[Outcome Measurement Report]

[Unite For Body Rights Program in Multan & Quetta]

[Rutgers WPF]

SARAH ASAD

Consultant

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Acronyms

AIDS	Auto Immune Deficiency Disease
CSO	Community Service Organization
FGD	Focus Group Discussion
FP	Family Planning
IPPF	International Planned Parenthood Federation
KAP	Knowledge Attitudes Practices
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
IP	Implementing Partner
LHV	Lady Health Visitor
LHW	Lady Health Worker
LSBE	Life Skills Based Education
MDG	Millennium Development Goals
OM	Outcome Measurement
RH	Reproductive Health
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TOR	Terms of Reference
WPF	World Population Foundation
UFBR	Unite for Body Rights

Executive Summary

This study was undertaken by Rutgers WPF as part of its UFBR program in order to measure the outcome after a period of two years of conducting activities related to this initiative. The main objective of undertaking this Outcome Measurement activity in Multan and Quetta was to provide the local teams there with an analysis of the progress in the various components of the program as well as to highlight the challenges and way forward.

The objectives of the UFBR program are given below:

1. Increased capacity of young people, women and marginalized groups to make safe and informed decisions on issues concerning relationships and sexuality, to deal with gender power relations and to seek quality, comprehensive SRHR services and information

2. Increased capacity of civil society organizations to manage SRHR education and services interventions

3. Increased quality of and access to comprehensive SRHR and SGBV services for young people, women and marginalised groups.

4. Policy dialogue maintained or increased in favour of SRHR in civil society organization's countries and/or the region.

A team of four data collectors gathered information through both qualitative and quantitative methods, which was then analyzed. The tools included Pre-test, Focus Group Discussions, Exit Interviews, Youth Friendliness Checklists, SGBV Referral Checklists, and Community Power Mapping Exercises.

The survey was conducted with 480 school going girls and boys of classes 7-10, studying in both government and private schools of the city. A total of 20 FGDs were conducted in rural and urban areas of the city, of which 16 were with the community and 2 each were with CSOs and HCPs. Four community Power Mapping Exercises (rural and urban each) were also conducted. A total of fifteen formal healthcare facilities were also visited to collect the relevant data.

Although the findings are reflective of the general SRHR issues faced by the Pakistani adolescent, they cannot be expostulated over the entire province or country, as each area has its own particular issues and problems.

The OM exercise, in comparison with the baseline indicated that there needs to be a change in direction in an accelerated manner for the program to achieve its objectives in a meaningful way.

The interaction with the HCPs as well as the Youth Friendly services they run was reflective of the fact that although the facilities exist at the grassroots level to be provided to the adolescents, there is a lack of the target group (unmarried adolescent boys and girls) seeking such services. The reasons for this low level of service delivery are several, of which the main ones are: a) lack of awareness in

the target group about the services and b) lack of privacy and discomfort regarding seeking such services due to cultural barriers.

The activities conducted with the CSOs by the IP has led to a good understanding of the topic of SRHR, a topic previously not touched upon in detail as a part of the various CSOs programmes and projects. However, the relationship between the IP and CSOs needs further strengthening in order to accomplish targeted, result-oriented change at the community level through the various planned awareness sessions. Furthermore, there is also a need to develop the Alliance partnership in a more progressive manner so that SRHR can emerge as a leading cause at the district level.

The most promising aspect of the program is the education component, wherein the case studies shared by one of the IPs reflect that the provision of targeted information in schools to the adolescents leads them to good decision-making skills as well as gives them confidence to seek help in case of abuse. This component has much potential to be developed further during the course of the program. According to the benchmark set for assessing the knowledge, skills, and attitudes of the students in the sample, about 78% were found to have good capacity, which is a strength that can be further developed in the Parwan program.

Chapter 1: Introduction

1.1 Background

The SRHR Alliance consists of 5 Dutch NGOs, active in the field of sexual and reproductive health and rights. The Dutch member organizations of the SRHR Alliance are:

- Rutgers WPF
- AMREF
- Simavi
- Dance4life
- Choice

The aim of the SRHR Alliance is to work towards a society free of poverty in which all women and men, girls and boys, and marginalized groups have sexual and reproductive rights irrespective of their ethnic, cultural and religious background, age, sex and sexual orientation. In order to achieve this goal, the Alliance has – in collaboration with partner organizations in developing countries – developed the 'Unite for Body Rights (UFBR)' programme, which is funded by the Dutch Ministry of Foreign Affairs.

The UFBR programme is being implemented in nine countries, five in Africa and four in Asia: Ethiopia, Kenya, Malawi, Tanzania, Uganda, Bangladesh, India, Indonesia and Pakistan. In each country, the SRHR Alliance works through local partner organizations of the members of the Alliance. The programme is being implemented in a period of 5 years: 2011 – 2015.

Beginning of 2010, a context analysis was conducted in each country. In the analyses, four priority areas were identified that require urgent and increased attention in order to meet the MDGs 3, and 4-6, the International Conference on Population and Development (ICPD) Programme of Action and other international agreements for promoting sustainable development:
(1) improved sexual and reproductive health services
(2) comprehensive sexuality education
(3) combating sexual and gender-based violence
(4) freedom of expression of sexual diversity and gender identity.

1.2 Introduction of Outcome Measurement in relation to country

Pakistan is a country of stark contrasts, be they geographical, ideological, or the practical life choice its people make. There is as much diversity amongst the various ethnic and religious groups in the country as there is between its highest vantage point in the Himalayan Range in its northern region and the depths of the Arabian Sea in its South.

The rationale for stating this comparison is to reiterate that it is not smooth sailing for those trying to create change, break taboos and shatter myths in a

society with so much multiplicity. Coupled with this broad cultural milieu is the omnipresent shadow of terrorism and uncertain political situation, adding to the daily challenges of advocating for issues that may not be a priority for the masses or the State.

It is in such a background that the Parwan programme (UFBR program of SRHR Alliance) being undertaken in the nine countries mentioned before - was begun in 2011. The broad aim is to work towards a society free of poverty in which all women and men, girls and boys, and marginalized groups have sexual and reproductive rights irrespective of their ethnic, cultural and religious background, age, gender and sexual orientation.

In particular to the scenario in Pakistan, the programme was designed to contribute to MDGs 3, 5 and 6 by addressing:
1) Poor SRHR (maternal mortality, early pregnancies, unsafe abortion, STIs, HIV/AIDS) and
2) Sexual and Gender-Based Violence (SGBV)

The four key result areas of the UFBR programme are:
a. **Result Area 1:** Civil Society Strengthening
b. **Result Area 2:** MDG3, MDG4-6
c. **Result Area 3:** Strengthened capacity of Southern partner organizations
d. **Result Area 4:** International lobby and advocacy

With particular reference to SRHR, it is essential to provide education to youth as well as to support the creation of relevant systems of SRHR-related services and coordination mechanisms. These have been crucial areas of the Parwan programme in Pakistan, with the focus being on the creation of space for dialogue on this sensitive - and often misperceived - topic. Parwan was especially important for the country because of its particular demographics concerning adolescents: the emerging youth bulge of the country (21.6% population aged between 15-24 years[1]), through the practical and replicable model of Parwan programme, will contribute to positive view on youth sexual well being. Similarly, it is essential that SRHR be made part of the mainstream healthcare agenda of the country through advocacy from programmes such as Parwan, in order to address the population growth rate, prepare unmarried youth for making safe and informed choices, and address global issues, such as HIV at the local level. It was in this spirit that the Parwan programme was initiated in Pakistan.

1.3 Introduction of Outcome Measurement in relation to country

Before the commencement of the UFBR programme, a **baseline survey** and needs assessment was carried out in 2011 in all countries where the programme was being made operational. As a follow up to the baseline, Rutgers WPF this

[1] Pakistan Demographics Profile 2013 www.indexmundi.com

Outcome Measurement (OM) study in 2013 was requested and undertaken in Parwan districts by Consultant for Rutgers WPF and PMEL Rutgers WPF Netherlands.

In this regard, a **planning workshop**[2] was held on 17th -19th June 2013 in Karachi with the implementing partners (Rutgers WPF Pakistan Field Office, Awaz-CDS Multan and PIDS Quetta) through the coordination of Rutgers WPF PMEL Head Office.

Briefly, the **outputs of the workshop** were as follows:

1. To track the achievements and challenges of the program
2. To reflect upon and refine the methodology, work plan, tools, and analysis to be used in the OM

The roles of the concerned **partner organizations** in conducting the OM activity were defined as follows:

- Local partners (Awaz-CDS in Multan and PIDS in Quetta) to provide the logistics and help execute the OM process in their respective districts
- Country partner (Rutgers WPF Pakistan) to support the overall process between the Consultant, local partners and Rutgers WPF Netherlands through creating coordination and facilitation at the country level
- International partner (PMEL Rutgers WPF Netherlands) to organize and facilitate the in–country OM workshop, incorporating the feedback from the in-country report; as well as providing a lead role in the definition and scope of the methodology of the OM data collection process, including tools, sample, and analysis.

The **specific objectives of the Outcome Measurement process** are listed below:

- Measure progress towards the intended results
- Identify the processes that are leading towards the results, and into the programmatic strengths and/or constraints
- Identify the challenges, lessons learnt and way forward

In light of the above specific objectives, a roadmap (see Annex 1 for OM work plan) was developed as one of the outcomes of the workshop. The key target groups included in the OM process were youth in the education program, youth seeking SRHR services, and women affected by SGBV.

[2] Activity Report available with Rutgers WPF Pakistan Office

Chapter 2: Methodology

2.1 Tools/Instruments for data collection & sampling

The following tools were used as part of the data collection in the OM process (See Annex 2 for detailed tools). The tools that had been originally used in the baseline were deliberated upon extensively in the OM workshop and modified according to the learning of the baseline. In summary, the KAP tool was replaced by the Pre-test. The FGD Guidelines, Power Mapping Tool, Exit Survey, and the Youth Friendliness Checklist were included in the OM process, with a few modifications from the baseline. The Services Statistics Checklists were removed based on the fact that in the first years the programme was not able to build a strong service component and is as such also not able to retrieve any data concerning service statistics, i.e. service delivery has not been a clear focus of the Parwan programme. However, when the data will become available as a result of stronger linkages, these will be measured through output measurement. Two new tools were developed as per the sample of the OM process: FGD with CSOs and FGD with HCPs. A more detailed summary of the finalization of each tool is given below:

1. Pre-test (A) and (B): The Pre-tests (Pre-test A for Boys and Pre-test B for Girls) was developed as a replacement of the KAP tool used in the baseline. It was deliberately made shorter in length than the KAP tool, so as to make it easier for the students to attempt and the schools to facilitate the process. It was also made simpler to calculate, i.e. the Pre-test comprised of True/False and Yes/No statements, instead of providing a range of grading answers (scale 1-5), as had been developed for the baseline.

While the majority of the questions were the same in both the Pre-tests (Pre-test A for Boys and Pre-test B for Girls), the questions pertaining to sexual changes were asked separately in both sexes. In addition, terms, such as “condom” and “sex” that had created a bit of discomfort at the school administration level in the baseline were deliberately avoided. The books in the paper-based curriculum that is to be taught in the selected schools, was pored over to select the statements that were converted into True/False and Yes/No questions. A balance was developed between knowledge, attitude and behavior questions.

The Pre-test was administered in classes where the students had not yet begun the classes, as the LSBE curriculum had not yet been started there after the summer vacations. The purpose of selecting this sample was to measure the knowledge, attitudes and behavior of those who have never been exposed to SRHR information through a formal school-based curriculum.

Since the program is going to focus on students of Grade 7-10, the sample was selected from these classes. The variables for selection procedure were defined as follows, for a total sample size of 480 students.

- City
- Government or Publicly Owned Schools/Private Schools

- Sex: Male/Female
- Grade 7-10

The tool was administered in the Urdu language in both cities, except in the selected Hazara community in Quetta, where it was conducted in English. This is because the Hazaras, being an immigrant community, are not as fluent in Urdu, and are taught English in the schools as a main language.

Testing of the Pre-test survey was conducted prior to the Pre-test survey in both cities in order to assess the language comprehension for the students. The test was given to 10% of the total sample (24 students in each city; 12 girls and 12 boys each = total 48 students for the entire survey). The students included in the Field Test were not included in the actual survey the next day. Based on the feedback of the team and the survey results, only minor changes in the wording in one question were made, and the tool was finalized accordingly.

The methodology adopted for the Pre-test entails that the progress in learning would be measured after the administration of the same tool (renamed as Post-test) to the same students once they have undergone the stipulated number of lessons in the curriculum. A scale is to be developed to measure the endorsing answers and minimum criteria from the Pre-test in order to compare to the Post-test. The schedule of conducting the Post-test is beyond the scope of the current assignment, and would be decided upon between the implementing partners and Rutgers WPF Country and Head Office.

2. FGD Guidelines with Community: These were modified from the version used in the baseline, where there had been three types of guidelines used with the community. The Guidelines were shortened to focus on only three topics, as these are the focus of the Parwan interventions in the community: Early Marriage, Access to SRHR Education and Services and Eve Teasing. However, the process was made simpler in the OM by keeping one all-encompassing tool. A total of 16 FGDs were conducted with the community, 8 in each city. Each FGD was comprised of 9-12 persons, based on the following criteria:

- Sex
- Marital Status
- Rural and Semi Urban/Urban

A total of 153 participants took part in the FGDs. The sample was selected from the communities where the program is being implemented through the various CSOs that are part of the Parwan Alliance. As per the program documents, the focus of Parwan activities in the community was to be on raising awareness at the grassroots level as well as the creation of systems for referral and coordination. Therefore, the sample was selected from these communities to assess the outcomes of the interventions conducted in their particular geographical area.

The FGDs in Multan were conducted in their respective communities, while those in Quetta (for females) were conducted in the CSO offices due to the volatile security situation in the city. The FGDs in both cities were in urban or semi urban

areas. There was no purely rural community selected, as the programme is being carried out in urban and semi urban areas.

3. FGD with CSOs: This activity had not been included in the baseline, but was included in the OM process based on the discussion in the OM Workshop. Since the programme is being implemented at the community level through the CSOs that comprise the Parwan Alliance, it was thought imperative that their viewpoint regarding their participation be included in the process. Therefore, two FGDs were arranged (one in each city) for this purpose. At least one member from each partner CSO participated in the discussion.

4. FGD with HCPs: The HCPs that are part of the Youth Friendly Services component were invited for an FGD (one activity in each city). This activity was also not part of the baseline but included in the OM because it was considered imperative that the opinions and attitudes of the service providers be taken into account in order to assess the overall YFS component. The HCPs from each of the services were invited to be part of the discussion.

5. Assessment of Community Leaders: This tool was modified in its methodology from the baseline. The scoring of each Community Leader, as named by the participants was not scored on a scale of 1-5 this time. The purpose behind administrating this tool was to assess the presence of the community leaders at the grassroots level, so that they can be effectively mobilized for Parwan activities, and also to gauge how frequently/what level of participation they have given in the past two years of the programme. The CSOs that are part of the Parwan Alliance were divided over two groups in each city, i.e. those that work with rural/semi urban communities and those that coordinate with urban communities. A total of 4 discussions around this tool were conducted (2 in each city), based on these rural/urban categories.

6. Exit Survey: The tool was shortened from the original used in the baseline in order to make it more concise. There was also a change in the envisioned sample from all youth (in the baseline) to only unmarried youth in the OM. This shift was based on the premise that the married youth, no matter how young (even cases of child marriages) are not denied any service due to their "legit" marital status. On the other hand, it was assumed that the unmarried youth would not be able to avail services easily at the health centers. It was also assumed that the latter would be miniscule in number. A target sample of 64 was envisioned for the OM study. However, this was not available at the services, despite two visits of the data collectors at each facility on two different days. Therefore, the target sample achieved in this component was zero.

7. Youth Friendliness Checklist: The checklist was simplified from the version used earlier in the baseline. Each YFS considered part of the Parwan program was included in the assessment in both cities. A total of 15 services were visited (7 in Multan and 8 in Quetta). Since most of the services that were part of the baseline were not now part of the programme, it was decided not to compare the data between the baseline and the OM study. Instead, the services selected now

will be considered as a baseline sample and will be compared to the data collected in 2015.

Table 1: Tools and sample size used to measure indicators, by indicator

No.	Tool	Sample	Indicator
1.	Pre-test/Post-test	FIELD TEST: 24 students (6 boys + 6 girls) x private schools + (6 boys +6 girls) x public schools PRE-TEST/POST-TEST: a. Public School 4 x 30 (15M+ 15F) = 120 x 2 cities = 240 b. Private School 4 x 30 (15M+15F) = 120 x 2 cities = 240 Total = 480 students	Outcome indicator 2.1a – exposed target groups has an increased capacity to make safe and informed decisions (on SRHR)
2.	FGDs[3]	a. Urban x 4 FGDs (UM Boys, Married Men, UM Girls, Married Women) x 2 cities = 8 FGDs b. Rural/Semi Urban x 4 FGDs (UM Boys, Married Men, UM Girls, Married Women) x 2 cities = 8 FGDs c. FGD with CSOs x 2 cities = 2 FGDs	Outcome indicator 2.4b - Increased acceptance of SRHR at community level
3.	Exit Survey	NONE AVAILABLE	Outcome indicator 2.2b – Increase in the number of young people satisfied with SRHR services
4.	Youth Friendliness Checklist	a. Quetta Health Facilities (8) b. Multan Health Facilities (7) Total = 15 Health Facilities c. FGD with Service Providers x 2 cities = 2 FGDs	Outcome indicator 2.2a – targeted (youth friendly) services increasingly comply with IPPF standards for youth friendly services
5.	Assessment of Community Leaders	a. Communities x 2 types (rural + urban) x 2 cities = 4 Total = 4 Power Mapping exercises	Outcome indicator 2.4c – Increased involvement of community leaders in realisation of SRHR
6.	Case Studies	a. 3 case studies x 1 city b. 2 case studies x 1 city Total = 5 case studies	Outcome Indicator 2.1a and 2.3a
7.	SGBV Services	NONE AVAILABLE	Outcome Indicator 2.3.1

[3] The age criteria for the FGDs is as follows:
Unmarried Boys and Girls = 14+ Years; Married Sample = 30+ Years

2.2 Translation and contextualization of the tools

The tools that had been adapted in the OM workshop in Karachi were further fine tuned between the Rutgers WPF offices in Islamabad, Netherlands and the Consultant. The UFBR indicators for each thematic area were defined during the workshop and relevant questions were added to the tool by the program and PME teams afterwards. The Pre-test was separately adapted for both boys and girls, and translated into Urdu.

It was decided that the Pre-test would be guided by the team so that the respondents would collectively do each question and have the confidence to ask for clarity, thus minimizing the risk of non-response.

2.3 Selection and training of data collectors

The following steps were taken in selection of the team:

1. The Partner Organizations in both cities were requested for identification of the data collectors according to the criteria below:
    - An equal number of males and females
    - Some experience of research, even as a student
    - Fluent in local languages as well as English and Urdu
    - For Pre Test, to be friendly in appearance and demeanor
    - For male FGDs, to have relevant experience of conducting both and to have thematic knowledge of SRHR.

2. A total of 08 team members were selected and assigned duties according to the following criteria:

    Table 2: No. of Data Collectors

TOOL	**QUETTA**		**MULTAN**	
Sex	M	F	M	F
Pre-Test	2	2	2	2
FGDs[4]	2	-	2	-
YFS/Exit Survey	2	2	2	2
TOTAL	**2**	**2**	**2**	**2**

3. One day training sessions were conducted in both cities for the teams, wherein the data collection process and methodologies, as well as sample sizes and other logistics were discussed in detail. The training was designed and undertaken by the Consultant.

4. The Field Plan was finalized through the Implementing Partners and one designated person from their offices was assigned with each team of data collectors.

[4] The female FGDs were conducted by the Consultant

5. The Pre Test was subjected to a Field Test, and finalized according to the feedback received.

2.4 Ethical aspects

It was explained to the students that the Pre-Test is a voluntary and anonymous exercise. All of the participants agreed to be a part of the survey.

The participants in the FGDs in the community were also assured of the anonymity of their replies and the voluntary nature of the participation.

2.5 Quality Control, data entry, cleaning and analysis

The software used for the purpose is IBM SPSS statistics 19. The process included the following steps:

Table 3: Data Entry Process

1. Data Recognition
2. Data Sorting into Cities
3. Data Sorting into Sexes
4. Data Entry Boys Multan
5. Data Entry Girls Multan
6. Data Entry Boys Quetta
7. Data Entry Girls Quetta
8. Data Compiling
9. Data Checking
10. Data Quality checking
11. Removing Errors
12. Data Analysis
13. Table creation
14. Graphs building
15. Analysis Quality Checks
16. Removing Errors

The analysis included the following:

- Descriptive statistics: Cross tabulation, Frequencies, Descriptive, Explore, Descriptive Ratio Statistics
- Bivariate statistics: Means, t-test, ANOVA, Correlation (bivariate, partial, distances), Nonparametric tests
- Prediction for numerical outcomes: Linear regression
- Prediction for identifying groups: Factor analysis, cluster analysis (two-step, K-means, hierarchical), Discriminate

2.6 Limitations

1. The fact was apparent that young people have a very limited access to the YFS that are part of the Parwan programme. However, it was beyond the scope of the study to assess where the unmarried young people are actually assessing the services, i.e. whether they are going anywhere at all, or accessing quacks and unqualified practitioners.
2. Although some of the YFS facilities assessed during the baseline were the same as those in the OM (1 in Multan and 5 in Quetta), due to the otherwise changed overall facilities in both cities, the data is not being compared to the baseline.
3. The sample selected for the Pre-Test can only be assessed and statistically valid for comparison if the same students are available for the Post-Test, which, in turn is dependent on whether the implementing partners continue to work with the selected schools.
4. The FGD sample was selected through convenient sampling because the issue was being discussed for the first time in new communities by the partner organizations. Due to security concerns it was considered better to keep a low profile, due to which random sampling methodology was not followed.
5. The findings from the FGDs are not statistically representative for a larger sample. They can only provide an adequate snapshot of the existing norms and practices.

Chapter 3: Results

Per Indicator presentation of findings (table with quantitative results & qualitative information)

The following pages summarize the results of the OM survey, per indicator and result area. It is important to note that because of the change in the ground realities from the originally planned interventions, most of the components in the OM survey are being considered as a baseline, and the results will be compared to the progress measured in 2015.

A: Result Area: Strengthening SRHR Education

- Outcome indicator 2.1a – exposed target groups has an increased capacity to make safe and informed decisions (on SRHR)

3.1 Results from the Pre-Test

The schools selected for the baseline in 2011 were later not considered for the intervention due to the IPs internal programmatic decisions, such as in choosing certain communities and locations. Therefore, the impact could not be assessed in the current process, due to which the OM is to be considered a baseline as far as the education component is concerned.

The following table presents the survey results, indicating the number of children with the good capacity of making informed decisions regarding SRHR. The term "good capacity" includes the students who have reached the benchmark in ANY TWO OF THE THREE categories: Knowledge, Skills and Attitudes. The benchmark for each category was set in mutual consultation between Rutgers WPF Netherlands as well as Rutgers WPF Pakistan. The ***benchmark*** was set as follows:

- Knowledge: 11/15 questions = 73%
- Attitudes: 11/17 questions = 65%
- Skills: 6/9 questions = 67%

Given below are the detailed results from the Pre-test, indicating the number of students who have reached the benchmark and how the process was derived:

Table 4: Sample Having Good Capacity

No. of students according to benchmark		No. of Students	% age
Binary Value for Skills	0-5 Score (below benchmark)	157	32.7%
	6-9 Score (reaching benchmark)	323	67.3%
Binary value for Attitude	0-10 Score (below benchmark)	54	11.3%
	11-17 Score (reaching benchmark)	426	88.8%
Binary value of Knowledge	0-10 Score (below benchmark)	239	49.8%
	11-15 Score (reaching benchmark)	241	50.2%

No. of students according to capacity		No. of Students	% age
Scores according to benchmark	Score 0 (reached benchmark in 0/3 category)	14	2.9%
	Score 1 (reached benchmark in 1/3 category)	91	19.0%
	Score 2 (reached benchmark in 2/3 category)	226	47.1%
	Score 3 (reached benchmark in 3/3 category)	149	31.0%
	No. of students having good capacity	**375/480**	**78.1%**

As is apparent from the above Table, about 78% of the sample can be considered as having good capacity. Key learnings from the detailed tables and graphs (given in Annex), as well as a few case studies (given in the next section) indicate the clear need of the adolescents for access to a structured curriculum in order to enhance their Knowledge, Skills and Attitudes in SRHR and to build their capacity in reporting abuse or making choices based on assertiveness and confidence.

The break up of the city-wise, sex-wise and school-wise data for each city can be found in detail in the Annex. However, it is relevant to mention some of the key findings here, in order to highlight future programmatic focus on certain emergent issues:

- **The boys were found to have more conservative and less rights-based views regarding gender norms (girls working outside the house/doing outdoor sports/marrying before the age of 20 years):** This reiterates the need for boys to be taught about being more gender-sensitive and to consider their females more independent at the individual level instead of the boys being in charge of their females' "morality" and "honor".
- **There is a dearth of knowledge regarding the modes of transmission of HIV/AIDS:** While there is good knowledge about the blood related modes of transfer of the disease (razors, transfusions, used needles), the entire sample is not aware about the sexual aspect of spread of HIV. There is much prevalence of myths, which is necessary to dispel so that people living with HIV face less discrimination (e.g. wearing/touching the clothes of an HIV positive person or sharing food of such a person can spread this disease). In addition, there is also prevalence of the belief that AIDS is completely curable. The knowledge regarding the prevention of Hepatitis B & C through screened blood, new razors, and packed syringes was found to be better than that related to sexual modes of transmission.
- **About half of the students think it is inappropriate to be taught about reproductive health:** When this question was asked in the FGDs and the term "reproductive health" was unpacked, the adolescents expressed the need for access to such information. It is interesting to note that the majority of the students feel that it is all right for (married) couples to be able to practice family planning. The problem they perceive is in unmarried students being taught about this topic. Therefore, based on the question in the survey, it is apparent that unless the adolescents (and assumingly, their caregivers) are advocated in detail about the curriculum and what it entails, the IPs may face opposition at teaching the SRHR component in schools. There is also mixed responses and not

good knowledge in the sample about the myths prevalent to puberty changes (wet dreams and menstruation).

- **There is a mixed response of boys and girls regarding assertive behavior and other essential skills:** This "behavior" concerns the assertiveness of the students as perceived about themselves in the classroom or amongst friends, sharing problems with someone, expressing anger through aggression, etc. It is important to note that about half the sample does not claim to have these skills where they feel that they can stand up to their friends, or speak up in class. Although quite a few students claim that they are aware of signs of sexual abuse if it happens to them, it could not be ascertained which signs they could recognize correctly or whether they were actually able to assess what sexual abuse is. Most of the sample stated that they would NOT protest if an adult caregiver hits them. Another interesting finding is that most of the students (73% boys and 76% girls) said they were comfortable about approaching their teacher in case of any problem (although it did not state whether or not they had approached the teacher for problems, and if yes, what kind). A possible implication could be that if the teachers are trained appropriately, they can be a tool for encouraging the adolescents to confide their issues in them, thereby being the primary source of reporting and referral. This is especially important as about half the students in the survey feel they are not confident about sharing questions about their sexual health with anyone.
- **A clear majority gave endorsing answers regarding smoking, drugs and bullying being uncool:** This is a positive finding, as it indicates that adolescents may not be under the influence of their peers to such a great extent that they take up smoking to gel in with the crowd. Similarly, nearly the entire sample is of the opinion that it is not all right to do drugs. The majority is also against the bullying of younger students. However, these questions do not actually indicate the prevalence of smoking in the sample, or the prevalence of drugs, or bullying.

3.2 Case Studies on SRHR Education

In order to supplement the information acquired through the questionnaire, it was requested from the partners to provide case studies (see Annex) reflecting the impact of the education component on the students. This is important in order to reflect upon the various qualitative aspects of the program as well as provide insights into the possible types of interventions present.

Although the number of case studies available was limited, the stories reflect the positive impact created through the education component on students, whereby they are first able to recognize that they are facing a problem, and are consequently confident in approaching the teachers to discuss the issue. There is also the implication that before the lectures delivered through the LSBE curriculum, there was no structured source of information regarding SRHR, thus the students were not aware about normal bodily changes leading to guilt, and misdirected interventions. Further, when empowered with the relevant strategies, they are able to address the issues affecting their daily lives, such as

eve teasing. The examples clearly reflect that when the students have been exposed to the relevant knowledge, especially about any form of sexual abuse or the changes in their bodies not being their fault and deserving to be addressed as an issue, the students take the positive actions they possibly can to alleviate their situations, such as confiding in the teacher after class, or seeking help from their parent. Needless to state, the education component would have a direct impact on the health seeking behavior and increased reporting of sexual or other abuse, especially if tied up to a post-information services component whereby the children are encouraged to seek help beyond the classroom setting. It is noteworthy that this conclusion and suggestion of the effectiveness of the SRHR education component is not based on a representative sample, considering that the number of case studies shared was three (and only in one district). However, they are reflective of the natural progression of the process beyond the imparting of the information to adolescents, who need to be equipped with this information in order to face the challenges of abuse and exploitation that they have the potential to encounter.

B: Result Area: Strengthening SRHR Services

- Outcome indicator 2.2a – targeted (youth friendly) services increasingly comply with IPPF standards for youth friendly services

- Outcome indicator 2.2b – Increase in the number of young people satisfied with SRHR services

3.3 Results from the Youth Friendly Services Survey

There were seven facilities selected in Multan and eight in Quetta. Of these, in Multan, only one facility was the same as in the baseline, while in Quetta six facilities were the same. The list of YFS facilities included in both the cities is given in Annex.

The findings of the survey in this section should be considered in conjunction with the detailed discussion with the HCPs (section 3.4). During the baseline, the HCPs had not been interviewed, thus the entire YFS component and its analysis was dependent on the observation skills of the data collectors and the Exit Surveys conducted at the time. During the process of finalizing the methodology of the OM, it was decided to include detailed discussions with the HCPs in order to gauge the on-ground situation of whether or not the facilities are being used by the target group (unmarried adolescents) and how feasible these services are for them. Indeed, the discussion in the next section more properly encapsulates the limitations, challenges and opportunities of availing services in the designated facilities. Therefore, the data above should not be taken as standalone figures, but in combination with the discussion with the health care providers.

3.4 Summary of the FGDs with Health Care Providers

A total of two FGDs were held with the Health Care Providers, one in each city. The purpose of developing this tool – which was not present during the baseline – was to assess the opinions and perceptions of the HCPs regarding the unmarried young people seeking services in their centers. The participants were part of the Parwan Alliance and operating the YFS facilities in both cities. The discussions are summarized below:

1. *FGD with HCPs in Multan:*

The FGD was conducted with seven participants, of which 5 were LHVs and 2 were males (Senior Medical Officers of BHUs). Regarding the availability of servies to the unmarried girls, the group shared that they did provide services to this group but these were limited to only a few aspects of SRHR, namely problems related to menstruation, pelvic inflammation or urinary infections. The girls who sought services for these issues were almost always accompanied by their mothers. The LHVs said that they see about 8-10 patients of such problems per month.

They also shared that in case they get cases of abortion, which is quite rarely, they pass them on to Marie Stopes Society instead of performing the procedure at their own facility. They get about 1 such case per month, and having been caused by rape or personal relationship.

A factor that was deemed important in the adolescent girls seeking services at the facilities was the age of the service provider. The younger the latter, the more comfortable (according to the LHVs) were the patients who could discuss their problems easily with them.

It was stated by the male doctors that boys did not visit their facilities at all, due to lack of awareness about the existence of such facilities as well as due to sexual health being a cultural taboo. They shared that boys did visit their private clinics but that too for infections, never for family planning awareness. They said that transvestites also visited the male clinics but did not have specialized clinics so their health seeking behavior for SRHR services was low.

An interesting but expected finding was that adolescents do not access the facilities for pre-marital counseling, especially for contraceptive awareness or information on family planning. This is attributed to the fact that in order to consider a marriage as successful in Pakistan, the couple is expected to quickly produce offspring. A failure to do so indicates a "problem", which is why it is almost unthinkable for unmarried couples to seek counseling about birth spacing before their impending marriages.

The service providers shared that the local midwives had an interaction with their facilities and referred the cases to them (of married women, not target group). However, the Community Mid Wives program of the government was not linked to them in any official or unofficial manner.

The service providers had been trained by Awaz for a total of three trainings, which they state, have helped them in gaining confidence and counseling their patients more effectively.

2. FGD with HCPs in Quetta:

The following participants were part of the activity, which was held on two different days due to a curfew in a part of the city. The notes have, however, been combined to present as a single discussion.

Participants:

1. LHV, BHU, Kachi Beg
2. Female Medical Technician, BHU Wahdat Colony
3. Female Medical Technician, BHU Junior Assistant Colony
4. LHV, MCH Center, Gawalmandi
5. Dispenser, School Health Service

Two of the three HCPs belonging to BHUs do not have a functional labor room in their BHUs. One of them has a labor room supported by an NGO-government funded project. About 80% of the patients who visit these facilities are there due to gynae issues, while the rest are regular outdoor patients with general complaints (diarrhea, flu, routine lab tests, etc). Of the 80% gynae cases, about 2-3% are unmarried girls, who are almost all presenting with problems related to Pelvic inflammatory Diseases (e.g. amonherea, discharge and pain) or issues related to menstruation. The incidence of unmarried girls seeking abortion or presenting with miscarriage is about 1-2 girls per month. The usual 'excuse" they give for their bleeding is falling in washroom etc. but because of their experience and expertise, and the general unease of the girls, the HCPs are able to recognize that they are unmarried and have come to seek medication for their botched up abortion or had a miscarriage. The HCPs stated that they do not conduct abortion at their clinics unless it's a life saving requirement, and if they are sure that the girl has nowhere else to go to. They say they make this decision based on how desperate the girl is (usually they beg us as they say that if we do not help them they have no choice but to die) and how bad her condition is.

The HCPs shared that their participation with the Parwan programme had been limited to two trainings (Feb and Aug 2013) on youth friendliness and dealing empathetically with SGBV victims. The government employees who were part of the BHUs/MCH had been selected by their Supervisor for the training. The criteria for nomination was unknown to the participants: "We ourselves don't know why we were selected". Regarding the training sessions, they said that they had been able to build their capacity regarding truly understanding the issues of the youth. Another advantage of the training, according to the participants, had been that they now they had started being more careful about managing SGBV cases (only the non technical part as the PIDS training did not cover how to medically assist the victim; the HCPS already knew that as part of their own medical education). Before the training, they used to simply give the treatment or medicines to the victims, but since they attended the Parwan sessions they are more vigilant in keeping records of such patients and asking them to come for follow up visits. They also mentioned that the mother/sister-in law almost always accompanies the victims of SGBV, and now they try to actively counsel these female relatives as well about convincing their male relative not to beat up his wife. The participants added that the female relatives were not there out of empathy for the victim, but only as a chaperone and because they had been sent by the same husband of the victim as a gesture of reconciliation after having hit his wife in anger. They said it was virtually impossible for a woman victim of SGBV to leave her house independently and seek services at their center, lest she wants to be beaten up again when she goes back home. Also, one of the HCPs operating a YFS in a Baloch area said that she did not have any SGBV case at her clinic, as the Baloch do not allow their "shame" to become public. Therefore, the victims of violence remain at home and never visit the clinic.

With regard to SGBV referral, the participants shared that they only provide the data to PIDS, as they (HCPs) have their own previously established network of referrals for such cases (police/hospital). As an example, one of the HCPs mentioned that she had received a case of a woman being shot in the head by her

husband. She immediately made the call to the police and the hospital, whose staff took her away in an ambulance. The data was shared with PIDS, but there was no intervention from Parwan programme in this – or such similar – cases. There was no clear break up of roles and responsibilities/expectations and procedures regarding follow up of the identified/referred cases between HCPs and Parwan SGBV component.

They shared that no one else from the staff in their YFS facilities had been given training, it was only them (in charge of their centers) that had been taken as participants, as the rest of the staff (according to the HCPs) was too junior/irrelevant for such sessions.

Regarding the quality of the services, one of the HCPs shared that she had a private room in her facility, which is why the girls who came to her easily confided in her, whereas the others stated that they did not have any private consultation room in their facilities. In fact, everyone from the sweeper to the medical technicians, dais, LHVs, and 8-10 patients are present in a typical facility in one room (7 x 10 feet large). They all agreed that privacy is a major factor for those few that come in as unmarried girls for disclosing the facts of their case. The HCPs also said that they had no way of following up on such patients as they hardly came back to the facility. They could not even ask them to come to their private clinics at home so that they could talk to them more discreetly because the home-based clinics are located too far away from their official facility. They said they were unaware about where the patients who do not seek treatment at their clinics end up.

Regarding the fee structure at the YFSs operated by the HCPs, the participants shared that they had been charging PKR 100 per patient since always, and even now, were charging the fee. One of the HCPs, who manages her private clinic at the government facility after closing hours (this is officially allowed?) said that she uses the saving from the patient fee to pay the electricity and water bills at the center, as the government does not pay these. She charges money from the patients after 2pm when the government timings are over.

The five YFS in charge HCPs (3 BHUs + 2 private clinics) shared that about a quarter of the gynae patients they examine are victims of early marriage, they say that they are unable to do anything about them since they are already married and pregnant, sometimes only showing up for delivery at the clinics. They said the idea of a married girl practicing FP to delay the birth of her first child was unheard of. Therefore, these early marriage victims do not come to seek contraceptives, but mostly visit for antenatal or delivery only.

When asked what sort of support – apart from the trainings – was being extended to the HCPs, they said PIDS had procured some material for their centers. The following is a list of the material handed over to the HCPs to make their centers more youth friendly (This is the total list; not all YFS were given everyitem in the list below):

- 1 torch

- 1 sheet of cloth
- 1 DNC kit
- Disposable gloves
- 1 Blood Pressure Apparatus
- Curtains
- Cupboard
- Chair
- Table
- Cooler
- IEC material

The HCPs mentioned that the extent of their participation in Parwan was quite limited and they would prefer if it could be expanded to some services that actually would be practical for the patients. They mentioned several issues whereby dais and untrained traditional birth attendants are misusing the medicines (e.g. prescribing Orthotec, etc. for inducing labor) or involved in general malpractice and hoped that Parwan can take up these with the local authorities. Furthermore, they suggested active lobbying by Parwan on issues such as: "There are many quacks and dais who use injections which 'guarantee the birth of a son' and they instead ruin a mother's health. Parwan should do something to stop this". The HCPs also opined that there should be awareness created at community level through Parwan about essential facts that ned to be told. For instance: "mothers refuse to believe that their sons can be infertile, they always blame the daughter in law for not bearing a child and insist to us that we give some medicine to cure the woman of her 'disease'" or "mothers-in-law refuse to acknowledge the need for their daughters-in-law to be taken to the hospital in time, thus resulting in essential loss of time, that endangers a woman's life". In this regard one of the HCPs shared that she went to a private gathering for condolence, where she was asked by a neighbor woman visiting the same place to check her daughter-in-law when she accidentally found out that she (the HCP) was an LHV. When she saw the patient, she realized that her baby had been dead and trapped inside her for three days and the woman was almost passed out due to the pain and weakness. As no supplies were available, she used shopping bags instead of gloves to deliver the dead baby and asked the mother in law to rush the woman to the hospital. Her reply was "I cannot take her anywhere as her husband is not here. How can she go without a male accompanying her?" Such strong taboos are existing in the society regarding the access of women to healthcare, which is why, according to the HCPs, it is important for programmes like Parwan to create awareness at the community level.

The only male participant of the FGD – who is in charge of a school dispensary being run by the government as part of the school health services - manages the program in six schools. Of these, three are girls' institutes (2 schools/1college), one is a co-educational school and two are boys' schools. The total student strength is 12000 children in these six schools. The YFS where this HCP is stationed is housed in one of the schools. The mandate of this facility is to provide first aid during school hours. The typical cases they encounter are dehydration, sports injuries, headaches, diarrhea, or food poisoning from

unhygienic food at the school canteen. No screening of diseases is done at the facility. Part of their mandate is to inculcate the LSBE curriculum in the schools under the facility (six – as mentioned above). The HCP shared that he conducted the classes for boys at his office from three schools. The beneficiaries are only the school going children enrolled in these schools, there is no community-based program for out of school children covered through this component. The material support extended by Parwan in order to make the facility into a YFS includes the following:

- 10 chairs
- 1 cupboard
- 2 revolving chairs
- 1 stretcher
- 2 coolers
- 1 first aid box
- IEC material

Conclusion: The conclusion from both the discussions (Quetta and Multan) is that while the training has been effective in changing the attitude of the selected HCP in the relevant facilities, there is a dearth of relevant youth clientele in these clinics. Therefore, the effectiveness of the strategy to train the HCPs is questionable. Where there are some clients seeking services, they are limited due to the structural issues in the facilities (lack of privacy, lack of legal or other follow up services, etc.). Furthermore, there is wide variety of the kinds of HCPs that are selected as part of the programme, it seems to be a random selection with no clear stratification of geographical area, male vs. female ratio, or the type of health care service selected. The incentives given for the inclusion of the HCPs in the programme were found to be ineffective and irrelevant.

3.5 Summary of Status on SGBV Services within the Parwan programme

The detailed discussion with the designated Parwan staff for this component in both the cities is summarized below:

1. There are no services available that can be truly attributed to the Parwan programme with regard to proper referral and linkage creation. At the moment, there is a list of services as per follows, which is maintained in the respective offices regarding SGBV services. The last column indicates the types of cases that are expected to be received from these linkages in the future. As of now, there is no formal MOU that details the exact level of linkage.

Table 5: List of SGBV contacts in both cities

CITY		
Quetta		
1.	Medical Officer Asghar	
2.	National Madadgar Helpline	SGBV cases
3.	Antinarcotics hospital	Drug cases

4.	Social Welfare Officer of Medical and Civil Hospital	SGBV cases
5.	Shah Clinic	
6.	FPAP Saiban Clinic	HIV/drugs/child abuse
7.	Al Khidmat Hospital	SGBV cases
8.	LHVs at an MCH near Noor Masjid	
Multan		
1.	RHC Qadir Pur Awan	SGBV cases
2.	RHC Sher Shah	SGBV cases
3.	Women Crises Center, Darul Aman and Edhi Center	Meetings held

2. The Quetta office has gathered a few case studies of SGBV women that are receiving services through the above-mentioned linkages. The names mentioned in the linkages given above were actually provided through HDS to PIDS. The role of Parwan programme in rehabilitating such cases has not yet been active except that there has been a creation of referral at FPAP for counseling the cases referred by Islamia High School (YFS) regarding SRHR issues. So far, three cases have been referred.

3. The Multan office plans to collect data and further strengthen the linkages in the above-mentioned table during the next phase of the program.

3.6 Case Studies on SRHR Services

The case studies have been made available by PIDS from Quetta (see Annex), which are indicative of the kind of clients that are received at the various SRHR services that are part of the Parwan programme. The data is limited so no definitive conclusion can be made regarding the effectiveness of the services available. However, the case studies do reflect that the availability of a helpline to the victims is a convenience for those trying to reach out for support, as are the awareness programs through mass media (radio, etc.) about the availability of such services.

Conclusion: The SGBV component is currently in the nascent stages of the overall programme. There is a definite presence of victims in the communities that the HCPs are linked with. However, there is a lack of interface between the services and the communities, thus creating a need for the development of an active mechanism of support. As of now, the Parwan programme has not concentrated on the development of such linkages, as this services component had not been active in the first two years of the programme.

C: Result Area: Improved Enabling Environment on SRHR

- Outcome Indicator 2.4a/b – SRHR/SGBV Policies and Legislation Implemented Changed or Adopted at Local, Institutional or National Level
- Outcome indicator 2.4e - Increased acceptance of SRHR at community level
- Outcome indicator 2.4c/d - Increased involvement of community leaders in realization of SRHR/SGBV

3.7 Advocacy on Parwan Issues: Stepping-stones towards policy and legislation

Aimed Policy or Legislation Change	Agenda setting	Policy influencing
1. Incorporation of LSBE into both provinces' curriculum	• Series of meetings with relevant departments in Punjab and Baluchistan • Regular advocacy on these issues at all forums	• *Curriculum revision has taken place by the joint efforts of Baluchistan Bureau of Curriculum, Policy Planning and Implementation Unit, and Provincial Institute of Teachers Education. Currently Rutgers WPF is awaiting the consolidated version of curriculum.* • *In Punjab, the process of talks with the government was derailed due to negative influences against the LSBE, as it was promoted as "immoral" in some isolated incident through some factions of media and parent body. Currently, the re-building of relations is on going with the Department*
2. Health Policy to include Youth Friendly Services	• Series of meetings with relevant departments in Punjab at district level and Baluchistan at provincial level	
3. Creating an enabling environment for the overall discussion on SRHR	• Parwan Alliance has been formed in both provinces to promote the agenda of access of adolescents to SRHR services as well as to create vocal advocate groups on issues such as early marriage, domestic violence, responsible fatherhood, etc. • A series of round table conferences on domestic violence at Federal and in both provinces • The Bill on Early Marriage for Sindh was drafted by Rutgers WPF and the latter is advocating on pushing	• *All levels of policy making bodies and individuals are regularly made part of the activities conducted at Federal and both provincial levels regarding these issues* • *Rutgers WPF is advocating for the adoption of the Domestic Violence Bill at Federal level as well as through Alliance members at district and provincial levels*

	the same agenda in both Punjab and Baluchistan	

3.8 Summary of the FGDs with CSOs of Parwan Alliance

Two sessions were held – one in each city – with members of the Parwan Alliance in order to gauge their feedback about the programme and their own role in its success. The objective was also to assess the challenges and way forward regarding the Alliance. The following is a summary of the discussions, while the detailed discussions are available in the Annex:

- The CSOs have been able to reach many people through the Parwan programme with a specific focus on topics related to SRHR
- There is overall increased media attention on these issues in terms of coverage of the CSO events
- The CSOs are appreciative of the trainings conducted by the Parwan Alliance as well as the fact that being a part of the Alliance has helped build their own profile of work
- There is a need for more female staff in Quetta in order to properly reach the women in the communities, as well as more regular activities in the field
- The financial component needs to be greater in order to create more impact in the community by having more sustainable and regularly planned activities
- Issues such as child abuse, early marriage, domestic violence need to be tackled aggressively at the community level
- There are communication gaps between the IPs and the CSOs, which are impacting the potentially robust nature of the Alliance
- The awareness activities need to be linked with the demand and referral
- There needs to be greater allowance by the IPs to the CSOs for innovation in methodology (street theater, radio programs, etc.) while delivering the messages in the community
- The Alliance has not been acting as a collective body to push predefined agendas at the provincial level with regard to specific issues regarding SRHR
- IEC material developed as part of the Alliance needs to be more age/culture/sex/context specific and in greater number

3.9 Summary of the FGDs with Community

A total of 16 FGDs were conducted with the community in Quetta and Multan. The sample size was an average of 9-12 persons per activity. A total of 153 participants were part of the FGDs. They were asked questions regarding their attitudes and prevalent community practices on the issues that are being addressed through the Parwan programme. This section summarizes the findings, while the detailed FGDs are available in the Annex. It is important to mention that although there was supposed to be a comparison between the issues discussed in the communities in 2011 to the same in 2013, this has not been possible due to the fact that the communities were different from the ones selected for the baseline, due to programmatic decisions at the end of the IPs. Therefore, a "retrospective analysis" is not possible based on the community but a general overview of the issues faced under the Parwan program in Pakistan is presented.

The following is a summary of the discussions:

- In the opinion of this Consultant, It is a brave decision to work on SRHR issues, especially in these communities. People are more open to discuss the existence of these issues as compared to 2011, even though the communities are different from the ones originally targeted. According to the CSOs and IPs, this could be due in part to the advocacy created at the district and provincial levels as well as increased media coverage of SRHR issues.

- Parwan activities (limited to community sessions by CSOs) were not recalled by most of the community; perhaps because the FGD sample had not participated in the sessions.

- It was found that there is no service delivery and referral attached to the awareness raising; the awareness raising needs to be more robust and continued instead of random sessions in different parts of the city. There are limited services available, and those that are existent are not really known to the community or linked to them through Parwan or any other avenue.

- One of the FGDs (urban married women, Quetta) showed that the participants were more aware about issues and had a better willingness to discuss the issues. They recalled having attended sessions on domestic violence etc. and the female community mobilizer in this CSO was found to be very involved at the grassroots. Therefore, the skills and dedication of the end communicator directly explaining to the community are essential.

- The issues mentioned are similar in type and magnitude to the ones in the baseline. According to the sample, women suffer from SRHR problems but do not have the power to change their ground realities.

- Talking about SRHR is equated with promiscuousness and loose morality, according to the community.

- The community reflected that parents have strict distance with their kids so fathers don't talk about this issue with sons of pubertal age.

- The community also reflected that fathers always stop girls' education if they are eve teased instead of focusing on countering eve teasing.

- It was found through the discussions that quackery is a commonly present phenomenon (including faith healers, untrained women traditional practitioners, unqualified hakims, etc.). The community shared that there is greater acceptance and presence of female quacks/unqualified practitioners, such as *Dais* and no ethical checks on the kind of medication they prescribe or the social needs they exploit (e.g. giving "guaranteed medicine" for the birth of a son). They are also popular due to being available at the doorstep and as their services can be purchased in barter (clothes/sweetmeats/food or monthly installments). Here are also no issues of acceptability as they are familiar or respected figures in the community.

- Boys have easy access and exposure to pornography but no access to proper information on SRHR, according to the community.

- It was found through the discussions that the source of information of girls on menstruation is through their mothers/elder sisters, predominantly after the menarche, never before. The Always sanitary pads school campaign is another source of information for school going girls and provides access to information through a female doctor.

- Girls do not have access to technology (mobile/net), according to he community.

- Most groups think that 25 years is the ideal age of marriage.

- There is acceptance of pre marriage counseling class for females but only if separate for boys and girls and by male and female teachers separately for either sex; according to the participants, the curriculum should focus on medical and social point of view and mothers should be able to accompany the daughters; the mothers also said it would be best if community health worker/doctor checks their daughters in such a place. They were against their daughters being made aware of sex and about boys' body changes, etc.

- Potential advocacy points based on real issues of the community regarding the FGD topics, as suggested by the Consultant:

    a. Large family size is an issue that needs to be addressed

b. Focus on early marriage from the viewpoint of emotional and health aspects
c. Focus on boys and men to advocate against early marriage i.e., young males need to be told that a mentally and physically immature marriage partner will not be able to make them happy, and that they themselves also need to be mature to take on the responsibility of marriage
d. Traditional harmful practices need to be addressed (watta satta/walwar/foetus marriage/dowry)
e. Preventable deaths due to pregnancy and childbirth need to be discussed. Unmarried girls should be taught about maternal mortality etc; the importance of antenatal care needs to be highlighted
f. It should be taught that it is ok for unmarried girls to go to the community LHW/LHV
g. Brothers of young girls need to be targeted for effective intervention
h. Breaking myths about menstruation/male sexuality is important
i. Focus on parents to teach good values to sons (in context of eve teasing)
j. Have testimonials on early marriage from survivors of this issue (research/evidence based data)

- The real issues of the community women regarding access to SRHR services are mostly based on FP/RH, for which they have no avenue. If things continue like this then the current group of girls will also face the same issues, including maternal mortality. The concept of not taking a woman to a hospital unless there is an emergency or complication (often realized too late) is quite prevalent, and regular antenatal care is thought to be a superfluous concept. The concept of preventive services is missing.

- SGBV and its various aspects (early marriage, domestic violence, etc.) are considered to be private family matters and equated with "honor"; any confrontation on these issues by "outsiders", such as NGOs, law enforcers, or communities is shunned by the family.

Conclusion: There has not been any significant impact of the awareness raising activities conducted in the communities. The reasons for this were found to be: a lack of continuity in the activities in terms of topics; random selection of communities and no follow up with the participants; no follow up of the activities or sharing of resources (technical, service delivery linkages), i.e. no process carried out beyond imparting information.

3.10 Summary of the Assessment of District Leaders Involvement

This activity had been undertaken in the baseline to assess which community leaders can be effective in promoting the Parwan agenda at the higher forums and even within the community. The original plan was to provide this list of potential assets to the IPs so that they could start advocating with these

individuals in an official and semi official capacity and build their knowledge and skills on SRHR issues. However, due to the following factors, it was found that the lists made in 2011 were now redundant:

a) Change of government
b) Change of working area/community within the city
c) Absence of concrete action plan on how to involve the community leaders

The following is a summary of the discussions conducted with the CSOs in both cities in order to identify the (new) list of community leaders in their respective line of work concerning Parwan. **It is important to note that the level of involvement of these individuals has been limited to participation in the CSOs activities (and not necessarily for Parwan activities but for activities conducted for other donors as well). On this basis, the overall score given to them is 1 in both categories of reporting required: a. low involvement and b. low knowledge.**

Assessment of District/Provincial Leaders in Multan (Rural):

A total of twelve participants from various CSOs took part in the discussion. These are all part of Parwan Alliance and are operational in the semi urban/rural areas of the district under this programme. According to the tool, they named a few people (excluded from the report for reasons of anonymity but available with the IPs) from the following sectors as important Community Leaders with regard to participation in their activities:

Educational sector:

Religious sector:

Political sector:

Other sectors: (Business, Police and Media)

The CSOs (rural) also named a few persons as creating negative influence about the Parwan programme and other NGO activities in their areas.

Assessment of District/Provincial Leaders in Multan (Urban):

A total of eight CSOs took part in the discussion. These are all part of Parwan Alliance and are operational in the urban areas of the district under this programme. According to the tool, they named the following persons as important Community Leaders with regard to participation in their activities:

- Provincial Minister for Jails: participation
- Various MPAs
- Religious scholars, school owners, media persons, local government authorities, etc.

Assessment of District/Provincial Leaders in Quetta (Rural):

A total of four CSOs took part n the discussion. They are operational as part of the Parwan Alliance in the rural/semi urban parts of the district. Before sharing the names of the Community Leaders, the participants discussed that since they were working in a tribal environment, it was not possible to approach the subject of SRHR in a very open manner in the communities. Therefore, they cloaked it as a women's health issue, which was why they were able to convince the community leaders to cooperate with them. The CSOs explained that it is not possible in the local context to penetrate in a community without the influence and support of the community leaders, as the grassroots are divided upon the basis of tribes, ethnicity, minority and religious lines. Also, the community is not attracted towards the CSO until they are sure that the organization has come to them through the approval of the proper hierarchy. They also shared that they were unable to actively contact the parliamentarians – specially those in power- as their protocol and other requirements for participation were too complicated and time consuming, specially due to the current security situation. Therefore, it was more effective for these CSOs to contact the local level bigwigs. The CSOs stated that a common issue was the whenever they wanted to start a programme in any area, the local politicians/leaders pressured them into hiring their (politician's) designated staff. A positive change reported in the provincial scenario of Balochistan was that the new government was perceived to be approachable and from the middle class, therefore the CSOs were hopeful that they would have greater approachability to their elected leadership in the future. They also shared that they had realized that it is important to look beyond the political sector to the other stakeholders who can help influence their work; e.g. police, army and other law enforcement agencies have been successful in promoting polio campaigns. Other important stakeholders at the community level are the local influential women ("appa") for mobilizing women, the teachers and the local prayer leaders: "The support of these people can lead to gateways being opened and angering them can mean having doors shut in our faces", described a participant. They can be potentially approached for helping to create space for other issues, such as SGBV, as well. The participants also stated that the terms "NGO", "funds" "project", etc. always create trouble in the community, so they try their utmost to avoid this aspect of their work and only present themselves as a local organization.

The participants named several persons from political sector as their community leaders for the projects they had been undertaking. Their level of participation was described as supportive to providing facilitation for organizing community activities as well as participating in them to some extent.

Assessment of District/Provincial Leaders in Quetta (Urban):

A total of three organizations participated in the discussion. They are part of the Parwan Alliance as CSOs that work in the urban areas of the district. They shared that they could not operate without the influence of local level

community members, and, in order not to offend them, they had to discuss only neutral subjects with the community, such as marriage contract ("Nikkah nama"), HIV, hepatitis, etc. but not hardcore SRHR issues. The CSOs said that one of the local newspapers had agreed to print a special one-page section on Parwan but the material had not yet been provided to them for printing. They also suggested that PIDS should compile a relevant media list and share amongst Parwan Alliance so that they could be approached by the CSOs for covering their Alliance-related activities.

Conclusion: There is no comparison possible with the baseline due to a lack of continuity of the work with the communities selected back in 2011. Due to the change in the government after the elections, the political leadership is also different from that of 2011. The involvement of the new leadership (as well as that in 2011) is limited to facilitating the CSO in conducting their awareness-raising sessions within "their" geographical area; requesting their electorate to attend such meetings; and sometimes gracing these occasions with their own presence. There was no evidence reflective of garnering support for the Parwan cause through the politicians to advocate for policy level changes at the provincial level. The CSOs have created in-roads and linkages in other sectors as well, such as education, media, religion, local authorities, etc. but the involvement of individuals from these sectors is also limited to participation in functions or allowing the CSOs to conduct activities in their respective institutions.

Chapter 4: Conclusions and Recommendations

The Parwan programme tackles a new frontier in terms of the topics it addresses in a conservative – even physically and ideologically challenging environment. The security issues and increased fundamentalism, coupled with a general lack of political will to address seemingly "unimportant" issues such as domestic violence, early marriage, maternal mortality, awareness of and access to SRHR services, as well as an overall limited focus on adolescents as a demographic group are factors that have led to a situation where only a handful of organizations are confronting SRHR as an agenda. In this regard, the Parwan programme has been a groundbreaking phenomenon in the conservative geographical settings of Balochistan and South Punjab – both areas having clear lower indicators in terms of social development than some other parts of the country.

The various components of the programme can be summarized according to their respective indicators as per the following:

a. Increased capacity of Young People: The data has not been able to reflect any change due to the methodological issues, such as the baseline schools being different from those included in the OM. Therefore, the current exercise is to be considered as the baseline for the schools education component, as the Post-test will be a measure of the impact of the school lessons. The case studies available with the partners, although less in number, do reflect the success of carrying out such a component and the potential positive impact on the students in identifying problems and seeking help for them.
b. Increased quality access of Young People to SRHR services: There is a dearth of Young People accessing these services. The comparison could not be made to the baseline considering the fact that the data is mostly not from the same services as were selected in the baseline. The decision of selection of government facilities for the implementation of IPPF guidelines needs to be revisited, as it is not bearing results due to bureaucratic red tape and lack of priority by the government. Furthermore, the Young People are not visiting the government facilities but are instead going to private (mostly unqualified) practitioners, which is why the focus of training the service providers should be shifted to those facilities where the Young People are present.
c. SGBV Services access to Women: There is no comparison possible with baseline as no proper data has been collected in this area and no significant linkages have been made till now.
d. Advocacy and Policies: There is the creation of overall space in this area in terms of forming a positive environment regarding the promotion of SRHR in education curriculum. However, this aspect often gets derailed due to the negative impact created in some sections of the media/religious lobby and the efforts have to be restarted.
e. Community acceptance and participation in SRHR activities: There have been ad hoc, limited activities regarding awareness raising on randomly selected topics instead of a focused approach toward creating a change.

There could be no comparison to the baseline due to the fact that the communities were different from the ones in 2011.

f. Community Leaders Involvement: The methodological issues prevented a comparison to the baseline.

Despite the fact that the key theme of SRHR is an essential topic to be addressed with all relevant stakeholders in the above mentioned areas, there have been several outcomes since the baseline which require a restructuring of strategy and overall redirection of the programme methodology. The discussions with the stakeholders indicate that a dent has been created in terms of raising awareness about the existence of various components that comprise SRHR in the context of the Parwan programme. However, a movement has yet to build up organically from this seed that has been planted, and there is need of good nurturing of this sapling in order to turn it into a fruit-bearing tree.

Recommendation: Many of the changes that need to be made in order to strengthen the Parwan Alliance are related to obtaining clear direction at the part of the IPs through internal reflection about the goals and outcomes of the programme.

It was found through the case studies that teaching SRHR information and skills at the school level (on topics such as awareness about one's body and abuse/exploitation, etc.) helps to create confidence in young girls and boys about their issues related to normal pubertal changes, identification of issues that may be causing a problem during such transitions, and knowledge of steps to take to redress such issues. In addition, although the external environment may not change so easily, the imparting of LSBE does instill the ability in young boys and girls to face problems (such as eve teasing, pressure created by boys on girls to elope with them, etc.) and seek help accordingly. Similarly, the preventive aspect of teaching such a program is potentially hugely beneficial because it can help enable young girls and boys to display more assertive behavior when faced with threatening/bullying/peer pressure situations.

Recommendation: It is not enough to limit the intervention to imparting lessons, as the true effectiveness of can only be utilized if the information is linked to a proper system of referral and services, including counseling. There are several ways in which this is possible for school going children where LSBE is being undertaken through Parwan; for instance, an after school counselor who visits once a week and is hired as part of the programme, rotating between the schools in the city. Such a counselor could be the direct source of interaction between the students and teacher, as well as the student and doctor/other service providers (helpline, etc.) for availing the relevant services.

The major areas where the strategies need to be refocused include the YFS facilities and community advocacy regarding the components of the Parwan programme. With regard to the strengthening of the YFS services and bringing them at par with the IPPF standards, the first question that needs to be asked internally is: where is the youth that would need to visit the centers? There are capacity building programs for the service providers in these centers as well as

physical up gradation of the facilities, and budget is being spent on these activities as part of the program. On the other hand, the services are not selected through a pre-designated framework or even present in the areas where the awareness of their existence (should ideally) be created. There is also no visible effort to bring the adolescents to such centers, and it seems more an arrangement of convenience than well-designed program planning. The latter is the need of the hour, and innovative, out-of-the-box thinking is required at the IPs and Parwan Alliance partners' level to address the situation of lack of usage of health facilities by the target group.

Recommendation: A proposed solution is for the YFS facilities to be shifted from the current government set ups to community-based existing pharmacies, where there is a trained staff available to give out the required information and supplies. Also, the existing LHWs and LHVs present in the areas can be approached to promote the required messages for adolescent girls. Needless to state, such messages should be culturally acceptable, and from a health perspective in order to give parents the confidence to send their daughters for such classes. This is important due to the fact that girls and boys do not have proper sources of information and are perpetually seeped in an intergenerational cycle of myths regarding puberty and its consequent related issues.

Recommendations: It is also necessary that the counselor/contact point in the community be linked effectively with other relevant service providers for referral and treatment so that there is increased service utilization instead of the random awareness activities being conducted at the moment. There is also the need to properly plan the selection of community areas vis-à-vis geographical spread, presence of the CSOs at the field level, and existence of the issues within the community as well as the current formal and informal services available.

With regard to community awareness, it is essential to design context specific material and approach it from a more acceptable and palatable viewpoint than that currently adopted. For instance, issues such as early marriage, traditional practices (watta satta, etc.) and domestic violence need to be also endorsed from a religious perspective in order to counter the negative effect created by orthodox interpretation of these issues. Similarly, the emotional and psychological impacts of such issues on the family unit – especially the male – needs to be highlighted and special focus should be made on conducting awareness sessions with men (particularly fathers and brothers). Another aspect of early marriage is to link it to girls' education, such as creating messages about "not marrying off one's daughter before she has completed her Bachelors degree".

There is also the need to continue to break taboos regarding the health aspects of issues such as maternal mortality, which are usually deliberately not discussed with unmarried girls. This is especially important, as the mothers were found accepting of such information to be passed on to their daughters, as long as it involved preventive health aspects and not too much detail about the process of conception.

Overall, large family size and FP methods have not been part of the active agenda of SRHR in Parwan, even though this is literally an enormous problem at the family level. Linked to this are the issues of maternal mortality as well as complications in mothers during and post-birth, or miscarriages and lack of access to FP methods. The Parwan programme would bear better results and create strong impact if these issues are given equal weightage as part of the SRHR, because these are the practical issues faced by the women of childbearing age in the communities. It is important to create awareness through radio or street theater and other mass media through innovative methods such as "verbal autopsy" (analyzing the factors through a story of why a certain death happened in the community), etc.

Another aspect that specifically needs to be highlighted is that of child abuse, especially in terms of enabling adults to protect their children through the recognition of signs and symptoms as well as preventing abuse by teaching youth and children about the problem.

Yet another emergent issue is of the gender attitudes that are taught within families to boys and girls. There is a need to focus on advocating gender sensitive education to boys and men, in order to raise sensitized males at the community level. For instance, eve teasing was found to be a deeply rooted issue, and directly attributed to the current gender roles prevalent in the society. As another example, parents think that their boys are safe on the internet while the girls are not: on the one hand they do not let their daughters access net technology and on the other they keep absolutely no boundaries on the internet usage of their sons, as they are not aware that pornography etc. are commonly accessed through this medium. There is also the need to highlight the importance of a mature, educated female in marriage as compared to a child bride, so that the emotional aspects of a marriage are also given importance. Similarly, the importance of boys themselves first being emotionally mature before getting married needs to be an advocacy point.

There is a strong programmatic need to revise the methodology adopted for the SGBV component and actively develop a mechanism to enumerate the exact impact being created through Parwan in this component. For instance, if a helpline is already being managed through another donor, how will it be possible to attribute its success as an SGBV component of Parwan? There is a need to clearly attribute the exact link between other programmes and Parwan, especially in terms of a symbiotic relationship (e.g. the helpline workers are trained through Parwan). Also important to note is the programs' extremely limited level of access to SGBV victims. In order to turn them into survivors, they must be accessed but as of now most of those suffering from domestic violence are in their homes without any services.

With regard to the Parwan Alliance members, there needs to be a re-strategizing undertaken through the partner CSOs and the IPs. The Alliance should ideally emerge as a movement/pressure group in each province, with a focused agenda/positioning of the policy level changes that are required. Currently, there

is an over-reliance on local level politicians to attend the CSOs' activities at the filed level, while there is a need to actually involve them to a better degree than their mere presence.

The internal coordination with the CSOs needs to be revised, and more vigorous presence is needed at the field level of the IPs male and female staff so as to guide and communicate with the community and assess the impact of on going activities on a regular basis. More active coordination and transparency would result in better achievement of programme objectives. Similarly, the activities planned at the community level with them should be more focused, and results based as well as more regular than ad-hoc. The capacity, willingness and performance of the CSOs also need to be reassessed.

There is a strong need to involve the youth in all aspects of the Parwan programme, through social media and direct interventions, so that there is a greater achievement of the desired objectives.

ANNEXES

1. Outcome Measurement Work Plan
2. Tools in English & Urdu
3. Overview of Changes Researched in OM
4. Detailed analysis per indicator
5. Country specific result chain

Annex 1: Outcome Measurement Work Plan

Annex 1 A: Daily Plan in Both Cities

Day	Time	Team Distribution[5]		
		Team 1 (M)	*Team 2 (F)*	*Team 3 (SA)*
Day 1	Morning	Team Orientation at PIDS/Awaz	Team Orientation at PIDS/Awaz	Team Orientation at PIDS/Awaz
	Afternoon	Field Planning at PIDS/Awaz	Field Planning at PIDS/Awaz	Field Planning at PIDS/Awaz
Day 2	Morning	Field Testing at 1 public school	Field Testing at 1 private school	2 rural FGDs
	Afternoon	3 YFS facilities	3 YFS facilities	2 rural FGDs
Day 3	Morning	Pre-test at 4 public schools	Pre-test at 4 public schools	2 urban FGDs
	Afternoon	Client Exit I	Client Exit II	2 urban FGDs
Day 4	Morning	Pre-test at 4 private schools	Pre-test at 4 private schools	1 FGD HCP
	Afternoon	Client Exit I	Client Exit II	1 FGD CSO
Day 5	Morning	Client Exit III	Client Exit IV	Assessment of CL (Rural)
	Afternoon	Client Exit V	Client Exit VI	Assessment of CL (Urban)
Day 6	Morning	Client Exit III	Client Exit IV	Discuss SGBV
	Afternoon	Client Exit V	Client Exit VI	Discuss SGBV
Day 7	Any pending field work + debriefing Remaining 1 YFS + its Client Exit Survey			

[5] M= Male; F = Female; SA = Sarah Asad

Annex 1 B: Daily Plan in Multan

Day	Time	Venue	Sample	Team
Day 1 Wed 2nd Oct	1100am	Awaz Office	Field Planning	Sarah
	0100pm	Awaz Office	Team Training	Sarah
	0400pm	Awaz Office	CSO FGD	Sarah
	0530pm	Dr. Ghulam Mujtaba Clinic (Urban)	1 M YFS	Salman + Absar
Day 2 Thu 3rd Oct	0830am	PEF Rafi Education School (Public)	6 boys + 6 girls	Erum + Absar
	0830am	Tibah Masud Pur (Rural)	1 M YFS + 1 F YFS	Salman + Tasneem
	1030am	Shahwar Model School (Pvt)	6 boys + 6 girls	Erum + Absar
	1100am	Gulgasht (Urban)	1 M YFS + 1 YFS	Salman + Tasneem
	1100am	Basti Hinjran	Rural FGD	Sarah
	0100pm	Khairabad (Rural)	1 M YFS	Salman
	0100pm	Buch Khusrobad (Urban)	1 F YFS	Tasneem
	0100pm	Awaz Office	Documentation	Erum + Tasneem
	0300pm	Basti Shah Hussain	Rural FGD	Salman+Absar
	0500pm	Basti NawabPur	Rural FGD	Salman+Absar
Day 3 Fri 4th Oct	0830am	Quaid e Millat School (Public)	15 boys + 15 girls	Erum + Absar
	0830am	Al Khalid School (Public)	15 boys + 15 girls	Salman + Tasneem
	1030am	Al Ilm Rehbar School (Public)	15 boys + 15 girls	Erum + Absar
	1030am	Iqbal Model School (Public)	15 boys + 15 girls	Salman + Tasneem
	0100pm	Nadrabad Phatak	Urban FGD	Sarah
	0100pm	Awaz Office	Documentation	Erum + Tasneem
	0300pm	Dera Adda	Urban FGD	Salman+Absar
	0400pm	Pul Monday Wala	Urban FGD	Salman+Absar
	0500pm	Razabad Catholic Church	Urban FGD	Sarah
Day 4 Sat 5th Oct	0830am	Masali Junior School (Pvt)	15 boys + 15 boys	Salman + Absar
	0830am	Masali Junior School (Pvt)	15 girls + 15 girls	Erum + Tasneem
	1030am	Bright Ways School (Pvt)	15 boys + 15 girls	Salman + Tasneem
	1030am	Ujala Girls High School	15 boys + 15 girls	Absar + Erum
	1100am	Basti Moran Wali	Rural FGD	Sarah
	0300pm	Awaz office	FGD HCP	Sarah
Day 5 Mon 7th Oct	0900am	Tibah Masud Pur YFS 1	Client Exit I	Salman + Absar
	0900am	Tibah Masud Pur YFS II	Client Exit II	Erum + Tasneem
	1030am	Gulgasht YFS III	Client Exit III	Salman + Absar
	1030am	Gulgasht YFS IV	Client Exit IV	Erum + Tasneem
	1200pm	Khairabad YFS V	Client Exit V	Salman + Absar
	1200pm	Buch Khusrobad YFS VI	Client Exit VI	Erum + Tasneem
	1100pm	Awaz Office	Assessment CL-R	Sarah
	0100pm	Awaz Office	Assessment CL-U	Sarah
Day 6 Tue 8th Oct	1000am	Awaz Office	Debrief	Sarah
	0100pm	Awaz Office	Documentation	Sarah
	0200pm	Awaz Office	Wrap up	Sarah

Annex 1 C: Daily Plan in Quetta

Day	Time	Venue	Sample	Team
Day 1 Mon 21st Oct	1000am	PIDS Office	Field Planning	Sarah
	0100pm	PIDS Office	Team Training	Sarah
	0300pm	PIDS Office	CSO FGD	Sarah
	0300pm	Kauser Perveen YFS	1 F YFS	Anjum/Nighat
Day 2 Tue 22nd Oct	0930am	Islamia Dispensary	1 M YFS	Sakim/Shakeel
	0930am	Gawalmandi BHU	1 F YFS	Nighat/Rehmat
	1000am	MRDS Office	Semi Urban FGD	Asif/Kashif
	1100am	Islamia School (Public)	6 boys	Sakim/Shakeel
	1100am	Danish School (Private)	6 boys + 6 girls	Asif/Darryl /Nighat
	1200pm	Wahdat Colony BHU	1 F YFS	Nighat/Rehmat
	0100pm	Ahmad Jan School (Public)	6 girls	Rehmat/Nighat
	0100pm	FPAP	1 M YFS + 1 F YFS	Shakeel/Sakim/Anjum
	0100pm	Kauser Perveen	1 F YFS	Nighat/Rehmat
	0330pm	NWO Office	Semi Urban FGD	Sarah/Kashif
	0400pm	Killi Nohsar	1 M YFS	Asif/Shakeel
Day 3 Wed 23rd Oct	0930am	Railway Girls High School (Public)	30 girls	Anjum/Nighat/Rehmat
	0930am	Islamia High School (Public)	30 boys	Sakim/Asif/Shakeel
	1030am	Postal Girls High School (Public)	30 girls	Anjum/Nighat/Rehmat
	1030am	Central Boys High School (Public)	30 boys	Sakim/Asif/Shakeel/
	0100pm	KIND Office	Urban FGD	Sakim/Asif/Shakeel
	0330pm	NWO Office	Urban FGD	Sarah/Kashif
Day 4 Thu 24th Oct	0930am	Hira Public School (Private)	15 boys + 15 girls	Anjum/Sakim/Shakeel
	0930am	Universal High School (Private)	15 boys + 15 girls	Nighat/Asif/Darryl
	1030am	Perfect High School (Private)	15 boys + 15 girls	Nighat/Asif/Darryl
	1100am	PIDS Office	FGD HCP	Sarah
	1200pm	Danish School (Private)	15 boys + 15 girls	Nighat/Asif/Darryl
	1200pm	KWS Office	Semi Urban FGD	Sarah
	0100pm	HDS Office	Urban FGD	Sarah/Kashif
	0130pm	HDS Office	Urban FGD	Sakim/Asif/Kashif
	0330pm	AIDB Office	Semi Urban FGD	Sakim/Asif/Kashif
Day 5 Fri 25th Oct	0930am	Islamia Dispensary	Client Exit I	Sakim/Asif/Shakeel
	0930am	Gawalmandi BHU	Client Exit II	Nighat/AnjumRehmat
	1030am	PIDS Office	Assessment CL-R	Sarah/Kashif
	1030am	Kauser Perveen	Client Exit III	Nighat/Anjum/Rehmat
	1200pm	FPAP	Client Exit IV + V	Sakim/Anjum/Darryl
	1200pm	KWS Office	Semi Urban FGD	Sarah/Kashif
	0300pm	PIDS Office	Assessment CL-U	Sarah
	0400pm	Killi Nohsar	Client Exit VI	Sakim/Anjum/Shakeel
	0530pm	Killi Kambrani	Client Exit VII	Sakim/Anjum/Shakeel
Day 6 Sat 26th Oct	1000am	PIDS Office	Debrief	Sarah
	1200pm	PIDS Office	FGD HCP	Sarah
	0100pm	PIDS Office	Documentation	Sarah
	0200pm	PIDS Office	Wrap up	Sarah

Annex 2: Tools in English & Urdu

PRE-TEST (Boys)

To be completed by the data collector

01. Pre Test number _____

02. Name of data collector _____

03. Date _____

04. Duration of completion Time start: _____ Time finished: _____

05. Name of school _____

06. Name of class _____

07. Name of community _____

07. Name of city _____

INSTRUCTIONS for respondents

Please help us by filling in this questionnaire. Your responses are very important to us and will help us to make good programmes for young people.

Your name will not be used in the interview, **all the information you give us will be kept private.** Nobody will know who filled in this questionnaire. Your teachers, neighbours, family and schoolmates will not see your answers.

Filling in this questionnaire is completely **voluntary**. If it makes you feel uncomfortable, you can stop at any time.

Please take your time and answer carefully. There is enough time to complete the questionnaire.

1. Please write down your age: **_____** years old

2. Please specify your marital status (tick one box only)
a) Married ❒
b) Engaged/Nikkah ❒
c) Unmarried ❒

3. Are you part of any school club? **❒ Yes ❒ No**
a) If yes, please name the club: _____

4. Did you participate in the following phases of the programme?

a) Inspire Phase: ❒ Yes ❒ No

b) Educate Phase: ❒ Yes ❒ No
If yes, how frequently:
(i) Less than 3 activities ❒
(ii) 4-6 activities ❒
(iii) 7-9 activities ❒
(iv) More than 9 activities ❒

c) Activate Phase:❒ Yes ❒ No
If yes, how many activities: (Please tick one of the following)
i. Between one - three ❒
ii. Between three – six ❒

5. Please answer the following statements:

i. "I am confident about speaking up in class " ❒ Yes ❒ No
ii. "I feel as valuable as other children in my class" ❒ Yes ❒ No
iii. "I always feel compelled to say yes to my family's decisions" ❒ Yes ❒ No
iv. "I always feel compelled to say yes to whatever my friends ask of me" ❒ Yes ❒ No
v. "I never share my problems with any one" ❒ Yes ❒ No
vi. "I sometimes express my anger through hitting/aggression" ❒ Yes ❒ No
vii. "I think cigarette smoking will make me more popular" ❒ Yes ❒ No
viii. "In my opinion, it is okay to do drugs" ❒ Yes ❒ No
ix. "In my opinion girls should be allowed education equal to boys" ❒ Yes ❒ No
x. "In my opinion I should have the freedom to choose my marriage partner" ❒ Yes ❒ No
xi. "In my opinion girls should be married before the age of twenty years" ❒ Yes ❒ No
xii. "In my opinion if boys cry it means they are weak" ❒Yes ❒ No
xiii. "In my opinion, girls should never express their anger" ❒ Yes ❒ No
xiv. "In my opinion teenage girls should not play sports in public spaces" ❒Yes ❒ No
xv. "In my opinion girls should not do jobs outside the house" ❒ Yes ❒ No
xvi. "In my opinion it is all right for boys to stare at girls who step out of home" ❒ Yes ❒ No
xvii. "In my opinion, if a boy stares at a girl or teases her in the street it is better for her to stay quite about it" ❒Yes ❒ No
xviii. "In my opinion it is ok to hit a woman if she is disobedient" ❒Yes ❒ No
xix. "In my opinion it is ok to bully younger students" ❒Yes ❒ No
xx. "I will be able to recognize sexual abuse if it happens to me " ❒ Yes ❒ No
xxi. "I know where to seek help in case of sexual abuse" ❒Yes ❒ No
xxii. "If an adult caregiver hits me, I will protest against such an act" ❒ Yes ❒ No
xxiii. "In my opinion it is important for couples to be able to practice family planning" ❒ Yes ❒ No
xxiv. "I feel more confident about myself after attending the Schools4Life session" ❒Yes ❒ No
xxv. "According to the law everyone has the right to choose their own marriage partner" ❒Yes ❒ No
xxvi. "HIV/AIDS affects non-muslims only" ❒ Yes ❒ No
xxvii. "AIDS is completely curable" ❒ Yes ❒ No
xxviii."It is possible for a healthy-looking person to have HIV" ❒ Yes ❒ No
xxix. "Wet dreams are a normal part of growing up" ❒ Yes ❒ No

6. Can HIV/AIDS be prevented through the following?

a. New, packed syringes ❒ Yes ❒ No

b. New razors ❒ Yes ❒ No

c. Screened blood transfusion ❒ Yes ❒ No

d. Safe intimate interaction ❒ Yes ❒ No

7. Please answer true or false to the following statement:

a) Wearing/Touching the clothes of an HIV/AIDS infected person can spread HIV/AIDS

❒ True ❒ False

b) Eating the food of an HIV/AIDS infected person can spread HIV/AIDS

❒ True ❒ False

8. Can you protect yourself from Hepatitis B & C through the following?

a. New, packed syringes ❒ Yes ❒ No

b. New razors ❒ Yes ❒ No

c. Screened blood transfusion ❒ Yes ❒ No

d. Safe intimate interaction ❒ Yes ❒ No

9. Has the school guided you about whom to approach in case you have any problems regarding your sexual/emotional or physical health? ❒ Yes ❒ No

a) If yes, did u go to this recommended place/person? ❒ Yes ❒ No

a) If yes, please specify whom you visited and for what purpose: _____ _____

10. Are you comfortable about approaching your teacher in case of any problem?

❒ Yes ❒ No

11. Do you feel confident about sharing questions about your sexual health with anyone?

❒ Yes ❒ No

12. Do you think it is appropriate for unmarried people to be taught about reproductive health?

❒ Yes ❒ No

PRE-TEST (Girls)

To be completed by the data collector

01. Pre Test number _____

02. Name of data collector _____

03. Date _____

04. Duration of completion Time start: _____ Time finished: _____

05. Name of school _____

06. Name of class _____

07. Name of community _____

07. Name of city _____

INSTRUCTIONS for respondents

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Your name will not be used in the interview, **all the information you give us will be kept private.** Nobody will know who filled in this questionnaire. Your teachers, neighbours, family and schoolmates will not see your answers.

Filling in this questionnaire is completely **voluntary**. If it makes you feel uncomfortable, you can stop at any time.

Please take your time and answer carefully. There is enough time to complete the questionnaire.

1. Please write down your age: **_____** years old

2. Please specify your marital status (tick one box only)
a) Married ❒
b) Engaged/Nikkah ❒
c) Unmarried ❒

3. Are you part of any school club? **❒ Yes ❒ No**
a) If yes, please name the club: _____

4. Did you participate in the following phases of the programme?

a) Inspire Phase: ❒ Yes ❒ No

b) Educate Phase: ❒ Yes ❒ No
If yes, how frequently:

d) Educate Phase: ❒ Yes ❒ No
If yes, how frequently:
(v) Less than 3 activities ❒
(vi) 4-6 activities ❒
(vii) 7-9 activities ❒
(viii) More than 9 activities ❒

c) Activate Phase: ❒ Yes ❒ No
If yes, how many activities: (Please tick one of the following)
i. Between one - three ❒
ii. Between three – six ❒

5. Please answer the following statements:

i. "I am confident about speaking up in class " ❒ Yes ❒ No
ii. "I feel as valuable as other children in my class" ❒ Yes ❒ No
iii. "I always feel compelled to say yes to my family's decisions" ❒ Yes ❒ No
iv. "I always feel compelled to say yes to whatever my friends ask of me" ❒ Yes ❒ No
v. "I never share my problems with any one" ❒ Yes ❒ No
vi. "I sometimes express my anger through hitting/aggression" ❒ Yes ❒ No
vii. "I think cigarette smoking will make me more popular" ❒ Yes ❒ No
viii. "In my opinion, it is okay to do drugs" ❒ Yes ❒ No
ix. "In my opinion girls should be allowed education equal to boys" ❒ Yes ❒ No
x. "In my opinion I should have the freedom to choose my marriage partner" ❒ Yes ❒ No
xi. "In my opinion girls should be married before the age of twenty years" ❒ Yes ❒ No
xii. "In my opinion if boys cry it means they are weak" ❒Yes ❒ No
xiii. "In my opinion, girls should never express their anger" ❒ Yes ❒ No
xiv. "In my opinion teenage girls should not play sports in public spaces" ❒Yes ❒ No
xv. "In my opinion girls should not do jobs outside the house" ❒ Yes ❒ No
xvi. "In my opinion it is all right for boys to stare at girls who step out of home" ❒ Yes ❒ No
xvii. "In my opinion, if a boy stares at a girl or teases her in the street it is better for her to stay quite about it" ❒Yes ❒ No
xviii. "In my opinion it is ok to hit a woman if she is disobedient ❒Yes ❒ No
xix. "In my opinion it is ok to bully younger students" ❒Yes ❒ No
xx. "I will be able to recognize sexual abuse if it happens to me " ❒ Yes ❒ No
xxi. "I know where to seek help in case of sexual abuse" ❒Yes ❒ No
xxii. "If an adult caregiver hits me, I will protest against such an act" ❒ Yes ❒ No
xxiii. "In my opinion it is important for couples to be able to practice family planning" ❒ Yes ❒ No
xxiv. "I feel more confident about myself after attending the Schools4Life session" ❒Yes ❒ No
xxv. "According to the law everyone has the right to choose their own marriage partner" ❒Yes ❒ No
xxvi. "HIV/AIDS affects non-muslims only" ❒ Yes ❒ No
xxvii. "AIDS is completely curable" ❒ Yes ❒ No
xxviii."It is possible for a healthy-looking person to have HIV" ❒ Yes ❒ No
xxix. "During menstrual periods girls should not shower or bathe " ❒ Yes ❒ No
xxx. "During menstrual periods, girls are too weak to participate in sports or exercise" ❒ Yes ❒ No

6. Can HIV/AIDS be prevented through the following?

a. New, packed syringes ❒ Yes ❒ No

b. New razors ❒ Yes ❒ No

c. Screened blood transfusion ❒ Yes ❒ No

d. Safe intimate interaction ❒ Yes ❒ No

7. Please answer true or false to the following statement:

a) Wearing/Touching the clothes of an HIV/AIDS infected person can spread HIV/AIDS

❒ True ❒ False

b) Eating the food of an HIV/AIDS infected person can spread HIV/AIDS

❒ True ❒ False

8. Can you protect yourself from Hepatitis B & C through the following?

a. New, packed syringes ❒ Yes ❒ No

b. New razors ❒ Yes ❒ No

c. Screened blood transfusion ❒ Yes ❒ No

d. Safe intimate interaction ❒ Yes ❒ No

9. Has the school guided you about whom to approach in case you have any problems regarding your sexual/emotional or physical health? ❒ Yes ❒ No

a) If yes, did u go to this recommended place/person? ❒ Yes ❒ No

a) If yes, please specify whom you visited and for what purpose: _____ _____

10. Are you comfortable about approaching your teacher in case of any problem?

❒ Yes ❒ No

11. Do u feel confident about sharing questions about your sexual health with anyone?

❒ Yes ❒ No

12. Do you think it is appropriate for unmarried people to be taught about reproductive health?

❒ Yes ❒ No

Youth Friendliness of Health Facilities

Brief Description:

Data collectors will visit selected health facilities

They will assess the facility for each selected topic. This assessment will be done through observation of the facility (waiting area, distance, privacy etc.) and in conversation with the service provider(s).

Note: the data collectors will not be present during consultations between the service providers and the clients.

The data collectors will give a score on each selected topic.

Scores will range from 1 – 4. Give a narrative remark to be able to compare at a later stage.

Topic list

Note: Please score each issue as per the corresponding guide below

Topic	**Outcome measurement (2013)**	
	Quantitative	**Qualitative**
	Score 1-4	**Remarks**
1 Training of service provider		
2 Privacy		
3 Opening hours		
4a Accessibility (as per chart given later)		
4bAre the SRH services available to young people regardless of their ability to pay		
4c Are the SRH services accessible to all young people irrespective they are accompanied by some guardian/elder?		
5 Referral		
6 Community and parental support		

Topics and their scoring:

1. **Training of service provider.** Are the service providers trained to work competently, sensitively and respectfully with young people on their sexual and reproductive health needs?
Specify whether training received for only males, only females, or both

1: None of the service providers have ever received training on working with young people
2: Some service providers have received some/little training on working with young people
3: Most of the service providers received adequate training on working with young people
4: At least one of the service providers has received extensive training on working with young people and is able and willing to train other service providers on the job

2. **Privacy.** Is there a separate private consultation room available where young people can speak with the service provider?
Specify whether privacy for only males, only females, or both
1: There is no separate private consultation room
2: There is a private consultation room, but there are also consultations taking place in a none-private setting
3: Privacy is guaranteed almost all the time
4: Privacy is always guaranteed

3. **Opening hours**. Are the opening hours convenient for young people?
Specify whether opening hours convenient for only males, only females, or both
1: The opening hours are always very inconvenient (for instance only during school time)
2: The opening hours are very inconvenient on most days
3: The opening hours are convenient
4: There are special opening hours for young people

4. Accessibility.

4a. Are the SRH services accessible to all young people?

Facility	Explanation when relevant	Do you provide…?	**Who do you provide to?**			
			Males		Females	
			Married	Unmarried	Married	Unmarried
Condom distribution						
Pregnancy test			NA	NA		
Contraceptives (give details of types of contraceptives)						
Voluntary counselling and testing for HIV						
STI screening (syndromic approach)						
Counselling on safe sex, sexuality and life skills (specify what is provided)						
Referrals for all services not provided *(with follow-up mechanisms in place)*						
Psycho-social support for young people living with HIV						
Support for young victims of sexual violence						
Emergency contraception			NA	NA		
Post-abortion care, including incomplete abortion care, counselling and post-abortion contraception			NA	NA		
Other services						

4b. Are the SRH services accessible to all young people irrespective of their ability to pay?

Specify whether free service available for only males, only females, or both

1: If a young person cannot pay, he/she will not be helped

2: If a young person comes with an emergency, he/she will be helped and can pay later

3: Preventative SRH services are given to young people for free

4: All SRH services are given to young people for free

4c. Are the SRH services accessible to all young people irrespective they are accompanied by some guardian/elder?

Specify whether available for unaccompanied males and unaccompanied females

1. If a young person is not accompanied with some guardian/elder, he/she will not be helped

2: If a young person comes alone with an emergency, he/she will be helped.

3: Preventative SRH services are given to young people irrespective guardian accompanying or not

4: All SRH services are given to young people irrespective guardian accompanying or not

5. Referral. Is there referral system in place for the following:

- **a. STIs** ❒1 ❒2 ❒3 ❒ 4 ❒
- **b. Complicated pregnancy** ❒1 ❒2 ❒3 ❒ 4 ❒
- **c. Sexual abuse** ❒1 ❒2 ❒3 ❒ 4 ❒
- **d. Other** ❒1 ❒2 ❒3 ❒ 4 ❒

1. Absent and don't refer
2. Absent but refer
3. Present but not effective because of lack of transport or far distances or affordability or confidentiality
4. Present and effective

6. **Community and parental support:** Do the service providers involve the parents and the community to ensure that adolescents have access to sexual and reproductive health services?

1. Not involve them at all
2. Sometimes involve them
3. Involve them actively
4. Involve them actively and support parents and community to do so

Tool: Client Satisfaction Exit Survey

Brief Description:

Instructions for the interviewer

It is highly recommended to conduct the interview in a separate room or a quite setting to ensure that the person being interviewed is at ease. The below paragraph can be used as introduction to the interview. It is very important to explain the confidentiality of answers and the use of answers to improve the facilities.

Introduction before beginning the interview

We are conducting this interview to assess the quality of care at this clinic and hope to use this information to improve services. We are asking clients about their satisfaction with the services provided. We hope that you can help us by agreeing to let me interview you today. I will not take your name and your participation or refusal to participate in this interview will not affect the services you receive in any way. The interview will take about 10-15 minutes and will be kept confidential.

Please reconfirm that the marital status of the respondent is Unmarried before proceeding:

Respondent No. _____

Name of the interviewer:

Name of the clinic

Location of the clinic

City: _____

Date: _____

Time _____

1. Sex: ❒ **Male**
❒ **Female**

2. Education level:

❒ No formal schooling

❒ Primary

❒ Secondary

❒ Matric or equivalent

❒ F.A or equivalent

❒ B.A or equivalent

❒ Masters

3. What type of service did you come for today? (Record what respondent tells).

4. Is this your first time at this clinic? Yes/no

5. Age (in years):

6. How satisfied are you with the information you have received?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very dissatisfied:	No information received
Somewhat dissatisfied:	Received some information but wanted more information
Somewhat satisfied:	I received the information I expected
Very satisfied:	I received more information than I expected

7. How satisfied are you with the treatment you have received?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very dissatisfied: I received no treatment
Somewhat dissatisfied: I received incomplete treatment
Somewhat satisfied: I received treatment as I expected
Very satisfied: I received treatment more than I expected

8. How do you perceive the level of skills and knowledge of the service provider?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very low: The service providers seemed to be lacking the skills and knowledge to help me
Somewhat low: The service provider had some skills and knowledge but it seemed not enough to help me completely
Somewhat good: The service providers seemed to have the skills and knowledge I expected
Very good: The service provider seemed to have more skills and knowledge than I expected

9. The opening hours are convenient to me

Strongly disagree	Disagree	Agree	Strongly agree
0	1	2	3

Strongly disagree: The opening hours are very inconvenient due to school/work/ other reason
Disagree: The opening hours are inconvenient, but I can make it
Agree: The opening hours are ok for me
Strongly agree: The opening hours offer me more opportunity to visit the facility than I need

10. The waiting time was acceptable

Strongly disagree	Disagree	Agree	Strongly agree
0	1	2	3

Strongly disagree: I had to wait more than 2 hours
Disagree: I had to wait between 1 and 2 hours
Agree: I had to wait less than 1 hour
Strongly agree: I was helped immediately

11. The cost of the service was acceptable

Strongly disagree	Disagree	Agree	Strongly agree
0	1	2	3

Strongly disagree: I had to pay more than I can afford
Disagree: I found the service expensive
Agree: I found the cost reasonable
Strongly agree: The service was cheap/for free

12. How is your satisfaction with the level of privacy offered to you?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very dissatisfied: I had no privacy when talking to the service provider
Somewhat dissatisfied: I had some privacy but people could hear me if they would try
Somewhat satisfied: There was privacy during the consult but I don't know if confidentiality is secured
Very satisfied: There was privacy during the consult and I am sure there is confidentiality

13. How is your satisfaction with the level of confidentiality offered to you?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very dissatisfied: I had no privacy when talking to the service provider
Somewhat dissatisfied: I had some privacy but people could hear me if they would try
Somewhat satisfied: There was privacy during the consult but I don't know if confidentiality is secured
Very satisfied: There was privacy during the consult and I am sure there is confidentiality

14. How satisfied are you with the manner in which the clinic staff treated you?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very dissatisfied: I was treated badly (rude, yelled at, blamed, judged etc.)
Somewhat dissatisfied: I was treated unfriendly and impersonal
Somewhat satisfied: I was treated as I expected
Very satisfied: I was treated friendlier than I expected

15. How do you feel about the time for your consultation?

Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied
0	1	2	3

Very dissatisfied:	The time for consultation was very long / very short
Somewhat dissatisfied:	The time for consultation was longer/shorter than I expected
Somewhat satisfied:	The time for consultation was as I expected
Very satisfied:	The time for consultation was better (longer/shorter) than I expected

16. I feel comfortable to return any time if I have questions or problems?

Strongly disagree	Disagree	Agree	Strongly agree
0	1	2	3

Strongly disagree:	I will never return
Disagree:	I will only return if it is an emergency
Agree:	I will return if I need to without hesitation
Strongly agree:	I am happy to return and will recommend this facility to others

What suggestions can you make to improve this clinic and the services provided?

_____

_____

Tool: Focus Group Discussions

Brief Description:

Introduction

In the introduction the FGD facilitator explains to the participants:

Who he/she is

What the outcome measurement **research** is about

How the **information** that is given by the participants will be used and why

Informed consent is needed (Take consent forms with you and have them filled out prior to the FGD)

How **anonymity** and **confidentiality** will be guaranteed

That the informant can withdraw his/her **participation** in the research, at any point during the FGD or research process and without having to give an explanation

It is important to practice this a number of times before going to the field.
Fill in the responses through the note-taker on the note-taking guidelines and record the FGD on a voice recorder.

FGD Guidelines (Community)

Key questions on sexuality, norms and acceptance

Opening question:
Detailed discussion on following topics

1. What is your attitude towards early marriage/pregnancy?
Is it present? Have there been any incidents of early marriage in your community lately? Please describe frequency. Was there ever anything done to prevent such marriages?
Is it same for all types of girls in the community? What factors increase the probability of being married at an earlier age (socio-economic background, number of female siblings, education, etc.)?
What is your opinion about this? What do you think is the ideal age for marriage?
What are the health implications of early marriage and consequent pregnancy? Has there been any change in your opinion and in your community's attitude about this issue? If yes, what is the change and what do you attribute it to?
Do you think males and females in your community have the same ideas about this? Do you think there is a difference between the attitude and opinion of adults and young people regarding this? What is the difference?
When there is a teenage marriage issue, what do you think could be the possible role of young people? Are young people able to execute this role (religion, norm, tradition)?
Has there been any change in this regard: (a) at the societal level and (b) at the individual level? Have you been able to stop any such marriage from happening? How? What helped you to take action in this regard? If you were not able to take any action, why was that so?
What has been your source of information regarding this topic? Have you participated in any activity or heard of the Parwan program in the context of early marriages? Please describe your affiliation with this program.

2. What in your opinion constitutes eve teasing?
What are the attitudes of young people towards eve teasing?
Is it present?
What is your opinion about this?
Do you think girls who step out of the house should be subjected to teasing? Why or why not?
What is your source of information on this topic? Have you participated in any activity or heard of the Parwan program in the context of prevention of

eve teasing? Please describe your affiliation with this program.
Do you think males and females in your community have the same ideas about this? Do you think there is a difference between the attitude and opinion of adults and young people regarding this? What is the difference?
When there is an eve teasing issue, what do you think could be the possible role of young people? What could be the possible role of adults?
For unmarried groups:
Do you think you are able to execute an active role in this regard? Do you feel more empowered after having participated in the Parwan programme? If yes, how?
Where do young people go for help with these issues? Has there been any change in this regard? Have you been able to stop any such incident from happening? How? What helped you to take action in this regard? If you were not able to take any action, why was that so?

3. What are the attitudes of young people towards <u>access to information on sexuality for young people?</u>
For both groups:
How do you feel about the option of young people getting access to SRHR information? Should this be available for both girls and boys or neither or only boys/only girls? In which areas is it different for boys and girls (pornography etc.)
What is your opinion about these various types and sources of information? Have there been changes in the situation in the last years? Why? What do you think of it?
For unmarried groups:
Did you ever receive any information on sexuality? (body changes, risky behavior, protection against STI/HIV/Hepatitis, drug abuse, etc.)
What were the sources of such information? Did you actively seek out such sources of information or were they made available to you? Why? Why not? (religion, norm, tradition, etc.)
Is it same for both girls and boys? In which areas is it different for boys and girls (pornography etc.)
What is your opinion about these various types and sources of information?
For both groups:
Have you participated in any activity or heard of the Parwan program in the context of SRH education or access to services? Please describe your affiliation with this program. Has there been any change at the

personal/community level due to your participation in this program? If yes, what change at the individual, family, societal levels?

For married groups:

Are you comfortable talking about SRHR issues to your children? How has the experience been? Where else do you think your children go to take information about SRH? Where do you think they should go to take information? If they come back to you with new information, what is your reaction? Has being part of the Parwan programme made any change in the way you approach such topics with your children? If yes, how? What effect has that resulted in?

For unmarried groups:

Who are you most comfortable talking to about SRHR issues? How have they been helpful? Who has been the most challenging to talk to? Why?

Do you think adults in your community have the same ideas about this as the youth? If not, what is the difference in opinion?

FGD Guidelines (Health Care Providers)

1. What categories of Young People frequent your clinics? (male/female/transgender; married/unmarried; STI, HIV; age groups..)
2. What categories of Young People do not visit your clinics? Where do they go instead?
3. Do you ever refuse certain category of Young People? Who and Why?
4. Do you actively work with unmarried young people? Please describe the type of issues and services they seek and what is provided to them
5. Who should be refused service at health facilities?
6. What are the most frequented services at your clinics for Young People?
7. What are the barriers that prevent Young People from seeking services at clinics run by professionals like you?
8. Are there any services that you would like to offer but are prevented due to legal/cultural/technical issues? Please elaborate.
9. Could you think of anything that would make it easier for you to provide services to young people
10. Has there been a change in your/your co-workers'/team's ideas concerning this topic, during the past year? Why?
11. Have you received any training regarding Youth Friendliness of services?
12. If yes, was this as part of Parwan program? Please describe the topics, duration and frequency. Please describe the effectiveness of the training in terms of bringing the learning into practicality? What new skills did you learn? How has it changed your attitude towards creating services for young people?
13. Have you ever trained the staff working in your clinics? If yes, on which staff on what topics and how frequently? How has the experience of training others been? What were the opportunities, challenges and acceptability?

Tool: Assessment of Community Leaders' Involvement in SRHR

Brief Description:

Identify the key stakeholders in the selected community from the list collected through the same exercise in the baseline survey in 2011.

Note: Are the people you want to target decision-makers by name only or by nature as well? **One needs to identify who really holds power and to target civil servants behind the scenes as well.**
When mapping key stakeholders, identify <u>persons</u> and not positions.

Define 'involvement in SRHR' for the community leaders
In this tool, we measure the involvement in SRHR of community leaders. This can be defined differently in different communities.
<u>Define involvement:</u>

1. Discuss the definitions of involvement[6] and the main definitions of the SRHR components
2. Based on the filtering of the names identified in 2011, seek to assess who is still there with the programme through involvement in activities/creating change? Are there any new entrants? How has the Parwan program identified/involved these old/new change makers?
3. Discuss in a group whether the individual people on the list have shown an increased involvement (and why not).
4. Do this for all stakeholders identified, then discuss it as a whole and write down the conclusion, if possible strengthened with the quantitative data (like 7 out of 20 have increased involvement).
5. Include in the analysis why there has been, or hasn't been an increase according to the group

[6] How are community leaders involved in the community? For example:
- Speeches
- Attendance to meetings
- Providing resources (financial, human, practical)
- Expression of norms in media or community gatherings
- Support of SRHR programmes in the community
- Problem solvers for any emerging social issue
- Social gathering (marriages, funerals)
- Sports activities, etc.

Pre-Test in Urdu (Boys)

In page file…shared separately with Rutgers WPF

Pre-Test in Urdu (Girls)

In page file…shared separately with Rutgers WPF

Annex 3: Overview of Changes Researched in OM

Indicator	Finding	Methodological reasons for (lack of) results	Programmatic reasons for (lack of) results	Theory of Change reasons for (lack of) results	Other remarks
Increased capacity etc	Quantitatively not been able to find any change.	Because of methodological issues, the baseline schools being different from implementation schools			Will be measured through the Post-test, process of implementation in schools is on track
	Qualitatively positive changes because of LSBE, specifically in young people approaching teachers for support in SRHR issues				The nr of case studies (3) is very low to make this conclusion
Increased quality	No change to be found (analysis not final though)	Different clinics	Implementation in this area has not receive ample attention in the first years of the program, and creating support from government is time consuming	It is questionable whether training health care providers in YFS, will increase access for young people. Even if HCP would be good, too many other limitations to have an effect for young people	
SGBV	No change	No baseline to show change	Little implementation in this area		
Policies	See a change in policies in curriculum.		*I think because of the successful implementation …*		
	Other policy changes…?		The advocacy is too broad to have a focussed change		

Acceptance community	No change	No baseline to compare, and retrospectively also no change	Limited coverage of the program, ad hoc activities, little focus, addressing the safe issues and thus not changes thinigs	Change might not take place at community level, maybe most change will take place at CSO level itself.	
Involvement community leaders	No change? (needs more analysis)	Methodology could not be reused to compare	?	>	

Annex 4: Detailed Analysis Per Indicator

A: CASE STUDIES (Indicator 2.1a)

The following case studies have been made available by Awaz CDS from Multan, which are reflective of the impact being created in the lives of the students who have undergone the LSBE curriculum.

1. Akmal, a student of class 9th, is the son of a vegetable seller in Multan. Of his six siblings, he is one of the few going to school, as the rest of them could not be educated due to a lack of resources. His father has always maintained a formal distance between the children, thus was impossible for Akmal to talk about his puberty changes with his him. In fact, he thought he had a fatal disease, and it was only a matter of time before he would die. This distracted him from his studies, made him emotionally volatile, and confused him to no end. It was only by coincidence that his fears were allayed: One day at school the class teacher gave a lecture to the boys on puberty changes and explained the normal signs of growing up. Akmal heaved a huge sigh of relief as he realized that what he had imagined to be an illness was only a regular part of growing up for an adolescent boy. He was also happy to learn that these lessons on puberty and related issues would be conducted weekly, as they were part of a programme called Parwan.

2. The shy, introverted 13-year old Fatima belongs to a village. Her mother had passed away when she was very young, so her father had sent her to a religious madressah to cover her worldly as well as religious education. As the school was some distance away from home, she was the victim of eve teasing on a daily basis. When her father came to know about this, he forbade her from going to school. Eventually, her aunt admitted her in a private school but the same thing happened here too. She did not want her education stopped permanently so this time Fatima did not talk to anyone at home. However, she used to feel miserable every day, on her way and back from home to school – carrying, besides her heavy school bag the excess baggage of anger, shame, frustration, fear and helplessness. It came as a pleasant surprise when she was taught about self- protection as part of the LSBE curriculum in her school. She confided in her teacher about her issue, who in turn gave her and the entire class several tips about how to tackle such situations. With her confidence restored and self-esteem high, Fatima is happy to have been a part of these lessons.

3. Maimoona is a 13-year-old student who lives in a joint family system. Older male cousins are often thought of as brothers in such families, and Maimoona was also the responsibility of one such male cousin. He used to pick and drop her from school, and would help her with her studies. One day, he showed her pornographic material based on school going girls and boys, and then asked for her to touch him intimately while he dropped her off to school. She was confused and scared about the situation. Fortunately, she was part of the student body learning the LSBE

curriculum and was taught about self-protection and sexual abuse as part of this course. This gave her the courage to approach her teacher, who listened to her patiently and advised her to share the issue with her mother. She also discussed the problem with the rest of the class while maintain Maimoona's anonymity and taught them about how to handle such situations. The young girl confided in her mother, who needed some convincing that she was indeed speaking the truth. When Maimoona threatened her mother that she would disclose this to her father if she herself did not address the situation, her mother spun into action and confronted the nephew. He was told to back off and stay in his limits and was told that he would be closely watched from now on. Eventually, when the dust settled, Maimoona's mother was all praise for her daughter's confidence and strength, which she attributed to the LSBE lessons.

B. RESULTS FROM THE PRE-TEST (Indicator 2.1a)

Skill Based Questions:		No. of Students	% age
I am confident speaking in Class.	yes/True	437	91.0%
I always feel compelled to say yes to whatever my friends ask of me.	No/True	271	56.5%
I never share my problems	No/True	263	54.8%
I sometimes express my anger through hitting/aggression.	No/True	359	74.8%
I will be able to recognize sexual abuse if it happens to me.	yes/True	341	71.0%
I know where to seek help in case of sexual abuse.	yes/True	316	65.8%
If an adult caregiver hits me, I will protest against such an act.	yes/True	134	27.9%
Are you comfortable about approaching your teacher in case of any problems?	yes/True	360	75.0%
Do you feel confident about sharing questions about your sexual health (Jinsi Sehat(with anyone?	yes/True	251	52.3%

Attitude Based Questions:		No. of Students	% age
I feel as valuable as other children in my class.	yes/True	463	96.5%
I always feel compelled to say yes to my family's decisions.	No/True	117	24.4%
I think cigarette smoking will make me more popular.	No/True	452	94.2%
In my opinion, it is okay to do drugs.	No/True	466	97.1%
In my opinion girls should be allowed education equal to boys.	yes/True	451	94.0%
In my opinion I should have the freedom to choose my marriage partner.	yes/True	309	64.4%
In my opinion girls should be married before the age of twenty years.	No/True	364	75.8%
In my opinion if boys cry it means they are weak.	No/True	229	47.7%
In my opinion, girls should never express their anger.	No/True	229	47.7%
In my opinion teenage girls should not play sports in public spaces.	No/True	235	49.0%
In my opinion girls should not do jobs outside the house.	No/True	278	57.9%
In my opinion it is all right for boys to stare at girls who step out of home.	No/True	454	94.6%
In my opinion, if a boy stares at a girl or tease her in the street it is better for her to stay quite about it.	No/True	380	79.2%
In my opinion it is ok to hit a woman if she is disobedient.	No/True	355	74.0%
In my opinion it is ok to bully younger students.	No/True	452	94.2%
In my opinion it is important for couples to be able to practice family planning.	yes/True	397	82.7%
Do you think it is appropriate for unmarried people to be taught about reproductive health?	yes/True	190	39.6%

Knowledge Based Questions:		No. of Students	% age
According to the law everyone has the right to choose their own marriage partner.	yes/True	324	67.5%
HIV/AIDS affects non-Muslims only.	No/True	403	84.0%
AIDS is completely curable.	No/True	223	46.5%
It is possible for a healthy-Looking person to have HIV.	yes/True	302	62.9%

During menstrual periods girls should not shower or bathe.	No/True	131	54.8%
During menstrual periods, girls are too weak to participate in sports or exercise.	No/True	120	50.0%
Wet dreams are a normal part of growing up.	yes/True	199	82.9%
Can HIV/AIDS be prevented through new, packed syringes?	yes/True	403	84.0%
Can HIV/AIDS be prevented through new razors?	yes/True	376	78.3%
Can HIV/AIDS be prevented through screened blood transfusion?	yes/True	376	78.3%
Can HIV/AIDS be prevented through safe intimate interaction?	yes/True	345	71.9%
Wearing and touching the clothes of an HIV/AIDS infracted person can spread HIV/AIDS.	No/True	214	44.6%
Eating the food of an HIV/AIDS infected person can spread HIV/AIDS.	No/True	162	33.8%
Can you protect yourself from Hepatitis B &C through new packed syringes?	yes/True	417	86.9%
Can you protect yourself from Hepatitis B &C through new razors?	yes/True	406	84.6%
Can you protect yourself from Hepatitis B &C through screened blood transfusion?	yes/True	409	85.2%
Can you protect yourself from Hepatitis B &C through safe intimate interaction?	yes/True	338	70.4%

No. of questions answered correct		No. of Students	% age
Skills Overall Score	1	1	.2%
	2	11	2.3%
	3	31	6.5%
	4	61	12.7%
	5	104	21.7%
	6	120	25.0%
	7	94	19.6%
	8	48	10.0%
	9	10	2.1%
Attitude Overall Score	5	3	.6%
	6	1	.2%
	7	6	1.3%
	8	17	3.5%
	9	26	5.4%
	10	57	11.9%
	11	77	16.0%
	12	80	16.7%
	13	83	17.3%
	14	54	11.3%
	15	45	9.4%
	16	26	5.4%
	17	5	1.0%
Knowledge Overall Score	4	10	2.1%
	5	6	1.3%
	6	16	3.3%
	7	23	4.8%
	8	31	6.5%
	9	41	8.5%
	10	70	14.6%
	11	80	16.7%
	12	75	15.6%
	13	81	16.9%
	14	34	7.1%
	15	13	2.7%

1. MARITAL STATUS OF THE SAMPLE

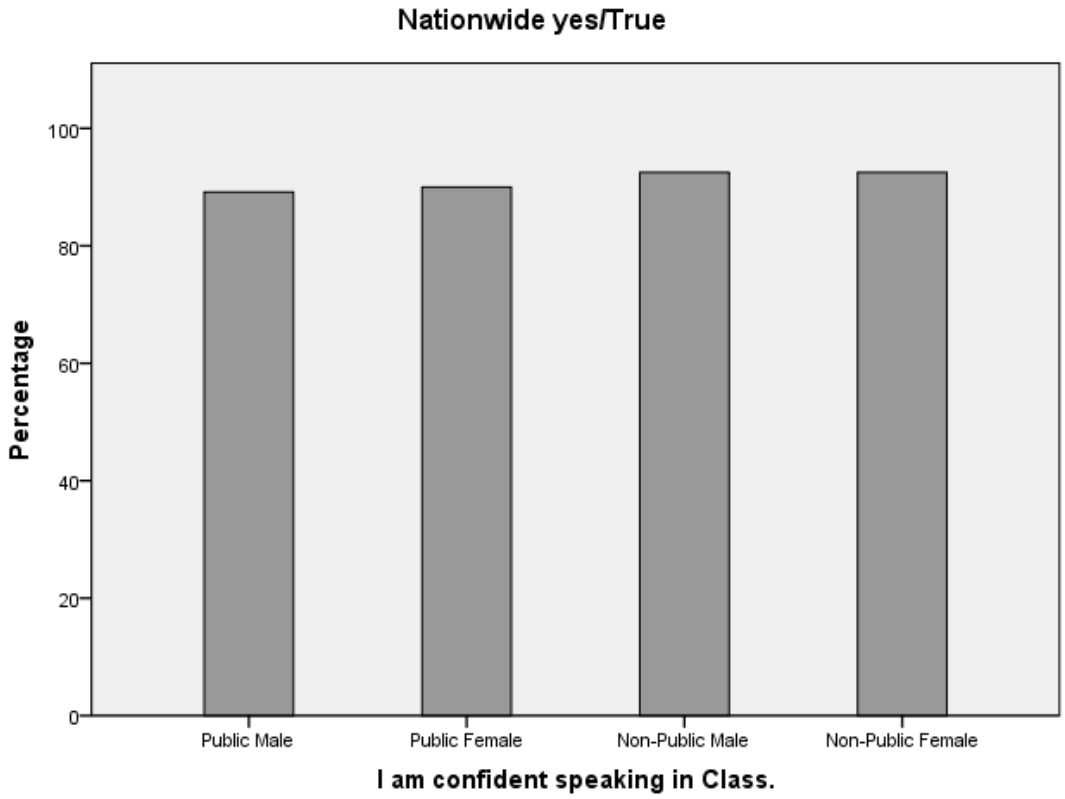
Marital Status of Students in Multan.		Multan		
		Married	Engaged/Nikkah	Unmarried
Public	Male	0	1	59
		.0%	1.7%	98.3%
	Female	0	0	60
		.0%	.0%	100.0%
Non-Public	Male	0	0	60
		.0%	.0%	100.0%
	Female	0	1	59
		.0%	1.7%	98.3%

Marital Status of Students in Quetta.		Quetta		
		Married	Engaged/Nikkah	Unmarried
Public	Male	0	7	53
		.0%	11.7%	88.3%
	Female	0	4	56
		.0%	6.7%	93.3%
Non-Public	Male	0	0	60
		.0%	.0%	100.0%
	Female	1	2	57
		1.7%	3.3%	95.0%

2. REPLIES OF THE SAMPLE TO SKILLS-BASED QUESTIONS

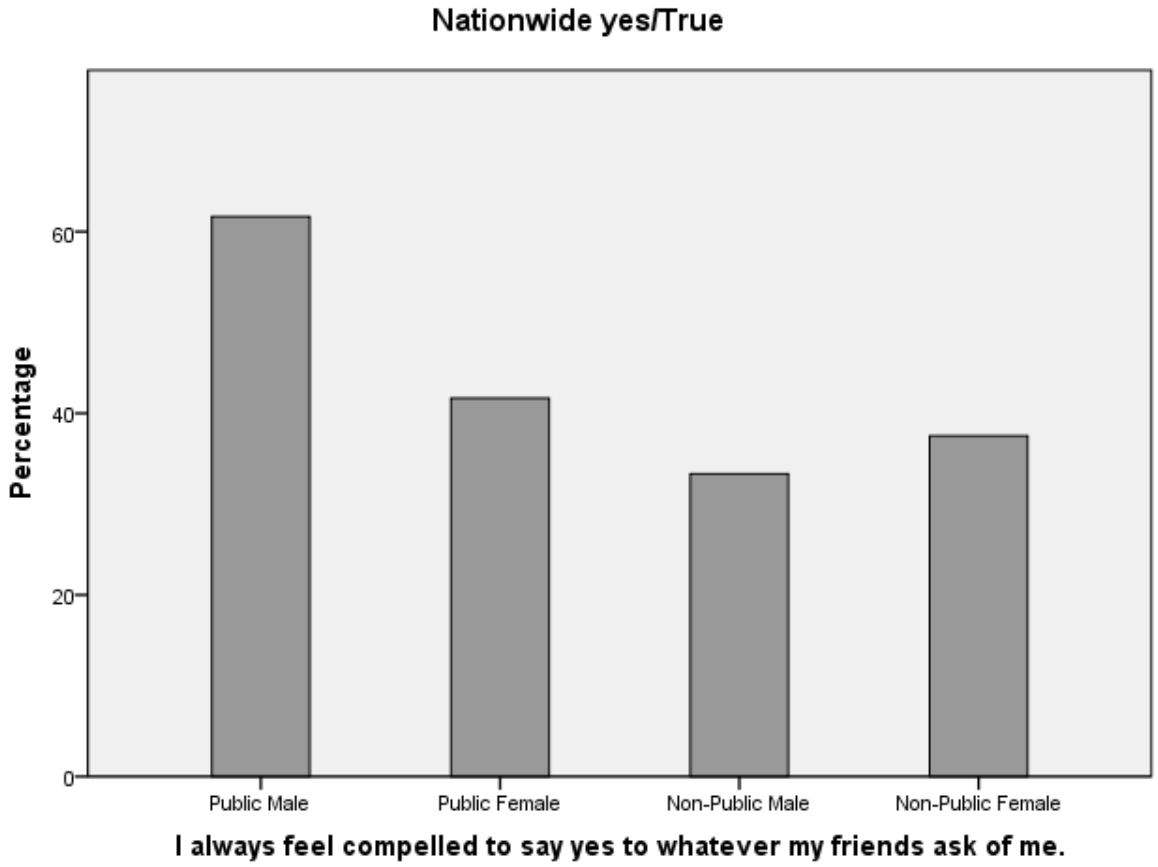
i. I am confident about speaking up in class.

I am confident speaking in Class.		Nationwide	
		yes/True	No/False
Public	Male	107	13
		89.2%	10.8%
	Female	108	12
		90.0%	10.0%
Non-Public	Male	111	9
		92.5%	7.5%
	Female	111	9
		92.5%	7.5%



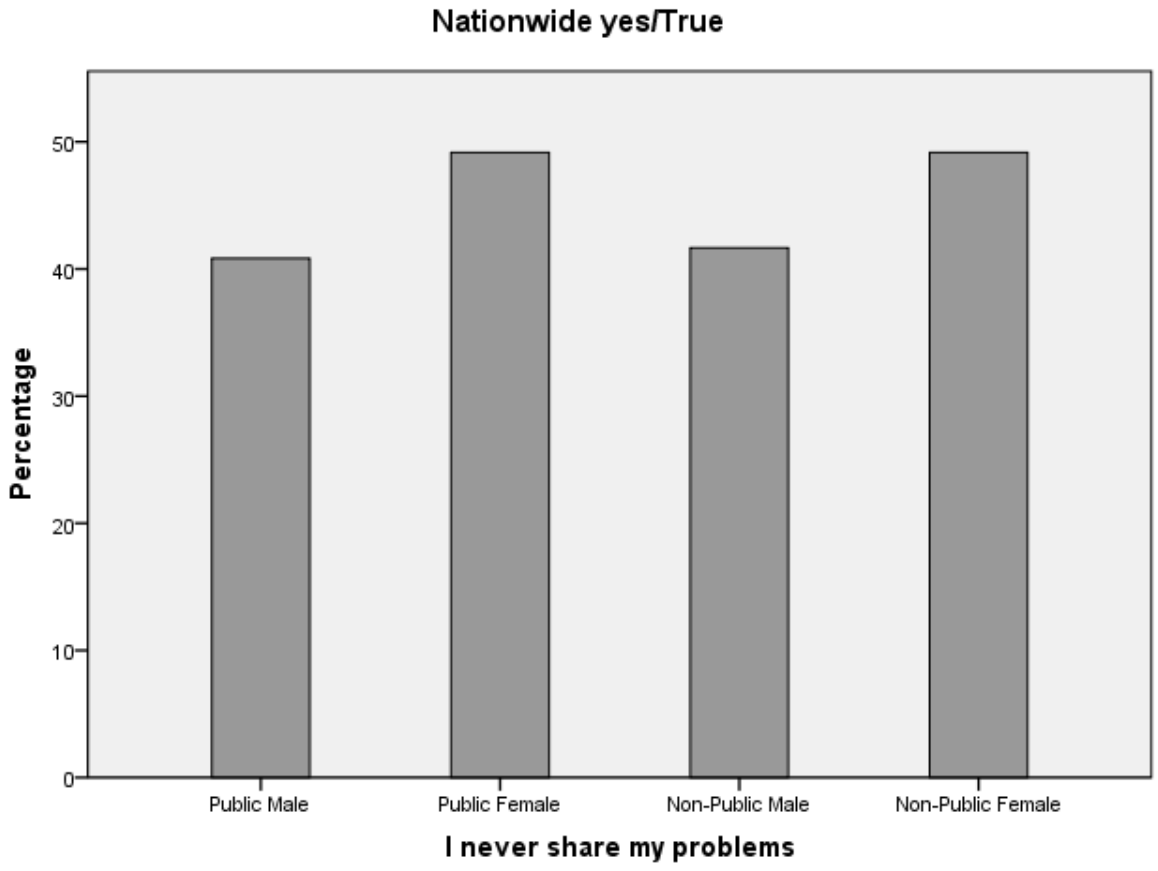
ii. I always feel compelled to say yes to whatever my friends ask of me.

I always feel compelled to say yes to whatever my friends ask of me.		Nationwide	
		yes/True	No/False
Public	Male	74	46
		61.7%	38.3%
	Female	50	70
		41.7%	58.3%
Non-Public	Male	40	80
		33.3%	66.7%
	Female	45	75
		37.5%	62.5%



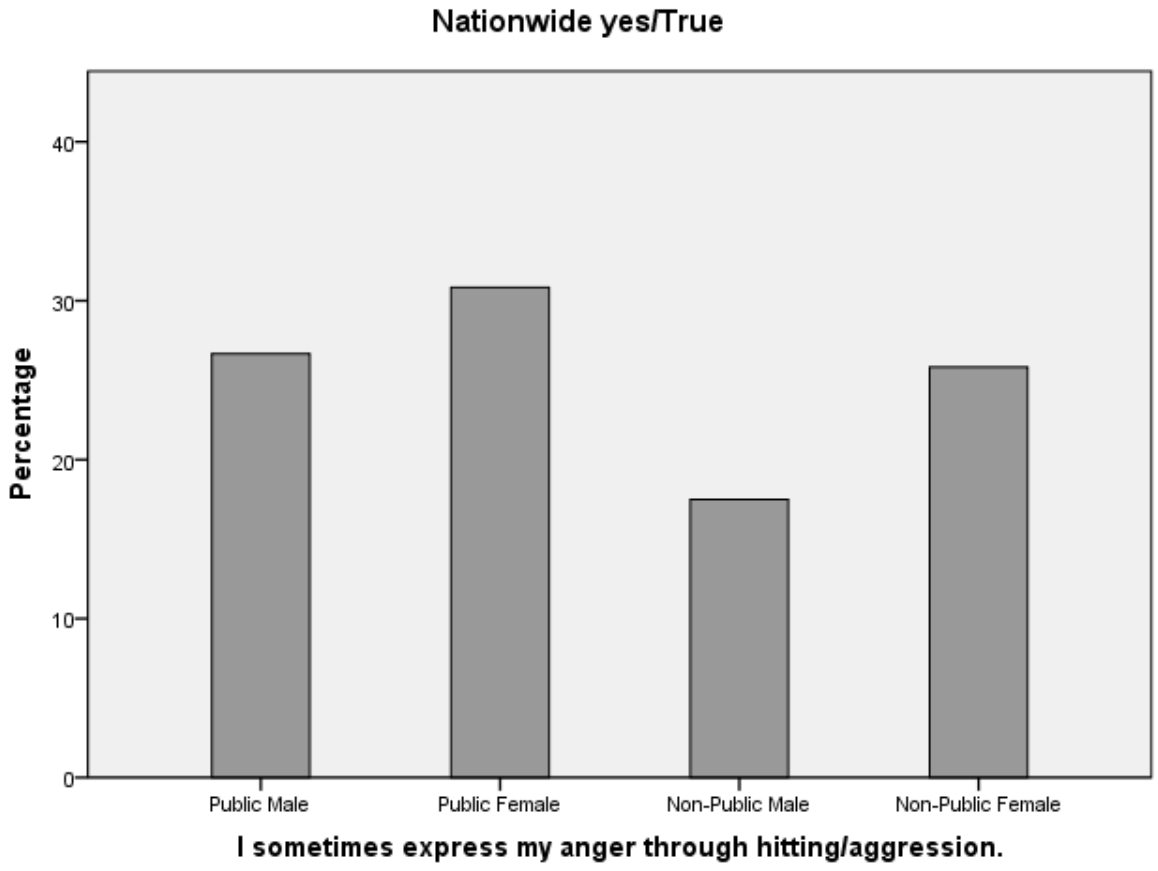
iii. I never share my problems with anyone

I never share my problems?		Nationwide	
		yes/True	No/False
Public	Male	49	71
		40.8%	59.2%
	Female	59	61
		49.2%	50.8%
Non-Public	Male	50	70
		41.7%	58.3%
	Female	59	61
		49.2%	50.8%



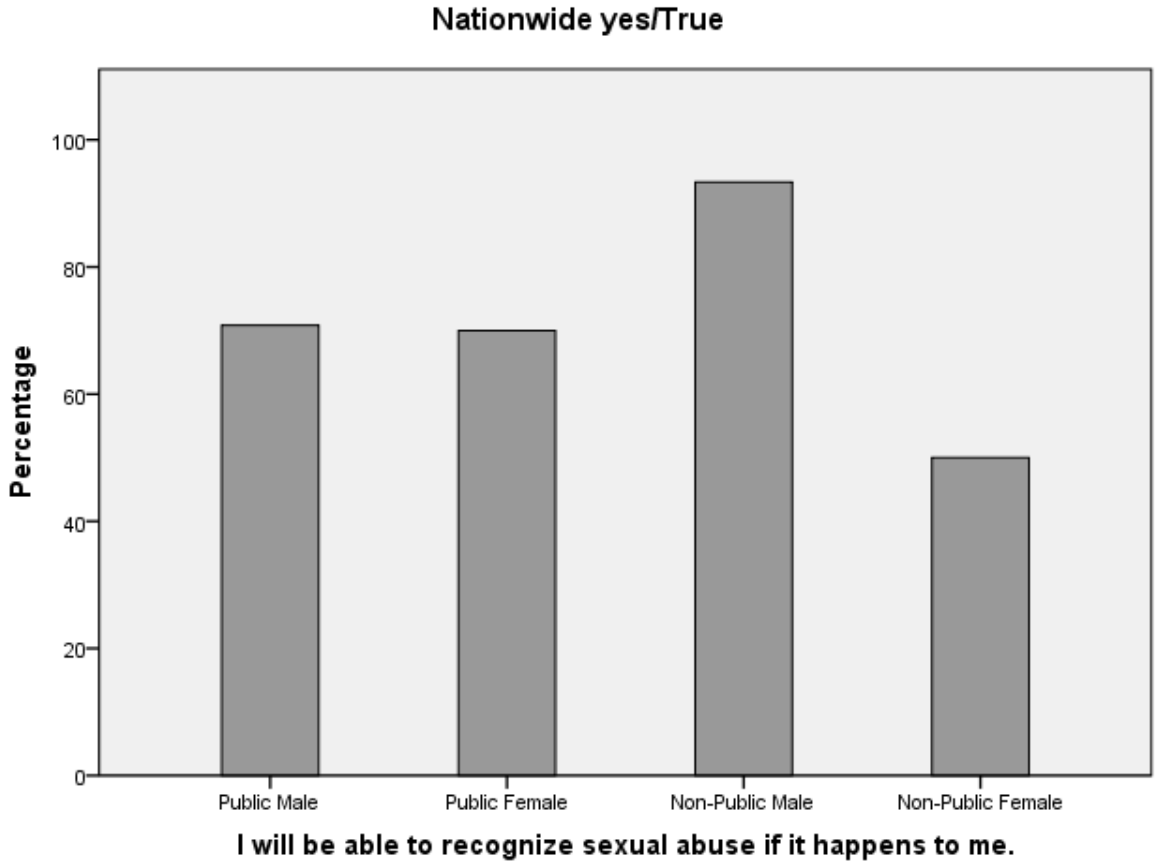
iv. I sometimes express my anger through hitting/aggression

I sometimes express my anger through hitting/aggression.		Nationwide	
		yes/True	No/False
Public	Male	32	88
		26.7%	73.3%
	Female	37	83
		30.8%	69.2%
Non-Public	Male	21	99
		17.5%	82.5%
	Female	31	89
		25.8%	74.2%



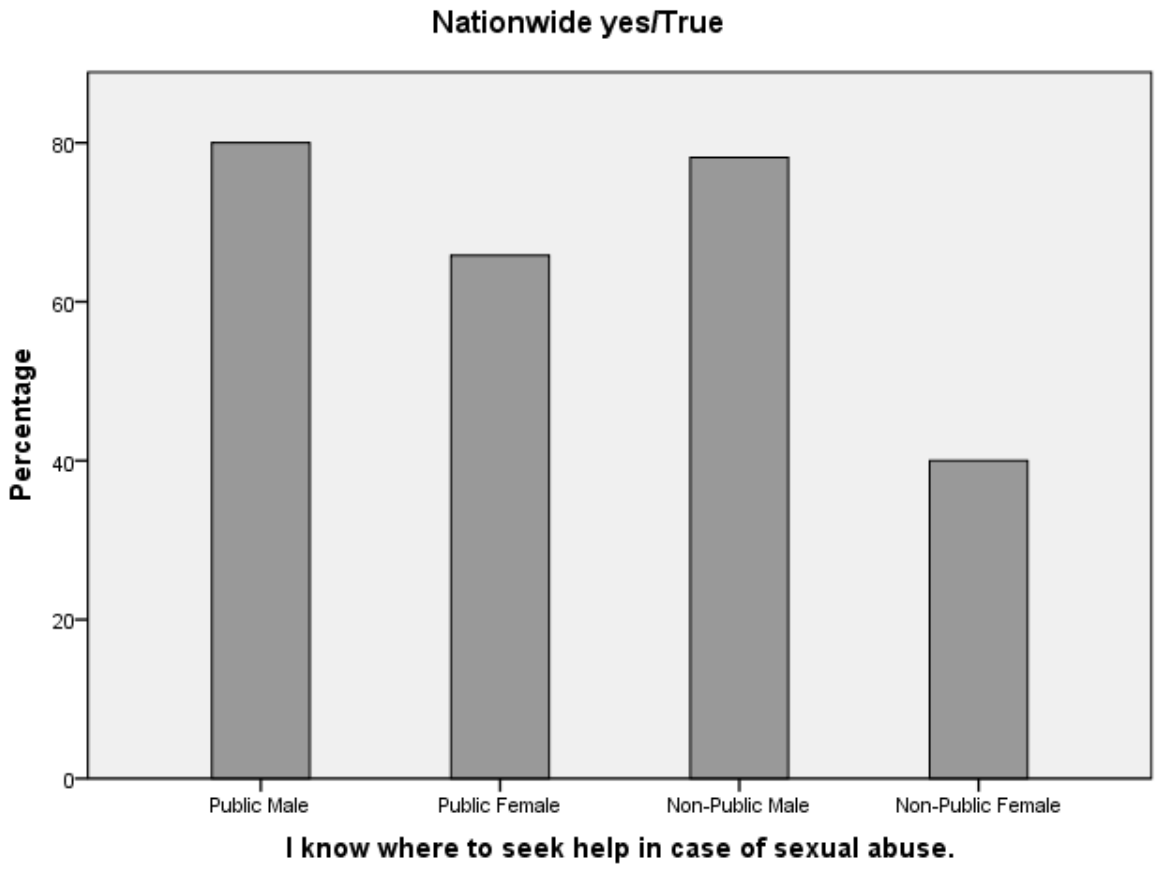
v. I will be able to recognize sexual abuse if it happens to me.

I will be able to recognize sexual abuse if it happens to me.		Nationwide	
		yes/True	No/False
Public	Male	85	35
		70.8%	29.2%
	Female	84	36
		70.0%	30.0%
Non-Public	Male	112	8
		93.3%	6.7%
	Female	60	60
		50.0%	50.0%



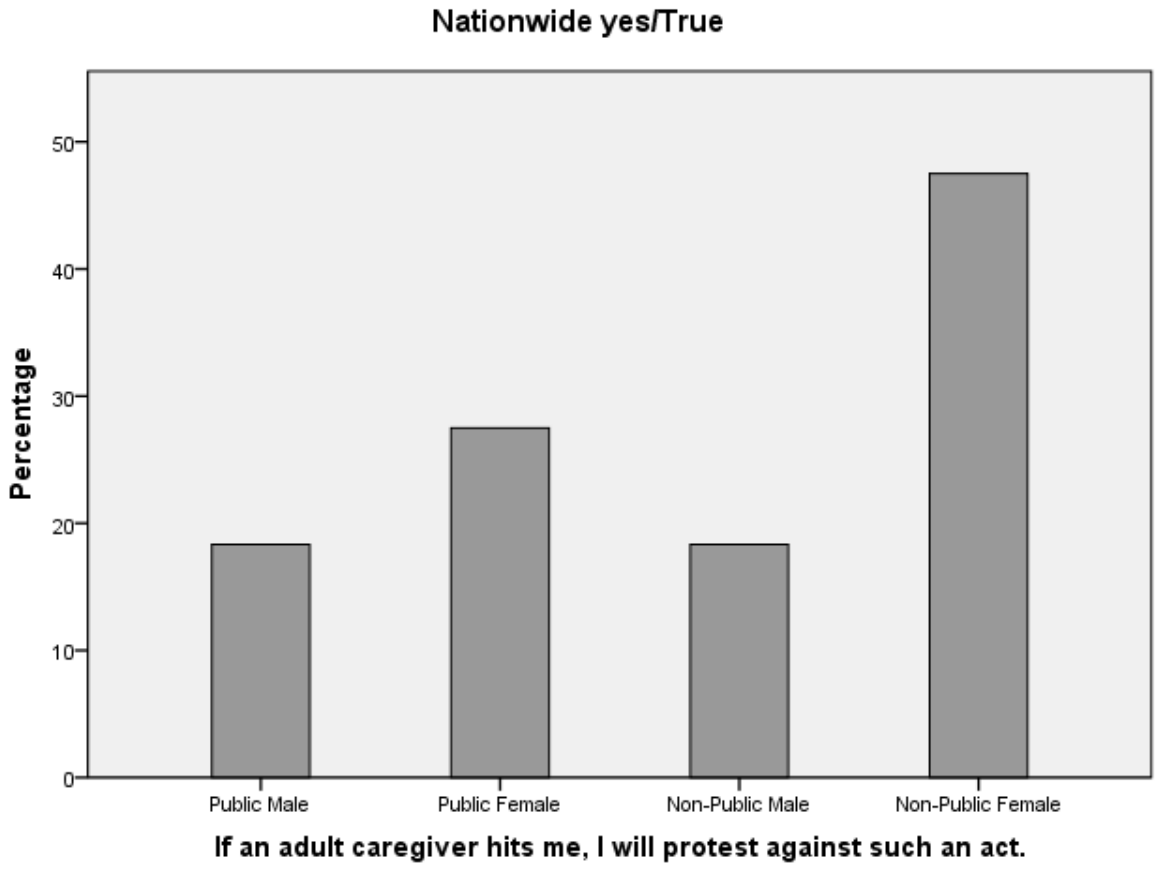
vi. I know where to seek help in case of sexual abuse

I know where to seek help in case of sexual abuse.		Nationwide	
		yes/True	No/False
Public	Male	96	24
		80.0%	20.0%
	Female	79	41
		65.8%	34.2%
Non-Public	Male	93	26
		78.2%	21.8%
	Female	48	72
		40.0%	60.0%



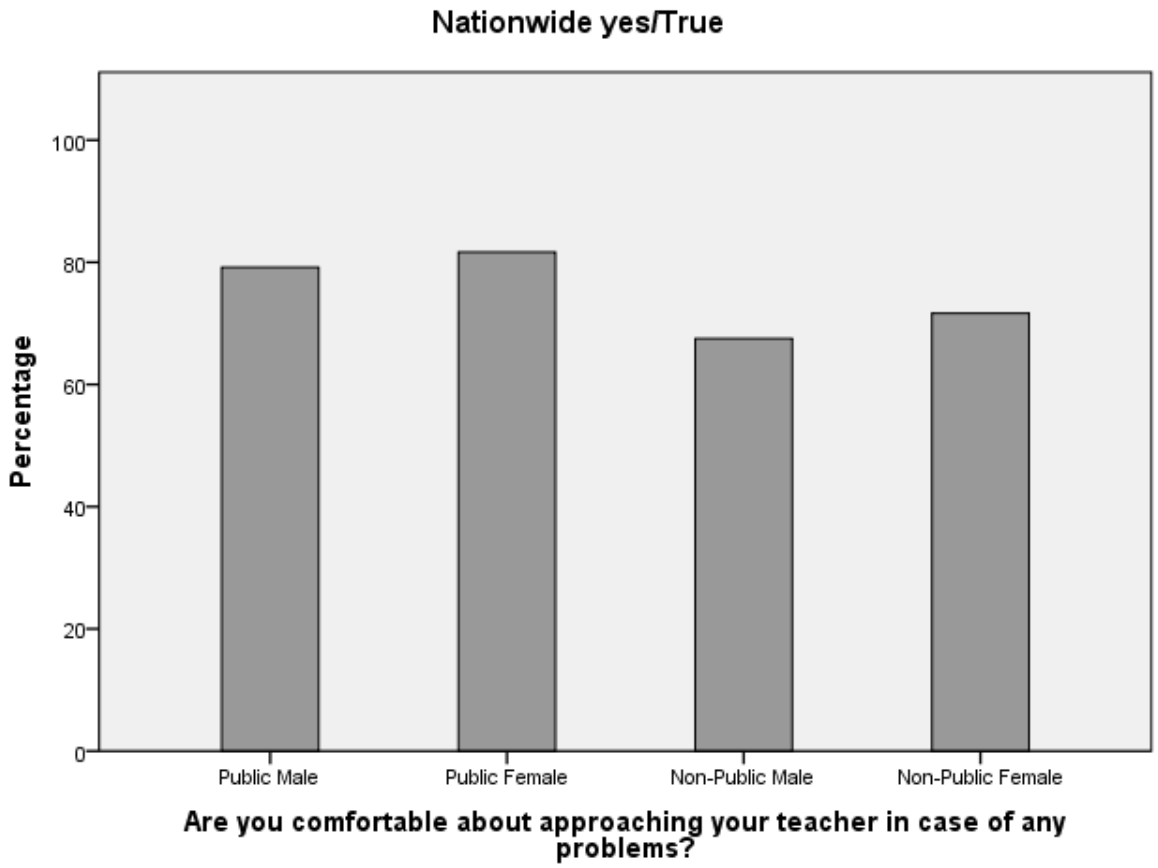
vii. If an adult caregiver hits me, I will protest against such an act

If an adult caregiver hits me, I will protest against such an act.		Nationwide	
		yes/True	No/False
Public	Male	22	98
		18.3%	81.7%
	Female	33	87
		27.5%	72.5%
Non-Public	Male	22	98
		18.3%	81.7%
	Female	57	63
		47.5%	52.5%



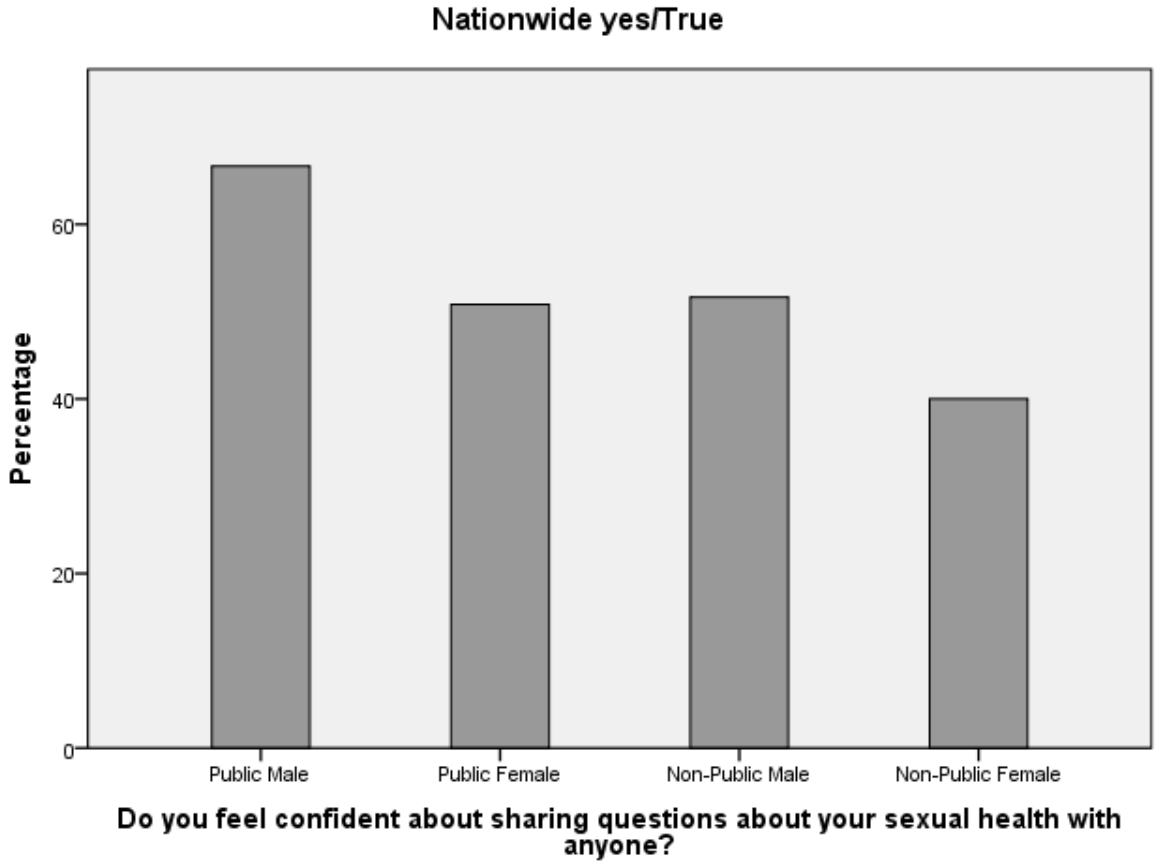
viii. Are you comfortable about approaching your teacher in case of any problem?

Are you comfortable about approaching your teacher in case of any problems?		Nationwide	
		yes/True	No/False
Public	Male	95	25
		79.2%	20.8%
	Female	98	22
		81.7%	18.3%
Non-Public	Male	81	39
		67.5%	32.5%
	Female	86	34
		71.7%	28.3%



ix. Do you feel confident about sharing questions about your sexual health with anyone?

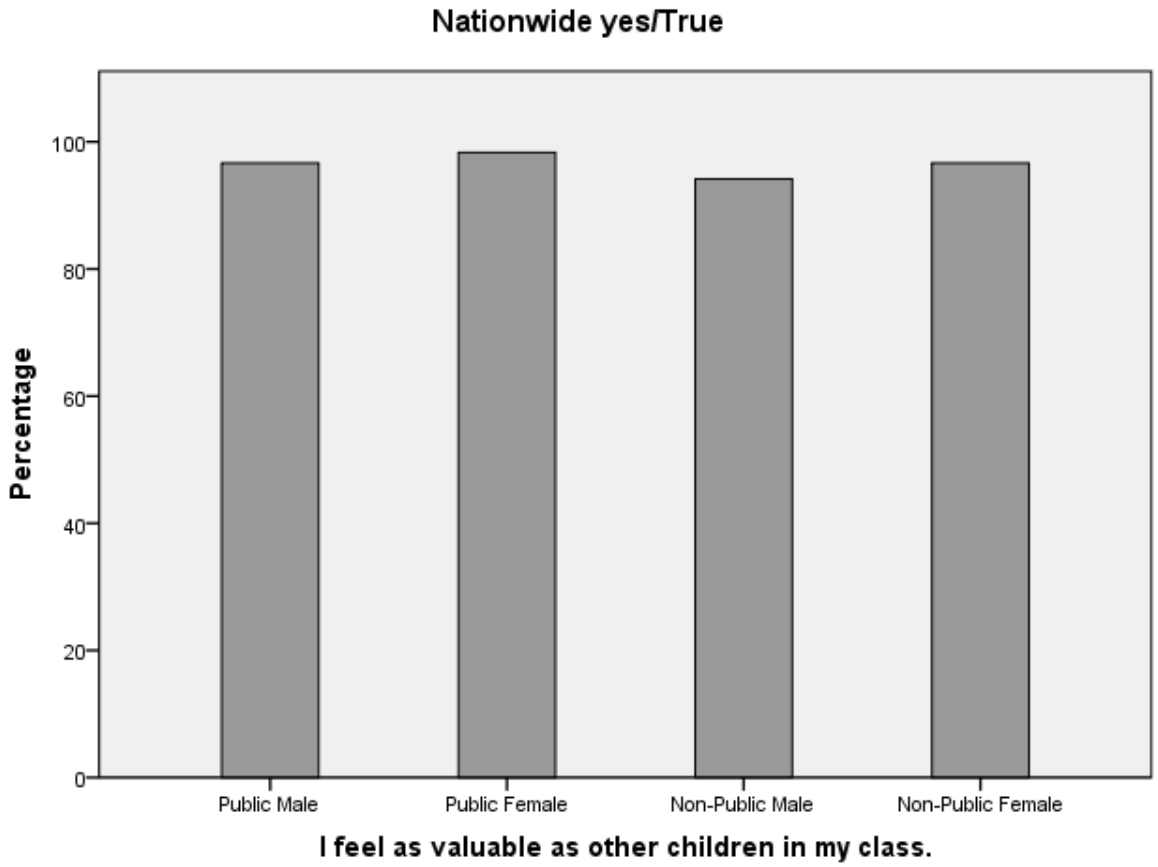
Do you feel confident about sharing questions about your sexual health with anyone?		Nationwide	
		yes/True	No/False
Public	Male	80	40
		66.7%	33.3%
	Female	61	59
		50.8%	49.2%
Non-Public	Male	62	58
		51.7%	48.3%
	Female	48	72
		40.0%	60.0%



3. REPLIES OF THE SAMPLE TO ATTITUDE-BASED QUESTIONS

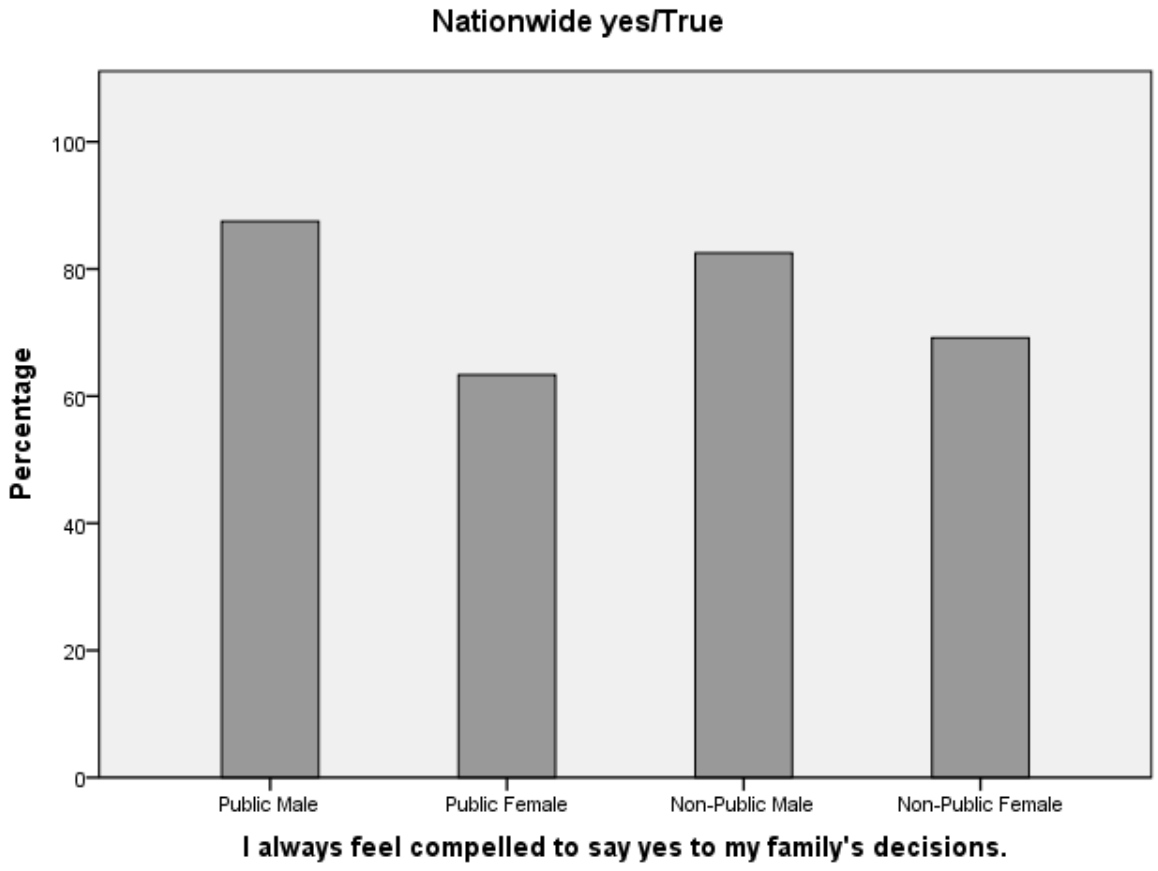
i. I feel as valuable as other children in my class

I feel as valuable as other children in my class.		Nationwide	
		yes/True	No/False
Public	Male	116	4
		96.7%	3.3%
	Female	118	2
		98.3%	1.7%
Non-Public	Male	113	7
		94.2%	5.8%
	Female	116	4
		96.7%	3.3%



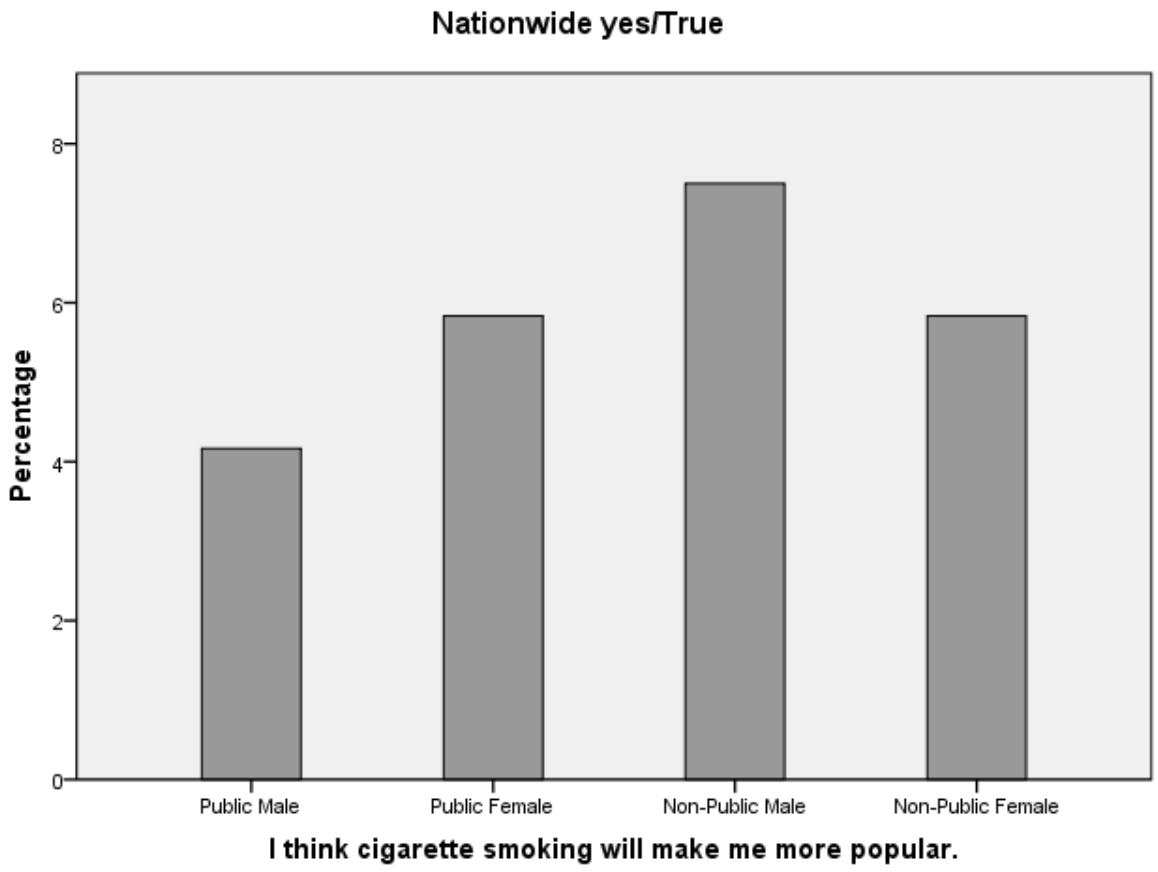
ii. I always feel compelled to say yes to my family's decisions

I always feel compelled to say yes to my family's decisions.		Nationwide	
		yes/True	No/False
Public	Male	105	15
		87.5%	12.5%
	Female	76	44
		63.3%	36.7%
Non-Public	Male	99	21
		82.5%	17.5%
	Female	83	37
		69.2%	30.8%



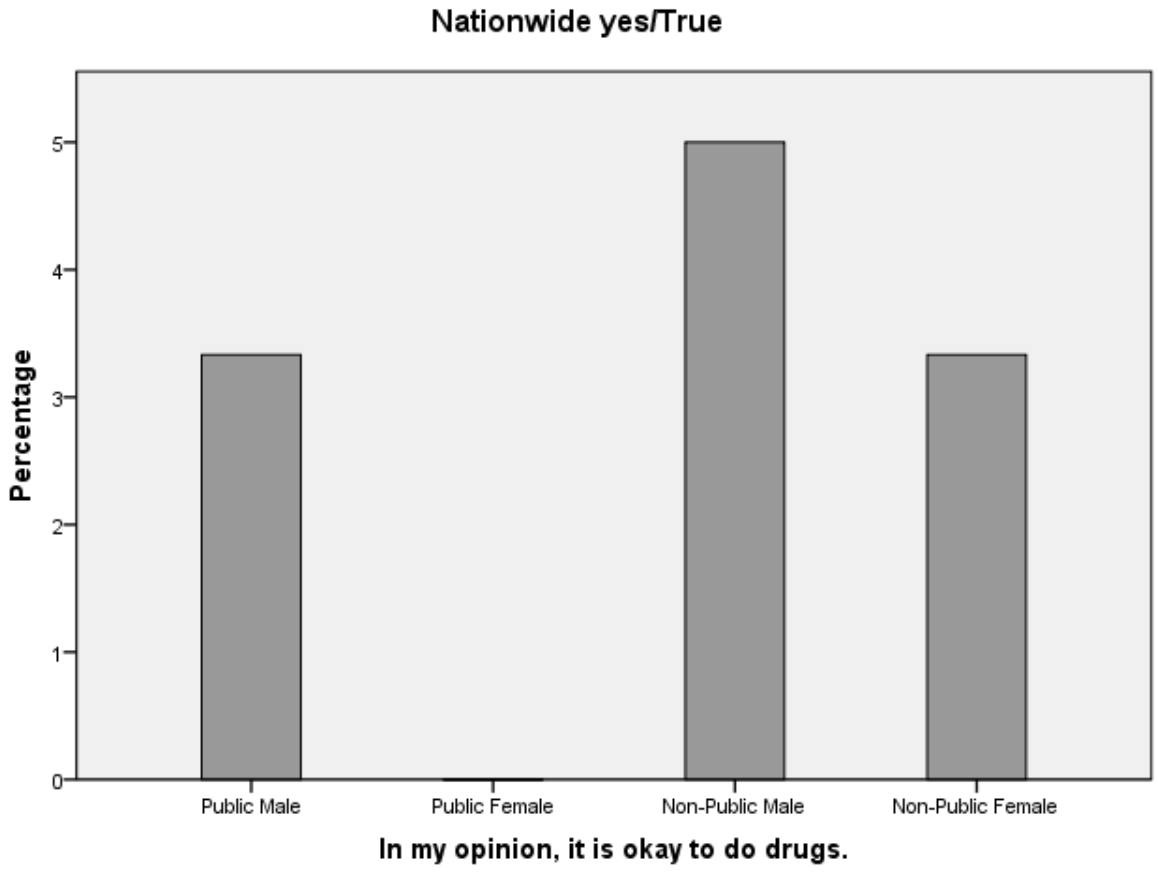
iii. I think cigarette smoking will make me more popular

I think cigarette smoking will make me more popular.		Nationwide	
		yes/True	No/False
Public	Male	5	115
		4.2%	95.8%
	Female	7	113
		5.8%	94.2%
Non-Public	Male	9	111
		7.5%	92.5%
	Female	7	113
		5.8%	94.2%



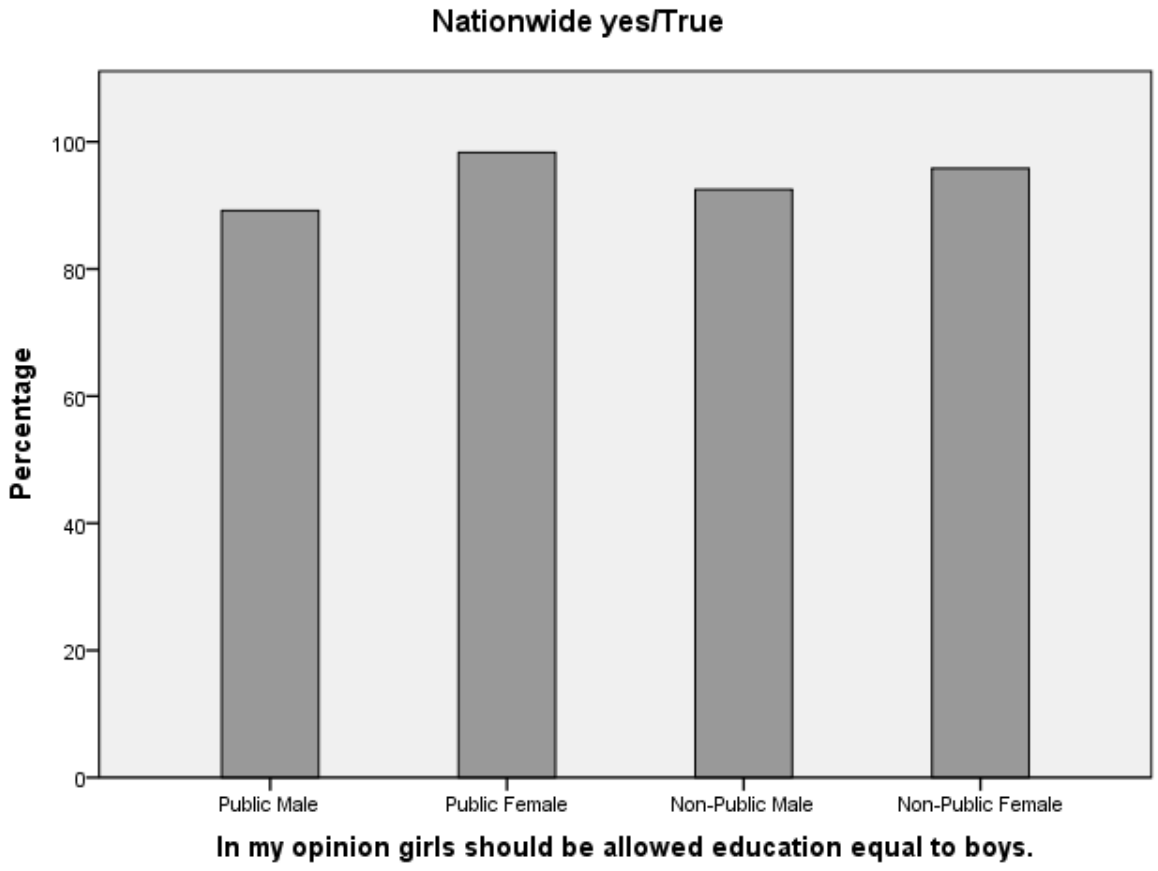
iv. In my opinion, it is okay to do drugs

In my opinion, it is okay to do drugs.		Nationwide	
		yes/True	No/False
Public	Male	4	116
		3.3%	96.7%
	Female	0	120
		.0%	100.0%
Non-Public	Male	6	114
		5.0%	95.0%
	Female	4	116
		3.3%	96.7%



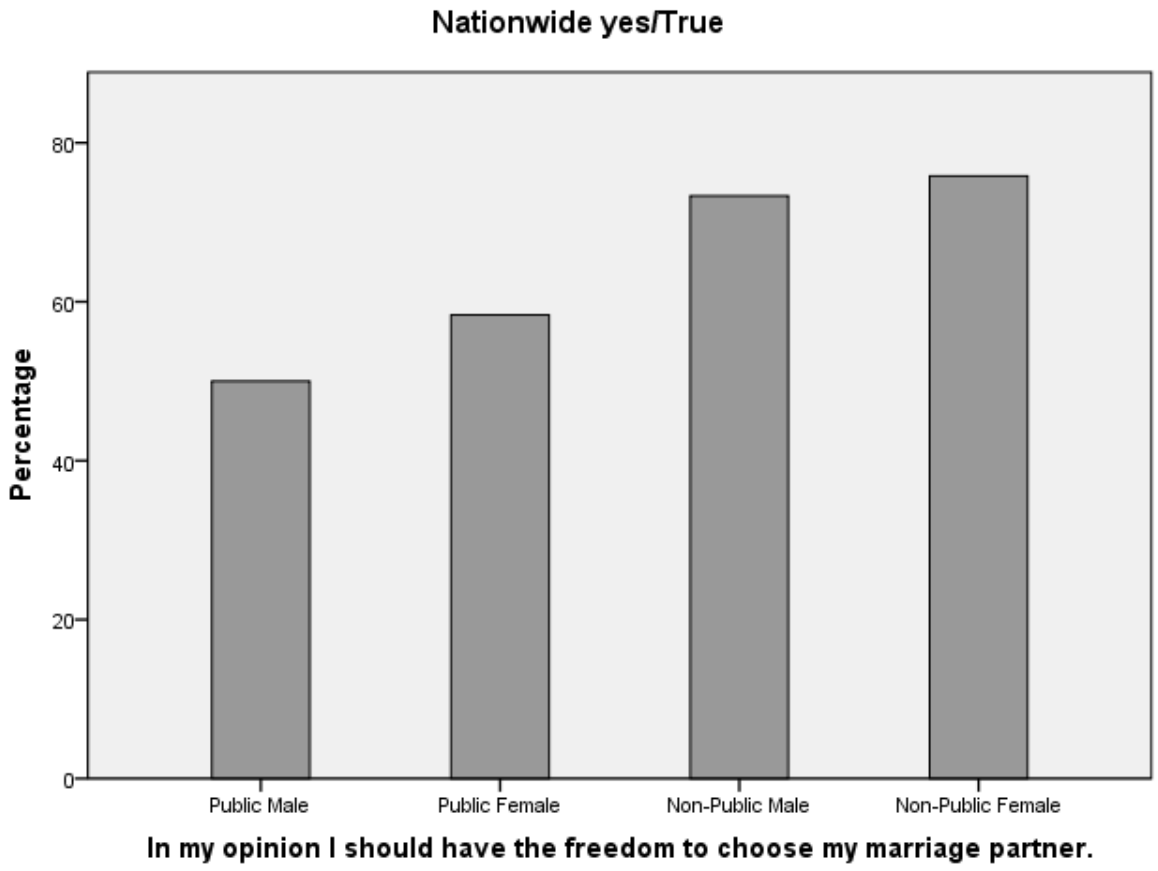
v. In my opinion, girls should be allowed education equal to boys

In my opinion girls should be allowed education equal to boys.		Nationwide	
		yes/True	No/False
Public	Male	107	13
		89.2%	10.8%
	Female	118	2
		98.3%	1.7%
Non-Public	Male	111	9
		92.5%	7.5%
	Female	115	5
		95.8%	4.2%



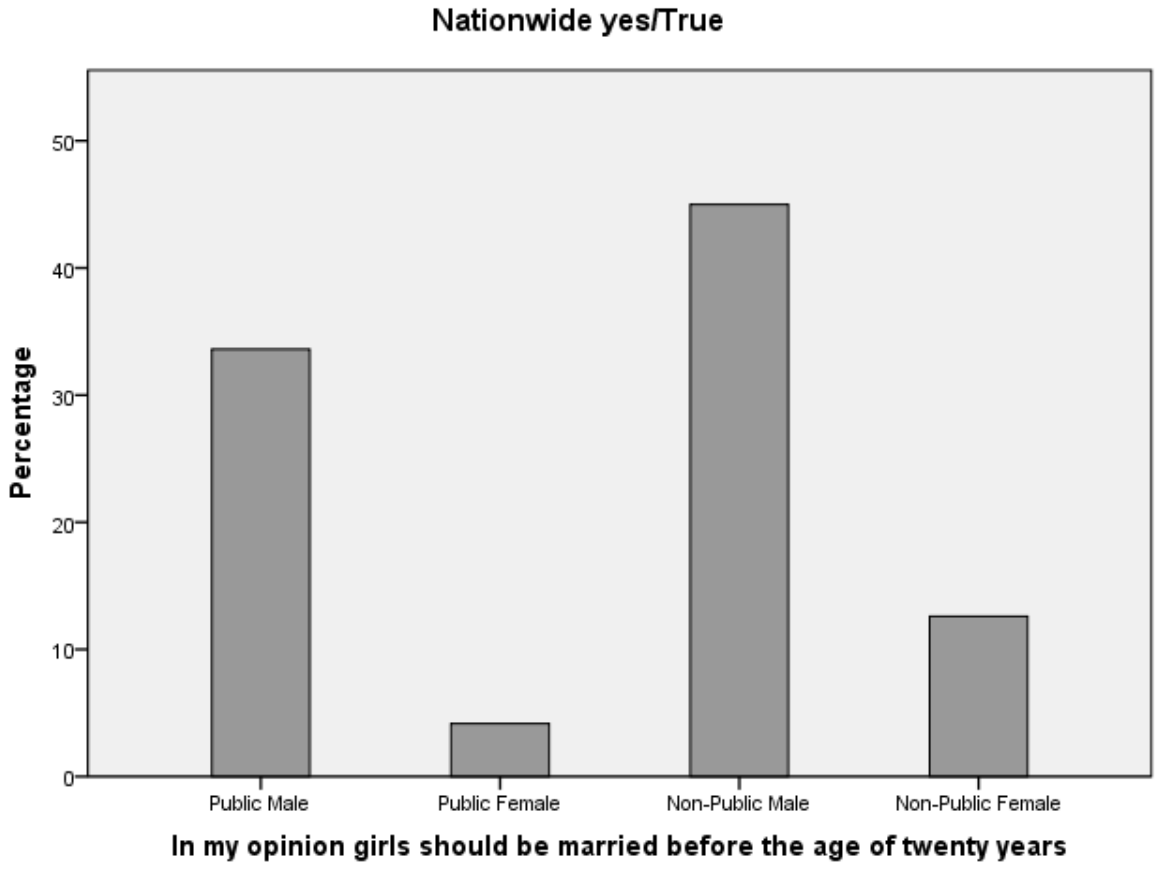
vi. In my opinion, I should have the freedom to choose my marriage partner

In my opinion I should have the freedom to choose my marriage partner.		Nationwide	
		yes/True	No/False
Public	Male	60	60
		50.0%	50.0%
	Female	70	50
		58.3%	41.7%
Non-Public	Male	88	32
		73.3%	26.7%
	Female	91	29
		75.8%	24.2%



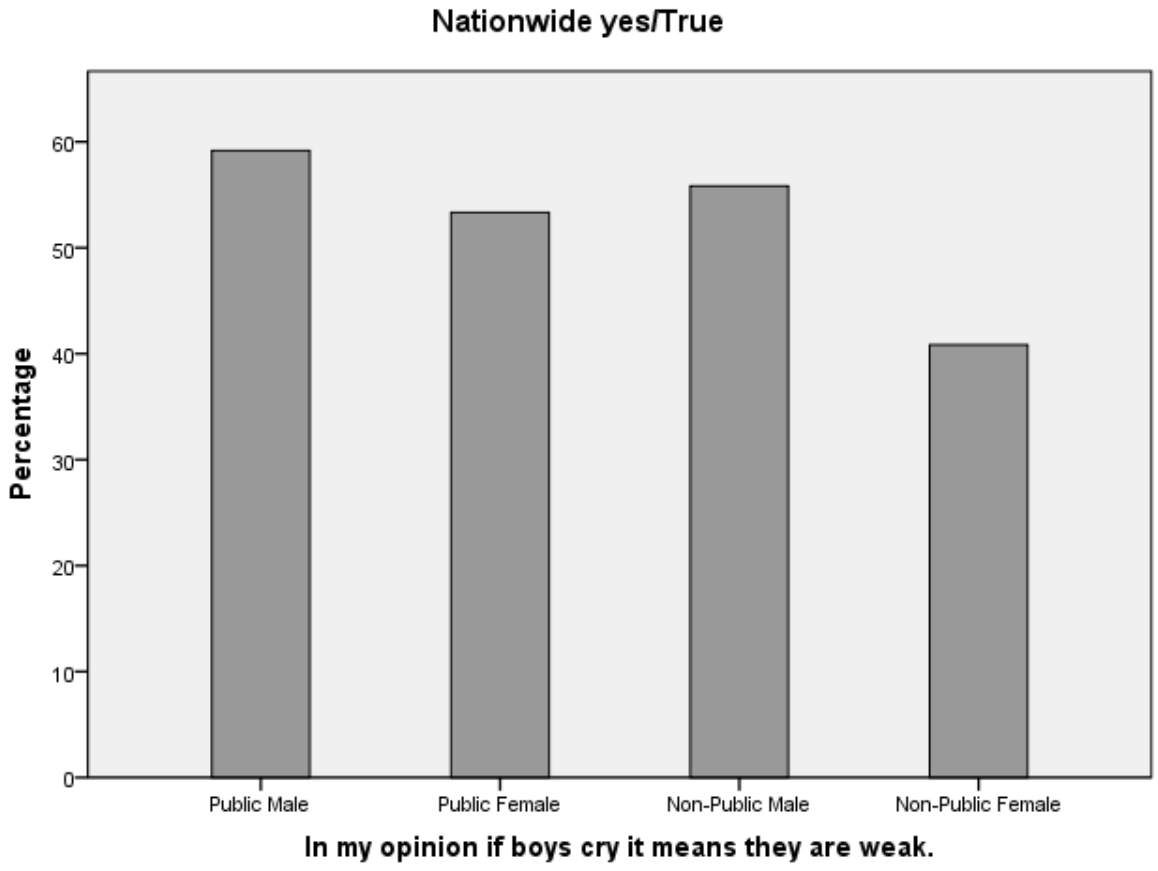
vii. In my opinion, girls should be married before the age of twenty years

In my opinion girls should be married before the age of twenty years.		Nationwide	
		yes/True	No/False
Public	Male	40	79
		33.6%	66.4%
	Female	5	115
		4.2%	95.8%
Non-Public	Male	54	66
		45.0%	55.0%
	Female	15	104
		12.6%	87.4%



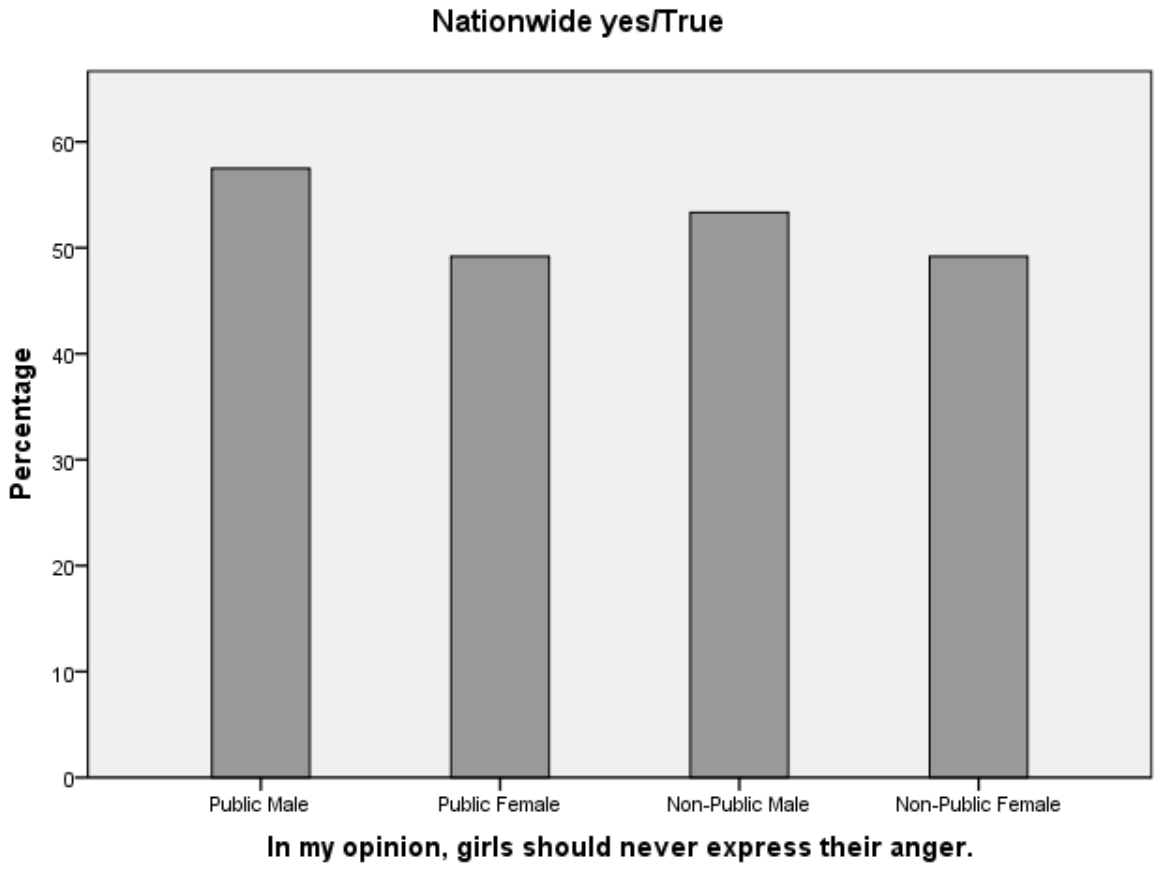
viii. In my opinion, if boys cry it means they are weak

In my opinion if boys cry it means they are weak.		Nationwide	
		yes/True	No/False
Public	Male	71	49
		59.2%	40.8%
	Female	64	56
		53.3%	46.7%
Non-Public	Male	67	53
		55.8%	44.2%
	Female	49	71
		40.8%	59.2%



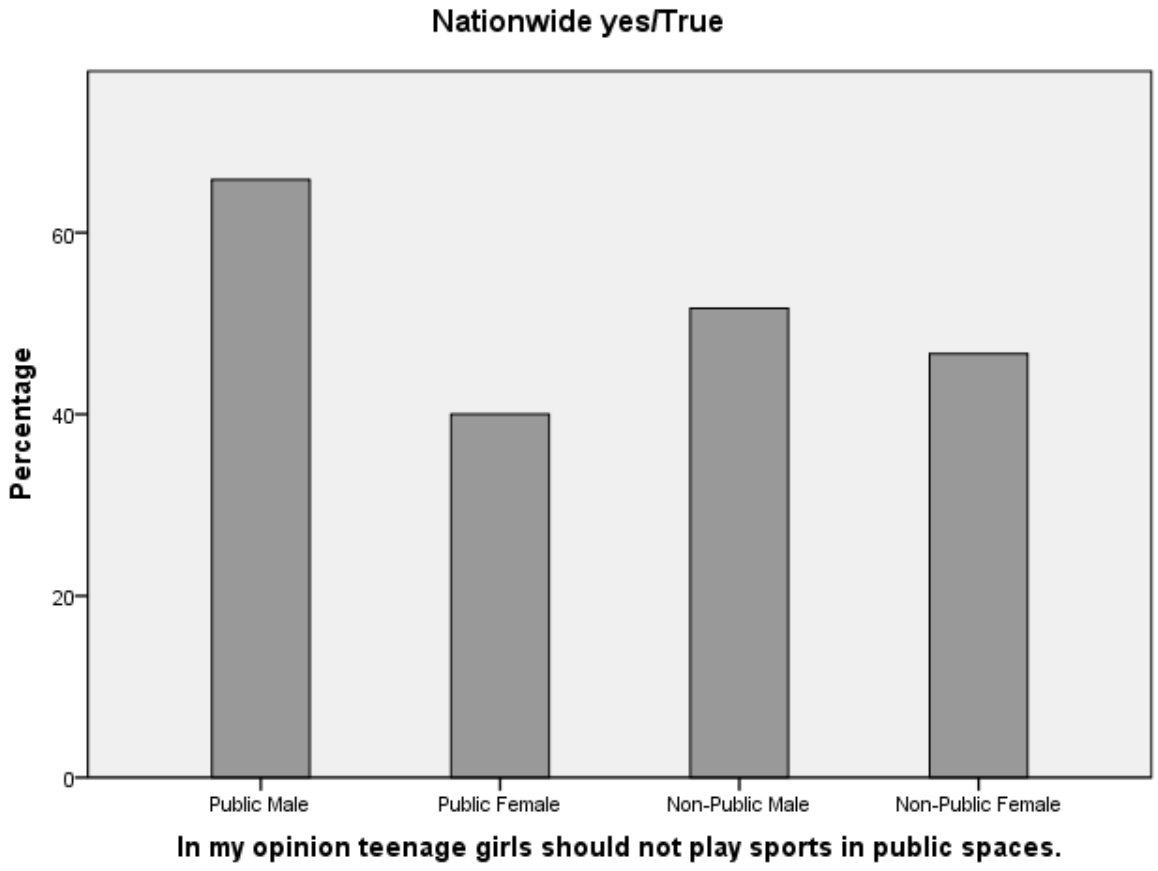
ix. In my opinion, girls should never express their anger

In my opinion, girls should never express their anger.		Nationwide	
		yes/True	No/False
Public	Male	69	51
		57.5%	42.5%
	Female	59	61
		49.2%	50.8%
Non-Public	Male	64	56
		53.3%	46.7%
	Female	59	61
		49.2%	50.8%



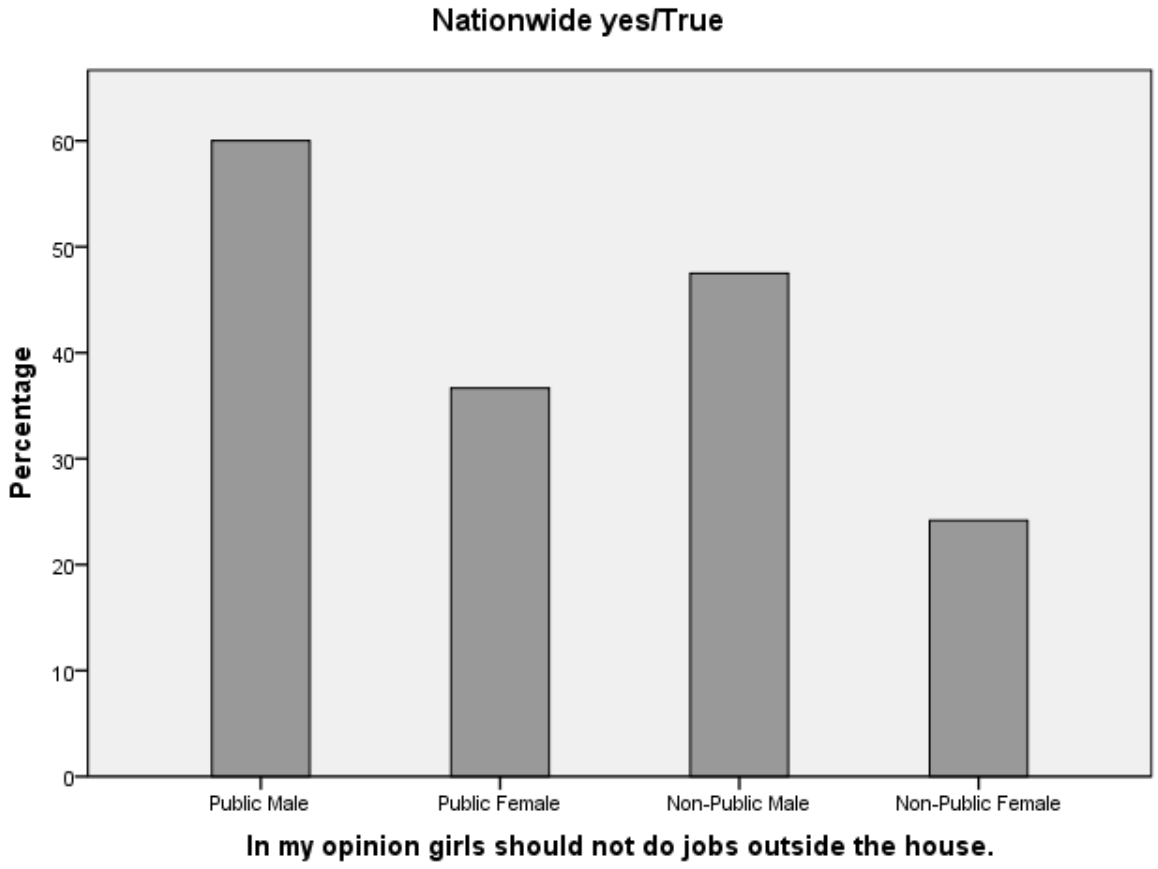
x. In my opinion, teenage girls should not play sports in public spaces

In my opinion teenage girls should not play sports in public spaces.		Nationwide	
		yes/True	No/False
Public	Male	79	41
		65.8%	34.2%
	Female	48	72
		40.0%	60.0%
Non-Public	Male	62	58
		51.7%	48.3%
	Female	56	64
		46.7%	53.3%



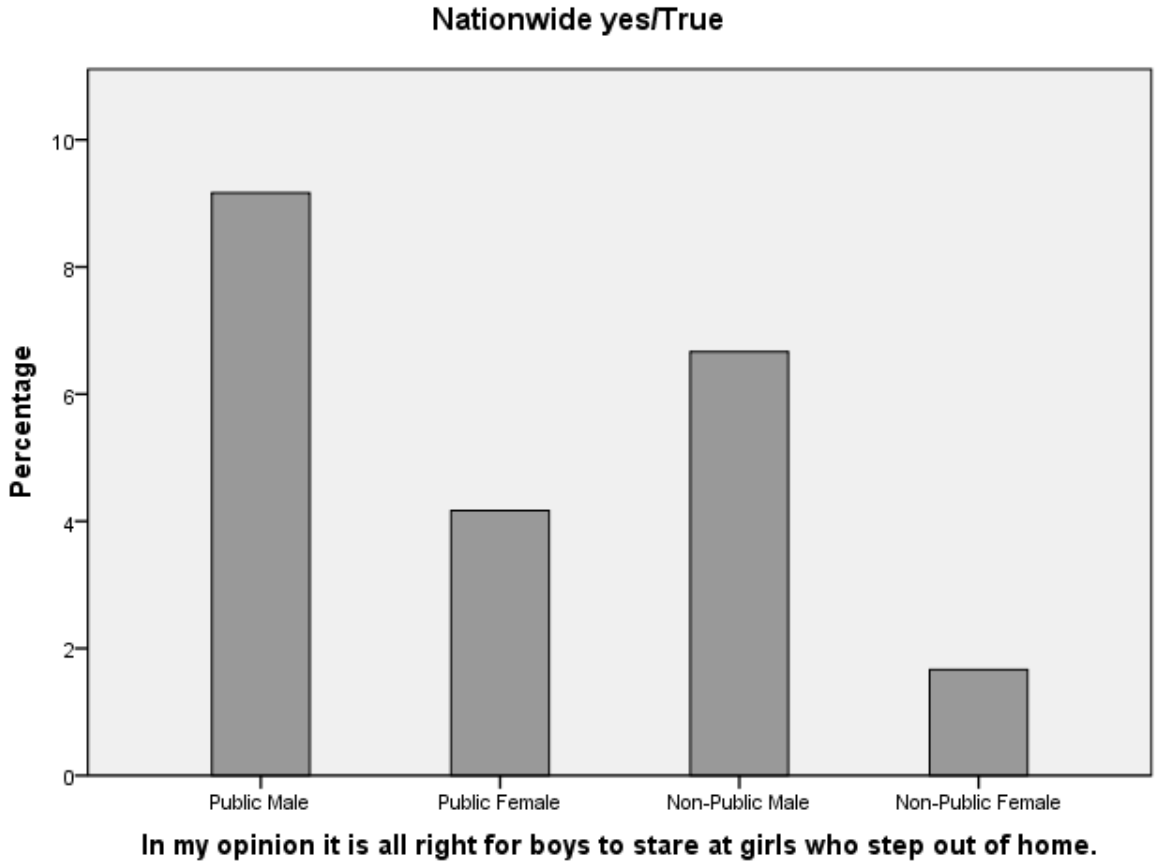
xi. In my opinion, girls should not do jobs outside the house

In my opinion girls should not do jobs outside the house.		Nationwide	
		yes/True	No/False
Public	Male	72	48
		60.0%	40.0%
	Female	44	76
		36.7%	63.3%
Non-Public	Male	57	63
		47.5%	52.5%
	Female	29	91
		24.2%	75.8%



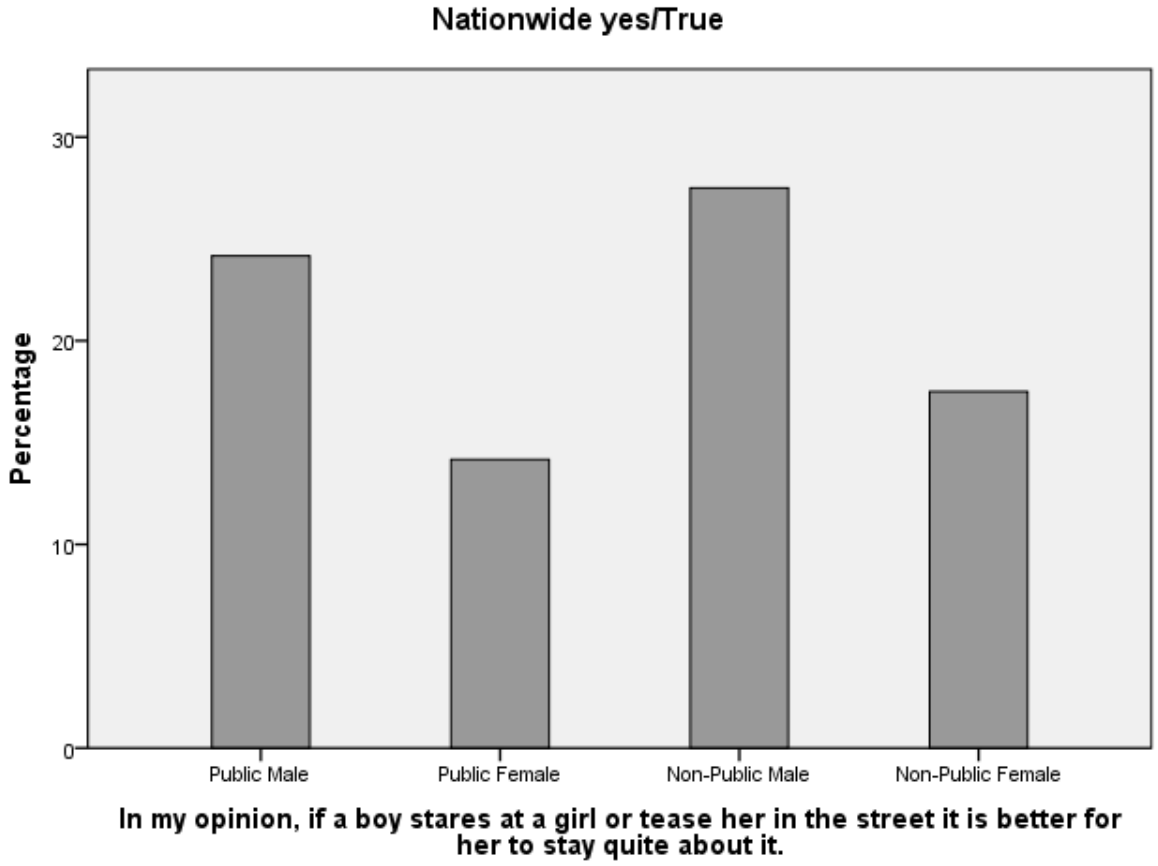
xii. In my opinion, it is all right for boys to stare at girls who step out of home

In my opinion it is all right for boys to stare at girls who step out of home.		Nationwide	
		yes/True	No/False
Public	Male	11	109
		9.2%	90.8%
	Female	5	115
		4.2%	95.8%
Non-Public	Male	8	112
		6.7%	93.3%
	Female	2	118
		1.7%	98.3%



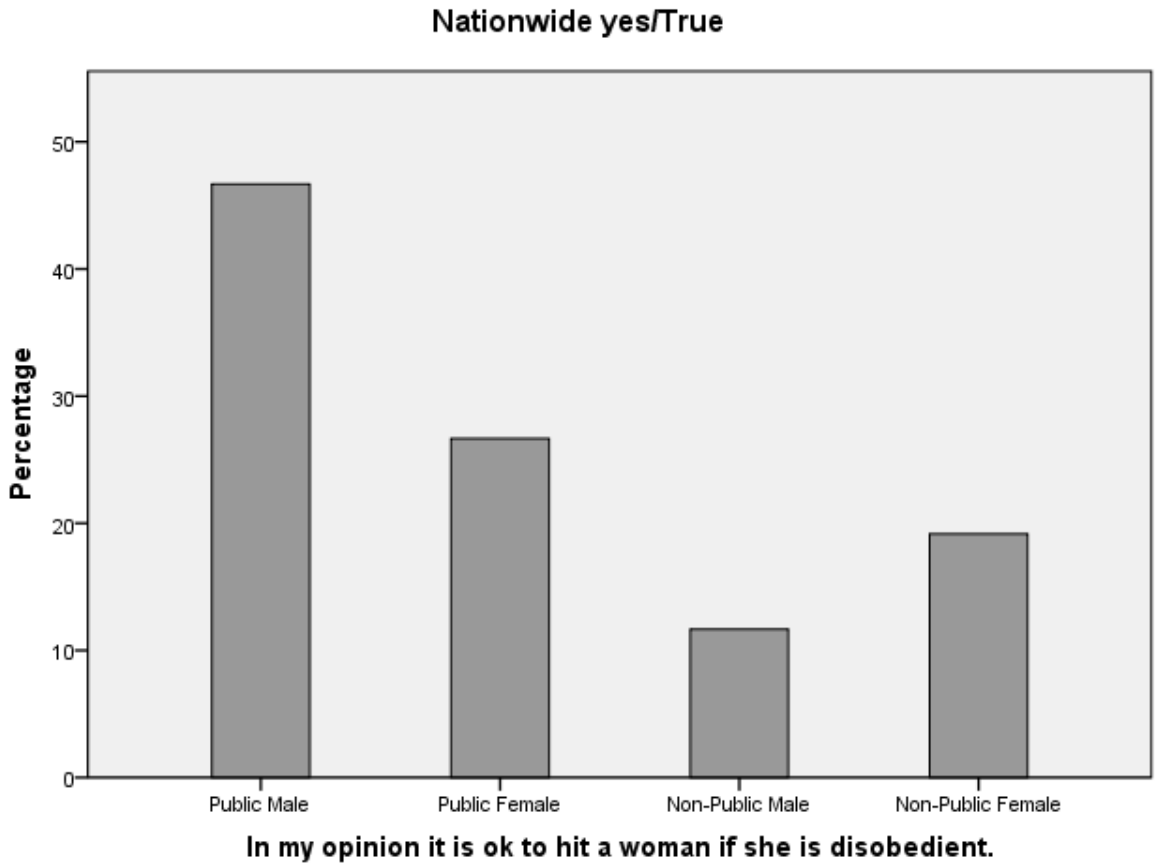
xiii. In my opinion, if a boy stares at a girl or teases her in the street, it is better for her to stay quite about it

In my opinion, if a boy stares at a girl or tease her in the street it is better for her to stay quite about it.		Nationwide	
		yes/True	No/False
Public	Male	29	91
		24.2%	75.8%
	Female	17	103
		14.2%	85.8%
Non-Public	Male	33	87
		27.5%	72.5%
	Female	21	99
		17.5%	82.5%



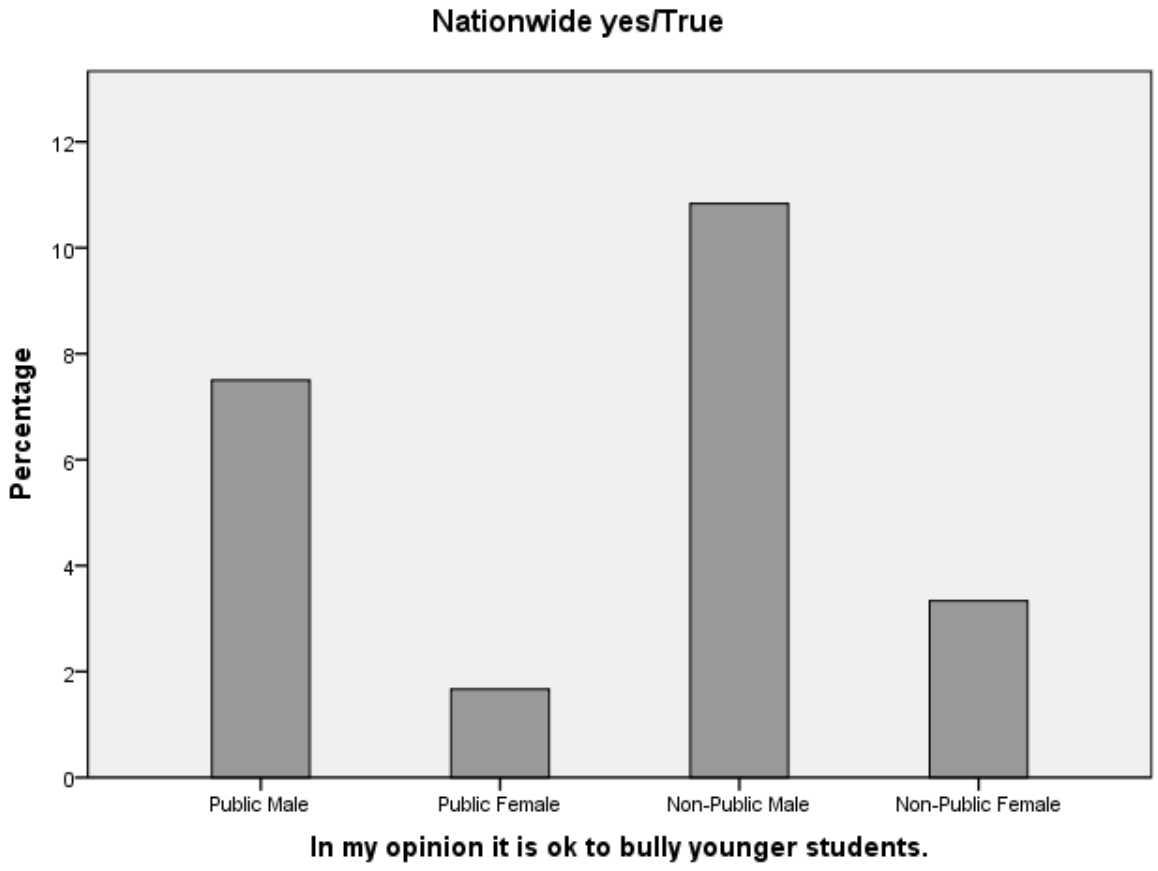
xiv. In my opinion, it is ok to hit a woman if she is disobedient

In my opinion it is ok to hit a woman if she is disobedient.		Nationwide	
		yes/True	No/False
Public	Male	56	64
		46.7%	53.3%
	Female	32	88
		26.7%	73.3%
Non-Public	Male	14	106
		11.7%	88.3%
	Female	23	97
		19.2%	80.8%



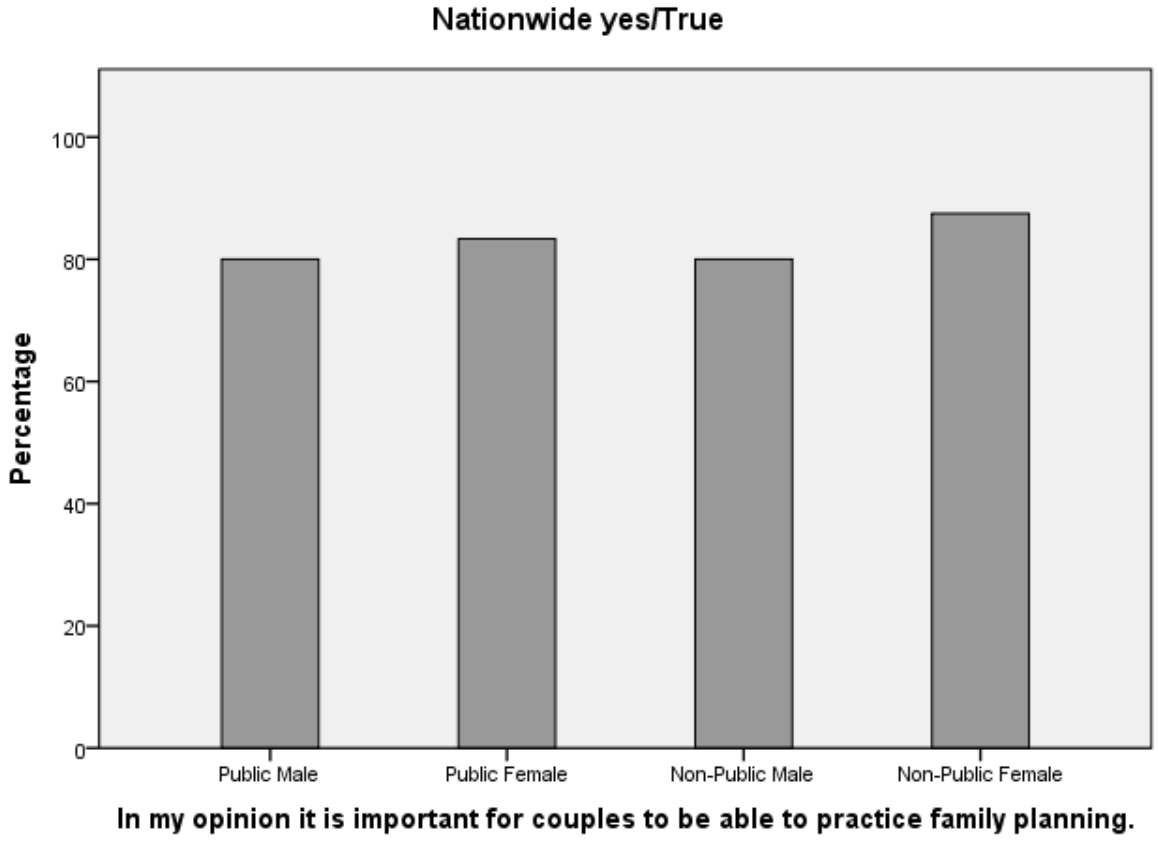
xv. In my opinion, it is ok to bully younger students

In my opinion it is ok to bully younger students.		Nationwide	
		yes/True	No/False
Public	Male	9	111
		7.5%	92.5%
	Female	2	118
		1.7%	98.3%
Non-Public	Male	13	107
		10.8%	89.2%
	Female	4	116
		3.3%	96.7%



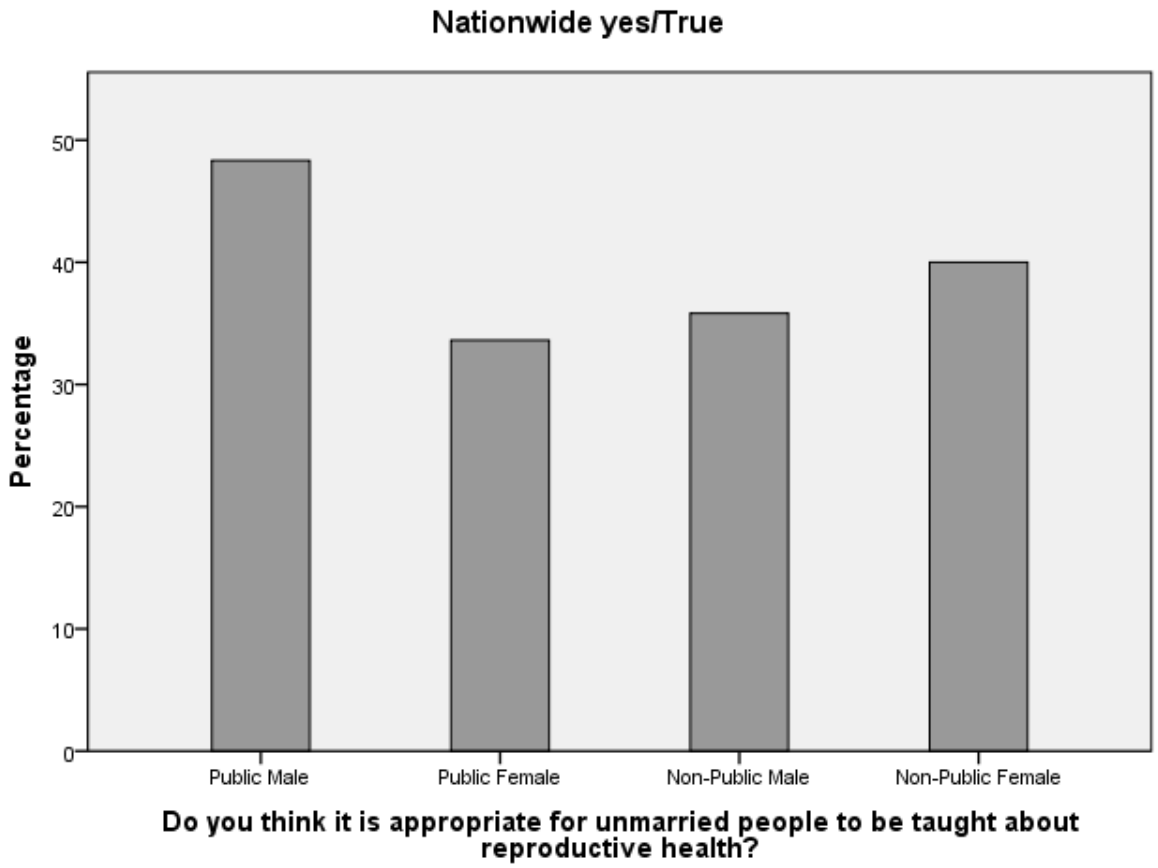
xvi. In my opinion, it is important for couples to be able to practice family planning

In my opinion it is important for couples to be able to practice family planning.		Nationwide	
		yes/True	No/False
Public	Male	96	24
		80.0%	20.0%
	Female	100	20
		83.3%	16.7%
Non-Public	Male	96	24
		80.0%	20.0%
	Female	105	15
		87.5%	12.5%



xvii. Do you think it is appropriate for unmarried people to be taught about reproductive health?

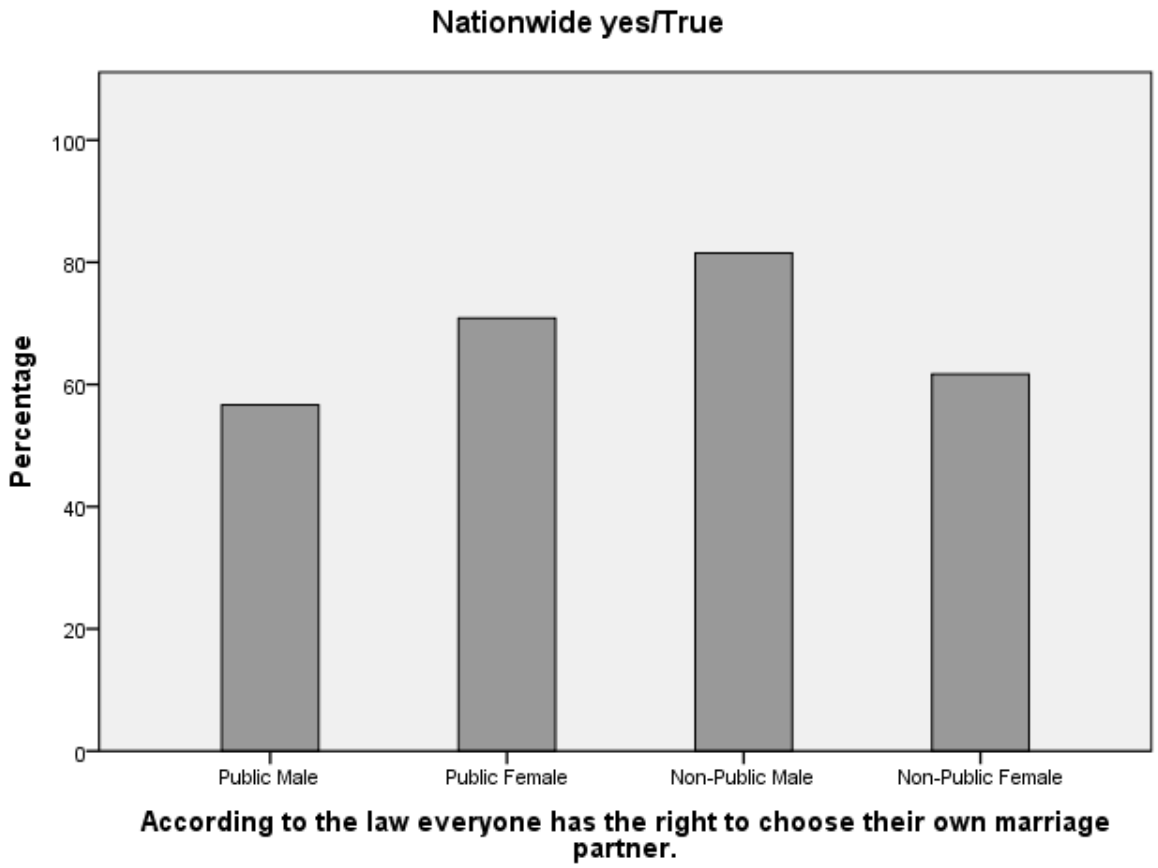
Do you think it is appropriate for unmarried people to be taught about reproductive health?		Nationwide	
		yes/True	No/False
Public	Male	58	62
		48.3%	51.7%
	Female	40	79
		33.6%	66.4%
Non-Public	Male	43	77
		35.8%	64.2%
	Female	48	72
		40.0%	60.0%



4. REPLIES OF THE SAMPLE TO KNOWLEDGE-BASED QUESTIONS

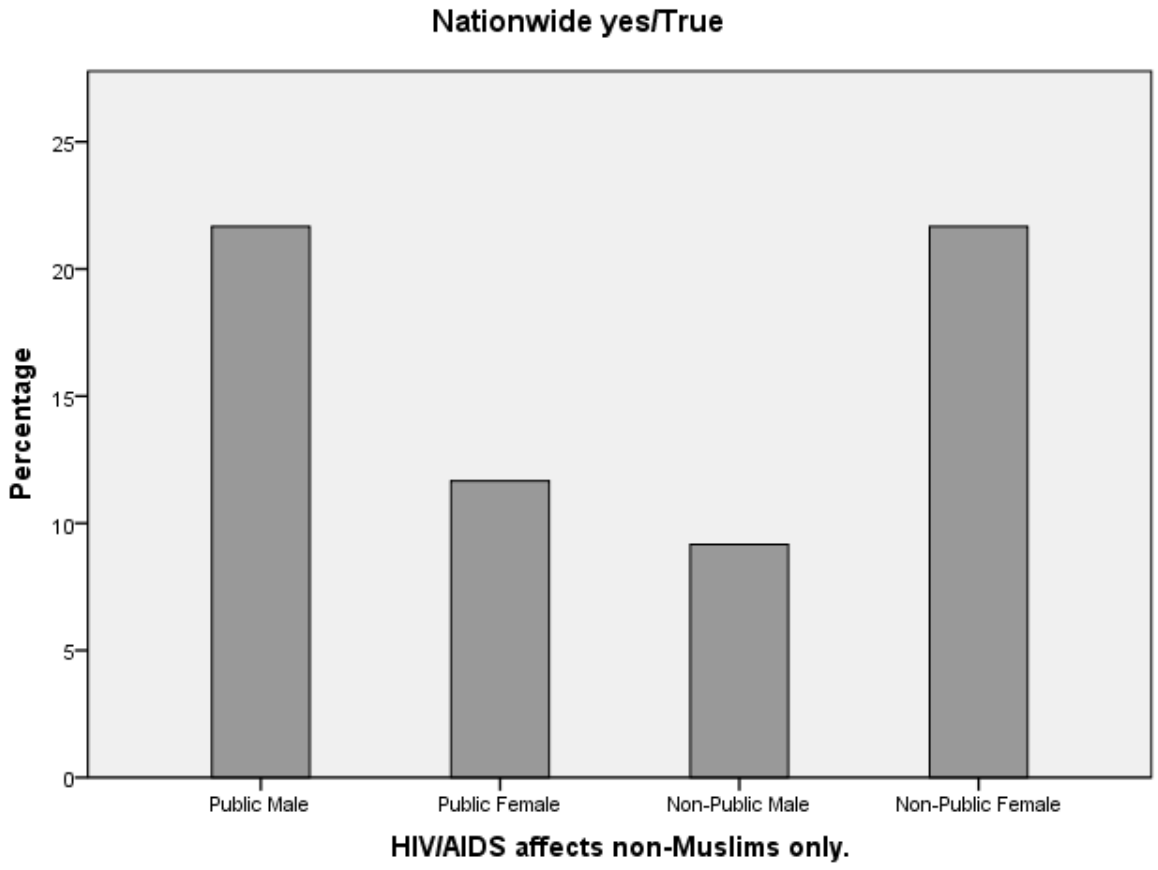
i. According to the law, everyone has the right to choose his or her own marriage partner

According to the law everyone has the right to choose their own marriage partner.		Nationwide	
		yes/True	No/False
Public	Male	68	52
		56.7%	43.3%
	Female	85	35
		70.8%	29.2%
Non-Public	Male	97	22
		81.5%	18.5%
	Female	74	46
		61.7%	38.3%



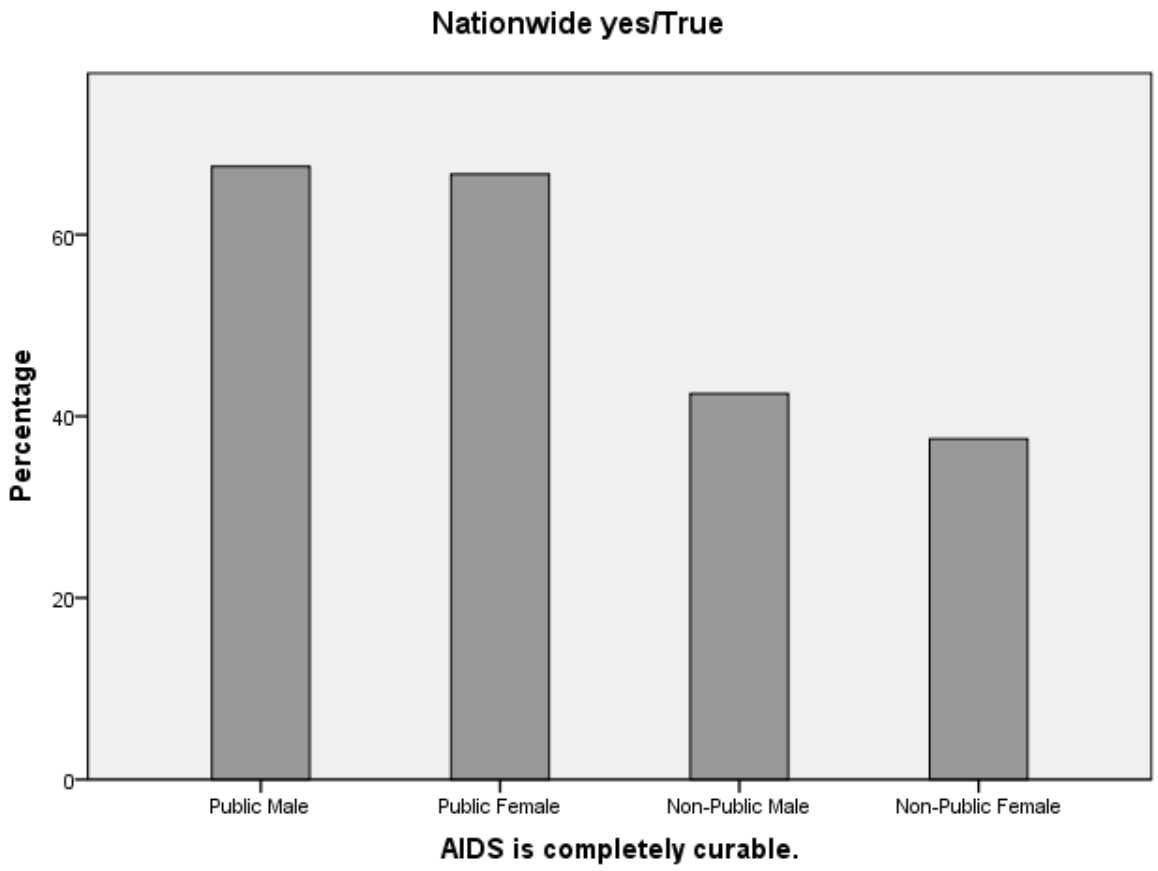
ii. HIV/AIDS affects non-Muslims only

HIV/AIDS affects non-Muslims only.		Nationwide	
		yes/True	No/False
Public	Male	26	94
		21.7%	78.3%
	Female	14	106
		11.7%	88.3%
Non-Public	Male	11	109
		9.2%	90.8%
	Female	26	94
		21.7%	78.3%



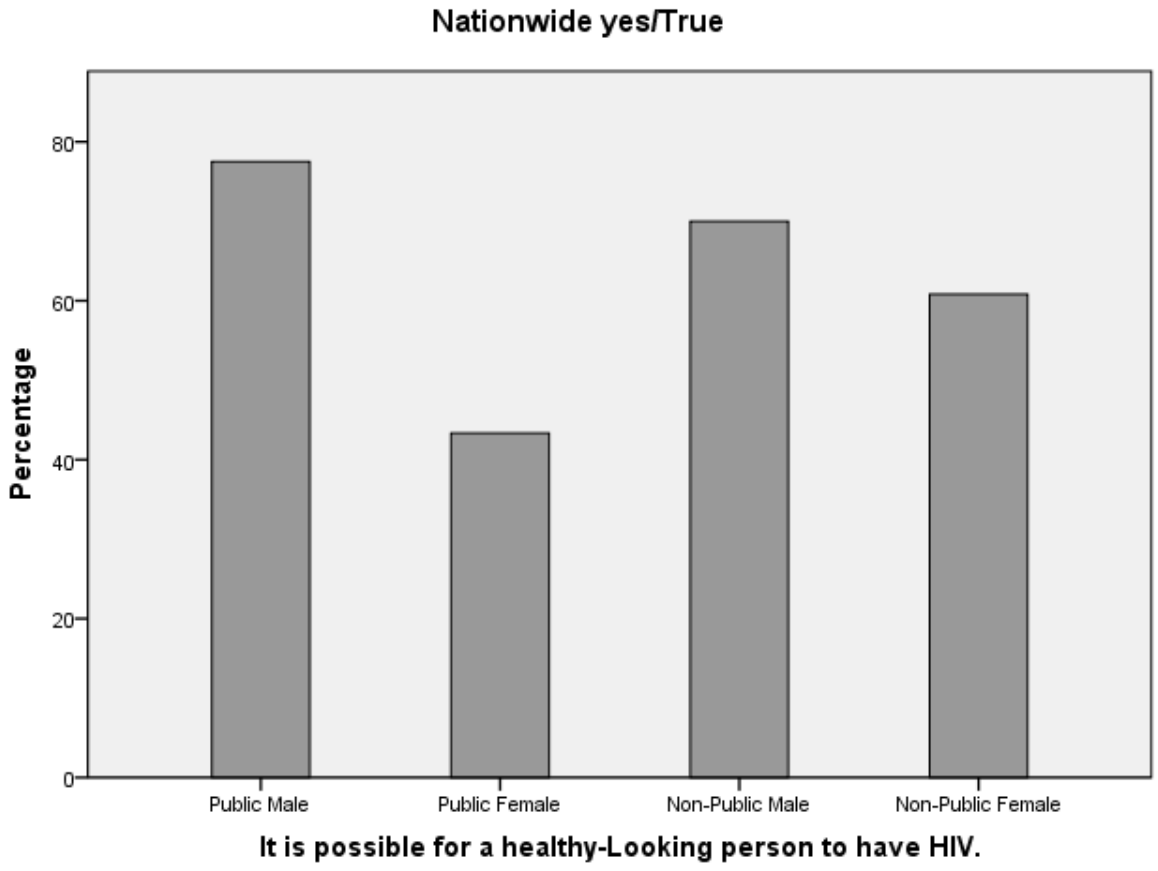
iii. AIDS is completely curable

AIDS is completely curable.		Nationwide	
		yes/True	No/False
Public	Male	81	39
		67.5%	32.5%
	Female	80	40
		66.7%	33.3%
Non-Public	Male	51	69
		42.5%	57.5%
	Female	45	75
		37.5%	62.5%



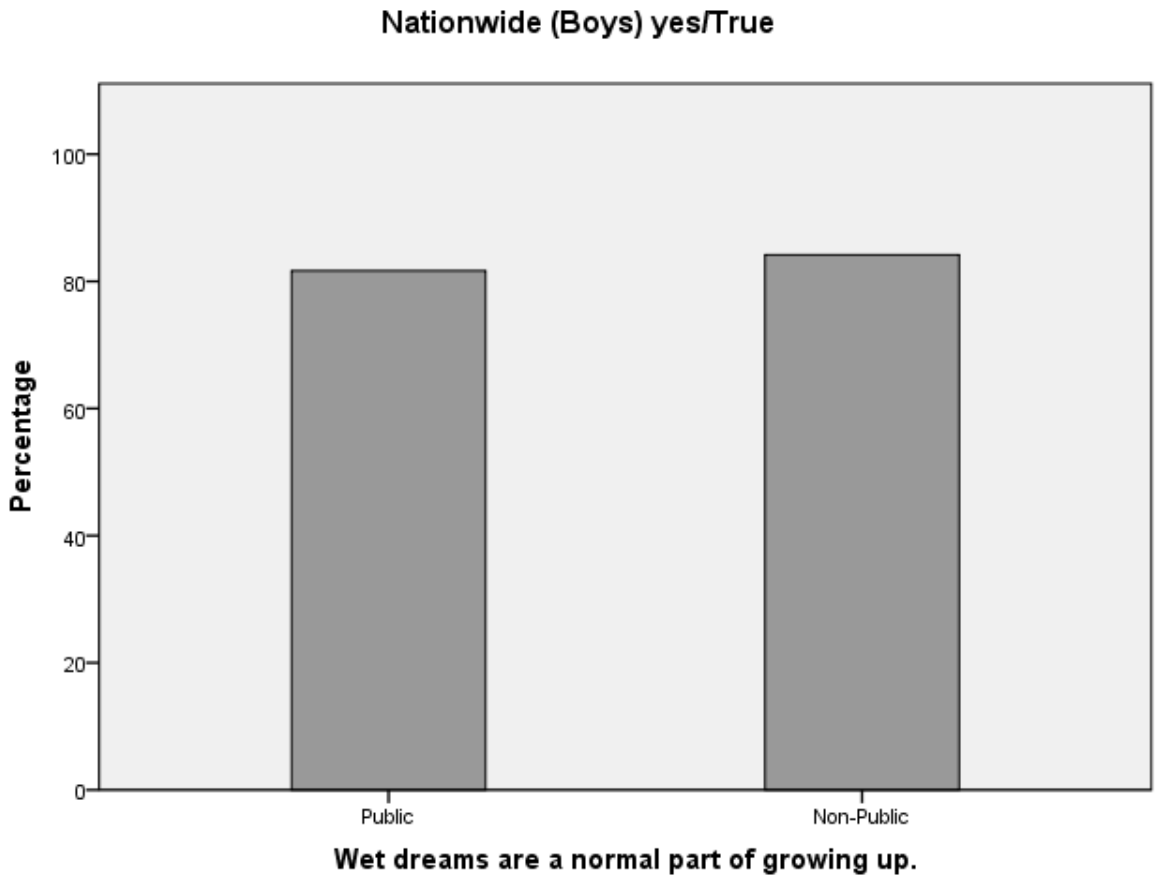
iv. It is possible for a healthy looking person to have HIV

It is possible for a healthy-Looking person to have HIV.		Nationwide	
		yes/True	No/False
Public	Male	93	27
		77.5%	22.5%
	Female	52	68
		43.3%	56.7%
Non-Public	Male	84	36
		70.0%	30.0%
	Female	73	47
		60.8%	39.2%



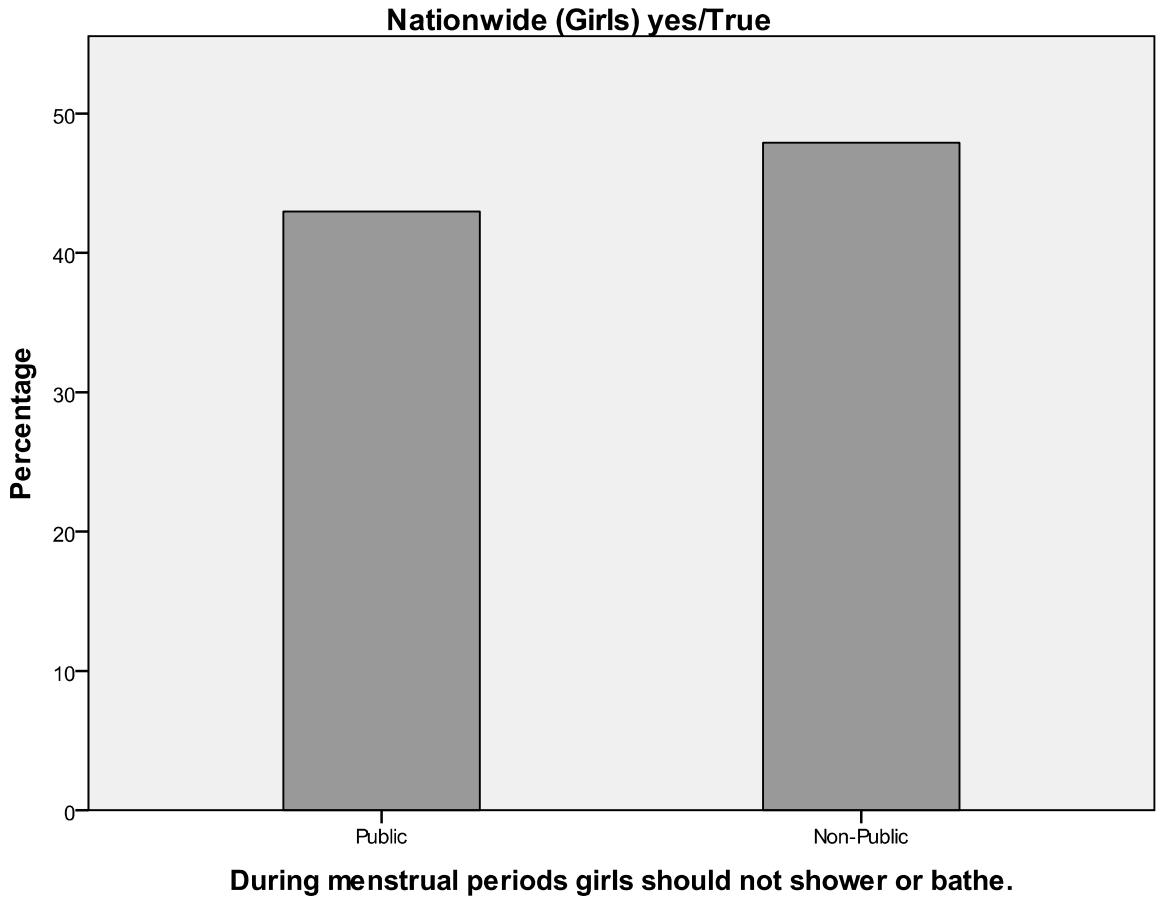
v. Wet dreams are a normal part of growing up (asked from boys only)

	Nationwide (Boys)	
	yes/True	No/False
Public	98	22
	81.7%	18.3%
Non-Public	101	19
	84.2%	15.8%



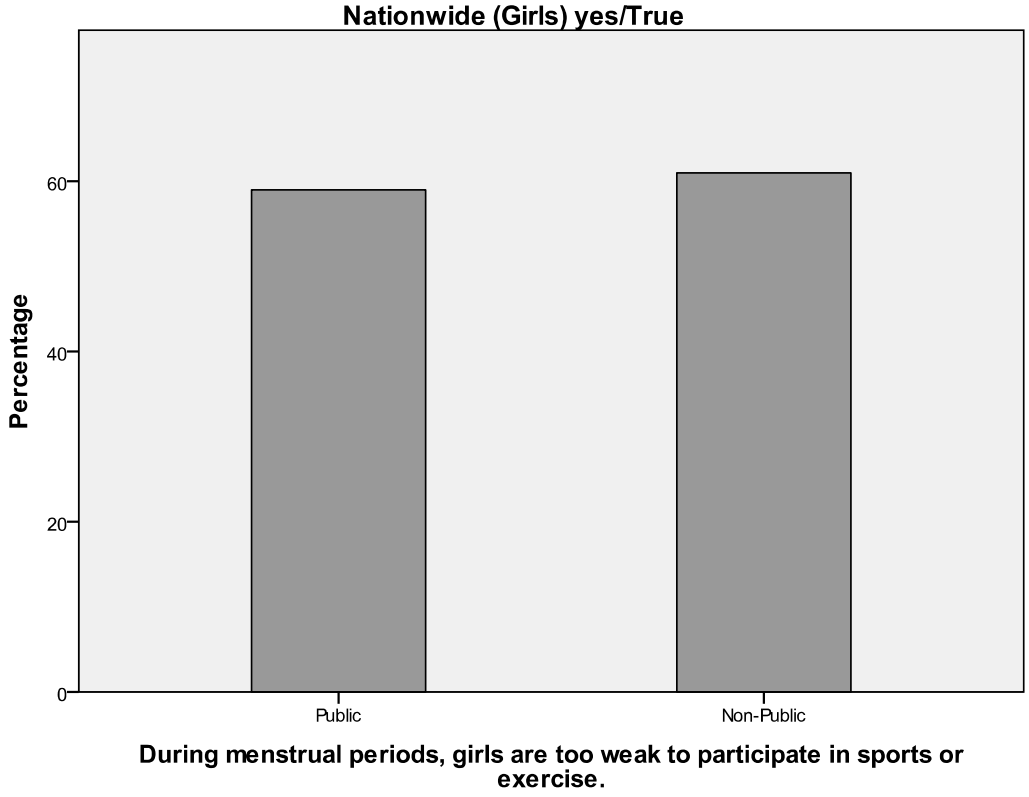
v. a. During menstrual periods, girls should not shower or bathe (asked from girls only)

	Nationwide (Girls)	
	yes/True	No/False
Public	52	69
	43.0%	57.0%
Non-Public	57	62
	47.9%	52.1%



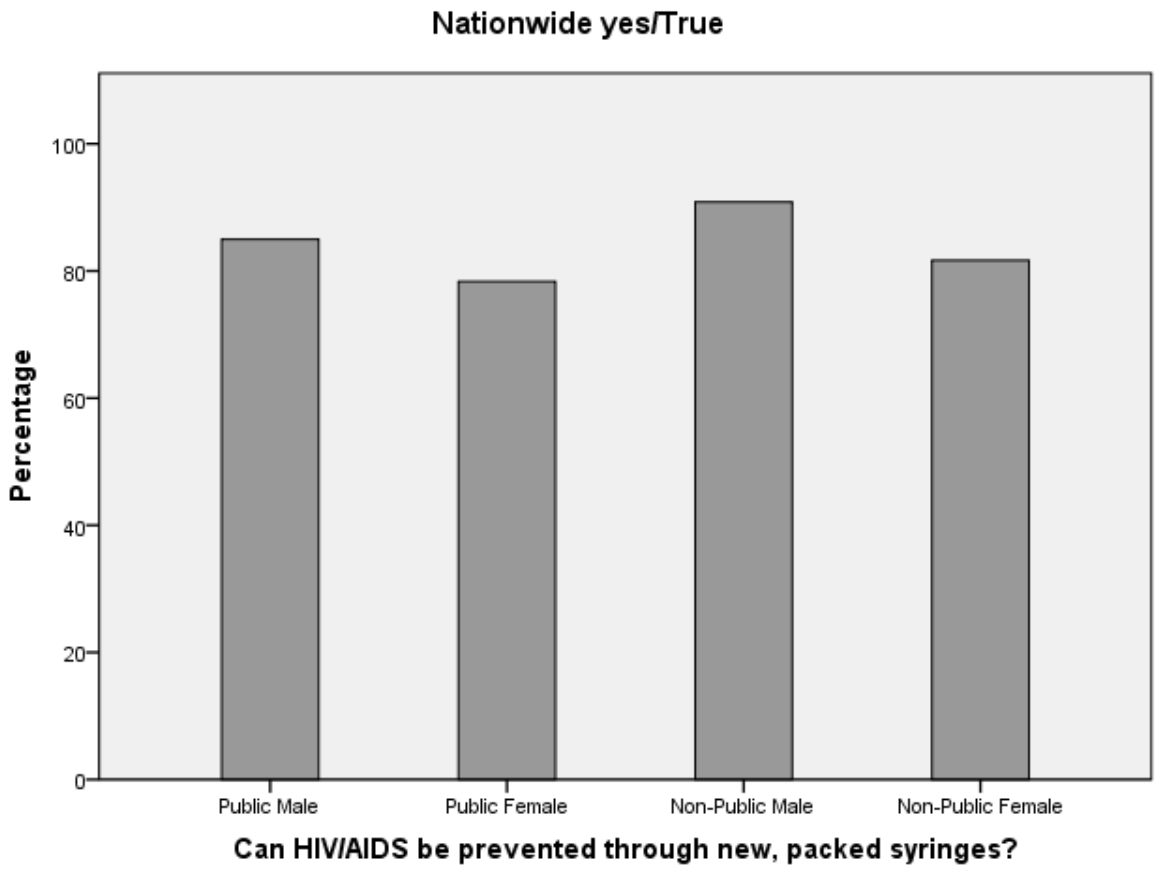
v. b. During menstrual periods, girls are too weak to participate in sports or exercise

During menstrual periods, girls are too weak to participate in sports or exercise.	Nationwide (Girls)	
	yes/True	No/False
Public	59	62
	48.8%	51.2%
Non-Public	61	58
	51.3%	48.7%



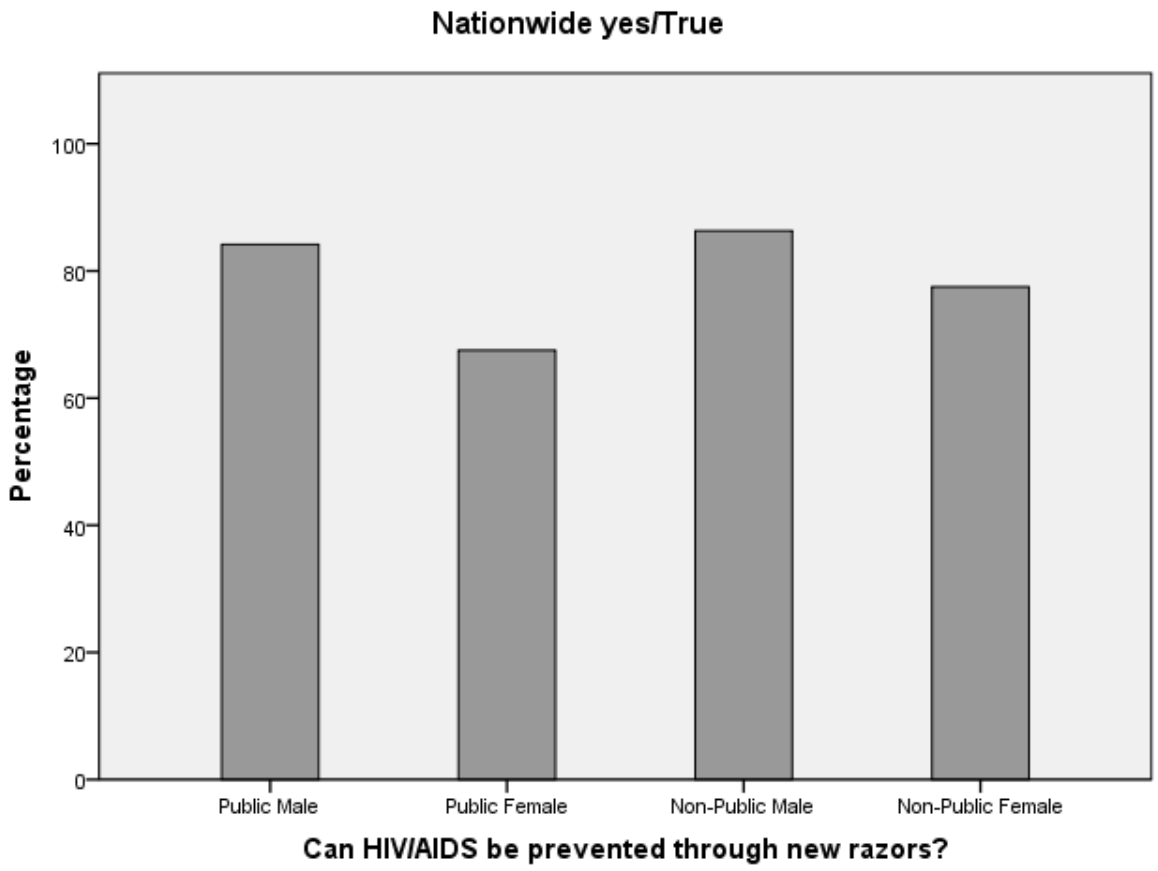
vi. Can HIV/AIDS be prevented through new, packed syringes?

Can HIV/AIDS be prevented through new, packed syringes?		Nationwide	
		yes/True	No/False
Public	Male	102	18
		85.0%	15.0%
	Female	94	26
		78.3%	21.7%
Non-Public	Male	109	11
		90.8%	9.2%
	Female	98	22
		81.7%	18.3%



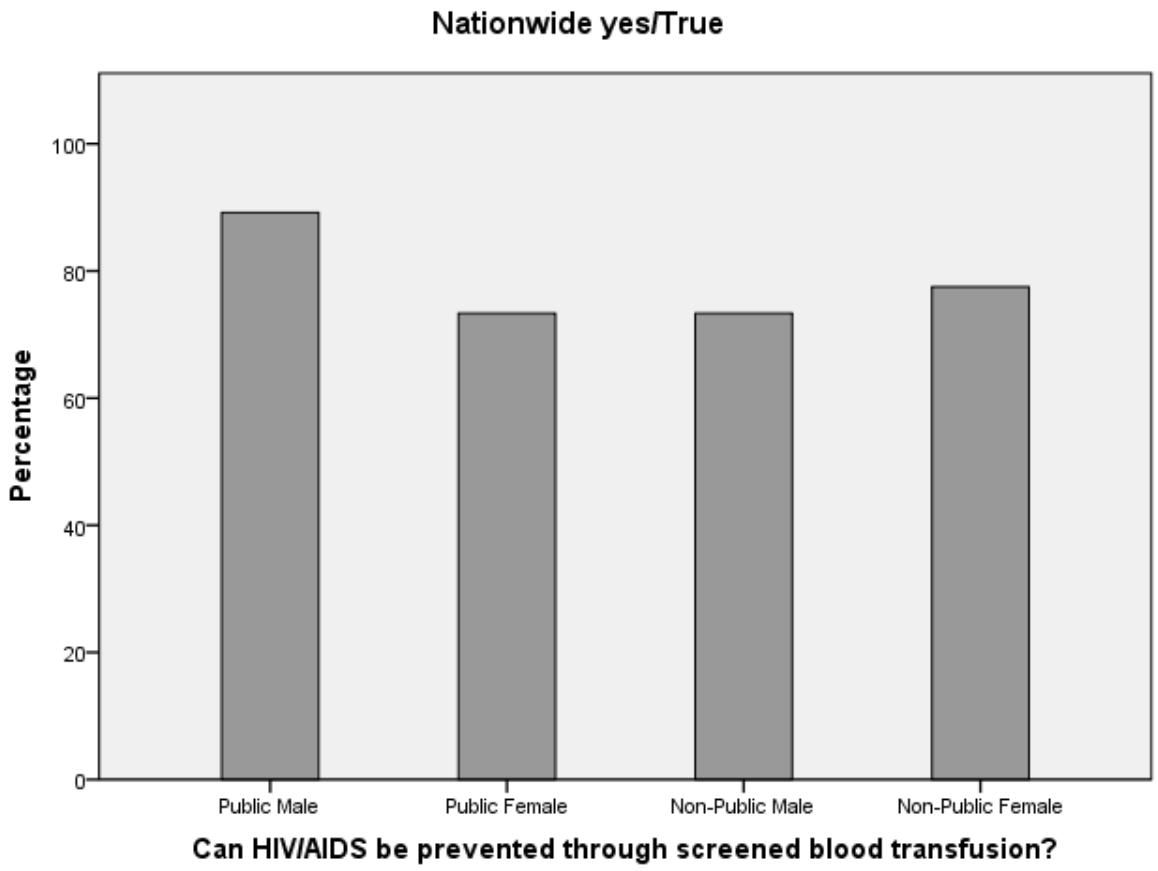
vii. Can HIV/AIDS be prevented through new razors?

Can HIV/AIDS be prevented through new razors?		Nationwide	
		yes/True	No/False
Public	Male	101	19
		84.2%	15.8%
	Female	81	39
		67.5%	32.5%
Non-Public	Male	101	16
		86.3%	13.7%
	Female	93	27
		77.5%	22.5%



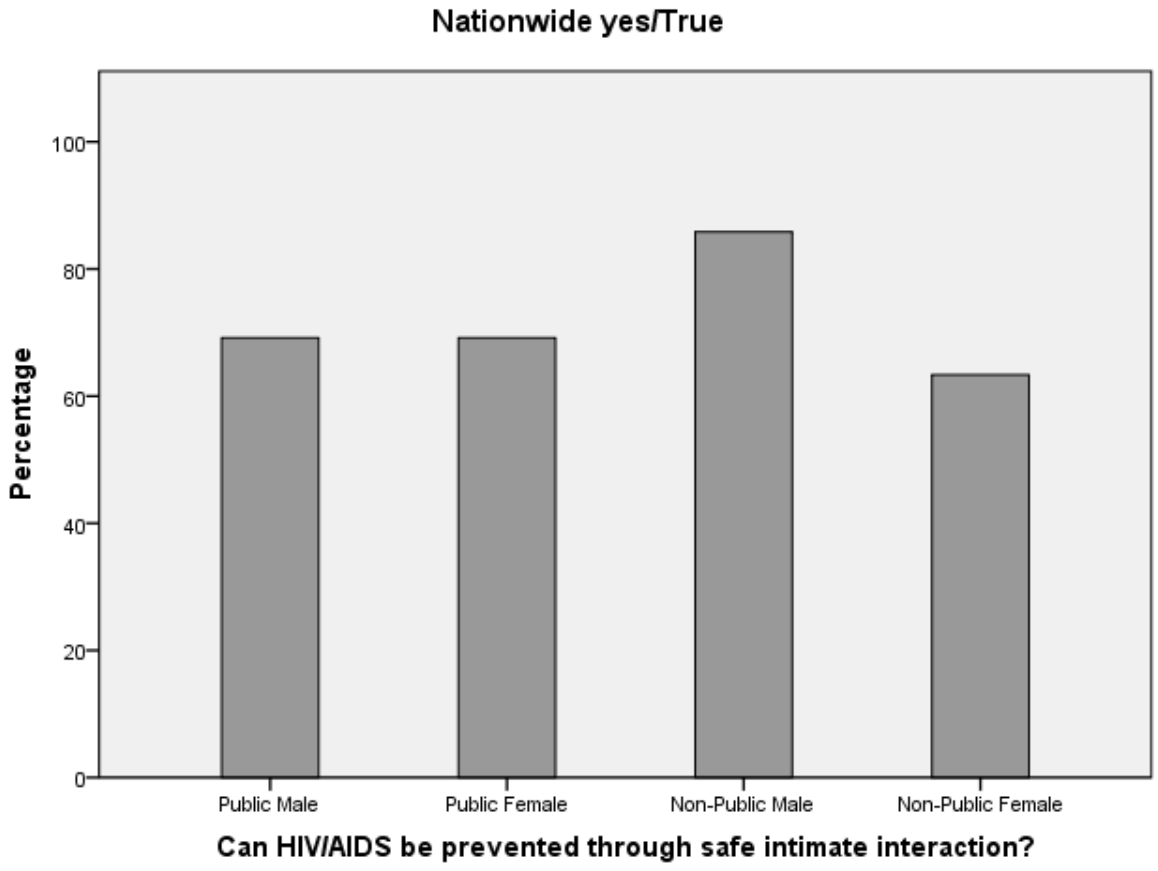
viii. Can HIV/AIDS be prevented through screened blood transfusion?

Can HIV/AIDS be prevented through screened blood transfusion?		Nationwide	
		yes/True	No/False
Public	Male	107	13
		89.2%	10.8%
	Female	88	32
		73.3%	26.7%
Non-Public	Male	88	32
		73.3%	26.7%
	Female	93	27
		77.5%	22.5%



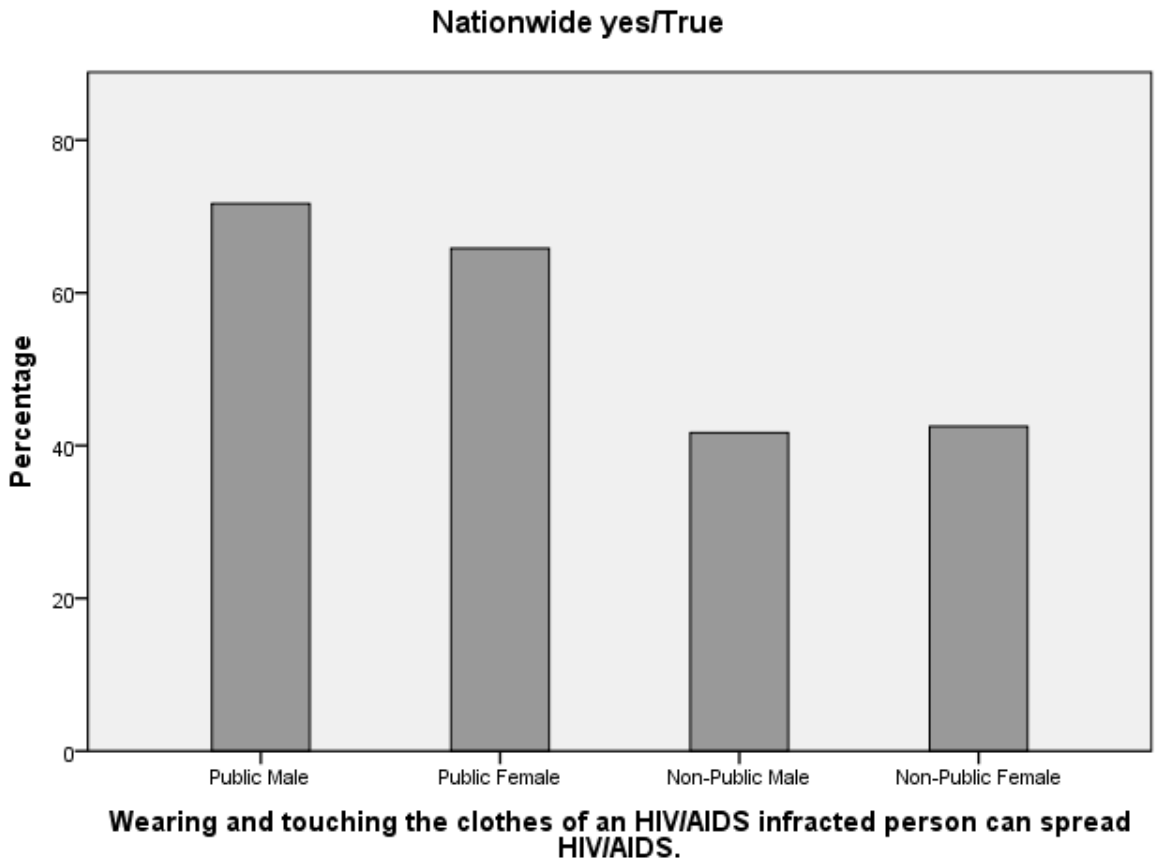
ix. Can HIV/AIDS be prevented through safe intimate interaction?

Can HIV/AIDS be prevented through safe intimate interaction?		Nationwide	
		yes/True	No/False
Public	Male	83	37
		69.2%	30.8%
	Female	83	37
		69.2%	30.8%
Non-Public	Male	103	17
		85.8%	14.2%
	Female	76	44
		63.3%	36.7%



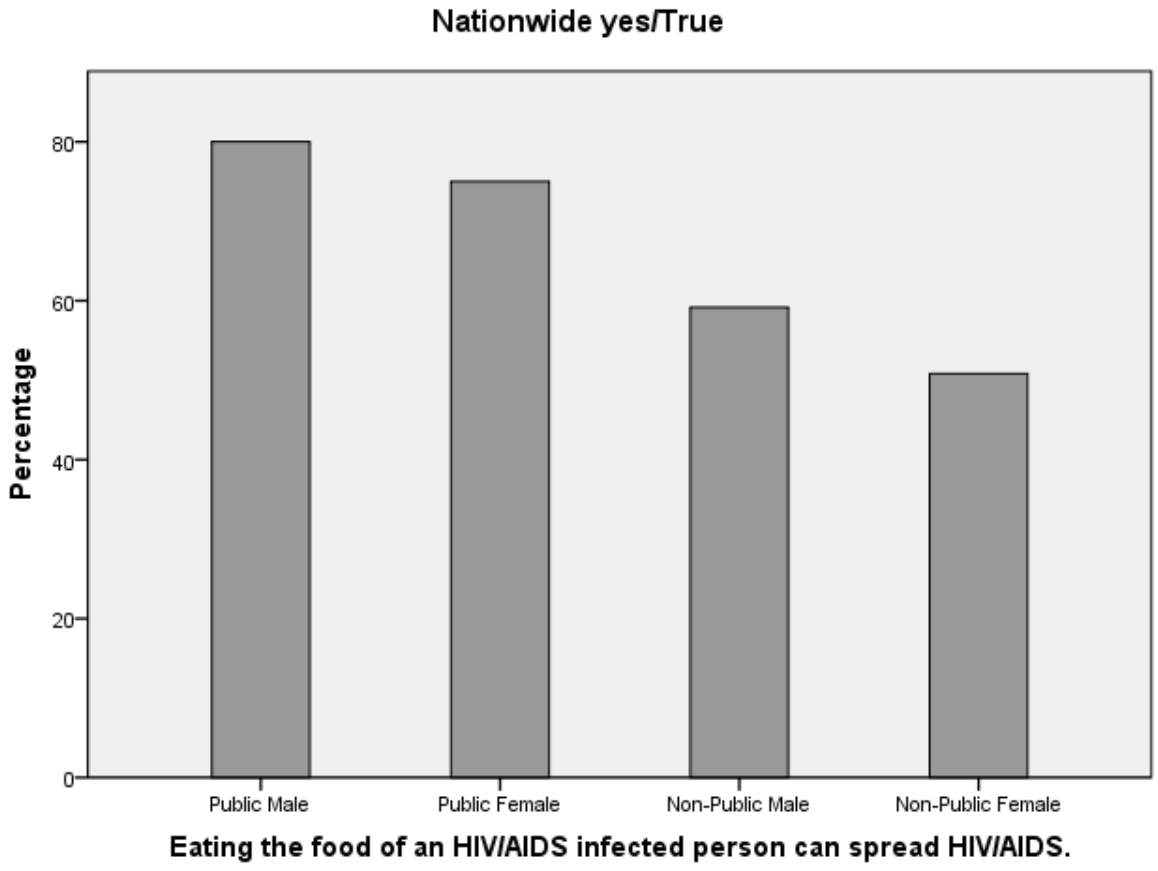
x. Wearing/touching the clothes of an HIV/AIDS infected person can spread HIV/AIDS

Wearing/touching the clothes of an HIV/AIDS infeccted person can spread HIV/AIDS		Nationwide	
		yes/True	No/False
Public	Male	86	34
		71.7%	28.3%
	Female	79	41
		65.8%	34.2%
Non-Public	Male	50	70
		41.7%	58.3%
	Female	51	69
		42.5%	57.5%



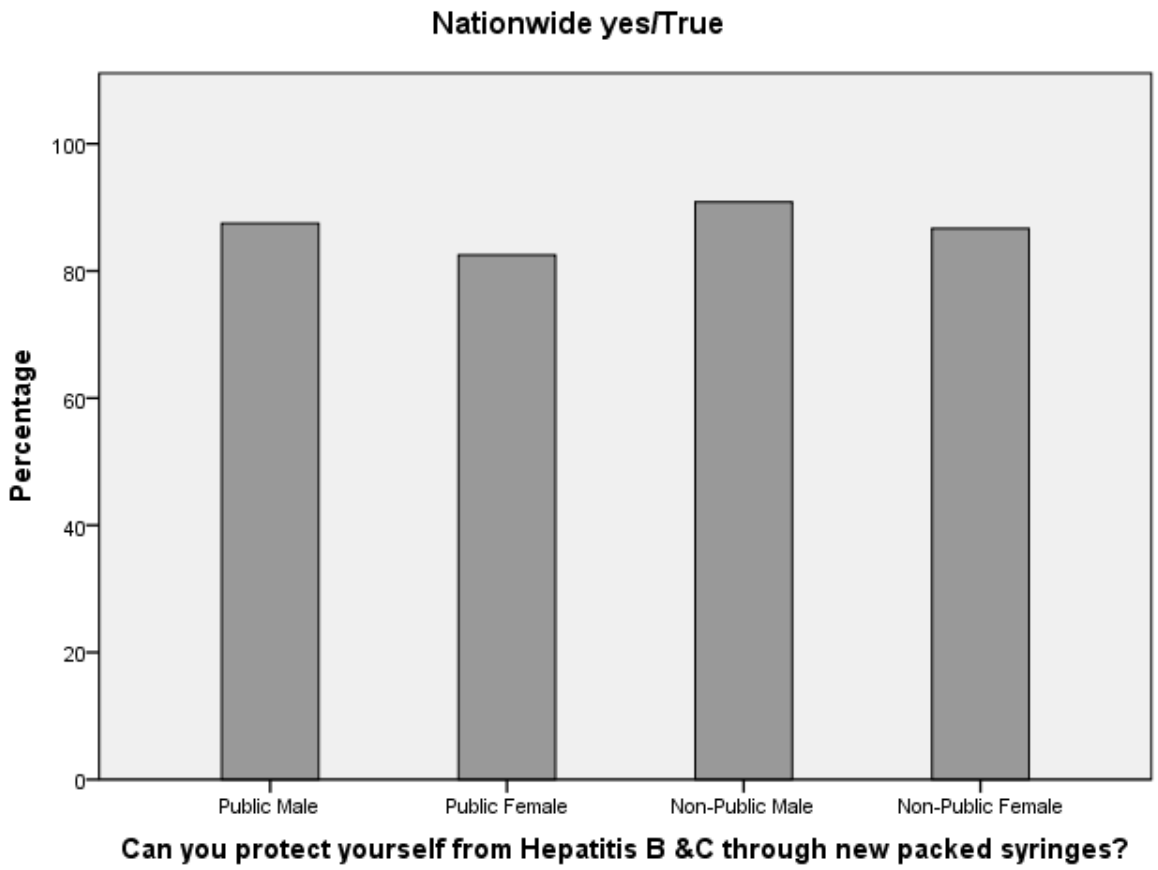
xi. Eating the food of an HIV/AIDS infected person can spread HIV/AIDS

Eating the food of an HIV/AIDS infected person can spread HIV/AIDS.		Nationwide	
		yes/True	No/False
Public	Male	96	24
		80.0%	20.0%
	Female	90	30
		75.0%	25.0%
Non-Public	Male	71	49
		59.2%	40.8%
	Female	61	59
		50.8%	49.2%



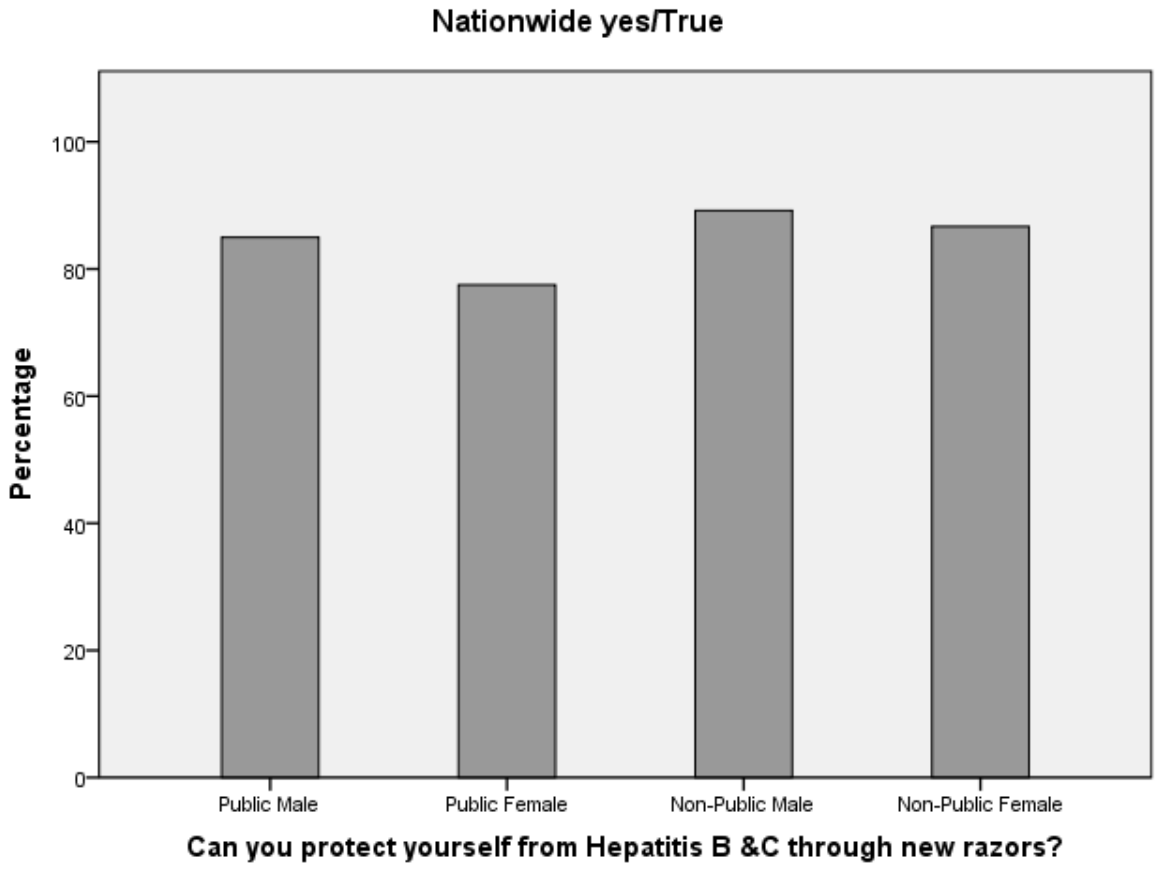
xii. Can you protect yourself from Hepatitis B &C through new packed syringes?

Can you protect yourself from Hepatitis B &C through new packed syringes?		Nationwide	
		yes/True	No/False
Public	Male	105	15
		87.5%	12.5%
	Female	99	21
		82.5%	17.5%
Non-Public	Male	109	11
		90.8%	9.2%
	Female	104	16
		86.7%	13.3%



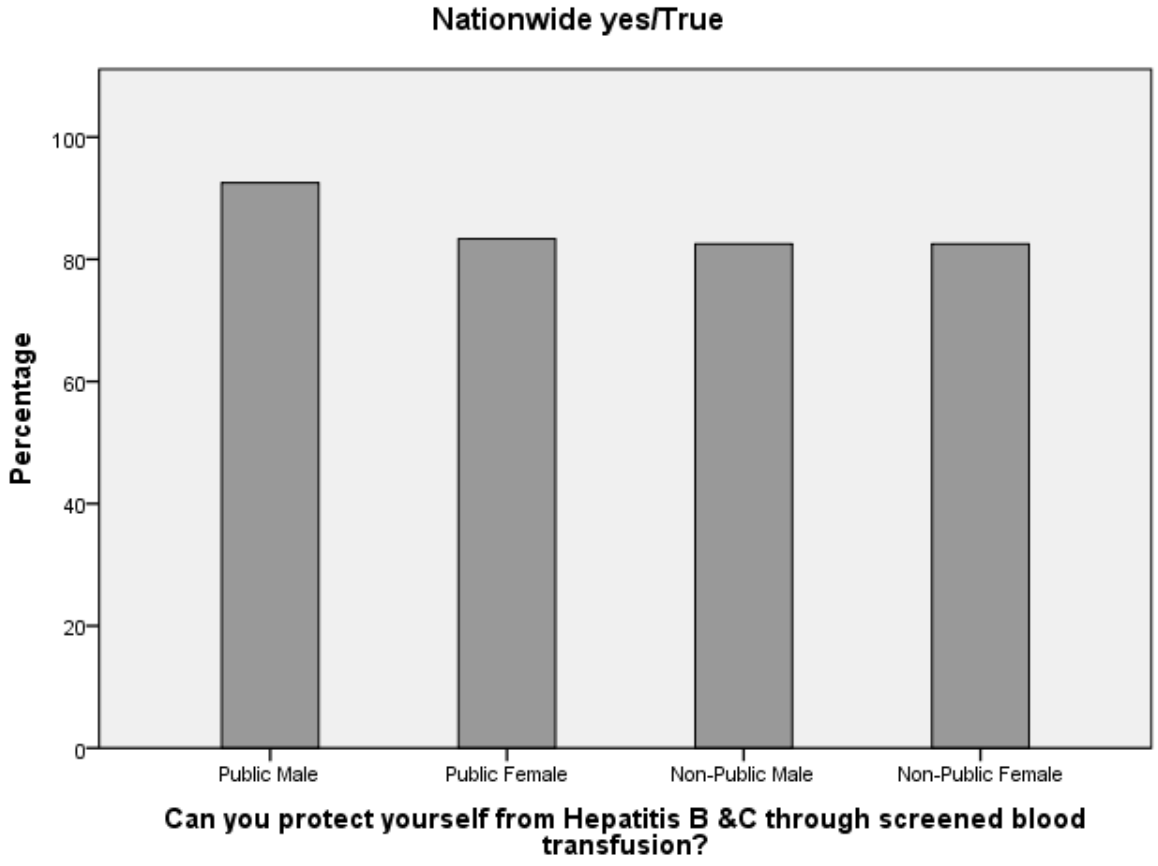
xiii. Can you protect yourself from Hepatitis B &C through new razors?

Can you protect yourself from Hepatitis B &C through new razors?		Nationwide	
		yes/True	No/False
Public	Male	102	18
		85.0%	15.0%
	Female	93	27
		77.5%	22.5%
Non-Public	Male	107	13
		89.2%	10.8%
	Female	104	16
		86.7%	13.3%



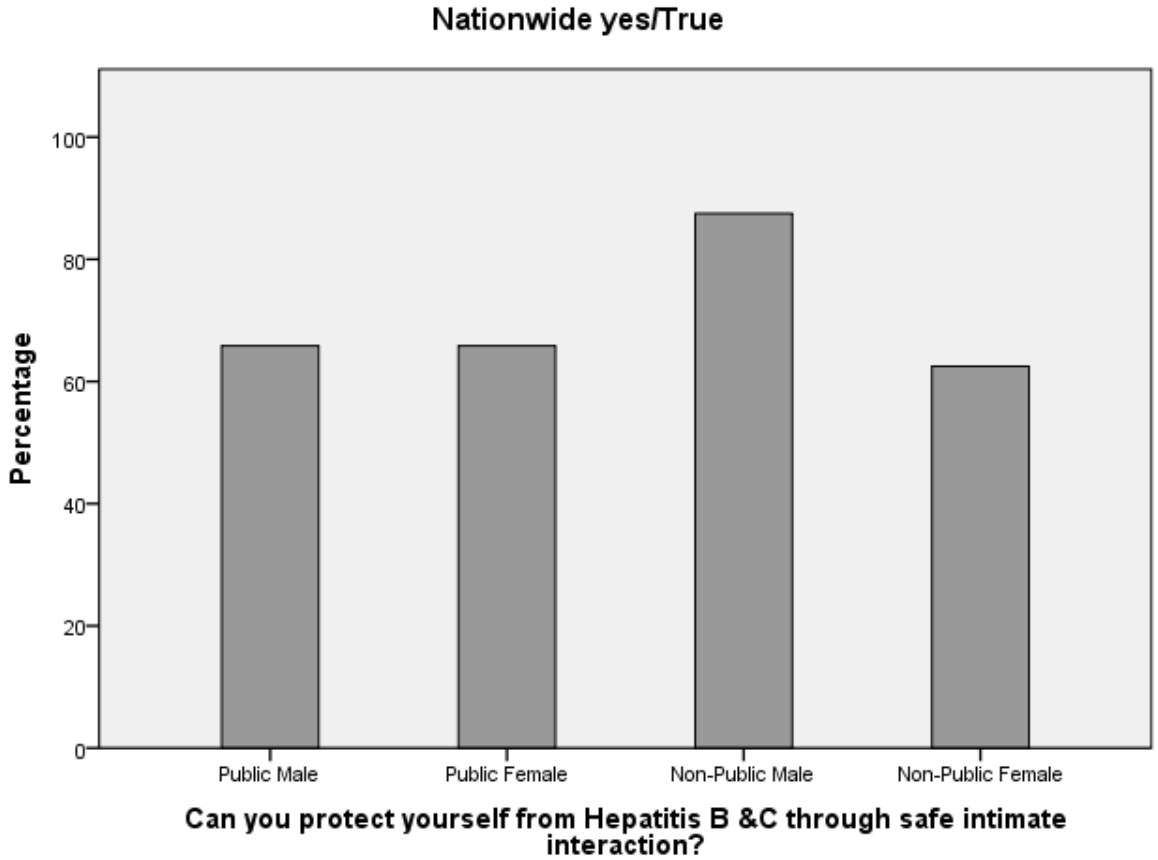
xiv. Can you protect yourself from Hepatitis B & C through screened blood transfusion?

Can you protect yourself from Hepatitis B &C through screened blood transfusion?		Nationwide	
		yes/True	No/False
Public	Male	111	9
		92.5%	7.5%
	Female	100	20
		83.3%	16.7%
Non-Public	Male	99	21
		82.5%	17.5%
	Female	99	21
		82.5%	17.5%



xv. Can you protect yourself from Hepatitis B &C through safe intimate interaction?

Can you protect yourself from Hepatitis B &C through safe intimate interaction?		Nationwide	
		yes/True	No/False
Public	Male	79	41
		65.8%	34.2%
	Female	79	41
		65.8%	34.2%
Non-Public	Male	105	15
		87.5%	12.5%
	Female	75	45
		62.5%	37.5%



C: YFS FACILITIES: (Indicator 2.2a)

The following is the list of YFS services selected in each city to assess their compliance to the IPPF guidelines:

Details of YFS Facilities

MULTAN		
No.	**Name**	**Status**
YFS 1	BHU Khairabad	New
YFS 2	Buch Khusrobad	New
YFS 3	MCH Gulgasht	New
YFS 4	MCH Gulgasht	New
YFS 5	BHU Tibbah Masud Pur	New
YFS 6	BHU Clinic Tibbah Masud Pur	New
YFS 7	Dr Ghulam Mujtaba Clinic	Old

QUETTA		
No.	**Name**	**Status**
YFS 1	Kauser Perveen, Qamrani Road, Abdul Hakeem Clinic	New
YFS 2	Islamia Dispensary	Old
YFS 3	Gowalmandi BHU	Old
YFS 4	FPAP (Male)	Old
YFS 5	FPAP (Female)	Old
YFS 6	Raza Clinic Killi Nohsar	New
YFS 7	BHU Wahdat Colony	Old
YFS 8	BHU Kauser Perveen Postal Colony	Old

The following is a summary of the overall mean score per city according to different aspects of the IPPF Guidelines.

Summary of YFS Components

City	Questions				
	Training of service provider	**Privacy**	**Opening hours**	**Accessibility**	**Service regardless of payment**
Quetta	2.1	1.8	2.0	1.8	1.7
Multan	3.0	3.8	3.0	2.2	2.8
Country	**2.5**	**2.8**	**2.5**	**2.0**	**2.3**

City	Questions			
	Service regardless accompanied by adult	**Referral**	**Community & parental support**	**MEAN SCORE**
Quetta	1.8	0.8	2.3	1.8
Multan	3.4	2.0	2.0	2.8
Country	**2.6**	**1.4**	**2.1**	**2.3**

Comparison of YFS Facilities with Baseline

No.	Facility	2011	2013	
		Mean Score	**Mean Score**	**Change**
MULTAN				
Female YFS Facilities				
1.	Tibba Masood Pur **YFS-02**	NA	2.8	NA
2.	Gulgasht MCH **YFS-04**	NA	3.1	NA
3.	BHU Khusrobad **YFS-06**	NA	3.5	NA
Male YFS Facilities				
4.	BHU Khairabad **YFS-01**	NA	2.7	NA
5.	Gulgusht MCH **YFS-03**	NA	2.7	NA
6.	Tibba Masood Pur **YFS-05**	NA	2.7	NA
7.	Dr. Ghulam Mujtaba Clinic **YFS-07**	3.8	2.0	Decreased
QUETTA				
Female YFS Facilities				
1.	Kausar Parveen Clinic **YFS-01**	NA	1.2	NA
2.	BHU Golmandi **YFS-03**	?	1.6	
3.	FPAP **YFS-05**	Data unavailable	2.7	NA
4.	BHU Wadat Colony **YFS-07**	?	1.1	?
5.	BHU Kausar Parveen **YFS-08**	?	1.2	?
Male YFS Facilities				
6.	Islamia Dispansary **YFS-02**	?	1.1	?
7.	FPAP **YFS-04**	3.1	3.3	Increased
8.	Killinohsar **YFS-06**	NA	2.2	NA

D: CASE STUDIES ON SRHR SERVICES: (Indicator 2.3a)

1. Sexual and Gender Based Violence is a major threat to the health and social fabric of a society. Its prevalence is compounded by factors such as poverty, lack of awareness, and limited services and sketchy legislature. Because of the pervasive nature of this problem, the acceptability of gender-based violence has led to a lack of action against perpetrators and a general tolerance of the issue. One of the few NGOs creating awareness on this topic is HDS, an implementing partner of the Parwan Alliance in Quetta. One of the cases reported to HDS was that of Jami – who was married off as a minor to a man who was twenty years older than her. She was subjected to marital violence from the beginning of her wedding. Jami was isolated for days from her son, and not allowed any medical aid, even after severe beatings. Because of a vicious cycle of violence, malnutrition and emotional trauma, she fell further ill in her second pregnancy. She heard from her cousin about the helpline of HDS – who, in turn, had heard about its existence through an FM Radio advertisement. They both waited for an opportunity to make the call when no one was around, and one day they were able to do so. They were encouraged by the Counselor (who had been trained by PIDS on YFS) to visit the FPAP office located in Satellite Town Quetta. When they did, Jami was given due medical attention at the Saiban Hospital, including a much-needed blood transfusion for her low hemoglobin. She was also counseled for tackling the violence on a daily basis.

2. Zainab, a 17-year old orphan girl from a poor household had befriended her neighbor Rizwan, who was several years older than her. Their relationship began innocently enough – over exchanging text messages on each other's mobile phones – but soon escalated into a physical one. Zainab used to meet Rizwan regularly and without much hindrance, as her mother was a daily wager in other people's homes and her brother used to work for long hours too. No one came to know of her secret meetings. Rizwan's interest in her eventually waned, and he started to ignore her, putting Zainab under extreme psychological pressure. She discussed the issue with her best friend Nosheen, who advised her to call the Helpline on SRHR, by HDS. Zainab took heed to her friend's advice and made the call. She was pleasantly surprised by the professional and calm mannered voice on the other end, which gave her courage to physically visit the center. Incidentally, Zainab started vomiting the night she had visited the center and when she went back the next day, she was told that she was pregnant after being examined by the programme doctor. Shocked and scared, she broke down emotionally, and shared the news with Rizwan, who threatened her not to repeat this to anyone else otherwise he would physically harm her. He also told her to stop calling him, saying he was getting out of her life forever and whatever the consequence of their relationship, it was hers to bear alone. The female psychologist at the Helpline (who had received Parwan YFS training) assisted Zainab in overcoming her devastated mental state and convinced her to confide in her mother. After much hesitation, she agreed and

brought her mother to the center. Initially shocked and furious, her mother was eventually in agreement upon the fact that Zainab's life could only be saved if she underwent an abortion. She did not want her daughter to end up as a victim of honor killing, as she knew her son would not spare his sister for bringing dishonor to the family. After the abortion, Zainab started working as a seamstress from home, having made peace with her past. The staff at the Helpline is till in touch with her, and she is grateful for their moral and physical support during the most trying time of her life.

E: FGDs with CSOs IN MULTAN AND QUETTA: (Indicator 2.4e)

FGD with CSOs in Multan:

A total of seventeen participants took part in the activity. They were appreciative of the Parwan Alliance and shared that it had been a challenge at the beginning but gradually the taboo topic of SRHR was helping to break the myths at the community level, specially regarding early marriage and sexual abuse of children. For instance, they have successfully conducted community sessions for more than three hundred women at one time, where initially the women were angry about the sort of information being given regarding early marriage and sexual abuse of children, but eventually changed their opinion. They expressed that the greatest sign of change was the fact that they received increased media coverage in newspapers and radio about their activities. They were enthusiastic about the fact that the gradual acceptance of the presence of Awaz in schools as part of Parwan activities is a sign of success.

The CSOs expressed the need for age and gender appropriate IEC material to disseminate in the local communities in local, easily understandable language. They also requested for more innovative IEC material, such as documentaries and scripts for street theater so that they could engage the participants more convincingly. One participant stated: "It is easier to teach the dramas of Shakespeare than to approach SRHR in the community due to the taboo nature of the topic, therefore if we can use some innovative technique of getting our message across, we should". The participants in particular asked for authentic research-based advocacy material on the religious aspects of early marriage, as the clergy promotes examples wherein it seems that it is beneficial and morally right for girls to be married off as soon as they are pubescent. Therefore, convincing IEC material is required to counter this propaganda.

In addition, they believe that child abuse needs to be made a more major topic in the overall SRHR topics, and that this should be pushed as an active agenda point through Parwan Alliance at the district level. There are many cases being reported in the media on a daily basis but no solid steps taken to form pressure on the authorities to take preventive and punitive measures.

They expressed the need for coordination meetings through the Parwan Alliance between the CSOs and the line departments of the government so that the Awaz could act as an effective bridge between the local authorities and the organizations trying to create change at the grassroots level.

They also suggested the need for more capacity building of the CSOs regarding proposal writing, technical knowledge, proposal writing, report writing, etc. through the Alliance.

The CSOs shared that the financial aspect involved in the activities they conducted under the Parwan programme was miniscule and needed to be made more realistic.

They stated that as far as policy makers were concerned, the CSOs did invite them to their activities of other programmes but their participation was limited to that of mere attendance and not active lobbying amidst their peers in the parliament. The CSOs expressed that the financial costs were so limited in the Parwan Alliance activities that it was not worth going to the trouble of convincing the politicians to attend such small scale events as the latter were not interested in coming to the basic grassroots level.

FGD with CSOs in Quetta:

A total of thirteen participants took part in the discussion. In general, the topics covered by the CSOs as part of the Parwan Alliance include SGBV, FP, early marriage and SRHR. They termed the Aahung curriculum as a good training tool at the community level and mentioned the small grants program as a worthy initiative.

They shared that their organizations have been holding community sessions on these issues in coordination with PIDS in the designated areas of Quetta. The representatives of the CSOs reported that the communities had been enthusiastic and receptive towards these activities, as these were taboo topics before being approached by Parwan. However, they were still not able to reach the womenfolk to a major extent due to the tribal system. The CSOs said that at least awareness is created at some level, specially regarding SGBV but women do not know about services. The CSOs help in creating an access point for seeking services. The CSOs pointed out that they have created these referrals through other projects and not through Parwan. For instance, the SGBV helpline by USAID is already functional through another project with one of the CSOs and Parwan should take the lead in using this platform for its own aims, such as creating more referrals from communities etc. Similar is the case with SRHR, i.e. if they hold sessions with the adolescent regarding these issues they have nowhere to turn in case of a problem. In short, there is an increase in demand or at least the identification of demand made through such awareness activities, but no supply of services.

The CSOs shared that they had been asked by PIDS to make a referral network in the last meeting regarding SGBV. They stated that as far as awareness-raising was concerned, the achievement of Parwan is that at least the taboo topics such as sexual abuse are being discussed in various parts of the city.

The participants shared that capacity building was a part of Parwan programme, which led to their staff being trained (through Aahung curriculum) and on SGBV. This has been a healthy and positive activity but has yet to lead to any change at the grassroots level as there is no channel to further carry out this work at the community level. They suggested that there should be phased, multiple activities in selected communities in order to achieve solid results.

The CSOs expressed their viewpoint that at the start of the programme there was much enthusiasm amongst the Alliance members as well as PIDS to get the programme off the ground. In this regard, they were asked to submit various

proposals, but these were not accepted and there was much confusion about what activities to undertake. In the end, it was decided that all the CSOs would simply hold community awareness sessions on the topics being covered under Parwan. They suggested that there should be more flexibility in approach at the organizational level, as they feel that they are always asked for innovative ideas and proposals but in the end are told to follow the same routine activities and told that their proposals (on conducting street theater, radio programs, etc.) are not acceptable due to financial, time, or other factors and instead they are only to conduct sessions.

The organizations stated that they were in favor of the uniqueness of the approach, in that the Alliance can potentially be a robust platform for change n the province if properly channeled. The participants suggested that instead of taking up individual tasks handed out through PIDS, the Alliance should be a dynamic organism in itself and should be redesigned to achieve some milestone at the provincial or at least district level. They shared that Parwan should act as an umbrella or pressure group for pushing the agenda of SRHR to the government. In addition, they suggested that the area of operations should be increased at the community level and there should be increased access to multiple policy makers. They shared the example of Child Rights Movement, which is an Alliance in Balochistan as well as other parts of the country. In Quetta they have advocated for the Child Rights Bill to reach the parliament through the joint pressure and single point agenda.

They also shared the need for greater cooperation and information sharing, and building on each others' strengths. For instance, if one of the CSOs that is part of the Parwan Alliance is an expert in creating referrals or giving training then all of the other CSOs should be informed about it through Parwan. Similarly, they suggested that there should be exchange visits organized through PIDS on behalf of Parwan to learn from the strengths of other partner CSOs activities under the same programme, or at least an invitation to participate in the activities of the others as observers. Similarly, it was suggested that if one partner develops IEC material under the Parwan programme it should be officially disseminated amongst the others through the coordination of PIDS.

One reason for the above-stated challenge was reported to have been that the CSOs entered the Alliance at different timings instead of it being started as one body, whereby there was no coordination or liaison at the beginning, resulting in a haphazard sort of activity. The CSOs shared that they have a good informal understanding with each other due to their own coordination in other projects but not through Parwan programme. One participant stated that only now had he come to know that the program had been operational for two years. There was also a lack of consensus about whether the TORs of the Alliance were shared with the CSOs at the beginning of the programme.

They were skeptical about the limited financial slot allocated to each CSO to carry out the community sessions, as the CSOs shared that this left them with no room but to simply conduct the activity and not undertake any follow up. They also stated suggested that financial training on the kind of financial reporting

required from them should be given once and for all, as there were many objections raised on the bills submitted by the CSOs for their activities and they had to visit the PIDS office several times to have their payments approved and released.

They shared that they were part of the Alliance to build the profile of their CSO, as this is a uniquely themed programme. Another reason the CSOs stated for being a part of Parwan was that it helped them have exposure to capacity building activities for their staff.

The CSOs said that they do not meet regularly as part of the Alliance, but only meet to discuss their respective activities. The only time they meet as a group is when there are visitors/staff from Islamabad who need their input as a body. They also opined that they should be kept abreast of the status of the coordination between the Rutgers WPF office and PIDS regarding activities that directly concerned the CSOs. For instance, they said that they had no update about the small grants program – which CSO received it on what basis, and which did not. The participants expressed that it is important to meet to discuss lessons learnt, identify gaps and create a joint way forward on a regular basis. They shared that they had been part of only one coordination meeting a couple of months ago. The lack of such meetings result in a replication of activities, which they said has happened several times: two CSOs undertaking sessions in the same area on the same topic under the same Alliance.

The participants suggested that there should be segregated, age and gender appropriate IEC material developed through the programme, i.e. more variety of the kind of messages to be disseminated as per the specific sub groups within the community. They also expressed that the quantity of IEC material printed should be sufficient to reach a large number of community members, as the CSOs do not have the budget to print/photocopy the material.

Another noteworthy point shared by the CSOS was that PIDS does not have female field staff who can visit the community sessions the CSOs undertake with the women. Therefore, they said, they are unable to receive feedback from PIDS regarding the quality, impact or general comments about the sessions.

F: FOCUS GROUP DISCUSSIONS (Indicator 2.4b)

The following is a summary sheet of the FGDs conducted and the cities they were conducted in.

No.	City	Target Group
FEMALES		
FGD 1	Multan	Unmarried Girls Rural
FGD 2	Quetta	Unmarried Girls Semi Urban
FGD 3	Multan	Unmarried Girls Urban
FGD 4	Quetta	Unmarried Girls Urban
FGD 5	Multan	Married Women Rural
FGD 6	Quetta	Married Women Semi Urban
FGD 7	Multan	Married Women Urban
FGD 8	Quetta	Married Women Urban
MALES		
FGD 9	Multan	Unmarried Boys Rural
FGD 10	Quetta	Unmarried Boys Semi Urban
FGD 11	Multan	Unmarried Boys Urban
FGD 12	Quetta	Unmarried Boys Urban
FGD 13	Multan	Married Men Rural
FGD 14	Quetta	Married Men Semi Urban
FGD 15	Multan	Married Men Urban
FGD 16	Quetta	Married Men Urban

FGD 1:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: Basti Moran Wali; 5th Oct, 2013

Time: 1100am

Target group: Unmarried Girls

No. of participants: 9

Description of the community: Rural, Multan

Summary of Discussion:

1. Early Marriage:

The participants said that early marriage is quite prevalent in their community.

2. Access of adolescents to SRHR education and services:

There is no dispensary for even common ailments in the area and the people go to Nawab pur (the nearby city) for any health issue. The LHW assigned to their area only visits for polio days and sometimes for antenatal, but no one really avails the antenatal services as everyone is against injections and "heavy medication". They said that they had no awareness about menstruation while growing up, and only came to know abut it when it happened the first time. With regard to their SRHR needs, they said that they reuse the same cloth and underwear every month after washing it. The participants said that access to SRHR is not a priority on their agenda, as the "troubles we face are more real". They said that the females do not even have access to toilets and have to go to the fields: "We do not eat or drink water at night so that we do not have to go at night. This is because we are not allowed to step out alone and if its night time then even our mothers cannot go with us. In the daytime, we go in groups. The new houses that have been built after the floods have a bathroom inside the house but all the family members have to use that and not every family has been given the new house". The average number of siblings reported per participant was 10-12. They said that family planning was not practised, as the philosophy was to have as many as possible, thus leading to more "earning hands": "It is God's responsibility to feed them so if he brings someone into this world why should we interfere in his ways?" The local dai, whose mother was also a dai is the one everyone goes to for delivery. The hospital/clinic/health facility in the city (Nawabpur) is only visited when she says that there is a complication. About half the participants quoted that they knew of close female relatives having died due to childbirth related issues.

3. Eve Teasing:

The girls said that eve teasing was not an issue in their community, as the girls never leave the house without a parent/guardian. They are all at home during

the day as the men in the community go to earn while the females take care of the household chores.
General Comments: The community was unable to recall any activity regarding Parwan. They shared that they had attended a drama long ago but that was a folk story arranged by a CSO and not any Parwan seminar. None of the girls had ever been to school and none of them knew their age. A community NGO school is present but the girls in the community do not attend it. The participants said that when they were young there had been no school and now it is too late for them to join. The participants also shared that they did not have ID cards, but the new generation was being registered at birth. This community had been uprooted by last year's flood and was living in temporary housing (tents). They had been provided housing, hand pumps, latrines, and soaps by an NGO. The average household income (as stated by the participants for their own families) is about PKR 80 (less than 1 US $) per day.

FGD 2:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: KWS Office; 25th Oct, 2013

Time: 1200pm

Target group: Unmarried Girls

No. of participants: 10

Description of the community: Semi Urban, Quetta

Summary of Discussion:

1. Early Marriage

This group of unmarried girls stated that early marriage was quite common in their community. The participants shared that they were all against this traditional practice, and condemned it strongly. They said that it was assumed by the elders that just because the girl was physically able to reproduce, she would also be mature to handle the ins and outs of a marriage. The group explained that even though they were going to school and college, their own parents wanted them to be married off as soon as possible so that they could be "rid" of their "burden and duty": "They are afraid because of the volatile situation of security, and also it is considered shameful for a man to keep his unmarried daughter at home. Education does delay the inevitable for a while but the hunt for a suitable match is always on". The girls said that while their mothers were not very keen to marry them off too early, it was the male guardians, i.e. fathers, brothers, and even uncles that were creating the pressure to marry them off. The more the number of daughters/sisters to marry off, the more they were in a hurry to start off the process.

Another aspect of the issue is honour killing, which they said happens when the girl is caught. They shared that it is becomingly increasingly common for girls to be ensnared by boys, who then abandon them after elopement. The girl is neither able to live with the man as his lawfully wedded wife nor is she able to return to her house as that would mean instant death at the hands of the male guardians. They suggested that it is important for the girls to be made aware about this issue and to "show them the true reality of life as they are lost in their fantasies".

Yet one more angle to early marriage is "foetus marriage", i.e. a version of watta satta wherein it is decided during pregnancy that if a girl is born she will be "given" to so-and-so's son in marriage and if a boy is born he will be pledged to this or that relative. This was reported to be quite common in the community. A further "twist" to this already grotesque custom is that if a grown up daughter is "given" to a relative they are asked in turn to produce two girls in return to be "given" in marriage to the family that gave their grown up daughter (considered a more valuable asset than a young pre-

adolescent girls, hence the balance is created by giving two pre-adolescent girls in lieu of one adolescent girl). One of the participants shared that her family had this tradition. Another said that she had been engaged in a formal ceremony at the age of four years and was still engaged eleven years on; the marriage is to take place in a couple of years.

A common problem reported by the participants is that there is usually no consideration for the age difference between a couple when the adults decide upon a marriage. It is quite common for a grown man to be married off to a very young girl, only because the bride's parents think that the groom is financially settled, which is a criterion that apparently takes over every other consideration of mental or physical compatibility. One of the participants shared that her brother-in-law (also her cousin) still remembers the day his wife (her sister) was born, as the age difference between them is so huge.

The usual bride-price ("walwar) as quoted by the group to be present in their community is 300,000-400,000 PKR (3000-4000 US$), while that of dowry ("jahez") is less.

According to this group, the ideal age of marriage is 25 years, and anything below 23 years should not be allowed. They said all girls should be able to pursue their Bachelors (BA) degree as the least qualification, after which they can be married off. This course is usually done by the age of 23 years. They also opined that the ideal number of children to be borne should vary from woman to woman, depending upon her physical health and financial resources of the family.

The girls shared that if they were to raise their voice against early marriage or marriage of their own free choice, they would be labelled as "fast" and "shameless", and the adults would blame such "scandalous thoughts" on their education. Therefore, if the subject ever comes up within the family, they have no option but to play along with whatever is decided by the adults. The group shared that they were happy that at least they were being educated, as their own parents had never been to school.

2. Access of adolescents to SRHR education and services:

The participants were aware that a woman's health is compromised due to early marriage but could not name any particular medical condition or particular problem that results in maternal death. Being unmarried girls, they are usually kept away from such details by their mothers. They were all able to name a close relative who had died in childbirth. They said if such a death happens in the community (and it often does), they are only told "she passed away because she was sick". It is only through their own "sources" that they

find out that it was childbirth related causes that resulted in the death. The girls suggested that instead of brushing the issue under the carpet they should actually be taught about the intricacies of pregnancy, the danger signs and the risks, so that they could face these problems with knowledge and understanding.

The average family size (number of siblings) of the participants in this group was 7 (ranging from 2-11 siblings per participant).

Regarding their current knowledge about SRHR issues they said that they had been exposed to a lecture on menstruation by Always sanitary pads campaign. The participants shared that their mothers had been happy when the girls had told them that they had been to such a school. The group shared that they and other girls attending the lecture had asked the lady doctor a lot of questions to clear their confusions. For instance, "how to deal with menstrual pain", "how to deal with multiple periods in a month", "irregular bleeding", etc. They said that they had not been told any contact number where they could be linked up with a healthcare provider. The group said that they were satisfied with this mode of learning through school, as they were not too comfortable discussing these issues with their mothers. Some of the girls shared that they felt the need to be checked up as they thought they might have some trouble "down there" but had not been taken for such check ups by their family. When probed, 4 of the 8 participants reported serious menstrual issues (swelling in the body and irregular menstruation; bleeding lasting up to none days every month and fainting due to weakness; unbearable pain) which needed to be checked up but they were unable to have this done as their mothers think it is normal for girls to go through this and/or that unmarried girls do not need to visit the doctor regarding these problems as their bodies may be subjected to "strong medicines" which may result in some problem after marriage: "The only time mothers really get worried about our sexual health is if the period is late, they think what is wrong that this has been delayed? Then they read verses from the quran on us and generally pray till the problem is solved on its own in a few days". One of the participants shared that it is common for mothers to beat up their daughters with a broom ("jharoo") to ward off evil spirits in case the menstrual cycle is disturbed.

Regarding internet accessibility, only one participant shared that she had internet at home. However, she was not allowed to use it (lest it pollute her mind) whereas her brothers (even younger) had easy access to it. Three of the nine girls had access to a mobile phone but were only given handsets that could not have access to the internet.

The participants shared that the health visitor in the community does have

iron supplements to share with unmarried anaemic girls but the parents do not allow them to take these as they think their daughters are being given undue medication.

3. Eve Teasing:

All of the participants admitted that they had been subjected to eve teasing: "The boys throw their numbers at us when we go out; sometimes we don't even know how, but we come home to find a mobile number tucked in a slip of paper in our handbag. We should complain about it to our parents but we don't, as otherwise we will not be allowed out of the house and our education will be discontinued. But sometimes we feel it is right to tell on day one of such an incident instead of hiding, as if something big happens then it will seem like it was our fault". The girls shared that they were not comfortable sharing this issue with their mothers, as they (mothers) are either not able to take any practical steps due to lack of authority in the household or the mothers are so strict in their upbringing that the daughters are not on the same wavelength with them.

General Comments:

When asked about the access of the participants to health workers, the girls shared that the LHVs were more present in the community on the polio days but that the local population was not too keen on having their children immunised. They reason for this is the prevalent myth that polio vaccines have a "spermicide" in them which is designed to wipe off the Muslim population as a tool by the West for genocide. This reflects the general level of trust and awareness of the local population.

Another unrelated but important background issue is that of missing persons in Quetta. In this locality, several Baloch families of the participants have been missing for months and years (and assumed dead) due to the current insurgency in the province.

FGD 3:

General information:

Name of the facilitators: Sarah
Place and date of the FGD: Nadrabad Phatak; 4th Oct, 2013
Time: 0100pm
Target group: Unmarried Girls
No. of participants: 9
Description of the community: Urban, Multan

Summary of Discussion:

1. Early Marriage:

The participants said that early marriage is not an issue in their community, more than 90% of the girls get married after the age of twenty years. They said the reason for this is that most of them are school going, which is a deterrent to early marriage.

2. Access of adolescents to SRHR education and services:

The girls said that all mothers should be taught about issues, such as "good touch/bad touch" so that they could keep their children safe by empowering them on this issue. As of now, they said that they do not have any formal access to any information on SRHR, except on menstruation through the Always sanitary pads campaign in their schools. Six out of ten girls had been exposed to such lectures in their respective schools. Eight out of ten participants had originally found out about menstruation through their mothers and the other two through their sisters. They said there was a lot of information, which had not been passed on to them through their mothers and sisters about menstruation, which instead had been explained properly through the Always lady doctor (e.g. how to take care of pain; how to keep clean during this time; not to re-use the same cloth; dealing with skin rashes, etc.). All of the girls said that they used proper sanitary napkins instead of washing and reusing the same rag every time, as now the trend was changing due to more awareness in girls through TV advertisement and discussion with their peers. There were still some myths prevalent amidst the group, e.g. "we should not bathe during menstruation" and "we should not take a pain killer even if it hurts a lot during menstruation".

3. Eve Teasing:

They shared that this is a major issue faced by the girls in the community, as boys try to follow them and throw their mobile numbers to them. If they visit restaurants for celebrating birthdays, boys follow their rickshaws on bikes.

General Comments:

The participants were all school going girls belonging to a minority Christian community. Due to their educational exposure they seemed more aware in general about issues. They shared that they felt unsafe about their daily life since

the recent two suicide bombings on Christians in a church in another city, where one of the participants said more than 20 relatives of hers had died. The girls in this group were very confident, which the researcher attributes in part to their exposure to extracurricular activities in their Church (seminars, dramas, meetings, etc.). They had not attended any Parwan activity in their community.

FGD 4:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: NWO Office; 23rd Oct, 2013

Time: 0330pm

Target group: Unmarried Girls

No. of participants: 10

Description of the community: Urban, Quetta

Summary of Discussion:

1. Early Marriage:

The girls in this group reported that the trend related to early marriage was gradually changing due to education as well as the general mind set and media exposure. The participants themselves were unmarried but they said that only one generation before, their mothers had been married very early. One of them shared that her mother had been wed even before she had her menarche. She also said that her own sisters had gotten married in their early teens, but as she was the last sister "left" so the pressure had eased on her parents to immediately marry her off. Another participant shared that she knew of a child bride who was so young that she was "returned" three days after the marriage to her parents on account of being totally ignorant about a sexual relationship, as she used to start crying every time the husband would approach her. The group said that ethnic Baloch communities are more prone to get their daughters married early as compared to Punjabi/Urdu speaking families settled in their part of the city. The participants shared that one of the key reasons that they themselves were still unmarried at this point in time was a paucity of good proposals, as it was not so easy to find well settled, educated and decent men. They said this suits them just fine, as it gives them a chance to complete their education while their parents are on the hunt for a good proposal for them.

2. Access of adolescents to SRHR education and services:

The girls shared that they had all heard of one or more cases of maternal deaths in their community. They said that they had not heard about them through their mothers as the family members considered it a bad omen to scare young unmarried girls with such hard facts of life. They always find out through their own network of gossip how so-and-so had passed away due to pregnancy related issues.

The participants shared that the media had given much exposure of these issues but no concrete information that was appropriate to their sex or age regarding SRHR issues. They questioned the role of such information, as they believe it only highlights the "bad side" of something but the educational, constructive aspect has been missing.

With regard to their own knowledge on SRHR issues, the participants said they were only aware of menstruation, and that too, because they were a "victim" of this process. All of them reported unpleasant encounters of learning about this phenomenon after their own menarche; I.e. there is no concept of preparing a girl before hand about what to expect, what it entails, and how to prepare for it. One of the girls shared that she had developed an ulcer merely from stress, as she had hidden her menstruation from her family for three months, as she was extremely stressed that she is actually dying of a disease. The group shared that the LHV visits only on polio days, and only the married women on regular days. The unmarried girls are kept away from them as it is considered a taboo for them to be in their company. The participants opined that it is important for girls of their age to be taught about family planning and limiting family size before their marriage so that they can convince their partners as well. They also stated that college girls should also be taught about the harmful effects of smoking and drugs, which were both becoming gradually common amongst female students: "Girls do this for fun and to appear cool. They do it hidden from the adults and have no idea that all this is bad for their health. Even if they do realise it, their need to seem hip takes over so it is important for them to learn to say no to such things". One important aspect that came to light was the prevalence of violence/corporal punishment as a tool used by female teachers on female students: "A teacher hit a student so badly on the breast and another one beat her student so much that her uterus ruptured. The teachers should be taught positive discipline so that the students can study in peace without any damage". It was reported by the group that they did not know of any parental or community involvement in the school system and neither was there NGO worker/trainer who was involved in giving awareness sessions at the school or community levels to the females.

3. Eve Teasing:

It was reportedly quite common in the community. The group requested that information and skills be provided regarding gaining confidence and self esteem so that the girls can handle such situations on their own.

General Comments:

The group had not attended any Parwan activity.

FGD 5:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: Basti Hinjran; 3rd Oct, 2013

Time: 1100am

Target group: Married Women

No. of participants: 12

Description of the community: Rural, Multan

Summary of Discussion:

1. Early Marriage:

The participants said that early marriage is a major issue in their community. The area being rural, the locals are especially more vulnerable to the customs that govern extended families (Baradari system), therefore early marriage is quite common. The women shared that each of them had been a victim of early marriage, and had regretted it because of the adverse effect on their relationships and health. They said that they were not ready for a sexual relationship at that young age, and were too immature to comprehend any aspect of it besides child bearing, i.e. they could not make an emotional bond with the husband and were always considered just vehicles for child bearing. One shared that because of being completely unaware of "what happens on the wedding night" (intercourse) girls would meet their parents and family the next day with much confusion, shame, guilt and pain. The participants were of the viewpoint that early marriage is a major detriment in the quality of the girls' life, as they are bound to extremely back breaking work in the form of doing household chores and trying to please the in-laws at such a young age. "The mother-in-law is always waiting to order the new daughter-in-law. The younger she is, the easier it is to subjugate her. All the relatives get jealous if a husband has a good relationship with the wife, so the husband also stays gruff with the wife and makes no attempt to be nice to her". All the participants agreed that emotional torture and mental breakdowns are a major consequence of early marriage. Some of them said that even after so many years of their marriage they were still afraid of their in-laws and husbands, and cry themselves to sleep at night due to their physical issues and emotional isolation, low self-esteem and sexual intimacy. Regarding the number of children they had borne, the highest was 9, while the average was 4. In addition, 4 women reported that they had had miscarriages or stillbirths. One of them shared that she continued to bleed for three months after her miscarriage. There was no one she could go to for her problem. The participants said that they were very much against marrying off their daughters at an early age (thirteen years). They consider 25 years to be the ideal age of marriage. However, they said that they did not have much say in the household decisions, so this was only a wish. Sometimes, they said, the ground realities were such that there was no other choice than marrying off

girls as soon as they hit puberty. E.g. a woman shared that she had been married very young because her father was a drug addict and the mother was afraid that he would sell her (his daughter) for money. The participants also shared that another cause of early marriage is that the young girls are alone at home while their mothers work in the fields so the fear of them being kidnapped/raped looms large. Therefore, marrying off such girls is considered a safer choice (the earlier the better; the benchmark being onset of puberty). Another reason quoted for early marriage is poverty, so the parents think they should be rid of their "burden" as early as possible. Yet another reason for early marriage of girls is "watta satta", a local custom whereby a set of siblings (brother and sister) is married off to another set of siblings (brother and sister) in order to create a "balance" within families. This is often done at the time of birth of the child, i.e. decided whom the new-born will be pledged to amongst the extended family. One of the participants shared that her marriage had been fixed at the age of 1 year, but she was sent to live with the in-laws when she attained puberty a decade later. When asked about the opinion of the opposite sex regarding early marriage, the participants, the women said that boys wanted to marry in their teens in their community, and would pressure their families to marry them off as soon as possible, because they fantasize about the "good side" of marriage while it's the girls who have to bear the brunt of childbearing and child rearing. Due to being a rural community, there is no pressure on the men to pursue an education and career before settling down, hence the pressure by them to be married off at a young age, to an even younger girl.

2. Access of adolescents to SRHR education and services:

There are no proper services available for antenatal care or safe delivery in the community, not even a dispensary for treating common ailments. There are no regular visits made by health workers to the community, they only visit on polio days. Only local, untrained *dais* are available in the community, who refer a "case" for delivery if it becomes too complicated and the situation is getting out of hand. The "referral" is not to be considered a formal one; it only means that she informs the family that they should take the woman to any other place, as the patient's situation is too complicated. In fact, antenatal care is an abstract concept to the local women, in fact the entire community, as they are too poor to afford private healthcare and not aware about its importance. It does not figure as a priority in their extremely hard lives. Only about half the participants could name a health facility in the main city, otherwise they were unaware of any place to go to for SRHR services. The participants shared that the information regarding puberty changes were given through their friend or older sisters. Most said that they had distant relationships with their mothers, which is why they were hesitant to speak to them about anything bothering them regarding their SRHR issues before

marriage. They were, however, conscious that they had to break this vicious cycle of maintaining a strict relationship with their daughters, and were of the view that they were comfortable in talking about SRHR issues (menstruation only) to their young girls. However, they did feel that they were not qualified enough to pass on proper information and could only share the little that they knew. They felt inadequate to discuss the issue in proper detail. Therefore, they said, they were comfortable with the idea that health workers should give lectures to them. They said that sometimes they were delivered health messages on photocopied pieces of paper through their community volunteer. These messages were on dengue or other communicable diseases.

3. Eve Teasing:

The participants shared that it is a very common issue for their girls, but is always brushed under the carpet because it is a close-knit community and no one wants to blame anyone's son for doing it. This is because customarily it would only result in trouble and slander for the girl who makes the accusation. One woman shared that her daughter had dropped out of school due to eve teasing. Another shared that she had confronted a rickshaw driver who had teased her in the city, which the rest of the participants applauded but also said that they were unable to display such courage.

General Comments:

The participants belonged to an extremely poor community and had been engaged through a partner CSO. They were mostly daily wagers who work in the fields for the local landlord, for an amount of PKR 100 (less than one 1US$) per day. Their workday is more than ten hours per day, in addition to which they have to manage their households as well. The participants were unaware of any Parwan activities in their community. They recalled having attended a drama on some other topic about income support but were not sure whether it was through Parwan or not. (It was later found that some other NGO had arranged a seminar on microfinance through the CSO and it was not on Parwan).

FGD 6:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: NWO Office; 22nd Oct, 2013

Time: 0330pm

Target group: Married Women

No. of participants: 8

Description of the community: Semi Urban, Quetta

Summary of Discussion:

1. Early Marriage:

Half of the total number of participants in the FGD had gotten married in their early teens. One of the women shared that she had gotten married at the age of 14 years and had vowed that she would not repeat history, but had been forced to marry off her daughter at the same age because of the pressure created by her father in law. The group acknowledged that it was not possible for the women in the community to stand up to male relatives. The women said that one factor that does become successful in delaying early marriage is putting girls into school. Education not only opens up the girls' minds, and it creates a positive difference in their lives: "The males were already being educated and there was no change, but since the girls are being put onto school it is leading to a change in behaviour. The group shared that the community they belonged to did not have early marriage as commonly prevalent as before. One of the reasons for this was reported to be the growing "demand" of boys for educated girls.

The participants were of the opinion that 25 years is the ideal age for marriage. They were aware of the various challenges faced by minor girls in managing a household, in-laws, children, and husband, as most of them had been through it themselves or knew close family relatives who had been through the same: "My cousin who was married as a minor still cries every time her baby cries because she just cannot handle him", said one. Another shared her own experience: "When I had my first child I had no idea that I was having a contraction and my labour had begun, as no one had told me anything about what to expect or watch out for. Finally, when my mother in law noticed, she called the "dai" and I was in labour for two days". Yet another woman said that she was so young that she never realised that she was having complications in her pregnancy, and she and her child had a difficult time surviving due to those health issues. One more participant shared that she had had two miscarriages and a complicated pregnancy due to anaemia and early marriage.

Regarding the marriage of girls of their own free will, it was reported that those who elope are actually taking a suicidal step, as it is a one-way street for

them. They can never come back home as they would simply be shot to death, and if they are unhappy (as is mostly the case) in marriage, or are abandoned by the man they ran away with, they have no shelter to turn to. The participants reported that young girls with impressionable minds are often the victims of such situations and they must be taught how not to get into these in the first place.

2. Access of adolescents to SRHR education and services:

The average number of children per participant was 3, while three of the participants had no children despite being married. Of the latter group, one had been practicing family planning out of choice and in agreement with her husband. She convinced her spouse to wait for a year after marriage, and he conveyed their decision to the in-laws. The other participant who did not have children said that she had been trying for two years but was suffering from infertility. She could not financially afford any services or cure for this. The third one had been married for six months and trying to have a baby.

The highest parity in the community to which the group belonged to was amongst the pathans in their area: "The pathan women have no control over their bodies. They are just treated as reproductive machines by their in laws and husbands, and a re in a perpetual cycle of childbirth and pregnancy". One of the participants quoted an example of a Pathan woman she knew of, who had borne twelve children, and had cut the umbilical cord of all of them herself as she had no help during delivery. This was because of the strict purdah (seclusion) her husband made her observe, and since he did not allow her to go to a hospital, she was left with no choice but to deliver her children herself.

Five out of eight of the participants knew someone in their close family circle who had died during pregnancy or childbirth related causes. All of these had had home-based deliveries through the local "dais", and not through any skilled birth attendant. The participants highlighted that whenever there was a case of maternal death, it was termed as "God's will". There was never any attempt to unfold the cause and learn a lesson from it at the community level and spread the learning to the other stakeholders at the grassroots. This resulted in never breaking the vicious cycle of ignorance and death due to preventable causes.

Family planning and contraception were reportedly very low in the community. A participant recalled that her cousin had lost three children during childbirth and her one surviving child was disabled. She was currently pregnant with twins. Her husband had not allowed her to practise contraception, even though the doctor had told him categorically that the

couple's cousin marriage was creating problems in the survival of his children. Another woman shared that her sister-in-law had eighteen children, of which six had survived. She had been told by the doctor to top destroying her health through these repeated pregnancies but she had no choice as she needed to produce a son for the in laws.

They shared that the LHV does visit but only on the polio immunization days. The regular visits for RH and FP are few and far between, and are only focussed towards married women. The unmarried girls are never taken to these women as it is considered taboo and can lead to "disrepute" about why a maiden should be seeking the services of an expert on reproductive health.

All of the participants emphasized the need for unmarried girls to be made aware of issues related to puberty, in particular to menstruation and, later, the importance of health and nutrition during pregnancy and childbirth. They named Always sanitary napkins as a source of information on this subject, which their daughters had been exposed to through their schools. They also shared that the local Girl Guide Association was also giving such lectures where present. They suggested that out of schoolgirls should also be taught about these issues through community workers. They were quite wary of girls getting access to "too much information", and opined that any intervention that takes place in this regard should create a "balance" as well as stay careful about the cultural sensitivities. One of the participants shared that she had found out about menstruation through the Girl Guide lecture in her school. Before this, she had been having her period for the last six months but had hid it from everyone at home, thinking that she probably has a strange, shameful disease. When she found out through the lecture that this is a normal experience for all teenage girls, she finally told her married sister that she "suffered" from this "ailment", who in turn told her to keep it hidden from their mother, as this would put pressure on the mother to marry her off.

3. Eve Teasing:

This was reported to be an everyday issue amongst the community. The participants shared that it does not matter if the girl is standing alone or in a group; or whether fully covered or not, the boys always try to find an excuse to tease or follow them. The girls, in turn, become submissive, which makes the boys more confident. In the rare case that a girl would reproach such boys for harassing them, the situation usually turns against the female for being out of the house in the first place.

General Comments:

The group had not attended any Parwan activity.

FGD 7:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: Razabad Catholic Church; 4th Oct, 2013

Time: 0500pm

Target group: Married Women

No. of participants: 6

Description of the community: Urban, Multan

Summary of Discussion:

1. Early Marriage:

The participants said that the ratio of early marriage in their community was much less than in other parts of the city. They attributed this to the education level as well as the fact that many of the unmarried females were working (as teachers, nurses, health workers, etc.). In their opinion, 25 years is the ideal age of marriage for both males and females.

2. Access of adolescents to SRHR education and services:

The participants said that they had no access to a doctor through the government, Church or any NGO. The LHW would only visit very occasionally, and was usually around on the polio days only. She was not doing her duty regarding SRHR issues for which she had been originally hired. The women said that they had only come to know about menstruation once they had had it, and their mothers/sisters would then explain about it to them. One of the participants said that she had had her period about seven years later than the normal age, but her mother had done nothing about this as she thought it would be scandalous to take an unmarried daughter to the doctor for such issues. However, they said, the new generation is more careful with their daughters and tries to tell them in advance and comfort them with whatever knowledge they have. One of the participants said that she had bought a "trainer bra" for her daughter when she realised that she was growing up. The mothers said that the Always sanitary pad company gives lectures in schools regarding menstruation in class 5. They said that girls even younger than class 5 are now having menarche. One woman shared an interesting anecdote about the general attitudes towards sexuality: "Have you ever noticed how women's undergarments are displayed so openly in the market? And men's underwear is never so openly exhibited. Why? It is because men enjoy it in the market when a woman has to buy undergarments, and they look at her discomfort and shyness and really like it. Otherwise, men always keep their women covered and locked up but they enjoy watching other women buying undergarments in front of them". The participants were all very keen that pre-marriage counselling classes (only for engaged couples) be started in the community. They said that if classes cannot be started at least a specialised book should be developed and sold in the community so that they would

know what to expect after marriage. They said that separate books should be made for both sexes and they should be available only secretly. They said its essential for boys to be taught love and affection for their women, as its common for the bridegrooms in their community to get drunk on their wedding and really violate the girl. The nurse in the FGD said that there were several cases of vaginal tears and violence that were referred to her from within her own community, which she in turn, referred to the hospital.

3. Eve Teasing:

The women shared that eve teasing is really common in the community. They claimed that they teach their sons to respect women but not everyone in the community is so vigilant, hence the existence of this issue. They said that the instances are usually hushed up as it is useless to bring them to the fore.

General Comments:

Arranging this activity was quite challenging due to a lack of coordination at the community CSO level. Eventually, when one participant showed up, she was requested by the researcher and Awaz team member to fetch her other friends (married women) from their households. Because it was evening, only 6 females showed up. The participants said that they had never heard of the Parwan programme or attended any seminar on this issue.

FGD 8:

General information:

Name of the facilitators: Sarah

Place and date of the FGD: HDS Office; 24th Oct, 2013

Time: 0100pm

Target group: Married Women

No. of participants: 8

Description of the community: Urban, Quetta

Summary of Discussion:

1. Early Marriage:

The participants shared that they had gotten married at the age of 12-13 years, as early marriage is quite prevalent in their communities. Their own daughters are mostly above 18 years and not married yet as the trend is now changing. If they find a good proposal for their daughters at an early age, they only do the engagement and wait for the marriage till her education is completed or she is of a more mature age. They numerated the various problems related to early marriage: "girls end up looking after the in-laws and get stuck in a cycle of child bearing". One of the participants shared that her sister had gotten married before puberty, at the age of 10 years, and used to sleep with the mother-in-law till she had her menarche two years later. After this, she was immediately pregnant and her health was compromised for life due to all the children she had to bear. The participants shared that their own lives had been a lesson to them, which is why this change has occurred in them to not let their daughters be subjected to the same issues. They acknowledged that mass media and education have also played a role in creating awareness. It was interesting to note that the women think that at the beginning of their marriage they could not talk to their husbands about these issues but feel more empowered at home now in terms of decision making and expressing their opinion to their husbands: "Its not the husband that is the issue so much as the sons; they want to marry off the sister as early as possible ad act as sorts of gatekeepers for the honour of their sisters. They want to be free of their responsibility as soon as possible". The practice of "bride-price" ("walwar"/"labb") exists in the community, and dowry ("jahez") is also present. The practice of "watta satta", a local custom whereby a set of siblings (brother and sister) is married off to another set of siblings (brother and sister) in order to create a "balance" within families was found to be commonly reported in this community. They also reported something called "foetus marriage", i.e. a version of watta satta wherein it is decided during pregnancy that if a girl is born she will be "given" to so-and-so's son in marriage and if a boy is born he will be pledged to this or that relative. When they grow up, it is oftentimes the boys who say they do not want to marry and the girl has to live with the label of a broken engagement, which makes her vulnerable to society's taunts and diminishes her "marriage value".

2. Access of adolescents to SRHR education and services:

The group explained that there was no access to any proper SRHR service within their community, not only for reproductive health related issues, but also for violence against women. They shared that many women at he community level suffer from domestic violence at the hands of the in-laws, but they have nowhere to go. They also expressed that merely giving a lecture about this issue by NGOs is not enough, as the community is already aware that physical and emotional violence is harmful (according to them, they are living through it so who would know better the detrimental effects of being a victim). The participants were of the opinion that NGOs should either share some services with them or give some concrete advice on how to tackle this issue. They were against the methodology adopted by NGOs in case a victim contacts them. The group complained that mostly such women are only publicised through the media instead of being helped and then they have to live with the stigma throughout their lives, and no rehabilitation. They also shared a few examples from within their community regarding violence against women and "challenged" the CSO/Consultant about what could be done about them. For instance: "A girl we know would get beaten up everyday by her husband and mother-in-law. She came to her mother's house and was kicked out by her father and brother on the pretext that it would bring shame for a married woman to stay at her parents' house. So she has no shelter, no place where she can live with dignity; and "Another girl in our community had her nose cut off by her husband to teach her a lesson. Before that, while she was sleeping, her mother in law cut off her plait to dishonour her. What is she to do?" Regarding services, the participants opined that at least in the past there used to be a jirga (local meeting of elders to decide upon crime) system whereby there was at least some decision-making on such issues. Now such jirgas do not take place and the normal judicial and criminal system are so full of delays and lacunas that in the end the victim gets no help, they said.

With regard to access to services on reproductive health, the group shared that they had no access to family planning. The average number of children per participant in the FGD group was 6 (ranging from 4-8). Regarding the number of miscarriages that the women had suffered themselves, it was reported by four of the eight participants that they had suffered at least one miscarriage. In fact, one of these women had had six miscarriages (and five children) and one had had three. The former had had no access to a hospital during any of these episodes. While these women had not had deaths of their neonates, they did report close female relatives (daughter/daughter-in-law) whose babies had expired shortly after birth due to unknown/"genetic" factors. Needless to state, they did not have access to affordable, quality

healthcare due to poverty, lack of access, and lack of priority.

The women also shared that they were in favour of family planning, especially for their daughters and daughters-in-law as the new generation could still save itself from all the trouble they had been through due to their high parity. However, they said, their husbands, sons, and sons-in-law were the deterring factor in this regard, as the males did not want to use FP methods.

The group also discussed that they were willing for their daughters to be trained on menstrual issues. Two of the eight participants said that their daughters had been briefed about this through the Always campaign in their respective schools. They had been given pads and told about the importance of wearing underwear and general vaginal hygiene. They suggested that those who do not go to school should be told about these issues through a community worker. They were also willing that their daughters be taught about Family Planning and "how babies are born" (health and nutrition in pregnancy) but not about "how babies are made" i.e. the sexual relationship between men and women, or the puberty changes in boys. The group said that they wanted to prepare the daughters to "be well prepared to handle the emotional and psycho-social aspects of their marriage and also that they should be able to cope with and prepare for the stresses to the body during pregnancy, childbirth, breast feeding, etc.

3. Eve Teasing:

The participants said that eve teasing is mostly a girl's fault, as boys would not follow her around if she were "shareef", i.e. shy and morally not corrupt. According to them, it is actually the girls who encourage the boys. They also shared that the limited numbers of girls in their community who do go to school do not share such instances with their mothers, as they know it would only result in their own education being stopped. They also advised that mothers should "raise their daughters properly" so as they do not succumb to "errant behaviour". They advised the mothers in general to have a relationship of trust and friendliness with their daughters. When asked by the Consultant whether they had ever thought of teaching their sons about this issue, they expressed surprise at the novelty of the idea. After some pondering, they all seemed to agree that it is important for boys to be taught the respect for the opposite sex from an early age, and that they had not actively thought about this aspect of it before today. They shared that they had been so busy and preoccupied throughout their lives in "bearing, feeding, and rearing" their children that "raising them right" had somehow not been a priority even if they had wanted to do so, because of the perpetual cycle of pregnancy and childbirth they had been involved in.

General Comments:

It was very informative talking to this group because they had been through the various SRHR related situations themselves during their lifetimes and could actually relate the community problems quite well, thus giving a unique snapshot into the real issues at the grassroots level. This group had attended a couple of sessions of Parwan, conducted through the CSO on domestic violence and harmful traditional practices.

FGD 9:

General information:

Name of the facilitators: Salman + Absar

Place and date of the FGD: Basti Shah Hussain; 3rd Oct, 2013

Time: 0300pm

Target group: Unmarried Boys

No. of participants: 10

Description of the community: Rural, Multan

Summary of Discussion:

1. Early Marriage:

This was reported to be an issue in the community that the participants belonged to. Most of the boys were aware that girls could face health issues if married young. Nonetheless they stated that the ideal age for their marriage is 16-18 years. They were in favour of marrying off girls early if there is a good proposal available.

2. Access of adolescents to SRHR education and services:

The boys had limited factual knowledge on SRHR through any proper programme. On the other hand they had exposure to age inappropriate and sexually explicit material. The group shared that they had access to pornography easily, and it was not an issue obtaining CDs and mobile cards that gave them access to the internet, where opening one site led to another. There were no parental checks or restriction of movement on their gender, so they could purchase anything that money can buy. They shared that girls who have boyfriends have access to Internet through their beloved as they secretly buy mobiles etc. for their girlfriends otherwise there are restrictions on females to purchase such things.

The participants said that they had not been told about STIs or any other sexual related problems through any adult caregiver. They had only heard of HIV and hepatitis through friends, and that too, to the extent of knowing the names of this disease.

3. Eve Teasing:

They claimed that it was all right to tease those girls who themselves appeared to be interested; otherwise the girls should be left alone. They shared that those boys who were involved in eve teasing were actually "sexually depraved and deprived" otherwise "normal boys" do not tease girls. The group shared that those girls who were out of the house to go to their jobs were serious minded so they should not be approached but those who were out there just for fun are approachable.

General Comments:

The participants said that they had heard of the Parwan programme.

FGD 10:

General information:

Name of the facilitators: Sakim + Asif

Place and date of the FGD: AIDB Office; 24th Oct, 2013

Time: 0330pm

Target group: Unmarried Boys

No. of participants: 8

Description of the community: Semi Urban, Quetta

Summary of Discussion:

1. Early Marriage:

The participants shared that early marriage was quite common amongst the Pashtun families in their community, where girls as young as twelve years old were married off as a matter of routine. It was also not unheard of to marry off a 15 year old to an 80 year old man. Education of families and girls does seem to create a dent in such customs but the change is slow and far between. The group shared that the general idea in their community was that it is a personal matter of when to marry of someone and no interference is tolerated by any outsider. In fact, due to the strict traditions of considering women as personal property, no one really wants to intercede in anyone else's business and neither do they consider such practices wrong due to the deeply ingrained cultural context. They also said that ideally girls and boys should be married at the age of 25 years. They were vaguely aware of the complications arising out of early age pregnancy. However, they did not know them in the right context. For instance: "The disadvantage of early age marriage is that it results in overflow of blood after pregnancy. Due to this the husband loses interest in the wife and this results in polygamy". Another disadvantage of early marriage, according to them was that the "offspring are born crippled". They agreed that it was the young generation that could put a stop to such practices by saying no to their elders.

2. Access of adolescents to SRHR education and services:

The boys shared that there was no realisation in the majority of the men in general that creating a healthy relationship is the responsibility of both men and women. Mostly, the child rearing is believed to be a woman's duty and maintaining peace at home amongst in laws and making sacrifices is also considered only a woman's responsibility.

3. Eve Teasing:

No discussionon this topic could take place due to shortage of time.

General Comments:

The group said that they had heard of the name Parwan.

FGD 11:

General information:

Name of the facilitators: Salman + Absar

Place and date of the FGD: Pul Monday Wala; 4th Oct, 2013

Time: 0400pm

Target group: Unmarried Boys

No. of participants: 12

Description of the community: Urban, Multan

Summary of Discussion:

1. Early Marriage:

This was reported to be a common issue in the city. The participants were of the opinion that the ideal age of marriage of girls should be between 16-18 years. They all agreed that early pregnancy is detrimental to the health of both the mother and the baby. They stated that they were against the early marriage of girls, but were also of the belief that it is fate when one will be married so if it is preordained that a girl has to get married at a certain age and have a certain number of children, no one can really do anything about it.

2. Access of adolescents to SRHR education and services:

The group shared that they had heard of HIV and hepatitis through their friends. They said that they had access to x-rated CDs and movies very easily, and it was common for them to watch it.

3. Eve Teasing:

The participants said that girls should not be teased unnecessarily but those that are "willing" should be taught a lesson by being followed around as they make themselves available to boys.

General Comments:

The group said that they had heard of Parwan.

FGD 12:

General information:

Name of the facilitators: Sakim + Asif

Place and date of the FGD: KIND Office; 23rd Oct, 2013

Time: 0100pm

Target group: Unmarried Boys

No. of participants: 9

Description of the community: Urban, Quetta

Summary of Discussion:

1. Early Marriage:

The group shared that early marriage is an issue in their community. They recalled three recent cases of such marriages and shared that no one could do anything to prevent them even if they had wanted to as it is considered a private matter. They said that it was actually the men and boys who wanted young wives that is why there was a pressure to marry off the young girls. They thought that the girls in the community are against the idea of being married off at an early age as they get into child bearing due to it. They feel that it is up to the current young generation (themselves included) who should put an end to such customs. However, they were of the opinion that they are not able to do so due to lack of proper training, skills, or authority. The group shared that it is actually the adults who control the society so it is not really possible to change their viewpoint unless some solid programme is undertaken.

2. Access of adolescents to SRHR education and services:

The participants stated that it was important to have the correct information on age appropriate sexuality. However, they had not had access to any such information. They think that TV, books, NGOs and proper religious guidance can help them have access to SRHR matters.

3. Eve Teasing:

They shared the view that eve teasing is against the religious context of respect of women. However, they said, that many young boys indulge in it because they "like it".

General Comments:

The group said they had not heard of Parwan programme.

FGD 13:

General information:

Name of the facilitators: Salman + Absar

Place and date of the FGD: Basti Nawab Pur; 3rd Oct, 2013

Time: 0500pm

Target group: Married Men

No. of participants: 10

Description of the community: Rural, Multan

Summary of Discussion:

1. Early Marriage:

This issue was not discussed due to lack of time.

2. Access of adolescents to SRHR education and services:

The group stated that it is important for young boys to learn about SRHR issues, as they believe that many marriages break up due to such problems. The current sources of information in the community are quacks or prayer leaders. They said that boys had no problem accessing pornography, as it was easily available and that the youngsters watch such material for sexual gratification. They also attributed a recent case of the rape of a five-year-old girl that was in the media as being the result of pornographic viewing by the perpetrator: "People get frustrated when they watch such stuff and then they do not even spare minors". The group shared that they did not talk to their own sons about such issues, but it is important for their offspring to be aware so there should be some information available. They feel that those parents who are educated are better able to approach such topics with their children. On the other hand, there was also the fear expressed by the participants that teaching such issues will expose the adolescents instead of keeping them innocent, and this would lead to more chaos than before: "When something is hidden then you don't know about it. When you open it up then the pandora's box opens". They were also against the use of the word "sex" in sexual education, as they feel it immediately turns everyone against the organizer as being a part of "western agenda". They feel that the words used in the community should be more locally acceptable and adapted properly.

3. Eve Teasing:

This issue was not discussed due to lack of time.

General Comments:

The particpants were not aware of Parwan programme.

FGD 14:

General information:

Name of the facilitators: Asif

Place and date of the FGD: MRDS Office, 22nd Oct, 2013

Time: 1000am

Target group: Married Men

No. of participants: 8

Description of the community: Semi Urban, Quetta

Summary of Discussion:

1. Early Marriage:

The group shared that early marriage is a common practice, and girls as young as 12 years old are being married off on a routine basis. They said that there are no steps taken by anyone in this regard to either advocate against this issue or stop it when it is happening. Some of the participants shared that they thought that the ideal age of marriage is 25 years, while legally any marriage under the age of 16 years is illegal. They were not clearly aware of the consequences on the family unit if a girl is married off early.

2. Access of adolescents to SRHR education and services:

They said that they did not have much information on the subject.

3. Eve Teasing:

They stated that this issue exists but there is not much to do about it as boys will be boys and a certain age comes when one cannot do anything to control them.

General Comments:

The participants could not name any Parwan activity.

FGD 15:

General information: *Name of the facilitators: Salman + Absar* *Place and date of the FGD: Dera Adda; 4th Oct, 2013* *Time: 0300pm* *Target group: Married Men* *No. of participants: 12* *Description of the community: Urban, Multan*
Summary of Discussion: 1. Early Marriage: 2. Access of adolescents to SRHR education and services: 3. Eve Teasing:
General Comments:

FGD 16:

General information:

Name of the facilitators: Sakim + Asif

Place and date of the FGD: HDS Office; 24th Oct, 2013

Time: 0130pm

No. of participants: 12

Target group: Married Men

Description of the community: Urban, Quetta

Summary of Discussion:

1. Early Marriage:

The participants shared that such marriages take place in the community. One of the participants shared the example of a 70-year-old man bing married to an 18-year-old girl. They said that young, educated people do not like such practices, but this was still quite common in the rural and semi urban communities due to lack of education. The group opined that the ideal age of marriage for males is 25 years and for girls it is 20 years. The participants expressed that early age marriages can result in poor health of the mother and child. They pointed out that it is the religious leaders who should and can put a stop to this issue, but actually it is they who condone it instead of condemning it. They also shared that religion is only a convenient excuse for any parents to marry off their daughters, whereas the true cause is economy. Whenever they find a good match they marry off the daughter without batting an eyelid, no matter how young she is or how old the man is, as this helps them be rid of a potential burden. In Balochistan, it is common for bride price ("walwar/labb") to be paid, and the younger the girl, the higher the amount paid to the parents: "In other words, one party buys the daughter-in-law, and the other sells their daughter for the best possible price".

2. Access of adolescents to SRHR education and services:

This issue could not be discussed due to lack of time.

3. Eve Teasing:

This issue could not be discussed due to lack of time.

General Comments:

The participants had not heard of Parwan programme.

Annex 5: Country Specific Result Chain
(As Taken from the Appendix Available in Baseline Study)

Appendix 1
Country result chain, highlighting the indicators that are relevant for baseline measurement

Result area	Indicator	Include in Baseline Y/N	Monitoring: Yearly/from 2013 onwards	Specific Remarks
EDUCATION	**Outcome 2.1** **Increased capacity of young people (boys & girls, 13-17 years) to make safe and informed decisions on SRHR issues**	Y	2013	KAP is used during baseline and monitoring. Additional refined tools will be developed for in-depth monitoring
	Output indicator 2.1.2a **# of educators who participated in training to deliver comprehensive sexuality education**	N	Yearly	Assess capacity (training needs) of teachers
	Output indicator 2.1.2b **# of educators with improved knowledge to deliver comprehensive sexuality education**	N	Yearly	Pre-post test during training
	Output indicator 2.1.3a **# of young people who participated in formal comprehensive sexuality education**	N	Yearly	
	Output indicator 2.1.1a	N	Yearly	Inventory of existing

	2 SRHR education programmes improved on quality standards of effective comprehensive sexuality education			CSE programs in schools in project area Assess the quality of the above identified CSE programs

Result area	Indicator	Include in Baseline Y/N	Monitoring: Yearly/from 2013 onwards	Specific Remarks
SERVICES	**Output indicator 2.2.1a** **# of service providers who participated in training to deliver YF-SRH services**	N	Yearly	Mapping available services, and quality
	2.3b# women accessing existing SGBV services	Y	Yearly	
	Output Indicator 2.3.1 **# of NGOs with strengthened linkages with SRHR and SGBV referral services**	Y	Yearly	Mapping existing SRH and SGBV services
	Outcome indicator 2.2a **% of targeted services increasingly comply with IPPF standards for youth friendly services**	Y	2013	IPPF standards
	Outcome indicator 2.3a **% increase in the use of targeted SRH services by young people**	Y	2013 onwards	Service statistics
	Output indicator 2.2.1a **# of service providers who participated in training to deliver YF-SRH services**	N	Yearly	Assessment training needs
	Output indicator 2.2.1b **# trained health service providers with improved knowledge on YF-SRH services**	N	Yearly	Pre-post test during training
	Outcome indicator 2.2b **# of young people in targeted areas satisfied with YF-SRH services is increased with %**	Y	2013 Onwards	

Result area	Indicator	Include in Baseline Y/N	Monitoring: Yearly/from 2013 onwards	Specific Remarks
ENABLING ENVIRONMENT	**Output indicator 2.4.1a** **4 partner organizations with an implemented advocacy strategy and advovacy work plan on SRHR**	N	Yearly	OCA / advocacy
	Output indicator 2.4.1b **4 partner organizations with an implemented advocacy strategy and advovacy work plan on SGBV**	N	Yearly	OCA / advocacy
	Output indicator 2.4.2a **X community members and community leaders participating SRHR awareness raising activities at community level**	N	Yearly	
	Output indicator 2.4.2b **X community members and community leaders participating SGBV awareness raising activities at community level**	N	Yearly	
	Outcome 2.4a **X number of SRHR policies and legislation implemented, changed, or adopted at district, provincial or national level**	N	2013 onwards	Inventory Assessment existing policies, legislation
	Outcome 2.4b **X number of SGBV policies and legislation**	N	2013 onwards	Inventory Assessment existing policies,

Result area	Indicator	Include in Baseline Y/N	Monitoring: Yearly/from 2013 onwards	Specific Remarks
	implemented, changed, or adopted at district, provincial, or national level			legislation
	Outcome indicator 2.4c **Increased involvement of community leaders in realisation of SRHR in x % of the targeted communities**	Y	2013 onwards	In baseline, but only start after start of program implementation in selected project areas
	Outcome indicator 2.4d **Increased involvement of community leaders in realisation of SGBV in x % of the targeted communities**	Y	2013 onwards	In baseline, but only start after start of program implementation in selected project areas
	Outcome indicator 2.4e **Increased acceptance of SRHR at community level in x % of the targeted communities**	Y	2013 onwards	
	Outcome indicator 2.4f **Improved attitude towards SGBV at community level in x % of the targeted communities**	Y	2013 onwards	

Result area	Indicator	Include in Baseline Y/N	Monitoring: Yearly/from 2013 onwards	Specific Remarks
Civil Society	**Output Indicator 1.1.1a** **PO's are actively involved in x relevant networks and SRHR and SGBV initiatives**	Y	Yearly	All 4 partners, incl Rutgers WPF Pakistan
	Output Indicator 1.1.2a **x NGO staff members participating in training to increase their knowledge and skills on SRHR, based on identified needs.**	N	Yearly	OCA to assess training needs in SRHR
	Output Indicator 1.1.3a **X Nr. of NGO staff members participating in training on SGBV**	N		OCA light to assess training needs in SGBV
	Outcome Indicator 1.1a **% of the NGOs initiating individual or joint interventions on SGBV**	N	2013 onwards	
	Outcome Indicator 1.1.b **% of the NGOs initiating individual or joint activities on SRHR**	N	2013 onwards	