

# SEXUAL AND REPRODUCTIVE HEALTH RIGHTS EDUCATION AND SERVICES IN PAKISTAN

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This case study covers the work of Aahung in Pakistan. Aahung is a Karachi-based NGO which aims to improve the Sexual and Reproductive Health (SRH) of men, women, and adolescents across Pakistan. Aahung works towards enhancing the scope and improving the quality of services that uphold sexual health and rights, while advocating for an enabling environment where every individual's sexual health and rights are respected, protected, and fulfilled as an inalienable human right.

This Case Study was a background briefing for Oxfam Novib's 2013 Annual Review, prepared in partnership with Aahung, and describes the programme in Pakistan. Although it is not a formal evaluation it does consider lessons learned by both Oxfam Novib and its partner organisations.

These Case Studies are shared in the form in which they were submitted, often written by partners whose first language is not English, and have not been edited since submission. We believe that the meaning is clear enough, and the authenticity of the reporting and the availability of Southern Voices on development makes their inclusion in the Oxfam iLibrary worthwhile for sharing with external readers.

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**Programme Partner: Aahung**



# AIM OF THE PROJECT

Aahung's aim is to create an enabling environment which provides quality sexual and reproductive health information and services so that people have comfort with their body, are practicing sexually healthy behaviours and are exercising their sexual rights.

## CONTEXT

### Larger country context

Pakistan, a lower middle income country with an estimated population of 169 million<sup>1</sup> is seen with great concern in the health and development sector not only due to its high population growth rate of 1.882 but also due to its soaring health and development indicators. The country's population that is deemed to double in the next 37 years is understood to exert undue pressure on the already overburdened resources and implicates upon planning, resource allocation and accountability mechanisms in the health and development sectors. Ensuring availability, affordability and access to acceptable quality healthcare services will be a challenge for the health sector in the years to come.

The recent demographic and health survey has shown an improving trend in indicators for literacy and living standards, yet more than 50% women and almost 33% men in the country have no formal education. Moreover, poverty and the widening gap between people in different wealth quintiles is on the rise and the worse affected population segments are rural residents and women, particularly of young age groups. Lack or inadequacy of education, health and social support services can lead to individual and collective frustration, despair and hopelessness that may manifest as disease or behavioural disorders including violence and criminal acts. Ensuring universal education and access to reproductive healthcare, promoting gender equality and reducing maternal and child mortalities are included as targets of various international agreements including Pakistan's most recent commitment to achievement of Millennium Development Goals, but their socio-cultural determinants especially those related to sexual and reproductive rights are often ignored due to stigma associated with openly discussing and addressing such issues. Limited communication on sexuality and sexual and reproductive health needs throughout the course of life have given way to lack of information among healthcare consumers and providers that in turn prevents exchange of quality sexual and reproductive health and rights education as well as services.

### Direct environment

Pakistan's demographic profile depicts the features of a population with high fertility levels with 41% individuals being under 15 years of age and 55% being between 15-64 years old. This demographic profile is suggestive of a population momentum that will maintain the number of adolescents and young adults for the next two decades and highlights the need for health policies and programs to focus on addressing the needs of children and young adults. According to figures reported by the World Health Organization (WHO) in 2009, the life and health of children in developing countries is most commonly affected by infectious diseases while road traffic accidents, complications during pregnancy and child birth, suicide, violence, HIV/AIDS and tuberculosis have been found to be the major causes of mortality in adolescents<sup>3</sup>. However, the WHO report has ignored grave problems like child abuse particularly sexual abuse that remains under reported and often unrecognized in developing countries. Based on news reports, a Pakistani NGO named Sahil has estimated that every day 4 children are sexually abused in Pakistan<sup>4</sup>.

The WHO report has highlighted that the underlying issues of adolescent mortality caused by suicide, violence, HIV/AIDS and complications during pregnancy and child birth pertain to sexual and reproductive health and rights issues that usually remain unattended due to social taboos and limited communication. Sexuality and life skills education, along with adolescent friendly healthcare services and parental or community support have been proposed as an option for ensuring the well being of adolescents and future generations. Adolescent health problems and their socio-cultural determinants remain fairly ignored in the Pakistani context. According to a study conducted by Marie

Stopes Society in selected districts of Pakistan<sup>5</sup>, the onset of menstruation was associated with anxiety in 47% girls as only 13% of them reported receiving information about puberty before the onset of menstruation. The study also revealed the cultural misconceptions that prompted early marriage and onset of pregnancies in young women while ignoring their sexual and reproductive health rights and needs. The dearth of communication and correct information on sexual health issues in Pakistan's society predisposes many adolescents and young adults to physical disease and dysfunction while the emotional and mental challenges of this age also remain unaddressed.

The induction of a national youth policy and inclusion of life skills based education in the national educational curriculum are noteworthy changes in the policy making arena that must be backed with comprehensive implementation plans. Unfortunately, a considerable part of the life skills curriculum is to be taught as extra-curricular activities that are often overlooked by teachers due to lack of time. In pockets where sexual health content is being prioritized, teachers are not equipped with the skills and comfort to deal with such sensitive topics. Moreover, lack of counselling, appropriate referral networks and youth-friendly services in school health programs and ignorance of adolescent health issues in general healthcare services compound the complexity of matters. Educational interventions are limited in their success as they ignore the uneducated and out of school adolescents and youth. More so, they miss out on creating an enabling environment in families and communities.

The more specific reproductive health indicators like maternal mortality ratio (MMR= 276 maternal deaths per 100,000 live births) have shown an improving trend in the recent demographic and health survey, but pregnancy-related and maternal mortality was found to be the highest in mothers below 20 years and 40-44 year age group. The survey has also revealed that one-fifth of Pakistani women in the reproductive age bracket of 15-49 years die of pregnancy complications, childbirth and puerperium while 35% of them receive no prenatal care. Additionally, only 61% of those who do receive prenatal care get it from skilled health providers (doctor, nurse, midwife or lady health visitor). Sixty-five percent of women of reproductive age deliver at home of which only 32% births are assisted by skilled medical providers and 52% by traditional birth attendants. Of the women who did not deliver their last child in a health facility, only 32% reported usage of safe delivery kits. Health seeking behaviours and access of Pakistani women vary by place of residence, educational level, wealth quintile, age group of mothers and the number of pregnancies or children but in general women living in rural settings, having limited education, belonging to lower wealth quintiles, having more children or in 15-20 or 40-49 year age groups are more vulnerable.

Although teenage marriages have declined, 80% women of reproductive age have been found to be ever married by the age of 25-29 years. Once again the 15-19 year old married Pakistani women tend to be least informed about sexually transmitted infections (STIs), HIV/AIDS and have less than 24 month birth intervals. More than 95% women of reproductive age have knowledge of contraceptive methods but only 30% were found to be current users of any method of contraception. Forty-eight percent of modern contraceptive users rely on public sector institutions while 30% rely on private medical sector as the source of information and services. The main public sector institutions accessed by modern contraceptive users include government hospitals and reproductive health service centers (32% users) while Lady Health Workers are a good source for 8% clients, Lady Health Visitors for 3% clients and family welfare centers for 2% clients. Most users are being reached through healthcare providers and only 23% non-users were found to be reached by field workers.

The availability of quality healthcare is one of the factors determining access and health seeking behaviours. In Pakistan, most healthcare providers often lack the necessary knowledge and skills required to treat sexual and reproductive health issues because these topics are not part of the health curricula. Furthermore, the fairly recent notions like client centered care and counselling are usually not incorporated into teaching practices thereby preventing the creation of an enabling environment for clients seeking healthcare. In addition, due to repressive social norms, clients often lack the necessary confidence and comfort in discussing sexual health issues openly while health care providers can exhibit judgmental attitudes regarding sexual practices which inevitably affects healthcare management. Evidence shows that there is great potential in the already existent public and private healthcare infrastructure and services that can be tapped for improving provision of sexual and reproductive health education and services, but without proper training, health care providers may also shy away from discussions concerning sexuality because they feel unable to

handle complex issues (e.g., sexual abuse, conflicts about sexual orientation, sexual dysfunction etc.) that can arise during such discussions.

Similar to the adolescent population, healthcare of adults on sexual and reproductive health and rights issues remains incomplete without concomitant education and communication. Pakistan's commitment to the Cairo Platform of Action (International Conference on Population and Development) in 1994 gave government and non-government organizations a framework with which to develop their sexual and reproductive health programs. The ICPD approach linked population and development in a holistic manner and helped introduce sexual health and rights concerns into the already existing dialogue on reproductive health. Sixteen years after ICPD, Pakistan continues to struggle with the ongoing reproductive health and population challenges present in the country. The NGOs and CBOs working in different areas of Pakistan have adopted the ICPD agenda and seem to be promising partners for reaching out to adult populations on sexual and reproductive health and rights education and services. Contrarily, the Pakistani Government has been resistant to openly acknowledging sexuality or sexual health as a relevant topic due to social, cultural and religious taboos, and continues to focus on population control programs. An obvious limitation of resources is also a problem as resources are more likely to be allocated towards addressing more pressing current needs. Furthermore, where resources are available, there is the threat of mismanagement compounded by the lack of accountability and transparency. In spite the challenges, efforts towards partnering with government institutions must not be abandoned keeping in mind issues of national ownership and sustainability.

## Main actors

- Young people and community adults
- Teachers
- Parents and Gatekeepers
- Healthcare Providers
- Policy Makers
- Clients of healthcare providers
- Students at medical education institutes
- Religious and community leaders

# METHODOLOGY

## Activities, strategies, theory of change

### Thematic Areas

Considering its organizational expertise and the critical needs and cultural acceptability concerns related to information, education and services of Sexual and Reproductive Health and Rights (SRHR) in Pakistan, Aahung works towards creating an enabling environment by focusing on institutionalization of SRHR education and services while constantly exploring new strategies for changing individual behaviours by direct communication campaigns. In this project cycle; Aahung focused on the following thematic areas:

Sexual and Reproductive Health Management (SRHM)

Sexual Rights (SR) – Education and Awareness

Adolescent Sexual and Reproductive Health (ASRH)

Child Sexual Abuse (CSA)

### Strategy

Aahung's core strength lies in usage of participatory methodology to promulgate gender equality and to utilize the rights based approach as a cross cutting theme in all activities. Aahung builds the capacity of institutions and advocates for policy change in order to create an enabling environment and empower individuals to exercise their sexual rights. Aahung follows a cascading model in its

work with institutions, such that the direct beneficiaries are the master trainers (that is faculty, community workers and teachers at the selected medical, nursing and regional training institutes, NGOs/GOs and schools of Pakistan), while the indirect beneficiaries are the fellow faculty, teachers and community workers who provide education and services to clients, students and community adults.

### **What was needed to achieve the changes?**

Aahung carried out this project with 170,000 Euros and 25 staff members.

## RESULTS

### Outputs

- Partnerships developed with 5 medical, nursing and Regional Training Institutes, 11 NGOs/GOs and 19 schools of Pakistan to take forward SRHR education and/or services in Pakistan
- Capacity strengthened of 179 faculty and 2569 fellow faculty, 124 community workers, and 348 teachers at selected medical, nursing and Regional Training Institutes, NGOs/GOs and schools of Pakistan to take forward SRHR education and/or services
- Follow-up and monitoring conducted with medical, nursing and Regional Training Institutes and schools for institutionalization of SRHR education and/or services in Pakistan
- SRHR information made available to 1 million low and middle income adolescents and adult males and females in Pakistan

### Outcomes

- Institutional provision of sexual and reproductive health and rights education and services strengthened in medical, nursing and Regional Training Institutes, NGO/GOs and schools in Pakistan
- Institutionalization of sexual and reproductive health and rights education and services promoted at the systems and/or policy level in medical, nursing and Regional Training Institutes, schools and charter school networks in Pakistan
- 1 million people have improved information on sexual and reproductive health and rights in Pakistan
- Internal institutional capacity strengthened

### Impact

- Results from the LSE small scale evaluation study show that the overall acceptability and receptivity of Aahung's LSBE program has been very positive. Teachers, parents and students have had a reported increase in knowledge and positive change in behaviors and attitudes. Teachers and parents shared that the students had become noticeably confident and aware, had increased knowledge about their bodies and their rights, and had a generally positive outlook. Teachers have started using activity based learning and are encouraging their students to explore their self worth and identify things about themselves that they are proud of.
- Key findings from the SRHM evaluation are that students and faculty are satisfied with and have made good use of training content covered through Aahung's training on 'Holistic Management of Sexual and Reproductive Health Issues'. There has been reported increase in knowledge levels of both faculty and students and a decrease in myths and misconceptions. Participants talk about the rights based approach and have used it as a starting point in their teaching strategies and in healthcare provision. There has also been an increase in actual and perceived comfort around talking about SRH issues with clients and teachers/students. Faculty has adopted participatory teaching methodologies in their classes which has yielded beneficial results.

## Policy and practice changes

- The project contributed to 12 out of total of 30 basic human rights as laid down in the Universal Declaration on Human Rights (1948).
- Leading medical teaching universities such as Liaquat University of Medical Sciences, Hyderabad and Ziauddin University of Medical Sciences have successfully integrated aspects of SRHR education into the teaching curricula of relevant departments along with having trained faculty to implement the education plans. The sexual and reproductive health education received by students has started to show a clear impact on their conceptual clarity, their comfort on discussing sexual health issues as a result of values clarification exercises, and their skill at taking a sexual history of clients.
- Aahung's advocacy initiatives with the Education Department thus far have not resulted in systemic curriculum change. This can be attributed to the fact that our current advocacy has not stemmed from a systematic mapping and analysis of the system that we are trying to penetrate. We have now realized that in order to integrate SRHR into the national curriculum, we first need to do a thorough mapping of the existing provincial education departments and the systems that they have in place. At the moment Aahung will work with Govt. schools that are adopted, and once a thorough mapping and advocacy strategy is developed it will work towards applying that at a larger scale with the Govt. school systems of the various provinces.
- The communication strategy of Aahung on SRHR and CSA via TV, radio and printed media has reached a large number of people in rural and urban areas, who after frequent exposure consider these media reliable sources of information, as research has shown. Improved access to SRHR education and information benefits adolescent and children by means of addressing taboos, myths, sexual abuse, unwanted pregnancies etc.

## LESSONS LEARNED

### Successes

- Dow Medical University, which has dozens of affiliated medical colleges across Pakistan, has successfully partnered with Aahung to fully integrate comprehensive SRHR education throughout the MBBS undergraduate curriculum in to various spirals according to student's capacity to understand and apply knowledge. The model of Dow University has set an exemplary model for replication in to other institutes.
- A reference book has been developed by the name of 'Prescribing Sexual and Reproductive Health' to overcome the existing dearth of locally appropriate material on SRH. The book is unique as it has been compiled with respect to the Pakistani context and socio-cultural background. It pledges involvement of all the relevant stake holders as it has been authored, advised, edited and reviewed by the local experts in the medical and humanitarian field.
- In addition, Aahung successfully developed the capacity of 191 faculty members from a total of 15 medical teaching institutions (MBBS, nursing and public health) across Pakistan on SRHR education. Preliminary findings from evaluation studies show that 117 trained faculty have replicated Aahung's SRHR teaching modules with a total of 36,248 medical students.
- Aahung's life skills education curriculum has been thoroughly reviewed and endorsed by an external review committee consisting of head masters, teachers, religious scholars and representatives from the Department of Education. Along with improvement in language and content, the review has also resulted in the curriculum being broken down into three levels of implementation making the content more age appropriate, comprehensive, and acceptable to schools and parents and ensuring repeated exposure and reinforcement of key SRHR topics. Level 1 targets ages 9 -12 (late primary and early secondary) and focuses on key aspects of puberty and development, nutrition, gender, body protection and builds core life skills including decision making, communication and negotiation; level 2 targets ages 13 – 15 (middle - upper secondary) and further elaborates on topics covered at the earlier level along with the addition of more complex health related topics such as early marriage, family welfare, population development, HIV and STIs and stigma/discrimination; level 3 of the curriculum is designed for

students above the age of 16 (premarital population) and along with aspects of already stated topics also moves into a discussion of family planning, marital rights and early marriage.

- Aahung's online credibility and visibility has been enhanced by the active use of social media for reaching different segments of online community with targeted messages for raising awareness on SRHR related issues. In particular, the website was redesigned to update information and activities on all the thematic areas of work. It now gives an opportunity to viewers to hear a number of Radio and TV spots that were conducted for reaching out to rural and urban communities, on issues like Child Sexual Abuse, topics covered through Life Skills Education, STIs & HIV.
- Aahung also facilitated 20 theatre performances in Hyderabad, through a partner theatre group, which focused on raising awareness on early marriage and marital rights. Through these performances Aahung was able to reach out to an additional 3100 community adult men and women. In order to ensure continued replication with secondary beneficiaries in the coming year, Aahung is planning on setting aside some financial compensation for a few CBOs and NGOs that are systematically conducting replication sessions. Aahung is also going to prioritize conducting in-person monitoring visits with select partner organizations that are replicating, in order to provide technical assistance and feedback on the process of implementation.
- Aahung met additional evaluation targets by conducting targeted evaluations in school and medical teaching institutions as a means to gather qualitative data surrounding service provider attitude and practice change as well as end beneficiary knowledge and attitude change. The qualitative evaluation will be used to compliment the baseline and end line quantitative evaluations being conducted by Aahung for a more nuanced picture of the impact Aahung's programs have on SRHR education and services. Both evaluations will be completed in 2014. Highlights from the 2 baseline studies are provided below, revealing the need for SRHR programming in schools and medical universities.

## Challenges

- The process of institutionalization is time intensive particularly in public (government) institutions because authority is distributed amongst various layers of hierarchy and decisions are often made taking into account a great deal of bureaucracy. Political influence and frequent changes in decision makers make the program prone to delays and changes in methodology. Moreover, public sector universities are often constrained by limited number of faculty members who are involved with multiple teaching assignments thereby increasing their workload, despite the commitment and replication of sessions in to their teachings. The procedure of following up with trained faculty including registrars, assistant professors and professors, to gather data is often very challenging.
- The deteriorating political and law and order situation has hampered advocacy efforts in several areas of Pakistan specially Balochistan. Several delays in program implementation and gaps in continuity have occurred with partners due to political threats at the institutional level and security threats for Aahung's team and implementing partners. One example in particular is the partnership established with Murshid teaching hospital in Karachi (in which Aahung had also collected baseline data) where teaching plans had to be stopped due to direct security threats made to the administrative head at Murshid who resigned before implementation could be completed.
- In the last year, Aahung learnt that while we have been very effective in strengthening the capacity of community outreach workers from partner NGOs and CBOs, it is challenging from them to integrate and sustain SRHR awareness raising into their existing programs. Reasons for this are twofold: 1. NGOs and CBOs are often accountable to donors and have to remain limited to the activities defined in their projects and 2. Aahung's partner NGOs and CBOs are geographically too widespread, making it very costly for us to follow up and support them in implementation at the community level. As a result of this it was challenging for NGOs and CBOs to meet the projected target of secondary beneficiaries through direct implementation, and Aahung is exploring alternative strategies to reach out to more community adults.
- Refresher trainings with Govt. secondary school teachers were unable to take place in the last 6 months due to political instability in the Sindh Education Department, following the 2013 elections in Pakistan. A constant turn-over in the post of Secretary Education of the Sindh

Education Department and other influential positions in the Department over the last one year have also made it very challenging to work with Govt. schools. There is a lack of commitment and accountability on the part of the management of individual Govt. schools, and they are resistant to take ownership of the SRHR program without constant letters and endorsements from the Secretary Education and other senior management within their department. In order to continue working with Govt. schools in some capacity, Aahung has entered into partnerships with networks that have adopted Govt. schools and are over-looking the management of these schools. By taking these organizations on board Aahung will ensure that work with Govt. schools continues in a structured and effective manner.

- Communications activities have been challenging due to the expense associated with larger scale distribution and the difficulty in incorporating key SRHR messages into dramas and public service messages because of their sensitive nature.

## Tips and more

- When working with small CBOs and NGOs there has to be a degree of financial compensation because these organizations run on project funding and do not have the luxury to assign their staff to new tasks without compensation.
- When working on LSBE it is important to engage parents and school management from the get go in order to ensure their buy in smooth implementation as well as sustainability.
- For organizations working on sensitive issues like SRHR it is important to engage with stakeholders such as media, progressive religious scholars and community leaders throughout the course of the project and come them apprised of updates in the field.

# HUMAN INTEREST

This case study highlights the story of a woman who attended a community awareness session being carried out by the Salvation Army after being trained by the SRRC component at Aahung:

*“My name is Neelam Chanda, I am 42 years old and have completed M.A in English. I have been married for three years and my husband works for the Pakistan army. We were happily married and a year after getting married, I gave birth to a baby girl. Unfortunately the baby died when she was a few days old. Since my husband is deployed in the army, he is only at home very occasionally and we hardly get to spend any time together.*

*One day, Salvation Army had arranged a session for women in which I was also been invited. There was a lady there who was conducting an awareness raising session. Her style of facilitation was very good and the topic that she discussed was also appreciated. After the session I asked her the name of book that she was sharing the information from and she told me it is titled “Peaceful and Satisfied Marital Life” and was developed by Aahung. I asked her to give me this book so I can read it, and she provided me with some literature. I shared the literature with my husband and he also really liked the content of the pamphlets. We both read the Aahung book together and found it very beneficial for us. After reading this book, we started to follow its guidance in our marital relationship and also started to understand each other’s feelings. No we don’t hide our emotions and communicate a lot more and also spend a lot more time together. This book has taught us the importance of inter spousal communication and that’s why we spend more time together and are now more content and happy in our marriage than before.*

*This book has also other benefits that can help us to make the foundation of a good family and it also teaches us marital rights. Forceful and early marriages have also been discussed in this book. I am really very thankful that such awareness is being shared in the community both with married and unmarried people and this is a very important need in our society. “*

# NOTES

<sup>1</sup> <http://data.worldbank.org/country/pakistan>

<sup>2</sup> Pakistan Demographic and Health Survey 2006-07.

<sup>3</sup> World Health Organization 2009. Progress report on Child and Adolescent Health and Development.

<sup>4</sup> [http://www.sahil.org/abt\\_csa\\_mythsnfacts.html](http://www.sahil.org/abt_csa_mythsnfacts.html)

<sup>5</sup> Marie Stopes Society 2006. Adolescence in Pakistan: sex, marriage and reproductive health.

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