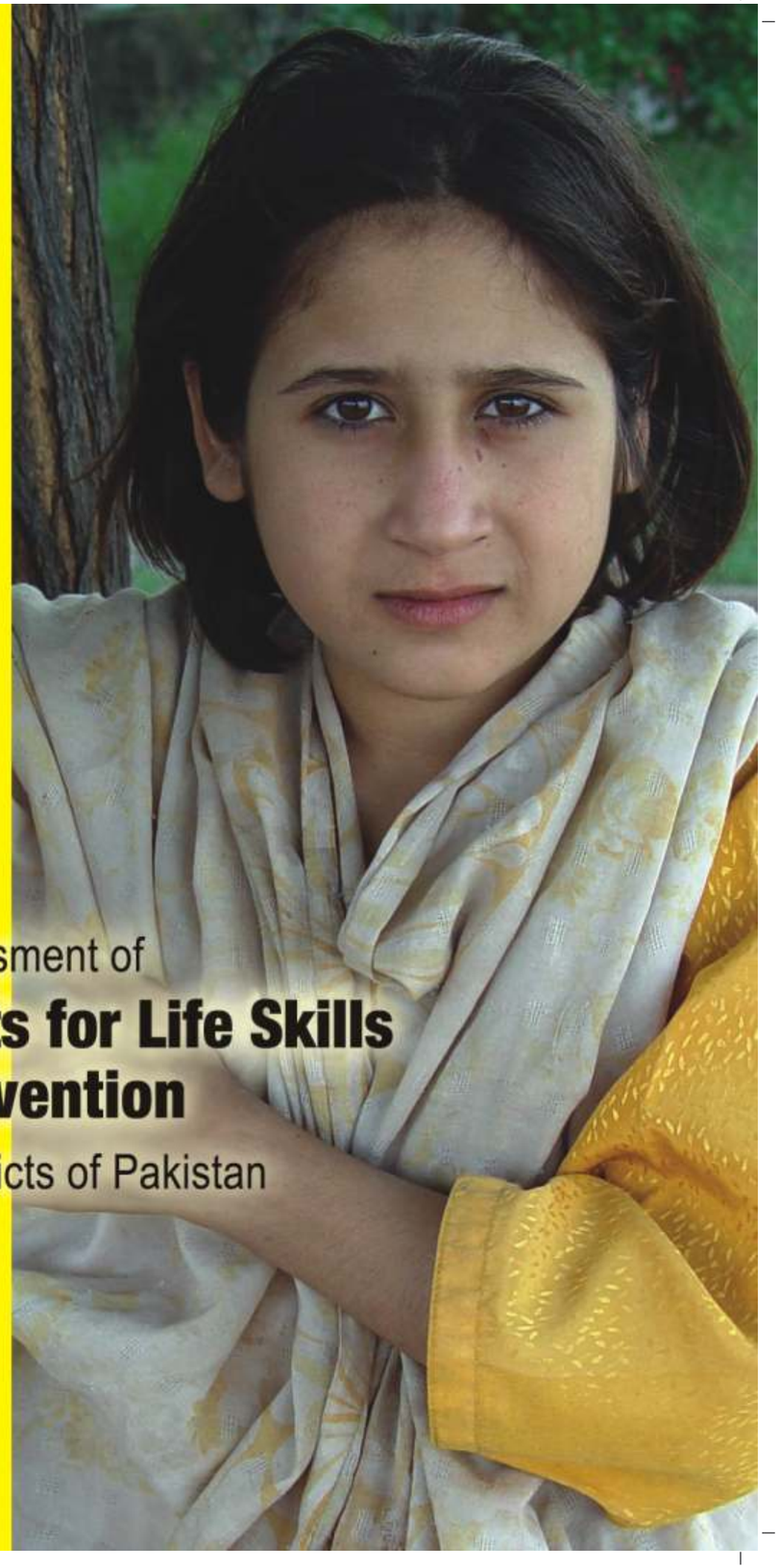

# Situation Assessment of **Adolescents for Life Skills** and **HIV Prevention** in selected districts of Pakistan

unicef

Ministry of Health
Government of Pakistan

UNITE FOR CHILDREN
UNITE AGAINST AIDS

Instant Print System, Islamabad

National AIDS Control Programme (NACP)
National Institute of Health

# Foreword

Young people in Pakistan need skills for life to protect themselves against HIV and AIDS. Life Skills provide children and young people with a developmental process of planned learning opportunities to acquire skills, knowledge, and attitudes which help them make informed decisions, communicate effectively with others, and deal with stress and emotions, in support of the practice of positive behaviours.

Young people in Pakistan confront a range of vulnerabilities which increase the likelihood of negative behaviours and then becoming exposed to HIV.

- Poverty and marginalisation drive young people from their homes, schools and communities into the labour market, increasing their vulnerability to abuse and exploitation. Economic frustration makes young people vulnerable to negative influences, including drug use.

- Harmful traditions impede access to information, skills and services, and limit control over sexual and reproductive health.

- Young people are denied the means to acquire knowledge and skills for self-development, protection and participation, thus increasing their vulnerability. Illiterate girls and young women are more vulnerable to child labour and early marriage, and have less control over decisions affecting their health.

- The rights of children and adolescents in Pakistan remain unrealised, making them vulnerable to abuse and exploitation. They are also denied the information they need to make decisions about their health, as well as the right to fully participate in decisions affecting them.

The National AIDS Control Programme recognises the need for young people in Pakistan to receive Life Skills Based Education and supports initiatives for both out-of-school adolescents and school-based adolescents in collaboration with the Ministry of Education and UNICEF. This assessment gives us the knowledge base to shape and enhance our programming to ensure young people in Pakistan are able to reach their full potential, protect themselves from HIV and contribute positively to the development of self, family, community and society.

Dr. Asma Bokhari
National Programme Manager
National AIDS Control Programme
August 2006

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# 1 Executive Summary

Adolescence is a critical period during which dramatic physical, physiological, emotional and behavioral changes take place quite suddenly. These changes coupled with the absence of authentic information to know, understand and appreciate them, cause anxiety among adolescents who may be pushed into courses of actions without having a chance to think fully of consequences[1].

Pakistan currently has the largest cohort of young people in its history and subsequent cohorts are expected to be even larger. Young people face a number of cri tical life decisions that relate to series of transitions to adulthood : school leaving, employment and greater responsibility for oneself and family[2]. Many researches in Pakistan have shown that the adolescents, due to their relative youth, lack of decision-making power, and incomplete personal development, are especially ill equipped to handle the reproductive health burden they face[3]. The links between these decisions, their sequencing and young people's agency in each sphere varies widely across and within the country.

Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life[4].

In Pakistan, there is a dearth of information on situation of adolescents and, thus, there is little evidence on which to build policies and programmes. Recognizing the need for generating this type of information, National AIDS Control Program (NACP) and UNICEF sponsored the instant study with the following **objectives:**

- To construct a profile of adolescents between the ages of 13 and 19
- To evaluate their existing life skills
- To assess adolescents' knowledge and sources of information about personal health with specific detail of leisure time activities and media habits.
- To evaluate adolescents' practices of health promoting behaviors and health seeking practices.
- To understand prevalent risk behaviors and factors contributing towards them

The study area included all four provinces of Pakistan, consisting of 14 districts of UNICEF and Global fund. The districts are: Lahore, Rawalpindi, Multan, Faisalabad, Bahawalpur, Sialkot, Gujranwala, Quetta, Karachi, Hyderabad, Larkana, Sukkur, Peshawar and Abbottabad

1 M.K.Hassan, M. Jayaswal and P.Hassan. Reproductive Health Awareness In Rural Tribal Female adolescents
2. Population Council (2002). Adolescent and You th in Pakistan 2001-2002.
3 Research report no.11, Adolescents and Reproductive Health in Pakistan: A literature review
4. WHO

The overall study design involved both quantitative and qualitative components keeping in view the need for representative results, without undermining more subtle and textured information that qualitative methods can provide.

A total of 3869 respondents were interviewed during the study. Highest percentage of respondents was of 13 year olds (18%) and lowest percentage was 17 year olds (12%). More than half (53%) were female and 48% were going to school. Majority of these adolescent (67%) belong to low middle class. The proportion of youth out of school increased with age and more girls were out of school (63%) than boys (41%).

***Self Awareness, Creative Thinking***

Self awareness and creative thinking in an adolescent determine the level of confidence and the ability to set goals. Career planning is an important milestone of self awareness. Among school going respondents, 25% wanted to be doctors, followed by teaching (22%), Engineering (11%) and Armed Forces (9%). The traditional trend of career planning was observed in some professional preferences. Almost equal number of boys and girls wanted to join medicine but among those, who wanted to be teachers, 68% were girls and 89% of those, who opted for engineering were boys.

Only 25% of the adolescents had a private bedroom. Among those, who had private bedrooms, 63% were boys. Gender discrimination is evident from the fact that more girls than boys have to share their bedroom with someone else even though more girls than boys who were interviewed had reached puberty. A feeling of discrimination is evident from the fact that only half of the female respondents (48%) were happy with nature's choice of gender for them, the rest were either not happy (15%) or not sure (32%).

The issue of how aware they were regarding risk of getting infected with HIV and hepatitis, the usual response during discussions was that they were safe because they were leading a pious life and stayed away from sin. Most of the respondents were aware of the dangers of sharing needles and untested blood transfusions. Reliance on God's will and helplessness in this matter was also mentioned.

***Problem Solving, Decision Making & Critical Thinking***

Life skills like decision-making, problem-solving and critical thinking were looked through important life decisions like marriage and dropping out of school.

Only 8% of the respondents were married. Out of them, 82% were females. The acceptance of traditional practices of arranged marriages was prominent; 72% adolescents endorsing arranged marriages. Only 8% thought that the couple should decide about marriage.

In 48% cases, the decision to drop out of the school was respondent's own decision. Among those, who were working for pay, 55% said that they give all their income to the parents, 25% were giving part of the income to the parents, while 10% were keeping all their income to themselves.

***Communication and Interpersonal Relationships***

Healthy interpersonal relationships build on effective communication. When adolescents are willing and able to express themselves and share their thoughts and events, misunderstandings melt away.

Sexual maturity is a milestone in the life of every adolescent. This is the stage, when they need somebody to answer their queries and guide them properly. Few adolescents said that they had discussed their sexual events and problems with anyone. Among those, who had reached puberty and had been informed about it, the person who informed them was mother (59%) for girls and a friend (60%) for boys. Only in 19% cases, the fathers had discussed this issue with their sons.

Some females said that it was shameful and it was very difficult to discuss such matters with anyone. However others mostly mentioned mothers and sisters with whom they had discussed such matters. Among the males, friends were the group with which they could talk about sexual issues. Talking about type of friends or contacts who could place a person at risk of HIV infection, mostly respondents said that people like smokers, drug addicts, people who drink and commercial sex workers were the type of people who should be avoided.

***Empathy***

Generally the respondents expressed sympathy for patients of AIDS. The perception was that the family with a person suffering from AIDS would have social and economic problems. There was also a danger of disease transmission to the other members of the family. The view of respondents to give special treatment to such patients was shared by majority.

The respondents said that such patients should be treated with care and sympathy as it is possible they got the disease due to ignorance and not due to some ill act. They are already suffering and we should do everything we can to help them however it is important to be careful so that the disease is not transmitted.

***Coping with Stress and Emotions***

Coping with stress and emotions is probably the most difficult area, which an adolescent has to go through during his/her transition from child hood to adulthood.

While feeling depressed, 28% respondents discussed it with their friends, 2% smoked while 28% mentioned a number of things which they do like watching TV, listening to music or going out with friends to eat or to the cinema. Some were of the view that the best way to beat depression is by praying, offering namaz and reading the holy Quran. None of the respondents admitted to any adverse solutions like smoking, taking drugs or drinking.

Exposure of working children including domestic servants to sexual advances by their employers was mentioned by the respondents. A very small proportion (3%) of respondents had been touched sexually by someone and the same proportion (3%) were not sure if such an incidence had every happened. The majority of responses (36%) for

person who had touched them sexually were from family or relatives. Friends were mentioned in 28% cases and teachers in 15% cases. There were incidences where these advances had been made by a stranger (13%). Among the others family friends or strangers were mentioned.

***Risk Behavior***

There were very few unmarried adolescents who were sexually active. Only 0.5% respondents admitted having sex with a commercial sex worker, 0.5% with a man and 1% with a woman. Forty five (1.2%) respondents admitted having taken drugs and 0.4% had ever taken alcohol.

Very few respondents were in favour of premarital sex. Only 9% said that pre marital sex was justified when both partners agreed, 6% each said that it was justified when they were in love or when they were engaged and 3% said it was alright to have premarital sex if they were mature. Nearly all the respondents who had opted for the others option (76%) said that they did not agree with premarital sex under any circumstances and sex should be avoided until marriage.

During face to face interview administered by an interviewer, very few unmarried adolescents both boys (3%) and girls (1%) said that they had sex with someone. However during the anonymous interview which was self administered by the respondent the percentage rose for boys to 5% and for girls it rose to 3%.

The proportion of respondents who mentioned the danger of HIV infection through sex with multiple partners was very low. Majority's concern was that it was a sin and if caught it would be shameful or it was illegal and you could get arrested. A high percentage said that they did not know about condoms. Majority of the ones who knew about them said that their use was for prevention of pregnancy and birth spacing.

During focus group discussions it was seen that knowledge of HIV / AIDS was confined to hearing about it and that it was a deadly disease but there was not much clarity about its mode of spread.

***Leisure and Media Habits***

Exposure to media during leisure time amongst adolescents mostly included television and internet. Majority of the respondents said that they had not seen pornographic material or any program related to sex.

During focus group discussions respondents mentioned internet cafes and video games shops as being places where the youth could be exploited sexually. It is perceived that in some of these places young boys and girls are targeted for sexual exploitation for small sums of money.

# 2 Introduction

Adolescence is a critical period during which dramatic physical, physiological, emotional and behavioral changes take place quite suddenly. These changes coupled with the absence of authentic information to know, understand and appreciate them, cause anxiety among adolescents who may be pushed into courses of actions without having a chance to think fully of consequences[3].

In Pakistan, children and adolescents are exposed to all of the risks associated with HIV/AIDS, including the risk of infection, as well as the vulnerability to losing a parent to the disease. (Ahmed 1998)[4].

Many researches[5] in Pakistan have shown that the adolescents, due to their relative youth, lack of decision-making power, and incomplete personal development, are especially ill equipped to handle the reproductive health burden they face. It has also been a major concern that the policies and programs, as well as legal provisions, do not protect adolescents. Policies and thus programs need to be especially designed to meet the needs of adolescents without disrupting their development into adults. Programs and policies need to protect adolescents from the specific biases they face that undermine their health, safety, and secure development.

Since Pakistan had been lacking information and adequate data on life skills with regards to adolescents, presence of good baseline information on such issues, for Pakistan as a whole and for certain districts that have been targeted by UNICEF for adolescent programs was much needed. This paved the way for conducting this study.

This study reviews the issues concerning adolescents including rapid social change; complex choices during adolescence and transition to adulthood as well as the need for a range of life skills in order to handle these choices. This study opens up issues and problems faced by the adolescents in Pakistan. This situation assessment is an amalgam of both KAP study and formative research.

***What are Life Skills?***

**Life skills** are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life *(WHO )*

- Life skills related to psychosocial competencies help people:
  - Make informed decisions
  - Solve problems

3 M.K.Hassan, M. Jayaswal and P.Hassan. Reproductive Health Awareness In Rural Tribal Female adolescents
4 Ahmed, Sadia. 1998. HIV/AIDS and children: A South Asian perspective. Kathmandu: Save the Children (UK).
5 Research report no.11, Adolescents and Reproductive Health in Pakistan: A literature review

- Think critically and creatively
- Communicate effectively
- Build healthy relationships
- Empathize with others
- Cope with emotions and stress
- Manage their lives in a healthy and productive manner

The study area reaches out to all the four provinces of Pakistan, consisting of 14 following districts of UNICEF and Global fund:

- Punjab
  - Lahore, Rawalpindi, Multan, Faisalabad, Bahawalpur, Sialkot and Gujranwala
- Balochistan
  - Quetta
- Sindh
  - Karachi, Hyderabad, Larkana and Sukkur
- NWFP
  - Peshawar and Abbottabad

## Justification of the study

Provide support to NACP in conducting situation assessment on in school and out of school adolescent behaviors and knowledge for life skills and HIV prevention, with an additional focus on vulnerable populations. This will serve as a baseline for next five year country program of UNICEF and Global Fund.

***Program Goal:*** Empowerment of adolescents for healthy life style

***Overall Objective of the study:*** To equip adolescents with knowledge and skills to reduce their vulnerability to HIV/AIDS and STIs.

## Objectives

- To construct a profile of adolescents between the ages of 13 and 19
- To evaluate their existing life skills
- To assess adolescents' knowledge and sources of information about personal health with specific detail of leisure time activities and media habits.
- To evaluate adolescents' practices of health promoting behaviors and health seeking practices.
- To understand prevalent risk behaviors and factors contributing towards them

# 3 The Research Plan

The overall study design involves both quantitative and qualitative components keeping in view the need for broadly representative quantitative/descriptive results, but at the same time the need for more subtle and textured information that qualitative methods can provide.

This study deals with a range of issues: from quality life skills-based education to critical thinking, decision-making, communication, coping and self-management which can be applied to specific contexts such as HIV/AIDS prevention or conflict resolution.

Through research, required information about individuals, communities, and major stakeholders of adolescent behavior was gathered during this study. It has been felt that this information will in turn enable development and implementation of knowledgeable and effectual *country programs focused on youth and their comprehension about basic life skills and specific awareness about HIV and reproductive issues*.

The instant research also facilitated in obtaining information about major key stakeholders or factors that have a direct or indirect influence on behaviors at community or household level, thus resulting in forming audience specific interventions. This study has been specifically aimed at providing support to NACP in conducting situation assessment on in-school and out-of-school adolescent behaviors and knowledge for life skills and HIV prevention, with an additional focus on vulnerable populations.

## *3.1 Survey Methodology*

### 3.1.1 Quantitative Research Component

#### 3.1.1.1 Sampling scheme

Quantitative research was carried on adolescents between the ages of 13-19 years. Contech adopted cluster sampling technique[6] for quantitative survey. Contech took out the sample through the formula for calculating sample size[7]. 10 randomly selected clusters were taken in one district whereas in one district 287 interviews were required to be completed. The task of random identification of clusters within each district was entrusted to **Federal Bureau of Statistics (FBS).** In each cluster 29 household interviews were completed i.e. 290 household interviews per district. In all 4060 household interviews were conducted in the 14 selected districts.

6 Cluster sampling is preferred in community based studies. The cluster sampling technique doubles the sample size to obtain the same precision by reducing the design effect (in cluster sampling it causes variation due to clustering).

7 Sample size determination in health studies by World Health Organization Geneva written by: S.K. Lwanga and S. Lemeshow

| Respondents | Interviews in 1 district | Interviews in 14 districts |
|---|---|---|
| **Adolescents of 13-19 years** | 290 | 4060 |

### 3.1.1.2 Field Methods

The study was conducted in a specific manner as approved by all major stakeholders i.e. UNICEF, NACP etc. The following strategy was adopted for carrying out the quantitative part of the survey:

***Selection of first household:***

Random selection of first household within the cluster was carried out in two steps

- Step 1: Random selection of direction from center of the cluster.
- Step 2: Random selection of the first household within the total number of households from the center to the end of the cluster

After the first household was visited subsequent households (nearest door, in whatever direction) were visited:

- Within the household one adolescent was interviewed. In case of households where more than one adolescent was present the respondent was selected randomly.
- The team kept visiting subsequent households in the cluster till 29 interviews were completed

### 3.1.1.3 The Questionnaire

Development of the questionnaire involved a broad range of persons either with technical training in one of several disciplines or direct field experience with adolescent or health programs in Pakistan.

The questionnaires were developed by the Contech team in consultation with UNICEF, NACP and other major stakeholders. They were then *pre-tested* and modified according to the feedback. The detailed main questionnaire and one pager anonymous questionnaire were used to collect data by interviewing adolescents between the ages of 13 to 19 years during the quantitative survey.

Instruments were in urdu while interviewers were local. Interviews were administered in local languages. In each cluster 29 interviews were conducted i.e. 290 interviews per district and in this way a total of 4060 interviews of adolescents were conducted in 14 districts. Random checks in the field were done by Contech monitoring team as well as NACP and UNICEF during field work.

The quantitative data collection questionnaire consisted of 3 parts:

- **Part 1 (Household roster):** It was completed for all the households that were visited.
- **Part 2 (Main questionnaire):** It consisted of personally administered detailed interview of an adolescent.
- **Part 3 (Anonymous questionnaire):** These were self administered by respondents and then returned to the interviewer in a sealed envelop for anonymity.

#### 3.1.1.4 Approaching sensitive issues

An anonymous questionnaire was included so that the respondent may comfortably give information about their own sexual knowledge and practices without giving out names or any other information which could disclose their identity. This close ended one page questionnaire was filled in by the respondent him/herself in private. The interviewers explained to the respondent about the anonymous questionnaire and read out the questions in case of illiterate respondents. The respondents were then asked to sit separately and fill out the form by marking the appropriate responses. After completion of the questionnaire the respondents placed it in an envelope provided to them by the interviewers and sealed it to ensure anonymity and confidentiality. The sealed envelop was then handed over to the interviewers.

**Main content areas:**

The **quantitative data** was focused on the following areas:

- Self awareness
- Communication and interpersonal relationships
- Decision making and problem solving
- Leisure and media habits
- Knowledge of HIV/AIDS and sexually transmitted diseases

Personal health and health seeking practices were also asked and risky behaviors were identified through them.

### 3.1.2 Qualitative research component

Focus Group Discussions (FGD) and in-depth interviews (IDI) were conducted for the qualitative research component. **8 FGDs** were completed of vulnerable groups distinguishing them into male and female population according to the following table while **112 in depth interviews** (***56 male and 56 female)*** were carried out with higher secondary male and female students, working children, parents and other community members like teachers in the selected 14 districts of Pakistan.

| Category | Focus Group Discussions | |
|---|---|---|
| | Male | Female |
| Orphans | 1 | 1 |
| Disabled children | 1 | 1 |
| Street children | 1 | 1 |
| Refugees | 1 | 1 |
| **Total** | **8 FGDs** | |

| Category | In depth Interviews | |
|---|---|---|
| | Males | Females |
| Higher secondary students | 14 | 14 |
| Working children (domestic and others) | 14 | 14 |
| Parents | 14 | 14 |
| Teachers | 14 | 14 |
| **Total** | **112 in-depth interviews** | |

The **qualitative data** was collected based on the guide questions specific to target groups prepared for FGDs and IDIs. The groups identified for ***Focus group discussions*** were the following:

- Orphans
  - Most orphans are a vulnerable group of children who spend their childhood in orphanages without the security of a family or home. These children are often exposed to sexual exploitation and more apt to adopt risky behavour. FGDs with orphan girls and boys were conducted in Rawalpindi. The orphans were assembled from orphanages in the city.
- Disabled children
  - FGDs with disabled children both boys and girls were arranged at the institute for deaf and dumb in Lahore. Deaf and dumb adolescents were chosen as they are mentally and physically normal except for their handicap in communication which could lead to lack of awareness and risky behavior.
- Street children
  - Street children spend most of their childhood without the secure environment of a home. This exposes them to sexual exploitation. FGDs with street children were arranged in Karachi being a metropolitan city having a large number of street children. The

children were contacted and gathered for FGDs from places where they usually hang out like bus stations and major roadsides.

- Refugee children
  - Refugee children are another group who are devoid of a secure environment and spend their lives in makeshift refugee camps. These children are also exposed to sexual exploitation at times. FGDs with refugee children were held in Peshawar and children were contacted at the Afghan refugee camps.

In addition to the FGDs, survey teams visited various schools and conducted IDIs with higher secondary students. Parents of higher secondary students were also contacted through them and interviewed. IDIs were also conducted with teachers who teach adolescents. Working children both domestic and others were contacted at their workplace for IDIs.

### 3.1.3 Strengths and Limitations of the Survey

#### 3.1.3.1 Strengths

For a universe defined as all persons aged 13-19 living in households in the 14 study districts, this study provided a broadly representative sample of that universe. In particular, clusters were selected randomly from complete lists of all clusters. Also, the field procedure (cluster sampling technique) tends to assure diversity of households along with broad representation.

The sample included all persons in the target cohort aged 13-19. Many adolescent surveys focus on females (or males) only, or only on the married or the single. These selection criteria produce severe limitations at the analysis stage and offer a narrow perspective on adolescent issues. Thus it was decided that this survey should follow the most effective adolescent survey methodology admitting to the sampling of all persons of any description within the defined age range.

The field procedures included a complete household screening exercise to determine whether and how many adolescents 13-19 lived in the selected households. This screening information is available for households without youth as well, thus providing an important indication of representation.

#### 3.1.3.2 Weaknesses

The age range selected takes age 19 as the oldest age covered. A broader age range, and in particular extending the target cohort at least part way into the 20s, would have allowed more analysis of causes and sequel which in the nature of things play out over periods of time. Also, the age 19 cut-off does not include the full range of ages during which the transition to adulthood is occurring. (For example, among males only 5.6% in the sample had married by age 19; even among females the % married at age 19 is only 36.8%.)

Only adolescents residing in households are included in the survey. The number residing outside of households is unknown and many of these will be males in the age range targeted by this survey. Presumably the problems of interest in this study are likely to be more prevalent among adolescents living outside of households.

The districts selected for this study are all relatively urban in character. The sample clusters are therefore more likely to be urban, and the rural clusters are more likely to be peri urban rather than entirely rural. The study therefore describes most accurately the urban and peri urban parts of selected districts. If some of the randomly selected clusters do fall in the rural areas situated close to the cities within these districts they will be a very small representation which will not allow separate tabulation. Comparisons between the districts will not be meaningful with the sample size and would require a much larger sample size.

The major limitation of this survey was faced while conducting interviews with female adolescents since in most cases their families especially mothers did not allow them to be interviewed alone. It was considered a major road block due to which correct and authentic behavior, practices or knowledge of these girls could not be known in some cases. In fewer cases this was seen while interviewing male respondents also.

# 4 General Characteristics of Adolescents included in the Survey

## 4.1 Age & sex of Respondents

**Table 1: Age Distribution of Respondents**

| Age of Respondent (Years) | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| 13 years | 703 | 18.2 | 18.2 |
| 14 years | 547 | 14.1 | 32.3 |
| 15 years | 511 | 13.2 | 45.5 |
| 16 years | 522 | 13.5 | 59.0 |
| 17 years | 448 | 11.6 | 70.6 |
| 18 years | 519 | 13.4 | 84.0 |
| 19 years | 619 | 16.0 | 100.0 |
| Total | 3869 | 100.0 | |

A total of 3869 respondents were interviewed during the study. Highest percentage of respondents was of 13 year olds (18%) and lowest percentage was 17 year olds (12%).

**Figure 1: Age Distribution of Respondents**

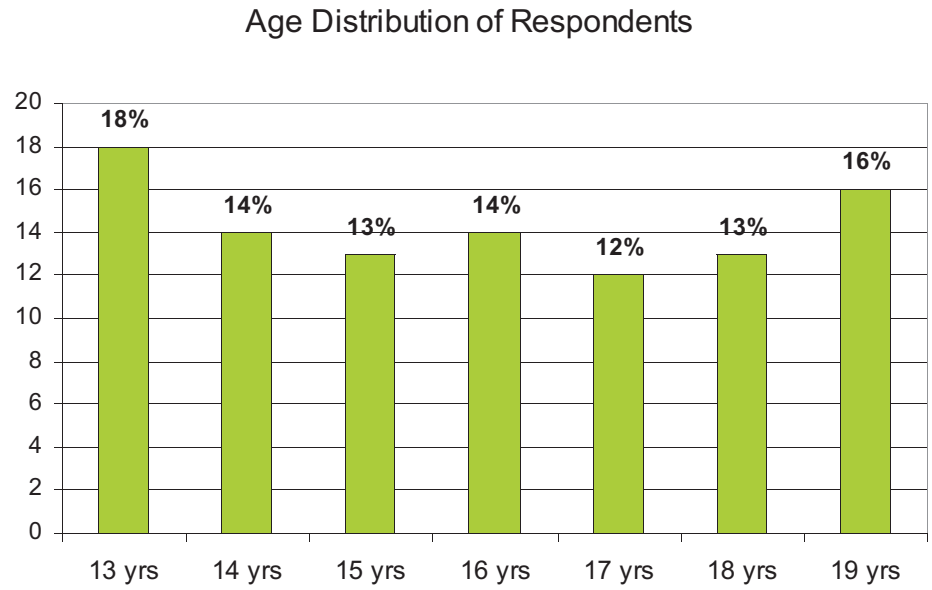
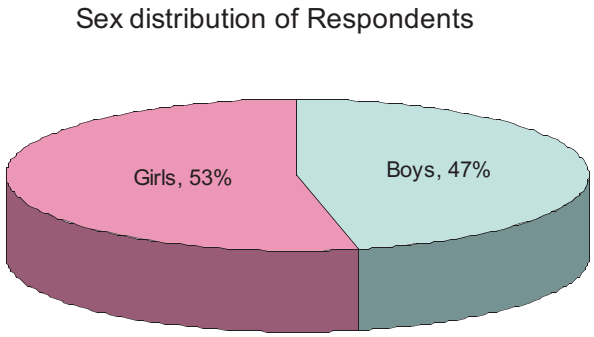


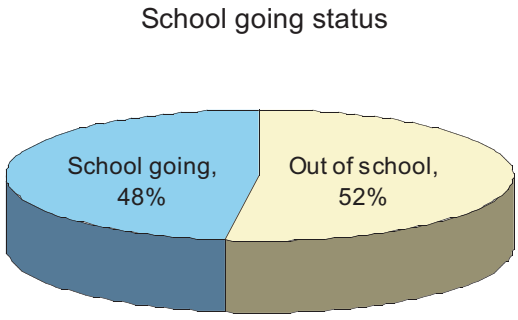
**Figure 2: Sex Distribution of Respondents**




Among the respondents 53% were girls and 47% were boys.

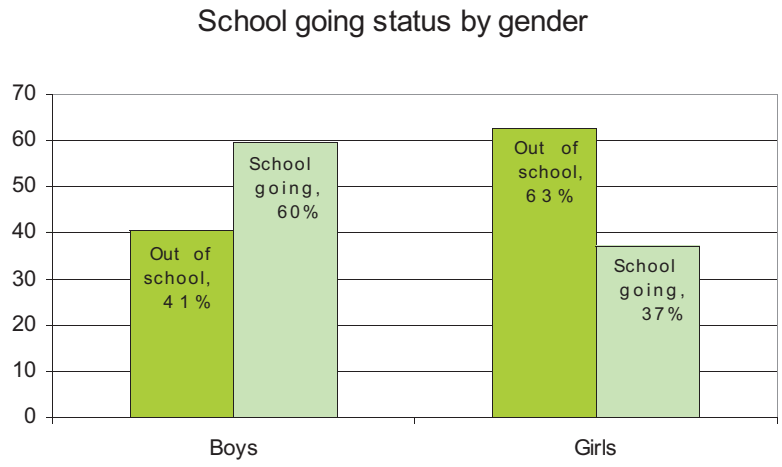
## 4.2 School going status

**Figure 3: School going status**



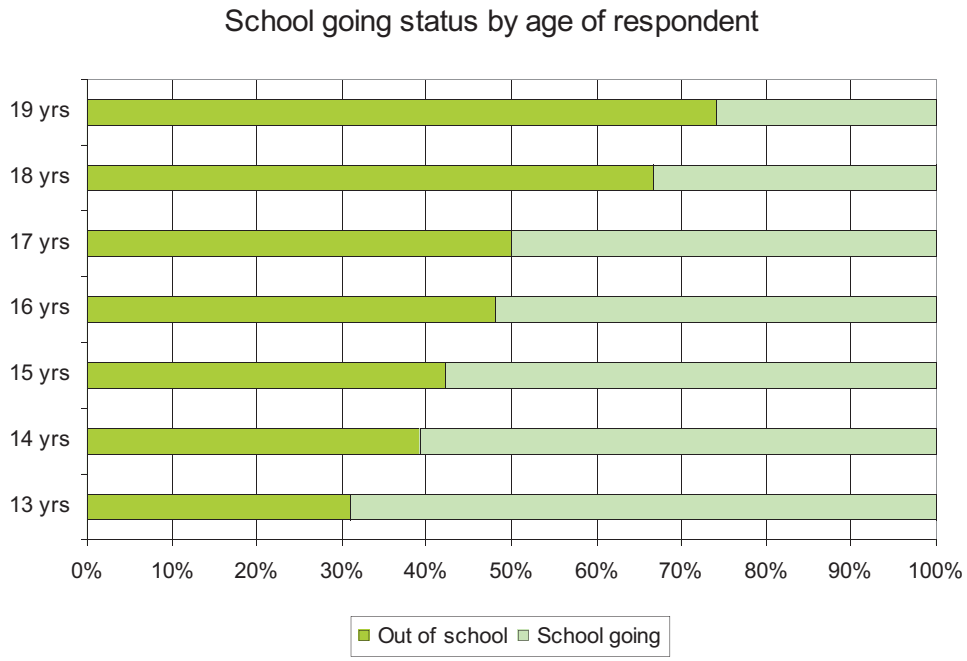

At the time of interview the respondents who were not attending any school or college was alarmingly high (52%).

**Figure 4: School going status by gender**



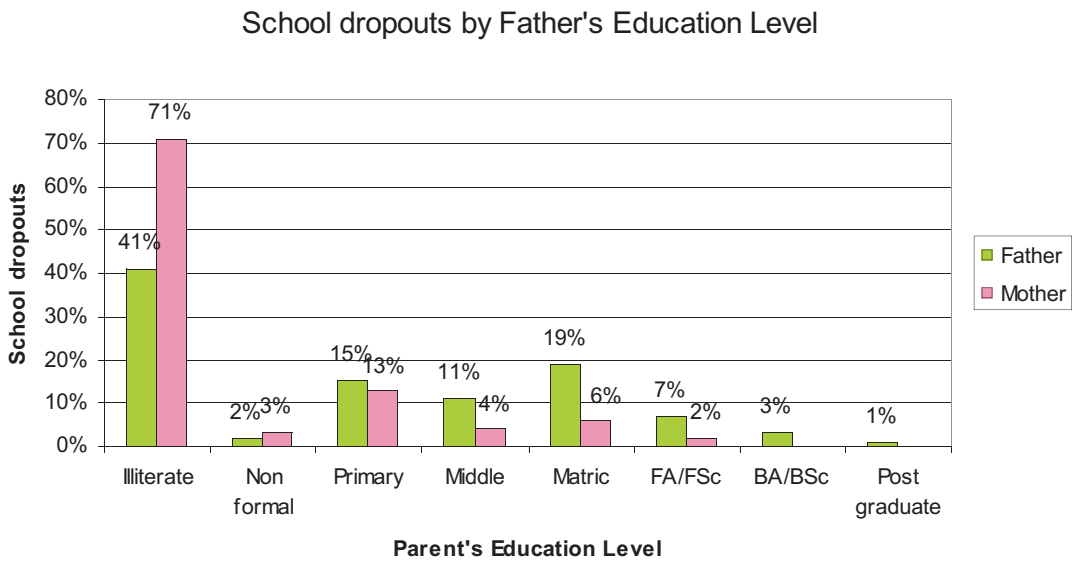
The proportion of girl respondents who were not attending school was higher than boys. Amongst the male respondents 41% were out of school whereas the same category in female respondents was 63%. The trend of dropping out of school among girls is higher than in boys.

**Figure 5: School going status by age of respondent**




School going trend at difference ages can be seen in figure 5. The proportion of youth out of school increased with age, at age 13 it is the lowest at 12% and shows a gradual rise with highest proportion of 23% at age 19.

**Figure 6: School dropouts by Parent's education level**



Comparing the education status of parents' with school dropouts we see that as the level of education of parents' increases there is a decrease in school dropout rate of their children. Maximum number of dropouts were adolescents whose parents were illiterate and minimum dropouts were where the parents had achieved post graduate education.

## 4.3 Socio Economic Status (SES)

To better understand the distribution of characteristics of interest a socio economic score was constructed. Values were assigned to variables and the end score is being presented in one summary table which would reflect the socio economic status of households of respondents.

The scores have been assigned as follows:

| Utility/source | Score |
|---|---|
| ***Source of water*** | |
| 1. Piped water | 2 |
| 2. Electric pump | 1 |
| 3. Hand pump | 1 |
| 4. River/canal | 0.5 |
| 5. Other | 0.5 |
| ***Utilities/transport*** | |
| 1. Electricity | 1 |
| 2. Gas | 1 |
| 3. Telephone | 2 |
| 4. Mobile phone | 1 |
| 5. Automobile | 2 |
| 6. Motor cycle | 1 |
| ***Source of information*** | |
| 1. Radio | 1 |
| 2. Television | 2 |
| 3. Newspaper | 1 |
| 4. Cable television | 1 |
| 5. Health worker | 1 |
| 6. Friends/relatives | 1 |
| 7. Internet | 1 |

Using these scores five groups were formed for further analysis. The scoring of groups is as follows:

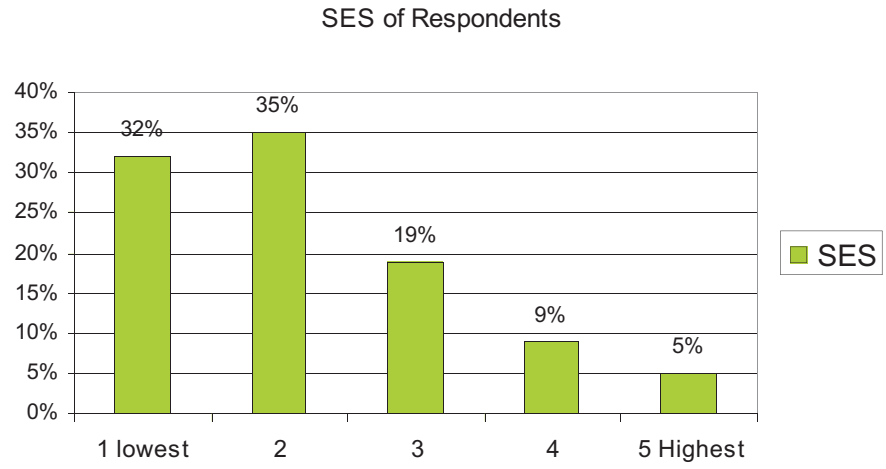
| | |
|---|---|
| Lowest to 4 | score 1 |
| 4.5 to 6 | score 2 |
| 6.5 to 8 | score 3 |
| 8.5 to 10 | score 4 |
| 10.5 to highest | score 5 |

The resulting 5 categories are being used with 1 being the lowest and 5 the highest.

**Table 2: SES groups of the respondents**

| | Count | Percent |
|---|---|---|
| SES1 (Lowest) | 1239 | 32 |
| SES2 | 1351 | 35 |
| SES3 | 722 | 19 |
| SES4 | 355 | 9 |
| SES5 (Highest) | 202 | 5 |
| Total | 3869 | 100 |

**Figure 7: Socio economic score of respondents**




The maximum proportion of respondents (35%) fall in SES category 2. Thirty two percent are in the lowest category whereas 19% are in category 3, 9% in 4 and 5% in the highest socio economic category of 5.

# 5 An Overview of Life Skills Among Adolescents

Assessment of life skills among adolescents has been seen in the context of following enlisted abilities. The findings of the survey will be presented under these headings:

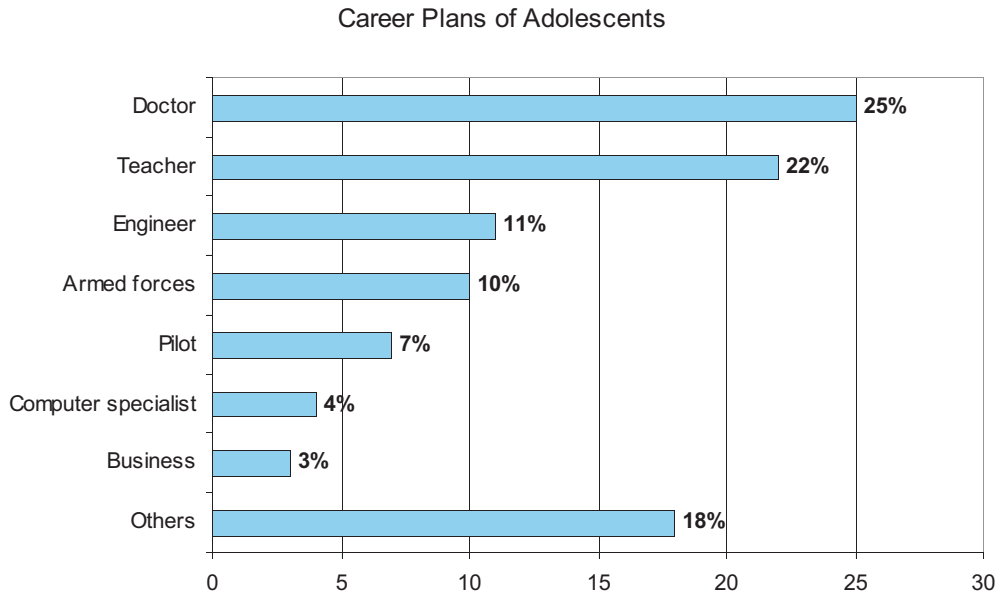
i. *Self awareness, creative thinking*
ii. *Problem solving, decision making and critical thinking*
iii. *Communication and interpersonal relationships*
iv. *Empathy*
v. *Coping with stress and emotions*
vi. *Dealing with depression*
vii. *Risk behavior*
viii. *HIV awareness*
ix. *Leisure and media habits*

Quantitative findings are in tabular or graphic form followed by 'Findings & Analysis'. In the 'Findings & Analysis' part at the end of each life skill section, quantitative as well as qualitative analysis has been presented. Shaded boxes containing specific narrations by respondents or anecdotes have been added in each descriptive part. These have been taken from FGDs and IDIs.

## *5.1 Self Awareness, Creative Thinking*

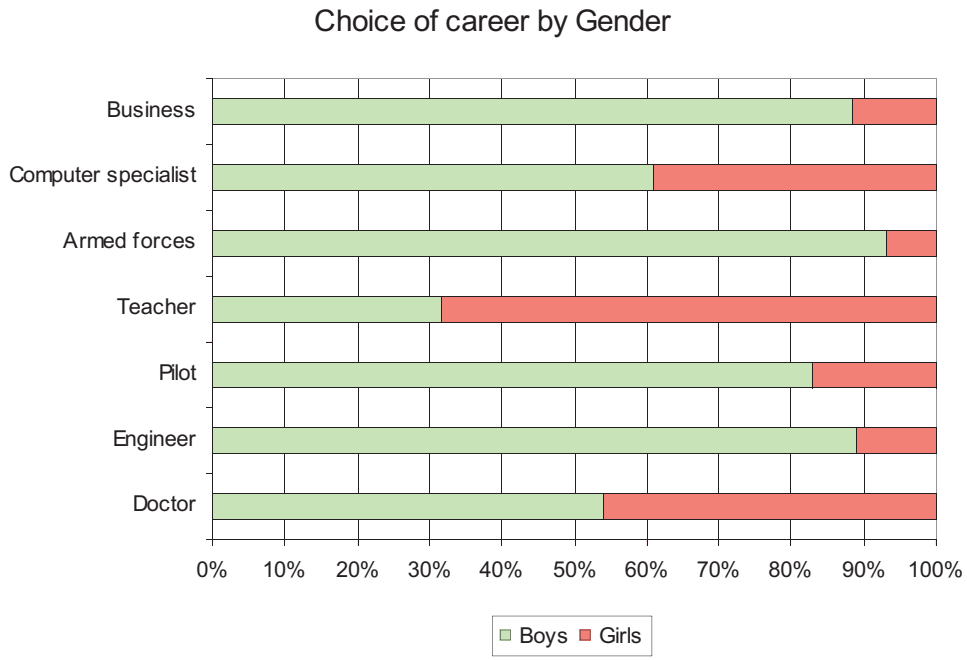
### 5.1.1 Future Ambitions

**Figure 8: Future Career Plans**



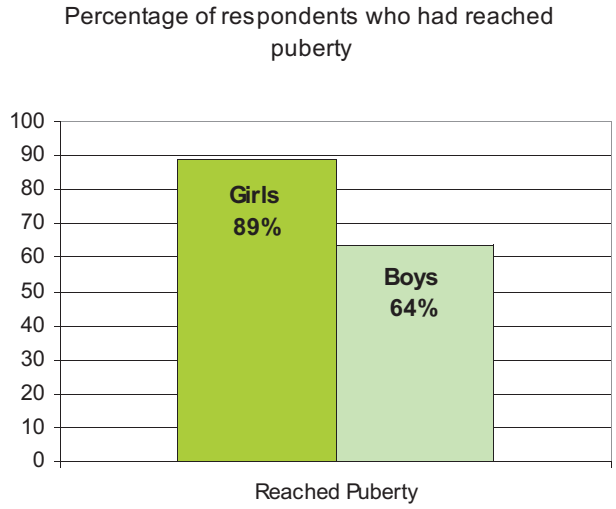
The school going respondents were asked about their future career plans. A quarter (25%) of the respondents opted for the medical profession and said they wanted to be doctors, the next popular career among the youth was teaching (22%). 11% wanted to be engineers and 9% wanted to join the armed forces.

**Figure 9: Choice of career by gender**




The medical profession was found to be equally popular with both boys and girls with 46% girls and 54% boys opting for it. Amongst the 22% who wanted to be a teacher the proportion of girls was higher (68%) than boys (32%). Engineering on the other hand was more popular among boys with 89% boys and 11% girls among those respondents who had opted engineering as their choice of career.

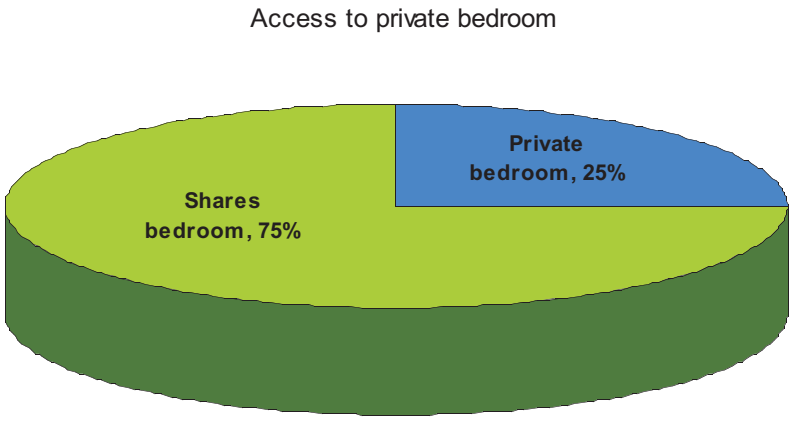
**Figure 10: Respondents who had reached puberty**



The percentage of respondents who said that they had reached puberty at the time of the interview was higher for girls (89%) than boys (64%).

### 5.1.2 Access to Privacy

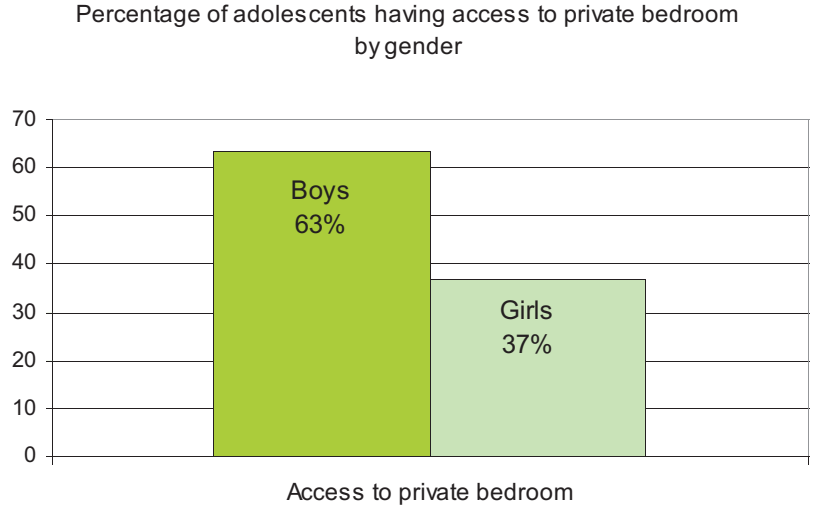
**Figure 11: Unmarried adolescents who have a private bedroom**




To assess access to privacy the respondents were asked if they shared their sleeping room with someone else. Among the unmarried respondents a quarter (25%) said that they slept in their own bedroom, whereas 75% said that they shared their bedroom with siblings or others.

### 5.1.3 Gender Discrimination

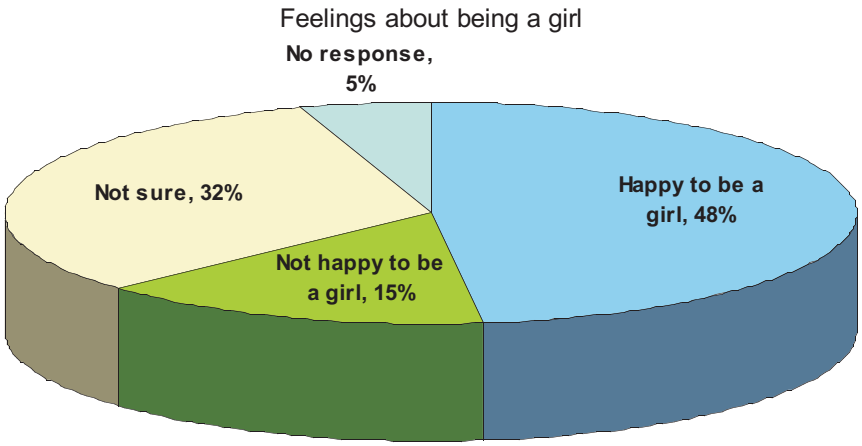
**Figure 12: Access to private bedroom by gender**




Breakup according to gender of respondents who had access to their private bedroom revealed that there was marked difference between boys and girls. Among the

respondents who had said that they slept alone in their bedroom 63% were boys and 37% were girls.

**Figure 13: Feelings about being a girl**




The girl respondents were asked how they felt about being a girl. 15% said that they were not happy, whereas 48% said that they were happy. However a high percentage (32%) was not sure and 5% did not respond.

### 5.1.4 Findings & Analysis

Self awareness and creative thinking in an adolescent determine the level of confidence and the ability to set goals. The traditional trend of career planning can be seen here, whereas the boys have opted for medicine and engineering the girls opted for medicine and teaching.

Gender discrimination is evident from the fact that more girls than boys have to share their bedroom with someone else even though more girls than boys who were interviewed had reached puberty. A feeling of discrimination is evident from the fact that only half of the female respondents were happy with nature's choice of gender for them, the rest were either not happy or not sure.

Pollution free environment, good diet, personal hygiene, exercise and routine checkups by doctors are perceived to be protective measures.

Mainly the girls who had said that they were not happy felt that boys were considered superior and were much more independent than girls. Some girls said that they were considered someone else's property and are seen as a burden. They felt that as girls they were not able to contribute much to the family. Some of the respondents also mentioned that they were leading a restricted life and are helpless. It was also mentioned that people were not happy on the birth of a girl.

On the issue of how aware they were regarding risk of getting infected with HIV and hepatitis, the usual response during in-depth interviews and focus group discussions was that they were safe because they were leading a pious life and stayed away from sin.

Most of the respondents were aware of the dangers of sharing needles and untested blood transfusions. Some knew about the importance of immunization against hepatitis and for HIV they said that if infected they would get treatment. Reliance on God's will and helplessness in this matter was also mentioned, however they were confident that God willing they would never get this disease.

In one case a respondent felt safe because he did not smoke cigarettes or the huqqa. One respondent mentioned that he was safe because he had sex a couple of times and both times had used a condom.

On how they can protect themselves from these diseases, mostly the respondents mentioned transfusion with tested blood, use of new syringes and new blade during shave from a barber, staying away from sin and offering namaz. Abstinence from sex with strangers was also mentioned.

> *"Taking a bath immediately after kissing or having sex with a sex worker can reduce the risk of having a sexually transmitted disease".* (An orphan boy)

In case they got infected most said that they would get treatment from doctors and some mentioned prayer and recitation of *darood sharif*. Some thought that in such a case they would stay away from other people so as not to spread the disease further. One respondent said that he would lead a complete life and do everything to fight the disease while one girl said that she may kill herself.

## *5.2 Problem Solving, Decision Making & Critical Thinking*

### 5.2.1 Making decision on marriage

**Figure 14: Marital status of respondents**

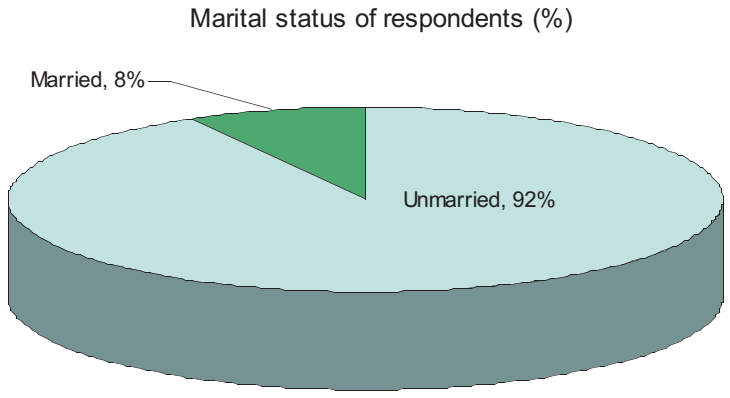
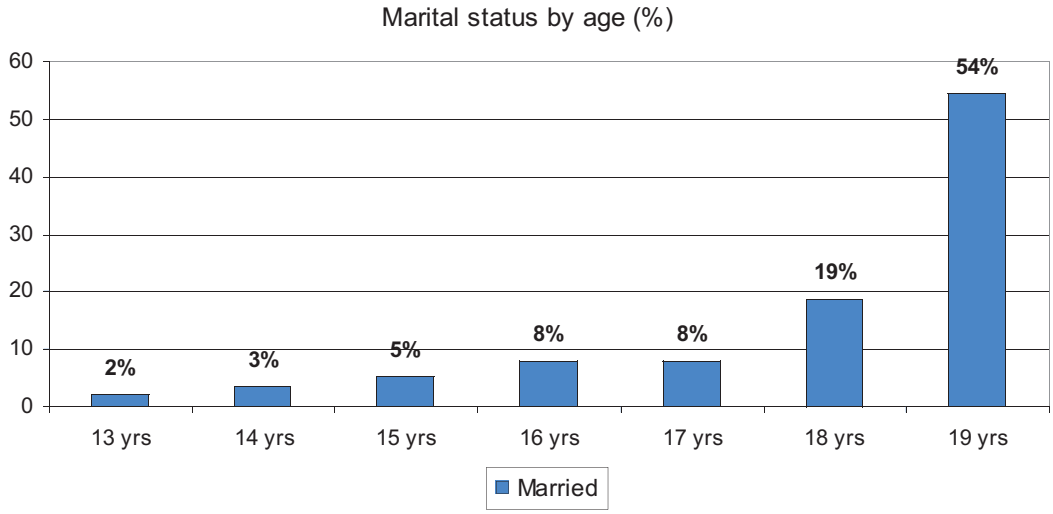
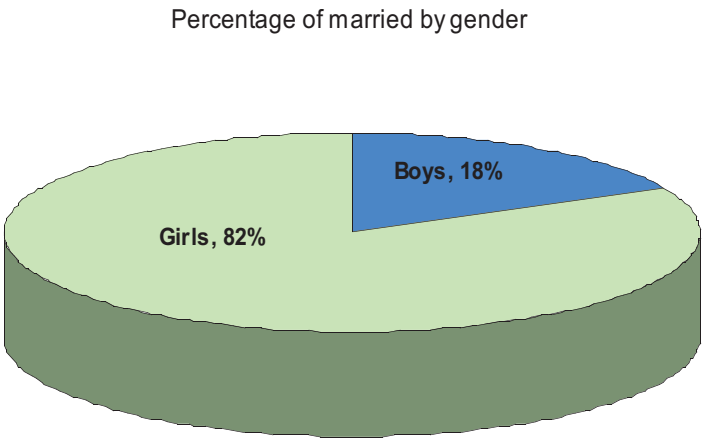


**Figure 15: Marital status by age**



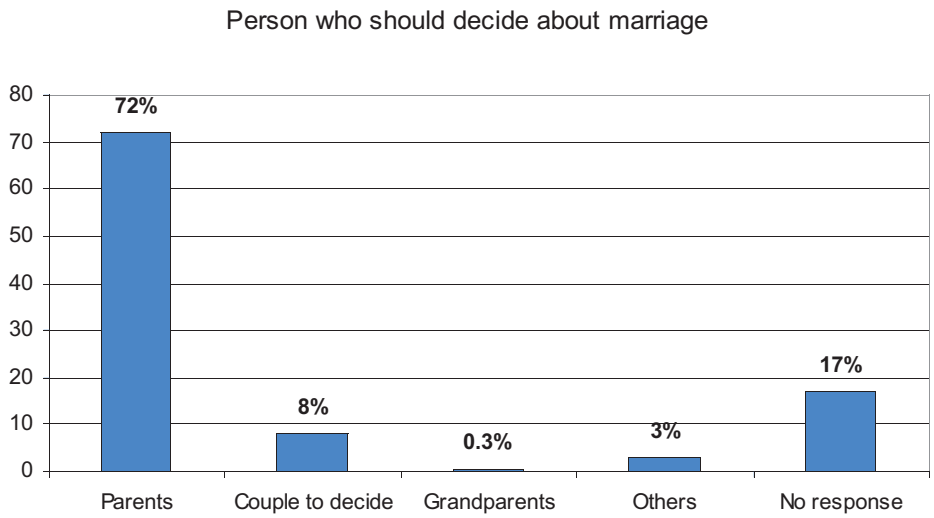

The percentage of married respondents was found to be 8% out of which more than half (54%) were 19 year old and 19% were 18 years old. The percentage of younger married respondents was 2% for 13 year olds and 3% for 14 year olds. 5% married respondents were 15 years of age and 8% each for 16 and 17 year olds.

**Figure 16: Marital status by gender**




Break up of married respondents by gender showed that 82% were girls whereas 18% were boys.

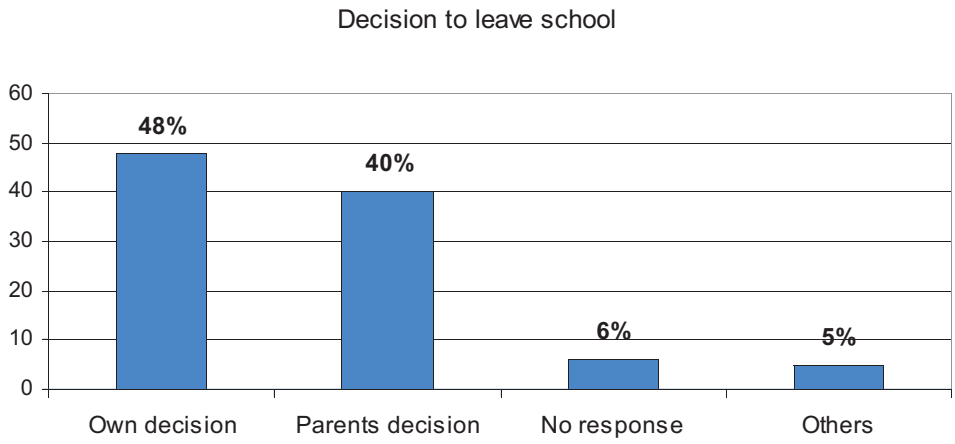
**Figure 17: Person who should make decision on marriage**




The trend of accepting the traditional way of arranged marriages is still preferred by adolescents. 72% said that the decision about marriage should be made by the parents and only 8% said that the couple should decide.

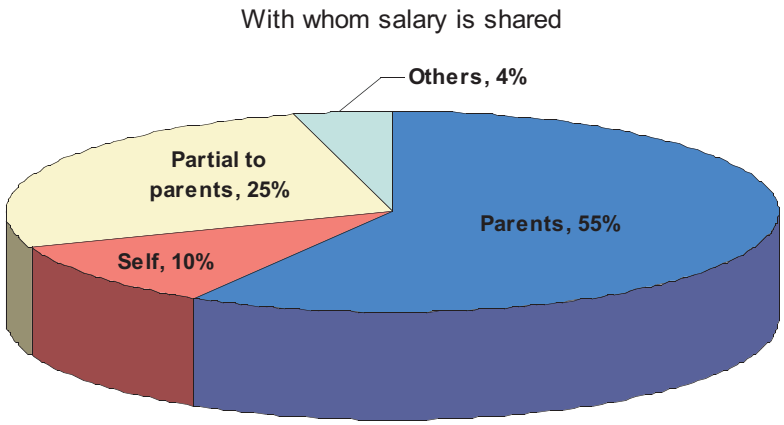
## 5.2.2 Parental pressure

**Figure 18: Decision to leave school among dropouts**




The respondents who had dropped out of school were asked whose decision this was. Nearly half of them (48%) said that it was their own decision whereas 40% said that it was their parents' decision. 6% did not respond.

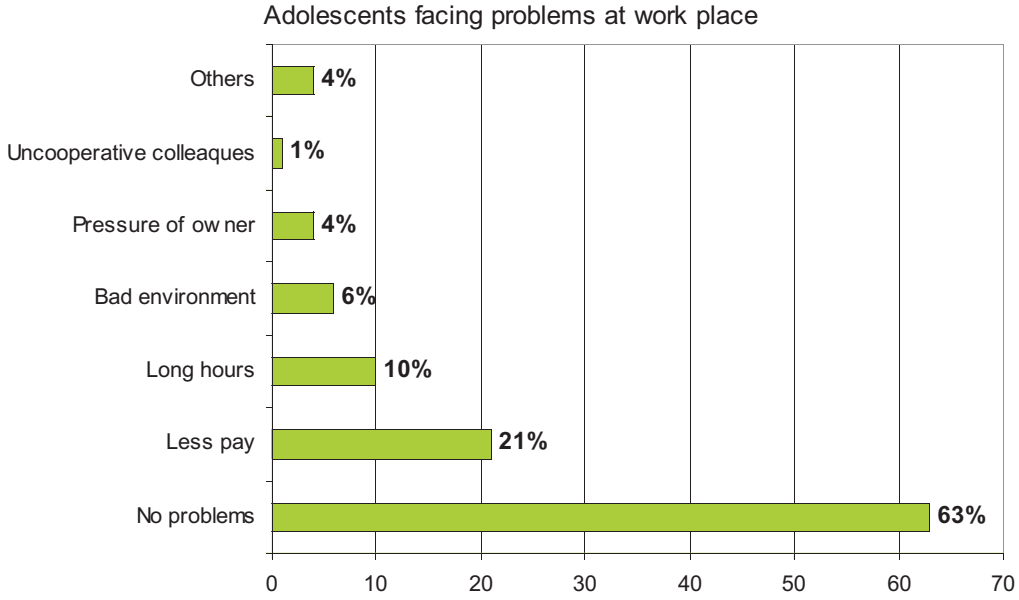
**Figure 19: With whom salary is shared**




The respondents who work for pay were asked whether they had to share their income with someone or they could keep it all to themselves. More than half (55%) said that they give all their income to their parents and 25% said that they only give partial income to their parents. Only 10% were those who keep it all to themselves.

### 5.2.3 Main problems faced by teenagers

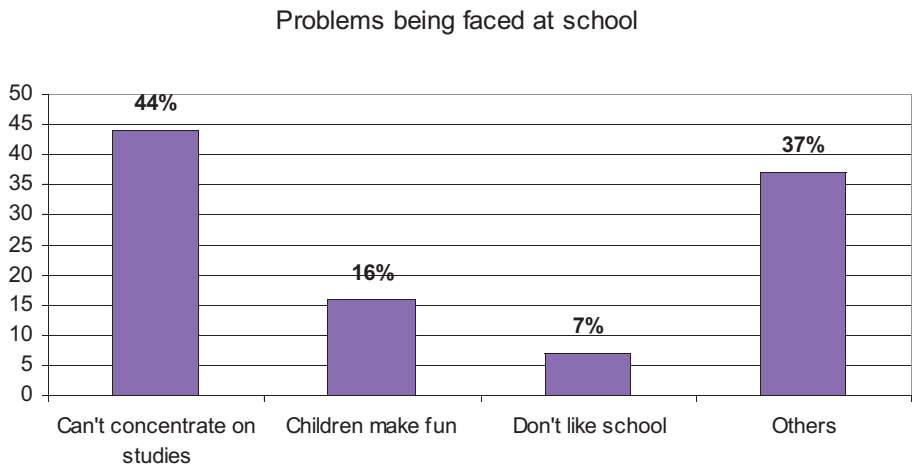
**Figure 20: Adolescents facing problems at work**




The responses of working adolescents regarding problems at the work place show that a vast majority (63%) do not have any problems however the rest did mention some problems like, less pay (21%), long hours (10%), bad environment (6%), pressure of owner (4%) and uncooperative colleagues (1%).

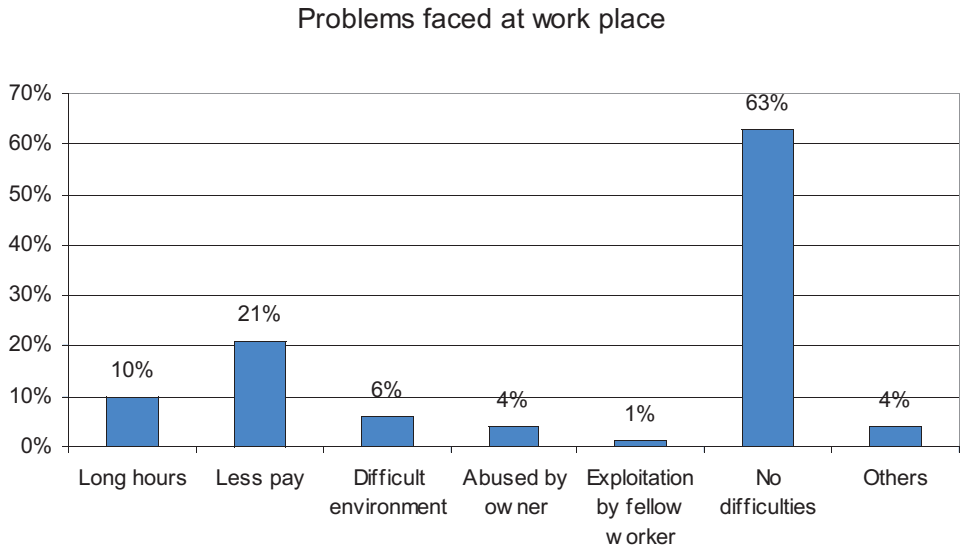
### 5.2.4 Problems at School

**Figure 21: Problems being faced at school**




The reasons adolescents gave for not liking school were that they could not concentrate on studies (44%), children make fun of them (16%) and that they did not like school (7%). Among the 37% responses for other reasons, some of the main reasons given were that the attitude of the teacher wasn't good and school was far off.

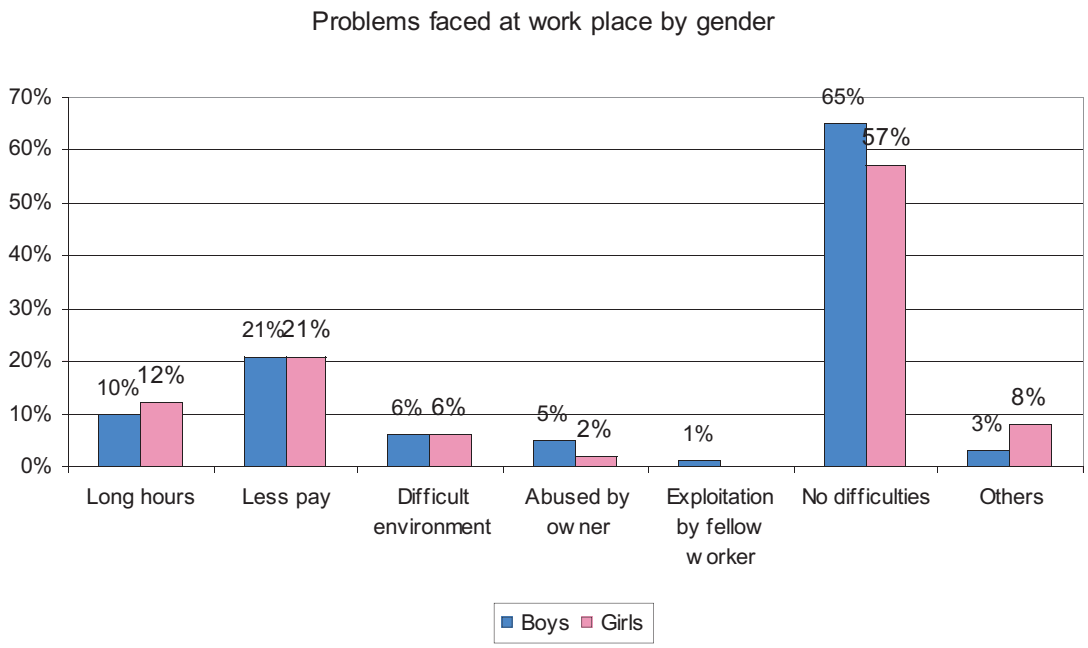
**Figure 22: Problems faced at workplace**




The adolescents who did jobs were asked if they faced any problems at their workplace. Majority (63%) said that they did not have any problems. Rest of the respondents had some problems. 21% were not happy with the pay they were getting and 10% complained about the long hours. 6% said that it was a difficult environment and 4% were being verbally or physically abused by their owners. Only 1% said that they were being

exploited by their fellow workers.

**Figure 23: Problems faced at workplace by gender**




Comparing boys with girls the difficulties at work place are more or less the same for both. In both cases the majority have said that they don't have any problems.

## 5.2.5 Findings & Analysis

Life skills in adolescents like decision making, problem solving and critical thinking were looked through important life decisions like marriage and dropping out of school. Parents' role was discussed in making decisions, sharing income and the perception of adolescents about it. The trends of early marriages among girls and acceptance of traditional practices of arranged marriages were prominent. Influence of parents in forcibly dropping their children out of school and sharing of income can also be seen.

For assessing life skills for problem solving, decision making and critical thinking, hypothetical situations were discussed with the adolescents like what they would do if a loved one was in need of blood. Most knew the requirements of getting clean healthy blood and the dangers of avoiding blood from addicts and professional donors. Testing of blood for diseases before transfusion was mentioned however some thought testing was required for compatibility. They preferred blood from relatives.

*"Buying blood from a good laboratory would be safe".* (Orphan girl)

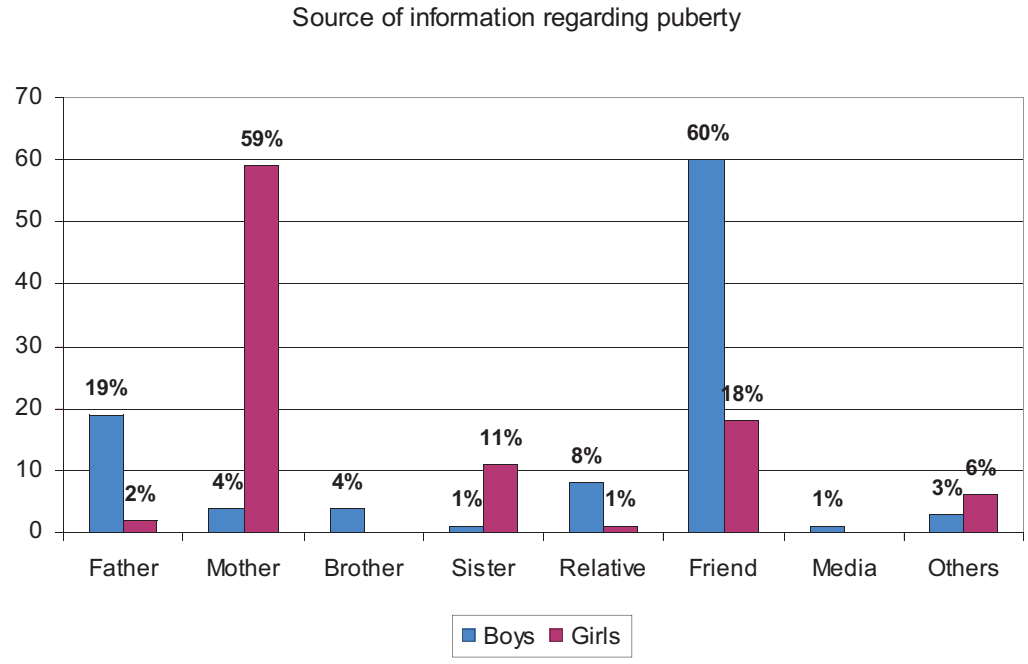
While discussing dangers of blood transfusion the respondents mentioned that diseases like AIDS, hepatitis, malaria, asthma, TB, typhoid and cancer can be transmitted through untested blood.

On having sex with a stranger or commercial sex worker, the respondents mentioned AIDS which could be avoided if a condom is used. Some respondents said that such acts are a sin, work of satan and against the teaching of Islam, if such an act is committed the person will be punished by God. There was a danger of getting caught, a person could be arrested by police and this would bring a bad name to the family. A married man if infected could transfer the disease to his wife and subsequently to his children. However a respondent thought that there was no danger as long as you are not caught. In other countries commercial sex workers are given certificates that they are free of disease but this is not practiced in Pakistan.

Apart from the factors already mentioned earlier some respondents mentioned that food touched by AIDS patient should not be eaten. There should be a complete ban on pornography and children should not be allowed to visit internet cafes. Generally food sold in the market and especially food which stimulates sexual desires should be avoided. One respondent said that the vulnerable groups should be shunned from the society and then mentioned how he had been responsible for the expulsion of a sex worker from his street.

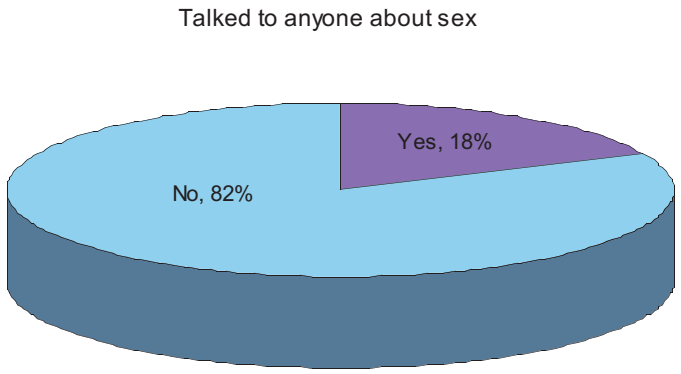
## 5.3 Communication and Interpersonal Relationships

**Figure 24: Person who informed about puberty**



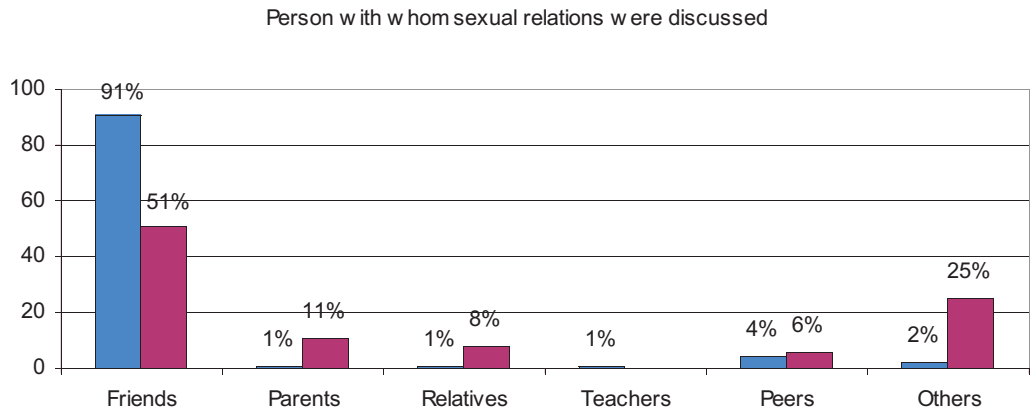

In case of respondents who had reached puberty and had been informed about it, the person who had informed them was their mother (59%) for girls and friend (60%) for boys. Only 19% boys said that they had been informed about it by their fathers. The main source of information for boys which was friends was very low in case of girls (18%).

**Figure 25: Talked to anyone about sexual relations**



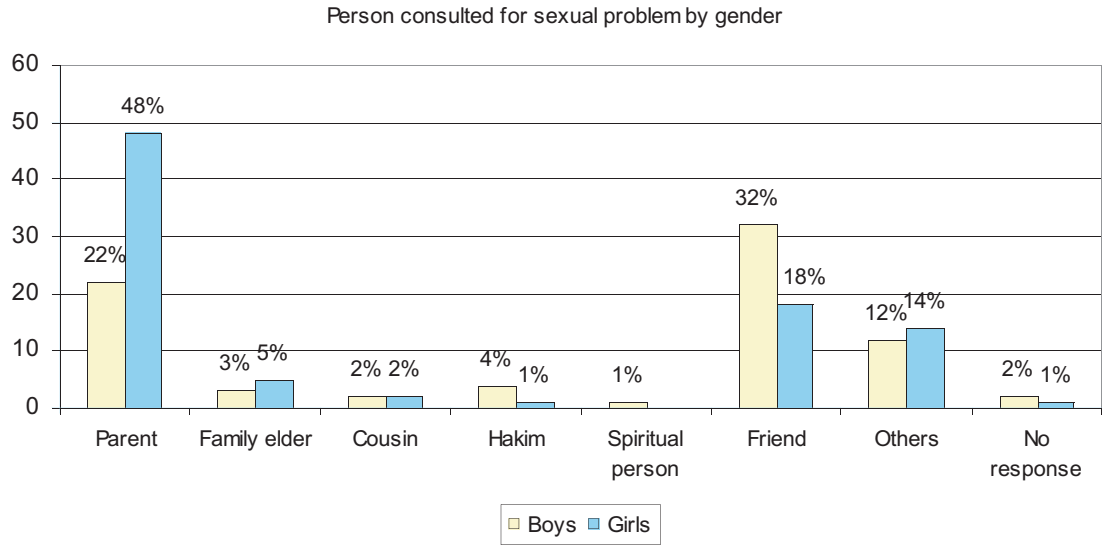

Only 18% respondents said that they had talked to someone about sexual relations.

**Figure 26: Person with whom sex was discussed by gender**



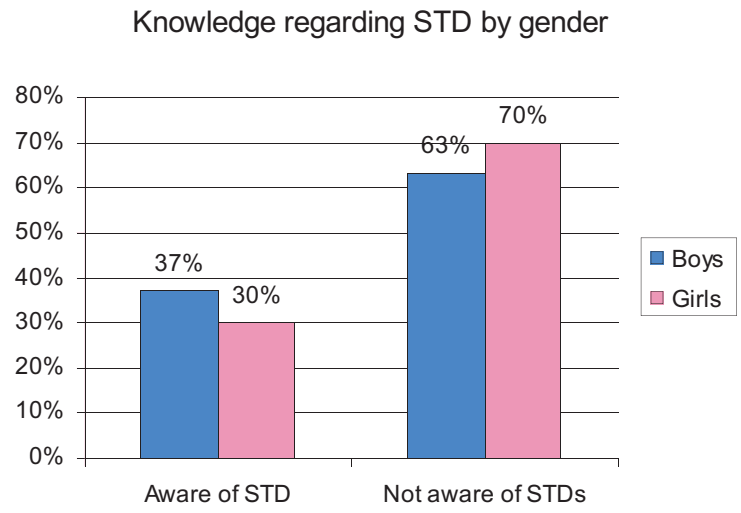

Nearly all the male respondents (91%) who discussed sexual relations with someone had done it with friends whereas only half of the girls had discussed sexual relations with friends. Girls had also discussed them with parents (11%), relatives (8%) and peers (6%).

**Figure 27: Person consulted for sexual problems**



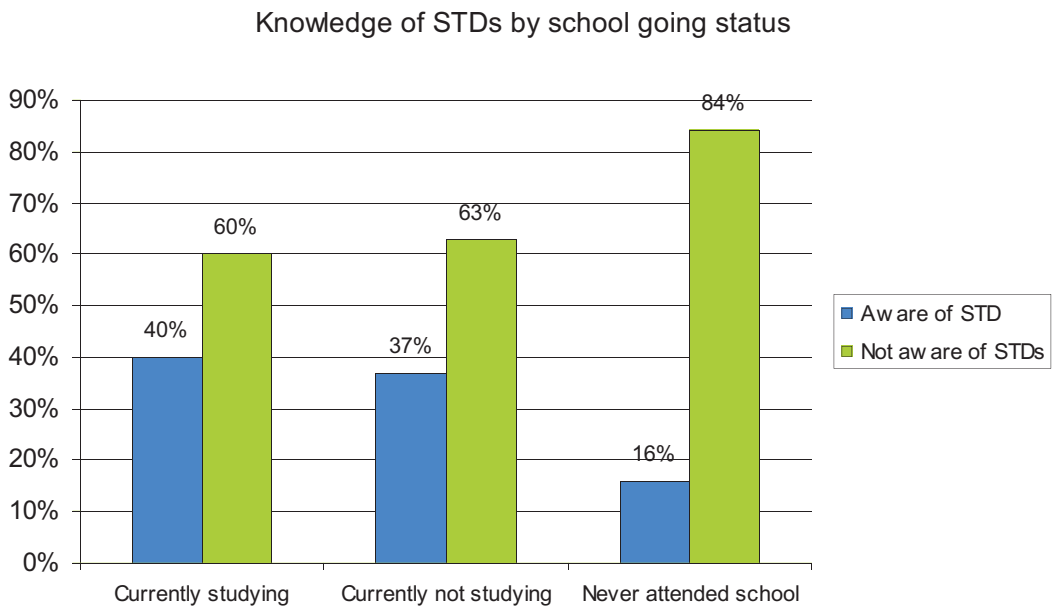

Parents in case of girls and friends in case of boys were the preferred people with whom the respondents had discussed their sexual problems. 48% girls had discussed their sexual problems with a parent whereas only 22% boys preferred a parent for such a discussion. On the other hand 32% boys said that they discussed their sexual problem with a friend and only 18% girls had mentioned a friend.

**Figure 28: Knowledge regarding STD by gender**



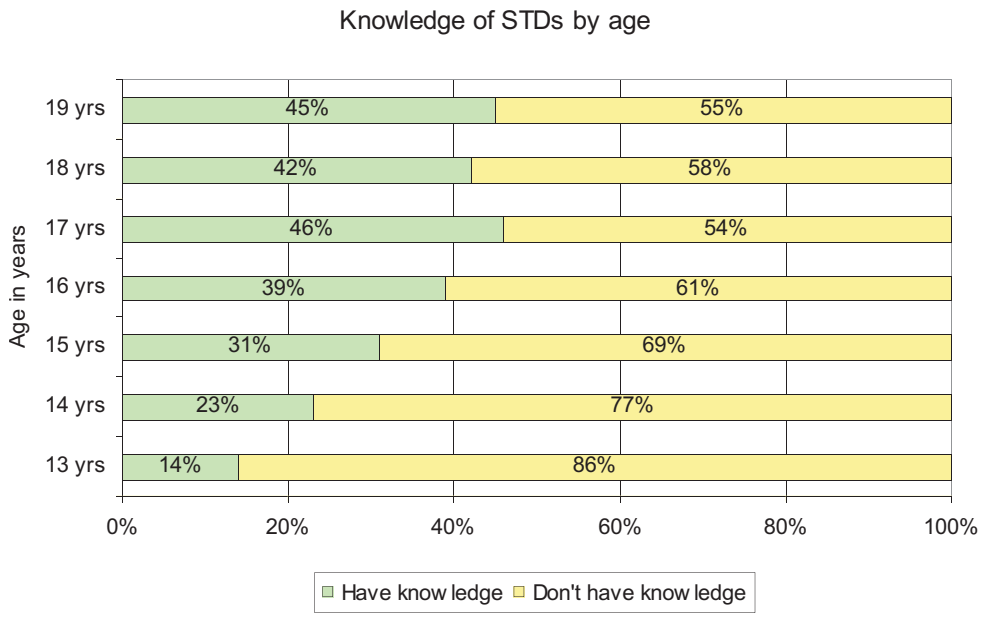

More than half of the male respondents (63%) and nearly a quarter of the female respondents (70%) said that they were not aware of the sexually transmitted diseases (STDs).

**Figure 29: Knowledge regarding STD by school going status**




A vast majority of respondents who had never attended school (84%) were not aware of STDs. Among the ones who were attending any school or college 60% said that they did not know. Among the school dropouts 63% were not aware of STDs.

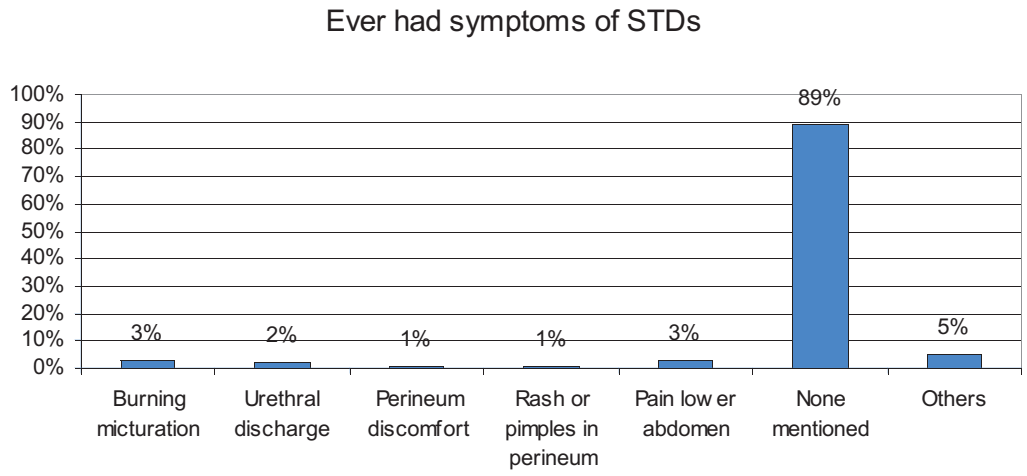
**Figure 30: Knowledge of STDs by age**




Awareness regarding sexually transmitted diseases increased with increase in age. Only 14% of the 13 year olds were aware of STDs. This proportion rose to 23% among 14 year olds, 31% among 15 year olds, 39% among 16 year olds and nearly half (46%) of 17 year old respondents. Among the 18 and 19 year old group the proportion of respondents who

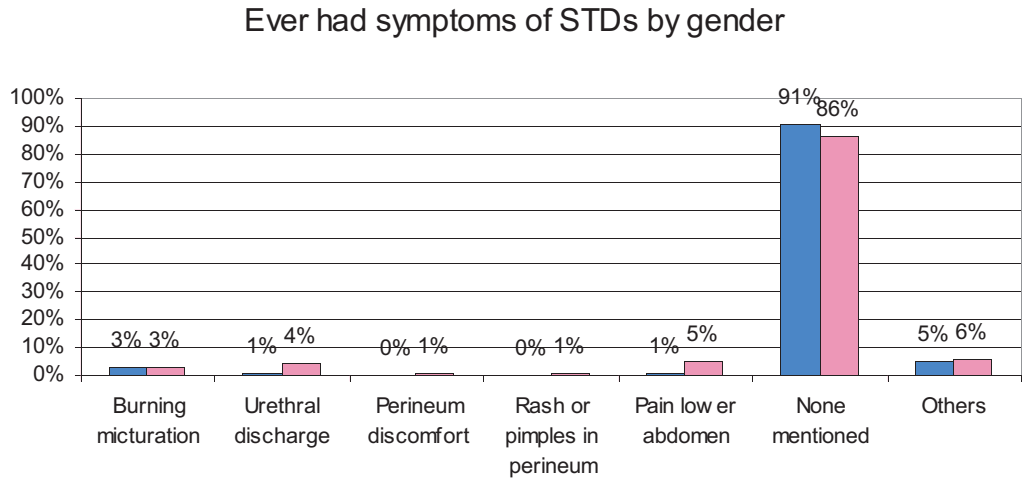
were aware of STDs was 42% and 45% respectively.

**Figure 31: Ever had symptoms of STDs**



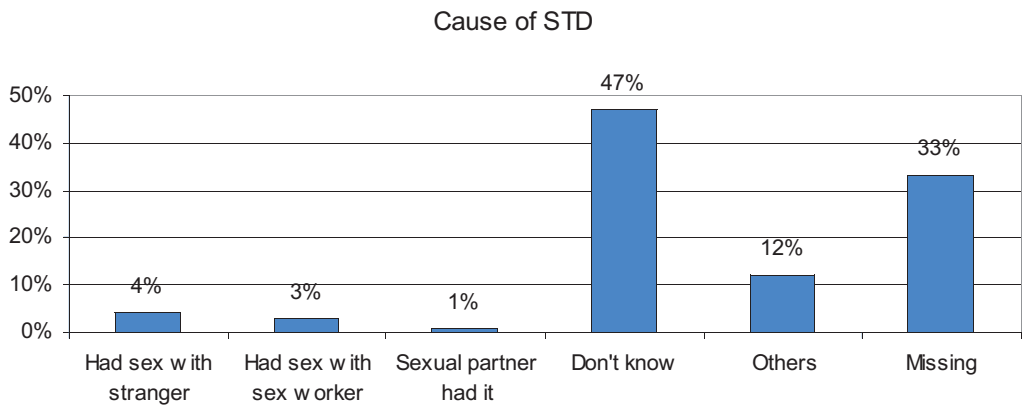

A very small proportion of respondents admitted to ever having symptoms of STDs and 89% said that they had never experienced any of the symptoms mentioned.

**Figure 32: Ever had symptoms of STDs by gender**




Breakup by gender also showed that a very small proportion of boys and girls ever experienced any of the symptoms mentioned. Only 5% girls mentioned that they had experience lower abdominal pain.

**Figure 33: Cause of STD**




Among the ones who had mentioned that they had experienced any of the symptoms mentioned nearly half (47%) had no idea what had caused the disease. However 4% said that it was the result of having sex with a stranger, 3% said that they had sex with a commercial sex worker and 1% said that they had been infected by their sexual partner.

### 5.3.1 Findings & Analysis

Healthy interpersonal relationships build on effective communication. The survey has tried to see how well the adolescents communicate with the people in their lives and for issues and problems faced by them. When adolescents are willing and able to express themselves and share their thoughts and events, misunderstandings melt away. Strong communication skills improve interpersonal relationships and help in resolving conflicts encountered in day to day life.

Few adolescents said that they had discussed their sexual events and problems with anyone. Some females said that it was shameful and very difficult to discuss such matters with anyone. However others mostly mentioned mothers and sisters with whom they had discussed such matters. Among the males, friends were the group with which they could talk about sexual issues. In case they did suffer from a sexual problem the respondents mentioned doctors or other healers in addition to the family members mentioned earlier.

Talking about type of friends or contacts who could place a person at risk of HIV infection, mostly respondents said that people like smokers, drug addicts, people who drink and commercial sex workers were the type of people who should be avoided. In general bad company should be avoided and you should choose good friends.

Talking about prevention from HIV infection, the respondents were of the view that adherence to religious practices could keep a person safe from such diseases. Religion provides complete guidance in the form of teachings in the holy Quran. Offering namaz and spending your life according to the Islamic principles is a way which can be

protective. Some were of the view that the custom of early marriages could also be protective.

Disabled youth especially those who are devoid of the ability to speak and hear are at a disadvantage when it comes to mass media communication. Although these adolescents are physically and mentally normal and in most cases very intelligent, their handicap at communication with the outside world may put them at a loss during awareness campaigns. Focus group discussions with deaf and dumb adolescents was an opportunity to communicate with them and try to assess their life skills inspite of their handicap. The moderator communicated with the group through an interpreter of sign language and also by writing on the board.

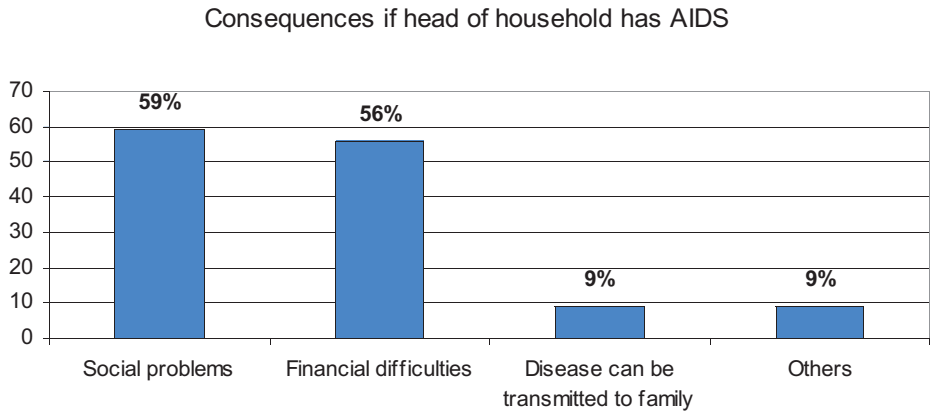
*"Only men can have AIDS and a person can be safe from HIV/AIDS if he cuts his nails and takes regular bath".*
(Deaf and dumb girl)

It was encouraging to see that these special adolescents were very eager to participate in the discussions. The initial confusion and curiosity turned into a useful discussion. During the initial discussions about growing up, girls showed their discomfort with changes during growing up like the onset of menarche and restrictions imposed on them by the male family members.

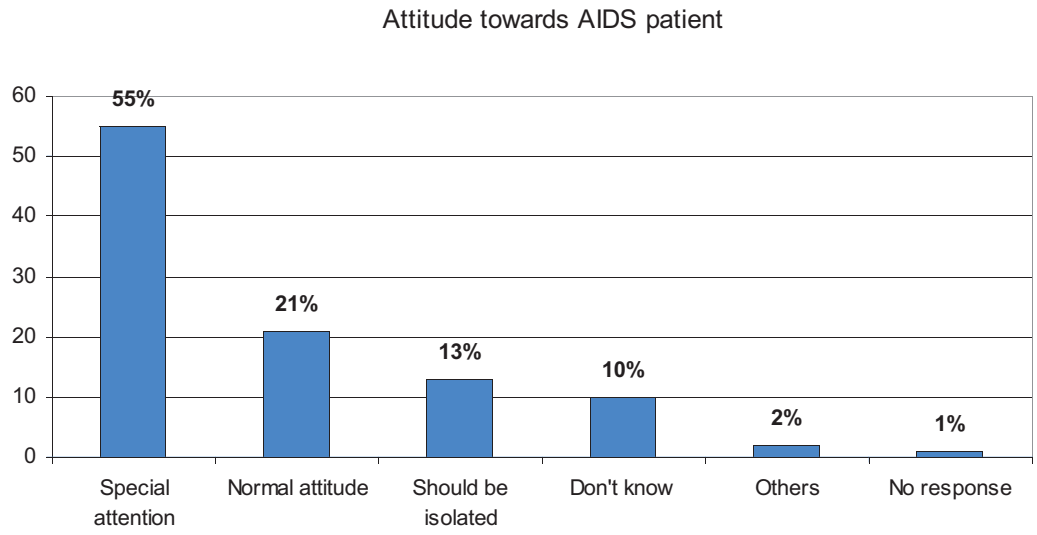
The group knew that AIDS was a deadly disease but their knowledge about the means of spread of the disease was poor. In their opinion AIDS could be spread by close contact with a patient like flu and can be treated by a doctor.

## 5.4 Empathy

**Figure 34: Consequences to Household if Head has AIDS**




Social and financial problems were quoted as the main issues a family will have to face if the head has AIDS. 59% responses were that the family will be facing social problems and 56% responses were for financial difficulties. Very few (9%) were for danger of disease transmission.




More than half (55%) of the respondents were in favor of special attention towards an AIDS patient. 21% said that such a person should be treated normally. Only 13% favored something drastic like isolation of the patient.

### 5.4.1 Findings & Analysis

Generally the respondents expressed sympathy for patients of AIDS. The perception was that the family with a person suffering from AIDS would have social and economic problems. There was also a danger of disease transmission to the other members of the family. The view of respondents to give special treatment to such patients was shared by majority.

*"We can be safe from AIDS if we maintain good personal hygiene, clean the house properly, don't associate with an AIDS patient and don't eat and drink with him".* (Orphan boy)

Discussing the consequences of HIV infection for a family or community the respondents said that the family of such a person would be devastated with grief and there would be a big economic burden on them. Some of the respondents had a sympathetic view of the situation and said that such a person should be given more attention while others said that we should keep away from such a person and not even share his or her utensils.

*"What can we do for a person suffering from AIDS? We can pray for him and take him to a doctor".* (Street boy)

The respondents said that such patients should be treated with care and sympathy as it is possible they got the disease due to ignorance and not due to some ill act. "They are already suffering and we should do everything we can to help them however it is important to be careful so that the disease is not

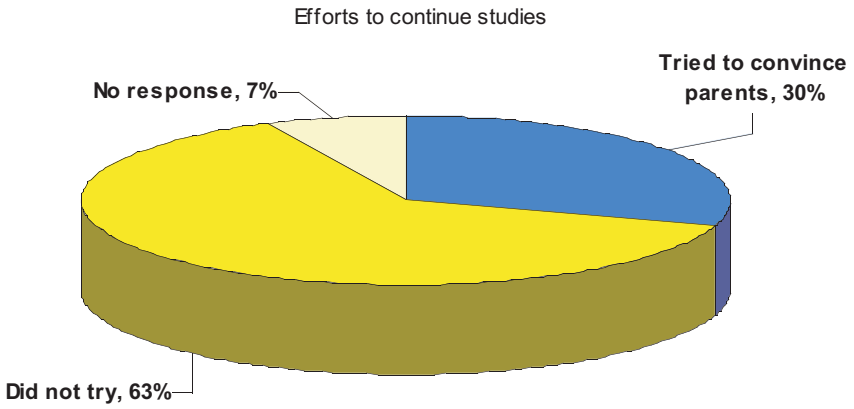
*"Even if a close friend has AIDS we will stay away from her so that the disease is not transferred to us. To avoid getting AIDS we will not go close to a person suffering from AIDS".* (Orphan girl)

transmitted".

Discussing the feelings of the patient the respondents felt that he/she must feel very depressed as they knew that they would die. Patient should seek forgiveness for his/her sins. One respondent was of the view that such patients should not be told of their condition as this would be very hard for them to face and they would feel lonely and frustrated.

## *5.5 Coping with Stress and Emotions*

### 5.5.1 Handling disagreement with parents




Less than a third (30%), tried to convince their parents that they wanted to continue with their studies among those who had been asked by their parents to leave school.

### 5.5.2 Extreme behavior of family members

**Figure 35: Going out of home alone**

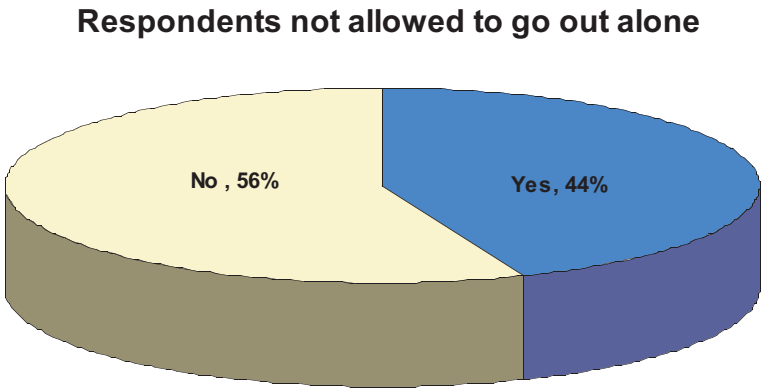
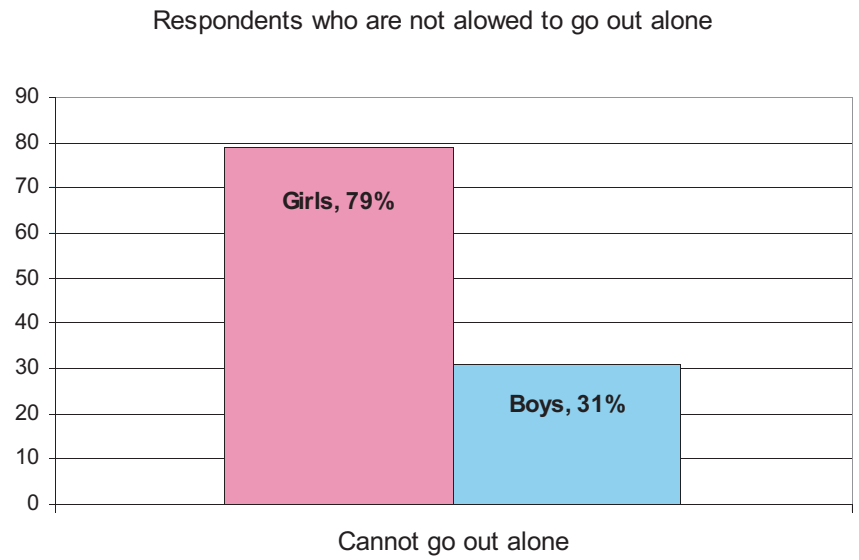
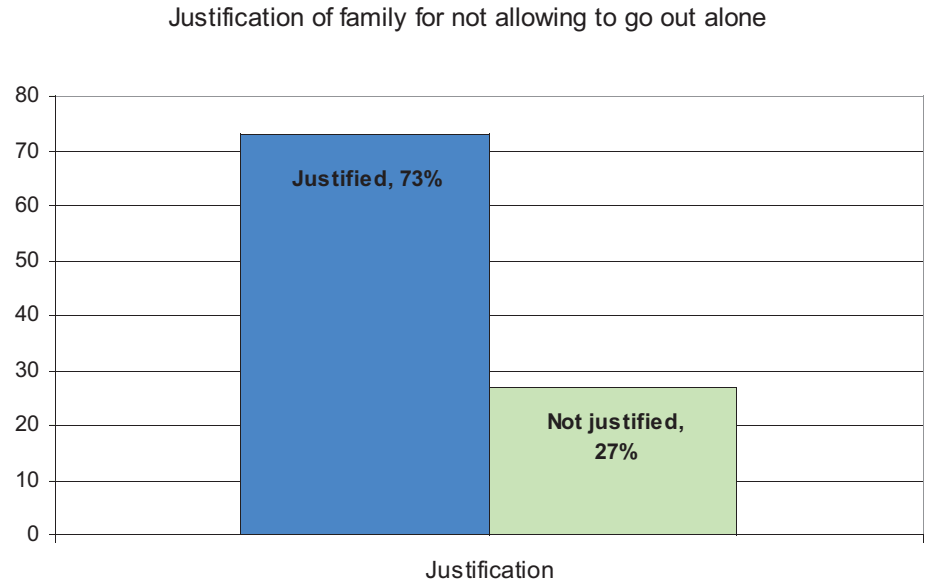


**Figure 36: Going out of home alone by gender**



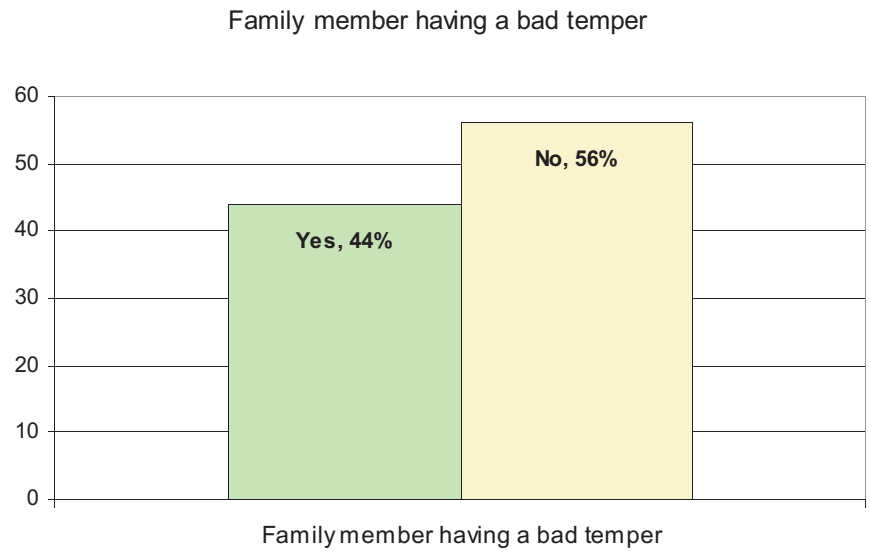

More than half (56%) of the respondents were not allowed to go out of their home alone. Among them a vast majority (79%) were girls.

**Figure 37: Family justified for not allowing respondent to go out alone**



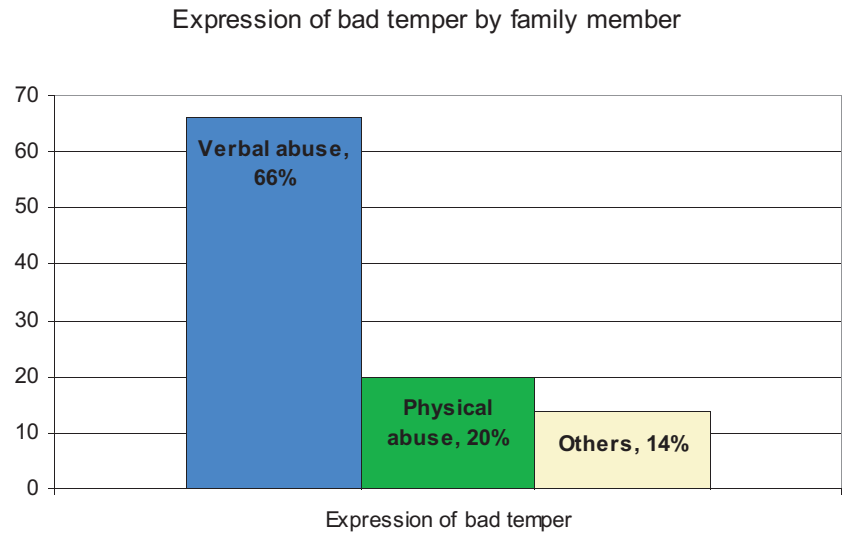

Majority of the respondents (73%) who were not allowed to go out alone by their parents said that their parents were justified however over a quarter (27%) said that they were not justified.

**Figure 38: Family member having a bad temper**



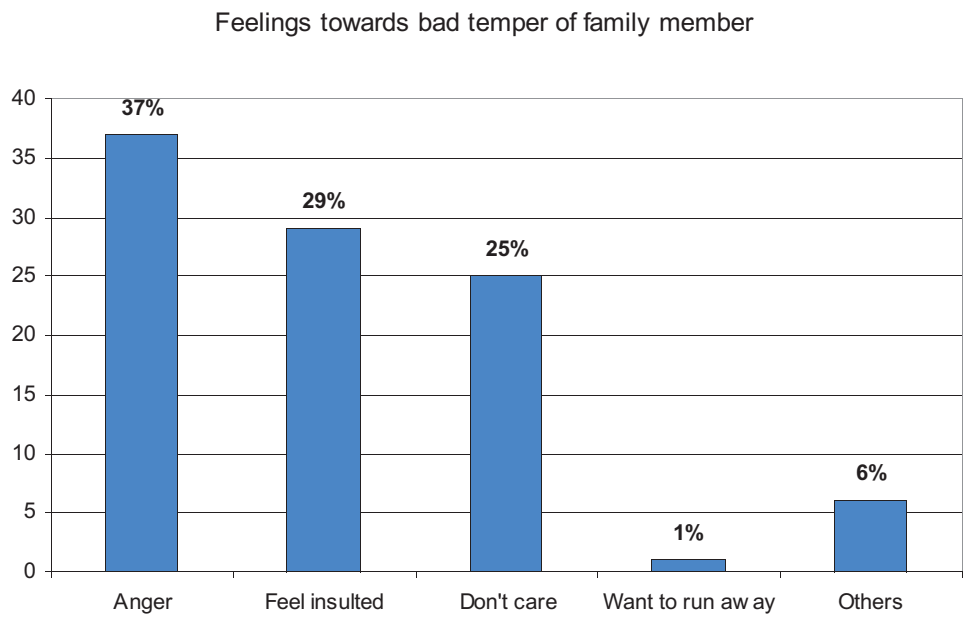

More than half (56%) respondents said that their families did not have a person with a bad temper however in 44% cases a person with a bad temper was present in the family.

**Figure 39: Expression of bad temper by family member**



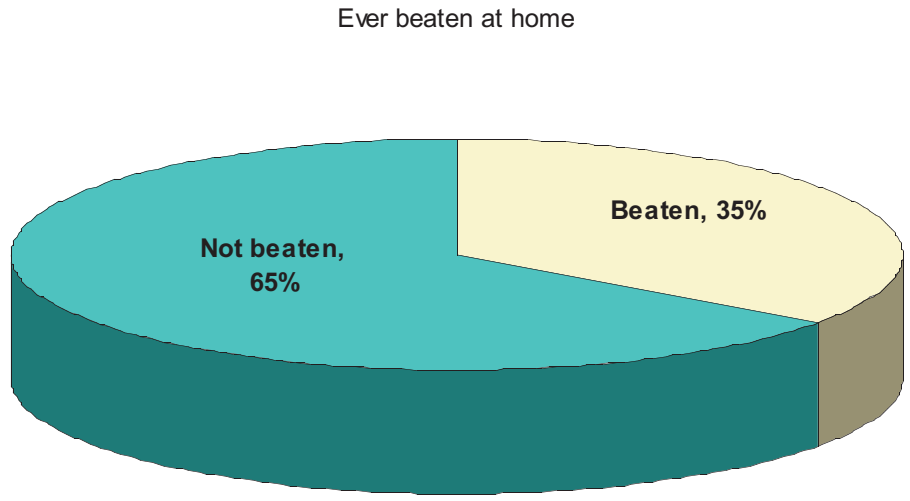

Less than a quarter of the respondents who had a bad tempered person at home said that the person expressed his/her temper with physical abuse. Majority (66%) said that it was verbal abuse only.

**Figure 40: Feelings towards bad temper of family member**



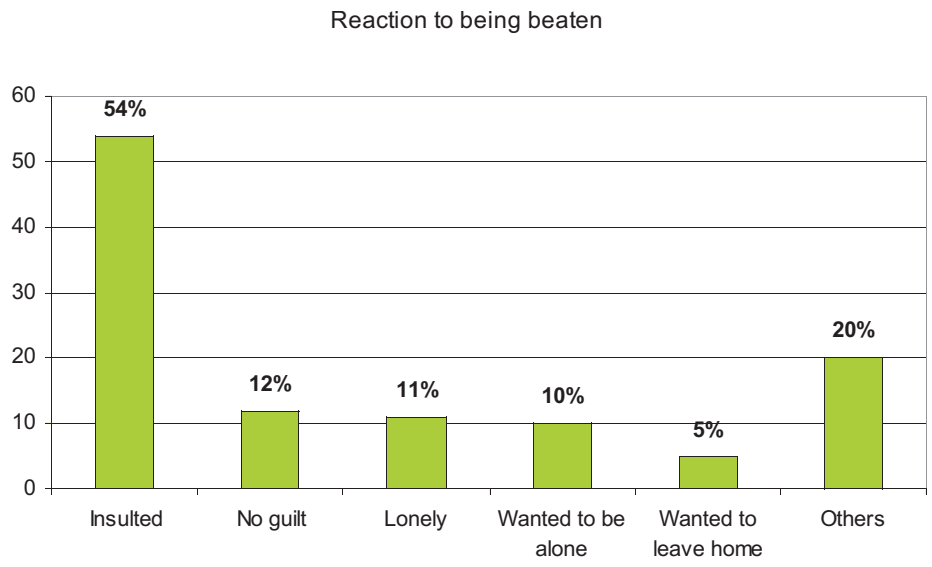

Majority of the respondents either felt anger (37%) or felt insulted (29%) in response to bad temper of a family member. However a quarter (25%) did not care. A very small proportion (1%) expressed extreme ideas like running away from home.

**Figure 41: Ever being beaten**




Majority (65%) had never beaten at home by their parents or family elders however 35% said that they had received a beating at home one time or the other.

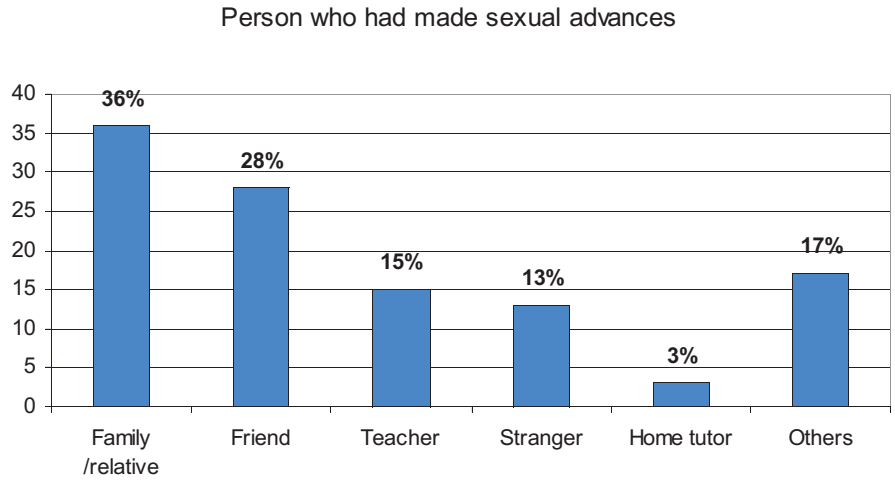
**Figure 42: Reaction to being beaten at home**




After being beaten more than half (54%) of the responses were of feeling insulted. A few (12%) responses were that they did not feel any guilt. 21% responses were either for being alone or feeling lonely. Some even said that they had thought of leaving home (5%).

## 5.5.3 Dealing with sexual advances

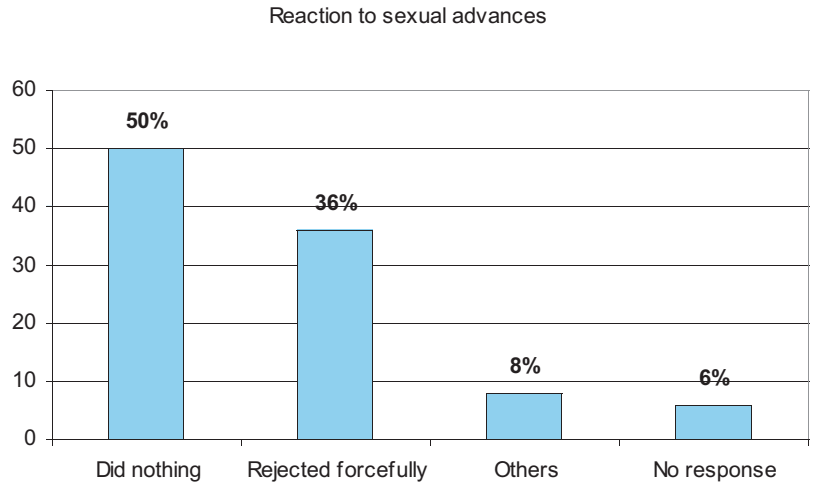
**Figure 43: Person who had made sexual advances**




A very small proportion (3%) of respondents had been touched sexually by someone and the same proportion (3%) were not sure if such an incidence had every happened. The majority of responses (36%) for person who had touched them sexually were for family

or relatives. Friends were mentioned in 28% cases and teachers in 15% cases. There were incidences where these advances had been made by a stranger (13%). Among the others family friends or strangers were mentioned.

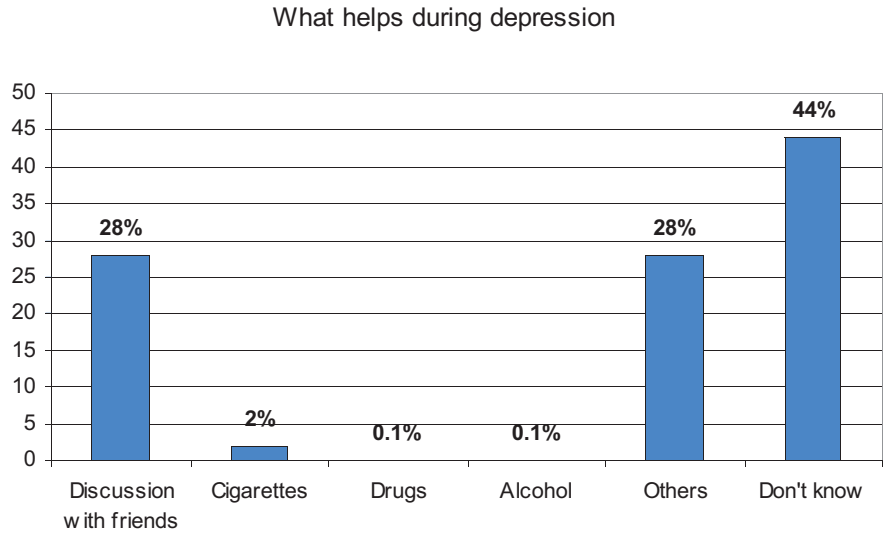
**Figure 44: Reaction to sexual advances by someone**




Half of the respondents (50%) who had experienced inappropriate physical contact by someone did not do anything about it, however 36% reacted by forcefully rejecting such advances.

## 5.6 Dealing with depression

**Figure 45: What helps during depression**




Majority of the respondents (44%) did not know or did not want to respond when asked what helps them during depression. A little over a quarter (28%) said that they discuss it with their friends. Very few cases were for cigarettes, drugs or alcohol. Among the 28%

responses who mentioned others the most frequent were playing games especially cricket, listening to music and praying.

**Table 3: Succumbing to peer pressure**

| No. | Responses | Count | Percent of Cases |
|---|---|---|---|
| 1 | Cigarette smoking | 89 | 2.3 |
| 2 | Drugs | 8 | 0.2 |
| 3 | Drinking alcohol | 5 | 0.1 |
| 4 | Sex with commercial sex worker | 19 | 0.5 |
| 5 | Sex with a man | 19 | 0.5 |
| 6 | Sex with a woman | 37 | 1.0 |
| 7 | None of the above | 1994 | 51.7 |
| 8 | All of the above | 198 | 5.1 |
| 9 | Don't know | 1402 | 36.4 |
| 10 | Others | 230 | 6.0 |
| **Total responses** | | **4001** | **103.8** |

Succumbing to peer pressure was something where majority of the responses showed resistance. In 52% responses the adolescents who were interviewed said that they would not indulge in any of the listed activities like cigarette smoking, taking drugs or alcohol, having sex with commercial worker or anyone due to peer pressure. However a very small proportion of responses (5%) confessed that they could indulge in all of the listed activities under peer pressure. A considerable proportion of responses (36%) did not know or were not sure.

### 5.6.1 Findings & Analysis

Coping with stress and emotions is probably the most difficult area which an adolescent has to go through during his/her transition from child hood to adulthood. Physical, physiological and emotional changes are playing havoc with the mind. Frustration and mood swings are common and if the adolescent is living in an unfriendly atmosphere the situation may become difficult to handle.

While feeling depressed the respondents mentioned a number of things which they do like watching TV, listening to music or going out with friends to eat or to the cinema. Some were of the view that the best way to beat depression is by praying, offering namaz and reading the holy Quran. Even keeping quiet and keeping to oneself was mentioned. One respondent said that they were poor people and there was nothing much they could do except pray to God. Sleeping and crying were also ways of fighting depression. None of the respondents admitted to any adverse solutions like smoking, taking drugs or drinking. Even when they were asked if

*"I used to work for a wealthy family in Peshawar. One day when the children were in school and the man of the house had gone out of the city my mistress called me to her bedroom and asked me to have sex with her. At first I refused but she tore my clothes off and forcibly had sex with me. Later she told me that if ever I told anyone she would have me arrested for raping her. I left the job as soon as I got the opportunity".* (Refugee boy)

they would indulge in such practices if their friends insisted and by refusing it would seem they were being cowardly they were firm that they would rather give up such friends than agree to smoking, taking drugs or alcohol.

*"I worked as a domestic servant in a house. One boy in the family used to constantly offer me money and clothes if I had sex with him. I kept on refusing and ultimately had to give up the job".* (Street girl)

Exposure of working children including domestic servants to sexual advances by their employers was mentioned by the respondents. Street children were also vulnerable to sexual assault from strangers. During focus group discussions with street adolescents a group member mentioned that his friend had been approached by a police officer who offered him money for having sex with him. A refugee boy was fired from his factory job because he reported to the manager that the supervisor had offered him Rs. 500 for having sex with him.

Video shops where youngsters hang out were mentioned to be one of the favorite spots for sexual offenders looking for their prey.

Generally it was seen that working adolescents whether they were refugees, street children or domestic and factory workers were at a greater risk of being sexually assaulted or were exposed to drug addiction.

## *5.7 Risk Behavior*

### 5.7.1 Drug /alcohol use

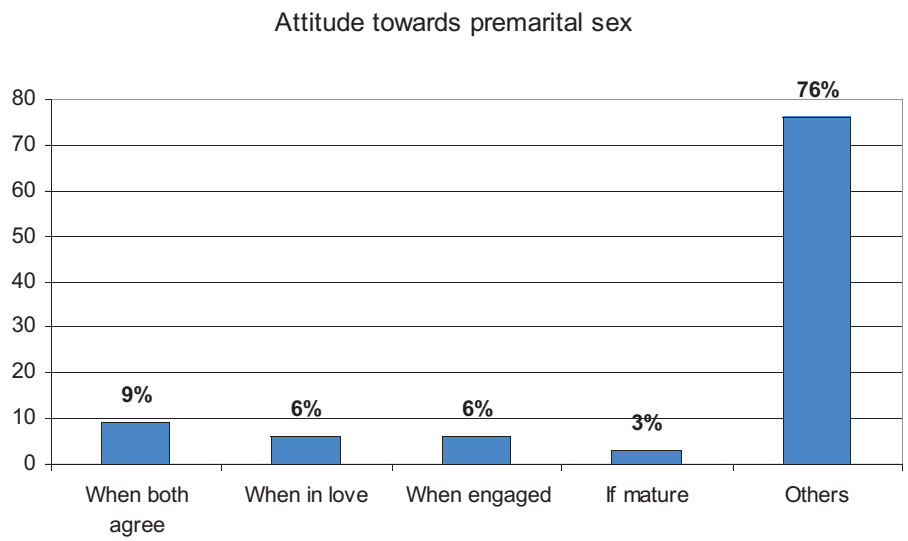
**Table 4: Use of drugs or alcohol**

| Behavior | Frequency N= 3869 | Percent |
|---|---|---|
| Take drugs | 45 | 1.2% |
| Drink alcohol | 14 | 0.4% |

Only one percent of the respondents admitted that they had taken drugs and even less than one percent said that they had taken alcohol.

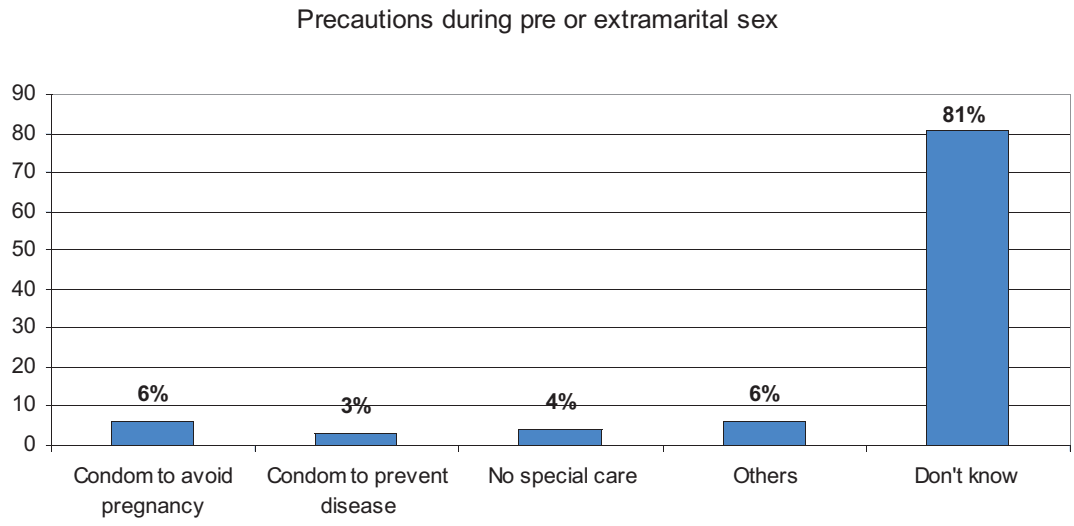
## 5.7.2 Attitude toward premarital sex

**Figure 46: Attitude towards premarital sex**




Very few respondents were in favour of premarital sex. 9% said that pre marital sex was justified when both partners agreed, 6% each said that it was justified when they were in love or when they were engaged and 3% said it was alright to have premarital sex if they were mature. Nearly all the respondents who had opted for the others option (76%) said that they did not agree with premarital sex under any circumstances and sex should be avoided until marriage.

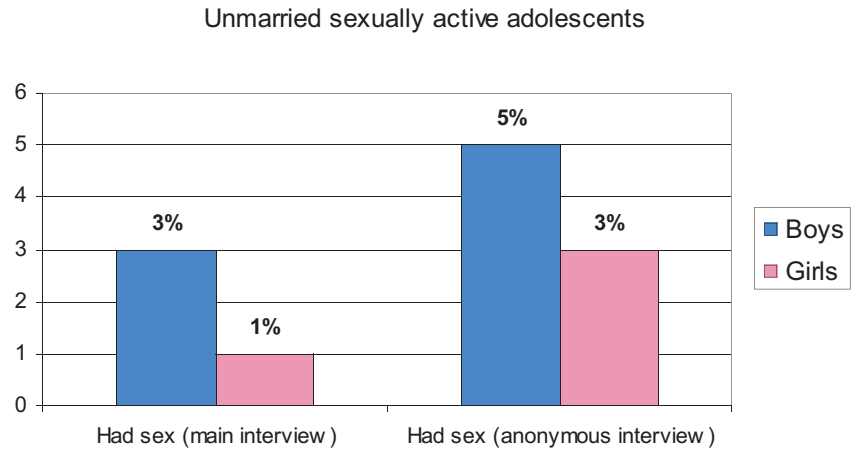
**Figure 47: Preventive measures for pre or extra marital sex**




A very high proportion of respondents (81%) said that they did not know if any precautions were necessary during pre or extramarital sex. Only 3% mentioned use of condom to prevent disease. 6% said that condom should be used to avoid pregnancy and 4% thought that there was no need of any precaution.

## 5.7.3 Unmarried Adolescents' sexual behavior

**Figure 48: Unmarried adolescents who are sexually active**




During the face to face interview administered by an interviewer, very few unmarried adolescents both boys (3%) and girls (1%) said that they had sex with someone. However during the anonymous interview which was self administered by the respondent the percentage rose for boys from 3% to 5% and for girls it rose from 1% to 3%.

## 5.7.4 Findings & Analysis

A very small percentage of respondents agreed to ever having some sort of drugs or some sort of sexual experience. There was a slight rise in percentage of respondents admitting to pre marital sex in the anonymous questionnaire however this was a very small percentage.

Very few adolescents interviewed admitted to ever having tried out drugs or alcohol or had any experience in sex themselves but many especially refugees and street children admitted to have seen or come across drug addicts regularly. Some even had uncles or close relatives who were addicted to some drug. In most cases charas (hashish) and naswar were mentioned. Among the groups of refugee children nearly all came across drug addicts on a daily basis. They even mentioned that drugs were easily available inside the camps. A girl related a story how her uncle was addicted to heroine and ultimately died of it.

*"One day a friend of mine went to a neighbor's house and found that only one of the sons was present alone in the house. He offered her tea which she refused but he kept insisting so she drank it. As soon as she drank the tea she fell unconscious and the boy raped her".* (Refugee girl)

Talking about premarital sex, a girls point of view was that it should be avoided because if a girl has sexual relations with a boy and later is married to some one else there could be problems for the girl

*"Premarital sex can cause AIDS and it is a sin in Islam. The life of a girl can be spoiled. We can take the example of a rotten egg once it is bad there is no way it can be cleaned".* (Orphan girl)

if her husband found out. She would lose her respect with the in laws.

During the discussions with street adolescents it was mentioned that railway station and its surroundings were a favorite spot for drug addicts to hang out.

#### 5.7.4.1 Findings and Analysis of Anonymous Interview

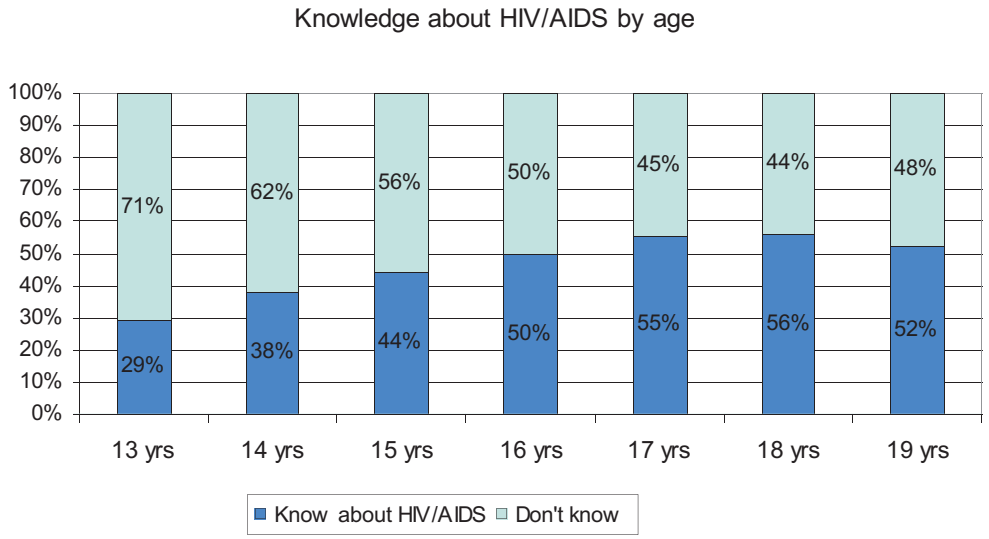
A total of 3700 respondents filled out the anonymous questionnaire. Out of these 1836 (49.6%) were males and 1864 (50.4%) were females. Among the males 5% had premarital/extramarital sex and among the females 3% had premarital/extramarital sex. Among the males the highest proportion (19%) who had sex were 14 year olds and 14% were 13 year old. As age advanced the proportion of respondents admitting to having sex dropped and the proportion of 19 year olds was only 4%. Among the females the highest proportion (26%) who had sex was 15 year olds and 15% were 13 year old. As among males as age advanced the proportion of respondents admitting to having sex declined and the proportion of 19 year olds was only 4%.

Among the male respondents 33% had relations with a commercial sex worker. About half (49%) knew about a condom but among them only 21% knew that condom was used for prevention of disease. Twenty six percent had used a condom during their sexual act. Out of these 28% used it for prevention of disease. Among the male respondents who did not use a condom during their sexual act, 7% did not use it because they did not know where to get it from and 8% do not enjoy sex with a condom. Out of the total male respondents 7% said that they would have sex if given an opportunity.

Among the female respondents 9% had become pregnant out of wedlock. More than half (61%) knew about a condom but among them only 4% knew that condom was used for prevention of disease, whereas 67% said that condom was used to avoid pregnancy. Thirty percent had used a condom during their sexual act. Out of these only 13% used it for prevention of disease. Among the female respondents who did not use a condom during their sexual act, 8% did not use it because they did not know where to get it from, 21% do not enjoy sex with a condom and 11% do not consider it necessary. Out of the total female respondents 2% said that they would have sex if given an opportunity.

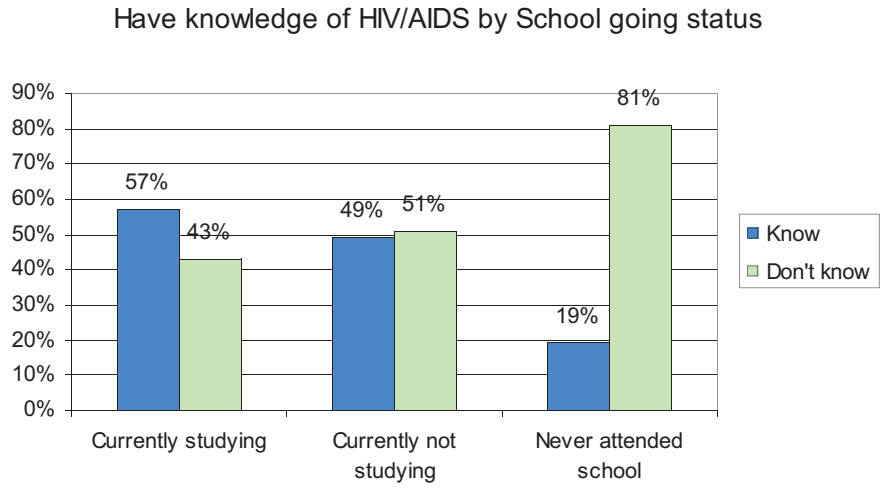
## 5.8 HIV Awareness

**Figure 49: Knowledge about HIV/AIDS by age**




Comparing the knowledge of HIV/AIDS among the different age groups, we can see that as age increases the proportion of respondents who know about HIV/AIDS also increases. The lowest (29%) being at age 13 with a gradual rise to 38% at age 14 going upto 56% at age 18. There is a slight reduction to 52% at age 19.

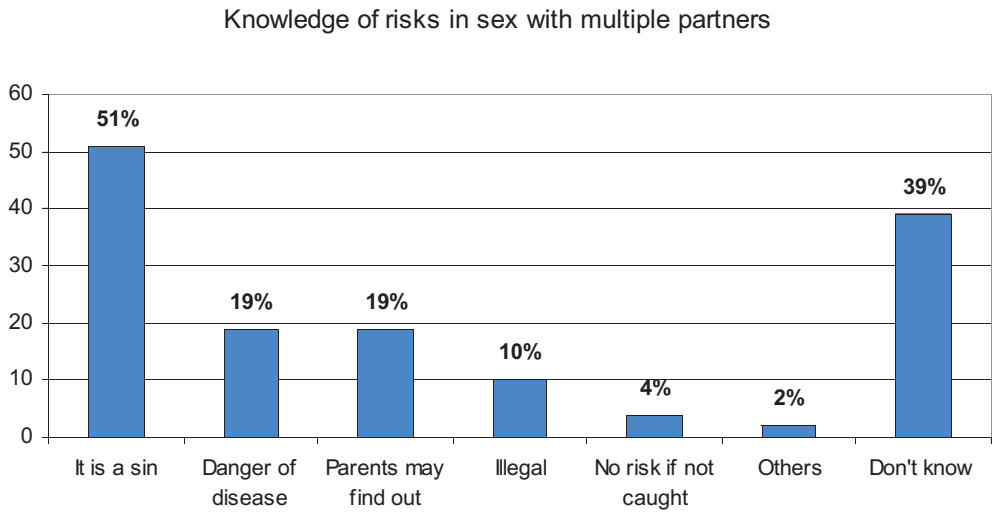
**Figure 50: Having knowledge of HIV/AIDS by School going status**




Comparing the knowledge about HIV/AIDS among adolescents who were currently going to a school or college, who had attended school in the past and those who never went to school, it is seen that the among those who were currently in school or college the proportion of those who had knowledge about HIV/AIDS was higher (57%). In the group who were currently not enrolled the proportion of respondents who had knowledge of HIV/AIDS was slightly lower (49%) than the ones who did not know (51%). However

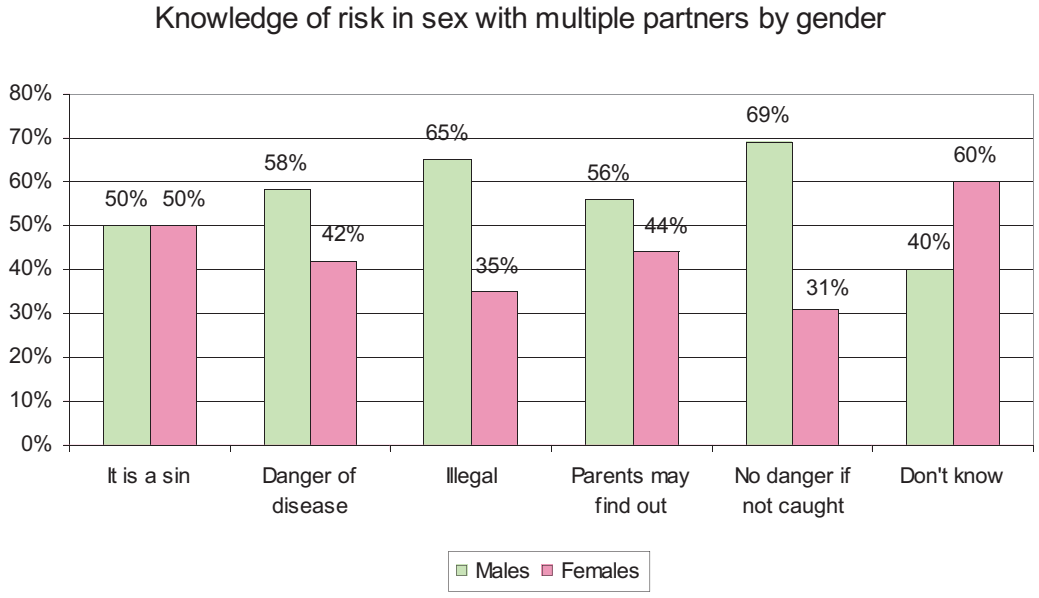
among the respondents who had never attended school the difference was quite high with only 19% knowing about HIV/AIDS and 81% who had no knowledge.

**Figure 51: Knowledge of risk in pre/extra marital sex with multiple partners**




The knowledge of respondents regarding risks of pre or extra marital sex with multiple partners is poor as only 19% responses mentioned disease as being a risk. Half of the responses (51%) were that it was a sin, 19% responses mentioned risk of parents finding it out and 10% responses were that it was illegal. According to 4% responses there was no risk if a person is not caught. A high percentage (39%) of responses was for 'don't know'.

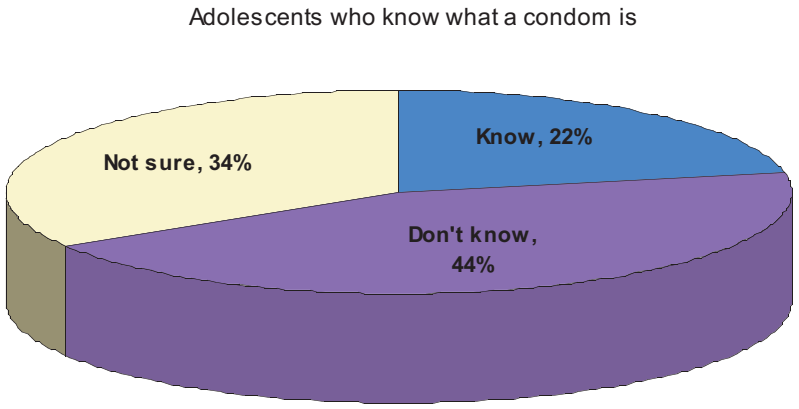
**Figure 52: Knowledge of risk in pre/extra marital sex with multiple partners by gender**




Comparing the responses of males and females regarding knowledge of risks in pre or extramarital sex with multiple partners, we see a variation in most responses except for

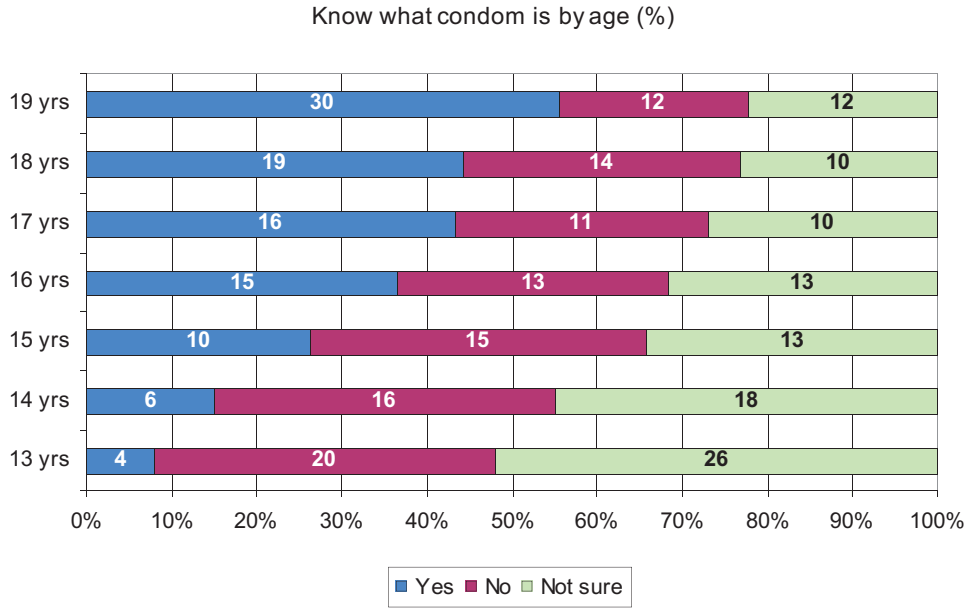
one. Within the ones who mentioned 'danger of disease' 58% were males and 42% were females showing that boys have better knowledge in this regard. Equal proportion of male and female respondents said that it was a sin. Among those who thought that the only problem was that it was illegal, 65% were boys and 35% were girls. Some were afraid that parents may find out, among them 56% were boys and 44% were girls. The ones who believed that there was no danger if they were not caught had 69% boys and 31% girls. A higher proportion of girls 60% said that they did not know.

**Figure 53: Adolescents who know what a condom is**




A large proportion of respondents either did not know what a condom was (44%) or were not sure (34%). Only 22% said that they knew about a condom.

**Figure 54: Knowledge about condom by age**

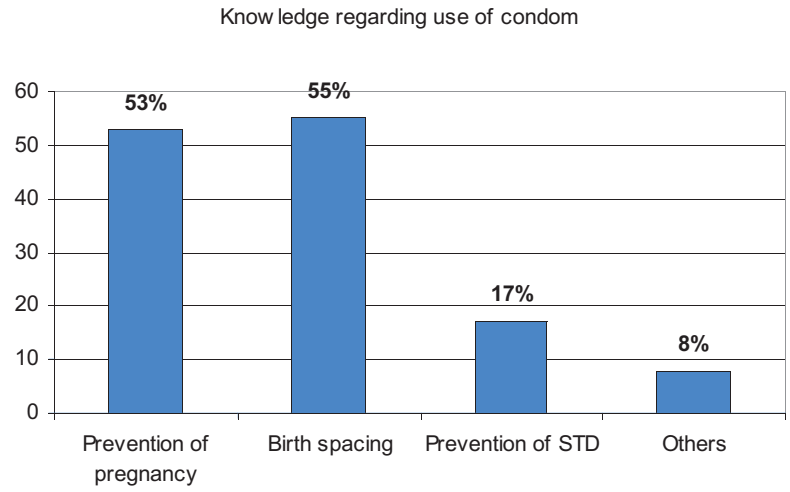



From the above table it can be seen that as age advances the knowledge regarding condoms also increases.

**Figure 55: Knowledge about condoms by gender**


Knowledge of boys regarding condoms was seen to be better than girls. 32% were boys who knew about condoms and the percentage of girls was only 13%.

**Figure 56: Knowledge regarding use of condom**

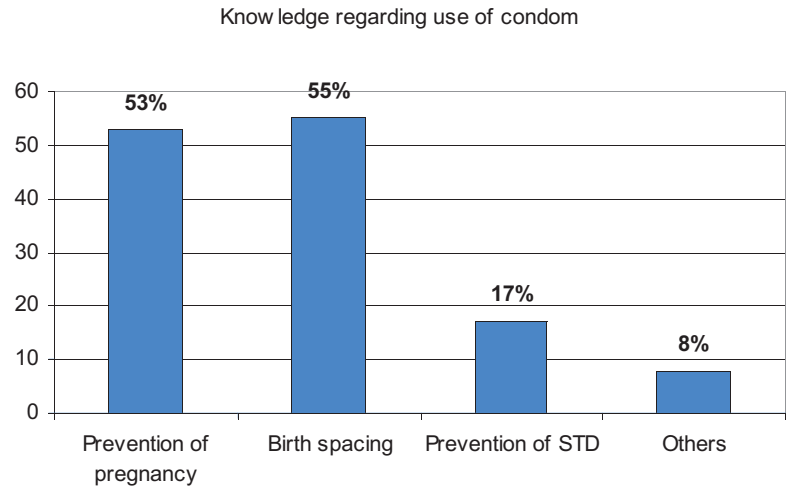



Talking about the use of condoms, only 17% responses were for prevention of Sexually Transmitted Diseases (STD). Responses for prevention of pregnancy were 53% and for birth spacing, they were 55%.

**Figure 55: Knowledge about condoms by gender**

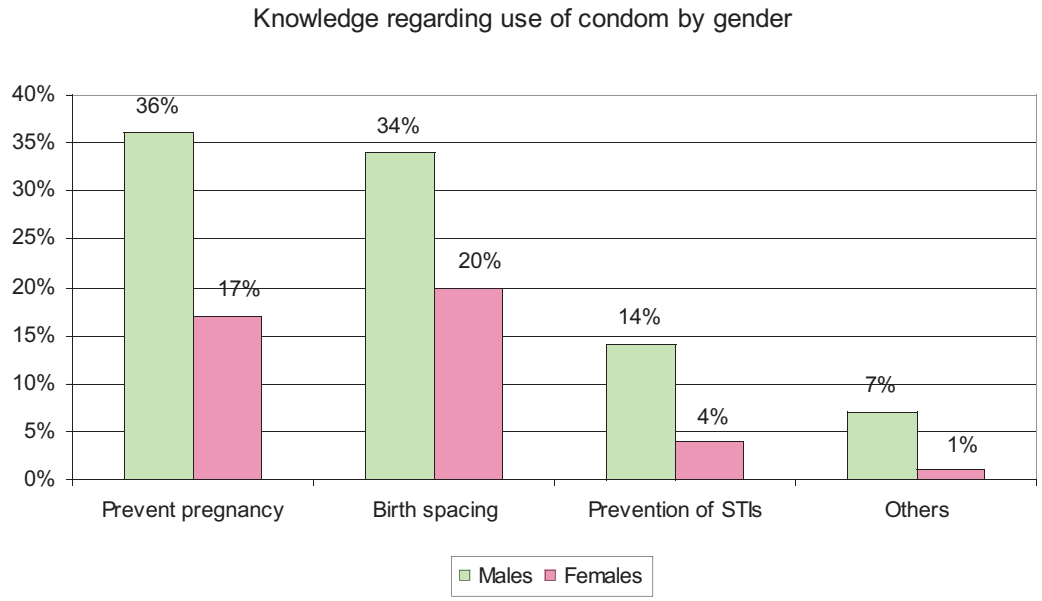

Knowledge of boys regarding condoms was seen to be better than girls. 32% were boys who knew about condoms and the percentage of girls was only 13%.

**Figure 56: Knowledge regarding use of condom**



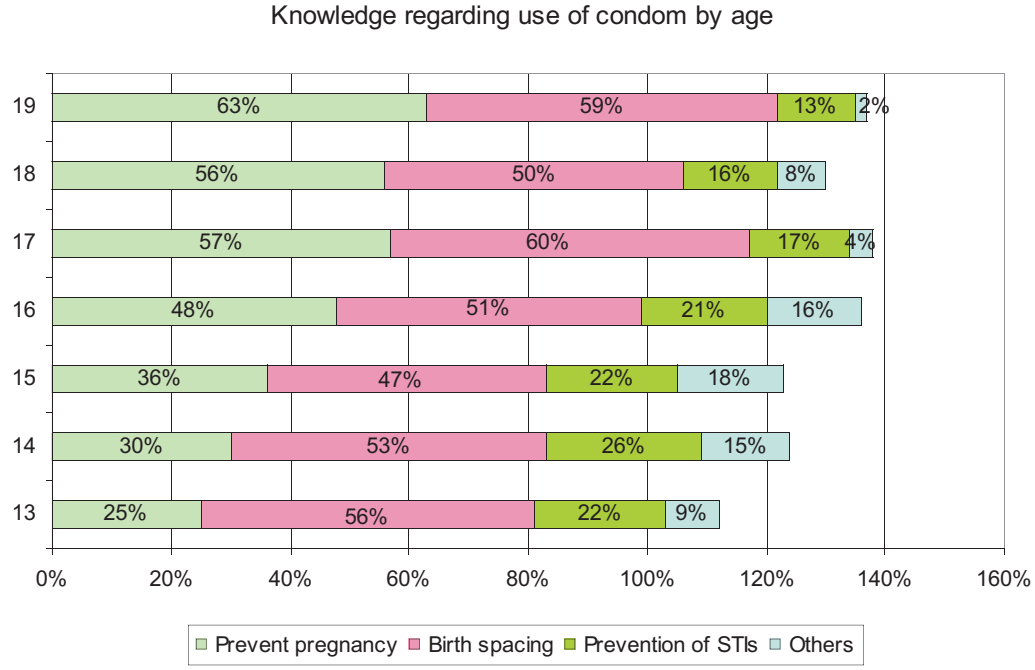

Talking about the use of condoms, only 17% responses were for prevention of Sexually Transmitted Diseases (STD). Responses for prevention of pregnancy were 53% and for birth spacing, they were 55%.

**Figure 57:Knowledge regarding use of condom by gender**




The knowledge of use of condom for prevention of STIs was very poor. Only 14% responses by boys and 4% by girls were for use of condoms to prevent STIs. Majority of the responses, 36% and 34% among boys and 17% and 20% among girls were either for use of condom as a pregnancy preventing or birth spacing measure.

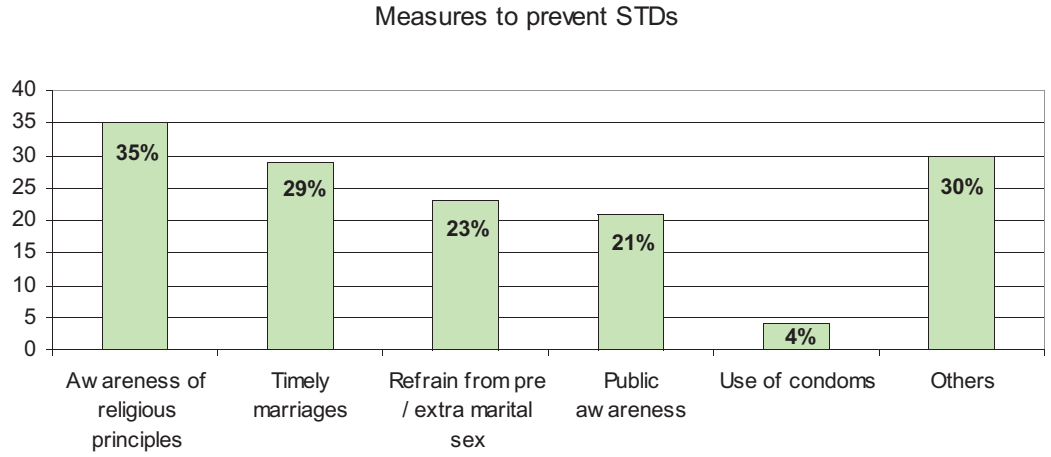
**Figure 58: Knowledge regarding use of condom by age**




The general trend of knowledge regarding use of condoms among adolescents remains the same as seen earlier. The perception is that it is used for prevention of pregnancy and birth spacing. This pattern remains the same among the different age groups with a rising

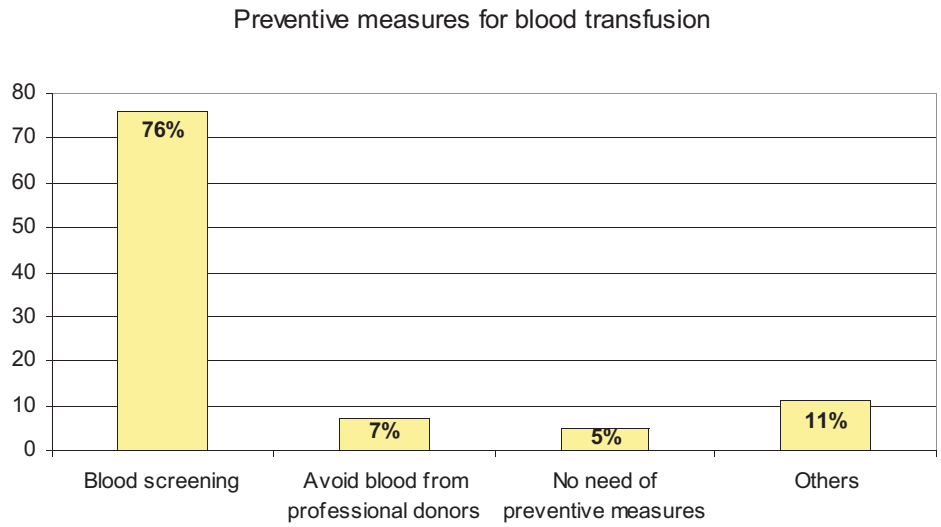
proportion as age increases. However the proportion of responses by younger age groups from 13 to 16 are higher for prevention of STIs than the older group from 17 to 19 years old. The highest proportion of responses for prevention of STIs (26%) comes from the 14 year olds and the lowest (13%) from the 19 year olds.

**Figure 59: Measures to prevent STD**




When discussing various measures which could be used to prevent sexually transmitted diseases a very small proportion of responses (4%) were for use of condoms. 35% responses were for awareness of religious principles, 29% for timely marriages, 23% for avoiding pre and extra marital sex and 21% responses were for public awareness. 30% mentioned other measures which mostly included adhering to religious values. Many in the 'others' category were those who said that they did not know.

**Figure 60: Preventive measures to be taken before accepting blood for transfusion**

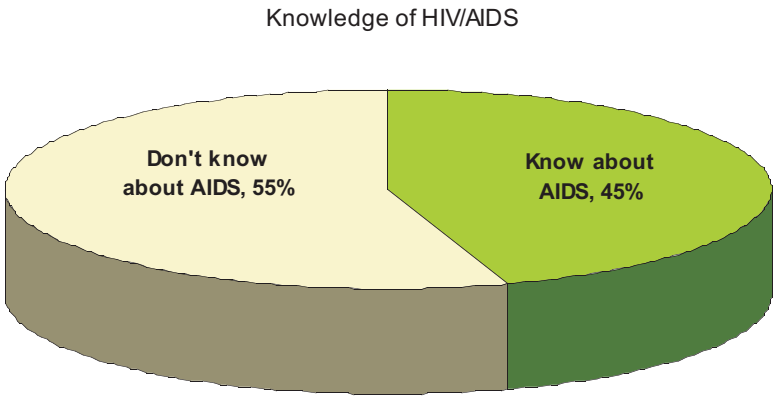



Awareness of precautions before blood transfusion was found to be good. 76% respondents mentioned blood screening as a requirement before blood transfusion. 7% said that blood from professional blood donors should be avoided. However 5% said that

there was no need of any preventive measures. 11% mentioned other preventive measures which included accepting blood from relatives or friends only; testing of blood and a small proportion said that they did not know.

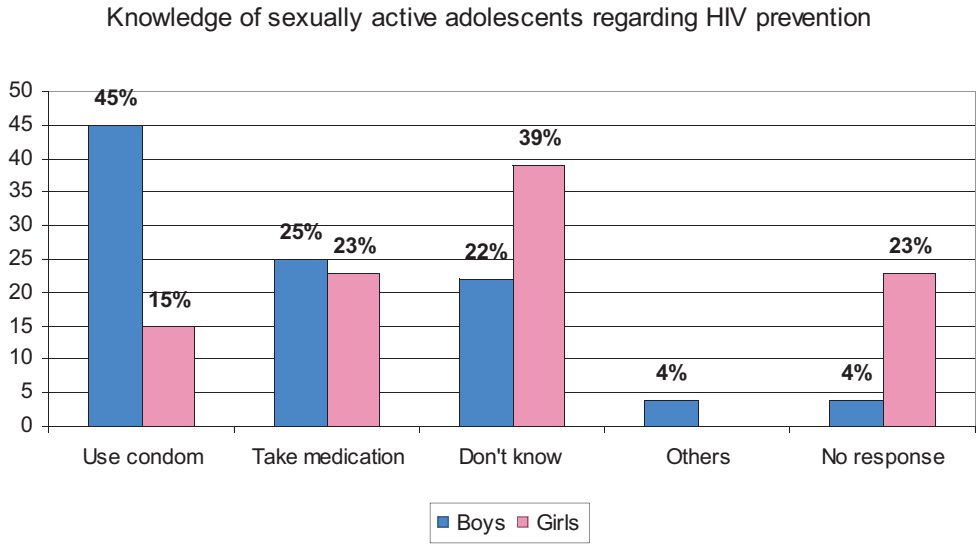
### 5.8.1 Knowledge about HIV/AIDS

**Figure 61: Know what HIV/AIDS is**



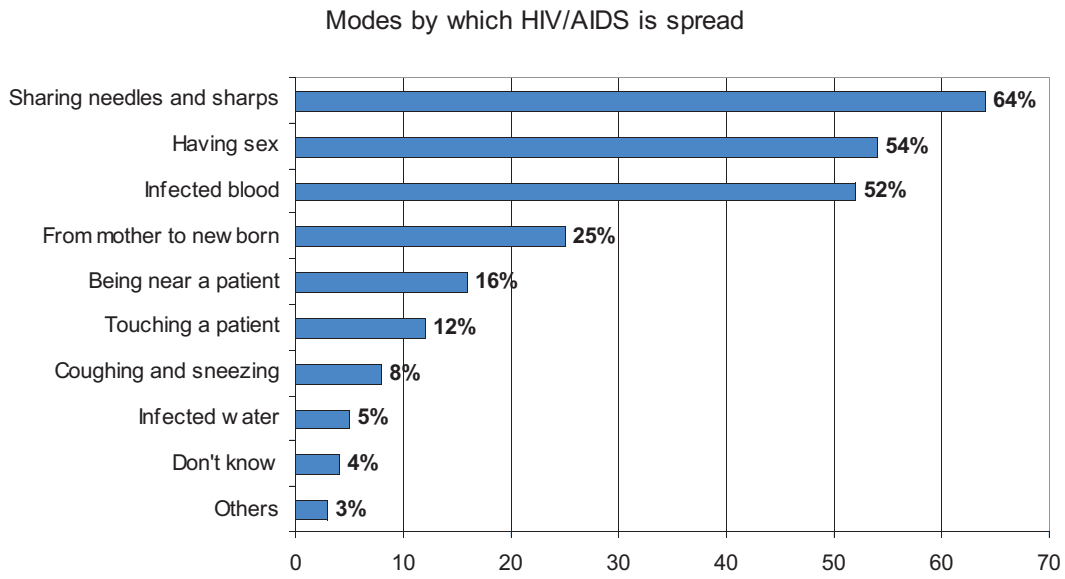

More than half of the respondents (55%) admitted that they did not know about HIV/AIDS.

**Figure 62: Knowledge of unmarried sexually active adolescents regarding HIV prevention**




The level of awareness of boys among unmarried sexually active adolescents was seen to be better than girls. 45% boys mentioned the use of condom to prevent HIV infection whereas only 15% girls said that condoms should be used for HIV prevention. About a quarter in both categories, 25% in boys and 23% in girls thought that HIV infection could be prevented by taking medication. 22% among boys and 39% among girls did not know.

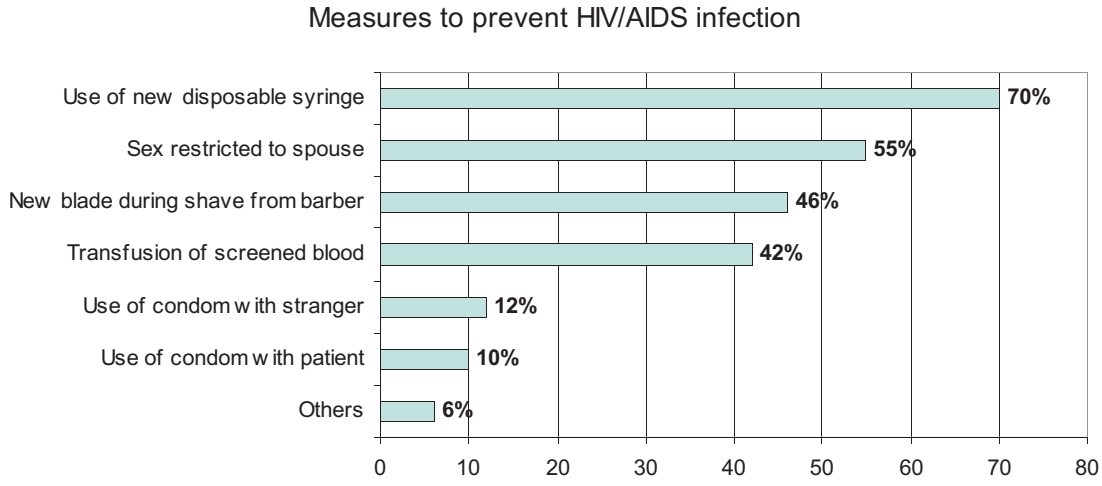
**Figure 63: Knowledge of adolescents regarding spread of AIDS**




The respondents had a fair knowledge of modes of HIV/AIDS spread. 64% responses were for sharing needles and sharp objects with a patient. Other high proportion of responses was for having sex with a patient of HIV/AIDS (54%) and through infected blood (52%). Transmission of disease from mother to her newborn was mentioned in 25% of responses. A lesser proportion of responses were for being near a patient of HIV/AIDS (16%), touching a patient of HIV/AIDS (12%), through coughing and sneezing (8%) and through infected water (5%).

## 5.8.2 Knowledge regarding prevention of spread of AIDS

**Figure 64: Measures to prevent spread of HIV / AIDS**

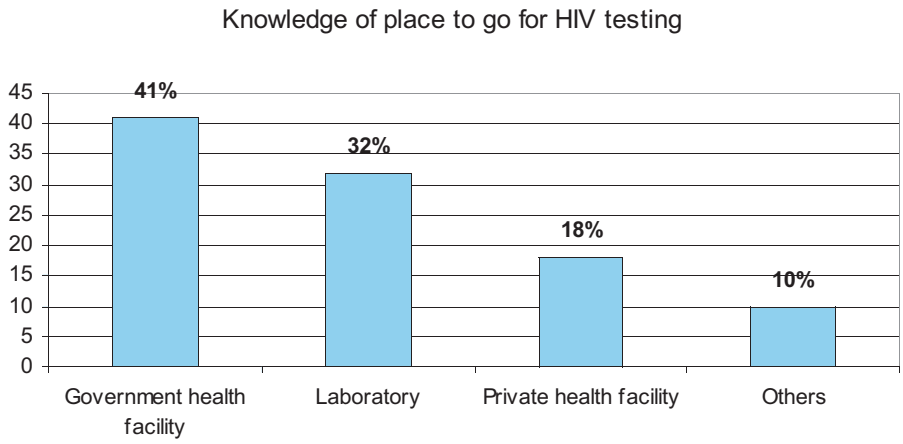



The respondents were asked what measures they thought should be taken to prevent HIV/AIDS infection. Use of new disposable syringe (70%) was the most popular

prevention measure. The other responses were for sex restricted to spouse (55%), new blade during shave from a barber (46%), transfusion of screened blood (42%), use of condom during sex with a stranger (12%) and use of condom during sex with an HIV infected person or a patient of AIDS(10%).

### 5.8.3 Knowledge about HIV-related services

**Figure 65: Knowledge of a place to go for HIV testing**




In the perception of majority of the adolescents interviewed a government health facility would be the place to get tested for HIV (44%). 32% mentioned any laboratory and 18% said it would be a private health facility.

### 5.8.4 Findings & Analysis

There were very few unmarried adolescents who were sexually active. The proportion of respondents who mentioned the danger of HIV infection through sex with multiple partners was also very low. Majority's concern was that it was a sin and if caught it would be shameful or it was illegal and you could get arrested. A high percentage than expected said that they did not know about condoms. Majority of the ones who knew about them said that their use was for prevention of pregnancy and birth spacing. A very small proportion of respondents mentioned use of condoms to prevent sexually transmitted diseases. However knowledge regarding blood screening was good.

*"The only way to help an AIDS patient is to take the patient to a doctor and or pray to Allah for the patient. Other than that I don't know what we can do or help someone who is suffering from AIDS".* (Male refugee)

During discussions it was seen that knowledge of HIV / AIDS was confined to hearing about it and that it was a deadly disease but there was not much clarity about its mode of spread. Unhygienic conditions at hospitals and also in the community at large was said to be the sources of such diseases. Some respondents thought that sharing soap and even food could be the source of spread. Intimate relations and not only sexual contact

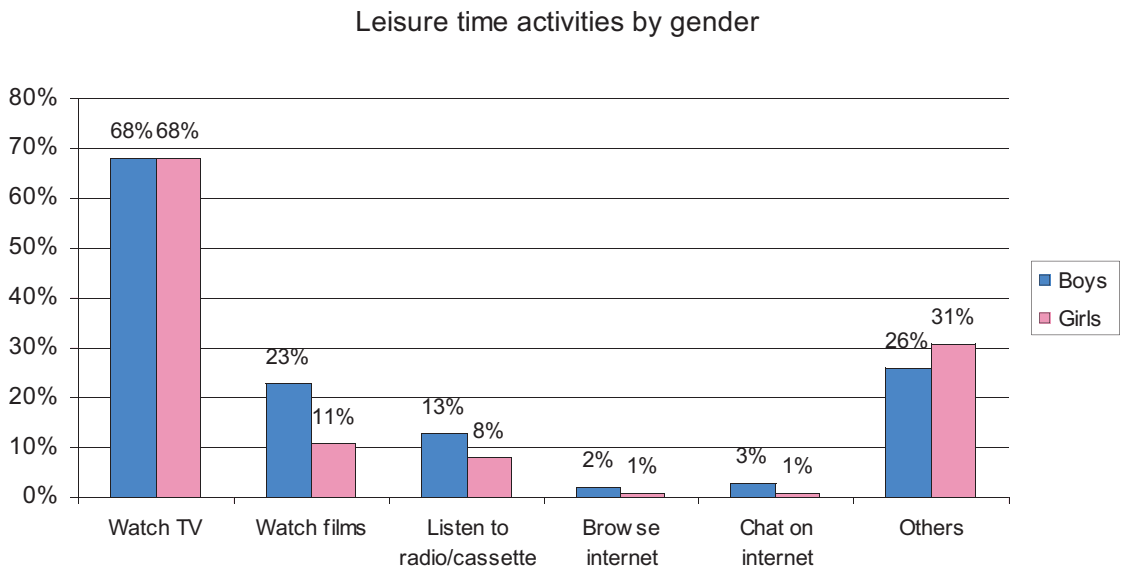
*"If I get AIDS, I will pray to God and take medicines prescribed by a doctor".* (Street boy)

were a mode of spread. A boy mentioned that if a person took a bath after kissing or having sex with a prostitute he would be safe from HIV /AIDS. It was seen that whenever respondents mentioned HIV/AIDS they grouped it with other diseases like cancer, TB and malaria. The main source of information about HIV/AIDS was television or friends.

Discussing the dangers girls could be exposed to in the society regarding sexual relations, the girls said that there are men who have sex with girls with the promise of marrying them and then blackmail them into having sex with their friends and later with clients for money thus turning them into prostitutes.

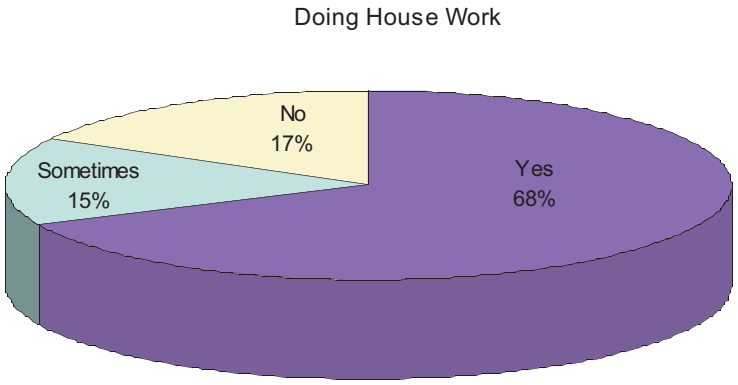
## 5.9 Leisure and Media Habits

**Figure 66: Leisure time activities by gender**



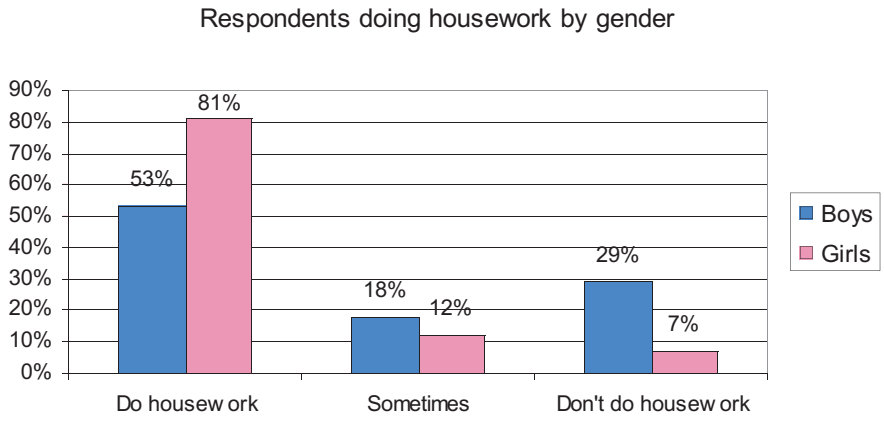

Majority of the girls and boys (68% each) said that they watched TV during their leisure time. 23% boys and only 11% girls watched films, 13% boys and 8% listened to radio or cassette player. A very small proportion of respondents said that they browse or chat on the internet.

**Figure 67: Doing house work**



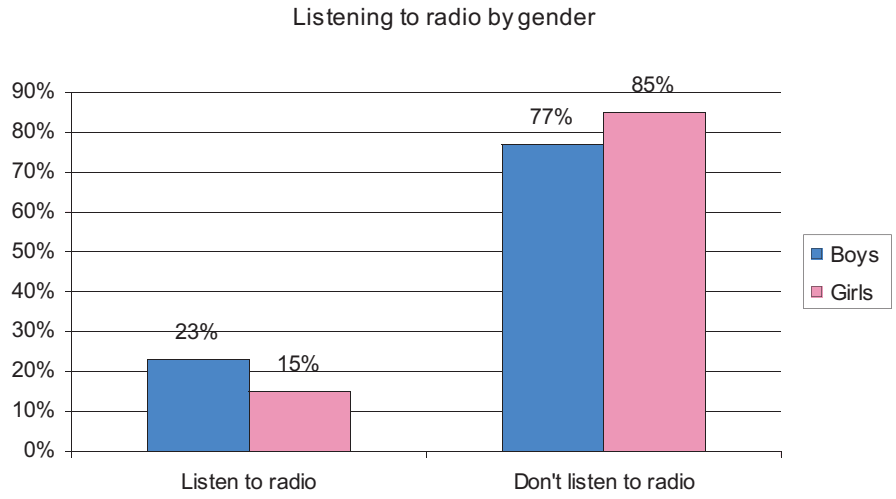

Sixty eight percent of the respondents said that they do housework whereas 17% said that they don't. 15% said that they do it sometimes.

**Figure 68: Doing housework by gender**



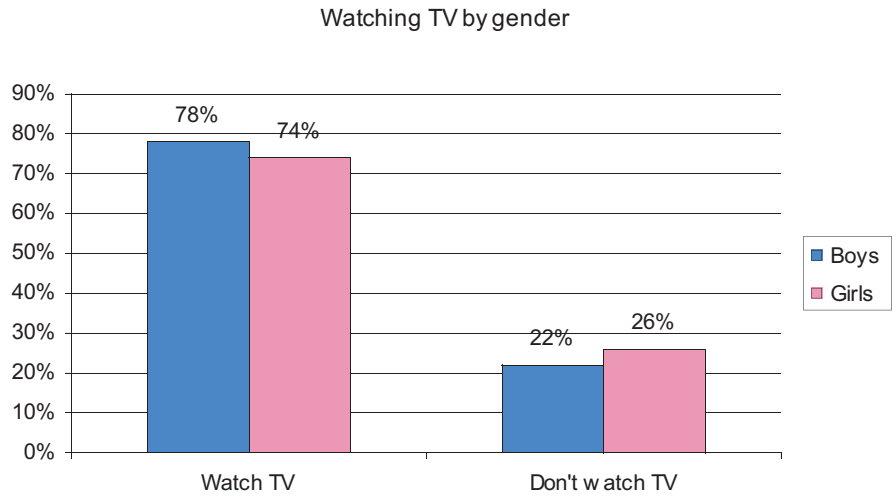

As would be expected 81% of the girls said that they do housework compared to 53% boys. Comparing the respondents who do not do any housework the proportion of boys was 29% to only 7% girls.

**Figure 69: Listening to radio by gender**



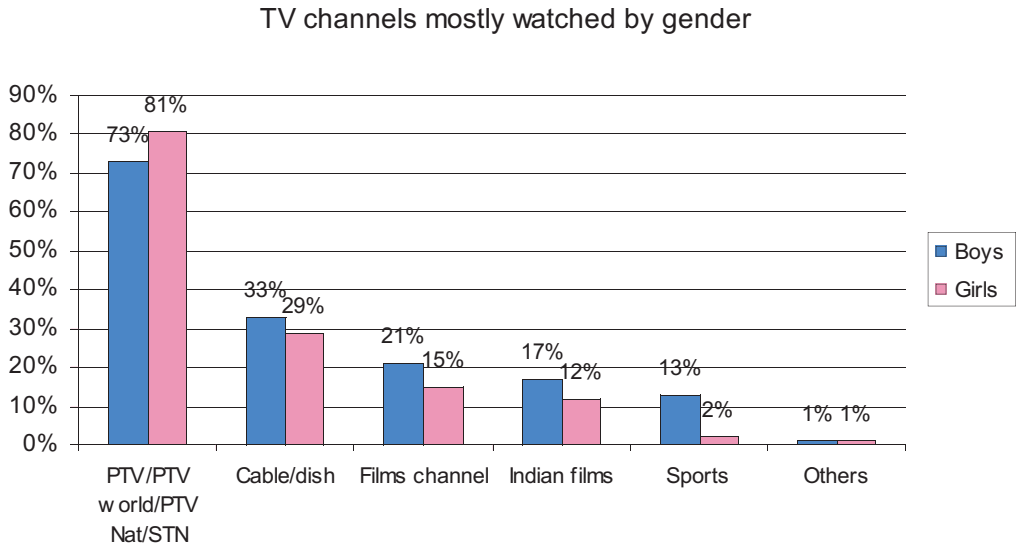

The respondents were asked if they listened to the radio. Only 23% boys and 15% girls said that they listened to the radio.

**Figure 70: Watching TV by gender**



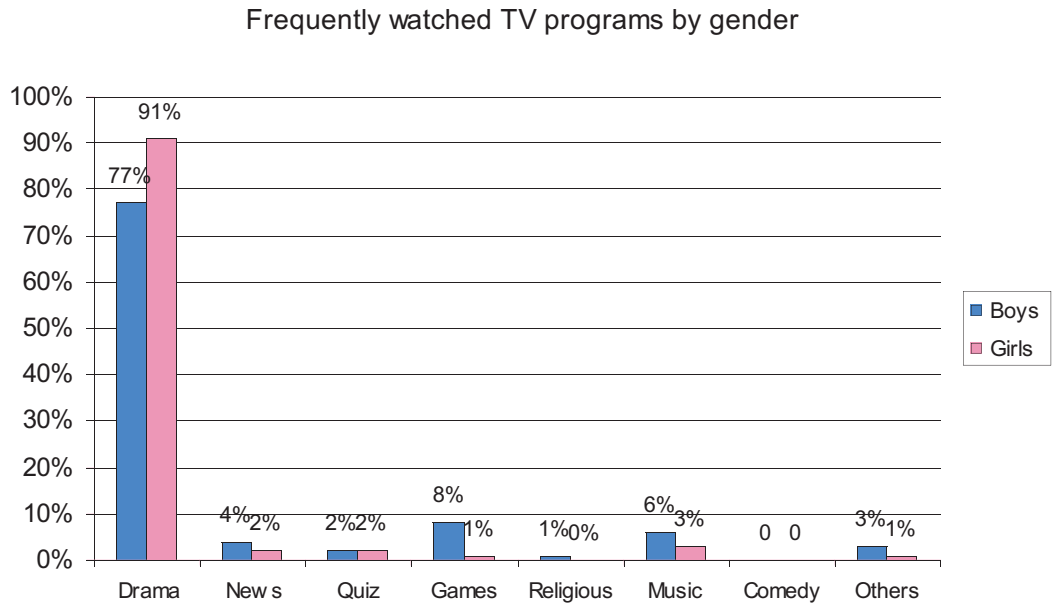

TV is the most popular medium among adolescents who were interviewed. 78% boys and 74% girls said that they watched TV regularly.

**Figure 71: TV channels mostly watched by gender**



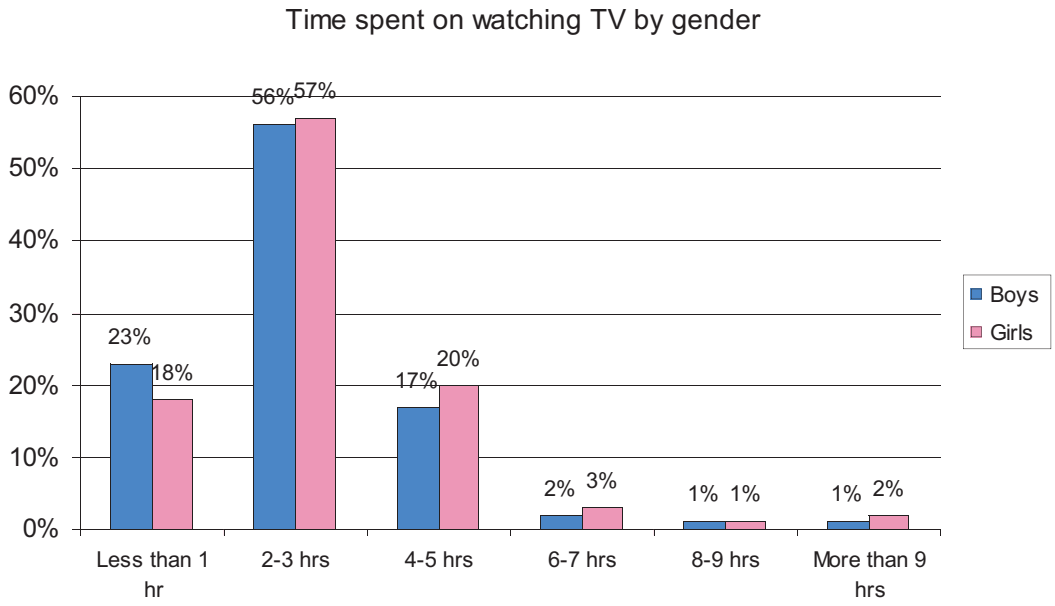

Local Pakistan television channels and STN were the most watched channels by boys (73%) and girls (81%). Cable or dish channels were viewed by 33% boys and 29% girls whereas 21% boys and 15% girls watched film channels. Indian films were seen by 17% boys and 12% girls. Sports channels were more popular among boys (13%) and only 2% girls saw these channels.

**Figure 72: Frequently watched programs by gender**



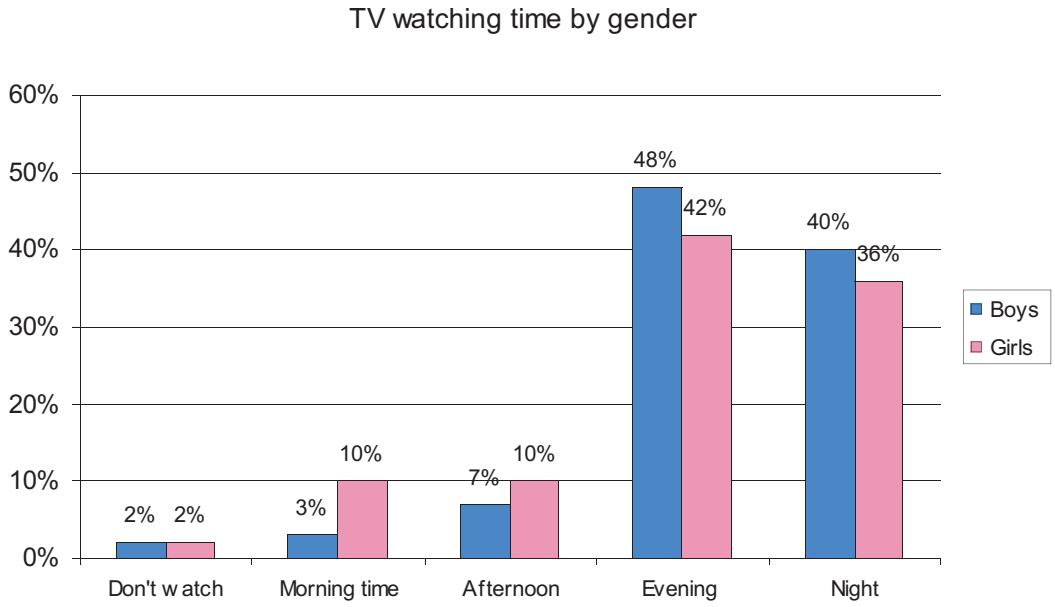

Drama was by far the most frequently watched TV program with 91% girls and 77% boys watching it. The rest of the programs were watched by a small proportion of respondents.

**Figure 73: Time spent on watching TV by gender**



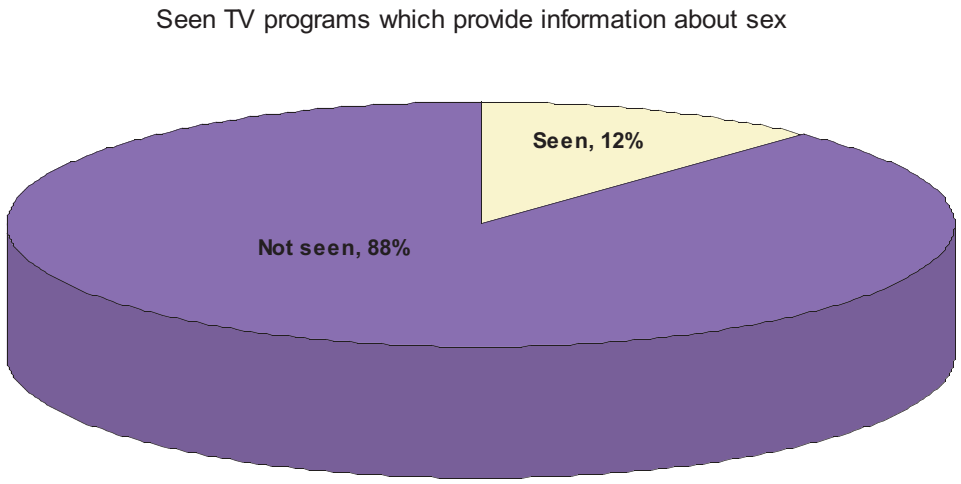

Majority of the respondents, 56% boys and 57% girls watched TV for 2 to 3 hours in a day. 23% boys and 18% girls watched it for less than 1 hour. However 17% boys and 20% girls watched it for 4 to 5 hours.

**Figure 74: TV watching time by gender**



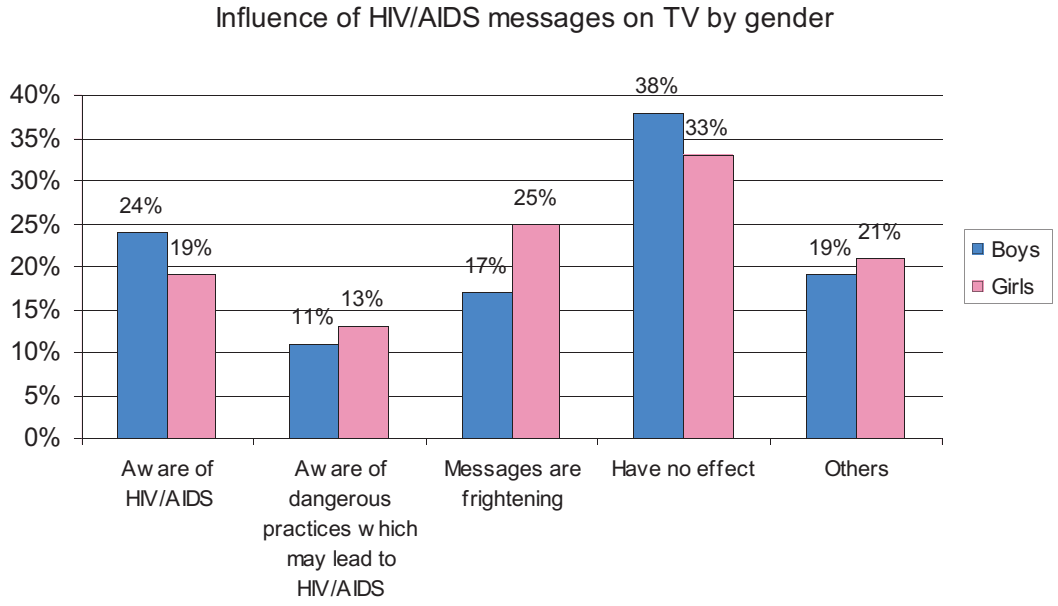

Majority of the respondents watched TV during the evening hours or at night. A small proportion watched it in the morning or afternoon. Evening was the most popular time when 48% boys and 42% girls among the respondents watched it. At night the proportions dropped to 40% boys and 36% girls.

**Figure 75: Seen TV programs which provided information about sex**




Only 12% respondents said that they had seen some TV program which contained information about sex.

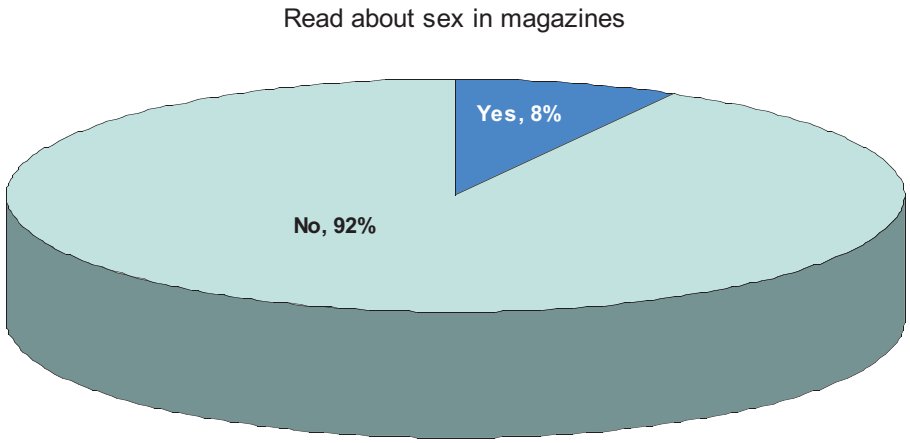
**Figure 76: Influence of HIV/AIDS messages on TV by gender**




When asked whether the HIV/AIDS messages being aired on national television had any effect on them, most of the respondents 38% boys and 33% girls said that it had no effect on them. However more boys (24%) than girls (19%) said that due to these programs they were aware of HIV/AIDS. 11% boys and 13% girls said that they were aware of the dangerous practices which may lead to HIV/AIDS. Some respondents (17% boys and 25% girls) said that the messages were frightening.

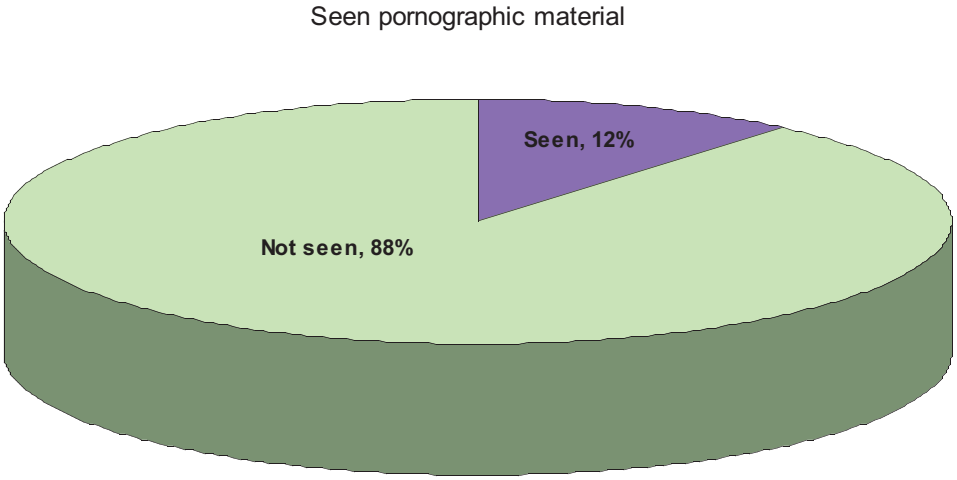
### 5.9.1 Source of pornographic material

**Figure 77: Read about sex in magazines**



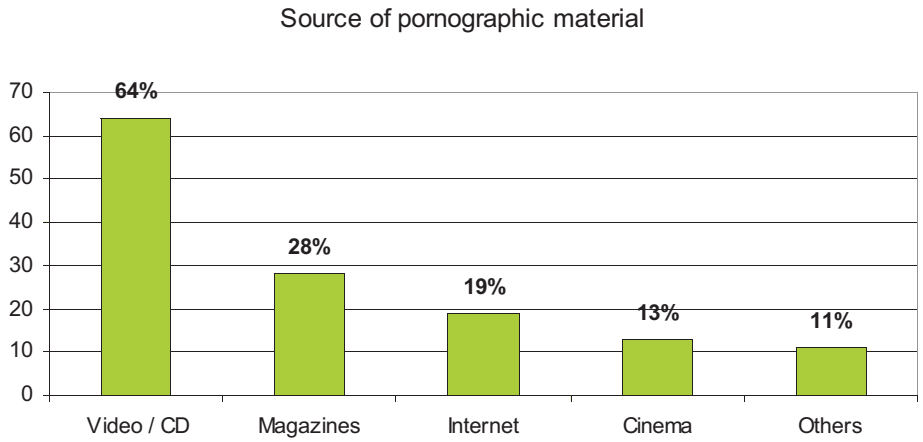

Very few adolescents admitted to have read about sex in magazines (8%).

**Figure 78: Seen any pornographic material**



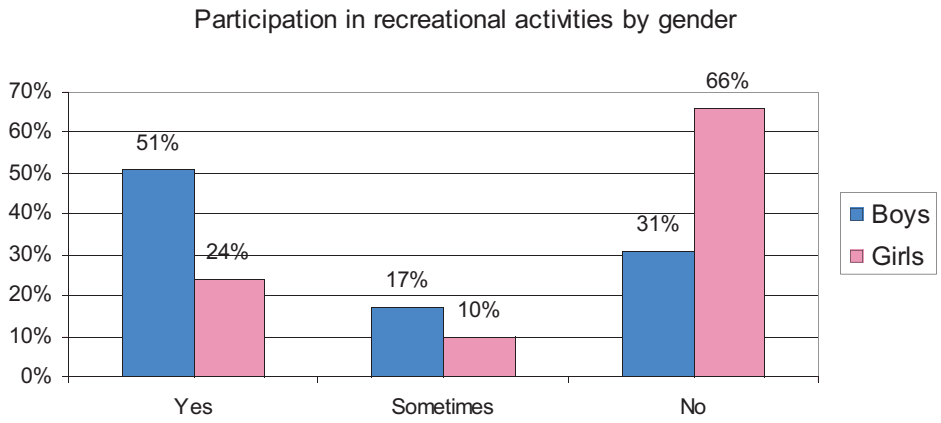

As in other media sources a very low proportion of respondents admitted to have seen pornographic material (12%).

**Figure 79: Source of pornographic material**



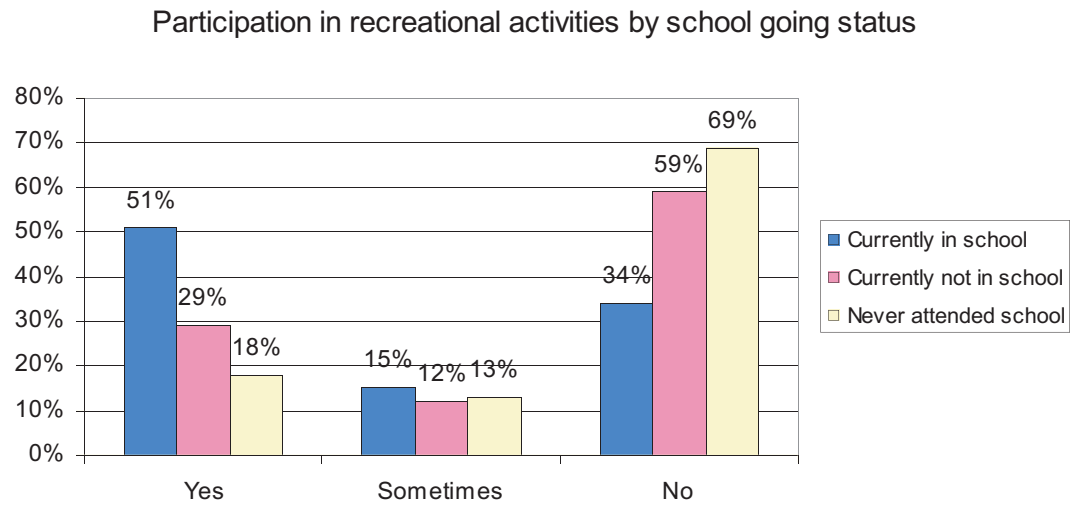

Those adolescents who had admitted to seeing pornographic material were asked where they had seen it. The sources which they mentioned were video or CD (64%), magazines (28%), internet (19%) and cinema (13%).

**Figure 80: Participation in recreational activities by gender**



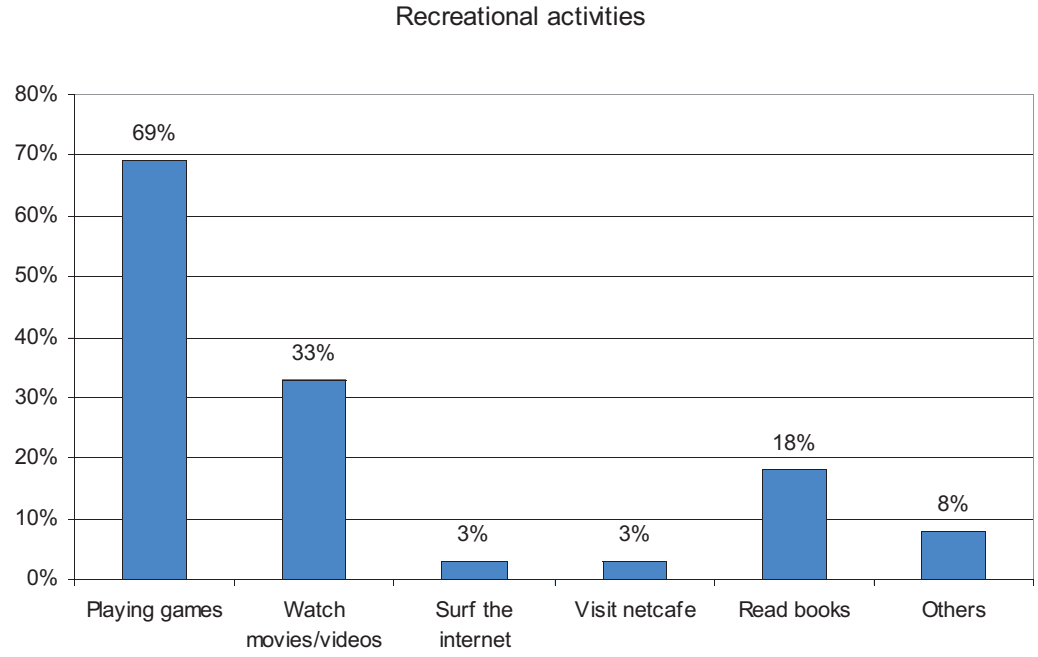

Boys were more involved in recreational activities. 51% boys said that they involved themselves in recreational activities where as only 24% girls admitted to it. 17% boys and 10% girls said that they involved themselves sometimes. However 31% boys and 66% girls said that they did not take part in these activities.

**Figure 81: Participation in recreational activities by schooling going status**



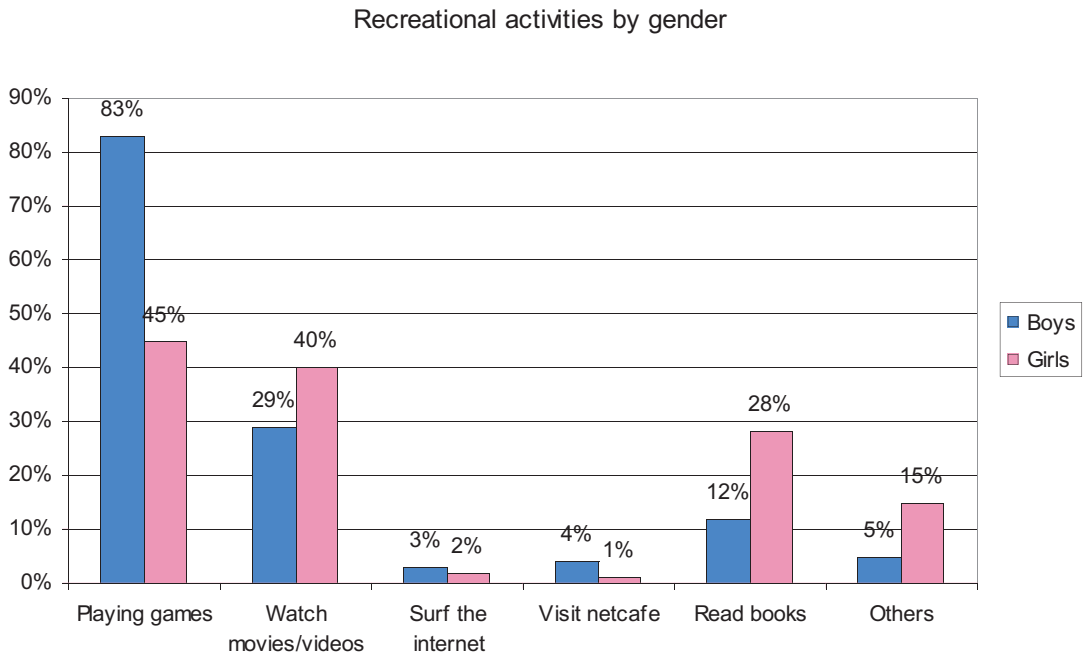

There was an apparent difference between childrens' school going status and their involvement in recreational activities. Highest proportion of respondents who said they were involved in recreational activities (51%) were also those who were enrolled in school. Similarly highest proportion of respondents who said that they were not involved in recreational activities had never attended school.

**Figure 82: Type of recreational activities**




A high proportion of respondents (69%) said that they play games for recreation, 33% watch movies or videos, 3% surf the internet, 3% visit netcafe and 18% read books. Other activities were mentioned by 8% respondents.

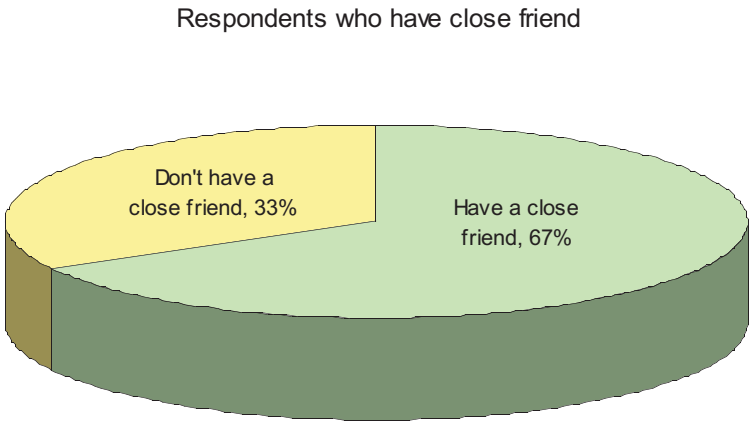
**Figure 83: Type of recreational activities by gender**




Playing games was a more popular recreational activity among boys (83%) as compared to girls (45%). However watching movies and reading books were more popular among girls. Very few mentioned surfing the internet and visiting netcafes.

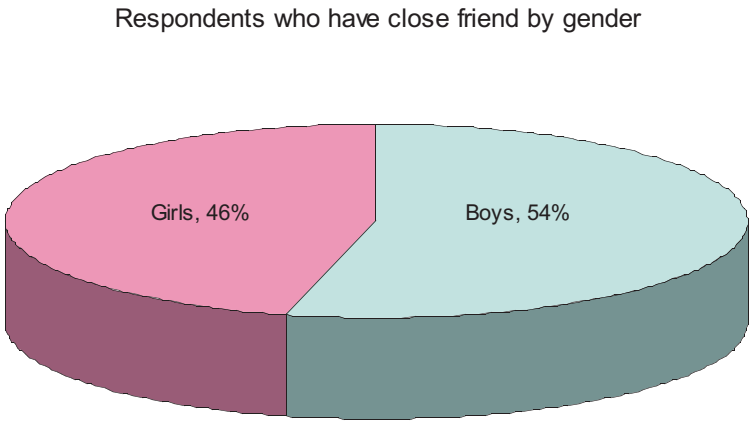
## 5.9.2 Connectedness

**Figure 84: Respondents who have a close friend**



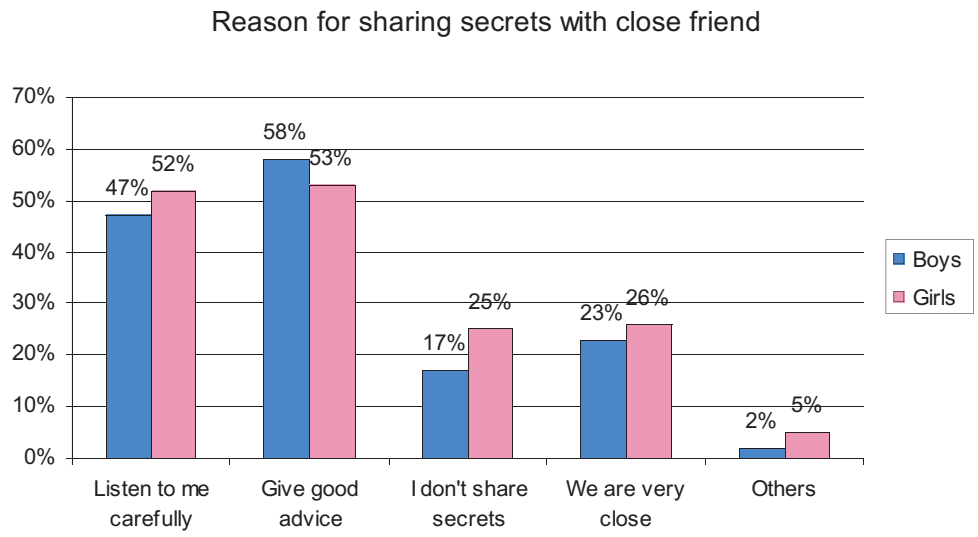

Majority of the respondents said that they had a close friend (67%), whereas 33% said that they did not have a friend whom they could call close.

**Figure 85: Respondents who have a close friend by gender**



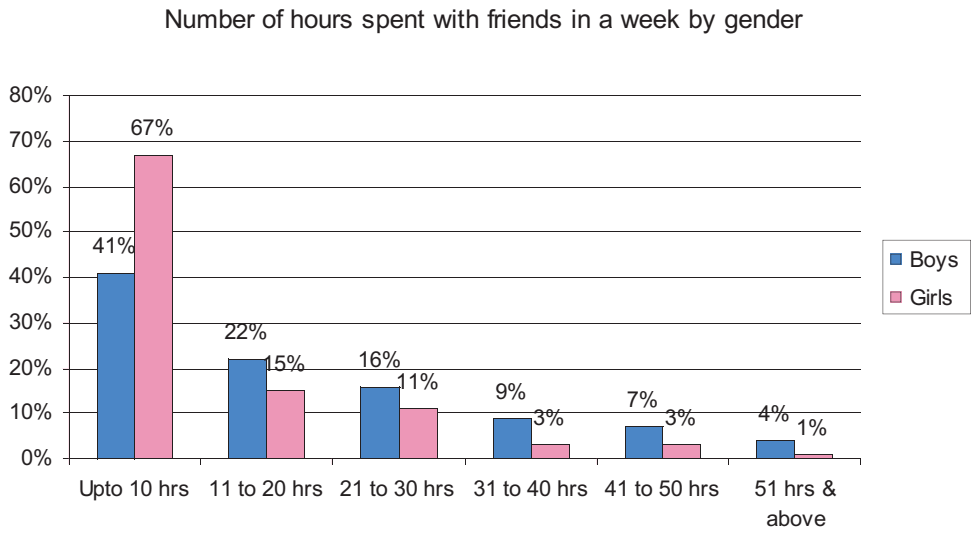

Comparing the proportion of respondents who had a close friend among boys and girls, it was seen that a larger proportion of boys (54%) have a close friend, whereas among girls this proportion was 46%.

**Figure 86: Reason for sharing secrets with close friend by gender**



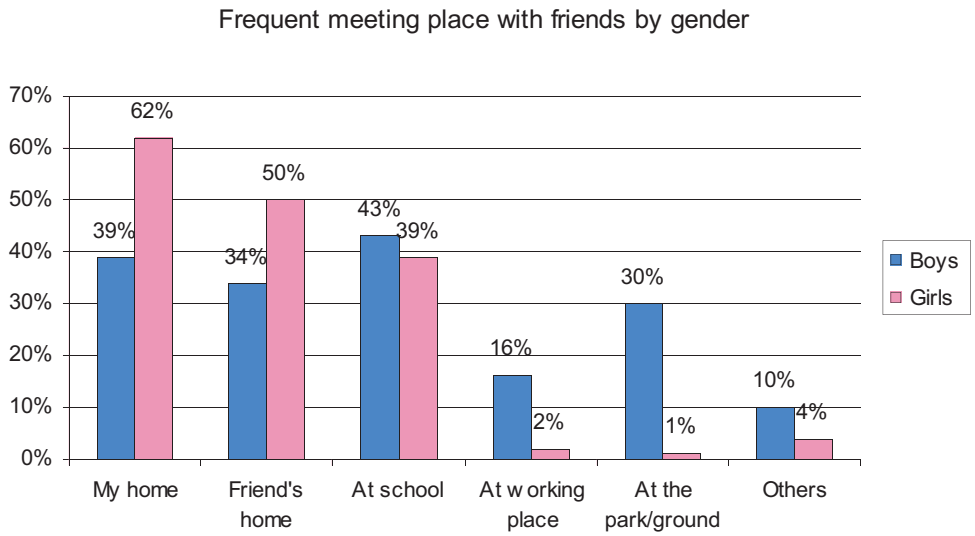

The respondents were asked why they share secrets with their close friends. 47% boys and 52% girls said that the friend listens to them. More girls than boys give priority to this quality. Whereas more boys (58%) than girls (53%) are looking for good advice. 17% boys and 25% girls said that they do not share their secrets with anyone. The reason given by 23% boys and 26% girls for sharing their secrets with their close friends was that they were very close to their friends.

**Figure 87: Number of hours spent with friends in a week by gender**



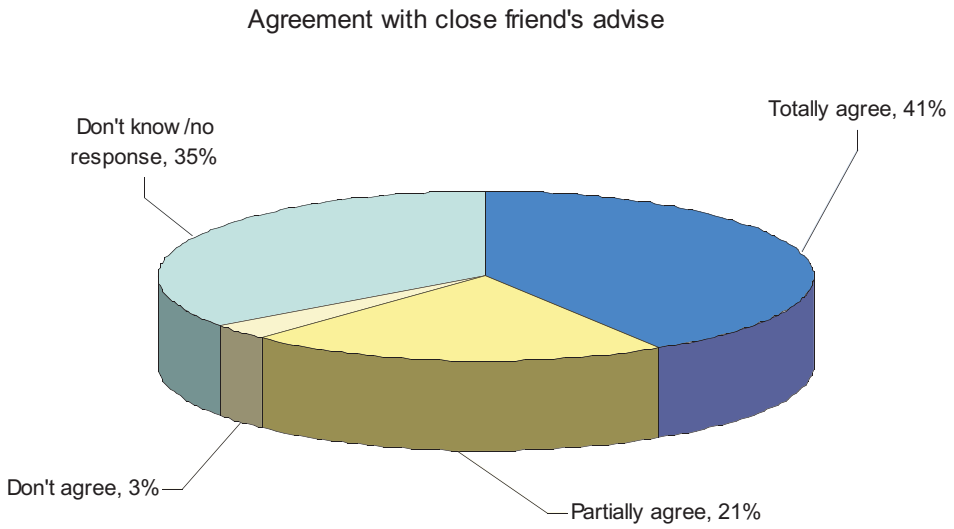

Majority of the girls (67%) were spending upto 10 hours in a week with their friends whereas only 41% boys were spending the same time in a week. 22% boys and 15% girls were spending between 11 to 20 hours in a week with their friends. Higher proportion of boys than girls were spending more time with their friends.

**Figure 88: Frequent meeting place with friends by gender**



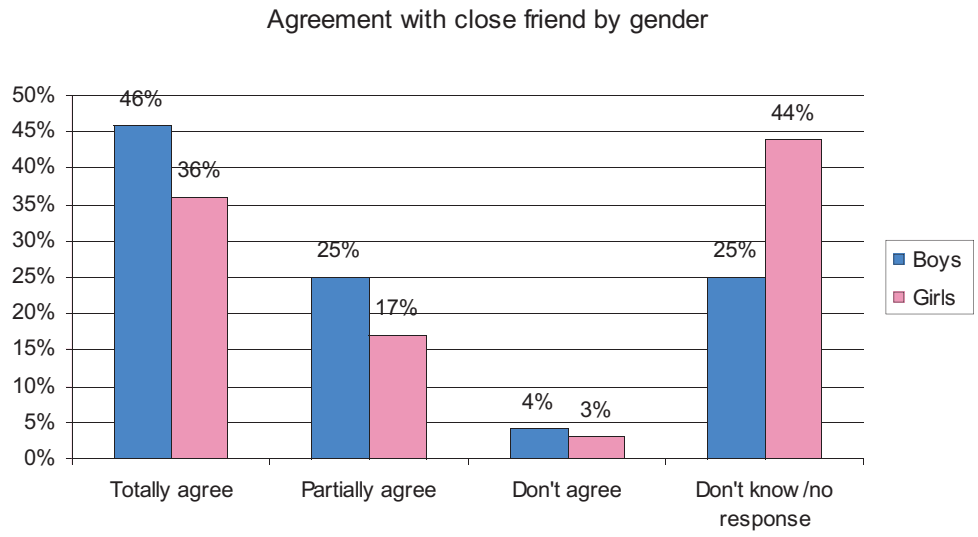

For girl respondents, their homes (62%) or the their friends home (50%) were the meeting place most frequently used to meet with their friends. On the other hand the most popular place for boys to meet with their friends were school (43%), workplace (16%) and in the playground and park (30%).

**Figure 89: Do you always agree with whatever your close friend advises you?**



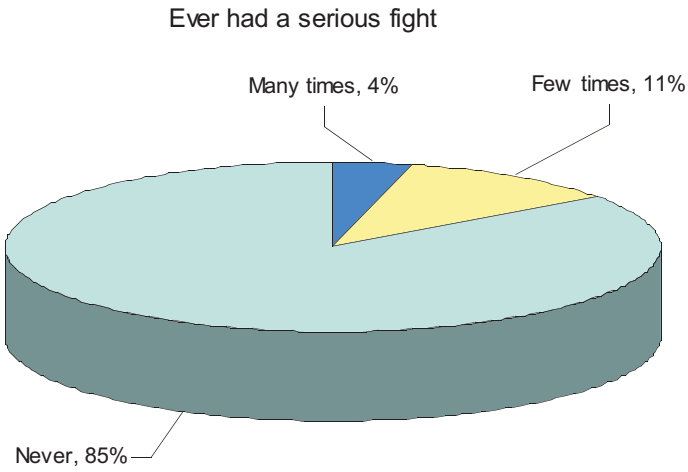

The respondents were asked if they agreed with whatever their close friends told them. 41% said that they always agree, 21% partially agree and 3% don't agree. 35% either said that they did not know or did not respond.

**Figure 90: Agreement with close friend by gender**




Forty six percent boys and 36% girls said that they totally agreed with their close friends whereas 4% boys and 3% girls said that they do not agree. 25% boys and 17% girls said that they did not always agree or disagree.

**Figure 91: Ever had a serious fight**




The respondents were asked if they had ever been in a serious fight. A vast majority (85%) said that they had never been in a serious fight. However 4% said that they had been in a serious fight many times and 11% said that they had been in such a fight a few times.

### 5.9.3 Findings & Analysis

Exposure to media during leisure time amongst adolescents mostly included television and internet. Majority of the respondents said that they had not seen pornographic material or any program related to sex. Most of the respondents who had seen pornographic material had seen it in videos and magazines. More girls than boys were doing housework. Listening to the radio was not very popular. The popular TV channels being watched were PTV and cable/dish channels. TV drama and films were mostly watched. Majority watched TV for an average of 2 -3 hours every day and the popular TV watching time was in the evening and at night. Very few had seen any sex related program on TV.

A mass media campaign has been launched on HIV prevention. The view of most of the respondents about this campaign was that these messages had given them an awareness about HIV/AIDS and the dangerous practices that may lead to HIV/AIDS. Some said that the messages were frightening.

Playing games and watching movies were the popular recreation activities among adolescents. It was seen that a higher proportion of school going adolescents were spending time in recreation activities than dropouts or those who had never been to school.

During focus group discussions respondents mentioned internet cafes and video games shops as being places where the youth could be exploited sexually. It is perceived that in

some of these places young boys and girls are targeted for sexual exploitation for small sums of money.

During focus group discussions the main source of information regarding HIV/AIDS had been television. Even deaf and dumb adolescents mentioned that they had seen messages on television about HIV/AIDS and its spread.

A large proportion of respondents had a close friend whom they could trust and with whom they could share their secrets. The reason for sharing secrets was that the friends listened to them and gave them good advice. Boys were spending more time with friends than girls. In Pakistan this could be attributed to the fact that girls are far less independent than boys and have a less opportunity of going out on their own or with friends.

# 6 Conclusions and Recommendations

Adolescence is a developmental period marked by discovery and experimentation that comes with a myriad of physical and emotional changes. Risky sexual behavior and/or drug use are often a part of this exploration. During this time of growth and change, young people get mixed messages. Teens are urged to remain abstinent while surrounded by images on television, movies and magazines of glamorous people having sex, smoking and drinking. Double standards exist for girls who are expected to remain virgins and boys who are pressured to prove their manhood through sexual activity and aggressiveness. In the name of culture, religion or morality, young people are often denied access to information about their bodies and health risks that can help keep them safe.

During the instant study it was seen that most adolescents were quite comfortable discussing sexual issues if alone but there was a marked difference in their attitude if in the company of a family elder. In most cases mothers and elder sisters were a barrier between the interviewers and the respondents. During the focus group discussions with deaf and dumb girls, the interpreter was not comfortable with the discussion although there was no problem with the group. This calls for some action in the shape of awareness campaigns targeted towards parents, teachers and family elders to encourage them to discuss freely sexual matters with their children so that they grow up comfortably knowing that changes they are experiencing are a natural process. Widespread misconceptions which are a source of anxiety for adolescents are usually concocted by so called hakims and quacks.

The impact of mass media campaign of HIV/AIDS prevention is evident and vast majority of youth knows and understands that it is an incurable disease however their concepts on mode of spread are not very clear. It was further observed that majority of adolescents were not aware of condoms.

Gender discrimination is evident. Religious and cultural beliefs are thoroughly imbedded and the youth are in agreement with them.

Youth who are refugees and live in the streets are vulnerable to sexual exploitation and drug addiction through drug pushers and sex offenders who are looking for easy prey offering money to these youth for sexual favors. It was surprising to see that a number of adolescents mostly among the refugee and homeless groups regularly came across drug addicts.

Another group of adolescents vulnerable to sexual exploitation are young domestic servants especially females who fall prey to their employers who offer them money for sexual favors.

On the whole a lot needs to be done for the benefit of adolescents in Pakistan. There is a need to clear the concepts of the adolescents regarding sexuality and its issues. There is

also a need to target the parents and teachers so that the barrier of silence which exists between them and adolescents in such matters can be overcome.

## 6.1 Recommended Strategies & Activities

**Mass media**

⇒ **Awareness campaigns** targeted towards community at large identifying risks to adolescents from drug pushers and sex offenders at public places especially video game joints, gaming zone shops and internet cafes.
⇒ Enhanced HIV program in Pakistan should specifically **focus on Adolescents** as a target group where awareness programs should be started in coordination with representatives from the youth itself and not alone by policy makers.

**Educational sector**

⇒ Inclusion of **sex education** in schools and revision of curricula accordingly.
⇒ **Seminars and discussion forums** on HIV/AIDS prevention and youth affairs to be held in schools and colleges instead of hotels. These activities should be conducted by personalities who are popular among teenagers and not those whom elders think should be popular amongst them. This would promote a sense of ownership and have a greater impact on the youth.
⇒ Target teachers to develop a **resource pool** which can coordinate activities at the school level.
⇒ Target students' community to develop a **resource pool** who can work at the peer as well as community level.
⇒ Hold **competitive programs** amongst the students to obtain their and the community's interests.
⇒ Conduct **capacity building and sensitization programs** for the head of the institutions & teachers
⇒ Initiate **clubs and societies at college and school level** where representatives of students are encouraged to start an awareness program on their own with their group of volunteers/club members. This will ensure that the youth will have a sense of ownership of their program and they will consider themselves to be decision makers and not mere spectators.
⇒ **Concerts, plays, dramas, tableaus** should be held at school and colleges promoting AIDS prevention.
⇒ A **red ribbon day** should be celebrated in all public schools every month, when an hour or two should be spent talking about HIV/AIDS and its prevention.

**Access to information**

⇒ **Telephone helpline services** may be provided free of charge to adolescents ensuring complete confidentiality.
⇒ A **help desk** at major markets and shopping plazas/fairs should be set up where youth can come and ask their questions. These help desk would encourage out of school children.

⇒ Counseling centers should be established where adolescents can have counseling sessions in privacy and ensuring confidentiality.
⇒ Adolescents should have easy access to literature and other sources of information on the natural process of growing up and risky behaviour.

**Facilitation for constructive activities**

⇒ Promotion of local healthy activities like **sporting events** where the adolescents can take part. It is very important to keep them involved in healthy activities.
⇒ Conduct **Drama & Poster Competitions** emphasizing awareness
⇒ Create a group of **youth leaders** who will enhance the level of awareness for HIV/AIDS and STI prevention issues among their peers, parents or other community members.
⇒ **Youth Ambassadors** should be selected at provincial level through bottoms up approach. Union council>>Tehsil>>District>>Province. A pool of youth should be selected from various schools out of which the best at each tehsil should be selected and then out of them the best in each district followed by the best in the province. He/she shall be given a chance to come in liaison with the National and provincial policy makers and AIDS Control programs. Proving to be a "Voice of the Youth". They will also target out of school youth.

**Code of ethics and regulation**

⇒ Code of ethics should be developed for video games centers and gaming zones to provide a healthy and pleasant atmosphere. Smoking should not be allowed in these places and suspicious characters should be apprehended.
⇒ Internet cafes should also be bound to provide an open, healthy and pleasant environment. Close cabins and confined places should be prohibited.

## *6.2 Recommendations for Life Skills Manual preparation*

Transition from childhood to youth brings about dramatic physical, physiological, emotional and behavioral changes. These changes coupled with the absence of authentic information to know, understand and appreciate them, cause anxiety among adolescents who may be pushed into courses of actions without having a chance to think fully of consequences**.** It is therefore important to provide guidance through different means so that a young adult is able to develop life skills which will enable him/her to lead a healthy and productive life. Following are some recommendations for development of a life skills manual in light of the instant study:

- A clear understanding of the anatomical and physiological changes during the transition phase from childhood to adulthood. The aim is to enable the individual to comfortably accept the transition without misconceptions.
- Addressing and clarification of misconceptions which are usually spread by quacks and faith healers.

- Identifying dangers of sexual encounters with easily accessable sexual contacts like family members and family friends.
- Coping with peer pressure regarding smoking, drug use, alcohol use and sex.
- Highlighting the importance of two way communication channel between youth and their parents/teachers.
- Importance of adherence to moral values especially religious and cultural.
- Highlighting the role of role models in the society and training of adolescents to become youth leaders and role models by involving them in healthy activities.
- Identifying dangers lurking in places where youth usually hang out like internet cafes, video arcades and gaming zones.
- Importance of involving adolescents in sports and extra curricular activities.

Pakistani community has a large segment of young adults and children passing through a stage of transition. Though it is encouraging to see many positive perceptions of the youth, much remains to be done in helping them to grow up into physically and mentally healthy and useful members of the society.