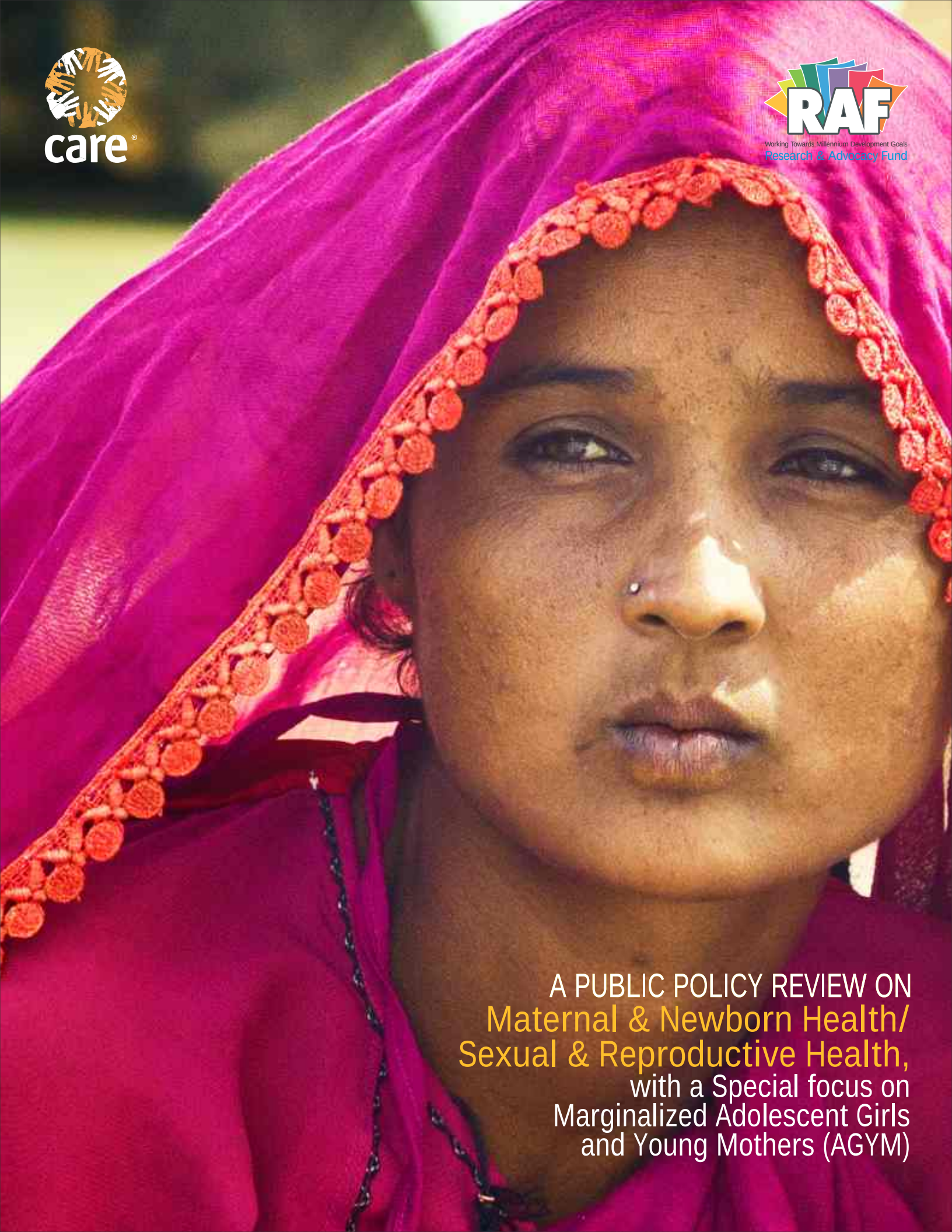

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Research & Advocacy Fund

A PUBLIC POLICY REVIEW ON Maternal & Newborn Health/ Sexual & Reproductive Health, with a Special focus on Marginalized Adolescent Girls and Young Mothers (AGYM)

CARE International in Pakistan

CARE is a leading humanitarian and development organization fighting global poverty, with a special focus on working alongside poor women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty. Women are at the heart of CARE's community-based efforts to improve basic education, prevent the spread of disease, increase access to clean water and sanitation, expand economic opportunity and protect natural resources. CARE also delivers emergency aid to survivors of war and natural disasters, and helps people rebuild their lives.

CARE International Pakistan opened its Pakistan office in June 2005. Since setting up, CARE has been dealing with a series of large-scale disasters, CARE, through emergency programs, has provided relief, as well as recovery and rehabilitation support to millions of Pakistanis affected by disastrous floods, cyclones, earthquakes, and displacement. Recognizing long-term needs for support to full recovery, and their nexus with poverty, CARE Pakistan focuses on implementing developmental projects linked to emergency response, with a special focus on women and girls, working closely with partners and local communities in all provinces of the country, including some of the most remote rural areas.

Acknowledgment

"Advocating for Improved MNH and SRH Policy and Practice for Adolescent Girls and Young Mothers (AIMS) is a project funded by the Maternal and Newborn Health Programme Research and Advocacy Fund, and is implemented by CARE International in Pakistan"

Principal Investigator: Dr. Muhammad Suleman Qazi
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AIMS

In Pakistan many adolescents and young women are pushed into early marriage and early pregnancies, resulting in high rates of maternal and infant mortality and morbidity. Adolescent girls face a number of challenges in accessing essential healthcare due to restrictions on their mobility, low availability of adolescent-friendly services, lack of financial resources and limited information and awareness. This situation is worse for ethnic and religious minorities and those living in remote, underserved feudal and tribally controlled areas. Despite this, the reproductive and sexual health needs of adolescent girls and young mothers (AGYM) between the ages of 15-24 years remain unacknowledged in Pakistan and are conspicuously absent in major policies such as the National Health Policy 2009 and the Youth Policy 2008.

In February 2012 CARE Pakistan started the project titled: 'Advocating for improved maternal newborn health (MNH) and sexual reproductive health (SRH) policy and practice for adolescent girls and young mothers (AIMS).' Implemented in partnership with Rahnuma-Family Planning Association of Pakistan (FPAP), this 14 month initiative combined evidence based research with targeted advocacy to successfully bring about changes in Pakistan's policies regarding MHN and SRH for adolescent girls and young mothers. The AIMS project aimed to increase awareness regarding the specific reproductive and sexual health needs of AGYM, and to advocate for their inclusion in provincial health policies in four provinces of Pakistan by:

- Conducting research on the knowledge and practices of AGYM, including their priority needs and the barriers impeding their access to MNH and SRH services
- Undertaking a comprehensive review and analysis of Pakistan's government policies to identify key gaps regarding the reproductive and sexual health needs of AGYM
- Using findings from the research to advocate with key stakeholders for policy change to address the sexual and reproductive health needs of AGYM

CARE and FPAP used evidence from the project's research to design a targeted advocacy strategy and to engage with key stakeholders including provincial parliamentarians, district officials, community leaders, civil society and media representatives, through a structured process of meetings, workshops and consultations. The report in your hands is one of the outcomes of the project's research component.

A PUBLIC POLICY REVIEW ON Maternal & Newborn Health/ Sexual & Reproductive Health, with a Special focus on Marginalized Adolescent Girls and Young Mothers (AGYM)

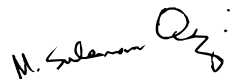
ABOUT THE AUTHOR

Dr. Muhammad Suleman Qazi holds an MBBS degree from Bolan Medical College and an M.Sc degree in Health Policy and Management from Aga Khan University, Karachi. Dr. Qazi served UNFPA, Balochistan as Provincial Coordination Officer [April 2006 - June 2009] working on MDGs at the provincial level and assessing provincial economic, social and political situation in the context of its potential impact on the UNFPA's programs in the areas of population development and reproductive health.

Dr. Qazi has also worked in similar capacities with national/multinational development agencies such as United Nations Program on HIV-AIDS; Mercy Corps, Oxfam, and Taraqee Foundation Balochistan. He is a member of National Volunteer Movement and Population Association of Pakistan and .has various health related publications to his credit and has also diverse experience in facilitating a variety of trainings.

DECLARATION

We have read the report, titled '*Advocating for Improved SRH/MNH policy & practice for the marginalized Adolescent Girls and Young Mothers (AGYM)*', and acknowledge & agree with the information, data and findings contained therein.



Dr. Suleman Qazi

ACKNOWLEDGEMENTS

We would like to express their gratitude to Research and Advocacy Fund (RAF) for their support and timely assistance. We are also grateful to Dr. Suleman Qazi for conducting this research which was coordinated and reviewed by Dr. Aisha Zaman. Dr Qazi and Dr. Zaman can be reached at suleman.qazi@gmail.com and aisha_zaman@hotmail.com, respectively.

CONTENTS

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LIST OF ABBREVIATIONS

ADB	Asian Development Bank
ADP	Annual Development Program
AGYM	Adolescent Girls and Young Mothers
AIMS	Advocating for Improved SRH/ MNH Policy & Practice for the Marginalized Adolescent Girls and Young Mothers (project)
BISP	Benazir Income Support Program
BRSP	Balochistan Rural Support Program
CCI	Council of Common Interests
CDS	Comprehensive Development Strategy
CEDAW	Convention on Elimination of all Forms of Discrimination against Women
CERD	Committee on the Elimination of All Forms of Racial Discrimination
CIP	CARE International Pakistan
CM	Chief Minister
CPO	Chief Planning Officer
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of Child
DNA	Disaster Needs Assessment
DoH	Department of Health
ECNEC	Executive Committee of the National Economic Council
FP	Family Planning
FPAP	Family Planning Association of Pakistan
GRAP	Gender Reform Action Plan
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICYA	Information, Culture & Youth Affairs
IEC	Information, Education and Communication
INGOs	International Non- Governmental Organizations
IPs	Implementing Partners
IPH	Institute of Public Health
KPK	Khyber Pakhtunkhwa
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Neonatal/Newborn Health
MoH	Ministry of Health
MoHR	Ministry of Human Rights
MoPW	Ministry of Population Welfare
MoWD	Ministry of Women Development
MTDF	Medium Term Development Framework
MWD	Ministry of Women Development
NCSW	National Commission on Status of Women
NFC	National Finance Commission
NGO	Non-governmental Organization

LIST OF ABBREVIATIONS (contd...)

NHPU	National Health Policy Unit
NHS	National Health Service
NIPS	National Institute of Population Studies
NYP	National Youth Policies
P&D	Planning and Development
PC-1	Planning Commission Proforma 1
PCNA	Post Crises Needs Assessment
PCSW	Provincial Commission on Status of Women
PDHS	Pakistan Demographic & Health Survey
PHC	Primary Healthcare
PLHIV	People Living with HIV
PMDGP	Punjab Millennium Development Goals Program
POL	Petrol, Oil, Lubricant
PRSP	Poverty Reduction Strategy Paper
PWD	Population Welfare Department
RAF	Research and Advocacy Fund
RH	Reproductive Health
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SWs	Sex Workers
TBA	Traditional Birth Attendant
TRF	Technical Resource Facility
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
WB	World Bank
WDD	Women Development Department
WHO	World Health Organization
WPF	World Population Foundation

EXECUTIVE SUMMARY

Pakistan's reproductive health (RH) indicators are far from satisfactory. Many adolescent girls and young mothers (AGYM-15-24 years) are hurled into early marriages and pregnancies leading to high rates of maternal and infant mortality and morbidity. The draft National Health Policy 2009 addresses the concerns of Maternal Neonatal Health(MNH) to some extent; however, it does not include adolescent's health issues nor does the Youth Policy 2008 talk of sexual health, rather mentions reproductive health needs of young people above the age of 18 and married. Those under 18 and unmarried fall through the policy gap and remain invisible. The Health Policy lacks Sexual Reproductive Health (SRH) rights perspective – only the right to access affordable services is mentioned.

This policy review is intended to explore gaps in policies in identification, prioritization and response to AGYM's MNH and SRH needs. The policy review attempts to determine whether various policies considered issues surrounding social exclusion, stigmatization, discrimination, and gender based constraints that significantly contribute to the success/failure of policy implementation. It also proposes recommendations for actions intended for a targeted and rights based approach to strengthen and focus weak areas of national programs, such as information systems; planning processes; and governance.

In Pakistan, this policy review is being undertaken at a very important point in time, especially, when under the post 18th constitutional amendment many of public sector policies (including health and population) have become a provincial subject. Now, responsibility to overcome inter district and within districts inequalities in access to SRH services for marginalized people in culturally appropriate way lies with the provinces.

For the policy document review, EquiFrame – a peer-reviewed, analytical framework and tool for policy analysis & benchmarking was employed. This tool assesses policy content or 'policy on the books'. A parallel study was also undertaken to identify the stakeholders and their positions viz a viz their power and interest in AGYM's SRH/MNH policy issues. This review includes findings from the in-depth interviews of those stakeholders as well.

From national to provincial level the policy review points out a number of gaps in identification, prioritization and response to the marginalized adolescent girls and young mother's MNH and SRH needs. With the application of EquiFrame for the policy analysis it was found that in terms of overall quality none of the policies could be ranked as 'high'. Both the national health policies (2001, 2010), both the Population Policies (2001. 2010) and the National Youth Policy (2008) ranked as 'poor'; whereas, National Mother and Child Health Policy & Strategic Framework, PC1 Lady Health Worker(LHW) Program and Punjab Youth Policy 2012 stood as 'moderate'. In the context of AGYM none of these policies has a special focus.

Public policy documents under consideration do not reflect a political/administrative will to address SRH/ MNH issue of marginalized AGYM. The SRH/MNH policies/programs claim targeting the vulnerable groups yet these groups have loosely been defined, mostly as - rural women but not necessarily the marginalized AGYM and these documents are silent on how the target groups are defined. The SRH and MNH needs of the marginalized AGYM seem out of focus of most of the public sector institutions and some of the major non public sector players. It seems beyond the mandates of ministries and departments working on child, youth, women, health, population, social welfare or national harmony issues.

One notices that over the period these policies have shown some common features such as discontinuity in policies, absence of the 'arms and teeth' of policies (poor financing, implementation and M&E mechanisms), misplacement of policies viz a viz planning (illogical pattern of policy formulation - after rolling out plans) and contradictory policies.

For effective SRH/MNCH policies for the marginalized AGYM a realization of their existence is primary requisite. The policies need to be reoriented on the rights based approaches implying that the state takes affirmative action to assert its role as a duty bearer, responsive and accountable to citizens in general and the marginalized in particular. At policy level this would entail horizontal cooperation between the social and public sector policies and programs for ensuring the betterment in the lives of the rights holders (marginalized AGYM in our case) and vertical articulation; provincial/district authorities' knowledge and will to implement national/provincial level policies, decentralised structures to facilitate local implementation and coordination.

1 INTRODUCTION AND BACKGROUND

1 INTRODUCTION AND BACKGROUND

1.1 AIMS AND OBJECTIVES

The overall aim of this study is to contribute towards improvement of sexual & reproductive health including maternal and newborn health status of the marginalized adolescent girls and young mothers of Pakistan through understanding the policy scenario and engaging with the policy level stakeholders.

Objectives of this research are as under:

1) Undertake policy review to point out gaps in the policy in identification, prioritization and response to adolescent girls and young mother's MNH and SRH needs
2) Determine whether policies considered issues surrounding social exclusion, stigmatization, discrimination, and gender based constraints
3) Identify the gaps in the public policies in responding to and prioritizing marginalized AGYM's MNH and SRH needs
4) Propose recommendations for actions to strengthen national programs & policies

1.2 BACKGROUND

In Pakistan the adolescent birth rate per 1,000 women (15-19) in 2005 was reported as 20.3 (UNFPA 2010-1). This indicates that one out of five adolescent girls & young women (15-24 year) are hurled into early marriage and pregnancy making them vulnerable to maternal mortality and morbidity. A gender differential in access to healthcare (supply side) worsens the already poor health indicators of these Adolescent Girls and Young Mothers (AGYM). Pakistan's reproductive health (RH) indicators are far from satisfactory. Last Demographic and Health Survey (National Institute of Population Studies 2006-07) indicates that the RH status is marred by a high maternal mortality ratio (276/100,000 live births), infant mortality rate (78/1000 live births) and under five mortality rate (94/1,000 live births) combined with high fertility (4.1 births per women). Skilled birth attendance has slightly improved from 18% in later 1990s to 39% in 2005-2009; whereas, antenatal care coverage is still 28%. Twenty five percent of married women in Pakistan have an unmet need for family planning services. However, issues pertaining to the social exclusion and marginalization of religious, ethnic, poorer income quintiles, living in remote and underserved areas of Pakistan and under the strong tribal and feudal influence have not been addressed in the survey.

Gender based disparities embedded in social structure exacerbate the marginalization of AGYM. Social norms enforce segregation between the sexes as means of preserving a girl's honor and consequently adolescent girls are less educated, lack access to credible SRH information and are generally married early, bearing the burden of MNH and SRH related issues. Yet, their plight is neither adequately researched nor such research has ever translated into policy. The draft National Health Policy 2009 addresses the concerns of MNH to some extent; however, it does not include adolescent's health issues nor does the Youth Policy 2008 talk of sexual health. It only mentions reproductive health needs of young people above the age of 18 and married. Those under 18 and unmarried fall through the policy gap and remain invisible. The Health Policy lacks SRH rights perspective – only the right to access affordable services is mentioned.

World Population Foundation (WPF) conducted a research in 2010 with the aim to analyze the prevalent status of Sexual and Reproductive Health and Rights of young people in Pakistan. Their findings revealed extreme discrimination

against marginalized communities and limited realization of young people's SRH Rights. Reproductive Health advocates have yet to achieve any substantial results at the policy level on the issue of unsafe abortions. The research also pointed out an acute absence of understanding among the young girls regarding their right to decide whether or not they wanted to conceive, and that decisions on the size of the family as well as use of contraceptives were solely considered men's domain. The study recommended institutionalizing sex education to facilitate adults to understand what young people already know and adding to their existing knowledge and correcting any misinformation they may have. The study also recommended that the civil society organizations should undertake mass level advocacy efforts alongside the marginalized groups to bring change at the level of policy and legislation to ensure the provision of basic human rights to these marginalized populations.

With financial assistance from Maternal and Newborn Health Programme Research and Advocacy Fund (RAF), CARE International Pakistan (CIP) in partnership with Rahnuma-FPAP is conducting a research and advocacy project titled 'AIMS- 'Advocating for Improved SRH/ MNH Policy & Practice for the Marginalized Adolescent Girls and Young Mothers (AGYM)' by engaging duty bearers at different levels of governance to enhance political will, commitment to policy formulation and adequate resource allocation. The current study is undertaken to review SRH/MNH related public policies with a focus on marginalized Adolescent Girls & Young Mothers, for the AIMS project.

1.3 RATIONALE

Although the International Conference on Population and Development (ICPD) Programme of Action (1994) provided the initial context for determining the scope of youth and adolescent's reproductive health issues which need to be addressed by policies and programs, given the diversity in these issues across countries (and within countries) the policy reviews should take into account the specific sexual and reproductive health (SRH) needs of young and adolescents in each geographical area.

ICPD broadened the horizons of reproductive health from a tunnel vision of equating it just with contraception to a level where physical, mental as well as social wellbeing aspects of reproductive health were realized. ICPD set forth the rights based approach towards RH (Shalev, C., 2000 and Erdman, J.N. and Cook, R.J., 2006) and in congruence with ICPD, the Commission on the Status of Women (CSW) emphasized that government and UN agencies should identify groups at high risk of discrimination and violence and ensure financial resources and targeted, innovative programs that address the needs and priorities of girls who have difficulties in accessing services and programs; enhance opportunities for adolescent girls to develop leadership capacities, networking and secure economic independence; and develop additional indicators for monitoring the situation of vulnerable girls (Commission on the Status of Women, 2007).

At present, the following scenario calls for an increased focus on the adolescent and young women's sexual and reproductive health:

1. The most comprehensive agenda of reproductive health ever was declared in International Conference on Population and Development (ICPD) in 1994. However, towards the end of the twentieth century 'Millennium Development Goals (MDGs)' appeared in arenas of development as a priority agenda which undermined emphasis on comprehensive RH. MDGs 4, 5, and 6 narrowed down the ICPD approach to maternal and child health and HIV. Pakistan has many policies, programs and projects for giving a proper place to the goals of MDGs. For instance, National Maternal and Child Health Policy emphasised on raising awareness about safe motherhood, newborn's health, family planning and increasing number of skilled human resource. The national policies, however, have been somewhat deficient in addressing the other common RH problems such as adolescent RH, abortion, referral mechanisms etc. On the other hand, the entire emphasis seems to be on promoting family planning alone. Being a signatory of both of the international agendas (ICPD and MDGs), Pakistan needed to strike a balance in articulating its policies to keep the balance between the two agendas (Abrejo. F.G, Shaikh. B.T, and Saleem. S, 2008).

2. The current stage of demographic transition in Pakistan depicts a burgeoning population of young people. Increasing alongside this segment of population is the

number of vulnerable and risks associated with early marriages, unwanted pregnancies, STIs, HIV and AIDS. This is especially true for those adolescent girls and young mothers (AGYM) who constantly face discrimination, social exclusion and marginalization on grounds of religion, ethnicity, income level, or on account of residing in remote, underserved areas where the strong tribal and feudal systems govern their lives. However, there is a vulnerability and discrimination intersection that makes the issue more complex for a policy response.

3. Pakistan is the most rapidly urbanizing country in the region and rural to urban migration is no more male specific. In the wake of economic downturn, energy crises, income deprivation, labor migration and employment structures and processes, the social-support structures are being affected. The supply side of basic social services (such as health, education, safety and security) is not keeping pace with the rapid urbanization, resulting in disparities especially for the marginalized and excluded segments of Pakistani society. Various factors can contribute to exclusion from access especially to reproductive health information and services for adolescents. Young people might be unable to access mainstream SRH services or programs for reasons of poverty, age, marital status, ethnicity, gender, language, disability, geographical inaccessibility; or might be denied access because of stigmatization/discrimination or restrictive laws and policies. This does not only hold true for the rural poor, but also remains true for the urban population living below the poverty line. .

4. In the wake of natural and man-made disasters during the last decade, Pakistan has seen some massive human migrations and consequent economic deprivation which has added tremendously to the vulnerability of AGYM.

5. *Eighteenth Constitutional Amendment:* Under the post 18th constitutional amendment scenario, health policy has become a provincial subject. Now, it has become provinces' responsibility to overcome inter district and within districts inequalities in accessing SRH services for marginalized people in culturally appropriate ways. Previously, the social dynamics of exclusion have little been addressed in the policies and programs mainly due to programs and policy developers following a biomedical approach to the RH problems. The 18th amendment offers a window of opportunity as it provides a chance to review old policies and formulate new policies for provinces and to identify the province specific gaps.

6. The current rights discourse and the women rights' activism has successfully raised the issue of gender based violence in Pakistan. The serving Pakistan People's Party government has passed several important pieces of legislation focusing on sexual harassment at the workplace, anti-women practices, and acid throwing (Weiss, A.M., 2012). However under these general moves at policy an accentuated response is needed for the marginalized AGYM.

7. In order to ensure that the service delivery mechanisms are sensitive to the needs of the marginalized AGYM, a policy review is required on the grounds that "*If social inclusion and human rights do not underpin policy formation, it is unlikely they will be inculcated in service delivery*" (MacLachlan M, Amin M, Mannan H, El Tayeb S, Bedri N, et al. 2012).

1.4 THE INVISIBILITY

There are several vulnerable categories yet invisible from the sight of policy makers and program managers marginalized AGYM for instance those in jails, home based workers, People Living with HIV (PLHIV) and AGYM with disabilities. This invisibility may have been a consequence of: absence/lack of access to data/evidence and sensitization about the needs, and resource constraints to meet the needs; or, on the demand side, absence of unified voice from this bracket of oppressed population.

"Many of these girls do not show up in surveys or statistics and are not served by policy and programme interventions because their communities receive insufficient attention to begin with, because data are sometimes not disaggregated by sex and age, and because they sometimes appear in surveys only as young wives, as domestics, or as girls out of school. This "invisibility" is

exacerbated by cultural traditions of low status, stigmatization, and gender stereotypes. These in turn are used to justify the nature of their work and livelihoods, their enforced seclusion and, at times, even their detention. Many girls are marginalized in more than one way, e.g.: HIV-infected single mothers, or girls from displaced minorities, or disabled and out-of-school girls"
(United Nations Inter-Agency Task Force, 2008)

The phenomenon of invisibility is not simple. There could be layers and layers of vulnerability within social institutions. The deeper penetration into levels of vulnerability and discrimination nexuses can be understood from the following example:

Being a woman,

A poor woman,

A poor-rural-woman,

A minority-poor-rural-woman,

A minority-poor-rural-woman with physical disability

A minority-poor-rural-woman with physical disability, living in a conflict zone

1.5 WHO ARE MARGINALIZED ADOLESCENT GIRLS & WOMEN?

Categories of Marginalized Adolescent Girls:

- Girls affected by harmful traditional practices: e.g. child marriage and its consequences, such as early and unattended child-bearing;
- Girls belonging to socially excluded and vulnerable groups: such as ethnic, religious and linguistic minorities, indigenous and nomadic communities, and populations living in remote areas and urban slums;
- Girls living in areas that are insecure and vulnerable to natural disasters, the effects of climate change, armed conflict, and gender-based and generalized violence, and at risk to HIV infection
- Girls who do not have adequate protection at household level, such as girls in institutions, girls living apart from both parents, girls in violent households, girls in domestic labour, girls who are trafficked or living on the street, and girls without families in refugee camps and internally displaced populations;
- Girls excluded from education due to poverty, lack of safety and security, disability, having to care for family members with HIV or affected by traditional practices which force them to leave school early;
- Girls living with physical or mental disabilities.
(United Nations Inter-Agency Task Force, 2008)

Another way of categorising the marginalized women could be on political, economical and social grounds:

Politically Marginalized: Women who are excluded from or have limited participation in decision-making and access to justice

Economically Marginalized: Women, whose labor is unrecognized and who are excluded from the workforce, who have limited access and control over productive assets, and whose livelihoods are highly vulnerable to disasters

Socially Marginalized: Women whose freedoms and rights are restricted by gender, cast, ethnicity, religion, and disability

1.6 WHY FOCUS ON MARGINALIZED AGYM?

Marginalized AGYM may lack access to basic amenities and facilities of life; be subjected to harmful practices and traditions, violence, abuse and denial of their human rights and dignity. Strategic investments in the social protection, health, education, and livelihoods skills of marginalized AGYM not only promotes social justice but also are essential for achieving internationally-agreed development goals, human rights norms and other global commitments. Opening up opportunities for marginalized AGYM can contribute to fulfilling the Millennium Development Goals (MDGs) in a number of ways:

Goal 1: Eradicate extreme poverty and hunger:

Establishing a strong economic base requires building girls' social and economic assets. Research shows that when women have access to, and control of income and resources, their families and communities benefit as much as the

women themselves.

Goal 2: Achieve universal primary education:
Educated girls are more likely to marry later and to have better maternal and child health outcomes, and are more able and inclined to invest in the health and education of their children. Girls' education is the best development investment in terms of human capital formation, social justice, and economic return.

Goal 3: Promote gender equality and empower women:
Too often marginalized adolescent girls bear the burden of sex discrimination and human rights violations that hinder the achievement of women's empowerment and gender equality. Specific investments are needed to protect marginalized girls and provide opportunities to girls at risk of school dropout and exclusion, child marriage, HIV infection, exploitation and other human-rights violations simply because they are young and female.

Goal 4: Reduce child mortality:

Goal 5: improve maternal health:

Goal 6: combat HIV/AIDS, malaria and other diseases:
Promoting schooling, building livelihood skills and social assets, and providing better access to sexual and reproductive health education and services for these girls, before they become mothers, will help reduce child mortality and maternal deaths and reduce HIV infection.

Goal 7: Ensure environmental sustainability:
Programmes targeting slum dwellers will positively affect millions of marginalized girls in urban settings.

Goal 8: Develop a global partnership for development:
This must include civil-society partnerships in which the assets and capacities of marginalized girls can be mobilized, and their rights respected.

[*Adapted from United Nations Inter-Agency Task Force on Adolescent Girls (2008)*]

1.7 STATUS OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF AGYM IN PAKISTAN

> *"The health of the women was never considered an important issue because woman as a gender has little respect in the community. In the name of culture, tradition and religion they were never given equal status in the society. A system which is based on gender inequality will not adopt policies for the well being of women who are poor, powerless, pregnant (most of the time without their consent), and weak as a class. It is also disturbing to note that religious political parties and traditional political parties with lethal image have little time for women and their issues. Our assemblies and political institutes have a great number of women but most of them are not interested on those issues related to women health and their rights".*
>
> (Society of Obstetricians & Gynaecologists of Pakistan. 2009)

From the time of conception till her adolescence a girl child remains under threats. SOGP (2009) reports female foeticide as a common occurrence since the development of sex determination tests. Families seek termination of pregnancy based on ultrasonic confirmation of gender in early pregnancy. Clandestine or illegal abortion for such female foetuses is a major cause of maternal morbidity. The girl child infant mortality rate is higher than male child infant mortality. The discrimination doesn't stop here. The girl child has no equal opportunity in the society. They have limited opportunities for primary and secondary education. They have less access to playgrounds, social functions and other community activities as compared to their male counterpart.

In Pakistan, 16% of the women aged 15-19 years are married. Many get married shortly after they attain menarche (National Institute of Population Studies, Macro International MD. 2008). These marriages lead to early

pregnancies and associated morbidities due to immaturity adding to the vulnerability of these adolescent girls (Sajan F, and Fikree F, 2002).

SOGP (2009) states that a large number of girl children are forced to marry without taking into account their consent, liking or disliking. Selling of girl children, bartering and giving them as compensation to resolve family and tribal feuds is in practice. Girls are also given as "blood money" to settle crimes such as murder, and are exploited sexually and physically. It is also disturbing to note that traditions like vana, swara, watta satta, dundee, karo kari and other kind of activities are directed to girl child.

Hennink M, Rana I, and Iqbal R. (2005) while exploring young peoples' experiences of gaining knowledge of personal and sexual development found that young women typically gained information from a limited number of sources within the home. For them gaining information was frequently event-based, whereby specific events (i.e. puberty, marriage) trigger information provision to young people, however, often too late to be educative. Overall, the quality of information was poor, which often led to confusion and stress in understanding sexual development.
Demographic and Health Survey showed that half of Pakistani women are married by the age of 19.1. Some of them get married at a very early age (13 percent were married by age 15 and 40 percent were married by age 18). Poor literacy is a common factor behind early marriage. Women who managed to acquire higher education get married at a median age of 24.5—more than 6 years later than those with no education (National Institute of Population Studies, Macro International MD, 2008).

In Pakistan, half of women have their first birth by age 21.8. While, 18 % of women had their first birth by age 18, women in rural areas have their births almost one year earlier than women living in urban areas. Women with more education also wait longer to have their first birth. Women who have been to secondary school have their first birth at a median age of 23, while women with no education have their first birth at a median age of 21 (National Institute of Population Studies, Macro International MD, 2008).

Pakistan Demographic and Health Survey has shown that 9% of young women age 15-19 have begun childbearing; 7% are mothers and an additional 3% are pregnant with their first child. Young motherhood is more common in rural areas than in urban areas, and young women with no education are more than ten times as likely to have started childbearing by age 19 than those who have completed secondary school (16 versus 1 percent) (National Institute of Population Studies, Macro International MD, 2008).

Qureshi N & Shaikh BT. (2007) note that four institutions of power play a role in women's right to health in the society. These are family, community, health care systems and the state. Women's empowerment and their health status and that of their families are challenged by women's low status, deprivation of education and lack of control over their own lives and bodies. Concerted efforts are needed by all the four institutions to work towards gender equality and the greater empowerment of women.

The research shows that there is an acute absence of understanding among the young girls regarding their right to decide whether or not they wanted to conceive, and that decisions on the size of the family as well as use of contraceptives were solely considered men's domain (World Population Foundation, 2010).

Hamid. S, Johansson. E, and Rubenson. B, (2009) while exploring the preparedness for and actual experiences of married life (inter-spousal relationship, sexual activity and pregnancy) among adolescent women residing in slums of Islamabad noted that the girls were submissive; some of them seemed contended with their status, whereas the others considered themselves as victims. The married young women who lived under compromised conditions, yet described themselves as satisfied with their situation, were older than the other group identifying themselves as victims. The research also noted that none of the respondents felt prepared for marriage. Women belonging to the victimized group experienced physical and verbal abuse for their inability to cope with the duties of a wife, caretaker of the home and bearer of children. Their situation was compounded by the power dynamics within the household.
Issues pertaining to the social exclusion and marginalisation of religious, ethnic, poorer income quintiles, living in remote and underserved areas of Pakistan, and under the strong tribal and feudal influence have not been adequately addressed in policies. Research

points out that at policy level little has been done for the prevalent status of Sexual and Reproductive Health and Rights of young people in Pakistan. For instance, the activists have not been able to achieve any substantial results on the issue of unsafe abortions (World Population Foundation, 2010).

1.8 PAKISTAN AND INTERNATIONAL TREATIES AND DOCUMENTS RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Pakistan has ratified a number of international conventions, but has done little on implementing acts. Therefore, the provisions of the conventions are not legally binding on the citizens of Pakistan.

The International Conference on Population Development; Program of Action(ICPD PoA) recognizes reproductive rights as an essential part of human rights, which should be included in country's laws, policies, and services. As a follow-up to Pakistan's strong showing at the ICPD the government attempted to develop a national reproductive health policy at first, but later it launched a Reproductive Health Package during the 1998-2002 planning period.

1.9 POLITICAL ECONOMY OF POLICY MAKING

Zaidi. AS, (1985) argues that policy making reflects the class structure in Pakistan. Under a capitalist style growth, the maldistribution of resources is biased in favour of bourgeois (predominantly urban) classes. Policies are made by the ruling class and allocations within and outside the health sector are made not on need, but on political expediency and the ability to pay. A study 'The Drivers of Change' (Nadvi. K, and Robinson. M, 2004) attempted to determine the levers of, and impediments to pro-poor policy change in Pakistan. it shows that there is little prospect of sustained pro-poor change in the short to medium term due to powerful and deeply rooted structural or institutional factors (such as the underlying structure of land ownership, a highly skewed distribution of wealth, entrenched patterns of inequality, a low rate of capital formation and economic growth, enduring ethnic and religious tensions, and fixed and unequal gender relations), and few sources of agency with the commitment and power to stimulate an enduring change process.

1.10 LEGISLATIVE PROCESS IN PAKISTAN

Legislation or law-making is the fundamental responsibility performed together by the two Houses of Parliament (Majlis-e-Shoora), i.e. the Senate and the National Assembly. A 'Bill' is a legislative statement, which becomes an 'Act of Parliament' if passed by both houses and duly assented by the President. The process of law making in Pakistan is described as follows: [Pakistan Institute for Parliamentary Services (PIPS)].

TABLE 1: PAKISTAN AND INTERNATIONAL TREATIES & DOCUMENTS RELATED TO SRHR

	CEDAW	ICESR	ICCPR	ICERD	CRC	ICPD PoA	BPfA	MDGs
Pakistan	Convention on the Elimination of All Forms of Discrimination against Women	International Covenant on Economic, Social and Cultural Rights	International Covenant on Civil and Political Rights	International Convention on the Elimination of All Forms of Racial Discrimination	Convention on the Rights of the Child	International Conference on Population Development; Program of Action	Beijing Platform of Action	Millennium Development Goals 2000
	Acceded	Signed & Acceded	Signed & Acceded	Signed & Acceded	Signed & Acceded	Signatory	Signatory	Signatory

Step 1: Introducing a Bill

Three copies of the bill along with a 'Statement of Objectives and reasons shall accompany a 10-day written notice to the secretary to move a bill.

Step 2: Order of The Day

Motion to introduce private Member's bill shall be set down on the Orders of the day for private Member's day and copies of it would be circulated to all Members.

Step 3: Bills Repugnant to Islam

Such a bill is referred to Council of Islamic Ideology for advice.

Step 4: 1st Reading - Discussion on Principles of Bill

The bill is circulated among Members for eliciting their opinion in addition to discussing its principles.

Step 5: Motion of Consideration

Motion of Consideration by Member in Charge.

Step 6: Reference to Committees

All bills other than the Money Bill stand referred to the concerned Standing Committee or Select Committee for recommendations.

Step 7: Committee's Recommendation

The Committee may allow the bill to be taken into consideration as a whole, with respect to particular clauses or amendments only or with instruction to make some particular or additional provision in the bill.

Step 8: 2nd Reading - Amendments

One day notice of amendments from the day a bill is to be considered has to be given by a Member. Thus, the whole bill, clause by clause, goes through the second reading and the Speaker decides if amendment proposed meets conditions of admissibility.

Step 9: 3rd Reading – Debate

Members argue on general character of a bill either in support, or to reject the bill. It may be noted that only verbal amendments can be moved at this stage.

Step 10: Vote

After the debate, the Speaker puts the motion for the decision of the House.

Step 11: Transmission of Bills to Senate

Once a bill (other than Money Bill) is passed by the House in which it originated, it is sent to the other House. The bill undergoes a similar process of debate and committee scrutiny, and when it is passed, it is sent to the President for assent.

Step 12: Authentication and Submission of Bills for Assent

When a bill is passed by the National Assembly, without amendment, an authenticated copy signed by the Speaker is transmitted to the President.

Step 13: Promulgation

When the President assents a bill, the secretary shall immediately ensure its publication in the Gazette as an Act of Majlis-e-Shoora.

Ordinances: The President may promulgate an Ordinance, having the same effect as an Act when the Assembly is not in session. It remains valid for four months and it is put forth in both Houses (only National Assembly for Money Bill) for acceptance or rejection within four months of promulgation. Additionally, the President can withdraw the Ordinance.

1.10.1 Constitution Amendment Procedure

(1) The Constitution may be amended by Act of Parliament. A Bill to amend the Constitution may originate in either House and, when the Bill has been passed by the votes of not less than two-thirds of the total membership of the House, it shall be transmitted to the other House.

(2) If the Bill is passed without amendment by the votes of not less than two-thirds of the total membership of the House to which it is transmitted under clause (1), it shall, subject to the provisions of clause (4), be presented to the President for assent.

(3) If the Bill is passed with amendment by the votes of not less than two-thirds of the total membership of the House to which it is transmitted under clause (1), it shall be reconsidered by the House in which it had originated, and if the Bill as amended by the former House is passed by the latter by the votes of not less than two-thirds of its total membership it shall, subject to the provisions of clause (4), be presented to the President for assent.

(4) A Bill to amend the Constitution which would have the effect of altering the limits of a Province shall not be presented to the President for assent unless it has been passed by the Provincial Assembly of that Province by the votes of not less than two-thirds of its total membership.

(5) No amendment of the Constitution shall be called in question in any court on any ground whatsoever. The constitution declares that there is no limitation whatever on the power of the Majlis-e-Shoora (Parliament) to amend any of the provisions of the Constitution.

The provincial assemblies have their own legislative procedures.

2 PREVIOUS REVIEWS ON PUBLIC POLICIES IN PAKISTAN

2 PREVIOUS REVIEWS ON PUBLIC POLICIES IN PAKISTAN

2.1 POVERTY REDUCTION STRATEGY PAPER II

Abrejo. F.G, Shaikh. B.T, and Saleem. S, (2008) in their comparative analysis of policies with ICPD PoA 1995, found that Poverty Reduction Strategy Paper (PRSP 2001) recognized the following principles of ICPD: RH care services and their accessibility through Primary Health Care (PHC) system, involvement of NGOs, need to institute system of monitoring and evaluation, need for a proper referral mechanism, and expansion/up-gradation of training of reproductive health services providers. However, the PRSP remained silent on issues of reproductive rights, adolescents' education, community participation by decentralizing the management, RH services for migrants, FP services, abortion, promotion of breast feeding, and involvement of political and community leaders.

The Population chapter of MTDF on the other hand has references to reproductive rights, community participation, political and community leaders and NGO involvement.

However, it misses out the issues of migrants' RH needs and abortion services.

2.2 HEALTH POLICIES

Green. A, Rana. M, Ross. D, and Thunhurst. C, (1997) noted that the success of health planning needs to be flexible, participative and integrated with other decision processes. However, the health planning system in Pakistan has generally failed to incorporate this approach. They also mention various problems such as weakness in the links between strategic and operational planning; very centralized decision-making; lack of functional clarity in the respective roles of bureaucrats and politicians; and, poor links between capital and recurrent budgets as well as between planning and implementation. As a result, there are a number of imbalances in the allocation of resources.

Lashari. T, (2004) found that policy prioritization remained highly hierarchical and inconsiderate to evidence driven approach. The real issues of the poor, marginalized and vulnerable were therefore not prioritized.
Khan. MM, and Heuvel. WV, (2006) have shown that due to underlying fact that Pakistan has experienced unbalanced power structures and frequent changes in governments,; health policy-making, planning and implementation have ever faced disruption. They conclude that the political context has had a negative influence on the health policy process in Pakistan.

Siddiqi. S, Haq IU, Ghaffar A, Akhtar T, and Mahaini R. (2004) in their analysis of MNH policies of Pakistan (till 2001) have compared various policies as follows:

National Health Policy, 1990: The policy did not mention Reproductive Health (because of the fact that RH was defined later in ICPD 1994). However, it made family planning mandatory with the involvement of private practitioners. In the context of maternal health the policy focused on the availability of trained personnel for attending births (Lady HealthVisitors (LHVs) and public health nurses) and Lady Health Workers (LHWs)/Traditional Birth Attendants (TBAs) and (MCH) program Expansion including IEC, breast feeding promotion, antenatal care and natal care.

1997 National Health Policy (vision for 2010): This policy also emphasized on family planning and availability of trained personnel (LHVs/TBAs/LHWs), MCH units at federal and provincial level, EOC at FLCFs and health education. The policy recognized the importance of addressing HIV and AIDS and management of STI focusing on safe blood, information and education.

1993–2002 Social Action Program and Related Projects: These focused on increased investment in recurrent and development expenditure in primary health and increasing availability of enhanced package of MCH/FP services and availability of female paramedics. There was continued emphasis on expansion LHWs. Increased contraceptive supply, social marketing and expansion of FP services in public and private sector and increased Information Education and Communication (IEC). Reproductive health package defined with 9 important components.

1999 RH Package was focused on safe motherhood and pre/post abortion care. It promoted comprehensive FP for males and females including social marketing and expansion of FP services in public and private sector and increased IEC. Reproductive health was approached using a life cycle approach in line with ICPD including.

The Health Policy 2001 had no long term vision and it was rather like an implementation plan in ten identified areas. However, the policy had a priority shift from curative to preventive and from urban to rural sector with additional focus on mother and child health. The 2001 Health and Population policies fostered expanding programs for female paramedics. There was a continued emphasis on expansion of LHWs services with focus on underserved areas and merger of outreach workers. It promoted expansion of social marketing and FP services in public/private sector, male involvement and multi-sector program development. The policy included an enhanced HIV/AIDS prevention program including service delivery programs for high risk groups. Issues of RH followed life cycle approach. Availability of emergency obstetric facilities was offered for selected districts.

Rizvi N & Nishtar S. (2008) in their analysis of National Health Policy 2001 found that the policy focuses on women's health through prioritization of gender equity as an isolated theme without acknowledging the vital role gender inequalities in health and health-related sectors play in defining women's health needs. The policy has an extremely narrow view on gender equity through translating into provision of RH services to married mothers, ignoring various critical overarching issues of women's life such as threatening neglect women face since childhood, early age at marriage its consequences, sexual abuse and violence, mental illnesses, unfavourable work environment and high abortion rates that affect their morbidity patterns and mortality rates and hence modify their health needs are completely missing from the policy document.

Financial risk protection gradually lost emphasis over the period. National Health Policy 1990 had health insurance schemes and National Health Policy 1997 proposed the Health Card Scheme. However 2001 population and health policies had nothing to offer in terms of financial risk protection.

In terms of targeting poor and vulnerable population segments the Health Policy 1990 did not have specific focus for MNH. However food supplementation was considered for targeting of poor in urban and rural areas. The 1997 Health Policy also did not specifically mention targeting poor and vulnerable populations for MNH services. The population and health policies of 2001 explicitly mentioned targeting rural and underserved areas, child bearing women and vulnerable groups for HIV and AIDS. The 2001 National Population Policy identified adopting a shift from target oriented to people-centred needs and services and to ensure the provision of quality services especially to the poor, under-served and un-served populations in rural areas and urban slums, as its strategies. Describing its areas the policy mentions the intrinsic interrelation of population with poverty, status of women and sustainable development as progress in any component can catalyze improvement in others. The policy 2002 therefore recommends strengthening the community-based services for the population in rural and remote areas where there is established unmet need due to inadequate access to affordable family planning & RH services. Addressing the issue of population momentum, it addresses adolescents through population and family life education in the formal & non-formal education sector and intends to reach out to young couples with appropriate media, interpersonal messages and services.

However, with the launch of Benazir Income Support Program (BISP) the financial protection and targeting regained attention.

2.3 BENAZIR INCOME SUPPORT PROGRAM (BISP)

BISP, launched in 2008, plans to start a Public Health Insurance program on the lines of Rastriya Swasthiya Bima Yojana (RSBY) program in India. Under RSBY Health Insurance Scheme, every family below the poverty line would be given insurance amounting to Indian Rupees 30,000 for maximum five family members. Insurance would cover pre-existing diseases as well as health services related to hospitalization and certain surgical procedures, which can be provided on a day-care basis. The coverage for hospitalization will be mostly cashless with a few exceptions. The insurance also covers pre and post hospitalization expenses. Moreover, a transport allowance up to Rs.1000 would be given to participants as part of the benefits. While this is a commendable initiative of BISP certain issues need to be addressed when designing a Public Health Insurance program. Some Conditional Cash Transfer Programs have demonstrated positive impacts for women health and for the complete family. This may happen when the Programs include the obligation for women to attend regular health visits for check-ups and gain access to family planning methods in culturally adequate ways (Hermosillo. GR, Sayeed. A, and The World Bank Social Protection Team, 2010).

2.4 POPULATION POLICIES

Khan. A, (1996) undertook a historical review of Policy making in Pakistan's population programme in the context of deep-rooted structural problems such as the political considerations of the various military and civilian regimes, the role of religion in politics, the influences of Western donors, and the effect of international development ideology. She concluded that conflicts and rivalry between

the separate population and health programmes within government; the politically charged over-centralized federal control over population; and the poor working relationship between government and non-government organizations will continue hampering the programs.

Lee. K, Lush. L, Walt. G & Cleland J. (1998) undertook a comparative policy analysis in eight low-income countries, including a comparison between family planning policies of Bangladesh and Pakistan. They found that the extent to which family planning programmes are successful at reducing fertility is associated with factors such as formation of coalitions among policy elites, spread of policy risk, and institutional and financial stability. These factors supported or inhibited the adoption of strong population policies and family planning programmes.

Siddiqui. F, (2001) focusing on demand side of family planning suggested that an effective population policy must address the following three objectives: (a) reduction in the rate and incidence of unwanted fertility; (b) reduction in demand for large-size families; and (c) greater investment in adolescents to tackle the population momentum problem. Hakim. A, (2001) analyzing the failures and policy shifts in Pakistan's population programme recommended that the departments need to get out of administrative approach to a service oriented approach. He also emphasized on the role of MoH in extending maximum clinical facilities to the far flung populations.

2.5 POLICIES ON WOMEN DEVELOPMENT

Pakistan became formally committed to promoting conscious public policies toward increasing women's economic participation in development in 1979 with the establishment of a separate Ministry of Women's Development (MWD) in the Sixth 5-Year Plan. After 1979, the goal changed from a welfare perspective to integration of women into the development planning, which emphasized enhancing employment opportunities for women. Both the Sixth and Seventh 5-Year Plans were multi-sectoral, and special women's programs were to be undertaken by the Ministry of Women's Development. Policy focused on enhancing capacity and increasing government service jobs for women. Special credit facilities for poor women were offered and women's organizers in government, cooperatives, and NGOs were also proposed. Program integration limited to the fields of education, health, and nutrition; agriculture, where most women are employed, was given very little attention. Women were viewed as consumers rather than producers. Kazi. S, & Raza. B, (1992) critically examined the ineffective role of ministry of women's development (MWD) in becoming catalyst for change and as legal guardian of women's rights. MWD had minimally influenced government and programs and hence could not translate policy into action and small number of the projects remained isolated from the mainstream, compartmentalized, and had traditional social welfare schemes. The biggest failure in the MWD was in protecting the legal rights of women; some of the most discriminatory legislation against women was passed after 1979. The limited resources and lack of power meant MWD has been a token gesture only.

Hafeez, S. (1992) further pointed out that the issues of the root causes of gaps in planning and implementation of policies and programs for women in development was that that MWD was not really been given administrative authority to promote social change. He identified that it was the strong social, not political, will to enhance women's welfare prevalent at that time.

2.6 ADOLESCENT AND YOUTH POLICIES

Khan. A, and Pine. P, (2003) identified four major areas of policy concerns for the adolescent and youth reproductive health. These were early, high-risk pregnancy; unwanted pregnancy and abortion; STIs and HIV/AIDS and Sexual abuse; and forced sex work. They found that generally, adolescent needs were not recognized as specific and valid enough to ensure major program and policy interventions. Pertinent policies address some aspects of ARH and the government notes that others are planned. The National Health Policy states that reproductive health as well as health education will be among the Health Ministry's priority programs. It mentions that all aspects of the reproductive system and its functions will be taught, but the document does not mention sexuality. The core of the population policy 2002 remained family planning and demographic targets. Accordingly the Interim Population Sector Perspective Plan 2012 that arose out of this policy retained the same programming focus. However within this

strategy, there is no detailed attention paid to adolescents other than the intent to include them in outreach and advocacy, and to include adolescent males in the efforts to involve men more in family planning. Even if one takes into account the difficulty of addressing the needs of unmarried adolescents in a conservative society, the proportion of married adolescent girls and the pressures they face to produce children early in their marriage required particular programming efforts to meet their needs.

2.7 NATIONAL POLICY FOR THE PERSONS WITH DISABILITIES, 2002

The policy is based on the rights based approach. It mentions disability patterns as well as burden of disabilities in various age groups. The policy mentions the health needs in terms of prevention and treatment and early detection. However there is no reference to disabled AGYM and their SRH/MNH needs.

Ahmed. M, Khan. AB, and Nasem. F, (2011) in their policy analysis focusing on special people in Pakistan didn't touch upon the health and reproductive health needs of the special people. They have, however, identified a general lack of reliable data, inappropriate needs assessment, and inadequate policy and legislative frameworks in all areas.

3 STUDY DESIGN AND METHODOLOGY

3 STUDY DESIGN AND METHODOLOGY

3.1 IDENTIFICATION OF POLICY AREAS

As the title of the study suggests, it is focused on policies related to:

- SRH/ MNH
- Adolescent Girls and Young Mothers (AGYM)

The review provides details of existing policies and/or provisions given in other documents (whole or part) addressing Sexual & Reproductive Health and Maternal & Neonatal Health at national and provincial levels.

3.2 METHODOLOGY

3.2.1 Desk Review

The public policy review was done through desk review of the available literature. The purpose of the review of literature was to critically analyze the existing material on SRH/ MNH in AGYM-Policy available literature at global-regional-country levels. It also helped in developing the tools for field work.

FIGURE 1: FOCUS OF THE POLICIES

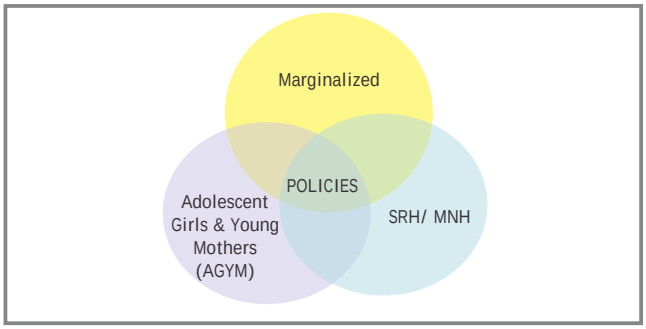


TABLE 2: KEY AREAS AND THE PERTINENT POLICIES CONSIDERED FOR THIS REVIEW

Area	Policies
AGYM	Women, Youth and Child Policies
SRH-MNH	Population Policies, Health Policies
Marginalized	Minorities, special people, poverty reduction policies

The documents reviewed included:

1. Public policies (national & provincial policy documents)
2. Demographic & Health surveys (PDHS, PSLSM) – and strategic documents/reports of relevant provincial / national department
3. Articles/abstracts/ research document on Medline & Pub-Med etc. related to SRH/ MNH in AGYM-Policy context
4. Analyses undertaken elsewhere on ASRH/ MNH in AGYM-Policy context

The research questions for policy review can be seen as Annexure 1

3.2.2 Application Of Equiframe For Policy Review

For the policy document review, EquiFrame was adapted. EquiFrame is a tool for policy analysis and benchmarking, and provides a means for evaluating policy revision and development. Amin, M., et al, (2011) have widely employed

this peer reviewed analytical framework to assess policy content or 'policy on the books'. MacLachlan. M, et al. (2012) applied it to assess inclusion of human rights in 51 health and health related policies from Malawi, Sudan, South Africa and Namibia.

EquiFrame evaluates:

1) The extent to which 21 Core Concepts of human rights are addressed in policy documents,
2) Coverage of 12 Vulnerable Groups who might benefit from such policies.

For our purpose we have made adaptations in the EquiFrame to tailor it to requirement of present study. The application of EquiFrame is described as follows:

Core Concepts (CCs)

Core concepts that related individually, or collectively, to principles of universal, equitable and accessible health services, following 21 CCs were utilized for analysis:

1. Non-discrimination
2. Individualized services
3. Entitlement
4. Capability based services
5. Participation
6. Coordination of services
7. Protection from harm
8. Liberty
9. Autonomy
10. Privacy
11. Integration
12. Contribution
13. Family resource
14. Family support
15. Cultural responsiveness
16. Accountability
17. Prevention
18. Capacity building
19. Access
20. Quality
21. Efficiency

The details of these 21 Core Concepts and the key questions and key language used in the EquiFrame are given in Table 3.

TABLE 3: EQUIFRAME - KEY QUESTIONS AND KEY LANGUAGE OF CORE CONCEPTS

#	Core Concept	Key Question	Key Language
1	Non-discrimination	Does the policy support the rights of vulnerable AGYM with equal opportunity in receiving health care?	Vulnerable AGYM are not discriminated against on the basis of their distinguishing characteristics (that is, Living away from services; AGYM with disabilities or ethnic minority).
2	Individualized Services	Does the policy support the rights of vulnerable AGYM with individually tailored services to meet their needs and choices?	Vulnerable AGYM receive appropriate, effective, and understandable services.
3	Entitlement	Does the policy indicate how vulnerable AGYM may qualify for specific benefits relevant to them?	AGYM with limited resources are entitled to some services free of charge or AGYM with disabilities may be entitled to respite grant.
4	Capability based Services	Does the policy recognize the capabilities existing within vulnerable AGYM?	For instance, peer to peer support among women headed households or shared cultural values among AGYM from the ethnic minorities.
5	Participation	Does the policy support the right of vulnerable AGYM to participate in the decisions that affect their lives and enhance their empowerment?	Vulnerable AGYM can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.
6	Coordination of Services	Does the policy support assistance of vulnerable AGYM in accessing services from within a single provider system (interagency) or more than one provider system (intra-agency) or more than one sector (inter-sectoral)?	Vulnerable AGYM know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required.
7	Protection from harm	Are vulnerable AGYM protected from harm during their interaction with health and related systems?	Vulnerable AGYM are protected from harm during their interaction with health and related systems.
8	Liberty	Does the policy support the right of vulnerable AGYM to be free from unwarranted physical or other confinement?	Vulnerable AGYM are protected from unwarranted physical or other confinement while in the custody of the service system/provider.
9	Autonomy	Does the policy support the right of vulnerable AGYM to consent, refuse to consent, withdraw consent, or otherwise control or exercise choice or control over what happens to her?	Vulnerable AGYM can express “independence” or “self-determination”. For instance, AGYM with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice

TABLE 3: EQUIFRAME - KEY QUESTIONS AND KEY LANGUAGE OF CORE CONCEPTS (contd...)

#	Core Concept	Key Question	Key Language
10	Privacy	Does the policy address the need for information regarding vulnerable AGYM to be kept private and confidential?	Information regarding vulnerable AGYM need not be shared among others.
11	Integration	Does the policy promote the use of mainstream services by vulnerable AGYM?	Vulnerable AGYM are not barred from participation in services that are provided for general population.
12	Contribution	Does the policy recognize that vulnerable AGYM can be productive contributors to society?	Vulnerable AGYM make a meaningful contribution to society.
13	Family Resource	Does the policy recognize the value of the family members of vulnerable AGYM in addressing health needs?	The policy recognizes the value of family members of vulnerable AGYM as a resource for addressing health needs.
14	Family Support	Does the policy recognize individual members of vulnerable AGYM may have an impact on the family members requiring additional support from health services?	AGYM with chronic illness may have mental health effects on other family members, such that these family members themselves require support.
15	Cultural Responsiveness	Does the policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic, aspects of the person?	i) Vulnerable AGYM are consulted on the acceptability of the service provided. ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, that is, respectful of the culture of vulnerable groups.
16	Accountability	Does the policy specify to whom, and for what, services providers are accountable?	Vulnerable AGYM have access to internal and independent professional evaluation or procedural safe guard.
17	Prevention	Does the policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?	Vulnerable AGYM have access to various level of health services within different tiers of the healthcare system.
18	Capacity Building	Does the policy support the capacity-building of health workers and of the system that they work in addressing health needs of vulnerable groups?	The healthcare providers are provided training on various health issues of Vulnerable AGYM.
19	Access	Does the policy support vulnerable groups –physical, economic, and information access to health services?	Vulnerable AGYM have accessible health facilities (that is, transportation; physical structure of the facilities; affordability and understandable information in appropriate format).
20	Quality	Does the policy support quality services to vulnerable groups through highlighting the need for evidence-based and professionally skilled practice?	Vulnerable AGYM are assured of the quality of the clinically appropriate services.
21	Efficiency	Does the policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups?	

Vulnerable Groups

Although the EquiFrame identifies 12 vulnerable groups, in our study of AGYM we adapted the list and limited to 10 categories as shown in Table 4.

TABLE 4: VULNERABLE GROUPS CONSIDERED FOR POLICY REVIEW

	Vulnerable Group	Attributes or Definitions
01	Limited Resources	Referring to the idea of poor AGYM or AGYM living in poverty
02	Increased Relative Risk For Morbidity	Referring to AGYM with HIV and AIDS, TB
03	Mother Child Mortality	Referring to factors affecting maternal and child health (0-5 years). Early marriage, unwanted pregnancy
04	AGYM (with Special Needs)	Referring to marginalized AGYM by a special contexts, such as orphans; out of school, street based; home based workers; jailed ; divorced; widow, victims of swara, feudal / tribal AGYM
05	Age	Referring to 15-24 years old females
06	Fertility status	Referring to adolescent and young mother

TABLE 4: VULNERABLE GROUPS CONSIDERED FOR POLICY REVIEW (contd...)

	Vulnerable Group	Attributes or Definitions
07	Ethnic Minorities	Referring to AGYM from non-majority groups in terms of culture, race or ethnic identity
08	Displaced Populations	Referring to AGYM among the people who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence.
09	Living Away from Services	Referring to people living far from health services, either in time or distance.
10	Disabled	Referring to AGYM with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability.

Each Core Concept received a rating of quality of commitment to Core Concept within the given policy document

Score on continuum of 1-4:

1. Concept only mentioned
2. Concept mentioned and explained
3. Specific policy actions identified to address Concept
4. Intention to monitor Concept expressed

Summary Indices

1. Core Concept Coverage: Number of Core Concepts mentioned out of 21 Core Concepts
2. Vulnerable Group Coverage: Number of Vulnerable Groups mentioned out of 10 Vulnerable Groups
3. Core Concept Quality: Number of Core Concepts rated as 3 or 4 (stating a specific policy action or intention to monitor action) out of 21 Core Concepts
4. Overall Summary Ranking:
   (i) High = policy achieved <50% on all of three indices above
   (ii) Moderate = policy achieved <50% on two of three indices above
   (iii) Low = policy achieved<50% on two or three of three indices above

3.2.3 In-depth Interviews (IDI)

After identification of the potential stakeholders at federal and provincial levels the researcher approached the key informants during May and June 2012. The preliminary data were collected through visits to the websites of the concerned entities, where applicable. The key contacts of informants were obtained through various sources. Two of the key informants were stationed abroad and were contacted through email and then interviewed via skype. All the key informants were briefed about the background of the research and were requested for time for interview. The key informants included:

1. Concerned working or former managers in national and provincial ministries, departments, programs and bodies (former policy people in the defunct federal ministries)

2. Concerned working or former managers of UN and INGOs working on SRH/ MNH in AGYM context

3. Local NGOs working on SRH/MNH in AGYM policy issues

4. Technical bodies (e.g. Population Council, NIPS)

The interview guide can be seen at Annexure 2, and the list of respondents is given as Appendix-1.

4 RESULTS AND FINDINGS

4 RESULTS AND FINDINGS

4.1 DESK REVIEW

The findings from the review of policy documents are described in a thematic and chronological manner as follows:

- PRSP-II,
- National Health Policy 2001,
- National Health Policy 2009,
- Program PC-1 of National Program for FP and PHC (2003-2008),
- National Maternal and Child Health Policy and Strategic Framework (2005-2015),
- National Population Policy 2010 (Draft),
- National Youth Policy 2008, and
- Punjab Youth Policy 2012

4.1.1 Poverty Reduction Strategy Paper (PRSP) – II

Finance Division, Government of Pakistan, (n.d.) in Poverty Reduction Strategy Paper (PRSP) – II states "Protecting the Poor and the Vulnerable" as one of its pillars. The principles that support its vision are grounded in the principles of equity, solidarity, social justice, people-centered priorities, gender mainstreaming, community empowerment, universal coverage for essential services, evidence-based decision-making the inter-sectoral approach to health, outcome orientation, fair financing, quality management, subsidiary and technical efficiency.

The Strategy envisages addressing special needs of the vulnerable population, especially women and children particularly in the rural areas of Pakistan.

PRSP has mentioned a number of weaknesses in safety nets for the poor and marginalized. These include insufficient funding given programme objectives and target populations; fragmented and often duplicative programs with limited coverage, inadequate administrative arrangements and poor Monitoring and Evaluation (M&E) capacity which negatively impacted programme efficiency and quality of service delivery. Poor targeting with small benefit levels relative to household income and the poverty

gap and Infrequent and irregular payments to beneficiaries. (These being the reasons that GoP launched the BISP)

PRSP states that the policy objectives for health systems reform set a vision for a future health system that effectively addresses social inequities and inequities in health and is fair, responsive and pro-poor; supports people and communities to attain the highest possible level of health and well-being; reduces excess mortality, morbidity and disability and care-givers burden — especially in poor and marginalized populations. The health system envisaged by PRSP "mitigates risks to health that arise from environmental, economic, social and behavioural causes; meets the specific needs of health promotion as well as treatment, prevention and control of diseases; and is there when you need it — a health system that encourages you to have your say, and ensures that your views are taken into account".

PRSP states that the health strategy has been constructed on the key principles of equity, universal access to essential healthcare, timeliness, results, accountability, strong leadership and strategic coordination of the overall effort.

4.1.2 The National Health Policy 2001

The National Health Policy 2001-The Way Forward-Agenda for Health Sector Reform (Ministry of Health, Government of Pakistan, 2001) is based on the vision of "Health for All". Health sector investments are being viewed as a part of the Government's Poverty Alleviation Plan; priority attention has been accorded to the primary and secondary tiers of the health sector and good governance is seen as the basis for health sector reforms to achieve quality health care. However against this vision the policy failed to provide explicit inter-linkages with PRSP, MDGs and MTDF. No targeting strategy was envisaged to ensure pro-poor healthcare interventions.

It provides ten areas of reforms among which key Area No. 5 is 'To bridge the Basic Nutrition Gaps in the target-population i.e. children, women and vulnerable population groups'. However it doesn't explain who those vulnerable groups are. The document has no direct reference to adolescents. It has no reference to youth as well.
The policy has gender equity as one of the 10 key areas for reforms but has limited its scope to pregnancy and not the life cycle approach.

The policy mentions about the vulnerable however doesn't expand on whom it considers vulnerable. It is not mentioning abortion, sexual abuse and unwanted pregnancies.

The policy envisaged the participation of NGOs just to the extent of mass awareness programs.

To summarize the 2001 'Policy was inefficient in terms of resource usage for policy objectives, ineffective in terms of producing a measurable impact on intended beneficiaries and inequitable in terms of benefiting relatively more urbanites and is gender insensitive'. The policy seems more a plan than a policy.

4.1.3 National Health Policy 2009: Stepping Towards Better Health

Ministry of Health, Government of Pakistan (2009), National Health Policy 2009: 'Stepping Towards Better Health' remained a draft policy. The Policy envisages a long term vision to reorient the health system endorsing the concept of health for all strategy albeit -a health system that: is efficient, equitable & effective to ensure acceptable, accessible & affordable health services. It will support people and communities to improve their health status while it will focus on addressing social inequities and inequities in health and is fair, responsive and pro-poor, thereby contributing to poverty reduction.

The draft policy has no direct reference to adolescents and adolescent girls. It has one reference to youth and that is in the context of demographic bulge.

Among its principles, the policy mentions its paradigm is based on health as a right as envisioned in the Constitution of Pakistan. The document mentions human development as a basic right of every individual. It argues that health is a pre-requisite for the economic development and that Ill health contributes to poverty due to "catastrophic costs" of illness and reduced earning capacity during illness. It agrees that poor people suffer disproportionately from disease and are at higher risk of dying from their illness than are better off and healthier individuals. It then states that women and children are particularly vulnerable. Illness keeps children

away from schools, decreasing their chances of productive adulthood.

Unlike its predecessor policy the 2009 policy intends that the government will further promote the role of the private sector in the delivery of health services, with attention to quality and patient safety and safeguarding the interests of the poor and marginalized.

The policy states that protecting the poor and under privileged population subgroups against catastrophic health expenditures and risk factors will be one of its core objectives. The policy also states that the government will provide free specialized care (dialysis services, eye surgery, treatment of heart diseases and other long term illness and disabilities) to the poorest people who are registered with BISP. It however doesn't specifically mention the SRH needs of the disabled.

The policy has special recommendations for the vulnerable such as cost effective and quality services. The policy also considers RH issues in the context of vulnerability and refers to HIV and AIDS and Viral hepatitis; however it has not mentioned the peculiar vulnerabilities of AGYM.

Addressing issue of entitlement the policy took inspiration from National Health Service (NHS), and to ensure the poorest people to access health services the scheme envisages using the database of Benazir Income Support Programme (BISP) with registering the poorest families at the level of the union council or sub district level and issuing a health card with basic health characteristics; the card will also entitle citizens to services (not provided by the state) through private providers.

The document specifically mentions the sex work as a risk of HIV. Although it agrees that abortion is among the killers of the women it has nothing to offer for the unwanted pregnancies except post abortion care.

4.1.4 Programme PC-1 of National Programme for Family Planning and Primary Health Care

The Programme PC-1 (NP-FP & PHC: PC-1; 2003-2008)) provided an important strategic arm both for the new National Health Policy (2001) and for poverty reduction. The overall vision of the Policy was to ensure Health-For-All with priority attention directed towards the primary and secondary levels of the health care system. The program focus is on the poor far flung rural areas as well as underserved urban areas. The thrust of services is on pregnant and lactating women and young anaemic children. However the document is silent about the needs of the adolescent girls. Hence except gender, health condition (pregnancy/lactation), age bracket and geographical focus, no further details of the marginalized have been provided.

The program is offering a services package individually tailored for the women of reproductive age. With the exception of distinguished training program in Sindhi language, the cultural aspect is not referred to in detail. The services are free. The element of community participation has been stressed upon. It is intended that members of the community become organized for participation in health promoting activities including participation in decision making during project planning/project implementation at the local level, and monitoring and evaluation. There is intention to collaborate with NGOs, donors and education department and between federal provincial and district health departments. The element of integration is observed as the program has role in EPI, Hepatitis-B, Malaria, and TB programs.

However, the document is weak in terms of individual's rights of confidentiality, privacy, and consent. The policy has an intense emphasis on the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups. Counselling in family planning and health education are peculiar aspects of the program.

The program is conceived to provide PHC services at the doorsteps of the poor communities. There is a particular stress on the preventive aspects and referral to secondary or tertiary level facilities.

The PC-1 has no reference to abortion, sexual rights, sexual abuse, and early or unwanted pregnancy. There is no reference to program's role in disasters however during earthquake 2005 and other natural and manmade disasters the program indeed served for the displaced population.

4.1.5 National Maternal and Child Health Policy and Strategic Framework (2005-2015)

The goal of National Maternal and Child Health Policy and Strategic Framework (Ministry of Health, (2005) is to improve maternal and neonatal health status, particularly among the poor and the marginalized, by creating an enabling environment for effective service delivery at all levels of healthcare delivery system.

Generally this Strategic Framework has targeted poor, and the high-risk women (those already having four births, those having a poor obstetric history and those under-18 years or over 35 years of age). However it doesn't specifically mention adolescents. The one incident it refers to adolescents is in the area on nutrition. While targeting it speaks of the need to focus on promotion of equity and thus rural populations and deprived districts. It highlights that peri-urban populations may be even more deprived than rural populations in terms of access and inequity of care.
In order to protect marginalized population from financial crises in seeking maternal & neonatal services the framework mentions exploring various modalities including material (voluntary blood donation, supply emergency medicines) and cash support (zakat and insurance). It also has references to free services for the poor.

The policy has no reference to sexual health. Regarding abortion it mentions the need for collaboration in legislation, however it doesn't indicate any intervention for safe abortion services, rather its focus is on post abortion care.

The framework mentions some key areas of reforms:

- Developing a unified policy on maternal and child health, implemented through an integrated national MCH program
- Training of LHVs and community skilled birth attendants, with an objective to ensure that each birth is attended by skilled health personnel
- Ensuring comprehensive family planning services across all health care infrastructure
- Ensuring easy and organized access to high quality 24/7 Basic and comprehensive EmONC for all
- Ensuring implementation of Integrated Management of Childhood Illness and Child Survival Interventions through skill building of health care providers, strengthening of health system and implementing community component
- Expansion of Lady Health Workers' Programme with enhanced community based MNH interventions
- Designing and implementing culturally appropriate behavior change interventions targeting women, men and communities at large
- Developing mechanisms for social safety nets for the poor
- Devising innovative approaches for public-private partnerships
- Institutionalizing management and organizational reforms for improving governance
- Developing referral and transportation services, particularly in remote rural areas
- A functional monitoring and evaluation system facilitating use of information in decision-making.

The document values the role of community and family. It refers to information and education for empowerment and change (IEEC) approach through support groups or other participatory methods, using culturally adapted pictorial booklets and audiocassettes on pre-defined locally needed range of MNH topics.

The strategy gives value to improvement in governance and mentions that there is need for improved public access to information on maternal health performance as a way to increase the accountability of health care providers and elected officials (e.g. publication of league tables on maternal and neonatal health coverage, proportion of female attending antenatal care etc).

For inter-sectoral collaboration, the document points out cross cutting issues such as gender, Family Planning services, Nutrition education and sensitization, intra-household food allocation, food fortification, incorporating MNH in school curricula, training of teachers in MNH issues, occupational and environmental health risks to women, particularly pregnant women, transportation, legislation regarding promotion of breastfeeding, blood safety, inheritance, early marriage, right to abortion and post-abortion care, etc. Besides these vocational training for women, addressing domestic violence through social and legal structures, financial empowerment for women through

micro credit schemes; recognition of women's participation in labor force, etc. have also been considered.

4.1.6 National Population Policy 2010 (Draft)

The draft policy (Government of Pakistan, 2010) mentions 'Promoting family planning as an entitlement based on informed and voluntary choice' as one of its guiding parameters. The draft policy also refers to life cycle approach.

It takes stock of international comparative research studies that reveal benefits of family planning to maternal health and child survival. These studies depicted that there would have been around four million additional maternal deaths during 1985-2005 if there had been no increase in FP use over 1985 level. Similarly, 54 percent additional maternal deaths would occur during 2005-2025 if no increase in family planning use is recorded over 2005 level.

Access to information regarding contraceptives remained weak to effectively address persistent misperceptions regarding family planning and misinformation regarding contraceptives despite repeated surveys indicating side effects as a major barrier to the adoption and continuation of hormonal contraceptives. Furthermore, persistent confusions and misconceptions among less educated and illiterate segment of population regarding religious aspects of family planning created socio-psychological barriers.

The draft policy states that the role interpersonal communications to remove inaccurate information regarding family planning methods, disinformation regarding non-use according to religious precepts, and encourage small families, etc. remained ineffective. A special cadre of male mobilizers was established to bridge the prevailing social mobilization gap especially for men, but its contribution has remained negligible due to inadequate training, poor understanding of role and responsibilities, and absence of any mobility support to cover assigned communities The draft policy admits that high unmet need for family planning services, the high levels of unwanted fertility and the large number of induced abortions to avoid having and rearing an unwanted child are reflection of the failure of program to fulfil the demand for easy, accessible, affordable good quality information and services.

Although the draft policy has mentioned ICPD there is no reference to Sexual and Reproductive Health and Rights. Similarly while the draft policy recognizes abortion as an important issue it suggests only prevention of it through family planning and post abortion care. The policy has no reference to adolescents while focused youth mainly in the context of economic development. It has no direct reference to mainstreaming of population in the development.

4.1.7 National Youth Policy 2008

The national youth policy (Government of Pakistan, 2008) has only one reference to adolescents when it states that programmes for guidance of youth in adolescence age group would be undertaken and youth friendly confidential counselling help line would be established with the help of Ministry of Health.

The overall impression of the policy is that it is urban youth focused. There is only one reference to 'early' 'marriage' i.e. the policy intends to provide necessary life skills for youth through university and school curriculum and in the non-formal education sector in order to make youth capable of coping with their problems in the 'early years of marriage'.

The policy is silent about the modus operandi of its implementation.

4.1.8 Punjab Youth Policy 2012

The Punjab Youth Policy (Government of Punjab, 2012) has generally discussed the phenomenon of poverty and its relationship to youth and the dynamics of poverty viz a viz the AGYM. The policy identifies following 7 priority groups:

1. Youth from rural and semi-urban areas of the province.
2. Out-of-school/illiterate youth.
3. Girls/young women.
4. Adolescents particularly the female adolescents.
5. Youth with disabilities.
6. Vulnerable youth (Street youth, rural poor youth,

Migrant youth, physically and sexually abused youth, youth in flood affected areas, etc.).

7. Minority youth.

The policy is cognizant of matrimonial challenges that female youth has to face. These include criminal activities such as forced and early marriages and the customary practices such as *watta satta*, *vani*, *pait likkhi*, *vulvar*, etc. Girls are deprived from schooling and considered as economic burden due to poverty and they have little choice in marriages. Gender discrimination restricts their mobility and soon they become a victim of forced and early marriage. The policy highlights the vulnerabilities of the adolescent girls in Punjab. Referring to PDHS 2006-7 it points out towards the out of school adolescent who are denied the opportunities to develop physical and cognitive skills and the knowledge and information necessary to becoming healthy, productive adults. 11.6% and 44.8% girls are married at the tender ages of 15 and 18 years, respectively. This has further implications on pregnancies and having children at an early age. 22.5% of females aged 15-24 are 10 or more years' younger than their spouses. In the same age category, 70.5% girls have never used any contraceptive method. Likewise the knowledge of using contraceptives is also limiting. Majority of girls go to traditional birth attendants for delivery assistance.

The policy takes a forward leap stating that there will be no discrimination on the basis of sexual orientation.

4.2 FINDINGS FROM THE APPLICATION OF EQUIFRAME LENS

With the application of EquiFrame for the policy analysis, it was found that in terms of overall quality none of the policies could be ranked as 'high'. Both the national health policies (2001, 2010), both the Population Policies (2001. 2010) and the National Youth Policy (2008) ranked as 'poor', whereas PRSP II, National MCH Policy & Strategic Framework, PC1 LHW Program and Punjab Youth Policy 2012 stood as 'moderate'.

In the context of AGYM none of these policies has a special focus. Table 5 indicates the level of inclusiveness of various core concepts in policies. The numbers 1 and 0 stand for the presence and absence of a concept respectively.

4.3 FINDINGS FROM IN-DEPTH INTERVIEWS

Key stakeholders, policy makers and divisional/ ministerial office bearers & managers were interviewed; findings of the key informant interviews (KII) are grouped in sections below;

TABLE 5: PUBLIC POLICIES OF PAKISTAN FROM EQUIFRAME LENS

key words for Core Concepts	Health Policy (National)		National MCH Policy & Strategic Framework	PC1 LHW Program	Population Welfare Policy		National Youth Policy	Punjab Youth Policy	PRSP-II
	2001	2010 (Draft)	2005-2015	2003-2008	2002	2010	2008	2012	n.d.
Targeting	1	1	1	1	1	1	0	0	1
Adolescent	0	0	1	0	1	0	1	1	1
Young/Youth	0	0	0	1	1	1	1	1	1
Girl[s]	0	0	0	1	0	0	1	1	1
Mothers/Maternal	1	1	1	1	1	1	1	0	1
Poverty	1	1	1	1	1	1	0	1	1
Poor	1	1	1	1	1	1	0	1	1
Marginalized	0	0	1	0	1	0	0	1	1
Minority	0	0	0	0	0	0	0	1	0

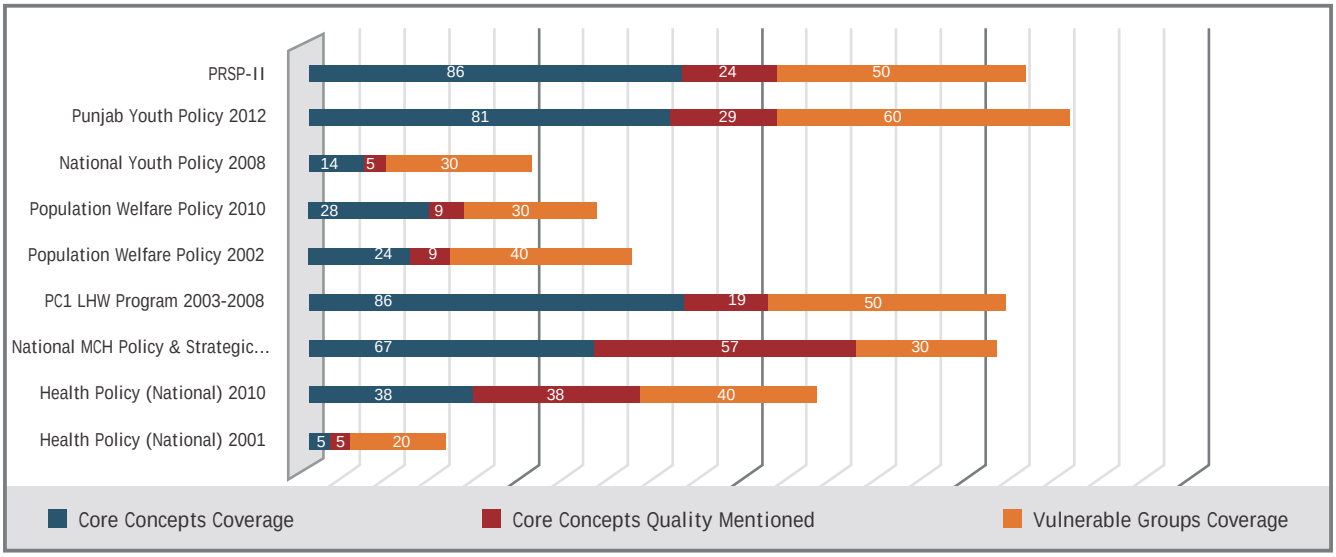
TABLE 5: PUBLIC POLICIES OF PAKISTAN FROM EQUIFRAME LENS (contd...)

key words for Core Concepts	Health Policy (National)		National MCH Policy & Strategic Framework	PC1 LHW Program	Population Welfare Policy		National Youth Policy	Punjab Youth Policy	PRSP-II
	2001	2010 (Draft)	2005-2015	2003-2008	2002	2010	2008	2012	n.d.
Down-trodden	0	0	0	0	0	1	0	0	0
Disability	0	1	0	0	0	0	0	2	1
Disadvantaged	0	0	1	0	0	0	0	0	1
Deprived/ Deprivation	0	0	1	0	0	0	0	3	1
[Un/Under]privileged	0	1	0	0	0	0	0	0	0
Gender	1	1	1	1	0	0	0	1	1
Women	1	1	1	1	1	1	0	1	1
Mainstreaming	0	0	0	0	0	0	0	1	1
Justice [social justice]	0	0	0	0	1	0	1	1	1
Right (in the context of human rights)	0	1	3	0	0	0	1	1	1
Vulnerable	1	1	1	1	0	0	0	1	1
[Non]-discrimination	0	1	0	0	0	0	0	1	1
Equality	0	1	0	0	0	0	0	1	1
Equity	1	0	1	1	0	0	1	1	1
Entitlement	0	1	1	0	0	0	0	1	1
Reproductive	1	1	1	0	1	1	1	1	1
Sex(ual)	1	1	0	0	0	0	0	1	1
ICPD	0	0	0	0	1	1	0	1	1
STIs /STDs	1	1	1	0	0	0	0	1	1
HIV (AIDS)	1	1	1	1	0	0	1	1	1
Abuse (sexual abuse)	0	0	0	0	0	0	0	1	0
Early [marriage]	0	0	1	0	0	0	0	1	1
unwanted pregnancy	0	0	1	0	0	1	0	0	0
Abortion	0	1	3	0	0	1	0	0	0
safety (social safety net)	0	1	3	0	0	0	0	0	1
Free [service]	1	3	1	1	0	0	0	0	1
Capability/Potential	0	0	1	0	0	0	0	0	1
Participation	1	1	1	1	1	1	0	1	1
Accountability	0	1	1	0	0	1	0	1	1
inter[-agency, sectoral] collaboration	1	0	1	1	0	0	1	0	1
Partnership	1	1	1	1	1	0	1	1	1
Harm	0	1	0	0	0	0	0	0	1
Quality [of service]	1	1	1	1	1	1	0	1	1
Consent	1	1	0	0	0	0	0	0	0
Privacy	0	0	0	0	0	0	0	1	0
Confidentiality	0	0	0	0	0	0	1	0	0

TABLE 5: PUBLIC POLICIES OF PAKISTAN FROM EQUIFRAME LENS (contd...)

key words for Core Concepts	Health Policy (National)		National MCH Policy & Strategic Framework	PC1 LHW Program	Population Welfare Policy		National Youth Policy	Punjab Youth Policy	PRSP-II
	2001	2010 (Draft)	2005-2015	2003-2008	2002	2010	2008	2012	n.d.
Efficiency	1	1	1	0	0	1	0	1	1
Family (support)	0	0	1	1	0	0	0	0	0
Community	1	1	1	1	1	1	0	0	1
Culture/tradition	0	0	0	0	0	0	0	0	0
Capacity	0	0	0	0	0	0	0	0	0
Liberty	0	0	0	0	0	0	0	0	0
Core Concepts Coverage (%)	5	38	67	86	24	28	14	81	86
Core Concepts Quality Mentioned (%)	5	38	57	19	9	9	5	29	24
Vulnerable Groups Coverage (%)	20	40	30	50	40	30	30	60	50
Overall Quality	Poor	Poor	Moderate	Moderate	Poor	Poor	Poor	Moderate	Moderate

FIGURE 2: EQUIFRAME ANALYSIS OF THE POLICIES



4.3.1 Thematic areas identified:

The responses were clustered under the following scheme:

Key players & stakeholders:

- Government (capacity)
- Donor (interest, agenda)
- NGO/ Civil Society Organization/ Networks

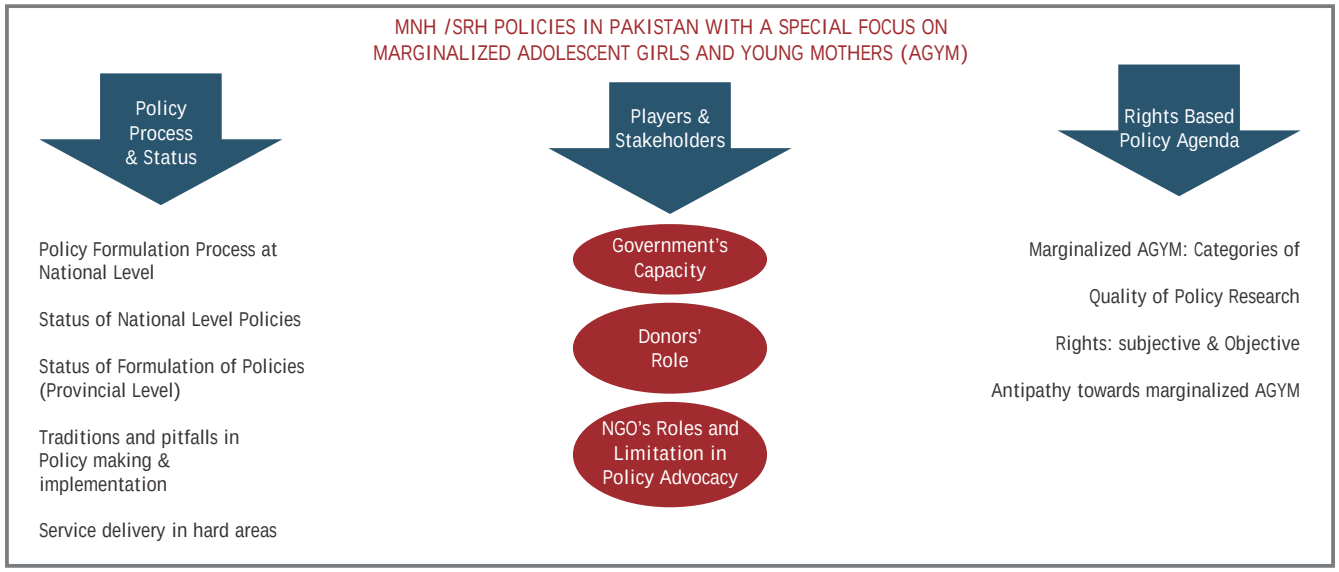
Aspects of Policy Process

- National level policy formation, role, status (implementation, M&E, etc.)
- Provincial level policy formation, role, status (implementation, M&E, etc.)
- Difficulties in policy making, barriers, hindrance, implementation, monitoring
- Implementation and service delivery to all

Reflections on rights-based policy approach

- Categories of special group – identification, need, appreciation of needs..etc
- Policy Research
- Rights – subjective and/ or objective

FIGURE 3: MAJOR THEMES THAT EMERGED FROM THE IN-DEPTH INTERVIEWS



- Apathy / prioritization of polices for specials groups by policy makers

4.3.2 Current Status of Public Policies

Provincial level health and population policies

The analysis based on in-depth interviews has shown that after 18th amendment the provinces were, by and large, not prepared for their new policy role in the social sectors. The Punjab and Khyber Pakhtunkhwa seemed better positioned to the changing policy scenario but that was limited to health and population sectors in Khyber Pakhtunkhwa, and to health sector in the Punjab.

Punjab

Realizing that The Punjab's social sector indicators are lagging as compared to other countries with similar economic development, Government of the Punjab is making efforts to improve its social sector and particularly the health sector indicators through a number of initiatives such as Punjab Devolved Social Services Program, Punjab Health Sector Reforms Program and Punjab Millennium Development Goals Program (PMDGP). (Health Department, Govt. of the Punjab, n.d.).

In Punjab public policy process is in well advanced stage with respect to the other provinces. Health sector reforms 1998 that focused on autonomy and decentralization is an important milestone in this regard. There are 3 important documents showing that policy debates were there:

1. Health sector reforms 1998 and hospital and institutional autonomy act
2. Health Sector Framework 2004 - the health sector reforms and policy strategy
3. In 1998, Long Term Vision (LTV 2020)

Hence it was not a huge policy shift as many of the policy initiatives were already started before 18th amendment.

In 2008, a working group on health was formed which produced an important document on strategy and implementation, titled "Health Today and Beyond 2008". That was an important milestone in policy formulation at provincial level. Devolution created bit confusion in 2010-11 for implementation but that was not due to policy making.

However per se' there is no health policy of the Punjab. Recently, a health sector strategy was developed by the province. The population policy in Punjab is in abeyance. The decision regarding the fate of population welfare program is awaited.

Sindh

Back in 2005 Sindh health policy was introduced that qualifies to be revised now after 18th amendment. Moreover it was not referred to in the past. Newly established HSRU is

a platform for health policy. It has total financing by government of Sind and with substantial allocation in ADP.

After 18th amendment nothing has been done in the area of population policy. There is an on-going debate on the status of PWD. The program is facing major constraints in rendering its role.

Khyber Pakhtunkhwa (KPK)

Four documents have played a key role in setting health policy direction in KPK:

1. The KPK considered its due participation in the process of draft National Health Policy 2010 as legitimate and after devolution moved ahead with a further step and entered into strategy development.
2. In 2010 Government of KPK developed CDS- a Comprehensive Development Strategy approved by the Cabinet which is now serving as the mother document for all the policy documents in KPK.
3. The IDP crises in KPK followed a PCNA-Post Crises Needs Assessment with the support of WB and ADB.
4. There was a DNA- Disaster Needs Assessment conducted by WB, as well.

Based on the recommendations of these documents the Health Sector Strategy 2010-2017 was formulated for KPK. As these documents mostly been grounded in the wake of humanitarian crises hence their prime concern was the marginalized people.

KPK took the population agenda most seriously and with strategic and strong advocacy was able to retain the population welfare program. It brought the program on current side budget after 18th amendment, all employees except contractual were included as permanent employees, even federal (RTI) employees were adjusted in the provincial strength. At present 2002 Population Policy is being referred to because ECNEC approved the last PC1 on the basis of the old policy so KPK is following it but innovatively and with some flexibility.

Balochistan

Till May 2012, Government of Balochistan had no policy reform unit. However a unit is being established. A proposal on development of health sector strategy is being processed with TRF, Islamabad however given the security situation there might be some delays in initiating work on it.

As such, health department had no concrete direction under post 18th amendment scenario for revision of its role. Even most of the PC1s have not been revised. Though PC1s of LHW program and MNCH program had been revised the Planning Commission during consultation advised that Balochistan chapter must move as it is and that Balochistan should keep on sending the work-plans and Planning Commission would keep on sending the finances till 2015.

> *"It appears that provincial secretariat has not realized what will be the implications of 18th amendment".*
> (A public sector representative)

Post 18th amendment scenario opened the doors of serious governance concerns in Balochistan. Despite an increase in NFC award and financial support the situation remains dismal. On legislative level Balochistan Assembly has not taken appreciable initiatives on civil, human, women or child rights, even standing Committee on Human Rights have not been formed. At administrative and management level, there remained confusion on settlement of personnel, post devolution.

> *"Civil society moved some bills such as Child Protection Bill which is not being tabled for last 8 months. The department is now supposed to send the draft to Law Department but it is not moving the file. Similarly a bill on Domestic Violence is lying for 10 months."*
> (A Civil Society Representative)

In order to accommodate and allocate portfolios to the bulk of ministers, the organs and departments to mainstream the law e.g. Education, Social Welfare, Women Development have been divided into multiple parts e.g. Ministry of Education is divided into Education, Quality Education and Higher Education. The secretary is single hence the departmental confusion is there.

"Security is the top most problem in Balochistan. Donors don't come, hence don't support or are shrinking the support. UN agencies shifted all risk activities (but not security measures and support!) to local Implementing Partners (Ips)."
(A Civil Society Representative)

Balochitan Development Strategy is in process. It offers an important opportunity for considering many aspects of poverty and marginalization.

Population Policies

There is no population policy at present to guide the population program in Pakistan; rather 2002 policy is being used as reference document. However 2002 policy was a commitment at federal level. Things are in limbo at provinces.

"Governance is about the capacity to develop a policy and devise regulations to implement the policy. The political commitment is a must for this but unfortunately these are missing for policy...Every health policy 1990, 1997, 2001, and 2010 has a shift. There was no continuity. How can we believe that a federal population or health policy will have a place in provinces and [will enjoy] continuity"
(Federal level policy expert)

"A policy needs commitment from bureaucratic and political circles. But bureaucrats have never been in population policy making process at provinces. The population policies have been a failure in the past. It was result of socio-cultural, economic and religious beliefs. "The policy makers were oblivious of the anthropologic and socio-cultural sensitivities. When people don't use polio drops and iodized salt for fear of Family Planning, the social acceptance of FP becomes questionable. The stigma of population control is not vanishing. The conflicting messages of past such as 'two children' message was against the 'economic benefits of children' perception of the masses, so they didn't buy that idea. Hence the evidence base was not there and the bureaucrats took the decision. Just recently the government took a turn and linked FP with maternal and child health."
(Federal level policy expert)

Ministry of Women Development

Like other ministries, after the 18th amendment and closure of the MoWD, the provinces were not ready for this change. Most of these Women Development Departments (WDDs) are located within Social Welfare, Special Education, or Youth Affairs etc. This impedes the function of WDD due to different nature of agendas of Social Welfare (that follows a welfare approach) and that of WDD (that is meant for gender mainstreaming). Within these parent departments WDDs have been side-lined. With the exception of WDDs in Sindh the roles of WDDs in other provinces have become ambiguous. Most of WDDs are not aligned with gender related national and international commitments of the government of Pakistan and instead of playing the role of catalyst and advocate for gender concerns these WDDs are now implementing certain activities.

"Strengthening of WDD as a replica of MOWD seems an uphill task. At present no areas have been defined in the policy at provincial level. Research and Policy wing that were present at federal level are no more there and are not established at provincial level. WDD is not an ordinary department, half of Pakistan is its mandate but extremely poor in resources and technically weak".
(PCSW Representative Sind)

"PCSW is working on larger issue for women and domestic violence bill and women empowerment. The said issues of AGYM might come as cross cutting issues but not very specific to health. We are too new. Unlike NCSW, donors and technical support is

lacking and we are still struggling with bureaucracy. The topic is not their immediate priority"
(PCSW Representative Khyber Pakhtunkhwa)

The Ministry of Human Rights

The Federal Government of Pakistan established, the full fledge, Ministry of Human Rights in November' 2008. With the much appreciated and anticipated support, the Ministry of Human Rights looks forward to converting its vision into reality. Vision is to create a society free of human rights suffering and deprivation.

Mission of the Ministry of Human Rights is to safeguard and protect the Fundamental Rights enshrined in the articles 8-28, Principles of Policy's article 29-E, and the Universal Declaration of Human Rights without any distinction of creed, race or religion.

Bill for the establishment of National Commission for Human Rights placed at the floor of the National Assembly. Presently it is viewed by the Standing Committee on Human Rights. Currently the Ministry of Human Rights is eagerly pursuing ratifications of International Convention Against Torture, Inhuman, or Degrading Treatment or Punishment (CAT) and International Covenant on Civil & Political Rights. In this regard, a good number of consultative meetings with concerned Ministries have already taken place in the Ministry. Also recently, completed research studies on implications of the ratifications of the said conventions have been circulated to all relevant Ministries for their views/comments before initiating a Summary for soliciting the formal approval of the Cabinet.

Pakistan has ratified International Convention on the Elimination of All Forms of Racial Discrimination and requires submission of periodic progress reports to the Committee on the Elimination of All Forms of Racial Discrimination (CERD).

Youth Policies

The process of development of youth policies has witnessed at least five drafts during 1990s till date. These drafts of National Youth Policies (NYP) were prepared in 1989, 1993, 2002, 2004 and 2008. The draft NYP of 1989 and 1993 were not presented to the Cabinet. In 2001 the Federal Ministry of Culture, Sports and Youth Affairs started national and provincial consultations with civil society on the National Youth Policy. Later Ministry of Youth Affairs, provincial youth departments and civil society organizations and students prepared a comprehensive NYP (2002). The draft NYP 2002 was presented to the Cabinet which suggested some changes. The fourth NYP draft was prepared in December 2004.

The federal Ministry of Youth Affairs came into existence in November 2005. It presented the National Youth Policy 2008 (approved in 2009). As was the case of Women Development there were many ministries and organizations working on various youth related issues. The purpose of the National Youth Policy was to integrate such programmes and provide overall sense of direction consistent with the needs of the country.

In the light of the 18th constitutional amendment the Federal Government devolved Ministry of Youth Affairs to provinces in 2010. In the Punjab, the Information, Culture & Youth Affairs (ICYA) department prepared the first draft of Punjab Youth Policy in August 2011 to address youth issues at priority.

"*Regarding forced and early marriage, these issues are in there in the policy. We can't give detailed solutions, we just give framework. The policy recommended establishment of Youth Commission and Youth Foundation. Such two institutions may respond to the needs e.g. of AGYM*".
(Participant of Youth Policy Process)

4.3.3 Policy Process

The meaning of power:

What determines if a Ministry is powerful?

1. Domain (e.g. Finance is most powerful because it has the 'purse')
2. Human resource recruitment and career (e.g. Establishment Division- decides about career and promotion and Insecurity!)
3. Control on administration (Police, Law, Establishment)
4. Laws, acts making ministries

5. Ministry with a competent manager (Policy formulation has a leadership role-political leadership)
6. National Assembly's Standing Committees (especially Public Accounts Committee) active role

Do we really need policies?

It was found in the analysis of KII that there were two different arguments on the need of policy. Before 2002 programs were being run on strategies (and the strategies were known as policy). The respondents argued that a policy document essentially is required by the donor and the government has to prepare it in order to receive the grant. Respondents' views were:

- At times policies are formulated after the plans were rolled out (e.g. population policy 2002). Hence the plans were never developed in the light of the policy.
- Recently the Health Sector Strategies of Khyber Pakhtunkhwa and Punjab were developed without a Health Policy. The other two provinces are working on the same lines.

This approach very much questions the need of a policy.

However to another respondent policy is a must to determine the direction:

> "*In the absence of policies, they come up with quick fix. Everyone is uttering words MDGs 4 and 5 without knowing the meanings. The concerned people become panic when in 2012 they feel that 2015 deadline is approaching. They panic and then take erratic decisions. We need to realize that we can't achieve and like Vietnam we may need to define our own goals*"
> (Federal level policy expert)

Challenges and pitfalls in policy making and policy realization

Policy as such is not formulated on sound foundations, if formulated waits for approval. It is because the technical people have not been able to sell policies to political regimes.

> "*Historically it is customary in Pakistan that most of the decisions at policy level get approved but without a follow up. Policies are more of powerful interest group's reflections in policy. So that in future that group, Health sector strategy needs politicians' involvement but involving them and attracting them will require some modes*".
> (Respondent from Federal Level)

Policies are not demand and supply based and bottom up. Little if any evidence is used in policy formulation. No gap analysis is performed.

> "*PC1 is not problem based.*"
> (Respondent from a Province)

Within institutional framework, different policy documents should be interlinked. A policy should be followed by five years plan which should enter into strategic plan and onwards into project documents and Pc1. The cultural sensitivity needs to be a cornerstone for any policy.

> "*We are good at forming laws but inconsiderate of the culture. For instance we made a law of blood screening for viral hepatitis B&C and Thalassemia before marriage. No implementation was achieved. We didn't consider cultural sensitivity.*"
> (Respondent from Khyber Pakhtunkhwa)

4.3.4 Players, Stakeholders and Dynamics

Key Partners in Policy Making

Historically the partners at Federal level were:

1) Federal Government
2) Development Partners (Donors)
3) Provincial Governments: "Now becoming key players #1"
4) Civil Society/NGOs
5) Corporate sector (e.g. pharmaceuticals and equipment providers, WTO)

6) Media

Development Partners'/Donors' Role

There were confronting remarks about the role of donors in the policy process:

> *"Policy is donor driven, especially the case of vertical programs including MNCH program."*
> (MNCH Expert)

Policy Advocacy

There is a lack of coherence in policy advocacy for the RH. The advocacy is not being approached in a strategic manner.

> *"Health Advocacy was never treated as rights based advocacy. If the right to one's own body is not recognized then the right to contraception seems a distant dream"*
> *"In the name of advocacy there are isolated event reports by individual NGOs".*
> *"We [policy advocates] follow an adhoc approach; we consider NGOs only and not the Civil Society as a whole."*

4.3.5 Rights Based Policy Agenda

Categories of marginalized AGYM

The respondents identified a number of ways of determining categories of the marginalized AGYM.

- On the basis of residence: slums, rural areas. Urban slums that may have worst kind of poverty
- Situational marginalized due to sudden health related shocks/ health expenditures on MNH/ abortion issues they become marginalized.
- Socially unable to access due to traditional practices, such as who are not allowed e.g. right to participation of a grown up girl in decision making. Lack of empowerment to take decision about self. For example poorer and rural communities that force girls to early marriage. Tribal areas having traditions of trade of girls on resolving feuds and enmity.
- Girls who don't go to school and are out of school.
- Many girls born in large families face gender based barriers. For example there is late appearance in hospital
- Displaced and disaster affected: vulnerable to sexual abuse violence, HIV and sex work

> *"On the supply side there are geographical and physical aspects of marginalization, on the demand side, socio-cultural marginalization."*
> (MCH Program Expert)

Another way of approaching the issue of marginalization of AGYM was narrated as follows:

> *"1. Health Care Perspective: The age group is challenging, the policy and service delivery has no focus on it, and there is no understanding of their needs.*
> *2. Food and Nutrition: Differential treatment*
> *3. Socio-Cultural Aspects:*
> *4. Women Empowerment Sense: The low maturity level of the AGYM demands that the elderly supervise them. This might sound contrary to the empowerment concept but we should not blindly adopt the west without thinking because some of our traditions have strengths".*
> (MNCH Expert)

It was suggested that the marginalization and vulnerability can be considered in a continuum:

> *"We can approach the vulnerable population and within it the girl child followed by her MNH needs. We need to be wary of the special vulnerabilities such as FSW in the context of PLHIV. This approach implies a need to define the target population. For that some scales of marginalization might be needed."*
> (Health Sector Specialist)

Apathy towards Specific Policies for the Marginalized AGYM

Some respondents challenged the very need of a policy for AGYM this way:

"Policy and laws are for everyone, but if there are violation then that is reported through a complaint mechanism. That means the policy has to be for everyone; so marginalized AGYM is basically implementation issue, not a policy issue."
(A Child Rights Expert)

"*Why we need to devise policies for the special or marginalized? We already have programs for the marginalized. A family welfare centre offers services for everyone. Who asks for human rights and reproductive rights in Pakistan? The real issue is of service delivery and access*"
(A Population Expert)

"You refer to nomads, HIV positive and disabled girls and young mothers; my question is 'what is their proportion?'. Policy has to be at broader level, for the whole population. There is opportunity cost involved which matters a lot. In order to balance out the available resources we have to tackle the greater challenges and we can't bear opportunity cost for such a small segment of society... So our policies are not blind, these were federal policies that were blindly being implemented. Our Health Sector Strategy is health systems focused, instead of targeting. The strategy is focused on governance aspects, the accountability and responsiveness... What is needed is to enhance the strength of the existing system so that it captures the marginalised as well....Unless your system gets matured you can't go for targeting."
(MNCH Expert)

Access of the mainstream Vs the marginalized

"*Unless the needs of the mainstream population are not met and we have something left from the routine expenditures, we may not offer anything to such communities*"
(A Population Expert)

Human rights aspects in public policies of Pakistan

Broadly speaking the Human rights aspect has been missing from public policies. Scheduled casts and non-privileged are not specifically targeted in the policies. However lately some considerations can be noticed for instance, in HIV and AIDS context interventions indeed targeted Injecting Drug Users (IUDs) and Sex Workers (SWs) however these were at programmatic level and not at policy level. Nevertheless there seems an inclination towards human rights aspects, for instance initiative of national human rights cell, legislations on women rights (such as domestic violence). The media played an important role in it through voicing the issues. Recently the opening of health ombudsman was another step.

Non inclusiveness of the concerned departments and ministries

"*No orders have been issued to get the policy drafts vetted by the ministry of Human Rights!*"
(Health Policy Expert, Federal Level)

AGYM with Special Needs

The people with disabilities have ever been ignored in the public policies.

"*Very unfortunately there is a common tendency of ignoring the sexual and reproductive needs of the people with physical disabilities. It is as if a physically handicap has no feelings and desires...We have knowledge of cases of sexual abuse and exploitation of the disabled youth and adolescents in our city [Karachi]. The victim is unable to protect herself and you won't believe how inhuman way the culprits behave towards such handicapped.*"
(Special People's Activist)

Research

Referring to evidence based policy formulation some respondents pointed out a concern about the research quality:

> "*Research on SRH is of poor quality- not even representative sampling being followed*."
> (A youth activist)

A particular reference was made in this regard to hard to reach geographical areas and territories such as federally administered tribal areas (FATA).

Segmentation and lack of interface

> "*There is a clear lack of interface between the segments and departments. Health is limited to PHC and Policy, RH is confined to FP and MNCH, Youth related work is equated with entrepreneurship or exposure visits. Hence no interface is defined*."
> (A youth activist)

Framework of Economic Growth of Pakistan (Planning Commission, Government of Pakistan, 2011) describes three pillars on which health reforms are based. Essentially these three pillars are derived from WHO's health systems approach. These pillars are:

- Access and availability of health services
- Equity and fair financing of services
- Governance and accountability

This is a dynamic document and since it was made after 18th amendment, it reflects provincial policy priorities as well. However most of the participants at provinces had no information of this important document and its policy implications. Perhaps the situation is rightly depicted by a federal level respondent:

> "*The devolved scenario is too young to comment upon. It is just one year old process. So far the main focus has been on the outstanding issues and unfinished agenda of devolution with little attention to the strategic issues*".
> (Public Policy Expert)

5 DISCUSSION & CONCLUSION

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"There is nothing more unequal than the equal treatment of unequal people"
Thomas Jefferson

5.1 DISCUSSION

The review reveals that majority of the public policy documents do not reflect a political/administrative will to address SRH/ MNH issue of marginalized AGYM. The SRH/MNH policies/programs claim targeting the vulnerable groups yet these groups have loosely been defined, mostly as - rural women but not necessarily the marginalized AGYM and these documents are silent on how the target groups are defined.

It seems as if, SRH and MNH needs of the marginalized AGYM dropped off the radar of most of the public sector institutions, as well as some of the major nonpublic sector players. A kaleidoscopic view of the policies shows that this issue is beyond the mandates of ministries and departments working on child, youth, women, health, population, social welfare or national harmony issues.

The Ministry of Human Rights (MoHR) should ideally be responsible to safeguard and act as a watchdog of the rights of AGYM. However, at present, like other social sector ministries, MoHR itself is struggling to establish as an institution. It still has a long way to go before it affirms its own roles and existence.

The review also identifies the need for a critically positioned, motivated and able leadership that can make a huge difference in policy formulation (e.g. Women Development and Population Policies 2002). However, this must not compromise the element of inclusiveness in broader policy debates. The study also observes that over the years, there has been a positive trend in terms of increased focus on broader dialogue and participation of the stakeholders in setting the direction of the policy formulation.

The political party manifestos may also serve a push on the health agenda (e.g. the case of draft National Health Policy 2010). This implies that political parties' manifestoes may be analyzed for the health and population rights perspective and accordingly advocacy agenda might be set and followed. Political parties have been mentioned as one of the most important 'Driver of Change' for pro poor policy in Pakistan (Nadvi. K, and Robinson. M, 2004).

During 2008-2010, a great deal of efforts was channelized during participatory policy formulation for health and population sectors at federal level. However the 18th amendment has pushed that effort in limbo. Since the provinces and other actors and stakeholders were involved in these policies these documents can serve as a reference point for the provinces to formulate their specific policies under the new amendment.

Our review has also raised questions on the rational need of delay in marriage and the felt need of early marriage by the adolescents. Rashid. SF, (2011) has pointed out that the discourses on 'universal human rights' are often removed from the reality of adolescent women's everyday lives. Vulnerable adolescent women's understanding of their rights such as the decision to marry early, have children, terminate pregnancies and engage in risky sexual behaviour, are different from the widely accepted discourse on rights globally, which assumes a particular kind of individual thinking and discourse on rights and a certain autonomy women have over their bodies and their lives. Perveen. R, (2007) has raised the similar concerns in the Pakistani context. According to her research, the common aspects of all the policies reviewed for this study are:

- Discontinuity in policies
- Absence of the 'arms and teeth' of policies: poor financing, implementation and M&E mechanisms.
- Shelving of policy after its formulation
- Misplacement of policies viz a viz planning: illogical pattern of policy formulation - after rolling out plans.
- Contradictory policies: e.g. population policy anti-natalist whereas NFC award is population based and hence 'pro-natalist'.

5.2 CONCLUSION AND RECOMMENDATIONS:

In order to strengthen national programs and policies, the policy review helped highlighting the following remedial steps:

Recognition of AGYM's Needs:
In order to formulate and implement an effective SRH/MNCH policy for the marginalized AGYM, recognition of their existence as a separate group with specific needs is a primary requisite. The existing policies need reorientation on the rights based approaches implying that the state takes affirmative action to assert its role as a duty bearer, responsive and accountable to citizens in general and the marginalized in particular. At policy level this would entail horizontal cooperation between the social and public sector policies and programs for ensuring the betterment in the lives of the rights holders (marginalized AGYM in our case) and vertical articulation; provincial/district authorities' knowledge and will to implement national/provincial level policies, decentralised structures to facilitate local implementation and coordination (Gill R, and Stewart DE. 2011) .

Ensuring Gender Equity As suggested by Rizvi. N, & Nishtar. S, (2008) In order to be relevant and appropriate to women's health needs the health policy should:

(1) Use gender equity in health and health-related sectors as an approach to develop a healthy policy
(2) Expand the focus from reproductive health to life cycle approach to address all issues around women's life
(3) Strengthen health systems through creation of

gender equity among all cadres of health providers
(4) Tailoring health interventions to counter gender-based obstacles to utilization of healthcare services and
(5) Dissemination interventions for behavior change.

Life Skill Based Education

Knowledge about sexuality can prepare the adolescents better for the future life and give them more control of their fertility (Hamid. S, Johansson. E, & Rubenson. B, 2009). Adolescent development and life skills education need to be addressed through innovative interventions to reach out and provide support to young women in disadvantaged homes. Institutionalizing sex education to facilitate adults to understand what young people already know and adding to their existing knowledge and correcting any misinformation they may have is imperative. The civil society should undertake mass level advocacy efforts alongside the marginalized groups to bring change at the level of policy and legislation (World Population Foundation, 2010). However, the formal systems of information provision might have a limited role in SRH education because of low school attendance and high drop-out rates amongst girls. This implies that that alternative mechanisms of reaching AGYM need to be identified.

Fostering Health Equity

In the context of social determinants of health, four policy intervention options fostering health equity as identified by Solar O and Irwin A. (2010) can be adopted: :

Policy option # 1: Striking the socioeconomic factors and structural determinants such as reducing the prevalence of poverty, illiteracy and gender biases.

Policy option # 2: Striking the specific or intermediary determinants that mediate the effect of socioeconomic position on health, such as early pregnancy. Interventions at this level will aim to change the distribution of such specific or intermediary determinants across socioeconomic groups, e.g. by reducing the number of early pregnancies in lower socioeconomic groups through access to contraceptives and family planning services.

Policy option # 3: Addressing the reverse effect of health status on socioeconomic position, for example would be strategies to mainstream HIV + AGYM.

Policy option # 4: Delivery of curative healthcare. It becomes relevant only after people have fallen ill. One might offer people from lower socioeconomic positions extra healthcare or another type of healthcare, in order to achieve the same effects as among people in higher socioeconomic positions. For instance services for AGYM with obstetric and vesico-vaginal fistula (VVF) and safe abortion services.

5.3 ACTION AREAS

From the discussion above, it can be concluded that serious and active advocacy efforts can considerably improve MNH/SRH situation of the marginalized AGYM in Pakistan. Only through advocacy this group can be made visible, identify their needs, create and promote evidence based, innovative models of service delivery, raise their voice and establish a mechanism of follow up. The positive sign is that under the present regime around 32 women related legislative initiatives have been passed. Another historic gain for women in Pakistan is the fact that women's commission has gained an autonomous status. This is indicative of a conducive environment for policy advocates.

While the government needs to take notice and provide legislation that would ensure the provision of basic human rights to the marginalized populations, it is equally important that young people from the very beginning are made sensitive to various gender identities and the importance of extending respect to each. Moreover, while it is a welcome development that the Supreme Court of Pakistan is already active with regard to chalking out legislation for the protection of the rights of transgender people, similar attention needs to be accorded to other groups. Here, the civil society organizations would have to undertake mass level advocacy efforts alongside the marginalized groups to bring change at the level of policy and legislation.

A roadmap, based on United Nations Inter-Agency Task Force on Adolescent Girls, 2008 recommends:

Participatory Identification

- Identify marginalized AGYM and map to locate concentrations of marginalized AGYM and analyze further to define subgroups within.
- Involve marginalized AGYM directly and incorporate their opinions into situation analyses.
- Develop social profiles of diverse groups of marginalized AGYM.
- Measure marginalized AGYM's social assets, access, and safety
- Assess marginalized AGYM's current share of existing programme resources.
- Engage and build the skills of marginalized AGYM and involve them in programme design.

Strategy Development

- Implement an age-appropriate approach. Marginalized adolescent girls require different interventions from marginalized young mothers, even of the same age.

- Develop local leaders among the marginalized AGYM as mentors to be role models for the other marginalized AGYM.

- Assure access to safe havens from trauma, stress, violence and abuse, where girls can develop friendship networks, learn about their rights, and become leaders.

- Create livelihoods by leveraging marginalized AGYM's capabilities and assets to reduce vulnerabilities and expand opportunities simultaneously.

- Promote participation that will help AGYM develop self-confidence and skills, build competencies, learn to be active, shape their own lives and expand their own freedoms.

- Involve families and communities, including political and social leaders, from the beginning, so that they help support and create opportunities for marginalized AGYM's empowerment.

- Involve boys and men and improve their attitudes to overcome biased gender socialization through education.

- Involve local and national governments to factor gender equality and gender-responsive budgeting into development planning.

Policy Recommendations:

The concerned duty bearers need to follow a specific strategy encompassing the following:

1. Concerned duty bearers need to join hands to define the problems of marginalised AGYM, determine the best possible approach to handle their problems and then advocate for it as a single voice.

2. Worthwhile to explore the stance of various political parties on the marginalized AGYM's SRH needs, and to sensitize their leadership on these issues to ensure GYM sensitive health agenda before these parties enter the election arena.

3. Given the devolution in place and diversity in cultures, there is need to tailor province specific approaches and messages for their marginalised AGYM.

4. Targeted advocacy interventions are needed. The concerned stakeholders need to identify the established champions or potential cause ambassadors for AGYM's SRH issues within opinion makers and preferably within the legislature to make the changes being advocated (and those who have influence on them). After sensitizing them technical assistance will be needed to draft the necessary amendments in the existing laws or policies or for new legislations and policies in order to address the ASRH needs of the AGYM.

5. Crisp, to the point and convincing briefing

papers/policy briefs along with clear policy options and potential action points can serve a great purpose for those interested in policy engagement process.

6. A regular and effective monitoring of provincial and national legislatures is important in order to assess and utilise opportunities for influencing policies. For instance advocacy can be timely during an upcoming policy process relevant to the issues of AGYM.

7. Identification and net-working with local communities, change agents and opinion makers such as religious/community leaders and elders, power brokers, school teachers, landlords, tribal chiefs, local councillors and women's groups can be crucial for the success of the policy on marginalised AGYM.

8. It would be important to raise the profile of SRH issues of AGYM through strategic use of the media through sensitisation and capacity building of journalists and media people to build pressure for change. Issue specific recommendations for the key findings from this public policy review are summarised below:

TABLE 5: PUBLIC POLICIES OF PAKISTAN FROM EQUIFRAME LENS

Issues	Recommendations
PRSP: PRSP remained silent on issues of reproductive rights, adolescents' education, community participation by decentralizing the management, RH services for migrants, FP services, abortion, promotion of breast feeding, and involvement of political and community leaders.	PRSP formulation should be wholistic and sensitive towards the SRH needs of different categories of the vulnerable. In order to be a need based strategy, PRSP might consider 'the life cycle approach' to ensure that SRH needs at various stages of life get due attention. PRSP should be considerate of power dynamics within communities.
National Health Policies 2001 and 2009: - No targeting strategy to ensure pro-poor healthcare interventions - Extremely narrow view on gender equity - No direct reference to adolescents and adolescent girls.	The health policies need to clearly spell out the modus operands of ensuring health services to the poor and marginalised. The policies need to consider 'health' in the context of "physical, mental and social wellbeing" instead of a medicalised approach. This implies defining ways and means for multisectoral approach towards the health needs of the marginalised AGYM whereby the responsible entities in public sector approach the problem in its entirety. This would entail areas of concern such as neglect of women since childhood, early age at marriage and its consequences, sexual abuse and violence and high abortion rates etc.
National Population Policy 2010: - No reference to Sexual and Reproductive Health and Rights. - Suggests only prevention of abortion through family planning and post abortion care - No reference to adolescents while focused youth mainly in the context of economic development - No direct reference to mainstreaming of population in the development.	A population policy should be considerate of population structure and the SRH needs of various age groups, including AGYM. The problem of abortion should be taken upfront and instead of addressing in piecemeal fashion, the policy should take a strong position on the services for abortion.
PC-1 of LHW Program: - Marginalized ill-defined - Age group segregation not given - The PC-1 has no reference to abortion, sexual abuse, and early or unwanted pregnancy.	Given the demographic shift and the unaccounted SRH problems of the less visible and marginalised AGYM, the devolved LHW program has an unprecedented opportunity to redesign and offer a province specific, age sensitive, needs based package of SRH services through LHWs and referral.
National Maternal and Child Health Policy and Strategic Framework (2005-2015): - No reference to sexual health. - Regarding abortion it mentions the need for collaboration in legislation, however it doesn't indicate any intervention for safe abortion services, rather its focus is on post abortion care	The design of planning commission proforma might be improved to cater the needs of the marginalised. It may include a checklist of defined categories of the marginalised viz a viz their specific needs. The planning process needs to be strengthened to address the problems in a result based manner.
National Youth Policy 2008: - No mention of adolescent - Urban youth focused - Misses on addressing preventive aspect of problems of early marriage - The policy is silent about the modus operandi of its implementation.	A youth policy needs to be comprehensive enough to address various stages of youth and various categories of youth. It should speak for the real challenges that the youth face in their private and social circles, in their physical, mental and economic life, in their sexual and reproductive matters, in urban, peri-urban and rural settings and prevention, care/cure and rehabilitation of their problems. The policy should devise mechanisms for implementation.
Punjab Youth Policy 2012: - SRHR neglected	A youth policy needs to be conscious of the reproductive rights and must recognise these as basic right of all (couples/individuals) 'to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health'; and 'the right of all to make decisions concerning reproduction free of discrimination, coercion and violence'.

TABLE 5: PUBLIC POLICIES OF PAKISTAN FROM EQUIFRAME LENS

Issues	Recommendations
Weak Ministry of Human Rights	The recently established ministry of human rights needs a strong leadership, institutional strengthening organisational development to assert its role.
Some of the experts are of the view that the policies are open to all and hence non-discriminatory.	The content of policies speaks of their sensitivity and inclusiveness for the marginalised itself. Some policies do in-fact mention marginalisation from, say, rural and urban lens but there is need to apply more 'sieves' to bring under the radar the layers that accentuate invisibility. The decision makers must recognize specific needs of AGYM facing particular challenges through disaggregation of public policies and making them sensitive to different types of need.
Weakness in Advocacy	In order to make the policy advocacy effective, there is a need to follow the agenda through effective and consistent engagement. The strategy of advocacy should clearly define the distinguished roles of partners such as civil society and NGOs.

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ANNEXURES

7 ANNEXURES

ANNEXURE 1: RESEARCH QUESTIONS FOR POLICY REVIEW

For the policy review following set of questions was prepared:

- Do public policies and guidelines reflect a political recognition - and will to address SRH/ MNH issue of AGYM? (the extent to which this has become a government priority)
- Has the formulation of SRH/ MNH Policies/programs considered targeting the vulnerable AGYM-population? How the target groups are defined?
- Have policies and programs included plans for implementation? Are the adequate resources available for implementation as well as the scope of ASRH program activities?
- Have monitoring and evaluation tools been defined? What methodology has been proposed for their use in AGYM program planning?
- How the coordination and cooperation of public and private efforts envisaged? How are the roles of the partners and the level of coordination among programs defined?
- What was the level and nature of AGYM involvement at each stage of policy and program design?

ANNEXURE 2: INTERVIEW GUIDE

- *How policies were being formulated before 18th Amendment?*
- *After 18th amendment:*
    - What is the Mission/Aim of your organization?
    - Who are the key players in policy formulation?
    - How public policies in your domain conform to human rights?
    - How do you define the marginalized AGYM?
    - How the needs of the marginalized AGYM are catered in policy formulation?
    - What are the constraints in public policy realization? How these can be overcome?

ANNEXURE 3: LIST OF RESPONDENTS

Respondents from Outside Pakistan

- Dr. Arif Hussain, Jeddah, KSA
- Mr. Peter Miller, Vietnam

Respondents from Pakistan

ISLAMABAD

- Mr. Taimoor, DG, Ministry of Human Rights
- Dr. Talib Lashari, Advisor Health, Planning Commission
- Mr. Afzal, EAD
- Mr. Qamar Abbas: Deputy Chief Planning Commission
- Dr. Athar Qayyum, former Director Technical Coordination, MoPW
- Mr. Abdul Ghaffar Khan, former Director General Technical, MoPW
- Mr. Imran, Ministry of National Harmony
- Ms. Soofia Naureen, NCSW
- Mr. Muzaffar Mehmood Qureshi (MMQ), Green-star
- Ms. Pilar Gonzalez Rams. Child Protection Specialist UNICEF Pakistan
- Ms. Sadia Ata, Youth Specialist, UNFPA
- Dr. Rakhshinda Parveen, NGO, Sachet
- Dr. Irfan Health Advisor PLAN Pakistan
- Mr. Fatih-ud-Din, NIPS
- Dr. Arshad Mahmood, Population Council
- Ms. Syeda Aysha Ali, Program Manager Rutgers-WFP
- Mr Hassan Mangi, Director Child Rights, Ministry of Human Rights
- Mr. Manan Rana, UNICEF
- Ms. Zeba Sathar; Population Council Pakistan
- Dr. Nasser Mohayyuddin, NATPOW

PUNJAB

- Dr. Qamar Salman; Provincial Coordinator Punjab; Technical Resource Facility (TRF)
- Dr. Mian Naeem Uddin Contech
- Mr. Farasat Iqbal; Prog. Dir. Punjab health reform project (PHSRP)
- Ms. Sabeeha, NGO Bargad
- Ms. Kaneez Fatima, Gender specialist PDMA
- Ms. Khawar Mumtaz, Shirkat Gah
- Dr. Jamil Chauhdry, PCO UNFPA
- Dr. Saman Yazdani. Director CHPS

KHYBER PAKHTUNKHWA

- Dr. Shabina Raza, HSRU
- Ms. Zubaida Khatoon PCSW
- Dr. Shaheen Afridi. NMNCH

- Ms. Lubna Tajik, PCO UNFPA
- Dr. Najma, Population Welfare Department

SINDH

- Dr. Yasmeen Sabih Qazi, Packard Foundation
- Dr. Sikandar Sohani, Aahung
- Dr. Shahnaz Shalwani, PCO UNFPA
- Dr. Nisar Solangi. Coordinator Health Sector Reform Unit (HSRU)
- Mr. Mohsin Sheikh; Planning
- Mr. Muzaffer Hussain Panwhar, Former Manager Pakistan Fisher Folk ForumDr. Ashar Malik, Health Economist (former NHPU)
- Mrs. Imtiaz Kamal; NCMNCH
- Dr. Suleman Ottho: Global Fund-HIV and AIDS
- Dr. Fawad Sheikh Provincial Coordinator TRF Sindh
- Ms. Mussart Jabeen, Deputy Secretary Women Development and Social Welfare
- Mr. Nooruddin. S . Bhamani, President (Pakistan Chapter): World Association of Persons With Disabilities

BALOCHISTAN

- Ms. Rehana Khilji, UNWOMEN
- Ms. Ayesha Ayub, UNWOMEN
- Ms. Farkhanda Aurangzeb (Former DG MOWD)
- Mr. Asad Khan Mengal Secretary PWD
- Mr. Tariq Sohail, Director Admin (Former Director P&D)
- Dr. Tariq Jaffar (Former Chief Planning Officer, Health)
- Dr. Amjad Ansari, (Former Chief Planning Officer, Health)
- Mr. Abdul Wudood; SEHER NGO
- Mr. Amanullah Kakar NGO Socio Pak

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