COUNTRY OVERVIEW

Size of population: 174,578,558 (July 2010 est.)

Life expectancy at birth: 65 years (2010 est.)

Percentage of population under 15 years (2010): 36.7%

Population below income poverty line of $1 per day (2010): 36.7%

Youth literacy ratio (male rate as per cent of female rate, ages 15-24) (2007): 53%

Health expenditure per capita per year (2008): US$8

Main ethnic groups (2010): Punjabi 44.68%, Pashtun (Pathan) 15.42%, Sindhi 14.1%, Sariaki 8.38%, Muhajirs 7.57%, Balochi 3.57%, other 6.28%

Main religions (2010): Muslim 95% (Sunni 75%, Shia 20%), other (includes Christian and Hindu) 5%

HIV ESTIMATES

Number of people living with HIV (2008): 110,099

Number of people newly infected with HIV (2008): 22,701

Adult (15-49) HIV prevalence (2008): 0.1%

Young men (15-24) HIV prevalence (2008): 0.05%

Young women (15-24) HIV prevalence (2008): 0.13%

Number of AIDS-related deaths (2008): 4,407

Percentage of people living with HIV receiving antiretroviral therapy (2008): 43.3%

Percentage of population who inject drugs (2006): 0.14% of the adult population

HIV DATA FOR SEX WORKERS

HIV prevalence among sex workers in major metropolitan areas:

Female (2006): 0.5% Male (2006): 1.5% Transgender (2007): 6.4%

Percentage of sex workers who have an HIV test in the last 12 months and who know their results (2006):


Percentage of sex workers who reported to have been reached with HIV prevention programmes (2006):

Knowledge of HIV prevention programmes: Female: 11.4%21; Male: 14%22; Transgender: 31%23

Utilised HIV prevention services: Female: 2%24; Male: 8.5%25; Transgender: 18.5%26

Percentage of sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (2009):

Female: 25.2% Male: 26% Transgender: 15.8%

Percentage of sex workers reporting the use of a condom during penetrative sex with their last client – breakdown for oral, vaginal and anal sex (2006):

Female: Vaginal sex: 45% Anal sex: 7.9% Oral sex: 32.4%

Male: Anal sex: 34.7% Transgender: Anal sex: 32.3%

Condom price as a percentage of price of sexual service – breakdown for oral, vaginal and anal sex (2010):

1-3% for female sex workers. Up to 5% for male and transgender sex workers

Percentage of HIV funding spent on programmes for sex workers between 2003-2008 vs. general population:

Female sex workers: 4.6% (US$3.3 million) Male and transgender sex workers: 1.5% (1.1 million)
Sex work is illegal in the Islamic Republic of Pakistan, yet it has a long history and is a thriving industry in the country. Pakistan was until recently considered a ‘low HIV prevalence, high risk country’ in relation to HIV. However, surveillance data now shows there is a concentrated epidemic among people who use drugs and transgender/hijra sex workers. Whilst one needs to be cautious about the surveillance data due to the difficulty reaching out to sex workers, HIV transmission trends among female, male, transgender/hijra sex workers are a good indicator to comprehend the transmission dynamics of HIV among key populations. For example, HIV prevalence among transgender/hijra sex workers increased from 1.8 per cent in 2006 to 6.4 per cent in 2008. National HIV sero-prevalence data revealed that 1.5 per cent of male sex workers and 0.5 per cent of female sex workers were living with HIV in 2006 and this remained unchanged in 2008.

Size and makeup of the sex worker population: Mapping data shows that in Pakistan there are an estimated 167,500 female sex workers, 79,900 male sex workers and 39,200 transgender/hijra sex workers. However, the actual numbers could be as much as 25 per cent higher due to the hidden nature of the industry. Various groups of female sex workers have been defined by the way in which they operate. These include: brothel-based, kothikhana-based, street-based and home-based female sex workers. A small number of female sex workers are also identified as working as call girls.

In Pakistan transgender people are often referred to as hijras yet there are other groups such as ‘zenanas’ and ‘chavas’. Most transgender sex workers identify themselves with the female gender. Both hijras and zenanas are the receptive partners in anal sex. Chavas however may switch sexual role and become either the penetrated or the penetrating partner. The average monthly income of female sex workers is 8,000 rupees (US$100) and approximately 45 per cent had an income source other than sex work. Most of male and transgender/hijra sex workers belong to a low socio-economic class. Transgender/hijra sex workers earn an average of 4476 rupees per month (US$60), significantly more than male sex workers who earn only 3328 rupees a month (US$45). However, all sex workers have to share a significant proportion of their earnings with the police to continue their work.

Female sex workers report an average number of 25 to 60 clients a month but this number varies for the different types of female sex workers. Brothel based sex workers have the highest number of clients, while home-based sex workers and call girls have the least. The average number of clients for male sex workers is reported to be approximately 20 per month. Client volume varies considerably across cities and ranges between 13 and 31 clients per month. Transgender/hijra sex workers reported an average of 49 clients per month. Client volumes also vary substantially across cities, ranging between 15 clients to 119 clients per month.

Migration pattern: Nearly 22 per cent of female sex workers have migrated to the city where they work. Young women are often brought from rural areas by network operators. Migration in the same province from rural areas to major cities is the most common phenomenon, followed by migration between provinces. There is some movement in and out of the country by larger networks and more up-market groups mainly to the United Arab Emirates. 23.9 per cent of transgender/hijra sex workers had migrated into the city they now work in. Among those who migrated, more than three quarters lived in Deras (hijra dwellings), and a large majority (85 per cent) of the migrants had moved to the city for sex work. Nearly 17 per cent of male sex workers had migrated to a city within the past year, with the majority moving from a smaller to a larger city in the same province.

Working environment: Sex work in Pakistan is both a criminalized and stigmatized occupation and social acceptance is poor. Sex workers in most circumstances are scared to identify themselves as such. They usually work in disguise as ‘Kothiwalli’ or musicians. In almost all circumstances they are forced to share their income with those who look after them and the police. As sex work is illegal, the operation of brothels requires the collaboration of officials and police, who must be willing to ignore or work with controllers, managers, pimps and traffickers in return for bribes. The exploiters – including traffickers, corrupt officials and even some managers and brothel owners – make money not only from the sale of sex, but by harassing sex workers as well as their clients. In addition to the clients, sex workers are surrounded by a complex web of ‘gatekeepers’ including the owners of sex establishments, managers and local power brokers who often have control or power over their daily lives. The laws present against prostitution are used not to control prostitution, but to make money for the police and law enforcement agencies. Anecdotal evidence suggests that nearly all kothikhanas and brothels have to pay a share of their income to the local police. This is a known practice across the country.

Violence: Violence is very common in sex work settings in Pakistan. A section of police and members from religious outfits are the usual perpetrators of violence. Sex workers rarely report incidents of violence or seek legal redress as they believe that the result will always be against them and fear further harassment.

DEFINITIONS

Sex workers: includes all men, women and transgender people who engage in sex work – the exchange of money or goods for sexual services – either regularly or occasionally.

Transgender: Transgender is an umbrella term for individuals whose gender identity and expression does not conform to norms and expectations traditionally associated with their sex assigned at birth. Transgender people may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoey, waria or one of many other transgender identities, and may express their genders in a variety of masculine, feminine and/or androgynous ways.
Sex work is illegal in the Islamic Republic of Pakistan, but has existed ever since its existence and over years has become a commercial industry that exists as an open secret.\(^3,4,5\)

The tag of illegality attached to sex work, makes it difficult to determine the true extent of the sex work industry in Pakistan. Sex workers operate in a highly discrete and concealed fashion.\(^6\)

The major laws against sex work are severe and are enacted under the Hudood Ordinance which was enforced in 1979. These laws criminalize adultery and non-marital consensual sex, with punishments as severe as death. The Hudood Law was intended to implement Islamic Shari’a law, by enforcing punishments mentioned in the Quran and Sunnah for Zina (extramarital sex).\(^7\) The Ordinance was partially replaced by the Women’s Protection Bill in 2006.\(^8\)

The laws against sex work are rarely used to control it, but to make money for the police, corrupt officials and even pimps and brothel owners. Incidences have been reported where clients have been blackmailed by managers and police, and money has been received.\(^9\)

Sex workers are routinely harassed by law enforcement agencies. Violence against sex workers is not only widespread, but is also legitimized, and accepted by many.\(^10,11\)

In the 1950s, ‘dancing-girls’ were legitimised as ‘artists’ in a High Court order allowing them to perform for three hours every evening. This is the only legal cover sex workers have obtained to date. Other activities such as red-light districts and brothels remain in business by offering huge sums in bribes to the police.\(^12\)

A National HIV and AIDS Policy was drafted in 2007, which states that Pakistan has a concentrated HIV epidemic that will be most efficiently controlled by working in a targeted manner through the key populations most likely to be exposed to HIV, in particular people who use drugs, men who have sex with men and female, male and transgender sex workers. The policy, however, is still in draft form and has not yet been approved and implemented.\(^13\)

A National Strategy on HIV and Sex Work was also drafted in 2009 following the first National Consultation on HIV and Sex Work.\(^14,15\)

There are no media campaigns specifically addressing HIV prevention among the sex workers and their clients. Mass media (both electronic and print media) are generally reluctant to raise issues related to sex work and sex workers in Pakistan.\(^16,17\)

**KEY POINTS:**

- Sex work is illegal in the Islamic Republic of Pakistan, but has existed ever since its existence and over years has become a commercial industry that exists as an open secret.\(^3,4,5\)

**QUOTES AND ISSUES:**

- “Laws and policies against sex work – and non-existence of any legislation to protect the rights of sex workers – adds to stigmatization and marginalization linked to sex workers, restricting them from openly approaching any health services and receiving them.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

- “Female sex workers and transgender sex workers are an illegal entity in Pakistan and therefore they are being marginalized by law enforcement agencies and the population in general. This leads to the greater vulnerability of sex workers to HIV and other STIs.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

- “Although sex work is illegal, our biggest protector is the police. They take care of us, as long as they are paid their share of the money. If we don’t pay them, they will put us in jail, and will charge large amounts and also blackmail our clients and friends. We have to cooperate with them to continue our work.” (Focus group discussion, female sex worker, Lahore)

- “The police use us at times to charge a lot of money from clients. They make us pick clients and when the client is having sex with us, they raid and catch them red-handed.” (Focus group discussion, male sex worker, Karachi)

- “The police are the biggest terrorists in Pakistan. They are the biggest source of harassment for us, and the only reason they do it is to make money.” (Focus group discussion, transgender/hijra sex worker, Lahore)

- “As sex work is illegal in Pakistan sex workers have to pay bribes routinely to continue with their work, otherwise they are harassed by the law enforcement agencies. Due to the hidden nature of sex work and police harassment, carrying out HIV prevention work with sex workers is a huge challenge.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

- “The national HIV and AIDS policy is in draft stage and since it has not been approved by the parliament, members of high risk groups are unable to use preventive health services with ease.” (Interview with National HIV Officer, WHO Pakistan)

- “We have developed policies, protocols and guidelines. But the unavailability of legislative support always hampers the NACP preventive efforts.” (Interview with Focal Point for Sex Worker Programmes, National AIDS Control Programme)
PREVENTION COMPONENT 2

AVAILABILITY OF SERVICES

**KEY POINTS:**

- Due to cultural issues the national AIDS response has not incorporated broad-based prevention campaigns for sex workers, or for other similar groups which are known to be at a higher risk of acquiring HIV.\(^{45}\)

- The major initiative taken for the control of HIV among sex workers is the development of service delivery programmes in the major cities. These are being implemented through public private partnerships of Government with NGOs.\(^{46}\)

- The only places providing clinical services for sex workers are the sex worker service delivery programmes. These are drop-in or primary health care centres. These services are few and far between, only being available in major cities.\(^{47}\)

- There are 17 voluntary counselling and testing centres (VCT) throughout Pakistan none of which are designated for sex workers. Stigma and discrimination are major hindrances to sex workers utilizing these services. VCT services are also provided by service delivery programmes, but as the number of service delivery points is limited access is a problem.\(^{48,49}\)

- There are 13 HIV Treatment and Care centres providing comprehensive HIV treatment and care services to HIV positive people including free antiretroviral therapy. These facilities are not specific to sex workers and accessibility and issues of stigma and discrimination have been major hindrances in the utilization of these services by sex workers.\(^{50}\)

- Harm reduction services to sex workers using drugs in Pakistan are provided by the United Nations Office on Drugs and Crime under the auspices of Ministry of Narcotics Control Project through a programme called HIV and AIDS prevention, treatment and care for female drug users and female prisoners. Oral substitution therapy is not available in Pakistan.\(^{51}\)

**OUTCOMES AND ISSUES:**

- “We know of NGOs who provide HIV prevention services but these are very few in number and there are many sex workers who are scattered over the whole city. Although STI treatment services are available we mostly prefer to go to the health care providers nearest to our homes.” (Focus group discussion, female sex worker, Lahore)

- “Only NGOs provide services that are available for us. We have developed a support group for our peers; if someone comes across any sort of violence we support them in getting medical aid, or any service, including dealing with the police.” (Focus group discussion, male sex worker, Karachi)

- “There is only one place where we can go, and it wastes a lot of time getting there. If there are more places like this, run by NGOs, we can certainly come more regularly” (Focus group discussion, female sex worker, Lahore)

- “The services available for hijras are not satisfactory. There are no separate programmes for transgender sex workers and we are not treated as a focus group.” (Focus group discussion, transgender/hijra sex worker, Lahore)

- More funding is required as there is no certainty that the service delivery programmes will continue. More outreach is required as all sex workers cannot access these services. (Interview with National HIV Officer, WHO Pakistan)

- “It needs to be a holistic approach for supporting sex workers. Providing condoms and lubricant alone will not work.” (Interview with Focal Point for Sex Worker Programmes, National AIDS Control Programme)

- “Condoms are easily available in the medical stores, shops and other outlets, but women cannot buy them. We rely on our clients to bring condoms or depend on service delivery programmes for provision.” (Focus group discussion, female sex worker, Lahore)
3
PREVENTION COMPONENT 3
ACCESSIBILITY OF SERVICES

KEY POINTS:

• Only about 11.4 per cent of female sex workers and 14 per cent of male sex workers, are reached by HIV prevention programmes, yet far fewer have ever utilized the services. The major barriers are accessibility, quality, affordability and the non-cooperative attitude of healthcare providers.\(^{52}\)\(^{53}\)

• Due to the stigma and discrimination attached to sex work, sex workers do not declare their profession. However once the occupation of the sex worker is known to the community, or even to healthcare provider a significant amount of stigma is observed.\(^{54}\)\(^{55}\)

• Many sex workers avoid public health providers altogether because they fear discrimination, harassment or abuse.\(^{56}\)

• Service delivery programmes for sex workers focus on HIV and STI services and often do not provide comprehensive sexual and reproductive health services.\(^{57}\)

• UNFPA has initiated sexual and reproductive health services integrated into HIV prevention services for sex workers as part of an sexual and reproductive health and HIV linkages initiative.\(^{58}\)

QUOTES AND ISSUES:

• “High risk groups are unable to use preventative health care services with ease.” (Interview with National HIV Officer, WHO Pakistan)

• “General health providers have a discriminating attitude towards sex workers, which over time is getting worse.” (Interview with Asia Pacific Network of Sex Workers Representative, Karachi)

• "Enabling sex workers to openly access prevention services with dignity must be part of every national HIV programme." (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

• “Due to stigma and discrimination, sex workers often don’t use public health care services. All service delivery programmes operate through drop-in centres, providing free HIV prevention services for sex workers. Accessibility and opening times contribute to low utilization of services at these drop-in centres.” (Interview with National HIV Officer, WHO Pakistan)

• “It is most difficult for a transgender person to access health services as not even a doctor likes a transgender sitting in the waiting room of his clinic as this will affect his status.” (Focus group discussion, transgender/hijra sex worker, Lahore)

• “We don’t know whom to listen to when it comes to HIV. What the ‘doctor’ and NGO workers tell us is totally different from what our ‘hakim’ (‘traditional healer) says. This leaves us in great confusion.” (Focus group discussion, transgender/hijra sex worker, Lahore)

• “It’s only the NGOs that care for us, the government facilities and health providers only abuse us and try to make money out of us.” (Focus group discussion, female sex worker, Lahore)

• “It’s only these NGOs that give us knowledge of HIV and also give us condoms for protection. If these programmes are not there, we will all die of AIDS.” (Focus group discussion, male sex worker, Karachi)
**KEY POINTS:**

- Laws and policies against sex work, and lack of any legislation to protect the rights of sex workers, along with the stigmatization and marginalization linked to sex work, have stopped sex workers from openly approaching any services and participating in their promotion and delivery.  

- There are no national programmes to build the capacity of sex workers to understand their rights.

- An assessment conducted by Family Health International in 2009 found that most of the organizations working with sex workers had a limited understanding of the concept of empowerment, and some level of stigma and discrimination against sex workers by the programme staff was also observed.

- Due to the illegality associated with sex work in Pakistan, sex workers have always been reluctant to come together and form sex worker’s forums. They have always found it risky to volunteer and speak for their peers as advocates. Recently sex workers in a couple of cities have formed groups through the help of service delivery programmes. Such groups are disguised as ‘women’s empowerment associations’ and sex workers do not disclose their occupation to the community.

- Currently there is no national group or coalition advocating for HIV prevention among sex workers or a forum to actively challenge human rights violations and the causes of sex worker’s vulnerability. However a few support groups and civil society organizations of sex workers have emerged from the sex worker service delivery programmes.

**QUOTES AND ISSUES:**

- “The national policy on HIV and AIDS and the national HIV and AIDS Strategic Framework speak about the rights of sex workers in general and their rights for sexual and reproductive health services. The main issues are with implementation and the lack of an organization or a system to ensure its execution.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

- “Perhaps the national consultation on HIV and sex work by UNFPA was first event in Pakistan where sex workers got a chance to sit with the government, civil society and donors, and to voice their concerns for their rights in Pakistan.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

- “We are doing a criminal thing which is not recommended by the society. How can we have any rights or any legal privileges? This is all part of our fate.” (Focus group discussion, female sex worker, Lahore)

- “We would love to organize ourselves, but that is a very difficult thing to do. The police and the law will never allow us to do this because sex work is an illegal activity.” (Focus group discussion, female sex worker, Lahore)

- “A few NGOs do try to organize us, tell us about our rights, and work to reduce the stigma against us. Unfortunately these people are very few, and the ones who discriminate us are in the millions. Until the government helps, it won’t make much of a difference.” (Focus group discussion, transgender/hijra sex worker, Lahore)

- “Empowerment initiatives to support collective organizing, community mobilization and community-led processes are key to ensuring that sex workers benefit from HIV policies and programmes.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)

- “HIV programming needs to be devised in true partnership with sex workers. It must be dynamic, participatory, non-coercive and address the diverse realities of human sexuality and sexual expression.” (Interview with the National Programme Officer for HIV, UNFPA Pakistan)
NOTES AND REFERENCES

2 Ibid.
3 Ibid.
4 Ibid.
8 Ibid.
10 Ibid.
11 Ibid.
12 Ibid.
13 Ibid.
14 Ibid.
15 Ibid.
30 Focus group discussion report with female sex workers in Lahore, October 2010.
32 Kothikhana are generally small premises that are rented by a madam and/or broker where a small number of female sex workers engage in sex work.
39 Focus group discussion report with female sex workers in Lahore, October 2010.
41 Family Planning Association of Pakistan (2008) Baseline research on VIOLENCE, HARASSMENT AND DISCRIMINATION faced by Female Sex workers in Quetta. Lahore: Rahnuma-FPA.
50 Ibid.
58 UNFPA (2009) Sexual and reproductive health needs of female sex workers, Karachi, Pakistan – linking SRH within HIV and AIDS. Islamabad: UNFPA.
60 Ibid.
63 Ibid.
64 Pakistan Voluntary Health and Nutrition Association (2010) Naya Qadam Project for Key Vulnerable Communities for HIV and AIDS. Islamabad: PVHNA.
KEY RECOMMENDATIONS

Based on this report card, a number of programmatic, policy and funding actions are recommended to enhance HIV prevention for sex workers in Pakistan. Key stakeholders – including government, relevant intergovernmental and non-governmental organizations, and donors – should consider the following actions:

LEGAL AND SOCIAL CONTEXT
• Work with national policy makers to recognize the rising trend of HIV among sex workers vis-à-vis its predictable impact on the general population. The Ministry of Health, with support from other stakeholders needs to take the initiative to ensure an already developed HIV Bill is passed into law by parliament.
• Form a multi-stakeholder consortium to carry out a concerted national level advocacy programme to reduce stigma faced by male, female and transgender sex workers.
• Design a media strategy, in consultation with media representatives and community members, which focuses on the key HIV-related issues faced by sex workers while being sensitive to the prevalent cultural and social sentiments of the society.
• Address harassment and exploitation by the law enforcement agencies by involving women’s organizations, UN agencies and regional networks of sex workers in regular dialogue with the Ministry of Interior, police officials and religious leaders.
• Develop an in-service values clarification programme for police officers to appreciate human rights issues pertaining to marginalized communities such as sex workers, transgender people and men who have sex with men.

AVAILABILITY OF SERVICES
• Create a minimum services package for sex worker programmes based on consultation with the government, bilateral agencies, NGOs and the sex worker community.
• Advocate for government authorities in partnership with civil society organizations to mobilize adequate resources to scale-up services for sex workers, both geographically and numerically, based on the agreed minimum service package.
• Ensure service delivery points are sited in ‘safe spaces’ – such as beauty parlours or women’s health clubs where groups of sex workers can gather.
• Strengthen referral systems for services which are not directly provided by existing service delivery programmes. These services include hospital referrals in cases of sickness and provision of HIV treatment and care as well as the referral of sex workers to appropriate agencies in case of homelessness and for drug treatment and rehabilitation.
• Advocate for service delivery programmes to provide integrated HIV and sexual and reproductive health services for sex workers. In addition, promote the introduction of oral substitution therapy for drug users through the service delivery programmes.

ACCESSIBILITY OF SERVICES
• Strengthen peer based outreach within specialized service delivery points for sex workers so sex workers are approached at their workplaces (street, kothikanas, brothels, deras, hotels etc.) or at home and provided with HIV information, condoms, lubricant and basic medical services.
• Ensure that service delivery points are located in areas that are easy to get to for sex workers and have extended opening hours suitable for sex workers.
• Carry out values clarification training among policy makers in the Ministry of Health, and for service providers on issues around stigma and discrimination related to sex workers and sexual orientation in healthcare settings.
• Develop and implement policies and guidelines to protect the privacy and confidentiality of clients receiving services through the service delivery programme and the public healthcare delivery system.
• Establish consumer-led quality control mechanisms – involving the sex worker community – to ensure the quality of services delivered through service delivery programmes.

PARTICIPATION AND RIGHTS
• Develop service delivery programme advisory committees both at the programme and provincial levels with active participation from community members to ensure the rights of service recipients are upheld, including their role of ensuring service quality. Any recommendations made by the committee should be incorporated into programme design.
• Support existing networks of sex workers to develop and mentor self-help groups to overcome problems of isolation, deal with issues pertaining to their life and occupation, and provide information about HIV and looking after their sexual health.
• Build the capacity of sex worker networks to advocate on sex worker rights. Training should be provided to sex workers on human rights and legal issues in addition to leadership development.
• Include sex worker representatives in all discourses related to HIV programme development both at district and service delivery point levels.
• Incorporate a violence redressal mechanism as one of the integral components of the HIV intervention programme for sex workers.

CONTACT DETAILS
For further information about this report card, please contact:

International Planned Parenthood Federation
4 Newham Row
London SE1 3UX
Tel +44 20 7939 8200
Email info@ippf.org
www.ippf.org
UK Registered Charity No.229476

Global Network of Sex Work Projects
72 Newhaven Road,
Edinburgh EH6 5QG,
Scotland UK
Tel +44 131 553 2555
Email secretariat@nswp.org
www.nswp.org

UNFPA Country Office, Pakistan
Sarena Business Complex; 2nd Floor;
Khayaban-e-Suhrawardy; Sector G - 5/1
Islamabad
PAKISTAN
Tel: (92-51) 835 5751
Fax: (92-51) 835 5966

UNFPA
605 Third Avenue
New York,
NY 10158
USA
Tel +1 212 297 5000
www.unfpa.org

The views and opinions expressed in this publication are those of the authors and do not necessarily reflect those of UNFPA, the United Nations Population Fund.