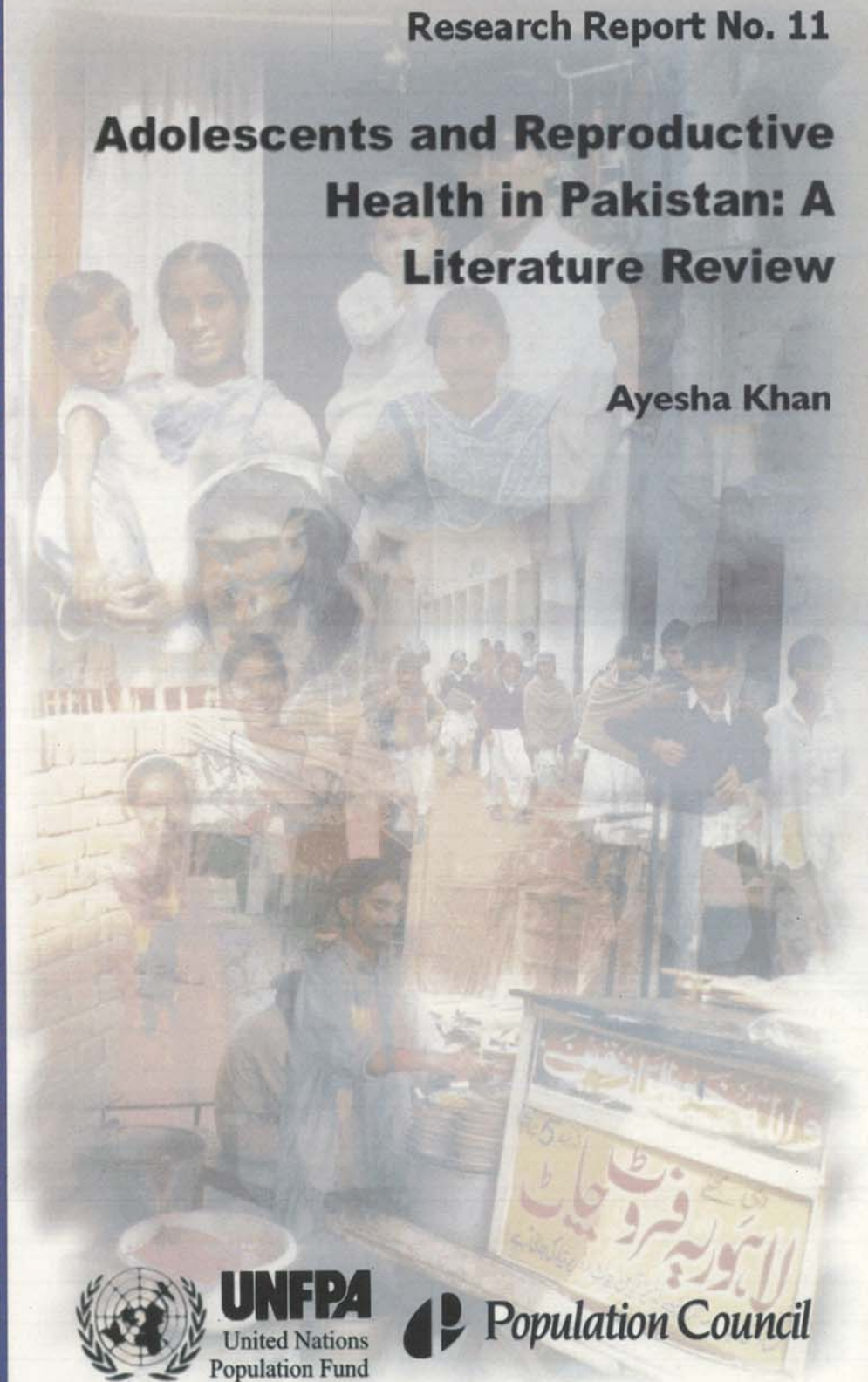
Research Report No. 11

Adolescents and Reproductive Health in Pakistan: A Literature Review

Ayesha Khan



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Population Council

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FINAL REPORT

ADOLESCENTS AND REPRODUCTIVE HEALTH IN PAKISTAN: A LITERATURE REVIEW

Ayesha Khan

June 2000

Population Council

Population Council, a nonprofit, nongovernmental research organization established in 1952, seeks to improve the wellbeing and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources.

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EXECUTIVE SUMMARY

This report is a review of research and findings on adolescents and reproductive health in Pakistan. The material is drawn from a range of national surveys and medical research, as well as information gathered by nongovernmental organizations, with an effort to cover a broad range of subjects within the reproductive health area. Although adolescents make up a quarter of the population of Pakistan, they are still a new subject for research, and work in Pakistan remains at a preliminary stage.

The characterization of adolescents for the purpose of this review is those individuals ages 10-19, whether or not they are married, sexually active, or parents. The discussion of the research material is based on the assumption that adolescence is a developmental phase, a transition from childhood to adulthood, a period best used for capability-building and not for carrying burdens for which young people are not fully equipped, such as marriage, work, and childrearing. (Mensch et al. 1998) Basic data on education, employment, and reproductive health among adolescents shows that they are not receiving the adequate schooling and capability building to equip them for the future.

Research shows that there are clear gender differentials in access to health care. Upon entering puberty, adolescent girls face more difficulty in accessing health care than adolescent boys. (Ahmed 1990) Limitations on female mobility particularly affected younger women under age 25 studied in rural Punjab, even if they were married. (Kazi and Sathar 1997) Unmarried girls in that province faced the most restrictions on their overall mobility, including access to health services, due to social norms enforcing segregation between the sexes as a means of preserving a girl's chastity, or honor. (Khan 1998)

Anemia is the most prevalent micronutrient problem in Pakistan. The National Nutrition Survey of Pakistan found that anemia affected over 35 percent of adolescent married women (ages 15-19), and the problem increased with age. (Nutrition Division 1988) Anemia is also a common problem among boys (Agha et al. 1992); it is most prevalent among the age group 5-14 and decreases until ages 25-44, after which levels rise again. (Nutrition Division 1988) The problem of under-nutrition has not improved in recent decades; most affected are infants and young children, along with pregnant/lactating mothers. (Kazi and Qurashi 1998)

Sexuality among adolescents is little researched, primarily due to taboos restricting open discussion of sexuality in general. Legal controls, such as the 1979 Hudood Ordinances and customary practices, such as *karo kari* in Sindh, make sex outside of marriage punishable by death. Studies of male sexual awareness and behavior show that young men are particularly anxious about masturbation and homosexuality. (Qidwai 1996; Aangan 1998) Men acknowledge their lack of

information on reproductive health issues and have expressed a need for more information. (Raoof Ali 1999; Aahung 1999)

Female sexuality is tightly controlled, and this is expressed most severely in restrictions placed on unmarried girls. (Khan 1998) A Peshawar study of 300 high school students, ages 14-16, found that 88 percent felt that sex education in schools is inadequate, although they themselves were shy about discussing topics related to sex. The formal curriculum includes some population education but does not include sex education, although adolescents express an interest in more information. At present, adolescents rely on informal sources for their knowledge. (Qidwai 1996; Aahung 1999) Girls seem to rely on female relatives for information about sex and menstruation. (Mumtaz and Rauf 1996). The Family Planning Association of Pakistan has taken the lead in spreading reproductive health education among Pakistan's youth, while the Karachi Reproductive Health Project is one of the only programs in place where sexuality is a topic of discussion.

Existing research demonstrates that adolescent sexual exploitation may be a widespread social problem in Pakistan. (Sahil 1998) Male child prostitution exists in Northern Punjab, while *bachabazi*, the practice of older men keeping boys for sexual favors, is common in the North West Frontier Province. (NGO Coalition on Child Rights 1998) The trafficking of women and girls within the region includes adolescents and is a lucrative business. (LHRLA 1996) Small surveys of local prostitutes reveal that many begin the profession while in their adolescence. (SOCH n.d.)

In the last few years, the problem of child and adolescent sexual abuse has begun to be monitored and publicized by nongovernmenal organizations. In 1997, newspapers reported one child's rape/sexual abuse per day. (Sahil n.d.) According to Sahil, an organization working exclusively on this problem, females are more vulnerable than males on every count of abuse, with the most vulnerable age group being 10-18. Boys age 15-18 are most often targets of sexual abuse, pointing to a worrying lack of protection for adolescents. (Sahil 1997, 1998, and n.d.) Incest is a particularly under-reported form of sexual abuse possibly because it involves family members. (WAR 1998) Pornography has been linked to the sexual abuse of young boys in particular, and subsequent exploitation of them for prostitution. (Sahil 1998)

While laws exist to partially protect children from sexual exploitation, no law exists to specifically prohibit child sexual abuse. (Fayyazuddin et al. 1998; Jillani 1989) At the policy level, concrete action has not yet been taken to combat child trafficking and sexual abuse, despite intentions stated by the National Commission for Child Welfare and Development. (Ministry of Women Development 1997)

The threat of an HIV/AIDS pandemic has prompted some research into high-risk sexual behavior. Pakistani children and adolescents are exposed to all of the risks associated with HIV/AIDS, including the risk of infection, as well as the vulnerability to losing a parent to the disease. (Ahmed 1998) Adolescents do figure

in statistics of high-risk behaviors, as shown particularly in studies of truck drivers (Ahmed et al. 1995), commercial sex workers (Baqi et al. 1998; SOCH n.d.; Manzoor et al. 1995), male prisoners in Sindh (Khan et al. 1995), and juvenile prisoners (Fayyazuddin et al. 1998). To date there is little evidence that the spread of sexually transmitted diseases is growing among Pakistani adolescents, while some believe there is an increase internationally. (Mensch et al. 1998) However, a low level of awareness and information regarding AIDS prevails in Pakistan. (Hyder and Khan 1998) Policies and programs supported by the government continue to resist programs aimed at widespread raising of awareness (Khawaja et al. 1997), although the Ministry of Health's National AIDS Programme has recently begun a series of short spots for television on AIDS. The small nongovernmental sector has launched a series of community-level campaigns during the last decade.

Informal assessments conclude that the practice of induced abortion is widespread in Pakistan. Community level studies show a prevalence of around 11 percent among their respective samples of married women in Karachi communities, and women presenting at tertiary care facilities. (Fikree et al. 1996) The reasons why women seek induced abortions include contraceptive failure or an unwilling husband, which explains why younger women are also seeking this option. (Saleem 1998; Fikree et al. 1996) Studies show a small but potentially significant adolescent component to the problem. (Tayyab and Samad 1996; Rana 1992) Laws and policies make the option of safe abortion very difficult. Hospital-based studies show that women often require medical care from abortion-related complications. Presumably adolescent girls will have the most obstacles to overcome in accessing the limited services available.

The average age at marriage is increasing in Pakistan, 26.5 for men and 22 for women. Nonetheless, 17 percent of adolescent girls are currently married (Hakim et al. 1998) and over half of women ages 20-24 surveyed in the 1995-96 Pakistan Integrated Household Survey said they were married before the age of 20. (Durrant 1999) Preliminary qualitative research in the Punjab reveals that the ideal age at marriage expressed by girls is between ages 20-25. (Population Council 1999) Low female status and little decision-making power among younger women suggests that those who marry young may not be doing so out of their own choice and that preparation for married life is likely to be inadequate.

Within an overall context of high maternal mortality and morbidity, adolescents are at particular risk. Infant mortality is strongly linked with mother's age at first birth. (NIPS/IRD 1992) Hospital and clinic-based research shows that adolescents make up as much as 10 percent of maternal deaths. (Jafarey n.d.; Ashraf 1996; Jafarey and Korejo 1995) Reasons for delay in reaching a hospital in time are both social and economic and thus may limit adolescents most severely. (Jafarey and Korejo 1993)

Married adolescent girls ages 15-19, surveyed in the Pakistan Contraceptive Prevalence Survey 1994-95, show a high knowledge of at least one contraceptive

method, but a low (5 percent) ever-use rate. The unmet need level is 22 percent. (Population Council et al. 1998) Since those girls who are married as adolescents are more likely to be rural-based and uneducated, it also follows that their contraceptive use rate is likely to be low. Further, the adolescent fertility rate is also negligible. (PIHS 1998) This suggests that the motivation to have children is high among this age group, not only to prove fertility but also out of a simple desire for offspring.

In conclusion, the research shows that adolescents, due to their relative youth, lack of decision-making power, and incomplete personal development, are especially ill equipped to handle the reproductive health burden they face. Policies and programs, as well as legal provisions, do not protect adolescents; policies and programs need to be especially designed to meet the needs of adolescents without disrupting their development into adults. Programs and policies need to protect adolescents from the specific biases they face that undermine their health, safety, and secure development. At the government level, existing education, population, health, and information infrastructures should be used to address the reproductive health needs of adolescents. At the nongovernmental level, where organizations have outreach to the young but do not address these needs, they should be encouraged to introduce relevant programs into their work or to strengthen their existing small-scale efforts.

I. INTRODUCTION

Today the world is home to the largest generation of 10-19 year olds in history; they number over one billion and are increasing. At the same time there are wrenching changes due to increased urbanization and industrialization, as well as the revolution in modern communications and information technology. (Alan Guttmacher 1998) The demands on young people are new and unprecedented; their parents could not have predicted many of the pressures they face. How we help adolescents meet these demands and equip them with the kind of education, skills, and outlook they will need in a changing environment will depend on how well we understand their world.

In Pakistan, as throughout the world, adolescents are a new category for researchers, policymakers, and even the public's consciousness. With a view to developing new strategies for addressing adolescents' needs, UNFPA began the groundwork by commissioning reports focussing on the adolescent girl and identifying the reproductive health issues she faces in the current social, legal, and economic environment. (Rafiq 1996; UNFPA 1998a) Continuing this process, this paper provides the first comprehensive literature review bringing together the full range of existing research on adolescents and reproductive health in Pakistan. The material discussed is diverse and acquired from a wide range of sources. The exercise is essential, however, in helping us understand adolescents and their particular needs.

Current policies and programs that affect young people do not directly address their reproductive health needs. However, these needs are valid and urgent, as the research discussed below will demonstrate. In future, policy and program responses based on appropriate understanding will be vital to meeting the health and development requirements of young people in Pakistan and helping them to build a successful future.

Characterizing Adolescence

The first step toward deepening our understanding is to clarify the concept of adolescence. There is no universal method for doing so, and in Pakistan policies and programs affecting young people are bound to be affected by a lack of consistency. For example, UNFPA terms "youth" as all those people between ages 15-24; below this age young people are categorized as "children." However, the government of Pakistan defines "child" as up to age 14, although for specific sexual crimes the criteria to determine adulthood is the onset of puberty. UNICEF, meanwhile, holds that a "child" is someone between ages 5-19. Now that the close of this century brings with it a new sensitivity and understanding of the needs of those people who are neither child nor adult, but struggling to negotiate the years that fall between, efforts have begun within organizations and research bodies to categorize this age group separately.

For international research and statistical purposes, ages 10-19 are used to identify adolescents. Traditionally, the term "adolescence" has been used to identify the transition from childhood to adulthood, encompassing the interval between puberty and marriage. In most societies around the world this interval ends sooner for girls, who marry younger than boys, and is currently lengthening as both boys and girls are delaying marriage. This developmental phase has come to be associated primarily with modern, industrial societies in which a distinct period of transition to adulthood has evolved. (Mensch et al. 1998)

Defining and characterizing adolescence, however, is also a value-laden task. In their excellent study, *The Uncharted Passage: Girls' Adolescence in the Developing World*, Mensch et al. (1998) argue that adolescence is an inherent developmental phase, common in all cultures at all times, and not immediately brought to an end with marriage and/or childbearing. "It is a time of heightened vulnerability for girls and critical capability-building for children of both sexes. These are defining features of adolescence; they apply to all 10-19-year-old children, regardless of their marital and/or childbearing status" (Mensch et al. 1998: 5). It follows from such a characterization, then, that a 17-year-old mother is not to be considered an adult who is adequately equipped with the resources and decisionmaking power to fulfill her responsibilities, but rather that she is still in transition to adulthood and is ill-equipped and over-burdened for her role.

The reproductive health profile of adolescents around the world bears out the validity of this approach. For example, childbirth in adolescence increases the risk of premature labor, miscarriage, and stillbirth. Adolescents are four times more likely to die from pregnancy-related causes than women above age 20, and their infants have greater chances of being underweight at birth and dying by age one. Adolescents are more likely to delay seeking abortion, and therefore incur more complications from the procedure, due to lack of information and resources. They are at higher risk of reproductive tract infections from sexual intercourse because they have fewer protective antibodies than do older women. Females of younger ages, married or not, have less control over unwanted sex and the use of condoms. Half of all HIV infections occur among people younger than age 25. Finally, youth all over the world experience sexual abuse, incest, and rape. (Alan Guttmacher 1998)

It also follows from the Mensch et al. characterization of adolescence that the period of transition to adulthood must equip young people with the education, skills, decisionmaking power, and information to function as responsible adults in society. This includes complete schooling and access to services, information, and opportunities, as well as protection, until they reach adulthood. It also means that experts and policymakers around the world will necessarily become engaged in some revision and re-setting of standards for adolescents to define more clearly what is meant, in a modern context, by a healthy transition to adulthood.

Comprehensive research into adolescents' needs and realities in developing and industrialized nations is becoming a priority for the first time, and the results should lead to programs and policies that help to facilitate a successful and empowering transition to adulthood. This implies that the research itself will be motivated by a set of values and beliefs about adolescents (that is, how "adolescents" are defined and characterized, and what the quality of their lives should be). For example, documents such as *Adolescent Health and Development: The Key to the Future,* prepared by the World Health Organization (1995) for the Global Commission on Women's Health, provide a framework for addressing adolescents' health needs directly based on results of research in developing countries.

The Pakistani Context

The concept of adolescence as a distinct period of development is still fairly new in Pakistan. Most beliefs and practices in this multi-cultural society are still premised upon the assumption that the transition from childhood to adulthood is brief and marked by the onset of marriage, particularly for girls. But the reality of life here is rapidly changing. One in three people lives in an urban center (Population Census Organization 1998), which means that Pakistan is unlikely to remain a primarily rural society. Access to electronic media is increasingly widespread, bringing with it unprecedented cultural influences and information from the outside world. Education levels and age at marriage are also on the increase, which have the effect of lengthening the transition to adulthood.

We do not yet know the full range of implications that modernization and its attendant influences are having on adolescents in Pakistan because research is still at a preliminary stage. Some research efforts are underway to piece together a larger profile of those ages 10-19, including analyses of existing data on employment and education as an essential starting point.[1] We do know adolescents comprise almost one-quarter of the population in Pakistan (which will reach a peak number of youth in the year 2035). (Xenos 1998) There are some data, particularly from the Pakistan Demographic and Health Surveys 1990-91, Pakistan Contraceptive Prevalence Survey 1994-95, and Pakistan Integrated Household Surveys, that provide enough age-specific information to assess some aspects of adolescents' reproductive health status. Other aspects of the health and development profile of adolescents may be pieced together from medical research and nongovernmental organizations, which provide insight into adolescent issues but are not based on nationally representative data samples.

This report will review the existing research on adolescents and reproductive health, and will also present policy and program interventions when they are applicable. Since planners are only just beginning to conceptualize adolescence, a

[1]The Population Council in Islamabad is currently conducting analyses of Pakistan Integrated Household Survey 1990-91 data on adolescents, as well as preliminary research into adolescents' education and reproductive health requirements, as part of an effort to prepare an integrated research agenda on this age group in Pakistan.

full critique of policies is not yet possible. Throughout the main report, and the sections reviewing topics in reproductive health research, gaps in available figures, research, and information will be pointed out repeatedly. This is an inevitable result of the preliminary nature of the research. Much of the material that will be discussed was not intended to focus on adolescents at all. Some of the findings have been extracted from more general research as part of an effort to build a preliminary reproductive health profile.

The report will present research and findings from Pakistan within the approach to adolescence characterized by Mensch et al. (1998). The ages 10-19 are a useful parameter within which to limit a definition of adolescence, and findings pertaining to boys and girls within these ages will be considered appropriate to present. This parameter does have its shortcomings, however. For example, the onset of puberty, which may start earlier or later than age 10, is obviously a developmental milestone critical to understanding the period of adolescence. Also, the needs and realities of 17-year olds and 10-years olds may be quite different and resist being encompassed by the over-arching concept of "adolescence." The category of young adults aged 20-24 is often included in research on youth because the period of transition continues into the early twenties. Particularly in Pakistan, young people, including those who may be married, are often treated as children at the household level until they are well into adulthood. However, despite these limitations, the age parameter 10-19 still covers a general period of transition that is neither clearly childhood nor adulthood, and is therefore uniquely its own.

The research findings will also be discussed within a normative approach premised on certain assumptions regarding adolescence as a developmental phase that must unfold in a healthy and safe environment. Where a reproductive health burden falls on adolescents (for example, sexual activity, exposure to risks of disease, early marriage, and childbearing), the implicit argument will be that such a burden should not exist at all prior to adulthood. Where such burdens do exist, adequate support services and opportunities for education and work must be offered to adolescents. Where lack of information and resources limit opportunities for adolescents, and prevent them from making informed decisions, the emphasis in the discussion will be on the need to amend the situation. And finally, the gender disparities and the increased vulnerabilities of adolescent girls will be presented with a view to emphasizing the urgency of creating equity and equality between the sexes.

Two strong themes run through the report, and if kept in mind by the reader will assist in the task of conceptualizing what it means to be an adolescent today in Pakistan. *First, adolescents in Pakistan are not exempt from the reproductive health problems faced by the adult population, particularly females. Second, the research conducted in Pakistan thus far will reveal that there are particular biases against adolescents that put their reproductive health at greater risk than that of adults.*

The problems that adults and adolescents face include: lack of information, inability to access services, maternal health burden, taboos on sexuality, and risk of exposure to sexually transmitted diseases and sexual violence/exploitation. However, adolescents are not adults: they are more vulnerable and require more information and protection. Adolescents face the same issues as adults, but with different emphases. For example, adolescent girls are often more restricted in their mobility and access to health and family planning services, even if married, than are older women.

One bias against adolescents that shows up throughout the research is the discrimination against girls. Another bias, which puts adolescents as a group at risk compared to adults, is the added vulnerability to sexual violence that is experienced by both boys and girls. Finally, decisions and mistakes made during adolescence will define and limit their options for the rest of their lives. For example, if an unmarried girl experiences an unwanted pregnancy due to lack of adequate information and support, she is likely to suffer extreme consequences of punishment that will negatively impact the rest of her life.

The research presented in this review is organized into subtopics within the larger definition of reproductive health agreed on by the international community, including Pakistan, at the 1994 International Conference on Population and Development. The ICPD reproductive health definition bears repeating:

> *Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. People are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility, as well as access to health care for safe pregnancy and childbirth.* (Alcala 1994: 10)

The ICPD also committed its member states to protecting and promoting the rights of adolescents to reproductive health information and services. (Alcala 1994) Within this framework, the research discussed in this report has been organized under headings of health and nutrition, sexual awareness and behavior, prostitution and trafficking, sexual violence and sexual abuse, sexually transmitted diseases, abortion, marriage and childbearing, and fertility and family planning. Unfortunately the findings will reveal that the information, rights, and access elements essential to achieving reproductive health are out of the reach of Pakistan's young people and are therefore bound to elude them in adulthood as well.

II. BASIC DATA

At present our information on adolescents in Pakistan is limited in scope and lacking in depth. For example, we may know how many adolescents there are, what proportions attend school, go to work, and are married, but we know very little about their behavior patterns and how decisions that shape their futures are actually taken. Nonetheless, a brief look at the available information will give us a profile of this age group that is helpful in developing a perspective on their lives and options.

Latest census figures put the total population of Pakistan at 130.58 million, with an average inter-censal growth rate (1981-1998) of 2.61 percent. (Population Census Organization 1998) For purposes of quantitative research, adolescents are defined as those individuals falling within the ages of 10-19. According to the Pakistan Integrated Household Survey, between 22-25 percent of the population are adolescents: 52 percent are male and 48 percent are female. (PIHS 1995)

The education levels of one-quarter of Pakistan's population, who are soon to be the adults and decisionmakers of this society, are inadequate to equip them for their future responsibilities (see **Tables 1** and **2**).

Table 1: Percentage of adolescents who are literate, by age, according to residence and sex, Pakistan Integrated Household Survey 1996-97

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

Source: PIHS 1996-97: 46.

Table 2: Percentage of adolescents who have ever attended school, by residence and age, according to sex, Pakistan Integrated Household Surveys 1991 and 1996-97

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

Source: PIHS 1991; PIHS 1996-97: 21

During the 1990s the percentage of adolescents surveyed in the PIHS who have ever attended school did not show a steady increase. In fact the 1996-97 PIHS

figures for Pakistan suggest that the total number of adolescents who have ever attended school may be dropping, particularly for boys. The most recent figure for girls who have ever attended school (35 percent) is little more than half that of boys (66 percent). Girls in rural areas are even further disadvantaged than their urban counterparts, where over twice as many females say they have ever attended school. PIHS 1996-97 also reports that 16 percent of all adolescents (and 25 percent of females in rural areas) drop out before completing primary school.

There are numerous unanswered questions regarding the quality of education received by adolescents, the reasons why they do not remain in school, and the obstacles faced by girls in accessing the school system. While the government, particularly through its multi-sectoral Social Action Programme, seeks to address these problems, there is still insufficient research available to shed light on the adolescent's experience of education in Pakistan.

Rural girls are at a disadvantage compared to their urban counterparts when it comes to marrying early. Recent PIHS 1996-97 figures show that 18 percent of 15-19 year old rural girls were ever married as compared to only 8 percent of their urban counterparts. (**Table 3**) Married adolescent girls reported almost negligible numbers of children ever born. Once girls cross the 20-year age barrier, there is a dramatic increase, more than four-fold, in the proportion of those married. The mean number of children ever born for the 20-24 year old age group jumps to 0.9.

Table 3: Selected demographic characteristics of women below age 25, according to residence, Pakistan Integrated Household Survey 1991 and 1996-97

	PIHS 1991			PIHS 1996-97		
Characteristic	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Percent women ever married						
15-19 years	14	26	22	8	18	14
20-24 years	58	74	69	47	66	60
Overall	68	76	73	62	71	68
Mean number of children ever born						
15-19 years	0.1	0.1	0.1	0.0	0.1	0.1
20-24 years	0.9	1.3	1.2	0.7	1.0	0.9
Overall	3.0	3.3	3.2	2.6	3.0	2.9
Age specific fertility rates						
15-19 years	68	118	102	32	55	47
20-24 years	266	285	279	200	238	226

Source: PIHS1996-97: ix.

The proportion of adolescent males who are married is far less than that of adolescent females. The latest figures from the Pakistan Fertility and Family Planning Survey 1996-97 (Hakim et al. 1998) show that among those currently ages 15-19, 3 percent of males and 17 percent of females are married.

Table 4: Percentage of adolescents who worked one or more hours in the past week, by age, sex, and residence, Pakistan Integrated Household Survey 1995-96[a]

Characteristic	Percent
Age	
10-14 years	13.3
15-19 years	31.0
Total (10-19 years)	21.0
Sex	
Male (10-19 years)	28.0
Female (10-19 years)	13.5
Total (10-19 years))	21.0
Residence	
Urban	
Males 10-14 years	10.5
Females 10-14 years	4.7
Males 15-19 years	37.4
Females 15-19 years	9.4
Total (10-19 years)	15.3
Rural	
Males 10-14 years	18.2
Females 10-14 years	15.9
Males 15-19 years	49.5
Females 15-19 years	21.5
Total (10-19 years)	25.1

[a]Work includes both paid and unpaid labor performed in the domestic or the public sphere.
Source: PIHS 1995-96 data, as analyzed by Dr. Valerie Durrant, Population Council.

According to a survey sponsored by the International Labor Organization in 1996, 3.3 million (8 percent) out of a total of 40 million children ages 5-14 were economically active and 73 percent of these were boys. (Ministry of Women Development, Social Welfare and Special Education 1997) However, figures will vary depending upon the definition of labor or employment in use. The PIHS 1995-96 gathered age-specific information on respondents' work beyond one hour per week, which is a formulation that would apply well to young people who may be partially employed or earn occasional wages. Figures were highest for males (28 percent), for both males and females in the age group 15-19 (31 percent), and for rural respondents (25 percent). (**Table 4**) More than double the numbers of rural females reported that they worked one hour or more in the past week compared to their urban counterparts.

Underage labor is the subject of great international and domestic controversy, centered on issues of how to classify labor, how to protect children from hazardous employment, and how to balance their economic needs with their educational needs. In Pakistan, adolescent labor, as opposed to the labor of young children, may not be as striking a problem to program and policymakers because it involves individuals over ages 14-16, when certain types of work become legal. However, when more detailed information regarding the impetus behind adolescent labor emerges through further research, the implications of their work on their on-going education, reproductive health, and patterns of decisionmaking will be more clearly identified.

In light of the above figures, the profile of the Pakistani adolescent is one of disadvantage, particularly in education. We also know that adolescents are marrying and entering the labor force in large numbers, and doing so prematurely. In particular, adolescent girls and rural adolescents face greater disadvantages than do their male and urban counterparts. With such a profile, it is no surprise that the reproductive health issues discussed below overwhelm adolescents and increase their disadvantages before they enter adulthood.

III. HEALTH AND NUTRITION

The period of adolescence for Pakistani children marks an increase in a trend of gender differentials in nutrition levels and access to health care. The differentials become even more marked with the onset of adulthood, resulting in high maternal mortality rates. Intervention at this stage in life is essential not only for adolescents themselves, but also for the health of future adults.

Access to Health Care

Research conducted in Pakistan confirms a strong gender bias in access to health care. Exploring gender differentials in access to health care in the North West Frontier Province, Akhtar (1990) found that access of the female child to urban-based health facilities was half that of the male child. The continuation of this bias has serious repercussions for the health of women, particularly adolescents and married women, whose access to services is curtailed by their low decisionmaking power in the household, limited mobility, and strict *purdah* (segregation of the sexes) norms.

Ahmed (1990) found, through interviews with mothers at the outpatient departments of the Islamabad Children's Hospital, that adolescent girls faced more difficulty in accessing health care than did adolescent boys. While the boys could travel on their own to a health care facility, parents had to hire a wagon to transport a girl or else summon a doctor to their home. Both mothers and fathers felt that *purdah* norms interfered with the access of their adolescent girls to treatment, and that the presence of a lady doctor was essential. Ahmed found that in a rural area with a female physician present at the health center, the number of adolescent boys and girls seeking health care was roughly the same.

A small survey of adolescents in a low-income community in Karachi echoes this gender bias limiting female access to services. (Aahung 1999) Out of 80 girls ages 11-19 interviewed in-depth, 78 percent said they could not go to a doctor without permission; out of 71 boys interviewed, 32 percent said it was necessary for women in their homes to get their permission to go to the doctor.

Similar findings emerge from rural-based studies. Adolescent girls, in a qualitative survey conducted in three northern Punjab villages, complained that they only troubled their parents to go to a doctor if they were seriously ill. (Khan 1998) The mobility of unmarried girls was severely restricted by their families and communities, dramatically limiting their access to education and employment opportunities out of a fear that their honor (or chastity) would suffer as a result of contact with the public, and particularly with males. This fear is a major factor in favor of marrying girls off young, as a means to ensure that control over her sexuality is not lost. The fear of whether villagers would suspect sexual misconduct,

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

Kazi and Sathar (1997) found Southern Punjabi communities were more restrictive of women's freedom of movement than the more developed villages of Central Punjab where almost half of the women can visit a health center alone. On the whole, women under age 25 were the most restricted in their freedom to go to a health center alone (only 13 percent), while 46 percent of older women could do so. Married adolescent girls, in particular, require access to the full range of health and family planning services, including information on sex and family planning, treatment for ailments associated with sexual activity, and, of course, care during pregnancy and childbearing. However, the bias against their young age restricts their access to services even when they are married.

As is demonstrated in the above studies, younger women suffer the most severe social barriers to their mobility and access to health care. Even if an adolescent girl is married, her decisionmaking power within the household is unlikely to be enough to allow her to access care when necessary. This bias poignantly captures the dilemma of being adolescent in Pakistani society, where a girl's biological development signals her "entry into a world in which her value is largely determined by her sexual and reproductive functions" (Mensch et al. 1998). As a result, her mobility is severely restricted and her every move is scrutinized for its potential sexual suggestiveness. It is her youth that prevents her from being able to claim some of the status and increased mobility which women who are older come to enjoy after many years.

Anemia

Anemia is commonly known to affect Pakistani girls and women, weakening them during pregnancy and adding to problems of maternal morbidity and mortality. Research shows that the problem starts in childhood; it includes boys, and, in the case of girls, becomes worse as they grow older.

The last comprehensive National Nutrition Survey (NNS), in 1985-87, identified iron deficiency anemia as the most prevalent micronutrient problem in Pakistan, found in 65 percent of young children. Iron deficiency, defined in the NNS as consumption below 70 percent of the recommended intake, affected approximately 80 percent of pregnant/lactating women and 50 percent of other adult females. (Nutrition Division 1988) Over a decade later the situation has barely improved, as demonstrated by the findings of one study near Peshawar in which 90 percent of 275 surveyed children under two were anemic. (Paracha et al. 1997) The 1990-94 National Health Survey of Pakistan found that among women ages 15-44, 43-47 percent of rural women and 35-39 percent of urban women are anemic. (Pakistan Medical Research Council 1998)

A dramatic finding of the National Nutrition Survey was that among mothers the prevalence of anemia increased with age. (**Table 5**) A problem that already affected over

35 percent of the adolescents surveyed (age 15-19) seemed only to deepen with the onset of adulthood and further childbearing. This finding is a demonstration that the negative health status of adolescents is a warning of the health profile of future adults, particularly when problems such as anemia are allowed to grow more serious through lack of adequate care.

Table 5: Percentage of pregnant and lactating women with anemia, by age, National Nutrition Survey 1985-87

Age	Percent
15-19	35.2
20-24	39.4
25-29	42.4
30-34	48.6
35-39	51.3
40-44	50.7
45-50	65.8
(N)	**(3,270)**

Source: Nutrition Division, 1988: 47.

UNICEF (1998a) has identified iron deficiency anemia as one of the leading causes of Pakistan's high maternal mortality rate, contributing to more than 20 percent of maternal deaths. In addition to maternal mortality, anemia leads to increased risk of miscarriage, stillbirth, premature birth, low birth-weight, and perinatal mortality. (Mensch et al. 1998) Factors contributing to high rates of anemia include early marriage and childbearing, short intervals between pregnancies, frequent pregnancies, poverty leading to poor nutrition, unbalanced food distribution within households, and intestinal worms. (Tinker 1998) Therefore adolescent girls, whose iron requirement will exceed that of boys as the years increase, are poised to develop a problem of iron deficiency particularly if they are poor, marry early, and have children frequently.

Anemia is as common among boys as girls in developing countries. Among girls, however, the problem does not lessen as they enter adulthood, due to iron deficiency brought on through menstruation. (Mensch et al. 1998) **Table 6** shows the results from one of the only available studies of iron deficiency in Pakistani adolescents, conducted among 270 students, ages 13-20, from low-income families attending government schools in the suburbs of Islamabad. (Agha et al. 1992)

Table 6: Percentage of adolescents (ages 13-20) studying in the suburbs of Islamabad with iron-deficiency related conditions, by condition, according to sex

Condition	Boys	Girls	Both
Anemia	17	18	
Iron deficiency[a]	30	54	
Overall iron depletion			39
(N)	**(170)**	**(100)**	**(270)**

[a]Serum ferritin levels below 16 mg/ml.
Source: Agha et al. 1992: 5.

These findings indicate that while both boys and girls suffer from overall iron depletion and anemia to a similar extent, the gender differential for iron deficiency is more pronounced. Agha et al. (1992) point out that girls with iron deficiency would require iron therapy in pregnancy to avoid developing iron deficiency anemia and would not be able to donate blood without developing anemia. The problem is attributed to low dietary iron and the loss of iron due to menstruation, and the economic conditions of poverty which prevent eating foods containing iron.

The pattern of anemia for boys is opposite from the development of anemia among girls, according to the National Health Survey (Pakistan Medical Research Council 1998). The highest prevalence of anemia among males is in the age group 5-14, with 47 percent of rural and 33 percent of urban boys being anemic. The prevalence of anemia in the next age groups decreases, reaching its lowest among ages 25-44, and then increases in the next older age groups. The high anemia rate among young and adolescent boys is due to their rapid muscle development, which calls for supplementation through consumption of iron-rich foods. (Kurtz et al. 1994)

Under-nutrition

The problem of under-nutrition, leading to dangerous malnutrition, has not improved in recent decades; this particularly affects infants and young children and pregnant/lactating mothers. (Kazi and Qurashi 1998) Malnutrition includes micronutrient deficiencies, such as iron-deficiency discussed above, and deficiencies in iodine and vitamin A. The latter two deficiencies not only impair the development of children, but also increase maternal mortality in impoverished regions and increase the risks of stillbirths, miscarriages, and mental retardation in infants. Malnutrition also includes protein-energy malnutrition, which is assessed by physical growth and body measurements. Gender differences in malnutrition among children under five have not been established in national surveys (UNICEF 1998a) but among adults women suffer more from malnutrition than men. (Tinker 1998)

Pregnant women in Pakistan receive only 87 percent of recommended calories and lactating women only 74 percent; their protein intake is only 85 percent of recommended levels. (Tinker 1998) Data from the National Nutrition Survey (Nutrition Division 1988) show that 34 percent of pregnant and lactating mothers were underweight compared to other women in the study, but the findings are unclear. This survey also found no apparent major restriction in types of food eaten by pregnant/lactating women and other adult females and no major difference in food intake between adult men and women.

In a comparison between schoolboys and schoolgirls (ages 6-15) food intake was equal between the sexes. But in an assessment of which percent of boys and girls (ages 6-15) were consuming below 70 percent of recommended nutrients, the results showed some gender differential, particularly in regard to the consumption of high-protein foods such as meat, fish, and eggs. (**Table 7**) This may be because

boys are given preference within the family in the consumption of more costly high-protein foods, while girls rely more on high-calorie staple foods.

Table 7: Percentage of boys and girls whose intake of nutrients is below 70 percent of recommended amount, National Nutrition Survey 1985-87

Sex and age	Calorie intake	Protein intake	Iron intake
Boys 6-15	28	14	14
Girls 6-15	18	18	15

Source: Nutrition Division 1998: 103-4.

Food consumption among adolescents has not been studied in any detail in Pakistan; however, it is clear from the above data that problems of malnutrition affect both boys and girls, and become exacerbated for girls in combination with pregnancy and lactation. Further study is required to determine the proportion of pregnant/lactating women who are malnourished and to assess the extent of the problem for young women.

IV. SEXUAL AWARENESS AND BEHAVIOR

Whereas many aspects of reproductive health discussed in this review are becoming accepted areas for research, sexual awareness and behavior is probably the least studied. The threat of HIV/AIDS worldwide has prompted a series of small-scale studies on this and other sexually transmitted diseases (see following section), but this research in Pakistan is highly selective in favor of small high-risk behavior groups. Studies investigating the sexual awareness and behavior of married and unmarried adolescents are virtually nonexistent.

One reason for this is that sexuality, while recognized in Pakistan as a healthy part of married life and even encouraged by religious teachings, is still subject to extreme legal and social controls. That is, sex outside of marriage is a crime against the state (Hudood Ordinances 1979). Suspicion of such sexual relations is cause for women, in particular, to be immediately killed by customary law (*karo kari* in Sindh,[2] for example) or, at the least, to cause a family's reputation to be tarnished and a girl's future prospects ruined. Whereas women's sexuality and the control of it by male elders or husbands is a foundation of social values and norms in Pakistan, men, on the contrary, are understood to have sexual desires that may or may not be satisfied by their wives. Possibly for these reasons, there exist a few more research findings on male than female sexuality.

In Pakistan, as in many developing countries, women and men are marrying later. Some international researchers conclude that adolescent premarital sexual activity must be increasing because of this longer gap before marriage (Friedman 1992), but Mensch et al. (1998) warn that the evidence across countries of increased premarital sexual behavior is still inconclusive.

There are other specific issues, however, which merit further research. For example, the question of whether sex within marriage is always consensual has barely been examined, particularly when one partner may be considerably younger and less empowered than the other. (Mensch et al. 1998) Pakistani law does not recognize rape within marriage as a possibility. Since over 20 percent of all adolescent girls ages 15-19 surveyed in the 1990-91 PDHS were ever married, a large group of young women are sexually active, and at the same time vulnerable to exploitative power dynamics with their husbands. (NIPS/IRD 1992) One Indian study found that married adolescent girls' experiences of sex have been initially very negative. (Jejeebhoy 1998)

[2] *Karo Kari,* the killing of a man or woman by a community on the suspicion that they have committed adultery or had sexual contact without being married, is prevalent in Sindh and Balochistan. Although figures have not been reliably collected over the years, informal estimates indicate that in parts of upper Sindh as many as one woman or man may be killed a day in this way. Those killed include adolescent girls, although the proportion of these deaths cannot be ascertained. (Personal communication with Nafisa Shah 1999)

The unpleasant reality of nonconsensual sex and the extent to which adolescents outside of marriage are subject to abuse and rape is also necessarily an element of adolescent sexual behavior. (Mensch et al. 1998) There is more information on sexual violence in Pakistan than there is on mainstream sexual behavior, perhaps reflective of a growing negative trend in this society. Unfortunately, adolescents are particularly vulnerable to unwanted sexual experiences, as the discussion in the next sections on prostitution and sexual abuse will reveal.

Male Awareness and Sexual Behavior

Boys and young men may have more access to the outside world and exposure to diverse sources of sexual information, nevertheless, they seem to be deeply concerned about elements of their own sexuality. The prevalence of misinformation, perpetrated by so-called sex clinics which seek to "cure" men of unwanted sexual habits, as well as traditional and religious taboos, exert a powerful hold on males. Since they seem reluctant to discuss their concerns and questions about their own sexuality with peers, it may be only when they marry and experience intimacy with their wives that they can lay some anxieties to rest.

Some small studies venture into the unexplored territory of young peoples' attitudes towards sexuality. Although they do not represent a wide sample of respondents, their findings can be used in developing future research. For example, young men seem particularly anxious about masturbation, homosexuality, nocturnal emissions, and infertility. In a study conducted among 188 male patients (ages 18-30) presenting at Aga Khan University in Karachi (Qidwai 1996), 80 percent said they had masturbated at some point in their lives. Their misconceptions included the belief that masturbation causes impotence (22 percent), physical illness (31 percent), and weakness (63 percent). Strong feelings of guilt remained with 69 percent of respondents. The misconceptions were more prevalent among respondents from lower and middle-income groups. Their concerns were often exploited by sex clinics, where they would pay thousands of rupees for treatment for infertility prior to getting married, simply because they had masturbated.[3]

A series of focus groups with adolescents in Chanessar Goth, a low-income multi-ethnic community in Karachi, were conducted by Aahung (part of the Karachi Reproductive Health Project) in preparation for developing an AIDS awareness program within the local schools. (Aahung 1999) The discussions with both boys and girls attending the Urdu-medium secondary schools revealed that adolescents exhibited a general lack of confidence and ability to be assertive, and had inadequate information about the body. Child sexual abuse, sexual harassment, drug use, and shame and guilt associated with the body were identified as key concerns that inhibited their health-seeking behavior. In in-depth interviews conducted with 71 boys ages 11-19, 18 percent said one should not talk about his

[3] Personal discussion with Dr. Waris Qidwai, Department of Family Medicine, Aga Khan University, Karachi, December 1998.

body, and 11 percent said they would not tell anyone if they experienced discomfort in their genital area. Most boys believed that masturbation endangered one's health, and commonly associated it with causing the penis to become crooked or loose.

Aangan, a community program to raise awareness about child sexual abuse, analyzed 45 letters received from young people (75 percent young males) requesting information on sexual health. (Aangan 1998) Masturbation was the most commonly expressed concern (46 percent). The letter writers feared that their future sexual performance would be negatively affected, that physical weakness, infertility, reduction in penis shape, loss of virginity, or related health problems may result from masturbation. These misconceptions are so deeply rooted in culture and tradition, that researchers may be amazed to discover the hold of some extraordinary myths. For example, male child prostitutes interviewed in the North West Frontier Province believed that among all the sexual practices they knew of, including sex with girls, sex with men or boys, sex with animals, and masturbation, the latter was by far the most sinful. In fact, they believed that if someone masturbated God would get a fever.[4]

Young men are also concerned about nocturnal emissions (or "wet dreams"), possibly to a lesser extent than masturbation. In the Qidwai study (1996), 94 percent of respondents admitted to having nocturnal emissions and 15 percent considered them a cause of physical illness. Respondents associated dark circles around the eyes with the consequences of masturbation and nocturnal emissions.

A study in Punjab of male needs and attitudes regarding reproductive health (Raoof Ali 1999) found that men, women, and service providers all felt that men lack awareness and knowledge of reproductive problems. This included their own issues, identified as infertility, sexually transmitted diseases, weakness, sexual "debility," and masturbation. Service providers specifically suggested that information and education begin to be provided to boys at age 14, and that services are also needed to help prevent the spread of homosexuality and prevent frequent masturbation.

Onset of Menstruation

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

[4] Personal discussion with Anusheh Hussain, Sahil, Islamabad, December 1998.

In a study on the transfer of health and reproductive knowledge in a southern Punjab village menstruation was "the watershed between being a girl child and becoming a woman" (Mumtaz and Rauf 1996). A girl was immediately expected to observe *purdah* and wear a *burqa*, and would be married within two to three years of her first period. Although such dramatic changes in a girl's status do not occur among all communities in Pakistan, particularly in urban centers, the social silence maintained around menstruation that was observed by the researchers can be observed across class and cultural divides. Girls in the study relied on elder sisters or sisters-in-law for information about menstruation and its practical management.

Some practices related to menstruation are worrisome from the health and hygiene point of view. For example, Mumtaz and Rauf (1996) found that women were considered unclean while menstruating. Some were made to sleep on a mat on the floor, forbidden to bathe, and advised to avoid some foods (in the belief that certain foods would make them ill).

The Aahung (1999) interviews conducted with 80 girls ages 11-19 in the low-income community of Chanessar Goth, Karachi, found that 64 percent of the girls believed that it was harmful to shower during menstruation. Only about half of those interviewed said that menstruation was related to a woman's ability to give birth, while the rest were unsure whether the two were linked. Both of these studies reveal a low level of awareness about the process of menstruation. The relationship between poor hygiene practices and infections in women and girls needs to be examined in future research.

While a variety of home remedies and traditional therapies are used to manage menstrual cramps, until recently premenstrual syndrome has not been recognized as a problem. However, in a study of 1,600 women in Karachi the total incidence of PMS was 33 percent. (Shersha et al. 1991) The figure was slightly higher for married women (34 percent) than for unmarried women (32 percent). It was inversely proportional to the number of pregnancies. Complaints of symptoms associated with PMS were most frequent in the lower socioeconomic groups and among those women who lived in parts of Karachi most affected by the law and order problem.

Mensch et al. (1998) point out that more research needs to be done on customs and restrictions, particularly the health dimensions, surrounding menstruation. In a country with a cultural mix, such as Pakistan, there is a need to understand in more detail how girls from different tribes and regions manage the practical and health dimensions of menstruation. While anthropological literature, and some development literature, includes limited information on practices surrounding menstruation among different tribes, the subject has not been the focus of sustained or comparative research.

Female Awareness and Sexual Behavior

More is known about the cost of female sexuality in Pakistan than its reality. This is true of married as well as unmarried women, young and old alike. The concept of honor, which binds families, communities, and society into intricate webs of interdependency and territories, is premised upon control of people and their lineage. Essential to the honor system is the sexual control of women, and in this regard the virginity and unblemished reputation of unmarried girls is of critical importance. As girls enter puberty and become of marriageable age, they find their mobility and access to opportunities – such as education and employment – severely curtailed, all in the name of preserving their (and their community's) honor. (Khan 1998; Mumtaz and Rauf 1996) If a girl violates social norms and is discovered to have engaged in sexual relations, or even flirtation, with a boy then she will be either beaten or killed according to customary laws, or she will be vulnerable to charges of adultery under the Hudood Ordinances that may lead to imprisonment or death.[5]

Since the cost of female sexuality is so high, so too are the fears surrounding sexuality. Women and girls interviewed in rural Punjab exhibited a morbid preoccupation with the dangers posed by the world outside their homes and villages. This arose mainly through fears of male sexual harassment, rape, abduction, and loss of reputation in case a community member observed a female speaking with a male who was not related. Although girls resented the restrictions imposed on them, they had internalized these fears and were reluctant to express any positive sentiments about their own sexuality. (Khan 1998)

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

A rare study on reproductive health awareness in adolescent girls was conducted with 300 students in Peshawar high schools. (Majid 1995) A questionnaire was distributed to girls in Classes IX and X, presumably ages 14-16. Their responses are summarized in **Table 8**. Majid concluded that teenage sexuality was not a major issue for the students, but that there was still a great need for multidisciplinary educational programs in schools to give adolescents "the right answers at the right time." Certainly students clearly articulated their demand (88 percent) for sex education in schools, which belied the low level of expressed

[5] See Jahangir and Jilani (1990) for a discussion of such legal cases. To date no death sentence under the Hudood Ordinances has actually been carried out.

curiosity about sex. Finally, girls were shy about discussing menstruation and felt that virginity was a virtue.

Table 8: Percentage of adolescent girls' responses to selected questions regarding reproductive health[a]

Reproductive health topic	Percent
Aware of menstruation before its onset	50
Source of menstruation information	
Mother	38
Sister	50
Friend	12
Aware of sexual relationship	65
Source of knowledge regarding sexual relationship	
Books, magazines, etc.	25
Mothers and sisters	30
Curious about sex	25
Curious about sex but hesitant to ask	15
Sex education in schools is inadequate	88
Sex education in schools not essential	22
Matters related to sex not discussed in their families	90
Ideal age at marriage is 20-25	75
Knowledge of contraception vague or absent	25
Definite knowledge of contraception	11
(N)	**(300)**

[a]Respondents were high school girls in Peshawar.
Source: Majid 1995: 214.

In the Aahung (1999) in-depth interviews, conducted with 80 girls ages 11-19 in Chanessar Goth, Karachi, most girls felt it inappropriate to talk about their bodies, although almost all said they would tell their mothers if they experienced discomfort in their genital area.

Research from other developing countries suggests a change in awareness and behavior. It is possible that trends in India, arising out of a comparable social and economic environment, may serve as an indicator of what might be happening in Pakistan. In India, roughly one in four unmarried adolescent boys ages 10-19 have had sexual relations, as reported by school and college students through self-administered questionnaires in four small surveys. In contrast, sexual activity among unmarried adolescent girls is at a lower level. However, almost 25 percent of rape victims are under age 16, and 20 percent of all sex workers are adolescents, according to Indian government figures. Unmarried adolescents are a disproportionately large number of abortion seekers. (Jejeebhoy 1998) In a survey of mainly female university students in Delhi, it emerges that women were fairly open in expressing their sexual needs, including masturbation, and few thought that intercourse required marriage first. Nonetheless, only a small minority had premarital sex or dated, suggesting that their attitudes were more open than their behavior. Further, there was a high level of ignorance about contraception and basic sexual functioning. (Sachdev 1998) These findings may suggest that sexual awareness and attitudes among highly educated females here are also changing. Further, lack of

information on abortion rates among unmarried girls in Pakistan must not be taken to mean that the practice is nonexistent.

Access to Information and Knowledge about Sex

There is some level of demand for sex education among young people. (Raoof Ali 1999; Qidwai 1996; Aangan 1998) Boys and girls are concerned not only with their own developing sexuality, but request more information about the other sex. Boys may be more open in demanding information, while girls are generally more inhibited about expressing their concerns. (Aangan 1998)

The mainstream media and education system do not offer adolescents the information they need. Parents are also not a source of sex education for their children. (Qidwai 1996) The tacit assumption among adults and policymakers, as well as health and family planning service providers, seems to be that young people will get whatever information they need when it is proper, that is, when they are married. It may be pointed out here that media and educational tools are not only inadequate, but they fail to obtain opinions and views from young people themselves. Tacit assumptions about adolescents' needs and future aspirations may be faulty. UNFPA produced an unusual documentary in 1999 in which dozens of adolescent boys and girls across the country were interviewed, eliciting their views on a range of issues for the first time. More endeavors such as this would help projects/programs be more responsive to adolescents' stated needs.

The reality of adolescents' lives, which includes sexual abuse and rape, misconceptions and anxieties about their developing sexuality, lack of information about the other sex, pregnancy risks, and sexually transmitted diseases, is being denied out of fear that information will lead to an increase in premarital sex. As a result, even adolescents who are married and in need of sex education have no source of neutral information to protect their health and improve their sexual relations. Figures from numerous developing countries show that adolescents, including married girls, have little knowledge of either their reproductive health and biology or how to protect themselves from disease. (Mensch et al. 1998)

Adolescent girls are more likely to get their sexual and reproductive knowledge from women within their families. Unfortunately even this hypothesis is difficult to verify through research, since unmarried girls and young women are often forbidden to give interviews to outside researchers. (Khan 1998; Mumtaz and Rauf 1997) The information adolescent girls do receive from the women in their families is likely to be related to menstruation, while information about sex itself may only be passed on to a girl from a female relative on the wedding day itself. (Mumtaz and Rauf 1997) There is no formal research available on unmarried girls' concerns about sex or reproduction prior to marriage. However, research findings among married couples have established that women's need for sexual satisfaction within marriage is accepted by couples, and it is not necessarily the case that women always

subsume their sexual needs in deference to their husbands, as is sometimes assumed. (Ministry of Population Welfare and Population Council 1998)

Needless to say the formal education curriculum, including medical training, does not include sex education, although population and family planning issues are incorporated. Sexuality, apart from reproductive biology or contraception that are taught in specific settings, is a taboo subject. While the new Education Policy (Ministry of Education 1998) states that curricula at the secondary level will include additional subjects such as awareness about drugs, AIDS, and environmental issues, it still falls short from recommending a basic introduction to the facts of life. Even this effort at reproductive health education is further limited in impact because only a small proportion of all adolescents completes secondary school.

The National Health Policy states that reproductive health as well as health education will be among the Health Ministry's priority programs. (Ministry of Health 1997) The discussion of reproductive health mentions that all aspects of the reproductive system and its functions will be taught, but the document does not mention sexuality. Activities will be undertaken to empower the community to work for the promotion of its own health, but clearly without basic sex education being taught to young people. This gap in curricula, combined with the fact that young people do not rely on their parents for information on sexual issues, means that sources of information are often unreliable and exploitative. (Qidwai 1996)

There are some projects underway that will begin the process of sex education, although they are tentative and introductory. Neither the family planning program nor the kind of objectives stated by the government, as indicated in the preceding discussion, were incentive enough to inspire service providers to discuss sex education; however, the threat of an HIV/AIDS epidemic has forced those tackling these issues to discuss sexual relations in unprecedented detail with their target communities. For example, Aahung, the AIDS awareness program at the Karachi Reproductive Health Project, is trying to develop a curriculum for secondary schools, for both male and female students, in which sexuality and reproductive health can be taught. They are currently experimenting with modules in selected secondary schools in Chanessar Goth, a low-income, multi-ethnic community in Karachi.

The Family Planning Association of Pakistan, the largest NGO in this sector, has stated, "reproductive health care also includes sexual health, the purpose for which is the enhancement of life and personal relations" (FPAP 1995: 45). Although FPAP has targeted young people in a number of other projects, it is currently preparing the groundwork for a new initiative. Join In Educating Adolescents and Teenagers (JEAT) is directly aimed at addressing the knowledge and attitudes of young adults toward reproductive and sexual health, with a view to influencing their behavior in favor of the small family norm and responsible parenthood. (FPAP Youth Programme n.d.) The project has multiple components including: a) establishing baseline information on adolescents' existing level of information on sexuality and

reproduction; b) establishing a resource and information base on adolescent sexual health; c) developing modules on reproductive and sexual health for youth; and d) sensitizing staff on youth issues and training counselors to work with youth. The program will work with adolescents already participating in existing youth activities.

Certain other nongovernmental organizations have a great potential to become providers of reproductive health education because they have access to a broad spectrum of young people in Pakistan. For example, the Girl Guides and Boy Scouts Association, and Pakistan Red Crescent Youth Societies do provide basic health and nutrition information, but stop short of introducing sex and related reproductive health matters in their activities. This reflects social taboos that make sex education, and even associations of adolescents, threatening activities in Pakistan.

V. PROSTITUTION AND TRAFFICKING

Preliminary findings suggest that both adolescent boys and girls are vulnerable to exploitation and that the prime age for entry into prostitution may be the teenage years. The problems of prostitution have been addressed not by policymakers or national programs, but by small nongovernmental organizations involved in protecting the rights of women and children in particular. Therefore the research is modest, but comes from firsthand experience with victims and their rehabilitation.

In its overview of child sexual abuse and exploitation in Pakistan, the Islamabad-based nongovernmental organization Sahil argues that existing research is enough to demonstrate that child sexual abuse is in fact widespread in Pakistani society but that walls of silence prevent communities and the government from speaking out. (Sahil n.d.) Worse, child prostitution and trafficking enjoy police protection since some police earn financial compensation from the pimps who run the business.

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

Male Child Prostitution

In Pakistan male prostitutes are believed to be cheaper for clients than female prostitutes. The prime age for male prostitutes is 15-25. (Fayyazuddin et al. 1998) It is likely that even less is known about their working environment and specific problems because the social taboos for boys admitting to sex with male clients are even greater than for girls.

Preliminary findings of Sahil's (1998) own research into male child prostitution in northern Punjab show that the children are usually runaways who are coerced by local hotel owners in urban centers to exchange their bodies in return for board and lodging. This points to the reality that children and adolescents have limited skills to rely on to support themselves, if they need to do so, and that prostitution is often the most practical and lucrative means of providing for themselves.

The children surveyed by Sahil allege that police and army soldiers are a significant portion of their clientele. Children as young as age eight were found working as male prostitutes. Although many of these young boys state that they are free to leave whenever they wish, the combination of financial compensation (a child

prostitute can bring in up to Rs. 12,000/month) and lack of alternatives usually cause them to stay and eventually grow up into pimps themselves.

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

A survey in NWFP found that out of 1,710 adult male respondents in communities throughout the province, about 83 percent said they knew about the practice of *bachabazi*. Almost half of those who knew about it thought the practice was either common or very common. Similarly, almost 81 percent of the respondents said they knew that some boys in their own communities sell sex for money. The places from which boys could be procured for sexual services included hotels, schools, workplaces, markets, bus stations, and video shops. The study concluded that there was a high prevalence of male sexual abuse and commercial sexual exploitation of children in NWFP and that social norms such as *bachabazi* helped to perpetuate the widely tolerated practice of adults keeping young boys for sexual services. (NGO Coalition on Child Rights 1998)

Trafficking of Women and Girls

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

The trafficking issue has been most consistently addressed and publicized by a legal aid service in Karachi that helps women and girls arrested for prostitution and languishing in local jails without passports or the means to return home even if they were freed. Lawyers for Human Rights and Legal Aid (LHRLA) publishes updated reports on the "flesh trade" which include comprehensive figures from its own surveys. LHRLA (1996) estimates that up to 150 Bangladeshi women and children are trafficked into Pakistan each day, coming through an elaborate network of pimps and corrupt law-enforcement agents that covers the region. Women and young girls are auctioned off at sales reminiscent of the slave trade during the nineteenth century, and each "sale" brings the pimp over two hundred dollars. The buyer, to whom the woman or girl is married off, may be a pimp himself or a man who uses her as a laborer. The occasional runaway or victim of a rare police raid finds herself

in jail charged under the Hudood laws with illegal sex outside of marriage or else with illegal entry into the country. Their only hope for release and rehabilitation, even if only within Pakistan, is free legal aid offered by a limited number of nongovernmental organizations in the country and refuge at one of the Edhi Welfare Trust charitable homes for the destitute.

Girls from within Pakistan are also working in brothels around the country. Pimps will pick up destitute or runaway girls and women from the streets and persuade or force them into the profession. Other victims are sold into the business by their own family members or even kidnapped from their own homes. Auctions of girls have been reported in small towns, where they fetch Rs. 30-40,000 for their "owners." (HRCP 1996)

One early study identified four broad categories of prostitutes: dancing girls, society ("call") girls, students or nurses earning additional income through prostitution, and full-time prostitutes in brothels. (Abbas et al. 1985) In a small survey of 40 full-time prostitutes (ten from each province), it emerged that most of them were between 20-35 years of age and had been sold and married off to their pimps by their families. This was particularly common in northern parts of the country such as Swat and Parachanar, from which girls would end up in brothels in other regions. From within the category of dancing girls, or *kanjars* as the community in the red-light district is known, further sub-categories have been identified within a hierarchy. (Khilji n.d.) It is possible that adolescent girls predominantly occupy one of these sub-categories, although age breakdowns are not always available. In another study of 100 commercial sex workers in Lahore, 47 were ages 15-25. (SOCH n.d.)

The Human Rights Commission of Pakistan has documented numerous reported incidents of the kidnapping and sale of women within Pakistan, as well as the trafficking of Afghan women in Peshawar. (HRCP 1996) Accurate figures on the proportion of trafficked women who are adolescents are impossible to obtain, but the fact that young girls are sold into prostitution and that mothers and daughters are sold separately demonstrates that the business values the young independently. Further, those who find themselves bought and sold are invariably victims of poverty, and lack the support and protection of their families.

Laws and Policies

Legal provisions do exist that partially protect children from sexual exploitation, although no law exists which specifically prohibits child sexual abuse. For example, the 1979 Hudood Ordinances prescribe severe punishments (imprisonment and whipping) for unlawful sexual intercourse with a child. However, a girl child is defined as someone under age 16 or pre-pubescent, a definition in violation of the Convention on the Rights of the Child (CRC) and too vague to protect many adolescents. Further, provisions in the Pakistan Penal Code 1860 make the act of seduction of a girl under age 18 punishable by imprisonment or fine, and the Sind Children Act 1955 prohibits a child over age 4 from living in or frequenting a brothel.

(Fayyazuddin et al. 1998) However, the Provincial Suppression of Prostitution Ordinance 1961 comprehensively forbids the practice of prostitution, including encouraging the seduction or prostitution of a girl less than 16 years of age. (Jillani 1989)

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

These weaknesses in the law, which may not create the problem of child prostitution but arguably facilitate its continuation, remain despite Pakistan's commitment to the Convention on the Rights of the Child. Under Article 34 of the CRC, state parties commit to taking all appropriate national, bilateral, and multilateral measures to prevent the inducement or coercion of a child in unlawful sexual activity, the exploitative use of children in prostitution or other unlawful sexual practices and pornographic performances. (Jillani 1989) Particularly with regard to the trafficking of women and children in the region, such bilateral and multilateral measures are not being taken by Pakistan.

The National Commission for Child Welfare and Development has begun a project with ILO/IPEC to conduct research and "establish administrative measures" to combat child trafficking in the South Asian region. (Ministry of Women Development 1997) The commission has prepared a report on combating the trafficking of children which is still in draft form and was not available for this literature review. Meanwhile, the recommendations made by the Working Group on Youth Development in preparation for the Ninth Five Year Plan (1998-2003) do not mention the need to combat child sexual abuse/exploitation or trafficking by addressing the underlying causes of this social problem. In fact, the report lists "problems in maintaining traditional moral values" as one of the major issues "afflicting" Pakistani youth. It is unclear, therefore, whether sexual exploitation of adolescents is being encouraged by default at the policy level.

VI. SEXUAL VIOLENCE AND SEXUAL ABUSE

The above discussion introduced one type of sexual violence and abuse to which adolescents are vulnerable, that of the commercial sex industry. Even more difficult for Pakistani society to tackle effectively are the violence and abuse endured by the young within their own homes or communities – where the criminals are not pimps but ordinary members of society and often well-known to their victims. Despite the "walls of silence" surrounding these crimes and the difficulty in exposing and prosecuting the perpetrators, nongovernmental organizations have made steady progress in documenting and publicizing the extent of the problem and the press has begun to report incidents more frequently.

Sexual Abuse

Sahil argues that child sexual abuse is rooted in mainstream culture and strengthened by the power imbalance encouraged between children and adults. The problem is reinforced by society's refusal to acknowledge a child's rights over his or her body and the right to live free from violence. Children lack a voice in our society, and thus are unable themselves to break the silence surrounding child sexual abuse. (Sahil n.d.)

Table 9: Child sexual abuse as reported in Pakistani newspapers, by type, according to sex of child, January 1997-December 1998

Crime[a]	Male	Female	Total
Abduction	13	124	137
Sodomy	171		171
Molestation	55	114	169
Rape		359	359
Gang rape	114	287	401
Child sexual abuse (CSA) and murder	46	81	127
Total	**399**	**965**	**1,364**

[a]Explanation of terms used by Sahil in categorizing crimes from newspaper articles for this table: **abduction**--abduction of children when the sexual intent is stated in the newspaper report; **sodomy**--sodomy of boys only, equivalent to rape (girls are never reported in the press to have been victims of sodomy, however abusers do confess to this); **molestation**--includes acts such as tearing clothes, attempted rape, and all acts of a sexual nature done with sexual intent (excluding rape); **rape**--rape of girls only (boys are covered under sodomy), includes penetration with an object (see comment under sodomy regarding girls); **gang rape**--gang rape of girls only, involves more than one abuser with penetration having taken place, whether by object, penis, finger, etc (similar cases for boys are classified as gang sodomy); and **CSA and murder**--of children, is used when a child has been molested or raped and then murdered.
Source: Sahil Fact Sheet, January-December 1997 and 1998.

Figures reflecting the number of reported cases of child sexual abuse in a Sahil survey of Pakistani newspapers are noted in **Table 9**. These data are limited by the reality that police and subsequent newspaper reporting of cases is rare and represents only a fraction of all cases. Details of the cases may be sensationalized

or inaccurate (Khan 1994) and boys may be even more reluctant than girls in some social settings to report sexual abuse. A study among 151 adolescents ages 11-19 in a low-income community in Karachi suggests that while the majority felt that touching someone without their consent was wrong, a significant proportion nevertheless felt that the victim was at fault. (Aahung 1999) The study suggests that this attitude contributes to the underreporting of incidences of abuse.

The figures indicate a widespread problem of sexual abuse. In 1997, for example, one child every day was reported either gang raped, raped, murdered after a sexual act, or abducted for purposes of sexual fulfillment. (Sahil n.d.) Females are more vulnerable than males on every count of abuse. Most disturbing is that rape and sodomy are most often reported as the type of abuse for both boys and girls. This may reflect the fact that these crimes are most likely to attract police and press attention. Seventy-three percent of the abusers identified in connection with the cases in **Table 9** were acquaintances of the victim. The second largest category of abusers was of strangers (19 percent), followed by relatives, teachers, police, and maulvis.

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

War Against Rape, a small organization with offices in Lahore and Karachi, conducted a similar exercise based on newspaper reports of sexual abuse cases of girls in the Punjab between 1991-1993. These findings confirm that adolescent girls are particularly vulnerable to sexual abuse. Out of 149 press cases analyzed, 85 percent were of girls between ages 10-20. Rape and gang rape were again the most commonly reported types of sexual abuse. Most of the girls came from lower or lower-middle income groups, which may simply indicate that girls from higher socio-economic groups either do not report cases as often or else manage to avoid press coverage of cases. Since the total number of child sexual abuse cases registered with the Punjab police in this time period was 4,200, an analysis of these cases would probably reveal with more accuracy the class distribution of victims.

The Punjab study provides valuable insight into how sexual abuse occurs. For example, in half of the cases where the time frame of abuse could be determined, cases were evenly distributed in the ranges of 24 hours, and extended over periods of 2 to 29 days and from one month to one year. There were even six cases of reported abuse lasting over one year. In 89 percent of the cases, abduction/attempted abduction, and physical abuse also accompanied sexual

abuse. The abuser was most often identified as an acquaintance; only 33 abusers (22 percent) were confirmed as arrested.

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

We already know that adolescent female mobility is particularly restricted as compared to the mobility of older women, and that research (Khan 1998) has shown that fears of sexual violation underpin these restrictions. The figures on sexual abuse and rape suggest that these fears are not baseless, but that the perception of the outside world as a violent place, for young girls in particular, is correct to some extent. Nonetheless, the unhealthy and morbid fear of assault that pervades social norms limiting girls' movement (Khan 1998) is still likely to be exaggerated and manipulated. For example, scant attention is paid to acknowledging the problem of incest, which takes places within the home (discussed below). Further, sexual assault and abuse also affects boys; however, their mobility is not restricted as a result and they do not have a sense of constant threat pervading their perception of the outside world. It seems likely that the threat of sexual assault serves most to restrict the movement of girls rather than boys, and in so doing is used to limit their growth and participation in society.

Incest

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

Another Islamabad-based project to tackle child sexual abuse, Aangan, analyzed a randomly selected pool of 100 confidential letters it had received from victims/survivors of child sexual abuse. Forty-seven of them were incest cases. (Aangan 1998) (**Table 10**) This figure is dramatically higher than the number of incest cases monitored in press reports, possibly because the writers are self-selected and anonymous and know that their information will be shared in a safe environment.

Aangan found that all of the abusers identified in the study had been victims of child sexual abuse themselves. Abuse may not only begin at a young average age (6–8 years) but it is also known to last for years, particularly because the abuser

is usually a close relative. Findings suggest that girls are more likely to be victims than boys, and that abusers are more likely to be male than female. Boys are more likely to become victims in their early adolescence while girls may become victims early. The most common reported psychological effects suffered by the victims were negative self-esteem and problems in relationships, followed by sexual difficulties, fear of marriage, and others. Finally, incest is not confined to one social class, but has been reported across classes in Pakistan.

Table 10: Major findings of Aangan study on incest

Variable	Statistic
Number of cases	47 cases
Percent who were survivors (incest stopped)	76 percent
Percent who were victims (incest continuing)	17 percent
Percent of survivors who were also abusers	4 percent
Percent who were abusers	2 percent
Average age of incest victim	8 years
Percent of victims by sex	66 percent female
	34 percent male
Percent of abusers by sex	88 percent male
	8 percent female
	4 percent not identified
Percentage of abusers by relationship to incest victim	
Older cousin	32 percent
Real uncle	28 percent
Real brother	19 percent
Father	6 percent
Aunt	6 percent
Grandfather	2 percent
Other relative	6 percent

Source: Aangan 1998: 1-3.

Pornography

There is almost no research on child pornography and the exposure of children to pornographic material in Pakistan. However in the North West Frontier Province it was reported that the showing of pornographic movies to children was on the rise (NGO Coalition on Child Rights 1998) and the practice is linked to the sexual abuse of young boys in particular and subsequent exploitation of them for prostitution. (Sahil 1998) Further, children who are victims of sexual abuse are known to be blackmailed by their abusers who threaten that they will, or have, publicized photographs of the abusive acts. (Khan 1994; Fayyazuddin et al. 1998)

Protecting Adolescents from Sexual Abuse

Since the problem of child sexual abuse, as well as the definition of a child as under age 18, has been slow to be accepted in Pakistan, little is being done at the national/policy level to protect young people.

Sahil is currently the only nongovernmental organization devoted solely to the task of raising awareness about child sexual abuse and handling crisis cases. Based in Islamabad, Sahil activities include: conducting small research studies, organizing seminars, and publishing educational information about child sexual abuse. In addition, Sahil offers immediate medical and psychological aid to victims, free legal aid through a team of volunteer lawyers, and referral services to those who need long-term care. (Saifullah 1998)

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

Like Aangan, which grew out of an organization devoted to the empowerment of women, War Against Rape (WAR) works with victims of child sexual abuse as an outgrowth of its experience with violence against women. WAR handles individual cases of sexual abuse and provides legal help to survivors in Lahore and Karachi. Research and raising awareness are also WAR activities, and the organization works in close collaboration with legal aid services and human rights organizations.

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

One reason for this apparent inaction is the legal complexities that need to be unraveled in order to provide full protection to the under-eighteen age group. Although there are laws that clearly forbid prostitution, trafficking, seduction of minor girls under age 18, and sodomy, the laws are not consistent. For example, the Pakistan Penal Code (Section 366A) makes the seduction or forced intercourse with a girl under age 18 punishable by imprisonment, but does not mention boys. In Sindh, the law pertaining to seduction and trafficking defines a minor as under age 18, whereas in Punjab the girl child is defined as under age 16. (Saifullah 1998)

The Hudood Ordinances 1979, which apply to rape and sex outside of marriage, cause the most damage of all. Under Hudood (Offence of Zina Ordinance, Clause 6), a woman or a man can commit rape with someone to whom he/she is not validly married if it is against the will or consent of the victim or if the victim is put in fear of death or believes him/herself to be married to the offender. Further, under the

Zina Ordinance sex committed with a non-adult girl under age 16 is considered rape, but if the girl has attained puberty the accused is to be awarded a lighter sentence. Both boys and girls are considered adult if they are age 18 or 16 respectively, or have attained puberty. An adult can be charged with adultery and awarded maximum punishment of whipping and death. (Chohan 1996) Worst of all, if a victim alleges rape and cannot prove it, he or she becomes liable to be charged with illegal sex outside of marriage and receive maximum punishment. Hence, it was not out of any misinterpretation of the law that a boy of age 12 found himself in a Punjab jail, convicted under the Hudood Ordinances. (Saifullah 1998)

The Hudood Ordinances enjoy specific ideological protection since they were the first laws enacted under Pakistan's process of Islamizing its social and legal system, begun under military rule in the late 1970's. Although it would take only a majority of votes in the National Assembly to repeal these laws, as recommended by the latest Report of the Inquiry Commission for Women 1997, governments avoid taking a stand on these discriminatory laws for fear of a back-lash from the religious right. (Saeed and Khan 1998)

VII. SEXUALLY TRANSMITTED DISEASES

The threat of an HIV/AIDS pandemic has prompted Pakistan's policymakers, donors, and development workers to attempt an initial exploration into high-risk sexual behavior with a view to controlling the spread of serious sexually transmitted diseases. Because any research into sexual behavior patterns, as well as open discussion of how to reduce high-risk behavior, is fraught with social taboos, available research is limited to small-scale studies and does not represent any solid national sampling. One major weakness in the available data, as with research on other areas of reproductive health, is a lack of clear age breakdowns within the sample population. Thus, the limited data on AIDS and STDs in Pakistan, although more than the available general information about sexual behavior, does not give us specific information about high-risk behavior among adolescents.

However, we know that adolescents are exposed to high-risk behavior through sexual abuse, commercial sex, homosexual relations, and life in jails, and are also more powerless than adults in exploitative circumstances. It is reasonable to assume, then, that adolescents are among the high-risk groups for such diseases, although it is not possible to say in what proportion. Though it is possible to speculate on whether those at risk (especially girls) are even more vulnerable due to their young age and lack of decisionmaking power to protect themselves, there is no literature to document this.

HIV/AIDS

Pakistan is fertile ground for an AIDS epidemic, due to its low social indicators, economic status, and state of epidemiological transition. (Hyder and Khan 1998) The reported number of HIV-infected cases has been low – up to August 1997 the figure was 1,232. However, the number of total estimated HIV-infected population is as high as 80,000, and the estimated national prevalence figure for HIV is 64 per 100,000. The dominant modes of transmission are heterosexual contact and blood transfusion/blood products. (HIV Working Group 1998)

Only 20 Pakistani children, up to age 19, have been reported HIV-positive. Since children and adolescents are often not even tested out of the mistaken belief that they cannot be sexually active, and most screenings are done of so-called high-risk groups only, we cannot know the real level of infection among them. (Ahmed 1998) As Ahmed explains in her overview of HIV/AIDS and children in South Asia, the disease is a grave issue for children because they are vulnerable themselves to the multiple patterns of transmission and also to the manifold consequences of losing a parent to the disease.

Pakistani children and adolescents are exposed to all of the risks and issues associated with HIV/AIDS highlighted by Ahmed. Mother-to-child transmission may condemn an infected baby to death before age 2, particularly when immunity is low,

and death can be caused by diarrhea, measles, tuberculosis, and other respiratory tract infections. Because poverty in developing countries promotes the spread of these illnesses and weakens the immune system, the time from infection to death is shorter for children with AIDS.

Ahmed points out other aspects of the disease pattern which impact children. Male migration, particularly between Pakistan and Gulf countries, has been a source of AIDS transmission and death or social ostracism for wives who become infected. Women and girls are physically more likely to contract HIV from men than the other way around. Women's lower social status and the high rate of rape in Pakistan further limits their ability to protect themselves from HIV transmission.[6] Changing social patterns and urbanization have increased levels of sexual abuse, and child prostitutes and street children are presumably at higher risk of contracting HIV and other sexually transmitted diseases. Finally, young people are also at risk through contaminated blood transmitted through blood transfusions and the increasing use of needles for drug use.

Studies done with high-risk groups in Pakistan do not have age-specific data for adolescents because adults are the focus of the research. However, these studies do mention that men and women can begin their pattern of high-risk behavior while still adolescents. For example, truck drivers have been identified as a potentially important conduit for the spread of HIV/AIDS. Among 35 drivers and truck cleaners, Ahmed et al. (1995) found a high rate of male-to-male sexual contact and contact with female commercial sex workers, as well as a significant rate of drug use. The cleaners were younger than the drivers and included adolescent boys, whose practices were found to be similar. More than half the drivers had been cleaners first, which establishes how they were initiated into this line of work and high-risk behavior. One Indian study of adolescent truck cleaners, quoted in Jejeebhoy (1998), found that 4 percent had a history of sexually transmitted disease, but this figure is likely to be an underestimate.

The commercial sex industry, also a high-risk group, has been the subject of a number of HIV/AIDS prevalence and awareness studies. (Baqi et al. 1998; Khilji n.d.; Manzoor et al. 1995; SOCH n.d.) Baqi et al. (1998) found that the average age of first intercourse for the female commercial sex workers was 14-15 years, and age 11 for male transvestites. Condom use by CSWs was very low. In the Lahore Red Light Area, daughters inherit the profession from their mothers (SOCH n.d.). In one study almost half of CSWs reported they began selling sex at the onset of menstruation. (Manzoor et al. 1995) This is yet another example of how the young are set on the road to high-risk behavior in an environment where knowledge about HIV and others STDs is low and the use of condoms is inadequate.

[6] To date among the reported cases of HIV and AIDS there is a 5 to 1 ratio of men to women, not reflecting the fact that women are physically more vulnerable to the disease. (Hyder and Khan 1998) However the future pattern that the spread of the disease makes in the population may reflect this gender difference.

In a study of 3,392 male prisoners ages 11-81, interviewed in Sindh jails, they reported symptoms of STDs as well as sexual intercourse with multiple partners (male and female). (Khan et al. 1995) They also reported past experiences with commercial sex workers (26 percent) and blood donations (22 percent), and 121 prisoners said that had injected drugs. The study concluded, "prisons in Sindh are potential reservoirs of sexually transmitted diseases" (Khan et al. 1995: 12), and recommended that the Sindh government control the spread of STDs in prisons if it wished to limit the problem among the general population.

There are only 2 juvenile jails in Pakistan. As a result, children find themselves in adult jails, albeit in separate cells, where they experience the same deprivation as older prisoners. According to a survey conducted by the Society for the Protection of Child Rights in 1997, out of a total of 72,714 prisoners in Pakistan, 3,480 were juveniles. Most of them were languishing in jail awaiting trial, while only 282 were convicted. (Fayyazuddin et al. 1998) Juvenile prisoners are therefore likely to be exposed to similar high-risk behavior as their adult, particularly male, counterparts, and therefore at risk of contracting STDs.

Exclusive focus on high-risk groups and behaviors obscures the reality that all citizens of Pakistan, including those who are not sexually active, are at risk of contracting AIDS. For example, everyone is vulnerable to transmission through contaminated blood from hospitals or contaminated needles used in injections, regardless of their age. The risk increases because bad health care practices have resulted in an excessive use of blood transfusions and injections in treating patients. (Khawaja et al. 1997) In Pakistan only 30-40 percent of the blood used for transfusions is being screened for HIV. (UNICEF 1998a)

Other Sexually Transmitted Diseases

Some experts argue that the STD epidemic among adolescents is growing globally, probably due to the large proportion of older adolescents who are sexually active either within or outside marriage. (Mensch et al. 1998) Throughout South Asia studies to substantiate or negate this claim are few. However one study from India quoted in Jejeebhoy (1998) reported that the typical patient at STD clinics is a young man barely out of adolescence. In another study quoted by Ahmed (1998) 16 percent of 362 STD cases at a private hospital in Delhi were of children under age 14.

The Karachi Reproductive Health Project undertook a survey to establish a baseline STD prevalence among women in a low-income community in Karachi. (KRHP 1997) Six hundred and one married women between the ages 14-45 were tested for syphilis, gonorrhea, chlamydia, trichomoniasis, and candida in accordance with standards set by WHO and the National AIDS Control Programme. The study found the prevalence of STDs to be extremely low (the highest prevalence was candida at 6 percent) despite that fact that more than half the women complained of vaginal discharge. The researchers recommended modifying the WHO protocol for

the management of discharge as it may not be relevant to the population studied. They found that there is confusion surrounding vaginal discharge, and when the WHO protocol is followed to determine the need for testing, it resulted in 500 percent over-treatment. KRHP is currently developing its own protocol to assess vaginal discharge among women and reduce unnecessary testing and treatment.

Awareness and Prevention

Studies conducted among the high-risk groups susceptible to STDs and HIV/AIDS, such as commercial sex workers, drug users, prisoners, truck drivers and blood recipients, show a generally low level of knowledge about HIV/AIDS and its transmission. (Khwaja et al. 1997)

Qidwai's (1996) study of 188 men ages 18-30 in Karachi reveals that lack of awareness/information is not confined to high-risk groups of men: 41 percent of respondents did not know that condoms offer protection from STDs and 30 percent did not know that an otherwise healthy person can still transmit an STD. Ignorance levels were higher among the lower socioeconomic and less-educated respondents.

Among adolescents interviewed in Chanessar Goth, Karachi (151 male and female respondents ages 11-19), most had heard of HIV/AIDS and knew it was fatal, but only 23 percent knew that sexual activity was a mode of transmission. (Aahung 1999) Only 31 percent knew that using a condom reduces the chance of acquiring AIDS. Raoof Ali's findings from 37 discussion groups with men in rural Punjab also confirm that there is lack of knowledge and information about STDs, particularly regarding the role of condoms in protecting against infection. (Raoof Ali 1999)

There was an interesting gender differential in the Aahung study findings regarding knowledge about general STDs: 44 percent of 71 males interviewed said that sexual activity was a mode of transmission while only 11 percent of 80 females interviewed could correctly state the same. Twice as many boys as girls knew that sexual activity was a mode of transmission of the AIDS virus.

The low level of awareness and information regarding AIDS in Pakistan has been attributed to a complex set of factors; these include urbanization, migration, exploitation of women, and the legal framework surrounding marriage and sexuality. (Hyder and Khan 1998) These are the same factors that put people at risk for contracting the disease, particularly the young and disempowered. (Ahmed 1998) The stigma of STDs and taboos surrounding sex education both cause and reinforce current ignorance.

Policy and program interventions have been slow to respond effectively to the potentially dangerous levels of ignorance and high-risk behavior in Pakistan. For example, because of a government ban on the use of television and radio for raising AIDS awareness, the first condom advertisement did not appear until March 1994, after the official stance was changed. (Khwaja et al. 1997) In 1999, the Ministry of

Health, along with the National AIDS Control Programme (NACP), began a television campaign explicitly warning that the AIDS virus could be sexually transmitted.

The National AIDS Control Programme (NACP) was established in 1987. It has established blood-screening centers across the country and conducted a media campaign to increase awareness; nonetheless, misconceptions and ignorance prevail among the population. Further, the problem of organizing the health sector nationwide to screen blood and to educate health practitioners about reducing risks to patients remains in the hands of separate provincial governments, because health is often dealt with at the provincial rather than the national level.

The United Nations in Pakistan, led by UNAIDS and including UNICEF and UNFPA, is including education and awareness about STD/AIDS in its programs. In its upcoming program cycle, UNICEF plans give special attention to youth, in addition to high-risk groups, and to training nongovernmental and health workers in prevention and counseling techniques. (UNICEF 1998b)

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

The best way to reach adolescents and equip them with the knowledge to protect themselves is through the media and the educational system, both of which are constrained by an official refusal to inform the public about sexual issues. This refusal arises out of a fear that is rooted in a combination of tradition and religious interpretation and is reflected in state structures and institutions throughout the country. The result is that reproductive health information is made available only through a small number of nongovernmental organizations or individual health practitioners, both of which have limited outreach.

VIII. ABORTION

WHO has estimated that out of the 500,000 maternal deaths worldwide each year, 115,000-204,000 result from complications of illegal abortions performed by unqualified practitioners. WHO also estimates that more than half of the deaths caused by induced abortion take place in South and Southeast Asia. (Henshaw and Morrow 1990: 81)

Policymakers in Pakistan are slowly recognizing that women practice induced abortion in this country, often in unsafe environments, and that this poses a public health problem. In the Pakistan Country Paper submitted to the 1995 Fourth World Conference on Women, the government estimated that illegal abortions cause up to 15 percent of all maternal deaths "and form the largest and single most alarming indicator of the present inadequacy of reproductive health services" (Ministry of Women Development and Youth Affairs 1995: 31). Pakistan is signatory to the ICPD 1994 document that includes a condemnation of the danger unsafe abortions pose to women around the world but stops short of stating that it should be legalized. Pakistan also ratified the Convention on the Elimination of Discrimination Against Women (CEDAW) in March 1996, which states that the state shall ensure the equality of men and women in deciding freely and responsibly the number and spacing of their children.

Despite such international commitments, Pakistani law does not allow abortion unless it is for the purpose of saving the life of the woman or providing her necessary medical treatment.[7] A similar law exists in Bangladesh, although the government allows for induced abortion under the guise of "menstrual regulation" up to 10 weeks after a woman's last menstrual period. India, however, has a more liberal abortion law, allowing women to have induced abortions for social and social-medical reasons, although implementation of this law has not yet resulted in safe abortion services for all women.

Women's groups, along with legal experts, have demanded that abortion laws be made more flexible ever since the 1976 Report of the Pakistan Women's Rights Committee, which listed the recommendations of a high-level government committee of experts on women's issues. The last Inquiry Commission on Women published its

[7] The Pakistan Penal Code inherited its original abortion law (Section 312) from the British colonial Penal Code. This version states that if someone causes a pregnant woman to miscarry not in good faith for the purpose of saving her life, that person would be punishable with fine or imprisonment up to three years or both, and the woman herself could be imprisoned up to seven years and also be liable to fine. This law was amended by the promulgation of the Qisas and Diyat Ordinance in 1991; a law brought in as part of the government's efforts to Islamize the legal code. This presidential ordinance amended the existing Penal Code and became a law approved by Parliament in 1996. This law differentiates between abortion caused to a fetus whose limbs have not been formed and one whose limbs have been formed. The former is punishable with imprisonment provided it is not caused "in good faith for the purpose of saving the life of the woman or providing necessary treatment to her." The latter is punishable with imprisonment as well as financial compensation to the victim's heirs if it is not done in good faith for the purpose of saving the life of the woman. It should be noted that the amended law includes the provision "necessary treatment" which can be interpreted in favor of a woman who has had an abortion. (Shirkat Gah 1996)

findings in August 1997, stating categorically that induced abortion in the first trimester must be made legal so as to avoid the serious social and public health costs for women undergoing unsafe illegal abortions.

The prevalence of induced abortion is difficult to determine with any accuracy because research into the practice has been limited, and there is an understandable reluctance among the public to admit to illegal activity when questioned. The rate of induced abortions in a Karachi community-based study was 12 percent out of 283 pregnancies reported by 34 women. (Fikree et al. 1996) Medical practitioners often informally share the opinion that more than half of the work of gynecologists in hospitals is the treatment of complications caused by induced abortions, although women are reluctant to admit that they sought a back-street abortion. (Rana 1992; Khan et al. 1996) The risks and exploitation experienced by women who seek an illegal abortion have been the subject of a number of press articles over the years and a limited amount of in-depth discussions among women's groups. (Shirkat Gah 1996)

The social and religious taboos and legal restrictions on the practice inhibit the ability of organizations to delve into the problem more fully. But small-scale community studies and hospital-based surveys do exist, and their findings continue to be disturbing. In a follow-up of the Fikree et al. (1996) study in other settlements, it was found that those seeking abortion are generally married, young, illiterate, and have an average of 3.7 living children. In a study of three squatter settlements in Karachi, the 100 women who reported an induced abortion in recent years were more likely to be educated, between the ages of 26-35, and have had more than 4 pregnancies. (Saleem 1998) The context in which the decision to terminate a pregnancy took place included the initial problem of contraceptive failure or an unwilling husband, combined with children born too often and with too little spacing for the mother to handle. Doctors were most commonly asked to conduct the abortion. Patients rated dilatation and curettage as the most successful method. Fikree et al. (1996) also found that women sought induced abortion mainly for economic reasons or because of short pregnancy intervals.

In a hospital-based study in Karachi two groups of women were studied in 1977-78 and 1990-91. (Zaidi et al. 1993) Out of a total of 3,462 women, 81 (2 percent) gave a history of induced abortion. Although data for women under age 20 is not analyzed separately, it is revealing that 34 of these women were aged 15-25, 9 had no children, 35 had 1-4 children, and five were unmarried. Such findings establish that younger women, including those who are not married and those with less than 4 children, do seek abortions.

In Lahore, a study of 125 abortion cases found that 20 percent were between ages 15-19 and 10 percent of the women were unmarried. (Rana 1992) Although most of the induced abortions took place among older women (aged 30-40) who were grand multipara and belonged to a lower socioeconomic group, this study establishes clearly that adolescents in Pakistan are seeking abortions. The findings of a Karachi hospital-based study of 37 cases of induced abortion are similar.

(Tayyab and Samad 1996) Over 78 percent were among women aged 25-34 and over 75 percent of all cases were multiparous. But with 6 of the patients between ages 15-24, and 3 with no previous children, once again the data suggest a small but potentially significant adolescent component to the induced abortion problem. Mensch et al. (1998) in their discussion of adolescent girls in the developing world note that adolescents may be over-represented in studies such as these because of the increased risk among younger abortion patients of sepsis and other related complications, caused possibly by delays in seeking medical care. This makes it difficult to correctly estimate the proportion of adolescent abortion patients.

These hospital-based studies reveal that the consequences of induced abortion are severe and often result in death. In Zaidi et al. (1993) the patients presented with a range of problems including trauma to their pelvic organs/bowels, vaginal bleeding, and sepsis. Over half of them had their abortions induced by a *dai* (traditional birth attendant) and a total of 13 women died in hospital. Eighty percent of the cases in the Rana report (1992) were for perforation of the uterus, and 12 percent died. Out of the 37 cases discussed in Tayyab and Samad (1996), nine died, with the rest reporting trauma, haemorrhage, and sepsis. Such findings contrast sharply with the lower mortality rates in developed countries where abortions are legal and the procedure is safer than pregnancy or childbirth; for example, in the United States the mortality rate associated with legal abortions between 1980-1985 was 0.6 per 100,000. (Henshaw and Morrow 1990)

For those women, and adolescents, who seek medical care after an induced abortion, there are few options other than large urban hospitals. Family welfare clinics do not treat abortion complications, and in fact lack any surgical facilities. The scarcity of medical services in the rural areas means that an undetermined number of women never access medical treatment for abortion-related complications. The difficulties of accessing urban-based services will be even greater for adolescent girls, most obviously unmarried ones, whose decisionmaking power and physical mobility is so restricted by their social environment that seeking any medical help outside of the village is fraught with barriers. (Khan 1998)

A few nongovernmental organizations have begun to offer treatment for post-abortion complications. Marie Stopes Services (MSS) in Pakistan pioneered this work, and the Family Planning Association of Pakistan and Behbud Welfare Association have recently equipped some of their urban centers across the country to perform simple dilatation and curettage and provide other treatments for complications. These services are provided in addition to a range of traditional family planning services and also include tubal ligations and vasectomies. Although the largest client demand at MSS, for example, is for tubal ligations and injectables, there is a consistent stream of clients presenting with incomplete abortion. MSS estimates that 15-20 percent of their clients are adolescents, who are presumed to be married.[8]

[8] Personal Communication, Marie Stopes Services, Karachi, December 1998.

IX. MARRIAGE AND CHILDBEARING

Age at marriage is on the increase throughout the world, although a substantial number of adolescent girls still marry early. Data from 40 Demographic and Health Surveys in developing countries show that up to 50 percent of women marry by age 18. Singh and Samara (1996) note that studies identify the socioeconomic factors most influencing a woman's age at marriage as: female labor force participation, acquisition of formal education, and urbanization. In countries with a higher proportion of women with secondary education, the proportion of women who marry in adolescence is lower.

The consequences of early marriage for the development of young women in particular have yet to be adequately researched. One reason for this is that the needs of adolescents are not yet recognized as specific and valid enough to ensure major program and policy interventions. Mensch et al. maintain "that a girl remains an adolescent – with stage-specific vulnerabilities, capacities, and development opportunities – roughly from the time she turns 10 until she turns 20, whether or not she marries or gives birth. Recognition of this fact will help to bring much-deserved attention to the large proportion of adolescent girls who become wives before they become adults" (Mensch et al. 1998: 70).

In Pakistan, the average age at marriage is increasing for both men and women, and at a faster rate for the latter. The singulate mean age at marriage according to the Pakistan Fertility and Family Planning Survey 1996-97 (Hakim et al. 1998) is 26.5 for men and 22 for women. PCPS data show the traditionally larger age gap between spouses is shrinking, with only 18 percent of married women ages 15-19 married to men ten or more years older, while 28 percent of married women 35-39 are married to men over a decade older. Age at marriage is slightly lower for both men and women in rural than in urban areas, and is substantially higher, particularly for women, with increased levels of education. (Population Council et al. 1998)

Table 11: Percentage of married adolescents and youth by sex, Pakistan Fertility and Family Planning Survey 1996-97

Sex	Ages 15-19	Ages 20-24
Male	3.4	24.2
Female	17.0	57.9

Source: Hakim et al. 1998: 90-1.

According to the most recent figures, as shown in **Table 11**, a substantial proportion of adolescents and youth are married. There is a strong bias in favor of females marrying younger than males, most dramatically so among adolescents. While the PFFPS figures show that the proportion of married adolescent girls is less than in earlier surveys, there is still clearly a strong tendency toward girls marrying at

a young age, and particularly before age 25. In rural areas, the earliest age at marriage is lower for both males and females than in urban areas. For example, at age 19, 85 percent of females in major urban areas are single, while only 58 percent are single in rural areas. (Hakim et al. 1998)

The figures in **Table 12** provide further data adding depth to the reality of age at marriage figures. Whereas **Table11** shows how many adolescents are currently married, it cannot predict how many have yet to marry by age 19. **Table 12** shows that over half of women ages 20-24 were married as adolescents (i.e., before age 20). Even among men the comparable figure of 13 percent is much higher than the proportion of current adolescents who are married. An analysis of Pakistan Integrated Household Survey 1990-91 data (Durrant 1998) finds that the factors associated with higher rates of marriage as an adolescent were: being female, living in a rural area, living in the NWFP or Balochistan, never having attended school, and having illiterate parents and/or parents with low levels of education.

Table 12: Percent of men and women in various age groups married before the age of 20, by age group, according to sex and residence, Pakistan Integrated Household Survey 1995-96

Age group	Men			Women		
	Urban	Rural	Total	Urban	Rural	Total
20-24	6	17	13	38	59	52
25-29	12	24	20	51	61	58
30-34	13	21	18	56	63	61
35-39	12	18	16	62	67	66
40-44	12	20	17	67	62	64
Total	**11**	**20**	**17**	**53**	**62**	**59**

Source: PIHS data, as analyzed by Dr. Valerie Durrant, The Population Council.

Adolescents, particularly girls, who marry do not necessarily wish to do so. A study of female autonomy and relations within marriage in Egypt found that among girls who married before age 16, only 1 in 10 chose their husband, while 40 percent of those who married after age 25 selected their spouse. (Mensch et al. 1998) In Pakistan, arranged marriages are still the norm and female status is significantly lower than that of males. In this context, girls' decisionmaking power in timing and choice of spouse is obviously limited, but further research is required to determine under what circumstances early marriage is against the will of the adolescent girl.

A series of focus group discussions (Population Council 1999) with adolescent boys and girls in rural Punjab revealed that they have different approaches to the question of marriage timing and choice. While boys felt the ideal age at marriage was between 18-29 years, girls limited the range to 20-25 years only – out of the adolescent years. Interestingly, boys said that the choice of spouse should rest with both the boy and girl and that they did express their own views on the matter, while girls generally felt that parents should be trusted to find them a suitable match but girls ought to be consulted.

Singh and Samara (1996) point out that married adolescent girls are likely to find motherhood the sole focus of their lives, at the expense of development in other areas, such as formal education, training for employment, work experience, and personal growth. The fact that Pakistan still has a substantial number of married adolescent girls implies, using Singh and Samara's analysis, that these girls have not had the education or employment opportunities associated with delayed marriage and reside predominantly in the rural areas. This is supported by the analysis in the PCPS report showing that age at marriage is lowest in rural areas and increases with education. (Population Council et al. 1998)

Risks Associated with Early Childbearing

There are numerous negative consequences of bearing children while one is still young. It brings not only risks to the mother's health, but reduces her life options in terms of education and economic independence. Although the broader consequences of early childbearing have rarely been studied, findings from some countries suggest girls who give birth during adolescence are likely to be more economically disadvantaged than those who give birth later are. (Mensch et al. 1998)

The overall context of maternal mortality and morbidity in Pakistan is weak: only 20 percent of women are assisted by a trained provider during delivery, the country ranks third in the world in numbers of infants who die of neonatal tetanus, and the maternal mortality ratio is 340 per 100,000 live births. (Tinker 1998) Only limited information is available on the consequences of early childbearing among young Pakistani women, and that comes only from general maternal morbidity and mortality studies that do not focus specifically on adolescents.

First, infant mortality is strongly linked with mother's age at first birth, with younger mothers associated with the highest mortality figures. The Demographic and Health Survey 1990-1991 found that neonatal deaths occur at a rate of 70 per 1,000 births for mothers under 20, and post-neonatal occur at a rate of 51 per 1,000 births. The figures drop as the age of mothers increases, and only climbs again for mothers 40 years or older. (NIPS/IRD 1992)

Existing research shows that adolescents figure prominently in deaths associated with childbearing. In a survey of 30 hospitals and private clinics across Pakistan, covering 104,551 live births, there were 703 maternal deaths (Jafarey n.d.) Ten percent of those whose ages were determined were between 15-20. Patients who were not enrolled in regular antenatal care and suffering primarily from direct causes, such as hemorrhage, hypertensive diseases, and sepsis, accounted for most of the deaths. Jafarey identified social, economic, cultural, and logistical factors as preventing women from seeking medical advice even though they were urban residents.

As expected, the data are revealing for what they imply about severe and unapprised problems for adolescents. In a four-year review of maternal deaths in a Quetta hospital, 10 maternal deaths (8 percent) of women between ages 16-20 were caused by the same triad of disorders mentioned in the Jafarey study. (Ashraf 1996) Seventeen deaths (13 percent) were primigravida and 6 women died from induced septic abortion.

Jafarey and Korejo (1995) conducted a study in Karachi between 1981-1990 into the causes of delay that resulted in women arriving at hospitals already dead. Out of the 150 pregnant or recently delivered women who were dead on arrival at hospital, 10 were under age 20. Twenty-two (15 percent) of the women were primigravida; as a guess, this number probably included most if not all of the adolescent girls. The researchers found that most of the deaths were preventable had health services been accessed in time. The most disturbing finding was that all but 5 of the women who were dead on arrival lived only 5-10 kilometers away from the hospital, but a combination of social and economic factors delayed their access to the facility. Reasons for delay included: lack of available transport and finances, reluctance of family to bring the woman to hospital, absence of husband from the house, and inadequate maternal services that failed to refer the patient to the tertiary care facility in time.

Although all of the studies reviewed show that the risk of death increases with higher parity and that the causes of death are easily preventable, the specific reasons for mortality among adolescents, who obviously have little or no history of previous births, need to be identified. Findings mentioned earlier in this section on the restricted mobility and access to health care experienced by adolescent girls could be explored further to ascertain causes of adolescent maternal deaths in hospital. For example, it is important to establish whether adolescent girls who are pregnant have more difficulty seeking regular antenatal care and reaching the hospital in time in case of emergency. If they do, then it is important to develop interventions to overcome these restrictions.

X. FERTILITY AND FAMILY PLANNING

Fertility and family planning information regarding Pakistani adolescents is severely biased, since existing surveys have only covered those who are married. We have only anecdotal evidence from hospitals and family planning service providers that unmarried adolescents are seeking abortions, which implies that some are sexually active and not using contraceptives effectively. Existing surveys exploring fertility and related issues are also biased in favor of women, such that we have insufficient age-specific data on male attitudes and practices.

Table 13: Percentage of married female adolescents aged 15-19, according to characteristics of contraceptive knowledge and practice, Pakistan Contraceptive Prevalence Survey 1994-95

Knowledge of at least 1 method	Knowledge of at least 1 traditional method	Knowledge of the source of at least 1 modern method	Ever used any traditional or modern method	Want a child soon	Unmet need for contraceptives
75.5	17.3	58.8	4.7	74.1	21.7

Source: Population Council et al. 1998: 70, 78, 146.

Table 13 shows that out of the 520 married female respondents aged 15-19 surveyed for the Pakistan Contraceptive Prevalence Survey, 76 percent had knowledge of at least one contraceptive method, with only 17 percent knowing of at least one traditional method. Over half of the women surveyed knew of the source of at least one modern method. The figures for knowledge of at least one method increase with age, peaking at 95 percent for married women ages 35-39. This means that adolescent respondents had somewhat less contraceptive knowledge than older women did, as well as less knowledge of how to access a modern method. In contrast, 84 percent of married women ages 25-29 knew of a source of at least one modern method. (Population Council et al. 1998)

According to the PCPS 1994-95, only 5 percent of married women aged 15-19 had ever used (past or present use) any method, traditional or modern, while the figure jumped to 17 percent for women ages 20-24. The survey establishes that across the sample of women surveyed, ever use is higher in urban than in rural areas, and is highest among the provinces in the Punjab. Women with secondary education are nearly three times as likely to have ever used family planning as have women without schooling. Women with two or more living children are more likely to have ever used any modern method (20 percent), in striking contrast with female ever users who have only one child (10 percent), or no living children (1 percent). Out of the women aged 15-19 surveyed in the PCPS, 74 percent wanted a child soon, compared with 52 percent of those ages 20-24. The unmet need for contraceptives was calculated at 22 percent for the adolescents. (Population Council et al. 1998)

In light of these findings, contraceptive use among adolescent girls is indeed extremely low, probably for a variety of reasons. We know from other research that rural and uneducated girls are more likely to be married as adolescents than older girls are, automatically placing them among those women who are less likely to have ever used family planning. Further, married adolescents fall into that category of women who are more likely to have one or no living children, and therefore are also less motivated as compared to older women, to become contraceptive users. This lack of motivation to limit childbearing, combined with PCPS findings that adolescents have the least amount of knowledge about contraceptive methods and their sources compared to older age groups, confirms their low level of use.

However the fact that there is a substantial unmet need cannot be ignored by service providers, for it proves the profile of married adolescents and their needs is more complex than planners assume. The nuances of even married adolescents' attitudes toward using contraceptives and limiting childbearing have clearly not been adequately explored. For example, it is not know which is the more powerful influence on adolescent's family planning decisions: their limited information and access to contraceptives or their desire to enhance their status within their new families through childbearing. Further, the restrictions on mobility among adolescent girls may also be a reason why those who are married and wish to use contraceptives do not actually act on that desire.

Young married adolescents possibly need to be accessed by information and service providers who tailor services to their age group in order to meet their unmet need. Further, information on the sexual activity and reproductive health needs of unmarried adolescents is available at government and nongovernmental family planning service outlets as well as hospitals, but this needs to be systematically collected and analyzed in order to correctly assess adolescents' needs and to provide useful program interventions.

Finally, levels of education have been shown to exert a strong influence on adolescent fertility. According to PDHS 1990-91 data, 17 percent of women ages 20-24 have given birth by age 18; 21 percent have less than seven years of schooling, while only 2 percent have more than seven years of schooling. (Alan Guttmacher Institute 1998) In order to make accurate linkages between education, employment, and adolescent fertility and family planning, a clearer picture needs to emerge first of the issues they face with regard to schooling and work. The Population Council in Islamabad is currently engaged in research in this regard.

XI. CONCLUSION

The preceding discussion has shown that in Pakistan adolescents, particularly girls under age 20, are not exempt from a reproductive health burden that they share with their older counterparts. This includes burdens of maternal health and morbidity, risks of exposure to sexually transmitted diseases, vulnerability to sexual violence, restricted access to health and family planning services, and lack of adequate information on reproductive health issues. Adolescents, due to their relative youth, lack of decisionmaking power, and incomplete personal development, are especially ill equipped to handle the reproductive health burden they face.

In light of the research findings discussed above, it is clear that policies and programs, as well as legal provisions, do not meet the reproductive health needs of adolescents. For example, the only adolescent-specific policy document available, the National Youth Policy of 1989, concerns itself primarily with inculcating national and cultural ideology in the country's youth and helping them to become active contributors to overall national development. (Youth Affairs Division 1989) The only health-related policy objective is to eliminate drug addiction. The draft Population Welfare Programme for the Ninth Five Year Plan 1998-2003, setting out the reproductive health strategy for the nation, has no specific agenda for adolescents and remains focussed on increasing contraceptive prevalence rates through expanding family planning service provision to married couples. (Ministry of Population Welfare 1998)

Unfortunately the reality of young people's lives continues to expose the paucity of policies that affect them. Research findings discussed in this paper have also shown that adolescents, and in particular girls, have specific vulnerabilities and biases within the reproductive health issues they tackle, that are not necessarily shared with adults to the same extent. For example, adolescent boys appear to be prime targets of sexual abuse, while discrimination in the laws will make an adolescent girl liable to adult prosecution for illegal sex if she has attained puberty. Adolescent girls, whether or not they are married, face the greatest social restrictions in accessing health care, which is likely to have serious implications for their gynecological well-being, as well as ability to control their own fertility and manage the consequences of abortion safely. Programs and policies need to protect adolescents and to promote their health, safety, and secure development, rather than continuing to leave them ill-equipped to manage in an adult world.

Throughout this discussion some consistent themes have emerged. Clearly, more research is needed on the reproductive health topics outlined above through national sampling as well as in-depth qualitative work. To date the bias in findings lies in favor of information regarding married adolescents only, as well as research on violence and high-risk behavioral categories. The major gaps in knowledge regarding the vast majority of adolescents in this country need to be addressed.

Another strong theme that pervades research findings is the need for adolescents to have access to reliable information on reproductive biology and sexuality. Issues such as menstruation, masturbation, and general sexuality are fraught with misconceptions and taboos. As a result, young people exhibit an anxiety level about their own sexual development and sexuality that is unhealthy and unnecessary. Official policies and programs do not address this need; however, limited research and interviews with young people show that they have a high level of demand for accurate information.

Channels for outreach to adolescents are predominantly in place. At the policy level, relevant ministries need only to introduce adolescent reproductive health information and services into existing education, health, population, and media programs. The nongovernmental sector already has some innovative programs in operation, as highlighted in this paper, but more support is needed to expand their outreach in order to have an impact at the national level. Those organizations with outreach to the wider population that do not address adolescent reproductive health needs can be encouraged to insert programs into their existing infrastructure. Once consensus is built around the need to focus on adolescents, it should not be too costly or cumbersome to implement programs.

In conclusion, this review has shown that the importance of treating adolescents as a distinct segment of our population, with specific developmental needs, cannot be overstated. If adolescents cannot enjoy the space and protection they need now in order to function as adults with a full capacity for independent decisionmaking later, then certainly the task of making reproductive health a reality for men and women in Pakistan will remain impossible. Planners and policymakers need to rethink their characterization of adolescents in Pakistan if they wish for people to enjoy a future filled with possibilities.

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