print/292923-call-to-review-punjab-youth-policy

[68] Iram Kamran, Population Council KII, August 2018 "New report: 49% of nation's girls not attending schools" The Express Tribune, March 9, 2017, https://tribune.com.pk/story/1350176/new-report-49-nations-girls-not-attending-schools/

ANALYSIS

Ministries responsible for implementing these policies lack capacity and understanding of the youth's issues at large, let alone the segmented issues of youth, particularly the rural and urban divide. The ground realities of those located in different classes varies hugely – something the policy fails to cater to or even recognise.

Even if policies are implemented, biases existing on ground not recognised by the policies will significantly impede access. Biases and constraints disproportionately affect unmarried girls, who have little to no access to information related to their RH and are ignored by door-to-door service providers, such as LHWs; In Sindh, this is not done despite it being a part of their mandate to educate young girls regarding their menstrual health.

Unmarried youth, particularly girls, and their access to RH services remains a subject that policy makers are largely silent on. A young girl's needs to SRH services and rights are only considered after she is married as cemented in the silence around their specific needs in all youth policies. This is vividly reflected in all of SG's raw data of ethnographic research.

The ACC, while innovative in nature, do not bridge the gap of accessibility to information for the youth. These clinics are set up at a district level, within the premises of larger public hospitals. Research shows that access to these larger public hospitals is limited due to distance and transportation costs, and further curtailed by socio-cultural norms that restrict youth and adolescents' access to services in the first place. Females (unmarried females especially) find it harder to access basic health care services; SRH services are even further out of reach. The stigmas attached to unmarried girls visiting doctors or family health clinics are a deterrent for unmarried females from pursuing the healthcare they need. The hours of operation and days (Monday-Friday) further hinder access to services; the timings set for service provision (9am-2pm) are during school hours and thus are not conducive for school going youth. For those out of school, access is impossible due to social and familial barriers and negative associations to youth visiting hospitals for RH related services. Still, it is important to note that during the piloting of the centres, it was recorded that while numbers in access overall remained minimal, many of those accessing were indeed out of school youth, indicating that these centres could be used to fill the gap of information access to out of school youth.

The LSBE curricula makes no mention of RH related information or counselling, re-establishing the silence of policy makers with respect to the topic. The content is moulded to cover topics such as communication, peer pressure, negotiation and decision making. This information, however, would be limited to school going children, and with high dropout, low retention and low enrolment rates in Pakistan overall, the government's focus on education institutions may not be enough.

"It is not like [CSE] that is taught in other countries there are certain limitations within our context that we have accepted. You can't even call it CSE; you hear the word sexuality and your entire program will be shut."

Aahung was not permitted to add content related to puberty, due to the fact that both boys and girls would be accessing the same information and it would be culturally inappropriate for the boys to access menstrual health related information. The policing and censorship of information under the garb of cultural sensitivity limits the impact of CSE and does not address the need or fulfil international commitments to provide comprehensive RH rights information. Providing FP to minors (under 18) is contentious and not permitted; lines are blurred between married and unmarried youth. It is seen as a taboo to provide FP related information to unmarried youth, even if over the age of 18.

Progress on the implementation of LSBE in Sindh has been ad-hoc and slow; there seems to be a gap in communication between the intention of policy makers and those responsible for implementation at the ministry level. Despite a clear-cut policy, implementation lags far behind, giving the impression that the provincial government is more concerned with fulfilling promises on paper rather than in practice.

In Punjab and KP, there is no indication of an interest to formulate and implement LSBE curricula. Surprisingly, in Balochistan, progress is faster and initiated by the government itself, despite not having a youth policy in place.

Overall, adequate financing and budget allocations are missing to prompt or ensure the effective implementation of initiatives. Allocations of budgets may prompt ministries to carry out programmes and speed up implementation, reducing the blame game that ensues when asking for accountability. Reliance on donor/international funding, or civil society filling the gap of funds, further reduces state responsibility for rolling out initiatives, allowing for lapses and delays in program roll out. A multi sectoral approach and joint responsibility needs to be stressed upon, amongst government ministries and departments, in order for program implementation actualisation.

RECOMMENDATIONS FOR THE GOVERNMENT:

1. The importance and interconnections between SRHR, women's empowerment (social and economic) and appropriate population policies needs to be recognised and emphasised upon by the state, through initiating programmes that provide crosscutting solutions to these issues,
   - **a.** Health needs to be constitutionally recognised as a right of all citizens, and universal access to health services, including SRH, needs to be incorporated within government budgeting and spending as a consistent point, not as a secondary scheme;
   - **b.** The State must realign its national policies in line with its international obligations with special attention to the commitments made on youth issues;
2. Mainstream the youth through the incorporation of youth needs within the larger SRH framework, with a special focus placed on the varied needs at different life cycle stages of differently located youth;
   - **a.** The youth must be recognised as a priority area under all national health policies, particularly the National Health Vision, 2016-2025
   - **b.** Youth policies need to formally incorporate comprehensive SRH services and information as a part of mandatory services provided to all youth, including the unmarried at all facilities;
   - **c.** Youth Policies need to encompass and address the different needs of the youth over the adolescent life cycle and adolescent transitional ages, as well as take into account gender, marital status, socio-economic status and sexuality;
   - **d.** Formulation of all sexual and reproductive health policies need to feature the youth and emphasis on non-discriminatory provision of SRH services, especially marital status.
3. Emphasis on youth specific hurdles, for instance provider biases, must be addressed in formal policy and incorporated into mandates and trainings down the line, with a strong monitoring mechanism in place, to ensure these hurdles are effectively addressed.
4. Formal mechanism must be designed and implemented to ensure the integration of activities under the youth, health and education departments, for youth programmes to be rolled out and be holistic in nature.
5. Staff providing any form of youth services must be trained, with a communication strategy especially designed to cater to the youth;
   - **a.** These trainings must include and emphasise on confidentiality, handling of sensitive cases such as rape, sexual assault and sexual abuse, with components addressing issues such as moral policing;
   - **b.** Client-centric approaches, technical skill and knowledge development must be emphasised in trainings.
6. The location, operation timings and general protocols for the ACC should be revisited; socio-cultural barriers need to be taken into consideration when designing these centres to support youth access.
7. Budget allocation and financing of youth issues, especially RH related programmes, need to be prioritised.
8. Monitoring systems need to be put in place to monitor progress and effectiveness of programmes;
   - **a.** Data collection and data analysis must be emphasised and incorporated in larger management information systems such as the Health Management Information Systems (HMIS) database.
9. The menstrual health of young girls needs to be made a priority and special initiatives instituted to improve MHHM to ameliorate RH outcomes for young girls;
   - **a.** The link to hygiene management and school enrolment must be made and addressed to encourage retention at schools;
   - **b.** Puberty needs to be understood as a trigger for early age marriages and the state must include parents/ families in awareness campaigns related to puberty, to reduce stigma and possibly influence decisions against early marriages.
10. Campaigns targeting parents and families must be undertaken by the state to highlight the importance of LSBE, CSE, RH and SRH for youth development and growth;
    - **a.** Campaigns should target all key stakeholders, including parents, teachers and influential community members;
    - **b.** Key messages should be tailored and designed for the different stakeholder being addressed, for specific targeting and impact.
11. The state must bear in mind the large numbers of out-of-school population when designing programmes such as LSBE and MHHM and design programmes to include OOSC.

RECOMMENDATIONS FOR CIVIL SOCIETY

1. Special attention and care should be given to youth agenda by civil society, through focused programmes and activities catered towards improving youth health outcomes;
    - **a.** Programmes and activities must be developed keeping in mind youth's needs and wants, tailored to creating an enabling environment for promotion of youth access to health services.
2. Civil society must act as advocates for the youth, ensuring the State's compliance to international and national commitments;
    - **a.** Civil society must continue to monitor progress and hold the State accountable for failures in compliance.
3. Data, successes and best practices must continue to be documented and shared with the state and other key stakeholders,
    - **a.** Advocacy efforts for uptake must be undertaken to assist the State in adopting success models for youth programmes;
    - **b.** Civil society should consider investing in health research particularly targeted for the youth, to undertake evidence based and informed advocacy related to youth.
4. Civil society must monitor government budgets and health spending, to ensure programmes that are committed are reflected in State spending

ANNEXURE: INTERVIEWEE'S LIST

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This research is part of State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25) monitoring initiative by ARROW. This initiative includes 13 partners and generates monitoring evidence around twenty-five years of implementation of the ICPD Programme of Action (ICPD POA) in the respective countries for advocacy. The evidence from the report is expected to inform the Mid-term Review of the 6th Asia Pacific Population Conference (APPC) in 2018 at the regional level, the national policy dialogues in 2019 at the national level, and the ICPD+25 review in 2019 at the international level.

ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

Shirkat Gah (SG) was initiated as a small voluntary women's collected in Pakistan in 1975, and has evolved into a leading women's rights organisation that operates out of offices in Karachi, Peshawar, Lahore, and four field stations across all four provinces. SG's core strategies in its work with grassroots organisations in more than 20 districts, include research to generate evidence for capacity building and advocacy in the areas of sexual and reproductive health and rights (SRHR); personal status law matters; a gendered perspective in sustainable development and promotion of peace, with violence against women traversing the four focus areas. Nationally, SG has contributed significantly to the overall policy and legal framework and works with elected representatives and government functionaries to bolster an environment conducive for women to claim rights and to facilitate accountability. SG also engages regularly with international development organisations and agencies both for setting norms and standards as well as ensuring accountability on Pakistan's international obligations.

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