



ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN THE ASIA/NEAR EAST REGION

Status, Issues, Policies,
and Programs

October 2003



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POLICY Project



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PREFACE

The POLICY II Project began July 7, 2000, and is funded by the U.S. Agency for International Development (USAID), GH/OPRH/PEC under Project No. 936-3078.02 and Contract No. HRN-C-00-00-00006-00. The Futures Group International implements the project in collaboration with The Centre for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI).

Building on more than 25 years of experience in population and development, the POLICY Project works with host-country governments and civil society groups to achieve a more supportive policy environment for family planning/reproductive health (FP/RH), HIV/AIDS, and maternal health. Multisectoral engagement, community and organizational empowerment, and promotion of human rights and gender equality characterize POLICY's approaches to better reproductive health policies and programs.

The POLICY Project brings to its work a strong background in program management and support, capacity development, advocacy, training, strategic planning, policy formulation, research, and monitoring and evaluation. POLICY staff also contribute their expertise in public health, gender analysis, law and human rights, economics and health finance, community mobilization, and data analysis and modeling.

POLICY Project papers are intended to promote policy dialogue on FP/RH issues and present timely analysis of issues that will inform policy decision making. Papers are disseminated to a variety of audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations.

An up-to-date listing of POLICY publications is available on the POLICY Project website. Copies of POLICY publications are available at no charge. For more information about the project and its publications, please contact:

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EXECUTIVE SUMMARY

The POLICY Project conducted assessments of adolescent and youth reproductive health in 13 countries in the Asia and Near East (ANE) region that represent diverse population sizes and geographical, cultural, and socioeconomic settings. The countries included Egypt, Jordan, Morocco, and Yemen in the Near East; Bangladesh, India, Nepal, Pakistan, and Sri Lanka in South Asia; and Cambodia, Indonesia, the Philippines, and Vietnam in Southeast Asia. In 2000, there were 354 million young people ages 15–24 in these 13 countries combined. The purpose of the assessments was to highlight the reproductive health status of adolescents and youth in each country within the context of the lives of young males and females.

Most young people in the ANE region begin their sexual lives within marriage, although as the age at marriage rises in the region, an increasing number are beginning to engage in sex before marriage. While programs can and should promote delayed sexual initiation, regardless of when sexual activity begins, young people need to be adequately prepared for their sexual lives and relationships instead of “being kept in the dark” until marriage. Programs can help prepare young people for sexual relationships by increasing their understanding of sexuality and the choices they can make to protect their reproductive health. Correspondingly, addressing adolescent and youth reproductive health necessitates a multisectoral approach—one that focuses on decreasing girls’ vulnerability and promoting gender equity, schooling, and expanding life options for both females and males. Every country has more progress to make in this regard.

Social, policy, and programmatic progress has been made in the ANE region, with some countries having made substantially more progress than others. Some countries’ adolescent and youth populations have greater knowledge, improved access to information and services, and better overall life circumstances as a result of policies and programs designed to address their needs. Other populations of young people, however, have experienced little progress, and these adolescents and youth are at greater risk of early pregnancy, gender-based violence, and sexually transmitted infections (STIs), including HIV, as well as limited options for education and other life choices.

The social and cultural context pertaining to young people differs considerably among the 13 countries, but the assessments found several challenges that are universal in the region. These challenges include the paucity of research and data on the age group, particularly with regard to rural and minority adolescents and youth; insufficient attention paid to enormous gender disparities; lack of information and services available to young people (including married adolescents and youth), often leading to unwanted pregnancy and disease; weakness or lack of policies directly addressing adolescent and youth reproductive health; and small-scale and generally weak programs, even where national and other policies exist. Additionally, the global environment in terms of both information (e.g., from films and TV) and resources (e.g., dependence on foreign aid) has had both positive and negative effects on the status of adolescent and youth reproductive health throughout the region.

The 13 country assessments indicate that adolescent and youth reproductive health should be addressed by involving youth in policy design and implementation; advocating for policy and program development; educating policymakers, teachers, parents, adolescents and youth; facilitating family communication; promoting gender equity; expanding access to information and services; and conducting needed research to ensure that programs are evidence based. These challenges are not new, although they take on more urgency in this era of rising prevalence of HIV/AIDS in the region. Nor are the challenges unique to the ANE region, although that region is home to the world’s largest group of adolescents and

youth. Nevertheless, it is imperative that the following challenges be addressed to improve the reproductive health of this and future generations of adolescents and youth.

1. Involve youth in developing policies and programs to meet their needs

Since the 1994 ICPD, programs have increasingly included a range of stakeholders to articulate and design policies and programs to meet the needs of clients. Yet, young people are often left out of discussions about policies and programs that affect them. Youth must be actively involved in discussing the issues facing their generation and in developing solutions that meet their needs for good reproductive health.

2. Inform policymakers about the needs of young people and advocate for policy and program change

Policymakers, lawmakers, and stakeholders are too often inadequately informed about the conditions and specific and special needs of young people and the consequences of not addressing them. Adolescent and youth reproductive health remains a politically and socially sensitive topic; policymakers are often reluctant or unable to develop multisectoral policies that address adolescent and youth reproductive health. Stakeholders need to advocate to policymakers based on an understanding of laws and policies that already exist. Advocacy must be based on human rights principles and take into account various social, economic, and religious points of view. Youth and adolescent reproductive health advocates should encourage development of relevant laws, policies, and guidelines to ensure adequate protection and promotion of adolescent and youth reproductive health and associated social issues, such as gender equity in education and the economy. Training is also needed so that key individuals can adequately motivate and lead their constituencies and assist in disseminating policy information to other relevant groups, such as community leaders and service providers.

The support of an individual, high-profile political figure can be crucial to improving adolescent and youth reproductive health policies and programs in a country. This single person's advocacy and action can catalyze high-level discussion and even change. Ibu Khofifah Indar Parawansa, the former Minister of Women's Empowerment and Head of the National Family Planning Board in Indonesia, First Lady Suzanne Mubarak in Egypt, and Princess Lalla Fatima Zohra in Morocco, have all addressed sensitive topics related to adolescent and youth reproductive health.

3. Educate policymakers, teachers, parents, community leaders, and young people to change public opinion about the need to meet youth and adolescent reproductive health needs

General public opinion must change to further enhance adolescent and youth reproductive health. Village and community leaders and religious and opinion leaders must be reached in order that they, in turn, can influence community members, families, and parents. Parents need a better understanding of adolescent and youth reproductive health issues so that they can better communicate with their children and support conditions that will improve their health. Careful thought needs to be put into the appropriate means for reaching these constituencies. In most countries, the appropriate message may be one underscoring the "healthy development of youth." Young people should be fully engaged in the development of messages and the "packaging" of information for adolescents and youth.

Teachers and others who are in regular contact with youth and adolescents need to feel both comfortable and adequate in dealing with adolescent and youth reproductive health once they have the social platform on which to do it. Given the conservative nature of most of societies in the ANE region, these special gatekeepers will need assistance in acquiring these attitudinal and skill changes. Training can be developed and conducted through cooperation among governments, NGOs, and private organizations.

Adolescents should also have input. Communication among all stakeholders will be key to comprehensive programming.

4. Promote communication in families

As policymakers and teachers are given information and training, parents cannot be forgotten. For change to occur, the gap between sociocultural norms and the realities of adolescent and youth reproductive health requires great attention. Because premarital sex is inappropriate according to many countries' cultures or religions, there is often little realization or acknowledgment that young people are increasingly sexually active and that as the age of marriage rises young people find themselves increasingly exposed to premarital sexual activity. This lack of acknowledgment hinders policy and programmatic responses to addressing adolescent and youth reproductive health.

Parents need to realize that social norms are changing, such that many adolescents and youth are sexually active. They also need accurate reproductive health information and to be comfortable discussing these topics to help and teach young people and to support appropriate policies and programs. Parents can be a great source of assistance and information for their adolescent children, who want their first information on sexual and reproductive health to come from their parents. Parents can also be strong advocates on a political level.

One way to educate parents is through their children's education. Young people could take information home to their parents to engage their families in discussions about sexual relationships and to educate their parents, who may have incomplete or inaccurate knowledge.

Exchange in families can also be facilitated by faith-based organizations (FBOs). FBOs have had success addressing the HIV/AIDS pandemic in Africa, and perhaps this model has a place for reaching young people in the ANE region. Religion has a strong influence in many ANE countries, so people might feel comfortable with a religious context for discussions about adolescent and youth reproductive health. While some religions may not support the discussion of certain topics, religious institutions may be open to facilitating dialogue about some aspects of adolescent and youth reproductive health, such as relationships, gender equity, gender-based violence, and sexual abuse.

5. Promote gender equity in all youth-related policies and programs

Promoting gender equity and positive gender norms around sex and reproductive health, such as reducing early marriage and eliminating or helping to redefine social systems (including the dowry system) that make females the chattel of males, must form the underpinning of comprehensive, multisectoral, and thereby functional and successful programming.

6. Increase young people's access to information and services

Adolescents and youth in all countries need increased access to accurate and complete information. Reproductive health education in schools needs to be designed to make young people (and teachers) knowledgeable and comfortable with the information. The most effective curricula are comprehensive, covering the biological and social aspects of reproductive health. Adequately trained peer educators can be useful additions to adolescent and youth reproductive health education programs. Adolescents and young people should also have access to information through community clinics, satellite clinics, premarital counseling, family welfare centers, schools, peer education, local youth forums, mass media, clubs, and so forth.

Young people who are sexually active, including newly married couples, need access to condoms for disease protection and contraceptives for reducing unintended pregnancy. Providers are often the biggest barrier young people face in seeking access to services. Additional support is needed to increase providers' knowledge and catalyze attitudinal and behavior change with regard to adolescent and youth reproductive health. Service providers at all levels need to be trained in all aspects of adolescent and youth reproductive health. Female doctors need to be deployed for the provision of services to young females. Counseling services for male and female adolescents and youth are needed, and the services need to address the realities of the respective country conditions. For example, reference to marriage as "the" protective agent for HIV/AIDS should be modified. Marriage is not necessarily a protective factor; both men and women can bring HIV to a marriage either initially or later during the marriage. Each country should also examine the possibility of developing or strengthening links between various services, such as between clinics/pharmacies and youth activities, to achieve an integrated approach to adolescent and youth reproductive health.

Policies and programs that do exist are often limited because of lack of sustainability, limited scope, and short timeframes. While this can be an advantage because policymakers and stakeholders are forced to revisit and revise policies and programs with frequency and regularity, shorter timeframes can also be a liability to sustainability. Funding shortages plague most programs. In addition, few programs have wide enough scope to reach a great number of young people. For example, many programs are concentrated in urban areas or schools, neglecting rural or out-of-school adolescents and youth. Many are small-scale projects or pilot projects that work with small groups of young people for short periods of time.

Often, NGOs have more flexibility in providing information and services to young people. In addition, NGO staff tend to be more youth-friendly than government health care providers. Yet, NGOs often have small coverage areas in a country. Governments and donors should consider providing more support to NGOs to undertake adolescent and youth development work. Programs that have limited potential for scaling up should not be undertaken.

7. Develop and promote evidence-based programs

Programs should draw on existing information on what works to promote adolescent and youth reproductive health. For example, the evidence shows that sex education does not increase sexual activity and that young people want to know more about abstinence, safer sexual practices, and other aspects of reproductive health. This knowledge should be disseminated widely and applied in developing and implementing adolescent and youth reproductive health education programs, especially as the age of marriage rises and the risk of premarital sex increases.

Furthermore, taking a youth development approach can be more culturally appropriate than focusing solely on reproductive health. Also, addressing a range of issues facing adolescents and young people will likely be more acceptable to young people. Often, young people themselves are often more concerned about education and jobs than about reproductive health.

While there is some information to draw on, all of the country reports indicated that more research is necessary to inform these efforts. Countries differ in the type of research needed, but at a minimum, research should focus on various segments of society, including underserved, minority, and rural populations—those most at risk for poor reproductive health outcomes.

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ANE	Asia and Near East
A&YRH	Adolescent and youth reproductive health
CEDPA	Centre for Development and Population Activities
CMS	Commercial Market Strategies (Project)
FBO	Faith-based organization
FLE	Family life education
FP	Family planning
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
MOH	Ministry of Health
NGO	Nongovernmental organization
RCH	Reproductive and child health
RH	Reproductive health
RTI	Reproductive tract infection
RTI	Research Triangle Institute
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

1 INTRODUCTION

Adolescents and young people¹ are at the beginning of their sexual and reproductive lives; they are also the next generation of parents. How they are prepared for this journey has tremendous implications for their own lives as well as for national reproductive health outcomes, including fertility, safe motherhood, and sexually transmitted infections (STIs), including HIV/AIDS. In the Asia and Near East (ANE) region, as in other parts of the developing world, approximately one in four persons is between the ages of 15 and 24. Governments throughout the region have agreed that adolescents and youth should be accorded access to good reproductive health through information and service provision. The 1994 International Conference on Population and Development (ICPD) *Programme of Action* emphasized a holistic concept of reproductive health that included adolescent and youth reproductive health as a key component. The *Programme of Action* noted that signatory “countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information, and care.”² In addition, United Nations member states agreed to the Millennium Development Goals to reduce poverty, which include young people’s need for gender equity, education, safe pregnancy, and reduction in the spread of STIs and HIV/AIDS.³

Despite international agreements, however, countries’ policies and programs do not sufficiently promote or provide for adolescent and youth reproductive health. To understand how countries in one diverse region are addressing the adolescent and youth reproductive health, the POLICY Project conducted assessments of 13 countries in the ANE region: Egypt, Jordan, Morocco, and Yemen in the Near East; Bangladesh, India, Nepal, Pakistan, and Sri Lanka in South Asia; and Cambodia, Indonesia, the Philippines, and Vietnam in Southeast Asia.

The assessments examined each country’s social context and status, policies, and programs regarding adolescent and youth reproductive health and made recommendations for future action. Adolescent and youth reproductive health status and the sociocultural and political influences that shape it vary among the countries, making it difficult to tackle adolescent and youth reproductive health as an ANE regional issue. However, the assessments found several themes that are universal to this diverse region that may be addressed to improve adolescent and youth reproductive health status throughout the ANE region. These challenges include the paucity of research and data on the age group, particularly with regard to rural and minority adolescents and youth; insufficient attention paid to enormous gender disparities; lack of information and services available to young people (including married adolescents and youth), often leading to unwanted pregnancy and disease; weakness or lack of policies directly addressing adolescent and youth reproductive health; and small-scale and generally weak programs, even where national and other policies exist. Additionally, the global environment in terms of both information (e.g., from films and TV) and resources (e.g., dependence on foreign aid) has had both positive and negative effects on the status of adolescent and youth reproductive health throughout the region.

¹ WHO defines adolescents as persons ages 10–19, youth as 15–24, and young people as 10–24. The 13 assessment reports, however, have used varying definitions of adolescents and young people: the Bangladesh, Indonesia, Morocco, Philippines, and Vietnam reports refer to 15–24 year olds (this category is also sometimes referenced as “young people”); the Egypt, India, Sri Lanka, and Yemen reports refer to 10–19 year olds; and the Cambodia, Jordan, Nepal, and Pakistan reports refer to 10–19 year-old “adolescents” and 15–24 year-old “young people.” These disparities preclude precise comparisons of age-related research (of which there is little), but important similarities and comparisons still can be examined.

² ICPD *Programme of Action*, Chapter VII, Section E. www.un.org/ecosocdev/geninfo/populatin/icpd.htm

³ www.developmentgoals.org

This paper discusses the social context that sets girls and boys in the ANE region on different life paths; the sexual, reproductive health, and STI/HIV/AIDS issues facing young people; the countries' policies and programs; operational policy barriers to addressing adolescent and youth reproductive health; and recommendations for policies and programs in the region. The findings are generally grouped by the subregions within the wider ANE region, namely the Near East, South Asia, and Southeast Asia, and country examples illustrate specific points.

2 DEMOGRAPHIC AND SOCIAL CONTEXT OF ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH

Young people in the ANE region live in a wide range of political, economic, social, cultural and religious settings. Nevertheless, the similarities in issues affecting adolescent and youth reproductive health in the ANE region are stronger than the differences. Overall economic development remains weak, and there are wide urban–rural disparities with regard to health, education, and other indicators. Religious beliefs and practice have an overarching influence on adolescent and youth reproductive health issues, policies, and programs in many of the countries. Similarly, social issues related to gender socialization, education, employment, and marriage affect adolescent and youth reproductive health in the region. In addition, young people in virtually all countries are being influenced by global and national media.

Demographic Profile, 2000–2020

In all, these 13 countries in Asia and the Near East were home to 354 million young people in 2002. The 13 countries in the region vary greatly in population size, from Jordan with approximately 5 million people to India with more than 1.03 billion. Correspondingly, Jordan has approximately one million youth (ages 15–24) compared with 200 million in India. In five of the countries—Jordan, Nepal, Pakistan, the Philippines, and Yemen—youth populations will continue to grow through 2020. In Bangladesh, Cambodia, Egypt, India, Indonesia, and Morocco, the size of the youth population will start to decline after 2015. The size of the youth populations in Sri Lanka and Vietnam will begin to decline before 2015.

Social Context

Gender norms and roles. Gender socialization sets girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. Adolescence is a crucial period of the life cycle for socialization of gender roles regarding sexuality and reproductive health. The 13 country assessments all noted unequal gender norms regarding what constitutes appropriate behavior among boys versus girls and how these views are manifest in the behavior of young people.

The assessments noted the social subordination of girls and the inequity and discrimination to which they are subjected as a result. During childhood, more work at home is expected of girls than boys, allowing adolescent boys to have more leisure time and focus more on studies. The assessments also noted that adolescence marks a period in which boys enjoy increased social mobility while social mobility for girls is curtailed. Adolescent girls are kept closer to home, especially in some Islamic countries that practice *purdah* norms, which separate the sexes and restrict females socially—particularly after adolescence and puberty.

After marriage, females' power over resources and decision making within the home and family tend to be far less than that of their husbands, particularly for those living in extended families. In all of the countries, females are expected to be wives and mothers responsible for the domestic sphere, including childrearing. With growing educational and career options, opportunities for young women are expanding, although females are not necessarily released from traditional expectations.

Near East. In Egypt, “the movements of adolescent girls are restricted and their participation in public activities is severely limited...Women strive to be ‘marriageable’ and to fulfill the conventional vision of womanhood.”⁴ The situation for young women was similarly characterized in Jordan, where “young women’s marriageability is an important consideration.”⁵ In Morocco, as elsewhere in the region, “early on, girls discover that they are second to their brothers. From a young age, girls have to assume adult responsibilities, starting with domestic chores, whereas boys can enjoy a more leisurely childhood. Imposing these responsibilities on girls is part of the process of training them to become good wives.”⁶ In Yemen, “in childhood, the male child’s needs (e.g., education, care, and nutrition) take precedence. The focus for the female child is on become a good, obedient wife and mother, which entails early training in domestic activities and agricultural work, including transporting water in rural areas.”⁷

South Asia. The India assessment notes that the differences in attitudes toward boys and girls leads to discriminatory behaviors that begin at birth with prenatal sex determination and female feticide and continue with nutritional deprivation, lower allowance for educational attainment, greater household work expectations, and early marriage for girls.⁸ The situation for women in Bangladesh and Pakistan is much the same. In Pakistan, menstruation marks a girl’s transition to womanhood. In Punjab Province, “a girl was immediately expected to observe *pardah* and wear a *burqa* [full body covering] and would be married within two or three years.”⁹ In urban Nepal, “for boys...adolescence marks a period of increased mobility, reduced supervision, growing interest in fashion, and increased participation in youth clubs... For girls...adolescence is marked by decreased social mobility. Within the household, girls are expected to do more housework than their brothers, and, consequently, have no time for leisure.”¹⁰ In Sri Lanka, adolescents, “face lower levels of gender discrimination at home and at school relative to adolescents in the rest of South Asia. However, despite performing as well, if not better than, their male counterparts at school and university...Sri Lankan women continue to be burdened with productive, reproductive, and social expectations.”¹¹

Southeast Asia. In Cambodia, “marriage and domestic labor are viewed as the primary goals for girls, and young girls are often removed from school to care for younger siblings and help with household and agricultural tasks.”¹² In Indonesia, “the girl children in the family have to be trained to be responsible for domestic chores and care giving...An Indonesian woman is taught to submit, maintain harmony in her family, and devote her life to domestic concerns and her family’s wellbeing...”¹³ The Vietnam assessment noted a “conflict between the modern and traditional models of gender relations...While gender roles are in transition in Vietnam...many stereotypes and gender values have changed little over centuries. Although what women do as part of their daily tasks has changed dramatically in recent years, the image of the ideal Vietnamese woman is still the traditional one of housewife.”¹⁴

The subordinate position of females in all 13 countries is also manifest in gender-based violence, noted explicitly in Bangladesh, Cambodia, Jordan, Pakistan, and the Philippines, although its extent is unknown. The Bangladesh assessment highlighted physical and sexual violence perpetrated on girls and

⁴ Beamish, 2003, p. 3.

⁵ Almasarweh, 2003, p. 3.

⁶ Beamish and Tazi Abderrazik, 2003, p. 4.

⁷ Al-Rabee’, 2003, p. 3.

⁸ Registrar General and Census Commissioner [India], 2001; IIPS, 2000; and Government of Rajasthan, 1995, cited in Gupta, 2003.

⁹ Khan and Pine, 2003, p. 8.

¹⁰ Pradhan and Strachan, 2003, p. 4.

¹¹ De Silva et al., 2003, p. 4.

¹² Fordham, 2003, p. 5.

¹³ Utomo, 2003, p. 4.

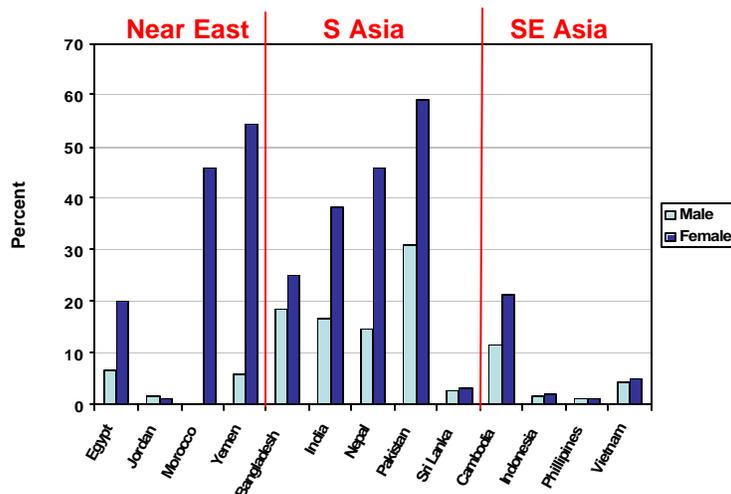
¹⁴ Hong, 2003, p. 4.

women, including marital rape, which is not uncommon in that country.¹⁵ The Cambodia assessment notes that the rape of girls younger than 12 and adolescent girls is sometimes used as a means to force marriage, and the violence often continues after marriage.¹⁶ The Jordan assessment describes a “culture of silence” in Jordan that results in most domestic violence going unreported.¹⁷ Jordanian females may also be victims of honor killings, in which a male family member kills a female for a crime, such as adultery, to restore honor to the family. Females have little recourse against the violence.

Education

While educational attainment is rising for both females and males throughout the region, inequality in access to and completion of education is apparent in most of the countries. More female than male youth remain uneducated (Figure 1), and fewer young females have completed secondary and/or higher education. In several countries, the magnitude of young female’s educational disadvantage is remarkable. In Yemen, for example, 54 percent of female youths have no education compared with 6 percent of males. Data for Cambodia, India, Nepal, and Pakistan also indicate great gender gaps in educational attainment. In Cambodia, by age 15, the male school enrollment rate is 50 percent higher than that of females.¹⁸ In Nepal, although the government adopted a policy in 1990 of free education for all children through the seventh grade and places special emphasis on the need to educate girls, a significant gap between educational attainment for boys and girls remains.¹⁹

Figure 1. Adolescents Ages 15–24 With No Education, by Sex, in Selected ANE Countries, Various Years



Note: The Morocco country report did not include data on the percentage of adolescent boys with no education

Sources: 2000 Bangladesh DHS, 2000 Cambodia DHS, 2000 Egypt DHS, 1999 India NFHS, 1997 Indonesia DHS, 1997 Jordan DHS, 1995 Morocco DHS, 2001 Nepal DHS, 1991 Pakistan DHS, 1998 Philippines DHS, Sri Lanka Department of Census and Statistics 2000, 1997 Vietnam DHS, 1997 Yemen DMCHS

The gender gap in education is not as dramatic in some countries, however, and there are exceptions to the general trends. In Jordan, Indonesia, the Philippines, Sri Lanka, and Vietnam, few young people are uneducated and the percentage of female youth with no education is nearly identical to that of male youth. In Jordan, Sri Lanka, and the Philippines, a higher proportion of female than male youth has completed secondary and/or higher education.

The country assessments also noted an urban–rural gap with regard to education. In Indonesia, for example, after the first nine years of compulsory education for both girls and boys, the gap widens, with

¹⁵ Barkat and Ahmed, 2001, cited in Barkat and Majid, 2003.

¹⁶ LICHARDO, 2001, cited in Fordham, 2003.

¹⁷ Nassar et al., 1998, cited in Almasarweh, 2003.

¹⁸ Beaufils, 2000; and Ministry of Education, Youth, and Sports [Cambodia], 1998, cited in Fordham, 2003.

¹⁹ MOH [Nepal] et al., 2002, cited in Pradhan and Strachan, 2003.

60 percent of young people ages 15–19 no longer in school in rural areas compared with 33 percent in urban areas.²⁰

These gaps exist despite many countries' education policies. Egypt, Indonesia, Jordan, Sri Lanka, and Yemen have policies that make some level of education compulsory for males and females. Bangladesh, Cambodia, and Morocco state that education is equal opportunity, accessible to all, and a universal right, respectively. However, in reality, not all children are able to attend school in these countries. In Cambodia, for example, education is free, but teachers charge extra fees to supplement their paltry salaries. In Vietnam, school fees are no longer subsidized by the government. Therefore, in both countries, many children cannot afford to attend school, and often, girls in rural areas are pulled out of school. Women's education is related to family planning use and reproductive health outcomes; worldwide increases in education are linked with higher contraceptive use, smaller family size, and better birth outcomes. Thus, the level of education, particularly of young women, has direct relevance to reproductive health as well as to issues of broader gender equity.

Employment

Young people of both sexes share some employment trends. Several country assessments noted that unemployment rates are highest among youth and thus identified underutilization of young people's time as a concern. Many young people who work do so to help their families, often without pay. In all of the countries, young females have far fewer employment opportunities compared with young males. In Egypt, for example, one-half of young males and one-sixth of young females work.²¹ Both young males and females in Morocco have difficulty finding jobs; however, the areas in which jobs are being sought and found differ, with young females working in factories and young males providing manual labor.²² In Bangladesh, a larger percentage of females work in agriculture than in manufacturing.²³ In Vietnam, more females than males ages 15–29 work in the state sector of socialist enterprises.²⁴

The treatment of some girls with regard to employment is of concern. In Morocco, for example, girls as young as five or six in rural areas are often sent to work for well-to-do families, in which some experience beatings and/or sexual abuse.²⁵ A similar situation exists in Pakistan.²⁶

Marriage and Childbearing

The expectation and reality of marriage is universal in the ANE region, although young females are marrying later, on average, than their mothers' generation. Figure 2 shows the percentage of young females ages 20–24 and older females ages 45–49 who were married by age 18. In all countries, except Yemen, a smaller percentage of younger females than older females were married by age 18. Young females in South Asia tend to marry earlier than do young females in the other subregions. In Bangladesh in 2000, nearly 65 percent of young females ages 20–24 were married before age 18, and close to one-half of young Indian and Yemeni females were married by age 18. In comparison, in Vietnam, approximately 10 percent of young females were married by age 18.

²⁰ CBS [Indonesia], 1998, cited in Utomo, 2003.

²¹ Ibrahim et al., 1999, cited in Beamish, 2003.

²² Beamish and Tazi Abderrazik, 2003.

²³ MOHFW [Bangladesh], 1998, cited in Barkat and Majid, 2003.

²⁴ GSO [Vietnam], 2000, cited in Hong, 2003.

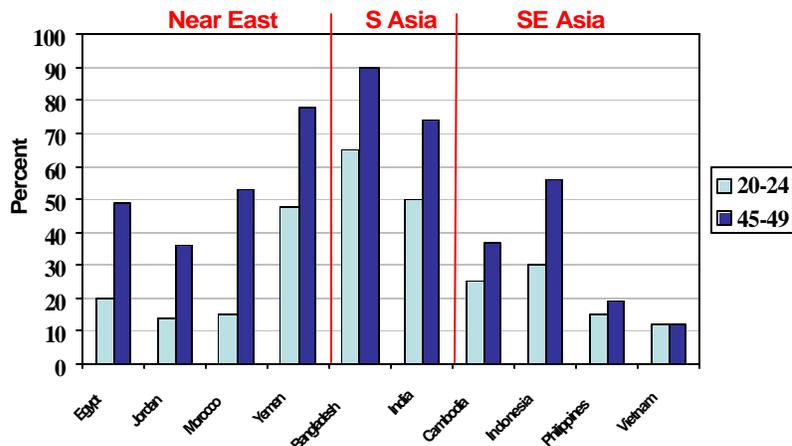
²⁵ Guessous, 2000, cited in Beamish and Tazi Abderrazik, 2003.

²⁶ Khan and Pine, 2003.

Early and arranged marriage remains the norm in a few countries, particularly those in the Near East and South Asia. In some countries, including Nepal, child marriages are still sometimes arranged in rural areas to cement economic relations between families. Dowry was an issue highlighted in the Bangladesh and Morocco assessments and is known to be of concern in Yemen. The Bangladesh assessment characterizes dowry as providing a platform for economic and sexual gain for the paid groom and providing little regard and doubtful benefit for his future wife.²⁷ In contrast, “love marriages” are now more common than arranged marriages in Indonesia.²⁸

Childbearing often begins soon after marriage. The percentage of young women that has given birth by age 20 ranges from 17 percent in Jordan and Morocco to more than 60 percent in Bangladesh (Figure 3). Still, just as the age at marriage is rising in most countries, age at first birth is rising among young women compared with their mothers’ generation in all countries except Yemen and Vietnam.

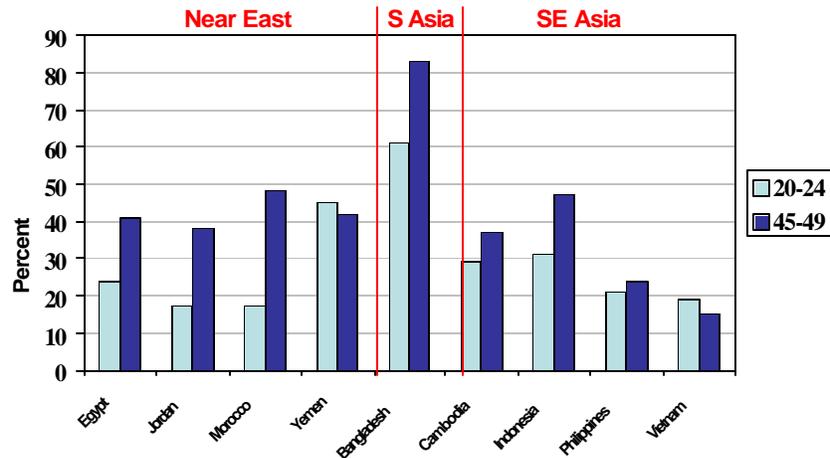
Figure 2. Percent Married by Age 18 Among Females Ages 20–24 and 45–49 in Selected ANE Countries, Various Years



Note: Only the countries for which data were available were included in this figure.

Source: Demographic and Health Surveys or other national reproductive health surveys, various years. Egypt (2000); Jordan (1997); Morocco (1995); Yemen (1997); Bangladesh (2000); India (1999); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

Figure 3. Percent Who Gave Birth by Age 20 Among Females Ages 20–24 and 45–49 in Selected ANE Countries, Various Years



Note: Only the ANE countries with available data were included in this figure

Source: Demographic and Health Surveys or other national reproductive health surveys, various years. Egypt (2000); Jordan (1997); Morocco (1995); Yemen (1997); Bangladesh (2000); India (1999); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

Adolescent and Youth Sexuality

Throughout the region, cultural norms and religious beliefs dictate attitudes toward adolescent and youth sexuality and sexual practices, which differ for female and male young people. For females, only sex within marriage is considered socially acceptable; tradition continues to place a premium on female

²⁷ Barkat and Majid, 2003.

²⁸ Hull, 2002; Jones, 1994; and Hull and Hull, 1984, cited in Utomo, 2003.

virginity at the time of marriage. In Morocco, for example, the bride's father declares to the groom, "I give you as a bride my daughter who is still a virgin" in the current marriage certificate.²⁹ In Cambodia, "adolescent girls are expected to uphold the virtue and honor of their family by taking care of their reputation and maintaining not only their actual virginity but also their imputed sexual reputation."³⁰

In contrast, young males are not held to the same standard, and sex before marriage, while not socially condoned in all of the countries, is more accepted. In Cambodia, it is expected that young males will "seek out multiple partners both prior to and after marriage."³¹ In the Philippines, young males often receive a sexual "baptism" with a prostitute, which is arranged by a male family member.³² In general, homosexual behavior is not condoned, although it does occur in the ANE countries included in this study.

While data on the topic of adolescent and youth sexual behavior are scant, in reality, due to rising ages at marriage and increased exposure to national and global media and changes in traditional norms, more adolescents and youth in the ANE region are engaging in premarital sex.³³ This increased sexual activity takes place in the context of highly unequal gender relations and, as described in the next section, limited information on reproductive health and safer sex practices, leading to exposure to the risk of unintended pregnancy, abortion, and STIs/HIV/AIDS.

²⁹ Ech-Channa, 2000, p. 145, cited in Beamish and Tazi Abderrazik, 2003, p. 4.

³⁰ Fordham, 2003, p. 5.

³¹ Fordham, 2003, p. 5.

³² Varga and Zosa-Feranil, 2003.

³³ Pachauri and Santhya, 2002.

3

ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH ISSUES

The reproductive health status of young people in the ANE region results from a number of factors that are not unique to the region but affect young people around the world, including inadequate knowledge about sexuality, fertility, and STIs/HIV/AIDS; and early sexual activity without adequate protection resulting in the risk of unintended pregnancy, induced abortion, and STIs/HIV/AIDS.

Lack of Knowledge About Sexuality and Reproductive Health

Throughout the region, young people begin sexual activity, even within marriage, with inadequate information to protect their reproductive and sexual health. While knowledge of family planning is high, social conservatism makes discussion of sex sensitive, inhibited, and often taboo, affecting family communication and formal reproductive health education. For example, in the Philippines, “the [Catholic] Church’s primary stand is that one should not have sex before marriage. According to this view, there is no point in providing reproductive health services to adolescents and youth because by definition they are not sexually active.”³⁴ Cambodia likewise maintains an official denial about adolescent and youth sexuality. In Bangladesh, “the current information and services that are available are not specific to adolescents, and the quality of such information and services is often poor or inappropriate for this age group.”³⁵ Other country assessments noted similar situations regarding the lack of information available to and knowledge among adolescents and youth regarding sexuality and reproductive health. Even in Sri Lanka, where adolescents and youth are aware of family planning, as a result of the social taboo surrounding discussion of adolescent and youth reproductive health, “the usual channels of information on safe sex, RH, and countering peer pressure are not available to adolescents.”³⁶

Parents are for the most part uncomfortable and socially proscribed from discussing sex with their children. Teachers and health care providers, like parents, are sometimes uncomfortable teaching adolescents and youth about sex. In addition, because many parents have had little education about sex and teachers may not have sufficient training to properly teach reproductive health education, they do not necessarily have good quality information to convey to adolescents and youth.

Beyond issues of discomfort and social taboo, many adults do not want to discuss sex with unmarried adolescents and youth because they worry that providing information encourages premarital sexual activity, although recent evaluations of sex education programs worldwide have concluded that such programs do not promote or lead to increased sexual activity.³⁷ Some adults, therefore, prefer maintaining the ignorance of adolescents and youth, believing that they will get the information they need at the proper time—at the time of marriage. However, married couples may remain uninformed because sex is still a sensitive topic and thus there are few opportunities for discussion or education.

³⁴ Respondent, cited in Varga and Zosa-Feranil, 2003.

³⁵ Barkat and Majid, 2003, p. 8.

³⁶ De Silva et al., 2003, p. 16.

³⁷ Kirby, 2001; Grunseit et al., 1997. These two exhaustive reviews of studies on school-based programs concluded that sex education programs do not promote or lead to an increase in sexual activity among young people, either with regard to the initiation of sex or frequency of sex. A U.S. study found that HIV programs were more likely to result in a decrease in the number of sex partners and an increase in condom use.

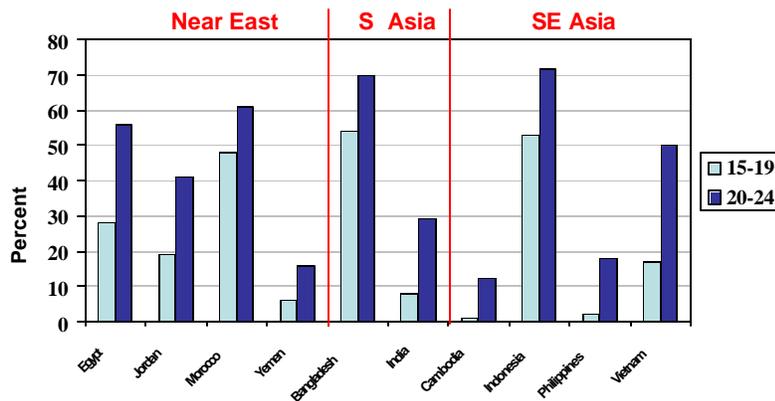
Adolescents and youth often turn to peer groups or the media for information. The Egypt assessment notes that “what young people do know they seem to have gathered from the media.”³⁸ The Indonesia assessment points out the conflicting messages young Indonesians receive about sexuality. On the one hand, the topic is socially taboo for discussion either in public or in families; on the other hand, young people are exposed to sex-related information from various media. “Therefore, while young people are provoked by the media about sex and sexuality, they lack accurate information about sex, reproduction, and reproductive health.”³⁹ Similarly, the Philippines assessment noted, “what youth now get in terms of information is from their peers and the media. And this is likely to be incorrect or misleading...They get information from the wrong sources.”⁴⁰

As a result, most adolescents and youth in the ANE region have a paucity of reproductive health knowledge. Even in countries such as Morocco, where contraceptive awareness is high among urban adolescents and youth, their actual knowledge is deficient.⁴¹ “[Moroccan] adolescents are starved for sexual and reproductive health information.”⁴² In Jordan, young married females can identify an average of 2.6 modern family planning methods,⁴³ but “young couples know little about sexuality and reproductive health when they marry, so they embark on their sexual and reproductive lives with little or no knowledge and limited skills for discussing or negotiating sexual and reproductive health preferences and needs.”⁴⁴

Knowledge about STIs and HIV/AIDS is also scant among young people in the region, as discussed below.

Low Contraceptive Use

Figure 4. Ever-use of a Modern FP Method Among Married Females Ages 15–19 and 20–24 in Selected ANE Countries, Various Years



Note: Only ANE countries for which data were available were included in this figure.
 Source: Demographic and Health Surveys or other national reproductive health surveys, various years. Egypt (2000); Jordan (1997); Morocco (1995); Yemen (1997); Bangladesh (2000); India (1999); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

Contraceptive use tends to be low among young females, many of whom are discouraged from using family planning until at least the birth of their first child (Figure 4). Ever-use of family planning among young married females ages 15–19 ranges from 1 percent in Cambodia to more than 50 percent in Bangladesh and Indonesia. Use increases among young females ages 20–24 compared with females ages 15–19, presumably because the older group has had more children and wishes to begin either spacing or limiting childbearing.

³⁸ Beamish, 2003, p. 9.

³⁹ Utomo, 2003, p. 9.

⁴⁰ Respondent, cited in Varga and Zosa-Feranil, 2003, p. 6.

⁴¹ AMPF/Experdata, 1995, cited in Beamish and Tazi Abderrazik, 2003.

⁴² Beamish and Tazi Abderrazik, 2003, p. 23.

⁴³ DOS [Jordan] and Macro International, Inc., 1997, cited in Almasarweh, 2003.

⁴⁴ Almasarweh, 2003, p. 16.

Incomplete or inaccurate information may affect contraceptive use. For example, despite high levels of modern method knowledge, confusion exists among Jordanian adolescents and youth due to misunderstandings about Islam’s position on modern contraception. Some Filipinos believe that contraceptives have damaging side effects, such as sterility and cancer; and some Vietnamese believe that contraceptives are harmful to unmarried females.

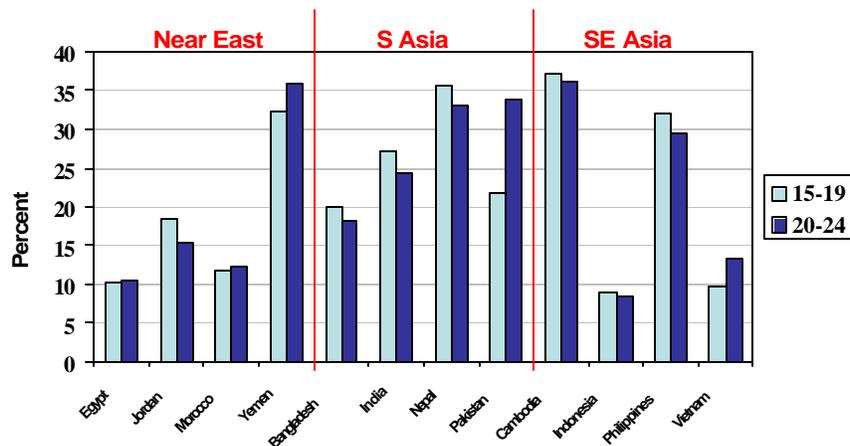
Social stigmas associated with contraception also create barriers. In many countries, there is great social pressure for adolescents and youth to hide their sexuality, especially from their parents. They do not want to be caught obtaining or possessing contraception. Also, due to the social premium placed on girls’ virginity, many young females want to appear naïve with regard to sex. In Vietnam, many girls do not negotiate contraceptive use with their boyfriends to maintain impressions of their sexual innocence. Condom use among young people in the Philippines is almost nonexistent, probably due to their association of condoms with STI and HIV/AIDS prevention rather than pregnancy prevention.⁴⁵ Filipinos often consider condoms the tool of prostitutes or promiscuous girls. This is also true in Cambodia.

High Unmet Need for Contraception

Unmet need for contraception⁴⁶ is generally high among young females in the ANE region, in both age groups 15–19 and 20–24, ranging from around 9 percent in Indonesia to over 35 percent in Cambodia (Figure 5). Unmet need for family planning among young females in union is highest in Cambodia, Nepal, Pakistan, the Philippines, and Yemen. Unmet need translates into unintended pregnancies and risk of abortion and maternal morbidity and mortality in addition to exposure to STIs/HIV.

While childbearing is expected to begin early in marriage, not all young married females intend to get pregnant when they do so. Figure 6 shows that among the young females younger than age 20, a significant percentage had experienced a mistimed pregnancy, ranging from 5 percent in Egypt to 36 percent in the Philippines. Pregnancies among young females are more likely to have complications.

Figure 5. Unmet Need for Contraception, Among Females Ages 15–19 and 20–24 in Selected ANE Countries, Various Years

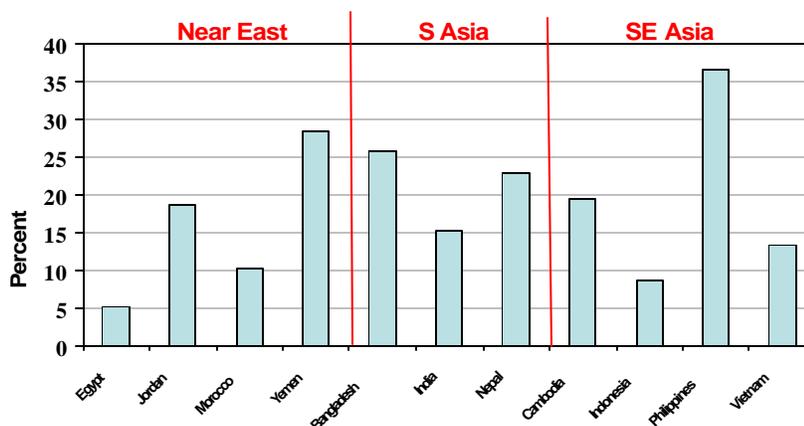


Note: Only the countries for which data were available were included in this figure. Source: Demographic and Health Surveys or other national reproductive health surveys, various years. Egypt (2000); Jordan (1997); Morocco (1995); Yemen (1997); Bangladesh (2000); India (1999); Nepal (2001); Pakistan (1995); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

⁴⁵ Respondent, cited in Varga and Zosa-Feranil, 2003.

⁴⁶ The data represent sexually active young women in union who either wish to postpone childbearing by at least two years or who wish to have no more children and yet are not using contraception.

Figure 6. Mistimed Pregnancies Among Females Younger than Age 20 in Selected ANE Countries, Various Years



Note: Only countries for which data were available were included in this figure.
 Source: Demographic and Health Surveys or other national reproductive health surveys, various years. Egypt (2000); Jordan (1997); Morocco (1995); Yemen (1997); Bangladesh (2000); India (1999); Nepal (2001); Pakistan (1995); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

Abortion

Abortion among adolescents and youth is becoming more common because of premarital pregnancies, which are generally socially unacceptable. It is most common in Southeast Asia—Cambodia, Indonesia, the Philippines, and Vietnam. In Indonesia, one study showed that young unmarried females accounted for 40 percent of villagers seeking abortions.⁴⁷ The premarital abortion rate in Vietnam has doubled in the past 10 years, perhaps because increasingly prevalent sexual activity among young unmarried females has led to more unwanted pregnancies.^{48,49}

Abortion often has serious health effects. Because abortion is illegal in most countries, except in certain circumstances, such as when the life of the mother is threatened, many abortions are clandestine and thus may be self-induced or performed by unqualified providers.⁵⁰ Health consequences for females include sepsis of the uterus and birth canal.

STIs and HIV/AIDS

HIV prevalence among youth in the ANE region is low, overall, but it is rising, particularly in Cambodia, India, Nepal, and Vietnam (Figure 7). Most countries have similar HIV prevalence rates among young males and females, although Cambodia, India, and Vietnam are exceptions, due in part to the predominant modes of transmission in these countries. Young females in Cambodia and India have higher HIV prevalence because of prostitution. In Vietnam, young males have higher HIV prevalence because most infection in the country is associated with injecting drug use, which is more common among boys.

⁴⁷ Marcus study cited in Wilopo et al., 1999, cited in Utomo, 2003.

⁴⁸ MOH [Vietnam], 2001, cited in Hong, 2003.

⁴⁹ Goodkind, 1994, cited in Hong, 2003.

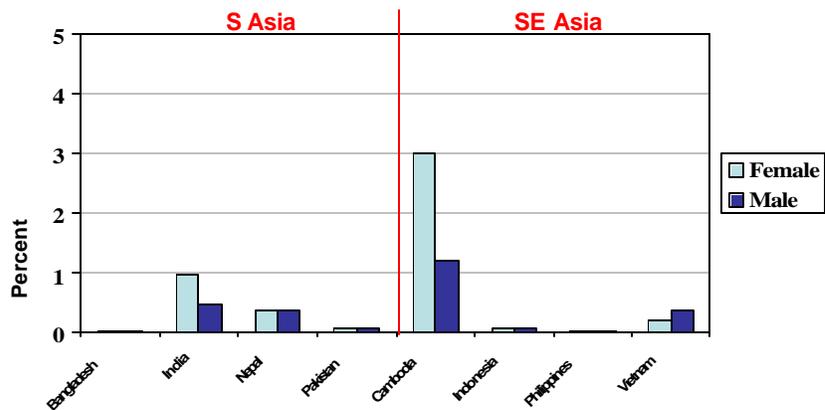
⁵⁰ Government of Bangladesh and UNICEF, 2000, cited in Barkat and Majid, 2003.

STI and HIV prevalence is increasing among adolescents and youth as more are sexually active before marriage. For example, 12–25 percent of STI cases in India are among teenage boys, where STIs are the third most prevalent communicable disease.⁵¹ In Jordan, adolescent and youth cases account for a significant proportion of reported STIs.⁵² Also, STI prevalence is rising among Sri Lankan adolescents and youth.

Young people are generally uneducated about STIs and HIV/AIDS. Perhaps this is because the topic is so stigmatized in many cultures that reproductive health education does not teach it adequately. For example, more than one-half of Bangladeshi adolescents and youth could not identify a mode of STI transmission and only 13–14 percent were aware of gonorrhea and syphilis.⁵³ Many countries have made efforts to educate the public about HIV/AIDS, thus many young people have heard of it but their knowledge is insufficient overall. Figure 8 shows that for the Southeast Asian countries and India, knowledge of methods of preventing HIV using the ABC approach (abstaining from sex, being faithful to one uninfected partner, and using condoms correctly and consistently) is far from universal. While more than 60 percent of females ages 15–24 know that a healthy looking person could be HIV-positive, this knowledge is low in South Asia (under 30%) and Indonesia (32%).

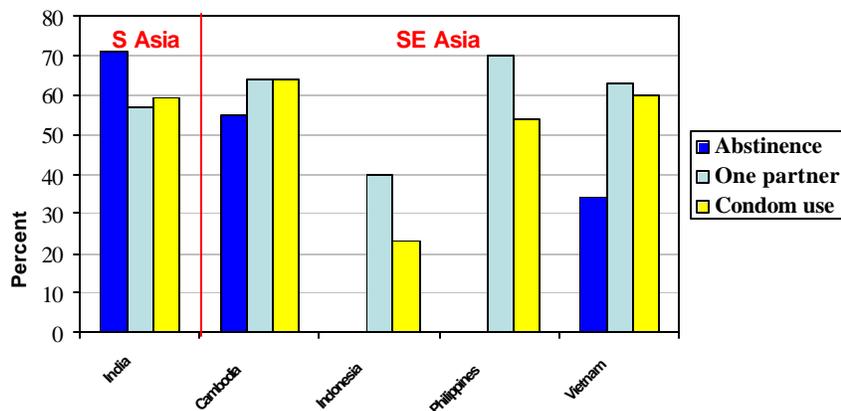
Young people engaging in premarital sex often engage in high-risk sex, increasing their chances of contracting STIs or HIV. They know little about preventing infection and often do not have access to condoms.

Figure 7. HIV Prevalence Estimates Among Youth Ages 15–24 in Selected ANE Countries, 2001



Note: Only countries for which data were available were included in this figure. These estimates represent the "high" estimates for HIV prevalence among this age group. Source: UNICEF, UNAIDS and WHO. "Young people and HIV/AIDS: Opportunities in Crisis," www.unicef.org/pubsgen/youngpeople-hiv-aids.pdf. Various data sources.

Figure 8. Knowledge of Prevention Methods Among Youth Ages 15–24 in Selected ANE Countries, 2001



Note: Only the countries for which data were available were included in this figure. Source: UNICEF, UNAIDS and WHO. "Young people and HIV/AIDS: Opportunities in Crisis," www.unicef.org/pubsgen/youngpeople-hiv-aids.pdf. Various data sources.

⁵¹ Ramasubban, 1995, cited in Gupta, 2003.

⁵² JAFPP, 2001, cited in Almasarweh, 2003.

⁵³ Barkat et al., 2000, cited in Barkat and Majad, 2003.

Even with knowledge and access, however, many adolescents and youth do not obtain condoms because of stigma associated with condoms, sexual activity, and, among young females, knowledge about safer sex. Young people may also be misinformed by cultural myths that lead them to unsafe sexual practices. For example, popular Moroccan beliefs are that females harbor STIs and HIV is most common among females because it is a result of their debauchery.⁵⁴ Consequently, Moroccan males seem to be exempt from STI prevention responsibilities.⁵⁵

Health-seeking behavior for STI and HIV infection is also hampered for adolescents and youth. STIs and HIV/AIDS are highly stigmatized in ANE countries, thus young people hesitate to seek advice or care when they may have been infected. In addition, many adolescents and youth do not have access to reproductive health services.

Sexual Abuse, Exploitation, and Prostitution

Young females and males in the region are too frequently victims of sexual abuse and exploitation. Only a few country assessments identified this issue; however, it may in fact be more widespread. In Pakistan, child sexual abuse is prevalent within homes and communities and may be rooted in the culture because of an encouraged child-adult power imbalance.⁵⁶ *Bachabazi*—older males providing adolescent boys with education, clothing, and care in exchange for sex—is frequently practiced in Pakistan’s North-West Frontier Province.

Adolescent prostitution is a problem in most countries; only the Egypt and Yemen assessments do not specifically address it. In Cambodia, adolescent girls are sometimes sold into prostitution by their families or boyfriends or are pressured to become prostitutes based on financial and social obligations to the family.⁵⁷ It seems that many prostitutes in these countries begin work during adolescence. In India, for example, two out of five prostitutes are younger than 18.⁵⁸ This population has limited education about contraception and disease prevention, and prostitutes are often not able to negotiate safer sex with their clients. In addition, young prostitutes are often victims of sexual violence.

⁵⁴ Dialmy, 2000; and AMPF/Experdata, 1995, cited in Beamish and Tazi Abderrazik, 2003.

⁵⁵ MSP [Morocco] and AIDSCAP, 1997, cited in Beamish and Tazi Abderrazik, 2003.

⁵⁶ Sahil, n.d., cited in Khan and Pine, 2003.

⁵⁷ See CARAM, 1999 and Greenwood, 2000, cited in Fordham, 2003.

⁵⁸ Gupta, 2003.

4 LEGAL AND POLICY ENVIRONMENT FOR ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH

While all 13 countries that were included in the ANE regional assessment have policies that affect young people, some countries, such as India and Jordan, have many policies and others, such as Yemen, have only a few. Only India and the Philippines have specific adolescent and youth reproductive health policies.

In addition, there are varying degrees of fortitude with which the policies address issues affecting adolescents and youth and with which they are implemented. The policies' existence does not necessarily translate into adequate protection or services. Some governments have made headway in developing awareness about adolescent and youth reproductive health and have publicly underlined its importance to young people and society, in general. However, politics, culture, and religion still build major barriers to ensuring good adolescent and youth reproductive health.

Table 1 summarizes the legal and policy environments for adolescent and youth reproductive health in the 13 countries by subregion. More details for each country are presented below.

Table 1. Policy Environment for Providing Adolescents and Youth with Services in 13 ANE Countries, 2002–2003

Country	Status
<i>Near East</i>	
Egypt	Recent political interest in ensuring a healthy transition to adulthood. Public sector services are for married females.
Jordan	Policies and programs for adolescents and youth are limited in scope. Public sector services are for married females. The government is promoting cross-generational communication on reproductive health.
Morocco	Marriage is the only setting in which sexual activity is allowed. Reticence to serve adolescents and youth.
Yemen	Very difficult for unmarried and not-in-school youth to get services.
<i>South Asia</i>	
Bangladesh	MOH recently listed adolescent and youth reproductive health as a priority. Still difficult for unmarried youth to get services in the public sector.
India	Adolescent and youth reproductive health addressed explicitly in some policies. No clear definition of a strategic approach and activities to provide adolescent and youth health care.
Nepal	Recent law specifying that unmarried youth can receive services.
Pakistan	Public sector services are for married females.
Sri Lanka	Cultural taboos about addressing adolescent and youth reproductive health. Policy goal is to make young people responsible for their behavior.
<i>Southeast Asia</i>	
Cambodia	No legal barriers, but lack of services; denial of youth sex.
Indonesia	Government recognizes needs of adolescents and youth, but still politically sensitive. Services are geared toward married females.
Philippines	Policy is to provide services to the unmarried, but still limited.
Vietnam	For decades nothing done, no specific policies addressing adolescent and youth reproductive health; unmarried ignored.

Near East

Egypt. The interrelationship of religious teachings and prevailing attitudes and culture with regard to sexuality is an important consideration in many countries, and in Egypt as well. A significant breakthrough was made in 2001 with the development of a document by the Ministry of Health and Population Reproductive Health/Information, Education, and Communication (RH/IEC) Project that provides a foundation for a national adolescent and youth strategy. It gives an assessment of the health, well-being, and status of adolescents and youth, offers recommendations for addressing their needs, and provides examples of ways to address these needs. It also provides background for a yet-to-be developed national adolescent and youth strategy. Supporters refer to the strategy document, noting the importance of eliminating gender discrimination and girls' illiteracy, increasing the age at marriage for girls to 18, providing specific reproductive health services for young females, implementing the new law that bans female genital cutting, and increasing the role of nongovernmental organizations (NGOs) in addressing the needs of girls and young females.

To this point, however, Egyptian policies have provided a mixed message regarding adolescent and youth reproductive health. While numerous ministries and their policies address issues pertinent to adolescents and youth, Egypt does not yet have a clear or consistent definition of adolescence. In addition, Egypt's population policy focuses explicitly on young female adults' need for health care prior to marriage and premarital exams and counseling. The prevalent attitude in the country is that the best way to protect children and young adults from engaging in unacceptable behaviors, such as premarital sex, is not to provide them with any information on these practices. While Ministry of Health and Population services and university clinics and hospitals are available to people of all ages, and while school health programming is prevalent in Egypt (preventive health care, including check-ups, vaccinations, and curative and rehabilitation services are provided through the School Health Insurance System as a result of a 1992 law mandating health services for students), the services provided do not systematically include reproductive health care. Also, there is no scheme comparable to the School Health Insurance System for out-of-school youth, although as of 1998, several ministries were discussing ways to provide health insurance to these young people.⁵⁹ What limited reproductive and sexual health education young people receive has been and continues to be the responsibility of families.⁶⁰ Laws and policies do exist that address specific issues, such as motherhood and abortion, providing the right to maternity leave⁶¹ and protection "against unsafe abortion";⁶² however, the exact parameters of the abortion issue, for example, are not entirely clear. The next few years should provide a clearer picture of Egypt's commitment to adolescent and youth reproductive health.

Jordan. There are important policies affecting adolescents and youth, and there are four ministries, a specialized committee for youth within the Parliament, and two specialized councils responsible for addressing the needs of adolescents and youth in Jordan. The Jordanian National Population Commission has also developed the first National Reproductive Health and Life Planning Youth Communication Strategy, which is for 2000–2005. The strategy is introducing innovative approaches to cross-generational communication by targeting two key audiences: primary audiences, consisting of married and unmarried youth ages 15–24; and secondary audiences, consisting of parents and family members, educators and school social workers, government officials and decision makers, and religious leaders.⁶³ The policy on the age at marriage was successfully changed in 2001 from 15 and 16 for girls and boys, respectively, to 18 years for both (except in specific cases that are left to a judge to decide). Various other

⁵⁹ Ibrahim et al., 1999; Shafey, 1998; and UNFPA/MOHP, 2001, cited in Beamish, 2003.

⁶⁰ Shafey, 1998, cited in Beamish, 2003.

⁶¹ Shafey, 1998, cited in Beamish, 2003.

⁶² Al-Bindari, 2001, cited in Beamish, 2003.

⁶³ JNPC/GS, 2001, cited in Almasarweh, 2003.

policies, particularly those that have been developed in recent years, are focused on the health and well being of society in general. These include Public Health Act No. 21 of 1972, which obligates the Ministry of Health (MOH) to do everything in its power to safeguard the health of citizens; a 2001 royal decree establishing the National Council for Family Affairs; successive national socioeconomic development plans, such as the 1999–2003 plan, stressing improvements in health with specific objectives in all health areas, including maternal and child health;⁶⁴ and the Labor Law and Civil Service By-law, which entitles working females to fully paid maternity leave and time for breastfeeding for one year.⁶⁵ These and other areas of focus affecting adolescent and youth reproductive health, such as family violence, are being given high priority by Their Majesties King Abdullah and Queen Rania, providing hope for improvements in adolescent and youth reproductive health.

However, there is no one, clear or consistent definition of adolescence; thus, developing a clear policy on adolescent and youth reproductive health in Jordan remains difficult. Existing policies may also be inadequate. For example, there is a lack of specific provisions for first-time or adolescent mothers (even though working females are entitled to maternity leave). In addition, Jordan's National Population Strategy explicitly addresses young people's need for reproductive health education; however, reproductive and sexual health education is minimal in schools and often nonexistent within families because of prevailing attitudes and a focus on familial protection.

Morocco. In Morocco, as in other predominately Muslim countries such as Pakistan, marriage is the only setting in which sexual activity is allowed under Islam and in which pregnancy and childbearing are legally legitimate.⁶⁶ This affects the legal and political response in a reality in which premarital sexual relationships typically occur long before marriage.⁶⁷ While IEC programming has been increasingly available, the current situation with regard to adolescent and youth reproductive health policies and laws in Morocco is described in the following way:

[It] impedes investigating the issues in-depth to gain a real understanding of the situation. It constrains educating youth to enable them to develop healthy attitudes about sexuality and reproduction and to avoid high-risk sexual behaviors. It precludes designing and funding reproductive health and related programs to target the large and ever-growing population of adolescents and unmarried young adults in Morocco. It rules out providing services in a manner that is friendly and acceptable to youth. In general, the condemnation, prohibition, and denial of unmarried adolescents' sexuality is a major impediment to improving the sexual and reproductive health and even the opportunities and lives of this large and growing segment of the population.⁶⁸

Yemen. Yemen's Population Policy addresses young adults explicitly through provisions for reproductive health education and services, including antenatal care, immunization, and family planning services.⁶⁹ However, there is a lack of clear and consistent definitions with regard to adolescence and youth and policy direction for them, even while there are policies affecting adolescents and youth and numerous ministries that are involved with their issues. Programming remains slim as a result.

The government is trying to address issues related to adolescent and youth reproductive health. It has done so through efforts that include a 1991 Presidential Decree that established the National Council for Childhood and Motherhood; an entire chapter of the current five-year plan (2001–2005) devoted to

⁶⁴ MOP [Jordan], 1999, cited in Almasarweh, 2003.

⁶⁵ Labor Law No. 8, 1996; Civil Service By-law for 1996, cited in Almasarweh, 2003.

⁶⁶ Dialmy, 2000; Ech-Channa, 2000; and Joutei, 2001, cited in Beamish and Tazi Abderrazik, 2003.

⁶⁷ Mounabih, 2001; and Reynolds, 1999, cited in Beamish and Tazi Abderrazik, 2003.

⁶⁸ Beamish and Tazi Abderrazik, 2003, p. 13.

⁶⁹ National Program of ARH and FP and Child Health (2001–2005), NPC [Yemen]. [NPC [Yemen], 2001, cited in Al-Rabee, 2003.

motherhood and childhood; Civil Service Law No. 19 (1991), which entitles working women to maternity leave and reduced work days when pregnant and breastfeeding; and the 1999 decree (No. 59) that established the General Strategy for Youth, Adolescents, and Sport (2000–2004), which aims at providing a planned and scientific base for ensuring the infrastructure necessary to make headway on youth-oriented issues. In addition, Yemen has committed itself to the National Strategy for Integrating Youth into Development (1998). The strategy presents an analysis of issues, provides recommendations for addressing the needs of adolescents and youth, identifies strategic actions, and supports the development of subcommittees to coordinate and follow up on activities. It stresses the importance of providing information to decision makers. In addition, a youth strategy exists that helps provide a basis for action on issues defined in the ICPD. Other existing policies that also affect adolescent and youth reproductive health in Yemen include the legal age at marriage, which is 15 years.

South Asia

Bangladesh. The Constitution of Bangladesh stipulates equal rights for men and women irrespective of caste, creed, and color. Numerous policies and acts have been passed that address various aspects of issues pertinent to adolescent and youth reproductive health (e.g., the Dowry Prohibition Act of 1980, the Cruelty of Women Act, the Child Marriage Restraint Act, and the Penal Code, which provides capital punishment for causing grievous injuries or acid throwing). However, the limited laws, regulations, or ordinances that are specifically designed to protect adolescents and youth, particularly young females, are often not enforced or do not protect young people from exploitation and violence directly enough. Thus, the numerous current laws, rules, regulations, and ordinances that might positively affect various aspects of young people's lives do not de facto ensure their rights or health.

In January 2001, the Director General of the Directorate of Family Planning declared a number of adolescent and youth health problems as priorities, including nutritional deficiency, early and unwanted pregnancy, maternal mortality related to early and risky pregnancy, lack of information and services, and problems due to unsafe abortion, accidents, and violence. For the first time, he suggested relevant information and service delivery for young people at various tiers of the public health system. Steps taken since that time are promising. They include provision of health education materials for adolescents and youth on general health and reproductive health; IEC on adolescent and youth reproductive health for guardians, teachers, and social leaders; distribution of vitamins to adolescents; medication for dysmenorrhea; provision of consultation and treatment for adolescent and youth reproductive health problems; and provision of counseling for young people's physical and mental health problems.

India. Since the early 1990s, India's national government has developed 12 bills, plans, or policies that deal with children, the girl child, labor, population, and youth. In addition, some Indian states have developed their own population policies and policies on women. Some state governments have specifically underlined concerns about adolescent and youth health and development. At the time the India report was written, India's National Health Policy of 2000 was being finalized. It highlights adolescent and youth health as a strategic focus in achieving socio-demographic goals. The policy aims to ensure that young people's need for information, counseling, population education, and accessible and affordable contraceptive services is met; food supplements and nutrition services are available; and the legislation on restraint of child marriage is enforced. The population policy also emphasizes that reproductive health services for adolescent girls and boys are especially needed in rural areas, where adolescent marriage and pregnancy are most prevalent. The policy underscores the need for programs that encourage delayed marriage and childbearing and the need for education about the risks of unprotected sex.⁷⁰

⁷⁰ Government of India, 2000, cited in Gupta, 2003.

Some earlier focus on adolescents and youth was important in the development of policies and programs present today. The National Youth Policy (1986) placed adolescent health as a subsection under the health sector and recognized youth empowerment and gender justice as major thrusts of the policy. Various acts also have helped safeguard the health and social welfare of children (e.g., the Immoral Traffic (Prevention) Act (1956), the Child Marriage Restraint Act (1976), and the Child Labor Act (1986)). Other sectors have also been useful in helping focus attention and services on adolescents and youth. The National Education Policy (1974) recognized the right to education for all segments of the population and made elementary education for all children compulsory, helping lead the way to more equitable conditions.

Nepal. As in many countries, support and numerous initiatives along with barriers are the sum of conditions with regard to adolescent and youth reproductive health in Nepal. However, progress has been made with regard to policy over the past decade. The Prime Minister formulates and monitors all development programs, including the reproductive health program; the issue therefore has the highest level involvement. Also, since the mid-1990s, reproductive health has received an additional boost from the creation of the ministries of Population and Environment and Women, Children, and Social Welfare. The existing population policy focuses on gender equity and population management through good governance and on the need to address demand for family planning among couples. It also articulates the need to alleviate poverty, accelerate economic development, decentralize, and develop public-private partnerships. The National Reproductive Health Strategy, adopted in 1998, identifies adolescent and youth reproductive health as a key component of integrated health services. The National Adolescent Health and Development Strategy, adopted in 2000, aims to improve the health and socioeconomic status of adolescents through access to information and services; the steps the government takes to implementing this strategy are important to watch. The National IEC Strategy also includes an adolescent component. The National Safe Motherhood Plan, which targets a 15-year period beginning in 2002, emphasizes improved access to and use of services for women during pregnancy, childbirth, and postpartum in order to prevent maternal death. It focuses on developing basic and essential obstetric care throughout the country, working in tandem with community-level facilities. Also, abortion may soon become legal in certain circumstances. Unmarried adolescents and youth had been legally prohibited from receiving FP/RH care until recently, with the passing of a policy by the National Reproductive Health Program Steering Committee that allows unmarried adolescents and youth to obtain family planning services. This changes the requirement for service providers to ascertain whether a client is married or not. To ensure equity, girls' empowerment issues also need to be addressed by policy.

Pakistan. As in other heavily Muslim countries, religious beliefs and traditions have an intricate relationship with state structures and institutions, although other geopolitical and cultural influences also affect adolescent and youth reproductive health in Pakistan. Policy planners are only just beginning to conceptualize adolescence in Pakistan, and research is in preliminary stages. There is an official refusal to inform the public about sexual issues. As a result, reproductive health information is made available only through a small number of NGOs or health practitioners with limited outreach. The National Health Policy, which was developed nearly a decade ago, states that reproductive health and health education will be among the health ministry's priority programs; however, it leaves out any reference to providing information about sexuality. Progress on both the provision of health education and sexuality has been stalled since that time.

Sexual exploitation is a significant adolescent and youth reproductive health problem, but policies do not adequately address it. No law exists that specifically prohibits child sexual abuse. In addition, while sodomy is punishable by up to 10 years in prison, vaginal or oral penetration or any other sexual violence

to a child is punishable only up to two years.⁷¹ Weaknesses in the law arguably facilitate child prostitution given the lack of clear definition of a “child” and inconsistencies (e.g., prohibiting a child older than four living in or frequenting a brothel through the Sind Children Act of 1955 while forbidding the practice of prostitution entirely, including encouraging the seduction or prostitution of a girl younger than 16). Child trafficking is a well-known problem in South Asia, but recommendations made by the Working Group on Youth Development in preparation for the Ninth Five-Year Plan (1998–2003) do not mention the need to combat child sexual abuse/exploitation or trafficking by addressing the underlying causes of it. The Hudood Ordinances of 1979 continue to help create an unsafe environment where, for example, if a victim charges rape and cannot prove it, he or she can be charged with illegal sex outside of marriage and receive the maximum punishment.

Sri Lanka. More attention to policy and legal matters are needed in Sri Lanka; however, some progress has been made. After the 1994 ICPD, the government of Sri Lanka appointed an intersectoral task force to formulate a national population and reproductive health policy and an action plan. The National Health Council and the Cabinet Ministers approved the Population and Reproductive Health Policy in 1997. The policy stipulated eight goals to be achieved within 10 years, with a focus on a number of issues, including reducing fertility, ensuring safe motherhood, achieving gender equity, increasing public awareness of population and reproductive health issues, promoting responsible adolescent and youth behavior, and improving population planning. Policies addressing the protection of mothers, children, adolescents and youth have also been strengthened over the past decade and have increased attention on the protection of the girl child. However, numerous issues have either not been adequately dealt with or dealt with at all.

Southeast Asia

Cambodia. Cambodia has no adolescent and youth reproductive health policies, but adolescent and youth reproductive health activities are addressed in other policy areas. The country’s pronatalist policies of the 1980s were reversed in the early 1990s under a maternal health rationale. Policies and laws enacted within the last decade include the National Safe Motherhood Policy (1997), a fairly liberal abortion law (1997), and the Birth Spacing Policy (1995), resulting in a widespread dissemination of contraceptives and contraceptive information.⁷² Correspondingly, knowledge of family planning is high in Cambodia—92 percent of all women and 96 percent of married women know of a contraceptive method—and contraceptives are being used for both birth spacing and limiting.⁷³

There are no legal barriers to the implementation of adolescent and youth reproductive health activities; however, there are substantial infrastructure barriers and a vast gulf between policy and implementation, particularly in rural areas. The focus on curative, rather than preventive, health continues in Cambodia.⁷⁴ Cambodia’s MOH and other relevant ministries do not yet recognize the need for an adolescent and youth reproductive health policy, thus adolescent and youth reproductive health activities are conducted within the context of other policy areas (e.g., maternal and child health policy, population/birth spacing policies, gender equity, and equality policies). Due to the problem of HIV/AIDS in Cambodia and the perilous state of maternal and child health, the focus of policy has been on these areas. To adequately address the problems of adolescents and youth, maternal and child health, and HIV/AIDS, a definitive focus on adolescence is needed.

⁷¹ Sahil, n.d., cited in Khan and Pine, 2003.

⁷² Chhuan et al., 1997; and MOH [Cambodia], 1998, cited in Fordham, 2003.

⁷³ National Institute of Statistics [Cambodia] et al., 2001, cited in Fordham, 2003.

⁷⁴ Chhuan et al., 1997, cited in Fordham, 2003.

Indonesia. Policymakers in Indonesia have recently begun to discuss mainstreaming gender concepts in the school curriculum,⁷⁵ which could have a profound impact on knowledge, understanding, and, ultimately, the behaviors of young people with regard to unsafe sex and marital relations and responsibilities as well as societal attitudes and behaviors. However, laws will need to be reviewed if policies and programs on adolescent and youth reproductive health are going to be implemented in Indonesia. While a number of laws exist that affect adolescent and youth reproductive health, they do not address the issues that would improve adolescent and youth reproductive health directly enough. For example, Law No. 2/1979 makes nine years of education compulsory for all; however, the law does not address the importance of including information on reproductive health or gender issues. Another example is Law No. 1/1974, the Marriage Law, which identifies the minimum age at marriage for girls as 16. The law needs to update the minimum age for girls to be 18 or older so that they and their families can focus more on their education. Due to sociocultural, religious, and political reasons, programming for adolescent and youth reproductive health, while available, does not fall under the rubric of a national adolescent and youth reproductive health program, thereby curtailing the strength of the focus and reach.

Philippines. A number of direct (e.g., those specifically designed to influence population, health and reproductive health, adolescent and youth reproductive health, and HIV/AIDS) and indirect policies (e.g., those focusing on educational policies) are in effect in the Philippines. The 1987 Constitution states that it is the “right and duty” of parents to ensure the welfare of and instill proper moral development in their children.⁷⁶ It also stipulates that the state has an obligation to help parents in this endeavor. Such emphasis has set the tone and focus of much policy and programming surrounding adolescent and youth reproductive health in the Philippines, which has been described as “indirect and cautious.”⁷⁷ Some positive developments are in the works. The Adolescent and Youth Health Policy (2000) recognizes adolescents and youth ages 10–24 as the priority group in terms of pressing health needs. It provides guidance for youth-friendly health service center development, stipulates that there be access to contraceptive services and supplies, and supports the integration of the Adolescent and Youth Health Development Program into the health care system with a focus on IEC, advocacy, technical capacity, services, partnerships, and improved data collection. Another important development was the National Family Planning Policy, which was approved by the Department of Health in 2000 and stresses the importance of family planning as a health and poverty reduction intervention.

Vietnam. In Vietnam, sexual activity among adolescents and youth has increased and there has been a reported increase in gender-based violence. While little has previously been done to address adolescent and youth reproductive health—no national adolescent and youth reproductive health program has been developed nor has programming been institutionalized despite the lack of substantial legal barriers—and while adolescents and youth have been neglected in population and family planning policies, the government has now publicly recognized the shortcomings of this approach. This is an important step in policy and program development.

The government has provided support for and approved the development of a National Strategy on Reproductive Health for 2001–2010. Adolescent and youth reproductive health is identified as the second among seven outstanding problems that the new reproductive health program must address. The strategy has an objective of improving adolescent and youth reproductive health through education, counseling, and provision of reproductive health services. A focus on providing information on healthy sexuality also exists. The strategy supports the provision of information through the schools. The focus on adolescent and youth reproductive health services in the strategy underlines the importance of counseling and medical assistance to adolescents and youth, including contraceptive methods, safe abortions, and

⁷⁵ Suharto, 2001, cited in Utomo, 2003.

⁷⁶ Article II, sec. XII, Constitution of the Republic of the Philippines, 1987, cited in Varga and Zosa-Feranil, 2003.

⁷⁷ Various key informants, cited in Varga and Zosa-Feranil, 2003.

treatment of reproductive tract infections (RTIs), as well as of paying particular attention to the needs of rural and remote areas. Related policies that exist or are in development include the safe motherhood master plan integrating adolescent and youth reproductive health components; the strategy for healthy living and life skills education for children, adolescents, and youth (through capacity building for teachers and others and the development of partnerships between various societal sectors); and support for local NGOs working with adolescent and youth reproductive health education and services provision. The lack of adolescent and youth reproductive health impact or monitoring and evaluation indicators, however, is going to present difficulties for planning, implementing, and assessing progress.

5

ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH PROGRAMS

Adolescent and youth reproductive health programming for the ANE region is mixed; however, overall, countries lack concrete and comprehensive programs. Some countries in the region have moved steadfastly ahead in implementing programs that are aimed at young people; others have made timid progress. Generally, the policies and programs of most countries do not support provision of services to unmarried youth; and in fact, some programs are reluctant to provide family planning to young women until after they have had at least one child.

Near East

Egypt. The 1994 ICPD helped mobilize government institutions in Egypt, and that influence has continued to affect attitudes and programming with regard to adolescent and youth reproductive health. A renewed focus on female education and a reduction in employment inequities has resulted.⁷⁸ A national media campaign run by the State Information Service of the Ministry of Information, in collaboration with the Ministry of Health and Population is worth noting, given its focus on the mass media promotion of excellence in reproductive health services for young women. Other important initiatives include telephone hotlines and peer education for HIV/AIDS prevention. The Ministry of Education and other ministries, such as the Ministry of Youth, are also involved in adolescent and youth reproductive health activities. For more than two decades, the Ministry of Education has ensured that primary and secondary school curricula cover some information on physiology and family planning, and the science curricula now includes HIV/AIDS information (although only girls are privy to some of the education). However, among the uneducated, levels of knowledge about HIV/AIDS remain low and other fundamental knowledge is lacking.⁷⁹

While NGOs are highly regulated by the Egyptian government, some do important work with adolescent and youth reproductive health. One example is the New Horizons Project, which is proving successful in breaching the reproductive health information gap among adolescents and youth and may be a model for other programs in Egypt and elsewhere. New Horizons is a “non-formal education program designed to demystify and communicate essential information in the areas of basic life skills and reproductive health” to girls and young women. The project is community-based and demand-driven, designed to address the specific needs articulated by its target population. New Horizon’s principal target group is illiterate girls and young women in villages. Most are 9-20 years old; however, New Horizons now also involves young women and mothers as old as 25. It is also targeting boys. Thus far, 16,000 girls have completed the thorough, 100-hour program. The project is active in all the governorates/provinces of Upper Egypt and is expanding into Lower Egypt. It is low-cost and proving to be sustainable, with local organizations taking the initiative to request training, participate in educator training, and subsequently carry out the program. A project evaluation is being completed.⁸⁰ In general, more leeway for programming is needed for the NGO sector to be successful.

Jordan. To date, public programs affecting adolescent and youth reproductive health have been scarce in Jordan, and unmarried youth do not receive reproductive health services. However, the 1994 ICPD was a catalyst for action on reproductive health in Jordan, and NGOs have become active since that time. The

⁷⁸ El-Zanaty and Way, 2001, cited in Beamish, 2003.

⁷⁹ Shafey, 1998; Ibrahim et al., 1999, cited in Beamish, 2003.

⁸⁰ Gamal, 2001; CEDPA and Notkin, 2000; and CEDPA, 2000, cited in Beamish, 2003.

strategy for reaching Jordan's population objectives has been broadened to support expanded availability of reproductive health information to adolescents and youth by governmental and nongovernmental organizations. The new strategy also stresses female education and calls for increased employment opportunities for women to reduce the gender gap. This policy shift is being translated into action.

Many programs involving the private sector, NGOs, donors, and cooperating agencies, however, currently focus on adolescent and youth reproductive health in Jordan. The "Shabab 21" campaign is a noteworthy, national media campaign run by the National Population Commission that promotes reproductive health information and life planning skills for young men and women. The "Ingaz" youth economic opportunities program, originally sponsored by Save the Children Fund, USAID, and the private sector, aims to enhance the leadership skills, networking, voluntarism, and employability of Jordanian youth.⁸¹ The MOH launched a hotline in 2001 to provide young persons with medical information and counseling on HIV/AIDS and other reproductive health issues. Home visits also are being conducted. In addition, school-based health education contributes a great deal to dissemination of reproductive health information through the curricula, although the quality of education has been criticized. While Jordanian youth are not often involved in clubs, a few community-based interventions are making inroads in terms of providing important reproductive health information to youth (e.g., Festivals of Innovative Youth). The Jordan Association for Family Planning and Protection and the Ministry of Youth and Sports are collaborating on a project funded by the Netherlands Fund, called "Youth to Youth for Safe Reproductive Health," which is focused on awareness raising. With regard to clinical services, the public and private sectors together provide approximately two-thirds of the clinical availability (NGOs provide the other one-third), with most of the burden carried by the private sector. The Commercial Market Strategy (CMS) Project is showing great promise for reaching a sizable number of youth with health services. CMS in Jordan has been funded by USAID since 1999.

Other programmatic initiatives outside the health sector are being undertaken by various groups such as the Higher Council for Youth (leadership program), the Ministry of Education (involvement in productive activities for girls and boys), and the Jordan University of Science and Technology (awareness-raising workshops on various topics, including women's issues).

Morocco. Although the focus on reproductive health education began nearly three decades ago in 1974 following the international population conference in Bucharest, reproductive health programs specifically targeting adolescents and youth still consist primarily of population and health education efforts. A population education coordinating body has been in effect since the mid-1970s, consisting of the Moroccan Family Planning Association and the ministries of the Interior, Public Health, Employment and Social Affairs, Youth and Sports, and Education. The Ministry of Youth and Sports and the Ministry of Education carry out formal health education and other ministries provide informal health education.⁸² The Ministry of Youth and Sports' programming includes reproductive and sexual health education through summer camps, sports clubs, youth centers in poorer neighborhoods, and other institutions. One component of this program reached more than 100,000 youth in 1997–1998 alone. In association with the Association Marocaine de Planification Familiale (AMPF), the Ministry of Youth and Sports provides information through 340 public sector youth houses around the country and supports endeavors that assist in enhancing discussion and communication on adolescent and youth reproductive health. The Ministry of Youth and Sports is also involved in IEC campaigns specifically designed for Moroccan youth through youth festivals and the Internet. The Ministry of Public Health is quite active in the programming arena as well, organizing a "Week on Reproductive Health" in 2000 that reached 1.2 million youth with health messages. Additionally, the Ministry of Public Health plans to focus on young adults with peer and other

⁸¹ Ingaz Program, 2001, cited in Almasarweh, 2003.

⁸² Dialmy, 1998, cited in Beamish and Tazi Abderrazik, 2003.

education efforts to influence sexual behaviors.⁸³ With acknowledgment from the Ministry of Youth and Sports that Moroccan youth are now typically sexually active long before marriage, governmental agencies recognize the need for additional programs addressing reproductive health.⁸⁴

Morocco was the first country in the Near East region to introduce population education into the national high-school science curriculum, and Moroccan schools continue to provide information on human reproduction, contraception, and STIs,⁸⁵ although through a number of standard school subjects rather than as a subject of its own. The information provided, however, is not satisfying young people's need for information.⁸⁶ The possibility of implementing sex education in the schools ran into opposition, and topics such as STI and HIV/AIDS were cut back while the Ministry of Education started to slowly implement a newer curriculum.

The nongovernmental sector has more liberty to act on adolescent and youth reproductive health than the public sector.⁸⁷ The Association de Lutte Contre le SIDA, a well-respected, Casablanca-based organization, has been raising topics of STIs and HIV/AIDS, high-risk sexual behaviors, sex work, and other sensitive but pressing issues to the attention of policymakers and the public through awareness-raising and advocacy efforts. The Institution Nationale de Solidarité avec les Femmes en Detresse helps single mothers and their children by providing an in-depth adult education curriculum in reproductive health. The PASA Project of Association Marocaine de Solidarité et le Développement has an exemplary community-based, needs-driven social development program similar to the New Horizons Project in Egypt⁸⁸ (see Egypt above); it provides in-depth adult education on reproductive health to communities after first working to gain their trust. Other NGO initiatives are also underway or planned, including a large, comprehensive program that could effectively begin to fill in sexual and reproductive health services and information gaps in the national family planning and education sectors. The focus of the plan is on the integration of women in development, and it provides a focus on reproductive health, with provision for reproductive health counseling and youth programming.

Yemen. In Yemen, programming is scarce but progress is being made. The government has begun to institute programs to educate youths about risky behaviors.⁸⁹ The National Council for Childhood and Motherhood of the Ministry of Youth is involved in awareness-raising efforts. NGOs, such as the Yemeni Association of Family Planning and international agencies, such as the European Project, fund reproductive health and sexual health education in schools. As it stands, however, few young women receive information about family planning. Only 30 percent of 15–19 year-old women had recalled receiving family planning information through the media in 1997, and that number is only slightly higher among women ages 20–24 at 34.2 percent.⁹⁰ This overall lack of awareness and information possessed by women, as well as members of other societal segments, is part of what stalls progress on programs in Yemen.

South Asia

Bangladesh. The government of Bangladesh identified adolescent and youth health and education both as a priority and a challenge; and to face the challenge, it incorporated this issue in its Health and

⁸³ Alami, 2001, cited in Beamish and Tazi Abderrazik, 2003.

⁸⁴ Mounabih, 2001; and Reynolds, 1999, cited in Beamish and Tazi Abderrazik, 2003.

⁸⁵ Tyane, 2001, cited in Beamish and Tazi Abderrazik, 2003.

⁸⁶ AMPF/Experdata, 1995; and Dialmy, 1998, cited in Beamish and Tazi Abderrazik, 2003.

⁸⁷ Maasri, 2001; Mounabih, 2001; Alami, 2001; and Graigaa, 2001, cited in Beamish and Tazi Abderrazik, 2003.

⁸⁸ CEDPA and Notkin, 2000, cited in Beamish and Tazi Abderrazik, 2003.

⁸⁹ Aoyama, 2001, cited in Al-Rabee', 2003.

⁹⁰ CSO [Yemen] and Macro International, 1998, cited in Al-Rabee', 2003.

Population Sector Program. With a focus on providing more services, it is expected that there will be an overall increase in the quantity and quality of information and services available through a network of clinics at community, thana (upazilla), and district levels. However, without additional efforts from other agencies, the improvements to be delivered through the Health and Population Sector Program are unlikely to make significant contributions to achieving results in the area of adolescent and youth reproductive health during the life of the program (1998–2003).

Fortunately, government and NGO collaboration is filling some of the gaps. Nearly 200 NGOs work with adolescents and youth in some capacity.⁹¹ Activities in which they are involved include vocational training for skill development, micro-credit, leadership training, adolescent family life education (FLE), sex education, reproductive health services, personal hygiene education, and legal assistance in cases of violence and abuse against women. Many are developing and most are disseminating materials.

In addition, other sectors have become involved in adolescent and youth reproductive health. Through work in the education sector, the gender gap in education continues to be further reduced. The secondary school education curriculum has incorporated adolescent and youth reproductive health and includes education on population, reproductive health, and family life issues.⁹² Various other sectors are involved through ministries and NGOs, focusing on issues such as income generation and justice.

India. Both regionally and internationally supported governmental and nongovernmental organizations have initiated programs as a part of the strategy to implement the various existing policies and regulations that address adolescent and youth reproductive health. However, there is a need to scale up the efforts in order to produce a larger impact. The government programs addressing adolescent and youth reproductive health include the Reproductive and Child Health (RCH) Services Program; the Integrated Child Development Services Scheme; the Adolescent Girl Scheme; and the State Plans of Action for the Girl Child Scheme. The RCH Services Program was launched 1996 to provide holistic RCH care through the existing, vast network of the primary health care system. It encompasses provisions for all aspects of safe motherhood and child survival interventions, including emphasis on increased access to contraceptives, safe management of unwanted pregnancies, enhanced nutrition, prevention and management of RTIs and STIs, availability of reproductive health services to adolescents and youth, and educational outreach. The RCH program also focuses on providing services for gynecological problem management and cancer screening for women. The Integrated Child Development Services Scheme offers an integrated package of early childhood care services, which include supplementary feeding, immunization, health checkups, referral services for children up to six years of age and expectant and nursing mothers, and nutrition and health education for mothers. The Integrated Child Development Services Scheme covers almost 85 percent of the “blocks” in India.⁹³ The Adolescent Girls Scheme, which was started 1991, targets girls ages 11–18 and aims to meet adolescent girls’ special nutrition, education, and skills development needs. The scheme also envisages imparting skills and encouraging the involvement of girls in useful economic activities later in life. This scheme has been extended to 3.9 million adolescent girls throughout the country.

A number of NGO and other sector programs are also addressing adolescent and youth issues. These include the Department of Education, Scouts and Guides organizations, Ministry of Labor, and Ministry of Social Justice and Empowerment. The Department of Education’s program, for example, has various endeavors that focus on achieving universal coverage of primary education through decentralized planning and management, decentralized target setting, community mobilization, and district- and

⁹¹ Hossain et al., 1998, cited in Al-Rabee’, 2003.

⁹² Nath and Barkat, 2000, cited in Al-Rabee’, 2003.

⁹³ For administrative purposes, a district is divided into smaller segments having a population of 100,000 to 120,000. These are called “blocks.”

population-specific planning. The numerous foreign and indigenous NGOs working in the country, such as the Population Council, the Health Institute for Mother and Child in New Delhi, the Healthy Adolescents Project in India, the International Center for Research on Women, the Society for Social Uplift through Rural Action, Planned Parenthood Federation, and CEDPA, are all working on various aspects of adolescent and youth health issues as well. The Society for Social Uplift through Rural Action, based in Jagjit Nagar, Himachal Pradesh, for example, regularly undertakes training programs, seminars, workshops, and courses for capacity building among women's groups, local governing councils, and adolescent and youth girls' groups. Activities are geared toward imparting a broad understanding of reproductive health.

Nepal. The progress that has been made in policy and strategy development in the past decade on reproductive health generally and adolescent and youth reproductive health specifically is beginning to translate into important adolescent and youth reproductive health programs in Nepal. The National Adolescent Health and Development Policy and Strategy was developed and adopted in 2000, a policy was passed by the National Reproductive Health Program Steering Committee that allows unmarried adolescents and youth to obtain family planning services, and the National Health Education Information Communication Center of the MOH was developed—all have catalyzed progress. The National Health Education Information Communication Center has launched an adolescent and youth program in 55 districts through its health post staff to address adolescent and youth reproductive health issues among school students. Various educational curricula and IEC programming for adolescents and youth are being implemented through schools and with distributed materials. Lower and secondary level students (those in the levels 6 through 10) are targeted as well. Topics covered include FLE, quality of life, safe motherhood, community health, and so forth. Radio and TV programs, such as “Jana Swasthya Karyakram,” have also provided information on adolescent and youth reproductive health.

NGOs are active at the grassroots level. The Family Planning Association of Nepal, one of the largest NGOs in Nepal, is engaged in advocacy, IEC, and providing services to young people. Adolescent and youth reproductive health services are integrated with other reproductive health services and are provided through its clinics. Other NGOs, such as the Ama Milan Kendra, focus on issues such as male involvement and working with young females to make informed decisions regarding social, economic, and health needs and rights. PHECT-Nepal provides safe motherhood, family planning, and STI services to adolescents and youth in one municipality. Sunaulo Pariwar Nepal, a local NGO affiliated with Marie Stopes International, provides youth-friendly services through one of its clinics in the far western region of Nepal and is extending similar services to other parts of the country through its clinics.

Pakistan. Relative to other countries of the ANE and other regions in the developing world, Pakistan has done little with regard to adolescent and youth reproductive health programming, in great part due to policy and legal barriers. Public sector adolescent and youth reproductive health programs include limited school health education, which does not include even a basic introduction to “the facts of life,” and an attempt by Aahung, an AIDS awareness program in Karachi, to develop a coeducational, sexuality and reproductive health education curriculum for secondary schools.

In the NGO sector, some adolescent and youth reproductive health issues are being addressed. The Family Planning Association of Pakistan has targeted young people and is currently preparing the groundwork for a new initiative aimed at addressing the knowledge and attitudes of young adults toward reproductive and sexual health to influence their behavior in favor of the small family norm and responsible parenthood.⁹⁴ Treatment for postabortion complications has been pioneered by Marie Stopes Services, which also provides traditional family planning services, and furthered by Behbud Welfare Association. UNAIDS, UNICEF, and UNFPA are including education and awareness about STIs and

⁹⁴ FPAP, n.d., cited in Khan and Pine, 2003.

HIV/AIDS in their programs, and UNICEF aims to train nongovernmental and health workers in prevention and counseling techniques.⁹⁵ In addition, a few small, local NGOs have taken up the challenge to raise awareness about HIV/AIDS to a broad population, including adolescents and youth to a limited extent.

Community-based interventions that are addressing child sexual abuse have been undertaken by various NGOs. Sahil is an NGO devoted to raising awareness about child sexual abuse through research, seminars, and educational materials, and to handling crisis cases. Aangan tackles child sexual abuse through the press, seminars, and counseling. War Against Rape handles individual cases of child sexual abuse and conducts research and awareness-raising activities.

Sri Lanka. Achievements in the health sector in Sri Lanka have been impressive, but little attention has been put on the health of young people, particularly with regard to sexual and reproductive health. While much work has been initiated, there is still no organized program for providing information to adolescents and youth.

The existing adolescent and youth reproductive health programs are implemented through the Department of Health, the Department of Education, the National Youth Service Council, and NGOs, which, collectively, have undertaken a number of important initiatives. A project initiated by the Family Planning Association of Sri Lanka and founded by the European Commission/United Nations Population Fund (EC/UNFPA) was launched in 1998 to provide reproductive health information, counseling, and health care services to adolescents and youth.⁹⁶ The project covered 13 districts and also raised community awareness and involvement. Implemented by seven NGOs, the project was successful in reaching more than 575,000 adolescents and youth through counseling and service delivery points, many in schools. Another project, a partnership between the Department of Health and the university, produced recommendations for promoting adolescent and youth health and information in higher level schools. In addition, the Department of Health's Family Health Bureau has incorporated adolescent and youth health into its training programs for the public health sector staff. The National Youth Campaign, established in 1970, undertook the Reproductive Health Information Project in 1997 with support from UNFPA. Its objective was to provide leadership training for youth and peer groups. The training covered issues such as HIV/AIDS and STIs, drugs, family planning, and empowerment of women.⁹⁷ The project reached thousands of out-of-school youth—its primary target group. The Family Planning Association of Sri Lanka has launched a hotline service to provide medical information on reproductive health issues. While the line does not specifically target adolescents and youth, they are regular callers. Another important project undertaken by the National Institute of Education in 1993 with UNFPA funding focuses on school health, including selected reproductive health components. As a part of that project, the Health Education Bureau of the Ministry of Health established 1,074 school health clubs in 10 high-risk districts and provided training for teachers. A number of NGOs also are working on adolescent- and youth-related issues. Several are working with UNFPA on a project to distribute condom vending machines island-wide, focusing on vulnerable groups. The International Rotary Society, in collaboration with UNFPA, is involved in important advocacy and awareness-raising work on reproductive health issues among adolescents and youth in school.

Southeast Asia

Cambodia. With no strong barriers for adolescent and youth reproductive health programming in Cambodia, numerous types of organizations have taken on the challenge of developing programs. School

⁹⁵ UNICEF, 1998, cited in Khan and Pine, 2003.

⁹⁶ Gnanissara, 2002, cited in De Silva et al., 2003.

⁹⁷ UNFPA, 2000, cited in De Silva et al., 2003.

curricula have recently been revised to incorporate reproductive health and HIV/AIDS information into the science and social studies curricula. However, teachers need additional training to adequately present the material. Also, many students do not benefit from the materials provided in later grades because numerous years of schooling are still the exception rather than the rule. Various local and international NGOs are working nearly unconstrained on the provision of information and services, some focusing directly on adolescent and youth reproductive health and others working on areas related to it. Some NGOs have even incorporated “adolescent- and youth-friendly” services, with separate waiting rooms for young people. Innovative informational programming is not unusual; radio phone-in programs and question-and-answer newspaper and journal columns are seen regularly.

Indonesia. The focus in adolescent and youth reproductive health remains on education, largely to the neglect of addressing the need for services. Currently, while programming in reproductive health has been available for many years and while a number of adolescent and youth reproductive health-related programs are identifiable, there is some question as to the extent of their reach, services, and efficacy, since they are not nationally implemented. Sectors providing programming include the National Family Planning Coordinating Board, the Department of Health, the Department of Social Welfare, the Department of Religion, and the Department of National Education. The primary focus of existing programming is in schools. In Jakarta, West Java, and Daerah Istimewa Yogyakarta, adolescent and youth reproductive health education has been provided in some schools.⁹⁸ The schools that provide adolescent and youth reproductive health education integrate it into other subjects, such as biology, social studies, and religion, which address topics of marriage and sexuality. Courses are taught by teachers who have received training in counseling.

In 2000, Ibu Khofifah Indar Parawansa, the former Minister of Women’s Empowerment and Head of the National Family Planning Board, initiated a new Adolescent and Reproductive Rights Protection Directorate at the National Family Planning Coordinating Board and a division responsible for adolescent and youth reproductive health at the state Ministry of Women’s Empowerment. In addition, she advocated for allowing pregnant students to finish their schooling and for providing “emergency contraceptives” in certain circumstances.⁹⁹ There was a great deal of dissent with regard to her proposals. However, in large part due to Indarparawangsa’s persistence, policymakers in the Health and Education Department held discussions on the need to emphasize the importance of including reproductive health education in the school curriculum. Impetus for programming seems to be growing, with the MOH having developed and implemented peer education programs and the Department of Religious Affairs having focused on efforts to develop reproductive health education for religious schools.¹⁰⁰ Additionally, due in part to the progress that government offices are making, NGO programming has been able to “take off” to a larger degree; NGOs are less constrained by government policies and regulations and tend to be more adolescent and youth-friendly, although they are in need of better documentation and evaluation procedures.

Philippines. The Philippines Local Government Code mandates that local government units provide family planning and health programs. The Philippines has put a number of programs into place that have tried to focus attention on both increasing the understanding of and services for young people. The programs need additional management capability, technical skills, and resources to effectively serve a broad population. In addition, key informants expressed concern about the willingness of government workers to provide adolescent and youth reproductive health services. According to one informant, the reality is that young unmarried teens asking for contraceptive services or information from a clinic will be provided services at the moral discretion of the health care provider. Noteworthy are the National

⁹⁸ Yuwono and Roque, 1999, cited in Utomo, 2003.

⁹⁹ *Kompas*, 2000; and Media Indonesia Online, 2000, cited in Utomo, 2003.

¹⁰⁰ Hasmi, 2001; and Suharto, 2001, cited in Utomo, 2003.

HIV/AIDS Prevention and Control Program, which targets several age groups; Population Awareness and Sex Education, which is a population and sexuality education program specifically targeted at out-of-school youth; Commission on Population of the Adolescent and Reproductive Health (ARH) Program, which identifies adolescence as one of its five programmatic areas and focuses on reducing the incidence of early marriage and teenage pregnancy, among other issues; and a program conducted by the Family Planning Association of the Philippines that stipulates that all individuals of reproductive age (specified as persons ages 15–44) have the right to information, counseling, physical examinations, and contraceptive supplies, specifically condoms or contraceptive pills.

Vietnam. Since the early 1990s, some adolescent and youth reproductive health programs and activities, including ones that are school- and community-based, have been developed and implemented in different areas of Vietnam. However, most of these programs and activities have focused primarily on IEC and have not included the provision of contraceptives or other reproductive services. Since 1988, with support from UNFPA and UNESCO, the school curriculum has included family life and sexuality education and population education, which are usually integrated into biology or other subjects and have been available primarily for students in grades 10–12. Unfortunately, teachers have been uncomfortable with the subject matter, and the information has often been provided in the form of moralistic lectures that can quickly lose young people's interest. The most recent programming in schools has been more successful, such as the National Education and Training Program on Reproductive Health and Population Development, which included a training component for teachers.

Community-based programmatic efforts supported by various internal and external donors are furthering the adolescent and youth reproductive health effort through clubs and counseling centers (e.g., Vietnam Youth Union), mobile teams, and campaigns, such as the 1998 UNFPA-supported national campaign to raise awareness of the benefits of postponing sexual activity and to motivate those who were already sexually active to practice safer sex. Coordination is also underway by large organizations, such as the Vietnam Women's Union and the Vietnam Red Cross, which are providing IEC materials and methods. It is expected that with the development of new reproductive health policies there will be further and important gains in programming in the relatively near future.

Summary

Table 2 provides a snapshot of the strength of policies and programs related to adolescent and youth reproductive health in the countries, including the extent to which political commitment to adolescent and youth reproductive health exists, the presence of school-based FLE programs and other information programs and services for young people, whether NGOs are active in adolescent and youth reproductive health activities and whether the programs are multisectoral and gender-focused.

Adolescent and youth reproductive health issues remain politically sensitive in all countries, primarily because governments do not want to be perceived as encouraging young people to have sex before marriage. That sensitivity manifests itself, however, into a mismatch between the information needs of young people and the general population education programs, FLE programs, and family discussions that do not directly address sexuality and family planning. In some of the countries, STI/HIV/AIDS topics are slowly being included in school-based FLE programs. In other countries, such as Indonesia, the government recognizes the need to include more specific information; however, the political fortitude to do so does not yet exist. Political will for adolescent and youth reproductive health is emerging in Southeast Asia, where fewer legal and policy barriers to reaching young people exist. Governments in the Near East and South Asia remain conservative in dealing with adolescent and youth reproductive health, although some surprising policy developments have occurred; for example, in Nepal, unmarried

adolescents and youth are no longer prohibited from receiving services (although substantial operational policy barriers exist to young people actually receiving the services).

Information programs for young people cover a range of topics, but again tend to consist of general messages about responsible parenthood. Parents are considered the most appropriate conduit of information about sexuality and reproductive health to their adolescents and teens, generally when they marry, but provide little information in reality. Some regular and peer counseling programs exist, which are generally run by NGOs, that provide more detailed information on sexual and reproductive health to young people. Married adolescents and youth can receive services in all countries; however, in many places, young women are discouraged or not allowed to receive family planning until they have had at least one child. With the growing awareness of STIs/HIV/AIDS, that topic is slowly being introduced to young people, again mostly by NGOs.

Nearly all countries are addressing adolescent and youth reproductive health in the broader context of youth development or life skills enhancement. Education is a high priority for all of the countries' governments. Reducing the education gap between males and females is important to some but not all governments. Providing livelihoods for young people as they reach adulthood is also a priority. Programs such as New Horizons in Egypt are seeking to provide young women with a broader range of life choices than only early marriage and childbearing. Eight of the 13 countries have recognized that gender inequities between young women and young men must be addressed as part of youth development and reproductive health programs. NGO programs particularly are addressing gender inequities, including gender-based violence.

In all, the ANE countries are increasingly aware of the reproductive health issues facing young people. Putting that knowledge into practice through policies and programs, however, remains a challenge.

Table 2. Status of Political Commitment and Adolescent and Youth Reproductive Health Programs^{i,ii} in 13 ANE Countries: 2002–2003

Country	Political commitment ⁱⁱⁱ	Programs			NGOs working in A&YRH ^v	Multi-sectoral focus	Gender focus
		Family Life Education ^{iv}	Information	Services			
<i>Near East</i>							
Egypt	*** growing	***	**	**	Small, growing	***	***
Jordan	**	***	**	**	Small/ Active	***	-
Morocco	*	*** FLE/Pop ed focus	*** starting to include HIV	**	Small/ Active	**	***
Yemen	** recent	-	*	*	Small	***	-
<i>South Asia</i>							
Bangladesh	**** growing	*** NGO-driven	***	***	Active	***	***
India	***	**	**	**	Small/ Active	***	***
Nepal	**	*** FLE/Pop ed focus	**	**	Small/ Active	***	**
Pakistan	*	*** FLE/Pop ed focus	*	*	Small/ Active	-	-
Sri Lanka	***	***	**	**	Small/ Active	***	***
<i>Southeast Asia</i>							
Cambodia	** emerging	*** new	*** including HIV	**	Small/ Active	***	-
Indonesia	** emerging	** recognize need	**	**	Small/ Active	**	**
Philippines	*** mixed	***	** including HIV	**	Small/ Active	***	-
Vietnam	** emerging	***	** including HIV	**	Small/ Active	***	***

ⁱ Key: *** Exists; ** Limited; * Very limited

ⁱⁱ This table does not include information on resources because all country reports listed resources as inadequate.

ⁱⁱⁱ All countries have policies that at least indirectly (e.g., those focusing on educational policies) relate to adolescent and youth reproductive health.

^{iv} FLE refers to school-based education programs. No country has a strong, nationwide program that deals with sexual and reproductive health, including STI/HIV/AIDS.

^v NGOs have more flexibility in working on adolescent and youth reproductive health issues, but they do not have wide coverage of information and services.

6

OPERATIONAL BARRIERS TO ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH

National policies directly influence operational policies—the “rules, regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services.”¹⁰¹ Operational policies in turn shape public sector regulations, which in their turn help shape health systems management. Ultimately, this affects reproductive health service delivery. Thus, where there is a break in this chain, as is common in the ANE region, problems in developing or implementing adolescent and youth reproductive health programs occur.

Operational barriers to adolescent and youth reproductive health programming abound. Lack of understanding of the gravity of the issue or willingness to address it on the part of policymakers, the public, and young people themselves is often a problem. Policies are often weak and indirect, and some countries’ policies do not address certain aspects of adolescent and youth reproductive health at all. While some adolescent and youth reproductive health programming design and implementation is excellent, other programming is weak. Programs often have poorly defined objectives and lack clearly outlined plans, coordination with other organizations, and project monitoring guidelines (e.g., in India, the Philippines, and Vietnam). Resources, both human and monetary, for support of adolescent and youth reproductive health programming are also often inadequate or missing altogether. Access to services that do exist is yet another problem, along with the quality of services.

An obvious problem exists where national policies that directly address adolescent and youth reproductive health are nonexistent. Informational barriers contribute to this problem. Often, governments have not yet tackled even the definition of adolescence, such as in Yemen. There is a general lack of research on adolescent and youth reproductive health and their needs throughout the region, particularly for underserved and minority groups. The paucity of research is mentioned in a number of reports, including those of Nepal, the Philippines, Sri Lanka, and Yemen. The Sri Lanka assessment notes that data are lacking on teenage pregnancies, abortions, contraceptive use, child abuse, and gender-based violence. These are sensitive issues but, as noted in the Sri Lanka assessment, “as long as data are scarce and the severity of adolescent and youth RH issues is not made known to the public, political commitment for a coherent policy initiative will be hard to achieve. In the long run, this could prove to be the greatest operational barrier to adolescent and youth RH.”¹⁰² Social barriers often foster operational policy barriers. Traditional or religious values and norms may impede discussion of adolescent and youth reproductive health issues and support for policy development. Policymakers, stakeholders, including parents, and society at large are not often comfortable with or interested in changing mores; they either have difficulty addressing or refuse to address the pressing problems of adolescent and youth reproductive health, believing that these issues are best dealt with by the family alone or not at all. Some leaders maintain a stance of “official denial.”¹⁰³

¹⁰¹ Cross et al., 2001.

¹⁰² De Silva et al., 2003, p. 17.

¹⁰³ Tarr (1996), Tarr and Aggleton (1999), and Ly Solim et al. (1997) all suggest an increasingly high level of adolescent and youth sexual activity, among girls in particular. In contrast, the Reproductive Health Association of Cambodia (1999) notes that 26.8 percent of girls and 44.9 percent of boys ages 12–25 are sexually active, although they assume that many of these adolescents and youth are likely married. Cited in Fordham, 2003.

Where there are policies, barriers at other points in the chain often prevent good adolescent and youth reproductive health. Resources—informational, human, operational, and commodities—are a problem throughout the ANE region. The lack of sustained support means that both government and NGO programs are implemented for a limited time and lessons learned are rarely shared. In countries such as Yemen, there is a scarcity of Arabic-language materials and other objective references with regard to adolescent and youth reproductive health. In addition, training of service workers and counselors is relatively rare in the region. The issue of abortion services is difficult to address in most nations, and where services exist, providers may think that counseling is an unnecessary or nonessential component.¹⁰⁴ Decentralized authority is often blocked by bureaucrats, inhibiting timely decisions, appropriate action, and the provision of services during the wait for central government approval for action. This occurs in the Philippines, for example, where central government officials do not yet consider decentralized authority quite legitimate. Coordination between public and NGO groups is also often lacking in the ANE countries, limiting the learning that could be available to others and preventing the integration of reproductive health, family planning, and treatment of STIs and HIV. NGO groups also often have difficulty obtaining commodities such as condoms. Finally, there is a heavy reliance on foreign aid throughout the region, which could, in the short- and long-term, put overall programming, which is already in jeopardy, at further risk.

Table 3 lists operational policy barriers to providing adolescents and youth with reproductive health information and services. In most countries, young people have limited access to services and information on reproductive health.

Table 3. Operational Policy Barriers to Serving Adolescents and Youth in 13 ANE Countries, 2002–2003

Near East	
Egypt	Difficult to get contraceptives before first birth; limited information.
Jordan	Family planning only after the first birth; lack of knowledge before marriage and first birth.
Morocco	Sex out of marriage not recognized.
Yemen	Physical access limited, quality of care issues. Limited information available to adolescents and youth.
South Asia	
Bangladesh	Physical access limited, quality of care issues.
India	Lack of services on a large scale; difficult for young people to get information.
Nepal	Policies sufficient, difficult for young people to get information and access services.
Pakistan	Official refusal to inform the public about sexual issues; particularly adolescents and youth. Social and physical access limited; mobility restricted.
Sri Lanka	Lack of access to services; lack of information for vulnerable groups.
Southeast Asia	
Cambodia	Substantial infrastructural barriers.
Indonesia	Lack of policy implementation and enforcement due to sensitivity over adolescent and youth reproductive health.
Philippines	Lack of access to reproductive health services for unmarried adolescents and youth; limited information and supplies.
Vietnam	Lack of resources generally for reproductive health; limited information and services available.

¹⁰⁴ Population Council, 2000.

The lack of information and education is a barrier in and of itself. It bars young people's understanding of what is happening to them, the changes they will encounter as they enter their adult years, and how to best care for themselves and future generations. The information young people do receive tends to be of a general nature, often because parents and community leaders fear that sex education will promote sexual behavior starting at an early age. Young people throughout the region, however, indicate that they would prefer to receive more specific information on sexual and reproductive health. Where there are segments of populations with low literacy levels—a common situation throughout the region—many adolescents and youth may not be able to access available reproductive health information. There is a need to develop basic infrastructure and education in order to realistically address adolescent and youth reproductive health in the region. However, where education is the norm rather than the exception, as is the case in certain countries or segment populations, there are often problems with school administrators, teachers, or others in positions to reach adolescents and youth through the educational systems being uncomfortable with teaching reproductive health, as is the case in Jordan.

In most countries, there is a lack of services that either include adolescents and youth or are directed specifically for them. In no country are unmarried youth particularly welcome in public sector clinics, and some countries maintain the illegality of providing reproductive health services to unmarried adolescents or make access extremely difficult. There may be private clinics, but services are often unaffordable and inaccessible to the average person, and certainly the average young person.¹⁰⁵ This is the case even in countries such as Morocco, Sri Lanka, and Vietnam, where sexual mores continue to change. Where services do exist for young people, quality barriers may exist. For example, clinics may lack privacy and confidentiality for adolescents and youth. They may also lack professional staff, resulting in poor treatment of young people. Insensitive interview questions or poor counseling skills often make the critical period of contact with adolescents and youth difficult and uncomfortable and can deter young people from seeking services. In many ANE countries, NGOs have tried to overcome these barriers by implementing programs that try to meet the needs of sexually active unmarried youth.

¹⁰⁵ Belouali and Guédirea, 1998; and MSP [Morocco] and AIDSCAP, 1997, cited in Beamish and Tazi Abderrazik, 2003.

7 RECOMMENDATIONS

Countries throughout the ANE region are increasingly aware of adolescent and youth reproductive health as a topic of concern, requiring attention. The 13 countries assessed have all created various plans, policies, and programs to address adolescent and youth reproductive health and the factors affecting it. Governments, to different degrees, have committed to reducing or eliminating gender discrimination, gender gaps in education and employment, and reproductive health education and services.

Adolescent and youth reproductive health in the ANE region is influenced in great part by the traditional cultural and religious norms and values that pervade and dictate both family communication and national policymaking. In this context, the 13 country assessments suggest that adolescent and youth reproductive health should be addressed by advocating for policy and program development; involving youth in policy design and implementation; educating policymakers, teachers, parents, adolescents and youth; facilitating family communication; promoting gender equity; expanding access to information and services; and conducting needed research to ensure that programs are evidence based. These challenges are not new, although they take on more urgency in this era of rising prevalence of HIV/AIDS in the region. Nor are the challenges unique to the ANE region, although that region is home to the world's largest group of adolescents and youth. Nevertheless, the challenges must be addressed to improve the reproductive health of this and future generations of adolescents and youth.

1. Involve youth in developing policies and programs to meet their needs

Since the 1994 ICPD, programs have increasingly included a range of stakeholders to articulate and design policies and programs to meet the needs of clients. Yet, young people are often left out of discussions about policies and programs that affect them. Youth must be actively involved in discussing the issues facing their generation and in developing solutions that meet their needs for good reproductive health.

2. Inform policymakers about the needs of young people and advocate for policy and program change

Policymakers, lawmakers, and stakeholders are too often inadequately informed about the conditions and specific and special needs of young people and the consequences of not addressing them. Adolescent and youth reproductive health remains a politically and socially sensitive topic; policymakers are often reluctant or unable to develop multisectoral policies that address adolescent and youth reproductive health. Stakeholders need to advocate to policymakers based on an understanding of laws and policies that already exist. Advocacy must be based on human rights principles and take into account various social, economic, and religious points of view. Youth and adolescent reproductive health advocates should encourage development of relevant laws, policies, and guidelines to ensure adequate protection and promotion of adolescent and youth reproductive health and associated social issues, such as gender equity in education and the economy. Training is also needed so that key individuals can adequately motivate and lead their constituencies and assist in disseminating policy information to other relevant groups, such as community leaders and service providers.

The support of an individual, high-profile political figure can be crucial to improving adolescent and youth reproductive health policies and programs in a country. This single person's advocacy and action can catalyze high-level discussion and even change. Ibu Khofifah Indar Parawansa, the former Minister

of Women's Empowerment and Head of the National Family Planning Board in Indonesia, First Lady Suzanne Mubarak in Egypt, and Princess Lalla Fatima Zohra in Morocco, have all addressed sensitive topics related to adolescent and youth reproductive health.

3. Educate policymakers, teachers, parents, community leaders, and young people to change public opinion about the need to meet youth and adolescent reproductive health needs

General public opinion must change to further enhance adolescent and youth reproductive health. Village and community leaders and religious and opinion leaders must be reached in order that they, in turn, can influence community members, families, and parents. Parents need a better understanding of adolescent and youth reproductive health issues so that they can better communicate with their children and support conditions that will improve their health. Careful thought needs to be put into the appropriate means for reaching these constituencies. In most countries, the appropriate message may be one underscoring the "healthy development of youth." Young people should be fully engaged in the development of messages and the "packaging" of information for adolescents and youth.

Teachers and others who are in regular contact with youth and adolescents need to feel both comfortable and adequate in dealing with adolescent and youth reproductive health once they have the social platform on which to do it. Given the conservative nature of most of societies in the ANE region, these special gatekeepers will need assistance in acquiring these attitudinal and skill changes. Training can be developed and conducted through cooperation among governments, NGOs, and private organizations. Adolescents should also have input. Communication among all stakeholders will be key to comprehensive programming.

4. Promote communication in families

As policymakers and teachers are given information and training, parents cannot be forgotten. For change to occur, the gap between sociocultural norms and the realities of adolescent and youth reproductive health requires great attention. Because premarital sex is inappropriate according to many countries' cultures or religions, there is often little realization or acknowledgment that young people are increasingly sexually active and that as the age of marriage rises young people find themselves increasingly exposed to premarital sexual activity. This lack of acknowledgment hinders policy and programmatic responses to addressing adolescent and youth reproductive health.

Parents need to realize that social norms are changing, such that many adolescents and youth are sexually active. They also need accurate reproductive health information and to be comfortable discussing these topics to help and teach young people and to support appropriate policies and programs. Parents can be a great source of assistance and information for their adolescent children, who want their first information on sexual and reproductive health to come from their parents. Parents can also be strong advocates on a political level.

One way to educate parents is through their children's education. Young people could take information home to their parents to engage their families in discussions about sexual relationships and to educate their parents, who may have incomplete or inaccurate knowledge.

Exchange in families can also be facilitated by faith-based organizations (FBOs). FBOs have had success addressing the HIV/AIDS pandemic in Africa, and perhaps this model has a place for reaching young people in the ANE region. Religion has a strong influence in many ANE countries, so people might feel comfortable with a religious context for discussions about adolescent and youth reproductive health. While some religions may not support the discussion of certain topics, religious institutions may be open

to facilitating dialogue about some aspects of adolescent and youth reproductive health, such as relationships, gender equity, gender-based violence, and sexual abuse.

5. Promote gender equity in all youth-related policies and programs

Promoting gender equity and positive gender norms around sex and reproductive health, such as reducing early marriage and eliminating or helping to redefine social systems (including the dowry system) that make females the chattel of males, must form the underpinning of comprehensive, multisectoral, and thereby functional and successful programming.

6. Increase young people's access to information and services

Adolescents and youth in all countries need increased access to accurate and complete information. Reproductive health education in schools needs to be designed to make young people (and teachers) knowledgeable and comfortable with the information. The most effective curricula are comprehensive, covering the biological and social aspects of reproductive health. Adequately trained peer educators can be useful additions to adolescent and youth reproductive health education programs. Adolescents and young people should also have access to information through community clinics, satellite clinics, premarital counseling, family welfare centers, schools, peer education, local youth forums, mass media, clubs, and so forth.

Young people who are sexually active, including newly married couples, need access to condoms for disease protection and contraceptives for reducing unintended pregnancy. Providers are often the biggest barrier young people face in seeking access to services. Additional support is needed to increase providers' knowledge and catalyze attitudinal and behavior change with regard to adolescent and youth reproductive health. Service providers at all levels need to be trained in all aspects of adolescent and youth reproductive health. Female doctors need to be deployed for the provision of services to young females. Counseling services for male and female adolescents and youth are needed, and the services need to address the realities of the respective country conditions. For example, reference to marriage as "the" protective agent for HIV/AIDS should be modified. Marriage is not necessarily a protective factor; both men and women can bring HIV to a marriage either initially or later during the marriage. Each country should also examine the possibility of developing or strengthening links between various services, such as between clinics/pharmacies and youth activities, to achieve an integrated approach to adolescent and youth reproductive health.

Policies and programs that do exist are often limited because of lack of sustainability, limited scope, and short timeframes. While this can be an advantage because policymakers and stakeholders are forced to revisit and revise policies and programs with frequency and regularity, shorter timeframes can also be a liability to sustainability. Funding shortages plague most programs. In addition, few programs have wide enough scope to reach a great number of young people. For example, many programs are concentrated in urban areas or schools, neglecting rural or out-of-school adolescents and youth. Many are small-scale projects or pilot projects that work with small groups of young people for short periods of time.

Often, NGOs have more flexibility in providing information and services to young people. In addition, NGO staff tend to be more youth-friendly than government health care providers. Yet, NGOs often have small coverage areas in a country. Governments and donors should consider providing more support to NGOs to undertake adolescent and youth development work. Programs that have limited potential for scaling up should not be undertaken.

7. Develop and promote evidence-based programs

Programs should draw on existing information on what works to promote adolescent and youth reproductive health. For example, the evidence shows that sex education does not increase sexual activity and that young people want to know more about abstinence, safer sexual practices, and other aspects of reproductive health. This knowledge should be disseminated widely and applied in developing and implementing adolescent and youth reproductive health education programs, especially as the age of marriage rises and the risk of premarital sex increases.

Furthermore, taking a youth development approach can be more culturally appropriate than focusing solely on reproductive health. Also, addressing a range of issues facing adolescents and young people will likely be more acceptable to young people. Often, young people themselves are often more concerned about education and jobs than about reproductive health.

While there is some information to draw on, all of the country reports indicated that more research is necessary to inform these efforts. Countries differ in the type of research needed, but at a minimum, research should focus on various segments of society, including underserved, minority, and rural populations—those most at risk for poor reproductive health outcomes.

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