Sexual and reproductive health of young people in Asia and the Pacific

A review of issues, policies and programmes

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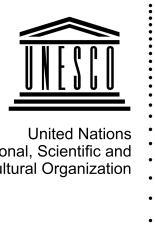

United Nations
Educational, Scientific and
Cultural Organization

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Regional Office

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Sexual and reproductive health of young people in Asia and the Pacific

A REVIEW OF ISSUES, POLICIES AND PROGRAMMES

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MAPS AND DESIGNATIONS

The designations employed and the presentation of material in maps in this report do not imply the expression of any opinion whatsoever on the part of UNFPA, UNESCO and WHO concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

LIST OF ACRONYMS

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ASRH	Adolescent sexual and reproductive health
CSE	Comprehensive sexuality education
DHS	Demographic and Health Survey
DPR of Korea	Democratic People's Republic of Korea
FP	Family planning
FSM	Federated States of Micronesia
GBV	Gender-based violence
GNI	Gross national income
HIV	Human Immunodeficiency virus
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
IHME	Institute of Health Metrics and Evaluation
IUD	Intrauterine device
MICS	Multiple Indicator Cluster Survey
SPC	Secretariat of the Pacific Community
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPD	United Nations Population Division
WHO	World Health Organisation

3 EXECUTIVE SUMMARY

There are almost one billion young people aged between 10 and 24 years living in Asia and the Pacific, accounting for more than a quarter of the population in this region. These young people live in diverse socio-cultural and economic contexts, yet they share important challenges and opportunities related to their sexual and reproductive health. In all countries, increasing access to media, urbanisation and globalisation are contributing to changing sexual values, norms and behaviours of young people, often in conflict with the traditional, conservative socio-cultural attitudes towards premarital sex and gender norms. These factors contribute to significant barriers that limit young people's access to information and services that they need to make a healthy transition into adulthood.

A significant proportion of young people in the region are sexually active, and while for many the onset of sexual activity is associated with marriage, an increasing number are initiating sex before marriage. The available information indicates that most young people are ill-prepared for this transition, having insufficient knowledge and life-skills to negotiate safe and consensual relationships and facing considerable barriers to accessing services and commodities needed to avoid unsafe sex and its consequences. Additionally, a significant proportion of adolescent girls and young women report coerced sex and up to half have experienced sexual violence. Rates of violence are also high among young female sex workers, men who have sex with men, and young transgender people.

As a result, young people are at risk of poor outcomes such as early and unintended pregnancy, unsafe abortion, sexually transmitted infections, and HIV. Poor sexual and reproductive health not only impacts on the health and well-being of young people, but also has significant socioeconomic implications, impacting on education, economic participation and poverty. These negative consequences extend to young people's families and future generations, and can perpetuate a cycle of poor health and disadvantage.

KEY RECOMMENDATIONS

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One in seven girls in the region has given birth by the age of 18, often in the context of high unmet need for contraception and child marriage, with more than a third of girls married before their 18th birthday. Up to 63% of adolescent pregnancies in the region are unintended, contributing to a significant, although underreported, burden of unsafe abortion.

While knowledge of condoms is generally high among young people, in most countries were data are available less than half of 15-24 year olds report condom use at last higher risk sex. Higher risk behaviour, including early sexual debut, multiple partners, and sex under the influence of alcohol, are prevalent in some countries, and up to 10% of males and 20% of females report having had an STI or symptoms in the last 12 months.

Less than a third of young people have comprehensive knowledge of HIV. While the prevalence of HIV among this age group is low, there were an estimated 620,000 young people living with HIV in 2014. The majority (95%) of new infections occur among young key populations including young female sex workers, men who have sex with men, transgender young people, and people who inject drugs. These young people have among the poorest access to essential information and services and also suffer disproportionately from other poor sexual and reproductive health outcomes such as sexual violence, sexually transmitted infections, and unwanted pregnancy. Young people living with HIV, migrant and displaced young people, and the urban poor also lack equitable access to information and services, increasing their risk of poor health. There are many examples of good policy and programmes in the region that aim to improve young people's sexual and reproductive health.

These include approaches to create a more supportive environment for young people, increase access to comprehensive sexuality education, and improve youth-friendly delivery of sexual and reproductive health services. However there remain considerable policy and legislative barriers, and more is needed to improve the coverage and quality of programmes. Importantly, there are also opportunities to strengthen and scale-up effective approaches in the region.

1. SUPPORT RESEARCH TO ADDRESS IMPORTANT KNOWLEDGE GAPS

Despite an increasing number of studies and surveys, several important knowledge gaps remain:

1.1. Relatively limited data for some important cohorts: a. Unmarried, sexually active young people b. Young adolescents aged 10- 14 years c. Young key populations, including SRH needs of young people living with HIV

1.2. Relatively limited data for some important issues: d. Comprehensive knowledge of puberty and reproduction e. Knowledge and use of contraception among unmarried young people f. Knowledge and prevalence of STIs g. Practice and outcomes of abortion among young people, particularly in settings where it is highly legally restricted h. Forced and coerced sex

1.3. Limited rigorous evaluations of programmes to demonstrate impact and cost-effectiveness to support evidence-informed programming and guide scale-up of effective approaches

To address these gaps, there is a need to increase support for, and investment in, local research as well as advocating for the inclusion of unmarried and young adolescents, and a minimum set of SRH indicators, in national-level surveys.

2. SUPPORT EFFORTS TO CREATE A MORE SUPPORTIVE ENVIRONMENT FOR YOUNG PEOPLE'S SRH

Socio-cultural factors, as well as national laws and policies, are among the most significant barriers to improving young people's SRH. To address these challenges, there is a need to:

2.1. Review existing laws and policies that limit young people's access to SRH information and services, including requirements for parental consent for medical care, and provision of services based on marital status.

2.2. Advocate for laws and policies that support young people's rights, including those that prohibit discrimination, and decriminalisation of sexual activity between consenting young people of similar ages and consensual same-sex relationships.

2.3. Support implementation of laws and policies that aim to protect young people, including those that prohibit child marriage, trafficking, and sexual violence.

2.4. Support the delivery and evaluation of programmes that aim to address socio-cultural and gender norms that impact negatively on young people's SRH, including communitybased programmes to prevent child marriage and early pregnancy.

2.5. Continue to support broader initiatives to improve young people's health and well being, such as increasing access to secondary education

3. INCREASE THE QUALITY AND COVERAGE OF COMPREHENSIVE SEXUALITY EDUCATION

There is considerable international evidence of the effectiveness of comprehensive sexuality education which is gender transformative and life skills based. However, the coverage and quality of such programmes remains low in many countries.

3.1. Support the scale-up of ageappropriate school-based sexuality education in both primary and secondary schools. This includes advocating for the development

and implementation of comprehensive, evidence-based curricula and greater investment in teacher training and support.

3.2. Invest in other mechanisms to reach young people with comprehensive information and life-skills training, including those who are out-ofschool. This should include approaches to improve parentadolescent communication and peer education.

3.3. Explore the potential of using mass media and communication technologies to provide information and education, and invest in research to determine the feasibility, coverage and impact of such approaches in the region.

3.4. Invest in rigorous evaluation of CSE and other approaches to improve knowledge and life-skills to document best practices and effectiveness in the region.

4. IMPROVE ACCESS TO YOUTHFRIENDLY HEALTH SERVICES

Access to quality SRH services, particularly for unmarried young people, is limited in the region, contributing to low use of condoms and contraceptives and delayed careseeking. Substantial efforts are required to improve access to youth-friendly services:

4.1. Support local research to define the context-specific features of a 'youthfriendly' health service and identify local challenges.

4.2. Support the development and implementation of national standards of youth-friendly service delivery. This includes allocating sufficient budget to youth-friendly health service implementation, formalising the participation of young people in the design and monitoring of services, and linking interventions to strengthen services with those aiming to generate demand and community support for young people's SRH.

4.3. Support the development of a minimum package of SRH services to be provided to young people. This should include provision of SRH information and counseling, contraception (including long acting reversible methods and emergency contraception), access to comprehensive abortion care (including safe abortion where legal), pregnancy-related care, HPV vaccination and cervical cancer screening, STI diagnosis and treatment, HIV testing, treatment and care, and management of sexual violence. Youth-friendly health services should also address other priority health needs, such as mental health, substance use, and nutrition, which also have important implications for SRH.

4.4. Support efforts to make existing public-sector services more youthfriendly, including investing in training and support of primarylevel health care providers. This includes developing clear certification criteria and quality monitoring tools and establishing supportive supervision and monitoring of facilities and providers.

4.5. Address financial and regulatory barriers (such as requirements for parental consent) that limit young people's access to services, and ensure adolescent SRH services are included in universal health coverage financing mechanisms.

4.6. Strengthen partnerships and referral networks with non-government providers and explore innovative models to reach marginalised young people (such as engaging nontraditional providers). Other approaches to provide out-offacility services through outreach or school-based SRH services should be explored and evaluated.

4.7. Build on lessons learned from successful pilot programmes to increase coverage and scale-up service provision.

5. SUPPORT RESEARCH AND APPROACHES TARGETING KEY YOUNG POPULATIONS

Young key populations, including young people living with HIV, have high unmet needs for SRH information and services. Additional approaches are required to reach these young people:

5.1. Support further research to better understand the needs and information and service delivery preference of young key populations.

5.2. Strengthen school-based sexuality education to include sexual orientation and gender identity to better meet the needs of same-sex attracted and transgender young people and address attitudes that lead to discrimination, bullying and harassment.

5.3. Strengthen the delivery of comprehensive education and services through outreach activities and engagement with nongovernment and non-traditional providers.

5.4. Support efforts to make publicsector services not only more youthfriendly, but also more accessible to marginalised young people. This should include supporting local research to identify young key population's specific needs,

barriers and preferences and development of clear national standards and guidelines that address these issues.

5.5. Integrate SRH into existing HIV prevention programmes, to address the broad health needs of these young people.

6. INCREASE YOUTH PARTICIPATION IN POLICY AND PROGRAMMING

Youth participation is key to ensuring that policies and programmes are effectively meeting young people's needs. This should include efforts to:

6.1. Support the active and meaningful engagement of youth and youth-led organisations in national and regional policy dialogue and programme development. This should include capacity building to strengthen young people's skills and confidence in policy, programme design, communication, advocacy and research as well as strategies to generate support among adult stakeholders.

6.2. Strengthen existing youth networks in the region, both within countries and between countries.

6.3. Advocate for greater participation of underserved and marginalised young people in youth networks, policy dialogue, programme design, implementation and evaluation – particularly policy and programmes aiming to meet their needs.

6.4. Improve documentation and rigorous evaluation of programmes that include youth participation to generate better evidence on processes, best practices and effectiveness of youth participation approaches.

INTRODUCTION

5

Today's generation of young people is the largest in history: globally, 1.8 billion people are aged between 10-24 years, accounting for a quarter of the world's population. The overwhelming majority of young people live in low and middle-income countries, and over 60% live in Asia and the Pacific.[1] Young people are one of society's most valuable resources. Investment in their health and development can have substantial returns, contributing to the achievement of global health goals (such as combating HIV and reducing maternal and child mortality) as well as driving progress towards poverty reduction and gender equality.[2]

Adolescence (Box 1) is the critical life stage that marks the transition from childhood to adulthood. It is a time of rapid growth and development leading to physical and sexual maturity. It is also characterised by significant cognitive, emotional and behavioural transformations that enable young people to develop their own identity, critical thinking capacity, and independence.[3] Adolescence is also defined by important social role transitions, with completion of education, employment, marriage and childbearing usually signifying a young person's entry into adulthood. How successfully young people navigate this transition has enormous implications for their current and future health and well being, and that of their families and communities.[4]

It is during adolescence that young people develop the physical capacity to have sex and reproduce. They also experience an increasing interest in sex, learn social and relationship skills, develop their own sexuality and sexual identity, and, for many, adolescence marks the onset of sexual activity. However this transition also occurs during a time when young people may not have fully developed impulse-control or rational decision-making capacity. This contributes to a period of vulnerability, when young people take risks but may not have the knowledge and life-skills necessary to be able to negotiate safe and consensual sex.[5]

BOX 1. DEFINITIONS

"Adolescence" represents the transition from childhood to adulthood: puberty heralds its onset, with social role transition (completion of education /employment / independent living/ marriage / child rearing) signalling adulthood.

"Adolescence" has historically been defined as coinciding with the ages 10- 19 years, with "Youth" referring to 15-24 years.

"Young people" is a less formally defined term, corresponding to 10-24 years; this age bracket is increasingly used as it more reliably captures the social and developmental transitions of adolescence that extend to early adulthood, including risk factors for poor health. This period is often divided into early adolescence (10-14 years), late adolescence (15-19 years) and early adulthood (20-24 years).

This is compounded in many settings by significant barriers that limit young people's access to information and sexual and reproductive health (SRH) services needed to make a healthy transition into adulthood. Consequently, young people suffer a disproportionate burden of poor SRH.[6]

Additionally, it is during adolescence that young people develop a greater awareness of their own gender identity and roles, and when differences in gender norms and expectations emerge most starkly. In many contexts this profoundly influences the trajectories of boys and girls, with broad implications for young people's wellbeing.[7] This is particularly true for SRH, as gender norms significantly influence attitudes, expectations, behaviours and risks related to sexuality and SRH. For young people who do not conform to gendered expectations or are conflicted about their gender identities these challenges can be substantial.[5]

There are strong incentives for addressing young people's SRH. Globally, young people aged 15-24 experience the highest rates of sexually transmitted infections (STIs) of any age group, and accounted for 42% of new HIV infections in 2010.[6, 8] An estimated 16 million girls aged 15-19 give birth every year, representing 11% of all births but almost a quarter of the ill health related to pregnancy and childbirth, including the consequences of unsafe abortion.[9] Indeed, maternal disorders remain among the leading causes of death of girls aged 15-19 in low and middle-income countries.[10, 11] Additionally, around 30% of young women aged 15-24 have ever

experienced physical and/or sexual violence and a significant proportion of young people report that their first sex was coerced or forced.[12]

Poor SRH during adolescence has important implications for health later in life. For example, STIs can lead to future infertility and cervical cancer, and early pregnancy increases the risk of chronic obstetric morbidity.[9] There are also substantial socioeconomic and development imperatives for investing in the SRH of young people. Ill health, gender-based violence, and early and unintended pregnancy can limit young people's educational attainment and future economic productivity. This can have profound long term and intergenerational impacts, contributing to poorer child health outcomes and perpetuating a cycle of gender inequality and poverty.[9, 13]

Enabling young people to have the highest attainable standard of SRH is also a fundamental human right. As described in the Convention on the Rights of the Child[14] and the International Covenant on Economic, Social and Cultural Rights[15] young people have the right to non-discrimination, privacy, autonomy, and the right to participate in decisions that affect them. In addition, the International Conference on Population and Development (ICPD)[16] Programme of Action has committed governments to protect and promote the rights of young people to sexual and reproductive health education, information and care to ensure a healthy transition into adulthood. There are also several regional commitments that have articulated the rights of young people to SRH information and services and committed countries to ensuring equitable access for young people, addressing gender inequality and violence against women and girls, and eliminating discrimination.[i]

i These include: UN Economic and Social Commission for Asia and the Pacific; Association of South East Asian Nations; Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities, including Condoms

6 REVIEW PURPOSE AND METHODS

Aim

The aim of the review was to describe the current status of young people's SRH and policy and programme responses in the Asia and Pacific regions to support evidenceinformed policy, programming and advocacy.

Objectives

The review focused on four main objectives:

- Describe current sexual and reproductive health risks, outcomes and coverage of key interventions and services for young people aged 10-24 years in the Asia and Pacific region
- Describe the underlying social, cultural and economic determinants of young people's SRH in the Asia and Pacific regions
- Review current policy and programmes related to SRH in the Asia and Pacific regions to identify the evidence-base for interventions to improve SRH outcomes and document best practices and lessons learned to support implementation
- Identify gaps in research, programming and policy and provide recommendations to address priority needs

Methods

This desk-based review included two major approaches:

1. Review and analysis of national-level data

Nationally-representative and comparable data were sought from Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and other reproductive healthy surveys for each included country where available. Data were also sought from UN agency databases and reports (AIDS Data Hub, International Labor Organisation, Population Reference Bureau, UN Data, UNESCO, UNFPA State

of World Population, UNICEF State of the World's Children, World Bank Indicators, World Health Statistics).

The key domains and indicators sought included socio-demographic characteristics, marriage, sexual behavior, SRH knowledge, adolescent fertility, STIs and HIV and sexual and gender-based violence. Where available data disaggregated by age, sex, location, education and wealth were included. Data were entered into a purposebuilt Excel spreadsheet. UNFPA countries were grouped according to the UN Population Division sub-regions,[ii] and population-weighted sub-regional estimates calculated for selected indicators. Data for key indicators for all included countries are included in Appendix 1.

2. Scoping review of peer-reviewed and grey literature

Empirical studies published between January 2005 and June 2015 were sought from PubMed, Cochrane Library, Scopus, CIHAHL and PsychInfo. Search terms were informed by the UNFPA Framework for Action on Adolescents and Youth and Reproductive Rights and Sexual and Reproductive Health framework (Box 2). Major areas of inquiry included: sexual behaviour, contraception, fertility, abortion, STIs, condom use, HIV, sexuality education, youth-friendly health services, young key populations.

Unpublished or non-indexed reports, including national and regional policies, were sought through general internet searches using Google Scholar and targeted searches of regional UN agency, government and non-government websites with the same terms as above. Policy documents were sought from government websites, UN agencies (including the HIV and Health Clearing House), the Secretariat of the Pacific Community and Youthpolicy.org.

Studies and reports that primarily focused on (or included age-disaggregated data for) young people aged 10-24 years in Asia and/or the Pacific or one of 32 included countries were included. Studies focusing on high-income countries were not included. Titles and abstracts were screened for eligibility. Data from relevant full text articles or reports were extracted to identify major topic area, type of study, countries included, target population, setting and findings. Findings were organised thematically to synthesise existing status, knowledge, evidence and gaps.

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ii South Asia: Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, Sri Lanka; South-east Asia: Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, Viet Nam; East Asia: China, Democratic People's Republic of Korea, Mongolia; Oceania: Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu.

Limitations

A key limitation of the review was that it was desk-based, and therefore only documents available electronically from the above sources were included. Additionally, only English resources and documents were reviewed. It is likely therefore that a number of government policy documents and unpublished project reports and case studies have not been identified.

BOX 2. SEARCH TERMS

Search terms

youth OR adolescen* OR young adult

AND

Asia OR Oceania OR Afghanistan OR Bangladesh OR Bhutan OR Cambodia OR China OR Democratic People's Republic of Korea OR India OR Indonesia OR Iran OR Lao PDR OR Laos OR Malaysia OR Maldives OR Mongolia OR Myanmar OR Burma OR Nauru OR Nepal OR Pakistan OR Papua New Guinea OR Philippines OR Sri Lanka OR Thailand OR Timor- Leste OR Viet Nam OR Fiji OR Federated States of Micronesia OR Kiribati OR Marshall Islands OR Samoa OR Solomon Islands OR Tonga OR Tuvalu OR Vanuatu

AND

induced abortion OR adolescent-friendly health services OR contraception OR sex education OR family planning services OR HIV OR intimate partner violence OR peer education OR unintended pregnancy OR early pregnancy OR early marriage OR premarital sex OR sexual behavior OR sexual health OR reproductive health OR sexually transmitted infection OR condom utilization OR sexual violence OR dating violence OR youth-friendly health services OR media OR communication media OR conditional cash transfer OR pornography

7

CONTEXT OF YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH IN ASIA AND THE PACIFIC

There is great diversity in the socioeconomic, cultural and religious contexts in which young people in Asia and the Pacific live. These have a considerable impact on social and gender role transitions, opportunities and aspirations of young people, which in turn have implications for their SRH.

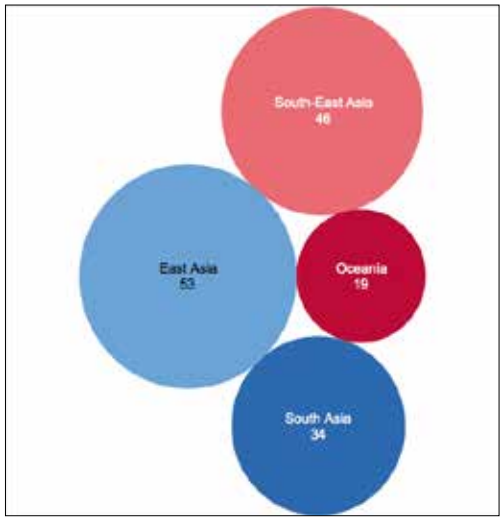
Demographic profile

There are almost one billion young people aged 10-24 years living in Asia and the Pacific, comprising 27% of the total population in this region (Figure 1). In countries characterised by a high but declining total fertility rate and significant gains in child mortality, such as Afghanistan, Pakistan, Lao PDR, Philippines, PNG, Solomon Islands and Vanuatu, young people now account for almost a third of the population.[1] There are 108 males for every 100 females aged 10-24 years in the region.

almost **one billion young people** in Asia and the Pacific

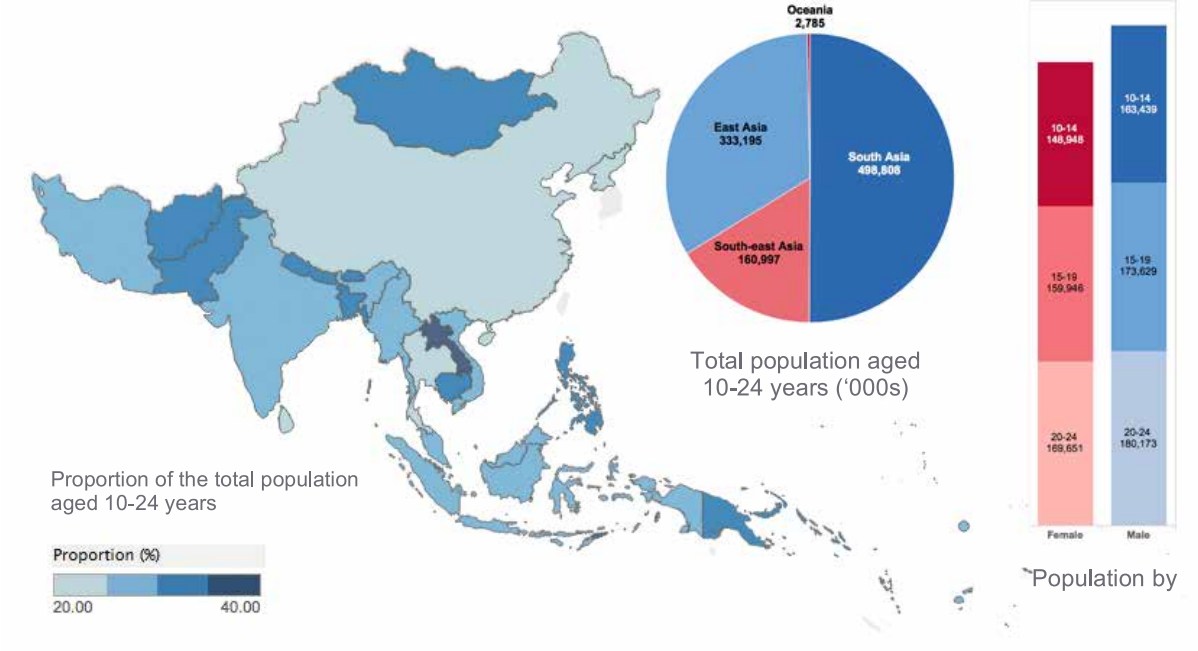
The disparity in sex ratio is largely due to high distorted sex ratios in India (110) and China (112), as a result of persistent son preference and prenatal sex selection.[17] While some countries in the region, most notably in South Asia, are increasingly recognising transgender and intersex populations, there is currently very limited demographic data for these young people.

FIGURE 1. PROPORTION OF THE POPULATION LIVING IN URBAN AREAS (%)



Source: UNICEF State of the World's Children 2015

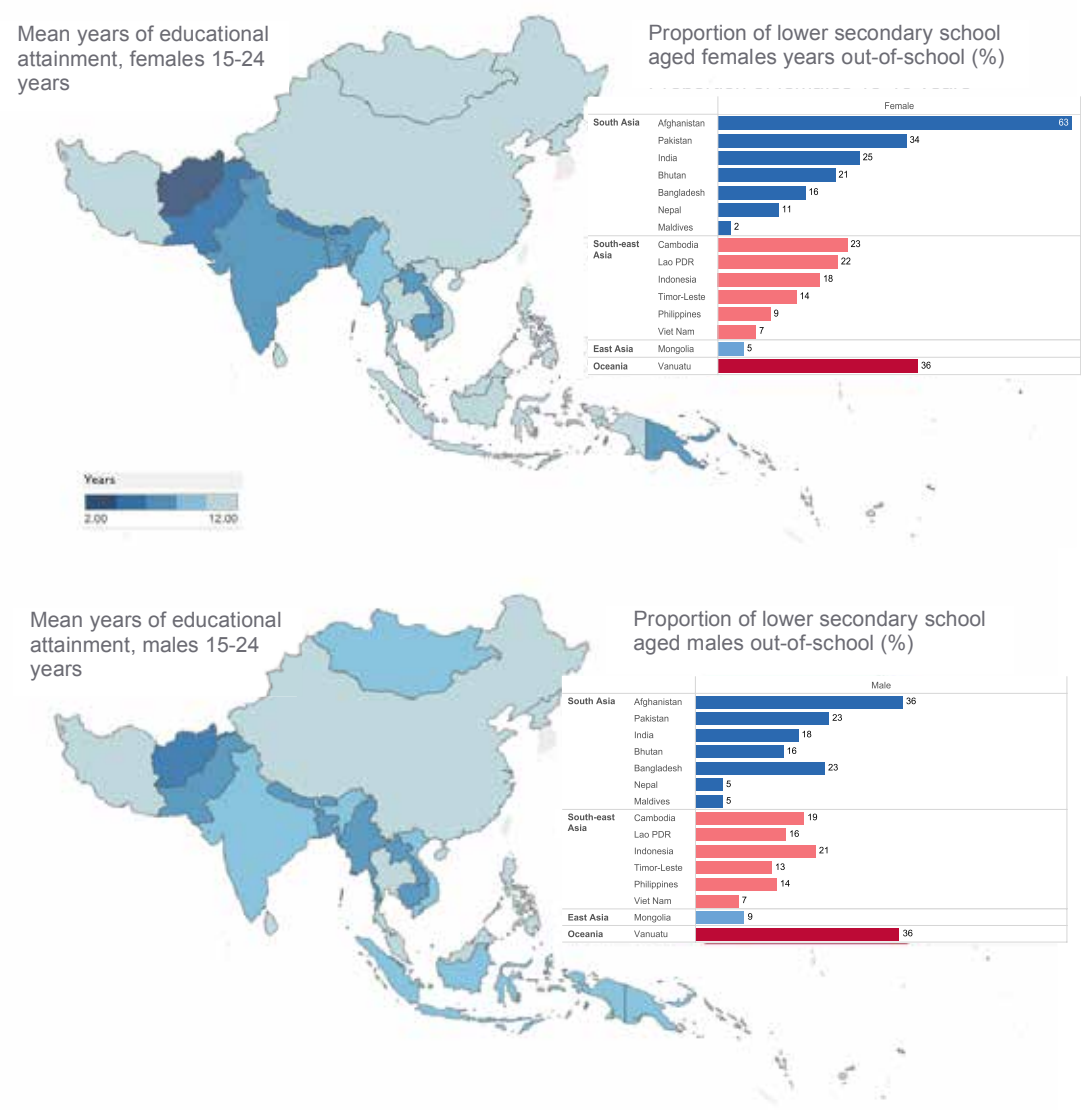
FIGURE 2. POPULATION OF YOUNG PEOPLE AGED 10-24 YEARS



Source: UNICEF State of the World's Children 2015

While the majority of young people in South Asia, South-east Asia and Oceania live in rural areas (Figure 2), increasing urbanisation means that much of the growth in the youth population in this region is likely to be in urban areas. Labour migration is a major factor contributing to urbanisation, and young people make up at least a quarter of all migrants in the region.[18] Conflict and natural disasters are also important drivers of internal and international migration contributing to urbanisation.[19]

FIGURE 3. EDUCATIONAL ATTAINMENT AND OUT-OF-SCHOOL ADOLESCENTS, 2004-2013



Source: IHME Global Educational Attainment 1970-2015; UNESCO Institute for Statistics

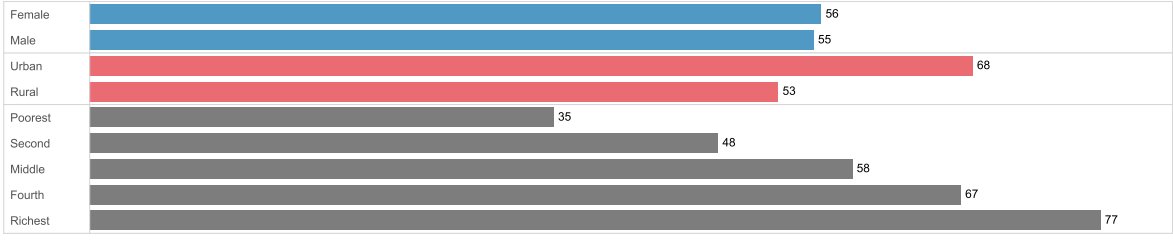
Education and employment

There has been significant progress to improve access to education in the region, with most countries on track to achieve universal access to primary education (Millennium Development Goal 2).

However significant inequities still exist in secondary education between countries: the mean years of educational attainment are less than seven in Afghanistan, Bhutan, Nepal and Pakistan compared with more than 12 years in Democratic People's Republic of Korea (DPR of Korea), Fiji, Federated States of Micronesia (FSM) and Malaysia (Figure 5).[20] Persistent disparities between male and female adolescents also exist. In many countries, particularly those in South Asia, adolescent girls achieve lower rates of educational attainment than boys and a greater proportion are out-of-school.[21] Rural adolescents and those from the poorest households are also less likely to attend secondary school than their urban and wealthier peers (Figure 3).

A greater proportion of young males than females aged 15-24 are participating in the labour force and, with the exception of East Asia, young females are more likely to be unemployed (Figure 4).[22] Young people account for almost half the unemployed population in the region and are at least three times more likely to be unemployed than adults.[18]

FIGURE 4. NET ADJUSTED SECONDARY ATTENDANCE (%) BY SOCIO-DEMOGRAPHIC CHARACTERISTICS, 2003-2013



Excluding China and India
Source: UNICEF State of the World's Children 2015

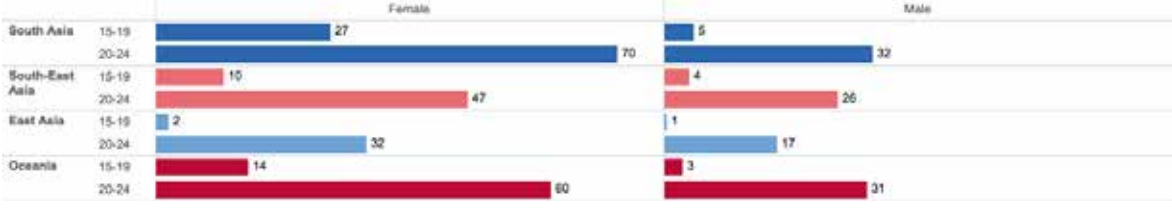
FIGURE 5. PROPORTION OF YOUNG PEOPLE 15-24 YEARS PARTICIPATING IN THE LABOUR FORCE AND YOUTH UNEMPLOYMENT (%), 2013

Source: International Labour Force Organisation

Marriage

The majority of adolescents 15-19 years have never been married, however the proportion married or in union increases sharply for 20-24 year olds (Figure 6). In all countries a much greater proportion of females are married than males, most marked in South Asia where 27% of adolescent girls are married compared with 5% of boys reflecting strong socio-cultural and gender norms that support early marriage and fertility among females.

FIGURE 6. PROPORTION OF YOUNG PEOPLE CURRENTLY MARRIED OR IN UNION, 2006-2013

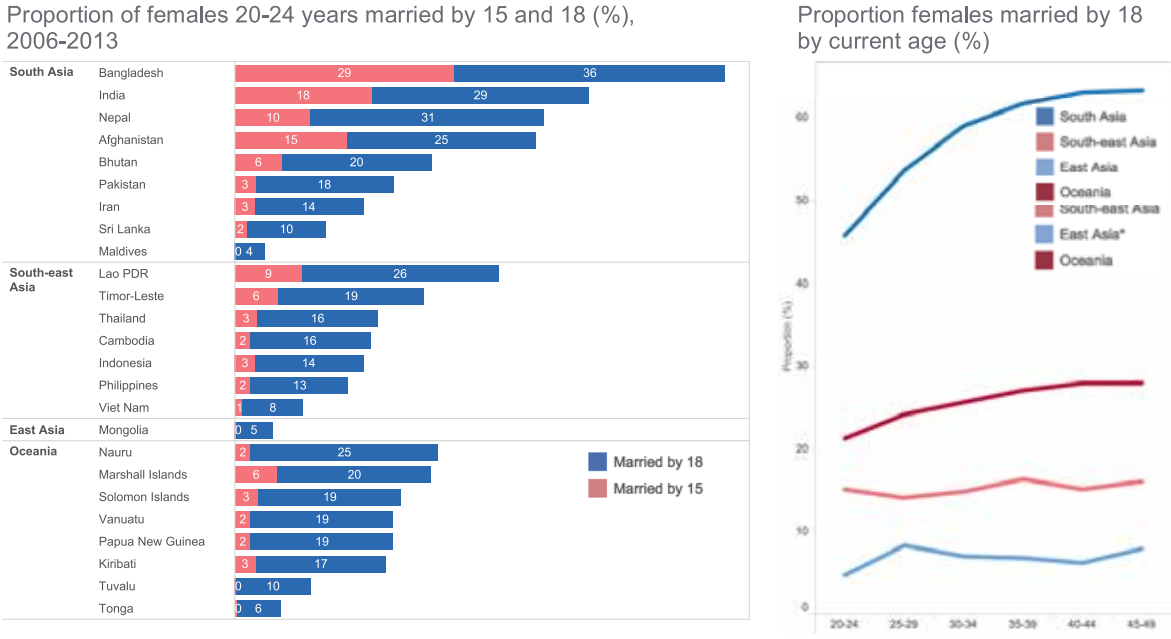


Source: UNPD. World Marriage Data 2012

Despite legislation in most countries prohibiting child marriage, more than a third of young women in the region were married by 18, and one in eight married by15 (Figure 7).[23-49] Rates of early marriage among adolescent girls varies significantly: over a third of girls are married by 18 in Bangladesh, India, Nepal, Afghanistan and Lao PDR compared with 5% or less in Mongolia and Maldives. South Asia has seen the most significant reduction in child marriage in the last two decades (63% of 45-49 year olds were married by age 18 compared with 46% of 20-24 year olds), however rates are still more than double those of other sub-regions (Figure 7). While rates of child marriage are generally low in South-East Asia, there has been comparatively little progress in recent years.

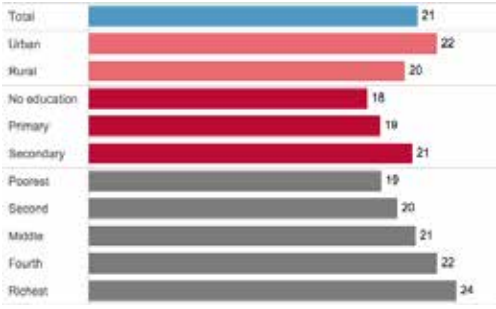
In all countries, girls living in rural areas, those with less education, and girls from poorer households are more likely to be married or in union (Figure 8). Child marriage is not only a violation of girls' rights but also has significant health, gender and socioeconomic consequences. Early marriage is associated with an increased risk of early pregnancy, STIs (including HIV) and gender-based violence, and is also a critical factor in girls' low educational attainment.[50, 51]

FIGURE 7 CHILD MARRIAGE RATES AND TRENDS



Source: DHS and MICS surveys 2006-2013; * Includes Mongolia only

FIGURE 8. MEDIAN AGE OF FIRST MARRIAGE AMONG 25-29 YEAR OLDS, 2006-2013



Excluding China and India
Source: DHS and MICS surveys 2006-2013

These risks may be particularly acute for girls whose partner is significantly older, and the available data in the region indicates that as many as one in five adolescent girls who are married have a partner aged 10 years or more older (Table 1).[24, 26, 27, 30, 32, 43, 48]

TABLE 1. SPOUSAL AGE DIFFERENCE 10+ YEARS

	Proportion of adolescent girls aged 15-19 years currently married or in union whose partner is 10+ years older (%)
Afghanistan	11
Bangladesh	20
Bhutan	12
Lao PDR	11
Mongolia	9
Thailand	11
Viet Nam	7

Source: MICS surveys 2011-2013

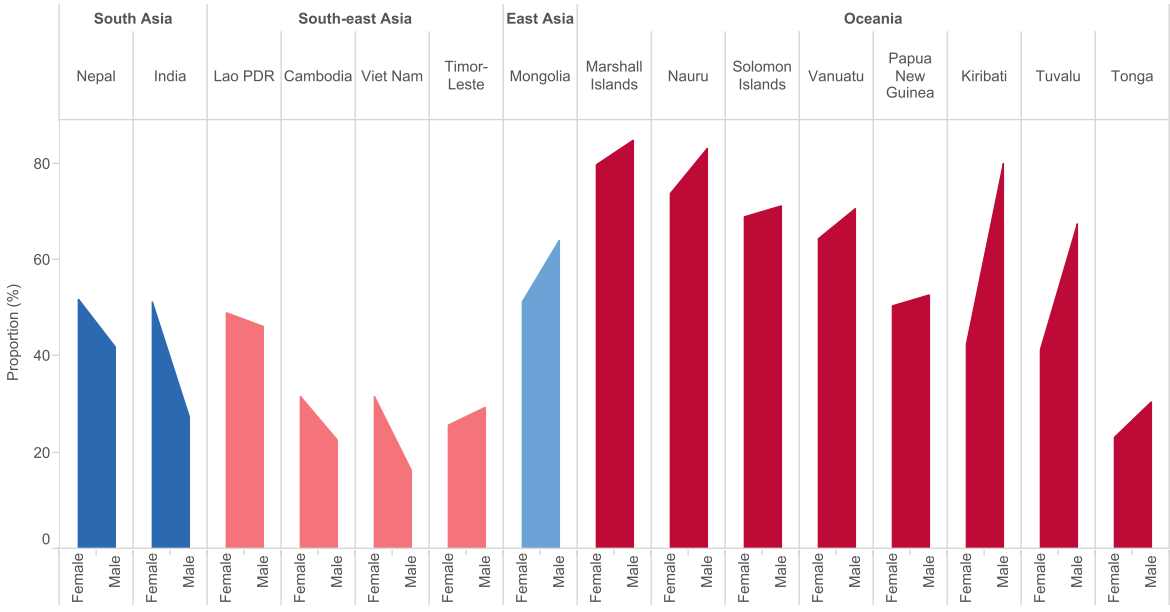
Sexual behaviour of young people

National-level data describing sexual activity of young people, particularly unmarried young people and young adolescents (10-14 years), are limited for many countries. Where information is available, it suggests that many young people initiate sexual activity during adolescence and in those countries with higher rates of early marriage among girls, a greater proportion of young women have ever had sex compared with young men.[27-35, 37-40, 42, 44-49] Where early marriage of girls is less prevalent, boys are more likely to have ever had sex than girls, reflecting more permissive attitudes towards premarital sex among boys. Figure 9 presents available data for the proportion of 15-19 year olds who have ever had sex, the angle of the bar reflecting the difference between males and females.

Other national and sub-national studies of secondary and tertiary students also indicate that a significant proportion of young people are sexually experienced: of 1139 students (15-20 years) surveyed in Malaysia in 2010, 13% reported having ever had sex;[52] a national survey of 144,000 urban secondary and college students in China reported that 5% and 11% respectively had ever had sex;[53] in Iran a cross-sectional study of 1500 university students reported that 41% had ever had sex (39% of girls and 45% of boys);[54] and in Myanmar, a 2010 study of 400 medical students and 410 community youth (15-24 years) found that 10 and 12% respectively were sexually experienced.[55]

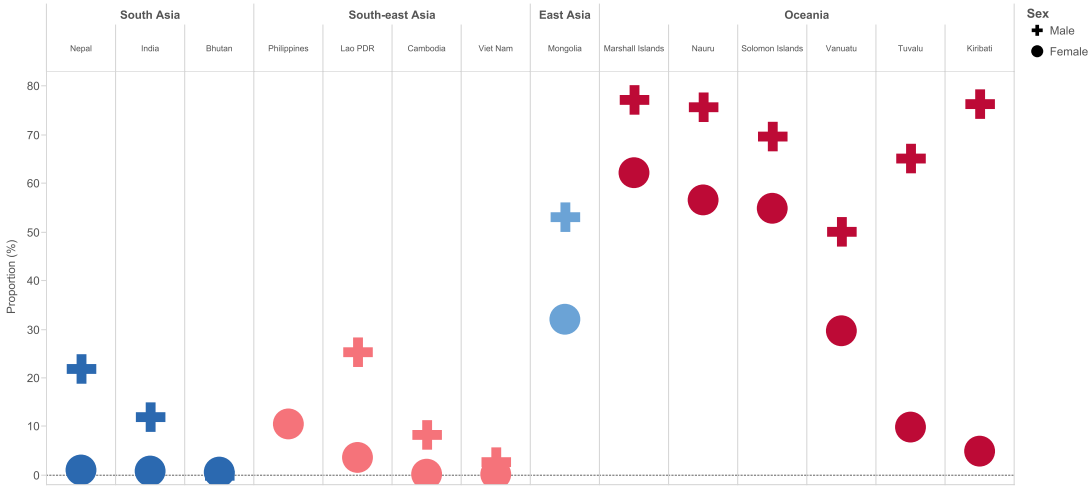
For most young people in Asia, particularly females, the onset of sexual activity coincides with marriage. However with rising ages of marriage and changing socio-cultural norms, studies from several countries indicate that an increasing number of young people commence sexual activity before marriage.[38, 56-58] In China, for example, nationally representative sample of unmarried women aged 15-24 years reported that 19% were sexually active, in the context of very low levels of SRH knowledge.[59]

FIGURE 9. PROPORTION OF ADOLESCENTS 15-19 YEARS WHO HAVE EVER HAD SEX, 2006-2013



Source: DHS and MICS surveys 2006-2013

FIGURE 10. PROPORTION OF YOUNG PEOPLE AGED 15-24 YEARS WHO REPORT SEX BEFORE MARRIAGE, 2006-2013



Source: DHS and MICS surveys 2006-2013

Premarital sex is more common in the Pacific: over half of 15-24 year olds report sex before marriage in Marshall Islands, Solomon Islands and Nauru (Figure 10). A greater proportion of urban young people also report sex before marriage than their rural peers who are more likely to be married at a younger age: in Cambodia, for example, 18% of young men in urban areas have had premarital sex compared with 6% in rural areas.[28] A nationally representative sample of unmarried women aged 15-24 years in China reported that 19% were sexually active, in the context of very low levels of SRH knowledge.[59] In some settings young people who are out-of-school are also more likely to engage in premarital sex: a study of urban adolescents aged 17-20 in Thailand reported that 90% of out of school boys and 53% of out of school girls had commenced sexual activity, compared with 33% and 15% who were still at school, respectively.[60]

A substantially greater proportion of young men engage in sex before marriage than young women. Some studies also suggest that young men and women engage in premarital sex in different circumstances: young women are more likely to report that their first sex was within a committed relationship or with a partner they planned to marry; young men are more likely to have sex with a casual partner or sex worker.[61] However, this pattern appears to be changing in some settings as attitudes towards premarital sex among young women become more permissive, meaning more young women and men engage in sexual activity in the context of romantic relationships.[62]

Sex before marriage in itself is not necessarily a risk factor for poor SRH. Increasing interest in sex and sexual experimentation are a normal part of adolescent development, and young people who are equipped with knowledge, skills and access to services can have healthy, positive sexual relationships. However, where significant cultural taboos surrounding sexual activity outside of marriage exist, premarital sex often occurs in the context of inadequate knowledge and poor access to services, placing young people at increased risk of STIs and unintended pregnancy. Additionally, the psychosocial consequences of the negative outcomes of unsafe sex can be substantial in settings where premarital sex is highly stigmatised.

The proportion of young people reporting higher risk sexual behaviour varies considerably in the region, although data are very limited for some countries (Figure 11). Higher risk sex includes behaviours that increase the risk of HIV and STI transmission. These include early sexual debut (<15 years), multiple sexual partners, intergenerational sex, transactional sex and sex under the influence of alcohol.[63] These factors may also be associated with other SRH risks and outcomes such as forced or coerced sex and unintended pregnancy. Non-use of condoms is also a high-risk behaviour, but is addressed in more detail in subsequent sections.

For females, early sexual debut is most common in countries with high rates of early marriage. Significant partner age disparity is also more common in these countries, particularly in South Asia where around one in 10 females aged 15-24 years report having had sex with a partner 10 or more years older in the last 12 months.[27-35, 37-40, 42, 44-49] Young men are more likely to report multiple sexual partners, particularly in the Pacific where up to half of young men who have ever had sex report two or more partners in the last 12 months. Additionally, up to 6% of men aged 15-24 years report having paid for sex in the past year, with some studies suggesting that young clients of sex workers have low levels of SRH knowledge and condom use. Among 1013 youth clients surveyed in Bangladesh only 12% reported regular condom use with a high prevalence of chlamydia (4%) and herpes simplex virus (13%).[64]

Numerous studies have documented the relationship between substance use and risky sexual behaviour. Use of alcohol and amphetamine-type stimulants, among others, is associated with higher risk behaviour (including non-use or inconsistent use of condoms), sexual violence and coercion, and higher rates of STIs and unintended pregnancy.[17, 55, 63, 65-72] A study of 880 young people aged 16-24 years in Viet Nam found that alcohol use was significantly associated with risky behaviour among young men: 40% who did not use condoms and 45% who had multiple sexual partners had ever consumed alcohol.[73] A study of 1385 urban adolescent boys in Iran found an association between alcohol consumption and multiple sexual partners.[74]

For countries with national-level data, young men report much higher rates of sex while drunk than young women, most significantly in the Pacific.

Alcohol use among adolescents varies considerably in the region. Between 0 and 2% of adolescents aged 15-19 years report at least one episode of binge drinking (consumption of at least 60 grams of pure alcohol on at least one occasion) in the past 30 days in Afghanistan, Bangladesh, Bhutan, DPR of Korea, India, Indonesia, Iran, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.[70] Between 9 and 12% report binge drinking in Cambodia, China, Kiribati, Lao PDR, FSM, Mongolia, Nauru, Philippines, Samoa, Tuvalu, Vanuatu and Viet Nam. The highest rates of binge drinking are reported in Fiji (21%), PNG (18%) and Solomon Islands (16%). In all countries risky alcohol use is more common among males than females, with binge drinking rates 2-3 times higher among adolescent boys.

FIGURE 11. PROPORTION OF YOUNG PEOPLE AGED 15-24 YEARS REPORTING HIGHER RISK SEXUAL BEHAVIOUR, 2006-2013

		Female				Male			
Subregion	Country	Sex before 15	Multiple partners*	Alcohol and sex^	Sex with partner 10+ years older**	Sex before 15	Multiple partners*	Alcohol and sex^	Paid for sex**
South Asia	Bhutan	4	0		13				
	India	10	0		11	2	7		1
	Maldives	0							
	Nepal	7	0		11	3	11		2
South-east Asia	Cambodia	1	0			0	1		3
	Indonesia	2							3
	Lao PDR	6			13	3			
	Philippines	2			11				
	Timor-Leste	2		0		1	1	1	6
	Viet Nam	1	0	3	9	0	2	2	1
East Asia	Mongolia	1	1		5	4	13		
Oceania	Kiribati	2	2	1		14	16	23	
	Marshall Islands	14	7	2	4	27	13	19	1
	Nauru	15	17	12		31	53	32	0
	PNG	5	2			4	13		
	Solomon Islands	12	11	1	6	12	22	5	3
	Tonga	1	4	1		1	24	5	
	Tuvalu	2	3	1		15	16	19	2
	Vanuatu	6	4	1	1	7	16	5	3

* Among young people who have ever had sex, proportion reporting sex with two or more partners in the last 12 months
^ Proportion reporting sex while drunk in the last 12 months
** In the last 12 months

Source: DHS and MICS surveys 2006-2013

Young key populations

Young key populations are those who are more likely to be exposed to, or transmit, HIV. They are not only disproportionately affected by HIV, they are also key to the HIV response.[75] These key populations include young people living with HIV, young people who buy or sell sex, young people who inject drugs, young men who have sex with men, and young transgender persons. Higher risk behaviours for HIV, including early sexual debut, multiple partners, unprotected sex (including transactional sex), and sharing injection equipment, often commence from an early age. Where data are available they suggest that the majority of women, men and transgender people who sell sex initiated sex work during adolescence and early adulthood.[76] In Viet Nam,[77] Indonesia,[78, 79] and Thailand,[80, 81] young men who have sex with men and transgender young people report high rates of early sexual debut and multiple partners, as well as inconsistent condom use and experience of sexual coercion. Similarly, studies in the Philippines,[82] Cambodia,[83] Lao PDR,[84] Indonesia,[85] China and Viet Nam [86] have described high rates of multiple partners and low condom use, as well as sexual violence, STIs and abortion among young women who sell sex.

Many factors contribute to higher risk sexual behaviour and poor SRH outcomes among young key populations. Socio-cultural norms and taboos concerning premarital sexual behaviour contribute to barriers faced by many people in the region, however young key populations also experience substantial stigma and discrimination (including within health facilities) and legislative barriers preventing access to essential information and services to support good SRH.[86-88] Young key populations may also be more vulnerable to exploitation, coercion and violence than their adult counterparts, contributing to higher risk behaviours such has non-use of condoms.[72] In the Philippines, for example, adolescent female sex workers (aged 14-17) were more than three times less likely to negotiate condom use with their clients than adult sex workers.[82] Young key populations are also more likely to report substance use, which is associated with a higher prevalence of high-risk behaviours.[89-91] In China, over half of adolescent female sex workers surveyed in Kunming reported sex while drunk in the past week and of these 56% did not use condoms.[92] They are also less likely to report protective factors such as engagement with school and family, which has broad ramifications for their health and wellbeing.[73] In addition to HIV, these young people are also likely to face other threats to their SRH, including sexually transmitted infections, unintended pregnancy, and sexual violence.

in 2013 an estimated 210,000 adolescents were living with **HIV**

Young people living with HIV have particular needs related to SRH, including young people who were perinatally infected. Improved access to antiretroviral therapy has contributed to a shift in the paediatric HIV epidemic, with an increasing number of perinatally-infected children surviving to adolescence and early adulthood.[93] In 2013 an estimated 210,000 adolescents aged 10- 19 years were living with HIV in

Asia and the Pacific.[94] Like all young people, they are just beginning their sexual and reproductive lives and require comprehensive, nondiscriminatory information and services that enable them to have safe, consensual relationships and supports their future plans for marriage and parenting. There are relatively limited data describing sexual activity of young people living with HIV in this region, but where available it suggests that these young people are not being adequately prepared and supported for this transition. A study of 92 HIV-positive young people aged 14-21 years in Thailand conducted in 2013 reported that around 14% had had sex in the past six months, but many lacked knowledge and skills regarding safe sex, and almost 60% had never used a condom.[95] In China, of 124 rural adolescents with perinatally-acquired HIV only 20% had discussed sexuality with their parents, more than half had not heard of condoms, and 5% had comprehensive knowledge of HIV.[96] Persisting stigma related to HIV contributes to poor access to services, including SRH services, and also contributes to low rates of disclosure.[97-100]

in China
20%
had discussed sexuality with their parents

Underlying determinants of young people's sexual and reproductive health

Family and peers

Family can be an important protective influence on young people's health and wellbeing. Studies from Indonesia, Thailand and the Philippines have demonstrated an association between delayed sexual initiation and having a close relationship with parents.[101, 102] Conversely, a lack of parental support or living away from family has been associated with early initiation of sex.[68, 71] Family support may be particularly important for girls: studies from India,[103] Viet Nam,[104] Cambodia[6] and the Philippines[58] have suggested that adolescent girls' connectedness to parents, particularly their mothers, and a family environment that supports gender equality are associated with delayed first sex among girls. While religious taboos may be a barrier limiting open discussion of sexual health and access to services, a family's religious or spiritual beliefs can also be protective against risky sexual behaviours.[105]

Peers are also a strong influence on young people's attitudes and behaviours. While a positive peer culture is protective, peer delinquency can be associated with risky behaviour, particularly among boys.[6, 104] Additionally, a perception that the majority of friends or peers are already having sex increases pressure on young people, and has been associated with early sexual initiation in the Philippines,[106, 107] Lao PDR,[108] Viet Nam,[104] Cambodia[6] and Malaysia.[9]

Education

Education is protective against a range of health risk behaviours, including higher risk sexual behaviour. Increased educational attainment is associated with delayed age at

first marriage and first sex for adolescent girls in many settings. Young people who attend school are more likely to delay sexual debut, have better perception of their own risk related to STIs, and are more likely to practice safer sex.[104, 109, 110] For example, a study of 1360 adolescents aged between 14 and 19 in Lao PDR demonstrated that school attendance reduced the odds of risky sexual behaviour (including sexual debut less than 15 years, multiple partners, non-use of condoms) for both boys (Odds Ratio (OR) 0.53) and girls (OR 0.17).[108]

Media

Today's young people are growing up in a rapidly changing society. Urbanisation, globalisation and increasing access to media expose young people to a great diversity of ideas, attitudes and norms. As a result young people's attitudes towards sexual activity are changing, with studies in Malaysia,[111] Viet Nam,[61, 112, 113] Thailand,[62] Philippines,[107] Indonesia,[114] China[115] and Iran[54] revealing a more permissive attitude towards dating and premarital sex than their adult counterparts.

in Viet Nam **the Internet** is wildly used as a space to learn about sexual relationships

The increased access to, and use of the Internet has had a significant impact on sexrelated knowledge and behaviour. A study of Chinese and Vietnamese youth, for example, found that over half had learned about sex from the Internet.[116] For a number of youth, the Internet is also a platform by which to express their sexual identity and desires. In Viet Nam, the Internet is being widely used as a space to learn about sexual relationships from the personal experience of others, particularly when SRH information is not available from other sources.[117]

Strict anti-pornography laws exist in many countries, however evidence suggests that adolescents are still gaining access to sexually explicit content. One study examining the prevalence rates and patterns of pornography consumption in Indonesia, found pornography to be as readily and widely consumed as in comparable samples from more sexually liberal and less conservative countries.[118] Significant gender differences in consumption rates were also observed, with men consuming more often, for longer periods, and at an earlier age than women. Pornography consumption was significantly associated with premarital sexual activity among young men, but not women. These findings are comparable with international counterpart studies, and lend support to additional studies that have demonstrated the steady liberalisation of youth sexuality in Indonesia over the past decade.[119] A study of 1500 university students in Iran reported that 88% of girls and 84% of boys had viewed pornographic material in the last six months, although there was no statistically significant association between exposure to pornography and sexual activity.[54] While concern about young people's exposure to pornography is common, currently global research linking pornography to higher risk sexual behaviour is inconclusive and the long term impacts require further investigation.[120]

Marginalisation and socio-economic disadvantage

Young people who are disadvantaged have an increased risk of poor SRH in many settings. Studies of young people of lower socio-economic status living in urban slums have reported higher rates of premarital and higher risk sexual behaviour: in Thailand 56% of young women (15-24 years) living in a slum in Bangkok were sexually active, and 42% had had sex without a condom.[56, 121] Homeless young people in many settings report particularly high rates of risky behaviour. In Pakistan, for example, a survey of 565 homeless boys aged 5-19 years reported that 40% had transacted sex in the past three months.[122]

Young migrants also suffer poorer SRH outcomes. In Shanghai, China, migration was independently associated with having had sex in the last three months (OR =1.23, CI:1.01-1.72)[123] SRH and female factory workers in Dhaka, Bangladesh had low SRH knowledge and condom use and high rates multiple sexual partners.[124] SRH needs and risks may be particularly high in humanitarian settings: a study of young refugees (15-24 years) from Myanmar in Thailand found that more than half had engaged in premarital sex, but few had the knowledge or access to services needed to avoid STIs and unintended pregnancy.[125] Young people living with a disability also have sexual and reproductive health needs, but often face additional barriers to accessing information and services and/or experience violations of their sexual and reproductive rights. However, there is very little data regarding SRH of young people living with a disability in the region.

Socio-cultural norms

Most young people in the region live in settings where considerable traditional norms and taboos regarding sexual behaviour persist, particularly in relation to premarital sex. These socio-cultural norms create significant barriers that limit young people's access to information and services.

In addition to sexual norms, gender norms have a profound influence on young people's SRH. At puberty, gender roles take on a new significance for adolescents. In addition to dealing with the complexities of their own emerging sexuality, emotions, and physical development, young people must also learn the gendered social norms and rules regarding values, attitudes and behaviours related to sexuality.[5]

In most countries, young men are more likely to have permissive attitudes towards premarital sex than young women, and both sexes are more permissive of male premarital sex than female premarital sex.[66, 126, 127] Female virginity until marriage is still highly valued in many countries, and as such young women are expected to remain sexually inexperienced and naïve. This contributes to the significant stigma surrounding sexual activity of young unmarried women, inhibiting their access to information and services.[13, 50, 111] A qualitative study in Iran described strong negative social and religious attitudes towards premarital sex contributing to lack of access to SRH information for adolescent girls.[128]

In many South Asian countries, gender norms contribute to high rates of child marriage. Highly negative attitudes towards premarital sexual activity among girls, lower value placed on girl children compared to boys, and financial pressures related to dowry are among the complex factors that contribute to ongoing early marriage of girls despite legislation prohibiting child marriage.[129, 130] Gender norms can also contribute to early pregnancy, particularly in the context of marriage where young women may be under pressure to prove fertility and conceive soon after marriage. In these settings girls often lack decision-making power with respect to use of contraception and timing of pregnancies, with husbands, parents or inlaws strongly influencing or controlling married girls' reproductive behaviour.[131, 132]

Traditional gender roles also impact on young women's ability to negotiate safe and consensual sex. In a study of 1181 young women in Viet Nam, an attitude that women were subordinate to men was associated with less frequent discussion of safer sex with their partner and reduced self-efficacy to negotiate safe sex, including requesting condom use or refusing unwanted sex.[133] Expectations that girls should be sexually naïve also contributed to less discussion about condom use among young women in Thailand.[62] Such gender norms can also contribute to marked power disparity within relationships, increasing vulnerability to coerced or forced sex.

Gender norms also impact negatively on young men. Expectations that men should be sexually experienced, or a perception that their status depends on their sexual conquests, contributes to risky sexual behaviour, such as early onset of sexual behaviour and an increased number of partners.[127, 134, 135] In many countries, including the Philippines and Cambodia, these gender norms also contribute to many young men engaging in sex with commercial sex workers, which, in the context of inconsistent condom use, can increase their risk of STIs and HIV.[109]

Socio-cultural factors can present significant barriers for young people whose sexuality and/or gender identity do not conform to traditional norms. Cultural and religious attitudes and beliefs that are disapproving of sexual and gender diversity contribute to substantial stigma and discrimination against young people who are same-sex attracted, transgender or intersex.[76, 136] Consensual male same-sex behavior is illegal in half of the countries included in this report, and in many others no legal protections against discrimination on the basis of sexual orientation or gender identity exist.[137] Such legislation, socio-cultural and religious norms contribute to large unmet needs for comprehensive, acceptable and appropriate SRH information and services, and exposure to abuse and violence, with significant negative impacts for physical and mental health.[138]

8 KEY SEXUAL AND REPRODUCTIVE HEALTH ISSUES

Puberty

There is very little information about young people's understanding of reproduction and puberty, particularly that of young adolescents (aged 10-14 years). The limited data that are available suggest that many do not have a comprehensive understanding, and misconceptions predominate. In Malaysia, for example, only 30% of 1034 secondary school students knew that a girl could get pregnant after a single act of vaginal intercourse.[139] A qualitative study of young people in Myanmar found that few could correctly name reproductive organs or their functions, most could not explain where or how pregnancy took place, and none could explain menstruation.[140]

The most recent DHS from Indonesia indicates that while the majority of young people can name a sign of puberty, around 10% do not know any sign in a boy, and up to 20% do not know a sign in a girl (Table 2).[141] Additionally, a substantial proportion had not discussed puberty with anyone before it commenced, and the majority of those that did had sought advice from friends.

TABLE 2. PROPORTION OF INDONESIAN YOUNGPEOPLE 15-24 YEARS WITH KNOWLEDGE OF PUBERTY

	Female	Male
Don't know any signs of puberty in a boy	10	11
Don't know any signs of puberty in a girl	5	20
Had not discussed puberty with anyone before it commenced (menstruation; wet dreams)	25	50

Source: Indonesia DHS special report on adolescent reproductive health, 2012

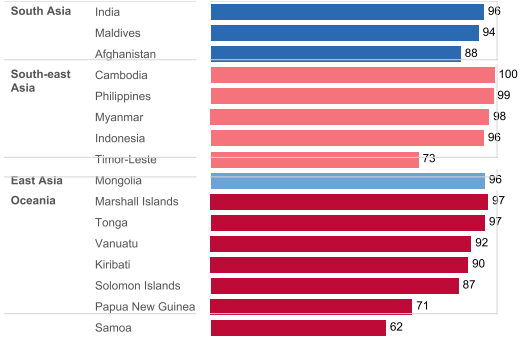
Lack of comprehensive information about menstruation prior to menarche is common in many countries in the region, contributing to substantial anxiety, fear and lack of preparation for menses among adolescent girls.[142] In India, one study found that 86% of girls felt 'completely unprepared' for their first menstruation, and 64% found menarche a fearful experience.[143] Poor knowledge about menstruation, limited access to safe, effective and affordable menstrual hygiene materials and inadequate water and sanitation infrastructure are important contributors to poor menstrual hygiene practices among adolescent girls.[144, 145] In many countries in the region there are also significant cultural and religious taboos surrounding menstruation contributing to negative psychosocial and health consequences.[146] Importantly, poor access to materials and water and sanitation facilities and strict behavioural restrictions are an increasingly recognised cause of school absenteeism and drop out. A recent study in four provinces of Indonesia found that one in seven girls missed one or more days of secondary school a month due an inability to manage menstruation safely and discretely at school.[147]

Early and unintended pregnancy

Knowledge and use of contraception

While the majority of married young people in the region can name a modern method of contraception few have comprehensive knowledge and many myths and misconceptions exist (Figure 12).[28,38,148-150] There are limited data describing knowledge among unmarried young people, and boys: in Indonesia 95% and 93% of unmarried females and males respectively could name a modern method of contraception,[141] while in Malaysia only 54% of girls and 49% of boys knew a contraceptive method.[151] Other studies in Lao PDR and Viet Nam have also described poor understanding of different contraceptive methods, including emergency contraception, and lack of knowledge about sources of contraception.[152, 153] Additionally, many report

FIGURE 12. PROPORTION FEMALES AGED 15-24 YEARS CURRENTLY MARRIED OR IN UNION WHO HAVE HEARD OF AT LEAST ONE METHOD OF MODERN CONTRACEPTION (%), 2006-2013



Source: Indonesia DHS special report on adolescent reproductive health, 2012

misconceptions about the health effects of modern methods of contraception (such as infertility), contributing to fear of contraception and a preference for traditional methods that are perceived to be safer and more effective.[9]

Many unmarried young people find it difficult to discuss contraception with their parents or health workers because of the stigma of premarital sexual activity. Young people have poorer knowledge of contraception than adults and are less likely to be exposed to family planning messages in the media, or discuss it with a health worker – even if they are married.[154] Instead many young people rely on friends or the internet for information.[9]

Use of modern methods of contraception among currently married young women varies considerably in the region (Figure 13). Fewer married adolescents are using contraception compared with women aged 20-24 years. In all countries where data are available, use of modern methods among young women is lower than women over the age of 25, and a larger proportion of young women who are using a method rely on less effective traditional methods.[154] Injectables, pills and condoms are the most commonly used methods among married adolescent girls who are currently using modern method (between 60-100% of girls report using one of these methods).[24, 26-33, 35-45, 47, 48, 155-157] In Afghanistan, Bangladesh, India, Maldives, Nepal, Pakistan, Cambodia, Lao PDR, Philippines, Thailand, Viet Nam, Mongolia, PNG and Vanuatu more than half of adolescent girls rely short-acting methods (pills and condoms). Use of highly effective longer acting reversible methods is generally very low among this age group with the exception of Viet Nam (40% of modern users report using an intrauterine device (IUD)), Mongolia (24% IUD) and Marshall Islands (20% implants). Limited range of contraceptives available, provider bias and costs are likely to contribute to low use of longer-acting methods in this age group.

There is limited information about contraceptive use by sexually active unmarried young people, but available DHS data demonstrate the use of modern methods is low (Table 3). Studies from Malaysia and Viet Nam have reported than many sexually active unmarried youths are not using any method of contraception, or are relying on less effective traditional methods such as folk medicines or withdrawal, and so are at risk of unintended pregnancy. Some young women also rely on periodic abstinence, despite having very poor understanding of the fertile period.[9, 152] In the Marshall Islands, 12.7% of sexually active unmarried girls aged 15-19 reported using a modern method compared with 40% of women over 25.[39] A higher proportion of unmarried girls were using a method than married, largely accounted for by increased use of condoms among unmarried girls. Similar trends were reported in Vanuatu and Solomon Islands.[40, 47]

Many factors contribute to low use of contraception. Lack of knowledge and misconceptions about health effects, lack of girls' decision-making power, and poor access to services are considerable barriers. Among unmarried young people, sociocultural disapproval of premarital sex, legislative and regulatory barriers that prevent unmarried people obtaining contraception and/or requirements for parental and spousal consent, and judgmental health worker attitudes are key factors.[158] In Lao PDR, many health workers report discomfort discussing family planning with unmarried youth, and more than 40% said they would not provide contraceptives.[159] In Vanuatu, judgemental health care workers, concerns about confidentiality and negative attitudes of community gatekeepers were also major barriers to contraceptive use.[160] The unpredictable and infrequent pattern of sexual activity can also make it difficult for young people to plan to have protected sex.

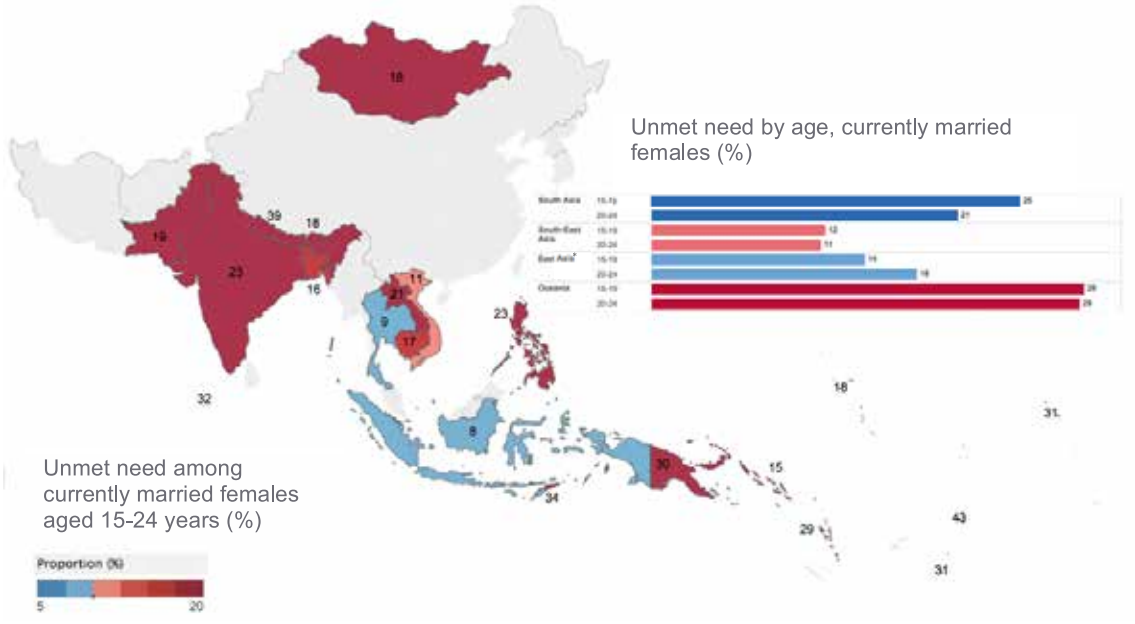
Barriers also exist for married young women, particularly where there are strong sociocultural pressures to have a child soon after marriage and prove fertility.[161] Conversely, where young women are more able to communicate with supportive spouses they are more likely to use contraception to delay or space pregnancies.[148] Subsequently a significant proportion of young females have an unmet need for contraception (largely for birth spacing). For the countries were agedisaggregated data are available, between 8% and 43% of young married women want to avoid pregnancy but are not using any contraceptive method (including traditional methods) (Figure 14).

TABLE 3. CURRENT USE OF MODERN CONTRACEPTION AMONG UNMARRIED, SEXUALLY ACTIVE FEMALES (%)

Country	15-19	20-24
Cambodia	0	22
India	25	25
Indonesia	7	26
Marshall Islands	13	27
Philippines	19	26
Solomon Islands	14	16
Vanuatu	25	20

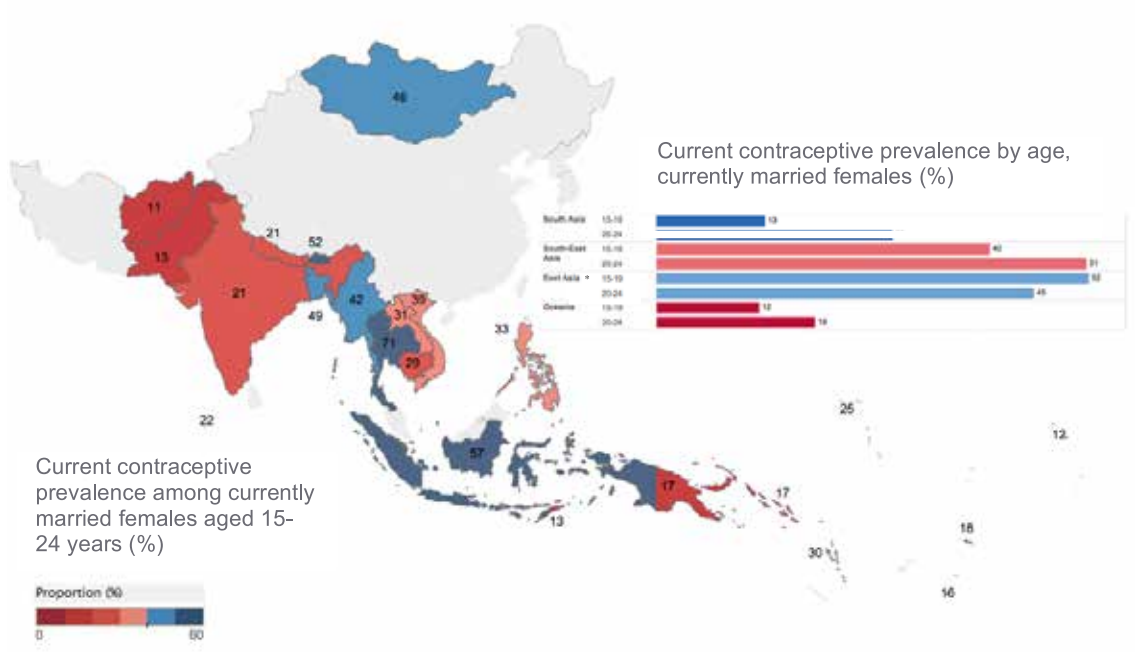
Source: DHS surveys, 2006-2013

FIGURE 13. UNMET NEED FOR CONTRACEPTION AMONG YOUNG WOMEN 15-24 YEARS CURRENTLY MARRIED OR IN UNION, 2006-2013



Source: DHS and MICS surveys, 2006-2013. * Includes Mongolia only

FIGURE 14. CURRENT USE OF MODERN CONTRACEPTION AMONG YOUNG WOMEN 15-24 YEARS CURRENTLY MARRIED OR IN UNION, 2006-2013



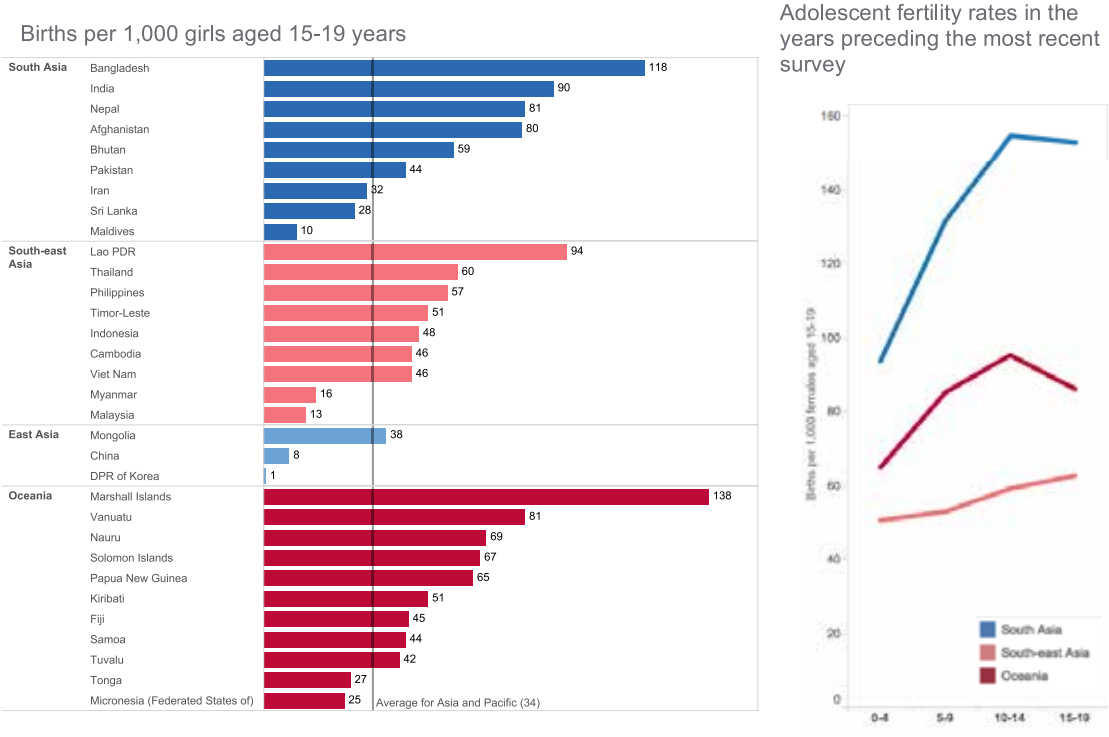
Source: DHS and MICS surveys, 2006-2013. * Includes Mongolia only

Adolescent pregnancy

There is considerable variation in adolescent fertility rates in the region (Figure 15), ranging from less than 1 birth per 1000 girls aged [15-19] in DPR of Korea to 138 in the Marshall Islands.[24, 25, 27-48, 155, 157, 162, 163] Adolescent fertility rates have declined in the last two decades in all countries with available data, with the exception of the Philippines where there has been little change. The greatest reduction has been in South Asian countries, where the adolescent fertility has fallen by almost 40%, in part due to a reduction in child marriage in these countries.[164] Fertility rates are higher in settings where early marriage is prevalent and among rural girls compared with those living in urban areas. Adolescent pregnancy is also associated with less education attainment and lower socio-economic status (Figure 16).[165, 166]

Early pregnancy (<18 years of age), whether intended or unintended, is associated with poor maternal and perinatal health outcomes. The highest rates of early childbearing occur in South Asia and Oceania where almost one in five and one in 10 girls gave birth before 18, compared with one in 15 in South-East Asia and only 2%

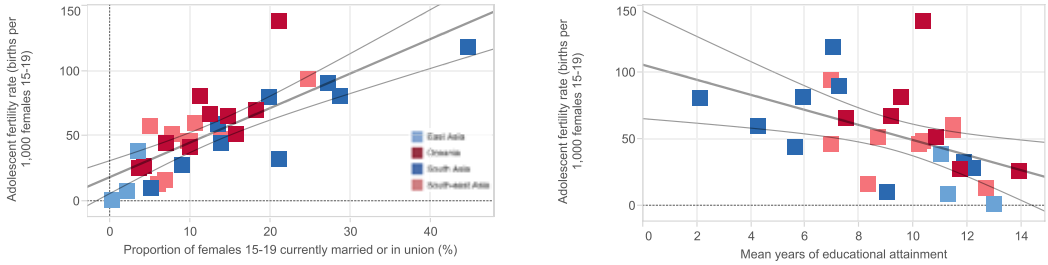
FIGURE 15. ADOLESCENT FERTILITY RATES, 2006-2013 AND TRENDS



Source: DHS and MICS surveys, 2006-2013; UNPD World Fertility Report 2013

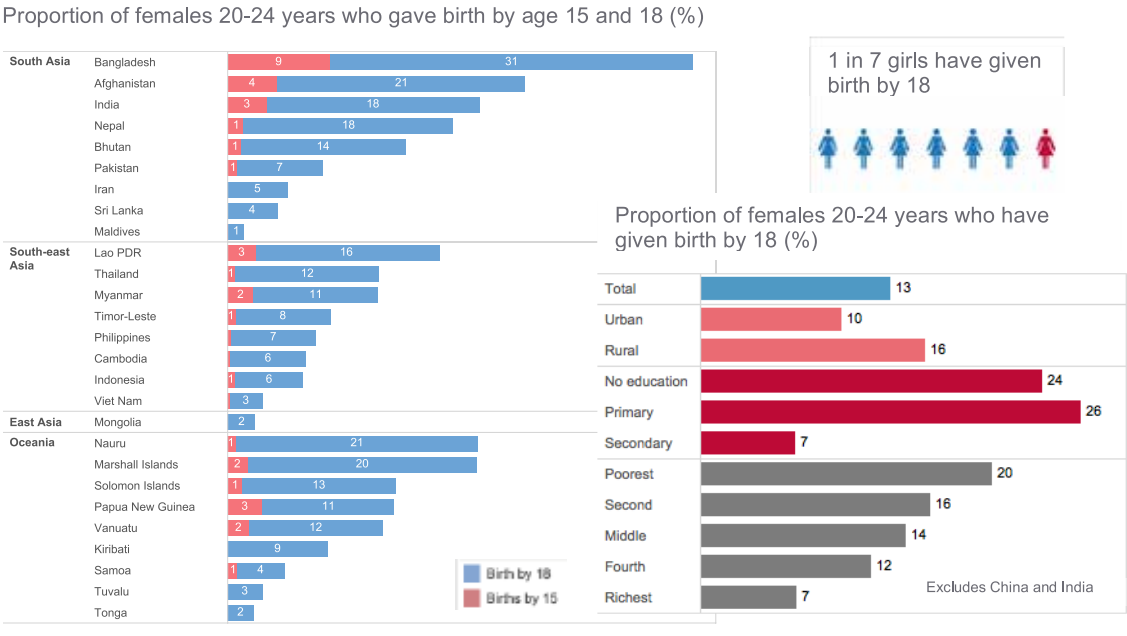
in East Asia (Figure 17). In South Asia almost one in 25 girls have given birth by 15. Early childbearing is more common in rural areas: in Lao PDR, 24% of rural women had their first birth before age 18, compared with 6% of urban women. Girls who are less educated and come from poorer households are also more likely to give birth as adolescents.

FIGURE 16. DISTRIBUTION OF COUNTRIES BY ADOLESCENT FERTILITY RATE, PROPORTION CURRENTLY MARRIED OR IN UNION, AND MEAN YEARS OF EDUCATIONAL ATTAINMENT, 2006-2013



Source: DHS and MICS surveys, 2006-2013; UNPD World Marriage Data 2012; IHME Educational Attainment 1970-2015

FIGURE 17. EARLY CHILDBEARING, 2006-2013



Source: DHS and MICS surveys, 2006-2013

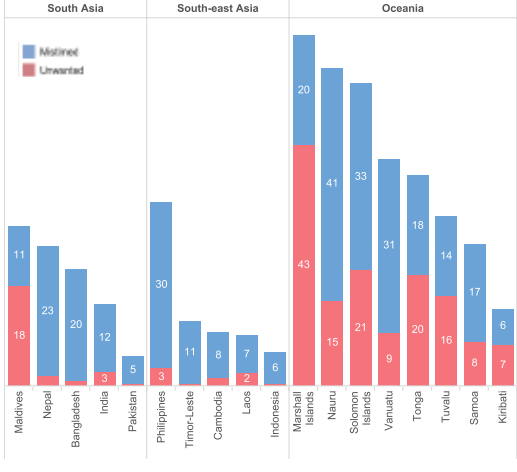
The majority of adolescent births occur within the context of early marriage. However, recent analysis conducted by the UN Department of Economic and Social Affairs Population Division revealed that up to 25% of first births before the age of 20 in Asia were conceived before marriage, suggesting that premarital pregnancy may result in earlier marriage than planned for many adolescent girls.[164] Unpublished analysis of 2013 DHS data from the Philippines reported that around a third of adolescent pregnancies were conceived prior to marriage.[167]

Unintended pregnancy and induced abortion

Not all adolescent pregnancies are intended or wanted. Available national-level data indicate that between 5% and 63% of pregnancies to 15-19 year olds are unintended (Figure 18).[25, 28-31, 33-36, 38-40, 42, 44-47, 157] The majority of unintended pregnancies are mistimed, however in the Pacific up to 43% of births are unwanted. In general, unintended pregnancy is more common in countries that also report higher unmet need for contraception among 15-24 year old females (Figure 19).

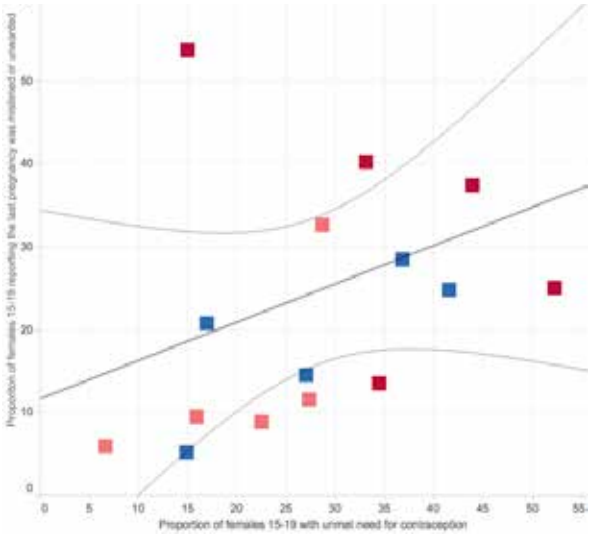
Unintended pregnancy, particularly if it occurs outside of marriage, can have substantial consequences for young people including stigma, social isolation, school expulsion, forced marriage, and in some cases violence and suicide.[9] Globally around half of all unintended pregnancies end in induced abortion, which, in settings where legal abortion is highly restricted and the majority are unsafe, can lead to considerable morbidity and mortality.

FIGURE 18. PROPORTION OF BIRTHS TO ADOLESCENTS 15-19 YEARS THAT WERE UNINTENDED (%), 2006-2013



Source: DHS and MICS surveys, 2006-2013

FIGURE 19. DISTRIBUTION OF COUNTRIES BY UNINTENDED PREGNANCY AND UNMET NEED FOR CONTRACEPTION, 2006-2013



Source: DHS and MICS surveys, 2006-2013; UNPD World Marriage Data 2012; IHME Educational Attainment 1970-2015

There were an estimated 27 million induced abortions in Asia in 2008, although data for many countries in the region, particularly in the Pacific are very limited.[168] Data from available DHS surveys suggests that between 0% and 4% of 20-24 year olds have had an induced abortion, although given the significant stigma (particularly in settings were abortion is highly legally restricted) current data likely underestimate the true magnitude of abortion in the region (Table 4).[28, 31, 35, 36, 42]

Other studies also suggest high rates of abortion among adolescents: in Thailand, an estimated 14% of all adolescent pregnancies ended in abortion in 2010;[169] a nationallyrepresentative study of unmarried women 15-19 in China reported that 17% of sexually active adolescents had experienced a premarital pregnancy and 91% ended in abortion.[115]

The practice of abortion varies considerably depending on the legal status. In settings where abortion has been legalised, young women more commonly report safe abortion: in Cambodia, the majority (68%) sought abortion from a trained provider, 10% from family or friends, and 21% sought help from no-one.28 Abortion is more likely to be unsafe (conducted by unskilled providers and/or using unsafe methods) in settings where it is highly legally restricted. Fourteen countries (44%) only permit abortion to save a woman's life or prohibit it all together; and additional three countries only allow abortion in the case of rape, incest or foetal abnormality (Table 5).[170]

TABLE 4. INDUCED ABORTION

Country	Proportion of females 20-24 years who have ever had an induced abortion (%)
Cambodia	4.4
Indonesia	0.0
Maldives	0.3
Nepal	3.1
Pakistan	1.0

Source: DHS surveys 2009-2013

TABLE 5. ABORTION LEGISLATION

Source: DHS surveys 2009-2013

Close to 11 million abortions in Asia in 2008 were unsafe (up to 65% of abortions in South-East Asia) leading to 17,000 deaths and 2.3 million hospitalisations due to complications. Women under the age of 25 account for 34% of all unsafe abortions (11% among 15-19 year olds and 23% among 20-24).[171] In these settings young women are often forced to resort to unsafe methods and providers: studies in Indonesia[172] and the Philippines[173] reported that the majority of young women reporting abortion had used traditional or unsafe methods such as ingesting herbs, uterine massage, or insertion of foreign objects into the uterus and only sought care after these attempts had failed or due to complications. Unsafe abortion is associated with high rates of morbidity and mortality: a review of maternal deaths in Goroka General Hospital, Papua New Guinea from 2005-2008 reported that sepsis secondary to induced abortion was the second leading cause of death and accounted for all deaths of women under the age of 19.[174]

In addition to legal restrictions there may also be regulations that prevent some people accessing government services (such as migrants) or requirements for parental or spousal consent that may prevent young people seeking care. Even where abortion is more legally accessible, it often remains highly stigmatised which prevents young people accessing safe services, or delay seeking post-abortion care for complications of unsafe abortion. Adolescents are more likely to delay seeking abortion, resort to unsafe providers or unsafe methods, and delay seeking help for complications.[175] A study of unmarried adolescents attending for abortion in a tertiary hospital in India found that 75% had delayed seeking abortion until the second trimester because of fear of disclosure, lack of support, and limited resources.[176] Consequently, adolescent and unmarried young women are also at higher risk of abortion-related morbidity and mortality in some settings.[177]

Pregnancy-related care and health outcomes for adolescent mothers

The proportion of pregnant adolescents who receive skilled care during pregnancy and childbirth varies considerably in the region (Table 6). While antenatal care coverage is high in most countries, significantly fewer pregnant girls give birth with a skilled birth attendant or in a health facility. In most countries, particularly high fertility settings such as Bangladesh, adolescent mothers are more likely to receive skilled care during delivery compared with older women (46% versus 29%).[26] However in others, fewer adolescents than older women receive skilled care. For example in Indonesia, only a third of adolescents gave birth in a health facility compared with 46% of older women, and two thirds had a skilled birth attendant compared with three quarters of adult women.[42]

Smaller studies in Thailand,[165, 178-180] Myanmar,[181] and Viet Nam[182] have reported that pregnant adolescents present later for antenatal care and receive less adequate maternal care than adults. Adolescent mothers are also more likely to suffer poorer health outcomes such as anaemia, preterm labour, stillbirth and low birth weight babies (Table 7).[183] In many countries adolescent births are also associated with higher neonatal and infant mortality rates.

There is very little information about adolescent boys' experience with early and unintended pregnancy. One of the few qualitative studies, conducted in Viet Nam, found that many young men were unprepared for fatherhood, lacking knowledge and skills related to maternal and child health despite their traditional role as decision-makers in the family.[184]

TABLE 6. PROPORTION OF MOTHERS <20 YEARS RECEIVING SKILLED MATERNAL HEALTH CARE (%)

Subregion	Received antenatal care from a skilled provider	Delivered with a skilled birth attendant	Delivered in a health facility
East Asia*	100	98	98
Oceania	82	67	65
South Asia	74	46	38
South-East Asia	91	68	70

Source: DHS and MICS surveys, 2006-2013. *Includes Mongolia only

TABLE 7. PROPORTION OF PREGNANCIES PRESENTING TO URBAN HOSPITALS REPORTING COMPLICATIONS (%), THAILAND, 2011

	Age		
Complication	11-15	16-19	20-34
Anaemia	53	45	30
Postpartum complications	4	2	1
Preterm labour	2	3	2
Very low birth weight (<1500g)	2	1	0

Source: Thaithae and Thato, 2011

In addition to poor maternal and perinatal health outcomes, early pregnancy is also associated socioeconomic consequences such as reduced educational attainment and limited employment opportunities. This has significant implications for the future health and wellbeing of adolescent girls as well as implications for poverty reduction and gender equality. Such consequences can be intergenerational, extending to their children and communities and perpetuating a cycle of disadvantage and poor health. As such, efforts need to focus on delaying first birth and preventing early pregnancy, as well as improving the quality of care for pregnant adolescent girls and their babies.[9, 131]

Sexually transmitted infections and HIV

Knowledge and use of condoms

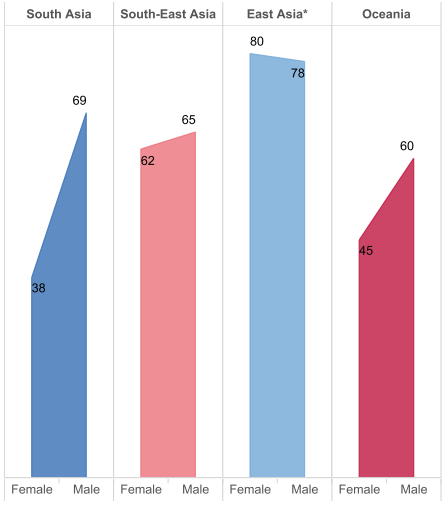
in Pakistan only **28% of young men** were aware that a condom could prevent **HIV**

Across the region most young men know that using a condom can prevent HIV (Figure 20),[24, 25, 28-40, 42-48, 155, 157] however knowledge is very low in some settings: in Pakistan only 28% of young men aged 15-24 years were aware that a condom could prevent HIV.[36] There is a considerable disparity in condom knowledge between girls and boys in South Asia and Oceania. In eight countries (Papua New Guinea, Nauru, Afghanistan, Bangladesh, India, Pakistan, Indonesia and Timor-Leste) less than half of all 15-24 year olds females know that condoms can prevent HIV. Even where knowledge is high, knowledge of a source of condoms is low, particularly among girls. For example, despite 88% of 15-19 year olds girls knowing about condoms in Viet Nam, only 45% knew where a condom could be obtained.[49]

National level data regarding condom use by young people are scarce, however where available indicate 80% or more did not use a condom the first time they had sex, with the exception Vanuatu where around 40% of females and males reported condom use.[29, 32- 34, 37, 39, 40, 45, 47, 49] Condom use at last higher risk sex (sex in the last 12 months with a partner who is not a spouse) varies considerably (Figure 21), however in the majority of countries with available data less than half of young people report condom use. In all countries use of condoms by young women is notably lower than for young men. Rates of condom use at last sex among young women who sell sex, young men who have sex with men and young people who inject drugs varies considerably in the region (see Figure 26).

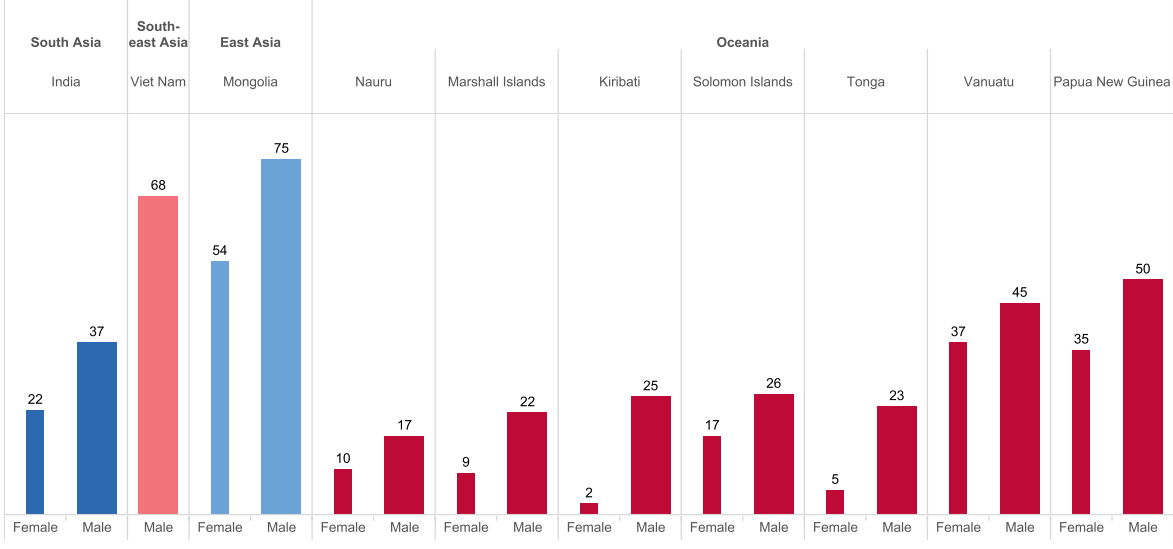
Smaller studies in the region have also suggested that consistent condom use by young people is low. A study of 210 youth in Myanmar reported that 30% had ever had sex, but only 16% used a condom consistently.[185] In Lao PDR, 31% of secondary school students had ever had sex, and while 70% had ever used a condom, only 44% used them consistently.[186] Similarly, studies in Thailand have reported that only

FIGURE 20. PROPORTION OF YOUNG PEOPLE 15-24 YEARS WHO KNOW A CONDOM CAN PREVENT HIV (%), 2006-2013



Source: Thaithae and Thato, 2011

FIGURE 21. PROPORTION OF YOUNG PEOPLE WHO REPORT HIGHER RISK SEX IN THE LAST 12 MONTHS WHO USED A CONDOM AT LAST HIGHER RISK SEX (%), 2006-2013



Source: DHS and MICS surveys, 2006-2013

6% of young people report consistent use of a condom at the beginning of a new relationship,[187] and a quarter of boys and a third of girls had never used condoms.[66]

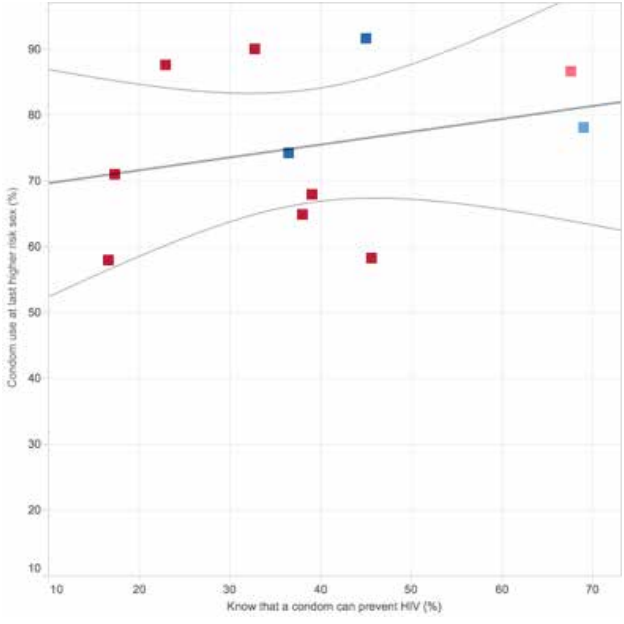
There are many reasons why young people don't use condoms. Lack of knowledge, low condom use self-efficacy, poor perception of their own risk of STIs, and misconceptions (including that a condom can get stuck inside a woman's body) contribute to low demand.[188] In general, there is a weak correlation between higher knowledge of condoms and greater use of condoms at last higher risk sex among boys (Figure 22), indicating that knowledge alone is insufficient to ensure condom use. Attitudes that condoms are inconvenient, interfere with sex, and decrease enjoyment are also common reasons for non-use, particularly among young men. Religious objections and social disapproval of premarital sex contribute to embarrassment and difficulty obtaining condoms, even where young people intend using them.[189-191] A qualitative study conducted in Vanuatu and Tonga reported that despite most young people have positive attitudes towards condoms, socio-cultural barriers and fears of community stigma and disapproval were the most important reasons for non-use.[192] Studies from Malaysia,[193] Viet Nam,[194] Thailand[66] and the Philippines[190] have also indicated that young people are much less likely to use condoms with romantic partners, as condoms imply promiscuity or unfaithfulness that violates their notions of trust and love.

Sexually transmitted infections

Knowledge of STIs, other than HIV, appears to be limited: in Indonesia, up to 80% of women aged 15-24 and 56% of men could not name any STI symptoms.[141] In Myanmar, 74% of ever-married adolescent girls had heard of STIs, but most referred only to HIV with fewer than 50% reporting knowledge of other STIs. In both countries friends and family were the most common source of information.[149] Low knowledge has also been reported among adolescents in Malaysia, India and Pakistan - where only 44% of adolescents could name at least one STI.[52, 195, 196]

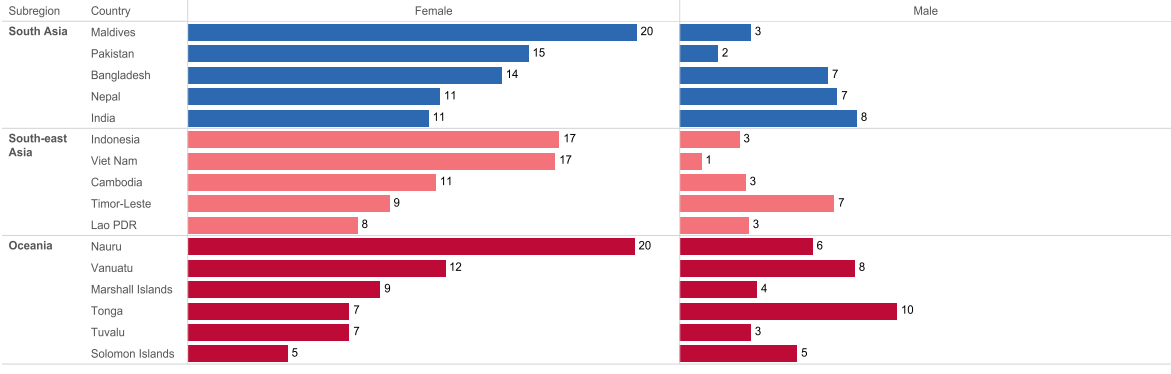
For countries where national-level data are available, up to 10% of young men and 20% of women report that they had an STI or symptoms of an STI in the last 12 months (Figure 23). In Asia, the rates of selfreported STI are similar to those over the age of 25 years, however in the Philippines and Nepal self-reported STI among young men is at least three times higher than among older men.[35, 197] In the Pacific, STI surveillance data reported a prevalence of chlamydia among 15-19 year olds females of over 35% (27% for males) compared with less than 15% for adults aged 30-34 years.[198] Smaller studies have reported higher rates of STIs among some populations, such as migrant workers and young military conscripts, associated with multiple partners and inconsistent condom use.[199] In some settings there has been an apparent increase in both risky sexual behaviour and STI prevalence: a study of students in

FIGURE 22. DISTRIBUTION OF COUNTRIES BY KNOWLEDGE OF CONDOMS AND USE AT LAST HIGHER RISK SEX AMONG MALES 15-24 YEARS, 2006-2013



Source: DHS and MICS surveys, 2006-2013

FIGURE 23. PROPORTION OF YOUNG PEOPLE 15-24 YEARS WHO HAVE EVER HAD SEX WHO REPORT STI OR STI SYMPTOMS IN THE LAST 12 MONTHS (%), 2006-2013



Source: DHS and MICS surveys, 2006-2013

northern Thailand reported an increase in the number of partners and reduction in condom use over a three year period, and a corresponding increase in prevalence of chlamydial infection (from 3% to 8% in women and 3% to 6% in men).[200] Higher prevalence of STIs are also reported among key populations, such as men who have sex with men and female sex workers, but data are often not disaggregated by age.

Human papilloma virus vaccination

Human papilloma virus (HPV) is an STI and a well-established cause of cervical cancer. There are two highly effective HPV vaccines available, and it is estimated that vaccinating all 12-year-old girls would reduce cervical cancer deaths in this cohort by 76%.[201] WHO recommends the inclusion of a two-dose HPV vaccine in national immunisation programmes, with the primary target group of girls aged 9-13 years.[202] In Asia and the Pacific, only 22% of countries (7/32) have a national HPV immunisation programme, where the HPV vaccine is available on a limited or universal basis through the public sector (Table 8).[203] Eleven countries (34%) have pilot programmes for HPV vaccination currently in place. However, the majority of countries in the region (44%) have no HPV immunisation programme.

vaccinating **all 12-year-old girls** would reduce cervical cancer deaths in this cohort by **76%**

While universal HPV vaccination programmes can be controversial in settings where premarital sexual activity is highly stigmatised, a study on the acceptability of HPV vaccine in Viet Nam found that 90% of mothers surveyed were in favour of their daughters receiving the vaccine.[204] A pilot project in Nepal also indicated the acceptability of HPV vaccine among girls attending secondary schools.[205] The HPV vaccine can be administered at schools or within primary health care facilities,

TABLE 8. NATIONAL HPV VACCINE PROGRAMMES

National HPV vaccine program	Pilot HPV vaccine program	No HPV vaccine program
Bhutan Fiji Malaysia Marshall Islands Kiribati Federated States of Micronesia Vanuatu	Cambodia India Indonesia Laos Mongolia Nepal Papua New Guinea Philippines Solomon Islands Thailand Vietnam	Afghanistan Bangladesh China DPR Korea Iran Maldives Myanmar Nauru Pakistan Samoa Sri Lanka Timor-Leste Tonga Tuvalu

Source: DHS and MICS surveys, 2006-2013

however the evidence from this region for which setting is most effective is currently limited. Bhutan implemented a national routine HPV immunization programme for 12-year-old girls in 2010, which started in schools and was then moved to primary health care centres. It was found that vaccination coverage was substantially higher when the programme was in schools (99% versus 68%).[206] This suggests that in settings with high secondary school attendance rates, schools should be prioritised for implementation of HPV vaccination programmes.

As well as the beneficial effects of the vaccine itself, HPV immunisation programmes are a potential opportunity to reach young adolescent girls, a population that often has very little contact with the health care system.[207] A review of health interventions for 9-15 year old girls and boys that could be usefully combined with HPV vaccination programmes in low and middle-income countries found that several interventions were appropriate for integration, including SRH health promotion.[208] WHO consequently recommends integrating short-term health interventions such as SRH education, HIV prevention and condom promotion into HPV vaccination programmes.[174]

HIV

Knowledge is an important predictor of HIV prevention behaviours.[209] Despite most young people having heard of HIV, comprehensive knowledge of transmission and prevention is low among 15-24 year olds in all countries (Figure 24).[24, 25, 27-36, 39, 40, 42-48, 157] Misconceptions are also common: a study of 300 adolescent boys aged 16-19 in Lao PDR reported that up to three quarters had misconceptions about HIV transmission, including that HIV can be transmitted by sharing a toilet or through mosquito bites.[186] Comprehensive knowledge is higher among urban and married young people, and is higher among young adults than adolescents.

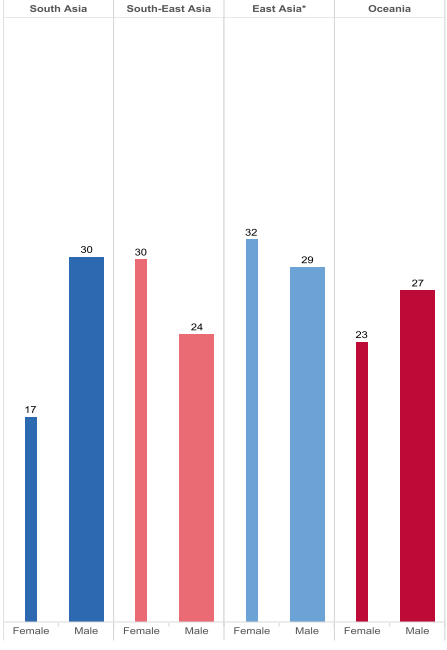
In 2014 there were an estimated 620,000 young people aged 15-24 years living with HIV in Asia and the Pacific; just over half (53%) were males.[210] The number of young people living with HIV has declined since 2005, more so among females (17% reduction) compared with males (14%). The greatest number of adolescents (10-19 years) living with HIV are in India (120,000), Indonesia (46,000), Thailand (11,000), Myanmar (7,700), Pakistan (7,000), Cambodia (3,500), Iran (3,200), Viet Nam (2,600) and Nepal (1,200). In the Pacific, PNG accounts for the greatest number of adolescents living with HIV (1,800).[94] These countries also account for the greatest number of new infections in this age group.

The prevalence of HIV among 15-24 year olds is less than 0.4% in all countries in the region, and most young people are at very low risk of HIV infection (Table 9).[210] However, there is considerable variation in HIV prevalence within some

countries: in Indonesia, for example, HIV prevalence among 15-24 year olds in Papua was estimated at 3.1% in 2013, compared with a national estimate of 0.4%.[211] Up to 95% of new HIV infections among young people occur among key populations, including young people who buy and sell sex, young men who have sex with men, transgender young people, and young people who inject drugs.[212] HIV prevalence among these young populations is much higher than overall rates for 15-24 year olds: HIV prevalence ranges from 1 to 10% among young men who have sex with men; 0.2 to 13% among young female sex workers; and, 0.7 to 41% among young people who inject drugs (Figure 26).[210] Higher prevalence of HIV is also reported among transgender people, although there are very few estimates that are disaggregated by age to report for 15-24 year olds.[210] Limited smaller studies have reported HIV prevalence among adult transgender women ranging from 0.5% in Lahore to 49% in Dehli. Age-disaggregated data are lacking as well as data for young transgender men.[138]

Many people who engage in sex work or inject drugs begin doing so as adolescents or young adults, and a significant proportion of these key populations are made up

FIGURE 24. PROPORTION OF 15-24 YEAR OLDS WITH COMPREHENSIVE KNOWLEDGE OF HIV (%), 2006-2013



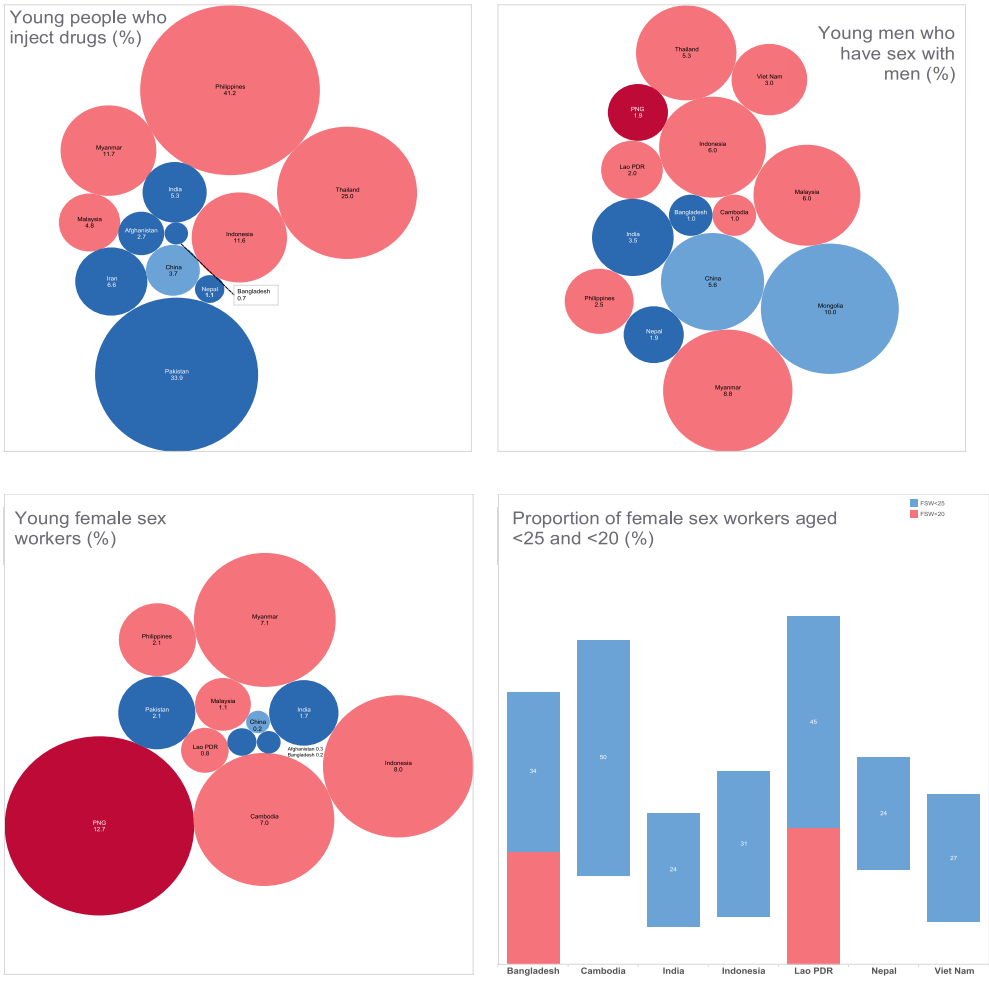
Source: DHS and MICS surveys, 2006-2013. *Includes Mongolia only

TABLE 9. HIV PREVALENCE AMONG YOUNG PEOPLE 15-24 YEARS (%), MOST RECENT ESTIMATES

		Female	Male
South Asia	Afghanistan	<0.1	<0.1
	Bangladesh	<0.1	<0.1
	Bhutan	<0.1	<0.1
	India	-	-
	Iran	<0.1	0.1
	Maldives	<0.1	<0.1
	Nepal	<0.1	<0.1
	Pakistan	<0.1	<0.1
	Sri Lanka	<0.1	<0.1
South-east Asia	Cambodia	0.2	0.2
	Indonesia	0.5	0.4
	Lao PDR	<0.1	<0.1
	Malaysia	<0.1	0.2
	Myanmar	0.3	0.2
	Philippines	-	-
	Thailand	0.3	0.3
	Timor-Leste	-	-
	Viet Nam	<0.1	<0.1
East Asia	China	-	-
	Democratic People's Republic of Korea	-	-
	Mongolia	<0.1	<0.1
Oceania	Fiji	<0.1	<0.1
	Kiribati	-	-
	Marshall Islands	-	-
	Micronesia (Federated States of)	-	-
	Nauru	-	-
	Papua New Guinea	0.2	0.1
	Samoa	-	-
	Solomon Islands	-	-
	Tonga	-	-
	Tuvalu	-	-
	Vanuatu	-	-

Source: AIDSInfo

FIGURE 25. HIV PREVALENCE AMONG YOUNG KEY POPULATIONS



Source: AIDSInfo

of young people (Figure 25).[213] In the Philippines, for example, the median age that 15-18 year olds began selling sex was 16 years, and in Indonesia and Thailand around a third began selling sex before the age of 18.[214]

Comprehensive HIV knowledge among young key populations is low in most countries and condom use varies considerably (Figure 26).[210] Access to HIV testing also varies, but as few as 4% of some young key populations report having had an HIV test in the last 12 months and being aware of the result. In most countries where disaggregated data are available, young key populations have poorer knowledge, less condom use, and less uptake of HIV testing than those over 25 years.

FIGURE 26. COVERAGE OF KNOWLEDGE, CONDOM USE AND TESTING AMONG YOUNG KEY POPULATIONS

		Female sex workers <25 years			Men <25 years who have sex with men			People <25 years who inject drugs		
Subregion	Country	Comprehensive knowledge HIV (%)	Condom use last sex (%)	HIV test in the last 12 months and know result (%)	Comprehensive knowledge HIV (%)	Condom use last sex (%)	HIV test in the last 12 months and know result (%)	Comprehensive knowledge HIV (%)	Condom use last sex (%)	HIV test in the last 12 months and know result (%)
South Asia	Afghanistan	1	53	4		17			43	22
	Bangladesh		65		23	45	11		43	4
	India	23	88	38	35	44	8	27	13	21
	Iran		62			45			24	
	Maldives			21			12			15
	Nepal	35		29	59	91	36		40	19
	Pakistan	1	34	16		24	4	20	22	8
	Sri Lanka		88	25	17	61	7			
South-east Asia	Cambodia		99	66		69	33			36
	Indonesia		49		40	64	92	52	56	84
	Lao PDR	44	93	12	30	24	13			
	Malaysia		67			72			25	79
	Myanmar	65	96	68	68	84	45	78	79	26
	Philippines	29	43	16	32	38	4	37	15	6
	Thailand		94		19	86	24		49	54
	Viet Nam	52	93	32	48	66	31		47	20
East Asia	China	52	86	34	51	76	39	49	47	27
	Mongolia	50	70	46	55	70	59			
Oceania	Fiji		91							
	PNG	39	75	42	72	60	63			
	Vanuatu					63				

Source: AIDSInfo

Sexual and gender-based violence

Sexual and gender-based violence has significant implications for the health and well being of young people. Physical and sexual violence is associated with higher rates of unintended pregnancy and abortion, increased risk of STIs including HIV, and other health issues such as depression and substance use.[12] Globally 30% of everpartnered adolescent girls aged 15-19 years have experienced physical or sexual violence from a partner, and one in 10 girls have experienced sexual violence.[12, 215] Rates of intimate partner violence are extremely high in the Pacific, with lifetime prevalence of violence among women 15-49 years around 60-77%.[216]

There are limited data regarding young people's experiences of violence in Asia and the Pacific, although available information suggests rates of violence are high among this age group (Table 10). National-level surveys report that between 10% and 44% of girls aged 15-19 have experienced physical violence and 2-52% sexual violence.[33, 35, 36, 38, 39, 44, 46, 47]

A study of 4,838 women aged 18-60 years conducted in Viet Nam in 2010 reported that more than 20% of ever-married 18-24 year olds had experienced physical violence by their partner, and 12% had experienced violence in the past 12 months – higher than all other age groups. Additionally, around 5% had experienced sexual violence in their lifetime.[217]

Among married and unmarried girls the major perpetrators of violence are current or former partners. For unmarried girls in particular, family members are also an important cause of physical violence. In Timor-Leste, for example, 51% and 63% of 15-19 year old girls who had ever experienced physical violence reported their father or mother respectively as the perpetrator.[215] Despite school attendance being an important protective factor for a range of SRH outcomes, school-related physical and sexual violence is common in the region, including sexual harassment and violence at school or during travel to and from school.[218] Such violence is particularly marked for young people who are same-sex attracted or transgender.[219]

Many unmarried young people report unwanted, coerced or forced sex. Studies in Thailand revealed that around 20% of young women and 7% of young men reported that they were coerced or forced to have sex (Figure 27).[220] The majority of the perpetrators were known to the young person (such as a romantic partner) and most occurred at first sex.[62, 65, 69] A study of urban young people in Lao PDR found that 22% of women aged 15-24 had been coerced into their first sexual intercourse, the majority by their boyfriends.[221]

Forced first sex is particularly common among young people who report sex before the age of 15, when they often lack the knowledge and skills to be able to negotiate consensual sex and are vulnerable to exploitation and abuse. In Thailand and the Philippines for example, 20% and 15% of adolescent girls who had sex before the age of 15 reported that their first sex was forced, compared with 7% and 5% who had sex over the age of 15.[221]

Forced first sex is particular common among young people who report sex before **the age of 15**

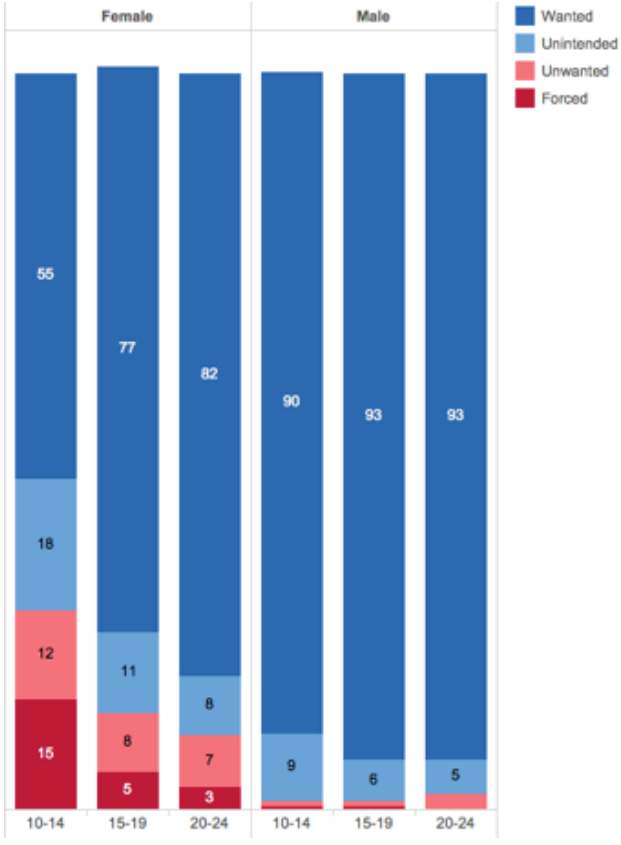
TABLE 10. PROPORTION OF YOUNG WOMEN REPORTING LIFETIME EXPERIENCE OF PHYSICAL OR SEXUAL VIOLENCE (%), 2006-2013

		Physical violence		Sexual violence	
		15-19	20-24	15-19	20-24
South Asia	India	21	31	5	9
	Nepal	10	18	5	11
	Pakistan	30	28		
South-east Asia	Philippines	17	20	4	6
	Timor-Leste	30	35	2	2
Oceania	Marshall Islands	35	25	33	21
	Tuvalu		41		20
	Vanuatu	44	59	52	52

Source: DHS surveys 2006-2013

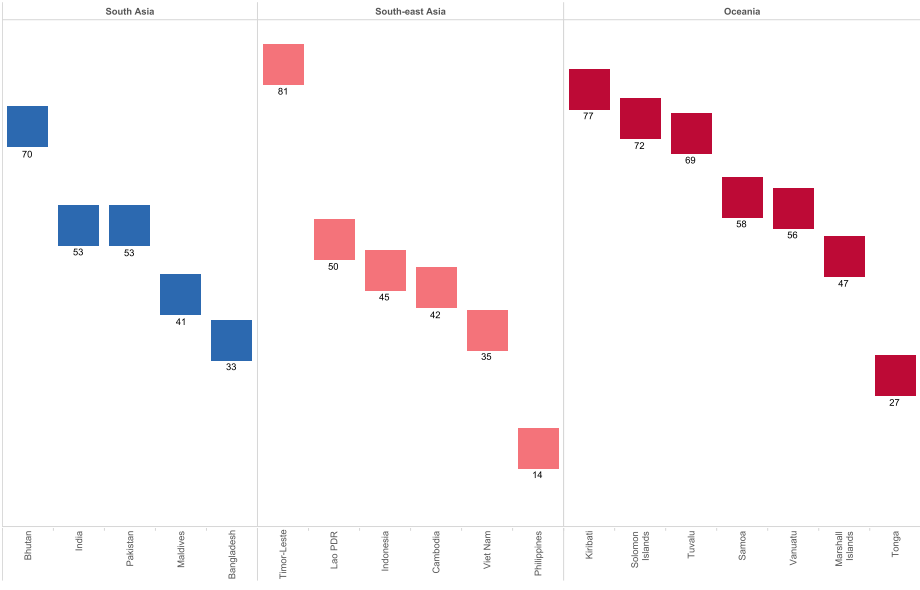
Rates of sexual violence and coercion are also high among young people with disability and young key populations. In a study in the Philippines, around 50% of men who have sex with men reported that their first sexual encounter with a man was forced.[222] More than half of all transgender persons in Phnom Penh in Cambodia reported that they had been raped in 2004.[210] In Thailand, 18% of all men who have sex with men reported ever experiencing forced sex, and more than 55% had first occurred during adolescence.[223] In Pakistan, young transgender men described significant violence and sexual abuse, often starting in early adolescence.[224] Research from Thailand has demonstrated that coerced sex is strongly associated with inconsistent condom use among these young people.[85] High rates of violence have also been reported by young female sex workers. A study of 815 female sex workers in Thailand reported that 25% of adolescent female sex workers experienced violence in the previous week, compared with 12% of those over the age of 30.[225] adolescent girls and young women is also prevalent in settings of conflict.

FIGURE 27. FIRST EXPERIENCE OF SEX BY AGE OF FIRST SEX (%), THAILAND, 2007



Source: Kanchanachitra et al, 2007

FIGURE 28. PROPORTION OF ADOLESCENT GIRLS 15-19 YEARS WHO BELIEVE A HUSBAND IS JUSTIFIED IN BEATING HIS WIFE FOR AT LEAST ONE REASON (%), 2006-2013



Source: DHS surveys 2006-2013

Fewer young men than women report forced or coerced sex, although many young women identify young men (particularly their partner) as the perpetrator of sexual violence. A cross-sectional study of over 10,000 men reported that 11% of men in Bangladesh, 21% in Cambodia, 23% in China, 32% in Indonesia and 61% in Papua New Guinea had ever perpetrated rape (against a partner or non-partner). A third to half had first committed rape as adolescents 15-19 years, and up to 25% before the age of 15. Additionally, up to 8% had ever raped a man and between 2 and 14% had been involved in multi-perpetrator rape.[226] Sexual entitlement was the most common reason given for perpetration of the most recent rape.

Socio-cultural and gender norms and attitudes are an important influence on the prevalence and acceptance of violence. A substantial proportion of adolescent girls believe that a husband is justified in beating his wife for at least one reason, including for refusing sex (Figure 28).[25, 27-31, 33, 36, 38-40, 42, 44-48, 157] Data from Cambodia, India, Bangladesh and Nepal indicate that permissive attitudes regarding violence against women are also common among adolescent boys: between 25% and 51% reporting that wife beating was justified. Low educational attainment, unemployment and a family history of violence were positively associated with acceptance of violence.[227]

9 POLICIES AND PROGRAMMES: GAPS, OPPORTUNITIES AND BEST PRACTICES

Improving sexual and reproductive health outcomes for young people requires a multisectoral approach that not only addresses young people's need for information, lifeskills and quality services, but also strives to create a more supportive and enabling environment.

Creating a supportive environment for young people's sexual and reproductive health

Legal and policy environment

Most countries have addressed young people's SRH to some extent in national HIV, reproductive health, population, youth and education laws and policies (Table 11).[228] In general, these include references to providing age-appropriate SRH information, increasing access to youth-friendly services, and ensuring protections against violence and exploitation, with a particular focus on key young populations. Most have also enacted laws that ensure the right of all people to access to services, including SRH services, free from discrimination. However, the provision of SRH services is restricted in some settings: in Bangladesh, Indonesia, Malaysia and China for example, regulatory barriers mean that government contraceptive services are generally not accessible to unmarried young people.

The age at which young people are legally able to consent to sex, marriage and medical treatment varies considerably between countries, and also varies for males and females within countries (Table 12).[229, 230]

Laws regarding the legal age of consent to sex are important for protecting young people from sexual abuse and exploitation. However, such laws may also deter young people engaging in consensual sex with their peers from accessing services for fear of disclosure and prosecution of their partner. To address this, countries such as the Philippines and Cambodia permit sexual conduct between young people who are of similar age. In some settings, such as Malaysia and Aceh Province of Indonesia,

TABLE 11. INCLUSION OF ADOLESCENT SRH IN AVAILABLE NATIONAL POLICIES

Subregion	Country	Health / reproductive health / population	HIV	Adolescent health	Youth	Education
South Asia	Afghanistan	Includes ASRH	Includes ASRH	Draft / being developed	Includes ASRH	Includes ASRH
	Bangladesh	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Bhutan	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	India	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Iran	Includes ASRH	Draft / being developed	Not available	No policy / plan / strategy	Not available
	Maldives	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Nepal	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Pakistan	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Sri Lanka	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Not available
South-east Asia	Cambodia	Includes ASRH	Includes ASRH	No policy / plan / strategy	Includes ASRH	Includes ASRH
	Indonesia	Includes ASRH	Includes ASRH	Includes ASRH	No policy / plan / strategy	Includes ASRH
	Lao PDR	Includes ASRH	Includes ASRH	No policy / plan / strategy	No policy / plan / strategy	Includes ASRH
	Malaysia	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Myanmar	Includes ASRH	Includes ASRH	Draft / being developed	No policy / plan / strategy	Includes ASRH
	Philippines	Includes ASRH	Includes ASRH	Includes ASRH	Draft / being developed	Includes ASRH
	Thailand	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Timor-Leste	Includes ASRH	Includes ASRH	Not available	Does not include ASRH	Not available
	Viet Nam	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
East Asia	China	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	DPR of Korea	Not available	Not available	Not available	Not available	Not available
	Mongolia	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Not available
Oceania	Fiji	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Kiribati	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Marshall Islands	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Micronesia (Federated States of)	Not available	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Nauru	Not available	Not available	Not available	Includes ASRH	Not available
	Papua New Guinea	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Samoa	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH	Includes ASRH
	Solomon Islands	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Tonga	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH
	Tuvalu	Not available	Not available	Not available	Draft / being developed	Not available
	Vanuatu	Includes ASRH	Includes ASRH	Not available	Includes ASRH	Includes ASRH

Islamic law prohibiting sex outside of marriage may result in penalties for young people engaged in consensual premarital sex (or suspected of sexual activity), and act as a considerable deterrent to accessing care. Most countries have laws that prohibit marriage under the age of 18, however implementation and law enforcement remain challenging. Additionally, many countries permit marriage at much younger ages with parental consent or permission of local government and/or religious authorities.[137]

In most countries, young people aged 18 years and over are considered to have the legal capacity to consent to medical treatment, although some allow young people less than 18 to provide consent under certain circumstances.[230] In Nepal, for example, young people between the aged of 14-17 can receive confidential counseling and testing for HIV without parental consent if the counselor determines they are of

sufficient maturity; adolescent girls aged 16 and over can consent to abortion without requiring parental consent. Similarly, a number of countries have enacted or are proposing legislation to allow adolescents to access HIV testing without parental consent, including Cambodia, Fiji, Lao PDR, Marshall Islands, Papua New Guinea. Philippines, FSM, Thailand, Viet Nam, India and Pakistan.[137] No countries have similar specific legislation concerning consent to contraception or other essential SRH services. In many settings the legal age for consent for services is older than the age to consent to sex, meaning that sexually active young people may be required to obtain parental consent to access SRH services, creating a significant barrier for those who do not want to disclose sexual activity to their parents. As discussed

TABLE 12. SUMMARY OF MINIMUM LEGAL AGE OF CONSENT TO SEX AND MARRIAGE

Subregion	Country	Consent to sex		Consent to same sex		Minimum age marriage (without parental consent)	
		Female	Male	Female	Male	Female	Male
South Asia	Afghanistan	After marriage	After marriage	Illegal	Illegal	16	18
	Bangladesh	14	Not specified	Not specified	Illegal	18	21
	Bhutan	18	18	Not specified	Illegal	16	18
	India	18	18	18	18	18	21
	Iran	After marriage	After marriage	Illegal	Illegal	15	18
	Maldives	After marriage	After marriage	Illegal	Illegal	18	18
	Nepal	16	Not specified	Not specified	Not specified	20	20
	Pakistan	16 (after marriage)	After marriage	Ambiguous	Illegal	16	18
	Sri Lanka	16	16	Illegal	Illegal	18	18
South-east Asia	Cambodia	15	15	15	15	18	20
	Indonesia	15	19	18	18	21	21
	Lao PDR	15	15	15	15	18	18
	Malaysia	16 (after marriage)	After marriage	Illegal	Illegal	21	21
	Myanmar	14	Not specified	Not specified	Illegal	18	18
	Philippines	12	12	12	12	21	21
	Thailand	15	15	Not specified	15	21	21
	Timor-Leste	17	17	17	17	17	17
	Viet Nam	16	16	Not specified	16	18	20
East Asia	China	14	14	14	14	20	22
	DPR of Korea	15					
	Mongolia	16	16	16	16	18	18
Oceania	Fiji	16	16	16	16	18	18
	Kiribati	15	15	Not specified	Illegal	21	21
	Marshall Islands	16	16	Not specified	16	18	18
	Micronesia (Federated States of)	15	15			16	18
	Nauru	17	Not specified	Not specified	Illegal	16	18
	Papua New Guinea	16	16	Not specified	Illegal	16	18
	Samoa	16	16	16	Illegal	19	21
	Solomon Islands	15	Not specified	Illegal	Illegal	18	18
	Tonga	16	Not specified	Not specified	Illegal	18	18
	Tuvalu	15	15	Illegal	Illegal	21	21
	Vanuatu	15	15	15	15	21	21

Source: UN Data; UNESCO 2013; World Legal Information Institute

previously, highly restrictive abortion laws also contribute to mortality and morbidity among young women with an unwanted pregnancy who resort to unsafe abortion.

Several countries criminalise behaviours of key populations, including consensual samesex relations, sex work and injecting drug use. In 17 countries male same-sex behavior is illegal and punishable by imprisonment, or, in the case of Iran, death. Many countries that do not criminalise consensual same-sex relations still lack legislation prohibiting discrimination on the basis of sexual orientation or gender identity.[231] In addition to contributing to substantial stigma and discrimination, such laws are additional barriers to these young people accessing services for fear of discrimination or arrest.[137]

In 17 countries male same-sex behavior is illegal and punishable

Addressing socio-cultural barriers

Socio-cultural norms and taboos present significant barriers to improving young people's SRH, and there are a number of examples of programmes that aim to address these factors. A global review of strategies (including programmes in Bangladesh, Bhutan, Cambodia, China, Lao PDR, India, Nepal, Sri Lanka, Thailand and Viet Nam)

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concluded that mass media, community mobilisation, and involving key gatekeepers in programme design can have a positive impact on community attitudes towards young people's SRH and may facilitate access to information and services.[232] While there is limited evidence for the effectiveness of strategies to create an enabling environment for young people's SRH, a recent review highlighted a number of promising interventions including empowering girls, building parental support, and engaging men, boys and the wider community to transform gender norms.[233]

Mobilising community support is an essential component of successful programmes. The Development Initiative Supporting Healthy Adolescents, a community-based project in India, engaged community leaders through mass communication activities and by facilitating the establishment of both adult groups and youth-adult partnerships.[234] This contributed to the success of the programme, which led to an increase in age at marriage for young people, an increase in contraceptive use and positive changes in knowledge of and attitudes to early marriage by adult community members.[234] The 10-year research programme Improving the Reproductive Health of Married and Unmarried Youth in India found that the involvement of communities was crucial for changing social norms that discouraged young people from accessing SRH information and services.[235]

A project in Nepal demonstrated the importance of creating an enabling environment among parents, in-laws and key community members in order to improve health outcomes for married adolescents. This programme resulted in noticeable changes in the attitudes of family and community members, which in turn contributed to improved access to health services for married young people.[236] Similarly, the Adolescent Health and Development Programme carried out in ten Pacific Island countries (including Vanuatu, Marshall Islands, Tonga, Kiribati, Tuvalu, Federated States of Micronesia, Solomon Islands, Fiji and Samoa as well as Cook Islands) successfully generated greater acceptance and recognition from governments of the importance of addressing adolescent health issues, including SRH.[237] A pilot project in Iran looking at HIV prevention through the provision of adolescent-friendly health services found that the support of parents, communities and key stakeholders was essential for the implementation and sustainability of the programme.[238]

Other examples in Viet Nam,[239, 240] Nepal,[241] Thailand,[242] China,[243] Lao PDR,[244] and the Philippines[245] have used participatory approaches to engage communities to improve awareness and attitudes towards SRH and have demonstrated a significant improvement in young people's knowledge, self-efficacy and in some cases behaviour change.

Engaging boys and men to address harmful gender norms is also critical to improving the SRH of young women, as well as supporting better health outcomes for young

men. Such approaches address men's behaviours, attitudes and roles to support equal and shared responsibility, mutually respectful relationships, combat violence against women and girls, and also address gender norms related to sexual risk-taking that put young men at risk. Engaging adolescent boys and young men is ideal as it is during this time that their own values and attitudes regarding sexuality and gender are developing, and therefore are likely to be more amenable to change.[246]

The Playing Safe project targeted urban male youth in Cambodia with a range of activities including peer education, community events, and drop in youth centres. The aim was to create positive social networks among young men, encourage safe and responsible behaviour and increase access to services. The project integrated concepts of gender equity, human rights and consent into communication activities, addressing men's own vulnerabilities as well as the rights of women. The project reported that the approach was an effective way of addressing norms around masculinity and creating a more supportive environment for responsible behaviour.[247]

In Thailand, an in-school programme targeting 8-16 year olds, used group education and interactive activities (such as games and group work) to explore gender-roles and their link to physical and sexual violence. The programme also focused on building communication and relationship skills. The programme involved eleven sessions of 2.5 hours each, for boys and girls, and demonstrated a significant improvement in attitudes towards gender to roles at the completion of the programme.[248]

There have also been a number of initiatives to address HIV-related stigma and discrimination, including efforts to address socio-cultural attitudes towards young key populations. A 2010 review of 26 pilot projects carried out in South Asia reported a range of approaches that were acceptable to communities, effectively addressed sensitive and taboo issues and reached large numbers of people.[249] Several strategies were piloted including: community-based workshops, theatre and mass media to address attitudes, misconceptions and support advocacy; health worker training: capacity building and empowerment of marginalised people; and establishment or strengthening of community-based organisations. Projects that incorporated multiple strategies and engaged diverse stakeholders were identified as more successful, as were projects that were led by key populations.

While there are some promising examples of programmes, further research is needed in this region to identify effective approaches to generate community support and overcome socio-cultural barriers.

Comprehensive sexuality education

Comprehensive sexuality education (CSE) is the cornerstone of improving the SRH of young people. In order to make healthy, responsible decisions, young people need accurate information about puberty, reproduction, relationships, sexuality, the consequences of unsafe sex, and how to avoid HIV, STIs and unintended pregnancy. They also need the skills and confidence to be able to deal with peer pressure and negotiate safe and consensual relationships.[250]

CSE programmes that address these components have been demonstrated to have a positive impact not only on knowledge and attitudes, but also contribute to safer sexual practices (such as delaying sexual debut, reducing the number of partners, and increasing condom and contraceptive use) and can also reduce the negative consequences of unsafe sex.[251] Importantly, there is no evidence that sexuality education programmes lead to early sexual debut or increased sexual activity. Such programmes also provide an opportunity to develop values and build life skills important not only for SRH but other aspects of adolescent development. It can also address sexual and gender norms to help foster positive relationships and address

harmful socio-cultural factors. Gender norms and gender-based power disparity within relationships is a crucial determinant of young people's SRH, and there is some evidence that CSE programmes that are gender-transformative (that is, challenge gender norms and promote genderequitable relationships) may be more effective.[252] Characteristics of effective programmes are summarised in Box 3.

BOX 3. CHARACTERISTICS OF EFFECTIVE SEXUALITY EDUCATION PROGRAMMES

Development of programmes: involve experts in sexuality, sexual health and young people; assess the needs and strengths of young people and use a logic model that specifies health goals; take into account community values and available resources; involve young people; begin with pilot-testing and obtain ongoing feedback.

Content of programmes: provide accurate information and give clear messages: focus on clear goals such as prevention of HIV, STIs and unintended pregnancy and the behaviours that contribute to these; address risk and protective factors that contribute to key behaviours; address individual and peer attitudes and norms regarding sexual activity, condoms and contraception; address specific situations that can lead to unwanted or unsafe sex; address skills and self-efficacy.

Delivery and implementation of programmes: enlist support of relevant institutions; select motivated educators and provide quality training; employ educationally sound and participatory teaching methods that enable young people to personalise information; implement a comprehensive package of activities; provide ongoing management, supervision and support.

Source: UNESCO 2009

School-based sexuality education

School-based CSE is an effective means of reaching a large population of young people, particularly where school attendance is high. While most national education policies make some reference to 'life-skills' education or some aspect of SRH, only 11 countries provide specific reference to sexuality education, and of those only six (Cambodia, China, Indonesia, Nepal, Papua New Guinea and Viet Nam) include detailed policies.[228] Twenty-two countries have a national sexuality education curriculum for secondary students, with curricula planned or in development in a number of other Pacific countries (Table 13).

Only 11 countries also include curricula for primary students despite recommendations that age-appropriate CSE should be introduced in primary school before the onset of puberty.[253] Four countries (Iran, Pakistan, DPR Korea and FSM) have no national curricula. Data describing actual coverage of school-based CSE are very limited, but where available suggest that despite the existence of national policies and curricula, implementation of programmes has been weak in many countries. While some impressive progress has been made, coverage is less than 50% in all countries where data are available, except for Papua New Guinea where 100% coverage is reported (Table 14).[254]

TABLE 13. SUMMARY OF NATIONAL CSE CURRICULA AND TEACHER TRAINING

Subregion	Country	Primary	Secondary	Out-of-school	Teacher training
South Asia	Afghanistan	No national curriculum	National curriculum	National curriculum	No national curriculum
	Bangladesh	Planned	National curriculum	National curriculum	National curriculum
	Bhutan	National curriculum	National curriculum	National curriculum	Planned
	India	No national curriculum	National curriculum	National curriculum	National curriculum
	Iran	No national curriculum	No national curriculum	No national curriculum	
	Maldives	No national curriculum	National curriculum	National curriculum	National curriculum
	Nepal	No national curriculum	National curriculum	National curriculum	National curriculum
	Pakistan	No national curriculum	No national curriculum	No national curriculum	No national curriculum
	Sri Lanka	No national curriculum	National curriculum	National curriculum	National curriculum
South-east Asia	Cambodia	National curriculum	National curriculum	National curriculum	National curriculum
	Indonesia	National curriculum	National curriculum	National curriculum	National curriculum
	Lao PDR	National curriculum	National curriculum	National curriculum	National curriculum
	Malaysia	National curriculum	National curriculum	National curriculum	National curriculum
	Myanmar	National curriculum	National curriculum		National curriculum
	Philippines	No national curriculum	National curriculum	National curriculum	National curriculum
	Thailand	National curriculum	National curriculum	National curriculum	National curriculum
	Timor-Leste	National curriculum	National curriculum	No national curriculum	National curriculum
	Viet Nam	National curriculum	National curriculum	National curriculum	National curriculum
East Asia	China	No national curriculum	National curriculum	National curriculum	National curriculum
	DPR of Korea	No national curriculum	No national curriculum		No national curriculum
	Mongolia	No national curriculum	National curriculum	Limited	Limited
Oceania	Fiji	National curriculum	National curriculum	National curriculum	National curriculum
	Kiribati	No national curriculum	Planned		
	Micronesia (Federated States of)	No national curriculum	No national curriculum		
	Papua New Guinea	National curriculum	National curriculum	National curriculum	National curriculum
	Samoa	No national curriculum	National curriculum	National curriculum	No national curriculum
	Solomon Islands	Planned		National curriculum	Limited
	Tonga	No national curriculum	Limited		
	Tuvalu	Limited	National curriculum		No national curriculum
	Vanuatu	Limited	Planned	National curriculum	

Source: UNESCO 2012; SPC 2010

TABLE 14. REPORTED COVERAGE OF NATIONAL CSE PROGRAMMES, 2010

100% coverage	26-50% coverage	≤25% coverage
Papua New Guinea	Cambodia India Lao PDR Viet Nam	Afghanistan Bangladesh Malaysia Nauru Nepal Thailand Tonga Vanuatu

Source: Clarke and Aggleton 2012

Challenges in most countries include the lack of teacher training and support for delivery of content, limited availability of teaching resources, lack of supervision and monitoring, and lack of compulsory status meaning that inclusion is up to the discretion of schools and teachers. Perceived or real opposition from leaders, parents, communities and religious leaders, in addition to resistance within education systems, are also important barriers.[228, 255, 256]

Even where coverage is reportedly high, ensuring quality of programmes and incorporating comprehensive approaches that build life-skills remains challenging. Many national curricula focus on knowledge (often limited to biology and reproduction) with little inclusion of content to address behaviour change, rights and discrimination, or gender norms. A review of 28 programmes in the region documented that only five included a focus on behaviour change, four addressed rights and discrimination and only two (Cambodia and Papua New Guinea) included some aspect of gender norms.[228] Even in those countries with more comprehensive life-skills based curricula implementation remains challenging and programmes tend to emphasise theory rather than skills.[228]

A review of Family Life Education in 10 Pacific Island countries also found that health-based curricula were widely adopted, but participatory, genderbased and life-skills curricula were still significantly underdeveloped and implemented, with the exception of Fiji.[257]

Little has been documented regarding the inclusion of other important SRH topics such as sexual orientation and gender identity, and the extent to which existing CSE programmes address the needs of young people who are same-sex attracted or transgender remains unclear. A study of young people in Hanoi and Shanghai documented a high prevalence of negative perceptions and attitudes towards same-

sex relationships, and a significant association between negative attitudes and low SRH knowledge, highlighting the important opportunity CSE provides to address stigma and discrimination.[258] However, there are very few examples of these issues being addressed systematically in national curricula. A noted exception is Nepal, where content related to sexual orientation and gender diversity, bullying and harassment is reportedly being introduced into the curriculum for lower secondary schools.[219] There are also some non-government projects specifically providing education on sexuality and gender identity through the development of curricula, materials and training programmes, such as the Seksualitas Rasa Rainbow Cake initiative developed by Arus Pelangi in Indonesia.[219]

Despite these challenges there are examples of innovative, pilot and smaller-scale programmes delivered through schools, particularly targeting secondary and college students (Box 4).[255] Programmes in Indonesia,[259] Thailand[260-262] and Malaysia[263] have combined teacher-led activities with participatory peer-led activities (including small group discussions, skills-building exercises, and distribution of educational materials).

To overcome challenges related to teacher training, some programmes have also used nongovernment organisations to provide inschool education or introduced computerassisted approaches.[264, 265] Such programmes have demonstrated a significant impact on knowledge, attitudes and behaviour intentions among students. In Iran, for example, a peer and teacher-led education programme about HIV delivered to female secondary students found a two-fold increase in knowledge among girls exposed to peer education, significantly higher than the teacher-only led programme.[266] A randomised controlled trial of a 10 session school-based programme delivered to girls in India (aged 11-14 years) reported a significant improvement in 13 or more health-related behaviours, including reproductive health.[267] Other studies of school-based education interventions in Nepal,[268] Mongolia,[269] and China[270] have reported significant improvements in SRH knowledge and attitudes, but did not measure changes in behavior. There are few published studies examining the impact of curriculum-based CSE on health outcomes in the region. A review of 83 CSE programmes globally reported that only 13 measured pregnancy rates and ten STI rates (of which two and three studies found significant positive impacts respectively).[271] Only one study from Thailand met criteria for inclusion in the review, highlighting the need for support for rigorous evaluation of approaches in this region.

Many documented programmes are implemented as pilot-projects that are noncompulsory and rely on extra-curricular delivery. It is likely that compulsory, intracurricular approaches will reach more young people and be more sustainable. Additionally, much of the current focus is on secondary level students. However,

BOX 4. COMPREHENSIVE SEXUALITY EDUCATION IN THAILAND

Teenpath – Thailand

The Teenpath HIV prevention programme has been implemented in over 6000 schools in Thailand since 2003. Key features of the approach include:

Creating a supportive policy and community environment:

- High level support from the Ministry of Education and the Permanent Secretary, who are represented on the advisory board
- Media campaign to promote sexuality education
- Forums and conferences on sexuality education that engaged a range of stakeholders
- Youth participation in advocacy activities

Focusing curriculum development on three key concepts:

- Biological, socio-cultural, psychological and spiritual elements of sexuality
- Positive youth development with attention to providing sufficient information, exploring attitudes and values, and supporting skills development to enable young people to make healthy decisions
- Student-centred approach to facilitate learning

Building capacity to deliver high quality sexuality education:

- Partnership building between non-government and government organisations to support coordination and implementation
- Developing a master trainer training curriculum
- Teacher training focusing on attitudes, knowledge and communication skills
- Ongoing support to participating schools

Integrating the programme with other initiatives that support youth participation and increase access to information and services:

- Building leadership capacity among young people through youth camps focusing on drama, media advocacy and communication skills
- Development of a website that provides youth-friendly SRH information
- Development of a parent-child communication manual
- Strengthening linkages with youth-friendly health services

A key challenge of the programme is that it is largely externally, rather than government, funded. The capacity of schools to continue the programme without ongoing resources, and therefore the sustainability of the programme, is unclear.

Source: Clarke 2010

given the low rates of secondary attendance and completion in some countries, many young people are missing out on these programmes. Evidence also suggests that education should begin early, so further efforts to improve the coverage of age-appropriate education for primary students are needed.[250]

Parent-adolescent communication

Parents have an important role as health educators, and are also an important influence on young people's attitudes and behaviours.[272, 273] Parents are an uncommon source of SRH information for young people in the region, with parents' own lack of knowledge, discomfort and socio-cultural taboos among the reasons given for little parent-adolescent communication.[274-276] However, many young people report that they would like to be able to discuss SRH issues with their parents.[9, 277, 278]

Despite sex education programmes being gradually implemented across a variety of settings,[279] limited attention has been paid to parent-adolescent sex communication in China.[277] Traditional Chinese norms preclude parents from discussing sex-related issues directly with their children because they are considered to be too sensitive, embarrassing, and personal.[277] Many parents also hold the view that providing sex education to their children may encourage them to engage in sexual activity much earlier than deemed appropriate.[280] Results from a recent study suggest that parent-adolescent sex communication in China is very infrequent, with only 17.1 and 30.6% of adolescents having ever discussed a sex-related issue with their fathers or mothers, respectively.[277] Significant gender differences were also observed, with male youth being more inclined to talk with their fathers, and females with their mothers.

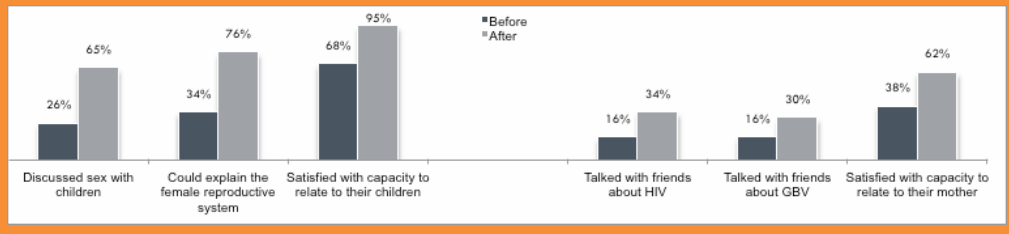
Similarly to China, traditional cultural norms in India contribute to parents' reluctance to talk openly about sexual issues with their children. In addition, traditional gender norms remain dominant, particularly in rural India, where power differentials between the genders significantly influence sex communication.[278] Communication about sex is usually culturally unacceptable and when it does occur, is usually vague and almost entirely restricted to mother-daughter and father-son dyads. However, despite sex communication being relatively 'taboo', recent evidence suggests that Indian parents are increasingly concerned about their adolescent children being at risk of unwanted pregnancy, contracting HIV/STIs, and are in fact interested in talking about sexual topics, albeit in a nuanced way. The need for increased communication is mutual, with adolescents exhibiting a strong desire to receive information about sex from their parents.[278]

There are some examples of programmes that have targeted parents to improve parentadolescent communication about SRH. In Viet Nam, the Exploring the

BOX 5. PARENT-ADOLESCENT COMMUNICATION IN VIET NAM

Creating Connections – Viet Nam

Creating Connections was developed by the University of Melbourne in partnership with the Women's Union, Viet Nam and Consultation of Investment in Health Promotion and has been implemented in selected provinces since 2005. It was designed to improve mother-daughter communication about puberty, relationships, sexuality, family planning, gender and substance use, providing information as well as building life skills. The programme was delivered over 13 sessions, held monthly and lasting 2.5 hours. Girls and mothers attended separate sessions until the last, when the groups were brought together to encourage dialogue about the issues raised during the programme. The sessions were highly interactive, using participatory methods to build communication, problem-solving, and assertiveness skills. An evaluation of the programme found the approach to be highly acceptable to mothers and adolescent girls, with a considerable increase in participants' own knowledge, confidence discussing sensitive issues, and likelihood of mother-daughter communication.



Key factors that contributed to the programme's success included:

- Use of local research with the target populations to inform the programme
- Intensive training and support of facilitators, including session plans and resources
- Comprehensive information about puberty, reproduction, SRH as well as the determinants of SRH (such as gender and substance use)
- Highly participatory to help build life-skills in a safe and enabling environment

The programme has since been scaled up and expanded to include a boys and fathers programme. The model has also been translated for use in Myanmar, Philippines, Lao PDR, China, Cambodia, Papua Indonesia, Bangladesh and Nepal.

Source: Anh 2009

World of Adolescents programme included a parent curriculum, involving six two-hour sessions focusing on knowledge, attitudes and communication skills. The programme resulted in a significant increase in parents' knowledge, frequency of parent-adolescent communication and improved comfort discussing sexual matters, most notably among mothers.[281] Other initiatives in Viet Nam have included Mother- Daughter and Father-Son clubs, established by the Centre for Reproductive and Family Health to enable parents and their children to receive SRH education together.[282] Creating Connections, delivered to adolescent girls and mothers in Viet Nam reported an increase in mother-daughter communication about gender, HIV, family planning and SRH following 13 interactive sessions aimed at increasing knowledge as well as life skills. The programme has been translated for use in other countries, including Bangladesh, Cambodia, China, Myanmar, Lao PDR and Indonesia with support of UNESCO, UNICEF and UNFPA (Box 5).[283, 284]

In the Philippines, the Commission on Population has implemented the Parent Education Programme on Adolescent Health and Development. The programme includes threeday workshops for parents covering topics "Me as a Parent", "Me and My Family", "Knowing and Understanding My Adolescent", "Building Positive Relationship with My Adolescent" and "Harnessing the Life Skills of My Adolescent" to improve parents' knowledge, attitudes and communication skills. The programme also includes workshops for parents to attend with their children.[285] In Thailand, a programme to address risky behaviours among boys aged 10-13 years included a programme for parents, resulting in a significant increase in comfort talking about sex and contributed to improved condom use skills among participating boys.[286]

Peer education

Peer education is a widely used strategy throughout the region, with great diversity in approaches. The roles of peer educators have included the provision of information through distribution of educational materials, one on one or group discussions, interactive activities (such as street theatre), referral to services, and distribution of commodities such as condoms.[282] Peer educators are an important mechanism to link young people with services and increase access to information, and can also help to develop life skills. In some settings peer educators have also had an important role in advocating for the rights of young people and mobilising community support. When implemented well they have potential to reach large numbers of young people, and can be especially effective for reaching young key populations and those out of school.[287] A summary of the key advantages and challenges is provided in Table 15.

TABLE 15. ADVANTAGES AND CHALLENGES OF PEER EDUCATION PROGRAMMES

Advantages	Challenges
• Peers are often more trusted and accessible than non-peers • May be better able to address sensitive issues related to sexuality • Can improve knowledge, attitudes, norms, motivation and behaviours • Can reach large numbers of young people, including marginalised or vulnerable groups • Can generate community support	• Can be resource-intensive to maintain • Recruitment and retention of peer educators can be difficult and turn-over high • Require considerable training and supervision to maintain quality and motivation • Peer educators may also lack the knowledge, maturity and skills to respond to the needs of their peers and communities • May face stigma from community when dealing with sensitive or taboo issues

Source: Maticka-Tyndale 2006

Few programmes in the region have been rigorously evaluated to demonstrate their impact on young people's SRH. However, recent global reviews of peer-led approaches to improve adolescent SRH concluded that peer-education interventions (including studies in Bangladesh, India, Indonesia, Nepal, Philippines, Sri Lanka and Thailand) can be effective in improving knowledge, attitudes, and behavioural intentions. Few studies evaluate specific outcomes, although those that did showed some promising results in terms of reduction in risk behaviours such as decreasing the number of sexual partners, increased condom self-efficacy and increased use of condoms and contraceptives.[287-289] Many interventions also demonstrated an ability to reach large numbers of young people and in some cases improve community attitudes towards young people's SRH. However the evidence base for the effectiveness of peer education in improving health outcomes remains relatively weak, and should be considered one component of a more comprehensive approach rather than a standalone intervention.[290]

Peer education programmes require careful planning, implementation and management

To be successful, peer education programmes require careful planning, implementation and management. In Indonesia, a pilot project in Central and East Java that trained 80 peer educators, reported that gaining support form community leaders and stakeholders in the early stages, strengthening linkages between peer educators and local health providers, providing peer educators with comprehensive information materials, and ensuring ongoing monitoring were critical to the success and sustainability of the programme.[291] Contextual factors have also been highlighted in global reviews, highlighting that creating a supportive environment for peer education is critical to success.[203] In some cases, enlisting 'peer' educators who are older than the target group may be an effective approach. Again in Indonesia, young adults were trained as educators and were well accepted by adolescents in part due to their superior knowledge, communication skills, and perceived authority to provide SRH information.[292] While there are a number of examples in the region, further research is required to better understand the effectiveness of this approach and identify key factors that would support scale-up.

Youth centres

Youth centres are youth-friendly spaces where young people can access a range of information and services, in addition to recreational, vocational and educational activities. There are many examples of youth centres, in both urban and rural settings, that provide written materials, electronic resources, peer education, counsellors and SRH services.[282] Some are standalone facilities; others are attached to clinics or schools. Because they typically provide non- SRH activities, in addition to SRH services, they may be more acceptable to communities and more accessible to young people who would otherwise be deterred by the stigma associated with sexual health clinics.

A global review of youth centres in low and middle income countries concluded that these approaches generally only reach a small proportion of young people, are mainly used by women and men outside the target age group, and are often accessed for non-SRH education or recreational activities.[293] None of the studies included in the review were conducted in Asia or the Pacific, and there have been few rigorous evaluations of the approach in this region. There are some examples, although not well evaluated, such as youth centres in Vanuatu,[294] Indonesia[295] and the Friend Corner in Thailand,[296] that have reported to improve awareness, attitudes and behaviours related to reproductive health. A review of approaches included in the Reproductive Health Initiative for Youth in Asia in 2007 concluded that youth centres were an important entry point for SRH information and counseling, were a convenient focal point for peer educators, and were acceptable to young people.[297] Locating centres in places easily accessible to young people, engaging young people in the design and delivery of centres, and providing ongoing support and resources were identified as factors that increased the use and acceptability of youth centres. Sustainability however was a key challenge, and more research is required to determine if this is an effective, or cost-effective, strategy in the region. While there may not be good evidence to support youth centres to improve SRH outcomes, such centres may have other outcomes relevant to adolescent wellbeing such as education, employment and other social benefits – although these impacts have not been evaluated.[298]

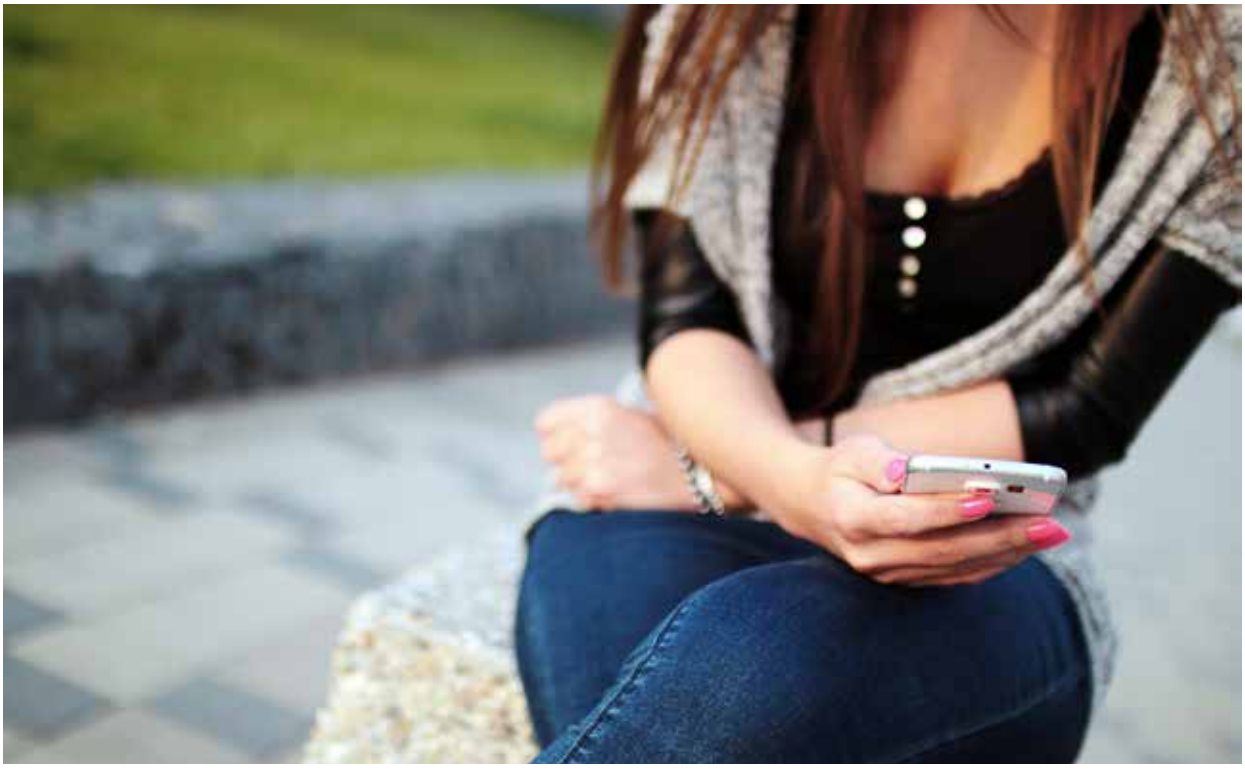
Media and communication technologies

There is increasing potential to use media to reach a large number of young people with SRH information, particularly with increasing access to mobile phones, the Internet and social media. In Thailand and Indonesia alone there were over 15 million users of social media in 2010.[299] Mass media also has the potential to transform attitudes and norms related to sexuality and gender, as well as facilitate community and parentadolescent communication about sexual matters.[300] Studies in several countries, including Thailand[110, 301, 302] and Viet Nam,[303, 304] have indicated that media is already an important influence on young people's attitudes, and is a common source of SRH information particularly where such information is not readily available from family or school. Because these technologies are engaging and entertaining, they are cited as a popular and preferred source of information by young people in many settings.[305]

The anonymous yet interactive nature of communication technologies has the potential to overcome young people's concerns about embarrassment and lack of privacy while also offering a platform for providing individually-tailored information.[306] Text messaging and online social networking sites have been shown to be an effective way of delivering sexual health promotion to young people and linking them with

services in highincome settings.[307, 308] Studies from low and middle-income countries have also suggested that these approaches may be feasible and effective, although the ability to reach rural and disadvantaged young people is not well established.[306, 309, 310] There are some documented examples using these technologies. In Thailand, text messages were used to promote safe sex among young army conscripts, with the project demonstrating a significant increase in knowledge and increased condom use at last high risk sex.[311] Countries such as China, have now taken advantage of young people's widespread adoption of information and communication technologies, and started conducting sex education via the Internet.[116] In Shanghai, for example, secondary school students were randomly assigned access to a purpose-built website providing SRH information and counseling. The site included animations and videos, online discussion and question / answer board and professional counseling via email. Post-intervention knowledge among participants was 2.8 times higher than the control group and improvements in attitudes. No significant change in self-reported behaviours was reported.[116]

SRH hotlines may also be an effective way of providing tailored information and counselling to young people in a largely private and anonymous way. In Myanmar,



BOX 6. REACHING YOUNG PEOPLE THROUGH TELEVISION DRAMA IN THE PACIFIC

Love Patrol

This television soap, produced by Wan Smolbag Theatre, Vanuatu, aimed to increase awareness and understanding of socially relevant issues throughout the Pacific. Given the low levels of literacy in the region and the geographic isolation of many of the Pacific Island countries, an "edutainment" was believed to be the best medium, with the most reach. The programme covers a wide range of topics, including STIs, such as HIV, crime, gender inequality, violence, and family breakdowns and is broadcast in Vanuatu, Fiji, Papua New Guinea, Kiribati, America Samoa, Samoa, the Solomon Islands.

A combination of qualitative and quantitative research was carried out in three countries to evaluate series one. Across Fiji, Vanuatu and the Solomon Islands, focus group sessions, workshops, and street surveys were used to assess individuals' changes in attitudes, knowledge, and practices. Survey results from Fiji and Vanuatu illustrated the significant reach of the series, with viewership especially high amongst adolescents and young women, both of which have been identified as key intended audiences for Love Patrol due to their vulnerability to HIV and STIs. In Fiji, 96% of viewers felt extremely positive about the series and could connect with the realistic quality of the show. Focus group discussions with teachers highlighted the effectiveness of the series as an educational tool, with DVDs and educational materials developed to accompany the programme.

Key features that contributed to success included:

Realistic quality of the series, which allowed viewers to identify with the characters and the messages communicated;

- Responsive and tailored to local contexts and attitudes and addressed higher risk behaviours
- The medium used was non-threatening and engaging, entertaining and informative;
- It promoted advocacy, representation, and change;
- Broadcasting it into people's living rooms fostered family and community dialogue and communication; and
- Continuity of the series and resource guides allowed a consistent and comprehensive flow of information.

Source: Wan Smolbag Theatre 2011

In Myanmar
21% of callers to a pilot SRH hotline were aged 15-25

21% of callers to a pilot SRH hotline were aged 15-25 years, with most seeking advice on reproductive functions, sexual problems, birth spacing and adolescent health. The factors considered key to the pilot project's success were the non-judgmental attitudes of trained health workers who took calls and publicising the hotline through print media.[312] Radio can also be an important source of information and counselling, particularly for rural populations and young people with low literacy. Viet Nam and Cambodia, for example, have developed radio programmes focused on young people including serial radio dramas followed by on-air discussion where listeners can call in to ask questions and seek advice.[282, 313]

Television has also become a popular medium by which to engage with young people and provide knowledge on a number SRH issues. In Nepal, awareness of safe sex practices was raised through the engagement with the world's largest television network, MTV, with adolescent viewers of the popular channel exhibiting positive attitudes toward HIV prevention behaviours after a global prevention campaign was aired by the network.[314, 315] In the Pacific, a highly popular television soap has been successful in exposing viewers to important social issues, such as HIV, which were rarely talked about before the series was broadcast (Box 6).[316]

Theatre is also a popular means of engaging young people in SRH issues, used by a number of community-based organisations in Asia and the Pacific. In Viet Nam, interactive street theatre has been used to raise sensitive issues around adolescent sexuality and substance use, stimulating discussion and tackling attitudes and misconceptions.[317, 318] Harnessing traditional means of communication and story-telling may also be important in some settings. In Lao PDR, incorporating SRH messages into traditional folks songs was an acceptable way of providing health education and useful for memorising and sharing information.[319] While all these approaches have much potential to reach young people, there is little research of these methods in the region to determine effectiveness and inform scale-up.

Youth-friendly health services

Health services play an important role in reducing preventable poor health and supporting young people make a healthy transition into adulthood. In addition to essential curative care, health services are also a crucial source of preventive services for a range of adolescent health needs, including SRH. This includes provision of information, counseling, services and referral. Many young people come into contact with services for common health complaints, therefore services are an important entry point to reach young people with SRH interventions.

BOX 7. WORLD HEALTH ORGANISATION: GLOBAL STANDARDS FOR QUALITY SERVICES FOR ADOLESCENTS

Standard 1. Adolescents are knowledgeable about their own health, and know where and when to obtain health services, and use them.

Standard 2. Parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents. They support such provision, and utilization of services by adolescents.

Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfil the needs of all adolescents. Services are provided in the facility, through referral linkages and outreach.

Standard 4. Health care providers demonstrate technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-judgmental attitude and respect.

Standard 5. The health facility has convenient operating hours, a welcoming and clean environment, and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

Standard 6. The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, schooling, ethnic origin, sexual orientation or other characteristics.

Standard 7. The health facility collects, analyses and uses data on service utilization and quality of care disaggregated by age and sex to support quality improvement. Health facility staff are supported to participate in continuous quality improvement.

Standard 8. Adolescents are involved in the planning, monitoring and evaluation of health services, in decisions regarding their own care as well as in certain appropriate aspects of service provision.

Source: WHO 2014

The particular health needs of young people, their rapidly evolving emotional and cognitive capacity, and the socio-cultural context in which they live have important implications for health systems and service delivery.[320] Health workers require additional knowledge and skills, including counselling skills, to deal sensitively and effectively with young people. Young people's increasing autonomy and need for privacy have implications for the facility environment and policies related to confidentiality and consent.

Despite the incentives to provide SRH services to young people, many face considerable barriers to accessing quality SRH services. Across the region, major barriers include:[160, 321-324]

- Health providers' judgmental attitudes and poor communication and counselling skills
- Lack of privacy and confidentiality
- Stigma and discrimination
- Facility environment that is not welcoming or provide adequate privacy
- Poor quality of care
- Providers spending insufficient time with clients
- Regulatory barriers that prevent access to certain SRH services (or services denied by providers)
- Lack of educational and other materials appropriate for young people
- Costs of services
- Inconvenient opening hours

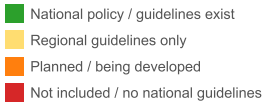
Many of these barriers are substantial for unmarried young people and young key populations. Importantly, socio-cultural norms that prohibit premarital sex are strong disincentives to seek care if young people are afraid of disclosing sexual activity, particularly if confidentiality is not guaranteed. This often results in young people delaying seeking care, or turning to private clinics, pharmacies, unskilled providers, or self-treatment rather than public facilities.[325, 326] Laws or policies that require parental or spousal consent, or that prohibit access to some services for unmarried people, also contribute to low uptake of SRH services and poorer health outcomes.

What does 'youth-friendly' mean?

Youth-friendly health services are those that provide quality care that is accessible, appropriate and acceptable to young people. The key characteristics are summarised in Box 7.[327 320, 328] Evidence from Africa and Asia (including Bangladesh, Mongolia and China) has shown that where efforts have been made to incorporate these features into health services, use of services by young people has increased.[320, 329] Importantly, approaches should not only include efforts to improve the facility environment. A review

TABLE 16. INCLUSION OF YOUTH-FRIENDLY HEALTH SERVICES (YFHS) IN NATIONAL POLICIES AND AVAILABILITY OF NATIONAL STANDARDS OR GUIDELINES

Subregion	Country	YFHS included in national reproductive health / HIV policy	National standards / guidelines for YFHS
South Asia	Afghanistan		
	Bangladesh		
	Bhutan		
	India		
	Iran		
	Maldives		
	Nepal		
	Pakistan		
	Sri Lanka		
South-east Asia	Cambodia		
	Indonesia		
	Lao PDR		
	Malaysia		
	Myanmar		
	Philippines		
	Thailand		
	Timor-Leste		
	Viet Nam		
East Asia	China		
	DPR of Korea		
	Mongolia		
Oceania	Fiji		
	Kiribati		
	Marshall Islands		
	Micronesia		
	Nauru		
	PNG		
	Samoa		
	Solomon Islands		
	Tonga		
	Tuvalu		
	Vanuatu		



Source: Maticka-Tyndale 2006

of health services in 2015 concluded that effective programmes included a package of interventions to provide or strengthen health worker training, improve the physical environment to make it more adolescentfriendly, and strategies to increase community approval and support.[206] Improving young people's health literacy is also important: a review of youth-friendly services in Cambodia in 2009 highlighted the importance of including strategies that empowered young people to seek services and increase their confidence discussing sexual matters and asking questions of health workers.[330]

National policies and standards

Nearly all countries refer to youth-friendly health services in national reproductive health, HIV or youth policies and identify young people as requiring special attention (Table 16). Most have also developed, or are developing, national standards or guidelines to define youth-friendly service delivery and support implementation. Consideration also needs to be given to other policies and legislation that impact on young people's access to comprehensive SRH services. As discussed previously, policy or legal restriction on access of unmarried young people to some services (such as contraception in Indonesia and Malaysia), legal requirements for parental or spousal consent, and criminalisation of some behaviours will continue to result in poor access and adverse SRH outcomes among young people, even where 'youth-friendly' health services exist.[137]

The available national and regional standards detail characteristics of youthfriendly health services consistent with the WHO global standards: emphasising nonjudgmental care that respects young people's rights, privacy and confidentiality; skills and training of providers; attention to the facility environment and opening times; provision of information and education materials; and, linkages with activities to increase awareness and demand for services and generate community support.[331] Most also specify a package of services that should be available to young people, with a strong focus on SRH including information and counseling about puberty and SRH, provision of condoms and contraception, pregnancy-related care, management of STIs, and provision of, or referral for, HIV testing and care and services for sexual violence. Some guidelines address other key adolescent health concerns (such as mental health and substance use) that are priority needs for young people and are also linked to SRH outcomes, although these issues are often not comprehensively addressed. There are also other important gaps: while many policies and guidelines highlight marginalised and young key populations as facing particular barriers, few national standards provide specific standards or guidance on supply-side actions required to meet the needs of these young people. Additionally, few provide clear guidance on issues of consent for adolescents under the legal age of majority.

Some countries have also actively engaged young people and other key stakeholders in the development of national guidelines. Myanmar's National Service Standards and Guidelines on Adolescent and Youth Health Care were developed following consultation with a range of agencies including government stakeholders, UN agencies, nongovernment organisations and youth groups.[332] Involving young people in defining what 'youth-friendly' means and planning services is critical, including research to identify important local barriers and preferences. At community level, engaging young people with health service initiatives is also key. In Viet Nam, young

BOX 8. NATIONAL ADOLESCENT FRIENDLY HEALTH CLINIC GUIDELINES INDIA

The **National Implementation Guide for Adolescent Reproductive and Sexual Health** (2006) specifies seven service standards for adolescent friendly health clinics (AFHCs):

1. Health facilities provide a specified package of services that adolescents need
2. Health facilities deliver effective services to students
3. Adolescents find the facility environment conducive
4. Service providers are sensitive to adolescents needs and are motivated to work with them
5. An enabling environment exists in the community for adolescents to seek services
6. Adolescent are well informed about the services
7. Management systems are in place to improve quality of service

The Standards are accompanied by an Operational Framework that provides detailed guidance on:

- The number of AFHC to be provided per population and at different levels of health facility from primary health centre to district hospital
- The package of services to be provided (including counselling and services for menstrual problems, sexual violence, STIs, HIV, pregnancy, puberty, nutrition, mental health, injury and substance use) and also specifies what services and commodities should be provided at each level of care
- Suggested opening hours for AFHC and counselling services
- Minimum levels of trained staff at each level of care (including both male and female trained providers and counsellors)
- A training package for providers
- Infrastructure requirements to ensure a private and welcoming environment
- Monitoring and supervision requirements and responsibilities

Source: Ministry of Health and Family Welfare, India 2014

people were engaged to develop a drama illustrating the problems they faced accessing services that was performed for health workers and other stakeholders. This was followed by discussion between young people and health workers to define youth-friendly features and identify ways that services could be improved.[321]

Models of service delivery

Youth-only facilities

Young people may be reluctant to access health facilities that provide services to the general adult population because of concerns of privacy and confidentiality. Youth-only services can have the advantage of providing young people with a greater degree of privacy in an environment that is welcoming and appealing. They may also have the advantage of being located in areas that young people already congregate, making them physically more accessible.[293] As described previously, youth centres that provide SRH services often also provide an array of resources, activities and services, enabling young people to avoid the stigma associated with SRH services.

There are a number of examples of youth centres or youth-only clinics that provide SRH counselling and services to some extent, although many are small-scale or pilot projects. Most are run by, or in partnership with, non-government organisations. For example, in Aceh Province, Indonesia, a local youth organisation helped to establish a youth clinic, co-located with a 24 hour youth drop-in centre and peer education programme (Box 9).[333] Governments have also established youth-only centres: in Malaysia, the government has introduced kafe@TEEN youth centres – facilities that provide reproductive health information, skillsbuilding programmes, counselling and services for people aged 13-24 years.[242] While often providing quality and accessible services, youth-only facilities are generally located in urban areas and so have limited coverage. Required resources to establish and maintain such facilities, and their sustainability, remains unclear.

Making existing services more youth-friendly

Providing youth-only clinics services in all settings is unlikely to be feasible. Therefore it is important that existing service delivery points are strengthened to make them more 'youth-friendly' as this will result in greater coverage and is also likely to be more sustainable.

There are some examples of successful approaches to integrate youth-friendly health services into existing public facilities. In Viet Nam, Pathfinder International piloted an approach to make government facilities more youth-friendly in six sites.[334] The approach included conducting an initial needs assessment at each facility that was followed by training health workers (particularly focusing on counselling skills) and upgrading facilities to provide a separate, private space for young people. Advocacy activities were also undertaken with leaders and communities to orientate them and gain support. Services were promoted to young people through

BOX 9. YOUTH-ONLY CLINIC IN ACEH, INDONESIA

YAKITA clinic in Aceh Province, Indonesia

A local youth organisation, YAKITA, helped to establish a youth clinic in Aceh to serve the health needs of young people following the 2005 tsunami. The clinic was co-located with a youth drop-in centre and linked to an existing peer education programme, which was an important mechanism for increasing awareness of the service and providing referrals. The clinic was staffed by trained health workers offering free services and counselling related to pregnancy, family planning, STIs, HIV and violence. A review of the clinic, that included focus group discussions and interviews with young people, health workers, peer educators and community members, concluded that the service was respectful, welcoming, and accessible and that health workers provided quality, non-judgmental care. In the second year of operation, over 1,000 young people had accessed the clinic, around a third of these for SRH services.

Ongoing challenges related to:

- Health worker capacity and comfort discussing sensitive issues in a conservative context
- Promotion of the service and gaining community support
- National laws and policies that limited the provision of some services to unmarried young people

Factors that contributed to success included:

- Youth participation in the programme design, implementation and evaluation
- Linkages with peer education to increase referral and awareness
- Integration with other youth-orientated resources and activities
- Supportive policies and procedures in place in the clinic to ensure confidentiality and quality of services

Source: The Nossal Institue for Global Health, 2009

distribution of information and education materials, social marketing, and outreach through exiting youth networks to increase demand. The facilities were also provided with regular follow up and evaluation to identify successful models for scale-up. The programme was extended to include 23 sites in 17 provinces across the country. Evaluation of the approach found that integrating youth services into existing services was feasible and resulted in improved quality of care and health worker attitudes, and increased uptake of services by young people (7,112 clients in 2006 increased to 61,996 in 2010). There are fewer examples of nation-wide

implementation of youth-friendly health services in government facilities, although a notable standout is Nepal (Box 10).[335]

A review of youth-friendly health services in five Pacific Island countries (Tonga, Solomon Islands, Vanuatu, Kiribati and Tuvalu) as part of the Adolescent Health and Development Programme found that non-government clinics were generally performing better than government facilities on all indicators, in large part due to greater resources and support for staff training and supervision, facility environment, and adolescent-specific information materials. However, the review identified several actions that could improve the delivery of youth-friendly care through government facilities and emphasised the need to prioritise investment in government facilities given their population coverage. Recommended actions included: development of national standards and guidelines to be used for facility accreditation and monitoring; better use of mass media and other communication networks to generate demand; improve privacy and confidentiality by developing and displaying standards at all facilities and ensuring consultation rooms offer privacy; training providers in counseling skills; providing a separate waiting area or youth-only clinic times; improving data management; increasing youth participation and feedback; and linking with other community-based health promotion activities to generate support among community gatekeepers.[336]

Outreach services and other approaches to reach young people

Not all young people will be able to access youth-friendly services, even if they exist. Young people in rural or remote areas, or poorly serviced urban settings, may have very little geographical access to services. Marginalised young people, including those most affected by HIV, can face considerable barriers to accessing health facilities. While the strength of global evidence documenting the impact of outreach services on SRH outcomes is currently limited,[206] for some populations and settings outreach services may help overcome barriers accessing facilities, and can also provide an essential link between these young people and mainstream services. In Lao PDR, for example, mobile clinics were used in rural areas to reach underserved young people. The approach demonstrated an increase in knowledge of modern methods of contraception and an increase in the proportion of sexually active young people who had ever used contraceptive from 24% at baseline to 52%.[297]

There are also some innovative examples of engaging pharmacies and private clinics to provide young people with better access to commodities such as condoms and contraceptives. Recognising that pharmacies are commonly sought by young people for SRH care, there have been a number of initiatives in Viet Nam to make pharmacies more youth-friendly. This has included training pharmacy staff to increase their knowledge about young people's SRH and counselling skills and providing them

BOX 10. NATIONAL SCALE-UP OF ADOLESCENT FRIENDLY HEALTH SERVICES IN NEPAL

The **National Adolescent Sexual and Reproductive Health** programme was developed in 2010, drawing on lessons learned from a review of activities conducted as part of the Reproductive Health Initiative for Youth in Asia programme and a pilot of 26 adolescent friendly clinics across five districts. National standards were developed and accompanied by a detailed implementation guide to support delivery, with the goal of establishing adolescent friendly health services in 1,000 government facilities by 2015. Implementation included delivery of an orientation programme to community stakeholders at each facility to generate support and demand, and delivery of technical training to at least one health worker per facility.

In 2014 over 700 facilities were implementing the programme, and a mixed-methods review was conducted of 72 facilities in 12 districts to assess progress and challenges. In the six months leading up to the review almost 8,000 adolescents aged 10-19 years had accessed services, including counselling, from the 72 facilities – most (78%) were girls, and the majority had attended for pregnancy-related care. Health workers and facility managers reported an increase in adolescent clients since the programme was initiated and also reported positive impacts of training, such as improved knowledge and confidence addressing adolescent health issues, including SRH.

The review also highlighted key challenges impacting on utilisation and quality of services including low awareness among young people, community-level socio-cultural barriers particularly for unmarried adolescents, inadequate training and supportive supervision of providers and facilities, insufficient record keeping and reporting, limited resources to address the facility environment, and lack of youth participation. The review recommended some key actions to improve implementation:

- Integrate promotion of health services into information delivered to young people through existing channels (such as school-based education, youth organisations, peer educators, media) to increase demand and improve linkages between facilities and young people
- Target community gatekeepers, including parents, to address socio-cultural barriers and generate community support
- Strengthen regular (six-monthly) monitoring and supportive supervision of facilities by district-level supervisors. This includes developing certification criteria and quality monitoring tools to ensure and support facilities to meet minimum standards
- Strengthen competency-based, participatory training for health providers
- Increase financial support to facilities, including mobilisation of community resources, to improve the physical environment – with priority given to ensuring auditory and visual privacy of consultation rooms
- Ensure at least two adolescents are active members of the health facility management committee by making it a compulsory requirement of certification

Source: Centre for Research on Environment Health and Population Activities 2015

with youth-friendly educational resources. The pharmacies were also 'branded' with welcoming logos and promoted in the local media and through youth networks to increase demand. Evaluations of such approaches demonstrated improved knowledge and quality of service provided by pharmacy staff, and contributed to an increase in contraceptive use at last sex by young people.[297] Similar approaches have also been used in Cambodia.[337]

Studies from other regions have reported that school-based services are popular among young people and are potentially an important source of SRH services, although there is paucity of quality research evaluating their impact on health behaviours and outcomes.[298, 338] While some basic health services are provided in schools in many countries in Asia and the Pacific, there are no documented examples or evaluations of approaches providing SRH services in school settings.

Social marketing can also be an effective way of generating behaviour change. In Indonesia, local research with young people was used to develop a safe sex campaign, focusing on increasing demand for condoms. The Fiesta condoms were developed to appeal to young people, produced in a range of colours, flavours, shapes and pricing, and distributed in areas that young people often congregated. The campaign also involved a range of media initiatives, including TV commercials, radio, print media and mobile text messaging. After three years the branded condom had gained 10% of the market and contributed to a 22% increase in condom sales.[339]

Health Financing

The cost of health services can be a significant barrier preventing young people from accessing quality SRH services. Globally, an estimated 100 million people are pushed below the poverty line each year as a result of out-of-pocket payments for health care.[340] Despite the recognition that adequately financing the health care of adolescents is essential for achieving universal health coverage, there remains limited evidence on the impact of health financing on young people.[341] Young people face unique challenges to accessing health care such as limited access to cash for user fees, and limited freedom to access services independently of their parents.[341] Young people and their health needs may be overlooked in national health financing mechanisms due to competing health priorities and lack of visibility of their SRH needs in policy and national data.

Financial barriers faced by young people can potentially be addressed through a range of mechanisms, such as waiving fees for young people, health insurance or pooled financing, and voucher schemes. A number of countries in the region have national policies that provide for free essential services, which include a number

of SRH-specific services relevant for young people such as maternal health care, HIV-related testing, counselling and treatment, and in some cases contraceptive services.[342] Free services are also identified by young people themselves as a key feature of youth-friendly services[160] although may not address other financial barriers related to transport costs or informal fees.

Prepaid pooled financing arrangements such as taxes or insurance schemes can be effective in increasing coverage of health services. A number of countries in the region have adopted pooled financing for health care including Vietnam, Indonesia, India, the Philippines and Thailand.[343] However, disaggregated data on coverage for young people is lacking. In many countries, adolescents are able to access health care services through family, employee or schoolbased insurance schemes.[344] Financial benefits for children through insurance or copayments may cover young people up to a specific age, often 18 years.[341] In the Philippines, the health insurance scheme PhilHealth covers whole families including children up to the age of 21 years. Enrolment in PhilHealth is mandatory for employees in the formal sector and the premium cost is financed by local governments for low income individuals or families.[343] However such pooled financing programmes may not always include services needed young people, such as contraceptive services. Adolescents who are older, unemployed, out of school, marginalised or from low-income households are more likely to face financial barriers to accessing health services.[344] Pooled financing arrangements for lowincome families are a potential way to overcome some of these barriers. One example from Andhra Pradesh in India is the Aarogyasri scheme, a taxed-based system developed to improve access to health care for those living below the poverty line. All residents of Andhra Pradesh living below the poverty line are eligible for the fully funded health care package, including adolescents and young people.[343]

Other strategies that have shown potential to overcome financial barriers include the use of vouchers entitling young people to subsidised or free SRH services, often linked with other interventions to improve the quality of youthfriendly health services.[232] There are examples of voucher schemes for reproductive health in a number of countries in Asia, including Pakistan,[345] Bangladesh[346] and Cambodia[347] but these typically target married women but no published studies examining the effectiveness of such approaches for adolescents in the region.[348]

To adequately address the SRH needs of adolescents, health care must be affordable and accessible to all young people. More research is needed to comprehensively document the current coverage and healthfinancing systems used in each of the countries in the Asia-Pacific region. A review of existing health financing strategies in Asia and the Pacific, with a focus on children and adolescents, is currently being undertaken by UNICEF and the Asian Development Bank.

Challenges and lessons learned

While there is increasing need for services that meet the SRH needs of young people, availability is very limited, particularly in government facilities. Despite many project examples, delivery of youth-friendly health services at large scale remains challenging and coverage is generally low.[297] Common challenges include:

- Inadequate budget to implement national standards and guidelines
- Poor facility infrastructure and lack of private waiting areas for young people
- Lack of private counselling and consultation rooms offering both visual and auditory privacy
- Inadequate health worker training and supportive supervision, and lack of job aids
- Infrequent or absent monitoring and quality improvement processes
- Poor record-keeping and data management to track progress
- Shortages of commodities such as condoms
- Inadequate publicity and awareness of services among young people, particularly in conservative settings where promotion of SRH is difficult
- Poor access for young people in rural areas and underserved urban areas
- Little documented regarding accessibility and utilisation by marginalised young people and young key populations

Health worker capacity is a key obstacle. As health workers in Indonesia observed, many of young people's needs relate to social and relationship issues that require a different clinical approach, and one that many health workers may not be familiar with. Additionally, being able to discuss sensitive and taboo topics and developing effective communication and counselling skills takes training and practice.[333] Some countries, such as Thailand have developed standard training materials and guidelines for health workers, but generally there is little documented regarding the coverage and quality of training in adolescent health competencies in the region.[299]

Despite these challenges, there are many opportunities to improve young people's access to SRH services. Factors that have contributed to successful pilot projects that would support scale-up in the region include:

- Ensuring government engagement and ownership
- Building partnerships with nongovernment organisations to increase coverage and provide quality services where government facilities do not have capacity
- Undertaking advocacy and community sensitisation to increase support for service provision
- Conducting needs assessments to identify priorities for training and facility upgrade
- Providing ongoing training and supervision to health workers

- Supporting health workers with clinical guidelines, education materials and job aids
- Integrating services with other initiatives to increase young people's awareness, demand and uptake
- Engaging young people in the design, implementation and evaluation of services, and using local research to define 'youthfriendly'
- Monitoring and evaluation to ensure quality and accessibility of services
- Beginning with pilot projects with gradual scale-up based on successful models

Reaching marginalised young people

Young key populations experience the double stigma associated with premarital sexual activity and engaging in behaviours that may be highly taboo or criminalised. For this reason, these they face additional barriers to accessing SRH information and services. They are also often marginalised, and so may not be reached by general programmes targeting young people, such as school-based CSE. Some general approaches may not meet the needs of key groups: for example, CSE programmes often do not include topics such as sexual orientation or provide key messages for young men who have sex with men, or may be inaccessible to marginalised young

people who are not engaged in school. Young people who are particularly vulnerable to abuse and exploitation may also require a greater focus on life-skills and self-efficacy.[213] For these reasons, marginalised young people require targeted approaches in addition to mainstream approaches that will benefit all young people.

There are many examples of projects in the region that focus on HIV prevention among key populations, which in many cases will also include young people. However there are fewer examples of those that specifically target young people, particularly adolescents, and how best to reach young key populations remains a critical knowledge gap.[349] This is important in some settings: many approaches target locations where men who have sex with men or transgender people congregate, or where transactional sex and substance use occurs (such as bars and nightclubs), however these locations are often not able to be accessed by people under the age of 18. Therefore a different approach may be needed to reach these young people, who may be more likely to be located in informal and often higher risk settings.[45]

In general, the coverage of HIV prevention programmes for key populations in the region is low, particularly for men who have sex with men, transgender people, and people who inject drugs. In all countries where data are available, fewer young people than adults over 25 years have been reached by these programmes (Table 17).[245]

A review of how young key populations are addressed in national AIDS strategic plans in Asia and Pacific found inadequate inclusion of these important groups. The report recommends the development of programmes and interventions designed specifically for young key populations, the adoption of a human rights approach, appropriate training of health care providers and representation of young people in support groups and organisations for key populations. Strategies to address the HIV epidemic among young key populations must also be prioritised for future national AIDS plans throughout the region.[231]

TABLE 17. COVERAGE OF HIV PREVENTION PROGRAMMES AMONG KEY POPUALTIONS (%)

	Female sex workers		Men who have sex with men		People who inject drugs	
Country	<25 years	≥25 years	<25 years	≥25 years	<25 years	≥25 years
Indonesia	14	20	20	25	37	46
Myanmar	70	79	62	78	46	57
Philippines	60	68	20	27	10	13
Thailand	48	63	49	49		
Viet Nam	42	50	18	30	10	18

Source: AIDS Data Hub

BOX 11. REACHING ADOLESCENT SEX WORKERS IN THE PHILIPPINES

PRIME II – reaching adolescent sex workers in the Philippines

This USAID-funded programme focused on reaching adolescent sex workers and their clients/partners in four sites in the Philippines: Angeles, Cebu, Iloilo and Zamboanga. The programme worked with non-traditional providers including community health outreach workers and peer educators, who had already established relationships and trust with this hard to reach group. The focus was on promotion of dual protection (use of a condom and another effective method of contraception) to address high rates of STIs, HIV and unintended pregnancy.

Adolescent sex workers, outreach workers and peer educators provided input into the design and delivery of the programme to ensure it was acceptable and addressed young people's needs. Activities included:

- Refresher training to outreach workers on pregnancy prevention and reproductive health needs of adolescents
- Development of a job aid on dual protection to ensure standardisation of key messages
- Development of pocket-sized educational materials to convey key facts and give details about youth-friendly pharmacists where young people could access condoms and contraceptives
- Establishment of a referral network linking with government programmes for family planning counselling

A review of the programme after 12 months found that young female sex workers who were exposed to the programme were more likely to report condom use (76%) than those who had not been exposed (52%), had increased use of modern contraception (93% versus 84%) and were more likely to seek appropriate treatment for STIs (75% versus 55%).

Source: PATH 2013

The WHO consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations include some specific recommendations for young key populations.[349] These include essential recommendations to improve SRH of all young people such as the provision of youth-friendly SRH services (including STI, contraception, safe abortion, and HIV counseling and services), provision and promotion of condoms and lubricant, scale-up of HPV vaccination, and removal of agerelated policy barriers, such as age of consent. The guidelines also recognise that young key populations face considerable stigma, discrimination and other barriers impacting on access to information and

services and so recommend a range of approaches that have shown potential to be accessible and acceptable to young people such as peer-led distribution of condoms and life-skills education, and peer, outreach, mobile health and online approaches to support life-skills education and promote behavior change.

Common approaches in this region include peer education and outreach to provide information, counselling and distribution of commodities or services. Studies in Lao PDR and Thailand have demonstrated that outreach and peer support to young people who sell sex and young men who have sex with men and transgender young people can improve knowledge, increase selfesteem, improve access to services and increase condom use.[350] A review of most at risk young people in six Pacific Island countries, (including FSM, Marshall Islands, Tonga, Tuvalu and Samoa) found that the most common strategies implemented in these settings were peer education outreach activities and condom distribution.[351]

Engaging with non-traditional providers and non-government organisations can also help to overcome the significant barriers young key populations face trying to access public services. A non-government youth-friendly clinic in Aceh Indonesia for example reported that 11% of all clients were transgender.[333] Programmes targeting young key populations often focus narrowly on HIV, despite the high needs related to other aspects of SRH such as prevention of pregnancy, STIs and violence. There are some examples however of projects that have successfully integrated SRH into HIV programmes (Box 11).[352] Other health concerns such as mental health and substance use may also be important for young key populations, with social isolation, stigma and discrimination and violence linked to higher rates of depression, anxiety and harmful alcohol use.[353] Therefore HIV-related information and services for young key populations need to be integrated with comprehensive services that address their broad needs.

Young people living with HIV have a particular need for sensitive services to help them navigate the complexities of treatment adherence, disclosure of status to partners and negotiation of safe sex, while also supporting their intentions regarding future relationships, marriage and parenting.[354] Despite these high needs, there are few documented examples of programmes in the region that target this important population with SRH information and services. A comprehensive review of HIV programmes and policies for adolescents living with HIV in Asia and the Pacific highlighted significant gaps in the region.[355] The report recommends better data, high quality health care, access to sexuality education, safe housing, a supportive disclosure process and peer-led interventions for adolescents living with HIV.

There are also some innovative examples of projects that have targeted other vulnerable young people. A programme to address the high needs homeless young

people in Cambodia, provided youth-friendly clinics, drop in centres and mobile services to increase access to information and services among this mobile population. The programme reported that the proportion of sexually active young people who used a modern method of contraception increased from 53% at baseline to 72% at endline.[297] A project in Sri Lanka developed and provided specific educational materials aimed at young out of school adolescents in order to facilitate the transition back to the classroom. This programme also engaged heavily with parents and the community, and established an inclusive and proactive learning environment at the school. The project resulted in all out of school children in the area enrolling in the formal education system after completing the necessary competencies.[356]

The Integrated Community and Industrial Development Initiative in Bangladesh established night shelters and drop-in centres for boys living on the streets of Dhaka. These centres provided a range of activities including non-formal education and life-skills training, as well as medical and legal services. The aim was to reduce child sexual abuse and exploitation, and to address the human rights and gender-related needs of the boys. The life-skills training programme included anger and stress management, masculinity and genderrelation analyses, STI and substance abuse prevention and peer-led violence prevention, in order to help break the cycle of abuse. As well as providing a safe space for this vulnerable population, the project strengthened the capacities and skills of the boys involved and empowered them to take responsibility and influence positive changes in their environment.[357]

A programme targeting Myanmar migrant adolescents in Thailand found that a participatory education programme (developed with young people) significantly increased knowledge, attitudes and intentions to prevent pregnancy compared with young migrants who had received standard education, or no intervention.[358] Similarly, a project in China aimed to improve the reproductive health knowledge of young female migrant workers through implementation of an educational intervention involving distribution of educational materials, free lectures, counselling and access to contraceptives. The study found a significant improvement in knowledge, attitudes and behaviour regarding SRH in the intervention group compared with the control.[359]

Youth participation

The ICPD Programme of Action emphasised the need to involve young people in the design and implementation of programmes that aim to address their needs to ensure programmes are relevant and effective. Participation is also key to empowering young people to be agents of change, and supports the development of responsible and active citizens and leaders. Despite challenges, particularly those related to cultural norms that support hierarchical relationships between adults and young people,[360]

many of the projects described in this review involved young people to some extent in the design and delivery of SRH programmes, and a number reported that doing so was key to the project's success.

In addition, there are numerous youth-led or youth-serving organisations and associations focused on youth issues, including SRH, active in almost all countries. There are also a number of initiatives to increase youth participation in advocacy, policy and programming for SRH, particularly HIV, at sub-national, national and regional level. The main approaches of these initiatives include:[360]

- Youth representation on government and/or UN agency working groups, often in the form of a youth advisory panel. Youth representatives are generally selected from national organisations working in SRH
- Networking between youth-led and youth-serving organisations, supported by non-government organisations and/or UN agencies

In Cambodia for example, the UN Country Team Youth Advisory Panel has been established since 2007 to increase dialogue and information sharing between UN agencies and young people, ensure a youth perspective is applied to development programmes, and build leadership and communication skills among young representatives. The initiative is the first such example of a UN-wide approach in the world, and was developed with input from many youth non-government organisations.[360] Similar approaches exist in Indonesia and the Philippines.

The Sexual and Reproductive Health Initiatives for Joint Action Network (SRIJAN) was established in India in 2001 to bring together youth-led organisations and support youth forums in seven states across the country. The SRIJAN Network has engaged in extensive capacity building, facilitated the development of a group of peer educators including SRHR Youth Ambassadors representing young people at national and international forums, and has established youth forums and information centres.[360]

In the Philippines, the Voice of the Youth Network facilitates discussion and information exchange between youth organisations, as well as providing tools and resources to support youth action. The network also facilities communication between young people and organisations, and between young people themselves, connecting people through multiple channels including email, internet blogs, text messages, and radio programmes.[361]

At a much larger scale, the UNFPA-initiated Youth Peer Education Network (Y-PEER) brings together a network of over 500 nongovernment and government organisations across the globe to promote youth participation, increase access to information and resources, and share lessons learned. The network also includes peer educators and youth advocates from 36 countries, including several in Asia and the Pacific.[362] YouthLEAD, an Asia-Pacific network of young people from key populations affected by HIV, supports youth leadership and advocacy in 19 countries in the region, including Bangladesh, Bhutan, Cambodia, China, Fiji, India, Indonesia, Lao PDR, Myanmar, Mongolia, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Viet Nam.[363]

While there are many examples of such networks, there is little research or documentation to describe best practices, impact, or sustainability. A comprehensive review of youth participation in SRH policies and programmes found very few studies that evaluated the participation of young people as a specific component of SRH programmes. Peer education, discussed earlier in this report, appears to be the most commonly implemented and evaluated youth-related intervention type in SRH programmes.[364] A mapping of youth networks in Asia conducted in 2010 concluded that there was a general absence of well-established youth networks for SRH and HIV.[360] It also highlighted that key groups of young people (including married adolescents, very young adolescents, rural young people, migrants, out-of-school young people, and young key populations) were under-represented in youth organisations, advisory panels and networks and there were missed opportunities for youth leaders and organisations to increase participation of these important groups. While evidence of the effectiveness of youth participation on SRH outcomes is lacking, ensuring young people engage with and participate in programmes related to their own health and wellbeing is essential, and projects should also be evaluated in terms of meaningful youth participation as well as effectiveness and impact.[364]

10 CONCLUSIONS AND RECOMMENDATIONS

Young people in Asia and the Pacific live in diverse socio-cultural contexts, yet they share some important challenges and opportunities related to their SRH. In all countries, increasing access to media, urbanisation and globalisation are contributing to changing sexual values, norms and behaviours of young people, often in conflict with the traditional, conservative socio-cultural attitudes towards premarital sex. These factors contribute to significant barriers that limit young people's access to information and services that they need to make a healthy transition into adulthood.

A significant proportion of young people in the region are sexually active, and while for many the onset of sexual activity is associated with marriage, an increasing number are initiating sex before marriage. The available information indicates that most are ill-prepared for this transition, having inadequate knowledge and life-skills to negotiate safe and consensual relationships and facing considerable barriers to

accessing services and commodities needed to avoid unsafe sex. As a result, both married and unmarried young people are at risk of poor outcomes such as early and unintended pregnancy, unsafe abortion, and STIs.

There are, however, many examples of good policy and programmes in the region that have aimed to create a more supportive environment for young people and improve their access to SRH information and services. Additionally, there are important opportunities to increase the coverage and improve the quality of such approaches.

RECOMMENDATIONS

1. SUPPORT RESEARCH TO ADDRESS IMPORTANT KNOWLEDGE GAPS

Despite an increasing number of studies and surveys capturing reproductive health knowledge, behaviours and outcomes of young people, several important knowledge gaps remain:

1.1. Relatively limited data for some important cohorts:
   a. Unmarried, sexually active young people
   b. Young adolescents aged 10- 14 years
   c. Young key populations, including SRH needs of young people living with HIV

1.2. Relatively limited data for some important issues:
   d. Comprehensive knowledge of puberty and reproduction
   e. Knowledge and use of contraception among unmarried young people
   f. Knowledge and prevalence of STIs
   g. Practice and outcomes of abortion among young people, particularly in settings where it is highly legally restricted
   h. Forced and coerced sex

1.3. Limited rigorous evaluations of programmes to demonstrate impact and cost-effectiveness to support evidence-informed programming and guide scale-up of effective approaches

To address these gaps, there is a need to increase support for, and investment in, local research as well as advocating for the inclusion of unmarried and young adolescents, and a minimum set of SRH indicators, in national-level surveys.

2. SUPPORT EFFORTS TO CREATE A MORE SUPPORTIVE ENVIRONMENT FOR YOUNG PEOPLE'S SRH

Socio-cultural factors, as well as national laws and policies, are among the most significant barriers to improving young people's SRH. To address these challenges, there is a need to:

2.1. Review existing laws and policies that limit young people's access to SRH information and services, including requirements for parental consent for medical care, and provision of services based on marital status.

2.2. Advocate for laws and policies that support young people's rights, including those that prohibit discrimination, and decriminalisation of sexual activity between consenting young people of similar age and consensual same-sex relationships.

2.3. Support implementation of laws and policies that aim to protect young people, including those that prohibit child marriage, trafficking, and sexual violence.

2.4. Support the delivery and evaluation of programmes that aim to address socio-cultural and gender norms that impact negatively on young people's SRH, including communitybased programmes to prevent child marriage and early pregnancy.

2.5. Continue to support broader initiatives to improve young people's health and well being, such as increasing access to secondary education

3. INCREASE THE QUALITY AND COVERAGE OF COMPREHENSIVE SEXUALITY EDUCATION

There is considerable international evidence of the effectiveness of comprehensive sexuality education, which is gender-transformative and life-skills based, to reduce risk behaviours and improve health outcomes of young people. However, the coverage and quality of such programmes remains low in many countries.

3.1. Support the scale-up of ageappropriate school-based sexuality education in both primary and secondary schools. This includes advocating for the development and implementation of comprehensive, evidence-based curricula and greater investment in teacher training and support.

3.2. Invest in other mechanisms to reach young people with comprehensive information and life-skills training, including those who are out-ofschool. This should include approaches to improve parentadolescent communication and peer education.

3.3. Explore the potential of using mass media and communication technologies to provide information and education, and invest in research to determine the feasibility, coverage and impact of such approaches in the region.

3.4. Invest in rigorous evaluation of CSE and other approaches to improve knowledge and life-skills to document best practices and effectiveness in the region.

4. IMPROVE ACCESS TO YOUTHFRIENDLY HEALTH SERVICES

Access to quality SRH services, particularly for unmarried young people, is limited in the region, contributing to low use of condoms and contraceptives and delayed careseeking. Substantial efforts are required to improve access to youth-friendly services:

4.1. Support local research to define the context-specific features of a 'youthfriendly' health service and identify local challenges.

4.2. Support the development and implementation of national standards of youth-friendly service delivery. This includes allocating sufficient budget to youth-friendly health service implementation, formalising the participation of young people in the design and monitoring of services, and linking interventions to strengthen services with those aiming to generate demand and community support for young people's SRH.

4.3. Support the development of a minimum package of SRH services to be provided to young people. This should include provision of SRH information and counseling, contraception (including long acting reversible methods and emergency contraception), access to comprehensive abortion care (including safe abortion where legal), pregnancy-related care, HPV vaccination and cervical cancer screening, STI diagnosis and treatment, HIV testing, treatment and care, and management of sexual violence. Youth-friendly health services should also address other priority health needs, such as mental health, substance use, and nutrition, which also have important implications for SRH.

4.4. Support efforts to make existing public-sector services more youthfriendly, including investing in training and support of primarylevel health care providers. This includes developing clear certification criteria and quality monitoring tools and establishing supportive supervision and monitoring of facilities and providers.

4.5. Address financial and regulatory barriers (such as requirements for parental consent) that limit young people's access to services, and ensure adolescent SRH services are included in universal health coverage financing mechanisms.

4.6. Strengthen partnerships and referral networks with non-government providers and explore innovative models to reach marginalised young people (such as engaging nontraditional providers). Other approaches to provide out-offacility services through outreach or school-based SRH services should be explored and evaluated.

4.7. Build on lessons learned from successful pilot programmes to increase coverage and scale-up service provision.

5. SUPPORT RESEARCH AND APPROACHES TARGETING KEY YOUNG POPULATIONS

Young key populations, including young people living with HIV, have high unmet needs for SRH information and services. Additional approaches are required to reach these young people:

5.1. Support further research to better understand the needs and information and service delivery preference of young key populations.

5.2. Strengthen school-based sexuality education to include sexual orientation and gender identity to better meet the needs of same-sex attracted and transgender young people and address attitudes that lead to discrimination, bullying and harassment.

5.3. Strengthen the delivery of comprehensive education and services through outreach activities and engagement with nongovernment and non-traditional providers.

5.4. Support efforts to make publicsector services not only more youthfriendly, but also more accessible to marginalised young people. This should include supporting local research to identify young key population's specific needs,

barriers and preferences and development of clear national standards and guidelines that address these issues.

5.5. Integrate SRH into existing HIV prevention programmes, to address the broad health needs of these young people.

6. INCREASE YOUTH PARTICIPATION IN POLICY AND PROGRAMMING

Youth participation is key to ensuring that policies and programmes are effectively meeting young people's needs. This should include efforts to:

6.1. Support the active and meaningful engagement of youth and youth-led organisations in national and regional policy dialogue and programme development. This should include capacity building to strengthen young people's skills and confidence in policy, programme design, communication, advocacy and research as well as strategies to generate support among adult stakeholders.

6.2. Strengthen existing youth networks in the region, both within countries and between countries.

6.3. Advocate for greater participation of underserved and marginalised young people in youth networks, policy dialogue, programme design, implementation and evaluation – particularly policy and programmes aiming to meet their needs.

6.4. Improve documentation and rigorous evaluation of programmes that include youth participation to generate better evidence on processes, best practices and effectiveness of youth participation approaches.

APPENDIX

SELECTED SOCIODEMOGRAPHIC INDICATORS

	Population aged 10-24 years (000s), 2012		Proportion population aged 10-24 years (%), 2012	GNI ($USD), 2013	Mobile phones per 100, 2013	Internet users per 100, 2013	Mean years educational attainment 15-24 years, 2013		Proportion 15-24 years out of school (%), 2004-2013		Labour force participation rate 15-24 years (%), 2013		Proportion 15-24 years unemployed (%), 2013		Adolescents 15-19 years married or in union (%), 2006-2013		Females 20-24 years married by 15 (%), 2006-2013	Females 20-24 years married by 18 (%), 2006-2013	Spouse is 10+ years older (%), 2011-2013
Country	Female	Male	Total	Total	Total	Total	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Female	Female
Afghanistan	4,681	4,878	34	690	70	6	2	5	63	36	13	61	23	16	20	14	15	25	11
Bangladesh	23,218	23,863	31	1,010	67	7	7	7	16	23	51	67	10	9	45	2	29	36	20
Bhutan	112	116	32	2,330	72	30	4	8	21	16	51	46	7	7	14	5	6	20	12
Cambodia	2,220	2,296	31	950	134	6	7	8	23	19	73	72	1	1	10	1	2	16	
China	154,320	172,178	24	6,560	89	46	11	11			54	59	8	12	2	1			
DPR of Korea	2,877	3,000	24		10	0	13	13			65	60	9	11	0	0			
Fiji	115	122	28	4,370	101	37	13	12			32	50	25	16	0	0			
FSM	18	20	37	3,280	30	28	14	14							4	3			
India	166,341	182,439	29	1,570	71	15	7	9	25	18	18	51	11	10	27	5	18	29	
Indonesia	31,145	32,037	26	3,580	122	16	10	10	18	21	40	60	22	21	14	6	3	14	
Iran	10,800	11,024	29	5,780	84	31	12	12			13	49	42	26	21	2	3	14	
Kiribati	16	16	33	2,620	17	12	11	10							16	5	3	17	
Lao PDR	1,115	1,145	35	1,450	66	13	7	7	22	16	68	59	3	4	25	9	9	26	11
Malaysia	4,328	4,095	30	10,430	145	67	13	12			33	48	12	11	6	5			
Maldives	54	56	34	5,600	181	44	9	9	2	5	49	59	36	19	5	1	0	4	
Marshall Is.	10	10	37	4,310	0	12	10	9			24				21	5	6	20	
Mongolia	407	413	30	3,770	124	18	11	10	5	9	31	41	10	9	4	1	0	5	9
Myanmar	7,192	7,136	28		13	1	8	8			57	58	11	9	7	4			
Nauru	1	1	32			0									18	0	2	25	
Nepal	4,397	4,171	32	730	71	13	6	8	11	5	75	76	3	6	29	7	10	31	
Pakistan	28,067	29,694	33	1,360	70	11	6	8	34	23	22	67	12	8	14	2	3	18	
Philippines	14,228	14,826	31	3,270	105	37	12	10	9	14	37	58	19	15	5	2	2	13	
PNG	1,032	1,096	31	2,020	41	7	8	8			59	57	5	4	15	3	2	19	
Samoa	27	29	30	3,970	0	15									7	1			
Solomon Is.	80	84	31	1,600	58	8	9	9			42	56	11	9	13	0	3	19	
Sri Lanka	2,426	2,470	24	3,170	95	22	12	11			26	49	24	14	9	2	2	10	
Thailand	6,964	7,089	21	5,340	138	29	11	11			40	56	3	3	11	3	3	16	11
Timor-Leste	196	203	37	3,940	0	0	9	9	14	13	11	18	19	10	8	0	6	19	
Tonga	15	16	30	4,490	55	35	12	11			32	45			4	1	0	6	
Tuvalu	2	2	27	5,840	34	37	0	0							10	2	0	10	
Vanuatu	36	37	31	3,130	59	11	10	9	36	36	51	62			11	4	2	19	
Viet Nam	12,106	12,677	28	1,740	131	44	10	10	7	7	61	65	6	5	10	3	1	8	7

Data sources: population, UNPD World Population Prospects; GNI, World Bank Indicators; mobile phones, International Telecommunication Union; internet users, International Telecommunication Union; educational attainment, Institute of Health Metrics and Evaluation; out of school youth, UNESCO; labour force participation, International Labour Organisation; unemployment, International Labour Organisation; currently married, UNPD; married by 15 and 18, DHS and MICS; spousal age, MICS.

SEXUAL BEHAVIOUR, CONDOM USE AND SELF-REPORTED SEXUALLY TRANSMITTED INFECTION

	Adolescents 15-19 years who have ever had sex (%), 2006-2013		Young people 15-24 years who report sex before marriage (%), 2006-2013		Young people 15-24 years who report sex before age 15 (%), 2006-2013		Young people 15-24 years who had sex while drunk in the last 12 months (%), 2006-2013		Sex with two or more partners in the last 12 months among 15-24 year olds who have ever had sex (%), 2006-2013		Young people 15-24 years who paid for sex in the last 12 months (%), 2006-2013	Young people 15-24 years who had sex with a partner 10+years older (%), 2006-2013	Young people 15-24 years who know a condom can prevent HIV (%), 2006-2013		Young people 15-24 years who report condom use at last higher risk sex (%), 2006-2013		Young people 15-24 years who have ever had sex who report STI or STI symptoms in last 12 months (%), 2006-2013	
Country	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Male	Female	Female	Male	Female	Male	Female	Male
Afghanistan													14					
Bangladesh													49	72			14	7
Bhutan	43		1	0	4				0			13						
Cambodia	32	23	0	8	1	0			0	1	3		83	84			11	3
China																		
DPR of Korea																		
Fiji																		
FSM																		
India	51	27	1	12	10	2			0	7	1	11	39	74	22	37	11	8
Indonesia	38				2						3		45	53			17	3
Iran																		
Kiribati	42	80	5	77	2	14	1	23	2	16			80	90	2	25		
Lao PDR	49	46	4	25	6	3						13	73	82			8	3
Malaysia																		
Maldives	33				0								76	90			20	3
Marshall Is.	80	85	62	77	14	27	2	19	7	13	1	4	70	88	9	22	9	4
Mongolia	51	64	32	53	1	4			1	13		5	80	78	54	75		
Myanmar													55					
Nauru	74	83	57	76	15	31	12	32	17	53	0		47	58	10	17	20	6
Nepal	52	42	1	22	7	3			0	11	2	11	79	92			11	7
Pakistan													16	28			15	2
Philippines	35		11		2							11	51					
PNG	50	53			5	4			2	13			30	45	35	50		
Samoa													53	56				
Solomon Is.	69	71	55	70	12	12	1	5	11	22	3	6	61	68	17	26	5	5
Sri Lanka																		
Thailand													90					
Timor-Leste	26	29			2	1	0	1		1	6		36	46			9	7
Tonga	23	30			1	1	1	5	4	24			64	71	5	23	7	10
Tuvalu	41	68	10	65	2	15	1	19	3	16	2		79	88			7	3
Vanuatu	64	71	30	50	6	7	1	5	4	16	3	1	59	65	37	45	12	8
Viet Nam	31	16	0	3	1	0	3	2	0	2	1	9	88	87		68	17	1

Data sources: DHS and MICS.

ADOLESCENT PREGNANCY, CONTRACEPTIVE USE AND LIFETIME EXPERIENCE OF VIOLENCE

	Adolescent fertility rate (births per 1,000 girls 15-19 years), 2006-2013	Females 20-24 years who gave birth by 15 (%), 2006-2013	Females 20-24 years who gave birth by 18 (%), 2006-2013	Females currently married who have heard of modern FP (%), 2006-2013	Contraceptive prevalence rate (modern methods), married females (%), 2006-2013		Unmet need for FP, married females (%), 2006-2013		Proportion of births unintended (%), 2006-2013		Received antenatal care from a skilled provider (%), 2006-2013	Delivered with a skilled birth attendant (%), 2006-2013	Delivered in a health facility (%), 2006-2013	Females reporting lifetime experience of sexual violence (%), 2006-2013		Females reporting lifetime experience of physical violence (%), 2006-2013		Adolescents 15-19 years who believe a husband is justified in beating his wife for at least one reason (%), 2006-2013	
Country	15-19	20-24	20-24	15-24	15-19	20-24	15-19	20-24	15-19	20-24	15-19	15-19	15-19	15-19	20-24	15-19	20-24	Female	Male
Afghanistan	80	4	21	88	6	13					48	39	34						
Bangladesh	118	9	31		42	53	17	15	21	25	57	32	29					33	
Bhutan	59	1	14		30	56	27	17			96	58	57					70	
Cambodia	46	0	6	100	19	31	16	17	9	11	92	73	57					42	25
China	8																		
DPR of Korea	1																		
Fiji	45																		
FSM	25																		
India	90	3	18	96	7	26	27	21	14	18	78	47	38	5	9	21	31	53	57
Indonesia	48	1	6	96	48	59	7	8	6	7	95	53	75					45	48
Iran	32		5																
Kiribati	51		9	90	0	15	35	29	14	14	92	78	71					77	65
Lao PDR	94	3	16		22	35	23	21	9	9	50	41	37					50	50
Malaysia	13																		
Maldives	10	0	1	94	10	23	37	32	28	21	100	93	92					41	
Marshall Is.	138	2	20	97	24	25	33	13	62	48	96	94	83	33	21	35	25	47	71
Mongolia	38	0	2	96	52	45	14	18			100	98	98						
Myanmar	16	2	11	98	44	42					75	62	21						
Nauru	69	1	21		0	13			57	54	96	91	96						
Nepal	81	1	18		14	24	42	38	25	19	64	42	41	5	11	10	18		
Pakistan	44	1	7		7	15	15	21	5	10	76	55	49			30	28	53	33
Philippines	57	0	7	99	21	34	29	22	33	27	96	75	63	4	6	17	20	14	
PNG	65	3	11	71	12	19	30	30			81	63	61						
Samoa	44	1	4	62	8	21	52	42	25	9	94	86	81					58	50
Solomon Is.	67	1	13	87	13	18	15	15	54	57	89	88	88					72	73
Sri Lanka	28		4																
Thailand	60	1	12		68	72	12	8			97	99	99						
Timor-Leste	51	1	8	73	7	15	27	35	12	14	86	33	25	2	2	30	35	81	72
Tonga	27		2	97	9	17	44	28	37	18	92	99	100					27	27
Tuvalu	42		3		0	10	0	22	30	15	0	100	100	0	20	0	41	69	83
Vanuatu	81	2	12	92	26	31	33	29	40	27	77	93	93	52	52	44	59	56	63
Viet Nam	46	0	3		15	44	16	10			88	86	82					35	

Data sources: adolescent fertility rate, DHS, MICS and UNPD; knowledge of contraception, DHS; contraceptive use and unmet need, DHS and MICS; unintended pregnancy, DHS; maternal health care, DHS and MICS; physical and sexual violence, DHS; attitudes towards violence, DHS and MICS.

HIV-RELATED KNOWLEDGE, BEHAVIOURS AND PREVALENCE

	Young people 15-24 years				Young key populations <25 years											
	Comprehensive knowledge of HIV (%), 2006-2013		HIV prevalence (%), 2008-2013		Comprehensive knowledge of HIV (%), 2006-2013			Condom use at last sex (%), 2008-2013			HIV test in last 12 months and know result (%), 2008-2013			HIV prevalence (%), 2008-2013		
Country	Female	Male	Female	Male	Female sex workers	Men who have sex with men	People who inject drugs	Female sex workers	Men who have sex with men	People who inject drugs	Female sex workers	Men who have sex with men	People who inject drugs	Female sex workers	Men who have sex with men	People who inject drugs
Afghanistan	2		<0.1	<0.1	1			53	17	43	4		22	0.3	0	3
Bangladesh	12	14	<0.1	<0.1		23		65	45	43		11	4	0.2	1	0.7
Bhutan	21		<0.1	<0.1												
Cambodia	44	44	0.2	0.2				99	69		66	33	36	7	1	
China					52	51	49	86	76	47	34	39	27	0.2	6	4
DPR of Korea																
Fiji			<0.1	<0.1				91						0		
FSM																
India	20	36			23	35	27	88	44	13	38	8	21	2	4	5
Indonesia	11	10	0.5	0.4		40	52	49	64	56		92	84	8	6	12
Iran			<0.1	0.1				62	45	24				0	0	7
Kiribati	44	49												0		
Lao PDR	24	28	<0.1	<0.1	44	30		93	24		12	13		0.8	2	
Malaysia			<0.1	0.2				67	72	25			79	1	6	5
Maldives	35	40	<0.1	<0.1							21	12	15	0	0	
Marshall Is.	27	39														
Mongolia	32	29	<0.1	<0.1	50	55		70	70		46	59		0	10	
Myanmar			0.3	0.2	65	68	78	96	84	79	68	45	26	7	9	12
Nauru	13	10														
Nepal	26	34	<0.1	<0.1	35	59			91	40	29	36	19		2	1
Pakistan	4	5	<0.1	<0.1	1		20	34	24	22	16	4	8	2		34
Philippines					29	32	37	43	38	15	16	4	6	2	3	41
PNG			0.2	0.1	39	72		75	60		42	63		13	2	
Samoa	3	6														
Solomon Is.	29	35														
Sri Lanka			<0.1	<0.1		17		88	61		25	7		0	0	
Thailand	56		0.3	0.3		19		94	86	49		24	54		5	25
Timor-Leste	12	20														
Tonga	12	14							12						0	
Tuvalu	39	61														
Vanuatu	18	19							63							
Viet Nam	51	50	<0.1	<0.1	52	48		93	66	47	32	31	20		3	

Data sources: DHS, MICS, AIDS Data Hub, AIDSinfo online.

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