A Research Study on

Status of Sexual and Reproductive Health Rights of Young People in Pakistan

Findings and Recommendations

November 2009

Conducted By

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PREFACE & ACKNOWLEDGEMENT

I am very pleased to share with you the research report which presents the research findings and recommendations aimed at compiling and synthesizing information on the "Status of Sexual and Reproductive Health and Rights of Young People in Pakistan". This study, which is part of World Population Foundation (WPF), Pakistan's European Union supported project, "Rights-driven Institutionalization of Sexual and Reproductive Health and Rights" lays the foundation for the first ever comprehensive research on the Sexual and Reproductive Health Rights (SRHR) of a given population that will facilitate scientifically sound interventions on the same lines in the future. The report has benefitted from the significant input and collaboration of numerous partners that comprised a Project Management Team, a national and an international panel of SRH Experts (List attached as Annexure__) and a National Project Steering Committee (NPSC). The findings and recommendations of this report are a sincere effort to address data and information gaps and needs, and provide valuable information for guiding the next steps in the process of realizing the Sexual and Reproductive Health Rights of the young people of Pakistan who currently form more than 64% of our total population. The recommendations presented in the report were developed by the Project Team in consultation with a Panel of SRH Experts.

This report provides a wealth of information about the current status of young people's Sexual and Reproductive Health, neglecting which has resulted in serious vulnerabilities confronting the youth. Accordingly, identifying the impediments has prepared ground for advocating for the long avoided cause of Sexual and Reproductive Health and Rights in our country.

World Population Foundation, Pakistan gratefully acknowledges the role of European Union, without whose support and commitment, this publication would not have been possible. WPF extends its deep appreciation to the individuals serving on the Project Team, International and National Expert Panels for their significant contributions of time, talent and ideas in the conduct and successful completion of this research report. Membership lists of these five groups are included in the Appendix.

Especially, I acknowledge the leadership and hard work of the core research team i.e. Mr. Saeed-ur-Rehman, Project Manager and Ms. Areebah Shahid, Programme Officer for the development of research framework, conducting the research and compilation of the final report. I also acknowledge the contribution of Mr. Kashif Muneer and Ms. Aasia Niazi for their technical support, all through the research process, especially analyses of quantitative data. Many thanks to other WPF Team members who participated in conducting FGDs and IDIs. A great deal of gratitude for Dr. John de Witt, Professor and Director of the National Centre of HIV Social Research at the University of New South Wales, who served as the international advisor and offered invaluable insight in developing the research framework, research tool and provided critical feedback on the compilation of this report and toolkit. WPF, Pakistan also extends its appreciation to WPF, Headquarters team, i.e. Mr. Rolink Henk, Head of the International Programmes and Ms. Ellen. M. Eiling, Research, Monitoring & Evaluation Officer, for their continuous guidance, input and support.

Sincerely

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ABSTRACT

More than any other development issue, achieving good Sexual and Reproductive Health (SRH) is dependent on the recognition of specific human rights. It is not a matter of simple funding or providing education and health services. In Pakistan more than any other issue, human sexuality is the subject of strong ideology and moral views and traditions, often rightly or wrongly presented as part of religion. There is little evidence on the Sexual and Reproductive knowledge and behaviours of 12 – 18 year olds. The assumption that boys and girls under 18 are "too young" to need Sexual and Reproductive Health information and services ignores the realities and environmental factors and denies young people from acquiring practical knowledge and skills they need to protect themselves and their partners from STIs/HIV, pregnancy, unsafe abortion or childbirth, and sexual abuse or violence. While advocacy efforts over the last decade or so, mostly geared by civil society organizations have been propagating young people's right to receive comprehensive information, education, health services, and other social and legal supports regarding their Sexual and Reproductive Health and Rights, however lack of empirical evidence has always been a major hurdle in influencing comprehensive change at the policy level. Pakistan is currently undergoing demographic dividend and with over 60% of its population consisting of young people, it is important to design interventions to meet the unique needs of this group.

With this background, World Population Foundation (WPF), Pakistan conducted this study to get a clear picture of SRH Rights' situation of young people in Pakistan. The purpose of this research was to get a vivid image of the current situation on one hand and on the other hand to use the findings of the research to influence positive change with regard to the realization of young people's Sexual and Reproductive Health and Rights through programmatic interventions and policy advocacy initiatives.

Both quantitative and qualitative methods of research were used for the purpose of this research. A web-based questionnaire was developed and shared with Knowledge Bearers forming part of the quantitative component while Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) were conducted directly with various groups of stakeholders for the purpose of qualitative methods. Moreover, literature review of previously published national and international researches and other documents was also done.

The findings will provide a base on which WPF, Pakistan and other SRHR focused organizations ads well as Government agencies will be able build its advocacy strategy and interventions in education and health sectors to make them more youth and SRHR friendly.

1- INTRODUCTION

World Population Foundation (WPF) Pakistan through generous funding from the European Union (EU) has initiated, "Rights-driven Institutionalization of Sexual and Reproductive Health in Pakistan". WPF will implement the project in three districts through its implementing partners i.e. Aahung (Karachi), Awaz Foundation-Center for Development Services (Multan) and Health and Nutrition Development Society (HANDS-District Mitiari). The overall objective of the programme is to "Improve the Sexual and Reproductive Health and Rights (SRHR) status in Pakistan". The specific objectives of the project are as following:

1. To create an enabling environment at policy and societal level for Sexual and Reproductive Health and Rights in Pakistan;
2. To integrate SRHR in Education services and systems in Pakistan (and)
3. To integrate SRHR in health services mechanisms in Pakistan.

WPF will be implementing several strategies to achieve the overall objective of the project through a three pronged approach named **A.I.M:**
A: Assessing Status of SRHR; to assess the current status of Sexual and Reproductive Health Rights in Pakistan through a rights-based framework- SeHRAF, i.e. Sexual and Reproductive Health Rights Assessment Framework. The pioneering national status report will also be used for improving SRHR status and to create an enabling environment.
I: Institutionalizing SRHR in Demand and Supply Mechanisms; to institutionalize the Sexual and Reproductive Health education in education system as well as to promote client-centered SRHR services in health management system to cater for the needs of 64% of the young people.
M: Monitoring of SRHR Situation resulting due to Institutionalization; to sustain the project as well as monitor its progress and effectiveness during implementation. Several M&E mechanisms will be strengthened within the existing systems of health and education from an SRHR Perspective.

To implement the assessment part of the project, WPF aimed to conduct this study to get a clear picture of SRH Rights status of young people in Pakistan. The findings of this research will provide a base on which WPF will build its advocacy strategy and interventions in education and health sector.

1.1 Problem Description

More than any other development issue, achieving good SRH is dependent on the recognition of specific human rights. It is not a matter of simple funding or providing education and health services. In Pakistan more than any other issue, human sexuality is the subject of strong ideology and moral views and traditions, often rightly or wrongly presented as part of religion.

There is little evidence on the Sexual and Reproductive knowledge and behaviours of 12 – 18 year olds. The assumption that boys and girls under 18 are "too young" to need Sexual and Reproductive Health information and services ignores the realities and environmental factors and denies young people from acquiring practical knowledge and skills they need to protect themselves and their partners from STIs/HIV, pregnancy, unsafe abortion or childbirth, and sexual abuse or violence. Young adolescents have the right to receive comprehensive information, education, health services, and other social and legal supports during this highly formative stage of their lives. Results are lack of knowledge, lack of access to modern contraceptives, lower social status and sexual harassment of women; violence against homosexuals, an increase in HIV-infections and life-long psychological and physical damage caused by unsafe abortions carried out as a result of inadequate prevention of unwanted pregnancies and restriction. Young people who seek Reproductive Health services often face judgmental health providers who offer neither confidentiality nor privacy. In Pakistan, the few projects that are there for Reproductive Health of young people focus on delaying child bearing and birth control and not on the over all well being of young people or on providing opportunities to practice and exercise their rights. These programmes focus more on SRH as a public health agenda and less on the effects on individuals and their rights.

In the area of SRHR a remarkable difference exists between public statements and acts by political, religious and other leaders in the public domain, and what can be said and done in smaller, safer environments by people "on the ground". To address these issues leadership from the very top is the key, therefore advocacy with the relevant stakeholders from different levels of Government is the key to initiate and sustain the programmes. SRHR education and information on these issues should be part of the education system. Young people are dependent on the accountability of adult policymakers, programme directors, clinicians, teachers and parents so programmes on SRHR of young people should take in account working with these target groups to ensure their participation and sensitization to create a more conducive environment for young people.

1.2- Objectives and Target Group

The overall objective of the assessment part of the project / research was the mapping and assessment of SRHR situation in Pakistan as a first country in Asian region through a newly developed and tested assessment tool- Sexual Health Rights Assessment Framework (SeHRAF) contributing to the existing pool of evidence based knowledge available on SRH rights issues in Pakistan with specific and particular focus on young people. The process was aimed to lead towards an enabling environment in the society at various levels of policy as well as community for realization, practice and implementation of SRHR through increased awareness among stakeholders from local government officials, media, religious groups, parents, school community, civil society organizations and parliamentarians. The operational objectives are as follows:

- Contextualize, define and asses the indicators of Sexual and Reproductive Health and Rights (SRHR) of young people in Pakistan.
- Provide an assessment of the SRH Rights of young people at the initial stage of project implementation through the findings of the National Research Report.
- Serve as a basis to initiate interventions to create an enabling environment in which Sexual and Reproductive Health is considered as a basic human right that can be practiced by young people.

The main and direct target group of the research were the 'SRHR knowledge bearers' who had experience of working with young people (boys and girls) belonging to the age group of 12 to 24 years. The Knowledge bearers were professionals from civil society organizations, government departments, health and formal / non-formal education systems, media and international development agencies.

1.3- Background

Sexual and Reproductive Health is a right for both men and women. This was agreed by 180 nations at the 1994 International Conference on Population and Development (ICPD). As well, various international human rights instruments and laws include and recognize men and women's Sexual and Reproductive Health Rights (SRHR). According to Action Canada for Population and Development (2009) Sexual and Reproductive Health is a vital first step for both women and men. It leads to broader choices in life, empowerment and a chance to escape from the poverty that afflicts so many of the world's people, particularly women.

Development agencies have long addressed issues of sexuality and reproduction. However, traditionally, they have dealt with them in largely negative ways. Whether through population programmes or the use of scare tactics in HIV prevention work, sex and sexuality have been regarded as a problem that needs to be controlled - rather than a positive force that can be part of the solution. Now, as a result of international agreements and activism from non-governmental organizations over the past two decades, new approaches are emerging which recognize sexual and reproductive health and rights as human rights - an end in themselves - as well as being central to health and well-being. These positive approaches recognize that good reproductive health, and the realization of sexual rights, including rights to pleasure and fulfillment, are crucial for achieving equity and social justice. Indeed, sexual well-being is integral to human development, underpinning all the major health and development goals. As rates of HIV infection continue to rise, and women's and men's sexual and reproductive ill-health threatens international development targets, there has never been a more pressing need to make positive connections between sexuality, health and human rights.

Sexuality is an integral part of the personality of every human being. Its full realization hinges upon the fulfillment of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. Sexuality is constructed through the interaction between the individual and social structures (World Association of Sexology 2009). Without the full development of an individual's sexual being it is impossible to ensure an individual's interpersonal and societal well being. Sexual rights are universal human rights based on the inherent freedom, dignity and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, International Planned Parenthood Foundation (IPPF) chalked out the Charter of Sexual and Reproductive Health and Rights, which ought to be recognized, promoted, respected and defended by all societies through all means (IPPF 1994). Sexual health is the result of an environment that recognizes respects and exercises the sexual rights.

Today SRH Rights are increasingly being recognized as commanding integral importance vis a vis human health and well-being. It is for this reason that 3 out of the 8 Millennium Development Goals (MDGs) focus directly or indirectly on issues related to Sexual and Reproductive Health. While MDGs 3, 4 and 5 (focusing on gender equality, combating HIV/AIDS and child and maternal health) directly alleviating SRH Rights, other MDGs are also subtly linked with the same (EuroNGOs 2009). In the developed quarters of the world, it is widely believed that poverty is intrinsically linked with Sexual and Reproductive Health and until there is universal access to the same, eradication of widespread poverty cannot be achieved (Kvinna till Kvinna 2009).

In 2006, nations began moving away from merely assessing the development made towards reaching the MDGs, and heading towards chalking out definite strategies and national plans for meeting the goals (EuroNGOs 2009). This provided clear scope for constructive intervention on the part of the SRHR and development communities to support policy and implementation of appropriate initiatives (Ibid). It is then believed that advocates must continue to build on the World Summit momentum and develop even more support for SRHR (Ibid). For this purpose countries around the world have begun taking SRHR as an important theme for the realization of Millennium Development Goals. In this realm, the health of adolescents is being paid special attention. According to WHO (2000) addressing the needs of young people, and endorsing healthy Sexual and Reproductive development, maturation and behaviour, undoubtedly represent a considerable challenge for many countries. This need is all the more pressing as more than 1.5 billion people are between the ages of 10 and 25 (UNFPA 2009). This largest-ever generation of adolescents is approaching adulthood in a world their elders could not have imagined (Ibid). Globalization, the AIDS pandemic, global warming, electronic communications and a changing climate have irrevocably altered the landscape (Ibid). According to UNFPA (2009):

> *"More than half of young people live in poverty, on less than $2 per day. Often they lack access to the technology and information. Many also face social inequality, poor schools, gender discrimination, unemployment and inadequate health systems. They deserve better. And investing in them is an investment in the future leaders of families, communities and nations".*

The Programme of Action stemming from the International Conference on Population and Development propounds a holistic perspective for achieving population and development goals. It reiterated that reproductive rights are an intrinsic component of human rights and have been acknowledged in various international treaty documents and consensus documents and emphasizes the importance of:

- Meeting the needs and aspirations of individual women and men for a better quality of life;
- Achieving gender equality and the empowerment of women;
- Making family planning universally available in the context of a broad reproductive rights and reproductive health approach;
- Expanding access to education, especially for girls; and,
- Reducing infant, child and maternal mortality.
- Ever since the emergence of ICPD, a number of international instruments have surfaced that acknowledge the importance of SRH Rights of men and women. The **international human rights instruments that include and recognize Sexual and Reproductive Health and Rights include:**

- Universal Declaration of Human Rights
- The International Covenant on Civil and Political Rights;
- The International Covenant on Economic, Social and Cultural Rights;
- The Convention on the Elimination of All Forms of Discrimination Against Women;
- The Convention on the Rights of the Child; and,
- The International Convention on the Elimination of All Forms of Racial Discrimination.

The above synopsis manifests the importance of realizing Sexual and Reproductive Health and Rights for vibrant, forward looking societies to flourish. However, sadly, SRHR bring the subject of a number of interational covenants still remains a neglected cause in Pakistan. Consequent governments have been engaged in development initiatives that are divorced from Sexual and Reproductive Health needs of the population and the cultural barriers around thus subject have not done much to address government's reluctance to take SRHR onboard as an important theme for national development.

This research report is divided into 6 chapters, including the introductory chapter. The last section of "Introduction" will also provide the readers with the situation analysis regarding the state of SRH Rights in Pakistan. The consequent chapters will elaborate in detail the "Methodology" that was adopted for the purpose of assessing the SRH Rights' status of young people, followed by the narration of both quantitative and qualitative findings. Chapters 4, 5 and 6 will then go on to sum up the findings in the "Conclusions" section, offer "Discussion" into the results received and finally give "Recommendations" for improving the Sexual and Reproductive Health and Rights indicators for young people in Pakistan.

1.4 - Situational Analyses

Right to Life:

Article 3 of UDHR defines the right to life as "…the right to life, liberty and security of person" (UN 2009). This fundamental right has also been reflected in IPPF's 1994 SRHR Charter stating, "The Right to life should be invoked to protect women whose lives are currently endangered by pregnancy". In the same realm, IPPF's 2008 Sexuality Declaration talks about this right in **Article 3, "**The rights to life, liberty, security of the person and bodily integrity".

According to IPPF (1997) Right to Life can be used to propagate for such things as safe motherhood practices including using contraceptives to prevent such pregnancies that carry high risk for maternal and infant mortality and morbidity. On the flip side this Right to life also encompasses advocacy for easy access to sexual and reproductive health facilities as well as legal and economic provisions to facilitate access to such facilities as well as the creation of an enabling environment where they can be made use of with out condemnation or offense (Ibid). Apart from UDHR, this particular right is also supported by ICPD Programme of Action (Ibid).

The constitution of Pakistan phrases this right in Article 35 with the pledge by the State to "….protect the family, mother and child". To ensure the implementation of this fundamental human right and specifically in the context outlined by the constitution, the Government adopted the National Health Policy in 2001 to bring about an overhaul of the Health Sector in Pakistan (Ministry of Health 2009a). As a result of this policy National Programme for family Planning & Primary Health Care and National Maternal, Neonatal and Child Health Programme were initiated. (Ministry of Health 2009b). The National Health Policy aims to reduce the maternal mortality rate to 250 per 100,000 live births by 2010.

However, despite the legal cover complimented by a relevant policy and service delivery mechanism, as reported by The Daily Times (2007), Ministry of Health revealed the maternal mortality rate in Pakistan to be 500 deaths per 100,000 births, while it is highest within the country in Balochistan at 673 (Ghauri 2007). One of the major reasons for this high maternal mortality rate is malnutrition, which affects 34 percent of pregnant women (Ibid). Around 48 percent of lactating mothers have a calorie intake of 70 percent less than the recommended level, something which is bad for both health of the mother and baby (Ibid). Another reason is

child delivery at home without assistance by trained medical attendants. The MMR is much higher in Pakistan's rural areas than in urban areas. For example, the MMR in Karachi is 281 compared to 673 in rural Balochistan (Ibid). This is largely due to the fact that skilled medical staff attends a fairly low proportion of births in rural areas. As reported by Aslam, Aftab and Janjua (2005) there was 1 doctor available for 1, 432 patients compared to 390 patients per doctor in United States. In addition, 45 percent of Pakistani women suffer from iron deficiency that results in stillbirths, birth defects, mental retardation and infant deaths. Hemorrhage, hypertension, unsafe abortion, infections and prolonged labour are other factors contributing to the higher mortality rate among women in rural areas.

Right to Liberty and Security

Article 7 of UDHR states (UN 2009); ***"All are equal before the law and are entitled without any discrimination to equal protection of the law"***. Moreover, this right also receives mention in Fourth World Conference on Women (FWCW) Platform of Action concerning practices and acts of violence against women (IPPF 2003). Once again, both the Charter and the Declaration penned by International Planned Parenthood Federation, speak of this right. The 1994 SRHR Charter states, "All persons must be free to enjoy and control their sexual and reproductive life and that no person should be subject to force pregnancy, sterilization or abortion"; while 2008 Sexuality Declaration covers the Right to Liberty and Security once again Article 3.

Right to liberty and security of a person advocates protection of all humans from sexual abuse and protection from medical intervention related to sexual and reproductive health unless it is carried out with the full and informed consent of the concerned person (Ibid). The latter point thus emphasizes upon forced sterilization and/or abortion. According to IPPf (2003), this right also advocates against laws or practices requiring spousal or parental consent for contraception or abortion, against laws that imprison women for terminating their own pregnancies and forced pregnancies or continuation of the same.

With regard to the Constitution of Pakistan, the law which lies closest to the Right to Liberty and Security of a person, falls in Article 9 of Chapter 1, stating ***"No person shall be deprived of life or liberty save in accordance with law"*** (Government of Pakistan 2009).

This right then essentially encompasses the idea of sexual autonomy. According to Helmut (2004) "sexual self-determination" enshrines two basic things: the right to engage in wanted sexuality and the right to be free and protected from unwanted sexuality, from sexual abuse and sexual violence. Unless both these aspects are met, human sexual dignity can not be realized in its true essence (Ibid).

However, there is no policy or law in Pakistan, which specifically protects the freedom to control one's sexual and reproductive life; neither are there laws that endorse an individual's right to practice or her sexual rights according to their free will. On the other hand, laws have been enunciated against both, perpetrators of sexual abuse as well as those who indulge in sexual activity outside wedlock (Interpol 2009). In Pakistan, there is no separate law or section dealing exclusively with sexual intercourse with a child (Ibid).

Services in this regard are mainly provided under the Ministry of Interior; such as a network of law enforcement agencies around the country, which are designated with the task of up holding the mission of the Ministry (Ministry of Interior 2009). However, very often police and other law enforcement agencies have been known to hinder the course of justice and worst of all be party to unlawful activities such as abductions and rape. In "Double Jeopardy: Police Abuse of Women in Pakistan," released by Asia Watch and the Women's Rights Project, two divisions of the New York-based Human Rights Watch, charged the government of Pakistan with responsibility for an epidemic of unpunished police violence against women (Human Rights Watch 2008). The 106-page report revealed that more than 70 percent of women in police custody were subjected to physical and sexual abuse by law enforcement agents in Pakistan (Ibid). The report also revealed that police routinely deny women basic protection due them by law. Police often refuse to register rape complaints by women, particularly if the complaint implicates an officer (Ibid).

Right to Equality and to be Free from all Forms of Discrimination

UDHR categorically states in its very first Article (UN 2009) that "All human beings are born free and equal in dignity and rights". With specific reference to gender discrimination this particular right can also be cited in various paragraphs of ICPD Programme of Action and FWCW Platform for Action (IPPF 2003). For instance, Chapter I of FWCW Platform for Action, paragraph affirms the commitment of all the United Nations (1995) to:

> ***"Take all necessary measures to eliminate all forms of discrimination against women and the girl child and remove all obstacles to gender equality and the advancement and empowerment of women".***

IPPF's 2008 declaration takes this right a step forward, "Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender". The right to equality and to be free from all forms of discrimination then stands for laws that prohibit discrimination against any minority group and their effective enforcement; freedom from prejudicial, customary and other practices that are based on the idea of the inferiority of women and gender sensitive interpretation of human rights (IPPF 2003). Moreover, IPPF (2003) also defines the scope of this right to campaign against discrimination with regard to sexual and health care services where women need spousal consent but men don't; where young people need parental consent and where services are only made available to married women. Moreover, it also includes discrimination against women, which denies them access to appropriate nutrition and care as well as legal protection against violence, especially domestic violence (Ibid). Here it is also important to mention that the scope of this discrimination also extends to other genders and sexualities and/or marginalized strata of the society including transgender people, bisexuals and homosexuals.

Researches reveal that gender discrimination and other forms of social exclusion have very direct effects on sexual and reproductive health (DFID 2004). They increase vulnerability to HIV and other sexually-transmitted infections, particularly amongst younger girls and women (Ibid). Social restrictions and decision-making power in the household, limit women's use of services and ability to adopt healthy sexual and reproductive behaviour (Ibid). "***The 2004 UN Commission on Human Rights explicitly recognized women's sexual rights as essential to combating violence and promoting gender equity"*** (Ibid).

Complimenting this right, the Ministry of Social Welfare (2009) states:

> ***"Social Welfare is on the concurrent list of subjects. It is concerned with the well being and uplift of the community at large and vulnerable groups in particular. Focus of the programs is on the neglected, disadvantaged, underprivileged and exploited children, women, youth, aged, disabled, indigents, destitute, beggars, prisoners and ex-convicts etc".***

However, human rights' organizations have a different tale to narrate. The New York-based Human Rights Watch, in one of the most detailed reports on domestic violence in the country published in 1999, found that up to 90 percent of women in Pakistan were subject to verbal, sexual, emotional or physical abuse, within their own homes (IRIN 2007). Women's rights activists have long argued that the issue is linked to the "second class" status of women in society (Ibid). This is a reality reinforced by laws that discriminate against them in terms of the right to inherit property, the amount of blood money given as compensation for physical hurt, and by the failure to eradicate traditions such as 'vani', under which a woman is handed over in marriage to an aggrieved party to settle a dispute, usually after a murder (Ibid). Moreover, few Pakistani women are aware of their rights; they accept the regular slaps, kicks and severe verbal abuse meted out to them by their husbands as "what can be expected in married life" (Ibid).

At the government level, there are shelter homes for women, known as "Darul Aman" (i.e. house of peace). According to a research carried out by Medicines du Monde (2007most of the women residing in Dar-ul-Amans (DUA) fled their homes after years of domestic violence, and seek divorce, remarriage or just protection. They access these institutions, usually voluntarily and heavily traumatised, by court orders. However, the custodial

control exercised over them, the difficult living conditions, as well as the deficit of appropriate services, have a negative impact on the psychological health of the residents (Ibid).
Even more perturbing is the situation of people belonging to other genders and sexualities. The recent case study of Shazina and Shumail (elaborated in the box below) amply highlights the miserable plight of people belonging to such communities or backgrounds. The case study illustrates that not only are such people not accorded due respect by the society but are also discriminated against in the law.

The Right to Privacy
The Right to Privacy includes the right to make autonomous decisions regarding one's Sexual and Reproductive life, and to have the privacy to do so respected (IPPF 2003). This right can be used to ensure that service guidelines will ensure that personal information given will remain confidential (Ibid). Moreover, according to IPPF (2003) this right also stands for legal frameworks that recognize the right of individuals to make autonomous choices related to reproduction and sexuality including safe abortion. Right to privacy also advocates reproductive health information and services for young people, which respect their privacy (Ibid). This right can in addition be used to advocate against forced pregnancy and continuation thereof; breach of confidentiality and laws and practices requiring spousal or parental consent for contraception or abortion (Ibid).

In Paragraph 93, FWCW Plan of Action talks about a woman's right to privacy, confidentiality and respect while Paragraph 103 it talks about how women are frequently not treated with respect, nor are they guaranteed privacy and confidentiality, nor do they always receive full information about the options and services available (UN 1995). Accordingly, outlining "Actions to be Taken", Paragraph 106 (f) of FWCW urges the governments to work in partnership with non-governmental organizations and employers' and workers' organizations and with the support of international institutions to "***Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality…"*** (Ibid).
Moreover, the Universal Declaration of Human Rights in Article 12 also reiterates every individual's right to not be ***"…subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation".***

Thus, if studied in the context of Sexual and Reproductive Health and Rights, then the Right to Privacy had direct relevance with doctors and healthcare providers vis-à-vis their patients. Ancient ethical codes were often compiled in the form of oaths, the most famous being the Oath of Hippocretes (Mehmood 2005). Whilst the earlier notions of 'no-harm' and 'best-interest' have been preserved, their application has evolved from paternalism into practices of informed consent, privacy and confidentiality that now find their place among the fundamental concepts of medical ethics (Humayun, Fatima, Naqqash, Hussain, Rasheed, Imtiaz, and Sardar Zakariya Imam 2008).

While these codes of conduct are universal, however the situation on ground in Pakistan shows otherwise. According to a research conducted by Bio Med Central it was revealed that doctors took proper informed consent from very few patients coming to these hospitals (Humayun, Fatima, Naqqash, Hussain, Rasheed, Imtiaz, and Sardar Zakariya Imam 2008). One of reasons behind such practice is that the cultural trends in Pakistan still tend to accept the paternalistic model of medical care (Ibid).

This restrictive culture is not specific to information only but also extends to such things as spousal consent. Spousal consent and notice laws require a pregnant woman to obtain written consent from, or give notice to, her husband prior to receiving such services as abortion (NARAL 2009). Such laws severely restrict a woman's right to make decision about her own body and health (Ibid). A significant number of women in this country are victims of systematic physical and psychological abuse at the hands of their husbands (Ibid). Consent and notice requirements become a substantial obstacle when a woman fears for her safety and the safety of her children if she must tell an abusive husband about her decision to end a pregnancy. More recent legislation on this issue requires a pregnant woman to obtain consent from, or give notice to, the man involved in the pregnancy regardless of her relationship with him (Ibid). Such a requirement can delay a woman from seeking earlier, safer abortion care, thus putting her health at risk(Ibid).

The Right to Freedom of Thought

This right stands for every individual's right to make decisions about sexual and reproductive health and rights and the right to seek, receive and impart information and ideas via any media (IPPF 2003). It can be used to campaign for:

> ***"The right of health care professionals to conscientious objection with regard to their participation in providing contraception and safe abortion services provided that they can refer the client to health professionals willing to provide the service; however, no such right exists in emergency cases where lives are at risk (Ibid)".***

Article 6 of IPPF's Declaration of Sexual Rights talks about this right under the heading of "Right to freedom of thought, opinion and expression; right to association" while its predecessor states that "The Right to Freedom of Thought should be invoked to protect the right of all persons to access education and information related to their sexual and reproductive health free from restrictions on grounds of thought, conscious and religion".

According to IPPF (2003), this right can also be used to propagate against restrictions on the grounds of thought, conscience and religion to access to Sexual and Reproductive Health and Rights information and services. While Article 18 of the Universal Declaration of Human Rights mentions every person's right to "freedom of thought, conscience and religion" (UN 2009), however, the main sources of international law from which this right derives its essence include the International Covenant on Civil and Political Rights, the World Conference on Human Rights, and the World Medical Assembly on the right to freedom of thought, cultural differences and conscientious objection respectively (IPPF 2003).

As outlined above, provision of safe abortion services figure prominently in what this Right stands for. The reality factor, however, is that there are still more 'technically illegal' abortions than legal ones (Ibid). Amongst other factors, one of the main obstacles to access to this constitutionally enshrined human right is the right to conscientious objection/refusal (Ibid).

> ***"Although the right to conscientious objection is also a basic human right, the case of refusal to provide abortion services on conscientious objection grounds should not be seen as absolute and inalienable, at least in the developing world. In the developed world, where referral to another service provider is for the most part accessible, a conscientious objector to abortion does not really put the abortion seeker's life at risk. The same cannot be said in developing countries even when abortion is decriminalized. This is because referral procedures are fraught with major obstacles. Therefore, it is argued that the right to conscientious objection to abortion should be limited by the circumstances in which the request for abortion arises"*** (Ibid).

The UN staff on the Committee on the Elimination of ALL Forms of Discrimination Against Women (CEDAW) committee have been attempting to influence several nations to do away with their laws that make abortion in their country illegal (Café Theology 2007). As reported by Café Theology (2007) in 2007 Pakistan, undergoing its first review, had told CEDAW that abortion was considered murder once a fetus was conceived and defended its law allowing abortions in the rare instance when the pregnancy threatens the mother's life.

The Right to Information and Education

The key concept of this right encompasses access to information and education on sexual and reproductive health and rights for all (IPPF 2003). It invokes the right of youth to have access to sexual and reproductive health and rights information and education; provision of SRHR information and education programmes that are gender sensitive, free from stereotypes, and presented in an objective, critical and pluralistic manner as well as programmes that enable service users to make all decisions on the basis of full, free and informed consent (Ibid). Provision of education for all, in generality, has been accorded mention in Article 26 (clauses 1 and 2) of UDHR. As explained by UN (2009), Article 26 reads as follows:

> ***"Article 26 (1): Everyone has the right to education.***
> ***Article 26 (2): Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms".***

However, when specifically talking about SRHR education, this specific right consists of paragraphs from the ICPD Programme of Action and the FWCW Platform for Action concerning the need for education, specifically sexual and reproductive health information and education, education for young people, and the need to remove unnecessary barriers preventing access to information and education (IPPF 2003).

Article 26 (clauses 1 and 2) are dedicated to the right of providing information and education to all. As explained by UN (2009), Article 26 reads as follows:

> ***"Article 26 (1): Everyone has the right to education.***
> ***Article 26 (2): Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms".***

The state of sex education programmes in Asia is at various stages of development. Indonesia, Mongolia, South Korea have a systematic policy framework for teaching about sex within schools. On the other hand, Bangladesh, Myanmar, Nepal and Pakistan have no coordinated sex education programmes (UN ESCAP 2009).

UNESCO (2009) developed International Guidelines on Sexuality Education: An Evidence Informed Approach to Effective Sex, Relationships and HIV/STI Education". These *International Guidelines* have been developed primarily to assist education, health and other relevant authorities in the development and implementation of school-based sexuality education programmes and materials. It does this primarily by recommending a set of age-specific standard learning objectives for sexuality education.

The right to education is enshrined in Article 37 (b and c) of the Constitution of Pakistan in the following manner:

> ***"The State shall remove illiteracy and provide free and compulsory secondary education within the minimum possible period; make technical and professional education generally available and higher education equally accessible to all on the basis of merit".***

While no where in the constitution or the Education policy, is sex education mentioned, it is worth mentioning here that Pakistan is one of the 164 signatories of Dakar Education for All (EFA), which very clearly identifies and states "Life Skills" as a basic learning need for all young people. However a number of non-governmental organizations have been working on various projects to impart the same to children at various levels of schooling. After concerted efforts from various indigenous and international organizations working on SRH Rights, the Ministry of Education has developed a Life Skills Based Education curriculum; however it is yet to be implemented in schools.

The Right to Choose Whether or not to Marry and to Found and Plan a Family

Under this SRH Right, all persons have the right to choose voluntarily whether or not to marry and to found and plan a family (IPPF 2003). This Right stands for non-discriminatory access to sexual and reproductive health services, including family planning, infertility treatment, and the prevention and treatment of sexually transmitted infections, including HIV/AIDS and stands against the practice of marriage without the full, free and informed consent of both individuals concerned; child marriage; forced pregnancy, or continuation thereof and forced sterilization (Ibid).

The Universal Declaration of Human rights categorically mentions this right in Clauses 1 and 2 of Article 16 in the following words (UN 2009):

> ***Article 16 (1): Men and women of full age, without any limitations due to race, nationality or religion, have the right to marry and to found family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.***
> ***Article 16 (2): Marriage shall be entered into only with the free and full consent of intending spouses***

IPPF has also based this right on paragraph from the ICPD Programme of Action concerning the need for strictly enforced laws that ensure that marriage is entered into only with free and full consent and the requirement of a minimum (IPPF 2003). Moreover, 2008 Sexuality Declaration also mentions this right in Article 9 Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children

Despite being among the SRH Rights that is mentioned explicitly in some of the most authentic legal documents, facts and figures reveal that much needs to be done for its enforcement. In southern Benin, for instance, girls aged 10-13 are often forcibly removed from their families and taken away to be child brides (IPPF 2009). In Asia and Eastern Europe, girls as young as 13 are trafficked as 'mail order brides' (Ibid).

When we discuss Pakistan specifically, no provision in the constitution of Pakistan endorses this universal human right. Although 1997 Saima Waheed case sets a precedent whereby a women's right to marry was up held but called for amendments in the current family laws to discourage "love marriages" (Bret Marston 2003). In some parts of the country, expressing a desire to choose a spouse and marrying a partner of one's choice are seen as major acts of defiance in a society where most marriages are arranged by fathers (Amnesty International 1999). They are seen to damage the honour of the man who negotiates the marriage and who can expect a bride price in return for handing her over to a spouse (Ibid).

With regard to the service delivery mechanism, while the Government offers no services for the establishment of this right, a number of non-governmental organizations advocate for the right to choose whether or not to marry and found a family and offer legal as well as shelter services to women facing opposition to marry out of their free will (Ibid).

The Right to Decide whether or When to have Children

According to IPPF (2003), under this right ***"All persons have the right to decide freely and responsibly on the number and spacing of their children. This includes the right to decide whether or when to have children and access to the means to exercise this right".*** Article 9 of the Sexuality Declaration also includes the right.

It can be used to advocate, services that offer the widest possible range of methods of fertility regulation that are safe, effective and acceptable as well as the freedom of all women and men to choose and use a method of protection against unplanned pregnancy that is safe and acceptable to them (Ibid). It can also be used as a means to speak out against forced pregnancy, or continuation thereof and parental or spousal consent requirements for access to contraception or abortion services (Ibid).

IPPF (2003) has based this right on paragraphs from the ICPD Programme of Action and the FWCW Platform for Action concerning the right to a full range of reproductive health services and the recognition that "The ability of women to control their own fertility forms an important basis for the enjoyment of other rights" respectively (Ibid).

Much has already been discussed with regard to various abortion laws in the course of this situation analyses. Let us then focus specifically on the case of Pakistan. While no law endorsing the Right to decide whether or when to have children can be found, according to Pakistan Penal Code Article 312, if a woman is "quick with child", the penalty is imprisonment for up to 7 years and payment of a fine (Reference). The same penalty

applies to a woman who causes herself to miscarry. There are however circumstances when abortion is allowed; the following table summarizes the instances in which abortion is and is not allowed:

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	No
Fetal impairment	No
Economic or social reasons	No
Available on request	No

The Right to Healthcare and Health protection

This right provides for the highest possible level of physical and mental health services for all (IPPF 2003). According to IPPF (2003) this right can be used for:
"• Programmes that provide the highest possible quality in health care. Comprehensive health care services, including:-
- Access to all methods of fertility regulation including safe abortion
- Diagnosis and treatment for infertility and sexually transmitted infections, including HIV/AIDS
• Pregnancy and infertility counseling that empowers people to make their own decisions based on information impartially presented
• Sexual and Reproductive Health care services that are:-
- Comprehensive
- Accessible, both financially and geographically
- Private and confidential
- Respectful of the dignity and comfort of the service user
• The availability of appropriate pregnancy, confinement and post-natal services, including adequate nutrition during pregnancy and lactation".

Moreover, it can also be used to advocate against traditional practices that are harmful to health; e.g. female genital mutilation and restrictive abortion laws, especially where continuing the pregnancy would be harmful for the physical or mental health of the woman.

The Right to Healthcare and Health protection has been derived from paragraphs from the Programmes of Action of ICPD and the World Summit on Social Development and the FWCW Platform for Action concerning the provision of health care services, including sexual and reproductive health. It also contains paragraphs 7.2 and 8.25 from ICPD, which define reproductive health and deal with unsafe abortion respectively (Ibid).

Further more, UDHR also talks about in relevance of this right in the following words:

> ***"Article 21 (1): Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".***
>
> ***"Article 25 (2): Motherhood and childhood are entitled to special care and assistance…"***

The Constitution of Pakistan does not specifically talk about "Health" but Article 38(a) speaks of "raising the standard of living" of the citizens (Ministry of Health 2009). While the 2001 Health Policy also corresponds to this SRH Right, the consequent services that are offered to compliment this right encompass an extensive

system of hospitals, dispensaries, maternal and child health centers, rural health centers and basic health units run by the Federal Ministry of Health and the provincial health departments (Ministry of Health 2009).

Despite this, according to UNICEF's latest report "The State of the World's Children 2009", I in every 89 Pakistani women die of childbirth related causes compared to 1 in 8000 in the developing world. Poverty, gender and other inequalities, lack of information, weak health systems, lack of political commitment and cultural barriers are some barriers that are responsible for the this dismal state of affairs (WPF 2009).

Under the same right when we talk about people living with HIV/AIDS, in the indigenous context, it reveals that Pakistan has recently witnessed changes in the epidemiological trends of the disease owing particularly to rapid rise in infection among injecting drug users (FPAP …) and the lack of outreach to MSM communities, especially in the metropolitan hub of Karachi. According to UNAIDS estimates, some 70,000 to 80,000 persons, or 0.1 percent of the adult population in Pakistan, are infected with HIV although cases reported to the National AIDS Control Programme are less.

As in many countries, the numbers may be underreported - mainly due to the social stigma attached to the infection, limited surveillance and voluntary counseling and testing systems, as well as the lack of knowledge among the general population and health practitioners (UNAIDS, 2007). As reported by Medical News Today (2009) research published in the Journal of General Internal Medicine reveals that 26% of HIV-infected individuals reported that they felt discriminated against by physicians and other health care providers. According to the same source:

> ***"Most reported that a provider had been uncomfortable with them (20%), treated them as an inferior (17%), or preferred to avoid them (18%). According to the study, the discrimination was attributed to physicians (54%), nurses and other clinical staff (39%), dentists (32%), hospital staff (31%) and case managers and social workers (8%)".***

In Balochistan, for instance, the maternal mortality is 785 deaths per 100,000 live births which is nearly triple the national rate. It should be noted here that in rural Pakistan, the maternal mortality is nearly twice than that in cities. The sad reality is that 80 per cent of maternal deaths are preventable (DHS 2008).

The Rights to the Benefits of Scientific Progress

As the right explains, it stands for every individual's right to enjoy the benefits of scientific progress. It can be campaigned for access to the benefits of all available reproductive health technology, including newer methods of contraception, abortion, and infertility treatment, provided those technologies are safe and acceptable; the provision of information on any harmful effects of reproductive health care technology and to campaign against the withholding of access to safe and acceptable reproductive technologies (IPPF 2003).IPPF (2003) has based this right on ICPD Plan of Action as well as World Conference on Human Rights Vienna Declaration and Programme of Action concerning the need for research on new methods of fertility regulation; methods for men, the involvement of the private sector and the need to respect human rights and dignity in research in biomedical and life sciences. Moreover, International Covenant on Economic, Social and Cultural Rights, 1966, Art. 15.1 states: "The States Parties to the present Covenant recognize the right of everyone ... (b) to enjoy the benefits of scientific progress and its applications" (IPPF 2009c). Facts and figures reveal that with regard to Sexual and Reproductive Health and Rights, a lot of scientific progress has been done in the world.

On the contrary, this particular right, is not merely absent from the national constitution but also does not have scientific work in the local context. Ministry of Science and Technology (2009) comes with an elaborate policy and its mission statement aims to ***"…improve the living standard of masses and ensuring the national security through S&TR applications"***. Nevertheless no where in the S&TR policy or in the related services is any mention of technologies specific for the progress of SRHR.

The Right to Freedom of Assembly and Political Participation

The Right to Freedom of Assembly and Political Participation includes the right to form and join a non-governmental organization (NGO) to advance sexual and reproductive health and rights (IPPF 2003).

This right can be used to advocate active individual or NGO advocacy in the field of sexual and reproductive health and rights and can be used to advocate against persecution of individuals or organizations who seek to influence national policy on matters relating to sexual and reproductive health and rights (Ibid).

It is based on standard sections of paragraphs from the ICPD Programme of Action concerning the need to respect sexual and reproductive rights as human rights; for governments to involve NGOs in decision-making; to increase the participation of women, and women's organizations in sexual and reproductive health and rights work and increase the capacity of NGOs to participate effectively in the implementation of the Programme of Action (Ibid). Moreover, Article 20(1) that compliments this right in the UDHR states, ***"Everyone has the right to freedom of peaceful assembly and association".***

The international facts and figures reveal vigorous activism in line with this right on various issues and forums.

Endorsing the Right to Assembly and Political participation, the Constitution of Pakistan states (Government of Pakistan 2009):

"Article 16: Every citizen shall have the right to assemble peacefully
Article 17 (1):Every citizen shall have the right to form associations or unions…"

Over the years, a number of efforts have been made to advocate for Sexual and Reproductive Health and Rights. The efforts have produced mixed results. The civil activism has mainly been against discriminatory laws that infringe a number of women's rights. The **Hudood Ordinance** is of special mention here as this law enacted in 1979 as part of then military ruler Zia-ul-Haq's Islamization process led "***hundreds of incidents where a woman subjected to rape, or even gang rape, was eventually accused of Zina***" (HRCP 2004). In 2006, then President Pervez Musharraf again proposed reform of the Ordinance (Dawn 2006). On November 15 2006, the Women's Protection Bill was passed in the National Assembly, allowing rape to be prosecutable under civil law (Ibid). The bill was ratified by the Senate on 23 November 2006, and became law after President Musharraf signed it on 1 December 2006 (Ibid).

Asian Centre for Human Rights (2006) stated that the revised Protection of Women (Criminal Laws Amendment) Bill, 2006 fell short of Pakistan's obligations under international human rights law.

As reported by Human Rights Education associates (2006):

> ***"Any relief provided to those charged under these unjust laws is welcome," said Brad Adams, Asia director of Human Rights Watch. "But the proposed amendments don't end the discrimination. The Hudood Ordinances are fundamentally flawed and must be repealed in their entirety."***
>
> ***Human Rights Watch said that Pakistan should ensure that it complies with its obligations under the Convention on the Elimination of Discrimination Against Women, which calls on states to modify or abolish laws that discriminate against women. Human Rights Watch called on Pakistan to decriminalize adultery and non-marital consensual sex and adopt rules of evidence that give equal weight to testimony given by men and women.***
>
> ***In addition, Human Rights Watch said that Pakistan should improve support services such as shelters and burn units for women, raise public awareness about the laws and better train police to deal with victims of sexual assault".***

The Right to be Free from Torture and Ill-Treatment

Under this IPPF right, all men, women and children have the right not to be subjected to torture or to cruel, inhuman or degrading treatment and not to be subjected to medical or scientific treatment without free and informed consent (IPPF 2003). This right can then be used to advocate protection of all persons from rape,

sexual assault, sexual abuse, sexual harassment and violence, including domestic violence (Ibid). It can also be used to campaign against degrading treatment and violence against women and men in relation to their sexuality and reproduction as well as domestic violence (Ibid).

It consists of paragraphs from the Programmes of Action of ICPD and the World Summit on Social Development and the FWCW Platform for Action concerning the elimination of all forms of exploitation, abuse, harassment and violence against women, adolescents and children; measures to address the root factors that encourage trafficking in women and girls; condemnation of the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ensuring that ethical professional standards, conforming to human rights, are applied to the delivery of health services (Ibid).

Further, as enshrined in international law, Article 5 of UDHR states, ***"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment"*** (UN 2009). On the other hand, Article 3 of the Sexuality Declaration also speaks of this right under the heading of "Article 3 The rights to life, liberty, security of the person and bodily integrity".
The inadequate legal cover for women in Pakistan has already been elaborated upon. While Article 14(2) of the Constitution of Pakistan, 'No person shall be subjected to torture…", this right is not specific to sexual and reproductive health.

According to a report published by Amnesty International (1995):

> ***"Women in Pakistan suffer widespread human rights violations. Police officers torture and rape women in their custody with impunity. If the victims bring complaints of rape before the courts, unless they can prove that they did not give their consent they may be punished for unlawful sexual intercourse under laws which explicitly discriminate against women. Women face cruel, inhuman and degrading punishments such as floggings and stoning to death".***

While, there has been relative improvement in the situation since 2006 when the Women's Protection Bill was passed, the situation in Pakistan's tribal areas is still not alarming, where women are subjected to inhuman treatment in the name of Taliban Justice (World Watch 2009).

Chapter 2: Methodology

Design of the Research

A mixed method data collection approach was used that consisted of a quantitative self-completion survey of Knowledge Bearers' perceptions of the status of SRHR of young people in Pakistan as well as additional Focus Group Discussions and In-depth Interviews with Knowledge Bearers from diverse target groups and various areas of the country. For the quantitative survey a new SRHR Assessment Tool was developed by the project team.

Development of the SRHR Assessment Tool

The development of the tool for the Sexual and Reproductive Health Rights Assessment Framework (SeHRAF) embodied an extensive process of brainstorming, consultations and feedback only after which it was finalized.

Initially the International Planned Parenthood Federation's Charter of Sexual and Reproductive Health and Rights, which surfaced in 1994, was taken as the primary reference document for the tool. This was the case because not only was the 1994 Charter based on international agreements, such as the Universal Declaration of Human Rights (UDHR), ICPD and CEDAW, but it also provided a clear set of 12 rights specifically in the SRHR context. This provided the tool development process with a head-start as in the presence of the Charter – providing a sound theoretical framework – there was little need to start from scratch to identify core SRHR issue. However as more headway was made, other documents, such as IPPF's 2008 Sexuality Declaration, were also used as a reference to enrich the issues covered under the original set of Sexual and Reproductive Health and Rights. This led to the inclusion of the related SRHR issues of marginalized groups such as sex workers, homosexuals, bisexuals and transgender people.

Moreover, related documents, such as the Plan of Action resulting from the International Conference on Population and Development (ICPD), the WHO Framework for Priority Linkages of Sexual and Reproductive Health & HIV/AIDS; the Convention on the Elimination of All Forms of Discrimination Against Women and the Universal Declaration of Human Rights (UDHR), were also studied by the project team to develop a comprehensive understanding of SRH Rights, including their definition and issues covered. Here it needs to be emphasized that in the final assessment tool the SRH Rights identified in the IPPF Charter, only served as a broad framework to gauge the realization of a wide range of specific issues related to Sexual and Reproductive Health Rights as set out in the various internationally acknowledged agreements. It also needs to be noted that the Assessment Tool only covered 11 of the 12 Rights as the topic of "Political Participation" (Right 11) vis-à-vis SRHR was something that could be investigated better if asked directly from the young people instead of the Knowledge Bearers. Accordingly, this topic was dealt with during the Focus Group Discussions with adolescents and young adults.

Together with an International consultant, Professor John de Wit, Director of the National Centre in HIV Social Research at the University of New South Wales Australia, the project team engaged in several extensive, internal brainstorm sessions to develop a preliminary set of indicators of each SRH Right. These brainstorm sessions resulted in a matrix in that for each Sexual and Reproductive Health Right specified the following:

- Contextualized and detailed description of the Right as derived from the IPPF 1994 Charter;
- Enrichment of the definition from other relevant sources, including IPPF's 2008 Sexual Health Rights Declaration;
- Potential indicators for Assessment of the SRH Rights in Pakistan (and)
- Proposed questions against the indicators.

To further develop the Assessment Tool, WPF convened two National Panels of SRHR Experts (See Annexure IIa for details of National Panellists). To gain maximum input from the 22 participating experts, the National Expert Panels were set-up at two locations i.e. one in Islamabad and the other one in Karachi. The members of these panels worked in close collaboration with the international consultant and WPF research team. As part of a wider brief, the National Panellists discussed the research design of the project and the adaptation of SRH Rights to the Pakistani context. Panel members in particular contributed their expertise to the further development of indicators for the assessment of SRH Rights in Pakistan as well as the questions against these indicators. In addition, extensive feedback on the indicators and related questions was received from the 12 members of an International Panel of SRHR Experts (See Annexure IIb for details of International Panellists). A comprehensive list of over 100 indicators resulted from WPF staff brainstorming and expert suggestions.

Against the feedback received from the experts, the comprehensive list was next refined in an in-house exercise to identify the most relevant indicators. Through extensive discussion, any over-lap between the indicators was resolved and any indicators that could not be measured through consultation with Knowledge Bearers were removed, resulting in a list of 70 indicators against each of which a question for the Assessment Tool was developed.

The draft questionnaire was shared with 12 Knowledge Bearers from civil society and media in Karachi for their feedback. Once again revisions were made in light of the new issues that came forth as a result of feedback received. For a second pilot test, the Assessment Tool was sent to the National Expert Panels and all staff at World Population Foundation, Pakistan and relevant expert staff at WPF, Headquarters. It was only after receiving this input that the tool was considered ready for a formal pilot-test with 50 randomly selected Knowledge Bearers. Following the completion of this pilot test, the Assessment Tool was once again fine-tuned and revised according to the feedback received.

Respondents to the Survey

The survey was conducted in a sample of experts of SRHR in Pakistan (Knowledge Bearers; i.e. people who had knowledge about SRH issues and experience of working with young people from across Pakistan). For this purpose a list of Knowledge Bearers was developed from the WPF, Pakistan mailing list of experts consisting of approximately 6,000. An e-mail was sent out to all the people on the list with the aim to confirm:

- That the e-mail addresses were entered correctly;
- The location of the potential respondents (and)
- Their willingness to be on our list of potential participants.

As a result of this exercise, the list was narrowed down to 1600 Knowledge Bearers as potential respondents. Furthermore, other SRH-focused organizations, including Rozan, Heartfile, Population Council, Packard Foundation, Awaz Foundation Pakistan, Aahung and HANDS were requested to share their lists of Sexual and Reproductive Health and Rights experts. As a next step, the initial list of

about 1600 Knowledge Bearers was matched against the lists that were received from other organizations and the names that overlapped across the various lists were extracted to develop a final list of about 1000 potential respondents.

An e-mail invitation was then sent out to these Knowledge Bearers for the full scale launch of the e-survey. This e-mail contained a hyper-link to the study's website and from this electronic invitation 280 respondents (28%) were recruited. In addition, paper and pen versions of the questionnaire were shared with Knowledge Bearers across Pakistan to support rural representation, resulting in an additional 70 respondents. Accordingly, a total of 350 Knowledge Bearers participated in the survey. Participation in the survey was voluntary and confidential and this was extensively explained in the information about the survey. The respondents' e-mail address was asked in the questionnaire, but this was only done to ensure that those experts who had participated would not receive a reminder e-mail. These e-mail addresses were discarded upon termination of data collection and removed from the data set.

The characteristics of the respondents in the survey are given in the table below. What can be seen is that respondents lived all regions of the country but were predominantly from Islamabad, Punjab and Sindh. Also, the majority of the respondents lived in the urban areas. Males and females were approximately equally represented in the survey and respondents differed widely in terms of their age with the majority being mature adults. Respondents were very highly educated and over half of the respondents worked in the non-profit sector and a substantial minority worked in the public sector. The majority of the respondents were currently married and some what over a quarter were single.

Table 1. Characteristics of Survey Respondents (%)

Province	
Balochistan	6.1
FANA	2.0
ICT	21.3
NWFP	8.6
Punjab	32.3
Sindh	29.7
FATA	0.0
AJK	0.0
Urbanization	
Urban	68.9
Semi Urban	8.3
Rural	22.9
Gender	
Male	54.3
Female	47.7
Transgender	0.0
Age	
18 – 29	29.1
30 – 45	51.0
46 – 60	17.6
Over 60	2.3
Education	

Ph. D	2.3
Post Graduate	77.4
Graduate	19.4
Intermediate	0.9
Profession	
Public Sector	17.1
Non-Profit	59.1
Profit	5.4
Students	3.7
Unemployed	2.6
Other	12.0
Marital Status	
Married	65.1
Separated	1.7
Widowed	0.9
Single	28.3
Not Married, in a Relationship	4.0

Focus Group Discussions and In-depth Interviews

The initial results generated by the survey brought forth a number of areas that required further investigation. These issues were then included in the guides prepared for the Focus Group Discussions.

To have maximum representation of all stakeholders, 23 Focus Group Discussions (FGDs) were conducted with 6 groups of adolescents (12-18 years of age), 4 groups of young adults (19-24 years of age), 4 groups of members of civil society and media; 2 groups of religious leaders, 5 groups of school teachers (who also played the dual role of parents), 1 group of young transgender people and 1 group of young female sex workers. Focus Group Discussions on average included 12 participants. For the purpose of conducting these Focus Group Discussions, the research team travelled to 7 districts across Pakistan to ensure that there was representation from all the four provinces of the country. All FGDs were conducted by a trained facilitator and a second person was present to take written notes. In addition, all Focus Group Discussions were audio recorded and used as reference to compliment written notes.

Alongside the FGDs, 33 In-Depth Interviews (IDIs) were also conducted. While one set of IDIs was conducted with 28 participants identified from the FGDs, a second set was conducted with policy makers and Sexual and Reproductive Health and Rights experts whose names had been previously identified by the research team. IDIs were conducted according to the Discussion Guides developed for the FGDs. In-Depth Interviews were conducted by a trained interviewer who took written notes and audio recorded the interview.

Participation in the FGDs and IDIs was voluntary and confidential. Participants provided informed consent (written for FGDs and oral for IDIs) and no personal identifiers were included in written notes and audio recordings. Audio recordings were erased upon completion of data analysis.

Data Analysis

Quantitative data obtained with SRHR Assessment Tool were analyzed in two ways, firstly according to the SRH Rights from the IPPF Charter, and secondly according to themes. For each Right average scores across the related questions were calculated and these summary scores of Rights were compared between urban and non-urban areas.

For the thematic analysis questions were distinguished into 11 Sexual and Reproductive Health topics: Basic Healthcare Services, Family Planning Services, Infertility Treatment, Safe Abortion Services, Post Abortion Healthcare Services, Information/Education/Counseling, Relationship of Young People with Service Providers, Gender, Sex and Marriage; Gender Equality, People with HIV/AIDS and Marginalized Communities. For each of these themes mean scores and percentages of responses to each of the related questions were calculated. In addition, analyses of variance were conducted to gauge the differences in responses between respondents from urban and non-urban areas. When separate questions were asked with regard to boys and girls or the public and the private health sectors, responses were compared with paired T-tests.

Qualitative data obtained from the Focus Group Discussions and In-Depth Interviews were analyzed thematically on the basis of the written notes, complimented by information abstracted from the audio recordings when appropriate. Initial themes were identified in the guides for the FGDs and IDIs and refined on the basis of an analysis of the issues discussed in the FGDs and IDIs. Information extracted from the FGDs and IDIs was then organized according to theme. Matrices were constructed that presented extracted information against the themes from the different groups within a specific target group. In addition, a summary of information per theme was developed for each target group.

RESULTS

PART 1- THEMATIC ANALYSIS

Theme I – Basic Health Services

The responses of the participants in the e-survey regarding basic health services in their communities indicate that mean scores for availability, accessibility and quality of these services are at the mid-point of the response scale, suggesting that these are fair. The results also indicate that the community acceptance of quakes is limited. A Paired T-Test showed that the quality of basic health services was significantly higher for boys than for girls (see Annexure III for details of T-Tests). Analyses of variance showed significant differences between urban and non-urban areas for all indicators related to basic health services (See Annexure IV for details of analyses of variance); availability, accessibility, and quality of basic health services was significantly higher in urban than non-urban areas, while community acceptance of quakes was lower in Urban than non-urban areas.

Table 2. Basic Health Services

	N	Mean	SD
Availability	345	3.30	0.98
Accessibility	338	3.03	1.01
Quality for Boys	327	3.13	1.00
Quality for Girls	318	2.97	1.11
Community Acceptance of Quakes	311	2.63	0.97

Focus Group Discussions with religious leaders in Quetta and Peshawar suggested that poverty is a limiting factor in the accessibility of healthcare services. Adolescents from Lahore noted that accessibility of healthcare services was in particular an issue for girls. Teachers and adolescents from Multan added that the lack of female doctors, paired with the limited mobility of girls noted by adolescents and teachers from Peshawar and Karachi, also restricted women's access to healthcare services. Adolescents as well as young adults from Lahore were of the opinion that discomfort with doctors resulted in going to quakes and back-streets clinics. Representatives of civil society and media organizations from Mitiari and Karachi, as well as teachers from Karachi, also perceived that going to quakes was a common practice, in particular among boys, resulting from a lack of adequate information. Religious leaders from Quetta suggested that young people in particular visited quakes for the treatment of sexually transmitted infections (STIs) because no regular treatment was available. Young people from Karachi also agreed that young people involved in sex often go to quakes, as do boys who masturbate. Sex workers and transgender people felt that they were discriminated by doctors, particularly in public hospitals, and were at the risk of sexual abuse.

A female student at Bahauddin Zakariya University shared during an in-depth interview that it was not that basic healthcare services were not available, but that there was a lack of female doctors, especially in remote areas. Since parents are reluctant to take their daughters to a male doctor, many girls are given medicines without consulting a healthcare provider, if sick.

Theme II – Family Planning Services

The responses of the participants in the e-survey regarding family planning services in their communities indicate that mean scores for availability are at the mid-point of the response scale, while the accessibility and quality of these services scored lower. The results also indicate that community acceptance of family planning services is relatively favorable. Paired T-Tests showed that the quality of family planning services was limited for both boys and girls and scores did not differ significantly (see Annexure V for details of T-Tests). Analyses of variance showed significant differences between urban and non-urban areas for availability, quality for girls and community acceptance of family planning services, while marginally significant differences were found with regard to accessibility and quality of services for boys (See Annexure VI for details of analyses of variance). Scores were higher for urban than non-urban areas.

Table 3. Family Planning Services

	N	Mean	SD
Availability	341	3.05	0.98
Accessibility	322	2.70	1.00
Quality for Boys	305	2.47	1.07
Quality for Girls	302	2.42	1.11
Community Acceptance	342	3.51	0.82

Focus Group Discussions with all target groups suggested that contraceptives were easily available. However, teachers and representatives from CSOs and media were of the opinion that the attitudes of people were not very supportive of their use, especially among married couples. Members of CSOs and media from Quetta further felt that a high level of discomfort prevailed among families if they found contraceptives in the room of their married son. Focus Group Discussions with religious leaders of Quetta and Peshawar indicated they felt that awareness of family planning services should not be promoted, as it leads to sin. They were of the opinion that natural ways to prevent pregnancy should be adopted by a married couple and that they should decide about their family size in view of their economic situation. They also felt that, even if a pregnancy results after adopting natural contraceptive methods, the couple need not worry as God has taken it upon Himself to provide for every individual. Young adults and adolescents in all the target areas were aware of various types of contraceptives and places from where they could get these. However, the adolescent girls in Peshawar were less well-informed with regard to contraceptives. The FGDs also showed that young people often got contraceptives from non-professionals (e.g. shopkeepers), rather than health services.

A young adult in an in-depth interview in Karachi claimed that even 10 year olds were well aware of contraceptives, due to internet and pornography.

Theme III – Treatment of Infertility

The third theme – "Treatment of Infertility" – consisted of three sub-themes that included community acceptance of infertility treatment and attitudes of private and public healthcare providers regarding infertility. The responses of the participants in the e-survey regarding community acceptance indicate that acceptance of infertility treatment for both females and males is fair. The comparison of mean scores showed that with regard to the attitudes of healthcare professionals towards clients who want infertility treatment, attitudes in the private sector were more favorable than in the public sector. Mean scores were similar for women and men. Analyses of variance showed that there were significant differences with regard to community acceptance of treatment of infertility for both females and males between urban and non-urban areas, with scores in urban areas being more favorable (See Annexure VI for details of analyses of variance). The same trend was found with regard to 'Community Acceptance' of infertility treatment for females; however, the 'Community Acceptance' for males was only marginally significant. A Paired T-Test showed that the attitudes of private healthcare providers for treatment of infertility were significantly favorable for girls than for boys (see Annexure V for details of T-Tests).

Table 4. Treatment of Infertility

	N	Mean	SD
Community Acceptance			
Treatment of infertility for females	337	3.79	0.86
Treatment of infertility for males	332	3.42	1.01
Health Care Provider Attitudes: Private Sector			
Females who want treatment of infertility	314	3.46	0.96
Males who want treatment of infertility	299	3.32	1.02
Health Care Provider Attitudes: Public Sector			
Females who want treatment of infertility	291	2.86	0.95
Males who want treatment of infertility	276	2.82	1.01

Male school teachers in a Focus Group Discussion in Karachi were of the opinion that a marked change had occurred in the attitudes of people with regard to infertility treatment and that there now was more openness and acceptance. Representatives of civil society and media from Mitiari were of the opinion that although the initial recipients of pressure for treatment of infertility were usually females, males could eventually be convinced to seek treatment. Participants from civil society and media in Quetta were of the opinion that men were usually reluctant to go to doctors for infertility treatment, because they considered that their masculinity was being questioned. Religious leaders from Peshawar suggested that treatment of infertility had no religious and ethical implications and that married couples could seek such treatment, if necessary.

A participant from a CSO in Karachi in an in-depth interview further claimed that treatment of infertility was generally practiced for females, while males always considered themselves healthy and kept on having second and third marriages to reproduce a child.

Theme IV – Safe Abortion Services

Theme IV has been divided into four sub-themes, with the first addressing the general availability, accessibility and quality of safe abortion services' and the other three sections presenting results in terms of community acceptance of safe abortion services and attitudes of private and public healthcare providers.

The responses of participants indicate poor mean scores regarding the availability, accessibility and quality of abortion services. Mean scores are also low for community acceptance, with community acceptance of abortion services for young unmarried girls scoring lowest and being comparatively most favorable for abortion to to save the lives of married women. Scores are low for attitudes of both private and public healthcare providers, even with respect to their attitudes regarding abortion to save the life of a married women. Healthcare providers' attitudes regarding abortion are perceived to be lowest with regard young unmarried girls and lower than perceived community acceptance of abortion in this situation. Analyses of variance showed that there was a significant difference between urban and non-urban areas with regard to availability of safe abortion, and the situation was comparatively better in urban areas. The situation regarding community acceptance for such services was also found comparatively better in urban areas. The attitudes of both public and private healthcare providers regarding abortion for unmarried young girls and of public healthcare providers regarding abortion for married women who do not want to or can not sustain a child was found non-significant between urban and non-urban settings. However, the difference was found to be significant for saving life of women and also with regard to private health care service providers towards married women who don't want/ can't sustain a child (See Annexure___ for details of analyses of variance). Paired T-Tests showed that there were significant differences between the attitudes of private and public healthcare providers with regard to abortion services to save a life, for married women who do not want to or can not sustain a child and for unmarried young girls. According to the perceptions of the respondents, private healthcare providers were thought to hold more favorable attitudes with respect to all these abortion services (see Annexure V for details of T-Tests).

Table 5. Safe Abortion Services

	N	Mean	SD
Availability	307	2.23	1.03
Accessibility	226	2.32	0.95
Quality	215	2.24	1.01
Community Acceptance of Abortion Services for:			
Young unmarried girls	325	1.93	0.98
Married women for saving their lives	326	3.47	0.99
Unmarried women who don't want/cant sustain a child	331	2.82	0.93
Survivors of rape	286	3.03	1.10
Attitudes of Private Health Care Providers regarding Abortion services for:			
Saving life	307	2.89	1.14
Married women who don't want/can't sustain a child	307	2.86	0.94
Unmarried young girls	305	1.80	0.96
Attitudes of Public Health Care Providers regarding Abortion services for:			
Saving life	299	2.53	1.11
Married women who don't want/can't sustain a child	303	2.42	0.98

Unmarried young girls	302	1.48	0.80

Focus Group Discussions with Civil Society and media representatives in Karachi suggested that safe abortion facilities were limited, as a result of which women turned to female health providers or backstreet clinics if they wanted an abortion. However, young adults in Lahore and Karachi and members of the civil society and media from Karachi and Multan were of the opinion that safe abortion could be clandestinely done by using the right contacts or paying hefty amounts to healthcare professionals. Religious leaders from Quetta and Peshawar offered varying interpretations with regard to the status of abortion in Islam. While Religious leaders from Quetta were of the opinion that abortion was allowed in case the mother's life was at risk, those from Peshawar were of the view that it was not allowed under any circumstances if done after 3 months and 17 days of conception.

A civil society representative in an in-depth interview in Islamabad was of the opinion that the situation with regard to the provision of safe abortion services was not likely to figure prominently on the agenda of policy makers any time soon. "There is hardly ever a well-thought through agenda when it comes to social issues and abortion being very controversial to begin with is not likely to experience mainstream attention any time soon. However, that said one can't be sure because very often there is external pressure and something that was likely to never see the light of the day becomes the most important subject", she explained.

Theme V – Post-abortion Healthcare Services

The responses from the e-survey for post abortion healthcare services follow the trend for safe abortion services. The mean scores for availability, accessibility and quality of post-abortion healthcare services are all low, with the comparably highest score seen for community. Analysis of variance showed that there were significant differences between urban and non-urban areas with regard to availability and community acceptance of post-abortion healthcare services, with urban areas being better off. However, differences were not significant for accessibility and quality of post-abortion healthcare services (See Annexure VI for details of analyses of variance).

Table 6. Post Abortion Health Care Services

	N	Mean	SD
Availability	311	2.27	1.03
Accessibility	230	2.42	0.93
Quality	224	2.27	1.01
Community Acceptance	319	2.94	0.99

Focus Group Discussion with Civil Society and Media Representatives in Multan suggested that, in the absence of safe abortion services, it was only natural that post-abortion healthcare would be very limited.

Theme VI – Information/Education and Counseling

Theme VI was divided into two sub-themes that analyzed access to information on SRHR, quality of Life Skills Education and Quality of Counseling Services for the two sexes.

Responses of the participants in the e-survey showed very low mean scores for access to information on SRHR, quality of Life Skills education and quality of counseling services for both boys and girls. Analyses of the variance further showed significant differences between urban and non-urban areas regarding access to information on SRHR for boys and quality of Life Skills education for girls; urban areas were better off with respect to both these indicators (See Annexure VI for details of analyses of variance). Paired T-Tests showed that boys had significantly higher scores against all of the indicators than girls (see Annexure V for details of T-Tests).

Table 7. Information/Education/Counseling

	N	Mean	SD
Boys			
Access to information on SRHR	333	2.43	1.19
Quality of Life Skills Education	317	2.44	1.14
Quality of Counseling Services	324	2.12	1.03
Girls			
Access to information on SRHR	333	1.87	1.03
Quality of Life Skills Education	310	2.27	1.14
Quality of Counseling Services	316	2.04	1.04

Focus Group Discussions with adolescents and young-adults in all the districts suggested that puberty begins in panic for most of the young people, since they are provided no prior information regarding sexual and reproductive health (SRH). Adolescents and young people were also of the view that SRH education should be institutionalized to ensure that young people in all respects are well prepared at the time of puberty. Male teachers from Vehari were of the opinion that there was no concept among families of educating young people about biological changes and boys often learnt about issues like wet dreams by talking with their friends or older peers. Female teachers in Karachi and from Multan and Mitiari were of the opinion that mothers should pass on information regarding menstruation to girls but never did; sometimes when a girl got her first period while in school, she did not have any clue of what it was. Civil society and media representatives from Quetta, Mitiari and Multan were of the opinion that lack of knowledge regarding pubertal changes instigates feelings of guilt and confusion in young people who often turn to quakes for treatment, thinking they have an illness.

A Parliamentarian interviewed in Islamabad was of the opinion that lack of information about sexual and reproductive health often leads many young people to be exploited sexually by quakes or older acquaintances. She felt that if SRHR education were institutionalized, sexual abuse would decrease manifold.

Theme VII – Relationship of Young People with Service Providers

Theme VII was divided into three sub-themes. The first sub-theme dealt with ease of disclosure while the second and third with issues pertaining to confidentiality and informed Consent respectively.

The responses of the participants in the e-survey conveyed that low mean scores for both ease of disclosure with regard to sexual orientation and sexual history. An analysis of variance revealed significant difference between urban and non-urban areas with regard to ease of disclosure of sexual orientation to service providers. Urban areas had more favorable mean scores compared to non-urban areas (See Annexure VI for details of analyses of variance).

For the second sub-theme, i.e. "Confidentiality", mean scores were low for confidentiality of medical record maintained by healthcare providers in the public sector while mean score for private sector health practitioners lay on the mid-point. Mean scores for level of confidentiality maintained by media were also low while those for NGOs and the general confidentiality around HIV status were slightly above the mid-point. The analyses of variance exhibited a significant difference between urban and non-urban for all categories under the second sub-theme except confidentiality of names of names and information about survivors by NGOs (See Annexure V for details of analyses of variance). Urban areas, once again fared better than the non-urban areas.

A similar trend was evident when analyzing the practice of taking "Informed Consent"; mean scores for healthcare providers and media were found to be low while those for NGOs went slightly above the mid-point. Further investigation by analyzing the variance revealed significant differences between urban and non-urban areas for informed consent taken by healthcare providers and NGOs (See Annexure VI for details of analyses of variance).

Table 8. Relationship of Young People with Service Providers

	N	Mean	SD
Ease of Disclosure of			
Sexual orientation to service providers	337	2.01	0.83
Sexual history to service providers	336	2.26	0.87
Confidentiality of			
Medical record in private health care	293	3.08	1.15
Medical record in public health care	273	2.62	1.11
Names of individual/survivors of sexual violence in media	317	2.36	1.02
Names and information about survivors by NGOs	314	3.53	1.06
HIV status by service providers	291	3.16	1.06
Informed Consent taken by			
Healthcare providers	282	2.63	1.07
NGOs	292	3.23	1.16
Media	284	2.61	1.15

Focus Group Discussions with adolescents and young adults in all the districts revealed the discomfort of young people with revealing issues regarding their Sexual and Reproductive Health to medical professionals. They were of the opinion that going to the neighborhood doctor was completely out of question because s/he would deem informing that young person's parents as part of his / her responsibility. Members of the Civil Society and Media from Karachi and Multan felt that it was this lack of confidence that the young people had on the healthcare providers that often led them to the doors

of quakes with whom they felt that their secret would be safe. A sexologist from Multan, when interviewed shared that things were not as bad as they perceived but the true issue laid in the fact that most young people were unaware that there were specialized doctors who could be consulted for issues of Sexual and Reproductive Health. Civil Society and Media representatives from Karachi were of the opinion that Pakistani media was still in its infancy and most of the reporting done against issues of sexuality was sensationalized and irresponsible.

A local reporter of a national television channel in Peshawar shared during an interview that she agreed most of the reporting done against issues of sexual violence was sensationalized. However, she added that the whole journalist community could not be blamed for this. She complained that whenever a case of sexual violence was reported, community often contacted crime reporters instead of journalists working on human rights beat, hence resulting in sensationalized instead of rights-based reporting.

Theme VIII – Gender, Sex and Marriage

This theme, i.e. "Gender, Sex and Marriage" was divided into two sub-themes. The first sub-theme dealt with "Community Acceptance" while the second analyzed "Response of Law Enforcement Agencies towards Sexual Offenders".

With regard to community acceptance, mean scores were extremely low for forced teenage marriages and voluntary teenage marriages; indicating that the incidence of early marriages are high. Mean score was marginally low for taking consent from a female regarding selection of her life partner and extremely low for acceptance of sex before marriage. Mean scores for other categories, including "Birth of a female child", "Customary/Traditional practices (wani, watta satta, marriage to Quran etc.)", "Honor Crime" and "Marital Rape" were slightly above the mid-point. The analyses of variance revealed that urban areas were significantly better off compared to non-urban areas for all categories in the first sub-theme except marital rape and sex before marriage – for which the differences were non-significant (See Annexure VI for details of analyses of variance).

Both the mean scores were extremely poor for response of law enforcement agencies towards accused sexual offenders, whether the survivors of violence were boys or girls. However, analyses of the variance showed significant difference between urban and non-urban areas where the former was found better than the latter (See Annexure VI for details of analyses of variance).

Table 9. Gender, Sex and Marriage

	N	Mean	SD
Community Acceptance			
Birth of a female child	346	3.70	0.86
Forced Teenage marriages	337	2.85	1.07
Voluntary teenage marriages	326	2.79	0.97
Taking consent from female regarding selection of her life partner	343	2.97	1.00
Customary/Traditional practices (wani, watta satta, marriage to Quran etc.)	330	3.31	1.17
Honor crime	314	3.55	1.13
Marital rape	303	3.25	1.26
Sex before marriage	333	1.72	0.85
Response of Law enforcement agencies towards Sexual offenders			
For Boys	315	1.76	0.85
For Girls	309	1.67	0.84

Female teachers from Multan during a Focus Group Discussion were of the opinion that although birth of a female child often did not instigate an extremely unwelcome reaction in the community, nevertheless the birth of a male child was celebrated more. This sentiment was shared across the board among all groups with whom FGDs were conducted; however responses of groups from Peshawar suggested that while the birth of the first female child be tolerated, the birth of a second female child led to hostile reactions in some parts of the provinces. An adolescent girl during an in-depth interview shared that it was a common practice in her tribe to abort the female fetus of a second or third female child.

Young adults and adolescents across all districts shared that adults often tried to impose their decision regarding marriage on the young people. However, young people from Lahore, Karachi and Multan were of the opinion that things had gradually been improving and that parents were now more open to allow marriage of choice. However, groups of young people and members of the Civil Society and Media in Peshawar and Quetta shared that marrying out of one's own choice was completely out of question for girls while boys were given some level of freedom to make this decision on their own. The average age of marriage for girls, they further shared was usually between 15-17 years while boys married once in their twenties. "*Boys in our community are shown at least a hundred photographs of girls to choose while the girls are merely told whom they will be married to and saying 'No' is never an option for the females",* a civil society representative shared this in an in-depth interview at Peshawar.

Focus Group Discussions with members of the Civil Society and Media in Quetta, Mitiari and Multan suggested that the average age of first intercourse was between 14-17 for both boys and girls – most of these young people were having sex outside of marriage. Young adults and adolescents from Quetta and Peshawar shared that many boys indulged in sexual intercourse with the same sex because of stringent segregation between the two sexes in their culture. Young people in Peshawar, Quetta, Multan and Mitiari and representatives of CSOs in Mitiari were of the opinion that most of the boys did their first sex with animals including female donkeys, goats, hen etc. A representative from CSOs in Mitiari, in an in-depth interview claimed it as a nursery for young boys to learn about sex and intercourse. A young boy in Mitiari, during in depth interview confirmed that sex with animals was very common among young people of his age and it was also found in mature people who even got married. Young adults from other areas including Karachi, Lahore and Multan shared that homosexuality was not uncommon but its incidence was low because boys often had easy and cheap access to sex workers. A civil society representative during an in-depth interview in Multan shared that it was not very uncommon for men to continue having sex with men even after a heterosexual marriage because they are unable to derive pleasure from intercourse with women after being in the habit of having sex with men. He was also of the view that intercourse with the same sex was often not part of homosexual behavior but associated with child abuse.

Focus Group Discussions with Civil Society and Media representatives across all four provinces revealed that customary practices existed in all regions of the country in one form or the other. While '*Swara/Vani'* were issues in Baluchistan and NWFP, *"Wutta Sutta"* was prevalent in Punjab while honor crime was still very much an issue in interior Sindh , South Punjab and Tribal areas of the country, although not so much in urban areas such as Karachi. FGDs also suggested honor crime as an issue in NWFP and Baluchistan, while in the latter province the tradition of *"Wul Wul"* was also widely practiced. Religious leaders from Peshawar were of the opinion that *Sawara* was an un-Islamic tradition and brutally unfair with the girl. A media representative from Peshawar during an interview shared that the incidence of traditional practices was gradually decreasing as people; especially women became more and more aware of their rights. She said that media was trying to play its role by reporting any incidents of such things as *sawara* immediately, so that local governments were made aware to take action against the perpetrators.

Theme IX – Gender Equality

Theme IX was divided into two sub-themes in which same questions were asked to gauge the level of freedom for boys and girls.

The responses of the participants of the e-survey showed mean scores for boys were high or at the mid-point for all categories except freedom to make choices about body characteristics while those for girls were towards the unfavorable quantum with freedom to independently engage in all stages of procedures in courts and tribunals and freedom to make choices about their body characteristics being the lowest. The analyses of the variance revealed that there was no significant difference for boys in urban or non-urban areas against all fields except freedom to choose life partner, where urban areas scored better. On the contrary, all categories for girls showed a significant difference between urban and non-urban areas except freedom to make choices about their body characteristics where again the score was favorable for urban areas (See Annexure VI for details of analyses of variance). A Paired T-Test showed that boys had significantly more freedom than for girls with regard to all noted categories (see Annexure V for details of T-Tests).

Table 10. Gender Equality

	N	Mean	SD
Boys' Freedom to			
Engage in various recreational activities	342	3.99	1.13
Move and travel freely to go wherever they want	346	4.06	1.06
Express themselves through dress of their choice	348	4.03	1.02
Independently engage in all stages of procedures in courts and tribunals	321	3.10	1.42
Choose their partners	346	3.40	1.14
Make choices about their body characteristics	325	2.81	1.10
Girls' Freedom to			
Engage in various recreational activities	340	2.37	1.16
Move and travel freely to go wherever they want	345	2.28	1.11
Express themselves through dress of their choice	348	2.72	1.08
Independently engage in all stages of procedures in courts and tribunals	320	1.77	1.05
Choose their partners	345	2.28	1.13
Make choices about their body characteristics	324	1.94	1.10

Focus Group Discussions in Multan with female teachers and representatives of the Civil Society and Media suggested that widespread gender inequality prevailed. Civil society and Media representatives from Quetta shared that women had no freedom in terms of mobility and were completely dependent on men. Adolescent out-of-school girls in Lahore shared that, boys in their community were often given more food and were the first ones to be served a meal. However, young adults from Karachi and Lahore were of the view that gender discrimination was not a pressing issue in their areas since, girls in those urban areas were allowed most privileges as boys including choosing the profession of their choice and

wearing what they deemed fit. Young adults (boys) in Lahore also felt that parents often tried to impose the selection of life partner on their off-springs although things were improving for both the sexes.

A young girl, during an in-depth interview in Peshawar claimed that she was always treated differently (discriminated) by her parents as compared to her brothers.

Theme X – People with HIV/AIDS

Theme X was divided into two sub-themes in which same questions were asked to gauge the attitudes of private and public healthcare providers with patients of HIV/AIDS.

The responses of the Knowledge Bearers showed that the behavior and level of confidentiality maintained by both private and public healthcare professionals with patients of HIV/AIDS were poor. Analyses of variance revealed no significant difference between urban and non-urban areas (See Annexure VI for details of analyses of variance). A Paired T-Test showed that the behavior and level of confidentiality maintained by private healthcare providers was significantly better than that of public healthcare providers (see Annexure V for details of T-Tests).

Table 10. People with HIV /AIDS

	N	Mean	SD
Health Care Provider Attitudes: Private Sector			
Behavior Towards Patients	278	2.30	1.07
Confidentiality of Patients	206	2.51	1.14
Health Care Provider Attitudes: Public Sector			
Behavior Towards Patients	278	1.94	0.93
Confidentiality of Patients	203	2.21	1.07

Theme XI – Marginalized Communities

Theme XI was divided into three sub-themes. While the first sub-theme gauged community acceptance for marginalized communities, the second and the third sub-theme analyzed the attitudes of private and public healthcare professionals respectively for the same.

The responses of the participants of the e-survey showed a very low level of acceptance for marginalized communities including homosexuals, bisexuals, transgender people and sex workers as mean scores were some of the lowest across all themes.

The same trend continued for the two subsequent themes, where low mean scores remained constant with regard to the attitude of both private and public healthcare providers for all marginalized communities.

Analyses of variance revealed no significant difference between urban and non-urban areas across all categories of each theme although the difference was marginally significant with regard to community acceptance and attitude of private healthcare professionals for transgender people who are employed in other professions (See Annexure VI for details of analyses of variance).

A Paired T-Test showed that the attitude of private healthcare providers was significantly better for all marginalized communities compared to public healthcare providers (see Annexure V for details of T-Tests).

Table 11. Marginalized Communities

	N	Mean	SD
Community Acceptance			
Transgender people who are working as sex workers and/or dancers	323	2.08	0.90
Transgender people who work in other professions	310	2.51	0.92
Homosexuality	325	1.82	0.81
Bisexuality	320	1.96	0.91
Sex workers	333	1.78	0.88
Health Care Provider Attitudes: Private Sector			
Homosexuals	275	1.78	0.92
Bisexuals	272	1.89	0.96
Transgender people who are working as sex workers and/or dancers	281	1.87	1.03
Transgender people who are employed in other professions	263	2.10	1.07
Sex workers	285	1.75	0.91
Health Care Provider Attitudes: Public Sector			
Homosexuals	276	1.57	0.79
Bisexuals	270	1.68	0.90
Transgender people who are working as sex workers and/or dancers	284	1.62	0.90
Transgender people who are employed in other professions	266	1.88	0.96

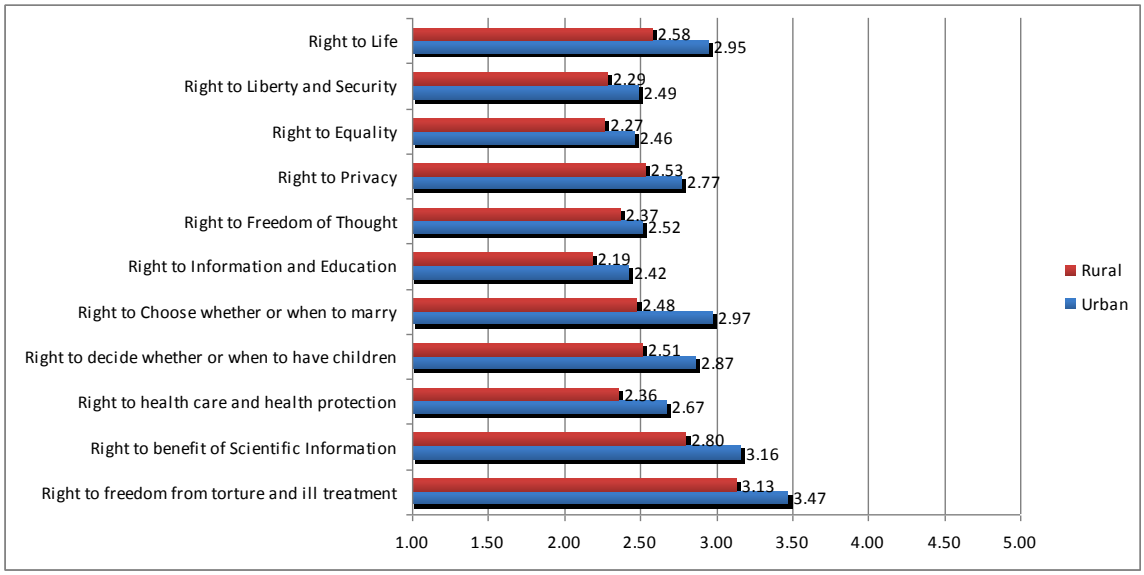
Sex workers	288	1.57	0.84

Focus Group Discussions with transgender people in Kasur suggested that widespread discrimination prevailed against their community at all societal levels. They shared that they were often subjected to humiliation at the hands of public healthcare professionals and although the behavior of private healthcare providers was better, they were often very expensive. They also shared that people from their community were often sexually violated. Going to the law enforcement agencies, they further shared served no purpose but to stand at risk of being sexually assaulted again.

Female Sex Workers, during a Focus Group Discussion in Karachi shared that many clients subjected them to violence, including physical and verbal abuse as well as rape. They shared the same dilemma as the transgender people, saying that law enforcement personnel were often themselves involved in sexually assaulting them. With regard to healthcare professionals, they shared that they preferred keeping their identity a secret as revealing it often placed them at risk of being mistreated or even molested by the doctors.

Focus Group Discussions with young boys in Peshawar, Quetta and Mitiari suggested that situational homosexuality existed between school going young people which started from abuse. A boy during in-depth interview in Peshawar identified that there were networks of offenders and once a young boy of lower class was abused by a relatively older boy, then the later was referred to other offenders by the primary offender. He further added that in such cases, the victims became habitual of having sex in return of money.

PART II- RIGHTS ANALYSIS



Graphical Representation of Rights- Realization Vs Unmet Gap

N	Mean	SD	Total	N	Mean	SD	Total
	Urban		Gap		Rural		Gap
235	3.47	0.973198	1.53	105	3.13	0.95	1.87
241	3.16	0.58338	1.84	108	2.80	0.59	2.20
241	2.67	0.557179	2.33	109	2.36	0.48	2.64
241	2.87	0.513949	2.13	109	2.51	0.49	2.49
241	2.97	0.670015	2.03	109	2.48	0.47	2.52
240	2.42	0.737949	2.58	108	2.19	0.80	2.81
241	2.52	0.633387	2.48	109	2.37	0.58	2.63
240	2.77	0.658678	2.23	106	2.53	0.61	2.47
241	2.46	0.525606	2.54	109	2.27	0.44	2.73
240	2.49	0.532531	2.51	109	2.29	0.47	2.71
241	2.95	0.56754	2.05	109	2.58	0.47	2.42

Mean scores of Rights- Urban Rural Comparison

Right to Life

Analyses of the Right to Life show that this SRH Right stands away from the mid-point, leaving a considerable gap that needs to be met for its full realization. However, results of a paired T-test showed that realization of Right to Life was significantly better than all other SRH Rights except "Right to Choose Whether or When to Marry" for which the difference was not significant (see Annexure VII for details of T-Tests).

Right to Liberty and Security of a Person

Analysis of the "Right to Liberty and Security of Person" showed a very low mean score placing it far away from the optimal point of realization. Results of a Paired T-test further showed that there was a significant "Right to Liberty and Security of a Person" scored significantly better than "Right to Information and Education" while its score was significantly unfavorable against all other SRH Rights except "Right to Equality" and "Right to Freedom of Thought" for which the differences were not significant (see Annexure VII for details of T-Tests).

Right to Equality

Analysis of "Right to Equality" gave the over all second lowest mean score. A paired T-test further revealed that except two SRH Rights there was a significant difference between the "Right to Equality" and all other Rights with scores for "Right to Equality" being poor. There was no significant difference between "Right to Equality" and Rights to "Information and Education" and "Liberty and Security of a Person" (see Annexure VII for details of T-Tests).

Right to Privacy

The mean score for the "Right to Privacy" followed the previous trend with a low mean score that sat away from the mid-point. Moreover, the results of a paired T-test showed that the "Right to Privacy" fared significantly better than the Rights to "Liberty and security of a Person", "Equality", "Freedom of Thought", "Choose" and "Healthcare and Health protection" while it scored significantly poorer against the Rights to "Life", "Benefits of scientific progress" and "Freedom from Torture and Ill-treatment". The difference was not significant when paired against "Right to Decide" (see Annexure VII for details of T-Tests).

Right to Freedom of Thought

The mean score for this Sexual and Reproductive Health Right was once again poor. Further, the results of a paired T-test showed that this SRH Right scored significantly better only against the Rights to "Equality" and "Information and Education" while its score was significantly poor compared to other SRH Rights. There was no significant difference between the "Right to Freedom of Thought" and the "Right to Liberty and Security of a Person" (see Annexure VII for details of T-Tests).

Right to Information and Education

This Sexual and Reproductive Health Right had had the lowest mean score among all other SRH Rights. The results of the Paired T-test show that all other Rights scored significantly better than the "Right to Information and Education" except the "Right to Equality" with which the difference was not significant (see Annexure VII for details of T-Tests).

Right to Choose

Although the "Right to Choose" also had a poor mean score, however it lay closer to the mid-point. When compared with other SRH Rights in a Paired T-test, the "Right to Choose" did significantly better compared to all other Rights except the Rights to "Benefits of Scientific Progress" and "Freedom from Torture and Ill-treatment". The difference was not significant when compared with the "Right to life" (see Annexure VII for details of T-Tests).

Right to Decide

Right to Decide had a low mean score, demonstrating that the overall level of its realization in Pakistan was poor. Furthermore, results of the paired T-test suggested that its realization was significantly poorer compared to that of Rights to "Life", Choose", Benefits of Scientific Progress" and "Freedom from Torture and Ill-treatment". It scored significantly better against other SRH Rights, except the "Right to Privacy" against which the difference was not significant (see Annexure VII for details of T-Tests).

Right to Healthcare and Health Protection

The Right to Healthcare and Health Protection had a low mean score. When analyzed against other SRH Rights, the Right to Healthcare and Health Protection scored significantly poor against the Rights to "Life", "Privacy", "Choose", "Decide" "Benefits of Scientific Progress" and "Freedom from Torture

and Ill-treatment" while its score was significantly better than the remaining SRH Rights (see Annexure VII for details of T-Tests).

Right to Benefits of Scientific Progress

This Sexual and Reproductive Health Right had a comparatively better mean score, lying just a little beyond the mid-point. Results of a paired T-test showed that "Right to Benefits of Scientific Progress" fared significantly better compared to all other SRH Rights except "Right to Freedom from Torture and Ill-treatment", which had a significantly better score (see Annexure VII for details of T-Tests).

Right to Freedom from Torture and Ill-treatment

The Right to Freedom from Torture and Ill-treatment had the highest mean score compared to all other SRH Rights. Results of a Paired T-test showed that it fared significantly better than all other Sexual and Reproductive Health and Rights (see Annexure VII for details of T-Tests).

Conclusion

This research was initiated with the aim to analyze the prevalent status of Sexual and Reporductive Health and Rights of young people in Pakistan and in doing so contextualize SRH Rights in the local context as well as to achieve a baseline against which future studies on the same lines could be conducted for comparison.

Based on past precedents, it was deemed best to conduct an e-survey with knowledge bearers rather than go into a community survey, which entailed the risk of backlash and roll back. To validate and further investigate the findings of the e-survey, Focus Group Discussions and In-depth Interviews were also conducted.

Resultantly, the final research study explicitly illustrates extremely limited realization of Sexual and Reproductive Health Rights of young people in Pakistan. None of the SRH Rights, stand at the optimal (or even closer to optimal) level of realization. Investigation has further revealed that the Sexual and Reproductive Health and Rights situation in Pakistan becomes all the less favorable in non-urban areas.

A closer look at the analyses reveals that out of the eleven themes chalked out for the purpose of clustering together the hundred odd indicators and analyzing them, there are some themes from which, most issues emerge. These themes include:

- Abortion and post-abortion healthcare services
- Information, education and counseling
- Gender equality
- Marginalized communities

A 2004 study 'Unwanted pregnancy and post-abortion complications in Pakistan,' carried out over a two-year period by the Population Council of Pakistan, was an eye-opener. It said some 29 of every 1,000 Pakistani women of reproductive age seek to terminate their pregnancies and that an estimated 890,000 abortions were occurring in Pakistan annually. But whenever activists and health practitioners, who regularly witness women dying from pregnancy-related complications, bring up the issue it only gets more entangled in an irrelevant debate over whether or not terminating a pregnancy (matured beyond 120 days) is un-Islamic and, therefore, illegal. With abortion illegal, safe abortion services naturally remain elusive, forcing women to turn to backstreet clinics run by untrained TBAs, despite the risk of complications. According to Dr Shershah Syed, a practicing gynecologist at the government-owned Qatar General Hospital, complications include "bleeding, infections, septic shock, perforated uterus, perforated bowels and, if they have survived these, infertility and chronic pain syndrome". Most abortions are carried out as a means of preventing unwanted births, according to studies. Reasons cited for not using contraception include inaccessibility of FP services, financial constraints and in some cases differences between husband and wife over the size of the family.

To discourage the incidence of unsafe abortions, it is imperative that the Government of Pakistan ensures accessibility of to modern contraceptive methods including safe emergency contraceptive and family planning counseling and services. It is also most important that within the legal framework for safe abortion, the Government creates awareness about the legal status of abortion in Pakistan among service providers, community and policy-makers.

Further, with regard to post-abortion healthcare services it is recommended to provide quality post abortion care, including safer methods for managing incomplete abortion and quality emergency treatment for other complications.

The next turbulent theme focuses on "Information/Education/Counseling". It will not be out of place to mention here, that the Sexual and Reproductive Health Right, which according to our findings is left most unrealized, is the Right to Information and Education. This goes to show that most young people in our country are not made aware of the biological and psychological changes at occur at the onset of puberty, leaving most of them confused, in guilt and most of all open for exploitation. In light of these facts, it is most important that these young people are timely provided Sexual and Reproductive Health education so that they are aware and better able to protect themselves at he advent of puberty. It is therefore, strongly recommended that young SRH education be made a compulsory part of the syllabi from 7th grade onwards.

Inequality on the bases of sex is another theme that requires dire attention. The analyses of the results had shown that there was a significant difference between boys and girls against all categories that measured the level of freedom accorded to them at various levels. In such a situation, it is a small wonder then that most girls in Pakistan (especially in the rural areas) are malnourished and underserved at every level. Thus, a mass sensitization campaign is important to educate the communities on the importance of providing equality to both the sexes. In this regard again, inclusion of SRH education in the national curriculum would play a vital role, as Sexual and Reproductive Health and Rights education will go a long way in educating a whole generation on the subject of equality among the sexes.

Finally, we come to the last theme, i.e. "Marginalized Communities". Needless to say, a high level of discrimination prevails across the country, at every level against the members of marginalized groups such as, homosexuals, bisexuals, transgender people and sex workers. The Government of Pakistan needs to take notice and provide legislation that would ensure the provision of basic human rights to these marginalized populations. It is welcome development that the Supreme Court of Pakistan is already active with regard to chalking out legislation for the protection of the rights of transgender people. Similar attention needs to be accorded to other groups. Here, the civil society organizations would have to undertake mass level advocacy efforts alongside the marginalized groups to bring change at the level of policy and legislation.

The research findings, across the board have exhibited that community acceptance, for even generally controversial subjects such as abortion has been more positive than the attitudes of healthcare professionals, in particular those in the public sector. This issue needs to be tackled at two levels: sensitization of the healthcare providers and awareness of confidentiality laws among the young people.

Discussion

This research study is the first of its kind, not merely in Pakistan but the world over. Previous studies conducted focused on any one or two aspects of the Sexual and Reproductive Health and Rights paradigm while the current study takes an all inclusive, holistic approach to assess the status of SRHR of young people in Pakistan from every possible dimension.

Since, it was the first effort of its kind, it consisted of a non-random sample of "hidden population", i.e. the Knowledge Bearers instead of direct interaction with the communities. This was done after consultation with SRHR experts who were of the opinion that a community survey may not be feasible at this level. Examples of previous project were also considered that had to be stalled after strong reaction from the community. It was thus, concluded that a survey with the Knowledge Bearers would serve the purpose as these individuals had sound knowledge about Sexual and Reproductive Health and Rights issues of young people as well as vast experience of working on these issues directly with the communities. Moreover, within the given resources, an e-survey was the most cost-effective alternative.

The over representation of urban population in certain regions was then an obvious outcome of our sample choice since most Knowledge Bearers are housed in urban areas (although they might work with non-urban populations).

To off-set the over-representation of urban respondents due to the sample of Knowledge Bearers and the use of internet for responding to the e-questionnaire, additional respondents from FGDs were also taken onboard (as explained in the "Methodology" chapter). It also needs to be borne in mind that the use of internet did not merely allow more confidentiality but did not serve as a hindrance in the number of responses received: the moderate response rate, for the e-survey was not unlike many other paper-and-pen surveys conducted.

Once again it needs to be emphasized that this was the first effort of its kind to comprehensively assess the status of SRHR – not only in Pakistan but globally. It is a starting point for future research on this issue and has opened a window for modified versions of the research tool to be used in the future with different sampling approaches, across various countries and regions.

Moreover, we hope that this research in itself will provides valuable information for advocacy and programme development – not only to World Population Foundation but to SRHR focused organizations and governments across the globe.

Recommendations

Sexual and Reproductive Health and Rights is often viewed as a subject that inspires discomfort in the Pakistani community. Discussion on sexuality is often perceived as being synonymous to pornography and its understanding is often limited to the act of sex only. For these misconceptions, this subject has been long swept under the carpet. However, with the advent of information explosion in the shape of mass communication devices, sexuality is no longer a topic that can be kept hidden or left undiscussed. It is important to acknowledge that young people, guided by basic instinct, biological changes and natural curiosity will always find ways and means to acquaint themselves with sexuality. At this point a critical question that needs to be addressed is whether or not the society is ready to take on the responsibility of educating the young people with regard to their Sexual and Reproductive Health or will it still choose to turn its back to the plight of its young people while they go on to sate their curiosity from potentially damaging sources?

Our first and foremost recommendation is then linked with the introduction of universal Life Skills/Sexuality education for adolescents so that upon reaching puberty, they are well-equipped with correct information to deal with biological as well as psychological changes that they under go. Since there is no possible way of ensuring that this information is provided to the young people at their homes, thus introducing sexuality education as a separate subject in schools is the best way of ascertaining that SRHR education reaches the youth.

However, merely provision of information will not serve the purpose as having information and not being able to exercise one's rights will merely fuel frustration. Accordingly, it is imperative that not only are young people well informed about their Sexual and Reproductive Health Rights but service providers are also sensitized simultaneously to extend SRHR friendly and youth-centric services. Healthcare providers in this regard are most important actors. Unless and until they are ready to offer confidential SRH services to young people, the demand will remain largely unmet and despite having ample information regarding sexuality will still end up the doorsteps of quakes – face to face with the vulnerability of abuse and exploitation. Thus, civil society and the Government need to join hands to launch sensitization campaigns whereby the healthcare sector is made more youth friendly. Special emphasis needs to be laid on maintaining the confidentiality clause to ensure the young people can share their sexual history and sexual orientation without the fear of being exposed. On the other hand, young people need to be made aware of the laws that exist to protect doctor-client confidentiality so that they can demand the protection of any sort of information that is shared.

Hence, this presses home the need to create an enabling environment for the young people – at the domestic, school and community level – to ensure that they are well informed and able to exercise their SRH Rights. At the domestic level while it is important to work with parents and caregivers to communicate the importance of discussing Sexual and reproductive Health related issues with the young people, at the level of schools it is imperative that not only is this information provided to the students in an institunalized way but also that schools are made "safer" places for children and adolescents. The research has shown that children are still at great risk of being victimized by pedophiles within the boundaries of their educational institutions. Thus, measures both at the level of school administration as well as at the policy level need to be taken to ensure that the probability of abuse is reduced to the minimum level in educational institutions and that offenders do not remain unpunished. In the tri-pronged approach of creating an enabling environment for the realization of young people's Sexual and Reproductive Health Rights, it is finally important to come up with a conducive community

environment where young people can demand, propagate and exercise their SRH Rights without any fear of persecution.

Here it is important to realize that for the above recommendations to actually materialize, a mass sensitization campaign is important. Since no amount of donor driven initiatives may be enough to break the silence around the subject of sexuality while also sensitizing the masses simultaneously. It is for this reason that media needs to play a more active role – disseminating information, instigating debates and highlinting the importance of sexuality education for the overall well being of young people.

And last but the most important of all recommendations deals with acknowledging young people as sexual beings. It is important to understand that whether or not the society approves, young (unmarried) people have sexual needs and desires. We can either choose to remain oblivious to this fact and allow entire generations to grow up amid emotional chaos or take responsibility now to accept, respect and nurture our young!

Annexure

Annexure 1: IPPF Charter of Sexual and Reproductive Health and Rights-1994

1) The right to information and Education As they relate to sexual and reproductive health and to ensure the health and well-being of persons and families	**7) the right to be free from torture and ill treatment** Including the rights of adolescents and young people to be protected from sexual exploitation and abuse, and the right of all people to protection from rape, sexual assault, sexual abuse and sexual harassment.
2) the right to healthcare and health protection This includes the frights of health care clients to: information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion.	**8) the right to choose;** whether or not to marry and to found and plan a family
3) the right to freedom of thought This includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies, and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.	9) **the right to privacy** Meaning that all sexual and reproductive health care services should be confidential and all women have the right to autonomous reproductive choices.
4) the right to decide whether and when to have children Which includes choice of having child or not on behalf of both men and women	**10) the right to the benefit of scientific programmes** This includes the recognition that all clients of sexual and reproductive health services have the right to access to new reproductive technologies which are safe and acceptable.
5) the right to life This means among other things that no woman's life should be put at risk or endangered by reason of pregnancy.	**11) the right to freedom of assembly and political participation** Meaning, among other things, that all persons have the right to seek to influence governments to place a priority on SRHR.
6) the right to liberty And security of the person which recognizes that all persons must be free to enjoy and control their sexual and reproductive life and that no person should be subject to force pregnancy, sterilization or abortion.	1**2) the right to equality** And to be free from all forms of discrimination including in sexual and reproductive life.

Annexure II-a List of National Panelists

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Annexure III- Details of Paired T- Tests (Themes- National)

Thematic Area	M	M	Difference test
Quality of Basic Health Services	Boys: 3.13	Girls: 2.97	T=6.02, p=.000
Quality of Family Planning Services	Boys: 2.46	Girls: 2.43	T=0.87, p=.385
Private Health Care Providers Attitudes towards treatment of infertility	Male: 3.32	Female: 3.43	T=2.45 , p=.015
Public Health Care Providers Attitudes towards treatment of infertility	Male: 2.82	Female: 2.86	T=0.75 , p=.452
Health Care Providers Attitudes towards abortion services for saving a life	Private: 2.86	Public: 2.54	T=7.82, p=.000
Health Care Providers Attitudes towards abortion services for married women who don't want/can't sustain a child	Private: 2.84	Public: 2.43	T=9.53, p=.000
Health Care Providers Attitudes towards abortion services for unmarried young girls	Private: 1.76	Public: 1.48	T=6.77, p=.000
Access to information on SRHR	Boys: 2.42	Girls: 1.87	T=10.53, p=.000
Quality of Life Skills Education	Boys: 2.43	Girls: 2.27	T=5.18, p=.000
Quality of Counseling Services	Boys: 2.11	Girls: 2.03	T=3.43, p=.001
Engage in various recreational activities	Boys: 3.99	Girls: 2.37	T=23.49, p=.000
Move and travel freely to go wherever they want	Boys: 4.07	Girls: 2.28	T=26.82, p=.000
Express themselves through dress of their choice	Boys: 4.03	Girls: 2.72	T=20.66, p=.000
Independently engage in all stages of procedures in courts and tribunals	Boys: 3.10	Girls: 1.77	T=17.37, p=.000
Choose their partners	Boys: 3.40	Girls: 2.28	T=18.65, p=.000
Make choices about their body characteristics	Boys:	Girls:	
Behavior of Healthcare providers Towards Patients with HIV/AIDS	Private: 2.29	Public: 1.94	T=7.25, p=.000
Confidentiality of Patients with HIV/AIDS	Private: 2.46	Public: 2.20	T=4.73, p=.000
Healthcare provider Attitudes with Homosexuals	Private: 1.77	Public: 1.58	T=5.67, p=.000
Healthcare provider Attitudes with Bisexuals	Private: 1.88	Public: 1.69	T=5.56, p=.000
Healthcare provider Attitudes with Transgender people working as sex workers/dancers	Private: 1.86	Public: 1.62	T=6.24, p=.000
Healthcare provider Attitudes with transgender people engaged in other professions	Private: 2.08	Public: 1.87	T=5.87, p=.000
Healthcare provider Attitudes with sex workers	Private: 1.74	Public: 1.57	T=5.39, p=.000

Annexure IV : Statistical Test of Differences between urban and non-urban areas (Themes-National)

	Urban	Non-urban	Difference test
	M	**M**	
Basic Health Services			
Availability	3.51	2.84	F (1,343)=38.86, p=.000
Accessibility	3.18	2.70	F (1,336)=16.54, p=.000
Quality for Boys	3.28	2.79	F (1,325)=17.48, p=.000
Quality for Girls	3.18	2.51	F (1,316)=27.32, p=.000
Community Acceptance of Quakes	2.71	2.46	F (1,309)=4.31, p=.04
Family Planning Services			
Availability	3.21	2.69	F (1,339)=21.33, p=.000
Accessibility	2.77	2.53	F (1,320)=3.72, p=.055
Quality for Boys	2.54	2.29	F (1,303)=3.70, p=.055
Quality for Girls	2.50	2.22	F (1,300)=4.22, p=.041
Community Acceptance	3.62	3.26	F (1,340)=15.20, p=.000
Treatment of Infertility			
Community Acceptance			
Treatment of infertility for females	3.88	3.57	F (1,335)=9.05, p=.003
Treatment of infertility for males	3.49	3.27	F (1,330)=3.56, p=.060
Health Care Provider Attitudes: Private Sector			
Females who want treatment of infertility	3.64	3.04	F (1,312)=27.89, p=.000
Males who want treatment of infertility	3.47	2.99	F (1,297)=14.44, p=.000
Health Care Provider Attitudes: Public Sector			
Females who want treatment of infertility	2.98	2.60	F (1,289)=9.91, p=.002
Males who want treatment of infertility	2.92	2.61	F(1,274)=5.81, =.017
Safe Abortion Services			
Availability	2.43	1.82	F (1,305)=25.39, p=.000
Accessibility	2.34	2.26	F (1,224)=0.23, p=.635
Quality	2.31	2.04	F (1,213)=2.88, p=.091
Community Acceptance of			

Abortion Services for:			
Young unmarried girls	2.01	1.75	F (1,323)=4.76, p=.030
Married women for saving their lives	3.58	3.23	F (1,324)=9.513, p=.002
Unmarried women who don't want/cant sustain a child	2.92	2.59	F (1,329)=9.44, p=.002
Survivors of rape	3.22	2.61	F (1,284)=20.60, p=.000
Attitudes of Private Health Care Providers regarding Abortion services for:	Urban	Non-urban	Difference test
	M	**M**	
Saving life	3.06	2.53	F (1,305)=14.74, p=.000
Married women who don't want/can't sustain a child	2.96	2.64	F (1,305)=8.02, p=.005
Unmarried young girls	1.83	1.73	F (1,303)=0.76, p=.386
Attitudes of Public Health Care Providers regarding Abortion services for:			
Saving life	2.65	2.27	F (1,297)=7.51, p=.007
Married women who don't want/can't sustain a child	2.45	2.34	F (1,301)=0.81, p=.369
Unmarried young girls	1.47	1.50	F (1,300)=0.12, p=.731
Post Abortion Healthcare Services			
Availability	2.45	1.90	F (1,309)=20.18, p.000
Accessibility	2.47	2.27	F (1, 228)=1.92, p=.167
Quality	2.29	2.20	F (1,222)=0.33, p=.568
Community Acceptance	3.02	2.76	F (1,317)=4.80, p=.029
Information/Education/Counseling			
Boys			
Access to information on SRHR	2.51	2.25	F (1,331)=3.25, p=.072
Quality of Life Skills Education	2.50	2.32	F (1,315)=1.67, p=.197
Quality of Counseling Services	2.15	2.05	F (1,322)=0.63, p=.427
Girls			
Access to information on SRHR	1.93	1.75	F (1,331)=2.07, p=.151
Quality of Life Skills Education	2.36	2.10	F (1,308)=3.40, p=.066
Quality of Counseling Services	2.10	1.90	F (1,314)=2.60, p=.108
Relationship of Service Providers with Young People			
Ease of Disclosure of			
Sexual orientation to service providers	1.94	2.16	F (1,335)=5.11, p=.024

Sexual history to service providers	2.25	2.28	F (1,334)=0.08, p=.784
Confidentiality of			
Medical record in private health care	3.25	2.68	F (1,291)=15.93, p=.000
Medical record in public health care	2.76	2.32	F (1,271)=9.59, p=.002
Names of individual/survivors of sexual violence in media	2.45	2.15	F (1,315)=6.00, p=.015
Names and information about survivors by NGOs	3.55	3.50	F (1,312)=0.125, p=.724
HIV status by service providers	3.29	2.86	F (1,289)=10.00, p=.002
Informed Consent taken by	Urban	Non-urban	Difference test
	M	**M**	
Healthcare providers	2.78	2.28	F (1,280)=14.23, p=.000
NGOs	3.34	2.97	F (1,290)=6.59, p=.011
Media	2.64	2.52	F (1,282)=0.74, p=.391
Gender, Sex and Marriage			
Community Acceptance			
Birth of a female child	3.78	3.51	F (1,344)=7.10, p=.008
Forced Teenage marriages	3.01	2.48	F (1,335)=18.70, p=.000
Voluntary teenage marriages	2.87	2.63	F (1,324)=4.07, p=.045
Taking consent from female regarding selection of her life partner	3.14	2.59	F (1,341)=23.65, p=.000
Customary/Traditional practices (wani, watta satta, marriage to Quran etc.)	3.50	2.90	F (1,328)=19.03, p=.000
Honor crime	3.68	3.25	F (1,312)=10.08, p=.002
Marital rape	3.24	3.29	F (1,301)=0.10, p=.755

Sex before marriage	1.71	1.74	F (1,331)=0.07, p=.796
Response of Law enforcement agencies towards Sexual offenders			
For Boys	1.83	1.61	F (1,313)=4.41, p=.036
For Girls	1.75	1.49	F (1,307)=6.27, p=.013
Gender Equality			
Boys' Freedom to			
Engage in various recreational activities	4.03	3.89	F (1,340)=1.23, p=.268
Move and travel freely to go wherever they want	4.11	3.96	F (1,344)=1.41, p=.235
Express themselves through dress of their choice	4.02	4.06	F (1,346)=0.11, p=.743
Independently engage in all stages of procedures in courts and tribunals	3.19	2.91	F (1,319)=2.67, p=.104
Choose their partners	3.50	3.18	F (1,344)=5.88, p=.016
Make choices about their body characteristics	2.85	2.69	F (1,323)=1.45, p=.229
Girls' Freedom to	Urban	Non-urban	Difference test
	M	**M**	
Engage in various recreational activities	2.51	2.05	F (1,338)=12.19, p=.001
Move and travel freely to go wherever they want	2.40	2.02	F (1,343)=9.07, p=.003
Express themselves through dress of their choice	2.82	2.52	F (1,346)=5.80, p=.017
Independently engage in all stages of procedures in courts and tribunals	1.86	1.56	F (1,318)=5.90, p=.016
Choose their partners	2.43	1.94	F (1,343)=13.88, p=.000
Make choices about their body characteristics	1.99	1.83	F (1,322)=1.51, p=.220
People with HIV/AIDS			
Health Care Provider Attitudes: Private Sector			
Behavior Towards Patients	2.37	2.14	F (1,276)=2.59, p=.108

Confidentiality of Patients	2.54	2.44	F (1,204)=0.35, p=.556
Health Care Provider Attitudes: Public Sector			
Behavior Towards Patients	1.95	1.93	F (1,276)=0.03, p=.870
Confidentiality of Patients	2.21	2.22	F (1,201)=0.00, p=.967
Marginalized Communities			
Community Acceptance			
Transgender people who are working as sex workers and/or dancers	2.12	1.98	F (1,321)=1.73, p=.189
Transgender people who work in other professions	2.58	2.37	F (1,308)=3.38, p=.067
Homosexuality	1.80	1.86	F (1,323)=0.47, p=.492
Bisexuality	1.98	1.93	F (1,318)=0.18, p=.671
Sex workers	1.81	1.72	F (1,331)=0.74, p=.392
Health Care Provider Attitudes: Private Sector			
Homosexuals	1.82	1.69	F (1,273)=1.34, p=.248
Bisexuals	1.95	1.78	F (1,270)=2.01, p=.158
Transgender people who are working as sex workers and/or dancers	1.91	1.78	F (1,279)=0.94, p=.334
Transgender people who are employed in other professions	2.18	1.92	F (1,261)=3.57, p=.060
Sex workers	1.81	1.63	F (1,283)=2.37, p=.125
Health Care Provider Attitudes: Public Sector	Urban	Non-urban	Difference test
	M	**M**	
Homosexuals	1.54	1.64	F (1,274)=0.91, p=.342
Bisexuals	1.68	1.67	F (1,268)=0.01, p=.923
Transgender people who are working as sex workers and/or dancers	1.58	1.69	F (1,282)=0.86, p=.355
Transgender people who are employed in other professions	1.90	1.83	F (1,264)=0.35, p=.556
Sex workers	1.56	1.59	

			F (1,286)=0.09, p=.768

Annexure VII- Details of Paired T- Tests (Rights - National)

Rights in Focus	Mean of R1	Mean of R2	Difference test
1. Right to Life paired with Right to Liberty and Security	2.83	2.43	T=12.89, p=.000
2. Right to Life paired with Right to equality	2.83	2.40	T=14.31, p=.000
3. Right to Life paired with Right privacy	2.83	2.70	T=3.50, p=.001
4. Right to Life paired with Right to Freedom of Thought	2.83	2.47	T=9.42, p=.000
5. Right to Life paired with Right to Information and education	2.83	2.35	T=13.05, p=.000
6. Right to Life paired with Right to Choose	2.83	2.82	T=0.52, p=.605
7. Right to Life paired with Right to decide	2.83	2.76	T=4.39, p=.000
8. Right to Life paired with Right to Healthcare and Health Protection	2.83	2.58	T=15.46, p=.000
9. Right to Life paired with Benefits of Scientific progress	2.83	3.05	T=-7.49, p=.000
10. Right to Life paired with Right to Freedom from Torture and Ill-Treatment	2.83	3.37	T= -11.19, p=.000
11. Right to Liberty and Security paired with Right to Equality	2.43	2.40	T=1.11, p=.267
12. Right to Liberty and Security paired with Right privacy	2.43	2.70	T=-6.79, p=.000
13. Right to Liberty and Security paired with Right to Freedom of Thought	2.43	2.47	T=-1.17, p=.241
14. Right to Liberty and Security paired with Right to Information and education	2.43	2.35	T=2.21, p=.028
15. Right to Liberty and Security paired with Right to Choose	2.43	2.82	T=-10.83, p=.000
16. Right to Liberty and Security paired with Right to decide	2.43	2.76	T=-11.61, p=.000
17. Right to Liberty and Security paired with Right to Healthcare and Health Protection	2.43	2.57	T=-4.10, p=.000
18. Right to Liberty and Security	2.43	3.05	T=-18.20, p=.000

paired with Benefits of Scientific progress			
19. Right to Liberty and Security paired with Right to Freedom from Torture and Ill-Treatment	2.43	3.37	T=-20.25, p=.000
20. Right to Equality paired with Right Privacy	2.40	2.70	T=-8.57, p=.000
21. Right to Equality paired with Right to Freedom of Thought	2.40	2.47	T=-3.05, p=.002
22. Right to Equality paired with Right to Information and education	2.40	2.35	T=1.49, p=.136
23. Right to Equality paired with Right to Choose	2.40	2.82	T=-12.92, p=.000
24. Right to Equality paired with Right to decide	2.40	2.76	T=-13.10, p=.000
25. Right to Equality paired with Right to Healthcare and Health Protection	2.40	2.58	T=-7.32, p=.000
26. Right to Equality paired with Benefits of Scientific progress	2.40	3.05	T=-23.22, p=.000
27. Right to Equality paired with Right to Freedom from Torture and Ill-Treatment	2.40	3.37	T=-17.83, p=.000
28. Right to Privacy paired with Right to Freedom of Thought	2.70	2.47	T=5.46, p=.000
29. Right to Privacy paired with Right to Information and education	2.70	2.34	T=7.75, p=.000
30. Right to Privacy paired with Right to Choose	2.70	2.82	T=-2.75, p=.006
31. Right to Privacy paired with Right to decide	2.70	2.76	T=-1.79, p=.075
32. Right to Privacy paired with Right to Healthcare and Health Protection	2.70	2.57	T=3.70, p=.000
33. Right to Privacy paired with Benefits of Scientific progress	2.70	3.05	T=-9.63, p=.000
34. Right to Privacy paired with Right to Freedom from Torture and Ill-Treatment	2.70	3.36	T=-10.88, p=.000
35. Right to Freedom of Thought paired with Right to Information and education	2.47	2.35	T=3.81, p=.000

36. Right to Freedom of Thought paired with Right to Choose	2.47	2.82	T=-9.03, p=.000
37. Right to Freedom of Thought paired with Right to decide	2.47	2.76	T=-7.72, p=.000
38. Right to Freedom of Thought paired with Right to Healthcare and Health Protection	2.47	2.58	T=-2.82, p=.005
39. Right to Freedom of Thought paired with Benefits of Scientific progress	2.47	3.05	T=-16.76, p=.000
40. Right to Freedom of Thought paired with Right to Freedom from Torture and Ill-Treatment	2.47	3.37	T=-15.35, p=.000
41. Right to Information and Education paired with Right to Choose	2.35	2.82	T=-11.68, p=.000
42. Right to Information and Education paired with Right to decide	2.35	2.76	T=-10.79, p=.000
43. Right to Information and Education paired with Right to Healthcare and Health Protection	2.35	2.58	T=-6.29, p=.000
44. Right to Information and Education paired with Benefits of Scientific progress	2.35	3.05	T=-19.43, p=.000
45. Right to Information and Education paired with Right to Freedom from Torture and Ill-Treatment	2.35	3.37	T=-18.47, p=.000
46. Right to Choose paired with Right to Decide	2.82	2.76	T=2.30, p=.022
47. Right to Choose paired with Right to Healthcare and Health Protection	2.82	2.58	T=8.46, p=.000
48. Right to Choose paired with Benefits of Scientific progress	2.82	3.05	T=-6.88, p=.000
49. Right to Choose paired with Right to Freedom from Torture and Ill-Treatment	2.82	3.37	T=-12.71, p=.000
50. Right to Decide paired with Right to Healthcare and Health Protection	2.76	2.58	T=12.70 , p=.000

51. Right to Decide paired with Right to Benefits of Scientific progress	2.76	3.05	T=-12.69, p=.000
52. Right to Decide paired with Right to Freedom from Torture and Ill-Treatment	2.76	3.37	T=-12.17, p=.000
53. Right to Healthcare and Health Protection paired with Right to Benefits of Scientific progress	2.58	3.05	T=-19.07, p=.000
54. Right to Healthcare and Health Protection paired with Right to Freedom from Torture and Ill-Treatment	2.58	3.37	T=-15.40, p=.000
55. Right to Benefits of Scientific progress paired with Right to Freedom from Torture and Ill-Treatment	3.05	3.37	T=-5.96, p=.000

Local Terms and Their Definitions

Watta satta is a custom in Pakistan of exchanging brides between two families. At the time of marriage, both families trade brides. That is, both families must have a daughter and a son and be willing to betroth them to a daughter and son of the other family. For example, in order for one to marry off his son, he must also have a daughter to marry off in return to the same family.

Swara/Vani is a child marriage custom in tribal areas of Pakistan and Afghanistan. This custom is tied to blood feuds among the different tribes and clans where the young girls are forcibly married to the members of different clans in order to resolve the feuds. It is most common among Pashtuns.

Karo-kari is part of a tradition in Pakistan where if a killing occurs and it is claimed that victim brought dishonour to the family, pardon can often be obtained from the relatives of the victim. Once such a pardon has been secured, the state has no further writ on the matter.

Wul Wul is a customary practice in the province of Balochistan where the bride's family quotes a price to the prospective in-laws for marrying off a girl.

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