

## Status and Policies related to Adolescent Health in Pakistan

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### Background

Despite being signatory to key international agreements that support youth access to Family Planning (FP) Information and Services such as ICPD (International Conference on Population and Development), CRC (Convention of the Rights of the Child), and ICESCR (International Covenant on Economic, Social and Cultural Rights), the Government of Pakistan continues to score poorly in providing access to basic sexual and reproductive healthcare (SRHR) services, such as access to contraception, FP counseling, and sex education, especially to unmarried youth and adolescents.

A 2013 report by the Planning Commission of Pakistan provides evidence of the government’s failures to meet the commitments made under the Millennium Development Goals. Pakistan had committed to meeting 37 of the 48 indicators; it only met 3 out of the 37 targets, failing to achieve any of the Millennium Development Goals in their entirety.

Health is not recognized as a fundamental human right under the Pakistani Constitution. Public spending on the health sector is low while public health units across the country are either non-functional in terms of staff and facilities, or function in dilapidated conditions. Access to basic health services is difficult due to lack of infrastructure and distance. For the youth access to sexual and reproductive health (SRH) in particular is further restricted due to social mores, stigma, cultural taboos, and shame and fear, particularly if they are unmarried<sup>1</sup>.

The Global Youth Development Index, 2016<sup>i</sup> ranks Pakistan high in the *Health and Well-Being* domain compared to other domains. Evidence presented in the report suggests that all countries in the Commonwealth either maintained or improved their level of youth development from 2010 to 2015, except Pakistan, which ranked amongst the bottom 40 out of 183 countries and was the only country to slide from the medium to low category on the overall index over the same period.<sup>2</sup>

In terms of Health and Wellbeing, while the report ranks Pakistan better amongst other domains, ground realities present a very different picture. Further, the indicators and targets<sup>ii</sup> used in assessing performance in this domain are severely limited, and do not account for difficulties faced by the youth in accessing services.<sup>3</sup>

Prominent issues concerning the youth in Pakistan related to their SRH include early and forced marriages (which disproportionately affect girls), high adolescent fertility and lack of SRHR information and services<sup>iii</sup>. While there is evidence<sup>4</sup> suggesting a decline in early age marriages in recent years, reproductive health services are still largely inaccessible, especially without a family chaperone to accompany unmarried girls. Information related to SRH, according to a Population Council Report, is mostly accessed through mid-level media, such as television, and there

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<sup>1</sup>Shirkat Gah’s field researches, on health system governance and community access to health services (not published)

<sup>2</sup> “The 18 per cent slide in Pakistan’s YDI score over the past five years was the most for any country in the region as well as globally. It has been brought about by a dramatic fall in the domains of Civic Participation (58 per cent) and Political Participation (69 per cent). The indicators that contributed the most to this decline are: voiced an opinion to an official, existence of a youth policy, volunteered time, and helped a stranger. Pakistan scores below the South Asian average in all domains except Health and Well-being.” - Global Youth Development Index and Report 2016; pp 54

<sup>3</sup>For example, HIV rates amongst the 15-24 years age cohort olds is used as an indicator of overall health and wellbeing. With sex-education and pre-marital sex being taboo in Pakistan, unmarried youth are not likely to report STDs, access healthcare providers or even understand that they could be at risk for HIV/AIDS.

<sup>4</sup> PDHS 2012-2013, Average age of marriage cited in Population Council Report  
[https://www.popcouncil.org/uploads/pdfs/2016PGY\\_YouthInPakistan.pdf](https://www.popcouncil.org/uploads/pdfs/2016PGY_YouthInPakistan.pdf)

is heavy reliance amongst youth on elder married siblings or peers for information related to sexuality, child bearing and other marital issues.

In 2015, under the Global Strategy on Women’s, Children’s and Adolescent’s Health (GSWCAH)<sup>iv</sup>, the government of Pakistan pledged to take concerted action to end preventable maternal, neo-natal and adolescent deaths, and ensure their wellbeing and progress.<sup>v</sup> Provision of ‘appropriate reproductive health services, immunization services and better nutrition’ were prioritized, along with continued support for improvement in ‘newborn, child and maternal survival’ to reduce morbidity and mortality rates. A National Health Insurance scheme<sup>5</sup> was mentioned as part of the commitment alongside allocations for a Public Sector Development Program worth \$517.5 million, for the expansion of immunization programs over a course of 5 years (2015-2019). Further, health spending was to be increased to 3% of the GDP to improve the health status, with a special focus on women, adolescents and children’s issues.

In terms of budgetary allocations, however, **the federal health sector budget remains at 0.5% of the total federal budget, while the total health budget is 0.42%<sup>vi</sup> of the GDP<sup>6</sup>** and out of pocket expenditure for health stands at 32.2%.<sup>vii</sup> The latter constitutes the largest per-capita burden of healthcare in the region, while provincial healthcare spending is the lowest compared to other countries (as of 2013).<sup>viii</sup>

As per the Every Newborn Progress Report, 2015<sup>7</sup>, Pakistan reported passage of one provincial policy in 2015, and did not report on progress with regards to adolescents and youth, despite this population being part of the overall Strategy commitments.<sup>ix</sup>

## The National Vision, Pakistan, 2025

Pakistan is among the 193 countries that have committed to advancing the 2030 Agenda for Sustainable Development. In the Agenda, targets 3.7 and 5.6 emphasize universal access to SRHR services as pivotal to realizing the overall Goals and Targets. In pursuance of this Agenda, Pakistan has developed a national visionary blueprint, the National Vision 2025, to align national priorities with global ambitions. A closer look at the document, however, reveals that health in general or SRH in particular for the younger population, hardly bear mention. While the Vision recognises Pakistan’s poor performance in areas of social development, and reckons strong social capital as pivotal to the country’s growth, it also suggests cuts in public spending for essential services. The focus instead is on increasing youth employment and economic empowerment, without making necessary connections to health and SRHR, as both an exacerbating factor and a direct result of poverty and high rates of unemployment. It also does not mention any plans to address social norms and cultural practices that restrict young people’s access to information and services and create adverse outcomes for marginalised populations, particularly women and girls.

## The National Health Vision, 2016-2025

The precarious silence around youth and adolescents in terms of policy is also felt in the National Health Vision (2016-2025)<sup>x</sup> document, where the words youth and adolescent do not feature.<sup>8</sup> The exclusion of the youth and adolescents specifically with regards to SRHR is worrisome, while an inclination towards encouraging Public-Private Partnerships in the health sector could result in more expensive and less accessible health services. Given the dearth of information amongst the general populace regarding SRHR, silence regarding the health concerns of the younger population is expected to further discourage health-seeking behavior amongst youth and adolescents.

<sup>5</sup> Currently only these districts are included in this programme (in the first phase) are Narowal, Khanewal, Sargodha, Rahim Yar Khan, Sheikhpura, Badin, Shaheed Benazirabad, Sanghar, Mardan, Malakand, Kohat, Chitral, Quetta, Loralai, Lesbela, Kech, Muzaffarabad, Kotli, Diamer, Skardu, Bajaur Agency, Khyber Agency and Islamabad Capital Territory (ICT).

<sup>6</sup> Federal Budget of Health 2016-2017 is 22.4 billion, of the 4.4 trillion allocated for federal spending  
<https://en.dailypakistan.com.pk/headline/live-finance-minister-unveils-budget-for-2016-2017/>

<sup>7</sup> Every Newborn Progress Report, page 11. [http://www.who.int/pmnch/ewec\\_progressreport.pdf?ua=1](http://www.who.int/pmnch/ewec_progressreport.pdf?ua=1)

<sup>8</sup> The National Health Vision (2016-2025) provides an “overarching national vision and agreed upon common direction, harmonizing provincial, federal, inter-provincial and inter-sectoral efforts for achieving the desired health outcomes and to create an impact on health”.

## Health System Governance in Pakistan

Health was amongst the subjects amongst seven others that were devolved from federal to provincial authority on the basis of an amendment to the Constitution in 2010, which materialized on 1<sup>st</sup> July, 2011. The (18<sup>th</sup>) Constitutional amendment made six health-relevant changes to the overall health governance structure most significant of which was the removal of health from the Concurrent Legislative List (CLL), which limited the powers of the federal government from imposing laws and policies regarding health, and provided provincial governments with higher autonomy for setting their own policy roadmaps.

However, currently, four subjects within health still falls under the national health ministry: health information (inclusive of research in health); health regulation; international commitments; and national health policy (with respect to federal mandates in health, overarching norms, norms of care, inter-sectoral action, trade in health, health technology and disaster response)<sup>xi</sup>. Ensuring policy cohesion, interdepartmental coordination, and extension of support to provinces in terms of capacity to formulate and roll out laws and policies remain Federal prerogatives.

Despite extensive changes to the overall health governance structure and devolution of powers to the provinces following the 18<sup>th</sup> Amendment, there is still room for the Federal government’s involvement, causing duplication of efforts, lack of clarity on roles and responsibilities and lack of cohesion between the Federation and administrative units. For example, regulation of medicines and service delivery falls within the provincial mandate, while the Federal authority retains power to regulate matters concerning human resources and medical education; taxation is a federal subject while administrative units are to mobilise resources to fund their policies. Further, confusion persists in terms of reporting and authority to take action.

## Pakistan Health Indicators and Status of Adolescent Health and Services

According to the Human Right Commission of Pakistan (HRCP), low spending and resource allocation on health has rendered the government unable to provide adequate services and translated into evasion of responsibility in protection from disease outbreaks. The report<sup>9</sup> also laments the high individual burden of healthcare with citizens bearing the brunt of expensive private healthcare in the absence of public services.

The HRCP report further mentions Pakistan’s failure to meet any of the MDGs including but not limited to lowering under-5 mortality, infant mortality, or increasing the proportion of fully immunised children. Pakistan has been successful, in reducing rates of diarrhea among children albeit nutrition levels remain low, with only one of the 5 targets of the World Health Assembly<sup>xii</sup> having been met as of 2015. Stunting and wasting remain high, with 44% of children under age 5 years being stunted, 32% being underweight and 15% suffering from acute malnutrition. Imperative to note here is that the Federal government did not allocate separate funds in the Public Sector Development Plan (PSDP)<sup>xiii</sup> for fighting malnutrition in the 2015-16 outlay.

The focus in terms of adolescents and their health care has largely on polio and obstacles in fighting the disease, such as resistance from the community, threats to and physical attacks on polio workers, and lack of service delivery at the local level. An 82% drop in rates of children affected with polio was reported, from 306 cases going down to 54 in 2015. The Sindh province reported 12 cases of polio in 2015, due in big part to government-sponsored immunisation drives. In a bid to penalize resistance, however, the province of Khyber Pakhtunkhwa (KP)

<sup>9</sup> According to the State of Human Rights 2015 report, about 70% to 80% of outpatient services are provided by the private health care sector in Pakistan. Report available from: <http://hrcp-web.org/hrcpweb/wp-content/uploads/2016/04/Health.pdf> (Caution: Website may contain a virus).

issued orders in early 2015 to arrest parents refusing polio immunization resulting in 471 detentions<sup>10</sup> in the city of Peshawar alone.

## Provincial Youth Policies

Pertaining to the youth specifically, all four administrative units (Sindh, Punjab, Khyber Pakhtunkhwa and Balochistan) have drafted their respective youth policies. Implementation, budgeting, monitoring and evaluation, and accountability responsibilities lay with the provincial government’s youth departments. The policies while recognizing the need to include the youth as a separate priority area for the development of Pakistan, fail to strategically address the pertinent issues, e.g., the differences in impact on adolescent SRHR by age cohort of 10-15 years is not recognized; no specific SRH strategies or initiatives proposed vis a vis adolescents; and the policies fail to align their overall objectives with their proposed strategies, which will inadvertently lead to implementation issues. It is also pertinent to note the policies use the words youth and adolescents interchangeably.

### SINDH

Sindh’s Youth Policy was drafted in 2012, and intends to implement short-, medium- and long- term strategies to address a dynamic range of youth-related issues. The strategies are broadly broken up into 3 development goals: economic empowerment, social empowerment and political empowerment of the youth. Health falls under social empowerment, (as objective 2.2) and includes:

- The establishment of a “Youth Helpline” for counseling of adolescents on their health and reproductive issues;
- Undertaking education and communication activities in reproductive rights at the school level with cultural sensitivities of the regions in view;
- Increasing medical health awareness and literacy of youth especially on the issues of drug use, tobacco use, aids, hepatitis, sexually transmitted diseases, etc.;
- Portrayal of equality of boys and girls through all public messages and curricula, and initiating life-skill programmes for children and youth;
- Consolidation of pro-youth legislative measures on early marriage and violence against women by ensuring strict implementing of existing laws against forced and early marriages and violence against woman; and
- Youth debates and essay writing competitions on forced and early marriages, and involvement of religious scholars and print and electronic media in this thematic campaign.<sup>xiv</sup>

The monitoring and evaluation process includes:

- Development of indicators by the Sports and Youth Affairs Department; and
- Annual progress report on the state of youth in Sindh, in collaboration with the Standing Committee of the Youth, to be presented in the provincial assembly.

After a lapse of four years since the initiation of the policy, no indicators have been developed. A Youth Development Commission, regulated by the Sports and Youth Affairs Department is to be established as per Sindh’s policy which would be included in the monitoring process, but no such Commission has yet been established after a lapse of 1 year since the notification of its establishment.

<sup>10</sup> KP Police Arrest 471 Parents for Refusing Polio Vaccine, DAWN, : <https://www.dawn.com/news/1166901>

The policy fails to directly address provision of FP services to the youth; while *married* youth are covered under the Sindh Population Policy, unmarried youth and adolescents continue to be neglected and sidelined in terms of reproductive health services.

Access to FP services post sexual assault have not been discussed, nor has there been any attempt to link provision of FP to adolescents and youth to broader FP, health or population welfare policies. Barriers to accessing services such as parental consent/necessary age or marital status to access FP services have not been eliminated (however, it is not explicitly/legally required), and neither is respect for privacy emphasized. No dedicated budget allocation has been mentioned for the roll out of the Sindh Youth Policy, the Sindh Budget<sup>xv</sup> or the Sindh Budget Speech for 2016-2017<sup>xvi</sup>; there is a mention of a centralized information data collection system on youth development against progress indicators, but no details or mechanisms have been outlined thus far. It is important to note here that the Sindh Youth Policy has not yet been brought into force, and therefore, no progress can be made under the policy until it is officially adopted.

In order to address commitments made under the Family Planning 2020, however, a Costed Implementation Plan (CIP)<sup>xvii</sup> has been developed and rolled out in Sindh in 2015, to bring up the Contraception Prevalence Rate (CPR) from 35% to 45%<sup>11</sup>. While the youth SRHR needs have been mentioned in the plan, they have not been explicitly addressed, whether in terms of targets, indicators or services to be extended. The Plan also omits any tangible initiatives to cater to adolescents.

## **PUNJAB**

The Punjab Youth Policy 2012<sup>xviii</sup> looks to initiate life skill programmes, spearheaded jointly by provincial education and health departments. Cultural sensitivities have been emphasized in the policy in terms of sex education, which are explained as educative and communication activities. Given that discussions around sexuality are taboo, the emphasis on “cultural sensitivities” in the policy might mean that information provided may omit topics such as menstruation, safe sex practices, sexuality, etc., that are deemed inappropriate for a young and/or unmarried audience.

Similar to Sindh, Punjab Policy discusses promotion of FP through widespread awareness campaigns, establishing a youth helpline for health and reproductive issues, but it does not directly address the provision of FP services to the youth.<sup>12</sup> Yet, the policy commits to creating awareness and making information related to SRH available. Plans are expressed for establishing youth help lines for counseling related to health and reproductive health, but no explicit mention has been made of FP or FP services to the youth under this policy. Punjab has also committed to creating Adolescent Health Centres, where youth can access services to discuss and for the treatment of ‘sexual, emotional and psychological problems’. However, no ostensible plans have been announced regarding accompanying guidelines for the provision of these services, including equitable treatment of married and unmarried youth, or for clinical management of cases. Strict measures regarding implementation of laws against forced and early age marriages are also promised, but what these measures would include is not mentioned. However, it is important to note here that the age of marriage for a girl child in Punjab is 16 years, and not 18 years as it is in Sindh.

Different schemes have been discussed but no budget has been specified in the Punjab policy against the activities planned and while there is a monitoring and evaluation unit discussed in the policy, which is responsible for assessing the impact and progress of the youth policy, no clear mechanisms are outlined. A Youth Commission is to be established under the Punjab policy (similar to the Sindh Youth Policy), which is tasked with the preparation of an annual progress report on state of youth in the Punjab, and for submission to the Punjab Assembly for discussion and approval; however, there is no evidence to suggest that such a Commission has yet been constituted.

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<sup>11</sup>Plans to develop a similar roadmap are underway across all administrative units, and stand at different stages towards finalization.

<sup>12</sup> It is assumed that the youth mentioned in these policies are the unmarried youth of reproductive age

In terms of budget, the 2016-2017 Budget for Punjab has allocated Rs. 9 billion to various youth schemes.<sup>xix</sup> Under healthcare, Rs. 150 billion has been assigned, with Rs 43 billion allocated for ‘healthcare advancement’. This would specifically cater to the establishment of Intensive Care Units (ICUs) at hospitals, and upgrading drug testing laboratories (particularly in Lahore). Other schemes for the youth that have been allocated budgets include: Government of Punjab Laptop Awards Program (2013-2018), Punjab Education Endowment Funds (PEEF) (2012-2016), Upgrading of Institutions of Special Education, Market-oriented and Skills-based Subjects for Deeni Madaris (Religious schools), Self-Employment and Entrepreneurship Promotion, Punjab Women Empowerment Package (2012), Punjab Skills Development Fund (2011), Special Initiative for Youth in Jails, Vocational Training Programs (2014), Cab Scheme for Unemployed Youth (2015).

In the Budget, activities and initiatives listed in the Punjab Youth Policy have not been taken into account; the proposed budget for 2016-2017 does not include programs related to the youth’s sexual and reproductive health care services that were categorically mentioned and approved under the youth policy in 2012.

Under the Integrated Reproductive Maternal Newborn Child Health & Nutrition Program of Punjab, maternal, newborn and child health is emphasised, with specific objectives to reduce morbidity and mortality, promote FP services, and improve nutritional status of women and children. Unmarried youth have again been overlooked, despite the fact that this program could have had a promising impact on the youth health status.

## **BALUCHISTAN**

The government of Baluchistan, under the Baluchistan Youth Policy 2015, commits to providing youth-friendly primary health care services that are in line with integrated health frameworks and practices, and aimed towards addressing youth needs, specifically the commitments under the Convention on the Rights of the Child. Adolescent health rights incorporate physical, mental and social health, and the policy includes social, economic and political development of the youth. It proposes collaboration with the private health sector to impart information and counseling to adolescents with regards to gender equality, relationships, violence, responsible sexual behavior, responsible FP practices, family life, reproductive health, and sexually transmitted diseases (including HIV/AIDS and prevention). The policy, however, does not mention provision of FP services directly to youth or making contraception available to the youth.

In keeping with cultural sensitivities, the Baluchistan policy mentions the need to address puberty and changes to the body, and therefore proposes services in relation to sexuality, safe sex reproductive health; contraception and protective method provision; STI diagnosis and management; counseling (and referral for testing and care); pregnancy testing and antenatal and postnatal care; counseling on sexual violence and abuse (and referral for needed services); and post-abortion care (PAC), etc., at certain facilities. However, it is not clear if all these services would be made available to unmarried youth, as across provinces, unmarried youth are generally not recognized as needing reproductive health services.

The policy also proposes the use of ‘youth researches, events and debates on the scale and depths of youth bulge in the province and mass awareness campaigns for promoting FP in the province’. Youth cohorts and organizations are encouraged to promote ‘healthful practices and health services’, along with promoting healthy lifestyles, and highlighting harmful effects of drug addiction. These groups will be included in the creation and implementation of education programmes on nutrition, anemia, early age marriages and reproductive health. Formal curricula will also incorporate Life Skills Education, according to the policy.

The responsibility for data collection has been fixed with the provincial Environment Sports and Youth Affairs Department, which is to establish a dedicated Baluchistan Youth Development Resource Centre tasked with coordinating between youth groups and organizations, registration of new and informal groups, research and documentation, information dissemination, and promotion of integration of government and non government programmes. A Commission will also be constituted similar to Punjab and Sindh which would act as the overall supervisory committee to oversee implementation. Like Punjab and Sindh, monitoring and accountability mechanisms have not been mentioned in the policy, and neither has a budget been allocated for its implementation.

The Balochistan Youth Policy, has **not** been approved by the provincial assembly as of yet and therefore, no initiatives or programs have been rolled out.

## **KHYBER PAKHTUNKHWA**

According to the youth policy adopted by the Khyber Pakhtunkhwa (KP) government, strategies on adolescent and youth health rights, include policies to address holistic health needs of the youth, protection, survival and development of children and the youth, education and communication activities related to reproductive health, gender sensitive public messages and curricula, and drug addiction reduction projects. Pro-youth legislative measures include taking strict action and ensuring implementation of early and forced marriages laws; inclusion of religious leaders in debates; and essay writing competitions amongst students on early and forced marriages. Apart from the education and communication activities, there is no mention of the provision of reproductive health services to the youth or adolescents, or ensuring that basic reproductive health services are provided. Further, no budget or monitoring and accountability mechanisms have been detailed in this policy.

On February 6<sup>th</sup> 2016, it was announced that the KP government would allocated 2% of its annual budget for youth development, aligning the allocation with initiations under the youth policy<sup>xx</sup>. However, the KP budget revealed in June 2016 does not convey any allocation for youth development and it is difficult to determine if the youth and adolescents are was being catered to under a broader category.<sup>xxi</sup>

## **National Protocols for Adolescent Counseling Centres**

A National Protocols for Adolescent Counseling Centres has been proposed by the federal government (not yet approved) for provincial adoption. These Protocols provides guidelines that relate specifically to the Centres that have also been mentioned in provincial youth policies. The basic non-clinical services outlined in the document are counseling on emotional, sexual and reproductive health, mental health, gender-based violence and post abortion care; information on sexual and reproductive health issues including FP, puberty, post-abortion care, STDs (including HIV and prevention), maternal health (ante- and post-natal) and gender-based violence; and referrals to relevant departments, that would provide services needed (such as FP).

It is important to note that these Centres will not provide clinical services to youth and adolescents, and Population Welfare Departments are instructed to create a referral mechanism to ensure that patients from the Adolescent Counseling Centres are treated at the Family Health Clinics (also known as the Reproductive Health Services). These clinics are set up at a district level, within the premises of larger public hospitals. This brings up the argument of access. Research shows that access to these larger public hospitals is limited due to distance and transportation costs, and further curtailed by socio- cultural norms that restrict youth and adolescents’ access to services in the first place.<sup>13</sup> Females (unmarried females especially) find it harder to access basic health care services, while SRH services are further out of reach. Further, the stigmas attached to unmarried girls visiting doctors or these family health clinics will acts as a deterrent for unmarried females from pursuing healthcare they need.

## **Recommendations**

- Health must be recognized as a fundamental human right in the Constitution of Pakistan;
- The Federal government and its administrative units must ensure universal access to healthcare services, as part of the commitment in the Agenda 2030 and related Global Strategy Women’s, Children’s and Adolescent’s Health.

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<sup>13</sup>Shirkat Gah’s field researches related to health system governance strengthening , and early age marriage and the health sector’s response to it. These researches are not published as yet

- Adequate and complimentary budgets should be allocated to ensure that national and provincial health goals and targets are met.
- Health Policies at all levels must be aligned with national and international commitments and synced with local priorities based on existing research around youth and adolescent health issues;
- A life- cycle approach to SRHR must adopted, which ensures continuum of quality care for all citizens at all ages.
- The youth must be recognized as a priority area under all national health policies, particularly the National Health Vision, 2016-2025.
- Provincial Youth Policies must define proposed objectives and strategies, with an emphasis on sexual and reproductive health information and services, whether as part of the policies (where not approved by Assemblies), or as related rules of business.
- Equitable and gender-sensitive financing needs to be ensured and the progress on implementation needs to be tracked by setting, collecting data and comparing key performance indicators for each program or initiative the government undertakes. Time lines for indicator development and implementation must be committed to for activities to be rolled out immediately and efficiently.
- Youth policies must also be implemented, with specific activities supported by provincial budgets.
- Periodic impact assessment mechanisms against youth policies and their implementation (including achievements, challenges and gaps) must be put in place; the setting up and implementation of such mechanisms must be done through a consultative process and should involve all stakeholders, particularly youth and adolescents.
- Provincial youth policies must recognize “young people’s needs based on their age, their gender, the economic status of the household, and the profile of the community where they live (Sathar, et al., 2003), and services and opportunities provided to them accordingly”.
- The Adolescent Counseling Centres (ACC) proposed in all the provincial policies must provide clinical services, particularly to the unmarried youth and adolescents who are not able to avail the services at the Family Health Clinics (FHCs). Family Health Centres must be mandated to provide back-referrals, from FHCs to ACC, particularly for specialized counseling services.
- Re-evaluation of international indexes, especially the indicators set for the Global Youth Development Index, is necessary to negotiate for a fuller appraisal of progress and challenges at the national level. Cultural and ground realities need to be taken into account in the development of indicators related to youth and adolescents, with due consideration for gender implications.



## ENDNOTES

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