A national level effort of its kind in Pakistan where extensive data was collected directly from the communities to investigate the knowledge, attitude and behaviours of the communities regarding Sexual and Reproductive Health (SRH) Rights and their access to SRH services

Status of Sexual and Reproductive Health Rights in Pakistan

A Research Study
Conducted by AWAZ Foundation Pakistan: Centre for Development Services

A Research Study On

Status of Sexual and Reproductive Health and Rights in Pakistan

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LIST OF ACRONYMS

BHUs	Basic Health Units
CEDAW	The Convention on the Elimination of all Forms of Discrimination Against Women
FWCW	Fourth World Conference on Women
GII	Gender Inequality Index
HDR	Human Development Report
HIV / AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HRCP	Human Rights Commission of Pakistan
HCP	Healthcare Providers
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IPPF	International Planned Parenthood Federation
LSBE	Life Skills Based Education
LGBT	Lesbian, Gays, Bisexuals and Trans-genders
MNA	Members National Assembly
MPA	Member Provincial Assembly
PDA	Pakistan Development Alliance
PMLN	Pakistan Muslim League Nawaz
PTI	Pakistan Tehreek-e-Insaaf
PPP	Pakistan People's Party
PLWDs	People Living with Disabilities
RHCs	Rural Health Centres
STDs	Sexually Transmitted Diseases
SRHR	Sexual and Reproductive Health & Rights
SED	School Education Department
SAFPAC	Safe Access to Family Planning and Post Abortion Care
STI	Sexually Transmitted Infections
SDGs	Sustainable Development Goals
UDHR	Universal Declaration of Human Rights
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNDP	United Nations Development Program
UNICEF	The United Nations Children's Fund
UNFPA	United Nations Fund for Population Affairs
WHO	World Health Organization

PREFACE & ACKNOWLEDGEMENT

The Report is being reviewed by experts – The final report with acknowledgements and review statements will be shared soon.

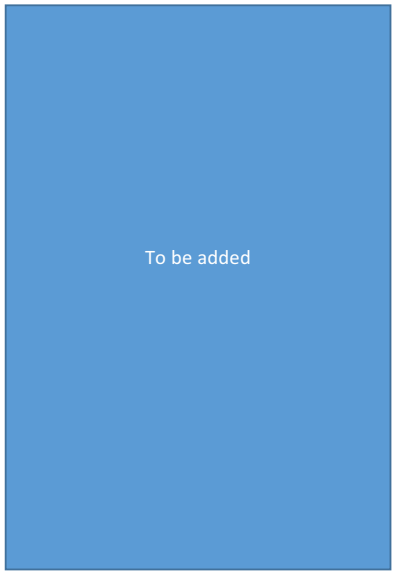
ABSTRACT

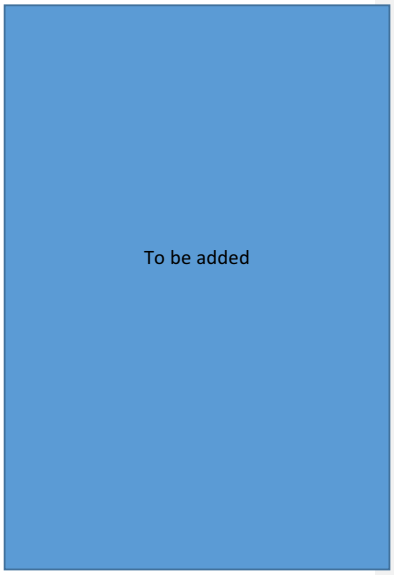
Following the International Conference on Population and Development (ICPD) in 1994 Sexual and Reproductive Health and Rights (SRHR) became an integral part of the human rights framework. However, despite the lapse of over two decades since Pakistan signed the ICPD Plan of Action, the country's SRHR indicators remain poor. Pakistan's performance vis-à-vis SRH Rights is especially significant in view of the fact that it is the sixth most populous country in the world with more than 60% of its population consisting of citizens under 24 years of age.

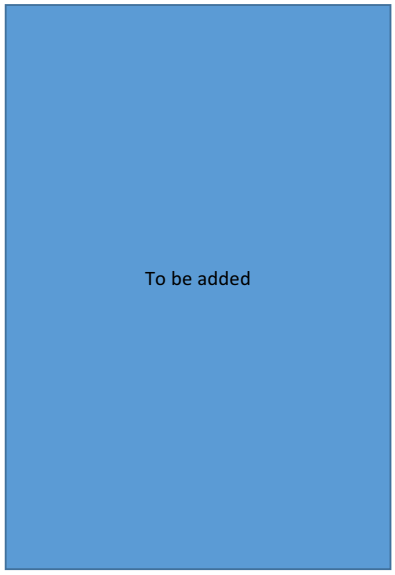
However, despite international commitments and a sizable population that indisputably has sexual and reproductive health requirements, there has never been a comprehensive effort, either by the state or the non-state actors to understand these needs, identify the gaps and address the issues that are responsible for the country's dismal SRHR indicators.

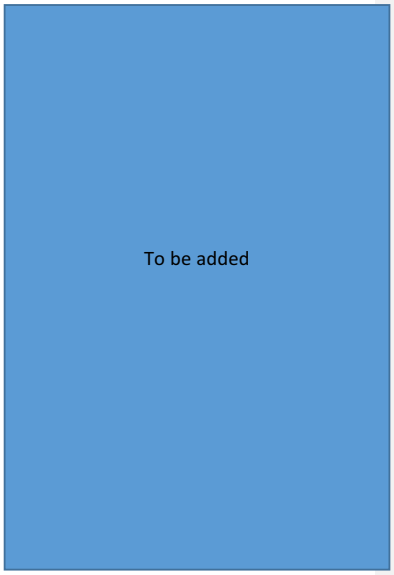
The research in hand is then the first effort of its kind in Pakistan that assesses the needs and gaps vis-à-vis the sexual and reproductive health and rights of the citizens, especially the overwhelming population of the country's young people.

EXPERT REVIEWS









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1- INTRODUCTION

Availability of scientifically generated evidence is paramount to the success of any advocacy and/or lobbying efforts encapsulating social causes. This is especially important since government representatives and policy makers always ask for the references of credible and local studies before taking any advocacy asks seriously. It is especially going to strengthen a cause if the available evidence specifically focusing on the country or region where policy or practice level reforms are desired.

The government of Pakistan is signatory of ICPD, CEDAW, SDGs and among other global commitments that lay emphasis on the realization of Sexual and Reproductive Health and Rights. In order to fulfil the requirements outlined in these international agreements, the Government of Pakistan has introduced a number of both policy and legislative reforms over the years. However, it has been observed that once reforms have been introduced on paper, there is little effort made in terms of their implementation on ground. For instance, in the revised Education Policy 2009, Life Skills Based Education (LSBE) including SRHR focused modules for young people in government and private schools was pledged. However, no directive was issued by the Government to practically introduce a curriculum corresponded to this pledge. Moreover, following the passage of the 18th Constitutional Amendment education became a provincial subject and each province was tasked with devising its own policy leading to a renewed need to lobby individually with each provincial government for the incorporation of SRHR focused LSBE curriculum at the policy level and eventually at implementation level. However, in the absence of Pakistan and province-specific data that highlights the importance of SRHR education and other services, the task has become even more complicated than it was a decade ago.

That said, years of rigorous advocacy by the Pakistani civil society has finally begun to show positive results. The political manifestos that were issued in 2018 ahead of the general elections in Pakistan included pledges to improve the indicators vis-à-vis various sexual and reproductive health rights. For instance, Pakistan Tehreek-e-Insaf (PTI) promised to set-up gender based violence courts to provide speedy justice to female survivors. Similarly, Pakistan Muslim League (Nawaz) pledged to establish Anti-Harassment Cells for women to ensure prompt registration of complains against harassers. In the same way, Pakistan People's Party (PPP) categorically mentioned in its manifesto that it would launch community campaigns specifically aimed at the realization of reproductive health rights.

In view of the factors impacting Pakistan's SRHR landscape and encouraged by the political leadership's resolve to address the SRHR concerns of Pakistani citizens, AwazCDS-Pakistan – decided to conduct a nationwide research study that mapped Pakistan's situation vis-à-vis the SRHR landscape and provided comprehensive policy recommendations to ensure the realization of people's SRH rights in the country.

1.1 Problem Description

Lack of access to Sexual and Reproductive Health care is among the leading health concerns globally. Absence or deficiency of SRHR services, challenges to their accessibility and lack of overall awareness regarding one's own SRH rights adversely impacts populations across the board. Men, women, adolescents, trans-gender/sexual people and people with intersex bodies all require quality sexual and reproductive health services to live full and healthy lives. However, despite the dire need for such

healthcare facilities, a significant portion of the global population remains unattended. For example, in Africa, less than one-third of the population has access to sexual and reproductive health services[1].

Sexual and Reproductive Health issues are often undermined by gender inequality and strong ideological views. These factors go on to restrict the population – especially segments belonging to marginalized groups such as women, young people and trans people – from freely making decisions about their sexuality and sexual and reproductive health.

Thus, more than any other development issue, achieving good Sexual and Reproductive Health indicators is reliant on the recognition of specific human rights. Simply increasing financing itself cannot address the glaring gaps between the need and availability of SRH services including literature and quality healthcare. For instance, in a country like Pakistan where Sexual and Reproductive Health is the subject of immense resistance by conservative groups, there is an urgent need to generate a body of evidence that objectively depicts the dismal state of SRH Rights of the country's population. This body of evidence in turn needs to be used extensively to advocate for attitudinal and behavioural change, bridging the gaps vis-à-vis the availability and accessibility of the local communities to educational material and corresponding services.

It is important to point out here that depriving entire populations – or segments within – from understanding their SRH Rights and accessing related services makes them vulnerable to abuse, exploitation and disease. Every individual has the right to receive comprehensive information, education, health services, and social and legal support for the realization of their Sexual and Reproductive Health & Rights. The infringement of these rights results in lack of knowledge, lack of access to modern contraceptives, lower social status and sexual harassment (especially in the case of females, trans people and young people of all genders); violence against marginalized groups, an increase in HIV-infections and life-long psychological and physical damage.

In Pakistan, much like most of the developing – and even sections of the developed world – a remarkable difference exists between public statements and acts by political leaders in the public domain, and what can be said and done in smaller, safer environments by people "on the ground." Thus, the key to inspire positive change at the grassroots level lies within the political will of the country's top tier leadership. Therefore, advocacy with relevant stakeholders from different levels of the government is perhaps the first step towards initiating and sustaining long term programs aimed at addressing the country's dismal SRHR indicators.

1.2 Objectives and Target Group

The primary aim of this research is to map the situation vis-à-vis Sexual and Reproductive Health and Rights in Pakistan. In the past efforts geared at understanding the SRH landscape in Pakistan have largely been part of public health efforts with the entire research design aimed at facilitating the healthcare sector. Data collection for research studies that did try to analyse Sexual and Reproductive Health from the rights' lens was not carried out directly from the communities due to the fear of backlash. Instead, the primary source of information for such studies were knowledge bearers, i.e. experts who work on SRHR issues. Accordingly, this is the first effort of its kind in the country where data has been extensively collected directly from the communities to investigate the knowledge, attitude

[1] Faith, Gender & Sexuality: A Toolkit http://spl.ids.ac.uk/sexuality-gender-faith/sexual-reproductive-health-rights-overview

and behaviours of the communities vis-à-vis SRHR on one hand and to learn about the availability and accessibility of SRH services on the other.

Through this research, AwazCDS-Pakistan and its partners hope to generate a body of evidence that it is hoped will lead towards a more enabling environment in Pakistan at the levels of policymaking and implementation; community acceptance, 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 research directly reached out to three core groups, i.e. Adults (including parents, SRHR experts, media personnel, religious scholars, policy makers, transgender individuals and people living with disabilities who were 29 years or above); Healthcare Providers and Young People (between the ages of 15 – 29 years).

These groups were accessed both through the quantitative survey questionnaire as well as through qualitative data collections means that included Focus Group Discussions (FGD) and In-depth Interviews (IDI).

Government of Pakistan's Participation in the Research

To ensure that this study also included voices from the Government of Pakistan, special efforts were made to reach out to policy makers and parliamentarians. In this regard the following esteemed individuals were contacted and their views ultimately informed both the findings and the recommendations projected in this study:

Khyber Pakhunkhwa

- Ms. Riffat (Member of Provincial Assembly)
- Mr. Akbar Ali (Assistant Director; Directorate of Human Rights)

Punjab

- Ms. Fouzia Viqar (Chairperson PCSW)
- Dr. Aliya Aftab (Member Provincial Assembly)

Sindh

- Mr. Mehfooz Yarkhan (Member Provincial Assembly)
- Director Women Development Department Sindh

Balochistan

- Ms. Raheela Durrani (Speaker Provincial Assembly)
- Ms. Yasmeen Lehri (Member Provincial Assembly)

2- LITERATURE REVIEW

2.1 Origins of SRHR

Sexual and Reproductive Health and Rights" (SRHR) was first termed as a human right more than 20 years ago at the 1994 Cairo International Conference on Population and Development (ICPD). The following year, i.e. 1995 SRHR again came in the limelight at the Fourth World Conference on Women (FWCW) held in Beijing. Taking a leaf from the World Health Organization's (WHO) definition of health, the Cairo Program defined reproductive health as:

> *"…a state of complete physical, mental and social well-being and...not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (para 72)."*

Additionally, the concept of reproductive rights was further elaborated in Chapter 7 of the Cairo Program of Action stating that such rights, *"…rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive and sexual health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence as expressed in human rights documents."*

Interestingly, governments were reluctant to explicitly mention sexual rights or sexual orientation at FWCW in Beijing, however, despite this reluctance major break-through in the way of acknowledging SRH as a human right were immediately achieved following ICPD and FWCW. Moreover, the Platform for Action (adopted by 189 delegations) in Beijing, reaffirmed the Cairo Program's definition of reproductive health. Paragraph 96 stated:

> *"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviours and its consequences."*

As previously stated, there most governments at the Beijing Women's Conference had reservations regarding the sections that spoke about reproductive health. However, the conference achieved landmark success by securing agreements by the attending delegations on elevating violence against women from a private or domestic issue to an international concern that demanded attention and public policy. It was also successful in broadening the definition of violence against women to include those acts that had previously been justified in the name of culture and tradition. The Conference also succeeded in securing acknowledgement for both women's rights (in general) and their sexual rights (in particular) as human rights.

2.2 SRHR as a Human Right

The Universal Declaration of Human Rights (1948) remains as the single most important guiding document for any discourse pertaining to human rights. UDHR clearly outlines that human rights apply to everyone and that no one should be or can be excluded.

With specific reference to SRHR United Nations Population Fund (UNFPA) describes human rights defined in UDHR as:

- *Universality* – They apply equally to all persons and they are the rights of every individual, there are no exceptions. This means that SRHR apply to everyone, including all children, adolescents and young people.
- *Inalienability* – This means that you can never lose your rights. You have them, from the moment you are born, because you are human.
- *Indivisibility* – No right is more important than another right, they are all connected and you cannot have one without the other. Denial of one right impedes the enjoyment of the other rights.
- *Interdependency and interrelation* – The fulfilment of one right may depend in part or in whole on the fulfilment of other rights.

2.3 Organizational Perspectives on SRHR

Apart from international agreements and convents a number of organizations have tried to define the scope of SRH Rights of people.

Action Canada

Action Canada for Population and Development (2009) lists down the following as integral elements under Sexual and Reproductive Health Rights:

- Sexual and Reproductive Health as a component of overall lifelong health;
- Reproductive decision-making, including choice in marriage, family formation, and determination of the number, timing and spacing of one's children; and the right to the information and the means to exercise those choices;
- Comprehensive, good quality reproductive health services that ensure privacy, fully informed and free consent, confidentiality and respect;
- Sexual and Reproductive security, including freedom from sexual violence and coercion.

World Health Organization

Similarly, World Health Organization (WHO) also introduced the Sexual and Reproductive Health and HIV/AIDS – A Framework for Priority Linkages. This framework proposed a set of key policy and program actions to strengthen linkages between SRH and HIV/AIDS interventions. These linkages work in both directions, by integrating HIV/AIDS issues into ongoing SRH programs and conversely by incorporating SRH issues into HIV/AIDS program. This strategy was based on the objective to enhance SRH, contribute to the reversal of the AIDS epidemic and mitigate its impact.

Based on experience and programing realities, the four priority areas (illustrated in the matrix below) were identified.

SRH	Key Linkages	HIV/AIDS
Family Planning	Learn HIV status	Prevention
Maternal and Infant Care	Promote safer sex	Treatment
Management of Sexually Transmitted Infections	Optimize connection between HIV/AIDS and STI services	Care
Management of Other SRH Problems	Integrate HIV/AIDS with maternal and infant health	Support

This approach has been found to be particularly useful in areas with high prevalence of HIV/AIDS. For example, in settings with high prevalence of HIV infection and high utilization of family planning services, offering all family planning clients the opportunity to learn their HIV status has helped enhance the quality of family planning services and make an important contribution to HIV prevention efforts. This approach is however, not very useful in settings with low HIV prevalence and poor utilization of family planning services.

International Planned Parenthood Federation

Perhaps the most comprehensive work in terms of devising a framework for SRHR has been carried out by the International Planned Parenthood Federation (IPPF).

Over the last 3 decades, the International Planned Parenthood Federation has produced 3 frameworks vis-à-vis Sexual and Reproductive Health Rights. Each document guides the Federation's strategic vision for the corresponding decade. These strategic frameworks include, the Charter of Sexual and Reproductive Health and Rights (hat came in 1994), the Declaration of Sexual Rights (in year 2008) and Locally Owned, Globally Connected: A Movement for Change Strategic Framework (2016 – 2022).

The motivation behind the 2008 Declaration was that ever since 1994 a number of important changes had taken place on the SRH landscape bringing forth new and previously uncovered dimensions. Thus, the 2008 Declaration of Sexual Rights in addition to all the areas covered in the 1994 Charter also encompassed such themes as gay, lesbian and transgender rights; called for the right to personal autonomy and recognitions and called for mechanisms for accountability and redress.

On the other hand, the 2016 Strategic Framework is aimed at guiding IPPF and its member countries/organizations to achieve focused outcomes under the domain of SRH Rights.

The Charter of Sexual and Reproductive Health and Rights – IPPF 1994

Being a world wide body of 170 national member associations, IPPF works in the field of Sexual and Reproductive Health and Rights (IPPF 2004)[2]. Its vision, values and mission are rooted in the principled conviction that health and choice about one's Sexual and Reproductive life are the human rights of each individual (Ibid). IPPF consolidated these ideals in the 'IPPF Charter on Sexual and Reproductive Rights' (Ibid). As outlined by IPPF (1996), the 12 Sexual and Reproductive Health and Rights with their elaboration are as follows:

[2] https://www.ippf.org/about-us/member-associations

Right	Explanation
The right to life	Should be invoked to protect women whose lives are currently endangered by pregnancy.
The right to liberty and security of the person	Should be invoked to protect women currently at risk from genital mutilation, or subject to forced pregnancy, sterilization or abortion.
The right to equality (and to be free from all forms of discrimination)	Should be invoked to protect the right of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to sexual and reproductive health.
The right to privacy	Should be invoked to protect the right of all clients of sexual and reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers.
The right to freedom of thought	Should be invoked to protect the right of all persons to access to education and information related to their sexual and reproductive health free from restrictions on grounds of thought, conscience and religion.
The right to information and education	Should be invoked to protect the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.
The right to choose…	…whether or not to marry and to found and plan a family should be invoked to protect all persons against any marriage entered into without the full, free and informed consent of both partners.
The right to decide…	…whether or when to have children should be invoked to protect the right of all persons to reproductive health care services which offer the widest possible range of safe, effective and acceptable methods of fertility regulation, and are accessible, affordable, acceptable and convenient to all users.
The right to health care and health protection	Should be invoked to protect the right of all persons to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
The right to the benefits of scientific progress	Should be invoked to protect the right of all persons to access to available reproductive health care technology which independent studies have shown to have an acceptable risk/benefit profile, and where to withhold such technology would have harmful effects on health and well-being.
The right to freedom of assembly and political participation	Should be invoked to protect the right to form an association which aims to promote sexual and reproductive health and rights.
The right to be free from torture and ill treatment	Should be invoked to protect children, women and men from all forms of sexual violence, exploitation and abuse.

The Charter set out a rights-framework within which IPPF was to carry out its mandate – the Vision 2000 Strategic Plan. The Charter aimed to bring about real improvements in the quality of people's lives by:

- Raising awareness of the extent to which sexual and reproductive rights had already been recognized as human rights
- Highlighting the link between human rights language and service delivery realities in the field
- Increasing the capacity of non-governmental organizations to participate with human rights processes.

The Charter has been organized in the following way: Twelve rights have been identified, all of which appear in international human rights instruments including the Universal Declaration of Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; and the Convention on the Rights of the Child. All rights have been taken from sources which are international in scope and each right is sourced to the relevant instrument.

The Charter is legal in character, as it is based on recognized international human rights law (UN charters, conventions etc.), which refers to relations between the state and its population and to state obligations to the population. In the Charter of Sexual and Reproductive Rights, IPPF has taken some of these concepts, and has supplemented them with principles relating to SRH. By drawing on relevant extracts from international human rights instruments, the Charter demonstrates the legitimacy of Sexual and Reproductive Health Rights as key human rights issues.

Owing to these facts IPPF claims that the Charter remains as significant today as when it was written almost 14 years ago. IPPF member associations have used it, both in program and advocacy work, in their mission to help individuals achieve Sexual and Reproductive Health and well-being.

Sexual Rights – An IPPF Declaration – 2008

According to International Planned Parenthood Federation (2008[3]), *Sexual Rights: An IPPF Declaration* represents the culmination of more than two years of work that spanned the globe. The Declaration was developed through regional meetings and events that took place across the Federation and built on the IPPF Charter of Sexual and Reproductive Rights (Ibid). It was felt that while there had already been some progress towards meeting the Millennium Development Goals and the targets of the 1994 ICPD (International Conference on Population and Development) Program of Action, there was still much work to be done in the context of Sexual Rights (Ibid).

Sexual rights refer to specific norms that emerge when existing human rights are applied to sexuality. These rights include freedom, equality, privacy, autonomy, integrity and dignity of all people; principles recognized in many international instruments that are particularly relevant to sexuality. Sexual rights offer an approach that includes but goes beyond protection of particular identities. Sexual rights guarantee that everyone has access to the conditions that allow fulfilment and expression of their sexualities free from any coercion, discrimination or violence and within a context respectful of dignity.

[3] https://www.ippf.org/sites/default/files/sexualrightsippfdeclaration_1.pdf

The Declaration talks about the rights of marginalized groups such as young people, transgender people, sex workers, men having sex with men, people who are gay, lesbian or bi-sexual, child brides and girl mothers (Ibid). The Declaration applies equally to girls and women who are vulnerable to or have been subjected to gender-based violence, including traditional norms such as female genital mutilation and discrimination based on male preference (Ibid).

The Declaration not only includes international agreements to which IPPF ascribes but is informed by the findings and recommendations of several UN treaty bodies and UN Special Rapporteurs, particularly the 2004 report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health (Ibid).

The 10 Articles of the declaration are outlined in the table below:

Article	Brief Explanation
Article 1Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender.	All human beings are born free and equal in dignity and rights and must enjoy the equal protection of the law against discrimination based on their sexuality, sex or gender.
Article 2 The right to participation for all persons, regardless of sex, sexuality or gender	All persons are entitled to an environment that enables active, free and meaningful participation in and contribution to the civil, economic, social, cultural and political aspects of human life at local, national, regional and international levels, through the development of which human rights and fundamental freedoms can be realized.
Article 3 The rights to life, liberty, security of the person and bodily integrity.	All persons have the right to life, liberty and to be free of torture and cruel, inhuman and degrading treatment in all cases, and particularly on account of sex, age, gender, gender identity, sexual orientation, marital status, sexual history or behaviours, real or imputed, and HIV/AIDS status and shall have the right to exercise their sexuality free of violence or coercion.
Article 4 Right to privacy	All persons have the right not to be subjected to arbitrary interference with their privacy, family, home, papers or correspondence and the right to privacy which is essential to the exercise of sexual autonomy.
Article 5 Right to personal autonomy and recognition before the law.	All persons have the right to be recognized before the law and to sexual freedom, which encompasses the opportunity for individuals to have control and decide freely on matters related to sexuality, to choose their sexual partners, to seek to experience their full sexual potential and pleasure, within a framework of non discrimination and with due regard to the rights of others and to the evolving capacity of children.
Article 6 Right to freedom of thought, opinion and expression; right to association	All persons have the right to exercise freedom of thought, opinion and expression regarding ideas on sexuality, sexual orientation, gender identity and sexual rights, without arbitrary intrusions or limitations based on dominant cultural beliefs or political ideology, or discriminatory notions of public order, public morality, public health or public security.

Article 7 Right to health and to the benefits of scientific progress.	All persons have a right to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and access to sexual health care for prevention, diagnosis and treatment of all sexual concerns, problems and disorders.
Article 8 Right to education and Information.	All persons, without discrimination, have the right to education and information generally and to comprehensive sexuality education and information necessary and useful to exercise full citizenship and equality in the private, public and political domains.
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.	All persons have the right to choose whether or not to marry, whether or not to found and plan a family, when to have children and to decide the number and spacing of their children freely and responsibly, within an environment in which laws and policies recognize the diversity of family forms as including those not defined by descent or marriage.
Article 10 Right to accountability and redress.	All persons have the right to effective, adequate, accessible and appropriate educative, legislative, judicial and other measures to ensure and demand that those who are duty-bound to uphold sexual rights are fully accountable to them. This includes the ability to monitor the implementation of sexual rights and to access remedies for violations of sexual rights, including access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition and any other means.

Locally Owned, Globally Connected: A Movement for Change Strategic Framework (2016 – 2022)

In IPPF's own words, "Strategic Framework 2016–2022 is a bold and aspirational vision," that outlines what the federation plans to achieve and provides for a roadmap to highlight how it will achieve its objectives. The Strategic Framework focuses on four key outcomes that cover such aspects as advocacy/lobbying, creation of an enabling environment, service delivery and a strong IPPF. The four outcomes under the framework are provided in the Table below.

Outcome 1	100 governments respect, protect and fulfil sexual and reproductive rights and gender equality
Outcome 2	1 billion people to act freely on their sexual and reproductive health and rights
Outcome 3	2 billion quality integrated sexual and reproductive health services delivered
Outcome 4	A high performing, accountable and united Federation

IPPF hopes to achieve these outcomes by creating champions of rights at the grass root level, empowering communities to act freely on their sexual and reproductive health and rights, directly powering service delivery initiatives and evolving its internal structures to be more effective and efficient as a Federation.

2.4 SRH Rights: Pakistan's Score Card

Patriarchal values embedded in Pakistani culture predetermine the social value of gender; thus women are primarily viewed in terms of their reproductive roles resulting in lack of investment in their human capital[4]. Consequently, while boys are provided with better education and efforts are made to develop their skills to compete for resources in the outside world, for many girls in Pakistan the acquisition of domestic skills (to become better mothers and wives) continue to remain their families' focus (Ibid). Resultantly, their lack of professional skills, limited opportunities available to them in the job market and social and cultural restrictions limit women's chances of competing for resources outside the four walls of their homes (Ibid). In this section, we will analyse Pakistan's performance in each of the 12 SRH Rights outlined by IPPF.

2.4.1 The Right to Life

Article 3 of UDHR defines the right to life as "…the right to life, liberty and security of a 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." 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 without condemnation or offense (Ibid). Apart from UDHR, this particular right is also supported by ICPD Programme of Action (Ibid)[5].

Global Overview

The work carried out across the globe under MDG 5 (i.e. improving maternal health) between 2000 and 2015 significantly helped improve the overall situation world over. For instance, between 1990 to 2015, the global maternal mortality ratio declined by 44 per cent – from 385 deaths to 216 deaths per 100,000 live births (UNICEF 2018[6]). This translates into an average annual rate of reduction of 2.3 per cent. While impressive, this is less than half the 5.5 per cent annual rate needed to achieve the three-quarters reduction in maternal mortality targeted for 2015 in Millennium Development Goal 5.

Pakistan

In Pakistan, like most developing countries, the poorest women have the least options when it comes to family planning and access to antenatal care. They are also being most likely to give birth without the assistance of a doctor or midwife. According to the Population Council — an international, non-profit, non-governmental organization — nearly 8.6 million women become pregnant here in Pakistan. Of these, 1.2 million (or 15 percent) women are likely to face obstetric complications[7]. Indeed, just a decade ago, the Pakistan Demographic and Health Survey (PDHS) 2006-2007 estimated the country's MMR to

[4] Tarar, Maliha Gul, and Venkat Pulla. "Patriarchy, Gender Violence and Poverty amongst Pakistani Women: A Social Work Inquiry." *International Journal of Social Work and Human Services Practice*2, no. 2 (April 2014): 56-63. Accessed September 10, 2018. http://www.hrpub.org/download/20140405/IJRH8-19200116.pdf.

[5] Estimates of MMR, number of maternal deaths, lifetime risk, and range of uncertainty by United Nations MDG regions, 2005 (UNFPA 2009)

[6] https://data.unicef.org/topic/maternal-health/maternal-mortality/

[7] https://www.dawn.com/news/1131728

be 276 per 100,000 live-births;[8] unfortunately the figure remained unchanged in the most recent PDHS report that was published in 2013[9]. As per current estimates, Pakistan loses 14,000 women die in childbirth every year; translating into one death every 37 minutes[10]. Punjab suffers 302 maternal deaths per 1000 live-births and Khyber Pakhtunkhwa 275[11]. This raises important questions over the quality of emergency obstetric care available at the facility level as well as the lack of a functional referral system at the district level. Obstetric haemorrhage and pregnancy-induced hypertension represent the two major causes of maternal death in Pakistan[12].

2.4.2 The Right to Liberty and Security of the Person

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 attention in Fourth World Conference on Women (FWCW) Platform of Action concerning practices and acts of violence against women (IPPF 2003). Once again, the Charter and the Declaration penned by International Planned Parenthood Federation, speaks 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 forced pregnancy, sterilization or abortion."

Thus, the "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.

Global Overview

Global estimates published by WHO indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime. Globally, as many as 38% of murders of women are committed by a male intimate partner.[13] Researches show that Men are more likely to perpetrate violence if they have low education, a history of child maltreatment, exposure to domestic violence against their mothers, harmful use of alcohol, unequal gender norms including attitudes accepting of violence, and a sense of entitlement over women. On the other hand, researches also show that women are more likely to experience intimate partner violence if they have low education, exposure to mothers being abused by a partner, abuse during childhood, and attitudes accepting violence, male privilege, and women's subordinate status. There is evidence that advocacy and empowerment

[8] https://dailytimes.com.pk/128572/pakistans-maternal-death-shame/
[9] http://www.nips.org.pk/abstract_files/PDHS%20Final%20Report%20as%20of%20Jan%2022-2014.pdf, pg 129
[10] https://www.popcouncil.org/uploads/pdfs/2015RH_MMR-ReportPunjab.pdf
[11] Ibid
[12] Ibid
[13] http://www.who.int/mediacentre/factsheets/fs239/en/

counselling interventions, as well as home visitation are promising in preventing or reducing intimate partner violence against women. Situations of conflict, post conflict and displacement may exacerbate existing violence, such as by intimate partners, as well as and non-partner sexual violence, and may also lead to new forms of violence against women.

Pakistan

According to Madadgaar National Helpline 1098 and National Commissioner for Children, Zia Ahmed Awan as reported in the Express Tribune Pakistan is among those countries where 70% women and girls experience physical or sexual violence in their lifetime by their intimate partners and 93% women experience some form of sexual violence in public places in their lifetime[14]. In the same realm, according to Sahil's Cruel Numbers Report at least 11 cases of sexual violence are reported in Pakistan every day. This brings the annual total of the reported cases of sexual violence against children to 4,000. It needs to be borne in mind that these 4000 cases only constitute reported figures and it is feared that unreported figures might take the total to a much higher number.

2.4.3 The Right to Equality (and to be free from all forms of discrimination)

UDHR categorically states in its very first Article (UN 2009), "*All human beings are born free and equal in dignity and rights".*

With specific reference to gender discrimination this particular right has also been 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).

Global Overview

Gender inequality exists globally despite of substantial national and international measures that have been taken towards gender equality. The Gender Inequality Index (GII) is an index for measurement of gender disparity that was introduced in the 2010 Human Development Report 20th anniversary edition by the United Nations Development Programme (UNDP). According to the UNDP, this index is a composite measure to quantify the loss of achievement within a country due to gender inequality. It uses three dimensions to measure opportunity cost: reproductive health, empowerment, and labor market participation. The top 10 countries to have achieved gender equality are all European. They include the Netherlands, Sweden, Denmark, Switzerland, Norway, Finland, Germany, Bulgaria, France

[14] https://tribune.com.pk/story/1348833/93-pakistani-women-experience-sexual-violence/

and Belgium. Yemen is scored the lowest across all dimensions[15]. The degree and causes of gender inequality vary throughout the world. Noticeable crimes against women consist of violence, femicide (murder of women), and rape (including war rape).

Pakistan

Pakistan ranks on number 147 on the Gender Inequality Index, indicating medium human development[16]. Earlier in 2018, the United Nations published a report on gender equality for its Sustainable Development Agenda 2030 with Pakistan being one of the main four countries in focus. Using data from a UN Demographic and Health Surveys 2012-2013 report which took into account variables such as wealth, location and ethnicity, the report revealed that 12 per cent of women in Pakistan (4.9 million) aged 18-49 were simultaneously deprived in four Sustainable Development Goals-related dimensions: 1. Child marriages, 2. Education, 3. Healthcare, and 4. Employment[17].

The data highlighted that women from marginalized ethnic groups living in poor rural households fared worse across a variety of well-being and empowerment indicators. The most disadvantaged ethnic group oscillated between Sindhi, Saraiki and Pashtun belts. A unique disparity was found in employment with the richest more likely to lack employment as compared to the poorest – at 86.8 per cent and 53.3 per cent respectively. While poverty pushed the poorest women into precarious, often informal and unpaid work, the rich face significant barriers including biased gender norms, discrimination in wages and limited job options.

Even more perturbing is the situation of people belonging to other genders and sexualities. Pakistan does not have civil rights laws to prohibit discrimination or harassment on the basis of sexual orientation. The LGBT community in Pakistan has not officially begun to campaign for LGBT rights and it remains a long distance dream for that community. That said, Pakistan has seen rapid improvement with regard to the recognition of the rights of the transgender people in recent years.

In 2018 for instance, The Senate Functional Committee on Human Rights passed a string of proposed amendments to 'The Transgender Persons (Protection of Rights) Bill, 2017'. Following the amendments, the Trans people will now be recognized as their gender without requiring consent from a medical board. They will also now have the same protections to dignity and security under the law as other citizens of Pakistan.

The government of Khyber Pakhtunkhwa in this regard has been especially active. Adhering to the Yogyakarta Principles, the provincial government's Human Rights Policy 2018 pledges to take appropriate steps to safeguard the rights of the transgender community. This includes initiating vocational skills development programs for the transgender people, launching awareness raising drives to sensitize local communities on the rights of the transgender population and enact legislation for the protection, promotion and enforcement of the rights of this bereaved community[18]. Since the issuance of the policy, KP government has begun to translate its pledges into action though the issuance of

[15] https://www.huffingtonpost.com/nake-m-kamrany/gender-inequality_b_1417535.html
[16] https://www.pakistantoday.com.pk/2017/03/23/pakistan-ranked-147th-on-human-development-index-un-report/
[17] https://tribune.com.pk/story/1634815/1-un-women-report-shows-worrying-degree-gender-inequality-pakistan/
[18] http://www.humanrights.kp.gov.pk/sites/default/files/resources/KP%20Human%20Rights%20Policy%202018.pdf

driving licenses[19], distribution of health cards[20] and organizing special events to engage the transgender community in sporting activities[21].

The government of Punjab has also taken similar steps by dedicating a special section to the rights of the transgender community in its Human Rights Policy 2018. Apart from birth registration and issuance of national identity cards, the document also recommends affirmative action to mainstream transgender persons in the work force, promulgation of a comprehensive law to include transgender persons as aggrieved or victims in cases of violence against them and ensuring inheritance rights[22].

As a follow-up on the policy document, the School Education Department (SED) in Punjab directed district education authorities to ensure that transgender children were treated as equals in both government and private institutions throughout the province[23]. Schools were also instructed to include "Transgender" as an option in the admission forms[24].

However, the country faces an uphill battle to change social attitudes, with attacks on trans people in the country not uncommon.

2.4.4 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).

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

[19] https://www.dawn.com/news/1393351
[20] https://nation.com.pk/12-Jan-2018/health-for-all-kp-government-enrolls-transgender-community
[21] https://www.samaa.tv/sports/2018/05/kp-govt-organises-first-ever-sports-festival-for-transgenders/
[22] https://hrma.punjab.gov.pk/system/files/Punjab%20Human%20Rights%20Policy%202018%20_%20Print%20Version_Gazatte_0.pdf
[23] https://tribune.com.pk/story/1776787/1-punjabs-education-department-enforces-equal-opportunity-transgender-children/
[24] Ibid

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 Hippocrates[25]. 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 [26].

Global Overview

While these international codes are universal, practices across the globe paint a different picture. In European countries like Lithuania, the practices of doctors often do not meet the moral and legal requirements for medical ethics (Ibid). As reported in the same study, the situation in US was not much different till the 1960s, however the current medical practice in US lays significant focus on the concepts of informed consent and shared decision-making.

Pakistan

Article 14 of the Constitution of Pakistan touches upon the subject of privacy in the following words: "The dignity of man and, subject to law, the privacy of home, shall be inviolable."

While the constitution speaks about a citizen's right to privacy, Article 14 of the Constitution restricts itself to the privacy of one's home. The Constitution thus, is silent on an individual's right to exercise sexual autonomy without arbitrary interference. The Constitution is also silent with regard to the right to confidentiality regarding sexual health services, medical records and in general the right to protection of information concerning their HIV status, their sexual choices and other matters relating to sexuality.

Currently, the only set of rules governing the practice of health care professionals is the "Code of Ethics" formulated by the Pakistan Medical and Dental Council[27]. Under this Code of Ethics, privacy is enshrined as the very basis of the doctor-patient relationship. The Code makes it binding on healthcare providers uphold the privacy of their patients and if a healthcare provider is found guilty of breaching a patient's privacy, s/he may lose their professional license[28]. Similarly, taking informed consent from a patient before prescribing a treatment is also an integral part of the medical code of ethics practices in Pakistan[29].

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 is in

[25] Mahmood, Kaiser. (2016). Informed consent and medical ethics. Ann King Edward Med Coll. 11. 247-249. 10.21649/akemuv11i3.1012.
[26] Humayun, Ayesha, Noor Fatima, Shahid Naqqash, Salwa Hussain, Almas Rasheed, Huma Imtiaz, and Sardar Zakariya Imam. "Patients' Perception and Actual Practice of Informed Consent, Privacy and Confidentiality in General Medical Outpatient Departments of Two Tertiary Care Hospitals of Lahore." *BMC Medical Ethics* 9, no. 14 (September 25, 2008).
[27] https://tribune.com.pk/story/729734/rights-of-patients-2/
[28] Ibid
[29] Ibid

line with the Asian culture as a whole, where the decision-making is often left purely to the doctors or other family members (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 decisions 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). Thus, 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.

2.4.5 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)".*

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).

Global Overview

Even the most developed countries in the world such as the United States of America struggle with laws that restrict a woman's access to safe abortion services. For instance, just before vacating the White House in 2008, the Bush administration had passed a controversial law that allowed healthcare workers to deny abortion counselling or other family planning services if doing so would violate their moral beliefs (Levey 2009). However, with the entrance of Obama administration rescind a controversial rule that allowed this roll-the law was rolled-back within two months of its introduction (Ibid).

Developed countries or regions are not the only places actively struggling actively against the "conscientious" rule. The South African Choice on Termination of Pregnancy Act 92 of 1996 gives women the right to voluntary abortion on request (Bogaert 2002). 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).

Pakistan

Aspects under this right have already been covered under previous sections.

2.4.6 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 programs 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 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).

Global Overview

Sexuality education is at different stages of development in various parts of the world. In Africa it has focused on stemming the AIDS epidemic. Most governments in the region have established AIDS education programs (Health GAP 2006). Egypt teaches knowledge about male and female reproductive systems, sexual organs, contraception and STDs in public schools at the second and third years of the middle-preparatory phase (when students are aged 12–14). A coordinated program between UNDP, UNICEF, and the ministries of health and education promotes sexual education at a larger scale in rural areas and spreads awareness of the dangers of female genital cutting.

Similarly, Indonesia, Mongolia and South Korea have a systematic policy framework for teaching about sex within schools. Malaysia, the Philippines and Thailand have assessed adolescent reproductive health needs with a view to developing adolescent-specific training, messages and materials. In India, there is a huge on-going debate on the curriculum of sex education and when should it be increased. Attempts by state governments to introduce sex education as a compulsory part of the curriculum have often been

met with harsh criticism by political parties, who claim that sex education "is against Indian culture" and would mislead children[30].

Then there are countries such as Sri Lanka, Iran and countries in the MENA region such as Lebanon, where comprehensive sexuality education has been made part of the curriculum but data collected from within classrooms shows that these classes are often rushed, censored and conducted by untrained instructors[31] [32].

According to "Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education – A Global Review 2015," in the Asia-Pacific region, 21 out of the 25 countries' national HIV strategies emphasized the role of education. Similarly,

> *"…in West and Central Africa, most countries had a policy on life skills based HIV and AIDS sexuality education, while in Latin America and the Caribbean, health and education ministers signed a declaration affirming a mandate for national school-based sexuality and HIV education.[33]"*

In developed regions of Europe, such as Finland, France and Germany, sex education has been a part of school curricula since the 1970s (The Courier 2000).

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

UNESCO followed these *International Guidelines* with a fully updated International Technical Guidance on Sexuality Education published in 2018[34]. Under this revised version, UNESCO advocates quality comprehensive sexuality education to promote health and well-being, respect for human rights and gender equality, and empowers children and young people to lead healthy, safe and productive lives[35].

Pakistan

The right to education is enshrined in Article 37 (b and c) of the Constitution of Pakistan (Reference) 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 nowhere in the constitution is education about sexual and reproductive health and rights 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

[30] http://unesdoc.unesco.org/images/0021/002150/215091e.pdf
[31] http://www.dailynews.lk/2018/08/27/features/160747/sex-education-still-taboo
[32] https://en.annahar.com/article/773530-sexual-health-a-pressing-issue-in-lebanon
[33] http://www.un.org/youthenvoy/2016/03/comprehensive-sexuality-education/
[34] http://www.unaids.org/en/resources/presscentre/featurestories/2018/january/20180110_sexuality-education
[35] http://www.unaids.org/en/resources/documents/2018/international-technical-guidance-on-sexuality-education

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 federal Ministry of Education had incorporated SRHR education in the National Education Policy 2009 and also developed a corresponding Life Skills Based Education curriculum. However, the curriculum was never implemented in schools. Following the passage of the 18th constitution amendment that devolved the subject of "Education" to the provinces, it became all the more difficult to push for the introduction of this curriculum in schools as instead of one tier, advocacy efforts had to be geared individually towards each provincial government.

However, following the much publicized case of the rape and consequent murder of a minor in the town of Kasur, the government of Punjab introduced a booklet on children's safety with special focus on protection against sexual abuse[36].

In February 2018, the Government of Sindh approved the introduction of LSBE to be integrated into the curricula for grades six to nine in both government and private schools and was devising an age appropriate curriculum on the same lines for students of grades three to five[37]. Schools across the province will begin imparting LSBE classes from year 2019[38].

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

Global Overview

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 Program 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

[36] https://tribune.com.pk/story/1612321/1-govt-booklet-just-first-step/
[37] https://www.thenews.com.pk/print/278777-sindh-s-plan-to-revise-school-curricula-is-easier-said-than-done
[38] Ibid

brides (IPPF 2009). In Asia and Eastern Europe, girls as young as 13 are trafficked as 'mail order brides' (Ibid).

Pakistan

When we discuss Pakistan specifically, no provision in the constitution of Pakistan endorses this universal human right. However, the 1997 Saima Waheed case was the first to set a precedent whereby a women's right to marry was up held by the court of law. However, the judgment also 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).

On a related note, currently around 7% of Pakistan's population (i.e. roughly 10 million) constitutes underage girls between the ages of 15 to 19 years. Of these 15% (or 1.5 million) are married[39].

This is true despite the fact that Pakistan is a signatory of the 2009 Khartoum Declaration issued by the Organization of Islamic Conference (OIC). Article 26 of the Declaration pledges to:

> *"Take the necessary measures to eliminate all forms of discrimination against girls and all harmful traditional or customary practices, such as child marriage and female genital mutilation, in the light of the relevant declarations, instruments and conventions."*

However, despite 9 years having passed since the Khartoum Declaration and almost 30 years since Pakistan ratified the UN Convention on the Rights of the Child, the country is still unable to provide adequate safeguard to its girl-children. Pakistan does have a Child Marriage Restraint Act in place, however, the law contradicts both the Constitution of Pakistan and the many human rights conventions that the country has signed and ratified.

Under the Constitution of Pakistan as well as various UN Conventions, a child is defined as any individual under the age of 18 years. While, the Child Marriage Restraint Act 1929 sets the minimum age of marriage of males at 18 years, the minimum age of marriage for girls in the same piece of law is 16 years.

The civil society in Pakistan has become very active in the recent years demanding 18 years to be set as the minimum age of marriage for both boys and girls in the country. In this regard in 2010, Punjab introduced eight amendments to the nikkah-nama law. The most important amendment demanded that instead of mentioning only the age of the bride and bridegroom, their exact dates of birth "…shall be recorded as in their school certificates/CNIC/Passports.[40]" However, since the law did not make CNIC a legal requirement for both the bride and groom at the time of marriage, the law did not necessarily serve to raise the minimum age of marriage to 18 years. For this reason, it was widely criticized by rights activist and left-wing political parties, who felt that it would only patronize forced and early marriages[41]. Success was achieved in 2013 when Sindh became the first province to raise the minimum age of

[39] http://bolojawan.com/how-child-marriages-in-pakistan-are-hurting-our-little-girls/
[40] https://tribune.com.pk/story/26497/new-nikkahnama-law-makes-medical-checkup-compulsory/
[41] Ibid

marriage for both boys and girls to 18 years. however, despite the law in place, Sindh has the highest incidence of child marriages in Pakistan.

2.4.8 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).

Global Overview

The proportion of reproductive-age married women who use a modern or traditional contraceptive method has risen from 55% to 63% between 1990 and 2010, according to a global analysis[42]. Most of the increase was due to a 10–percentage-point rise in contraceptive prevalence in the developing world, although contraceptive use also increased in developed countries. The proportion of married women with an unmet need for family planning declined from 15% to 12% worldwide, but remained above 25% in 42 countries, most of them in Africa. In 2010, overall, 146 million married women had an unmet need for family planning - 131 million in the developing world and 15 million in developed countries.

In the same realm, it is important to point out here that underage marriages are a leading cause of early/adolescent pregnancies. Married underage girls usually do not have the social standing or understanding to prevent from getting pregnant right after getting married. Every year, an estimated 21 million girls aged 15 to 19 years and 2 million girls aged under 15 years become pregnant in developing regions. Approximately 16 million girls aged 15 to 19 years and 2.5 million girls under age 16 years give birth in developing regions[43].

That said the global adolescent birth rate has declined from 65 births per 1000 women in 1990 to 47 births per 1000 women in 2015. Despite this overall progress, because the global population of adolescents continues to grow, projections indicate the number of adolescent pregnancies will increase globally by 2030, with the greatest proportional increases in West and Central Africa and Eastern and Southern Africa.

Additionally, regional differences reveal unequal progress: adolescent birth rates range from a high of 115 births per 1000 women in West Africa to 64 births per 1000 women in Latin America and the Caribbean to 45 births per 1000 women in South-Eastern Asia, to a low of 7 births per 1000 women in

[42] https://www.guttmacher.org/journals/ipsrh/2013/07/global-levels-contraceptive-use-married-women-have-risen-especially
[43] http://www.who.int/mediacentre/factsheets/fs364/en/

Eastern Asia. As per the UNFPA report, "State of World Population 2013 – Motherhood in Childhood, Facing the Challenges of Adolescent Pregnancies" South Asia has the fifth largest adolescent birth rate in the world with 49 births per 1000 women[44]. There are also up to three times more adolescent pregnancies in rural and indigenous populations than in urban populations. Much has already been discussed with regard to various abortion laws globally in the course of this literature review in the previous sections.

Pakistan

As revealed in "Landscape Analysis of Family Planning Situation in Pakistan," report in 2016 only around a third of married women use contraceptives in the country. The large gap is in part due to a lack of supply of contraceptives at both public and private health facilities and pharmacies[45]. In other words, of an estimated 31 million married women of reproductive age (15-49 years) in Pakistan, only 8.1 million currently use modern contraceptives.

As per the statistics shared by the World Bank in 2015, adolescent birth rate in Pakistan stood at 38 births per 1000 women[46].

In the same realm, it goes without saying that children are much less likely to be assertive than adults. Thus, when a teenage girl is married, she has little to no say in terms of contraceptive use. For instance, a study showed that between 2000 – 2008, only 15% of the married girls aged 15-19 years in Khyber Pakhtunkhwa used contraception to space their pregnancies[47].

With regard to abortion in Pakistan, there is currently 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

2.4.9 The Right to Health Care and Health Protection

Global Overview

This right provides for the highest possible level of physical and mental health services for all (IPPF 2003). According to IPPF these programs include access to all methods of fertility regulation including

[44] https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf
[45] https://tribune.com.pk/story/1191548/family-planning-around-third-married-women-use-contraceptives/
[46] : adolescent birth rates range from a high of 115 births per 1000 women
[47] http://kpbos.gov.pk/files/1403499483.pdf

safe abortion; diagnosis and treatment for infertility and sexually transmitted infections, including HIV/AIDS as well as pregnancy and infertility counselling that empowers people to make their own decisions based on information impartially presented. Additionally, these also include 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 and offer 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 Program 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).

Furthermore, 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…"*

Pakistan

Aspects under this right have already been covered under previous sections.

2.4.10 The Right 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).

Global Overview

The last two decades have seen rapid scientific advancement in the field of Sexual and Reproductive Health. For instance, Mifepristone has been registered for use as medical abortion in most of Europe, including Austria, Belgium, Denmark, Finland, France, Germany, Great Britain, Greece, Luxembourg, the Netherlands, Norway, Spain, Sweden and Switzerland. This expands a woman's options when having decided to terminate a pregnancy.

On a related note, there is also increasing awareness regarding the use of various SRH related drugs even in the most under-developed regions of the world. For example, studies in sub-Saharan Africa found that only 25-54 per cent of new contraceptive users were fully informed about side-effects.

Perhaps, the most ground-breaking advancement in terms of contraception came from Australia where scientists have developed a reversible male contraceptive - a combination of a four monthly implant containing testosterone and a three monthly injection of progestin. A study in 55 couples reported no pregnancies over a year. The aim is to now produce a single injection containing testosterone and a progestin which can easily be given by local doctors on a 3-4 monthly basis[48].

Pakistan

With regard to Pakistan, 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, nowhere in the S&TR policy nor in the related services is any mention of technologies specific for the progress of SRHR (Ibid).

The work carried out under this domain within Pakistan has largely led by the non-governmental sector. For instance, Safe Access to Family Planning and Post Abortion Care (SAFPAC) is a global initiative to test the efficacy of most modern contraceptive technologies. Through partnerships with international and national organizations in Pakistan, SAFPAC has been supporting the provision of family planning, post-abortion care and reproductive health services in the country[49].

2.4.11 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 Program of Action concerning the need to respect sexual and reproductive rights as human rights; for governments to involve NGOs in

[48] https://www.newscientist.com/article/dn4237-male-contraceptive-trial-has-100-success/
[49] https://www.care.org/sites/default/files/documents/SAFPAC_Final.pdf

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 Program 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".*

Global Overview

The international facts and figures reveal vigorous activism in line with this right on various issues and forums. From the most developed countries in the world to those that struggle against abject poverty, there has been a strong global movement to push for the realization of this particular right.

A few cases highlighting the work carried out under this right and successes achieved are given below:

- Non-governmental organizations (NGOs) and individuals worldwide have campaigned against the Global Gag Rule, which denies U.S. family planning assistance to foreign NGOs that use funding from any source to carry out abortion related activities. The Global Gag Rule restricts lobbying to make abortion legal, or more accessible.
- Women parliamentarians and NGOs fought for the legalization of the oral contraceptive pill in Japan. The Japanese government, after deliberating for nine years, finally decided to allow its limited sale in 1999.
- Amina Lawal, a young Nigerian woman with a young baby, was sentenced to death by stoning in March 2002 after being found guilty of committing adultery. Human rights organizations worldwide strongly opposed this outcome and have advocated on Amina Lawal's behalf. On 23 September 2003, Amina Lawal was cleared of adultery by an Islamic court.
- The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, a network of affiliates in 26 African countries and three European countries, has raised awareness about female genital mutilation through campaigns and training in schools and communities.

Pakistan

Endorsing the Right to Assembly and Political participation, the Constitution of Pakistan states:

"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).

Similarly, there are two legal provisions that govern sexual harassment throughout Pakistan: section 509 of the Pakistan Criminal Penal Code and the Protection Against Harassment of Women at the Workplace Act of 2010. Both laws apply to the entire country and are in line with Pakistan's

constitutional provisions and international commitments, such as the Convention on the Elimination of Discrimination Against Women and ILO conventions under the EU's Generalised Scheme of Preferences. Under the criminal provision, sexual harassment against women in public spaces is now a criminal offence. The law can attract a maximum penalty of three years' imprisonment and/or a fine of up to Rs500, 000[50].

Despite these achievements, most provinces in Pakistan are without a comprehensive bill against domestic violence. In 2016 Punjab took lead when Punjab Assembly, for the first time in the history of the country, passed a comprehensive protection for women bill. The Act caters to a range of crimes including abatement of an offence, domestic, emotional, psychological and economic abuse, stalking and cybercrime. Earlier, the Bill had been approved by the provincial cabinet in 2015 but could not be passed by the assembly because of in-house objections even by those belonging to the ruling party[51]. The much hailed Women Protection Law is not without its glaring loopholes. For instance, there is currently only one Violence Against Woman Centre in the entire province situated in Multan[52]. This technically makes the law applicable only in the district of Multan. Promises for the establishment of more centres have been repeatedly made by the government but there has been no significant development[53]. Even the Multan centre has been facing operational difficulties leading to speculations that it might be closed down[54].

A similar bill has been proposed in Khyber Pakhtunkhwa assembly but it is yet to be passed and made into legislation. Similarly, in 2015 Baluchistan Assembly unanimously passed the "Harassment Against Baluchistan Women at Workplace Bill 2015.[55]" However, till date the rules of business for the implementation of this Act have not been made.

2.4.12 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).

[50] https://tribune.com.pk/story/1628822/6-sexual-harassment-laws-pakistan/
[51] https://www.dawn.com/news/1241751
[52] https://www.dawn.com/news/1323301
[53] Ibid
[54] https://tribune.com.pk/story/1603684/1-multans-vawc-brink-closure/
[55] https://www.dawn.com/news/1233545

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".

Global Overview

Despite significant international attention, At least 20.9 million adults and children are bought and sold worldwide into commercial sexual servitude, forced labour and bonded labour. About 2 million children are exploited every year in the global commercial sex trade. 54% of trafficking victims are trafficked for sexual exploitation. Women and girls make up 96% of victims of trafficking for sexual exploitation[56].

Additionally, throughout the world, as many as 5,000 women and girls a year are murdered by members of their own families, many of them for the 'dishonour' of being raped, often by a member of their own family. Experts estimate that the actual number of honour killings is much higher. Honour violence has been reported in both developed and developing countries, including Canada, Great Britain, United States, Sweden, Germany, France, 15Bangladesh, Brazil, Ecuador, Egypt, India, Gaza, West Bank, Italy, Jordan, Pakistan, Morocco, Sweden, Turkey, Uganda, Afghanistan, Iraq, and Iran[57].

Pakistan

Powerful gangs of organized criminals are trafficking hundreds of women and children from different parts of the country through Iran for labour and beggary in Europe and the Middle East. These smugglers promise unsuspecting parents that their children would get decent and lucrative jobs in Europe – but instead the children are subjected to forced labour in domestic servitude. Women and children from Punjab, particularly from Gujrat, Gujranwala, Mandi Bahauddin, Dera Ghazi Khan, Multan and Sialkot are an easy target for human traffickers.

Gender inequalities and disparities in Pakistan are the added causes of women trafficking and exploitation. With many families favouring sons, daughters are viewed as an economic burden; early marriages and traditional dowry practices also augment the financial burden, forcing parents to sell their daughters. The smuggled women and children are at the mercy of their 'employers', they might force them into sex slavery[58].

According to various reports, an estimated 1000 women and girls are killed in Pakistan in because of honour crime[59]. In Pakistan, tribal courts (commonly known as *Jirga* / *panchayats*) are also known to order honour-based violence in cases of family disputes.
A study conducted by Awaz CDS in 13 tehsils of South Punjab, "Peoples' Perceptions about

Discriminatory Laws & Customary Practices Promoting Violence against Women," revealed that informal judicial structures were rampant in the region and were responsible for handing out verdicts

[56] https://www.equalitynow.org/sex-trafficking-fact-sheet
[57] https://www.honordiaries.com/wp-content/uploads/2013/06/HD-FactSheet-HonorViolenceEast.pdf
[58] http://www.hamariweb.com/articles/article.aspx?id=96145
[59] http://www.telegraph.co.uk/news/worldnews/asia/pakistan/9160515/1000-Pakistani-women-and-girlshonour-killing-victims.html

that were often at the expense of women's dignity and their right to be free from torture and ill-treatment[60]. These verdicts range from giving away women in blood feuds (*vani*) to ordering rape and acid attacks[61]

2.5 Status of the SRHR Advocacy and Resourcing

World Overview

Based on the strategy developed by the WHO in 2001 and Resolution 57.12 of the 2004 World Health Assembly, in 2006 the *Strategy of Reproductive Health Improvement* and 2007-2015 a timetable was adopted by the WHO and UNFPA. During the course of this period significant breakthroughs were achieved globally. A number of strategies and projects, laws and decrees were adopted and implemented to improve the Sexual and Reproductive Health indicators. The impacts recorded in developing countries was especially encouraging. For example, during this period Armenia experienced increased modern contraceptive use (20% to 27%); improved antenatal care (90% of pregnant women had 4-6 antenatal visits and 3 ultrasounds); and increased inpatient deliveries to 99.7%[62].
Similarly, the Republic of Tajikistan recorded decreased maternal mortality ratio from 45 per 100,000 live births in 2002 to 29.2 in 2014; increased antenatal care coverage from 58.7% to 98%; increased contraceptive prevalence rate from 15% to 35.3% and decreased number of home deliveries from 38.7% to 7.4%[63].

However, as illustrated in the examples above, most of the SRHR-related achievements in the last decade or so have been directly associated with maternal health. While improved maternal health indicators are extremely encouraging for SRHR advocates, other aspects such as crimes of a sexual nature, abortion and LGBT rights remain far from realized.

The Global Gag Rule for instance has been preventing US foreign aid to be used for abortion care services since 1973. In 2017 this law was further expanded by the US government to include such clauses that require foreign nongovernmental organizations receiving US global health assistance to certify that they do not use their own non-US funds to: provide abortion services, counsel patients about the option of abortion or refer them for abortion, or advocate for the liberalization of abortion laws[64]. As observed by Human Rights Watch, this law further limits conversations that health providers can have[65] with their patients and prevents them from pressing for legal change in their own countries[66]. The Global Gag Rule and its expansion have, however met with stiff resistance from other developed

[60] http://awazcds.org.pk/Downloads/rstudies/Peoples%20perception%20About%20Discriminatory%20Laws%20and%20Customary%20Practices%20promoting%20volence%20against%20women.pdf
[61] Ibid
[62] http://www.euro.who.int/__data/assets/pdf_file/0011/296903/Achievements-in-Sexual-and-Reproductive-Health-Ministerial-statements-from-WHO-Member-States.pdf?ua=1
[63] Ibid
[64] https://www.hrw.org/news/2018/02/14/trumps-mexico-city-policy-or-global-gag-rule
[65] Ibid
[66] Ibid

countries. Sweden, for instance, pledged to stop giving aid to any organization that agreed to abide by the anti-abortion rule reinstated by US President Donald Trump[67].

Despite criticism the 2018 budget announced under the Trump presidency was termed as a "…war against women.[68]" The budget proposed a complete elimination of all funding for reproductive health and family planning services, serving as a devastating cut that came amid more than $2 billion in overall reductions to global health funding[69]. The international Women's Health Coalition observed that such a huge reduction in funding would have catastrophic global impact. This is especially true given the fact that the United States is the largest donor of reproductive health services in the world. The United States provides contraceptives for more than 26 million women in the Global South, preventing 8 million unintended pregnancies, 3.3 million induced abortions (most of them unsafe), and 15,000 maternal deaths every year.

Pakistan

In 2013 a study conducted by Rutgers World Population Foundation (WPF), revealed that the majority of the country's young people did not have awareness about or access to SRHR services. Of the 1,340 youth surveyed across the country, only 47 per cent of boys and 38 per cent of girls had access to SRHR[70]. The study further revealed that among all adolescents, girls in remote communities faced the greatest levels of discrimination. Transgender people also reported widespread discrimination – both in domestic and public spheres[71].

Purniya Awan, observes that poor Sexual and Reproductive Health and Rights indicators in Pakistan are a reflection of the general human rights situation in the country[72].

This observation becomes all the more relevant in recent years with an increasingly shrinking space for non-governmental organizations in Pakistan. Entities and activists working for the advancement of SRH Rights are especially finding it difficult to have their voices heard. According to ARROW's, 2017 report, "SRHR in the Era of SDGs," it was stated that Pakistan was among those countries whose government was observed to make relentless attacks on actors working in the realm of Sexual and Reproductive Health Rights[73].

Accordingly, for development to take place in real terms, it is imperative that policies dealing with education, health and social security are holistic with a specific focus on the realization of basic human rights[74]. However, when we talk about adopting an all-encompassing, holistic approach for the realization of alleviated living standards for the youthful population in Pakistan, it is important to understand that achieving this goal without paying specific attention to young people's Sexual and Reproductive Health and Rights would not be possible. This is especially true in light of the fact that 5 out of the 17 Sustainable Development Goals (SDG), focus on targets that demand an improvement in

[67] https://www.independent.co.uk/news/world/europe/sweden-donald-trump-anti-abortion-rule-foreign-aide-ban-mexico-policy-organisations-pro-life-a7837591.html
[68] https://iwhc.org/2017/05/trumps-2018-budget-wages-war-women/
[69] Ibid
[70] https://tribune.com.pk/story/536992/sexual-and-reproductive-health-denial-of-rights-lack-of-awareness-hurting-youth/
[71] Ibid
[72] http://www.wluml.org/media/sexual-and-reproductive-health-and-rights-pakistan
[73] http://arrow.org.my/wp-content/uploads/2017/08/AFC-23_2_2017-WEB-2.pdf
[74] http://www.rutgerswpfpak.org/content/pdfs/IEC/HK/SRHR-End-Line-Report.pdf

SRHR indicators. These include, SDG 3 (Good health and well-being), SDG 4 (Quality education), SDG 5 (Gender equality), SDG 10 (Reduced inequality) and SDG 16 (Peace, Justice and Strong Institutions). These targets provided under these goals touch upon (among other themes) such SRHR elements as maternal health, freedom from crimes of sexual nature, gender parity, better educational prospects for women and girls, inclusive education providing necessary life skills and non-discrimination on the basis of sex and/or sexuality[75].

Moreover, within all the SDGs one of the important points is that women and girls, everywhere, must have equal rights and opportunities, and be able to live free of violence and discrimination[76]. Women's equality and empowerment is one of the 17 Sustainable Development Goals, but also integral to all dimensions of inclusive and sustainable development. In short, all the SDGs depend on the achievement of Goal 5. Pakistan is also one of the signatory and ranked on 122 on the SDG index of 157 nations compared to Bangladesh's 120 and India's 116 position, according to July 2017 results[77].

More importantly, in Pakistan parliament has adopted the SDGs as a national development agenda unlike the MDGs that were generally considered an UN-driven initiative only to be complied with by four-yearly progress reports. But in recent times, Pakistan has initiated special SDG units, which are established at the Planning Commission and provinces[78]. At the federal level, three separate SDG units have been created — one at Prime Minister Office, another at parliament and at the Planning Commission. In Punjab the Government has already inculcated the SDG agenda in the vision 2025 and Punjab growth strategy 2018.

According to a research conducted by Pakistan Development Alliance (PDA) in 2018 to map the current status of SDGs' implementation in Punjab, 70.4 percent women claimed to be more vulnerable to experience poverty, discrimination and violence. Furthermore, gender based discrimination and sexual orientation were found to be among the major factors impeding their marginalisation[79]. In the case of the Millennium Development Goals it was observed that there was little political will at the highest levels of leadership to bring any substantial change in the country's SRHR indicators[80]. A study conducted by RutgersWPF in 2013 manifested that among all the healthcare services in the country, the quality of abortion related services as well as their availability and accessibility were the most dismal[81].

To ensure that SRH Rights become a priority for the government under the SDG wave, the civil society and media in Pakistan have a key role to play. This role will be further discussed in the consequent sections.

[75] http://www.undp.org/content/undp/en/home/sustainable-development-goals.html
[76] https://dailytimes.com.pk/228998/pakistan-achieving-the-sdgs/
[77] Ibid
[78] Ibid
[79] http://awazcds.org.pk/where-pakistan-stands-on-sdgs-2018/
[80] http://www.rutgerswpfpak.org/content/pdfs/IEC/HK/SRHR-End-Line-Report.pdf
[81] Ibid

3- METHODOLOGY

3.1 Purpose of the Research

The instrument is designed to document knowledge, beliefs and behaviours with regard to the Sexual and Reproductive Health Rights of young people in Pakistan. Thus, this research assessed the needs and gaps vis-à-vis young people's SRHR on one hand and serve as an essential prerequisite for future interventions and/or advocacy efforts in this domain.

3.2 Design of the Research

A mixed method data collection approach was used for the research with both quantitative and qualitative tools applied to gather data.

Since this is the first research of its kind in Pakistan where data regarding sexual and reproductive health and rights was directly gathered from the communities, it was imperative that the tool was both comprehensive and culturally appropriate to limit the possibility of community backlash. Thus, prior to the development of the survey tool a detailed process was first undertaken in which previous models adopted to conduct SRHR research in Pakistan were reviewed and subject experts (both from the government and the civil society) were taken on-board to steer the process of tool development.

As a first step, the research team reviewed a tool developed by Rutgers Pakistan that had been developed for a SRHR online survey. However, since the tool was developed for an online survey that was limited to SRHR knowledge bearers alone, it was concluded that the same could not be utilized for a community-wide survey. After the development of the first draft of the research questionnaire, it was shared with the expert panel for detailed review. The feedback communicated by the experts was then duly incorporated. One of the most important inputs from the panel was the use of three variations of the same tool for three different groups, i.e. Adults, Healthcare Providers and Young People.

Following participants were part of working group panel:

Sr.#	**Name**	**Organization**	**Designation**
1	Sadia Atta Mehmood	UNFPA	Program+Technical Analyst
2	Shabbir Awan	IPAS	CD
3	Qamar Naseem	Blue Viens	Program Coordinator
4	Sana Ahmad	Blue Viens	Research Officer
5	Zia ur Rehman	AwazCDS	C.E
6	Aftab Ahmad	SSD	CEO
7	Qaiser Mahmood	PCSW	Divisional coordinator GMIS PCSW
8	Tayyaba Qurban	Group Development Pakistan	Program Officer
9	Wasim Durrani	Oxfam	Program Manager
10	Tahir Abbas	LCPP	Advocacy Specialist

11	Areebah Shahid	Pakistan Youth Change Advocates	Head of Programs
12	Marium Khan	AwazCDS	Campaign Manager

All the three tools were in turn piloted with the respective groups that they had been developed for. The tool developed for adults for instance was piloted with teachers (1 Male and 1 female) and parents (1 father and 1 mother) while the questionnaire for young people was piloted with 1 girl and 1 boy. Similarly, the tool developed for Healthcare Providers was piloted with a lady doctor. The pre-testing took place in Multan district.

3.3 Quantitative Data Collection

To ensure that a picture of the SRHR landscape of Pakistan could be captured, three quantitative data collection tools were developed. The first tool was developed for "Adult" stakeholders. These included parents, teachers, SRHR experts, media professionals, policy makers, parliamentarians, religious leaders, transgender individuals and people living with disabilities. The respondents in this group were 30 years and above. The second tool was designed for "Healthcare Providers." These included doctors, nurses, Lady Health Visitors (LHVs), Lady Health Workers / Community trained birth attendants and pharmacists.

The third tool was developed for "Young People." The ages of the respondents in this category lay between 15 – 29 years. The tool for "Adults" served as the primary document and the remaining two survey questionnaires served as its variations. For the questionnaire used for the Healthcare Providers, Section 6 (i.e. Use and perceptions of health services) was entirely modified from the perspective of healthcare providers. In the same way, in the tool developed for young people sections 3 and 8 (i.e. Sexual and Reproductive health: services and social attitudes) were entirely eliminated to avoid the incidence of community backlash.

3.4 Respondents to the Survey

The survey was administrated in 40 districts across Punjab, Sindh, Khyber Pakhtunkhwa and Baluchistan provinces with 2008 individuals belonging to the three categories defined previously.

S. No.	District	Province
1.	Faisalabad	Punjab
2.	Bahawalpur	
3.	Rahim Yar Khan	
4.	Chakwal	
5.	Lahore	
6.	Vehari	
7.	Rajanpur	
8.	Kasur	
9.	Muzaffarharh	
10.	Multan	
11.	Mirpur Khas	
12.	Tando Adam Khan	
13.	Sukkher	
14.	Umer Kot	

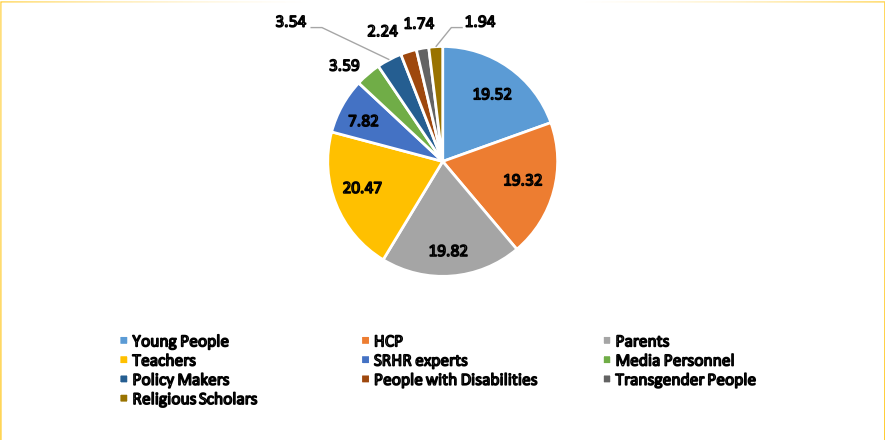
15.	Thatta	Sindh
16.	Hyderabad	
17.	Dadu	
18.	Karachi (East)	
19.	Karachi (Central)	
20.	Larkana	
21.	Quetta	Baluchistan
22.	Pashin	
23.	Noshki	
24.	Khuzdar	
25.	Naseerabad	
26.	Jafferabad	
27.	Lasbela	
28.	Sibi	
29.	Kohlu	
30.	Bannu	Khyber Pakhtunkhwa
31.	Mardan	
32.	Peshawar	
33.	Nowshera	
34.	D. I Khan	
35.	Swat	
36.	Mansehra	
37.	Lower Dir	
38.	Karak	
39.	Lora Lai	
40.	Kohat	

Table 1: List of Districts where quantitative survey was administered

	Punjab	**KP**	**Baluchistan**	**Sindh**	**Total**
Adults	318	314	303	293	1228
Healthcare Providers	98	99	97	94	388
Young People	98	100	97	97	392
Total	514	513	497	484	2008

Table 2: Categories and No. of Respondents in each Province

The pie-chart below indicates the percentage representation of the various groups of respondents who participated in the survey.



Graph 1- Percentage Representation of Different Groups of Respondents

3.5 Focus Group Discussions and In-depth Interviews

To validate the initial results generated by the survey and to probe areas that required further investigation, 34 Focus Group Discussions and 63 In-depth Interviews were also conducted. A total of 408 participants were included in the qualitative research, the details of which are provided in the tables below:

S. No.	Group	Lahore & Kasur	Karachi & Thatta	Peshawar & Mardan	Quetta & Ziarat
1.	Young boys (15 – 29 years) and married men (30 years or above)with rural background	2	2	2	2
2.	Young girls(15 – 29 years) and married women(30 years or above) with rural background	2	2	2	2
3	Young boys (15 – 29 years) and Married men(30 years or above) with urban background	2	2	2	2
4	Young girls(15 – 29 years) and Married women (30 years or above) with urban background	2	2	2	2
5.	Female sex workers		1		
6.	Transgender people		1		

Table 3: No. and type of FGDs held in each province

Total 63 IDIs were conducted with married men, women, policy makers, media personnel, religious leaders, transgender, sex worker and young girls and boys.

Both the FGDs and IDIs were conducted by trained facilitators and interviewers who took written notes and audio recorded the proceedings. Participation in the FGDs and IDIs was voluntary and their data was kept confidential. Participants were also requested verbally to provide informed consent before the commencement of the FGDs and IDIs. The recorders were switched on only after consent had been received from the participants and even then no personal identifiers were included in written notes and audio recordings.

3.6 Data Analysis

Data analysis for each of the three survey tools was carried out separately. For each of the themes in all the three types of tools, percentages of responses to each of the questions were calculated.

3.7 Limitations

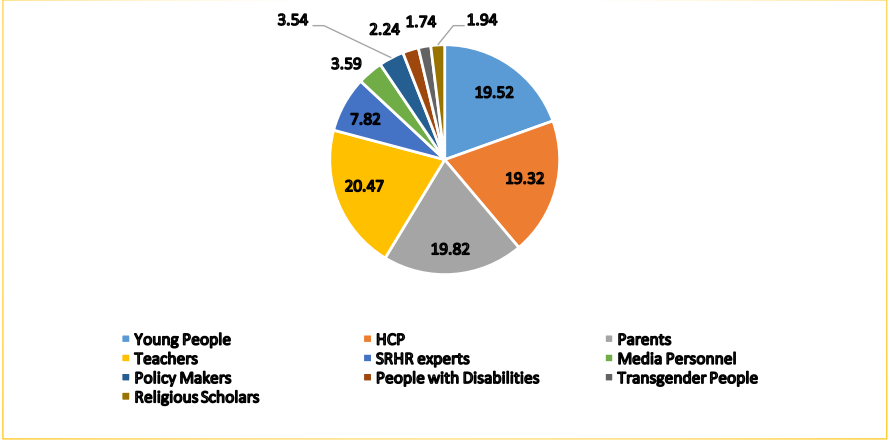
It is important to mention here that the nature of the research is sensitive given the strong conservative influences in the society. Accordingly, to ensure that this first of its kind study on the Sexual and Reproductive Health Rights in Pakistan was conducted smoothly, the number of the survey respondents was limited to 2008. Additionally, questions related to contraceptive use and abortion were not asked from young people as this could have been misconstrued as spreading obscenity and corrupting young minds by the communities. This is among the most significant limitations of the study as the inability to investigate these aspects prevented the research from documenting the prevalent sexual practices among young people in Pakistan. This data could also have been instrumental in unpacking the causes for a sizable chunk of abortions (as found in the study) that take place because the girl/woman is unmarried.

Lastly, sex-workers could not be included in the quantitative part of the study. This was primarily because of the hurdles that prevented a sizable number of sex-workers to be identified who were willing to participate in the research. However, being extremely important stakeholders, it was ensured that they were not entirely excluded from the study and that their opinions were included through focus group discussions and in-depth Interviews.

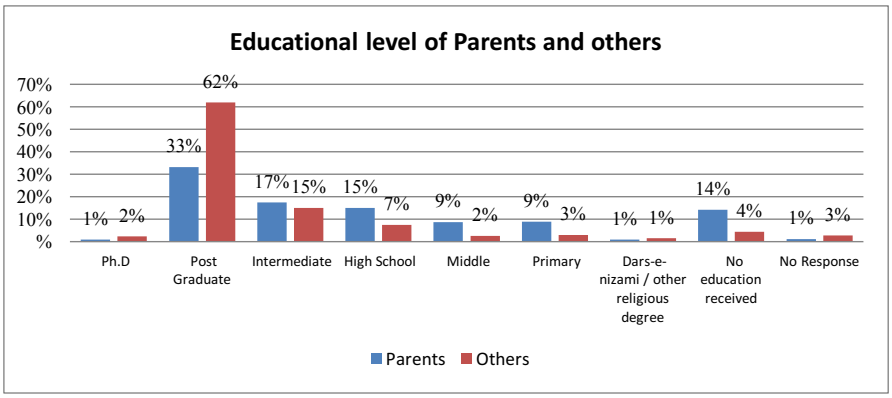
4- RESULTS & ANALYSIS

4.1 Socioeconomic and Family Characteristics

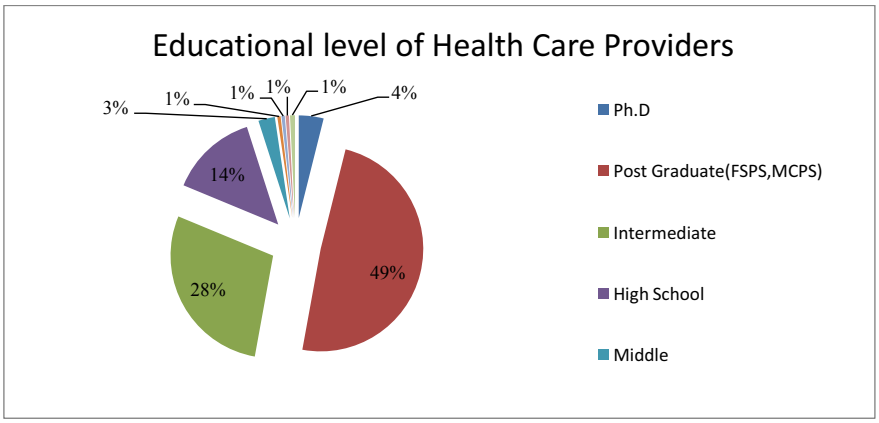
The pie chart below indicates the percentage representation of respondents who were part of quantitative survey.



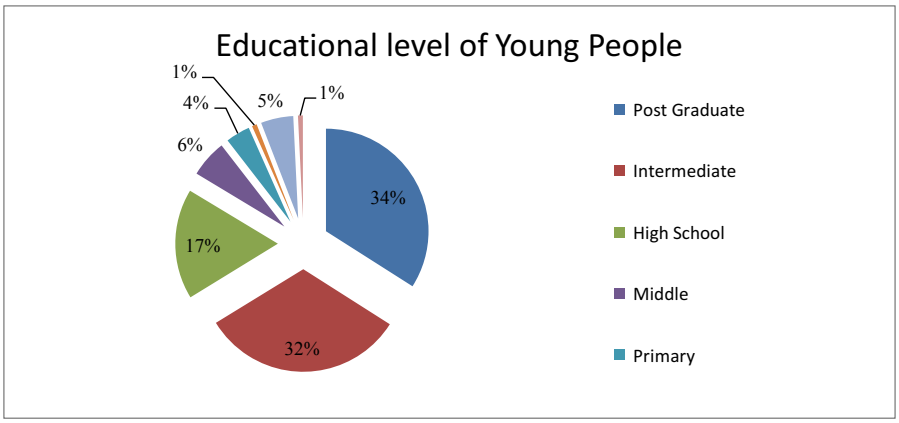
The graph below indicates the percentage of educational level of Parents vs. other categories in Adults.



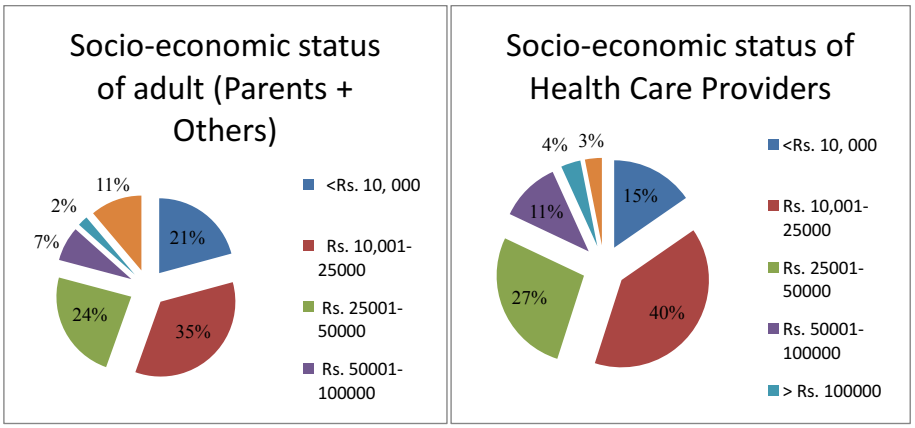
The Pie chart below indicates the percentage of educational level of Health Care Providers who were respondents in quantitative survey.



The Pie chart below indicates the percentage of educational level of Young people who were respondents in quantitative survey.



Below pie charts indicates the socio-economic status of Health care providers and adult category.



4.1.1 Sources of Puberty-related Information

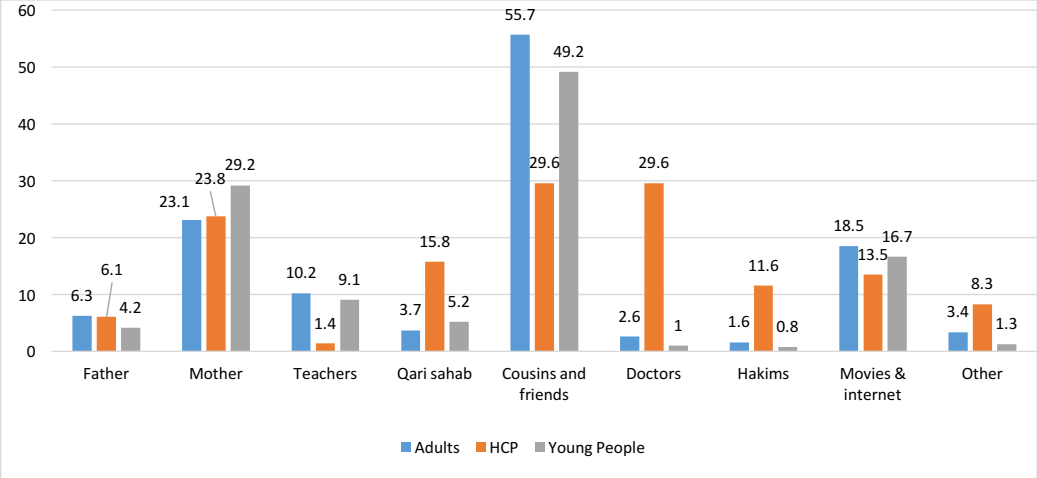
For Adults and Young People, "Friends" remained the primary source of information. 38.8% and 37.5% of the respondents in these categories (respectively) named "Friends" as their primary source of

information for SRH related queries. Most of the Healthcare Providers (29.6%) on the other hand named "Doctors" were their primary source of information.

With regard to caregivers, "Mothers" remained the most referred source for SRH queries with 23.1% of the Adults, 23.8% of the HCP and 29.2% of the Young People sharing that they went to their mothers to seek information about sexual and reproductive health. Only 6.3% of the Adults, 6.1% of the HCP and 4.2% of the Young People named "Fathers" as their primary source of information.

Interestingly, significantly more Healthcare Providers (11.6%) named "Hakims" as their primary source of SRH information compared to Adults (1.6%) and Young People (0.8%).

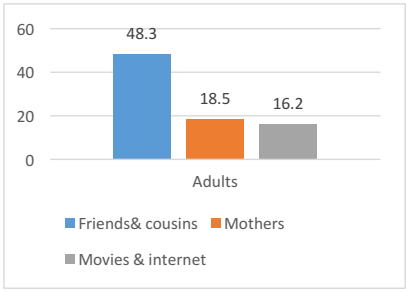
Collectively, 55.7% Adults, 29.6 HCP and 49.2% of the Young People cited cousins and friends as their primary sources of information. Similarly, 11.5% of adults, 8% of HCP and 10.2% of young people shared that collectively films and magazines were among their primary sources of SRH information.

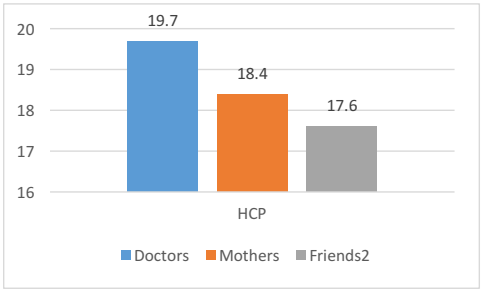


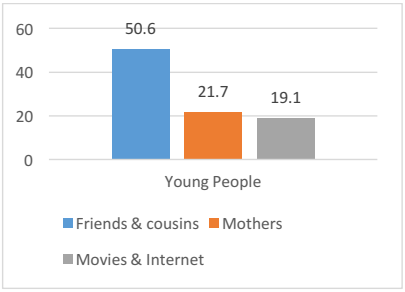
Graph2: Primary Source of Information on SRH issues (in percentage)

The most quoted secondary source of information for Adults and young people were "Friends and cousins with 48.3% and 50.5% respectively". 19.7% of the HCP reported that "Doctors" were their most referred secondary source of information for SRH information.

18.5% of the Adults, 18.4% of the HCP and 21.7% of the Young People shared that their "Mothers" had been the second most preferred source for receiving SRH information.

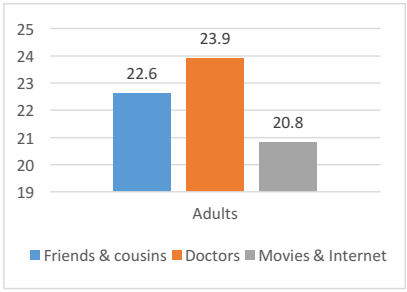


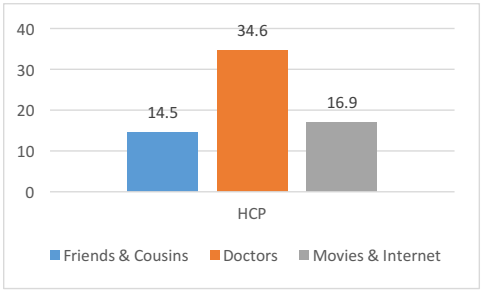


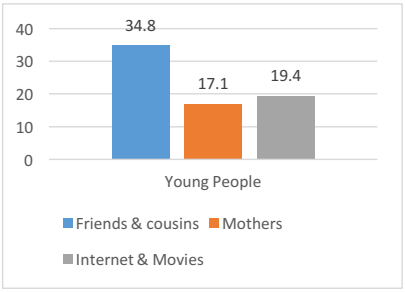


Graph 3.1 3.2 & 3.3: Secondary Source of Information on SRH issues (in percentage)

To probe further, respondents were asked as to who would they prefer receiving information about sexual and reproductive health if they were given another chance. 23.9% of the Adults and 34.6% of the HCP replied with Doctors but Young people preffered "Friends & cousins" with 34.8%. "Friends and cousins" were the second most preferred choice for Adults (22.6%) and for HCP "Movies & Internet" with 16.9%. while "Mothers" were the third most preferred source for the Young People (17.1%), "Movies & Internet" was the third most reported answer for Adults and it was the "Friends & cousins" for HCP.



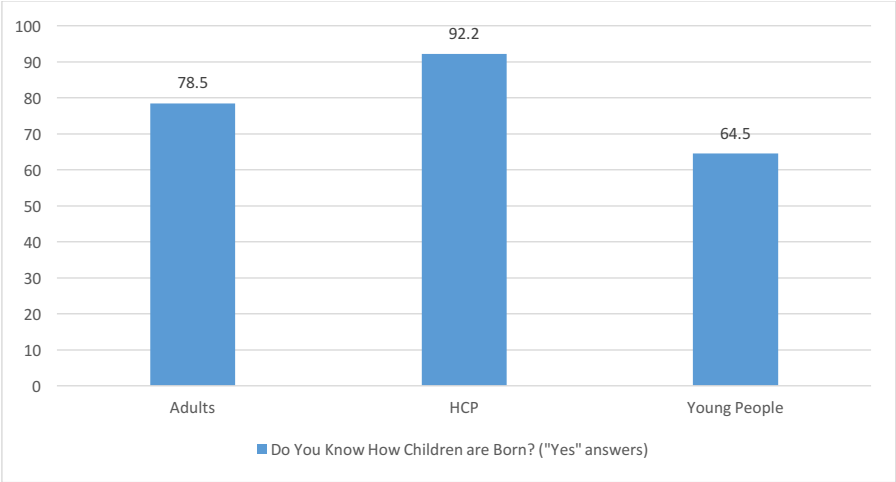




Graph 4.1 4.2 & 4.3: Preferred Source of Information on SRH issues (in percentage)

4.1.2 SRH Information

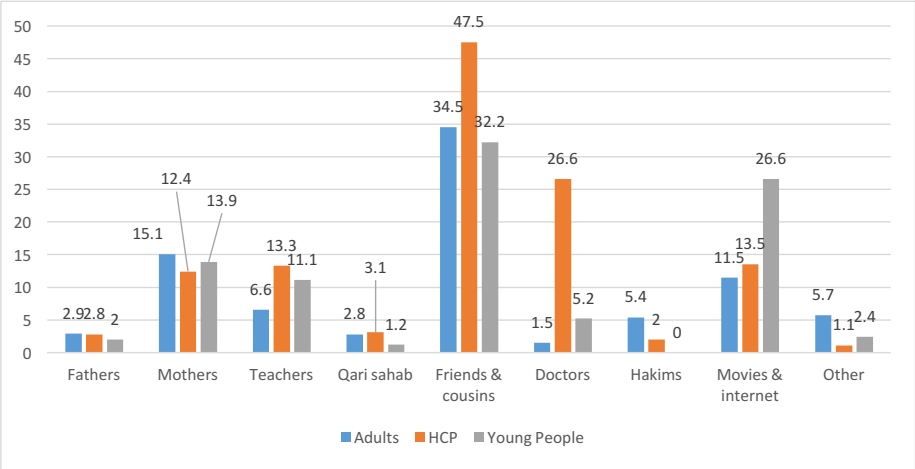
The majority of respondents (i.e. 78.5% of adults, 92.2% of HCP and 64.5% of young people) were aware of the biological process leading to child birth.



Graph 5: percentage of Respondents aware of biological process leading to child birth

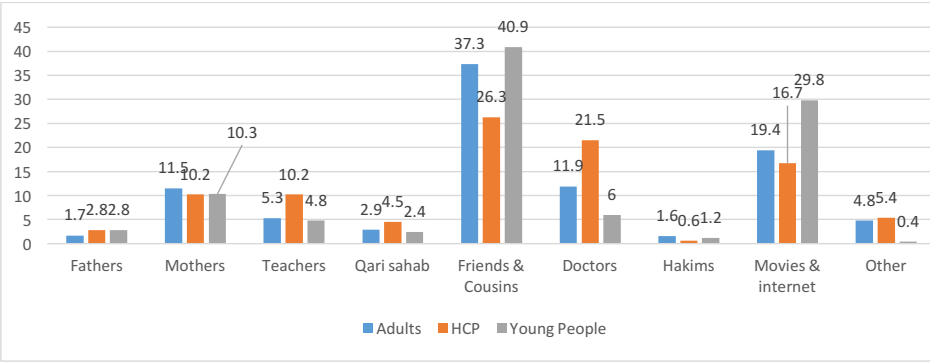
When asked as to what had been their primary source of information regarding child birth, the most cited source among HCPs, adults and young people was "Friends & cousins," with 47.5%, 34.5% and 32.2 respectively.

"Mothers" remained the most sought out source of information with 15.1% of the adults, 26.6% doctors for the HCP and 26.6% Movies & internet for the young people. Fathers on the other hand, remained least popular with only 2.2%, 2.8% and 2% of adults, HCP (respectively) and young people citing them as a source.



Graph 6: percentage of primary source of information regarding biological process of child birth

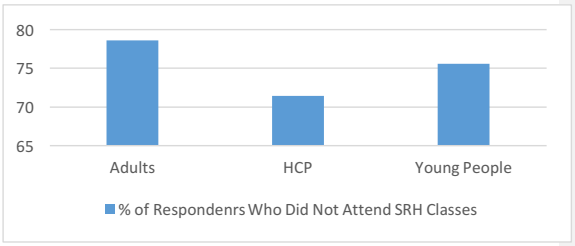
Similar results were recorded for secondary sources of information vis-à-vis child birth with most of the adults, HCPs and young people citing friends and cousins (37.3%, 26.3% and 40.9% respectively) and HCP citing doctors with second highest secondary source with (21.5%). Mothers were once again the most important care giver in terms of providing child-birth and pregnancy related information with percentages standing at 11.5% (adults), 10.2% (HCP) and 10.3% (young people). On the other hand, father once again fared worst among caregivers with percentages standing at 1.7% (adults), 2.2% (HCP) and 2.8% young people. It is important to point out here that 29.8% of the young people and 19.4% of adults cited the internet as a secondary source of information vis-à-vis child birth and pregnancy indicating a growing tendency among youth to refer to the World Wide Web for SRH related information in Pakistan.



Graph 7: percentage of secondary source of information regarding biological process of child birth

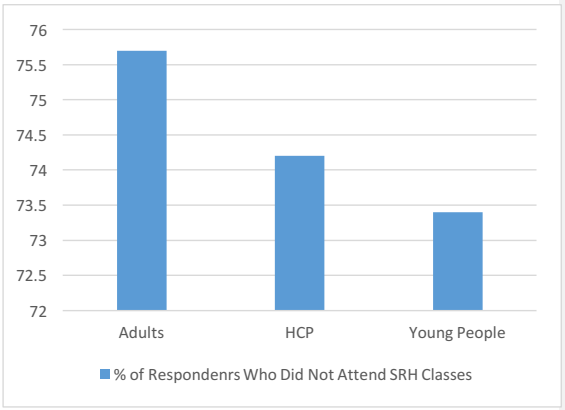
4.1.3 Sexual and Reproductive Health Education

78.6% of the Adults, 71.4% of the Healthcare Providers and 75.6% of the Young People did not attend any formal classes in their schools offering SRH education. This indicates that most schools in Pakistan do not have any arrangements to educate their students on sexual and reproductive health issues (e.g. good and bad touch, puberty, self-protection etc.) through formal coaching.



Graph 8: percentage of respondents who did not attend SRH classes in Schools

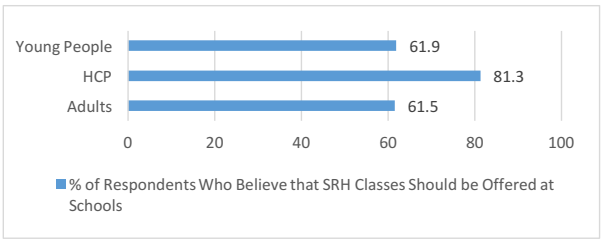
When asked if the respondents knew of any schools that offered SRH classes for their students, 75.7% of the Adults, 74.2% of the HCP and 73.4% of the Young People were unaware of any such classes.



Graph 9: percentage of respondents who did not know of any schools that offered SRH classes

While the survey reported an acute lack of SRH coaching in schools, majority of the respondents (i.e. 61.5% of the Adults, 81.3% of the Healthcare Providers and 61.9% of the Young People) believed that classes on sexual and reproductive health should be offered in schools. This indicates a favourable attitude of the communities towards formal SRH education for children.

Fear that young minds would be corrupted came forth as the primary reason why communities might be reluctant for their children to receive SRH education with 60.4% Adults and Young People and 58.3% Health Care Providers voicing this misgiving.



Graph 10: percentage of respondents who believe SRH classes should be offered at schools

72.6% of the Adults, 76.6% of the Healthcare Providers and 70.1% of the Young People shared that counselling services to guide young people about physiological and psychological changes during puberty were not available in their areas.

33% of the young transgender respondents were of the view that counselling services for adolescents were available while 66% stated that they were unaware of the availability of such services. None of the young transgender respondents responded in the negative. This implies that transgender communities are more inclined to reach out to counselling services for their adolescents compared to other groups.

Are there any counselling services in your area to help young boys and girls cope with changes when reach puberty? (HCP)	
HealthCare Providers	Percentage / Total
Yes	12.0%
No	76.6%
Don't know	10.9%
No Response	5%
Total Respondents	384

Table 5: Respondents (HCPs) view regarding availability of counselling services

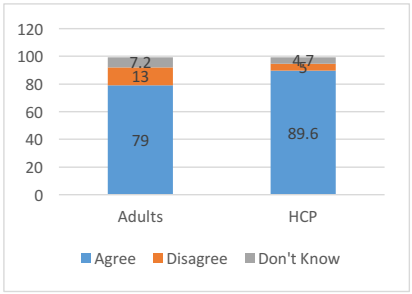
Are there any counselling services in your area to help young boys and girls cope with changes when reach puberty? (Adults)	
Adults	Percentage / Total
Yes	9.1%
No	72.6%
Don't know	17.2%
No Response	
Total Respondents	1215

Table 6: Respondents (Adults) view regarding availability of counselling services

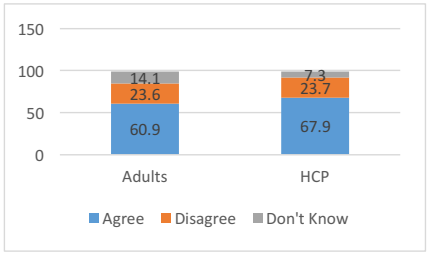
Are there any counselling services in your area to help young boys and girls cope with changes when reach puberty? (Young People)				
Young People	Sex of Respondent			
	Male	Female	Transgender / Transsexual	Total
Yes	7.5%	9.1%	33.3%	8.4%
No	72.3%	68.6%	0.0%	70.1%
Don't know	19.7%	21.7%	66.7%	21.0%
No Response	.5%	.6%	0.0%	.5%
Total Respondents	213	175	3	391

Table 7: Respondents (Young People) views regarding availability of counselling services

79% of the Adults and 89.6% of the Healthcare Providers) either "Strongly Agreed" or "Somewhat Agreed" that counselling services were important for the adolescents to guide them through puberty. This reflects an overwhelming agreement among stakeholders that adolescents require support and guidance during puberty.



Graph 11.1: %age of respondents (HCP and Adults) who believe counseling services are important for adolescents

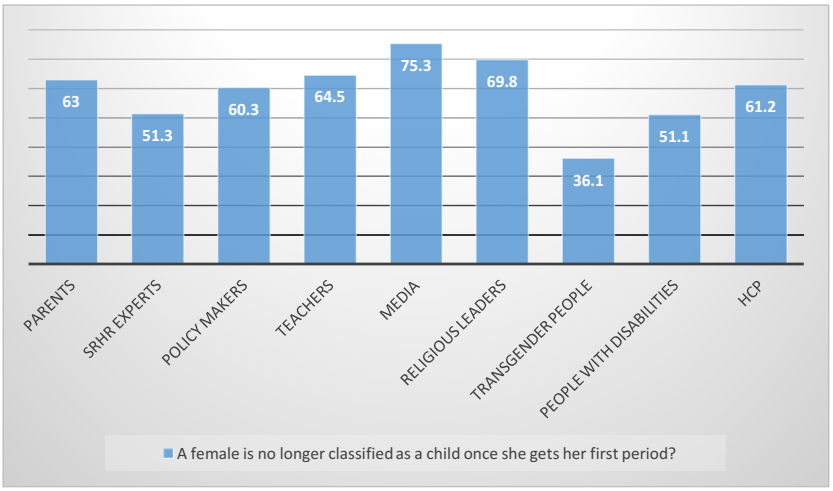


Graph 11.2: %age of respondents (HCP and Adults) who believe communities will be supportive of SRHR counseling services for adolescents

When asked if the communities would be supportive of SRHR counselling services for young people, 60.9% of the Adults and 67.9% of the HCP were of the view that the communities would support such an initiative.

4.1.4 Understanding of Sexual and Reproductive Health

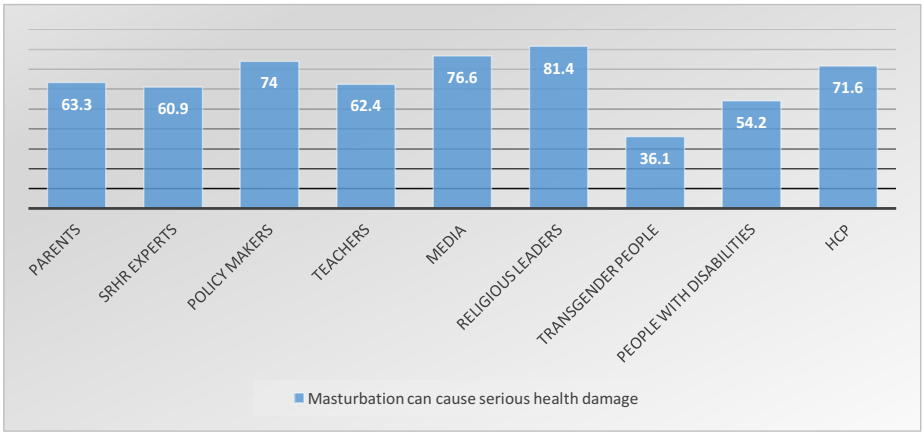
62% of the respondents from among "Parents and Other Stakeholders" and 61.2% of the "Healthcare Providers," were of the view that a female is no longer a child once she gets her first period. This indicated that a majority of the respondents, including 51.3% of the SRHR experts and 61.2% of the healthcare providers were unable to differentiate between sexual maturity and adulthood in females.



Graph 12: %age of respondents who believe a female is no longer a child once she gets her menstruation period

Similarly, the majority of the respondents, including 60% of the SRHR experts and 71.6% of the Healthcare providers believed that masturbation causes serious health risks. Again, this indicates a lack of understanding on part of the respondents including subject experts.

The only group that largely disagreed with this statement was that of the transgender people. Only 36.1% of the Transgender respondents believed that masturbation caused serious health risks. This reflects a greater level of awareness among the transgender community compared to the other groups that responded to the survey questionnaire.



Graph 13: %age of respondents who believe masturbation can cause serious health damage

4.1.5 Qualitative Findings

4.1.5.1 Information about Puberty

The qualitative data collected through FGDs and KIIs further strengthened the quantitative findings. Virtually all the young boys and girls when asked about their encounter with puberty shared that they had no prior knowledge of the phenomenon and even after they had experienced it, their parents/adult caregivers were not very inclined to talk about the subject.

Most young girls recalled their ordeal upon receiving their first period. Recalling her ordeal, a young girl from Quetta shared during a Focus Group Discussion, "I was in school the first time I had periods. I was very scared and cried the whole day. When my elder sister found me crying, she asked me what had happened and I told her that I was dying!"

The female participants, both young and old, unanimously felt that young girls must be told about mensuration before its advent. A married woman from Kasur voicing her opinion on the subject said, "A girl should be told about mensuration once she is about seven or eight years old."

Boys and men shared similar views. "We live in a society where talking about sexual health is considered a sin. This is why many boys refer to the internet to seek information; sometimes this habit leads them astray," shared one boy during a focus group discussion in Quetta.

4.1.5.2 Information about SRHR

During Focus Group Discussion and Key Informant Interviews it was revealed that owing to the absence of any formal channels of communication regarding SRH matters, most people had inaccurate information regarding such things as pregnancy and child-birth.

"For a very long time I was under the impression that if a man and woman shake hands, the woman becomes pregnant," shared a young female participant during a Focus Group Discussion in Baluchistan.

During FGDs while most married men shared that they went to a medical professional to seek help regarding their Sexual and Reproductive Health issues, women had a different story to narrate. "Women often keep their sexual and reproductive health issues concealed from their husbands owing to financial difficulties. Seeking medical help would mean spending money and so, many women choose to remain untreated rather than adding to the expenses," shared one woman during a FGD in Mardan.

Female participants from urban centres however were comparatively better informed and empowered. "We do go to doctors but access to the internet has also made life very easy. Young girls especially first seek information online and then if need be, refer to a doctor," shared a married woman from Karachi.

4.1.5.3 Sources of Information

Most of the adults during discussions shared that growing up they had no formal means of information regarding SRH either at home or in their schools. The same holds true as young people and minors interviewed during the research mostly shared that their school did not offer classes to educate them about sexual and reproductive health.

A few young people in urban centre like Karachi, however shared that they had attended classes on SRH in their schools.

At the same time, parents were more receptive to the idea of having their children receive SRH education than is otherwise perceived. "There should be a separate book that is taught in schools to educate our children about SRH education," shared a married woman during a Focus Group Discussion in Kasur.

Most girls and women quoted their sisters and mothers to be their primary source of information regarding puberty and SRH matters while most men and boys quoted their friends and elder cousins.

4.1.6 Analysis and Conclusion of Section 1

The findings under this section reveal that a significant majority of individuals in every part of the country and belonging to every socio-economic class, irrespective of their sex are deprived of authentic sources of information regarding their sexual and reproductive health.

In the absence of formal channels of communication young people often turn to sources such as peers and the internet to understand their SRH matters. This in turn leads to the spread of misinformation and an overall inability of the individuals to handle the sexual and reproductive health aspects of their lives effectively.

Interestingly, the concept of shame attached with one's sexual and reproductive health is so strong that even if given a chance now, most adults prefer going to their friends rather than their parents, doctors or teachers for SRH related issues.

This unnecessary cycle of confusion has remained unchanged for generations.

However, many participants cited the heinous rape and murder of a 9-year-old girl-child in the town of Kasur in 2018 for having a huge impact on their belief system vis-à-vis SRHR education for children. Most participants shared that the horrendous crime had made them more conscious of the need to educate their children against sexual violence and not turn their face away from the issue like their elders.

This awakening also resonated in the results of the quantitative survey where the majority of respondents favoured the introduction of sexual and reproductive health classes in schools.

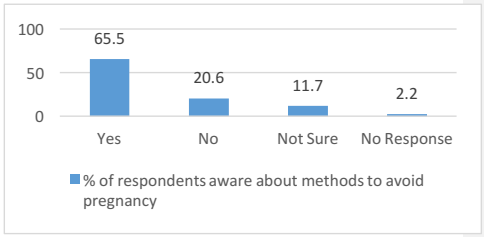
However, in this time and age when parents and caregivers are more receptive to the idea of SRH education and counselling in schools, both private and government institutes are unable to address this demand. There is still a conspicuous fear of backlash from conservative elements who continue to oppose sexuality education as a means to corrupt young minds.

It is therefore imperative that the federal and provincial governments step-in to propagate the importance of sexuality education for children as a means to empower them against misinformation, exploitation and sexual violence.

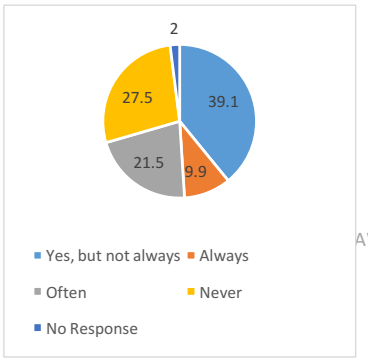
4.2 Sexual Practices

4.2.1 Contraceptive Use

65.5% respondents (in the "Adult" category") were aware of at least 1 method of contraception. However, only 9.9% "Always" used contraception and 21.5% "Often" used contraception. The positive finding however, was that only 27.5% of the respondents shared that they "Never" used contraceptive. These results indicate that there is greater awareness about contraceptive methods and even though their regular use is not very high, people are more open to using them. The responses of the survey participants belonging to the transgender community, however, suggested that regular use of contraception is not a common practice among this group.



Graph 14: %age of respondents who are aware of at least one method of contraception



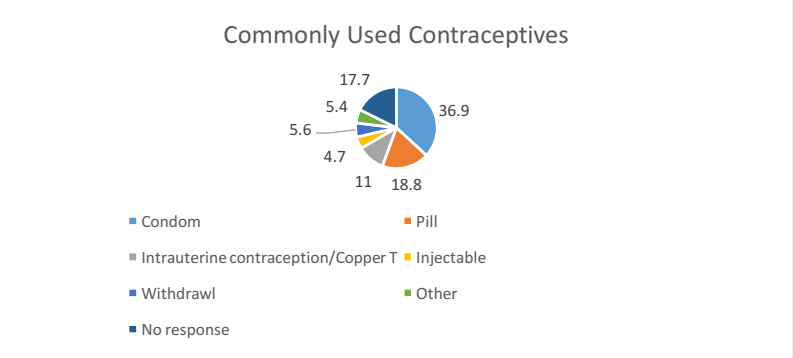
As per the recorded results, condom was the most well-known contraceptive followed by the pill among the Adults. Conversely, intrauterine contraception and injectable contraception were the least known types.

The responses provided by the respondents in the Adults category indicate that there is limited knowledge about

emergency contraceptives among communities. The groups whose majority of respondents were aware about emergency contraceptives were "SRHR Experts" and "Policy makers."

This finding is further strengthened by the responses of the healthcare providers with 63.8% sharing that only "Some of them (the patients) were aware about ECP.

Graph 15: %age of respondents who used method of contraception



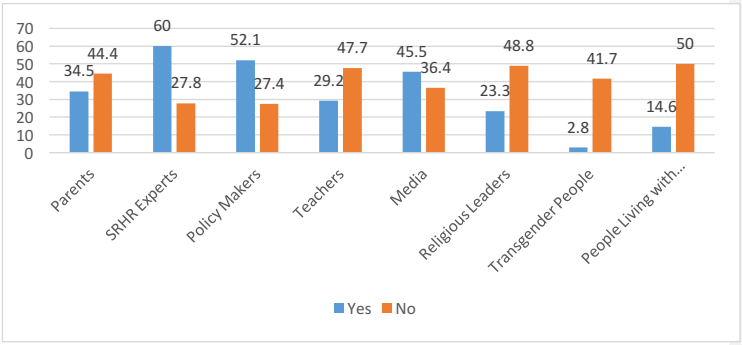
Graph 16: %age of respondents using different kind of contraception

It is perhaps this lack of knowledge because of which the majority of the participants (61.3%) shared that they had never used or had asked their partner to use an emergency contraceptive pill. For the same question, all the Transgender respondents answered with, "No," since transgender people do not see conception as a concern during intercourse.

	Type of Respondent								
	Parents	Experts	Policy makers	Teacher	Media	Religious Leader	Transgender	Person with disability	Total
Yes	39.5%	43.5%	42.1%	30.4%	22.9%	30.0%	0.0%	42.9%	36.3%
No	59.2%	53.6%	57.9%	67.0%	71.4%	70.0%	100.0%	42.9%	61.3%
No Response	1.3%	2.9%	0.0%	2.7%	5.7%	0.0%	0.0%	14.3%	2.4%
Total	152	69	38	112	35	10	1	7	424

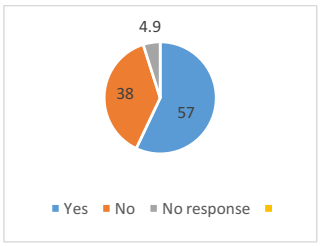
Table 8: %age of respondents who either used or asked their partners to use contraceptives

When asked if they had ever prescribed an emergency contraceptive to a patient, majority of the healthcare providers answered

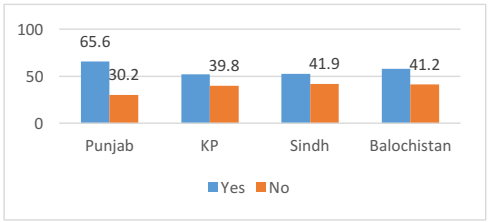


with, "Yes," showing that there was both a demand and a growing inclination among healthcare providers to utilize ECP.

A province wise breakdown revealed that a greater percentage of doctors in Punjab (65.6%) were willing to prescribe ECP to their clients compared to the other provinces. On the other hand, 41.9% of doctors in Sindh shared that they had never prescribed ECP to their patients.



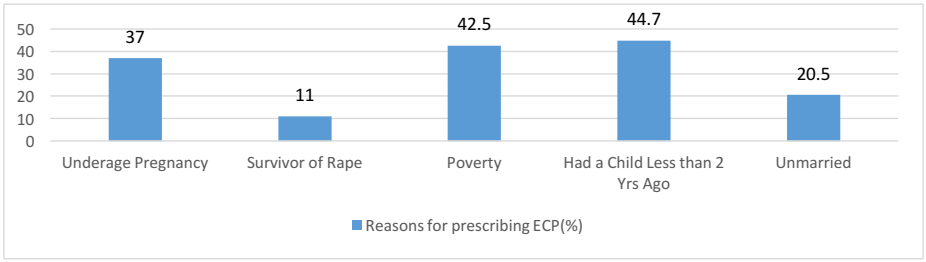
Graph 18: %age of healthcare providers prescribing contraceptives



Graph 19: % age breakdown of contraceptive prescribed by healthcare providers by province

Desire to space pregnancies among women (44.7%), poverty (42.5%) and underage pregnancies resulting (37%) were reported as the leading causes for prescribing emergency contraceptives by the Healthcare Providers. The desire to space the pregnancies as well as to abort an underage pregnancy are both directly linked to the limited control that women are allowed on their own bodies and the toll that their health is likely to take as a result of both un-spaced and early pregnancies.

It is also important to highlight that 20% of the respondents shared that they prescribed ECP to women who had conceived in consensual relationships but were not married. This indicates a huge tendency among unmarried people to engage in pre-marital sexual relations.



Graph 20: Key Reasons of prescribing contraceptives by HCPs (%age)

4.2.2 Qualitative Findings

4.2.2.1 Knowledge about Contraceptive Use

Across all the provinces where FGDs took place women shared that they were now much better aware about family planning methods to space their pregnancies. "Media and the internet have a huge role to play in helping me understand about contraceptive use," explained one female married participant during a Focus Group Discussion in Karachi.

4.2.2.2 Access to Contraceptives

Interestingly, most men during Focus Group Discussions supported a woman's right to access SRH information and space pregnancies. However, married woman across the country shared of various restrictions on their access to SRH information and contraceptive methods.

For instance, it was shared that in many parts of the country women were not the primary decision-makers about this matter. "Our mother-in-laws and husbands decide whether we should use family planning methods," told a married woman during a Focus Group Discussion in Mardan (Khyber Pakhtunkhwa).

Similarly, married women from Thatta, rural Sindh shared that men were often unwilling to use male contraceptive method themselves and most women secretly asked for medical help to space their pregnancies. "If you talk to the men about birth spacing, they often respond with, 'As many children are destined to come will come.' So we end up going to the nearest health facility alone and getting contraceptive injections or pills to prevent pregnancies."

This finding was further strengthened after discussions with married men. While most men shared that they were aware of and often used condom themselves, they also shared that it was not a common practice among men at large. This was found to be true even in urban centres. "There are not very many men who use condom; its use is very limited in our community," shared a married man during a FGD in Lahore.

Most women, from (the remote areas of) Punjab and Sindh and across Khyber Pakhtunkhwa and Baluchistan shared that they often used domestic hacks to prevent a pregnancy from occurring and/or maturing. Eating foods that are culturally considered unsafe for pregnant women, carrying weight and excessive physical exertion were quoted among the most commonly used domestic hacks.

4.2.3 Analysis and Conclusion of Section 2

There is an evident divide between contraceptive use in urban and rural Pakistan. While urban women, have a say in whether or not to conceive, rural women are still largely dependent on the decisions of their husbands and mothers-in-law.

This divide is largely due to the fact that urban women are more educated with access to various types of media including the World Wide Web. They are thus much more informed about the various options available to them to space or avoid pregnancies. They are also more empowered to have an equal say in matters of procreation and reproduction.

Rural women in Pakistan face an almost diametrically opposite situation where their lack of education and limited access to media and mobility hinder them from making empowered decisions about reproduction. Rural settings also confine them in traditional roles and norms. With limited to no

education and exposure and a community that looks down upon women, they then automatically stand at a disadvantage which is very difficult to turn unless serious efforts at behaviour change are made in their communities that educate their men about positive masculinity.

A Healthcare Provider during an FGD in Quetta further ossified this finding when she shared, "Men do not want to use contraceptives. It is almost impossible to convince them to use a condom but it is also no easy task to convince them to allow their wife to use a contraceptive if they themselves don't want to."

Misinterpretation of religious beliefs was also cited a huge concern. During an interview in Karachi a religious leader categorically stated that Islam had clearly articulated every aspect of life including sexual relations. He was of the opinion that often wrong interpretations were associated with Islamic preaching that were in reality could neither be considered religiously or socially acceptable.

However, despite these challenges more and more women are beginning to access medical help to space and/or prevent pregnancies. The increasing availability of and awareness about family planning clinics and other medical facilities that provide contraceptive services has been integral to this process. Even though most women reported that they seek these services secretly from their husbands and in-laws, it can nevertheless not be denied that women have gained a certain level of control on their own sexual and reproductive health – something that was not available to their elders at all.

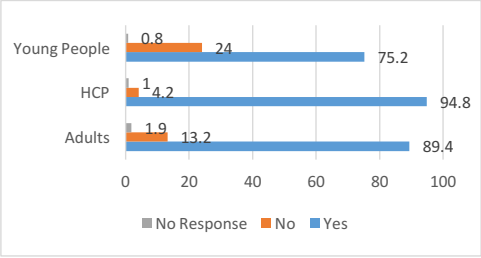
It is also important to give credit to the government here whose efforts to increase availability and accessibility to contraceptives is finally beginning to show results after more than two decades since the campaign was first launched.

At the same time, it also needs to be borne in mind that there is still a long way to go before Pakistan experiences universal accessibility to contraceptives. To achieve this goal, it is not merely important to set-up a greater number of medical facilities offering contraceptive guidance and services but is also equally important to change patriarchal behaviours that have been identified as the leading cause for limiting women's access to contraption.

4.3 HIV/AIDS and Sexually Transmitted Diseases

4.3.1 Knowledge of HIV/AIDS

A huge majority of the respondents had heard the term, "HIV/AIDS," indicating that the efforts of both the government and the civil society to raise awareness about HIV/AIDS have borne positive results.



As per the survey findings, a fair percentage of the Adults (42.5%) know that HIV/AIDS is not a curable disease. On the other hand, majority of the Young People, have limited understanding of the issue. Among Young People, it is the transgender youth particularly (at 66%) that does

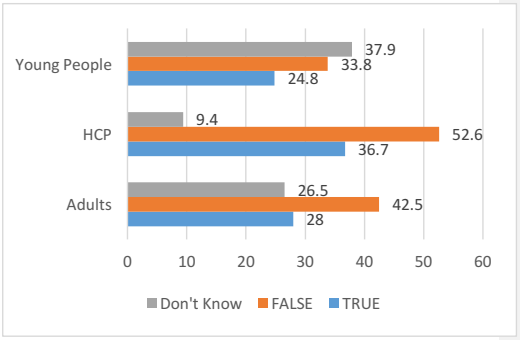
not know about the incurable nature of HIV/AIDS.

Graph 21: % age of Respondents who ever heard about HIV/AIDS

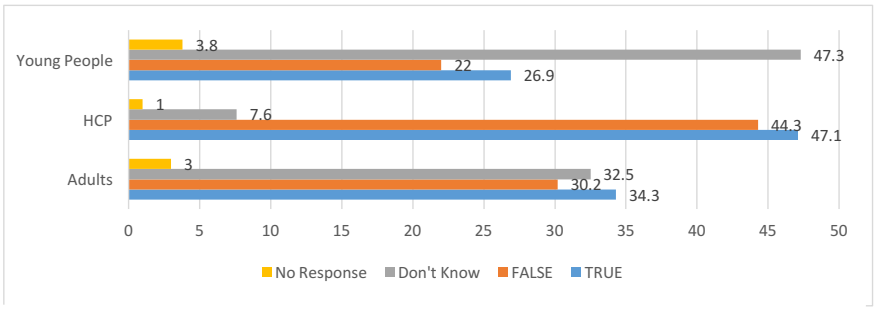
A majority of the healthcare providers (i.e. 52%) are aware that HIV/AIDS is an incurable disease. However, this is not an impressive percentage for individuals working in the health sector.

On the other hand, results reflect that most respondents, including healthcare providers are unaware of how HIV/AIDS can be diagnosed. Only 34.3% of the Adults, 47.1% of the HCP and 26.9% of the Young People were aware of the fact that HIV/AIDS can be diagnosed with a simple test.

This finding indicates a huge informational gap at all tiers of the society regarding HIV/AIDS and calls for awareness drives that can inform people beyond mere sensitization regarding the symptoms of this disease.

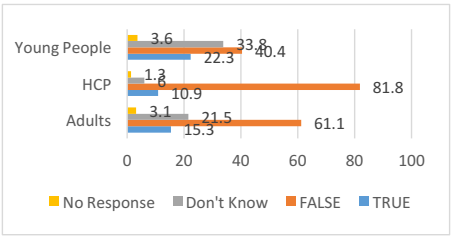


Graph 22: %age of Respondents who think if HIV/AIDS is curable



Graph 23: %age of Respondents who know a simple test can reveal whether someone has HIV/AIDS or not

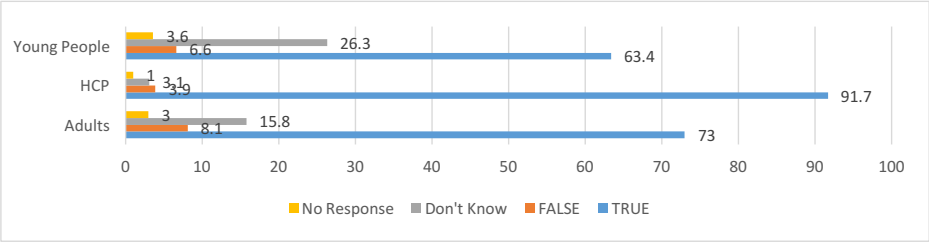
On the other hand, however, most groups of people are aware that HIV/AIDS does not spread through shaking hands and/or sharing food. The only groups that exhibited limited knowledge regarding this question were people living with disabilities and young people in general.



Graph 24: %age of respondents who think HIV/AIDS can even spread through eating together and shaking hands

73% of the Adults, 91.7% of the HCP and 63.4% of the Young People were aware that HIV/AIDS can be transmitted through sexual contact. Thus, the results indicated that respondents are generally

well-aware of the fact that among other ways, HIV/AIDS is also a sexually transmitted disease.



Graph 25: %age of respondents who think HIV/AIDS is a sexually transmitted disease

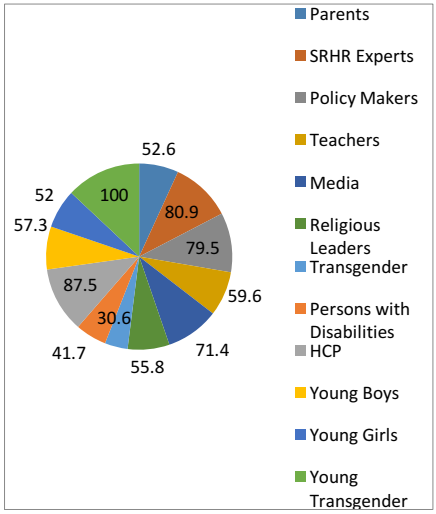
4.3.2 Other Sexually Transmitted Infections

Majority of the respondents knew about the incidence of sexually transmitted diseases. Transgender, adults scored the highest with 100% of the respondents being aware.

When asked to substantiate their previous response by naming a few Sexually Transmitted Diseases, 69.7% of the Adults and 64.3% Young People could name between 1 to 3 STDs[82].

48.8% of the HCP could name between 1 to 2 STDs while 28.3% of the Healthcare Providers could name more than 4 Sexually Transmitted Diseases.

On the whole favourable results were indicated through the responses of the survey participants.



No. of STIs	Adults	HCP	Young People
0	15.7	19.3	12
1	30.5	24.7	32.4
2	25.3	24.1	19.9
3	13.9	0	12

[82] Percentages of responses given under options 1, 2 and 3 were added to interpret the result.

Table 9: %age of respondents who were able to name few STIs

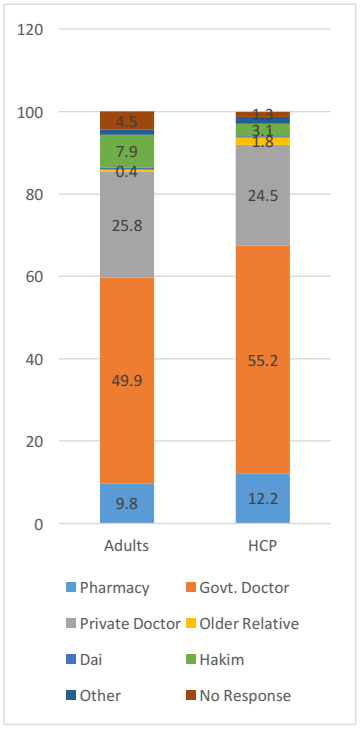
More than 3	0.6	28.3	0
No Response	13.9	3.6	23.6

The recorded results depicted a favourable trend with 75.7% of the Adults and 79.7% of the Healthcare Providers being of the view that in case a male in their community required treatment for a sexually transmitted disease, he would either go to a government hospital/health centre/clinic or a private doctor/nurse/clinic.

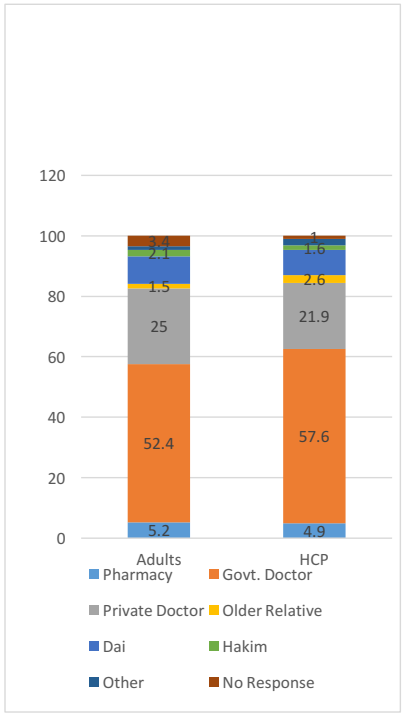
Similar results were recorded when respondents were asked where a female who needed treatment for a sexually transmitted disease would go with 77.4% of the Parents and Other Stakeholders and 79.5% of the Healthcare providers being of the view that the patients would either go to a government hospital/health centre/clinic or a private doctor/nurse/clinic.

Comment [WU1]: Please rename it with "Adults" as mentioned this category earlier.

In the opinion of the respondents, both males and females who required treatment for a Sexually Transmitted Disease were least likely to go to an older relative.



Graph 27: %age of respondents think where male will go for STI treatment



Graph 28: %age of respondents think where female will go for STI treatment

4.3.3 Qualitative Findings

Qualitative findings complimented the quantitative results as far as basic knowledge about HIV/AIDS is concerned. For instance, most participants, even young, unmarried people were aware about the disease and how it can be contracted. For instance, boys during a FGD in Lahore shared, "HIV can be contracted even by using an infected tool for shortening hair and through sexual contact."

Adult research participants, especially women and sex workers were aware about other sexually transmitted infections and even if they did not know the medical name of the disease, they were able to identify symptoms such as vaginal discharge and itching.

Young people's knowledge about STIs was limited. While they had heard about HIV/AIDS they seemed largely unaware about sexually transmitted infections. Young people mostly identified with mensuration-related discomfort (in girls) and premature ejaculation in boys as their leading reproductive health issues. However, neither can be classified as a sexually transmitted infection or disease.

4.3.4 Analysis and Conclusion of Section 3

As far as knowledge about the phenomenon of HIV/AIDS and other sexually transmitted Infections goes, people are generally aware about them. However, for most people the level of knowledge – especially with regard to HIV/AIDS ends there. Even healthcare providers themselves are not fully aware of the nature and diagnosis of the illness.

The most alarming finding in this regard is perhaps that only 47.1% of the healthcare providers who filled out the survey were aware that HIV could be diagnosed through a simple blood test. This leaves a huge question mark on the ability of healthcare providers to effectively diagnose and deal with a case of HIV/AIDS.

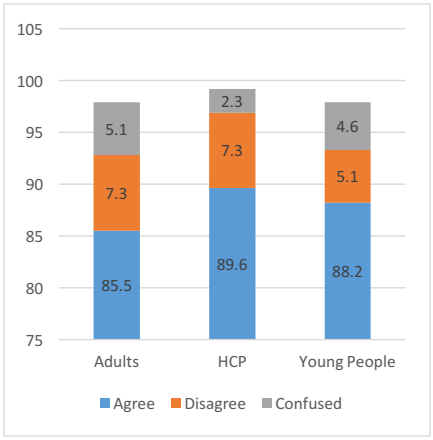
The level of knowledge vis-à-vis other STIs is relatively better. This is partially owing to the fact that more people are inclined to go to a certified medical practitioner rather than a peer/hakim/quack to have their STI treated, thereby improving their understanding of its incidence and treatment.

While it goes to the government's credit to have made more people aware about the phenomenon of HIV/AIDS, it is important to point out that this knowledge needs to be supplemented with more information regarding diagnosis, options for treatment and preventive measures.

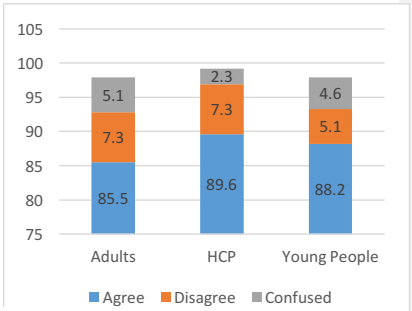
4.4 Sexuality, Gender and Norms

4.4.1 Gender Discrimination

Generally favourable results were recorded in the quantitative survey with regard to the acceptance of a female child. 85.5% of the Adults, 89.6% of the Healthcare providers and 88.2% of the Young People believed that the birth of both a girl and a boy should be celebrated.



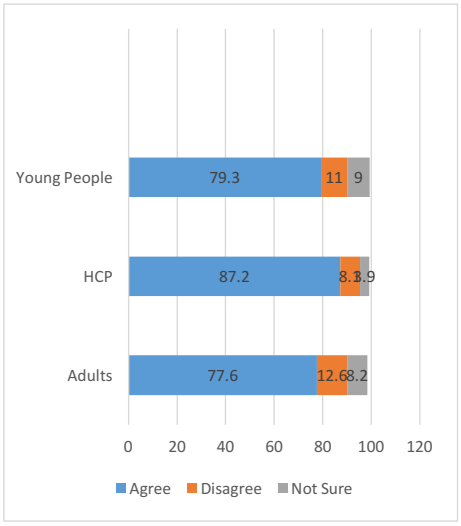
The previous, favourable trend continued with regard to prevalent gender norms, as a huge majority of the respondents across all groups believed that both males and females have the right to education.



Graph 29: %age of respondents who believe birth of both girl and boy should be celebrated

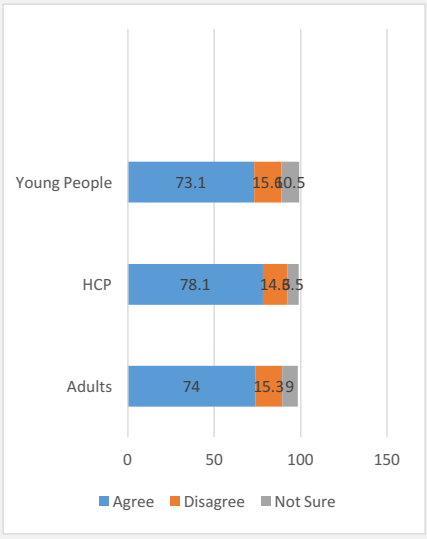
Graph 30: %age of respondents who believe both girls and boys should be given equal education opportunities

Similarly, the majority of the respondents, i.e. 77.6% of the Adults, 87.2% of the HCP and 79.3% of the Young People believed that both men and women have the right to various recreational activities.



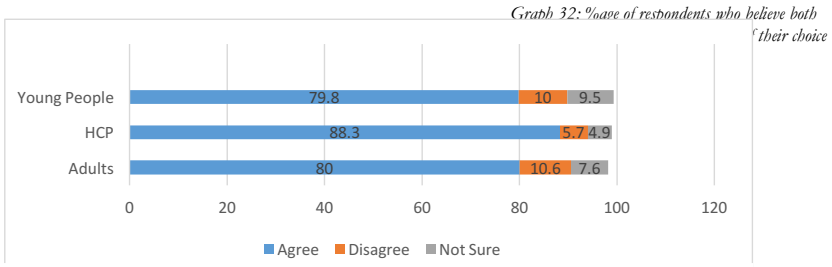
In line with the positive trend, the majority of the respondents believed that both men and women should have the right to travel freely.

Majority of the respondents believed that both boys and girls should have the right to express themselves through the dress of their choice.



Graph 31: %age of respondents who believe both girls and boys have right to recreational activities

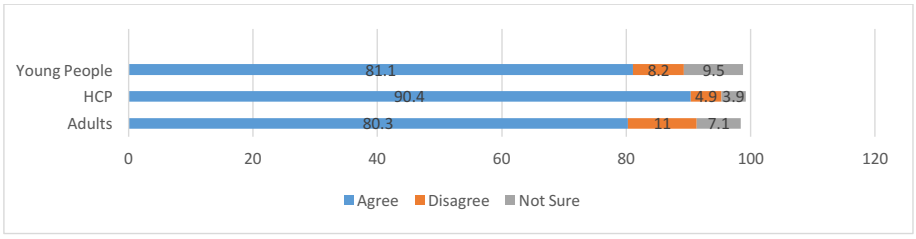
The majority of the survey respondents, (80% of the Adults, 88.3% of the HCP and 79.8% of the Young People) were of the opinion that both men and women should have access to formal justice systems the right to engage in legal matters independently.



Graph 33: %age of respondents who believe both girls and boys have equal right to be engaged in legal matters

Following the same trend, 80.3% of the Adults, 90.4% of the HCP and 81.1% of the Young People from among the survey respondents believed that both men and women should have the right to choose the life partner of their choice.

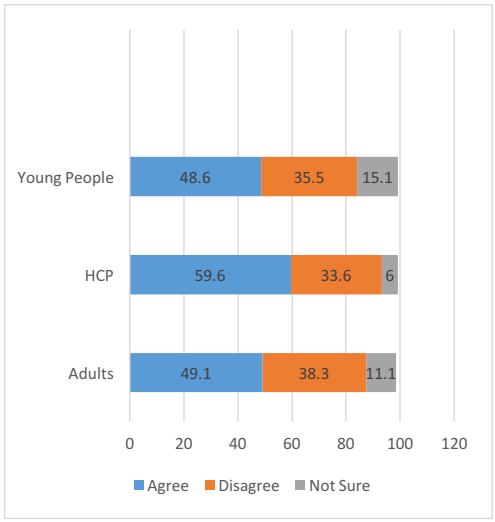
Comment [WU2]: We need to see the gender dynamics in it, we will request sajjad shb to share its gender wise %.



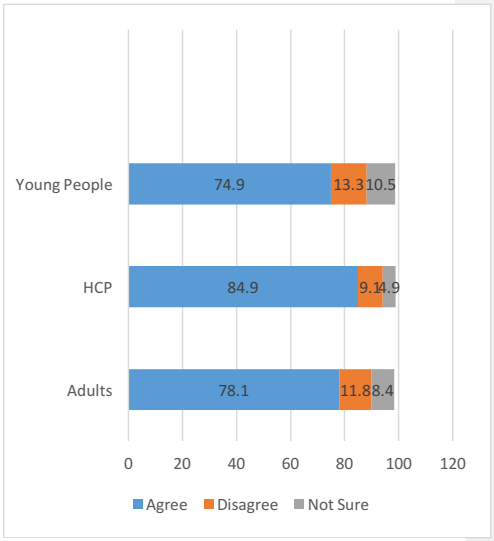
Graph 34: %age of respondents who believe both girls and boys have equal right to choose their life partner

Departing the previous trend, the survey results showed that there was limited acceptance of dating among Adults (49.1%) as well as Young People (48.6%). Healthcare Providers on the other hand demonstrated a fair result with 59.6% of them favouring the courtship before marriage.

Majority of the participants (74.9 % young people, 84.9 % HCPs and 78.1 % Adults) were of the opinion that both men and women have the right to pursue economic activities.



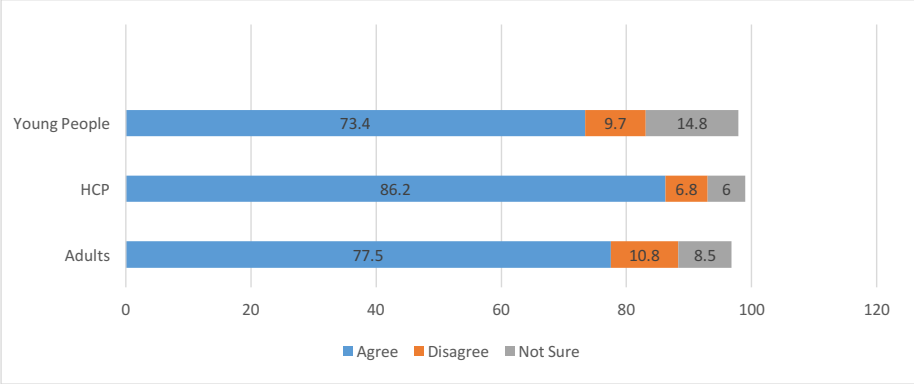
Graph 35: %age of respondents who believe both girls and boys can go on date before marriage



Graph 36: %age of respondents who believe both girls and boys have equal right to economic opportunities

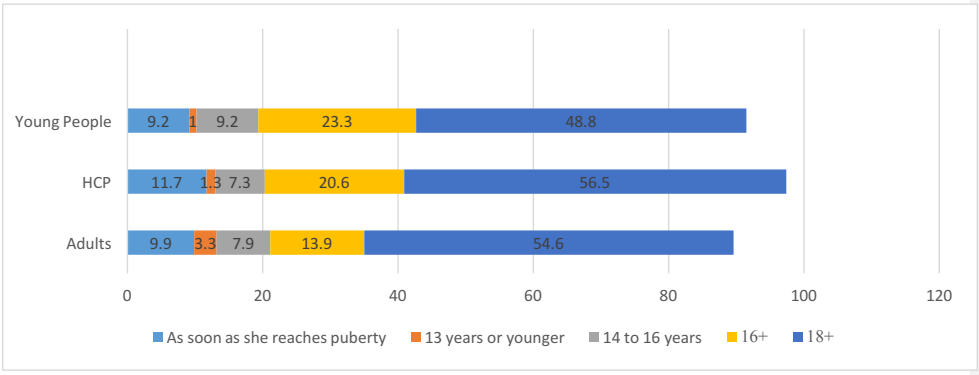
77.5% of the Adults, 86.2% of the HCP and 73.4% of the participants were of the view that both men and women have the right to receive information regarding their sexual and reproductive health.

Graph 37: %age of respondents who believe both girls and boys have right to attain information regarding sexual and reproductive health

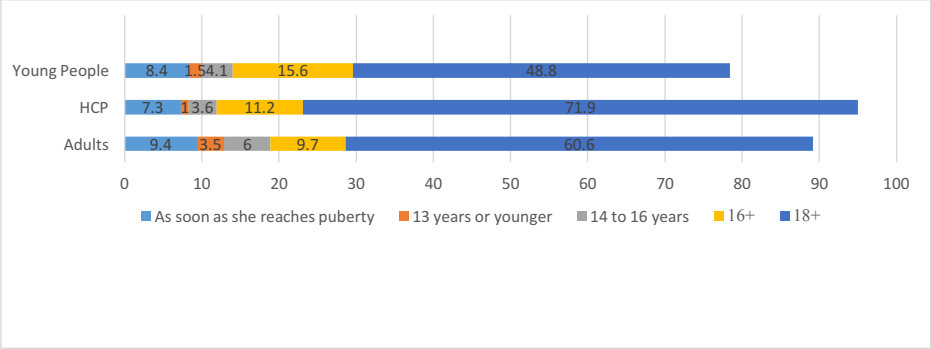


A little over 50% of the Adults and Healthcare Providers shared that girls in their communities were considered of marriageable age after they had reached at least 18 years of age. A relatively fewer number of Young People (48.8%) opted for the same response as the other groups.

A significantly higher number of respondents opted for "18 and above" when asked about the prevalent age of marriage for boys in their communities compared to the responses recorded for girls.

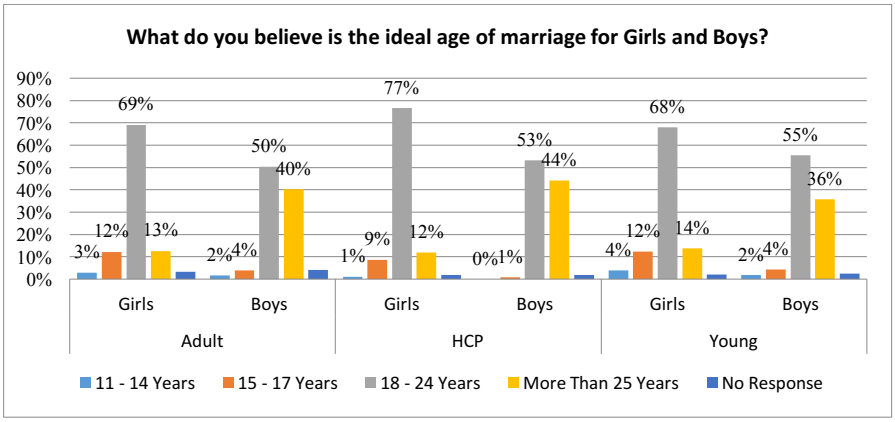


Graph 38: At what age a girl should be married- The perception among the community (in %age)



Graph 39: At what age a boy should be married- The perception among the community (in %age)

The respondents' own opinion about the marriage age for both boys and girls was also taken. Over 50% of the respondents under each category were of the opinion that the ideal age of marriage for both girls and boys was over 18 years and somehow between 18-24 years. However, significantly more respondents under each group believed that girls should be married at 18 years or above compared to boys.

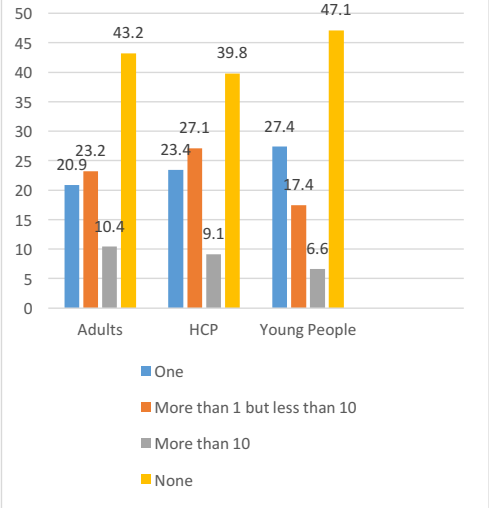


Graph 40: %age of respondents believe the ideal age of a girl and a boy to marry

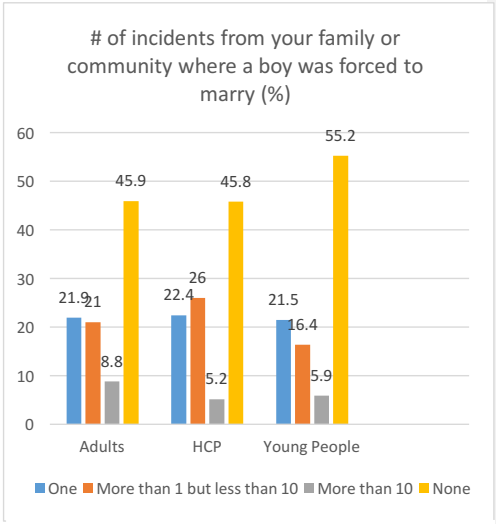
The results point out an important trend with regard to society's changing attitudes towards underage marriages. A significant majority of the respondents believed that the ideal age of marriage commenced from 18 years and above

To gauge the prevalence of forced marriages, survey participants were asked to quantify the number of instances that they personally knew of forced marriages for both boys and girls. Over 50% of the respondents belonging to the groups of Adults as well as the Healthcare Providers recalled between 1 to over 10 such instances. This indicates that seeking the consent of the majority of young people before marriage is still not a very common practice in most parts of the country.

Young People on the other hand responded with more positive results with 45% and 47% stating that they had never heard of a girl or boy (respectively) being married off forcibly.



Graph 42.1: %age of respondents reported incidents where a girl was forced to marry



Graph 42.2: %age of respondents reported incidents where a boy was forced to marry

Alternatively, he results can also be interpreted to reflect that 54.5% of the adults, 59.6% of HCP and 51.4% of the young people had witnessed between 1 – 10 instances of forced marriages among girls. Similarly, 51.7% adults, 53.6% of the HCP and 43.8% of the young people had seen between 1 – 10 instances of boys being forced into marriage. These results indicate an alarmingly high rate of forced marriages across Pakistan.

4.4.2 Qualitative Findings

Focus Group Discussions with married women and young girls revealed of widespread discrimination.

4.4.2.1 Birth of a Female Child

"Our husbands desire sons rather than daughters," shared a married woman in Mardan. Another married FGD participant from Mardan shared, "Women are asked to terminate their pregnancies if the couple already has a daughter. This is never the case no matter how many sons are conceived." This finding was seconded by a healthcare provider in Quetta who said, "A lot of times women come to me for abortion because they are expecting a girl. They fear that if their husbands find out they will marry a second or third wife to bear a son."

4.4.2.2 Right to Choose

Regarding one's right to choose their life partners, most participants across the country shared that some level of consent was increasingly being taken from both men and women. However, a love marriage is still a far cry from reality for many girls. "If a boy chooses his life partner, no one has an issue. But the moment a girl shares her preference, people start pointing fingers at her character," stated a married woman during an FGD in Karachi.

A young female participant from a Focus Group Discussion in Mardan shared that some mothers do talk to their daughters about the possibility of love and relationships. "However, those discussions are more focused on scaring their daughters into never having an affair rather than guiding them to be in a healthy and safe relationship if the opportunity comes," she shared.

However, forced marriages are not unique to females alone. "There are many cases of forced marriages in our communities. This happens more with girls; however, boys too are forced. This happens even in the poshest communities of the city," reported one married woman from Karachi.

4.4.2.3 Age of Marriage

Most FGD participants, both males and females shared that the age of marriage for both boys and girls should be 18 years or above. However, at the same time they also reported widespread underage marriages.

A stark difference between the responses of some men compared to other participants were observed where they believed that girls should be married off as early as possible while boys should not be married until they are older and wiser. During an in-depth interview, the President of Press Club (Thatta, Sindh) said, "Girls should be married off by 17 or 18 years but boys should be married at about 24 or 25 years so that they get time to establish a career and attain mental maturity."

Highlighting the issues that girls face after underage marriages, a female healthcare provider from Quetta shared, "A lot of times very young girls come with pregnancy related complication. Their husbands are often in their fifties while the girl is barely a teenager. Their bodies are immature and unprepared to bear a child yet they have no control over the decision to reproduce."

Member of the Provincial Assembly of Baluchistan during an in-depth interview shared that efforts were underway to raise the minimum age of marriage; however, such endeavours were being met with resistance from conservative/religious parties within the assembly.

4.4.3 Analysis and Conclusion of Section 4

The quantitative and qualitative results reflected a contradiction in some aspects of the research. Most notably, this was observed vis-à-vis the celebration of a female child. While survey participants shared a more optimistic picture of the scenario, most female participants during the qualitative leg of the research had a different story to tell.

Especially based on the qualitative feedback received from across Pakistan, gender discrimination in one or the other form is rampant across the country. While in more conservative areas of Pakistan men go as far as to have their wife's pregnancy terminated if she is expecting a girl-child, urban girls face discriminatory practices vis-à-vis their right to choose their life partners and in some cases their mobility.

Early marriages are another important issue that demands immediate attention. However, no serious effort by the government seems to be in place as out of all the four provinces, only Sindh has a law that puts the minimum age of marriage at 18 years for both boys and girls as opposed to other provinces where the minimum age of marriage stands at 18 years for boys and 16 years for girls. The primary challenge for rights' activists in the regard is then achieving legal amendments in the provincial laws of Punjab, Baluchistan and Khyber Pakhtunkhwa.

That said, legal amendment without effective implementation and the will of the state will not solve the problem. This is amply illustrated by the fact that even though Sindh has a law barring marriages of girls below 18 years of age in place, the province still struggles against the highest number of child marriages in the country.

As observed through interactions with various groups, gender discrimination is on a slow but steady decline in urban areas and its severity is significantly less for urban women. An important testament of this lies in the opinions of both the survey respondents and the participants of FGDs and IDIs with regard to the age of marriage. A significant number of participants believed that the ideal age of marriage for both boys and girls begins from 18 years and above – clearly rejecting child marriages.

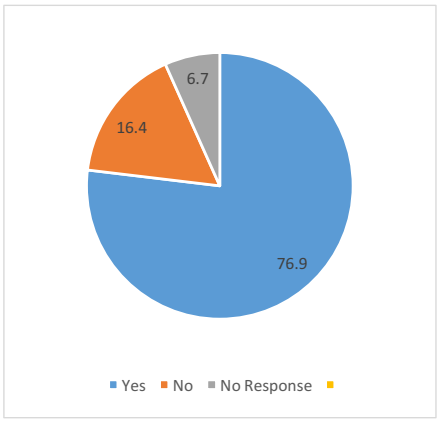
However, at the same time it also needs to be considered that the survey results reflected an alarming rate of forced marriages, both among boys and girls. This reflects that awareness drives over the past decade or so regarding the ills of child marriages have successfully helped to improve attitudes and has more people are now willing to wait at least until 18 years before marrying off their children. However, forced marriages are still a huge concern and behaviour change drives must now also focus on sensitizing parents on their child's right to decide his/her life partner. It can potentially prove helpful to take religious scholars on-board as misinterpretation of religion remains a leading cause to justify forced marriages, especially those of girls. "Islam demands that a girl's approval be sought before she is married off; there can be no two opinions about this," stated a religious scholar from Lahore during an in-depth interview.

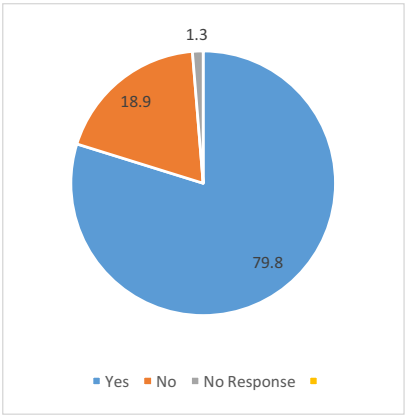
The fact remains that by and large Pakistan is still a patriarchal society governed by misogynistic norms that limit women's rights starting from the moment they are born.

4.5 Use and Perceptions of Health Services

4.5.1 Government Health Facilities

To investigate the availability of government health facilities, Parents and Other Stakeholders as well as Minors and Young Adults were asked whether a government health facility was located in their area. 76.9% of the Adults and 79.8% of the Young People confirmed that government health facilities were available in their areas.

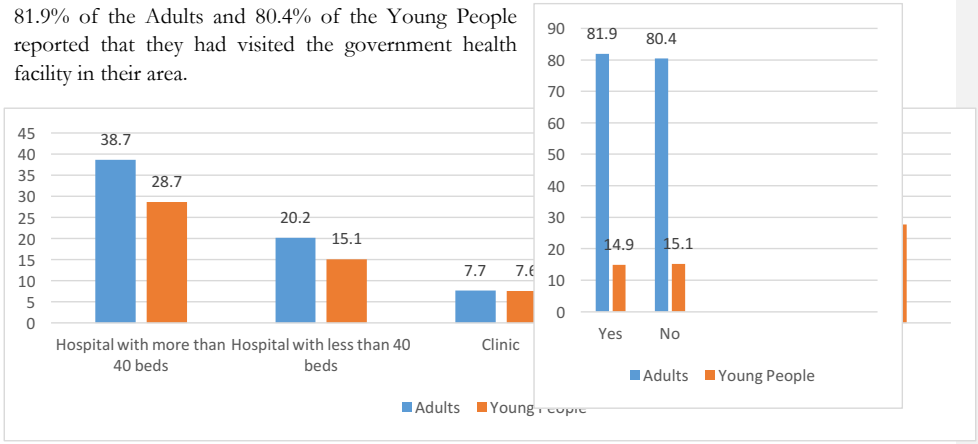




Graph 43. Graph 43.2: %age of young people confirmed availability of government health facility in their area

58.9% of the Adults shared that the government facility in their area was a hospital while 43.8% of the Young People shared the same result[83].

81.9% of the Adults and 80.4% of the Young People reported that they had visited the government health facility in their area.



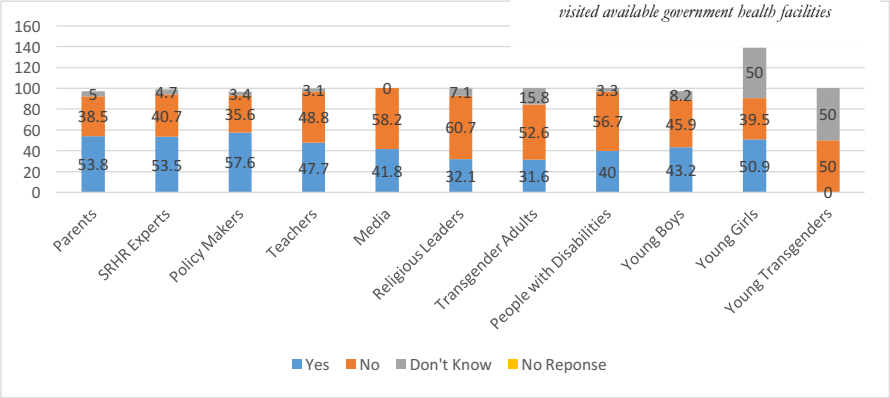
Graph 44: %age nature of available government health facilities confirmed by adults and young people

[83] For the sake interpretation, hospitals with more than and less than 40 beds were clubbed.

Interestingly there was not much difference in positive and negative responses when Adults and Young People were asked whether the government health facilities in their areas were well-equipped. 49.6% Adults and 46.2% of the Young People responded with, "Yes," while 44.7% and 43.1% responded with, "No," respectively.

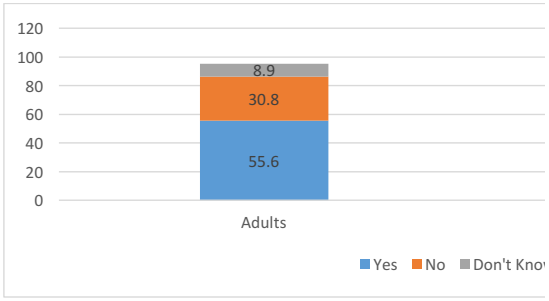
Among all the respondents, the transgender participants were most dissatisfied with the healthcare facilities in their areas with 52.6% Adults and 50% of the Young Transgender respondents responding in the negative. 0% of the Young Transgender participants who responded felt that the healthcare facilities were well-equipped.

Graph 45: %age of adults and young people who ever visited available government health facilities

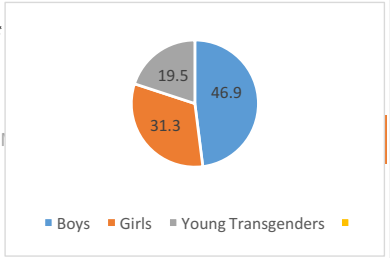


Graph 46: %age of respondents who found available government health facilities well-equipped

A fair number of respondents, i.e. 55.6% of the Adults and 46.9% of the Young People found the staff of the government hospitals in their areas to be well-trained.



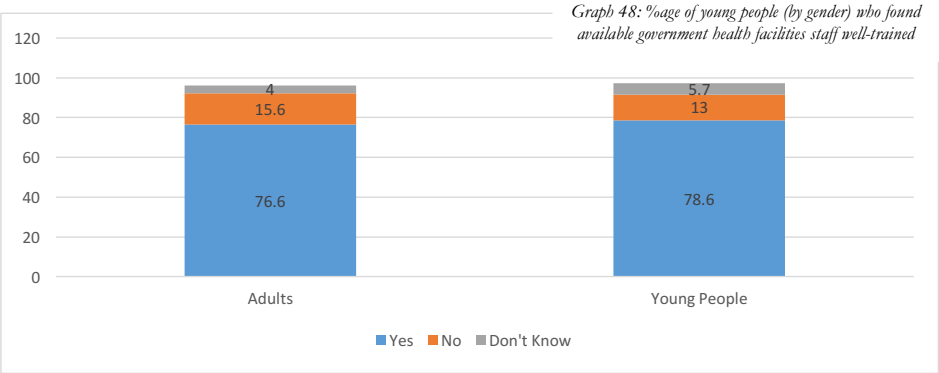
Graph 47: %age of respondents who found available government



None of the young transgender respondents found the staff of the government health facility in their area to be well-trained.

Although Pakistan does not have a free healthcare system, a very nominal fee is charged to ensure access for low income individuals. Not surprisingly then, 76% of the Adults and 78.6% of the Young People found the government health care facilities to be affordable.

Graph 48: %age of young people (by gender) who found available government health facilities staff well-trained



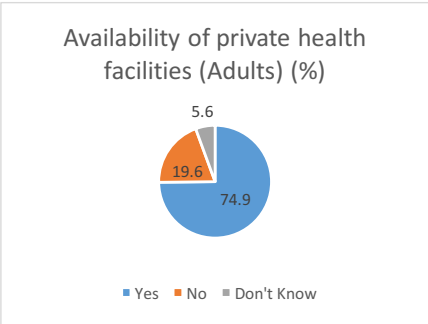
Graph 49: %age of respondents who found available government health facilities affordable for poor people

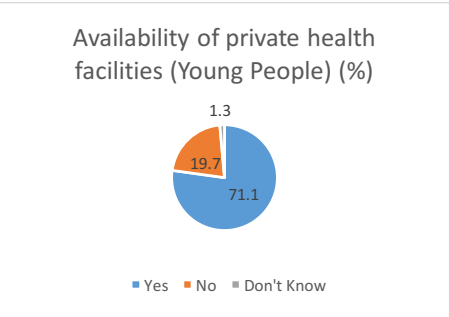
A fair percentage of respondents, i.e. 65.7% Adults 59.2 Young People found the doctors and nurses in the government health facilities to be well-mannered and helpful.

However, 100% of the young transgender respondents refrained from answering with either a "Yes," or a "No," and instead opted for, "Don't know/Not sure."

4.5.2 Private Health Facilities

74.9% of the Adults and 71.1% of the Young Adults reported of having a private healthcare facility in their area.



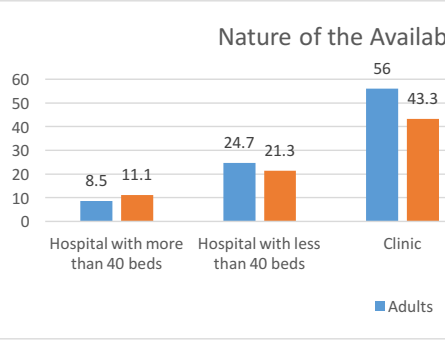


Graph 50.2: %age of young people confirmed availability of private health facility in their area

While private healthcare facilities are widely available, most of these facilities are at a small scale. According to adult respondents, 56% of the private healthcare facilities in their areas are clinics and 4.5% were BHUs and dispensaries.

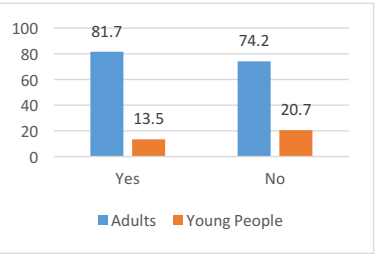
Young People also gave similar responses, with 43.3% clinics, 8% BHUs and 6.4% dispensaries.

Graph 50.1: %age of adults confirmed availability of private health facility in their area



Graph 51: %age nature of available private health facilities confirmed by adults and young people

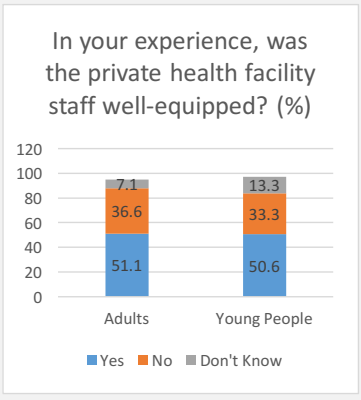
Majority of the respondents, i.e. 81.7% of the Adults and 74.2% of the Young People shared that they had visited the private healthcare facility in their area.



Graph 52: %age of adults and young people who ever visited available private health facilities

A fair number of respondents, i.e. 51.1% Adults and 50.6% of the Young People found the private healthcare facilities in their areas to be well-equipped.

However, 100% of the young transgender survey participants replied with, "No."

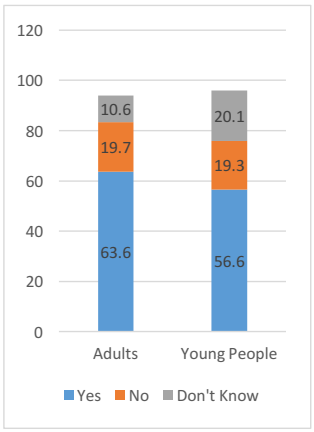


Overall, a fair percentage of respondents also found the staff at the private healthcare facilities in their areas to be well-trained with 63.6% of the Adults and 56.6% of the Young People giving a positive response.

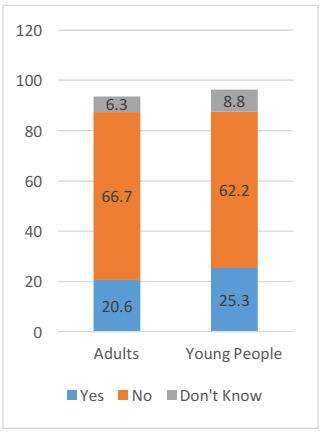
Interestingly, the transgender young people, when asked about the level of competence of the staff of the private health facility in their area, neither replied with "Yes" or "No," but rather with "Not Sure."

Majority of the respondents, i.e. 66.7% of the Adults and 62.2% of the Young People were of the opinion that the available private healthcare facilities in their areas were not affordable for people belonging to the low income strata.

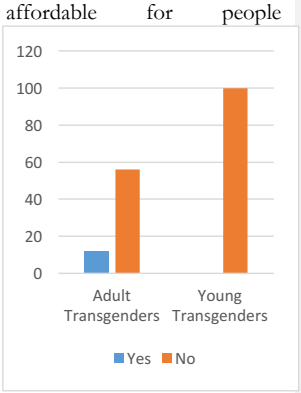
Graph 53: %age of adults and young people who found private health facility staff well equipped



Graph 54.1: %age of adults and young people who found private health facility staff well trained



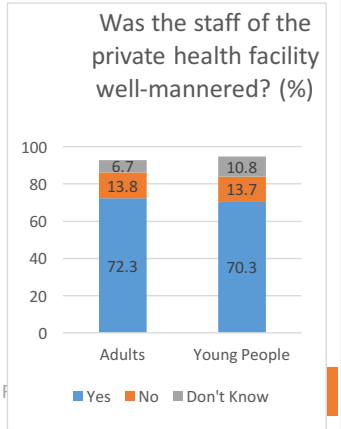
Graph 54.2: %age of adults and young people who found private health facilities affordable for poor people



Graph 54.3: %age of adults and young trans-genders who found private health facilities affordable for poor people

56% of the Adult transgender respondents and 100% of the young transgender respondents believed that the private health care facilities in their areas were not affordable for poor people.

Majority of the respondents with 72.3% of the Adults and 70.3% of the Young People found the staff at the private healthcare facilities to be helpful and well-mannered. However, 100% of the young transgender people responded with, "Not Sure."



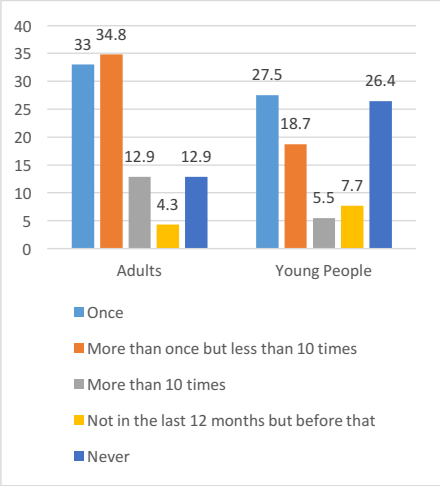
4.5.3 SRH Services

72.6% of the Adults and 76.7% of the Young People had never been to a health facility or doctor to seek information on bodily changes and puberty. This indicates that majority of the people in

Pakistan do not refer to a medical professional to understand puberty related changes themselves or for the minors in their care.

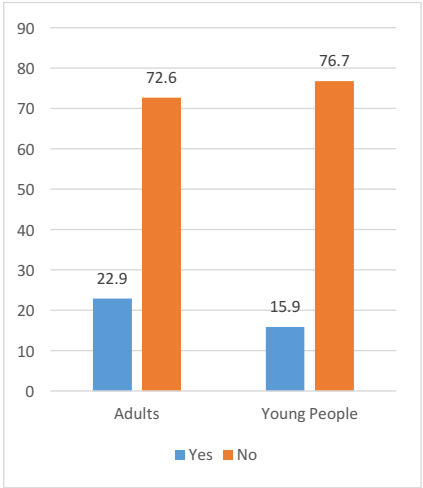
Of those who had previously seeked guidance on bodily changes and puberty related matter from a medical professional, 80.7% of the Adults had visited a medical professional for this purpose during the previous 12 months.

Compared to adults, a smaller percentage of Young People (51.7%) had seeked medical guidance for puberty related matters.



Graph 56: %age of adults and young people who consulted a doctor or a nurse for SRH services during last 12 months

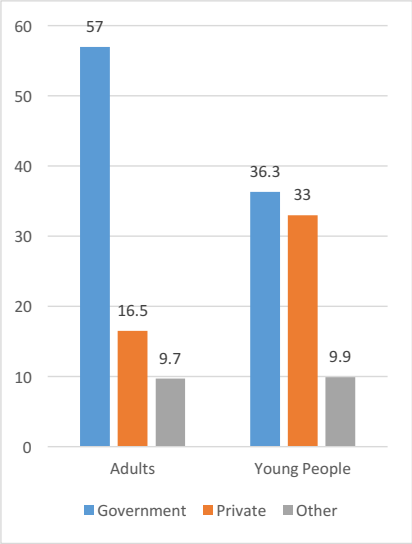
Of those adults who had visited a health facility for SRH related matters, 57% had gone to a government health facility while 16.5 to a private facility.



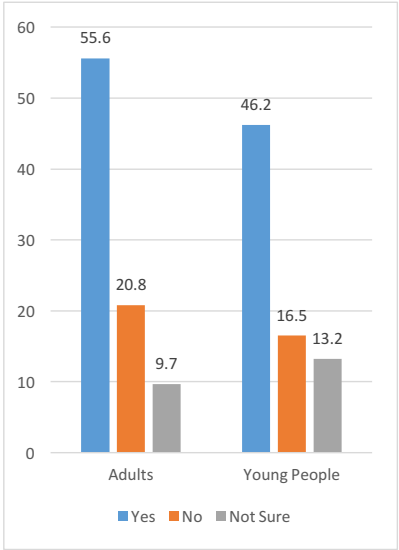
Graph 57: %age of adults and young people who visited health facilities to seek information on puberty

Graph 55: %age of adults and young people who found private health facilities staff well-mannered

From among the young people, 36.3% had visited a government health facility while 33 had visited a private facility.



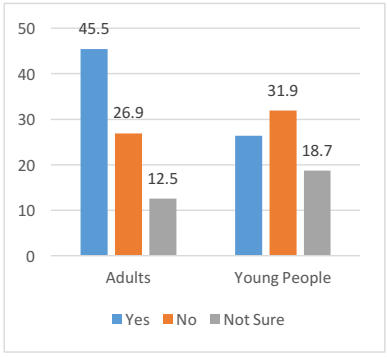
Graph 58: %age of adults and young people who visited private or public health facility



Graph 59: %age of adults and young people who found any visibility material / poster regarding contraceptive use

A fair percentage of respondents, 55.6% of the Adults and 46.2% of the Young People reported that they had observed that the healthcare facility that they visited for SRH related advise displayed material on contraceptive use.

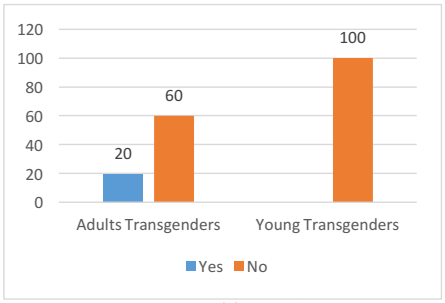
45.5% of the Adults while only 26.4% of the Young People felt comfortable asking questions about bodily changes and puberty from the healthcare professional at the facility that they visited. This indicates that while both adults and young people feel hesitant to openly discuss SRH matters with a medical professional, Young People are more prone to feeling reluctant and shy.

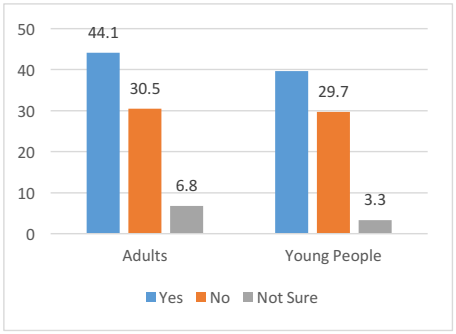


Graph 60: %age of adults and young people who were comfortable asking questions about puberty / bodily changes

Only 44.1% of the Adults and 39.6% of the Young People felt that their questions about bodily changes and puberty were satisfactorily answered by the healthcare providers.

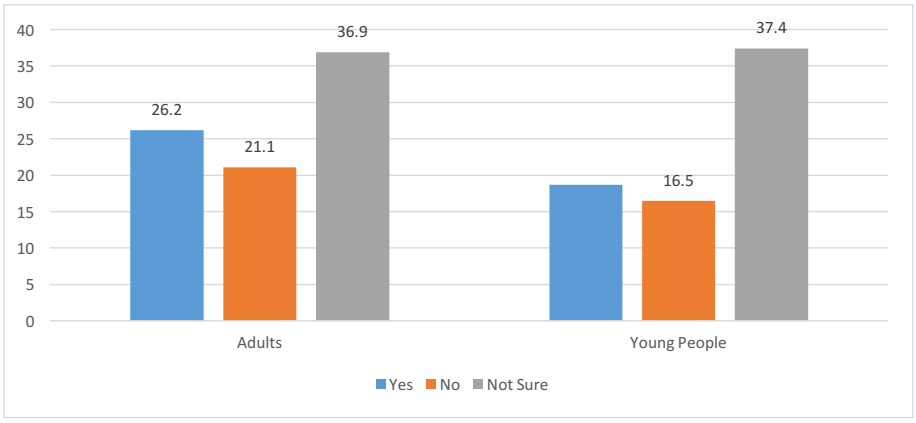
This was especially true for transgender participants as 60% of the Adults and 100% of the Young Trans-genders indicated that they were dissatisfied with the responses of the healthcare professionals.





Graph 61: %age of adults and young people who confirmed that their questions on puberty were adequately answered

Only 26.2% of the Adults and 18.7% of the Young People felt that the health facility staff protected their confidentiality by not divulging the details of their visit to a third person. This indicates a very low level of trust that patients have in their healthcare providers when discussing their sexual and reproductive health.



Graph 63: %age of respondents feel that HCPs ensured their privacy while providing information

4.5.4 Qualitative Findings

4.5.4.1 Availability and Accessibility of SRH Services

The qualitative findings echoed quantitative results in terms of availability and accessibility of basic healthcare services. Most participants, even in the rural and remote areas shared that they had health facilities in their areas. Most participants also shared that family planning clinics offering SRH services (including abortion) were available nearby. A majority of these health facilities were run by the government.

That said, a few FGD participants, especially men also complained about the scarcity of SRH service in their neighbourhoods. Pockets of deprived areas were identified even in urban centres. For instance, as one married man (from Lahore) pointed out during a FGD, "In my area there is not even a clinic nearby where a person can go to seek information and treatment for sexual issues."

4.5.4.2 Quality of SRH Services

Much like the quantitative results, people's perceptions and experiences of healthcare facilities were polarized as per the qualitative findings as well. "The staff of the government hospitals and LHVs treat us like dirt," shared a married woman from Mardan. On the other hand, another married woman from Kasur shared that women in her community only went to government facilities as the staff and the quality of treatment there is satisfactory.

4.5.4.3 Attitudes of the Healthcare Providers

While the participants were divided on the quality of services in public health facilities, there was a unanimous agreement regarding the discriminatory and irresponsible attitude of healthcare providers across the board. A young girl from Quetta sharing her ordeal said, "I had been experiencing abdominal pain for a few days so my mother took me to a doctor. The doctor's first question was, 'How long ago did you get an abortion?' This unexpected question put both me and my mother in a very uneasy spot as I had never had an abortion! After thorough examination the doctor agreed that I had never undergone an abortion and my pain was related to other physiological issues, however to this day my mother suspects me!"

Transgender participants and sex workers also reported widespread discrimination at the hands of healthcare providers, especially in government facilities. One sex worker shared, "If we require an abortion or treatment for a sexually transmitted disease, we exclusively go to private hospitals as the people in the government facilities create problems for us and are rude."

4.5.5 Analysis and Conclusion of Section 5

A lot depends on the province and its context when gauging the availability, accessibility and overall quality of SRH related healthcare services. However, by and large availability of healthcare services and access to them in one form or the other was not flagged as a primary concern by the participants.

The most pronounced points of concern were the quality of services and the attitudes of the healthcare providers. The government health facilities were often cited as under-staffed or not very well-equipped and it was shared that private health facilities were very expensive and hence not affordable for the majority of the population.

On the other hand, people had serious concerns about the attitudes of healthcare providers, whom they felt were dismissive, rude and inattentive. This was especially true for the transgender community that expressed zero confidence in the abilities and sincerity of the healthcare providers.

Similarly, majority of the survey participants were sceptical about healthcare providers protecting their privacy and not discussing their SRH related issues with others in the community.

It is perhaps for this reason that most of the survey participants did not prefer going to doctors to seek information regarding their sexual and reproductive health issues and those who did go preferred private healthcare practitioners rather than government doctors.

In the same realm, from among those who did visit doctors to seek information about SRH issues did not feel comfortable asking questions.

These findings speak volumes about the rampant lack of ethical consideration and empathy among healthcare providers and flags an urgent need to not merely make health staff more responsive to the unique emotional requirements of their patients but must also be held accountable for not respecting the privacy of those who choose to seek their help.

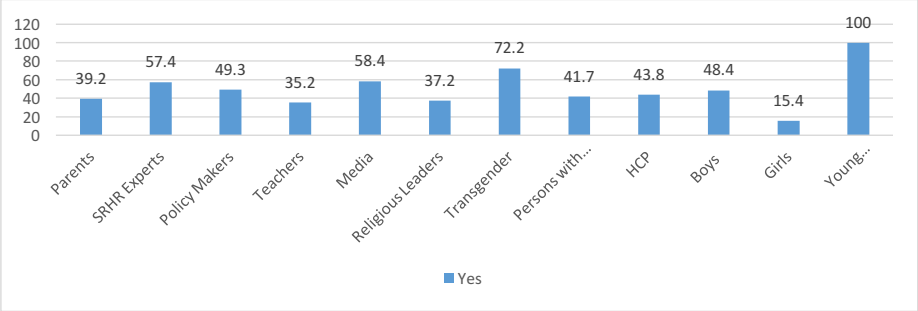
Most of the SRH services (where available) focus on the women. This is perhaps partially because women are more inclined to seek SRH services such as contraceptive use, pre- and post-natal and abortion services compared to men. However, men like women require just as much access to SRH services and for these to be an absence even in urban areas is alarming.

4.6 Exploring Genders and Sexualities (homosexuality, bisexuality, trans-sexuality, transgender)

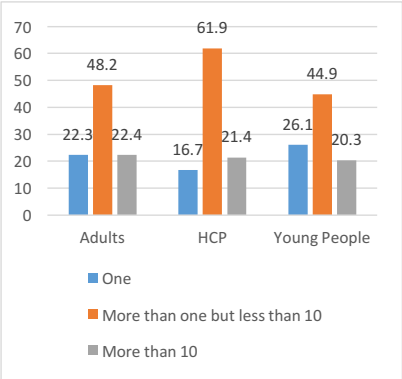
4.6.1 Types of Sexualities

While more than 50% of the respondents under each group shared that they did not know of anyone who was attracted to the same sex, a fair percentage of respondents, i.e. 42.5% of the Adults, 43.8% of the healthcare providers and 34% of the Young People shared that they knew people attracted to the same sex.

Among the sub-groups, 72.2% of the Adult transgender respondents and 100% of the Young Transgender respondents shared that they knew people who were attracted to the same sex. Similarly, 57.4% of the SRHR experts reported of knowing individuals who were attracted to the same sex.



Graph 64: %age of respondents who know homosexuals in their communities

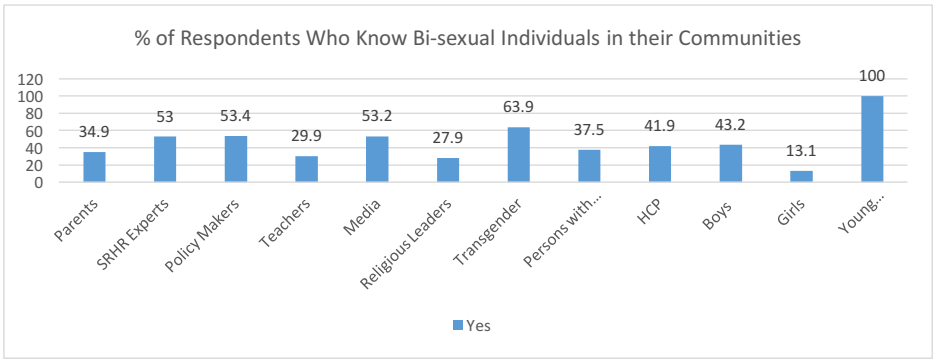


From among those who replied with, "Yes" in the previous question, 92.9% of the Adults, 100% of the Healthcare Providers and 91.3% of the Young People shared that they knew between 1 to (over) 10 people attracted to the same sex.

57.4% of the Adult[84] survey participants, 55.9% of the Healthcare Providers and 57.3% of the Young People shared that they did not know of individuals who might be bi-sexual.

63.9% of the Adult transgender respondents and 66.7% of the Young Transgender respondents, however confirmed that they knew of individuals who were attracted to both the sexes.

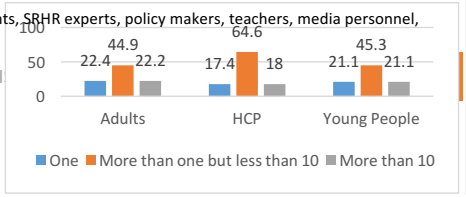
Graph 65: %age of respondents who confirmed number of homosexual people attracted same sex



Graph 66: %age of respondents who confirmed they know bi-sexual individuals in their communities

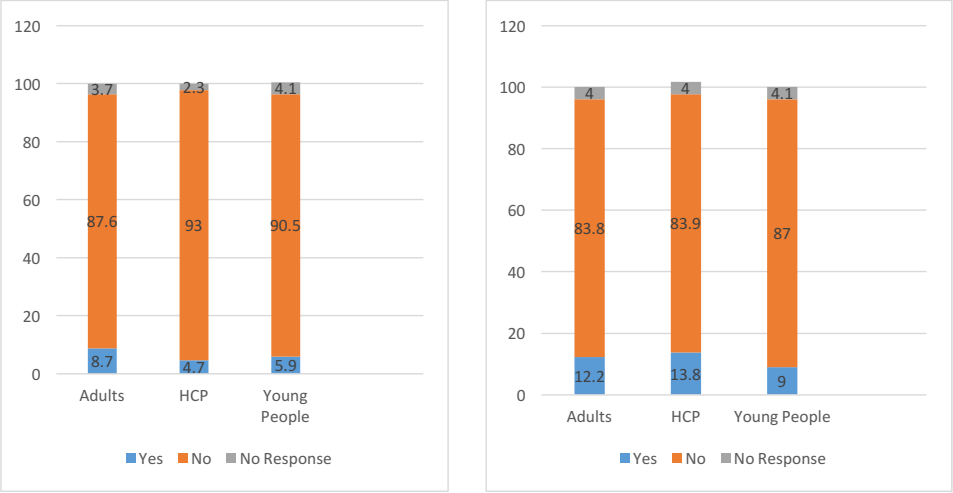
While quantifying, 89.5% of the Adult respondents, 100% of the Healthcare Providers and 87.5% of the Young People shared that they knew between 1 to (over) 10 people attracted to both the sexes.

Graph 67: %age of respondents who confirmed number of bisexual people attracted both sexes



[84] Those who fall under the adult survey respondents included parents, SRHR experts, policy makers, teachers, media personnel, religious leaders, transgender and persons with disabilities.

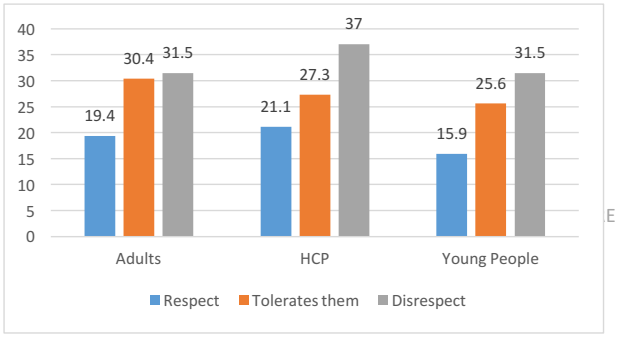
Generally negative trends were recorded for societal acceptance of homosexuality and bi-sexuality among men with 83.8% of the Adults, 83.9% of the Healthcare Providers and 87% of the Young People sharing that their community did not respect/accept men who are attracted to the same sex or both the sexes.



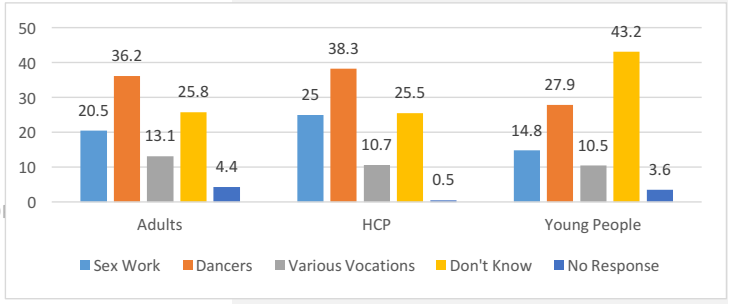
Graph 69: %age of respondents confirmed community acceptability and respect for homosexual or bisexual men

Similar results were recorded vis-à-vis community acceptance of females who are attracted to the same sex or both the sexes with 87.6% of the Adults, 93% of the Healthcare Providers and 90.5% of the Young People responding in the negative. Across all the groups a very small percentage of respondents shared that transgender people were respected in their communities.

Graph 70: %age of respondents confirmed community respect and attitude towards trans-gender



Most of the responses either indicated that



communities tolerated the presence of transgender people or that they were treated with disrespect.

A very small percentage of respondents shared that they knew of transgender people who worked in various vocations.

Over 50% of the respondents across all groups shared that transgender people in their communities either worked as sex workers or as dancers.

Graph 71: %age of respondents confirming type of livelihoods trans-genders adopt in their communities

4.6.2 Qualitative Findings

4.6.2.1 Prevalence of Homo- and Bi-Sexuality

While the quantitative survey reflected very limited prevalence of homo- and bi-sexuality, the qualitative findings painted another picture. Married women, especially hailing from Khyber Pakhtunkhwa and some parts of Baluchistan shared during Focus Group Discussions that homosexuality among men was a common practice. "Most married men in our area have a male lover," shared one lady from KP while another stated, "There have been murders in our community because of jealousy instigated by another person trying to woo the homosexual partner of a man."

4.6.2.2 Acceptance of Homo- and Bi-sexuality

While homo- and bi-sexuality is seen as a delinquency by most, qualitative findings also showed that in certain pockets of the country, communities accept homosexuality among men as an established norm. "A man is considered deficient if he does not have at least one male lover in our community,' shared a woman from Khyber Pakhtunkhwa.

However, homosexuality among women is largely condemned across the country. "It's not just the sexual attraction to the same sex that the society doesn't accept," told one key informant in Karachi who was herself homosexual, "But they don't even want to give us the space to dress as we desire. The society expects men and women to have a certain dress code and if someone dares to rebel, they are left isolated."

4.6.2.3 Plight of Transgender Community

At the same time, while societal attitudes towards the transgender community in educated, urban pockets are gradually improving, there is very limited acceptance for them in remote areas or less literate communities. During a Focus Group Discussion in Khyber Pakhtunkhwa, a transgender person shared, "Sexual violence is a frequent reality for us. At night we are often stopped at gun-point by men who kidnap and sexually violate us."

Another transgender person during the same discussion shared, "We can't do something as simple as go out and shop! People have all sorts of names for us that they start calling out once we step into the marketplace. Then there are those who sexually harass us in broad daylight in public places simply because of our sexual identities."

4.6.3 Analysis and Conclusion of Section 6

Both quantitative and qualitative results reveal that there is a sizable population of homo and bi-sexual individuals in Pakistan. However, any discussion on the subject in public discourse is impossible without receiving widespread condemnation. This inevitably forces people attracted to the same sex or both the

sexes closeted and guarded, not even trusting their own families with information about their sexuality. At the same time, there are also communities, especially within Khyber Pakhtunkhwa province where homosexuality among men is an accepted norm that is viewed with a sense of pride and power by men.

On the other hand, Pakistan has seen some significant steps in the right direction with regard to laws protecting the rights of the transgender people. However, discrimination of the highest order – including indiscriminate sexual violence – remains the plight of this community.

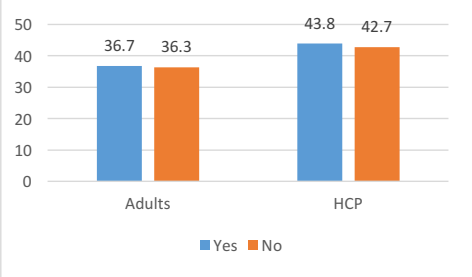
Survey results showed that most of the respondents were unaware about the sources of earning of the transgender community indicating a general sense of apathy and indifference to their plight. This also indicates that transgender individuals by and large remain isolated and communities do not interact or mingle with them to be truly aware of their day-to-day struggles and dismal plight.

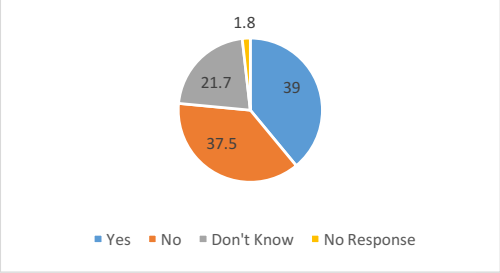
Unless the masses become more accepting and respectful of the third gender their rights –including the right to education, equal opportunities for employment – will remain a far cry from reality.

4.7 Reproductive Health (services and social attitudes)

4.7.1 Treatment of Infertility

As per the recorded responses, no significant difference was recorded between "Yes," and "No," responses vis-à-vis the availability of infertility services.



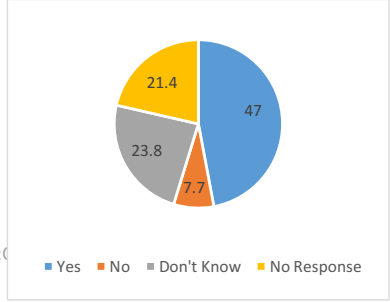


Graph 73: %age of community members who know men around them seeked infertility treatment

There was no significant difference between "Yes," and "No" responses when adult/community members were asked if they knew of men who had seeked treatment for infertility.

When healthcare providers were asked if they had attended to a male patient in the previous month seeking treatment for infertility, 47% of the respondents replied with,

Graph 72: %age of respondents confirmed availability of infertility treatment services

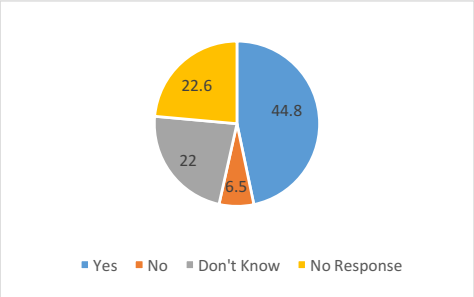


"Yes," while only 7.7% responded with, "No." A

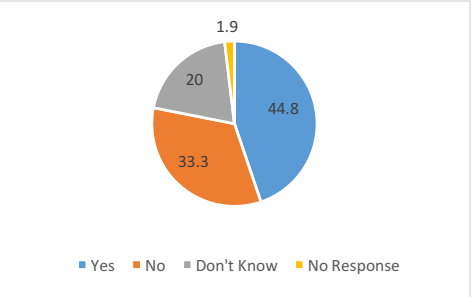
statistically significant difference was found between the responses.

Similar results were recorded when investigating the prevalence of infertility treatment for women. A statistically significant difference was calculated for "Yes," and "No," responses across both the groups of respondents. When adult community members were asked about the community attitudes towards people who seeked treatment for infertility, 18.7% shared that such individuals were respected while 19.5% shared that such individuals were looked down upon.

Graph 74: %age of HCPs who know men seeked

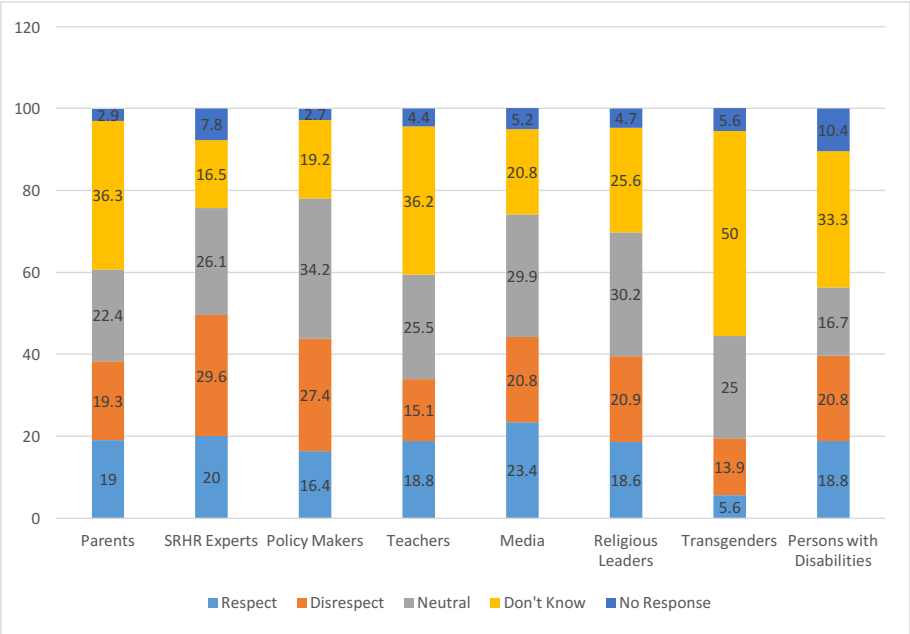


Graph 75: %age of community members who know women seeked infertility treatment

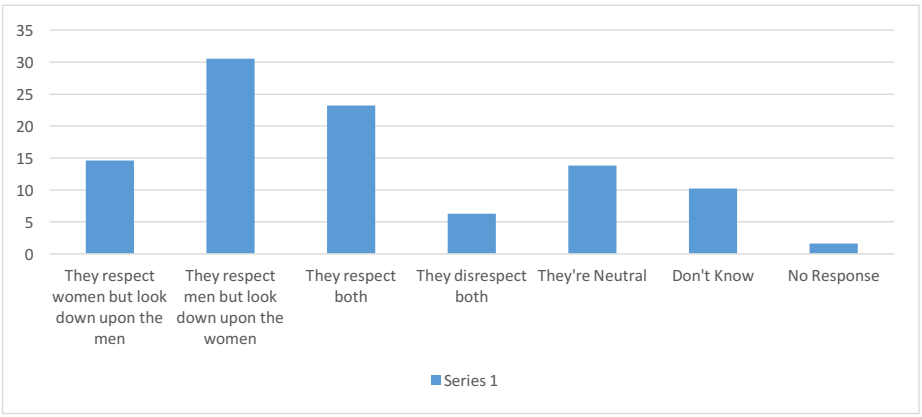


Graph 76: %age of HCPs who know women seeked infertility treatment

No statistically significant difference was recorded between these responses. 32.3% of the respondents shared that they were unaware of the treatment meted out to people who seeked treatment for infertility. When healthcare providers were asked to share how individuals seeking infertility treatment were treated in their communities, 14.6% stated that the community respected such women but disrespected men; 30.5% shared that they respected men but disrespected women while 23.2% were of the opinion that the community accorded respect to both men and women.



Graph 77: %age of adults (different types) confirmed behaviour of communities towards people seeking infertility treatment



Graph 78: %age of HCPs confirmed behaviour of communities towards people seeking infertility treatment

4.7.2 Abortion

Majority of the Adult respondents, i.e. 67% were aware of the phenomenon of abortion.

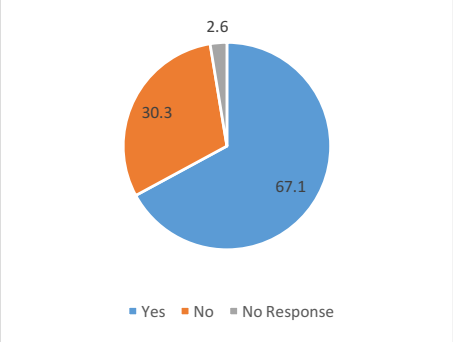
54.6% of the Adult respondents shared that health facilities in their areas did offer abortion services.

As per the responses, 38.5% of these health facilities offering abortion services were led by doctors, while 11.9% and 15% were led by nurses and midwives respectively.

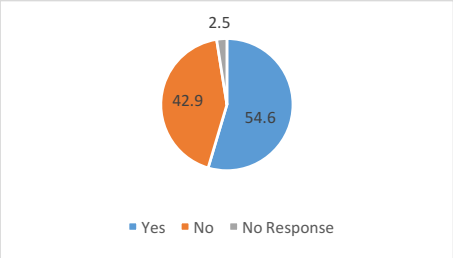
53.9% of the Adult respondents shared that they knew of women who had seeked abortion services. 72.2% of the Adult participants also shared that they knew between 1 to (over) 10 women who had seeked abortion.

Collectively, 72.8% of the Adult respondents shared that they knew of between 1 and (more than) 10 women who had seeked abortion.

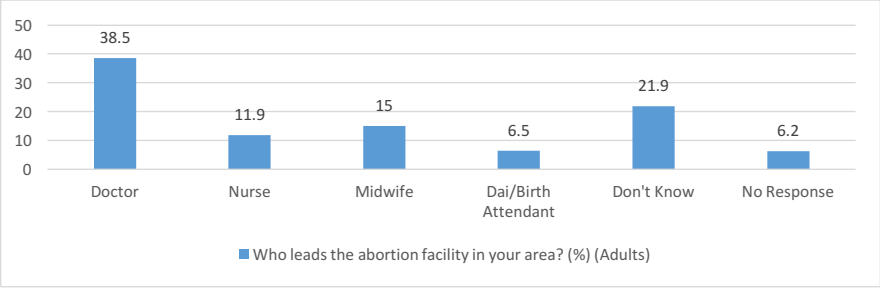
These results showed that there is a sizable demand for abortion services in Pakistan and that despite legal barriers, healthcare providers were offering abortion services.



Graph 79: %age of adults know what does 'abortion' mean?

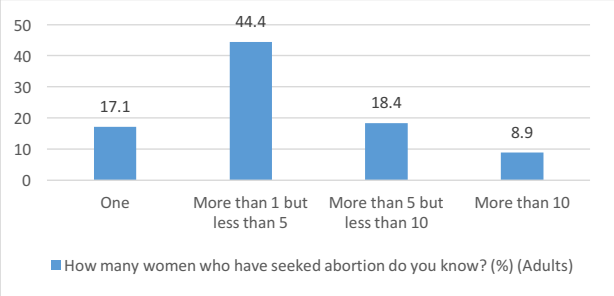


Graph 80: %age of adults confirmed availability of 'abortion' services



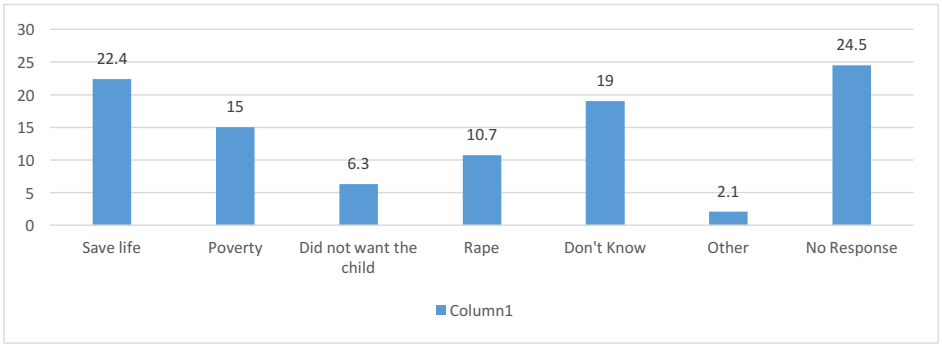
Graph 81: %age of respondents confirmed different types of abortion service providers

These results were further strengthened by the responses of Healthcare Providers as 88.9% confirmed that between 1 to (more than) 10 women came to their facility to seek abortion on monthly basis.

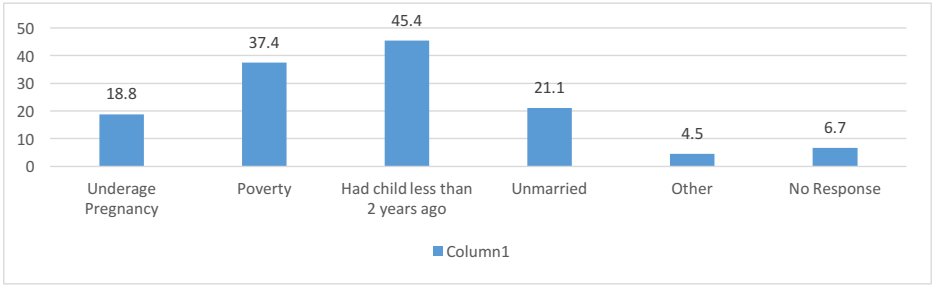


Graph 82: %age of HCPs confirmed average number of women coming in a month for abortion services

When asked to share the reasons for which women seeked abortion services, 22.4% of the Adult community members stated that it was to save their lives while 15% were of the opinion that those women were poor and could not financially sustain another child. 10.7% stated that the women they knew seeked abortion because they had become pregnant as a result of rape.

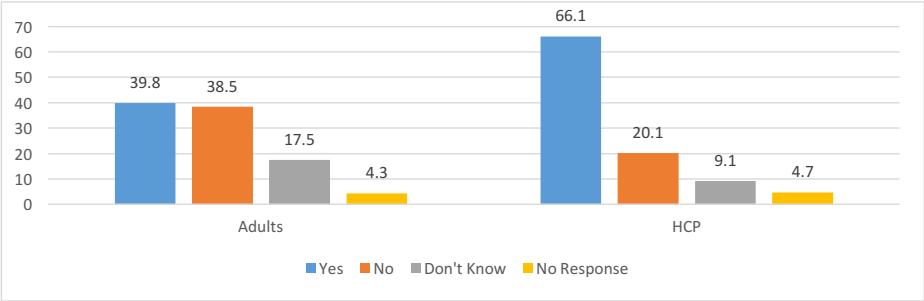


Graph 83: %age of respondents reported different type of reasons for abortion



Graph 84: %age of HCPs reported different type of reasons for abortion

Among healthcare providers, 37.4% of the respondents were of the opinion that women who seeked abortion were often poor and unable to sustain another child while 45.4% shared pregnancy in close succession of the previous child was a major cause. The results indicated that poverty remained an important factor for seeking abortion in Pakistan.



Graph 85: %age of respondents reported confirmed healthcare centres providing abortion and post-abortion services

In the same realm, 18.8% and 21.1% of the respondents believed that underage pregnancy and conception out of wedlock (respectively) were the reasons for seeking abortion among most of their patients. These figures indicate two important aspects: (1) underage pregnancies (within or outside wedlock) were considered reason enough to seek abortion for the girl-child and (2) pre-marital sexual relations are common and healthcare providers regularly receive patients who seek to terminate pregnancies that result from sexual relations outside marriage.

39.8% of the Adult respondents shared that the health facility in their areas offered post-natal and post-abortion care services while 38.5% replied in the negative. 17.5% were unaware of the availability of such services.

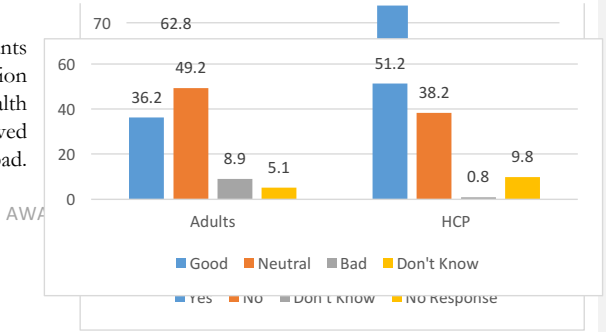
Majority of the Healthcare Providers, i.e. 66% confirmed that their health facility offered post-natal and post-abortion care services for women.

62.8% of the Adult respondents confirmed that they or people that they knew had availed pre- and post-natal and/or post-abortion services.

75% of the Healthcare providers shared that women came to their facility for post-abortion care services.

Graph 86: %age of respondents confirmed they know women who availed post-abortion services

36.2% of the Adult survey participants were of the opinion that post-abortion care services offered at their health facility were good while 49.2% believed that they were neither good nor bad.



Only 8.9% reported that the services were bad or sub-par.

51.2% of the healthcare Providers were of the opinion that the post-abortion services offered at their facility were good, 38.2% were neutral while only 0.8% replied with a negative response.

Graph 86: %age of respondents confirmed quality of post-abortion services

4.7.3 Qualitative Findings

4.7.3.1 Treatment of Infertility

Qualitative results indicated the availability and accessibility of health services for infertility treatment in most areas. They also showed that there is a growing trend among communities to seek medical help to overcome infertility related issues.

That said, qualitative findings also revealed that the burden of treatment often fell on the woman alone. "If there is an issue and the woman is not getting pregnant, she will be asked to seek treatment again and again but the man himself will never get checked or treated for infertility," shared a female participant from Lahore.

4.7.3.2 Abortion

Qualitative findings confirmed the quantitative results regarding the prevalence of abortion across the country.

Women from all over the country confirmed that both private and government hospitals offered abortion services. "In our area the government and private health facility both give abortion services," shared a married woman from Thatta (rural Sindh).

Healthcare providers reached out through Focus Group Discussions and in-depth interviews confirmed that they regularly treated women came to them for abortion.

Married female participants from Mardan and Quetta shared the conception of a girl-child as the leading cause to seek abortion. Other women from Punjab and Sindh provinces shared that in the absence of contraceptive use they had no other option but to seek abortion in case of an unwanted pregnancy.

While abortion is fairly common, most married women seeked it clandestinely from their husbands and in-laws. A doctor in a FGD in Quetta shared, "Women often come demanding that their pregnancy be terminated there and then even tough abortion is a time consuming process and cannot be carried out in minutes. This is usually because they do not want their husbands to find out that they terminated their pregnancy."

Not all women went to a medical professional as shared by one married woman, "Men would never allow their wives to seek an abortion; neither would our mothers-in-law. But over the years we have learnt manual ways to cause ourselves to miscarry like carrying heavy objects or doing strenuous physical work."

Abortion was not only a concern for married women but also for female sex workers. During a Focus Group Discussion in Karachi, one participant shared, "Most of us have each had at least 15 abortions! Men refuse to use condoms and get us pregnant frequently."

Similarly, a finding from the FGDs that strengthened quantitative results was that seeking abortion was not limited to married women. Healthcare providers and women shared that they knew of many

instances where unmarried girls had become pregnant as a result of pre-marital sexual relations and had thus seeked to terminate their pregnancies.

4.7.4 Analysis & Conclusion of Section 7

Despite having restrictive abortion laws, there continues to be a high demand for abortion services, which women continue to seek and healthcare professionals continue to provide. This high demand is partially because of the low prevalence rate of contraceptives and partially because women's access to contraception is restricted or entirely denied by their husbands.

In this situation many women are left with little option but to either seek abortion from a health professional secretly or resort to unsafe, manual methods. A female participant during a FGD in Mardan shared, "Men need to be taught to give greater respect to women and their bodies. We often have no say at all in getting pregnant."

Infertility, treatment on the other hand is gradually becoming less of a taboo and there is greater acceptance among the communities for both women and men to receive treatment for infertility. That said, infertility treatment is still largely considered a woman's responsibility. Toxic masculinity nurtured by generations of patriarchy discourages men in many pockets of the country from accepting infertility as a male concern let alone seek treatment for it.

This discriminatory attitude and disregard for a woman's right to control her own body is widespread, irrespective of socio-cultural and geographical barriers. Women in urban Lahore are just as vulnerable to unwanted pregnancies and for solely shouldering the burden of infertility treatment as those in rural Sindh or Khyber Pakhtunkhwa. However, as observed, perhaps the only factor that truly helps alleviate a woman's standing in the scenarios is her and her husband's level of education. It was found that women who were themselves well-educated and were in turn married to well-educated men had less to complain. They shared that they made decisions about birth spacing, contraceptive use and even infertility treatment at par with their husbands.

Education is then undeniably the single most important factor to ensure that a greater number of women going forward are empowered and treated as equals in matters of their and their partners' sexual and reproductive health matters.

4.8 Gender Based and Sexual Violence / Crimes

4.8.1 Forced Sexual Intercourse

Majority of the respondents, i.e. 73.4% of the Adult respondents and 79.7% of the Healthcare Providers reported that they had never experienced forced sexual intercourse.

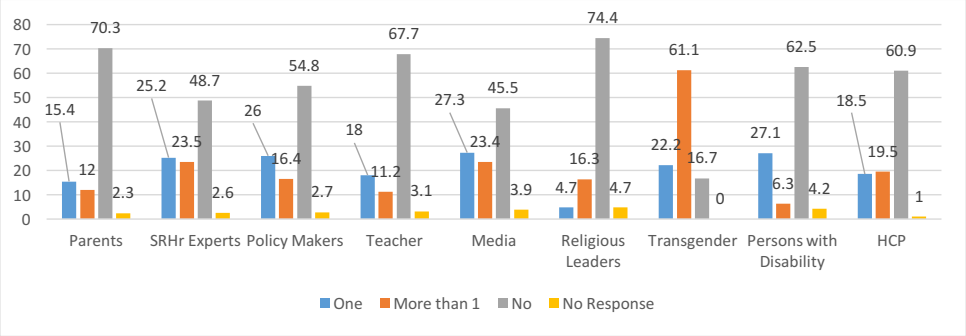
However, 18.8% of the transgender respondents reported on having been forced to have intercourse at least once while 61.1% reported that they had been forced more than once.

These results indicate that transgender people are more vulnerable to rape than men and women. At the same time the results also show that no segment of the society (including influential such as policy makers, media personnel and SRHR experts) is entirely safe from sexual violence.

Type of Response	Parents	Experts	Policy makers	Teacher	Media	Religious Leader	Transgender	Person with disability	HCP
Yes, once	14.5%	22.6%	13.7%	12.8%	22.1%	4.7%	13.9%	18.8%	10.4%
Yes, more than once	8.6%	13.0%	9.6%	6.8%	9.1%	2.3%	61.1%	2.1%	8.9%
No	75.3%	63.5%	74.0%	78.1%	66.2%	88.4%	25.0%	75.0%	79.7%
No Response	1.6%	.9%	2.7%	2.3%	2.6%	4.7%	0.0%	4.2%	1.0%

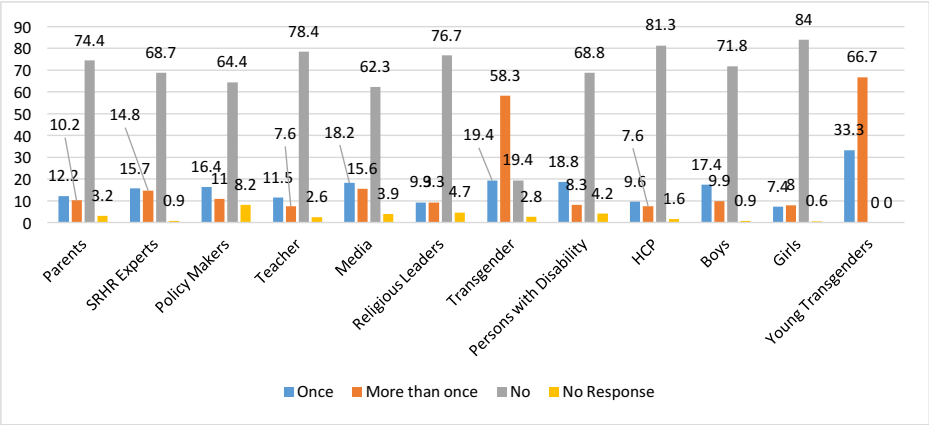
Table 9: Have you ever been forced to engage in sexual intercourse without your will?

Similar results were recorded when respondents were asked if they knew a person who had been forced into sexual intercourse. While the majority of the respondents (63.2% of the Adults and 60.9% of the Healthcare Providers) replied in the negative, 61.1% of the transgender respondents shared that they knew of more than one person who had experienced forced sexual intercourse.



Graph 87: %age of respondents confirmed they know someone who was forced for sexual intercourse

Once again, while the majority of men and women (72% Adults, 81.3% of the healthcare providers and 76.7% of the Young People) replied in the negative regarding being inappropriately touched, the answers of the transgender respondents did not conform to the trend. From among the Adult transgender respondents 19.4% reported that they had been inappropriately touched at least once while 58.3% shared that this had happened to them more than one time. Similarly, from among the young transgender

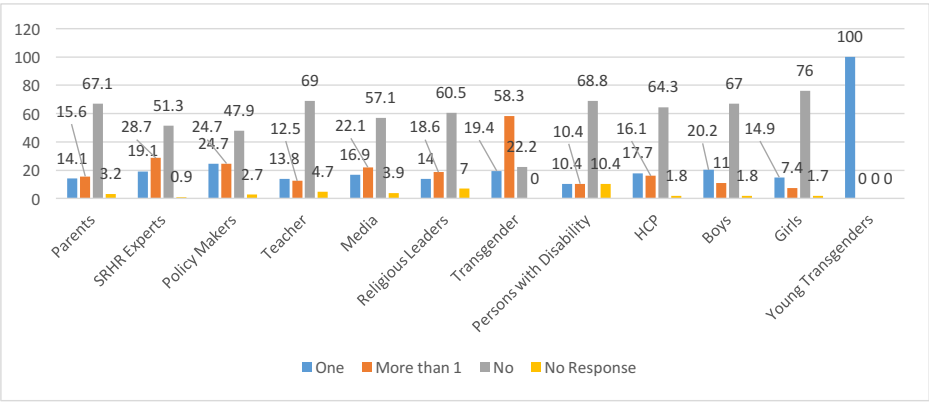


Graph 88: %age of respondents confirmed they were inappropriately touched

respondents, 33.3% reported at being inappropriately touched at least once while 66.7% reported that this had happened to them more than one time.

The results were not much different when the survey participants were asked if anyone that they knew had been touched inappropriately. 62.9% of the Adult respondents, 64.3% of the Healthcare providers and 67% of the Minors/Yong Adults replied in the negative.

However, the majority of the transgender respondents, i.e. 77.7% of the Adult Transgender and 100% of the Young Transgender respondents reported that they knew one or more person who had been touched inappropriately.

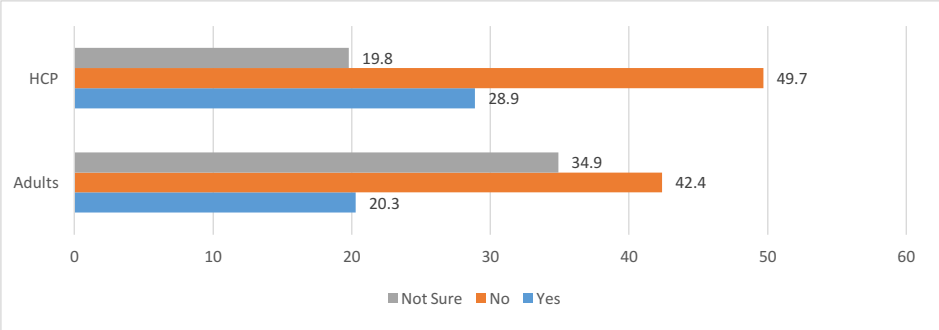


Graph 89: %age of respondents confirmed they know someone who were inappropriately touched

4.8.2 Marital Rape

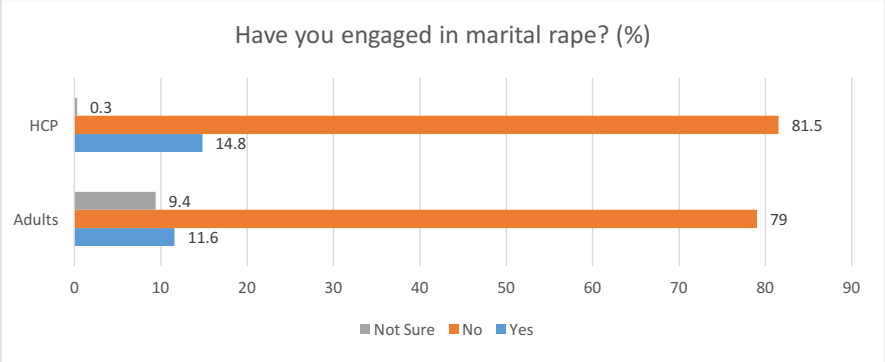
20% of the Adult respondents shared that they knew of women who had experienced marital rape, 42.45 replied with, "No," while 34.9% were unsure.

Similarly, 28.9% of the healthcare Providers shared that they knew of women who had experienced marital rape while 49.7% stated in the negative and 19.8% shared that they were unsure.



Graph 90: %age of respondents confirmed they know women who faced marital rape

Majority of the respondents, i.e. 79% Adults and 81.5% of the healthcare Providers shared that they had never engaged in marital rape. From qualitative findings we came to know that women take it as their responsibility to say yes when their husbands wish (From Islamic point of view). So they don't consider it marital rape when it is without their wish.



Graph 91: %age of respondents confirmed they were engaged in marital rape

Adult community members were further probed if they knew of any incidents with women who had been forced to have sexual intercourse by their intimate partner even during illness or when they were not inclined. 75.1% of the respondents replied that they did not know of such an incident while 61.1% shared that they had never been a party to such an act.

	Type of Respondent								
	Parents	Experts	Policy makers	Teacher	Media	Religious Leader	Transgender	Person with disability	Total
Yes	20.4%	37.4%	31.5%	17.7%	23.4%	14.0%	22.2%	16.7%	21.7%
No	78.0%	60.0%	63.0%	79.2%	71.4%	81.4%	63.9%	79.2%	75.1%
No Response	1.6%	2.6%	5.5%	3.1%	5.2%	4.7%	13.9%	4.2%	3.2%
Total	441	115	73	384	77	43	36	48	1217

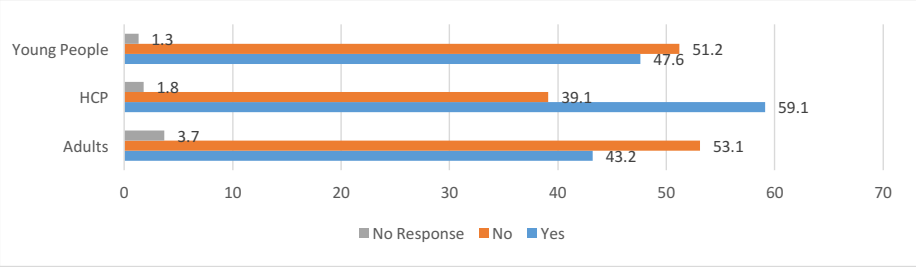
Table 10: Some people, especially women complain of forced sexual intercourse by their partners even when they are unwell or not inclined. Do you know of any such incidents?

	Type of Respondent								
	Parents	Experts	Policy makers	Teacher	Media	Religious Leader	Transgender	Person with disability	Total
Yes	10.7%	8.7%	6.8%	9.4%	5.2%	2.3%	11.1%	2.1%	8.9%
No	60.1%	67.8%	58.9%	63.8%	63.6%	76.7%	19.4%	50.0%	61.1%
Not sure	21.3%	14.8%	19.2%	16.9%	20.8%	16.3%	36.1%	35.4%	20.0%
No Response	7.9%	8.7%	15.1%	9.9%	10.4%	4.7%	33.3%	12.5%	10.0%
Total	441	115	73	384	77	43	36	48	1217

Table 11: Have you ever engaged in such a practice (i.e. forced sexual intercourse) with your intimate partner?

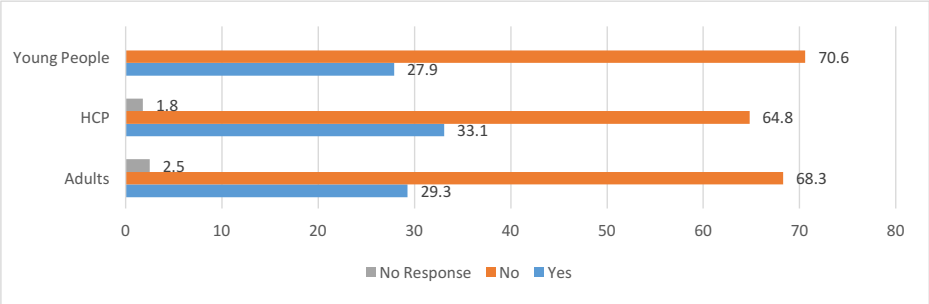
4.8.3 Cyber Crime

43.2% of the Adult respondents and 47.6% of the Young People shared that they knew of incidents where cyber-crime of a sexual nature had taken place while 53.1% and 51.2% (respectively) replied in the negative. However, 59.1% of the healthcare Providers shared that they had heard of instances where cyber-crime of a sexual nature had taken place.

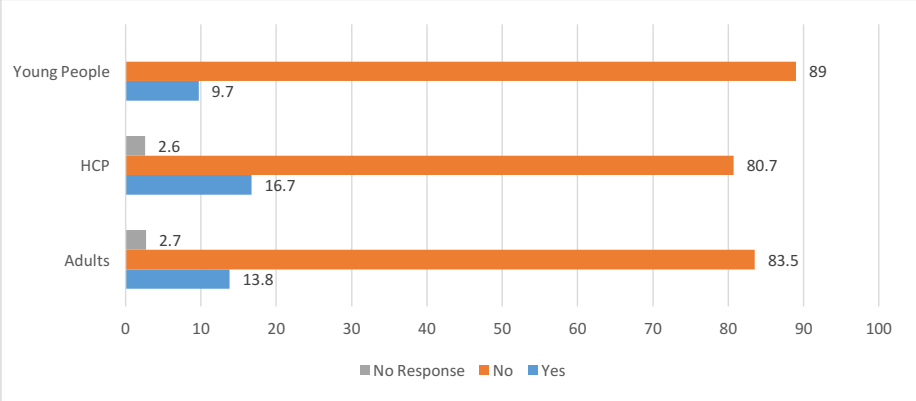


Graph 92: %age of respondents who know a cyber-crime of sexual nature

The majority of the respondents (i.e. 68.3% of the Adults, 64.8% of the Healthcare Providers and 70.6% of the Young People) shared that they did not know of anyone who had experienced a sexually motivated cyber-crime.



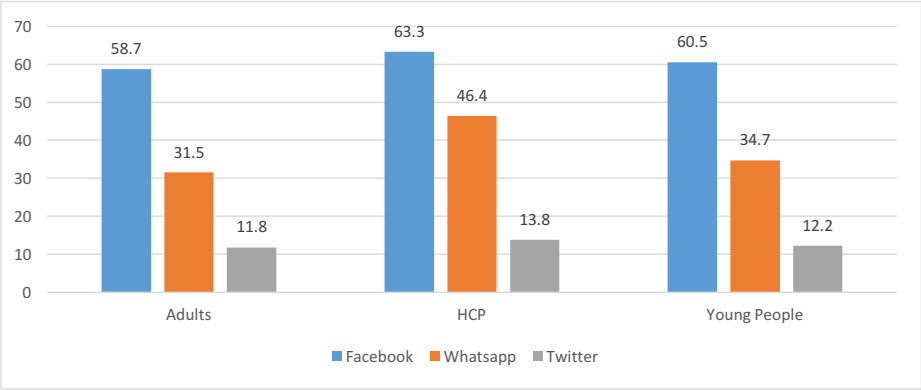
Similarly, 83.5% of the Adults, 80.7% of the Healthcare Providers and 89% of the Young People reported that they had never experienced a cyber-crime of sexual nature.



Graph 94: %age of respondents who have themselves experienced a cyber-crime of sexual nature

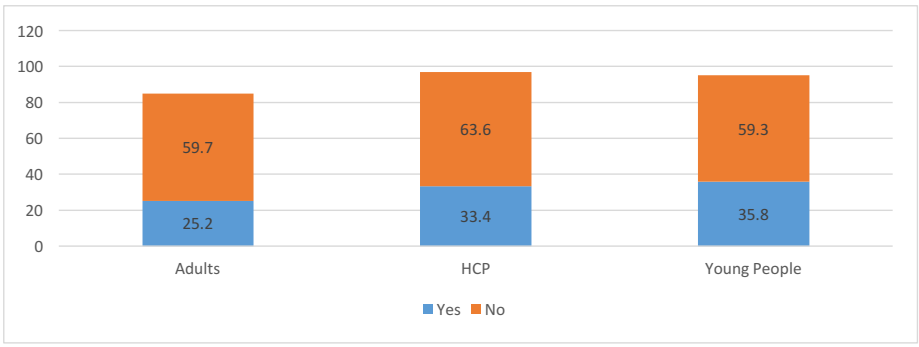
To understand the use of social media websites, respondents were asked to name all such websites that they actively used.

Majority of the respondents (58.7% of the Adults, 63.3% of the Healthcare Providers and 60.5% of the Young People) had active profiles on Facebook while WhatsApp remained the second most used social networking tool among the participants.



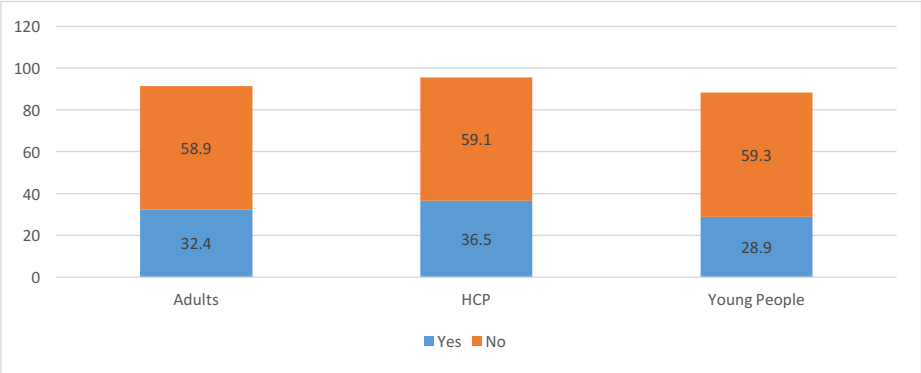
Graph 95: %age of respondents identified three main social media sites used for cyber-crime of sexual nature

The majority of the participants, i.e. 59.7% of the Adults, 63.6% of the healthcare Providers and 59.3% of the Young People) reported that they had never received any messages on social media that made them uncomfortable.



Graph 96: %age of respondents received discomforting private messages of sexual nature through social media

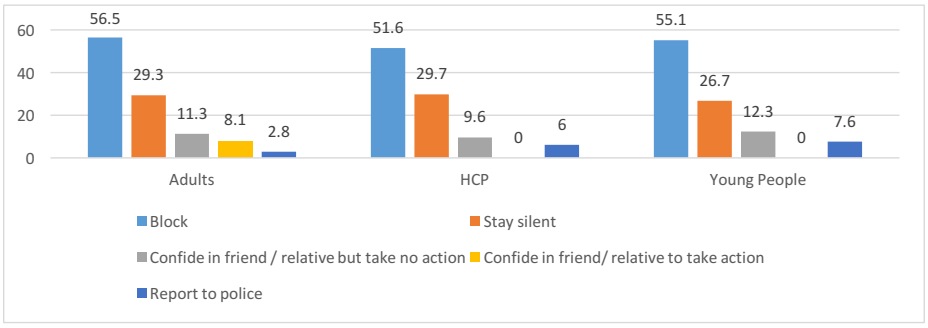
Similarly, 58.9% of the Adults, 59.1% of the healthcare Providers and 67.8% of the Young People shared that they did not know of anyone who had received discomforting messages on their social media accounts.



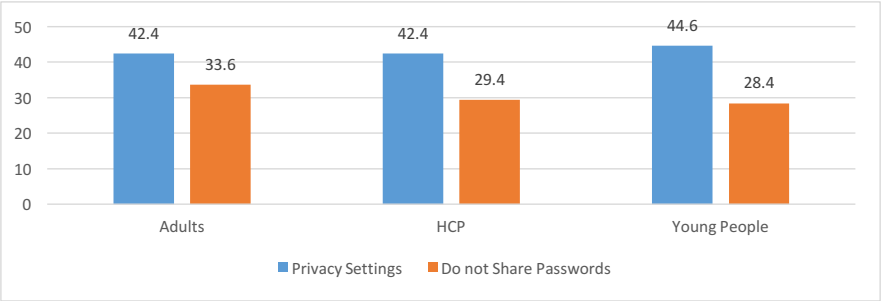
Graph 97: %age of respondents who confirmed they know someone who received discomforting private messages of sexual nature through social media

Majority of the survey participants, i.e. 56.5% of the Adults, 51.6% of the Healthcare Providers and 55.1% of the Young People were of the opinion that people who received sexually intimidating messages on social media often ended up blocking the offensive person as a mitigation measure. Only 2.8% of the Adults, 6% of the Healthcare Providers and 7.6% of the Young People shared that the offensive person was reported to the police.

To investigate the respondents' understanding of keeping oneself safe in the cyber space, participants were asked to share the measures that they or those they knew frequently took in this regard. Most of the participants either made use of the privacy settings to limit their audience and/or refrained from sharing their password with others.



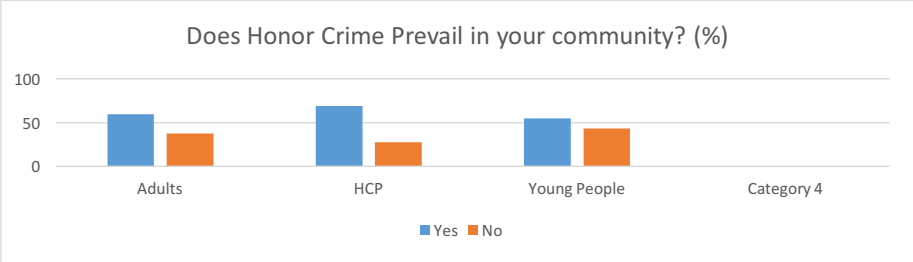
Graph 98: % age of respondents confirmed type of actions taken against private messages of sexual nature through social media



Graph 99: % age of respondents indicated top 2 protection measures to avoid cyber crime

4.8.4 Honor Crime

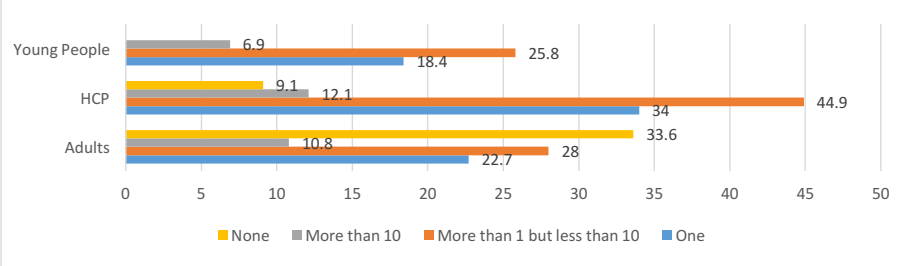
59.7% of the Adults, 69% of the Healthcare Providers and 54.7% of the Young People confirmed the prevalence of honour crime in their communities.



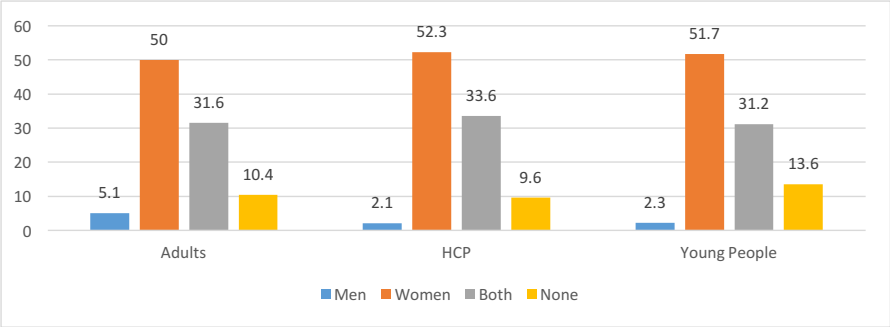
Graph 100: % age of respondents confirmed prevalence of honour crime in the community

61.5% of the Adults, 91% of the Healthcare Providers and 51.1% of the Young People personally knew of between 1 and (over) 10 incidents of honour crime in their families and/or communities.

50.1% of the Adults, 52.3% of the Healthcare Providers and 51.7% of the Young People were of the opinion that women were more affected by honour crime compared to men.

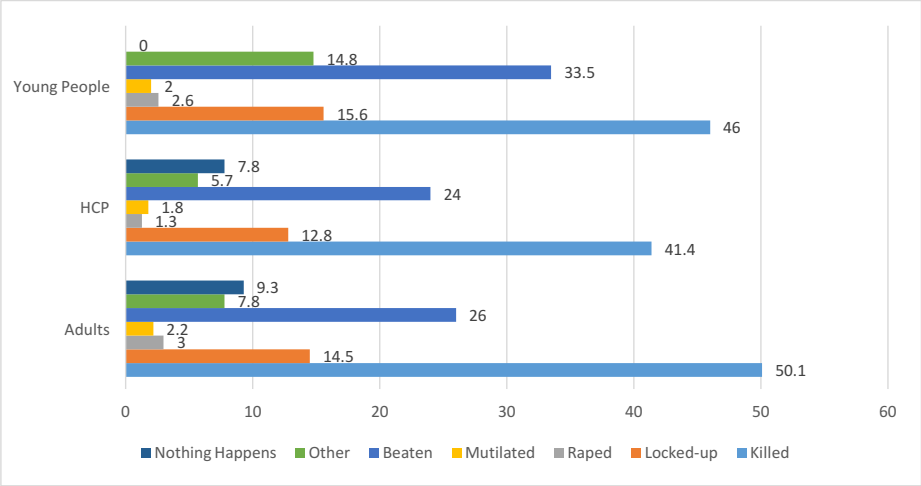


Graph 101: % age of respondents confirmed number of honour crimes they know of



Graph 102: % age of respondents confirmed who is most affected of honour crimes

50.1% of the Adults, 41.4% of the Healthcare Providers and 46% of the Young People shared that those in their communities who had been apprehended for honour crime had been killed. 7.8% of the

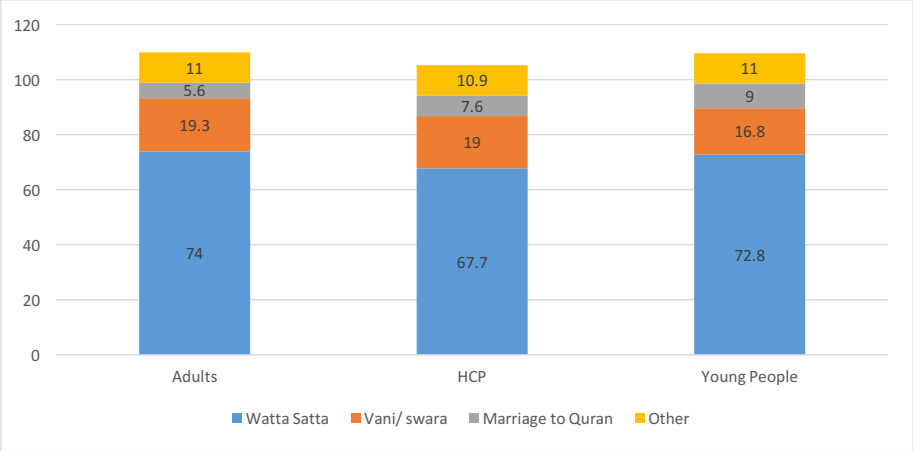


Adults and Healthcare Providers and 0% of the Young People reported that no harm had been brought on those apprehended for honour crimes in their communities.

Graph 103: What happens to those who are punished for bringing a bad name to the family/ community? (%)

4.8.5 Traditional Practices

74% of the Adult respondents, 67.7% of the healthcare Providers and 72.8% of the Young People reported on the prevalence of traditional practices such as *wani/swara and watta satta* in their



Graph 104: Most common types of traditional practices (%age)

communities.

62.4% of the Adults and 68.7% of the Healthcare Providers shared that they knew of between 1 to (over) 10 incidents of traditional practices in their areas/communities. 48.3% of the Young People shared that they knew of such incidents while 49% replied in the negative.

4.8.6 Qualitative Findings

4.8.6.1 Physical Violence

The qualitative findings revealed rampant violence against women. Most married women complained about being beaten by their husbands while other reported frequent verbal and psychological abuse.

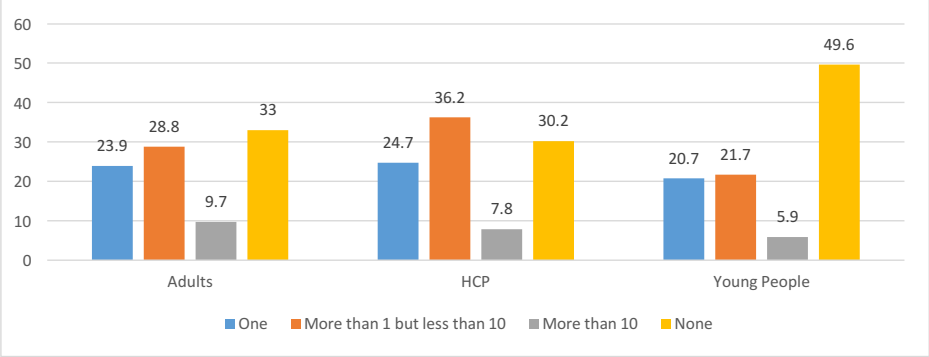
"It doesn't happen in every house but in most homes husbands do beat their wives or at least slap and push them without a thought" told a married woman from Lahore.

Talking about psychological abuse, a woman from Mardan said, "I know of someone whose husband stopped sharing the same bed with her simply because she was pregnant with a girl."

4.8.6.2 Sexual Violence

Married women from Mardan, Thatta and Quetta reported of rape in marriage. "They (the husbands) don't care about the woman's consent at all," shared one married female from Mardan while another from Thatta said, "Some men ask but there are also those don't seek consent." Married women from Lahore however shared that they had neither experienced not heard of a husband having intercourse without the wife's consent.

During FGDs with married men it was observed that most men did not see the need to seek their wife's



Graph 105: %age of respondents confirmed most common types of traditional practices prevail in their communities and which they know of

consent before sexual intercourse. For instance, in a FGD in Peshawar with married men when they were asked whether or not they took their wife's consent before initiating sexual contact, only three out of the twelve men shared that they did.

4.8.6.3 Traditional Practices

Parallel legal systems were reported in almost all the areas. When asked if Jirga and panchayats decided who would marry whom a woman from Thatta replied, "These are almost exclusively the sort of decisions that these *panchayats* make!"

Commenting on the incidence of honour crime, a woman from Thatta reported that while they had heard of such incidents in other villages, they themselves did not know of one in their community.

4.8.6.4 Plight of Sex Workers

The plight of sex workers is perhaps the most dismal when investigating violence against women. During a Focus Group Discussion with sex workers in Sindh, one woman reported, "They (the male clients) often hit us, verbally abuse us and even burn us during intercourse."

Another sex worker shared, "Physical violence is a common occurrence. Often when we are called in by one man but when we reach the venue we find out there are three or four men. If we refuse, we are beaten and raped."

Yet another one shared, "90% of the women in this business have undergone severe violence at the hands of their clients. It is the same for every sex worker whether she works at a brothel or deals in the street."

4.8.7 Analysis and Conclusion of Section 8

Violence against women remains a common place in most households in the country. Undeniably however, things are much worse for women in rural settings. While physical violence is a common occurrence, women in remote areas are also more vulnerable to marital rape. This behaviour by men is guided by a culture that demands complete submission to the husband.

Urban women on the other hand are both more aware of their rights and in most cases also educationally and economically empowered to walk out of an abusive marriage. This automatically helps alleviate their social standing and serves as a protection against violence. However, generations of sub-ordination have taken even these empowered women to a point where they do not count slapping and shoving as a form of violence. "Some men hit but others only slap. Look at me, I've been married for 22 years and my husband hit me only twice or thrice!" stated one married woman from Lahore.

At the same time marital rape, which is not recognized as a punishable offence by the Pakistan Penal Code is also the plight of most women. 11.6% of the adult respondents and 14.8% of the healthcare providers stated that they had experienced marital rape. This quantitative finding seems like a small figure in view of the stories of regular marital rape shared by women from all over the country (except Lahore) and the indifferent attitude of men regarding taking their wife's consent prior to intercourse as recorded in during focus group discussions.

Sex workers remain at the bottom of this pyramid experiencing physical, verbal and sexual violence on a daily basis. Their refusal to "serve" more than one client or request for the use of condom is often enough for the men to beat them up. In the same realm, ironically if they are raped, there is no legal means for them to seek justice as sex work is neither legally recognized nor is the rape of a sex worker considered a crime by the law enforcers.

There can be no two opinions about the fact that violence against women is a serious problem in Pakistan. The status of a woman (married, unmarried, educated, illiterate or sex worker) is of little consequence when faced with toxic masculinity. On the other hand, sexual violence, both in and out of marriage is also a hard reality for many – if not most – women.

The state needs to venture beyond rhetoric and ensure the strict implementation of laws that protect women from all forms of violence. Unless, there is strict legal repercussions for such acts, women in Pakistan will continue to live under the shadow of male savagery.

4.9 SRHR and People Living with Disabilities

9.7% of the Adult, 2.9% of the Healthcare Providers and 2.8% of the Young People who participated in the survey lived with disabilities. On the other hand, 73% of the Adult respondents, 85.9% of the Healthcare Providers and 74.9% of the Young People knew of people who lived with disabilities.

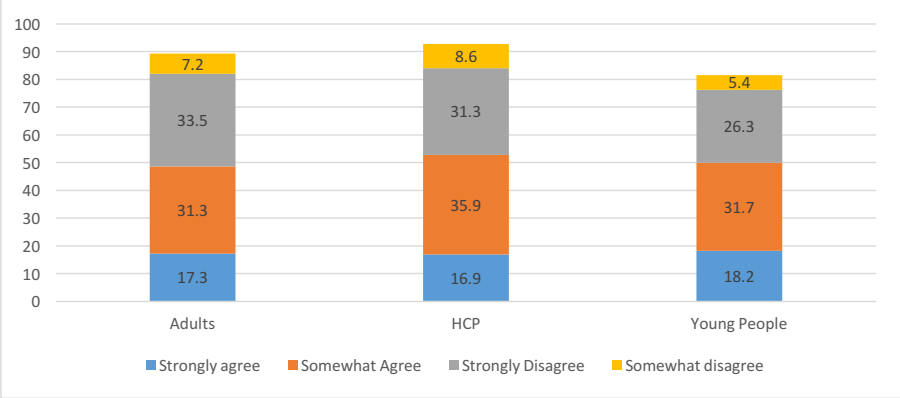
4.9.1 Perceptions About People Living with Disabilities (PLWDs)

To understand the perceptions regarding people living with disabilities a set of three value check questions were asked.

When asked if people living with disabilities enjoyed equal rights in their communities, 48.6% of the Adults, 52.8% of the Healthcare providers and 49.9% of the Young People either strongly agreed or agreed.

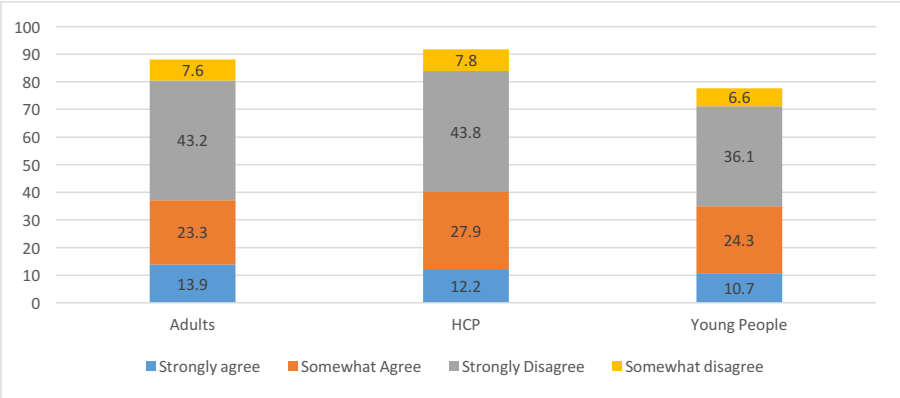
At the same time, it is also important to consider that a sizable percentage of respondents (40.7% adults, 39.9% HCP and 31.7% young people) either strongly disagreed or somewhat disagreed.

The findings thus indicate a somewhat polarized opinion among the survey respondents.



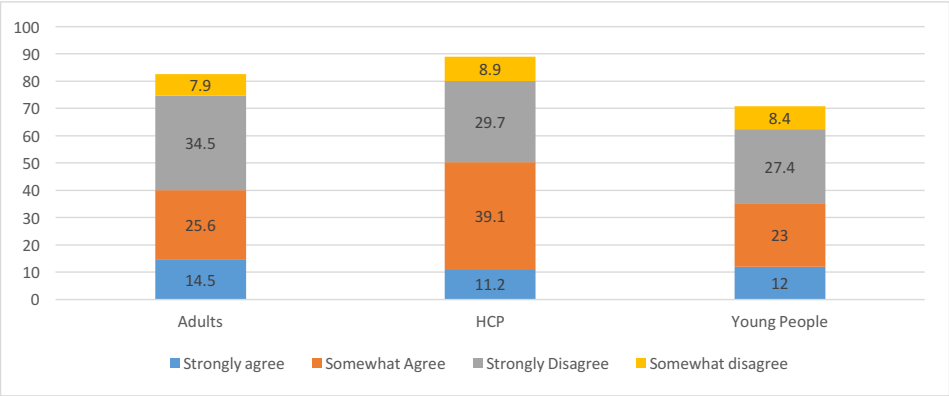
Graph 106: %age of respondents believe PLWDs have equal rights in their communities

Only 13.9% of the Adults, 12.2% of the Healthcare Providers and 10.7% of the Young People were of the opinion that people living with disabilities had no problem finding a life partner.



Graph 107: %age of respondents believe PLWDs can easily find life partners

Similarly, only 14. 5% of the Adult respondents, 11.2% of the Healthcare Providers and 12% of the Minors/Young Adults "Strongly Agreed," that people living with disabilities did not have any problem accessing information about their sexual and reproductive health.



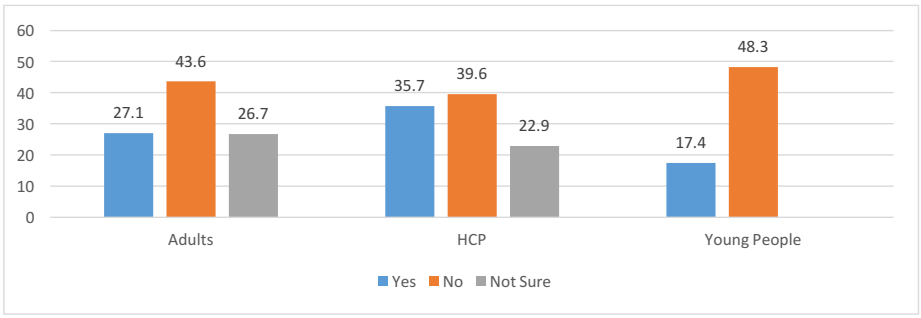
Graph 108: %age of respondents confirmed access of PLWDs to SRH information

4.9.2 Sexual Violence against PLWDs

27.1% of the Adult respondents shared that they knew of people living with disabilities who had been sexually violated while 43.6% replied in the negative.

35.7% of the Healthcare Providers shared that they knew of people living with disabilities who had been sexually violated while 39.6% replied in the negative.

17.4% of the Young People Adults shared that they knew of people living with disabilities who had been sexually violated while 48.3% replied in the negative.

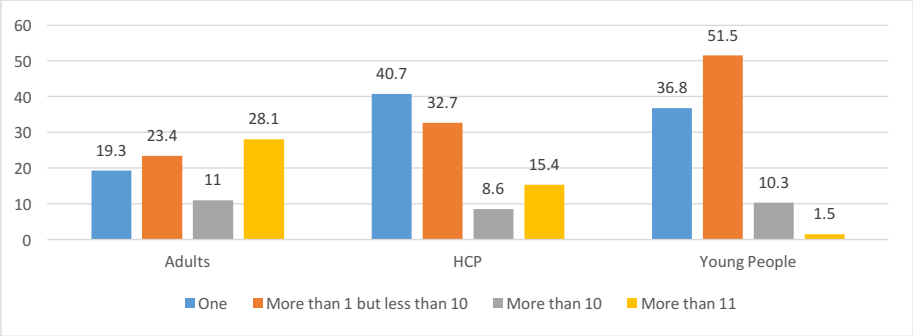


Graph 109: %age of respondents who know some PLWDs affected from sexual violence

19.3% of the Adult participants shared that they knew of at least 1 incident where a person living with disability had been sexually violated while 23.4% shared that they knew of more than 1 but less than 10 incidents and 11% shared that they knew of more than 10 incidents.

40.7% of Healthcare Providers shared that they knew of at least 1 incident where a person living with disability had been sexually violated while 32.7% shared that they knew of more than 1 but less than 10 incidents and 8.6% shared that they knew of more than 10 incidents.

36.8% of the Young People shared that they knew of at least 1 incident where a person living with disability had been sexually violated while 51.55% shared that they knew of more than 1 but less than 10 incidents and 10.3% shared that they knew of more than 10 incidents.



Graph 110: %age of respondents who know different number of sexual violence cases against PLWDs

4.9.3 Qualitative Findings

Majority of focus group discussion participants confirmed and validated the findings of quantitative data regarding availability of SHR information and services for PLWDs. They also confirmed the vulnerability of such people to incidents of sexual abuse.

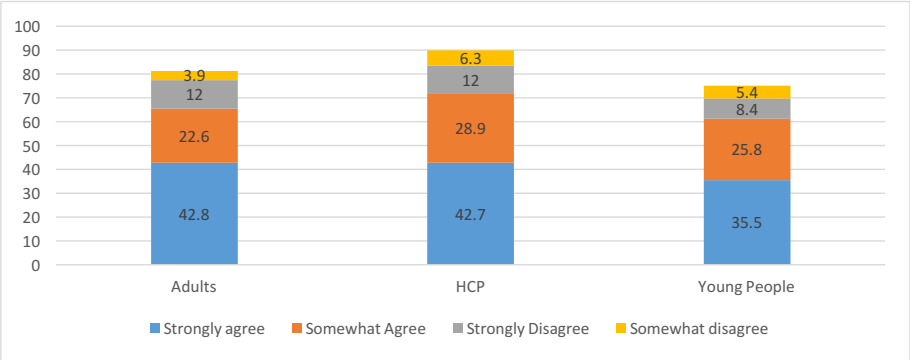
4.9.4 Analysis and Conclusion of Section 9

It is evident that the risk of sexual violence perpetrated against people with disabilities is comparatively higher than usual. "It is an urgent, unaddressed issue, of epidemic proportions," one of the policy maker quoted during IDI. Those who work on violence prevention at People with Disability describe close relatives as "key offenders" in relation to violence against women and young girls with disabilities. It was noted that staff members of a private facility for PLWDs may in fact be perpetrators in some circumstances.

4.10 Community Gate Keepers and SRHR

4.10.1 Religious Leaders

Majority of the Adult respondents (65.4%), Healthcare Providers (71.6%) and Minors/Young Adults (61.3%) either "Strongly agreed," or "Somewhat agreed," that religious leaders had an important role to play in educating people on sexual and reproductive health matters.

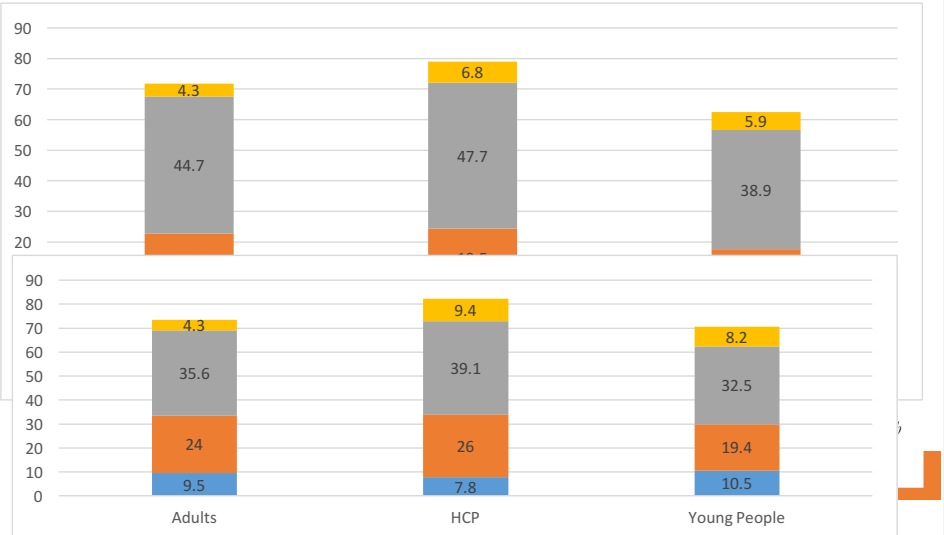


Graph 111: %age of respondents who believe religious leaders have an important role to play in educating people regarding SRHR

Despite agreement that religious leaders had an important role vis-à-vis SRH education the majority of the respondents shared that religious figures did not speak about SRH issues during sermons and gatherings. Only 9.5% of the Adults, 7.8% of the Healthcare providers and 10.5% of the Young People "Strongly Agreed," as opposed to those who "Strongly Disagreed" (35.6%, 39.1% and 32.5% respectively).

4.10.2 Local Influential People

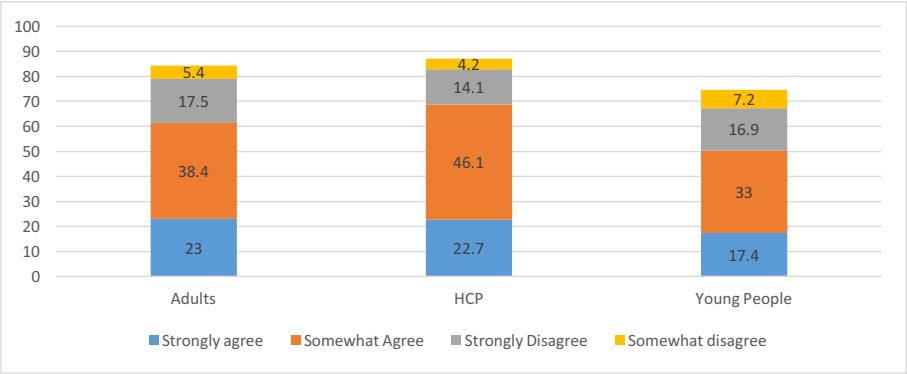
Only 5.7% of the Adult respondents, 4.9% Healthcare Providers and 3.6% of the Young People "Strongly agreed" that local influential people took interest in addressing the sexual and reproductive health issues of their communities.



Graph 112: %age of respondents who believe religious leaders talk about SRH issues in their sermons and other religious activities

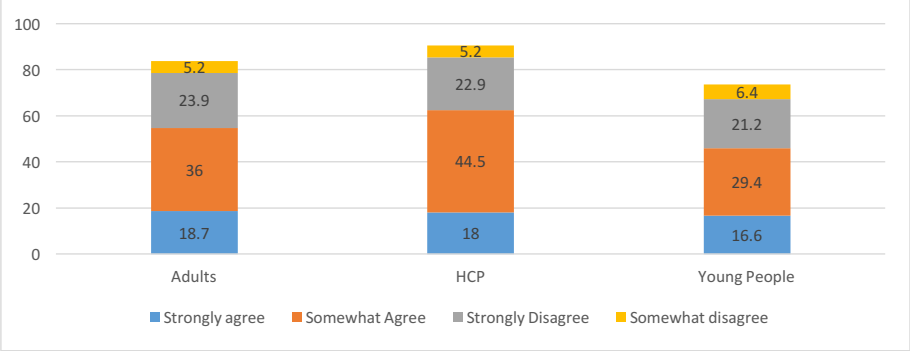
4.10.3 Media

Majority of the survey participants (i.e. 61.4% Adults, 68.8% of the Healthcare Providers and 50.4% of the Young People) either "Strongly agreed," or "Somewhat agreed" that media was playing an important role in providing people with authentic information on sexual and reproductive health rights.



Graph 114: %age respondents believe that media is playing an important role in providing people with authentic information on SRHR

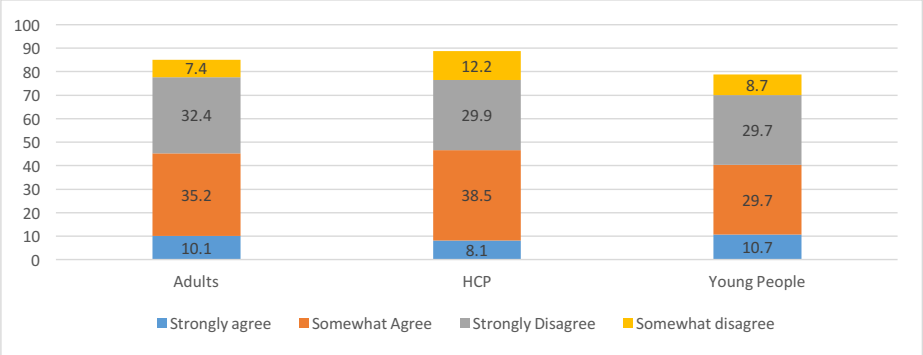
54.7% of the Adults, 62.5% of the Healthcare Providers and 46% of the Young People were of the opinion that media responsibly protected the identities of those affected by sexual violence as opposed to 29.1%, 28.1% and 27.6% (respectively) of those who either "Strongly disagreed" or "Somewhat disagreed."



Graph 115: %age respondents believe that media is responsible and protects the identities of people affected by sexual violence

4.10.4 Law Enforcement Agencies

Majority of the survey respondents indicated low levels of confidence in the abilities of the law enforcement agencies to effectively and efficiently respond to cases of sexual violence with only 45.3% of the Adults, 46.6% of the Healthcare Providers and 40.4% of the Young People replying with either "Strongly Agree" or "Somewhat agree."



Graph 116: %age respondents believe that law enforcement agencies like the police respond efficiently to cases of sexual violence

4.10.5 Qualitative Findings

A religious leader from Lahore was of the view that educating children about their sexual and reproductive health was the primary responsibility of the parents. However, we at our madrassah try to educate children under our care on these issues."

A senior journalist commenting on the same said, "It is easy for you and I to seek on issues of sexual and reproductive health. However, the larger society is not ready to talk about it openly and unless that happens, media can only play a limited role."

Seconding this view, member of Provincial Parliament, Dr. Aliya said, "Parliamentarians are aware of these issues but even they are scared of openly talking about them fearing public backlash. A lot of times female parliamentarians talk amongst themselves but feel shy about bringing up these topics in front of the Chief Minister."

4.10.6 Analysis and Conclusion of Section 10

Almost two decades' worth of advocacy by the civil society has given rise to a new generation of religious leaders who are now more receptive to the idea of SRHR education for children. For the same reason there is also a growing sense of responsibility among the media fraternity.

However, unless the government takes ownership of sexual and reproductive health concerns of the population, community gatekeepers can play a limited role in changing the norms on their own. In turn, the government is unlikely to take serious remedial action unless there is significant demand at the grass root level.

While the research in hand shows an existing "demand" at the grass-root level for SRHR reforms, there is need to mainstream this existing demand so that the legislators feel propelled to take action.

It is only after there is a strong political will to address the SRHR concerns of Pakistani citizens will a road be paved for legal reforms and existing laws will begin to be implemented in letter and spirit.

5- RECOMMENDATIONS

A wide range of recommendations were received from the Focus Group Discussions and In-depth Interviews conducted during the course of the research. The recommendations under each area of investigation are detailed below:

5.1 Sources of Information on, and Knowledge of Reproductive Health

- Government needs to run behaviour change campaigns to make communities more receptive to the idea of SRH education for their children.
- The civil society and government must partner to develop SRH education curriculum that can incrementally be mainstreamed into schools.
- Trained healthcare providers must be given access to schools to hold informational seminars with students regarding their sexual and reproductive health.
- Government and private schools must have mandatory SRH Education classes for their students.
- Religious leaders must play a more pro-active role in denouncing those narratives that misinterpret Islam to curtail the SRH rights of the people.
- Religious schools (just as secular educational streams) must introduce compulsory classes for their students to educate them about their sexual and reproductive health.

5.2 Sexual Practices

- Comprehensive and prolonged behaviour change campaigns on positive versus toxic masculinity need to be introduced in rural areas of the country to inspire behaviour change among men and to empower women to assume decision-making roles at par with their husbands.
- Media, including print, electronic and social media need to be extensively utilized by both state and non-state actors working on family planning to educate both men and women about contraceptive use, including emergency contraceptives.
- Contraceptive prevalence and use need to be improved across the country. This is especially important in low-income areas where contraceptives are seen more as a luxury rather than a need.
- To encourage contraceptive use, the government needs to introduce programs offering free contraceptives to people in low-income urban areas and rural areas.

5.3 Knowledge of HIV/AIDS and STDs

- Government and civil society organizations need to make extensive use of all forms of media to educate the masses about the causes, symptoms, treatment options and preventive measures regarding HIV/AIDS.
- Both private and public hospitals should make awareness seminars on HIV/AIDS mandatory for its medical staff irrespective of their medical specialty.

5.4 Sexuality, Gender and Norms

- Community and media campaigns need to be introduced on the wrongs of toxic masculinity.
- Portrayal of women in media needs to significantly improve from the traditional gender roles so that the masses can see – and begin to accept them – in more empowered roles.

- Classes on positive masculinity need to be introduced for young boys in schools to help mitigate the impact of misogynistic, patriarchal norms in which they are socialized.
- Female feticide needs to be accepted as an issue and strict laws need to be made to prevent its incidence.
- A long-term public-private partnership is integral to the realization of people's SRH rights.

5.5 Use and Perceptions of Health Services

- Lady health Workers and staff in government health facilities needs to be trained to respect their patients and their confidentiality.
- SRH services for men should receive equal importance as those for women.

5.6 Exploring Genders and Sexualities

- Special efforts need to be made to ensure that transgender children are enrolled in schools and later given preferential seats in higher education institutes.
- Campaigns around transgender rights must not only demand legal amendments and highlight the dismal plight of this community but also focus on behaviour change among the masses so that there is acceptance of transgender children at homes at the time of birth as opposed to the prevalent practice of abandoning them or handing them over to *gurus*.
- A sense of acceptance and empathy needs to be inculcated through media among the masses regarding homo- and bi-sexual individuals as well as the transgender community.

5.7 Reproductive Health (services and social attitudes)

- Awareness raising campaigns at the community and media level need to be introduced to inform men about male infertility.
- Behaviour change campaigns also need to be launched simultaneously to encourage men to change their negative attitudes and ultimately behaviours regarding treatment of male infertility and women's right to access healthcare services without intimidation.
- Abortion laws need to be revised in light of its high rate of prevalence and modern pre- and post-abortion care services need to be given at BHUs and RHCs.

5.8 Gender Based and Sexual Violence

- Women need to be educated about their rights both under the constitution as well as the religion that they follow.
- Matriarchs also need to be educated to protect and preserve the rights of their daughters their daughters-in-law.
- Awareness campaigns targeting both men and women regarding various laws, including laws against domestic violence, sexual harassment and cyber bullying need to be launched as laws are available but most women are not aware about them.
- Rules of business for all existing laws aimed at curtailing gender based and sexual violence ought to be formalized by the provinces on priority to ensure their immediate implementation.

5.9 SRHR and People Living with Disabilities

- Drives aimed at creating awareness about sexual and reproductive health rights and their ultimate realization must be inclusive of the needs and rights of people living with disabilities.
- Government policies and laws aimed at enhancing the quality of life of people living with disabilities must factor in their access to quality SRH services.

5.10 Community Gatekeepers and SRHR

- Law enforcement personnel must undergo rigorous programs to make them more aware and sensitive to cases of gender and sexual violence.
- Media must follow international ethical standards of keeping the identity (including names, pictures and/or any other identifiers) of victims and survivors of sexual violence strictly confidential while reporting a case.
- Pakistan Electronic Media Regulatory Authority (PEMRA) must ensure the strict observation of the code of conduct that protects the identities of those impacted by sexual violence.
- Religious leaders must be sensitized and engaged as part of the solution on SRH issues

----------End…….